Impact of the Legal System on Medical Malpractice in Florida

by

Anthony Patete

Thesis

Presented to the Faculty of the Graduate School
of Everglades University-Sarasota Campus
in Partial Fulfillment of the Requirements for the Degree of

Master in Business Administration

Everglades University-Sarasota

February 2010

The thesis committee for Anthony Patete certifies that this is the approved version of the following thesis:

Impact of the Legal System
on Medical Malpractice in Florida

Approved by

Supervising Committee:

Chair: _____
Michael McCalister, PhD

Member: _____
James Fetterman, PhD

Member: _____
Susan Long, PhD

Impact of the Legal System on Medical Malpractice in Florida

by

Anthony Patete

Abstract

Master in Business Administration
Everglades University-Sarasota

February 2010

Supervisor: Michael McCalister, PhD

When adopting reforms geared at the medical malpractice crisis, the Florida Legislature made certain findings about the medical malpractice industry. Those findings are: a. Medical malpractice liability insurance premiums have increased and resulted in increased medical care cost for patients and unavailability of malpractice insurance for some physicians; b. The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase and loss payments to claimants; c. The average cost of medical negligence claims has escalated in the past decade and has interfered with quality medical services; d. the high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merits of claims, by providing for early arbitration claims, by reducing delay, attorney fees and by imposing reasonable imitations on damages; e. The recovery of 100% of economic losses constitute overcompensation because such recovery fails to recognize that such awards are not subject to taxes on economic damages. Fla. Stat. 766.201 (1) (2009).

Using statistical data from 2003 to date, the legislative findings were benchmarked. The conclusions are as follows: Since 2004, medical malpractice premiums have decreased a total of

30.7%; damages paid to plaintiffs totaled 74.14% of closed claim payments for 2008-09; loss adjusted expenses for the 2008-09 closed claims totaled 25.87% of closed payments for 2008, representing a decrease from previous years; there has been no substantial change in the number of days to resolve these type of claims; damages claims have remained steady; carriers of medical malpractice policies experienced consistent double-digit profitability, and the number of carriers willing to issue medical malpractice insurance policies in Florida has consistently increased; and patient safety has been ignored allowing reckless medical practitioners to continue to practice medicine.

Keywords: medical malpractice, tort reform, attorney's fees, damages cap, patient, physician, insurance company, jury verdict, hospital, patient safety, arbitration, mediation, sovereign immunity, Florida, adverse medical incident, premiums.

Vita

Anthony Patete, was born in Philadelphia, Pennsylvania, on June 18, 1961, the first-born son of Anthony Richard Patete and Mary Lou Patete. After graduating from Roman Catholic High School in 1979, he entered college and graduated from Temple University. He received the degree of Bachelor of Arts (Political Science) from Temple University in May 1983. Immediately upon graduation, he matriculated at Whittier University School of Law and graduated in May 1986 with a Juris Doctorate. Currently, he is the Department Chair of Legal Studies at Keiser University-Sarasota Campus.

Permanent Address: 2447 Sonoma Drive
Nokomis, FL 34275

This thesis was typed by the author.

Table of Contents

List of Tables

List of Figures

Chapter One: Introduction

Background of Problem/Area of Study

The area of study for this thesis will be the impact of the legal system on medical malpractice in the state of Florida. Potentially, this study impacts three important groups, medical malpractice insurers, doctors, and attorneys/patient advocates. The issue is polarizing and has created great debate. Insurers and doctors blame trial attorneys for filing frivolous lawsuits, for choosing out-of-control juries and for causing a spike in insurance premiums. Physicians and consumer groups accuse insurance companies of price gouging and greed. Trial attorneys point to an out-of-control rate of medical errors, the need to deter malpractice, and the provision of compensation to injured patients. Doctors blame attorneys and insurance companies for the increase in premiums and an 80 percent increase in healthcare costs.

Conflicts with the insurance companies, the medical profession, and the trial attorneys are acrimonious and lead to debate for improving patient safety. This, coupled with the three decades of debate over rising malpractice premiums, leads to a complex problem for which none of these groups is appropriately equipped or willing to resolve. Efforts have been made at both the state and federal level to resolve this issue; however, after three decades the problem — or crisis — still exists.

The data available to address the medical malpractice insurance crisis is inconclusive. Government and academic literature is replete with opinions and justifications on the cause of the crisis and how to correct the problem. An example of inconclusive data is the cause of rapidly rising medical malpractice insurance premiums. Many factors are attributable to this cause and will be addressed in detail. Of the many factors, those that are often cited are an increase in the number and amount of claims, the severity of the malpractice claims, the loss of

income generated on insurance company investments and the tort reform in place at the state level. Doctors often do not want to disclose or report medical malpractice errors for fear that the results may impact them personally, professionally, economically and monetarily. Tort reform as a remedy for a three-decade malpractice crisis is not supported by the data, and tort reform is often cited as not addressing the issue of patient safety. Medical errors are serious and costly, killing between 44,000 to 98,000 people annually in the United States (Appendix E). The total national cost of medical errors is estimated to be between $17 and $29 billion annually (Marchev, page 2, 2002). Finally, the great majority of patients injured by medical negligence do not file a medical malpractice claim and of those who do a file a claim, only one-third receive compensation for their injuries (Marchev, 2002).

The challenge is to address all of the interests of the three groups. Doctors want lower premiums, insurance companies require larger profits, and trial attorneys and patient advocates require patient safety. A fourth group in the fight is the state. States want quality medical care and hospital services to be accessible in their jurisdiction and to be available for their citizens. States also want reduced medical errors and in the event of medical malfeasance, fair compensation. As can be seen by the identification of the four parties, the challenge is of great importance and one which often requires the interaction and cooperation of all parties to find a viable solution to a complicated problem.

According to the Congressional Budget Office (CBO) in an article published January 2004, rising insurance premiums involve issues of time, insurers' income from premiums between the time they are collected and the time the payment is made, the profits to companies on setting aside funds for claims (reserves), and overall profit an insurance company earned in the short run on its investments (CBO, 2004). Of particular concern to insurance companies, and

one that is often made popular in the news media, is the payment of claims and the amount of those claims that are made to patients as a result of medical errors. As was previously mentioned, the amount of claims and the value of those claims is inconsistent and various, however according to the CBO, the national average amount of a claim paid in 1986 was $95,000 and rose to $320,000 in 2000. This increase represented an annual growth rate of almost 8% (CBO, 2004). One-third of the cost of a malpractice claim for insurers is legal costs for the policyholder, underwriting and administrative expenses (CBO, 2004). Malpractice costs amounted to an estimated $24 billion in 2002 but that figure represents less than 2% of overall health care spending (CBO, 2004 and Seninger & Herling, 2006). Assuming a reduction of 25% in medical malpractice costs, the effect on lower healthcare costs would amount to only 0.4% (CBO, 2004).

But according to the General Accounting Office (GAO) (GAO, 2003a), multiple factors contribute to increased medical malpractice premiums. Some of the cost factors are attributable to medical malpractice insurers' losses on medical malpractice claims, their experiences of a decrease in new investment income, and their vigorous competition for the medical malpractice business. In the end, the insurers want greater profits and predictability (GAO, 2003a).

Of particular concern in the medical malpractice insurance field are the implications of rising premiums on access to health care. In other words, does a rise in medical malpractice premiums adversely impact access to the health care system by the patient? In a report authored by the GAO, the data available to make a definitive statement on this issue was not available (GAO, 2003b). Although premium rates for medical malpractice did increase, especially in some specialties such as general surgery, internal medicine, and obstetrics/gynecology, these fears, often publicized by the media and implemented by the individual physician, resulted in the practice of defensive medicine (GAO, 2003b). Qualitative results are indicative of what is

reported in the news media, however the quantitative data available suggests that access to health care as a result of rising premiums cannot be determined (GAO, 2003b). For example, there are some reports of physicians relocating to other states, retiring, and closing practices; however, the quantitative data suggests an increase in the issuance of medical licenses (Appendix H). In addition, the impact to the physicians' practice of defensive medicine in certain clinical conditions is not and has not been a reliable measurement; when it has been measured, the limited available data is insufficient to form a statistically significant conclusion (GAO, 2003b). Rather, the rise in premiums was related to the four factors mentioned earlier.

Statement of the Problem

For more than three decades, the health insurance industry and health care providers in general, have been complaining and, indeed, declared a medical malpractice crisis. Doctors specifically have threatened to retire, move out of urban and rural areas, change the focus of their practice, or to become employees of hospitals. The net effect of such a move would be to restrict an individual's access to health care. Insurance companies have complained that although they are in the risk business, they have not made sufficient profits in the medical malpractice arena. Because they are "for profit," publicly traded or otherwise, they are responsible for profits and dividends to their shareholders. Trial attorneys and patient advocates have complained that an increase in medical errors by physicians and health care providers has caused an increase in claims filed with malpractice carriers.

It is intended that this study will analyze the impact of the legal system on medical malpractice and premiums in Florida. This will include a review of constitutional amendments adopted by the electorate to reduce medical malpractice premiums for Florida doctors, the statutes passed to adopt tort reform, capping limits for a recovery based on non-economic

damages, tort reform providing for alternative dispute resolution, case law adopting private tort reform between doctors and patients, and the financial impact all of this has on healthcare overall. Also addressed will be the sovereign immunity statute which limits the amount of recovery against state-owned hospitals. The hypothesis is that malpractice claims do not have a dramatic impact on an increase in physician premiums.

The medical malpractice crisis is not unique to Florida but is perceived to be a nationwide problem; however, the focus of this research will be in the state of Florida. When adopting reforms geared at the medical malpractice crisis, the Florida Legislature made 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 unavailability of malpractice insurance for some physicians;

b. The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase and lost payments to claimants caused by tremendous increases in the amount of paid claims;

c. The average cost of medical negligence claims has escalated in the past decade to the point where it has become imperative to control costs which are in the interest of the public needs for quality medical services;

d. The high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination on the merits of claims; by providing for early arbitration of claims; by reducing delay, attorney fees and 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% of economic losses constitute an over compensation because such recovery fails to recognize that awards are not subject to taxes on economic damages. Fla. Stat. 766.201 (1) (2009).

Once the Florida Legislature identified the problem with medical malpractice liability insurance premiums, its members set out to devise a plan to resolve the increase in premiums. The plan to resolve the problem involves pre-suit investigation, arbitration, mediation, limits on non-economic damages, the availability of medical records for pre-suit investigation, penalties for not participating in non-binding arbitration, a prompt payment of arbitration awards with interests, and adoption of the collateral source rule, penalties for three medical malpractice claims being filed against a physician resulting in a loss of the medical license, and public reporting of medical malpractice claims. See generally Chapter 766 Florida Statutes. Nowhere in the statutes or the literature is the filing of frivolous lawsuits identified as a problem or cause of increased premiums.

The focus of this study will be to determine if the actions of the Legislature has had a substantial or dramatic impact on a reduction in physician premiums. Statistical evidence will be examined and is available from the Florida Office of Insurance Regulation and other government agencies and departments.

Definition of Terms

Advanced notice of claim. The advance notice of claim provisions contained in the state statutes require claimants to give medical malpractice defendants notice of the claim, for example, 90 days prior to the filing of the lawsuit. Once the claim is presented, an investigation begins by insurers and attorneys. The investigation is required to determine whether not the

claim is meritorious and allow the parties to settle the claim in an expedient and efficient manner (GAO, 2003a); see also Fla. Stat. 766.106 (2) and 766.203(1) (2009).

Arbitration. Arbitration is a way of addressing certain civil disputes without going through the expense of a civil judge and a jury trial. In other words, medical malpractice claims can be, and often are, diverted out of the litigation process to the arbitration process. The arbitration process involves the appointment of three independent and unbiased individuals to hear evidence and to render a decision (GAO, 2003a); see also Fla. Stat. 682.01, et seq (2009) and 44.1011(1) (2009).

Attorney contingency fees. Plaintiff attorneys are paid on a contingency fee basis. The contingency fee is one in which the lawyer, instead of charging an hourly fee for services, agrees to accept a percentage of the recovery or verdict. Some laws limit attorney contingency fees. Provisions that decrease attorneys' financial incentives to accept cases could decrease the number of attorneys willing to accept such personal injury cases (GAO, 2003a). Attorney contingency fees are approved as a social policy to grant access to the court system for those claimants who could not otherwise be able to afford an attorney's hourly fee. Fl. R. Prof. Cond. 4-1.5 (f) (1) (2009).

Bad faith claims. A statutory provision often enacted by the state legislature which causes insurers to be liable for amounts beyond an insurance policy contractual limits if the policyholder requests the insurer to settle with the plaintiff for the amount equal to or less than the policy limit. If the insurer does not settle the claim and then takes the case to trial, loses, and a judgment is entered in an amount in excess of the policy limits, then the insurer is liable for the amounts beyond the insurance policy limits (GAO, 2003a); see also Fla. Stat. 766.1185 (2009).

Case law. See common law, *infra*.

Catastrophic injury. Catastrophic injury means a permanent impairment constituted by: 1) Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk; 2) Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage; 3) Severe brain or closed-head injury as evidenced by: a) Severe sensory or motor disturbances; b) Severe communication disturbances; c) Severe complex integrated disturbances of cerebral function; d) Severe episodic neurological disorders; or e) Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a-d; 4) Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands; 5) Blindness, defined as a complete and total loss of vision; or 6) Loss of reproductive organs which results in an inability to procreate. Fla. Stat. 766.118 (1) (a) (2009).

Claimant. Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence. Fla. Stat. 766.202 (1) (2009).

Clear and convincing. "It is evidence indicating that the thing to be proved is highly probable or reasonably certain. This is a greater burden than preponderance of the evidence, the standard applied in most civil trials, but less than evidence beyond a reasonable doubt," the burden of proof in a criminal case. Black's Law Dictionary (8^{th} ed., 2004).

Closed Claim. Closed claims are those claims closed in the year reported. A database is maintained (Appendix A) by the Florida Office of Insurance Regulation that collects data on medical malpractice claims. The actual occurrence dates of the incidents are often several years prior to the date of closure; as a result, closed claims may not be a representative of trends and

conditions unless other data is taken into consideration (Florida Office of Insurance Regulation, 2009 Annual Report). See also Appendix F for professional liability claims reporting.

Collateral source payments. At common law, or without any legislative intervention, the plaintiff would be able to cover all damages sustained from the liable defendant, even if the plaintiffs were going to receive money from other sources, called "collateral sources," like a health insurance policy or Social Security. Some states have modified this common law rule with statutes to allow defendants to show that the claimant is going to receive funds from collateral sources that will compensate the claimant for damages he or she is attempting to collect from the defendant (GAO, 2003a); see also Fla. Stat. 766.202(2) (2009).

Common law. The common law is that body of law which originated in England and was adopted in the United States of America. It is a body of principles which derive their authority from usages and customs and from judgments and decrees offering and enforcing usages and customs and which are applied and modified, originally from the sovereign and later from the courts. Jurisprudence applied and modified by the courts is the modern-day version of common law and is also known as case law. Black's Law Dictionary (Revised 4th ed., 1968).

Contingency fee. "A fee may be contingent on the outcome of the matter for which the service is rendered, except in a matter in which a contingent fee is prohibited … by law. A contingent-fee agreement shall be in writing and shall state the method by which the fee is to be determined, including the percentage or percentages that shall accrue to the lawyer in the event of settlement, trial, or appeal, litigation and other expenses to be deducted from the recovery, and whether such expenses are to be deducted before or after the contingent fee is calculated. Upon conclusion of a contingent-fee matter, the lawyer shall provide the client with a written statement stating the outcome of the matter and, if there is a recovery, showing the remittance to the client

and the method of its determination." Fl. R. Prof. Cond. 4-1.5 (f) (1) (2009). A contingency fee is a fee that is earned by an attorney representing claimants that is based on a percentage of the amount received by judgment, settlement, or otherwise. Fl. R. Prof. Cond. 4-1.5 (2009). For example 25% of $100,000 would result in an attorney's fee of $25,000.

Defendant. The person or company defending or denying a claim or allegation lodged by a plaintiff in a civil suit or the government in a criminal case. Black's Law Dictionary (Revised 4th ed., 1968).

Defensive medicine. When physicians order tests, interventions or referrals, not because they are medically justified, but rather to protect themselves from future litigation (Rutsohn, 2007).

Direct premiums earned or premium. Money paid by a policyholder to an insurance carrier for coverage as specified. This is a contractual relationship (Florida Office of Insurance Regulation, 2009 Annual Report). "Premium" means the consideration paid or to be paid to an insurer for the issuance and delivery of any binder or policy of insurance. Fla. Stat. 627.041(2) (2009).

Economic damages. Economic damages generally consist of past and future monetary damages, such as lost wages or medical expenses (GAO, 2003a); see also Fla. Stat. 766.202 (3) and 768.81 (1) (2009).

Expert certification. Many states require that medical experts certify, in one way or another, the medical malpractice claim. These statutes are designed, in part, to keep cases without merit, also known as frivolous cases, out of the civil court system. Expert certification requirements also have the potential to get many relevant facts out in the open early in the claims process, so that settlement discussions are fruitful, and it becomes unnecessary to take as many

cases to trial. The intent is to decrease the claim handling costs of the case (GAO, 2003a); see also Fla. Stat. 766.102 (2009).

"**Going naked."** *Going naked* refers to the practice of professionals operating in their profession without the benefit of insurance of any means of compensating injured parties or patients.

Healthcare provider. Health care provider means a birth center, an ambulatory surgery center, a licensed hospital, a physician or physician assistant licensed under Florida Statutes chapter 458, chiropractic physician, podiatric physician, a registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner, a midwife, a health maintenance organization, health care professional association and its employees or a corporate medical group and its employees, if any other medical facility the primary purpose of which is to deliver medical and medical diagnostic services, a dentist or dental hygienist, a free clinic, or any other healthcare professional, practitioner, provider. Fla. Stat. 766.1115(3)(d) and 766.202(4) (2009).

Insurance. "Insurance" is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies. Fla. Stat. 624.02 (2009).

Insurer. "Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity. Fla. Stat. 624.03 (2009).

Investigation. 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 the expert. Fla. Stat. 766.202 (5) (2009).

Joint and several liability. Joint and several liability is the rule where the plaintiff can collect the entire judgment from any liable defendant, regardless of the degree of fault of the defendant's actions. Some states make each defendant responsible for only the amount of damage he or she caused the plaintiffs. Other states have eliminated joint and several liability only for non-economic damages. Some states have eliminated joint and several liability for defendants responsible for less than a specified percentage of the plaintiff's harm; for example, if the defendant is less than 50% responsible, that defendant might need to pay only for that percentage of the plaintiff's damages (GAO, 2003a); see also Fla. Stat. 766.112, 768.31 and 768.81 (2009).

Limit on damages. Also known as a damages cap, are those monetary damages to be awarded in medical malpractice cases and are usually kept at certain dollar amounts and are broken down into two distinct categories: economic and non-economic damages; however, these are not the only damages available to injured patients. Damages can also include punitive damages (GAO, 2003a); see also Fla. Stat. 766.118 (2009).

Mediation. This is a self-determination process whereby two parties voluntarily agree to sit down with a neutral third party in an attempt to informally resolve any disputes they may have. The process is often non-binding; and when a settlement is reached, it is reduced to a written settlement agreement. The process is often defined by state statute and may include provisions of confidentiality. Fla. Stat. 44.1011, et seq.(2009).

Medical expert. Medical expert means a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in Fla. Stat. 766.102. Fla. Stat. 766.202(6) (2009).

Medical malpractice. Medical malpractice is the equivalent of professional negligence. A cause of action involving medical malpractice involves a health care provider; the patient claims that the licensed professional breached the general principles of negligence (GAO, 2003b). A claim for a medical negligence means a claim arising out of the rendering of, or the failure to render, medical care or services. Fla Stat. 766.106 (1) (a) (2009).

Medical negligence. Medical negligence means medical malpractice, whether grounded in tort or in contract. Fla. Stat. 766.202(7) (2009).

Negligence. Negligence is a cause of action whereby the claimant must prove four separate elements to receive a damages award. The first element is the application or imposition of a standard of care (duty of care) that a licensed professional is held to when acting (Bajtelsmit, 2008). The second element is that the actor breached this or her duty of care. Next, there must be a causal relationship that is foreseeable between the breach of the duty of care of the actor and the harm or damages caused. Last, there must be a harm that is caused by a breach of the duty of care (*Cevallos v. Rideout*, 2009).

Non-economic damages. Non-economic damages generally consist of past and future damages, are subjective, and include pain, suffering, marital loss and anguish (GAO, 2003a); see also Fla. Stat. 766.202(8) (2009) which defines "Non-economic damages" as non-financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non-financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Periodic payment of damages. The defendants traditionally pay damages in a lump sum, even if they are being collected for a future time period such as future medical care or future

wage losses. Some states, however, allow or require certain damages to be paid over time, such as over the life of the injured party for a disability, either through the purchase of an annuity or through self-funding by institutional defendants (GAO, 2003a); see also Fla. Stat. 766.202 (9) (2009).

Plaintiff. A person or company who complains of another's actions or files a civil suit for damages against a defendant. Black's Law Dictionary (Revised 4th ed., 1968).

Practitioner. Practitioner in Florida means any person licensed under the Florida statutes including chapter 458 (medical doctor), chapter 459 (osteopathic doctor), chapter 460 (chiropractor), chapter 461 (podiatric doctor), chapter 462 (naturopathy), chapter 463 (optometry), chapter 466 (dentistry), chapter 467 (midwife), or chapter 486 (physical therapy) or certified under Fla. Stat. 464.012 (nursing). "Practitioner" also means any association, corporation, firm, partnership or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on non-economic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner. Fla. Stat. 766.1116 (2009).

Practitioner Profile. A profile is self-reported information about the practitioner and is designed to help choose or remain with a practitioner. The profile is mandated by law. Fla. Stat. 456.041, 456.039, and 456.0391 (2009). It includes information such as education and training, specialty, financial responsibility, final disciplinary action and criminal offenses (Appendices A and B).

Preponderance of evidence. The greater weight of evidence which is more credible and convincing to a mind. Black's Law Dictionary (Revised 4th ed., 1968).

Return on surplus. Net income as a percentage of surplus held by insurance companies. This ratio is often a substitute for return on equity, a common measure of profitability in other industries (Florida Office of Insurance Regulation, 2009 Annual Report).

Statutes. Enacted law that comes from the legislative branch of the government. Black's Law Dictionary (Revised 4th ed., 1968).

Standard of care. The professional standard of care for a given health care provider is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. Fla. Stat. 766.102(1) (2009).

Statute of limitations. The period of time within which the plaintiff must file or present a claim for damages or negligence. Some states have shortened their statute of limitations on medical malpractice claims. This decrease forestalls the number of cases filed by claimants (GAO, 2003a); see also Fla. Stat. 95.011 (2009). Generally, the time within which to bring a medical malpractice claim is 2 years. The action must be "commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence …" Fla. Stat. 95.11 (4)(b) (2009).

Tort. A tort is a wrongful act of a civil nature for which relief may be obtained in the form of monetary damages. Fault is determined. The legal system then compensates those who have been wronged with monetary damages (Marchev, page 9, 2002).

Tort reform. Tort reform is an attempt to control the frequency and severity of claims. Common provisions of tort reform include measures that make it more difficult for injured patients to have access to the court system, to win the lawsuit, or to determine the amount of a successful award or settlement (Marchev, page 9, 2002).

Professional Significance of Subject

This study will analyze the impact of the legal system on medical malpractice and medical malpractice premiums in Florida. This will include constitutional amendments adopted by the electorate to reduce medical malpractice premiums for Florida doctors, the statutes passed to adopt tort reform, capping damage limits for recovery based on economic damages, tort reform providing for alternative dispute resolution, case law adopting private court tort between doctors and patients, and the financial impact of this on health care in general. Also of interest is the impact of sovereign immunity laws, which limit the amount of recovery a claimant can receive against the state, its agencies and its employees such as state-owned hospitals. The intent is to prove that malpractice claims do not have a substantial or dramatic impact on the increase in physician premiums and an overall increase in the cost of health care.

Assumptions and Limitations

Although many of the academic sources are of a national basis, the scope of this study is limited to that of Florida. Some research includes Florida as a subject state for purposes of observations; however, where applicable, specific generalizations involving Florida and other states will be used to predict outcomes.

Delimitations of the Study

The scope of this study is limited to Florida. The statutes of Florida are specific and outline tort reform and legislative findings. From a quantitative view, the data is limited to that

made available in the public records. Data from private companies and corporations, such as insurance companies and the Florida Medical Association, was not available.

As this topic addresses academic, legal and medical issues, an attempt has been made to be intellectually honest in a fair and impartial presentation of the data and in reaching conclusions. Rule 1.1 of the American Bar Association's Model Rules of Professional Conduct requires an ethical duty to possess and exercise a degree of knowledge and skill ordinarily possessed by others in the profession. One aspect of competency requires that a legal problem be researched with intellectual honesty. Intellectual honesty means to research and analyze a problem or subject objectively. A particular outcome is not intended or inferred, rather, the purpose is to review and present the law and facts for the reader to draw his or her own conclusions; a conclusion will be made but it is intended to be objective.

Ethics in research

Ethical decision making in research is left to an individual's moral value system as no universal adoption of a code of ethical conduct can be applied to researchers due to their diverse and varied backgrounds. Researchers are faced with ethical challenges from the very beginning of their research and throughout the research due to economical and financial pressures. Several solutions include providing a universal code of conduct, mandating disclosure of all conflict of interests, and disclosing any appearance of unethical conduct in the research. Several attempts have been made to codify ethics in research. The areas of concern involve 1) relations with and responsibilities towards research participants; 2) relations with and responsibilities towards sponsors, funders and employers; 3) relations with and responsibilities toward colleagues and the discipline; 4) relations with own and host governments; and 5) responsibilities to the wider society. The author has no relationship with research participants, sponsors, employers or

government and is writing this thesis in partial fulfillment of an academic degree. It should be noted that the author did at one time practice law as a trial lawyer and represented plaintiffs but never filed a medical malpractice claim nor defended an insurance company. The author's primary focus during the practice of law was criminal defense and a general practice.

Ethics involves the norms and standards of behavior that lead to moral choices. In the professions, such as medicine and law, ethics constitute the minimum standards of professional conduct. In research, there are no universal standards for ethical research. This is due primarily to the vastness of the field of research and diverse populations engaging in research. Therefore, results and the ethics of research are left to the individual researcher. This, is dependent on the variables of background, gender and religion of the individual to adhere to ethical standards. The individual is, in turn, affected by economical and financial pressures that often comprise the researcher's ethics. A suggested way of adhering to ethics in research is to make such principles contractual and to disclose them in the research as one does with methodology, validity and reliability.

As in all aspects of business or a profession, researchers should exhibit ethical behavior. "Ethics are norms or standards of behavior that guide moral choices about our behavior and our relationships with others. The goal of ethics in research is to ensure that no one is harmed or suffers adverse consequences from research activities (Cooper, 2008, p. 34)." Despite this tenet, ethical violations are pervasive. Areas of concern are disclosure of confidential information, misrepresenting results, deception, invoicing irregularities and avoiding legal liability (Cooper, 2008). Therefore, research, especially when the data is used to make important decisions and is relied on by these same decision makers, should be cloaked in ethics. In fact, when a research report spells out its methodology, reliability and validity, the report should also disclose what

ethical efforts were taken and how any were avoided. It should also disclose any potential conflicts of interests or apparent improprieties.

Purpose of Ethics. To be effective and maintain the integrity of the research, ethical considerations should occur at three levels: personal integrity from the researcher, the project manager and the research sponsor (Cooper, 2008). Because of the potential for unreliable results or harm to others or business, the current debate in both the literature and in research is whether or not to codify ethical standards or to continue relying on an individual's personal sense of morality (Cooper, 2008).

Professional Ethics. Since ethics is a norm or standard that is used in decision making to make moral or professionally correct courses of action, many professions, including those not required to adopt or adhere to ethical guidelines have adopted a code of ethics (Allen, 1993). Even though business or non-professional organizations have adopted codes of conduct, evidence of compliance or effectiveness in preventing unethical behavior is only partially available and no evidence is complete that it is prophylactic in nature (Allen & Davis, 1993). To the contrary, evidence exists that ethical codes create a value system of "counternorms, which may be viewed as inappropriate" (Allen & Davis, 1993, para. 8). Another possible explanation for limited success of ethical codes in research is a lack of accepted procedures for certification of business research (Allen & Davis , 1993). Professions such as medicine or law have highly developed ethical standards and laws to protect against "incompetent practitioners, quacks, and charlatans" (Allen & Davis, 1993, para. 10). Whereas, researchers come from diverse backgrounds and disciplines (Allen & Davis , 1993), a uniform system of ethics may appear inequitable and even be unenforceable. The dilemma is that adherence to ethical codes will serve to legitimize research, yet they are not universal and remain unenforceable. Research

professionals and those relying on the data, therefore, are left to the individual values and personal integrity of the researcher, the project manager and the research sponsor.

Individual Values. Assuming arguendo that a universal code of conduct existed for researchers, the code itself is a guide upon which the individual builds personal integrity (Allen & Davis, 1993). Likewise, the code of conduct for professionals is intended as a guide and not as commandments. In no way is a code of conduct omnipotent. Also, how one practices ethical or moral behavior depends in large part on the individual and the value system the researcher brings to the project. One way to combat this situation could be to contractually impose a set of standards and adopt them into the research methodology; moreover, disclosure of ethical violations or potential for conflicts of interest should be prominent and not hidden behind the small print of lawyers.

As the author is law trained, the appropriate ethical standard is that of the legal profession. Even though an argument can be made that because this thesis is academic in nature, no ethical or research code of conduct should apply that would detract from the significance of the study and be counterproductive. The appropriate ethical guidelines for the legal profession in Florida are contained in the Rules of Professional Conduct. These rules are promulgated by the Florida Bar Association and ratified by the Supreme Court. "The purpose of The Florida Bar shall be to inculcate in its members the principles of duty and service to the public, to improve the administration of justice, and to advance the science of jurisprudence." Fl. R. Prof. Cond. 1-2 (2009). Additionally, a lawyer shall not "assert or controvert an issue … unless there is a basis in law and fact for doing so that is not frivolous, which includes a good faith argument for an extension, modification, or reversal of existing law." Fl. R. Prof. Cond. 4-3.1 (2009); See also, Fl. R. Prof. Cond. 4-3.3 and 4-3.4 (2009) regarding candor to a tribunal and an opposing party.

The research is being conducted without personal bias, and without a conflict of interest. Moreover, the author is self-imposing the Rules of Professional Conduct to avoid any allegation of bias or conflict of interest. Although the topic is of interest it is still one of an academic nature and is being conducted to fulfill an academic requirement, to expand academia by allowing it to be peer reviewed and to advance the goals of the medical and legal professions.

Participants and Stakeholders

Providers: Physicians and Hospitals. Physicians, also known as practitioners, and hospitals have an interest in tort reform. Their similar interests are costs of medical malpractice premiums and profits. They advocate damages caps on claims as a means of controlling administrative costs. These individuals are represented by numerous groups including the American Medical Association, the Florida Medical Association, and the Florida Hospital Association. Many practice defensive medicine for fear of litigation and charge that these fears limit access to healthcare. Thus, they order more diagnostic tests and argue that such practices increase healthcare costs, however, the increase healthcare costs resulting from increased medical malpractice premiums and limited access to healthcare is unclear and has not been reliably measured. Hospitals are assuming physician liability costs to prevent access to healthcare and reduced perceived pressure from increased malpractice pressures (GAO, 2003b). As consumers, they are concerned with rising premiums, affordability and availability of insurance (Neale, Eastman & Drake 2009).

Attorneys and Patients. This group of individuals is concerned with preventing medical errors, awarding fair compensation for injuries if one is harmed during a medical procedure and guaranteeing the constitutional right to a jury trial. Individuals and patients are represented by attorneys. As a group, patients do not identify with one group; therefore, the legal profession,

specifically the trial attorneys, represents this class of people and does so based upon a contingency-fee basis. The trial attorneys are represented by their own group in Florida, the Florida Academy of Trial attorneys and the Florida Bar Association (Vidmar, MacKillop & Lee, 2006 and GAO , 2003b). The trial attorneys state that rising premiums are a result of decreased investment income, mismanagement of the business and claims predicted on past performance and greed of the lawyers (Neale et al., 2009).

Payors. The payors referenced are insurance companies and HMOs who provide health insurance coverage. As insurance companies, they are concerned with the increase in the cost of healthcare, the cost of procedures and the number and frequency of procedures due to the defensive practice of medicine (GAO, 2003b).

Insurance Companies. This group is self-represented and often regulated by a government agency. Insurers cite the reasons for increased premiums as being increases in claim frequency, severity, loss of competition and uncertainty of jury awards (Neale et al., 2009). As insurers, their concerns are to return a profit and the critical point is when investment income and income from premiums is insufficient to report a profit (Neale et al., 2009). These concerns have lead to insufficient loss reserves, affecting profitability and, ultimately translating into availability problems and rising premiums for physicians (Neale et al., 2009). In Florida, insurers are regulated through the Department of Financial Services and the Florida Office of Insurance Regulation. See generally, Florida Statutes Title XXXVII (2009). Multiple factors have contributed to increases in malpractice premiums. First, insurer losses have increased, which include payments to plaintiffs and costs of administration of claims, including the payment of the insureds' defense costs and attorney fees. The average payment of losses increased by 18.7 percent from 1998 to 2001. Because insurers base their premium rates on

expected costs, their anticipated losses are primary in determining premium rates. Second, investment income has decreased; therefore, costs and dividends paid to shareholders must be covered by increasing premiums. Third, many malpractice carriers have left the market place due no profitability in the sale of malpractice policies (GAO, 2003a).

Chapter Two: Literature Review

Overview of Literature Review and Selection

Since the focus of this study is limited to medicine in the state of Florida, it is appropriate to begin with a review of Florida's laws. The cornerstone of a state's laws begins with the constitution and Florida is no different. In 2004 the citizens of the state of Florida passed Article I, section 26 of the Florida Constitution. This article addresses a claimant's right to fair compensation when presenting a medical liability claim. This article dictates claimants are to receive more of the damages awarded in a medical malpractice claim and restricts the amount of attorneys' fees; the constitutional amendment was adopted in 2004.

Consistent with Article I, section 26 is Article X, section 25 of the Florida Constitution. This article was also adopted by the electorate in 2004. This amendment guarantees a patient's right to know about adverse medical incidents. Essentially, in Florida, a patient has a right to have access to any records made or received by a healthcare facility or provider relating to any adverse medical incident. The amendment goes further and defines what constitutes an adverse medical incident. The phrase is defined as including medical negligence, and any other act, neglect, or fault of a healthcare facility or health care provider that caused an injury to or death of a patient. Such adverse medical incidents are required to be reported to the state and reviewed by a healthcare facility or provider, peer review committee, risk management, quality assurance, professional services or credentials committee or any representative of a similar committee. Florida Constitution, Article X, section 25.

Again in 2004, an additional constitutional amendment was passed. This section is commonly known as "Amendment 8," or the "three strikes law," but is formally known as Florida Constitution, Article X, section 26. This article prohibits the issuance of a medical

license after repeated medical malpractice claims. This amendment commands that a medical doctor who has been found to have committed three or more incidents of medical malpractice shall not continue to be licensed in the state of Florida or to provide health care services as a medical doctor. The article goes on to define medical malpractice and the phrase “found to have committed” The finding of medical malpractice has to be by a final judgment of a court of law, agency board or arbitration and does not include a settlement for a medical malpractice claim.

Consistent with the dictates of reforming medical malpractice and the medical malpractice insurance crisis, the Florida Legislature also enacted Chapter 766 of the Florida statutes. Chapter 766 is wide reaching and definitive.

As defined by the Florida Legislature, medical malpractice liability insurance premiums have increased dramatically, resulting in increased medical care costs for most patients, and has prevented access to health care by the citizens of the state of Florida. Fla. Stat. 766.201 (2009). Chapter 766 establishes medical review committees for the evaluation and improvement of the quality of health care rendered by providers of health services and to determine whether or not health services were professionally indicated and in compliance with the applicable standards of care. Fla. Stat. 766.101 (1)(l) (2009). This chapter goes on to outline specific tort reform aimed at lowering medical malpractice premiums and providing quality health care to Florida’s citizenry. Types of tort reform include but are not limited to a damages cap (Fla. Stat. 766.118), credentialing of expert witnesses (Fla. Stat. 766.102), an abolishment of punitive damages (Fla. Stat. 766.104), advanced notice of filing a claim (Fla. Stat. 766.106), court-ordered arbitrations (Fla. Stat. 766.107), mediation (Fla. Stat. 766.108), sovereign immunity for certain government contractors who are also health care providers, (Fla. Stat. 766.1115), comparative fault among

tortfeasors (Fla. Stat. 766.112), a determination and limitation of non-economic damages (Fla. Stat. 766.118) and the payment of settlements and awards after arbitration (Fla. Stat. 766.211).

Review of Theoretical and Empirical Literature

In a study using data from the National Association of Insurance Commissioners (NAIC) for a period of time between 1984-2003 considering the effects of tort reform on malpractice premiums, it was determined that over the long-run, during a period of time consisting of 5, 7 and 10 years, reforms influenced premiums. Reforms were not the only items that influenced premiums; other influences on premiums included investment income and the severity of claims, not the number of claims (Born, Viscusi & Baker, 2009). Measuring the effects of reforms focused on the reported losses versus loss development. *Reported losses* include losses paid on claims and the administration of claims, and an estimate of losses reported but not yet paid and losses incurred but not yet reported. *Loss development* reflects a business motivation including predicting losses and calculating the number and value of losses. This calculation is based upon past experience and projections. These calculations are influenced by inflation rates, monetary policy and underwriting concerns. Often these loss developments are misreported (Born et al., 2009). These patterns of loss for loss development vary among insurers. Tort reforms, especially damages caps, impact those claims in the top 10% of all claims, but do not impact the other 90% of claims (Born et al., 2009).

Health care providers and tort reformers “claim that the medical malpractice litigation system is rife with behaviors that are irrational, unpredictable and counterproductive” (Hyman & Silver, p. 1085, 2006). These same providers complain about civil juries, skyrocketing verdicts, patients who are paid where no negligent act was performed (frivolous lawsuits), greedy lawyers, random compensation to patients, and a broken tort system (Hyman & Silver, 2006). “Many of

the preceding claims are facially implausible" (Hyman & Silver, p.1085, 2006). Professor Hyman supports this statement of implausibility with empirical data. For example, of every 100 Americans injured in an auto accident, ten make a claim and two file suit.

In the medical malpractice field, the estimated number of medical injuries exceeds 1 million per year; roughly 85,000 lawsuits are filed. The conclusion is that injured patients rarely sue (Hyman & Silver, 2006). Supporting this conclusion is a Harvard Medical Practice Study. That study concluded that only 2% of those negligently injured filed a claim for damages. Also, in Florida, from 1996 to 1999, hospitals reported 19,885 incidents of medical negligence; 3,177 of those made a medical malpractice claim. Similarly, injuries to babies during birth, a potential 220 incidents were reported and no claims filed (Hyman & Silver, 2006). The patient rationale for a failure to file a claim is based on six factors: 1) medical errors are hard to spot; 2) most medical errors inflict harm that is small or temporary; 3) health insurance generally covers most of the treatment costs associated with negligent injury; 4) the malpractice system is expensive, slow and burdensome; 5) the malpractice system is stingy; and 6) when dealing with defective care, the alternatives are to file a disciplinary complaint with a government regulatory agency (Hyman & Silver, 2006). What does prompt the filing of claims is the severity of the injury, out-of-pocket expenses and patient irritation with the health care provider (Hyman & Silver, 2006).

Providers, justifying tort reform, claim that frivolous malpractice suits are filed and paid. Academicians and federal judges agree that if frivolous claims are filed, they are a minor problem and do not negatively impact the tort system (Hyman & Silver, 2006). Additionally, attorneys screen many malpractice cases because they are expensive and laborious. These types of attorneys accept meritorious claims. Empirically, 97% of malpractice claims are rejected by attorneys; modest cases, those with expected damages less than $50,000 are routinely rejected

and this does not account for cases that are accepted and then dropped after research and review (Hyman & Silver, 2006). Due to the high cost of medical malpractice litigation and the fact that the attorneys are on a contingency-fee agreement, the cases that are pursued tend to be the most severe and the ones with the highest potential damages recovery (Hyman & Silver, 2006).

Regarding the value of claims and remuneration for plaintiffs, the data reveals that plaintiffs tend to be under-compensated, especially in the most severe of cases including death and injuries to babies. On average, plaintiffs recovered about half of their losses, with the exception of those who went to trial who recovered 22% more of their economic losses (Hyman & Silver, 2006).

Summary of Previous Research on Subject

One of the commonly proposed reforms in medical malpractice claims is the cap on non-economic damages or pain and suffering verdicts. Damages caps are proffered by practitioners and insurance companies issuing malpractice polices. This is often bolstered by sensational headlines of runaway jury verdicts issuing millions of dollars in damages for malpractice claims. Trial lawyers and consumer groups oppose these reforms, claiming that there is a high incidence of medical error and those errors are so egregious that million-dollar verdicts are justified. Moreover, these same groups blame mismanagement of the companies, downturns in the corporate economic investments, the ordinary business cyclical nature of the business and overstated losses presented to insurance regulators (Vidmar et al., 2006). Simply, there is no available empirical evidence to adequately study the allegations of the stakeholders. Florida has the closest thing to a systematic database with its closed-claim database.

Jury verdicts constitute a small portion of medical malpractice payments or losses. Evidence exists that jury verdicts make up only 3% of malpractice payments nationwide and

verdicts of $1 million or more in Florida made up 7.5% of the jury verdicts (Vidmar et al., 2006). A review of fifty cases, from 1990 to 2004, that went to trial and resulted in verdicts or settlements in excess of $1 million showed that the injuries suffered were severe or resulted in death. In summary, 34% involved death; 18% involved grave injuries such as quadriplegia or severe brain damage; 26% involved permanent injuries such as paraplegia or blindness; 16% involved permanent injuries such as deafness, loss of an eye, kidney or lung; and 6% involved minor permanent injury such as a loss of a finger or organs (Vidmar et al., p. 1358, 2008). During that same period of time, 10.1% of the settlements (115 claims) in excess of $1 million were paid without a lawsuit being filed, "[p]resumably the health care provider did not contest liability" (Vidmar et al., p. 1360, 2008). In summary, 42% of the claims resulted in death; 30% resulted in grave injury; 20% resulted in major permanent injuries and 8% involved lesser permanent injury. Professor Vidmar concludes that tort reform focused on jury verdicts are "misdirected," because jury verdicts constitute a small portion of $1-million verdicts (Vidmar, p. 1381, 2006). The focus in the tort reform "debate should be on the basis of and dynamics of settlement rather than trial." (Vidmar et al., p. 1381, 2006). The data available in Florida with regard to $1-million-or-more verdicts or settlements suggests that the cost of medical errors have *increased* and that more patients are suffering serious injuries in the medical malpractice area (Vidmar et al., p. 1381, 2006).

The General Accounting Office (GAO) in 2003 issued two major reports on medical malpractice that included a look a Florida's medical malpractice, and the crisis nationwide and among select states (GAO, 2003a and GAO, 2003b). The GAO was unable to formulate definitive conclusions due to a lack of empirical data. The GAO concluded that there were multiple factors that combined to increase medical malpractice premiums. Those factors were

losses or payments on malpractice claims which include administrative costs, losses or changes in investment income and a reduction of the competitive market in the malpractice premium business, and the cyclical nature of the insurance business. The GAO concluded that while these observations provide answers to market conditions, they do not answer the larger question or give an explanation of the causes of rising losses over time (GAO, 2003a). As for the question of whether or not rising premiums limit access to health care or increase the cost of health care by physicians practicing defensive medicine, the GAO was again limited by empirical data and had to rely on qualitative data by interviewing stakeholders over the telephone and conducting surveys. Many of the provider actions in opposition to increased premiums, such as walkouts, practice relocation, retirement, changes in specialty or refusal to be on call, were not substantiated or involved relatively few physicians (GAO, 2003b). In fact, when the GAO analyzed Florida physician departures in response to rising malpractice premiums, the GAO concluded that the reports were "anecdotal, not extensive, and in some cases we determined them to be inaccurate" (GAO, p. 17, 2003b).

In December 2008, the Congressional Budget Office (CBO) issued a general report on key issues in analyzing a major health insurance proposal (CBO, 2008). The report was issued in response to pending federal legislation; however, it addressed the impact of malpractice reform on healthcare. CBO identified two basic objectives of the medical malpractice system: a) "[c]ompensating injured patients for their losses (which can include medical costs, wages, and pain and suffering); and" b) "[d]eterring negligent behavior by medical providers" (CBO, 2008b). As part of its conclusion, CBO determined that limits on tort claims at the state level would "reduce total health care spending by less than 0.2%" (CBO, p. 154, 2008b). Finally CBO predicted that the cost to defend and pay medical malpractice claims could be $30 billion or 1.5

% of national health expenditures and less than 3% of the total payments to doctors and hospitals. Of that amount, about half of the expenses are spent on administrative costs in the malpractice system, legal fees (defense only because plaintiffs compensate their attorney based on a contingent-fee agreement), administrative costs for the malpractice insurers and court costs. A majority of the expense reflects the cost of determining legal liability, whether negligence occurred and what the damages award should be to the injured patient (CBO, 2008b, 2008a, and 2004).

Another study focused on the growth or medical malpractice payments using the National Practitioner Data Bank (NPDB) (Chandra, Nundy & Seabury, 2005 and Baicker, Fisher & Chandra, 2007). Professor Chandra states the American Medical Association (AMA) and the Physician Insurers Association of America (PIAA) attribute the dramatic increase in premiums to malpractice payments on claims, specifically jury verdicts, even though 4% of payments are attributable to verdicts at trial; settlements account for 96% of payments. The AMA and PIAA use verdicts to advocate a cap on non-economic damages.

All malpractice payments made on behalf of a licensed health care provider must be reported to NPDB within thirty days. Non-compliance is subject to civil penalties. The NPDB has data on 250,137 payments for the period September 1, 1990, to December 31, 2003 (Chandra, 2005). During this time period the number of payments remained steady; however, the average payment amount increased by 52%. Payments per person grew 41% from $9.2 in 1991 to $13.0 in 2003 (Chandra et al., 2005). Professor Chandra concludes that the focus on verdicts as a primary or significant cause of premium increases is incomplete as presented by the AMA and PIAA. Rather, the data shows that while payments have remained steady, increases in payment amounts are driven by the severity of the claims and not the number of the claims. In

other words, an increase in premiums is caused by the severity of the medical errors and not the amount of errors. Also contributing to rising premiums is the increase in administrative costs, a decline in investment income, an increase in insurance regulation, and a decrease in local or statewide competitive malpractice carriers (Chandra et al., 2005). Professor Chandra's study agrees with many of the conclusions of Professor Vidmar and the GAO.

Premiums, claim costs and investment income are income generators for insurance companies. Being in the risk business, they need to predict losses and contain costs while keeping premiums from their customers within control. Regarding premiums, there is a positive relation between losses on claims and the fluctuation in premiums; however, the causal relation between the two are not consistent yearly (Neale et al., 2009). Simply, as claims or claim severity increase, so do premiums; as investment income goes down, premiums increase. Moreover, losses, premiums, defense costs of claims and claim-containment fees do not follow a similar rate of growth, i.e. they are not dependent factors. Again, there is a misalignment of premiums and costs, suggesting instability and deterioration in the insurance market (Neale et al., 2009). Because of this, many insurers have left the malpractice market, citing no profitability. In fact, nationwide there were 328 insurers in 1996; in 2001, the number of insurers dropped to 221 (Neale et al., 2009). Addressing the concern of trial attorneys that premiums increase due to mismanagement, there is no credible evidence of this (Neale et al., 2009). More credible is the relation between an increase in claims and severity of claims and an increase in premiums (Neale et al., 2009). To resolve the issue of increased premiums, claims must be reduced, the severity of claims must be reduced and investment income must increase. The problem is what control, if any, do insurers have over their customers — physicians — to control severity of claims or

frequency of claims? Does justification lie in the three-strikes amendment and the regulatory scheme of physicians?

Patient Safety. The two key functions of the medical malpractice system are to compensate victims of negligent care and to provide incentives for healthcare professionals to supply safe and efficient care (Hellinger & Encinosa, 2006). Empirically, only 2% of medical malpractice injuries resulted in a claim (Hellinger & Encinosa, 2006).

> None of the tort provisions enacted to date addresses pervasive and troubling issues of patient safety. Reducing the number or value of malpractice claims by tightening the rules for compensation through the tort system does nothing to foster quality improvement. Future initiatives should take a creative approach toward integrating tort law and patient-safety measures to achieve the dual goals of accountability and quality of care (Waters, Budetti, Claxton & Lundy, 2007).

Nationally, patient safety appears to now be the focus of tort reform on a national level. Carolyn Clancy, M.D., Director of the Agency for Healthcare Research and Quality (AHRQ) summarized the Medical Liability Demonstration Project, a 2008 National Health Care Quality Report as follows: a) health care quality is suboptimal and improves at a slow pace; b) reporting of hospital quality is spurring improvement but patient safety is lagging; c) it is hard to know whether hospital care is better than 10 years ago because there are no good patient-safety measurements due to fear and emotion. Fear is a potent factor in perpetuating a culture of secrecy (Clancy, 2008).

In regard to patient safety (Schoenbaum & Segel, 2006), some scholars have suggested health courts which could serve two purposes, expedient resolution of claims and patient safety, since they would be responsible to police the medical profession (Barringer, 2008 and Struve, 2004). Additional reforms include consume- directed health care (Bloche, 2006) and medical malpractice safe harbors (Blumstein, 2006, Jain, 2007 and Liang & Ren, 2004). As for Florida, the legislature has adopted a Patient's Bill of Rights (Appendix D) and a Patient Safety Brochure

(Appendix E). The purpose is to promote the interests and well-being of patients and to improve communication between the patient and the health care provider.

Indeed, changes in direct losses, claim-containment costs, the size of the insurer, liquidity and group membership do not affect premiums; what does affect premiums is a growth in direct losses and the severity of those losses. The growth in direct losses alone is responsible for 25% of net premium increases (Neale et al., 2009). Better quality of care would reduce claims, would reduce severity of claims and would reduce premiums.

Other researchers clearly point to insurers as the culprit for inefficient tort reform and their effective fear marketing campaign (Rutsohn & Sikula, 2007). Fear marketing by insurers is intended to force feed tort reform in an effort to reduce their cost of doing business and increase profitability (Rutsohn & Sikula, 2007). A review of the empirical evidence indicates that for tort reform in medical malpractice to be effective, it must cause physicians to perceive that there is a malpractice insurance crisis (Rutsohn & Sikula, 2007). To do that, the marketing of insurers must impact the profitability of physicians, their cost of doing business and increase the profitability of insurers (Rutsohn & Sikula, 2007). If society has a goal to reduce overall healthcare costs, the empirical evidence in unclear (Rutsohn & Sikula, 2007). Rising premiums are microeconomic for physicians but macroeconomic for society (Rutsohn & Sikula, 2007).

Nationwide, malpractice settlement increased from $95,000 per claim in 1986 to $320,000 per claim in 2002. Nationwide, the number of claims remained the same, constant at 15 per 100 physicians (Rutsohn & Sikula, 2007). The inference is that if the frequency of claims has not increased, then the severity of claims certainly did. To blame the increase on the tort system is to ignore the data. Seventy percent of all malpractice suits are either won by physicians, dismissed or dropped (Rutsohn & Sikula, 2007). At trial, physicians win 80% of the

cases (Rutsohn & Sikula, 2007). The average cost of defending a physician at trial where the verdict is in favor of the physician is $66,767. This average is for year ending 2000 (Rutsohn & Sikula, 2007). Yet, despite this, premiums still increase. Malpractice litigation is not driving physicians out of business but is increasing their cost of doing business and impacting their profitability; while malpractice reform may impact premiums, it will not drive down the cost of healthcare overall (Rutsohn & Sikula, 2007). The Congressional Budget Office (CBO) estimates that malpractice costs represent only 2% of national health spending and significant reductions in premiums would not dramatically impact overall health spending. Similarly, the same conclusion is present for the practice of defensive medicine; a reduction in liability costs would be small (Ranji, Gutierrez & Salganicoff, 2005).

If the cost of doing business is increasing and premiums of insurance are increasing, the obvious question then is why do physicians purchase insurance? This is especially true in Florida where physicians can go naked, and there are damages caps on non-economic damages. One researcher suggests that the purchase of insurance actually increases the number of negligence cases because there is a level of protection present.

> Liability insurance protects individuals against the risk of having to pay legal sanctions and may undermine the effect of the law. In fact, we conclude that the purchase of insurance leads some individuals to reduce care below the negligence standard, which increases the expected number of accidents … Potential injurers who buy insurance are better off, whereas potential injurers who do not buy insurance are no worse off. In particular, potential victims are better off since they receive compensation for some accidents when insurance is available.
>
> (Bajtelsmit & Thistle, 2008, page 823).

Chapter Three: Research Methodology

Research Model/Criteria

No independent quantitative data collection was done to form the conclusions for this paper. The data collection was done by the state of Florida pursuant to legislative directive. The data was collected over several years and was reported to the public and the legislature. This data set was used to form conclusions. Consistent with ethical research standards and where appropriate, conclusions were adopted from the reports and studies. As stated earlier, the professional significance is to address what impact, if any the legal system has on the medical professional including medical malpractice claims and premiums. Supra, Chapter One.

Practicality: Why Doing This? Practicality is concerned with the wide range of factors of economy, convenience and interpretability (Cooper, 2008). This data is reported in published data sets gathered by a government or its agency. For purposes of this study, it was believed that the source and factors were deemed reliable and relevant.

Validity: Does It Measure What It Intends to Measure. Validity is the extent to which the test measures what it actually wishes to measure (Cooper, 2008). Upon review of the data set and conclusions drawn from the data, the validity of the research is not in question. Objective opinions are reported, and the conclusions are supported by the data. From the published data, randomly selected data was chosen from the original data, along with summations. It was then analyzed and conclusions drawn and reported. A sample of the data is reported and included in tables and the Appendix where appropriate. Validity could be questioned if the extracted and analyzed data did not match the original data collection (Shadish, Brasil, Illingworth,White, Galindo, Nagler & Rindskopf, 2009).

This is not an issue since the original data was available for analysis. What was used to draw conclusions were the reported graphs and the original data.

Content. The extent to which a measuring instrument provides adequate coverage of the investigative questions guiding the study. If the instrument contains a representative sample of the universe of subject matter of interest, then the content validity is good (Cooper, 2008). Most of the Florida data used was not a sample but represented the population.

Criterion. Reflects the success of measures used for prediction or estimates. E.g., You may want to predict an outcome or estimate the existence of current behavior (Cooper, 2008). The data used was required by law to be reported from licensed providers and facilities. It is a condition precedent to licensure to report medical errors or adverse incidents. Failure to report these incidents may result in a fine or revocation of a license.

Reliability: Accuracy and Precision of the Results. Reliability deals with the accuracy and precision of a measurement procedure (Cooper, 2008). In other words, the data used would yield the same conclusions. Not all data was collected from all sources, nor is it required. Statistically speaking, random samples are permitted to be drawn from a population. Based upon that data set, inferences and conclusions can be made and drawn. Upon review of the Florida data set, conclusions and inferences, not to mention the source of the data and the measurement of the data, it is concluded that reliability is not in question. Note also that the data was collected over several years and reported publicly. Reliability could become an issue if different data was extracted from the reported data (Shadish et al., 2009); however, because no independent data was collected and the only data used was that as reported publicly, reliability is in tact.

Chapter Four: Medical Malpractice

Defined and in General

An action for medical malpractice is defined as a claim in tort or in contract for damages because of the death, injury or monetary loss to any person arising out of any medical, dental or surgical diagnosis, treatment or care by any provider of health care. "An action for medical malpractice shall be commenced within 2 years from the time the incident or within 2 years from the time the incident is discovered, or should have been discovered … [I]n no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued, except that this 4-year period shall not bar an action brought on behalf of a minor on or before the child's eighth birthday." Fla. Stat. 95.11(4)(b) (2009).

Essentially, medical malpractice is a negligence action filed against a licensed health care provider. It is also known as professional negligence. The term "negligence" has been defined in terms describing the conduct of a prudent person involved in certain acts. It is known as accidental conduct as opposed to intentional conduct. Succinctly, negligence forms the basis of a civil action whereby a person failed to do what a reasonable and prudent person would ordinarily have done under the circumstances, or the doing of what a reasonable and prudent person would not have done under the circumstances. Negligence has also been defined as a failure to observe the protection of another's interest as the circumstances demand, which caused injury. In addition, a person can be negligent by failing to act as a responsible person and to use the degree of care, diligence, and skill that was his or her legal duty to use to protect another person from injury that, in a natural and continuous sequence, causes unintended damage to the latter. *De Wald v. Quarnstrom* (1952); *Frank v. Lurie*

(1963); *Russell v. Jacksonville Gas Corp.* (1960); *Jacksonville Journal Co. v. Gilreath* (1958).

Elements: Negligence

A cause of action for negligence depends on a plaintiff proving four essential elements. Elements of negligence claim under Florida law are: (1) legal duty of the defendant to protect plaintiff from particular injuries, also known as the standard of care; (2) defendant's breach of that duty; (3) plaintiff's injury being actually and proximately caused by breach; and (4) plaintiff suffering actual harm from injury. Liability for negligence depends on a showing that the injury suffered by the plaintiff was caused by the alleged wrongful act or omission of the defendant. Showing a connection between the negligence and the injury is not sufficient to establish liability for negligence. The connection, or proximate cause of the injury, must be such that the law regards the negligent act as the proximate cause of the injury. *Zivojinovich v. Barner* (2008). Simply, in Florida, the necessary elements of a negligence claim are duty, breach, causation, and damages. *Williams v. National Freight, Inc.* (2006). The determination of whether or not a person’s conduct was negligent is not a matter of law to be decided by judges,but is a factual determination and is left to the province of a jury. (Rhee, 2008).

Medical Malpractice Elements

The elements are the same for malpractice as they are for negligence; however, the standard of care is statutorily defined. “The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.” Fla. Stat. 766.102(1) (2009); *Sweet v. Sheehan* (2006). To

determine the standard of care, Florida has legislated that it be determined by an expert upon a review of the case and related and relevant medical records. *Sweet v. Sheehan* (2006).

Expert Witness. What constitutes an expert for purposes of determining the standard of care is also statutorily defined. To give an opinion on a medical professional's standard of care is defined by Fla. Stat. 766.102(1) (2009), that medical professional must be:

> A licensed health care provider and meets the following criteria:
> (a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:
>
> 1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and
> 2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
>
> a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;
> b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or
> c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
>
> (b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:
>
> 1. The active clinical practice or consultation as a general practitioner;
> 2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
> 3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
>
> (c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the three years immediately preceding the date of the occurrence that is the basis for the action

> to:
>
> 1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;
> 2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or
> 3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.
>
> Fla. Stat. 766.102 (5) (2009); *Meyer v. Caruso* (1999).

Burden of Proof

Negligence, professional or otherwise, is insufficient to give rise to a cause of action or to be successful; rather, the plaintiff needs to prove the following elements by a preponderance of the evidence:

(1) the defendant owed him or her a legal duty;

(2) the defendant breached that duty;

(3) the plaintiff suffered injury as result of that breach; and

(4) the injury caused damage.

When these elements are brought together, they constitute actionable negligence and the facts will be submitted to a jury. The absence of, or the failure to prove, any one of these is fatal to recovery. Note, the intent of the actor is not a material element of negligence. *Zivojinovich v. Barner* (2008).

Preponderance of Evidence

Social policy, and therefore the law, can never be based on complete certainty. In determining fault in a civil case, the legal system has never demanded anything close to certainty

as a basis for shifting losses. “The plaintiff in an ordinary tort case need only prove by a preponderance of evidence that the defendant bears responsibility for the loss. Thus, even the common law requires only a showing that reallocation is justified ‘more likely than not (Farber, 2007).’” To use a metaphor, think of the scales of justice. Lady Justice is blind and is balancing two scales. The plaintiff need only tip one scale in his or her favor ever so slightly. If the plaintiff is successful in tipping the scales, he or she will have met his or her burden of proof and therefore will have proven fault, negligence or responsibility by a preponderance of the evidence.

Damages Available

Damages are an essential element of a cause of action for negligence, and therefore medical malpractice *Schornberg v. Panorama Custom Home Builders, Inc*. (2007). Conceivably, a health care provider could be legally responsible for his or her actions, negligent, i.e., breached his or her standard of care to a patient; he or she will not be ordered to pay damages if the patient suffered no damages. Also, failure to be liable civilly does not mean the professional may not be held accountable for his or her actions. The provider or practitioner may face a disciplinary violation or be arrested for an intentional act. “The fundamental principle of the law of damages is that the person injured by breach of contract or by wrongful or negligent act or omission shall have fair and just compensation commensurate with the loss sustained in consequence of the defendant's act which [gave] rise to the action … the objective [is] to make the injured party whole … The plaintiff is entitled to damages which are the ‘natural, probable or direct consequence of the act *McLeod v. Continental Insurance Co.* (1992).’”

In *McLeod*, the court recognized that the legislature has the right to modify the common law definition of damages, but there must be evidence of a legislative intent to do so. See also *Thornber v. City of Fort Walton Beach* (1990). (Statutes do not change the common law except

as they clearly and plainly specify, and when there is such a change the common law is displaced no more than is necessary); *accord, State v. Ashley* (1997); See also,(Federbush, 2004). Therefore, in Florida, when the legislature adopted tort reform, it was required to state its intent. This was done when its members set forth their legislative findings and intent in section 766.201.

Florida's Statutory Scheme

In changing the common law determination of liability and damages for medical malpractice claims, the Florida Legislature, consistent with existing case law, made specific findings as to why there was an increase in medical malpractice premiums. Interestingly, the findings cited by the legislature did not include overzealous plaintiffs' attorneys filing frivolous claims. Instead, the focus was on the cost of processing claims and a predetermination of meritorious claims prior to the filing of lawsuit. The exact verbiage of the legislative findings is contained in Chapter Six, *infra*. In an attempt to reduce medical care costs and create functional availability of malpractice insurance premiums for physicians, Fla. Stat. 766.201(1)(2009), the common law tort system was amended by: a) capping damages to be awarded to claimants, Fla. Stat. 766.118(2009); authorizing presuit investigation of claims, Fla. Stat. 766.203(2009); capping attorney fees for those representing claimants in medical malpractice cases, Fla. Const. art. I, sec.26 (2009); mandating court-ordered arbitration, Fla. Stat. 766.107 (2009), and mediation, Fla. Stat. 766.108 (2009); and capping damages for state- and county-owned health care providers and facilities pursuant to the sovereign immunity statute, Fla. Stat. 768.28 and 766.1115 (2009). Some of the above concepts will be covered generally here as they apply to medical malpractice, but others are discussed at length in Chapter Six, *infra*.

Damages Caps

Damages for medical malpractice claimants at common law were unlimited and left to the jury to determine based upon the facts, damages caused, past pain and suffering, future pain and suffering, unpaid medical bills, future estimates of medical bills, unpaid lost wages and estimated future lost wages. This common law remedy for damages still exists in negligence actions such as automobile accidents, slip and falls and intentional torts. However, consistent with the legislative findings to reduce malpractice premiums, damages caused as a result of medical negligence are limited or capped. To be clear, *economic damages* such as unpaid medical bills are not limited; *non-economic damages* are capped. "Non-economic damages means non-financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non-financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act." Fla. Stat. 766.202(8) (2009).

Non-economic damages for a health care provider or practitioner who causes personal injury or wrongful death arising out of medical negligence shall not exceed $500,000 per claimant; if there is more than one claimant, the damages limit is unchanged. Fla. Stat. 766.118 (2) (a) (2009). This limit may be increased to $1 million from all practitioners if a court determines an injustice would be caused and the trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient. Fla. Stat. 766.118 (2) (b) (2009).

Similar to the rules outlined for a health care practitioner, non-economic damages for a non-practitioner are limited to $750,000 per claimant and an aggregate amount of $1.5 million. Fla. Stat. 766.118 (3) (2009). Practitioners providing emergency care have their non-economic

damages limited to $150,000 and an aggregate amount of $300,000. Fla. Stat. 766.118 (4) (2009). Non-practitioners providing emergency care have their non-economic damages limited to $750,000 per claimant and an aggregate amount of $1.5 million. Fla. Stat. 766.118 (5) (2009).

In the event a jury awards damages in excess of the limits mentioned herein, then the court is required to reduce the damages to conform to the appropriate statute. Fla. Stat. 766.118 (6) (2009). Also, the damage limitations outlined have been extended to insurers, prepaid limited health services organizations, health maintenance organizations and prepaid health clinics that employ a licensed health care provider and who may be liable for medical negligence. Fla. Stat. 766.2021 (2009).

Pre-suit Investigation

Consistent with the legislative finding that costs of processing a medical negligence claim are partially at fault for rising premiums, the legislature has mandated pre-suit investigation by both the claimant and prospective defendant. Fla. Stat. 766.203 (2009). The claimant must conduct a pre-suit investigation to determine that there are reasonable grounds to believe that a) a named defendant was negligent in the care or treatment of the claimant; and b) this medical negligence resulted in injury to the claimant. Reasonable grounds for medical negligence must be corroborated in writing by a medical expert and shared with the defendant. Fla. Stat. 766.203 (2) (2009). The pre-suit investigation of the defendant must be conducted to determine whether there are reasonable grounds to believe that a) the defendant was negligent in the care or treatment of the claimant; and b) this medical negligence resulted in injury to the claimant. Lack of reasonable grounds for medical negligence must be corroborated in writing by a medical expert and shared with the plaintiff. Fla. Stat. 766.203 (3) (2009). Pre-suit investigation by both the plaintiff and defendant include copies of relevant medical records. Fla.Stat.766.204 (2009).

Failure to comply with any of the pre-suit requirements may cause the claim or any defenses to be stricken from the record or dismissed with prejudice. Fla. Stat.766.205 (2009).

Attorney fees caps

Victims of malpractice receive no less than 70% of the first $250,000 in damages, exclusive of costs, and 90% of damages in excess of $250,000. Fla. Const. art. I, sec. 26 (a) (2009). This is a truncated scale and decreases as the amount of the recovery increases or at different stages of the claim. For example: 1) 33 1/3% of any recovery up to $1 million; plus 2) 30% of any portion of the recovery between $1 million and $2 million; plus 3) 20% of any portion of the recovery exceeding $2 million. Fl. R. Prof. Cond. 4-1.5(f)(4)(B)(i)(a) (2009). It should be noted that a client may waive his or her constitutional right limiting attorney fees, provided the Florida Rules of Professional Conduct are adhered to and the waiver is approved by a court of general jurisdiction. Fl. R. Prof. Cond. 4-1.5 (2009). If waived, the fees are still regulated by the rules or professional conduct previously mentioned; the maximum agreed upon fee may range from 33 1/3% to 40% of any recovery up to $1 million; plus 20% to 30% of any portion of the recovery between $1 million and $2 million; plus 15% to 20% of any recovery exceeding $2 million. Fl. R. Prof. Cond. 4-1.5 (2009).

Arbitration and mediation

Overall, there is a policy in favor of alternative dispute resolution in the state of Florida. Fla.Stat. 682.02 (2009). In fact, arbitration and mediation, two forms of alternative dispute resolution (ADR) are codified in the Florida Statutes. Arbitration is codified at Fla. Stat. 682.01, et seq. (2009); mediation is codified at Fla. Stat. 44.1011, et seq. (2009).

Mediation is " …a process whereby a neutral third person called a mediator acts to encourage and facilitate the resolution of a dispute between two or more parties. It is an informal

and non-adversarial process with the objective of helping the disputing parties reach a mutually acceptable and voluntary agreement. In mediation, decision making authority rests with the parties. The role of the mediator includes, but is not limited to, assisting the parties in identifying issues, fostering joint problem solving, and exploring settlement alternatives." Fla. Stat. 44.1011 (2) (2009). Arbitration is "… a process whereby a neutral third person or panel, called an arbitrator or arbitration panel, considers the facts and arguments presented by the parties and renders a decision which may be binding or non-binding as provided in this chapter. Fla. Stat. 44.1011 (1) (2009).

These two forms of ADR are incorporated into the statutes involving medical malpractice claims. In fact, ADR in malpractice claims is consistent with the legislative finding that "[t]he high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merit of claims, by providing for early arbitration of claims, thereby reducing delay and attorneys' fees, and by imposing reasonable limitations on damages, while preserving the right of either party to have its case heard by a jury." Fla. Stat. 766.201(1)(d) (2009). ADR does not abrogate a person's constitutional right to a trial by jury in a civil matter and access to the courts. Fla. Const. art. I, sec. 22; Fla. Const. art. I, sec. 21; and U.S. Const. amend VII.

Sovereign Immunity

Another way of reducing medical malpractice premiums is, again, to limit damages for any and all negligent acts caused by health care professionals who are deemed agents of the state. This is not a new concept but one that is centuries old. Essentially, citizens could not sue the king or state, because to do so would harm the public. The sovereign provides essential services and the common law notion of paying damages without limits was not well received.

Therefore, a compromise was made to limit damages to those matters and monetary limits as agreed by the king or state. Thus, the concept of sovereign immunity was created. In general, it is codified at Fla. Stat. 768.28 and 766.1115 (2009) for state-operated medical facilities and those health care professionals working therein.

In general, the state and its agencies are not liable for damages resulting to others that arise out of negligent actions, including "for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any employee of the agency or subdivision while acting within the scope of the employee's office or employment." Fla. Stat. 768.28 (1) (2009). This provision is waived, but limited, and the state agrees to be responsible for general damages, not punitive damages, in an amount not to exceed $100,000 per claimant or $200,000 in the aggregate. Fla. Stat. 768.28 (5) (2009). What constitutes a state agency or subdivision is defined and includes "the executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities, including the Florida Space Authority." Fla.Stat.768.28 (2) (2009). This definition is expanded to include health care professionals who contract with the agents of the state, i.e., county or state medical facilities, to provide medical care to the residents of the state. Fla. Stat. 766.1115 (2) (2009).

As with other legislative changes to the common law damages scheme, the legislature made the following findings for health care providers who provide quality medical care to state agencies:

> … [A] significant proportion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care because health care providers fear the

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

Fla. Stat. 766.1115 (2) (2009).

Accordingly, damages caused by state health care professionals is limited in medical negligence cases to $100,000 per claimant and $200,000 in the aggregate. The damages limits set forth in Fla. Stat.766.1115 (2009) are specifically exempted for state agencies and sovereign immunity. Fla. Stat.766.1115 (7) (2009).

Chapter Five: Tort Reform

Current Law

Florida Constitution. In 2004, three Constitutional Amendments were passed by Florida voters which were directed at medical malpractice claims in general. Of the three amendments, one has caused the most litigation, resulting in a Florida Supreme Court ruling in favor of consumer protection. That amendment is commonly known as Amendment 7, formally cited as Fla. Const. amend. X, sec. 25 (2009), Patients' right to know about adverse medical incidents. The remaining two address a claimant's right to fair compensation, Fla. Const. art. I, sec. 26 (2009), and a prohibition of medical license after repeated medical malpractice, Fla. Const. art. X, sec. 26 (2009).

Peer review. Amendment 7 was overwhelmingly approved by Florida voters. According to public records, 5,849,125 citizens voted for it, while only 1,358,183 voted against it (Harris, 2009). The adoption of Amendment 7 "represents the most sweeping changes in law and public policy ever adopted in this state (Harris, page 1, 2009)." Effectively, Amendment 7 pierces the once clandestine of all medical reviews, that being peer review, credentialing, investigations, quality assurance and risk assessments of health care providers' and facilities' adverse medical incident (Harris, 2009). By way of history, for years, health care providers and facilities would self-police adverse medical incidents under a shroud of confidentiality and claimed privilege from disclosure. Disclosure was even barred during the discovery process of a lawsuit, including court orders and subpoenas (Harris, 2009). Health care providers and facilities argued that it improved the quality of care to patients (Harris, 2009) and allowed those providers to learn from their mistakes. The problem with this process was that it was not transparent and allowed many providers and facilities to "bury" their mistakes, giving rise to the adage that doctors "bury" their

mistakes in graves. The days of “protect our own” mentality are now gone with the adoption of Amendment 7.

The purpose of Amendment 7 is “to create a constitutional right for a patient or potential patient to know and have access to records of a health care facility's or provider's adverse medical incidents, including medical malpractice and other acts which have caused or have the potential to cause injury or death (Harris, page 2, 2009).” Since this adoption was significant and an emerging concept, the implicit purpose of the amendment, as voted by citizens, was consumer protection. Citizens are now afforded access to all records, peer review, credentialing, investigations and quality assurance assessments for individual providers and facilities as it relates to an adverse medical incident. Fla. Const. amend. X, sec. 25.

The Supreme Court in *Florida Hospital Waterman, Inc., v. Buster* (2008) has stated, since the passage of Amendment 7, there is no statutory guarantee of confidentiality in adverse medical incident reports. As such, peer review of medical errors and the self-policing efforts of the medical profession are dead. Consumers now have access to these reports. The healthcare providers and facilities have not given up the fight. They are now claiming that these peer reviews are protected by the attorney-client privilege or work-product doctrine because, now, their attorneys are present during a peer review. *Advisory Opinion to the Attorney General* (2004), *Southern Bell Telephone and Telegraph Co. v. Deason* (1994), Fla. Stat. 90.502 (attorney-client privilege) and Fl. R. Civ. P. 1.280(b)(3) (defining attorney work product). This is an issue that has not been settled and is still winding its way through the court system. The two majority stakeholders are attorneys on behalf of consumers and the health care profession, including hospitals and practitioners. Ultimately, this issue will wind up before the Supreme Court.

The amendment is simple and written in clear unmistakable language. It is set forth herein at length:

> SECTION 25. Patients' right to know about adverse medical incidents.—
>
> (a) In addition to any other similar rights provided herein or by general law, patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.
>
> (b) In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained.
>
> (c) For purposes of this section, the following terms have the following meanings:
>
> (1) The phrases "health care facility" and "health care provider" have the meaning given in general law related to a patient's rights and responsibilities.
>
> (2) The term "patient" means an individual who has sought, is seeking, is undergoing, or has undergone care or treatment in a health care facility or by a health care provider.
>
> (3) The phrase "adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.
>
> (4) The phrase "have access to any records" means, in addition to any other procedure for producing such records provided by general law, making the records available for inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that current records which have been made publicly available by publication or on the Internet may be "provided" by reference to the location at which the records are publicly available.
>
> Fla. Const. art. X, sec 25 (2009); See also Fla. Stat. 395.0197 (5) (2009) (definition of adverse medical incident) and Chapter Seven, infra.

Peer review is also a mandated statutory requirement for any licensed healthcare facility such as a hospital or ambulatory surgery center. Fla. Stat. 395.0193 (2) (2009). Essentially facilities are mandated to self-police adverse medical incidents and those healthcare practitioners

involved. The focus of the peer review process is to review professional practices, reduce morbidity and mortality rates and improve patient care. Fla. Stat. 395.0193 (2)(g) (2009). The peer review panel established by the facility is charged with investigating adverse medical incidents and determining grounds for discipline which may include suspension, denial, revocation, curtailing of privileges, reprimand, counseling, education or any other remedial action. Grounds for discipline under the peer review process are:

> (a) Incompetence.
>
> (b) Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself, 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 paragraph (d) or paragraph (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.
>
> Fla. Stat. 395.0193(3) (2009).

Once a determination of discipline is made, the incident, the specifics thereof, and any disciplinary action taken must be reported to the Division of Health Quality Assurance within thirty working days after the initial occurrence. Fla. Stat. 395.0193(4) (2009).

"**Three strikes."** The second significant amendment regarding medical malpractice, as voted on by the citizens, was a prohibition of a medical license where there have been repeated incidents of medical malpractice. Fla. Const. art. X, sec. 26 (2009). This is commonly known as the "three strikes" amendment. "No person who has been found to have committed three or

more incidents of medical malpractice shall be licensed or continue to be licensed by the State of Florida to provide health care services as a medical doctor." Fla. Const. art. X, sec. 26 (a) (2009).

Medical malpractice is defined as "… the failure to practice medicine in Florida with that level of care, skill, and treatment recognized in general law related to health care providers' licensure, and any similar wrongful act, neglect, or default in other states or countries which, if committed in Florida, would have been considered medical malpractice." Fla. Const. art. X, sec. 26 (b) (1) (2009). The phrase *found to have committed* is defined as "… that the malpractice has been found in a final judgment of a court of law, final administrative agency decision, or decision of binding arbitration." Fla. Const. art. X, sec. 26 (b) (2) (2009).

Those supporting the amendment suggested that it benefitted patients by eliminating repeatedly negligent physicians from practicing in the state. Those opposing the amendment stated that it limited patients' access to quality care because those physicians in high-risk fields, i.e., gynecologists, neurosurgeons and trauma surgeons would leave Florida (Matthew, 2006). The Florida legislature responded by establishing a "clear and convincing" standard for determining whether a negligent act qualifies as a strike. Fla. Stat. 456.50 (2009).

An unintended outcome of this amendment is that it threatens the livelihood of potential physician defendants (Matthew, 2006). Physicians will opt to settle cases rather than risk an adverse finding of malpractice, thus jeopardizing revocation of their license to practice medicine. Conversely, insurance companies retain the right to defend a malpractice action; therefore, should a physician want to settle, to avoid a "strike," carriers could compel a physician to defend. This is not without a solution. The legislature allows "bad faith" claims by physicians against carriers for damages in excess of the policy limits. Fla. Stat. 766.1185 (2009). This statute does not address the effect of not settling by the carrier and whether it constitutes a strike

against the physician. Moreover, there are no reported cases interpreting this statute and this issue. As a matter of opinion, it would be wrong to penalize a physician for the actions of a carrier who does not settle a case in good faith and being sued by a patient; this would be contrary to public policy, i.e. providing quality medical care to Floridians.

Attorney fees. Lastly, Florida citizens adopted a constitutional amendment allowing a claimant in a malpractice case to receive more of the settlement proceeds than his or her attorney(s). The amendment passed with 63.6% of the voters in favor (Yes: 4,583,164; No: 2,622,143). Essentially, this amendment lowered the percentage an attorney receives, a contingency fee, "whether received by judgment, settlement, or otherwise." Fla. Const. art. I, sec. 26 (a) (2009). Victims of malpractice receive no less than 70% of the first $250,000 in damages, exclusive of costs, and 90% of damages in excess of $250,000. Fla. Const. art. I, sec. 26 (a) (2009). A contingency fee is a fee that is earned by an attorney representing claimants that is based on a percentage of the amount received by judgment, settlement, or otherwise. Fl. R. Prof. Cond. 4-1.5 (2009). The adoption of contingency fees is rooted in public policy. It is a way of providing access to the courts for those who are harmed or injured and cannot afford to pay an attorney a retainer fee or an hourly fee. Interestingly, the "trial lawyers spent nearly $25 million trying to defeat the measure, suggesting this amendment would make Florida's health care system less safe and effective by limiting access to the courts and costing taxpayer money to help care for medical malpractice victims (Matthew, 2006).

The inevitable downside to this amendment is that plaintiff attorneys may pressure clients to settle cases that should necessarily go to trial (Matthew, 2006). Justification for this outcome is the expense advanced by the attorney to pursue such claims. On average, the cost bringing a case to trial is between $35,000 and $50,000 (Matthew, 2006). This coupled with a potential

unfavorable outcome or one less than deserving and a shift of more damages to the patient, make premature settlement realistic (Matthew, 2006). Another downside is that the trial attorney may not be willing to accept a meritorious claim due to a reduced fee; patients are effectively barred from pursuing a valid claim against a negligent or reckless practitioner or provider.

As it stands now, the result of public tort reform has had a chilling effect on the number of closed civil claims made against physicians. Since 2004, the number of closed civil claims filed has decreased from 701 in 2003-2004 to an average of 294 since then. This represents a 41.9% decrease in the number of claims filed. The inference is that public tort reform has dramatically impacted the number of medical malpractice cases filed (Appendix K).

Florida statutes. Tort reform in medical malpractice is codified at Chapter 766 of the Florida Statutes. Common law theories of recovery, for example negligence and malpractice, can be changed by the legislature where the legislative purpose and intent is clear and plain. *Thornber v. City of Fort Walton Beach* (1990); See also, *State v. Ashley* (1997).

In Chapter 766, the legislature made specific legislative findings when it set out to change the common law theory of recovery and damages in medical malpractice cases. In addressing medical malpractice Fla. Stat. 766.201 (2009) states:

> (1) The Legislature makes the following findings:
>
> (a) Medical malpractice liability insurance premiums have increased dramatically in recent years, resulting in increased medical care costs for most patients and functional unavailability of malpractice insurance for some physicians.
>
> (b) The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims.
>
> (c) The average cost of a medical negligence claim has escalated in the past decade to the point where it has become imperative to control such cost in the interests of the public need for quality medical services.

> (d) The high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merit of claims, by providing for early arbitration of claims, thereby reducing delay and attorney's fees, and by imposing reasonable limitations on damages, while preserving the right of either party to have its case heard by a jury.
>
> (e) The recovery of 100 percent of economic losses constitutes overcompensation because such recovery fails to recognize that such awards are not subject to taxes on economic damages.
>
> (2) It is the intent of the Legislature to provide a plan for prompt resolution of medical negligence claims. Such plan shall consist of two separate components, pre-suit investigation and arbitration. Pre-suit 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.

In addressing the need for reform in birth-related neurological injuries, the Florida legislature made the following findings at Fla. Stat. 766.301 (2009):

> (1) The Legislature makes the following findings:
>
> (a) Physicians practicing obstetrics are high-risk medical specialists for whom malpractice insurance premiums are very costly, and recent increases in such premiums have been greater for such physicians than for other physicians.
>
> (b) Any birth other than a normal birth frequently leads to a claim against the attending physician; consequently, such physicians are among the physicians most severely affected by current medical malpractice problems.
>
> (c) Because obstetric services are essential, it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida.
>
> (d) The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault. The issue of whether such claims are covered by this act must be determined exclusively in an administrative proceeding.
>
> (2) It is the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. This plan shall apply only to birth-related neurological injuries.

Public Tort Reform. Public tort reform involves those actions taken by a government agency, a state's legislature or the judiciary. In Florida, what is referred to as public tort reform has been enacted by the legislature and can be found in Chapter 766 of the Florida Statutes. This type of reform includes but is not limited to damages caps for non-economic damages, alternative dispute resolution, pre-suit investigation, a cap on attorney fees for those attorneys representing victims of medical malpractice and a cap on punitive damages. Justification for public tort reform is based upon a tenet that the public must have quality health care and rising costs in health care, through rising premiums, payment of damages claims and costs of administering such claims, detracts from the overall general good of providing quality health care to Floridians.

Private Tort Reform. There is a new age in medicine where doctors are not only to be trained in medicine, but also must also perform as businessmen. Gone is the day where an administrator runs the office and the doctor treats the patients. Doctors must now be active in the operational side of the business of medicine. They must be focused on costs and expenses, attention to detail, contractual terminology, staffing and employee issues as well as their treatment of patients. With the onset of litigation and the skyrocketing of medical malpractice premiums, they must also be concerned about legal issues. These legal issues include but are not limited to privacy laws, federal and state licensing requirements and tort reform.

Private tort reform is legal and enforceable; in the future, it will have a burgeoning appearance and use alternative dispute resolution (ADR) agreements in the practice of medicine.

In the business of medicine, doctors and healthcare providers alike are faced with disputes in medicine that often times require a lawyer but can be settled in ADR (Steen, 2004). They include but are not limited to:

- Patient billing
- Reimbursement
- Medical malpractice
- Third-party administrators
- HMOs, PPOs and BC/BS
- Landlords, etc.

Alternative dispute resolution takes many forms, however, it usually appears in the form of mediation and arbitration in a majority of cases. Arbitration is the submission by the parties of their dispute to an impartial tribunal for resolution. Mediation is a formal conference between parties and a neutral person with the intent to arrive at a settlement. A decision is not rendered; instead the parties try to reach a mutually agreeable settlement. Fla. Stat. 682.01, et seq and Fla. Stat. 44.1011 (2009).

Currently, the legislature has enacted many statutes to allow ADR in medicine. Those statutes are:

- *766.107* Court-ordered arbitration.
- *766.108* Mandatory mediation and mandatory settlement conference in medical negligence actions.
- *766.207* Voluntary binding arbitration of medical negligence claims.
- *766.208* Arbitration to allocate responsibility among multiple defendants.
- *766.209* Effects of failure to offer or accept voluntary binding arbitration.
- *766.21* Misarbitration.
- *766.211* Payment of arbitration award; interest.

Florida Arbitration Code, Fla.Stat. 682.01, et seq (2009).

Recently, the court decided the issue of the enforceability of an arbitration agreement signed between a doctor/healthcare provider and a patient where the patient claimed malpractice. The court held that the arbitration agreement was enforceable and could not be stricken for either procedural or substantive unconscionability reasons. *Florida Eye Health vs. Shedden* (2008) and *Slusser vs. Life Care Centers of America, Inc.* (2008). *Slusser* held that arbitration agreements for

disputes involving a nursing home are binding and enforceable under the Nursing Home Residents Act, Fla. Stat. 400.023, et seq (2005). See also, *Woebse v. Healthcare and Retirement Corp.* (2008) and *Shotts v. OP Winter Haven, Inc.* (2008).

The *Shedden* court cited the following reasons for enforceability:

- in large bold capital letters, "PLEASE READ CAREFULLY PATIENT-DOCTOR ARBITRATION AGREEMENT."
- The Agreement was specifically brought to Shedden's attention;
- He was given the opportunity to read it;
- He was told that if he had any questions about the Agreement, he could ask the staff to assist him;
- He was also told that, if he would prefer, he could take the Agreement with him and review it with anyone else, including an attorney, before signing it.

For the healthcare provider, there are numerous benefits to enforceability:

- Result in better patient care and disclosure
- Reduced costs in event of claim
- Cap damages claim in tort to $250,000
- Possible reduction in malpractice premiums
- Faster claim resolution
- Expand process to tort claims
- Expand to contract and collection claims resulting in higher collections and reimbursement
- Expand to employee disputes

Some patient advocates may argue that limiting damages and a right to a jury trial infringe upon patient rights, however, what the *Shedden* court outlined is not far from what already exists in the Florida Statutes. The legislature has already enacted alternatives to judicial action in medical malpractice claims, those alternatives to judicial action are:

- *766.102* Medical negligence; standards of recovery; expert witness.
- *766.107* Court-ordered arbitration.
- *766.108* Mandatory mediation and mandatory settlement conference in medical negligence actions.
- *766.203* Pre-suit investigation of medical negligence claims and defenses by prospective parties.
- *766.205* Pre-suit discovery of medical negligence claims and defenses.
- *766.206* Pre-suit investigation of medical negligence claims and defenses by court.
- *766.207* Voluntary binding arbitration of medical negligence claims.

- *766.208* Arbitration to allocate responsibility among multiple defendants.
- *766.209* Effects of failure to offer or accept voluntary binding arbitration.
- *766.21* Misarbitration.
- *766.212* Appeal of arbitration awards and allocations of financial responsibility.

If these provisions are incorporated into an ADR agreement, then a healthcare provider can actively participate in private tort reform, reduce malpractice premiums and reduce the risk of loss in their own practices. Many physicians have already implemented such agreements in Florida, however, the result or savings on premiums has not been reported; no data is available on the effect this has had on premiums or the loss or gain of the number of patients asked to sign such an agreement. Many physicians are taken aback by such an idea because it means they must advocate against their patients when their training and skills dictate that they be advocates for their patients. Yet, when confronted about the high cost of premiums, they are reluctant to take such actions and want the government to curb runaway juries, cap damages awards, and derail attorneys who take medical malpractice cases.

The question then becomes a rhetorical one, "Why sign an ADR agreement in medicine?" The short answer is because it is legal and enforceable and can be expanded beyond the scope of malpractice claims. The savings expense of litigation in time and money, from a business perspective, justifies consideration of this agreement being implemented. It is predicted that medical malpractice carriers will compel providers to use private tort reform in their practice to cap damages, reduce costs of litigation, privatize settlements and, ultimately, increase profit for the carriers. While this may be cost effective, patient advocates and attorneys will fight this initiative despite its legitimacy and legality.

"Going Naked." As a condition precedent to obtaining a license to practice medicine, a licensed practitioner must provide evidence of financial responsibility for medical malpractice claims. Fla. Stat. 458.320 (2009). This can be accomplished in a number of ways, the most

widely acceptable being to maintain professional liability coverage in an amount not less than $100,000 per claim or $300,000 in the aggregate. Fla. Stat. 458.320 (1)(b) (2009). Practitioners may also meet the financial responsibility requirement by maintaining an escrow account (Fla. Stat. 458.320 (1) (a) (2009)) or an irrevocable letter of credit in the same amounts. (Fla. Stat. 458.320 (1) (c) (2009). Physicians who perform surgery must maintain limits in the amount of $250,000 per claim, or $750,000 in the aggregate. (Fla. Stat. 458.320 (2) (2009).

Going naked refers to the practice of professionals operating in their profession without the benefit of insurance of any means of compensating injured parties or patients. Under the current statutory scheme, physicians can go naked by maintaining an escrow account (Fla. Stat. 458.320 (1)(a), (2) (b) (2009) or obtaining an irrevocable letter of credit (Fla. Stat. 458.320 (1) (c), (2)(c) (2009). These requirements for financial responsibility do not apply if a physician meets one of the following:

> (a) Any person licensed under this chapter who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. …
>
> (b) Any person whose license has become inactive under this chapter and who is not practicing medicine in this state. …
>
> (c) Any person holding a limited license ….
>
> (d) Any person licensed or certified under this chapter who practices only in conjunction with his or her teaching duties at an accredited medical school or in its main teaching hospitals ….
>
> (e) Any person holding an active license under this chapter who is not practicing medicine in this state….
>
> (f) Any person holding an active license under this chapter who meets all of the following criteria:
>
> 1. The licensee has held an active license to practice in this state or another state or some combination thereof for more than 15 years.
>
> 2. The licensee has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year.
>
> 3. The licensee has had no more than two claims for medical malpractice resulting in an indemnity exceeding $25,000 within the previous five-year period.
>
> 4. The licensee has not been convicted of, or pled guilty or nolo

> contendere to, any criminal violation specified in this chapter or the medical practice act of any other state.
>
> 5. The licensee has not been subject within the last 10 years of practice to license revocation or suspension for any period of time; probation for a period of three years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction. The regulatory agency'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, constitutes action against the physician's license for the purposes of this paragraph.
>
> 6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with this paragraph.
>
> 7. The licensee must submit biennially to the department certification stating compliance with the provisions of this paragraph. The licensee must, upon request, demonstrate to the department information verifying compliance with this paragraph. Fla. Stat. 458.320 (5) (f) (2009).

If a physician meets all of the above criteria, he or she must post a sign "… prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. The sign or statement must read as follows: 'Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.'" Fla. Stat. 458.320 (5) (f) (2009).

Moreover, any physician holding an active license must pay the lesser of $100,000 if a final judgment is entered for malpractice, and who does not maintain hospital privileges or $250,000 if he or she maintains hospital privileges. (Fla. Stat.458.320 (5) (f) (2009). Failure to pay this amount will subject the licensee to a license suspension. (Fla. Stat. 458.320 (5) (f) (2009). License suspension is the only remedy for failure to comply with this statutory provision

for financial responsibility; moreover, the statute does not provide for an independent cause of action against a healthcare physician for failure to comply with the statute, nor does it impose a duty on a hospital or ambulatory surgery center to enforce these provisions or make them vicariously liable for the actions of a physician. *Horowitz v. Plantation General Hospital* (2007).

Pending State and Federal Legislation

Florida. On the state level, Florida does not have any pending legislation that would specifically address medical malpractice premiums. It appears that Florida is content with the reforms made in the legislature and by the electorate in 2004. These reforms and the savings are being studied and monitored by the Florida Office of Insurance Regulation. The results and opinions are addressed in this thesis. However, that is not the case at the federal level.

Federal. At the federal level, the White House and Congress have been working for months to address healthcare. There have been several bills introduced by both the House of Representatives and the Senate. Because this issue has not been resolved, no definitive statement can be made; however, several provisions that may impact medical malpractice premiums and healthcare in general are part of the proposed legislation. Most recently in November 2009, H.R. 3962, containing 1,990 pages, was introduced. No specific provision addresses a reduction of medical malpractice premiums, but several provisions have the potential to impact premiums, defensive medicine and healthcare overall. For example, section 1114 replaces “physicians” with “physician assistants” in overseeing care for hospice patients; sections 1158-1160 authorizes a reduction in payments for patient care to those costs in the lowest regions of the country (House Bill proposed, 111th Congress). Effectively, this will reduce payments for care (and, by implication, the standard of care) for hospital patients in high-cost and aging population

areas such as Florida; section 1402 will authorize the government to conduct research to “guide” doctors on the use of medical items and services.” Again, this has the potential to change the standard of care to a standard based on costs and not necessity or quality of care.

Because this matter has not been resolved at the federal level to any conclusion, future research should be to focus on the impact any new federal legislation will have on medical malpractice premiums. The focus of the new legislation appears to provide healthcare to all citizens with a reduction in costs when they seek or require healthcare. However, Senator Max Baucus, Senate Finance Chairman, in his white paper on the pending new federal legislation for healthcare, discounted the impact that increased liability costs have increased overall healthcare costs. (Baucus, 2008).

Chapter Six: Related Topics and Issues

National Issues

Since the 2002-2003 medical malpractice "crisis" Florida has taken steps to control medical malpractice premiums. One of the goals is to provide "quality medical services" to the citizens of Florida. Fla. Stat. 766.201(1)(c) (2009). As part of the reform that took place in 2003, the Florida legislature required that the Florida Office of Insurance Regulation (FLOIR) prepare an annual report summarizing the financial reports of malpractice carriers, including a comparison to other states. Fla. Stat. 627.912(6) (2009).

Essentially, the comparison looks at loss ratios and the costs of administering claims as a means of determining whether carriers are willing to write policies in Florida. Since the enactment of reform for medical malpractice in 2003, the reforms have had a positive effect on controlling rising premiums, thus allowing physicians to remain in Florida to provide medical care to its citizens. The reforms are listed in Chapter Six, supra. As compared to other states, Florida and its legislation has benefited policyholders (physicians), the industry, assisted with the solvency of carriers and lowered administration of costs (Florida Office of Insurance Regulation, 2009 Annual Report). Carriers have also benefited from these legislative reforms by experiencing greater profitability, quelling the industry concerns of paying more claims than earned premiums. This was one of the issues complained of by carriers during the medical malpractice "crisis" in early 2000s.

When compared to other states, Florida in the fifth largest market when measured by the number of direct premiums earned. The top ten states are numerically listed as follows: New York, California, Pennsylvania, Illinois, Florida, New Jersey, Ohio, Texas, Georgia and Massachusetts. Florida ranks fourth among the top ten most populous states when measured by

losses incurred to earned premiums with a ratio of 22.4% (Florida Office of Insurance Regulation, 2009 Annual Report).

Table 1. Loss ratios of the states with the most medical malpractice earned premiums.

State	Incurred Losses/ Direct Premium Earned
New York	68.4%
Illinois	46.9%
Pennsylvania	44.0%
Massachussetts	43.0%
New Jersey	40.2%
Georgia	27.0%
Florida	22.4%
Ohio	18.6%
California	18.3%
Texas	14.1%

Florida Office of Insurance Regulation, 2009 Annual Report, p. 8.

Comparing Florida to all 50 states on profitability of those carriers issuing malpractice policies, Florida carriers are profitable. The national average of profitability is 54%, Florida's percentage is 38.4%. A lower percentage indicates a higher profitability.

Table 2. 2008 comparison of profitability with ten most populous states.

States	Profitability
New York	93.0%
Illinois	69.4%
Pennsylvania	65.3%
Massachusetts	66.5%
New Jersey	54.4%
Georgia	44.6%
Florida	38.4%
Ohio	35.4%
California	35.1%
Texas	25.4%
National Average	54%

Florida Office of Insurance Regulation, 2009 Annual Report, Appendix B.

The inference is that Florida's legislative reform from 2003 has increased profitability for Florida's medical malpractice carriers and benefited policyholders (physicians). No inference can be drawn as to whether or not lower premiums have reduced the number of claims or payment of damages to victims of medical malpractice.

Rankings of Malpractice Companies-Florida

As required by statute, the Florida Office of Insurance Regulation (FLOIR) is required to report data, financial and other, for the companies comprising 80% of the medical malpractice net written premiums in Florida. Fla. Stat. 627.912 (2009). As part of that reporting, FLOIR ranks those companies as follows:

Table 3. Ranking of Florida medical malpractice carriers.

Rank	Company	Direct Premium Written	Market Share	Cumulative Market Share
1	First Professionals Insurance Company	$139,231,343	23.50%	23.50%
2	MAG Mutual Insurance Company	$65,620,806	11.10%	34.60%
3	Doctors Company, An Interinsurance Exchange	$48,048,126	8.10%	42.70%
4	Proassurance Casualty Company	$31,029,000	5.20%	48.00%
5	Florida Doctors Insurance Company	$22,477,033	3.80%	51.80%
6	Medical Protective Company	$18,403,365	3.10%	54.90%
7	Physicians Preferred Insurance Company	$17,179,907	2.90%	57.80%
8	Evanston Insurance Company	$14,915,796	2.50%	60.30%
9	Continental Casualty Company	$13,749,080	2.30%	62.60%
10	American Casualty Company of Reading Pennsylvania	$10,683,487	1.80%	64.40%
11	Columbia Casualty Company	$10,140,311	1.70%	66.10%
12	Healthcare Underwriters Group of FL	$9,703,666	1.60%	67.80%
13	Physicians Insurance Company	$9,155,948	1.50%	69.30%
14	Landmark American Insurance Company	$8,917,987	1.50%	70.80%
15	Anesthesiologists Professional Assurance Company	$8,486,644	1.40%	72.30%
16	Physicians Professional Liability Risk Retention Group, Inc.	$8,222,988	1.40%	73.60%
17	Admiral Insurance Company	$7,384,158	1.20%	74.90%
18	National Union Fire Insurance Company Of Pittsburg	$7,155,590	1.20%	76.10%
19	Darwin Select Insurance Company	$6,991,753	1.20%	77.30%
20	Podiatry Insurance Company Of America	$6,642,433	1.10%	78.40%
21	Ophthalmic Mutual Insurance Company, (A R.R.G.)	$6,472,249	1.10%	79.50%
22	Oms National Insurance Company, Risk Retention Group	$5,350,098	0.90%	80.40%
	Top 80% Total	**$475,961,768**		
	Total Florida Market	**$596,894,986**		

Florida Office of Insurance Regulation, 2009 Annual Report, p. 13.

N.B. The highlighted rows indicate insurers domiciled in Florida. Of the 22 listed companies, six are domiciled in Florida and 22 are domiciled outside of Florida.

Historically, those companies compiling the 80% market share requirement have increased since 2004 and five new companies were added for the 2009 FLOIR Annual Report (Florida Office of Insurance Regulation, 2009 Annual Report.) This indicates more insurers are entering the Florida market, presumably based upon the profitability in this market sector. This has partially resulted in a benefit to policyholders recognizing a decrease in overall medical malpractice premiums since 2004 of 30.7%. Other contributing factors include physicians

"going naked" and purchasing insurance through hospitals/employers (Florida Office of Insurance Regulation, 2009 Annual Report).

Table 4. Number of insurers comprising statutory market share.

Year	Insurers
2004	11
2005	12
2006	15
2007	17
2008	22

Florida Office of Insurance Regulation, 2009 Annual Report.

Profitability. Carriers have also benefited from these legislative reforms by experiencing greater profitability, quelling the industry concerns of paying more claims than earned premiums (Hoyt, 2006). This was one of the factors complained of during the medical malpractice "crisis" in early 2000s. The trend has been a higher return on surplus as indicated below:

Table 5. Return of profit on surplus.

Year	2001	2002	2003	2004	2005	2006	2007	2008
Return on Surplus	-7%	19%	-12%	10%	13%	20%	11%	9.5%

Florida Office of Insurance Regulation, 2009 Annual Report, p. 35.

The return on surplus ratio reported relates to all insurance company profitability and does not isolate medical malpractice policies.

For a better understanding of the effect the legislative reform has had on premiums, it is best to look at the number of rate increase requests made by carriers. The downward trend for premiums, rate increases for physicians and surgeons continued in 2008, with rates decreasing by 7% (Florida Office of Insurance Regulation, 2009 Annual Report). In 2008, 31 rate filings were filed, down from 63 in 2007. These filings were for specialized malpractice premiums such as

dentists, podiatrists, optometrists and chiropractors; however, overall, 61% of the market did not make rate changes (Florida Office of Insurance Regulation, 2009 Annual Report). Note, 21 carriers issuing medical malpractice policies in Florida filed for rate changes (increases or decreases) in the first half of 2009. The results of the rate changes have not been reported or are not available (Florida Office of Insurance Regulation, 2009 Annual Report).

Payment of medical malpractice claims in Florida. In 2008, Florida's medical malpractice carriers reported 3,336 closed claims (Appendix K). A closed claim is one that was closed during the year in question and does not represent a universal picture of all claims filed and resolved for that year. It is more probable that the occurrence and the report date were from prior years[1] (Florida Office of Insurance Regulation, 2009 Annual Report.) The total of these closed claims amounted to damages payments totaling $700,190,126. Of this amount, the amount paid in economic losses was $365,539,224 compared to $267,834,838 in non-economic damages (Florida Office of Insurance Regulation, 2009 Annual Report.) It is important to remember that proponents of tort reform cite the high payments to plaintiffs for non-economic damages or pain and suffering as the cause of skyrocketing premiums. This data shows that the payment of economic damages, past and future medical bills and lost wages, exceeds non-economic damages. The inference is that medical malpractice damages result in more medical care as a result of physician or surgeon negligence than plaintiffs' attorneys who file these types of claims or runaway juries who award damages for pain and suffering.

A breakdown of the total amount of claims paid in 2008 includes the amount paid to the plaintiff in full for all damages and the amount of loss adjustment expense (LAE) and economic and non-economic damages. LAE includes agent commissions and brokerage fees, taxes and

[1] For the claims closed in 2008, the average difference between the date of the occurrence and when the claim was filed was 471 days; the difference between when a claim was filed and closed was 896 days.

licensing, and defense cost containment or legal fees paid by the insurer/carrier (Florida Office of Insurance Regulation, 2009 Annual Report and Studdert, 2006). These damage payments are broken down as follows:

Table 6. 2008 damages paid for medical malpractice closed claims.

Number of closed claims		3,336	
Category of payment		**Amount**	**% of Total**
Damages paid to Plaintiff		$ 519,091,049.00	74.14%
LAE to Defense counsel		$ 137,413,305.00	19.63%
All other LAE		$ 43,685,772.00	6.24%
Total paid		$ 700,190,126.00	100.00%
Average cost per claim		$ 209,889.13	
Damages Paid to Plaintiffs			
Non-economic damages		$ 267,834,838.00	42.29%
Economic damages		$ 365,539,224.00	57.71%
Total		$ 633,374,062.00	100.00%
Estimate of fees-Plaintiffs' attorney			
per Constitutional Cap			
- Fla. Const. art. I, sec 26(a)	33.33%	$ 267,834,838.00	$89,278,279.33
Percentage of Non-economic damages			33.33%
Average per claim	33.33%	$209,889.13	$69,963.04

Florida Office of Insurance Regulation, 2009 Annual Report.

Medical malpractice claim breakdown. The severity and location of all closed medical malpractice claims for 2008 is reported as follows:

Table 7. 2008 Injury locations of malpractice closed claims.

Injury Location	Number of Claims	% of Total
Hospital-Inpatient	1,584	47.48%
Physician's Office	693	20.77%
Emergency Room	436	13.07%
Other Outpatient Facility	185	5.55%
Hospital-Outpatient	126	3.78%
Other Location	93	2.79%
Prison	83	2.49%
Other Hospital/Institution	54	1.62%
Patient's Home	54	1.62%
Nursing Home	28	0.84%
Total	**3,336**	**100.00%**

Florida Office of Insurance Regulation, 2009 Annual Report, p. 44.

Table 8. 2008 distribution of severity of medical malpractice closed claims.

Frequency Distribution of Severity of Claims		
Severity	**Number of Claims**	**% of Total**
1	216	6.47%
2	200	6.00%
3	533	15.98%
4	295	8.84%
5	429	12.86%
6	280	8.39%
7	217	6.50%
8	120	3.60%
9	1046	31.35%
Total	**3,336**	**100.00%**

Florida Office of Insurance Regulation, 2009 Annual Report, p. 44.

Table 9. Severity of injury classification.

Severity of Injury Field-Description		Value Assigned
Emotional only: fright, no physical damages		1
Temporary: slight lacerations		2
Temporary: minor infections, missed fracture, fall in hospital		3
Temporary: major burns, dug reaction		4
Permanent minor: loss of finger, damage to organs		5
Permanent significant: deafness, loss of limb, loss of eye		6
Permanent grave: paraplegia, blindness, loss of limbs		7
Permanent grave: quadriplegia, brain damage		8
Permanent: death		9

Florida Office of Insurance Regulation, 2009 Annual Report.

Florida Physician Workforce

Pursuant to Florida law, the Department of Health is charged with preparing an annual report on the physician workforce in Florida. This dictate comes from the Legislature who recognizes that physician workforce planning is essential to ensuring an adequate and appropriate supply of well-trained physicians to meet this state's future health care needs; long-term strategic planning is essential as completion of graduate medical education may range from seven to 10 years or longer; develop strategies to provide for a well-trained supply of physicians must include quality graduate medical schools in this state. Fla. Stat. 381.4018 (1) (2009). Because healthcare is determined to be a “critical need” this strategic plan is to be comprehensive and ongoing to determine and maintain an adequate supply of well trained physicians and healthcare providers to meet the health care needs of Floridians (Florida Department of Health, 2008 and Florida Board of Governors, 2005).

In developing the state strategic plan to increase and monitor the physician workforce, the department of health shall:

(a) Monitor, evaluate, and report on the supply and distribution of licensed physicians.

(b) Develop a model and quantify, on an ongoing basis, the adequacy of the state's current and future physician workforce. The model must take into account demographics, physician practice status, place of education and training, generational changes, population growth, economic indicators, and issues concerning the "pipeline" into medical education.

(c) Develop and recommend strategies to determine whether the number of qualified medical school applicants who might become competent, practicing physicians in this state will be sufficient to meet the capacity of the state's medical schools.

(d) Develop strategies to ensure that the number of graduates from the state's public and private allopathic and osteopathic medical schools are adequate to meet physician workforce needs.

(e) Pursue strategies and policies to create, expand, and maintain graduate medical education positions in the state based on the analysis of the physician workforce data.

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state.

(g) Coordinate and enhance activities relative to physician workforce needs, undergraduate medical education, and graduate medical education provided by the Division of Medical Quality Assurance, the Community Hospital Education Program and the Graduate Medical Education Committee established pursuant to s. 381.0403, area health education center networks established pursuant to s. 381.0402, and other offices and programs within the Department of Health as designated by the State Surgeon General.

(h) Work in conjunction with and act as a coordinating body for governmental and nongovernmental stakeholders to address matters relating to the state's physician workforce assessment and development for the purpose of ensuring an adequate supply of well-trained physicians to meet the state's future needs.

(i) Serve as a liaison with other states and federal agencies and programs in order to enhance resources available to the state's physician workforce and medical education continuum.

(j) Act as a clearinghouse for collecting and disseminating information concerning the physician workforce and medical education continuum in this state.

Fla.Stat. 381.4018 (3) (2009).

The 2008 Annual Physician Workforce report summarized the following data from the Practitioner Profile:

Of the half of allopathic (n= 25,850, and all osteopathic (n=4,839), physicians that renewed their medical licenses, 99% (n= 30,492) responded to the survey.

There were a total of 25, 654 allopathic and 4,838 osteopathic physicians completing the survey, but only 71% (21,610) of the total indicated they were practicing in Florida and had an active practice address.

Of those 21,610 physicians currently practicing in Florida and with an active practice address, 76.9% (n=16,595) were male.

Of those 21,610 physicians responding to the survey, 78% (n=13,912) indicated that they were white/non Hispanic

Physicians aged 25-45 years (n= 7,738) made up only 36% of the current workforce in Florida

Thirteen percent (n=2,765) of respondents indicate they will change the scope of their practice (significantly reduce or leave practice) in the next five years.

Of those 21,610 physicians responding to the survey, the top four specialties indicated were Family Medicine (15%; n= 3,125), Internal Medicine (13%; n=2,707), Medical Specialties (13%; n= 2,690) and Surgical Specialties (12%; n= 2,557).

Only 31% (n= 6,758) of the respondents indicate they take emergency calls or work in an emergency department.

Of the 31% taking emergency call or working in an emergency department, 78% (n=5,208) were specialty on call and 22% (n= 1,431) were full-time emergency.

Of those taking emergency on-call hours, 11% (n= 567) have reduced the number of hours in the last two years.

In the next two years, of the radiologists who responded that they currently read mammograms or other breast-imaging exams (n= 97) almost 18% indicated that they will decrease or discontinue performing the procedures.

Only 40% (n= 554) of those respondents practicing obstetric care indicated they deliver babies.

> Over 14% (n= 80) of respondents who provide obstetrics services indicated they will discontinue providing obstetric care in the next two years (Florida Department of Health, 2008).

New medical schools. To address immediate and impending physician workforce shortages and to meet legislative dictates, the Florida Board of Governors approved two new medical schools at the University of Central Florida and Florida International University. The requests for these two medical schools were first filed in 2005, however, they were not approved until march 23, 2006 (Appendix L). The approval became law in 2006. Fla. Stat. 1004.384 and .385 (2009)[2]. The rationale for approval of these medical schools as part of the State University System were in line with the legislative mandate and followed the approval of Florida State University's College of Medicine in 2000[3]. Essentially, the schools meet the community needs, replace physicians leaving the practice of medicine, recognize that Florida is a growing and dynamic state and to continue "must be proactive in planning for the future healthcare of its citizens," the creation of medical residencies is a priority for Florida's healthcare system, and to attract and retain new physicians. Appendix G contains a list of all Florida medical schools;

---

[2] 1004.384 University of Central Florida College of Medicine.--A college of medicine, as approved by the Board of Governors on March 23, 2006, is authorized at the University of Central Florida.

1004.385 Florida International University College of Medicine.--A college of medicine, as approved by the Board of Governors on March 23, 2006, is authorized at Florida International University.

[3] 1004.42 Florida State University College of Medicine.-- (1) CREATION.--There is hereby established a 4-year allopathic medical school within the Florida State University, to be known as the Florida State University College of Medicine, with a principal focus on recruiting and training medical professionals to meet the primary health care needs of the state, especially the needs of the state's elderly, rural, minority, and other underserved citizens.

Appendix C is a list of all Florida hospitals and selected data (Florida Department of Health, 2008).

Changing scope of practice. The data gathered from the practitioner profile and responses to a physician survey seem to support the legislative findings for being proactive in planning for the future healthcare of Florida citizens. The data was reported in the 2008 Physician Workforce Report. Figure 9 from the report indicates that 15.7 percent of physicians between the ages of 25-45 are planning to retire or relocating their practice. The majority of physicians who plan to retire or reduce their practice was 55.1% and were between the ages of 46-65. Figure 10 from the report lists the top reasons for changing the scope of practice as follows: liability (27.4%), reimbursement (24.4%), lifestyle considerations (20.5%), regulatory and administrative burden (12.1%), other (10.8%), and retirement (4.9%) issues. It is interesting to note that physicians are still concerned about liability issues even though there are damages caps and other tort reforms in place that have lowered premiums and reduced the number of claims being filed. Additional charts are attached which further break down physician issues.

Additional concerns that impact the state's physician workforce include malpractice insurance and liability costs, reimbursement rates and the "three strikes" amendment codified in Article X, Section 26 of the Florida Constitution. It is perceived that these issues may hinder the recruitment of doctors to Florida. The Department of Health, through the physician workforce survey and the financial information disclosure (Appendix A and B) will report to what degree liability coverage and malpractice claims influences practice by specialty and location. The results will be published in the 2009 Annual Physician Workforce Report (Florida Department of Health, 2008).

Figures 9 and 10.

Figure 9. Distribution of Physicians Planning to Retire or Reduce the Scope of Practice Within the Next Five Years by Age Category

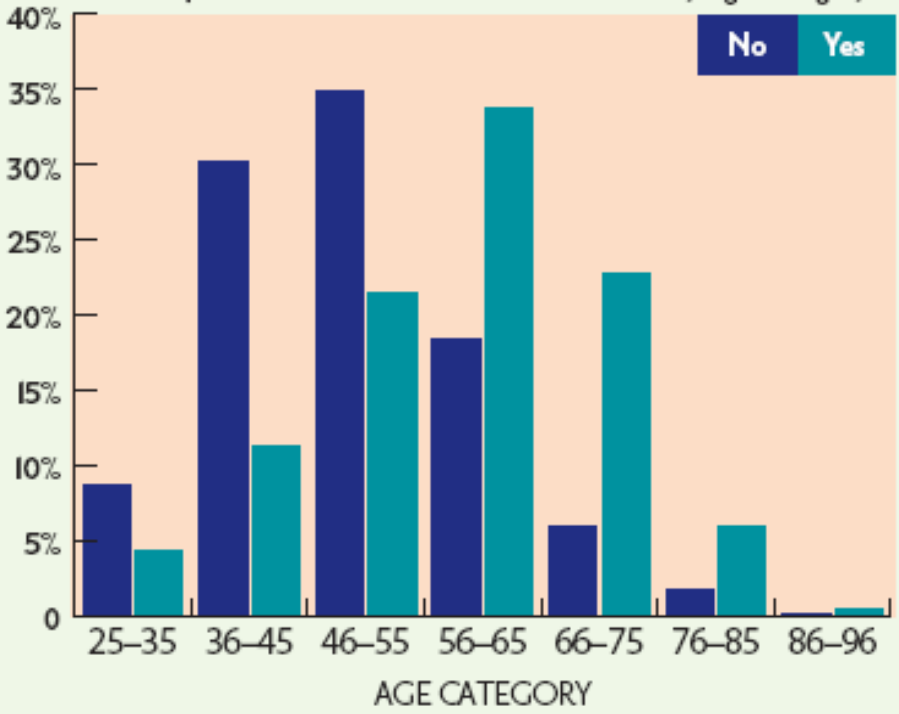
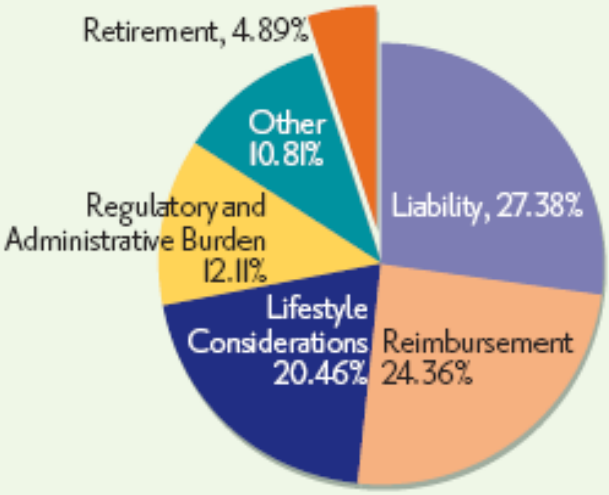
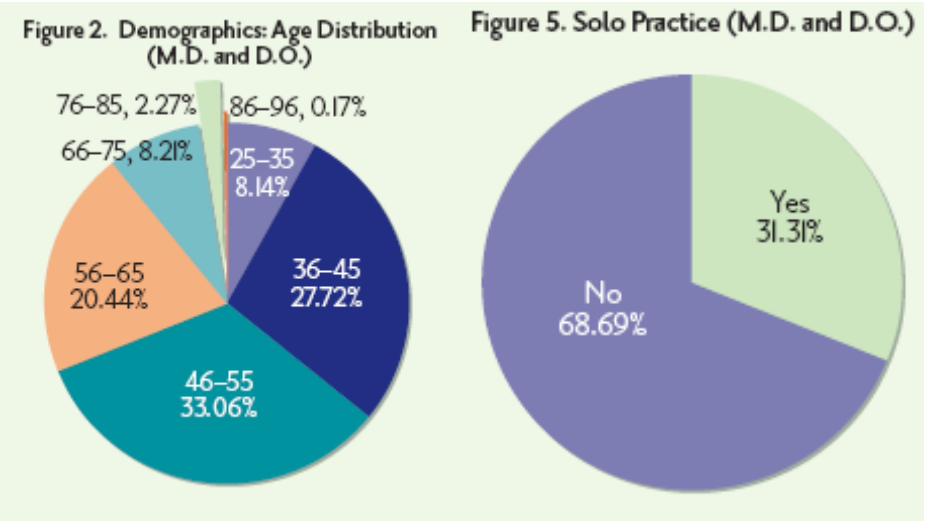


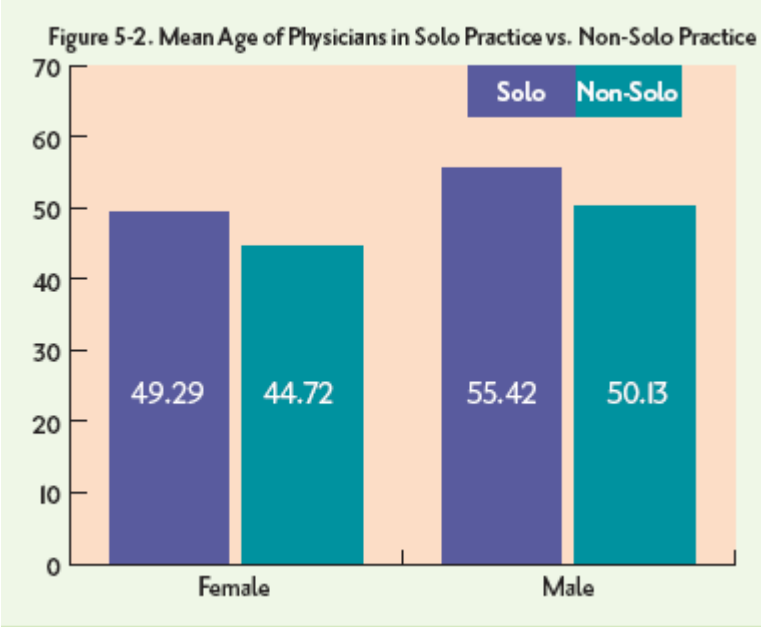
Figure 10. Top Reasons for Changing the Scope of Practice in the Last Two Years



Florida Department of Health, 2008, p. 27.

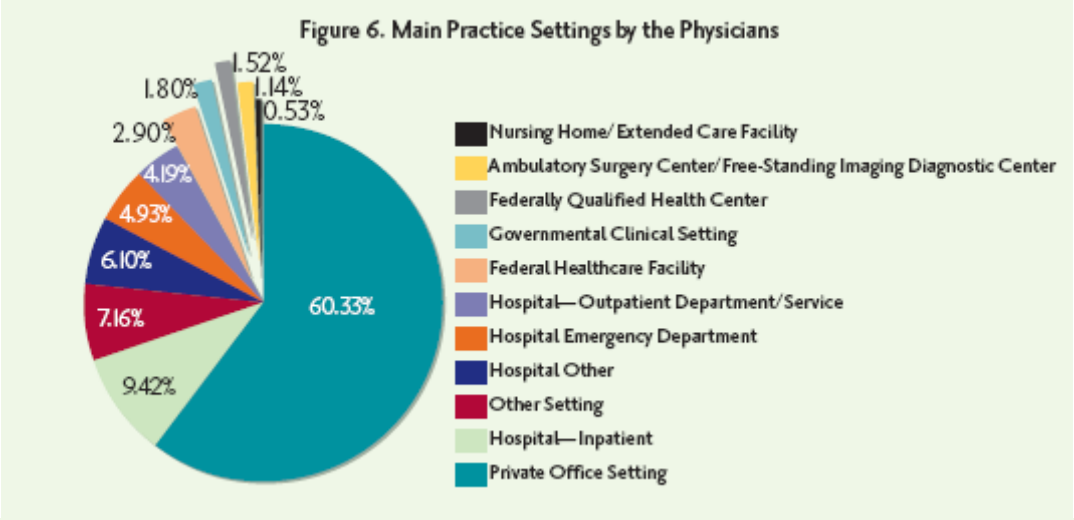
Figures 2, 5, and 5-2

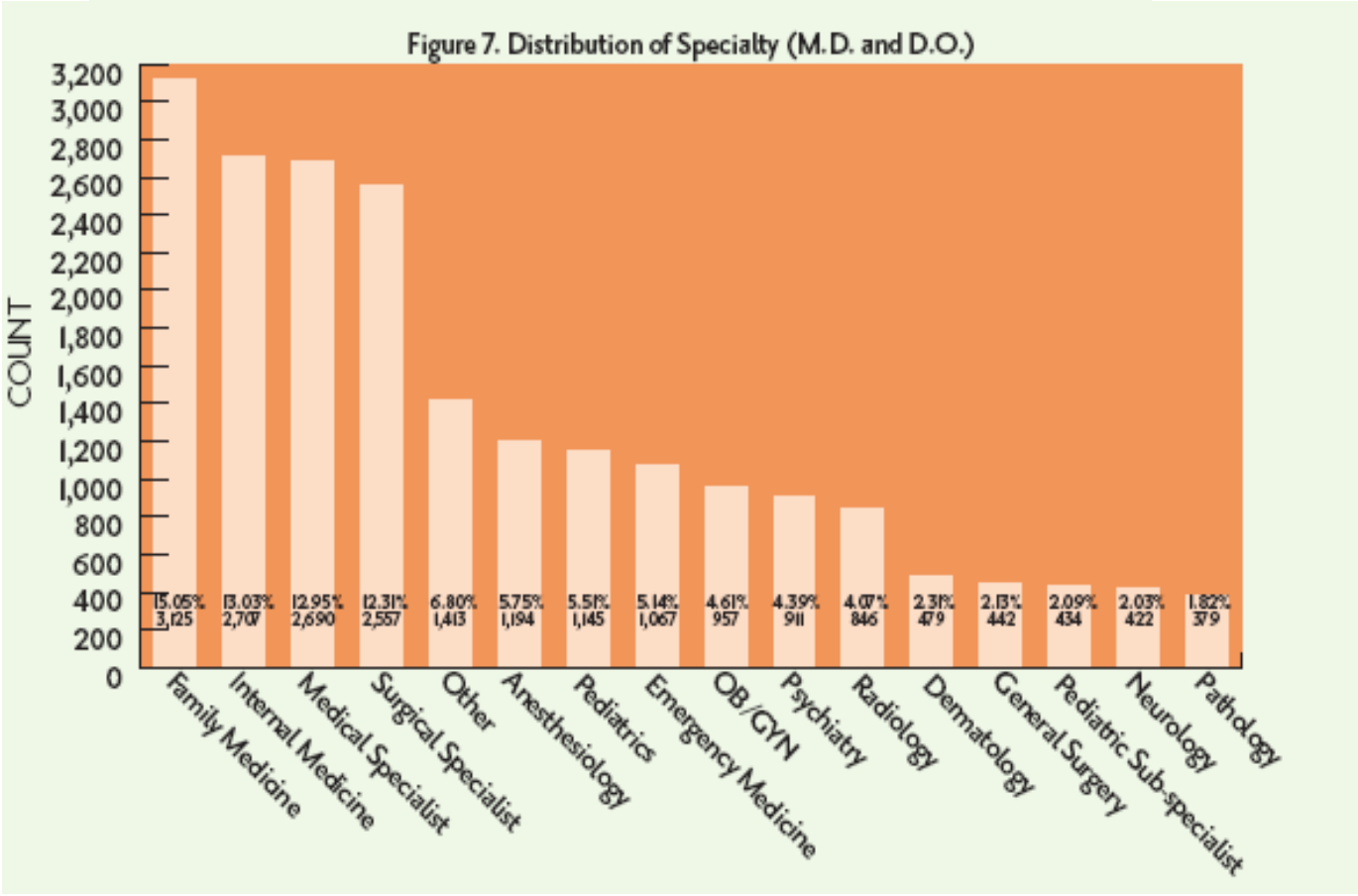




Florida Department of Health, 2008, pp. 17 and 18.

Figures 6 and 7





Florida Department of Health, 2008, p.19.

Adverse Medical Incident

Adverse medical incidents can be used to predict liability claims and therefore the effect they may have on medical malpractice premiums. An adverse medical incident is defined statutorily as well as defined in the Florida Constitution. Pursuant to Fla. Stat. 395.0197(5) (2009) the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, … and which results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

Adverse medical incidents are required to be reported to the licensing agent of a hospital or ambulatory surgical center on an annual basis. These reports are commonly referred to as a "Code 15." Code 15 or adverse medical incidents are required to be reported to either to licensed facility or state licensing agency within three to fifteen days. Fla. Stat. 395.0197 (1)(e) and (7) (2009). These incidents are a matter of public information and can be analyzed to assist in predicting medical malpractice claims. The annual report of a licensed facility shall include the following:

> 1. The total number of adverse incidents.
>
> 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 using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.
>
> 5. A description of all malpractice claims filed against the licensed 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.

Fla. Stat. 395.0197(6) (2009).

Based upon this mandatory reporting the following chart was created for the years 2004-2008. A color graph showing the same data follows after the chart and is appropriately marked and referenced.

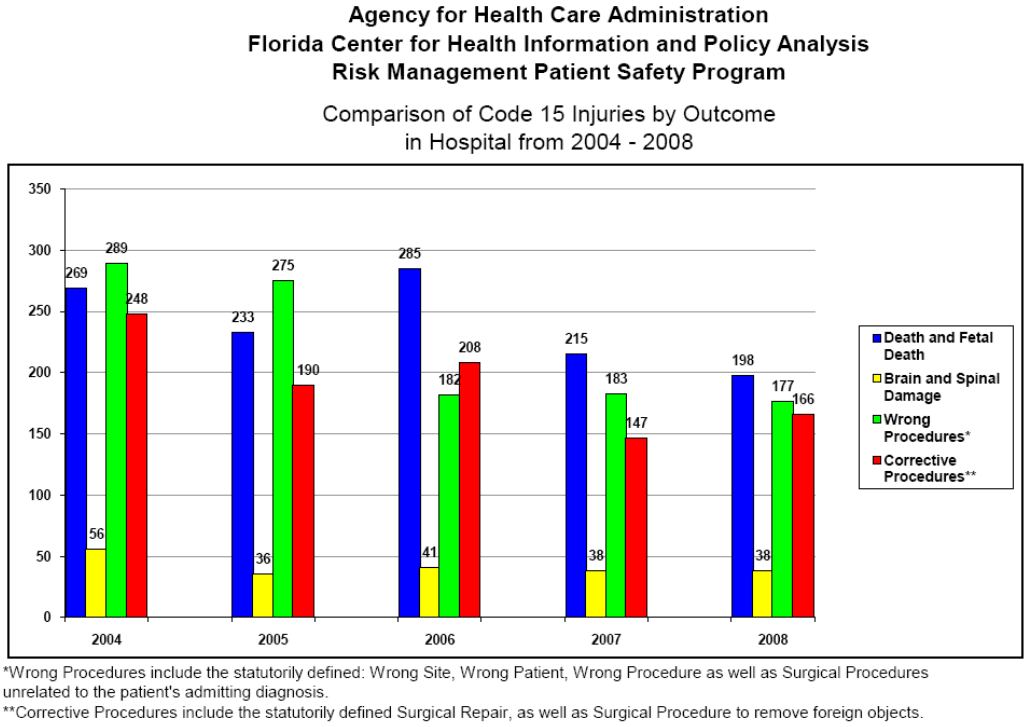
Table 10. Adverse Medical Incidents by Licensed Facility-Summary

Year	Hospital	Ambulatory Surgery Center	HMO
2004	862	94	36
2005	734	105	21
2006	716	80	21
2007	583	84	28
2008	579	87	25

Compiled from Figure 1.

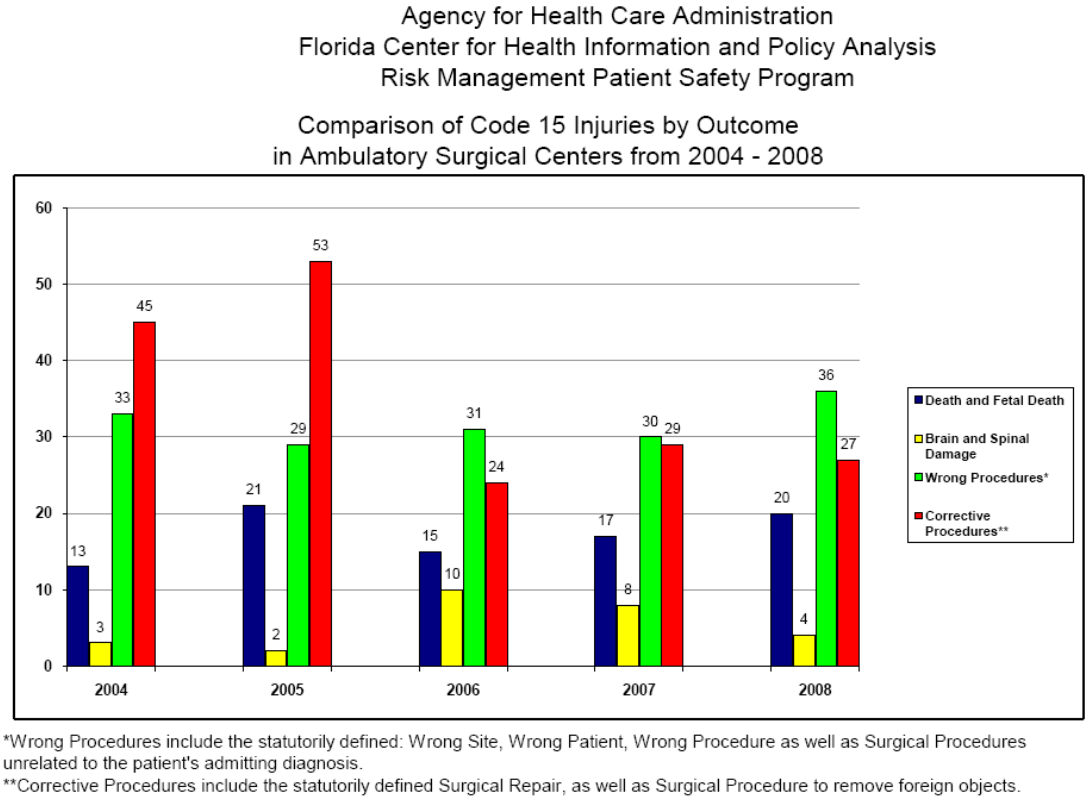
From this chart, adverse medical incidents started to decline in 2005 and again in 2007. It can be inferred that the decline in 2005 was due in part to the passage of the three constitutional amendments in 2004, supra, Chapter Six; the decline in 2007 was due in part to the passage of the three constitutional amendments, especially the "three strikes" amendment and the ongoing litigation on the confidentiality of peer review and these incidents being made public and available to plaintiff's attorneys. The "three strikes" amendment could have had a chilling effect on physicians and caused them to be more careful or to practice defensive medicine for fear of losing their license to practice medicine. An exact correlation cannot be made because the data is not available. Licensed facilities are not required to report the cause of an increase or decrease in adverse medical incidents but are only required to report the number and kind of incidents. Fla. Stat. 395.0197(6) (2009). Facilities are however required to establish and maintain an internal risk management program. The components of that program are to include an "investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients" and the "development of appropriate measures to minimize the risk of adverse incidents to patients…" Fla. Stat. 395.0197 (1) (2009).

Figure 1.



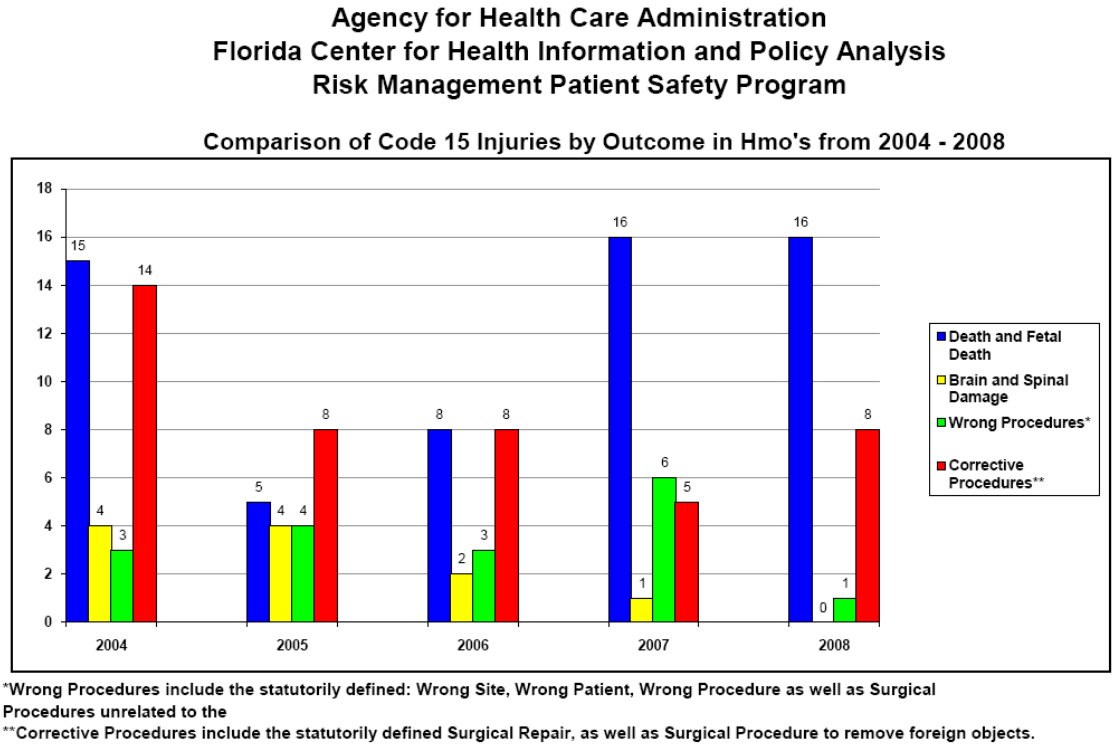
http://ahca.myflorida.com/SCHS/risk/documents/2004-2008_Hosp_ComparisionChartC15InjuriesByOutcome.pdf (Florida Agency for Health Care Administration, 2008).

Figure 3.



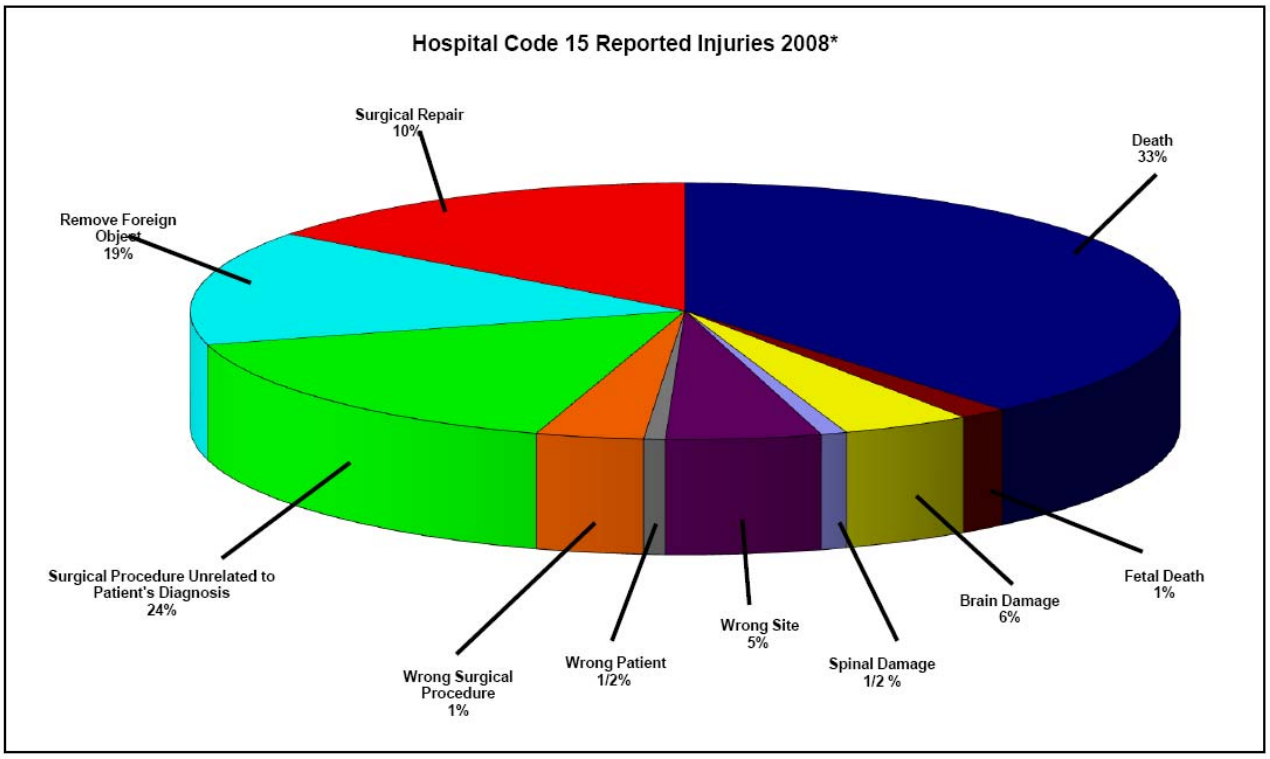
http://ahca.myflorida.com/SCHS/risk/documents/2004-2008_AS_GraphAdverseIncidentsComparison.pdf (Florida Agency for Health Care Administration, 2008).

Figure 4.



http://ahca.myflorida.com/SCHS/risk/documents/2004-2008_HMO_AdverseIncidentsComparisonGraph_ByOutcome.pdf (Florida Agency for Health Care Administration, 2008).

Figure 8.



http://ahca.myflorida.com/SCHS/risk/documents/2008_Hosp_C15Injuries_Percentage_PieChart.pdf (Florida Agency for Health Care Administration, 2008).

Figure 11.

Agency for Health Care Administration
Florida Center for Health Information and Policy Analysis
Risk Management Patient Safety Program

Summary of Code 15 Injuries by Outcomes
Reported by Hospitals
Monthly in 2008

OUTCOME	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	TOTAL
Death	14	15	12	10	23	13	22	21	19	12	16	16	193
Fetal Death	1	0	1	0	0	0	0	0	2	0	0	1	5
Brain Damage	2	1	0	2	3	8	4	4	2	4	2	3	35
Spinal Damage	0	0	0	0	0	0	1	0	0	1	0	1	3
Surgical Procedure Performed on the Wrong Site	1	1	3	1	3	2	5	5	1	3	2	1	28
Surgical Procedure Performed on the Wrong Patient	0	0	0	1	0	1	0	0	1	0	0	0	3
Wrong Surgical Procedure Performed	0	0	0	0	2	1	0	0	0	1	1	2	7
Surgical Procedure Unrelated to Patient's Diagnosis or Medical Needs	8	15	9	21	11	9	15	11	11	6	10	13	139
Surgical Procedure to Remove Foreign Object from a Surgical Procedure	12	6	10	8	6	11	12	10	10	11	7	5	108
Surgical Repair of Injuries / Damage Resulting from Planned Surgical Procedure	6	3	2	3	4	5	7	6	7	3	6	6	58
Outcome Other Description	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	44	41	37	46	52	50	66	57	53	41	44	48	579

http://ahca.myflorida.com/SCHS/risk/documents/2008_Hosp_SummaryC15InjuriesByOutcome_Monthly.pdf (Florida Agency for Health Care Administration, 2008).

Similar data, as displayed in Figure 11, is available for years 1995 to 2008 and can be found at the AHCA website http://ahca.myflorida.com/SCHS/risk/annual_report.shtml (Florida Agency for Health Care Administration, 2008).

Chapter Seven: Findings and Results

General Findings

When adopting reforms geared at the medical malpractice crisis, the Florida Legislature made the following findings:

> a. Medical malpractice liability insurance premiums have increased dramatically in recent years, resulting in increased medical care cost for most patients and unavailability of malpractice insurance for some Physicians;
> b. The primary cause of increased medical malpractice liability insurance premiums if has been the substantial increase and lost payments to claimants caused by a tremendous increases in the amounts paid claims;
> c. The average cost of medical negligence claims has escalated in the past decade to the point where it has become imperative to control costs which are in the interest of the public needs for quality medical services;
> d. the high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merits of claims, by providing for early arbitration claims, by reducing delay, attorney fees and imposing reasonable imitations on damages, while preserving the right of either party to have its case heard by a jury;
> e. The recovery of 100% of economic losses constitute over compensation because such recovery fails to recognize that such awards are not subject to taxes on economic damages. Fla. Stat. 766.201 (1) (2009).

Using these findings as a benchmark, the applicable statistical data since 2003 can be analyzed to determine if the legislative findings and reforms enacted achieved the intended goal.

Decreased premiums. Since 2004, medical malpractice premiums have decreased a total of 30.7%. Chapter 7, supra.

Loss payments to claimants. Damages paid to plaintiffs totaled 74.14% of closed claim payments for 2008-09. Table 7, supra. This represents an increase from previous years: 70.7% in 2007-08; 69.99% in 2006-07 and 72.81% in 2005-06 (Appendix M).

Administrative cost reductions. Loss adjusted expenses for the 2008-09 closed claims totaled 25.87% of closed payments for 2008. Table 7, supra. This represents a decrease from previous years: 29.3% in 2007-08; 30.01% in 2006-07 and 27.19% in 2005-06 (Appendix M).

Early determination of claims. For closed claims in 2008-09, the average difference between the date of occurrence and when the claim was filed was 471 days; the difference between when a claim was filed and when the claim was closed was 896 days (Florida Office of Insurance Regulation, 2009 Annual Report.) From previous years, there has been no significant change in this data (Appendix M).

Reduction of economic damages. For 2008-09, economic damages exceeded non-economic damages by 15.42%. Table 7, supra. With the exception of 2007-08, this percentage is lower than in previous years: 2006-07: 24.24%; 2005-06: 37.54%. In 2007-08, non-economic damages exceeded economic damages by 7.08% (Appendix M).

Increased profitability of medical malpractice carriers. Since 2004, carriers of medical malpractice policies experienced consistent double digit profitability. Table 6, supra. Also, as a result of increased profitability, the number of carriers willing to issue medical malpractice insurance policies in Florida has consistently increased. Chapter 7, supra.

Patient care. There is no objective way to quantitatively measure improved or decreased patient care since this is subjective in nature and too many variables enter into what causes a patient to file a claim or not. However, if we study the number of disciplinary complaints filed against doctors in general we can come to some sort of conclusion. The risk reward for those doctors prone to medical malpractice has been somewhat suspended by a capitation of non-economic damages and the coverage of such damages by insurance carriers. To counter this effect and attempt to provide quality medical service to Floridians, the *three strikes* amendment was enacted. This has not proven to be a deterrent as physicians subject to the amendment are able to avoid the sanction by settling the claim. Appendix J summarizes disciplinary activity in

Florida. Since the three strikes amendment, the data of disciplinary action involving revocation, voluntary suspension of suspension of a medical license is as follows:

2003-04	Medical Doctor	55
	Osteopathic	8
Average through 2008-09		
	Medical Doctor	29
	Osteopathic	4.2

Tort Reform Impact

As it stands now, the result of public tort reform has had a chilling effect on the number of claims made against physicians. Since 2004, the number of civil claims filed against medical doctors has decreased from 701 in 2003-04 to an average of 294 through 2008-09. This represents a 41.9% decrease in the number of civil claims filed. For osteopathic doctors, the number decreased 57.95, with 48 civil claims being filed in 2003-04 and an average of 27.8 through 2008-09. The inference is that public tort reform has dramatically impacted the amount of damages paid to plaintiffs, reduced administrative expenses, increased the profitability of the insurance companies and lowered premiums to healthcare providers. However, the number of medical malpractice cases filed has increased (Appendix K). It is interesting to point out that the number of closed claims for 2003-04 for medical doctors was 993 and the average number of closed claims through 2008-09 was 3051; for osteopathic doctors, the closed claims for 2003-04 was 70 and the average through 2008 was 334.2. This represents a 67.4% increase in the number of closed claims for medical doctors and a 377% increase for osteopathic doctors (Appendix K).

Since 2003, the number of newly issued medical licenses, for medical and osteopathic doctors, grew by a total of 8.4% through 2008-09. The average number of newly issued licenses

to medical doctors through 2008 was 2822, compared to 291 issued to osteopathic doctors (Appendix H). In 2003, Florida issued 2382 licenses to medical doctors and 247 licenses to osteopathic doctors.

To determine if tort reform has had an impact on physicians in the state and whether those same reforms have attracted physicians to the state, it is note worthy to review the total number of licenses issued since 2003. In 2003-04, Florida issued a total of 32,383 licenses, 29,956 to medical doctors and 2727 to osteopathic doctors. The average number of licenses since 2003-04 has grown consistently since then through 2008-09 with an average increase of 25% in licenses being issued to medical doctors and an average increase of 24% to osteopathic doctors (Appendix I).

As for a reduction in the cost of medical care, there has been no impact on the reduction of premiums or the cost of medical care due to a lowering of malpractice premiums. According to the federal government, any impact is minor at best *Supra*, p. 13.

Needed Reform

In general, the needed reforms depend on who you ask. If you ask the trial attorneys, the needed reform is patient focused and they advocate no cap on non-economic damages; these damages compensate the plaintiff for damages sustained and preserve the constitutional right to a jury trial. If malpractice carriers are asked, tort reform has not gone far enough and damages caps need to be lower, thus availing healthcare providers access to liability insurance. Physicians and surgeons demand lower damages caps arguing that trial attorneys make too much money on the victims of medical malpractice.

Objectively speaking, past tort reform has been successful to meet some or all of the objectives of the three groups. The focus of future reform should be directed toward patient

safety and the reduction of medical errors. The peer review system is not working properly and has not resulted in a reduction of the number or kind of malpractice claims. For example, death due to medical error has ranged between 20-30% since 1990 (Florida Office of Insurance Regulation, 2005-2008 Annual Reports). Inferred from this statistic is that the three strikes amendment and malpractice claims have not been an effective deterrent to reduce medical errors. Overall, tort reform rewards risky or negligent doctors by capping their liability and allow them to enjoy more financial success (Rodwin, 2006). These same doctors are left to ignore the reasonable man standard for a duty of care and ignore the professional standards for care in the community. Essentially, these same doctors are allowed to be more reckless, ignore professional standards of care, remain in practice and continue to injure innocent patients. A reduction in medical errors and patient safety should be the focus of future tort reform. Whether or not tort reform will result in a reduction of health care costs is not likely; the cost of malpractice claims is not a significant impetus toward the increase in healthcare costs or the defensive practice of medicine.

Chapter Eight: Summary and Discussion

Discussion of Thesis

It was intended that this study would analyze the impact of the legal system on medical malpractice and premiums in Florida. The study included a review of constitutional amendments adopted by the electorate to reduce medical malpractice premiums, the statutes passed to adopt tort reform, capping limits for a recovery based on non-economic damages, tort reform providing for alternative dispute resolution, case law adopting private tort reform between doctors and patients, and the financial impact all of this has on healthcare overall. Also addressed was the sovereign immunity statute which limits the amount of recovery against state owned hospitals. The hypothesis was that malpractice claims do not have a dramatic impact on an increase in physician premiums. Based on the review of the data and the academic journals, the hypothesis is correct.

Conclusions

As it stands now, the result of public tort reform has had a chilling effect on the number of closed civil claims made against physicians. Since 2004, the number of closed civil claims filed has decreased from 701 in 2003-04 to an average of 294 since then. This represents a 41.9% decrease in the number of closed civil claims filed. The inference is that public tort reform has dramatically impacted the number of medical malpractice cases filed (Appendix K).

Although there has been a reduction in premiums, this reduction is due in part to a reduction in administrative costs, presuit determination, an early determination of claims and an increase in investment income due to increased profitability. The number of closed claims has increased dramatically, yet the average cost per claim has not increased at the same rate. For example, since 2003, the number of closed claims has increased 67.4% for medical doctors and

377% for osteopathic doctors. During the same period the average increase in the average cost per claim has increased as follows:

2005-06 9.4%

2006-07 4.6%

2007-08 .07%

Recommendations:

To resolve the issue of patient safety, the number of claims must be reduced, the severity of claims must be reduced and investment income for insurance companies must increase. The problem is what control if any do insurers have over their policyholder/physicians, to control the severity of claims or frequency of claims? Justification lies in the enforcement of the three strikes amendment and the disciplinary/regulatory scheme of physicians.

The focus of future reform should be directed toward patient safety and the reduction of medical errors. Deaths due to medical error have ranged between 20-30% since 1990 (Florida Office of Insurance Regulation, 2005-2008 Annual Reports). Inferred from this statistic is that the three strikes amendment and malpractice claims have not been an effective deterrent to reduce medical errors. Overall, tort reform rewards risky or negligent doctors by capping their liability and allow them to enjoy more financial success.

To counter this, Department of Health should strictly regulate repeat offenders.

The ban on the cap for attorney fees on non-economic damages claims should be lifted as contingent fee agreements provide access to the courts and allow claims to be filed, especially against repeat offenders.

Abolish the cap on damages for repeat offenders by not allowing these repeat offenders to benefit from legislation which caps their damages for reckless behavior.

Discipline repeat offenders by strengthening the peer review process and the professional standards committee of hospitals and outpatient centers. Also, make this information more readily available to the public by making it easier to access on the internet and conduct public service announcements which are geared at educating the public on how to investigate and choose and quality health care professional.

Recommendations for Future Work

The practitioner profile should be expanded to include the number of claims filed against a physician and the amount of insurance available to the public in the event of a claim. Currently, some of this information is available to the public but access is not easily available unless a person knows where to look. The information should be expanded to include more disclosure of the type of claim filed and the facts thereof. Currently, insurance companies report most of this data. The data should be expanded to include the physicians area of practice, specialization and training. If a claim is filed, the closed claim data base and practitioner profile should reflect as much data as possible, including specialty and cause of injury. This could be used to better track and analyze reckless doctors and determine a pattern or practice. The data base should be cross referenced with the disciplinary data base. Since not all claims result in a claim or in a disciplinary action, reporting of this type of data may help further define areas of potential claims and physicians of interest. Also, empirical data should be collected and cross referenced regarding the types of procedures and the amount of reimbursements from third party administrators. This could help identify if a practitioner was reckless because they went outside of their area of specialty or need more training. It could also help identify whether a claim was an adverse incident, negative outcome, negligent or reckless act. Moreover, other healthcare professionals should be encouraged to report negligent acts without fear of reprisal in the

workplace. Although ethical requirements mandate such reporting, more often than not, the perpetrator knows who the reporting party was and reprisals appear in the workplace or professional arena. This would encourage reports and encourage an already mandated professional duty of care. Increase the strength of peer review and risk management committees by granting them more disciplinary action. As it stands now, many healthcare providers know who are good practitioners and who are not. Disclosure and sanctions should be swift and public so that the general public can make these same determinations. Such disclosures would be patient safety oriented.

References

Advisory Opinion to the Attorney General, 880 So.2d at 621 (Fla. 2004).

Allen, J. & Davis, D. (1993). Assessing Some Determinant Effects of Ethical Consulting Behavior: The Case of Personal and Professional Values. *Journal of Business Ethics. 12*(6), 449. Retrieved May 16, 2009, from ABI/INFORM Global database. (Document ID: 571897).

American Bar Association Model Rule of Professional Conduct 1.1. (2009). Competence. Retrieved from http://www.abanet.org/cpr/mrpc/rule_1_1.html.

Baicker, K., Fisher, E., & Chandra, A. (2007). Malpractice Liability Costs and the Practice of Medicine in the Medicare Program. *Health Affairs*, 26(3), 841-52. Retrieved from ABI/INFORM Global database. (Document ID: 1274856901).

Bajtelsmit, V., & Thistle, P. (2008). The Reasonable Person Negligence Standard and Liability Insurance. *Journal of Risk and Insurance*, 75(4), 815-823. Retrieved from ABI/INFORM Global database. (Document ID: 1601432571).

Barringer, P. (2008). Health Courts, Medical Injury Compensation, and Patient Safety. *Benefits Law Journal*, 21(1), 79-90. Retrieved from Law Module database. (Document ID: 1419337541).

Baucus, M. (2008) Call to Action: Health Reform 2009. Retrieved from http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

Black's Law Dictionary (Revised 4th ed. 1968).

Black's Law Dictionary (8th ed. 2004).

Bloche, M. (2006). Consumer-Directed Health Care. *The New England Journal of Medicine*, 355(17), 1756-9. Retrieved from Research Library Core database. (Document ID: 1152357131).

Blumstein, J. (2006). Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" as a New Role for QIOs? *Vanderbilt Law Review*, 59(4), 1017-1049. Retrieved from ABI/INFORM Global database. (Document ID: 1167635561).

Born, P., Viscusi, W., & Baker, T. (2009). The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses. *Journal of Risk and Insurance*, 76(1), 197-219. Retrieved from ABI/INFORM Global database. (Document ID: 1660983901).

Cevallos v. Rideout, 18 So.3d 661 (Fla. App. 4 Dist., 2009).

Chandra, A., Nundy, S., & Seabury, S. (2005). The Growth Of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank. *Health Affairs: Web Exclusives*, 24, 240-249. Retrieved from ABI/INFORM Global database. (Document ID: 911043741).

Clancy, C. (2008). 2008 National Healthcare Quality & Disparities Reports. Retrieved from http://www.ahrq.gov/qual/qrdr08.htm.

Congressional Budget Office. (2004). Limiting Tort Liability for Medical Malpractice. Retrieved from http://www.cbo.gov/doc.cfm?index=4968.

Congressional Budget Office. (2008). Behavioral Economics: Lessons from Retirement Research for healthcare and beyond. Retrieved from http://www.cbo.gov/ftpdocs/96xx/doc9673/08-07-Presentation_RRC.pdf.

Congressional Budget Office. (2008). Key issues in analyzing major health insurance proposals.

Retrieved from http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

Cooper, D. & Schindler, P. (2008). Business Research Methods, Tenth Edition. New York: The McGraw-Hill Companies, Inc.

De Wald v. Quarnstrom, 60 So. 2d 919 (Fla. 1952)

Farber, D.A. (2007). Adapting to Climate Change: Who Should Pay. 23 *J. Land Use & Envtl. L.* 1,

Federbush, D.J. (2004). Damages under the FDUTPA. *78 Fla. B.J. 20*.

Florida Agency for Health Care Administration. (2008*).* 2008 Risk Management Statistical Reports. Retrieved from http://ahca.myflorida.com/SCHS/risk/statistics2008.shtml.

Florida Board of Governors. (2005). Strategic Plan 2005-2013: State University System of Florida. Retrieved from http://www.flbog.org/about/_doc/strategicplan/StrategicPlan_05-13.pdf.

Florida Constitution, Article I, sec. 21. (2009). Access to courts.

Florida Constitution, Article I, sec. 22. (2009). Trial by jury.

Florida Constitution, Article I, sec. 26. (2009). Claimant's right to fair compensation.

Florida Constitution, Article X, sec. 25. (2009). Patients' right to know about adverse medical incidents.

Florida Constitution, Article X, sec. 26. (2009). Prohibition of medical license after repeated medical malpractice.

Florida Department of Health. (2008). 2008 Florida Physician Workforce Annual Report. Retrieved from http://ahca.myflorida.com/Medicaid/quality_management/workgroups/hospital/2d-PhysicianWorkforceReptNov08.pdf.

Florida Eye Health vs. Shedden, 974 So.2d 1193 (Fla. 2d DCA 2008).

Florida Hospital Waterman, Inc., v. Buster, 984 So.2d 478 (Fla. 2008)

Florida Office of Insurance Regulation. (2003). Review of Subcommittee for Senate Bill 2-D: Presumed Factor Calculation. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2004). Medical Malpractice Financial Information, Closed Claim Database and Rate Filings: Fla. Stat. 627.912(6)- 2004. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2005). Medical Malpractice Financial Information, Closed Claim Database-Statistical Summary: Fla. Stat. 627.912(6)(a)- 2005, Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2006). Office of Insurance Regulation-Transition Manual-2006. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2006). Medical Malpractice Financial Information, Closed Claim Database and Rate Filings: Fla. Stat. 627.912(6)- 2006. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2007). Medical Malpractice Financial Information, Closed Claim Database and Rate Filings: Fla. Stat. 627.912(6)- 2007. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2008). Medical Malpractice Financial Information, Closed Claim Database and Rate Filings: Fla. Stat. 627.912(6)- 2008. Retrieved from http://www.floir.com/LegislativeAffairs/reports_studies.aspx.

Florida Office of Insurance Regulation. (2009). Medical Malpractice Financial Information, Closed

Claim Database and Rate Filings- 2009 Annual Report. Retrieved from http://www.floir.com/pdf/medmalreport10012009.

Florida Rule of Civil Procedure 1.280. (2009). General provisions governing discovery. Retrieved from http://www.floridabar.org/TFB/TFBResources.nsf/Attachments/10C69DF6FF15185085256B29004BF823/$FILE/Civil.pdf?OpenElement.

Florida Rule of Professional Conduct 1-2. (2009). Purpose. Retrieved from http://www.floridabar.org/divexe/rrtfb.nsf/FV?Openview&Start=1&Expand=1.2#1.2.

Florida Rule of Professional Conduct 4-1.5. (2009). Fees and costs for legal services. Retrieved from http://www.floridabar.org/divexe/rrtfb.nsf/FV/A8644F215162F9DE85257164004C0429.

Florida Rule of Professional Conduct 4-3.1. (2009). Meritorious claims and contentions. Retrieved from http://www.floridabar.org/divexe/rrtfb.nsf/FV/01078BBFEA50C31B8525717100654FB8.

Florida Rule of Professional Conduct 4-3.3. (2009). Candor toward the tribunal. Retrieved from http://www.floridabar.org/divexe/rrtfb.nsf/FV/C7603354C3858947852574F60059B58C.

Florida Rule of Professional Conduct 4-3.4. (2009). Fairness to opposing party and counsel. Retrieved from http://www.floridabar.org/divexe/rrtfb.nsf/FV/C5A0AE7DB2FD85DE85256BBC00516464

Florida Statutes Title XXXVII (2009). Insurance.

Florida Statute 44.1011. (2009). Definitions. Note: Use full URL; APA rule 6.15; A7.02

Florida Statute 90.502. (2009). Lawyer-client privilege.

Florida Statute 95.011. (2009). Applicability.

Florida Statute 95.11. (2009). Limitations other than for the recovery of real property.

Florida Statute 381.4018. (2009). Physician workforce assessment and development.

Florida Statute 395.0193. (2009). Licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.

Florida Statute 395.0197. (2009). Internal risk management program.

Florida Statute 456.50. (2009). Repeated medical malpractice.

Florida Statute 458.320. (2009). Financial responsibility.

Florida Statute 624.02 (2009). Insurance defined.

Florida Statute 624.03 (2009). Insurer defined.

Florida Statute 627.041 (2009). Definitions.

Florida Statute 627.912. (2009). Professional liability claims and actions; reports by insurers and health care providers; annual report by office.

Florida Statute 627.9126. (2009). Reports by liability insurers.

Florida Statute 682.01. (2009). Florida arbitration code.

Florida Statutes Chapter 766. (2009). Medical Malpractice and Related Matters.

Florida Statute 766.101. (2009). Medical review committee, immunity from liability.

Florida Statute 766.102. (2009). Medical negligence; standards of recovery; expert witness.

Florida Statute 766.104. (2009). Pleading in medical negligence cases; claim for punitive damages; authorization for release of records for investigation.

Florida Statute 766.106. (2009). Notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.

Florida Statute 766.107. (2009). Court-ordered arbitration.

Florida Statute 766.108. (2009). Mandatory mediation and mandatory settlement conference in

medical negligence actions.

Florida Statute 766.1115. (2009). Health care providers; creation of agency relationship with governmental contractors.

Florida Statute 766.1116. (2009). Health care practitioner; waiver of license renewal fees and continuing education requirements.

Florida Statute 766.112. (2009). Comparative fault.

Florida Statute 766.118. (2009). Determination of noneconomic damages.

Florida Statute 766.1185. (2009). Bad faith actions.

Florida Statute 766.201. (2009). Legislative findings and intent.

Florida Statute 766. 202. (2009). Definitions; ss. 766.201-766.212.

Florida Statute 766.2021. (2009). Limitation on damages against insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics.

Florida Statute 766.203. (2009). Presuit investigation of medical negligence claims and defenses by prospective parties.

Florida Statute 766.204. (2009). Availability of medical records for presuit investigation of medical negligence claims and defenses; penalty.

Florida Statute 766.205. (2009). Presuit discovery of medical negligence claims and defenses.

Florida Statute 766.211. (2009). Payment of arbitration award; interest.

Florida Statute 766.301. (2009). Legislative findings and intent.

Florida Statute 768.28. (2009). Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.

Florida Statute 768.31. (2009). Contribution among tortfeasors.

Florida Statute 768.81. (2009). Comparative fault.

Florida Statute 1004.384. (2009). University of Central Florida College of Medicine.

Florida Statute 1004.385. (2009). Florida International University College of Medicine.

Florida Statute 1004.42. (2009). Florida State University College of Medicine.

Frank v. Lurie, 157 So. 2d 431 (Fla. 2d DCA 1963).

General Accounting Office. (2003). Medical Malpractice Insurance–Multiple factors have contributed to increased premium rates. GAO-03-702. Retrieved from http://www.gao.gov/new.items/d03702.pdf.

General Accounting Office. (2003). Medical Malpractice –Implications of Rising Premiums on Access to Healthcare. GAO-03-836. Retrieved from http://www.gao.gov_new.items_d03836

Harris, J.B. (2009). Riding the Red Rocket, 83 *Fla. B.J.* 20.

Hellinger, F., & Encinosa,W. (2006). The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures. *American Journal of Public Health*, 96(8), 1375-81. Retrieved from ABI/INFORM Global database. (Document ID: 1117375111).

Horowitz v. Plantation General Hospital, 959 So.2d 176 (Fla.2007).

House Bill ____, 111th Congress, Session 1. Proposed Bill in the House of Representatives, 111th Congress, retrieved from http://www.defendyourhealthcare.us/images/111_ahcaa.pdf.

Hoyt, R., & Powell, L. (2006). Assessing Financial Performance in Medical Professional Liability Insurance. *Journal of Insurance Regulation,* 25(1), 3-13. Retrieved from ABI/INFORM Global database. DOI: 1174953021.

Hyman, D., Silver, C. (2006). Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid. *Vanderbilt Law Review*, 59(4), 1085-1136. Retrieved June 15, 2009, from

ABI/INFORM Global database. (Document ID: 1167635611).

Jacksonville Journal Co. v. Gilreath, 104 So. 2d 865 (Fla. 1st DCA 1958).

Jain, S. (2007). The Medical Malpractice Myth. *Law & Society Review*, 41(3), 737-738. Retrieved June 15, 2009, from Research Library Core database. (Document ID: 1425233291).

Liang, B., & Ren, L. (2004). Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare. *American Journal of Law and Medicine*, 30(4), 501-41. Retrieved from Health Module database. (Document ID: 772064621).

Marchev, M. (2002). The Medical Malpractice Insurance Crisis: Opportunity for state action. *National Academy for State Health Policy.* Retrieved from http://nashp.org/sites/default/files/medical_malpractice_crisis.pdf.

Matthew, E.S., (2006)14 *U. Miami L. Rev.* 331, 337, A New Prescription: How a Thorough Diagnosis of the "Medical Malpractice" Amendments Reveals Potential Cures for Florida's Ailing Citizen Initiative Process.

McLeod v. Continental Insurance Co., 591 So. 2d 621, 624-25 (Fla. 1992).

Meyer v. Caruso, 731 So.2d 118 (Fla. 4th DCA 1999).

Neale, F., Eastman, K., & Drake, P. (2009). Dynamics of the Market for Medical Malpractice Insurance. *Journal of Risk and Insurance*, 76(1), 221-247. Retrieved from ABI/INFORM Global database. (Document ID: 1660983921).

Ranjii, U, Gutierrez, C, & Salganicoff, A. (2005). Medical Malpractice Policy. *The Henry J. Kaiser Family Foundation.* Retrieved from http://www.kaiseredu.org/topics_im.asp?id=226&imID=1&parentID=59.

Rhee, R. (2008). Tort Arbitrage, 60 *Fla. L. Rev.* 125.

Rodwin, M., Chang, H., & Clausen, J. (2006). Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence. *Health Affairs,* 25(3), 750-8. Retrieved from ABI/INFORM Global database. (Document ID: 1038492701).

Russell v. Jacksonville Gas Corp., 117 So. 2d 29 (Fla. 1st DCA 1960).

Rutsohn, P., & Sikula, A. (2007). Medical Malpractice Reform: A Societal Crisis or Fear Marketing? *Journal of Medical Marketing,* 7(2), 169. Retrieved from ABI/INFORM Global database. (Document ID: 1249847271).

Sataloff, J. (2008). The First Step Toward Stopping the Malpractice Insurance Crisis. *Ear, Nose & Throat Journal,* 87(9), 492-4. Retrieved from ProQuest Health and Medical Complete database. (Document ID: 1575673681).

Schoenbaum, S., & Segel, K. (2006). Long-Term Solution to Malpractice Crises: Reduce Harm to Patients. *Physician Executive,* 32(2), 26-31. Retrieved from ABI/INFORM Global database. (Document ID: 1016648041).

Schornberg v. Panorama Custom Home Builders, Inc., 972 So. 2d 243 (Fla. 2d DCA 2007).

Seninger, S., & Herling, J. (2006). Health Care Costs: Regulation and Reform. *Montana Business Quarterly,* 44(1), 25-28. Retrieved from ABI/INFORM Global database. (Document ID: 1028702551).

Shadish, W., Brasil, I., Illingworth, D., White, K., Galindo, R., Nagler, E., & Rindskopf, D.. (2009). Using UnGraph to extract data from image files: Verification of reliability and validity. *Behavior Research Methods, 41*(1), 177-183. Retrieved from Psychology Module. (Document ID: 1655322931).

Shotts v. OP Winter Haven, Inc., 988 So.2d 639, 2008 WL 2435576 (Fla. 2d DCA), 33 Fla. L. Weekly D1579 (2008).

Slusser vs. Life Care Centers of America, Inc., 977 So.2d 662, 2008 WL 441644 (Fla. 4th DCA 2008).

Southern Bell Telephone and Telegraph Co. v. Deason, 632 So.2d 1377 (Fla. 1994).

State v. Ashley, 701 So. 2d 338, 431 (Fla. 1997)

Steen, R. (2004). New Jersey: Med-Mal Reform Addresses ADR. *Dispute Resolution Journal*, 59(3), 6-7. Retrieved from ABI/INFORM Global database. (Document ID: 697601961).

Studdert, D., Mello, M., Gawande, A., & Gandhi, T., et al. (2006). Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *The New England Journal of Medicine*, 354(19), 2024-33. Retrieved from Research Library Core database. (Document ID: 1035902091).

Struve, C. (2004). Improving The Medical Malpractice Litigation Process. *Health Affairs*, 23(4), 33-41. Retrieved from ABI/INFORM Global database. (Document ID: 661524631).

Sweet v. Sheehan, 932 So.2d 365 (Fla. 2d DCA 2006), rehearing denied, review denied 944 So.2d 987.

Thornber v. City of Fort Walton Beach, 568 So. 2d 914, 918 (Fla. 1990).

United States Constitution, amendment VII. Trial by jury in civil cases.

Vidmar, N., MacKillop, K., & Lee, P. (2006). Million Dollar Medical Malpractice Cases in Florida: Post-Verdict and Pre-Suit Settlements. *Vanderbilt Law Review*, 59(4), 1343-1381. Retrieved from ABI/INFORM Global database. (Document ID: 1167635651).

Waters, T., Budetti, P., Claxton, G., & Lundy, J. (2007). Market Watch: Impact of State Tort Reforms on Physician Malpractice Payments. *Health Affairs*, 26(2), 500-9. Retrieved from

ABI/INFORM Global database. (Document ID: 1232226971).

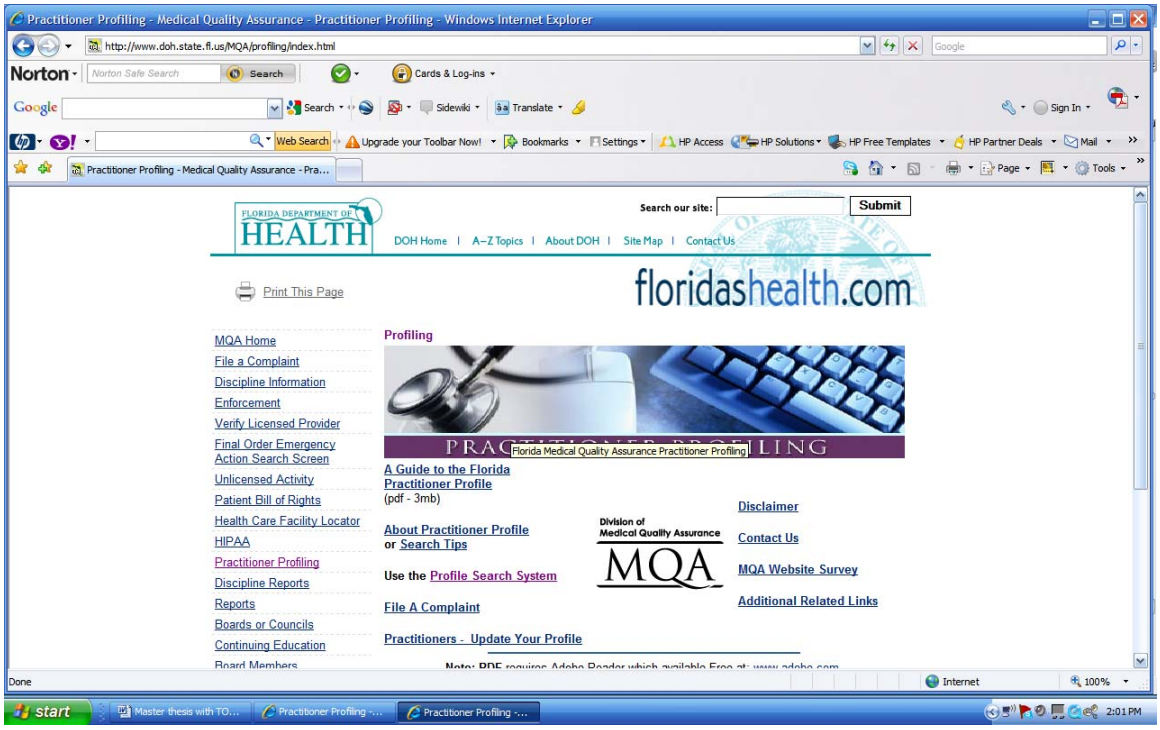
Williams v. National Freight, Inc., 455 F. Supp. 2d 1335 (M.D. Fla. 2006).

Woebse v. Healthcare and Retirement Corp, 977 So.2d 630, 33 Fla. L. Weekly D424 (2008).

Zivojinovich v. Barner, 525 F.3d 1059 (11th Cir. 2008).

Appendix A

Practitioner Profile Information and Closed Claim Database

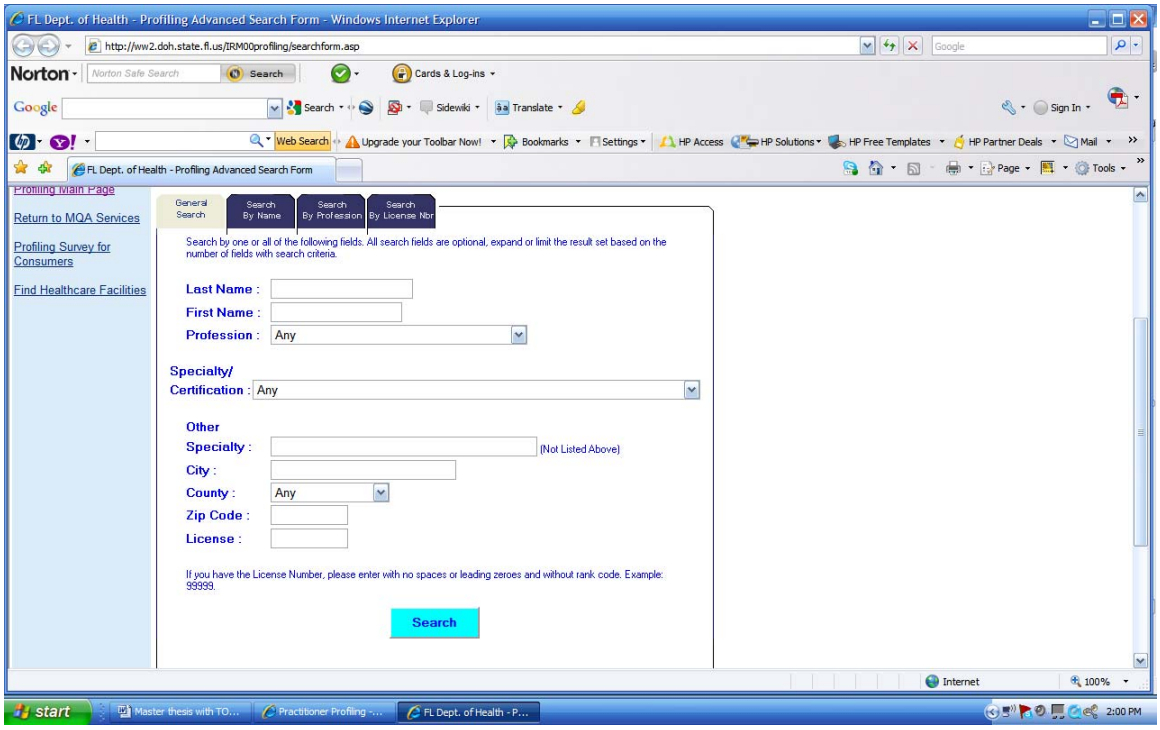


Welcome to the State of Florida Practitioner Profile Web site. Here you will find profiles for all licensed doctors of medicine, osteopathy, chiropractic, podiatric and advanced registered nurse practitioners. A profile is self-reported information about the practitioner and is designed to help you choose a practitioner or find out more about a practitioner you go to now.

Practitioner's Guide to Completing and Updating the profile (pdf - 2mb)

A Guide to the Florida Practitioner Profile (pdf - 3mb)

Retrieved on 11-28-09 from, http://www.doh.state.fl.us/MQA/profiling/index.html



http://ww2.doh.state.fl.us/IRM00profiling/searchform.asp

Practitioner profiles

Database Category :	Professions
Statute or Law Reference:	456.041, 456.039 and 456.0391 FS
Regulatory Rules:	64B-2 FAC
Reporting Entities:	Licensed medical doctors, osteopathic physicians, podiatric practitioners, chiropractic practitioners, and advanced registered nurse practitioners
Web-1:	**http://www.doh.state.fl.us/mqa/proflist.htm**
Web-2:	**http://doh-mqaservices.com**

Database Purpose:

Public information

Types Of Data Collected:

Name, license number, business address, hospital staff privileges, Medicaid participation, education and training, specialty certification, financial responsibility, final disciplinary action, criminal offenses

Department:	Department of Health
Division:	Medical Quality Assurance
Bureau:	Operations
Contact Name:	Candy Tyre
Contact Phone:	(850)245-4757
Contact Email:	**candy_tyre@doh.state.fl.us**
Supervisor Name:	Lola Pouncey
Supervisor Title:	Bureau Chief
Supervisor Phone:	(850)245-4064

Date Record Updated: 12/30/2008 11:53:23 AM
http://www.floridahealthfinder.gov/StateHealthDataDirectory/StateHealthDirectoryEntries.aspx, retrieved 11-28-09

Professional Liability Closed Claims Disclaimer and Notice

Disclaimer || Search || Order || Industry Statements || Statute

---

DISCLAIMER and IMPORTANT CONSUMER NOTICE

Consumers are urged to read this notice prior to searching the closed claims database.

1. Florida's professional liability reporting statute (Chapter 627.912, F.S.) doesn't cover all licensed professionals or institutions. The law requires only that three entities -- insurance companies, self-insurance funds and joint underwriting associations -- file reports of alleged error, omission or negligence by *insured* doctors, dentists, hospitals, health maintenance organizations (HMOs), abortion clinics, ambulatory surgical centers, crisis stabilization units and lawyers.

2. The reports on this site stem from patient or client allegations and are public record. The site contains a listing of only those claims in which an insurer made a payment to a claimant to satisfy a judgment or reach a settlement, which companies sometimes do because it's less costly than fighting the matter in court. Consumers should also note that:

(a) Some providers and institutions covered by the closed claims law will not appear in this listing for various other reasons. For example, some may not carry professional liability insurance; and, others may be self-insured.

(b) Some of the closed claims -- because they date back many years -- involve professionals who have moved, retired or passed away. Likewise, some institutions may no longer exist; or, they may have changed names.

(c) Over the years, the claims reporting forms have changed. Prior to March 1988, for example, insurers could only report the name of a law firm instead of the name of the individual lawyer deemed responsible for the claim. In any event, neither the number nor amount of any claim is necessarily an indicator of professional competence or quality.

3. Consumers are advised to discuss and verify all information with the professional service provider or institution, and check all identifying factors to avoid confusion with similar names. Instructions for obtaining additional information from a closed claim report can be found by clicking here. (The average report is five pages long.)

4. Additional information from the Florida Medical Association, the Florida Hospital Association and certain HMOs can be viewed by clicking here.

5. Neither the Department of Financial Services nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers.

6. Inappropriate use of any closed claims information to make incomplete or misleading comparisons of professional providers or institutions may violate the law.

http://www.floir.com/Liability/, retrieved on 11-28-09

Professional Liability Closed Claims Orders

Disclaimer || Search || Order || Industry Statements || Statute

---

INSTRUCTIONS FOR ORDERING COPIES OF FLORIDA PROFESSIONAL LIABILITY CLOSED CLAIM FILES

All requests for copies of closed claim reports must be in writing. This can be done by mail or FAX. The mailing address is:

Department of Financial Services
Attn: Document Processing Section
P.O. Box 5320
Tallahassee, FL 32314-5320

If you wish to FAX your request, please address it to "Attn: Document Processing Section" and FAX to (850)488-3429.

All requests submitted must have the following information:

For doctor's and lawyer's closed claims:

1. The professional's name (please be sure to specify whether your request applies to medical professional liability claims or legal professional liability claims)
2. Department file number or date time frame (ie. 1983-1994)
3. License number of the doctor (in case there is more than one name listed)

For hospital closed claims:

1. The hospital's name
2. Date time frame

3. County of hospital (in case there is more than one hospital with the same name)

Please note: The Document Processing section of the Department of Financial Services is only responsible for processing the requests submitted for copies of closed claim files. They can not accept requests to change or "correct" information listed on this Internet site.

http://www.floir.com/Liability/, retrieved 11-28-09

Professional Liability Closed Claims Industry Statements

Disclaimer || Search || Order || Industry Statements || Statute

Statement by affected HMOs
Statement by the Florida Medical Association
Statement by the Florida Hospital Association

Statement by affected HMOs

Not all claims against HMOs are included on this site. For example, five of the seven largest HMOs in Florida do not appear in this listing as having claims. The fact that an HMO has no or few claims may be due to the absence of professional liability insurance. Likewise, claims against HMOs in amounts below their liability policy deductible may not be reported. Further, HMOs that employ doctors (staff-model HMOs) are subject to lawsuit for the alleged acts of their doctors. HMOs that contract with outside doctors (group- or IPA-model HMOs) aren't as likely to be sued even when its doctors are. As a result, there may be fewer claims involving HMOs that contract with doctors.

In some instances, although a service provider or institution believes it isn't liable, it may nevertheless choose to settle disputed claims quickly rather than incur sizable legal costs in lengthy litigation.

[To view the total number of malpractice incidents for each of the past three years on all Florida HMOs - as reported to the Department of Insurance by the companies in their annual financial statements - click here.]

Inappropriate use of such malpractice information or closed claims reports may violate various provisions of law, including Section 641.3903(9), F.S., which prohibits:

"Knowingly making any misleading representations or incomplete or fraudulent comparisons of any health maintenance contracts or health maintenance organizations or of any insurance policies or insurers for the purpose of inducing, or intending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or health maintenance contract or to take out a health maintenance contract or policy of insurance in another health maintenance organization or insurer."

Back to Top

Statement by the Florida Medical Association

The Florida Medical Association cautions that the settlement of malpractice claims occurs for a variety of reasons, which do not necessarily reflect negatively on the professional competence or

conduct of the individual provider or institution. Payment of a claim should not be a presumption that malpractice has occurred. Physicians often have little control over whether the insurance company pays an award. An insurance company may pay a claim on behalf of the insured physician, even when there is no liability, if the cost of defending the claim might exceed a potential settlement.

A large payment in a malpractice case does not necessarily indicate the provider or institution made a serious error. It could indicate, instead, that the patient suffered significant economic damages as a result of alleged malpractice.

Back to Top

Statement by the Florida Hospital Association

The Florida Hospital Association strongly supports providing meaningful data to consumers. However, liability claims information can be misleading. Insurance companies may settle claims for business reasons without consideration of fault and certain physicians are more prone to lawsuits because of the specialty in which they practice.

These issues are complex. Medical incidents, like medical malpractice suits, are often not clear cut. Experts disagree on medical practice and whether a result could have been prevented or was within the range of expected outcomes. Not all patients react the same to identical treatment. Hospitals have checks and balances in place to reduce the potential for human error. Hospitals have policies, procedures and training to help prevent mistakes. They have teams of physicians, nurses and licensed risk managers who examine, identify and correct problems. The liability claims on this site should not be used as a measure of quality care.

Top

DISCLAIMER and IMPORTANT CONSUMER NOTICE

Consumers are urged to read this notice prior to searching the closed claims database.

1. Florida's professional liability reporting statute (Chapter 627.912, F.S.) doesn't cover all licensed professionals or institutions. The law requires only that three entities -- insurance companies, self-insurance funds and joint underwriting associations -- file reports of alleged error, omission or negligence by *insured* doctors, dentists, hospitals, health maintenance organizations (HMOs), abortion clinics, ambulatory surgical centers, crisis stabilization units and lawyers.

2. The reports on this site stem from patient or client allegations and are public record. The site contains a listing of only those claims in which an insurer made a payment to a claimant to satisfy a judgment or reach a settlement, which companies sometimes do because it's less costly than fighting the matter in court. Consumers should also note that:

(a) Some providers and institutions covered by the closed claims law will not appear in this listing for various other reasons. For example, some may not carry professional liability insurance; and, others may be self-insured.

(b) Some of the closed claims -- because they date back many years -- involve professionals who have moved, retired or passed away. Likewise, some institutions may no longer exist; or, they may have changed names.

(c) Over the years, the claims reporting forms have changed. Prior to March 1988, for example, insurers could only report the name of a law firm instead of the name of the individual lawyer deemed responsible for the claim. In any event, neither the number nor amount of any claim is necessarily an indicator of professional competence or quality.

3. Consumers are advised to discuss and verify all information with the professional service provider or institution, and check all identifying factors to avoid confusion with similar names.

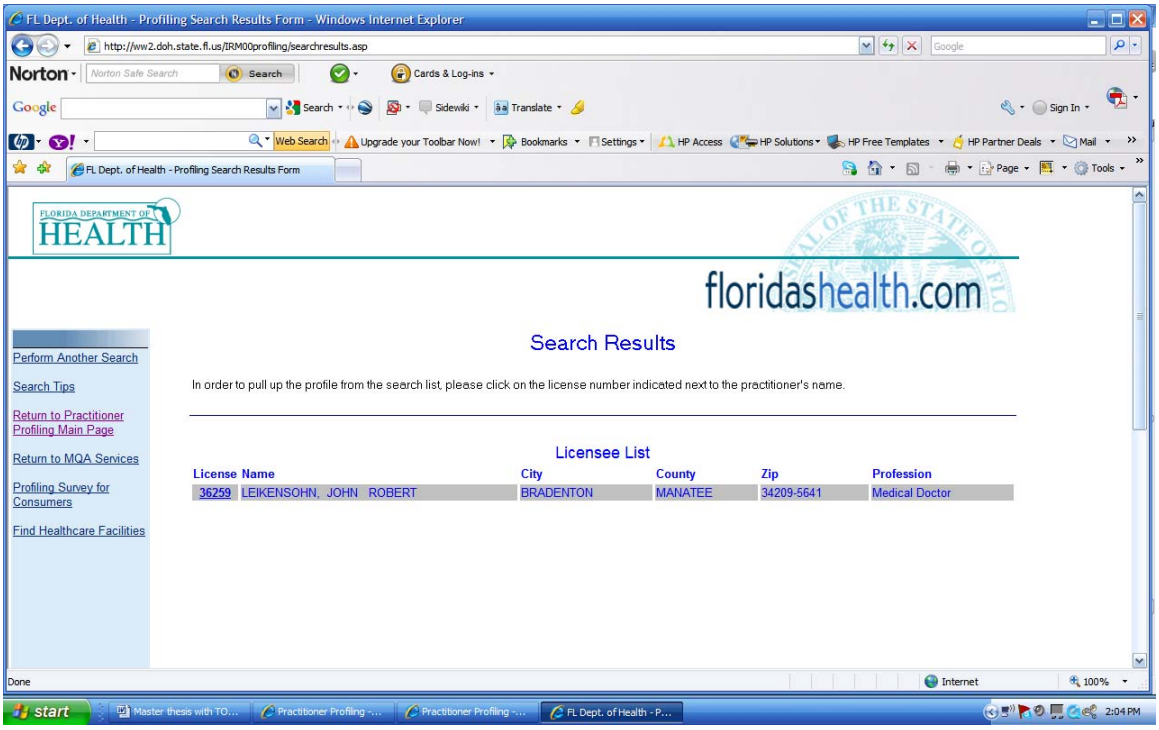
Instructions for obtaining additional information from a closed claim report can be found by clicking here. (The average report is five pages long.)
4. Additional information from the Florida Medical Association, the Florida Hospital Association and certain HMOs can be viewed by clicking here.
5. Neither the Department of Insurance nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers.
6. Inappropriate use of any closed claims information to make incomplete or misleading comparisons of professional providers or institutions may violate the law.
Search now for closed liability claims on:
Doctors / Dentists / Hospitals / HMO's / Abortion Clinics
Ambulatory Surgical Centers / Crisis Stabilization Units / Lawyers.

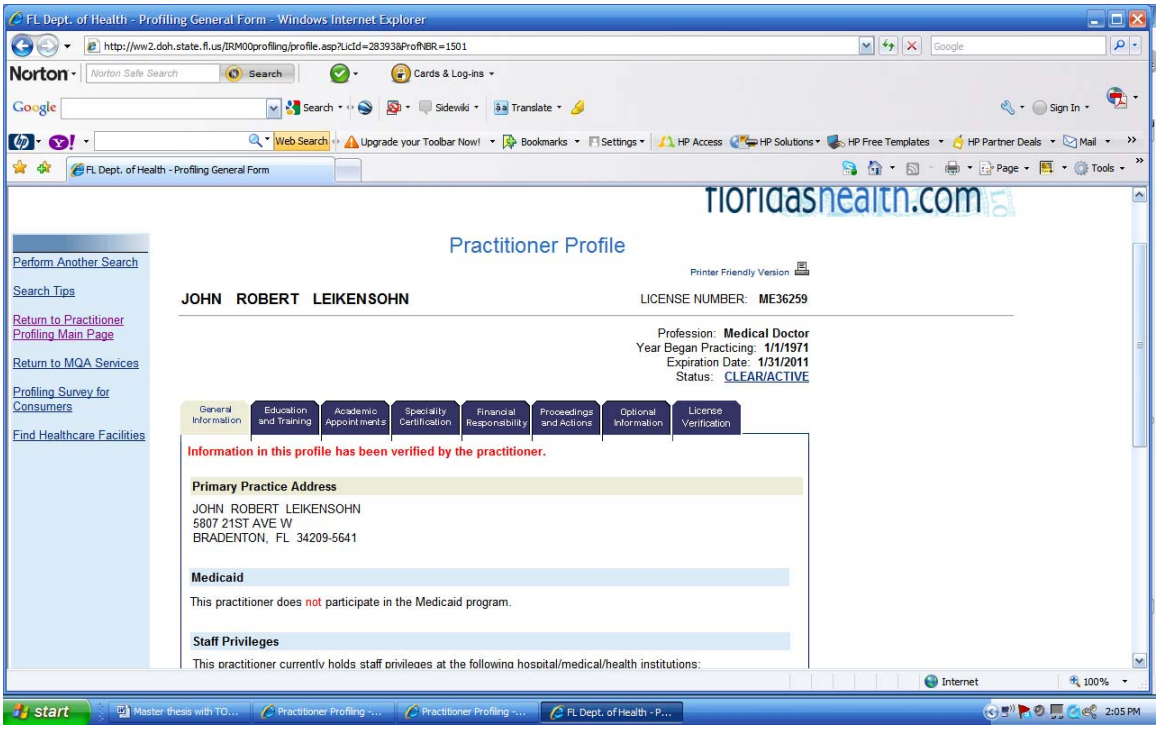
Retrieved from http://www.floir.com/Liability/hmofma.aspx, retrieved 11-28-09

Appendix B

Sample public disclosure of adverse medical incident and/or claim.

Practitioner Profile





JOHN ROBERT LEIKENSOHN LICENSE NUMBER: **ME36259**

Profession: **Medical Doctor**
Year Began Practicing: **1/1/1971**
Expiration Date: **1/31/2011**
Status: **CLEAR/ACTIVE**

General Information | Education and Training | Academic Appointments | Speciality Certification | Financial Responsibility | Proceedings and Actions | Optional Information | License Verification

Information in this profile has been verified by the practitioner.

Primary Practice Address

JOHN ROBERT
LEIKENSOHN
5807 21ST AVE W
BRADENTON, FL 34209-5641

Medicaid

This practitioner does not participate in the Medicaid program.

Staff Privileges

This practitioner currently holds staff privileges at the following hospital/medical/health institutions:

Institution Name	MANATEE MEMORIAL HOSPITAL
City	BRADENTON
State	FLORIDA

Institution Name	WEST FLORIDA SURGERY CENTER
City	BRADENTON
State	FLORIDA

E-Mail Address

Please contact at: **info@floridacosmeticsurg.com**

Other State Licensure

This practitioner has indicated the following additional state licensure:

State	
Profession	MEDICINE

Profession: **Medical Doctor**

Year Began Practicing: **1/1/1971**
Expiration Date: **1/31/2011**
Status: **CLEAR/ACTIVE**

General Information | Education and Training | Academic Appointments | Speciality Certification | Financial Responsibility | Proceedings and Actions | Optional Information | License Verification

Information in this profile has been verified by the practitioner.

Criminal Offenses

The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public. Information is verified by DOH at the time of initial licensure through FDLE and FBI. Changes after initial licensure may be self-reported by the practitioner or updated based on a report received from FDLE. DOH conducts statewide criminal background checks every two years, immediately following a renewal cycle for the practitioner.

This practitioner has indicated that he/she has NO criminal offenses.

Information provided has been verified through a criminal records check as of 6/17/2009 5:12:57 PM.

Medicaid Sanctions and Terminations

This practitioner has not been sanctioned or terminated for cause from the Medicaid program.

Final Disciplinary Actions (Within last 10 years)

For instructions on how to order copies of final disciplinary actions, please click here.
This information is self reported by the practitioner:

Final disciplinary action taken by a specialty board within the previous 10 years:

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

Final disciplinary action taken by a licensing agency within the previous 10 years:

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

Disciplinary action taken by a health maintenance organization, pre-paid health clinic, nursing home, hospital or ambulatory surgical center within the previous 10 years:

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home,

hospital or ambulatory surgical center.

Resigned from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, hospital or ambulatory surgical center:

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, hospital or ambulatory surgical center.

Liability Claims Exceeding $100,000.00 (Within last 10 years).

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

Additional claims information may have been reported to the Department of Financial Services. To check their web site, please click here.

The following liability actions have been reported as required under section 456.049, F. S., within the previous 10 years:

Incident Date	1/10/2006
County	SARASOTA
Judicial Case	2007-ca-011800-
Settlement Date	11/17/2008
Amount	$500,000.00
Policy Amount	$1,000,000.00

Retrieved from http://ww2.doh.state.fl.us/IRM00profiling/ProfileACTIONS.asp?LicId=28393&ProfNBR=1501, retrieved 11-28-09

Appendix C

List of all Florida Hospitals (208) and Selected Data

Category: All Hospitalizations
Condition/Procedure: All
Age Group: All Ages
Time Period: January 2008 through December 2008

Facility / City	Total Hospitalizations	Charges Low	Charges High	Average Length of Stay
STATEWIDE	**2,502,608**	**N/A**	**N/A**	**4.7 days**
ALL CHILDREN'S HOSPITAL INC - 100250 **SAINT PETERSBURG**	8,035	$10,549	$41,727	5.1 days
ANNE BATES LEACH EYE HOSPITAL - 100240 **MIAMI**	160	$15,790	$28,650	5.0 days
ARNOLD PALMER MEDICAL CENTER - 120001 **ORLANDO**	39,338	$2,872	$19,065	4.6 days
AVENTURA HOSPITAL AND MEDICAL CENTER - 100131 **AVENTURA**	17,733	$16,987	$52,823	5.2 days
BAPTIST HOSPITAL INC - 100093 **PENSACOLA**	16,290	$7,116	$30,679	4.6 days
BAPTIST HOSPITAL OF MIAMI - 100008 **MIAMI**	35,970	$15,420	$54,380	4.8 days
BAPTIST MEDICAL CENTER - 100088 **JACKSONVILLE**	32,283	$7,704	$33,928	5.0 days
BAPTIST MEDICAL CENTER - BEACHES - 100117 **JACKSONVILLE BEACH**	8,220	$7,832	$25,702	4.9 days
BAPTIST MEDICAL CENTER - NASSAU - 100140 **FERNANDINA BEACH**	2,724	$5,227	$15,677	4.0 days
BAPTIST MEDICAL CENTER	8,711	$7,016	$24,578	5.0 days

SOUTH - 23960052 **JACKSONVILLE**				
BARTOW REGIONAL MEDICAL CENTER - 100121 **BARTOW**	3,987	$12,253	$30,447	4.5 days
BAY MEDICAL CENTER - 100026 **PANAMA CITY**	15,605	$10,714	$34,301	4.5 days
BAYFRONT MEDICAL CENTER INC - 100032 **SAINT PETERSBURG**	20,251	$9,622	$39,870	4.7 days
BERT FISH MEDICAL CENTER - 100014 **NEW SMYRNA BEACH**	4,390	$8,874	$26,308	3.9 days
BETHESDA MEMORIAL HOSPITAL - 100002 **BOYNTON BEACH**	20,205	$9,998	$39,009	4.9 days
BLAKE MEDICAL CENTER - 100213 **BRADENTON**	12,144	$18,712	$53,134	4.6 days
BOCA RATON COMMUNITY HOSPITAL - 100168 **BOCA RATON**	18,651	$11,506	$38,015	4.6 days
BRANDON REGIONAL HOSPITAL - 100243 **BRANDON**	25,771	$15,391	$48,822	4.4 days
BROOKSVILLE REGIONAL HOSPITAL - 100071 **BROOKSVILLE**	5,589	$22,420	$54,945	4.2 days
BROWARD GENERAL MEDICAL CENTER - 100039 **FORT LAUDERDALE**	30,854	$8,494	$36,081	5.3 days
CALHOUN-LIBERTY HOSPITAL - 100112 **BLOUNTSTOWN**	565	$4,481	$11,366	4.7 days
CAMPBELLTON-GRACEVILLE HOSPITAL - 100138 **GRACEVILLE**	243	$3,765	$10,349	3.6 days
CAPE CANAVERAL HOSPITAL - 100177 **COCOA BEACH**	7,019	$10,088	$32,088	4.4 days
CAPE CORAL HOSPITAL - 100244 **CAPE CORAL**	14,910	$10,125	$29,737	4.8 days
CAPITAL REGIONAL MEDICAL CENTER - 100254	10,320	$13,975	$47,766	4.7 days

TALLAHASSEE				
CENTRAL FLORIDA REGIONAL HOSPITAL - 100161 **SANFORD**	9,840	$12,257	$43,696	4.3 days
CHARLOTTE REGIONAL MEDICAL CENTER - 100047 **PUNTA GORDA**	9,350	$13,902	$52,170	4.8 days
CITRUS MEMORIAL HOSPITAL - 100023 **INVERNESS**	12,184	$10,971	$42,618	4.0 days
CLEVELAND CLINIC FLORIDA HEALTH SYSTEM NONPROFIT CORPORATION - 100056 **WESTON**	11,446	$13,457	$40,890	3.9 days
COLUMBIA HOSPITAL - 100234 **WEST PALM BEACH**	9,176	$11,675	$36,723	4.2 days
COMMUNITY HOSPITAL - 100191 **NEW PORT RICHEY**	14,437	$18,050	$55,258	4.9 days
CORAL GABLES HOSPITAL - 100183 **CORAL GABLES**	6,023	$22,056	$53,066	5.3 days
CORAL SPRINGS MEDICAL CENTER - 110019 **CORAL SPRINGS**	14,213	$6,954	$26,541	4.5 days
DELRAY MEDICAL CENTER - 100258 **DELRAY BEACH**	19,805	$20,476	$62,269	4.5 days
DEPOO HOSPITAL - 100150 **KEY WEST**	679	$4,940	$13,060	5.9 days
DESOTO MEMORIAL HOSPITAL - 100175 **ARCADIA**	2,693	$4,488	$15,154	4.2 days
DOCTORS HOSPITAL INC - 100020 **CORAL GABLES**	7,107	$21,431	$59,484	5.6 days
DOCTORS HOSPITAL OF SARASOTA - 100166 **SARASOTA**	6,710	$21,768	$59,211	4.0 days
DOCTORS MEMORIAL HOSPITAL - 100078 **BONIFAY**	1,285	$4,837	$12,691	4.8 days
DOCTORS' MEMORIAL HOSPITAL INC - 100106	1,357	$3,323	$9,634	3.6 days

PERRY				
DOUGLAS GARDENS HOSPITAL - 100197 **MIAMI**	511	$1,905	$10,800	6.2 days
DR P PHILLIPS HOSPITAL - 120002 **ORLANDO**	11,460	$16,552	$42,262	4.1 days
ED FRASER MEMORIAL HOSPITAL - 100134 **MACCLENNY**	19	X	X	X
EDWARD WHITE HOSPITAL - 100239 **SAINT PETERSBURG**	3,555	$19,150	$58,075	4.4 days
ENGLEWOOD COMMUNITY HOSPITAL - 110004 **ENGLEWOOD**	3,739	$19,766	$45,707	3.7 days
FAWCETT MEMORIAL HOSPITAL - 100236 **PORT CHARLOTTE**	9,797	$21,173	$64,765	4.4 days
FISHERMEN'S HOSPITAL - 100024 **MARATHON**	635	$12,694	$40,398	4.2 days
FLAGLER HOSPITAL - 100219 **SAINT AUGUSTINE**	14,781	$9,196	$35,014	4.8 days
FLORIDA HOSPITAL - 100007 **ORLANDO**	48,650	$12,572	$50,856	5.1 days
FLORIDA HOSPITAL ALTAMONTE - 120004 **ALTAMONTE SPRINGS**	18,864	$11,430	$30,104	4.6 days
FLORIDA HOSPITAL APOPKA - 120003 **APOPKA**	2,650	$10,528	$21,933	3.8 days
FLORIDA HOSPITAL CELEBRATION HEALTH - 23960017 **CELEBRATION**	11,470	$9,835	$31,223	3.9 days
FLORIDA HOSPITAL DELAND - 100045 **DELAND**	9,595	$7,918	$24,117	4.3 days
FLORIDA HOSPITAL EAST ORLANDO - 100021 **ORLANDO**	14,938	$13,400	$31,066	4.3 days
FLORIDA HOSPITAL FISH MEMORIAL - 100072 **ORANGE CITY**	9,104	$12,140	$29,195	4.0 days

FLORIDA HOSPITAL FLAGLER - 100118 **PALM COAST**	5,700	$13,255	$32,501	4.1 days
FLORIDA HOSPITAL HEARTLAND MEDICAL CENTER - 100109 **SEBRING**	10,112	$8,541	$28,205	3.8 days
FLORIDA HOSPITAL KISSIMMEE - 100089 **KISSIMMEE**	3,887	$14,407	$32,575	4.9 days
FLORIDA HOSPITAL LAKE PLACID - 120013 **LAKE PLACID**	2,093	$11,656	$27,789	4.0 days
FLORIDA HOSPITAL MEMORIAL MEDICAL CENTER - 100169 **DAYTONA BEACH**	11,388	$9,878	$31,879	4.1 days
FLORIDA HOSPITAL OCEANSIDE - 100068 **ORMOND BEACH**	8	X	X	X
FLORIDA HOSPITAL WATERMAN - 100057 **TAVARES**	12,597	$10,373	$30,540	4.3 days
FLORIDA HOSPITAL WAUCHULA - 100282 **WAUCHULA**	228	$11,134	$19,725	3.6 days
FLORIDA HOSPITAL ZEPHYRHILLS INC - 100046 **ZEPHYRHILLS**	8,810	$14,631	$46,089	4.2 days
FORT WALTON BEACH MEDICAL CENTER - 100223 **FORT WALTON BEACH**	12,792	$18,179	$68,249	4.9 days
GEORGE E. WEEMS MEMORIAL HOSPITAL - 100153 **APALACHICOLA**	363	$4,067	$10,478	4.2 days
GLADES GENERAL HOSPITAL - 100130 **BELLE GLADE**	3,822	$5,446	$18,416	3.9 days
GOOD SAMARITAN MEDICAL CENTER - 110403 **WEST PALM BEACH**	9,088	$11,447	$39,544	4.5 days
GULF BREEZE HOSPITAL - 110003 **GULF BREEZE**	3,839	$12,408	$34,698	3.9 days
GULF COAST MEDICAL CENTER - 100242 **PANAMA CITY**	12,959	$10,399	$49,516	4.1 days

GULF COAST MEDICAL CENTER LEE MEMORIAL HEALTH SYSTEM - 100220 **FORT MYERS**	14,893	$13,550	$44,462	4.3 days
H LEE MOFFITT CANCER CTR & RESEARCH INSTITUTE HOSPITAL - 110009 **TAMPA**	7,446	$17,886	$48,928	4.3 days
HALIFAX HEALTH MEDICAL CENTER - 100017 **DAYTONA BEACH**	25,611	$6,806	$30,026	4.9 days
HALIFAX HEALTH MEDICAL CENTER- PORT ORANGE - 23960051 **PORT ORANGE**	3,668	$8,608	$19,743	4.4 days
HEALTH CENTRAL - 100030 **OCOEE**	11,162	$8,521	$26,681	4.5 days
HEALTHMARK REGIONAL MEDICAL CENTER - 100081 **DEFUNIAK SPRINGS**	1,162	$4,533	$9,649	3.6 days
HEALTHPARK MEDICAL CENTER - 120005 **FORT MYERS**	24,853	$7,239	$25,471	4.8 days
HEART OF FLORIDA REGIONAL MEDICAL CENTER - 100137 **DAVENPORT**	11,361	$14,760	$45,580	4.4 days
HELEN ELLIS MEMORIAL HOSPITAL - 100055 **TARPON SPRINGS**	5,823	$11,712	$33,417	4.3 days
HENDRY REGIONAL MEDICAL CENTER - 100098 **CLEWISTON**	1,197	$5,412	$13,523	3.7 days
HIALEAH HOSPITAL - 100053 **HIALEAH**	13,437	$15,755	$44,672	5.4 days
HIGHLANDS REGIONAL MEDICAL CENTER - 100049 **SEBRING**	5,359	$9,415	$31,926	4.0 days
HOLMES REGIONAL MEDICAL CENTER - 100019 **MELBOURNE**	28,578	$11,404	$42,422	5.1 days
HOLY CROSS HOSPITAL, INC. - 100073 **FORT LAUDERDALE**	17,738	$17,317	$60,556	4.6 days
HOMESTEAD HOSPITAL - 100125	11,440	$13,318	$38,863	4.9 days

HOMESTEAD				
IMPERIAL POINT MEDICAL CENTER - 100200 **FORT LAUDERDALE**	7,952	$9,124	$28,820	4.1 days
INDIAN RIVER MEDICAL CENTER - 100105 **VERO BEACH**	15,824	$6,168	$23,338	4.7 days
JACKSON HOSPITAL - 100142 **MARIANNA**	3,837	$3,521	$13,061	4.7 days
JACKSON MEMORIAL HOSPITAL - 100022 **MIAMI**	51,680	$8,704	$39,654	6.0 days
JACKSON NORTH MEDICAL CENTER - 100114 **NORTH MIAMI BEACH**	14,274	$8,573	$26,323	5.2 days
JACKSON SOUTH COMMUNITY HOSPITAL - 100208 **MIAMI**	12,527	$6,777	$21,272	4.3 days
JAY HOSPITAL - 100048 **JAY**	1,130	$8,664	$18,259	5.2 days
JFK MEDICAL CENTER - 100080 **ATLANTIS**	26,064	$18,373	$65,065	4.4 days
JUPITER MEDICAL CENTER - 100253 **JUPITER**	11,903	$10,694	$39,064	4.2 days
KENDALL REGIONAL MEDICAL CENTER - 100209 **MIAMI**	19,194	$13,395	$50,165	4.3 days
LAKE BUTLER HOSPITAL HAND SURGERY CENTER - 100241 **LAKE BUTLER**	133	$7,173	$14,629	8.1 days
LAKE CITY MEDICAL CENTER - 100156 **LAKE CITY**	4,109	$13,399	$30,205	4.7 days
LAKE WALES MEDICAL CENTER - 100099 **LAKE WALES**	6,002	$14,695	$33,335	4.3 days
LAKELAND REGIONAL MEDICAL CENTER - 100157 **LAKELAND**	39,460	$8,888	$35,829	4.8 days
LAKEWOOD RANCH MEDICAL CENTER - 23960046	5,050	$3,737	$20,087	3.5 days

BRADENTON				
LARGO MEDICAL CENTER - 100248 **LARGO**	12,924	$23,542	$63,004	4.4 days
LARKIN COMMUNITY HOSPITAL - 100181 **SOUTH MIAMI**	4,993	$10,858	$29,744	4.6 days
LAWNWOOD REGIONAL MEDICAL CENTER & HEART INSTITUTE - 100246 **FORT PIERCE**	15,584	$18,253	$57,968	5.0 days
LEE MEMORIAL HOSPITAL - 100012 **FORT MYERS**	11,179	$14,570	$39,840	4.7 days
LEESBURG REGIONAL MEDICAL CENTER - 100084 **LEESBURG**	18,825	$10,010	$34,313	4.5 days
LEHIGH REGIONAL MEDICAL CENTER - 100107 **LEHIGH ACRES**	3,624	$14,926	$34,738	4.3 days
LOWER KEYS MEDICAL CENTER - 100195 **KEY WEST**	4,168	$7,830	$28,939	4.9 days
MADISON COUNTY MEMORIAL HOSPITAL - 100004 **MADISON**	699	$3,821	$9,090	7.4 days
MANATEE MEMORIAL HOSPITAL - 100035 **BRADENTON**	18,609	$5,998	$30,263	4.8 days
MARINERS HOSPITAL - 100160 **TAVERNIER**	873	$23,208	$51,889	4.9 days
MARTIN MEMORIAL HOSPITAL SOUTH - 120009 **STUART**	4,223	$17,816	$49,427	4.2 days
MARTIN MEMORIAL MEDICAL CENTER - 100044 **STUART**	15,142	$10,534	$41,203	4.6 days
MAYO CLINIC - 100151 **JACKSONVILLE**	13,555	$12,663	$41,235	3.9 days
MEASE COUNTRYSIDE HOSPITAL - 110001 **SAFETY HARBOR**	17,929	$9,535	$30,519	4.4 days
MEASE DUNEDIN HOSPITAL - 100043 **DUNEDIN**	6,401	$12,776	$37,283	4.6 days

MEMORIAL HOSPITAL JACKSONVILLE - 100179 **JACKSONVILLE**	22,344	$19,354	$62,029	5.0 days
MEMORIAL HOSPITAL MIRAMAR - 23960050 **MIRAMAR**	13,418	$6,736	$25,333	4.2 days
MEMORIAL HOSPITAL OF TAMPA - 100206 **TAMPA**	5,936	$11,405	$32,853	4.6 days
MEMORIAL HOSPITAL PEMBROKE - 100230 **PEMBROKE PINES**	6,980	$16,932	$41,410	4.1 days
MEMORIAL HOSPITAL WEST - 111527 **PEMBROKE PINES**	26,325	$9,722	$31,530	4.5 days
MEMORIAL REGIONAL HOSPITAL - 100038 **HOLLYWOOD**	39,609	$9,567	$38,362	4.8 days
MEMORIAL REGIONAL HOSPITAL SOUTH - 100225 **HOLLYWOOD**	2,582	$15,473	$39,326	4.3 days
MERCY HOSPITAL - 100061 **MIAMI**	19,184	$14,010	$53,077	4.8 days
METROPOLITAN HOSPITAL OF MIAMI - 100076 **MIAMI**	4,579	$11,763	$28,090	4.7 days
MIAMI CHILDREN'S HOSPITAL - 110199 **MIAMI**	12,060	$10,822	$35,068	5.0 days
MORTON PLANT HOSPITAL - 100127 **CLEARWATER**	30,476	$9,002	$33,989	4.3 days
MORTON PLANT NORTH BAY HOSPITAL - 100063 **NEW PORT RICHEY**	4,761	$13,846	$37,553	4.3 days
MOUNT SINAI MEDICAL CENTER - 100034 **MIAMI BEACH**	23,003	$13,995	$46,852	5.6 days
MUNROE REGIONAL MEDICAL CENTER - 100062 **OCALA**	26,311	$9,183	$31,781	4.3 days
NAPLES COMMUNITY HOSPITAL - 100018 **NAPLES**	18,623	$16,779	$45,142	4.2 days
NATURE COAST REGIONAL HOSPITAL - 100139 **WILLISTON**	739	$3,749	$7,158	4.0 days

NCH HEALTHCARE SYSTEM NORTH NAPLES HOSPITAL CAMPUS - 120006 **NAPLES**	15,412	$5,139	$20,940	4.3 days
NORTH BROWARD MEDICAL CENTER - 100086 **POMPANO BEACH**	13,334	$12,463	$38,246	4.9 days
NORTH FLORIDA REGIONAL MEDICAL CENTER - 100204 **GAINESVILLE**	23,714	$16,230	$62,345	4.6 days
NORTH OKALOOSA MEDICAL CENTER - 100122 **CRESTVIEW**	6,786	$14,343	$50,535	3.9 days
NORTH SHORE MEDICAL CENTER - 100029 **MIAMI**	13,406	$8,565	$32,853	5.1 days
NORTH SHORE MEDICAL CENTER - FMC CAMPUS - 100210 **LAUDERDALE LAKES**	11,227	$21,217	$62,075	4.7 days
NORTHSIDE HOSPITAL - 100238 **SAINT PETERSBURG**	9,793	$27,334	$72,971	4.8 days
NORTHWEST FLORIDA COMMUNITY HOSPITAL - 100147 **CHIPLEY**	554	$5,219	$12,873	4.4 days
NORTHWEST MEDICAL CENTER - 100189 **MARGATE**	14,342	$12,188	$40,625	4.2 days
OAK HILL HOSPITAL - 100264 **BROOKSVILLE**	12,491	$25,282	$73,272	4.5 days
OCALA REGIONAL MEDICAL CENTER - 100212 **OCALA**	10,597	$23,586	$61,854	4.5 days
ORANGE PARK MEDICAL CENTER - 100226 **ORANGE PARK**	15,478	$11,800	$52,389	4.5 days
ORLANDO REGIONAL MEDICAL CENTER - 100006 **ORLANDO**	27,022	$20,094	$64,028	4.4 days
OSCEOLA REGIONAL MEDICAL CENTER - 100110 **KISSIMMEE**	16,361	$12,065	$51,446	4.8 days
PALM BAY COMMUNITY	3,733	$14,564	$35,606	4.8 days

HOSPITAL - 120007 **MELBOURNE**				
PALM BEACH GARDENS MEDICAL CENTER - 100176 **PALM BEACH GARDENS**	10,632	$22,242	$63,759	4.8 days
PALM SPRINGS GENERAL HOSPITAL - 100050 **HIALEAH**	7,877	$11,225	$26,008	5.9 days
PALMETTO GENERAL HOSPITAL - 100187 **HIALEAH**	21,777	$13,987	$47,331	5.0 days
PALMS OF PASADENA HOSPITAL - 100126 **SAINT PETERSBURG**	5,616	$12,711	$39,042	5.0 days
PALMS WEST HOSPITAL - 110006 **LOXAHATCHEE**	12,927	$11,896	$36,874	4.7 days
PARRISH MEDICAL CENTER - 100028 **TITUSVILLE**	8,759	$7,878	$25,889	4.5 days
PASCO REGIONAL MEDICAL CENTER - 100211 **DADE CITY**	5,340	$12,463	$35,778	3.7 days
PEACE RIVER REGIONAL MEDICAL CENTER - 100077 **PORT CHARLOTTE**	9,743	$8,362	$32,335	4.6 days
PHYSICIANS REGIONAL MEDICAL CENTER - COLLIER BOULEVARD - 23960057 **NAPLES**	4,069	$11,099	$31,969	4.0 days
PHYSICIANS REGIONAL MEDICAL CENTER - PINE RIDGE - 23960025 **NAPLES**	4,961	$18,080	$46,109	4.0 days
PLANTATION GENERAL HOSPITAL - 100167 **PLANTATION**	12,752	$7,188	$29,193	5.0 days
PUTNAM COMMUNITY MEDICAL CENTER - 100232 **PALATKA**	5,946	$6,418	$20,590	5.1 days
RAULERSON HOSPITAL - 100252 **OKEECHOBEE**	4,313	$14,435	$35,342	4.9 days
REGENCY MEDICAL CENTER - 120010 **WINTER HAVEN**	4,083	$2,491	$9,930	4.5 days

REGIONAL MEDICAL CENTER BAYONET POINT - 100256 **HUDSON**	12,620	$23,975	$69,455	4.7 days
SACRED HEART HOSPITAL - 100025 **PENSACOLA**	28,473	$5,377	$25,319	4.2 days
SACRED HEART HOSPITAL ON THE EMERALD COAST - 23960041 **MIRAMAR BEACH**	4,234	$9,670	$39,485	3.7 days
SAINT ANTHONY'S HOSPITAL - 100067 **SAINT PETERSBURG**	11,712	$12,054	$36,643	4.7 days
SAINT LUCIE MEDICAL CENTER - 100260 **PORT SAINT LUCIE**	12,527	$16,769	$54,243	4.5 days
SAINT MARY'S MEDICAL CENTER - 100010 **WEST PALM BEACH**	20,417	$8,178	$26,924	5.3 days
SAINT VINCENT'S MEDICAL CENTER - 100040 **JACKSONVILLE**	28,645	$10,334	$41,295	4.9 days
SANTA ROSA MEDICAL CENTER - 100124 **MILTON**	4,879	$9,081	$24,154	4.0 days
SARASOTA MEMORIAL HOSPITAL - 100087 **SARASOTA**	27,385	$8,349	$33,058	4.1 days
SEBASTIAN RIVER MEDICAL CENTER - 100217 **SEBASTIAN**	4,824	$13,465	$42,388	4.7 days
SEVEN RIVERS REGIONAL MEDICAL CENTER - 100249 **CRYSTAL RIVER**	7,284	$8,854	$35,049	3.9 days
SHANDS AT AGH - 100082 **GAINESVILLE**	11,722	$7,218	$26,940	4.5 days
SHANDS AT LAKE SHORE - 100102 **LAKE CITY**	4,559	$5,944	$20,850	4.9 days
SHANDS AT LIVE OAK - 100146 **LIVE OAK**	574	$7,328	$13,849	3.7 days
SHANDS AT STARKE - 100103 **STARKE**	1,095	$8,240	$16,602	3.5 days
SHANDS HOSPITAL AT THE	32,421	$7,723	$40,754	4.7 days

UNIV. OF FLORIDA - 100113 **GAINESVILLE**				
SHANDS JACKSONVILLE MEDICAL CENTER - 100001 **JACKSONVILLE**	30,098	$7,572	$34,680	4.3 days
SOUTH BAY HOSPITAL - 100259 **SUN CITY CENTER**	6,355	$22,168	$52,238	4.7 days
SOUTH FLORIDA BAPTIST HOSPITAL - 100132 **PLANT CITY**	6,729	$11,460	$29,894	4.1 days
SOUTH LAKE HOSPITAL - 100051 **CLERMONT**	7,055	$11,571	$35,220	3.9 days
SOUTH MIAMI HOSPITAL, INC - 100154 **SOUTH MIAMI**	19,805	$11,876	$44,826	4.7 days
SOUTH SEMINOLE HOSPITAL - 100263 **LONGWOOD**	13,709	$7,279	$23,779	4.4 days
SPRING HILL REGIONAL HOSPITAL - 111525 **SPRING HILL**	8,300	$11,327	$37,209	4.3 days
ST CLOUD REGIONAL MEDICAL CENTER - 100074 **SAINT CLOUD**	4,215	$13,795	$30,457	4.8 days
ST JOSEPH'S HOSPITAL - 100075 **TAMPA**	52,130	$8,328	$30,713	4.7 days
ST PETERSBURG GENERAL HOSPITAL - 100180 **SAINT PETERSBURG**	9,515	$12,195	$54,980	4.8 days
SUN COAST HOSPITAL - 100015 **LARGO**	4,816	$10,740	$38,596	4.3 days
TALLAHASSEE MEMORIAL HOSPITAL - 100135 **TALLAHASSEE**	26,921	$6,580	$26,993	4.7 days
TAMPA GENERAL HOSPITAL - 100128 **TAMPA**	41,010	$10,557	$65,559	5.0 days
TOWN & COUNTRY HOSPITAL - 100255 **TAMPA**	4,773	$11,209	$36,352	4.8 days
TWIN CITIES HOSPITAL - 100054	2,003	$27,303	$63,076	3.8 days

NICEVILLE				
UNIVERSITY COMMUNITY HOSPITAL - 100173 **TAMPA**	25,474	$12,355	$44,613	4.8 days
UNIVERSITY COMMUNITY HOSPITAL AT CARROLLWOOD - 100069 **TAMPA**	5,140	$17,721	$51,248	4.1 days
UNIVERSITY HOSPITAL AND MEDICAL CENTER - 100224 **TAMARAC**	10,045	$13,722	$39,690	4.2 days
UNIVERSITY OF MIAMI HOSPITAL - 100009 **MIAMI**	17,728	$16,395	$54,488	5.1 days
UNIVERSITY OF MIAMI HOSPITAL AND CLINICS - 100079 **MIAMI**	1,327	$26,021	$75,205	4.2 days
VENICE REGIONAL MEDICAL CENTER - 100070 **VENICE**	9,306	$12,661	$42,280	4.1 days
VILLAGES REGIONAL HOSPITAL, THE - 23960032 **THE VILLAGES**	7,646	$11,286	$26,657	4.2 days
WELLINGTON REGIONAL MEDICAL CENTER - 110010 **WELLINGTON**	12,139	$8,290	$27,711	4.5 days
WEST BOCA MEDICAL CENTER - 110008 **BOCA RATON**	11,847	$8,217	$24,658	4.6 days
WEST FLORIDA HOSPITAL - 100231 **PENSACOLA**	10,439	$15,465	$58,024	4.9 days
WEST MARION COMMUNITY HOSPITAL - 23960039 **OCALA**	4,634	$21,896	$60,964	4.4 days
WESTCHESTER GENERAL HOSPITAL - 100165 **MIAMI**	5,531	$9,879	$24,614	6.3 days
WESTSIDE REGIONAL MEDICAL CENTER - 100228 **PLANTATION**	13,507	$17,841	$52,508	4.4 days
WINTER HAVEN HOSPITAL - 100052 **WINTER HAVEN**	14,615	$13,813	$42,575	4.4 days

WINTER PARK MEMORIAL HOSPITAL - 100162 **WINTER PARK**	16,913	$9,903	$34,796	4.7 days
WUESTHOFF MEDICAL CENTER - MELBOURNE - 23960034 **MELBOURNE**	6,560	$7,974	$23,881	4.8 days
WUESTHOFF MEDICAL CENTER-ROCKLEDGE - 100092 **ROCKLEDGE**	13,655	$8,490	$28,685	4.6 days

Retrieved from http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx.

Appendix D

Patient's Bill of Rights and Responsibilities

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

A patient has the right to:

Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.

Receive a prompt and reasonable response to questions and requests.

Know who is providing medical services and who is responsible for his or her care.

Know what patient support services are available, including if an interpreter is available if the patient does not speak English.

Know what rules and regulations apply to his or her conduct.

Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.

Refuse any treatment, except as otherwise provided by law.

Be given full information and necessary counseling on the availability of known financial resources for care.

Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare. .

Receive prior to treatment, a reasonable estimate of charges for medical care.

Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.

Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.

Express complaints regarding any violation of his or her rights.

A patient is responsible for:

Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.

Reporting unexpected changes in his or her condition to the health care provider.

Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.

Following the treatment plan recommended by the health care provider.

Keeping appointments and, when unable to do so, notifying the health care provider or facility.

His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.

Making sure financial responsibilities are carried out.

Following health care facility conduct rules and regulations.

Retrieved from http://www.floridahealthfinder.gov/reports-guides/patient-bill-rights.shtml

Appendix E

Patient Safety Brochure

The Florida Agency for Health Care Administration is the chief health policy and planning group for the state and licenses and regulates health care facilities and health maintenance organizations (HMOs) in Florida. The Agency also manages the Medicaid program that provides health care to Florida's low-income and disabled citizens. The mission of the Agency is better health care for all Floridians. As part of this mission, we publish the *Consumer Awareness Series*, a variety of brochures to help the public make informed health care decisions.

This brochure looks at medical errors and steps you can take to protect yourself.

Note: This brochure is not designed to offer medical or legal advice. Please consult with your physician for medical advice and an attorney for legal advice.

Information in this brochure is current as of April 2009.

Introduction

The Institute of Medicine (IOM) of the National Academies reported in 1999 that between 44,000 and 98,000 people die in U.S. hospitals each year from medical errors. A medical error is defined as the failure to carry out a plan of action or use of the wrong plan. An individual can cause the error or it might happen because of a failure in the system.

Medical errors can take place in health care facilities, pharmacies, your doctor's office, and even in your home. They can involve surgeries, medical procedures, treatments, medicines, equipment, diagnoses, or lab reports, among others. They can involve complex systems like how a hospital tracks the medical services given to patients, or common tasks like giving food high in salt to a patient who needs a salt-free diet.

While advances have improved medical care and extended the lives of many people, the complexity of the American health care system also contributes to medical errors. Poor communication between patients and their health care providers can lead to mistakes as well.

You can play an important part in patient safety by being actively involved in your own health care and the health care of your loved ones. This brochure will look at some of the problems and the actions each of us can take.

Health Care Team

Most people no longer have one physician who takes care of them throughout their lives and knows their entire history. You might change primary care physicians, visit various specialists, or find yourself in a hospital emergency department. At your doctor's office you might see the

doctor, nurse practitioner, or another professional. You might receive your care through a clinic where you see a different provider each time you visit.

The one constant in this care is you. You are an important member of your health care team. You know your history, medications, allergies, illnesses, and surgeries. Part of your responsibility is to educate yourself about your conditions and treatments and to share important information about your health with your health care providers.

Communication between you and your health care providers is an important part of patient safety. You have the right to ask questions and to have matters explained to you in a way you understand. You have the right to know what treatment choices are available for your care.

In addition you may find yourself being an advocate for loved ones because they are unable to make health care decisions, or a loved one may need to represent you if you are unable to speak for yourself.

Tips for Being a Part of Your Health Care Team:

Inform all of your health care providers of your medical history including any treatments, surgeries, medications, allergies, or medical conditions.

Tell all of your providers about every medication you take, including prescriptions, over-the-counter medicines, vitamins, and herbal supplements.

Write down questions and take them to your appointment. You might want to take notes during the visit or take someone with you as your advocate. They can help you speak up, ask questions, and write notes. Later you can talk with this person about your situation and choices.

If you need to have medical care, ask what treatment choices you have.

If something is said you don’t understand, ask for a clearer explanation.

If tests are performed and you don’t receive results, call the office and ask for them. You can also request a copy of the results.

If you want another opinion about a diagnosis or treatment, request one from another doctor. Ask if your health insurance will pay for a second opinion.

If you’re not satisfied with your health care provider you may want to choose another one.

If you have a medical condition, are getting a certain treatment, or are taking medications, educate yourself in these matters. Ask your health care provider for educational materials and use your local library or the Internet to learn more.

Health Care Surrogate Designation:

If you're unable to be active in your health care due to physical or mental incapacity (like being in a coma or developing dementia) and if you don't have a health care advance directive, health care decisions may be made for you by a guardian appointed by the courts, your spouse, adult child, parent, adult sibling or, under certain circumstances, another adult relative or close friend.

If you would like someone to represent you if you are unable to make decisions yourself you can designate a health care surrogate. Further information can be found in the pamphlet Health Care Advance Directives – The Patient's Right to Decide. View it on-line at www.FloridaHealthFinder.gov .

Medicine Safety

Actively managing and learning about your medications is an important part of patient safety. Following are suggestions to better protect yourself and your loved ones when taking medications.

Do your health care providers know all of the medications you take?

Some medicines and supplements may cause harm if used together. Learn about the medications and supplements you take and any interactions they may have. At least once a year review all of your medicines (prescription and non-prescription) and supplements (vitamins and herbs) with your health care providers.

Whenever you are prescribed medication ask if the new medicine will interact with other medications or supplements you currently take.

Can you read your prescription?

If you can't read your prescription the pharmacist may misread it and give you the wrong medicine. Florida law requires that the prescription be written clearly, so make sure you ask for a clearly written prescription.

Before leaving the pharmacy check the medication label to see that it is written to you and it's the same name and strength as written on the prescription. Check this every time you fill a prescription.

Be familiar with how your medicine looks. If it looks different than what you took before talk with your pharmacist before taking it.

Do you read your medication label and insert?

The label will tell you how much to take, when and how long to take it, and if there are restrictions. For example, the label might say you shouldn't drink alcohol while taking the medication, stay out of the sun, or avoid certain foods or other medications. The insert will include information about safety precautions and side effects. (A side effect is, for example,

when an allergy or cold medicine might also make you sleepy.) If you have questions about the label directions, safety precautions, or side effects talk with your pharmacist.

If you cannot clearly read the label ask the pharmacist to use larger type. If you don't understand the directions ask the pharmacist to explain.

Is there a danger of buying medication that has been altered or that isn't what the label says it is?

A good way to protect yourself is to confirm that the pharmacy where you buy your medication is licensed by the State of Florida. Each pharmacy is required to post the company's license as well as the license of the pharmacy manager.

If you buy prescription medication over the Internet, or by mail order, it is important to be a wise shopper. First see your own health care provider for a prescription. Check to see if the company is licensed in the state in which it operates or if the National Association of Boards of Pharmacy (NABP) certifies the company through its VIPPS program (Verified Internet Pharmacy Practice Sites™). You can read more on the NABP website at www.nabp.net or call (847) 391-4406.

Be cautious buying medications over the Internet or by mail order. If the company is not legitimate, you may end up with fake, altered, or expired medication that will not help you and may cause harm. In addition, the website or mail order company may appear to be based in the United States, but actually be operating outside of the U.S. where quality and safety controls may not be available.

Is there a danger in taking over-the-counter (OTC) medications?

Some OTC medications should not be used with certain prescription drugs. Read your medication label and insert, and talk with your pharmacist if you have questions.

Also compare active ingredients before taking more than one medication at the same time. Many OTC and prescription medications contain the same active ingredient, which means you could take more than the recommended dose. For example, if you take a pain medication along with a cough, allergy, or sleep medicine, they may contain the same drug and the combination may be more than is safe to take at one time.

While your health care provider or pharmacist can alert you to unsafe combinations of drugs, you can also watch for the following two common ingredients:

Acetaminophen is used in over 600 products, especially headache and cold medicines. Taking more than is recommended can lead to liver damage or failure.

NSAIDs (nonsteroidal anti-inflammatory drugs) are common pain relievers. Overuse, or when used in combination with some drugs, can lead to stomach bleeding or kidney damage.

OTC medications are meant for temporary relief. If you need to use a medication longer than it says on the label, see your health care provider. You may have a serious medical condition or your provider may recommend another form of treatment.

Why is it important to know the correct dosage to take?

Medications can make you sick, injure you, or sometimes cause death when taken incorrectly. Do not take more of the medication than is recommended. Some things to watch out for:

Over-the-counter (OTC) medications come in a variety of strengths. For example, pain relief medication may be regular, extra strength, or time-release; they may be pills, liquid, or capsules. Follow package directions for dosage.

Some people mistakenly think taking three pain relief pills at one time will relieve the pain more quickly. Or they take too many pills within a 24-hour time or for too many days. Taking more than the recommended dose can be dangerous.

If you take prescription medication do not change the dosage before discussing it with your health care provider.

An adult dosage of medication should not be given to children. Follow directions prescribed by your child's doctor and for OTC medications buy the children's strength and follow the directions. An incorrect dosage can quickly have a dangerous effect on children because of their smaller size.

Some seemingly harmless OTC medications may not be appropriate for children. For example, the American College of Pediatrics recommends that aspirin not be given to children.

The elderly can also be more sensitive to medications and their side effects. Check with your physician if you become drowsy, confused, dizzy, or have other side effects, as your physician may be able to adjust or change your medication.

Tips on Safe Handling of Medications:

Put medications in a safe place away from children (and animals) and keep them in childproof bottles.

If there is an adult who has difficulty reading labels or in knowing when to take medication, have another adult oversee the medication.

If medication poisoning occurs call your doctor or the Poison Information Center at (800) 222-1222 or, if life threatening, call for emergency assistance which in most areas is 911.

Do not store medications in your bathroom as the moisture and heat could change or destroy their effectiveness. If you store medication in the kitchen protect it from heat and moisture. Find out if your medication should or should not be stored in the refrigerator.

At least once a year review all of your prescription and over-the-counter medications, as well as vitamins and supplements. Do not continue to use medications that have changed color, consistency, or odor. Safely throw away any that have expired, that you no longer use, or whose labels you can't read.

Throw out old medicine in a sealed, outdoor trash can in a manner that children, animals, or other adults cannot take it. Used syringes and needles should be placed in a hard container (like a used laundry soap bottle) with a tight lid and then thrown into the trash. To dispose of controlled substances, like narcotics, you may want to ask your pharmacist or health care provider for advice.

If you take several medications you may want to keep a list and schedule of when you take each one. Some people keep track of their medications by using a pill organizer they fill once a week. Ask your pharmacist about pill organizers or other tracking aids.

If your medications are delivered by mail or another delivery service make sure they don't sit outside your home for a lengthy period of time, they're not exposed to heat or cold, and they won't be tampered with or stolen.

Safety Tips on Taking Medications:

If you have an allergic reaction immediately call your health care provider, or if life threatening, call for emergency assistance which in most areas is 911.

Learn about possible side effects of your medication, what you can do about them, and when they might be dangerous or life threatening.

If you forget to take your medicine, as scheduled, immediately taking the missed dose may not be the best thing to do. Read the package insert or call your pharmacist for advice. It's easy to forget, so find out what to do before it happens.

Some people do not take their prescribed medications because they can't afford them. If you do not take your medications or you skip doses, you may be able to get less expensive drugs by comparing the pharmacy prices in your area. View the State of Florida Prescription Drug Price website at www.MyFloridaRx.com. The site has price information on the top most commonly used prescription drugs in Florida.

If you cannot afford your medications talk with your health care provider as he or she may recommend a less expensive medicine or may have free samples. Also, you may be eligible for prescription assistance programs (see the next section of this brochure).

Some medications should not be cut in half, chewed, or have the capsules opened as this will affect the medication and could cause harm or with some medications can even result in death. Read the insert or ask your pharmacist if you have questions.

If you arrange for your child to be given medication at day care or school, ask about the procedures for storage, administration, and record keeping. Every so often confirm that your child is being given the medication correctly.

Do not take medication for recreational use or use medication prescribed to a friend or family member, even if you have the same illness or symptoms as that person. Doing so is illegal and can be dangerous or deadly.

Because older established drugs have been on the market longer more is known about their effectiveness and side effects. When you're prescribed a medication ask your physician how long it's been on the market. If there are medication choices ask which will best serve your needs.

Prescription Assistance Programs:

The following programs may offer assistance if you meet their eligibility requirements:

Medicare Part D Prescription Drug Assistance is an insurance benefit to help people with Medicare pay for prescription drugs and is provided through Medicare approved private health plans. For more information contact Medicare's toll-free number (800) 633-4227 (TTY 877-486-2048) or view the website www.Medicare.gov.

Sunshine for Seniors, a state sponsored program, is for people 60 years or older. It provides referral to drug assistance programs, helps seniors choose the best program, and can help with the application process. Call the Elder Helpline toll-free number (800) 963-5337.

The National Council on Aging has a referral service for people 55 years or older. View their website at www.BenefitsCheckUp.org.

Some drug companies offer low or no cost medicine to low-income individuals. Ask your pharmacist if he or she knows of programs or do a search on the Internet of the companies that make your medicines. Some programs are also listed on www.FloridaHealthFinder.gov (click "Medical Help Resources").

You may also want to read our brochure, Understanding Prescription Drug Costs. Order a free copy by calling toll-free (888) 419-3456 or read it on the above website.

For further information: The National Library of Medicine has a website with information on medicines and other health care topics: www.MedlinePlus.gov.

Safety in Health Care Facilities and in Home Care

As a patient or resident in a facility or a person receiving home care services it might be challenging to be an active member of your health care team. You may not feel well. You may be given medication that makes you drowsy. You may be frail and find it difficult to speak up for yourself. But even with these challenges you still play a very important part in your health care team and you have the right to be involved in your care.

It's important to have clear communication with your health care providers. If you think you may not be able to be clear, due to a temporary condition or to longer term declining health, you may want to have a loved one be your advocate and speak up for you. You may also want to designate someone as your health care surrogate as mentioned earlier in this brochure.

Before entering a health care facility or receiving services from a home care provider you may want to learn more about the choices you have. You can request a copy of the following publications by calling the toll-free number (888) 419-3456 or view them on-line at www.FloridaHealthFinder.gov.

You can learn about nursing homes through the Nursing Home Guide.

You can read the consumer brochures: Long Term Care, Assisted Living in Florida, and Home Health Care in Florida.

You can compare Florida hospitals, ambulatory surgery centers, emergency rooms, hospices, and health plans at www.FloridaHealthFinder.gov. On the same website you can find a list of facilities and home care providers licensed, registered, or certified by the Agency for Health Care Administration.

The federal Medicare program also provides information on nursing homes, hospitals, home health agencies, and dialysis facilities that serve Medicare patients. To learn more view the Medicare website www.Medicare.gov.

While Receiving Care:

You have the right to review records related to your care. If you're receiving medical care under a physician's orders you will have a plan of care that describes your treatment. If a plan of care is not required other kinds of records may be kept.

When you are admitted, transferred, or discharged from a health care facility review your medications with your physician. Find out if there were medication changes and if you need to throw away any unused medicine that was replaced by a different drug or dosage.

If you're in a facility where you have an identification (ID) bracelet, check that it can be read and correctly identifies you. If your ID bracelet doesn't have the correct information, if it comes undone or if it can't be read ask that it be replaced.

When you're given medication, ask the person to check the medication, the order, and your identification so you receive the correct medicine and dosage at the correct time.

Be familiar with how your medicine looks and if it looks different than what you were given before, talk with the nurse or aide before taking it.

Ask what hours you are scheduled for medications. Tell the nurse or aide if a medication time passes and no one has brought your medication.

Before a medical test or procedure is done, ask the person to check the order and your identification. Ask what is going to be done and why.

Tell your nurse or physician if you have a reaction to your treatment or if your symptoms get worse.

If you are bed bound ask what safeguards are in place to prevent blood clots and skin ulcers.

While staying in a hospital or ambulatory surgery center, try to have a family member or friend with you at all times, if possible.

While Receiving Care in a Health Care Facility:

If you have a loved one with Alzheimer's disease or dementia in a health care or long-term care facility ask what safety precautions are in place for patients who wander.

Ask the facility what procedures are in place should the facility need to be evacuated due to an emergency or natural disaster, like a fire or hurricane.

Ask the facility what their policies are concerning restraints and seclusion of patients or residents.

While Receiving Care In Your Home:

When receiving services in your home try to have a backup plan if the caregiver does not show up for the scheduled appointment. A home health care provider is required to provide all scheduled visits, so tell the agency's director of nursing or administrator if someone doesn't show. If the problem continues you may want to change agencies.

If you need medical equipment and supplies, your home care provider is required to train you and your loved ones in the correct use of the equipment. Keep written instructions and the company's phone number nearby. Call them if you have questions or problems. If the equipment has alarms or error messages learn what these mean and what you need to do.

The home care provider is required to give you a phone number to call when you have questions or problems. If you're receiving nursing or therapeutic services or if you're on life-support equipment the company must be on-call 24-hours a day, 7 days a week.

If you have a physical or mental condition that will require help with evacuation and sheltering during a disaster, like a hurricane, the home care provider must help you register with the Florida Division of Emergency Management.

Safety Tips for Surgery & Medical Procedures:

If you have a choice, pick a health care provider and facility that have experience with the surgery/procedure you are having. The Agency's website, www.FloridaHealthFinder.gov,

provides information on the number of procedures performed at hospitals and ambulatory surgery centers in Florida.

Carefully follow directions about what you need to do prior to the surgery or procedure. If you don't understand the directions ask them to be explained to you.

Ask your health care provider if you need to stop any of your medications prior to the surgery/procedure, plus ask what you can eat or drink.

Make sure it is clear who will perform the surgery/procedure, what exactly will be done, and what to expect during and after the surgery/procedure.

Ask what safeguards are in place to ensure the correct surgery/procedure is done at the correct site on the correct patient.

Ask if you will need a blood transfusion and what safety precautions are in place to assure you receive the correct blood type. If possible, you may want to donate your own blood prior to the surgery/procedure. Tell your doctor if you have ever had a reaction to a blood transfusion.

Ask if there's a risk of complications after your surgery/procedure and what symptoms you should watch for.

Have a loved one available during your surgery/procedure to be your advocate. Tell your physician if you want your loved one consulted, if needed, and to report to them once the surgery/procedure is complete.

Learn about your follow-up care including healing of the surgery site; how much rest you will need; what medications, food, and activities to avoid; and when you can return to work and other activities.

Make sure your health care provider answers all your questions and concerns.

Safety Tips for Anesthesia:

When preparing for a surgery or procedure you will also want to learn about anesthesia. Anesthesia is medication that keeps you from feeling pain and sensations during a surgery/procedure. Ask exactly who will give you anesthesia and monitor your vital signs.

Tell your doctor and the anesthesiologist if you have ever had a reaction to anesthesia. Tell them all the medications you take (prescribed, over-the-counter, vitamins, and herbal supplements) and any allergies you have. Also, let them know if you have any medical problems and, though this may feel personal, if you have a drinking problem or use drugs recreationally. This information is very important for safe anesthesia care.

Ask about restrictions on medications, food, and alcohol before and after the use of anesthesia.

After surgery under general anesthesia (the kind that puts you to sleep) you may continue to feel drowsy, tired, or weak for a few days and you may have problems with coordination and thinking clearly. For at least 24 hours after receiving general anesthesia don't drive, use machines, or do things that could be dangerous if you are not alert.

If You Have a Complaint:

If you have a complaint about your health care provider or health care facility talk with them first to see if the matter can be resolved. If you are still not satisfied and want to file a complaint with the State of Florida call the toll-free number (888) 419-3456.

Prevention of Infections

The Centers for Disease Control (CDC) states that about two million people a year get an infection during their stay in a hospital in the United States. A person can also get an infection in non-hospital settings like nursing homes, dialysis centers, physicians' offices, or in their own home.

Data is available on infection rates at Florida hospitals. If you are going to receive care or treatment in a hospital you may want to check your hospital's infection rates or compare several hospitals in your area. You can find this information at www.FloridaHealthFinder.gov.

Tips on Infection Prevention:

A patient can be at risk of getting an infection, so if you are ill do not visit a person who is sick at home or in the hospital. If a patient has an infection, he or she may transfer it to others, so take precautions to protect yourself.

The CDC states that clean hands are the most important part in preventing the spread of infection.

If you are giving care be sure to wash your hands before and after, and if you are receiving care don't be afraid to ask your health care providers if they washed their hands.

As a patient it's also important to keep your hands clean, particularly after handling soiled items or after using the bathroom.

If you are visiting an ill person, wash your hands before and after the visit.

Gloves should be worn if coming into contact with body fluids, soiled items, or when inserting any invasive devices (like a catheter). Hands should be washed before and after using gloves. The gloves should be thrown out after caring for a patient.

If you have a drainage tube or a catheter that comes lose, immediately tell your caregiver or health care provider. A drainage tube might be inserted to drain a wound; a catheter might be a

Foley catheter (a thin tube inserted to remove urine from the bladder) or an intravenous line (or IV) that is inserted into a vein to give fluids.

If you have either a catheter or a wound, keep the skin clean and dry around your IV catheter dressing or wound dressing. If the dressing gets wet or comes lose tell your caregiver or health care provider.

Long nails and artificial nails can continue to hold infectious germs even after a good handwashing. If a patient is at risk of getting an infection the CDC states caregivers should keep their nail tips to ¼ inch in length and should not wear artificial nails.

Other ways germs can spread are through droplets (from an infected person coughing, sneezing, or talking, etc); airborne transmission (which may require special air handling and ventilation for treatment); items that have picked up germs like medical equipment or any item that can then spread infection; or when animals or bugs transmit infection (like mosquitoes, flies, or rats).

Sometimes it may be necessary for the patient, staff, or visitors to wear protective masks or gowns.

Under certain circumstances a patient may be placed in isolation in a hospital to protect the patient and to prevent the spread of infection. Patients placed in isolation will have signs posted outside their hospital doors. Before entering the room ask the hospital staff about visiting restrictions and any protective requirements for the patient, staff, or visitors.

Some medical equipment and items may require special handling during and after use, for example, needles, catheters, or items soiled with body fluid (like blood on a bandage), etc. Some items can be thrown in the regular trash, but others may need to be placed in a biohazard waste container. Other items may be able to be sterilized or disinfected for future use.

Ask your health care provider about proper use and disposal of gloves, gowns, masks, medical equipment, and supplies.

The patient’s bed linens and clothing should be changed and washed regularly or if they become soiled. The patient’s surroundings should be kept clean.

Tell your health care provider if you show signs of a possible infection, like a fever, chills, pain, redness, swelling, a discharge, or other symptoms.

If you are diabetic you have a higher risk of developing an infection. Be careful about controlling your blood sugar and especially talk with your health care provider about your diabetic care needs if you have surgery, need wound care, will be bedridden, or other situations that might lead to infection.

If you are given antibiotics for an infection, use all the medication until it is finished. Even if you feel better do not stop taking the antibiotic.

Prevention of Falls

Injuries from falls are of particular concern for the elderly and for patients who might be frail or disoriented from illness, recovering from surgery, or on medication. Whether you're in a health care facility or your own home, check for the following to help prevent falls:

If you're in a hospital bed the side rails may need to be kept up. Ask your caregiver to lock the brakes on your bed. And, if needed, call for help to get out of bed.

Make sure throw rugs and floors aren't slippery. Keep the floor clear of clutter.

Use shoes that give good support and are not slippery.

Use a walker, cane, or wheelchair if needed and learn how to use them correctly.

Eyeglasses or a change in eyeglasses may help as poor vision can contribute to falls.

Make sure there is good lighting.

Consider a bedside commode if walking to the bathroom in the middle of the night is difficult.

Use chairs and a bed that are easy to get in and out of.

Grab bars in the bathroom, a raised toilet seat, shower chair, and non-slip mat in the tub or shower are good safety features.

Stairs should have handrails on both sides, have good lighting, and be clear of objects./

Ask your physician if an adjustment in your medications could improve coordination.

An exercise program, even for the frail elderly, can help improve balance and strength and help prevent falls. You may want to consult an exercise trainer or participate in an exercise program geared towards your skill level. Review your surroundings and see what other actions can be taken to help prevent falls.

Resource Directory

Agency for Healthcare Research and Quality
(301) 427-1364
www.ahrq.gov

American Association of Blood Banks
www.aabb.org

Anesthesia Patient Safety
American Association of Nurse Anesthetists
www.AnesthesiaPatientSafety.com

Association for Professionals in Infection Control and Epidemiology
(202) 789-1890
www.apic.org

Centers for Disease Control (CDC)
(800) 232-4636 or TTY (888) 232-6348
www.cdc.gov

Food and Drug Administration (FDA)
(888) 463-6332
www.fda.gov

Institute of Medicine of the National Academies
(202) 334-2352
www.iom.edu

MedlinePlus
www.MedlinePlus.gov

National Patient Safety Foundation
(617) 391-9900
www.npsf.org

Poison Information Center
(800) 222-1222
www.fpicn.org

The Joint Commission
(630) 792-5000
www.JointCommission.org

The Leapfrog Group
(202) 292-6713
www.LeapFrogGroup.org

Additional Consumer Brochures Include:

A Consumer's Guide to Health and Human Services Programs

A Patient's Guide to a Hospital Stay

Assisted Living in Florida

Emergency Medical Care

End-of-Life Issues – A Practical Planning Guide

Florida Medicaid – A Reference Guide

Health Care Advance Directives (only available online)

Home Health Care in Florida

Long-Term Care

Understanding Prescription Drug Costs

For additional copies of this brochure, or any of the brochures listed above, please contact the AHCA Call Center at (888) 419-3456.

To view or print any brochure in the Consumer Awareness Series, please visit www.FloridaHealthFinder.gov.

This brochure may be copied for public use. Please credit the Agency for Health Care Administration for its creation.

If you have comments or suggestions, please call (850) 922-5771.

The Agency for Health Care Administration established the following websites to help Florida residents be well informed health care consumers.

www.FloridaHealthFinder.gov provides search tools to compare short-term acute care hospitals, ambulatory (outpatient) surgery centers, health plans, and nursing homes. The site includes the A.D.A.M. Health Encyclopedia with thousands of articles and illustrations. The site also provides a list of health care facilities; information about insurance, medications, seniors, medical conditions, and resources for medical care; a variety of consumer publications; information for health care professionals; and much more.

www.MyFloridaRx.com
This website compares prices for the top most commonly used prescription drugs in Florida.

http://ahca.MyFlorida.com
This website includes information on health care facility regulation and licensing, the Florida Medicaid program, managed care (HMOs), and other topics related to the Agency for Health Care Administration.

Retrieved from http://www.floridahealthfinder.gov/reports-guides/patient-safety.shtml, retrieved 11-28-09.

Appendix F

Professional Liability Claims Reporting

Professional Liability Claims Reporting	
Database Category :	Complaint
Statute or Law Reference:	627.912; 627.9122 FS
Regulatory Rules:	690-171.003; 690-171.005; 690-171.006 FAC
Reporting Entities:	Self-insurers authorized under s. 627.357, commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and joint underwriting association providing professional liability insurance to a practitioner of medicines licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part 1 of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance to a member of The Florida Bar and insurers providing coverage for officers' and directors' liability coverage.
Web-1:	**https://apps.fldfs.com/PLCR/Reports/Home.aspx**

Database Purpose:

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: 1. A final judgement in any amount. 2. A settlement in any amount. 3. A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured. AND Any claim or action for damages claimed to have been caused by error, omission, or negligence in the performance of the officer's or director's services, if the claim resulted in: 1. A final judgement in any amount. 2. A settlement in any amount. 3. A final disposition not resulting in payment on behalf of the insured.

Types Of Data Collected:

(a)The name, address, health care provider professional license number, and specialty coverage of the insured.OR The name, address, and position held by the insured, and the type of corporation or organization, including classifications as provided in s. 501(c) of the Internal Revenue Code of 1986, as amended. (b)The insured's policy number. (c)The date of the occurrence which created the claim. (d)The date the claim was reported to the insurer or self-insurer. (e)The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by

the office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence. (f)The date of suit, if filed. (g)The injured person's age and sex. (h)The total number, names, and health care provider professional license numbers of all defendants involved in the claim. (i)The date and amount of judgement or settlement, if any, including the itemization of the verdict. (j)In the case of a settlement, such information as the office may require with regard to the injured person. (k)The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense. (l)The date and reason for final disposition, if no judgement or settlement. (m)A summary of the occurrence which created the claim. (n)Any other information required by the commission, by rule, to assist the office in it analysis and evaluation.

Department:	Department of Financial Services
Division:	Office of Insurance Regulation
Bureau:	Communications Office
Contact Name:	Anita Durham
Contact Phone:	(850) 413-2515
Contact Email:	**anita.durham@floir.com**
Supervisor Name:	Edward Domansky
Supervisor Title:	Director of Communications
Supervisor Phone:	(850) 413-2515
Date Record Updated:	1/20/2009 11:17:27 AM

Retrieved from http://www.floridahealthfinder.gov/StateHealthDataDirectory/StateHealthDirectoryEntries.aspx, retrieved 11-28-09

Florida Statute 627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.--

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance to a member of The Florida Bar **shall report** to the office as set forth in paragraph (c) any written 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.

(b) For purposes of this section, the term "claim" means the receipt of a notice of intent to initiate litigation, a summons and complaint, or a written demand from a person or his or her legal representative stating an intention to pursue an action for damages against a person described in paragraph (a).

(c) The duty to report specified in paragraph (a) arises upon the occurrence of the first of:

1. The entry of any judgment against any provider identified in paragraph (a) for which all appeals as a matter of right have been exhausted or for which the time period for filing such an appeal has expired;

2. The execution of an agreement between a provider identified in paragraph (a) or an entity required to report under that paragraph and a claimant to settle damages purported to arise from the provision of professional services, which agreement includes the indemnity payment of at least $1; however, if any applicable law requires any such agreement to be approved by the court, the duty arises when the agreement is approved;

3. The final payment of any indemnity money by any of the entities required to report under paragraph (a) on behalf of any provider identified in that paragraph for damages purported to arise from professional services rendered; or

4. The final disposition of a claim for which no indemnity payment was made on behalf of the insured but for which loss adjustment expenses were paid in excess of $5,000. As used in this subparagraph, the term "final disposition" means the insurer has brought down all reserves and closed its file.

(d) After any calendar year in which no claim or action for damages was closed, the entity shall file a no claim submission report. Such report shall be filed with the office no later than April 1 of each calendar year for the immediately preceding calendar year. If a reporting entity submits such a report for a particular calendar year and subsequently discovers that its report was submitted in error, the reporting entity shall promptly notify the office of the error and take steps as directed by the office to make the needed corrections.

(e) If a claim is initially opened and then closed, and is subsequently reopened, the reopened claim shall be treated as a new claim and reported after the occurrence of the first of any event listed in paragraph (c).

(f) Each health care practitioner and health care facility listed in paragraph (a) must report any claim or action for damages as described in paragraph (a), if the claim is not otherwise required to be reported by an insurer or other insuring entity.

(g) Reports under this subsection shall be filed with the office no later than 30 days following the occurrence of the first of any event listed in paragraph (c). An insurer is not required to file a new or amended report on a claim more than 1 year after submitting an initial report.

(2) The reports required by subsection (1) shall contain:

(a) The name, address, health care provider professional license number, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number, names, and health care provider professional license numbers of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict.

(j) In the case of a settlement, such information as the office may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the 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, 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 insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the commission, by rule, to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases.

(3) The office shall provide the Department of Health with electronic access to all information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. The Department of Health 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. 456.073 shall apply.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting hereunder or its agents or employees or the office or its employees for any action taken by them under this section. The office may impose a fine of up to $250 per day per case, but not to exceed a total of $10,000 per case, against an insurer, commercial self-insurance fund, medical malpractice self-insurance fund, or risk retention group that violates the requirements of this section, except that the office may impose a fine of $250 per day per case, not to exceed a total of $1,000 per case, against an insurer providing professional liability insurance to a member of The Florida Bar, which insurer violates the provisions of this section. If a health care practitioner or health care facility violates the requirements of this section, it shall be considered a violation of the chapter or act under which the practitioner or facility is licensed and shall be grounds for a fine or disciplinary action as such other violations of the chapter or act. The office may adjust a fine imposed under this subsection by considering the financial condition of the licensee, premium volume written, ratio of violations to compliancy, and other mitigating factors as determined by the office.

(5) Any self-insurance program established under s. 1004.24 shall report to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the state university board of trustees through an employee or agent of the state university board of trustees, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic medicine licensed under chapter 459, podiatric physicians licensed under chapter 461, and dentists licensed under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, or a settlement in any amount. The reports required by this subsection shall contain the information required by subsection (3) and the name, address, and specialty of the employee or agent of the state university board of trustees whose performance or professional services is alleged in the claim or action to have caused personal injury.

(6)(a) The office shall prepare statistical summaries of the closed claims reports for medical malpractice filed pursuant to this section, for each year that such reports have been filed, and make such summaries and closed claim reports available on the Internet by July 1, 2005.

(b) The office shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports for medical malpractice filed pursuant to this section and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include an analysis of closed claim reports of prior years, in order to show trends in the frequency and amount of claims payments, the itemization of economic and noneconomic damages, the nature of the errant conduct, and such other information as the office determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida, including an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year, including a loss ratio analysis for medical malpractice written in Florida and a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information as the office deems relevant.

(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.

(7) The commission may adopt rules requiring persons and entities required to report pursuant to this section to also report data related to the frequency and severity of open claims for the reporting period, amounts reserved for incurred claims, changes in reserves from the previous reporting period, and other information considered relevant to the ability of the office to monitor losses and claims development in the Florida medical malpractice insurance market.

627.9122 Officers' and directors' liability claims; reports by insurers.--

(1) Each insurer providing coverage for officers' and directors' liability coverage shall report to the office any claim or action for damages claimed to have been caused by error, omission, or negligence in the performance of the officer's or director's services, 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 office no later than 60 days following the occurrence of any event listed in paragraph (a), paragraph (b), or paragraph (c).

(2) The reports required by subsection (1) shall contain:

(a) The name, address, and position held by the insured, and the type of corporation or organization, including classifications as provided in s. 501(c) of the Internal Revenue Code of 1986, as amended.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer.

(e) The name of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the office without the consent of the injured person. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The total number and names of all defendants involved in the claim.

(h) The date and amount of judgment or settlement, together with a copy of the settlement or judgment.

(i) In the case of a settlement, such information as the office may require with regard to the claimant's anticipated future losses.

(j) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expenses 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. Whether the injuries claimed were the result of physical damage to the claimant, were the result of damage to the reputation of the claimant, were based on self-dealing by the defendant, or were in the nature of a shareholder dispute.

2. A description of the type of activity which caused the injury.

3. The steps taken by the officers or directors to assure that similar occurrences are less likely in the future.

(m) Any other information required by the office to analyze and evaluate the nature, causes, costs, and damages involved in officers' and directors' liability cases.

(3) The office shall include a summary of this information in its annual report.

Appendix G

Florida Medical Schools

School Name: American University of the Caribbean (Miami office) School of Medicine
Address: 901 Ponce de Leon Blvd., Suite 700
Zip & city: Coral Gables, FL 33134
Phone:
Web: http://www.aucmed.edu/; May not be fully accredited

School Name: Florida International University-Miami
Address: 11200 S.W. 8 Street, University Park
HLS II - #693
Zip & city: 33199, Miami, Florida
Phone: Tel: (305) FIU-DOCS (348-6627)
Web: http://medicine.fiu.edu/index.php

School name: Florida State University (College of Medicine)
Address: 1115 West Call Street
Zip & city: FL 32306-4300 Tallahassee
Phone: 850-644-1855
Web: http://med.fsu.edu

School Name: Grace University School of Medicine
Address: 23123 State Road 7 Suite 300D
Zip & city: Boca Raton, FL 33428
Phone: (561) 451-9152
Web: n/a: May not be fully accredited

School name: Lake Erie College of Osteopathic Medicine
Address: 5000 Lakewood Ranch Boulevard, Bradenton, Florida
Zip & city: 34211-4909 Bradenton
Phone: (941) 756-0690
Web: http://www.lecom.edu/

School name: Nova Southeastern University (College of Osteopathic Medicine)
Address: 3200 South University Drive, Fort Lauderdale, Florida
Zip & city: 33328 Fort Lauderdale
Phone: (954) 262-1100
Web: http://medicine.nova.edu/

School Name: Saint Matthew's University School of Medicine
Address: 12124 High Tech Ave. Suite 350
Zip & city: Orlando, FL 32817
Phone:
Web: http://www.stmatthews.edu/
May not be fully accredited

School Name: University of Central Florida-College of Medicine (New School)
Address: P.O. Box 160116
Zip & city: Orlando, FL 32816
Phone: 407.823.4244; Fax: 407.823.4048
Web/email/Bio:
mdadmissions@mail.ucf.edu
The University of Central Florida College of Medicine was established in 2006 by the Florida Legislature and the Florida Board of Governors to address the growing physician shortage nationwide and provide economic benefits to Central Florida and the state.
http://www.med.ucf.edu/, retrieved 11-28-09

School name: University of Florida (College of Medicine)
Address: J. Hillis Miller Health Center
Zip & city: FL 32610 Gainesville
Phone: 352-392-4569
Web: http://www.med.ufl.edu

School name: University of Miami (Leonard M. Miller School of Medicine)
Address: 1600 N.W. 10th Avenue
Zip & city: FL 33136 Miami
Phone: 305-243-6791
Web: http://www.med.miami.edu

School name: University of South Florida (College of Medicine)
Address: 12901 Bruce B. Downs Blvd
Zip & city: FL 33612 Tampa
Phone: 813-974-2229
Web: http://hsc.usf.edu/medicine

Appendix H

Medical licenses issued 1998 to 2008

TABLE ONE	APPLICATIONS RECEIVED AND INITIAL LICENSES ISSUED

YEAR	7/1 to 6/30	
PROFESSION	APPLICATIONS RECEIVED	LICENSES ISSUED
	2008-09	
Medical Doctor-MD	2,699	2,844
Osteopathic Phy-DO	321	289
	2007-08	
MD	3,028	2,805
DO	303	289
	2006-07	
MD	3098	3001
DO	300	275
	2005-06	
MD	2933	2656
DO	309	290
	2004-05	
MD	3059	2804

DO			375			313
	2003-04					
MD			3367			2382
DO			330			247
	2002-03					
MD			3432			2034
DO			308			159
	2001-02					
MD			3116			2471
DO			317			276
	2000-01		No Data Available			
MD						
DO						
	1999-00		No Data Available			
MD						
DO						
	1998-99		No Data Available			
MD						
DO						

Appendix I

Summary of licensed health care practitioners 1998 to 2008

		SUMMARY OF LICENSED PRACTITIONERS								
		IN-STATE	IN-STATE	IN-STATE	OUT-OF STATE	OUT-OF STATE	OUT-OF STATE	MILITARY	RETIRED	TOTAL
		ACTIVE	INACTIVE	DELIQUENT	ACTIVE	INACTIVE	DELIQUENT	ACTIVE		
	2008-09									
Medical Doctor-MD		41,952	173	689	13,214	860	1,265	133	1,237	59,522
Osteopathic Phy-DO		3,886	14	71	1,153	238	139	43	108	5,652
Total - all licensed practitioners		715,345	4,788	67,697	78,912	5,867	23,288	2,066	7,299	905,262
	2007-08									
MD		40,936	169	726	12,642	910	1,283	157	1,063	57,886
DO		3,689	21	81	1,028	244	188	34	114	5,399
Total - all licensed practitioners		687,131	5,636	59,221	80,478	6,846	16,891	1,962	6,588	864,753
	2006-07									
MD		40,065	190	674	105	11,968	941	1,285	733	55,961
DO		3,619	21	55	11	1,100	263	130	52	5,251
Total - all licensed practitioners		685,863	6,631	31,512	2,503	76,789	7,320	16,515	4,658	831,791

	2005-06										
MD			39,016	275	797	11,391	976	1,373		355	54,183
DO			3,439	21	92	975	264	187		50	5,028
Total - all licensed practitioners			650,865	7108	253555	72,956	7,241	21,159		2,250	1,015,134
	2004-05										
MD			38,160	348	790	10,944	985	1,334			
DO			3,345	32	58	1,107	230	144			
Total - all licensed practitioners			756,555	7100	28437	70,794	6,657	16,545			
	2003-04										
MD			29,956	231	259	17,849	1,079	702			
DO			2,727	25	66	1,375	240	162			
Total - all licensed practitioners			353,053	4747	18253	132,774	8,797	13,723			
	2002-03										
MD			29,159	255	405	17,671	1,028	752			
DO			2,650	11	38	1,573	213	76			
Total - all licensed practitioners											
	2001-02			Del. Active	Inactive	Del. Inactive					
MD			43567	1542	1310	330					46749
DO			3943	174	228	56					4401
Total - all licensed practitioners			757670	58282	11747	4472					832171
	2000-01							Del. Inactive			
MD			43517	1352	1657			500			47027
DO			3889	202	197			132			4420
Total - all licensed			724320	11575	62853			4994			803742

practitioners											
	1999-00		Active	Inactive							
MD			50003	1930				51933			
DO			4134	371				4505			
Total - all licensed practitioners			732322	16086				748408			
	1998-99		Active	Inactive							
MD			47609	970				48579			
DO			3766	316				4082			
Total - all licensed practitioners			647375	10625				658000			
Notes/Definitions:											

In State Active- the licensed practitioner has a Florida mailing address and is authorized to practice subject to any restrictions or obligations imposed.

In State Inactive- the licensed practitioner has a Florida mailing address and is not authorized to practice

In State Delinquent- the licensed practitioner has a Florida mailing address of record and is not authorized to practice his/her profession in the state of Florida, because he/she failed to renew his/her license by the expiration date.

Out of State Active-the licensed practitioner has an out of state mailing address and is authorized to practice subject to any restrictions or obligations imposed.

Out of State Inactive-the licensed practitioner has an out of state mailing address and is not authorized to practice.

Out of State Delinquent-the licensed practitioner has an out of state mailing address of record and is not authorized to practice his/her profession in the state of Florida, because he/she failed to renew his/her license by the expiration date.

Military Active-the licensed practitioner is authorized to practice only on a military installation in Florida.

Retired-the licensed practitioner is not practicing in the state of Florida, but maintains a retired license statutes. The licensed practitioner is not authorized to practice in the state of Florida. The practitioner is not obligated to update his/her licensure data.

Appendix J

Summary of Disciplinary complaints against healthcare licensees 1998 to 2008

TABLE TWO		SUMMARY OF DISCIPLINARY COMPLAINTS AGAINST HEALTHCARE LICENSEES								
YEAR	7/1 to 6/30									
PROFESSION	YEAR	REVOKED	VOL. SURR.	SUSPEND	PROB.	LIMIT/OBLI	FINE	REPRIM	CITATION	DISMISSED
	2008-09									
MD		7	52	17	16	113	130	23	315	49
DO		1	1	10	3	10	16	5	170	4
	2007-08									
MD		20	44	28	29	164	200	51	305	100
DO		3	6	12	5	36	43	13	22	6
	2006-07									
MD		16	38	33	29	196	207	46	273	49
DO		4	1	8	6	45	45	13	113	9
	2005-06									
MD		17	35	37	14	190	185	41	472	45
DO		2	3	6	7	12	17	7	28	8
	2004-05							No data		
MD		17	31	40	13	154	207		432	30
DO		0	5	1	3	8	11		13	0
	2003-04							No data		
MD		6	24	25	32	163	192		341	40

DO		3	2	3	3	21	26		26	2
	2002-03							No data		
MD		12	15	19	12	153	150		30	92
DO		2	1	3	3	43	36		7	4
	2001-02							No data		
MD		25	13	23	20	215	206		19	
DO		0	1	3	3	23	26		7	
	2000-01							No data		
MD		37	24	19	23	158	194		1	
DO		2	3	4	2	11	14		0	
	1999-00							No data		
MD		15	18	12	22	71	84		17	
DO		4	0	6	7	6	8		5	
	1998-99							No data		
MD		12	18	15	29	80	95			
DO		1	0	2	4	13	23			

Appendix K

Medical malpractice closed claims 1998 to 2008

MEDICAL MALPRACTICE CLOSED CLAIMS								
YEAR	7/1 to 6/30							
PROFESSION	YEAR	CIVIL COURT CLAIMS RECEIVED	CLOSED CLAIMS RECEIVED	NICA CLAIMS RECEIVED	EMERGENCY 3 IN 5 INITIATED	EMERGENCY 3 IN 5 DISCIPLINES	CLOSED CLAIMS DISCIPLINED	CLOSED CLAIMS NON-DISCIPLINE
	2008-09							
MD		292	3,291	42	413	0	19	408
DO		28	303	3	38	0	0	31
	2007-08							
MD		283	4,364	51	235	5	9	200
DO		34	712	5	32	1	1	15
	2006-07							
MD		291	4811	45	168	10	18	224
DO		22	395	2	7	1	1	17
	2005-06							
MD		263	1431	37	124	0	7	121
DO		16	125	1	14	0	0	10
	2004-05							
MD		342	1358	53	3	1	7	147
DO		39	136	0	1	0	0	7

	2003-04							
MD		701	993	53	37	6	16	104
DO		48	70	2	0	0	0	8
	2002-03							
MD		691	459	55	107	3	6	107
DO		64	35	3	4	0	0	1
	2001-02							
Total		686						91
	2000-01	No Data Available						
MD								
DO								
	1999-00	No Data Available						
MD								
DO								
	1998-99	No Data Available						
MD								
DO								

Notes/Definitions:

3 in 5 Disciplines-disciplines as a result of investigations initiated when the practitioner has had three or more closed medical malpractice claims within a five year period as required by Fla. Stat. sections 458.331(6), 459.015(6), 461.013(1)(s), and 466.028(6).

3 in 5 Initiated-investigation started when the practitioner has had three or more closed medical malpractice claims within a five year period as required by Fla. Stat. sections, 458.331(6), 459.015(6), 461.013(1)(s), and 466.028(6).

Closed Claims- Civil suits alleging medical malpractice against health care practitioner that have been resolved.

Appendix L

Florida Board of Governor Minutes

INDEX OF MINUTES
FLORIDA BOARD OF GOVERNORS
TURNBULL CENTER FOR PROFESSIONAL DEVELOPMENT
FLORIDA STATE UNIVERSITY
TALLAHASSEE, FLORIDA
MARCH 23, 2006

…

Resolution
With Regard to the Future of Medical Education in Florida

WHEREAS, the Board of Governors finds that Florida's future healthcare service needs are a joint responsibility among multiple stakeholders including hospitals, other healthcare providing institutions, academic accrediting bodies, Florida's postsecondary institutions and, critically, the Florida Legislature; and

WHEREAS, the Board of Governors recognizes that virtually all potential actions to expand medical education have significant cost implications, the funding for which would need to be approved and provided by the Florida Legislature and, further, that any program leading to a degree offered as a credential for a license under Florida Law must be approved by the Florida Legislature pursuant to 1004.03(3), Florida Statutes; and

WHEREAS, the Board finds that there is a shortage of physicians in Florida, particularly in certain geographical areas; that Florida's historical reliance on a large importation of physicians from other parts of the United States and beyond is not in the best interests of the public for the long-term; that, left unattended, this shortage will not diminish; and that, accordingly, Florida, a growing and dynamic state, must be proactive in planning for the future healthcare needs of its citizens; and

WHEREAS, the Board finds that, historically and currently, access to medical education for fully qualified Floridians has been limited by the number of seats in Florida's existing medical schools; and

WHEREAS, the Board finds that the policy of the State with respect to medical education must be a comprehensive approach, including at least the elements contained in this resolution, in order to meet the healthcare needs of Floridians; and

WHEREAS, the Board finds, along with virtually all stakeholders, that creating more medical residencies is a first and immediate priority for Florida's healthcare system, and therefore urges the Florida Legislature to work with the Board, the existing medical schools, and all other appropriate bodies and constituents to increase and fund an appropriate number of additional high-quality residencies affiliated with those medical schools through

existing or new programs in order to attract and retain more Florida medical school graduates; and

WHEREAS, the Board finds that institutions providing residency programs must be encouraged to periodically review their residency programs, making adjustments to ensure that residencies are in specialties that meet the needs of the population and that attract and retain new physicians; and

WHEREAS, in addition to the creation of high quality residencies, as a matter of policy the Board encourages the Legislature to consider providing funding for the existing Florida Health Service Corps and the Medical Education Reimbursement and Loan Repayment Program or by other means, to consider changes in law, as appropriate, that would incent Florida medical school graduates to practice in rural areas, and to provide changes to our liability system such that new physicians can afford insurance and be able to enter the practice of medicine with the highest levels of professionalism without the overlay of financial insecurity and which will encourage those physicians to remain in the state long term; and

WHEREAS, the Board supports and encourages cost-efficient plans for expanding current medical education programs in the State University System, subsequent to the Board's formal approval, and as a priority matter requests the Legislature to fully fund all current enrollments and future expanded enrollments; and

WHEREAS, the Board finds that, in addition to its findings set forth above, the two medical school proposals submitted by the University of Central Florida ("UCF") and Florida International University ("FIU") will create a source of high quality jobs in their respective regions; that they will serve as growth engines for cutting-edge life sciences research and businesses; that the quality of life can be improved for the general population and surrounding areas; and that the growth will generate significant increases in state and local taxes annually that will support infrastructure needs and still result in a payback of the state's investment by the 10th year while continuing to support the operation of the two medical programs as presented; and

WHEREAS, the Board encourages the Legislature to evaluate the sources of these increased taxes to optimize the capture and use of these revenues by the state as needed to support the continued operation of these medical education programs and their ancillary needs; and

WHEREAS, it is the finding of the Board of Governors after extensive deliberation, testimony, and consideration, that Florida International University has performed the requisite feasibility and need and demand studies; planning and cost projections; analysis of current capabilities and resources; receipt of significant private funding commitments and continued exploration of such future private commitments; developed alliances and partnerships with appropriate hospitals and other institutions for high quality residencies; and demonstrated return on investment in the form of regional economic development to warrant the Board's concurrence that this institution is positioned and stands ready to add

to Florida's future medical education by implementing a high quality school of medicine; and

WHEREAS, it is the finding of the Board of Governors after extensive deliberation, testimony, and consideration, that the University of Central Florida has performed the requisite feasibility and need and demand studies; planning and cost projections; analysis of current capabilities and resources; receipt of significant private funding commitments and continued exploration of such future private commitments; developed alliances and partnerships with appropriate hospitals and other institutions for high quality residencies; and demonstrated return on investment in the form of regional economic development to warrant the Board's concurrence that this institution is positioned and stands ready to add to Florida's future medical education by implementing a high quality school of medicine; and

WHEREAS, the Board received advice and counsel from the Council for Education Policy, Research and Improvement's November 2004 "Medical Education Needs Analysis" (CEPRI Report) and considers it to be a cornerstone and blueprint for addressing Florida's future healthcare needs in a manner that is comprehensive, logical, action-oriented, collaborative, and expectant of tangible commitments on the parts of the Legislature, the Board of Governors, and the State University System.

NOW THEREFORE BE IT RESOLVED that the Board of Governors takes the following action:

1. The Board of Governors approves the comprehensive approach to medical education as set forth above and in the CEPRI Report.

2. The Board of Governors approves Florida International University's request for a medical school with the understanding that any program leading to a degree offered as a credential for a license under Florida Law must also be approved by the Florida Legislature pursuant to 1004.03(3), Florida Statutes.

3. The Board of Governors approves the University of Central Florida's request for a medical school with the understanding that any program leading to a degree offered as a credential for a license under Florida Law must also be approved by the Florida Legislature pursuant to 1004.03(3), Florida Statutes.

4. The Board of Governors will not seek funding with regard to the FIU and UCF medical education programs approved above during the 2006 Legislative Session, beyond any related matters already contained in its current 2006-07 Legislative Budget Request.

5. The Board of Governors has and will continue to seek full funding of the current unfunded medical school expanded enrollments at the existing medical schools within the State University System and state funding of additional residencies, as expeditiously as possible.

6. The Board of Governors directs staff to transmit to the Legislature a copy of this resolution, the CEPRI Report with a view toward its implementation, and the economic impact

studies prepared by consultants for UCF and FIU, and requests that the Legislature undertake an evaluation of the tax revenue to be generated by these medical schools in order to create new state revenue sources, if appropriate, to support the ongoing needs of these medical education programs, residencies, and expanded enrollments associated with all of the state's medical education programs.

7. The Board of Governors finds that it will not consider any future requests for medical schools, professional programs, or doctoral programs unless such requests are consistent with the Board of Governors' Strategic Plan, as it is modified from time to time, and are submitted in accordance with the Board's process for program approval….

http://www.flbog.org/documents_meetings/0042_0129_1028_08%20-%20bogminutes-03-23-06.doc

Appendix M

Analysis of Closed Claims

Number of closed claims-2008-09				**2007-08**		**2006-07**		**2005-06**	
3,336				3553		3811		3753	
Category of payment		**Amount**	**% of Total**		**% of Total**		**% of Total**		**% of Total**
Damages paid to Plaintiff		$519,091,049.00	74.14%	523,644,436	70.70%	530,973,921	69.99%	492,869,563	72.81%
LAE to Defense counsel		$137,413,305.00	19.63%	174,737,224	23.59%	166,031,692	21.89%	133,984,552	19.79%
All other LAE		$43,685,772.00	6.24%	42,263,676	5.71%	61,597,440	8.12%	50,088,039	7.40%
Total paid		$700,190,126.00	100.00%	740,645,336	100.00%	758,603,053	100.00%	676,942,154	100.00%
Average cost per claim		$209,889.13		208,456		199,056		180,374	
Damages Paid to Plaintiffs									
Non-economic damages		$267,834,838.00	42.29%	239,317,064	53.54%	228,114,702	37.88%	203,589,745	31.23%
Economic damages		$365,539,224.00	57.71%	207,664,138	46.46%	374,021,292	62.12%	448,269,730	68.77%
Total		$633,374,062.00	100.00%	446,981,202	100.00%	602,135,994	100.00%	651,859,475	100.00%
Estimate of fees-Plaintiffs' attorney									
per constitutional cap									
- Fla. Const. art. I, sec 26(a)	33.33%	$ 267,834,838	$89,278,279.33	79,764,377		76,030,630		67,856,462	
Percentage of Non-economic damages			33.33%	33.33%		33.33%		33.33%	
Average per claim	33.33%	$209,889.13	$69,963.04	69,478		66,345		60,119	

For the years 1990-2004 the data is not compiled in the same format as above and for the years 2005 to 2009 making it difficult to analyze therefore it was not analyzed. The data is available in the applicable year end reports and published on the Florida Office of Insurance website pursuant to Florida Statute 627.912 (6)(a) (2009). The data collected is not reflective of and does not present a complete picture of closed claims. The above chart represents a compilation of data from the annual reports for the applicable years and is accessible at the Florida Office of Insurance Regulation website www.floir.com.