Compensation of Victims: As the cost of medical malpractice insurance has increased some healthcare providers carry only minimum insurance of $250,000 or are "going bare." This leaves victims with minimal or no compensation should they be injured.

Professional Regulation of Medical Care: The current disciplinary process requires the Division of Administrative Hearings judges to make the determination when conduct fails to meet minimum standards of care and is formally charged against a healthcare provider or facility. Frequently those rulings frustrate and thwart the ability of the healthcare provider regulatory boards to appropriately discipline healthcare providers. Issues such as defining the standard of care in a given set of facts and whether the practitioner breached that standard are responsibilities best left to the professional boards. Additionally, hospitals find it very difficult to discipline or remove healthcare professionals for actions below the accepted standard of care.

In addition to receiving extensive testimony regarding the existence of a medical malpractice insurance crisis and the current related law, the Task Force requested speakers and participants to offer the Task Force recommendations for addressing the problem. The Task Force requested proposals in the areas of:

- Improving the quality of medical care
- Discipline of healthcare practitioners/providers
- Tort reform
- Alternative dispute resolution
- Insurance reform

Proposals Heard

In total the Task Force heard testimony regarding over 100 proposals for change, which fell into one of the categories below:

(1) Improving healthcare quality
(2) Physician discipline
(3) Tort reform
(4) Insurance reform
(5) Alternative dispute resolution reform

The remainder of this report contains the specific recommendations of the Task Force and the rationale for each recommendation. It is organized according to the above five issue areas. Chapter six contains the healthcare quality issues. Chapter seven contains the physician discipline reform. Chapter eight contains the tort reforms. Chapter nine contains the insurance reforms. Finally, chapter ten contains the alternative

dispute resolution reforms. These recommendations recognize that it is possible to reduce the cost of medical malpractice and the severity and frequency of claims. These recommendations include a comprehensive reform package designed to strengthen quality healthcare in Florida. The Task Force believes that these recommendations constitute a carefully balanced set of ideas, the content of which has been determined by the results of extensive testimony and research. The Task Force recommends that the Florida Legislature adopt these proposals.

Chapter 6 - Improving Healthcare Quality

"The culture of medicine creates an expectation of perfection and attributes errors to carelessness or incompetence. Liability concerns discourage the surfacing of errors and communication about how to correct them."

"Patient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations."

Institute of Medicine, To Err is Human: Building a Safer Health System 22, 43 (Linda T. Kohn et al. eds., 2000)

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the following issues with respect to reducing medical errors and improving healthcare quality:

Should a patient safety authority or patient safety center be created to:

- Require mandatory reporting of serious events or near misses?
  - Should information be confidential?
  - Should information be subject to discovery?
- Analyze and make recommendations directly to medical facilities to improve care?
  - Require retraining or mentors for those with adverse events?
- Require all hospitals to have patient safety plans, patient safety committees, and patient safety officers?
- Require written notice of serious events to impacted patients or their representatives?
- Evaluate objective criteria for evaluating the effectiveness of the current mandatory reporting system?
- Evaluate factors that limit the effectiveness of the current reporting system?
- Implement a system for reporting near miss events?
- Develop objective criteria for evaluating the effectiveness of a near miss reporting system?

- Analyze reported data and make recommendations directly to healthcare facilities and providers to improve care?
- Provide malpractice insurance discounts if a hospital implements a certified patient program?

In addition, the Task Force requested staff to include the recommendations included in the testimony made by Donald Berwick, M.D. Dr. Berwick's recommendations were:

- Implement a safety reporting system, based on the aviation model, which uses "the best people" to analyze medical mistakes. This recommendation is similar to the Patient Safety Authority model in Pennsylvania that is based, in part, on the Institute of Medicine's recommended model described in the To Err is Human and Fostering Rapid Advances in Health Care reports.
- Adopt a strategy to provide all hospitals with a computerized physician order medication system.
- Develop a single inexpensive electronic medical record at the state level that would contain essential information so that all physicians, hospitals, and other facilities would have access to the record.
- 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: (1) all patients are told when they are injured; (2) an apology to the patient is made; (3) injured patients are compensated just as in the workers' compensation system; (4) the "entity" would be responsible for liability, not the individual; and (5) the demonstration project should have a study component to study injuries to continually reduce risk.
- Include courses on patient safety and safety improvement in medical and nursing school curricula.
- Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.

At the January 16 meeting of the Task Force, by a 4-0 vote, staff was directed to prepare a recommendation requiring state government to determine the feasibility of providing information to the public to assist in making better healthcare decisions. The information would not be made available as a "report card."

Current Situation

Florida law requires hospitals, ambulatory surgery centers and nursing homes to have internal risk management programs that are designed to identify and minimize the risk of adverse incidents to patients. Florida law governing risk management programs for hospitals and ambulatory

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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

[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 state. 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

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[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

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[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

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[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] [illegible] 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 J/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 obse ved:

> 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 under-served 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

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[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

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[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:

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[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

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[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]

The 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. Harnage, 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

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[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.