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The seal of the University of Miami School of Law is a circular emblem. It features a central scale of justice with a sword pointing upwards from the center. The year '1926' is inscribed above the scales. The outer ring of the seal contains the text 'UNIVERSITY OF MIAMI' at the top and 'SCHOOL OF LAW' at the bottom. A Latin motto, 'Justitia ab hominibus sub Deo et lege', is written in a smaller font around the inner edge of the seal.

How Not to Do Medical Malpractice Reform: A Florida Case Study

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HOW NOT TO DO MEDICAL MALPRACTICE REFORM:
A FLORIDA CASE STUDY

Mary Coombs¹

Malpractice reform has been a subject of scholarly attention and efforts to reform the law for at least thirty years.² While there have been efforts to put malpractice reform on the federal legislative agenda, none have succeeded.³ Significant changes have occurred, however, at the state level.⁴ The vast majority of this change has occurred through legislative action and has typically taken the form of bills seeking to institute a variety of changes in the malpractice system. Some, following the model of California's MICRA,⁵ have focused on

¹ With thanks to Lili Levi, Patrick Gudridge, Grayson McCouch and Bernard Oxman. I particularly want to thank Art Simon, for sharing his knowledge and insights about the Florida facts described herein, for providing entrée to the various interviewees and for encouraging me in the project, to Larry McPherson of the Florida Board of Medicine for guiding me through some of the relevant Florida government data, and to all my interviewees. This could not have been done without the assistance of Barbara Brandon and the rest of the University of Miami Law Librarians. Earlier drafts of this article were presented at the University of San Diego, in 2006, and the University of Miami, the Health Law Professors Conference and the Law & Society Association Conferences in 2007. Finally, for her extraordinary help, thanks to my research assistant, Ashley Bruce. I also want to express my gratitude to all the people whom I interviewed: Paul Jess, Scott Carruthers and Debra Henley, the professional leadership of the Academy of Florida Trial Lawyers (hereinafter "AFTL"); Sandra Mortham, Jeff Scott and John Knight, the professional leadership of the Florida Medical Association (hereinafter "FMA"); Bob White, CEO of Florida Professional Insurance Corporation (hereinafter "FPIC"); Dr. Carl Lentz, the President of the FMA in 2004-05, William Large, Executive Director of the 2003 Governor's Task Force on Healthcare Professional Liability Insurance; Bill Bell, Executive Director of the Florida Hospital Association (hereinafter "FHA"), Mark Delegal, lobbyist for insurers, Robert Wychulis, CEO of Florida Association of Health Plans, Rep. David Simmons (R.-Ocala), a key drafter of the 2005 malpractice legislation; Gail Parenti, of the Florida Defense Lawyers Association, and Lincoln Connolly, a plaintiff's malpractice attorney.

² "In the mid-1970s, a crisis involving the availability of malpractice insurance coverage in the United States led to the enactment of various first-generation tort reform laws in several states. In the mid-1980s, a crisis of affordability led to another round of tort reform legislation in the most affected states" (citations omitted). Theodore R. LeBlang, *The Medical Malpractice Crisis—Is There A Solution?*, 27 J. Legal Med. 1, 2 (2006).

³ Failed House legislation: H.R. 229, § 7, 104th Cong. (1995); H.R. 1091, § 204, 105th Cong. (1997); H.R. 5344, § 4, 106th Cong. (2000); H.R. 1639, § 4, 107th Cong. (2001); H.R. 321, § 4, 108th Cong. (2003). Failed Senate legislation: S. 11, § 202, 104th Cong. (1995); S. 1370, § 6, 107th Cong. (2001).

⁴ "In 2005, 48 states introduced more than 400 bills in an attempt to address 'fevered calls for medical liability reform.' Moreover, at least 29 states passed more than 50 medical malpractice tort reform bills that state governors signed in to law." Theodore R. LeBlang, *The Medical Malpractice Crisis—Is There A Solution?*, 27 J. Legal Med. 1, 7 (2006).

⁵ Medical Injury Compensation Reform Act (MICRA), 1975 Cal. Stat. 2d Ex. Sess. 3949.

changing the system for malpractice litigation in order to control malpractice insurance costs and to induce other changes that would improve the climate for health care professionals and, indirectly, for patients.⁶ Others expanded their focus to include provisions dealing directly with the malpractice insurance industry or to reduce the level patient-harming behavior by changes in physician discipline or the support of the patient safety movement.⁷

Some reform, however, has occurred by means of the citizen initiative.⁸ While initiatives can sometimes be in the form of a more wide-ranging, legislative-like approach, they will always be designed by the particular entities that put them on the ballot. Some are very narrow, designed for quite specific

⁶ See, e.g., Fla. Stat. Ann. § 766.118 (West 2003); Tex. Civ. Prac. & Rem. Code Ann. Ch. 74 (West 2007); Utah Code §78-14-17 (West 2004); Ohio Rev. Code Ann. § 2323.41 (West 2006).

⁷ See, e.g., Fla. Stat. Ann. §381.0271 (West 2004) (establishing the patient safety corporation); Fla. Stat. Ann. §395.1012 (West 2002) (creating the patient safety requirements for licensed facilities); Chapter 8, Laws of 2006 (Wash. 2006) (focusing on patient safety, malpractice insurance oversight, and litigation); Or. Rev. Stat. §442.820 (West 2003) (establishing a patient safety commission).

⁸ In addition to the Florida initiatives discussed herein, voters in five other states have faced initiatives dealing with malpractice issues in the last ten years:

| Year | State | Kind | Number | Subject | Result |
|------|------------|-----------|------------|---|--------|
| 2003 | Texas | Const. | Prop. 12 | NonEconDamage Limit | Pass |
| 2004 | Nevada | Statutory | Q. 3 | Limit Conting'cy Fees, Π recovery | Pass |
| | Nevada | Const. | Q 4 | Control Ins. Rates | Fail |
| | Nevada | Const. | Q. 5 | Penalize lawyers for frivolous suits | Fail |
| | Oregon | Const. | Measure 35 | NonEconDamage Limit | Fail |
| | Wyoming | Const. | Amdt. C | Authorize mandatory arbit'n | Pass |
| | Wyoming | Const. | Amdt. D | Authorize NonEconDamage Limit | Fail |
| 2005 | Washington | Statutory | I-330 | NonEconDamage Limit;Contingency Fee Limit, Mandatory Arbit., etc. | Fail |
| 2005 | Washington | Statutory | I-336 | Malpractice Ins. Reg; Patient Safety; Malpr. Litigation Reform | Fail |

purposes and not re-formed in a legislative process.⁹ In this paper, I explore in detail a case study of such malpractice reform by initiative.

In Florida in 2004, three constitutional initiatives dealing with malpractice reform were placed on the ballot. Amendment Three severely restricted attorney's contingency fees in malpractice suits. Amendment Seven gave citizens access to reports of adverse incidents involving hospitals and doctors with whom they had or might have a treatment relationship. Amendment Eight required the revocation of the license of any physician found three times to have committed an act of malpractice. All passed easily. At least two and possibly all three,¹⁰ have been very largely undermined by subsequent events which, in effect, returned the situation to something close to the status quo ante. Their direct impact on the law surrounding malpractice and malpractice litigation is thus likely to be minimal.

However, we can learn something both about the process by which malpractice reform occurs by a close examination of how each of these provisions came about and how each reflected the substantive and strategic interests of one of the stakeholders in the medical malpractice system. We can also use the opportunity to examine closely the meaning and implications of the specific provisions on their face as limit cases in the kinds of "reform" that may be enacted.

In Part Two, I describe the Florida story: the available initiative process in the Florida Constitution, the legislative background, the initiative battle between the medical association and the trial lawyers, the subsequent legislative and judicial maneuvering and the current status of the three amendments. In Part Three, I assess what the amendments, in the form anticipated by sponsors and voters, might have meant for malpractice reform and the likely effect of these processes on the prospects for such reform. Part Four briefly concludes .

⁹ The role the legislature may play in responding to an initiative varies widely, and only in part by whether the initiative is in the form of a proposed statute or constitutional provision. In a companion paper, *Two Cheers for the Citizen Initiative*, on file with the author, I explore the roles that initiatives can play as part of the governance process.

¹⁰ The fate of Amendment Seven depends on the decision of the Florida Supreme Court in *Florida Hospital Waterman v Buster*, 932 So. 2d 344 (5 DCA 2006), cert. granted. 926 So. 2d 1269 (Fla. S. Ct. (table)).

The Florida Story

The initiative process in Florida is unusual and, as I hope to demonstrate below, some of the particularities of that process help explain how the initiative system was used by the physicians and trial lawyers and why what they accomplished did not advance genuine reform.

Most initiative states are in the west; they adopted initiatives as a means of giving voice to the people, when the legislature was seen as captive to special interests. The forces calling for initiatives represented the confluence of the populists, who sought to advance the interests of farmers and workers, and the progressives, who sought a means to combat corruption, in the early part of the twentieth century.¹¹ Florida, in contrast added the citizen initiative to its constitution only in 1968 with the revision of its constitution. While the drafters adopted a well-established tool of governance, they adopted a rather unusual variant of it, because, it seems, they were responding to a quite different problem, the perception that prior constitutions had been “larded with special interest amendments.”¹² Thus the goal was to add a variety of means to amend the constitution, including the citizen initiative.¹³ There is no evidence that the drafters even considered a provision for statutory initiatives.¹⁴

At the most general level, the Florida process is similar to that for initiatives in other states. Proponents must file their proposed amendment with a government authority; in this case the Secretary of State’s office. They must, using petitions clearly indicating what the proposed amendment will say, gather

¹¹ See Kenneth P. Miller, *Constraining Populism: The Real Challenge of Initiative Reform*, 41 *Santa Clara L. Rev.* 1037 (2001); Nathaniel A. Persily, *The Peculiar Geography of Direct Democracy: Why the Initiative, Referendum and Recall Developed in the American West*, 2 *Mich. L. & Pol’y Rev.* 11 (1997).

¹² *Evans v Firestone*, 457 So. 2d 1351, 1358 (Fla. 1984) (McDonald, J., concurring).

¹³ Fla. Const. Art. XI, § 3. The new constitution simultaneously added a provision for the use of a Constitution Revision Commission, Art. XI, § 2, and provided procedural hoops to cabin the use of all the means of revision. See *Evans v Firestone*, 457 So. 2d 1351, 1358 (Fla. 1984) (McDonald, J., concurring). See generally P.K. Jameson and Marsha Hosack, *Citizen Initiative in Florida: An Analysis of Florida’s Constitutional Initiative Process, Issues and Statutory Initiative Alternatives*, 23 *Fla. St. U. L. Rev.* 417, 424-25 (1995)

¹⁴ See generally Talbot D’Alemberte, *The Florida State Constitution: A Reference Guide* 147-48 (1991). As D’Alemberte notes, the citizenry can in effect force the legislature to act by placing in the constitution a provision that says some specific provisions shall be binding “until changed by law.” *Id.* At 148. See Florida Const. Art II, §8 (i) (the ethics in government provision, added by initiative in 1976).

a sufficient number of voters' signatures.¹⁵ The initiative becomes law upon a sufficient affirmative vote of the electorate at the next regularly scheduled election.¹⁶

There are three other aspects of Florida's initiative process that make it unusual; each seem related to the fact that initiatives are solely constitutional. First, the Supreme Court reviews proposed initiatives before they are placed on the ballot. Once the proponents have obtained ten percent of the required signatures and notified the secretary of state, they may request that the Secretary of State submit the amendment to the Attorney General, who will then petition the Supreme Court for an advisory opinion.¹⁷ Both proponents and opponents may brief and argue these cases.¹⁸ The advisory opinion deals with two issues: whether the petition satisfies the single subject requirement in the Constitution,¹⁹ and whether the ballot title and summary are clear and unambiguous.²⁰ The procedure avoids, in most cases, the particular counter-majoritarian difficulty inherent in a court rejecting a proposal already approved by the majority of the voting citizens.²¹

Second, while many states' laws indicate that initiatives must deal with only a single subject, the Florida courts take this requirement extremely

¹⁵ In Florida, the required number is eight percent of the votes cast in the most recent presidential election. As many other states do, Florida also requires that there be a sufficient geographic dispersion of signatures, here by requiring that the eight percent requirement also be met in at least one-half of the congressional districts. Fl. Const. Art XI Sec 3. The processes for qualifying a proposed amendment in Florida can be found at the website for the Florida Department of State, Division of Elections. See <http://election.dos.state.fl.us/initiatives/init.shtml> (last accessed Feb. 5 2007).

¹⁶ In 2006, legislatively-proposed Amendment 3 passed, raising the required vote for from a simple majority to sixty percent. See Fl. Const. Art. XI, sec. 5.

¹⁷ Fla. Stat. §15.21, §16.061 In any event, this review must occur before the initiative is placed on the ballot.

¹⁸ Art. IV, sec. 10; Art. V, sec. 3(b)(10).

¹⁹ Art. XI, sec. 3.

²⁰ Required by Fla. Stat. § 101.161. See generally Advisory Opinion to the Attorney General Re: The Medical Liability Claimant's Compensation Amendment, *supra* note 55 (setting out the scope of review for these issues). Some critics have noted that there is no provision for the Court to change a title or summary; if these are found misleading, it must strike the proposal from the ballot. Harry Lee Anstead, et al., The Operation and Jurisdiction of the Supreme Court of Florida, 29 Nova L. Rev. 431, 491 (2005).

²¹ It does not eliminate this possibility, since other issues are not considered in the advisory opinion and may provide a basis for voiding it after passage. See Patrick O. Gudridge, Complexity and Contradiction in Florida Constitutional Law and cases discussed therein (manuscript on file with author).

seriously.²² They provide several rationales for this doctrine: First, because initiatives are constitutional, it is seen as important “to insulate Florida’s organic law from precipitous and cataclysmic change.”²³ Second, because citizen initiatives lack the opportunity for debate and amendment that inheres in the legislative process, it is necessary to avoid “logrolling” which forces voters “to accept part of a proposal which they oppose in order to obtain a change which they support.”²⁴ Finally, reflecting the nature of the proposal as both citizen initiative and, if adopted, constitutional text, it should not “substantially *alter* or *perform* the functions of multiple branches” of government²⁵ or affect multiple sections of the constitution in a way that is not clear to the electorate.²⁶ Legal scholars have disputed the desirability of the current procedures for judicial review and the jurisprudence the Supreme Court seems to have used.²⁷ The pre-election procedure seems particularly useful given the greater scrutiny Florida courts use in deciding if the single subject rule has been followed. Finally, Florida lacks a provision that many states have for a voter pamphlet which provides a relatively neutral description of each proposed initiative, sometimes

²² “[T]he Florida Supreme Court is the only court in the United States that has in recent years repeatedly treated the single-subject requirement as a real constraint on initiative-proposed state constitutional amendments.” Patrick O. Gudridge, Florida Constitutional Theory (For Clifford Alloway), 48 U. Miami L. Rev. 809, 816 (1994).

²³ In re Advisory Opinion to Attorney General - Save Our Everglades Trust Fund, 636 So 2d 1336, 1339 (Fla.1994)

²⁴ Fine v Firestone 448 So. 2d 984, 988,993 (Fla. 1984). It is perhaps worth noting that logrolling is a condemnatory term, used with special force for initiatives. In the context of legislative activity, logrolling might also be seen as the normal and desirable process of forming coalitions in which each member seeks to advance his position on the issues most salient to him, while agreeing to support the positions of others on issues as to which he is relatively indifferent. Because elected representatives interact over time and their votes are open, the process can occur over a series of bills. This sort of “coalition-building” can still occur within a single proposal in the initiative context. For example, California’s Proposition 70 called for substantial new funding on parks and specified about sixty particular projects, each supported by a local environmental group that was expected to provide concrete support to help pass the initiative. See Peter Schrag, Paradise Lost: California’s Experience, America’s Future(1998) 217-18.

²⁵ In re Advisory Opinion to Attorney General-Save Our Everglades, *supra* note 23.

²⁶ Fine v Firestone 448 So. 2d 984, 989 (Fla. 1984). For a subtle and incisive analysis of the Florida single-subject rule requirement, see Gudridge *supra* note 22, at 893-901 (concluding that the best explanation is that a proposal violates the single subject rule is when it overlaps with existing constitutional law in a way that leaves the courts with insufficient guidance as to how to properly interpret the resulting document).

²⁷ See Jameson & Hosack, *supra* n. 13 at 453-54)

together with summary arguments of proponents and opponents, which is provided to each voter well before the election date.²⁸

To understand the 2004 initiative battle requires a bit of historical context. The Florida Medical Association leaderships' decision to propose Amendment Three was a response to what they saw as their failure to achieve what they had hoped in the legislature. In response to one of the periodic malpractice crises,²⁹ which was particularly acute in Florida, Governor Bush had convened a Task Force in 2002, which held hearings around the State, invited expert testimony and produced a report proposing a number of reforms.³⁰ The one it pressed as most likely to ameliorate the perceived problem was a \$250,000 "hard" cap on non-economic damages.³¹ The Governor pressed the legislature to enact these reforms, both in the regular session and in four special session he called to deal

²⁸ The State only has the obligation to ensure that copies of the constitutional amendments are to be posted or available in booklet form at polling places on the day of election. Fla. Stat. §101.171

²⁹ In an example of déjà vu all over again, this reprised the situation in 1975 when a malpractice crisis had induced a legislative task force report and a "Comprehensive Medical Malpractice Reform Act." See Thomas Horenkamp, *The New Florida Malpractice Legislation and Its Likely Constitutional Challenges*, 58 U Miami L Rev 1285,1287 (2004)

³⁰ See Governor's Select Task Force on Healthcare Professional Liability Insurance (2003), available at <http://www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf> (last visited April 9 2007).

³¹ See *id.*, Executive Summary at xvii (the "Task Force if of the opinion that . . . the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a \$250,000 cap on non-economic damages"). This was explicitly modeled after the parallel provision in California's 1975 MICRA reform. *Id.* at 193. The report set out 60 different recommendations, under five headings: healthcare quality, physician discipline, tort compensation, alternative dispute resolution, and insurance code reform. Executive summary at v-xvi. The presentation of the hard cap as essential was designed, at least in part, to provide the basis to meet the Florida Supreme Court's prior decision indicating that such a rule, limiting access to courts, would be constitutional if the legislature determined that it was essential to meet an "overwhelming public necessity." Interview with William Large, Executive Director of the 2003 Governor's Task Force on Healthcare Professional Liability Insurance, Tallahassee, Fla. (December 5, 2006), tr. at 2 (referring to *University of Miami v Echarte*, 618 So. 2d 189, 196 (1993)(finding a limit on malpractice litigation passed in response to an earlier crisis to be constitutional under this test).

Oddly, although the malpractice insurers and FMA fought hard for this proposal, both in the task force processes and in the legislature, in my interview with Bob White, of FPIC, he discounted the significance of a damage cap, given that many Florida doctors carry no malpractice insurance and only a small number carry policies larger than \$250,000. White interview, Jacksonville Fla. (Dec. 15, 2006) tr. at 1. Cf. Kathryn Zeiler, et al., *Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990-2003*, *Journal of Legal Studies*, Forthcoming ; available at SSRN: <http://ssrn.com/abstract=981192> (indicating that insurance policy limits declined over time in real terms (Figure 7) and that out-of-pocket payments by physicians were extremely rare, even when physicians carried low limit policies (text at figure 5 and tables 5-6).

specifically with malpractice reform. While the House was an eager ally, the Senate was recalcitrant.³² (The general perception was that the trial lawyers had more influence in that body, while the health care industry was the dominant influence in the House and the Governor's mansion.³³) A bill was finally passed, but it reflected the conflicting agendas of the different stakeholders.³⁴ Most disappointing to the doctors and hospitals, the cap was now a "soft cap" of \$500,000 for physicians and \$750,000 for hospitals; these caps were subject to doubling in certain circumstances and to a judicial override in others.³⁵

The leaders of the Florida Medical Association, both the professional staff and the incoming and outgoing elected leaders, were unwilling to accept their loss. At the annual convention, only days after the end of the last special session, they decided that it was time for war. That rhetorical flourish is theirs, not mine. The new President, Dr. Carl Lentz, put on his flak jacket from his days in the military and told the assembled delegates that "this is a blood sport" and they "need to be prepared for war."³⁶ They would seek a constitutional initiative to sidestep what they saw as the capture of the Florida Senate by trial lawyers. The proposed amendment, however, would not respond directly to the failure to get hard non-economic damage caps. Instead it would seek a cap on attorney's

³² Horenkamp, *supra* note 29, at 1290.

³³ See, e.g., AFTL interview, Tallahassee, Fla., Dec. 4, 2006 at tr. 3, 5; Lentz interview Daytona Beach, Fla. (Dec. 14, 2006) tr. at 2 (claiming that "it was pretty obvious that [the recalcitrant Republican Senators] had had some dealings with a trial lawyer . . . and some threats")

³⁴ See Laws of Florida Ch. 2003-415. The 94-page statute did some things that are particularly focused on patient safety, including requiring medical facilities to adopt a patient safety plan, and requiring a course in limiting medical errors as an obligatory part of continuing medical education and on providing information relevant to patient safety by ordering the Department of Health to create a practitioner profile, which is to include records of malpractice actions, and have it publicly accessible. Other significant areas of reform included provisions regarding malpractice insurance and physician discipline.

None of the stakeholders was completely satisfied, which may simply reflect the expected outcome of a legislative process where there are conflicting interests. As one interviewee put it, "Nobody was happy, which meant it was probably the right thing. See interview with Gail Parenti, Miami, Fla. (Nov. 30 2006) tr. at 2.

³⁵ 2003 Fla. Laws ch. 416 §54, codified in Fla. Stat. §766.118 (2003). The caps were doubled if the patient was left in a permanent vegetative state (though this would seem to reduce any pain-and-suffering or conscious loss of enjoyment) and could be increased if the trial court determined that the non-economic harm was "particularly severe."

³⁶ Lentz interview, *supra* note 33, tr. at 3.

contingency fees in malpractice actions.³⁷ The shift has been explained in different ways. Some suggested that attorney fee caps was always the most desirable reform but had not been the focus of legislative efforts because, under Florida's separation of powers, any such bill might be struck down by the Florida Supreme Court as trenching on its authority over the judicial system.³⁸ Others suggested that a cap on damages would be less attractive to voters and thus less likely to pass.³⁹ Finally, the Florida Medical Association, after consulting with the head of the largest malpractice insurer in Florida, was convinced that an attorney fee cap was the change most likely to reduce the number and size of malpractice awards and thus to solve what the doctors saw as the central problem needing reform.⁴⁰

The trial lawyers were prepared for the possibility of such a battle. In 1988 the physicians had placed a \$250,000 hard cap on non-economic damages onto the ballot as a constitutional amendment. The trial lawyers had expended millions of dollars and barely succeeded in defeating it.⁴¹ After the fight ended, the leadership of the Academy of Florida Trial Lawyers⁴² vowed that they would

³⁷ The amendment stated that "in any medical liability claim involving a contingency fee, the claimant is entitled to receive no less than 70% of the first \$250,000 in all damages received by the claimant, exclusive of reasonable and customary costs" and "90% of all damages in excess of \$250,000." Fl. Const, Art I '26.

³⁸ See, e.g., Parenti interview, *supra* note 34, tr. at 4; FMA interview, Tallahassee, Fla. (Dec. 4, 2007) tr. at 2 (suggesting that task force had indicated that a contingency fee cap could not be done legislatively). There had been a limitation on attorney's fees as part of legislative malpractice reform in 1985; its constitutionality was never determined since, at the time it was challenged as unconstitutional, the court adopted the same schedule as a court rule, extended to all personal injury actions. See Contingency Fee, 494 So. 2d 960 (Fla. 1986).

³⁹ Lentz interview, *supra* note 33, tr. at 4 (noting that arguments over amount of a damage cap are complicated and the contingency fee cap "sells better to the public").

⁴⁰ White interview, *supra* note 31, tr. at 2-3; Lentz interview, *supra* note 33, tr. at 4; Interview with Mark Delegal, a lobbyist for insurers, Tallahassee, Fla. (Dec. 4, 2006) tr. at 3 (the attorney fee cap will "take the fuel away from the engine" of malpractice litigation); FMA interview, *supra* note 38, tr. at 2.

⁴¹ AFTL interview, *supra* note 33, tr. at 3. Amendment 10 lost 49.6% to 50.4%. See <http://election.dos.state.fl.us/initiatives/initiativelist.asp> (query: "1988/defeated"). The Florida Hospital Association had considered another attempt at a constitutional damages cap before the 2003 session but concluded that they were more likely to succeed in the legislature. Interview with Bill Bell of the Florida Hospital Association, Tallahassee Dec. 4 2006 (tr. at 2); the unattractiveness of the constitutional amendment route may have been influenced by the hostile response of the AFTL. AFTL interview, *supra* note 38, tr. at 2.

⁴² The Academy has since changed its name to the Florida Justice Association. See <http://www.floridajusticeassociation.org/>. In this article I continue to use the name of the organization at the relevant time.

never again be the only ones at risk in an election.⁴³ They chose to create a stockpile of weapons, and had drafted, tested and redrafted a number of possible initiatives, which were ready for use.⁴⁴ This was described as “a policy similar to the mutual assured destruction policy” between the US and the USSR,⁴⁵ the primary goal was not to have them enacted but to use them to dissuade others from pressing for initiatives that the trial lawyers saw as attacks. The potential weapons at this time included initiatives rolling back insurance rates,⁴⁶ and imposing an obligation on health care providers to charge no patient more than the lowest rate they charged to Medicaid and health insurance plans,⁴⁷ as well as what became amendments seven – “Patients’ Right to Know About Adverse Medical Incidents” -- and eight -- “Prohibition of medical license after repeated medical malpractice.”⁴⁸

With the threat of these proposals, the Academy leadership tried to persuade the Florida Medical Association not to go forward, but were rebuffed.⁴⁹ They also took their arguments to a variety of other stakeholders: Associated Industries of Florida, the Florida Chamber of Commerce, the Florida Association

⁴³ As Dr. Lentz remembered it, an AFTL leader said that after 1988 “we would never, ever go on the defensive again. We are going on the offensive. And we are going to take you out.” Lentz interview, *supra* note 33, tr. at 5.

⁴⁴ These were designed to threaten the interests of those, such as the insurance industry and the business community, who might ally with physicians and hospitals and provide funding for anti-trial lawyer proposals. AFTL interview, *supra* note 33, tr. at 2-3. This strategy was not unique to the organized trial bar in Florida. Trial lawyers in California similarly “employed a counter proposition strategy” to seek to deflect the propositions of tort reformers. Todd Donovan, Shaun Bowler, David McCuan and Ken Fernandez, *Contending Players and Strategies: Opposition Advantages in Initiative Campaigns* 80, 85 in *Citizens as Legislators* (Shaun Bowler, Todd Donovan & Caroline J. Tolbert, eds. 1998).

⁴⁵ AFTL interview, *supra* note 33, tr. at 2.

⁴⁶ The trial lawyer’s group, Floridians for Patient Protection, filed an amendment “Requiring New Standards for Insurance Rating,” which was withdrawn in 2004. See <http://election.dos.state.fl.us/initiatives/initiativelist.asp>

⁴⁷ See Floridians for Patient Protection’s “Physician Shall Charge the Same Fee for the Same Health Care Service to Every Patient,” still listed as ‘active’ in 2008. <http://election.dos.state.fl.us/initiatives/initiativelist.asp> .

⁴⁸ The full text of each can be found on the website <http://election.dos.state.fl.us/initiatives/initiativelist.asp> (query “2008, passed”).

⁴⁹ Lentz interview, *supra* note 33, tr. at 5-6. AFTL tried unsuccessfully to negotiate with physicians outside FMA through county and specialty medical societies. AFTL interview, *supra* note 33, tr. at 5.

of Health Plans and the Florida Insurance Council.⁵⁰ The leaders of these groups coalesced around an agreement to urge the FMA to back off, so that none of the Academy's proposals would be on the ballot.⁵¹ The FMA refused their entreaties as well.⁵² The trial lawyers did obtain a partial victory. The coalition members agreed that they would not support amendment three, either by speaking out in favor of it or by providing money for it.⁵³ In return, the trial lawyers agreed not to go forward with any proposal other than amendments seven and eight.⁵⁴

The battle was now joined. All three proposals were approved by the Supreme Court to go on the ballot.⁵⁵ All obtained the necessary signatures. (The

⁵⁰ The AFTL also spoke with the FHA, but they were apparently not part of the coalition induced to oppose the FMA. The Executive Director of the FHA recalls that, though he had engaged in discussions with the trial lawyers, the organization independently decided that it would not support the FMA proposal and was not part of the coalition. Bell interview, *supra* note 41, tr. at 2-3.

⁵¹ See November 19, 2003 letter from Associated Industries, Florida Chamber of Commerce, Florida Insurance Council and Florida Association of Health Plans to FMA (on file with author), . The threat to the insurance industry's anti-trust exemption led the Florida Insurance Council to insist that FPIC go along, a precondition to the trial lawyers agreeing not to go forward with that initiative. White interview, *supra* note 31, tr. at 4. Delegal, the FIC lobbyist, called the proposed amendment as "bullets and guns pointing at our heads", Delegal interview, *supra* note 40, tr. at 3. White said the technique was "blackmail," while also describing Amendment Three as "too extreme to be widely accepted as a credible civil justice reform". The FMA leadership also used the word "blackmail," and bemoaned that the others "didn't have the gust to move forward on our proposal," John Knight, FMA interview, *supra* note 38, tr. at 2.

⁵² November 24 2003 responding letter from FMA (on file with author). See generally Lentz interview, *supra* note 33, tr. at 5. Delegal described the negotiations between coalition members and FMA as involving "shouting matches" and a comment by Lentz that "these lawyers are terrorists and they need to be treated like terrorists and we don't negotiate with terrorists." Delegal interview, *supra* note 40.

⁵³ Delegal interview, *supra* note 40, tr. at 4. Associated Industries also sent a letter to each physician in Florida urging them not to support the amendment. Associated Industries letter of January 30 2004 (on file with author). The FMA leadership noted that, while most were silent, some business groups came out against amendment three, a position they found "shocking." They noted that the Chamber of Commerce, part of the coalition, had earlier indicated that such a limit would be part of their legislative agenda. Jeff Scott, the FMA associate general counsel, suggested that the business interests were opposed in general to the initiative process. FMA interview, *supra* note 38, tr. at 4.

⁵⁴ As they described it the other proposals remain available as bullets for another day. AFTL interview, *supra* note 33, tr. at 5-6.

⁵⁵ Substantial questions were raised by the opponents of each amendment in the arguments before the Florida Supreme Court. In regard to Amendment Three, Justice Lewis, joined by Justice Anstead, dissented, finding that the ballot title and summary did not provide fair notice to the voters. He argued that the court should look behind the direct effect of providing the claimant a larger share of any recovery and find the summary misleading for not making clear that the "singular and *only* purpose" of the amendment, was to "imped[e] a citizen's access to the courts and that citizen's right and ability to secure representation for a redress of injuries" Advisory Opinion to the Attorney General Re: The Medical Liability Claimant's Compensation Amendment,

FMA proudly pointed out that they had obtained most of their signatures by having doctors keep petitions in their offices and urge patients to sign them.⁵⁶) The election campaign was quite expensive. One public interest organization estimated the total spending as over \$8.5 million by the proponents of amendment three and over \$25 million by its opponents.⁵⁷

Almost all the efforts on both sides focused on amendment three, because polling indicated that amendments seven and eight would pass easily.⁵⁸ The state's major newspapers' editorials were overwhelmingly negative on all three amendments.⁵⁹ It made no difference to the voters. The polling was accurate and

880 So. 2d 675, 682-83 (Fla. 2004). The Court unanimously concluded that Amendment 7 comprised only a single subject and that the title and summary were accurate in saying that current law "restricted" access to information about adverse medical incidents, since the amendment would broaden the right to such information. Advisory Opinion to the Attorney General Re: Patients' Right to Know About Adverse Medical Incidents, 880 So. 2d 617 622 (2004). Finally, the Court majority found no defect in Amendment 8, rejecting Justice Bell's contention that the summary was misleading by stating that "current law allows medical doctors who have committed repeated malpractice" to remain licensed." While Bell argued that this could suggest that there was no mechanism under current law to revoke licenses in such situations, the majority concluded that the amendment, as suggested by the summary, would impose a stricter limitation than under current law. Advisory Opinion to the Attorney General Re: Public Protection From Repeated Medical Malpractice, 880 So. 2d 667, 673 (majority) 674-5 (Bell, J., dissenting) (2004).

⁵⁶ FMA interview, *supra* note 38, tr. at 13 ("we did not do what the trial bar did which was go out and buy them all"). Their expressed distaste for professional signature gathering companies may be slightly self-serving, since the AFTL battle plans included placing all the major signature gathering firms under contracts that forbade them from working for FMA. AFTL interview, *supra* note 33, tr. at 6.

⁵⁷ This data is calculated from Ballot Initiative Strategy Center's report "Money talks: Ballot Initiative Spending in 2004, at 8, accessed at

http://www.ballot.org/index.asp?Type=B_PR&SEC={AE1E33E7-19A6-4DE9-8520-3A0AD7FB5EF1}&DE={0672B4DA-5CC5-4E99-B5ED-DAA6038B2C3C}

These numbers are somewhat higher than the estimates of the FMA and the AFTL; the latter noted that a large portion of its money was spent on the campaign to avoid the election campaign. AFTL interview, *supra* note 33, tr. at 6.

⁵⁸ "No one fought for 7 & 8; . . . it just passed," Delegal interview, *supra* note 40, tr. at 5. Dr. Lentz also explained the FMA's position by arguing that Amendment 8 could safely be ignored since it would be changed by the legislature (as happened) to a form that largely eliminated its risk for physicians. Lentz interview, *supra* note 33, tr. at 6.

⁵⁹ The newspapers in the three largest areas – Tampa, Orlando, and Miami/Fort Lauderdale – recommended a no vote on all three amendments. Of the eight other newspapers included in the Westlaw database the only exceptions to this position were that one recommended a positive vote on three and three recommended a positive vote on seven (data available from author). Governor Bush, who had been very active in pressing the 2003 legislation, was largely silent on the fight over the amendments (which occurred simultaneously with his brother's re-election campaign). See Large interview, *supra* note 31, tr. At 5.

seven and eight both passed easily.⁶⁰ Amendment three, entitled “claimant’s right to fair compensation,” was not quite as popular, but even it received more than the sixty percent super majority since imposed for citizen initiatives.⁶¹ The proponents’ story line was clear and easy to understand: You, the plaintiff, were injured. You, the plaintiff, not your greedy lawyer, should receive the lion’s share of the damages.⁶² The counter-arguments are more complex, in part because they require focusing the voter not on what the amendment said but what the consequences of enacting it would be in the real world.⁶³

So, on November 2, 2004, there were three new provisions in the Florida constitution. Let us put aside for the moment, what effect each of these would have had had on malpractice and/or malpractice litigation,⁶⁴ had they taken effect in precisely the way their proponents intended (and, presumably, as the voters might have assumed they would). It is unlikely that any of them will have that effect and essentially certain that two of them will not. We now separate our story into three strands, looking at the post- enactment story of each of the amendments.

Even before Amendment Three passed and became Art. I, § 26 of the Florida Constitution, the trial lawyers were apparently considering how it might be interpreted to do the least damage to their interests.⁶⁵ The conclusion many of

⁶⁰ Amendment seven received 81.2% of the votes; amendment eight 71.2%. See <http://election.dos.state.fl.us/initiatives/initiativelist.asp> (query: 1994/passed)

⁶¹ It passed with a 68.4% vote; Ironically, the legislatively proposed super-majority initiative itself obtained only 57.8% of the vote. *Id.*

⁶² That story line “sells pretty easily,” Lentz interview, *supra* note 33, tr. at 4. See also FMA interview, *supra* note 38, tr. at 4 (“the victim[s] . . . need to have their fair share and the greedy trial lawyers are not who they need to be concerned about.”)

⁶³ The FMA described the anti-three campaign as one where the trial lawyers “had probably six different messages and obviously nothing was working,” FMA interview, *supra* note 38, tr. at 4. The trial lawyers described the campaign of sequential ads as needed to communicate a “more sophisticated” message. *Id.* at 8.

There would have been a similar message problem with combating Amendment Seven, had anyone thought it worthwhile to spend the resources to try. No on Seven “is a particularly difficult message to package and sell to the public, especially when they’re looking at an amendment that says the “right to know. “ Everybody wants to know. I want to know. And it’s a difficult message to sell especially on short notice with no budget to be able to articulate why it’s important to keep information confidential.” Parenti interview, *supra* note 34, tr. at 6.

⁶⁴ These questions are considered in Section III, *infra*.

⁶⁵ In addition to the technique described in text for avoiding the impact of Amendment Three, the trial lawyers suggested to me that they could use the initiative’s wording to argue that it required

them apparently reached was that this constitutional right of clients, like other constitutional rights (such as the right to a jury trial) could be waived.⁶⁶ They proceeded to ask new clients in at least some cases to do so, and agree to a higher fee, within the limits that the ethics rules of the Florida Bar set for fees that could be charged without judicial approval.⁶⁷ The proponents of Amendment Three were, to put it mildly, not happy.⁶⁸ To some extent, they were trapped by their own political choices. The attorney contingency fee caps in other states are drafted as a limit on how much attorneys may charge their clients.⁶⁹ In contrast, Article I, § 26 is written in terms of the percentage of the recovery that “the claimant is entitled to receive.” The possibility of waiver is built into the language

that plaintiffs receive seventy/ninety percent of the actual damages as assessed by the jury and thus that amendment three makes statutory caps on non-economic damages unconstitutional. AFTL interview, *supra* note 33, tr. at 9. In their briefs to the Supreme Court during the post-Amendment Three struggle, they had suggested that it would trump any subrogation or hospital lien claims insofar as they would reduce what the plaintiff received from the judgment below this level. Comments and Objections to Proposed Amendment to Rule 4-15.(f)(4) B) of the Trial Lawyers Section of the Florida Bar (Supreme Court of Florida, Case No. SC05-1150) at 7-8.

⁶⁶ Comments of Alexander Clem, then-President of the AFTL. Florida Doctors, Lawyers at Odds over Effects of Malpractice Amendments, *Insurance Journal* (Nov. 5, 2004), at <http://www.insurancejournal.com/news/southeast/2004/11/05/47480.htm> (last accessed 4/19/07).

⁶⁷ Under Rule 4-1.5(F)(4)(b) of the Rules Regulating Professional Conduct, these caps are 40% of the first \$1 million of the recovery, 30% of the next \$1 million and 20% of anything above that. These amounts are increased if the trial court judgment is appealed, lowered if the recovery is obtained before the filing of an answer or the demand for appointment of arbitrators, and lowered still more if all defendants admit liability at the time they file their answers and request a trial only on damages.

⁶⁸ Bob White of PFIC said that he had raised this risk earlier with the FMA but that they had replied that “the Supreme Court won’t let” the lawyers obtain a waiver from their clients. White interview, *supra* note 31, tr. at 5. The parties seeking to dissuade the FMA had raised the risk of plaintiffs’ attorneys indirectly undermining of the cap by charging hourly fees and then waiving them in whole or in part or, worse, by proposing a prevailing party fee shifting provision through legislation or initiative. Associated Industries Nov. 19, 2003 letter, *supra* note 51, at 7-8. William Large, though he thought the cap should never have been in the constitution, also thought it should be enforced as written once it had passed. Large interview, *supra* note 31, tr. at 7. See also FMA interview, *supra* note 38, tr. at 7. Cf. Gerber, Lupia, McCubbins & Kiewiet at 13 (noting, in the context of governmental resistance to implementing initiatives, that vague language in initiatives, chosen to enhance the chance of passage, may “backfire when it is time for implementation”)

⁶⁹ All the statutes and regulations cited in Casey L. Dwyer, Note, An Empirical Examination of the Equal Protection Challenge to Contingency Fee Restrictions in Medical Malpractice Reform Statutes, 56 *Duke L.J.* 611, 615-16 nn. 20-22 (2006) are of this form. See, e.g. Ann. Cal. Bus. & Prof. Code §6146(a); Del. Code. Tit. 18 §6865; Mich. Court Rules §8.121(b); 5 Okl. S. Ann. §7. Even in Nevada, which also imposed caps in 2004 by initiative, the proposal created a statutory cap drafted as a limit on attorneys. See Nev. Rev. Stat. §7.095 (“An attorney shall not contract for or collect a contingent [fee in an action] against a provider of health care based upon professional negligence in excess of . . .”).

of the provision. But that language is surely not inadvertent. A majority of the electorate voted for a provision titled “claimant’s right to fair compensation.” That might have been held to be misleading if the text was drafted as a regulation of what lawyers can charge. And the amendment might not have been so intuitively attractive to voters if it had been titled, “restriction on attorney fees in medical liability cases.”

Since the Bar seemed disinclined to step in, lawyers who had represented the FMA⁷⁰ collected the signatures of more than fifty Florida attorneys, thus triggering a process whereby the Florida Supreme Court would have to consider their petition seeking to make it an ethics violation to seek such waivers of client’s constitutional rights.⁷¹ The Court referred the issue to the Florida Bar to study it and report back.⁷² The Bar in turn created a Special Committee which held hearings and drafted a proposed rule, which the Bar approved.⁷³ Under that rule, a lawyer may ethically seek and obtain a waiver from his or her client and an agreement to pay a contingency fee higher than that set out in Art. I, sec 26. To do so, the lawyer must follow certain procedures described in the rule and the waiver must track a form included therein. After additional comments,⁷⁴ the Florida Supreme Court issued an opinion which adopted the Bar’s proposed rule with only minor modifications.⁷⁵ The opponents of the proposed rule had argued that the constitutional provision “embrace[d] certain policies that are beyond the control of the claimants themselves.” The court responded that “on its face, article I, section 26 unquestionably creates a personal right, one for the

⁷⁰ This effort was led by Stephen Grimes, a former Florida Supreme Court justice, who had represented the FMA. The other signatories to the petition were almost all either lawyers or lobbyists who represented the health care industry in Tallahassee or members of Grimes’ law firm, Holland + Knight. Trial Lawyer section comments, *supra*, at 5.

⁷¹ Rule Regulating the Florida Bar 1-12.1(f)

⁷² Florida Bar, Notice of Filing, in Re: Amendments to the Rules Regulating the Florida Bar – Rule 4-1.5(F)(4)(b) of the Rules of Professional Conduct, (S. Ct. Fla. Case No. SC05-1150) at 1, referenced in the final opinion of the Supreme Court on this matter, 939 So. 2d 1032 (2006).

⁷³ *Ibid* at 1 and Appendix C (text of proposed rule).

⁷⁴ Both at the stage after the initial petition was filed and after the Bar filed its proposed rule, the Supreme Court received hundreds of comments. See in Re: Amendments to the Rules Regulating the Florida Bar – Rule 4-1.5(F)(4)(b) of the Rules of Professional Conduct, 939 So. 2d 1032, 1038 n. 2 (2006)

⁷⁵ In Re: Amendments to the Rules Regulating the Florida Bar – Rule 4-1.5(F)(4)(b) of the Rules of Professional Conduct, 939 So. 2d 1032 (2006)

direct benefit of a medical malpractice claimant,” and that such a right, like other fundamental constitutional rights could be waived.⁷⁶ The Court then rejected the arguments that a judicial hearing was required for the contract to be effective;⁷⁷ they deemed it sufficient that clients know they could request such a hearing if they wished.⁷⁸

It is unclear what has actually happened as a result. Anecdotal evidence from trial lawyers is that they seek waivers in any case where the constitutional fee cap would erode the financial incentive to take the case. The process requires “up-front” time with the client to explain, but, they say, no client has taken the option of leaving and seeking an attorney who would take the case at the constitutionally set fee limit.⁷⁹ On the other hand, the head of FPIC, the largest malpractice insurer in Florida, and the executive leadership of the FMA

⁷⁶ 939 So. 2d 1032, at 1038. More precisely, they approved modifications to the Rules of Professional Conduct which allowed attorneys to seek waivers without violating these rules, while stating that they “decline[d] to actually determine the legal issue of whether [these] rights. . . may be waived.” *Id.* at 1038. These broader interests related to the claim that a major purpose of the amendment was to reduce the number of frivolous lawsuits, which would curb the costs of medical malpractice insurance and, in turn, reduce the costs of health care. Comments of American Medical Association and Mississippi State Medical Association in support of the Petition to Amend Rules Regulating the Florida Bar – Rule 4-1.5(F)(4)(b) of the Rules of Professional Conduct, at 7-8.

⁷⁷ 939 So. 2d 1032, 1038-39. The court indicated that an important basis for this decision was the representation by the Florida Bar that judges who were consulted indicated that judicial fee review under the prior rule are ex parte and thus “in effect, a form over substance requirement.” *Id.* at n. 4. The Court did not rely on the additional argument that it might be difficult to get such hearings quickly in some circuits. Since any mandatory review of a fee agreement would have to occur before the contract of representation was signed it could create serious problems for potential clients given the short statute of limitations for these actions and the requirement of a pre-suit investigation and preparation of expert affidavit under Florida law. The opinion also ignored the debate at oral argument whether a judge should refuse to permit a waiver absent a finding that the client could find no attorney willing to take the case without a waiver. See Gary Blankenship, Med mal fee waiver procedures argued, 33 (13) The Florida Bar News 1, 13 (July 1, 2006) (describing the oral arguments).

⁷⁸ 939 So. 2d 1032, 1040. Since the client is always free not to agree to waive and the attorney free not to agree to represent the client absent a waiver, a non-mandatory pre-contractual judicial review is a rather meaningless gesture.

⁷⁹ Interview with Lincoln Connolly, plaintiffs’ attorney, Miami, Fla. (December 18, 2006) tr. at 12 (explaining that the process of explaining the process to a client is “a pain in the neck,” but that, once you do so, the clients will agree). Debra Henley of AFTL concurred. AFTL interview, *supra* note 33, tr. at 11-12. Mark Delegal, who lobbies on behalf of insurance companies concluded that “the amendment has been gutted,” though he recognized his clients at FPIC viewed the situation differently. Delegal interview, *supra* note 40, tr. at 7.

claim that the amendment continues to have the effect they sought.⁸⁰ They say that some lawyers have withdrawn from the field, moving out of Florida, or shifting their practice away from medical malpractice.⁸¹ The lack of data makes it impossible to move beyond impressions, perhaps consciously or unconsciously colored by self-interest. At least some lawyers' practices are essentially unchanged; undoubtedly some lawyers are doing fewer malpractice cases, or moving their practices out of Florida but there are too many other potential causes to judge the impact of this one.⁸²

Amendment eight, which became Art. X, sec 26, of the constitution, has been referred to as "Three Strikes and You're Out."⁸³ As written, it would seem to require that a physician's license be revoked on the occurrence of the third

⁸⁰ John Knight of FMA was "ecstatic" that three was in the constitution and believed "It is having an effect every day." FMA interview, *supra* note 38, tr. at 7. See also White interview, *supra* note 31, (tr. at 5). Large said that "ethical lawyers" will not seek waivers. Large interview, *supra* note 31, tr. at 6. The FMA responded to the Supreme Court's decision declining to make it unethical to seek waivers with the assertion that it "would encourage its embers to have patients sign a waiver stating that they will not sue their doctor for more than \$250,000 in noneconomic damages." Jordan Mishory, Medmal Plaintiffs can waive fee caps, 81 (78) Daily Business Review A1, A 16 (Sept. 29 2006) (quoting Sandra Mortham). There is no indication that doctors are doing so, presumably because the situations are legally distinct. Such contractual limitations on damages from future incidents of malpractice are, as they always were, unenforceable under the theory that they violate public policy. See *Tunkl v Regents of the University of California*, 383 P. 2d 441 (Cal. 1963), adopted in Florida by *Banfield v. Louis*, 589 So.2d 441, 446 (Fla. 4th DCA 1991). Presumably the FMA would agree that there are no strong public policy needs to ensure access to the essential service of a malpractice attorney.

⁸¹ Delegal interview, *supra* note 40, tr. at 7 (some lawyers moved a medical malpractice practice to Georgia).

⁸² One trial lawyer saw this as simply one of a number of changes that made bringing a malpractice suit more complicated or expensive, creating "more hoops to go through," and that it was probably true that some lawyers no longer took these cases. Connolly interview, *supra* note 79, tr. at 6. Another pointed to the non-economic damage caps, Fla. Stat. §766.118, and the near-elimination of the bad faith claims against insurance companies, Fla. Stat. § 766.1185, that were part of the 2003 legislative reform (the latter had sometimes allowed plaintiffs to collect more than the often low policy limits) along with the total elimination of joint and several liability in mid-2006 with the enactment of Fla. Stat. §768.81 as more significant impediments. Telephone conversation with Scott McMillen, March 15 2007 (he's in Orlando, I'm in Miami). (The 2003 legislation also tightened the requirements for a pre-suit investigation. Fla. St. §766.106.)

⁸³ Keep Malpractice Fight Out of State Constitution (editorial), Palm Beach Post 18A (Oct. 7, 2004) ("[p]laintiffs' attorneys advertise it as a 'three-strikes-and-you're-out' solution to the problem of bad doctors"). The official ballot title was, "Public Protection from Repeated Medical Malpractice;" the summary read:

Current law allows medical doctors who have committed repeated malpractice to be licensed to practice medicine in Florida. This amendment prohibits medical doctors who have been found to have committed three or more incidents of medical malpractice from being licensed to practice medicine in Florida.

strike, where a strike is a finding by the Board of Medicine, a court or an arbitration panel that the physician had engaged in an act of malpractice.⁸⁴

Bills were quickly pre-filed for the 2005 session of the Florida legislature to “fix” the problems with this amendment.⁸⁵ With relative ease, a bill doing just that passed.⁸⁶ Under the statute, a number of limits were included on what could count as a strike for purposes of Art X, sec 26. First, the act of alleged malpractice itself must occur after Nov. 2 2004.⁸⁷ Second, no matter how many claims were brought, one act or series of related acts could never count for more than one strike.⁸⁸ Third, and most important, the legislature determined that Amendment Eight was not meant to change the constitutional right that doctors had to be sanctioned by the State only under a clear and convincing evidence standard.⁸⁹ Thus, if there were a finding by a court or arbitration panel based on

⁸⁴ The text of the constitutional provision is:

(a) No person who has been found to have committed three or more incidents of medical malpractice shall be licensed or continue to be licensed by the State of Florida to provide health care services as a medical doctor.

(b) For purposes of this section, the following terms have the following meanings:

(1) The phrase “medical malpractice” means both the failure to practice medicine in Florida with that level of care, skill, and treatment recognized in general law related to health care providers’ licensure, and any similar wrongful act, neglect, or default in other states or countries which, if committed in Florida, would have been considered medical malpractice.

(2) The phrase “found to have committed” means that the malpractice has been found in a final judgment of a court or law, final administrative agency decision, or decision of binding arbitration

⁸⁵ By the day after the election, the head of the FMA, referring to both Amendments Seven and Eight, indicated that the organization “would be working to persuade [the Florida legislature] of an interpretation that limits the amendments’ negative impact on doctors.” Florida Doctors, Lawyers at Odds over Effects of Malpractice Amendments, *Insurance Journal* (Nov. 5, 2004), at <http://www.insurancejournal.com/news/southeast/2004/11/05/47480.htm> (last accessed 4/19/07).

⁸⁶ Gregory A. Chaires, Amendment 8: Its Impact Still Unknown, 3 (3) *Risk Rx* 1 (2004), available at www.ufhscj.edu/resnet/risk-rx.newsletter_7_06.pdf. The bill that passed was the senate substitute, S.B. 940, for H.B. 1739. There were only three dissenting votes in the senate and none in the house. See Legislative History available at <http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=16097&>. Although the bill also amended a few existing statutes, the heart of the change was in new Fla. Stat. §456.50.

⁸⁷ Fla. Stat. §456.50(1)(b).

⁸⁸ Fla. Stat. §456.50 (1)(d) (defining “incident”).

⁸⁹ See *Ferris v Turlington*, 510 So. 2d 292, 294 (Fla. 1987) (“the revocation of a professional license is of sufficient gravity and magnitude to warrant a standard of proof greater than a mere preponderance of the evidence. . . The correct standard for the revocation of a professional license such as that of a lawyer, real estate broker, or, as in this instance, a teacher, is that the evidence must be clear and convincing”). While the brief *Turlington* opinion does not cite to any particular provision of either the federal or Florida constitution, the Florida Supreme Court has construed it as interpreting the Florida Constitution. Advisory Opinion to the Attorney General Re: Public Protection, *supra* note 55 (refusing to strike Amendment 8 because it might interact with another part of the constitution). It is unclear if the Court would agree that the new provision was

a lesser standard (such as the preponderance of the evidence standard that applies in malpractice actions), that in itself could not constitute a strike. Instead, the transcripts of such a trial or hearing were to be provided by the physician to the Board of Medicine. If, but only if, the Board concluded that that evidence clearly and convincingly demonstrated malpractice would there be a strike.⁹⁰ As a result of the new law, it will be a long time, if ever, before any physician will have his license revoked based on the application of the statute.⁹¹

The meaning of Amendment Seven (the Patient's Right to Know proposal), which became Article X, section 25 of the Constitution, is still very much in contention. The language is very broad: it gives patients a right to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.⁹² It would seem to apply to

not meant to change that interpretation of the pre-amendment Florida constitution where it applied. If this were a federal due process right, it would trump any contrary rule of Article X, '26. However, it is unclear that there is such a federal right. The majority of states permit revocation based on the preponderance of the evidence. See William P. Gunnar, *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review and the NPDB?* 14 *Annals Health L.* 329, 339 (2005).

⁹⁰ Fla. Stat. §456.50 (2). The relevant administrative rules were amended as of January 30 2007. According to Ed Tellechea, legal counsel of the Board of Medicine, the Board itself reviews the transcripts in cases that arise under this provision. Email from Tellechea, April 9 2007. Only one case has come before the board in which there was discipline constituting a strike. *Id.*

⁹¹ One could readily argue that the statute undermines rather than implements the constitutional provision, which refers to the consequences of being "found" to have committed malpractice in a "final judgment of a court of law," a finding which has no direct legal effect under the statute. However, it is hard to conceive who could have standing to challenge the statute as unconstitutional. Physicians, who are most directly affected, are benefited. I raised this question with my interviewees and none had a satisfactory scenario. The AFTL staff suggested that a patient who had won a malpractice judgment but then discovered that the Board of Medicine had not used it as a "strike" to revoke the physician's license might feel aggrieved and sue, but could not explain how the patient would have standing. They concluded that, The bottom line is I agree with you, I don't think any of us are holding our breath waiting for litigation to erupt, over Amendment 8, but I think some day there will be litigation over it." AFTL interview transcript at 13.

⁹² The full text is:

- (a) In addition to any other similar rights provided herein or by general law, patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.
- (b) In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained.
- (c) For purposes of this section, the following terms have the following meanings:
 - (1) The phrases "health care facility" and "health care provider" have the meaning given in general law related to a patient's rights and responsibilities.
 - (2) The term "patient" means an individual who has sought, is seeking, is undergoing, or has undergone care or treatment in a health care facility or by a health care provider.
 - (3) The phrase "adverse medical incident" means medical negligence, intentional misconduct,

allow potential patients, by checking these records, to make more informed judgments when considering whether to use physician A or B, or to have an elective procedure in hospital C or D, and the amendment was advertised to the public in large part as providing a means to do so.⁹³ In fact, the provision has overwhelmingly been used in the context of malpractice lawsuits or, occasionally, investigative journalism.⁹⁴ Almost as soon as the election results were in, lawyers for the Florida Hospital Association sought an injunction prohibiting enforcement of Amendment Seven.⁹⁵ Meanwhile, lawyers with pending cases cited the amendment in requests for various documents related to peer review of adverse incidents involving the defendants.⁹⁶ The defendants resisted and sought protective orders, arguing that the amendment did not apply because it was not retroactive, or because it was not self-executing, or that it

and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.

(4) The phrase "have access to any records" means, in addition to any other procedure for producing such records provided by general law, making the records available for inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that current records which have been made publicly available by publication or on the Internet may be "provided" by reference to the location at which the records are publicly available.

⁹³ "[T]he 'Statement and Purpose' section of the amendment does not indicate that furthering medical malpractice claims was a factor in its proposal. On the contrary, the amendment indicates that it was primarily intended to reassert the 'Patients' Bill of Rights,' which the legislature had curtailed through a series of statutes limiting the right of access to certain medical documents. *Michota v. Bayfront Medical Center, Inc.*, 2005 WL 900771 Fla. Cir. Ct.). Trial lawyers still describe it in those terms. See, e.g., Connolly interview, *supra* note 79, tr. at 5 ("patients should be able to have all the information available as to that doctor's qualifications or competence before making that decision to go under anesthesia with that doctor or go under knife with that doctor or trust that this doctor is the one who going to be up to date on the latest treatments, prescriptions and what not for their condition").

⁹⁴ Steven Stark, head of the office of patient protection for the University of Miami Medical Group, reports that there had been no requests that did not fall within one of these categories. Private conversation, March 30 2007 (Miami Florida). Bill Bell of the FHA said that "probably 99.9% of all requests we got on amendment seven were trial lawyers who had active malpractice cases." Bell interview, *supra* note 41, tr. at 9.

⁹⁵ *FHA v. Florida Agency for Healthcare Administration and Florida Department of Health*, Case # 2004 –CA-002670 (2004). The Circuit court dismissed the case on the grounds that there was no case in controversy. See Senate Staff Analysis and Economic Impact Statement Regarding SB 938 [prepared by the Health Care Committee] at 3 (April 1 2005)

⁹⁶ See, e.g. *Richardson v Nath*, 2005 WL 408132 (Fla. Cir. Ct. 2005) (subpoena seeking discovery under Amendment 7 filed on December 15 2004); *Rusiecki v Jackson-Curtis*, 2005 WL 408133 (Fla. Cir. Ct.) (letter request for adverse incident reports regarding physician-defendant sent to hospital on November 3, 2004).

should be construed not to abrogate existing statutes protecting peer review from discovery and admissibility. The earliest reported court decisions ruled for the physicians and hospitals.⁹⁷

Meanwhile, organizations of hospitals and physicians sought protection from the Florida legislature.⁹⁸ In the 2005 session, the legislature “implemented” art X sec 26.⁹⁹ The new statute narrowed the potential scope of the constitutional provision in several ways. It stated that the provision was not retroactive, meaning that it would apply only to reviews of adverse incidents occurring after passage of the amendment.¹⁰⁰ Only final reports were covered; preliminary reports, materials considered by review committees and transcripts of the deliberations of such bodies thus remained subject to statutory protections of confidentiality and non-discoverability.¹⁰¹ Patient-requesters were only entitled to records of an incident involving the same condition, treatment or diagnosis as their own.¹⁰² Finally, the statute reiterated that any information a patient obtained

⁹⁷ See *Bridgman v Health Management Associates*, 2005 WL 900630 (Fla. Cir. Ct. Jan. 14, 2005) (amendment doesn’t violate federal constitution or law, but is not self-executing and not retroactive); *Richardson v. Nash*, 2005 WL 408132 (Fla. Cir. Ct. Jan. 18 2005)(amendment was intended to change existing law, but not self-executing, not retroactive); *Rusiecki v Jackson-Curtis*, 2005 WIL 408133 (Fla. Cir. Ct. Jan. 31 2005(amendment is neither retroactive, nor self-executing). Apparently only one judge found that the Amendment was both self-executing and retroactive and thus issued an order requiring the production of the documents requested. *McHale v Tenewitz*, 2005 WL 900744 (Fla. Cir. Ct. 2005).

⁹⁸ John Knight, *What You Need to Know About Amendments 3, 7 and 8* (Florida Medical Association – Quarterly Journal January 2005) (on file with author); Andi Atwater, *Amendment 8 will hurt, doctors say*, *The News-Press* (Fort Myers, FL) (Nov. 14, 2004) 1A; Interview with Rep. David Simmons, Orlando, Fla. (Dec. 14, 2006) tr. at 2, FMA interview, *supra* note 38, tr. at 7-8

⁹⁹ Like the legislation on Amendment 8, the bill passed with only two dissents in the senate and three in the house. One of the chief architects in the Florida House referred to the project as finding “a solution to the problems that were created by the passing of these constitutional amendments.” Simmons interview, *supra* note 98, tr. at 1.

The legislative history indicates that part of the impetus for the legislation was to resolve the conflict in the decisions interpreting the amendment. Senate Staff Analysis and Economic Impact Statement Regarding SB 938 at 3-4 (April 1 2005).

¹⁰⁰ Fla. Stat. §381.028 (5) (announcing that the constitutional provision only applied to records created or incidents occurring after Nov. 2, 2004 and, further, that at no time would a patient be entitled to records created more than four years prior to the date of request).

¹⁰¹ Fla. Stat. §381.028 (3)(j).

¹⁰² Fla. Stat. §381.028 (7)(a). Thus, for example, it would appear that a patient would not be entitled to adverse incident reports regarding such general issues as infection rate or medication errors, except insofar as the requester had already been the subject of such an adverse incident. This provision also, in contrast to the amendment, seems only to grant access to records of a “facility or provider of which he or she *is* a patient” (emphasis added). The Senate staff analysis concludes that “[t]hese restrictions would make it impossible for a person seeking treatment to

under its terms was still subject to the very broad protections against discovery or admissibility at trial under existing Florida law.¹⁰³

Litigation continued. Three cases that came down while the legislation was under consideration took three different approaches. *Michota v Bayfront Medical Center* held that the Amendment was intended to provide access to documents that had been protected under existing law.¹⁰⁴ It also concluded that the provision was self-executing, but not retroactive, and therefore granted the plaintiff's motion to compel insofar as it sought documents created after Nov. 2, 2004.¹⁰⁵ *McHale v Tenewitz* found that the provision was both self-executing and retroactive "as it relates to extant records," and denied the defendant's motion for a protective order.¹⁰⁶ *Brown v Graham* found the amendment not self-executing and not retroactive and thus granted the motion for a protective order.¹⁰⁷ It also held that the amendment should be narrowly read so as not to interfere with the operation of existing law providing confidentiality to various records and the processes that created them and protecting them from discovery or admissibility, particularly in light of the significant public policy behind these laws.¹⁰⁸ In its discussion of whether the amendment was self-executing, it noted that the Legislature was considering proposed legislation and found it "significant that the broad outlines of the current proposal mirror the conclusions reached in this order."¹⁰⁹

obtain records of adverse medical incidents as is provided in the constitution." Senate Staff Analysis and Economic Impact Statement Regarding SB 938 at 14 (April 1 2005) (also raising constitutional doubts about other aspects of the bill). See also the comments of then-representative Jeff Kottkamp (now Lieutenant Governor) that this provision was "limiting the constitution with a statute and I'm not really convinced that is permissible." Gary Blankenship, House works on med mal amendment implementation," Florida Bar press release (April 1 2005).

¹⁰³ Fla. Stat. §381.028(6).

¹⁰⁴ 2005 WL 900771 (Fla. Cir. Ct. Feb. 24 2005) at 4-5 (while rules regarding admissibility of such documents remain in place, the broad right of access comprises the right of access through discovery)

¹⁰⁵ *Id.* at 6-11. Note that this is a more plaintiff-friendly interpretation of "non-retroactivity" than in the statute.

¹⁰⁶ 2005 WL 900744 (Fla. Cir. Ct. Feb. 28 2005) (quoted language at 5).

¹⁰⁷ 2005 WL 900722 at 4-6 (Fla. Cir. Ct. March 18 2005).

¹⁰⁸ *Id.* at 3-4

¹⁰⁹ *Id.* at 5.

After the legislation passed,¹¹⁰ the litigation also focused on questions of the validity of the statute: did it correctly answer the question of retroactivity? Was it consistent with the amendment or was it an invalid attempt to restrict constitutional rights? Again courts took somewhat different positions on these issues.¹¹¹ *Notami Hospital of Florida, Inc. v Bowen*¹¹² held that the constitutional provision was self-executing¹¹³ and that the statute that purported to implement it instead conflicted with it, noting that it “drastically limits discovery of records the amendment expressly states are discoverable, and limits the ‘patients’ qualified to access those records,” and was thus unconstitutional.¹¹⁴ Finally, it ruled that Amendment Seven was intended to be retrospective as to existing records.¹¹⁵

*Florida Hospital Waterman v Buster*¹¹⁶ agreed only in part with Notami’s analysis. *Florida Waterman* involved a request for certiorari review by the defendant of a trial court ruling holding that Amendment 7 was self-executing, should be applied retroactively and trumps any contrary legislation and thus denying the defendant’s motion for a protective order.¹¹⁷ The appellate court first determined that the Amendment “preempts the statutory privileges” of peer

¹¹⁰ The implementing legislation in regard to both Amendments 7 and 8 was signed into law by the governor on June 20, 2005. See Melissa Morgan Hawkins, Amendments 7 and 8 update: Legislation Enabling the Patients’ Right to Know Act and Three Strikes Rule, 25 (2) Trial Advoc. Q. 7 (2006).

¹¹¹ In addition to the three cases discussed in text, two other cases dealt with Amendment Seven in somewhat tangential contexts. *Bayfront Medical Center v Neavins*, 920 So. 2d 185 (2006) involved an appeal of a trial court order finding that the provision was self-executing. In light of the statute that had since passed, the court found that issue moot. *HCA Health Services of Florida, Inc. v Florida Agency for Healthcare Administration*, 2005 WL 2546494 (Fla. Cir. Ct. 2005) held that the *St. Petersburg Times* was not a patient within the meaning of the provision and thus was not entitled to records of adverse medical incidents.

¹¹² 927 So. 2d 139 (1st DCA 2006). Later that year, the 4th DCA in *North Broward Hospital District v Kroll*, 2006 WL 3208052 (Fla. Dist. Ct. App. Nov. 8, 2006) per curiam followed Notami and rejected *Waterman*.

¹¹³ 927 So. 2d at 144 (finding that the provision laid down a specific clear rule and did not require legislative action and citing *Gray v Bryant*, 125 So. 2d 846 (Fla. 1960) for the rule that constitutional provisions are presumed to be self-executing, to avoid giving legislatures the power effectively to nullify the will of the people).

¹¹⁴ 927 So. 2d at 142-43.

¹¹⁵ 927 So. 2d at 144-45 (relying on the language allowing access to *any* record relating to *any adverse medical event* and granting the right, on the day of enactment, to patients who had previously received treatment).

¹¹⁶ 932 So. 2d 344 (5 DCA 2006).

¹¹⁷ 932 So. 2d at 348-9.

review insofar as it allows such records to be discovered in litigation.¹¹⁸ It then concluded that the newly enacted statute wrongly narrowed the meaning of the amendment to make it as consistent as possible with this prior statutory law.¹¹⁹ It found support for its conclusion that the new statute was unconstitutional in the Supreme Court's advisory opinion.¹²⁰ However, Florida Waterman, disagreeing with Notami, held that the provision was not intended to be retroactive,¹²¹ and that retroactive application would be constitutionally impermissible.¹²² Finally it certified to the Supreme Court these three questions: whether amendment 7 preempts existing statutory privileges for peer review, whether it is self-executing, and if it should be applied retroactively.¹²³

In the long run, the questions of pre-emption and self-execution are the most interesting and are interrelated. The fundamental test of whether a constitutional provision is self-executing is whether it "lays down a sufficient rule" to meet its purposes "without the aid of legislative enactment."¹²⁴ The presumption is that citizen initiated provisions are self-executing since "such

¹¹⁸ 932 So. 2d at 350-52. As the court noted it would "make little sense" to allow a patient access to information, but then deny that same access upon the filing of a lawsuit and rejected the Hospital's view that prior legislative privileges should be seen as unchanged by the passage of the amendment.

¹¹⁹ 932 So. 2d at 353. The statute was also unnecessary, since the court found that the amendment was self-executing. *Id.* At 355.

¹²⁰ 932 So. 2d at 353. The Court had said in passing that "the amendment would affect [those] sections . . . of the Florida statutes which currently exempt the records of investigations, proceedings, and records of the peer review panel from discovery. . . . Indeed, this is a primary purpose of the amendment." Advisory Opinion to the Attorney General Re: Patients' Right to Know, *supra* note 55.

¹²¹ 932 So. 2d at 354. It relied on the presumption that legislation is intended to operate prospectively. Nothing in the language rebutted that presumption and, it concluded, the existence of an effective date confirmed it.

¹²² *Ibid.* Focusing on the information health care professionals provided during the peer review process, it found that they had a vested right in its confidentiality.

¹²³ 932 So. 2d at 356. Interestingly, while all the other briefs filed with the Supreme Court respond directly to one or more of these questions, the amicus brief of the Florida Patient Safety Corporation focuses instead on trying to ensure that Amendment Seven be read in light of several federal statutes protecting patient privacy and patient safety processes. Proposed Amicus Curiae Brief of Florida Patient Safety Corporation, Inc. On Behalf of All Patients in Florida in the Interest of Patient Safety (July 5 2006)

<http://web2.westlaw.com/result/previewcontroller.aspx?TF=756&TC=4&tf=-1&rs=WLW7.06&serialnum=2009705104&fn=top&sv=Split&tc=-1&findtype=Y&docname=2006+WL+2302682&fkcgcd=Y&vr=2.0&rp=%2ffind%2fdefault.wl&mt=LawSchoolPractitioner&RP=/find/default.wl&bLinkViewer=true>

¹²⁴ Gray v Bryant, 125 So. 2d. 846, 851 (Fla. 1960). In effect, the court concludes that any gaps or ambiguities are sufficiently minor that they can be filled by judicial interpretation.

construction avoids the occasion by which the people's will may be frustrated."¹²⁵ Even if a provision is self-executing, however, the legislature may supplement it by legislation "further protecting the right."¹²⁶ Prior legislation is, of course, invalid insofar as it conflicts with a subsequent constitutional provision and this is true even if the provision is not self-executing.¹²⁷ Similarly, later legislation is valid only if it is consistent with the provision. In either situation, the ultimate arbiter of these questions will be the Florida Supreme Court.

The Florida Supreme Court granted review to decide these issues on May 5 2006.¹²⁸ The issue is viewed as extremely important to the trial bar on the one hand and hospitals and physicians organizations on the other, and there have been a number of amicus briefs.¹²⁹ Oral argument was held on June 7 2007.¹³⁰

If the Florida Supreme Court concurs with the arguments of the defendants, then Amendment seven will also have changed little in Florida law. If, however, the justices were to find the statute unconstitutional and construe the constitutional provision broadly, much peer review activity and reports of the results of such activities that had once been kept confidential could now be open to public view.¹³¹ The Florida State Representative most involved in the drafting

¹²⁵ *Id.* The Florida Supreme court has made it clear that constitutional provisions "must be construed or interpreted in such manner as to fulfill the intent of the people." *Zingale v Powell*, 885 So 2d 277, 282 (2004) (emphasis original).

¹²⁶ *Bryant v. Gray*, *supra* note 113.

¹²⁷ *Barley v South Florida water Management District*, 823 So. 2d 73 (2002)(stating that prior statutes remain in effect so long as they do not conflict with the clear intent of the amendment).

¹²⁸ 926 So. 2d 1269 (Fla. S. Ct. (table)). Apparently the Fifth DCA opinion was not published until two months after it had been issued and the Supreme Court had accepted the hospital's petition for review. It later granted certiorari in *Notami Hospital and Kroll* as well, which will presumably be decided together. See *Wellner v East Pasco Medical Center, Inc.*, 2007 WL 866003 (Fla. App. 2 Dist. March 23 2007) at 2. The briefs all refer to Florida Waterman.

¹²⁹ These include briefs from the Florida Hospital Association, the Florida Defense Lawyers Association, the Academy of Florida Trial Lawyers, and Floridians for Patient Protection. (all the appellate briefs can be found at <http://web2.westlaw.com/find/default.wl?fn=top&rs=WLW7.06&rp=%2ffind%2fdefault.wl&mt=LawSchoolPractitioner&vr=2.0&sv=Split&cite=932+So.+2d+344>) The position of the trial lawyers is that the Amendment did not require any implementing legislation and that "the legislation that did pass is unconstitutional, because it is inconsistent on its face with the Amendment. . . .It unimplements it" AFTL interview, *supra* note 33, tr. at 14.

¹³⁰ (Go to http://jweb.flcourts.org/pls/docket/ds_docket_search%20 and look for case no. SC06-688).

¹³¹ While the provision refers only to patients' right to know, if that is read broadly it would not be difficult for the media to find an appropriate requester and then publicize the peer review materials that were obtained and shared with them. Note also that federal law may provide

and passage of the statute, David Simmons, has said that in that situation he would “push to have the Legislature place a measure on the ballot to repeal Amendment 7.”¹³²

In toto, it is unlikely that much direct benefit or harm will come from Amendments 3 or 8. There is almost certainly no substantive change in the consequences for a physician’s licensure status from losing a malpractice case. There is little necessary change and probably no more than a modest change in fact in the contingency fees lawyers can collect. The impact of Amendment 7 will only be discernible once the Florida Supreme Court rules. In the interim, there has been little legislative focus on issues relevant to malpractice. The most significant change was the elimination of joint liability in all unintentional tort cases in 2006, a reform that all the business interests, including the health care industry, made their top legislative priority.¹³³ As the former Executive Director for the 2003 Governor’s Task Force on malpractice issues put it,

What a waste of the [Florida Medical] association’s money, dues, for 3 which is now essentially mummified, 7 which I believe will lead to poor patient care and will be mummified, 8 [which] will never have a practical effect. . Just a terrible, horrific waste of resources.¹³⁴

One reason for this lack of focused attention to malpractice recently may be that malpractice claims experience has substantially improved since 2004 from the perspective of health care practitioners, hospitals and their insurers.¹³⁵

substantial protections for peer review, whatever the outcome of Florida Waterman. See text at note 206, *infra*.

¹³² Dan Lynch and Harris Meyer, *Revealing Discovery*, 80(77) *Daily Bus. Rev.* A1, A 16 (Sept. 28 2005).

¹³³ Fla. St. §768.81 (2006). There is an odd link between this bill and the initiative story. According to one source, the defeat of the trial lawyers at the polls persuaded the business community to think that they could also be defeated in the legislature and encouraged them to focus on this bill despite knowing that the trial lawyers would be working to defeat it. Delegal interview, *supra* note 40, tr. at 5.

¹³⁴ Large interview, *supra* note 31, tr. at 8. See also interview with Robert Wychulis, CEO of Florida Association of Health Plans, Tallahassee, Fla., Dec. 5, 2006, tr. at 8 (“I don’t believe any of those constitutional amendments were implemented in a way which in which they were intended by the parties”).

¹³⁵ Aon Consulting reported in 2006 that the number of claims against hospitals fell 26% in the previous five years. Brian Bandell, *South Florida Business Journal*, Study: Hospital Malpractice losses down 10% (Oct. 25 2006).

The number of claims has fallen.¹³⁶ The frequency of claims per physician has fallen.¹³⁷ The severity of claim per physician has fallen or been flat.¹³⁸ According to a report from the Commissioner of the Florida Office of Insurance Regulation¹³⁹ incurred losses and the pure loss ratio dropped steeply from 2002-2005,¹⁴⁰ while the number of practitioners who were forced into the joint underwriting residual market declined as eighteen new companies entered the market.¹⁴¹ As a result, malpractice insurance rates are declining or flattening. (While malpractice insurance rates around the country also declined during this period,¹⁴² the rates in Florida declined less than the Florida Insurance Consumer Advocate suggested was appropriate given the declines in insurance companies' loss ratios.)¹⁴³ While there is no consensus, and no reliable research-based evidence, explaining this change,¹⁴⁴ the change itself erodes pressure to

¹³⁶ The number of claims against hospitals fell 26% over five years. Bandell, *supra* note 135. "Newly reported claims and incidents were down 29% for 2004" at FPIC. quoted by the Florida Justice Association, 2007 Medical Malpractice Fact Sheet 6 along with other, similar quotes. (available from <http://www.floridajusticeassociation.org> (search keyword for "2007 Medical Malpractice Fact Sheet").

¹³⁷ The number of claims per physician declined by 27 % between 2001 and 2005. Bandell, *supra* note 135.

¹³⁸ Severity of claim per physician was \$135,000 in 2003; in both 2004 and 2005 it was \$108,000. Bandell, *supra* note 135. The numbers are different, but the pattern is similar in the National Practitioner Data Bank. It shows a median payment on a medical malpractice claim of \$175,000 in 2005 which ranked it 23rd among all states; this was a significant improvement from the cumulative data, which showed a median of \$150,000, ranking Florida 6th among all states. U.S. Dept. of HHS, National Practitioner Data Bank, 2005 Annual Report, Table 13 at 70.

¹³⁹ The 2007 report is available at <http://www.floridajusticeassociation.org> (search keyword for "2007 Medical Malpractice Fact Sheet").

¹⁴⁰ *Id.* at Figures at pp. 4 & 6. Each flattened during 2006.

¹⁴¹ *Id.* at 3.

¹⁴² Rate filings for malpractice for physicians and surgeons shows a decline in the percentage increase from 2003 (19.6% approved rate increase) to 2004 (9.2%) to 2005 (7.05). Florida Office of Insurance Regulation, 2005 Annual Report on Medical Malpractice Financial Information at 37; 2006 Annual Report on Medical Malpractice Financial Information at 35. See also the quotes from Crittenden's Medical Insurance News indicating such changes in premiums more generally, quoted by the Florida Justice Association, 2007 Medical Malpractice Fact Sheet 3-4 (available from <http://www.floridajusticeassociation.org> (search keyword for "2007 Medical Malpractice Fact Sheet").

¹⁴³ Florida Office of Insurance Regulation Report, *supra* note 142, at 5.

¹⁴⁴ As noted earlier, leaders of the malpractice insurance industry and the FMA attribute this to Amendment Three; trial lawyers to legislative reforms in 2003 and earlier. The timing seems inconsistent with an explanation based on an amendment that would not have taken effect until November 2004 and then only as to cases not yet accepted by the plaintiffs' attorneys. One malpractice plaintiff's attorney said that it "is too early for the tort reform laws to affect the number and severity of claims." Brian Bandell, *supra* note 135. The Insurance Commissioner's Report references both the legislative reform and the constitutional amendments without attempting to

deal with malpractice. As others have noticed, reform efforts, whether the policies they seek are good or bad, are most intense when there is a perceived malpractice crisis. Similarly, reform efforts, and focus on malpractice, is cyclical. Florida having devoted significant time and political effort to passing a bill in 2003 is probably unready to seriously revisit the issue until those reforms prove inadequate in the eyes of at least some major stakeholders.

III The Impact of Florida's Initiatives

The effect of the malpractice amendments and the process leading up to them on the legal space and the political will to engage these issues is a complex question, that is beyond the scope of this story.¹⁴⁵ However, it is worth considering the particular measures as they were passed as examples of malpractice reforms. This story might help us think about how to do – or more precisely how not to do – malpractice reform. What counts as good reform is an enormous and enormously controversial task. One could, I suspect, exceed the page count most law reviews are imposing with nothing but a single footnote citing the literature on this question.¹⁴⁶ To say that we cannot agree on the “good,” does not mean however that we cannot agree on the bad. As I hope to demonstrate below, each of these reforms as adopted were likely to make matters worse for patients, the ultimate touchstone of malpractice and, indeed, health care reform generally.

Each of them substantively seems to suffer from the problems one would expect given their origins. Amendment three was modeled on caps on attorney's fees that were part of the law elsewhere, beginning with California's MICRA reform in 1975.¹⁴⁷ By 2006, a substantial minority of states had adopted such

parse out chains of causality. It is perhaps worth noting, given the claims of Bob White of FPIC (the largest malpractice insurer in the state) on this point, that the Insurance Commissioner's Report indicated that the “industry . . . assert[ed] that declines in loss ratios are a general national trend during the 2003-2006 timeframe, and cannot be attributed to specific legal changes in Florida.” Insurance Commissioner's Report, *supra* note 142, at 5.

¹⁴⁵ See Coombs, Two Cheers, *supra* note 9, for a study of the role of initiatives within governance, particularly in the context of malpractice reform.

¹⁴⁶ In the interests of avoiding controversy, I am not inserting a “see, e.g.,” footnote.

¹⁴⁷ Cal. Bus. & Prof. Code §6146 (1975). The Medical Injury Compensation Reform Act of 1975 was the first comprehensive malpractice reform statute, where reform means changes designed

caps.¹⁴⁸ No other state, except Delaware,¹⁴⁹ however, had set the cap as low as did Amendment Three.¹⁵⁰

There have been arguments by some scholars that the United States system of contingency fees is itself the source of bad public policy, encouraging unethical behavior by lawyers and a litigation explosion.¹⁵¹ There has been heated debate over whether contingency fees are excessive.¹⁵²

to reduce the frequency and size of malpractice judgments leading to lower malpractice premiums and thus increased availability/affordability of health care services. It was enacted during the first malpractice crisis in the mid-1970s, when California doctors went on strike to protest the situation. Nicholas M. Pace, Daniela Golinelli & Laura Zakaras, Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA 4-6 (2004). In addition to the limit on attorney contingency fees, it includes a \$50,000 cap on non-economic damages; allows the introduction of evidence of collateral source payments; requires claimants to give a 90-day notice of intent to sue; shortens the statute of limitations to three years from the injury or one year from when the injury was or should have been discovered; allows defendants to choose to pay the future damages portion of a judgment in periodic payments and permits binding arbitration clauses in contracts between patients and health care providers. See Californians Allied for Patient Protection, Provisions of MICRA, <http://www.micra.org/about-micra/micra-provisions.html>

¹⁴⁸ See generally Dwyer, *supra* note 69, at 616-17 n. 20-25. Dwyer asserts that there are twenty-four states with some form of statutory or regulatory contingency cap, a number he reaches by including both statutory caps and those in the form of ethics rules, both malpractice specific caps and caps for all personal injury actions, caps that set out numerical limits and those that require court review, in all cases or at the request of a party, or in the case of a dispute. He even includes Oregon, which applies its cap only to punitive damages in medical malpractice cases and Indiana, which applies only when the state patient's compensation fund represents the defendant.

¹⁴⁹ Del. Code Ann. Tit. 18 '6865 (2004) (35% of the first \$100,000, 25% of the next \$100,000, and 10% of all amounts over \$200,000).

¹⁵⁰ Consider the different outcomes under the Florida and California provisions at three levels of recovery.

| Total Recovery | \$250,000 | \$500,000 | \$1,000,000 | \$3,000,000 |
|-------------------|-----------|-----------|-------------|-------------|
| Atty Fee: Calif | \$74,200 | \$136,700 | \$221,700 | \$521,700 |
| Atty Fee: Florida | \$75,000 | \$100,000 | \$150,000 | \$450,000 |

¹⁵¹ See, e.g., David E. Bernstein, Procedural Tort Reform: Lessons from Other Nations 10-12 (Cato Institute, available at <http://www.cato.org/pubs/regulation/reg19n1e.html>); Walter Olson, Sue City: The Case Against the Contingency Fee, Policy Review (Winter 1991), available at <http://walterolson.com/argicles/contingcy1.html>.

¹⁵² The argument has been made that lawyers on contingency fees, because of market imperfections, obtain excessively high fees, harming their clients and those whom they sue. The primary proponent of this view is Lester Brickman. See, e.g., Lester Brickman, The Market for Contingency Fee-Financed Tort Litigation: Is It Price Competitive? 25 *Cardozo L. Rev.* 65 (2003). Herbert M. Kritzer has claimed, to the contrary, that the data show that contingency fee lawyers receive incomes consistent with what one would expect in a reasonably well-functioning market. See, e.g., Herbert M. Kritzer, The Wages of Risk: The Returns of Contingency Fee Legal Practice, 47 *DePaul L. Rev.* 267 (1998). Meanwhile, Alexander Tabarrok and Eric Helland have made theoretical arguments supporting the Kritzer position that contingency fees ought not to be regulated. See, e.g., Alexander Tabarrok and Eric Helland, Two Cheers for Contingent Fees (AEI Press 2005) from the perspective of free-market economists who assume that, if contingency fee lawyers were earning high rates of return, not justified by special expertise, other lawyers would

The move to cap attorney's contingency fees in malpractice cases evokes much the same arguments. The proponents of caps on fees in malpractice cases, in Florida as elsewhere, indicated that their goal was to reduce the number of claims, particularly "frivolous" claims¹⁵³ and thus the financial impact on physicians.¹⁵⁴ One can certainly argue that reducing the level of claims and thus lowering malpractice insurance rates redounds to the benefit of patients by increasing the availability and reducing the costs of medical care. The argument is much stronger, however, if the proposed reform screens out weak claims,¹⁵⁵

begin to compete with them, since barriers to entry within the legal profession are low. Note, however, that trial lawyers themselves describe the malpractice bar as a "specialty bar" "because of the complexity of the cases and the cost," AFTL interview, *supra* note 33, tr. at 10, 12. Patricia Danzon produced two earlier, less ideologically charged data-driven studies of the impact of contingency fees, specifically in the context of medical malpractice. Unfortunately, the inferences from the results of the two studies are somewhat inconsistent. Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims*, R-33410-ICJ, Rand Corporation, Santa Monica (1986); Patricia M. Danzon and Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. Leg. Studies 345 (1983).

¹⁵³ See, e.g., comments of American Medical Association in Support of Petition to Amend Rules Regulating the Florida Bar, Case No. SC05-1150 at 6 (asserting that Amendment 3 "simply compels attorneys to absorb more of the risks involved with filing non-meritorious lawsuits") Hereinafter I use the term "weak" rather than "frivolous" That a claim is ultimately withdrawn does not mean it was frivolous when filed, particularly where a lawsuit may be a necessary means to determine what went wrong, and such discovery may demonstrate that there was not actionable malpractice. See Tom Baker, *The Medical Malpractice Myth*, at 83-85 (2005). A claim that appears, at the time of filing, to have a significant chance of prevailing, even if less than a preponderance, is not necessarily frivolous if it is withdrawn once the facts are clarified and it becomes apparent that it is unlikely to win.

¹⁵⁴ Some proponents of limiting fees also suggest that this would lead plaintiffs to settle cases sooner, since the attorney's incentive to maintain the case in hopes of a substantially larger fee is less when his percentage of the recovery declines with the size of the recovery, as under the most common form of fee limitation. Cf. Walter Olson, *Sue City: The Case Against the Contingency Fee*, Policy Review (Winter 1991) available at <http://walterolson.com/articles/contingcy1.html> (last visited Oct. 1, 2007) (arguing that even where clients might tire of the fight and want to settle, the "lawyer with a big war chest has an incentive to make you wait in order to go for the extra money"). Yet David Bernstein, a harsh critic of contingency fees claims that they will lead the lawyer to settle too quickly, so he need not spend any more hours on the case. Bernstein, *supra* note 151, at 10. A Rand study of MICRA, which includes attorney fee caps, as well as non-economic damages caps concluded that the damage caps saved defendants \$125.1 million out of the \$420.6 million they would have paid without MICRA; because of the fee cap, plaintiffs absorbed \$40.9 million of this and plaintiff's attorneys absorbed the other \$84 million and notes that this may make attorneys even more selective in accepting only cases with a good chance of receiving a high value economic damages award. Nicholas M. Pace, *et al.*, *supra* note 147.

¹⁵⁵ See, e.g., Fla. Stat. § 766.201-766.206 (requirement that the plaintiff do an investigation including the obligation to provide an expert affidavit indicating that there was malpractice before suit may be filed).

rather than a more random subset of existing claims, both weak and clearly valid ones.¹⁵⁶

One study that focused specifically on contingent fees in malpractice cases was triggered by amendment three itself. After it had received sufficient signatures to be placed on the ballot, but before the 2004 election, the Tort Trial and Insurance Practice Section of the ABA commissioned a report.¹⁵⁷ Perhaps unsurprisingly, the report concluded that caps on contingency fees were unwarranted,¹⁵⁸ though it did suggest some procedural reforms to empower clients to negotiate with attorneys over fee arrangements.¹⁵⁹ One point it rather gleefully makes, which was repeated to me by leaders of the AFTL,¹⁶⁰ is that witnesses before the Florida legislature, who had claimed that frivolous lawsuits drove the need for reform, were unable to “cite a single example of a frivolous lawsuit” when put under oath.¹⁶¹

Critics of the current contingency fee system seem to assume that plaintiffs’ lawyers play a lottery: they bring large numbers of cases, without concern for their validity. The high profits from the few that succeed more than cover the costs to them of the ones that fail.¹⁶² Meanwhile, large numbers of innocent people must suffer the financial and psychological costs of defending themselves in lawsuits. This theory, even assuming it were valid for, e.g., auto accident claims,¹⁶³ seems particularly inapt for medical malpractice. Other

¹⁵⁶ See Fla. Stat. §95.11(4)(b)(providing a two year statute of limitations and, in effect, a four year statute of repose except for claims by minors for medical malpractice actions).

¹⁵⁷ Report on Contingent Fees in Medical Malpractice Litigation (Sept 20 2004).

¹⁵⁸ *Id.* at 37-42. Though many of the members of the task force were not plaintiff’s attorneys, all were attorneys. *Id.* (unpaginated list of Task Force members). All the witnesses were attorneys, although they did include two academics, William Sage and David Hyman who have both J.D. and M.D. degrees. *Id.* at 13-14 The Florida Medical Association, though invited to speak, declined. *Id.* at 39 and n. 108.

¹⁵⁹ *Id.* at 43-45.

¹⁶⁰ AFTL interview, *supra* note 33, tr. at 3.

¹⁶¹ Task Force report, *supra* note 30, at 19. Bob White, the head of FPIC, testified that Florida “fixed its frivolous lawsuit problem in 1988.” Hearing on Medical Malpractice before the Senate Committee on Judiciary, July 14, 2003 (transcript at 56) (on file with author).

¹⁶² Bernstein, *supra* note 151, at 10, citing Walter Olson.

¹⁶³ This kind of practice is more likely to be a volume operation, in which a lawyer has numerous outstanding cases, of which he can expect a fair number to settle before he must invest substantial resources in them, and in which the occasional high damages, high fee case helps finance the rest of the practice.

reforms, such as various forms of pre-suit notice or mandatory mediation, are specifically designed to filter out weak claims at an early stage. Furthermore, each malpractice case, because it requires extensive time and the hiring of experts, both to determine if the case is worth bringing and, if so, to prepare for trial, is costly.¹⁶⁴ Assuming the plaintiff's attorney can make a reasonable prediction of the strength of a case, she is unlikely to take a weak one.¹⁶⁵ The fact that the attorney may be wealthy because of success in other cases should make her less willing, not more, to invest her time in weak cases.

Medical malpractice cases are also unusual in the extent of the need for a contingency fee that represents a risk premium. Critics of malpractice litigation argue that, because such a high percentage are dropped or dismissed, and the plaintiff's success rate at trial is low, many of the cases brought must be frivolous. Whether or not this shows that the case should never have been brought, it surely shows that the malpractice attorney's hourly-equivalent income will be lower, everything otherwise equal, than that of a lawyer bringing other kinds of personal injury cases.¹⁶⁶

A contingency fee cap will deter attorneys from taking some cases that they would otherwise have brought. To some extent these will be weaker cases; a case in which liability appears clear and thus easy to prove can still be worth taking even with relatively modest damages.¹⁶⁷ But the cap will also deter attorneys from taking cases without *enough* damages. Even without state-imposed caps on attorney's fees, a very large percentage of situations of actual

¹⁶⁴ "It can take tens to hundreds of thousands of dollars – and sometimes more – to prepare a complex medical malpractice action," Gary Blankenship, Dueling amendments pass (Florida Bar press release (Nov. 15 2004)(quoting Florida Bar President Kelly Overstreet Johnson). If the case is dropped without an indemnity payment or lost at trial, as a practical matter the plaintiff's attorney must absorb all these costs.

¹⁶⁵ One attorney estimated that at his firm, "we probably don't take 90%-95% of the malpractice cases that come through our door." Connolly interview, *supra* note 79, tr. at 10.

¹⁶⁶ Brickman's argument that contingency fees are too high because lawyers prevail in 70-90% of their cases is likely false in general; it is wildly false if applied to malpractice litigation. Brickman, *supra* note 152, at 80.

¹⁶⁷ One plaintiffs' attorney told me that in such cases, which are likely candidates for quick settlement, he does not even bother to ask his clients waive the fee limits imposed by Amendment Three. Conversation with Scott McMillen, *supra* note 82.

malpractice never lead to a lawsuit.¹⁶⁸ Many of these are cases where the harm to the plaintiff is insufficient to be worth the attorney's time, even where liability could be proven relatively easily.¹⁶⁹ As suggested in the table in footnote 144, a cap will, definitionally, raise the floor of predicted recovery that is necessary for a rational attorney to be willing to take the case.

Thus the cap, even if it reduced the number of cases brought – and assuming that this was itself a social good – is a poorly designed reform from the perspective of its proponents.¹⁷⁰ Cases with predicted multimillion dollar judgments will still attract plaintiffs' attorneys. Yet it is those cases, in which the carrier is at risk of very high potential damages, that are particularly problematic for the insurance companies and thus have a disproportionate impact on insurance rates.¹⁷¹ Contingency fee caps are an inefficient way of reducing the extent of frivolous claims, and the more stringent the cap, the more harm they do in limiting valid claims relatively to the benefit of deterring frivolous ones.

Similarly, amendment eight is -- at best -- an ill-designed response to a real problem. The arguments in its favor assumed that there was a core of particularly bad doctors, who caused significant harm to their patients, and that the Florida Board of Medicine was unwilling or unable to provide effective discipline.¹⁷² It is difficult to know how well Florida's Board of Medicine is, either

¹⁶⁸ Paul C. Weiler, *Medical Malpractice on Trial* (1991).

¹⁶⁹ The low damages may be because there was little harm in the sense that the plaintiff's harm was temporary. It may also be a situation of long-term harm to someone whose recoverable damages are low because the plaintiff is retired, with no lost income, and where medical expenses are modest or covered by third parties in a state that has abrogated the collateral source rule.

¹⁷⁰ It can only serve their purposes if it drives lawyers away from the malpractice field altogether, because there are not enough cases with enough potential profit for a rational attorney to take the time to develop the expertise to do a good job. Either no malpractice cases will be brought, or they will be brought by personal injury generalists who will make fatal errors trying to navigate the particular minefields of malpractice law or will quickly settle even the most meritorious claims so as not to risk doing so.

¹⁷¹ Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 *DePaul L. Rev.* 393, 422-26 (2005)(describing the impact on the swings between hard and soft markets in the malpractice insurance of volatility, long tails and risks of large and hard-to-predict damages in claims not yet brought).

¹⁷² See, e.g., Public Citizen, *Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies, Not the Legal System* 4 (Sept. 2002), available at <http://www.citizen.org/documents/FLAreport.pdf> at 8.9. In a more recent document, Public Citizen shows Florida as ranking number 32 in number of serious disciplinary actions per 1,000

absolutely or in comparison to other states, at discovering which doctors fail to do their work properly and imposing the appropriate sanctions when there are problems.¹⁷³ The Board of Medicine reported that there were 276 disciplinary proceedings in the 2005-06 fiscal year.¹⁷⁴ The Federation of State Medical Boards Annual Report for 2005 showed that there were 872 prejudicial actions in Florida, against 815 physicians.¹⁷⁵ Public Citizen showed that there were 182 serious actions during 2005 and calculated that the number of serious actions/1000 physicians ranked Florida 32nd in the nation.¹⁷⁶

In some sense, even this data might be viewed as overstating the extent to which “dangerous doctors” are disciplined. In Florida, as in most states, there are many grounds for discipline tangentially related, if at all, to

physicians from 2003-05. Ranking of State Medical Board Serious Disciplinary Actions: 2003-05, Table 1, available at http://www.citizen.org/publications/print_release.cfm?ID=7428.

¹⁷³ The three public data sources are non-comparable. The annual report of the Board of Medicine Prosecution Services Unit is based on a fiscal year, deals only with disciplinary actions (and not determinations not to issue a Florida license), and does not include citations (these actions, most typically based on failure to document continuing education credits, are considered penalties, but not disciplinary actions, unless the behavior is repeated. It does, however, provide detail regarding the kinds of discipline and the types of violations. The Annual Report of the Federation of State Medical Boards is presented as calendar year data, includes actions taken through both the licensure and disciplinary process, and has included citations (although Florida’s Board will no longer forward non-disciplinary citations to the FSMB as of next year, so it will appear that Florida is disciplining fewer physicians). Finally, Public Citizen includes only the more severe forms of discipline, so that their data will indicate that fewer physicians are being disciplined than the FSMB data across all states. See email from Larry McPherson, Executive Director of the Florida Board of Medicine to author, April 17 2007.

¹⁷⁴ Board of Medicine Annual Report for 2005-06 at 9 (available from author). These totals had ranged in the five prior years from 200 to 279. *Ibid.*

¹⁷⁵ Federation of State Medical Boards, Trends in Physician Regulation (April 2006) at 22. A seeming large increase in the number of actions between 2003 and 2004 is an artifact of a recent law affecting CME requirements for initial licensure and a corresponding bump in citations.

¹⁷⁶ Public Citizen, *supra* note 172. Another difficulty with reconciling the sources is their variant data regarding the denominator. The Public Citizen study shows 51,025 physicians in Florida in 2004; the FSMB Report shows 49,448 licensed physicians, with 38,216 practicing in-state for the same year (and each of these numbers increasing by about 3,000 by 2005. The Board of Medicine report does not include this data, but the Annual Report of the Florida Department of Health Division of Medical Quality Assurance for 2005-06 shows 39,016 medical doctors (plus a few hundred in specialty categories such as limited license and critical need area). The difference between the two latter numbers may simply be an artifact of using calendar vs. fiscal year data; the Public Citizen data clearly must include physicians with Florida licenses but not practicing in-state.

While these numbers are modest, they have increased over time. In 1963-67 only 938 disciplinary actions were taken nationwide. Robert C. Derbyshire, Medical Licensure and Discipline in the United States (1969) at 77.

incompetence.¹⁷⁷ Meanwhile, the Board has had the authority to consider malpractice judgments as part of its assessment of whether discipline was appropriate even prior to the changes wrought by the amendment. Under Florida law, physicians must forward information on malpractice closed claims to the Office of Insurance Regulation (which in turn informs the Department of Health).¹⁷⁸ In turn, the Department is authorized to treat these reports as a complaint if the case was closed within the prior six years with a payment of at least \$50,000, and investigate to determine if the facts suggest the need for submitting the file to the Board of Medicine for possible discipline.¹⁷⁹

Nonetheless, one may be concerned that the State fails to act in too many situations where a doctor has demonstrated that he or she has problems that may interfere with the ability to consistently provide good medical care.¹⁸⁰

¹⁷⁷ The lengthy list of sanctionable behaviors are set out in Fla. Stat. §456.079 and Adm. Code 64B8-8.001. The Board of Medicine Report indicated that 156 of the disciplinary violations in 2005-06 were for patient care issues. *Id.* At 9. One study showed that only a small portion of sanctions nationwide were based on the codes most clearly linked to malpractice; however a very large portion were based on other, ill-defined, codes that might well also suggest harm or risk of future harm to patient care. Darren Grant & Kelly Alfred, *Physician Discipline by State Medical Boards: A Nationwide Assessment* 11, 19 (18.8% in the Public Citizen report for “substandard care, incompetence, negligence;” 12.2% in the FSMB report for “failure to conform to minimal standards of acceptable medical practice”). In the past, the focus of discipline was even more clearly on actions not directly related to competence, but easier to prove: writing inappropriate prescriptions, generally involving narcotics, and self-abuse with alcohol or drugs. See Office of Analysis and Inspections, Office of the Inspector General, Dept. of Health and Human Services, *Medical Licensure and Discipline: An Overview* (1986) at 13; Robert C. Derbyshire, *supra* note 176 at 78 (Table 5). Indeed, incompetence was not even included as a ground for discipline until 1965 and in the late '70s roughly half the states still did not include it. Frank P. Grad & Noelia Marti, *Physicians' Licensure & Discipline: The legal and professional regulation of Medical practice* (1979) at 125.

¹⁷⁸ Fla. Stat. § 456.049.

¹⁷⁹ Fla. Stat. § 456.073 (1). This provision tracked the language of 456.072(2)(t), prior to its revision by Fla. Laws Ch. 2005-266 (enacted in response to the passage of amendment 8). Under that version, the Board could discipline a physician for repeated malpractice, defined to include “three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of \$50,000 in a judgment or settlement.” According to the MQA Annual Report for 2005-06, 1431 closed claims against medical doctors were reported to them, three investigations were opened because the practitioner had three or more closed claims within the prior five years and five closed claims investigations led to discipline. Report at 38. Note that closed claims includes settlements as well as judgments and so may include cases in which the evidence of malpractice is weak but the potential damages are sufficiently high that settlement is highly rational for the defense.

¹⁸⁰ A frequent source of criticism is that there are physicians who have been repeatedly sanctioned by the board of medicine; the inference is that the first sanction was inadequate and this indicates that the board is ineffective. A prime advocate of this view is Public Citizen. In one publication it asserted that “six percent of the doctors in Florida are responsible for half the

Observers have suggested that state boards of medicine frequently lack sufficient resources to investigate thoroughly even all the situations that are brought to their attention.¹⁸¹ And they may well be inhibited from acting by the kind of professional courtesy that affects all professional self-regulation.¹⁸²

This does not translate, however, into an obvious conclusion that all situations of three or more malpractice judgments should lead to license revocation. As an absolute matter, it is obvious that most incidents of malpractice do not lead to disciplinary action, in Florida or elsewhere.¹⁸³ But on reflection, it is also obvious that they should not. Most automobile accidents, even if one of the drivers were at fault, do not lead to a license revocation or even suspension. Is revocation, however, the appropriate answer for “repeat offenders”? The answer may often be yes. Surely the doctors who are the topic of Public Citizen’s horror

malpractice,” yet the licensing board has not been effective in reducing malpractice. See Public Citizen, *supra* note 172. See also Grant and Alfred, *supra* note 177, at 12-14. The authors, analyzing both Public Citizen and FSMB data sets, note that in both the disciplinary and the malpractice system, those who have been sanctioned at time one are disproportionately likely to be sanctioned at time two. Yet the usual system of dealing with human problems is a form of progressive discipline. A large percentage of those disciplined once will not get into trouble again. The fact of recidivism indicates a problem with the system of discipline only insofar as there was a better system, not employed, that could have predicted, with reasonable accuracy, which among the pool of first offenders would turn out to be incapable of rehabilitation.

¹⁸¹ See R. John Kinkel & Norma C. Josef, *Disciplining Doctors: How Medical Bards are Dealing with Problem Physicians in the Midwest*, 9 Res. In the Soc. Of Heal Care 207, 211-12 (1991); Office of Inspector General, Dep’t. of Health and Human Services, Region I, *Medical Licensure and Discipline: An Overview* (1986)

In Florida, the first steps of receiving complaints and investigating are done by the Department of Health, which deals with all complaints against health care providers. Fla. Stat. §456.073 (1)-(2); it is thus unusually difficult to assess resources since the resources at this stage are a common pool for these and a variety of other issues within the jurisdiction of the Department of Health.

¹⁸² See, e.g. Stanley J. Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (1993); Robert A. Adler, *Stalking the Rogue Physician*, 28 Am. Bus. L. J. 683, 691 (1991); Mark Crane, *Why Did It Take So Long To Nail This Crooked Doctor?* 66 Med. Econ. 54 (March 20 1989). Similar criticisms have been made regarding the effectiveness of lawyer discipline, which similarly is a government function carried out by a body largely made up of fellow professionals. According to the President of the Florida Bar, approximately 9,000 complaints are made per year against lawyers; between 20 and 38 lawyers were subject to disbarment, the most serious punishment, and additional 133-155 were suspended, while there were over 70,00 attorneys in the Bar. Hearing on Medical Malpractice before the Senate Committee on Judiciary, July 14, 2003 at 134-37 (testimony of Miles McGrane).

¹⁸³ Grant and Alfred indicated that the total number of annual sanctions of all types for all behaviors nationwide during the period 1992-2004 ranged from 3370 to 6212. See Grant and Alfred, *supra* note 177, Table I at p. 18.. Meanwhile, the Institute of Medicine has estimated that there were between 44,000 and 98,000 annual hospital deaths due to medical error. See, e.g., Linda T. Kohn, Janet M. Corrigan and Molly S. Donaldson, eds, *To Err Is Human: Building a Safer Health System* (2000) [hereinafter IOM 2000]. The MQA data cited in n. 180 *supra* indicates a similar gap.

stories should have been subject to intervention and, if rehabilitation were unsuccessful, removed from practice before they had the opportunity to cause so much harm.¹⁸⁴ But not always. Consider the problem of disentangling cause and effect. We know that most incidents of avoidable adverse events, or even malpractice, do not lead to lawsuits.¹⁸⁵ For a whole variety of reasons, patients don't sue.¹⁸⁶ A doctor who has been sued once, however, is considerably more likely to be sued again.¹⁸⁷ One explanation: he is an incompetent physician who needs to be removed. Another: he is arrogant and rude: his patients are consistently more willing to sue him when things go wrong. Or, for structural reasons, he has substantial assets that would be reachable in a malpractice judgment.¹⁸⁸ Still another: plaintiffs' attorneys are more likely to bring suit against a physician who has past malpractice judgments, because the likelihood of a good settlement is higher. And, finally, physicians in certain specialties such as obstetrics and neurosurgery, where the expected harm from an act of malpractice is much higher, are more likely to be sued and, perhaps, sued again, than dermatologists or gastroenterologists.¹⁸⁹

¹⁸⁴ Public Citizen, *supra* note 172, at 7-8. See also Timothy Stolfus Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 Hous. L. Rev. 525 (1988); Timothy Stolfus Jost, Oversight of the Quality of Medical Care: Regulation, Management, or the Market? 37 Ariz. L. Rev. 825 (1995). Other sources affirm that a small but significant percentage of doctors, often estimated at five percent, have impairments that should lead to restrictions on their right of practice. See Robert C. Derbyshire, Medical Licensure and Discipline in the United States 88 (1969); sources cited in Robert S. Adler, *supra* note 182, at 690 n. 26.

¹⁸⁵ The Harvard Medical Practice Study showed that "there were more than seven negligent injuries for every medical malpractice claim and, accordingly, that most patients injured as a result of negligent medical management do not make a claim," Tom Baker, Reconsidering The Harvard Medical Practice Study Conclusions About The Validity Of Medical Malpractice Claims, 33 J. L. Med. & Ethics 501, 503 (2005).

¹⁸⁶ According to Public Citizen the number of medical errors reported by Florida hospitals exceeded the number of medical malpractice claims by 6 to 1. Public Citizen, *supra* note 172.

¹⁸⁷ Public Citizen, *supra* note 172 at 7-8. Somewhat surprisingly, past malpractice claims is a weaker predictor of future claims than a combination of demographic and practice pattern information, such as activity level of surgery, age, and practicing in an inner city hospital or on a heavily Medicaid population. John E. Rolph, John L. Adams, and Kimberly A. McGuigan, Identifying Malpractice-Prone Physicians, 4 J. Empirical Legal Studies 125 (2007).

¹⁸⁸ Leaders at the University of Miami Medical School have regularly decried the perceived effects on plaintiff's judgments about whom to focus on in bringing malpractice actions of the fact that its physicians have the deep pockets of the university available to them while Jackson Memorial Hospital, in which they practice, is insulated by sovereign immunity. See email from John G. Clarkson, former dean of the school to Mary Coombs, October 4, 2007.

¹⁸⁹ Finally, in a sense, mere randomness would mean that some physicians would be the subject of more than one claim and, almost definitionally, would contribute disproportionately to the total

Note also that barring physicians with three or more judgments against them will have only a limited effect on the extent of malpractice; most incidents of avoidable error and even of malpractice are the consequence of predictable errors by essentially good doctors.¹⁹⁰ Nonetheless, to the extent there is a core of dangerous doctors the disciplinary system should remove them.¹⁹¹ And doing so may respond to an understandable public desire for retribution against “bad apples.” The language of “three strikes and you’re out” with which Amendment Eight was promoted¹⁹² fed into this concern, as well as the poorly grounded belief of much of the general population that suspending the licenses of health professionals who make mistakes is among the “very effective” solutions to medical error.¹⁹³

payouts. It is unclear if these theories can fully account for data such as that in a study of physicians in D.C., showing that 4.3% of all physicians, each with two or more payouts, were responsible for 47.3% of the value of all judgments and settlements. Public Citizen, District of Columbia Medical Malpractice Payout Trends 1991-2004: Evidence Shows Lawsuits Haven’t Caused Doctors’ Insurance Woes (May 2005) at

<http://www.citizen.org/documents/WDC2005malpracticeanalysis.pdf>

¹⁹⁰ The patient safety movement is built around this insight that most avoidable errors are the consequence of bad systems rather than simply bad doctors. See, e.g., IOM 2000, *supra* note 183; Lucian L. Leape, Foreword: Preventing Medical Accidents: Is “Systems Analysis” The Answer? 27 *Am. J. L. & Med.* 145 (2001).

Cf. John L. Adams and Steven Garber, Reducing Medical Malpractice by Targeting Physicians Making Medical Malpractice Payments, 4 *J. Empirical Legal Studies* 185, 198-201 (2007) (demonstrating with mathematical models that investigating all physicians with multiple paid claims would have a de minimis effect, at most, in the future rate of malpractice. The relatively low rate of malpractice causing sufficient injury to induce claims, and the imperfect correlation between malpractice in fact, suing and obtaining compensation means that only a tiny percentage of all malpractice is committed by those who have had such paid claims in the past). While Amendment Eight would have been limited to those with judgments, not settlements, and would have led to automatic revocation, this is unlikely to change the conclusions shown therein.

¹⁹¹ Timothy Stolfus Jost carefully distinguishes between the kinds of quality of care problems best dealt with by physician education or systems changes and those most amenable to discipline, Oversight of the Competence of Healthcare Professionals, *supra* note 184, at 17. Even where a physician is less competent than average, the most effective and appropriate response may involve forms of discipline that improve his performance or channel it in ways that minimize his ability to do harm, rather than a license revocation.

¹⁹² It also, of course, evoked an analogy between bad doctors and the career criminals to whom the phrase had earlier been applied.

¹⁹³ Among the public, twenty-three percent selected the former and fifty percent the latter; unsurprisingly only three and one percent of doctors surveyed thought these were effective. Robert J. Blendon, et al. Views of Practicing Physicians and the Public on Medical Errors, 347 *NEJM* 1933, 1938 (Table 4) (2002). Cf. the claim of Dr. Carl Flatley, the head of Floridians for Patient Protection “the group created by trial lawyers to get the amendment on the ballot” that “[there are a small minority of doctors that cause the problems.” Lisa Greene, Few Doctors will pay under amendment, *St. Petersburg Time* (July 21 2004). It is impossible to know if the public

But, of course, all this is based on a narrow and static view of what the amendment would have done. Its primary effect would have been to make losing even a second malpractice judgment in Florida highly dangerous to a physician's livelihood. Physicians would feel forced to settle any case with even a small chance that they might lose at trial.¹⁹⁴ Plaintiffs' attorneys would be encouraged to bring more and weaker cases.¹⁹⁵ Malpractice insurance rates would rise.¹⁹⁶ Physicians would make additional efforts to avoid being sued. While some of these are desirable – more care to avoid error and better communication with patients both before and after treatment, others, such as increased defensive medicine, avoiding higher risk specialties and patient populations and not locating one's practice in Florida, are not.¹⁹⁷

would want physicians who had lost multiple suits sanctioned as a form of punishment even if they knew that doing so would have no measurable effect on the quality of future care.

¹⁹⁴ “ Three strikes and you're out: well, it is essentially meaningless from a practical perspective, because what I see is a wedge issue for mandating the settlement of cases,” Large interview, *supra* note 31, tr. at 7. See also Chaires, *supra* note 86.

¹⁹⁵ Indeed, the one group that would seem clearly to benefit from the passage of Amendment Eight was its sponsors, the plaintiffs' trial bar, whose bargaining position would be enhanced.

¹⁹⁶ Chaires, *supra* note 86. See also Randall R. Bovjberg and Laurence R. Tancredi, Liability Reform Should Make Patients Safer: “Avoidable Classes of Events” are a Key Improvement, 33 J.L. Med. & Ethics 478, 493(2005)(Amendment 8 “may prompt more lawsuits and will certainly raise physicians' willingness to settle cases before trial, probably at higher levels of payment”).

¹⁹⁷ There is little data to support the sweeping claims that the malpractice litigation crisis has led to a shortage of physicians in the state. When leaders of the Florida Medical Association testified under oath, they conceded that their claims were based on anecdotal evidence without any data indicating a pattern of physicians leaving Florida or shutting down their practices. Hearing on Medical Malpractice before the Senate Committee on Judiciary, July 14, 2003, at 96-97, 101 (testimony of Jeff Scott, FMA counsel), 125-30 (testimony of Sandra Mortham, FMA CEO). According to the Annual Reports of the Medical Quality Assurance Commission (a state agency), there were 50,407 active licensed medical doctors in Florida in 2005-06 (of which 11, 391 were listed as out of state), 47,805 in 2003-04 (17,849 out of state) and 43,517 in 2001-02 (when the report did not break out out-of-state Florida licensed doctors). See annual reports available at www.doh.state.fl.us/mqa/reports.htm Data from 2002-03 indicates that Florida was below average, but far from the bottom, among states in the number of physicians per capita. Interestingly, it was disproportionately low in the number of primary care physicians, a category at a relatively low risk of malpractice claims. See Table 222 of the Health Workforce Personnel Handbook of the US Dept. of HHS, Health Resources and services Administration (available at <http://bhpr.hrsa.gov/healthworkforce/reports/factbook02/FB222.htm>). It is highly plausible, however, that fear of sanctions, whether malpractice judgments directly or the indirect effect of such judgments that Amendment Eight threatened, might lead some physicians to practice less, to relocate their practices away from southern Florida (seen as the more litigation-prone region), to reduce or eliminate the practice of higher risk specialties such as obstetrics, and to avoid patients seen as high risk. The amendment would thus have had a disproportionate effect on such specialties, perhaps exacerbating the shortages of those physicians. It is, unfortunately, very difficult to find more than anecdotal evidence at this level of specificity. (For an example of such anecdotal evidence, see Mortham testimony, *supra* note 197).

The most difficult reform to assess is Amendment Seven. On its face, it seems to provide a very broad right of access to records.¹⁹⁸ The right belongs to patients, but that term includes “any individual who has sought, is seeking, is undergoing or has undergone care or treatment in a health care facility or by a health care provider.”¹⁹⁹ Depending on whether proof of a concrete plan to seek care were required, this might exclude no one.²⁰⁰ Read literally, it does not limit the “patient” to seeking records only from the particular facilities or providers with whom she has or is considering having a treatment relationship.²⁰¹ While the records are limited to those “relating to any adverse medical incident,” this last phrase is defined extremely broadly:

The phrase "adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.²⁰²

It thus includes near-misses as well as adverse medical events as ordinarily defined. It includes “but [is] not limited to” reports relating to incidents that must be reported to any governmental body and to reports either created by or reviewed by any of a wide range of internal review committees and the members thereof. It is difficult to imagine any form of peer review that would not be included. The term “records” is undefined and thus might include notes and drafts as well as any final reports. Furthermore, as an attorney who represents hospitals noted, absent limiting legislation, it might require, in addition to the

¹⁹⁸ “[P]atients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.” Fla. Const. Art. X, § 25(a).

¹⁹⁹ Fla. Const. Art. X, § 25(c)(2).

²⁰⁰ If, as the proponents argue, this is to serve as a consumer information device, one might want the information prior to making any decision about where to seek treatment or from whom.

²⁰¹ If so read it would facilitate requests in the context of investigative journalism. And it is difficult to conceive of what sort of proof the person seeking information would have to provide to the health care provider that she was considering seeking medical care which it might provide.

²⁰² Fl. Const. Art. X, § 25(c)(3).

material more obviously covered by the language above, the production of patient complaint forms, hospital incident reports, and loss runs, i.e., the list of open cases with the amount that had been reserved for indemnity and expenses, since all these are “made or received in the course of business” and relate to adverse medical incidents.²⁰³ The law would create substantial burdens, particularly on health care facilities, to keep the relevant documents,²⁰⁴ to access them when requested, and to redact them of any patient-identifying information.²⁰⁵

Even without the “implementing legislation,” the impact of Amendment Seven might have been less than would appear from the language. First, the Patient Safety & Quality Improvement Act of 2005 may provide federal protection against discoverability for at least some of these records.²⁰⁶ Second, some of those subject to Amendment Seven indicated that they would reorganize some of their peer review processes by involving their attorneys more closely and thus bringing the records within the attorney client privilege.²⁰⁷

Even if the amendment had the impact that its text alone would suggest, the benefits might well be less and the costs higher, than its proponents and the voters assumed. The Amendment was promoted as a consumer protection measure, providing people information about hospitals and doctors that they could use in deciding where to obtain the best, safest health care. How valuable

²⁰³ Parenti interview, *supra* note 34, tr. at 8.

²⁰⁴ It was this concern that led the hospitals to request, successfully, that the legislation state that no records created prior to November 2, 2004 be required to be produced and that, going forward, records need only be provided for the four years prior to the date of any request. Fla. Stat. §381.028(5).

²⁰⁵ As acknowledged in Fla. Const. Art. X, §25(b), such redaction is required by the Health Insurance Portability and Accountability Act of 1996 [HIPAA], Pub. L. No. 104-191, 110 Stat. 1936 (Aug. 21, 1996) (codified as amended in scattered sections of 26 and 42 U.S.C.).

²⁰⁶ The PSQIA, 42 USC §§299b-22 (a), provides that “patient safety work product shall be privileged and shall not be . . .subject to discovery in connection with a . . .State . . .civil or administrative proceeding” with certain exceptions not relevant here. Patient safety work product is defined to include “data, reports, records, memoranda, analyses . . . or written or oral statements . . . which identify or constitute the deliberations or analysis of . . . a patient safety evaluation system,” which in turn is defined to mean “the collection, management, or analysis of information for reporting to or by a patient safety organization.” 42 U.S.C. §299b-21. The FMA leadership indicated that the Act “might lend itself to a form where you could shelter things,” FMA interview, *supra* note 38, tr. at 17. In effect, insofar as the kinds of reports otherwise subject to discovery under Fl. Const. Art. X, § 25 are prepared for reports to patient safety organizations, they will instead be privileged. If the Florida Supreme Court decides that the narrowing legislation is not consistent with the constitutional provision, the available scope of federal privilege will become far more significant.

²⁰⁷ FMA interview, *supra* note 38, tr. at 10.

that information would be to consumers depends both on the accuracy and usability of that information and on the alternatives otherwise available to make such decisions. There are already a number of entry points through which a consumer could learn about a physician or a hospital.

As for physicians, the most extensive source of information, including malpractice payments, adverse actions by licensing boards, clinical privileges actions and professional society actions is the National Practitioner Data Bank; which is, however, not accessible to the general public.²⁰⁸ Florida does have a state level web resource, the Practitioner Profile.²⁰⁹ Anyone can look up a licensed practitioner by name or license number. The profile includes information on education, staff privileges, reported financial responsibility, legal actions and board final disciplinary actions taken against him or her, and liability claims against the practitioner above a dollar threshold (\$100,000 for physicians). In theory, this should provide all the information that would be available through the NPDB. However, much of the information is self-reported; at least in the absence of an alternative, reliable data source (such as there is for malpractice claims, which are also independently reported to the Department of Health by the Office of Insurance Regulation), important negative information may not appear.²¹⁰

There are also web resources to compare hospitals. Florida's Agency for Health Care Administration has a website which allows the user to find information about any hospital in the state, including readmission rates, mortality rates, infection rates and complication rates, in some cases including national

²⁰⁸ The only exception is that a plaintiff or his attorney may access the databank if they have sued a hospital and have shown that the hospital did not, as required, query the data bank in the course of granting or continuing a physician's credentials. See Fact Sheet for Attorneys and Fact Sheet for the General Public of the National Practitioner Data Bank. <http://www.npdb-hipdb.hrsa.gov/factsheet.html>

²⁰⁹ See A Guide to the Florida Practitioner Profile <http://www.doh.state.fl.us/mqa/Profiling/guide.pdf>

²¹⁰ Among the items of information subject to Department of Health verification are licensure, licensure elsewhere, staff privileges and degrees [these are verified at the time of initial licensure, but any later changes are not], information about final disciplinary actions within the prior ten years taken by licensing agencies, specialty boards, health maintenance organizations, clinics, nursing homes and hospitals, resignations from or revocation of such privileges; and liability claims. *Id.* At least one newspaper report indicated that some information that should have appeared, under the Department of Health's own rules and systems, was absent. See Jacob Goldstein, State's files on doctors fall short, Miami Herald, December 10 2006.

and statewide averages as a benchmark.²¹¹ The U.S. Department of Health & Human Services also has a website allowing the user to compare hospitals.²¹² This site provides information on the frequency with which the hospital provides specific recommended treatments for heart attack, heart failure, pneumonia and surgery. Neither of these sites necessarily provide all the specific information a consumer might want to know, and they do rely on self-reporting. On the other hand, the information provided is substantial and the sites are easy to navigate to find reasonably comprehensive, comparative information about specific hospitals.

It seems doubtful that there is much additional consumer value in being able to obtain copies of the information that is (or would have been) provided via Amendment Seven. Depending on the scope of the request, it could readily provide, in effect, too much information for effective decision making.²¹³ Furthermore, if consumers were to obtain all the information available through Amendment Seven on several practitioners or facilities, they might well be misled. This essentially raw data does not include the guidance on how to assess the data that the various websites do. Thus a consumer might well assume that more reports of adverse incidents is evidence of more adverse incidents and thus of a practitioner or facility to be avoided, without taking account of such confounding factors as the patient population or the commitment to patient safety, which might lead to more reports in order to uncover and respond to errors.²¹⁴

²¹¹ See <http://www.floridacomparecare.gov>. Legislation in 2006 requires hospitals to provide this information and the agency to make it publicly available. See Fla. Stat. §§408.061, 408.05(k)(2006).

²¹² <http://www.hospitalcompare.hhs.gov/Hospital/Static/About-Overview.asp?dest=NAV|Home|About|Overview#TabTop>

²¹³ Cf. Judith H. Hibbard, Paul Slovic and Jacquelyn J. Jewett, Informing Consumer Decisions in Health Care: Implications from Decision-Making Research, 75 *Milbank Quarterly* 395, 399 (1997)(demonstrating that heuristics may lead people to make worse decisions, in terms of their own values, when there is too much, too complicated information)

²¹⁴ “Good hospital systems have a lot of hospital incident reports because they have people who are caring about what happens, so they want to have an increase every year in the number of things that are reported.” Parenti interview, *supra* note 34, tr. at 8. This problem is particularly acute since Amendment Seven extends to reports of near-misses. Neither JCAHO nor the State require such reports; see Fla. Stat. §395.0197(7); Joint Commission on Accreditation of HealthCare Organizations, Sentinel Event Policy and Procedure. The federal Patient Safety and Quality Improvement Act of 2005 encourages reporting of near-misses but protects those done following its procedures with guarantees of confidentiality. 42 USC §§299b-21 et seq. A facility

A distinct effect of Amendment 7, probably the most desirable for its proponents, is as a tool for malpractice litigation.²¹⁵ The records themselves are inadmissible and even the proponents concede that Amendment 7 would not change that.²¹⁶ But they might lead to admissible evidence, by pointing the plaintiff to potential witnesses who might be willing to speak and by providing a road map for questioning defendants.²¹⁷ Both plaintiff and defense attorneys see such records as a potentially powerful force in the dynamic of cases. A plaintiff's lawyer said that the discovery of records that a physician had committed errors in the past and that a hospital was aware of it "would lead to early resolution of disputes."²¹⁸ An attorney who represents hospitals said that "the availability of material like this in a suit has a dramatic impact on the settlement dynamic."²¹⁹ There is, I believe, no neutral objective point from which to assess whether this would ultimately be good or bad for patients.

The most significant likely aspect of the Amendment would be on the peer review system and thus on the processes of patient safety. Currently essentially all of these processes are privileged; the processes are to be treated as confidential, the participants may not testify about them, and the documentation created is neither discoverable nor admissible. Much of this protection is

that creates near-miss related reports is thus one which is taking a more proactive stance in advancing patient safety and yet could appear to be less safe.

There is a similar problem of potential misuse of information about individual practitioners since outcomes may "depend on processes mainly under the control of health systems." William M. Sage, Joshua Graff Zivin & Nathaniel B. Chase, Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice, 59 Vand. L. Rev. 1263, 1278 (2006).

²¹⁵Courts have generally rejected the arguments that documents to which a person was otherwise entitled under Amendment Seven magically become inaccessible once the person has filed a malpractice suit. See, e.g., *Michota v. Bayfront Medical Center, Inc.*, 2005 WL 900771 Fla. Cir. Ct.) at *5 ("the discoverability of these documents in civil litigation can be no more narrow than the right of access this same patient would have if he sought access before becoming a litigant").

²¹⁶ AFTL interview, *supra* note 33, tr. at 14.

²¹⁷ Information that had been presented to a medical review committee is not privileged if requested from some other source. *Mount Sinai Medical Centers of Greater Miami, Inc. v. Bernstein*, 645 So. 2d 530 (3rd DCA 1994). For example, a plaintiff could not obtain a defendant's application for staff privileges from the credentialing committee, but could obtain them from the defendant physician himself. *Boca Raton Community Hospital v. Jones*, 584 So. 2d 220 (4th DCA 1991).

²¹⁸ Lynch and Meyer, *supra* note 132.

²¹⁹ *Id.* (quoting an attorney, whose firm represents malpractice defendants).

statutory;²²⁰ prior to Amendment Seven, the Florida courts had read these protections broadly, consistent with the perceived high social value of these processes and the need for privilege:

[D]octors seem to be reluctant to engage in strict peer review due to a number of apprehensions: loss of referrals, respect, and friends, possible retaliations, vulnerability to torts, and fear of malpractice actions in which the records of the peer review proceedings might be used. It is this ambivalence that lawmakers seek to avert and eliminate by shielding peer review deliberations from legal attacks.²²¹

There is apparent unanimity that patient safety measures are socially desirable and that the system to develop such measures depends on a sufficiently reliable system for reporting errors.²²² There is also a wide, though not universal consensus that the protections of confidentiality and immunity for reports of errors are crucial to ensuring the data necessary for patient safety processes.²²³ The consensus view is based on a number of claims. Those industries in which safety measures have been particularly effective, such as the airline industry, protect error reports from discovery.²²⁴ Patient safety is seen as requiring a focus on systems, rather than a culture of blaming; punishing those whose errors are reported is thus seen as counter-productive.²²⁵ Health care personnel are seen as reluctant to report errors, whether theirs or their

²²⁰ See, e.g., Fla. Stat 395.0191(8); 395.0193(8);766.101(5).See generally Jason A. McGrath, A Practical Guide to Protected Internal Healthcare Facility Information and Documents in Florida, 25(2) Trial Advoc. Q. 13 (2005).

²²¹ *Cruger v Love*, 599 So. 2d 111, 115 (Fla. 1992) (quoting Gregory G. Gosfield, *Medical Peer Review Protection in the Health Care Industry*, 52 Temp. L.Q. 552, 558 (1979)); see also *Holly v Auld*, 450 So. 2d 217 (Fla. 1984).

²²² William Sage and his co-authors refer to “the political ascendancy of ‘patient safety.’” Sage, et al., *supra* note 214, at 1269. Reporting is, of course, necessary but not sufficient. There must also be a commitment to analysis and follow-up if change is to occur. IOM 2000, *supra* note 183, at 87;.. See, e.g., Randall R. Bovbjerg, *Beyond Tort Reform: Fixing Real Problems*, 3 Ind. Health L Rev 3, 16-17 (2006)(describing patient safety as “the most promising difference” from earlier times), ..

²²³ “Fear of legal discoverability or involvement in the legal process is believed to contribute to underreporting of errors.” IOM 2000, *supra* note 183, at 127. See also Barry R. Furrow, *Medical Mistakes: Tiptoeing Toward Safety*, *Houston J. Health L. & Pol’y* 181, 183 (2003); Brian A. Liang & Steven D. Small, *Communicating About Care: Addressing Federal-State Issues in Peer Review and Mediation to Promote Patient Safety*, 3 *Hous. J. Health L. & Pol’y* 219, 225 (2003).

²²⁴ See Bryan A. Liang , *Error In Medicine: Legal Impediments To U.S. Reform*, 24 *J. Health Pol. Pol’y & L.* 27, 29-30 (1999).

²²⁵ IOM 2000, *supra* note 183, at 87. See also Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, 21 *Ga. St. U. L. Rev* 831, 837-38, 840-41 (2005).

colleagues, for a variety of reasons.²²⁶ Some empirical data confirms these claims.²²⁷

One of the perceived impediments to open reporting of errors is the risk of blame through the malpractice system.²²⁸ Thus patient safety advocates often support measures to narrow or even displace that system.²²⁹ Others, by contrast, insist on the values advanced by malpractice litigation and resist “tort reforms” which fail to provide adequate alternatives for compensating those who are injured and/or deterring harmful medical error.²³⁰ Concurrently, they argue that the reporting that patient safety advocates insist is essential is not dependent on confidentiality or protection from the risk of malpractice litigation.²³¹ The requisite open sharing of error reports has never been part of the culture of medicine, even when malpractice suits were far rarer than they are now.²³² And even with protections, the level of reporting, whether voluntary or “mandatory” is frequently too low to serve its purposes.²³³

When the question is the extent to which malpractice liability risk should be reduced in order to induce more reporting and analysis of error and thus to

²²⁶ See, e.g., Bovbjerg & Tancredi, *supra* note 196, at 5; Furrow, *supra* note 223, at 192. Cf. Atul Gawande, *Complications* (2002) at 94-97 (describing the various reasons why health care professionals find it difficult to take action when a colleague shows signs of being a danger to his or her patients).

²²⁷ See studies cited in Sage, et al. *supra* note 214, at 1289 nn. 79-80.

²²⁸ “[T]he tort system poisons the openness and honesty that are preconditions to safety improvement,” Bovbjerg & Tancredi, *supra* note 196, at 497 (quoting quality improvement advocate Donald Berwick). See also IOM Report 2000, *supra* note 183, at 109-110

²²⁹ Bovbjerg & Tancredi, *supra* note 196, at 17. The IOM 2000 report floated the idea of no-fault or enterprise liability – ideas which went nowhere – in part as reforms that “might promote reporting by eliminating the adversarial inquiry into fault and blame that characterizes the current liability system.” *Id.* at 111.

²³⁰ See, e.g., Tom Baker, *supra* note 153. See also Bovbjerg & Tancredi, *supra* note 196, at 480-81 (noting that patient safety advocates undermine the political viability of their cause by linking it to reducing legal remedies for injured patients).

²³¹ Cf. Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit: Is It Time for a Change?* 24 *Am. J. L. & Med.* 7, 9-12 (1999) (study indicates that confidentiality protections are not correlated with greater use of the peer review process).

²³² David A. Hyman and Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?* 90 *Cornell L. Rev.* 893, 926-27 (2005).

²³³ Furrow, *supra* note 223, at 203; Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report Have Reporting Systems Made a Measurable Difference?* 14 *Health Matrix* 329, 350-51 (2005). Harrington at 363 notes the strikingly disparate number of reports in New York and Florida, suggesting substantially different rates of under-reporting.

promote patient safety, the answer is unclear.²³⁴ There is little direct data to support the “common wisdom . . . that medical malpractice lawsuits impede efforts to improve health care quality by encouraging providers to hide mistakes.”²³⁵ Indeed, the opponents of patient safety-based “tort reform” note that the biggest patient safety success story has been in anesthesiology,²³⁶ and the impetus for that project was the extremely high malpractice risks and malpractice insurance rates that anesthesiologists had been experiencing.²³⁷

If the question, however, is the desirability of Amendment Seven, the balance shifts, I believe, rather decisively against it. The benefit to current and potential future patients of having ready access to this information is more attenuated than is the benefit of malpractice litigation itself. And the deleterious effect on people’s willingness to report adverse events and participate in root cause analyses is far more direct. The precise effect of the Amendment is to promise that the reports one makes and the documentation of one’s participation in various forms of peer review can readily become public,²³⁸ thus evoking all the reasons why people are reluctant to make such reports.²³⁹

In the case of each amendment, some modification of the law in the direction of the proposal might be a genuinely positive reform. In each case, however, the specific proposal incorporated in the Florida Constitution, standing alone, is so extreme that its downsides almost surely outweigh its benefits.

We don’t and probably can’t, at this point, know what will work to protect patients, compensate those avoidably injured, ensure that the needed health care providers and facilities are available and affordable and facilitate the

²³⁴ As noted in Sage, et al., *supra* note 214, at 1271, there is a tension between the needs of improvement and accountability in terms of the availability of information about medical error.

²³⁵ Hyman & Silver [Cornell] *supra* note 232, at 893.

²³⁶ *Id.* at 917-23; Atul Gawande, *supra* note 226 at 64-69.

²³⁷ Frederick W. Cheney, ASA closed claim project: where have we been and where are we going? 57 ASA Newsletter 8 (1993), cited in Baker, *supra* note 153, at 108-09.

²³⁸ Recall that the Amendment seems on its face not limited to final reports or to conclusions leading to actions; thus it provides public access and scrutiny to far more than needs to be reported to the National Practitioner Data Bank.

²³⁹ Two of the strongest opponents of the argument that malpractice impedes effective communication among providers, note that “the risk of a leak [to potential plaintiffs or their attorneys] is substantially attenuated by the statutory peer review protections most states have put in place.” David A. Hyman & Charles Silver, Speak Not of Error, 28 (1) Regulation 52, 55 (Spring 2005) available at <http://www.cato.org/pubs/regulation/regv28n1/regv28n1.html>

processes that can make all this possible. We may, at least, make some progress, by knowing what would not work.

Conclusion

The changes wrought by Amendments 3, 7 & 8, had they occurred as intended by their proponents, would likely have been bad for patients. This is unsurprising, given the processes by which they were proposed and enacted. Each was designed by a single stakeholder, trial lawyers (7 &8) or physicians (3). The primary purpose seemed to be to harm or threaten to harm the interests of other stakeholders, trial lawyers (3) or physicians and hospitals (7 & 8), although they had to be sold to the public as designed to advance the public interest. Given that dual nature, they were drafted to serve the interests of the sponsors as much as possible while still being sufficiently appealing to the electorate.²⁴⁰ The pattern seemed to be to take something that already existed as part of a larger reform project elsewhere, extract it, and push it to an extreme. Furthermore, because these proposals were to be part of the state constitution, they needed to be clear, simple and unsubtle. Finally, the expectations of both the proponents and of the voters may have been that this was the final word on these issues. As I examine in more detail elsewhere, this has – fortunately -- not turned out to be the case, and need not: initiatives can be a step in a complex governance process. But the expectations themselves may run the risk of either making further governance changes harder (even if experience were to show the undesirability of the provisions as enacted) or to create cynicism towards government as expectations of the “finality” when the people speak are disappointed.

This story also, I hope, demonstrates the value of such story-telling. Legal scholarship has traditionally been analytic, whether it is done at the level of specific doctrine or more conceptual and theoretical. Critical race theory and critical feminist theory led the way to the addition of narrative as an explicit

²⁴⁰ Indeed, when asked in late 2006, if they would have done anything differently, Paul Jess, one of the AFTL leaders, indicated that they would have crafted the language of these amendments to poll a smaller majority, so the FMA would have been induced to use some of their resources in an attempt to fend them off, rather than concentrating entirely on passing amendment three. AFTL interview, *supra* note 33, tr. at 15.

aspect of legal scholarship, and a necessary corrective to the hegemonic views of law and the obscuring of the relevance of race and gender to what the law does and how it is experienced in traditional scholarship.²⁴¹ Although there was much dispute in the 1980s and 1990s about the legitimacy of such scholarship and the appropriate role it should play within the universe of legal scholarship,²⁴² it now seems to have been accepted as a legitimate part of the universe of legal scholarship.²⁴³ But narrative as an aspect of legal scholarship is not and should not be limited to those stories in which the author is herself a part of the story or to voices from the bottom (though these may well be the voices that have been most obscured by traditional scholarship). Law, particularly the common law, is shot through with stories.²⁴⁴ There does not appear to be the same narrative urge within legal scholarship for the “back stories” of legislation.²⁴⁵ It is sometimes

²⁴¹ Some of the most prominent and most influential works in the field have been collected within the anthologies edited by Richard Delgado, Jean Stefancic, *The Cutting Edge* (2000), and been the subject of discussions of the field in the works cited in n. 236 [next note] The term has sometimes also included the use of explicitly fictional writings to illuminate limitations in dominant scholarship or political understandings. The most prominent practitioners are Derrick Bell and Richard Delgado. See, e.g., Derrick Bell, *And We Are Not Saved: The Elusive Quest for Racial Justice* (1987), Richard Delgado, *The Rodrigo Chronicles: Conversations About America and Race* (1995).

²⁴² See, e.g., Daniel Farber and Suzanna Sherry, *Beyond All Reason: The Radical Assault on Truth in American Law* (1997) and Richard Delgado, *On Telling Stories in School: A Reply to Farber and Sherry*, 46 *Vand. L. Rev.* 665 (1993). Less contentious approaches to these questions can be found in, e.g., Jane Baron, *Resistance to Stories*, 67 *S. Cal. L. Rev.* 255 (1994); Mary I. Coombs, *Outsider Scholarship: The Law Review Stories* 63 *U. Colo. L. Rev.* 683 (1992), Edward L. Rubin, *On Beyond Truth: A theory for Evaluating Legal Scholarship*, 80 *Calif. L. Rev.* 889 (1992).

²⁴³ For a very thoughtful contemporary example of narrative legal scholarship, see Mario L. Barnes, *Black Women’s Stories and the Criminal Law: Restating the Power of Narrative*, 39 *U.C. Davis L. Rev.* 941 (2006).

²⁴⁴ One sub-category of narrative scholarship involves the recounting of stories in which the scholar-author played a role, but as a relatively minor character in a story focusing on the client. Probably the most famous example is Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 *Buff. L. Rev.* 1 (1990). See also, e.g. Anthony V. Alfieri, *Impoverished Practices*, 81 *Geo. L. J.* 2567 (1993).

One quite prominent collective example of the use of stories in the writing of legal academics is the collection of “Law Stories,” providing a rich context, historical, personal and political, for cases that students are likely to encounter in their casebooks, organized by doctrinal categories, such as property, legal ethics or immigration. A complete listing can be found via <http://www.westacademic.com/Professors/ProductLines.aspx?tab=1>

²⁴⁵ Political theorists and political journalists, and the occasional law professor, have provided such close studies of the political process in general, see, e.g., Thomas A. Mann & Norman J. Ornstein, *The Broken Branch: How Congress is Failing America and How to Get it Back on Track* (2006), or in the context of particular processes, see, e.g., Peter Schrag, *Paradise Lost: California’s Experience, America’s Future* (1998) (discussing the effects of the citizen initiative in

useful, as I hope it has been here, to provide such a story, a “thick description” if you will, of how legal change occurred. We can see how the multiple, sometimes conflicting, sometimes overlapping agendas of various legal actors operate to produce outcomes and lay the groundwork for ongoing processes of conflict, cooperation or cooptation. It may help us understand the contingency of legal change and the importance at times of individual choices. Law must reflect reason; to understand it fully we must bear in mind that, particularly outside the judicial context, it inevitably reflects much more.

California) or subjects of legislation, see e.g. Michael J. Graetz and Ian Shapiro, *Death by a Thousand Cuts: The Fight Over Taxing Inherited Wealth* (2005).