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FLORIDA DEPARTS FROM TRADITION: THE LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE CRISIS

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I. INTRODUCTION

The "medical malpractice crisis" emerged in early 1975 when insurance carriers writing professional liability insurance for physicians suddenly realized that what had traditionally been a profitable market was turning into a financial disaster. Carriers everywhere responded by refusing to renew existing policies or by offering renewals at astronomically increased premiums. Insurance coverage for the new physician or for others insured for the first time was virtually unavailable at any price. The impact of all this on the medical community touched off shock waves that were soon felt by the public at large. The situation commanded and received immediate attention from legislative bodies across the nation.

The Florida experience is typical of that in most of the larger states, both in terms of the chronology of the crisis and the legislative response. Most of the legislation enacted in the medical malpractice area in Florida since 1975 has also been adopted in one form or another by many other states. While it is fair to say that Florida has gone farther than most states in the variety and scope of legislative enactments intended to address the problems of malpractice insurance, it should be pointed out as well that some states have adopted measures which are much more extreme in their impact on the traditional tort liability/insurance compensation system. 2

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1. For an extensive review of legislation enacted on a state-by-state basis, see AMERICAN MEDICAL ASS'N, 5 STATE HEALTH LEGISLATION REPORT (1977). For further comprehensive treatment of medical malpractice issues, see also U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, LEGAL TOPICS RELATING TO MEDICAL MALPRACTICE (1977), and White & McKenna, Constitutionality of Recent Malpractice Legislation, 13 FORUM 312 (1977-78).

2. For example, California, Ohio, and South Dakota place ceilings on the amount of general damages which may be recovered in medical malpractice cases. At least eight other states have adopted ceilings under certain circumstances. At least 12 states have adopted statutes regulating attorney fees by placing contingency fees on sliding scales. In addition, Illinois, Nebraska, Pennsylvania, and Rhode Island allow the awarding to defendants of costs and attorney fees for ill-founded suits or appeals from pretrial screening panels. None of these measures has been adopted in Florida.
The purpose of this article is to review the legislative response to the medical malpractice insurance crisis in Florida. In so doing, an effort will be made to illustrate the public policy considerations posed by the malpractice problem as well as the logic underlying the legislature’s proposed solutions. This article is intended to provide the legal practitioner with a working knowledge of the panoply of Florida statutes on medical malpractice.

II. BACKGROUND

The inability of physicians to obtain liability insurance coverage at affordable premiums must be viewed in terms of its impact on the general public in order to comprehend the rapid and far-reaching response by the Florida Legislature. The reaction of Florida’s physicians in early 1975 when professional liability coverage became virtually unobtainable was predictable. Responsible members of the medical community seriously considered major curtailments of services in order to minimize potential exposure to liability. Older physicians weighed early retirement against risking the assets they had accumulated over the years. New physicians decided to open their practices in neighboring states where liability coverage was still available.

The situation posed a clear threat to the availability of quality health care in Florida. Because the costs of liability insurance premiums are ultimately passed on to the consumer through higher charges for goods and services, the physicians, confronted with dramatically increased premiums, increased their bills to patients accordingly—thereby adding a new inflationary element to the spiraling cost of health care. Furthermore, the increased practice of “defensive medicine”—the ordering of a surfeit of x-ray or laboratory studies to confirm the physician’s judgment—drove medical bills even higher.

III. LEGISLATIVE RESPONSE

In the eyes of Florida legislators, the inability of the physician to obtain affordable insurance coverage posed the dual threats of unaffordability and unavailability of health care services. Their response can be categorized into three general areas. The first area includes provisions designed to assure the availability of medical liability insurance coverage through mandatory risk pooling by insurance carriers and by the establishment of alternative insurance mechanisms. The second area includes measures to insure the quality of medical services and to reduce the incidence of malpractice by identifying and disciplining incompetent or negligent physicians. The
third includes both procedural and substantive modifications to the tort system by providing new review mechanisms for highly technical malpractice claims and by altering the basis for damage awards by juries.

A. The Medical Malpractice Reform Act of 1975

The Medical Malpractice Reform Act of 1975\(^3\) was undoubtedly the broadest and most far-reaching action taken by the Florida Legislature to address the medical malpractice problem. This Act contained major substantive provisions in each of the three general areas described above and provided the basic framework for Florida's present statutory scheme in the malpractice field.

In an effort to make professional liability insurance more readily available, the legislature mandated the formation of a temporary joint underwriting association (JUA) composed of all insurance carriers writing casualty insurance in the state.\(^4\) The JUA is analogous to the "assigned risk pool" for automobile liability insurance. It forces carriers to participate in writing malpractice coverage as a requirement for writing other types of casualty coverage in Florida. The JUA is designed as a stop-gap measure to provide an insurance market until the "crisis," as reflected by premium levels, stabilizes or subsides. The legislature voted to extend the life of the JUA in 1978 following a finding that an adequate voluntary market still did not exist.\(^5\)

In addition to mandating the availability of coverage through the private market, the 1975 Act also allowed the establishment of self-insurance trusts by groups of health care providers.\(^6\) After receiving approval from the Department of Insurance, these groups may self-insure and may purchase basic and/or specific excess coverage as well as aggregate excess coverage. Such trusts are tightly regulated by the department according to the actuarial soundness of the premium structure and the capability of management personnel or consultants.

One of the most innovative features of the 1975 Act was the establishment of the Patient’s Compensation Fund (Fund).\(^7\) The Fund is intended to provide liability coverage in excess of basic policy limits for participating health care providers and hospitals. It was made

3. Ch. 75-9, 1975 Fla. Laws 13 (current version in scattered sections of FLA. STAT. (1977)).
4. Id. § 14 (current version at FLA. STAT. § 627.351(7) (1977)).
5. SB 481 by Senator John Ware and others was approved by both the senate and the house and sent to the Governor on May 9, 1978.
6. Ch. 75-9, § 4, 1975 Fla. Laws 13 (current version at FLA. STAT. § 627.357 (1977)).
7. Id. § 15 (current version at FLA. STAT. § 768.54(3) (1977)).
necessary by the almost total lack of a viable excess insurance market. All hospitals must participate in the Fund unless they obtain satisfactory alternative coverage. An annual premium based on the number of beds in each facility must be paid. Other health care providers have the option of joining the Fund upon a showing of financial responsibility for the first $100,000 of any claim and upon payment of a base premium plus an adjusted premium based on the type and the location of practice.⁸

The statute absolves participants in the Fund from any liability in excess of $100,000, the portion of any settlement or judgment over this amount being paid from the Fund.⁹ While there is no limit as to the total amount a claimant may recover from the Fund, the legislature amended the statute in 1976 to limit actual payment to a single individual, based on a single occurrence, to $100,000 per year to insure the continuing solvency of the Fund.¹⁰ Costs and attorneys’ fees, however, must be paid in a lump sum and are not subject to the $100,000 limitation. When combined with the basic coverage available through the JUA or through a self-insurance trust, the Fund provides a health care provider with the opportunity to insure himself completely against a malpractice judgment—assuming, of course, affordable premiums.

The second area of major significance in the 1975 Act relates to the prevention of patient injuries. The Act provides for the disciplining of errant health care providers and for the identification of recurring injury situations in hospitals.¹¹ What was widely misinterpreted as a lack of desire on the part of the medical community to "police its own ranks" was actually, in most cases, a lack of the statutory disciplinary power to do so.

While Florida led the nation in progressive medical licensure in terms of sanctions against physicians who were incapacitated due to alcohol or drug-related problems (the "Sick Doctor Act"),¹² the Florida Board of Medical Examiners lacked the power to discipline a licensee for practicing bad medicine. Furthermore, hospital medi-

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⁸ Physicians are categorized into five rating classifications depending on specialty and the nature of practice. A Class I physician (a general practitioner, etc.) pays significantly lower rates than a physician in Class V (orthopedic surgeons, anesthesiologists, etc.), due to the obvious differences in the level of risk involved in their respective practices. In addition, Florida is divided into two geographic rating areas. Dade and Broward Counties comprise one area by themselves, and the rest of Florida comprises the second area. This differentiation is based on the high frequency and severity of claims emanating from these two counties, as opposed to the rest of the state.

⁹ FLA. STAT. § 768.54(2)(a)-(b) (1977).

¹⁰ Ch. 76-260, § 6, 1976 Fla. Laws 660 (current version at FLA. STAT. § 768.54 (1977)).


cal staffs and similar local professional groups lacked the authority to impose sanctions on members. Peer pressure—the only available sanction—was ineffective in most situations.

Section 12 of the 1975 Act vested the board with broad new powers to suspend or revoke licenses for practicing bad medicine. A finding of liability for medical malpractice, a finding of guilt for negligence, or the imposition of disciplinary action by a hospital staff or a similar body now subjects a physician to an array of potential professional sanctions ranging from limitations on his practice to permanent license revocation. It is significant to note that the board now has the tools to rehabilitate a physician, while protecting the public from that physician’s lack of ability during the rehabilitation period.

Hospital medical staffs were given similar powers in section 13 of the Act. This provision allows the staff to “suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause . . . .” Good cause includes incompetence, negligence, an adjudication of liability based on malpractice, and habitual use of intoxicants or drugs. The staff and its individual members are held harmless from liability for imposing these sanctions if such actions are “without malice or fraud.”

In a related provision, hospitals having more than three hundred beds were required by the 1975 Act to establish an internal risk management program designed to identify the causes of patient injuries and to take appropriate preventive measures to minimize the potential for such injuries. This was a major step toward loss prevention and, when combined with the new disciplinary powers described above, represented a significant movement toward reducing injuries and reducing possible malpractice claims.

The third major area of the 1975 Act provided for both substantive and procedural modifications of the tort system as it applies to medical malpractice litigation. The most significant provision in this area was the establishment of the medical liability mediation panel system for pretrial review of potential malpractice claims.

The mediation panel system is based on the precept that medical malpractice litigation is highly technical and deals with scientific data and professional judgments which are beyond the comprehen-
sion of the average juror. The commonality of experience which exists in situations in which jurors deal with questions of everyday life (such as driving automobiles) is simply not present in a malpractice context. The mediation panel—composed of a doctor, lawyer, and judge—is intended to provide an intermediate level of expert review for purposes of weeding out unworthy claims and for facilitating settlements where recoverable injuries have occurred.  

Under the statute, any claim based on allegations of medical malpractice must be submitted to mediation as a prerequisite to filing an action in circuit court. The defendant has twenty days in which to file his response to the claim or the jurisdiction of the mediation panel lapses, allowing the claimant to proceed to court. In effect, this provision gives the defendant the option of mediating or taking his chances in court, while the claimant is denied this alternative. If the defendant chooses to mediate—and most do—the full array of discovery tools that would be available in other types of litigation conducted pursuant to the Florida Rules of Civil Procedure is available to both parties.

Hearings are conducted by the panel in accordance with rules set forth by the Florida Supreme Court. Parties may call witnesses, introduce evidence, and cross-examine witnesses of the opposing party. Within thirty days after the hearing, the panel makes a written finding as to whether the defendant was "actionably negligent" in his care or treatment of the claimant. Findings of the panel as to liability, or the lack thereof, are admissible as evidence in any subsequent trial and may be commented on like any other evidence. The jury, however, is instructed that the findings of the panel are not binding and should be given no greater weight than other evidence.

While medical mediation panels have existed for a relatively short time and no formal data have been collected on a statewide basis quantifying the results of panel activity to date, most observers feel that the mediation panel system is an unqualified success. The settlement of meritorious claims is being expedited, claims lacking merit are being weeded out, and truly disputed claims are still going to the jury. The panels appear to provide an effective screening mechanism without imposing undue hardship on the participants. And the jury system is functioning in its purest form—settling true disputes.

19. For further material on the concepts of pretrial mediation and arbitration, see Ladimer & Solomon, Medical Malpractice Arbitration: Laws, Programs, Cases, 1977 INS. L. JOUR. 335. See also Nocas, Arbitration of Medical Malpractice Claims, 13 FORUM 254 (1977-78).

20. See Fla. Rules for Mediation Panels as adopted by the Supreme Court of Florida.
As might have been expected, though, the constitutionality of the mediation panels was challenged almost immediately following the enactment of the statute.

On July 18, 1975, eighteen days after the effective date of the 1975 Act, Nellie Mae Sparkman filed suit in Brevard County Circuit Court alleging that she had been injured by the negligence of Dr. James Carter. Defendant Carter moved for dismissal of her action because she had not submitted it to mediation in accordance with the provisions of the Act. Plaintiff Sparkman responded by asserting the unconstitutionality of the mediation panel sections of the Act on several grounds. The trial court concurred with her assertions and held the new statute unconstitutional as abrogating the plaintiff's due process of law, equal protection of law, and timely access to the courts.21

On appeal, the Florida Supreme Court reversed the trial court and held the mediation panel statute constitutional.22 To reach this conclusion, the court had to provide judicial interpretations of certain provisions of the statute in order to render it valid. In so doing, the court reasoned:

It is incumbent on this Court when reasonably possible and consistent with constitutional rights to resolve all doubts as to the validity of a statute in favor of its constitutional validity and if possible a statute should be construed in such a manner as would be consistent with the constitution, that is in such a way as to remove it farthest from constitutional infirmity.23

The court went on to recognize that there are a number of conditions which the legislature may place on a person's right of access to the courts as a valid exercise of the state police powers in the areas of public health and welfare. Reflecting on the crisis atmosphere surrounding the passage of the Act as expressed in the so-called "Whereas Clause," the court held that the Act was valid in the light of the "imminent danger to public health" existing at that time:

The Legislature felt it incumbent upon itself to attempt to resolve the crisis through exercise of the police power for the general health and welfare of the citizens of this State and accordingly enacted Chapter 75-9, Laws of Florida, to effectuate that purpose. The

22. 335 So. 2d at 806.
23. Id. at 805.
statutes involved here deal with matters related directly to public health and obviously have for their purpose an effort to have the parties mediate claims for malpractice thereby reducing the cost of medical malpractice insurance and ultimately medical expenses.  

Yet, in an apparent admonition to the legislature, the court went on to state: "Even though the pre-litigation burden cast upon the claimant reaches the outer limits of constitutional tolerance, we do not deem it sufficient to void the medical malpractice law."  

Justice Roberts, writing for the majority, was joined by Chief Justice Overton and Justices Adkins, Boyd, Sundberg, and Hatchett. Chief Justice Overton and Justices Sundberg and Hatchett also joined, however, in a special concurring opinion by Justice England. After accepting the premise stated by the majority that the legislature validly exercised its police powers in the light of an apparent public health crisis, Justice England analyzed Sparkman's constitutional arguments and decided they held no real merit. He expressed concern over the equities of requiring a plaintiff to mediate while giving defendants the option of participation. But he concluded:

While I find the inequity in this procedure harsh to a large and undefined class of litigants, I cannot in good conscience invalidate the statute on that basis. A disparity of resources has always been an imbalance in litigation which the courts are relatively powerless to adjust. Accordingly, although I might have preferred a more delicate balance for this type of litigation, I cannot conclude that the Legislature was unreasonable in setting a procedure for this class of lawsuit which has widened existing disparities.  

Three important observations may be made concerning Justice England's concurring opinion in Carter. First, it is totally lacking in the implications of unconstitutionality which permeate Justice Roberts' opinion, for there is nothing in Justice England's words to suggest that the legislature had reached "the outer limits of constitutional tolerance." Nor are there similar admonitions. To the contrary, the clear thrust of the concurring opinion is that, while the legislature might have used more restraint, it acted in a constitutionally valid manner.  

24.  *Id.* at 806.  
25.  *Id.*.  
26.  *Id.*.  
27.  *Id.* at 808.  
28.  *Id.* at 807.
Second, Justice England recognized a growing trend toward alternatives to the court system as the initial point of entry for disputes. In referring to the mediation panel as a mechanism for the screening and resolution of disputes, he looked to the future, stating: "In fact, it is likely that the Legislature will more frequently attempt to accommodate the resolution of individual disputes without the use of the judiciary in areas where other forums or procedures can readily provide adequate dispute adjustment." 29

The third observation adds current relevance to the first two in that, as of this writing, Justice England and the three justices concurring in his opinion constitute a majority of the Florida Supreme Court. Those who take comfort in Justice Roberts' admonition concerning the "outer limits of constitutional tolerance" must shudder at the fact that a majority of the present court clearly recognized the wide latitude which must be afforded to the legislature in the valid exercise of its police powers.

Another major modification by the 1975 Act was a shortening of the statute of limitations for medical malpractice claims. Previously, the limitation extended two years from the time the cause of action was discovered or should have been discovered through the exercise of due diligence. This virtually open-ended period rendered calculation of insurance rates extremely difficult in that reserves had to be allocated for claims which potentially could be filed years in the future. Furthermore, statistics tended to indicate that the vast majority of all claims were reported during the first few years after the date of injury. 30

The Act provided for a statute of limitations of two years from the time the incident occurred or within two years from the time at which the incident is discovered or should have been discovered


30. Data from the Insurance Services Office, the statistical and actuarial clearinghouse for most major liability insurers, indicate that between 88% and 95% of all injuries resulting in claims are reported within the first 24 months following the injury, and that 97% of all claims are reported within 48 months. See Insurance Services Office, Special Malpractice Review: 1974 Closed Claim Survey Preliminary Analysis of Survey Results 24-30 (Dec. 1, 1975). Similar studies in Florida and around the nation verify the fact that all but a very few injuries are reasonably discoverable within the shortened statute of limitations.
through the exercise of due diligence, but in no event later than four years from the date of the incident.31 However, the Act provided an exception where the injury is not discovered because of fraud, concealment, or intentional misrepresentation of fact by the health care provider, in which case the statute runs for two years from the date of discovery up to a maximum of seven years. Research indicates no Florida cases to date in which the statute has been extended for any of these reasons.32

The Act included three additional modifications of the tort system as it relates to medical malpractice. As a predicate to a cause of action for breach of contract against a health care provider, guarantees or similar assurances of the results of the medical procedure were required to be put in writing, thus placing them within the Statute of Frauds.33 Second, statutory criteria for informing a patient of the risks involved in a given medical procedure were set forth to establish a standard of recovery based on assault and battery due to the lack of "informed consent on the part of the patient."34 Third, the statute also provided that in all actions brought to recover damages for personal injury or wrongful death (as opposed to medical malpractice only), the amount of general damages sought may not be stated in the complaint other than for purposes of establishing the requisite jurisdictional amount.35 This so-called "ad damnum" clause is intended to prevent the enhancement of public expectations as to the amount of damages recoverable in medical malpractice litigation which might result from newspaper headlines concerning complaints seeking multi-million dollar amounts in general damages.

In summary, the Medical Malpractice Reform Act of 1975 reflected a comprehensive approach by the Florida Legislature to the malpractice insurance crisis then at hand. With a few notable exceptions, which will be discussed below, legislative activity in this area in subsequent sessions has focused on improving the content of the 1975 Act rather than on breaking new conceptual ground.

31. Ch. 75-9, § 7, 1975 Fla. Laws 13 (codified at Fla. Stat. § 95.11(4) (1977)). Note that the filing of a claim in medical mediation tolls the applicable statute of limitations until the written decision or verdict is issued or the jurisdiction of the mediation panel is terminated. Fla. Stat. § 768.44(4) (1977); see, e.g., Nardone v. Reynolds, 333 So. 2d 25 (Fla. 1976); Salvaggio v. Austin, 336 So. 2d 1282 (Fla. 2d Dist. Ct. App. 1976).
32. For a differing point of view as to the fairness of Florida's statute of limitations in medical malpractice actions, see Note, The Florida Medical Malpractice Act of 1975, 4 Fl. St. U.L. Rev. 50 (1976). The author, however, in her dogmatic defense of the tort system, fails to recognize that any statute of limitations is a balancing of the rights of the injured individual against those of society in terms of affordable insurance in all litigable areas.
33. Ch. 75-9, § 10, 1975 Fla. Laws 13 (codified at Fla. Stat. § 725.01 (1977)).
34. Id. § 11 (codified at Fla. Stat. § 768.042 (1977)).
35. Id. §§ 8-9 (codified at Fla. Stat. § 768.46 (1977)).
B. 1976 and 1977 Legislative Changes

Contrary to the hopes and expectations of the Florida Legislature and almost everyone else, the "malpractice crisis" did not subside following the enactment of the 1975 legislation. In fact, the crisis atmosphere seemed to intensify in the succeeding months. The newly formed JUA announced a premium structure which was considerably higher than the rates being paid by Florida physicians six months earlier. As previously mentioned, the medical mediation statute was immediately challenged and subsequently invalidated on constitutional grounds in a number of judicial circuits. Thus, no track record was established as to the impact of the mediation panels on the frequency and severity of malpractice claims. With insurance rates continuing to escalate and with a crisis atmosphere permeating both the medical community and the public at large, the legislature was confronted once again in 1976 with medical malpractice as a major issue.

As is typical in Florida politics, the senate and the house of representatives took very different approaches to the malpractice problem. The house approach was to concentrate almost entirely on tort system modifications, while the senate placed its primary emphasis on developing an alternative compensatory mechanism for malpractice claims. The end product was a partial synthesis of both approaches which was once again incorporated into an omnibus medical malpractice act: chapter 76-269, Laws of Florida.36

The 1976 Act established an entirely novel mechanism for the early identification and compensation of potential medical malpractice claims through the establishment of the "Medical Incident Committee" concept.37 This mechanism uses the risk management requirements of the 1975 Act as a point of departure and is based on the pervasive belief among insurance claims adjusters that "the sooner you get to the injured person and make him happy, the less it's going to cost you." The system also envisions handling the preponderance of potential claims at the hospital level instead of burdening the insurance system with the extremely heavy costs which are inherent in litigating a claim through the judicial process. The overriding desires of the legislature in establishing the committees appear to be twofold: (1) to avoid potential litigation, and (2) to

36. Ch. 76-260, 1976 Fla. Laws 660 (current version in scattered sections of Fla. Stat. chs. 626, 768 (1977)). Persons desirous of reconstructing the tortuous route by which the 1976 Act became law should review the legislative history of Senate Bill 586 (1976) and thus the various house and senate bills which were eventually included or rejected. The journals of the respective legislative bodies provide an arena for this perverse form of scholarly recreation.

37. Id. §§ 2-4 (current version of § 2 at Fla. Stat. § 768.41; §§ 3-4 repealed 1977).
fulfill the moral obligation of compensating a patient who is injured through no fault of his own.

The Act required every hospital or other health care facility in the state to establish a medical incident committee composed of two members of the hospital governing body and two members of the medical staff. Members of the hospital staff as well as other hospital employees were placed under an affirmative duty to report any patient injuries to a risk manager named by the hospital. The risk manager screens these reports and submits legitimate patient injuries to the medical incident committee.

The primary function of the committee is to determine whether a compensable injury has occurred and whether compensation should be offered to the patient. The legislature set forth criteria for making these decisions. The Act requires at least a nuance of fault before the committee is authorized to make an offer.38 The committee is vested with wide latitude as to whether to make an offer.

Although the legislature was unwilling to deny the right to file a future civil action to a patient who accepted compensation, it nevertheless perceived a need to incorporate some form of deterrent to keep the patient from accepting compensation from the hospital and then using this compensation to finance subsequent litigation. Accordingly, the legislature limited the amount of general damages which a patient who accepted compensation could recover in a subsequent lawsuit to $250,000—a figure most observers believed at the time to be too high to serve as an effective deterrent. In addition, the Act provided that an amount equal to the compensation received by the patient plus the fair value of any free medical treatment or other services received by him would be deducted from the amount of any damages eventually awarded.

Possibly the most unique (and definitely the most controversial) aspect of the system was that a medical incident committee had the right to levy an assessment against a physician or other health care provider whose negligence was determined to have been the cause of a patient injury, should the patient decide to accept an offer of compensation.39 Such determinations were subject to arbitration and judicial review. The ability of the committee to make determinations which were binding on physicians and, more importantly, on their insurance carriers, drew a highly unfavorable response from both the medical community and the insurance industry.

Almost immediately after the 1976 Act became law, the Board of

38. See ch. 76-260, § 3(6), 1976 Fla. Laws 660 (repealed 1977), for review criteria.
Governors of the JUA sought to have the medical incident committee system declared unconstitutional on a number of grounds—including an alleged lack of due process and the denial of a trial by jury. The trial court held the medical incident committee system unconstitutional on several grounds, (including the denial of due process of law, trial by jury, equal protection of the law, and abrogation of the right to contract). In addition, the court declared the entire 1976 Act violative of article 3, section 6 of the Florida Constitution, which prohibits the inclusion of more than one subject matter in a legislative enactment. While an appeal was taken to the Florida Supreme Court, it appeared that a decision of that court would not be rendered until well after the beginning of the 1977 legislative session. Therefore, the incoming legislative leadership decided that the only way to establish a reasonably level of certainty and stability in the medical malpractice area was to reenact the 1976 legislation in a constitutionally acceptable form.

Consequently, the legislature revisited the medical incident committee system early in the 1977 session and decided to strengthen the medical incident reporting mechanism while abolishing the concept of patient compensation. The legislation mandated the Department of Health and Rehabilitative Services to promulgate rules governing the establishment of internal risk management programs in individual hospitals. Such programs were to include mandatory incident reporting, professional risk managers, and categorization of incident reports to identify and correct problem areas. As will be discussed in detail later, the legislature also reenacted the provisions of the 1976 Act which made significant modifications in the tort system.

While the medical incident committee system never had an effective opportunity to operate, its creation alone reflected a growing frustration on the part of the legislature with the tort liability system as it currently functions in our judicial process. It also evidenced a legislative willingness to experiment with alternative compensation systems. Many observers feel that the concepts embodied.

41. Id.
42. Ch. 77-64, § 2, 1977 Fla. Laws 98, 100 (repealed Fla. Stat. §§ 768.42-.43 (Supp. 1976)).
43. Id. § 1, at 99 (codified at Fla. Stat. § 768.41 (1977)). As of January, 1978, the Department of Health and Rehabilitative Services had not yet promulgated new risk management rules and could not provide a target date for promulgation. The inability of the department to fulfill its statutory responsibility in this area denies an early test of the prelitigation intervention mechanism that is central to the risk management concept and which many see as providing solutions to the problems that exist in this area.
in the medical incident committee system are sound from both the limited perspective of proven insurance principles and the broader perspective of good public policy. It is not unreasonable to speculate that similar concepts in a more functional, as well as more constitutionally acceptable, form will be considered by the legislature in future years as it seeks to address medical malpractice as well as other problem areas of the tort liability system.

The other major area of the 1976 Act greatly modified some of the traditional bedrock principles of the tort system. Perhaps the most significant tort modification in the Act was the abrogation of the common law "collateral source rule" in medical malpractice situations. As every first-year law student knows, the collateral source rule provides that a defendant is not entitled to a credit for amounts which may be paid to the plaintiff as compensation for his losses from "collateral sources," such as insurance policies and wage continuation plans. The rule originated at a time when it was contrary to public policy for a tortfeasor to be able to insure against his negligent acts. Under this "punishment theory" of tort liability, it was considered unjust for the defendant to benefit fortuitously from the ability of the plaintiff to obtain collateral sources.

The rule is theoretically sound in the absence of insurance. It must be remembered, however, that all types of insurance are based on a gamble on the part of the insurer that he can collect a little money from a lot of people and will only have to pay a lot of money to a few from whom he has collected. In other words, the premium dollars of many individuals go to pay the loss incurred by only one. The practical effect of the application of the collateral source rule where first- and/or third-party insurance is present is that the plaintiff often recovers more than 100% of his actual economic loss at the expense of the premium-paying public. It may well be that there are social considerations which justify this overpayment, but the traditional reasoning behind the collateral source rule is no longer applicable in an insurance-oriented society.

Under the provisions of the 1976 Act, the trial court is required to reduce the amount of any award of damages based on medical malpractice by the total of all amounts paid or to be paid to the claimant from all collateral sources which are available to him. Collateral sources include payments from governmental programs such as social security, all types of health, income disability, automobile, and other types of insurance (except life insurance), and

44. Ch. 76-260, § 11, 1976 Fla. Laws 660 (current version at Fla. Stat. § 768.50 (1977)).
45. Id.
any type of wage continuation or medical benefit plan provided by employers.46

This modification provides further evidence of a legislative willingness to make each component of the system stand up to a critical analysis in terms of its applicability to modern society. It also evinces the strong political and social pressures generated by the "medical malpractice crisis"—pressure strong enough to move the legislature from the traditionally safe shelter of the status quo.

In reenacting this provision, the 1977 legislature considered how courts would ascertain the amount of collateral sources to be received in the future. The exact amount of future medical expenses to be paid by the plaintiff's health insurance, the extent to which his inability to work in the future would require him to draw on an income disability plan, and the uncertainty of other such variables, raised the specter of perpetrating an injustice on the injured party by reducing his claim by amounts which he might not actually receive in the future. The provision was thus amended to require an offset of only those collateral sources which have already been received by the plaintiff at the time of the award.47 The balance of the statute was reenacted intact.

The 1976 Act incorporated another significant modification of the traditional tort system by providing for the periodic payment of future damages in certain instances in medical malpractice claims in lieu of the requirement that judgments be paid in a lump sum.48 In malpractice awards where the amount of future damages exceeds $200,000 the court may, at the request of either party, enter a judgment ordering that future damages be paid in whole or in part by such periodic payments. The total of such payments must equal the amount of all future damages before any reduction to present value. The period of time over which the payments are made is the life expectancy of the plaintiff or such other period of years as may be determined by the trier of fact. The judgment debtor is required to post a security to insure that payments will be made when due.

Under the 1976 Act, if the claimant died prior to the termination of the period of years during which the payments were to be made, the liability of the defendant for amounts intended to compensate for future medical expenses and future pain and suffering would cease. At the same time, the outstanding balance of amounts intended to compensate for future lost wages and other economic losses would be paid into the estate of the claimant in a lump sum.

46. Id.
47. Ch. 77-64, § 7, 1977 Fla. Laws 98, 109 (codified at Fla. Stat. § 768.50 (1977)).
However, should the claimant outlive the period of years over which the payments are to be made, he would not be entitled to receive any payments beyond that time. In revisiting this provision in 1977, the legislature, believing a claimant should be entitled to continue receiving periodic payments if he were fortunate enough to outlive his life expectancy, incorporated this requirement into the new law.49 Other provisions of this statute were left intact.

In order to facilitate periodic payments, it was necessary that provision be made for the trier of fact to apportion an award of damages into amounts intended to compensate for past and future losses as well as to categorize these amounts in terms of awards for general and special damages. The 1977 legislature adopted language requiring that medical malpractice verdicts be itemized as to amounts intended to compensate for past and future medical expenses, past and future lost wages, and other such economic losses on the one hand, and amounts intended to compensate for past and future general damages, such as pain and suffering and loss of companionship, on the other.50 In awarding future damages, the trier of fact is also required to set forth the period of years over which such amounts are intended to provide compensation. This provision was reenacted verbatim in 1977.51

In another provision of the 1976 Act, subsequently reenacted in 1977, the legislature adopted a statutory standard of care for health care providers.52 This has the effect of defining medical negligence in terms of a breach of the “accepted standard of care.” The “accepted standard of care” is posed in terms of “that level of care, skill, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances.”53

The significance of the provision is found in the term “similar health care provider,” which reveals adoption by the legislature of the so-called locality rule for general practitioners and a national standard of care rule for specialists.54 Clearly the legislature did not intend to establish rigid standards for the qualification of expert witnesses based solely on whether the proposed expert is a “similar health care provider” to the defendant. The provision allows the qualification of an expert witness if, to the satisfaction of the court,

49. Ch. 77-64, § 10, 1977 Fla. Laws 98 (codified at FLA. STAT. § 768.51 (1977)).
50. Ch. 76-260, § 13, 1976 Fla. Laws 660 (current version at FLA. STAT. § 768.48 (1977)).
51. Ch. 77-64, § 9, 1977 Fla. Laws 98 (codified at FLA. STAT. § 768.45(2) (1977)).
52. Ch. 76-260, § 12, 1976 Fla. Laws 660, reenacted by ch. 77-64, § 8, 1977 Fla. Laws 98 (codified at FLA. STAT. § 768.45 (1977)).
54. Id. § 768.45(2)(a)-(b).
he "possesses sufficient training, experience, and knowledge to provide such expert testimony as to the acceptable standard of care in a given cause."{55}

Another significant provision of this statute precludes the application of res ipsa loquitur in medical malpractice cases except in instances where the cause of action is based on the presence of a medically unnecessary foreign body such as a sponge or a clamp.{56}

The final provision of the 1976 Act which dealt with the tort system codified the common law doctrines of remittitur and additur in medical malpractice situations.{57} This provision allows the trial court a great deal of latitude in reviewing the adequacy or inadequacy of jury verdicts and in proposing changes in such verdicts through a modified application of these traditional common law principles. Upon proper motion, the court is required to review an award to determine if it is "clearly excessive or inadequate in light of the facts and circumstances which were presented to the trier of fact."{58} This is a significant departure from the traditional standard of whether the award "shocks the judicial conscience."

Specific criteria for determining excessiveness or inadequacy are set forth in the statute and generally reflect the traditional case law standards for remittitur and additur.{59} However, the final criterion, "[w]hether the amount awarded is supported by the evidence and is such that it could be adduced in a logical manner by reasonable persons," is a significant modification of the "clear error" standard which characterized the common law in this area.{60} This criterion places the trial judge in the place of the trier of fact in determining whether the award is reasonable in the light of the evidence presented. It may result in an increased level of judicial activism in reviewing the jury product.

If, after applying the statutory criteria, the court finds that the amount awarded by the jury is clearly excessive or clearly inadequate, it will increase or decrease the award accordingly. If the party adversely affected by such an order does not concur, the court will order a new trial in the cause as to the issue of damages. This provision was reenacted by the 1977 legislature.{61}

56. FLA. STAT. § 768.45(4) (1977).
57. Ch. 76-260, § 15, 1976 Fla. Laws 660 (current version at FLA. STAT. § 768.49 (1977)).
58. FLA. STAT. § 768.49(1) (1977).
59. Id. § 768.49(2)(a)-(d).
60. Id. § 768.49(2)(e).
61. Ch. 77-64, § 11, 1977 Fla. Laws 98 (codified at FLA. STAT. § 768.49 (1977)).
IV. Constitutional Aspects

As of this writing, no cases have been reported in Florida's appellate courts which speak to the constitutionality of the 1977 Act. However, a discussion of the constitutional implications of the Act is in order in that many of its provisions impose major modifications on the tort system as it existed prior to the so-called "Malpractice Wars" of 1975-77. In addition, many of these modifications apply only to litigation in the area of medical malpractice, thus immediately raising major constitutional issues concerning the equal protection of the laws.

Carter v. Sparkman provides the most expansive and illuminating statement of Florida law in terms of the wide latitude which is vested in the legislature in wielding the police powers of the state. The medical mediation panel statute was upheld there despite the fact that: (1) its application is limited to one category of litigation—medical malpractice; (2) the plaintiff is denied immediate access to the courts due to the necessity of submitting his or her claim to mediation; and (3) the plaintiff is required to mediate, while the defendant has the option of mediating or going directly to court.

It would appear, in the light of Carter, that the court would require a clear abrogation of a fundamental constitutional provision in order to invalidate a legislative exercise of the police powers. The provisions of the 1977 Act should be construed with this in mind. Even in the absence of Carter, however, sufficient precedent exists at both the state and the federal level to justify a conclusion that the provisions of the 1977 Act will meet the various tests of constitutional validity. 62

V. Conclusion

It would appear as of this writing that the "medical malpractice crisis" is over—at least for the present. Although professional liability insurance rates for health care providers have not decreased and probably never will, the rate increase has lessened considerably and appears to be stabilizing. 63 A viable insurance market exists in Florida today through the JUA as well as through several physician-owned insurance companies and self-insurance trusts. There are

62. E.g., consider the procedure established for litigating workmen's compensation cases through an industrial claims court pursuant to Fla. Stat. ch. 440 (1977).
63. This conclusion is drawn through an examination of reports by insurers and by the JUA, which are filed with the Department of Insurance, and from verbal reports given by the department to the House Commerce Committee in early 1978.
even preliminary indications that one or more of the established national insurance carriers is interested in reentering the professional liability insurance market. Most important, however, the medical community and the general public seem to have adjusted to the situation. The attention of both the public and the legislature appears to have shifted to new crises.

The medical malpractice insurance situation which emerged in early 1975 was not an isolated incident resulting from a unique relationship among the medical community, the insurance industry, the judicial system, and the public at large. Rather, it would seem to be the harbinger of things to come, in that similar "crises" are emerging in the areas of products liability, workmen's compensation, automobile liability, and liability for attorneys, architects, certified public accountants, and other professionals.64

It would appear in retrospect that the medical community had the unfortunate experience of being at the point of initial contact in a monumental collision of conflicting social forces. Those professions now bearing the brunt of this collision should learn from the experiences of the medical community. They should seek legislative relief at least as comprehensive as that already provided in medical malpractice before the full weight of their respective crises is felt.

The legislature has already demonstrated a high level of responsiveness to a crisis atmosphere and, in the eyes of many, has acted in a responsible and restrained manner in seeking practical solutions without abandoning the basic precepts of the judicial process. However, lawmakers will be under increasing pressure to make more dramatic changes in the system as we now know it as more and more people are faced with higher insurance premiums.

A critical evaluation is needed of each component of each of the interrelated social systems for compensating injuries or losses.65 We in the legal community must do our part by making certain that each and every element of the tort system—and of the entire judicial process—provides just compensation to an injured party in the most efficient and least costly manner. No reasonable person will substitute efficiency for justice. Yet we must be equally careful not to equate "tradition" with "the best and only way of doing things."

Some say that we must hold on dearly to what we have now

64. At this writing, the Board of Governors of The Florida Bar is considering the establishment of a lawyer-owned insurance company to write professional liability insurance for Florida attorneys in light of a rapidly deteriorating situation in the private market.

65. See, e.g., Chittenden, The Designated Compensable Event in Medical Malpractice, 13 Forum 919 (1977-78) (suggests a workmen's compensation-type fee schedule for the remuneration of malpractice injuries).
because it will all be gone in a few years. It is more rational, however, to modify the existing system in a reasonable manner to insure that it works in the best interests of all involved than to wait for others to impose a new system which may not work in the interest of anyone.