The Second Reformation: Florida's Medical Malpractice Law

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"As to diseases, make a habit of two things—to help, or at least to do no harm."

Hippocrates

I. INTRODUCTION

On May 30, 1985, the Florida Legislature passed the Comprehensive Medical Malpractice Reform Act of 1985 and ended a decade of stalemate between warring factions in the medical malpractice arena. The Act synthesizes a vast array of prior bills, current judicial trends, industry interests, and political concerns. The Act effects major changes in the area of medical risk prevention, and effects somewhat less significant changes in the areas of medical claims resolution and medical malpractice insurance.

The legislature debated and revised the medical malpractice reform bill into the final hours of the 1985 Regular Session. Last minute maneuverings arose while the bill was in Conference Committee, which faced the unenviable task of trying to meld the House version of the malpractice bill, House Bill 1352, with the vastly different Senate version, Committee Substitute for Senate Bill 1232. The final legislation, however, is largely the culmination

1. REISER, DVCK & CURRAN, ETHICS IN MEDICINE 7 (1977).
3. The Conference Committee consisted of Reps. Tom Gustafson, Dem., Ft. Lauderdale; Fred Lippman, Dem., Hollywood; Chris Meffert, Dem., Ocala; Art Simon, Dem., Miami; Jim Watt, Repub., North Palm Beach; and Tom Woodruff, Repub., Clearwater; FLA. H.R. JOUR. 732, 733 (Reg. Sess. May 28, 1985); Sens. Mattox Hair, Dem., Jacksonville; Dempsey Barron, Dem., Panama City; Bill Grant, Dem., Tallahassee; Richard Langley, Repub., Clermont; William Myers, Repub., Jupiter; and Peter Weinstein, Dem., Margate; FLA. S. JOUR. 587, 588 (Reg. Sess. May 28, 1985). Reps. Gustafson and Simon were the chief negotiators on behalf of the House and Sen. Hair was the chief negotiator on behalf of the Senate.
4. Fla. CS for SB 1232 (1985), a 16-page bill with 15 sections, followed Fla. HB 1352 (1985), a 101-page bill with 55 sections, in only 5 areas, all of which were noncontroversial. These identical sections appear in ch. 85-175, § 21, 1985 Fla. Laws 1180, 1211 (informed consent); id. § 22, 1985 Fla. Laws at 1211 (group insurance policies); id. § 43, 1985 Fla. Laws
of months of changes and redrafts of the original House subcommittee bill, PCB HC 85-2. Still, two key provisions of the original proposal, the imposition of vicarious liability on hospitals for their staff doctors' negligence and the caps for medical malpractice premiums based on doctors' incomes, were deleted by the compromise legislation.

This Article analyzes the major provisions in the Act concerning risk prevention, claims resolution, and malpractice insurance. The Article reviews many of the sources relied upon by the drafters of the legislation, examines the anticipated legal and practical effects of the Act's provisions, and identifies some of the difficulties or ambiguities inherent in the Act's major provisions. Finally, an analysis is made of the essential omitted provisions, tracing their history, purpose, and potential for later enactment by the legislature.

at 1225 (repeal of prevailing party's attorney's fees); and id. § 47, 1985 Fla. Laws at 1229 (severability).

The content of ch. 85-175, § 6, 1985 Fla. Laws at 1187, dealing with malpractice insurance contracts, was essentially the same in both its Senate and House forms, although the Senate bill deleted reference to an insured's duty to cooperate in the pre-suit screening process. Compare Fla. HB 1352, sec. 6 (1985) with Fla. CS for SB 1232, sec. 13 (1985). The House version of sec. 6 was adopted because the pre-suit screening process was retained in the Act.


6. Fla. H.R. PCB HC 85-2 was created by the House Subcomm. on Med. Mal., which was chaired by Rep. Art Simon, and which consisted of Reps. Charles Canady, Dem., Lakeland; Mary Figg, Dem., Temple Terrace; Tom Gustafson; Dennis Jones, Repub., Seminole; Hamilton Upchurch, Dem., St. Augustine; and Tom Woodruff. Rep. Gustafson was chairman of the principal Comm. on Health Care and Ins. and also was a member of the Subcomm. on Med. Mal. Rep. Art Simon was primarily responsible for overseeing the generation and vicissitudes of PCB HC 85-2. Rep. Gustafson was ultimately responsible to the Speaker of the House for the vitality and philosophy of the bill.
II. Medical Risk Prevention

Without doubt, the most progressive aspects of the Malpractice Reform Act emphasize preventing medical injuries. Many provisions of the Act are unique in the country and represent original approaches to a comprehensive attack on the occurrence of medical injuries.

The Malpractice Reform Act recognizes that the most intelligent approach to the entire malpractice malaise is simply to reduce the risk of medical injury whenever possible. Consequently, the Act necessarily assumes that current law does not do enough in the area of risk prevention, and that both hospitals and doctors can improve their performance in this area.\(^7\)

A. Hospital Monitoring of Medical Staff

Section 23 of the Act requires health care facilities to actively screen and review the competence of their medical staff. Facilities, including hospitals, must periodically review medical staff as well as supervise the performance of staff.\(^6\) Additional requirements to monitor medical staff are imposed in section 8, which requires each hospital's medical review committee to screen, evaluate, and review medical staff competence.\(^9\) Section 3 of the Act requires the governing board to discipline staff members when sufficient grounds exist.\(^10\)

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7. Not everyone agrees that risk prevention can be a significant contributor to avoiding the malpractice problem. The Florida Medical Association argues that bad doctors do not contribute to the medical malpractice problem. \(\text{FLA. MED. ASS'N, PROFESSIONAL LIABILITY CRISIS REPORT, Tab H (1984) (on file with Fla. H.R. Comm. on Health Care & Ins.).}\) Note that the Act includes a "Whereas" clause finding that monitoring of physician quality can prevent injuries due to malpractice. \(\text{See ch. 85-175, 1985 Fla. Laws 1180, 1183.}\) These "Whereas" clauses were added by the Conference Committee at the Senate's request to bolster the constitutionality of the Act. They were never part of either the House or Senate bills which formed the bases of the Act. \(\text{Compare ch. 85-175, 1985 Fla. Laws 1180, 1183 with Fla. CS for SB 1232 (1985) and Fla. HB 1352 (1985).}\)

8. Ch. 85-175, § 23, 1985 Fla. Laws 1180, 1211 (to be codified at Fl. Stat. § 768.60(1)(a)-(c)).

9. Id. § 8, 1985 Fla. Laws at 1189 (amending Fl. Stat. § 768.40(2) (1983)).

10. Id. § 3 1985 Fla. Laws at 1184 (amending Fl. Stat. § 395.0115(1) (1983)). The hospital board must take some disciplinary action against a staff doctor who has settled one or more cases exceeding $10 thousand that "involve" negligent conduct. Id.
The source of these duties to monitor is the developing national case law. A growing number of state courts have held that hospitals must assess their physicians' quality and determine their medical competence before granting or renewing staff privileges. One of the most influential of these decisions is *Elam v. College Park Hospital*, in which the court held that, under the doctrine of corporate liability, a hospital has a duty to protect patients from medical staff negligence: "[F]or, as a general principle, a hospital's failure to insure the competence of its medical staff through careful selection and review creates an unreasonable risk of harm to its patients." The court in *Elam* recognized that a hospital environment could not be fairly segmented into the facility and the medical doctors, but that the medical care provided in a hospital was a cooperative and mutual effort between the hospital and its medical staff.

The provisions in the Act imposing on hospitals a duty to monitor were relatively unchanged during the legislative process. How-

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11. See generally Peters & Persaino, *Malpractice in Hospitals: Ten Theories for Direct Liability*, 12 LAW, MEDICINE & HEALTH CARE 254 (1984); Note, *Wisconsin Hospital Held to Owe a Duty to Its Patients to Select Qualified Physicians*, 65 MARQ. L. REV. 139, 143 n.20 (1981) (more than one-quarter of the states have adopted the doctrine of hospital corporate negligence in regard to staff selection or supervision).


13. *Id.* at 161; see also Loveridge & Kimball, *Hospital Corporate Negligence Comes to California: Questions in the Wake of Elam v. College Park Hospital*, 14 PAC. L.J. 803 (1983).

14. *Elam*, 183 Cal. Rptr. at 164. Indeed, hospitals have found it increasingly necessary to use model regulations to develop a workable, interrelated organization. The main source of private regulations is the Joint Commission on Accreditation of Hospitals (JCAH), which has promulgated procedural standards for hospitals to follow in screening, reviewing, and dismissing medical staff. Current Florida law requires a hospital to use JCAH standards, among others, for these actions. See *Fla. Stat.* § 395.0115 (1983); *see also* Holly v. Auld, 450 So. 2d 217 (Fla. 1984) (discovery privileges for peer review committees broadly interpreted); Carida v. Holy Cross Hosp., Inc., 427 So. 2d 803 (Fla. 4th DCA 1983) (standards of pleading for wrongful dismissal of staff member); *Comment, The Medical Staff Privileges Problem in Florida*, 12 FLA. ST. U.L. REV. 339 (1984).
ever, specific duties to manage risk comprehensively were added to section 23 when an important, original part of this section, imposing vicarious liability on hospitals for staff doctors' negligence, was deleted.\textsuperscript{15} The vicarious liability provision was withdrawn by the bill's prime sponsors on the House floor in response to concerted opposition by hospitals and their lobby groups to the provision. In its place, increased duties to comprehensively manage risks and to enforce risk management procedures were imposed on hospitals.\textsuperscript{16} Additionally, a new section was added to section 23 allowing hospitals to purchase "umbrella" insurance policies covering their staff doctors.\textsuperscript{17}

The Act imposes a duty on hospitals which has not been precisely defined by judicial decision in this state. Although nationally there is a growing minority trend toward imposing corporate liability on hospitals, holding them to a duty of due care for patients' welfare by preventing staff incompetence, Florida courts have yet to impose such a duty.\textsuperscript{18}

Under the Act, a hospital may be directly liable both for failure to screen new physicians and for failure to continually monitor existing staff.\textsuperscript{19} Thus, if a hospital knows or should have known that a member of its staff is practicing medicine below a reasonably acceptable standard, the hospital must act to remedy the situation or risk exposure for negligent failure to monitor its staff.\textsuperscript{20} Further, since periodic review of medical staff is required, failure to dili-

\textsuperscript{15} The vicarious liability provision in the original proposed bill read: "All health care facilities, including hospitals and ambulatory surgical centers, as defined in Chapter 395, are liable for the negligent acts or omissions of their medical staff and personnel, committed within the scope of the health care facilities' business." Fla. H.R. PCB HC 85-2, sec. 21 (draft of Apr. 4, 1985) (words underlined are additions).


\textsuperscript{17} Ch. 85-175, § 23, 1985 Fla. Laws 1180, 1211 (to be codified at FLA. STAT. § 768.60(2)). Another section of the bill, sec. 22, already allowed group medical malpractice policies, so the addition of the umbrella provision is redundant. The purpose of "umbrella" coverage is to reduce insurance costs by consolidating hospital and doctor insureds under a single, comprehensive policy. A concomitant benefit is "channeling," which occurs when malpractice claims are asserted against a single entity, typically the hospital, regardless of the entity's fault. See infra notes 202-11 and accompanying text.

\textsuperscript{18} See Comment, supra note 14, at 341 n.14; Note, Hospital Corporate Liability: An Effective Solution to Controlling Physician Incompetence?, 32 Rutgers L. Rev. 342 (1979); Lisko, Hospital Liability Under Theories of Respondeat Superior and Corporate Negligence, 47 UMKC L. Rev. 171 (1978).

\textsuperscript{19} Ch. 85-175, § 23, 1985 Fla. Laws 1180, 1211 (to be codified at FLA. STAT. § 768.60(1)(a)-(c)).

\textsuperscript{20} Staff of Fla. H.R. Comm. on Health Care & Ins., HB 1352 (1985) Staff Analysis 23 (final June 4, 1985) (on file with committee).
gently conduct such review to discover a problem physician would also expose the hospital to liability.\(^2\) Finally, the Act requires the hospital to supervise staff and medical treatment to ensure compliance with standards established in a comprehensive risk management program.\(^2\)

The point of this duty to monitor is to provide a hospital with the incentive to control the quality of medical care delivered by its staff.\(^2\) Since the vast majority of malpractice occurs in hospitals, the hospital is in the optimum position to prevent the greatest amount of malpractice.\(^2\) By imposing responsibility on the hospitals, early detection of problem physicians is encouraged.\(^2\)

The effectiveness of the Act's monitoring provisions depends largely upon the goodwill of individual hospitals in carrying out the Act's intent. A hospital that can ill-afford to remove a highly productive physician from its staff may not do so because the economic consequences are difficult to accept.\(^2\) Further, even though

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22. Ch. 85-175, \$ 23, 1985 Fla. Laws 1180, 1211 (to be codified at Fla. Stat. \$ 768.60(1)(a)-(c)). A claim based on breach of the hospital's duty to monitor staff through selection and review suffers serious proof problems. See infra notes 32-35 and accompanying text. Therefore, this additional duty to supervise medical treatment to fulfill risk management obligations could be critical. Cf. Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966) (hospital must supervise medical treatment provided by physicians). The duty to supervise recognizes the superior, controlling position of the hospital, similar to an employer or partner, and foreshadows liability based on principles of respondeat superior.

23. References to legislative intent not included in the Act or events that occurred during meetings of the Conference Committee are based upon the author's experience as the attorney for the House Subcomm. on Med. Mal., as the primary draftsman for Fla. HB 1352, from discussions that occurred at meetings of the Subcomm. and the House Comm. on Health Care & Ins. regarding HB 1352 (recorded and on file with the Fla. H.R. Comm. on Health Care & Ins.), and from conversations with Rep. Tom Gustafson, Chairman, Comm. on Health Care & Ins., as well as with other members of the Committee.

24. Between 75% and 80% of all malpractice arises in hospitals. See Note, Hospital Corporate Liability, supra note 18, at 376; Fla. Comm'r of Ins., Report to the Florida Legislature on Medical Malpractice Insurance in the State of Florida 8 (Feb. 1983) (on file with Fla. H.R. Comm. on Health Care & Ins.) [hereinafter cited as Fla. Ins. Comm'r Rep.]

25. The Florida League of Hospitals (FLH) has taken the position that only a minimum amount of malpractice is avoidable by increased hospital monitoring. Based on insurance credits of 10% for active risk management programs, the FLH projected the 10% amount as a possible maximum savings. Fla. League of Hospitals, Economic Impact of PCB 85-2, Section 21 Position Paper at 1-2 (May 8, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.) [hereinafter cited as Fla. League of Hospitals Position Paper].

26. Ironically, an excess supply of physicians in Florida may have the practical economic effect of encouraging hospitals to dismiss marginal physicians who may easily be replaced by
the Act provides increased protection for hospitals from reprisal suits brought by rejected, dismissed or disciplined physicians, a hospital must still afford physicians elaborate due process procedures before it can act in relative confidence.27

Various sections of the Act deal extensively with the problem of reprisal suits. The Act attempts to extend immunity to the entire peer review process to the greatest extent allowable within due process limitations. Sections 2, 3, and 8 grant broad immunity to those involved in the peer review process, except for actions taken with intentional fraud.28 Additionally, these sections impose unilateral attorney's fees on the physician bringing a reprisal suit, and require the physician to post a bond to cover potential fees.29 Finally, the investigative proceedings and records of a hospital board, associated with denying and reviewing privileges, are protected from discovery, as currently provided for medical review committees.30

These protections were given to hospital and peer review committees to encourage the diligent monitoring of medical staff without fear of reprisal suits.31 Unless individual hospitals are moti-
vated to raise the quality of medical practice, one cannot expect significant progress in the prevention of malpractice.

A final problem with imposing on the hospital a duty to monitor staff is that the same protection from discovery granted to encourage participation in the peer review process essentially forestalls a patient who attempts to prove a hospital's negligence in fulfilling the new statutory obligations. At the heart of such an action, a patient must prove notice by the hospital of problems or reasonably anticipated problems with its staff doctor. Without proof outside the protected peer review process, a patient's action for negligent failure to monitor staff would appear doomed. Sections 2, 3, and 8 of the Act prohibit discovery or admission of investigations, proceedings, and records of the hospital board and review committee that concern the peer review process. Therefore, a patient must rely on evidence detailing previous dismissals from other hospitals, inadequate training, other malpractice claims, state disciplinary actions, or records of other victims of the same defendant. Further, the medical records of other patients, which could reveal a pattern of malpractice and notice to the hospital, are initially protected from discovery and afforded confidential status under current law. One commentator has suggested a solution to this predicament: allow discovery of records of other patients treated by a defendant doctor, with patients' names and identify-

process to the level of "state action" protected under the Parker doctrine. See Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984) (hospitals' peer review action protected by Parker doctrine since review required by state law and state actively supervised peer review process).

32. See Note, Corporate Negligence Actions Against Hospitals—Can The Plaintiff Prove A Case?, 59 WASH. L. REV. 913 (1984). If unrelated to the plaintiff's case, prior actions by a medical review committee against a defendant doctor would theoretically be discoverable. Thus, only a peer review action arising from a plaintiff's case would be protected by statute from discovery. See Segal v. Roberts, 380 So. 2d 1049 (Fla. 4th DCA 1979), cert. denied, 388 So. 2d 1117 (Fla. 1980). Ironically, these prior review actions may nevertheless be protected from discovery by public policy. Courts may allow discovery "only in the most necessitous circumstances." 380 So. 2d at 1052.

33. See Note, supra note 32, at 924.

34. FLA. STAT. § 395.017 (1983). As this statute seems to protect the negligent doctor and the hospital that should have known of the doctor's prior negligence as much as it protects patient confidentiality, one wonders whether patient confidentiality was the sole purpose of the statute. Note, however, that a plaintiff may seek discovery of patient records by subpoena, id. § 395.017(3)(d), and that a previous requirement of "good cause" was deleted from the statute in 1983, ch. 83-108, § 2, 1983 Fla. Laws 358, 359 (amending FLA. STAT. § 395.017(3) (Supp. 1982)). Nevertheless, since other patient records are "privileged and confidential," plaintiffs would still have the onus of overcoming the protected status by some reasonable showing of necessity.
ing materials expunged.\textsuperscript{35} Unless a realistic means of proof is given to patients who claim against a hospital for negligent failure to monitor staff physicians, the incentive for risk management reform remains ephemeral.

\textbf{B. Hospital Risk Management}

Hospitals are required under the Act to adopt and enforce a comprehensive risk management program.\textsuperscript{36} The program must be supervised by a certified risk manager.\textsuperscript{37} The Act provides for a complete certification program for these risk managers.\textsuperscript{38} Further, hospitals are required to periodically report in detail to the Department of Health and Rehabilitative Services (HRS) all medical incidents, and promptly to report severe medical incidents. HRS may issue mandatory risk management requirements to reporting facilities.\textsuperscript{39}

The certification requirements for risk managers were patterned directly after the existing statute for nursing home administrators’ licensure, with appropriate modifications recommended by the Florida Society for Hospital Risk Management.\textsuperscript{40} The medical incident reporting requirements were based on HRS recommendations.\textsuperscript{41}

Hospitals have been required to implement risk management programs since 1975.\textsuperscript{42} This law, however, has not proven entirely satisfactory. Hospitals were only required to “designate” a risk manager who need merely meet the hospital board’s own requirements.\textsuperscript{43} Although an incident reporting system was also required,

\begin{itemize}
\item \textsuperscript{35} See Note, supra note 32, at 925-26.
\item \textsuperscript{36} Ch. 85-175, § 23, 1985 Fla. Laws 1180, 1211 (to be codified at Fla. Stat. § 768.60(1)(b)).
\item \textsuperscript{37} Id. § 9, 1985 Fla. Laws at 1191 (amending Fla. Stat. § 768.41 (1983), to be codified at Fla. Stat. § 395.041(2)).
\item \textsuperscript{38} Id. § 38, 1985 Fla. Laws at 1219 (to be codified at Fla. Stat. §§ 626.991-.995).
\item \textsuperscript{39} Id. § 9, 1985 Fla. Laws at 1191 (amending Fla. Stat. § 768.41 (1983), to be codified at Fla. Stat. § 395.041).
\item \textsuperscript{40} See supra note 23. The certification program was originally included in PCB HC 85-2 as a licensure program under the Department of Professional Regulation (DPR). Fla. H.R. PCB HC 85-2, sec. 37 (draft of Apr. 4, 1985). It was later moved to the Department of Insurance (DOI) at the latter’s verbal request. See supra note 23. Because smaller hospitals objected to the cost of a complete licensure program, the program as finally enacted was a simplified, less costly certification process. The nursing home administrators are licensed under Fla. Stat. §§ 468.1635-.1775 (1983).
\item \textsuperscript{41} See Staff of Fla. H.R. Comm. on Health Care & Ins., HB 1352 (1985) Staff Analysis 10 (final June 4, 1985) (on file with committee).
\item \textsuperscript{42} Ch. 75-9, § 3, 1975 Fla. Laws 16 (current version at Fla. Stat. § 768.41 (1983)).
\item \textsuperscript{43} See Fla. ADMIN. CODE R. 10D-75.02(12) (1983).
\end{itemize}
no direct state agency supervision or management of medical incidents was in effect." Indeed, the entire risk management program statute lacks meaningful preventive devices.46

The Act requires health care facilities to hire a risk manager certified by the Department of Insurance (DOI).46 The purpose of the certification program is to create a specialized profession of risk managers.47 The Act also provides for an advisory council of risk managers who will assist in further development of risk manager qualifications and model risk management programs. Basic certification requirements focus on minimum education or experience in risk management.48

The certified risk manager is the hospital employee accountable for implementation of the risk management program required under section 9 of the Act. An essential part of the program is medical incident reporting to HRS.49 Section 9 requires, for the first time, detailed medical incident reports which include the names of physicians involved in each medical incident. The reports must also describe all medical claims filed against the facility and disciplinary actions taken against staff by the facility. An immediate report of severe medical injuries is also required. In response, HRS may prescribe mandatory measures to be taken by the facility and report physicians with disciplinary problems to the Department of Professional Regulation (DPR).50 Since these provisions come within HRS's jurisdiction, HRS can use its full panoply of health care facility licensure powers and penalties to enforce facility compliance.51

Risk management requirements similar to those imposed on hospitals are now imposed on health maintenance organizations

44. FLA. STAT. § 768.41 (1983).
45. Fortunately, several hospitals have voluntarily implemented comprehensive model risk management programs. For example, Mount Sinai Medical Center in Miami, under the direction of Roberta Carroll, has adopted an exemplary program. See R. Carroll, Policy and Procedures of Mt. Sinai Medical Center (unpublished manual) (on file with Fla. H.R. Comm. on Health Care & Ins.).
46. Ch. 85-175 § 9, 1985 Fla. Laws 1180, 1191 (amending FLA. STAT. § 768.41 (1983), to be codified at FLA. STAT. § 395.041(2)).
47. See supra note 23.
48. Ch. 85-175, § 38, 1985 Fla. Laws 1180, 1219 (to be codified at FLA. STAT. § 626.994(1)-(2)).
49. Id. § 9, 1985 Fla. Laws at 1191 (amending FLA. STAT. § 768.41 (1983), to be codified at FLA. STAT. § 395.041).
50. Id.
51. For example, the continued failure to meet adequate risk management standards or a continued experience of avoidable medical incidents could allow HRS under FLA. STAT. § 395.003(7) (1983) to suspend or cancel the hospital's license.
(HMOs) by section 46. The HMO must hire certified risk managers only if it is large and maintains a health care facility. The purpose of the medical incident reporting requirements is to provide statewide data to detect trends of malpractice through consolidation of information. Once the state agency recognizes recurrent or avoidable problems, appropriate corrective actions should be taken either by adjusting individual hospital procedure or issuing statewide information bulletins. A central difficulty encountered in the risk management area is the lack of discernible and specific risk management standards which can be uniformly required by law. Hence, the certification of risk managers and reporting of medical incidents to HRS represent initial, pragmatic steps in developing comprehensive risk management programs. DOI will develop model risk management programs that may, in the future, be statutorily mandated.

Another difficulty with medical incident reporting lies in defining an “adverse or untoward” incident. The term is pointedly left without definition. HRS, however, is accorded specific rulemak-

52. Ch. 85-175, § 46, 1985 Fla. Laws 1180, 1226 (to be codified at Fla. Stat. § 641.391). A health maintenance organization (HMO) is an organization certified by DOI under Fla. Stat. ch. 641, part II (1983) and which employs or contracts with health care providers to render comprehensive health care, usually including preventive care, to persons enrolled in the organization's prepaid plan. An HMO plan typically does not charge the enrollee a deductible or require coinsurance.

53. Ch. 85-175, § 46, 1985 Fla. Laws 1180, 1226 (to be codified at Fla. Stat. § 641.391(2)). Certain HMO facilities provide no health care treatment but merely refer patients to appropriate providers. When an HMO facility merely refers patients for treatment, the necessity for a risk manager seems questionable. The HMO was previously required to manage its risk under the ineffective Fla. Stat. § 768.41 (1983). The hospital risk management and reporting requirements were moved to Fla. Stat. ch. 395 to provide HRS with significant licensure enforcement powers against hospitals and ambulatory surgical centers. HMO risk management requirements, originally deleted in Fla. H.R. PCB HC 85-2, were added to the Act upon the recommendation of DOI. See ch. 85-175, § 46, 1985 Fla. Laws 1180, 1226 (to be codified at Fla. Stat. § 641.391). HRS was given supervision of the HMO risk management programs but lacks appropriate enforcement powers under Fla. Stat. ch. 641. It would seem necessary that DOI, as the ultimate certifying authority for the HMO, be given the supervisory capacity for HMO risk management.

54. See supra note 23.

55. The data gathered by HRS is neither discoverable nor admissible, except for purposes of disciplinary actions by the appropriate state agency. Ch. 85-175, § 9, 1985 Fla. Laws 1180, 1191 (to be codified at Fla. Stat. § 395.041(5)(a)(6), (6)-(7)). Without such protection, it is doubtful that diligent and candid reporting of all adverse medical incidents could be achieved. Note, however, that individual incident reports are apparently still discoverable but not admissible under Fla. Stat. § 395.041(4).

56. Coincidentally, the term “untoward, adverse medical incident” as used in § 9 of the Act was also used to describe compensable medical injuries under the “Medical Adversity Compensation Law,” proposed by Sen. Barron along the lines of the Workers' Compensation Law. See Fla. CS for SB 1022, sec. 1 (1984).
ing power under this section, and one would anticipate an evolving definition based on agency experience. Because the facility's risk manager generally determines what constitutes an "adverse or untoward" medical incident, again the success of the provision depends largely on the good faith assessment and reporting of the risk manager.

C. Insurance Reporting Requirements

Although current law requires insurers annually to report closed medical malpractice claims to DOI, the Act significantly increases the informational requirements in these claim reports. More importantly, for the first time the public will have access to the information contained in these closed claim reports.

The source of the increased reporting requirements was a standardized reporting form used by the National Association of Insurance Commissioners, entitled "NAIC Medical Professional Liability Insurance Uniform Claims Report." Section 7 of the Act requires reporting the names of all defendants, the name of the facility involved, a detailed description of the injury and misdiagnosis, and risk management steps taken by the insured to avoid similar injuries. Closed claims must be reported within 60 days of closure.

The increased information should prove useful to DOI in identifying potential disciplinary problems. Since DOI is required to report to DPR any physician or osteopath who has three or more paid indemnities within a five-year period, the increased information will assist DPR in initiating mandatory investigations of doctors with recurrent claims as required by sections 4 and 5 of the Act.

57. Ch. 85-175, § 9, Fla. Laws 1180, 1191 (amending Fla. Stat. § 768.412 (1983), to be codified at Fla. Stat. § 395.041(10)).
58. Id. § 7, Fla. Laws at 1187 (amending Fla. Stat. § 627.912 (1983)).
59. Id. (creating Fla. Stat. § 627.912(3)).
60. Use of the NAIC form to enhance closed claims reporting requirements was first recommended in the ADVISORY COUNCIL REP., supra note 10, at 17, and partially included in Fla. CS for HB 522 sec. 4 (1984).
62. Fla. HB 1352 (1985) (Second Engrossed) provided that thresholds for mandatory or triggered review be two paid claims within five years, which would have produced an annual review of about 30 doctors, according to DOI. When the Conference Committee met, the Senate conferees verbally requested that thresholds for mandatory or triggered review be increased to three paid claims within a five-year period. The Senate position prevailed, ch. 85-175, § 4, 1985 Fla. Laws 1180, 1185 (amending Fla. Stat. § 458.331(1)(t), (5), (6) (1983)); id. § 5, 1985 Fla. Laws at 1186 (amending Fla. Stat. § 459.015(1)(t), (5) (1983)), which
The purpose of the increased reporting requirements is to provide DOI and the public with increased data about closed malpractice claims. There is a dearth of empirical data in the malpractice area despite inordinate attention from interested parties and the public. More timely and complete data is also intended to assist DPR in assessing, under the new triggered review provision, doctors who may have problems. Assessment through mandatory or triggered review limits DPR's discretion by requiring DPR to investigate a doctor who pays a certain number of indemnities within a given period. However, since only a few doctors will be reviewed each year, mandatory review cannot be expected to effect substantial malpractice prevention.

means that the mandatory review will produce an annual evaluation of about 8 to 10 doctors, which significantly lowers the effectiveness of the Act. Since these closed claims are public records, DPR is itself capable of reviewing all closed claims reports, and determining when an investigation is warranted, regardless of the number of closed claims reported against an individual doctor.

63. See supra note 23.

64. For example, there is no data indicating the extent of actual malpractice in Florida's hospitals. The only source from which to extrapolate such information is a 1977 California study. See CAL. MED. ASS'N & CAL. HOSPITAL ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (1977) (this report is generally known as the Mills Study); see also D. MILLS, MEDICAL INSURANCE FEASIBILITY STUDY, A TECHNICAL SUMMARY, 128 W.J. MED. 360 (1978). When these findings are applied to Florida, an alarming rate of medical injuries is projected which far exceeds the approximately 2,500 malpractice suits brought yearly. See Gov.'s Task Force Rep., supra note 10, at 52-53 (showing a projected rate of 92,790 injuries in hospitals per year of which 15,774 were due to medical negligence).

65. DOI information shows that of 1,544 claims reported in 1980-81, 377 (or 24.4%) were paid by 149 physicians having multiple claims. See Advisory Council Rep., supra note 10, at 16. See also supra note 62.

66. See supra note 62. Several other provisions in the Act, recommended by various groups, encourage prevention. DPR's recommendations appear in ch. 85-175, § 29, 1985 Fla. Laws 1180, 1216 (amending FLA. STAT. § 458.311 (Supp. 1984)), which limits the number of attempts to pass the Federal Licensing Examinations (FLEX); id. § 34, 1985 Fla. Laws at 1218 (to be codified at FLA. STAT. § 205.194), which restricts local occupational licensure without exhibition of a state license or registration; id. § 35, 1985 Fla. Laws at 1219 (amending FLA. STAT. § 463.011 (1983)), which requires exhibition of licenses; id. § 36, 1985 Fla. Laws at 1219 (repealing FLA. STAT. §§ 205.195, 197-199, 480.051 (1983)); id. § 31, 1985 Fla. Laws at 1217 (to be codified at FLA. STAT. § 455.2287), which provides penalties for giving false information; id. § 32, 1985 Fla. Laws at 1217 (amending FLA. STAT. § 458.327 (1983)), which lists acts constituting a third-degree felony; id. § 33, 1985 Fla. Laws at 1218 (amending FLA. STAT. § 459.013 (1983)), which lists felonious acts applicable to osteopaths; id. § 30, 1985 Fla. Laws at 1216 (to be codified at FLA. STAT. § 455.213), which provides for mandatory continuing medical education; id. § 40, 1985 Fla. Laws at 1223 (amending FLA. STAT. § 458.337 (1983)), which increases DPR access to reports of disciplinary actions by medical organizations and hospitals; id. § 41, 1985 Fla. Laws at 1224 (amending FLA. STAT. § 455.241 (Supp. 1984)), which increases DPR access to patient records; id. § 42, 1985 Fla. Laws at 1224 (to be codified at FLA. STAT. § 395.017(3)(e)), which allows DPR access to patient records otherwise having a privileged and confidential status.
III. Medical Claims Resolution

The Malpractice Reform Act modifies several procedures of the current legal system. Rather than major changes, these are discreet reforms which fine-tune the system. A few minor substantive changes, including modification of the rules of contribution among joint tortfeasors and rewording the medical standard of care, were also included in the Act to remedy perceived problems with the legal system.67

A. Pre-suit Screening and Arbitration

Section 14 of the Act adopts for malpractice actions a pre-suit screening process originally proposed by the Insurance Commissioner's Medical Malpractice Insurance Advisory Council.68 The process provides for a ninety-day pre-suit notice by the claimant, during which time a prospective defendant's insurer must conduct some review of the claim which "fairly" evaluates the claim.69 The

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67. One recent study by Prof. Danzon suggests that there is very little correlation between malpractice insurance premiums based on claim frequency and severity and various tort reforms enacted in 1975. See Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 J.L. & Econ. 115, 137-44 (1984).

68. See Advisory Council Rep., supra note 10, at 7-14. This pre-suit screening process was included in Fla. CS for HB 522 (1984), from which the Act's version was drawn. Apparently, the notice of intent to claim for malpractice need not even specify the basis for such a claim. See ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(3)(a)). Peer review panels are suggested by the Act as an alternative method of reviewing claims, but are not required. Id. (to be codified at Fla. Stat. § 768.57(3)(a)(3)). The original plan recommended in the Advisory Council Rep., supra note 10, followed an informal New Jersey model, carried out by insurance companies which used peer review as the plan base. This so-called "New Jersey plan" is not a state statute or rule of court, and no 90-day waiting period is required under New Jersey law. The 90-day period appears to be a product of the Insurance Advisory Council. See supra note 68; cf. Cal. Civ. Proc. Code §§ 364, 365 (West Supp. 1985) (90-day pre-suit notice required in medical malpractice cases). New Jersey does have a voluntary malpractice mediation process, the unanimous findings of which are admissible before a jury. See N.J. Civ. Prac. R. § 4:21-1 to 4:21-8 (1985). The "New Jersey plan" is actually a voluntary agreement between insurers and trial attorneys to screen malpractice claims through a peer review process. The Medical Inter-Exchange of New Jersey entered an informal understanding with the Association of Trial Lawyers of
insurer can require the claimant to appear before a review panel and to undergo a physical exam. The claimant must cooperate or risk later dismissal of his claim. Presumably, the insurer or review panel could interrogate the claimant concerning his malpractice claim. Interestingly, there is no corresponding ability of a claimant to interrogate the prospective defendant or insurer about the claim or defense, although both sides must make discoverable information available. Statements generated in the review process are neither discoverable nor admissible.

A prospective defendant may respond to the claimant by rejecting the claim, making a settlement offer, or admitting liability and requesting arbitration on damages. An attorney representing a claimant must advise his client in writing of the terms of the prospective defendant’s response, the costs to the client of proceeding to trial, and the likelihood of success. There is no time limit for acceptance of a settlement offer, but an offer to arbitrate damages must be accepted or rejected within twenty days. If accepted, an offer to arbitrate imposes binding arbitration on both parties if settlement of damages is not reached within thirty days. Section 14 sets out a straightforward procedure for binding

America, New Jersey. The New Jersey ATLA recommended on October 26, 1979 that its New Jersey members afford the Exchange 90 days to investigate a claim before the attorney files the suit. Each side is requested to disclose theories of liability or defense. The Exchange will supply the medical records, if available. If only damages are contested, use of arbitration is encouraged. See B. Genest, REPORT TO THE FLORIDA DEPARTMENT OF INSURANCE’S MEDICAL MALPRACTICE INSURANCE ADVISORY COUNCIL (Attach. D, Exhib. I) (Sept. 9, 1982) (on file with Fla. Dep’t of Ins.) [hereinafter cited as Genest Rep.].

70. Ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(3)(a)).
71. Id. (to be codified at Fla. Stat. § 768.57(6)).
72. Ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(5)). As with many procedural changes, a manipulative party can exploit the intricacies of the system. Even though information an insurer gleans through the review process is not directly admissible or discoverable, knowledge of such information could easily be exploited to produce admissible evidence. Pre-suit screening may simply be used by some prospective defendants as a tool to build a better defense. Section 14 of the Act requires “parties” to make available discoverable information during the process. Id. (to be codified at Fla. Stat. § 768.57(6)). This raises the interesting possibility that such information would later be inadmissible under Fla. Stat. § 768.57(5).
73. Ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(3)(b)).
74. Id. (to be codified at Fla. Stat. § 768.57(3)(d)).
75. Id. (to be codified at Fla. Stat. § 768.57(7)). Since an offer of liability and arbitration on damages apparently could be withdrawn anytime, it seems anomalous to limit claimant’s acceptance time to 20 days, especially since there is no limit for settlement offers. Apparently this 20 day period would run subsequent to the 30 day period during which claimant’s attorney may transfer the offer, although this is unclear.
arbitration on damages, which incorporates the Florida Arbitration Code. During this process, the statute of limitations is tolled as to all potential defendants.

Section 14 of the 1985 Act was based largely on the version in Committee Substitute for House Bill 522 proposed during the 1984 Regular Session of the legislature. During the 1985 Regular Session, this provision remained practically unchanged through two months of constant rewriting of the bill. The sole purpose of this section has always been the encouragement of earlier and more frequent settlement of meritorious claims.

Once a claimant goes through pretrial screening and counsel

76. Ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(9)).

77. Id. (to be codified at Fla. Stat. § 768.57(4)). Thus, if a claimant serves notice of a claim on one defendant, the statute of limitations is tolled during the 90-day period as to all "potential" defendants which the claimant might later join. Id. (to be codified at Fla. Stat. § 768.57(4)). Additionally, a claimant could have another 60 days after the prospective defendant rejects the claim or after an offer of arbitration is rejected by a claimant. Id. (to be codified at Fla. Stat. § 768.57(7)(a)). A claimant need only reject an offer to arbitrate after 20 days, so there is another tolling potential here. Id. (to be codified at Fla. Stat. § 768.57(7)). Finally, a claimant may obtain an automatic 90-day extension for reasonable investigations of bad faith claims required by section 12 of the Act. Id. § 12, 1985 Fla. Laws at 1196 (to be codified at Fla. Stat. § 768.495(3)). These combined provisions potentially allow for a maximum eight-month extension of the statute of limitation for all potential defendants. This is significant since the current malpractice statute of limitations may be as short as two years. See Fla. Stat. § 95.11(4)(b) (1983). This concession by defendants seems reasonable in view of the delay that pre-suit screening and statutory investigation requirements impose on claimants. Note, however, that section 14 of the Act is internally inconsistent: while it clearly requires only that notice be served on prospective defendants, since no case has yet been docketed, the section also seems to require filing of the notice with the court to toll the statute of limitations. See ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(2)-(3)), cf. id. (to be codified at Fla. Stat. § 768.57(4)).

If a plaintiff files a complaint within the limitation period but fails to file or serve a notice of intent to initiate litigation within the period, a question arises as to whether the statute of limitation is tolled. The Act requires that a notice of intent be filed (served) within the limitation period. See ch. 85-175, § 14, 1985 Fla. Laws 1180, 1199 (to be codified at Fla. Stat. § 768.57(2)). The Act does not indictate that failure to do so results in the running of the statute of limitation. Whether the courts will construe a complaint as tantamount to the notice of intent is an open question. Since the defendant is already on notice of the litigation after a complaint, dismissing the action and allowing the limitations period to run produces a rather harsh, overly technical result. Also, a defendant would be encouraged to wait out any remaining limitations period and then raise objection for failure to serve a notice of intent. Otherwise, a plaintiff could simply file the notice and amend his complaint to show compliance. Such "ambush" tactics should not be encouraged through overly technical application of the Act.

78. Small changes were made, such as the addition of a longer nonsuit period consistent with the sovereign immunity statute for governmental entities, Fla. Stat. § 768.28 (Supp. 1984), and the deletion of a minimum $250 thousand limit on general damages as part of an offer to admit liability and arbitrate damages.

79. See supra note 23.
complies with the requirements under section 12 for certification of reasonable investigation of the claim, suit may be filed. After filing suit, the plaintiff and defendant may then be required by the court to submit to a mandatory mediation process as specified by section 15. Although the Act denotes this proviso as “court-ordered arbitration,” it is more accurately described as a mediation process. The panel hearing the case cannot make a “determination,” instead, it can only make a recommendation to assist settlement of the claim. The entire process bears a haunting similarity to the Medical Mediation Panels established by the Medical Malpractice Reform Act of 1975. The mediation panels under the 1975 Act fell when the court in Aldana v. Holub found that time limits in the mediation process, particularly a ten-month limit that could not be extended, operated arbitrarily to deny parties due process. Under the new Act, unless a panel hearing is scheduled within ninety days of selection of panel members, which must occur within forty days of submission to arbitration, the panel arbitrarily loses its authority over the matter. Notably, court-ordered arbi-

80. A certificate is only required of claimants who hire an attorney. A claimant proceeding pro se would not be obligated to file a certificate of reasonable investigation and good faith belief of grounds for suit. A written opinion from a medical expert is not a prerequisite to proof of good faith, but is merely an exemplary and presumptive means of proof. If an attorney could not obtain the client’s medical records from a potential defendant, the attorney’s good faith efforts should suffice, even though a medical opinion might be impossible to obtain under those circumstances. Further, the written expert opinion could simply state that there is apparent evidence of medical negligence. Cf. CAL. CIV. PROC. CODE §§ 411.30-.35 (West Supp. 1985) (similar statutory requirement).

81. Ch. 85-175, § 15, 1985 Fla. Laws 1180, 1202 (to be codified at FLA. STAT. § 768.575). This definition of the mediation process is based on the definitions contained in a recent study on mediation and arbitration. LEGISLATIVE STUDY COMM’N ON ALTERNATIVE DISPUTE RESOLUTION, FINAL REPORT (Appendix B) (Mar. 1, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.) [hereinafter cited as DISPUTE RESOLUTION REP.]. This report notes that the point of mediation is to arrive at a mutually acceptable agreement, a process similar to the Malpractice Reform Act’s court-ordered arbitration. Conversely, the point of arbitration is to submit a disputed matter for determination. Id. at B-1, 2.

82. For a comprehensive history of the mediation panels, see Ehrhardt, One Thousand Seven Hundred Days: A History of Medical Malpractice Mediation Panels in Florida, 8 FLA. ST. U.L. REV. 165 (1980).

83. 381 So. 2d 231 (Fla. 1980).

84. Id. at 235-36.

85. See ch. 85-175, § 15, 1985 Fla. Laws 1180, 1202 (to be codified at FLA. STAT § 768.575). One could fairly characterize the Act’s arbitration provision in section 15 as an attempt to circumvent the clear warning of Aldana that a mandatory mediation process is unavoidably unconstitutional. The Commission on Alternative Dispute Settlements determined that the entire mediation process should last no longer than 90 days to satisfy access to court requirements under Carter v. Sparkman, 335 So. 2d 802 (Fla. 1976), cert. denied, 429 U.S. 1041 (1977). See DISPUTE RESOLUTION REP., supra note 81, at 7. The Act’s arbitration provision could delay a case up to 130 days.
tration under section 15 is neither binding on the parties nor ad-
missible in a later trial.66 Although the process is mandatory if or-
dered by the court, there are no penalties for failure to accept the
panel’s suggested award.67

As with the ninety-day screening process, court-ordered arbitra-
tion is designed to encourage early and more frequent settlement
of meritorious claims. However, because there are few incentives to
actively participate in the arbitration process, it is doubtful that
the process will achieve these goals. Since the process is supple-
mental to the judicial proceedings, one could expect that the over-
all costs of malpractice cases will increase for both plaintiffs and
defendants.68 Furthermore, it will be difficult to assess whether ar-
bitration actually encourages settlement since ninety percent of
malpractice cases currently settle without arbitration.69

86. Ch. 85-175, § 15, 1985 Fla. Laws 1180, 1202 (to be codified at Fla. Stat. §
768.575(2)(h)).

87. See id. This arbitration provision is the only section in Fla. HB 1352 (1985) that is
based on any provision in the Senate malpractice bill, Fla. CS for SB 1232 (1985). The
Senate bill contained penalties of attorney’s fees, arbitration fees, and costs assessed against
a party who rejected the panel’s suggested award and then failed to obtain a more favorable
judgment. Fla. CS for SB 1232, sec. 11 (1985) also made this process mandatory, rather than
discretionary with the court, in all malpractice cases.

88. Although the arbitration section is ostensibly distinct from the parallel judicial pro-
cess, the provision does prohibit at trial “any reference to insurance, insurance coverage, or
joinder of the insurer,” directly affecting the court procedure. Ch. 85-175, § 15, 1985 Fla.
Laws 1180, 1202 (to be codified at Fla. Stat. § 768.575(2)(h)). The legislature’s choice of
this language poses a potential constitutional problem. This insurance reference prohibition
was taken directly from Fla. Stat. § 768.47, which is repealed by the Act and which is a
statutory remnant of the old medical mediation panels that were declared unconstitutional
in Aldana v. Holub, 381 So. 2d 231 (Fla. 1980). See supra notes 82-85 and accompanying
text. In Carter v. Sparkman, 335 So. 2d 802 (Fla. 1976), the Florida Supreme Court found
the insurance reference prohibition of § 768.47, then codified at Fla. Stat. § 768.134(1)
(1975), unconstitutional as an infringement on the court’s rulemaking powers. The court,
nevertheless, agreed with the policy behind the statute. To resolve any potential problems
in application, the court adopted the substance of the statute as FLA. R. Civ. P. 1.450(e).
Carter, 335 So. 2d at 806. Later the court declined to delete the rule, see The Florida Bar: In
re Rules of Civil Procedure (Deletion of Rule 1.450(e)), 429 So. 2d 311 (Fla. 1983), but after
further consideration the court withdrew the rule as an inappropriate separate rule for mal-
practice cases, see In re Amendments to Rules of Civil Procedure, 458 So. 2d 245, 254-55
(Fla. 1984). Interestingly, the court upheld a similar nonjoinder statute that apparently ap-
plies only to automobile and related casualty insurance. VanBibber v. Hartford Accident &
constitutional); see generally Note, Statute Which Prohibits Joinder of a Liability Insurer
Thus, given the court’s prior treatment of insurance reference prohibitions, this new enact-
ment should also be unconstitutional under Carter. Nonjoinder is now the rule for automo-
bile and casualty insurance cases but may not necessarily be the rule for malpractice insur-
ance cases.

The success of both the ninety-day screening process and the arbitration procedures depends largely on the good faith assessment of claims by defendants and their insurance companies. insurers wishing to exploit these new procedures can use both procedures for delay, a tactic ultimately to the advantage of insurers who are not liable for prejudgment interest. Moreover, since a claimant is required to comply with the pre-suit screening process for each defendant, the potential exists for multiple interrogations of a claimant by successive review panels of various insurers. Indeed, the benefit of these provisions of earlier, more frequent settlement is precariously balanced against the risk of further delay to the meritorious claim.

B. Offer and Demand for Judgment

The Act adopts in section 16 a new offer of judgment rule for malpractice actions, which allows either side to make a settlement offer and imposes a penalty of attorney's fees for unreasonable rejection of the offer. Unreasonable rejection by a plaintiff exists when a plaintiff obtains a judgment which is at least twenty-five percent less than the defendant's offer. Unreasonable rejection by a defendant exists when a defendant must pay a judgment which is at least twenty-five percent greater than the plaintiff's demand.

This section was generally motivated by the recently proposed changes to Federal Rule of Civil Procedure 68 concerning offers of judgments, which would allow the imposition of attorney's fees and prejudgment interest for unreasonably rejecting an offer. The

90. See infra note 101 and accompanying text.
91. Ch. 85-175, § 16, 1985 Fla. Laws 1180, 1205 (to be codified at Fla. Stat. § 768.65).
92. Id.
93. Proposed Fed. R. Civ. P. 68 reads as follows:

Rule 68. Offer of Judgment Settlement; Sanctions

At any time more than 10 days before the trial begins, a party defending against a claim may serve upon the adverse party an offer to allow judgment to be taken against him for the money or property or to the effect specified in his offer, with costs then accrued. If within 10 days after the service of the offer the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance together with proof of service thereof and thereupon the clerk shall enter judgment. An offer not accepted shall be deemed withdrawn and evidence thereof is not admissible except in a proceeding to determine costs. If the judgment finally obtained by the offeree is not more favorable than the offer, the offeree must pay the costs incurred after the making of the offer. The fact that an offer is made but not accepted does not preclude a subsequent offer. When the liability of one party to another has been determined by verdict or order or judgment, but the amount or extent of the liability remains to be determined by further proceedings, the party adjudged liable may make an offer of
Act's actual procedural changes were based more directly on the recommendations of the Insurance Advisory Council, which were incorporated by the legislature in Committee Substitute for House Bill 522 during the 1984 Regular Session.\textsuperscript{94}

\begin{quote}
judgment, which shall have the same effect as an offer made before trial if it is served within a reasonable time not less than 10 days prior to the commencement of hearings to determine the amount or extent of liability.

At any time more than 60 days after the service of the summons and complaint on a party but not less than 90 days (or 75 days if it is a counter-offer) before trial, either party may serve upon the other party but shall not file with the court a written offer, denominated as an offer under this rule, to settle a claim for the money, property, or relief specified in the offer and to enter into a stipulation dismissing the claim or to allow judgment to be entered accordingly. The offer shall remain open for 60 days unless sooner withdrawn by a writing served on the offeree prior to acceptance by the offeree. An offer that remains open may be accepted or rejected in writing by the offeree. An offer that is neither withdrawn nor accepted within 60 days shall be deemed rejected. The fact that an offer is made but not accepted does not preclude a subsequent offer. Evidence of an offer is not admissible except in proceedings to enforce a settlement or to determine sanctions under this rule.

If, upon a motion by the offeror within 10 days after the entry of judgment, the court determines that an offer was rejected unreasonably, resulting in unnecessary delay and needless increase in the cost of the litigation, it may impose an appropriate sanction upon the offeree. In making this determination the court shall consider all of the relevant circumstances at the time of the rejection, including (1) the then apparent merit or lack of merit in the claim that was the subject of the offer, (2) the closeness of the questions of fact and law at issue, (3) whether the offeror had unreasonably refused to furnish information necessary to evaluate the reasonableness of the offer, (4) whether the suit was in the nature of a "test case," presenting questions of far-reaching importance affecting non-parties, (5) the relief that might reasonably have been expected if the claimant should prevail, and (6) the amount of the additional delay, cost, and expense that the offeror reasonably would be expected to incur if the litigation should be prolonged.

In determining the amount of any sanction to be imposed under this rule the court also shall take into account (1) the extent of the delay, (2) the amount of the parties' costs and expenses, including any reasonable attorney's fees incurred by the offerer as a result of the offeree's rejection, (3) the interest that could have been earned at prevailing rates on the amount that a claimant offered to accept to the extent that the interest is not otherwise included in the judgment, and (4) the burden of the sanction on the offeree.

This rule shall not apply to class or derivative actions under Rules 23, 23.1, and 23.2.
\end{quote}

Committee on Rules of Practice and Procedure, Proposed Rules, 9 U.S. Code Cong. & Admin. News at G342-43 (Nov. 1984) (words in \textit{strikethrough} type are deletions from existing law; words underlined are additions.)

94. Fla. CS for HB 522, sec. 10 (1984). \textit{See Advisory Council Rep., supra} note 10, at 13. The prevailing party's attorney's fees rule, Fla. Stat. § 768.56 (1983), is repealed by ch. 85-175, § 43, 1985 Fla. Laws 1180, 1225. This repeal was necessary to implement the new offer of judgment rule, awarding attorney's fees based on unreasonable rejection of an offer. The repeal was also deemed advisable since most interested parties agreed that Fla. Stat. § 768.56 was ineffective to prevent suits or encourage settlements. Repeal was also recommended in the \textit{Advisory Council Rep., supra} note 10, at 1-2.
The changes to the offer of judgment rule could bring about more frequent and rapid settlements. By significantly penalizing unreasonable rejection of settlement offers, the Act could actively encourage both sides to make and accept realistic offers. Nevertheless, current law does provide prevailing party attorney's fees in malpractice cases, theoretically encouraging settlement to avoid trial. Under current law, a defendant can avoid the attorney's fees by making an offer which proves more favorable than a later judgment. One may fairly question whether the Act's new offer of judgment rule has significantly altered the existing attorney's fees statute, or whether the Act has merely rearranged an unpopular procedural device.

Much of the potential for use of the offer of judgment as a settlement device was stifled by the elimination of prejudgment interest for the plaintiff. Interest would have run from the time the demand was made if the demand proved to be twenty-five percent less than plaintiff's judgment. The prejudgment interest penalty was deleted in Conference Committee at the Senate's request. As a result, insurance companies defending malpractice claims will continue to be economically motivated to refuse early settlement since they can earn significant investment interest on the retained monies. Protracted litigation will continue to benefit insurers by...
allowing retention of such investment income.\textsuperscript{101}

Severe problems may also exist in the mechanical approach of the Act's offer of judgment rule. There is no judicial discretion to allow for cases that do not fairly warrant imposition of attorney's fees, regardless of whether a favorable offer was made. Conversely, there is no discretion under the rule to award attorney's fees if a judgment is only twenty-four percent more or less favorable than an offer. The trigger for attorney's fees is arbitrary and inflexible.\textsuperscript{102} By comparison, proposed Federal Rule of Civil Procedure 68 allows a judge to consider subjective factors in determining unreasonable rejection, such as the merit of a party's position, close legal questions, and information withheld by an offeror.\textsuperscript{103} If the legal issues were close and the merits of a party's case were strong, it might be inequitable to award attorney's fees to a party mathematically prevailing by the twenty-five percent factor. Moreover, the 1985 Act provides no method to judicially screen sham offers made by defendants merely to exploit the penalty provisions of the offer

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settlement offer prior to trial and plaintiff does not recover more than 125\% of the offer. See 42 PA. CONS. STAT. ANN., R. CIV. P. 238 (Purdon Supp. 1985). This Pennsylvania statute bears a striking resemblance to the offer of judgment provision in Florida's 1985 Medical Malpractice Reform Act. Michigan also mandates prejudgment interest on tort judgments unless a defendant makes an offer equal to or more favorable than the judgment. See MICH. COMP. LAWS ANN. § 600.6013 (West Supp. 1985). Some states do not tie prejudgment interest for tort suits to offers of judgment. See N.C. GEN. STAT. § 24-25 (Cum. Supp. 1983) (allowing prejudgment interest on compensatory damages for tort, if covered by insurance).

101. This advantage to insurers of delaying settlement until it is unavoidable is well recognized. The Fla. Dep't of Ins., Medical Malpractice Ins. Advisory Council, received testimony regarding the insurance practice in New Jersey, and that state's efforts to combat the practice:

In New Jersey, we have pre-judgment interest which, although not particularly liked by the insurance companies, was put into effect so that those companies which wanted to invest their money rather than pay the injured party would have to pay 12\% interest at the time of trial going back to six months from the date the case was originally filed.

GENEST, supra note 69, at 7; see also N.J. R. Ct. 4:42-11(b) (1985). As a result, the Insurance Advisory Council recommended allowance of prejudgment interest to a plaintiff making a favorable offer. See ADVISORY COUNCIL REP., supra note 10, at 13. Prejudgment interest is especially appropriate once a plaintiff makes a favorable offer because damages at that point effectively become liquidated and the defendant will have to ultimately pay at least as much as the offer in order for the offer of judgment rule to operate. The traditional argument against prejudgment interest is that damages in tort are unliquidated and therefore prejudgment interest should not be awarded on an uncertain amount. See Ross & Goelz, supra note 100, at 14. Plaintiff's demand precipitates liquidation, obviating this objection. See Bergen Brunswig Corp. v. Dep't of Health & Rehab. Servs., 415 So. 2d 765, 767 (Fla. 1st DCA 1982), approved, Argonaut Ins. Co. v. May Plumbing Co., 10 Fla. L.W. 353 (July 5, 1985) (prejudgment interest part of full compensation).

102. Ch. 85-175, § 16, 1985 Fla. Laws 1180, 1205.

103. FED. R. CIV. P. 68, supra note 93.
of judgment rule.\textsuperscript{104}

Most of these problems could be avoided by abandoning the mathematical formula of the Act in favor of the subjective standards of proposed Federal Rule 68, which grants the judge discretion in determining when a party has acted unreasonably in rejecting an offer and the type and amount of sanction to be imposed.\textsuperscript{108} Without subjective factors such as good faith, the Act's mechanical rule, although easy to apply, could produce inequitable results. To avoid these problems, a good faith standard must be read into the Act's offer of judgment rule until a more flexible rule can be adopted.

C. Attorney's Fees

In section 17 of the Act, attorney's fees in malpractice cases are addressed, and standards for presumptively reasonable contingent fee amounts are set forth. The first part of this section merely codifies general standards of reasonableness for all attorney's fees.\textsuperscript{106} The second part sets out a schedule of percentages of a recovery which are presumed reasonable for plaintiff's contingent attorney's

\textsuperscript{104} The entire problem of determining the subjective factor of unreasonable rejection by a mathematical formula was studiously avoided in proposed Fed. R. Civ. P. 68. The federal rules committee recognized that broad discretion was necessary in an offer of judgment rule, especially when significant penalties such as attorney's fees and prejudgment interest were involved. See Committee Note, supra note 93, at G343-46. The complexities of an offer of judgment rule have created convoluted problems even under the straightforward, existing rule. See Delta Airlines, Inc. v. August, 450 U.S. 346 (1981) (defendant cannot recover costs under offer of judgment rule when plaintiff lost at trial, only when plaintiff recovered less favorable judgment; avoids confronting issue of sham offers). Sham offers by defendants are a problem under existing law, and some courts have read a requirement of good faith into current Fed. R. Civ. P. 68. Id.

Under the Act, sham or token offers by defendants are encouraged since attorney's fees are awarded regardless of the reasonableness of an offer to encourage settlement. Theoretically, a defendant could offer one dollar and be entitled to attorney's fees if a plaintiff recovered nothing. However, assuming that Florida courts follow the rationale of Delta Airlines, a defendant would never be awarded attorney's fees when a plaintiff lost, since there would be literally no "judgment obtained by the plaintiff" and the rule could not apply. Token offers could only be effective when a plaintiff actually recovered at least a nominal amount.

Notably, plaintiffs cannot make sham demands. Low demands would be accepted by defendants and unrealistically high demands would avail plaintiffs nothing under the rule because the judgment must be 25\% greater than the demand to trigger attorney's fees. A separate problem exists when both sides have a 50-50 chance of prevailing since it may be unfair to penalize a party who acted reasonably under the circumstances by assessing all of the prevailing party's attorney's fees against the losing party.

\textsuperscript{105} Fed. R. Civ. P. 68, supra note 93.

\textsuperscript{106} Ch. 85-175, § 17, 1985 Fla. Laws 1180, 1205 (to be codified at Fla. Stat. § 768.575(1)-(5)).
fees.\textsuperscript{107}

The text for the first part of section 17 comes from the Florida Code of Professional Responsibility.\textsuperscript{108} Under these professional standards promulgated by the Florida Supreme Court, an attorney is subject to disciplinary action for failure to comply. The Act codifies the existing disciplinary rules and slightly clarifies them.\textsuperscript{109} An essential addition, however, is court review, upon client request, of a fee agreement for excessiveness\textsuperscript{110} and the requirement that the court shall review all divisions of fees between attorneys.\textsuperscript{111} With this change in current practice, the initial determination of a fees dispute shifts from the Florida Bar’s grievance committee to the court.\textsuperscript{112}

The second part of the attorney’s fees section, setting forth the fee schedule, is not based on any existing fee schedule. Rather, it is essentially a product of the House Committee on Health Care and Insurance produced in conjunction with interested parties.\textsuperscript{113} As originally submitted, PCB HC 85-2 contained a sliding schedule of attorney’s fees for plaintiffs which ultimately capped contingent fees at twenty percent of any recovery which exceeded $300 thousand.\textsuperscript{114} This provision proved extremely controversial and drew heated opposition from the Academy of Florida Trial Lawyers and consumer groups who actively lobbied against the provision.\textsuperscript{115} As a result, it was deleted by the Subcommittee on Medical Malpractice.\textsuperscript{116} However, during the meeting of the full House Committee on Health Care and Insurance, the Act’s current schedule was added as a slightly less offensive limit on contingent fees.\textsuperscript{117}

\begin{itemize}
  \item 107. \textit{Id.} (to be codified at \textit{FLA. STAT.} § 768.575(7)).
  \item 109. Ch. 85-175, § 17, 1985 \textit{Fla. Laws} 1180, 1205 (to be codified at \textit{FLA. STAT.} § 768.575(1)-(5)).
  \item 110. \textit{Id.} (to be codified at \textit{FLA. STAT.} § 768.575(2)).
  \item 111. \textit{Id.} (to be codified at \textit{FLA. STAT.} § 768.575(4)).
  \item 112. \textit{See FLA. BAR INTEG. R. BY-LAWS, art. V, § 5.}
  \item 113. Rep. Tom Gustafson drafted this section in consultation with representatives of the Academy of Florida Trial Lawyers.
  \item 114. \textit{Fla. H.R. PCB HC 85-2, sec. 14} (draft of Apr. 4, 1985).
  \item 115. The members of the House Subcomm. on Med. Mal., of course, recognized that any limitation on the amount plaintiffs’ attorneys could charge would generate great controversy and opposition from the plaintiffs’ bar. However, because of the respective positions of the House and Senate in previous years, the former generally supporting trial lawyers and the latter the medical profession, members of the Subcommittee perceived that a malpractice bill could not pass both chambers without including some regulation of contingent attorney’s fees.
  \item 117. \textit{Fla. H.R. PCB HC 85-2, sec. 15} (draft of Apr. 30, 1985).
\end{itemize}
MEDICAL MALPRACTICE

provision remained in the bill through Conference Committee as the Senate did not seriously oppose the provision.

The purpose of the Act’s fee schedule is primarily to encourage early settlement of malpractice claims.118 Under the structured schedule, contingent attorney’s fees are relatively low in the early stages of a claim. Defendants are thereby encouraged to settle early.119 Overall settlement amounts should be lower as plaintiffs will necessarily receive a larger part of the settlement.120 Without the Act, an attorney’s normal contingent fee would be thirty to thirty-five percent of the settlement or judgment amount. Under the Act, if a defendant settles a claim in the pre-suit screening period, the plaintiff’s attorney’s fees will be presumptively limited to fifteen percent.121 Effectively, a defendant is afforded a fifteen to twenty percent discount in the settlement value of the case. As the case progresses, the savings available to a defendant decrease. If a defendant waits until trial is underway to settle, the fee percentage is only limited to thirty-five percent, which accords with fees generally charged.122

There is also an overall presumptive cap of fifteen percent on the amounts of a recovery exceeding $2 million.123 Amounts less than $2 million are not affected by this limit, so fees of up to $900 thousand could be reasonably charged on those amounts if the case proceeded to appeal or postjudgment proceedings. This limit was included as a response to perceived public concern over grossly excessive attorney’s fees based on percentages of multi-million dollar awards.124 Since there were only twelve Florida malpractice cases in 1983 for over $1 million, this limitation can be expected to affect only a handful of cases.125

The Act’s fee schedule is more equitable than the statutes of other states that merely cap recoveries at certain amounts.126 The

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118. See supra note 23.
119. Id.
120. This, of course, ignores the common practice of many plaintiffs’ lawyers who voluntarily reduce their fees if a case settles quickly.
121. All of the percentages in the fee schedule are merely presumptions of reasonableness. An attorney could show special efforts or expenses and be entitled to a greater percentage. Ch. 85-175, § 17, 1985 Fla. Laws 1180, 1205 (to be codified at Fla. Stat. § 768.575(7)(a)).
122. Ch. 85-175, § 17, 1985 Fla. Laws 1180, 1205, (to be codified at Fla. Stat. § 768.575(7)(a)(5)).
123. Id. (to be codified at Fla. Stat. § 768.575(7)(b)).
124. See supra note 23.
126. Attorney’s fees are regulated by statute in about 20 states. Of these, about one-half
Act recognizes that a lower fee schedule may fairly be imposed on plaintiffs’ attorneys in the earlier stages of a case since less work is usually involved. Thus, lower fees tied to the earlier stages of a case are designed to avoid discouraging plaintiffs’ lawyers from accepting malpractice cases as uneconomical, the primary objection of consumer groups to contingent attorney’s fees caps. The Act accomplishes its primary goal of encouraging early settlement without discouraging plaintiffs’ lawyers from accepting malpractice cases.

D. Periodic Payment of Future Damages

Section 13 of the Act modifies the existing statute governing the
periodic payment of future damages in malpractice cases. The three noteworthy changes in this section include an increased threshold before future damages will be structured, a mandatory grant of requests for periodic payments, and the discontinuance of payments to a plaintiff who outlives the period. The other changes in the statute attempt to further balance the equities of structured payments between plaintiffs and defendants.

Under current law, if future damages exceed $200 thousand arguably all future damages could be subject to periodic payment. During the early consideration of House Bill 1352 by the House Committee on Health Care and Insurance, the Committee considered several proposals to change the threshold amount. The Act as passed settles on structuring payments only when future damages exceed $500 thousand and requires such payments to be made periodically, when requested by either party. Although a request for periodic payments initially leaves no discretion with the court to grant or deny such a request, the Act allows the judge to deny the request if manifest injustice would result.

The initial version of the structured judgment provision was quite different. The House Health Care and Insurance Committee originally proposed making the request for structured judgments mandatory, but to offset this change, future general damages would have been excluded from periodic payment, thereby ensuring a larger lump sum payment to needy plaintiffs. The Senate disagreed with the House’s proposed rewrite of the statute and ultimately succeeded in having the Act include the structuring of future general damages. However, in addition to prevailing on this provision, the Senate also managed to have removed from the law the present detailed categorization of verdicts, which includes past and future medical expenses, past and future wage losses, and past

129. Ch. 85-175, § 13, 1985 Fla. Laws 1180, 1197 (amending Fla. Stat. § 768.51 (1983)).
131. The various proposals to amend Fla. Stat. § 768.51(3) (1983) would have varied the threshold from $1 million, Fla. PCB HC 85-2, sec. 11 (draft of Apr. 4, 1985), to $500 thousand, Fla. PCB HC 85-2, sec. 12 (draft of Apr. 26, 1985).
133. Id. (amending Fla. Stat. § 768.51(1)(b) (1983)).
134. Id.
135. Fla. H.R. PCB HC 85-2, sec. 11 (draft of Apr. 4, 1985) (proposed amendment to Fla. Stat. § 768.51(1)(b) (1983)).
and future general damages.Senate conferees were concerned that the detailed itemization encouraged larger jury awards since the individual categories de-emphasized the overall size of an award. The itemized verdict provision contained in the Act requires itemization only of past and future damages. To utilize a periodic payments plan, the Act also establishes increased security requirements that a defendant must satisfy while providing for increased judicial flexibility in enforcing the defendant’s payments.

The period over which payments are to be made under the Act is that which the trier of fact established as the period for which future losses were to be awarded. The total amount of the payments will equal the judgment amount before reduction to present value. As for the plaintiff's attorney's fees, these are initially paid by the plaintiff out of nonstructured damages to a maximum of the agreed contingency percentage. The remaining amount of the attorney's fees is paid by the defendant out of the structured part of the award with an appropriate reduction of the balance.

The bill, as passed by the House, also would have provided for extended medical payments to a plaintiff who outlived the period of structured payments. This provision was altered at the Sen-

138. See supra note 23.
139. See ch. 85-175, § 11, 1985 Fla. Laws 1180, 1196 (amending Fl a. Stat. § 768.48 (1983)). Unfortunately, deletion of the existing categories of special and general damages could severely hamper DOI in its efforts to attain reliable statistics concerning relative percentages of special and general damages which comprise a verdict. One could conjecture that without such data, efforts by the Fla. Med. Ass'n to impose a cap on general damages, a now unknown factor, would also be hampered. Such a change seems especially curious when other states have increased itemization requirements in order to implement more progressive structured judgment statutes. See Ill. H.B. 1604, secs. 2-1109, 2-1701 to 2-1719 (adopted as amended May 23, 1985).
142. Id. (amending Fl a. Stat. § 768.51(2) (1983)).
143. Id. (amending Fl a. Stat. § 768.51(6) (1983)). Under the Act, if a plaintiff recovered $400 thousand in past damages and $2 million in future damages, $900 thousand would be unstructured and $1.5 million would be structured. Assuming a contingent percentage of one-third, plaintiff would pay $300 thousand to his attorney and defendant would pay the remaining attorney's fee of $500 thousand. Plaintiff's lawyer receives his entire fee of $800 thousand and defendant effectively structures the remaining $1 million in future damages. The foregoing is also a rough approximation of the way the 1983 law may have operated concerning payment of plaintiff’s attorney’s fees. See Fl a. Stat. § 768.51(6) (1983).
144. Fla. HB 1352, sec. 13 (1985) (Second Engrossed) (proposed amendment to Fl a.
ate's request, such that under the Act if a plaintiff outlives the projected period the payments simply cease. The discontinuance of periodic payments to a plaintiff outliving the period is counter-balanced by another Conference Committee change that allows the estate of the plaintiff who dies prematurely to receive a lump sum payment of all outstanding award damages. Under current law, future medical and pain and suffering losses cease when the plaintiff dies.

The purpose of altering the periodic payment statute was to encourage greater use of it by defendants who faced large awards of future damages. The existing statute granted a court the discretion to refuse to impose periodic payments. Such discretion seemingly contributed to the statute's disuse. The primary goal of the change was to limit this judicial discretion by requiring a finding of "manifest injustice" before periodic payments could be denied. Increasing the structure threshold was simply a balancing concession to limit the number of cases which could be affected by the new mandatory provision.

Although the proposed amendments to the structured judgment statute created considerable controversy, the efficacy of the amended statute remains questionable. In spite of the Florida Supreme Court's recent removal of the constitutional cloud over the existing provision, current data indicates that fewer than a dozen cases could even qualify for potential structured judgment treatment under the new law. Furthermore, judges could be ex-

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146. Ch. 85-175, § 13, 1985 Fla. Laws 1180, 1197 (amending Fla. Stat. § 768.51(2) (1983)).

147. Id.


149. See supra note 23.

150. Id.; ch. 85-175, § 13, 1985 Fla. Laws 1180, 1197 (amending Fla. Stat. § 768.51(1)(b) (1983)).

151. See supra note 23.

152. See Florida Medical Center, Inc. v. Von Stetina, 10 Fla. L.W. 286 (May 24, 1985) (upholding the constitutionality of Fla. Stat. § 768.51 (1983)).

153. See Gov.'s Task Force Rep., supra note 10, Appendix at 4, 6. The report shows that future medical expenses and lost wages account for about 15% of a verdict, while general damages account for about 54%. Since part of the general damages is for past pain and suffering in most cases, one could estimate that all future damages generally represent about one-half of the award. Twelve Florida cases exceeded $1 million in total damages in 1983; probably only these cases could meet the $500 thousand minimum for structured judgments.
pected to find “manifest injustice” in at least some of these cases and deny the requested periodic payments. In sum, these modifications to the structured judgment statute cannot be expected to cause a substantial increase in the use of periodic payments. However, the provision should prove advantageous to defendants in settlement negotiations since the mere threat of its application should give defendants leverage to obtain more favorable structured settlements.\(^\text{154}\)

**E. Standard of Care & Expert Witness Qualifications**

One of the few arguably substantive changes made in the Act rewords the medical standard of care. Instead of the “accepted” standard of care, which currently defines the duty owed by a health care provider, the Act defines this medical duty in terms of the “prevailing professional” standard of care.\(^\text{155}\) This change is one of semantics, which should only tenuously affect the average

Moreover, since only future damages in excess of $500 thousand could be structured, even fewer cases would warrant structuring as a practical matter. Finally, the structured judgment provision expires on October 1, 1987. See ch. 85-175, § 51, 1985 Fla. Laws 1180, 1229. It is doubtful that many large malpractice cases will be filed after the provision’s effective date of October 1, 1985, and be brought to final judgment in less than two years.

154. The Act also contains three other minor procedural changes to periodic payments of future damages. The most important of these is in § 18, which slightly enhances the trial court’s ability to order remittitur or additur in malpractice cases. Note that Florida courts generally have no authority to order additur other than in medical malpractice and automobile negligence cases. See Fla. Stat. §§ 768.49 (1983); Reinhart v. Seaboard Coast Line Ry., 10 Fla. L.W. 1470 (2d DCA June 21, 1985). Section 18 deletes the existing requirement of a finding that a verdict is “clearly” excessive or inadequate before a trial court can intervene. There is an added expression of legislative intent, subjecting awards in malpractice cases to close judicial scrutiny. Ch. 85-175, § 18, 1985 Fla. Laws 1180, 1207. The Tort Litigation Review Commission originally recommended deletion of the word “clearly.” Tort Litigation Rev. Comm., Report to the Florida Bar, 64-69 (Jan. 1984). This slight modification brings Florida law into conformity with the laws of most states.

A second minor procedural change in § 12 prohibits the initial pleading of punitive damages in malpractice cases until an evidentiary showing of a “reasonable basis” has been made. The change was recommended by the Tort Review Commission in its report at 27-29. See also Advisory Council Rep., supra note 10, at 6. The purpose of this change is to dispel the interrorem effect of initial pleadings containing pleas for punitive damages. To date, there are no reported appellate decisions in Florida sustaining punitive damages against a medical provider. Therefore, punitive damages themselves would not seem to be a significant, practical problem.

The third procedural change mandates settlement conferences in malpractice cases. See ch. 85-175, § 19, 1985 Fla. Laws 1180, 1206. It is patterned after Cal. R. Ct. 222 (1985), except that a plaintiff is not required under the Florida Act to file an itemized demand, as in California. Since federal courts already follow this practice, see Fed R. Civ. P. 16, Florida courts would simply be brought into line with the federal practice.

juror’s interpretation of the applicable standard of care. Further, since the breach of the duty of medical care is normally an issue of fact for the jury, the changed language will have little utility for appellate purposes.

One possible purpose of rewording the duty owed by a health care provider is to emphasize that the standard of acceptable medical care falls within a spectrum of professional behavior. The point is further made by other changes in this section which allow consideration of “all relevant surrounding circumstances.” This reading, though, is undercut by other parts of the Act. The level of care must still be recognized as “acceptable and appropriate” by the reasonable health care provider, returning one inexorably to the prior statute’s requirement of “accepted” standard of care.

Indeed, under the new wording, a reasonable argument can be made that a health care provider is placed under a greater burden to stay abreast of new medical technology and developments. The “prevailing” standard of care offered by the majority of modern medical providers may well be more exacting than the accepted standard of care. Further, under the Act, health care must not only be “acceptable” but must also be “appropriate” and in accord with prevailing professional standards. The Act seems to impose a greater number of more exacting duties on health care providers.

156. Id.
157. Id.
158. Id.

159. This rewording of the standard of care was originally proposed by the Subcomm. on Med. Mal. See Fla. H.R. PCB HC 85-2, sec. 8 (draft of Apr. 4, 1985). This proposed committee bill also contained language that required that the standard of care be “liberally construed in favor of health care providers.” Id. Provision was also made for consideration of respected minority opinions. Id. Both of these provisions were deleted from the bill in subcommittee due to strong opposition from consumer groups. Fla. H.R., Subcomm. on Med. Mal., tape recording of proceedings (Apr. 22, 1985) (on file with committee) (discussion of Amendment 28). Even though the Act appears to impose a greater spectrum of duties on providers, other changes in the health care system may help define and limit these duties. The adoption of prospective payment systems, such as Medicare’s diagnostic related groups (DRGs), may help standardize acceptable medical treatment under given circumstances. Similarly, utilization review may foster uniformity of a standard of care. See Medical Malpractice, supra note 127, at 8. Restriction of utilization, whether under a DRG system, a health maintenance organization, or a preferred provider organization (PPO), also offers a potential of increased liability exposure for both the provider and the entity controlling utilization. See Blumstein, Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis, 59 Tex. L. Rev. 1345, 1395-1400 (1981); Bovbjerg, The Medical Malpractice Standard of Care: HMOs and Customary Practice, 1975 Duke L.J. 1375; Note, Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting, 98 Harv. L. Rev. 1004 (1985); Comment, California Negotiated Health Care: Implications for Malpractice Liability, 21 San Diego L. Rev. 455 (1984). Under a PPO plan, a group of physicians or hospitals agree
In this same section, the Act increases the requirements for medical expert witnesses. The Act requires medical experts to have practiced or taught medicine within a five-year period prior to the malpractice incident at issue. This change was designed to deal with the professional medical expert, or "hired gun." It is questionable whether this change will accomplish a cost reduction in the malpractice system. Presumably, since a plaintiff must now have a more qualified expert, the plaintiff's case should be more thoroughly prepared. Also, the plaintiff's expert will be less open to attack on cross-examination for lack of practical experience or enjoyment of a large income derived from testifying as a medical expert. Further, experts with better medical qualifications would cost both sides more. Conversely, a requirement for experts with better practical qualifications could possibly decrease the frequency of frivolous or nonmeritorious malpractice suits.

F. Joint and Several Liability

The second substantive change in the claims resolution system occurs in section 20 of the Act, which deals with comparative fault and contribution in malpractice cases. Although this section is rather long, its changes are minimal, solely affecting the right of contribution among three or more medical, joint tortfeasors. The Act provides for a more equitable distribution of an insolvent defendant's share of a judgment among at least two solvent defendants, based on the proportionate share of fault of the solvent defendants. This change is patterned after the Uniform with an insurer to provide care for insured individuals at negotiated and typically discounted rates, subject to utilization guidelines. These guidelines may be used by plaintiffs to establish a minimum standard of care to which a provider must adhere or be attacked as falling below an acceptable standard of care, thereby exposing the entity which set the guidelines to direct liability.


161. This change was originally proposed in Fla. CS for HB 522, sec. 7 (1984), arising from a compromise position between the Academy of Florida Trial Lawyers and south Florida doctors.

162. The qualifications of a witness are initially determined by the court, effectively acting as a trier of fact. See Fed. R. Evid. 104(a); Fla. Stat. § 90.105(1) (1983). Because an expert witness' qualifications would be screened by the trial court and fully explored on cross-examination, the Tort Litigation Review Commission opposed increasing statutory requirements for medical experts. Tort Litigation Rev. Comm., supra note 154, at 59-63.


164. Id. (to be codified at Fla. Stat. § 768.59(3)).

165. Id. (to be codified at Fla. Stat. § 768.59(2)(c)). A large part of the impetus for including a provision in the malpractice bill affecting joint and several liability undoubtedly
Comparative Fault Act, which is altered in several significant aspects. Critically, the Malpractice Act does not provide for reallocation onto a plaintiff-at-fault. It applies only in medical malpractice cases. The Act retains current Florida law as to the effects of settlement, providing that a claim is reduced by the amount of

originated in response to the movement in the House to abolish the doctrine of joint liability among joint tortfeasors. See Fla. HB 1037 (1985), which passed the House but died on the Senate calendar. FLA. LEGIS., HISTORY OF LEGISLATION, 1985 REGULAR SESSION, HISTORY OF HOUSE BILLS at 142, HB 1037. In the Conference Committee’s consideration of HB 1352, the Senate conferees wanted partial abolition of joint liability, along the lines of the Uniform Comparative Fault Act, see infra note 166. However, under the rules, only the version in Fla. HB 1352, which affected contribution among joint tortfeasors, or Fla. HB 1037, which abolished joint liability completely, were available as options to the Senate conferees, who ultimately chose the former.

The joint liability doctrine has been under attack in recent years. However, only five of the less populous states, including Kansas, New Mexico, and Vermont, have abolished joint liability. See KAN. STAT. ANN. § 60-258a(d) (1983); Bartlett v. New Mexico Welding Supply, 646 P.2d 579 (N.M. Ct. App. 1982); VT. STAT. ANN. tit. 12, § 1036 (Supp. 1984). Approximately eight states have partially abrogated joint liability, typically abolishing the rule only when the plaintiff’s negligence exceeds the defendant’s. See, e.g., TEX. REV. CIV. STAT. ANN. art. 2212a, § 2(c) (Vernon Supp. 1985); LA. CIV. CODE ANN. art. 2324 (West Supp. 1985). Often, the motivation for abolition or partial abrogation of joint liability is to protect public entities from devastatingly large judgments when the public entity was only partially at fault. See Granelli, The Attack on Joint and Several Liability, 71 A.B.A. J. 60 (July, 1985) (citing several cases in which California cities faced paying multimillion dollar awards). This underlying justification for abolition of joint liability is particularly inappropriate in Florida where public entities, including cities, are already protected from judgments exceeding $100 thousand by sovereign immunity. See FLA. STAT. § 768.28 (Supp. 1984).

166. The Uniform Comparative Fault Act was originally approved by the National Conference of Commissioners on Uniform State Laws in 1977. See UNIF. COMPARATIVE FAULT ACT, 12 U.L.A. 40 (Supp. 1985). It provides for an insolvent defendant’s share of a judgment to be reallocated among all other defendants and plaintiffs, in accordance with relative degrees of fault. For example, assume plaintiff was 20% at fault, defendant A was 50% at fault, defendant B, 20%, and defendant C, 10%, and the judgment was for $100 thousand. If defendant A were insolvent, plaintiff could currently collect $80 thousand (for which he was not at fault) from either B or C. Under the Uniform Act, all solvent defendants and plaintiff must absorb a proportionate share of the insolvent amount ($50 thousand), based on relative degrees of fault. Thus, plaintiff would absorb two-fifths of the uncollectible $50 thousand ($20 thousand), defendant B, two-fifths ($20 thousand), and defendant C, one-fifth ($10 thousand). Defendant B would pay a total of $40 thousand and C a total of $20 thousand. Only Minnesota has adopted the Uniform Act, and has done so only in principle. See MINN. STAT. ANN. § 604.02 (West Supp. 1985). For a detailed and erudite explanation of the Uniform Act, see Note, The Modification of Joint and Several Liability: Consideration of the Uniform Comparative Fault Act, 36 U. FLA. L. REV. 288 (1984).

167. Ch. 85-175, § 20, 1985 Fla. Laws 1180, 1208 (to be codified at FLA. STAT. § 768.59(3)(a)). Reallocation onto the plaintiff was originally provided in the initial draft of the proposed committee bill. Fla. H.R. PCB HC 85-2, sec. 18 (Apr. 4, 1985). Reallocation was deleted in subcommittee due to opposition from consumer groups, and in recognition of the fact that relatively few medical malpractice cases involve jury findings of contributory negligence of the patient himself. Fla. H.R., Comm. on Health Care & Ins., tape recording of proceedings (Apr. 22-24, 1985) (on file with committee) (discussion of HB 1352 (1985)).
the settlement and the settling party is released from all liability for contribution. 168

The Act does, however, alter one part of the existing contribution statute, which prohibits any tortfeasor from paying contribution beyond his pro rata share. Under current law, when there are three or more defendants, an insolvent defendant's share is paid by whomever the plaintiff chooses; thus, a targeted defendant may be called upon to pay more than an equitable share. 169 Under the Act, a targeted defendant is placed in a better position to seek contribution, which may be collected in excess of a pro rata share if circumstances warrant. 170

This change should help targeted defendants, such as hospitals, seek more equitable contribution from solvent joint tortfeasors, such as doctors. Further, if one doctor is underinsured and another is overinsured, a hospital could seek excess contribution from the overinsured doctor, assuming that underinsurance is tantamount to uncollectibility under the Act.

There are problems in the complicated, interrelated area of indemnity and what effect, if any, the Act has on enhancing rights of indemnity. It is conceivable that a vicariously liable defendant, seeking recovery by way of indemnity, could recover less from a codefendant than a partially-at-fault defendant seeking contribution. 171 It is unclear whether reallocation principles of the Act can apply when indemnity is the basis of recovery.

168. See Ch. 85-175, § 20, 1985 Fla. Laws 1180, 1208 (to be codified at Fla. Stat. § 768.59(5)); Fla. Stat. § 768.31 (1983). The Uniform Act shifts the entire burden of estimating a settling tortfeasor's percentage of liability to the plaintiff. See UNIF. COMPARATIVE FAULT ACT, 12 U.L.A. 43 (Supp. 1985). For example, if a plaintiff settles with one defendant for $5 thousand when that defendant's fault is later determined to be 25% of a $100 thousand judgment, plaintiff absorbs a $20 thousand loss. This could easily discourage settlement and was deleted for that reason.

169. See Fla. Stat. § 768.31(2)(b) (1983). If defendant A were 50% liable but insolvent, B 30% liable, and C 20% liable, and C paid the entire $100 thousand judgment, C could only recover $30 thousand from B through contribution.

170. See ch. 85-175, § 20, 1985 Fla. Laws 1180, 1208 (to be codified at Fla. Stat. 768.59(4)). In the example at supra note 169, C could recover three-fifths of the insolvent amount ($50 thousand) from B, or $30 thousand in addition to B's proportionate share of the liability (30% of the $100 thousand), for a total of $60 thousand. B would pay only $40 thousand.

171. This would assume that in indemnity a codefendant is only liable for his pro rata share of the judgment. Indemnity is only available to a defendant who was held vicariously or indirectly liable. Direct fault of a defendant, however slight, bars indemnity recovery. See Houdaille Indus. v. Edwards, 374 So. 2d 490 (Fla. 1979). Certainly, a faultless defendant should be able to collect as much through indemnity as a partially-at-fault defendant could collect through contribution.
IV. MEDICAL MALPRACTICE INSURANCE

A. Financial Responsibility

The Act's only major change to the malpractice insurance system imposes financial responsibility requirements for physicians and osteopaths. These doctors are required, as of January 1, 1987, either to maintain an escrow account or to obtain malpractice insurance. Minimum levels are $100 thousand per claim, $300 thousand annual aggregate for doctors practicing outside of hospitals, and $250 thousand/$750 thousand for doctors with hospital staff privileges. The $100 thousand/$300 thousand requirement is a condition of licensure. The higher $250 thousand/$750 thousand level is a condition of hospital staff privileges, and is presumably enforceable by the hospital.

Mandatory financial responsibility requirements were initially recommended by the Insurance Advisory Council. The rationale of mandatory financial responsibility is three-fold. First, mandatory coverage ensures that victims of malpractice will receive at least certain minimum levels of compensation from the tortfeasor. Second, mandatory coverage effectively spreads the financial responsibility requirements across all doctors, regardless of the hospital's power to grant or deny staff privileges. The Act is unclear whether HRS could use hospital licensure powers under FLA. STAT. ch. 395 to coerce hospital compliance with this insurance requirement. Since the requirements appear in FLA. STAT. chs. 458 and 459 governing doctors' licensure, HRS's power to enforce this requirement is questionable.

172. Ch. 85-175, § 27, 1985 Fla. Laws 1180, 1214 (to be codified at FLA. STAT. § 458.320).
173. Id. § 28, 1985 Fla. Laws 1215 (to be codified at FLA. STAT. § 459.0085).
174. Id.; ch. 85-175, § 27, 1985 Fla. Laws 1180, 1214 (to be codified at FLA. STAT. § 458.320). Ironically, FLA. STAT. chs. 458 and 459, containing the financial responsibility requirements, are repealed on October 1, 1986, and must be reviewed pursuant to FLA. STAT. § 11.61 (1983) prior to that date. It is not altogether clear whether the new financial responsibility requirements survive this Sunset review. If not, they would be repealed prior to ever becoming effective.
175. Ch. 85-175, § 27, 1985 Fla. Laws 1180, 1214 (to be codified at FLA. STAT. § 458.320); id. § 28, 1985 Fla. Laws 1215 (to be codified at FLA. STAT. § 459.0085). The higher coverage requirement for hospital doctors appears to be predicated on the hospital's power to grant or deny staff privileges. The Act is unclear whether HRS could use hospital licensure powers under FLA. STAT. ch. 395 to coerce hospital compliance with this insurance requirement. Since the requirements appear in FLA. STAT. chs. 458 and 459 governing doctors' licensure, HRS's power to enforce this requirement is questionable.
176. See ADVISORY COUNCIL REP., supra note 10, at 23. This recommendation was endorsed by the Insurance Commissioner. See FLA. INS. COMM'R REP., supra note 24, at 25-26. The Governor's Task Force also recommended mandatory coverage. See GOV.'S TASK FORCE REP., supra note 10, at 121-22.
177. This rationale would certainly dictate that state and county doctors also meet minimum financial responsibility requirements to ensure compensation for injuries. Due to strong lobby opposition by state agencies and certain public hospitals in south Florida, state and county doctors were exempted from meeting any financial responsibility requirements. See ch. 85-175, § 27, 1985 Fla. Laws 1180, 1214 (to be codified at FLA. STAT. § 458.320(4)); id. § 28, 1985 Fla. Laws 1215 (to be codified at FLA. STAT. § 459.0085(4)). Mandatory insurance would have resulted in a partial waiver of sovereign immunity by these state doctors, to the extent of insurance coverage. See FLA. STAT. § 286.28 (1983); Ingraham v. Dade County
risk of loss among a larger number of doctors, and ultimately could lower insurance premiums of doctors who have voluntarily obtained coverage. Finally, mandatory coverage prevents certain hospitals from soliciting medical staff by declining to require malpractice insurance as a condition of hospital staff privileges.

House Bill 1352 originally required mandatory coverage in the amounts of $1 million per claim with a $3 million annual aggregate by August 1, 1987. In Conference Committee, the Senate opposed any mandatory financial responsibility requirements, but eventually the Senate conferees accepted the reduced requirements that appear in the Act. The effect of financial responsibility requirements for doctors is speculative. If DOI statistics are reliable, almost ninety-eight percent of doctors are already insured. Since required levels of coverage are relatively low, the Act may have almost no effect on increasing insurance coverage for Florida doctors.

Challenges should be expected to the constitutionality of requiring financial responsibility for doctors, both on the basis of denial of due process and equal protection. In the handful of states that have enacted mandatory insurance laws, the majority of these provisions have withstood constitutional challenge.

School Bd., 450 So. 2d 847 (Fla. 1984). The public agencies were concerned about increased financial exposure to injured patients, who are now limited to a maximum recovery of $100 thousand, exclusive of the political claims bill process through which a random minority of claimants with judgments receive additional compensation. FLA. STAT. § 768.28 (Supp. 1984). As a result of this exclusion, radiologists and anesthesiologists employed in a public hospital supported by a taxing district need not meet financial responsibility requirements; the same doctors employed in private hospitals must demonstrate financial responsibility. The Act inconsistently applies the insurance requirements to federally employed doctors who have Florida licenses.

178. According to DOI data, 98% of all Florida doctors have malpractice insurance, although the levels of coverage are unknown. About three-quarters of all Florida hospitals require doctors to carry malpractice insurance. More than one-half of these require coverage of $500 thousand or more. See Gov'ts Task Force Rep., supra note 10, at A-29. Given the current high percentage of coverage, one can assume that some insurance typically is available to compensate injured patients.

179. See supra note 23.

180. Fla. H.B. 1352, sec. 27 (1985). Minimum limits of $1 million/$3 million were passed by the House based on DOI data showing those limits to be the median level of coverage in Florida. See Memorandum from J. Vogel to D. Hazlett, (Mar. 1, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.) (discussing the limits of medical malpractice liability insurance).

181. See supra note 23.

182. See supra note 178.

183. See generally Note, Constitutionality of Requiring Physicians and Other Health Care Providers to Carry Malpractice Insurance, 7 W. St. U.L. Rev. 75 (1979). State courts in Idaho, Kansas, and Pennsylvania have rejected constitutional challenges to mandatory
follow this trend when reviewing the Act’s financial responsibility requirements, the constitutionality of the requirements should be sustained.\textsuperscript{184}

\textbf{B. Group Malpractice Insurance}

As previously mentioned, the Act specifically allows health care providers to join together to purchase a group medical malpractice policy.\textsuperscript{188} Section 23 describes one possible type of group malpractice policy that a hospital, at its option, may purchase to cover negligent acts of its medical staff. The cost of this policy can be passed on to the medical staff.\textsuperscript{186} As another option, a hospital may require its staff member to pay a deductible amount.\textsuperscript{187} As these provisions are all optional, this part of the Act merely encourages more efficient insurance arrangements in which the hospital takes on the primary role. Nothing is mandated.\textsuperscript{188}

In contrast, the 1985 New York Legislature passed a medical malpractice law which significantly altered the New York malpractice insurance system.\textsuperscript{189} The New York law requires that all malpractice insurers offering policies with primary limits of $1 million per claim/$3 million annual aggregate, or greater, must provide identical $1 million/$3 million excess coverage. Moreover, the insurer must provide any additional, requested excess coverage, subject to the insurance superintendent’s approval. This law essen-

\textsuperscript{184} The Florida Supreme Court has generally required merely a rational basis to support the constitutionality of malpractice legislation. See Pinillos v. Cedars of Lebanon Hosp. Corp., 403 So. 2d 365 (Fla. 1981). Unless a stricter standard is applied, the constitutionality of mandatory malpractice insurance seems assured.

\textsuperscript{185} See supra note 17, and accompanying text. Group policies are sanctioned by the Act. See ch. 85-175, § 22, 1985 Fla. Laws 1180, 1211 (amending FLA. STAT. § 626.973 (1983)).

\textsuperscript{186} Ch. 85-175, § 23, 1985 Fla. Laws 1180, 1211 (to be codified at FLA. STAT. § 768.60). \textsuperscript{187} Id. (to be codified at FLA. STAT. § 768.60(2)).

\textsuperscript{188} See id. These optional group insurance plans were proposed by the Florida League of Hospitals as a substitute for the hospital vicarious liability provision which was deleted due to strong opposition from hospital lobbies. See supra note 17, and accompanying text. 

\textsuperscript{189} Ch. 294, 1985 N.Y. Laws.
tially mandates that excess insurance coverage be made available to a doctor or hospital requesting such coverage. 190

The New York law contains another innovative approach to malpractice insurance. Hospitals that render emergency medical care must provide the excess malpractice coverage of $1 million/$3 million for each member of their emergency medical staff. The New York law mandates that hospitals take on the primary role of purchasing excess coverage earmarked for their emergency care staff. This law moves in the direction of efficiently channeling malpractice claims through the health care facility, rather than targeting individual doctors. 191

Because the malpractice malaise is primarily a concern over high malpractice insurance rates, a legislative focus on malpractice insurance itself would seem to be of first order. The Florida Legislature could be expected to examine the lead of New York in reorganizing the basic malpractice insurance system, and in future sessions move toward significant reforms in this critical area. 192

190. Id. Many Florida hospitals opposed a proposal in the committee version of HB 1352 that would have imposed vicarious liability on hospitals for the negligence of their medical staff. Hospitals based their objections on the unavailability of excess insurance and reinsurance. FLA. LEAGUE OF HOSPITALS, POSITION PAPER, ECONOMIC IMPACT OF PCB 85-2, SECTION 21 at 3 (May 8, 1985) (on file with Fla. H.R. Comm. on Health Care Ins.). The New York approach of mandated excess insurance could be used to dispel some of this concern. See infra notes 97-110 and accompanying text.

191. Ch. 294, 1985 N.Y. Laws. See also infra notes 195-211 and accompanying text. In both New York and Florida, hospitals have been held vicariously liable on agency principles for the negligence of their emergency room doctors. A mandate that a hospital provide excess coverage is eminently pragmatic and serves both the hospital and the staff doctor. See Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527 (N.Y. App. Div. 1976); Irving v. Doctors Hosp. of Lake Worth, Inc., 415 So. 2d 55 (Fla. 4th DCA 1982).

192. The Act also contains several minor malpractice insurance reforms. The Act requires an insured to cooperate with the 90-day pre-suit screening process. The insurer is given ultimate authority to settle a case. Ch. 85-175, § 6, 1985 Fla. Laws 1180, 1187 (to be codified at FLA. STAT. § 627.4147). See also supra notes 68-78 and accompanying text. According to a national survey, the “single most important impediment to settlement was reported to be the defendant’s right to refuse to allow a settlement.” W. CURRAN, HOW LAWYERS HANDLE MEDICAL MALPRACTICE CASES: AN ANALYSIS OF AN IMPORTANT MEDICOLEGAL STUDY at 17 (Feb. 1977) (U.S. Dept. of Health, Educ. and Welfare; National Center for Health Servs. Research Rep. Ser.; D.H.E.W. (Pub. No. (HRA) 77-3152). The Act also requires a malpractice insurer generally to give 60 days notice before cancellation. Ch. 85-175, § 6, 1985 Fla. Laws 1180, 1187 (to be codified at FLA. STAT. § 627.4147(1)(c)). This notice period was added after complaints were received from south Florida neonatologists whose policies had been perfunctorily cancelled by their malpractice insurers. Finally, insurers are authorized to require their insureds to be members in good standing of local professional societies with medical review committees. Id. (to be codified at FLA. STAT. § 627.4147(2)). This change is designed to encourage greater participation in risk management and peer review at the local, professional society level. See supra note 23.
V. Key Deleted Provisions

The original bill proposed by the Subcommittee on Medical Malpractice contained two provisions that represented dramatic and progressive changes to the basic medical malpractice system. The first of these proposals would have imposed vicarious liability on a hospital for the negligent acts of the hospital’s medical staff. The second proposal would have capped doctors’ malpractice insurance premiums at a level based on the individual doctor’s income. Both of these far-reaching changes were deleted due to lobbying by medical groups. They are examined here in anticipation of their resurrection in future sessions.

A. Hospital Vicarious Liability

The Subcommittee on Medical Malpractice proposed a most fundamental change in the medical malpractice system: hospitals and other health care facilities would become legally responsible for all acts committed in furtherance of the hospital medical care complex. The hospital’s liability would be vicarious, not direct. It need commit no negligent act to be held liable for negligence of its medical staff, just as an employer or principal is vicariously liable, regardless of his own lack of fault, for the negligence of an employee or agent.

This proposed change echoed a basic shift in the status of the hospital within the modern health care complex. The hospital is no longer merely the “doctor’s workshop,” furnishing facilities and equipment. Rather, it is the center of an incredibly complicated and technologically advanced organization providing comprehensive health care. The public perceives the hospital as the quintessence of the modern health care system:

The community hospital has evolved into a corporate institution,

194. Id. sec. 22.
195. See supra note 15 for the original language of the hospital liability provision in Fla. H.R. PCB HC 85-2 (1985). This language was altered twice before its eventual deletion. First, the full House Comm. on Health Care & Ins. exempted noninvasive, medical diagnoses from medical acts for which a hospital would be vicariously liable. Fla. H.R., Comm. on Health Care & Ins., tape recording of proceedings (Apr. 29, 1985) (on file with committee) (discussion of Amendment 1). Second, the bill was amended in the House Comm. on Approp. to limit the amount of damages for which a hospital could be vicariously liable. Fla. H.R., Comm. on Approp., tape recording of proceedings (May 7, 1985) (on file with committee). Both amendments were included in a futile effort to make the vicarious liability principle acceptable to hospital interests.
assuming "the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care." The patient treated in such a facility receives care from a number of individuals of varying capacities and [is] not merely treated by a physician acting in isolation. The patient relies upon the effectiveness of this "highly integrated system of activities ...." Consequently, "[t]he concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact. The complex manner of operation of the modern-day medical institution clearly demonstrates that they furnish far more than mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons, nurses, administrative and manual workers and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid. Certainly, the person who avails himself of our modern 'hospital facilities' (frequently a medical teaching institution) expects that the hospital staff will do all it reasonably can to cure him and does not anticipate that its nurses, doctors and other employees will be acting solely on their own responsibility."  

Time and health care have thus changed.

In the shadow of this increasingly integrated medical care complex, a consensus has arisen that the current negligence system does not effectively prevent medical malpractice or serve to realign the incompetent or marginally incompetent doctors. Recognizing that between seventy-five and eighty percent of medical malpractice occurs in hospitals, one has to conclude that the entity best able to control this health care environment must do so and be encouraged to do so with diligence. The question recurs as how

197. See Note, Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine, 10 AM. J.L. & MED. 115, 120 (1984); Note, supra note 18, at 350 & n.64.
198. Note, supra note 18, at 353.
199. "[T]he hospital is in the best position to evaluate the competence of physicians .... as it constitutes the only institutional 'vehicle available to coordinate the delivery of health care of reasonable quality to large numbers of people .... .'" Elam, 183 Cal. Rptr. at 164 (quoting Southwick, The Hospital as an Institution-Expanding Responsibilities Change its Relationship with the Staff Physician, 9 CAL. W.L. REV. 429, 466 (1973)).
best to achieve this.

As health care has become increasingly centralized and institutionalized within the hospital complex, the law has acknowledged the increased control of these institutions over the health care system and has steadily imposed more liability on the hospital for medical injuries occurring within the facility. Increased control has fostered increased responsibility, which will ultimately engender legal liability. As Professor Southwick, accurately observes in his excellent article:

The trend toward increased imposition of vicarious liability upon the hospital has been observable for more than two decades. When medical care is provided by a highly specialized, sophisticated team of professional individuals all working within an institutional setting, it is frequently difficult to determine at any given point in time who is exercising direct control over whom. Where such difficulty in determination arises, it is only natural and logical that ultimate liability be placed upon the corporate institution and not upon the private physician.\(^2\)

As hospitals assume greater roles in coordinating and overseeing the delivery of comprehensive health care, distinctions between individual physician responsibility and institutional responsibility are increasingly difficult to support. Compartmentalization of health care providers according to artificial legal concepts, such as that of independent contractor, has simply become inappropriate.\(^3\)

Vicarious liability for hospitals acknowledges the hospital's true position in the medicolegal system. This concept comports with reasonable patient expectations. For patients, the hospital is the linchpin in the medical care complex. Patients are undoubtedly surprised to learn that hospitals may have no responsibility for negligent acts of medical staff doctors committed under the auspices and protocols of the hospital. Vicarious liability also recognizes that hospitals and doctors receive mutual economic benefits from the health care enterprise, and that these benefits are ines-

\(^2\) Southwick, Hospital Liability: Two Theories Have Been Merged, 4 J. LEGAL MED. 1, 16 (1983). Professor Southwick convincingly argues that the formerly independent theories of hospital corporate negligence and vicarious liability have merged into a single concept of hospital responsibility. Id.

\(^3\) "It should rather be acknowledged that, in the hospital setting, there is no longer a viable distinction between the rules of respondeat superior [vicarious liability], on one hand, and corporate or independent negligence, on the other." Id. at 46.
capably symbiotic. Since the benefits of a doctor's hospital practice are derivative to the hospital, logically the hospital's liability for the doctor's acts should also be derivative.²⁰²

Significant advantages to society are gained through imposition of hospital vicarious liability. Hospitals have an economic stake in pursuing effective risk management with vigor, since they are the party responsible for all negligence occurring within the hospital. Vicarious liability effects a system of “channeling,” whereby an injured patient need sue only the single responsible organization. Since there is no need to prove a separate negligent act by the hospital in failing to monitor a negligent doctor, the problems associated with proving the hospital's notice by means of sensitive disciplinary or patient records are entirely avoided by expanding hospital vicarious liability.²⁰³ Further, the health care organization can better spread the risk of loss from malpractice over its broader financial base. Consolidation of liability would allow hospitals and doctors to lower defense costs by allowing presentation of a uniform, common defense. This could well encourage earlier settlements of meritorious claims since fighting among defendants and their insurers over who is to blame for an obvious incident of malpractice would be largely eliminated.²⁰⁴ Consolidation of risks would allow simplification of the present insurance system by concentrating insurance coverage on the hospital rather than on individual doctors.²⁰⁵ Development of joint liability insurance pro-

²⁰². Prof. Southwick also implies that hospitals may not be able to delegate to a physician, as an independent contractor, a duty of care owed to the public or community at large. Further, if hospital care could be considered an inherently dangerous activity, the hospital could not delegate to doctors its duty of patient care. See id. at 5.

²⁰³. See supra notes 32-35 and accompanying text. Because a plaintiff would have such a difficult time gathering proof of a hospital's notice that a doctor has previously been negligent, the fear of hospital corporate liability based on its negligence may prove an inadequate incentive to effectively manage risks.

²⁰⁴. See Note, supra note 18, at 352-54 & n.84.

²⁰⁵. The American courts have always favored doctrines that result in simplification of rules on the liability of an enterprise for injuries to the public it serves. Simplification leads to reducing the need for lengthy and complex litigation. . . . [T]his simplification also usually results in lower costs of insurance, since the administrative costs of investigation and trial are substantially reduced. Economies of scale are achieved by concentrating insurance coverage in the corporate structure rather than individualizing costs and claims reserves around each practicing physician, which is further complicated by the different premium rates for the various medical specialties. This complex rate structure would no longer be necessary if coverage were provided at the hospital level.

grams should result in lower insurance costs.\textsuperscript{206}

These compelling reasons have led several authorities to support the concept of vicarious liability for hospitals. The American Bar Association, through its Commission on Malpractice, recommended for serious consideration the advantages when hospitals assume responsibility for the negligent acts of their medical staff.\textsuperscript{207} Professor Southwick is one of the most consistent supporters of hospital vicarious liability.\textsuperscript{208} Other medical malpractice commentators also recommend adoption of this concept.\textsuperscript{209}

When hospital vicarious liability was proposed by the House Subcommittee on Malpractice, hospitals raised one overriding and ostensibly cogent objection: vicarious liability will raise hospital malpractice insurance rates.\textsuperscript{210} Assuming that hospitals and doctors continue to buy separate policies from separate insurers, as is currently done, this objection may have merit. But such an assumption is not valid. Indeed, the entire thrust of hospital vicarious liability is unification of liability concurrent with unification of insurable risks. As such, the only sensible insurance scenario under a system of joint liability is joint liability insurance:

Although it would be very difficult to accomplish in an industry still characterized as being engaged in free enterprise, it is

\begin{itemize}
\item \textsuperscript{206} Until legal liability of doctors and hospitals is actually consolidated through principles of vicarious liability, cosmetic efforts to implement joint insurance policies naming doctors and hospitals as coinsureds are futile. These parties will still have adverse interests under a system that can impose total fault for a malpractice incident on the doctor alone. Under the current system, hospitals have an adverse interest in establishing total fault on the doctor as an independent contractor. Group insurance under such adversarial circumstances is not pragmatic. Shared liability and responsibility is an essential part of a successful group insurance program.

\item \textsuperscript{207} ABA, REPORT OF THE COMMISSION ON MEDICAL PROFESSIONAL LIABILITY 54, 85-86 (Oct. 1977) (on file with Fla. H.R. Comm. on Health Care & Ins.); see also Note, supra note 10, at 353 n.82, for other authorities making the same proposal.

\item \textsuperscript{208} See generally Southwick, supra note 200.

\item \textsuperscript{209} Curran, supra note 205, at 704-05; see also Note, supra note 18, at 353-54. One commentator has recently proposed a rebuttable presumption of joint hospital-physician liability whenever failure to adequately hospitalize patients or order tests results in medical injury. The presumption would apply automatically to those patients receiving care under Medicare's diagnostic related group (DRG) reimbursement scheme. See Note, Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting, 98 HARV. L. REV. 1004, 1019-22 (1985). DRGs are a cost-cutting system which allow a predetermined rate of reimbursement for a patient's DRG classification, regardless of services rendered. The Harvard Law Review commentator asserts that both the hospital and physician should share equally in the increased risk of malpractice suits brought about by these cost-cutting efforts under Medicare. One problem with such a presumption is the possibility of increased litigation between hospitals and physicians over the application of the presumption itself. Id. at 1021.

\item \textsuperscript{210} Fla. LEAGUE OF HOSPITALS POSITION PAPER, supra note 25.
\end{itemize}
time for the hospital, all its employees, and all physicians admitted to membership on the medical staff to be insured by the same insurance carrier. This would do much to eliminate the damage that results from the casting of blame or fault upon codefendants in the context of litigation. It would also do much to reduce the costs and the excessive length of the litigation process. When the doctor is insured by one carrier and the hospital by another, there is strong incentive to advance the classical defenses to respondeat superior and to maintain distinctions between vicarious and direct liability of the hospital. In the long run this is unproductive and very costly to the health care industry as a whole. In turn, it is costly to patients.

Short of hospitals and staff physicians joining together to be insured by the same carrier, agreements should be developed between carriers for hospitals and physicians respectively to share joint liability in negligence or malpractice cases arising in the hospital or institutional setting. Rather than attempting to cast liability upon the doctor, for example, the hospital carrier should simply agree to share liability with the doctor’s carrier. Likewise, the reverse would be true. Over the longer term, savings in both cost and trauma would likely be realized. Hospitals and physicians have more to gain than lose by cooperating with each other on the development of joint liability insurance programs to facilitate claim settlement and to provide for payment of judgments that may be rendered. Continuation of the current adversary relationship among multiple defendants can only result in continually escalating costs.¹¹

Simplification of the overall malpractice insurance system through legal consolidation of insurable risks will inevitably be more efficient and serve society more effectively.

Hospital vicarious liability is an innovative principle. As such, it was met with hostility and mistrust when proposed by the Subcommittee on Malpractice. This concept is also progressive. For these reasons, it can be expected to reappear in the medical malpractice arena.

²¹ Southwick, supra note 200, at 49-50 (footnote omitted). Prof. Southwick notes that this system has long been in operation in England, where doctors are considered employees of the hospital. Id. at 49 n.122. See also supra note 190. Consolidation of insurance would also eliminate any need for a hospital to seek indemnity or contribution against its staff doctor whose negligence has caused the hospital to be held vicariously liable. Since one insurer would cover both the hospital and its doctors, probably under a single group policy, the insurer would have no need to seek indemnity or contribution from its own insured doctor. This elimination of indemnity and contribution actions serves to further reduce costs to the entire system.
B. Caps on Malpractice Insurance Premiums

A second, fundamental restructuring of the malpractice system was also proposed by the House Subcommittee on Malpractice, but was deleted in Conference Committee. The bill proposed, through the Florida Medical Malpractice Joint Underwriting Association (FMMJUA), a malpractice premium cap for physicians and osteopaths. These doctors would be able to buy insurance from the FMMJUA, with a maximum premium equal to the greater of $5 thousand or fifteen percent of the individual doctor's gross medical income. The FMMJUA would write insurance up to $1 million.

212. The FMMJUA ensures that medical malpractice insurance is available on an involuntary basis. See Fla. Stat. § 627.351(4) (1983). Health care providers who are unable to obtain coverage, either because they are involved in high-risk specialties or because of unfavorable claims experience, can obtain insurance from the FMMJUA, although at expectedly higher rates. Florida law requires that most liability insurers participate in the FMMJUA, effectively pooling high-risk medical insureds among all liability insurers. Rates set by the FMMJUA are, in theory, actuarially sound. If a deficit does occur, insureds may be assessed up to one-third of their yearly premium. Remaining deficits are absorbed by the participating insurers, on a pro rata basis. Id.

213. Relevant parts of the special risk category, appeared in the proposed committee bill as follows:

627.351 Insurance risk apportionment plans.—

(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.—

(d) . . . The plan shall include, but shall not be limited to:

4. Establishment of a special risk category, which includes a premium cap on the rates paid by physicians licensed under Chapter 458 and osteopaths licensed under Chapter 459, equal to the greater of $5,000 or 15 percent of the physician's or osteopath's gross income derived from the delivery of medical services. A physician or osteopath seeking the imposition of the premium cap on his rates shall have the burden of establishing his gross income derived from the delivery of medical services to the association's satisfaction.

6. . .

(e) The underwriting deficit which exists for the special risk category in subparagraph (d) 4. for any policy year shall be recovered first from the Florida Medical Malpractice Trust Fund, created from the following sources:

1. Each insurer, self-insurer, and Joint Underwriting Association, in addition to taxes imposed elsewhere, shall annually pay to the Department of Revenue, a surcharge on medical malpractice premiums collected from physicians licensed under Chapter 458, osteopaths licensed under Chapter 459 and health care facilities licensed under Chapter 395, equal to 10 percent of the gross amounts of such premium receipts. The insurer's payment of this surcharge shall be a condition precedent to doing business in this state. . .

2: If there is any remaining special risk category deficit under the plan after maximum collection of the premium contingency assessment, after collection from the Florida Medical Malpractice Trust Fund, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct pre-
Doctors qualifying for the premium cap would be part of a “special risk category.” Deficits produced by this premium cap would be primarily subsidized by a ten percent surcharge on malpractice insurance premiums of hospitals and doctors. Any remaining special risk deficit would be paid by participating insurers, partially offset by a fifty percent tax credit.

miums of each such member written during the calendar year immediately preceding the end of the policy year for which there is a deficit assessment bears to the aggregate net direct premiums written in this state by all members of the association. The term “premiums” as used herein means premiums for the lines of insurance defined in s. 624.605(1)(b), (k), and (q), excluding homeowner’s, mobile home, and farm owner’s casualty, including premiums for such coverage issued under package policies. Any company which is assessed for an underwriting deficit under this paragraph shall receive a 50 percent tax credit, of the amount assessed, against its state income tax payable under Chapter 220, Florida Statutes.

Fla. H.R. PCB HC 85-2, sec. 22 (Apr. 4, 1985) (words in struck through type are deletions from existing law; words underlined are additions).

214. The FMMJUA can presently write limits of $250 thousand/$750 thousand. See Fla. Stat. § 627.351(4) (1983). This was not altered by the Malpractice Reform Act. Increases in the current FMMJUA limits were recommended by the Insurance Commissioner. Fla. Ins. Comm’s Rep., supra note 176, at 25 (limits should be $1 million/$3 million and $2 million/$4 million). The limits of $1 million/$3 million in Fla. H.R. PCB HC 85-2 also coincided with original mandatory malpractice limits.

215. DOI projections showed that the 10% premium surcharge would produce approximately $31.7 million with FMMJUA limits of $1 million/$3 million. At FMMJUA limits of $500 thousand/$1.5 million, the surcharge still produces $29.1 million. DOI also projected that only $27 million in subsidy was needed for the special risk category, capped at 15% of a doctor’s gross medical income. See Memo from B. Bodiford to Rep. A. Simon (May 9, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.) (discussing income limitations on malpractice premiums). Doctors’ income by specialty was derived from the Gov.’s TASK FORCE REP., supra note 10, at A-35, which produced an average annual income for all specialties of $184,281, using the weighting of the study. According to a recent survey, Florida’s doctors gross one-fourth more than the national average and also net more than doctors in all other states. See Owens, How Doctors’ Economic Profiles Vary in 13 Major States, Med. Econ. 242, 246-47 (Feb. 6, 1984).

216. Due to the predilection of the House Comm. on Fin. & Tax. to generally oppose tax credits, the committee deleted this tax credit when it heard the bill. Fla. H.R. Comm. on Fin. & Tax., tape recording of proceedings (May 6, 1985) (on file with committee). Of the 20 states with medical joint underwriting associations, 6 states have tax credit provisions to offset deficits of the joint underwriting association. Most of these provisions are 100% credits. See, e.g., ALA. CODE § 27-26-29 (1975); ILL. ANN. STAT. ch. 73, § 1065.214 (Smith-Hurd 1985); MINN. STAT. ANN. § 62F.06 (West Supp. 1985). Colorado allows a 50% tax credit, similar to that proposed in Fla. H.R. PCB HC 85-2 (draft of Apr. 4, 1985). See COLO. REV. STAT. § 10-4-908 (Supp. 1984). HB 1352 was amended on the House floor to allow limited deficit assessments against participating doctors, effectively increasing their potential exposure for malpractice premiums. FLA. H.R. JOUR. 393 (Reg. Sess. May 16, 1985) (adoption of Substitute Amendment 3). The entire special risk category was deleted in Conference Committee due to the Senate’s opposition. FLA. S. JOUR. 982 (Reg. Sess. May 30, 1985) (Conference Committee Report on HB 1352); FLA. H.R. JOUR. 1104 (Reg. Sess. May 30, 1985) (Conference Committee Report on HB 1352). See supra note 23.
The special risk category was essentially the product of the House Subcommittee on Malpractice. The purpose of this section was to ensure that malpractice coverage was not only available, but also affordable. Affordability was defined in terms of percentage of a doctor’s gross medical income, based on the premise that doctors with a greater medical income could afford to pay higher malpractice rates. Doctors who would qualify for the special risk category are generally high-risk specialists such as surgeons, obstetricians/gynecologists, and anesthesiologists. These doctors generally pay disproportionately high malpractice rates due to the risks associated with their areas of practice.

The special risk category created a mechanism by which doctors paying disproportionately high malpractice rates could be subsidized by other sources dependent upon these health care specialists. Hospitals and general practitioners were both included in the subsidizing class because they rely heavily upon high-risk specialists for the delivery of comprehensive medical services.

High-risk specialists serve a vital role in the delivery of health care. This group is, however, the primary target of malpractice suits and accordingly pays extraordinarily high malpractice premi-


218. See supra note 23.

219. Based in part on rate increases effective July 1, 1985 by St. Paul Fire and Marine Insurance Co., Florida’s largest medical malpractice insurer, DOI, Bureau of Rates, estimated that the average Florida doctor’s insurance rate in 1985 is about $10,300. See memorandum from J. Vogel to F. Hawkes (July 19, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.) (estimating average liability insurance). This average is extremely low when compared to the highest rate of $92,600 charged by St. Paul’s for neurosurgeons in Dade and Broward Counties. Dept. of Ins. & Treasurer, Bureau of Rates, Physicians and Surgeons Professional Liability Rates Schedule (July 9, 1985) (on file with Fla. H.R. Comm. on Health Care & Ins.). There are only about 133 neurosurgeons in Florida. Similarly, obstetricians in Dade and Broward pay $73,100 for St. Paul’s coverage, although obstetricians in other counties pay $48,800. Id. The lowest rates charged by St. Paul are to family physicians not in Dade or Broward Counties who perform no surgery, amounting to $5,900. Id. Family practice doctors comprise the largest category of physician insureds, exceeding 5,000. Rates are based on limits of $1 million/$3 million.

220. Other subsidizing sources were considered in the initial drafting of Fla. H.R. PCB HC 85-2 (draft of Apr. 4, 1985). One such alternative source was a gross receipts tax on medical services. This tax has the advantage of spreading the subsidization across a very broad base of health care delivery. Since the entire health care system depends heavily on high-risk specialities, broad allocation of the subsidy throughout the health care system is warranted and achieves optimum socialization of malpractice insurance costs. A second alternative source considered was a hospital staff privileges fee. Since highly specialized doctors typically center their practices in hospitals, staff membership gives the general practitioner access to these specialists. A fee for staff privileges would also discourage doctors from spreading their practices too thinly through multiple staff memberships.
ums. If the medical malpractice problem is really one of excessive malpractice insurance rates, a systematic approach dictates that this high-risk group must have its rates controlled. The special risk category would have done exactly this. By capping malpractice rates based on gross income, the proposal effectively controlled the maximum amount any Florida doctor would have to spend from his income for malpractice insurance. The costs of capping these rates would then have been spread across the health care system, defraying the impact of these extraordinary rates. In this manner, malpractice insurance affordability problems could have been resolved.

VI. Conclusion

Florida's new malpractice legislation represents the first significant effort in ten years by the legislature to deal with specific problems in the area of medical malpractice. Its major innovations affect medical risk prevention by allocating greater duties and powers to health care facilities in a scheme of comprehensive risk management. Discreet reforms affecting the claims resolution system and insurance system complement risk prevention reform.

Nevertheless, the Comprehensive Medical Malpractice Reform Act of 1985 may be more notable for what it lacks than for what it provides. Radical tort reforms advocated by medical interests, such as limiting damages for pain and suffering or abolition of joint and several liability, are conspicuously absent from the Act. Also absent are important preventive reforms such as hospital vicarious liability and much needed malpractice insurance reforms such as limits on malpractice insurance rates. The Act has left much undone. It remains to be seen whether the Florida Legislature ultimately will choose simply to limit the rights of malpractice victims or to attack the problems of medical malpractice in a more perspicacious fashion.