HB
472
(File 7 of 7)

surgery centers is found in section 395.0197, Florida Statutes.[583] This law was initially enacted in 1975 in response to an earlier crisis in malpractice insurance. In addition, legislation enacted in 1985 amended this statute to require hospitals and ambulatory surgery centers to have licensed healthcare risk managers. In 2001, legislation was passed requiring nursing homes and assisted living facilities to also have risk management programs.[584]

Section 395.0197, Florida Statutes, governs internal risk management programs and requires that adverse incidents be investigated and analyzed, that measures be developed to minimize the risk of adverse incidents to patients, that patient grievances related to patient care and quality be analyzed, and that incident reporting systems be developed. In subsection (16), the Agency for Healthcare Administration (AHCA) is given the responsibility to determine if risk management programs are "...conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents."

Internal risk management programs are confidential pursuant to subsection (15), which states that meetings held solely for the purposes of risk management are not open to the public and the records of meetings are confidential and exempt from public disclosure.

Although section 395.0197, Florida Statutes, requires hospitals and ambulatory surgical centers to annually report to ACHA serious medical injuries and patient deaths that are the result of medical injuries, these reports are confidential and not available to the public. There are three medical injury reports:

(1) the annual report which includes all adverse incidents (patient injuries);

(2) the Code 15 Report which reports serious patient injuries; and

(3) the 24 Hour Report which is a preliminary report on certain serious injuries: death, brain or spinal damage, wrong patient surgery, wrong site surgery, and wrong surgical procedure.

In addition, hospitals and ambulatory surgical centers also report new malpractice claims. AHCA publishes aggregated data for all hospitals and ambulatory surgical centers combined. Under current law, hospitals and ambulatory surgical centers are not required to report "near misses" or to develop strategies to minimize these types of errors. The current system

[583] See also Tanya Williams, testimony, Nov. 4, 2002, pgs. 38-46.
[584] Sections 400.071(11), section 400.147, Florida Statutes.

also does not assist healthcare providers by using experts to identify ways to prevent errors.

Section 395.0197, Florida Statutes, requires hospitals, ambulatory surgery centers, and nursing homes to have risk management programs to "reduce risk to patients." However, there is no requirement that specific committees be created to foster improvements in patient safety, nor that members of the public be included in the process. Subsection (2) of this section simply states that the internal risk management program "is the responsibility of the governing board." The statutes are silent with regard to how risk management is to be conducted in facilities. In addition, subsection (2) states that a risk manager may be responsible for up to four risk management programs in separately licensed facilities, or more than four separate facilities if the facilities are under the same corporate ownership or are in rural hospitals. A large multi-hospital corporation could, under Florida law, have one risk manager for all of its hospitals

The following table was prepared by AHCA and reports the most recent data available. The table appears on their website. It is important to note that the Legislature changed the definition of "adverse incident" for annual reports and Code 15 reports. Beginning in 1999, adverse incidents resulting from surgical procedures that were described in patient consent forms ceased to be reported. It is also important to note that this chart reflects gross numbers, only, and makes no attempt to analyze these numbers or to relate them to patient days, number of surgical procedures, or any other indicator of volume that could explain fluctuations or provide a relative measure of the rate of occurrence.

Table 17

Annual Report	1996	1997	1998	1999	2000
Annual Report (all adverse incidents)	5,140	5,517	5,113	3,808	4,541
(New) Malpractice Claims	733	718	783	916	949
Code 15 Reports 24 Hour Reports	856	1,102	994	720	920

**Though the number of facilities continually fluctuates, as of January 2001, agency records indicate there were 273 licensed hospitals and 263 licensed ambulatory surgical centers.

As of January 6, 2003, data for 2001 were not available.

Source: Agency for Health Care Administration
http: //www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/index.shtml.

The quality of healthcare has received considerable attention since the publication of the Institute of Medicine's (IOM) To Err is Human report in

2000.[585] The report estimated that medical errors in hospitals result in 44,000 to 98,000 patient deaths per year. Although these figures are controversial, there is no doubt that many persons are injured, some of them seriously, by medical errors that could have been prevented.[586] A recent New England Journal of Medicine article reported that large percentages of both physicians and members of the public are aware of medical errors made on members of their own families.[587]

To reduce medical errors, the authors of the IOM study wrote,

> Healthcare organizations must develop a culture of safety such that an organization's care processes and workforce are focused on improving the reliability and safety of care for patients. Safety should be an explicit organizational goal that is demonstrated by the strong direction and involvement of governance, management and clinical leadership. In addition, a meaningful patient safety program should include defined program objectives, personnel, and budget and should be monitored by regular progress reports to governance.[588]

To achieve a culture of safety, the authors recommended that healthcare organizations establish patient safety programs that include non-punitive systems for reporting and analyzing medical errors made within their organizations.

The IOM also recommended that standardized mandatory reporting systems of serious medical errors be established.[589] The mandatory reporting systems would be "linked to systems of accountability," such as professional licensure regulation; the information would be made available to the public and states would have flexibility regarding their implementation.

A recent article in the New England Journal of Medicine reported on the findings of parallel national surveys of 831 practicing physicians and 1,207 members of the public regarding perceptions of medical errors.[590] The findings of these surveys indicate that sizeable proportions of both

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[585] Institute of Medicine, National Academy of Sciences, To Err is Human: Building A Safer Health System (2000).

[586] See Thomas H. Lee, A Broader Concept of Medical Errors, 347(24) New England Journal of Medicine 1965-1966 (Dec. 12, 2002).

[587] Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1933-1940 (2002).

[588] See Institute of Medicine, To Err is Human: Building A Safer Health System 12.

[589] Id. at 88-89.

[590] See Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1933-1940 (2002).

physicians (35 percent) and the public (42 percent) report medical errors in either their own care or a family member's care.

The findings also indicate that a large proportion of physicians believe that most medical errors can be prevented; that the understaffing of nurses and the overwork, stress, or fatigue of health professionals are very important causes of preventable medical errors; and that effective recommendations for reducing medical errors that would be very effective include requiring hospitals to develop systems for preventing medical errors and increasing the number of nurses in hospitals.

The following tables excerpt key findings from the surveys.

Table 18

Preventable Medical Errors

(Responses in Percentages)

All Respondents	Physicians (N=831)	Public (N=1207)
Error made in own or family member's care	35	42
Health consequences serious	18	24
Serious consequences		
Severe pain	11	16
Substantial loss of time at work or school or other important activities	12	17
Temporary disability	8	12
Long-term disability	6	11
Death	7	10
Respondents reporting an error*		
Parties who had "a lot" of responsibility for error		
Doctors	70	81
Nurses	25	25
Health professional involved		
Told respondent that error had been made	31	30
Apologized to respondent or family member	34	33
Respondent or family member sued health professional	2	6

*290 physicians (35% of 831) and 507 (42% of 1207) members of the public reported an error either in their own care or in the care of a family member.

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1935 (2002).

As the above table indicates, 35 percent of practicing physicians and 42 percent of the general public reported they or someone in their family had experienced a medical error; roughly half of the errors were reported as serious. Seven percent of physicians and 10 percent of the general public stated someone in their families died as a result of medical errors.

Although these survey findings have significant policy implications for improving medical care, only 5 percent of physicians and 6 percent of the

public said medical errors were among the most serious problems in healthcare. Much larger problems reported by physicians were the cost of malpractice insurance and lawsuits (29 percent of physicians), and insurance company and health plan problems (27 percent). The public cited the cost of healthcare as the greatest problem (38 percent), followed by the cost of prescription drugs (31 percent).

It is important to note most physicians believed that medical errors occur infrequently. Only 1 percent indicated preventable medical errors occurred very often and 19 percent indicated they occurred somewhat often. In contrast, 10 percent of the members of the public believed medical errors occurred very often and 39 percent believed they occurred somewhat often.

Table 19

Beliefs About the Frequencies of Medical Errors and Preventable Deaths

(Responses in Percentages)

Question and Response	Physicians (N=831)
How often are preventable medical errors made?	
Very often	1
Somewhat often	19
Not very often	59
Not often at all	21
No response	0
What proportion of (deaths due to medical errors) could realistically have been prevented?	
All of them	8
Three-quarters of them	27
Half of them	41
One-quarter of them	21
None of them	2
No response	1

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1936 (2002).

Table 20

Causes of Preventable Medical Errors (Responses In Percentages)	
Response	Physicians (N=831)
Very important causes	
Understaffing of nurses in hospitals	53
Overwork, stress, or fatigue of health professionals	50
Failure of health professionals to work together or communicate as a team	39
Influence of HMOs and other managed care plans on treatment decisions	39
Complexity of medical care	38
Insufficient time spent by doctors with patients	37
Poor training of health professionals	28
The more important reason for errors	
Mistakes made by individual health professionals	55
Mistakes made by institutions	43
Volume of procedures	
An error is more likely at a low-volume hospital	71
Volume does not make a difference	24

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1937 (2002).

Table 21

Possible Solutions to the Problem of Medical Errors

(Responses in Percentages)

Solution	Physicians (N=831)	Public (N=1207)
Very effective		
Requiring medical error prevention systems in hospitals	55	74
Increasing the number of nurses in hospitals	51	69
Giving physicians more time to spend with patients	46	78
Limiting certain high-risk procedures to hospitals that perform many of these procedures	40	45
Improving the training of health professionals	36	73
Hospital reports of serious medical errors		
Should be confidential (used only to learn how to prevent future medical errors)	86	34
Should be released to public	14	62

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1938 (2002).

Most physicians surveyed believed the majority of deaths due to medical errors "could have realistically been prevented." A total of 41 percent stated half of the deaths could have been prevented, 27 percent stating three-fourths, and 8 percent stated all. Summing these responses, 76 percent stated half or more of deaths were preventable. Surprisingly, the views of the members of the public were very similar to the views of physicians with regard to the feasibility of preventing errors.

Physicians believed the most important cause of preventable medical error was the understaffing of nurses in hospitals (53 percent of physicians). Nearly as many (50 percent) believed overwork, stress, or fatigue on the part of health professionals was a very important cause of preventable medical errors. Physicians believed other very important causes included the "failure of health professionals to work together or communicate as a team" (39 percent); the "influence of HMOs and other managed-care plans on treatment decisions" (also 39 percent); "the complexity of medical care" (38 percent); and "insufficient time spent by doctors with patients" (37 percent).

When asked about possible solutions to the problem of medical errors, the strategy physicians believed would be most effective was to require hospitals to develop systems for preventing medical errors, with 55 percent of physicians stating this would be a very effective strategy. Increasing the number of nurses in hospitals was believed to be a very effective strategy by 51 percent of physicians, followed by giving physicians more time to spend with patients (46 percent), and limiting

certain high-risk procedures to hospitals that perform many of these procedures (40 percent).

The following table shows responses to a hypothetical situation in a hospital. An antibiotic is ordered by a surgeon to be given to a patient by a nurse despite a notation in the patient's medical record that the patient has an allergy to antibiotic drugs. In one case, the patient has a rash that disappears when the antibiotic is stopped. In the other case the patient dies because of the drug.

Table 22

Responses to Hypothetical Situation Where Patient Is Given a Drug Inappropriately

(Responses in Percentages)

	Outcome without harm (rash)		Outcome with harm (patient dies)	
Response	Physicians (N=404)	Public (N=603)	Physicians (N=427)	Public (N=604)
Party with "a lot" of responsibility for error				
Surgeon	90	89	95	92
Nurse	81	52	82	48
Hospital	42	55	48	57
Should be sued for malpractice				
Surgeon	4	30	55	69
Nurse	3	12	44	21
Hospital	2	22	33	44
Should be fined by a government agency				
Surgeon	5	51	21	65
Nurse	6	26	18	29
Hospital	9	39	21	50
Should have license suspended				
Surgeon	0	23	8	50
Nurse	1	11	8	25
Should be required to report error to patient or family				
Surgeon	85	95	90	95
Nurse	74	67	70	57
Hospital	60	78	71	84
Should be required to undergo training in the prevention of this type of error				
Surgeon	66	80	78	80
Nurse	71	67	81	72
The hospital should be required to develop systems for preventing similar errors	74	79	84	84

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1938 (2002).

Finally, the survey found large proportions of both physicians and members of the public believed medical errors should be reported to the patient or family and hospitals should be required to develop systems for preventing errors. In addition, sizeable percentages of both physicians and the public believed physicians and nurses who commit preventable medical errors that do not harm patients but cause a medical problem should be fined or otherwise disciplined. It is also important to point out that the study reflects perceptions from two classes of individuals: those in the medical profession and consumers of medical services. The study does not attempt to prove or disprove the truth of those perceptions.

Information Presented to the Task Force

Ms. Jacqueline Imbertson, representing Floridians for Patient Protection, stated at the October 21 meeting of the Task Force that hospital report cards that contain information pertaining to staffing, services, infection rates, and medical errors by type should be available on the Internet to aid consumers in choosing a hospital.[591]

The Task Force heard testimony from Dr. Robert Muscalas, Physician General, State of Pennsylvania, at the November 4 meeting in Miami, and again at the December 3 meeting in Tallahassee. Dr. Muscalas spoke regarding the establishment of a Patient Safety Authority, based on the aviation model (which analyzes "near misses"), to reduce medical errors and improve the quality of care in hospitals, ambulatory surgical centers, and birth centers.[592] The State of Pennsylvania has adopted legislation creating a Patient Safety Authority that is an independent, advisory, non-regulatory agency. The legislation requires mandatory confidential reporting of serious events and near misses. Serious events and near misses are analyzed and recommendations are made directly to medical facilities to improve care. Information is not subject to discovery in lawsuits. In addition, the legislation requires all hospitals to have patient safety plans, patient safety committees, and patient safety officers and there is a process for hospitals to receive malpractice insurance discounts if they implement certified patient safety programs. Finally, patients who experience serious events must be provided written notice.

The Task Force invited nationally recognized experts to present at the November 4 task force meeting in Miami. Professor Eleanor Kinney, J.D., who has authored numerous articles on medical malpractice in major peer-reviewed journals, stated "the development of systems for ensuring patient

[591] See Jacqueline Imbertson, testimony, Oct. 21, 2002, pgs. 165-166.
[592] See Robert Muscalas, D.O., testimony, Nov. 4, 2002, pgs. 121-126, 135.

safety and improving the quality of care in different patient venues" was a "third-generation" medical malpractice reform that would be part of the concept of "enterprise liability."[593] Professor Kinney, in discussing reducing errors in hospitals, went on to state:

> It's a good thing. And the fewer errors, the fewer frequency of—-well, supposedly, you would have fewer malpractice claims. But I think if you really respect the patient safety effort and do it in the right way, I think there is an effort to identify problems and I would imagine opportunities for heading off claims where damage has been done. Ideally, that would be what I would like to see from a really strong patient safety program in a hospital.[594]

In a previous commentary, Ms. Kinney has noted:

> A political basis for second-generation reform in either states or Congress does not exist. Clearly the political power of the medical profession and liability insurers is great as well as focused. On the other hand, the organized power of consumers is diffuse and not focused on malpractice. The only focused advocate for the consumer in the malpractice debate is the trial bar, and it has much at stake in maintaining the common law tort system without reforms. Finally, the third constituency of third-party payers, which cuts across party lines is interested in the issue only as it affects health system costs.... There is simply too much focused opposition to and no political constituency for second-generation reforms in the current debate over health system reform.[595]

Robert G. Brooks, M.D., stated at the November 4 meeting that the Florida Commission on Excellence in Healthcare recommended that a center on patient safety be established to collect, analyze, and distribute information related to adverse incidents and near misses that was similar to recommendations by the Institute of Medicine. Dr. Brooks also stated that legislation (HB 1219 and CS/SB 2294) was introduced in the Florida Legislature in the 2002 session to establish a center on patient safety, based on voluntary reporting, but the legislation was not passed.[596]

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[593] See Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 181. The concept of enterprise liability is included in the design of "no fault" compensation programs, a third-generation reform, which are discussed later in this chapter.
[594] Id. at 187-188.
[595] Eleanor D. Kinney, Learning from Experience, Malpractice Reforms in the 1990s: Past Disappointments, Future Success? 20 Journal of Health Politics, Policy, and Law 99, 124-125 (1995).
[596] See Robert G. Brooks, M.D., testimony, Nov. 4, 2002, pg. 198; Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pgs. 187-188.

Robert Berenson, M.D., who was co-chair of the malpractice reform working group on the Clinton Health Reform Task Force in 1993 and who worked to administer a demonstration grant program in medical malpractice reform for the Robert Wood Johnson Foundation between 1994 to 1998, stated at the November 4 meeting that healthcare quality is a very important component of medical malpractice reform. Dr. Berenson stated:

> ...we now have a new opportunity and, indeed, a new imperative to deal with a malpractice crisis with more than standard tort reform. The Institute of Medicine's two reports on safety and on quality correctly point to the impediment of the current tort system with or without caps on damages places on efforts to actually do something systematically to improve quality and reduce the frequency and magnitude of errors. I agree with those who assert that threat of suit has a chilling effect on creating an environment conducive to efforts to improve patient safety. Further, protecting patient safety activities from discovery is something Congress is now considering, while desirable, misses a unique opportunity we now have of recasting the malpractice liability system into one that itself is a major contributor for improved patient safety. The legal system should be more than permissive to patient safety activities. Properly designed, it can positively promote patient safety.[597]

Randall Bovbjerg, J.D., who has published extensively on the subject of medical malpractice reform, particularly with regard to no-fault compensation models, stated at the November 4 meeting the "big problems" in medical malpractice are "legal performance and patient safety."[598]

Finally, Michelle Mello, J.D., Ph.D., who has also published extensively in peer-reviewed journals on the subject of medical malpractice, stated that the public is very concerned about medical errors and testified:

> ... my own view is that it's imperative that any liability limiting reform in Florida or elsewhere be paired with some accompanying measures to address problems with patient safety, and most importantly, accountability in medicine.[599]

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[597] See Robert Berenson, M.D., testimony, Nov. 4, 2002, pgs. 213-215.
[598] See Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pg. 267; see also Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pgs. 273-276.
[599] See Michelle Mello, J.D., Ph.D., testimony, Nov. 4, 2002, pg. 305.

At the December 20 meeting of the Task Force in Tallahassee, Donald Berwick, M.D., M.P.P., Clinical Professor of Pediatrics and Healthcare Policy at the Harvard Medical School, gave a presentation regarding the quality of healthcare. Dr. Berwick has been a member of numerous advisory committees, including the Committee on Quality of Healthcare in America that produced the To Err is Human report by the Institute of Medicine.

Dr. Berwick began his testimony by stating patient safety is a serious problem and the burden on public health is substantial. He stated he believed that the estimates of patient deaths in hospitals due to medical errors reported by the Institute of Medicine (the estimate ranges from 44,000 to 98,000 deaths annually) were sound.[600] Dr. Berwick went on to say the problem does not result from a deficient work force. He said incompetence and carelessness might explain 1 or 2 percent of patient injuries. The remaining 98 or 99 percent result from mistakes made by normal people who try "quite hard to do well" but have complex jobs in work systems which are fragile. Sometimes there are "too many things going on at the same time" in very complicated processes. He next stated there are process failures or system failures due to needed information not being transferred from one part of the system to another. For example, he stated 7 of every 100 people hospitalized experience a major medication error.[601]

To improve patient safety, Dr. Berwick stated four types of changes were needed:

(1) a change in awareness and will to address patient safety;
(2) technical changes to modernize healthcare such as computerized medication ordering systems which have software to check for drug interactions and that dosages are within proper range;
(3) cultural changes to promote effective communication, including communication "against the authority gradient"; training for safety, and the open discussion of mistake; and
(4) environmental changes such as changes in the professional education system to include training for teamwork, safety awareness, and communication in medical student and nurse educational programs, elimination of the fear of lawsuits to promote patient safety communication, and increasing the availability of capital to permit hospitals to invest in patient safety efforts such as computerized medication ordering systems. Dr. Berwick stated one of four patient

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[600] See Dr. Donald Berwick, M.D. M.P.P., testimony, Dec. 20, 2002, pg. 5.
[601] Id. at 7-9.

injuries is a medication injury and 80 percent of medication injuries can be eliminated with computerized medication ordering systems.[602]

Dr. Berwick's presentation to the Task Force included six recommendations:

(1) Implement a safety reporting system, based on the aviation model, which uses "the best people" to analyze medical mistakes.[603]

This recommendation is similar to the Patient Safety Authority model in Pennsylvania that is based on the Institute of Medicine's recommended model described, in part, in the To Err is Human and Fostering Rapid Advances in Healthcare reports.

(2) Develop a strategy to generate capital to provide all hospitals with a computerized physician order medication system.[604]

(3) Develop, at the state level, a single inexpensive electronic medical record that contains essential information including "problem list, registry functions, drug medication lists and a few other things."[605] The electronic medical record would be used in both the inpatient and outpatient environments so all physicians, hospitals and other facilities could have access to the record. The November 2002 IOM report states the key components of a computer-based patient record also include laboratory, imaging, and prescription drugs.[606]

(4) Conduct a four-year "no-fault" medical malpractice demonstration project that would use the Workers' Compensation method of compensation for injuries. The system would have five elements:

a. all patients are told when they are injured;
b. an apology to the patient is made;
c. injured patients are compensated just as in the Workers' Compensation system;
d. the "entity" would be responsible for liability, not the individual; and
e. the demonstration project should have a study component to study injuries to continually reduce risk.[607]

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[602] Id. at 9-17.
[603] Id. at 19-20.
[604] Id. at 20.
[605] Id. at 21.
[606] Id. at 63.
[607] Id. at 23-24; see also Albert W. Wu, Handling Hospital Errors: Is Disclosure the Best Defense?, 131(12) Annals of Internal Medicine 970-972 (Dec. 21, 1999) for a discussion of the relationship between informing patients of injuries and malpractice lawsuits.

(5) Include in medical schools and nursing schools curricula courses on patient safety and safety improvement.[608]

(6) Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.[609]

In November 2002, the IOM published a study that made recommendations to improve quality in several areas of healthcare. These areas include: (1) information and communications technology (ICT) that includes physician medication order entry and computer-based patient records with clinical information; and (2) demonstration projects that provide for non-judicial ("no-fault") compensation for medical injuries.[610]

The study recommended the enactment of "paperless healthcare system" demonstration projects, administered by public-private partnerships. These demonstration projects should use computer-based patient records to be available in time for use by clinicians and patients on a right- and need-to-know basis. Improvements in patient safety and quality would be expected due to enhanced communications, access to patient information, knowledge management, and decision support.[611] The study stated computer-based patient records should include a summary of current problems, medications, and allergies and also should include results, notes, and disease management guidelines.[612] In addition, clinicians should have access to computer-based clinical information including laboratory and radiology results.[613] Other features would include appointment and billing and "performance measurement data for ongoing assessment of quality and safety improvements."[614] Over time, the system would include functions for disease surveillance, telemedicine, and a public health rapid alert component.[615] The study concluded: "Properly structured ICT also has great potential to reduce some administrative costs and burden."[616]

The study described a web-based patient data system used by twenty-five healthcare organizations, which account for the majority of care provided in Santa Barbara County in California, as the "best-known" example of a data exchange platform for patient information.[617]

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[608] Dr. Donald Berwick, M.D. M.P.P., testimony, Dec. 20, 2002, pg. 25.
[609] Id. at 26.
[610] Institute of Medicine, National Academy of Sciences, Fostering Rapid Advances in Healthcare (Nov. 2002).
[611] Id. at 58-59.
[612] Id. at 60-61.
[613] Id. at 7.
[614] Id. at 59.
[615] Id. at 63.
[616] Id. at 23-24.
[617] Id. at 62.

According to the IOM report, the Santa Barbara system has the following features:

- Users (such as clinicians, hospitals and laboratories) need an Internet connection and web browser to access data.
- Patient data resides at original locations (such as a hospital system, imaging center system, etc). Only authorized users can view the data.
- Protocols govern who can have access to patient data. When patient information is requested, the requestor's "digital credentials" are verified by the data exchange.
- Patients do not have unique identifiers; rather, the data exchange maintains a file with patient demographic data and correlates these data with those maintained by the provider organization to produce a validated patient search. The locations of the patient records are then stored with the patient's demographic data as "pointers" or "locators."
- Data is exchanged "peer-to-peer" through a secure portal in the data exchange.
- An audit log is maintained by the data exchange that includes who requested the data, what data was requested, and when the request was made.

Another recommendation made in the November 2002 IOM report was the implementation of systems for "computer-based order entry and prescription writing, with dosage and interaction checking."[618] As discussed earlier, Dr. Berwick also made this recommendation in his presentation to the Task Force at its December 3, 2002 meeting.

Dr. Berwick's recommendation to establish a four-year "no-fault" non-judicial compensation program for avoidable medical injuries parallels recommendations made by the IOM in its November 2002 report. In addition, several of the national experts who gave presentations at the November 4 meeting of the Task Force referenced "no-fault" approaches to improve patient safety and ameliorate many of the problems in the tort system.[619] Two countries, Sweden and New Zealand, have no-fault

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[618] Id. at 61.

[619] See Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pgs. 180-181; Robert Berenson, M.D., testimony, Nov. 4, 2002, pgs. 213, 218-225 (esp. 223); Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pgs. 285-288; Michelle Mello, J.D. testimony, Nov. 4, 2002, pgs. 307-316. Michelle Mello discussed no-fault in considerable detail. For a discussion of the potential for quality improvement in a no-fault program see

compensation systems for medical injuries. Florida and Virginia have no-fault compensation systems for newborns with neurological impairments. No-fault compensation for medical injuries has been the subject of considerable academic interest and numerous articles have been published in medical and legal journals on this subject since the early 1990s. In a 1998 University of Cincinnati law review article, Randall Bovbjerg and Frank Sloan, both of who presented at meetings of the Task Force, discuss no-fault compensation for medical injuries at length, with particular reference to the Florida and Virginia programs.[620]

According to Bovbjerg and Sloan, there are theoretical advantages and disadvantages of no-fault compensation programs for medical injuries. With respect to advantages, Bovbjerg and Sloan predict in a no-fault program:

- compensation is improved as more people should be compensated because negligence need not be proved;
- costs associated with claims will be lower because "adversarial tension" is reduced;
- the payment of benefits should be faster than in the tort process;
- "more benefits should be paid relative to premiums because the administrative share of spending will decline without a highly formalized and adversarial litigation process [and] as a result claimants will not be forced to compromise on the amount paid in order to get a certain and rapid settlement";
- payments will better meet individual needs because payments are made when needed;
- "payments should be better managed because a unified large-scale program can develop expertise in particular medical services, as well as negotiate for efficacious and cost-effective services from providers"; and
- periodic payments of benefits will improve compensation because there is protection against changes in needs that are not anticipated. In addition, reduced injuries and improved quality are anticipated because there is motivation to "investigate the causes of injury and take cost-effective precautions" and because more information will be available regarding injuries and their causes that will improve quality.[621]

David M. Studdert and Troyen A. Brennan, No-Fault Compensation for Medical Injuries – The Prospect for Error Prevention, 286(2) Journal of the American Medical Association 217-223 (July 11, 2001).

[620] Randall R. Bovbjerg & Frank A. Sloan, No-fault for Medical Injury: Theory and Evidence, 67 University of Cincinnati Law Review 1 (Fall 1998); see also Randall R. Bovbjerg et al., Obstetrics and Malpractice – Evidence on the Performance of a Selective No-Fault System, 265(21) Journal of the American Medical Association 2836-2843 (June 5, 1991).

[621] Randall R. Bovbjerg & Frank A. Sloan, No-fault for Medical Injury: Theory and Evidence, 67 University of Cincinnati Law Review 70-71 (Fall 1998).

Potential disadvantages, according to Bovbjerg and Sloan, include:

- non-economic damages are normally limited, thus reducing compensation to injured persons;
- wage losses (economic damages) would likely not be compensated to the same extent as in the tort system;
- there may be lower quality of representation because attorney's fees may be lower than in the tort system;
- the options of claimants are reduced because of periodic payments are received rather than a lump-sum; and
- no-fault may "succeed too well, by compensating more cases [and this] increased coverage will make it un-affordably more expensive than liability coverage."[622]

The IOM's November 2002 report recommends that "Patient-Centered and Safety-Focused, Non-judicial Compensation" demonstration projects be established by the U.S. Department of Health and Human Services. These demonstration projects would be established as an alternative to the current tort system of compensation for avoidable medical injuries. According to the IOM report, the current liability system, "hampers efforts to identify and learn from errors, and likely encourages 'defensive medicine.'" In addition, the report cited research that has found that:

- "many legal claims do not relate to negligent care";
- "judgments are sometimes inconsistent with the medical evidence base";
- "compensation is highly variable";
- "legal fees and administrative expenses consume upwards of half the cost of liability insurance premiums;" and
- "volatility in liability insurance markets has led to escalating malpractice premiums in certain geographic areas, precipitating closure of practices and shortages of certain types of specialists and services."[623]

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[622] Id. at 72-73. For a discussion of the potential cost-effectiveness of a no-fault compensation system in the United States see David M. Studdert et al., Can the United States Afford a "No Fault System of Compensation for Medical Injury?, 60(2) Law and Contemporary Problems 1-34 (Spring 1997): "We conclude that adoption of a Swedish-style approach could lead to a system that is both affordable and positioned to compensate a considerably larger proportion of medically injured patients than the current malpractice system manages or even allows." However, the authors believe the Swedish system is not "neatly transplantable." Id. at 33.

[623] See Institute of Medicine, National Academy of Sciences, Fostering Rapid Advances in Healthcare 10, 81-83 (Nov. 2002). For discussions of no-fault compensation, see also Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas Law Review 1595-1637 (June 2002); Randall R. Bovbjerg et al., Administrative Performance of "No-Fault" Compensation for Medical Injury, 60(2) Law and Contemporary Problems 71-115 (Spring 1997).

According to the IOM report, these demonstration projects would:

- "create injury compensation systems outside of the courtroom that would provide timely, fair compensation to injured patients and promote apologies and non-adversarial discussions between patients and clinicians";

- be intended "to create an environment that encourages providers to report and analyze medical errors and to involve patients in safety improvement activities";

- limit financial exposure of providers, "thus contributing to the stabilization of malpractice insurance premiums";

- replace the "existing tort system with an alternative system for compensating patients who have experienced avoidable injuries, allow quicker payments to be made to many more injured patients, and reward providers who put effective programs in place to reduce medical injuries."[624]

The IOM recommends that the Department of Health and Human Services issue a Request for Proposals to states. Four or five states would be selected to receive "modest start-up" funds. States would need to enact appropriate implementing legislation. The IOM projects that within one to two years, benefits should be realized with regard to administrative efficiency. Improvements in patient safety and in stabilizing the medical malpractice insurance premiums would accrue over the longer term. The two types of projects are:

- "Provider-Based Early Payments": This model "offers predetermined limits on non-economic damages including pain and suffering, and federally-subsidized reinsurance to self-insured provider groups that promptly identify and compensate patients for avoidable injuries."[625]

The IOM report states that the "Provider-based Early Payment" model creates incentives for, "...physicians and hospitals to join together to form well-managed clinical entities that bear primary financial responsibility for avoidable errors and have the medical know-how to minimize patient injury."[626]

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[624] Id.
[625] Id. at 10.
[626] Id. at 84.

- "Statewide Administrative Resolution": This model "grants all healthcare professionals and facilities, however organized, immunity from tort liability under most circumstances in exchange for mandatory participation in a state-sponsored, administrative system for compensating avoidable injuries."[627]

According to the IOM, the "Statewide Administrative Resolution" model "gives all healthcare providers equal, immediate access relief from the current liability crisis and does not depend upon particular organizational forms (e.g., integrated group practice) that may not be well developed in many jurisdictions."[628]

The IOM states that both models are compatible with reforms that cap non-economic damages and both support the concept of "early offers." The report states that:

> ...the time is now ripe for successful implementation of [both models] because of two contributions by the emerging science of patient safety.
>
> First, human factors engineers have shown that non-punitive approaches encourage the detection of avoidable injuries and foster systems for continuous improvement, which suggests that resolving malpractice cases without a determination of fault will help rather than harm quality.
>
> Second, as more healthcare providers accept their responsibility to disclose errors to patients, capping liability at defined amounts – an essential attribute of any affordable non-judicial system – will likely result in more rather than fewer patients receiving compensation.[629]

The IOM states that both the Provider-Based Early Payments and Statewide Administrative Resolution models will require four actions by states.

1. **Infrastructure:** States will need to determine which injuries result from "avoidable errors" that patients would be compensated for and also determine "schedules" for calculating economic and non-economic damages.

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[627] Id. at 10.
[628] Id. at 84.
[629] Id. at 85-86.

2. **Legal Environment:** Tort law would need to be revised to permit either or both models and "create clear, narrow exceptions to the malpractice reform (e.g., intentional harm). Individuals and organizations who implement a demonstration model in good faith would need protection from legal exposure. Health insurers and others who pay the costs "incurred by patients suffering compensable injuries" would need protection from lawsuits. In addition, "[s]tates will need to ensure that all apologies and other systematic communications, such as mediated discussions between providers and patients following the occurrence of an avoidable injury, do not increase provider's financial liability or legal exposure."

3. **Patient Safety Reporting Systems** – Oversight mechanisms to ensure that avoidable injuries are detected and disclosed would need to be developed. Mechanisms that collect data on avoidable injuries, and provide for the voluntary confidential reporting of "near misses," would need to be established. Patient safety data would need to reside in computer-based reporting systems.

4. **Education** – The IOM recommends that states implement public education programs to explain the benefits and costs of liability reform and work with principal stakeholders to build trust.

Findings and Recommendations

After reviewing studies published by the Institute of Medicine and others, including the New England Journal of Medicine, and after hearing the testimony of nationally-recognized experts in the area of medical malpractice, the Task Force finds that improving the quality of healthcare is an important and integral component of medical malpractice reform. The Task Force further finds that the analysis of medical errors and the creation of a statewide automated infrastructure to support the delivery of healthcare services by Florida's healthcare providers has the potential to improve quality and reduce the incidence of adverse events and medical errors.

Recommendation 1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine, is to have two systems, one for the mandatory reporting of adverse events and another for the voluntary reporting of near misses. The second option is to have a single entity, similar to the Patient Safety Authority in Pennsylvania, that would analyze all adverse events and near misses. Experts would analyze these data and make recommendations to

facilities about how to reduce these events and near misses. Information would not be subject to discovery in lawsuits.

Recommendation 2. The Legislature should timely develop or adopt a statewide electronic medical record and physician medication ordering system. The system should be developed in partnership with hospitals, physicians, and other health providers. The physician medication ordering system should be implemented first. The system could then be implemented in stages with a possible approach of beginning with a web-based data exchange platform that establishes interconnectivity between providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

Recommendation 3. The Legislature should consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority, statewide electronic medical record, and build an Information Technology infrastructure to support the delivery of healthcare that would include a statewide physician medication ordering system. Funding could possibly come from a $1 per year surcharge on all health professional licenses; all hospital, ambulatory care surgery center, nursing home, home health agency, and birth center discharges; and all individuals in managed care plans and insurance plans licensed under chapters 627 and 640, Florida Statutes. Health providers, insurers, businesses, and government would be represented on the governing board of directors. Options for implementation include:

- Affiliating with a university for the analysis of voluntarily reported adverse events and "near misses."
- Contracting with an Information Technology firm(s) for a statewide physician medication ordering system, web-based platform for health provider interconnectivity, and electronic patient record.
- Developing a business plan and future financing strategy to supplement the $1 annual surcharge, which will likely be necessary to achieve full implementation.
- Including in the business plan a strategy to begin with computerizing business functions, for providers to quickly achieve cost-savings due to automation efficiencies, and then include clinical functions.

Recommendation 4. The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the November 2002 report, Fostering Rapid Advances in Healthcare, by the IOM at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.

Recommendation 5. If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.

Recommendation 6. The Legislature should require each hospital and ambulatory surgery center to have a patient safety plan, a patient safety committee, and a patient safety officer. Members of the public should have representation on patient safety committees.

Recommendation 7. The Legislature should require healthcare providers to notify patients who experience serious medical injuries to be notified of the injury in person.

Recommendation 8. The Legislature should examine the feasibility of using Medicaid funding to create a pilot project for an electronic medical record and a physician medication ordering system for Medicaid patients.

Recommendation 9. The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 10. The Legislature should establish a high-technology simulation center for use by all health providers. Florida should encourage use of this center by practitioners in other states to help offset the costs for the center.

Recommendation 11. The Legislature should require all medical schools, nursing schools, and allied health schools to include in their curricula courses on patient safety and patient safety improvement.

Recommendation 12. The Legislature should require the Agency for Health Care Administration (AHCA) to conduct a study to determine if it is feasible to provide information to the public to help them make better healthcare decisions regarding the choice of a hospital. The information would not be presented in a "report card" format. AHCA should be provided with sufficient resources to conduct the study in cooperation with hospitals, physicians, and other healthcare providers and provide the Governor and Legislature with a report.

Chapter 7 - Physician Discipline

"Much of the medical profession's resistance to regulatory accountability can be traced to the sense of betrayal and persecution most physicians feel when accused of malpractice."

William M. Sage, Principle, Pragmatism, and Medical Injury, 286(2) Journal of the American Medical Association 226 (June 11, 2001)

Issue

The Task Force voted on December 20, 2002, by a vote of 5-0, to examine the following issues with respect to physician discipline in the context of medical malpractice cases

- Should the law be clarified to ensure that the Board of Medicine, rather than a Division of Administrative Hearings (DOAH) administrative law judge (ALJ), establishes when a physician has complied with the community standard of care?

- Should the law be clarified to require the Board of Medicine to determine the community standard of care in any given case and a DOAH ALJ to determine whether facts substantiate the physician's compliance or failure to comply with the community standard of care?

- Should the law be clarified to strengthen the state's ability to discipline physicians?

- Should the law be clarified to strengthen the healthcare provider's ability to perform peer review?

Current Situation

Discipline of the medical professions has historically been the purview of regulatory boards in Florida.[630] These legislatively-created boards are

[630] Chapter 458, Florida Statutes, is the Medical Practice Act, which grants authority to the Board of Medicine to regulate the physicians in the State of Florida. section 458.301, Florida Statutes, specifically states, "The primary legislative purpose in enacting this chapter is to ensure that every physician practicing

comprised primarily of licensed practitioners in the same healthcare field,[631] and have two major responsibilities, licensure in the profession[632] and discipline of those licensed practitioners who are found to be practicing outside the standards for the profession.[633] A major component of the two responsibilities of the boards concerns the promulgation of rules regarding standards of care for the practice of the profession.[634]

In developing the rules as to standard of care, the board has adopted specific requirements to address what would be the standard of care in a particular area of practice.[635] This standard provides the basis upon which the board carries out its disciplinary responsibilities.[636]

Complaints alleging that a physician has failed to provide services within the standard of care are initially investigated by the Department of Health and all reports are then transmitted to a probable cause panel of the Board of Medicine for further investigation, administrative action, or closure.[637] With the exception of closing the matter, further investigation and possible disciplinary action requires the complaint to be processed through specific administrative procedures which may ultimately lead to final board disciplinary action.

Specifically, following the completion of an investigation of a complaint against a physician, an investigative report is provided to a probable cause panel of the Board of Medicine for a determination of probable cause. Assuming probable cause is found, the matter becomes a case and an administrative complaint is served on the physician.[638] At that point the

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in this state meets minimum requirements for safe practice. It is the legislative intent that physicians who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state."

[631] Section 458.307(2), Florida Statutes.

[632] Sections 458.311, 458.313, Florida Statutes.

[633] Section 458.331, Florida Statutes.

[634] Section 458.309(1), Florida Statutes, provides that the "Board has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it."

[635] Rule 64B8-9, Florida Administrative Code, is the rule adopted by the Board of Medicine regarding the standards of practice for medical doctors. For example, see Rules 64B8-9.003, Standards for Adequacy of Medical Records; 64B8-9.009, Standard of Care for Office Surgery; and 64B8-9.013, Standards for the Use of Controlled Substances for Treatment of Pain.

[636] Section 458.331(1)(nn), Florida Statutes, provides as grounds for discipline, "violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto."

[637] Section 456.073, Florida Statutes, provides that all legally-sufficient matters shall be investigated and referred to the probable cause panel for consideration as to whether the complaint should be prosecuted or closed.

[638] Section 456.073(2), Florida Statutes, states "If the probable cause panel finds that probable cause exists, it shall direct the department to file a formal complaint against the licensee. The department shall follow the directions of the probable cause panel regarding the filing of a formal complaint. If directed to do so, the department shall file a formal complaint against the subject of the investigation and prosecute the complaint pursuant to chapter 120."

physician can elect to resolve the case by settlement or proceed to administrative hearings.[639]

Should a settlement be agreed upon by the parties, the settlement document is presented to the board for acceptance or rejection. Assuming the board accepts the settlement document, the matter is resolved in accordance with the agreement and a Final Order issued reflecting the terms of the discipline.[640]

Should the physician elect to proceed to an administrative hearing, two possible procedures exist. In those circumstances where the physician is not disputing the material facts of the case, but rather seeks to demonstrate mitigation as to those facts, an informal hearing, or specifically a hearing where there is no material facts in dispute, is held before the Board of Medicine.[641] In those circumstances where the physician disputes the material facts, a formal hearing before the DOAH is held.[642]

In the circumstances where the physician has not disputed the material facts in the case, the hearing before the Board of Medicine will be conducted and at such time the physician will be given an opportunity to present mitigation as to his/her specific situation, argue applicable law, and discuss appropriate penalties. Once the hearing is completed, the board will resolve the matter and issue a Final Order, including the assessment of an appropriate penalty.[643] If the physician does not agree with the board's decision, an appeal may be taken to an appellate court.[644]

In the circumstances where the physician disputes the material facts in the case, the matter will be handled by DOAH in a formal non-jury trial proceeding. These hearings are similar to trials in a court of law with the exception that specific administrative rules apply.[645] For example, all discovery and evidentiary rules are applicable and the process parallels the proceedings found in civil non-jury trials.[646] Following the evidentiary

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[639] Sections 120.57(1), Florida Statutes, (procedures applicable to hearings involving disputed issues of material fact); 120.57(2), Florida Statutes, (procedures applicable to hearings not involving disputed issues of material fact); 120.57(4), Florida Statutes, (informal disposition by stipulation, agreed settlement, or consent order).

[640] Section 120.569(2)(l), Florida Statutes.

[641] Section 120.57(2), Florida Statutes.

[642] Section 120.57(1), Florida Statutes.

[643] Section 120.569(2)(l), Florida Statutes.

[644] Section 120.68, Florida Statutes.

[645] Chapter 28-101 - 110, Florida Administrative Code, provides the procedural rules for administrative causes of action.

[646] Section 28-106.206, Florida Administrative Code, provides "After commencement of a proceeding, parties may obtain discovery through the means and in the manner provided in Rules 1.280 through 1.400, Florida Rules of Civil Procedure; section 28-106.213, Florida Administrative Code, outlines some of the evidentiary guidelines to be followed in administrative cases.

portion of these proceedings, the ALJ will render a recommended order. That order will include the findings of fact, conclusions of law, and the disposition of the matter.[647]

Upon receipt of the recommended order from the ALJ, the board is statutorily authorized to accept, reject, or modify the recommended order.[648] If the board accepts the recommended order, then the matter will be disposed of in accordance with the ALJ's order. The physician may take an appeal to the appropriate appellate court for further review. If the board rejects or modifies the recommended order, then the board must review the record in its entirety and cite with particularity the basis supporting the board's conclusion that there is no competent and substantial evidence to support the specific recommended order.[649] Upon a finding that the recommended order is unsupported by the record, the board may reach different findings of fact, conclusions of law, and/or assess culpability as to guilt and determine the degree of penalty. The board will issue a final order following the rejection or modification of the recommended order. The physician may appeal to the appropriate appellate courts the final order of the board.[650]

On June 28, 2002, the Fifth District Court of Appeal issued an opinion in Gross v. Department of Health,[651] wherein the court reversed a final Order of the board regarding the discipline of Dr. Gross. This case provides the latest example of why reforms in the manner in which the board is authorized to dispose of physician disciplinary cases are needed.

The facts of the Gross case may be found in Judge Orfinger's concurrence when he succinctly provides:

> the tragic events that lead up to the demise of Dr. Gross's patient are not in substantial dispute. In preparation for a diagnostic ventriculogram, a nurse employed by Orlando Regional Medical Center's cardiac catherization lab was responsible for loading an injector with dye. The injector was to be utilized to inject dye into the patient's heart to opacify the flow of blood. Apparently, the nurse was called

[647] Section 120.57(1)(k), Florida Statutes.

[648] Section 120.57(1)(l), Florida Statutes; in the case of Lusskin v. Department of Health, Board of Medicine, 820 So. 2d 424, 426 (Fla. 4th DCA 2002), the court stated "The Board is imbued with the authority to accept or reject the hearing officer's penalty recommendations...When it does so, it must conduct a review of the complete record, and state 'with particularity its reasons therefore in the order, by citing to the record in justifying the action' §120.57(1)(l), Fla. Stat. (2001). Simply referring to the record in general is insufficient to comply with this subsection."

[649] Section 120.57(1)(l), Florida Statutes; see also Greseth v. Department of Health and Rehabilitative Servs., 573 So. 2d 1004 (Fla. 4th DCA 1991).

[650] Section 120.58, Florida Statutes.

[651] 819 So. 2d 997 (Fla. 5th DCA 2002).

> away while preparing the injector for use and inadvertently left the plunger in a position so that it appeared that the injector had been loaded with dye as required. In fact, it had not been, and when the injector was wheeled to the patient's side, Dr. Gross connected it to the catheter that had been inserted into the patient's heart and then injected a large volume of air, rather than dye, into his patient, causing the patient's sudden death.[652]

In August 2000, the DOH filed an administrative complaint against Dr. Gross in light of the foregoing facts. The Department alleged that the air injection was a failure on the part of Dr. Gross to practice medicine with the "level of care, skill, and treatment required by section 458.331(1)(t)."[653] Dr. Gross elected to proceed to formal hearing before the DOAH. At the hearing both parties presented evidence concerning the circumstances leading up to the patient's death and presented expert testimony as to the applicable standard of care. The ALJ issued its recommended order finding substantial competent evidence that Dr. Gross did not violate section 458.331(1)(t), Florida Statutes. The matter was then submitted to the board for adoption of the recommendation.[654]

At the board's meeting, a number of board members took issue with the recommended order's findings that Dr. Gross did not fall below the appropriate standard of care. The board then issued its final order substituting its finding that Dr. Gross's performance was below the applicable standard of care and that he did violate section 458.331(1)(t), Florida Statutes.[655] Dr. Gross later appealed the board's action.

In deciding Gross, the court observed, "the courts have encountered difficulties when the administrative law judge's findings are supported by substantial competent evidence which are rejected or modified by the agency's adoption of its own findings which are also supported by substantial competent evidence."[656] The court concluded that where the above circumstances exist, that is, when there is substantial competent evidence to support both the administrative law judge's findings and the agency's own findings, the agency's order must be reversed.[657]

Specifically the court rejected the board's argument that the "deference rule" required that policy considerations left to the discretion of an agency

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[652] Gross v. Department of Health, 819 So. 2d 997, 1006 (Fla. 5th DCA 2002).
[653] Id. at 1000.
[654] Id.
[655] Id.
[656] Id. at 1002.
[657] See City of Umatilla v. Public Employees Relations Comm'n, 422 So. 2d 905, 907 (Fla. 5th DCA 1982).

take precedence over findings of fact by an ALJ.[658] The court rejected the board's argument that whether Dr. Gross failed to comply with the applicable standard of care is a matter infused with overriding policy considerations and it may, therefore, give less deference of the finding of fact by the administrative law judge.[659] The court held:

> We reject the argument by the Board that the deference rule applies to the instant case because, as will be discussed . . . the courts have generally held that the issue of whether an individual violated a statute by breaching the applicable standard of care is a factual issue that is susceptible to ordinary proof and is an issue that is not infused with policy considerations.[660]

In his concurrence with the special opinion, Judge Orfinger observed that:

> Common sense notwithstanding, the ALJ was presented with conflicting evidence regarding Dr. Gross's obligation to ensure that the injector was properly loaded with dye prior to utilizing it. Although the conclusion that Dr. Gross had no responsibility defies common sense, legally, the ALJ was free to accept the testimony of Dr. Gross and that of his expert witnesses, that the standard of care did not require Dr. Gross to ensure that the injector was properly loaded with dye before utilizing it. Apparently, the ALJ did not consider Hippocrates's prescription to "do no harm" as establishing a reasonable standard of care to be followed by medical practitioners in Florida or standards found in section 458.331(1)(t). . . . Because the law does not allow this court or the Board of Medicine to reweigh the conflicting evidence, I concur, albeit reluctantly, with the courts opinion.[661]

Judge Orfinger further lamented:

> The requirement that we use reasonable care in our daily endeavors is not unique to medicine. Indeed, the standard of care that society requires of us increases in direct proportion to the risk inherent in the activity being performed. Everyday life gives us many analogous situations. The pilot of a commercial airliner is not obliged

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[658] Baptist Hosp., Inc. v. Department of Health and Rehabilitative Services, 500 So. 2d 620, 623 (Fla. 1st DCA 1996).
[659] Gross v. Department of Health, 819 So. 2d 997, 1002 (Fla. 5th DCA 2002).
[660] Id. at 1003.
[661] Id. at 1006-1007.

> to personally fill the fuel tanks of the airplane; however, the traveling public reasonably expects the pilot to check the fuel gauges prior to takeoff to ensure that the plane has adequate fuel. Similarly, prudence dictates that someone holding a gun check to make sure it is not loaded, before pointing it toward someone and pulling the trigger. Likewise, I believe the standard of care should require Dr. Gross, and other physicians performing similar procedures, to ensure that the injector is properly filled with dye so that air is not injected into the patient, particularly given the significant adverse consequences of doing so. Such a standard seems to be no more than common sense. *However, at least as it relates to the protocols for injecting dye into patients, the medical profession appears not to have set the bar very high.*[662]

The issue that remains to be resolved is whether the resolution of the Gross case based on the law as it existed in 2002 mandates reform which would allow the Board of Medicine to assess the appropriate standard of care.

Information Presented to the Task Force

Testimony regarding physician discipline and its impact on medical malpractice cases was heard on two separate occasions, December 3, 2002, and December 20, 2002. Generally, each stakeholder opined that improvements in physician discipline were warranted. Each, however, proffered a variety of solutions to the concerns relating to physician discipline.

During the December 3 meeting, two speakers addressed the issue of physician discipline. Gary Winchester, M.D., a Board of Medicine member, stated that Florida was known to be one of the toughest states in which to obtain a medical license because of its comprehensive screening process and extensive criminal background checks.[663] Currently, 44,000 physicians are licensed to practice medicine in the State of Florida.[664]

Proactively, the Board of Medicine has taken the initiative to address many standard of care issues within some specific areas of practice through its rulemaking process. Areas addressed by the board such as the Internet,[665] office surgery,[666] pain management,[667] and telehealth[668] have

[662] Id. (emphasis added).
[663] Gary Winchester, M.D., testimony, Dec. 3, 2002, pg. 243.
[664] Id.
[665] Id. at 244.

been codified in rules or continue to be the subject of task force discussions. Specifically, Dr. Winchester reported that the purpose of at least one of these rules, pain management, was to:

> try to make sure that physicians get the pain management they need. That is, to get the medications they deserve to have. A lot of times they don't. In fact, the AMA survey not too long ago showed that pain management was the absolute worst thing that patients felt that the healthcare system did. The second part of that rule was to make doctors feel comfortable, that if they do the following things, they won't be in trouble with the Board of Medicine for doing prescribing.[669]

Criticisms relating to the physician disciplinary process were presented. Specifically, it was noted "One of the problems we find is with some of the DOAH cases...Occasionally, we will have a case come back to us from DOAH, and the board will look at it and look at the facts and just have a gut-wrenching feeling that the [ALJ] was wrong, period, wrong. They missed the standard of care."[670] Part of the reason, it was believed, was due to having young attorneys with a high turnover rate and a lot of cases to handle.[671] Another reason offered was that the "[ALJs], of course, write their final orders in such a way that it is essentially impossible for us to get them overturned. We try every now and then, but the DCA always tells us no."[672]

Recommendations offered regarding the DOAH cases included working it out so that the "Board of Medicine decides the standard of care. And then when that standard of care is decided, then the DOAH officer looks at the conclusion of law and the penalty."[673] Another suggestion was to allow the Board of Medicine to decide what the costs are in a case since part of the board's mandate is to recover all costs.[674] A third proposal was to allow the board greater flexibility in fine assessments in "situations that are really bad situations."[675] For example, it was suggested, "where a doctor caused permanent scarring of three ladies' faces, to charge him $10,000 is really kind of silly."[676] Finally, it was recommended that

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[666] Id. at 245.
[667] Id. at 246.
[668] Id. at 247.
[669] Id. at 246.
[670] Id. at 248.
[671] Id.
[672] Id. at 249.
[673] Id. at 252.
[674] Id.
[675] Id.
[676] Id.

mediation be explored, especially at the probable cause level, before "either side has to spend a lot of money on experts" and to bring the matter to rapid conclusion.[677]

Former First District Court of Appeal Judge Robert Smith concurred with Dr. Winchester's comments[678] and further stressed the role of DOAH in physician discipline. Specifically, Mr. Smith took exception to the Legislature's passage of amendments to chapter 120, the Administrative Procedures Act, which "withdrew from the Board of Medicine and all other medical care boards the power to hold these disputed fact hearings themselves or to designate one member of their collegial board to hold the hearings."[679] Mr. Smith opined that the Legislature has "stripped away" from the executive branch, and transferred to quasi-judges, the "power that is in substantive statutes committed to the substantive agencies, such as this medical board...and that section 120.80(15) which prohibits the Board of Medicine from holding hearings where a fact is in disputes 'is unconstitutional.'"[680] Repeal of section 120.80(15), Florida Statutes, is recommended to make tort reform effective.[681]

Mr. Smith affirmed the need to give back to the board the "option of holding these disputed fact hearings themselves and avoiding such things as occurred" in those cases.[682] In all three cases, it was judged that the rulings by the DOAH judges were in error and in the Gross case especially, the "Board of Medicine was weeping at the prospect of having to let this doctor go without even an admonition."[683]

Mr. Smith further concluded that without strengthening the regulation of medical care providers, the Supreme Court might once again find unconstitutional any approved tort reform. Specifically, Mr. Smith reasoned that "...unless you do this simple thing, the Supreme Court is going to look back at [previous rulings] and say this tort reform is unconstitutional because you have not recommended, and...the Legislature has not addressed...the strength and regulation of negligent medical care providers, which is the source of medical malpractice litigation."[684]

During the December 20, 2002 meeting, three speakers addressed the issue of physician discipline with diverse solutions. First, Amy Jones, Director of Medical Quality Assurance, offered legislative proposals to help

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677 Id.
678 Robert Smith, testimony, Dec. 3, 2002, pg. 256.
679 Id. at 260.
680 Id. at 259, 263.
681 Id. at 261.
682 Id. at 266.
683 Id. at 265.
684 Id. at 258.

strengthen the disciplinary process. One proposal was to enhance the existing subpoena authority of the DOH.[685] It was explained that the DOH had no subpoena authority over the physician, a nursing home, or an assisted living facility.[686] Instead, patient records could only be obtained from hospitals and therefore if a patient refused to cooperate in giving their consent to release patient records, the Department would not be able to prove the case and the matter would be over.[687] Thus, "Even though we suspect and think that malpractice occurred, we can't get the records to prove it and that case is over."[688] Another recommendation was to allow a physician "one bite at the apple" for minor violations by making citations not reportable to the national database.[689] The incentive for this proposal is that physicians will settle those cases more quickly, and they will be out of the system sooner thus allowing limited resources to be concentrated on the more serious violations.[690] A third suggestion was to extend, from fifteen days to forty-five days, the statutory timeframe for the referral of cases to the DOAH.[691] This recommendation was based on the belief that since 95 percent of the cases settle, the additional time would allow better resolutions that get through the process more quickly.[692] Finally, Ms. Jones suggested that mediation be used to assist in the resolution of matters.[693]

A second speaker, Deborah Zappi, representing the Florida Academy of Trial Lawyers, focused most of her testimony regarding physician discipline in the area of improving the patient's access to physician information. Although the Department website provides doctor information in its physician profiles, it was suggested that there was "missing critical information" and the website was not as "user friendly" as it should be.[694] Ms. Zappi stated that "patients are entitled to know what their odds are when they gamble on their choice of healthcare provider. Very simply, patients must have access to more information. They need to avoid physicians and hospitals with bad track records and, therefore, they can avoid malpractice and malpractice suits."[695] The following suggestions were made regarding the physician profiles: physicians should not be allowed to practice or renew their license until the profile is complete and "on the air for the public";[696] for initial

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[685] Amy Jones, J.D., testimony, Dec. 20, 2002, pg. 140.
[686] Id.
[687] Id.
[688] Id.
[689] Id.
[690] Id.
[691] Id. at 142.
[692] Id.
[693] Id. at 143.
[694] Deborah Zappi, J.D., testimony, Dec. 20, 2002, pgs. 150-151.
[695] Id. at 151.
[696] Now, a physician can practice over a year before the profile is put on the web. Id. at 151-152.

profiles, physicians should be given no longer than thirty days to verify the information and fifteen days for updates on disciplinary actions for closed claims;[697] the Department should be required to "fill in the blanks" in the doctor's profile when he/she fails to provide the mandatory information, such as disciplinary action by a state agency;[698] the Department should be required to verify criminal information rather than state "the criminal offense information provided by the practitioner has not been verified at this time";[699] the physician profile, at a minimum, should state, "what the physician was disciplined [for] and what section of the law the physician has been found violated";[700] hospital disciplinary actions should be included in the physician profile;[701] information regarding bankruptcies and closed claim data should be included and verified;[702] and, finally, the Department should know how many physicians are closing their practices or entering/leaving the state.[703]

A third speaker, Gary Blankenship, believed that "at least a major cause of your high rates of medical malpractice is the state's ineffective regulation of the medical profession."[704] Mr. Blankenship's criticisms of the disciplinary process focused on the "secrecy" of the proceedings, and its effect on the number of physicians disciplined and the effectiveness of the volume of cases reviewed and processed through the system.

His first proposal was to mandate the "opening of the grievance filings in the State of Florida, except for patient names or any information that would identify the patients."[705] Mr. Blankenship reported that the staff or the probable cause panels close 98 percent of the filings. Those files "cannot be reviewed...are secret and nobody can go back and challenge the reasons for closure." Thus, this causes a big problem and "a lot of bad doctors are getting through. . . ."[706] Therefore, a second suggestion was to "conduct a thorough performance audit of the way medical complaints are handled."[707] Specifically, this might require that a panel of academic experts, and not a Florida doctor, be able to conduct the audit.[708] The third

[697] Currently, there is no time frame as to how soon a profile must be updated. Id. at 152.
[698] Id. at 153.
[699] Id.
[700] Currently, there is not description in the profiles of the disciplinary action taken against a physician. Id.
[701] Disciplinary actions by HMOs, am-surgical centers and nursing homes are included, but not disciplinary action by hospitals. Id. at 155.
[702] Id.
[703] Id. at 157.
[704] Gary Blankenship, testimony, Dec. 20, 2002, pg. 162.
[705] Id. at 161.
[706] Id. at 163-164.
[707] Id. at 161.
[708] Id.

proposition was to have a commission go over the "past year's complaint files in detail."[709]

A small number of physicians, approximately 0.32 percent, are actually disciplined in the State of Florida.[710] Review as to why so few physicians are disciplined is unavailable because the closed cases are sealed.[711]

Finally, Mr. Blankenship was troubled by the volume of cases processed through the disciplinary system. It was reported that "[t]he probable cause statistics in 1999-2000 report from the Agency for Health Care Administration . . . talked that they prepared over 800,000 pages of documents for the two probable cause panels with three on each, that's six people who got over 800,000 pages of documents. I did the math. It was a wonderful symmetry there. If you broke that down, each one of the six people had to read 365 pages a day, 365 days of the year, to keep up with the paperwork. There is no way six people can exercise effective oversight. Yet you have no oversight and what they do is closed."[712]

Mr. Blankenship believes that "insurance companies look at that lax regulation, and they look at nothing happened to those doctors...and they adjust their rates accordingly, and it's not downward."[713]

As part and parcel of physician discipline, the Task Force also voted to strengthen methods of peer review. Many healthcare providers widely view peer review as essential to encourage high quality medical care.[714] Peer review is the process by which members of a hospital's medical staff review the qualifications, medical mal-occurrences, and professional conduct of other physicians on the hospital staff.[715] The purpose of peer review is to critically examine the medical care rendered by a physician, and if deficiencies exist, to prevent a physician with quality problems from continuing to practice.[716] For example, a peer review panel may find that a general surgeon is qualified to perform an open cholecystotomy, but, based upon previous quality concerns, that he is unqualified to perform a laparoscopic cholecystotomy.

The American Medical Association has come out strongly in favor of peer review, stating it: "(1) strongly reaffirms its continuing commitment to the development and maintenance of voluntary, professional directed peer

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[709] Id.
[710] Id. at 165.
[711] Id.
[712] Id.
[713] Id. at 171.
[714] Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit—Is it Time for a Change?, 25 American Journal of Law and Medicine 7 (1999).
[715] Id.
[716] Id. at 13.

review of medical care; and (2) encourages physicians to expand their efforts to ensure that such care is of high quality, appropriate duration and reasonable cost."[717] Seeing the wisdom of peer review, almost all states have granted some type of immunity to physicians who participate in peer review.[718] These laws are meant to protect medical peer review participants from liability for their participation in the peer review process.[719] Forty-seven states and the District of Columbia have peer review immunity statutes.[720]

The federal government has also addressed the merits of peer review through statutory protections when Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA).[721] The HCQI\ grants broad immunity, subject to certain limitations, to professional review bodies, individual members of professional review bodies, persons under contract or other formal agreement with professional review bodies, and any persons who assist professional review bodies with respect to actions.[722] In addition, the HCQIA preempts state laws that provide less immunity that that offered under federal law.[723] Even with the HCQIA's immunity provisions, many cases are still filed against peer review committees that linger for years. The American Hospital Association's Senior Vice-President has noted: "Early resolution in these cases is impossible, even where there is no objective evidence of improper peer review activity."[724]

Florida has adopted statutes which are meant to protect medical review committees members, records, and information committees.[725] Florida laws grant protection in one of three ways: (1) providing physicians that participate in peer review immunity from lawsuits based upon their actions; (2) making peer review information privileged from discovery; and (3) requiring that physicians that participate in the process keep its findings confidential.[726] However, the Task Force has heard strong evidence that these protections are ineffective in accomplishing their public policy objects; as such, these laws should be reformed.

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[717] American Medical Association, policy compendium, H-375.996 (1998).
[718] Susan O. Scheutzow, State Medical Peer Review: High Cost But no Benefit—Is it Time for a Change?, 25 American Journal of Law and Medicine 8 (1999).
[719] Id.
[720] Id. at 29.
[721] See 42 U.S.C.sections 11101-11152.
[722] Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit—Is it Time for a Change?, 25 American Journal of Law and Medicine 30 (1999).
[723] Id. at 31.
[724] Id. at 32.
[725] Karen O. Emmanuel, The Peer Review Privilege in Florida, 69 August Florida Bar Journal 61 (July/August 1994).
[726] Section 766.101, Florida Statutes; section 395.0191, Florida Statutes; section 395.0193, Florida Statutes.

Hospitals and physicians have become reluctant to engage in peer review. "Serving on a hospital [peer review] committee was once a privilege. The privilege has now become a hazard."[727] A review of Florida's case law reveals that almost anytime a peer review committee denies a physician staff privileges or revokes a physician's hospital privileges, litigation ensues.[728] Physicians who have been disciplined by peer review committees for medical malpractice at a particular hospital usually retaliate by filing a civil suit against the hospital and other physicians on a variety of grounds, including: (1) defamation; (2) illegal discrimination; (3) tortuous interference with business relationship; (4) breach of contract; and (5) conspiracy to prevent them from practicing at the hospital in violation of federal antitrust laws.[729] Thus, there exist powerful disincentives to perform peer review. The damages awarded in these legal actions can be substantial.[730] These suits can be much more daunting to a physician than a medical malpractice suit. For starters, these actions are usually not covered by liability policies since antitrust suits have nothing to do with the "practice" of medicine in a negligent manner.[731] Additionally, successful plaintiffs can obtain three times their earning power losses resulting from the hospital privileges denial.[732]

For peer review to succeed, statutes must be strengthened to protect physicians and hospitals from costly liability and costly lawsuits. The current peer review protections have been ineffective in protecting those healthcare providers that engage in good faith peer review. The legislature must reassess the peer review statutes and develop methods to ensure that physicians and hospitals engage in constructive peer review.

Findings and Recommendations

To resolve this situation so as to authorize the regulatory boards to better maintain the standard of care for the practitioners, the Task Force recommends the following legislative changes:

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[727] F. M. Langley, Does Medical Peer Review Immunity Exist After Patrick v. Burget? A Review of the Legal Fundamentals, 2 University of Florida Journal of Law and Public Policy 137 (1988/89).

[728] Id. at 8.; see e.g., Palm Beach Gardens Community Hospital, Inc. v. Shaw, 446 So. 2d 1090 (Fla. 4th DCA 1984); Jacksonville Medical Center, Inc. v. Akers, 560 So. 2d 1313 (Fla. 1st DCA 1990); All Children's Hospital v. Davis, 590 So. 2d 546 (Fla. 2d DCA 1991); Cruger v. Love, 599 So. 2d 111 (Fla. 1992); Bolt v. Halifax Hosp. Medical Center, 980 F.2d 1381 (11th Cir. 1993); Bryan v. Holmes Regional Med. Ctr., 33 F.3rd 1318 (11th Cir. 1994); Noble v. Martin Memorial Hospital, 710 So. 2d 567 (Fla. 4th DCA 1997).

[729] Karen O. Emmanuel, The Peer Review Privilege in Florida, 69 August Florida Bar Journal 63 (July/August 1994).

[730] F. M. Langley, Does Medical Peer Review Immunity Exist After Patrick v. Burget? A Review of the Legal Fundamentals, 2 University of Florida Journal of Law and Public Policy 138 (1988/89).

[731] Id.

[732] Id.

Recommendation 1. The Legislature should allow the healthcare provider regulatory boards to appoint administrative law judges with expertise in the profession to hear standard of care cases.

Recommendation 2. The Legislature should statutorily provide that standard of care decisions are, as a matter of law, infused with overriding policy considerations best left to the healthcare provider regulatory boards.

Recommendation 3. The Legislature should authorize the healthcare provider regulatory boards to reassess and resolve conflicting evidence in standard of care cases based on the record in the case.

Recommendation 4. The Legislature should require physician profiles to provide professional qualifications information regarding physicians to consumers.

Recommendation 5. The Legislature should provide for an audit of the Department of Health's disciplinary process and closed claims files.

Recommendation 6. The Florida Legislature should strengthen Florida's peer review requirements so they can lead to earlier dismissal of meritless claims brought against hospitals by aggrieved physicians and protect physicians and hospitals from costly lawsuits and liability.

Recommendation 7. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 8. The Legislature should require that all first offense citations be non-disciplinary and non-reportable to the national data banks.

Recommendation 9. The Legislature should expand the timeframe for forwarding cases to the Division of Administrative Hearing from fifteen days to forty-five days when a demand for a formal hearing, pursuant to section 120.57(1), Florida Statutes, is received.

Recommendation 10. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases shall be included.

Recommendation 11. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 12. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 13. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Recommendation 14. The Legislature should expand the healthcare provider regulatory board's rulemaking authority in the areas of Internet prescribing and sexual misconduct cases so as to better address critical areas of discipline.

Chapter 8 - Tort Reform

"Present-day malpractice litigation misses [its] targets by a considerable margin. Most of the claims dollar goes toward legal fees, pain and suffering, and items that have already been compensated by varying sources of primary loss insurance, rather than being spent on the critical financial needs of the most severely injured patients. This acknowledged flaw of tort law as a mode of compensation might be acceptable if the system were living up to its promise as an effective incentive for injury prevention. Unfortunately, the little empirical evidence that we have, as well as systematic analyses of characteristic features of the tort process, lead to the conclusion that even though the threat of tort suits induces expensive reactions from doctors, there has been only a modest payoff in reducing injuries to patients."

Paul C. Weiler, Medical Malpractice on Trial 7 (1991)

Cap On Non-Economic Damages

Issue

During its December 20, 2002 meeting, the Task Force voted, by a 5-0 vote, to examine the following issues with respect to non-economic damages in medical malpractice cases:

- Should the Task Force recommend that the amount of non-economic damages potentially recoverable in a medical malpractice action be capped?
- If a cap is to be recommended, at what amount?
- If a cap is to be recommended, is there a finding of a commensurate benefit for an individual claimant?
- If a cap is to be recommended, is there a finding that there exists an overwhelming public necessity to impose a cap on non-economic damages?

- If a cap is to be recommended, is there a finding that there exists no alternative remedy to address this crises?

Current Situation

The term "economic damages," as used in this report, consists of:

- Medical expenses (i.e., the reasonable value or expense of hospitalization, medical and nursing care, and treatment necessarily or reasonably obtained by the claimant in the past, or to be so obtained in the future).[733]
- Lost earnings in the past. [734]
- Lost working time in the past.[735]
- Loss of ability (capacity) to earn money in the future.[736]
- Loss of a spouse's services in the past and in the future.[737]
- Other pecuniary losses.[738]

The term "non-economic damages" includes past and future:

- Pain and suffering.[739]
- Disability or physical impairment.[740]
- Disfigurement.[741]
- Mental anguish.[742]
- Inconvenience.[743]

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[733] Fla. Std. Jury Instr. (Civ.) 6.2(c). See also section 766.202(3), Florida Statutes (defining "economic damages" for purposes of the medical malpractice arbitration statute as financial losses which would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity).

[734] Fla. Std. Jury Instr. (Civ.) 6.2(d).

[735] Id.

[736] Id.

[737] Fla. Std. Jury Instr. (Civ.) 6.2(e).

[738] See also H.R. 4600, 107th Cong., 2d Sess. (2002), which defines "economic damages" as:

> objectively-verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

[739] Fla. Std. Jury Instr. (Civ.) 6.2(a). See also section 766. 202(7), Florida Statutes (defining non-economic damages for purposes of medical malpractice arbitration statute as non-financial losses which would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non-financial losses).

[740] Fla. Std. Jury Instr. (Civ.) 6.2(a).

[741] Id.

[742] Id.

[743] Id.

- Loss of capacity for the enjoyment of life.[744]
- Aggravation of an existing disease or physical defect.[745]
- Loss of a spouse's comfort, society, and attentions.[746]
- Humiliation.[747]
- Injury to reputation.[748]
- Shame.[749]
- Hurt feelings.[750]
- Other non-pecuniary losses.[751]

The Florida Standard Jury Instructions recognize that there is no exact standard for measuring such damages.

Under current Florida law, there is no limit on the amount of money a jury may award plaintiffs as past or future non-economic damages in a medical malpractice case.[752] This point is illustrated by the March 13, 2002, jury award against Sand Lake Hospital (part of Orlando Regional Healthcare System Inc.) in the amount of $78.5 million.[753] The economic damages awarded by that jury were $8.5 million; the non-economic damages were $70 million.

The amount the jury may be swayed to award as non-economic damages is the most unpredictable part of a Florida medical malpractice claim. The U.S. Department of Health and Human Services has concluded:

> Unless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status

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744 Id.
745 Fla. Std. Jury Instr. (Civ.) 6.2(b).
746 Fla. Std. Jury Instr. (Civ.) 6.2(e).
747 Fla. Std. Jury Insrt. (civ.) MI 4.4(a).
748 Id.
749 Id.
750 Id.
751 Fla. Std. Jury Instr. (Civ.) 6.2(a).
752 After the jury has returned its verdict, the court may, upon proper motion, order remittitur or additur where the jury has found the medical malpractice defendant liable but the jury's award of money damages is excessive or inadequate in light of the fats and circumstances which were presented to the trier of fact. Section 768.74(1), Florida Statutes.
753 Brain-Injured Patient Awarded $78 Million, Orlando Sentinel, Mar. 14, 2002. The case was was Henalori Shellow-McGee, by and through her legal guardian, Darrell McGee v. Orlando Regional Healthcare System d/b/a Sand Lake Hospital, No. CI-000-4009.

(educated, attractive patients recover more than others).[754]

Non-economic damages are inherently subjective; there are no objective standards by which they can be quantified. One article explains:

> Whatever pain and suffering damages encompass in a given jurisdiction, the law does not provide an objective formula for valuing them. It is difficult to assess another person's pain and suffering and then translate that into its financial equivalent. In fact, courts have usually been content to say that pain and suffering damages should amount to fair compensation or a reasonable amount, without any more definite guide. As a result, jurors can be improperly influenced by the presentation of guilt evidence. The amount of pain and suffering awards can, and does, fluctuate markedly.[755]

The U.S. Department of Health and Human Services has further observed:

> The cost of these awards for non-economic damages is paid by all other Americans through higher health care costs, higher health insurance premiums, higher taxes, reduced access to quality care, and threats to quality of care. The system permits a few plaintiffs and their lawyers to impose what is in effect a tax on the rest of the country to reward a very small number of patients who happen to win the litigation lottery. It is not a democratic process.[756]

As discussed below, the risk of excessive jury awards of non-economic damages has a profound effect upon the way plaintiffs, defendants, and their respective attorneys view medical malpractice claims. Among other things, plaintiffs may overvalue their claims and refuse reasonable offers to settle. Defendants' insurers may pay more to settle than a claim is really worth simply to avoid the possibility of a large verdict of non-economic damages.

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[754] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 9 (July 24, 2002) (Vol.1, Tab 1) (footnote omitted).

[755] Victor E. Schwartz & Leah Lorber, Twisting the Purpose of Pain and Suffering Awards: Turning Compensation Into Punishment, 54 South Carolina Law Review, 47, 59-60 (Fall 2002) (footnotes omitted).

[756] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 9 (July 24, 2002) (Vol.1, Tab 1).

In addressing their own crises of access to healthcare resulting from medical malpractice insurance unavailability and un-affordability, several state legislatures have imposed caps on awards of non-economic damages.[757] The Task Force finds that California has succeeded where Florida has failed at holding down medical malpractice insurance premium rates. California thus has enhanced access to healthcare for its residents. California implemented its cap as a component of a system of reforms through its Medical Injury Compensation Reform Act of 1975 (MICRA). Although there is some disagreement among the stakeholders over whether the cap is a cause of California's success,[758] there is substantial evidence, which the Task Force finds persuasive, that California has been successful.

Furthermore, based upon California's experience, the Task Force finds and concludes that, without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare.[759]

In the 1970s, California, like Florida, was facing a crisis in the availability of medical malpractice insurance. In response, California's legislature enacted MICRA. MICRA was the vehicle for several reforms. Among other things, it imposed a $250,000 cap on medical malpractice awards for non-economic losses; allowed evidence of payments from collateral sources; shortened the statute of limitations; and imposed a sliding contingency fee schedule for plaintiffs' attorneys. The full benefits of MICRA were not achieved until after 1985, when the final court challenges to the validity of the statute were concluded.[760]

MICRA's core statutory language governing awards of non-economic damages is as follows:

> In any action for injury against a healthcare provider based on professional negligence, the injured plaintiff shall be

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[757] See American Medical Association, chart, State Laws Chart: Liability Reforms (April 2002) (Vol. 1).

[758] See, e.g., Center for Justice & Democracy, California Restrictions on Malpractice Victims Have Not Affected Malpractice Premiums (May 29, 2002); see also Jay Angoff, testimony, Oct. 21, 2002, pgs. 220-229.

[759] See Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 1 (Nov. 7, 2002) (It is widely viewed that caps on non-economic damages are the most effective reform measure to help control escalating medical malpractice costs); American Academy of Actuaries, Issue Brief: Medical Malpractice Tort Reform: Lessons from the States (Fall 1996).

[760] See William G. Hamm, Californians Allied for Patient Protection, An Analysis of Harvey Rosenfield's Report: California's MICRA 1 (May 6, 1997). The full effect of MICRA on healthcare costs was not felt until the mid-1980s, when the law's constitutionality was finally upheld by the courts; see Fein v. Permanente Medical Group, 695 P.2d 665 (Cal. 1985), appeal dismissed, 474 U.S. 892 (1985) (upholding constitutionality of MICRA's cap on non-economic damages).

entitled to recover non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary damage.

In no action shall the amount of damages for non-economic losses exceed two hundred fifty thousand dollars ($250,000).[761]

Economist William G. Hamm, Ph.D., of LECG, Inc., prepared two studies[762] documenting California's success in reducing medical malpractice insurance premiums through MICRA. Dr. Hamm concluded that the most significant of these reforms was a $250,000 cap on the amount of non-economic damages that may be awarded to plaintiffs in medical malpractice lawsuits.[763] Dr. Hamm further concluded that the cap on non-economic damages has lowered medical malpractice premiums, which, in turn, has lowered healthcare costs and increased access to healthcare for all Californians.[764] Dr. Hamm's other important observations and conclusions about MICRA's success in keeping medical malpractice insurance premiums relatively low included the following:

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[761] MICRA's provisions governing caps are codified at section 3333.2, California Civil Code, which provides in full:

> (a) In any action for injury against a health care provider based on professional negligence the injured plaintiff shall be entitled to recover non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary damage.
> (b) In no action shall the amount of damages for non-economic losses exceed two hundred fifty thousand dollars ($250,000).
> (c) For the purposes of this section:
> (1) "Health care provider" means any person licensed or certified pursuant to division 2 (commencing with section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to chapter 2.5 (commencing with section 1440) of division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to division 2 (commencing with section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;
> (2) Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

Cal.Civ.Code section 3333.2 (West 2003). The constitutional validity of this language was upheld in Fein v. Permanente Medical Group, 695 P.2d 665 (Cal. 1985), appeal dismissed, 474 U.S. 892 (1985).

[762] William G. Hamm, Californians Allied for Patient Protection, An Analysis of Harvey Rosenfield's Report: California's MICRA (May 6, 1997); William G. Hamm, Californians Allied for Patient Protection, How the MICRA Cap Influences Health Care Costs for Safety Net Providers and Medi-Cal (July 1999).

[763] William G. Hamm, Californians Allied for Patient Protection, How the MICRA Cap Influences Health Care Costs for Safety Net Providers and Medi-Cal 1 (July 1999).

[764] Id.

- MICRA has significantly reduced both malpractice claims payments and incurred losses.[765]

- The reduction in claims and losses has led to a reduction in medical malpractice premiums.[766]

- Practitioners' premiums are lower in California than in states without MICRA-type reforms.[767]

- MICRA has played a critical role in promoting access to healthcare for high-cost and low-income groups.[768]

- Medical malpractice premiums in California have declined sharply since the California Supreme Court dismissed the final appeal challenging the validity of MICRA.[769]

- The empirical evidence indicates MICRA has reduced medical malpractice premiums in California.[770]

- MICRA has reduced California's healthcare expenditures.[771]

- The best available evidence suggests that tort reforms such as MICRA could lead to dramatic reductions in defensive medicine.[772]

- Reductions in medical expenses due to MICRA are being passed on to consumers in California.[773]

- Medical malpractice insurance losses have increased more slowly since the MICRA reforms have taken effect, and are now below the national average per physician.[774]

- Reduced loss rates have enabled malpractice insurers to reduce the premiums that physicians and hospitals are required to pay.[775]

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[765] William G. Hamm, Californians Allied for Patient Protection, An Analysis of Harvey Rosenfield's Report: California's MICRA 10 (May 6, 1997).
[766] Id. at 11.
[767] Id. at 12.
[768] Id.
[769] Id. at 13.
[770] Id. at 15.
[771] Id.
[772] Id. at 18.
[773] Id.
[774] Id.
[775] Id. at 19.

- Together, MICRA's favorable impact on losses and malpractice insurance premiums have reduced the cost of healthcare in California.[776]

- Cost-savings are reflected in health insurance premiums, making health insurance benefit programs more affordable to businesses, particularly small businesses.[777]

- Lower premiums will increase employee participation in health insurance programs offered by their employers.[778]

- Reduced malpractice pressure will increase the supply of physicians in California, especially obstetricians and other impacted specialists.[779]

- Lower malpractice insurance premiums contribute to the viability of community hospitals.[780]

- Lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a relatively high risk of failure, but offer the only real prospect of success for seriously-ill patients.[781]

- Reduced malpractice pressure is likely to free-up funds in the operating budgets of self-insured hospitals, allowing the hospital to treat more patients.[782]

- By reducing and stabilizing malpractice insurance premiums, MICRA reduced or eliminated the incentive for physicians to go without insurance.[783]

- By reforming the malpractice system, MICRA has significantly reduced the time required for plaintiffs to obtain awards.[784]

- MICRA has brought about significant improvements in access to healthcare within California.[785]

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[776] Id.
[777] Id. at 23.
[778] Id.
[779] Id.
[780] Id. at 24.
[781] Id.
[782] Id. at 25.
[783] Id.
[784] Id.
[785] Id.

In 1999, Dr. Hamm published a study that analyzed the effect that lifting the MICRA cap would have on the cost of healthcare provided to underserved and low-income groups. Dr. Hamm concluded:

> We find that eliminating the MICRA cap would increase costs to teaching and safety net hospitals as well as non-profit community clinics. . . . Raising the cap to a higher dollar level, rather than eliminating it, ... would be most strongly felt by healthcare facilities that self-insure, which would face dollar-for-dollar increases in their risk exposure with any increase in the MICRA cap.
>
> These higher costs would be borne by public and private healthcare insurers and out-of-pocket payments by patients.[786]

In particular, Dr. Hamm noted in particular that Medi-Cal (which is California's counterpart to Florida's Medicaid program) could face large cost increases, if the cap were eliminated or raised.[787] Others, similarly, have concluded that removing the MICRA cap would substantially increase the amount of total defense payments.[788]

MICRA's reforms, including its cap on non-economic damages, have reduced California medical liability premium rates by 40 percent (in constant dollars) over 1976 levels.[789] The average premium in 1976 was $23,698 (inflation-adjusted to 2001 dollars).[790] The average premium in 2001 was $14,107. Furthermore, for the past twenty-seven years in California, malpractice premiums have increased at a rate of less than 3 percent per year.[791]

MICRA's reforms, including its cap on non-economic damages, also have led to faster settlements of claims in California. According to claims data

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[786] Id. at 1.

[787] Id.

[788] See J. Clark Kelso & Kari C. Kelso, Jury Verdicts in Medical Malpractice Cases and the MICRA Cap 29 (Aug. 5, 1999):

> Based on the jury verdict data, entirely removing the MICRA cap would result in at least a 30 percent increase in the amount of damages paid by defendants in medical malpractice actions (the increase might ultimately be larger because the absence of any cap might encourage plaintiff's counsel to spend more resources developing a basis for a higher non-economic award).

[789] Richard E. Anderson, M.D., F.A.C.P., testimony, Nov. 4, 2002, pg. 51.

[790] Actual 1976 average premium of $7,614 adjusted to 2001 dollars on the Annual Urban CPI Index for a $1million/$3 million claims-made policy. Richard E. Anderson, M.D., F.A.C.P., PowerPoint presentation, Nov. 4, 2002.

[791] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 1 (Nov. 7, 2002).

gathered as part of a Physician Insurers Association of America (PIAA) Data Sharing Project, the average time to settlement of a claim in states that do not have caps on non-economic damages was 2.4 years, which is 33 percent longer than the 1.8-year period in California.[792]

In addition to California, the wisdom of a cap on non-economic damages has also been recognized by the federal government. At the federal level, Congress, the Congressional Budget Office,[793] the Government Accounting Office,[794] and the Department of Health and Human Services,[795] have recognized the crisis of medical malpractice availability and affordability, evaluated possible options, and proposed reform. Limiting potential awards of non-economic damages in medical malpractice cases has been at the forefront of the proposed reform measures. This past year, members of the House of Representatives, and the Senate, again sponsored bills that would implement tort reforms, including caps on non-economic damages.

The United States Congress has recognized the excessive burden the liability system places on the healthcare delivery system in H.R. 4600, a bill that passed in the House of Representatives on September 26, 2002.[796] If enacted, H.R. 4600 will create the Help Efficient, Accessible, Low-cost, Timely HealthCare (HEALTH) Act of 2002. The bill includes the following findings:

> EFFECT ON HEALTH CARE ACCESS AND COSTS: Congress finds that our current civil justice system is adversely affecting patient access to healthcare services, better patient care, and cost-efficient health care, in that the healthcare liability system is a costly and ineffective mechanism for resolving claims of healthcare liability and compensating injured patients, and is a deterrent to the sharing of information among healthcare professionals which impedes efforts to improve patient safety and quality of care.[797]

The purpose of H.R. 4600 is as follows:

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[792] Richard E. Anderson, M.D., F.A.C.P., testimony before the Subcommittee on Health of the U.S. House Committee on Energy and Commerce (July 17, 2002).
[793] See Congressional Budget Office Cost Estimate, H.R. 4600, 107th Cong., 2d Sess. (Sept. 24, 2002).
[794] U.S. General Accounting Office, Medical Malpractice: A Framework for Action (May 1987) (Vol. 1, Tab 10).
[795] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System (July 24, 2002) (Vol.1, Tab 1).
[796] H.R. 4600, 107th Cong. 2d Sess. (April 25, 2002).
[797] Id. at 2(a)(1).

PURPOSE: It is the purpose of this Act to implement reasonable, comprehensive, and effective health care liability reforms designed to:

1) Improve the availability of healthcare services in cases in which healthcare liability actions have been shown to be a factor in the decreased availability of services;

2) Reduce the incidence of defensive medicine and lower the cost of healthcare liability insurance, all of which contribute to the escalation of healthcare costs;

3) Ensure that persons with meritorious healthcare injury claims receive fair and adequate compensation, including reasonable non-economic damages;

4) Improve the fairness and cost-effectiveness of our current healthcare liability system to resolve disputes over, and provide compensation for, healthcare liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

5) Provide an increased sharing of information in the healthcare system, which will reduce unintended injury and improve patient care.[798]

H.R. 4600 would accomplish these purposes through a combination of complementary measures. It would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, reducing the statute of limitations, eliminating joint and several liability, and changing the way collateral-source benefits are treated.[799]

One of the features of the bill is a cap on non-economic damages. (The bill makes clear that economic damages are not capped.)[800] The bill provides:

ADDITIONAL NON-ECONOMIC DAMAGES: In any health care lawsuit, the amount of non-economic damages recovered may be as much as $250,000, regardless of the number of parties against whom the action is brought or the

[798] Id. at 2(b).
[799] Congressional Budget Office Cost Estimate, H.R. 4600, 107th Cong., 2d Sess. 1 (Sept. 24, 2002).
[800] H.R. 4600 provides: UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS: In any health care lawsuit, the full amount of a claimant's economic loss may be fully recovered without limitation. H.R. 4600, 107th Cong., 2d Sess. 4(a) (2002).

> number of separate claims or actions brought with respect to the same occurrence.[801]

The Congressional Budget Office (CBO) evaluated the impact of H.R. 4600 on medical malpractice premiums. Its conclusions included the following:

> CBO's analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.[802]

Senate Bill 2793[803] is a companion to H.R. 4600. Like the House bill, S.B. 2793 states its purpose as follows:

> To improve patient access to healthcare services, and provide improved medical care by reducing the excessive burden the liability system places on the healthcare delivery system.

The Senate bill uses the same language as the House bill in capping non-economic damages at $250,000.[804]

Chapters 1 through 4 of this report extensively discuss the current medical malpractice problems and its effects on Florida's citizens and visitors. The Task Force was particularly moved by the testimony, letters and e-mails in chapter 4 from physicians who are bearing the burden of this current medical malpractice crisis. This evidence led the Task Force to make its findings contained in chapter 5. The Task Force found that, in Florida, both medical malpractice insurance premium rates and rate

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[801] Id. at 4(b).

[802] Congressional Budget Office Cost Estimate, H.R. 4600, 107th Cong., 2d Sess. 4 (Sept. 24, 2002).

[803] S. 2793, 107th Cong., 2d Sess. (July 25, 2002).

[804] The language is as follows:

> In any health care lawsuit, the amount of non-economic damages recovered may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

S. 2793, 107th Cong., 2d Sess 4(b) (2002).

increase trends are substantially above countrywide levels.[805] Physicians are curtailing or abandoning their practices, and hospitals are reducing or eliminating services, particularly with respect to patients and procedures that pose higher risks of bad outcomes.[806] As a result, the access of Florida residents, and visitors to healthcare is being threatened.

The causes of the problem is analyzed in chapter 4, and the potential partial (but indispensable) solution of imposing a cap on awards of non-economic damages in medical malpractice cases, is discussed below. However, any contemplated legislative solution must be evaluated under applicable constitutional standards.[807] That analysis follows.

The Task Force recognizes that any legislative imposition of a cap on awards of non-economic damages in medical malpractice cases must be consistent with the protections afforded by the Florida and Federal constitutions. Because the imposition of such a cap would modify a recognized common law right,[808] the Task Force has carefully considered, in particular, the constitutional right of access to courts in formulating its recommendation.[809]

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[805] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 4 (Nov. 7, 2002).

[806] See generally Robert Cline, M.D., testimony, Dec. 20, 2002, pgs. 109-115; Jeff Scott, J.D., testimony, Dec. 20, 2002, pgs. 115-135; Florida Medical Association, Florida Hospital Association, PowerPoint presentation, Professional Liability Insurance Crisis: Access to Care Survey, Dec. 20, 2002.

[807] The Task Force also heard, and has considered, the testimony of others about the constitutionality of caps on non-economic damages in medical malpractice cases, including former First District Court of Appeal Judge Robert B. Smith (testimony, Nov. 4, 2002, pgs. 336-349); law professor Patrick Gudridge (testimony, Nov. 4, 2002, pgs. 349-366); former Florida Supreme Court Chief Justice Stephen Grimes (testimony, Dec. 3, 2002, pgs. 44-51); attorney Barry Richard (testimony, Dec. 3, 2002, pgs. 52-57); and attorney Joel Perwin (testimony, Dec. 3, 2002, pgs. 57-67). That testimony generally was consistent with this summary and discussion.

[808] Smith v. Department of Insurance, 507 So. 2d 1080, 1087 (Fla. 1987).

[809] The access to courts provision of the Florida Constitution is not the only limitation on the Legislature's power to limit awards of non-economic damages in medical malpractice cases. Opponents of tort reform raise all conceivable grounds in attacking reform legislation. The grounds frequently asserted include access to courts, equal protection, due process, right to jury trial, and separation of powers. See generally Daryl L. Jones, Fein v. Permanente Medical Group: The Supreme Court Uncaps the Constitutionality of Statutory Limitations on Medical Malpractice Recoveries, 40 University of Miami Law Review 1075 (1986) (discussing equal protection); St. Mary's Hospital v. Phillipe, 769 So. 2d 961, 971 (Fla. 2000) (as construed, cap on non-economic damages in medical malpractice arbitration proceedings did not violate equal protection); Zdrojewski v. Murhpy, 2002 WL 31546169 (Mich. Ct. App. Nov. 15, 2002) (Michigan's cap on non-economic damages did not violate equal protection); Kirkland v. Blaine County Medical Center, 4 P.3d 1115 (Idaho 2000) (Idaho's cap on non-economic damages did not violate right to jury trial or separation of powers doctrine); Victor E. Schwartz & Leah Lorber, Twisting the Purpose of Pain and Suffering Awards: Turning Compensation Into Punishment, 54 South Carolina Law Review 47 (Fall 2002); Carol A Crocca, Annotation, Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims, 26 A.L.R. 5th 245 (1995); Note, Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law, 58 Washington & Lee Law Review 315 (Winter 2001).

Article I, section 21, of the Florida Constitution, guarantees access to courts, providing as follows:

> The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.

The Florida Supreme Court has consistently held that the Legislature may not impose a monetary cap on non-economic damages unless it provides a commensurate benefit, or it shows:

- An overpowering public necessity for the abolishment of the right to such damages exists; and
- There is no alternative method of meeting that public necessity.

The court has considered the constitutionality of statutes creating monetary caps on non-economic damages on two occasions. In Smith v. Dept. of Insurance,[810] the court held that a section of the Tort Reform and Insurance Act of 1986, chapter 86-160, Laws of Florida, which placed a $450,000 cap on damages that a tort victim could recover for non-economic losses, violated a victim's constitutional right-to-access to the courts because:

> The legislature has provided nothing in the way of an alternative remedy or commensurate benefit and one can only speculate, in an act of faith, that somehow the legislative scheme will benefit the tort victim.[811]

In arriving at its holding in Smith, the court noted that:

> The 1986 Tort Reform and Insurance Act is the legislative solution to a commercial insurance liability crisis that the legislature found existed. For various reasons, both the insurance industry and the trial lawyers' bar challenged the act's constitutionality. The legislature, to ensure that the public and reviewing courts fully understood the reasons and purpose for enacting this legislation, set forth, in the preamble of the act, detailed legislative findings. . . .

The Smith court concluded:

> It is un-controverted that there currently exists a right to sue on and recover non-economic damages of any amount and

[810] 507 So. 2d 1080 (Fla. 1987).
[811] Id. at 1089.

> that this right existed at the time the current Florida Constitution was adopted. The right to redress of any injury does not draw any distinction between economic and non-economic damages nor does article 1, section 21 contain any language which would support the proposition that the right is limited, or may be limited, to suits above or below any given figure.

The Court noted the seminal case on the right of access to the courts is Kluger v. White.

> In Kluger, we addressed the question of whether the Legislature could restrict the right by establishing a minimum threshold of $550 for economic damages below which the injured plaintiff would have no right to sue. Our answer was no and our holding there is directly controlling here.
>
> [W]here a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the state pursuant to [section 2.01, Florida Statutes], the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the state to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown....
>
> There is no relevant distinction between the issue in Kluger and the issue here.[812]

The Smith court distinguished its prior decision in Lasky v. State Farm Ins. Co.,[813] in which it upheld a statutory provision which denied recovery for pain and suffering, and similar intangible items of damages unless the plaintiff was able to meet a $1,000 medical expense threshold, noting that the court did so there because the Legislature had provided plaintiffs with an alternative remedy, and a commensurate benefit.[814] The alternative remedy, and a commensurate benefit provided in the legislation addressed in Lasky, the court noted, consisted of:

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[812] Id. at 1087-1088 (emphasis added).
[813] 296 So. 2d 9 (Fla. 1974).
[814] 507 So. 2d 1080, 1088 (Fla. 1987).

- The vehicular no-fault insurance statute requiring that all motor vehicle owners obtain insurance or other security to provide injured persons with minimum benefits, and that, if the defendant vehicle owner failed to purchase the required insurance, the defendant's immunity was nullified, and the plaintiff retained the right to sue below the threshold.

- Under the statute, any given vehicle owner was as likely to be sued as to sue, and giving up the right to sue was compensated for by obtaining the right not to be sued.[815]

Based on these points, the Smith court concluded that, unlike the statute then before it, the legislation upheld in Lasky provided a reasonable trade-off of the right to sue for the right to recover uncontested benefits under the statutory no-fault insurance scheme and the right not to be sued. The court then noted that the benefits of the $450,000 cap on non-economic damages in the case, then before it, ran in only one direction, because the potential plaintiffs and defendants stand on different footing, observing that, by way of example, a medical patient or the client of a lawyer obtained no compensatory benefit from a cap placed on non-economic damages because of the unlikeliness of negligence by a patient or client.[816]

In Smith, Justice Overton dissented, on the ground that the Legislature's major purpose in capping non-economic damages was to assure available and affordable insurance coverage for all citizens and that this furnished a rational basis for the cap.[817] The Smith majority rejected this argument, observing:

> [W]e are dealing with a constitutional right which may not be restricted simply because the legislature deems it rational to do so. Rationality only becomes relevant if the legislature provides an alternative remedy or abrogates or restricts the right based on a showing of overpowering public necessity and that no alternative method of meeting that necessity exists. Here, however, the legislature has provided nothing in the way of an alternative remedy or commensurate benefit and one can only speculate, in an act of faith, that somehow the legislative scheme will benefit the tort victim. We cannot embrace such nebulous reasoning when a constitutional right is involved. Further, the trial judge below did not rely on—nor have appellees urged before this Court—that the cap is based on a legislative showing of an overpowering public necessity for

[815] Id.
[816] Id.
[817] Id. at 1089.

> the abolishment of such right, and no alternative method of meeting such public necessity can be shown.[818]

In University of Miami v. Echarte,[819] the court held that two statutes providing a monetary cap on non-economic damages in medical malpractice claims when the parties agreed to binding arbitration were not unconstitutional. The court reasoned that because the statutes under consideration provided a commensurate benefit to a plaintiff in exchange for the monetary cap, the Legislature showed that an overpowering public necessity existed with regard to control of medical malpractice insurance premiums, and no alternative or less onerous method of meeting the crisis had been shown.

Applying the Kluger test to these voluntary binding arbitration statutes, the Echarte court found, first, that they provided claimants with a commensurate benefit for the loss of the right to fully recover non-economic damages. This commensurate benefit consisted of:

- The statutes only limited a claimant's right to recover non-economic damages after a defendant agrees to submit the claimant's action to arbitration.
- The defendant's offer to have damages determined by an arbitration panel provides the claimant with the opportunity to receive prompt recovery without the risk and uncertainty of litigation, or having to prove fault in a civil trial.
- A defendant, or the defendant's insurer, is required to conduct an investigation to determine the defendant's liability within 90 days of receiving the claimant's notice to initiate a malpractice claim.
- Before the defendant may deny the claimant's reasonable grounds for finding medical negligence, the defendant must provide a verified written medical expert opinion corroborating a lack of reasonable grounds to show a negligent injury.
- The claimant benefits from the requirement that a defendant quickly determine the merit of any defenses and the extent of its liability; and, the claimant also saves the cost of attorney and expert witness fees, which would be required to prove liability.
- A claimant who accepts a defendant's offer to have damages determined by an arbitration panel receives the additional benefits of:

[818] Id. (emphasis added) (citation omitted).
[819] 618 So. 2d 189 (Fla. 1993).

- o The relaxed evidentiary standard for arbitration proceedings.
- o Joint and several liability of multiple defendants in arbitration.
- o Prompt payment of damages after the determination by the arbitration panel.
- o Interest penalties against the defendant for failure to promptly pay the arbitration award.
- o Limited appellate review of the arbitration award requiring a showing of manifest injustice.

The Echarte court went on to hold that, even if these statutes did not provide a commensurate benefit, it would find that they satisfied the second prong of Kluger, which requires a legislative finding that an overpowering public necessity exists, and further that no alternative method of meeting such public necessity can be shown. On this point, the court found the following elements sufficient to satisfy the second prong of Kluger:

- The preamble to the statutes clearly stated the Legislature's conclusion that the current medical malpractice insurance crisis constituted an overpowering public necessity;

- The Legislature made a specific factual finding that medical malpractice liability insurance premiums have increased dramatically in recent years, resulting in increased unavailability of malpractice insurance for some physicians; and

- The Legislature's factual and policy findings were supported by findings made in the report of a Task Force, established in the legislation, including findings that:

  - o A family physician who performed no surgery, and practiced outside Dade and Broward counties, saw a 229 percent increase in medical malpractice insurance premiums for the period of 1983 to July 1, 1987.
  - o A family physician who performed no surgery, and practiced in Dade or Broward counties, saw a 300 percent increase in medical malpractice insurance premiums for the same period.
  - o Rates for specialties had also increased sharply, giving, by way of example, the fact that rates for obstetricians had increased by 444 percent in Dade and Broward counties, as compared to 304 percent in the rest of the state.[820]

[820] Id. at 196.

The court found that these facts supported the Legislature's conclusion that increased costs in medical malpractice insurance premiums have resulted in increased healthcare costs and made liability insurance functionally unavailable for some physicians.[821]

Finally, the Echarte court found that the record supported the conclusion that no alternative or less onerous method exists to correct the difficulty at issue. On this point, the court relied on the following points:

- The Legislature acted to adopt the Task Force's recommendations both to enact the arbitration statutes and to strengthen regulation of the medical profession.

- The contrary conclusion that professional discipline alone was an alternative method to meet the public necessity of controlling medical malpractice insurance premiums was erroneous, as shown by the statement of the Task Force that, even though a small percentage of the physicians were responsible for 42.2 percent of the total claims paid out, the facts did not support the conclusion that these doctors were incompetent.

- The Task Force specifically found that strengthened regulation of medical care providers was not a substitute for tort and insurance reform.

- It was clear that both the arbitration statute, with its conditional limits on recovery of non-economic damages, and the strengthened regulation of the medical profession were necessary to meet the medical malpractice insurance crisis.

- No alternative or less onerous method of meeting the crisis had been shown in the analysis of the Task Force.[822]

It might be noted that the Echarte court observed that the Task Force stated in its report that it based its findings on:

- Seven public meetings, and hearings in Tampa and Miami, to receive presentations, recommendations, and comments from experts and interested citizens.

- A comprehensive literature search and review.

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[821] Id.
[822] Id.

- Eight research projects conducted in Florida, which surveyed medical malpractice claims, closed claims, loss payments, profitability, and other aspects of insurance companies; studied data from the Insurance Services Office, a non-profit organization which collects data, and files rate applications for liability carriers nationwide; examined a survey of 1,500 randomly selected physicians as well as a survey of 1,500 attorneys who regularly handle tort cases; conducted a computer analysis of the financial situation of commercial liability insurance carriers; and conducted an analysis of Florida's civil litigation rates.

The court also noted that the Task Force then conducted a six-hour hearing in Gainesville to preview the preliminary findings from the eight research projects.[823] The specific findings of the Legislature on which the court relied in Echarte are set forth in a footnote to the opinion.[824]

In a dissenting opinion in Echarte, Justice Shaw disagreed with the majority opinion on both prongs of the Kluger test. With regard to the first prong, he found that the statutes provided neither a reasonable alternative remedy nor a commensurate benefit to claimants in exchange for their common-law right to full redress for injuries because:

- While the statutes placed a burden on claimants to conduct an investigation to ascertain that there are reasonable grounds to believe that any named defendant in the litigation was negligent, and that such negligence resulted in injury to the claimant, together with the mandate that corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert from a medical expert, there was no quid pro quo, such as requiring the defendant to secure compulsory insurance to assure the claimant a recovery in the event that medical negligence is proved.

- Since a "relaxed evidentiary standard" does not alter the fact that conclusions must be supported by competent, substantial evidence, this standard was of no benefit to a claimant, and consequently was irrelevant to the quid pro quo evaluation.

- The fact that the negligent party could unilaterally limit the claimant's non-economic damages, whether the claimant accepts arbitration or goes to trial, demonstrated that the benefits of the statutes were not balanced between the patient-claimant and tortfeasor because a medical patient obtained no particular benefit from a cap placed on

[823] Id.

[824] University of Miami v. Echarte, 618 So. 2d 189, 192 n.12 (Fla. 1993) (quoting entire preamble to chapter 88-1, Laws of Florida).

non-economic damages, and the benefit of the damage cap adhered only to the negligent defendant.[825]

Justice Shaw also found that the second, alternative, prong of the Kluger test had not been satisfied because:

- This prong requires a finding that the Legislature had shown an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such a public necessity, and the word shown means shown by competent, substantial evidence, which had not been presented by the Legislature.

- The final report of the Task Force did not recommend a cap on non-economic damages as the sole solution to the crisis in the medical insurance industry.

- To the contrary, it expressly cautioned against unwarranted conclusions.

- The fact that the Legislature recited the reasons why it chose the method it did was not an adequate substitute for the required Kluger findings.

- The Task Force pointed to other methods of meeting the alleged public necessity, i.e., diligent management of medical malpractice, and the fact that the Legislature considered and rejected other methods was additional proof that the Kluger test had not been met.

- The majority had engrafted a no less onerous method test onto the established no alternative method test, which was a departure from the Kluger test, with no authority supporting that departure.

- The majority opinion departed from the court's previous opinion in Psychiatric Associates v. Siegel,[826] where the court held a statute unconstitutional because, although an overpowering public necessity was shown, the record failed to show that the solution adopted by the Legislature was the only method meeting the medical malpractice crisis and encouraging peer review, and the majority offered no authority for that departure.

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[825] Id. at 199-200.
[826] 610 So. 2d 419 (Fla. 1992).

- The majority erroneously implied that it was the claimant's burden to show that no alternative method of meeting a public necessity existed, whereas, under Smith, supra, the Legislature bears that burden.[827]

In addition to the above objections, Justice Shaw concluded that the statutes not only violated the right of access to the courts, but also the right to trial by jury, equal protection guarantees, substantive or procedural due process rights, the single subject requirement, the takings clause, and constituted an improper delegation of power. Specifically, Justice Shaw noted that the law requires that, when a statutory benefit is being given in lieu of a constitutionally-protected right, the statutory benefit must accrue to the particular claimant, not to the public at large, and that a general assertion of benefit will not pass constitutional muster. He then concluded that a benefit enjoyed by the general public at the expense of a particular claimant is a taking of the claimant's property without compensation, in violation of both the state and Federal constitutions. Finally, Justice Shaw was of the opinion that the statutes denied equal protection, and drew an arbitrary line between recovery and non-recovery without regard to the actual damages caused by a defendant's malpractice. On this point, he noted that, by allowing the less-seriously injured to recover full damages, while denying full compensation to the more-seriously injured, the statutes operated with increasing capriciousness as the severity of the injury increases – the greater the injury the greater the deprivation of recovery.[828]

In Psychiatric Associates v. Siegel, referred to by Justice Shaw in his dissent in Echarte, the court held that sections 395.011(10)(b), 395.0115(5)(b), and 776.101(6)(b), Florida Statutes, which required a person who brought an action against someone who participated in a medical review board process to post a bond sufficient to cover the defendant's costs and attorney's fees before an action could be prosecuted, violated the constitutional right of access to the courts and due process.

Siegel, like Echarte, is instructive of the court's view of Kluger, vis-a-vis medical malpractice concerns. With regard to the first Kluger element, i.e., whether the legislation provided a reasonable alternative remedy or commensurate benefit, the Siegel court found that, because a plaintiff under these statutes was only heard after posting a bond, and received no benefit from posting the bond, together with the fact that the statutes lacked reciprocity since they did not require defendants to pay a plaintiff's costs and attorney's fees if the claim proved meritorious, they did not provide a plaintiff with an alternative remedy or commensurate benefit.

On the first alternative Kluger prong, the Siegel court found that:

[827] University of Miami v. Echarte, 618 So. 2d 189, 201 (Fla. 1993).
[828] Id. at 201-202.

... The record shows that the legislature enacted the bond requirement statutes pursuant to an *overpowering public purpose*. The Task Force's report and the legislature's preamble to enacting the bond requirements *clearly outline the existence of a medical malpractice crisis in the state*. The legislature acted within its police powers to protect the health and welfare of its citizens by enactment of the statutes. Thus, we find that the bond requirement statute passes the first prong of Kluger.[829]

As to the second prong of Kluger, however, the Siegel court concluded that the statutes:

... do not satisfy Kluger's second prong because the record in the case does not show that the bond requirement is the *only method of meeting the medical malpractice crisis* and encouraging peer review. Consequently, we hold that the statutes are an unconstitutional restriction on a plaintiff's right of access to the courts.[830]

After a review of Florida case law, the Task Force is confident that its recommendations take into consideration the relevant constitutional hurdles that a cap on non-economic damages would entail.

Information Presented to the Task Force

The Task Force received testimony and numerous submissions dealing with the issue of caps on non-economic damages in medical malpractice actions. The testimony and submissions upon which the Task Force relies in making its findings, conclusions, and recommendations include those cited in the discussions below. Likewise, the Task Force relies on the testimony and submissions documented in chapters 3 and 4 of this report.

Florida healthcare providers fear a bleak picture for Florida, but the Task Force believes it could get worse in the coming years if no corrective action is taken. We know that in 2002, medical malpractice awards were increasing in severity to record levels throughout the U.S. Claim frequency also appears to be increasing, and medical malpractice insurance premiums continue to rise throughout the U.S. Many insurers and re-insurers have left, or are leaving the medical malpractice insurance market, creating several availability problems in many states. Medical malpractice insurance premiums may become unaffordable, and/or

[829] Id. at 424 (emphasis added).
[830] Id. at 424-425.

coverage may become unavailable at any price to many physicians and hospitals.

In Florida, the Task Force understands that some physicians and hospitals have reduced their limits of medical malpractice insurance coverage, and some have become uninsured, due to the high cost of such coverage. Some hospitals choose self-insurance, or other market mechanisms in an effort to save premiums at the risk of under-funding their exposure.

The Task Force finds that one of the primary drivers of the current medical malpractice crisis is that a large percentage of medical malpractice losses (77 percent in Florida) apply to non-economic damages (i.e., pain and suffering). Further, a review of the FDOI database reveals that if non-economic damages had been capped at $250,000 in 1992 through 2001, $400 million, or 21.1 percent of the $1.9 billion paid, could have been retained in the healthcare community. A cap of $500,000 would have generated a 9 percent savings and a $1,000,000 cap would have resulted in a 2 percent savings. Pain and suffering is subjective in nature, in that it cannot be tied to actual costs incurred by injured patients. Every new record award sets a new higher value on pain and suffering, and precedents keep getting established for higher valuations on all future awards and settlements.

The Task Force believes that caps on non-economic damages are particularly effective, because they limit the escalation of awards for pain and suffering, which fuels large increases for all awards and settlements. The impact of a cap on non-economic damages would be an immediate savings, and a tempering of one of the primary components of future loss trends. Non-economic damage caps seem to have worked extremely well in California, where medical malpractice costs are about 50 percent of the countrywide average. The Task Force feels that this is the strongest evidence that caps on non-economic damages (if there are no large loopholes and exceptions) are the most effective tort reform.[831]

The record shows, and the Task Force concludes, that access to healthcare by Florida residents and visitors is being restricted by the unavailability and unaffordability of medical malpractice insurance, which in turn is the result of Florida's existing system of tort laws. One presenter summed up the relationship between premium rates and access as follows:

> If society wishes to have unlimited judgments, then insurance companies will be required to charge unlimited premiums. Unlimited medical malpractice premiums means unlimited increases in the cost of healthcare. Unlimited increases in the cost of healthcare means

[831] Id. at 4-5 (emphasis added).

> decreased access to healthcare. Limitations of access inevitably affect the most vulnerable members of our society.[832]

In response to proposals presented to the Task Force on January 16, 2003, Michelle M. Mello, J.D., Ph.D, M.Phil., Troyen A Brennan, M.D., J.D., M.P.H., William M. Sage, M.D., J.D., and David M. Studdert, L.K.B., Sc.D., M.P.H. submitted a response in favor of cap, but against a flat cap. These academics noted:

> Many of the arguments made by the Task Force for imposing some limitation on non-economic damages are persuasive, but in our view the choice of a flat cap of $250,000 has not been adequately justified. We urge the Task Force to consider recommending a sliding schedule for non-economic damages. Such a schedule would permit award levels to vary by severity of injury and, if desired, the age of the injured individual. The maximum award in each severity bracket would be capped, but at a level more commensurate with the severity of injury.[833]

Although the Task Force finds the recommendations of these academics compelling, they offer no evidence that a sliding scale cap will or has worked.

Findings and Recommendations

As presented in chapter 4, the Task Force finds that there is a crisis in the availability and affordability of medical malpractice insurance in Florida, and a resulting crisis in the access of Florida residents and visitors to healthcare. The Task Force has carefully considered the potential effectiveness of the stakeholders' proposed legislative imposition of caps on awards of non-economic damages in medical malpractice cases. Based upon the record as a whole and for the reasons specified below, the Task Force concludes that such a cap is essential to the success of any reform plan that might be adopted toward reducing the exposure of healthcare providers to the risk of severe jury awards.

The Task Force finds the crisis exists because, under current Florida law, there is no limit on the amount of money a jury may award the plaintiffs as non-economic damages in a medical malpractice case.[834]

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[832] Richard E. Anderson, M.D., F.A.C.P., testimony, Nov. 4, 2002, pgs. 36-37.

[833] Letter from Michelle M. Mello, J.D., Ph.D., M.Phil., Troyen A. Brennan, M.D., J.D., M.P.H., William M. Sage, M.D., J.D., and David Studdert, L.K.B., Sc.D., M.P.H., (Jan. 16, 2003)

[834] After the jury has returned its verdict, the court may, upon proper motion, order remittitur or additur where the jury has found the medical malpractice defendant liable but the jury's award of money damages

Non-economic damages are inherently subjective; there are no objective standards by which they can be quantified. One article explains:

> Whatever pain and suffering damages encompass in a given jurisdiction, the law does not provide an objective formula for valuing them. It is difficult to assess another person's pain and suffering and then translate that into its financial equivalent. In fact, courts have usually been content to say that pain and suffering damages should amount to fair compensation or a reasonable amount, without any more definite guide. As a result, jurors can be improperly influenced by the presentation of guilt evidence. The amount of pain and suffering awards can, and does, fluctuate markedly.[835]

The risk of excessive jury awards of non-economic damages has a profound effect upon the way plaintiffs, defendants, and their respective attorneys view medical malpractice claims. Among other things, plaintiffs may overvalue their claims and refuse reasonable offers to settle. Defendants' insurers may pay more to settle than a claim is really worth simply to avoid a jackpot verdict on non-economic damages. These unfortunate dynamics are the result of the unpredictability engendered by a system of virtually unbridled jury discretion.

One of the author's of California's MICRA likewise observed that the intangible (subjective) aspect of medical malpractice claims leads to very widely varying jury awards and to very, very difficult settlement negotiations.[836] He further noted that quantification of pain and suffering, whether it be $250,000 or some other figure, leads to easier and earlier claims settlement.[837]

Increased predictability through a reduction in potential liability and resulting stability will encourage more malpractice insurers to participate in the Florida market. One actuary testified: "Making losses more predictable is a key to attracting companies to provide coverage, and it is also a key to getting more stable pricing in the marketplace."[838]

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is excessive or inadequate in light of the facts and circumstances which were presented to the trier of fact. Section 768.74(1), Florida Statutes.

[835] Victor E. Schwartz & Leah Lorber, Twisting the Purpose of Pain and Suffering Awards: Turning Compensation Into Punishment, 54 South Carolina Law Review, 47, 59-60 (Fall 2002) (footnotes omitted).

[836] Charles Bond, testimony, Nov. 4, 2002, pg. 67.

[837] Id. at 68.

[838] Jim Hurley, testimony, Nov. 4, 2002, pgs. 25-26.

Under current Florida law, there is no predictability when it comes to potential jury awards of non-economic damages. As a result, medical malpractice insurance premiums are higher here than in most other states.[839]

The testimony of witnesses before the Task Force and written submissions of stakeholders show the current depth of the crisis and its effect upon Florida residents and visitors as patients and consumers.

The reform measures recommended in this report, coupled with existing regulation of healthcare access and delivery, provide a commensurate benefit for the loss of the right to recover unlimited non-economic damages.

Commensurate benefit

The Task Force respectfully finds and concludes that the proposed reform plan as a whole,[840] including existing quality assurance measures that will remain in force, provides a commensurate benefit for the loss of the right to fully recover non-economic damages,[841] as required by the first prong of the Kluger test for validity under the access to courts provision of the Florida Constitution.

Every time a Florida resident or visitor seeks healthcare here, he or she will benefit from the combination of the proposed cap, the other proposed reform measures, and the current agency oversight of healthcare delivery that will be continued. It is the plan as a whole that will provide the commensurate benefit. This is so because, if the cap had been implemented as part of a single, comprehensive reform plan, all elements of the plan would have been considered in evaluating commensurate benefit.

The plan as a whole will provide many benefits to claimants, including the following:

- Physicians and hospitals will not be compelled to reduce or eliminate services, particularly those involving high risk. High-cost and low-income groups in particular will benefit. Lower malpractice insurance rates increase the willingness of physicians and hospitals to provide treatments that carry a relatively high risk of failure but offer the only real prospect of success for seriously-ill patients.

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[839] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 4 (Nov. 7, 2002) (Florida medical malpractice insurance premiums are over 50 percent above the countrywide average).
[840] University of Miami v. Echarte, 618 So. 2d 189, 197 (Fla. 1993).
[841] University of Miami v. Echarte, 618 So. 2d 189, 194 (Fla. 1993).

- The plan as a whole will include laws and agency rules designed to assure quality.

- Malpractice insurance premiums are a significant part of overall healthcare cost. Cost-savings will be reflected in health insurance premiums, making health insurance benefit programs more affordable to businesses, particularly small businesses. Lower premiums will increase employee participation in health insurance programs offered by their employers.

- Fewer tests, procedures, and visits will reduce the direct financial cost to the patient, and will also reduce time, travel, and other indirect costs.

- Malpractice insurance is a component of the overhead costs that providers must take into account in negotiating reimbursement rates with commercial insurers. Employers that pay all or portions of the premiums for their employees will save money. This may make the difference in whether an employer can afford to maintain current health insurance benefits for its employees.

- The time required for plaintiffs to obtain awards will be reduced.

- Reduced malpractice pressure will increase the supply of physicians, especially obstetricians and other impacted specialists.

- Lower malpractice insurance premiums will contribute to the viability of community hospitals.

- Reduced malpractice pressure is likely to free-up funds in the operating budgets of self-insured hospitals, allowing the hospital to treat more patients.

- The incentive for physicians to go without insurance will be reduced or eliminated.

- Costs for teaching and safety-net hospitals, as well as non-profit community clinics will be lower.

- Costs for healthcare facilities that self-insure will decrease.

- The Florida Medicaid Program will save resources, which can be used to provide additional healthcare goods and services.

The Task Force respectfully finds that these and the other benefits that will flow from the recommended plan as a whole are commensurate benefits for the loss of the right to fully recover non-economic damages.

Overwhelming public necessity and no alternative means

There is an overpowering public necessity for the reform measures recommended in this report, and no alternative method of meeting such public necessity can be shown.

The Task Force finds and concludes that, even if the reform measures recommended in this Report were deemed not to include a reasonable alternative to protect the rights of the people of the state to redress for injuries[842] or, stated another way, a commensurate benefit for the loss of the right to fully recover non-economic damages,[843] the record nevertheless shows that:

- there is an overpowering public necessity[844] for the reform measures recommended in this report, including the cap on awards of non-economic damages; and
- no alternative method of meeting such public necessity can be shown.[845]

Thus, in light of the record made by this Task Force, the findings of previous task forces (discussed above in this report) the specific findings enumerated below, and the Legislature's previous findings and declarations of public policy in the area of healthcare,[846] and considering the proposed reform plan as a whole,[847] including existing quality assurance measures that will remain in force, the Task Force respectfully finds and concludes that the second prong of Kluger is satisfied.

Overwhelming public necessity

There is an overpowering public necessity for the reform measures recommended in this report, including the cap on awards of non-economic damages.

The Task Force finds and concludes from the record before it that there is an overpowering public necessity for the reform measures recommended

842 Kluger v. White, 281 So. 2d 1, 4 (Fla. 1973).
843 University of Miami v. Echarte, 618 So. 2d 189, 194 (Fla. 1993).
844 Kluger v. White, 281 So. 2d 1, 4 (Fla. 1973).
845 Id.
846 See, e.g., chapter 88-1, Laws of Florida.
847 University of Miami v. Echarte, 618 So. 2d 189, 197 (Fla. 1993).

in this Report, including the cap on awards of non-economic damages. The cap will ease the problems of unavailable and unaffordable healthcare professional liability insurance and turn back the looming crisis of a lack of access to medical care.

The primary cause of increased medical malpractice premiums has been the substantial increase in loss payments to claimants caused by increases in both the severity of judgments and the frequency of claims.

The Task Force finds that the lack of predictability in the market, combined with a trend toward increased damage judgments, has caused instability in the market which, in turn, has led to insurance carriers either increasing their premiums (often to a level above what independent doctors can afford) or withdrawing from the marketplace.

The result of these actions has created a profound shortage of medical services available throughout the state. The Task Force has received thousands of correspondence in the form of letters or survey responses from concerned physicians, nurses, and administrators of healthcare facilities, urging the Governor and Legislature to take steps to avert this crisis. Of these, most express doubt that it will be possible to continue in the healthcare business if immediate action is not taken.

Failure to stabilize the market will result in additional, increased withdrawals from the market of companies incapable of remaining competitive in the industry. Therefore, it is imperative to stabilize the market in order to prevent a deepening of the current crisis of unavailability facing the state today.

Based upon the foregoing and the other information in the record before it, the Task Force finds and concludes that there is an overpowering public necessity for the reform measures recommended in this report, including the cap on awards of non-economic damages.

No alternative or less onerous method

As the legislative history in chapter 4 indicates, Florida's 27-year experiment has not solved the problem. Additional, complementary, measures are needed. The Task Force finds and concludes that, without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of controlling increases in healthcare costs and thereby promoting improved access to healthcare.

The Task Force has heard testimony, and received written submissions, proclaiming the potential benefits of other conceivable—but untested—

measures the proponents insist the Florida Legislature try before resorting to a cap on non-economic damages. Florida can no longer afford to continue to rely on measures that have not worked. Nor can it delay action based upon speculation about the viability of any number of conceivable other approaches that opponents of tort reform may dream up to stall the resolution of the crisis. California solved its crisis by enacting MICRA. The most important component of MICRA's approach to reform was the cap on non-economic damages.

The evidence before the Task Force shows that a cap of $250,000 per incident will lead to significantly lower malpractice premiums, which are an important factor in healthcare costs. Therefore, the Task Force recommends that, in medical malpractice cases, non-economic damages be capped at $250,000 per incident.

Since 1975, Florida has implemented (or attempted to implement) numerous alternatives to the cap on non-economic damages and the other reforms recommended in this Report. None, alone or together with the others, has solved the crisis of medical malpractice insurance availability and affordability. Instead, Florida's numerous attempts to solve this problem are nothing more than a failed litany of alternatives.

In spite of all these and other potential alternatives to a cap on non-economic damages with which it has experimented over the past 27 years, Florida has not succeeded in solving its crisis of medical malpractice insurance availability or affordability, and the corresponding crisis of access to healthcare. Many very creative minds have been put to the test to come up with a silver bullet that would resolve this problem with finality. Their past efforts have met with, at best, temporary success.

The Task Force finds that a cap on non-economic damages of $250,000 per incident limited only to healthcare professional liability cases is the only available remedy that can produce a necessary level of predictability. A cap on non-economic damages must be part of a package of reforms.

The Task Force finds and concludes that, without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of making medical malpractice insurance affordable and available, and thereby controlling increases in healthcare costs and promoting improved access to healthcare.

The Task Force finds the above-mentioned studies and experiences persuasive, and concludes that, without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of controlling increases in healthcare costs and thereby promoting improved access to healthcare. No

alternative or less onerous method for meeting the public necessity can be shown. No alternative or less onerous method for meeting the public necessity would be successful.

The amount of the cap

In an Issue Brief on federal medical malpractice tort reform, the American Academy of Actuaries recommended that Congress look to California's successful experience with a cap on non-economic damages.[848] The Academy concluded:

> For reform to be effective in reducing costs, the cap on non-economic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000).[849]

In light of this recommendation of the Academy of Actuaries and California's successful experience at the $250,000 level, the Task Force finds that a cap at the level of $250,000 on a per incident basis will be effective.[850]

The Task Force finds that actual and potential jury awards of non-economic damages (such as pain and suffering) are a key factor (perhaps the most important factor) behind the unavailability and un-affordability of medical malpractice insurance in Florida. The Task Force further finds that malpractice insurance premiums are a large component of the cost and availability of healthcare in Florida.

Based upon the evidence before it, including evidence of Florida's unsuccessful previous efforts to eliminate the ongoing medical malpractice crises, and the successful experiences of other states that have imposed caps on potential jury awards of non-economic damages, the Task Force finds that imposing caps on non-economic damages in medical malpractice cases will significantly reduce the exposure of Florida healthcare providers to risk of loss from jury awards of inherently subjective damages. Such a reduction of risk will make malpractice losses much more predictable, and thereby lead to stability in malpractice insurance premium rates.

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[848] American Academy of Actuaries, Issue Brief: Medical Malpractice Tort Reform: Lessons from the States (Fall 1996).

[849] Id.

[850] See also Richard E. Anderson, M.D., F.A.C.P., testimony, Nov. 4, 2002, pgs. 53-54 (twenty-seven years of California data show that there is no need to index the cap for inflation, as the average cost of indemnity in California is rising at two and one-half times the rate of inflation, despite MICRA, because plaintiffs' attorneys have become skilled at arguing for larger economic damages, such as wage loss).

A reduction in potential liability and resulting stability will encourage more malpractice insurers to participate in the Florida market. This, along with the reduced exposure to risk, will permit insurers to charge lower premiums on a sound financial basis. Lower premiums will encourage providers (particularly those in high-risk specialties) to offer healthcare services to Floridians, and persons visiting this state, and to do so at lower prices.

Recommendation 1. The Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident. The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare. The evidence before the Task Force indicates that a cap of $250,000 per incident will lead to significantly lower malpractice premiums.

The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the legislature five years after date of enactment.

Communications with Subsequent Treating Physicians

Issue

The Task Force voted on December 20, 2002, by a 3-2 vote, to examine the following issue with respect to communications with subsequent treating physicians in the context of medical malpractice cases:

- Should defendants have the ability to interview subsequent treating physicians without formal discovery or notice to the plaintiff?

Current Situation

The current law barring a defendant in a medical malpractice action from *ex parte* communication with a plaintiff's treating physicians places the defendant medical service provider in an institutional disadvantage in the litigation process, causing needless expenditures in both money and time, a condition which ultimately drives up the cost of healthcare.

The Legislature has created a statutory privilege prohibiting disclosure of information relayed to, or discovered by, a physician in the course of treating a patient.[851] This statute reads in pertinent part as follows:

> Ownership and control of patient records; report or copies of records to be furnished . . .
>
> (5)(a) Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other healthcare practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient. However, such records may be furnished without written authorization under the following circumstances:

[851] This statute was initially codified as section 455.241, Florida Statutes, and later renumbered as section 455.667, Florida Statutes. The law exists in its current form as section 456.057, Florida Statutes.

1. To any person, firm, or corporation that has procured or furnished such examination or treatment with the patient's consent.

2. When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff.

3. In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records.[852]

Notably, subpart (6) of the statute also provides for limited waiver of this privilege where the plaintiff places his or her physical condition at issue by instituting a malpractice action against a medical services provider that has treated the plaintiff:

(6) Except in a medical negligence action or administrative proceeding when a healthcare practitioner or provider is or reasonably expects to be named as a defendant, information disclosed to a healthcare practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other healthcare practitioners and providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.[853]

Therefore, the statute itself recognizes the need to balance the privacy interests of a patient with the need of a defendant to prepare a defense to charges levied against him or her. This statute, however, fails to provide an expeditious method for disseminating relevant information from a currently treating healthcare provider to a defendant conducting an investigation into the merits of a claim pursuant to an offer to settle.

This physician-patient privilege has been created by statute.[854] The Florida Supreme Court has stated that there was "no reason in law or

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[852] Section 456.057, Florida Statutes.
[853] Section 456.057(6), Florida Statutes.
[854] J.B. Harris, The Limits of *Ex parte* Communications with a Plaintiff's Treating Physician Under Florida Law, 70 Florida Bar Journal 57 (Nov. 1996); see also Morrison v. Malmquist, 62 So. 2d 415 (Fla. 1953) (noting that the doctor-patient privilege was not recognized in Florida).

equity" prohibiting a defendant from holding an *ex parte* conversation with a patient's treating physicians.[855] In addition, the Supreme Court has held that there existed "no common law or statutory privilege of confidentiality as to physician-patient communications in Florida" and, therefore, no legal impediment to *ex parte* conversations between a patient's treating doctors and the defendants existed.[856]

ie Legislature created this privilege with the passage of section 455.241, Florida Statutes, (the precursor to the current statute, section 456.057, Florida Statutes). The legislative history reflects that the Legislature intended to limit the disclosure of patient information to a potential defendant. Courts interpreting the provisions of this statute have held that only a very limited exception to the physician-patient privilege exists, and the information sought can be obtained only through the specific methods provided for in the statute.

In 1990, the First District Court interpreted the 1988 amendments, holding that in all cases other than those where the healthcare provider is a defendant, unless a plaintiff voluntarily provides a written authorization, the defendant's discovery of the privileged matter can be compelled only through subpoena power of the court with proper notice under the discovery provisions of the rules of civil procedure.[857] A three-pronged test emerged, which allowed a waiver of confidentiality in the following circumstances:

- In a medical negligence action, when a healthcare provider is or reasonably expects to be named as a defendant.
- By written authorization of the patient.
- When compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.[858]

The First District Court further noted that the reference to "proper notice" in the amendments was unquestionably included to preclude unilateral *ex parte* interrogation of a physician.[859]

The Florida Supreme Court has held that section 455.241, Florida Statutes (1993), precluded defense counsel from holding *ex parte* conversations with a claimant's current treating physicians during pre-trial discovery.[860]

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[855] Coralluzo v. Fass, 450 So. 2d 858, 859 (Fla. 1984).
[856] See Id.; see also Acosta v. Richter, 671 So. 2d 149, 150 (Fla. 1996).
[857] Franklin v. Nationwide Mutual Fire Ins. Co., 566 So. 2d. 529, 532 (Fla. 1st DCA 1990).
[858] Id.
[859] Id.
[860] Acosta v. Richter, 671 So. 2d 149, 150 (Fla. 1996).

Furthermore, the court held that "the primary purpose of the 1988 amendment [to section 455.241, Florida Statutes] was to create a physician-patient privilege where none existed before, and to provide an explicit but limited scheme for the disclosure of personal medical information."[861]

Although the court acknowledged that since the passing of the statute, Florida courts had split on the issue of the scope of the patient/plaintiff's waiver of privilege, the court commented:

> Considering our conclusion that the major purpose of section 455.241(2) is to restrict a physician from disclosing patient information, we believe this "medical negligence" exception permits disclosure of patient information only by a physician who "is or reasonably expects to be named as a defendant" in a medical malpractice action. We do not believe that the legislature, having created a broad physician-patient privilege earlier in the statute and a strict scheme for limited disclosure, would use such awkward language if its intent was simply to do away with the privilege entirely in medical negligence cases.[862]

The Supreme Court's justification for holding that the statute barred *ex parte* communication between defense counsel and subsequent treating physicians was if "unsupervised *ex parte* interviews [were] allowed, medical malpractice plaintiffs could not object and act to protect against inadvertent disclosure of privileged communication, nor could they effectively prove that improper disclosure actually took place."[863] This, despite the fact that the "strict scheme of limited disclosure" referred to by the court authorizes the release of this otherwise privileged information to the defendant doctor.[864]

Since Acosta, other appellate courts have followed the principles set forth therein. Recently, the Second District held that the statutory physician-patient privilege did not prohibit the clinic, a doctor, and counsel from communicating with a second doctor, who had been a former employee of the clinic and involved in the patient's treatment, but was not a defendant in the malpractice litigation nor was likely to be a litigant.[865] The statutory physician-patient privilege did not attach to prevent communications between the healthcare providers involved in the lawsuit

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[861] Id. at 154.
[862] Id. at 156.
[863] Id. at 155.
[864] Of course, were the information disclosed not pertinent to the instant suit, this information would be excluded as not relevant.
[865] Royal, M.D. v. Hamage, 826 So. 2d 332 (Fla. 2d DCA 2002).

as defendants and a second, unnamed physician who had participated in the treatment of the patient.[866] Specifically, the court observed that the defendants and the second doctor had been involved in treatment of a patient and the filing of the lawsuit could not create a privilege where none had previously existed.[867]

Relying on the Acosta decision, the Third District Court refused to allow the defendant, HRS, to inquire into the mental condition of a plaintiff who alleged that she had suffered psychological damage due in part to the negligent psychological care she received while a ward of the agency.[868] The Third District Court explicitly held, "HRS also claims that both the parties already are in possession of the medical records of Melody's healthcare providers. This, however, does not mean that she has in any manner waived the right to object to *ex parte* communications between them and defense counsel."[869] Therefore, under the existing case law, the statute in its current form prevents defense counsel even from requesting clarification of written information already released without engaging further disclosure proceedings.

Therefore, since the Acosta decision, the rule in Florida has been that counsel for a defendant doctor in a medical malpractice suit may not engage in any *ex parte* communication with the plaintiff's current treating physician, even for the limited purpose of gaining or clarifying information which would be used solely to assess the strength of the plaintiff's claim or to decide whether or not settlement of the claim is warranted. Instead, the defendant must engage in time-consuming and expensive pre-trial discovery proceedings in order to get to the information already recognized as available to the plaintiff.[870]

The constitutionality of statutes limiting the confidentiality of doctor-patient communications has been challenged at various times in the Florida courts. While no cases directly on point articulate how the instant proposed reform must be worded in order to pass constitutional scrutiny, the judicial reasoning applied in other contexts provides guidance.

In Jackson v. State,[871] the appellant challenged an order of involuntary commitment pursuant to the "Jimmy Ryce Act" on the grounds that, by requiring the appellant's treating psychotherapist to reveal medical records and to disclose opinions relating to the appellant's mental condition, the statute violated the appellant's constitutional right to privacy. In

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[866] Id.
[867] Id.
[868] Melody v. Department of Health and Rehabilitative Services, 706 So. 2d 115 (Fla. 3d DCA 1998).
[869] Id. at 118.
[870] Tommy Dukes, J.D., testimony, Nov. 22, 2002, pg. 294.
[871] Jackson v. State, 2002 WL 31870170 (Fla. 4th DCA 2002).

upholding the statute, the Fourth District Court of Appeal stated, "The right of privacy does not confer a complete immunity from governmental regulation and will yield to compelling governmental interests."[872] Additionally, the court relied on its previous reasoning[873] that "[a]lthough a person's subjective expectation of privacy is one consideration in deciding whether a constitutional right attaches, the final determination of an expectation's legitimacy takes a more global view, placing the individual in the context of a society and the values that the society seeks to foster."[874] Thus, the statute was found to be a reasonable limit on the right to privacy, in light of the fact that the statute "imposes a duty to safeguard the confidential nature of information received and used by the government in determining whether a person is or continues to be a sexually violent predator."[875]

Similarly, in State v. Johnson,[876] the Florida Supreme Court upheld the state's right to subpoena medical records, with proper notice, in a criminal D.U.I. manslaughter prosecution. The court reasoned:

> A patient's medical records enjoy a confidential status by virtue of the right to privacy contained in the Florida Constitution, and any attempt on the part of the government to obtain such records must first meet constitutional muster. The right to privacy is not absolute and will yield to compelling governmental interests. Therefore, in reviewing a claim of unconstitutional governmental intrusion, the compelling state interest standard is the appropriate standard of review.[877]

The court easily found that the necessity to prosecute criminal activity qualified as a "compelling state interest," justifying the state's intrusion into the personal, private medical records of the suspected criminal.

Similarly, the Legislature is properly acting within its power to restructure the method of discovery in civil malpractice cases in order to avert an impending crisis in the healthcare industry. This regulation protects the health and general welfare of the citizens of the state by preserving the availability of adequate healthcare; clearly this is a "compelling" state interest.

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[872] Id. at 1 (quoting Winfield v. Division of Pari-Mutual Wagering, Department of Business Regulation, 477 So. 2d 544 (Fla. 1985).
[873] Board of County Commissioners of Palm Beach County v. D.B., 784 So. 2d 585, 590 (Fla. 4th DCA 2001).
[874] Id.
[875] Id. at 2.
[876] State v. Johnson, 814 So. 2d 390 (Fla. 2002).
[877] Id. at 393.

Illinois' experience with reform is illustrative of the difficulty in drafting legislation that properly balances the competing needs of the parties with the constitutional right to privacy. The 1995 Illinois statute provided that, in all claims of medical negligence against a healthcare provider, the filing of a lawsuit would act as a waiver of any privilege the patient/plaintiff had regarding the patient's medical care or physical condition, and thus allowed *ex parte* communications between a defendant and the plaintiff's treating physicians. In addition, the legislation required every plaintiff seeking damages on a claim of personal injury, death, emotional injury, or pain and suffering to execute a consent form allowing disclosure of information from all healthcare providers. This consent was to be given within twenty-eight days of a request by a defendant and covered any and all treatment received by the plaintiff. The statute, however, allowed for *in camera* review of the underlying records prior to disclosure, in order to insure that the information sought was relevant to the defense.[878]

This statute was found to be unconstitutional by the Illinois Supreme Court in 1997.[879] There, the court found that the statute not only infringed upon the Illinois Constitution's separation of powers provisions, but that it violated the right to privacy, as explicitly provided in the Illinois Constitution (a provision similar to that of the Florida Constitution).[880] In reaching its conclusion, the court reasoned:

> The confidentiality of personal medical information is, without question, at the core of what society regards as a fundamental component of individual privacy. Physicians are privy to the most intimate details of their patients' lives, touching on diverse subjects like mental health, sexual health and reproductive choice. Moreover, some medical conditions are poorly understood by the public, and their disclosure may cause those afflicted to be unfairly stigmatized. Respect for the privacy of medical information is a central feature of the physician-patient relationship. Under the Hippocratic Oath, and modern principles of medical ethics derived from it, physicians are ethically bound to maintain patient confidences.[881]

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[878] Michael J. Gallagher et al., Illinois Tort Reform: The Judges' Perspective, 84 Illinois Bar Journal 124 (March 1996).
[879] Kunkel v. Walton, 689 N.E. 2d 1047 (Ill. 1997).
[880] Ill. Const. 1970, art I, section 6, reads, in pertinent part: "[T]he people shall have the right to be secure in their persons, houses, papers, and other possessions against unreasonable searches, seizures, *invasions of privacy* or interceptions of communications by eavesdropping devices or other means" (emphasis added); Fla. Const. art I, section 23 reads, in pertinent part, "Every natural person has the right to be let alone and free from *governmental intrusion* into the person's life..." (emphasis added).
[881] Id. at 357.

However, the court further held that "[t]he text of our constitution does not accord absolute protection against invasions of privacy. Rather, it is unreasonable invasions of privacy that are forbidden. In the context of civil discovery, reasonableness is a function of relevance."[882] The court further observed:

> *There is no language in this provision in any manner restricting the consent requirement to the injury that is the subject of the lawsuit* or to related medical conditions. Under section 2-1003(a), as a condition of proceeding with his or her lawsuit, an injured party must consent to the disclosure of medical information *wholly unrelated to the injury for which recovery is sought.* Indeed, under the unqualified language of section 2-1003(a), the injured party may have to consent to the release of complete medical records held by healthcare providers who have never treated the injured party for any condition even remotely related to the subject matter of the lawsuit. The consent procedure set forth in section 2-1003(a) goes well beyond the legitimate objectives of discovery as reflected in this court's rules. Instead, section 2-1003(a) seems to be designed to discourage tort victims from pursuing valid claims by subjecting them to the threat of harassment and embarrassment through unreasonable and oppressive disclosure requirements.[883]

Thus, the Illinois Supreme Court ruled that the statute violated the state constitution's right to privacy provision by failing to require that the intrusion into the plaintiff's medical condition and treatment be limited to those areas legitimately relevant to the plaintiff's alleged injuries arising from the alleged negligent conduct of the defendant.

Federal legislation and regulations have recently been enacted that could preempt a legislative attempt to allow *ex parte* communication between a defendant and a treating physician in a medical malpractice case. As an alternative, the Legislature could make the execution of a medical information release a precondition to the filing of a medical malpractice action. This could avoid a potential concern with federal regulations.

Other jurisdictions currently allow disclosure of medical negligence plaintiffs' relevant medical information through the use of informal, *ex parte* communications between defense counsel and physicians who have treated or are currently treating the plaintiff.

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[882] Id.

[883] Id. at 533 (emphasis added).

For example, the California Supreme Court found that California law allows third-party treating physicians to disclose information relating to the treatments, care, and physical condition of a medical malpractice plaintiff to the defendant physician's insurer.[884] The California law specifically states that medical information be disclosed "to persons or organizations which insure or are responsible for defending professional liability."[885] In Heller v. Norcal Mutual Ins. Co., the defendant's insurance company conducted an *ex parte* interview with the plaintiff's expert witness, in which the expert disclosed the plaintiff's medical records to defense counsel. The court found that the law was unambiguous and specifically allowed for the unauthorized disclosure of such information when the plaintiff proceeded on a medical malpractice theory.

Similarly, the New Jersey Supreme Court held that defense counsel has the right to interview treating physicians during the discovery process.[886] In Stempler v. Speidell, a woman died shortly after being admitted into a hospital for abdominal pains. During the discovery process of the ensuing lawsuit, the defendant learned that the decedent had been treated by a significant number of doctors and other healthcare providers prior to her arrival at the hospital. Defense counsel sought to have the plaintiff sign releases authorizing the decedent's prior healthcare providers to release medical records and discuss the decedent's prior health and treatments. The plaintiff, however, agreed only to the release of the medical records, and refused to authorize the defendant to speak with the healthcare providers on the grounds of physician-patient confidentiality.

Thereafter, the defendants sought a motion to compel unrestricted authorization to speak with these physicians. The defendant claimed that requiring the formality of depositions would impose unnecessarily cumbersome restrictions on his right to prepare for trial due to the cost and delay of the process. Instead, the defendant argued that informal interviews were a more appropriate way to ascertain whether any of the plaintiff's physicians possessed unprivileged information that could be relevant to the defense's case. Finally, the defendant argued that requiring formal depositions of these physicians was unfairly burdensome because no similar restrictions were imposed upon the plaintiff's counsel.[887]

In its decision, the New Jersey Supreme Court initially observed that instituting a lawsuit grounded in medical negligence "extinguishes the privilege to the extent that decedent's medical condition will be a factor in

[884] Heller v. Norcal Mutual Ins. Co., 876 P.2d 999 (Cal. 1994).
[885] California Civil Code section 56.10(c)(4).
[886] Stempler v. Speidell, 495 A. 2d 857 (N.J. 1985).
[887] Id. at 862.

the litigation."[888] After a lengthy discussion of the competing interests of the parties, (i.e., the patient's interest in ensuring open communication with his healthcare provider by requiring that these discussions remain confidential, versus the defendant's right to present a defense to a claim brought against him), the New Jersey Supreme Court stated:

> In our view, these competing interests can be respected adequately without requiring the formality of depositions in every case. The Rules regulating pretrial discovery do not purport to set forth the only methods by which information pertinent to the litigation may be obtained. Personal interviews, although not expressly referred to in our Rules, are an accepted, informal method of assembling facts and documents in preparation for trial. Their use should be encouraged as should other informal means of discovery that reduce the cost and time of trial preparation . . .
>
> Plaintiff may also seek and obtain a protective order if under the circumstances a proposed *ex parte* interview with a specific physician threatens to cause such substantial prejudice to plaintiff as to warrant the supervision of the trial court. Such supervision could take the form of an order requiring the presence of plaintiff's counsel during the interview or, in extreme cases, requiring defendant's counsel to proceed by deposition.[889]

Clearly, Stempler exemplifies the situation frequently facing defendants in medical malpractice actions throughout Florida. When the malpractice action is brought, the defendant is frequently in the position of having to investigate the plaintiff's medical history or current condition in order to discover other possible causes of the plaintiff's injury that could be used in defending the action. In addition, this information is often useful in determining the strength of the plaintiff's case, which the defendant could use to decide whether to settle the claim or proceed to trial. It is often necessary to interview several of the plaintiff's treating healthcare providers in order to acquire this information. But, because formal discovery is an expensive and time consuming process, defendants are often unable to adequately gather this information in preparation of their defense.

Streamlining this process would not only expedite the litigation process, but also reduce the process' cost, thus limiting the insurer's expense and slowing subsequent increases in insurance premiums. Further, as pointed out by the Stempler court, this reform creates no legitimate hardship for

[888] Id. at 859.
[889] Id. at 864.

the plaintiff because the plaintiff may still seek protection from the court in the event that the defendant attempts to abuse this less formal process.

Information Presented to the Task Force

Concerns about whether defendants may communicate extra-judicially with prior and subsequent treating physicians were expressed from opposite points of view. In one respect, the "playing field" was said to be one-sided, making more difficult a party's ability to quickly and fairly assess the merits of the case. On the other hand, the accessibility to treating physicians was believed to be adequate and available by use of the pre-suit and discovery procedures governing medical malpractice cases.

A practical impediment to the fair adjudication of medical malpractice claims is the issue of communications with subsequent treating physicians.[890] The issue arises at the onset of a medical malpractice suit and continues throughout. Prior to the 1988 amendments to section 455.241, Florida Statutes, the common law allowed for equal access to non-party treating physicians by both the plaintiffs and the defendants. However, the Legislature, in creating a privilege to protect the confidentiality of medical records, inadvertently caused a "great advantage to the plaintiffs and a great disadvantage to the defendants" once there was notice of litigation or the litigation actually commenced.[891] The disadvantage is seen as soon as a plaintiff "injects [the plaintiff's] medical condition in the sense of the public domain by pursuing or electing to pursue medical malpractice action, because the non-party treating physicians remain off-limits to the defendant healthcare provider."[892] The defendant's lawyer must take the deposition of the non-party treating physician to discover the facts of the case. This is after the plaintiff's attorney has had the opportunity to sit down with the non-party physician and, in confidence, share with the non-party physician the plaintiff's theory of the case.[893]

This unfair and unbalanced privilege, as it currently exists, also drives up the cost of litigation.[894] For example, if a problem arises in the legibility of medical records for a particular treating physician, rather than simply picking up a phone and calling the physician for clarification, the defendant's attorney must arrange a deposition involving court reporters, lawyers, and the involved doctor.[895] A more fair and cost-efficient

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[890] Tommy Dukes, J.D., testimony, Nov. 22, 2002, pg. 294.
[891] Id. at 295.
[892] Id. at 296.
[893] Id. at 297-298.
[894] Id. at 298.
[895] Id.

situation would be where each side, not only the plaintiff, is given access to the treating physicians in an informal fashion.[896]

Suggestions for proposed legislative language to change the existing situation to allow fair and equal access to non-party treating physicians by both entities were tendered. The proposal also included maintaining the privacy of the plaintiff by limiting its use to the context of the litigation proceedings.[897]

An alternative perspective opined "there is no other group of individuals or businesses in our state who have the ability to get more information about a case before it ever is filed in the circuit court."[898] Before a case commences, pre-suit notice is required, and a detailed affidavit must be provided.[899]

The Legislature "thought long and hard about a problem that was clearly demonstrated at the time" during the 1980s, when they enacted the statute, which was a compromise between the rights of the injured party's and the insurance issues existing at the time.[900] The problem the Legislature corrected was the private, closed-door meetings between insurance adjusters, defense lawyers, and the person being sued.[901] Typically, the person being sued would speak with his or her colleagues and say "I need your help here. I'm getting sued. I need you to help me out on either the causation issue or the liability issue or the damage issue".[902]

In effect, the Legislature said that to have access to this information, the rules of evidence and the rules of discovery must be followed including giving the patient's representative notice and an opportunity to be present when any questioning takes place.[903]

The present system is not broken.[904] Crafting language to go back prior to 1988, to allow unfettered access, is not appropriate.[905] To allow a situation where a defense lawyer or an insurance adjuster and the doctor go to see a patient's treating physician on an informal basis would further drive a wedge between that physician and the patient. That should not be permitted.[906]

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[896] Id. at 300.
[897] Id. at 300-301.
[898] Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 302.
[899] Id.
[900] Id.
[901] Id. at 303.
[902] Id.
[903] Id. at 303-304.
[904] Id. at 306.
[905] Id. at 304.
[906] Id. at 306.

The defendants do have access to information through duly-noticed depositions and discovery and there is no reason to change the current system.[907]

Findings and Recommendations

The Task Force finds that prohibiting *ex parte* communication by defense counsel increases the defendant/insurer's administrative costs by requiring formal depositions of all treating physicians. In many cases, an informal interview would reveal a particular treating physician has little or no information relevant to the plaintiff's claim. Under such circumstances, the expense of a formal deposition could be avoided.

Accordingly, the prohibition on *ex parte* contact reduces the chances of an early settlement. In addition, because the statute does not prohibit *ex parte* contact between the plaintiff's counsel and the treating physician, the defendant is at an unfair disadvantage. At an early stage of the litigation, the plaintiff has the opportunity to present to the treating physician his or her theory of the case. Such one-sided advocacy has the potential to tilt the treating physician's opinion in favor of the plaintiff. Should the treating physician's deposition testimony prove favorable to the defense, however, the present scheme prohibits the defendant from preparing the treating physician for his or her direct examination. The plaintiff would face no such obstacle if the treating physician's testimony supported his or her theory of the case.

Recommendation 1. The Legislature should amend the Florida Statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 2. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

[907] Id.

Expert Witness Qualifications

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the following issue with respect to expert witness qualifications in the context of medical malpractice cases:

- Should the qualifications for a medical expert testifying in a medical malpractice action be amended to require the expert testifying to be of the same specialty as the physician being sued?

Current Situation

The most critical issue regarding expert witness qualifications questions the need for that expert to be of the same specialty, or be a similar healthcare provider pursuant to section 766.102, Florida Statutes, regarding the nature of the healthcare services provided.

Section 766.102(2), Florida Statutes, provides definitions of inclusion for experts who may testify and further provides that courts have the authority to interpret the section's provisions broadly. As a result, a specialist may testify against a general practitioner or a specialist in one field and may be permitted to testify against a specialist in another field. The statute provides that "the prevailing professional standard of care for a given health care provider shall be the level of care, skill and treatment which, in light of all relevant circumstances is recognized as acceptable and appropriate by reasonably prudent similar health care providers."[908]

Historically, case law has reflected a case-by-case fact-based determination as to whether a tendered expert should be permitted to testify regarding qualifications and opinions as to the standard of care given. As summarized in Stewart v. Price,[909] "under the circumstances of the instant case, exclusion of the appellant's primary expert constitutes harmless error especially since this case, as many medical malpractice cases, was necessarily a 'battle of the experts'"[910]

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[908] Section 766. 102(1), Florida Statutes.
[909] 718 So. 2d 205, 209 (Fla. 1st DCA 1998).
[910] See Cenatus v. Naples Community Hosp., Inc., 689 So. 2d 302 (Fla. 2d DCA 1997); see also Barrio v. Wilson, 779 So. 2d 413 (Fla. DCA 2000) (specialist who frequently consulted on emergency room cases

With the exception of changes made by chapter 85-175, Laws of Florida (1985), regarding the "prevailing professional standard" for "accepted standard of care" in subsections (3)(a) and (4) and adding subsection (5), no significant modifications have been made to this provision.

The issue to be reviewed by the Task Force is whether a more stringent standard for determining expert witness qualifications is mandated based on prevailing practices and perceived problems with accountability under the current statute.

Section 766.102, Florida Statutes, partially regulates the prevailing professional standard of care for a given healthcare provider and the degree of expertise necessary for a similar healthcare provider to be qualified to testify against another in a court of law. If an individual is not certified by an appropriate American board as being a specialist, is not trained or experienced in a medical specialty, or does not hold himself or herself out as a specialist, then a similar healthcare provider is one who:

1. Is licensed by the appropriate regulatory agency of this state.

2. Is trained and experienced in the same discipline or school of practice; and

3. Practices in the same or similar medical community.[911]

For those individuals who are certified by the appropriate American board as a specialist, and trained and experienced in a medical specialty, or hold themselves out as specialists, a similar care provider is one who:

1. Is trained and experienced in the same specialty; and

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and saw patients in that setting was not qualified to testify on standard of care for emergency room physicians because he was not an emergency room physician and had not served on the staff in an emergency room department for at least fifteen years); Fuentes v. Spirer, 766 So. 2d 1081 (Fla. 3rd DCA 2000) (critical care and trauma specialist qualified as a standard of care expert witness case against allegedly negligent emergency room physician even where expert was not an emergency room physician, given the expert's experience over the past five years in having been intimately involved in care of emergency room trauma patients and coordinating with emergency medical faculty and having written triage policies followed by emergency room personnel); Myron v. South Broward Hosp. Dist., 703 So. 2d 527 (Fla. 4th DCA 1997) (pediatrician was qualified to give opinion as to negligence of neurosurgeon in failing to perform procedure on infant because a pediatrician is well qualified to provide an opinion on necessary procedures such as a spinal tap even by a neurosurgeon); Fort Walton Beach Medical Center, Inc. v. Dingler, 697 So. 2d 575 (Fla. 1st DCA 1997) (requirement for qualifications as medical expert under pre-suit notification statutes of engagement of practice of medicine is satisfied so long as expert's active involvement in practice occurred within five-year period before incident giving rise to claim).

[911] Section 766.102(2)(a)1-3, Florida Statutes.

2. Is certified by the appropriate American board in the same specialty.[912]

The statute further provides that if any healthcare provider is providing treatment or diagnosis for a condition which is not within his or her specialty, a specialist trained in the treatment or diagnosis of that condition shall be considered a similar healthcare provider and shall be permitted to testify as an expert in any action if he or she is:

1. A similar healthcare provider pursuant to paragraph (a) or paragraph (b); or

2. Is not a similar healthcare provider pursuant to paragraph (a) or paragraph (b) but, to the satisfaction of the court, possesses sufficient training, experience, and knowledge as a result of practice or teaching in the specialty of the defendant or practice or teaching in a related field of medicine, so as to be able to provide such expert testimony as to the prevailing professional standard of care in a given field of medicine. Such training, experience, or knowledge must be as a result of the active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.[913]

As previously noted, the determination as to whether an expert witness qualifies to testify against another healthcare professional depends upon case-specific facts and whether a trial court is convinced that the expert is qualified to testify.

Information Presented to the Task Force

In the early 1960s, the Frye standard was applied in ascertaining whether a potential expert witness qualified to testify regarding medical malpractice practices.[914] In moving away from the Frye standard and the court appointment of non-advocate experts, concerns have grown regarding whether experts hired by various parties in fact testify truthfully and reflect accurately the standard of care provided in cases under litigation.[915] Today, doctors are sought out for their medical opinions. When a doctor who can provide favorable testimony is located, more times than not, that doctor is hired and is told to provide an opinion but not to provide a report.[916] Under the current statute, judges have the authority to qualify experts based on the information provided from the potential expert

[912] Section 766.102(2)(b)1-2, Florida Statutes.
[913] Section 766.102(2)(c)1-2, Florida Statutes.
[914] Dennis Agliano, M.D., testimony, Nov. 22, 2002, pg. 334.
[915] Id. at 333-334.
[916] Id. at 334.

witness. For example, a family practitioner can be called as an expert against a neurosurgeon regarding a case involving brain surgery and the jury hearing the case will not appreciate that there is a quantitative and qualitative difference between hearing from a family practitioner versus an expert neurosurgeon as to whether the neurosurgeon rendered professional care.[917]

Some stakeholders believe that having a qualified, in-kind specialist testify, rather than allow a judge decide who is a specialist, will satisfy what is perceived to be a "fairness issue."[918]

Moreover, under current practices, medical practitioners not licensed within Florida are routinely hired to testify as experts in Florida courts. In these circumstances, there is no accountability in regulating the level of expertise of these experts, nor can Florida sanction them for any false testimony that may be provided.[919]

The fairness issue requires that expert witnesses be healthcare providers who have the same or equal qualifications beginning with the pre-suit affidavit level up to and including any trial. These experts not only must have similar or the same expertise but must also be in the active practice of medicine for five years and possess a Florida medical license.[920]

One stakeholder observed that the problem might not be as great as first perceived. In 80 percent of the cases where a healthcare provider was specializing as a cardiologist, a cardiologist would be hired to testify.[921] Further statements suggested that, since 1975, the courts have been doing a "pretty good job of being gatekeepers" regarding the admission of expert witnesses in medical malpractice cases. The case law reflects that suits have been decided on a case-by-case basis and that there are restrictions in place pursuant to the statutes regarding qualifying overlapping specialists as expert witnesses.[922] It was observed that the medical associations routinely deal with these kinds of issues and have successfully disciplined their own by expelling identified bad actors from their membership.[923] Regarding out-of-state experts and the need for certification to testify, some stakeholders were opposed to any changes. Further, those same stakeholders were opposed to any changes in evidentiary rules on expert witnesses, concluding that it would have no impact on the cost of insurance.[924]

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[917] Id. at 335.
[918] Id. at 335-336.
[919] Id. at 336-337.
[920] Id. at 337.
[921] Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 349.
[922] Id. at 339-340.
[923] Id. at 341.
[924] Id. at 343.

However, other anecdotal reports revealed that there are cases where doctors who had never performed the procedure under scrutiny or never reviewed the records provided for review signed pre-suit affidavits. It was reported that for a few thousand dollars, an expert witness would put their name on a signed affidavit.[925] Additionally, evidence reflected that 70 percent of the lawsuits are dropped because they are frivolous, and so it was concluded that 70 percent of the doctors signing these affidavits are doing so inappropriately. These kinds of statistics not only impact the physicians under scrutiny but the medical profession as a whole.[926]

Still additional evidence revealed that requiring in-kind specialists for pre-suit proceedings would cause the cost of litigation to escalate. For example, it was suggested that just to get started in a pre-suit case without an in-kind specialist, the cost ranged from $5000 to $7000 dollars per case. In a situation where a "specialist" is required, it could cost as much as $25,000 to just start the case with a mail out notice letter.[927] Ultimately, because these cases "take a lot of money to do correctly," care must be taken in crafting an outcome to the expert witness qualification issue.[928]

Findings and Recommendation

The Task Force finds, based on the testimony presented and the litigation to date, that in-kind specialists provide the greatest likelihood of satisfying the fairness issue regarding medical malpractice lawsuits. While trial judges traditionally determine qualifications of expert witnesses, the proliferation of expert witnesses in all disciplines has greatly diminished the ability of the courts to accurately assess the pertinent credentials of potential expert witnesses in a medical malpractice case.

Recommendation 1. The Legislature should examine ways to improve the use of in-kind experts at trial.

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[925] Dennis Agliano, M.D., testimony, Nov. 22, 2002, pg. 350.
[926] Id. at 350-351.
[927] Neal Roth, J.D., testimony, Nov. 22, 2002, pgs. 352-353.
[928] Id. at 353.

Limitation on Liability Related to Emergency Services

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the issue of a limitation of liability related to emergency services in the context of medical malpractice cases:

- Should the definition of "reckless disregard," as applied to emergency care in section 768.12(2)(b)3, Florida Statutes, be clarified to make it a more stringent standard than that currently applied by the courts?

Current Situation

One of the main issues relating to limitations on liability to emergency services is whether the definition of "reckless disregard" should be clarified. Specifically at issue is whether the definition as found in section 768.13(2)(b), Florida Statutes, and as applied in emergency care should be amended to provide a more stringent standard. A second issue which has also emerged is whether the "stabilization standard" found in section 768.13(2)(b)2a, Florida Statutes, should be deleted. Such a deletion would allow immunity to any hospital, hospital employee, or any person practicing medicine to be extended beyond the stabilization of the patient at the non-emergency level.

Although the Good Samaritan Act has existed since 1965, it was not until the mid 1980's that the act underwent modifications in reaction to a growing medical malpractice crisis. This crisis was more evident in the area of emergency room and trauma care than in any other area of medical practice.[929] In fact, from 1983 to 1987, emergency medical physicians experienced greater liability premium increases than any other medical specialty.[930]

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[929] Thomas R. Tedcastle & Marvin A. Dewar, Medical Malpractice: A New Treatment for An Old Illness, 16 Florida State University Law Review 535, 591 (Fall 1988).

[930] This fact was confirmed by the 1987 Academic Task Force for Review of the Insurance and Tort Systems in its report dated August 14, 1987, when it found that emergency room physicians experienced a 49 percent annual increase in premiums during the period of 1983 to 1987. Academic Task Force for Review of the Insurance and Tort Systems, Preliminary Fact-Finding Report on Medical Malpractice 29-30. Consequently, some emergency rooms in South Florida closed and others curtailed their services. Thomas R. Tedcastle & Marvin A. Dewar, Medical Malpractice: A New Treatment for An Old Illness, 16 Florida State University Law Review 535, 591 (Fall 1988).

In 1986, the Legislature, through chapter 86-160, section 62, Laws of Florida, added a subsection to the Good Samaritan Act. Subsection 768.13(2)(b), Florida Statutes, created a provision that a licensed physician who rendered emergency care or treatment in response to a "code blue" emergency within a hospital or trauma center would be eligible for immunity.[931] Immunity would be granted if the physician acted as would a reasonably prudent person licensed to practice medicine under the same or similar circumstances.[932]

In response to the medical malpractice crisis in 1987, former Governor Martinez organized the Governor's Task Force on Emergency Room and Trauma Care.[933] This Task Force recommended specific reform proposals such as changing the standard of care in medical malpractice cases involving emergency care to gross negligence; requiring physicians to provide emergency room coverage as a condition of staff membership; establishing qualification criteria for expert witnesses in emergency care malpractice cases; and expanding funding for indigent emergency care.[934] Former Governor Martinez also created the 1987 Academic Task Force for Review of the Insurance and Tort Systems, which was tasked to evaluate the state's tort and insurance laws in light of the growing malpractice crisis. Although Governor Martinez did not endorse all the proposals from the task forces, the 1988 Legislature did enact legislation that addressed a number of these proposals.[935]

In 1988, the Florida Legislature reformed the Good Samaritan Act's standard of care requirements for cases arising from injuries received in emergency rooms and trauma centers. Due to amendments to section 768.13(2)(b), Florida Statutes, the standard of care for emergency and non-emergency situations by physicians in offices or hospitals would no longer be indistinguishable.[936] Instead, the standard of care now required a change in the degree of culpability on the part of physicians and hospitals rendering care in emergency rooms and trauma centers.

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[931] "Code Blue" emergencies generally are those involving cardiopulmonary arrest that require immediate application of cardiopulmonary resuscitation (CPR). Id. at 535.

[932] Chapter 86-160, section 62, Laws of Florida.

[933] Thomas R. Tedcastle & Marvin A. Dewar, Medical Malpractice: A New Treatment for An Old Illness, 16 Florida State University Law Review 535, 591 (Fall 1988).

[934] Id. at 591-592.

[935] Id. at 592.

[936] A claimant in an action for medical malpractice had the burden of proof by the greater weight of the evidence to show that the healthcare practitioner breached the standard of care as measured by a reasonably prudent person licensed to practice medicine under the same or similar circumstances. Thomas R. Tedcastle & Marvin A. Dewar, Medical Malpractice: A New Treatment for An Old Illness, 16 Florida State University Law Review 535 (Fall 1988).

Section 768.13(2)(b), Florida Statutes, granted civil immunity to hospitals, hospital employees working within the facility, and persons licensed to practice medicine for injuries occurring as a result of medical care or treatment if the actions occurred in good faith and treatment was necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition which demanded immediate medical attention.[937] The patient receiving the care must have entered the hospital through the emergency room or trauma center.[938] Actionable malpractice occurring after February 8, 1988, would necessitate a demonstration of "reckless disregard" for the life or health of the patient.[939] Therefore, a hospital and its covered personnel would not be protected from civil liability if the injuries were a result of care, or lack of care or treatment, under circumstances that demonstrated a reckless disregard for the consequences of the life or health of a patient.

The Legislature chose to define "reckless disregard" as conduct which, at the time of the services were rendered, the healthcare provider knew or should have known would likely result in injury to the patient so as to affect the life or health of that patient.[940] The definition delineated five elements that addressed circumstances to be considered when determining if a person "knew or should have known" that injury was likely to occur. As codified, section 768.13(2)(b)3, Florida Statutes (1988), delineates these elements as follows: "the extent or serious nature of the circumstances prevailing; the lack of time or ability to obtain appropriate consultation; the lack of a prior patient physician relationship; the ability to obtain an appropriate medical history of the patient; the time constraints imposed by coexisting emergencies."[941]

Significant changes to the Good Samaritan Act relative to emergency rooms and trauma centers have not occurred since 1988. Moreover, appellate review has been *de minis* with few issues surfacing in the area of the "reckless disregard" standard. In the case of Garcia v. Randle-Eastern Ambulance Service, the Third District Court of Appeals determined that the issue of whether the facility acted with "reckless disregard" to the victim was a jury question based on the competent substantial evidence presented.[942] The court further stated it would apply the legislatively-created statutory definition of reckless disregard and would not rely on any common law definition of recklessness to determine liability under the Good Samaritan Act.[943]

[937] Section 768.13(2)(b), Florida Statutes.
[938] Id.
[939] Thomas R. Tedcastle & Marvin A. Dewar, Medical Malpractice: A New Treatment for An Old Illness, 16 Florida State University Law Review 535, 593 (Fall 1988).
[940] Section 768.13(2)(b)3, Florida Statutes.
[941] Id.
[942] Garcia v. Randle-Eastern Ambulance Service, 710 So. 2d. 74, 75 (Fla. 3d DCA 1998).
[943] Id.

Two subsections of section 768.13, Florida Statutes, are controlling in reference to liability limitations related to emergency services. One is section 768.13(2)(b)1, Florida Statutes, which sets forth the criteria for those who may be considered a covered party and what circumstances the covered party must be under before the immunity delineated in the Good Samaritan Act can be imposed. Specifically, section 768.13(2)(b)1, Florida Statutes, applies to hospitals licensed under chapter 395, Florida Statutes; employees of the hospitals working in the clinical area within the facility and rendering patient care; and any person licensed to practice medicine.[944] The second part of the statutory section lists certain elements that must be met before application of this immunity provision can be asserted. Those statutory elements are a good faith rendering of medical care or treatment of a sudden, unexpected situation or occurrence that results in a serious medical condition demanding immediate medical attention. Additionally, the patient must have entered the hospital through the emergency room or trauma center.[945]

However, the immunity granted by this statutory section has a caveat clause. Section 768.13(2)(b)1, Florida Statutes, states that a covered entity shall not be held liable for "any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another."

Section 768.13(2)(b)2, Florida Statutes, is the second controlling subsection that impacts the practical application of this statutory immunity law for emergency room and trauma center events. The immunity does not apply to causes of action under two different settings.

The first is when the injury is a result of any act or omission in providing medical care or treatment occurring after the patient is stabilized and is capable of receiving medical treatment as a non-emergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized.[946] As such, an actionable malpractice case for injuries occurring in emergency rooms or trauma centers is governed by the simple negligence standard unless all the criteria of the Good Samaritan Act are met.[947] While this subsection was enacted in an effort

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[944] Section 768.13(2)(b)1, Florida Statutes.

[945] Id.

[946] Section 768.13(2)(b)2, Florida Statutes.

[947] In Standard Jury Instructions – Civil Cases- Nos. 95-1, 95-2, 658 So. 2d 97 (Fla. 1995), the Florida Supreme Court adopted the jury instructions and commentary regarding the application of the degree of negligence standard submitted to the court by the Florida Supreme Court Committee on Standard Jury Instruction in Civil Cases. Standard Jury Instruction MI 9 was drafted "to address amendments to s. 768.13(2)(b), Florida Statutes. It applies only to cases described in that statute. MI 9 does not apply to cases

to clarify the circumstances in which immunity does not apply, unintended consequences have resulted. A line of demarcation as to when immunity may or may not apply has been drawn. This line of demarcation is predicated on "patient stabilization" which unwittingly creates an opportunity for prolific, protracted litigation. For example, questions such as what constitutes stabilization, at what point stabilization occurred and what is considered non-emergency care, may make ripe the opportunity for litigation that was not the intent of the legislation. Consequently, the stabilization element of this subsection brings into question, and may make meaningless, the Legislature's intent to provide immunity, thus requiring a case-by-case assessment in the granting of the immunity.

Second, immunity does not apply if the act or omission of providing medical care or treatment is unrelated to the original medical emergency.[948]

Based on the afore-noted discussion, it would appear that possible modifications are needed to conform current limitations as to any issue of stabilization to the applicability of any immunity.

Information Presented to the Task Force

Most of the testimony obtained pertaining to the reckless disregard standard and its application to emergency service events was presented to the Task Force at its December 3, 2002 meeting in Tallahassee. The testimony was derived from a point, counterpoint perspective.

Two reasons were outlined as to why the reckless disregard standard was not beneficial to emergency room doctors, the hospitals, and others.[949] First, the offered evidence noted that an emergency room doctor in Williston, Florida, was "desperately searching" and could not find malpractice insurance for his emergency services.

The second reason was based on fairness and common sense.[950] The reckless disregard standard has not changed the situation for emergency room doctors since its establishment "12 or 14 years ago."[951] It was

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involving patients capable of receiving treatment as nonemergency patients, even if treated in the emergency room. No reported decision construes the legislative intent behind the amendments. Based upon the definition of 'reckless disregard' in subpart (2)(b)3, the Committee has concluded that the intent was to limit liability in civil actions for damages arising out of fact situations to which the statute applies to cases where something more than 'simple' negligence is established. Therefore, the standard instructions dealing with 'simple' negligence are not appropriate for civil damage actions to which the statute applies."

[948] Section 768.13(2)(b)2, Florida Statutes.

[949] George Meros, J.D., testimony, Dec. 3, 2002, pgs. 124-125.

[950] Id. at 99.

[951] Id. at 100.

judged to be a "band-aid to try and calm down doctors" who were having problems. It has not done that because an expert is still going to come in and testify that "[O]h yes, that rises to the level of reckless disregard." In essence, notwithstanding the reckless disregard language, emergency room doctors and emergency care still have a problem.[952]

One suggestion proffered was to change the language to require the plaintiff to prove that the emergency provider committed a willful disregard for the rights of the patient. This would be consistent with the common law standard.[953]

Modifying the statute to add "willful" conduct to the reckless disregard standard is not supported by all stakeholders. It was suggested that adding the term "willful" to the standard would be "tantamount to intentional acts and would literally wipe out the law of medical negligence and the right for injured people in the state to bring medical negligence actions."[954]

Findings and Recommendations

Two related issues have come before the Task Force: (1) clarification of the "reckless disregard" standard, and (2) whether the "stabilization standard" should be redefined or abandoned.

The Task Force finds, based on the consideration of current law, the testimony provided during the meetings and the practical impact and application of the Good Samaritan Act to date, the definition of "reckless disregard" as defined by statute is sufficient and needs no further modification.

The Task Force further finds that as to the issue of patient stabilization as set forth in section 768.13(2)(b)2a, Florida Statutes, all references to patient stabilization should be repealed. The Task Force finds that because of the uncertainty of when patient stabilization occurs, undue and unintended litigation may result which dilutes the intent of this limited liability statute. By eliminating the patient's stability factor, the statute becomes more meaningful and more purposeful and greater immunity coverage is provided. As a result, the Task Force believes the limitation of liability in civil actions for damages arising out of emergency services provided to a standard of reckless disregard for life or health of another, satisfactorily protects patient's care in these identified circumstances and provides the necessary requirements for meeting liability immunity for covered parties.

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[952] Id.
[953] Id. at 101.
[954] Lance Block, J.D., testimony, Dec. 3, 2002, pg. 104.

Recommendation 1. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 2. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Sovereign Immunity

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the following issues of sovereign immunity for emergency room physicians in the context of medical malpractice cases:

- When emergency medical providers are performing medical services pursuant to the mandate imposed upon them in sections 395.1041 and 401.45, Florida Statutes, is there a reasonable basis to define the providers as agents of the state under section 768.28, Florida Statutes, due to the state-imposed mandate to implement the public policy goals underlying sections 395.1041 and 401.45, Florida Statutes?

- If so, should section 768.28, Florida Statutes, be amended to define emergency medical providers as agents of the state entitled to sovereign immunity for damages beyond the allowable caps, with the state to consider paying any clams exceeding the caps pursuant to the legislative claims bill process?

Current Situation

A proposal was made to apply sovereign immunity limits to emergency room physicians and hospital staff working within the hospital emergency room.

Sovereign immunity is derived from a medieval English doctrine that "one could not sue the king in his own courts; hence the phrase 'the king can do no wrong.'"[955] Justice Holmes explained the basis for the doctrine in 1907:[956] "A sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends."[957] The doctrine of sovereign immunity as applied by the Florida courts was based on two public policy considerations: "the protection of the public against profligate

[955] Cauley v. City of Jacksonville, 403 So. 2d 379 (Fla. 1981).
[956] Kawananakoa v. Polyblank, 205 U.S. 349, as cited in Cauley v. City of Jacksonville, 403 So. 2d 379 (Fla. 1981).
[957] Cauley v. City of Jacksonville, 403 So. 2d 379 (Fla. 1981).

encroachments on the public treasury[958] and the need for the orderly administration of government, which, in the absence of immunity, would be disrupted if the state could be sued at the instance of every citizen."[959]

Sovereign immunity is constitutionally absolute, subject only to the Legislature's right to waive immunity.[960] The state, its agencies, and counties have always been fully covered by sovereign immunity. Municipalities and quasi-governmental entities have been found by the courts to have limited immunity depending on whether the activity performed was considered a governmental function covered by sovereign immunity or a proprietary function for which the entity could be held liable. For instance, where a special taxing district operated a hospital that provided services to both paying and indigent clients, the court found the hospital was covered by sovereign immunity as to the indigent patients but not as to the paying patients.[961] More recently, the Legislature, through specific enactment, or the courts through application of the law, have applied sovereign immunity to public institutions created, owned, and controlled by the state or its subdivisions,[962] and public corporations or public quasi-corporations created by the Legislature to perform state-wide functions.[963]

The authority to grant relief from sovereign immunity was vested in the Legislature by the Constitution in 1896.[964] However, the Legislature did not exercise that authority until the passage of section 768.28, Florida Statutes, in 1973.[965] Prior to the passage of that section, any person wronged by actions of a governmental entity could only seek relief through payment from the Legislature via a claims bill. With the passage of section 768.28, Florida Statutes, the Legislature established a specific process for filing claims against governmental entities and the statute more clearly defined those entities the Legislature considered governmental entities. Additionally, after the passage of section 768.28, Florida Statutes, the Supreme Court receded from the analysis of sovereign immunity based on governmental and proprietary functions and deferred to the statutory scheme.[966]

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[958] Spangler v. Florida State Turnpike Authority, 106 So. 2d 421 (Fla. 1958).
[959] State Road Department v. Tharp, 146 Fla. 745, 1 So. 2d 868 (Fla. 1941).
[960] See Fla. Const. art. X, section 13.
[961] Suwannee County Hospital Corp. v. Golden, 56 So. 2d 911 (Fla. 1952).
[962] Smith v. Duval County Welfare Bd., 118 So. 2d 98 (Fla. 1st DCA 1960).
[963] Rabin v. Lake Worth Drainage Dist., 82 So. 2d 353 (Fla. 1955).
[964] See Fla. Const. art. IV, section 19 (1868) (now art. X, section 13).
[965] Prior to 1979 and passage of 768.28, Florida Statutes, a party suffering injury by the state could file a claims bill with the Legislature seeking relief.
[966] Commercial Carrier Corp. v. Indian River County, 371 So. 2d 1010 (Fla. 1979), Cauley v. City of Jacksonville, 403 So. 2d 379 (Fla. 1981), and Eldred v. North Broward Hospital District, 498 So. 2d 911 (Fla. 1986) (found the special taxing district to be covered by sovereign immunity on the basis of three actions: first, the passage of 768.28, second the specific recognition of special taxing districts as

The primary function of section 768.28, Florida Statutes, was the waiver of sovereign immunity for the state, its agencies or subdivisions. Additionally, the statute provides some limitations on suits against individuals and corporations who are not the sovereign but who pursue public or quasi-public objectives. Thus, the statute provides protection to the state, an agency, or subdivision, and to officers, employees, or agents of those governmental entities.

The section defines "state agencies or subdivisions" to include executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities, including the Florida Space Authority.

In 1979, the Legislature clarified section 768.28, Florida Statutes, to provide that an officer, employee, or agent of a covered entity was not personally liable when acting within the scope of his or her employment or function. The section defines "[o]fficer, employee, or agent" to include all officers, employees, or agents of any covered entity and in paragraphs (9)(b) and (c), specifically includes, but is not limited to, any healthcare provider when providing services pursuant to section 766.1115, Florida Statutes;[967] any member of the Florida Health Services Corps, who provides uncompensated care to medically indigent persons referred by the Department of Health; and any public defender or his or her employee or agent; volunteer firefighters; and members of the national guard except as specifically provided. The section has been amended over the years to specify others to be included as employees or agents of a governmental entity within the provisions of section 768.28, Florida Statutes.

Certain entities are to be considered agents of the state for purposes of the application of the waiver of sovereign immunity in the section. These include:

- Contractual agents of the Department of Corrections who provide healthcare services to inmates of the state correctional system.[968]

- Regional poison control centers created in accordance with law and coordinated and supervised under the Division of Children's Medial Services Prevention and Intervention of the Department of Health.[969]

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governmental entities in the constitution, and finally, the court's elimination of the governmental proprietary analysis).

[967] Section 766.1115, Florida Statutes.

[968] Section 768.28(10)(a), Florida Statutes.

[969] Section 768.28(10)(c), Florida Statutes.

- Contractors of the Tri-Rail Authority or the Department of Transportation providing security and/or rail facility maintenance in the South Florida Rail Corridor.[970]
- Contractors with the Department of Juvenile Justice providing services to children in need of services, families in need of services, or juvenile offenders.[971]

Other provisions of law provide for the application of section 768.28, Florida Statutes, to specified entities such as:

- The Hazardous Materials Emergency Response Commission and local committees established pursuant to section 252.89, Florida Statutes. The Federal Emergency Planning and Community Right to Know Act of 1986, requires the Governor to create a state commission and local committees to provide public information on the presence and release of toxic chemicals and to develop response plans for local communities and the state. The Governor appoints the commission members and the commission then appoints and supervises the local committees. Section 252.89, Florida Statutes, specifically provides that the commission and the local committees are state agencies and that the members of the commission and the local committees are officers, employees, or agents of the state for purposes of liability under section 768.28, Florida Statutes.

- Contractors with the Department of Business and Professional Regulations providing legal or investigative services to the Department or regulatory boards are provided sovereign immunity as to the investigations, conduct, and testimony provided to the various regulatory boards.[972]

- Persons or entities who allow governmental entities to use property for emergency shelters without compensation are immune from liability for any injury or death occurring during a real emergency or any practice or mock emergency.[973] If the individual or entity is compensated for the use of the property, the person or entity is deemed an instrumentality of the state or its applicable agency or subdivision for purposes of the limitations on liability provided by section 768.28, Florida Statutes.

- Charter schools are defined in section 1002.33, Florida Statutes, as public schools and part of the state's program of public education.

[970] Section 768.28(10)(d), Florida Statutes.
[971] Section 768.28(n), Florida Statutes.
[972] Section 252.89, Florida Statutes.
[973] Section 252.51, Florida Statutes.

Each school receives an approved charter from the district school board that sets out the operations of the charter school in accordance with the terms and conditions set out in law.[974] The approved charter schools receive state and local funding from the district school board based on the same funding standards as other public schools. Approved charter schools are eligible for state capital outlay funds in the same manner as other public schools.[975] Thus, approved charter schools are covered by the same sovereign immunity provisions as any other public school.

- Family foster homes are licensed and regulated by the state pursuant to section 409.175, Florida Statutes. Each home that accepts only children referred by the Department of Families and Children or its agencies enters into a contract with the Department regulating the services to be provided. These family foster homes are provided sovereign immunity as agents of the state.[976]

In reviewing the application of sovereign immunity and the provisions of section 768.28, Florida Statutes, the courts have examined the application to specific entities and types of actions. In these cases, it has been argued that by applying sovereign immunity, the Legislature has violated article I, section 21 of the Florida Constitution by denying access to the courts. In analyzing this issue the courts have applied the test set forth in Kluger v. White.[977] That test provides that "where a right of access to the courts for redress of a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the state of Florida, or where such right has become a part of the common law of the state pursuant to section 2.01, Florida Statutes, the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the state to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown."

The court, in evaluating the application of section 768.28, Florida Statutes, to municipalities, applied this analysis. In Cauley v. City of Jacksonville,[978] the Florida Supreme Court reversed prior applications of the limitation of sovereign immunity to municipalities and instead applied the provisions of section 768.28, Florida Statutes. The court applied the Kluger test in analyzing the application of sovereign immunity and section 768.28, Florida Statutes, to municipalities and found "[t]here was no

[974] Sections 1002.33(6)(a), 1002.33(6)(g), Florida Statutes.
[975] Section 1002.33, Florida Statutes.
[976] Section 409.175, Florida Statutes.
[977] 281 So. 2d 1 (Fla. 1973).
[978] 403 So. 2d 379 (Fla. 1981).

statutory right to recover for a municipality's negligence predating the adoption of the declaration of rights contained in the Florida constitution nor was there a cause of action at common law as of July 4, 1776, adopted under section 2.01, Florida Statutes."

The Kluger[979] analysis was again argued in White v. Hillsborough County Hospital Authority,[980] regarding the elimination of suit against a government employee. The court stated:

> [s]trong policy reasons support the legislative immunization of state employees from personal liability.[981] Here the right of an injured party to seek redress has not been abolished. Rather, the legislature has merely substituted the state and its agencies, which previously could not be sued because of sovereign immunity, for the individuals who could have been sued.[982] Thus, appellant's cause of action has not been destroyed but has been converted to an action against a state agency.[983]

Subsequently, in interpreting the provisions of section 768.28, Florida Statutes, the courts have covered contractors and agents of the state similarly to employees.

Finally, the courts examined who qualifies as an agent, employee, or contractor of the state within the definitions of section 768.28, Florida Statutes. In Skoblow v. Ameri-Manage, Inc.,[984] the district court of appeals found a state contractor who operated a state mental institution was operating as an agency of the state at the time of the plaintiff's alleged wrongful discharge. This determination was based on the court's examination of the contractual relationship between Ameri-Manage, Inc. and the state. In the case of Stoll v. Noel,[985] the Florida Supreme Court found that physician consultants with Children's Medical Services (CMS) were acting as agents of the state within the provisions of section 768.28(9), Florida Statutes, and thus were immune from suit individually. Here again, the court carefully examined the relationship between the doctors and CMS. The court stated that the determination "turns on the degree of control retained . . . by CMS." In making that determination the court examined the terms of the employment contract.[986] The court found the contract demonstrated that CMS had final authority over all care and

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[979] Kluger v. White, 281 So. 2d 1 (Fla. 1973).
[980] 448 So. 2d 2 (Fla. 1st DCA 1983).
[981] State Department of Transportation v. Knowles, 402 So. 2d 1155 (Fla. 1981).
[982] Id.
[983] White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 1st DCA 1983).
[984] 483 So. 2d 809 (Fla. 3rd DCA 1986).
[985] 694 So. 2d 701 (Fla. 1997).
[986] Stoll v. Noel, 694 So. 2d 701, 703 (Fla. 1997).

treatment provided to CMS patients, and it could refuse to allow a physician consultant's recommended source of treatment of any CMS patient for either medical or budgetary reasons.[987]

Hospitals and physicians providing emergency medical care in designated trauma units and hospital emergency rooms are also directed by the state and the Federal governments to provide such care. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires that all persons coming into an emergency department must be provided a screening exam to determine whether there is an emergency, and when an emergency is found, the person must be treated to the extent of the emergency room's capability without regard to ability to pay or the type of injury or illness.[988]

Each hospital providing emergency services is required to provide the Agency for Health Care Administration (AHCA) with a list of all emergency services within the service capability of the hospital.[989] Those services are to be listed on the hospital license.[990] The listed services are to be provided by the hospital upon the request of the patient, an emergency medical services provider, or another hospital.[991] Where the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services.[992] Each hospital must ensure the services listed on the hospital license can be provided at all times either directly or through another hospital.[993] Through these sections, the state directs and controls the actions and activities of hospitals and physicians providing designated trauma services and emergency services in a designated trauma center or hospital emergency room.

State regulation of designated trauma centers is even more intensive than for emergency rooms. Part II of chapter 395, Florida Statutes, provides for the designation and regulation of designated trauma centers and the filing of trauma center plans to be approved by ACHA.[994] To qualify as a designated trauma center, a hospital must meet the requirements of part II of chapter 395, Florida Statutes, and services must be provided in accordance with that part and rules adopted by ACHA.[995] Section 395.1041, Florida Statutes, requires every hospital with an emergency room to provide services or arrange for services in accordance with the

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[987] Id. at 703.
[988] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. section 1395dd.
[989] Section 395.1041(2), Florida Statutes.
[990] Id.
[991] Section 395.1041(3), Florida Statutes.
[992] Id.
[993] Section 395.1041(3), Florida Statutes.
[994] Section 395.401, Florida Statutes.
[995] Sections 395.401, 395.405, Florida Statutes.

needs of the patient for any patient requesting services. In enacting section 395.1041, Florida Statutes, the Legislature stated its intent as follows:

> It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other healthcare providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care.[996]

The Emergency Medical Transportation Services Act in chapter 401, Florida Statutes, similarly regulates the services provided by emergency medical technicians, paramedics, and ambulances. This chapter requires that services be provided to all persons requesting transportation to the capacity of the service without regard to ability to pay.[997]

Clearly those facilities and the staff's facilities providing emergency transportation, emergency care, and designated trauma services are providing a necessary and critical public function of care for the most seriously ill or injured. Once a facility and the doctors practicing within the facility agree to provide emergency or trauma care, they must provide that care within the parameters and requirements of state and federal law. In fact, the hospital license granted by the state sets forth the services the hospital has committed to provide and thus must provide on demand. This does not appear to be significantly different from the charter school that has its charter approved by the district school board or the family foster homes granted coverage under section 768.28, Florida Statutes.

While the courts have applied the Kluger test in cases evaluating the application of sovereign immunity to governmental agents, the courts have generally found that there was not an abrogation of a remedy but a substitution of a governmental entity for the agent or employee of that entity. The application of section 768.28, Florida Statutes, to providers of emergency services would be no different. In sum, the courts have extended sovereign immunity on numerous occasions to governmental and quasi-governmental entities. There appears to be a rational basis to extend the protections of section 768.28, Florida Statutes, to those who have the burden of implementing critical state objectives.

[996] Section 395.1041(1), Florida Statutes.
[997] Section 401.45, Florida Statutes.

Information Presented to the Task Force

At the November 22, 2002, meeting of the Task Force, Mr. George Meros, on behalf of the Florida College of Emergency Physicians, presented the need and rationale for providing limited sovereign immunity to physicians providing services in any state-licensed emergency room.[998] Mr. Meros stated that "emergency care personnel, which includes emergency physicians, . . . hospitals, on-call physicians and others attending emergencies pursuant to the state mandate in chapters 395 and 401, have the burdens of implementing state policy without the benefit of all others who act as arms of the state in implementing state policy."[999] As an example, Mr. Meros discussed the situation where county or state health personnel worked alongside private doctors in addressing a medical emergency such as Anthrax or a hurricane. The medical staffs employed by the state or local governments would have the benefit of sovereign immunity while the private doctors would be subject to full personal liability.[1000] Mr. Meros argued that an extension of sovereign immunity to emergency room physicians would be constitutional, and would not be subject to the Kluger test, because the plaintiff's cause of action is not abolished but the defendant is changed from the healthcare provider to the state.[1001] This is the same position excepted by the court in White.[1002] In the summary of testimony provided to the Task Force, the emergency physicians also stated, "Florida courts have held that the extension of 'sovereign immunity' to persons pursuing state objectives is constitutional."[1003] Further, he stated damages were not capped because the claims bill process would be available to the plaintiff.[1004]

In information provided to the Task Force, Mr. Meros has set forth the following benefits to the public and Florida's emergency care system that could be expected:

- Encouraging specialists to maintain hospital privileges or to provide needed services in a hospital environment, thus making such services available for emergency department patients.[1005]

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[998] George Meros, transcript, Nov. 22, 2002, pgs. 209-211.
[999] Id. at 209.
[1000] Id. at 209-210.
[1001] Id. at 211.
[1002] White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 2d DCA 1983).
[1003] Summary of Testimony of the Florida College of Emergency Physicians Before the Select Task Force on Healthcare Professional Liability Insurance (Nov. 22, 2002), citing White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 2d DCA 1983) and Campbell v. City of Coral Springs, 538 So. 2d 1373 (Fla. 4th DCA 1989).
[1004] Id.
[1005] Id.

- Enhancing recruitment of physicians to hospitals in Florida, thereby enhancing the availability of such emergency and specialist physicians to serve in Florida's emergency departments.[1006]

- Enabling smoother operation of Florida's EMS system through availability and stabilization of emergency physicians and specialists available to hospital emergency departments.[1007]

- Enhancing the trauma system by encouraging physicians who serve at trauma centers to remain available to the system and by encouraging other physicians to agree to serve at trauma centers.[1008]

- Reducing wait-time for patients needing emergency or specialist physician care through improving the availability of physicians at hospitals. Such improved availability of physicians will also reduce the number of medically-necessary transfers between hospitals and will reduce diversion of ambulances due to lack of specialty availability. The increased availability of prompt medical care will benefit patient care.[1009]

- Ensuring that our first responders (i.e., emergency medicine professionals in and out of the hospital setting) are available in the event of a weapons-of-mass-destruction event.[1010]

Mr. Joel Perwin presented the task force with his reasons why sovereign immunity should not be extended to emergency room physicians or other emergency room healthcare providers.[1011] Mr. Perwin stated that extending the provisions of section 768.28, Florida Statutes, to emergency room physicians created a cap that would be unconstitutional under the case of Smith v. Department of Insurance.[1012] The Smith case found $250,000 caps on non-economic damages in medical malpractice unconstitutional unless the Kluger test, which only allowed a preexisting right of access to the courts to be eliminated when the Legislature can show an overpowering public necessity for the abolishment of such right, and can show no alternative method of meeting such public necessity.[1013] Mr. Perwin stated that for sovereign immunity to apply "either you're an

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[1006] Id.
[1007] Id.
[1008] Id.
[1009] Id.
[1010] George Meros, Florida College of Emergency Physicians, Protecting Access to Emergency Care 7-8 (Dec. 27, 2002).
[1011] Joel Perwin, transcript, Nov. 22, 2002, pgs. 211-217.
[1012] Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), reh'g denied.
[1013] Kluger v. White, 281 So. 2d 1 (Fla. 1973).

employee of the state in which case you're protected, or an agency, or you are subject to the control of the state in performing a public function."[1014]

Findings and Recommendation

The Task Force finds that to further the public purpose of providing emergency healthcare to citizens and visitors to Florida, healthcare professionals providing services in emergency rooms or trauma centers should be defined as agents of the state.

Recommendation 1. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

[1014] Joel Perwin, transcript, Nov. 22, 2002, pg. 212.

Periodic Payment of Damages

Issue

The Task Force voted at its December 20, 2002, meeting by a 4-1 vote, to examine the following issue with respect to periodic payment of damage awards in the context of medical malpractice cases:

- Should the provisions of section 768.78(2) Florida Statutes, and other Florida laws be amended to require the periodic payment of economic and non-economic damages?

Current Situation

The definition of periodic payments for purposes of medical malpractice claims is set out in section 766.202, Florida Statutes. The section authorizes the payment of an award of future economic damages through structured payments over a period of time. The statute is specifically limited to "future economic damages" and does not address non-economic damages in any manner. The total amount of the payments made through the use of periodic payments must equal the amount of the judgment for future economic damages before it is reduced to present value but after collateral sources are deducted. The order or other agreement related to periodic payments must specify who is to receive the payments, the dollar amount of each periodic payment, the interval between payments, and the number of payments or the period of time over which payments must be made.[1015]

For the court to approve periodic payment of future economic damages, the defendant must post a bond or security or must otherwise assure full payment of the damage awards. The bond must be written by a company authorized to do business in Florida and must be from a company rated as an A+ by Best's. When all periodic payments have been made, the amount of the security remaining may be returned to the defendant. The company issuing the bond may not cancel the bond prior to the completion of all payments without 60 days notice to the court and to the claimant.

In implementing the provisions of this statute, the courts have examined whether limitations are placed on the fact finder when establishing the payment schedule and whether the defendant remains liable for the

[1015] Section 766.292(8)(c), Florida Statutes.

payments to the plaintiff when an annuity is purchased to make the future payments. In St. Mary's Hospital, Inc. v. Phillipe,[1016] the district court of appeals held that, based on the provisions of the statute authorizing periodic payments and rules applicable to the arbitration process, the arbitrator (fact finder) had discretion to establish the appropriate period for payment of the economic damages [1017]

In Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey,[1018] the court examined whether the defendant could purchase an annuity to cover future payments and have a final judgment entered and no further obligation to the plaintiff. The defendants argued that when the defendant purchased an annuity with an annuitant qualifying under the statute, that the plaintiff could be required to accept that annuity as discharging the obligation of the defendant and the defendant would be relieved of any further liability for damages.[1019] The court determined there was no expression in the law of the Legislature's intent to relieve the defendant of a future obligation to the plaintiff and had the Legislature wanted such a result, it could have written the law to provide for the relief requested.[1020] Research does not reveal any court that has taken a contrary position to the First District Court of Appeal.

The use of periodic payment of damages varies across states. Ten states have some form of mandatory periodic payment of all damages or just future damages with various thresholds for implementing the provision. Five states mandate periodic payment of some or all of the claimant's economic damages. Thirteen states provide a party may request periodic payment of some or all of the damages or provide for damages to be paid periodically at the discretion of the court.[1021]

For those states including a periodic payment of damages provision, the specifics vary greatly from state to state. In Arkansas,[1022] Delaware,[1023] and Colorado,[1024] some or all of the future payments are terminated at the death of the plaintiff. In California, at the death of the plaintiff, the future payments must be continued only to those to whom the plaintiff owed a duty of care.[1025] The amount of the judgment that triggers periodic

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[1016] 699 So. 2d 1017 (Fla. 1st DCA 1997), reh'g denied (Oct. 22, 1997).
[1017] Id. at 1025
[1018] 655 So. 2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995), review denied, 622 So. 2d 344 (Fla. 1995).
[1019] Id. at 1197
[1020] Id. at 1198.
[1021] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1022] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1023] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1024] Section 13-64-306, Colorado Revised Statutes Annotated (West).
[1025] See National Conference of State Legislatures, State Medical Liability Laws Table.

payments can be a judgment of any amount qualifying for periodic payments, to a requirement that the judgment exceed $500,000.[1026]

The method of securing the periodic payments also varies among the states. Some states, such as Florida, require the defendant to remain liable for the periodic payments until the obligation is paid in full.[1027] In other states, such as Colorado, the defendant can be discharged upon complying with requirements to secure funding of the periodic payments through an annuity.[1028] By providing for an annuity, the determination of the present value of an award is shifted from the jury to the market.[1029]

Information Presented to the Task Force

Two speakers presented arguments regarding whether the periodic payment provisions should be expanded to include future non-economic damages. Mr. William Fuller presented the proposal on behalf of the defense bar[1030] and Mr. Neal Roth argued on behalf of the Florida Trial Lawyers Association and plaintiffs.[1031]

Mr. Fuller argued that there should not be a distinction between future economic and future non-economic damages for purposes of allowing periodic payments. He argued that both compensate the plaintiff for damages in the future and should be treated the same. Mr. Fuller raised concerns and made recommendations from the defense bar regarding the current system of periodic payments for economic damages:

- The plaintiff may live longer than the number of years determined by the jury to be used in awarding periodic damages and may not have sufficient funds.[1032]
- Mr. Fuller recommended this be addressed by having the court determine the life expectancy of the plaintiff and an annuity be purchased to provide payment to the plaintiff for future non-economic and economic damages for as long as the plaintiff lives.[1033] When an annuity was purchased by the defendant and approved by the court, the defendant would be discharged from the case and no additional bond would be required.[1034]

[1026] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1027] Section 766.202, Florida Statutes; Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey, 655 So. 2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995).
[1028] Section 13-64-312, Colorado Revised Statutes Annotated (West).
[1029] Patricia M. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 165 (1985).
[1030] William Fuller, J.D., testimony, Dec. 3, 2002, pgs. 28-35.
[1031] Neal Roth, J.D., testimony, Dec. 3, 2002, pgs. 38-43.
[1032] William Fuller, J.D., testimony, Dec. 3, 2002, pg. 29.
[1033] Id. at 30-34.
[1034] Id.

- The plaintiff may die before the term of the periodic damages for medical care and pain and suffering expires, giving the estate a windfall for damages that were not incurred.[1035]
- With payment of periodic damages, the case remains open until the end of the term of the periodic payments or the plaintiff dies and a lump sum payment is made to the estate.[1036]

Mr. Roth did not support periodic payment of non-economic damages. He argued the plaintiff has a right to the money once the judgment is entered and it should be the plaintiff's decision as to whether the money is expended immediately or invested in an annuity or some other investment providing periodic payments. Mr. Roth also questioned how this proposal would further the Task Force goals of reducing insurance rates or providing better access to healthcare. He argued that non-economic damages "are supposed to make an injured medical malpractice victim whole, restore some dignity to their lives, allow them to do some things perhaps that either they can't do because of their disability, disfigurement, inability to lead a normal life, and it really should be up to the injured victim as to what they do, when they do it, how much money they care to spend."[1037] Mr. Roth argued that providing for periodic payment of non-economic damages would be "telling the injured victim what to do with their money by legislative fiat, and they should have the right to make those decisions themselves and for their families."[1038]

Mr. Marshall Criser questioned why a plaintiff should not be protected from bad advice or bad counsel by providing for periodic payment of all damages.[1039] Mr. Roth disagreed and reiterated his belief that the plaintiff should have the right to make the decision on how to spend non-economic damages since the economic damages were protected through periodic payments.[1040]

Findings and Recommendations

The Task Force finds that there is no basic distinction between payments for future economic damages and future non-economic damages. Both awards are intended to compensate the victim for damages that have not accrued as of the date the judgment is entered and are based on the jury's determination of what those future injuries will be. There does not appear to be any policy reason for distinguishing between these two types of future damages for purposes of periodic payments. Further, the use of

[1035] Id. at 29.
[1036] Id.
[1037] Neal Roth, J.D., testimony, Dec. 3, 2002, pg. 40.
[1038] Id. at 41.
[1039] Marshall Criser, J.D., testimony, Dec. 3, 2002, pgs. 41-42.
[1040] Neal Roth, J.D., testimony, Dec. 3, 2002, pg. 42.

periodic payment of damages for the payment of future non-economic damages may reduce the impact of large non-economic damages on the current assets of an insurance company. When the defendant insurance company makes the future payments it mitigates the impact of large verdicts by smoothing the cash needed to cover those verdicts over the years of the periodic payments.

The Task Force finds that termination of periodic payments of future damages related to medical expenditures and future pain and suffering upon the death of the defendant is appropriate.

Recommendation 1. The Legislature should amend the Florida Statutes to allow the periodic payment of future non-economic damages.

Recommendation 2. The Legislature should amend the Florida Statutes to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Pre-Suit Reform

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issue with respect to pre-suit reform in the context of medical malpractice cases:

- Should the pre-suit screening process be strengthened to:
    - Improve the quality of information exchanged?
    - Require that the qualifications of the physician providing the affidavit more closely equate with the qualifications of the defendant physician?
    - Require the physician to review all the medical records to the extent available prior to providing an affidavit and to certify that the records have been reviewed?
    - Require an attorney to sign all doctor affidavits prepared for the defendant and the patient?

Current Situation

In 1975, an intensive lobbying effort commenced addressing the medical malpractice crisis that had emerged due to the spiraling increases in insurance premiums, and which threatened to curtail the availability of healthcare services.[1041] The Legislature, in response to this crisis, created the Florida Comprehensive Medical Malpractice Act in 1975, which changed the procedural and substantive aspects of medical malpractice claims.[1042] One significant modification was the requirement that claimants submit their claims to an appropriate medical liability mediation panel before filing a cause of action in court.[1043] This requirement was challenged almost immediately, and in Carter v. Sparkman,[1044] the Florida Supreme Court determined that the mediation panel was not unconstitutionally violative of a plaintiff's rights.[1045] However, in 1980,

[1041] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 553 (Spring 1996).
[1042] Id. at 553-554.
[1043] Id. at 554.
[1044] 335 So. 2d 802 (Fla. 1976).
[1045] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 555 (Spring 1996).

in Aldana v. Holub,[1046] the Florida Supreme Court revisited the issue of mediation panels and overturned the Carter ruling, declaring the statute unconstitutional. The Court found "that the application of the statute and its rigid 'jurisdictional periods . . . [h]as proven intrinsically unfair and arbitrary and capricious,'" under the United States and Florida Constitutions.[1047]

In 1985, amendments to the act substituted mediation panels with a pre-suit screening process.[1048] This pre-suit screening process was created to require both the claimant and the defendant, prior to filing a claim or denying liability, to ensure that the potential suit was not a frivolous action.[1049] Specifically, the Legislature required claimants to certify in their complaints that they had conducted a reasonable investigation resulting in a good faith belief that sufficient grounds existed to support the filing of the action.[1050]

In 1988, the Legislature expanded the pre-suit screening statute in response to criticism that the statutory requirements were not alleviating the medical malpractice litigation crisis.[1051] Amendments were necessary to address the Legislature's conclusion that the "high cost of medical malpractice claims in the state can be substantially alleviated by requiring early determination of the merit of claims . . . thereby reducing delay and attorney's fees . . . while preserving the right of either party to have its case heard by a jury."[1052] Sections 766.201 through 766.206, Florida Statutes, enacted in chapter 88-1, Laws of Florida, established criteria to conduct pre-suit investigations of medical negligence claims and defenses of prospective defendants. Chapter 88-277, section 48, Laws of Florida, creating section 766.106, Florida Statutes,[1053] provides that a prospective plaintiff alleging medical malpractice must wait ninety days before filing a lawsuit against any named defendants. And, during the ninety-day period, informal discovery, including obtaining un-sworn statements from parties and witnesses may occur.[1054] "Because these designations exist today side

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[1046] 381 So. 2d 231 (Fla. 1980).

[1047] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 556 (Spring 1996).

[1048] Id.

[1049] Id.; section 768.495(1), Florida Statutes (1985) ("[N]o action shall be filed for personal injury or wrongful death arising out of medical negligence...unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant").

[1050] Cohen v. Dauphinee, 739 So. 2d 68, 70 (Fla. 1999).

[1051] Id.

[1052] Section 766.201(1)(d), Florida Statutes.

[1053] Chapter 88-277, section 48, Laws of Florida (renumbered sections 768.57-776.106, Florida Statutes); see also Cohen v. Dauphinee, 739 So. 2d 68, 71 (Fla. 1999).

[1054] Edward L. Holloran, III, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 Nova Law Review 333 (Fall 2001).

by side, it is apparent that the Legislature intended to distinguish between pre-suit screening, covering the period up to the serving of the notice of intent, and pre-suit investigation, covering the period between the serving of the notice of intent and the filing of the suit."[1055]

Since 1988, the pre-suit statutes have not been significantly modified. In 1996, the Florida Supreme Court observed: "[W]e agree with the proposition that the medical malpractice statutory scheme must be interpreted liberally so as not to unduly restrict a Florida citizen's constitutionally guaranteed access to the courts, while at the same time carrying out the legislative policy of screening out frivolous lawsuits and defenses.[1056] The Court in Cohen v. Dauphinee[1057] reaffirmed that the Legislature enacted the pre-suit process to "promote the settlement of meritorious claims at an early stage without the necessity of a full adversarial proceeding."

The purpose for having a pre-suit statute is to reduce the overall number of lawsuits either by preventing the filing of frivolous claims or by providing opportunities to settle meritorious cases.[1058] In adopting chapter 766, Florida Statutes, the Legislature attempted to abate the medical malpractice crisis by requiring pre-suit screenings and investigations.

The notice of intent to initiate litigation is a condition precedent to filing a suit. The medical malpractice claimant must first conduct a "reasonable investigation" to determine there are grounds for a good faith belief that there has been malpractice.[1059] This burden to investigate is set forth in section 766.203(2), Florida Statutes, which specifically requires that prior to taking any actions, the claimant and his or her attorney shall conduct an investigation into the reasonable grounds to believe that negligence and resulting injury have occurred.[1060] This investigation must be supported by a verified written expert opinion that shall "corroborate reasonable grounds to support the claim of medical negligence."[1061]

When the claimant's investigation is complete, and the corroborating affidavit is done, section 766.106(2), Florida Statutes, requires the claimant to serve all potential defendants with a notice of intent to initiate litigation.[1062] In Duffy v. Brooker,[1063] the court stated that "[T]he notice

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[1055] Cohen v. Dauphinee, 739 So. 2d 68, 71 (Fla. 1999).
[1056] Kukral v. Mekras, 679 So. 2d 278, 284 (Fla. 1996).
[1057] 739 So. 2d. 68, 70 (Fla. 1999).
[1058] Edward L. Holloran, III, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 Nova Law Review 334 (Fall 2001).
[1059] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 13-14 (Feb. 1994).
[1060] Id. at 14.
[1061] Id.
[1062] Id.

of intent to initiate litigation and the corroborating medical expert opinion, taken together, must sufficiently indicate the manner in which the defendant doctor allegedly deviated from the standard of care, and must provide adequate information for the defendants to evaluate the merits of the claim."[1064]

The defendant, upon the mailing of the notice of intent to litigate, has ninety days to investigate the claim and provide an appropriate response.[1065] Section 766.106(3)(a), Florida Statutes, applies a good faith standard to the defendant to investigate and respond to the claim.[1066] The defendant[1067] is required, pursuant to the statute, to initially undertake a review of the notice and comply with one or more of the four procedures set forth: (1) an internal review by a duly qualified claims adjuster; (2) creation of a panel comprised of an attorney, a healthcare provider, and a duly qualified claims adjuster; (3) a contractual agreement with a state or local professional society which maintains a peer review committee; and/or, (4) any other similar procedure which fairly and promptly evaluates a pending claim.[1068] This review mechanism is only part of the investigation process and is by no means sufficient to satisfy the investigation requirements of chapter 766, Florida Statutes.[1069]

Section 766.106(7), Florida Statutes, provides for a number of informal discovery options available during the ninety-day investigation period, which have sanctions for failure to comply.[1070] For example, the defendant may take un-sworn statements from experts or witnesses that are not discoverable or admissible in any proceeding, propound interrogatories and requests to produce documents, and require the claimant to undergo physical and mental examination.[1071] Failure by the claimant to comply could result in dismissal of the action or waive the requirement of a corroborating medical opinion for the opposing party.[1072]

[1063] 614 So. 2d 539 (Fla. 1st DCA 1993).
[1064] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 14 (Feb. 1994).
[1065] Id.
[1066] Id.
[1067] The statute contemplates that the defendant's insurer or a self-insurer will comply with the pre-suit process.
[1068] Section 766.106(3)(a)1-4, Florida Statutes.
[1069] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 14 (Feb. 1994).
[1070] Section 766.205, Florida Statutes provides grounds for dismissal of an applicable claim or defense asserted in those circumstances where reasonable access to information has not been provided to another party.
[1071] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 15 (Feb. 1994).
[1072] See also section 766.205(3), Florida Statutes.

At or before the conclusion of the ninety-day period, the defendant has four alternatives in response to the complaint. Section 766.106 (3)(b), Florida Statutes, provides that the defendant shall reject the claim; make a settlement offer; make an offer of admission of liability and arbitrate; or do nothing which shall be considered a final rejection of the claim.[1073] Four identified areas of concern have evolved with the creation of the pre-suit process.

Initially, the pre-suit investigations were very informal. Some commentators have indicated that the informal exchange of information does not work because after sharing expert affidavits, un-sworn statements and other discovery tools as set forth in the statutes, none of this information is discoverable or admissible at future proceedings. Time and money is spent pre-filing discovery without yielding any resolution or potential for resolution. In essence, the parties to the lawsuit undergo two discoveries if the matter goes to litigation.[1074]

Second, as a consequence of the pre-suit investigation, the parties will add an additional eight months to the case because the statute of limitation is tolled during this period.[1075]

Third, the statute as written has failed to provide reliability and has failed to satisfy the intent of the pre-suit investigative process. The statute does not require any expert witness to certify that all the medical records have been reviewed prior to rendering an opinion. Moreover, the statute does not obligate an attorney representing the claimant or defendant to sign the doctor affidavits to verify compliance with the statutes. And, section 766.202(5), Florida Statutes, defines the expert witness merely to be "a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree . . ." thus not requiring that similarly-situated experts are reviewing and rendering decisions about the claim.[1076] A family general practitioner could give a medical expert opinion about a surgical care event, merely because he or she holds a healthcare professional degree.

Finally, the purpose of the pre-suit investigation was to review potential claims, to verify evidence, presented and to provide an opportunity to settle or pursue litigation. What has occurred, however, is that routinely a claimant has two years (the time period for the statute of limitations) to

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[1073] Sections 766.106(3)(b)3, 766.106(3)(c), Florida Statutes.

[1074] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 558 (Spring 1996).

[1075] Section 766.104, Florida Statutes.

[1076] Section 766.202(5), Florida Statutes.

prepare the pre-suit investigation while the defendant has only ninety days to investigate and respond.[1077]

Information Presented to the Task Force

The stakeholders that testified concurred that strengthening the pre-suit process would improve the quality of the information exchanged. Testimony from the Task Force's November 22, 2002 meeting in Orlando, Florida, concluded that the current pre-suit process was not useful, but could be beneficial with suggested improvements for the early resolution of these type of cases.

First, the expert affidavits that are filed by both the claimant and defendant in the pre-suit process need to be more specific. The intent of the claimant's affidavit is to attest to the fact that there are reasonable grounds to bring a malpractice action against the defendant.[1078] While the content of most affidavits is not very detailed, is very conclusory and does not tell specifically what malpractice event occurred, it is clear that a more detailed affidavit, that sets forth the specifics of the malpractice event would address some of the problems that occur.[1079] Generally, the affidavit is a bare bones document that does not tell anything in terms of what the physician or hospital did that was inappropriate or what the care was that brought about the harm.[1080]

Second, the expert affidavit should be filed by an expert whom the plaintiff is "actually going to use at trial."[1081] During the pre-suit process, the plaintiff can use an affidavit of "somebody . . . they pay a few hundred dollars to" and "you hardly ever see that particular expert witness when it comes to testifying before a jury."[1082] And, that expert, even if used at trial, cannot be cross-examined or impeached with the affidavit that they prepared during the pre-suit process.[1083] Therefore, the proposal is to make the expert "real" by allowing him or her to be called as a witness at trial, which would force the claimants to make a decision about the merits of the case at an earlier stage.[1084]

However, an opposing position suggested that the quality of the expert affidavit may not be the real issue. At the time of the pre-suit evaluation,

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[1077] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 18 (Feb. 1994).
[1078] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 318.
[1079] Id. at 318-319.
[1080] Id. at 319.
[1081] Id. at 320.
[1082] Id.
[1083] Id.
[1084] Id. at 321.

all the facts of the case may not be known to the expert. Generally, it was agreed that the parties want credible experts. However, it was believed that "a credible expert is not going to give you a final opinion under oath without all the facts." And, when a pre-suit affidavit is filed, all the facts are not available yet. "For example, we haven't taken the deposition of the defendant doctor to find out what his defense is going to be. My experts want to know that before they go under oath and say a doctor did something wrong."[1085]

Moreover, the ninety-day period "is simply not enough time for the defendants to figure out whether they have done something wrong. Sometimes you are limited by the medical records that you receive from the plaintiff attorneys. Sometimes he doesn't have all the medical records. You've got to get those medical records off to independent experts" and 90 days is not enough time.[1086] Concerns regarding the ninety-day period in which the parties are suppose to resolve the differences between them, in reality, does not resolve their differences,[1087] because what anecdotally happens is that settlement "almost always [occurs] on the courthouse steps."[1088] One offered proposal was to allow the defendant a minimum of six months from the date the lawsuit is filed to undergo their investigation.[1089]

The informal exchange of information does not bring forth the intended end result.[1090] Every pre-suit involves much work on both sides at a tremendous expense and the vast majority of the information is privileged and cannot be used.[1091] To the extent that there are other procedures that might be used to accomplish a similar result, the practical affect would be to either shore up the pre-suit procedures or investigate the use of alternative dispute options.[1092]

Findings and Recommendations

The Task Force finds the expert affidavits filed in pre-suit proceedings are not sufficient for the parties to make informed decisions regarding the claim.

[1085] Lake Lytal, J.D., testimony, Nov. 22, 2002, pg. 322.
[1086] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 321.
[1087] Id. at 319.
[1088] Lake Lytal, J.D., testimony, Nov. 22, 2002, pg. 324.
[1089] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 321.
[1090] Id. at 322.
[1091] Id.
[1092] Lake Lytal, J.D., testimony, Nov. 22, 2002, pgs. 326-327.

Further, the Task Force finds there is not sufficient incentive for the parties to provide the most complete expert affidavit when the expert completing the affidavit is generally not called as a witness at trial and, even if called at trial, may not be cross-examined regarding the pre-suit affidavit.

The Task Force has reviewed the pre-suit procedures set forth in sections 766.106 and 766.201-206, Florida Statutes, for the purpose of determining what modifications, if any, are needed to improve the quality of information exchanged.

Recommendation 1. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar, if not identical, credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 2. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to joint and several liability in the context of medical malpractice cases:

- Should the Fabre[1093] decision be legislatively overturned?

- Should awards in medical malpractice suits be based solely on proportion of fault and not on Florida's structured joint and several liability provisions in section 768.81, Florida Statutes?

Current Situation

Florida is a state that equates fault with liability.[1094] Common sense[1095] dictates that tortfeasors are liable only to the extent of their fault.[1096] Such a conclusion has taken a long time to articulate[1097] and is still incomplete.[1098]

Florida is a state that recognizes the comparative fault of those tortfeasors who caused an injury,[1099] including the plaintiff himself or herself.[1100] Before 1973, Florida adhered to the rule of contributory negligence, which, when present, completely barred relief for a plaintiff found to be

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[1093] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).
[1094] See Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).
[1095] It is a "common sense notion" that liability should be equated with fault and that a defendant should not have to pay more than his fair share of the liability." Chanta G. Hundley & George N. Meros, Jr., Florida's Tort Reform Act: Keeping Faith with the Promise of Hoffman v. Jones, 27 Florida State University Law Review 461 (Winter 2000).
[1096] "The rule of contributory negligence as a complete bar to recovery was imported into the law by judges. Whatever may have been the historical justification for it, today it is almost universally regarded as unjust and inequitable to vest an entire accidental loss on one of the parties whose negligent conduct combined with the negligence of the other party to produce the loss." Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).
[1097] See Lousiville & Nashville Railroad Co. v. Yniestra, 21 Fla. 700 (1886); see also Smith v. Department of Insurance 507 So. 2d 1080 (Fla. 1987) (tracing the history of contributory and comparative negligence).
[1098] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.
[1099] See Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).
[1100] See Id.

partly responsible for causing the accident. [1101] By way of contrast, the comparative fault theory is that a plaintiff is only prevented from recovering that portion of the damages that is equal to his or her share of responsibility for the injury.[1102]

Once the amount of fault of the defendant tortfeasors is established, the exercise becomes one of allocating the liability for the damages among the tortfeasors. Florida has a hybrid system of allocating the liability.[1103] The doctrine of joint and several liability has been a part of that system since at least 1914.[1104] Under joint and several liability, all defendant tortfeasors are responsible for the total of the plaintiff's damages, without respect to the extent of each defendant's fault in causing the harm.[1105] For example, in 1987, the Supreme Court of Florida heard a case in which the plaintiff sustained injuries following a bumper car collision at Walt Disney World.[1106] The plaintiff was found to be 14 percent at fault, the other bumper car driver, 85 percent at fault and Disney 1 percent at fault.[1107] Because of joint and several liability, the court entered judgment against Disney for 86 percent of the damages, while Disney was only 1 percent at fault.[1108]

In 1986, the Florida Legislature enacted several changes to the joint and several liability doctrine as part of the Tort Reform and Insurance Act of 1986.[1109] The changes included the following:

- Abolished joint and several liability for non-economic[1110] damages over $25,000.

- Abolished joint and several liability for economic[1111] damages except when a defendant's fault equals or exceeds that of the plaintiff.

[1101] Id.

[1102] Id. "[T]he jury should apportion the negligence of the plaintiff and the negligence of the defendant; then, in reaching the amount due the plaintiff, the jury should give the plaintiff only such an amount proportioned with his negligence and the negligence of the defendant." Id. at 438.

[1103] Walt Disney World Co. v. Wood, 515 So. 2d 198, 201 (Fla. 1987).

[1104] Louisville & Nashville R.R. v. Allen, 67 Fla. 257, 65 So. 8 (1914).

[1105] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).

[1106] Walt Disney World Co. v. Wood, 515 So. 2d 198 (Fla. 1987).

[1107] Id. at 199.

[1108] Id.

[1109] See chapter 86-160, section 60, Laws of Florida (codified at section 768.81(3), Florida Statutes). In enacting these provisions, the Florida Legislature found that "there is in Florida a financial crisis in the liability insurance industry" and "that the current tort system has significantly contributed to the insurance availability and affordability crisis." Fabre v. Marin, 623 So. 2d 1182, 1185 (Fla. 1993) (quoting chapter 86-160, Laws of Florida).

[1110] See Issue on Caps for Non-Economic Damages, infra, for definitions of economic and non-economic damages.

[1111] Id.

Following these legislative changes was the Supreme Court of Florida's decision in the Fabre case, which held that, in determining non-economic damages, fault is apportioned among all the responsible entities who contribute to an accident, whether or not they are officially joined as defendants in the lawsuit.[1112]

In 1999, the Florida Legislature further limited joint and several liability by creating a series of damages caps and fault thresholds.[1113] The doctrine of joint and several liability to a particular defendant whose fault equals or exceeds that of a particular plaintiff is determined as follows:

- A defendant whose fault is up to 10 percent is not subject to joint and several liability.[1114]

- With a defendant whose fault is between 10 and 25 percent, there is no joint and several liability for economic damages over $200,000[1115] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $500,000.[1116]

- With a defendant whose fault is between 25 and 50 percent, there is no joint and several liability for economic damages over $500,000[1117] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $1,000,000.[1118]

- With a defendant whose fault is over 50 percent, there is no joint and several liability for economic damages over $1,000,000[1119] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $2,000,000.[1120]

The legislative changes in 1999 also codified the Supreme Court's holding in Fabre.[1121] Accordingly, section 768.81, Florida Statutes, now contains a procedure[1122] and burden of proof[1123] for requesting that a nonparty tortfeasor be placed on the jury verdict form for purposes of allocating

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[1112] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993); Nash v. Wells Fargo Guard Services, Inc., 678 So. 2d 1262 (Fla. 1996).
[1113] Chapter 99-225, section 27, Laws of Florida (codified at section 768.81, Florida Statutes).
[1114] Sections 768.81(3)(a)(1), (3)(b)(1), Florida Statutes.
[1115] Section 768.81(3)(a)(2), Florida Statutes.
[1116] Section 768.81(3)(b)(2), Florida Statutes.
[1117] Section 768.81(3)(a)(3), Florida Statutes.
[1118] Section 768.81(3)(b)(3), Florida Statutes.
[1119] Section 768.81(3)(a)(4), Florida Statutes.
[1120] Section 768.81(3)(b)(4), Florida Statutes.
[1121] Chapter 99-225, section 27, Laws of Florida.
[1122] Section 768.81(3)(d), Florida Statutes.
[1123] Section 768.81(3)(e), Florida Statutes.

fault among the totality of those who caused the injury, whether party defendants or not.

Based on these most recent legislative changes, a defendant can no longer be held jointly liable for a plaintiff's non-economic damages. Joint and several liability still exists under certain circumstances for economic damages, as outlined above. However, a defendant who is less than 10 percent at fault cannot be held jointly and severally liable for all the damages. Finally, there is no longer joint and several liability against a defendant who is found to be less at fault than the plaintiff.

The seminal case for the issue of whether a party pays its fair share is the Fabre case itself.[1124] In the Fabre case, the plaintiff, Mrs. Marin, was injured in an accident as a passenger in a car that was driven by her husband.[1125] Mrs. Marin sued the Fabres, claiming that their negligent driving caused the accident in which she was injured. During discovery, Mrs. Marin learned that the Fabres' insurance had liability limits of $10,000.[1126] Accordingly, she then also sued State Farm, her uninsured motorist carrier, as a defendant.[1127]

When the case was presented to the jury, the defendants requested that the verdict form be drafted so as to allow the jury to apportion fault for the accident between Mr. Marin, the driver but an unnamed defendant, and Mrs. Fabre. The court denied the request. But Mrs. Marin agreed to have the issue of Mr. Marin's negligence submitted to the jury subject to a posttrial determination of whether any affirmative finding on that issue would result in a reduction of her recovery. The jury returned a verdict finding Mrs. Fabre and Mr. Marin each 50 percent at fault and awarded Mrs. Marin $12,750 in economic damages and $350,000 in non-economic damages. The judge reduced the economic damages by $5000 but refused to reduce the non-economic damages.[1128]

The issue before the Supreme Court was "whether the liability for non-economic damages should be apportioned to the Fabres on the basis of the percentage of fault attributed to them."[1129] The court answered this question affirmatively. In analyzing this issue, the Supreme Court examined the 1988 version of section 768.81(3), Florida Statutes, which stated as follows:

[1124] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).
[1125] Id. at 1183.
[1126] Id.
[1127] Id. At the time of this lawsuit, Florida did not allow interspousal claims so Mrs. Marin could not also sue Mr. Marin as the driver of the car.
[1128] Id.
[1129] Id.

> (3) APPORTIONMENT OF DAMAGES – In cases to which this section applies, the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability; provided that with respect to any party whose percentage of fault equals or exceeds that of a particular claimant, the court shall enter judgment with respect to economic damages against that party on the basis of the doctrine of joint and several liability.[1130]

In construing this statutory language, the Third District Court of Appeal, the lower appellate court in Fabre, concluded that Mrs. Marin could not recover damages from her husband because of the doctrine of inter-spousal tort immunity.[1131] Accordingly, the Third District Court concluded that in discarding joint and several liability in section 768.81, Florida Statutes, the Florida Legislature did not intend to thwart a fault-free plaintiff's ability to recover her total damages.[1132] Rather, according to the Third District, the Legislature intended only to apportion liability among the tortfeasors who were defendants in the lawsuit.[1133]

Based on this case law history and the legislative intent[1134] of section 768.81, Florida Statutes, the Supreme Court in Fabre concluded that "[b]y [the] clear terms [of the statute] judgment should be entered against each party liable on the basis of that party's percentage of fault."[1135] The court reasoned that "[t]he 'fault' which gives rise to the accident is the 'whole' from which the fact-finder determines the party-defendant's percentage of liability. Clearly, the only means of determining a party's percentage of fault is to compare that party's percentage to all of the other entities who contributed to the accident, regardless of whether they have been or could have been joined as defendants."[1136] Furthermore, the court declared that "[l]iability is to be determined on the basis of the percentage of fault of each participant to the accident and not on the basis of solvency or amenability to suit of other potential defendants."[1137]

[1130] Section 768.81(3), Florida Statutes (Supp. 1988). The constitutionality of this statue was upheld by the Supreme Court. See Smith v. Department of Insurance, 507 So. 2d 1080, 1091 (Fla. 1987) (noting that the right of access to courts "does not include the right to recover for injuries beyond those caused by the particular defendant").

[1131] Fabre v. Marin, 623 So. 2d 1182, 1186 (Fla. 1993).

[1132] Id.

[1133] Id. at 1184.

[1134] The term "party" was not defined by the statute. At the time the Supreme Court decided the Fabre case, there were three judicial theories as to what was meant by "party." The term could refer to: 1) persons involved in the injury; 2) defendants in the lawsuit; or 3) all litigants in the lawsuit. See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).

[1135] Id.

[1136] Id.

[1137] Id. at 1186.

The result, then, in Fabre was that the court reduced Mrs. Marin's judgment by half of her non-economic damages. There was no reduction in the economic damages because under section 768.81(3), Florida Statutes (Supp. 1988), joint and several liability continued to apply when a defendant's fault equaled or exceeded that of the plaintiff.[1138]

Following the Fabre case, the Supreme Court in Nash v. Wells Fargo Guard Services. Inc.,[1139] outlined the pleading and proof requirements with which a defendant must comply to submit the issue of a nonparty's negligence to the jury.[1140] In order to include a nonparty on the verdict form under Fabre, the party defendant must plead, as an affirmative defense, the negligence of the nonparty and specifically identify the nonparty.[1141] The party defendant can move to amend the pleading to assert the negligence of a nonparty, subject to the requirements of Florida Rule of Civil Procedure 1.190. However, because the argument that non-economic damages should be apportioned against a nonparty affects both the presentation of the case and the trial court's rulings on evidence, notice before trial is necessary.[1142] In addition to these pleadings requirements, the party defendant also has the burden of proving that the nonparty's fault contributed to the injury in order to include the nonparty's name on the jury verdict form.[1143]

The rule adopted by the Supreme Court in Fabre is premised on an application of the comparative fault statute of section 768.81, Florida Statutes. If this statute does not apply, then Fabre does not apply. Accordingly, Fabre does not apply to actions in which the doctrine of joint and several liability applies.[1144]

Information Presented to the Task Force

The problem, as presented to the Task Force, is with deep pocket defendants, like hospitals or physicians with significant amounts of insurance coverage who are minimally liable for the harm to the plaintiff. An example might be if a plaintiff with significant long-term care issues sues the doctor, nurse, and the hospital. The hospital is often the least liable (assume 1 percent) but provides the deepest pocket for the payment of damages. Under the current state of the law, the hospital is still jointly

[1138] Id. at 1187.
[1139] Nash v. Wells Fargo Guard Services. Inc., 678 So. 2d 1262 (Fla. 1996).
[1140] See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).
[1141] Nash v. Wells Fargo Guard Services, Inc., 678 So. 2d 1262, 1264.
[1142] Id.
[1143] Id.
[1144] See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).

and severally liable for all the economic damages to the plaintiff.[1145] Those damages can, in a long-term care situation, amount to $15,000,000. The hospital, while only 1 percent responsible for the injury is jointly liable for $15,000,000.[1146] The recommended solution is to repeal joint and several liability for economic and non-economic damages for all medical malpractice suits.

The Task Force heard testimony in response to the claim that joint liability has been sufficiently limited in Florida.[1147] It also heard testimony regarding the claim that tort law favors a plaintiff receiving compensation for the injury caused, so that in the event one of the defendants is insolvent the plaintiff should be able to collect the entire amount of damages from a solvent defendant.[1148]

Findings and Recommendations

The Task Force finds that there is a problem with joint liability in the State of Florida and that modern times and fundamental fairness dictate the apportionment of fault among all parties who caused the harm to the plaintiff for both economic and non-economic damages. The fact that one defendant may be insolvent or for other reasons immune from payment of damages should not shift the burden to another defendant to fund the total amount of damages, beyond the degree of fault for that defendant.

Recommendation 1. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

[1145] This is the law pre-1999 passage of chapter 99-225, Laws of Florida.

[1146] See Gail Parenti, testimony, Nov. 22, 2002, pgs. 267-68.

[1147] See Joel Perwin, testimony, Nov. 22, 2002, pg. 276.

[1148] Fabre v. Marin, 623 So. 2d 1182, 1186 (Fla. 1993).

Set Off of Settlement Proceeds

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to set off of settlement proceeds in the context of medical malpractice cases:

- Should the collateral source rule be re-examined to ensure that payments received by the plaintiff that are not required to be repaid from a settlement or judgment are deducted from the award or are considered by the jury?

Current Situation

Under certain conditions, money received by a plaintiff under a settlement agreement with another defendant may be set off from the total damages awarded by a jury. The purpose of these set off laws is to prevent the plaintiff from receiving a windfall by recovering damages in excess of those awarded by the jury. However, these statutes predate Florida's partial abrogation of joint liability. Current case law interpreting these statutes forbids the setting off of the settlement dollars to non-economic damages in any tort action.

Florida law provides that settlement proceeds received by a plaintiff may, in certain circumstances, be credited toward or "set off" from the total damages awarded by a jury at trial.[1149] However, such set off allowances only apply to economic damages in a tort action, including a medical malpractice case; they do not apply to non-economic damages.[1150]

Florida's jurisprudence contains two cases that directly impact the issue of set offs. The first was decided by the Supreme Court in 1995.[1151] In Wells v. Tallahassee Memorial Regional Medical Center, Mrs. Wells sued TMRMC, Dr. Alford, and Anesthesiology Associates and its employees Raymond Johns and Dr. Sell, for the wrongful death of her husband.[1152] Before trial, Mrs. Wells settled with Dr. Alford for $250,000, $50,000 of

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[1149] See sections 46.015(2), 768.041(2), 768.31(5), Florida Statutes.
[1150] See Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249 (Fla. 1995); Gouty v. Schnepel, 795 So. 2d 959 (Fla. 2001).
[1151] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249 (Fla. 1995).
[1152] Id. at 250.

which were economic damages and $200,000 of which were non-economic damages. Mrs. Wells also settled with Anesthesiology Associates and its employees for $50,000, without apportionment between economic and non-economic damages. Accordingly, TMRMC was the sole defendant at trial.[1153]

The trial court instructed the jury to apportion fault, if any, among all the defendants, including those that had settled before trial. The jury returned the following verdict: TMRMC 90 percent at fault, Dr. Alford 5 percent at fault, and Anesthesiology Associates 5 percent at fault. The jury assessed the damages at $575,853: $202,853 in economic damages, and $371,000 in non-economic damages. The court awarded Mrs. Wells $508,467.70 in damages; 90 percent of $573,852, plus $9,000 in costs, less $17,000 social security benefits.[1154]

After the award was announced, TMRMC asked the court to reduce the judgment. TMRMC argued that the judgment should be reduced by $300,000. This was the total amount paid by the settling defendants to Mrs. Wells before trial. The court denied the request.[1155]

One question that was presented to the Supreme Court was whether a non-settling defendant, in a case tried under section 768.81(3), Florida Statutes, is entitled to a set off of his or her apportioned share of the damages based on amounts paid by settling defendants in excess of their apportioned liability as determined by the jury. The Supreme Court was also asked to determine whether the rule of set off applied equally to economic and non-economic damages.[1156]

Mrs. Wells argued to the court that with respect to non-economic damages, "the notion that each party is only responsible for his or her share of the damages dictates that payment by one tortfeasor should only extinguish that tortfeasor's liability and have no effect on another tortfeasor's liability."[1157] She further argued that the set off statutes[1158] apply only when there is common (i.e., joint) liability, like with economic damages.[1159] Therefore, Mrs. Wells argued, when a jury determined liability is a percentage of fault, section 768.81(3), Florida Statutes, the comparative fault statute, applied and there is no set off.[1160] In response, TMRMC argued that the purpose of set off is to "prevent duplicate or

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[1153] Id.
[1154] Id.
[1155] Id.
[1156] Id.
[1157] Id. at 251.
[1158] See sections 768.041(2), 46.015(2), 768.31(5)(a), Florida Statutes.
[1159] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249, 251 (Fla. 1995).
[1160] Id.

overlapping compensation for identical damages."[1161] Without set off, Mrs. Wells would recover a monetary amount in excess of her damages, as determined by the jury.[1162]

The Supreme Court was persuaded by other states that had abolished joint and several liability but had not legislatively extended set off requirements to the proportional liability setting.[1163] The court also examined the statutory language of sections 768.81(3), 46.015, and 768.041, Florida Statutes (1989), and concluded that the set off statutes did not apply to non-economic damages.[1164] However, the court held that the set off statutes do apply to economic damages for which parties continue to be subject to joint and several liability.[1165]

Once the Supreme Court determined set off did not apply to non-economic damages, the court had to determine how to divide the settlement proceeds between economic and non-economic damages.[1166] The court decided to divide the damages in the same proportion as the jury award.[1167] Accordingly, the economic damages were 35.349 percent of the total award. Applying this percentage to the total of the settlement resulted in $106,047 of the $300,000 in settlement proceeds being designated as economic damages. Thus, $106,047 was set off against the $202,953 award of economic damages. Because of collateral sources related to economic damages, the hospital received an additional set off of $17,000. This made the resulting award for economic damages to be $79,806. In addition, Mrs. Wells was entitled to recover the full non-economic damages, less 10 percent, for her comparative fault, which amounted to $333,900, as well at $9,000 in costs. Therefore, the total judgment entered in favor of the plaintiff was $422,706.[1168]

This formula for determining the non-settling defendant's right to a set off allows for a double recovery by the plaintiff. Both the settlement and the damages awarded by the jury were for the same harm (i.e., the wrongful death of Mrs. Wells' husband). The jury determined that the full value of damages for the wrongful death was $573,853. However, because the court only allowed that portion of the settlement attributable to economic damages to be used as a set off, Mrs. Wells' total recovery (settlement plus jury award) was $722,706 ($422,706 + $300,000). This amount was

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[1161] Id.
[1162] Id.
[1163] Id. at 252.
[1164] Id. at 252-253.
[1165] Id. at 253.
[1166] Id.
[1167] Id. at 254.
[1168] Id.

$180,892 more than the full value of the wrongful death as determined by the jury.[1169]

After this decision was issued, the question remained as to whether a defendant would be entitled to a set off against both economic and non-economic damages if that defendant essentially waived section 768.81, Florida Statutes, and did not ask the jury to apportion fault among nonparties. The reason for this question was that if there was no apportionment of fault to the settling defendant, then section 768.81, Florida Statutes, and the set off formula in Wells arguably would not apply.[1170] Instead, the set off statutes (sections 46.105(2), 768.31(5)(a), and 768.041(2), Florida Statutes) would control. These statutes authorized a dollar-for-dollar set off for settlements entered into before the enactment of section 768.81, Florida Statutes. The Fourth District Court of Appeal hinted that such an outcome might be possible.[1171]

However, in September 2001, the Supreme Court issued its opinion in Gouty v. Schnepel,[1172] which had the effect of requiring a defendant to place all settling defendants on the jury verdict form and request an apportionment of fault by the jury before any set off for economic damages would be allowed based on an earlier settlement.[1173]

In Gouty v. Schnepel, the plaintiff, Gouty, was shot and injured by a gun owned and operated by Schnepel and manufactured by Glock, Inc.[1174] Gouty sued both Schnepel and Glock. Before trial, Glock settled Gouty's claim, paying Gouty $137,500 in exchange for a release and dismissal of its claim. However, Glock was listed on the jury verdict form for the purpose of apportioning fault among the parties. The jury returned a verdict, finding Schnepel 100 percent liable, exonerating Glock altogether. The jury awarded damages of $250,000 total, $125,000 economic damages, $125,000 non-economic damages. Schnepel asked the court to reduce the verdict by the settlement amount, but the request was denied.[1175]

On appeal to the Supreme Court, the question was whether the set off statutes can be used in circumstances when a jury finds a non-settling defendant liable for economic damages but finds that the settling defendant is not liable.[1176] The court decided that without joint and several liability, the set off statutes do not apply to reduce a non-settling

[1169] Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002).
[1170] Id.
[1171] Id.; see also Anderson v. Ewing, 768 So. 2d 1161 (Fla. 4th DCA 2000).
[1172] Gouty v. Schnepel, 795 So. 2d 959 (Fla. 2001).
[1173] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002).
[1174] Id. at 960.
[1175] Id.
[1176] Id. at 961.

defendant's payment for liability.[1177] In so concluding, the court noted "as long as a defendant does not pay more than his or her percent of fault, that defendant is not entitled to contribution from another tortfeasor or entitled to a set off from a settling defendant."[1178] "However, if the defendant is required to pay damages on the basis of joint and several liability, that defendant's rights of contribution and set off remain unchanged."[1179]

The court essentially viewed this issue of set off vis-a-vis joint and several liability as an issue to be decided by the Florida Legislature. The court reasoned "the applicability of the set off statutes is predicated on the existence of other tortfeasors who are liable for the same injury as the settling party."[1180] The court recognized that the Legislature amended section 768.81(3), Florida Statutes, in 1999, but that the Legislature enacted the set off statutes before it enacted the comparative fault statute and the language of the set off statutes has not changed since Wells.[1181]

In conclusion, then, the court confirmed that Schnepel was 100 percent liable for Gouty's injuries and the jury expressly found that Glock was not liable at all (i.e., it was not a joint tortfeasor). Thus, the judgment against Schnepel for both economic and non-economic damages was not based upon joint and several liability, but on Schnepel's percentage of fault, which was found to be 100 percent. Accordingly, Schnepel was not entitled to the benefit of a set off from the award of economic damages.[1182]

As a result of the statutory scheme on set off, the partial legislative abrogation of joint and several liability in section 768.81, Florida Statutes, and the pronouncements of the Supreme Court of no set offs where there is no joint liability, plaintiffs are in the position to receive a double recovery for the same injury.[1183] Most medical malpractice cases involve plaintiffs suing multiple healthcare providers.[1184] At least some of the defendants in that suit will settle with the plaintiffs prior to trial.[1185] Assuming for example that $2,000,000 is paid in settlement dollars to the plaintiffs by other defendant doctors and the least culpable defendant doctor proceeds to trial, loses, and the plaintiff is awarded $2,000,000 for the same injury, for which he has already received $2,000,000, the plaintiff has received a double recovery.[1186] According to testimony

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[1177] Id.
[1178] Id. at 964.
[1179] Id.
[1180] Id. at 965.
[1181] Id. at 965-966.
[1182] Id. at 966.
[1183] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.
[1184] Id.
[1185] Id.
[1186] See Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.

provided to the Task Force, the only way to avoid that result is to place the settling defendants on the jury verdict form. The remaining, non-settling defendant does not get to tell the jury that the others have settled but that defendant must prove that the settling defendants were negligent.[1187] Essentially, the defense is turned into a plaintiff at this point: the doctor in the courtroom is forced to prove that the injury was caused by a nurse who is not there to defend himself or herself.[1188]

Information Presented to the Task Force

The Task Force heard testimony that plaintiffs are currently in a position to receive a double recovery for a single injury when a defendant settles prior to trial and no set off is allowed by the court to the ultimate jury award of damages for the previous settlement amount paid.[1189] Other testimony to the Task Force also highlighted practical defense problems because of the set off law in Florida. A remaining, non-settling defendant can often find himself or herself on the eve of trial having to "blame" another defendant who is no longer part of the litigation and not present in the courtroom because of a last minute settlement.[1190] The recommended solutions were legislative changes to the current set off statutes to allow set off of settlement proceeds from a jury verdict of damages for both economic and non-economic damages.[1191]

According to testimony provided to the Task Force, under the evolving hybrid system of apportionment of fault in the State of Florida, a defendant more closely pays according to his or her fault than was the case years ago. The plaintiffs' bar testified that when joint and several liability was in full force, set offs were allowed because each defendant, regardless of fault, was jointly liable for all other defendants' harm as well. Therefore, any payment received by the plaintiff from a defendant was set off against the ultimate award of damages because the damages were not assigned to any particular defendant. When joint liability is removed, each defendant is, in theory, paying only for his or her own fault. The payment, by another defendant, does not lessen the damages that should be paid by a remaining defendant.[1192]

[1187] Id.

[1188] Id.

[1189] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267, 286-291; see also Gail Parenti, testimony, Nov. 22, 2002, pgs. 267-269.

[1190] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 266-67.

[1191] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267, 286-291; see also Gail Parenti, testimony, Nov. 22, 2002, pgs. 269-70.

[1192] See Joel Perwin, testimony, Nov. 22, 2002, pgs. 274-282.

Findings and Recommendation

The Task Force finds that there is fundamental unfairness in a system that allows the possibility of a double recovery to a plaintiff for the same harm when there has to be a good faith belief on the part of the plaintiff that all named defendants participated in causing the harm. The Task Force further finds that it is not inconsistent to have a system that allows for several liability only and permits set off for settlement moneys received for the same harm that is also compensated by a jury.

Chief Justice Anstead has even recognized the Legislature's role on this issue. "It would be far better, however, since this is an area in which the legislature has broad discretion and authority, and has been very active, for the legislature to expressly indicate the limitations on the continuing use of the contribution scheme, including the set off provisions of sections 46.015(2), 768.31(5)(a), and 768.041(2)," he stated.[1193]

Recommendation 1. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

[1193] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249, 256 (Fla. 1995) (Anstead, J., specially concurring).

Chapter 9 - Alternative Dispute Resolution

"[C]hange is difficult. Even with the most enlightened leadership, creating a non-punitive atmosphere is a major challenge. The urge to punish is deeply entrenched. . . . If there is any lesson to be learned, it is that fear of reprisal and punishment produce not safety but defensiveness, secrecy and personal anguish."

Lucien L. Leape, M.D., Can We Make Health Care Safe?, (2000)

Mandatory Mediation

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to mandatory mediation in the context of medical malpractice cases:

- Should medical mediation panels be established to divert medical malpractice cases to either mediation or arbitration?
- Should the mediation panel be in addition to the current pre-suit process, or in lieu of the current process?
- If created, should the panel consist of one attorney and three physicians?

Current Situation

Medical malpractice litigants have several options set out in law for settling the law suit prior to litigation. Section 766.108, Florida Statutes, establishes a mandatory pre-trial settlement conference for medical malpractice cases and section 768.79, Florida Statutes, sets out the process for offers of judgment available in any civil action for damages.

Section 766.108, Florida Statutes, provides the court must require a settlement conference at least three weeks before the date set for trial in all medical malpractice cases. The attorneys who will conduct the trial, the parties and any person having the authority to settle the case must attend

this conference and must be excused by the court, for good cause shown, if they will not attend.

Section 768.79, Florida Statutes, sets out the procedures for either party to make an offer of judgment to settle the litigation. Either party may make an offer of settlement to the opposing party, which if not accepted within thirty days can result in the party not accepting the offer paying the offering parties attorney fees and costs from the date of the offer. If the plaintiff makes the offer that is not accepted then the defendant will owe the plaintiff's attorney fees and costs from the date of the offer if the final judgment obtained by the plaintiff is 25 percent higher than the offer. If the defendant makes the offer and the plaintiff rejects it then the defendant will be entitled to attorney fees and costs from the date of the offer if the judgment is one of no liability or is at least 25 percent lower than the offer. The amount of the offer is not admissible at trial but may be admitted for purposes of enforcing this section within thirty days after the entry of the judgment or voluntary or involuntary dismissal of the case. In making the determination as to the amount of the attorney fees and costs to be awarded, the statute provides specific criteria to be considered by the court, in addition to the standards generally considered by the court in awarding fees and costs. These criteria include:

- The apparent merit or lack of merit in the claim.
- The number and nature of offers made by the parties.
- The closeness of questions of fact and law at issue.
- Whether the person making the offer had unreasonably refused to furnish information necessary to evaluate the reasonableness of such offer.
- Whether the suit was in the nature of a test case presenting questions of far-reaching importance affecting nonparties.
- The amount of the additional delay cost and expense that the person making the offer reasonably would be expected to incur if the litigation should be prolonged.
- Evidence of an offer is admissible only in proceedings to enforce an accepted offer or to determine the imposition of sanctions under this section.[1194]

Information Provided to the Task Force

Mr. Perry Odom[1195] testified to the Task Force regarding his experience with mediation and its use early in the litigation process. He testified that the advantage of mediation over other dispute resolution processes is that

[1194] Section 768.79 (7)(b), Florida Statutes.
[1195] Perry Odom, J.D., North Florida Mediation and Arbitration Services.

the decision rests with the parties not with a third party.[1196] The purpose of the mediator is to assist the parties in narrowing the issues and understanding the strengths and weaknesses of the case.[1197] Early mediation can serve to substantially reduce the cost of the case and can allow the parties to meet and discuss settlement before "acrimony" between the parties has built.[1198] While some object to early mediation because of a lack of information about the case, Mr. Odom stated even at an early point, the plaintiff has a lot of information about the case and the insurance companies have a lot of experience on which to base an early assessment of the worth of the case.[1199]

Mr. Odom proposed a pre-suit mediation process as follows:[1200]

At the conclusion of the pre-suit screening period and any pre-suit informal discovery, but before the claimant files suit, the parties shall submit the matter to pre-suit mediation as follows:

- A certified circuit court mediator to be selected by mutual agreement of the parties shall conduct the pre-suit mediation. If the parties are unable to agree on a mediator within fifteen days after the claimant requests pre-suit mediation, a mediator shall be appointed by the general counsel of the Department of Health from the list of certified circuit court mediators maintained by the chief judge of the circuit in which the suit may be filed.

- Within thirty days after the mediator is selected, the mediation conference shall be scheduled by the mediator after conferring with the parties or their attorneys to determine a mutually acceptable date, time, and place, whereupon the mediator shall promptly give written notice to all parties of the date, time, and place of the mediation conference at least fifteen days prior to the scheduled mediation conference. Unless otherwise agreed by all of the parties, the pre-suit mediation shall be concluded within sixty days after the mediator is selected.

- The personal attendance of all parties at the pre-suit mediation conference is essential and required, unless excused by mutual agreement of all of the parties. Parties shall have absolute authority to settle the matter. If a party is a corporation, the corporate representative shall be either an officer of the corporation or a delegated representative, either of whom must have authority to bind the corporation to a settlement agreement. In the case of an insurance

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[1196] Perry Odom, J.D., testimony, Dec. 3, 2002, pg. 234.
[1197] Id.
[1198] Id. at 235.
[1199] Id. at 236.
[1200] Language provided to Task Force by Perry Odom, J.D.

carrier or self-insurer, the representative of the insurance carrier or self-insurer shall be empowered to resolve the matter for the lower of the demand of the claimant or the limits of coverage.

- Section 44.107, Florida Statutes, regarding judicial immunity for the mediator and Rule 1.700, et seq., Florida Rules of Civil Procedure shall apply to the pre-suit mediation.

- Each party involved in the pre-suit mediation process has a privilege to refuse to disclose, and to prevent any person present at the pre-suit mediation conference from disclosing, communications made during the pre-suit mediation conference. All oral or written communications in the pre-suit mediation proceedings, other than an executed settlement agreement, shall be exempt from the requirements of chapter 119 and shall be confidential and inadmissible in any subsequent legal proceedings, unless all parties agree otherwise.

- The statute of limitations is tolled as to all possible defendants until conclusion of the pre-suit mediation proceedings.

- Unless all parties agree otherwise, the parties shall share the fee or other costs charged by the mediator equally.

- If pre-suit mediation terminates in an impasse declared by the mediator, and the claimant thereafter files suit, nothing contained herein shall prevent the court from ordering the parties to submit to court-ordered mediation pursuant to chapter 44, Florida Statutes.

The Academy of Florida Trail Lawyers, in response to the discussion at the December 3, 2002 Task Force meeting, proposed the following language to provide for early mandatory mediation with sanctions but not pre-suit mediation.[1201]

- Within 120 days of suit being filed, the parties shall conduct mandatory mediation in accordance with section 44.102, Florida Statutes, if binding arbitration under sections 766.106 or 766.207, Florida Statutes, has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section. During the mediation, each party shall make a demand for judgment or an offer of settlement. At the conclusion of the mediation, the mediator shall record the final demand and final offer to provide to the court upon the rendering of a judgment.

[1201] Id.

- If a claimant rejecting the final offer of settlement made during the mediation does not obtain a judgment more favorable than the offer, the court shall assess the mediation costs and reasonable costs, expenses, and attorneys fees which were incurred after the date of mediation. The assessment shall attach to the proceeds of the claimant and attributable to any defendant whose final offer was more favorable than the judgment.

- If the judgment obtained at trial is not more favorable to a defendant than the final demand for judgment made by the claimant to the defendant during mediation, the court shall assess the mediation costs, and reasonable costs, expenses, and attorneys fees that were incurred after the date of mediation. Prejudgment interest at the rate established in section 55.03, Florida Statutes, from the date of the final demand shall also be assessed. The defendant and the insurer of the defendant, if any, shall be liable for the costs, fees, and interest awardable under this section.

- The final offer and final demand made during the mediation required in this section shall be the only offer and demand considered by the court in assessing costs, expenses, attorneys fees, and prejudgment interest under this section. No subsequent offer or demand by either party shall apply in the determination of whether sanctions will be assessed by the court under this section.

- Notwithstanding any law to the contrary, sections 45.061 and 768.79, Florida Statutes, shall not be applicable to medial negligence or to wrongful death cases arising out of medial negligence causes of action.

Findings and Recommendations

The Task Force finds encouraging the parties to seriously provide for early case evaluation and to mediate the case as soon as possible in the litigation process will reduce the litigation costs related to medical malpractice suits, thus reducing some of the medical malpractice litigation costs.

The Task Force finds the parties are currently free to mediate a case at any point but the confidentiality provisions currently available in chapter 44, Florida Statutes, do not cover any pre-suit mediation.

The Task Force finds mandatory mediation does not occur early enough in the litigation process to significantly reduce litigation costs and without sanctions for failure to mediate in good faith early mediation can be useless if the parties appear but are not ready or willing to work toward a settlement of the case.

Recommendation 1. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 2. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good faith offer of settlement is refused.

Recommendation 3. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 4. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 5. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to voluntary binding arbitration in the context of medical malpractice cases:

- Should the optional arbitration program be eliminated?
- Should the definition of the caps established in the voluntary arbitration process be clarified to apply a cap of $250,000 per incident regardless of the number of survivors (claimants)?

Current Situation

Chapter 766, contains two separate arbitration provisions: (1) section 766.106, Florida Statutes, and (2) sections 766.207-766.212, Florida Statutes. While both section 766.106, Florida Statutes, and sections 766.207 through 766.212, Florida Statutes, concern arbitration, they are two separate and distinct arbitration procedures. Parties cannot employ some of the provisions of section 766.106, Florida Statutes, and some of the provisions of section 766.207, Florida Statutes, to create a hybrid of arbitration.[1202]

Section 766.106, Florida Statutes

Section 766.106, Florida Statutes, was enacted as part of the Medical Malpractice Reform Act of 1985.[1203] Under this statute, the defendant may make an offer to arbitrate and the statute expressly contemplates an admission of liability with arbitration being conducted on the damages issue. More specifically, its provisions permit "an offer of admission of liability and for arbitration on the issue of damages" in response to a notice of intent to initiate medical malpractice litigation.[1204]

According to Gail Parenti, whose Coral Gables firm primarily represents hospitals, "I have never seen an arbitration proceed under 766.106 because there, frankly, is no reason to. It has done nothing but generate confusion

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[1202] Platman v. Holmes Regional Medical Center, Inc., 683 So. 2d. 671 (Fla. 5th DCA 1996), rev. denied, 687 So. 2d. 1305 (Fla. 1997); see also Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey, 655 So. 2d 1191 (Fla. 1st DCA 1995), rev. denied, 662 So. 2d. 344 (Fla. 1995).

[1203] Chapter 85-175, section 14, at 1199-1202, Laws of Florida.

[1204] See section 766.106(3)(b)3, Florida Statutes.

because it gives rise to arguments that an attempt to make an offer under 766.207 is somehow invalid because it's confusing."[1205]

Sections 766.207 through 766.212, Florida Statutes

In 1988, the Legislature was again asked to turn its attention to medical malpractice, enacting what is now chapter 766, Florida Statutes.[1206] While amendments changed some of what is now section 766.106, Florida Statutes, and added additional subsections, the substance of the provisions relating to admission of liability and voluntary binding arbitration of damages remained unchanged.

Instead, the Legislature adopted a completely separate set of procedures for admission of liability and binding arbitration of damages.[1207] Those provisions were subsequently codified as sections 766.207 through 766.212, Florida Statutes. While the motivation for enactment of those provisions is explained in section 766.201(2)(b), Florida Statutes, no reference is made to the provisions regarding admission of liability and voluntary binding arbitration of damages already set forth in section 766.106, Florida Statutes, or to the intended interplay between section 766.106, Florida Statutes, and sections 766.207 through 766.212, Florida Statutes.

Section 766.201(1), Florida Statutes, expressly sets forth the Legislature's intent to provide a mechanism for the prompt resolution of medical malpractice claims through mandatory pre-suit investigation and voluntary binding arbitration of damages.

Sections 766.203 through 766.206, Florida Statutes, set out the pre-suit investigation procedure that both the claimant and defendant must follow before a medical negligence case may be filed in circuit court. The first step in the pre-suit investigation is for the claimant to determine whether reasonable grounds exist to believe that a defendant acted negligently in the claimant's care or treatment, and to determine whether this negligence caused the claimant's injury.[1208] This section also requires that the medical negligence claim be corroborated by a "verified written medical expert opinion" from a medical expert as defined in section 766.202(5), Florida Statutes. Copies of any medical records relevant to the litigation must be provided to the claimant or defendant.[1209] From there, each party shall provide to the other party reasonable access to information within its

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[1205] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 206; but see Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 207 (recalling an offer, later revoked, to arbitrate under section 766.106, Florida Statutes).

[1206] Chapter 88-1, sections 48-87, at 164-186, Laws of Florida; chapter 88-277, sections 26-49, at 1473-1495, Laws of Florida.

[1207] Chapter 88-1, sections 54-59, at 169-173, Laws of Florida; chapter 88-277, sections 30-35, at 1476-1482, Laws of Florida.

[1208] Section 766.203(2), Florida Statutes.

[1209] Section 766.204(1), Florida Statutes.

possession or control in order to facilitate evaluation of the claim[1210] before giving notice to a defendant. After the completion of the pre-suit investigation by the parties pursuant to sections 766.203 through 205, Florida Statutes, with preliminary reasonable grounds for a medical negligence claim intact, the parties may elect to have damages determined by arbitration.

This arbitration mechanism is found in sections 766.207 through 766.212, Florida Statutes. If the claimant's reasonable grounds for the medical negligence claim are intact at the completion of the pre-suit investigation, either party may request that a medical arbitration panel determine the amount of damages.[1211]

The 1988 Legislature initially contemplated that these provisions would provide benefits to both a claimant and a defendant, the logic being that the claimant benefits from the requirement that a defendant quickly determine the merit of any defenses and the extent of its liability. The claimant also saves the costs of attorney and expert witness fees, which would be required to prevail in a civil trial. Moreover, a claimant who accepts a defendant's offer of voluntary binding arbitration receives the following additional benefits: (1) a relaxed evidentiary standard for arbitration proceedings; (2) joint and several liability of multiple defendants in arbitration; (3) prompt payment of damages after the determination by the arbitration panel; (4) interest penalties against the defendant for failure to promptly pay the arbitration award; and (5) limited appellate review of the arbitration award.

Likewise, a defendant benefits in that he or she is relieved of punitive damages and is assured that there will not be an award greater than $250,000 in non-economic damages. This limitation was intended to provide liability insurers with the ability to improve the predictability of the outcome of claims for the purpose of loss planning in risk assessment of medical malpractice premiums. At the same time, the arbitration mechanism forces parties to settle their disputes.

During the course of testimony, this Task Force heard from Gail Leverett Parenti. Ms. Parenti noted that at the time of the Echarte decision (to be discussed below), the Division of Administrative Hearings (DOAH) reported a total of 132 medical arbitration cases had been filed in the fourteen years since the enactment of the voluntary binding arbitration provisions. Of these cases, 106 had been resolved without a hearing.[1212] In other words, they had been settled. Ms. Parenti explained that voluntary binding arbitration was a highly-effective means of achieving the

[1210] Section 766.205(1), Florida Statutes.
[1211] Section 766.207, Florida Statutes.
[1212] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 184.

Legislature's stated goal of early settlement of medical malpractice cases. However, Ms. Parenti went on to further note that these statistics cannot capture the number of cases in which an offer to arbitrate has resulted in a settlement before the parties actually initiated arbitration proceedings, or those in which a credible threat to offer to arbitrate resulted in a settlement before the conclusion of the pre-suit period.[1213]

The Task Force heard conflicting testimony from defense and plaintiff's attorneys regarding the extent to which arbitration under sections 766.207 through 766. 212, Florida Statutes, is actually used. Ms. Parenti, citing the above-mentioned figures, stated that although settlements are actually taking place, the number of these settlements is lower than it should be because too few parties are taking advantage of the offer to arbitrate.[1214] Tommy Dukes, who is with the Florida Defense Lawyers Association, stated that, of the hundreds of malpractice cases he has handled, he has recommended arbitration in just two instances. Mr. Dukes explained that because the statute has been interpreted as allowing $250,000 per claimant (rather than per claim), and because the defendant must, in essence, admit liability to participate, arbitration under this section is simply not a viable option.[1215] However, Neal Roth, representing the Academy of Florida Trial Lawyers, countered the above testimony, stating he and his colleagues were seeing more and more offers to arbitrate.[1216] He also cited a recent survey of his group, which indicates that, in fact, arbitration was offered in at least fifty cases in the last two years.[1217]

University of Miami v. Echarte

The constitutionality of the voluntary binding arbitration provisions was ruled on in the seminal case of University of Miami v. Echarte.[1218] In Echarte, the claimants argued the voluntary binding arbitration provision had the effect of limiting the amount of non-economic damages they may recover for the defendant's neglect. The claimants argued the arbitration provision replaced their common law remedy of all damages proximately flowing from the neglect of the defendant. After reviewing the legislative history as well as the findings of the 1988 task force, the Florida Supreme Court expressly upheld the statutory scheme against an attack that the arbitration provision was an insufficient substitute for the common law right of an ordinary damages action. In so doing, the Florida Supreme Court explained:

[1213] Id. at 184-185.
[1214] Id. at 184.
[1215] Tommy Dukes, J.D., testimony, Oct. 21, 2002, pgs. 240-242.
[1216] Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 195.
[1217] Neal Roth, J.D., testimony, Oct. 21, 2002, pg. 272.
[1218] 618 So. 2d 189, 196 (Fla. 1993), cert. denied, 510 U.S. 915, 114 Sup. Ct. 304 (1993).

> The initial question in the instant case is whether the arbitration statutes, which include the non-economic damage caps found in sections 766.207 and 766.209, provide claimants with a "commensurate benefit" for the loss of the right to fully recover non-economic damages. Sections 766.207 and 766.209 only limit a claimant's right to recover non-economic damages after a defendant agrees to submit the claimant's action to arbitration. The defendant's offer to have damages determined by an arbitration panel provides the claimant with the opportunity to receive prompt recovery without the risk and uncertainty of litigation or having to prove fault in a civil trial. A defendant or the defendant's insurer is required to conduct an investigation to determine the defendant's liability within ninety days of receiving the claimant's notice to initiate a malpractice claim.
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> Before the defendant may deny the claimant's reasonable grounds for finding medical negligence, the defendant must provide a verified written medical expert opinion corroborating a lack of reasonable grounds to show a negligent injury. § 766.203(3)(b). The claimant benefits from the requirement that a defendant quickly determine the merit of any defenses and the extent of its liability. The claimant also saves the costs of attorney and expert witness fees which would be required to prove liability. Further, a claimant who accepts a defendant's offer to have damages determined by an arbitration panel receives the additional benefits of:
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> - the relaxed evidentiary standard for arbitration proceedings as set out by section 120.58, Florida Statutes (1989);
> - joint and several liability of multiple defendants in arbitration;
> - prompt payment of damages after the determination by the arbitration panel;
> - interest penalties against the defendant for failure to promptly pay the arbitration award; and
> - limited appellate review of the arbitration award requiring a showing of "manifest injustice.[1219]

The court went on to reject the claimant's assertion that the medical malpractice arbitration statute did not provide the claimant with a

[1219] University of Miami v. Echarte, 618 So. 2d 189, 194 (Fla. 1993).

commensurate benefit.[1220] After the holding in Echarte, it appeared the intent of the voluntary binding arbitration statute would be implemented.

However, after the Florida Supreme Court's decision in St. Mary's Hospital, Inc. v. Phillipe,[1221] it appears there is no future for voluntary binding arbitration. The Task Force heard testimony that most defendants will not consider voluntary binding arbitration in light of the St. Mary's decision.[1222] As Ms. Parenti noted, "Because I've been talking to defense lawyers for the last seven years about arbitration and they come to me and say, 'Gail, after [the Supreme Court rulings], I just can't do it. I cannot recommend to my client that they go to a forum where there's that risk.'"[1223]

St. Mary's Hospital, Inc. v. Phillipe

The St. Mary's decision was actually two separate cases that were consolidated for review: (1) St. Mary's Hospital, Inc. v. Phillipe,[1224] and (2) Frazen v. Mogler.[1225] Both were medical malpractice wrongful death cases in which the defendants conceded liability.

The facts of St. Mary's Hospital v. Phillipe were as follows: Juslin Phillipe died while giving birth to her daughter, Ecclesianne. Ecclesianne was born severely brain damaged. Charles Phillipe, Juslin's husband and the personal representative of her estate, brought a medical malpractice wrongful death action against St. Mary's Hospital on behalf of himself and the decedent's four surviving children.[1226]

St. Mary's conceded liability and the case proceeded under that arbitration process on the issue of damages. The independent personal injury action of the brain-damaged child, Ecclesianne, was not part of the arbitration process.[1227]

After a hearing, the arbitrators awarded the following damages: $250,000 in non-economic damages to both Charles, the husband, and Ecclesianne, the daughter; $175,000 in non-economic damages to each of the remaining children; $2,284,804 to the family in economic damages for loss of services; $943,000 in economic damages for loss of special services to Ecclesianne; $3,398 in funeral expenses; and $510,632 in

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[1220] Id. at 197.
[1221] 769 So. 2d 961 (Fla. 2000).
[1222] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 184.
[1223] Id.
[1224] 699 So. 2d 1017 (Fla. 4th DCA 1997).
[1225] 699 So. 2d 1026 (Fla. 4th DCA 1997).
[1226] St. Mary's Hospital v. Phillipe, 769 So. 2d 961, 963 (Fla. 2000).
[1227] Id.

attorneys' fees. The total amount of the arbitration award was $4,766,834.[1228]

St. Mary's argued that the arbitrators' total award of non-economic damages in the amount of $1,025,000 exceeded the $250,000 cap. That provision provides that "[n]on-economic damages shall be limited to a maximum of $250,000 per incident." St. Mary's asserted that the term "per incident" reflected that the limit applies in the aggregate to all claimants, rather than separately to each wrongful death beneficiary.[1229] The district court agreed with St. Mary's. The court concluded the plain language of the statute indicates "there can be no more than $250,000 in non-economic damages awarded by the arbitrators under section 766.207, Florida Statutes, no matter how many different people may have a direct benefit in the award, or the source of their entitlement to share in the award."[1230] The district court reversed the arbitration award of non-economic damages, and remanded for the reduction of such damages to $250,000.[1231]

St. Mary's also argued that the award of economic damages for the decedent's loss of earning capacity was improper because such damages are not available under the Wrongful Death Act. The district court disagreed, however, holding that the elements of economic damages available in a voluntary binding arbitration of a medical malpractice claim are controlled by the voluntary binding arbitration statute.[1232]

The facts of Franzen v. Mogler were as follows: Michael Mogler, a minor, died following treatment from Dr. Dirk Franzen. The parents of Michael Mogler brought a medical malpractice wrongful death claim on behalf of themselves and their son's estate against Dr. Franzen.[1233] As in Phillipe, the parties voluntarily chose to proceed under the voluntary statutory arbitration process. Dr. Franzen conceded liability, and the issue of damages proceeded to arbitration. After a hearing, the arbitrators awarded the following damages to Henry Mogler: $250,000 in past and future non-economic damages; $9,125 for past medical expenses; $29,750 for future medical expenses; and $7,950 for past and future loss of services.[1234] The arbitrators awarded the following damages to Donna Mogler: $250,000 in past and future non-economic damages; $46,593 for past medical expenses; $46,000 for future medical expenses; $57,636 for past wage loss; $304,189 for future wage loss; and $7,950 for past and future loss of

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[1228] Id.
[1229] Id. at 964.
[1230] Id.
[1231] Id.
[1232] Id.
[1233] Id.
[1234] Id.

services.[1235] The Estate of Michael Mogler was awarded the following damages: $3,078 for funeral expenses; $5,084 for medical expenses; and $388,272 for lost wages.[1236] The arbitrators also awarded attorneys' fees and costs in the amount of $210,844.[1237]

The total amount of the arbitration award was $1,616,471.[1238] Following its decision in Philline, the district court reversed the award of non-economic damages and affirmed the award of economic damages.[1239]

In the consolidated appeal, the Florida Supreme Court framed the controversy in terms of three separate issues:

ISSUE I: Stay pending review of medical malpractice arbitration award.[1240] The court disposed of this issue by rejecting the claim of unconstitutionality, and reasoned that both parties agreed to participate in voluntary binding arbitration. The court noted: "When a party voluntarily agrees to enter binding arbitration under this statutory alternative process, the party has bound itself to the statutory terms of that process."[1241]

The Task Force does not take issue with this particular finding. Instead, this Task Force is of the opinion that the results of the next two issues were much more troubling.

ISSUE II: Meaning of the clause "non-economic damages shall be limited to a maximum of $250,000 per incident." The second issue involved whether the $250,000 "per incident" limitation of non-economic damages in the arbitration provision limits the total recovery of all claimants in the aggregate to $250,000 or limits the recovery of each claimant individually to $250,000.[1242] The court reasoned that the legislative intent behind the statute should be gathered from consideration of the statute as a whole rather than from any one section.[1243] The court noted that for purposes of the statute, "claimant" was clearly defined as "any person who has a cause of action arising from medical negligence.[1244] The court further noted that the statute was perfectly clear when it referred to multiple parties.[1245] Likewise, the court noted that the Legislature had previously been clear when it intended to limit claimants' damages in the aggregate in other

[1235] Id.
[1236] Id.
[1237] Id.
[1238] Id.
[1239] Id.
[1240] Id. at 964.
[1241] Id. at 967.
[1242] Id. at 965.
[1243] Id. at 967-968.
[1244] Id. at 968.
[1245] Id. at 969.

contexts.[1246] For example, The court reasoned that in the Wrongful Death Act, the limitation read as follows: "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $100,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies . . . "[1247] Thus, the court concluded section 766.207(b), Florida Statutes, was neither unclear nor unambiguous.[1248]

The court concluded, that each claimant's non-economic damages must be independently determined.[1249] "Differentiating between a single claimant and multiple claimants bears no rational relationship to the Legislature's stated goal of alleviating the financial crisis in the medical liability insurance industry."[1250] As a final caveat, the court concluded that were it to interpret the non-economic damages cap to apply to all claimants in the aggregate, such an interpretation would create an equal protection problem.[1251]

ISSUE III: Economic Damages. The final issue involved the question of whether the elements of economic damages awardable in the voluntary binding arbitration or a medical malpractice wrongful death claim are controlled by the Wrongful Death Act.[1252] Unlike the voluntary binding arbitration statute, the Wrongful Death Act does not provide claimants with a full range of economic damages.[1253] The court ruled that the arbitration provisions of the voluntary binding arbitration statute expressly specify the elements of all the damages available when the parties agree to binding arbitration, regardless of whether the medical malpractice action involves a wrongful death.[1254] The court reasoned that the legislative intent of the voluntary binding arbitration statute was to enact reforms to prevent soaring non-economic damage awards, rather than the more predictable economic damage awards.[1255] The court concluded: "If the Legislature intended for the Wrongful Death Act to control the elements of damages available in a medical malpractice arbitration, it could have specifically provided for the application of the provisions of the Act in the [voluntary binding arbitration statute]. It has not done so."[1256]

[1246] Id.
[1247] Id.
[1248] Id.
[1249] Id. at 971.
[1250] Id.
[1251] Id.
[1252] Id.
[1253] Id. at 973.
[1254] Id.
[1255] Id.
[1256] Id.

Findings and Recommendations

As a result of the St. Mary's decision, the Task Force has found that defendants are no longer using arbitration as a means of resolving claims.[1257] In sum, the St. Mary's opinion has made it impossible for defendants to offer to arbitrate in wrongful death cases.[1258] Those defendants that agree to arbitrate now find themselves at risk of arbitrators awarding damages that are not compensable under Florida law. One speaker to the Task Force cogently noted: "As a result of the St. Mary's decision, the universe of claims in which an offer to arbitrate can reasonably be considered will be limited to these cases with a single claimant, or a decedent with no statutory survivors; with little or no economic damages; ironically, the cases which should not need the assistance of the arbitration mechanism to settle."[1259] The Task Force finds that voluntary binding arbitration in Florida is effectively dead as a result of the St. Mary's case.

Recommendation 1. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 2. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

[1257] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 191.
[1258] Gail Parenti, The Bells of St. Mary: Tolling the End of Voluntary Binding Arbitration of Medical Malpractice Claims, 19(4) Trial Advocate Quarterly 11 (Fall 2000).
[1259] Id.

Chapter 10 - Insurance Reform

"Malpractice fears and high premiums can contribute to 'excessive' service (such as unnecessary cesarean sections and diagnostic tests) or insufficient service (such as physicians no longer assisting in the birth of babies, especially to mothers who are uninsured or have only Medicaid coverage)."

Randall R. Bovbjerg et al., Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System, 265(21) Journal of the American Medical Association 2836

Florida Birth-Related Neurological Injury Compensation Act

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to the Florida Birth-Related Neurological Injury Compensation Act (NICA) in the context of medical malpractice cases:

- Should the criteria for a claim to qualify for referral to NICA be expanded to include lower birth weights?
- Should the criteria for a claim to qualify for referral to NICA be expanded to allow claims for mental and physical impairment rather than requiring both?

Current Situation

Two issues arise from the historical operation of the Florida No-Fault Compensation Plan created by the Florida Legislature in sections 766.301-316, Florida Statutes. First, whether the act has met its original purpose and continues to have value for that purpose. Second, whether the operation of the act is satisfactory, or whether changes are needed to enhance the purpose of the act.

Throughout the 1980s, a serious and highly-publicized crisis evolved regarding the costs of medical malpractice insurance for physicians. In 1987, the problem was specifically determined to be most serious for obstetricians, who were experiencing some of the highest insurance premium rates in the country.[1260]

Newspapers reported rising costs for malpractice insurance and the devastating effects these costs were having on physicians in their daily practices and on the patients who were unable to secure adequate medical attention. For example, a sample of the antidotal evidence reported clearly illustrates the scope of this crisis. One article appearing in the Sun-Sentinel written by the United Press International, stated that "most doctors are paying 81 percent more for medical malpractice insurance between 1982 and 1985, but that obstetrics and gynecologists paid as much as 113 percent more."[1261] A reporter for the St. Petersburg Times, noted that in "Broward and Dade County obstetricians' premiums will jump from $113,631 to $166,355 as of July 1."[1262] Another article in the St. Petersburg Times declared that the only one in 55 obstetricians in Palm Beach County was still accepting new patients.[1263] And, in Florida, two maternity wards were closed, one in Collier County and the other in Lake County.[1264]

In the State of Florida alone, the malpractice premium rates for obstetrics and gynecology rose 395 percent from 1980 to 1986.[1265] Florida experienced the effects of the problem more severely than most other states.

In an effort to address the mounting malpractice crisis, the Tort and Insurance Act of 1986 created the 1987 Academic Task Force for Review of the Insurance and Tort Systems, a task force to evaluate the state's tort and insurance laws.[1266] This task force was asked to examine the emergent problems facing the healthcare delivery systems, including

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[1260] House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) 2 (Apr. 2001).

[1261] Malpractice Rates Still Skyrocketing: Insurance Premiums Up 81% for Most Doctors, Sun-Sentinel, Aug. 1987.

[1262] Mark Journey, Malpractice Insurer Raises Rates, St. Petersburg Times, June 27, 1987, at 3B.

[1263] Patients Get Left Behind as Costs Push Doctors Out of the Delivery Rooms, St. Petersburg Times, June 9, 1987, at 4B.

[1264] Elizabeth Wasserman, Lake County Obstetrics Crisis Reaches Critical Condition, Orlando Sentinel, Dec. 23, 1987, at 3.

[1265] House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) app. 1 (Apr. 2001).

[1266] Academic Task Force for Review of the Insurance and Tort Systems, Preliminary Fact-Finding Report on Medical Malpractice 1 (Aug. 6, 1987).

physicians, hospitals, and other medical personnel and to make recommendations for reforms, where appropriate. The task force noted that the impact of the medical malpractice problems varied considerably among medical specialties.[1267] As a case in point, the task force found that:

- Obstetricians were more likely than other physicians to have claims filed against them;
- Obstetricians' malpractice premiums were among the highest; and
- The recent increases in malpractice premiums for obstetricians were much greater than for other physicians.[1268]

The task force noted that a generation ago abnormal births were regarded as an inherent risk of childbirth. They observed in 1986, most childbirth injuries resulted in increased claims against the obstetrician.[1269] Thus, the task force determined that, for birth related neurological injuries, distinctive treatment was warranted.[1270]

That 1987 task force was the first to propose the Florida Birth-Related Neurological Injury Compensation Act. Its November 6, 1987 report recommended the adoption of a no-fault compensation plan for birth-related neurological injuries.[1271] Accordingly, in 1988, the Legislature enacted section 766.301, Florida Statutes,[1272] (entitled Legislative Findings and Intent), and determined that physicians practicing obstetrics were high-risk medical specialists for whom malpractice insurance premiums were escalating.[1273] These medical specialists were found to be the most-severely affected group in the medical malpractice arena.[1274] Moreover, the costs of birth-related neurological injury claims for custodial care and rehabilitation were determined to be particularly high, thus warranting the establishment of a limited system of compensation that was irrespective of fault.[1275] The Florida Birth-Related Neurological Injury Compensation Plan was instituted with the intent to provide compensation to a limited class of catastrophically-injured infants on a no-fault basis to help alleviate the malpractice insurance crisis facing

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[1267] Id. at 12.
[1268] Id.
[1269] Id.
[1270] Id.
[1271] Academic Task Force for Review of the Insurance and Tort Systems, Medical Malpractice Recommendations (Nov. 6, 1987); see Galen of Florida, Inc. v. Braniff, 696 So. 2d 308, 310 (Fla. 1997).
[1272] Chapter 88-1, section 60, Laws of Florida.
[1273] Section 766.301(1)(a), Florida Statutes.
[1274] Section 766.301(1)(b), Florida Statutes.
[1275] Section 766.301(1)(d), Florida Statutes.

physicians practicing obstetrics. This no-fault compensation plan also provided participating physicians finite liability.[1276]

Sections 766.301 through 766.316, Florida Statutes, outline the components necessary to implement the no-fault compensation structure for participating physicians and eligible claimants.[1277]

The terms that are applicable to sections 766.301 through 766.316, Florida Statutes, are defined in section 766.302, Florida Statutes. The terms define the limitations expressed in this narrow compensation plan.

The critical definition as to "eligibility" for participation in the act is provided in section 766.302(2), Florida Statutes. This section defines "birth-related neurological injury" as an injury to the brain or spinal cord of a live infant weighing at least 2500 grams for a single gestation or, in a multiple gestation, a live infant weighing at least 2000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.[1278]

Section 766.302(3), Florida Statutes, identifies the persons who are authorized to file a claim on behalf of the infant. The claimant is a person who files a claim pursuant to section 766.305, Florida Statutes, for compensation for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator or personal representative, or legal representative.[1279]

A "participating physician" is a Florida physician who practices obstetrics or performs obstetrical services and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth related neurological injury compensation plan for the year in which the injury occurred.[1280] This definition is found in section 766.302(7), Florida Statutes.

[1276] Historically, since the establishment of NICA, some medical malpractice insurers have offered discounts on premiums for obstetricians who participated in the program. House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) (Apr. 2001).

[1277] Several revisions to the 1988 statute have been made since the inception of NICA. For a historical evolutionary discussion on the changes, see House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) (Apr. 2001).

[1278] Section 766.302(2), Florida Statutes.

[1279] Section 766.302(3), Florida Statutes.

[1280] Section 766.302(7), Florida Statutes.

Section 766.303, Florida Statutes, provides for the exclusiveness of remedies for the eligible claimants through administrative procedures except where there is evidence of bad faith, malicious purpose, or a willful and wanton disregard.[1281]

Exclusive jurisdiction vests with an administrative law judge. Section 766.304, Florida Statutes, provides that a claimant can no longer bring a civil action against a participating physician unless an administrative law judge from the Division of Administrative Hearings determines that the birth-related injury does not fall within the no-fault compensation plan.[1282]

Determination of the claims and the nature of the findings that may result are set forth in section 766.309, Florida Statutes. Subsections (1)(a), (b), and (c) provide the findings that shall be made as to: (a) whether the injury is birth-related neurological injury; (b) the obstetrical service is delivered by a participating physician in the course of labor; and (c) how much compensation, if any, is awardable.[1283]

For a determination that the infant has been found to have sustained a birth-related neurological injury, such an award to the parents or legal guardian shall not exceed $100,000; funeral expenses shall not exceed $1,500; and attorney fees shall be assessed per the criteria set forth in section 766.309(1)(c), Florida Statutes. Section 766.31(1)(b), Florida Statutes, set forth the maximum awards.[1284]

No claim may be filed more than five years after the birth of the injured infant, under section 766.313, Florida Statutes.

Terminally, section 766.316, Florida Statutes, requires that each hospital with a participating physician and all participating physicians must provide notice on the forms, furnished by the Association, to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries.[1285]

The Florida Legislature, in creating an assessment formula, has set forth requirements that initial assessments into the program and yearly

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[1281] Barden v. Haddox, 695 So. 2d 1271 (5th DCA 1997) (right to receive compensation under NICA, exclusive relief available to victims, is a substitute for common law rights which are otherwise available and as a result forecloses civil lawsuit against a doctor in the plan).

[1282] Since O'Leary v. Florida Birth-Related Neurological Injury Compensation Association, 757 So. 2d 624 (Fla. 5th DCA 2000), following the Florida Legislature amendment of section 766.304, Florida Statutes, correcting any confusion resulting from the decision in Florida Birth-Related Neurological Injury Compensation Association v. McKaughan, 668 So. 2d 974 (Fla. 1996), as to where jurisdiction reposed.

[1283] Section 766.309(1)(a-c), Florida Statutes.

[1284] Section 766.31(1)(b), Florida Statutes.

[1285] Galen of Florida V. Braniff, 696 So. 2d 308 (Fla. 1997).

assessments to remain in the program be made. Section 766.314, Florida Statutes, sets out monetary obligations for such assessments and provides for additional assessments when, under subsection (7)(b), the Department of Insurance finds that the plan cannot be maintained on an "actuarially sound basis".[1286]

Information Presented to the Task Force

Complaints about insurance costs are not new, however, increases since 1999 have shown that the availability of a million or more dollar of coverage has escalated premium costs so high that the dollar insurance amounts are beyond the reach of many physicians.[1287] The Professional Medical Insurance Services, Inc., underwriters for Florida physicians, estimates that, in 2003, for OB/GYNs who presently have coverage, costs for $1 million dollar of coverage will average between $70,000 and $110,000 per year; $250,000 of coverage will cost between $50,000 and $60,000 per year. For OB/GYNs seeking new insurance in 2003, estimates show that $1 million dollars in coverage will cost $150,000 per years and $250,000 in coverage will cost between $90,000 and $107,000 per year.[1288] As a result of these escalating costs, physicians are simply either under insuring or becoming uninsured with regard to their practices.[1289] Indeed, some experts suggest that Florida has reached a crisis status and some obstetricians and surgeons will be paying over $200,000 annually for premiums.[1290]

Evidence shows for example that OB/GYN physicians in areas such as Jacksonville are either retiring early, becoming college faculty members to obtaining sovereign immunity, or operating without insurance instead of meeting high premiums for adequate coverage. In Orlando, 20-25 percent of the OB/GYNs will operate without insurance and similar numbers exist in Tampa. In Miami, evidence reflects that 80 percent of the OB/GYNs carry no insurance and those who do are paying over $207,000 per year for $1 million dollars worth of coverage. Tallahassee's Neonatology

[1286] Section 766.314 (5)(b), Florida Statutes, authorizes the transfer of no more than $20 million from the Department of Insurance, Insurance Commissioner's Regulatory Trust Fund if the assessments collected are insufficient to maintain the plan on an actuarially-sound basis. In 1988, The Florida Legislature appropriated $40 million of the Insurance Commissioner's Regulatory Trust Fund in the Department of Insurance for NICA. Twenty million dollars of this appropriation has been set aside in case of actuarial need and the other twenty million dollars funded NICA's establishment. See House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) 5 (Apr. 2001).

[1287] Robert W. Yelverton, M.D., testimony, Oct. 21, 2002, pgs. 55-56.

[1288] Robert W. Yelverton, M.D., PowerPoint presentation, Oct. 21,2002.

[1289] C. Howard Hunter, testimony, Nov. 22, 2002, pg. 139.

[1290] Eleanor Kinney, J.D., testimony, Nov. 4, 2002; Eleanor Kinney, J.D, written statement, Legal Reforms Addressing Affordability and Availability of Medical Liability Insurance: Past Experience and Future Directions, Nov. 4, 2002.

Group at the local hospital has been unable to find insurance and is considering closing the neonatal intensive care unit.[1291]

Experts acknowledge that NICA, a second-generation level reform of the insurance liability issue, functions as intended according to empirical evidence. It was, however, never intended to be a cure to insurance rates, but rather, was intended to maintain lower insurance premiums.[1292] Based upon its intended purpose, NICA has been a success, however, adoption of no fault returns has been limited to Florida and Virginia and other countries like Sweden and New Zealand where it has been more fully developed.[1293] Because the exposure of these no-fault compensation plans is limited to a very few states, any empirical data may be skewed and therefore the total success of a no-fault compensation plan has not been embraced.[1294]

Clearly, attempts to reduce or maintain reasonable liability insurance costs may not stop doctor-flight without global reform or adoption of uniform insurance policies from state to state. The insurance liability crisis is not unique to Florida and the causes as well as solutions will likewise not be unique to Florida. Unavailable and unaffordable insurance will result in under-insured or uninsured practitioners and those who are injured will seek deeper pockets, because when liability is without restraints, it becomes unpredictable and can result in excessive payouts.[1295]

NICA provides for no-fault compensation that results in most stakeholders gaining some benefit.[1296] Instead of almost half of a settlement award going to attorney's fees, reports reflect that, under NICA, less than 1 percent is distributed to plaintiff's attorneys. As a result, a greater percentage of resources are distributed to the child in need of care.[1297]

In the fourteen years NICA has been in place, 161 cases have been accepted and there are presently eighty-seven current open cases. Reports reflect an average of $3 million dollars per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of a child, and the premise that as the child ages, care becomes more expensive.[1298]

[1291] Robert W. Yelverton, M.D., PowerPoint presentation, Oct. 21, 2002.
[1292] Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 180.
[1293] Robert Berenson, M.D., testimony, Nov. 4, 2002, pg. 219.
[1294] Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 180.
[1295] C. Howard Hunter, PowerPoint presentation, Nov. 22, 2002.
[1296] Kenney Shipley, testimony, Nov. 22, 2002, pgs. 20-21.
[1297] Id.
[1298] Id. at 21.

Findings and Recommendation

To suggest that the current structure of the NICA program should remain unchanged[1299] is not uniformly embraced by all stakeholders.[1300] Indeed, modifications as to eligibility requirements, including birth weight and changes to proof of "mental and physical impairment" to "mental or physical impairment,"[1301] may quiet many of the concerns expressed with regard to the willingness to participate.[1302] The broadening of the definition of eligible claimants[1303] may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services.

As a potential consequence of any changes made to NICA, financial assessments of hospitals and all physicians may need to be evaluated.[1304] However, at some time in the future, it is reasonable to assume that escalation of costs may level off for obstetricians as well as all physicians because of this no-fault system and the fact that other medical disciplines may be encouraged to urge passage of other no-fault compensation plans.

The Task Force, after hearing extensive input from a variety of experts, believes that the issues relating to the NICA program warrants further consideration and study. Additional hearings and testimony from experts are necessary for this worthy program.

Recommendation 1. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

[1299] William Brewster, testimony, Dec. 3, 2002, pgs. 134-136.
[1300] Theodore Babbitt, J.D., testimony, Dec. 3, 2002, pgs. 120-125.
[1301] Only when the infant meets the definitional criteria established by this section, will the exclusive remedies provided for by this limited no-fault compensation plan be available. The Florida Supreme Court in Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So. 2d 1349, 1355 (Fla. 1997), stated that because the NICA plan is a statutory substitute for common law right and liabilities, it should be strictly construed to include only those subjects that clearly embrace in its terms. Additionally, the court further narrowed the application of this statute by affirming the well-settled rules of statutory construction concluding that the word "and" in the phrase "permanently and substantially mental and physically impaired" should be read in the conjunctive. To do so does not lead to either an absurd result nor does it undermine the legislative policy of limiting the class. Therefore, an eligible infant to avail themselves of the no-fault compensation system must be at least 2500 grams weight and permanently and substantially mentally and physically impaired.
[1302] Tommy Dukes, J.D., testimony, Dec. 3, 2002, pgs. 108-113.
[1303] Mr. Dukes' proposal that modification to the definition of the "birth-related neurological injury" to allow the birth weight to be lowered to some number other than 2500 grams, would increase the number of infants eligible for NICA. Id. at 108-110.
[1304] William Brewster, J.D., testimony, Dec. 3, 2002, pgs. 139-143.

Bad Faith

Issue

The Task Force voted at its December 20, 2002 meeting, by a vote of 5-0, to examine the following issues with respect to bad faith claims in the context of medical malpractice cases:

- Should a bad faith cause of action be limited to a right of the insured and not extend to third-party claimants?
- Should criteria or standards be established for insurer conduct that constitutes bad faith and the duty of good faith when dealing with an insured and limited to protect the assets of the insured from judgment?

Current Situation

In Florida, there are two causes of action for bad faith claims by third parties to the insured/insurer relationship (e.g., injured plaintiffs). One of these causes of action arises out of common law and is therefore a creation of judicial case law. The other cause of action arises out of judicial interpretation of statute. At its fundamental core, the bad faith cause of action is intended to promote the following purposes:[1305]

- To economically protect the defendant insured from an excess judgment when the insurer has control of the defense and settlement;
- To make available to injured persons specified dollar limits that are available as compensation; and
- To encourage insurers to behave responsibly by making them liable for the financial damage that is caused by their breach of good faith duties.

By judicial interpretation of both the common law bad faith cause of action and the statutory law bad faith cause of action, "any person aggrieved" may sue an insurer for the insurer's alleged improper conduct in medical malpractice cases. Accordingly, in Florida, an insurer can be held liable to pay an entire judgment against its insured even when the

[1305] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs., 116-117.

judgment exceeds the limits of the insurance for which the insured has contracted.

In Thompson v. Commercial Union Ins. Co. of New York, the Supreme Court of Florida declared: "It is established in Florida that an insured has the right to sue and recover damages against his own insurer for an excess judgment on the basis of fraud or bad faith in the conduct of the insured's defense by the insurer."[1306] The Thompson court also extended the third-party beneficiary doctrine to allow injured plaintiffs to directly sue a defendant's insurer "for recovery of the judgment in excess of the policy limits, based upon the alleged fraud or bad faith of the insurer in the conduct or handling of the suit."[1307] This extension had the effect of enlarging the limits of liability of the insurer beyond those in the stated insurance policy at issue.[1308] Since Thompson, the law in Florida has placed very few limits on that liability.

In 1980, the Supreme Court of Florida decided the case of Boston Old Colony Ins. Co. v. Gutierrez.[1309] That case explains many of the principles on which the cause of action by a third party against an insurer for bad faith exists and outlines the Court's understanding of the problems raised thereby. In Boston Old Colony, the plaintiff and defendant were involved in a head-on collision. Both men claimed that the accident was the other's fault. Brown, the defendant in the original case, had a liability policy that covered him up to a limit of $10,000 in damages. However, because of Brown's recollection of the accident and some corroborating evidence, Boston Old Colony hired an accident reconstruction expert to further investigate the cause of the accident. That expert determined that Gutierrez, the plaintiff in the original suit, was on the wrong side of the road at the time of accident impact. Despite this evidence, Boston Old Colony's adjuster knew that there was still a question of Brown's liability and that Gutierrez's injuries were extensive. Therefore, there was a possibility of an excess judgment in the case. The adjuster warned Brown of these matters and suggested that an offer to settle the case be made. Brown refused. He had counterclaimed against Gutierrez for his own injuries and did not want to make the admission of fault that is implied in an offer to settle. Boston Old Colony then had Brown execute a "hold harmless" agreement, in which Brown assumed responsibility for any excess judgment.[1310]

[1306] Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259, 260 (Fla. 1971); see also Auto Mutual Indemnity Co. v. Shaw, 184 So. 2d 713 (Fla. 1969).

[1307] Id. at 264.

[1308] Id. at 260 (quoting Shingleton v. Bussey, 223 So. 2d 713 (Fla. 1969)).

[1309] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).

[1310] Id. at 784.

Before the trial, Gutierrez offered to take the policy limits of $10,000 in settlement of his claim against Brown. Boston Old Colony responded by denying liability. Then, Brown settled his counterclaim against Gutierrez and his insurer. Boston Old Colony offered Gutierrez the policy limits as settlement of the claim. Gutierrez refused. The trial resulted in a judgment against Brown for $1,400,000. Gutierrez then sued Boston Old Colony, alleging bad faith on its part because of its failure to settle the claim for policy limits when it had the opportunity. Gutierrez prevailed and obtained a judgment against Boston Old Colony for $1,400,000.[1311]

The question before the Supreme Court was whether the common law in Florida[1312] authorized "a bad faith action against an insurance company when that company [had] refused to settle a claim at the express direction of its own insured who obtains a settlement of his claim and the insurance company thereafter offers to settle for its policy limits before trial?"[1313] The court answered "no."

In analyzing this issue, the court noted that "[a]n insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business."[1314] The insurer assumes a duty to exercise "such control and made such decisions in good faith and with due regard for the interests of the insured" when the insured surrenders all control over the handling of the claim, including all decisions in the litigation and settlement to the insurer.[1315]

This good faith duty obligates the insurer to advise the insured of settlement opportunities, of the probable outcome of the litigation, of the possibility of an excess judgment, and of any steps the insured might take to avoid such a judgment. The insurer "must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so."[1316]

Justice Alderman wrote specially to voice his opinion on the issues of the bad faith cause of action in the Boston Old Colony case. He opined that an injured plaintiff should not be allowed to sue the defendant's insurer for bad faith failure to settle a claim. According to Justice Alderman, the good faith duty to settle is between the insurer and insured. "In the 'Alice-in-Wonderland' world created by the [common law] rule, it is to the

[1311] Id. at 784-785.
[1312] See Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259 (Fla. 1971).
[1313] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 784 (Fla. 1980).
[1314] Id. at 785.
[1315] Id.
[1316] Id.

injured party's benefit if the insurer breaches its duty to its insured and to his detriment if there is no breach."[1317] This result exists because "if the insurer settles, the plaintiff will receive no more than the policy limits, but if it does not, the plaintiff may end up with both the policy limits and an excess judgment."[1318] Accordingly, the common law rule induces a plaintiff not to settle.[1319]

While in Boston Old Colony, the Supreme Court found that the third party (Gutierrez) had failed to prove bad faith on the part of the insurer (Boston Old Colony), the Court continued to extend the common law cause of action itself to persons beyond the insured/insurer contract relationship. Furthermore, the same result has been reached by the courts with respect to the statutory cause of action for bad faith by an insurer.[1320]

Section 624.155, Florida Statutes, describes who may bring a civil action for bad faith and outlines the Insurance Code violations that subject the insurer to such suits. This section states that "[a]ny person may bring a civil action against an insurer when such person is damaged [by the enumerated provisions of the Insurance Code]."[1321] In 1995, the Supreme Court had the opportunity to interpret the phrase, "any person" in the context of a third-party bad faith claim against an insurer.[1322] The court concluded that these words were "precise and their meaning unequivocal. By choosing this wording the legislature has evidenced its desire that all persons be allowed to bring civil suit when they have been damaged by [statutorily] enumerated acts of the insurer."[1323]

Even though the Supreme Court interpreted "any person" to include those people beyond the insured/insurer contractual relationship, the court recognized the premonition of other courts that such an interpretation of this phrase would achieve an unreasonable result. Permitting a third party such a cause of action against the insurer any time the insurer allegedly

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[1317] Id. at 786 (Alderman, J., concurring specially).

[1318] Id.

[1319] Id.; see also Judge Carroll, in Canal Insurance Company of Greenville, South Carolina v. Sturgis, 114 So. 2d 469 (Fla. 1st DCA 1959), aff'd, 122 So. 2d 313 (Fla. 1960):

> No one can today question the legal right of the insured to sue the insurer for negligence or bad faith in failing to settle a claim within the policy limits for, if he has had to pay a part of the judgment, he had indeed suffered damages because of such failure of the insurer; but, when the judgment creditor directly so sues the insurer for an amount above such limits, a vastly different situation exists in the eyes of the law. The judgment creditor has not suffered because of the insurer's failure, but has, if anything, gained thereby. The judgment creditor would be in an anomalous position, for typically he would be claiming damages for the insurer's failure to settle the case for much less than the verdict he himself actually won.

[1320] See, e.g., Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995), State Farm Fire & Casualty Co. v. Zebrowski, 706 So. 2d 275 (Fla. 1997).

[1321] Section 624.155(1)(a)(1), Florida Statutes.

[1322] See Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995).

[1323] Id. at 929.

failed to settle in good faith could result in undesirable social and economic effects (such as multiple litigation, unwarranted bad faith claims, coercive settlements, excessive jury awards, and escalating insurance, legal, and other transaction costs).[1324]

In addition to a cause of action under section 624.155(1)(a), Florida Statutes, as interpreted in Auto-Owners Ins. Co. v. Conquest,[1325] a bad faith cause of action also exists under section 624.155(1)(b), Florida Statutes. This provision states, in pertinent part, as follows:

(1) Any person may bring a civil action against an insurer when such person is damaged:

(b) By the commission of any of the following acts by the insurer:

1) Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

2) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3) Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

In 1997, the Supreme Court interpreted this additional cause of action in section 624.155(1)(b), Florida Statutes, and reasoned as follows:

> In subsection (1)(a) there are no specified limitations upon claims for violation of any of the enumerated statutes. However, in subsection (b), the cause of action is predicated on the failure of the insurer to act "fairly and honestly toward its insured and with due regard for his interest." The duty runs only to the insured. Therefore, in the absence of any excess judgment, a third-party plaintiff cannot demonstrate that the insurer breached a duty toward its insured.[1326]

[1324] Id. at 930 (quoting Cardenas v. Miami-Dade Yellow Cab Co., 538 So. 2d 491, 496 (Fla. 3d DCA 1989)).
[1325] Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995).
[1326] State Farm Fire & Casualty Co. v. Zbrowski, 706 So. 2d 275, 277 (Fla. 1997).

Accordingly, section 624,155(1)(b), Florida Statues, allows a third party to sue a liability insurer for bad faith, without an assignment by the insured when the third party obtains a judgment in excess of the insured's policy limits. This result provides the basis for alleging a breach of duty to the insured.

While the Boston Old Colony case discussed above was decided in favor of the defendant insurer, the case demonstrates various issues facing insurers in fulfilling their obligations to defend their insureds.

First, insurers must remember that, despite their best efforts on behalf of their insured, they are still subject to a bad faith claim brought by the injured third party. Because the claim is brought after the jury returns a verdict in excess of policy limits against the insured, and given the inherent sympathy afforded to the injured plaintiff in a medical malpractice suit, the insurer faces a rather daunting obstacle in defending a bad faith action. Such a defense can require the insurer to maintain that, despite the plaintiff's serious injuries, and with the hindsight knowledge that the underlying suit resulted in a large jury award that exceeded the insured's policy limits, the insurer not only acted reasonably in not settling the underlying medical malpractice suit, but continues to act appropriately in refusing to pay the jury's award.

Second, the insurer has a duty to try to settle the case where a reasonably prudent person facing the prospect of paying the total judgment would do so. This is the simple negligence standard and makes the insurer's position more untenable. At least two standard jury instructions used by Florida judges[1327] charge the jury with the task of determining whether, under the totality of the circumstances, the insurer was reasonable in deciding to proceed to trial, rather than settle the claim. This standard, combined with the statutory "reasonable person" standard, seems to guarantee the success of a bad faith claim[1328] submitted to a jury, given its hindsight regarding the outcome of the already-decided underlying case.

The third issue from Boston Old Colony comes from language at the close of the Supreme Court's opinion there:

> By way of caveat, we point out that the "hold harmless" agreement in this case was not a determining factor in our

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[1327] See Fla. Std. Jury Instr. MI 3.1, 3.2.

[1328] Originally in Florida, bad faith cases fell within the same category of wrongs as frauds. See, e.g., Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259, 264 (Fla. 1971) (holding that a third-party plaintiff could directly sue an insurer for "alleged fraud or bad faith of the insurer in the conduct or handling of the suit"). By way of contrast, reasonable person standards are those that govern innocent (without malice) mistakes (i.e., basic negligence).

> decision. An insurer with control over defense and settlement must at all times act in good faith, and it may not insulate itself from a bad faith excess judgment by simply obtaining a hold harmless agreement from its insured.[1329]

Accordingly, even when an insurer acts at the insistence of the insured in refusing to settle the claim, an insurer is still susceptible to a bad faith judgment against it. An insurer must operate as a fiduciary in the insured's best interest but the insurer cannot defer to the insured's wishes regarding settlement of the case.[1330]

An insurer can also be liable in bad faith for delays in offering policy limits, failing to disclose policy limits, and failing to inform the insured of settlement overtures. Liability still attaches for these omissions when the third-party plaintiff refuses settlement offers so long as there was an opportunity to settle the case at some point in the claim process.[1331] For example, the Third District Court of Appeal decided a case in which an insured's daughter seriously injured a pedestrian in a car accident. The pedestrian's attorney contacted the insurer and requested disclosure of the insured's policy limit. But, the attorney never made a specific monetary demand. Ultimately, the insurer tendered an offer of policy limits, despite the injured pedestrian's lack of demand. The offer was rejected. At trial, the jury returned a verdict against the insured for $250,000. The insured filed suit against his insurer, alleging bad faith.[1332] The Third District Court found bad faith and noted:

> Any question about the possible outcome of a settlement effort should be resolved in favor of the insured; the insurer has the burden to show not only that there was no realistic possibility of settlement within policy limits, but also that the insured was without the ability to contribute to whatever settlement figure that the parties could have reached. [citations omitted]. Whether the insurer's delay in disclosing the policy limits foreclosed settlement negotiations and prevented an offer to settle is a relevant and material fact.[1333]

Thus, there is an affirmative duty on the part of the insurer to seek settlement of a claim against the insured within the policy limits. When

[1329] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 786 (Fla. 1980).
[1330] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 120-121.
[1331] See Powell v. Prudential Property & Casualty Ins. Co., 584 So. 2d 12 (Fla. 3d DCA 1991), rev. denied, 598 So. 2d 77 (Fla. 1992).
[1332] While the Powell v. Prudential Property & Casualty Ins. Co. case arose in a general tort context, the same result would have existed in the medical malpractice context, substituting in the fact pattern a doctor for the car driver and an injured patient for the pedestrian.
[1333] Id. at 14-15.

the insurer fails to obtain a settlement, it then has the burden of demonstrating that the plaintiff would not have accepted a settlement offer within policy limits at any time.

Furthermore, under section 627.4147, Florida Statutes, all medical malpractice insurance policies must contain a clause authorizing the insurer "to determine, to make, and to conclude, without the permission of the insured, any . . . settlement offer . . . if the offer is within the policy limits."[1334] This statute further proclaims that it "is against public policy for any insurance . . . policy to contain a clause giving the insured the exclusive right to veto any . . . settlement offer . . . when such offer is within the policy limits."[1335] The result of this provision is that the insurance carrier is expected to make an independent evaluation of the claim and to act accordingly, including settling the case, regardless of the insured's position as to whether settlement is appropriate. These statutory provisions place pressure on the insurer to settle claims filed against their insureds, at the risk of being liable to either the insured or a third-party plaintiff for the entire judgment rendered against the insured, and irrespective of the coverage limits of the insured's policy.

Despite this pressure to settle claims, however, the statutes also place a constraint on the insurer's ability to settle when the insured objects to the settlement. Section 627.4147(1)(b), Florida Statutes, also contains the following language: "any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured." This standard is open to many interpretations, including the insured's out-of-pocket expense, financial position, and the impact settlement may have on future employment possibilities or the insured's professional reputation.

The damages recoverable in bad faith actions under present law in Florida, as well as the other standards discussed above, have little relationship to the public purposes of asset protection, making specified coverage available, or encouraging reasonable behavior.[1336] When a $5,000,000 judgment is entered against an insured because of the insurer's failure to settle, the implication is that the "real" amount of the insured's damages is $5,000,000, when the insured may never have such an amount of reachable assets. Accordingly, the insurer is required to pay beyond the combination of its policy limits and the accumulated and future assets of the insured, with no rational basis. The conclusion is that the plaintiff is financially better off if the insurer behaves badly than if the insurer behaves properly.

[1334] Section 627.4147(1)(b), Florida Statutes. This mandate does not apply to all liability insurance contracts but almost all contracts give the insurer the exclusive right to settle.

[1335] Section 627.4147(1)(b)1, Florida Statutes.

[1336] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 1.

Like Florida, California allows bad faith causes of action when an insurer breaches its duty to attempt to settle meritorious claims.[1337] However, California does not require that the insured contract away his right to trial when the insurer feels that the case should be settled. Thus, when an insured refuses to consent to settle and the insurance contract allows the insured to veto settlement, the insurer cannot be held liable in fad faith for refusing to settle the plaintiff's claim against the insured's consent.[1338]

Other states also expressly articulate the standards that constitute bad faith acts. For example, Illinois law provides that seven factors should be considered in determining whether the insurer has failed to act in the good faith interests of the insured. These factors include:

- whether the insurer has considered the advice of the insurer's own adjuster;
- whether the insurer refuses to negotiate a settlement;
- what advice the insurer receives from its defense counsel;
- whether the insurer keeps the insured fully aware of the claimant's willingness to settle;
- whether the insurer conducts an adequate investigation into the claim;
- whether there exists a substantial prospect of an adverse verdict; and
- the potential for damages that exceed the policy limits.[1339]

Finally, Michigan is instructive as to an example in limiting damages in bad faith cases. In Michigan, the relationship with the insured is not a fiduciary relationship.[1340] On the other hand, the duty is greater than that of a buyer and seller of products and services. The duty of using good faith in settlement negotiations is a duty to protect the insured—it is of a fiduciary nature.[1341] The insurer must fulfill its policy-contracted obligation with the utmost loyalty to its insured.[1342]

Michigan law provides that bad faith may exist if the defense attorney advises the insurer that defense of the case is hopeless, recommends settlement, the insurer refuses to settle, and the jury returns a judgment in excess of policy limits.[1343] Arbitrary, reckless, indifferent, or intentional disregard of the interest of the insured amounts to bad faith.[1344]

[1337] See section 790.03, California Statutes.

[1338] See Carlile v. Farmers Ins. Exchange. 219 Cal. Rptr. 773 (Cal 3d DCA 1985).

[1339] See O'Neill v. Gallant Ins. Co., 769 N.E.2d 100 (Ill. 5th DCA 2002).

[1340] Drouillard V. Metropolitan Life Ins. Co., 107 Mich. App. 608, 621 (1981).

[1341] Lisiewski v. Countrywide Ins. Co., 75 Mich. App. 631, 637 (1977).

[1342] Meirthew v. Last. 376 Mich. 33, 38 (1965).

[1343] City of Wakefield v. Globe Indemnity Co., 246 Mich. 645 (1929).

[1344] Commercial Union Ins. Co. v. Liberty Mutual Ins. Co., 426 Mich. 127 (1986). This case outlines twelve factors that the "factfinder may take into account . . . in deciding whether or not the defendant

The most unique principle of Michigan's bad faith law is the insurer's liability for bad faith in the case of excess judgments. Michigan law limits the bad faith exposure of an insurer "by precluding collection on the judgment from the insurer beyond what is or would actually be collectable from the insured."[1345] In Frankenmuth Mutual Ins. Co. v. Keeley, Charles Keeley, the son of the insured, shot the plaintiff, Boone, rendering Boone a quadriplegic.[1346] The plaintiff demanded policy limits of $50,000, but the insurer initially offered to settle for $20,000 on the basis that the policy excluded intentional acts. Within the month and after the plaintiff filed his lawsuit, the insurer offered to settle for $25,000. Two and one-half years later, after much litigation over the claim and the coverage, the insurer tendered policy limits. Boone rejected this offer. The case proceeded to trial and the jury determined the damages to be $500,000, but found that the plaintiff, Boone, was 50 percent at fault. Judgment was entered against Keeley for $250,000. Boone agreed to forbear any action against Keeley for the excess judgment, and Keeley agreed to pursue action against the insurer for the excess judgment and to pay any sums recovered from the insurer to the plaintiff.[1347]

On first hearing, the majority of the Michigan Supreme Court held that "the insurer is liable for the excess without regard to whether the insured has the capacity to pay."[1348] On rehearing, the Michigan Supreme Court essentially reversed itself and limited the bad faith liability of the insurer to the amount that can actually be collected from the insured.[1349]

The reasoning behind the Michigan rule on bad faith liability rests on the issue of causal relationship to damages. The question was "whether . . . there was a causal relationship between the bad-faith conduct that the [judge] found in the handling of the claim and the loss claimed by Keeley resulting from the entry of the judgment in the amount of $250,000."[1350] Accordingly, the question should be whether the insurer caused damage to

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[insurer] acted in bad faith . . ." Id. at 137-139. The Florida Legislature may want to consider adopting some or all of these factors.

[1345] Frankenmuth Mutual Ins. Co. v. Keeley, 433 Mich. 525, 565 (1989). The quoted language is from the dissenting opinion of Justice Levin; however, Justice Levin's dissent was adopted by the majority in Frankenmuth Mutual Ins. Co. v. Keeley (on rehearing), 436 Mich. 372, 376 (1990).

[1346] Id. at 547.

[1347] See id. at 547-549.

[1348] Id. at 528. The court also adopted what is known as the "judgment rule," as contrasted with the "prepayment rule." The "prepayment rule" requires that the insured make some payment on the judgment before pursuing an action for bad faith against the insurer, while the judgment rule simply requires the entry of a judgment. Id. at 553. This portion of the majority opinion was adopted by the dissent on first hearing and then by the majority on rehearing. See Frankenmuth Mutual Ins. Co. v. Keeley (on rehearing), 436 Mich. 372 (1990).

[1349] Id. at 565.

[1350] Id. at 551.

the insured, and if so, what actual damage the insurer sustained. In reaching the decision that the Michigan law should be that the insurer is not required to pay more than the insured is able to pay on the judgment, the Michigan Supreme Court quoted extensively from a New York Court of Appeals case and from Judge Keeton:

> I do not suggest—although there are a number of decisions so holding—that an insured must pay the judgment before he, or another on his behalf, is able to proceed against a bad faith insurer. However, there must be some showing that he has been damaged. In the case before us, there is not the slightest evidence, or even intimation, that the insured was harmed by the judgment, that he had any assets which were imperiled or that either his reputation or credit was impaired.
>
> In short, the complaint in this case should be dismissed not only because there is no evidence that the insurer acted in bad faith but also because there is no evidence that the insured suffered any damaged.[1351]

Judge Keeton has expressed the following view:

> When it seems almost certain the insured will never pay anything at all on the excess judgment if the claim against the insurer is denied, arguments that the insured has been damaged by the increase in debts are rather weak support for any cause of action at all, much less for a measure of damages equal to the amount of the increase in the insured's debts. However, other courts have concluded that the entry of judgment against a person constitutes a loss and that the insured's "loss does not turn on whether the judgment has been satisfied.' Since, absent a discharge of the obligation through a bankruptcy proceeding, the third party's judgment can remain as an outstanding obligation for extended periods of time, in many circumstances there is considerable uncertainty in regard to predicting whether the insured may ultimately have resources or assets that may be taken to satisfy some portion of the judgment.
>
> Third party claimants are not in a position to assert that they were harmed as a result of the insurer's conduct in regard to having not settled the tort claim. The insurer's duty was to the insured, not to the claimant. Furthermore,

[1351] Gordon v. Nationwide Mutual Ins. Co., 30 N.Y. 2d 427, 441, 285 N.E 2d 849 (1972).

> in one sense, a third party benefits from the insurer's refusal to settle because the insurer's refusal to settle resulted in the claimant's obtaining a judgment in excess of the amount the claimant had offered to accept in settlement. Thus, although the third party claimant deserves further compensation, the theoretical justification for imposing liability on the insurer does not warrant a recovery by such a claimant any more than the innocent victims of an under-insured tortfeasor would be entitled to indemnification beyond the amount of the applicable coverage from a liability insurer who had not refused a settlement.[1352]

The Task Force finds that the Michigan law that precludes the collection on the judgment from the insurer beyond what is or would actually be collected from the insured is sound in principle, public policy, and reasoning.

Information Presented to the Task Force

The Task Force heard testimony that certain aspects of bad faith law have resulted in costing consumers more than it benefits them.[1353] According to testimony, one of the most frequent complaints of defendant medical providers is that they are not responsible for the plaintiff's injury and that they do not want to settle the case because they want to prove their "innocence" in court.[1354] However, insureds with low policy limits, as compared to the possible amount of a jury verdict, are often required by the law of bad faith to accept settlement offers that otherwise would be rejected.[1355]

For example, a physician is sued for $5,000,000 by a plaintiff who alleges medical malpractice on the part of the physician. The physician has $300,000 in liability coverage and $100,000 of reachable assets. The physician, based on evaluation of the case, appears to be innocent and when this insurer refuses to settle based on such an evaluation, he or she prevails 90 percent of the time. Under current law, if this case is lost at trial, the insurer would be liable for the $5,000,000 verdict. The difference of $4,600,000 was not caused by the insurer's bad faith but the plaintiff is the recipient of the windfall anyway.[1356] This scenario is the environment in which cases are litigated and it forces insurers to settle

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[1352] Frankenmuth Mutual Ins. Co. v. Keeley, 433 Mich. 525, 554-556 (1989).
[1353] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 2.
[1354] See Tommy Dukes, J.D., testimony, Oct. 21, 2002, pg. 239.
[1355] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pg. 121.
[1356] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 1-2.

cases at, near, or even somewhat above policy limits to avoid bad-faith claims.[1357]

The following solutions were provided to the Task Force:

- Restore the insured as the owner of the bad faith cause of action.[1358]

- The common law cause of action, as outlined by the Supreme Court in 1980[1359] should be preempted by the Florida Legislature so that only insureds, not third-party plaintiffs, can bring a bad faith cause of action against its insurer.[1360] In addition, section 624.155, Florida Statutes, should be amended to limit the proper party in a bad faith cause of action to the insured only.

- Legislatively identify common sense standards of what constitutes bad faith.[1361]

- The current law is vague as to what defines bad faith. Examples of some standards that were presented to the Task Force, include: (1) the insurer's proper investigation of a claim, providing an insurer with a reasonable period in which to investigate all aspects of potential liability of the insured and of the plaintiff's potential damages without being in bad faith; (2) no bad faith if the insurer tenders its policy limits sixty days before trial; (3) the insurer's willingness to negotiate, allowing the insurer to consider the interest of all its insureds in defending claims that it believes to be overstated; (4) clarify that an insurer has no affirmative duty to initiate settlement negotiations when it believes such an action would be detrimental to the ultimate settlement; (5) disallow bad faith claims when an insured refuses to consent to a proposed settlement and/or when the insurer agrees to indemnify the insured for excess judgments collectible from the insured's reachable assets; (6) the insurer's consideration of the advice of its defense counsel; and (7) whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain personal counsel and the risks of litigation.[1362]

[1357] Id. at 2.
[1358] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 117-118.
[1359] See Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).
[1360] Section 624.155(7), Florida Statutes, currently provides that "[t]he civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state." Id.
[1361] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 117-118.
[1362] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 3.

- Calculate the maximum liability for bad faith as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.[1363]

- The bad faith claimant should be required to prove that he has sustained actual financial damage as a result of the bad faith of the insurer and the claim of bad faith should be limited to such actual damage. In addition, the insured should be entitled to retain his assets while the insurer pays any excess judgment, up to the amount of the reachable assets of the insured. If the financial circumstances of the insured improved over the life of the judgment, the insurer should be responsible for such excess payments.[1364]

In response, the Task Force heard testimony that the current state of the law in Florida adequately protects insured and ensures that insurers protect insureds' assets.[1365] Insurers control the defense of the case and decide when and if to settle.[1366] The plaintiffs' bar testified that because judgments in Florida are effective for twenty years, a proposal to limit the bad faith exposure of an insurer to the reachable assets of the insured at the time of judgment may expose the insured's future assets.[1367]

Findings and Recommendations

The Task Force finds that there is a problem with the state of the law in Florida on the issue of bad faith. The problem is that the cost of settlement made under the veil of the bad faith law in Florida is a major factor in raising loss costs that insurers must pay and, in turn, in raising malpractice insurance premiums. The problem stems from the fact that third parties can sue the insurer for bad faith, when the good-faith duty is owed by the insurer to the insured. There is no corresponding good faith duty that extends from the insurer to injured plaintiffs who are not part of the insured/insurer contractual relationship. The law on bad faith is lacking in logical standards that constitute (or at least evidence) bad faith on the part of an insurer. Finally, a limitation on the amount of damages for which an insurer would be liable would promote consistency and predictability in the market.

The Task Force finds calculating the damages recoverable in an action for bad faith based on the actual damages caused by the insurer would have several beneficial effects. First, this calculation would allow insurers to

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[1363] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 123-124.
[1364] Id. at 121.
[1365] See Lake Lytal, J.D., testimony, Nov. 22, 2002, pgs. 123-124.
[1366] Id. at 124.
[1367] Id. at 126.

honor requests from well-informed insureds who prefer that actions be defended rather than settled because of the threat now posed by Florida bad faith standards and calculations of damages. Second, this calculation would enable insurers to more effectively resist the coercive effect of these standards and measurements of damage, which raise the costs of settlements and premiums. The assets of insureds would remain fully protected. The protection of assets that are replaced by insurance may logically be expected to encourage the purchase of insurance.

The Task Force recommends the following legislative solutions:

Recommendation 1. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980[1368] should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third-party plaintiffs, can bring a bad faith cause of action against its insurer.[1369] In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 2. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 3. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 4. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 5. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

[1368] See Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).

[1369] Section 624.155(7), Florida Statutes, currently provides that "[t]he civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state." Id.

Alternative Insurance Products

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to alternative insurance products in the context of medical malpractice cases:

- Should the Department of Insurance be directed to work with physicians and hospitals to expand self-insurance options?
- Should the Legislature create tax and other regulatory incentives for the creation of mutual, trust, and other physician-owned insurance companies to provide coverage?
- Should the patient compensation fund be reactivated?
  - Should there be mandatory participation by physicians and hospitals?
  - Should there be caps on payments?

Current Situation

The Florida Insurance Code provides several alternative insurance products that can be used by healthcare providers to provide medical malpractice insurance coverage. These include commercial Self-Insurance Funds in section 624.462, Florida Statutes, Risk Retention Groups in section 627.942, Florida Statutes, and Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Only the Medical Malpractice Risk Management Trust Fund statute is a specific alternative for commercial medical malpractice insurance; the other forms of self-insurance are available to any group providing self-insurance. A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. The Department of Insurance is directed to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund created pursuant to the act maintain sufficient reserve to cover contingent liabilities in the event of a dissolution.

The funding of a trust fund created pursuant to the section is provided by premiums paid by members. Additionally, each member has a contingent

assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. A member's share of any deficiency is to be computed by applying against the member's premium the ratio of the total deficiency to the total premiums earned. If a member fails to pay the assessment, the other members are proportionately liable for that amount. This assessment must be made if assets of the trust fund are insufficient to discharge the funds liabilities and meet the requirements of law or if a judgment remains unpaid for thirty days.

The Department of Insurance must review and approve all expense factors related to rates before a new rate can be implemented. For the Department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The statute provides that the premiums, contributions, and assessments are subject to taxation at 1.6 percent instead of the 1.75 percent provided in section 624.509(1) and (2), Florida Statutes, for insurance premiums and assessments generally.

In 1992, the statute was amended to provide that no Medical Malpractice Risk Management Trust Fund could be formed after October 1, 1992. Currently there are only two trust funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

Information Presented to the Task Force

Speakers on both sides of the medical malpractice issue discussed the need to reactivate the provisions of section 627.357, Florida Statutes, to again allow physicians and hospitals to create self-insurance funds. Speakers agreed that making this alternative form of insurance available would provide a viable insurance option to healthcare providers.

Mr. Neal Roth indicated physicians and hospitals needed the authority to create the self-insurance trust funds.[1370] To encourage the creation of these trust funds, Mr. Roth suggested the Legislature should provide tax incentives such as exemption from the tax on premiums and exemption of the companies from payment to the guarantee fund. He also suggested the Department of Insurance should be given additional authority to review the capitalization requirements for these trust funds.

Mr. Bruce Hill, an Orlando attorney who represents hospitals, also recommended removing the prohibition on creation of self-insured trust

[1370] Neal Roth, J.D., testimony, Nov. 22, 2002, pgs. 129-130.

funds.[1371] Mr. Hill was general counsel and chief trial counsel for the Florida Hospital Trust Fund created in the 1970s in response to that medical malpractice insurance crisis. Mr. Hill testified that the fund worked well until 1995, when the insurance companies under-cut the rates to the point it was more cost effective for the hospitals to purchase commercial insurance.[1372] At that point, the trust fund stopped selling insurance. Currently, all of the claims against the fund have been paid and an excess $30 million is to be refunded to the member hospitals.[1373] Mr. Hill testified that the fund was heavily regulated by the Department of Insurance to ensure the rates were actuarially sound and the investments were secure. He explained that the reason the fund worked was a low expense ratio resulting from no advertising and no agents. Additionally, the members who ran the trust fund had an interest in ensuring that the fund operated cost effectively because they had to pay part of the bill if assessments became necessary. Finally, the member-run trust fund encouraged the participating hospitals to maintain better risk management programs to reduce claims.[1374]

David McKinney, an executive with Pro National Assurance Company, pointed out some of the concerns with newly-formed alternative risk groups.[1375] First, they face the same uncertainty in claims experience that the insurance companies are facing and the managers often do not have the experience to assess those risks. This allows mistakes in underwriting and claims evaluation.[1376] Because of the significant lag time for claims to be made these problems can be long term in nature. Additionally, the physician-run operations are subject to losing members when the insurance market softens and commercial insurance rates decrease.[1377] His last major point was the fact that under these funds, the members are jointly and severally liable for all claims. He stated the key to a strong fund was having "good people" running the insurance program who know what they are doing.[1378]

Mr. Steve Roddenberry[1379] discussed the regulation of risk retention groups with the Task Force. After an extensive discussion of commercial insurance, Mr. Roddenberry brought up concerns regarding the regulation of risk retention groups.[1380] The rates and forms of risk retention groups domiciled outside of Florida are not subject to review by the Department

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[1371] Bruce Hill, J.D., testimony, Nov. 22, 2002, pgs. 143, 146-150.
[1372] Id.
[1373] Id.
[1374] Id.
[1375] David McKinney, testimony, Nov. 22, 2002, pgs. 151-155.
[1376] Id.
[1377] Id.
[1378] Id.
[1379] Steve Roddenberry, Director, Department of Insurance.
[1380] Steve Roddenberry, testimony, Nov. 4, 2002, pg. 401.

of Insurance.[1381] Further, they do not have the same minimum capital or surplus requirements as insurance companies and they are not eligible for the guarantee fund if a failure should occur.[1382]

Findings and Recommendations

The Task Force finds the healthcare community has an option to address medical malpractice self-insurance programs. Further, the Task Force finds that the Department of Insurance does not have sufficient rule-making authority to provide protection to the healthcare professionals and the victims of medical malpractice utilizing or making claims against self-insurance funds.

The Task Force recommends the Legislature encourage the use of self-insurance funds by healthcare providers and expand the rulemaking authority of the Department of Insurance to adopt rules providing for better regulation of the self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

The Task Force finds that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than "go bare," quit practicing medicine, or reduce services provided. Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

Recommendation 1. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 2. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 3. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

[1381] Id.
[1382] Id.

Insurance Code Reform

Issue

The Task Force voted at its January 16, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to insurance code reform:

- Should the Department of Insurance be authorized to require insurers to provide:
  - How much insurers pay for the different categories of damages;
  - How much claimants actually received in settlements or verdicts that are reduced post trial; and,
  - How much insurers pay in cases involving multiple defendants?

- Should the Department of Insurance prohibit punitive damages or bad faith judgments from being included in the rate base?

Current Situation

Section 627.912, Florida Statutes, requires all insurance companies, self-insurers, and joint underwriting associations providing professional liability insurance to a healthcare practitioner[1383] to report any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of the insured's professional services, or based on a claim the services were performed without consent. These reports must be made only if the claim resulted in a final judgment or a settlement in any amount.[1384] The reports must contain the following specific information:

> (2) The reports required by subsection (1) shall contain:
> (a) The name, address, and specialty coverage of the insured.
> (b) The insured's policy number.
> (c) The date of the occurrence with created the claim.
> (d) The date the claim was reported to the insurer or self-insurer.
> (e) The name and address of the injured person. This information is confidential and exempt from the provisions

[1383] Section 627.912 (1), Florida Statutes, provides the reports must be made for any practitioner of medicine licensed under chapter 458, any practitioner of osteopathic medicine licensed under chapter 459, any podiatric physician licensed under chapter 461, any dentist licensed under chapter 466, any hospital licensed under chapter 395, any crisis stabilization unit licensed under part IV of chapter 394, any health maintenance organization certificated under part I of chapter 641, any clinics included in chapter 390, any ambulatory surgical center defined in section 395.002, and any member of the Florida Bar.
[1384] Section 627.912(1), Florida Statutes.

of s. 119.07(1), and must not be disclosed by the department without the injured person's consent, except for disclosure by the department to the Department of Health. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

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

(h) The total number and names of all defendants involved in the claim.

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

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

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

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

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, costs, and damages involved in professional liability cases.

Subsection (4)[1385] provides that the entity making the report is not liable for any action taken in reporting to the Department of Insurance. However, the department may impose a fine of $250 per day per case, up

[1385] Section 627.912, Florida Statutes.

to $1,000 per case for violations of the requirements of the section. The subsection related to fines only applies to claims accruing on or after October 1, 1997.[1386]

According to the Department of Insurance, some insurers may not report as required and others, such as self-insurers, off-shore captive companies, risk retention groups, and surplus lines companies do not report at all.[1387]

Section 456.049, Florida Statutes, requires medical professionals to report any claim or action for damages for personal injury if the claim was not covered by an insurer required to report under section 627.912, Florida Statutes, where the claim resulted in a final judgment or settlement in any amount or a final disposition with no payment on behalf of the licensee.[1388]

The report is to be filed with the Department of Health no later than sixty days after the occurrence of the judgment, settlement, or determination of no payment. The report must contain the following:

(a) The name and address of the licensee.
(b) The date of the occurrence which created the claim.
(c) The date the claim was reported to the licensee.
(d) The name and address of the injured person. This information is confidential and exempt from s. 119.07(1) and shall not be disclosed by the department without the injured person's consent. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.
(e) The date of suit, if filed.
(f) The injured person's age and sex.
(g) The total number and names of all defendants involved in the claim.
(h) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.
(i) In the case of a settlement, such information as the department may required with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

[1386] Section 627.912(4), Florida Statutes.

[1387] Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance.

[1388] This includes injuries alleged to have been caused by error, omission, or negligence in the performance of the licensee's professional services or based on a claimed performance of professional services without consent.

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

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

(l) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within such institution, at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation or the diagnostic or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the licensee to make similar occurrences or injuries less likely in the future.

(m) Any other information required by the department to analyze and evaluate the nature, causes, location, cost and damages involved in professional liability cases.

On a national level, each entity making a medical malpractice payment under a policy of insurance, self-insurance, or otherwise in settlement of or to satisfy a judgment related to medical malpractice on behalf of a healthcare provider must, report to the National Practitioner Data Bank.[1389] The information to be reported includes:

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

[1389] 42 U.S.C. section 11131.

If an entity that is required to report to the data bank fails to report, it is subject to a civil penalty of not more than $10,000 for each payment not reported.[1390]

Section 627.062, Florida Statutes, provides the requirements to be met by medical malpractice insurance companies in establishing rates and to be used by the Department of Insurance in reviewing the rates filed. The rates filed are not to be excessive, inadequate, or unfairly discriminatory.[1391] The Department is required to review all rate filings to determine if the rate is excessive, inadequate, or unfairly discriminatory.[1392] In making that determination, the statute requires the Department to consider a series of criteria, including the past and prospective loss experience within and without Florida.[1393] The statute does not provide guidance regarding what losses should be included in determining the loss experience. Further, there is no provision in the statute prohibiting insurance companies providing medical malpractice insurance from considering bad faith awards or punitive damage awards in determining rates.

Section 627.651, Florida Statutes, provides for the calculation of rates for automobile insurance. Subsection (12) of that section prohibits motor vehicle insurers from including any portion of a judgment or settlement resulting from a bad faith action or punitive damages award or settlement against the insurer in the insurers rate base or to justify a rate or a rate change. Further, the insurer may not include any attorney fees or costs related to defending a bad faith or punitive damages claim in establishing rates or justifying a rate change.

Information Presented to the Task Force

According to Mr. Steve Roddenberry,[1394] the Department of Insurance does not warrant the accuracy of the data contained in the closed claim database. The database was established only to allow consumers to look up whether a doctor had a claim filed against him or her.[1395] It was never intended to be a "barometer of the medical malpractice insurance market."[1396]

[1390] Id.
[1391] Section 627.062(1), Florida Statutes.
[1392] Section 627.62(2)(b), Florida Statutes.
[1393] Section 627.062(2)(b)1, Florida Statutes.
[1394] Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance.
[1395] Steve Roddenberry, testimony, Nov. 4, 2002, pg. 398.
[1396] Id. at 399.

Mr. Roddenberry also discussed the issue of whether punitive damages and bad faith claims should be included in the determination of rates. He stated that while Florida law does not specifically prohibit the inclusion of those losses in rate determinations for medical malpractice insurance policies, the Department of Insurance tries to exclude those losses now.[1397] He testified the Department does all it can "to ensure that bad faith losses are either immaterial or backed out of claim losses prior to considering a rate increase."[1398]

Findings and Recommendations

The Task Force finds that section 627.912, Florida Statutes, does not require the covered insurers to provide information related to the amount paid in settlement or verdict for the categories of damages, the amount claimants actually received in settlements or verdicts reduced after a trial, or how much insurers pay in cases involving multiple defendants. Further, the information collected by the Department of Health pursuant to section 456.049, Florida Statutes, is not forwarded to the Department of Insurance for inclusion in the closed claims database. The information reported to the National Practitioner Data Bank is more comprehensive than the information reported to the Florida Department of Insurance. Further, the Task Force finds there is nothing in law that prohibits a medical malpractice insurer from including judgments or settlements of punitive damages or bad faith claims in establishing insurance rates or in the justification of a rate change.

Recommendation 1. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 2. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance

Recommendation 3. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

[1397] Steve Roddenberry, testimony, Jan. 16, 2003, pg. 47.
[1398] Id. at 48.

Recommendation 4. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 5. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Chapter 11 - Conclusion

> *"Our Harvard medical practice study found both the medical and legal systems in urgent need of change. We discovered that in New York's hospitals more than 100,000 patients were injured annually because of medical management practices, more than one-quarter from negligence. (More recently we have found a similar picture in Utah and Colorado.) Fewer than 7 percent of New York's injured patients received compensation through the courts, however, of those, fewer than 20 percent were injured because of negligence. So the legal system is even more prone to error than the medical system it attempts to judge."*
>
> Howard Hiatt & Paul Weiler, No Fault Medical Coverage Would Cure Many Ills, The Boston Globe A27 (Nov. 5, 1999)

This Task Force has received extensive testimony and written information related to the current healthcare provider liability insurance crisis. Information was presented to the Task Force on the extent of the crisis, the impact of the crisis on the provision of healthcare in Florida and the nation, and the causes of the crisis. The suggested causes included the medical malpractice insurance underwriting cycle, insurance company investment losses, and the significant increases in medical malpractice insurance company claims losses resulting from the increased frequency and severity of claims. Based on the Task Force's analysis of the information presented, the Task Force set out findings in chapter 5 of this report related to the extent and causes of the crisis.

The Task Force also received extensive testimony and documentation related to proposed solutions to the healthcare provider liability insurance crisis. The Task Force examined an extensive list of proposals from various persons or entities meant to address the crisis in whole or in part. Chapters 6 through 10 of this report examine the law and related testimony as well as documentary information received by the Task Force regarding those proposed legislative changes the Task Force determined would have some impact in addressing this crisis and in minimizing or removing the possibility this problem will arise again in the future.

In chapters 6 through 10, the Task Force proposes a comprehensive package of reforms including changes to improve the quality of care provided in our medical institutions, improved healthcare provider discipline, tort reforms, reforms to the alternative dispute resolution process, and insurance reforms. The Task Force is of the opinion that,

while these comprehensive reforms are important, the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus on the availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages.

In summary, the last few years have resulted in a marked decrease in profitability for professional healthcare liability insurance in the State of Florida. With an industry combined ratio of 184.2 percent, the viability of this market may be threatened if conditions continue to deteriorate.

The recommendations are listed below and are also listed, along with the discussions regarding each proposed recommendation, in chapters 6 through 10 of this report.

Recommendations

Healthcare Quality

Recommendation 1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine, is to have two systems, one for the mandatory reporting of adverse events and another for the voluntary reporting of near misses. The second option is to have a single entity, similar to the Patient Safety Authority in Pennsylvania, that would analyze all adverse events and near misses. Experts would analyze these data and make recommendations to facilities about how to reduce these events and near misses. Information would not be subject to discovery in lawsuits.

Recommendation 2. The Legislature should timely develop or adopt a statewide electronic medical record and physician medication ordering system. The system should be developed in partnership with hospitals, physicians, and other healthcare providers. The physician medication ordering system should be implemented first. The system could then be implemented in stages with a possible approach of beginning with a web-based data exchange platform that establishes interconnectivity between providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

Recommendation 3. The Legislature should consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority, statewide electronic medical record, and build an information technology infrastructure to support the delivery of healthcare that would include a statewide physician medication ordering system. Funding could

possibly come from a $1 per year surcharge on all health professional licenses; all hospital, ambulatory care surgery center, nursing home, home health agency, and birth center discharges; and all individuals in managed care plans and insurance plans licensed under chapters 627 and 640, Florida Statutes. Health providers, insurers, businesses, and government would be represented on the governing board of directors. Options for implementation include:

- Affiliating with a university for the analysis of voluntarily-reported adverse events and "near misses."
- Contracting with an information technology firm(s) for a statewide physician medication ordering system, web-based platform for health provider interconnectivity, and electronic patient record.
- Developing a business plan and future financing strategy to supplement the $1 annual surcharge, which will likely be necessary to achieve full implementation.
- Including in the business plan a strategy to begin with computerizing business functions, for providers to quickly achieve cost-savings due to automation efficiencies, and then include clinical functions.

Recommendation 4. The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the IOM November 2002 report, Fostering Rapid Advances in Healthcare, at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.

Recommendation 5. If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.

Recommendation 6. The Legislature should require each hospital and ambulatory surgery center to have a patient safety plan, a patient safety committee, and a patient safety officer. Members of the public should have representation on patient safety committees.

Recommendation 7. The Legislature should require healthcare providers to notify patients who experience serious medical injuries to be notified of the injury in person.

Recommendation 8. The Legislature should examine the feasibility of using Medicaid funding to create a pilot project for an electronic medical record and a physician medication ordering system for Medicaid patients.

Recommendation 9. The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 10. The Legislature should establish a high-technology simulation center for use by all health providers. Florida should encourage use of this center by practitioners in other states to help offset the costs for the center.

Recommendation 11. The Legislature should require all medical schools, nursing schools, and allied health schools to include in their curricula courses on patient safety and patient safety improvement.

Recommendation 12. The Legislature should require the Agency for Health Care Administration (AHCA) to conduct a study to determine if it is feasible to provide information to the public to help them make better healthcare decisions regarding the choice of a hospital. The information would not be presented in a "report card" format. AHCA should be provided with sufficient resources to conduct the study in cooperation with hospitals, physicians, and other healthcare providers and provide the Governor and Legislature with a report.

Physician Discipline

Recommendation 13. The Legislature should allow the healthcare provider regulatory boards to appoint administrative law judges with expertise in the profession to hear standard of care cases.

Recommendation 14. The Legislature should statutorily provide that standard of care decisions are, as a matter of law, infused with overriding policy considerations best left to the healthcare provider regulatory boards.

Recommendation 15. The Legislature should authorize the healthcare provider regulatory boards to reassess and resolve conflicting evidence in standard of care cases based on the record in the case.

Recommendation 16. The Legislature should require physician profiles to provide professional qualifications information regarding physicians to consumers.

Recommendation 17. The Legislature should provide for an audit of the Department of Health's disciplinary process and closed claims files.

Recommendation 18. The Florida Legislature should strengthen Florida's peer review requirements so they can lead to earlier dismissal of meritless claims brought against hospitals by aggrieved physicians and protect physicians and hospitals from costly lawsuits and liability.

Recommendation 19. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 20. The Legislature should require that all first offense citations be non-disciplinary and non-reportable to the national data banks.

Recommendation 21. The Legislature should expand the timeframe for forwarding cases to the Division of Administrative Hearing from fifteen days to forty-five days when a demand for a formal hearing, pursuant to section 120.57(1), Florida Statutes, is received.

Recommendation 22. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases shall be included.

Recommendation 23. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 24. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 25. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Recommendation 26. The Legislature should expand the healthcare provider regulatory board's rulemaking authority in the areas of Internet prescribing and sexual misconduct cases so as to better address critical areas of discipline.

Tort Reform

Cap on Non-Economic Damages

Recommendation 27. The Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident. The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare. The evidence before the Task Force indicates that a cap of $250,000 per incident will lead to significantly lower malpractice premiums.

The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the Legislature five years after date of enactment.

Communications with Subsequent Treating Physicians

Recommendation 28. The Legislature should amend the Florida Statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 29. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

Expert Witness Qualifications

Recommendation 30. The Legislature should examine ways to improve the use of in-kind experts at trial.

Limitation on Liability Related to Emergency Services

Recommendation 31. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 32. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Sovereign Immunity

Recommendation 33. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

Periodic Payment of Damages

Recommendation 34. The Legislature should amend the Florida Statutes to allow the periodic payment of future non-economic damages.

Recommendation 35. The Legislature should amend the Florida Statutes to terminate the payment of future economic and non-economic damages on the death of the plaintiff.

Pre-Suit Reform

Recommendation 36. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar if not identical credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 37. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Recommendation 38. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

Set Off of Settlement Proceeds

Recommendation 39. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

Alternative Dispute Resolution

Mandatory Mediation

Recommendation 40. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 41. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good-faith offer of settlement is refused.

Recommendation 42. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount to the offer the judgment must be and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 44. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Recommendation 45. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 46. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

Insurance Reform

NICA

Recommendation 47. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

Bad Faith

Recommendation 48. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 49. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 50. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were

actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance is to be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Alternative Insurance Products

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Insurance Company Regulation

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.