
FLORIDA MEDICAL ASSOCIATION

PHYSICIANS WHO CARE

GRASSROOTS MANUAL



LEGISLATIVE SESSION

— 2007 —

INTRODUCTION

The Florida Medical Association (FMA) is striving to enhance its legislative grassroots network throughout the state. Local legislative contacts by the membership have long been organized medicine's most effective medium for influencing public policy. The relationships between individual physicians and local medical societies with their legislators is a major key to the FMA's effectiveness in Tallahassee.

This manual has been developed to assist County Medical Societies (CMS) and their legislative Key Contacts to become more effective leaders and legislative proponents. Because the Key Contacts are on the front-line, they serve as a meaningful medium for the collection of information and are an important tool for influencing legislation.

Legislation debated by the House and Senate has become so voluminous that communicating organized medicine's position has become a year round responsibility. Key Contacts and other physicians need to meet with their local legislators often to ensure that they understand the FMA's legislative agenda and are willing to advance that agenda. The success of the FMA's legislative program depends on local physicians and Alliance members. Please stay up to date on the activities of the FMA Governmental Affairs Division by going to www.fmaonline.org. We will all be working towards making the legislative program one that assures the interests of physicians are preserved while protecting Florida's patients.

Your commitment to the practice of medicine is truly appreciated.



Sandra B. Mortham
Executive Vice President/CEO



Francesca Plendl
Director of Governmental Affairs

**The FMA/CMS
Legislative Key
Contact Program**

THE FMA LEGISLATIVE PROGRAM

The Florida Legislature meets annually for a consecutive 60-day session. Although the legislative session is scheduled to meet for two months, legislative activity continues year-round with a constant schedule of legislative committee meetings and frequent special legislative sessions. Because at least 20% of the legislation filed annually affects the practice of medicine and health care issues, it is a necessity that the FMA and CMS's maintain a continued presence at the Capitol, with agency heads and in the local district offices of legislators. To protect organized medicine and the patients of Florida, the House of Medicine must cooperate and coordinate its efforts to promote pro-medicine issues and oppose unwarranted governmental intrusions proposed by legislative adversaries.

In concert, the many facets of the FMA's legislative program are designed to increase the perception and reality that the medical community is an organized, unified voice for the physicians and patients of Florida, which deserves the attention and respect of the Legislature and regulatory departments and agencies.

Council on Legislation

Immediately following the end of the Legislative Session, the FMA staff prepares an assessment of organized medicine's legislative accomplishments and begins preparation for the next Session. Although the Session has just ended, it is often apparent which issues will resurface the following year and which new issues various interests may propose. A preliminary report and list of possible issues is prepared for review by the Council on Legislation.

In July, the FMA Council on Legislation meets and develops a legislative agenda for the next year. Suggestions are encouraged from the CMS's, Alliance, Specialty Societies, the FMA House of Delegates and individual members to be included in the preliminary legislative package considered by the Council. Once the FMA Board of Governors has approved the issues, a preliminary package is published and distributed for action to CMS's and Key Contacts at the local level.

Immediately prior to and throughout the legislative session, the Council is continuously updated on any new developments and takes the leading role in reacting to time sensitive changes that occur throughout the course of the legislative process. As critical situations arise, as they tend to do several times throughout the Session, FMA legislative staff work to bolster FMA member awareness of the issues and promote grassroots activities to educate and influence key decision makers in the Legislature.

Key Contacts are the Key to Success

Providing Key Contacts with issue packages or talking points on the issues in advance ensures that contact with local legislators will be made in a timely fashion. FMA legislative staff make these materials available to each Key Contact. The Key Contact should plan on meeting with their legislator(s) as soon as possible after the aforementioned materials are made available. Although some legislators are more

influential than others, it is extremely important that all legislators are contacted by well-informed Key Contacts with the intent of maintaining a relationship.

Thank Those Who Support Organized Medicine

After the legislative session has come to an end, it is important that the Key Contacts ensure that each legislator in the county who has been a friend of medicine is informed that he or she is appreciated. The CMS Executive should also commend the Key Contacts for their hard work and efforts. Illustrating appreciation for a legislator's efforts on behalf of medicine, even if it is just a simple thank you, has a profound effect on future FMA and CMS relationships with that legislator. Of course, getting involved with the legislator's campaign is the best mechanism to show medicine's gratitude.

KEY CONTACT PROGRAM

The role of the CMS Executives and Key Contacts are, without question, the most important of all facets of the FMA legislative infrastructure. Without a strong, continuous presence of physicians who are informed and able to communicate medicine's issues at the local level, legislators will perceive organized medicine as yet another large special interest group. All politics is local. Elected officials are much more likely to respond positively to influence from within their local constituencies than from influence in Tallahassee alone.

Organize in the Fall

Once the FMA Council on Legislation and Board of Governors have approved and published a preliminary legislative package, each CMS Executive should schedule a meeting with their Key Contacts to discuss the issues, and each Key Contact should schedule a meeting with their local legislators. The first meetings should begin in October. During election years, the scheduling of meetings with legislators is often difficult until after the first week in November. Regardless, legislators' schedules are quickly filled following an election or a non-election year. It is suggested that your committee members and Key Contacts attempt to schedule meetings as early as possible. The results of these meetings should be reported to the FMA.

Frequent Contact with Legislators is Important

Initial Meetings: Concentrate efforts on introducing the legislator to the issues and educating him or her on medicine's position. A commitment of support from the legislator is usually not sought at this time, but feedback on the meeting should be reported to the FMA Division of Governmental Affairs and CMS Executives.

Subsequent Meetings: Secondary contacts with legislators are usually most effective in the late fall or early winter. By mid-March, legislators are busy with the legislative session and often not available to devote a great deal of attention to lengthy and complicated meetings. Additionally, legislators usually have decided their positions on key issues by this time. Secondary meetings tend to be more issue specific and commitments are encouraged.

Maintain Contact During the Legislative Session

While the Legislature is in session, CMS Executives and Key Contacts may be asked by the FMA Division of Governmental Affairs to attempt to influence their legislators by telephone, letter or in person. If an individual vote on an issue gains critical importance, the physician may be asked to come to Tallahassee to make a request for support in person. Visitations to Tallahassee are very important. CMS's are encouraged to plan annual visitations. The FMA Governmental Affairs staff can assist in the planning of these visits.

Alliance Involvement with the Committee

From a statewide perspective, the FMA believes the FMA Alliance (FMAA) can further enhance the image of organized medicine and provide valuable input to our legislative efforts through the CMS legislative committees. Already involved in many aspects of the FMA and CMS's work, the FMAA should be involved on committees in a similar manner. This program lends itself equally to professional and social arenas. The talent and dedication of the FMAA members should be considered when implementing CMS legislative committee programs. Keep in mind that your spouse may be acquainted with an important legislator in your area or with that lawmaker's spouse. The spouse of a physician is well aware of the stressful nature of the practice and the potential impact of new laws on that practice. He or she can make an excellent advocate of the FMA and CMS's positions on current law.

CMS EXECUTIVE DIRECTORS' RELATIONSHIP WITH KEY CONTACTS

Your CMS Executive Director and FMA Governmental Affairs staff are experienced in the political process and frequently have a long-standing relationship with legislators and their staffs. Thus, they are often accessible to inside legislative information. Therefore, it is important that the Key Contacts and the CMS Executive Director communicate on a regular and timely basis. This will ensure the exchange of pertinent information and assist in the planning of future projects.

Listed below are just a few of the ways CMS Executive Directors can assist your county's legislative programs:

- Educate members about CMS/FMA legislative programs and issues;
- Assist in developing a local Key Contact Program;
- Assist in scheduling regular meetings, developing agendas and sending meeting notices;
- Facilitate and/or attend meetings between legislators and Key Contacts upon request;
- Pre-screen candidates and assess campaign viability prior to interviews by committees;

- Assist in the recruitment of new activists for membership;
- Meet with legislators to develop centers of influence; and
- Seek contacts at area hospitals.

LOCAL ACTIVITIES THAT SUPPLEMENT THE COUNTY MEDICAL SOCIETIES' LEGISLATIVE COMMITTEE EFFORTS

Hospital Contacts

Similar in function to the Key Contact, these physicians volunteer to inform their colleagues of important legislative matters at hospital staff meetings. This could also include placing FMA and CMS legislative bulletins throughout the hospital or in the medical staff lounge. At critical times, hospital contacts may be used to create a large volume of contacts aimed at assisting in the passage or defeat of a specific piece of legislation. It is important that a close relationship between the CMS Executive and the hospital contact be established and maintained.

FLAMPAC

After each election, FLAMPAC will conduct research to determine which FMA and CMS members have contributed to the campaigns of state legislators and meet with legislators to create a list of physicians who may be influential. This is an excellent tool for recruiting new activists to get involved in the legislative committee or as a Key Contact.

Key Contact/ Grassroots Tools

KEY CONTACT PROGRAM AN OVERVIEW

The success of the Key Contact Program will depend to varying degrees upon support by the FMA Division of Governmental Affairs, County Medical Societies, and the Key Contact. The CMS, in consultation with FMA legislative staff, will select individuals in their areas to be responsible for the Key Contact functions. The concept of the Key Contact involves having designated physicians contact their elected officials on matters of concern to organized medicine, including political involvement, at the local level.

The flow of information is a necessity in this program. Key Contacts are kept abreast of the major issues and are contacted for action through various FMA and CMS sources: Legislative Bulletins; Legislative Alerts; and other FMA publications. Much of this correspondence is done via e-mail, so Key Contacts need to give the FMA and their CMS updated e-mail addresses. On priority legislative matters during the legislative session, a copy of the bill and a short summary (fact sheet or talking points) can usually be furnished upon request to those needing further explanations.

A few basic guidelines are necessary to maintain a successful program. The Key Contact program should provide at least one Key Contact for each legislator. A Key Contact should:

- Cultivate the friendship of legislators on a year round basis.
- Actively support legislators who are supportive of organized medicine's positions.
- Actively respond if called upon for support during the legislative session and political campaign season.
- Invite legislators to CMS meetings and other social functions.
- Visit legislators when in Tallahassee during the legislative session.
- Recognize and show appreciation to each legislator when appropriate.
- Report results of legislative contacts on a regular basis to the FMA Governmental Affairs Division and their CMS.

INITIATING THE KEY CONTACT PROGRAM

The Key Contact program is a means of legislative advocacy that provides local expertise to legislators while at the same time solicits lawmakers' views on issues of concern to organized medicine. Even the most eloquent and effective lobbyist cannot always prevail in Tallahassee without a strong hometown constituency supporting the effort. With the Key Contact taking an active part in medicine's legislative program, the FMA and the CMS's will be much more successful over time. An effective Key Contact must:

1. Know the Issues

The Key Contact should have a general knowledge of the issue, but doesn't necessarily have to be an expert on every issue. The Key Contact should be well-informed and be able to respond intelligently to questions yet have the presence to defer when unsure of an answer.

2. Know the Legislative Process

Knowledge of the legislative process will enable the Key Contact to plan strategy most efficiently. This can be accomplished by self-education and by keeping abreast of happenings and information locally and statewide.

3. Know FMA and CMS Policies on Issues

A sufficient liaison is necessary to allow the legislator to develop confidence in the Key Contact and in the FMA and CMS. Access is the first step toward communication. Listed below are several ways in which access may be gained:

- ❑ Meet with legislators several times during the year, not just when there is an issue on which to vote.
- ❑ Get involved in election campaigns when possible and where appropriate (contact the CMS Legislative Committee or FLAMPAC).
- ❑ Develop a good rapport with lawmakers. Local issues are always good topics of conversation when a legislator is home.
- ❑ Offer useful information on issues. In this way, valuable advice is provided on issues especially on health care delivery that are of specific concern to the legislator. Recent events make "health care costs" an extremely viable topic of conversation, pro and con.
- ❑ The Key Contact should go to legislative and campaign functions when possible. Most legislators belong to delegations (e.g., the Broward and Dade delegations in South Florida). Obtain a schedule of local delegation functions and attend them when feasible.

- Invite legislators to attend local events and possibly speak. Set up a luncheon during election years. Make a special effort to see that the legislator(s) are personally introduced to other FMA/CMS members, speakers, civic leaders and friends. Remember when inviting a legislator to any event to furnish tickets and cover costs, if appropriate.
- A very effective tool is to invite legislators to visit a local facility or office. Give a first-class tour. Show what the FMA and CMS mean to local patients (constituents/voters). Introduce staff and other key persons during these visits.
- Create opportunities for social situations (e.g., parties, golf, dinner, fishing, etc.).
- At least once a year, sponsor a Legislative Appreciation Dinner / Reception. Traditionally, few speeches are given. A Legislative Appreciation Dinner provides an opportunity for legislators to get together in a comfortable, relaxed atmosphere and mingle with local FMA and CMS members.
- Give an outstanding legislator award from the CMS for passage of medical legislation or special service to the medical profession.

4. Thank Your Legislator

Make certain that appreciation is expressed to legislators who have supported our policies. It is only appropriate that legislators be recognized and thanked for their efforts.

5. Keep the FMA and CMS Informed

Report your results of legislative and political contacts to the FMA Governmental Affairs Division and the CMS promptly so that future strategies can be developed. A timely and accurate report of the legislator's attitudes will assist in developing a comprehensive and effective legislative program

EFFECTIVE LEGISLATIVE CONTACTS

Once selected as a Key Contact, it is imperative to act when called upon. Once access to the legislator is gained the Key Contact should be persistent but not preach after the initial message has been given. Reinforcement will be provided by the FMA lobbyists and by letters from colleagues generated by the CMS.

To assist the Key Contact in being most effective with legislators, the following suggestions are offered:

- ❑ Don't expect legislators to have a great deal of knowledge about the FMA and CMS, but do expect them to know a great deal more about issues than might be realized. Information will most likely have been presented to them by their staff or by other groups, and some possibly in conflict with our policy or current position.
- ❑ Make a good argument for the FMA and CMS's position. Have sound reasons to back up that position. If possible, have a written position paper or fact sheet on the issue expressing organized medicine's viewpoint and leave it with the legislator. Keep a copy of all distributed information and send copies to the FMA Division of Governmental Affairs and CMS Legislative Committee. A legislator may wish to help because of a relationship with a Key Contact, but will need valid reasoning in order to maintain a commitment throughout battles on critical issues.
- ❑ More than one visit may be necessary to explain a position. Legislators may need more time to review additional information or talk with others before they can give a firm commitment and even that commitment can change.
- ❑ Follow-up: Send a follow-up letter to the legislator. If the desired result is not achieved (and this will often be the case), let the CMS Executive and the FMA Division of Governmental Affairs determine what additional approach might be productive.
- ❑ Interpret the legislator's responses. "You can count on my vote" is a firm commitment. Anything less should be interpreted according to pressures on the legislator. Two factors must be kept in mind:
 1. Legislators usually will not give a totally negative response; and,
 2. Legislators usually will allow leeway to change their position, based on additional information or discussion.

THE LEGISLATOR'S WORLD

To understand how to communicate more effectively with Legislators, we must try to understand them better. We need to consider how their world looks--factors that may color their attitudes and thinking. Legislators want to do a good job, as we all do. We sometimes forget that this basic drive applies to all elected officials. Lawmakers live in a world of compromise. They want to be responsive and accommodate their constituents, but not at ANY cost--other considerations may prevent them from doing so. Elected officials are distinct personalities representing widely varying constituencies. Often, Legislators must think in terms of what is POSSIBLE and not necessarily in terms of what is IDEAL. Legislators are beset by numerous conflicting pressures. The Key Contact should be sensitive to those pressures, which include:

- Concern for literally hundreds of pieces of legislation annually.
- Varying perceptions of constituent thinking. Much of the time, legislators can only make educated guesses.
- Conflict sometimes arises from constituent thinking versus a legislator's own judgment. This is sometimes reflected in the media.
- Legislators have to know how legislation will affect their districts; however, they are not usually experts in individual professions other than their own.
- They are busy. Legislators are public property, and at times it seems that everyone wants a piece of their time. Their workload can be staggering.
- Legislators are likely to forget names and faces since they meet thousands of people each year. A Key Contact should not be offended if a legislator forgets a name --it can only be expected.
- Legislators rely heavily on their staff, both at home and in Tallahassee, for much of their research on issues and for day-to-day business. Developing sufficient rapport with staff will ensure that the legislator and the staff feel that you are a credible source and that they can give ample consideration to your association's position.

6. Make clear the position of the issue you are on, and ask the legislator to support your position.
7. Refer to exact bill numbers if available and short or popular titles.
8. Don't threaten or write in a belligerent tone.
9. Don't remind them of broken promises.
10. Don't write so often that your letters lose their impact.
11. Illustrate your position with a local example.
12. Sign your name legibly, and type your name under your signature.
13. Time your letters to arrive far enough in advance to be effective.

10 TIPS ON HOW TO GET ALONG WITH YOUR LEGISLATOR

1. BE FAIR

Remember that your legislator represents all of his or her constituents regardless of party or group affiliation. Don't condemn a legislator because he or she has taken a position you personally do not agree with.

2. BE UNDERSTANDING

Try to put yourself in your legislator's place. Try to understand his or her problem, outlook and aims. By having empathy for the legislator, he or she will be more inclined to listen objectively to your position and understand your problem.

3. BE REASONABLE

Recognize that there are legitimate differences of opinion. Never be vindictive! Continue to develop the relationship even though he or she may not vote your way. A legislator who votes against your position one day may very well be the deciding vote in your favor the next day.

4. BE FRIENDLY

Do not contact your legislator only when you want something done. Invite your legislator to local Board meetings, perhaps as a speaker. Go out of your way to keep in touch throughout the year.

5. BE THOUGHTFUL

Treat your legislator the way you would like to be treated. Let him or her know that you appreciate the good things they do. The golden rule applies in politics, too.

6. BE COOPERATIVE

If a legislator asks for help let him or her know that you can be relied on no matter how busy you are. Your assistance will be appreciated and remembered.

7. BE REALISTIC

Do not expect everything to go your way. Be ready at all times to consider the issues involved and compromise if necessary.

8. BE ACCURATE

Always be sure to have the necessary information and to do a good job at presenting your case. The only way to gain credibility is to know the issues thoroughly.

9. DON'T BE A BOTHER

Legislators do not like to be pestered, scolded, preached to, or "loved to death".

10. BE HONEST

Never stretch the truth to make your argument more saleable. If you learn new facts that would revise your assumptions, do not hesitate to bring the new situation to the attention of the legislator you have been contacting.

LEGISLATIVE TERMINOLOGY
THE FOLLOWING LEGISLATIVE TERMS AND THEIR DEFINITIONS
WERE TAKEN FROM **THE LANGUAGE OF LAWMAKING IN FLORIDA**
BY ALLEN MORRIS, AUGUST, 1977

1. PRE-FILING

When either House formally receives actual bills and other proposed legislation from members prior to the convening of the regular session.

2. BILL

A bill is proposed law.

3. COMPANION MEASURE

When identical bills are introduced in the House and Senate, these are known as companion measures. The purpose is to expedite progress by having simultaneous movement (in committees and on the Calendar) in both Houses on the proposal. When a House passes a bill, the sponsor in the other House must be careful to substitute this companion. Otherwise, as may happen, each House will pass its own bill but neither becomes law. While both Houses may have acted on identical text, each will have passed a separate bill.

4. SPONSOR

A bill's sponsor is understood to be the legislator introducing it although he may have done so at the request of someone who is not a member.

5. PRIME SPONSOR

The first legislator to sign a bill for introduction.

6. CO-SPONSOR

The legislator introducing a bill is known as the prime sponsor. Those who "sign on" afterwards are known as co-sponsors.

7. AMENDMENT

Changes in any bill or other proposed legislation may be offered either by a Committee or an individual legislator in the form of an amendment to a specific portion of the pending measure.

8. COMMITTEE AMENDMENTS

Committee amendments are offered ahead of any other (except technical amendments) and are usually adopted without debate since the acceptance of these was a condition of committee having reported the bill favorably.

9. FLOOR AMENDMENTS

Amendments offered by legislators in their individual capacity on the floor of the House or Senate.

10. TECHNICAL AMENDMENTS

Amendments correcting errors of a technical nature (spelling, section numbers, title, etc.) that are non-controversial. These amendments are accepted without objection (no debate or vote necessary).

11. CONSTITUTIONAL AMENDMENT, STATE

Florida's Constitution is amended by the Legislature proposing, by a three-fifths vote of the members elected to each House, the amendment and the people ratifying this by a majority vote of those participating in the general election. Unless otherwise provided by law, amendments go to the people at the next regular general election so long as this election is held more than 90 days after an amendment has been proposed by the Legislature.

12. COMMITTEE REPORT

A committee may report a bill "favorably," "favorably with committee amendment," "favorably with a committee substitute" (meaning the committee has accepted the idea by rewriting the language), or "unfavorably."

13. CONFERENCE COMMITTEE

A conference committee is actually two committees, one from each House, meeting together to attempt to work out language acceptable to the Senate and House on some measure where agreement could not be reached through amendments. A majority of the members of the committee from each House must agree before the conference committee report may be submitted to the House and Senate. Neither House is obligated to accept the report but usually they do since the alternative could be the failure of the legislation for the session.

14. CONCURRENCE

When one House agrees to amendments adopted by the other House, the action is known as concurrence.

15. RULES

The rules of each House determine how it shall go about its daily conduct of business. Rules generally originate in the standing Committee on Rules and Calendar, which also determines the priority of legislative measures to be considered.

16. CALENDAR

The Calendar is a listing of the bills (and other proposed legislation) reported from committees and generally ready for floor consideration. Usually, a calendar is the printed daily list of the bills, by their titles. However, calendars can be used in an intangible sense, as a stage in the process of making a bill eligible for consideration. The calendar also lists meetings of committees scheduled for that day. There are also calendars of the legislation given priority by the Committee on Rules and Calendar and calendars of local legislation.

17. CONSENT CALENDAR

The Consent Calendar contains bills of a non-controversial nature. The Committee on Rules and Calendar usually sets such a calendar for Fridays. Bills may be stricken from the Consent Calendar by a written objection from any member.

18. SPECIAL ORDER CALENDAR

The Committee on Rules and Calendar in each House is empowered to control the flow of legislation from committees to the floor. The priority listing of bills and other proposed legislation is known as the special order calendar. Unless otherwise stated, the special order calendar is good for one day. Rules Chairmen usually work closely with the presiding officers and committee chairmen in developing the list of priority legislation.

19. JOURNAL

The official record of the proceedings. Each legislative House issues its own; a daily one for each day of a session and a corrected Session book. The Journals record only the formal parts of what has happened in the Legislature and its committees. These include the titles of the bills introduced and considered and the way members voted on the passage of bills.

20. WAIVE THE RULES

The phrase most often heard in the Legislature is "move the rules be waived." The Constitution and the Rules of the Senate and House provide a series of braking action on the passage of bills. But if two-thirds of the members present are agreeable to foregoing procedural steps, such as reading a bill on three separate days, then a motion to waive the rules is in order.

21. WITHOUT OBJECTION

Much of the business of the chambers is done "without objection." This means the presiding officer has not put a motion to the body to dispose of a matter proposed by a member: for example, for a legislator to withdraw from further consideration a bill he has introduced but no longer wishes to pursue. "Without objection" is the same as saying "by unanimous consent."

22. ADOPTED

Resolutions are "adopted," bills are "passed." There is a difference. Adopt means to consent to or accept; pass means to enact by the requisite number of votes. In the Florida Legislature, resolutions usually are adopted by the votes of a majority of the members present.

23. TP'ED

A "TP'ed" bill is one the consideration of which has been "temporarily passed" or deferred, either in the chamber, on the calendar or in committee. The term is often confusing to newcomers because they think of a bill as being "passed" or conditionally agreed to. Not infrequently, a legislator asking that consideration of a bill be deferred actually means, "I think I'm in trouble."

24. FISCAL NOTE

A fiscal note seeks to state in dollars the estimated amount of increase or decrease in revenue or expenditures and the present and future fiscal implications of a piece of pending legislation. Each bill with fiscal implications is required by law to have a fiscal note attached.

25. GENERAL APPROPRIATIONS BILL

This is the big bill of each legislative session. Put together by the Senate and House Committees on Appropriations, and usually assembled in a conference committee, the General Appropriations bill distributes the money for financing the agencies of State government. Some of the money is derived from earmarked sources, highway funds, for example, but virtually all disbursements are included so legislators and others may have reasonably complete overview of state spending.

26. EFFECTIVE DATE

A law generally becomes effective, or binding, either upon a date specified in the law itself or, in the absence of such date, 60 days after the final adjournment of the session. That means either at the moment of approving signature by the Governor or the filing of the act in the Office of the Secretary of State without the Governor's signature.

27. ENACTING CLAUSE

The Constitution requires that each law be prefaced by the phrase "Be it Enacted by the Legislature of the State of Florida." An amendment to strike the enacting clause kills a proposed law.

28. ACT

After a bill has been passed by both legislative Houses in identical form and language it becomes an Act.

29. LAW

A law is the final product of the legislative process. It is the end result of the introduction of a bill, its passage by both Houses into an act, and its approval by the Governor (or the overriding by the Legislature of his veto), and its recording by the Secretary of State.

30. VETO

After both houses have passed a bill, and it becomes an act, the Governor possesses the constitutional right to veto it. A two-thirds vote of each House is necessary in order for the Legislature to override the Governor's veto.

31. INTERIM

The period between regular sessions is known as the interim. Committees may meet between sessions and take action on proposed legislation.

32. SESSION

Session has two legislative meanings. A session may be the daily meeting of the Senate or House. It also may be the regular, special, extended, or organization session, meaning the whole period for which the Legislature has been called together.

33. SINE DIE

"Sine die" means "without delay," and this is the action, which concludes a session of the Legislature.

Florida House Of Representatives

HOUSE HEALTHCARE COUNCIL

			<i>Party</i>	<i>District</i>
Aaron Bean (CHAIR)	200 HOB	488-6920	R	12
Juan Zapata (VICE CHAIR)	214 HOB	488-9550	R	119
Tom Anderson	417 HOB	488-8528	R	45
Loranne Ausley	1001 CAP	488-0965	D	09
Bill Galvano	214 HOB	488-4086	R	68
Rene Garcia	214 HOB	487-2197	R	110
Hugh Gibson	200 HOB	488-5991	R	42
Gayle Harrell	210 HOB	488-8749	R	81
Alan Hays	417 HOB	488-0348	R	25
Ed Hooper	1102 CAP	488-1540	R	50
Jimmy Patronis	1102 CAP	488-9696	R	06
Ari Porth	1301 CAP	488-2124	D	96
Elaine Schwartz	1401 CAP	488-0465	D	99
Kelly Skidmore	1401 CAP	488-1302	D	90
Priscilla Taylor	1401 CAP	488-8632	D	84

HOUSE HEALTH INNOVATION COMMITTEE

			<i>Party</i>	<i>District</i>
Rene Garcia (CHAIR)	214 HOB	487-2197	R	110
Jimmy Patronis (VICE CHAIR)	1102 CAP	488-9696	R	06
Jim Frishe	1102 CAP	488-9960	R	54
Eddy Gonzalez	1101 CAP	488-1683	R	102
Ed Homan, MD	317 HOB	488-3087	R	60
Ari Porth	1301 CAP	488-2124	D	96
Maria Sachs	1401 CAP	488-1662	D	86
Franklin Sands	1302 CAP	488-0590	D	98
Will Weatherford	1101 CAP	488-5744	R	61

HOUSE HEALTH QUALITY COMMITTEE

			<i>Party</i>	<i>District</i>
Gayle Harrell (CHAIR)	210 HOB	488-8749	R	81
Alan Hays (VICE CHAIR)	417 HOB	488-0348	R	25
Debbie Boyd	1401 CAP	488-9835	D	11
Larry Cretul	412 HOB	488-0887	R	22
Audrey Gibson	1301 CAP	488-7417	D	15
Doug Holder	1101 CAP	488-1171	R	70
Paige Kreegel, MD	308 HOB	488-9175	R	72
Julio Robaina	317 HOB	488-6506	R	117
Robert Schenck	1102 CAP	488-6641	R	44
Kelly Skidmore	1401 CAP	488-1302	D	90

HOUSE HEALTHY SENIORS COMMITTEE

			<i>Party</i>	<i>District</i>
Hugh Gibson (CHAIR)	200 HOB	488-5991	R	42
Thomas Anderson (VICE CHAIR)	417 HOB	488-8528	R	45
Donald Brown	313 HOB	488-4726	R	05
Richard Glorioso	405 HOB	488-0807	R	62
Richard Macheck	209 HOB	488-5588	D	78
JC Planas	1003 CAP	488-3616	R	115
Elaine Schwartz	1401 CAP	488-0465	D	99
James Waldman	1401 CAP	488-3164	D	95
Trudi Williams	221 CAP	488-2047	R	75

HOUSE HEALTHY FAMILIES COMMITTEE

			<i>Party</i>	<i>District</i>
Bill Galvano (CHAIR)	214 CAP	488-4086	R	68
Ed Hooper (VICE CHAIR)	1102 CAP	488-1540	R	50
Susan Bucher	410 HOB	488-0175	D	88
Michael Grant	303 HOB	488-0060	R	71
Denise Grimsley	223 CAP	488-3457	R	77
John Quinones	1101 CAP	488-9240	R	49
Yolly Roberson	218 HOB	488-7088	D	104
Priscilla Taylor	1401 CAP	488-8632	D	84
Nick Thompson	1003 CAP	488-1541	R	73

HOUSE SAFETY & SECURITY COUNCIL

			<i>Party</i>	<i>District</i>
Charles Dean (CHAIR)	218 HOB	488-0805	R	43
Dennis Ross (VICE CHAIR)	204 HOB	488-2270	R	64
Sandra Adams	204 HOB	488-0468	R	33
Jim Frishe	1102 CAP	488-9960	R	54
Luis Garcia	1301 CAP	488-9930	D	107
Dorothy Hukill	327 CAP	488-6653	R	28
Marcelo Lorente	218 HOB	488-5047	R	116
Mark Mahon	204 HOB	488-4171	R	16
Mitche Needelman	209 HOB	488-2528	R	31
Frank Peterman	1302 CAP	488-0925	D	55
Yolly Roberson	218 HOB	488-7088	D	104
Maria Sachs	1401 CAP	488-1662	D	86
William Snyder	1101 CAP	488-8832	R	82
Nick Thompson	1003 CAP	488-1541	R	73
Perry Thurston	1401 CAP	488-1084	D	93

HOUSE CONSTITUTION & CIVIL LAW COMMITTEE

			<i>Party</i>	<i>District</i>
Marcelo Lorente (CHAIR)	218 HOB	488-5047	R	116
Dorothy Hukill (VICE CHAIR)	327 CAP	488-6653	R	28
Donald Brown	313 HOB	488-4726	R	05
Anitere Flores	212 CAP	488-2831	R	114
David Mealor	203 HOB	488-5843	R	34
Maria Sachs	1401 CAP	488-1662	D	86
Elaine Schwartz	1401 CAP	488-0465	D	99
John (Jack) Seiler	212 CAP	488-0880	D	92
David Simmons	212 CAP	488-2231	R	37

HOUSE INSURANCE COMMITTEE

			<i>Party</i>	<i>District</i>
Donald Brown (CHAIR)	313 HOB	488-4726	R	05
Ralph Poppell (VICE CHAIR)	405 HOB	488-3006	R	29
Carl Domino	405 HOB	488-0322	R	83
Terry Fields	317 HOB	488-6893	D	14
Audrey Gibson	1301 CAP	488-7417	D	15
Eddy Gonzalez	1101 CAP	488-1683	R	102
Janet Long	1402 CAP	488-6197	D	51
Bill Proctor	327 CAP	488-2977	R	20
Robert Schenck	1102 CAP	488-6641	R	44
Priscilla Taylor	1401 CAP	488-8632	D	84

HOUSE POLICY & BUDGET COUNCIL

			<i>Party</i>	<i>District</i>
Ray Sansom (CHAIR)	418 CAP	488-1170	R	04
Stan Mayfield (VICE CHAIR)	222 CAP	488-0952	R	80
Kevin Ambler	410 HOB	488-0275	R	47
Loranne Ausley	1001 CAP	488-0965	D	09
Aaron Bean	200 HOB	488-6920	R	12
Dorothy Bendross-Mindingall	214 CAP	488-0625	D	109
Ellyn Bogdanoff	323 CAP	488-0635	R	91
Marty Bowen	322 CAP	488-2721	R	65
Mary Brandenburg	221 CAP	488-0260	D	89
Donald Brown	313 HOB	488-4726	R	05
Dean Cannon	422 CAP	488-2742	R	35
Joyce Cusack	316 CAP	488-0580	D	27
Charles Dean	218 HOB	488-0805	R	43
Bill Galvano	214 CAP	488-4086	R	68
Andy Gardiner	303 HOB	488-9770	R	40
Michael Grant	303 HOB	488-0060	R	71
Adam Hasner	322 CAP	488-2234	R	87
Alan Hays	417 HOB	488-0348	R	25
Will Kendrick	223 CAP	488-7870	R	10
Dick Kravitz	417 HOB	488-1304	R	19
Matt Meadows	317 HOB	488-8234	D	94
Joe Pickens	214 CAP	488-0665	R	21
Ron Reagan	317 HOB	488-6341	R	67
Curtis Richardson	1001 CAP	488-1798	D	08
David Rivera	422 CAP	488-7897	R	112
Yolly Roberson	218 HOB	488-7088	D	104
Dennis Ross	204 HOB	488-2270	R	64
Ron Saunders	1402 CAP	488-9965	D	120
John (Jack) Seiler	212 CAP	488-0880	D	92
Priscilla Taylor	1401 CAP	488-8632	D	84
Trey Traviesa	214 CAP	488-9910	R	56
Baxter Troutman	223 CAP	488-9465	R	66
Shelly Vana	1402 CAP	488-4791	D	85
Juan Zapata	214 HOB	488-9550	R	119

2007 – 2008 House Districts & Representatives

DISTRICT	REPRESENTATIVE	COUNTIES	PARTY
1	Evers, Greg	Escambia, Okaloosa, Santa Rosa	R
2	Murzin, Dave	Escambia	R
3	<i>**To be determined**</i>	Escambia, Santa Rosa	
4	Sansom, Ray	Okaloosa, Santa Rosa	R
5	Brown, Donald	Holmes, Jackson, Okaloosa, Walton, Washington	R
6	Patronis, Jimmy T.	Bay, Franklin, Gulf	R
7	Coley, Marti	Bay, Calhoun, Gadsden, Jackson, Leon, Liberty, Okaloosa, Wakulla, Walton	R
8	Richardson, Curtis	Gadsden, Leon	D
9	Ausley, Lorraine	Gadsden, Jefferson, Leon	D
10	Kendrick, Will	Alachua, Columbia, Dixie, Franklin, Hamilton, Jefferson, Levy, Madison, Taylor, Wakulla	R
11	Boyd, Debbie	Alachua, Columbia, Dixie, Gilchrist, Lafayette, Suwannee	D
12	Bean, Aaron	Baker, Bradford, Clay, Duval, Nassau, Union	R
13	Carroll, Jennifer	Clay, Duval	R
14	Fields, Terry	Duval	D
15	Gibson, Audrey	Duval	D
16	Mahon, Mark	Duval	R
17	Jordan, Stan	Duval	R
18	Davis, Don	Duval, St. Johns	R
19	Kravitz, Dick	Clay, Duval, St. Johns	R
20	Proctor, Bill	Clay, Flagler, St. Johns	R
21	Pickens, Joe H.	Bradford, Clay, Lake, Marion, Putnam, Volusia	R
22	Cretul, Larry	Alachua, Levy, Marion	R
23	Chestnut, Charles "Chuck"	Alachua, Marion	D
24	Baxley, Dennis	Marion	R
25	Hays, Alan D.	Lake, Seminole, Volusia	R
26	Patterson, Pat	Flagler, Volusia	R
27	Cusack, Joyce	Volusia	D
28	Hukill, Dorothy L.	Volusia	R
29	Poppell, Ralph	Brevard, Indian River	R
30	Altman, Thad	Brevard	R
31	Needelman, Mitch	Brevard	R
32	Allen, Bob	Brevard, Orange	R
33	Adams, Sandra "Sandy"	Orange, Seminole, Volusia	R
34	Mealor, David J.	Orange, Seminole	R
35	Cannon, Dean	Orange	R
36	Randolph, Scott	Orange	D
37	Simmons, David	Orange, Seminole	R
38	Nelson, Bryan	Orange	R
39	Thompson, Geraldine F.	Orange	D

40	Gardiner, Andy	Orange	R
41	Precourt, Steve	Lake, Orange, Osceola	R
42	Gibson III, Hugh	Lake, Marion, Sumter	R
43	Dean, Charles S. "Charlie"	Citrus, Hernando, Levy	R
44	Schenck, Robert C. "Rob"	Hernando, Pasco, Sumter	R
45	Anderson, Thomas "Tom"	Pasco, Pinellas	R
46	Legg, John	Pasco	R
47	Ambler, Kevin C.	Hillsborough	R
48	Nehr, Peter	Pasco, Pinellas	R
49	Quinones, John "Q"	Orange, Osceola	R
50	Hooper, Ed	Pinellas	R
51	Long, Janet C.	Pinellas	D
52	Heller, Bill	Pinellas	D
53	Kriseman, Rick	Pinellas	D
54	Frishe, James	Pinellas	R
55	Peterman Jr., Frank	Hillsborough, Manatee, Pinellas, Sarasota	D
56	Traviesa, Trey	Hillsborough	R
57	Culp, Faye B.	Hillsborough	R
58	Scionti, Michael	Hillsborough	D
59	Reed, Betty	Hillsborough	D
60	Homan, Ed	Hillsborough	R
61	Weatherford, Will	Hillsborough, Pasco	R
62	Glorioso, Richard "Rich"	Hillsborough, Pasco	R
63	McKeel, Seth D.	Hillsborough, Polk	R
64	Ross, Dennis A.	Polk	R
65	Bowen, Marsha L. "Marty"	Polk	R
66	Troutman, Baxter G.	Hardee, Highlands, Polk	R
67	Reagan, Ron	Hillsborough, Manatee, Sarasota	R
68	Galvano, Bill	Hillsborough, Manatee	R
69	Fitzgerald, Keith	Manatee, Sarasota	D
70	Holder, Doug	Sarasota	R
71	Grant, Michael J.	Charlotte, Lee, Sarasota	R
72	Kreegel, Paige	Charlotte, DeSoto, Lee	R
73	Thompson, Nick	Lee	R
74	Aubuchon, Gary	Charlotte, Lee	R
75	Williams, Trudi K.	Collier, Lee	R
76	Richter, Garrett	Collier	R
77	Grimsley, Denise	Collier, Glades, Hendry, Highlands	R
78	Machek, Richard A.	Martin, Okeechobee, Palm Beach, St. Lucie	D
79	Attkisson, Frank	Okeechobee, Orange, Osceola, Polk	R
80	Mayfield, Stan	Brevard, Indian River, St. Lucie	R
81	Harrell, Gayle B.	Martin, St. Lucie	R
82	Snyder, William D.	Martin, Palm Beach, St. Lucie	R
83	Domino, Carl	Palm Beach	R
84	Taylor, Priscilla	Palm Beach	D
85	Vana, Shelley	Palm Beach	D
86	Sachs, Maria L.	Palm Beach	D

87	Hasner, Adam	Broward, Palm Beach	R
88	Bucher, Susan	Palm Beach	D
89	Brandenburg, Mary	Palm Beach	D
90	Skidmore, Kelly	Broward, Palm Beach	D
91	Bogdanoff, Ellyn S.	Broward, Palm Beach	R
92	Seiler, John P. "Jack"	Broward	D
93	Thurston, Perry E.	Broward	D
94	Meadows, Matt J.	Broward	D
95	Waldman, James W. "Jim"	Broward	D
96	Porth, Ari	Broward	D
97	Kiar, Martin D. "Marty"	Broward	D
98	Sands, Franklin	Broward	D
99	Schwartz, Elaine	Broward	D
100	Jenne, Evan	Broward	D
101	Davis, Mike	Broward, Collier	R
102	Gonzalez, Eduardo "Eddy"	Broward, Miami-Dade	R
103	Holloway, Wilbert "Tee"	Broward, Miami-Dade	D
104	Roberson, Yolly	Miami-Dade	D
105	Gibbons, Joseph A. "Joe"	Broward	D
106	Gelber, Dan	Miami-Dade	D
107	Garcia, Luis	Miami-Dade	D
108	Brisé, Ronald A.	Miami-Dade	D
109	Bendross-Mindingall, Dorothy	Miami-Dade	D
110	Garcia, Rene	Miami-Dade	R
111	Rubio, Marco (SPEAKER)	Miami-Dade	R
112	Rivera, David	Broward, Collier, Miami- Dade	R
113	Lopez-Cantera, Carlos	Miami-Dade	R
114	Flores, Anitere	Miami-Dade	R
115	Planas, Juan-Carlos "JC"	Miami-Dade	R
116	Llorente, Marcelo	Miami-Dade	R
117	Robaina, Julio	Miami-Dade	R
118	Bullard, Edward S. "Ed"	Miami-Dade	D
119	Zapata, Juan	Miami-Dade	R
120	Saunders, Ron	Miami-Dade, Monroe	D

ADAMS, Sandy

33-R

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32-R

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30-R

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47-R

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45-R

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79-R

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74-R

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9-D

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24-R

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12-R

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109-D

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91-R

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65-R

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11-D

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89-D

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108-D

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5-R

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88-D

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118-D

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35-R

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13-R

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23-D

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7-R

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22-R

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57-R

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27-D

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18-R

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101-R

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43-R

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83-R

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1-R

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14-D

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69-D

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114-R

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54-R

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68-R

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107-D

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110-R

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40-R

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106-D

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105-D

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15-D

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42-R

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62-R

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102-R

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71-R

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77-R

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81-R

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87-R

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25-R

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HELLER, Bill

52-D

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(727) 552-2573*Email:* bill.heller@myfloridahouse.gov**HOLDER, Doug**

70-R

*Tallahassee Office:*1101 Capitol
(850) 488-1171*District Office:***8486 South Tamiami Trail
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103-D

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Miami 33169
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60-R

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(850) 488-3087*District Office:***9385 North 56th St., Suite 311
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(813) 983-3330*E-mail:* ed.homan@myfloridahouse.gov**HOOPER, Ed**

50-R

*Tallahassee Office:*1102 Capitol
(850) 488-1540*District Office:***2963 Gulf to Bay Blvd., Ste. 206
Clearwater, 33759-4259
(727) 724-3000*Email:* ed.hooper@myfloridahouse.gov**HUKILL, Dorothy**

28-R

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(386) 424-2365*E-mail:* dorothy.hukill@myfloridahouse.gov**JENNE, Evan**

100-D

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Davie, 33314
(954) 321-2760*Email:* evan.jenne@myfloridahouse.gov**JORDAN, Stan**

17-R

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(904) 359-2644*E-mail:* stan.jordan@myfloridahouse.gov**KENDRICK, Will**

10-R

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97-D

*Tallahassee Office:*1402 Capitol
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KRAVITZ, Dick

19-R

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72-R

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53-D

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46-R

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116-R

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51-D

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113-R

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78-D

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16-R

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80-R

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MCKEEL, Seth

63-R

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94-D

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Lauderhill 33313-3723
(954) 497-3367*E-mail:* matt.meadows@myfloridahouse.gov**MEALOR, David**

34-R

*Tallahassee Office:*203 House Office Building
(850) 488-5843*District Office:***225 Waymont Court, Suite 101
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(407) 328-3718*E-mail:* david.mealor@myfloridahouse.gov**MURZIN, Dave**

2-R

*Tallahassee Office:*308 House Office Building
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(850) 494-7330*E-mail:* dave.murzin@myfloridahouse.gov**NEEDELMAN, Mitch**

31-R

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(850) 488-2528*District Office:***1565 Sarno Road, Suite A
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48-R

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(727) 943-4880*E-mail:* peter.nehr@myfloridahouse.gov**NELSON, Bryan**

38-R

*Tallahassee Office:*1003 Capitol
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6-R

*Tallahassee Office:*1102 Capitol
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26-R

*Tallahassee Office:*402 House Office Building
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(386) 736-5100*E-mail:* pat.patterson@myfloridahouse.gov**PETERMAN Jr., Frank**

55-D

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PICKENS, Joe

21-R

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115-R

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29-R

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96-D

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41-R

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20-R

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49-R

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36-D

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67-R

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59-D

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RICHARDSON, Curtis

8-D

*Tallahassee Office:*1001 Capitol
(850) 488-1798*District Office:***402 South Monroe Street
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Tallahassee 32399-1300
(850) 488-1798*E-mail:* curtis.richardson@myfloridahouse.gov**RICHTER, Garrett**

76-R

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112-R

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117-R

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104-D

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64-R

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111-R

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86-D

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98-D

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4-R

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SAUNDERS, Ron

120-D

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44-R

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99-D

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1401 Capitol

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58-D

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92-D

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37-R

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90-D

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82-R

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84-D

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39-D

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THOMPSON, Nick

73-R

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93-D

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56-R

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66-R

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85-D

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95-D

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61-R

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75-R

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119-R

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Florida Senate

SENATE SOCIAL RESPONSIBILITY COUNCIL

			<i>Party</i>	<i>District</i>
Burt Saunders (CHAIR)	418 SOB	487-5124	R	37
Jeff Atwater	406 SOB	487-5100	R	25
Victor Crist	208 SOB	487-5068	R	12
Mandy Dawson	410 SOB	487-5112	D	29
Don Gaetz	320 SOB	487-5009	R	04
Gwen Margolis	214 SOB	487-5121	D	35
Steve Oelrich	310 SOB	487-5020	R	14
Jeremy Ring	326 SOB	487-5094	D	32
Gary Siplin	205 SOB	487-5190	D	19
Ronda Storms	318 SOB	487-5072	R	10
Frederica S. Wilson	202 SOB	487-5116	D	33

SENATE HEALTH POLICY COMMITTEE

			<i>Party</i>	<i>District</i>
Mandy Dawson (CHAIR)	410 SOB	487-5112	D	29
Victor Crist (VICE CHAIR)	208 SOB	487-5068	R	12
Nancy Argenziano	311 SOB	487-5017	R	03
Paula Dockery	314 SOB	487-5040	R	15
Rudy Garcia	416 SOB	487-5106	R	40
Arthenia Joyner	224 SOB	487-5059	D	18
Burt Saunders	418 SOB	487-5124	R	37

SENATE HEALTH REGULATION COMMITTEE

			<i>Party</i>	<i>District</i>
Jeff Atwater (CHAIR)	406 SOB	487-5100	R	25
Gary Siplin (VICE CHAIR)	205 SOB	487-5190	D	19
JD Alexander	412 SOB	487-5044	R	17
Dave Aronberg	405 SOB	487-5356	D	27
Mike Fasano	302 SOB	487-5062	R	11
Dennis Jones	408 SOB	487-5065	R	13
Al Lawson	210 SOB	487-5004	D	06
Durell Peaden	222 SOB	487-5000	R	02

SENATE JUDICIARY COMMITTEE

			<i>Party</i>	<i>District</i>
Alex Villalobos (CHAIR)	306 SOB	487-5130	R	38
Arthenia Joyner (VICE CHAIR)	224 SOB	487-5059	D	18
Carey Baker	316 SOB	487-5014	R	20
Ted Deutch	324 SOB	487-5091	D	30
Alex Diaz de la Portilla	414 SOB	487-5109	R	36
Mike Fasano	302 SOB	487-5062	R	11
Don Gaetz	320 SOB	487-5009	R	04
Steve Geller	228 SOB	487-5097	D	31
Jeremy Ring	326 SOB	487-5094	D	32
Burt Saunders	418 SOB	487-5124	R	37
Daniel Webster	330 SOB	487-5047	R	09

SENATE BANKING AND INSURANCE COMMITTEE

			<i>Party</i>	<i>District</i>
Bill Posey (CHAIR)	420 SOB	487-5053	R	24
Ted Deutch (VICE CHAIR)	324 SOB	487-5091	D	30
JD Alexander	412 SOB	487-5044	R	17
Jeff Atwater	406 SOB	487-5100	R	25
Mike Bennett	216 SOB	487-5078	R	21
Mandy Dawson	410 SOB	487-5112	D	29
Don Gaetz	320 SOB	487-5009	R	04
Al Lawson	210 SOB	487-5004	D	06
Durell Peaden	222 SOB	487-5000	R	02
Ronda Storms	318 SOB	487-5072	R	10
Frederica S. Wilson	202 SOB	487-5116	D	33

SENATE HEALTH AND HUMAN SERVICES APPROPRIATIONS *Party* *District*

Durell Peaden Jr. (CHAIR)	222 SOB	487-5000	R	02
Nan Rich (VICE CHAIR)	226 SOB	487-5103	D	34
Don Gaetz	320 SOB	487-5009	R	04
Burt Saunders	418 SOB	487-5124	R	37
Frederica S. Wilson	202 SOB	487-5116	D	33

2007 – 2008 Senate Districts & Senators

DISTRICT	SENATOR	COUNTIES	PARTY
1	Hill, Anthony C. "Tony"	Duval, Flagler, Putnam, St. Johns, Volusia	D
2	Peaden, Durell	Bay, Escambia, Holmes, Okaloosa, Santa Rosa, Walton, Washington	R
3	Argenziano, Nancy	Baker, Citrus, Columbia, Dixie, Hamilton, Jefferson, Lafayette, Leon, Levy, Madison, Marion, Suwannee, Taylor	R
4	Gaetz, Don	Bay, Escambia, Okaloosa, Santa Rosa, Walton	R
5	Wise, Stephen R.	Clay, Duval, Nassau, St. Johns	R
6	Lawson, Alfred "Al"	Bay, Calhoun, Franklin, Gadsden, Gulf, Jackson, Jefferson, Leon, Liberty, Madison, Wakulla	D
7	Lynn, Evelyn J.	Clay, Marion, Putnam, Volusia	R
8	King, James E. "Jim"	Duval, Flagler, Nassau, St. Johns, Volusia	R
9	Webster, Daniel	Orange, Osceola, Seminole	R
10	Storms, Ronda	Hillsborough, Pasco, Polk	R
11	Fasano, Mike	Citrus, Hernando, Pasco, Pinellas	R
12	Crist, Victor D.	Hillsborough, Pasco	R
13	Jones, Dennis L.	Pinellas	R
14	Oelrich, Steve	Alachua, Bradford, Columbia, Gilchrist, Levy, Marion, Putnam, Union	R
15	Dockery, Paula	Hernando, Lake, Osceola, Polk, Sumter	R
16	Justice, Charlie	Hillsborough, Pinellas	D
17	Alexander, JD	DeSoto, Glades, Hardee, Highlands, Okeechobee, Polk, St. Lucie	R
18	Joyner, Arthenia L.	Hillsborough, Manatee, Pinellas	D
19	Siplin, Gary	Orange, Osceola	D
20	Baker, Carey	Lake, Marion, Seminole, Sumter, Volusia	R
21	Bennett, Michael S. "Mike"	Charlotte, DeSoto, Lee, Manatee, Sarasota	R
22	Constantine, Lee	Orange, Seminole	R
23	Carlton, Lisa	Charlotte, Manatee, Sarasota	R
24	Posey, Bill	Brevard, Orange, Seminole	R
25	Atwater, Jeffrey H. "Jeff"	Broward, Palm Beach	R
26	Haridopolos, Mike	Brevard, Indian River, Osceola, St. Lucie	R

27	Aronberg, Dave	Charlotte, Glades, Hendry, Lee, Palm Beach	D
28	Pruitt, Ken (PRESIDENT)	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	R
29	Dawson, M. Mandy	Broward, Palm Beach	D
30	Deutch, Ted	Broward, Palm Beach	D
31	Geller, Steven A.	Broward	D
32	Ring, Jeremy	Broward	D
33	Wilson, Frederica S.	Miami-Dade	D
34	Rich, Nan	Broward, Miami-Dade	D
35	Margolis, Gwen	Broward, Miami-Dade	D
36	Diaz de la Portilla, Alex	Miami-Dade	R
37	Saunders, Burt L.	Collier, Lee	R
38	Villalobos, J. Alex	Miami-Dade	R
39	Bullard, Larcenia J.	Broward, Collier, Hendry, Miami-Dade, Monroe, Palm Beach	D
40	Garcia, Rudy	Miami-Dade	R

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17-R

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3-R

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25-R

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20-R

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21-R

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39-D

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23-R

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22-R

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12-R

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31-D

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14-R

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37-R

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38-R

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33-D

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Florida Congressional Districts

2007-2008 Florida Congressional Districts

(Democrats *italicized* and Republicans underlined)

U.S. Representatives	District
1 <u>Jeff Miller</u>	Pensacola
2 <i>Allen Boyd</i>	Monticello
3 <i>Corrine Brown</i>	Jacksonville
4 <u>Ander Crenshaw</u>	Jacksonville
5 <u>Ginny Brown-Waite</u>	Dunnellon
6 <u>Cliff Stearns</u>	Ocala
7 <u>John L. Mica</u>	Winter Park
8 <u>Ric Keller</u>	Orlando
9 <u>Gus Bilirakis</u>	Tarpon Springs
10 <u>C. W. Bill Young</u>	Indian Rocks Beach
11 <i>Kathy Castor</i>	Tampa
12 <u>Adam H. Putnam</u>	Bartow
13 <u>Vernon Buchanan</u>	Bradenton
14 <u>Connie Mack</u>	Fort Myers
15 <u>Dave Weldon</u>	Palm Bay
16 <i>Tim Mahoney</i>	West Palm Beach
17 <i>Kendrick Meek</i>	Miami
18 <u>Ileana Ros-Lehtinen</u>	Miami
19 <i>Robert Wexler</i>	Boca Raton
20 <i>Debbie Wasserman Schultz</i>	Pembroke Pines
21 <u>Lincoln Diaz-Balart</u>	Miami
22 <i>Ron Klein</i>	Ft. Lauderdale
23 <i>Alcee L. Hastings</i>	Miramar
24 <u>Tom Feeney</u>	Orlando
25 <u>Mario Diaz-Balart</u>	Miami
U.S. Senators <i>Bill Nelson</i> <u>Mel Martinez</u>	

(Democrats *italicized* and Republicans underlined)

2007-2008 Florida Congressional Districts

(Democrats *italicized* and Republicans underlined)

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FMA Staff Bios

Our Mission

The Florida Medical Association serves as an advocate for physicians and their patients to promote the public health, to ensure high standards in medical education and ethics, and to enhance the quality and availability of health care.

Our History

The Florida Medical Association was established January 14, 1874. This was the second attempt, and it proved successful with a charter membership of 25. Membership has grown to 17,500 in the 21st century.

In February 1875, the second annual meeting produced the Constitution and By-Laws naming the organization "The Florida Medical Association." The Association stated its objective as follows: "The objective of this Association shall be to organize the Medical Profession throughout the State in the most efficient manner, to promote union, harmony, professional acquirement, and ethics, and to inspire interest and zeal for the cultivation of medical science and literature."

The objective has changed to include patient advocacy. Patient advocacy was always the intent of the FMA's Mission. Physicians are the only true advocates for patients.

Today, the FMA along with its political arm, FLAMPAC, is among the most effective and highly respected advocacy groups in the State of Florida.

The FMA employs an in-house lobbying staff of 11 individuals, supplemented by nine contract lobbyists. In addition, FLAMPAC has a full-time political staff. All of these individuals are dedicated to advancing the legislative and political agenda of the patients and physicians of Florida.

Patrick M.J. Hutton, M.D., M.B.A., President, Florida Medical Association

Dr. Patrick Hutton, an orthopaedic surgeon, has been in private practice in Jacksonville and Orange Park, Florida for the past 25 years. He received his medical degree from New York Medical College in 1974 and received his M.B.A. from Auburn University. As FMA President, Dr. Hutton believes in the building blocks of legislative activism, membership development and fiscal responsibility. He pledges his commitment to making the FMA the leader in patient and physician advocacy.

Sandra Mortham, EVP/CEO

Over 20 years of public service. Secretary of State of Florida 1994 - 1998. Served in the House of Representatives 1986 - 1994 and as Republican Leader 1992 - 1994. Previously served as Largo County Commissioner and Vice Mayor. Graduate of Eckerd College.

Francesca Plendl, Director of Governmental Affairs

Responsible for the development and implementation of legislative and regulatory activities. Former attorney for the Board of Medicine. Graduate of Florida State University College of Law.

Tim Stapleton, FLAMPAC Executive Director

Responsible for the FMA's political operations. Served in this capacity during the last four election cycles. Over 15 years of legislative and political experience. Prior to joining the FMA, worked for the American Medical Association and the Medical Society of the State of New York. Served as legislative director for the Illinois Attorney General. Graduate of Indiana University with a B.A. in Political Science.

John Knight, General Counsel

Over 25 years of legal and lobbying experience, including representing physicians and hospitals before regulatory agencies. Expertise in managed care issues. Graduate of American University and Florida State University College of Law.

Jeff Scott, Associate General Counsel

Former trial attorney defending physicians in medical liability cases. Expertise in tort issues. Graduate of the University of Southern Mississippi and Florida State University College of Law.

Fred Whitson, Director of Medical Economics

Former attorney for the Florida Board of Medicine and Department of Insurance. Responsible for issues related to insurance, workers' compensation, managed care, Medicaid, public health and governmental programs. Graduate of the University of Utah and Florida State University College of Law.

Michelle Jacquis, Legislative Analyst

Responsible for tracking and analyzing legislation, and staffing the Specialty Society Section. Assists with legislative activities and lobbying. Joined the FMA in 1999. Graduate of Florida State University with a B.S. in Political Science.

Sarah Rothell, FLAMPAC Associate Director

Responsible for the daily operations of FLAMPAC. Assists with lobbying and grassroots activities. Joined FMA in 1999 after working for the Florida House of Representatives. Graduate of Iowa State University with a B.A. in Political Science.

Joyce Malone, Director of Grassroots Advocacy

Served as Executive Director of Citizens for a Fair Share and former special assistant to Jeb Bush. A veteran of numerous local, state and national campaigns. Served as the Director of the Transition team for the Republican Party of Florida in 2003. Joined the FMA in 2004. Ms. Malone holds a BAE from the University of Florida and an MBA from Stetson University.

Emily Fritz, Project Director

Former Director of Citizens' Services for Governor Bush and Director of Medicaid Community Relations. Previously worked in pharmaceutical and managed care industries. Graduate of the University of Alabama.

Diane Hood, Legislative Assistant

Provides support for the legislative section. Responsible for staffing the Council on Legislation and assisting with legislative activities. Joined the FMA in 2005 after working for the Florida Public Service Commission.

Amy Glover, Legal Specialist

Responsible for the daily operations of the Office of the General Counsel. Assists with legal and legislative activities. Joined the FMA in 2003 after working for Dennis, Jackson, Martin and Fontela, P.A., and the Board of Medicine.

Jon Johnson, Contract Lobbyist

Jon Johnson founded his lobbying and consulting firm, Johnson and Blanton, in 1995, representing a variety of corporate and non-profit clients. Johnson's lobbying and political consulting experience includes diverse areas such as: health care, managed care, worker's compensation, professional regulation, insurance, telecommunications, utilities and criminal justice.

Travis Blanton, Contract Lobbyist

A partner with Johnson and Blanton in Tallahassee, Travis has served as chief of staff for the Agency for Health Care Administration, legislative affairs director for the Florida Department of Elder Affairs, and senior Senate liaison for the Republican Party of Florida.

Brian Ballard, Contract Lobbyist

Brian is the Managing Partner of Smith & Ballard. He is currently Of Counsel to Panza, Maurer & Maynard, LLP. He earned a B.S. and J.D. from the University of Florida and is a Martindale Hubbell A.V. rated member of the Florida Bar. His practice area specializes in governmental affairs, including legislative and executive branch advocacy.

Mary Kay Cariseo, Contract Lobbyist

Joined the firm of Smith & Ballard after 10 years at the helm of the Florida Association of Counties. Prior to that she was an Assistant Vice President for Governmental Relations at FSU. She has worked in the Florida House and has lobbied for over 22 years.

Joe McCann, Contract Lobbyist

Served as an aide in the Florida House and Florida Senate from 1993-1998. Prior to that served as an aide to Congressman Jim Bacchus in Washington. Joined the Firm of Smith & Ballard in 1999.

Jorge Chamizo, Contract Lobbyist

An attorney and governmental consultant who represents a variety of clients before the Florida Legislature and several state regulatory agencies on health care, energy, telecommunications, and environmental issues. Graduated cum laude from the Florida State University College of Law in 2000, and received his undergraduate degree in finance from the University of Miami in 1996.

Rockie Pennington, Contract Lobbyist

Served as the executive director of the state Republican party before opening his own firm, Southern Campaign Resources. He is also the owner/President of Summit Communications and Direct Mail Systems, Inc.

Mark Zubaly, Contract Lobbyist

Served as a legislative aide in the Florida House before becoming a lobbyist/consultant with Southern Campaign Resources.

Erik Kirk, Contract Lobbyist

President of Kirk Consulting Group, Inc., with offices in Tallahassee and West Palm Beach. Worked as Legislative Affairs Director at the Florida Hospital Association and served as Chief of Staff in Governor Bush's State Technology Office before opening his own firm.

Missy Timmins, Contract Lobbyist

Began her career in Florida politics in 1994, as a legislative assistant for the Florida Department of Labor and Security. Prior experience includes working for State Senator Jack Latvala and governmental consultant for McLeod and Associates. Missy started her own consulting company in 2005, Timmins Consulting, LLC.

2007 Legislative Agenda

Patrick M.J. Hutton, M.D., M.B.A., *President*
Karl M. Altenburger, M.D., *President-Elect*
Steven R. West, M.D., *Vice President*
Vincent A. DeGennaro, M.D., *Secretary*
James B. Dolan, M.D., *Treasurer*
Madelyn E. Butler, M.D., *Speaker*
Alan B. Pillersdorf, M.D., *Vice Speaker*
Troy M. Tippett, M.D., *Imm. Past President*



FLORIDA MEDICAL ASSOCIATION, INC.

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Sandra B. Mortham, *EVP & CEO*

FMA 2007 LEGISLATIVE AGENDA

PRIORITY ISSUES TO OPPOSE:

SCOPE OF PRACTICE EXPANSIONS

Continue to oppose all scope of practice expansions including naturopaths, ARNPs, pharmacists, optometrists, psychologists and podiatrists.

PROTECT ABILITY TO SELF INSURE

Oppose legislation that will take away a physician's ability to self insure or that will make it more difficult for a physician to meet the financial responsibility requirements for licensure.

FOREIGN PHYSICIAN LICENSURE

Oppose any legislation that allows a physician to practice in Florida without meeting the same requirements as all other applicants.

PHYSICIAN PROFILE ISSUES

Oppose any legislation that makes the laws relating to profiles more onerous.

HEARING INTERPRETERS

Oppose any legislation that increases the cost of hearing interpreters.

FABRE CHANGES

Oppose any legislation changing current law relating to the Fabre doctrine.

PHYSICIAN SUPERVISION ISSUES

Protect advances we have made relating to physician supervision of nurses and PAs.

PRIORITY ISSUES TO PASS:

COVERAGE OF THE UNINSURED

Pass a package to address the issue of the uninsured that includes but is not limited to: coverage of the uninsured; incentives for businesses to provide health insurance; increase in reimbursement rate for Medicaid to the greater of Medicare level or current Medicaid level; requirement that Medicaid patients be given a medical home; consideration of tort relief for Medicaid providers; incentives for patients who help reduce costs; an increase in residency funding.

EXPERT WITNESS

Pass legislation that requires expert witnesses to become licensed in Florida and clarifies that giving expert testimony is the practice of medicine.

PIP

Pass legislation to retain the current personal injury protection (PIP) system.

ISSUES TO SUPPORT:

PROFESSIONALS RESOURCE NETWORK

Obtain sovereign immunity for the two state programs (PRN and IPN) that provide impairment services to health care licensees.

2007 Legislative Fact Sheets

Florida Medical Association FACT SHEET



INCREASE IN MEDICAID REIMBURSEMENT FOR FLORIDA PHYSICIANS

FMA Contacts: Francie Plendl / Fred Whitson

FMA Position

In order to ensure that Medicaid participants have access to a large pool of quality health care providers, the FMA supports an increase in Medicaid physician reimbursement rates from 57% of Medicare to 100% of Medicare; the creation of “medical homes” for patients; and an increase in the number of residency programs available to Florida medical school graduates,

Background

According to the Agency for Health Care Administration’s *Medicaid Summary of Services 2006-2007*, Florida’s Medicaid Program serves around 2.2 million people. The estimated cost of these services for Fiscal Year 2006-2007 is approximately \$15.9 billion. Despite recent efforts by the Florida Legislature to revamp the Medicaid system to curb costs and provide services to those in need, access to quality providers continues to be a growing problem. Currently, Medicaid providers only receive 57% of the current Medicare rate which, in many instances, does not allow a provider to cover the overhead costs of a patient’s office visit. For example, a primary care provider receives only \$24 for an office visit for a Medicaid patient. The cost of services and the number of Medicaid patients continue to increase while reimbursement rates for providers do not. As a result, the pool of high quality health care providers is becoming more and more limited. This has resulted in an access to care problem for Medicaid patients, particularly those who are considered high risk.

Discussion

To ensure that all Medicaid patients have access to a large pool of quality health care providers, Florida must make several vital changes. First, Medicaid physician reimbursement rates should be raised from the current 57% of Medicare to 100% of Medicare. Second, to improve the health care of all Floridians and reduce health care costs to the State, each Medicaid patient should have a “medical home” whereby each Medicaid patient would be assigned to a single physician responsible for the oversight of a patient’s care by monitoring a patient’s prescriptions and specialist services to prevent over-utilization. Third, Florida must also increase the number of residency programs available to Florida’s medical school graduates in order to increase access to health care in medical facilities.

Adequate reimbursement for services provided is crucial in order to retain quality providers willing to serve Florida’s most vulnerable patients. As patient load and overhead costs rise, physicians become less willing to treat Medicaid patients. With the creation of medical homes, physicians will be able to ensure that patient preventative care is accomplished and chronic conditions are identified early. In addition, the establishment of this stable patient-physician relationship will provide the patient with an advocate in health care matters. By increasing the reimbursement rates for Medicaid providers and creating medical homes, Florida will be able to fix the current disparities that are reflected in illness incidence rates. In addition, an increase in the reimbursement rates for providers will encourage doctors in Florida’s residency programs to remain in Florida. At hospitals, most of the Medicaid and indigent care is provided by residents. Many of Florida’s medical school graduates are leaving the state because there are not enough residency positions. An increase in residency programs for graduates will increase the number of quality providers available to Medicaid patients.

Conclusion

In order to counter a decrease in access to Medicaid providers, Florida must increase providers’ reimbursement rates to 100% of Medicare, encourage the creation of “medical homes” for patients, and increase the number of residency programs available to Florida’s medical school graduates.

1/12/2007

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Florida Medical Association FACT SHEET



SOVEREIGN IMMUNITY FOR STATE'S TREATMENT PROGRAMS FOR HEALTH CARE LICENSEES

FMA Contact: Erik Kirk
(850) 528-4424

FMA Position

The FMA supports legislation to grant sovereign immunity to the Professionals Resource Network (PRN) and the Intervention Project for Nurses (IPN) who, by contract with the Florida Department of Health, provide impairment services to all MQA licensees. This legislation is also supported by the Florida Nurses Association.

Background

PRN and IPN are contracted by the Florida Department of Health to identify, intervene and provide appropriate referral and case management for all health care providers who are affected by a variety of impairments, primarily drugs and alcohol. These programs are nationally recognized as among the most successful programs in the country. They serve physicians, nurses and 25 other health care professions including dentists, pharmacists and chiropractors. These programs help to keep unsafe practitioners out of practice until they are able to safely practice, and monitors them closely thereafter.

Discussion

The proposed legislation grants PRN and IPN sovereign immunity when acting pursuant to their contracts with the Department of Health (DOH) to provide impairment services. Providing sovereign immunity to impairment providers is very necessary as both PRN and IPN provide impairment services as an agent of DOH, and are currently subject to lawsuits arising out of those services. These lawsuits drain the programs' resources and will make it difficult for them to continue to provide much needed resources for Florida patients.

There is precedent in Florida law for this granting of sovereign immunity. Pursuant to Section 768.28, Florida Statutes, the following entities are some of many in Florida that have been granted sovereign immunity:

- The Florida Space Authority
- Members of the Florida Health Services Corps
- Health care providers or vendors, or any of their employees or agents, that have contractually agreed to act as agents of the Department of Corrections
- Regional poison control centers
- Operators, dispatchers, and providers of security for rail services and rail facility maintenance providers in the South Florida Rail Corridor
- Professional firm that provides monitoring and inspection services of the work required for state roadway, bridge, or other transportation facility construction projects as agents of the Department of Transportation
- Providers or vendors, or any of their employees or agents, that have contractually agreed to act on behalf of the state as agents of the Department of Juvenile Justice
- A health care practitioner who has contractually agreed to act as an agent of a state university board of trustees to provide medical services to a student athlete

Conclusion

Granting sovereign immunity to these programs will help to ensure the continued safety of Florida patients.

1/16/07

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Florida Medical Association FACT SHEET



MEDICAL MALPRACTICE LITIGATION REFORM

SB by Senator
HB by Representative
FMA Contact: Jeff Scott

FMA Position

Expert witness testimony not only plays a key role in the outcome of a medical malpractice case, it also impacts the way medicine is practiced in Florida. The FMA believes that all expert witness testimony should be fair and accurate. The only way to ensure that expert testimony given by out-of-state experts accurately reflects the actual standard of care is to hold all experts accountable for their testimony. To provide this accountability, the FMA supports legislation that would require out-of-state physicians to obtain an expert witness certificate to testify in Florida.

Background

Current Florida law (Section 766.102(5), F.S.) provides that a person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets other criteria. The statute does not require that an expert hold a Florida license. Thus physicians who are licensed in states other than Florida are authorized and routinely provide expert testimony in medical malpractice cases in this state. Unfortunately, in many instances the testimony given does not accurately reflect the prevailing professional standard of care. These experts can generate large fees providing inaccurate testimony with the knowledge that they can do so with impunity. Trial judges do not have the knowledge to determine if expert testimony accurately reflects the standard of care and the Board of Medicine has no jurisdiction over out-of-state physicians. Clearly there needs to be a mechanism that would enable the state to hold expert witnesses accountable for the testimony they give in medical malpractice cases in Florida.

Discussion

The proposed legislation seeks to enact the following changes related to expert witness testimony:

- The bill would require a physician who is licensed outside of the state and wishes to testify as an expert in a malpractice case in Florida to obtain an expert witness certificate from the Board of Medicine.
- The only requirement for getting the certificate is that the expert be a licensed physician in good standing in another state. The application fee cannot exceed \$50 and will only serve to offset administration costs. All other fees imposed on Florida physicians are waived.
- The Board has five days from the receipt of the application to grant or deny the certificate. If the Board does not act within five days, the certificate is deemed granted. This ensures that Board inaction will not delay the prosecution of a malpractice suit.

- Under this bill only physicians who hold a Florida license or an expert witness certificate would be allowed to testify as an expert in a medical malpractice case.
- It is important to note that this applies to all experts in a medical malpractice case, both for the plaintiff and the defendant.
- The certificate holder would be entitled to the full range of due process protections as a Florida licensed physician, including appellate review of any decision revoking the person's certificate.
- The bill also conclusively establishes that the Board of Medicine can discipline a physician for providing false, deceptive or misleading expert witness testimony related to the practice of medicine.

Conclusion

The requirement that the expert be licensed in Florida or hold an expert witness certificate will ensure that unscrupulous foreign experts are subject to the same discipline that Florida licensees are subject to if they testify fraudulently.

Florida Medical Association FACT SHEET



PIP

SB by

HB by

FMA Contact: Jeff Scott

FMA Position

The FMA supports reenacting Florida's Motor Vehicle No-Fault law and retaining the provision providing for personal injury protection (PIP) benefits. However, the FMA adamantly opposes the adoption of a medical fee schedule for PIP benefits.

Background

In 2003, the Legislature repealed Florida's Motor Vehicle No-Fault law to take effect October 1, 2007, unless reenacted by the Legislature during the 2006 Regular Session. The 2003 legislation also enacted a number of reforms to the PIP section of the No-fault Law. These reforms, along with those enacted in 2001, have led to a competitive auto insurance market in which coverage is readily available at reasonable rates. Unlike the situation that exists in the medical malpractice insurance market, for auto insurance **there is no crisis** present.

Despite the stable market, State Farm and a few large auto insurers have taken the position that the no-fault system should be allowed to sunset. The rest of the auto insurance industry wants to keep no-fault but use this opportunity to enact a whole host of new schemes that would benefit the insurance industry at the expense of patients and doctors. They have asked the legislature to adopt a fee schedule for physician services based on a percentage of Medicare, asked for the adoption of practice parameters, and advocated for the elimination of the one-way attorney fee provision in PIP suits. In addition, the industry is seeking legislation that would authorize auto insurers to bring civil suits (and receive punitive damages) against physicians who treat PIP patients. Grounds for such a suit can be as simple as an insurer's bare assertion that the medical care provided wasn't medically necessary.

Discussion

There has been absolutely no evidence presented of any major systemic problems in the no-fault system that would warrant a return to the traditional fault-based tort system – a system described in a 1971 Senate hearing as “about the worst possible . . . cruel, corrupt, dilatory, expensive and wasteful while it goes about the business of failure.”

As with any system there are problems to be addressed. The bills filed by Senator Posey and Representative Galvano propose rational changes intended to correct problems the Division of Insurance Fraud has identified as being specifically helpful in fighting fraud. These changes include increased penalties for those who cheat the PIP system and increased funding for law enforcement efforts to stop such fraud.

What the FMA does not support are so called anti-fraud efforts that are really measures designed to benefit insurance companies at the expense of the public. Arbitrarily fixing physician fees and mandating how they practice medicine will have no effect on fraud. What such provisions will do is develop the same access to care problems that exist in the Medicaid and Workers Compensation systems. Not only will it be difficult to find high quality medical care, the fraud problem will actually get worse as the unscrupulous clinics will take over the bulk of providing care for PIP patients.

Conclusion

The FMA feels that the no-fault system is working well and should be retained. There are a number of beneficial changes that we do support. The FMA will not support, however, fee schedules and other harmful changes to the PIP system as the price for repealing the sunset of the no-fault system.

Florida Medical Association FACT SHEET



NURSES SHOULD NOT BE AUTHORIZED TO PRESCRIBE CONTROLLED SUBSTANCES

SB 556 by Sen. Saunders

HB by

FMA Contact: Francie Plendl

FMA Position

The FMA is strongly opposed to increasing the scope of practice for nurses in relation to the prescribing of controlled substances. A patient who requires a prescription for controlled substances should be under the treatment of a physician to ensure that the condition is being appropriately diagnosed and treated. There is no reason to expand controlled substance prescribing to nurses.

Background

Legislation is being proposed that would allow nurses to prescribe controlled substances. The FMA recognizes the valuable contributions nurses make to the health care delivery team, but it is not in the public's best interest to grant nurses the ability to prescribe controlled substances.

Controlled substances are those drugs that the Federal government has determined to have a high potential for abuse, and should therefore be prescribed by a limited number of professionals.

There is no indication that patients who need controlled substances have had an access problem. In fact, the Governor's Office of Drug Control is currently struggling with the issue of too much access to controlled substances in Florida. The Office of Drug Control has collected statistics demonstrating the need for the state to have more oversight and control over controlled substance prescribing. These statistics show that Florida is leading the country in an upsurge of deaths due to controlled substance overdoses.

Discussion

Granting authority for ARNPs to prescribe controlled substances is not in the public's best interest. Inherent within the right to prescribe controlled substances is the need to correctly diagnose the patient. The practitioner must be able to make the appropriate diagnosis and suggest proper treatment options. Controlled substances can easily mask an underlying condition, and MDs and DOs are the only professionals capable of making these determinations. ARNPs simply do not have the required training and medical education necessary to support an expansion of their scope of practice. The requirement for a master's degree of nursing does not apply to all ARNP licensees. The Department of Health records reveal that over 20 percent of ARNPs do not hold a master's degree, and almost 300 do not hold a bachelor's degree.

Because of the amount of controlled substances that are available to patients, there is simply no reason to expand the number of prescribers. Widening prescriptive authority without a demonstrated need will increase the amount of abuses in the system. In 2002 and 2003, the Board of Nursing issued multiple final orders against ARNPs, some of which were for drug violations and misprescribing, demonstrating that ARNPs are by no means immune from this

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type of discipline.

On March 16, 2003, the United Way of Broward County Commission on Substance Abuse issued a letter expressing concern about legislation granting authority for ARNPs to prescribe controlled substances. The letter states that passage of such legislation will exacerbate the prescription drug crisis in Florida that the Commission is working so hard to control.

Conclusion

It is imperative for the safety and welfare of patients and the general public that this legislation not be passed into law. Patients who need controlled substances currently have adequate access, and expanding the number of persons who can prescribe these drugs is simply not warranted.

01/12/2007

Florida Medical Association FACT SHEET



PHARMACISTS – ADMINISTRATION OF IMMUNIZATIONS SCOPE OF PRACTICE EXPANSION

SB by

HB by

FMA Contact: Francie Plendl

FMA Position

The FMA is opposed to legislation allowing pharmacists to administer immunizations. This is a broad expansion of scope. The limitations put into this year's bill (requiring a protocol with a physician and 20 hours of CE) simply do not provide the protections needed for Florida patients.

Background

Pharmacists have been seeking to expand their scope of practice to allow them to administer immunizations to customers for years. They have failed to pass this legislation, but continue their efforts. This scope expansion is simply inappropriate. The practice setting of pharmacists is not adequately set up to allow them to administer immunizations safely, and they do not have the appropriate education and training to do so. It is important that Florida patients only receive medical care from individuals with proper medical education and training.

Discussion

Pharmacists are trained and licensed to compound and dispense drugs. They are not trained to diagnose conditions and initiate appropriate treatment. For instance, influenza vaccines should not be given to certain patients – the practitioner must be able to determine from the patient's medical history if he/she is an appropriate candidate for the vaccine. Many patients seeking vaccines are elderly with complex medical histories. In addition, a practitioner has to be able to respond to adverse reactions that a patient may have to certain vaccines. For instance, if a patient goes into anaphylactic shock, the practitioner must be able to appropriately respond rapidly. The administration of immunizations is a potentially dangerous medical act that should only be performed under the supervision of a physician. Pharmacists are not supervised at all. The focus of a pharmacist's training is in pharmacology, not hands-on treatment of patients.

A medical doctor receives the following training:

1. A Bachelor's degree in science;
2. Two years of medical school consisting primarily of classroom study;
3. Two years of medical school consisting of clinical work; and
4. A three-year labor-intensive residency program consisting of hands-on clinical practice.

In addition, many physicians complete a fellowship lasting two to four years, consisting of more clinical, hands-on practice. A physician receives a minimum of SIX years of classroom study and FIVE years of clinical practice before he/she becomes licensed as a physician in Florida. A pharmacist only completes FOUR-years of post-graduate training with no clinical requirements.

Additionally, the current legal and regulatory system cannot incorporate the proposed changes and still protect the public. The multiple laws and rules regulating the practice of medicine in the state of Florida do not apply to pharmacists. The laws simply do not envision a pharmacist treating a patient in a hands-on scenario, and patients are not protected under the current legal system.

Conclusion

The public should receive quality health care from persons appropriately trained to diagnose and treat medical conditions. The proposed changes to the law will not adequately protect the citizens of Florida. There is no indication that patients in Florida are under-vaccinated or are having trouble finding a practitioner from whom to receive a vaccine. This is not an access issue, it is a scope expansion issue, and should not proceed.

Florida Medical Association FACT SHEET



NATUROPATHS

HB by

SB by

FMA Contact: Francie Plendl

FMA Position

The FMA and many other health care associations are strongly opposed to naturopaths once again being licensed by the state of Florida as health care providers. This bill allows unqualified persons to practice several health care professions, including medicine. Under the bill, a person who attends a school of naturopathy would be allowed to diagnose, treat, operate and prescribe for disease, pain, injury or other physical or mental condition. This is the definition of the practice of medicine.

Background

The bill revives the Board of Naturopathic Medicine and recreates the profession of naturopathy in Florida. In the 1920s, the state of Florida began licensing naturopaths, but ended the process in 1959. In 1985, all individuals who were licensed prior to 1959 were granted active licenses under a grandfather clause. Currently, only a few individuals are practicing naturopathy with an active license.

The House Committee on Health Care prepared an Interim Project Report in January 2004, titled “Sunrise Report on Proposed Licensure of Naturopathic Physicians.” **The House report, citing concerns expressed by the Department of Health, states “...the proposed licensure of naturopathic physicians would likely increase the risk of harm to the public...”** The report expresses particular concern that the bill goes beyond allowing a naturopath to practice naturopathy – it would allow a naturopath to prescribe controlled substances.

The bill requires applicants for a naturopathic license to attend a naturopathic school. According to the House report, some of the colleges providing four-year programs are not yet fully accredited. The people who graduate from these schools are not adequately trained to become treating physicians, yet would be given the title “Naturopathic Physician” or “Doctor of Naturopathic Medicine” under this bill. The bill will allow “doctors” who are not adequately trained to, among other things, perform surgery, prescribe controlled substances and perform psychotherapy.

Since 1996, 20 different states have rejected licensing initiatives, including 12 states that have rejected initiatives more than once. There has been no consumer driven demand for licensing naturopaths in Florida. Florida should not become one of the few states to pass this type of legislation.

Discussion

The prerequisites for becoming a naturopath do not adequately prepare a person to perform the acts that the scope of practice would allow.

A medical doctor receives the following training:

1. A Bachelor's degree in science;
2. Two years of medical school consisting primarily of classroom study;
3. Two years of medical school consisting of clinical work; and
4. A three-year labor-intensive residency program consisting of hands-on clinical practice.

In addition, many physicians complete a fellowship lasting two to four years and consisting of more clinical, hands-on practice.

A physician receives a minimum of SIX years of classroom study and FIVE years of clinical practice before he/she becomes licensed as a physician in Florida.

A naturopath would be allowed to perform the same acts as a medical doctor, but is not required to receive a bachelor's degree.

It is also important to note that the Medical Quality Trust Fund is not adequately funded. It would not be fiscally prudent for the Trust Fund to take on an inadequately funded profession when the fund is already being depleted.

Conclusion

The Florida Medical Association, as well as many other health care associations, believes that it is imperative for the safety and welfare of patients and the general public that naturopaths not be licensed by the state of Florida as health care practitioners. They simply do not have the education or training needed to safely treat patients. It is also important to note that the Florida Association of Naturopathic Medicine opposes this legislation.

Florida Medical Association FACT SHEET



OPTOMETRISTS SHOULD NOT BE AUTHORIZED TO PRESCRIBE ORAL MEDICATIONS

FMA Position

The FMA is strongly opposed to increasing the scope of practice for optometrists in relation to the drug prescribing. A patient who requires a prescription for an oral medication should be under the treatment of a physician to ensure that the condition is being appropriately diagnosed and treated. There is no reason to expand the current scope of practice of optometrists.

Discussion

The bill as drafted will allow optometrists to prescribe ALL drugs, even those that they cannot currently prescribe topically. But the bill should be opposed even if it is amended to cover only those drugs that an optometrist can currently prescribe topically.

Optometry programs offer limited academic and clinical prescribing experience to its students. Conversely, ophthalmology resident students have over 15,000 patient encounters before graduation. Ophthalmologists have the necessary skills to understand the complexities of drug prescribing. The optometry profession does not have any such training program.

In 1986, the Florida legislature gave optometrists limited authority to utilize certain ointments and drops for certain eye problems. The legislature was keenly aware that optometrists were not medical doctors and lacked training to treat systemic diseases. The legislature, therefore, set up statutory safeguards to protect the public. Those safeguards include the following:

- Prohibited an optometrist from "prescribing, ordering, dispensing, administering, supplying, selling, or giving any systemic drugs . . . " . Section 463.014(3), Florida Statutes.
- Mandated that optometrists closely monitor patients that have been given creams and drops and refer patients to "medical specialists" in the event of an adverse reaction. Sections 463.0135(5)-(8), Florida Statutes.

THE FOLLOWING ARE SYSTEMIC ORAL EQUIVALENTS OF DRUGS NOW AUTHORIZED FOR OPTOMETRISTS TO ADMINISTER BY CREAMS AND DROPS, AND THE POSSIBLE ADVERSE REACTIONS.

Diclofenac, ketorolac, other nonsteroidal anti-inflammatory agents

- Gastrointestinal bleeding and perforation
- Liver toxicity
- Congestive heart failure (potentially fatal)
- Impaired blood clotting
- Suppression of bone marrow (potentially fatal)
- Kidney failure (potentially fatal)

Erythromycin, azithromycin, other macrolide antibiotics

Pseudomembranous colitis (potentially fatal inflammation of colon)

Interaction with other drugs including theophylline, digoxin, benzodiazepines, cisapride (potentially fatal)

Ofloxacin, ciprofloxacin, other fluoroquinolone antibiotics

Suppression of blood formation

Pseudomembranous colitis (potentially fatal inflammation of colon)

Serum sickness and hepatitis

Rupture of shoulder, hand, or ankle tendons

Severe dermatologic conditions (potentially fatal)

Pilocarpine, other parasympathomimetics

Alteration of heart rhythm (potentially fatal)

Alteration of blood pressure

Gastrointestinal spasm

Diarrhea

Mental confusion

Respiratory distress

Prednisolone, dexamethasone, other glucocorticoids

Decreased resistance to infection

Difficulty in controlling diabetes

Osteoporosis (thinning of bones)

Suppression of adrenal glands (potentially fatal)

Timolol, other beta blockers

Fatigue

Shortness of breath

Slowing of heart rate (potentially fatal)

Exacerbation of obstructive lung disease

Decreased libido

Dizziness

Mental depression

These drugs have been confined to prescription-only status in the United States for good reasons. They should be prescribed by allopathic or osteopathic medical doctors who are the only practitioners that have the training and experience to recognize and treat general medical diseases.

Conclusion

It is imperative for the safety and welfare of patients and the general public that this legislation not be passed into law. Patients who need oral medications for eye conditions should be seen by a physician who has the education, training and experience to handle the condition. **ORAL MEDICATIONS ARE VERY DIFFERENT THAN DROPS OR CREAMS – THEY AFFECT THE ENTIRE SYSTEM** and should only be prescribed by a physician.

Florida Medical Association FACT SHEET



PODIATRIC SCOPE OF PRACTICE

HB by

SB by

FMA Contact: Francie Plendl

FMA Position

According to the American Podiatric Medical Association, “Podiatry is a field of medicine that strives to improve the overall health and well-being of patients by focusing on preventing, diagnosing, and treating conditions associated with the foot and ankle.” The FMA strongly believes that the state statutes need to be clarified to ensure that podiatrists limit all treatments to the foot and ankle, therefore adhering to the professional training and standards established by the American Podiatric Medical Association.

Background

Current Florida law (Section 461.003(5), Florida Statutes) provides that the practice of podiatric medicine means the diagnosis or medical, surgical, palliative, and mechanical treatment of ailments of the human foot and leg. The statute states that surgical treatment of ailments of the human foot and leg are limited anatomically to that part below the anterior tibial tubercle (the knee). The Florida Orthopedic Society and Florida Medical Association have documented cases of podiatrists doing the following: performing lateral releases behind the knee; performing injections of the knee joints; ordering costly and unnecessary diagnostic tests of the knee; and taking weekend courses in how to incorporate all of the above into their practices. These practices endanger the safety of Floridians who may be unaware that these tests and procedures are being performed by professionals who lack adequate training.

Discussion

The proposed legislation seeks to conform current state statutes to the anatomical training and expertise of podiatrists. The American Board of Podiatric Surgery does not have a certification program or qualification for any treatments other than Foot Surgery and Foot and Reconstructive Rearfoot/Ankle Surgery. Only four states currently include the term “leg” in the definition of the practice of podiatry. A majority of states do not include leg in the definition, strictly limiting the practice to the foot and ankle. According to the report entitled, “Comprehensive Foot Care – The Report of the National Commission on Podiatric Medicine” prepared by the American Podiatric Medical Association, “The Commission believes that a uniform definition of scope of practice is overdue, and it recommends an anatomical scope that includes the foot, ankle, and soft tissue of the lower leg to the tibial tuberosity.”

Conclusion

Patients throughout Florida are unknowingly being subjected to treatment and procedures performed by untrained professionals. According to Florida law (Section 461.001, Florida Statutes), the sole legislative purpose for enacting Chapter 461 was to ensure that every podiatric physician practicing in this state meets minimum requirements for safe practice.

Florida Medical Association FACT SHEET



PSYCHOLOGISTS SHOULD NOT HAVE PRESCRIBING AUTHORITY

The Florida Legislature should reject psychologists' attempts to gain prescribing privileges. Psychologists do not have the medical background necessary to safely prescribe mental health medications for patients.

- Legislation to give psychologists prescribing authority is a high-risk experiment that has great potential to harm people with mental illness. Psychologists have always had a clear path to prescribing privileges: medical school. No psychology-designed and administered crash course in drug prescribing can substitute for the comprehensive knowledge and skills physicians achieve through medical education and rigorous clinical experience.

There is no demonstrated health care need to grant psychologists prescribing authority.

- Psychologists have failed to demonstrate an actual health care need to justify being granted prescribing authority. There is neither a shortage of prescribing health providers nor any evidence of consumer demand for prescribing psychologists.
- Rather than giving psychologists prescribing authority, the health care needs of underserved populations (e.g., rural communities) are best served by improving the mental health training of primary care providers (e.g., family physicians) who have better and broader health training and are more widely distributed than psychologists.
- Granting psychologists prescribing authority will increase health care costs with no apparent benefit to society. As prescribing psychologists would have limited and inadequate training to detect and treat most non-mental medical conditions, physician services – at additional costs – would be required. Also, granting psychologists prescribing authority would entail increases in, for example, state regulatory costs and liability insurance rates. Ultimately, these costs are borne by all taxpayers.

Medications for the treatment of mental illnesses are among the most potentially dangerous drugs for patients, requiring the utmost care and training in their use.

- If not appropriately prescribed and monitored, these medications – also known as psychotropics – could have potentially disabling and life-threatening side effects. For example, many anti-depressants can cause stroke, coma, seizures and tremors. Other possible complications include the following: convulsions, epilepsy, blood diseases, irregular heartbeat and severe high or low blood pressure. Individuals taking psychotropic medications are often vulnerable to drug abuse.
- An estimated 50 percent of persons whose mental illnesses require psychotropic medications also have other serious medical conditions requiring additional medications. This interaction of different medications, which can magnify or nullify the effects of certain drugs or even result in a deadly combination, presents an extremely difficult challenge to the most knowledgeable and skilled physicians. **Unlike physicians, psychologists simply do not have the broad-based medical education and clinical experience that is needed to safely and appropriately integrate treatments for mental illnesses and other medical conditions.**

Psychologists lack the education and training to prescribe safely.

- A physician's medical degree is clinically focused, emphasizing the physical sciences (e.g., biology, chemistry, anatomy, physiology, pharmacology, neurology) and hands-on evaluation and treatment of ill persons under the supervision of experienced physicians. During training in a hospital setting, a psychiatric physician, for example, manages the care of 200-300 patients with a range of emotional and other physical disorders. Management of care includes performing physical examinations, ordering and evaluating medical tests, making medical diagnoses, prescribing medication and other treatments, and monitoring the effects of such treatment.
- In contrast, a psychologist's Ph.D. is an academic degree with course work in the social and behavioral sciences. They are only trained in psychotherapy and psychological testing. Psychologists can obtain their degree by taking only one or two courses in the biological bases of behavior. Their training typically occurs in a non-medical setting in which they do not observe or participate in the treatment of patients with medical illnesses other than mental disorders. This limited training does not adequately prepare psychologists to detect and treat concomitant non-mental illnesses or to understand and deal with the interactions of psychotropics with other medications prescribed to help other body systems.

The U.S. Department of Defense's Psychopharmacology Demonstration Program (PDP) was terminated by Congress in 1996.

- At a cost of more than \$6 million, the PDP resulted in 10 prescribing psychologists in the military health service. The Congressional "watchdog" agency, the General Accounting Office, strongly criticized the PDP as "not adequately justified because the [military health system] has no demonstrated need for them [the prescribing psychologists], the cost is substantial, and the benefits uncertain."
- Reflecting their limited training, these psychologists needed to rely on supervision and backup of physicians to ensure they weren't missing underlying serious medical problems in the PDP. Also, for patient safety reasons, these psychologists were not permitted to treat certain categories of patients (e.g., children, elderly patients). That raises the question of what level of care the remaining patients were receiving.

Prescribing is strongly opposed by influential elements within the profession of psychology.

- Many psychologists, including practitioners and academicians, vigorously oppose prescribing authority for psychologists. Among the reasons for the opposition are as follows: prescribing would legislatively and adversely redefine the practice of psychology, and would impair the public's access to psychological services. Further, according to a report of The American Association of Applied and Preventative Psychology (AAAPP), this prescribing movement "seemingly derives from precipitous guild concerns" of practitioners [clinical psychologists]."
- The clinical affiliate of the American Psychological Society, the AAAPP, passed a resolution in 1995 to oppose prescription privileges for psychologists and continues to lead the opposition within psychology. Commenting on the resolution, the AAAPP president noted, "We are proud of the work we [psychologists] do. We will continue to work with the physicians when medication is needed. We don't want to see psychologists become just "junior doctors'."

Florida Medical Association FACT SHEET



PSYCHOLOGISTS ORDERING LABORATORY TESTS

SB by Senator

HB by Representative

FMA Contact: Francie Plendl

FMA Position:

The Florida Medical Association opposes this bill.

Background:

There is no reason for a psychologist to order and interpret laboratory tests. This is outside of their education, training and experience, and is a broad scope of practice expansion.

Discussion:

Psychologists do not have the necessary training to perform and interpret laboratory tests.

A significant portion of medical education, training and experience is devoted to learning about which tests are the best for which conditions. The vast majority of these tests make up a small portion a patient's complex health. A psychologist's education and training program does not provide adequate knowledge or skill to perform this task. This bill does not provide for any requirement of training that would prepare psychologists to order and interpret tests. Additionally, psychologists are not trained to perform tests such as lumbar puncture, abdominal tap, and culture of orifices. Psychologists are not able to document medical necessity as required for payment and, conversely, crucial tests may be omitted because of a lack of medical training.

Psychologists cannot apply test results to meet the standard of care.

After tests are ordered and interpreted, the next logical step would be to apply the results in a meaningful manner to the patient and his/her health care. The limited scope of diagnosis and treatment that psychologists provide makes this proposal nearly meaningless in the overall health of the patient. Tests are only ordered to review and consider change to the management of the patient in some manner. This consideration must involve the patient's physician. It is appropriate to handle these issues as they are currently handled: by consulting with the patient's physician. Failure to have adequate medical involvement will lead to patients being falsely reassured.

There is no established need or shortage of access to laboratory testing.

There is no demonstrated inability for patients to be able to receive the laboratory tests that are medically indicated. Furthermore, for any patient that needs laboratory tests, it will be necessary to involve their physician in order to ensure continuity of care and to make sure that the standard of care is met. Given the need for a physician's involvement, there is no benefit to permitting psychologists to order tests. The running of unnecessary tests will drive up health costs.

Fragmentation of care contributes to poorer care.

Communication failures will undoubtedly lead to test results that are not followed up on, are lost or misplaced, and are misinterpreted by multiple providers. All these contribute to a poorer level of health care for patients.

This is an unnecessary expansion of the scope of practice for psychologists.

This bill would allow psychologists to order tests that are far outside their area of expertise. For example, there is no need to permit psychologists to order tests for sexually transmitted diseases, urinary tract infections, cholesterol levels, or numerous other tests this bill would allow them to order.

Conclusion

For all the reasons above, there is no clear reason why this scope of practice expansion would benefit patients in Florida. If a psychologist has a concern and feels the need to have tests run on a patient, a physician should be consulted and the patient should be referred to that physician.

01/2007

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