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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] Review as to why so few physicians are disciplined is unavailable because the closed cases are sealed.[711]

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

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

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

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

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

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

The federal government has also addressed the merits of peer review through statutory protections when Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA).[721] The HCQIA 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 Instr. (civ.) MI 4.4(a).
[748] Id.
[749] Id.
[750] Id.
[751] Fla. Std. Jury Instr. (Civ.) 6.2(a).
[752] After the jury has returned its verdict, the court may, upon proper motion, order remittitur or additur where the jury has found the medical malpractice defendant liable but the jury's award of money damages is excessive or inadequate in light of the fats and circumstances which were presented to the trier of fact. Section 768.74(1), Florida Statutes.
[753] Brain-Injured Patient Awarded $78 Million, Orlando Sentinel, Mar. 14, 2002. The case was was Henalori Shellow-McGee, by and through her legal guardian, Darrell McGee v. Orlando Regional Healthcare System d/b/a Sand Lake Hospital, No. CI-000-4009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[764] Id.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In 1999, Dr. Hamm published a study that analyzed the effect that lifting the MICRA cap would have on the cost of healthcare provided to 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. Murphy, 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:

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

- The relaxed evidentiary standard for arbitration proceedings.
- Joint and several liability of multiple defendants in arbitration.
- Prompt payment of damages after the determination by the arbitration panel.
- Interest penalties against the defendant for failure to promptly pay the arbitration award.
- 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:

  - 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.
  - 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.
  - 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

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[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.

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

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

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

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

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

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

Information Presented to the Task Force

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

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

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

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

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

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

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

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

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

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

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

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

Findings and Recommendations

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

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

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

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

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[907] Id.

Expert Witness Qualifications

Issue

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

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

Current Situation

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

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

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

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[908] Section 766. 102(1), Florida Statutes.

[909] 718 So. 2d 205, 209 (Fla. 1st DCA 1998).

[910] See Cenatus v. Naples Community Hosp., Inc., 689 So. 2d 302 (Fla. 2d DCA 1997); see also Barrio v. Wilson, 779 So. 2d 413 (Fla. DCA 2000) (specialist who frequently consulted on emergency room cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information Presented to the Task Force

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

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

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

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

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

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

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

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

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

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

Findings and Recommendation

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

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

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

Limitation on Liability Related to Emergency Services

Issue

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

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

Current Situation

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

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

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

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

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

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

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

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

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

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

[934] Id. at 591-592.

[935] Id. at 592.

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

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

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

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

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

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

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

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

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

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

[945] Id.

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

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

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

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

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

Information Presented to the Task Force

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

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

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

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

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

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

[950] Id. at 99.

[951] Id. at 100.

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

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

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

Findings and Recommendations

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

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

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

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

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

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

Sovereign Immunity

Issue

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

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

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

Current Situation

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

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

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

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

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

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

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[958] Spangler v. Florida State Turnpike Authority, 106 So. 2d 421 (Fla. 1958).

[959] State Road Department v. Tharp, 146 Fla. 745, 1 So. 2d 868 (Fla. 1941).

[960] See Fla. Const. art. X, section 13.

[961] Suwannee County Hospital Corp. v. Golden, 56 So. 2d 911 (Fla. 1952).

[962] Smith v. Duval County Welfare Bd., 118 So. 2d 98 (Fla. 1st DCA 1960).

[963] Rabin v. Lake Worth Drainage Dist., 82 So. 2d 353 (Fla. 1955).

[964] See Fla. Const. art. IV, section 19 (1868) (now art. X, section 13).

[965] Prior to 1979 and passage of 768.28, Florida Statutes, a party suffering injury by the state could file a claims bill with the Legislature seeking relief.

[966] Commercial Carrier Corp. v. Indian River County, 371 So. 2d 1010 (Fla. 1979), Cauley v. City of Jacksonville, 403 So. 2d 379 (Fla. 1981), and Eldred v. North Broward Hospital District, 498 So. 2d 911 (Fla. 1986) (found the special taxing district to be covered by sovereign immunity on the basis of three actions: first, the passage of 768.28, second the specific recognition of special taxing districts as

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

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

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

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

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

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

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

[967] Section 766.1115, Florida Statutes.

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

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

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

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

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

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

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

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

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