

***Florida College of Emergency
Physicians***



**Prepared for the
Medial Liability Insurance Workgroup**

Florida House of Representatives
Room 1002 The Capitol
402 South Monroe Street
Tallahassee, Florida 32399-1300

Summary of Information and Comments
Submitted by the
Florida College of Emergency Physicians

1. **What Makes Emergency Medicine Different**

Federal and state law mandares emergency physicians to provide emergency services and care. In essence, emergency physicians perform an essential government function furthering the public policy goal of universal emergency care. Emergency medicine is highly complex and high risk. Fewer specialists are willing to go “on call” to ERs. Florida’s capacity for emergency care is being outstripped by patient demand.

2. **Remarks by Art Diskin, MD**

Insurance is becoming unavailable and unaffordable. Physicians are unwilling to practice emergency medicine in Florida. ER physicians are often deep pockets. They often practice defensive medicine. Sovereign immunity is necessary.

3. **Remarks by George Meros, JD**

Physicians are required by law to treat all emergency patients. Emergency physicians implement important state objectives and should be given some protection as others – sovereign immunity.

4. **EMTALA: What You Need to Know**

EMTALA refers to Emergency Medical Treatment and Active Labor Act of 1986. Intended to prevent “patient dumping,” effectively created a federal right to universal and unfettered emergency care. This article describes the elements and implications of the law.

5. **Florida’s Access to Emergency Services and Care Law**

Found in ss. 395.1041 and 395.022, F.S., this law is similar to federal law in creating certain requirements for providers and rights for patients.

6. **Florida’s Good Samaritan Law**

Found in s. 768.13, F.S., this law provides immunity from civil liability in certain emergency situations including care provided in hospitals.

7. **Florida Statutes Providing “Sovereign Immunity” for Volunteer Physicians**

This law, found I s. 766.1115, F.S., grants immunity for certain health care providers who contract with the state to provide volunteer, uncompensated care to the uninsured or Medicaid recipients.

8. Emergency Room Visits Compared to Board Certified Emergency Physicians

This chart shows that as the number of patients accessing the Emergency Department for care has continued to rise, the number of Board Certified Emergency Physicians has fallen.

9. Data on Settlement and Awards of Medical Malpractice Claims

This chart indicates that settlements and jury awards in medical malpractice cases have risen dramatically in Florida since the 1970s, but since peaking in 1996, paid out claims and legal costs have leveled off or fallen back.

10. Data on Central Florida Lawsuits Filed

This chart shows that the number of medical malpractice lawsuits filed each year has grown about 42% locally and statewide during the past decade, while the state's population grew about 23% between 1990 and 2000. The annual lawsuit count actually peaked in Central Florida counties in the late 1990s. Statewide, they resumed climbing higher last year after falling back slightly in 2000.

11. Survey of Uncompensated Care Provided by Emergency Department Physicians in Florida Progress Report – April 2001

This survey provides payer mix and uncompensated care statistics. In 1998, 70 responding hospital emergency physician groups provided more than \$100 million in uncompensated care.

12. Selected Newspaper Articles

Articles from around the state focusing on problems physicians are having in obtaining and paying for insurance and the effect of same.

13. Emergency Physician Malpractice Questionnaire – Survey Instrument

14. Emergency Physician Malpractice Questionnaire – Tabulated Results

15. Selected Comments from Emergency Physicians



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WHAT MAKES EMERGENCY MEDICINE DIFFERENT?

- Emergency Physicians are compelled by federal and state law to treat every patient who presents himself or herself at an emergency room for treatment. This essentially becomes a unilateral contract. **Therefore, the Emergency Physician, in performing this essential government function, becomes an arm of the state, as the instrument of state public policy to provide universal emergency care.**
- While Emergency Physicians are required to treat all patients, neither the government, nor the patient, nor the insurer (if there is one) is obligated to pay for the care given.
- Even though no one is obligated to pay for this care, patients have unlimited access to the courts for services delivered in good faith. Since most hospitals contract with Emergency Physicians to provide services, few are actually employees of the hospital. They are typically required to carry \$1,000,000 in malpractice coverage, while the remainder of the staff is only required to carry \$250,000 in coverage. This leaves the Emergency Physician as the “deep pocket” on the staff.
- The Emergency Physician operates in a high complex, high-risk environment, using rushed procedures often late at night. Hundreds of independent judgments must be made without benefit of the patient’s prior medical history. This puts the Emergency Physician at greater risk, since adverse outcomes are more likely to occur even when care is properly given.
- The Emergency Department remains on the first line of response to a terrorist attack, especially if it involves a biological, chemical or nuclear release.
- In every community statewide, the Emergency Department represents the only universal access to health care for low-income and indigent patients. Typically, one out of every three patients seen by an Emergency Physician is indigent.
- Fewer and fewer specialists, especially those in high-risk areas such as obstetrics and neurosurgery, are willing to go on call for Emergency Departments due to rising malpractice premiums. This means more transfers and diversions to facilities that may have specialists on call, threatening patient care.
- Florida’s capacity for emergency care is being outstripped by patient demand. In 1992, there were 1,146 Board Certified Emergency Physicians to treat the 4.57 million patients who came to the Emergency Department. By 1999, there were only 901 Board Certified Emergency Physicians, and the number of patients had risen to 5.9 million. Unless it is a life-threatening condition, it is not unusual for a patient to wait eight to twelve hours, or in some cases, even days, in an Emergency Department.
- The present crisis is forcing Emergency Physicians to practice more defensive medicine, according to a recent statewide study.



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**Remarks by Dr. Art Diskin
To the Governors Select Task Force on
Healthcare Professional Liability Insurance
October 21, 2002
Orlando, Florida**

Distinguished Members of the Committee:

Thank you for the opportunity to speak before you today. I come before you as an emergency physician concerned that the effective delivery of emergency health care in the state of Florida is threatened, the traditional safety net is jeopardized and in my opinion, one of the leading causes is the constant threat, reality and cost of medical malpractice litigation and professional liability insurance

I come to you as Chairman of the Department of Emergency Medicine at Mount Sinai Medical Center, here in Miami Beach, home to one of only three residency programs in Emergency Medicine in the State of Florida, as an academician who is finding that he spends more time explaining to his residents how to avoid regulatory violations, avoid malpractice litigation and comply with a myriad of governmental regulations than he does teaching them clinical medicine and how to save lives; and who finds himself explaining how every patient encounter is a potential adversarial relationship.

I come to you as a practicing emergency physician and advocate for my specialty with over 20 years of clinical practice and at the peak of my career. Despite this, you are looking at someone who will likely not be practicing Emergency Medicine, at least not in the state of Florida, unless a rapid and effective solution to this situation is found. I find

my chosen specialty under siege from all directions. I represent a physician group that may be unable to obtain malpractice insurance this coming year, after seeing premiums increase 400% this past May. Our premiums may soon exceed 40% of gross income, not the 2% of health care costs quoted by the trial bar.

I come to you as a physician privileged to review the work of colleagues who finds that members of his specialty are no longer sued for bad medicine, but are sued for bad outcomes, regardless of quality of medicine practiced or the unusual or life threatening nature of the patient's disease or presentation. The truth is that tragic results often give rise to costly lawsuits when absolutely no malpractice occurred. To defend a case and win costs in excess of \$100,000 and to lose may cost a career.

I come to you as a practicing physician who must often beg specialists who know they will not get paid and will likely get sued for any bad outcome, to get out of bed in the middle of the night to come see a patient in the emergency department.

I come to you as a physician who has seen emergency departments so overcrowded that cardiac patients are sitting in chairs with monitors attached and fire-rescue ambulances lined up out the door with their patients on stretchers.

I come to you as someone who is responsible for the staffing of physicians for six emergency departments. I have seen a precipitous drop in the number of qualified applicants for emergency physicians in the last two years. I have recently returned from a national conference where I was repeatedly told by physicians they would love to come to Florida but had no intention of doing so due to the current malpractice crisis. Recruiting and retention of quality physicians is becoming a greater issue as our state population continues to grow. We have to be concerned not only with the number of

physicians who will actively leave practice but on the ability to recruit and retain young physicians to treat future generations of Floridians. This is especially true in Emergency Medicine which has now become equivalent to obstetrics and neurosurgery in the cost of litigation and insurance. Many physicians who continue to practice only do so due to Florida's asset protection laws. Any change in those laws could result in a precipitous exit of physicians from practice in our state.

Lastly, I come to you as a private citizen who is afraid the safety net of our state's emergency departments is failing and that my family and your family will not be able to receive the care they need, when they need it and where they need it. The next time I have a medical emergency; will I be able to find an open emergency department offering the services I need? Will there be a specialist on call who will be willing to come take care of me? Will I be able to get past the 30% of patients who are indigent and use the emergency departments as their source of primary care because they have learned they can't be turned away? Will the best doctors in my area quit medicine or move away because they can no longer afford malpractice insurance or no longer wish to practice under the constant threat of losing everything they and their families have worked for their entire lives.

Distinguished members of the Committee I am trained as a physician to save lives. I am not trained to debate or argue. The chance of my being able to win a verbal debate with the trial lawyers is as likely as a plaintiff attorney saving somebody's life. All I can do is present the situation I see it based upon my personal experience and the experience of my colleagues.

How are emergency physicians different? This is described briefly in your handout.

Most importantly, the State, under its access to care laws, the state equivalent of EMTALA, mandates we see every single patient who presents to the emergency department. We cannot turn away a patient because we know that they have sued every doctor they have ever seen. We cannot choose to refuse a patient with a clinical condition we know often results in malpractice litigation, such as multiple trauma, headaches or dissecting aneurysms. We cannot refuse to see a patient because we know that they are indigent and may not receive adequate follow up care. We cannot refuse to see a patient because they are substance abusers and cannot be relied upon to make proper medical decisions regarding their own health care. Yet we are held responsible for seeing all of these patients under an unfunded mandate and are responsible for any mal-outcomes in their care. This is a one way contract without consideration. The State uses the emergency departments for a public purpose as an arm of the state. We are willing to do this job. However, we must be protected. The State already extends sovereign immunity when it sees fit to protect its own interests

We are responsible for delivering an astronomical amount of indigent care within the state of Florida. As emergency department physicians, we are mandated without remuneration by the State and by the Federal Government to see all patients presenting to the emergency department regardless of their ability to pay. A study by Dr. Barbara Langland-Orban at the University of South Florida will clearly show that upwards of thirty percent of emergency care in the state of Florida is delivered without any remuneration. If a physician retires from practice and agrees to see patients for free in a

clinic setting, they are protected by Florida law under sovereign immunity. We receive no such protection for the thirty percent indigent care we deliver. We are subject to lawsuit whether we are compensated or not for our services.

We see six million emergency department visits annually in the state of Florida. Errors will be made. We rarely have enough time to spend with a patient for any of these errors, to be intentionally negligent or be done with reckless disregard. I am sure in the course of these hearings the many patients who feel they've been wronged, and may well have been, by the medical professional will appear in front of you. What becomes very difficult for the lay public, juries and judges to determine is the difference between mal-occurrence or "bad outcome," and malpractice. We are not gods. We cannot make every diagnosis, especially in the period of time many patients are under our care in the emergency department. We cannot cure all disease, and we do make errors in the heat of battle. However, awards of seventy six million dollars for pain and suffering in the case where after my review I would have clearly been in the same position as that emergency department physician should frighten everyone and cause some action to protect those practitioners who save people's lives on a daily basis.

Emergency department physicians belong to a group of physicians referred to as hospital based, meaning our entire practice occurs within the hospital. Most hospitals, as an astute business decision, require their hospital based physicians to carry one million dollars in insurance per incident. Emergency physicians therefore are often the deep pocket of all the physicians involved in a malpractice case, often despite having no or limited liability. The private practitioner may have no insurance or only two hundred and fifty thousand dollar limits. We do not have the option to drop our limits to these low

levels. Additionally, there is no way that we can meet the requirements necessary for going bare. How do we tell a patient as they are being wheeled into the emergency department that we do not have insurance and they may want have the option to go to another facility. This would clearly violate EMTALA and it's certainly not practical.

The escalating cost of malpractice insurance will only lead to increasing patient to physician ratios in our emergency departments, increased waiting time and increased risk to patient safety.

The costs of the malpractice crisis are direct and indirect. One of our residents is in the process of completing a study wherein emergency department physicians in the state of Florida were surveyed with over 300 responses. The survey designed a series of cases where the ordering of specific diagnostic studies would be optional. The final results that will show that in almost all instances the physicians were highly likely to order the test in that particular clinical scenario. Additionally, almost without exception, the physicians stated that they have ordered tests that they did not feel were clinically indicated, but had done so strictly for medical legal protective reasons. The study will attempt to put a cost on those additional studies ordered, although that may be difficult.

What do I think can be done to help keep our emergency departments open, functional and best able to meet the needs of our citizens? Let me offer a few suggestions:

Distinguished members of the committee, as emergency physicians, we fully support all of the initiatives suggested by the Florida Medical Association in an attempt to rectify the current crisis. However, we at the front lines of Emergency Medicine need something additional and we need it now.

We must have sovereign immunity in a form that will be explained later today to allow us to continue to deliver quality emergency department services and allow us to begin to recreate panels of on-call physicians willing to respond to patients' needs in the emergency department. This sovereign immunity needs to be extended not just to the on-call specialists but to the emergency department physicians and practitioners. We cannot continue to create scenarios whereby we are the only deep pocket in every malpractice suit. We cannot continue to provide physician staffing in the emergency departments on the amount of dollars remaining after we have paid astronomical insurance costs, deductibles or settlements. Later on today you will hear more specifics on our proposal for sovereign immunity from Mr. Meros and information on the technical aspects on how sovereign immunity legislation might work for emergency department practitioners and physicians who respond to the emergency department. I implore you to pay careful attention to these recommendations.

Several years ago, the legislature attempted to help us by passing a reckless disregard standard for Emergency Medicine. Well, unfortunately, instead of plaintiff's experts from all over the country, coming into the state and testifying that the poor emergency department physician was just having a bad day and happened to be negligent, those experts now line up to state that the emergency department physician was so evil that he/she acted with reckless disregard for the patient's care. Quite the picture to paint for a lay jury, likely unfamiliar with the medical issues involved. This language must be corrected.

This problem has existed since 1975. Laws to date have merely provided band aids to the situation. The myths associated with poor insurance investments causing the crisis have only served to delay recognition of the scope of the problem.

Other states have come up with a variety of solutions. Mississippi recently had the courage to pass caps on pain and suffering to ameliorate their crisis. Nevada has clearly started on the road towards reason. Indiana's plan, with its medical review panels prior to litigation, as well as Louisiana's, have brought reason to those states as well. The model plan of which you will hear much about is the MICRA plan from California. Medical care in California faces many challenges; at least the area at medical malpractice has some reasoning attached to it.

We cannot continue to view every single patient encounter as a potential adversarial relationship and continue to teach our residents that this the way they must practice medicine. We must have the time, energy and resources to make sure our emergency departments are part of the homeland security system. I should be spending my time preparing my emergency departments for possible biological, hazardous material or other threats, not in our vocabulary several years ago, instead of searching and negotiating for malpractice insurance.

We need to be able to concentrate on patient safety initiatives without worrying if the reporting of clinical errors will result in possible malpractice litigation and the ruin of our careers and our families' future

Thank you for taking the time to listen to me today and to the time and effort you are putting forth to help resolve this crisis. I am available at any time to answer any questions that you might have.



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**Remarks by George Meros, Jr.
(Gray Harris PA)
To the Governors Select Task Force on
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October 21, 2002
Orlando, Florida**

- ! As a matter of common sense, good public policy, and the law, emergency medical personnel should be entitled to the same protections afforded all state actors who implement important state objectives.
- ! The people of Florida, acting through the Legislature, have declared that all persons presenting to a physician or a hospital in possible need of emergency care must be treated immediately. Section 395.1041, Florida Statutes, specifically provides that “the legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care.”
- ! Accordingly, every day in emergency rooms throughout Florida, emergency physicians are compelled by state law to treat all persons who present to the emergency room. Physicians have no discretion to turn people down if a possible emergency exists. They have no discretion to decline service if the patient cannot pay for the services. If a physician declines service, he or she is subject to significant state-imposed penalties.
- ! At the same time, the Florida Legislature has declared that persons acting on behalf of the State in pursuit of important State objectives should be entitled to the State’s sovereign immunity – that is, limitations on legal liability.
- ! At present, however, emergency personnel are not afforded sovereign immunity from damage lawsuits – despite the incontestable fact that they serve as an arm of the State in pursuing the “vital state importance” of providing emergency care to all persons in need of such care.
- ! The Florida College of Emergency Physicians asks only for what is obvious and just – emergency physicians who provide care to persons pursuant to Section 395.1041 should be afforded the same sovereign immunity protections as other state actors. No less, no more.

- ! Sovereign immunity does not mean an absolute cap on damages. Injured persons have the opportunity to collect full damages even with application of sovereign immunity.

- ! Express legislative extension of sovereign immunity to emergency personnel is consistent with the mandates of the Florida and Federal Constitutions. Florida's Constitution expressly recognizes the State's sovereign immunity and permits the Legislature to determine its contours. The Legislature has already conferred immunity to other persons who implement state policy – without constitutional challenge. The express extension of sovereign immunity to emergency physicians would be fully consistent with those efforts.

EMTALA: What You Need to Know

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SUMMARY

- EMTALA is an anti-discrimination statute. It requires hospital Emergency Departments (EDs) to provide medical screening examinations and stabilizing treatments to all patients who present for care, without regard to their insurance status, membership in a managed care organization, or ability to pay.
- The duty to the patient under EMTALA falls on the hospital, not the physician. Nevertheless, the emergency physician is acting as the hospital's agent and is responsible for reporting EMTALA violations to hospital authorities.
- EMTALA imposes specific legal definitions for common terms such as "transfer" and "stable" that are not necessarily consistent with their clinical meanings.
- If a patient presents to the ED with an emergency medical condition, the hospital must use all of its resources, including the services of an on-call specialist, if required, to stabilize the patient prior to transfer to another facility.
- The fact that a patient is an enrollee of a managed care organization has no relevance with regard to examination and treatment under EMTALA. Patient care in the ED may not be denied or delayed because a managed care organization refuses authorization for payment. Similarly, an on-call specialist cannot refuse to evaluate the patient because the specialist does not participate in the patient's health care plan.
- Both physicians and hospitals can be cited for violating EMTALA. Penalties include civil monetary fines of up to \$50,000 per violation and/or loss of a hospital's or physician's Medicare provider agreement with the federal government.

What is EMTALA?

- EMTALA refers to the Emergency Medical Treatment and Active Labor Act of 1986 (Public Law 99-272), passed by Congress and signed into law by President Reagan on April 7, 1986. As part of the Consolidated Omnibus Budget and Reconciliation Act of 1985, it is sometimes known as COBRA. In passing this act, the intent of Congress was to stop the practice of “patient dumping” - the explicit denial of emergency care to those who lack the means to pay for it, along with the transfer of indigent patients, often medically unstable, to public institutions for purely economic reasons. Although EMTALA was written primarily as an anti-discrimination statute, it effectively created a federal right to universal and unfettered emergency care for all.
- EMTALA is a federal statute, which means that it is applicable in all states and territories of the United States and supersedes any state law. An EMTALA violation is a civil infraction, punishable by a significant monetary fine, loss of a hospital’s Medicare provider agreement, or both. The federal agency responsible for the drafting, dissemination, interpretation and enforcement of EMTALA regulations is the Health Care Financing Administration (HCFA), a branch of the Department of Health and Human Services.

What are the basic implications of EMTALA?

- EMTALA is an anti-discrimination statute. This means that all individuals who present to the hospital requesting emergency medical care must be offered the same medical screening exam (MSE) for a given set of signs and symptoms, using the same personnel, protocols and degree of diligence, regardless of the individual’s insurance status, membership in a managed care organization (MCO) or ability to pay. Stated simply, you must treat all patients the same.
- Delaying timely access to a MSE on account of a patient’s insurance status is not permitted. In other words, it is not appropriate for a hospital to request, or a MCO to require, prior authorization before a MCO member receives a MSE. This “no delay” provision was specifically incorporated into the EMTALA law to prevent hospitals from effectively denying care by deliberately delaying MSEs for patients unable to pay in favor of insured patients. In enacting this provision, Congress recognized that medical care delayed was equivalent to care denied.
- A hospital with specialized capabilities cannot refuse to accept an appropriately transferred patient in need of such specialized treatment if the hospital has the capacity to provide those services. This is true even if the requested specialty hospital is not an “in-plan” hospital for the patient’s MCO.

- The crucial test, as set by the federal courts, is not the adequacy of the screening and transfer process, but whether the evaluation, stabilization and disposition of the patient deviated from the hospital's customary procedures for patients with similar emergency medical conditions. Physicians and hospitals that consistently follow their standard operating procedures for all patients do not violate the EMTALA statute, regardless of the patient's clinical outcome (although they may be held negligent under their state's malpractice laws if the patient has a bad outcome).

What are the basic elements of the MSE?

- The purpose of a MSE is to determine the existence of an emergency medical condition, defined by HCFA as one having "acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."
- Included in HCFA's definition of an emergency medical condition are such problems as pregnancy with contractions, alcohol or drug intoxication, substance abuse, psychiatric disorders and severe pain.
- A pregnant woman in active labor, i.e., with contractions, has an emergency medical condition if "there is inadequate time to effect a safe transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or unborn child."
- EMTALA provides that a MSE is to be provided to "any individual who comes to the ED and a request is made on the individual's behalf for examination or treatment." The term "any individual" obviously applies to all patients, including minors, illegal aliens, uninsured or under-insured patients, members of a MCO, patients sent to the ED by any health care provider (for tests, X-rays, procedures, medications or immunizations), or patients managed by telephone orders from their private physician. In addition, the request for treatment can come from anyone and does not need to be initiated by the patient.

What is an appropriate Medical Screening Examination (MSE)?

- As defined by HCFA, "a MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist." Thus, the purpose of the MSE is to decide whether an individual has an emergency medical condition.

- Any hospital, regardless of its size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities to any person who presents to the hospital seeking medical attention. The exam must be of the same type and complexity that would be performed on any person coming to the ED with those signs and symptoms, regardless of the person's ability or willingness to pay for their medical care.
- The scope of a MSE may range from "a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, CT scans, diagnostic tests and procedures, or involvement of on-call specialists." In short, the scope of the exam constitutes whatever is usual and customary for a particular ED to determine whether an emergency medical condition exists, within the resources available to the ED.
- Triage is not equivalent to the MSE because it does not establish whether a patient has an emergency medical condition. Triage simply determines the order in which patients will be seen.
- In certain situations, the services of on-call specialists may be required to provide the expertise to determine if an emergency medical condition exists. In these cases, the appropriate MSE would encompass the evaluation provided by the on-call specialist and would be incomplete in its absence.
- A patient's clinical outcome is not relevant in determining whether an appropriate MSE was done. In other words, an adverse outcome in a transferred or discharged patient is not per se evidence of an EMTALA violation with respect to an appropriate MSE. If a misdiagnosis occurred, but the hospital utilized all of its resources in conducting the MSE, a violation of the MSE requirement did not occur.
- If the MSE is appropriate and does not reveal an emergency medical condition, the hospital has no further obligations under EMTALA. Such patients can be transferred to another hospital or outpatient facility if requested by the patient or their MCO, even for economic reasons, without violating EMTALA.

Who can perform the MSE?

- According to HCFA, the MSE must be performed by "qualified medical personnel," as specifically designated by the hospital's governing body for the purpose of performing screening exams. Thus, medical professionals other than physicians (e.g., specially-trained nurses, nurse practitioners or physician assistants) may be allowed to perform the MSE on behalf of the hospital, as long as they have

access to the full capabilities of the ED to determine the existence of an emergency medical condition.

- Again, with regard to who performs the MSE, the test is one of anti-discrimination. That is, a hospital cannot systematically use physicians to perform MSEs on one class of individuals while using non-physician personnel to perform MSEs on others.
- The determination of whether an emergency medical condition exists must be done by the medical professional actually examining the patient at the treating facility, and not by off-site personnel employed by the managed care plan.

Where can the MSE be conducted?

- Any patient who arrives at, or is directed to, any part of a hospital campus for the purpose of seeking emergency care is entitled to a MSE, regardless of the patient's actual physical location at the time treatment is requested. Such locations include the ED, its driveway and parking lot, the hospital's helipad, the labor and delivery suite, any hospital-owned building whose land touches land where a hospital's ED is located (e.g., physicians' offices) and any hospital-owned facility that operates under the same Medicare provider number as the hospital. Recent revisions to EMTALA regulations now define "hospital property" as including other areas and structures within 250 yards of the hospital's main buildings.
- The MSE may occur in places other than ED as long as the patient is sent to a hospital-owned facility that is contiguous to or part of the hospital campus owned by the hospital and operating under the same Medicare provider number.
- If a patient comes to a hospital-owned off-campus facility that operates under the same Medicare provider number, EMTALA regulations apply and the patient must be screened and stabilized to the best of that facility's ability prior to being transferred to a higher level of care at the main hospital. Such facilities are required to have protocols for screening and stabilizing individuals with potential emergencies.
- A patient could be seen in an ED and directed to go to any on-campus or hospital-owned facility that the hospital deemed appropriate to complete a MSE, provided that (a) all patients with the same emergency medical condition are sent to this location regardless of their financial or insurance status; (b) there is a bona fide medical reason to move the patient; and (c) qualified medical personnel accompany the patient. This also applies to patients seen initially in an urgent care clinic and directed to go to the ED as provided by the hospital's usual protocol, provided conditions (a)-(c) apply.

- Hospital property includes ambulances owned and/or operated by the hospital, even if not on hospital property at the time. In addition, a patient lying in a non-hospital-owned ambulance while on hospital property is subject to EMTALA.
- The hospital may deny access to patients when under temporary “diversionary” status because it doesn’t have the staff or facilities to accept additional patients at the time. But if the ambulance disregards the diversion status and brings the patient to the hospital anyway, EMTALA applies.

What if the patient refuses a MSE?

- The courts have ruled that the hospital has the burden to prove that the patient affirmatively revoked his or her request for a MSE.
- According to HCFA, the hospital must “take all reasonable steps to secure the individual’s written informed consent to refuse.” Therefore, the hospital should develop a “Refusal of Offered Medical Screening Exam” informed consent, which includes an explanation of the hospital’s obligations under the law as well as the risks and benefits to the patient of leaving before the MSE is completed. The physician (not the nurse or clerk) should obtain the informed consent and the patient should be asked to sign the form. The physician should also document the patient’s competence to refuse and the circumstances behind his or her refusal.
- In cases where the patient’s primary care physician refuses authorization for payment, one court has ruled that the hospital has a fiduciary duty to the patient to explain that the primary care physician may have an economic incentive to deny authorization.

What is the meaning of the term “stabilized”?

- A patient is defined as “stabilized” when no material deterioration of the emergency medical condition is likely, within reasonable medical probability, to result from or occur during the transfer, or that the pregnant woman with contractions has delivered (including the placenta).
- The EMTALA stabilization requirements apply only to patients having an emergency medical condition as identified by the MSE. If such an emergency medical condition is found, the hospital must provide further examination and treatment, within the capabilities of the staff and facilities available to the hospital, until the patient is stabilized. If the hospital lacks the resources needed to stabilize the patient’s condition, it must transfer the patient to a hospital that can do so.

- In certain cases, the use of on-call specialists may be necessary to provide the expertise required to stabilize the patient's condition. Such stabilization efforts must be performed before any transfer occurs.
- Once the need for stabilizing treatment is identified, it must be applied in a non-discriminatory fashion without delay. As an example, stabilization procedures must not be delayed pending authorization by the patient's MCO.
- EMTALA requires mandatory stabilization regardless of any moral or ethical concerns. In other words, in the absence of advance directives to the contrary, full stabilization efforts must be provided to patients who are terminally ill, victims of severe brain injuries, or suffering from dementia.
- The determination that patients are "stable for transfer" and "stable for discharge" does not require final resolution of the emergency medical condition.
- Once a patient is stabilized, EMTALA no longer applies and hospitals are free to deny further treatment, or transfer the patient for purely economic reasons. On-call physicians can refuse to treat or admit stable patients. Other hospitals are not obligated to accept stable patients in transfer.
- In situations where the consultant physician and the emergency physician disagree on the patient's stability for transfer, HCFA has previously decided that the medical judgment of the initial treating physician usually takes precedence over that of any off-site physician.
- Documentation is important: the presence of an emergency medical condition and efforts at stabilizing it should be noted in the medical record, as well as whether the patient has been stabilized prior to discharge, admission or transfer.

What is the EMTALA definition of a patient "transfer"?

- "Transfer" is defined under EMTALA as "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital..."
- The movements of two groups of individuals are not considered transfers. These are patients who have been declared dead and patients who voluntarily leave the hospital without the permission of staff employed by, associated with or affiliated with the hospital.
- Under EMTALA, the term "transfer" has a legal definition. This means that ED discharges are transfers, as are all inpatient discharges of patients admitted through

the ED, even if they occur weeks after the initial ED visit. However, the movement of an individual to the ED from another hospital location is not considered a transfer under EMTALA because the move is within the hospital complex rather than an inter-hospital move.

What are the requirements for patient transfers under EMTALA?

- First, determine if the patient is stable. If the patient is stable (i.e., no emergency medical condition is present, or one was present but has since been stabilized), EMTALA does not apply. But if the patient is unstable, he or she can be transferred for either a valid *medical reason*, such as the lack of resources for treating the patient at the original facility, or at the patient's *personal request*. In the case of a minor or incompetent adult, the patient's legal guardian can request a transfer on the patient's behalf.
- For a medically-indicated transfer, the emergency physician is obligated to (a) obtain the patient's written informed consent for transfer; (b) certify that the medical benefits of transfer outweigh the risks; and (c) arrange an "appropriate transfer" (see below) as required by law.
- Patient-requested transfers may be initiated at the request of the patient, his or her personal physician, family members or the patient's MCO. In each case, it is the patient's (or the patient's guardian's or the power of attorney's) choice to leave, knowing that the necessary medical services are available at the transferring hospital. The legal requirements necessary to effect a patient-requested transfer are distinctly different from those of medically-indicated transfers and include: (a) informing the patient of the hospital's obligations under EMTALA; (b) informing the patient of the risks and benefits of transfer in an unstable condition, including the risks of transportation delays due to weather conditions or mechanical problems; (c) a written document setting forth the patient's request for transfer and the reason for transfer; (d) the patient's written informed consent, signed by the patient, indicating that the patient is aware of the risks and benefits of the transfer, as well as the hospital's obligations under EMTALA; and (e) arranging an "appropriate transfer" (see below).
- For an informed consent to be valid, the physician must explain in writing the hospital's obligation to a patient with an emergency medical condition, including the obligation to a woman in active labor; the risks and benefits to the patient based on clinical information available at the time of transfer, including the non-medical risks (i.e., those associated with ambulance or helicopter transport); and certify that the benefits of a transfer outweigh any reasonably foreseeable risks.

- The transfer of a *stable* patient from a hospital that does not participate in the patient's MCO but is otherwise qualified to treat the patient, solely for economic reasons, is not proscribed under EMTALA. The patient's condition, however, must be stable; transfer of unstable patients for economic reasons is not permitted under EMTALA under any conditions.
- If the transferring facility lacks the resources necessary to treat the patient, and the MCO hospital has the required facilities and personnel to manage the patient's condition along with any foreseeable complications, the transfer is permissible.
- Transfers of unstable patients to facilities with equal or lesser medical capabilities for treating the patient's condition, other than for patient-requested reasons, are potential EMTALA violations.
- EMTALA's "reverse dumping" clause states that "hospitals with specialized capabilities or facilities shall not refuse to accept appropriate transfers of individuals who require such specialized capabilities or facilities if the hospital has the capacity to treat the individual."

What are the five criteria for an appropriate transfer?

- The transferring hospital must do everything within its capabilities to stabilize the patient while waiting for the transfer to occur, in such a way as to minimize the risks to the individual's health and, in cases of a woman in labor, the health of the unborn child.
- The receiving facility must have an available bed and qualified personnel to care for the patient, along with the verbal permission of a physician who is authorized to accept transfers for the receiving facility.
- The transferring hospital must send copies of all medical records, diagnostic studies (lab tests, X-rays, CTs, ECGs, etc.), informed consent documents and physician transfer certifications. In situations where a patient is being transferred because an on-call physician refused or failed to provide needed stabilizing treatment at the request of the transferring physician, the name and the address of the on-call physician must also be provided.
- The transfer must be effected through the use of qualified personnel and transport methods appropriate to the patient's clinical condition and sufficient to manage any foreseeable complications that could arise en route. In certain cases, this may require the use of a medical helicopter, while in other cases, transport by a private car would

be sufficient. But in all cases, the transferring physician should document the thought process behind the transfer.

- The transfer must meet any other requirements that may be mandated by the Secretary of Health and Human Services in the interest of protecting the health and safety of the patients transferred.

What other aspects of a patient transfer are important?

- The failure of a receiving hospital to provide the care it claimed it could provide at the time when transfer was arranged should not be construed as an inappropriate transfer.
- Hospitals may designate the personnel who are authorized to accept or refuse transfers. Emergency physicians may be asked to act as the hospital's agents in accepting patient transfers.
- A patient transfer that is clearly not in the patient's best medical interests is an inappropriate transfer, and the proposed receiving facility is not obligated to accept such a patient. For example, if the transferring hospital clearly has the staff and resources available to stabilize an unstable patient, the requested hospital may refuse the patient.
- In situations where a hospital requests transfer for an unstable patient, prudent practice would suggest that the hospital considering this request should provide consultation advice to the transferring facility while arrangements for further stabilization and transfer are being discussed.

What are the obligations of on-call physicians under EMTALA?

- EMTALA requires hospitals to provide on-call physician specialists to help stabilize and/or treat patients with emergency medical conditions. By taking ED call, specialists agree to accept EMTALA responsibilities and therefore will be expected to respond to requests by the emergency physician to evaluate ED patients.
- EMTALA imposes a duty on hospitals to provide consultative services for ED patients in accordance with each hospital's organizational capability, including the specialty capabilities of its organized medical staff. Thus, all specialists who regularly provide elective consultations or perform elective procedures or surgery at the hospital, or admit their own patients, act as agents of the hospital and have a duty to provide the same scope of services to patients in the ED.

- The services of on-call specialists are considered part of the ED's capabilities in determining whether the patient has an emergency medical condition. Therefore, they must respond whenever needed to ascertain the presence of an emergency medical condition in an ED patient, or to help stabilize a patient already diagnosed with an emergency medical condition.
- The on-call physician must respond in a non-discriminatory manner, even if the patient does not have insurance or is a member of an MCO in which the on-call physician does not participate.
- In certain emergency medical conditions, the services of a specialist are needed because his or her evaluation is needed to complete the MSE and/or provide necessary stabilizing treatment. For example, if the emergency physician suspects appendicitis in the patient with an acute abdomen, surgical evaluation is part of the customary MSE. Thus, the on-call surgeon must come to the ED to examine the patient and if the surgeon agrees with the emergency physician, he or she must proceed with stabilizing treatment, which typically is immediate surgery.
- Under EMTALA, the emergency physician has the responsibility for determining when the on-call physician is obligated to come to the ED.
- EMTALA also gives the emergency physician the responsibility for determining a reasonable response time for the on-call physician. Faced with treating an unstable patient in the ED, the emergency physician must determine when a reasonable response time for the on-call physician has elapsed before making other arrangements to stabilize the patient.
- If the emergency physician is forced to transfer the patient because the on-call specialist is unavailable or refuses to come to the ED when asked, the transferring hospital is required to give the accepting institution the name and address of the specialist, thereby placing the transferring hospital in jeopardy for an EMTALA violation. The failure to provide this information constitutes an EMTALA violation by both the hospital and the transferring physician.

What are the hospital's obligations under EMTALA?

- The hospital must provide a MSE to all individuals who present to the ED (or alternative sites, such as Labor & Delivery) for evaluation and treatment.
- The hospital must do everything in its capacity to stabilize patients with emergency medical conditions, as identified by the MSE, prior to discharge or transfer from the ED.

- The hospital must post in the ED a written list of on-call physicians for each specialty, and must be able to retrieve the list in the future, if requested by HCFA.
- If the hospital is forced to transfer an unstable patient because an on-call physician refused or failed to come to the ED to evaluate a patient within a reasonable time, the hospital must send the name and address of that physician to the receiving facility.
- If the hospital receives an inappropriately transferred patient, i.e., one that is unstable, the hospital is obligated to report the transferring facility to HCFA. Reporting is mandatory, not discretionary, and hospitals have had their Medicare provider licenses terminated for failure to report inappropriate transfers. The duty is imposed upon the hospital and not the physician; therefore, emergency physicians who receive inappropriate transfers should report them to the hospital's risk management department or legal counsel.
- The hospital should have a written EMTALA compliance plan for its own protection. The failure of the hospital to follow its own policies and procedures regarding the MSE and physician on-call obligations is a common reason for a HCFA citation for violating EMTALA.
- The hospital must maintain a central log to track the care of all patients who come to the hospital requesting emergency care. The central log must contain the patient's name and whether the patient refused treatment or was denied treatment by the hospital, and whether the patient was transferred, admitted or discharged. The hospital can use its own discretion to determine the form in which the log is maintained. Other areas outside the ED that see patients on an emergency basis (e.g., Pediatrics, Labor and Delivery) must also maintain patient logs.
- Medical records must be kept for all patients presenting for emergency medical care, regardless of the physical location within the hospital where such care was provided. The record must reflect continuing monitoring until the patient is stabilized or appropriately transferred.
- The hospital must also keep medical records of all patients transferred to or from the hospital for a period of five years after the date of the transfer.
- The hospital must post a conspicuous notice in the ED that lists the rights of patients under EMTALA and whether the hospital participates in the Medicare or Medicaid program.

How does EMTALA apply to the transfer of psychiatric patients?

- First, ensure that the patient is “medically cleared.” This means that a psychiatric patient with an emergency medical condition identified by the MSE, such as a drug overdose or wrist laceration, should be stabilized medically prior to considering a transfer for psychiatric reasons.
- Patients with mental illness may have psychiatric symptoms that by themselves constitute an emergency medical condition, e.g., conditions that represent a danger to the patient or others. These patients require psychiatric stabilization, in addition to any medical stabilization, prior to transfer.
- Once a patient is stabilized from a psychiatric standpoint, the patient can be transferred, even for economic reasons, because EMTALA does not apply to the stable patient. For example, if a suicidal (or homicidal) patient is rendered incapable of causing self-harm (or harm to others) by chemical or physical means, then the patient could be considered stable for the purposes of transfer under EMTALA.
- In certain situations, attendance by an on-call psychiatrist or designated mental health consultant may be required to assess the ongoing risk of an emergency psychiatric condition and/or provide stabilization. Presumably, the same obligations of on-call medical specialists noted above would apply to the on-call psychiatrist.
- As always, proper documentation is required for transfers, especially if the transfer is done for economic reasons (i.e., in cases where the transferring private hospital has an established agreement to transfer uninsured patients to a publicly funded psychiatric facility). If the patient has an adverse event en route or after arrival at the receiving facility, the burden is on the transferring hospital to show the absence of economic incentives in executing the transfer.

What is required to prove a violation of EMTALA?

- A citation for violating EMTALA regulations should be based upon evidence that the hospital deviated from its usual non-discriminatory policies and procedures in offering the MSE, or that the hospital failed to execute an appropriate transfer, as defined by HCFA.
- Proof of harm to the patient is not required to substantiate an EMTALA violation. Practically speaking, however, an EMTALA violation resulting from an inappropriate transfer might come to light only when a patient is alleged to have suffered harm in another context.
- According to a recent U.S. Supreme Court decision, patients do not have to allege or prove that the hospital acted with improper economic motives in making a transfer. This places the transferring hospital in a potentially dangerous position, because an

honest mistake made in transferring a patient who was later found to be in an unstable condition, as judged retrospectively, places the transferring hospital at risk of being cited for an EMTALA violation.

- In a civil action brought by the patient against the transferring hospital or physician, because of an adverse event or a bad outcome, the specter of an EMTALA infraction is likely to be raised by a plaintiff's attorney in addition to allegations of medical malpractice.

How is EMTALA enforced?

- HCFA enforces EMTALA regulations by investigating reports of potential violations. The actual investigations are done by state survey agencies under contract to HCFA, and HCFA's regional offices decide whether to prosecute hospitals that they believe have violated the law.
- Each HCFA regional office has the authority to terminate the Medicare provider agreement of a hospital within its region that it determines has violated EMTALA law. Without such a provider agreement, a hospital cannot legally treat or admit Medicare patients. Such a sanction has obvious financial and public relations consequences for the hospital.
- HCFA has the option, at its discretion, of initiating either a 23-day termination process or a 90-day termination process. In the case of an EMTALA violation that HCFA views as "an immediate and serious threat to patient health and safety," HCFA will utilize the 23-day process. This gives the cited hospital 23 days to develop a "plan of correction" to correct the identified problem or discipline the hospital personnel responsible for the violation, or risk termination from the Medicare program.
- A 90-day proceeding may be used in cases where patient safety is not threatened, and HCFA may seek an outside medical opinion (e.g., from a professional review organization) to substantiate the perceived violation.
- There is no provision for due process, and no right to a pre-termination hearing. Furthermore, HCFA's decisions are made by its (nonmedical) regional administrators.
- Completion of a "plan of correction" does not imply that the hospital admits to an EMTALA violation.
- A hospital is obligated to report to HCFA any patient transfers that it feels are unsafe or inappropriate. Although emergency physicians are likely to be the first to recognize EMTALA violations, the legal duty to report falls on the hospital.

Therefore, emergency physicians should report suspected violations to the hospital administrator, legal counsel or risk management department.

- HCFA currently investigates more than 600 potential EMTALA violations annually and finds violations in at least 30 percent of the cases.

What are the penalties for violating EMTALA?

- As noted, a HCFA regional office has the authority to terminate the Medicare provider agreement with a hospital that it has determined to be in violation of EMTALA.
- Physicians are also liable for termination from the Medicare program if HCFA finds that their behavior presents an immediate danger to the health, safety or well-being of the individual who seeks emergency examination.
- Hospitals in violation of EMTALA are subject to civil monetary penalties of up to \$50,000 per violation (\$25,000 for hospitals with less than 100 beds).
- Physicians are also subject to a maximum penalty of \$50,000 per violation. Of note, professional liability insurance policies typically do not cover monetary awards for EMTALA violations, and thus the physician would have to pay the fine out-of-pocket.

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Web sites:

www.emtala.com (general and updated information on EMTALA)

www.medlaw.com (recent court cases)

emtala7.doc/031301

Florida's Access to Emergency Services and Care Law

Title XXIX

PUBLIC HEALTH Chapter 395

HOSPITAL LICENSING AND REGULATION View Entire Chapter

395.002 Definitions.--As used in this chapter:

- (1) "Accrediting organizations" means the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc.
- (2) "Agency" means the Agency for Health Care Administration.
- (3) "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.
- (4) "Applicant" means an individual applicant, or any officer, director, or agent, or any partner or shareholder having an ownership interest equal to a 5-percent or greater interest in the corporation, partnership, or other business entity.
- (5) "Biomedical waste" means any solid or liquid waste as defined in s. 381.0098(2)(a).
- (6) "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to render patient care services in a hospital, but does not include the privilege of admitting patients.
- (7) "Department" means the Department of Health.
- (8) "Director" means any member of the official board of directors as reported in the organization's annual corporate report to the Florida Department of State, or, if no such report is made, any member of the operating board of directors. The term excludes members of separate, restricted boards that serve only in an advisory capacity to the operating board.

(9) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(10) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(11) "General hospital" means any facility which meets the provisions of subsection (13) and which regularly makes its facilities and services available to the general population.

(12) "Governmental unit" means the state or any county, municipality, or other political subdivision, or any department, division, board, or other agency of any of the foregoing.

(13) "Hospital" means any establishment that:

(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

However, the provisions of this chapter do not apply to any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person. For purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

(14) "Hospital bed" means a hospital accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within 48 hours, excluding provision of staffing, and which conforms to minimum space, equipment, and furnishings standards as specified by rule of the agency for the provision of services specified in this section to a single patient.

(15) "Initial denial determination" means a determination by a private review agent that the health care services furnished or proposed to be furnished to a patient are inappropriate, not medically necessary, or not reasonable.

(16) "Intensive residential treatment programs for children and adolescents" means a specialty hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning.

(17) "Licensed facility" means a hospital, ambulatory surgical center, or mobile surgical facility licensed in accordance with this chapter.

(18) "Lifesafety" means the control and prevention of fire and other life-threatening conditions on a premises for the purpose of preserving human life.

(19) "Managing employee" means the administrator or other similarly titled individual who is responsible for the daily operation of the facility.

(20) "Medical staff" means physicians licensed under chapter 458 or chapter 459 with privileges in a licensed facility, as well as other licensed health care practitioners with clinical privileges as approved by a licensed facility's governing board.

(21) "Medically necessary transfer" means a transfer made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the facility lacks service capability or is at service capacity.

(22) "Mobile surgical facility" is a mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957 and in which inmate patients are admitted to and discharged from said facility within the same

working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.

(23) "Person" means any individual, partnership, corporation, association, or governmental unit.

(24) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital, ambulatory surgical, or mobile surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44), reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

(25) "Private review agent" means any person or entity which performs utilization review services for third-party payors on a contractual basis for outpatient or inpatient services. However, the term shall not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.

(26) "Service capability" means all services offered by the facility where identification of services offered is evidenced by the appearance of the service in a patient's medical record or itemized bill.

(27) "At service capacity" means the temporary inability of a hospital to provide a service which is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

(28) "Specialty bed" means a bed, other than a general bed, designated on the face of the hospital license for a dedicated use.

(29) "Specialty hospital" means any facility which meets the provisions of subsection (13), and which regularly makes available either:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16).

(30) "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(31) "Utilization review" means a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients.

(32) "Utilization review plan" means a description of the policies and procedures governing utilization review activities performed by a private review agent.

(33) "Validation inspection" means an inspection of the premises of a licensed facility by the agency to assess whether a review by an accrediting organization has adequately evaluated the licensed facility according to minimum state standards.

History.--ss. 1, 4, ch. 82-125; ss. 26, 30, ch. 82-182; s. 33, ch. 87-92; s. 52, ch. 88-130; s. 4, ch. 89-527; s. 12, ch. 90-295; ss. 3, 98, ch. 92-289; s. 724, ch. 95-148; s. 23, ch. 98-89; s. 37, ch. 98-171; s. 2, ch. 98-303; s. 102, ch. 99-8; s. 206, ch. 99-13; s. 4, ch. 2002-400.

Title XXIX

PUBLIC HEALTH Chapter 395

HOSPITAL LICENSING AND REGULATION View Entire Chapter

395.1041 Access to emergency services and care.--

(1) LEGISLATIVE INTENT.--The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.

(2) INVENTORY OF HOSPITAL EMERGENCY SERVICES.--The agency shall establish and maintain an inventory of hospitals with emergency services. The inventory shall list all services within the service capability of the hospital, and such services shall appear on the face of the hospital license. Each hospital having emergency services shall notify the agency of its service capability in the manner and form prescribed by the agency. The agency shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. On or before August 1, 1992, the agency shall request that each hospital identify the services which are within its service capability. On or before November 1, 1992, the agency shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt to respond to the notice. By December 1, 1992, the agency shall publish a final inventory. Each hospital shall reaffirm its service capability when its license is renewed and shall notify the agency of the addition of a new service or the termination of a service prior to a change in its service capability.

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.--

(a) Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
 - a. An emergency medical services provider who is rendering care to or transporting the person; or
 - b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(b) Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c) A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability or is not at service capacity, if:

1. The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected;
2. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical

treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or

3. A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification;

provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

(d)1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to timely respond to prehospital emergency calls.

3. A hospital shall not be required to ensure service capability at all times as required in subparagraph 1. if, prior to the receiving of any patient needing such service capability, such hospital has demonstrated to the agency that it lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the agency shall consider factors relevant to the particular case, including the following:

- a. Number and proximity of hospitals with the same service capability.
- b. Number, type, credentials, and privileges of specialists.
- c. Frequency of procedures.
- d. Size of hospital.

4. The agency shall publish proposed rules implementing a reasonable exemption procedure by November 1, 1992. Subparagraph 1. shall become effective upon the effective date of said rules or January 31, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an

exemption shall be deemed to be exempt from offering the service until the agency initially acts to deny or grant the original request. The agency has 45 days from the date of receipt of the request to approve or deny the request. After the first year from the effective date of subparagraph 1., if the agency fails to initially act within the time period, the hospital is deemed to be exempt from offering the service until the agency initially acts to deny the request.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(g) Neither the hospital nor its employees, nor any physician, dentist, or podiatric physician shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is made after screening, examining, and evaluating the patient, and is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or a determination, exercising reasonable care, that the hospital does not have the service capability or is at service capacity to render those services.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

(i) Each hospital offering emergency services shall post, in a conspicuous place in the emergency service area, a sign clearly stating a patient's right to emergency services and care and the service capability of the hospital.

(j) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k)1. Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may emergency medical services providers condition a transfer on the person's ability to pay when the transfer is made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or when the hospital is at service capacity. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for the transport or otherwise supply insurance or credit information promptly after the transport is rendered.

2. A hospital may enter into an agreement with an emergency medical services provider for purposes of meeting its service capability requirements, and appropriate compensation and other reasonable conditions may be negotiated for these services.

(l) Hospital personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

(4) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.--

(a)1. Each hospital shall maintain records of each transfer made or received for a period of 5 years. These records of transfers shall be included in a transfer log, as well as in the permanent medical record of any patient being transferred or received.

2. Each hospital shall maintain records of all patients who request emergency care and services, or persons on whose behalf emergency care and services are requested, for a period of 5 years. These records shall be included in a log, as well as in the permanent medical record of any patient or person for whom emergency services and care is requested.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted under this section shall report the apparent violation to the agency within 30 days following its occurrence.

(c) A hospital, government agency, or person shall not retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to:

1. A physician or other person for reporting in good faith an apparent violation of this section or the rules adopted under this section to the agency, hospital, medical staff, or any other interested party or government agency;
2. A physician who refuses to transfer a patient if the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the patient; or
3. A physician who effectuates the transfer of a patient if the physician determines, within a reasonable medical probability, that failing to transfer the patient will create a medical hazard to the patient.

(5) PENALTIES.--

(a) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed \$10,000 per violation, for the violation of any provision of this section or rules adopted under this section.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible hospital administrative or medical staff or personnel, damages, reasonable attorney's fees, and other appropriate relief. However, this paragraph shall not be construed to create a cause of action beyond that recognized by this section and rules adopted under this section as they existed on April 1, 1992.

(c) Any hospital administrative or medical staff or personnel who knowingly or intentionally violates any provision of this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(d)1. Any hospital, or any physician licensed under chapter 458 or chapter 459, who suffers a financial loss as a direct result of a violation by a physician or a hospital of a requirement of this section may, in a civil action against the physician or the hospital, obtain damages for financial loss of charges and such equitable relief as is appropriate, including reasonable attorney's fees and costs.

2. If the defendant prevails in an action brought by the hospital or physician pursuant to this paragraph, the court may award reasonable attorney's fees and costs to the defendant.

(e) A physician licensed under chapter 458 or chapter 459 who negligently or knowingly violates any requirement of this section relating to the provision of emergency services and care shall be deemed in violation of the provisions of such chapters for any of the following violations:

1. Failure or refusal to respond within a reasonable time after notification when on call.
2. Failure or refusal to sign a certificate of transfer as required by this section.
3. Signing a certificate of transfer stating that the medical benefits to be reasonably expected from a transfer to another facility outweigh the risks associated with the transfer, when the physician knew or should have known that the benefits did not outweigh the risks as required by this section.
4. Misrepresentation of an individual's condition or other information when requesting a transfer.

Any fine collected for a violation of this section, including any fine collected from a physician licensed under chapter 458 or chapter 459, shall be deposited into the Public Medical Assistance Trust Fund.

(f) In determining whether a licensee is deemed in violation of this section and in assessing any penalties for violation, the agency shall consider, and the licensee may offer as an affirmative defense or in mitigation, whether the licensee has established that the alleged violation arose from the unanticipated changes in service capability or other factors beyond the licensee's control.

(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

History.--s. 6, ch. 88-186; s. 1, ch. 89-296; s. 68, ch. 91-224; s. 4, ch. 91-249; ss. 24, 25, 98, ch. 92-289; s. 30, ch. 96-169; s. 2, ch. 96-199; s. 10, ch. 96-223; s. 182, ch. 98-166; s. 2, ch. 99-331; s. 1, ch. 2000-295.

Note.--Former s. 395.0142.

Florida's Good Samaritan Law

Title XLV

TORTS Chapter 768

NEGLIGENCE View Entire Chapter

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 hospital licensed under chapter 395, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a public health emergency declared pursuant to s. 381.00315 shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment:

a. Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery; or

b. Unrelated 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 which a health care

provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;

- a. The extent or serious nature of the circumstances prevailing.
- b. The lack of time or ability to obtain appropriate consultation.
- c. The lack of a prior patient-physician relationship.
- d. The inability to obtain an appropriate medical history of the patient.
- e. The time constraints imposed by coexisting emergencies.

4. Every emergency care facility granted immunity under this paragraph shall accept and treat all emergency care patients within the operational capacity of such facility without regard to ability to pay, including patients transferred from another emergency care facility or other health care provider pursuant to Pub. L. No. 99-272, s. 9121. The failure of an emergency care facility to comply with this subparagraph constitutes grounds for the department to initiate disciplinary action against the facility pursuant to chapter 395.

(c) Any person who is licensed to practice medicine, while acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, or while performing health screening services, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

(3) Any person, including those licensed to practice veterinary medicine, who gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency on or adjacent to a roadway shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

History.--ss. 1, 2, ch. 65-313; s. 1, ch. 78-334; s. 62, ch. 86-160; s. 46, ch. 88-1; s. 4, ch. 88-173; s. 42, ch. 88-277; s. 1, ch. 89-71; s. 37, ch. 91-110; s. 33, ch. 93-211; s. 3, ch. 97-34; s. 1164, ch. 97-102; s. 2, ch. 2001-76; s. 3, ch. 2002-269.

Florida Statutes Providing "Sovereign Immunity" For Volunteer Physicians

Title XLV

TORTS Chapter 766

MEDICAL MALPRACTICE AND RELATED MATTERS View Entire Chapter

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(1) **SHORT TITLE.**--This section may be cited as the "Access to Health Care Act."

(2) **FINDINGS AND INTENT.**--The Legislature finds that 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 malpractice 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.

(3) **DEFINITIONS.**--As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor. This contract shall allow the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services.

(b) "Department" means the Department of Health.

(c) "Governmental contractor" means the department, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.
2. An ambulatory surgical center licensed under chapter 395.
3. A hospital licensed under chapter 395.
4. A physician or physician assistant licensed under chapter 458.
5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.
7. A podiatric physician licensed under chapter 461.
8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.
9. A midwife licensed under chapter 467.
10. A health maintenance organization certificated under part I of chapter 641.
11. A health care professional association and its employees or a corporate medical group and its employees.
12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
13. A dentist or dental hygienist licensed under chapter 466.
14. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(c) of the Internal Revenue Code which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;
2. A person who is without health insurance and whose family income does not exceed 150 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or
3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

(4) CONTRACT REQUIREMENTS.--A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties pursuant to the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of the medical care or treatment provided on or after April 17, 1992, pursuant to contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services pursuant to the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services pursuant to the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if such incidents and information pertain to a patient treated pursuant to the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities pursuant to this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made solely by the governmental contractor, and the provider must accept all referred patients. However, the number of patients that must be accepted may be limited by the contract, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) Patient care, including any followup or hospital care, is subject to approval by the governmental contractor.

(g) The provider is subject to supervision and regular inspection by the governmental contractor.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.--The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28. With respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the federally funded community health center is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28.

(6) QUALITY ASSURANCE PROGRAM REQUIRED.--The governmental contractor shall establish a quality assurance program to monitor services delivered under any contract between an agency and a health care provider pursuant to this section.

(7) RISK MANAGEMENT REPORT.--The Division of Risk Management of the Department of Insurance shall annually compile a report of all claims statistics for all entities participating in the risk management program administered by the division, which shall include the number and total of all claims pending and paid, and defense and handling costs associated with all claims brought against contract providers under this section. This report shall be forwarded to the department and included in the annual report submitted to the Legislature pursuant to this section.

(8) REPORT TO THE LEGISLATURE.--Annually, the department shall report to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee chairpersons of both houses, summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income persons pursuant to this section.

(9) MALPRACTICE LITIGATION COSTS.--Governmental contractors other than the department are responsible for their own costs and attorney's fees for malpractice litigation arising out of health care services delivered pursuant to this section.

(10) RULES.--The department shall adopt rules to administer this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and cost-effective health care services and to maintain health care quality. The rules may include services to be provided and authorized procedures.

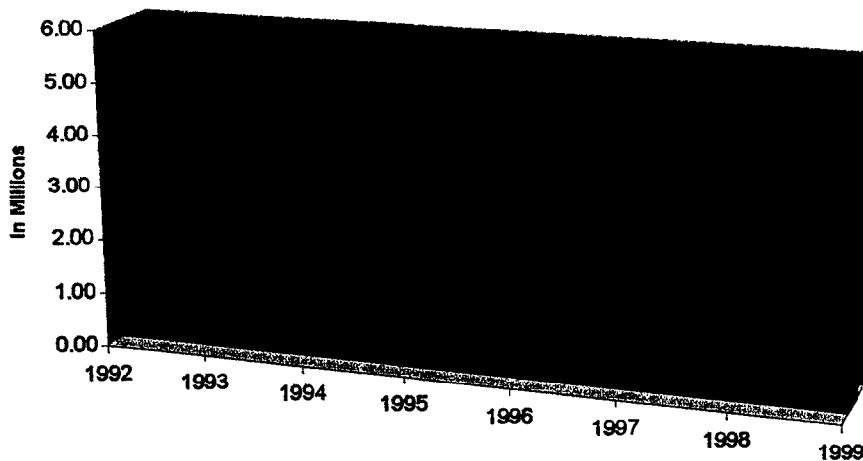
(11) APPLICABILITY.--This section applies to incidents occurring on or after April 17, 1992. This section does not apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a). Nothing in this section in any way reduces or limits the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

History.--s. 1, ch. 92-278; s. 22, ch. 93-129; s. 1, ch. 94-75; s. 246, ch. 94-218; s. 425, ch. 96-406; s. 126, ch. 97-237; s. 9, ch. 97-263; s. 11, ch. 98-49; s. 41, ch. 98-89; s. 233, ch. 98-166; s. 88, ch. 99-3; s. 286, ch. 99-8; s. 49, ch. 2000-242; s. 145, ch. 2000-318; s. 88, ch. 2001-277; s. 114, ch. 2002-1.

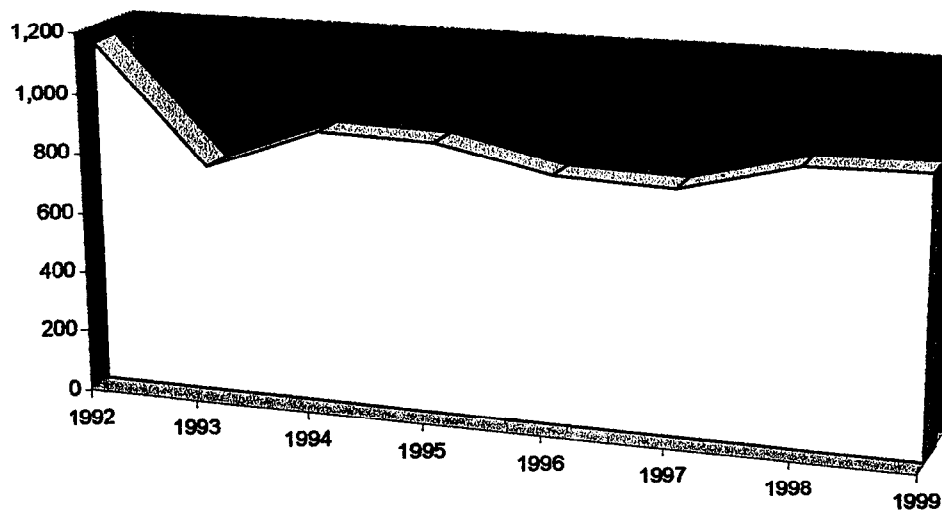
Emergency Room Visits Compared to Board Certified Emergency Physicians

	1992	1993	1994	1995	1996	1997	1998	1999
<i>ED Visits (in millions)</i>	4.57	4.85	4.80	5.34	5.15	5.42	5.72	5.90
<i>Board Certified Emergency Physicians</i>	1,146	753	894	890	808	796	895	901

Emergency Room Visits



Board Certified Emergency Physicians



As the number of patients accessing the Emergency Departments for care has continued to rise, the number of Board Certified Emergency Physicians has fallen. (source: Florida Hospital Association)

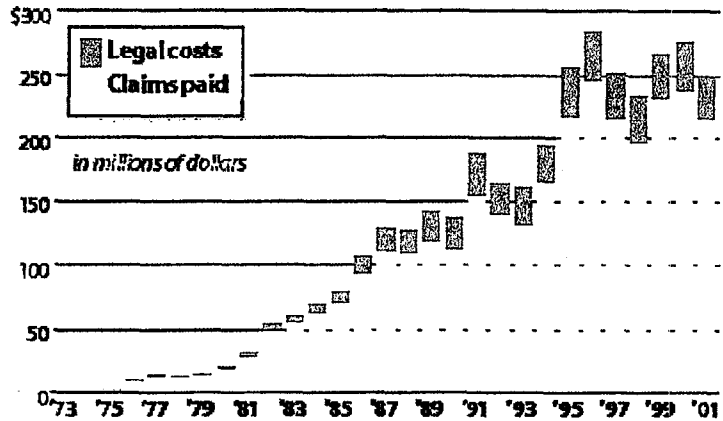
Orlando Sentinel

Settlements, awards
(ORLANDO SENTINEL)

Sep. 22, 2002

SETTLEMENTS, AWARDS

Settlements and jury awards in medical-malpractice cases have risen dramatically in Florida since the 1970s, but since peaking in 1996, paid-out claims and legal costs have leveled off or fallen back.



SOURCES: Florida Department of Insurance, First Professionals Insurance Co.

ORLANDO SENTINEL

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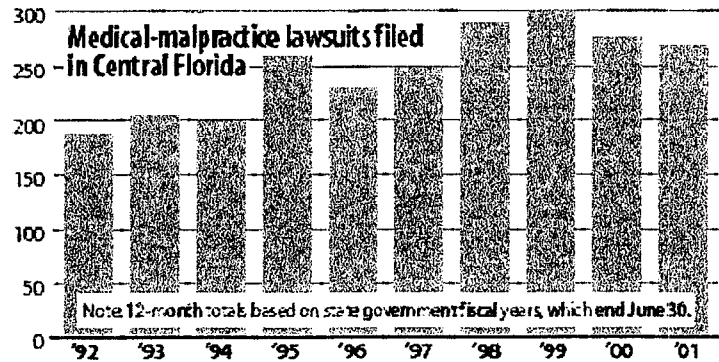
Orlando Sentinel

Central Florida lawsuits
(ORLANDO SENTINEL)

Sep. 22, 2002

CENTRAL FLORIDA LAWSUITS

The number of medical-malpractice lawsuits filed each year has grown about 42% locally and statewide during the past decade, while the state's population grew about 23% between 1990 and 2000. The annual lawsuit count actually peaked in Central Florida counties in the late 1990s. Statewide, they resumed dimbing last year after falling back slightly in 2000.



SOURCE: Florida Supreme Court, circuit division

ORLANDO SENTINEL

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Survey of Uncompensated Care Provided by Emergency Department Physicians in Florida

PROGRESS REPORT

April 2001

Barbara Langland-Orban, Ph.D.
Associate Professor and Chair
Department of Health Policy and Management
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All emergency physician groups at Florida hospitals were surveyed on emergency department visits, payer mix, charges, uncompensated care, and subsidies for uncompensated care for the 1998 fiscal year. The survey was sent by e-mail to the billing contact person or medical director of each hospital's emergency physician group for the approximately 150 Florida hospitals with emergency departments. Some emergency physician groups are still in the process of compiling information. The response rate was 47%, with groups responding for 70 hospital emergency departments.

The 70 responding hospital emergency physician groups provided information on 1,414,341 emergency department visits. Hospital ownership for the 70 reporting groups includes 15 (21%) private not-for-profit hospitals, 25 (36%) for-profit hospitals, 8 (11%) public hospitals, and 22 (31%) with ownership not reported. Hospital size for the reporting groups includes 18 (26%) with less than 200 beds, 18 (26%) with 200-300 beds, 12 (17%) with more than 300 beds, and 22 (31%) with bed size not reported. Responding emergency physician groups represent all ownership types and all hospital size categories.

The following table provides the payer mix of the 70 respondents.

PAYER SOURCE	PERCENT OF VISITS
Private Insurance	37.6
Self Pay	21.4
Medicare	20.1
Medicaid	11.2
Other insurance or health plan	9.7

In 1998, the 70 provided more than \$100 million in uncompensated care. Major findings on uncompensated care for the 70 hospital physician groups are summarized below.

UNCOMPENSATED CARE STATISTICS	PERCENT
Percent with no compensation received for visit	26.0%
Percent uncompensated care (uncompensated care charges divided by total charges)	31.2%
Percent uncompensated care (uncompensated care charges divided by gross revenues)	48.4%

The discrepancy between 26% of visits yielding no compensation while only 21.4% of visits are self pay, reflects that some visits of patients enrolled in a health plan are unfunded. Care is uncompensated for 31.2% of all visits when calculated using total charges. It is 48.4% when calculated using gross revenues (which is less than total charges due to adjustments to charges and negotiated discounts). The 48.4% is the accounting value of uncompensated care.

Orlando Sentinel

<http://www.orlandosentinel.com/news/local/lake/orl-1klhealth28092802sep28,0,7284966.story?coll=orl%2Dnews%2Dheadlines%2Dlake>

Forum decries health 'crisis'

By Andrea Perera
Sentinel Staff Writer

September 28, 2002

LEESBURG — Central Florida legislators, health-care professionals and insurers compared the rising costs of medical malpractice insurance to a gathering storm Thursday, and warned that the public would eventually bear the brunt of the downpour.

"The system's about to break if something doesn't happen soon," said John Hillenmeyer, president and CEO of Orlando Regional Healthcare. "If something isn't done, costs will be borne by the patients."

At the prodding of local doctors, state Sen. Anna Cowin, R-Leesburg, and Leesburg Regional Medical Center co-sponsored a forum on medical malpractice insurance at Lake-Sumter Community College. More than 100 people streamed into the school's gymnasium Thursday night to hear speakerstalk about a mounting "health-care crisis."

Doctors said they have watched colleagues leave the state or retire early to avoid paying pricey malpractice insurance premiums. Hospital administrators said they couldn't afford to pay often-immense malpractice awards. And malpractice insurers said they wondered how effectively juries could hand out fair medical-suit judgments.

The bottom line, according to the speakers, is that patients suffer when the costs associated with malpractice insurance premiums and claims rise or they lose their doctors to other states with cheaper insurance and fewer lawsuits.

"I don't see that Florida has the climate to keep physicians in state," Cowin said.

Dr. David Sustaric, vice chief of staff at Leesburg Regional Medical Center, said the problem boils down to two factors: availability and affordability.

As the amount of malpractice awards increases, the costs of malpractice insurance and legal defense also escalate. That leaves doctors raising overhead costs, cutting services, moving or retiring.

Sustaric also said sometimes unrelenting juries forget that "good medicine can be followed by a bad outcome."

The ever-looming threat of malpractice suits leaves doctors spending much of their time worrying about accusations of negligence or how to raise the money to pay for insurance in case they're taken to court, said Dr. Albert Moffett Jr., state chairman for the American College of Obstetrics.

"We can't practice medicine; we have to practice defense," Moffett said. "We're asking for the opportunity to practice medicine."

If the Legislature doesn't limit jury awards, soon the money to pay off exorbitant claims will be siphoned from a pool normally reserved for hospital services, salaries and technology, hospital administrators said.

Patients will end up paying more for fewer services, Hillenmeyer said.

"Where is this money coming from? It's not coming from stockholders," he said.

Insurers said the malpractice crisis is a nationwide concern but one that's even more worrisome in Florida. While one in 12 doctors is sued nationwide, one in five is sued in Florida, said Kurt Driscoll, vice president of First Professionals Insurance Co., the state's largest medical-malpractice carrier.

After more than two hours of talk, the speakers promised to take their concerns to the state Legislature.

The legislators who attended -- Cowin, state Sen. Daniel Webster, R-Winter Garden, and state Rep. Carey Baker, R-Eustis -- promised to listen but warned that real change might not come in the current legislative session.

"The lay of the land is that those who oppose any sort of reform have the upper hand," Webster said.

Consumer advocates disagree. They say the power lies in the hands of doctors, because winning a malpractice suit isn't easy.

"This is an uphill battle for consumers," said Frank Clemente, who recently co-wrote a report on Florida's malpractice claims for the consumer group Public Citizen.

"The whole debate needs to be shifted from what is best for doctors to what is best for patients," he said. "It should be a debate on the quality of care, not the cost of [malpractice] insurance."

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Rising med insurance rates creates local crisis

Two obstetricians lose insurance coverage; lone local neurosurgeon might leave town

By KEN LEWIS

Staff Writer

Publication Date: 09/27/02

Skyrocketing medical malpractice insurance rates have created a national and statewide crisis, experts say, and the impact on St. Johns County is immediate and grim.

Already, two obstetricians at Flagler Hospital lost insurance coverage, and regaining it for one would lead to a 315 percent rate increase in premiums: from \$26,000 annually to \$108,000.

Dr. James Joyner said he cannot afford the hike. He said he is delivering babies without insurance for now, leaving himself vulnerable to devastating lawsuits. He said he will leave the hospital soon if the situation does not change.

Dr. Miguel Machado, St. Augustine's first and only neurosurgeon, said he will probably leave town if his rates increase like Joyner's have.

In recent months, hospitals throughout the nation have lost doctors because of massive increases in medical malpractice insurance rates. Doctors in Nevada and West Virginia have refused to practice without coverage that they cannot afford.

The cause? Insurers blame the greed of trial lawyers and the collapse of the stock market; the lawyers blame the greed of insurance companies and the incompetence of certain doctors. The doctors, meanwhile, are pinned in the middle.

To allow obstetricians to practice without insurance, Flagler Hospital had to suspend its obligatory malpractice insurance policy for high risk doctors last week, said Machado, who is also Flagler Hospital's medical staff president.

Flagler Hospital Senior Vice President Joe Gordy said some doctors might not have enough patients to pay for their own insurance given the explosion in premiums.

"We could be in a position where there's nobody delivering babies, because they can't afford it, they can't afford the insurance," Gordy said.

Thursday, the U.S. House of Representatives voted to pass a bill that would, among other things, put a \$250,000 cap on damages for pain and suffering available to malpractice victims. This is supposed to decrease insurance rates,

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so that patients will not lose their doctors.

President Bush is reportedly in favor of House Resolution 4600, but many experts doubt it will become reality, and insurers will not guarantee a rate decrease. Reinforcing the gloom, the U.S. Senate has already rejected a similar measure.

The bill

The bill was made to cap non-economic damages -- pain and suffering -- and it would require that a suit be brought within three years of the injury. It also limits punitive damages and requires the courts to supervise payment-of-damage arrangements.

St. Johns County's congressman, U.S. Rep. Ander Crenshaw said he favors the measure. He said patients injured by doctors should be able to go to court, but frivolous lawsuits are increasing costs excessively.

Crenshaw said he was contacted by one physician south of St. Augustine who moved to South Carolina because he could not afford the malpractice rates in Florida.

Physicians have told him that insurers are hurting doctors' access to coverage, which limits patients' access to care.

"I think this has reached crisis proportions," Crenshaw said.

Proponents of the bill pointed to California, which enacted a cap on non-economic damages in the 1970s. Florida has no cap.

The Florida Medical Association's Government Affairs Director, Francie Plendl, referred to statistics from the Department of Health and Human Services. She said the statistics showed that California's cap lowers the state's rates.

In 2001 in Los Angeles, Calif., obstetricians' rates were \$60,000 a year. In Dade County the average was \$201,000.

For neurosurgeons, the average rate in Los Angeles was \$68,000 a year. In Dade County, it was \$279,000.

"I know that the neurosurgeons are getting slammed," Plendl said.

She did not have the numbers for St. Johns County but said the situation is a statewide problem.

Plendl added that the Florida Medical Association has pushed for reform for at least 10 years, but the last two years have been the worst.

The lawyers

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According to Brian Frere, communications coordinator for the Academy of Florida Trial Lawyers, the doctors are now in "a tight situation." However, he said the problem in Florida began in the 1990s, when intense competition among insurance agencies led to incredibly low premiums for Florida doctors.

Frere said that in 1988, the average yearly medical malpractice premium in Florida was \$24,700. In 1998, it was actually lower, \$20,500.

Frere said this was possible because profit-driven Florida insurance companies would gather money from premiums and invest it in the stock market. The 1990s was a golden decade for stocks, so the companies were able to support their insurance losses with profits from stocks.

After the attacks of Sept. 11, 2001, the stock market collapsed. Insurers now cannot rely on profits from stocks to carry them through debilitating losses in court, so premiums are increasing.

"The problem has nothing to do with the court system at all," Frere said.

He cited a 1992 national study conducted by Harvard University that said lawsuits are filed for only one out of eight patients severely injured or killed by medical malpractice in the United States.

Frere also pointed to an alert released Monday by a Washington, D.C., watchdog group, Public Citizen. The release argued that Florida doctors commit more malpractice than shown by the number of malpractice lawsuits. The release cited Florida's Agency for Health Care Administration, which said that from 1996 to 1999, Florida hospitals reported 19,885 "adverse incidents" but only 3,177 medical malpractice claims.

The release continues:

"Only 6 percent of Florida doctors are responsible for half the malpractice and its costs. According to the National Practitioner Data Bank, 2,674 of the state's 44,747 physicians have paid two or more malpractice awards to patients, making them responsible for 51 percent of all payments."

Frere said the bill will impede patients harmed by doctors, and there is no guarantee it will decrease rates.

The only benefit will be to insurance companies that will have limits on the damages they must pay for pain and suffering.

"The doctors are feeling a pinch. Everybody is feeling a pinch," he said.

The insurers

American Insurance Association spokeswoman Julie Pulliam said the association supported HR 4600. She said it will bring "predictability and

stability" to the medical malpractice insurance market if it becomes law.

She said it could increase the number of companies offering insurance in Florida, where many insurers do not offer coverage because of high claims. But there are no guarantees about rates, she said.

"We certainly never would make a promise along those lines, that it's going to decrease premiums," Pulliam said.

Insurance companies have been hit for \$40 billion worth of claims since the Sept. 11 tragedy, she said.

Prior to that, insurers would insure their own insurance through re-insurers.

An example of re-insurance existed at Flagler Hospital, according to Gordy. Flagler's former insurer gave the hospital \$10 million in coverage, but the insurer was only accountable for the first \$250,000, Gordy said. He said the rest was covered by re-insurers in Europe.

Pulliam said that after Sept. 11, re-insurance has been unavailable or extremely expensive.

As a result, companies like the ones in Florida have to boost their premiums.

"They can't spread their exposure, so they're on the hook, basically," Pulliam said.

Meanwhile, trial lawyers in every state are opposing legislation that would help insurers by limiting damages collected for pain and suffering, she said.

"Wherever you go across the country, it's the trial lawyers on one side and the medical community on the other, as well as the insurers," Pulliam said.

The doctors

Dr. Yank D. Coble is an endocrinologist in Jacksonville and a spokesman for the American Medical Association. He agreed that medical professionals and hospitals favor the bill, and mainly trial lawyers oppose it.

"That's understandable. It's been a lucrative thing," Coble said.

However, the immediate problem is that physicians in the United States are restricting their practices out of fear of lawsuits, he said. In Rio Grande, Texas, there is now only one neurosurgeon for a population of 600,000, Coble said. There is now no neurosurgery within 150 miles of Charleston, W. Va., because doctors left when their premiums spiked, he said.

A St. Augustine obstetrician ceased helping to deliver babies in January because it was no longer cost effective.

Dr. Anthony Mussallem, who has delivered at least 2,800 babies in St. Johns County, turned to semi-retirement and an office practice.

"If I have to do 50 operations a year to pay for the insurance, I might as well go fishing," Mussallem said.

Machado, St. Augustine's only neurosurgeon, currently pays \$60,000 a year for \$250,000 worth of coverage, he said. It lasts until April. He said he will "leave town" if his rates double.

Joyner's rates more than tripled.

Come April, people needing neurosurgery might have to travel elsewhere for it, Machado said. It could be the same for obstetric work.

"To ask mothers to go to Jacksonville or Daytona to deliver babies, it's just not fair. It's just not fair," Machado said.

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Or, maybe you're a woman who just recently learned you're pregnant — only to learn also that there are no obstetricians available to provide you with care.

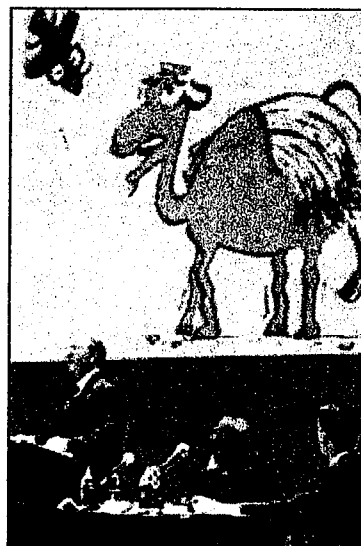
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In the near future, the state of Florida could face a very real shortage of doctors, physicians and surgeons — all because of skyrocketing medical malpractice insurance costs that are slowly sucking the life out of every medical practice from Key West to Pensacola.

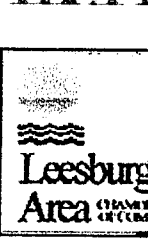
That was the message delivered during a special forum at Lake-Sumter Community College Thursday.

"There is a health care crisis," said Dr. Alfred Moffett Jr., Florida section chairman of the American College of Obstetrics and Gynecology. "We can't practice medicine anymore. We practice defense."

"The liability crisis will lead to a much larger health care crisis," said Dr. David Sustarsic, vice chief of staff for Leesburg Regional Medical Center. "We have a problem with malpractice premiums



Dr. David Sustarsic, vice chief of staff for Leesburg Regional Medical Center, uses a drawing to make a point during Thursday's forum on the health care crisis.
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decreasing the availability of physicians. Physicians are leaving Florida and the flood is just getting started."

"It's the focal point of every conversation physicians have. It's changed our lives," said Dr. John Robertson Jr., a general surgeon from Sanford. "In March, our carrier told us they were leaving the state. They gave us 'tail coverage' for approximately twice the amount of normal insurance. We applied to Lloyd's of London, and they wanted \$278,000 — with a \$50,000 deductible."

That's ridiculous, Sustarsic said.

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"In some cases, insurance rates have gone up between 30 percent to 300 percent," he said. "Some specialties are paying nearly \$200,000 to \$250,000 a year for coverage." Moffett said many physicians have no choice but to quit or take early retirement.

"My premiums last year were \$72,000," he said. "I've never had a claim in 30 years but I may have to quit next year. At Orlando Regional Healthcare and Florida Hospital, 12 out of 120 OB/GYNs have quit. That's 10 percent. A significant number of physicians are retiring early from OB/GYN surgery, there's a shortage of nurses, salaries are going up and federal requirements are increasing our expenses."

"The busiest obstetrician in Seminole County retired at 45 because his insurance costs were at \$228,000," Robertson said. "He decided to go to law school at the University of Florida — we're hoping he becomes an advocate for the rest of us."

State legislators are aware of the impending crisis and are working to fix it, according to state Sen. Anna Cowin, R-Leesburg.

"A lot of things are converging upon us," Cowin said. "I see a decrease in the number of (physician) residents, an increase in the number of physicians who are retiring, an increase in the number of aging patients, and increased malpractice insurance. I hope to ask the right questions as to what the future holds for Florida."

Despite the rising costs and shrinking profit margins, doctors and hospital administrators say they will continue to serve their patients.

"If we were all about money we would shut down the trauma center and Arnold Palmer Hospital," said John Hillenmeyer, president and CEO of Orlando Regional Healthcare. "But we're not about dollars. We were created to serve the community. Our doctors won't quit until there's nothing left."

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Emergency room physicians renew malpractice policies just in time

Saturday, September 21, 2002

By **LIZ FREEMAN**, epfreeman@naplesnews.com

The new policy came just in the nick of time.

Otherwise, the sliding glass doors into the emergency rooms at NCH's Naples and North Collier hospitals may have closed — under a worst-case scenario.

Hospital officials said they would have done their best to avoid such a crisis.

"We were running down to the wire," said Dr. Robert Tober, chairman of NCH's Department of Emergency Medicine.

Medical malpractice insurance expires Sept. 30 for the 30 or so physicians who work in the two emergency rooms. The group's current policy is part of the umbrella malpractice coverage through the hospital system.

As a result of a change in hospital policy, the physicians in January became self-employed yet were still covered under NCH's malpractice policy until its expiration at the end of the month. After that, they are on their own.

"As soon as they (insurance companies) heard we were emergency-room doctors, they didn't want us," Tober said.

With the help of NCH's in-house counsel, the group of physicians just recently secured new coverage that takes effect Oct. 1, he said.

If it wasn't obtained, Tober said he couldn't have continued practicing. The other doctors working in the emergency rooms likely would have made the same decision.

"Emergency room doctors are sick of being treated like lottery tickets," he said. "If something goes wrong, the patient sues."

The hardship the group faced getting new medical malpractice coverage is symptomatic of a widespread plight that physicians across the state are confronting. They receive renewal premiums that are doubling or tripling — or non-renewal notices and can't find new coverage.

"A \$200,000 premium for \$300,000 in coverage is not insurance," said Jake Bebber, deputy executive director of the Florida College of Emergency Physicians in Orlando. "That is an escrow account. When faced with the choice of living under the gun, they'll move someplace else."

Only a handful of insurance companies are still writing medical malpractice policies in the state, down from a couple dozen in the last few years, state insurance officials say. The companies cite big losses from malpractice trials, where juries are free to dole out huge pain-and-suffering damages.

Trial attorneys say the problem isn't the amount of damage awards but rather that insurance companies are taking hits with investment losses. Their solution is raising premiums or cutting off physicians in the high-risk specialties.

While the loss of physicians in any specialty is a blow to health-care access for the public, losing emergency-room physicians can be devastating, Bebber said.

"Emergency care, unlike most physician specialties, remains the basic community safety net," he said. "We are all going to be patients in the emergency room someday. They cover 30 percent of the patients who don't pay. They remain the last stopgap system for health care and the system is crumbling."

■ ■ ■

The emergency physicians' association is working on legislation as a temporary fix to the malpractice insurance predicament until the state Legislature can pass comprehensive tort reform, Bebber said.

The association has 1,000 members out of 1,400 board-certified emergency physicians in the state, he said.

The temporary fix is for limited sovereign immunity for emergency-room doctors and specialists who take emergency-room calls, similar to how the government provides malpractice immunity to retired doctors who provide medical care to the indigent in community clinics.

Emergency-room doctors in publicly run hospitals also generally have sovereign immunity.

The rationale for the proposed legislation, yet to be drafted, is that all emergency-room doctors and on-call doctors are "almost an agent of the state" because they serve the public, he said.

The emergency-room doctors who are employed physicians at Lee Memorial Hospital and HealthPark Medical Center have sovereign immunity, said Karen Krieger, spokeswoman for the publicly run Lee Memorial Health System.

At Cape Coral Hospital, the emergency-room physicians are under contract and must carry their own malpractice coverage.

Bebber said none of the details of the proposed legislation have been worked out, including the dollar limit for liability.

"Our goal is all emergency departments are covered, so practically speaking, including for-profit and non-profit hospitals, but the details have not yet been worked out," he said.

Dr. Perry Gotsis, NCH's chief medical officer, said he would support the legislation.

"Oh absolutely, not only for emergency department physicians but all doctors who take care of patients in the emergency room," Gotsis said. "I think the governor's group is going to take a look at that."

Gotsis was referring to a task force appointed by Gov. Jeb Bush in August to examine the malpractice problem and come up with recommendations by Jan. 31. The task force will have its first meeting Monday in Orlando.

At the same time, the emergency physicians' association is supporting efforts by the Florida Medical Association (FMA) to get a \$250,000 cap on pain-and-suffering damages, Bebber said.

The FMA is hoping to get a constitutional amendment placed on the 2004 ballot for voters to decide the fate of a proposed cap.

Bebber said if his group succeeds in getting legislation passed that gives limited sovereign immunity to emergency-room physicians, it wouldn't undermine what the FMA is striving for with a cap on pain-and-suffering damages.

"Any legislator or policymaker who thinks Florida's health-care system will be cured by doing this (limited sovereign immunity) is unfortunately mistaken," Bebber said. "This will not solve the medical liability problem. This will put a Band-Aid on the wound to allow Florida to continue for a few months."

Because of the escalating tide of malpractice lawsuits, physicians and hospitals are commonly practicing "defensive medicine." A patient comes to the emergency room or elsewhere with a medical complaint, and to shore up a diagnosis the doctor orders up expensive diagnostic tests that previously were used less frequently.

The practice is a defense mechanism to protect against missing something with the patient's condition and being sued. While the practice may seem good on the surface, an unnecessary amount of diagnostic testing is done and raising the cost of health care for everyone.

"Patients are getting blanketed with more and more tests," said Tober, head of NCH's emergency department.

For instance, if someone comes into the emergency room with stomach pain, invariably a double-contrast CT scan is ordered, costing \$3,000, he said.

Also commonly ordered up are CT scans for the brain, spinal taps, and "expensive blood cultures at the drop of the hat," he said. "Because we are much more scared of a (lawsuit) hit."

Gotsis, chief medical officer, said defensive medicine considerably increases the cost of medical care in the emergency room.

A fear of being sued by a patient is in the back of physicians' minds, he said.


"You can be a patient with a headache and it's almost guaranteed you're going to get a (CT) scan," Gotsis said. "It strictly is a liability issue here."


Ten years ago when there wasn't such a litigious environment, doctors relied much more on their clinical


judgment, he said.

NCH hasn't examined how much costs have risen as a result of the so-called defensive medicine, he said.

"It's really become so seamless a part of the care we render we couldn't separate it out," he said.

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Doctors in high-risk jobs are 'going bare'

By Robyn Suriano
Sentinel Staff Writer

September 22, 2002

Dr. Stephen Schreiber routinely ventures into high-risk areas as part of his job.

He cuts into the main artery of the brain to clear blockages that might trigger deadly strokes. He restores circulation in legs so people don't have to lose their limbs. He removes gallbladders, takes out ruptured appendixes and repairs hernias.

As a general and vascular surgeon, Schreiber always has paid more for malpractice insurance than physicians in less risky specialties.

But this year's insurance bill for himself and a partner went so high — \$244,000 — that he couldn't pay it at all. Now he is among a small number of Central Florida doctors who have dropped their coverage, essentially working without a net, to keep working in Florida.

"If I paid the premium, I would have had to close the practice, and it just seemed more important to keep the office open and running," said Schreiber, who has been in private practice in Central Florida since 1979.

State records show at least 1,514 physicians in Florida are self-insuring or "going bare," as it's sometimes called. It's still a small percentage of the state's 40,000 working physicians, but experts think more doctors will choose this option in coming months.

The trend could become a thorny issue for hospitals, which open themselves to greater liability if an uninsured doctor's actions take place within their walls. That's why many hospitals have required their staff physicians to carry private insurance in the past. But facilities statewide have suspended those requirements in recent weeks. For them, it simply comes down to having enough doctors in the building.

"It's kind of a double-edged sword for the hospitals. You have to have physicians on staff, and at this point, the hospital has to realize that some doctors just can't continue to carry their coverage," said Dr. Tim Bullard, chief of staff for Orlando Regional Healthcare, which has eight hospitals in Central Florida.

According to state law, doctors with hospital privileges have three options if they drop private medical-malpractice insurance.

- Establish a \$250,000 escrow account or get a \$250,000 bond that could be used to cover malpractice claims.
- Get an irrevocable line of credit from a bank for \$250,000.

- Pledge to come up with a maximum of \$250,000 within 60 days of a judgment against them. If physicians cannot pay that amount, they lose their Florida licenses.

It is this third option that is referred to as being self-insured. Schreiber opted to go that route. He thinks people will be less likely to sue a doctor who doesn't have a ready source of cash to take.

"The other two [options] still leave pots of gold for someone to go after," he said.

Schreiber has been involved in four settlements during his career, totaling more than \$700,000 in insurance payouts and dating to 1985.

His busy Maitland practice, called Orlando Vascular Associates, has four surgeons and an office staff of 22 to oversee the care of about 14,000 patients every year.

Schreiber, 56 and married with three adult children, said he typically works 7 a.m. to 10 p.m., juggling rounds at the hospitals with surgeries, patient visits, consults and emergencies. He and his partners perform 50 to 60 procedures every week. Their practice runs full-speed, every day, all year long.

These days, patients are given notices that Schreiber and a senior partner are no longer covered by malpractice policies. For now, the two younger doctors in the practice remain on insurance.

Schreiber said his patients have not stopped coming because of the change. If anything, they seem to be supportive of it.

"It makes absolutely no difference to me," said Marilyn Schaller, 69, one of his patients. "I go for the doctor and his ability; I don't care if he has insurance or not. But in fact, it would seem to me they would be all the more careful if they do drop insurance, because they wouldn't want to lose their shirts."

Although he has no intention of leaving the state, Schreiber worries that the two younger doctors in his practice might leave because Florida's malpractice-insurance rates are among the highest in the nation. He sees the insurance problem chipping away further at a health-care system already in trouble.

"All of these things are spokes on the wheel, and if enough of the spokes break, the wheel is going to collapse," Schreiber said.

Robyn Suriano can be reached at rsuriano@orlandosentinel.com or 407-420-5487.

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Malpractice rates soar -- doctors rethink risks

By Robyn Suriano and Greg Groeller
Sentinel Staff Writers

September 22, 2002

Dr. Eric Frohn closed his obstetrics practice last month to start anew in another state. Family physician Sanford Kinne is cutting back on the number of nursing homes he visits. Cardiologist Curtis Weaver gave up privileges at an Orlando hospital, partly to avoid being called in for high-risk emergencies.

Doctors throughout Central Florida and across the state are leaving or changing how they practice medicine, largely to get away from the skyrocketing cost of malpractice insurance. They blame the state's insurance rates — among the highest in the nation — on escalating malpractice claims fueled by aggressive lawyers, multimillion-dollar jury awards and patients with unrealistic expectations.

They say patients will suffer eventually because they won't be able to find an obstetrician or get an appointment with a high-risk specialist such as a neurosurgeon.

"It's gotten to the point where every time you deliver a baby, you are officially risking your financial future," said Frohn, who is moving back to his home state of Mississippi. "I don't know how long people can expect doctors to put themselves in that position."

Lawyers and consumer groups dismiss the dire predictions of doctors fleeing the state as scare tactics. They say Floridians are in greater danger from the state's lax oversight of physicians and their medical mistakes.

Caught in the middle are patients such as Dana Conroy of Hunter's Creek, who had to find a new doctor after Frohn's departure. Frohn delivered Conroy's second child, Madison, last year. He also was caring for her two pregnant sisters-in-law.

"It was hard for all of us," said Conroy, who is a nurse. "I wasn't mad, but it hurt. My husband and I both felt close to him, and we were looking forward to him doing the delivering again. Then all of a sudden, we have to start over again with a new doctor."

Lawyers vow to battle

Physicians, hospitals and insurers say Florida lawmakers could prevent more doctors from leaving the state or scaling back their practices by limiting the amount of "pain and suffering" money that a jury could award in a malpractice case.

In coming months, lawmakers in Tallahassee will be pushed to set a maximum of \$250,000 for such "noneconomic" damages, though some legislators wonder whether the issue will get much attention amid more-pressing problems. A committee in the U.S. House of Representatives approved national legislation recently, though that bill is not expected to make it through the U.S. Senate this year.

<http://www.orlandosentinel.com/templates/misc/printstory.jsp?slug=orl%2Dasecma1practi...> 9/23/2002

In Florida, lawyers and consumer groups vow to wage a high-profile battle during the 2003 Legislature to prevent such limits, which they say would protect bad doctors and make it difficult for many seriously injured patients to sue.

Rather than cap jury awards, they say, regulators should keep a better eye on insurance companies, who made poor business decisions in the 1990s and now must raise rates to compensate.

About the only point on which all sides agree is that doctors in Florida are being hit with staggering increases in the cost of malpractice insurance.

On average, physicians are paying 30 percent more for insurance this year compared with last year. But doctors in high-risk specialties such as obstetrics, heart surgery, neurosurgery and orthopedic surgery are getting bills that have doubled or even tripled. Some doctors are being asked to pay \$200,000 a year -- and that's for \$250,000 worth of coverage.

Other doctors can't get insurance at any price because some companies just aren't willing to write policies in Florida anymore. At least eight insurance carriers have gone out of business or stopped offering malpractice coverage in Florida. Only four companies are writing new policies, compared with dozens just years ago.

Amid this dearth of competition, doctors argue, insurers can raise their rates and be very choosy about who gets coverage, even when the doctors involved have few or no claims against them.

"They have so many applications coming in, why would they pick a doctor who has any kind of lawsuit?" asked Dr. Shelley Glover, a Clermont gynecologist who stopped doing obstetrics to avoid the higher costs of malpractice insurance when she moved here from Virginia. "You have very good doctors who are being quoted very, very high premiums."

Insurers blame lawyers

Insurance companies say they must increase their rates to stay in business.

They say Florida's doctors are subject to more claims in part because the state is home to an organized, cohesive population of trial lawyers who are adept at pursuing medical-malpractice cases.

"They work together to find theories of liability to advance and to educate one another on how best to prosecute high-value cases," said Bob White, chief operating officer for First Professional Insurance Co., Florida's largest medical-malpractice carrier. "That attracts the very best legal talent on the plaintiffs' side."

Statistics do show that the number of claims and the dollars paid out have been increasing, though less sharply in recent years.

The number of malpractice lawsuits filed each year in state courts rose about 43 percent between 1991 and 2001, to 2,257 suits last year. At the same time, settlements paid by insurance companies increased about 40 percent, to more than \$215 million last year. Both outpaced the state's population, which grew about 23 percent from 1990 to 2000. (The totals include nonmedical cases, such as legal malpractice, but the vast majority were medical suits.)

According to First Professional Insurance, one in every 18 Florida doctors settles a malpractice claim

each year, compared with one of every 44 doctors nationwide.

When cases go all the way to trial, Florida juries have handed out massive verdicts in some instances for noneconomic damages. A Lake Worth woman was awarded \$78.5 million for pain and suffering in March after her family sued an Orange County hospital, arguing that emergency-room doctors and staff had failed to detect internal bleeding that led to brain damage and rendered the woman helpless.

The hospital is appealing the verdict. But that number -- \$78.5 million -- is burned into the minds of doctors throughout Central Florida, who say they should not have to work in fear of such mammoth damages.

"Nobody wants to be a target for the rest of their lives," said Dr. John W. Robertson, a general and vascular surgeon in Sanford. "It would be nice to go home at night and not worry about being sued because you tried to help someone."

Even so, doctors may not find much sympathy from the general public. Physicians being hit with the steepest rate increases still drive fancy cars and live in homes that most of their patients couldn't afford. But people shouldn't begrudge them that -- or forget that high paychecks attract quality people to the profession, said David Webster, a Bethlehem, Pa.-based health-care consultant.

"Yes, these people are still making money," Webster said. "But there needs to be some financial return for a profession that demands 10 years of education and forgone earnings. If these premiums become a significant factor in decreasing those returns, you will have more physicians leaving specialties and retiring early."

Lawyers blame insurers

Lawyers say doctors are blaming the victims and using the legal system as a scapegoat for several forces that are causing the rise in premiums.

They say the insurance industry contributed to the problem by keeping premiums artificially low for years. In the early 1990s, doctors' insurance costs remained stable or even decreased as more companies moved into Florida and cut their rates to attract more customers. The companies then had money to invest in the stock and bond markets, using investment profits to cover the cost of paying off claims.

But times have changed, the financial markets have soured and insurance companies are going out of business or eliminating malpractice coverage.

This cycle is nothing new for Florida, said Neal Roth, a malpractice attorney in Miami and co-chairman of the Academy of Florida Trial Lawyers' medical-liability committee.

Doctors have decried rising premiums twice in recent decades and threatened to leave Florida, only to simmer down when natural economic forces restored balance to the system, Roth said. The latest rate increases are "exorbitant and inappropriate," he said, but the problem won't be solved until there is more regulation of the insurance industry's investment and underwriting practices.

"Why are the rates going up? The answer is less competition, poor management by a bunch of carriers which came in and undercut premiums, and terrible investment losses," Roth said. "Those are the factors that have put us in the position we're in now."

Nader group blames state

Lawyers and others also dispute the notion that malpractice claims are out of control in Florida. They say the state's unwillingness to discipline physicians for wrongdoing means that mistakes can continue unchecked.

In a report released last week, the consumer group Public Citizen, which was founded by Ralph Nader, said that Florida's Board of Medicine handed down serious punishments for doctors in just 36 percent of its cases in 2001. The board oversees doctors and investigates complaints of wrongdoing.

Only two other states, Wisconsin and North Carolina, were less likely to revoke a physician's license, suspend it temporarily or place a doctor on probation, according to Public Citizen. Just half of the 24 Florida doctors who have been sued 10 or more times have ever been disciplined by the medical board, the group said.

"The reality here is that there is no medical-malpractice insurance crisis," said Joan Claybrook, president of Public Citizen. "Rather, there is too much medical malpractice."

Better oversight of doctors would reduce errors and bring long-term stability to their insurance rates, said Jacqueline Imbertson of Jupiter, who said her husband was injured three years ago when he was given the wrong medication in a South Florida hospital.

The drug induced a heart attack that caused so much damage that Imbertson's husband now needs a transplant. She is barred from discussing the terms of the settlement that was reached with the hospital. Such secrecy is part of the problem, she said.

"The real issues are establishing greater accountability and preventive measures to screen out the ones who are causing the problems," she said. "And when all else fails, we should preserve the rights of people to seek justice in the courts."

Crisis ahead, doctors say

Whatever the underlying causes, there is growing evidence that rising malpractice insurance is affecting how Florida doctors work. Although no critical shortages have been identified as yet, health officials say the ripple effects will reach everyone eventually.

"Right now, this appears to be a conversation going on between doctors and attorneys, but I can tell you, in reality, this will become a crisis for our patients," said Dr. Monica Reed, senior medical officer for Florida Hospital, one of the area's two large hospital chains. "It is already a crisis for our doctors."

Florida Hospital has suspended, at least temporarily, a requirement that staff physicians carry private insurance, because hospital officials expect many doctors to have trouble finding coverage in the next few months.

Some doctors are calling for a one-day shutdown of their offices Oct. 16 to hold rallies and call attention to the situation. It's unclear how many doctors will participate.

One field that is particularly vulnerable is obstetrics, where physicians always have been more subject to lawsuits because of the high risk and high expectations that come with delivering babies.

Dr. Edgar Jimenez closed his Orlando obstetrics practice last month to look for a job in another state. He has not settled on anything yet, but his two partners have left in the past year for jobs in North Carolina

and Georgia.

Jimenez said his malpractice insurance was the final straw but not the only factor in his decision to leave. Doctors also say smaller payments from the government-run Medicare program and from private HMOs are making it harder to do business, especially in Florida, with its large elderly population and widespread use of HMOs.

"It was a lot of things for me: Reimbursements coming down and malpractice going up, along with the fact that there is a movement underfoot toward large judgments and some very good attorneys in town chasing the almighty dollar," he said.

Other doctors are cutting back on things that attract lawsuits, such as tending to nursing-home patients.

"Almost every day, we're getting referrals from nursing homes because these other doctors won't go in," said Kinne, a Volusia County doctor who reduced the number of homes he visits from 15 to five after his premiums rose this year. "The question is: Who is going to take care of these patients?"

Futures at risk

Radiologists say they face increasing danger from lawsuits when they examine mammograms for the first signs of breast cancer. Dr. David Harding, a radiologist who works at Orlando Regional Medical Center, recently decided to give up the task.

"It just got to the point where I had to decide if I was putting my entire future at risk," said Harding, president of the Orange County Medical Society. "It's one of those things that it doesn't matter if you've done everything right; you can still get sued."

Weaver, the cardiologist, and his practice, Florida Heart Group, gave up privileges at ORMC effective Sept. 1 because the hospital increased the number of days that doctors would have to be available to answer emergencies.

Because the group does only a small percentage of its work at ORMC, Weaver said, it didn't make sense to stay on staff at the hospital, which has a busy trauma center that treats many critical patients.

"We all have to re-evaluate how we practice, and limit our high-risk exposure in this malpractice climate," Weaver said.

If enough doctors stop answering calls at hospitals, physicians say, it eventually could affect the services that hospitals can offer. Central Florida hospitals say they are not at that point, but facilities elsewhere already are dealing with it.

A Largo hospital will stop delivering babies Dec. 1, while Las Vegas' only trauma center temporarily closed this summer after a massive exodus of doctors to other states.

"I can see things really coming to a head in the next six months," said Dr. Dennis Agliano, a Tampa surgeon and chairman of the Florida Medical Association's coordinating committee for legal reform. "We have families, and we have mouths to feed, and we want to protect our loved ones just like everyone else. And we're not going to stay in a climate where it's impossible to do that."

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Congress should act to avert healthcare crisis

As an emergency physician, I find it disheartening that Congress hasn't addressed the two most important issues affecting physicians' ability to deliver quality care.

How many are aware that Medicare payments to emergency physicians were cut by 8 percent this year while the cost of medical-liability insurance has increased up to 400 percent?

These developments are forcing hospitals to consider closing their emergency departments or canceling trauma services until physicians can obtain coverage. Physicians also are considering reducing their Medicare patient load, retiring or moving to states with lower insurance premiums.

Medicare cuts result from errors in the data and formula used to determine provider payments. As it is, physicians and other providers may soon face additional payment cuts of nearly 15 percent. Many will have to decide by year's end if they can afford to continue taking Medicare patients.

This liability crisis has been building for years. With numerous insurance companies leaving Florida and those remaining unable to offset losses, rates are skyrocketing.

Jury awards in a few malpractice cases have led to increased premiums. Florida leads this crisis -- not a particularly desirable image when trying to recruit physicians. The costs will be passed to patients, directly or through increased premiums.

These issues are pushing the nation's healthcare system to collapse. The Centers for Disease Control and Prevention reported that hundreds of hospital emergency departments have closed in the past 10 years, while ER visits have increased dramatically.

Congress can protect patients' access to healthcare. Legislation in the House and Senate (H.R. 4600, S. 2793) would help reduce the costs of liability insurance while allowing patients and families to keep a greater share of their awards in liability cases. State legislatures will consider other measures.

Based on the outcome of these efforts, many physicians, including me, will decide whether to continue medical practice in Florida.

Congress can alleviate the Medicare cuts by replacing the payment formula with one that tracks changes in the true cost of healthcare services.

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Orlando Sentinel

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COMMENTARY

Some doctors find Florida isn't worth it

Mike Thomas

September 17, 2002

Did you see the Corrections & Clarifications item in Monday's paper?

The sports section erred in reporting the length of the longest pass that Gator quarterback Rex Grossman threw against Miami.

I avoid such mistakes by being vague. I say things like: "Johnny Unitas could throw a football farther than Rex Grossman did against Miami."

But my time is coming. A slip-up eventually will slip in, and I'll be held up for public ridicule on Page A3.

It could be worse. I could be a surgeon with some guy's brains in my hands. And one wrong twitch could turn him into Mr. Potato Head.

No thanks, not even if it meant that tomorrow I could be towing my Maverick Mirage flats boat to Mosquito Lagoon behind a Lexus sport utility vehicle.

I do not begrudge good doctors their homes in Windsong. They have survived the brutalities of pre-med, medical school and years of grueling 80-hour workweeks in internships and residencies. Many graduate with six-figure loans to pay off.

So if it takes a fat income to induce people to go through this, so be it. To the extent that greed attracts the best and brightest, greed is good.

What worries me is that Florida is becoming not worth it to doctors.

Health-insurance companies have frozen, or in some cases even reduced, their fees. With only a handful of major insurers, the doctors pretty much have to play ball or lose their patients.

As salaries stagnate, malpractice premiums for some doctors have doubled in the past year, particularly in high-risk specialties such as obstetrics and neurosurgery. A few insurance companies have pulled out of Florida altogether.

Doctors are choosing to go "bare," practicing without malpractice insurance. Desperate to keep them on staff, some hospitals are allowing them to do so, opening themselves up as the "deep pockets" in the event of a malpractice lawsuit.

In some cases, doctors are leaving Central Florida, primarily OB/GYNs.

The insurance companies and doctors blame frivolous lawsuits.

The lawyers blame bad doctors. They blame insurance companies that charged artificially low premiums in the 1990s in hopes of making up for it in the booming stock market. The boom is gone, and losses are mounting, hence the malpractice crisis.

Both sides are right. I don't know who is more right. I do know lifesaving information is not shared because medical professionals fear if mistakes are scrutinized, lawsuits will follow.

And good doctors are getting squeezed in the middle, getting hit with huge premiums even if they've never been sued. The best medical students see this and avoid the high-risk specialties and instead opt for ophthalmology and dermatology.

And those who do go into the high-risk specialties are beginning to avoid Florida. This doesn't mean we'll be delivering our own babies at home next week. There are too many doctors with roots here who will find a way to manage. But what we are facing is a long-term drain of skilled medical professionals in the most key specialties.

It may be the time for a settlement pool for each specialty. Doctors pay into the pool, which is administered by the state using qualified hearing officers. Payments are based on judgments against the doctors, which would be public record.

If we don't provide good doctors some stability in this state, they'll go somewhere else to find it.

Mike Thomas can be reached at 407-420-5525 or mthomas@orlandosentinel.com.

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Insurance squeeze tightens for another SW Florida surgeon

Monday, September 9, 2002

By **LIZ FREEMAN**, epfreeman@naplesnews.com

When Dr. Aldo Beretta returned home from vacation two weeks ago, the stress of his profession as an orthopedic surgeon quickly returned.

His insurance company sent him a letter stating his medical malpractice coverage expires Oct. 15 and isn't being renewed.

"I called and they said they changed their policy and were not writing in Florida anymore," Beretta said.

He moved to Southwest Florida last year from Boston and set up practice in Bonita Springs. His hospital privileges are with the NCH Healthcare System in Collier County and he performs most of his surgeries at NCH's North Collier hospital off Immokalee Road.

His insurance company pointed to a 1991 claim paid out on his behalf in Massachusetts, but Beretta said he's had no claims this past year.

"I've been shopping around," he said of getting quotes.

The picture isn't pretty.

Last year his annual premium with Physician Protective Plan in Tampa was \$50,000 for \$250,000 coverage per incident. He also does spinal surgery, which increases his premium.

"I got one unofficial quote close to \$200,000," he said of his inquiries for the same amount of coverage. "That's ludicrous. I've only been here one year."

Beretta may be joining the increasing number of physicians locally and statewide, especially in high-risk specialties like his, who face moving to a state that has a cap on pain-and-suffering damages in medical malpractice trials. In Florida, juries face no such limit. Other options for physicians are dropping tricky medical services or declining to take on risky patients.

"I've got a couple of things I've been thinking about," he said. "I've put my name with recruiters, and I've contacted Cleveland Clinic, the (Veterans Administration), and I've looked into getting my real estate license. If I can't pay the bills, what do I do?"

Beretta said he would join colleagues in Tallahassee to lobby state legislators for tort reform. The Florida Medical Association hopes to get a constitutional amendment on the 2004 ballot that asks voters for a \$250,000 cap on pain-and-suffering damages.

The medical community blames zealous trial attorneys who see dollar signs by going to trial instead of settling out of court. The attorneys, in turn, point fingers at the insurance companies that have raised premiums to compensate for losses in the stock market.

Without a cap, premiums will continue escalating, health-care officials say. Patients will suffer as it becomes increasingly difficult to access medical care. Fewer doctors mean fewer choices.

Moreover, the state's draw as a retirement mecca and the vital role that plays in the state economy could erode. New retirees could scratch Florida from their choices to spend their golden years if the state develops the reputation of having insufficient health-care services.

"It's frightening," said Dr. Paul Jones, a family practitioner and president of Anchor Health Centers, a 40-physician group practice in Collier. "If we lose good health care, it will adversely affect the community and retirees won't want to come if they can't get good health care."

So far, three general surgeons in Collier have closed their practices and an obstetrician is no longer taking new obstetric patients. Other obstetricians may follow suit, and physicians in emergency medicine, critical care, radiology and other high-risk specialties are evaluating their options as they await premium renewal notices.

"We have not lost any more physicians at this present time, (but) two more surgeons are most likely going to leave," said Dr. Corey Howard, president of the 370-member Collier County Medical Society.

Dr. Dean Hildahl, an obstetrician in solo practice in Naples, received his renewal notice in late August and his premium was going up 400 percent. He cut back on his coverage, from \$1 million to \$250,000 per incident, and is still paying more than last year.

He declined to give figures but said, "For a fourth of the coverage, (the premium) is over \$100,000."

He is still accepting new patients but said it's becoming cost-prohibitive to keep practicing obstetrics.

"I don't think people realize how critical it is," he said of the malpractice insurance issue. "A number of obstetricians are no longer taking new patients."

Compounding matters is the significant number of indigent patients, and the obstetricians aren't reimbursed for taking care of them. Many of the indigent pregnant women have not been getting prenatal care and that increases their risk of complications.

"We're happy to do (the care) but those patients can be a liability," he said.

Physicians cannot pass their increased overhead costs to patients because of negotiated rates with managed-care plans. And Medicare, the government insurance for the elderly, is cutting reimbursement by 12 percent over the next three years. That's on top of a 5 percent cut in January. That's another blow physicians don't need on top of the malpractice insurance problem, Howard said.

Because of malpractice insurance hikes, the 168-bed Doctor's Hospital in Sarasota is closing its

obstetrics unit Dec. 1. The unit will continue delivering babies until Nov. 15. Owned by HCA-The Healthcare Corp., hospital officials said closing the obstetrics unit will save \$1 million annually.

"Patients are ending up having to suffer because of this crisis," Hildahl said. "There are threats to access to care in Naples. People are not aware of it."

One of the local obstetricians who is scaling back his practice because of his malpractice premium is Dr. Kevin Collins, who announced last month he will quit delivering babies next August.

Both Collins and Jones were invited to speak Sunday to the congregation of Vanderbilt Presbyterian Church in North Naples about the malpractice issue and the impact to patients.

"It's a community issue and people should be concerned," said Marjorie White, a congregation member who invited the physicians.

Family practitioner Jones said the public needs to understand what's happening and help by writing letters to state and congressional leaders.

"Physicians aren't going to be able to change it. People are going to have to change it," Jones said.

That's the Florida Medical Association's game plan for getting the constitutional amendment on the state ballot for a cap on pain-and-suffering damages and for garnering public support for a bill in Congress that would have the same result at a federal level.

The FMA printed up posters for doctors to post in their waiting rooms for patients to inquire about saving the state's health-care system.

About 370 posters have been sent to Collier, said Margaret Williams, executive director of the local medical society.

Another plan is for physicians from throughout the state to go to Tallahassee and lobby for tort reform once the state legislative session begins next year. The idea now is scheduling separate days for physicians from different communities to make the trip, Williams said.


Howard, president of the local medical society, was elected last week to the FMA's board of governors, which will be helpful for physicians to stay on top of what's happening in Tallahassee, Williams said.


The FMA also has put together a form letter for patients to send to U.S. Sens. Bob Graham, D-Miami Lakes, and Bill Nelson, D-Tallahassee, who both voted against the congressional bill to cap pain-and-suffering damages.


Late last month, Gov. Jeb Bush appointed a task force to examine the impact of skyrocketing malpractice premiums to make recommendations by Jan. 31. The intent is to offset the impact on the public in accessing health-care services.

"The task force is a good idea," Howard said. "It is a very good start."

(Anyone interested in getting a copy of the form letter to send to elected leaders supporting the need for tort reform should contact Margaret Williams at the Collier County Medical Society at 435-7727.)

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Malpractice insurance's prescription for trouble

By KRIS HUNDLEY, Times Staff Writer

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Here's some free advice for doctors who are desperate to find affordable malpractice insurance.

Here's some free advice for doctors who are desperate to find affordable malpractice insurance.

If the agent tells you to mail the premium to Belgrade, save the stamp and just flush the money down the toilet.

The Florida Department of Insurance this summer warned doctors that phony malpractice insurance companies were making sales calls in the state.

The questionable outfits operated under several names — Physicians Exchange Association Inc., Physicians Exchange Risk Retention Group and Doctors Liability Exchange. They all claimed to have a connection with Reliance General Insurance Co., which the state said appears to be headquartered in Yugoslavia. None of the companies is licensed in Florida.

The DOI was tipped off by a doctor in Central Florida, who got the pitch for these low-cost insurers through an agent. The agent assured the physician the companies were exempt from state regulation because they were covered under a federal plan. Though there are legitimate exemptions, the insurance department said these companies had not complied with legal requirements to meet the exemptions and were operating illegally.

The state said it did not know how many doctors had purchased coverage through the unlicensed companies. It's no surprise doctors are desperate for low-price malpractice insurance. The number of legitimate carriers in the state has dropped to a handful. And malpractice rates have skyrocketed as much as 200 percent for some high-risk specialties.

But DOI spokeswoman Tami Torres warns that doctors are likely to end up with unpaid claims if they sign on with unregulated insurers.

"Doctors should ask the agent for the name of the insurer carrying the risk and go a step further and call us to see if that insurer is licensed," said Torres, who added that the department has gotten questions about Reliance from as far away as New Zealand. "It's not enough that the agent offering the insurance is licensed."

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St. Petersburg Times

Malpractice insurance crisis hits home

St. Petersburg Times; St. Petersburg, Fla.; Aug 17, 2002; KRIS HUNDLEY;

Abstract:

Clarification (8/20/02): Dr. Carmen Damiani, a Clearwater physician who was forced to stop practicing at Largo Medical Center after her medical malpractice insurance expired, has not had an obstetrical claim in her 15-year career, but she has had two settlements related to gynecological procedures. A story Saturday was not clear on Damiani's claims experience.

Skyrocketing malpractice rates already have temporarily closed a trauma center in Las Vegas, severely limited obstetrical care in West Virginia and eliminated orthopedic service at a Philadelphia hospital. Dr. Carmen Damiani, one of the Largo obstetricians who lost her malpractice coverage at the beginning of August, said the worst is yet to come in the bay area.

[Carlos Vazquez] has since joined an obstetrics group in South Florida, where several hospitals allow doctors to practice without malpractice insurance. To practice in Florida, doctors with hospital privileges must have either commercial insurance; a \$250,000 bond or letter of credit; or they must agree to come up with \$250,000 per claim (a maximum of \$750,000 per year) within 60 days should there be an adverse judgment. The last option is considered self- insurance, commonly known as "going bare." Self-insured doctors also must post a sign in their office notifying patients that they have no malpractice coverage.

Full Text:

Copyright Times Publishing Co. Aug 17, 2002

Clarification (8/20/02): Dr. Carmen Damiani, a Clearwater physician who was forced to stop practicing at Largo Medical Center after her medical malpractice insurance expired, has not had an obstetrical claim in her 15-year career, but she has had two settlements related to gynecological procedures. A story Saturday was not clear on Damiani's claims experience.

South Bay Hospital in Hillsborough County has lost the services of three specialists in the past month, including a urologist and vascular surgeon, because of the doctors' inability to find affordable medical malpractice insurance.

At Largo Medical Center in Pinellas County, the maternity ward will close by year-end, stung by the loss of two busy obstetricians who could not find insurance coverage.

"These doctors found they could no longer afford to practice," said Tom Herron, chief executive of Largo Medical, which saw its deliveries drop 25 percent after the two specialists left. "And with two more obstetricians saying they expect to lose coverage, we can't afford to keep the unit open."

More than a dozen local hospital executives gathered Friday morning in Tampa to call for an overhaul of malpractice insurance and alert the public that the crisis is beginning to be felt locally as hospitals curtail services and doctors are forced to leave their staffs.

Skyrocketing malpractice rates already have temporarily closed a trauma center in Las Vegas, severely limited obstetrical care in West Virginia and eliminated orthopedic service at a Philadelphia hospital. Dr. Carmen Damiani, one of the Largo obstetricians who lost her malpractice coverage at the beginning of

August, said the worst is yet to come in the bay area.

"So far the problem has just been individual doctors coming up for renewal," she said. "But in October, some big groups in the area are coming due (for renewal) and it's going to blow up. The bigger crisis is coming."

In the past four years, 40 insurance carriers have stopped writing medical malpractice policies in Florida, leaving just a handful of carriers. The remaining insurers have raised their premiums by at least 30 and as much as 300 percent, saying they're being hit with an ever-increasing number of claims and huge jury awards.

The upshot is that experienced obstetricians like Damiani, who has not had a claim in her 15-year career, are not being renewed by their insurers. Dr. Carlos Vazquez, the other obstetrician to leave the Largo hospital, was offered renewal but at rates he considered astronomical. Dr. Richard Landrigan, the Brandon urologist who was forced to stop practicing at South Bay, was simply notified this summer that his long-time insurer was leaving the state.

Vazquez has since joined an obstetrics group in South Florida, where several hospitals allow doctors to practice without malpractice insurance. To practice in Florida, doctors with hospital privileges must have either commercial insurance; a \$250,000 bond or letter of credit; or they must agree to come up with \$250,000 per claim (a maximum of \$750,000 per year) within 60 days should there be an adverse judgment. The last option is considered self-insurance, commonly known as "going bare." Self-insured doctors also must post a sign in their office notifying patients that they have no malpractice coverage.

Hospitals in South Florida, which has the nation's highest medical malpractice rates, have been forced over the past several months to allow doctors to self-insure or post a bond in order to keep their doors open. So far, hospitals in the Tampa Bay area have largely resisted physicians' efforts to move in that direction, continuing to demand that doctors have commercial coverage.

The only exception is University Community Hospital in Tampa and Carrollwood, which allows doctors to put \$250,000 in an escrow account or bond to handle malpractice claims. Largo Medical Center is considering a similar proposal.

But as local hospital executives gathered to bemoan the medical malpractice crisis Friday morning, they avoided endorsing such options. Bill Bell, general counsel with the Florida Hospital Association, said his group has no statistics on the number of hospitals that have allowed doctors to practice without commercial coverage.

"Each hospital's board is trying to grapple with that," Bell said. "But hospitals prefer to help their medical staff find some other kind of remedy."

Landrigan, the Brandon urologist, thinks hospitals are being warned by their attorneys that they could be forced to pay more out of their malpractice insurance if doctors are uninsured. But he's angered that hospitals are adhering to higher standards than the state.

"Since when does an organization such as a hospital decide it's smarter and more powerful than the state?" he asks.

Landrigan now operates his office practice on a self-insured basis. He said about 10 of the 100 patients he had scheduled in the past month have canceled appointments after being told he no longer carries

malpractice. Those who remain with his practice but need surgery are referred to other local urologists. But Landrigan said the referral system isn't always smooth.

"A patient with kidney stones was told he couldn't be seen till mid-October," he said. "It's not life-threatening but it means more pain and suffering for the patient."

Shut out of surgical work, Landrigan's income has declined more than 50 percent. He says he has little choice but to keep searching for a malpractice carrier, though he's been told he could end up paying 300 to 400 percent more than the \$14,000 per year he paid in the past.

Damiani, the obstetrician, is likewise resigned to paying more. "I've never paid more than \$43,000 a year," she said. "Now I'm getting quotes of up to \$180,000."

Even when they find new insurance, both doctors said they'll probably curtail risky procedures. Damiani will likely give up general surgery and Landrigan expects to avoid emergencies like one he handled a couple of years ago involving a pregnant woman with kidney stones.

"If an insurer tells me my rate will be lower if I don't treat complicated cases like that, I'll go for the cheaper rate," he said. "Then the next time that happens I won't come in and you'll be talking life and death."

- Kris Hundley can be reached at hundley@sptimes.com or (727) 892- 2996.

Sub Title: [SOUTH PINELLAS Edition]
Start Page: 1E
Dateline: TAMPA
Personal Names: **Damiani, Carmen**
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Article published Sep 10, 2002

Another hospital abandons births

Doctors Hospital is closing its obstetrics department due to the high costs of malpractice insurance and because the department doesn't "make money." Doctors and hospitals simply cannot afford to pay the escalating premiums to keep such insurance in force, and cannot risk lawsuits without it. What will happen when there is no longer such coverage or OB/GYN physicians?

One hundred years ago the family doctor delivered babies in the farmhouse. There were no attorneys advertising assistance in filing lawsuits. (This used to be called barratry and could get a lawyer disbarred.)

Today, after lawsuits are filed, juries award exorbitant settlements, often in the millions of dollars. Everyone gets their fingers into the pie.

That may soon come to a halt. The eventual outcry when OB/GYN facilities and doctors disappear will force Congress to pass legislation limiting such awards and establish committees to review each case.

Bruce H. Thurber

>Sarasota

St. Petersburg Times ONLINE OPINION



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Letters to the Editors

Frivolous suits threaten quality of our health care

© St. Petersburg Times, published September 10, 2002

Doctors are leaving the state of Florida due to the unaffordable medical malpractice insurance. Insurance rates are skyrocketing due to a civil justice crisis in Florida manifested by an abundance of frivolous lawsuits filed by unscrupulous personal injury attorneys. The problem has become so bad that the Florida Medical Association is keeping track of doctors leaving the state.

Doctors are leaving the state of Florida due to the unaffordable medical malpractice insurance. Insurance rates are skyrocketing due to a civil justice crisis in Florida manifested by an abundance of frivolous lawsuits filed by unscrupulous personal injury attorneys. The problem has become so bad that the Florida Medical Association is keeping track of doctors leaving the state.

Last spring, I was profiled by your paper as one physician who is seriously considering leaving the state due to the crisis. I am a neurosurgeon who treats patients with highly complicated brain and spine disease. My insurance rates have nearly doubled despite the fact that I have never had a civil settlement or jury award against me.

I returned to my hometown, St. Petersburg, two years ago to practice medicine. I am a success story for the state's higher education system: I attended St. Petersburg Junior College and the University of South Florida as an undergraduate and medical student. By returning to Florida, I am providing care to the citizens of the state that helped educate me. I routinely provide free medical care to those with no insurance and discount service to those with Medicaid and Medicare.

I entered medicine to care for patients and I enjoy doing so. Sometimes there are bad outcomes. That is the nature of the human condition: not everyone gets better and sometimes people get worse. In very few cases does a bad outcome indicate that any error occurred. Despite this, according to national statistics, I will be sued every two years. I have a simple economic decision to make in one or two years. If I can afford insurance, I will stay. If I cannot, I will have no choice but to leave the state to work elsewhere. The state that helped educate me will no longer benefit from the dollars spent subsidizing my state tuition.

For now I choose to stay and fight. I will be fighting the industry that has eroded medical care throughout the nation: the personal injury industry built by trial attorneys. Their lawsuits have little to do with "defending the little guy" or "improving medical care." Their suits are about making money for themselves. For those lawyers who would deny it, ask them if they will take a case when there is no insurance money to go after or no deep pocket to pick.

I know that if I leave, Florida residents will have less access to care. When they need emergency brain

or spine surgery, there may not be a neurosurgeon at their hospital. During the transfer to another hospital, they may suffer irreversible brain or spinal cord injury. I do not want citizens in this state to lose access to care, so for now I choose to stay and fight. I want to be on the list of physicians who defended medical care for patients and not the list of physicians forced out by the personal injury industry.

-- David McKalip, M.D., St. Petersburg

The real problem is with insurance

Re: Malpractice insurance crisis hits home, Aug. 17.

The headline should emphasize that this is an "insurance" crisis. In Florida, we have been the recipients of so-called medical malpractice reforms in the 1970s and 1980s. Then, Miami obstetricians threatened to close shop because of exorbitant medical malpractice insurance premiums.

The propaganda then, and now, is identical. "We must put a stop to the increasing number of claims and huge, runaway-jury awards, greedy plaintiffs (patients) and frivolous lawsuits." The available evidence, however, does not support these myths.

In every state where so-called medical malpractice reforms have been implemented, there has not been a corresponding reduction in medical malpractice insurance premiums. Such reforms did not obligate the insurance industry to reduce premiums.

Experienced medical malpractice attorneys do not pursue frivolous medical malpractice suits. These cases are extremely complex, challenging, time-consuming and extraordinarily expensive. In Florida, before being able to bring suit, you must have an under-oath statement by a doctor that the case has merit. The burden at trial is a rightfully heavy one, requiring that the patient prove the doctor negligent and that negligence, more likely than not, caused the patient's injuries or death. Failures in proof to the satisfaction of either the judge or the jury more often favor the health care profession.

While there have been (and currently are) laws that provide significant sanctions against patients and their attorneys should they pursue meritless and frivolous court claims, the media -- with some exceptions -- generally do not find newsworthy medical malpractice cases that result in no jury award whatsoever. The "huge" jury awards are rendered because six to 12 fine citizens have heard all the evidence and determined that the catastrophically injured patient is so entitled.

The solution? It is not medical malpractice "reform." Imposing arbitrary caps on patients' potential financial recovery operates to immunize those responsible and works a discriminatory social injustice to those patients who are the most seriously injured and inalterably disabled.

But what can or should be done? Doctors, hospitals and consumers/patients should demand Congress and state legislators immediately convene investigation into the merits of this so-called "crisis." Specifically, they should investigate whether the medical malpractice insurers are engaged in a boycott (more than 40 insurers have pulled out of Florida) or conspiratorial coercion in the face of stock market losses versus paid claims. Why? The insurance industry is exempt from antitrust laws under the McCarren-Ferguson Act. The time has come to consider removing this exemption and force the insurance industry's accountability for what appears to be predatory underwriting and profit engineering scare tactics, crippling the public health, safety and welfare.

We do not need medical malpractice reform. What we need is health care reform and insurance industry

practices reform.

-- Roy L. Glass, medical malpractice attorney, St. Petersburg

Questions for the insurance industry

Recent articles in the St. Petersburg Times have focused on the twin crises we find ourselves facing: the so-called medical malpractice crisis and the crisis facing plain folks looking for reasonably priced homeowners coverage.

What have we, as ordinary citizens, done to bring about this situation? It is a fact, after all, that some doctors do injure and even kill their patients. It is also a fact that nature's winds and waters cause property damage. Why blame the weather or the lawyers?

Doctors and homeowners are willing to pay reasonable premiums for necessary protection. Neither are willing nor can they afford to pay insurance premiums that are clearly unaccountably high.

As a justification, we are told that the insurance companies are losing money under present premium rate schedules. If they are indeed losing money, the question becomes "Why?" Considering the importance of insurance, are we not entitled to know the facts? What documentary evidence exists in insurance companies' files supporting such increases? What happened to the surpluses acquired during the profitable years? What failed investment strategies contributed to the problem?

Over the years, crying "crisis" has been a very successful scheme in raising the cost of insurance. Unfortunately, it has also caused doctors to war against their own patients and the lawyers representing them. It has also caused the ordinary citizen to consider rejecting any insurance and going "bare," not in the best interest of the individual or the community.

One wonders whether cooked books and grossly overpaid executive salaries have anything to do with the problem.

-- Guy N. Perenich, Clearwater

There are too many uninsured people

Re: Health insurance woes, letter, Sept. 8.

I just finished reading this letter. My wife, through no fault of hers, is one of the 40-million uninsured that the writer mentions.

In January of this past year, the company she was with decided not to write policies in the state of Florida. She has tried unsuccessfully to obtain insurance to no avail. Some of the questions asked by insurance companies include, "Have you ever been to a doctor?" What person over 55 could say no? In my wife's case she had a doppler test for the carotid artery, and the results were negative, but when they send for the doctor's records this shows up and they deny her the insurance. One agent said, we only want to insure healthy people.

My wife has a cousin up north who has severe arthritis but had no trouble obtaining insurance without doctor's records or home interviews. Does this policy change from state to state? As we all know, there are a lot of us seniors living here and some are without insurance. I think the powers that be should investigate this practice. A country like this should never have that amount of people uninsured. When a

national health plan is brought up, our leaders cry out, socialism. They are the same representatives who have full medical coverage for themselves and their families for as long as they live.

Another practice that should be outlawed is the one where you pay an administration fee from \$25 to \$40 plus the first month's fee. When you are notified that they don't want to insure you, they send the premium back minus the administration cost. They make some money even when they don't approve you. I think this practice should be stopped.

-- Is there anyone in our Florida government looking into the number of people living in this state who are uninsured?
Jack Joyce, Spring Hill

Our humanitarian Floridians

Re: This lady is my angel, Aug. 29.

The Times should have put this touching article on the front page of its main section. It is a superb example that makes one proud of our humanitarian Floridians of which Sheila Bolden-Foy is No. 1!

Her last patient in the Times article, a World War II U.S. fighter pilot, said of Mrs. Bolden-Foy: "You're the best thing that ever happened to America." I agree 100 percent. I'm sure there are many more like Mrs. Bolden-Foy in Florida that deserve public recognition in the near future.

-- Peter Hlinka, St. Petersburg

Dispensing love and joy

For years I've watched these precious aides as they toil for hospice and our beloved patients. Your story on Aug. 29 showed Sheila Bolden-Foy's radiance as she dispenses love and joy in her work. Your reporter also caught the powerful love she received from her patients. These aides are the very heart and soul of hospice. Thank you for honoring them.

Praise, too, for Dirk Shadd's stunning photos, from a hospice volunteer who learns from them at each opportunity.

-- Dorothy Lecain, Palm Harbor

Share your opinions

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They should be brief and must include the writer's name, address and phone number. Please include a handwritten signature when possible.

Letters may be edited for clarity, taste and length. We regret that not all letters can be published.

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Physician Malpractice Questionnaire

Survey Questions

1) What is the yearly volume of your department? _____

2) Are you residency trained in Emergency Medicine?

Yes	No
-----	----

3) Are you Board Certified in Emergency Medicine?

Yes	No
-----	----

4) Are you Board Certified in another specialty?

Yes	No
-----	----

If yes, what specialty?

5) Number of post graduate years in practice? _____

6) Number of post graduate years in Emergency Medicine? _____

7) Predominant type of Emergency Department in which you currently work?

Urban, Teaching

Urban, Nonteaching

Suburban

Rural

8) How many times have you been sued in the past 10 years? _____

Won at trial? _____ Dropped? _____ Lost at trial? _____

Settled with payment > \$25,000? _____

Settled with payment < \$25,000? _____

Currently pending? _____

9) Case Scenarios

Please read the following cases and objectively complete the questions.

A) A 10 year old previously healthy male suffers a witnessed fall striking his head onto the playground floor. Questionable LOC, no change in behavior, no nausea/vomiting. When seen by you, the patient is alert, oriented and acting appropriately with a completely normal neurologic exam.

How likely are you to perform a CT scan of this patient's head?

1	2	3	4	5	6	7	8	9	10
←					→				
Very Likely					Very Unlikely				

**Mount Sinai Medical Center
Department of Emergency Medicine**

Physician Malpractice Questionnaire

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

B) 65 year old male with a 10 year history of controlled hypertension complains of left flank/back pain. Patient has a recent history of exertion, onset was while lifting a heavy object. Pain is aggravated with motion and relieved with rest and NSAID's. Symptom duration is 10 hours. Patient denies bowel or bladder incontinence or paresthesias.

How likely are you to perform a CT scan of the abdomen?

1	2	3	4	5	6	7	8	9	10		
Very Likely										Very Unlikely	

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

C) 6 month old female brought in by her parents after a witnessed 30 second generalized seizure. Patient has no prior medical history. According to the parents she developed a fever earlier today with URI symptoms. The rectal temperature was 103.5 F at home. Treated with acetaminophen without relief 1 hour prior to seizure. In the ED her temperature is 104.0 F Patient has an unremarkable past medical history. On physical exam no clear focus of infection is noted. Patient is now alert, consolable and makes good eye contact.

How likely are you to perform a lumbar puncture on this patient?

1	2	3	4	5	6	7	8	9	10		
Very Likely										Very Unlikely	

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

Physician Malpractice Questionnaire

D) A 27 year old male without significant past medical history is brought in by EMS, he was involved in an MVA. The patient was the restrained driver, struck in the rear bumper by a second vehicle at < 10 mph. His air bags did not deploy, damage to both vehicles was minimal. He denies LOC or striking the interior of his vehicle, he walked out of the car prior to EMS's arrival. He is now on a back board with C-collar. Physical exam reveals very minor paraspinal tenderness at the level of C5-6.

How likely are you to perform a C-spine series on this patient?

1	2	3	4	5	6	7	8	9	10
Very Likely					Very Unlikely				

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

E) 45 year old white male brought in by EMS complaining of retrosternal chest pressure lasting <5 minutes after an argument with his wife this afternoon. Patient has no prior medical or family history of heart disease or diabetes. Pain was not associated with diaphoresis, no nausea, no palpitations, no pain radiation. Pain has completely resolved. First EKG is completely normal.

How likely are you to obtain a set of cardiac enzymes?

1	2	3	4	5	6	7	8	9	10
Very Likely					Very Unlikely				

How likely are you to admit this patient?

1	2	3	4	5	6	7	8	9	10
Very Likely					Very Unlikely				

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

Physician Malpractice Questionnaire

F) A 45 year old female without significant medical history, LMP 15 days prior to arrival comes into emergency department after a non-syncopal trip and fall complaining of right wrist pain. She has minimal pain in the wrist joint. There is no bony tenderness to palpation and no snuffbox tenderness.

How likely are you to order an x-ray in this patient?

1	2	3	4	5	6	7	8	9	10
Very Likely					Very Unlikely				

How do the recent trends in malpractice litigation affect this decision?

1	2	3	4	5	6	7	8	9	10
Encourage			Neutral				Discourage		

10) Comments: _____

11) Can you describe a situation in which your clinical practice is affected by malpractice litigation concerns? _____

12) The threat of malpractice litigation adds excess stress to my practice.

1	2	3	4	5	6	7	8	9	10
Agree Strongly		Agree Somewhat			Disagree Somewhat			Disagree Strongly	

13) I have ordered tests in my clinical practice strictly due to the possibility of future litigation, even when I did not think the test was clinically warranted.

1	2	3	4	5	6	7	8	9	10
Agree Strongly		Agree Somewhat			Disagree Somewhat			Disagree Strongly	

Physician Malpractice Questionnaire

Survey Questions

1) What is the yearly volume of your department? 2 <10,000
25 10-20,000 63 21-30,000 61 31-40,000 36 41-50,000 28 51-60,000
36 61-70,000 34 71-80,000 10 81-90,000 18 91-100,000 13 >101,000

2) Are you residency trained in Emergency Medicine?

192 Yes	117 No
------------	-----------

3) Are you Board Certified in Emergency Medicine?

253 Yes	57 No
------------	----------

4) Are you Board Certified in another specialty?

76 Yes	234 No
-----------	-----------

If yes, what specialty?

Underseas & Hyperbolic medicine

2 General Surgery

Toxicology

Pain Medicine

Forensic Medicine

Addictions Medicine

General & Plastic Surgery

OB-GYN

11 Pediatrics

26 Internal Medicine

26 Family Practice

5) Number of post graduate years in practice?

9<1 68 2-5 56 6-10 58 11-15 49 16-20 50 21-25 23 >26

6) Number of post graduate years in Emergency Medicine?

10 <1 74 2-5 64 6-10 49 11-15 57 16-20 40 21-25 19 >26

7) Predominant type of Emergency Department in which you currently work?

60 Urban, Teaching

101 Urban Non Teaching

135 Suburban

12 Rural

Physician Malpractice Questionnaire

8) How many times have you been sued in the past 10 years?

139 0 96 1 38 2 21 3 10 4 7 5 3 6 1 7

Won at trial? 15

Dropped? 230 0 53 1 12 2 5 3 2 4

Lost at trial? 290 0 3 1

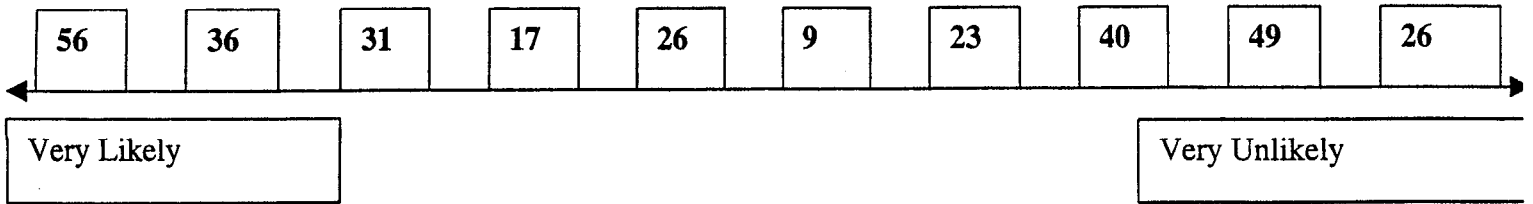
Settled with payment > \$25,000? 94

Settled with payment < \$25,000? 22

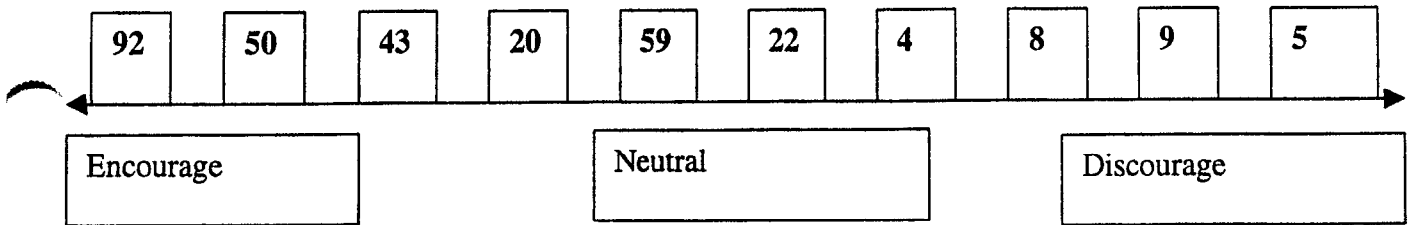
Currently pending? 241 0 54 1 12 2 2 3 1 4

9) Case Scenarios

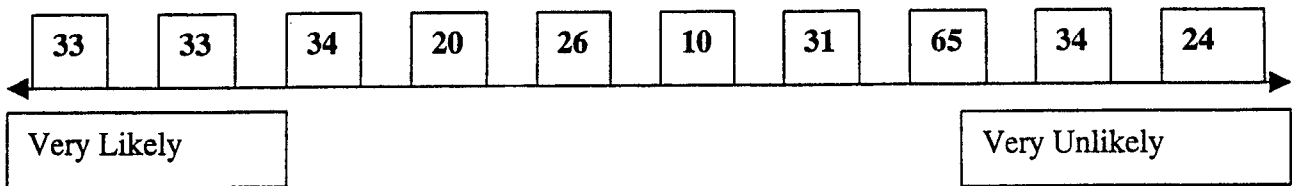
How likely are you to perform a CT scan of this patient's head?.



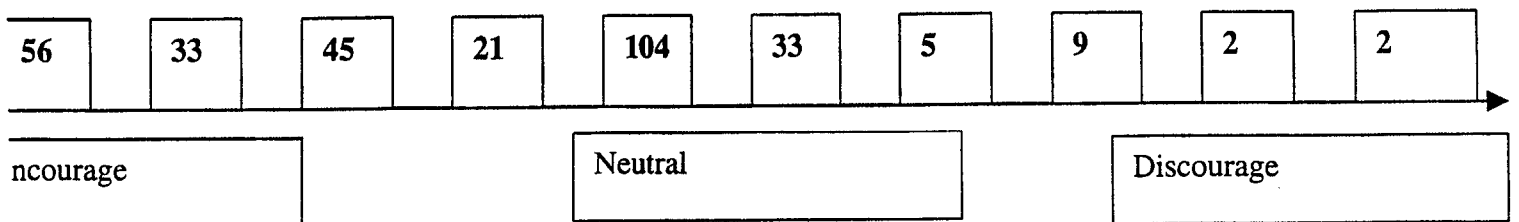
How do the recent trends in malpractice litigation affect this decision?



How likely are you to perform a CT scan of the abdomen?

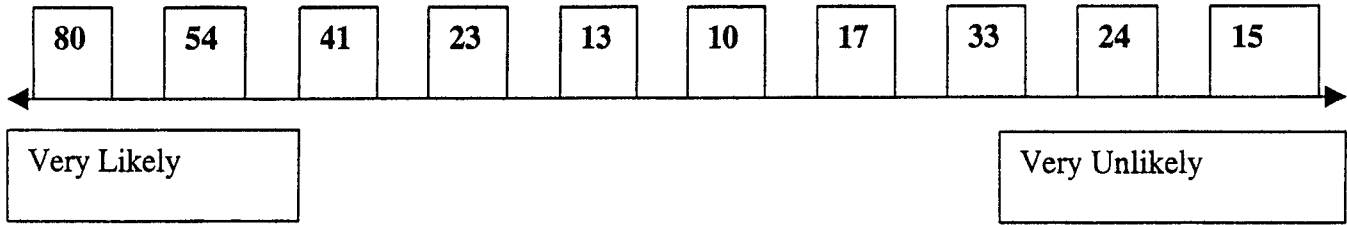


How do the recent trends in malpractice litigation affect this decision?

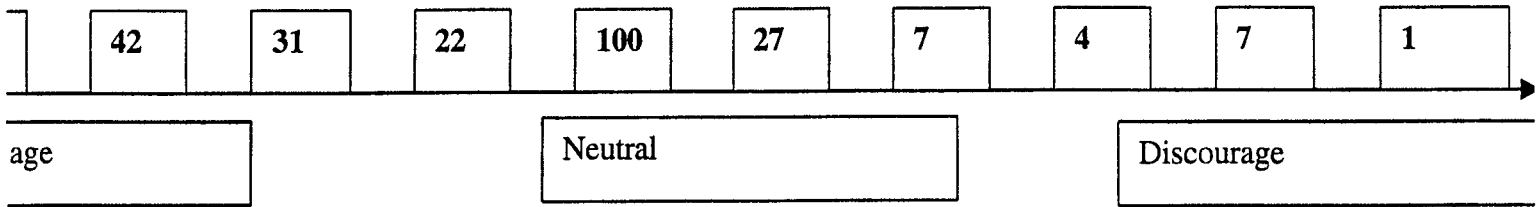


Physician Malpractice Questionnaire

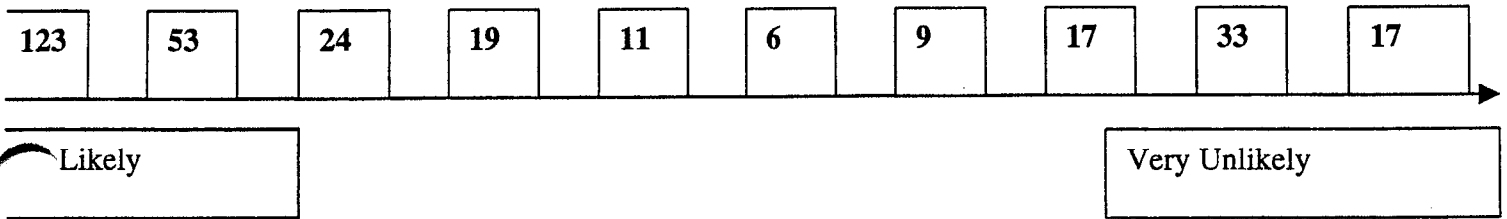
How likely are you to perform a lumbar puncture on this patient?



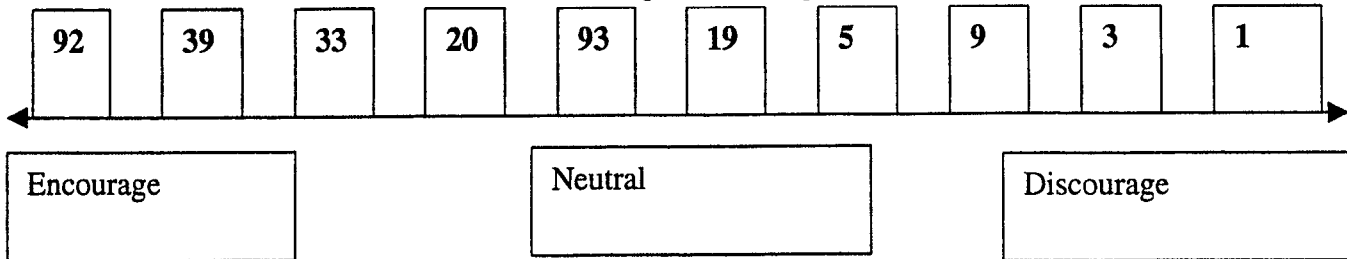
How do the recent trends in malpractice litigation affect this decision?



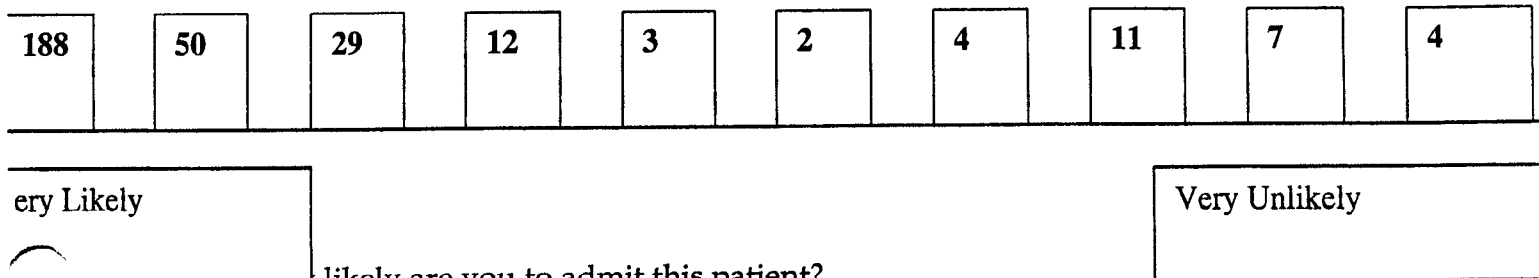
How likely are you to perform a C-spine series on this patient?



How do the recent trends in malpractice litigation affect this decision?

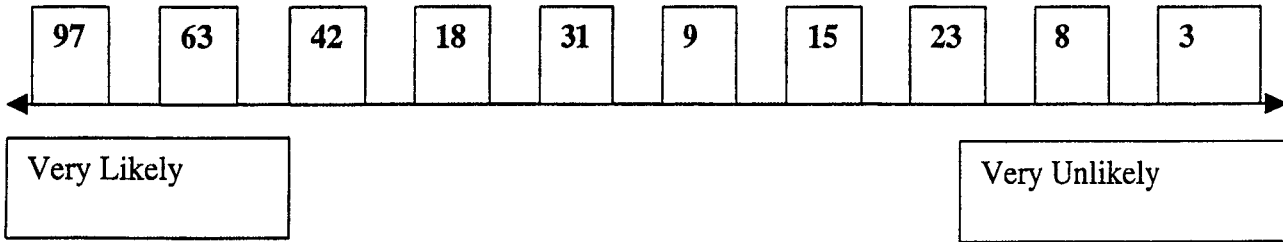


How likely are you to obtain a set of cardiac enzymes?

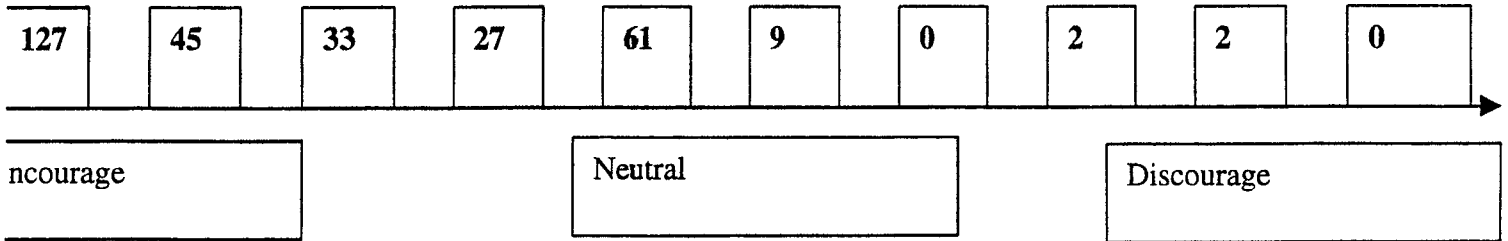


How likely are you to admit this patient?

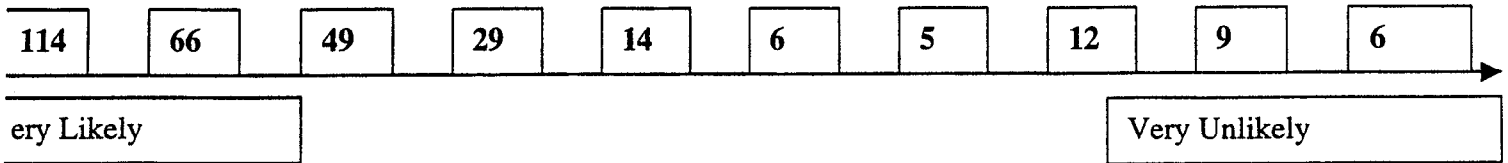
Physician Malpractice Questionnaire



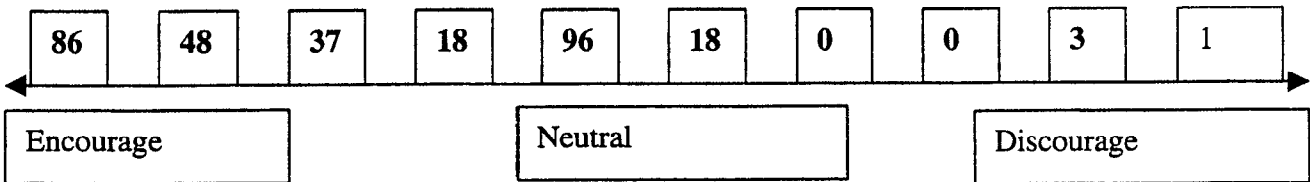
How do the recent trends in malpractice litigation affect this decision?



How likely are you to order an x-ray in this patient?



How do the recent trends in malpractice litigation affect this decision?



10) Comments:

Speaking for myself, there is certainly liability-minded decision making. I think it's part of the specialty we chose. In some of the examples, I think ordering certain tests is simply good practice.

I do not practice common sense based medicine anymore. I practice CYA.

I know this looks biased to always say malpractice concerns are at that level, but it is true. The only thing close to it: "consumer demand/satisfaction" ordering. Medical necessity would be 3rd.

PLI very definitely makes me order considerably more X-rays.

X-rays are ordered, not because you suspect will be abnormal, but to document negative results for future litigation.

Physician Malpractice Questionnaire

In this litigious climate I am more likely to work-up and document negative findings rather than utilize my clinical judgment on obviously benign illnesses. Because of this movement of patients through ED is slowed, and work is more tedious.

Each of these scenarios has potential tiger trap in it. Just as in real life. At least one part of what we do is to evaluate and treat based on limited information, whereas we DO have an issue with malpractice litigation it only affects our practice if we let it. I do practice more cautiously than I did when I first began this specialty, and that's not all bad. I do refuse to practice frightened medicine. I do refuse to "run scared" from every potential "train wreck" I see, and I still enjoy the VERY special opportunity for practice which EM affords us all. WE just need to take back our own practices.

I don't allow trends in litigation usually influence my decision.

For years I have practiced medicine in the best way I saw it. Now, I am forced by the group and my malpractice to practice defensive medicine for the last 1 ½ years. If I do not practice defensive medicine, I might not have a job with them. It is a very tough environment with paranoia.

A bad situation is in many respects. It needs government intervention and reform for caps on jury awards.

There is no protection in ordering tests. Defensive medicine is a myth.

Missed FX are one of the leading causes of malpractice litigations.
What is the point? Until we get total reform, we will all practice defensive medicine.

Most questions you asked were "standard of care" questions. My responses would not be based on litigation, it is simply what I would do. Cardiac risk is too risky to be overlooked.

I think about malpractice constantly. Especially with chest pain, OB-GYN and pediatrics.
Documentation is critical and rapport with family.

What we know should do and what we must do for medical legal reasons often are at odds.

I order \$5000 to \$10,000 of probably unnecessary tests per shift because of the need to practice defensive medicine.

I seek to give optimum patient care. That is the best preventative and defense against medical litigation.
The cost of insurance is more of a problem than the threat of a lawsuit.

If a patient wants or asks for a test of exam, I almost always order it.

If the patient has a negative PE and she has good common sense I might give her the option of taxing or not with good down.

My decision to order tests are based on what's best for the patient. It's not malpractice if you always treat a patient as you do your concerns for your own family. You and your patient will be fine.

Some of what we do is pushed by patient expectations and hospital peer reviews. Malpractice is a major concern sometimes knowledge or experience come into play. (sarcasm)
The number one factor to my decisions has been my personal experience clinically.

Workers comp liability if work related also affects decision to X-ray. Patients have therapeutic X-rays

Physician Malpractice Questionnaire

done everyday. It makes them feel better.

I need more clinical information. Why did the patient come to the E.D., was there swelling, was there pain on ROM.

Most of emergency physicians I know here today are practicing purely defensive medicine. This is in such a great contrast to the practice I was involved in the UK for 10 years some 24 years ago.

In a past statistic I heard malpractice concerns were only a small dollar cost of medicine. I disagree and feel this statistic may take into account the test ordered (in the ER) but fails to take into consideration the cost of unnecessary admissions, caths, consultations, MRIs, etc.

Needless tests needless referrals, needless follow-up visits, needless treatments are all done routinely by virtually all ER physicians due to the litigations of malpractice looming over.

Patient satisfaction plays an important role in the decision.

More information should be given on case scenarios for better decision making.

There are some other things that affect it so not all are of the extreme and including patient choice to refuse exam.

Malpractice litigation in FL leads to excessive testing hospital litigations and costs to avoid it. Some EDPs even drastically reduce their productivity to avoid medical malpractice suits and worsen delays in care.

It has come to the point in which I believe that if nothing wrong has been performed you are still likely to be sued if there is a bad outcome.

Most commonly, vague complaints from anxious patients require pushing expectations which could be done by their private physician if the fear of missing something was not there.

We have allowed the malpractice attorneys and patients with minor complaints and big hopes of winning a large settlement dictate our practice. We are no longer in charge. We are no longer able to practice medicine. We are just trying to keep the wolves from our heels. We are not allowed to make a mistake- EVER! The ED has turned into a war zone, and we are losing.

What gambler would take our odds- get \$50 -\$150 trying to save a life and could face all your personal assets each visit.

I do not practice defensive medicine. I practice evidence based medicine. If this is the standard to which I hold myself.

Often X-rays are ordered by nurse at triage. Practice habits are sometimes affected by practices and availability of adequate next day follow-up.

The threat of lawsuits and concerns reliability often affects every MD in our ED. You can sense it in so many of the patients. It is just beneath the surface. It is not unusual to hear patients say "I'll sue."

Excellent examples of how the need to practice "zero-rills" medicine drives the massive increase in costs.

Mixed X-rays, no matter how trivial, would be jumped on by the attorney.

We practice in fear. Many of the tests I ordered above, I would not have done if it were not for litigation

Physician Malpractice Questionnaire

fear.

Last questions answer affected more by community expectations than mal-practicing risk.

Although many decisions are affected by malpractice threat, this is not new. I don't think I've changed much the last few years.

We handle chest pain on a 23 OBS protocol in the ED that includes a stress test prior to discharge.

I have assumed that "encourage" and "discourage" refer to malpractice litigation supporting or not supporting my decision. IE. I try not doing heard CTs in the cases provided but I realize that malpractice fear would discourage my decision.

It is hard to postpone evaluation that could be done routine.

Many of these scenarios (although described very well) still requires clinical interaction and a "gestalt" of what is required.

I remain open to change decisions depending on patients or family knowledge or concerns. Their conflict level with the situation at Hamel is very important and carries certain degree of influence.

Inability to get malpractice insurance for our group has placed our large (5 hospital) group in peril and threatened the demise of our group.

Your questions about "trends in malpractice" give somewhat useless. When would anyone consider today's malpractice climate a reason "discourage" any test.
Risk of outcome has changed little.

Before making a final decision on whether to order most tests I would acquire more information both Hx and lab data.

Several of these cases need more information to arrive at the decision point you are inquiring about.

These scenarios are too incomplete to be meaningful. Case B for example lacks a general description of the patient, or the vital signs. How can the response to this be helpful.

Unless there is literature to support less conservative management (Nexus study for who needs C-Spine X-rays) I feel compelled to take a conservative route with my patients whether my index of suspicion is high or not.

Malpractice litigations are always in the back of my mind. The problem is that anyone can sue for anything, anytime, and whether or not the care was appropriate; patients get settlements.

The legal profession "rewards" patients for their injuries. I will maintain a defensive medicine posture. If there is any question, I will probably get a test, an X-ray.

Depends on numerous other factors. Workman's comp, MVA HX, patient insistence all make X-rays more likely.

Malpractice trends discourage you from practicing clinical medicine as taught and encouraged Dr. studies, etc. Cover yourself in the event of litigations.

Physician Malpractice Questionnaire

When ordering tests a bit of the decision process is influenced by patient and family expectations. Rational explanations are not always effective, especially the more educated the patients are. Malpractice is a huge factor in this country. The diagnostic technology we have is phenomenal but also very expensive. The public pays a lot of attention to the media, which often gives a one-sided view of the latest medical advances and everyone expects "the best care" despite cost and often times limited value of a test or medicine. At the same time, patients and insurance companies often do not pay for the best care.

The malpractice crisis is the biggest challenge facing physicians today.

In Florida, it's not "if" malpractice, but how much to settle for. In my settled cases, I did not feel I did anything wrong, but I was forced to settle. In once case, I didn't even see the patient.

You have to ask yourself why patient is in ER and what is their expectation of the visit.

American medical practice has long been conservative and risk averse in part due to malpractice concerns. This is only accentuated by recent trends.

I strongly concur with one of my partner's sayings he uses to justify the unnecessary ordering of tests for medical reasons..."I'm no one's lottery ticket."

You should use visual analogue scale with no numbers other than zero and one at each end.

We have had to decrease our coverage limits to be able to afford malpractice insurance for our group and have had to seek financial supplements from the hospital for the first time in our group existence.

If a FX being missed (even if it is unlikely to have FX) Physician might get into malpractice suit. Also X-ray is simple test, easy to do, even if preceded by BHCG.

For chest pain patients, we are performing immediate treadmill stress tests on moderate and low risk patients in the ED prior to D/C/ or admit.

Every case has it's own nuances. These scenarios are very simply stated. Was the patient requesting X-rays, CTs, etc.? Were parents upset, reasonable.

I believe a "careful and conscious practice" is what patients deserve. This is what guides my practice. Not the threat of malpractice. Doing the best for the patient, regardless of cost or malpractice concurs will always make you a winner. You may have to work harder, but that is why I chose my profession, and I an a winner.

We must practice defensive legal medicine and cover all the bases. You get one chance. All patients today are potential litigation dollars.

I am now much less cost effective than I was during residency. I tend to over order tests with low probability of positive findings because it is sure that a suit will be filed for an unexpected outcome.

The current legal system is destroying the art of medicine, negatively affecting patient care and encouraging conflict between patient and physician.

It is not clear on the "encourage/discourage" scale. I interpret it as does litigation trends discourage one from doing the appropriate choice.

Occasionally I order tests for "reverse" legal reasons. I document that the "on the job slip and fall" does

Physician Malpractice Questionnaire

NOT have a FX. Because I know that they will end up in court even if I don't.

Most of the patients want an X-ray.

11) Can you describe a situation in which your clinical practice is affected by malpractice litigation concerns?

Fall at grocery store.

The art of CYA is directly proportionate to the consequences of the outcome.

If test/procedure is "gray zone" indication and patient wants test after, explaining options will do it. If tests not indicate patient requests one, I will not do it.

I have increased admissions of chest pain patients, even a typical chest pain.

I don't usually take care of adult patients.

Chest pain/severe H/A fever in children.

Almost every patient concern.

X-rays to rule out foreign bodies 23h admit for rule out MI.

Too many to list.

Headaches/Subarachnoid hemorrhages

Chest pain rule out ACS.

I X-ray a lot of bones I'm pretty sure aren't broken. If the malpractice situation was different, I probably develop the films for 7-10 days.

Most patients, the elderly population.

US on all early OB bleeds and confirm IUP vs. ectopic.

Constant factor in all decisions

Patients with chest pain, even low risk we admitted due to malpractice risks.

Always almost all CTs and V/Q scans ordered to rule out situations that maybe on the differential but low down.

Ordering extra labs and X-rays.

So many situations occur on a daily basis. It affects virtually an significant true emergency.

The evaluation of stroke and the pressures to use thrombolytic TX when it has not been proven safe TX.

Cardiac workup on all chest pains

Physician Malpractice Questionnaire

I can not think of any that are not.

CT and in old people- nearly always with abdominal pain. Abdominal pain in children, chest pain.

Chest pain observation center developed as marketing tool and malpractice tool.

Mostly chest pain and abdominal pain workups are increased.

Unnecessary X-rays and labs ordered all the time.

Any back pain , previous surgery needs a complete work up.

Increased use of X-rays to document negatives.

Ordering unnecessary tests to cover minimal chance that a disorder might exist.

We have had increased CT usage to rule out apy in abdominal pain work up.

I almost always order chest CT's to rule out aortic dissection when chest pain radiates to the back even when the CXR is normal and the pain is clearly anginal in quality.

Most low risk clinical suspicion presentations of potentially serious conditions.

Virtually every interaction has CYA testing or wordy explanations on chart why no tests after a patient encounter only the labs and the chart exist. Do only one deposition and you see how a 2 year old encounter is solely a conspiracy of the chart and the labs. I am the least testing doctor in my group with the highest discharge percent. However, I walys treat the chart, get those damn knee jerk labs based on triage/nursing note chief complaints. Chest pain in 30 year old merits an EKG and one set of enzymes. Cough ESOB = CXR. MVA -X-ray everything that hurts ,etc, etc. Do ER medicine for a few years and the "remember that patient you saw yesterday" phrase changes your practice behavior. Though this may be more prominent in double and triple coverage EDs where doctors chat and talk along side each other the whole shift.

ERR on conservative side is now good rule.

Chest pains, headaches.

There is not a situation where it is not affected.

CT head for minor trauma admission of virtually all chest pain.

Malpractice, previous affect on salary increases

Almost daily, ordering unnecessary exams, tests, labs, done for litigation reasons.

Pelvic U/S in pregnant patients.

Increased likelihood to admit and to order multiple testing.

CT scans of head in migraine and head injury

Physician Malpractice Questionnaire

Chest pain- far more admits than warranted

Daily ED patients have a higher incidence of litigation

All the ones you mentioned if they had a little more in physical findings

Cervical pain MVC

I think every patient is a possible litigant. I try to methodically evaluate, assess, and diagnose patients. If there is any question, I do the tests.

All chest pain patients.

Crack chest pain admissions, MVAs in C-collar for cervical pain.

Headaches

Every patient, every case.

Admitting chest pains

Chest pain admits

Headache work up

Strokes TBA

Chest pain

Every patient I care for is a potential lawsuit.

Virtually every day I work in some way.

Almost all where an unlikely but potentially lethal outcome could occur.

Chest pain

No, however in Occupational Med this is slightly different

Results in spurt increase in costs to patients, and decrease in physician/patient relationship.

Principally regarding chest pain and meningitis (despite "C")

All chest pain and SOB patients, many abdominal pain patients, ordering CTs, etc.

Chest pain, very affected, potential missed fractures, very affected.

Inability to get malpractice insurance for our group has placed our large (5 hospital) group in peril and threatened the demise of our group.

Physician Malpractice Questionnaire

Head injury, chest pain, and abdominal pain

Lack of timely/appropriate follow-up

Ordering tests that the patient requests even though I believe them to be of low yield.

Rule out ectopic, SAH, Aortic dissection, elderly falls, trauma

Abdominal pain, threshold for CT of abdominal now very low

I order more tests

I worry about all cases.

Cost control

A typical chest pain more often admitted

Any patient presenting with chest pain

Every patient I see

Order more tests without a doubt . The threat of a lawsuit.

Head injury, abdominal pain

I limit resident documentation so that my charts are reflective of my impressions.

Chest pain, rule out Ectopic

Chest pain, headache, PEDS

Malpractice insurance premiums are driving us out of business

All chest pain patients and any arm pains are admitted

All the time, in every patient

Baker act, any possible suicidal/homicidal individual

Admitting lower risk chest pains

Chest pain, abdominal pain, PEDS

Parents in A request CT. Patient in F requests X-rays, etc

Need to see more patients to cover cost of malpractice.

Chest pain and headache

Head CTs in elderly with falls

Physician Malpractice Questionnaire

Overuse of X-rays

Any close calls get worked up and admitted
W/U and admission of low risk chest pain

All of my clinical practice is affected by malpractice concerns

With virtually every patient, I try to rule out the worst case scenario sometimes by history, sometimes by exam, and sometimes by tests.

Thrombolytics for acute CVA

Admission of D/C/ home orthopedics

Headache, chest pain, back pain, abdominal pain

Chest pain admits, headache

Headaches, low risk Chest pain

Any chest or abdominal pain

I used to say a prayer on the way to work, "God, let me use my skills and knowledge to help people today." Now after five lawsuits and the threat of a 6th in my 23 year career, I've changed my prayer to "This shift, everyone is sick, everyone is injured, everyone gets a work-up. I am not going to work today to save patients, time, or money. I will not be sued today." How's that for an attitude adjustment.

Most of the lab, many of the X-rays I order.

Stroke symptoms.

Chest pain

Abdominal pain evaluations

Chest pain, headaches, PED fever

For the most part, it drives my decision making now. It will ultimately be the reason I leave EM.

PE evaluations

One of the first things I think of in every case I see today is how to avoid a potential malpractice litigation here.

Patients in chest pain and headaches, CVAs

Admit almost all chest pains. Use of CTs for abdominal pain and headache injury.

Preventing litigation is my biggest concern

Physician Malpractice Questionnaire

Serial cardiac enzymes

Risk management data has sharpened my skills to look for the common pitfalls and to be very careful and thorough in my next physical.

Head CT for every minor head trauma

Every patient is a malpractice concern

All concur decisions

90 % of decisions regarding lab or X-rays are somewhat driven by this.

Patients who demand certain testing

Most of the lab and X-rays that we do in the ER are for malpractice litigation concerns.

CVA Chest pains and low risk factors

Retained foreign body

If you're conservative and cautious, there shouldn't be a problem.

All chest pain with any risk factors get admitted.

I can not hire new doctors for my urgent care clinic. No one is writing new policies in Florida.

Major factor in stopping (retiring)

Poor response time of an on-call consultant (surgery, OB/GYN, etc.)

More consults more W/U

Where the patient or family asks for high specificity answers.

Increased testing

Being asked for orders on patients admitted or awaiting transfer to another facility, while they remain in emergency department but attending MD and ER physician who originally evaluated the patient are no longer present in the department.

Chest pain more likely to be admitted

Prolonged and unnecessary tests are routinely performed which increases patients waiting room time.

Daily requirement for excessive diagnostic testing and excessive documentation

Chest pain, work up for HAs

Every patient encounter is an opportunity for litigation.

Physician Malpractice Questionnaire

Abdominal pain and over utilization of labs and/or CTs

Not only could I be sued, but my gray review charts put a lot of unnecessary stress in our practice.

Head and neck injuries

Abdominal pain

When patients or families are insistent on extensive diagnostics or admit

Most abdominal pain receives a CT scan

I don't blow off the crocks. I treat them all equally and with care.

Patient asks for some tests that does not need

The half of a shift I spend on documentation, for one: knee/ankle films for probable sprains would be another. The patient sent by a malpractice attorney for cervical spine evaluation two days after a car accident is another, as is the chronic pain patient sent to the ED for a narcotic refill because "they have to address your pain." Should I continue?

More likely to work-up and admit obviously none cardiac causes of chest pain whenever there is age or other risk factors present. Also the age at which I am more cautious has drastically decreased.

I order more exams due to this concern.

My malpractice premium tripled since last year while my population is becoming increasingly litigious.

Increased performance of L.P.s on PTs and how likelihood of CNs

Do need more for legal reasons than medical reasons.

Patient with severe headache without obvious cause.

Nurses notes state "worse headaches of life" PT gets LP regardless of clinical judgment.

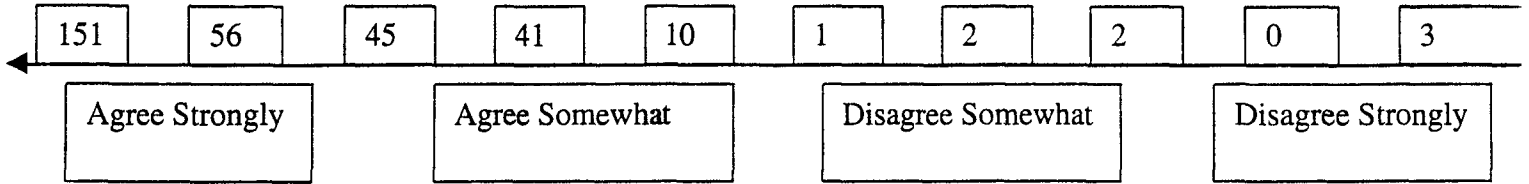
Every situations, patient I see, and chart I write is affected by this

Working up and admitting nearly all chest pains

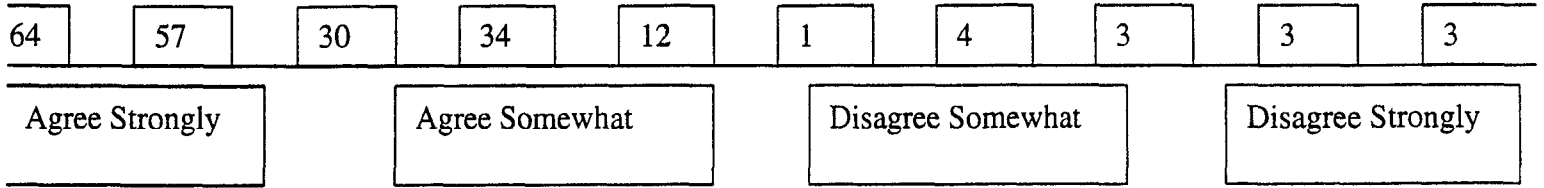
It's impact on the surgical specialists who are resigning from medical staffs, leaving the ED potentially uncovered.

Physician Malpractice Questionnaire

12) The threat of malpractice litigation adds excess stress to my practice.



13) I have ordered tests in my clinical practice strictly due to the possibility of future litigation, even when I did not think the test was clinically warranted.



Selected Comments from Emergency Physicians

Recently we have had two physicians leave the group and have been unable to find replacements because of this situation. In addition to the financial impact described above, the severe attrition of companies in the primary market has made it nearly impossible to find coverage for new physicians with even a single claim history. The only ones that they are willing to cover are those with no claims. This basically limits us to hiring physicians right out of residency rather than those with any experience, even though the experienced doctors are probably less likely to have claims in the future. Up until last year, our insurer (for seven years) has given us a discount because of a favorable claims history. Now our rates have skyrocketed and we are being told that we may be non-renewed at the end of the year. As a result of our inability to retain doctors or find replacements we have had to scale back plans to increase coverage. Combined with the hospital's inability to recruit nurses, this has resulted in long waiting times and increased diversion of ambulances.

Withdrawal of on-call specialists has been a major problem, particularly at Palm Bay Community Hospital. There we have no coverage for OB, vascular surgery, hand surgery, plastic surgery, urology, or neurosurgery. We have very thin coverage for cardiology, pediatrics, and other specialties. The high risk of litigation with emergency cases, coupled with the poor reimbursement (high percentage of uninsured patients), and is driving specialists off of hospital on-call panels. This is true in other states as well, but is particularly critical here. Just 2 days ago I had a patient come into the ER by ambulance in critical condition due to a leaking abdominal aortic aneurysm. Because of the recent withdrawal of vascular surgery coverage I had to transfer the patient to Holmes Regional Medical Center for emergency surgery. Another ER physician had to call multiple hospitals around the state in order to secure treatment for a patient with a thoracic aortic dissection. At Palm Bay we have to transfer about 40 patients per month because of these problems.

At Holmes Regional, we have had extreme difficulty in arranging treatment for hand injuries, despite the fact that we are a Regional Trauma Center. Most of the orthopedic doctors will no longer take care of hand injuries. It appears highly likely that our neurosurgeons will withdraw privileges from the trauma center and move their practices to the new (non-trauma center) hospital opening in Melbourne. Our night-time x-rays are being read by radiologists in Australia because the local group cannot attract new members.

Quite frankly, the members of our group are fed up with the situation in this state. We are tired going into work knowing that everything we own is on the line with every patient we see. We're angry knowing that our insurance coverage can be pulled at any time or that our rates can increase by 50%, 100% or more in a year. We're afraid that if we get even one claim made against us that we will be unable to work because of no access to insurance. Some of us are planning on leaving the state. Others are looking for

a way out of medicine entirely. Something needs to be done (and done fast) if we are to avoid a complete melt-down of the emergency care structure in the state.

Michael Shapiro, M.D.
Melbourne, FL

Every week patients are impacted by the malpractice crisis. Last week I had to send a subdural hematoma to St Joseph's in Tampa (another county) because no neurosurgeon available. My neurosurgeon is now covering most of the north county when he is on, his insurance quote was \$250000 coverage for \$200000.

This is not a physician issue, this is a community and patient issue, already there is no specialty coverage and the patient might end up in another county. Insurance is for medical expenses, loss of wages and possibly a small \$250000 pain and suffering, it is not a lottery.

Roberto Bellini, M.D.
Tampa, FL

My husband retired from the military after 25 years in military medicine as an OB-GYN. After his retirement 3 years ago we moved to Clermont Florida and he tried to open an OB-GYN practice in the growing community of Clermont. South Lake hospital in Clermont is presently building a new women's medical center, with the plan to deliver babies. Presently women drive 20 miles to Orlando for obstetric care. Unfortunately, my husband was unable to obtain reasonable malpractice insurance...all his quotes were way over \$100K per year. He will not open a practice now. Florida will not benefit.

Cheryl Durstein-Decker, M.D.
Clermont, FL

When I was working regularly at New Port Richey, there were patients that suffered because of specialists refusing to take call. We did have to transfer patients to other hospitals for the same reason. I can recall a case where an elderly patient with significant b/l epistaxis needed to be admitted and the primary refused to admit because of no back up ENT availability at the hospital. The ENT specialist who was normally consulted for in-patient care by the primary attending refused to accept the consult because he wasn't on call and he could refuse the consult if he so chose. After several hours of unnecessarily wasted time (for the patient and me) we made arrangements to admit the patient with an appropriate specialist consult.

Hema Pandit, M.D.
Tampa, FL

In Orlando we have face shortages of several specialists for some time; particularly a problem with General Surgery, Plastic Surgery and Neurosurgery. All three of these specialties are so short that the Florida Hospital system (Seven Hospitals with >250,000 ED visits per year) has been forced to transfer patients to the specialist (They have been unable to provide adequate coverage at all campuses). Recently Obstetric and Orthopedics have been severely affected by shortages of coverage.

The current Malpractice crises directly affect the Medical Staffs ability to provide specialist coverage at all of our facilities. The increased cost of Liability Insurance expenses, affects the Hospital ability to provide adequate nursing staff, which directly affects our ability to provide adequate ED care. It indirectly affects our ability to provide care due the absolute necessity to practice VERY DEFENSIVE MEDICINE, which increases ancillary test utilization and admissions.

Vidor Friedman, M.D., FACEP
Orlando, FL

Summary of Material Provided by the Florida Nurses Association

The Association is concerned that the medical malpractice crisis will have an adverse impact on nursing. The Association reports that some hospitals have responded to significant premium increases by cutting staff to lower overall operating costs, lowering the limits of employer-provided liability insurance, limiting involvement in the education and training of new healthcare providers, and by decreasing services, such as trauma care.

In addition, the Association is concerned that if physicians decide to reduce costs associated with perceived risk by limiting collaboration with nurse practitioners, nurse midwives, and nurse anesthetists, these specialized nurses will no longer be able to practice if physicians do not collaborate with them.

The Association did not recommend specific litigation reform but provided some tort reform options:

- (1) decreasing the amount of awards, e.g., caps on non-economic and punitive damages, and
- (2) changes in legal procedures, e.g., mandatory pre-litigation dispute resolution and restrictions on the time within which plaintiffs have to file suits.

Other measures being considered by the Association include:

- (1) quality assurance reforms aimed at improving patient care;
- (2) increasing public access to information, e.g., publication of disciplinary actions taken by medical and nursing boards;
- (3) insurance reforms, e.g., allowing insurance companies more time to pay awards, basing premiums on individual performance ratings, creation of larger insurance risk pools, and creation of new insurance products; and
- (4) possible reinvestment of a percentage of malpractice awards back into healthcare, e.g., for improvements in staffing and the integration of patient safety technology.



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PATRICIA A. QUIGLEY, PHD, ARNP, CRRN
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PAULA MASSEY, RN
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November 7, 2002

The Honorable J. Dudley Goodlette
Chair, Medical Liability Insurance Workgroup
Room 1102, The Capitol
402 South Monroe St.
Tallahassee, FL 32399-1300

Dear Representative Goodlette,

Thank you for the opportunity to submit the position of the Florida Nurses Association regarding the current problem, rapidly becoming a crisis, regarding the cost or unavailability of Medical Liability Insurance for health care providers in Florida.

Nurses are the largest group of health care providers in our State and Nation and they are "on the front line" of the provision of health and medical services in every setting where services are provided. Most importantly professional nurses are patient advocates as they care for all persons from birth to the end of life and nurses individually and collectively are very concerned that Florida's citizens are losing access to competent and dedicated health care providers.

I have attached a statement developed by two of our members, Dr. Dee Williams, PhD, RN Associate Dean of the College of Nursing at the University of Florida and Dr. Suzanne Collins, PhD, RN, Esquire a Nurse Attorney and Nurse Educator in Tampa, Florida.

The Florida Nurses Association is also signing a document prepared by the Florida Hospital Association for submission to your work group as we believe that document to be a good statement with suggestions for solutions.

The Florida Nurses Association believes that legislation to reform the current litigious environment of our health care system is needed but we also believe that all stakeholders must come together to participate in discussion and action to make health care practices safe for patients in every health care setting. We must move beyond rhetoric and come together as health care colleagues, policymakers, and consumers to join together to promote collegial and safe environments for the delivery of health care services.

Sincerely,

Patricia A. Quigley, PhD, ARNP, CRRN
President
Florida Nurses Association

Barbara Lumpkin, RN
Associate Executive Director
Florida Nurses Association

**TESTIMONY TO THE GOVERNOR'S SELECT TASK FORCE ON
HEALTHCARE PROFESSIONAL LIABILITY INSURANCE**

On behalf of the

FLORIDA NURSES ASSOCIATION

October 21, 2002

Statement of the Problem

The escalating cost of healthcare professional liability insurance is a very serious issue.

When insurance premiums rise to prohibitive levels, healthcare providers and their patients are negatively affected.

Insurance company investments have declined in value, and paid or pending claims, including those for malpractice lawsuits, have increased. In response, insurance companies have raised premiums or have stopped providing healthcare liability coverage in those states where jury awards have been the highest. The Florida Nurses Association urges the members of the Governor's Task Force to make thoughtful recommendations for legislation during the 2003 legislative session to relieve the current medical malpractice crisis in Florida.

Significance of the Problem – To Nurses in Hospitals

Nationally, some hospitals have responded to significant premium increases by cutting staff to lower overall operating costs, lowering the limits of employer-provided liability insurance, limiting involvement in the education and training of new healthcare providers, and by decreasing services, such as trauma care.

1. Decisions to cut staff impact nurses as the largest group of hospital employees.

Eliminating nursing positions results in a decline in the quality of patient care.

2. Decreasing the amount of liability coverage purchased by hospitals has the potential to increase the nurse employee's chances of being sued individually if the hospital employer's aggregate coverage limit has been reached.
3. Conflicts of interest arise between the nurse employees and the hospital employer as the aggregate policy limit is approached if other claims are settled before ones involving nurse employees.
4. Nursing organizations have long recommended that nurses purchase their own liability coverage, but many have not done so. The price to practice nursing will increase as nurses find it necessary to purchase their own insurance and hire their own attorneys when sued. In the face of a severe nursing shortage, increases in the price to practice decrease the attractiveness of nursing as a career choice.
5. As a result of attempts to reduce risk, hospitals become reluctant to participate in the education of healthcare professions students, thus adversely affecting the labor pool of future healthcare providers.

Significance of the Problem - To Nurses in Collaborative Practice With Physicians

Some physicians decide to reduce costs associated with perceived risk, including those of escalating liability insurance premiums, by limiting collaboration with nurse practitioners, nurse midwives, and nurse anesthetists, professionals who help address unmet healthcare needs in the state. Other physicians decide to reduce, or even totally eliminate, the amount of liability coverage they carry. This places the collaborating advanced practice nurse in a position of increased lawsuit exposure.

1. Nurse practitioners, nurse midwives, and nurse anesthetists are required by Florida law to have practice protocols with licensed physicians. If physicians are reluctant to partner with these advanced practice nurses, they cannot practice.
2. As more advanced practice nurses are being sued, especially nurse anesthetists and nurse midwives, they are experiencing the beginning of significant increases in liability insurance premiums. Although the increases have not been as severe as for physicians, it is anticipated that these nurses will face the same decisions as their physician counterparts – how to cut costs, and whether to limit services or leave healthcare practice altogether.
3. Some advanced practice nurses now bear the cost of liability coverage premiums previously paid by their employers. This change in the employment relationship increases the cost to practice.
4. Physicians trying to reduce costs associated with perceived risk may also decide not to participate in the education of nurse practitioners, nurse midwives, and nurse anesthetists. The result is fewer healthcare providers to meet the needs of Florida's citizens.

Significance of the Problem – To Patients of Nurses

Ultimately, patients are and will continue be the ones who are affected by changes in healthcare providers and changes in healthcare services resulting from efforts to control escalating costs associated with liability risks. Providing information to patients, serving as patient advocates, and assisting patients in their healthcare decision-making are central nursing roles in the healthcare system.

1. Nurses who are fearful of lawsuits may change the way they practice to the potential detriment of the patients they serve. If nurses feel reluctant to execute these roles, patients will suffer.
2. If nurses are reluctant to provide information to patients, decline to serve as patient advocates, and/or fail to assist patients with healthcare decisions, as a result of perceived risk, patients will suffer.
3. When hospitals reduce or eliminate entire specialty services, such as obstetrical and midwifery care, patients immediately lose access to those advanced practice nurses in whom they have confidence and with whom they have established trusting professional relationships.

Strategies to Address the Problem

Most attempts to address the problem of escalating healthcare liability insurance premiums have focused on tort reform legislation. These have typically taken two forms: 1) decreasing the amount of awards, e.g., caps on non-economic and punitive damages, and 2) changes in legal procedures, e.g., mandatory pre-litigation dispute resolution and restrictions on the time within which plaintiffs have to file suits. Other measures concurrently under consideration include: 1) quality assurance reforms aimed at improving patient care, 2) increasing public access to information, e.g., publication of disciplinary actions taken by medical and nursing boards, 3) insurance reforms, e.g., allowing insurance companies more time to pay awards, basing premiums on individual performance ratings, creation of larger insurance risk pools, and creation of new insurance products, and 4) possible reinvestment of a percentage

of malpractice awards back into healthcare, e.g., for improvements in staffing and the integration of patient safety technology.

The Florida Nurses Association knows that legislation is not a quick fix. Potentially positive effects can take three to four years because cases already filed or incidents that occurred before laws are changed must be resolved. Potentially negative impacts must be anticipated and explored. Lessons have been learned from long term care tort reform. In addition, the Florida Nurses Association supports the preservation of the right of patients to access the courts for redress when egregious negligence occurs.

Conclusion

The consequences that result when healthcare providers cannot afford to practice limit citizens' access to healthcare services and deter individuals from entering the healthcare field. All aspects of this dilemma warrant careful examination. What is the impact of tort reform in other states? What types of reform have the best outcomes? Are there options besides, or in addition to, tort reform that need consideration? How can patients' rights be preserved without bankrupting, or severely limiting access to, healthcare providers? How will the quality of healthcare be improved through these considered measures?

The Florida Nurses Association urges all involved parties – patients, nurses, physicians, hospitals, and insurers – to work together on this critical issue. This problem can be resolved through collaborative and cooperative dialogue leading to implementation of consistent, strategic, and successful action.

Thank you for the opportunity to express the thoughts of Florida's nurses to the
Governor's Select Task Force on Healthcare Professional Liability Insurance.

Respectfully submitted,

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