

DRAFT

Select Committee on

Medical Liability Insurance Report

March 2003



Florida House of Representatives

Speaker Johnnie Byrd

J. Dudley Goodlette, Chair

DRAFT



Speaker Johnnie Byrd
Florida House of Representatives

Select Committee on Medical Liability Insurance Report March 2003

Members

**J. Dudley Goodlette, Chair
Donald D. "Don" Brown
Gaston I. Cantens
Dan Gelber
Carole Green
Gayle B. Harrell
David Simmons
Christopher L. "Chris" Smith
Eleanor Sobel**

Staff

**Ed H. Moore, Staff Director
Margaret Cochran, Senior Administrative Assistant
Michael Billmeier, Project Coordinator & Senior Attorney, Committee on Judiciary
Tom Cooper, Project Coordinator & Chief Attorney, Committee on Insurance
Glen Mitchell, Project Coordinator & Senior Legislative Analyst, Committee on Health Care**

**317 The Capitol
402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 487-2290**

Table of Contents

Executive Summary	3
Section One -- Medical Liability Insurance Historical Issues	14
Section Two —Health Care Issues and Patient Safety Issues and Options	20
Section Three —Liability Issues	49
Section Four —Insurance Issues	70
Appendix I —Managed Care and Government Reimbursement	
Appendix II —Suggested Legislation	
Appendix III —Institute of Medicine “To Err is Human”	
Appendix IV —NGA Best Practices Report	
Appendix V —Florida Court Cases	
Appendix VI —Chapters 766, F. S.	
Appendix VII —ER Sovereign Immunity	
Appendix VIII —Select Committee on Medical Liability Insurance Agendas	
Appendix IX —GTF Approved and Not Approved	
Appendix X —Alternative Insurance Products-Hybrid Solutions	
Addendum Table of Contents	

FLORIDA HOUSE SELECT COMMITTEE
ON MEDICAL LIABILITY INSURANCE

J. DUDLEY GOODLETTE, CHAIRMAN

MARCH 2003

"These are very vexing issues, and what we have to do is to seek the Wisdom of Solomon to find the solutions."

House Speaker Johnnie Byrd
Office of the Speaker
Florida House of Representatives
402 South Monroe Street
Tallahassee, Florida 32399-1300

March 5, 2003

Mr. Speaker:

At your request the House Select Committee on Medical Liability Insurance has conducted an inquiry into the possible causes and potential solutions to the vexing problems associated with the availability of medical liability insurance in Florida. We have focused on the current and future impacts of this crisis on the access and availability of quality health care for both the citizens and visitors to our state.

Following is the work product of this committee. We have endeavored to explore all aspects of this issue, including detailed reviews of the several significant industries impacted by the associated problems: especially health care, the legal profession and related litigation issues, and the insurance industry. All of these professional areas serve as significant components of the Florida economy and each is a critical component of maintaining the quality of life all Floridians should expect.

Our intent, throughout this effort, has been to create a report which will be a useful tool for the Florida House of Representatives to begin to examine potential legislative solutions. We began this process with no preconceived notions about quick fixes or easy solutions. If solutions to these problems facing Florida's health care system were easy, we would not have needed this major effort as the last two major crises in liability insurance would have engendered effective solutions and we would not be where we are today.

We have coordinated our efforts with the respective substantive committee Chairmen and staffs in order to maximize the resources of the House in examining the multiple areas of concern. Our report is divided according to the appropriate topical sections in order to easily focus House resources as we move forward.

It has been a pleasure working with the dedicated Members of the House who were appointed by you to this Select Committee. I remain available to assist the House as these important public policy issues are deliberated.

Sincerely,

J. Dudley Goodlette, Chairman
House Select Committee on Medical Liability Insurance

Executive Summary

The Speaker of the House created the Select Committee to focus House efforts on the availability and access to health care services for our citizens while trying to find acceptable solutions to the problems associated with insurance coverage for service providers.

House Speaker Johnnie Byrd appointed the House Select Committee on Medical Liability Insurance, chaired by Rep. J. Dudley Goodlette. Other members of the Select Committee included Representatives: Don Brown, Gaston Cantens, Dan Gelber, Carole Green, Gayle Harrell, David Simmons, Christopher Smith and Eleanor Sobel. The Select Committee held a series of meetings in Tallahassee which were rich in content on issues related to the crisis. The Committee also held four hearings in four cities outside of the capital, Miami, Fort Lauderdale, Orlando and Tampa. Agendas from these meetings are included in the appendix to this report.

The Select Committee was charged with seeking potential solutions to the rapidly escalating crisis. Committee meetings served as focal points for discussion of the critical issues affecting several industries within Florida touched by this crisis. Few issues come before the Legislature involving as many critical constituencies, with each stakeholder playing an integral role in the economic well being of Florida. Further, there are few issues where inaction has the potential for such negative consequences as those that might befall the delivery of health care services for our citizens if effective solutions are not crafted this year.

The Select Committee solicited initial input from all of the affected stakeholders and part of the record supporting this report is included in the appendix. The Select Committee endeavored to examine every aspect of this problem with the underlying resolve that the primary goal is to find ways to preserve and protect access to quality health care services in all specialties throughout Florida. We conducted a detailed examination of how the reduced availability of affordable medical liability insurance affects the availability of medical services. The Committee was also mindful of the need to maintain the right of access to redress when citizens are harmed during the delivery of medical services.

The Committee endeavored to pursue every conceivable option and considered a multitude of possible remedies to the problems in the health care system. We sought the creation of a more permanent process and structure in order to avoid the cyclical nature of this problem as it is clear that the reforms adopted in prior legislative activities have been unsuccessful in creating an environment that offers available and affordable insurance coverage while protecting the health care needs of our citizens and visitors. We must strive to create an environment that fosters systems of medical care and insurance coverage that rely more on market solutions. The public need for access to quality health care should be the overriding concern.

We examined the records from previous Task Force efforts during prior crises in Florida as well as the records of the legislative bodies that examined these issues and presented legislation to attempt to remedy the problem. It is regrettable, but evident, that these efforts have come up short in creating remedies for the vexing issues we continue to address.

The Select Committee was staffed by House staff members from four different committees of the Florida House of Representatives which is reflective of the complexity of these issues. Ed Moore, Staff Director of the House Policy Committee served as Staff Director of the Select Committee. Tom Cooper served as a Project Coordinator for the Select Committee and is Chief Attorney for the Committee on Insurance. Michael Billmeier served as a Project Coordinator for the Select Committee and also serves the House as Senior Attorney for the Committee on Judiciary. Glen Mitchell served as a Project Coordinator for the Select Committee and serves as Senior Legislative Analyst for the Committee on Health Care. Margaret Cochran, Administrative Assistant for the House Policy Committee also served in this capacity for the Select Committee.

The Select Committee was charged by House Speaker Johnnie Byrd to examine the myriad issues relating to the availability of liability insurance to health care providers in Florida. Our focus, from the beginning, has been to view these issues through the lens of the average citizen of Florida. Our attention has been devoted towards the impact of these issues on the access and availability of health care services to the citizens of Florida and the millions of visitors to our state.

Our efforts began after the appointment by Governor Bush of the Governor's Select Task Force on Healthcare Professional Liability Insurance. The hearings held by our Select Committee have been used to magnify many of the issues contained within the report issued by the Governor's Task Force. We have received testimony from experts in each of the professional areas impacted by this crisis and have attempted to present a balanced approach in all public hearings.

Our intent has been to identify each of the substantive issues, collect as much information as possible, gather opposing points of view, and compile a Select Committee Report which can be used by the House as it develops and discusses specific legislation for consideration by Members. We have been able to collect (provided in Appendix II) suggested legislation, in many cases from opposing points of view. Where possible we have identified actions taken in other states as well as suggested remedies from the American Legislative Exchange Council among others.

It must be made clear from the outset that the challenges associated with these issues are complex and do not lend themselves to clear and obvious solutions. One observation that was readily identified is the need for government agencies and stakeholder groups to conduct on-going data collection activities. The records of both the Governor's Task Force and the Select Committee are replete with anecdotal evidence of the possible changes in behavior by medical practitioners, including institutional service provisions changes; however there was only minimal information available about specific cumulative totals of changes in service availability or the direct impact on healthcare services in any county in Florida due specifically to the rise in premium costs for service providers.

An example of this can be seen in one piece of correspondence received by the Committee from a practicing physician. He begins by placing emphasis on his stated desire of capping non-economic damages and how the rising cost of malpractice insurance has hampered his practice. However after this initial admonition he continues with some detail as to the burdensome impact on his practice by reduced Medicare reimbursement and the added limitations on income placed

on him by managed care programs. The record of the public hearings of the Governor's Task Force is replete with similar missives. The direct linkage between rising insurance costs and reduced healthcare services as a cause and effect relationship is not clear as a sole and primary cause. It is clear from the testimony received and the materials submitted that the healthcare community is under intense pressures to provide quality care in an environment that includes reduced or constrained incomes for providing services combined with concurrent rapidly accelerating cost factors, including significant increases in the premiums charged for medical liability insurance. It is also apparent that the public perception of the linkage between higher insurance premiums and reduced services is real; and that efforts must be made by the state to seek possible remedies.

While the quantity of practitioners terminating or reducing practices or the closing of specific hospital services can not be specifically calculated, using currently available data, it is clear from the record that enough providers have discussed or taken these actions to raise serious concerns about the future of service delivery in many regions or specialties in Florida. The record of the public hearings conducted by the Select Committee on February 13th and 14th in four cities across the state is replete with references by healthcare providers to the detrimental impact of either rising insurance costs or the cancellation of coverage in the current environment with the inability of service providers to secure adequate replacement coverage.

Reduced Quality of Care

An excellent example of how this crisis has affected patient services was given in testimony by Dr. William Barringer in Tampa. He once had a small family practice with several doctors but recently had to retire prematurely from practice due to two malpractice cases affecting his practice being settled by his insurer. He claimed he had no ability to defend these cases as they were settled to avoid litigation. In each case he stated he had only seen each patient one time and had no continuing relationship. In order for his partners to be able to obtain coverage he had to remove himself from practice. With 20 years of patient history and over 100,000 visits he was forced to retire, leaving his hundreds of active patients without a primary care giver. This problem was further emphasized by the testimony of Dr. Charles Campbell, a Tampa bay area surgeon. He testified that in his practice they have had six doctors leave the state, two retire early and one transfer to the Veterans Administration hospital. He voiced the concern that it is his experience that Florida is losing quality doctors and the "crisis is real." This trend was also confirmed by the testimony of Dr. Scott Lipoff who closed his practice when he received notice of non-renewal from his insurance carrier due to their decision to retreat from the Florida market and by the testimony of Dr. Bob Yelverton who has ceased offering mammography services after 25 years of claims free history due to the potential liability exposure. Dr. Denise Baker, Surgeon, and Dr. Douglas Sanders, General Practitioner, each also testified they have also either ceased to practice or reduced the delivery of services. The hearing records are replete with testimony from service providers; such as Dr. Barbara Sharpe who offered that there will be reduced or non-existent mammography services having a serious impact on breast cancer detection and prevention, each with specific reference to reduced access and availability of quality care. In each case it is the citizens of Florida who face reduced services from qualified medical service providers.

Further evidence of how this crisis is affecting the citizens of Florida was provided by another Tampa Bay area surgeon, Dr. Michael Binder. He testified he had never had a malpractice case in all his years of practice and yet his rates have climbed 115% in the past two years. He has adjusted his practice to the detriment of the citizens in his area since he no longer will accept Medicaid patients and has dropped participation in any managed care programs. His response has been an economic one; to sever relationships with those patients who are forced to use limited pay systems and to focus his practice on those patients who can provide full coverage health insurance products or pay cash for services. In this case those least able to pay must seek other providers in an apparently shrinking service provision environment. For example, Dr. George Banks, an Obstetrician-Gynecologist, testified to the Select Committee that in an area of Pinellas County there used to be 35 practitioners and now there are 13, with the prediction there will be 8-10 next year. He voiced a deep concern for the quality and availability of care.

Parsing the Problem **The Squeeze of Low Reimbursement Rates**

There is difficulty in separating the impact of rising insurance rates from the other burdens placed upon Florida's healthcare practitioners by both government reimbursement mechanisms and private sector regulated industries such as HMO's and PPO's. (See Appendix I) It is not specifically clear from the hearings or by a review of the record, that any specific point can be determined where costs in one area become too high to be offset by adjustments to medical practices and the search for increased efficiencies. Physicians, such as those mentioned above, have testified they have reached the saturation point of shortening patient visit times and extending their office hours. It is clear from the record that Florida's healthcare system is in a situation which in many cases forces medical personnel to stretch the limits of their capacities to offer quality medical services using these practice modification techniques. The end result is apparent; patients get less time and quality attention when there is a need to vastly increase the number of patients served in order to meet "bottom line" requirements. Less time spent with each patient brings an attendant lack of patient history knowledge and focus with an increased risk of potential error and "bad will" between patient and doctor; which might ultimately be a causative factor in increasing cases of medical error. These problems are addressed in our section on "Patient Safety Issues and Options".

Reduced rates of reimbursement to physicians for their services by managed care programs and by government reimbursement programs restrict their ability to cover the rising medical malpractice insurance costs. For example Medicaid physician fees have increased minimally for particular populations and specialties in recent years, but still average only 59 percent of Medicare fees for children-related procedures and 56 percent for adult-related procedures. According to the Agency for Health Care Administration, Florida Medicaid ranks 41st among the nation's Medicaid programs in the level of physician fees.

As a result, the Agency for Health Care Administration found in a recent study that there are critical shortages of Medicaid participating physicians throughout the state, especially in the areas of emergency medicine, OB/GYN, Pediatrics and Pathology.

It is clear to the Select Committee that not only is there not just one problem in need of resolution but also there are many solutions which must be considered as part of a total package of legislative and executive solutions. There are many government activities that can be altered to meet the challenges of creating a more permanent solution to these problems. No single specific remedy will offer the “silver bullet” to reduce rates, create greater competition in the insurance marketplace, or insure greater access and availability of quality health care for citizens and visitors in Florida.

Complex problems tend to raise the volume of public discourse, often with discontent and rancor taking the place of reasoned consideration. Medical liability insurance issues are not exceptions to this maxim. However, the Select Committee has had the cooperative and valuable assistance and input from an array of interested stakeholders and citizens. Each brought unique perspectives and differing toolboxes of solutions. Our challenge is to carefully weigh the evidence presented and offer solutions that, at best, are calculated, well-conceived, experiments crafted to reach some degree of remedy in this crisis. Our longer term goal is to find solutions to assist in avoiding the cyclical nature of this crisis. Prior state efforts have, in retrospect, served as steps in a long term process, applying a broad menu of options and prescriptions which have also been unknown in the degree of effectiveness at the time of passage. Just as there is no apparent single cause of the crisis, so there is no single remedy. Prior programs enacted by the Legislature should be viewed as partial solutions in a progression of options, each addressing specific remedies and each have varied levels of success or failure.

It should be clear to all concerned that our task is not to simply find means of reducing insurance costs for service providers. Legislatively forcing reduced costs in a market where no company is compelled to sell a product would be an act without commensurate results. The Select Committee heard from several proponents of implementing the California initiative of Proposition 103 which forced the roll back of premiums and refunds for several insurance sectors. However requiring rollbacks of rates in an environment where there is the significant problem of an absence of companies interested in entering into the market as much as it is the premium prices offered by those who are in the market offers little promise for Florida. Consideration should be given to many of the items listed in the Appendix Section “Recommendations Issued by the Governor’s Task Force and Issues Considered”, under the section on Insurance Issues. Rate approval and review should be considered a significant component of any reform package as problems created by components, such as predatory pricing to gain market share, create significant problems for companies interested in staying in the Florida market in both good and bad economies.

The Florida House has long held a position of advocacy for the functioning of free markets. However, it is clear in this instance that while large segments of our healthcare delivery system are seriously constrained by governmental intervention and regulation, these same segments are dependant upon receiving liability insurance from carriers whose rates are reviewed and approved but with no compulsion to even enter the market. The insurers have the freedom of product market selection while medical providers are faced with the burden of choosing between high premium costs, (when insurance can be purchased), or going without third party coverage and adjusting personal finances in order to continue offering services to the public. Our tasks, in this instance, are to seek ways of offering alternatives to going bare or paying escalating costs,

trying to create an attractive market for insurers to enter, and making sure that the practice of medicine remains an attractive field for students to enter. There are multiple actions that need to be taken; each is distinct areas of this crisis and each serving to solve single or multiple components of the problems, but not all. For example, consideration should be given to all of the items contained within this report and the Legislature should not focus on caps on damages or any single remedy, as none will serve alone to solve the dilemmas faced by the Florida system. Other partial remedies must be considered as components required for systemic approach.

Alternative dispute resolution programs, designed to either remove cases out of the tort system altogether or vet out the merits of a claim before it hits the tort system, are one of these partial remedies. These programs attempt to provide fairer, faster, and less expensive routes to a resolution for all parties.

The loss of the major insurance carriers and shortage of affordable liability coverage can be addressed directly through state assistance, the expansion of the availability of joint underwriting associations, alternative excessive insurance mechanisms, or physician owned funds subsidies, as other examples of actions that should be considered in a package of remedies.

Another option offering potential for assisting in the reduction of medical malpractice insurance rates is to create patient safety systems that help reduce the incidences of medical errors in the first place. Mechanisms are in place for Florida to better influence patient safety through licensure of health care facilities and providers and tougher sanctions against those that are negligent. Material has been presented to the Select Committee showing how Florida can utilize innovative solutions to make health care safer and of higher quality and greater access.

The Future of Medical Care

It would not be acceptable public policy in Florida to allow the situation to deteriorate to where Florida medical schools begin to see reductions in applicants and where trained students choose to go to other states to practice after receiving expensive educations in Florida. This potential problem is exacerbated when one factors the growing population of Florida and the increasing size of our senior population, which will require a greater availability of trained healthcare specialists.

One relevant perspective was offered by medical student David Winchester who presented a plea on behalf of other students who prefer to remain in Florida yet are seeking positions in other states. He expressed concern, that facing five years of practice after his training in order to get specialty certification, he might find more lucrative employment as an expert witness in malpractice litigation than he might find as a health care practitioner.

Florida citizens deserve to know that now and into the future, quality care is the driving force behind public policy decisions in Florida. Access to affordable care should be the template behind which all decisions are made in this arena. We must keep an eye on the current dilemma while crafting solutions which offer hope for future improvements and expansions to the Florida

health care delivery system. The citizens of Florida, as well as the millions of visitors who serve as critical components of our economy, need to be assured that access and availability of quality health care services is an important priority in public policy in Florida. We must seek ways of attracting our brightest youth into medical service while creating an inviting environment for trained personnel in other states to relocate to Florida. As our population grows, so will our need for qualified healthcare personnel. It is clear from the record of the Select Committee that concerns must be raised about how the current trends in reduced service delivery by doctors, by hospital administrators and by surveyed medical students seeking employment in other states, will impact the access and availability of quality care in the future.

Improvements must be made in the delivery of health care services to avoid medical errors and in turn avoid future litigation. This report highlights several opportunities for improvement in these areas which must go hand in hand with any reforms or alterations to both our liability system and our insurance product system. Throughout our hearings we have heard testimony as to how all three components are inextricably linked and how each offers potential partial solutions to components of the medical insurance liability system. We have also heard repeatedly, from advocates of particular stakeholder positions, how the blame should be placed on competing points of view. In excellent examples of rational-choice theory in practice we have seen advocates of change call for solutions which seek to only affect changes in the status of other stakeholders within this complex system. It is the task of the policy makers to separate the wheat from the chaff as we divine which advocacies result from competing calculated interests and which offer reasonable alternatives for improving the total system. The Select Committee advocates keeping the “policy eye” on the prize of improving health care for Florida’s citizens. Legislative actions might affect individual healthcare providers, physician groups, hospitals and extended care facilities, surgical centers, clinical laboratories, multiphasic health testing centers, and other healthcare facilities, but in the end, it is the consumers of services who will be impacted the most by action or inaction this session.

Report Sections

The Select Committee has collected a written and oral record of its proceedings. We also have additional material included as addenda to this report. All meetings have been taped and all materials cataloged to assist in the evaluation of alternatives by the substantive committees of the House. We have also reviewed the comprehensive record of the Governor’s Select Task Force on Healthcare Professional Liability Insurance and have available their 345 page report as well as thirteen volumes of supportive materials.

The report of the Select Committee is divided into several sections in part based on the three specific substantive committees of the Florida House of Representatives; Health Care, Judiciary, and Insurance. It should be noted that the name of the Select Committee also is based on these three substantive divisions, Medical-Liability-Insurance. This is a purposeful recognition of three significant segments of the Florida economy, each with a tightly linked involvement in these issues and each with potentially serious effects from changes passed by the Legislature.

It should be pointed out that some stakeholders have contended, in writing and in personal testimony, that the solutions to these long standing and vexing problems are readily accessible

and easily resolved. Some have contended that the imposition of caps on non-economic damages is all that is required and that all other issues are side issues of far less importance. This type of advocacy diminishes the depth of the issues contained within the parameters of this discussion. It is clear from our review that there are no easy solutions to the multitude of issues attendant to the single issue of availability of medical liability insurance. The related issues are complex and integrated with other problems and solutions. No one remedy offers any guarantee to health care providers that upon passage there will be immediate relief to the high cost of insurance products. In fact, some solutions considered are certain to face legal challenges which will delay any relief from this action for years into the future. Beyond the timeframe for potential litigation would be several years of experience required before rate actuaries could effectively predict the impact of the delayed solution.

Medical and Health Care Issues

Most discussions of medical malpractice revolve around changes in the tort law or changes in insurance law. Often left out of the debate is a simple proposition: if we can reduce the incidence of medical errors, we can reduce the number of cases where tort litigation is possible and limit the exposure faced by practitioners and insurance companies. Accordingly, the Legislature should consider proposals to reduce the incidence of medical errors and increase the quality of the health care delivery system.

Methods suggested to decrease the number of errors include increased reporting and analysis of errors. This will permit the study of why an error occurred and allow the determination of how to prevent the error in the future. Other proposals have included computer entry of drug information and medical history so that such information can both be easily retrieved by all medical providers and have a heightened degree of accuracy.

Proposals for reform should also focus on ensuring that patients have access to physicians. Increased costs to physicians lead to changes in practices such as requiring physicians to increase the number of patients they see and decrease the time they spend with each patient in order to meet the expenses placed upon the practitioner. This may lead to an increase in the number of errors in diagnosis and treatment that may have been prevented if the physician had more time for the patient and developed a deeper relationship.

Liability Issues

The role of tort law has a long history in the system of common law that serves as an essential component of the foundation of our governance. The imposition of risk factors in our liability system provides for compensation for victims as well as one component of a risk avoidance system due to the deterrent aspects of litigation. In theory, liability and negligence standards should lead to precautionary systems, actions and behavior by service providers while assuring potential victims of negligence that they can receive compensation for medical negligence. The deterrence or incentive role of tort law is but one component of a system that optimally provides for actions by deliverers of health care services that lead to improvements in safety. These

additional components are contained in our section on Medical and Healthcare Issues. Safety is also the driving force behind government regulation of healthcare delivery standards. Arguments have been made, and the European system is largely based, on the notion that best judgment and practices at the time the procedures or medical products are utilized should be based on the information available at that point in time. Once new knowledge or changes to practice are known then practitioners should be held liable and responsible for actions using this new information. Adherence to this kind of standard mitigates the need for the utilization of litigation remedies for promoting risk avoidance by providers.

There have been numerous proposals for litigation reform presented to both the Governor's Task Force and to the Select Committee. Some stakeholders have formed a coalition of groups in Florida, called the Coalition to Ensure Patient Access, which along with many insurance interests have argued that the Legislature should place a cap on non-economic damages. Those groups contend that a major cause of the current malpractice insurance crisis is the fear of multi-million dollar jury awards for non-economic damages, which forces settlement of non-meritorious cases by insurers and insured parties because of the fear of the risk of going to trial and facing the unknowns of the jury system. Those groups postulate that the current crisis is so great that the overwhelming public necessity, necessary under prior Supreme Court rulings has been shown. Opponents of caps, such as the Academy of Florida Trial Lawyers, argue that limiting damages will reduce the number of medical malpractice cases accepted by trial lawyers since these cases are expensive to prosecute and the upfront costs of complex cases are high; which they contend will serve as a barrier to the courts for some individuals. They, along with other opponents of caps, argue this kind of change in law will lead to a decrease in the quality of health care because hospitals and other health care providers will have little incentive to improve the health care delivery system under the assumption that fear of lawsuits is what motivates providers to provide quality care. They also contend victims of medical malpractice will be unable to recover the full damages to which they might be entitled based on the current system.

There have been proposals to extend sovereign immunity to emergency room physicians. (See suggested legislation Appendix II) Proponents argue this immunity grant is fair because emergency-physicians are required under state law to provide emergency care. Opponents of this proposal argue again that it serves to limit avenues of redress for possible victims by insulating a segment of the healthcare community from patients, who might be harmed, seeking legal recourse. They also contend this would be one component of reform which could be challenged as an unconstitutional cap on damages.

Other reforms have been suggested to streamline the litigation process. Mandatory mediation could lead to faster settlement of cases but opponents raise the concern this can also impose an additional barrier between a plaintiff and the courthouse. Different proposals have been submitted to alter the requirements for expert witness testimony. The current system of voluntary binding arbitration, which has a provision for caps on damages, is arguably not being used because of court decisions which have served to limit the utilization of this avenue. There have been proposals to revise that statute. Another proposal is to change the standard of proof in medical malpractice cases to make the standard the same as the standard used in a disciplinary case and conversely, there is also a proposal to make the disciplinary standard the same as the

standard used in civil actions. Additionally, there is a proposal to amend the comparative fault statute to limit the practice of placing blame on persons not involved in the lawsuit.

It is clear from the wide variety of proposals on many topics that this issue does not have a simple solution. The Select Committee has endeavored to provide the House with substantial background on each of the suggested remedies as well as potential draft legislation for many of the suggestions. (See Appendix II)

Insurance Issues

We have seen a medical liability insurance crisis repeated three times since the mid 1970's in Florida. In the two previous situations there were detailed studies and requisite Task Force and legislative reports and yet in each instance we have seen a return of similar circumstances where insurance product costs are too high to be afforded by healthcare practitioners and there are limited providers of insurance products in the marketplace. With an absence of competition and high prices one might expect market solutions to emerge in an open access market. It is clear that the current environment has served to create barriers to entry by potential insurers as the instability and unpredictability inherent in the medical liability area has served to stifle the competition usually required to help dampen increases in costs. Instead we see a counter-intuitive market force where the uncontrollable and unpredictable variables influence product availability. Potential companies have decided to place resources in other lines of insurance or in other locales. The section of "Insurance Issues" in this report offers suggestions as to potential remedies and alternative products designed to improve the competitive environment while offering alternatives for the maintenance of insurance coverage by healthcare providers as the insurance economy passes through the cycles evidenced in Florida over the past 28 years.

Conclusion

What is readily apparent to the Select Committee is that past efforts to find meaningful solutions to these critical issues have not been successful. We would not see a recurrence of a series of very similar problems each decade or so if the solutions of the past were the full and appropriate remedies for these vexing issues. On occasion issues come before policy makers that so polarize groups of stakeholders that the interests of each begin to build impregnable walls, causing good public policy to be a difficult accomplishment. The issues surrounding medical liability insurance are examples of how embedded interests can often battle in the court of public opinion to the ultimate potential detriment of the public. The primary interest of the House Select Committee on Medical Liability Insurance has been to seek avenues for fostering solutions so, now and in the future, the citizens and visitors to Florida will have access to available, quality medical care. Florida can not afford from just the perspective of our economic well being, to develop a national image of a state with substandard or inadequate health care systems or even a system in crisis. No region of this state should suffer a shortage of specialists and no citizen of Florida should be forced to travel unwarranted distances to receive care that should be readily available.

Florida is different than most states. Comparisons of legislative actions and statutory changes in other states are always difficult tasks. Florida has a very different combination of high population growth, large numbers of annual visitors, many seasonal residents, an expanding international community, and a growing senior population requiring different and more frequent kinds of healthcare availability. Florida is the fourth most populous state and by 2025 it is projected to be the third with 20.7 million people, the third largest gain in population during this time period. By 2025 Florida is expected to gain 1.9 million residents due to international immigration. We will be first in the country during this period for internal migration, people choosing to move here from other states. As the generation born between 1946 and 1964, frequently called Baby Boomers, continues to age, Florida's elderly population will continue to become a larger segment of the community. Florida's elderly will increase from 18.6 percent of the population in 1995 to 26.3 percent in 2025, the highest proportion of elderly in the general population than any other state. These population increases and demographic changes will place additional demands on our health care system.

Additionally, Florida just completed a record year for numbers of visitors, who chose to come here to enjoy our wonderful resources. According to Visit Florida Inc., 75.5 million tourists visited Florida in 2002, an eight percent increase over 2001 and a record number of visitors. The reputation of the state as a positive destination for tourism can not afford to be sullied by questions that might arise as to access and availability for the healthcare needs of our visitors. The economic well-being of our state is highly dependent upon revenue gained from the millions of visitors who choose Florida over other destinations in an internationally highly competitive vacation market.

Clearly, Florida will require increased access and availability to quality healthcare services for the changing population. In sheer numbers there will be additional requirements for medical services due to the increasing population and with the increased senior population there will be an even greater need for a wide range of medical services to meet the special needs of our aging population. We need to find ways to encourage providers to assist in meeting the future needs of our state by expanding practices and offering additional services.

Our task is clear. We must seek multiple solutions to the problems before us, each addressing the varied problems that weave the tapestry that surrounds the issues of medical liability insurance. We must be willing to accept that we can both improve upon the remedies of the past while taking the necessary additional steps to offer remedies to meet the overwhelming public necessity of improving the access and availability of quality health care in Florida.

We seek the creation of a more permanent process and structure to avoid the cyclical nature of this problem and to foster systems of both medical care and insurance coverage that rely more on market solutions than on government intervention. The public need for access to and availability of health care should be the overriding concern.

SECTION ONE

Medical Liability Insurance **Historical Issues**

It is clear to the Select Committee that one of the pre-eminent substantive issues to be addressed by the 2003 Legislature is the complex problem of medical liability insurance and the concomitant impact on the delivery of health care services to the people of Florida. A review of the history of this problem is warranted.

Background on Insurance Crisis and Past Legislative Action

Problems associated with the availability and affordability of medical liability insurance are not new. Previous crises occurred in the mid-1970s and the mid-1980s. These crises were characterized by: (1) lack of affordable and available liability insurance, (2) adverse financial impact on physicians, and (3) adverse impact on patients' access to care.

The causes of past and current insurance crises are hotly debated. However, they generally fall into two categories. One suggested cause is underwriting loss due to increases in the frequency (number) of claims, increases in the severity (size) of claims, and uncertainty due to the "long tail" (claims against a single year's policy are not all made and paid until a certain number of years later). The other suggested cause for the crises is investment loss due to a reduced rate of return on insurance company investment of premiums due to lower interest rates and the declining stock market.

It should be noted that this crisis is not restricted to Florida as many states across the country face similar problems of reduced or non-existent coverage due to the retreat of carriers from the market. To address past crises a series of tort reforms were implemented. Reforms aimed at the size of recoveries (severity) included caps on awards, periodic payments of damages, collateral source offset, joint and several liability changes, and punitive damage limits. Reforms aimed at the number of suits (frequency) included pretrial screening panels, arbitration, statutes of limitations, attorney fee contracts, certificates of merit, and costs awardable.

Nationally past insurance reforms have included patient compensation funds, joint underwriting associations, limits on insurance cancellation, mandates for liability coverage, and reporting requirements.

In Florida, many of these tort and insurance reforms have also been adopted in one variation or another. The most concerted recent legislative efforts to address the crises occurred in 1986 and again in 1988.

In 1986 the Legislature passed a law limiting non-economics damages to \$450,000 in all tort actions (not just medical malpractice). The Florida Supreme Court ruled that limitation unconstitutional in 1987, as discussed later in this Report. Also, in 1986, the Legislature created

the Academic Task Force for Review of the Insurance and Tort Systems. This task force undertook a comprehensive review of the subject and issued several recommendations which the Legislature acted upon in Special Session in 1988. Among other provisions relating to medical malpractice, the Legislature established a pre-suit investigation process to eliminate frivolous claims and a voluntary binding arbitration process to encourage settlement of claims. As part of the arbitration process a cap of \$250,000 on non-economic damages was established if parties agreed to arbitration, and a cap of \$350,000 was established at trial if the plaintiff refuses arbitration. These provisions have been upheld as constitutional by the Florida Supreme Court (See Report section on Liability Issues).

In addition, the Florida Legislature in 1988 created the Florida Birth-Related Neurological Injury Compensation Association (NICA). This is a no-fault plan which covers catastrophic birth-related neurological injuries based on a similar program in Virginia. Specifically, the statute covers a newborn of 2,500 grams or more, as a result of a single birth, 2,000 grams multiple, who is permanently and substantially mentally and physically impaired. As a no-fault system, negligence does not have to be proven, blame is not levied, and compensation is provided.

Notwithstanding these reforms, reports have been made to the Governor's Select Task Force and the House Select Committee that faced with escalating medical malpractice premiums, many providers are modifying their scope of practice, leaving the state, or retiring. Difficulties in recruiting new physicians to Florida have also been reported as has the increased numbers of current medical students who are being trained in Florida but choosing to move to other states to practice medicine.

Four Florida Supreme Court Cases Relevant to Medical Malpractice Issues

While there is greater detail in the Report section on Liability Issues it is worthwhile to briefly summarize the history of court actions and the impact on prior reform efforts here. In four related cases the Florida Supreme Court has ruled the Florida Constitution places some limits on the Legislature's ability to cap damages in tort cases or otherwise restrict a litigant's access to courts. In Kluger v. White, 281 So. 2d 1 (Fla. 1973), the Florida Supreme Court considered the Legislature's power to abolish causes of action. At issue in Kluger was a statute which abolished causes of action to recover for property damage caused by an automobile accident unless the damage exceeded \$550. Kluger, 281 So. 2d at 2-3. The court held that the statute violated the access to courts provision of the state constitution.

The "access to courts provision" (article 1, section 21) of the Declaration of Rights in the Florida Constitution requires that the courts "be open to every person for redress of any injury". In Kluger, the court held that where a right to access to the courts for redress for a particular injury predates the adoption of the declaration of rights in the 1968 state constitution, the legislature cannot abolish the right without providing a reasonable alternative unless the legislature can show (1) an overpowering public necessity to abolish the right and (2) no alternative method of meeting such public necessity. Kluger, 281 So. 2d at 4. Because the right to recover for property damage caused by auto accidents predated the 1968 adoption of the declaration of

rights, the court held that the restriction on that cause of action violated the access to courts provision of the state constitution.

The court applied the Kluger test in Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987). In 1986, the legislature passed comprehensive tort reform legislation that included a cap of \$450,000 on non-economic damages. The cap on damages was challenged on the basis that it violated the access to courts provision of the state constitution. The Florida Supreme Court held that the right to sue for unlimited economic damages at the time the constitution was adopted. Smith, 507 So. 2d at 1087. The court said that a cap on non-economic damages must meet the Kluger test in order to pass constitutional muster. Smith, 507 So. 2d at 1087-1088. If the legislature wishes to cap non-economic damages, it must (1) provide a reasonable alternative remedy or commensurate benefit; or (2) show an overpowering public necessity for the abolishment of the right to recover unlimited damages **and** show that no alternative method of meeting the public necessity. Smith, 507 So. 2d at 1088.

The Smith court held that the legislature did not provide an alternative remedy or commensurate benefit in exchange for limited the right to recover damages and noted that the parties did not assert that an overwhelming public necessity existed. Smith, 507 So. 2d at 1089. Accordingly, the court held that the \$450,000 cap on non-economic damages violated the access to courts provision of the Florida Constitution.

The issue of caps on non-economic damages arose again in University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993). In 1988, the legislature instituted a voluntary binding arbitration process in medical malpractice cases. Under the arbitration process, a defendant could decline to contest liability and request binding arbitration on the issue of damages. If a defendant requested arbitration, non-economic damages were capped at \$250,000 per incident if the plaintiff agreed to arbitration. Echarte, 618 So. 2d at 193. In exchange for the cap, the plaintiff was guaranteed prompt payment of any award, joint and several liability against the defendants, and payment of attorney's fees and costs by the defendant. Echarte, 618 So. 2d at 193. If the plaintiff rejected a defendant's offer to arbitrate, the plaintiff could proceed to trial but non-economic damages were capped at \$350,000. Echarte, 618 So. 2d at 193.

The Florida Supreme Court applied the Kluger test and found that arbitration statute provided a commensurate benefit for the loss of the right to recover full non-economic damages. Echarte, 618 So. 2d at 194. While the plaintiff lost the right to recover full damages, the plaintiff gained (1) the benefit of not having to prove liability; (2) joint and several liability; (3) relaxed evidentiary standards provided in an arbitration proceeding; (4) prompt payment of damages; (5) payment of attorney's fees and costs; and (6) limited appellate review of the award. Echarte, 618 So. 2d 194.

In addition, the Echarte court found that the legislature had shown an overpowering public necessity for instituting the caps and that there was no reasonable alternative. Echarte, 618 So. 2d at 195-197. The legislature made factual findings, relying on a study by an academic task force, to show that without reform, many persons would be unable to purchase liability insurance and claimants would be unable to recover any damages if providers were not insured. Echarte, 618 So. 2d at 197. The court, relying on information presented to the academic task force,

agreed that there was no reasonable alternative. Echarte, 618 So. 2d at 197. Based on these findings, the court upheld the statute.

The arbitration statute states that damages are capped at \$250,000 “per incident” but has other language referring to individual claimants. In St. Mary’s Hospital, Inc. v. Phillippe, 769 So. 2d 961 (Fla. 2000), the Florida Supreme Court considered whether the “per incident” language meant that each claimant could recover the full \$250,000 or whether all claimants in a single incident must divide \$250,000. In St. Mary’s, a woman died during childbirth due to medical malpractice. St. Mary’s, 769 So. 2d at 963. After arbitration under the medical malpractice statute, her husband was awarded \$250,000 in non-economic damages and each of her four surviving children was awarded \$175,000. St. Mary’s, 769 So. 2d at 963. The court had to decide whether the statute permitted that award or whether the total non-economic damages were capped at \$250,000.

The court held that the statute meant that each claimant was entitled to recover up to \$250,000 per incident. St. Mary’s, 769 So. 2d at 967-971. To hold otherwise, the court said, would raise equal protection concerns because a claimant’s recovery would be limited simply because there were multiple claimants in a given case. St. Mary’s, 769 So. 2d at 971-973. Accordingly, each claimant in a medical malpractice arbitration may recover up to \$250,000 per incident of medical malpractice.

Another issue raised in the St. Mary’s case is whether, in medical malpractice arbitration, economic damages are determined under the medical malpractice statute or under the wrongful death statute. Under the medical malpractice statute, “economic damages” is defined as “including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity.” St. Mary’s, 769 So. 2d at 973. In addition, the statute provides that arbitration shall be undertaken with the understanding that “[n]et economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments.” St. Mary’s, 769 So. 2d at 973. The court explained that the Wrongful Death Act does not provide the same economic damages:

Unlike the Medical Malpractice Act, the Wrongful Death Act does not provide claimants with such a full range of economic damages. Under section 768.21(1) of the Wrongful Death Act, each survivor may recover the value of lost support and services from the date of the decedent's injury, and under section 768.21(6), the estate may recover the decedent's loss of earnings, loss of prospective net accumulations, and medical and funeral expenses.

St. Mary’s, 769 So. 2d at 973.

The court held that in medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated. The court stated that the plain language of the statute “indicates that the full range of economic damages is available to claimants as an incentive to forego a jury trial.” St. Mary’s, 769 So. 2d at 973. The court reasoned that if the legislature had intended for the Wrongful Death Act to apply, it would have expressly stated that it should be applied. St. Mary’s, 769 So. 2d at 973.

National Issues

The release of the Institute of Medicine's report in 1999 (see Appendix III), coincided with efforts to enhance patient safety around the country. These efforts have dramatically increased on the national and state level. Nationally, professional groups such as the American Medical Association, American Nurses Association, American Hospital Association and various specialists' organizations have created patient safety initiatives.

Also, foundations, non-profit and government research organizations and patient/provider collaboratives are now focusing on improving patient safety and quality of care. The Health Care Issues Section as well as the Appendix and Addendum to this Report provide additional information about many of these entities.

On the legislative front, activity has also occurred on the national and state level. Recently President Bush called for national action on the medical liability insurance issues, including a national cap on non-economic damages placed at \$250,000 and the United States Department of Health and Human Services issued a report called "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System". (see appendix)

Several states have passed significant changes with Pennsylvania enacting the most recent legislation regarding approaches to patient safety. The Medical Care Availability and Reduction of Error Act (Act 13) was enacted on March 20, 2002 and testimony from the new Director of this program can be found in the record of the Florida Governor's Select Task Force. The Act addresses the issue of medical professional liability reform through tort reform, catastrophic insurance (CAT) fund reform, and patient safety; with Chapter 3 focusing on reducing medical errors and enhancing patient safety efforts.

Current Situation Florida

Organizational Response

Currently there does not exist in Florida a statewide coalition or collaborative organization promoting patient safety.

Legislative Response

The 2000 Legislature created the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement. The Commission presented its report to the Governor and Legislature on February 1, 2001. In response, the 2001 Legislature adopted many of the recommendations of the Commission as part of CS/SB 1558 (ch. 2001-277, L.O.F.). The 2001 Legislature, however, did

not address the recommendation of the Commission with regard to the formation of a Center for Patient Safety and Excellence in Health Care.

In 2002, the Florida House considered and passed a bill which would have established a statewide, academically based center to serve as the designated resource for patient-safety-related research, education, and policy information for the people and institutions of Florida. The bill created the Florida Center for Patient Safety at the Health Science Center at the University of South Florida and the College of Medicine at the Florida State University. The center would have been administratively housed and located at the Health Sciences Center of the University of South Florida in Tampa. It authorized the center to perform various functions relating to research, data analysis, and information. The bill passed the House 117-0. It and a companion bill died in the Senate.

SECTION TWO

Health Care Issues and Patient Safety Issues and Options

Patient Safety

Recent reports on the quality of health care and the rise in medical malpractice insurance rates have brought a great deal of attention to the issue of medical errors and patient safety. The national Institute of Medicine report, *To Err Is Human: Building a Safer Health System* (2000), estimates medical errors are responsible for injury in as many as 1 out of every 25 hospital patients.

Medical errors include:

- A patient inadvertently given the wrong medication,
- A clinician misreading the results of a test, and
- An elderly person with ambiguous symptoms (shortness of breath, abdominal pain, and dizziness) whose heart attack is not diagnosed by emergency room staff.

The Institute of Medicine report indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Even the lower estimate of 44,000 deaths, means medical errors are the eighth leading cause of death in this country; higher than motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516), according to the report. About 7,000 people per year are estimated to die from medication errors alone; about 16 percent more deaths than the number attributable to work-related injuries.

State improvements in patient safety have the potential to reduce medical malpractice insurance by helping reduce the incidences of medical errors in the first place, according to a recent report by the National Governor's Association on the medical malpractice insurance crisis (December, 2002).

What is an Error?

Errors depend on two kinds of failures: either the correct action does not proceed as intended, or the original intended action is not correct. Errors can happen in all stages in the process of care, from diagnosis, to treatment, to preventive care.

Not all errors result in harm. Errors that result in injury are sometimes called preventable adverse events. The patient who receives an antibiotic to which he or she is known to be allergic, goes into anaphylactic shock, and dies, represents a preventable adverse event.

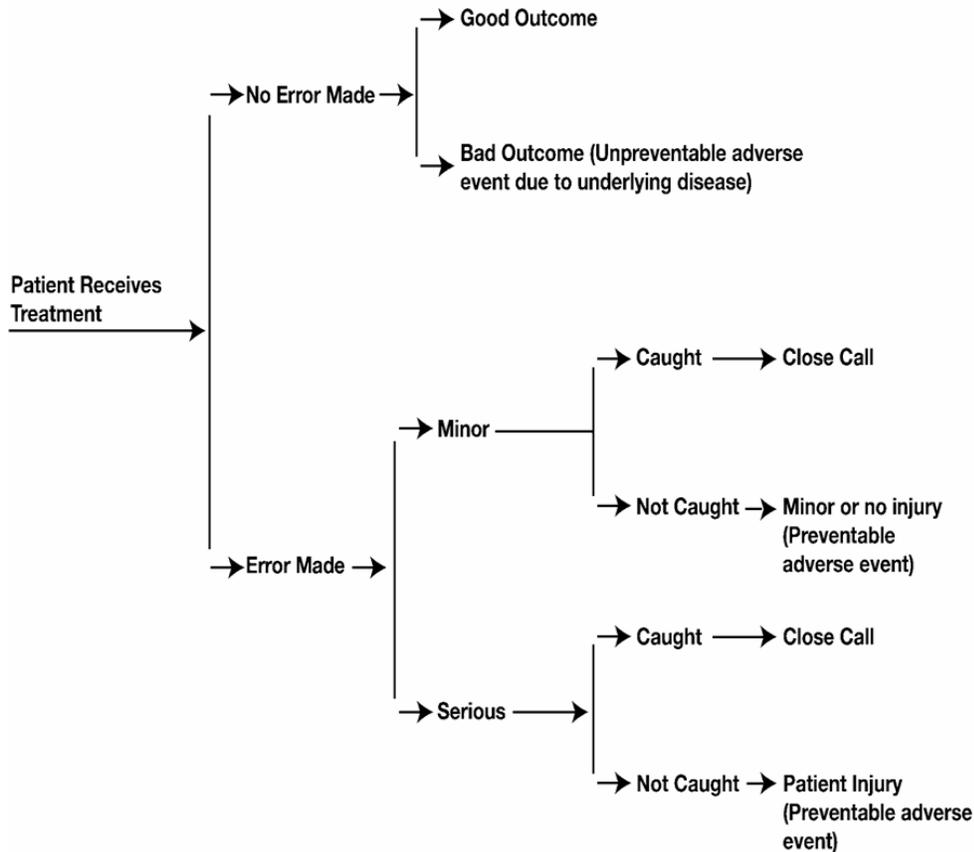
The Institute of Medicine report defines:

- **medical error** as the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim, and

- **adverse event** as an injury caused by medical management, rather than by the underlying disease or condition of the patient.

Some adverse events are not preventable; they can not be attributed to errors. They reflect the risk associated with treatment, such as a life-threatening allergic reaction to a drug when the patient had no known allergies to it.

Diagram of Medical Errors and Adverse Outcomes



From: Quality Interagency Coordination Task Force “Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact” 2000

Types of Errors

While most people believe that medical errors usually involve :

- **Medications** , such as a patient getting the wrong prescription or dosage, or
- **Mishandled surgeries**, such as amputation of the wrong limb.

The Institute of Medicine identifies many other types of medical errors, including:

- **Diagnostic error**, such as misdiagnosis leading to an incorrect choice of therapy, failure to use an indicated diagnostic test, misinterpretation of test results, and failure to act on abnormal results,

- **Equipment failure**, such as defibrillators with dead batteries or intravenous pumps whose valves are easily dislodged or bumped, causing increased doses of medication over too short a period
- **Infections**, such as nosocomial and post-surgical wound infections,
- **Blood transfusion-related injuries**, such as giving a patient the blood of the incorrect type, and
- **Misinterpretation of other medical orders**, such as failing to give a patient a salt-free meal, as ordered by a physician.

Costs

While death is the most tragic outcome, preventable medical mistakes cause other problems as well. They can lead to permanent disabilities, extended hospital stays, longer recoveries and even additional treatments. According to the Institute of Medicine, preventable health care-related injuries cost the economy from \$17 to \$29 billion annually, of which half are health care costs. Errors in health care have been estimated to cost more than \$5 million per year in one large teaching hospital.

These figures represent only part of the problem, since hospital patients are only a small proportion of the total population at risk, and direct hospital costs are only a fraction of total costs. Medical errors present a problem in any setting, not just hospitals. More and increasingly complex care is provided in ambulatory settings including outpatient surgical centers, physician offices and clinics. Home care requires patients and their families to use complicated equipment and perform follow-up care. Retail pharmacies play a major role in filling prescriptions for patients and educating them about their use. Other institutional settings, such as nursing homes, provide a broad array of services to vulnerable populations. Errors are also costly in terms of loss of trust in the system by patients and diminished satisfaction by both patients and health professionals. These are costs that can't be directly measured.

Public Concern

According to the federal Agency for Health Care Research and Quality, awareness of the issue of medical errors and patient safety has been growing. Americans have a very real fear of medical errors (AHRQ Fact Sheet, 00-PO37, 2000):

A survey, conducted by the American Society of Health-System Pharmacists, found that Americans are "very concerned" about:

- Being given the wrong medication (61 percent).
- Being given two or more medications that interact in a negative way (58 percent).
- Complications from a medical procedure (56 percent).

A recent article in the New England Journal of Medicine reported that many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care. The report was based on national surveys of 831 practicing physicians and 1,207 members of the public regarding their perceptions of medical errors. (Blendon, RJ, Views of Practicing Physicians and the Public on Medical Errors, 347(24), 2002.)

A Systems Problem

Most Medical Mistakes are Preventable

The real tragedy is that most of these medical mistakes are preventable. According to the Business Round Table's, Leapfrog Group, that addresses patient safety, errors are most often caused by systems that break down and do not support the highly qualified and dedicated hospital caregivers the way they should. Many drug names are mistaken due to handwriting that is difficult to read or names that sound alike. The drug codeine, for example, which is used to treat moderate pain or to control a serious cough, is sometimes misread as cardene, a drug used to treat high blood pressure and chest pain.

Studies reported by the federal Agency for Health Care Research and Quality (AHRQ Fact Sheet 00-PO37 and Pub. 00-PO58) have found that:

- 70 percent of adverse events found in a review of 1,133 medical records were preventable; 6 percent were potentially preventable; and 24 percent were not preventable.
- A chart review of 15,000 medical records in Colorado and Utah, found that 54 percent of surgical errors were preventable.

Most physicians surveyed in the New England Journal of Medicine article believed the majority of deaths due to medical errors "could have realistically been prevented."

- A total of 41 percent of physicians stated that half of the deaths could have been prevented, 27 percent stated three-fourths, and 8 percent stated all could have been prevented.

All together, 76 percent of the physicians surveyed stated half or more of deaths were preventable. The views of the members of the public were very similar to the views of physicians with regard to the feasibility of preventing errors. (Blendon, 2002.)

Research has shown that system improvements can reduce the error rates and improve the quality of health care (AHRQ Fact Sheet 00-PO37 and Pub. 00-PO58). According to the Institute of Medicine, much can be learned from the analysis of errors and building safety into processes of care, rather than blaming individuals. Some experts, such as Deming, believe improving processes is the only way to improve quality.

Potential System Improvements

The AHRQ has identified many strategies that reduce systems errors, including:

- **Use of information technology**, such as hand-held bedside computers, to eliminate reliance on handwriting for ordering medications and other treatment needs. One hospital in the Department of Veterans Affairs uses hand-held, wireless computer technology and bar-coding, which has cut overall hospital medication error rates by 70 percent. This system is being implemented in all VA hospitals.
- **Avoidance of similar-sounding and look-alike names and packages of medication.**

A 1999 study indicated that including a pharmacist on medical rounds reduced the errors related to medication ordering by 66 percent, from 10.4 per 1,000 patient days to 3.5 per 1,000 patient days.

- **Standardization of treatment policies and protocols** to avoid confusion and reliance on memory, which is known to be fallible and responsible for many errors. The specialty of anesthesia has reduced its error rate by nearly sevenfold, from 25 to 50 per million to 5.4 per million, by using standardized guidelines and protocols, standardizing equipment, etc.

Improvements Recommended by Physicians

- **Workforce Improvements:** In the New England Journal of Medicine article physicians believed the most important cause of preventable medical error was the understaffing of nurses in hospitals (53 percent of physicians). Nearly as many (50 percent) believed overwork, stress, or fatigue on the part of health professionals was a very important cause of preventable medical errors. (Blendon, 2002.)
- **Hospital Patient Safety Strategies:** When asked about possible solutions to the problem of medical errors, the strategy physicians believed would be most effective is to require hospitals to develop systems for preventing medical errors (55 percent said this would be very effective). Increasing the number of nurses in hospitals was believed to be a very effective strategy by 51 percent of physicians, followed by giving physicians more time to spend with patients (46 percent), and limiting certain high-risk procedures to hospitals that perform many of these procedures (40 percent).
- **Report Errors to Patients:** The survey also found large proportions of both physicians and members of the public believed medical errors should be reported to the patient or family.

Shift from Finding Blame to Preventing Errors

According to the Institute of Medicine, the focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. People must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

Health care is estimated to be a decade or more behind other high-risk industries in its attention to ensuring basic safety. Aviation has focused extensively on building safe systems, and has been doing so since World War II. Between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in mid century. According to the Institute report, although health care may never achieve aviation's impressive record, there is clearly room for improvement.

The Aviation Safety Reporting System

The National Governor's Association's report on the medical malpractice insurance crisis found that many health care provider groups and others are looking to the federal aviation reporting system as a model for medical errors (December, 2002). The Federal Aviation Administration's, Aviation Safety Reporting System (ASRS) has been operational since 1975. It collects, analyzes, and responds to voluntarily submitted aviation safety incident reports in order to lessen the likelihood of aviation accidents. The ASRS is effective in improving air safety because it relies on free, unrestricted information from its users. Pilots, air traffic controllers, flight attendants, mechanics, ground personnel, and others involved in aviation operations submit voluntary reports to the ASRS when they are involved in, or observe, an incident or situation in which aviation safety was compromised. Reports sent to the ASRS are held in strict confidence and those who report to the system or who are reported are immune from disciplinary action, unless the infraction is deemed criminal. The ASRS acts on the information these reports contain, identifies system deficiencies, and issues alerts.

Current Situation

National Organizations Addressing Patient Safety

Since the first release of the Institute of Medicine's report in 1999, efforts to enhance patient safety have increased dramatically on both the national and state level. Nationally, the governmental response has been directed by Congress and federal agencies. The health care industry and other private interests have also been involved, and public/private partnerships have formed. States have responded through their administrative agencies and licensure boards.

Federal Agencies

The Department of Health and Human Services has within it several entities that play a significant role in promoting patient safety, including:

- **The Agency for Healthcare Research and Quality** is the lead agency charged with supporting research designed to improve the quality of healthcare, reduce its cost, improve patient safety, decrease medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on these issues. AHRQ provides this information to decision makers, including patients and clinicians, health system leaders, and policymakers, to help them make more informed decisions and improve the quality of healthcare services. As part of this mission, AHRQ cosponsored the Florida Legislature's 2003 Health Care Summit.
- **Centers for Medicare and Medicaid Services (CMS)** is the federal agency that administers the Medicare, Medicaid and Child Health Insurance Programs. CMS also performs a number of quality-focused activities, including regulation of laboratory testing, surveys and certification of health care facilities, and development of coverage policies. Through its Peer Review Organizations, CMS is working to prevent failures and

delays in delivering services for breast cancer, diabetes, heart attack, heart failure, pneumonia, and stroke.

- **The Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA)** collect data on adverse events that are the result of treatment, such as hospital-acquired infections and the unintended effects of drugs and medical devices. Among hospitals participating in CDC's infection surveillance system, bloodstream infection rates have decreased by more than 30 percent since 1990, and wound infections following surgery have decreased by 60 percent among high-risk patients.
- **The National Practitioner Data Bank (NPDB)** serves as a nationwide system to assist state licensing boards, hospitals, and other health care entities to investigate the qualifications of health care practitioners they seek to license, hire or grant clinical privileges. The NPDB collects information on specific areas of the practitioner's licensure, malpractice payment history and record of adverse actions on clinical privileges. Only eligible entities, defined by statute and regulations, may report and query the NPDB. It is not open to the general public.

Public/Private Partnerships

Many research and policy institutes are addressing patient safety issues with support from federal and private foundation funding. Some of the major centers include:

- **The Institute of Medicine** was established in 1970 by the National Academy of Sciences to address health quality issues. The Institute has published the well-known reports on patient safety and quality, *To Err is Human*, 2000, and *Crossing the Quality Chasm*, 2001.
- **The National Quality Forum** is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Leaders in the public and private sectors created the Forum to improve the quality of healthcare that affects not only patient outcomes, but workforce productivity and healthcare costs. The Quality Forum has developed a minimum set of 27 event reporting indicators, and is working on additional safety practices and measures to improve quality of care.
- **The National Academy for State Health Policy** is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice.

The Health Care Industry

Various components of the health care industry have been active in promoting patient safety. Key players include academic health centers, ambulatory facilities, health maintenance organizations, hospitals, industry associations, long-term care facilities, and provider associations. In 1996, the American Medical Association and others founded the National Patient Safety Foundation (See below). The pharmaceutical industry, various physician specialists' societies, as well as the American Hospital Association and the American Nurses Association have very active patient safety initiatives.

- **The National Patient Safety Foundation** was established in 1996 by the American Medical Association and others, to improve patient safety by identifying and applying a core body of knowledge, raising public awareness and fostering communication, to create a culture of patient safety.
- **The Joint Commission on Accreditation of Health Care Organizations (JCAHO)** is an independent not-for-profit organization that voluntarily evaluates and accredits nearly 18,000 health care organizations and programs across the United States. JCAHO has a patient safety agenda including new standards that went into effect in July of 2001. Beginning January 1, 2003, organizations providing care relevant to the patient safety goals will be surveyed for compliance with the recommendations.

JACHO's 2003 national patient safety goals are to:

- Improve the accuracy of patient identification.
- Improve the effectiveness of communication among caregivers.
- Improve the safety of using high-alert medications.
- Eliminate wrong-site, wrong-patient, and wrong procedure surgery.
- Improve the safety of using infusion pumps.
- Improve the effectiveness of clinical alarm systems.

To support patient safety and quality of care, JCAHO launched the ORYX initiative in 1995 to introduce standardized core performance measures into the accreditation process. The initiative became operational in 1999, when accredited hospitals and long term care organizations began transmitting performance data. The Joint Commission is working with federal agencies and with the Leapfrog Group to establish consistent quality measures and identify standards applicable to all hospitals.

Purchasing Groups

The Leapfrog Group

One of the Institute of Medicine's recommendations is for large purchasers to provide more market reinforcement for quality and safety. The largest such group is the Leapfrog Group founded in 2000 by the Business Roundtable, a national association of Fortune 500 CEO's (Leapfrog Fact Sheet, 2003). The Leapfrog Group is a coalition of more than 130 Fortune 500 companies and other large private and public health care purchasers that provide health benefits to approximately 33 million Americans. Leapfrog members and their employees spend more than \$56 billion on health care annually.

Leapfrog is a voluntary program to mobilize large purchasers to improve patient safety and customer value through consumer education, performance comparison of providers, and hospital incentives. It seeks to reward provider improvements through preferential use and other market reinforcements. The Leapfrog Group has identified three initial hospital safety measures to focus on: computer physician order entry; evidence based hospital referral; and intensive care unit (ICU) staffing by physicians trained in critical care medicine.

- **Computer Physician Order Entry for Medications (CPOE)**—Physicians enter medication orders via computers linked to prescribing error prevention software. According to the Leapfrog Group CPOE has been shown to reduce serious prescribing errors in hospitals by up to 88%.
- **Evidence-Based Hospital Referral**—Patients needing certain complex medical procedures are referred to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a hospital performs these procedures each year. According to the Leapfrog Group research indicates that a patient’s risk of dying could be reduced by more than 30%.
- **ICU Physician Staffing**—Staffing ICUs with physicians who have credentials in critical care medicine. According to the Leapfrog group qualified staffing has been shown to reduce the risk of patients dying in the ICU by close to 30%.

Leapfrog's initial efforts focused on seven regions around the country (Atlanta, California, East Tennessee, Michigan, Minnesota, Seattle-Tacoma-Everett, and St. Louis). In April, 2002, Leapfrog announced 12 new regions, including Central Florida. The Central Florida Health Care Coalition was chosen in Florida because it is already an advocate for the health care of over a million people in member organizations.

State Purchasing Groups

Georgia is an example of such a purchasing initiative in the public sector, according to the National Academy for State Health Policy. In 2001, the Georgia Department of Community Health (DCH) revised its contract requirements for hospitals treating state employees and Medicaid recipients, to require that contract hospitals participate in a patient safety program. The Georgia Hospital Association’s (GHA) Partnership for Health and Accountability had already established a protected peer review system for voluntarily reporting, studying, and learning from non-fatal errors and “near misses.” The GHA’s voluntary error reduction program met the DCH patient safety program criteria. With the state’s support, hospital participation in GHA’s program increased substantially.

State Approaches to Patient Safety

The primary roles state governments play in patient safety that have been identified by the National Academy for State Health Policy are:

- Protecting public health and safety,
- Using oversight authority through licensure of healthcare facilities and providers,
- Regulating private health insurance,
- Purchasing significant amounts of health care, and
- Providing innovations to make the health care system safer.

The types of actions that states have taken to improve patient safety according to the academy are:

- Linking patient safety and reform.
- Creating patient safety centers to coordinate state agencies and develop innovative strategies for reducing errors.
- Including patient safety as part of facility licensure requirements.
- Developing provider profiles to provide information to the public.
- Joining purchasing groups devoted to improving patient safety.
- Providing patient safety educational programs and materials for consumers and providers.

Other steps the group has identified that states have taken to improve quality of care include: developing quality purchasing specifications for Medicaid managed care, implementing performance measures, and fostering interagency collaboration.

Recent State Legislation

The National Academy for State Health Policy has tracked state legislative responses to patient safety issues for several years. In its latest report, the academy analyzes 61 bills introduced during the 2001 legislative session to address the problem of medical errors. The report found that the number of bills has increased more than five-fold from 11 bills in 1999, when the Institute of Medicine report on medical errors was first released, to 61 in 2001. Since 1999, 106 pieces of legislation addressing some aspect of patient safety have been introduced in 26 states. Of the 61 bills introduced in 2001, 12 were enacted. (State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals, February, 2002.)

The academy report found state proposals to reduce medical errors fall into eight categories, reflecting the key strategies that state policy makers are using in each state.

Recent legislation in other states includes provisions for:

- System-wide analysis.
- Reporting systems.
- Conditions of licensure.
- Medication error reduction.
- Minimum staffing requirements.
- Financial incentives.
- Public disclosure requirements.
- Adequate funding of existing improvement efforts.

Pennsylvania: A Comprehensive Approach

Pennsylvania has enacted the most recent legislation that provides a comprehensive approach to patient safety. The Medical Care Availability and Reduction of Error Act (Act 13) was signed into law in March, 2002. The Act addresses the issue of medical professional liability reform

through tort reform, catastrophic insurance fund reform, and patient safety. Chapter 3 of Act 13 specifically relates to the reduction of medical errors and improvement of patient safety. The patient safety provisions of the act apply to ambulatory surgical facilities, birthing centers and hospitals. The chapter:

- Establishes a Patient Safety Authority.
- Establishes a patient safety trust fund.
- Requires medical facilities to develop, implement and comply with an internal patient safety plan.
- Requires reporting of serious events or incidents, as well as providing written notification to any patients affected by a serious event.
- Requires that each medical facility designate a patient safety officer, as well as create a patient safety committee.
- Includes confidentiality and compliance.
- Requires patient safety discounts under medical malpractice insurance.

Health care workers and medical facilities are now required to report serious events and incidents to a newly established Patient Safety Authority. The authority must in turn contract with an outside agency to analyze the reports and make recommendations to improve patient safety. Patients affected by a serious event in a medical facility must receive written notice of the event.

State Level Initiatives to Address Specific Patient Safety Issues

The National Governor's Association's (NGA), Issue Brief on Addressing the Medical Malpractice Insurance Crisis (December, 2002), identifies what states are doing to address patient safety, including licensure of healthcare facilities and providers, and enforcing sanctions against those that are negligent:

State Medical and Licensing Boards

The primary responsibility of state medical boards is to protect consumers of health care through proper licensing and regulation of physicians. Funding for medical boards' activities comes from licensing and registration fees. According to the NGA report some state boards are independent and exercise all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as the Department of Health, and exercise varied levels of responsibilities, or function in an advisory capacity.

The NGA report found state medical boards are frequently criticized for taking too long to investigate negligent providers and for not dispensing stiff penalties for those found guilty of negligence. They are accused of not providing adequate information to the public about physicians who have been disciplined or accused of malpractice. State medical boards in turn, argue that they can only perform their mission if they are properly organized, effectively empowered, and adequately funded. The NGA report suggests that states review their medical practice act to enhance the power of state medical boards.

Reporting Systems

Medical boards are the traditional institution to which negligence is reported. Because providers do not voluntarily report their own errors, hospitals, managed care organizations, and medical colleagues are usually required to report their members or peers. According to the NGA, state requirements for reporting errors and malpractice by managed care organizations and hospitals vary. Twenty states, including Florida, require mandatory reporting of medical errors and adverse events. Such reporting requires a delicate balance between the roles of public accountability and learning from errors, and between legitimate reports and those motivated for other reasons.

The NGA reports that New York has required hospitals to report adverse incidents since 1985. Adverse events include both unexpected bad outcomes and medical errors. The reporting system was created in partnership with hospital industry representatives, consumer advocates, and representatives of medical specialties, and phased-in over three years through a series of regional pilot projects. The reported information is used by the NY Department of Health for news and alerts for hospitals; public reports; and internally for surveillance activities and statewide quality improvement activities.

Hospitals use the information to compare themselves with peer groups and over time. They can focus on occurrences that appear unusual and look for patterns and trends to identify improvements and measure their effectiveness. The public has access to aggregate hospital-specific data to inform healthcare decisions.

Medical Guidelines

Medical guidelines set risk management protocols and practice parameters for specialists in obstetrics/gynecology, emergency medicine, anesthesia, and radiology or other high risk areas. Medical guidelines use scientific evidence to promote best practices in specific areas of medical care that allow physicians to defend themselves against malpractice claims.

Physicians who demonstrate they followed the practice criteria for safety and effectiveness set forth in the guidelines have an affirmative defense against medical malpractice claims. If the jury decides that the physician followed the published guidelines, the physician cannot be sued for malpractice. Doctors who follow the practice guidelines can limit their use of defensive medicine such as avoiding high risk patients and procedures and ordering extra tests, according to the NGA report.

Patient Safety Centers

In addition to reporting requirements for medical errors, states can create centers to collect data on medical errors for research and evaluation, develop innovative strategies to reduce errors, develop provider profiles and provide information to the public.

The Iowa Department of Health created the Iowa Patient Safety Program in 2000 to develop a collaborative strategy to improve patient safety and health outcomes in Iowa (NGA 2002). It is non-punitive. The program focuses on improving patient safety through information sharing and developing evidence-based best practices. It is addressing the legal issues surrounding the rights and responsibilities of health care providers and patients, including and assuring confidentiality of data for all stakeholders.

Patient Safety Organizations

Another state initiative to improve patient safety reported by the National Academy for State Health Policy (Statewide Patient Safety Coalitions, 2002) is state patient safety organizations. They serve as a single contact point or clearinghouse for receiving and disseminating information about state patient safety activities. Such organizations have been implemented in Georgia, Massachusetts, Minnesota, Pennsylvania, Wisconsin and Virginia. A common goal of these groups is to share information and resources in order to solve patient safety problems and avoid redundant and competing patient safety initiatives. The groups work to educate health care professionals, purchasers, consumers, patients and policymakers about the nature of medical errors, the culture of safety, and strategies for reducing risks.

Generally, there are four types of patient safety organizations .

- 1) **Public/private partnerships or coalitions** are the most prevalent. As of May 2002, there were twelve coalitions comprising a diverse membership of providers, government, insurers, health plans, consumers, and community stakeholders like major employers, labor unions, or teaching institutions. These groups focus on specific problems and solutions relating to medical errors and patient safety. The other three types of organizations include:
- 2) **Advisory committees, commissions, or task forces**, of which only one currently exists,
- 3) **Research focused groups** which exist in three states, and
- 4) **Provider-driven patient safety alliances** which are similar to public/private partnerships but have restricted membership that often does not include consumers or governmental agencies. Florida is one of two states which currently have this type of entity.

Pennsylvania Patient Safety Collaborative: The Pennsylvania collaborative is a network of 27 organizations representing health care providers, insurers, organized labor, private industry, and consumers. Its goal is to address the systemic issues that lead to medical errors and work to reduce patient injury through identification and correction of the causes of medical errors. The collaborative fosters information sharing about patient safety practices, changes in systems to prevent causes of errors, and ongoing stakeholder dialogue to support patient safety improvement.

Massachusetts Coalition for the Prevention of Medical Errors: The Massachusetts coalition was initiated in 1997 as a statewide collaborative effort to improve patient safety and minimize medical errors. The goals of the coalition are to:

- Establish a mechanism to identify and implement best practices to minimize medical errors;

- Increase awareness of error prevention strategies through public and professional education; and
- Identify areas of mutual interest and minimize duplication of state regulatory and Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) requirements to improve patient safety.

Virginians Improving Patient Care and Safety (VIPCS) is a coalition composed of various health care provider groups, health plans, and governmental agencies. It supports continuous improvement in quality of care and patient safety through:

- Collaborative efforts among consumers and other purchasers, providers, health plans, regulators, accrediting bodies, and others;
- Dissemination and implementation of best practices; and
- Education and training guided by appropriate data collection and analysis.

The Virginia group promotes confidential, non-punitive safety reporting systems. The group believes that policy makers and regulators should allow healthcare providers the flexibility to determine the specifics of error reduction programs that best suit local conditions, evolving science and a focus on systems improvement. It supports the role of purchasers in evaluating and rewarding those payers and providers who demonstrate clear improvements in healthcare quality and patient safety.

Recent Legislation in Florida

Florida Commission on Excellence in Health Care

In 2000, the Legislature explicitly addressed issues of patient safety raised in the Institute of Medicine's To Err is Human report in 2000. The Legislature created the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement.

The Legislature found that:

- The current system of regulating health care practitioners and health care providers is one of blame and punishment, and does not encourage voluntary admission of errors and immediate corrective action on a large scale.
- Previous attempts to identify and address areas which impact the quality of care provided by the health care industry have suffered from a lack of coordination among the industry's stakeholders and regulators.

Implementation of Commission Recommendations

The Commission presented its report to the Governor and Legislature on February 1, 2001. In response, the 2001 Legislature adopted many of the recommendations of the Commission as part of CS/SB 1558 (ch. 2001-277, L.O.F.). The legislation required:

- **Acts for Which a Physician May Be Disciplined:** Specific standards of care, including wrong site surgery and leaving a foreign body in the patient, were added to the acts for which a licensee may be disciplined.
- **Risk Management:** Risk management programs in hospitals and ambulatory surgical centers must implement measures to minimize surgical mistakes.
- **Notice Regarding Disciplinary Investigations:** The Department of Health be allowed if requested, to notify patients or their legal representatives of the status of disciplinary investigations, and provide any reports from experts held by the Department.
- **Notice to the Public:** The Department of Health must maintain a website with copies of healthcare regulatory board newsletters, information relating to adverse incident reports, and information about error prevention and safety strategies.
- **Continuing Education:** All healthcare personnel in hospitals and ambulatory surgical centers must complete a two-hour course approved by the Board of Medicine relating to the prevention of medical errors.

Expanded Reporting Requirements

The 2001 Legislature also passed Senate Bill 1202 that requires long term care facilities such as nursing homes and assisted living facilities to establish risk management and quality assurance programs as are already required of hospitals.

The Center for Patient Safety Was Not Established

The 2001 Legislature did not, however, address the recommendation of the Commission with regard to the formation of a Center for Patient Safety and Excellence in Health Care. The Commission recommended that the Legislature create a Center for Public Safety and Excellence in Health Care, and empower the center to, among other tasks:

- Collect and establish a statewide database on health care errors, adverse incidents, and near misses, maximizing the use of existing data.
- Analyze statewide data on health care errors in procedures, products and systems.
- Convene multi-disciplinary work groups of all stakeholders to address health care errors and patient safety practices that can be used in developing practice guidelines and standards.
- Disseminate research on health care errors and patient safety practices to professional societies, hospitals, health plans, and ambulatory surgical centers and encourage them to incorporate patient safety into their practice guidelines.
- Develop materials that professional organizations, regulatory bodies and consumers can disseminate, reprint, or adapt to improve patient safety.
- Encourage medical schools, teaching hospitals, and health care educational programs to incorporate the patient-safety training program into their curriculum.

In 2002, HB 1219 again addressed the need for such a center. The bill established a statewide, academically based center to serve as the designated resource for patient-safety-related research, education, and policy information. The bill created the Florida Center for Patient Safety at the Health Science Center at the University of South Florida and the College of Medicine at the

Florida State University. The bill passed the House 117-0. It and SB 2294 (its companion) died in the Senate.

Current Law in Florida

Florida already has in place many of the provisions being considered in other states.

Patient Safety Provisions for Healthcare Facilities

Risk Management Programs in Hospitals and Surgical Centers

Under s. 395.0197, F.S., each hospital, ambulatory surgical center, and mobile surgical facility is required to establish an internal risk management program. These programs are part of the quality assurance process that hospitals, ambulatory surgical centers, and mobile surgical facilities use in their operations to ensure that “adverse incidents,” are examined on a continuous basis. The statute:

Defines an adverse incident to be:

1. An event over which health care personnel could exercise control,
2. Which is associated with the medical intervention rather than the condition for which the intervention was performed, and
3. Which resulted in one of the following:
 - Death,
 - brain or spinal damage,
 - permanent disfigurement,
 - fracture or dislocation of bones or joints,
 - limitation of neurological, physical, or sensory functioning,
 - any condition that required specialized medical attention or surgical intervention, or
 - any condition that required transfer of the patient to another facility or a unit providing a more acute level of care.

An internal risk management program must provide for:

1. The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients,
2. The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including specifying the circumstances under which staff may have access to patients in a recovery room subject to alternative surveillance measures,
3. The analysis of patient grievances that relate to patient care and the quality of medical services; and
4. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents.

A facility's governing board is responsible for the internal risk management program. The governing board is required to engage a risk manager to implement and oversee the program. Risk managers are exempted from liability and legal action for activities they undertake in implementing an internal risk management program that is in conformity with law, as long as they are not intentionally fraudulent in their conduct. The qualifications of a risk manager, procedures for licensure, and fees are established in s. 395.10974, F.S.

AHCA is responsible for determining if risk management programs are "...conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents." (ss. 397.0197(16), F.S.)

Similar risk management programs are required for Nursing Homes, s. 400.147 F.S., Assisted Living Facilities, s. 400.423, F.S., and Health Maintenance Organizations, s. 641.55, F.S.

Adverse Incident Reports

Section 395.0197, F.S., also provides that three types of adverse incident reports are reported to the Agency for Healthcare Administration (AHCA): the 24-hour report, the 15-day report and the annual report. Facilities are required to investigate and analyze adverse incidents and develop measures to minimize the risk of adverse incidents to patients. They are also required to analyze patient grievances related to patient care and quality. In addition, hospitals and ambulatory surgical centers must report new malpractice claims.

A 24-hour report is to be issued by a facility within one business day after the risk manager receives an adverse incident report and determines that any of the following occurred:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong-site surgical procedure;
- The performance of a wrong surgical procedure;

The written notification must include the initiation of an investigation by the facility, and whether the events causing the adverse incident pose a potential risk to other patients.

A 15-day report must be issued within 15 calendar days after the occurrence of any of a 24 report and must include the following additional types of adverse incidents:

- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or condition;
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk; or,
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

An annual report summarizes the incident reports that have been filed in the facility for the year. The annual report must include:

- The total number of adverse incidents;

- A listing of the types of operations or diagnostic or treatment procedures that resulted in injury and the number of incidents;
- A listing of the types of injuries caused and the number of incidents;
- A code number using the health care professional's license number and a separate code number identifying all other individuals directly involved in the adverse incident; and,
- A description of all malpractice claims against the facility.

Publication of Summary Adverse Incident Reports and Trend Analysis: Section 395.0197(9), F.S., requires the AHCA to publish on its website a summary and trend analysis of adverse incident reports. The agency also must publish an annual summary of all adverse incident reports and malpractice claim information provided by the facilities in their annual reports. The quarterly and annual summaries must not include information that would identify the patient, the reporting facility, or the health care practitioners involved.

The following table of the number and types of adverse incident and malpractice claims reports is available on the AHCA website.

Adverse Incident Reports

Annual Report	1996	1997	1998	1999	2000
Annual Report (total incidents)	5,140	5,517	5,113	3,808	4,541
(New) Malpractice Claims	733	718	783	916	949
Code 15 Reports	856	1,102	994	720	920
24 Hour Reports	N/A	N/A	110	171	226

There were 273 licensed hospitals and 263 licensed ambulatory surgical centers, January 2001.
Source: Agency for Health Care Administration

In 1999, the Legislature changed the definition of adverse incidents for annual and code 15 reports. Events from surgical procedures described in patient consent forms are no longer reported.

Exemptions from Public Records Requirements

Section 395.0198, F.S., exempts information in a 24 hour adverse incident report from the disclosure requirements of ch. 119, F.S., relating to public records and s. 24(a) and (b), Art. I of the State Constitution for. The information is also made confidential. This exemption is scheduled for repeal on October 2, 2003, unless it is reviewed and saved from repeal by the Legislature.

Under s. 395.0197(8), F.S., the entire 15-day report is exempt from the public records law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. Under s. 395.0197(6), F.S., the annual report is also confidential and exempt from the public records law and is not discoverable or admissible in any civil or administrative action.

Public records exemptions for the 15-day report and the annual report were implemented prior to the Florida Constitution's requirement of a five-year renewal cycle for their continued effect. Thus, the public records exemption for the 24-hour report is the only exemption subject to repeal.

Other Statutory Requirements that Support Patient Safety

Additional agency authority that supports patient safety is established in s. 408, F.S., including:

- **The State Center for Health Statistics** which is established in s. 408.05, F.S., to collect, analyze and disseminate health care data, including the quality of care data, and provide technical assistance. Its purpose is to provide a comprehensive statewide health information system overseen by a State Comprehensive Health Information Advisory Council.
- **Practice Parameters**, defined as strategies for patient management developed to assist physicians in clinical decision making, are to be established under AHCA's leadership, s. 408.02, F.S. Every hospital, in conjunction with the hospital medical staff, is required to produce outcome data by diagnosis for each patient for use in developing practice guidelines.

Patient Safety Provisions for Healthcare Practitioners

General Provisions for Reporting and Discipline of Health Professionals

Chapter 456, F.S., provides for the regulation of health professions and occupations to protect the health, safety, and welfare of the public. Specific provisions for each health care profession are provided in different statutes. The general provisions to protect patient safety in chapter 456, F.S., include:

- **Licensing board disciplinary proceedings**, s. 456.073, F.S., including investigation, probable cause, and administrative law hearings for practitioner errors and negligence.
- **Practitioner self reporting of liability claims** and actions against them due to errors, and the safety steps they take (applies to medical physicians, osteopathic physicians, podiatric physicians and dentists). (s. 456.049, F.S.)
- **Continuing education in prevention of medical errors**, through a two hour course that includes root-cause analysis, error reduction and prevention, and patient safety; required for licensure and renewal. (ss.456.013(7),F.S.)
- **Department of Health analysis of claims data** to determine the nature, causes, costs and damages of professional liability cases.
- **Protection from civil liability for those who report** incompetence, impairment or unprofessional conduct of certain health care providers. (ss. 456.073(12), F.S.)
- **Department publishing of information on a web site** regarding adverse incidents, error prevention strategies and best practices.
- **Practitioner profiles published on a web site** for consumers that include information on the training and experience and disciplinary actions related to practitioner's competence to practice their profession.

For medical and osteopathic physician's the practitioner profiles also include criminal sanctions and liability actions. The profiles do not include any disciplinary action taken by a licensed hospital or an ambulatory surgical center.

Specific Provisions for Each Healthcare Profession

Each health care profession is regulated by separate statutes that state the purpose of licensure to protect the public safety, and establish the profession's scope of practice, grounds for disciplinary actions and other licensure functions.

Both medical physicians and osteopathic physicians have similar provisions for patient safety reporting and disciplinary actions. Other professions do not include reporting from offices.

Medical physicians:

- **Grounds for disciplinary actions** by the board and department, s. 458.331, F.S.
- **Reports of disciplinary actions** by medical organizations and hospitals, s. 458.337, F.S.
- **Reports of adverse incidents in office practice settings**. s. 458.351, F.S.

Osteopathic physicians :

- **Grounds for disciplinary actions** by the board and department. s. 459.015, F.S.
- **Reports of disciplinary actions** by medical organizations. s. 459.016, F.S.
- **Reports of adverse incidents in office practice settings**. s. 459.026, F.S.

Limitations of Current Statutes for Improved Patient Safety

The primary limitations of existing statutes for addressing improved patient safety are their focus on compliance, with required reporting of adverse incidents and sanctions for failure to comply with regulations.

- Under current law, hospitals and ambulatory surgical centers are not required to report "near misses" nor develop strategies to minimize these types of errors. There is no assistance to healthcare providers to identify ways to prevent errors.
- Self reporting of adverse incidents is not required of other healthcare professions than medical and osteopathic physicians, including chiropractic physicians, podiatric physicians and nurses.

Section 395.0197, F.S., requires hospitals, ambulatory surgery centers, and nursing homes to have risk management programs, but there are no provisions for how risk management is to be conducted in facilities

- Fears of liability from any reported information that may be made public may hinder risk management programs.
- Subsection (2) provides that a risk manager may be responsible for up to four risk management programs in separately licensed facilities, or more than four separate facilities if the facilities are under the same corporate ownership or are in rural hospitals. A large multi-hospital corporation may under Florida law, have one risk manager for all of its hospitals.

Most of the other data reporting and analysis functions that are provided for throughout the healthcare statutes are directed towards planning purposes, not improved operations that lead to patient safety and quality of care.

Current Florida Agency Programs that Address Patient Safety

Agency for Health Care Administration Programs

The Legislature created the Agency for Health Care Administration (AHCA) as part of the Health Care Reform Act of 1992 (Ch. 92-33, L.O.F.) to improve the state's efficiency in addressing health care issues. The agency includes a Managed Care and Health Quality Program to ensure access to quality health care through the licensure, monitoring and regulation of facilities and services.

Health Facilities Compliance with Regulations

The Hospital and Outpatient Services Unit within the Division of Health Quality Assurance is responsible for licensing, registering, and regulating hospitals, outpatient and health care service facilities. It ensures that facilities and services comply with standards of safety and quality established by state and federal regulation. The unit regulates 15 diverse types of facilities, providers, suppliers, and programs as follows:

Abortion Clinics	Organ & Tissue Procurement
Ambulatory Surgical Centers	Partial Hospitalization Program
Birth Centers	Portable X-ray
Comprehensive Outpatient Rehab. Facilities	Rehabilitation Agencies
Crisis Stabilization Units & Short Term Residential Treatment Facilities	Residential Treatment Facilities
Diagnostic Imaging Services	Risk Management
Hospitals	Rural Health Clinics
	Utilization Review

Health Facilities Compliance develops policies and procedures for facility licensure, background screenings and risk management, as well as certificate of need policies and financial analysis. Field Operations inspects health care facilities and recommends federal certification of health care facilities that participate in Medicaid/Medicare programs. Field Operations investigates complaints against facilities and imposes sanctions when facilities fail to meet minimum regulatory standards.

Adverse Incident Reporting

The three types of adverse incident reports required from healthcare facilities are sent to AHCA to monitor patient safety, and the agency is required to publish a summaries and trend analyses of adverse incident on its website. The following table is an example of such summaries.

Summary of Reported Code 15 Injuries by Outcome 2001

Outcome	Hospitals	Ambulatory Surgical Centers	Total Number Reported	Percent of Total
Death	321	21	342	33%
Brain Damage	52	4	56	5%
Spinal Damage	18	2	20	2%
Surgical Procedure Performed on Wrong Patient	9	0	9	1%
Surgical Procedure Unrelated to Patient's Diagnosis or Medical Need	83	2	85	8%
Surgical Procedure Performed on Wrong Site	39	13	52	5%
Surgical Procedure to Remove Foreign Objects	10	6	16	2%
Wrong Surgical Procedure Performed	116	3	119	11%
Surgical Repair of Injuries or Damage Resulting from a Surgical Procedure	286	66	352	33%
Total	934	117	1051	100%

Source: Agency for Health Care Administration, Div. of Managed Care and Health Quality, March 2002

The State Center for Health Statistics

AHCA houses the State Center for Health Statistics (SCHS) which serves as a source of available health care data and consumer information. Center databases include hospital inpatient, ambulatory outpatient, and other health-related information. SCHS uses the data to create detailed reports of health care trends and outcomes of specific diagnoses. Examples of databases used by the Center that include patient safety information are:

- **AHCA's adverse incidents reports in acute and outpatient care (RMMS).** Data on adverse outcomes and malpractice claims reported by hospitals, ambulatory surgical centers and HMOs.
- **Department of Health's health professional investigations (PRAES).** Information used to track the investigation and handling of complaints against health professionals.
- **Department of Insurance's malpractice and professional liability closed claims.** Information on closed claims against physicians, dentists, hospitals, HMOs, abortion clinics, ambulatory surgical centers, crisis stabilization units.

Consumer Complaint and Information Call Center

AHCA provides a toll-free telephone system for consumers to call in order to file complaints, and receive publications, information and referral numbers. This system is accessed by calling (888) 419-3456. The call center handles complaints against:

- Health care facilities, such as a hospital, nursing home, assisted living facility and home health agencies.
- Health maintenance organizations.
- Health care practitioners such as a doctor, nurse, dentist or therapist.

Department of Health Programs

Medical Quality Assurance

The Department of Health’s Medical Quality Assurance Program (MQA) regulates health care practitioners to ensure they meet the standards of their profession. Currently, the program supports licensure and disciplinary activities for 37 professions and 6 facilities, and works with 22 boards and 6 councils. In total, MQA regulates more than 750,000 health care practitioners and facilities. Practitioners must demonstrate their proficiency by meeting testing, licensing, credentialing and continuing education requirements. (MQA Annual Report 2001-2002.)

The regulated professions are:

Acupuncture	Naturopathic Physicians
Athletic Trainers	Nursing
Certified Nursing Assistants	Nursing Home Administrators
Chiropractic Physicians	Occupational Therapy
Clinical Laboratory Personnel	Opticianry
Clinical Social Workers/Counselors	Optical Establishments
Dentistry	Optometry
Dental Laboratories	Orthotists and Prosthetists
Dietetics/Nutrition	Osteopathic Physicians
Electrolysis	Pharmacists
Electrolysis Facilities	Pharmacies
Hearing Aid Specialists	Physical Therapy
Marriage and Family Therapists	Physicians
Massage Therapists	Physician Assistants
Massage Establishments	Podiatric Medicine
Master-Social Work	Psychology Examiners
Medical Physicists	Respiratory Care
Mental Health Counselors	Speech Language Pathology & Audiology
Midwifery	School Psychology

Professional Licensing Boards and Councils

Most health care practitioners in Florida are governed by professional licensing boards or councils that are independent entities assigned to the Department of Health for administrative support purposes. MQA also directly regulates some practitioner groups that are not governed by an external board or council, as well as some health care facilities, such as pharmacies.

Regulatory responsibilities include :

- Setting licensing requirements for the profession;
- Establishing standards of professional practice;
- Verifying applicant credentials (credentialing);
- Preparing and administering licensing examinations;
- Issuing and renewing members' licenses; and
- Curtailing unlicensed activity.

Enforcement Activities

The Medical Quality Assurance program is responsible for health care practitioner enforcement activities, including a consumer complaint call center, investigation, and legal services. The program investigates complaints and assesses probable cause for each case. Cases are then presented to licensing boards and councils for final action. If a board finds that an allegation is justified, it may take disciplinary action. If a practitioner contests a finding of probable cause, the case is heard by an administrative law judge. Disciplinary measures can range from a reprimand and fine to suspension or revocation of the practitioner's license. (MQA Annual Report 2001-2002.)

- **The Consumer Services Unit** is the central intake unit for receipt of complaints against health care professions regulated by the department. It analyzes complaints for possible violations of laws and rules to determine if they are legally sufficient for investigation. The unit received over 32,000 complaints and reports in fiscal year 2001-2002.
- **The Investigative Services Unit** has 11 offices located throughout the state, staffed with professional investigators and senior pharmacists, who investigate legally sufficient complaints against practitioners and monitor licensees who have been disciplined. The unit completed over 5,400 investigations in 2001-2002.
- **The Prosecutorial Services Unit**, located in Tallahassee, provides legal support for all healthcare boards and their councils, from filing of a complaint through the appeals process. The unit resolved over 7,000 complaints in 2001-2002.
- **Unlicensed Activity.** Prior to July 2002, AHCA handled unlicensed activity investigations. Currently all MQA enforcement activities, including unlicensed activity investigations, are consolidated in the Department of Health.

Practitioner Profiles

Practitioner profiles include information obtained from physicians, podiatrists, chiropractors, osteopathic physicians, and advanced registered nurse practitioners at the time of licensure or license renewal. The information includes the practitioner's educational and professional

background, and a description of any final disciplinary actions taken against him or her within the last 10 years by the profession’s regulatory agency or board. Profiles for 58,781 licensed practitioners can be accessed on MQA’s Physician Profiling website.

Physician Cases Adjudicated by the Division of Administrative Hearings

The argument that there is a national malpractice crisis implies the regulatory environment of specific states has little bearing on the problem. In fact, the Board of Medicine took action against 225 physicians during fiscal year 2001-02, which ranks first among large states in the percentage of licensed physicians disciplined according to the Federation of State Medical Boards. However, Florida ranked 26th among state boards for the rate of issuing tough sanctions for violations. For 2001, Florida imposed serious discipline on 3.04 physicians per 1000. California imposes serious discipline on 3.05 of its physicians per 1000 (Public Citizen).

In addition to state board discipline, the Division of Administrative Hearings, DOAH, has adjudicated an average of about 25 physician cases per year over the last 13 years. In about 63 percent of the cases, DOAH found the physician guilty. In about 46 percent of the cases in which DOAH found the physician guilty (or about 29 percent of all physician disciplinary cases), DOAH recommended serious discipline including revocation or suspension of license.

Annual Number of Physicians Adjudicated by
Department of Administrative Hearings

Year	Cases	Still Pending
1990	36	
1991	27	
1992	18	
1993	46	
1994	44	
1995	13	
1996	24	
1997	13	
1998	17	
1999	17	
2000	24	2
2001	30	1
2002	8	8
Total	317	11

Source: Department of Administrative Hearings, 2003

Repeated Malpractice Cases and Remedies

The record of DOAH provides a summary of cases heard involving physicians who are repeat offenders. Repeated malpractice, (s. 458.331(1) (t), F.S.) includes three paid claims (in excess of \$25,000) during a five year span. DOAH found that about ten percent (35 cases) of 333 cases over the last 13 years are potential repeat offenders, and yet no physicians have been charged as

a repeat offender. The Board of Medicine has not charged a physician with “repeated” malpractice since January 1, 1990.

Improvements Needed in State of Florida Programs

While information about facilities and practitioners is collected and some mechanisms are in place to correct problems, there is a concern that much of the information is not being used in a systematic way to improve patient safety. There is no center or coalition charged with coordinating and ensuring patient safety improvements statewide as have been established in other states. Current reporting and improvement efforts have met resistance from some health care organizations and providers who perceive the medical liability system as a serious impediment to systematic efforts to uncover and learn from errors.

The Office of Program Policy Analysis and Government Accountability, OPPAGA, found in its Justification Review of the AHCA’s Health Care Regulation Program, (Report No. 01-24, May 2001) that the agency needs to improve its response to serious situations that represent an immediate threat to consumers, and increase sanctions for hospitals that fail to report harm to patients.

Approaches to Addressing Patient Safety Issues

Choice and Competition

When the Speaker of the Florida House of Representatives, Johnny Byrd, addressed participants of the 2003 Florida Health Care Summit, January 9, 2003, he strongly urged legislators to involve the private sector in developing innovative solutions to Florida’s health care concerns. Speaker Byrd said “We will work together toward making Florida’s health care more efficient, modern and responsive. We can begin by focusing our healthcare priorities on legislation that protects the health and safety of the patient, practitioner and provider.” He urged that we “find a way to empower individuals and consumers in healthcare.”

According to Mark McClellan, Commissioner of the U.S. Food and Drug Administration, and a physician and economist, the direction of federal policy is also to approach to address health care problems through choice and competition, with patients working with doctors to make decisions that provide them with safe, quality care (Heritage Lecture #768, Nov. 2002).

Providing Information

McClellan argues that choice and competition can work in health care as in other economic sectors to promote innovation, and encourage new ideas for controlling costs and delivering care in a more effective way. One of the primary roles the government can play in improving the

health care market, according to McClellan, is to provide information so consumers can make informed choices, and providers can compare themselves with their competition. The government can help provide the right kinds of incentives so that doctors and patients are making the best use of the resources available.

According to the Institute of Medicine, the recommendations of their report are to encourage these types of incentives. The combined goal of the recommendations is to change the external environment of health care to create sufficient pressure to make errors costly to health care organizations and providers so they are compelled to take action to improve safety.

Options for Improved Patient Safety

The 2001 report of the Florida Commission on Excellence in Health Care addressed specific patient safety issues identified by the Institute of Medicine report, “To Err is Human” (2000). It recommended improvements in training curricula, dissemination of information, practice guidelines, error reporting, and creation of a center for patient safety to analyze error data and develop system improvements.

The following options identified through the work of the Florida House Select Committee on Medical Liability Insurance and review of national and state efforts, address improved patient safety using several related strategies. The strategies include identifying and learning from errors, setting expectations for safety and implementing safety improvement systems.

Suggested options include:

- 1) **The Legislature could establish a Patient Safety Authority to develop a “near miss” reporting system** to improve patient safety in Florida. The Authority would serve as a public/private partnership to coordinate and provide leadership to patient safety efforts in the state. The authority would work with hospitals, physicians and other healthcare providers, purchasing groups, consumers, the Agency for Health Care Administration, the Department of Health, and other stakeholders, to develop a “near miss” reporting system, identify causes of medical errors and develop systems to reduce them. The duties of the Patient Safety Authority could include:
 - a) Coordinating development of a new voluntary and confidential “near miss” reporting system. The purpose of the system would be to detect system weaknesses that cause medical errors before they result in serious harm.
 - b) Working with already existing data efforts by health care providers, purchasers and accreditation organizations, to develop standardization of data, data sharing, and analysis.
 - c) Helping to establish a source of data and analysis for health care facilities, providers and organizations to use in their own quality improvement efforts. The data systems and analysis could be maintained by the authority or contracted out to ensure responsiveness to healthcare providers.
 - d) Working with business, purchasing groups, and other organizations, to provide incentives to encourage health care providers to implement proven patient safety improvements.

- e) Coordinating development of better means to provide the public with information that helps them make health care decisions regarding the choice of a hospital or other facility or provider, without presenting the information in an over simplified “report card” format.
- 2) **The Legislature could require the better use of adverse incident data to identify and address sources of health care systems errors in Florida.** The effective use of adverse incident information reported to the Agency for Health Care Administration (AHCA), and statutorily required risk management programs in hospitals and other facilities could be improved by:
- a) Ensuring AHCA analyzes facility adverse incident data, identifies patterns of errors, and reports findings the information to health care providers and risk managers for investigation and solution as already required by statute.
 - b) Requiring already existing risk facility management programs in hospitals and other facilities to report to AHCA, the root causes of adverse incidents they investigate and best practice solutions they implement to address these causes, so that the information can be shared with other providers to reduce medical errors statewide.
 - c) Requiring AHCA to share information on adverse incidents with the proposed Patient Safety Authority (see above) to allow for its analysis and reporting along with “near miss” and other information used by the Patient Safety Authority.
- 3) **The Legislature could evaluate whether requiring facilities to notify patients in person when they experience serious medical errors, would increase patient satisfaction and reduce the potential for litigation,** by establishing a pilot project with public teaching hospitals and other facilities that are protected from litigation through sovereign immunity.
- 4) **The Legislature could extend statutory protection to “near miss” information, and its use by peer review and risk-management programs,** as already exists for adverse incidents, to ensure its confidentiality and protect it from discoverability and use in civil actions in court. Those who report the information should also be protected. The purpose of such protection is to encourage voluntary reporting or errors to correct system problems that cause the m.
- 5) **The Legislature could promote the formation of a statewide, public/private stakeholder, patient safety coalition** of health care professionals, purchasers, consumers and policymakers, to provide leadership and a single contact point for patient safety activities, to avoid redundant, overlapping and competing initiatives. The Legislature could authorize relevant state agencies to provide resources and support to initiate the formation of the coalition.
- 6) **The Legislature could encourage public and private purchasers to provide incentives to health care providers that demonstrate improvement in patient safety.** The Legislature could require state purchasers of health services, including Medicaid and state employee health insurance, to work with private purchasing groups to use their purchasing power as

incentives for hospitals and other facilities that implement proven safety improvement strategies.

- 7) **The Legislature could encourage state medical education programs to include patient safety improvement components in their curricula** for all health care professionals, including medical schools, nursing schools and allied health professions. Such curricula would educate professionals to recognize, report and address health systems problems that cause medical errors.

SECTION THREE

Liability Issues

Summary of Current Law

Florida's Medical Malpractice statute is found in Chapter 766, Florida Statutes. A copy is attached as Appendix VI.

Pre-suit Requirements and Expert Witness Requirements

Florida requires the parties in a medical malpractice action to take various actions prior to filing suit. The purpose of these pre-suit requirements is to encourage the settlement of meritorious claims early in the process and to prevent the filing of claims without merit. The current pre-suit process works as follows:

Claimant must conduct a pre-suit investigation

The claimant must conduct an investigation to determine whether there are reasonable grounds to believe the defendant was negligent and whether the negligence resulted in harm to the claimant. s. 766.203(2), F.S. As part of the investigation, the claimant must obtain a verified written medical expert opinion which shall corroborate reasonable grounds to support the claim of negligence. s. 766.203(2), F.S.

Expert Witnesses

The statute defines medical expert. "Medical Expert" means a person duly and regularly engaged in the practice of his or her profession, who holds a health care professional degree, and who has special training and experience or special health care knowledge about the subject of the opinion. s. 766.202(5), F.S.

The Academy of Florida Trial Lawyers and the Florida Medical Association have suggested reform of the expert witness statute. The proposals are attached as segments of Appendix 2.

Generally, the Academy's proposal would require that specialists be used as expert witnesses against specialists and general practitioners be used as expert witnesses against general practitioners. Specialists would be permitted to be expert witnesses in cases where someone is practicing outside his or her specialty. It would not allow experts to testify on a contingency fee basis. The Academy's proposal also has provisions to prohibit HMOs, professional associations, insurers, or drug manufacturers from prohibiting or discouraging expert testimony. It provides for a civil action for violation of that provision. The Academy's proposal gives the trial court the discretion to qualify or disqualify an expert witness despite the provisions of the statute.

Generally, the Florida Medical Association's proposal would require that specialists be used as expert witnesses against specialists and general practitioners be used as expert witnesses against

general practitioners. Specialists would be permitted to be expert witnesses in cases where someone is practicing outside his or her specialty. The FMA's proposal adds a provision requiring expert witnesses who are not licensed in Florida to obtain an "expert witness certificate". The proposal requires the Board of Medicine to control the issuance of such certificates and provides that the Board can revoke the certificates.

The Academy's proposal would allow testimony in certain cases if the expert has been engaged in practice during the three years preceding the incident while the FMA proposal is five years. It can also be argued that the Academy's proposal that a trial court be allowed to qualify or disqualify an expert on grounds other than the qualifications in statute creates an exception to the statutory qualifications that would undermine the rule.

The Select Committee heard testimony regarding expert witness certification. A witness appearing on behalf of the Academy said that out of state practitioners would not testify in Florida if the certificate requirement was added. A witness appearing on behalf of the FMA countered that such certification is necessary so the state can better control the quality of expert witness testimony. Currently, there is no mechanism for discipline if an out of state expert presents false testimony in Florida. The Academy countered that if an expert testified falsely, the expert could still be reported to the appropriate regulatory agency in their state of residence.

The Governor's Task Force recommended that the Legislature examine ways to improve the use of "in-kind" experts at trial.

Claimant must notify defendant of intent to file a medical malpractice action

After the completion of the pre-suit investigation, the claimant must notify, by certified mail, each prospective defendant of its intent to initiate a medical malpractice action. s. 766.106(2), F.S. The notice must contain corroboration by a medical expert. s. 766.203(2), F.S. No suit may be filed within 90 days of the mailing of the notice of intent. s. 766.106(3) (a), F.S.

Defendant must conduct pre-suit investigation during the 90 day period.

Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period. s. 766.106, F.S. Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. s. 766.106, F.S.

Before the end of the 90 days, the insurer or self-insurer shall provide the claimant with a response to either:

1. Reject the claim;
2. Make a settlement offer; or
3. Make an offer of admission of liability and for arbitration on the issue of damages. This offer may be made contingent upon a limit of general

damages. s. 766.106(3) (b), F.S. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt shall be deemed a final rejection of the claim for purposes of this section. s. 766.106(3) (c), F.S.

It has been suggested that perhaps the time frame of 90 days is too short for proper review by each side and that this period should be extended to a period up to twice that length.

Informal Discovery

Upon receipt of the notice to initiate, all parties must make discoverable information available to the other party. Informal discovery may be used by a party to obtain un-sworn statements, the production of documents or things, and physical and mental examinations. This informal discovery process allows the parties to investigate the case during the pre-suit process. s. 766.106(7), F.S.

Information generated during the pre-suit process is inadmissible in future proceedings. s. 766.205, F.S. Since so much information is privileged, it can be argued that the pre-suit process actually requires the parties to perform discovery twice: once in the pre-suit period and once as the parties prepare for trial.

At the conclusion of the pre-suit process, either party may move the court to determine whether the other party's claims or defenses have a reasonable basis. If either party moves, the court will review the proceedings and determine whether either party has failed to conduct reasonable investigations. The court can impose sanctions such as striking claims or responses and reporting attorneys or experts to the appropriate disciplinary authority. s. 766.206, F.S.

A mandatory settlement conference is held at least 3 weeks before the date set for trial. s. 766.108, F.S.

Voluntary binding arbitration – s. 766.207, F.S.

Florida's Medical Malpractice statute contains two arbitration provisions, s. 766.106, F.S., and s. 766.207, F.S. Testimony before the Governor's Task Force indicated that the provisions under s. 766.106, F.S., are rarely used so this discussion will deal with the provisions under s. 766.207, F.S.

The Process

After completion of the pre-suit process, the parties may agree to voluntary binding arbitration on damages. This section does not require a concession of liability but such a concession appears to be presumed under the case law. s. 766.207(2), F.S. A party may request binding voluntary arbitration within 90 days after the service of the notice of intent to initiate litigation. s. 766.207(2), F.S. The evidentiary standards for voluntary binding arbitration of medical negligence claims shall be as provided in S.S. 120.569(2) (g) and 120.57(1) (c). s. 766.207(2), F.S.

Upon receipt of a party's request for such arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days. However, in no event shall the defendant be required to respond to the request for arbitration sooner than 90 days after service of the notice of intent to initiate litigation under s. 766.106. Such acceptance within the time period provided by this subsection shall be a binding commitment to comply with the decision of the arbitration panel. The liability of any insurer shall be subject to any applicable insurance policy limits. s. 766.207(3), F.S.

The arbitration panel shall be composed of three arbitrators, one selected by the claimant, one selected by the defendant, and one an administrative law judge furnished by the Division of Administrative Hearings who shall serve as the chief arbitrator. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. If the multiple parties cannot reach agreement as to their arbitrator, each of the multiple parties shall submit a nominee, and the director of the Division of Administrative Hearings shall appoint the arbitrator from among such nominees. s 766.207(4), F.S.

The hearing is governed under rules promulgated by the Division of Administrative Hearings. s. 766.207(9), F.S. The rules can be found at www.doah.state.fl.us/internet/medmalrules/pdf.

Limitations on Damages after Arbitration

Arbitration pursuant to the voluntary binding arbitration statute precludes recourse to any other remedy by the claimant against any participating defendant. The statute provides for the following limitations on damages:

(a) Net economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments.

(b) Non-economic damages shall be limited to a maximum of \$250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than \$125,000 non-economic damages.

(c) Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(8) and shall be offset by future collateral source payments.

(d) Punitive damages shall not be awarded.

(e) The defendant shall be responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial.

(f) The defendant shall pay the claimant's reasonable attorney's fees and costs, as determined by the arbitration panel, but in no event more than 15 percent of the award, reduced to present value.

(g) The defendant shall pay all the costs of the arbitration proceeding and the fees of all the arbitrators other than the administrative law judge.

(h) Each defendant who submits to arbitration under this section shall be jointly and severally liable for all damages assessed pursuant to this section.

(i) The defendant's obligation to pay the claimant's damages shall be for the purpose of arbitration under this section only. A defendant's or claimant's offer to arbitrate shall not be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof.

(j) The fact of making or accepting an offer to arbitrate shall not be admissible as evidence of liability in any collateral or subsequent proceeding on the claim.

(k) Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation, as provided in s. 766.106. A defendant who rejects a claimant's offer to arbitrate shall be subject to the provisions of s. 766.209(3). A claimant who rejects a defendant's offer to arbitrate shall be subject to the provisions of s. 766.209(4).

Failure to accept offer of arbitration

If a claimant refuses a defendant's offer of arbitration, the case can proceed to trial but non-economic damages is limited to \$350,000 per incident. Net economic damages shall be awardable for past and future medical expenses and 80% of wage loss and lost earning capacity. Damages for future economic losses shall be made by periodic payments and shall be offset by future collateral source payments.

If a defendant refuses a claimant's offer to arbitrate, the case goes to trial without limits on damages and the claimant can recover prejudgment interest and attorney's fees.

Use of Voluntary Binding Arbitration

The voluntary binding arbitration withstood constitutional challenge in University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993). Two recent cases have clarified controversial portions of the statutes.

The arbitration statute states that damages are capped at \$250,000 "per incident" but has other language referring to individual claimants. In St. Mary's Hospital, Inc. v. Phillippe, 769 So. 2d 961 (Fla. 2000), the Florida Supreme Court considered whether the "per incident" language meant that each claimant could recover the full \$250,000 or whether all claimants in a single

incident must divide \$250,000. In St. Mary's, a woman died during childbirth due to medical malpractice. St. Mary's, 769 So. 2d at 963. After arbitration under the medical malpractice statute, her husband was awarded \$250,000 in non-economic damages and each of her four surviving children was awarded \$175,000. St. Mary's, 769 So. 2d at 963. The court had to decide whether the statute permitted that award or whether the total non-economic damages were capped at \$250,000.

The court held that the statute meant that each claimant was entitled to recover up to \$250,000 per incident. St. Mary's, 769 So. 2d at 967-971. To hold otherwise, the court said, would raise equal protection concerns because a claimant's recovery would be limited simply because there were multiple claimants in a given case. St. Mary's, 769 So. 2d at 971-973. Accordingly, each claimant in any medical malpractice arbitration may recover up to \$250,000 per incident of medical malpractice.

Another issue raised in the St. Mary's case is whether, in any medical malpractice arbitration, economic damages are determined under the medical malpractice statute or under the wrongful death statute. Under the medical malpractice statute, "economic damages" is defined as "including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity." St. Mary's, 769 So. 2d at 973. In addition, the statute provides that arbitration shall be undertaken with the understanding that "[n]et economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments." St. Mary's, 769 So. 2d at 973. The court explained that the Wrongful Death Act does not provide the same economic damages:

Unlike the Medical Malpractice Act, the Wrongful Death Act does not provide claimants with such a full range of economic damages. Under section 768.21(1) of the Wrongful Death Act, each survivor may recover the value of lost support and services from the date of the decedent's injury, and under section 768.21(6), the estate may recover the decedent's loss of earnings, loss of prospective net accumulations, and medical and funeral expenses.

St. Mary's, 769 So. 2d at 973.

The court held that in medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated. The court stated that the plain language of the statute "indicates that the full range of economic damages is available to claimants as an incentive to forego a jury trial." St. Mary's, 769 So. 2d at 973. The court reasoned that if the legislature had intended for the Wrongful Death Act to apply, it would have expressly stated that it should be applied. St. Mary's, 769 So. 2d at 973.

In Chester v. Doig, No. SC01-348 (Fla. February 6, 2003), the court again considered the medical malpractice voluntary binding arbitration statute. In Chester, the court held that it is not appropriate to setoff against the non-economic damages portion of an award against one tortfeasor in an arbitration action the amount received from a settlement with another tortfeasor

who is not a party to the arbitration. Accordingly, a plaintiff in an arbitration action may recover damages from the arbitrating party even if some of those damages have been paid by a non-arbitrating party.

The Division of Administrative Hearings provided information relating to the use of the procedure.

1997 - 14 cases filed, 12 closed without hearing, 2 arbitration awards
1998 - 11 cases filed, 10 closed without hearing, 1 arbitration award
1999 - 11 cases filed, 9 closed without hearing, 3 arbitration awards
2000 - 12 cases filed, 11 closed without hearing, 1 arbitration award
2001 - 17 cases filed, 15 closed without hearing, 1 hearing pending, 1 arbitration award
2002 - 19 cases filed, 12 closed without hearing, 4 set for hearing, 3 open cases without hearing date.

The Governor's Task Force recommended some reform of the voluntary binding arbitration statute. In response to the St. Mary's case, the task force recommended that the Legislature provide for a "per incident" cap rather than the "per claimant" cap. In addition, the task force recommended that the arbitration statute should be amended so that only damages recoverable under the Wrongful Death statute would be recoverable in arbitration.

Issue of Bad Faith

In Florida, an insurer can be held liable to pay an entire judgment against its insured even when the judgment exceeds the limits of the insurance for which the insured has contracted. In Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259, 260 (Fla. 1971), the court stated that it "is established in Florida that an insured has the right to sue and recover damages against his own insurer for an excess judgment on the basis of fraud or bad faith in the conduct of the insured's defense by the insurer." Thompson also allows injured plaintiffs to directly sue a defendant's insurer:

[We] hold that a judgment creditor may maintain suit directly against tortfeasor's liability insurer for recovery of the judgment in excess of the policy limits, based upon the alleged fraud or bad faith of the insurer in the conduct or handling of the suit."

Thompson, 250 So. 2d at 264.

The 1980 case Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980), discusses third party actions against an insurer for bad faith. In Boston Old Colony, Brown and Gutierrez were involved in a head-on collision and each claim the accident was the fault of the other. Gutierrez brought an action against Brown for his injuries and the action was defended by Brown's liability insurance carrier, Boston Old Colony. Brown's liability policy covered him up to a limit of \$10,000. Boston Old Colony investigated the accident and concluded that Gutierrez was at fault. Boston Old Colony warned that because Gutierrez's injuries were severe, there was a possibility of a judgment in excess of the policy limits, warned Brown of the risks, and

suggested they should settle for policy limits. Brown opposed a settlement because he had a pending counterclaim against Gutierrez and did not want to admit fault by making an offer to settle. Brown and Boston Old Colony executed, a "hold harmless" agreement in which Brown assumed responsibility for any excess judgment. Boston Old Colony, 386 So. 2d at 784.

Gutierrez offered to take the policy limits in settlement of his claim against Brown. Boston Old Colony responded by denying liability. Subsequently, Brown reached a settlement of his counterclaim against Gutierrez and his insurer. With the counterclaim no longer pending, Boston Old Colony offered Gutierrez the policy limits in settlement. By this time, however, Gutierrez preferred to proceed to trial. The trial resulted in a judgment for Gutierrez against Brown for \$1,400,000. Gutierrez then brought the present action against Boston Old Colony, alleging bad faith on the part of the insurance company because of its failure to settle the claim for policy limits when it had the opportunity. Gutierrez prevailed and obtained a judgment against Boston Old Colony for \$1,400,000. Boston Old Colony, 386 So. 2d at 784-785.

On appeal, Boston Old Colony argued that its motion for a directed verdict should have been granted since the evidence showed that Brown at all times contested liability and had evidence to support his position; that he requested that his insurer not settle the suit since he was pursuing his counterclaim against Gutierrez; and that after settlement of the counterclaim, Boston Old Colony offered the policy limits before trial.

The question before the Supreme Court was whether Thompson authorized "a bad faith action against an insurance company when that company has refused to settle a claim at the express direction of its own insured who obtains a settlement of his claim and the insurance company thereafter offers to settle for its policy limits before trial." Boston Old Colony, 386 So. 2d at 784. The court held that it did not.

The court noted that an insurer handling the defense of claims against its insured "has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business." Boston Old Colony, 386 So. 2d at 785. The court continued:

This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid the same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.

Boston Old Colony, 386 So. 2d at 785 (citations omitted).

The court held that Boston Old Colony did not act in bad faith and reversed the jury award against the company.

Justice Alderman criticized the result in Boston Old Colony case. He argued that an injured plaintiff should not be allowed to sue the defendant's insurer for bad faith. He wrote:

In the “Alice-in-Wonderland” world created by the Thompson rule, it is to the injured party's benefit if the insurer breaches its duty to its insured and to his detriment if there is no breach. This is so since, if the insurer settles, the plaintiff will receive no more than the policy limits, but if it does not, the plaintiff may end up with both the policy limits and an excess judgment.

Boston Old Colony, 386 So. 2d at 786 (Alderman, J., concurring specially).

The Thompson rule has been codified in section 624.155, F.S. It states that “[a]ny person may bring a civil action against an insurer when such person is damaged...” § 624.155(1), F.S. In Auto-Owners Insurance Company v. Conquest, 658 So. 2d 928 (Fla. 1995), the court held that use of the phrase “any person” meant that persons besides the insured could bring bad faith claims against insurers. The court noted potential problems with allowing third party actions:

permitting a third party such a cause of action against the insurer any time the insurer allegedly failed to settle in good faith could result in “undesirable social and economic effects... (i.e., multiple litigation, unwarranted bad faith claims, coercive settlements, excessive jury awards, and escalating insurance, legal, and other transaction costs).”

Auto-Owners Ins. Company, 658 So. 2d at 930 (quoting Cardenas v. Miami-Dade Yellow Cab Co., 538 So. 2d 491, 496 (Fla. 3d DCA 1989).

It can be argued that permitting third party plaintiffs, such as victims of medical malpractice claims, makes defending a bad faith claim difficult for insurance companies because an injured victim is a sympathetic plaintiff compared to a physician who is arguing against the company. Further, case law and statutes require the insurer to try to settle the case where a reasonably prudent person facing the prospect of paying the total judgment would do so. This forces an insurance company to defending a bad faith claim to argue that its actions were reasonable even when an excess judgment has already been returned.

The Governor’s Task Force recommended that the Legislature amend statutes to allow only the insured to bring a bad faith action against an insurer and that the statutes articulate exactly what constitutes bad faith by an insurer. The Task Force also recommended that the maximum damages be calculated as the amount of damages that were actually caused by the acts of bad faith and limited by the amount of the reachable assets of the insured. Finally, the Task Force recommended that Legislature should require that the Department of Insurance be notified if an insurer is found to be in bad faith or settles a case for bad faith and that the Department investigate the specific allegations and take necessary action against the insurer to punish and prevent future bad faith practices.

Proposals Regarding the Pre-suit Process

The Academy submitted a proposal to alter the pre-suit process. (See Appendix II) The Academy proposes that plaintiffs must provide potential defendants with a list of all known health care providers who have treated the plaintiff during the five years preceding the alleged malpractice and all providers seen after the malpractice. The plaintiff must also provide copies of all medical records relied on by the expert. The Academy argued that defendants are not properly evaluating claims during the pre-suit process and proposed that the defendants set forth the basis for denying that malpractice occurred in the response to the notice to initiate litigation.

The Academy proposes that sworn statements be taken during the pre-suit process and that those statements may be admissible at trial and updated by deposition during the discovery process. The proposal also allows requires parties to respond to written questions.

The Academy proposes permitting plaintiffs to extend the statute of limitations by 180 days, rather than the current 90, to allow investigation into the alleged act of malpractice.

The Governor's Task Force recommended that the Legislature require experts reviewing pre-suit claims and defenses possess similar, or identical, credentials and expertise in the defendant's specialty. The Task Force also recommended that the opinion of the expert who reviews claims and defenses be subject to discovery and that testimony be admissible in future proceedings.

Extension of Sovereign Immunity to Physicians

Some of the parties have suggested that sovereign immunity be extended to certain classes of physicians. For example, the Florida College of Emergency Physicians has proposed that emergency physicians be treated like state actors for liability purposes. The College argues that since emergency room physicians are required under state law to treat all patients that appear before them, they should be treated as agents of the state and be afforded protection from certain liability similar to how the state is protected from some liability under the doctrine of sovereign immunity. Suggested legislation as well as a rebuttal response from a Florida Trial Lawyer is included in Appendix VII of this report.

Sovereign Immunity

At common law, the state was immune from lawsuits. The doctrine is called sovereign immunity. Article X, section 13, Fla. Const., permits the state to waive sovereign immunity and permit lawsuits by general law. Florida's waiver of sovereign immunity is found in section 768.28, F.S. While it permits certain lawsuits, it imposes monetary limits on recovery - \$100,000 per claimant and \$200,000 per incident. Judgments or settlements in excess of those caps can be recovered by the passage of a claim bill in the Legislature.

Requirements Specific to Emergency Room Physicians

Emergency room physicians are required by state law to treat certain patients. Section 395.1401(3) (a), F.S., requires that hospitals provide “emergency services and care for any emergency medical condition” when any person requests emergency services and care. Section 395.002(10), F.S., defines “emergency services and care” as:

medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve the emergency medical condition, within the service capability of the facility.

Section 395.002(9), F.S., defines “emergency medical condition as:

A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. that a transfer may pose a threat to the health and safety of the patient or fetus; or
3. that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Room Physician Proposal

The College of Emergency Room Physicians has submitted a proposal to the Governor’s Task Force. Their proposal would provide that physicians providing treatment pursuant to section 395.1041, F.S., would be treated as agents of the state under s. 768.28, F.S., and therefore only be responsible for damages of \$100,000 per claimant and \$200,000 per incident. The College contends that extension of sovereign immunity is appropriate because the physicians are required by statute to provide certain treatment, regardless of the patient’s litigation history or ability to pay for services. The proposal is attached as Appendix VII.

Practical Issues Raised by the Proposal

The College has not been able to provide any statistics about the number of lawsuits that might be affected by the proposal or the judgment amounts. Without knowing the number of lawsuits, there is no way to estimate the costs of this proposal to the state.

Constitutional Issues Raised by the Proposal

The question has been raised (see rebuttal testimony in Appendix VII) as to whether the state can designate emergency room physicians as state agents to extend sovereign immunity protection to them. Current law designates certain persons as agents of the state in certain situations. For example, health care providers that contract to act as agents of the Department of Corrections are designated agents of the Department. s. 768.28(10) (a), F.S. Case law has upheld the designation in situations in which the state retained control over the activities of the actors. See Stoll v. Noel, 694 So. 2d 701 (Fla. 1997) (finding physicians were agents of the state when a state agency retained a great deal of control over patient treatment). In this situation, while the hospitals and health care professionals are statutorily required to provide treatment, the state does not have control over the treatment decisions. It is not clear if the court would find that a true agency relationship exists if the state does not exercise greater control over the treatment of patients. There does not appear to be a case where the Legislature has designated an essentially private actor as a state agent. Doing so would be an issue of first impression.

The Academy argued to the Committee that the College's proposal is just another form of caps on damages and would be held unconstitutional if it did not meet the Kluger test.

Caps on Non-economic Damages

The Florida Medical Association has proposed that the Legislature impose a cap on non-economic damages. The proposal would cap non-economic damages at \$250,000 per incident. Such a proposal raises constitutional issues.

The Florida Constitution, as interpreted by the Supreme Court in prior cases, places limits on the Legislature's ability to cap damages in tort cases or otherwise restrict a litigant's access to courts. In Kluger v. White, 281 So. 2d 1 (Fla. 1973), the Florida Supreme Court considered the Legislature's power to abolish causes of action. At issue in Kluger was a statute which abolished causes of action to recover for property damage caused by an automobile accident unless the damage exceeded \$550. Kluger, 281 So. 2d at 2-3. The court held that the statute violated the access to courts provision of the state constitution.

The "access to courts provision" (article 1, section 21) of the Declaration of Rights in the Florida Constitution requires that the courts "be open to every person for redress of any injury". In Kluger, the court held that where a right to access to the courts for redress for a particular injury predates the adoption of the declaration of rights in the 1968 state constitution, the legislature cannot abolish the right without providing a reasonable alternative unless the legislature can

show (1) an overpowering public necessity to abolish the right and (2) no alternative method of meeting such public necessity. Kluger, 281 So. 2d at 4. Because the right to recover for property damage caused by auto accidents predated the 1968 adoption of the declaration of rights, the court held that the restriction on that cause of action violated the access to courts provision of the state constitution.

The court applied the Kluger test in Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987). In 1986, the legislature passed comprehensive tort reform legislation that included a cap of \$450,000 on non-economic damages. The cap on damages was challenged on the basis that it violated the access to courts provision of the state constitution. The Florida Supreme Court held that the right to sue for unlimited economic damages at the time the constitution was adopted. Smith, 507 So. 2d at 1087. The court said that a cap on non-economic damages must meet the Kluger test in order to pass constitutional muster. Smith, 507 So. 2d at 1087-1088. If the legislature wishes to cap non-economic damages, it must (1) provide a reasonable alternative remedy or commensurate benefit; or (2) show an overpowering public necessity for the abolishment of the right to recover unlimited damages and show that no alternative method of meeting the public necessity. Smith, 507 So. 2d at 1088.

The Smith court held that the legislature did not provide an alternative remedy or commensurate benefit in exchange for limited the right to recover damages and noted that the parties did not assert that an overwhelming public necessity existed. Smith, 507 So. 2d at 1089. Accordingly, the court held that the \$450,000 cap on non-economic damages violated the access to courts provision of the Florida Constitution.

The issue of caps on non-economic damages arose again in University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993). In 1988, the legislature instituted a voluntary binding arbitration process in medical malpractice cases. Under the arbitration process, a defendant could decline to contest liability and request binding arbitration on the issue of damages. If a defendant requested arbitration, non-economic damages were capped at \$250,000 per incident if the plaintiff agreed to arbitration. Echarte, 618 So. 2d at 193. In exchange for the cap, the plaintiff was guaranteed prompt payment of any award, joint and several liability against the defendants, and payment of attorney's fees and costs by the defendant. Echarte, 618 So. 2d at 193. If the plaintiff rejected a defendant's offer to arbitrate, the plaintiff could proceed to trial but non-economic damages were capped at \$350,000. Echarte, 618 So. 2d at 193.

The Florida Supreme Court applied the Kluger test and found that arbitration statute provided a commensurate benefit for the loss of the right to recover full non-economic damages. Echarte, 618 So. 2d at 194. While the plaintiff lost the right to recover full damages, the plaintiff gained (1) the benefit of not having to prove liability; (2) joint and several liability; (3) relaxed evidentiary standards provided in an arbitration proceeding; (4) prompt payment of damages; (5) payment of attorney's fees and costs; and (6) limited appellate review of the award. Echarte, 618 So. 2d 194.

In addition, the Echarte court found that the legislature had shown an overpowering public necessity for instituting the caps and that there was no reasonable alternative. Echarte, 618 So. 2d at 195-197. The legislature made factual findings, relying on a study by an academic task

force, to show that without reform, many persons would be unable to purchase liability insurance and claimants would be unable to recover any damages if providers were not insured. Echarte, 618 So. 2d at 197. The court, relying on information presented to the academic task force, agreed that there was no reasonable alternative. Echarte, 618 So. 2d at 197. Based on these findings, the court upheld the statute.

The Academy argued to the Committee that the proposal to make emergency room physicians agents of the state would actually be a cap subject to the tests described in Kluger and Smith. If a court were to so hold, the Legislature would have to show an overwhelming public necessity and that no reasonable alternative to the cap exists to solve the problem.

Emergency room physicians have protection against some liability under the “Good Samaritan Act”, s. 768.13, F.S.

Standard of Proof

The Governor’s Task Force heard discussion on whether the standard of proof required in a medical malpractice case should be altered. The standard of proof is the level of proof necessary for the plaintiff to prevail.

In most medical malpractice cases, the plaintiff must prove the case by a preponderance, or greater weight, of the evidence. Section 766.102(1), F.S., states:

In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 768.50(2) (b), **the claimant shall have the burden of proving by the greater weight of evidence** that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. (emphasis added).

However, section 458.331(3), F.S., requires “clear and convincing” evidence before action can be taken to revoke or suspend a medical license. The “clear and convincing” standard of proof has been defined as “more than a 'preponderance of the evidence,' but the proof need not be 'beyond and to the exclusion of a reasonable doubt.’” In re: LaMotte, 341 So. 2d 513 (Fla. 1977). Similarly, the “clear and convincing” standard is used in Florida Bar disciplinary proceedings against attorneys; see The Florida Bar v. Pelligrini, 714 So. 2d 448 (Fla. 1998), as well as in proceedings to revoke or suspend business licenses. See Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987), Pic N' Save Cent. Florida, Inc. v. Department of Business Regulation, 601 So. 2d 245 (Fla. 1st DCA 1992).

“Preponderance of the evidence” simply means that which is more probable. See Walls v. State, 641 So. 2d 381, 390 (Fla. 1994). “Clear and convincing evidence” is evidence that is “precise,

explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction, without hesitation, about the matter in issue.” See Fla.Std.Jur.Instr. (Crim.) 2.03 (Commitment of Sexually Violent Predators); Standard Jury Instructions – Civil Cases No. 98-3, 720 So.2d 1077 (Fla. 1998)(“[Clear and convincing evidence” differs from the “greater weight of the evidence” in that it is more compelling and persuasive]. “Clear and convincing evidence” is evidence that is precise, explicit, lacking in confusion, and of such weight that it produces a firm belief or conviction without hesitation about the matter in issue.”).

There was testimony before the Governor’s Task Force which suggested that this disparity is not appropriate because it could lead to situations in which a physician committed malpractice under the preponderance of the evidence standard but could not have his or her license suspended or revoked because the case did not meet the “clear and convincing” evidentiary standard.

Most civil cases are decided under the “preponderance of the evidence” standard. A change to the clear and convincing evidentiary standard would presumably make medical malpractice cases more difficult to prove. It is not known how such a change would change rates charged for liability insurance.

Joint and Several Liability

Florida has used different methods of apportioning damages in tort cases. Under contributory negligence, any fault on the part of the plaintiff barred recovery. See Fabre v. Marin, 623 So. 2d 1182, 1184 (Fla. 1993). The court receded from the doctrine of contributory negligence in Hoffman v. Jones, 280 So. 2d 431 (Fla. 1973), and made clear that joint and several liability would apply in Florida. Under joint and several liability, each defendant is responsible for all of the plaintiff’s damages caused by all defendants, regardless of the extent of each defendant’s fault in causing the accident. See Fabre, 623 So. 2d at 1184. For example, in Walt Disney World v. Wood, 515 So. 2d 198 (Fla. 1987), one defendant was found 85% liable for an accident, co-defendant Disney was found 1% liable, and the plaintiff was found 14% liable. The court found that, under joint and several liability, Disney was liable for 86% of the plaintiff’s damages even though Disney was only 1% at fault. See Walt Disney World, 515 So. 2d at 198-202. The court declined to abolish joint and several liability in Walt Disney World, stating that such a decision should be made by the Legislature. See Walt Disney World, 515 So. 2d at 202.

Florida abolished joint and several liability when it passed its comparative fault statute. Section 768.81, Florida Statutes, is Florida’s comparative fault statute. The statute requires the court to enter judgment against a party in appropriate civil actions on the basis of fault rather than on the basis of contributory negligence or joint and several liability.

In cases where the statute is applicable, the court is required to enter judgment on the basis of each party’s percentage of fault and not on the basis of joint and several liability. See s. 768.81(3), F.S. The statute provides a formula for apportioning damages when the plaintiff is found to be at fault. Section 768.81(3), F.S., reads:

- (a) Where a plaintiff is found to be at fault, the following shall apply:

1. Any defendant found 10 percent or less at fault shall not be subject to joint and several liability.
2. For any defendant found more than 10 percent but less than 25 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$200,000.
3. For any defendant found at least 25 percent but not more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$500,000.
4. For any defendant found more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$1 million.

For any defendant under subparagraph 2, subparagraph 3., or subparagraph 4., the amount of economic damages calculated under joint and several liability shall be in addition to the amount of economic and non-economic damages already apportioned to that defendant based on that defendant's percentage of fault.

(b) Where a plaintiff is found to be without fault, the following shall apply:

1. Any defendant found less than 10 percent at fault shall not be subject to joint and several liability.
2. For any defendant found at least 10 percent but less than 25 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$500,000.
3. For any defendant found at least 25 percent but not more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$1 million.
4. For any defendant found more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of \$2 million.

For any defendant under subparagraph 2, subparagraph 3, or subparagraph 4, the amount of economic damages calculated under joint and several liability shall be in addition to the amount of economic and non-economic damages already apportioned to that defendant based on that defendant's percentage of fault.

(c) With respect to any defendant whose percentage of fault is less than the fault of a particular plaintiff, the doctrine of joint and several liability shall not apply to any damages imposed against the defendant.

(d) In order to allocate any or all fault to a nonparty, a defendant must affirmatively plead the fault of a nonparty and, absent a showing of good cause, identify the nonparty, if known, or describe the nonparty as specifically as practicable, either by motion or in the initial responsive pleading when defenses are first presented, subject to amendment any time before trial in accordance with the Florida Rules of Civil Procedure.

(e) In order to allocate any or all fault to a nonparty and include the named or unnamed nonparty on the verdict form for purposes of apportioning damages, a defendant must prove at trial, by a preponderance of the evidence, the fault of the nonparty in causing the plaintiff's injuries.

Section 768.81, Florida Statutes, requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 761.81(4)(a), F.S., defines "negligence" cases as including "civil actions for damages based upon theories of negligence, strict liability, products liability, professional malpractice whether couched in terms of contract or tort, or breach of warranty and like theories." Section 761.81(4) (b), F.S., states that the comparative fault statute does not apply to actions "based on an intentional tort."

In Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993), the court addressed how to apply section 768.81, F.S., when not all tortfeasors are parties to the lawsuit. In Fabre, the plaintiff was a passenger in a vehicle driven by her husband when the vehicle was involved in an accident with another vehicle. See Fabre, 623 So. 2d at 1183. The jury found the plaintiff's husband (who was not a party to the lawsuit) and the driver of the other vehicle each fifty percent at fault. See Fabre, 623 So. 2d at 1183. The trial court refused to apply the comparative fault statute and ruled that the other driver was liable, under joint and several liability, for all of the plaintiff's damages. See Fabre, 623 So. 2d at 1184. The Supreme Court held that was error. The court held that section 768.81, F.S., required the trial court to impose liability on a defendant equal only to that defendant's percentage of fault:

We are convinced that section 768.81 was enacted to replace joint and several liability with a system that requires each party to pay for non-economic damages only in proportion to the percentage of fault by which that defendant contributed to the accident.

Fabre, 623 So. 2d at 1185.

The court explained that by enacting section 768.81, F.S., the legislature eliminated joint and several liability and decided that for purposes of non-economic damages, a plaintiff must take each defendant as he or she finds them. See Fabre, 623 So. 2d at 1186. If a defendant is insolvent, the judgment of liability of another defendant is not increased. See Fabre, 623 So. 2d at 1186. The statute requires the same result in a case where a potential defendant cannot be joined in a lawsuit. See Fabre, 623 So. 2d at 1186. Based on that holding, the court reduced the award of non-economic damages by fifty percent to reflect the other driver's degree of fault. See Fabre, 623 So. 2d at 1187. Section 768.81(3), F.S., contains a procedure for pleading and apportioning damages to nonparties.

The Academy of Florida Trial Lawyers among others, including Select Committee Members, has proposed a change in law to overrule Fabre. Under their proposal, fault would only be apportioned among defendants at trial and apportioning fault to nonparties would be prohibited. It can be argued that the Fabre decision creates an incentive at trial to shift fault to a nonparty who is not present at trial to present a defense. It can also be argued that the Fabre doctrine causes more physicians to be brought into lawsuits. Conversely, it can be argued that overruling Fabre and limiting the appointment of fault to only party defendants would force party defendants to potentially pay more than their appropriate damages. The Academy's language is part of Appendix II.

The Florida Medical Association submitted a proposal to abolish joint and several liability in all medical malpractice actions and make all parties liable based on the percentage of fault. The proposal is attached in Appendix II.

Alternative Dispute Resolution

As discussed earlier (in the section on Current law), Florida has two statutes relating to arbitration in medical malpractice actions, sections 766.106 and 766.207, F.S., provide for arbitration to determine damages. In addition, s. 766.108, F.S., requires that the parties attend a mandatory settlement conference at least three weeks prior to trial.

Section 768.79, F.S., deals with offers of judgment to settle the case. The statute provides that if a defendant files an offer of judgment which is not accepted by the plaintiff within 30 days, the defendant is entitled to recover reasonable costs and attorney's fees from the date of filing of the offer if:

- (1) the judgment is one of no liability or;
- (2) the judgment obtained by the plaintiff is at least 25 percent less than such offer.

If a plaintiff files a demand for judgment which is not accepted by the defendant within 30 days and the plaintiff recovers a judgment in an amount at least 25 percent greater than the offer, the plaintiff is entitled to recover reasonable costs and attorney's fees incurred from the date of the filing of the demand.

Mediation is not required in medical malpractice actions. The Academy of Florida Trial Lawyers proposes that the parties be required to attend mediation within 120 days of suit being filed unless the parties have agreed to binding arbitration. During the mediation, each party shall make a demand for judgment or an offer of settlement. At the conclusion of the mediation, the mediator shall record the final demand and final offer to provide to the court upon the rendering of a judgment.

If a plaintiff who rejects the final offer of settlement made during the mediation does not obtain a judgment more favorable than the offer, the court shall assess the mediation costs and reasonable costs, expenses, and attorneys fees which were incurred after the date of mediation. If the judgment obtained at trial is not more favorable to a defendant than the final demand for

judgment made by the claimant to the defendant during mediation, the court shall assess the mediation costs, and reasonable costs, expenses, and attorney's fees that were incurred after the date of mediation. Prejudgment interest shall also be assessed.

Under the Academy's proposal, the final offer and final demand made during the mediation shall be the only offer and demand considered by the court in assessing costs, expenses, attorneys fees, and prejudgment interest. No subsequent offer or demand by either party shall apply in the determination of whether sanctions will be assessed by the court under this section.

The Governor's Task Force recommended that the Legislature require mandatory mediation within 120 days of filing suit and provide sanctions for refusing good faith settlement offers. Opponents of a mandatory mediation plan could argue that such a plan imposes a governmental barrier that must be crossed before the case can be tried. If mediation is an effective tool for resolving cases, it can be argued that the parties will use it without the need for governmental coercion.

Proponents of mandatory mediation believe that cases are not being reviewed early in the process. They contend this leads to increased costs in discovery that would be avoided if the case was valued and resolved early in the process.

Periodic Payment of Damages

Periodic payment of damages is the payment of damage awards over time, rather than in a lump sum. Section 766.202(8), F.S., defines "periodic payment" as the payment of an award of "future economic damages through structured payments over a period of time, as follows:"

- (a) A specific finding of the dollar amount of periodic payments which will compensate for these future damages after offset for collateral sources shall be made. The total dollar amount of the periodic payments shall equal the dollar amount of all such future damages before any reduction to present value.
- (b) The defendant shall be required to post a bond or security or otherwise to assure full payment of these damages awarded. A bond is not adequate unless it is written by a company authorized to do business in this state and is rated A + by Best's. If the defendant is unable to adequately assure full payment of the damages, all damages, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the defendant.
- (c) The provision for payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amounts of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made.

A similar definition is provided in section 768.78, F.S., relating to the payment of damages in medical malpractice actions.

The Florida Medical Association has proposed allowing the defendant the option of paying all damages, economic and non-economic, as a lump sum reduced to present value and offset by collateral source payments or paying by periodic payments for as long as the condition persists or the claimant lives. The proposal is attached in Appendix II.

Witnesses before the Governor's Task Force argued that there should not be a distinction between future economic and future non-economic damages for purposes of allowing periodic payments so both compensate the plaintiff for damages in the future. If a claimant dies after receiving payment for future damages that had not yet been incurred, it can be argued that the plaintiff receives a windfall from the incident.

Witnesses also argued against changing the current system. It can be argued that a plaintiff has a right to the money once the judgment is entered and it should be the plaintiff's decision as to whether the money is expended immediately or invested in an annuity or some other investment providing periodic payments. It is also unclear how changing the timing or method of payment would alter insurance rates.

The Task Force recommended that the Legislature should amend section 766.202, Florida Statutes, to allow the periodic payment of future non-economic damages and that the Legislature should amend section 766.202, Florida Statutes, to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Jury Pool

In 1991, section 40.01, F.S., was amended to require that jurors be selected from persons who have a driver's license or a valid Florida identification card rather than from voter registration lists. A Senate staff analysis recently noted problems that are alleged to have been caused by this change:

Another alleged problem with the [Department of Highway Safety and Motor Vehicles] source list is the contention by some parties that the quality of jurors has declined. Several state attorneys and judges have reported a higher incidence of convicted felons being summoned, with some of these statutorily ineligible individuals actually serving on a jury. Many state attorneys and judges also have reported more potential jurors having arrest records. There have been some reported cases, both criminal and civil, where convictions and final judgments have been reversed on appeal because jurors did not disclose personal convictions or arrest histories.

State attorneys, judges, and civil trial lawyers also have reported that more jurors appear to be less interested in fulfilling their civic duty. These sources contend that, compared to when the jury pool was drawn from registered voters, the current pool of jurors pay less attention to the proceedings and have less respect for the court system.

See Senate Staff Analysis and Economic Impact Statement, CS/SB 434, February 20, 2002.

A recent note in the Nova Law Review discusses perceived problems with the jury system in medical malpractice cases. The author argues that lay jurors often have difficulty understanding the complex scientific issues in medical malpractice cases, that college educated persons are often excluded from jury service, that the sacrifice required by jury service forces the exclusion of many professionals, and that current juries do not represent a cross-section of the community. See Holloran, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 Nova Law Review 331 (Fall, 2001).

Proposed changes include having “blue ribbon” juries decide complex cases, increasing juror compensation to encourage participation, returning to the voter registration lists as the jury pool, or even abolishing lay juries in civil cases. The Select Committee did not hear detailed testimony but notes that altering the method of selecting jurors could decrease diversity in the jury pools. Any method of altering the composition of jurors or limiting jury participation in the cases also raises constitutional concerns about limiting a litigant’s right to a trial by jury and should be closely studied. Other potential changes, like changing rules about juror note taking, allowing jurors to question witnesses, or modifications to the jury instructions raise separation of powers concerns because it could be argued that such changes encroach on the Supreme Court’s exclusive power to control court rules and procedure. It should further be considered that since the adoption of the Motor Voter Act that a detailed analysis of the composition and congruence of the pools of both licensed drivers and registered voters would need to be done to ascertain the degree of variance between these groups of citizens.

The Governor’s Task Force did not make a recommendation regarding changes to the jury system.

SECTION FOUR

Insurance Issues

Requirements

To practice medicine in Florida, allopathic and osteopathic physicians are required to show financial responsibility. Pursuant to ss. 458.320 and 459.0085 F.S., applicants for initial licensure or the renewal of their license must, by one of the statutorily specified methods, demonstrate financial responsibility to the satisfaction of the respective Boards and the Department of Health in order to pay claims and costs arising out of the rendering of, or the failure to render, medical care or services. Physicians with staff privileges at hospitals are also required to establish financial responsibility as a continuing condition of hospital staff privileges. It has been placed into the record that many physicians have resorted to self insuring according to the minimum standards of ss. 458.320, which may warrant a review of the minimum levels required in order to provide adequate assurance to the public that sufficient assets are available in instances of medical malpractice.

Pursuant to s. 627.4147 F.S, all medical malpractice insurance policies, including self-insurance policies and those of the Florida Medical Malpractice Joint Underwriting Association, must include clauses to:

- (1) require the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured;
- (2) authorize the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s.766.106, settlement offer, or offer of judgment, if the offer is within the policy limits and if made in good faith and in the best interests of the insured;
- (3) direct the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 60 days prior to the end of the policy or contract period. If cancellation or non-renewal is due to nonpayment or loss of license, 10 days' notice is required.

In addition, insurers may require insureds to be members in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which maintains a medical review committee.

Other Options

Florida Statutes specify three methods other than traditional commercial insurance for obtaining medical malpractice coverage. The Legislature in 1975, in response to medical liability insurance not being sufficiently available, passed these measures as part of the Medical Malpractice Reform Act.

Self Insurance

Section 627.357 F. S. authorizes a group or association of health care providers, composed of any number of members, to self-insure against medical malpractice claims. The entity may self-insure upon obtaining approval from the Department of Insurance and upon (1) establishing a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability and (2) employing a professional consultant for loss prevention and claims management coordination under a risk management program. The risk management trust fund may insure hospital parent corporations, hospital subsidiary corporations, and committees against claims arising out of the rendering of, or failure to render, medical care or services. The fund is subject to regulation and investigation by the department, to the rules which the department may adopt (which are found in Ch. 4-187 F.A.C.), and to the statutes regulating trade practices and frauds.

The trust fund is authorized to:

- purchase medical malpractice insurance up to determined limits, specific excess insurance, and aggregate excess insurance as necessary to provide the insurance coverages authorized by statute and consistent with market availability.
- purchase such risk management services as may be required and to pay claims as may arise under any deductible provisions.
- engage in prudent investment of trust funds and other activities reasonably related to the payment of claims and to provide medical malpractice self-insurance, to the extent otherwise consistent with the statute and the law generally applicable to medical malpractice insurers.

Subsection (7) sets forth the provisions for the liability of each member of a fund for the obligations of the fund, and assessments against members in the event of liquidation of the fund or a deficiency in it. Given the lack of any real solvency requirements for these funds the assessability features provided in law take on added significance. Each member has a contingent assessment liability for payment of actual losses and expenses incurred while the member's policy was in force. The trust fund may also periodically assess members and also assess them in the event of a liquidation of the fund.

The statute also specifies that a member's share of a deficiency for which an assessment is made is computed by applying to the premium earned on the member's policy or policies during the period to be covered by the assessment, the ration of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment. If one or more members

fail to pay an assessment, the other members are liable on a proportional basis for an additional assessment. The Fund, acting on behalf of all members who paid the additional assessment, shall institute legal action, when necessary and appropriate, to recover the assessment from the members who failed to pay.

If the assets of a trust fund are at any time insufficient to comply with the requirements of law, discharge the fund's liabilities, or meet the required conditions of financial soundness, or if a judgment against the fund has remained unsatisfied for 30 days, the trust fund must immediately make up the deficiency or levy an assessment upon the members for the amount needed to make up the deficiency.

Subsection (10) prohibits the formation of a self-insurance fund after October 1, 1992. During the late 1980's and early 1990's, medical malpractice insurance in the commercial market became more available and affordable. That event, coupled with the assessability feature of the self-insurance funds, led to decreased interest in utilizing the funds as an alternative to the commercial markets. The current statutory prohibition against the formation of these funds would need to be addressed by the legislature if this option were to be utilized for future self insurance availability.

On February 4, 2003, the Select Committee on Medical Liability Insurance heard from Bruce Hill on the subject of medical malpractice self-insurance. Mr. Hill, who also testified before the Governor's Select Task Force on Healthcare Professional Liability Insurance on November 22, 2003, regarding the same subject, is general counsel and chief trial counsel for the Florida Hospital Trust Fund. This self-insured trust fund formed in 1975 pursuant to s.627.357, F.S. He reported that the fund operated very successfully with up to 42 hospitals participating. All claims are now closed and \$30 million dollars will be refunded. Based upon his experience, he stated self-insurance offers the following benefits: 1) a much lower expense ratio than insurance companies due to not needing to advertise or utilize agents, for examples; 2) parties have a proprietary interest in the plan's operation and success, especially given the possibilities of assessments and refunds; 3) better risk management programs, 4) better control over claims; and 5) easier to form than an insurance company because, with assessability, one does not have the initial capital requirements. In order to make this option available again to other entities, Mr. Hill recommended the repeal of the current statutory prohibition on the creation of new funds.

Insurance Risk Apportionment Plan- JUA

The concept of apportionment of insurance risk is embedded in the Florida Medical Malpractice Joint Underwriting Association, found in s. 627.351(4) F.S. . Like other JUAs, this entity is a market of last resort, intended to be a supplement to the private voluntary insurance market, not a substitute or competitor. Florida's program is structured to function like an insurance company. Premiums and investment income are used to pay losses and expenses. There are notable differences between the JUA and voluntary market companies. First, a profit factor is not included in rates in the JUA. Second, the policy is both assessable and participating. When the association runs a deficit, the deficit is covered by assessments against policy holders (limited to 30% of premium), followed by unlimited assessments on all liability insurers (including both companies that write medical malpractice insurance and companies that write other forms of

liability insurance) for the remainder of the deficit. Third, when excess funds are accumulated, there will be a refund to policyholders. There has never been an assessment. There have been refunds for 10 of the 27 years.

The Association cannot refuse to insure any eligible applicant. Previous loss experience, more hazardous types of medical practice, or higher risk patients or procedures, for example, cannot be used as factors to deny an application. Because of these characteristics the rates for the JUA are generally higher than traditional plans. Interest and participation in the JUA alternative appears to fluctuate over time based on external insurance market conditions. In the past it has been suggested that some variation of the JUA format could be used to create a supplemental risk pool for extraordinary cases, over and above the base levels required for financial responsibility required under current law. This pool would require a uniform level of assessment against all providers and be subject to management by actuarial sound principles with assessments changing from year to year.

Patient's Compensation Fund

Also in 1975, the Legislature created the Florida Patient's Compensation Fund for the purpose of paying that portion of any claims arising out of medical malpractice which was in excess of the fund entry level selected by the health care provider. Initially, the Fund provided unlimited excess coverage over a healthcare provider or hospital's primary insurance coverage. Physicians could purchase unlimited excess coverage above a primary policy of \$100,000 for \$1,000 for the first year of coverage and \$500 for each subsequent year. Hospitals paid \$300 per bed for unlimited coverage. If the premiums for that year of coverage were insufficient to cover the losses, then insured physicians could be assessed for up to \$1,000 in additional premiums for the first year of coverage in the Fund and \$500 for each subsequent year. If the assessments were not sufficient to cover the loss, then the balance of the shortfall was assessed against hospitals. There was an absolute cap placed on the total amount of premiums the Fund could accumulate requiring in some years to return money.

By 1980, the rate structure established by statute had created severe problems. Rates being charged were not considered to be actuarially sound, but the Fund was considered sound, given the assessment mechanism in place. Indeed, in that year, the Fund levied a \$280 million assessment which was primarily paid by hospitals (although \$73 million was returned as unneeded.) Faced with unlimited exposure to fund the PCF hospitals contended that they were carrying a disproportionate amount of the financial burden.

In an effort to shift the focus from a cost shifting mechanism to an insurance mechanism the Fund established coverage limits and began to charge actuarially sound rates. In response, the hospitals then formed their own insurance mechanism and became self-insured or purchased all of their coverage from the private market. This reportedly made the physicians left in the Fund, a relatively small number compared to prior years, now fully responsible for all future assessments and also fearful of the potential exposure, consequently, they all withdrew from the Fund prior to the July 1, 1983 coverage year.

The Fund, now, is codified as s. 766.105, F.S. It is a voluntary, fee-and-assessment-funded liability insurer for non-hospital participants who are health care providers. Participation is mandatory for all private hospitals that do not elect to demonstrate financial responsibility for liability coverage, as provided in paragraph 766.105(2) (c), F.S.. According to the Office of Insurance Regulation, Florida Department of Financial Services, the FPCF has taken no new policies since June 3, 1983, and is currently servicing 37 policies with loss reserves of \$10.4 million.

In order for this or any type of patient compensation fund to succeed, a sufficient membership and revenue base must exist. Key factors to consider are whether to: 1) require mandatory or allow voluntary participation, 2) enable a fund to collect actuarially sound premiums and 3) establish upper limits on the liability of the fund, and 4) consider blending structured payouts and the use of purchased annuities to accomplish current obligations for future payouts. Also, regardless of the funding, reimbursement and coverage mechanisms in place, severity and frequency of claims and their impact on losses is still a major factor in the pricing of premiums.

The Impact of Bad Faith

As previously discussed in Section Four, aggrieved parties in Florida may pursue bad faith claims against insurers. Such actions are permitted when insurers have violated certain insurance code violations or have failed to adhere to certain settlement practices.

The Select Committee heard testimony that Florida's laws regarding bad faith prompts insurers to settle non-meritorious cases. This, in turn, drives up rates. Insurers cite large jury awards, involving both high economic and non-economic damages, as setting the benchmarks in which all plaintiffs' offers must be evaluated. Insurers suggest two possibilities weigh very heavily in their settlement considerations – the possibility of verdicts in excess of policy limits combined with the possibility of being sued for bad faith if such an event occurs.

Also, it has been represented that physicians often desire to proceed to trial only to be told that insurance companies must settle because of bad faith exposure. Physicians also complain that settlement information is reported to the National Practitioner Data Bank which affects credentialing and insurability. On the other hand, insurers state that physicians also demand that insurance companies settle cases to protect their interests, even when, from the insurers' standpoint, the claim should be defended.

All of these factors, it is suggested, results in medical malpractice cases being settled in Florida at a 50% rate, compared to a national average of 30%. The numbers of settlements are simply factored back into the rates, thus producing some of the highest rates in the country for physicians.

Insurers also cite other unacceptable side effects of current bad faith laws. These detrimental aspects include higher health care costs for consumers, the unavailability of certain health care services due to high medical malpractice premiums, and windfalls to some plaintiffs and attorneys who realize excess verdicts.

To remedy the present situation, representatives of the insurance industry have proposed amending s. 624.155, F.S. They state that: 1) ownership of the bad faith cause of action should rest with the policyholder; 2) standards should be established governing the good faith conduct by insurance companies; and 3) the insurance company's liability for bad faith should equal the reachable assets of the policyholder, and the assets of the policyholder should be exempt from judgment in an amount equivalent to the bad faith payment made by the insurance company.

Physicians have recommended a similar proposal. They suggest that only the insured should be able bring a cause of action alleging bad faith. They also recommend that, for settlement considerations, the interest of an insured be at least equal to the insurer and the interest of the insurer's policyholders. Demands for settlement would not have to be met based simply on the mere possibility of an excess verdict. They recommend that an insurer not be held liable in bad faith if it tenders its policy limits at least 60 days prior to trial. Also proposed is that an insurer cannot be held liable for an amount greater than the amount the injured party would have been able to recover from the insured absent insurance coverage.

Attorneys for plaintiffs argue that insurers in Florida have a fiduciary duty to act in good faith toward their insured. They contend that this fiduciary duty requires insurance companies to develop proper claim handling procedures, perform early and proper investigation and evaluation of their insured's risk and settle, if possible, within policy limits where a reasonably prudent person would do so if faced with the prospect of paying the entire judgment. In light of the risks that a judgment above the policy limits presents to an insured, advocates of the status quo argue that Florida law attempts to promote the early resolution of claims within the insured's policy limits.

Trial lawyers also contend that these good faith duties are imposed on insurers to give them an incentive to put the best interests of their insureds above the interests of the insurer. Without the consequence of paying a judgment above policy limits, it is argued, insurance companies would have no incentives to timely settle claims and protect their insured. Insurance companies would simply fail to timely settle, delay, draw out litigation, and hang onto the policy limits the insured purchased for as long as the insurance company chose. It would do this at no risk to itself. Attorneys assert that changing Florida's law of good faith would unleash full scale "gambling" by insurance companies and put all of the risk on the insureds.

In contrast to the recommendations of the insurance industry, plaintiffs' attorneys recommend keeping current Florida law which, they maintain, imposes a fiduciary duty of good faith conduct in full force and effect. Without the duty of good faith, they argue, all insurance companies will be able to act in ways which would have devastating consequences for not just doctors, but for all insurance consumers.

They also suggest the Florida Legislature should enact a law prohibiting medical liability insurers from including the payment of final judgments above the policy limits due to wrongdoing by insurers in the rate-making base. They cite the law for auto insurers, 627.065(12), F.S. as precedent. Attorneys assert that physicians should not have to pay higher premiums due to bad faith conduct on the part of insurers.

Alternative Insurance

As stated earlier in this report, the current environment for medical liability insurance in Florida is plagued with many problems. Increases in premiums for medical service providers are evident and more so in areas of high risk specialties. Coverage has either become largely unaffordable or unavailable. Solutions to this situation should account for current factors, contain flexibility to account for rising costs in medical care and other inflationary factors, and include components which will alleviate the vagaries of the obvious cyclical nature of these issues. Alternative approaches to insurance are tools to accomplish these goals.

The alternative insurance market provides a way to obtain malpractice coverage bypassing established insurance companies. Alternative options include: self-insurance, captive insurance and insurance pools.

Captive Insurance

Captive insurance organizations include insurance companies that are owned and controlled by their insureds. A captive insurance company is described as single parent captive if it is owned and controlled by one company and insures that company and/or its subsidiaries.

The reasons for forming a captive are varied. Some of the common reasons cited include:

- a. Greater availability of insurance coverages at a reasonable cost or any cost
- b. Use of a captive may have significant tax advantages
- c. Greater control of their insurance needs
- d. Better service for their insurance exposure. A captive can tailor its insurance program to meet its own specific situation. This can involve better loss control, better underwriting and more control over the handling and settlement of claims
- e. Ability to obtain broader coverages
- f. In general, the ability to have greater stability in the cost of insurance
- g. Potential for improved cash flow. The premium collected by the captive earns investment income which accrues for the benefit of the captive owner(s)
- h. Direct access to the reinsurance market
- i. More immediate reward for controlling the cost of claims

Sometimes, state laws do not allow captive insurance programs to issue insurance policies. In these instances a captive insurance company uses an admitted insurer to front the insurance program. A fronted program offers four major advantages:

1. Insurance policies are issued by the fronted carrier to meet state filing and financial responsibility requirements.
2. Fronted companies can offer a wide range of services including risk prevention, underwriting, pricing, claims handling, accounting, policy services and reinsurance.
3. A fronting arrangement allows the captive to generate cash/flow and investment income benefits from lines of insurance which cannot be written by the captive because of state insurance regulation.

4. Stable pricing and consistent coverage availability can be achieved from a long term partnership between the captive and fronted company.

Insurance companies benefit from fronting in several ways. Fronting insurance programs generate more business to the insurance companies that would otherwise be written by another insurance entity. A fronting program which is adequately secured with reinsurance and financial guarantees should generate a higher rate of return on equity to the fronted company than the traditional insurance company.

A significant risk for a fronted company is the credit risk of the captive. Credit risk is generated from the captive's inability to meet its financial obligations from the business and financial risk. They include adverse loss experience, catastrophic loss or inadequate spread of risk.

In Florida, captive insurers are governed under Part V of Chapter 628, F.S and licensed by the Department of Financial Services. Except as provided as to industrial insured captive insurers, a captive insurer is defined as a domestic insurer established to insure the risks of a specific corporation or group of corporations under common ownership owned by the corporation or corporations from which it accepts risk under a contract of insurance. No captive insurer, other than an industrial insured captive insurer, shall insure or accept reinsurance on any risks other than those of its parent and affiliated companies. In addition to the information otherwise required by the Insurance Code, each applicant captive insurer must file with the department evidence of the adequacy of the loss-prevention program of its insureds.

Currently, no captive insurer is permitted to join or contribute financially to any joint underwriting association or guaranty fund in this state; nor shall any captive insurer, its insured, or its parent or any affiliated company receive any benefit from any such joint underwriting association or guaranty fund for claims arising out of the operations of such captive insurer.

At the February 4, 2003 meeting of the Select Committee on Medical Liability Insurance, Charles Kolodkin, JD, MBA, CPCU presented information on alternative risk programs. (See materials in Addendum) At that meeting and in a follow-up letter, he suggested the state needs to: 1) be more receptive to the establishment of alternative risk funding mechanisms for physicians and other healthcare providers; 2) insist that each alternative risk entity conducting business in Florida have an annual actuarial certification of losses; 3) require any alternative risk funding entity permitted to do business in Florida to have an active risk management program addressing loss control and patient safety; and 4) require alternative risk funding entities to be covered by a guaranty fund paid for by a portion of the entity's annual premiums.

As to other alternative means to provide compensation to injured patients, Florida currently has the following program:

Florida Birth Related Neurological Injury Compensation Association (NICA)

In 1988, the Legislature created NICA to pay for the care of infants born with certain neurological injuries. According to NICA, their mission is threefold:

1. To encourage physicians to practice obstetrics and make obstetrical services available to patients.
2. To stabilize and help make malpractice insurance available to all physicians.
3. To provide needed care to injured children

The program is based on a “no-fault” model wherein negligence is not determined and litigation is reduced considerably. Specifically, coverage extends to infants weighing at least 2,500 grams (single birth) or 2,000 grams (multiple births) who because of oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period are permanently and substantially mentally and physically impaired.

The NICA Plan provides actual expenses for necessary and reasonable care, services, drugs, equipment, facilities, and travel, excluding expenses that can be compensated by state or federal governments, or by private insurers. A one-time payment, not to exceed \$ 100,000, is provided to the infant’s parents or guardians. Funeral expenses are authorized up to \$1,500. Reasonable expenses for filing the claim, including attorney’s fees are also covered.

The Association is funded by participating providers as well as all licensed physicians and hospitals. According to NICA, since its inception, 161 cases have been accepted; 87 are current open claims. On average \$3,000,000 is placed in reserve for each case. The amount varies by life expectancy, current condition and needs of the infant. The most recent financial audit (6/30/02) indicates invested assets of \$324,321,218, with total incurred claims of \$299,000,000.

Suggestions have been made to expand NICA. These include lowering the birth weight for eligibility, requiring only a substantial physical or mental impairment, and adding certain injuries for coverage. Concerns about such expansions focus on increased costs as well as removing additional causes of actions from the traditional tort system.

THE RATE REVIEW PROCESS

The Select Committee heard from several presenters who offered conflicting conclusions drawn from the data contained within the Closed Claim Data files of the Department of Insurance. The Select Committee also heard conflicting interpretations from stakeholders as to how insurance rates are approved and reviewed in the Florida system. In order to clarify these issues the Chairman asked the Office of Insurance Regulation to provide information relative to each of these issues. Following is a summation of the materials provided by the OIR.

In Florida there is a difference between the ratemaking process and the rate review process. The Office of Insurance Regulation (OIR) is charged with the responsibility of reviewing rate filings. This description will be relative to property and casualty rate review, although some of the more fundamental elements of the review are equally applicable in the review of health insurance rates. The materials for this section were obtained from the OIR.

All filings are submitted for OIR's approval. There are two ways that filings are submitted:

Use and File- Section 627.062, Florida Statutes, permits insurers to submit filings to the OIR even after they have actually been implemented. This provision of the statute requires that the insurer submit the filing no more than 30 days after the proposed rates have been put in effect. The purpose behind this provision of the rating law is to allow insurers the opportunity to react to changes in loss patterns or other components of the insurance environment, without having to await the Office's approval of the rate change. Should a rate be implemented that is ultimately determined to be excessive by the Office, the insurer can be required to return any premium collected in excess of that which is supported.

File and Use -Section 627.062, Florida Statutes, also provides insurers the opportunity to have their rate requests reviewed and approved by the OIR prior to implementation. This method assures the insurer that its assessment of its rate needs is consistent with the OIR's assessment. This method does not expose the insurer to the prospect of having to return premium should a rate filing be deemed unsupported by the OIR.

For most property and casualty rate filings (all except private passenger auto and workers' compensation), disagreements between the OIR and insurers over the approval of a rate filing can be referred the Division of Administrative Hearings, pursuant to Section 120.57, Florida Statutes, or an arbitration panel, pursuant to Section 627.062(6), Florida Statutes.

GENERAL

All rate filings must include certain fundamental data. The particular line of business in which the insurer is requesting a rate change will dictate the minimum contents of the rate filing. Various Rules in the Florida Administrative Code, and certain provisions of the Insurance Code, provide guidelines to insurers on what should be included in a rate filing.

Rate changes are based on historical claim experience. In fact, the goal of ratemaking is to project past claim experience into the future in order to determine what the rate needs will be. Company actuaries will consider any demonstrable changes in the frequency of filed claims and their relative severity. Company actuaries will look at prior claim experiences (both paid and incurred) and trend these losses prospectively. These anticipated losses will then be reconciled to the level of premium that would be generated by current rates. To the extent that this premium is inadequate to pay the anticipated claims and other expenses, an increase in rate may be appropriate. The OIR will generally consider all of the medical malpractice claim experience submitted by the insurer, but we will give less weight to data over five years old (stale) and data less than three years old (green).

This process continues with the insurer determining how much of a rate change is necessary to assure an ability to pay the anticipated claims and all other expenses. This process recognizes that there is a lag in time between the collection of the premium and the actual payment of the claim. It is during this time that insurers will invest the premium. The change in rate takes into consideration the generation of income from investments. The ultimately proposed rate change is reduced to recognize the contribution investment income will make to the accumulation of funds

with which claims and expenses can be paid. This recognition is contemplated in the Profit and Contingency Factor, as determined in accordance with Administrative Rule 4-170.003, Florida Administrative Code. This Rule provides for an underwriting profit of up to five percent, plus certain investment income. Based on industry statistics, the Profit and Contingency Factor for all liability lines is negative.

Once a change in an insurer's rates is calculated and approved, it is applied to the insurer's base rate. The base rate is the rate that literally serves as a foundation or building block for the other rates affected by the proposed change. In medical malpractice insurance, there are a number of specialties (neurosurgeon, radiologist, pediatrician . . .) that are charged individual rates due to the vagary in risks they pose. The various specialties are all relatively rated off of the base rate. These relativities reflect the particular experience in those specialties. Over time, insurers have begun to factor in the geographic location of the insureds to recognize the differences in loss patterns being experienced in different parts of the State.

While not a part of the rate review process, it is appropriate to mention two items:

1. Insurers are restricted in what they can invest. Section 625.305, Florida Statutes, establishes the minimum quality and maximum quantity of investments that insurers may purchase. This statute establishes certain diversification parameters that are designed to preclude an insurer from becoming concentrated in anyone stock or any one industry.
2. These assets are booked at cost and, irrespective of their appreciation or depreciation; they remain on the company's books at cost until they are sold.

As noted previously, rates are based on prior claim experience. Prior claim experience does not include investment losses. Nor does prior claim experience recognize reduced income from investments. Medical malpractice rate changes are almost exclusively a function of claim losses that have been paid or incurred. A reduction in anticipated investment income may be realized by a moderation of the negative Profit and Contingency Factor. It is not likely that this change would have a dramatic impact on rates given the investment restrictions established in Section 625.305, Florida Statutes.

The rate review process is designed to assure that rates are not excessive, inadequate, or unfairly discriminatory. The governing statutes and rules are subject to modification to reflect changes in the dynamics of the insurance industry. It is the responsibility of the OIR to make sure that the fundamental process remains sound.

CLOSED CLAIM DATA BASE

Section 627.912, Florida Statutes, requires that certain providers of professional liability insurance report to the Department of Insurance (now the Office of Insurance Regulation; hereinafter referred to as OIR), specific information on closed claims.

Questions have been raised concerning the integrity of the Closed Claim Database, and there are additional factors which should be considered when this data is used as a barometer of the current medical malpractice market. The database reflects claims that have been closed as of any

one point in time. The injuries occurred many years prior to the claims' closures. So, when one looks for changes in severity or for frequency trends, looking at the number and size of claims that have recently been closed evidences an incomplete picture. Better data would be the inclusion of the number of claims, and the associated reserves established thereon, that are currently being realized by insurers. Rate filings include data that reflect claims paid in prior years and the reserves that have been set relative to claims filed in those years, but not yet paid or closed.

It is the number and severity of claims currently being incurred that seem to be the most concern to the insurance industry. The industry is seeing two things happen that are not reflected in the Closed Claim Database. They are seeing an increase in the number of claims being filed. Likewise, some are finding the need to set higher reserves for those claims in response to recent experience in either litigating the claims or settling them prior to litigation. It may not matter whether or not this perception is ultimately deemed accurate. If such perception results in the legitimate establishment of increased reserves; reported losses (for income purposes) effectively rise; and rate increases naturally follow - or insurers reduce their willingness to provide the coverage - or the insurers even leave the State altogether.

The data in the Closed Claim Database is providing information relative to claims that occurred last year, and in 2000, and 1995, and 1993, and every year before, after and in between. While the insurers may not have actually cut a check for these losses until they are reported to the Closed Claim Database, they have already realized the impact on their financial statement when reserves were established for the claim. In addition, the impact of the claim was realized, for ratemaking purposes, in at least the first rate filing after the claim was filed.

For example, let's say that an insurer is notified of a claim on June 1, 1999. The insurer will evaluate the claim and, depending on its assessments of the merits of the claim, either pay it, or elect to contest (litigate) the claim. If the claim is not paid, a reserve is established on the claim. In this example, we'll say the reserve is established at \$100,000. For income statement purposes, the claim is effectively paid in the amount of \$100,000. The funds to ultimately pay the claim have been expensed and are no longer available to the insurer in the form of surplus (capital). The establishment of reserves for this claim will be recognized when the insurer evaluates the adequacy of its rates. The rates may need to be adjusted if other actual losses (and reserves on those claims that have not yet been paid) are rising at such a rate and severity that the current rate will not generate enough premiums to pay the claims and expenses, while also producing a profit.

Assume that the claim is paid in 2002. Whether the claim is settled or a courtroom judgment is entered, does not matter. The Closed Claim Database will report that a \$100,000 claim has been closed in 2002. The closing of this claim does not indicate the status of the medical malpractice market in 2002. The income effect of this claim was felt in 1999 when the reserve was established. The rate effect of the claim was realized in at least the first rate filing after the reserve was established. It is because of the relationship between the timing of when the claim is incurred, when it is reported, what the associated reserves are, and when it is actually paid and closed that conclusions drawn on the Closed Claim Database should be considered cautiously.

The Closed Claim Database is being increasingly relied upon to draw conclusions about the current state of the medical malpractice market. The OIR has contended that while the information in the Database is not without value, the contents do not reflect a current, comprehensive picture of the medical malpractice market. They note that the data is not validated. Conclusions drawn from the Database should recognize this fact. Not all entities providing medical malpractice in Florida are required to report closed claims to the Office. Moreover, it cannot be assured that all of the insurance entities required to report to the Database have consistently done so. Finally, not all licensed physicians have insurance. The OIR argues that, accordingly, analyses that presume a comprehensive Database may be fundamentally flawed.

There are a couple of additional concerns raised by the OIR with the Database. For more than 20 years, the information was submitted to OIR by insurers on paper. The paper information was then key-punched into the database by P.R.I.D.E. The OIR was not able to supervise this data entry, nor was there any formal OIR-administered audit program in place during these years. For the years this data was entered into the system via Florida's prison system, the OIR can not attest that all of the submitted data was entered, or that it was entered correctly.

For the first 23 and half years of the Closed Claim Database's existence, single claims involving multiple insureds were handled in such a way that portions of any payment were allocated to each of the insured's as determined by the insurance company. In mid July of 1999, insurers were provided a means by which the claim data could be submitted electronically, thus by-passing the data entry process. This new methodology allowed insurers to use an electronic template. Insurers could complete the worksheet and submit same to the Office via diskette. The OIR has requested funds for the 2003-04 fiscal year to allow for the collection of this data over the internet. During the re-engineering of the database, the OIR will establish comprehensive data validation business rules to enhance the integrity of that which is reported.

It is the contention of the OIR that there is a better way to more timely appreciate changes in the medical malpractice insurance market. This will require that insurers provide a different type of information to the Office: information that will measure what is currently going on right in the market. Insurers may not want to part with some of this information, as they may have concern this may disclose business practices considered proprietary. It is suggested that the OIR and those providing medical malpractice insurance could develop a reporting mechanism which would anonymously measure the health of the market and develop a more real-time means of reacting to adverse changes.