Title XLV TORTS Chapter 766 MEDICAL MALPRACTICE AND RELATED MATTERS

Statutes that you need be familiar with. (Please review the exact statutes because these have been modified for brevity and/or clarity):

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

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

(2)(a) If the injury is claimed to have resulted from the negligent affirmative medical intervention of the health care provider, the claimant must, in order to prove a breach of the prevailing professional standard of care, show that the injury was not within the necessary or reasonably foreseeable results of the surgical, medicinal, or diagnostic procedure constituting the medical intervention, if the intervention from which the injury is alleged to have resulted was carried out in accordance with the prevailing professional standard of care by a reasonably prudent similar health care provider.
(b) The provisions of this subsection shall apply only when the medical intervention was undertaken with the informed consent of the patient in compliance with the provisions of s. 766.103.

. . .

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless the person is a health care provider who holds an active and valid license and conducts a complete review of the pertinent medical records and meets the following criteria:
(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:
1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; 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 specialty;
b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same 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 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.

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

(7) Notwithstanding subsection (5), in a medical negligence action against a hospital, a health care facility, or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.
(6) A physician licensed under chapter 458 or chapter 459 who qualifies as an expert witness under subsection (5) and who, by reason of active clinical practice or instruction of students, has knowledge of the applicable standard of care for nurses, nurse practitioners, certified registered nurse anesthetists, certified registered nurse midwives, physician assistants, or other medical support staff may give expert testimony in a medical negligence action with respect to the standard of care of such medical support staff.
(7) Notwithstanding subsection (5), in a medical negligence action against a hospital, a health care facility, or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.

458.3175. *Expert witness certificate*

(1)(a) The department shall issue a certificate authorizing a physician who holds an active and valid license to practice medicine in another state or a province of Canada to provide expert testimony in this state, if the physician submits to the department:

1. A complete registration application containing the physician's legal name, mailing address, telephone number, business locations, the names of the jurisdictions where the physician holds an active and valid license to practice medicine, and the license number or other identifying number issued to the physician by the jurisdiction's licensing entity; and

2. An application fee of $50. See: https://flboardofmedicine.gov/licensing/expert-witness-certificate/

766.104. *Medical negligence cases; reasonable investigation required before filing*

(1) No action shall be filed for personal injury or wrongful death arising out of medical negligence, whether in tort or in contract, unless the attorney filing the action has made a reasonable

investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint or initial pleading shall contain a certificate of counsel that such reasonable investigation gave rise to a good faith belief that grounds exist for an action against each named defendant. For purposes of this section, good faith may be shown to exist if the claimant or his or her counsel has received a written opinion, which shall not be subject to discovery by an opposing party . . .

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

(3) For purposes of conducting the investigation required by this section, and notwithstanding any other provision of law to the contrary, subsequent to the death of a person and prior to the administration of such person's estate, copies of all medical reports and records, including bills, films, and other records relating to the care and treatment of such person that are in the possession of a health care practitioner as defined in s. 456.001 shall be made available, upon request, to the spouse, parent, child who has reached majority, guardian pursuant to chapter 744

766.106. *Notice before filing action for medical negligence; presuit screening period*

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

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

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

(2) Presuit notice.--

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

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

(3) Presuit investigation by prospective defendant.--

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

(b) At or before the end of the 90 days, the prospective defendant or the prospective defendant's insurer or self-insurer shall provide the claimant with a response:
1. Rejecting the claim;
2. Making a settlement offer; or
3. Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only on the issue of damages. This offer may be made contingent upon a limit of general damages.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt shall be deemed a final rejection of the claim for purposes of this section.

(d) Within 30 days of receipt of a response by a prospective defendant, insurer, or self-insurer to a claimant represented by an attorney, the attorney shall advise the claimant in writing of the response, including:
1. The exact nature of the response under paragraph (b).
2. The exact terms of any settlement offer, or admission of liability and offer of arbitration on damages.
3. The legal and financial consequences of acceptance or rejection of any settlement offer, or admission of liability, including the provisions of this section.
4. An evaluation of the time and likelihood of ultimate success at trial on the merits of the claimant's action.
5. An estimation of the costs and attorney's fees of proceeding through trial.

(4) Service of presuit notice and tolling.--The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 90-day period, the statute of limitations

is tolled as to all potential defendants. Upon stipulation by the parties, the 90-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

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

(6) Informal discovery.--

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

1. Unsworn Statements of parties (Depositions without an oath)

2. Documents or things (Request to Produce)

3. Physical and mental examinations (CME)

4 Written questions (Interrogatories)

5 *Interviews of treating health care providers*.--A prospective defendant or his or her legal representative may interview the claimant's treating health care providers. (Ex Parte interviews are now unconstitutional and prohibited)
RULED UNCONSTITUTIONAL BY THE FLORIDA SUPREME COURT November 9, 2017 *Weaver v. Myers*, 229 So.3d 118 (2017)

6 Unsworn statements of treating healthcare providers (Depositions without oath of other doctors). (See Weaver v. Myers which held the following sentence unconstitutional: "If the claimant's attorney fails to schedule an interview, the prospective defendant or his or her legal representative may attempt to conduct an interview without further notice to the claimant or the claimant's legal representative."

7 Sanctions for failing to cooperate may subject a party to strike claims or defenses

766.1065. *Authorization for release of protected health information*

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

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

Watch Out: There has not been any case law to suggest you don't have to give the authorization, so you should probably play it safe and give the form authorization. But note the part that has been deemed unconstitutional in the authorization to be safe and prevent an improper communication between the defense and a health care provider.

766.118. *Determination of noneconomic damages*

Caps on Damages have been ruled unconstitutional

Estate of McCall v. United States, 134 So. 3d 894 (Fla. 2014) **Holding:** The Florida Supreme Court, Lewis, J., held that statutory cap on wrongful death noneconomic damages recoverable in medical malpractice actions violates the right to equal protection under state constitution.

And again in *N. Broward Hosp. Dist. v. Kalitan*, 219 So. 3d 49 (Fla. 2017) **Holding:** The Supreme Court held that statutory caps on personal injury noneconomic damages in medical negligence actions violated Florida Constitution's equal protection clause.

766.1185. *Bad faith actions*

Is there Bad Faith for Medical Malpractice Insurance carriers?

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

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

1. The 210th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this subparagraph shall be extended by an additional 60 days if the court in the bad faith action finds that, at any time during such period and after the 150th day after service of the complaint, the claimant provided new information previously unavailable to the insurer relating to the identity or testimony of any material witnesses or the identity of any additional claimants or defendants, if such disclosure materially alters the risk to the insured of an excess judgment; or

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

The statute lists:

Depositions of all claimants(who controls that);

Depositions of all the defendants;

Depositions of all claimants' expert witnesses and;

Mediation.

Either party may request the court enter an order finding the other party has unnecessarily or inappropriately delayed any of the events specified above, and if the

claimant was responsible, No Bad Faith. There are a lot of technicalities here and the one thing you don't want to do extend any time limits, or be late with anything on your part of the case.

766.202. Definitions;

(1) "Claimant"
(2) "Collateral sources"
(3) "Economic damages"
(4) "Health care provider" means any hospital or ambulatory surgical center as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.
(5) "Investigation"
(6) "Medical expert"
(7) "Medical negligence"
(8) "Noneconomic damages"

(4) Definition of a Health Care Provider: This is the list of who you must Pre-Suit to bring an action. What is not defined as a health care provider are pharmacies, pharmacists and psychologists.

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

(2) Presuit investigation by claimant.--Prior to issuing notification of intent to initiate medical negligence litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:
(a) Any named defendant in the litigation was negligent in the care or treatment of the claimant; and
(b) Such negligence resulted in injury to the claimant.
Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(6), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence.

(3) Presuit investigation by prospective defendant.--Prior to issuing its response to the claimant's notice of intent to initiate litigation, during the time period for response authorized pursuant to s. 766.106, the prospective defendant or the defendant's insurer or self-insurer shall conduct an investigation as provided in s. 766.106(3) to ascertain whether there are reasonable grounds to believe that:
(a) The defendant was negligent in the care or treatment of the claimant; and
(b) Such negligence resulted in injury to the claimant.
Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(6), at the time the response rejecting the

claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

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

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

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

(2) Failure to provide copies of such medical records, or failure to make the charge for copies a reasonable charge, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the requirement of written medical corroboration by the requesting party.

How do you request and get records in 10 days? I suggest mailing your request via Certified Return Receipt Requested and stating that you are requesting the records pursuant to Florida Statute 766.204 and quote the language in your medical record request form. Caution, do not send this type of request to a friendly doctor, because this scares the heck out of them and they may have to notify their medical malpractice carrier. See my form below:

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

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

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

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

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

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

AMENDMENT SEVEN:

766.101. *Medical review committee, immunity from liability*

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

766.1016. *Patient safety data privilege*

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

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

Title XXIX PUBLIC HEALTH
Chapter 381 PUBLIC HEALTH: GENERAL PROVISIONS

381.028. Adverse medical incidents

(1) Short title.--This section may be cited as the “Patients' Right-to-Know About Adverse Medical Incidents Act.”

(2) Purpose.--It is the purpose of this act to implement s. 25, Art. X of the State Constitution. The Legislature finds that this section of the State Constitution is intended to grant patient access to records of adverse medical incidents, which records were made or received in the course of business by a health care facility or provider, and not to repeal or otherwise modify existing laws governing the use of these records and the information contained therein. The Legislature further finds that all existing laws extending criminal and civil immunity to persons providing information to quality-of-care committees or organizations and all existing laws concerning the discoverability or admissibility into evidence of records of an adverse medical incident in any judicial or administrative proceeding remain in full force and effect.

(3) Definitions.--As used in s. 25, Art. X of the State Constitution and this act, the term:

(a) “Agency” means the Agency for Health Care Administration.

(b) “Adverse medical incident” means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider which caused or could have caused injury to or the 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, incidents that are 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 committee.

(c) “Department” means the Department of Health.

(d) “Have access to any records” means, in addition to any other procedure for producing the 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 that 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.

(e) “Health care provider” means a physician licensed under chapter 458, chapter 459, or chapter 461.

(f) “Health care facility” means a facility licensed under chapter 395.

(j) “Records” means the final report of any adverse medical incident. Medical records that are not the final report of any adverse medical incident, including drafts or other nonfinal versions; notes; and any documents or portions thereof which constitute, contain, or reflect any attorney-client communications or any attorney-client work product may not be considered “records” for purposes of s. 25, Art. X of the State Constitution and this act.

(4) Patients' right of access.--Patients have a right to have access to any records made or received in the course of business by a health care facility or health care provider relating to any adverse medical incident. In providing access to these records, the health care facility or health care provider may not disclose the identity of patients involved in the incidents and shall maintain any privacy restrictions imposed by federal law.

(6) Use of records.--

(a) This section does not repeal or otherwise alter any existing restrictions on the discoverability or admissibility of records relating to adverse medical incidents otherwise provided by law, including, but not limited to, those contained in ss. 395.0191, 395.0193, 395.0197, 766.101, and 766.1016, or repeal or otherwise alter any immunity provided to, or prohibition against compelling testimony by, persons providing information or participating in any peer review panel, medical review committee, hospital committee, or other hospital board otherwise provided by law, including, but not limited to, ss. 395.0191, 395.0193, 766.101, and 766.1016.

(b) Except as otherwise provided by act of the Legislature, records of adverse medical incidents, including any information contained therein, obtained under s. 25, Art. X of the State Constitution, are not discoverable or admissible into evidence and may not be used for any purpose, including impeachment, in any civil or administrative action against a health care facility or health care provider. This includes information relating to performance or quality improvement initiatives and information relating to the identity of reviewers, complainants, or any person providing information contained in or used in, or any person participating in the creation of the records of adverse medical incidents.

2. A request for production of records must be submitted in writing and must identify the patient requesting access to the records by name, address, and the last four digits of the patient's social security number; describe the patient's condition, treatment, or diagnosis; and provide the name of the health care providers whose records are being sought.

Florida Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478 (Fla. 2008)
Holdings: The Supreme Court held that:

1 the amendment is self-executing with terms enforceable as of the date of its passage;

2 it applied retroactively to existing records;

3 retroactive application did not violate hospitals' due process rights;

4 several provisions of statute violated the amendment; and

5 the unconstitutional provisions were severable.

W. Florida Reg'l Med. Ctr., Inc. v. See, 79 So. 3d 1 (Fla. 2012)
Holdings: The Supreme Court held that:

1 a blank application for medical staff privileges does not fall within statutory privileges against discovery of documents considered by a hospital medical review committee or hospital licensing board during the peer review or credentialing process, disapproving Tenet Healthsystem Hospitals, Inc. v. Taitel, 855 So.2d 1257;

2 blank application for medical staff privileges was a record of an adverse medical incident and subject to disclosure under state constitutional provision governing patients' right to know about adverse medical incidents;

3 scope of constitutional provision governing patients' right to know about adverse medical incidents could not be limited by application of implementing statute, which attempted to limit disclosure of matters to those incidents found in certain reports; and

4 federal Health Care Quality Improvement Act of 1986 did not preempt state constitutional provision governing patients' right to know about adverse medical incidents through implied conflict preemption.

Title XXXII REGULATION OF PROFESSIONS AND OCCUPATIONS
Chapter 456 HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

456.001. Definitions

(4) “Health care practitioner” means any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491

Is a Pharmacy a Healthcare Provider?

Pharmacy is not a “healthcare provider” under Medical Malpractice Reform Act section pertaining to presuit investigation and notice requirements; thus, customer who sued pharmacy for misfilling prescription was not required to comply with those requirements. West's F.S.A. § 766.106(2); F.S.1985, § 768.50(2)(b).
Sova Drugs, Inc. v. Barnes, 661 So. 2d 393 (Fla. 5th DCA 1995)

458.320. Financial responsibility

(1) As a condition of licensing and maintaining an active license . . . must demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer . . .

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. . . The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and nontransferable. Such letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

(2) Physicians who perform surgery in an ambulatory surgical center licensed under chapter 395 and, as a continuing condition of hospital staff privileges, physicians who have staff privileges must also establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim . . .

7. . . . A licensee who meets the requirements of this paragraph must post notice in the form of 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.”

(g) Any person holding an active license under this chapter who agrees to meet all of the following criteria:

1. Upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the judgment creditor the lesser of the entire amount of the judgment with all accrued interest or either $100,000, if the physician is licensed pursuant to this chapter but does not maintain hospital staff privileges, or $250,000, if the physician is licensed pursuant to this chapter and maintains hospital staff privileges, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. Such adverse final judgment shall include any cross-claim, counterclaim, or claim for indemnity or contribution arising from the claim of medical malpractice. Upon notification of the existence of an unsatisfied judgment or payment pursuant to this subparagraph, the department shall notify the licensee by certified mail that he or she shall be subject to disciplinary action unless, within 30 days from the date of mailing, he or she either:

a. Shows proof that the unsatisfied judgment has been paid in the amount specified in this subparagraph; or

b. Furnishes the department with a copy of a timely filed notice of appeal and either:

(I) A copy of a supersedeas bond properly posted in the amount required by law; or

(II) An order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

2. The Department of Health shall issue an emergency order suspending the license of any licensee who, after 30 days following receipt of a notice from the Department of Health, has failed to: satisfy a medical malpractice claim against him or her; furnish the Department of Health a copy of a timely filed notice of appeal; furnish the Department of Health a copy of a supersedeas bond properly posted in the amount required by law; or furnish the Department of Health an order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

3. Upon the next meeting of the probable cause panel of the board following 30 days after the date of mailing the notice of disciplinary action to the licensee, the panel shall make a determination of whether probable cause exists to take disciplinary action against the licensee pursuant to subparagraph 1.

4. If the board determines that the factual requirements of subparagraph 1. are met, it shall take disciplinary action as it deems appropriate against the licensee. Such disciplinary action shall include, at a minimum, probation of the license with the restriction that the licensee must make payments to the judgment creditor on a schedule determined by the board to be reasonable and within the financial capability of the physician. Notwithstanding any other disciplinary penalty imposed, the disciplinary penalty may include suspension of the license for a period not to exceed 5 years. In the event that an agreement to satisfy a judgment has been met, the board shall remove any restriction on the license.

5. The licensee has completed a form supplying necessary information as required by the department.

A licensee who meets the requirements of this paragraph shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided.

Such sign or statement shall state: “Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.”

(6) Any deceptive, untrue, or fraudulent representation by the licensee with respect to any provision of this section shall result in permanent disqualification from any exemption to mandated financial responsibility as provided in this section and shall constitute grounds for disciplinary action under s. 458.331.

(7) Any licensee who relies on any exemption from the financial responsibility requirement shall notify the department, in writing, of any change of circumstance regarding his or her qualifications for such exemption and shall demonstrate that he or she is in compliance with the requirements of this section.

(8) Notwithstanding any other provision of this section, the department shall suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to the amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department or a payment schedule has been agreed upon by the physician and the claimant and presented to the department. This subsection does not apply to a physician who has met the financial responsibility requirements in paragraphs (1)(b) and (2)(b).

Title XLV TORTS
Chapter 768 NEGLIGENCE

768.0415. Liability for injury to parent

A person who, through negligence, causes significant permanent injury to the natural or adoptive parent of an unmarried dependent resulting in a permanent total disability shall be liable to the dependent for damages, including damages for permanent loss of services, comfort, companionship, and society.

See: Larusso v. Garner, 888 So. 2d 712 (Fla. 4th DCA 2004)

Holdings:

4) a child born alive may seek damages for loss of parental consortium based on pre-birth injury to parent;
5) filial consortium damages were limited to period of child's minority; and
6) child's claim for loss of parental consortium was not limited to period of child's minority.

Pleading Damages:

768.042. *Damages*

(1) In any action brought in the circuit court to recover damages for personal injury or wrongful death, the amount of general damages shall not be stated in the complaint, but the amount of special damages, if any, may be specifically pleaded and the requisite jurisdictional amount established for filing in any court of competent jurisdiction.

768.0755. *Premises liability for transitory foreign substances in a business establishment*

(1) If a person slips and falls on a transitory foreign substance in a business establishment, the injured person must prove that the business establishment had actual or constructive knowledge of the dangerous condition and should have taken action to remedy it. Constructive knowledge may be proven by circumstantial evidence showing that:
(a) The dangerous condition existed for such a length of time that, in the exercise of ordinary care, the business establishment should have known of the condition; or
(b) The condition occurred with regularity and was therefore foreseeable.

768.13. *Good Samaritan Act; immunity from civil liability*

(1) This act shall be known and cited as the “Good Samaritan Act.”

(2)(a) Any person, including those licensed to practice medicine, who gratuitously and in good faith renders emergency care or treatment either in direct response to emergency situations related to and arising out of a public health emergency declared pursuant to s. 381.00315, a state of emergency which has been declared pursuant to s. 252.36 or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, without objection of the injured victim or victims thereof, shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical

treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.
(b) 1. Any health care provider, including a hospital licensed under chapter 395, providing emergency services pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s. 395.1041, s. 395.401, or s. 401.45 shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.
2. The immunity provided by this paragraph applies to damages as a result of any act or omission of providing medical care or treatment, including diagnosis:
a. Which occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.
b. Which is related to the original medical emergency.
3. For purposes of this paragraph, “reckless disregard” as it applies to a given health care provider rendering emergency medical services shall be such conduct that a health care provider knew or should have known, at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent.

768.16. Wrongful Death Act

768.17. Legislative intent

It is the public policy of the state to shift the losses resulting when wrongful death occurs from the survivors of the decedent to the wrongdoer. Sections 768.16-768.26 are remedial and shall be liberally construed.

768.18. Definitions

(1) “Survivors” means the decedent's spouse, children, parents, and, when partly or wholly dependent on the decedent for support or services, any blood relatives and adoptive brothers and sisters. It includes the child born out of wedlock of a mother, but not the child born out of wedlock of the father unless the father has recognized a responsibility for the child's support.

(2) “Minor children” means children under 25 years of age, notwithstanding the age of majority.

(3) “Support” includes contributions in kind as well as money.

(4) “Services” means tasks, usually of a household nature, regularly performed by the decedent that will be a necessary expense to the survivors of the decedent. These services may vary according to the identity of the decedent and survivor and shall be determined under the particular facts of each case.

(5) “Net accumulations” means the part of the decedent's expected net business or salary income, including pension benefits, that the decedent probably would have retained as savings and left as part of her or his estate if the decedent had lived her or his normal life expectancy. “Net business or salary income” is the part of the decedent's probable gross income after taxes, excluding income from investments continuing beyond death, that remains after deducting the decedent's personal expenses and support of survivors, excluding contributions in kind.

768.20. Parties

The action shall be brought by the decedent's personal representative, who shall recover for the benefit of the decedent's survivors and estate all damages, as specified in this act, caused by the injury resulting in death. When a personal injury to the decedent results in death, no action for the personal injury shall survive, and any such action pending at the time of death shall abate. The wrongdoer's personal representative shall be the defendant if the wrongdoer dies before or pending the action. A defense that would bar or reduce a survivor's recovery if she or he were the plaintiff may be asserted against the survivor, but shall not affect the recovery of any other survivor.

768.21. Damages

All potential beneficiaries of a recovery for wrongful death, including the decedent's estate, shall be identified in the complaint, and their relationships to the decedent shall be alleged. Damages may be awarded as follows:

(1) Each survivor may recover the value of lost support and services from the date of the decedent's injury to her or his death, with interest, and future loss of support and services from the date of death and reduced to present value. In evaluating loss of support and services, the survivor's relationship to the decedent, the amount of the decedent's probable net income available for distribution to the particular survivor, and the replacement value of the decedent's services to the survivor may be considered. In computing the duration of future losses, the joint life expectancies of the survivor and the decedent and the period of minority, in the case of healthy minor children, may be considered.

(2) The surviving spouse may also recover for loss of the decedent's companionship and protection and for mental pain and suffering from the date of injury.

(3) Minor children of the decedent, and all children of the decedent if there is no surviving spouse, may also recover for lost parental companionship, instruction, and guidance and for mental pain and suffering from the date of injury. For the purposes of this subsection, if both spouses die within 30 days of one another as a result of the same wrongful act or series of acts arising out of the same incident, each spouse is considered to have been predeceased by the other.

(4) Each parent of a deceased minor child may also recover for mental pain and suffering from the date of injury. Each parent of an adult child may also recover for mental pain and suffering if there are no other survivors.

(5) Medical or funeral expenses due to the decedent's injury or death may be recovered by a survivor who has paid them.

(6) The decedent's personal representative may recover for the decedent's estate the following:
(a) Loss of earnings of the deceased from the date of injury to the date of death, less lost support of survivors excluding contributions in kind, with interest. Loss of the prospective net accumulations of an estate, which might reasonably have been expected but for the wrongful death, reduced to present money value, may also be recovered:
1. If the decedent's survivors include a surviving spouse or lineal descendants; or
2. If the decedent is not a minor child as defined in s. 768.18(2), there are no lost support and services recoverable under subsection (1), and there is a surviving parent.
(b) Medical or funeral expenses due to the decedent's injury or death that have become a charge against her or his estate or that were paid by or on behalf of decedent, excluding amounts recoverable under subsection (5).
(c) Evidence of remarriage of the decedent's spouse is admissible.
(8) The damages specified in subsection (3) shall not be recoverable by adult children and the damages specified in subsection (4) shall not be recoverable by parents of an adult child with respect to claims for medical negligence as defined by s. 766.106(1).(Medical Malpractice claims of an adult who is not married without minors cannot make a claim.)

768.22. *Form of verdict*

The amounts awarded to each survivor and to the estate shall be stated separately in the verdict.

768.23. *Protection of minors and incompetents*

The court shall provide protection for any amount awarded for the benefit of a minor child or an incompetent pursuant to the Florida Guardianship Law.

768.25. Court approval of settlements

While an action under this act is pending, no settlement as to amount or apportionment among the beneficiaries which is objected to by any survivor or which affects a survivor who is a minor or an incompetent shall be effective unless approved by the court.

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

(6)(a) An action may not be instituted on a claim against the state or one of its agencies or subdivisions unless the claimant presents the claim in writing to the appropriate agency, and also, except as to any claim against a municipality, county, or the Florida Space Authority, presents such claim in writing to the Department of Financial Services, within 3 years after such claim accrues and the Department of Financial Services or the appropriate agency denies the claim in writing; except that, if:

2. Such action is for wrongful death, the claimant must present the claim in writing to the Department of Financial Services within 2 years after the claim accrues.

(b) For purposes of this section, the requirements of notice to the agency and denial of the claim pursuant to paragraph (a) are conditions precedent to maintaining an action but shall not be deemed to be elements of the cause of action and shall not affect the date on which the cause of action accrues.

(c) The claimant shall also provide to the agency the claimant's date and place of birth and social security number if the claimant is an individual, or a federal identification number if the claimant is not an individual. The claimant shall also state the case style, tribunal, the nature and amount of all adjudicated penalties, fines, fees, victim restitution fund, and other judgments in excess of $200, whether imposed by a civil, criminal, or administrative tribunal, owed by the claimant to the state, its agency, officer or subdivision. If there exists no prior adjudicated unpaid claim in excess of $200, the claimant shall so state.
(d) . . . Except as provided otherwise in this subsection, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. For purposes of this subsection, in medical malpractice actions and in wrongful death actions, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 90 days after it is filed shall be deemed a final denial of the claim. The statute of limitations for medical malpractice actions and wrongful death actions is tolled for the period of time taken by the Department of Financial Services or the appropriate agency to deny the claim.

(7) In actions brought pursuant to this section, process shall be served upon the head of the agency concerned and also, except as to a defendant municipality, county, or the Florida Space Authority,

upon the Department of Financial Services; and the department or the agency concerned shall have 30 days within which to plead thereto.

(8) No attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement.

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

. . .
(f) For purposes of this section, any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, or any of its employees or agents, and which has agreed in an affiliation agreement or other contract to provide, or permit its employees or agents to provide, patient services as agents of a teaching hospital, is considered an agent of the teaching hospital while acting within the scope of and pursuant to guidelines established in the affiliation agreement or other contract.
(Shands Hospital, and other medical schools are a safe haven for malpractice)

SOME IMPORTANT CASE LAW YOU WANT TO KNOW:

"The requirements of the presuit process in medical malpractice actions must be interpreted liberally so as not to unduly restrict a Florida citizen's constitutionally guaranteed access to the courts. Fla. Stat. Ann. § 766.201(2)."
Morris v. Muniz, 252 So. 3d 1143 (Fla. 2018)

Probably the best case to read is: *Morris v. Muniz*, 252 So. 3d 1143 (Fla. 2018)
Where the Supreme Court of Florida explains in great detail how pre-suit investigation of a case is to be viewed.
"It has been observed that "there is an increasingly disturbing trend of prospective defendants attempting to use the [chapter 766] statutory requirements as a sword against plaintiffs." *Michael v. Med. Staffing Network, Inc.*, 947 So.2d 614, 619 (Fla. 3d DCA 2007)."

Cohen v. Dauphinee, 739 So. 2d 68 (Fla. 1999) stated: Presuit affidavit required to initiate medical malpractice action was protected from discovery and could not be admitted, and thus, opposing party could not impeach expert witness with corroborative

affidavit prepared by that witness in satisfaction of presuit affidavit requirements. West's F.S.A. §§ 766.203(2, 3), 766.205(4).

Patry v. Capps, 633 So. 2d 9 (Fla. 1994): “Physician's acknowledged receipt of timely written notice of intent to initiate medical malpractice action was sufficient, even though plaintiff served notice by hand, rather than certified mail, return receipt requested; physician was not prejudiced. West's F.S.A. § 768.57(2) (now § 766.106(2)).”

Moss v. Stadlan, 789 So. 2d 1069 (Fla. 4th DCA 2001) “Presuit notice to physician's employer of medical malpractice action operated as notice to physician, as physician and employer were in legal relationship. West's F.S.A. § 766.106(2); West's F.S.A. RCP Rule 1.650(b)(1).”

Oliveros v. Adventist Health Sys./Sunbelt, Inc., 45 So. 3d 873 (Fla. 2d DCA 2010) “Physicians and hospitals waived issue of qualifications of plaintiffs' expert who provided presuit corroborating affidavit as required for medical malpractice action, by failing to investigate and plead specifically and with particularity the issue; physicians and hospital were required to allege denial of performance or occurrence specifically and with particularity, but did not do so in their answers and affirmative defenses which were filed prior to expiration of statute of limitations on plaintiff's claims, and statute of limitations had expired by the time they raised the issue, and, thus, plaintiffs were prejudiced. West's F.S.A. RCP Rule 1.120(c); West's F.S.A. § 766.203(2).”