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MEDICAL MALPRACTICE IN FLORIDA: PRESCRIPTION FOR CHANGE

B. Richard Young

I. INTRODUCTION

Between 1970 and 1975, more than twenty medical malpractice liability insurers cancelled their coverage of Florida physicians and withdrew from the medical malpractice insurance market in Florida.¹ This action sparked a growing fear in Florida health care providers which peaked in 1975.² Concerned over the unavailability of medical malpractice liability coverage for some doctors³ and the "astronomical" premium rates being charged to those physicians who could obtain such coverage,⁴ Florida doctors demanded that the legislature take action on this crisis.⁵ With over $800,000 in the war chest,⁶ the doctors got results in the form of the Medical Mal-

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¹ St. Petersburg Times, Jan. 6, 1975, § B, at 1, col. 2. The following excerpt vividly demonstrates the demise: "In the first six months of 1973, the insurer's average cost per claim was $8,000. A year later the average cost hit $19,500. Year-end incurred losses for 1974 by Employers Fire Insurance Company and Argonaut of California, the two major writers in Florida, had jumped to $3.9 million." Ashler, Medical Malpractice Insurance—The Regulators View, 49 FLA. B.J. 498, 506 (1975) (one of five separate articles dealing with the problem of medical malpractice).


⁴ French, supra note 2, at 423.


⁷ Cunningham & Lane, Malpractice—The Illusory Crisis, 54 FLA. B.J. 114, 114 (1980). "In 1974-75, the Florida Medical Association assessed all physician members $100 each, raising over $800,000 with which to finance an intensive lobbying effort." Id.
practice Reform Act of 1975 (the Act). However, satisfaction with the Act was shortlived due to a host of inadequacies and constitutional infirmities. Consequently, the Florida Medical Association (FMA) is once again closing ranks and preparing for another assault on the Florida Legislature during its 1983 session. Unlike previous sorties, this lobbying effort represents the FMA's attempt to bring about significant and sweeping reforms which are certain to have a major impact on the treatment of medical malpractice in Florida.

This article will review past and present medical malpractice legislation with a view toward showing how Florida reached its present state of affairs. Alternative proposed reforms will be analyzed with respect to their potential viability. Finally, an attempt will be made to bring together the best of these proposals to form a possible solution to this new crisis.

II. THE MEDICAL MALPRACTICE REFORM ACT OF 1975

The Florida Legislature's response to the alleged medical malpractice crisis was designed to effectuate stop-gap measures until

9. As of this writing the Florida Patients Compensation Fund is insolvent and on the verge of bankruptcy, premiums for medical malpractice insurance are still rising, and debate rages on over virtually every aspect of the 1975 Act. See generally, the Florida Medical Association, Report and Recommendations to the 1983 Legislature, The Judiciary, and Citizens of Florida (1982); The Florida Academy of Trial Lawyers, Self-Preservation of a Privileged Class (1982).
10. Aldana v. Holub, 381 So. 2d 231 (Fla. 1980), held § 768.44, Florida Statutes (1979) (relating to medical mediation panels) unconstitutional in its entirety. Problems also may be encountered concerning Florida's constitutional provision guaranteeing "right of access to the courts for redress of any injury" as regards the new shortened statute of limitations in medical malpractice actions. See Dade County v. Ferro, 384 So. 2d 1283 (Fla. 1980) (court avoided constitutional issue by holding that the statute did not apply retroactively).
12. Id.
13. It was not very difficult to predict the coming of this second medical malpractice crisis. As stated by one writer:

A recent annual meeting of the Physician's Insurers Association of America produced clear warnings. It was stated that although physician-sponsored companies helped solve the 'availability crisis' for professional liability insurance for health care providers, and have provided a market where the commercial carriers have failed to do so, the basic problem has not been resolved. Very difficult times ahead are predicted. . . . The next crisis [is] predicted for the early 1980's, starting with much higher premium rates.

more concrete solutions could be worked out.\textsuperscript{14} The Act represented the legislature's attempt to combine these measures into one comprehensive piece of legislation. This legislation was aimed at achieving three goals: (1) greater availability and affordability of medical malpractice liability coverage through mandatory risk-pooling by insurance carriers and the establishment of alternative methods of insurance; (2) a reduction in the incidence of malpractice through "house-keeping" programs designed to weed out incompetent physicians and increase the quality of health care; and (3) sweeping tort reforms, including the establishment of a new review system containing both procedural and substantive rules calculated to screen out nonmeritorious claims and cut down on the total number of medical malpractice suits filed.\textsuperscript{15}

\textbf{A. Insurance Reform}

In an effort to guarantee the availability of malpractice liability insurance to all Florida physicians, regardless of risk category or past experience,\textsuperscript{16} the legislature established the Florida Medical Malpractice Joint Underwriting Association (JUA).\textsuperscript{17} The JUA, which is similar to the "assigned risk pool" in automobile liability insurance,\textsuperscript{18} requires that every insurance carrier licensed to carry casualty insurance in the state of Florida\textsuperscript{19} and every self-insurer licensed to issue medical malpractice insurance under Section 627.351(7), Florida Statutes,\textsuperscript{20} must participate in the plan. The FMA initially endorsed the JUA plan,\textsuperscript{21} but withdrew its endorsement upon discovering that the new premium rates set by the JUA were substantially higher than those offered by previous group liability insurers.\textsuperscript{22}

In addition to past FMA opposition,\textsuperscript{23} the JUA has also come

\begin{itemize}
\item \textsuperscript{14} Note, \textit{supra} note 2, at 104.
\item \textsuperscript{15} Ch. 76-260 1976 Fla. Laws (Preamble); French, \textit{supra} note 2, at 424-25.
\item \textsuperscript{16} Note, \textit{supra} note 2, at 93-95.
\item \textsuperscript{17} Ch. 75-9, § 14 1975 Fla. Laws 24 (current version at Fla. Stat. § 627.351(7) (1981)). As originally enacted, the JUA was to remain in operation for a period of only 3 years. However, the legislature voted in 1978 to extend the life of the JUA for another 3 years and in 1981 the JUA's temporary status was removed completely. Fla. Stat. § 627.351(7)(d) (1981).
\item \textsuperscript{18} French, \textit{supra} note 2, at 425.
\item \textsuperscript{19} Fla. Stat. § 627.351(7)(b) (1981).
\item \textsuperscript{20} Id.
\item \textsuperscript{21} Note, \textit{supra} note 2, at 94.
\item \textsuperscript{22} Id., at 95. See also \textit{supra} note 4.
\item \textsuperscript{23} Note, \textit{supra} note 2, at 95.
\end{itemize}
under recent attack by commentators who allege exorbitant profits and collusive attempts to suppress competition.\textsuperscript{24} The JUA presently offers coverage to Florida health care providers and health care facilities in amounts of $250,000 per claim or $750,000 per occurrence.\textsuperscript{25} Current annual premiums range from a high of $38,990 to a low of $2,570.\textsuperscript{26}

As a further method of making professional liability insurance more accessible to Florida physicians, the legislature adopted a provision authorizing any "group or association of physicians or health care facilities composed of any number of members"\textsuperscript{27} to self-insure against medical malpractice claims upon receiving approval from the Department of Insurance.\textsuperscript{28}

Of the numerous self-insurance programs which were spawned as a result of this legislation, the most successful has been the Florida Physician's Insurance Reciprocal (Reciprocal).\textsuperscript{29} The Reciprocal currently insures a significant number of physicians statewide and has been experiencing recent growth. Between December 1, 1975 and December 1, 1978, the Reciprocal collected over $51 million in

\textsuperscript{24} Cunningham & Lane, supra note 6, at 118:

The JUA was to be a temporary measure to create an insurance market until the crisis which was reflected in unstable premium levels no longer existed. . . . It is ironic that the desired result of these provisions of the Act were to establish an adequate insurance market at reasonable prices, yet the effect so far has been to impede competition by the extension of the JUA and to increase the price of available coverage.

The authors also point out "that between 1975 and the end of 1978, the JUA had earned premiums of $36,612,367. The JUA paid claims totaling $2,126,872 during the same period of time, had loss expenses in the amount of $385,805, and had reserved $4,034,324 for known incurred reserved claims." \textit{Id.}

\textsuperscript{25} Report, supra note 4, at 7.

\textsuperscript{26} \textit{Id.}

\textsuperscript{27} Ch. 75-9, § 4 1975 Fla. Laws 16 (current version at FLA. STAT. § 627.357 (1981)).

\textsuperscript{28} \textit{Id.} In addition to obtaining approval from the Department of Insurance, health care providers wishing to self-insure must comply with the following conditions:

(a) Establishment of a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability.

(b) Employment of professional consultants for loss prevention and claims management coordination under a risk management program.

\textit{Id.} at 17.

\textsuperscript{29} The FMA initially formed the Professional Liability Insurance Trust due to an inability to capitalize an insurance company. This trust was later dissolved and the Reciprocal was capitalized, assuming all assets and liabilities of the Trust. The Reciprocal enjoyed immediate support due to rates which were almost $20,000 less for high risk specialties at the time of its inception than those offered by the JUA. \textit{See Report of the FMA Committee on Professional Liability, J. FLA. M.A. (Nov. 1981) (adopted by the FMA Board of Governors, October 8, 1981).}
premiums while paying out less than $3.7 million in claims.\textsuperscript{30} This profit margin reflects an overwhelming underwriting gain and demonstrates the actuarial soundness of the Reciprocal. The Reciprocal presently offers coverage of up to $500,000 on a claims made basis.\textsuperscript{31} Current premium rates range from a high of $18,996 to a low of $964.\textsuperscript{32}

The most significant action taken by the legislature in the area of insurance reform was the establishment of the Florida Patient's Compensation Fund (PCF).\textsuperscript{33} The PCF presently provides unlimited liability coverage to qualified members who have paid the required annual premium and have demonstrated financial responsibility in the primary amount of $100,000.\textsuperscript{34} Thus, a health care provider could purchase primary coverage in the amount of $100,000 through the JUA or a self-insurance plan and then purchase unlimited liability coverage for claims in excess of $100,000 through the PCF, assuming affordable premiums.

Remarkably enough, the cost to an individual doctor in becoming a member of the PCF for the fiscal year beginning July 1, 1975 was a mere $1,000 for the first year of operation and $500 for each year thereafter.\textsuperscript{35} The cost to hospitals was $300 per bed in the first year of operation and $300 per bed for each year thereafter.\textsuperscript{36} Florida's health care providers were well pleased with this plan.

\begin{footnotes}
\item 30. Cunningham & Lane, supra note 6, at 118.
\item 31. Report, supra note 4, at 7. Insurance policies offered on a "claims-made" basis are superior to policies written on an "occurrence" basis for several reasons. "Claims-made" policies cover only those claims made during the policy year regardless of when the injury actually occurred. "Occurrence" basis policies, on the other hand, provide coverage for alleged acts of malpractice which occur during the policy period regardless of when the claim is made or the suit is filed. This latter type of policy gives rise to a problem referred to as the "long-tail" in insurance circles. Assume that Company A sold Dr. M an "occurrence" basis policy in 1980. If Dr. M is sued in 1988 by a patient who suffered an injury in 1980, then Company A will be responsible for compensating this injury even though it wasn't claimed until 1988. (Statute of limitation restrictions have been ignored for the sake of simplicity.) Clearly, Company A will have much difficulty in predicting this type of injury. "Claims-made" policies eliminate the "long-tail" problem by providing coverage only for those injuries claimed during the particular year when the policy is in effect.
\item 32. Id. These figures include a surplus contribution of 12.5 percent in 1982.
\item 33. Ch. 75-9, § 15, 1975 Fla. Laws 26 (current version at Fla. Stat. § 768.54 (1981)). Membership in the Fund is mandatory for all hospitals unless exempted under paragraphs (a) or (c) of § 768.54(2). Participation by individual health care providers is voluntary.
\item 34. A health care provider or a hospital may demonstrate financial responsibility either by posting bond in the amount of $100,000, establishing an approved escrow account in the amount of $100,000, or obtaining self-insurance through a private insurer, the JUA, or a self-insurance program.
\item 35. Fla. Stat. § 768.54(3)(c) (1981).
\item 36. Id.
\end{footnotes}
The ability to buy unlimited liability coverage for such nominal rates represented "the biggest bargain in the insurance industry, bar none."37

The euphoria over this apparent cheap solution was short-lived. It soon became painfully apparent that the fee rates being charged were not sufficient to pay out awards and maintain the solvency of the PCF.38 The PCF went from a net worth of $12,477 in 1976 to a net loss of $8,264,028 in 1981.39 Estimates for the current year place the fund $38 million in the red.40 To rectify this shortfall, the state's physicians were assessed $17 million in January and February of 1982 and face a possible further assessment of nearly $38 million.41 These assessments could have been avoided had doctors been paying actuarially sound fees, which could have been raised in yearly increments, if required, rather than artificially freezing fee rates and necessitating an enormous assessment.42

The Florida Legislature attempted to deal with the PCF's financial woes in its 1982 special session by once again enacting stop-gap43 legislation.44 The new law significantly alters the rate structure and potential liability of the PCF. Fees for individual doctors will be scaled up from a previous 1981-82 high of $4,323 to a 1982-83 high of $19,816, a 358 percent increase.45 Hospitals will go from a high of $360 per bed in 1981-82 to a high of $701 per bed in 1982-83, a 94 percent increase.46 In addition, the new law allows physicians to be assessed up to 200 percent of their annual fee in the event of a shortfall.47 Further, primary coverage limits will be

38. Memorandum from Linda McMullen, Governor's legislative office, to Dr. Charles Reed, Deputy Chief of Staff to Governor Bob Graham, May 20, 1982. During the early years of the Fund, $51,767,952 was paid in awards while only $47,895,736 was collected in premiums. Id.
42. Id. at col. 6. As stated by Rep. Tom Gufstafson (D., Fort Lauderdale), Chairman of the House Insurance Committee in an address to the Broward County Medical Association: "You weren't paying what you owed five years ago, so you're paying it now." Id.
44. FLA. STAT. § 627.351(4) (1982 Supp.); FLA. STAT. § 768.54 (1982 Supp.).
46. Id.
47. FLA. STAT. § 768.54(3)(c) (1982 Supp.). South Florida physicians vigorously opposed
increased from $100,000 to $150,000 per claim or $500,000 per occurrence as of July 1, 1983, $200,000 per claim or $500,000 per occurrence as of July 1, 1986, and $250,000 per claim or $500,000 per occurrence as of July 1, 1989.48 While these increases will place added costs on health care providers who must purchase this primary coverage, these costs could be balanced out by new PCF provisions which would provide premium credits for such excess coverage.49

More significant than the foregoing changes are the provisions which remove an outdated cap on PCF resources and place limits on the fund’s liability.50 The PCF had previously been limited to maintaining no more than $15 million in premiums at any one time.51 The current provision permits the PCF to maintain whatever amount is necessary to insure actuarial soundness.52 Another change designed to insure the solvency of the fund is the provision for limitations on liability.53 The new law allows PCF members to select liability coverage in limits of $1, $2, $3, $5, $8 and $10 million, beyond which physicians would be liable in the event of an award exceeding the selected limit.54 These reforms, when coupled with the PCF’s new ability to base rates on an individual doctor’s experience, should aid in driving down fee costs for some physicians.55 Fees are presently based on a three-area geographical breakdown and five categories of risk classifications.56 For example, physicians in Dade and Broward counties currently pay significantly more in fees than do physicians in the rest of the state and are expected to continue to do so.57

this move, threatening a walkout (which did not materialize) should the legislation be passed. See Florida Times-Union, June 14, 1982, § B, at 2, col. 1; Miami Herald, June 15, 1982, § A, at 12.

49. See infra notes 149-50 and accompanying text.
53. Id.
54. Id.
55. A physician in a low-risk, low-incident category will now be able to avoid paying premiums for unlimited coverage, which he is unlikely to need, by selecting a $1 or $2 million liability limit, thereby effectively covering himself while reducing his premiums. Also, “good doctors” will be rewarded for favorable claims experience through premium reductions. This last feature should benefit all physicians who have favorable claims experience regardless of geographic area or risk category.
57. Until 1979, all physicians in Florida paid a uniform premium amount to the PCF. In fiscal year 1979-80, however, doctors in Dade and Broward Counties had their annual premi-
B. Internal Reform

In an effort to decrease the incidence of medical malpractice and the resulting number of claims, the 1975 legislature incorporated three preventive measures into the Act. The first of these measures requires the establishment of an internal risk management program by all licensed Florida hospitals. While it is the responsibility of the governing board of the health care facility to establish and maintain its own risk management program, every program must include the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;
(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all personnel;
(c) The analysis of patient grievances which relate to patient care and the quality of medical services; and
(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse incidents to the hospital risk manager.

Subsection (d) was added to the original 1975 Act. To insure the effectiveness of this new provision, incident reports are considered to be part of the work papers of the attorney defending the health care facility and, while subject to discovery, are not admissi-
ble as evidence in court.\textsuperscript{62} In addition, persons filing an incident report cannot be subject to civil suit for libel by virtue of such a report.\textsuperscript{63} With the addition of subsection (d), this program provides health care facilities with a well-structured and effective method of minimizing future risks through the analysis of past incidents and grievances.

The second preventive measure passed by the legislature vests the Board of Medical Examiners with the power to discipline errant doctors.\textsuperscript{64} Under this provision, physicians may be subject to sanctions for, among other things:

\begin{quote}
[b]eing unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition . . . [or for] [g]ross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.\textsuperscript{65}
\end{quote}

Disciplinary actions for such violations may include refusal to certify for licensure, revocation or suspension of a license, restriction of practice, imposition of a fine, reprimand or placement on probation.\textsuperscript{66} This provision presents the Board of Medical Examiners with an opportunity to confront the problem of medical malpractice at its source — the incompetent or negligent physician. Adherence to a vigorous program calling "sick"\textsuperscript{67} or negligent doctors to task before they are allowed to practice bad medicine on the public could greatly reduce the incidence of malpractice and rising cost of malpractice insurance premiums. Recent data, however, suggest that the board is not taking advantage of this opportunity. For "the five-year period ending in June 1978, the Florida Board of Medical Examiners received 1,561 complaints, but revoked only ten licenses."\textsuperscript{68} If the medical malpractice problem is to be dealt with effectively, the board will have to exercise its power with

\begin{thebibliography}{68}
\bibitem{62} FLA. STAT. § 768.41(4) (1981).
\bibitem{63} Id.
\bibitem{64} Ch. 75-9, § 12, 1975 Fla. Laws 22 (current version at FLA. STAT. § 458.331 (1981)).
\bibitem{65} FLA. STAT. § 458.331(s), (1) (1981).
\bibitem{66} Id. at (2) (a)-(f).
\bibitem{67} As used here, the term "sick doctor" refers to those physicians mentioned in Section 458.331(s), Florida Statutes, who, due to alcohol or drug-related problems are incapable of practicing medicine with reasonable skill and safety to patients.
\bibitem{68} Miami Herald, June 13, 1982, § E, col. 3 at 3.
\end{thebibliography}
greater vigor. Perhaps the recent resurgence of malpractice claims, coupled with enormous jury awards and large premium increases, will provide the board with the impetus it needs.

The final preventive measure grants hospitals disciplinary powers similar to those of the Florida Board of Medical Examiners, outlined above.69 However, inadequacies which were present in the 1975 version of this provision still persist. Hospitals are merely authorized to take disciplinary action against a physician. As one commentator noted,70 this legislation would be much more effective if it required hospitals to carry out an investigation upon showing of “good cause.”

Since hospitals are not required to proceed with disciplinary action against a physician charged with malpractice,71 future patients of such hospitals face the prospect of being treated by a doctor who may well lack a minimal acceptable level of medical skill and competence. A solution to this problem would be to require hospitals to investigate any physician charged with medical malpractice and to proceed with disciplinary action should the situation warrant, regardless of the outcome of an independent judicial proceeding.

C. Tort Reform

1. Medical Liability Mediation Panels.

A significant change brought about by the Act in the area of tort reform was the establishment of medical malpractice mediation panels.72 Before a claim for malpractice could be filed in civil court,
it first had to be submitted to a mediation panel. Although a claimant was statutorily required to submit to mediation, a defendant had the option of foregoing mediation by not filing an answer within the required twenty day period. However, if the defendant did file a timely answer, the claim was heard before a mediation panel composed of a circuit judge acting as a judicial referee, an attorney and a licensed doctor. Once the claim was before the panel, the panel had one hundred and twenty days from the date the claim was filed with the clerk in which to hold a hearing on the claim. Either party could move for an extension in writing for good cause shown prior to the expiration of the one hundred and twenty day period. Failure to move for an extension before the expiration of the one hundred and twenty day period resulted in dismissal of the claim. Once an extension had been granted the panel had six months from the date the claim was filed within which to commence a hearing. Failure to commence the hearing within the six month period resulted in dismissal of the claim. If the hearing was properly commenced within the six month period, the panel had ten months from the date the claim was filed in which to conclude the hearing. Under no circumstances was the subject matter jurisdiction of the panel to extend beyond ten months from the filing date of the claim. Appeals would not toll the running of this ten month period. While the panel’s finding as to whether a defendant was actionably negligent was not binding on either of the parties, it was admissible in a subsequent trial.

73. Fla. Stat. § 768.44(1)(a) (1981). Some confusion and uncertainty existed as to the proper procedure to follow in filing and pursuing a mediation claim. In an attempt to clear up these discrepancies the Florida Supreme Court adopted the Rules of Medical Mediation Procedure which superseded the procedural portions of the Act. In re the Florida Bar, 348 So. 2d 547 (1977).
77. Id.; Fla. R. Med. P. 20.160(e), 348 So. 2d at 550.
83. Ehrhardt, supra note 72, at 187.
84. Carter v. Sparkman, 335 So. 2d 802, 805 (Fla. 1976), cert. denied, 429 U.S. 1041 (1977). Only the panel’s finding was admissible at trial. If a claimant chose to offer no evi-
Although the medical mediation panels withstood early constitutional attack, the Florida Supreme Court found them to be unconstitutional in *Aldana v. Holub* as violative of the due process clauses of the United States and Florida Constitutions. Since that time a move has been afoot to reenact the mediation panels in a constitutional manner. Such a move, however, is unwarranted and would only serve the interests of one party — the defendant.

From the claimant’s point of view medical mediation panels are undesirable for several reasons. First, the pre-litigation burden imposed upon a claimant is great. He must go to the expense of presenting his case not once, but twice. The effect of this is not to weed out frivolous claims which have no merit, but to weed out small claims which are not worth the added expense of an extra trial. Thus, a plaintiff who brings a claim which is not large enough to meet this threshold is denied access to the courts and a trial by jury. Secondly, allowing the finding of the mediation panel to be admitted into evidence at a subsequent trial has a potentially prejudicial effect on the losing party in the mediation hearing.
Juries are likely to give great weight to the finding of the mediation panel since they believe that the panel is composed of "blue ribbon" members. However, the jury is not allowed to view transcripts of the proceedings or to examine panel members and are thereby denied the opportunity to take into consideration any possible mitigating factors. Consequently, the right to a fair and impartial jury trial is severely impaired.

The Aldana court found the time limitations of the medical mediation act to be unconstitutional as "arbitrary and capricious in operation" and thus violative of federal and state due process clauses. Some doubt exists as to whether any scheme of time limitations could be devised which would be constitutional. Furthermore, the problem of "denial of access to the courts" must also be considered. In Aldana, the court made it clear that its decision in Carter v. Sparkman rested largely on the paramount concern of the continued availability of health care services in Florida. While there is a new crisis of sorts, the concern over the continued unavailability of health care services has not reached the proportions of the 1975 problem. Consequently, the court is not likely to tolerate today what it would not uphold in 1980 on the basis of outdated threats and incantations.

2. Statute of Limitations.

One of the gravest injustices wrought by the Act was the modification of the medical malpractice statute of limitations. Prior to the Act, the statute of limitations for medical malpractice was based on the "discovery rule," which provided that the statute of limitations ran for two years after the incident was discovered or should have been discovered with the exercise of due diligence. The new statute of limitations, as contained in the Act, provides that

[a]n action for medical malpractice shall be commenced within two years from the time the incident giving rise to the action occurred or within two years from the time the incident is discovered, or should have been discovered with the exercise of due dili-

72, at 205-06.
91. 381 So. 2d at 238. For an informative discussion of the due process problems of the medical mediation act, see Spence & Stillman, supra note 2, at 1169-82.
92. 381 So. 2d at 238 n.13. See supra note 87 and accompanying text.
94. Ch. 74-382, § 7, 1974 Fla. Laws 1209.
gence; however, 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.95

The sole exception to this four year limitation is for those actions "in which it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the 4-year period."96 However, even in these exceptional cases, the absolute limit of the statute from the date of injury is seven years.97 Therefore, an incompetent or negligent physician who injures a patient may knowingly and wilfully conceal his negligence and be immune from liability for malpractice if the victim is not fortunate enough to have discovered the injury and filed suit within seven years.98

Insurance carriers, citing "long-tail"99 problems created by the discovery rule, insisted that a much more restrictive statute of limitations would allow actuaries to make sounder predictions, thereby reducing insurance premiums and in turn reducing medical costs. It also was argued that ninety-seven percent of all malpractice claims were filed within four years of the date of injury, so few victims would be done an injustice anyway.100

However, insurance premiums continued to rise and so did medical costs. The only change brought about by this modification was that innocent victims of medical malpractice were denied an opportunity to seek redress. If, indeed, ninety-seven percent of all malpractice claims were filed within four years of the date of injury, then no need exists for such an unreasonably short statute of limitations. The insurers’ long-tail problem would only concern three percent of all malpractice claims filed and would not represent the invisible menace insurers would have the legislature believe it to be.

95. FLA. STAT. § 95.11(4)(b) (1981).
96. Id.
97. Id.
98. An illustrative case occurred regarding Tampa-based lawyer, Tony Cunningham. It seems that one of his clients went to a physician for a routine gall bladder removal. However, the client continued to suffer pain and gastric attacks. After twelve years of other medical treatment, an observant physician finally checked to see if maybe, after all, she did have a gall bladder. Indeed, she did since the original physician had never bothered to remove it. Cunningham & Lane, supra note 6, at 119.
Furthermore, a problem exists regarding Article I, Section 21 of the Florida Constitution. Section 21 provides that "[t]he courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." However, the current medical malpractice statute of limitations operates in such a manner that it may deny a malpractice victim with a legitimate claim the right to seek compensation for his injury. This contention was advanced by the claimant in Dade County v. Ferro. The court there, however, neatly side-stepped the issue by holding that the statute did not apply retroactively. The demise of Mrs. Ferro illustrates the problems of the four-year limitation period. Between December 1970 and May 1971 Mrs. Ferro received radiation therapy treatments. As a result of these treatments she lost the use of both of her arms. The injury was discovered in September 1975, more than four years after the date of the incident. Had the current statute of limitations been applied to Mrs. Ferro's claim, it would have been barred. Perhaps the judiciary's reluctance to apply this statute signals a possibility that this injustice will be remedied in an appropriate case. If not, then the legislature should take advantage of the opportunity coming up in its 1983 session to do so itself.


One piece of special interest legislation passed in the area of medical malpractice is the "recovery of cost law." This law provides that the losing party in a medical malpractice action must pay reasonable attorney's fees to the prevailing party. The only exception is that a party who is insolvent or poverty stricken may not have fees awarded against him. This law was strongly lobbied for by the FMA and medical insurance carriers and represents a clear intent to close the courthouse door to potential medical malpractice victims. Instead of reducing the incidence of malpractice and attacking the problem at its root, the recovery of cost

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102. 384 So. 2d 1283 ( Fla. 1980).
103. Id. at 1287.
106. Id.
law seeks instead to limit the number of claims filed after the malpractice has occurred.

Plaintiffs' attorneys and astute members of the Florida Defense Lawyers Association opposed this law from its very inception, but strong support from the FMA and insurance lobbies kept it in force. Recent developments have proven this to be a costly mistake.

While the recovery of cost law was an attempt to deter injured Plaintiffs from filing suit, in practical application it has backfired on its staunchest supporters. In a recent Broward County case, trial judge Robert Andrews awarded $4.4 million in attorney's fees to the family of a twenty-six year-old girl who was rendered comatose by a physician's negligence. Stunned by the size of this award and the possible future applications of this statute, the FMA quickly moved to have it repealed. With all interested parties lobbying for its removal, perhaps the Florida Legislature will take action to repeal the recovery of cost law in its 1983 session. Such action will not leave defendants in a medical malpractice action wholly without defense from frivolous claims. Florida already has a statute which allows the court to award attorney's fees to the prevailing party if it appears that the action was brought in "bad faith."

Consequently, a harsher provision such as the recovery of cost law is both unnecessary and unjustifiable.

4. The Contingent Fee System.

The contingent fee system is one of the most oft-cited culprits for the emergence of a new medical malpractice crisis. Opponents of the contingent fee system argue that "greedy attorneys, hungry for fat contingency fees, generate suits that would not oth-

108. Id., at 11.
109. Id., L. Martin Flanagan, former president of the Florida Defense Lawyers Association, attempted to have the statute declared unconstitutional when an FMA-insured doctor he represented was ordered to pay several hundred thousand dollars in legal fees. However, this action was vetoed by an emphatic FMA refusal to allow him to raise the issue.
110. Von Stetina v. Florida Medical Center, 81-05946 CH (Fla. 17th Cir. Ct. Sept. (1982)).
112. Fla. Stat. § 57.105 (1981). "The court shall award a reasonable attorney's fee to the prevailing party in any civil action in which the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party." Id.
erwise be brought,”114 driving up the cost of insurance premiums and health care. Proponents, on the other hand, argue that the contingent fee system is the poor man’s key to the courthouse.115 It is argued that without such a system persons with meritorious claims would not be able to bring them due to a lack of funds. In response to these competing interests a number of states have opted for a middle-of-the road approach, choosing to limit attorney’s fees rather than to abolish them outright.116 While Florida has taken no action in this respect, it is time for the legislature to consider the merits of doing so.

The FMA has suggested that Florida adopt “The New Jersey Plan,” one of the strictest contingency fee limitation schemes in use by any state.117 Under this plan, an attorney would be entitled to 50 percent of the first $1,000 recovered, 40 percent of the next $2,000 recovered, 33-½ percent of the next $47,000 recovered, 20 percent of the next $50,000 recovered and 10 percent of any amount recovered over $100,000.118 A special arrangement also is considered where the amount recovered is for the benefit of an infant or incompetent.119 Thus, a plaintiff’s attorney would be limited to recovering no more than approximately $38,667 of a $100,000 claim. Although this system serves its purpose of making medical malpractice litigation less lucrative to a plaintiff’s attorney, its results appear to be extreme.

Pennsylvania’s scheme of attorney compensation serves as a good model of the trade-off between these competing interests.120 Under this system, an attorney is entitled to 30 percent of the first $100,000 recovered, 25 percent of the next $100,000 recovered and 20 percent of the balance.121 Although the results of this scheme are similar to that of the New Jersey Plan for awards of $250,000

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114. Comment, supra note 111, at 670.
115. The Florida Academy of Trial Lawyers, supra, note 9, at 11.
117. See, N.J. Sup. Ct. R. 1:21-7(c) (1972). This restrictive fee system was affirmed by the New Jersey Supreme Court in American Trial Lawyers Ass’n v. New Jersey Supreme Court, 330 A.2d 350 (N.J. 1974).
118. Id. at 351 n.3.
119. Id. The rule provides that “where the amount recovered is for the benefit of an infant or incompetent and the matter is settled without trial . . . the fee on any amount recovered up to $50,000 shall not exceed 25%.” Id.
120. PA. STAT. ANN. tit. 40, § 1301.604 (Purdon 1982).
121. Id.
or less, the difference becomes more visible as the amount recovered exceeds $250,000. For example, assume there is a $1 million award. Under the New Jersey plan the plaintiff's attorney would be entitled to $116,967, while under the Pennsylvania scheme he would be entitled to $215,000. These awards represent 11.7 percent and 21.5 percent, respectively, of the total recovery. The higher the award, the closer these figures move toward 10 percent and 20 percent, respectively. Consequently, the important figure in setting limits on contingency fee recoveries is the last, the one indicating the percent of the balance to be received by the attorney. For this reason, the Pennsylvania system is preferable. It offers a plaintiff's attorney reasonable compensation for his time and effort while preventing exorbitant recoveries.

5. Limitations on Liability and Structured Payment of Damages

In response to "spectacular" jury awards and rising insurance costs many states have chosen to place caps on the amount recoverable in medical malpractice actions. These provisions vary from state to state with some placing limits on the total amount of general damages recoverable, others placing limits on the amount recoverable from the PCF or its equivalent and others limiting recovery for pain and suffering. The FMA, reacting to several large south Florida jury awards, is presently pushing for similar legislation in this state. The FMA proposal, which is modeled after the California and Indiana statutes, suggests that an absolute $250,000 limitation be placed on recovery of damages for pain and suffering and other non-economic loss. The reasoning behind this proposal is that damage awards for pain and suffering, loss of capacity for enjoyment of life, etc., are so speculative and incapable of measurement that the jury is given unfettered discretion to

122. For example, with a $10 million award an attorney under the New Jersey scheme would recover $1,016,967, or 10.2 percent. Under the Pennsylvania system the attorney would recover $2,015,000, or 20.1 percent.
124. Id.
125. Von Stetina v. Florida Medical Center, supra note 110.
126. Report, supra note 4, at 11-12.
127. See supra note 123.
return irrational awards. However, refusing to embrace these claims, a number of state courts have invalidated such statutes on constitutional grounds. In Carson v. Maurer, New Hampshire struck down a dollar limitation identical to that proposed by the FMA. The court determined that the New Hampshire damages limitation, which was also modeled after the California limitation, violated the equal protection clause of the New Hampshire Constitution. Quoting from the North Dakota case of Arneson v. Olson, the court stated that:

The limitation of recovery does not provide adequate compensation to patients with meritorious claims; on the contrary, it does just the opposite for the most seriously injured claimants. It does nothing toward the elimination of nonmeritorious claims. Restrictions on recovery may encourage physicians to enter into practice and remain in practice, but do so only at the expense of claimants with meritorious claims.

The court in Carson further stated that, "[i]t is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation." The Carson court ably recognized that caps on liability do not serve the purpose of eliminating or reducing frivolous claims since recovery for pain and suffering would not usually exceed $250,000 in these cases anyway. Rather, it restricts the ability of persons injured in amounts in excess of $250,000 from seeking full compensation for

129. Id.
132. Id. at 838.
133. 270 N.W.2d 125 (N.D. 1970).
134. 424 A.2d at 837.
135. Id.
their injuries. Furthermore, the court points out that the spectre of unreasonably large jury awards is illusory since remittitur is always available to reduce such verdicts.\textsuperscript{136} Florida has a similar remittitur option.\textsuperscript{137} Should the FMA proposal be adopted by the 1983 Florida Legislature, it is doubtful that it will survive the logic of Carson and the hostility of the Florida judiciary to such arbitrary limitations.

An alternative to limits on liability is available through Florida's structured payment of damage awards statute.\textsuperscript{138} Under this statute, a defendant, with approval of the court, has a choice of two options when the damage award exceeds $200,000. He may make a lump sum payment of all damages assessed, with future economic losses and expenses reduced to present value,\textsuperscript{139} or he may elect to pay past and present damages at once and future damages, in whole or in part, by periodic payments.\textsuperscript{140} If the defendant chooses the second option and the injured claimant dies before all future payments have been made, the defendant's liability for payments relating to non-economic losses and future medical care ceases and the estate may not present a claim.\textsuperscript{141} Thus, payments for pain and suffering and necessary medical expenses continue only so long as the need for them does.\textsuperscript{142} Furthermore, the court is given great discretion in determining the method, manner and amount of payment.\textsuperscript{143}

Therefore, the needs of each claimant may be assessed on an individual basis and payments may be correspondingly large or small. This best serves the needs of the claimant while avoiding

\begin{itemize}
\item 136. Id.
\item 137. FLA. STAT. § 768.49 (1981).
\item 138. Id. at § 768.51.
\item 139. Id. at § 768.51(1)(a). Neither the defendant nor the claimant actually have an absolute right to periodic rather than lump-sum payments as the ability to grant such a request lies within the court's discretion. However, the opportunity and ability to make such a request is certainly present and no reason appears to exist why, absent a showing of hardship on the claimant, such a request should be denied.
\item 140. Id. at § 768.51(1)(b).
\item 141. Id. at § 768.51(1)(b)(5). All damages for economic loss are automatically paid into claimant's estate upon death in one lump sum.
\item 142. Conversely, if the claimant lives past the termination date of the periodic payments, defendant is required to continue such payments at the regular periodic rate for the remainder of the claimant's life. Id.
\item While this may seem harsh at first glance, it is actually merely providing for the jury's inherent inability to accurately predict the claimant's life expectancy. The purpose of the jury award is to compensate the victim for his injuries based on his remaining life. Under this scheme, he receives such compensation.
\item 143. FLA. STAT. § 768.51(1)(b)(1) (1981).
\end{itemize}
the rigidity of statutes which have been declared unconstitutional in other states.\textsuperscript{144} Such a scheme is certainly preferable to an absolute limitation on the amount of damages which may be awarded. A structured payment of damage awards system allows a claimant to be compensated in full while relieving defendants of the burden of paying out huge lump sums for future non-economic losses. With this alternative available, no need exists for a restrictive and unjust limitation on a claimant's potential recovery.

\section*{III. A Proposal}

Now that the state of the existing law and its problems have been set out, some possible solutions should be considered.

One of the most troublesome areas is that of insurance reform. The purpose of the insurance provisions of the 1975 Act was to make medical malpractice insurance readily available and more affordable. While it has succeeded in increasing the availability of medical malpractice insurance, it has failed in attempting to make such insurance more affordable. The blame for this failure, however, does not rest with the concepts embodied in the Act. Rather it rests with the mismanagement which followed.

From its very inception, the JUA announced rates which, at the time, were considered by physicians to be exorbitantly high.\textsuperscript{145} Yet, because of these rates the JUA has remained actuarially sound and has even been experiencing gains.\textsuperscript{146} The PCF, on the other hand, initially charged rates which were so low that it never had a chance of achieving actuarial soundness. The PCF's soundness was also undermined by the artificial resource cap of $15 million which was placed on it.\textsuperscript{147} Additionally, the rates being charged were based upon a two-area geographical breakdown with three risk categories.\textsuperscript{148} This fact, coupled with the inability to base a member's rate on his past track record, kept the higher risk specialists and repeat offenders from contributing their proportionate share. Conversely, this small group of doctors accounted for a large percent-

\begin{thebibliography}{9}
\bibitem{144} See \textit{supra} note 130 and cases cited therein. Specific dollar limitations on periodic payments for all medical malpractice actions, regardless of individual need, seemed to be a major problem. The Florida statute lacks such a cap. Compare this with the $100,000 annual cap on PCF payments to injured claimants which was declared unconstitutional by the trial court in VonStetina v. Florida Medical Center, \textit{supra} note 110.
\bibitem{145} See \textit{supra} note 23.
\bibitem{146} See \textit{supra} note 24 and accompanying text.
\bibitem{147} FLA. STAT. § 768.54(3)(c) (1981).
\bibitem{148} FLA. STAT. § 627.351 (1981). Dade and Broward counties constituted one area with the rest of the state comprising the other.
\end{thebibliography}
age of the malpractice claims filed.\textsuperscript{149} With the PCF offering unlimited coverage, under these circumstances it was only a matter of time before it became insolvent. If bankruptcy is to be prevented, drastic action must be taken.

Many of the aforementioned inadequacies were remedied in the Legislature's 1982 special session.\textsuperscript{150} However, further action is necessary. To help reduce the cost of membership fees to the PCF, credits should be offered for carrying primary insurance in excess of the minimum amount required. The proposed credits, assuming the current $100,000 minimum primary coverage, would range from 22 percent for $200,000 in underlying coverage to 77 percent for $1 million in underlying coverage.\textsuperscript{151} This could result in a savings of $5,746 to a Dade or Broward county physician carrying $250,000 in primary coverage.\textsuperscript{152} When added to the doctor's ability to select liability limits of $1, $2, $3, $5, $8 or $10 million, a substantial premium savings can be realized.

An area in which immediate action must also be taken is the PCF's present financial condition. The PCF is currently so far in the red that no clear estimate of its liability has been revealed.\textsuperscript{153} Several proposals have been formulated to rectify this situation. The most obvious is a fresh assessment against all members of the PCF based on the new 200 percent contingency assessment feature.\textsuperscript{154} However, this probably would be insufficient to make up the deficit—not to mention being unappealing to the state's physicians. Among the alternatives suggested are a special assessment on insurance companies, a hospital bed tax and a subsidy from state general revenue.\textsuperscript{155} In the long run the only real difference between these forms of payment is whether they are visible to the public (payout from general revenue) or hidden (bed tax or assessment on insurance companies) since the ultimate payor will be the

\begin{itemize}
\item \textsuperscript{149} Memorandum from Ray Iannucci, analyst, Governor's Office of Planning and Budgeting, to Bill Kynoch, Policy Coordinator, Governor's Office of Planning and Budgeting, June 8, 1982, at 5. A 1978 California report suggests that fewer than one percent of the state's physicians account for almost 30 percent of all malpractice awards. \textit{Id.}
\item \textsuperscript{150} \textit{Fla. Stat.} § 678.54 (1982 Supp.).
\item \textsuperscript{151} Memorandum, \textit{supra} note 149, at 2.
\item \textsuperscript{152} \textit{Id.}
\item \textsuperscript{153} One commentator suggests the PCF is $38 million in the hole, Miami Herald, June 15, 1982, § A, at 12, col. 1; another places the figure between $50 to $150 million in the red, The Independent Prof., August 1982, at 16; while an inside government source sets it at $120 million, memorandum from Tom Herndon, Director, Office of Planning and Budgeting, to Governor Bob Graham, June 8, 1982, at 1.
\item \textsuperscript{154} \textit{Fla. Stat.} § 768.54(3)(c) (1982 Supp.).
\item \textsuperscript{155} Memorandum, \textit{supra} note 149, at 4.
\end{itemize}
consumer of medical services. For this reason a subsidy from general revenue is preferable to the other two methods of raising funds. With a bed tax or a special assessment on insurance companies, the cost will be passed on to the ultimate consumer with little or no chance of later recovery. However, a whole or partial government subsidy, extended on a one-time basis, may be recovered by providing that a moderate yearly assessment be imposed on PCF members. This assessment would operate in much the same way as the proviso that allows the PCF to borrow against successive years. While it is true that this cost also ultimately will be passed on to the consumer, it will be done in a more gradual manner and will be only temporary in effect, unlike a continuing bed tax or special assessment.

Another problem of great concern in the area of medical malpractice insurance is that of the physician who "goes bare" and carries no malpractice insurance. Such irresponsibility falls most heavily on the shoulders of the injured malpractice victim since he frequently will go without a remedy in this situation. Recovery may sometimes be had from the hospital at which the physician practices, but this is not a dependable alternative. This situation could be eliminated by requiring that any health care provider who wishes to practice in Florida demonstrate proof of malpractice liability coverage prior to licensing. Civil fines and penalties could also be used as a follow-up to insure that this coverage is not dropped subsequent to licensing. In this manner the primary goal of malpractice insurance will be furthered—to compensate victims of malpractice for their losses.

As regards the JUA and self-insurance plans, very little need be or should be done. Contrary to the belief of some commentators, a viable private insurance market still does not exist. Until one does exist, there is no alternative but to keep the JUA. To return

156. Fla. Stat. § 768.54(3)(c) (1982 Supp.). Rather than assessing physicians a full $30 to $50 million in one year, this amount could be borrowed from general revenue by the PCF and then repaid over a 5-10 year period with interest. Such a plan would not be as hard to swallow as an outright gift since that would be, in essence, indemnifying physicians who have been determined to be negligent.
157. Webb v. Priest, 413 So. 2d 43 (Fla. 3rd DCA 1982); Vigilant Ins. Co. v. Keiser, 391 So. 2d 706 (Fla. 3rd DCA 1980); Garcia v. Tarrio, 380 So. 2d 1068 (Fla. 3rd DCA 1980).
158. See Cunningham & Lane, supra note 6.
159. Memorandum, supra note 149, at 3. Mr. Iannucci states that “[t]he only companies who are writing excess coverage in the State are: St. Paul, Continental in Orlando, JUA with limit of $2.5 million in coverage, and Multi-Hospital, an off-shore insurance company which offers only limited coverage.” Id.
to a private market at this time might seem attractive, but it would probably only be a short while before rates once again skyrocketed and insurance became unavailable. Hopefully, the self-insurance alternative and the slow return of private insurers to Florida will eventually restore enough competition to the market that rates will start a downward movement. Finally, a legislative investigation into the financial status of the JUA with an aim toward possible mandatory rate reduction might well be in order.\textsuperscript{160}

While insurance reform is vitally necessary, as is some tort reform, neither go to the heart of the malpractice problem, which is malpractice itself. In the physician's defense, it must be recognized that not all patient related injuries arise from malpractice. Many are caused by the high-risk nature of life and death emergency treatment and others are caused by the inadequacies of the state of the art, with undesirable side-effects occurring years later.

Although not all of these injuries are caused by the negligent or incompetent physician, enough are so caused that some effective disciplinary mechanism must be implemented and enforced.\textsuperscript{161} As outlined previously, several effective means of self-policing programs have been enacted by the legislature. These provisions provide the medical community with the power it needs to discipline errant doctors and "sick" or incompetent physicians. One major improvement would be to require hospitals to investigate any physician who has been charged with malpractice.\textsuperscript{162} However, these provisions are not of much value if the medical profession chooses not to enforce them, as it seems to have done.\textsuperscript{163} A possible solution to this laxness might be to require that one member of each risk management board be an official of the Department of Health and Rehabilitative Services, who would be given full access to all records kept in connection with risk management. Physician errors would then be more readily exposed and disciplinary measures could be taken. At the very least, it would make it more difficult to ignore physician error.

Another troublesome area is that of tort reform. The FMA is pushing for broad tort reforms designed to restructure legal doc-

\textsuperscript{160} If the JUA has indeed been experiencing the kind of profits that its 1975-1978 financial statement reflects, then a premium refund should be forthcoming since the JUA was not set-up to produce a profit.

\textsuperscript{161} Memorandum, \textit{supra} note 149, at 6.

\textsuperscript{162} See \textit{supra} notes 70-71 and accompanying text.

\textsuperscript{163} See \textit{supra} note 68 and accompanying text.
trines in the area of medical malpractice. Trial lawyers' associations, on the other hand, are vigorously opposing anything which even resembles reform. The legislature would be well advised to proceed with extreme caution in this area. Many past changes have been improvidently made due to pressure from special interest groups, and further unnecessary modifications are not advisable. A balance must be struck between these competing interests which will best serve the needs of all parties involved, especially the injured patient. For this reason, few if any changes in established tort law doctrines should be made by the legislature. More emphasis should be placed, instead, on correcting past errors.

The current statute of limitations fails to serve any rational purpose in light of statistics regarding the filing of claims and should be repealed. Similarly, the recovery of cost law has proven to be a "pandora's box" for both claimants and defendants, bearing no rational relationship to the resolution of the malpractice crisis.

As stated previously, any attempt to reinstate medical mediation panels would be unwise. Further, the constitutionality of such an attempt would be doubtful. Voluntary arbitration could provide an effective alternative to these mandatory review panels. Several states have already adopted this type of plan. Under voluntary arbitration, a health care provider and his patient may agree in writing prior to treatment to submit any malpractice claim to binding arbitration. In the absence of such an agreement, the parties would still be able to reach an agreement at a later date if a claim were to arise. In addition, a thirty to sixty day period following the agreement should be allowed, during which either party could revoke the agreement. Voluntary arbitration would provide an inexpensive and reasonable means of handling disputes. Rather than foreclosing weak or small claims, it would encourage settlement of these claims as well as larger claims. Constitutional entanglements would also be avoided as long as procedural safeguards required by due process and equal protection are followed. This would include ensuring that the agreement to arbitrate was not the

164. See report supra note 4.
165. See The Florida Academy of Trial Lawyers, supra note 9.
166. See supra note 100.
167. See supra note 110.
168. See supra notes 85-92 and accompanying text.
170. Constitutional considerations become a problem when mandatory binding or non-binding arbitration is concerned. See Comment, supra note 113, at 683.
product of a contract of adhesion and that the patient’s waiver of his right to jury trial was knowingly and intelligently made.171

IV. CONCLUSION

Medical malpractice is real. The crisis is real. To attempt to discount it as a product of physician hysteria or insuror collusion is to take far too simplistic an approach to the problem. The issue cannot be drawn in terms of doctor versus lawyer or doctor versus patient. Much of the past medical malpractice legislation, however, has done just that. It has been drawn, on the whole, to serve the special interests of the medical community.

In its 1983 regular session, the legislature once again will be faced with a barrage of special interest proposals from all sides. The keynote here should be caution. Short-term solutions should be implemented where feasible, but they must be carefully considered regarding their possible long-term effects. Much unnecessary and unjust change has already been made in the search for a quick-fix. Long-term solutions must be pursued. Their development will be arduous and time-consuming, but the problem demands the effort.

Finally, the medical malpractice problem has been a major concern of Florida legislators for only seven years. Serious and searching thought must be given before legal doctrines which have evolved over generations are modified or abolished in an attempt to quickly dispose of the problem.

171. Id. at 685.