The Florida Medical Malpractice Act of 1975

Theresa Hooks

Follow this and additional works at: http://ir.law.fsu.edu/lr

Part of the Medical Jurisprudence Commons, and the Torts Commons

Recommended Citation
http://ir.law.fsu.edu/lr/vol4/iss1/3

This Note is brought to you for free and open access by Scholarship Repository. It has been accepted for inclusion in Florida State University Law Review by an authorized editor of Scholarship Repository. For more information, please contact bkaplan@law.fsu.edu.
THE FLORIDA MEDICAL MALPRACTICE REFORM ACT OF 1975

I. INTRODUCTION

The current medical malpractice insurance crisis threatens to disrupt the practice of medicine, the operations of insurance companies, and ultimately the availability of medical services. Medical doctors in several states have threatened to strike if legislatures fail to find a way to halt the drastically increasing costs of medical malpractice insurance premiums.¹ Several groups of California doctors staged walkouts to protest malpractice rates which they considered unsatisfactory.² Insurance companies throughout the country are abandoning the malpractice business.³ Patients are troubled by spiraling hospital and doctor fees and the unnecessary tests, treatments, and consultations ordered by doctors to protect themselves in case of a malpractice claim.⁴

¹. Physicians in California, New York, and Rhode Island have indicated that massive walkouts are inevitable if the cost of medical malpractice insurance coverage is not reduced. In New York, 1,500 doctors held a demonstration outside the headquarters of the New York Medical Society to display their dissatisfaction with emergency legislation passed by the New York Legislature. Newsweek, June 9, 1975, at 58. A spokesperson for the Dade County Medical Association has stated that nearly 3,000 South Florida doctors are preparing to stage a “work slowdown . . . to protest the high cost of malpractice insurance.” Dr. Janice Sherwood stated that “as of Jan. 1, Dade and Broward and other surrounding counties may well find themselves without physicians because of a necessary work slowdown.” Tallahassee Democrat, Aug. 14, 1975, at 26, col. 2.

². A strike by anesthesiologists and surgeons in northern California in May 1975, resulted in the elimination of all but emergency surgery in two-thirds of the area’s hospitals. Over 4,000 lay-offs of hospital personnel occurred in San Francisco alone. In the southern part of the state, including Los Angeles, as many as 22,000 beds in 113 hospitals were unoccupied; economic losses were estimated to be $1.1 million per day. Newsweek, June 9, 1975, at 58.

³. In 1973 more than 20 companies wrote malpractice insurance in the United States. Today there are about 10 and only six of these write on a national scale. Rubsamen, The Malpractice Crisis: How Did We Get There, Can We Get Out?, Modern Medicine, April 1, 1975, at 34. Over 20 insurance firms which offered malpractice coverage have terminated such coverage in Florida in the past 5 years. St. Petersburg Times, Jan. 6, 1975, § B, at 1, col. 2.

⁴. One of the most pervasive impacts of the medical malpractice problem arises out of what is commonly called “defensive medicine.”

Positive defensive medicine is the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability. . . . Negative defensive medicine occurs when a physician does not perform a procedure or conduct a test because of the physician’s fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question.
Nationwide, professional liability insurance premiums for hospitals rose over 260 percent between 1960 and 1970; for physicians other than surgeons, 541 percent; and for surgeons almost 950 percent. In Florida, Argonaut Insurance Company, which supplies group liability insurance for approximately half of the state's physicians, raised its rates an average of 96 percent effective January 1, 1975. In April 1975 Argonaut contended that its solvency was threatened and requested permission to increase its rates another 95 percent. The company threatened to withdraw coverage immediately if the increase were not approved. On May 19, 1975, however, United States District Court Judge Gerald B. Tjoflat ordered Argonaut to continue coverage for the remainder of 1975 at the January 1, 1975, rate. Only one other firm is currently writing new policies in the state, and its rates for high-risk categories are higher than Argonaut's.

Against this background, and in response to the pressure for a legislative solution to the malpractice situation, lawmakers throughout the nation have considered a variety of remedial proposals. The 1975 Florida Legislature passed a sweeping reform bill (The Medical Malpractice Reform Act of 1975, hereinafter referred to as the Act) which was endorsed and promptly signed into law by Governor Reubin Askew.

Satisfaction with the new law was short-lived, however, and...
doctors in the state complain that the new legislation will not ade-
quately relieve the situation.9
This note analyzes the reasons frequently given to explain the malpractice problem,10 and explains and critiques the malpractice legis-
lation passed by the 1975 Florida Legislature.

II. ANALYSIS OF THE MEDICAL MALPRACTICE INSURANCE PROBLEM

The rising cost of malpractice insurance is often attributed to the fact that the number of malpractice claims filed against doctors and health-care facilities has increased drastically over the past 10 years.11 The conclusion often drawn is that patients today are more willing to sue their doctors and are more capable of doing so. Several reasons for this trend have been suggested. The decline of the “family doctor” practice and the movement toward specialization12 has to a large extent eliminated personal relationships between patients and doctors and created a formal businesslike atmosphere; patients no longer feel warmth and loyalty toward their doctors and are not hesitant to sue if they believe that their treatment has been negligent or careless.13

It is also suggested that the conceptual expansion of certain legal doctrines, such as informed consent,14 res ipsa loquitur,15 the collateral


10. The author's investigation into this subject began as a result of a staff memorandum which she prepared while employed on the staff of the Health and Rehabilitative Services Committee of the Florida House of Representatives. The memorandum analyzes the reasons for premium increases and describes and compares some alternatives to the tort-liability system in the area of malpractice claims. Memorandum to Dr. Richard S. Hodes, Chairman of Committee on Health and Rehabilitative Services, from Tom Herndon, Staff Director, October 3, 1974.

11. NEWSWEEK reports that 20,000 malpractice claims are being brought against doctors each year and the number is rising steadily. NEWSWEEK, June 9, 1975, at 59. Only 1.7 physicians out of every 100 were sued in 1966. This figure jumped to three out of 100 in 1972. Washington Report for State Legislatures, supra note 5, at 1. According to a representative of the Florida Medical Association, 502 claims were filed against Argonaut insurance policy holders in Florida in 1974 as compared to 208 claims in 1973. American Medical News, supra note 7.

12. In 1971 more than four out of five physicians were specialists. G. ROEBECK, DISTRIBUTION OF PHYSICIANS IN THE UNITED STATES 35 (1971).

13. H.E.W REPORT 67. See also Hager, Communication: A Therapeutic Tool (Argo-

14. This doctrine is based on the theory that patients have a right to be informed of the choices of treatment available for their medical problem and the dangers potentially involved in each treatment. A patient's consent to treatment may not fore-

15. This is a legal doctrine that holds a defendant liable for the consequences of his own actions, even if he was not negligent, because the injury occurred in a situation in which he should have been aware of the possibility of harm.
source rule,\textsuperscript{16} and the locality rule,\textsuperscript{17} has broadened the scope of medical malpractice liability.\textsuperscript{18} It is said that the media tends to give special attention to cases involving substantial amounts of money. Such publicity encourages others to litigate their claims, some of which are entirely


\textit{15. "Res ipsa loquitur," which means "the thing speaks for itself," is a legal doctrine which creates an inference of negligence. When the \textit{res ipsa loquitur} theory is allowed in a malpractice suit, it is not necessary for the patient to prove the doctor's negligence by showing direct acts or omissions. Instead, if the plaintiff proves that the event or injury is such as will not ordinarily occur in the absence of negligence, that the person causing the harm was in exclusive control of the defendant, and that the event or injury was not due to any contribution on the part of the plaintiff, his case may be presented to the jury even though he produced no direct proof of negligence. HEW Appendix 124. See also, HEW Report 28; Annot., 82 A.L.R.2d 1262 (1962); 23 Fla. Jur. Negligence § 115, 116 (1959).}

\textit{The doctrine of \textit{res ipsa loquitur} has not been applied in medical malpractice cases in Florida when negligence is charged in diagnosis or treatment. Hine v. Fox, 89 So. 2d 13 (Fla. 1956); Roth v. Dade County, 71 So. 2d 169 (Fla. 1954); West Coast Hosp. Ass'n. v. Webb, 52 So. 2d 803 (Fla. 1951); Grubbs v. McShane, 198 So. 208 (Fla. 1940); Foster v. Thornton, 170 So. 459 (Fla. 1936).}

\textit{16. The widely accepted collateral source rule provides that "benefits received by the plaintiff from a source wholly independent of and collateral to the wrongdoer will not diminish the damages otherwise recoverable from the wrongdoer." 22 Am. Jur. 2d Damages § 206 (1965). The result of this rule is that a plaintiff's income from such sources as gratuitous medical care, salary, insurance proceeds, welfare, and pension funds will not be made known to the jury and thus will not be considered when damages are measured. \textit{Id. See also Annot., 18 A.L.R. 678 (1922). Collateral source rule is recognized by Florida courts. See Burke v. Byrd, 188 F.Supp. 384 (N.D. Fla. 1960); Paradis v. Thomas, 150 So. 2d 457 (Fla. 2d Dist. Ct. App. 1963); Finley P. Smith, Inc. v. Schectman, 132 So. 2d 460 (Fla. 2d Dist. Ct. App. 1961).}

\textit{17. The "strict locality rule," once prevalent but now diminishing in importance and usage, holds that a physician is required to treat his patients only in accordance with \textit{accepted medical practices in his own community}. In many jurisdictions this rule has been modified. The standard of care under the modified rule is that "which is ordinarily observed by other physicians and surgeons in good standing in either the defendants' locality or a similar locality." 27 Am. Jur. Proof of Facts § 1, at 4–5 (1971). The modified locality rule is followed in Florida. Bourgeois v. Dade County, 99 So. 2d 575, 577 (Fla. 1957); Crovella v. Cochran, 102 So. 2d 307, 311 (Fla. 1st Dist. Ct. App. 1958). But see Dillmann v. Hellman, 283 So. 2d 388 (Fla. 2d Dist. Ct. App. 1973); Potock v. Turek, 227 So. 2d 724 (Fla. 3d Dist. Ct. App. 1969). Some courts have abandoned the locality rule altogether. In these jurisdictions, the standard of care for judging the physician's acts is whether he failed, under the circumstances of the case, "to exercise the degree of skill and care that is usually exercised in similar cases by other members of the medical profession generally, irrespective of the particular geographic localities in which such other members of the profession, or the doctor himself, may practice." 27 Am. Jur. Proof of Facts § 1, at 4–5 (1971) (emphasis added).}

frivolous. Finally, the contingency fee system is often blamed for the increase in the number of claims because it enables those who could not otherwise afford to sue to do so. The increase in the number of suits filed has been accompanied by an increase in the number and size of awards received by plaintiffs.

Those who have analyzed the situation believe that this increase is due to a variety of reasons. One of the most important of these is the relative ease of obtaining medical witnesses to testify in the patient's behalf. The stigma attached to testifying against a professional colleague is disappearing as doctors realize that it is advantageous to the profession to refuse to protect "unfit" members. Moreover, the locality rule, which requires that the doctor-defendant be judged by local community standards is being limited by many jurisdictions, thus allowing doctors from outside the community to testify.

A second factor influencing the frequency and size of jury awards is that juries today are more willing to examine critically the medical evidence presented and to set a higher standard of care than in the past. It is also argued that highly skilled trial attorneys who are capable of convincing juries to award high amounts are being attracted to malpractice litigation because of the contingency fee system.

Those who argue that the greater numbers of claims filed and the higher jury awards are the principal reasons for the malpractice situation often tend to overstate certain factors and to ignore others. For

19. HEW REPORT 18; HEW APPENDIX 653.
20. The contingency fee arrangement allows a client who could not afford to pay a straight attorney fee to obtain legal counsel. An initial agreement is worked out between the attorney and the client concerning the fee. If the case is lost, the attorney gets nothing; if the attorney succeeds he or she receives a percentage, usually 30-40%, of the award. This system is under severe attack by physicians who "are convinced that the contingent fee system is the very root of today's malpractice problem." HEW REPORT 32. A St. Petersburg obstetrician is quoted as saying that "every time an attorney gets a contingency fee he's stealing from the patient." Whitney, Doctors Say Lawyers Push Suits, St. Petersburg Times, Jan. 22, 1975, § B, at 1, col. 2.
21. Nationwide, the number of claims paid during 1969 was 6,606; by 1973 the number had increased to 10,151. Florida Insurance Services Office, Data on Joint Underwriting Association, Florida Expense Provisions, exhibit 2, sheet 1 (1975).
22. During the calendar year ending June 30, 1969, the average paid claim countrywide was $8,400. By December 31, 1973, the average cost had jumped to $5,407 per claim. Id. It is reported that in New York the average amount of a malpractice award—either by judge or jury, or by out-of-court settlement—increased from $6,000 to $23,400 in 10 years. NEWSWEEK, June 9, 1974, at 59.
24. See note 17 supra.
27. Id.
instance, part of the increase in the number of claims filed against doctors can be explained simply by the higher number of people seeking medical aid. Major health and medical plans, including Medicaid, have made it possible for more people to obtain medical treatment. As the number of doctor-patient contracts increases, so does the opportunity for medical incidents which give rise to malpractice claims. Thus the increase in malpractice suits, to a certain extent at least, is merely a function of an increased number of patients. The emphasis on high jury awards is also worthy of closer scrutiny. As for the increased size of jury awards, one has only to look at the cost of living index and recent inflationary trends to understand why a jury must award more now than in the past to provide an injured person with the same quantity and quality of medical care. The higher awards may reflect only an effort to keep up with increasing medical service costs and not a sudden generosity on the part of juries. Another factor which is probably overrated as a cause of the malpractice crisis is the number of very large awards that have been received by patients. While it is true that a few patients have received extremely large amounts, such awards are very infrequent. Although the increased number of claims filed and amounts awarded are factors contributing in part to the malpractice crisis, they are often overemphasized.

One overlooked factor involves ratesetting and actuarial issues. Insurance companies base their rates on actuarial predictions. By analyzing past statistical data and future trends, the actuary determines the amount of premiums that must be charged in order to insure that the company has sufficient funds to cover losses and administrative costs, and to produce a margin of profit. The most accurate ratesetting is accomplished when there is a large volume of data and a stable, durable market. The malpractice insurance line certainly does not fit this description. The total premium volume for physicians' and surgeons' malpractice insurance does not exceed 2.5 percent of the total property-liability insurance premiums received by companies nationwide. This small volume provides neither the adequate statistical

29. Before 1971 only three malpractice claims were settled for amounts in excess of $1 million. Since 1971, about 15 settlements have exceeded $1 million. Washington Report for State Legislatures, supra note 5. Slightly conflicting figures have been published by Rubsam saw. According to his article, until 1965 there was only one jury verdict in the United States for medical malpractice which exceeded $1 million. But today approximately 30 awards of $1 million or more have been given by either jury verdicts or out of court settlements. Rubsam saw, supra note 3, at 30.
30. HEW APPENDIX 529. Due to the lack of readily available data in other areas, these figures are limited to physicians and surgeons; however, many of the descriptions
basis for complex actuarial techniques nor the incentive to spend time, resources, and money to improve the methods used. As a result, actuarial techniques are simpler and predictions less accurate than for other types of insurance. 31 Another aspect of this size disadvantage is that the affects of a loss are more severe. As David S. Rubsamen explains:

It is worthwhile recalling the purely arithmetic factor that contributes to high malpractice insurance premiums. The underlying philosophy of insurance is to share the risk. Among automobile carriers, the prospect of severe loss creates no special problem, because the necessary increase in premiums is spread among hundreds of thousands of a company's insureds. For the malpractice company, on the other hand, a bad claims experience among its few thousand physician-insureds must result in a large premium jump for each doctor. 32

Besides its size disadvantage, the malpractice insurance field is plagued by another unique and troublesome characteristic—the "long tail" phenomenon. The "long tail" refers to the extended period of time occurring between the opening and closing of a medical malpractice claim. On the average, 10 percent of all malpractice claims remain unsettled 6 1/2 years after the occurrence of an injury. 33 In contrast, nearly 100 percent of all automobile claims are settled within 3 years of the accident. 34 The average time from the onset of a medical injury to a final decision on the case is 40 months where there is a settlement, and 60 months where a trial is necessary. 35

Insurers complain that a major reason for the "long tail" is the discovery rule, which provides that the statute of limitations does not begin to run until the injury is discovered. 36 Data is available, however, which indicates that most injuries are recognized within 1 year of occurrence. 37 Insurers also dislike the rule followed in some jurisdictions which tolls the statute of limitations for minors until they attain

---

and conclusions apply to hospitals, dentists, etc. Id.
31. Id.
32. Rubsamen, supra note 3, at 34.
33. HEW REPORT 42.
34. Id.
35. HEW APPENDIX 258.
36. According to this rule the statute of limitations "does not begin to run until the patient knew, or in the exercise of reasonable care should have discovered, that a negligent act occurred." HEW REPORT 30. The statute of limitations provision of the Florida Medical Malpractice Reform Act of 1975 is discussed in section IIA1 of this note.
37. HEW APPENDIX 254.
majority. This situation also occurs very infrequently and certainly is not a major reason for the "long tail." Rather, the prolonged closing time for malpractice suits lies mainly in two other areas of the resolution process—the time from the recognition of the injury to filing of the suit, and the time from the filing of the suit to the final formal hearing. Among the factors cited for causing these delays are court congestion, the long time period necessary for the attorneys to prepare their cases, and a natural tendency to delay, combined, at times, with the strategic nature of delay.

Probably the most significant cause of malpractice insurance problems is the effect of the current economic conditions on insurance companies. Insurers are generally required by state statutes to maintain a certain amount of surplus capital to cover any catastrophic losses. The companies often invest this surplus in common stocks. During the past two years many companies over-invested, and as a result of the market decline, a number of them suffered reductions of surplus in excess of 50 percent. When surplus reduction occurs, companies must reduce their premium volume; naturally the least stable lines of insurance, such as medical malpractice, are dropped. This is precisely what has occurred in Florida. The limited availability of underwriters reduces competition and allows the insurers who continue to offer coverage to, in effect, name their own price. Thus a major factor in the malpractice insurance crisis involves current economic conditions and open-market competition.

It is apparent that those seeking a solution to the malpractice situation are faced with a number of complex and interrelated issues. There is no simple explanation for the situation, nor is there a simple method of resolving the problems.

III. THE FLORIDA LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE INSURANCE CRISIS

The demand for remedial legislation to alleviate Florida's malpractice crisis began early in 1975 when an intensive lobbying effort was staged by the Florida Medical Association, local medical societies, and

38. In Florida the limitation period for an action of negligence on behalf of an infant is not tolled by reason of infancy. 21 Fl. JUR. Limitations of Actions § 55 (Supp. 1976); Gasparro v. Horner, 245 So. 2d 901 (Fla. 4th Dist. Ct. App. 1971).
39. HEW Appendix 256.
40. Id. at 254.
41. Rubsamen, supra note 3, at 34.
42. Whitney, Malpractice Suits Viewed as Threat to Health Care, St. Petersburg Times, Jan. 6, 1975, § B, at 1, col. 3.
individual physicians. Physicians and others in the health care field came from all over the state to testify before various legislative committees that were analyzing the problem. Their combined efforts culminated in the passage by the legislature of a comprehensive and far-reaching law, the Medical Malpractice Reform Act of 1975.

The Act contains 17 sections, 12 of which may be termed operational sections. The 12 operational sections can be divided into four categories—alteration of legal doctrines, procedural changes, insurance-related changes, and measures designed to reduce medical malpractice incidents. Sections which affect legal doctrines include a provision which shortens the statute of limitations for malpractice claims, a statute of frauds provision which bars suits based on guarantees, warranties, or assurances made by health care providers unless the agreement is in writing, and a provision creating the Florida medical consent law. Procedural changes include authorization for the creation of medical liability mediation panels and the requirement that the amount of general damages be omitted from complaints filed in circuit court for personal injury or wrongful death. The insurance-related provisions include creation of the Florida Medical Liability Insurance Commission, authorization for groups or associations of medical doctors or health-care facilities to self-insure, directions for the Department of Insurance to adopt a temporary joint underwriting plan in which certain casualty insurers and self-insurers are required to participate, and establishment of a patient's compensation fund to pay specified malpractice claims in excess of $100,000. The provisions designed to reduce malpractice incidents include the requirements that

---

43. Meetings of the Commerce Committee of the Florida House of Representatives held during April 1975 attracted medical insurance personnel who spoke to the Committee about the malpractice situation.

44. Fla. Laws 1975, ch. 75-9, § 7 (§ 95.11(4)).

45. Id. § 10 (§ 725.01).

46. Id. § 11 (§ 768.182).

47. Id. § 5 (§ 768.139).

48. Id. § 8 (§ 768.042).

49. Id. § 2 (§ 627.352). The Commission is charged with the preparation of a report and recommendations to the Governor and legislature containing a plan which sets forth a "medical liability insurance system which can be operated at reasonable cost for the purpose of providing prompt, equitable compensation to those sustaining medical injury." § 627.352(5)(a). [Editor's Note: § 627.352 was not published in the 1975 statutes because of the reviser's decision that it is not a law of general applicability.] The report was delivered to the Governor and legislature in early January 1976. Florida Medical Liability Ins. Comm'n, Report to the Governor and the Florida Legislature (Jan. 1976).


51. Id. § 14 (§ 627.351(8)).

52. Id. § 15 (§ 627.359).
hospitals establish internal risk management programs\textsuperscript{53} and that the Florida Board of Medical Examiners and the medical staffs of licensed hospitals be given increased disciplinary powers.\textsuperscript{54}

Regardless of whether this new Act will operate to reduce medical malpractice problems in Florida, it is certain that it will significantly affect the patient's ability to sue the health care provider. Provisions of the Act which are sure to impact on the injured patient's ability to have his or her day in court, as well as those concepts introduced by the Act to assure the continued availability of malpractice insurance, are discussed in the following sections.\textsuperscript{54a}

A. Alteration of Legal Doctrines

1. The Statute of Limitations.—A statute of limitations prescribes a period beyond which an action at law or suit in equity cannot be maintained.\textsuperscript{55} Time limitations which are reasonable\textsuperscript{56} and "afford full opportunity to sue before the bar takes effect"\textsuperscript{57} are widely accepted as valid and necessary to encourage promptness in instituting actions; to suppress stale demands or fraudulent claims; and to avoid inconvenience which may result from delay in asserting rights or claims when it is practicable to assert them.\textsuperscript{58}

Statutes of limitations vary in length and are most often measured from the time the "right to bring the same [action] shall have accrued"\textsuperscript{59} or from "the time the incident occurred giving rise to the action."\textsuperscript{60} Using this measurement, the statute of limitations for a personal injury action begins to run on the day the injury occurred. Though the logic of this measure is apparent, its strict application to

\textsuperscript{53} Id. § 3 (§ 395.18).
\textsuperscript{54} Id. §§ 12, 13 (§§ 458.1201, 395.065).
\textsuperscript{54a} [Editor's Note: This note was set in print before the 1975 Florida Statutes were published. References in text and footnotes to specific sections are to the sections of the 1973 statutes which the legislature amended in the 1975 session. Because of editorial revisions by the Statutory Revision and Indexing Division of the Joint Legislative Management Committee, many section numbers have been changed, and editorial alterations made to text. Specific instances where the reviser's changes affect the substance of the text are noted.]
\textsuperscript{55} 51 AM. JUR. 2d Limitations of Actions § 2 (1970); 21 FLA. JUR. Limitations of Actions § 2 (1958).
\textsuperscript{56} Skinner v. City of Eustis, 2 So. 2d 116 (Fla. 1941).
\textsuperscript{57} 51 AM. JUR. 2d Limitations of Actions § 31 (1970).
\textsuperscript{59} See W. VA. CODE § 55-2-12 (Supp. 1959), amending W. VA. CODE § 55-2-12 (1931).
\textsuperscript{60} Fla. Laws 1975, Ch. 75-9, § 7 (§ 95.11(4)(b)).
medical malpractice situations sometimes causes harsh and unjust results. Occasionally the patient will not know immediately that an act of medical negligence has occurred. This often happens when a doctor unwittingly leaves a foreign object inside the patient during an operation and the object is not discovered until several years later. In cases such as this the patient is often totally and justifiably ignorant of the injury. Yet strict enforcement of the rule that the statute of limitations begins to run at the moment the foreign object is left in the body may operate to deny the patient who does not promptly discover the injury any right to redress within the court system. By the time the patient discovers the injury the statute of limitations may have run. A majority of jurisdictions in the past adhered to the interpretation that the statute of limitations for malpractice actions begins to run when the incident occurs, regardless of when the patient discovered, or reasonably should have discovered, the injury. Some courts, sensing the injustice of denying a person who was justifiably ignorant of his injury the right to a remedy, began to interpret the time the cause of action accrues in foreign object cases as the time when the patient discovers, or should have discovered, the foreign substance. A landmark case in this area was Urie v. Thompson, in which the United States Supreme Court ruled that a suit brought within 3 years from the time an employee discovered his occupational disease was not barred by a 3-year statute of limitations even though the claim was filed more than 3 years after the patient contracted the disease. The court opined:

If Urie were held barred from prosecuting this action because he must be said, as a matter of law, to have contracted silicosis prior to November 25, 1938, it would be clear that the federal legislation afforded Urie only a delusive remedy. It would mean that at some past moment in time, unknown and inherently unknowable even in retrospect, Urie was charged with knowledge of the slow and tragic disintegration of his lungs; under this view Urie's failure to diagnose within the applicable statute of limitations a disease whose

64. 337 U.S. 163 (1949).
symptoms had not yet obtruded on his consciousness would constitute waiver of his right to compensation at the ultimate day of discovery and disability.

... We do not think the humane legislative plan intended such consequences to attach to blameless ignorance. Nor do we think those consequences can be reconciled with the traditional purposes of statutes of limitations, which conventionally require the assertion of claims within a specified period of time after notice of the invasion of legal rights...65

The Urie decision unequivocally incorporated the discovery rule into federal law and extended its application to medical malpractice incidents not involving a foreign object left in the body. Many state courts followed this lead and overruled earlier decisions which held that the statute of limitations for malpractice incidents began to run when the injury occurred.66 Florida joined this group in 1954 when the supreme court declared that "the statute attaches when there has been notice of an invasion of the legal right of the plaintiff or he has been put on notice of his right to a cause of action."67

Although for over 20 years the Florida courts have faithfully followed the discovery rule, not until 1971 did the Florida legislature create a statute of limitations applying specifically to medical malpractice.68 Prior to this enactment the limitation period for such malpractice actions depended on whether the suit sounded in contract, for which the limitation period was 3 years,69 or tort, in which case the time limit was 4 years.70 The 1971 law provided a 2-year statute of limitations on actions "to recover damages for injuries to the person arising from any medical, dental... treatment or surgical operation,"71 and adopted the judicially created "discovery rule" by providing that "the cause of action in such cases [is] not... deemed to have accrued until the plaintiff discovers, or through use of reasonable care should have discovered, the injury."72

65. Id. at 169-70.
68. Fla. Laws 1971, ch. 71-254 (§ 95.11(6)).
70. Id.
71. Fla. Laws 1971, ch. 71-254 (§ 95.11(6)).
72. Id.
In 1974 the law was further amended to create a 2-year statute of limitations period regardless of whether the professional malpractice action was founded on contract or tort theory, and the "discovery rule," absent any restricting provisions, was again incorporated into the statute.\footnote{73}{Fla. Laws 1974, ch. 74-382 § 7 (§ 95.11(4)(a)).}

The 1975 legislature, obviously persuaded by the medical profession's argument that the discovery rule is a significant factor contributing to the malpractice crisis, restricted the rule by enacting legislation which limits the ability of a patient to sue on a bona fide malpractice claim. The statute provides:

(b) An action for medical malpractice shall be commenced within two years from the time the incident occurred giving rise to the action, or within two years from the time the incident is discovered, or should have been discovered with the exercise of due diligence, provided, however, that in no event shall the action be commenced later than four years from the date of the incident or occurrence out of which the cause of action accrued . . . . In those actions covered by this paragraph where it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the four-year period, the period of limitations is extended forward two years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed seven years from the date the incident giving rise to the injury occurred.\footnote{74}{Fla. Laws 1975, ch. 75-9, § 7 (§ 95.11(4)(b)).}

The statute retains the 2-year limitations period and the discovery rule, but it limits the use of the discovery rule to a 4-year period measured from the time of the incident upon which the claim is based. Where fraud, concealment, or intentional misrepresentation by the medical care provider has occurred, the discovery period is extended to 7 years. The result of this provision is that absolutely all malpractice claims are prohibited after 7 years from the date of the incident on which the claim is based, even where the resulting injury could not be discovered because of fraudulent misrepresentations by the doctor.

Three arguments can be made in support of the proposition that these restrictions should be repealed. First, it is undeniable that the statute may work an injustice on one who, through no fault of his own, fails to discover that he has suffered a medical injury until 4 years after the incident which gave rise to the claim has passed. Con-
sider the following hypothetical situation. A patient undergoes a major operation which is performed by Doctor A on June 1, 1975. During the surgery the doctor negligently leaves a sponge in the patient's body. The patient recovers from the surgery but continues to suffer discomfort and pain in the area of the wound. The doctor assures the patient that the pain is to be expected following major surgery and that recovery has been normal. Doctor A is unaware of his mistake and he continues to treat the patient for the pain. The patient, not being medically educated and having no way of knowing what the problem is, trusts his doctor's diagnosis and believes that the pain is an unavoidable result of the operation. In July 1979 the patient moves to another city where he contacts Doctor B. After taking X-rays of the area where the surgery was performed, Doctor B informs the patient that the pain is caused by the sponge which Doctor A left in the wound. The patient must undergo another costly operation to have the sponge removed. Under the 1975 amendment the patient would have absolutely no judicial remedy in the Florida courts because more than 4 years would have elapsed since the surgery was performed. The questions posed by a West Virginia court\textsuperscript{75} demonstrate equally well the inequity of the hypothetical situation. The court queried:

Can anybody reasonably assert that she [the patient] was guilty of lack of diligence when the evidence of the alleged wrong or tort committed by the surgeon was effectively sealed and hidden from view . . . ? Must she be penalized and denied a day in court and must the defendants . . . be rendered immune from any redress of the wrong inflicted merely because apparently the wrong could be discovered only by means of an X-ray . . .?\textsuperscript{76}

The statute limiting the period for discovery to no more than 4 years, or in cases of fraud to 7 years, is almost as unrealistic as a strict limitation period which provides no discovery rule at all. A limitation period which does not run from the time the injury is or should have been discovered "places a burden upon the wronged plaintiff [to discover the injury before the action is time-barred] which he or she would rarely, if ever, be able to carry."\textsuperscript{77} The following language from Judge Holtzoff's well reasoned opinion in \textit{Burke v. Washington Hospital Center}\textsuperscript{78} is apropos:

\textsuperscript{76.} \textit{Id.} at 161.
\textsuperscript{77.} \textit{Id.} at 159.
To confer a cause of action for damages on the one hand and on the other to let it be oozed away by lapse of time when the patient could not possibly know of the existence of his rights, would be to take away with the left hand what has been given with the right. It would be keeping the word of promise to the ear and breaking it to the hope.79

For the sake of reason and justice the legislature should abandon the restrictions on the discovery rule.

The second reason for repealing the new provision is that it probably will not significantly improve the medical malpractice situation. An empirical study has indicated that nearly all malpractice injuries are discovered within 1 year.80 It seems unlikely that a few isolated incidents of delayed discovery could cause the "long-tail" phenomenon.81 The HEW study suggests that it is delays other than the incident-to-injury recognition period which cause the total time from incident-to-settlement to be uncommonly long for malpractice cases.82

The legislature should carefully weigh the benefits to be derived from restricting the discovery rule against the injustices which will be suffered by individuals who are denied their right to redress as a result of the new statute of limitations. This author suggests that little if any improvement in malpractice insurance availability will accrue as a result of this restriction. Likewise the limitation will do little to stabilize the insurance market or reduce malpractice insurance premiums. It will, however, gravely injure those few individuals who are denied a legal remedy because they were unable, through no fault of their own, to discover the injury within 4 years, or even worse, were not able to pierce within 7 years a doctor's web of deceit and misrepresentation concerning a concealed injury. If the legislature would balance the benefits to be derived against the injustices which will be suffered, it might well conclude that the law should be repealed.

A third reason for repealing the new statute of limitations is that the statute may violate the Florida constitution. The proposition that for every wrong there is a remedy is a "bedrock principle of law."83 The Declaration of Rights of the 1885 constitution incorporated this idea as does article I, section 21 of the present constitution: "The

---

79. Id. at 1384.
80. See note 37 and accompanying text supra.
81. See notes 36-40 and accompanying text supra.
82. See note 40 and accompanying text supra.
courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay.\textsuperscript{84}

It has been suggested by at least one judge that to interpret a statute of limitations in such a way that the time runs from the time of the injury regardless of when the injury is discovered, might be a violation of the citizens' guaranteed right of access to the courts.\textsuperscript{85} After alluding to a provision in the West Virginia constitution guaranteeing that "every man for an injury done him . . . shall have remedy by due course of law,"\textsuperscript{86} Justice McBride, in a concurring opinion in \textit{Ayers v. Morgan},\textsuperscript{87} stated:

They [statutes of limitations] are desirable in that they prevent oppression by forbidding plaintiffs to litigate state claims and thus compel defense at a time when such defense is no longer practicable and sometimes even impossible. \textit{Nevertheless, the restrictions imposed may not be so arbitrary as to preclude a reasonable opportunity for one who has been harmed to make his claim.}\textsuperscript{88}

When an injured party is statutorily denied his remedy before he can reasonably ascertain that an injury has in fact occurred, the obvious inquiry should be whether the party has been denied his constitutional right to redress.

In \textit{Stewart v. Gilliam},\textsuperscript{89} the argument was made that if courts allowed recovery for psychic injuries without impact a "flood tide of litigation" would ensue.\textsuperscript{90} The Supreme Court of Florida, after pointing out the constitutional requirement that every person have access to the courts, stated:

\textit{It is far more consistent with justice to be concerned with the availability of a judicial forum for the adjudication of individual rights than to deny access of our courts because of speculation of an increased burden.}\textsuperscript{91}

The legislature would do well to realize that it is also more consistent with justice to be concerned with the availability of a forum for the adjudication of individual rights than to deny access to our courts

\textsuperscript{84} \textit{FLA. CONST. art. I, § 21.}
\textsuperscript{85} \textit{Ayers v. Morgan, 154 A.2d 788 (Pa. 1959) (concurring opinion).}
\textsuperscript{86} \textit{PA. CONST. art I, § 11 (1874, as amended 1969).}
\textsuperscript{87} 154 A.2d 788 (Pa. 1959).
\textsuperscript{88} \textit{Id. at 794–95 (emphasis added).}
\textsuperscript{89} 271 So. 2d 466 (Fla. 4th Dist. Ct. App. 1972).
\textsuperscript{90} \textit{Id. at 475.}
\textsuperscript{91} \textit{Id.}
because of speculation that restricted access might decrease the cost of medical malpractice insurance.

2. Statute of Frauds.—Section 10 of the Act amends Florida's Statute of Frauds\(^\text{92}\) to provide:

No action shall be brought . . . whereby to charge any health care provider upon any guarantee, warranty or assurance as to the results of any medical, surgical, or diagnostic procedure, performed by any physician . . . osteopath . . . chiropractor . . . podiatrist . . . or dentist . . . unless the agreement or promise upon which such action shall be brought, or some note or memorandum thereof shall be in writing and signed by the party to be charged therewith or by some other person by him thereunto lawfully authorized.\(^\text{93}\)

Prior to this amendment Florida courts followed the majority of jurisdictions in recognizing the right of a plaintiff-patient to bring an action against a doctor for breach of a contract to obtain a specific result or cure if the contract was expressed and supported by consideration.\(^\text{94}\) There has never been a judicially imposed requirement that the contract be in writing; in the malpractice cases based on a breach of guarantee or warranty, oral statements have been deemed to constitute a contract.\(^\text{95}\) For the plaintiff to maintain an action on a contract under the new amendment, the contract must be in writing and signed by the medical care provider.

A survey of the reported malpractice cases in this state indicated that while both the contract and the tort theories have been available to a plaintiff,\(^\text{96}\) patients and courts alike have most frequently used the tort theory.\(^\text{97}\) An element of negligence is involved in most malpractice

\(^{92}\) Fla. Stat. § 725.01 (1975).

\(^{93}\) Fla. Laws 1975, ch. 75–9, § 10 (§ 725.01).

\(^{94}\) Florida malpractice cases in which the courts have determined a breach of contract action to be appropriate include Anclote Manor Foundation v. Wilkinson, 263 So. 2d 256 (Fla. 2d Dist. Ct. App. 1972); Jackson v. Anderson, 230 So. 2d 503 (Fla. 2d Dist. Ct. App. 1970); Vilord v. Jenkins, 226 So. 2d 245 (Fla. 2d Dist. Ct. App. 1969); Brown v. Wood, 202 So. 2d 125 (Fla. 2d Dist. Ct. App. 1967); Fradley v. County of Dade, 187 So. 2d 48 (Fla. 3d Dist. Ct. App. 1966). "A physician or surgeon is not, however, a guarantor of the correctness of his diagnosis or of a cure and will not be held liable where he has employed reasonable skill and care in determining the diagnosis and has administered proper treatment without negligence, even though the desired results do not ensue." Atkins v. Humes, 107 So. 2d 253, 256 (Fla. 2d Dist. Ct. App. 1958), rev'd on other grounds, 110 So. 2d 663 (Fla. 1959).


\(^{97}\) See Annot., 43 A.L.R.3d 1221, 1225 (1972).
actions; thus even if the contract theory is unavailable, a plaintiff will usually have an alternative action in tort. For this reason the requirement that contracts be in writing probably will not bar many malpractice suits; its main effect will be to limit the choice of theories upon which an action may be brought to that of negligence.98

Supporters of the amendment argue that written contracts are necessary to protect medical care providers from vengeful patients who are not satisfied with the results of the treatment that they received, and who interpret a mere therapeutic reassurance as a guarantee or warranty that the procedure will be effective.99 The paucity of Florida cases decided in favor of the plaintiff on the contract theory indicates that the courts are aware of the potential for misinterpretation of the doctor's words and that the use of the theory has been restricted so as to avoid this problem.

It seems that in view of the court's restraint on the use of this theory, the Statute of Frauds provision is unnecessary. The legislation is similar to most of the other provisions in the Act in that it further limits the patient's choice of actions against a doctor. But because the negligence theory is almost always available as an alternative to the contract theory, hopefully the limitation created here will not significantly restrict the patient's ability to get into court.

3. The Florida Medical Consent Law.—Few legal theories in the medical malpractice area have been so thoroughly and intensely debated as the doctrine of "informed consent."100 Because the 1975 legislature significantly altered the doctrine101 as it had been developed by judicial decisions, an analysis of the changes made in the doctrine and a prediction of the effects they will have on the injured patient's ability to maintain a medical malpractice suit is appropriate.

98. But see Lane v. Cohen, 201 So. 2d 804 (Fla. 3d Dist. Ct. App. 1967). In this case a patient brought an action against Dr. Cohen on the ground of alleged negligence on the part of the physician because the patient's wife became pregnant after the doctor performed a vasectomy on the patient. The court held that the physician was not liable because a physician is not an insurer of the success of his treatment. The court suggested that had the pleading alleged that the doctor had orally guaranteed the success of the operation the outcome might have been different.

99. Information sheet prepared by the Florida Medical Association, April, 1975; see also Annot., 43 A.L.R.3d 1221 (1972).


The objective of the "informed consent" doctrine is simple and logical. A doctor may not lawfully treat a patient unless that patient gives his consent to the proposed treatment. If consent is not obtained, the treatment is unauthorized and the doctor may be liable for assault and battery or an action in trespass. Obviously a knowledgeable and intelligent choice of whether to consent to a certain treatment or procedure is impossible unless the patient is advised of the procedure or treatment to be followed, the risks involved in the treatment or procedure, and the alternatives which are available. The consent which results from a decision based on a thorough explanation of these facts is termed an "informed consent." Informed consent is necessary to preserve the patient's right to choose what happens to his body. Recognizing this right of self-determination, courts generally have held that a patient's consent to a proposed course of treatment is valid only to the extent that the patient gives consent after being sufficiently informed of the nature, risks, and alternatives available.

Florida courts have long adhered to the rule that consent is a prerequisite to medical treatment and in 1963 added the requirement that the consent be an informed one.

The informed consent theory, clear-cut as it seems, raises an immediate question: What standard is to be used to determine whether

102. The principle was best expressed by Judge Cardozo in Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914):

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. . . . This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained. See also Wall v. Brim, 138 F.2d 478, 481 (5th Cir. 1943), cert. denied, 324 U.S. 857 (1944); Hall v. United States, 136 F. Supp. 187, 192 (W.D. La. 1955), aff'd, 234 F.2d 811 (5th Cir. 1956); Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960), clarified, 354 P.2d 670 (Kan. 1960); Mohr v. Williams, 104 N.W. 12, 14–15 (Minn. 1905); W. Prosser, TORTS § 18 (4th ed. 1964); RESTATEMENT OF TORTS § 49 (1934).


105. 25 FLA. JUR. PHYSICIANS AND SURGEONS § 80 (1959).

106. In Bowers v. Talmage, 159 So. 2d 888, 889 (Fla. 3d Dist. Ct. App. 1963), the court stated: "Unless a person who gives consent to an operation knows its dangers and the degree of danger, a "consent" does not represent a choice and is ineffectual." Ditlow v. Kaplan, 181 So. 2d 226 (Fla. 3d Dist. Ct. App. 1965), is a later case recognizing the necessity of obtaining an informed consent.
adequate disclosure has been made and who is to set that standard? The majority of courts have attempted to resolve this question by adopting the "reasonable medical practitioner" standard.\textsuperscript{107} Under this standard the adequacy of the doctor's disclosure to the patient is measured by what "a reasonable medical practitioner" in "the same or a similar community"\textsuperscript{108} would disclose to his patient about the proposed treatment. To establish this standard most jurisdictions require that the plaintiff produce expert testimony to prove the extent of the defendant-doctor's duty to disclose.\textsuperscript{109} In these jurisdictions the case can proceed to the jury only if the plaintiff can show, through the testimony of a medical expert, that the defendant's disclosure fell short of that disclosure which a reasonable medical practitioner in the same or a similar community would have made.

Critics of the "reasonable medical practitioner" standard have attacked it for several valid reasons.\textsuperscript{110} One criticism is that it is often extremely difficult for a patient to convince a doctor to testify against his fellow professionals.\textsuperscript{111} The patient is therefore unable to supply the expert witness necessary to establish the standard of disclosure for the community.\textsuperscript{112} Also, in reality there is often no discernible community custom;\textsuperscript{113} rather the testimony is merely another doctor's personal opinion of what he would have done in the situation.\textsuperscript{114} Perhaps the most serious effect of the "reasonable medical practitioner" standard is that it allows the medical profession to set its own standards of disclosure. Perhaps this is necessary in ordinary malpractice suits, but it


\textsuperscript{108} See notes 17 and 25 supra. Florida cases on this subject include Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1957); Dillmann v. Hellman, 283 So. 2d 388 (Fla. 2d Dist. Ct. App. 1973); Brooks v. Serrano, 209 So. 2d 279 (Fla. 4th Dist. Ct. App. 1968); Bir v. Foster, 123 So. 2d 279 (Fla. 2d Dist. Ct. App 1960).

\textsuperscript{109} An extensive list of cases which require the use of expert testimony may be found in Comment, Informed Consent in Medical Malpractice, 55 CALIF. L. REV. 1396, 1397 n.5 (1967). See also Visingardi v. Tirone, 178 So. 2d 135 (Fla. 3d Dist. Ct. App. 1965) rev'd, 193 So. 2d 601 (Fla. 1967), vacated, 194 So. 2d 921 (Fla. 3d Dist. Ct. App. 1967); Bowers v. Talmage, 159 So. 2d 888 (Fla. 3d Dist. Ct. App. 1965).


\textsuperscript{111} Id. at 552; Note, Medical Malpractice—Expert Testimony, 60 NW. U.L. REV. 834, 835–37 (1966).


\textsuperscript{114} Id. at 784.
is not necessary in informed consent litigation. Several courts have recognized these objections to be valid and therefore have rejected the "reasonable medical practitioner" standard as the standard by which the doctor's duty to disclose is measured. Instead these jurisdictions have held that to obtain a valid consent, the doctor must supply the patient with all information material to the consent decision. In jurisdictions adhering to this standard, expert testimony to show what the reasonable medical practitioner would do is not essential. Instead, the standard is whether the disclosure contains all the elements which a reasonable patient would have considered material to a decision to consent to the treatment. It is up to the plaintiff to prove that the defendant-doctor failed to disclose information which a "reasonable patient" would consider material to his consent decision. Although the recently developed minority view is preferable from the patient's vantage point, the Florida courts have yet to consider it. To date, Florida courts have retained the "reasonable medical practitioner" standard.

One might conclude from the paucity of reported informed consent cases in Florida that this legal doctrine is not often used and thus could not be a significant factor in the medical malpractice insurance area. Evidently the Florida Legislature did not reach this conclusion, for the Florida Medical Consent Law is a sweeping attempt to restrict the use of the informed consent doctrine in medical malpractice actions. The law provides:

(3) No recovery shall be allowed in any court in this state against any physician . . . osteopath . . . chiropractor . . . podiatrist . . . or dentist . . . in an action brought for treating, examining, or operating on a patient without his informed consent where:

(a) The action of the physician, osteopath, chiropractor, podiatrist, or dentist in obtaining the consent of the patient . . . was in accordance with an accepted standard of medical practice.

115. Id. at 784–85.
119. See Ditlow v. Kaplan, 181 So. 2d 226, 228 (Fla. 3d Dist. Ct. App. 1965) in which the court recognized the uniform principle that "the standard to be applied is whether, according to expert testimony, a reasonable medical practitioner in the community would make such a disclosure under the same or similar circumstances."
120. Fla. Laws 1975, ch. 75–9, § 11 (§ 768.132).
among members of the medical profession with similar training and experience in the same or similar medical community; and

(b) A reasonable individual from the information provided by the physician, osteopath, chiropractor, podiatrist, or dentist under the circumstances, would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physicians, osteopaths, chiropractors, podiatrists, or dentists in the same or similar community who perform similar treatments or procedures; or

(c) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, osteopath, chiropractor, podiatrist, or dentist in accordance with the provisions of paragraphs (a) and (b) of this section.\(^\text{121}\)

The law attempts to describe certain situations in which the informed consent theory cannot be used by a patient in an action for malpractice. If the circumstances set out in subparagraphs (a) and (b) occur, recovery on the grounds of lack of an informed consent is barred. Subparagraph (c) describes another distinct situation, apparently independent of subparagraphs (a) and (b), where recovery is prohibited. First consider subparagraphs (a) and (b). The patient, according to these subparagraphs, may not recover for medical malpractice based on the informed consent theory if the doctor’s disclosure met the community standard for disclosures\(^\text{122}\) and if a reasonable individual, after hearing the disclosure, would have a “general understanding” of the procedures, alternatives, risks and hazards involved in the treatment.\(^\text{123}\) Because the “reasonable individual” test of subparagraph (b) is included, the law goes one step further than the court-instituted rule. Prior to this enactment, if the doctor could convince the trier-of-fact that the disclosures he made were comparable to the disclosures most other doctors in the same or a similar community would make, no liability would be imposed even though the patient might not have been given facts sufficient to enable him to understand the risks and procedures involved. In this respect subparagraphs (a) and (b) of the new law are a slight improvement over the judicial rule: not only must the disclosure meet the community standard, but it must also be a disclosure which would give a “reasonable individual”

\(^\text{121}\) Id. (§ 768.132(3)).

\(^\text{122}\) Id. (§ 768.132(3)(a)).

\(^\text{123}\) Id. (§ 768.132(3)(b)).
a "general understanding" of the procedures involved. One could surmise, therefore, that if the doctor complies with the community standard, but the community standard is not sufficiently detailed for a reasonable individual to understand the nature of the treatment, then "informed consent" has not been obtained and legal basis for a suit exists.

In summary, subparagraphs (a) and (b) of the new Florida Consent Law codify the judicially-created "reasonable medical practitioner" standard for disclosure in malpractice suits which are based on the informed consent theory and add the proviso that the disclosure be one which would give a "reasonable individual" a "general understanding" of the risks and procedures involved.

Subparagraph (c), however, adds an entirely new and thoroughly obnoxious restriction on individuals attempting to base litigation on the informed consent theory. This portion of the law says, in effect, that no recovery will be allowed under the "informed consent" theory if the defendant can convince the trier-of-fact that even though he neither obtained a valid consent nor made any disclosure, if he had made proper disclosures, the patient, being a reasonable person, would have agreed to the procedure. The incredible implication of this section is that even though no disclosure whatsoever has been made, and no consent whatsoever has been obtained, the patient may still be prohibited from recovering under the "informed consent" doctrine. Consider the following hypothetical situation: A patient consents to a back operation for the removal of a disc, and during the surgery the doctor notices a theretofore unknown spinal injury. Although no emergency exists, the doctor on his own initiative and without authorization surgically repairs the spinal injury. The procedure is known to carry a 5 percent risk of paralysis. The patient, as a result of the procedure, is paralyzed and brings a malpractice suit against the doctor, alleging that he performed a surgical procedure without obtaining her consent or informing her of the risks involved. The patient shows in court by uncontroverted evidence that no consent, informed or otherwise, was obtained prior to the operation. She also presents a medical expert who testifies that the spinal injury, if not corrected, would have been a source of occasional pain but would not have resulted in further injury or death. The patient testifies that had her consent been sought and had she been informed of the risks, she would not have agreed to the surgery. The doctor's argument is that the patient is precluded from recovering under the Act. His contention is that although he performed the procedure without disclosing the risks or obtaining consent, if he had made adequate disclosures for the purpose of
obtaining consent, and if his disclosure would have given a general understanding of the risks involved, the patient would reasonably have consented to the additional surgery. If the doctor can convince the trier-of-fact that his contention is correct, recovery is barred. Thus an injured patient on whom a dangerous surgical procedure was performed without consent would be without a remedy.

It seems unlikely that the legislature intended this result. The principle that a doctor must obtain consent from a patient before treating or operating, unless the patient is incapable of consenting or an emergency exists, is a well-settled rule in every jurisdiction.\textsuperscript{124} To take away the necessity of obtaining consent is to deny a patient the right to determine what happens to his or her body. Yet the language in subparagraph (c) implies that recovery will be denied upon a showing that the patient would have consented if consent had been sought after proper disclosure of the risks. This result is intolerable.

The language in subparagraph (c) is sufficiently vague to be interpreted in another way. The subparagraph could be read to apply in situations where consent has been obtained but disclosure prior to obtaining the consent was not adequate to inform the patient of the risks involved.\textsuperscript{125} In such a situation, the patient is nevertheless precluded from recovering because of the inadequate disclosure if the doctor can prove that the patient would have consented even if he had been adequately informed of the risks involved. In other words, even though a consent without adequate disclosure was obtained, the patient would have consented regardless of any risks the doctor might have disclosed and thus the doctor is not liable for an injury which the patient was willing to risk.

Persons involved in drafting subparagraph (c)\textsuperscript{126} indicated that the section was intended to cover emergencies and situations where the

\textsuperscript{124} See note 100 supra.

\textsuperscript{125} This interpretation could be achieved by reading the section as mandating that the doctor initially satisfy subparagraph (a). He would then have to satisfy either subsection (b) or (c) before he would have a valid defense. However, this construction is negated somewhat by the language of subsection (c) which appears to state that this subsection applies only where the doctor has failed to comply with the standards set forth in both subsection (a) and (b). The specific language which supports the interpretation that subsection (c) applies exclusive of subsections (a) and (b) is found at Fla. Laws 1975, ch. 75-9, § 11, (768.132(3)(c)) and reads as follows: "The patient would reasonably . . . have undergone such treatment or procedure had he been advised by the physician . . . in accordance with the provisions of paragraphs (a) and (b) of this section." (emphasis added). [Editors Note: As printed in the 1976 Fla. Stat., subsections (a) and (b) were combined into one subsection, thereby requiring the interpretation proposed by the author.]

\textsuperscript{126} Conversation with member of the staff of the Commerce Committee of the Florida House of Representatives (Sept. 1975).
patient is physically or mentally incapable of understanding a disclosure and giving a valid consent. Thus if a patient requiring immediate surgery is brought into the hospital in an unconscious state and with no relatives or acquaintances accompanying him, this section would protect the doctor from a suit based on the "informed consent" theory. If this is the result intended, one wonders why the drafters did not use explicit language referring to emergency and similar situations. The fact that at least three reasonable interpretations of the section are possible suggests that the provisions should be clarified. The informed consent provision should be rewritten to protect the patient's right of self-determination by defining the scope of the doctor's duty to disclose.

Several methods have been proposed to accomplish these objectives. These suggestions generally have been based on principles set forth in cases adopting the minority view concerning disclosure standards. The consensus is that the "reasonable medical practitioner" standard should be rejected. The better standard from the patient's standpoint is disclosure of all "facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." At least one commentator, however, believes that an informed consent standard should go even further and enumerate substantive topics which must be discussed with the patient. The author suggests that the required topics should include:

[T]he methods and means by which the treatment is to be administered; the risks and hazards involved, including temporary and permanent after- and side-effects; any alternative forms of therapy; expected beneficial effects of the treatments; and the prognosis if the patient foregoes treatment.

It is argued that statutorily designating the topics to be discussed would serve not only to insure the patient's right to self-determination but to protect the medical profession. A doctor would no longer be faced with vague and ambiguous standards to guide his disclosure, but would have specific guidelines that clearly delineate the degree of disclosure necessary to constitute "informed consent."

It has also been suggested that an "informed consent" statute should identify the elements which must be established to warrant re-

129. Note, supra note 110, at 555.
130. Id. at 559.
131. Id. at 560-61.
covery under the doctrine and indicate which party bears the burden of proof.\textsuperscript{132} One proposal based on the \textit{Canterbury}\textsuperscript{133} decision is that the initial burden be on the patient to establish that a particular risk or alternative was known or should have been known by the doctor\textsuperscript{134} and that this information was not disclosed.\textsuperscript{135} Expert testimony would probably be necessary to prove that potential risks were known or possible alternatives existed. According to this scheme, once the patient establishes that adequate disclosure was not made the burden shifts to the defendant-doctor to establish "a reasonable basis for nondisclosure."\textsuperscript{136} Thus if the doctor could show that an emergency existed, or that the patient already knew of the risk, or that the disclosure would so upset the patient as to threaten his condition or increase the risks involved,\textsuperscript{137} nondisclosure might be justified. If the doctor successfully justified his nondisclosure, he would be exonerated.

The \textit{Canterbury} court discussed another factor involved in the informed consent doctrine which perhaps should be statutorily addressed. The court pointed out that for the doctor to be liable to a patient, a causal relationship must exist between the doctor's failure to properly disclose and the injury incurred by the patient. According to this court such a relationship "exists when, and only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it."\textsuperscript{138} The opinion suggests that the causality issue is best resolved by asking "what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance."\textsuperscript{139}

A useful and equitable informed consent law could be derived from these proposals and principles. Such a law should contain the following components:\textsuperscript{140}

1. A requirement that the physician disclose all material information to the patient prior to obtaining consent; "material information"

\begin{enumerate}
  \item Note, \textit{supra} note 132, at 755.
  \item Stewart, \textit{supra} note 132, at 618.
  \item \textit{id.} This point is also discussed in Note, \textit{supra} note 132, at 750.
  \item \textit{id.} at 791.
  \item The suggested components are derived from the cases, notes and comments discussed in this section, especially Stewart, \textit{supra} note 132.
\end{enumerate}
should be defined in terms of what a "reasonable patient" would consider material.

2. A list of topics which must be discussed by the doctor. This list should be composed after careful consideration and substantial input from the medical profession.

3. A provision placing on the patient the burden of showing: (a) that certain risks were involved and alternatives were available, (b) that these were not disclosed for consent purposes, and (c) that a reasonable person would not have consented to the treatment or procedure if the risks or dangers had been known to that person.

4. A provision that the defendant could overcome the plaintiff's prima facie showing of nondisclosure of a material fact by proving that the failure to disclose was justifiable. The statute should enumerate exceptions that justify nondisclosure.

5. A provision making it clear that the following are questions for the jury: (a) whether the disclosure was inadequate; (b) whether there was justification for the inadequate disclosure; (c) whether a reasonable person in the patient's position would have decided against the treatment if he had been properly informed of the potential risks involved.

The Florida Legislature should either repeal the entire Medical Consent Law or amend it in such a way as to render it reasonable, just, usable, and decipherable.

**B. Procedural Changes**

1. Florida's Medical Liability Mediation Panel.—Critics of the traditional tort liability system, who believe that trial by jury in medical malpractice cases is too slow, too expensive, and substantially unjust, have devoted much time and thought to the search for a viable alternative to actions-at-law. The alternatives most frequently discussed include compulsory arbitration,\(^{141}\) no-fault compensation for medical injuries,\(^{142}\) and screening panels.\(^{143}\) Arbitration of malpractice cases has been used on a voluntary, contractual basis, but it has not yet been made compulsory in any state—probably because of the constitutional challenges which such legislation would precipitate.\(^{144}\) No-fault compensation, similar to workmen's compensation plans, has also been ex-

---

\(^{141}\) See HEW Appendix 214-449.

\(^{142}\) Id. at 450-95.

\(^{143}\) Id. at 214-314.

\(^{144}\) Id. 315-20. The main constitutional issues include whether compulsory arbitration would violate due process of law, deprive one of the right to trial by jury, result in a denial of equal protection, or amount to an unlawful delegation of legislative or judicial power.
haustively discussed, but lawmakers have been reluctant to introduce such programs because of the large sums necessary to initiate these programs. The screening panel concept, which requires that claims be filed with the panel and "screened" before court action is commenced, is considered by many to be a realistic alternative for many actions-at-law and the idea has been well received by state legislatures which, in the last 2 years, have created various "mediation panels," "medico-legal panels," and "medical liability mediation panels." 145

Several variations of the screening panel approach are utilized. The HEW Appendix describes four types: (1) physician screening panels with "a decision-making body composed entirely of physicians"; (2) physician-and-advisory screening panels composed mostly of physicians but with a nonmedical person serving as advisor to the group; (3) medical-legal screening panels consisting of approximately equal numbers of legal and medical representatives; and (4) court-sponsored screening panels, with the court system acting as a pretrial mediation body. Various other statutory plans have been created by state legislatures. 146

Proponents of the screening panel alternative believe that well-conceived and carefully implemented plans will deter lawsuits, encourage settlements, and reward meritorious claims. According to one commentator:

The goals and motives of malpractice screening panels are two-fold: To prevent, where possible, the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not warrant a reasonable inference of malpractice; and to make possible the fair and equitable disposition of legitimate claims against physicians. 147

The possible advantages of a screening panel program include:

(1) The unsophisticated jury is replaced by knowledgeable fact-finders who, because of their expertise, are more capable of distinguishing a meritorious claim from a frivolous, nuisance claim.

(2) Long delays between the initiation and final disposition of lawsuits may be avoided, thus providing the opportunity for rapid resolution of cases.

---

146. HEW APPENDIX 224-47, 280-81.
(3) The enormous expenses of actions-at-law is reduced because the technical, formal, time-consuming procedures characteristic of a trial are replaced by an informal and simple process.

(4) Unjustified, embarrassing lawsuits can be avoided if the panel is successful in identifying nuisance claims.

The favorable aspects of screening panels have been summarized:

[T]he medical-legal screening panels, due to their expertise, should be able to determine accurately the presence or absence of negligence. The panels also are designed to encourage seasonable settlement of just claims, thereby providing prompt compensation to aggrieved patients, and they may ultimately have a stabilizing effect on this factor in the cost of medical care.  

Certainly if all these advantages obtain when screening panels are used, they would be of great value. But whether mediation panels will, in reality, provide all the features that proponents espouse is questionable. Critics of the screening panel alternative believe that the following three serious shortcomings are common to most panels: (1) their jurisdiction is limited;  

(2) appearance before panels is generally voluntary; and (3) the decision of the panel is not binding. Nearly all the authorities agree that a voluntary screening scheme, where acceptance of the panel's decision is discretionary or where no strong inducements appear in the law to encourage acceptance of the decision, will ultimately fail to achieve its stated objectives.

During 1970 and 1971 Robert L. Winikoff, while a member of the William and Mary Law Review staff, undertook a study "to discover and analyze the substantive and procedural problems involved in the litigation of medical malpractice suits, and to determine whether these problems would be alleviated by the creation of medical-legal review panels." He attempted an empirical study based on data gathered from medical societies and bar associations throughout the country. An analysis of the data led the author to conclude that:

Medical malpractice screening panels are, at best, only partially successful. While in theory they appear to provide an ideal alternative to the traditional trial method for handling medical mal-

148. *Id.* at 710.
149. HEW APPENDIX 297–98.
151. *Id*.
152. *Id.* at 695.
153. *Id.* at 711.
practice claims, the fact is that in many areas the panel approach has been a near or total failure.

....

... For these reasons the medical-legal screening panel procedure for medical malpractice claims, as presently constituted, is not the most desirable alternative to the traditional trial procedure on a national basis.\textsuperscript{154}

Keeping the conclusions of the Winikoff study in mind, a consideration of the Florida “medical liability mediation panel”\textsuperscript{155} scheme is appropriate.

The Florida law requires that “any person . . . claiming damages by reason of injury, death or monetary loss on account of the alleged malpractice by any medical or osteopathic physician, hospital, or health maintenance organization and against whom he believes there is a reasonable basis for a claim”\textsuperscript{156} shall file a claim with the clerk of the circuit court and serve all named persons in the claim as well as the administrative board licensing the professional involved.\textsuperscript{157} Submission of the claim to a mediation panel is not voluntary; every such claim \textit{must} be filed pursuant to the provisions of this law prior to the initiation of any suit at law. The medical-care provider responds to the claim by filing an answer with the clerk within 20 days of the date of service.\textsuperscript{158} If no answer is filed, the mediation panel’s jurisdiction terminates and the claimant’s only alternative is to file a lawsuit.\textsuperscript{159} Assuming the potential defendant files a timely answer, within 30 days after service of process each party must file with the clerk a document designating the type of medical specialist who should hear the claim.\textsuperscript{160} If the parties do not agree on the speciality, the judicial referee, a circuit judge serving on the panel, will make the determination.\textsuperscript{161} The panel members—an attorney, a physician, and a judicial referee—are selected by a process explained in detail later.\textsuperscript{162} After the selection occurs, the clerk sets a date, time, and place for the hearing. The hearing must be held within 120 days of the date the claim is filed.\textsuperscript{163} Upon a showing of good cause this time may be extended to 6

\textsuperscript{154} Id. at 721–22.
\textsuperscript{155} Fla. Laws 1975, ch. 75–9, § 5 (§ 768.133).
\textsuperscript{156} Id. (§ 768.133(2)).
\textsuperscript{157} Id.
\textsuperscript{158} Id.
\textsuperscript{159} Id.
\textsuperscript{160} Id.
\textsuperscript{161} Id.
\textsuperscript{162} See note 180 and accompanying text infra.
\textsuperscript{163} Fla. Laws 1975, ch. 75–9, § 5 (§ 768.133(4)).
months.\footnote{164} If the hearing is not concluded within 10 months, the jurisdiction of the mediation panel terminates and the parties "may proceed in accordance with law."\footnote{165}

Parties are allowed to utilize any discovery procedure provided by the Florida Rules of Civil Procedure.\footnote{166} The hearing itself is to be conducted under procedural rules to be established by the supreme court.\footnote{167} The law specifies that strict adherence to rules of procedure and evidence is not necessary at the hearing.\footnote{168} During the hearing

[w]itnesses may be called, all testimony shall be under oath, testimony may be taken either orally before the panel or by deposition, copies of records, x-rays and other documents may be produced and considered by the panel and the right to subpoena witnesses and evidence shall obtain as in all other proceedings in the circuit court. The right of cross-examination shall obtain as to all witnesses who testify in person. Both parties shall be entitled, individually and through counsel, to make opening and closing statements. No transcript or record of the proceedings shall be required, but any party may have the proceedings transcribed or recorded. . . .\footnote{169}

Within 30 days after the completion of the hearing, the panel is required to file a written decision with the clerk of the court.\footnote{170} If liability is found, and if the adverse parties agree, the panel may continue mediation "for the purpose of assisting the parties in reaching a settlement."\footnote{171} If any party rejects the decision of the hearing panel, the claimant may institute litigation based upon the claim.\footnote{172} If such subsequent litigation occurs, the conclusion of the hearing panel on the issue of liability may be admitted into evidence\footnote{173} but a finding of damages is not admissible.\footnote{174} In the opening statement or argument to the court or jury, either party may comment on the panel's conclusion;\footnote{175} however, panel members may not participate in the trial either as witnesses or counsel.\footnote{176} The judge presiding at the panel hear-

\footnotesize{\begin{itemize}
  \item \footnotemark[164] Id.
  \item \footnotemark[165] Id.
  \item \footnotemark[166] Id. (§ 768.133(6)).
  \item \footnotemark[167] Id. (§ 768.133(7)).
  \item \footnotemark[168] Id.
  \item \footnotemark[169] Id.
  \item \footnotemark[170] Id. (§ 768.133(8)).
  \item \footnotemark[171] Id. (§ 768.133(9)).
  \item \footnotemark[172] Id. (§ 768.133(10)).
  \item \footnotemark[173] Id. (§ 768.133(11)).
  \item \footnotemark[174] Id. (§ 768.133(9)).
  \item \footnotemark[175] Id. (§ 768.133(11)).
  \item \footnotemark[176] Id. (§ 768.133(7)).
\end{itemize}}
ing shall not preside at the subsequent trial,¹⁷⁷ and no specific finding of fact made by the panel may be admitted in evidence at trial.¹⁷⁸

Superficially, at least, Florida's plan seems logical, relatively simple, and workable. There are, however, problems with the law—interpretative problems arising from the use of confusing language, and substantive problems relating to the nature and content of the law.

The provision for selection of panel members, in particular, is subject to interpretative problems and is probably too complicated. Although the language is far from clear, it seems that the selection process, as described in section 5 of the Act, is designed to function in the following manner. The chief judge of each judicial circuit is to prepare lists from which the attorney and doctor to serve on the three-member mediation panel will be chosen. One list is to consist of names of qualified attorneys. In composing this list, the chief judge may accept the recommendations of recognized professional legal societies. The other list to be prepared by the chief judge is to contain the names of doctors licensed to practice medicine in the state. The judge may take into consideration the recommendations of recognized professional medical societies concerning names suitable for this list. The list of doctors shall be further divided according to specialties of practice. Thus there would be a list of urologists, a list of heart specialists, and so forth. When a malpractice claim is filed, a three-member panel, consisting of a judicial referee, a physician, and an attorney must be empanelled. The judicial referee is to be a circuit judge who shall be appointed to serve on the panel.¹⁷⁹

In the event that the parties to the action cannot agree between themselves on a doctor and an attorney, these members of the panel are to be selected from the lists prepared by the chief judge. Five names from the list of doctors of the appropriate specialty, and five names from the list of attorneys would be selected at random by the clerk and mailed to the parties and to the doctors and attorneys whose names have been selected. The parties and the persons selected would have 10 days to challenge the selections. If there are disqualifications the clerk shall randomly select replacements from the lists so that five attorneys' names and five physicians' names are under consideration. From these two groups of five names each, the parties may agree on one attorney and one doctor to serve on the panel. If no agreement is reached on an attorney, each side shall strike names alternately from the attorneys' list, with the claimant striking first, until each side has

¹⁷⁷. Id.
¹⁷⁸. Id. (§ 768.133(11)).
¹⁷⁹. Id. (§ 768.133(1)).
stricken two names. The remaining attorney serves on the hearing panel. The same procedure is to be used if the parties cannot agree on a doctor. The attorney and doctor chosen by this elimination process serve, along with the judicial referee, as the three-member mediation panel.\textsuperscript{180}

Although the preceding is a reasonable explanation of the selection procedure, ambiguities in the drafting of this portion of the Act makes definite interpretation difficult. The selection provision states in part:

All hearings, as hereinafter provided for, shall be before a three-member panel hereinafter referred to as the panel, mediation panel or hearing panel composed as follows: a judicial referee who shall be the presiding member of the hearing panel, a licensed physician and an attorney. The judicial referee shall be a circuit judge. \textit{Such appointments shall be made by a “blind” system}. The other panel members shall be selected in accordance with the following procedure . . . .\textsuperscript{181}

A question arises as to what is meant by a blind system of selection. One might reasonably conclude that a blind system means a random system, but the term “blind system,” being neither a term of art nor words of common usage, should be defined and explained.

A valid question also may be raised as to what appointments are the subject of the sentence: “Such appointments shall be made by a ‘blind’ system.” Is the reference to the appointment of all the panel members, or the appointment of the judicial referee only? One logical interpretation is that only the judicial referee is to be chosen by a blind system while the other panel members (the doctor and the attorney) are to be selected in a different manner. This interpretation is buttressed by the sentence “The \textit{other} panel members shall be selected in accordance with the following procedure . . . .” This implies that the selection of the “other” panel members, the doctor and the attorney, is not to be by a blind system. Since the sentence “Such appointments shall be made by a ‘blind’ system” stands alone, however, it could also be meant to apply to the appointment of all three panel members. One person involved in the drafting of the legislation has stated that this was the intent.\textsuperscript{182} But such an interpretation would conflict with later provisions in section 5 (768.133(3)) of the Act which

\textsuperscript{180} \textit{Id. (§ 768.133(3))}.
\textsuperscript{181} \textit{Id. (§ 768.133(1))} (emphasis added).
\textsuperscript{182} Personal communication with Jack Hersoz, Attorney for the Florida House of Representatives Commerce Committee (Oct. 1975).
describe a detailed method for selection of the doctor and attorney members of the panel that is in no way random or blind. Because of this later provision, the most reasonable interpretation is that only the judicial referee is selected by a blind system and the attorney and doctor are selected by the system described in section 5 (768.133(3)) of the Act. Assuming this is the correct interpretation, the language could be clarified quite easily by providing that “the judicial referee, who shall be a circuit judge, shall be appointed by a ‘blind’ system.” Thereafter, the law should describe how the “blind” system operates.

The statute states that only circuit judges may be judicial referees.\(^1\) This provision may prove to be too restrictive. At least one other state\(^2\) has broadened the definition of judicial referees to include other judicial officers such as county judges, or masters appointed by the circuit judge. This approach might be advantageous if crowded circuit court calendars would prevent the prompt hearing which the Act demands.

Another defect in the selection process provision arises from misuse of the word “panel.” Section 5 (768.133(1)) of the Act defines the terms “panel,” “mediation panel,” and “hearing panel” as three-member panels each composed of one judicial referee, one attorney, and one physician. Yet two sentences later the Act states that “the other panel members shall be selected in accordance with the following procedure” (emphasis added) and goes on to describe how the lists of persons to be used as a basis for selection of the three-member groups are to be prepared. Obviously the drafters have used the word “panel” to mean two separate things: the three-member group that hears a particular case, and the lists from which the three-member groups are chosen. The confusion between the three-member panel and the lists from which the attorney and doctor for this panel are drawn is also apparent in section 5 (768.133(3)) which provides that “the clerk shall mail to the parties . . . the names selected at random of five attorneys who are members of the hearing panel and the names of five physicians . . . who are members of the hearing panel” (emphasis added). It is impossible to select five names of members of the hearing panel, as these provisions direct, since by definition a hearing panel can consist of no more than one attorney and one doctor. It is apparent that the lists compiled by the chief judge are being confused with the three-member hearing panel chosen to hear a specific case. The law should be revised to differentiate correctly between the lists of potential members and the panel itself. This could be done by consistent-

---

183. Fla. Laws 1975, ch. 75-9, § 5 (§ 768.135(1)).
ly referring to the lists as "selection lists" or some other appropriate
title which does not contain the word "panel." "Panel" should then
be used only in reference to the three-member group. Language dis-
cussing selection of names for the lists should be completely separated
from language discussing selection of panel members.

The complicated procedure outlined for the selection of a doctor
and an attorney for the panel should be eliminated in favor of a
simpler, more objective system. An alternative procedure would be
for the clerk to select the name of an attorney and a doctor at random
from the appropriate lists. If the person selected disqualifies himself
for cause, or if either party is able to persuade the judicial referee that
the person selected should be disqualified for cause, another random
selection from the appropriate list would be made. Additionally, the
parties could be allowed to exercise a limited number of challenges.
Such a procedure would provide a more objective process, in contrast
to the current provisions which give the parties a choice of 10 persons
from whom to select two panel members. The opportunity for either
party to "shop" for a panel member would be limited and the selection
process would be less complicated as well as less time consuming.

More troublesome than the ambiguity of certain language regard-
ing the mediation panel is the problem of whether the panel will, in
fact, function successfully as an alternative to litigation. This author
suggests that the law as presently written is not structured to offer
a real alternative to litigation; consequently it might serve only to
lengthen the litigation process for malpractice actions.

One provision which might thwart successful operation of the
mediation panel is contained in section 5 (768.133(2)) of the Act.
This part of the law requires that all defendants against whom a
claim is filed must answer the claim within 20 days of the date of ser-
vice. The Act further states that "If no answer is filed within such
time limit, the jurisdiction of the mediation panel over the subject
matter shall terminate, and the parties may proceed in accordance
with law." Thus although the law requires that an answer be filed,
there is no sanction for failure to do so, and the medical-provider may,
by merely refusing to answer, avoid the entire mediation panel pro-
ceeding. For practical purposes, the result of this provision is that
the panel hearing is mandatory for the claimant but only voluntary
for the defendant. Any result which allows the medical-provider in
every instance to decide whether a hearing will be conducted is of
limited value. To eliminate this situation the law could provide that
if the medical-provider does not answer within the time period, a

185. Fla. Laws 1975, ch. 75–9, § 5 (§ 768.133(2)).
panel would nevertheless be chosen, a hearing conducted, and a decision rendered by the panel. If the panel makes a finding of liability, the claimant may introduce the findings as evidence in a subsequent trial, but when the panel’s decision indicates no liability, the defendant may not use this finding as evidence in any subsequent trial if he did not appear at the panel hearing. The effect of such provisions would be to penalize the defendant who fails to answer. It is likely that the defendant will participate if it is clear that a hearing will be conducted regardless of his presence.

Another provision which may serve to thwart the prompt resolution of claims is the provision which allows either party to reject the panel’s decision. Thus, even in cases where the medical-provider does answer and a hearing is conducted, the panel’s decision is not binding. The rejection of the panel’s decision will necessitate the litigation in court of the same issues that were tried before the panel. Perhaps the only way to assure that screening panel decisions are followed is to statutorily mandate that the decisions are binding and final. The losing party would be allowed to take an appeal, perhaps to the circuit court. But such a mandate would change the nature of the remedy entirely and raise several constitutional questions. A more moderate alternative is to create provisions in the statute which, while not foreclosing the option of either party to reject the panel decision, strongly encourage acceptance of it. The Act as written does not supply sufficient incentives. Section 5 (768.133(10)) provides: “(10) In the event any party rejects the decision of the hearing panel, the claimant may institute litigation based upon the claim in the appropriate court.”

The following hypothetical situation demonstrates the unfairness of this provision: A patient files a claim against a doctor, following which the mediation panel makes a finding of liability and, upon further consideration and pursuant to the wishes of both parties, also decides that the amount of damages owed to the patient by the doctor is $6000. At this point, the doctor decides to reject the panel’s decision. The doctor's rejection renders the entire mediation panel proceeding practically void. The burden to go forward with a lawsuit falls exclusively on the claimant. If he fails to initiate legal action the entire matter is over, in spite of the fact that he has received a favorable decision for $6000 from a panel of experts. Only when the claimant files suit and proceeds to trial is the panel’s decision of any value. In a case where the claimant files suit the panel’s decision as to the issue of liability may be admitted into evidence. The inequity of the situation

186. See note 144 supra.
is obvious; it is another example of how this law favors the medical-provider over the patient.

The statute would be improved if: (1) the burden to go forward with an action-at-law fell upon the party rejecting the panel’s decision, whether claimant or defendant, and (2) the rejecting party, in order to obtain a trial de novo was required to file suit within 60 days of the panel’s decision and post bond. Applying this procedure to the hypothetical situation, the defendant-doctor would still be able to reject the panel’s decision, but to do so he would have to file suit in the court in whose jurisdiction the case arose. If he failed to file suit within 60 days the court administering the panel will presume acceptance and proceed accordingly. To obtain a trial de novo, it would be necessary for the doctor to post bond in the amount of $6000 plus the estimated cost of defending the new trial. Of course the same conditions must be met if the claimant decides to reject a panel’s decision. An outcome of this type is preferable to that which will occur under the present law because the rejecting party, whether plaintiff or defendant, has the burden of going forward with the appeal.

The following language would achieve the suggested result:

Any party to the hearing panel proceeding may reject the final decision of the panel as to liability or damages by filing suit in the court in whose jurisdiction the case arises for a trial de novo. If suit is not filed within 60 days following the date the decision is rendered, the parties are conclusively presumed to have accepted the findings as to both liability and damages. The party or parties filing the suit shall pay a fee of the same amount as if filing an initial complaint and shall post bond in an amount equal to the sum of the award assigned by the hearing panel plus the estimated cost of defending the new trial. The court shall set the amount of this bond and may excuse the posting of it if the plaintiff files a sworn affidavit stipulating that he is unable to post such a bond or if the court believes such a bond would hinder the interests of justice.187

Such a provision, which would give each party the choice of accepting the panel’s decision or filing suit in court for a new trial, would eliminate the unfairness of requiring the claimant to go forward with the lawsuit despite a favorable panel decision. Additionally, the necessity of filing a lawsuit, combined with a bond-posting requirement, would strongly encourage acceptance of the panel’s finding.

Problems persist under the present law even if both parties accept

187. This is substantially the same language used in a draft prepared in 1975 by the Health and Rehabilitative Services Committee of the Florida House of Representatives.
the panel's decision. The Act does not require the parties to give notice of their decision to accept or reject the panel's decision, nor does the Act provide for court administration of the payment of damages.

Inclusion of the following language could correct this omission:

Within 30 days following the date of the hearing panel's decision, the parties shall file written notice with the clerk, supplying copies of such notice to each other, of their acceptance or rejection of the decision. If both parties accept the decision, the party against whom any damages are assessed shall render payment to the prevailing party within 60 days. The award shall be subject to enforcement by the court in whose jurisdiction the case arose.\(^\text{188}\)

Some provisions of section 5 (768.133(4)) of the Act, which establish time periods applicable to panel proceedings, are also potentially too restrictive. The pertinent portion of the section states:

\[\text{[T]he hearing shall be held within 120 days of the date the claim is filed with the clerk, unless for good cause shown upon order of the judicial referee, such time is extended. Such extension shall not exceed six months from the date the claim is filed. If no hearing is held on the merits within 10 months of the date the claim is filed, the jurisdiction of the mediation panel on the subject matter shall terminate and the parties may proceed in accordance with law.}\]

A valid argument can be made that a 120 day time period is too long. One of the primary goals of screening panels is "to expedite the disposition of cases, thereby sparing the parties the added burden of time, expense, and emotional fatigue usually associated with prolonged litigation."\(^\text{189}\) A 60 or 90 day limit would give the parties a reasonable time period in which to prepare for the hearing and at the same time insure promptness. The statute should also contain language emphasizing that extensions are to be granted only in extreme circumstances, and that lack of preparation by either party will not ordinarily be considered an extreme circumstance.

The provision which terminates the panel's jurisdiction if the hearing is not held within 10 months\(^\text{190}\) should be stricken because the same provision requires that the hearing, even where an extension is granted, be conducted within 6 months of the time the claim is

\(^{188}\) Id.

\(^{189}\) Note, 13 WM. & MARY L. REV. 695, 705 (1972).

\(^{190}\) Fla. Laws 1975, ch. 75-9, § 5 (§ 768.133(4)).
This obvious inconsistency weakens the 6 month mandate and seems to indicate that the law does not mean what it says.

Another deficiency in the Act regarding mediation panels is that the initial decision by the panel does not include a finding of damages. Only after a finding of liability, and if the adverse parties agree, can the panel continue mediation “for the purpose of assisting the parties in reaching a settlement.” The HEW Appendix states: “The second most significant limitation of screening panels is that while the parties are advised about liability, no opinion or expert guidance as to damages is given to them.”

A decision combining liability and damages gives the parties a reasonable and informed benchmark around which to negotiate. The usefulness of the panel’s ability to propose equitable and sound decisions which obviate the necessity for other legal remedies is diminished when the panel’s scope of review is limited to the issue of liability. The legislature should consider revising the law to provide that damages be determined along with liability.

The legislature might also consider giving the panel the authority to propose and implement some type of annuity system in the form of a reversionary trust to pay the medical and related expenses of the injured patient instead of a lump-sum payment of damages. Creation of such a trust would reduce the amount of damages payable immediately and prevent a windfall to the claimant’s survivors in the event the injured patient dies sooner than anticipated. Consideration should also be given to the inclusion of provisions which disallow the awarding of damages for pain and suffering, the awarding of damages which duplicate benefits from other sources, and the awarding of damages in excess of the amount alleged in the claim.

The changes necessary to improve the medical liability mediation panel portion of the Medical Reform Act may be summarized as follows:

1. The ambiguities regarding use of the “blind” selection system should be removed, and the word “blind” should be defined.

191. Id.
192. Fla. Laws 1975, ch. 75-9, § 5 (§ 768.133(8)(9)).
193. Id. (§ 768.133(9)).
194. HEW APPENDIX 298.
195. Id. at 292–93.
197. Id.
198. See note 187 supra. The rationale behind these limitations is that the award should be restricted to that amount necessary to pay the tangible damages suffered by the patient which are not covered by medical or other insurance.
2. The definition of judicial referee should be expanded to include officials other than circuit judges.
3. The confusing use of the words “panel” and “lists” should be corrected.
4. The method of selecting the doctor and attorney panel member described in section 5 (768.133(3)) of the Act should be eliminated and a simple random system substituted.
5. The provision which terminates the jurisdiction of the hearing panel when the defendant fails to answer should be amended to penalize the defendant who does not answer.
6. Changes should be made in section 5 (768.133(4)) which (a) shorten the time period for conducting the hearing from 120 to 60 or 90 days, (b) restrict the granting of extensions, and (c) omit the language terminating jurisdiction if the hearing is not conducted within 10 months.
7. The panel should decide both the issue of liability and the issue of damages.
8. The law should be amended to provide that the party rejecting the panel’s decision must file suit for a trial de novo and must post bond as a condition precedent to the new trial.
9. Provisions should be included which describe a procedure for notifying the parties, the panel, and the court of each party’s intention to accept or reject the panel’s decision.
10. Provisions should be added which require the court to enforce payment of damages awarded by the panel.

Unless the statute is amended to delete the provisions unfair to the claimant, such as the portion of the law which tacitly approves the failure to answer a complaint, and to add provisions which increase the likelihood that the panel’s decision will be accepted, such as requiring the rejecting party to file suit for a new trial and to post bond, mediation panels will serve no practical purpose.

2. The Statement of General Damages in the Complaint Prohibited.—Section 8 of the Act creates a statutory restriction on the contents of the ad damnum clause of a complaint. The section provides:

Damages.—In any action brought in the circuit court to recover damages for personal injury or wrongful death, the amount of general damages shall not be stated in the complaint, but the amount of special damages, if any, may be specifically pleaded and the re-

199. That part of a complaint which describes the damages sought to compensate for the injury alleged is often termed the ad damnum clause. In some jurisdictions it is entitled the "prayer for relief."
This amendment prohibits a statement in the complaint of the specific amount of general damages sought. The amount of special damages sought may be specifically stated as may the requisite jurisdictional amount.

Sponsors of the legislation explained that often exorbitant amounts are alleged as damages in the initial complaint; not only are these amounts often unrealistic, but they also create an "atmosphere of the spectacular and the impression of guilt." It is thought that elimination of the request for a certain amount of general damages in the pleadings will decrease the publicity and sensationalism which such demands seem to generate and which, it is argued, encourages other dissatisfied patients to sue.

It is true that demands for large amounts generate much publicity. It is not so clear whether such publicity has the detrimental effects attributed to it. Nevertheless, the prohibition against specifically requesting the amount of general damages, as to malpractice suits at least, is probably wise, since few benefits are derived from such publicity.

An interesting question about this part of the Act is why the restriction on the *ad damnum* clause extends beyond malpractice actions to all wrongful death or personal injury actions. The result of this provision is that in the future a plaintiff seeking damages for personal injury arising from an automobile accident, for instance, will not be allowed to specifically allege general damages although his suit has nothing to do with medical malpractice.

Because the requirement of this section applies to actions other than those involving alleged medical malpractice, the Act might be constitutionally infirm. The Florida constitution states in part that: "Every law shall embrace but one subject and matter properly connected therewith and the subject shall be briefly expressed in the title." The subject of the Act is medical malpractice and matters related to or affecting medical malpractice. Section 8 of the Malpractice Act, however, creates legislation which affects a class of actions broader than medical malpractice; it is a civil law concerning all

---

202. HEW REPORT 18.
204. The first part of the Act states: "AN ACT relating to medical liability insurance and civil law revisions concerning medical malpractice actions . . . ."
personal injury and wrongful death actions. Thus the Act embraces
two distinct and unrelated subjects: (1) medical malpractice and
matters connected therein, and (2) the prohibition against specifying
general damages in a civil action for personal injury or wrongful death.

The case law interpreting article III, section 6 of the Florida
constitution is voluminous\textsuperscript{205} and no attempt will be made here to
exhaustively cite the cases which may support a constitutional chal-
lenge to the Act. One case, however, seems particularly on point. \textit{Smith v. Chase},\textsuperscript{206} a 1926 supreme court case, involved a law whose express
subject was the licensing and regulation of real estate brokers and
salesmen,\textsuperscript{207} and which included a description of offenses and penalties
therefore. One section of the Act, however, defined a crime of general
application to all persons, not just real estate people. The court set
out its interpretation of article III, section 6 thusly:

\begin{quote}
[T]he title must not express two distinct subjects; and the act must
not contain any provision that is not covered by the single subject
expressed in the title or that is not [a] matter properly connected with
or germane to the subject that is stated in the title.\textsuperscript{208}
\end{quote}

Applying these principles, the court decided that the provision of
general application, which made it a crime for anyone to publish a
false statement concerning land, was “broader than and not properly
connected with the restricted subject of licensing and regulating the
business of real estate salesmen.”\textsuperscript{209} The analogy to an enactment whose
subject is medical malpractice and whose title is “The Medical Mal-
practice Reform Act of 1975” is clear. To the extent the enactment
affects all persons bringing actions for personal injury or wrongful
death where no medical malpractice issue is involved, it is constitu-
tionally infirm.\textsuperscript{210}

This defect could easily be corrected by restricting the prohibition
against stating the amount of general damages to actions brought for

\begin{flushright}
206. 109 So. 94 (Fla. 1926).
207. Fla. Laws 1925, ch. 10233.
208. 109 So. at 97.
209. \textit{Id.}
210. Colonial Inv. Co. v. Nolan, 131 So. 178 (Fla. 1930), a case in which the un-
constitutionality of a statute was alleged on the grounds that both the title and the
body of the act contained two separate and distinct subjects, is another case in point.
The court agreed with the party challenging the enactment and ruled that a statute
embracing in its title and body “two separate subjects without logical connection”
violates the constitutional requirement that an enactment embrace only one subject
in its title.
\end{flushright}
medical malpractice. Until the prohibition is thus restricted, it provides another ground for challenging the Act.

C. Insurance Provisions of the Medical Reform Act

A major portion of the Act is devoted to provisions involving insurance. Aside from increased malpractice insurance premiums, the most immediate and pressing issue which faced the 1975 Legislature was a disappearing medical malpractice insurance source. Insurers were refusing to write new policies in Florida, and the state's major carrier would have cancelled its group policy covering approximately 50 percent of the state's doctors but for a court order prohibiting such action. Legislative action to insure that medical care providers in Florida could obtain malpractice insurance became urgent. A two-part solution to the problem, with provisions for a self-insurance plan and a joint underwriting plan, was adopted.

1. Self Insurance.—Prior to 1975, the doctor's ability to self-insure was limited in Florida. A group or association of doctors could partially self-insure against claims of medical malpractice only if the group had originally been organized for purposes other than the purchase of insurance and had been in continuing existence for a period of at least 2 years. The law did not extend the self-insurance option to hospitals and other medical care facilities. No group or association had ever qualified to self-insure under the pre-1975 law. The recent amendment to section 627.355, Florida Statutes, is an attempt to encourage the formation of self-insurance pools. The amendment seeks to accomplish this objective by: (1) extending the authorization to self-insure to groups and associations of health care facilities as well as individual providers; (2) providing that a group or association can be composed of any number of members; (3) repealing the requirements that the association must be primarily organized for noninsurance purposes and that the association must be in continuing existence for a period of 2 years; and (4) omitting the restriction that allowed only partial self-insurance. The resulting legislation authorizes any "group or association of physicians or health care facilities composed

211. Note 3 supra.
212. Note 6 supra.
214. Id.
of any number of members'\textsuperscript{217} to self-insure against claims of medical malpractice provided the following conditions are met:

(1) Approval from the Department of Insurance is obtained;
(2) A medical malpractice risk management trust fund is established to provide liability coverage; and
(3) Professional consultants for loss prevention and claims management coordination are employed.\textsuperscript{218}

Hopefully self-insurance programs will provide an economically feasible alternative to the purchase of insurance policies and thus decrease the medical profession's dependence on private insurance companies. The success of the state's workman's compensation self-insurance pool has been used to illustrate how such a plan could function successfully.\textsuperscript{219}

Apparently the legislative efforts to encourage the establishment of self-insurance programs has been successful. On August 9, 1975, a self-insurance trust fund established by the Florida Medical Association was approved by the Department of Insurance and will become effective when 1,000 members enroll.\textsuperscript{220} The Florida Hospital Association is in the process of obtaining approval of its self-insurance plan.\textsuperscript{221} The success of these plans remains to be seen. Since most claims are not filed until the third year after the injury occurs,\textsuperscript{222} it may be at least that long before it is clear whether the self-insurance programs will remain solvent. It may also be 3 years before a determination can be made as to whether the self-insureds saved money through a comparison of their insurance costs to the costs of similar insurance previously available from private insurers.

2. Joint Underwriters Association.—The provision of the Act which authorizes the formation of a Joint Underwriters Association Plan is producing an immediate impact on the malpractice insurance situation.

Section 14 (627.351) of the Act requires the Department of Insurance to adopt a temporary joint underwriting plan.\textsuperscript{223} The purpose of the plan is to assure the availability of medical malpractice insurance by establishing an association which will supply such insurance

\textsuperscript{217.} Id.
\textsuperscript{218.} Id.
\textsuperscript{219.} Memorandum to Senator John T. Ware, Minority Leader of the Florida Senate, from Carl Adams, Executive Assistant, Feb. 13, 1975.
\textsuperscript{221.} Note \textsuperscript{215} supra.
\textsuperscript{222.} Note 35 and accompanying text supra.
\textsuperscript{223.} Fla. Laws 1975, ch. 75-9, § 14 (§ 627.351).
to licensed health care providers regardless of the risk the provider might pose and whether the provider has previously been refused coverage. According to the statute, all entities licensed to carry casualty insurance224 in Florida and all self-insurers authorized to issue medical malpractice insurance under section 627.355, Florida Statutes,225 “shall participate in the plan and shall be members of the Temporary Joint Underwriters Association”226 (hereinafter “JUA”). The JUA is to function for 3 years from the date of its creation and will be supervised by a nine-member board of governors consisting of five participating insurers, one attorney from the Florida Bar, one physician from the Florida Medical Association, a hospital representative from the Florida Hospital Association, and the Insurance Commissioner or his designated representative, who shall serve as chairman.227

On June 19, 1975, State Treasurer Philip F. Ashler filed with the Secretary of State an Order adopting a temporary joint underwriting association plan.228 The plan, which went into effect July 1, 1975, is set out in certain articles229 which were promulgated by the Insurance Department after consultation with insurers and the public.

Medical care providers who choose to obtain insurance through the JUA will pay an annual premium assessed in accordance with sound actuarial methods. Ideally the premiums collected will adequately cover all administrative expenses, losses and loss adjustment expenses, and taxes for the year. Since the association operates on a non-profit basis, if the premiums generated during any fiscal year exceed the JUA's total expenses incurred, the policyholders will receive dividends. In the event a deficit occurs, each policyholder will be assessed an additional amount which may not exceed one-third of the annual premium. If a deficit still remains after the maximum assessment is made against each policyholder, such deficit will be recovered from the companies participating in the program. The plan thus “spreads the loss” among all of the insurers who participate in the plan.

The Florida Medical Association originally endorsed the JUA Plan.230 The FMA believed that the JUA would provide insurance to

224. The insurers to which § 14 of the Act applies are described in Fla. Stat. § 624.605(1)(b), (j) and (p) (1975).
226. Fla. Laws 1975 ch. 75-9, § 14 (§ 627.351(3)(b)).
227. Fla. Laws 1975 ch. 75-9, § 14 (§ 627.351(2)(c)).
Florida physicians at a lower rate than the FMA group policy rates. When the operating plan and premium rates for the JUA were announced in July 1975, the FMA was dismayed to learn that the JUA rates were higher than their group policy rates. It was also displeased with the contingency assessment feature of the plan. Doctors reacted angrily, calling the rates "exorbitant."\textsuperscript{231} A representative of the Dade County Medical Association announced that "the Florida legislature was unresponsive to the problems facing doctors during its 1975 session."\textsuperscript{232}

It is the opinion of some that the FMA and other critics have been too hasty in condemning the JUA Plan. The plan has certain features which could make JUA insurance extremely desirable. The most attractive aspect of the JUA is that it is not organized or intended to produce a profit. Whereas health providers who are insured by individual or group insurance pay premiums which include a profit factor for the insurer of approximately 5 percent,\textsuperscript{233} those who obtain JUA insurance will be participating in a non-profit venture and will receive a rebate if any "profits" have accrued at the end of a fiscal year. JUA policyholders also benefit by the fact that private insurance companies are required to make up any deficits which occur after JUA policyholders have been assessed a maximum amount. The JUA policyholders enjoy this deficiency coverage without paying a fee or premium directly to the insurers. The JUA is also exempt from paying premium taxes. Initially it was thought that the JUA would be required to pay a 2 percent premium tax from which the FMA was exempt. A recent attorney general opinion, however, states that "insurance business written through the Florida Medical Malpractice Joint Underwriting Association, as insurer, is not subject to the premium tax . . . because such insurance business would be within the exemption . . . ."\textsuperscript{234}

Those less enthused about the JUA Plan point out that any decrease in the JUA premium due to the non-profit nature of the association will be off-set by another factor. Self-insurers will be writing on a "claims-made" basis which results in lower annual premiums that JUA policies which are written on an "occurrence" basis.\textsuperscript{235} As long as the

\begin{itemize}
\item \textsuperscript{231} St. Petersburg Times, June 27, 1975, at 26, col. 2.
\item \textsuperscript{232} Tallahassee Democrat, Aug. 14, 1975, at 26, col. 2.
\item \textsuperscript{233} See note 215 supra.
\item \textsuperscript{234} 1976 FLA. ATT'Y GEN. OP. 076–35, at 4.
\item \textsuperscript{235} Insurance policies written on an "occurrence" basis cover the acts of alleged malpractice which occur during the policy period regardless of when the claim is made or the suit is filed. "Claims-made" policies, on the other hand, provide coverage
JUA is temporary in nature it cannot use the more economical claims-made rating method.

If these factors cause JUA rates to exceed the FMA self-insurance program rates, the FMA plan will enjoy a large market and can be selective in its choice of participants. In such a situation it is possible that high-risk medical care providers would be rejected by the FMA. The high-risk doctors would then be forced to turn to the JUA for insurance. A large number of high-risk participants would increase the likelihood of JUA fund deficiencies. The result of these deficiencies could be that the casualty insurers, who are required to cover the deficiencies, would raise their rates to cover these losses. In effect, all casualty insurance purchasers would be subsidizing the JUA insurance program. The possibility of increasing automobile insurance rates to provide doctors with “free” insurance is distasteful indeed.

Many persons involved in implementation of the JUA Plan believe that it will operate successfully only if given permanent status. This would allow the more economical claims-made method of rate-making to be used which would attract more participants and stabilize the program. Legislation converting the plan to permanent status has been proposed for the 1976 legislative session. Despite all the speculation and predictions surrounding the JUA, it is too early to determine the success of the plan. Only the passage of time will reveal whether a sufficient number of participants will be attracted to the program and whether large deficits in the fund can be avoided without setting high premium rates.

3. Patient’s Compensation Fund.—The third section of the Act

only for claims made during the policy year no matter when the injury actually occurred. Assume, for instance, that in 1974 Dr. X procured an “occurrence” policy and Dr. Y, for the same year, obtained a “claims-made” policy. In 1976 both doctors are sued for an injury suffered by a patient in 1974. The company insuring Dr. X with the “occurrence” policy in 1974 would be responsible for covering the 1976 claim, even if it was no longer Dr. X’s insurer, since the incident giving rise to the claim occurred in 1974. Dr. Y’s 1974 insurer would not be responsible for the claim against Dr. Y because the insurance it offered covered only claims filed in 1974. Because the period for which the “claims-made” insurer’s liability is restricted, the “long tail” is eliminated and the coverage may be offered at lower rates.

238. See note 235 supra.
239. Commerce Committee, Fla. H.R., Proposed Committee Bill Relating to Permanent Malpractice JUA. The proposed bill passed out of the Commerce Committee’s Insurance Subcommittee on Oct. 6, 1975.
which addresses the insurance problem involves an innovative attempt to protect medical care providers from excessive liability for malpractice claims by establishing a "Patient's Compensation Fund." 240 Under the plan, the malpractice liability of certain medical care providers 241 is limited to $100,000 if the provider pays a yearly assessment to the Fund and maintains a specified minimum amount of malpractice insurance. That portion of a judgment or settlement against such a participating provider in excess of $100,000 is paid from the Patient’s Compensation Fund. To be entitled to the benefits of the Fund, any hospital, physician, physician’s assistant, osteopath, or podiatrist must: (1) demonstrate financial responsibility in the amount of $100,000 either by posting bond, establishing an approved escrow account in the amount of $100,000, or obtaining insurance through a private insurer, the JUA, or a self-insurance program; (2) deposit an annual fee in the Fund. 242

For individual doctors the annual fee for the fiscal year beginning July 1, 1975, is $1,000; for hospitals the first year fee is $300 per bed. The fee after the first year of operation shall be a base fee of $500 for individuals and $300 per bed for hospitals plus an additional amount to be assessed against each individual and hospital based on past and prospective loss and expense experience in different types of practices and different geographical areas, prior claims experience, and various risk factors. 243 The base fees may be adjusted downward, and the additional fees may not be levied, if it is determined that the Fund can tolerate a decreased income. However, the Insurance Commissioner may levy a deficit assessment against all participants in the Fund if the monies are insufficient to cover expenses and claims for any fiscal year. 244 A person or hospital having insurance or other coverage in excess of $100,000 may also participate in the Fund. In such a case the participant shall be liable for losses up to the amount of his

241. The list of persons and associations appearing in § 14 (§ 627.351(8)(d)) of the Act, eligible for the Joint Underwriters Association is not the same as the list of persons and associations in § 15 (§ 627.353(2)(a)), which are eligible for the Patient’s Compensation Fund. Those who may contribute to the Fund include hospitals, physicians, physician’s assistants, osteopaths and podiatrists. The persons and associations which may join the JUA include hospitals, physicians, osteopaths, podiatrists, dentists, nurses, nursing homes, and professional associations composed of these persons or associations. The Florida Medical Liability Insurance Commission Report recommends that “the same persons and associations thereof which are eligible for participation in the Florida Medical Malpractice Joint Underwriting Association would also be allowed membership in the Florida Patient’s Compensation Fund . . . .” Insurance Comm’n Report, supra note 49, at 18.
242. Fla. Laws 1975, ch. 75-9, § 15 (§ 627.353(1)(b)).
243. Id. (§ 627.353(2)(c)(1)-(3)).
244. Id. (§ 627.353(2)(c)).
coverage, but shall receive a reduction in the fee that he must pay into the Fund.\(^{245}\)

Participation in the Patient's Compensation Fund is voluntary for physicians, physician's assistants, osteopaths, and podiatrists. If these individuals decide not to participate, their liability for malpractice claims is unlimited. Hospitals must participate in the Fund unless they secure insurance, post bond, or establish an escrow account in an amount equivalent to $10,000 per bed.\(^{246}\) If a hospital chooses this option, the amount of insurance, bond, or escrow furnished need not exceed $2.5 million.\(^{247}\)

The law provides a specific procedure by which claims are to be asserted against the Fund. A claimant may file an action for damages against a person or entity covered under the Fund, but unless the claimant names the Fund as a defendant to the suit, he may not recover from the Fund.\(^{248}\) Thus in a situation where a claimant obtains a $500,000 judgment against a doctor participating in the Fund, but the Fund was not named as a defendant, the doctor, because he has fulfilled the requirements for limited liability under section 15 (§ 627.353(1)(b)) of the Act, is liable for only $100,000, and the Fund completely escapes liability.

If the Fund is named as a defendant and if it appears that the claim will exceed $100,000, the Fund must appear and defend itself.\(^{249}\) This appearance does not relieve the medical care provider's insurer from the responsibility of defending the suit and the insurer "shall act in a fiduciary relationship with respect to any claim affecting the fund."\(^{250}\) Whenever the Fund is involved, no settlement may be agreed to unless approved by the JUA, which manages the Fund.

The Patient's Compensation Fund is generally looked upon as one viable method of resolving some of the malpractice insurance problems. An unanswered question is whether the Fund will remain solvent. This, to a large extent, depends on the number of medical care providers that choose to participate in the Fund. The distinct advantage of Fund membership is that doctors and hospitals will be relieved of the difficult task of estimating the amount of insurance needed to adequately cover any claims that may be brought against them. By contributing to the Fund and maintaining a minimum amount of insurance, they are assured that no matter how large a judgment is obtained, their personal

\(^{245}\) Id. (§ 627.353(2)(e)(5)).

\(^{246}\) Id. (§ 627.353(1)(c)).

\(^{247}\) Id. (§ 627.353(1)(c)(3)).

\(^{248}\) Id. (§ 627.353(2)(e)(1)).

\(^{249}\) Id. (§ 627.353(2)(e)(2)).
liability will be limited to $100,000. Because the Fund, like the JUA
and the self-insurance plan, is untested, its success cannot yet be pre-
dicted or measured.

D. Preventive Measures

Included in the Medical Reform Act are three sections containing
legislation designed to decrease the frequency of medical accidents and
injuries. The first of these preventive provisions requires all licensed
Florida hospitals maintaining over 300 beds to establish an internal
risk management program. The program must be supervised and
directed by either a person on the administrative staff of the hospital,
a committee composed of members of the hospital's board of trustees
or board of directors, or the hospital's medical staff. Those persons
directing the hospital's internal risk management program are charged
with three functions:

(1) The investigation and analysis of the frequency and causes of
general categories and specific types of adverse incidents causing
injury to patients;
(2) The development of appropriate measures to minimize the risk
of injuries and adverse incidents to patients through the cooperative
efforts of all personnel; and
(3) The analysis of patient grievances which relate to patient care
and the quality of medical services.

The statute, by mandating the creation of hospital programs which
use information concerning past incidents and patient grievances as
a basis for the development of measures to minimize future risks, adopts
an excellent method of reducing malpractice claims. The weakness of
the law lies in the fact that the establishment of internal risk manage-
ment programs is required only in hospitals having over 300 beds. Only
49 of the 240 licensed hospitals in Florida have over 300 beds. Thus,
only 20 percent of the state's licensed hospitals are affected by these pro-

---

251. The Florida Medical Insurance Liability Commission recommended that the
Patient's Compensation Fund legislation be modified to provide "for the cost of cor-
rective and rehabilitative procedures, and other out-of-pocket costs necessary in connec-
tion with a patient's care in-hospital medically related incidents." This coverage would
be funded by an admission fee charged to each person admitted to a hospital. Insurance
Comm'n Report, supra note 49, at 8-10.
252. Fla. Laws 1975, ch. 75-9, § 3 (§ 395.18).
253. Id. (§ 395.18(3)).
254. Fla. Laws 1975, ch. 75-9, § 3 (§ 399.18).
255. Personal communication with Patrick Haines, Assistant Vice President, Florida
visions. There is no compelling reason why small hospitals should be excused from establishing risk management programs. A minor change extending these provisions to all licensed hospitals, regardless of size, would result in a major improvement in the law.256

The second preventive measure passed by the legislature appears as a series of amendments to chapter 458, Florida Statutes. This chapter assigns to the Florida Board of Medical Examiners the function of licensing and regulating Florida physicians. Since 1969 the Board has had the power to discipline licensed physicians for 14 types of conduct.257 The 1975 legislation attempts to expand the disciplinary powers of the Board by expanding the list of punishable actions and conduct.258 One such addition authorizes disciplinary action for "incompetence, negligence, or willful misconduct."259 Another addition alters the definition of unprofessional conduct to include "any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice in his area of expertise as determined by the board . . . ."260 Additionally, the statute now authorizes the Board to discipline a physician who has been "found liable for medical malpractice or any personal injury from an act or omission committed or omitted by a person in his capacity as a physician . . . ."261 Finally, the statute authorizes discipline when a physician has been removed or suspended or has been the subject of disciplinary action taken by any professional medical association, society, professional standards review organization262 or other professional body or by a licensed hospital or medical staff.263 To insure that the Board will be promptly informed of any such peer review, the law requires any person taking disciplinary action against a physician to report such action to the Board within 30 days of the occurrence. The penalty for failure to report is a fine in an amount not to exceed $500.264

256. The Florida Medical Liability Insurance Commission recommended that "[s]ection 395.18, Florida Statutes . . . be amended to include all hospitals of all sizes, ambulatory surgical centers as defined in Section 381.499(3)(j), Chapter 75-167, Laws of Florida, Health Maintenance Organizations and other areas of inhouse patient care, such as nursing homes and convalescent centers. . . ." Insurance Comm'n Report, supra note 49, at 7-8.
259. Id. (§ 458.1201(l)(m)).
260. Id.
261. Id. (§ 458.1201(l)(o)).
263. Id.
264. Id.
Although the amendments sound impressive, more drastic steps will be necessary to force the Board of Medical Examiners to function as an effective regulatory body. The Board has had the power for several years to closely scrutinize and discipline the medical profession, but has failed to exercise that power. The preamendment language of the Medical Practices Act, although somewhat vague, could have been interpreted to give authority to investigate and discipline any unacceptable action on the part of a physician. For example, section 458.1201(1)(h), Florida Statutes, authorizes the discipline of physicians who engage "in any unethical, deceptive, or deleterious conduct or practice harmful to the public." Certainly the phrase "conduct . . . harmful to the public" is broad enough to use as authority to control most unacceptable physician conduct. Another preamendment provision, section 428.1201(1)(m), Florida Statutes, authorized the Board to discipline a physician for any "departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice . . . or the committing by a physician of any act contrary to honesty, justice, or good morals . . . ." An active and aggressive Board could have invoked this section as authority to take disciplinary action against those guilty of negligence, malpractice, or other unacceptable conduct. But the Board had traditionally been hesitant to regulate and discipline the medical profession. Some statistics obtained from the Board of Medical Examiners illustrate this point. During the 4-year period from 1970 through 1973, 468 investigations were conducted. As a result, 12 licenses were suspended, three licenses were revoked, and 17 doctors were reprimanded. This is an average of only 3 suspensions, .75 revocations, and 4.2 reprimands per year. These low figures lead one to question the intensity of the investigations conducted by the Board. Also significant is the complaint and investigation data available for the year 1975. This data shows that during 1975, 240 complaints were filed but only 106 investigations were conducted. Thus 44 percent of the complaints received were not even investigated. Although statistics indicating the number of complaints filed before 1975 are not available, it is probable that investigation of complaints was similarly limited in previous years. These statistics indicate that the Board has interpreted the scope of its authority very narrowly and suggest that it may not be helpful to confer additional powers on a

266. These statistics cover the period through October 28, 1975.
body that has failed to make maximum use of the powers it already possesses.

Possibly a more radical approach will be necessary to induce the Board to carry out its regulatory functions more conscientiously. One method might be to restructure the Board in such a way that the licensing and regulatory functions are separated. Under such a plan the Board would be divided into two sections. An all-physician panel would be maintained for licensing purposes and a panel consisting of both physicians and laypersons would be created to handle regulatory functions. The establishment of a regulatory panel whose sole function is to investigate and discipline would emphasize the importance of professional regulation and insure that an adequate amount of time and energy is available for this important function. In the absence of such a panel, the legislature should seriously search for a way to encourage the Board to earnestly perform its regulatory functions.

The last preventive section of the Act addresses the subject of hospital disciplinary powers. Under the Act, the medical staff of any licensed hospital is authorized to "suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause . . . ." Good cause which may precipitate disciplinary action includes, but is not limited to:

1. incompetence;
2. negligence;
3. being found a habitual user of intoxicants or drugs to the extent that the physician is deemed dangerous to himself or others; or
4. being found liable by a court of competent jurisdiction for medical malpractice.

This legislation is commendable in that it gives hospital staffs heretofore unavailable powers against incompetent, negligent, or otherwise unfit staff members. The weakness of the statute is that disciplinary action is only authorized—it is not required or encouraged. A stronger plan would mandate an investigation and hearing in any case where unacceptable conduct is suspected or complained of.

A criticism may also justifiably be leveled against the part of this statute authorizing discipline by the hospital staff where a staff member has been "found liable by a court of competent jurisdiction for medical malpractice." This provision could be interpreted to mean that a

268. Id. (§ 395.065(1)).
269. Id.
270. Id. (§ 395.065(1)(d)).
hospital staff member involved in a medical malpractice lawsuit may be disciplined only after a court proceeding is held in which liability is found. The filing of the lawsuit, however, should alert the hospital to the possibility that the physician named in the lawsuit may have been negligent or may be incompetent. The physician should be subject to disciplinary action as soon as the hospital determines that he or she is incompetent or has been negligent. Realistically, the physician is not likely to be subjected to disciplinary action before the malpractice claim is resolved. Since the hospital is often named as a codefendant in malpractice suits and since the hospital might also be liable if the defendant physician is found liable, the hospital will not be anxious to establish the negligence or unfitness of the physician.

Nonetheless, the time to begin an investigation into an alleged act of malpractice is when the act complained of is brought to the attention of the hospital, not when a judgment is finally rendered. If in fact malpractice has occurred, many patients will be exposed to the risk of similar incidents during the period of litigation. The law should require the hospital staff to initiate an investigation to determine if disciplinary action is appropriate immediately upon notice of a lawsuit against any staff member. To encourage the hospital to conduct a thorough investigation, the law could provide that findings and actions of the hospital be confidential, and hence not admissible before the panel or before any court. To wait for the slow wheels of justice to grind to a conclusion before hospital action is taken needlessly endangers the health and lives of many patients.

**Conclusion**

The 1975 Medical Malpractice Reform Act is a far-reaching attempt to alleviate the medical malpractice insurance crisis. A few of the provisions of the new law may prove to be beneficial while others are likely to cause confusion and to create gross injustices. The shortcomings of the Act are explained partly by the fact that the Act is the product of the desperate, emotion-charged atmosphere which surrounded the medical malpractice issue during the 1975 legislative session.

The Act demonstrates the need to approach the problem in a more objective and analytical manner. One important analytical process which should precede passage of medical malpractice legislation is a cost-benefit analysis. An effort should be made to determine whether the benefits to be derived from proposed legislation justify the costs to the public. The potential consequences of reducing patients' legal rights should also be carefully considered. The legislature should note that
If the burden of responsibility for the injured patient does not fall on the negligent doctor or hospital, it will most likely fall on the general public.

During the 1976 legislative session the entire Act should be reviewed. Some of the provisions, such as those dealing with insurance, disciplinary powers, and the internal risk management programs, could be vastly improved by making relatively minor changes. The value of other provisions, such as those which alter the statute of limitations, the Statute of Frauds, and the informed consent doctrine, should be scrutinized with care. The section creating medical mediation panels should be revised in its entirety in an effort to clear up both technical inaccuracies and substantive inadequacies. Finally, the legislature should recognize that the long-term medical malpractice problem cannot be solved by stop-gap measures such as those in the 1975 Act. Although a divergence of opinion exists as to what has caused the malpractice crisis and how the situation should be handled, nearly all agree that medical malpractice insurance rates will be reduced only when malpractice claims can be resolved in an efficient, rapid, and predictable manner. Use of the tort liability system can never be an efficient way to resolve a disputed issue. It is by nature a slow and expensive process. For this reason, the legislature should investigate the feasibility of creating an alternative method of medical malpractice claim resolution. Both binding arbitration and no-fault medical compensation systems are alternatives which should be carefully considered. The Liability Insurance Commission should also consider these possibilities.

No matter what action is taken, the medical malpractice problem will not immediately disappear. The demands for rapid legislative resolution will persist. Hopefully, the legislature in the future will resist the pressures of the interest groups and cautiously and analytically seek a practical and realistic solution.

Theresa Hooks