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The Good Samaritan Act: "Immunity" in the Emergent Care Setting

By Francys C. Martin

The next article argues that Florida's Good Samaritan Act is underutilized, and suggests one reason may be the lack of established definitions for certain of the Act's terms. The article also explores potential legislative revisions to the Act.

Most of us know the story of the Good Samaritan[1] as a call to help those who are sick or injured, even when we have no obligation to do so. That call has been affirmed in modern culture by the creation of laws supporting the moral imperative that we help others in need. In fact, all 50 states have passed some variation of the "Good Samaritan Act." Some of these laws create a duty to rescue and encourage bystanders to assist. Yet other Good Samaritan laws are intended to protect the actions of private citizens assisting others in emergency circumstances, outside of a hospital or physician's office, where some injury is inadvertently caused.

This article reviews the history of the Good Samaritan Act in Florida[2] and the intent behind its implementation and evolution. Portions of the Good Samaritan Act are examined, particularly those dealing with health care providers, as well as the definitions, both within and outside of the Good Samaritan Act, that may guide application of the Act. Also examined are successful applications of the Good Samaritan Act in recent case law. Finally, future potential revisions and improvements of the Good Samaritan Act are explored.

Florida's Good Samaritan Act begins by addressing any person providing assistance, as follows:

> 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…, a state of emergency…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.[3]

When originally enacted, Florida's Good Samaritan Act ensured protection to those who provided emergency care outside of a hospital facility setting.[4] With regard to any individual, it did not require a person to act; should a person decide to act, however, he or she must act reasonably.[5] Florida later extended the scope of the Good Samaritan Act to provide additional protections specifically to health care providers. At the time, these protections were only applicable when the patient entered through the hospital's emergency or trauma center.[6] In 2003, the Good Samaritan Act was broadened even further by eliminating that requirement.[7]

The portion of the Act pertaining to medical providers now reads "[a]ny health care provider, including a hospital licensed under chapter 395,[8] providing emergency services…shall not be held liable for any civil damages as a result of such medical care or treatment…"[9] It would appear, then, that legislators recognized that emergent care could be

ABOUT THE AUTHOR...

FRANCYS CALLE MARTIN is a Claims and Litigation Coordinator with the State University System of Florida Board of Governors Self-Insurance Programs, serving primarily the Self-Insurance Program at the University of Florida, as well as Florida Atlantic University, Florida International University, University of Central Florida, and Florida State University. Her work focuses on claims management, litigation defense, and loss prevention services. She graduated from the University of Florida College of Law and was admitted to the Florida Bar in 2000.

provided in facilities that did not have a dedicated emergency room or were not designated as trauma centers. This may be argued to be in better alignment with the intent of the Good Samaritan Act.

The intent of Florida's legislature was clear: "to encourage health care practitioners to provide necessary emergency care to all persons without fear of litigation."[10] Florida legislators recognized that extending these protections to health care providers would encourage the treatment of emergency patients and serve the public good. In fact, the statute provides for the protection of "health care practitioners" and does not specify that these be only practitioners of emergency medicine.[11] Therefore, this may be interpreted to include and protect the care provided not only by physicians, but also physician assistants, nurses, midwives, and all other extenders, and a number of other specialized providers that may be rendering emergency care.[12]

Overview of Definitions

Although the primary focus of this statute is emergency care, the Good Samaritan Act does not define emergency care, emergency services, or emergency treatment. The First District Court of Appeal has found sufficient definition in section 768.13(2)(b)2.a, which extends the Act's protection for an act or omission

> [w]hich occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery. [13]

The First District has stated that this language describes the scope of the Act, and "provides a temporal limitation on the 'emergency services' that are subject to immunity."[14] It is at least arguable that the Act provides more guidance regarding when an emergency ends than it does regarding the point in time at which an emergency begins. Until the Florida Supreme Court addresses the issue or the Legislature amends the Act, definitions from other chapters of Florida Statutes may be helpful.

Though not exact in its terminology, the closest definition of "emergency care or treatment" is found under section 395.002, Florida Statutes, dealing with hospital licensing and regulation. It provides a definition of "emergency services and care" as follows:

> 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.[15]

This definition, however, begets the need for the definition of an "emergency medical condition." Section 395.002 also defines this term, in part, as "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" serious jeopardy, impairment, or dysfunction.[16] The combination of these two terms provides us with a fairly good understanding of the nature of a medical condition severe enough that it requires immediate attention and which begins from the time of the patient's initial screening by health care personnel.

The assessment of the patient as having been deemed stabilized becomes critical to the determination of the umbrella of liability protection for the health care provider under the statute. This may be an appropriate area for the trier of fact to determine when the patient was stabilized and capable of receiving medical treatment as a nonemergency patient. The Act does not define "stabilization." However, Chapter 395, Florida Statutes, governing hospital licensing, defines "stability" similarly to the Federal Emergency Medical Treatment and Active Labor Act (EMTALA),[17] to mean "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."[18]

Under the Good Samaritan Act, one may argue that if the patient was never deemed to be stable by a health care provider or does not appear to meet the definition for stability under either EMTALA or Florida statutes, the protections of the Act may extend for an indefinite period of time. Further, if the patient is stabilized prior to surgery, these protections may still be extended through and including the surgery, if that surgery occurs within a reasonable time after the stabilization. If never stabilized prior to surgery, plaintiff's counsel may argue that the further out the surgery is scheduled, the higher the likelihood that the patient should be deemed stable and further limit the scope of the protections under the Act. Yet another potentially difficult hurdle for the health care practitioner to overcome is the occurrence of stabilization prior to surgery and what measurement of time between stabilization and subsequent surgery is considered reasonable. Legislators anticipated that some creative defendants might seek to extend these protections by arguing that subsequent medical emergencies followed as a result of the original emergency. Consequently, the Act limits the protections of immunity to those "related to the original medical emergency."[19]

Once a health care provider has been able to successfully establish

that the patient presented for emergency services, is not stable, and is not capable of receiving medical treatment as a nonemergency patient, the immunity of the Good Samaritan Act should apply. However, the First District points out that, though titled in part as providing "immunity from civil liability," it does not provide absolute immunity to the health care provider, but instead imposes a higher standard of proof before liability can be imposed.[20] When the Act is applied and statutory requirements are met, any health care provider providing emergency services "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."[21] Reckless disregard is defined as "conduct that a health care provider knew or should have known, at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent."[22] The Third District Court of Appeal has specifically held that the determination of reckless disregard is an issue for the jury.[23]

Jury Instructions

Fortunately, there are standard jury instructions to assist the jury.[24] Of note, however, these jury instructions do not conform with the current language of the Act in some respects, as they were formed in 1995 in response to the 1988 amendment of the Act. [25] In the first of these jury instructions, there is no issue for the jury to address as to the applicability of the Act, but rather whether the health care provider acted with reckless disregard and was the legal cause of the patient's injury.[26] These jury instructions also elaborate upon the definition of "reckless disregard" and appear to provide a greater appreciation for the emergency setting and all the considerations made by the health care provider. Though not authoritative, these instructions provide factors to consider in the evaluation of reckless disregard, including:

- the seriousness of the situation;
- the lack of a prior patient-physician relationship;
- the time constraints due to other emergencies requiring care or treatment at the same time;
- the lack of time or ability to obtain appropriate medical consultation; and
- the inability to obtain an appropriate medical history of the patient.[27]

This instruction very clearly takes into account the emergency department environment, the patient population, and the need to triage patients in a state where there are over eight million emergency department visits per year.[28] Nevertheless, the standard of care expected of the health care provider is not diminished by any of these factors. Each of these factors considers whether the healthcare provider knew or should have known that they created an unreasonable risk of injury. Consequently, while plaintiffs must prove reckless disregard rather than simple negligence, it is not impossible for them to show that a physician should have known that their act or omission would result in harm to the patient. Further, this standard of care is not necessarily limited to state-licensed Florida hospitals. This standard may also apply to military hospitals under the Federal Tort Claims Act (FTCA), despite the fact that those are not licensed by the State of Florida or specifically required to comply with the Good Samaritan Act.[29] Where the military hospital is found to be "sufficiently analogous" to a similarly situaed state hospital, it may also benefit from the Good Samaritan Act.[30]

The second of these jury instructions is intended for use when there remains a jury issue as to the applicability of the Good Samaritan Act.[31] It provides yet another definition for consideration of an emergency. Although the definition predates the most recent amendment of the Act, it may still assist in adding to the weight and breadth of the Act's applicability, defining "emergency circumstances":

> Care/treatment is rendered under emergency circumstances when a hospital/physician renders medical care/treatment required by a sudden, unexpected situation or event that resulted in a serious medical condition demanding immediate medical attention, for which claimant/decedent initially entered the hospital through its emergency room/trauma center, before claimant/decedent was medically stabilized and capable of receiving care/treatment as a nonemergency patient.[32]

Interpretive Case Law

Despite the importance of the Good Samaritan Act, its long history, and its potential to eliminate the liability of a health care provider, there is little case law interpreting it. In one recent case decided by the First District Court of Appeal, *Harris v. Soha*,[33] the court affirmed a directed verdict for a defendant-anesthesiologist based on the Act. In *Soha*, the patient presented to the hospital's emergency room with tongue and throat swelling. Though there were no on-call anesthesiologists at this hospital, the emergency room attending physician called for anesthesia assistance. The anesthesiologist, who was on-call for obstetrics, had already been called into the hospital for an obstetric procedure and responded to the request for assistance in the emergency room. The anesthesiologist assessed the patient's tongue and throat swelling, but refused to perform an oral or nasal intubation because the patient was on blood thinning medications and there was concern this would cause additional care issues. Plans were made to transfer the patient to another facility but, while waiting to be airlifted, the patient died. The patient's

estate filed a wrongful death suit against the anesthesiologist, alleging that he failed to act and could have prevented the patient's death.

The trial court ruled for the anesthesiologist on a motion for directed verdict seeking immunity under section 768.13(2)(c)1 of the Act, and the estate appealed. The relevant portions of this section apply where the health care provider "is in a hospital attending to a patient of his or her practice…and who voluntarily responds to provide care or treatment to a patient with whom at that time the practitioner does not have a then-existing health care patient-practitioner relationship."[34] The estate first argued this section of the Act was not applicable because the anesthesiologist was not at the hospital "attending to a patient of his or her practice" when he responded to the emergency room request for assistance and that anesthesiologists do not have patients of their own practice. The First District found this to be too narrow a reading of this section.[35] The estate's next argument, that the anesthesiologist did not present to the emergency room voluntarily, was also rejected for failure to demonstrate the anesthesiologist had a responsibility to patients in the emergency room.[36]

Most recently, in *University of Florida Board of Trustees v. Stone*,[37] the First District Court of Appeal again undertook the task of interpreting another section of the Good Samaritan Act, focusing on the heightened standard of proof. That case resulted in the reversal of a directed verdict for the defendant.[38] In the underlying action, the patient presented to the emergency room of one university-affiliated hospital with severe stomach pain and vomiting. He was examined, treated, and underwent testing and radiology. A surgeon was not available at this facility, requiring that the hospital arrange transfer to another facility. The physician at another university-affiliated hospital, Alachua General Hospital (AGH), was contacted and suggested the patient undergo a CT scan prior to transfer to avoid possible delays at the accepting facility. The physician also noted concern for a gastric outlet obstruction. But the doctors at the first hospital were not informed of these issues prior to ambulance. The patient was admitted to the medical/surgical floor at AGH, a surgical consultation was ordered and he was administered additional treatment. He arrested about four hours after arrival at AGH and was transferred to the intensive care unit, where he expired the following morning after a second arrest. The estate filed suit for wrongful death against the University of Florida Board of Trustees (UF).

The arguments for and against the application of the Good Samaritan Act centered on the patient's status as stable or unstable. UF asserted that the Good Samaritan Act should apply because the patient was suffering from an emergency medical condition when he arrived at AGH and was not stable. The estate argued that the patient was stable when he was transferred, before ever arriving at AGH. If he were deemed to be unstable upon arrival to AGH, the Good Samaritan Act would apply. Following a motion for directed verdict by the estate, the trial court ruled that the Good Samaritan Act did not apply as a matter of law and did not allow the question of its application to be presented to the jury for determination. The jury awarded the estate $2.8 million in damages, and UF appealed. Arguments on appeal included issues with the qualifications of an expert and possible juror misconduct, but the First District focused on the Good Samaritan Act.

The court acknowledged that there is little case law interpreting the Good Samaritan Act, but proceeded to provide a very thorough analysis of the legislative history and intent.[39] The definition of "emergency services" was of fundamental importance, as the parties disagreed on whether the patient was receiving emergency medical care at the time of his admission. UF argued that the definitions of "emergency services and care" and "emergency medical condition" contained in section 395.002, Florida Statutes, should apply.[40] The estate countered that these definitions applied only to Chapter 395, Florida Statutes, and further, that the immunity of the Act should apply only to those physicians "who act or proceed as if the patient is suffering an emergency medical condition."[41] The First District was not swayed by either position, seemingly finding the argument of the hospital too objective and that of the estate too subjective. The court instead defined "emergency services" as:

> those provided for the diagnosis or treatment of an emergency medical condition prior to the time the patient is stabilized and capable of receiving treatment as a nonemergency patient. This interpretation does not hinge solely on the existence of an emergency medical condition, nor does it depend solely on the physicians' subjective view of the patient's condition at the time; rather, it takes into account both considerations and, consistent with the plain language of the GSA, focuses on whether the patient's emergency medical condition was stabilized to the point that it no longer required emergency care.[42]

Though this definition speaks to the status of the patient and therefore, whether the patient's medical care comes within the scope of the Good Samaritan Act, the question of the patient's stability provides us with a time period during which that emergent condition exists. In other words, the patient's stability practically quantifies that period. The First District referred to this as a "temporal limitation on the 'emergency services' that are subject to immunity."[43] The court opined that the applicability of the Good Samaritan Act may at times be a question of law, and at others, a question of fact. Nonetheless, the determination of the patient's stability, as in this case, will likely always hinge on a determination of fact.

The patient in *Stone* was reported to have been nonresponsive and in a great deal of pain, yet there was testimony that he was stable at that time. Moreover, his ambulance

transfer was regarded as routine.[44] Another issue of fact considered by the First District was the timing of his surgery, which had been scheduled for the following morning. The court did not rule on these issues, but found that questions regarding the patient's stability and ability to receive non-emergent care should have been presented to the jury.[45]

The protections afforded for the provision of negligent emergency medical care extend to the damages that may be awarded as well. In causes of action against practitioners who have provided "emergency services and care", section 766.118(4), Florida Statutes, provides for an award of no more than $150,000 per claimant for noneconomic damages, with an aggregate cap of no more than $300,000 in noneconomic damages for all claimants against all practitioners.[46] Further, the "practitioner" includes not only the health care provider directly involved in the emergency care, but also includes any "association, corporation, firm, partnership, or other business entity" with which the health care provider practices, as well as those individuals or entities linked by vicariously liability.[47] This expressly includes a limitation on damages resulting from medical care rendered prior to stabilization and up through and including stabilization, even if surgery is required and the patient is not stabilized until after surgery.[48]

Recommendations

As explained above, there is very little case law interpreting the Good Samaritan Act. As a result, the courts and those who seek to apply the defenses made available by the Good Samaritan Act are significantly hampered. Though "reckless disregard" is specifically defined and other definitions can be inferred, the lack of settled definitions makes its application more challenging and serves to benefit detractors of the Act.[49] Consequently, the definitions of "emergency medical condition" and "emergency medical services" may be a sensible addition to the body of the Good Samaritan Act.[50]

Furthermore, there may be some language of the Good Samaritan Act that could be removed to promote clarity in application of the Act. In *Harris*, for example, one of the arguments of the Appellant hinged on which patients would be considered part of the health care practitioner's "practice."[51] This language is arguably superfluous and confusing. If the health care practitioner is in the hospital attending to a patient, it serves no purpose to further explain whether it is a patient of his or her practice.[52] Yet another portion of this same section of the Good Samaritan Act, also challenged in *Harris*, is whether the health care practitioner provided these services "voluntarily."[53] This section of the statute may simply convey that the health care practitioner is in the hospital and responds to a person requiring emergency medical services.

Finally, there is data to suggest that the Good Samaritan Act in Florida is underutilized by defense counsel. In a recent paper summarizing malpractice claims data involving emergency medicine, the number of claims has been steadily increasing, as have the number of paid claims.[54] Not surprisingly, the indemnity paid in these claims has also increased. From 2007 through 2011, this study noted 1,998 closed claims involving emergency medicine, yet there are only a handful of cases utilizing the protections afforded by the Good Samaritan Act. The American College of Emergency Physicians gave Florida a C- in a state report card comparing emergency care environments across the nation.[55] This report pointed to Florida's physician workforce shortage, noting an inadequate supply of emergency physicians and "with specialty coverage for emergency departments posing a particular challenge." The report recommended that Florida do more to hire and retain physicians and specialists who will take call in the emergency department. It also recommended that Florida encourage insurers to write liability policies in the state and "reduce the highest-in-the-nation insurance premiums." This will certainly be more difficult to accomplish if defense counsel do not do more to avail themselves of the protections of the Good Samaritan Act. Failing to do so will only exacerbate the problem, discouraging physicians from practicing in Florida and thereby compromising emergency care.

Every health care provider sets out with the intention of providing the highest standard of professional care within their training and preparation. They are, by their nature, training, and oath, desirous of helping those who are ailing and in need, and keeping them from harm. Prospectively, they do not intend to harm a patient or fail to meet the applicable standard of care. In an emergency situation, there is often not a great deal of time to consider the legal ramifications of failing to meet the standard of care. The Florida Good Samaritan Act allows health care providers to render care in high-tension situations without the fear of litigation. The protection from liability and high damage awards that the Good Samaritan Act provides makes it more likely that health care providers will help even when they have no obligation to do so and therefore, positively affects the lives and well-being of patients. The application of the Good Samaritan Act supports the legislature's efforts to improve public health and safety. However, if the Good Samaritan Act remains underutilized, it cannot effectively protect health care providers in Florida and the good care available in facilities across the state will be further compromised.

1 In the New Testament, a certain lawyer asks Jesus, "…who is my neighbor?" Luke 10:25–29 (King James Version). This seemingly simple question begins the parable of the Good Samaritan, which throughout the ages has led to a number of ethical and allegorical interpretations. Jesus responds with the story of a man who is beaten, robbed, and left for dead, and only a Samaritan stops to render him aid. He then instructs this lawyer to, "Go, and do thou likewise." Luke 10:30–37 (King James Version).

2 § 768.13(2)(a), Fla. Stat. (2013).

3 *Id.*

4 Ch. 65-313, Laws of Fla.

5 The concept of the "undertaker's doctrine" is defined in 324A of the Restatement (Second) of Torts (1965), providing that, "One who undertakes…to render services to another which he should recognize as necessary for the protection of a third person…is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking…" and was recently addressed in *Limones v. School Dist. of*

Lee County, 111 So. 3d 901 (Fla. 2d DCA 2013).

[6] Ch. 88-1, § 45(2), Laws of Fla.

[7] § 768.13(2)(b)1, Fla. Stat. (2002).

[8] This section specifies those created under Chapter 395, to include those providing emergency services pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s. 395.1041, s. 395.401, or s. 401.45, relating to the provision of emergency and trauma services.

[9] § 768.13(2)(b)1, Fla. Stat. (2013).

[10] § 768.13(2)(c)3, Fla. Stat. (2013).

[11] § 768.13(2)(c)1, Fla. Stat. (2013).

[12] Though § 768.13 does not define a "health care practitioner", it does refer to it as defined in § 456.001(4), which in turns defines a "health care practitioner" as "any person licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491."

[13] *Univ. of Florida Bd. of Trustees v. Stone*, 92 So. 3d 264, 269 (Fla. 1st DCA 2012) ("The plain language of the GSA defines its scope and, therefore, it is unnecessary to look outside the Act for clarification of its terms.").

[14] *Id.* at 270.

[15] § 395.002(9), Fla. Stat. (2013). *But see Stone*, 92 So. 3d at 270 (rejecting argument that § 395.002 definitions should be imported into the GSA).

[16] § 395.002(8)(a), Fla. Stat. (2013). Notably, this definition is practically identical to that provided by the federal EMTALA regulations.

[17] The Emergency Medical Treatment and Active Labor Act, passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires a hospital to provide emergency care. It does not allow for transfer or discharge of the patient without their consent or stabilization.

[18] § 395.002(29), Fla. Stat. (2013).

[19] § 768.13(2)(b)2.b, Fla. Stat. (2013).

[20] *Stone*, 92 So. 3d at 269.

[21] § 768.13(2)(b)1, Fla. Stat. (2013) (emphasis added).

[22] § 768.13(2)(b)3, Fla. Stat. (2013).

[23] *Garcia v. Randle-Eastern Ambulance Serv., Inc.*, 710 So. 2d 74 (Fla. 3d DCA 1998).

[24] *See Stone*, 92 So. 3d at 271. The standard instructions were adopted in *Standard Jury Instructions --- Civil Cases Nos. 95-1 and 95-2*, 658 So. 2d 97 (Fla. 1995). They have since been renumbered as Florida Standard Jury Instruction (Civil Case) 402.16, Emergency Medical Treatment Claims.

[25] *See Standard Jury Instructions—Civil Cases Nos 95-1 and 95-2*, 658 So. 2d 97 (Fla. 1995). For example, these continue to refer to the patient having entered through the emergency room or trauma center, which is no longer a requirement of the Good Samaritan Act.

[26] *Id.* at 99.

[27] *Id.*

[28] The Emergency Department Utilization Report 2011, published in September 2013 by the Florida Center for Health Information and Policy Analysis of the Agency for Health Care Administration, reported 8,479,256 emergency department visits in 2011.

[29] *Turner v. U.S.*, 514 F.3d 1194 (11th Cir. 2008).

[30] *Id.* at 1205.

[31] 658 So. 2d at 100.

[32] *Id.* at 101.

[33] *Harris v. Soha*, 15 So. 3d 767 (Fla. 1st DCA 2009).

[34] § 768.13(2)(c)1, Fla. Stat. (2013).

[35] *Soha*, 15 So. 3d at 769.

[36] *Id.* at 770.

[37] *Stone,* 92 So. 3d 264.

[38] *Id.* at 265.

[39] *Id.* at 267.

[40] § 395.002(8) and § 395.002(9), Fla. Stat. (2013). At the time of the *Stone* decision, these definitions were contained under § 395.002(9) and § 395.002(10), Fla. Stat. (2004).

[41] *Stone*, 92 So. 3d at 269.

[42] *Id.* at 270. The *Stone* court refrained from altering or interpreting the definition of an "emergency medical condition."

[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] § 766.118(4)(a) and (b), Fla. Stat. (2013).

[47] § 766.118(1)(c), Fla. Stat. (2013) states in part, "For the purpose of determining the limitations on noneconomic damages set forth in this section, the term 'practitioner' includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner."

[48] § 766.118(4), Fla. Stat. (2013).

[49] For example, in *Stone*, the Appellee argued that the definitions of the terms "emergency services and care" and "emergency medical condition" would not apply outside of Chapter 395, Florida Statutes, and therefore should not apply to the Good Samaritan Act. *Id.*

[50] Section 395.002 is specifically incorporated into the definitions in the Workers' Compensation Act. See § 440.13(1)(e), Fla. Stat. (2013) ("'Emergency services and care'" means emergency services and care as defined in s. 395.002.").

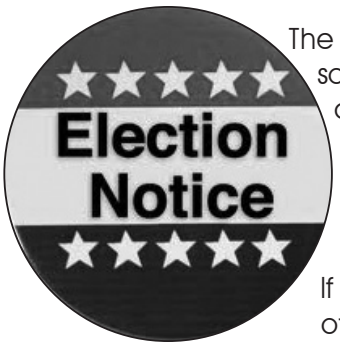
[51] *Soha*, 15 So. 3d at 769.

[52] § 768.13(2)(c)1, Fla. Stat. (2013)

[53] *Soha*, 15 So. 3d at 770.

[54] Charles Grassie, M.D., J.D., FACEP, Michael Nauss, M.D., FACEP, Thomas Syzek, M.D., FACEP, *Summary of Malpractice Claim Date & Trends from Three Sources,* American College of Emergency Physicians, October 2013. This informational paper included data compiled by Controlled Risk Insurance Co., The Doctor's Company, and Physician Insurers Association of America.

[55] *America's Emergency Care Environment, A State-by-State Report Card,* American College of Emergency Physicians (2014 ed.) at 35-36.



The election of Officers and Board of Directors of the Florida Defense Lawyers Association will take place as part of the Association's Annual Meeting on Saturday, August 9, 2014, beginning at 8:00 am.

Nominations are being accepted for the positions of the Officers of the Association and Members of the Board of Directors. The chair of the Nominating Committee is FDLA Immediate Past President, Jeffrey E. Bigman.

If any member has an interest in serving as an Officer or Member of the Board of Directors, or would like to nominate any other member of FDLA for a position, please contact Jeff Bigman or the FDLA office.

Jeffrey E. Bigman
Phone: 386-254-6875
Email: jbigman@daytonalaw.com

FDLA Office
Phone: 813-885-9888
Email: ljude@fdla.org