IN THE CIRCUIT COURT ,FOURTH JUDICIAL, IN AND FOR DUVAL COUNTY, FLORIDA

CASE NO.: 2006-CA-06423
DIVISION: CV-C

SHIRLYN GAIL GALLAGHER
and DAVID GALLAGHER
her husband

Plaintiffs

v.

SOUTHERN BAPTIST HOSPITAL OF FLORIDA, INC. d/b/a/BAPTIST MEDICAL CENTER, a Florida corporation

Defendant

ORDER DENYING IN PART AND GRANTING IN PART DEFENDANT'S MOTION TO STRIKE AFFIRMATIVE DEFENSE INVOKING FLA. STAT. 766.118 (CAPS ON NONECONOMIC DAMAGES AS UNCONSTITUTIONAL

This cause came on for hearing on the above styled motion following jury verdict. The motion was not called for hearing until the morning of trial. The Court agreed that Plaintiff could proceed to jury selection and trial with a provisional finding of validity except for the issue of the caps on noneconomic damages, if any. Following the trial, extensive motions were heard and disposed of, including a motion for jury interview. the interview of former jurors and motion for new trial.

Each of the attorneys argued vigorously and was well prepared. Many documents were

furnished the Court along with several boxes of documents during the days following the hearing. At the close of the hearing the Court deferred a ruling in order to consider the voluminous documents submitted during the hearing and the days following in an effort to make a trial record for review.

Plaintiffs have challenged the validity of Fla. Stat. 766.118 on asserted grounds that the statute violates Plaintiffs' rights to access to the courts, the right to trial by jury, the separation of powers, equal protection of the law due process and Article I, Section 26 of the Florida Constitution.

GOVERNOR'S SELECT TASK FORCE on HEALTHCARE and PROFESSIONAL LIABILITY INSURANCE COVERAGE

In 2002, Governor Jeb Bush created the Governor's Select Task Force on Healthcare and Professional Insurance by Executive Order No. 02-041 The Task Force was ordered to make findings from an examination of the liability medical and healthcare providers market, relevant tort statutes and case law and analyses of other sates' efforts in order to provide "an assessment of the impact of the cost, accessibility and availability of healthcare liability insurance on the cost, accessability and availability of high quality healthcare in this state."

The Task Force was comprised of no members of, nor any person who represented members of, special groups or representatives of special groups. The members were:

John C. Hill, Ph.D., President of the University of Central Florida

Richard A Beard, Trustee of the University of South Florida

Marshall Criser, Jr., President Emeritus of the University of Florida

Fred Gainous, P.D President , Florida A & M University

Donna E. Shalala, President of the University of Miami and former Secretary of U.S. Department Of Health and Human Services

The report was transmitted to the Governor with a letter of transmittal, dated January 29, 2003, and signed by John C. Hill, a member of the Task Force. Copies were delivered to the Speaker of the House and the President of the Senate. The letter cited the inclusion of 13 volumes of reports, presentations, letters, and testimony. During the five month period the Task Force held 10 public meetings hearing testimony ".... from healthcare providers and malpractice victims throughout the state.....". The transmittal letter. also reported the Committee's reading of hundreds of letters from concerned citizens and conducting its own independent research of published studies and relevant literature; it also reported ".....great care to conform its recommendations to the Florida Constitution and case law...." when considering its recommendations.

An Executive Summary opens the Report and provides a glimpse of the process by which the Task Force arrived at its conclusions. See Report of Governors Select Task Force on Healthcare Insurance, Executive Summary, pg. s. iii, iv. The group reviewed state procedures for healthcare and professional discipline. It also extensively examined the tort system, including its impact on the frequency and severity of claims, alternative dispute resolution processes, and factors influencing medical malpractice insurance rates. The Task Force also sought proposals from interested persons and entities who proposed solutions to the problems. Over 100 such proposals were received and considered. The Task Force divided the prospective problems into five categories: (1) healthcare quality; (2) physician discipline; (3) need for tort reform; (4) alternative dispute resolution; and, (5) insurance premiums and markets. *id* p. iv.

professional liability insurance for the healthcare provider nationwide. They also make medical care less accessible for the consumer in that high premium rates were paid by doctors, especially in specialty areas of medicine. Doctors were closing their practices or scaling back their services in order to avoid the necessity of carrying the required insurance. In addition, many doctors were practicing a defensive type of medicine in which additional tests and treatments performed that were unnecessary; the purpose was to avoid potential malpractice claims, thereby increasing the costs of quality medical care. *id,* p.11 (citations omitted)

The national perspective revealed various reforms instituted by various states, including Florida, which were intended to address the problems in the medical malpractice system. The reforms included healthcare quality improvements, healthcare provider discipline, tort reforms, including caps on damages, alternative dispute reforms and, insurance reforms. The Task Force concluded *inter alia* that some of the tort reforms had slowed the growth of jury awards in medical malpractice cases. *id* ps.15-23. (citations omitted)

The study of the Florida healthcare condition began with a study of the history of the law as it related to prior attempts to improve healthcare in this state. It was found that in 1974 an insurance carrier threatened to discontinue writing medical malpractice in the state after being refused an increase in its rates. Argonaut, the carrier, wrote 60 percent of the market at the time and was large enough to attract Tallahassee's attention. In 1975 a legislative determination that a medical malpractice existed brought about the first legislative attempt in recent history of a number of such attempts to deal with the crisis as it existed at that time. *id.*, Chapter 4, Medical Malpractice: The Florida Perspective, 33 - 56 (citations omitted). The last legislation enacted to cope with the continuing problem was accomplished in 2001. After discussion of the various

years' attempts the Task Force concluded that the crisis remains and is growing, citing the departure of five of the major companies in 2001-2002, four companies writing new business generally, and three companies writing specific types of business. *id.*, 56-57.

The Task Force took testimony during public hearings in six cities around the state. The testimony was taken from consumers and their advocates and from health care providers and their advocates. The Task Force also had the testimony of persons given before other investigative bodies, for example, the testimony of Joanne Doroshow, a consumer activist, before the U.S. House Subcommittee on Commercial and Administrative Law, Oversight Hearing on Healthcare Reform, " Does Limitless Litigation Restrict Access to Health Care?" (June2, 2002). Considerations made by the Task Force as summarized in behalf of consumers are found on pages 64-68, Chapter 4 of the Report. Advanced as causes for the consumer were theories of bad doctors: an influx into Florida of inexperienced insurance companies who failed and in desperation raised rates before departing the state; insurers lowering rates in order to increase market share; doctors pressured because of lower fees from HMOs and Medicare; tort reform will not lower insurance rates; bad hospitals and other issues. All statements are well documented.

The Task Force considerations in behalf of the health care providers can be found on pages 69-102, Chapter 4 of the Report. The communications were by testimony, letters form physicians or groups of doctors who practiced together, E-mails, and presentations. The communications described the conditions under which the doctors and hospital officials found an inability to function efficiently because of the drastic increase in insurance rates. Doctors were not performing many procedures they felt necessary to properly treat or diagnose a patient's condition; other doctors were performing "defensive medicine " by performing procedures that were

unnecessary medically but done to protect themselves legally; emergency rooms were unable to obtain specialists to see patients; doctors were leaving the state or threatening to leave without relief from high rates and excessive verdicts. Again all statements are well documented.

In addition, the Task Force had the benefit of studies done by various groups who had special interests in the issue. In early 2002, the Florida Hospital Association conducted a survey of acute care hospitals in the state which had experienced difficulty in obtaining, or affording medical malpractice insurance.[3] Fifty two hospitals responded. Seventy five per cent of respondents reported having problems obtaining insurance. Many of those reporting no problem had not received their renewal notices for 2002 but anticipated having problems. Fourteen hospital systems reported a refusal by their carrier to renew their policies. Seven of those had been insured by St. Paul Insurance Company which was leaving the state. Of seventeen hospitals reporting premium amounts, ten reported liability costs had more than doubled between 1999 and 2001 with premium amounts increasing 140 per cent for the two year period.

The Florida Medical Association conducted a survey in September, 2002 on the availability of medical malpractice insurance in Florida.[4] More than 2600 doctors who were practicing in over 40 specialties from 42 of Florida's 67 counties responded with 98 per cent reporting impacts by increased insurance rates. The impacts included discontinuance of the practice of medicine; discontinuance of calls at nursing homes; reducing or eliminating emergency rooms calls and hospital calls; eliminating treating Medicaid patients; eliminating certain procedures; seeing certain

[3]Florida Hospital Association, *Survey on the Availability and Affordability of Liability Coverage in Florida* (May 2002).

[4]Florida Medical Association & Florida Hospital Association, *Access to Care Survey*, presentation, Dec. 20, 2002.

types of patients; difficulty in getting new partners; with a large percentage considering the departure from the practice of medicine. Chapter 4, *id.* 110-111.

Another survey conducted by Floridians for Quality Affordable Healthcare[5] revealed similar results among reporting doctors in Palm Beach, Dade and Broward counties in October and November, 2002 with some doctors reporting "going bare" meaning practicing without insurance and others reporting doing increasingly more defensive procedures. The survey was assailed by the Academy of Florida Trial Lawyers for using a flawed methodology.[6] While agreeing that the survey had a lack of responses and there would be a continuing need for more data on the problem, the Task Force assigned credibility to the survey finding that the responses to be in accord with other evidence in their investigation.

During the investigation, the Task Force considered closed claims data as a means of explanation to the crisis it had found in Florida. Florida Hospital Association retained Milliman USA, Inc. to provide a quantitative analysis of the healthcare professional liability insurance problem and possible solutions. A similar study was provided by the Florida Academy of Trial Lawyers. The study was done by Dr. Lance deHaven-Smith. In order to assist the Task Force in its review of the studies, the Task Force had its staff perform its own analysis of each of the reports.

As should be expected, the studies differ in their results. The analysis done by the Task Force staff noted a number of differing methodologies used in arriving at conclusions reached by

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[5]RCH Healthcare Advisors, LLC, Floridians for Quality Affordable Healthcare, *Summary of Results. Physician Professional Liability Survey*

[6]James T. Kitchens, Ph.D., *Analysis of Reports by RCH Healthcare Advisors* (Jan. 2003)

the studies. The deHaven-Smith study found that "the annual payout amount after adjusting for inflation has not escalated over the decade" which was 1991 -2001. The staff analysis found his conclusion to be reasonable based upon "*....the statistics and the adjustments that he performed and the information he furnished the Task Force....*". (emphasis not in text) Chapter 4,pgs.132-133. A second major finding was that payout amounts are quite rational and predictable. That finding by the study appears to be based, in part, on a statistically significant correlation between payout for economic losses and payout for noneconomic losses. The staff analysis refutes deHaven-Smith's finding of predictability to be unreasonable and a finding that payout amounts depend on injury severity. *id.* pgs. 134-135.

A staff analysis of Milliman study reveals similarities in percentage increases in closed claims amounts when based on the same data base, FLDOI, as used by deHaven-Smith. The Milliman study concludes that noneconomic damages account for approximately 77 per cent of loss payments made by hospitals in Florida. *id.* pgs. 134-135 They constituted 72 per cent for physicians who practice in Florida. The deHaven-Smith did not perform this type analysis so no comparison could be made. *id.* p. 135.

The Case for Caps on Nonecomic Damages

Chapter 8, Task Force report sets forth its findings, conclusions, and recommendations as to the issue of caps on noneconomic damages. In doing so, the Task Force relied upon the testimony and submissions documented in chapters 3 and 4 of their report. *id.*, 211. A summary of their findings as they relate to the crisis in medical malpractice awards follows on pages 211-213. Significant among their findings is that set forth above, 77 per cent of medical malpractice losses in Florida are nonecnomic damages. They noted that there is no exact standard for measure

of such noneconomic damages and therefore, there is no limit to the amount a jury may award. Excessive awards have had a profound effect on the way parties to a malpractice action and their attorneys as well view the claim. Plaintiffs' attorneys overvalue their claims and refuse reasonable offers to settle. Defendant insurers may pay more that the claim is worth to avoid the possibility of a large verdict of noneconomic damages. The Task Force seemed particularly impressed by a verdict award of $78.5 million within the state, in an Orlando medical malpractice case. The nonecnomic damages were found to be $78 million.[7] *Id.* 191

The Task Force was extremely impressed in the manner in which the State of California had dealt with a medical malpractice crisis in 1975. See full discussion, *id.*, 193-198. The California legislature responded by the enactment of the Medical Injury Compensation Reform Act of 1975. Of significance was the enactment of a cap on noneconomic damages in the amount of $250,000. The full benefits of the Act were not achieved until the constitutionality was upheld by the Supreme Court of California. *Fein v. Permanente Medical Group,* 695 P 2.2d 665 (Cal. 1985), appeal dismissed, 475 U.S. 892 (1985).

Among other facts upon which the Task Force based its conclusions were two studies done by William G. Hamm[8]. Dr. Hamm, Ph.D., of LECG, Inc. found that the cap on noneconomic damages had lowered medical malpractice premiums, which, in turn had lowered healthcare costs and increased access to healthcare for all Californians The studies pointed out another 21 benefits

[7]Cited from Orlando Sentinel news article, March 14, 2002.

[8]William G. Hamm, Californians Allied for Patient Protection, *An Analysis of Harvey Rosenfield"s Report: California's MICRA* (May 1997); William G. Hamm, Californians Allied for Patient Protection, *How the MICRA Cap Influences Health Care Costs For Safety Net Providers and Medi-Cal (July 1999).*

derived by California citizens. *id.*, 194-196. Dr. Hamm concluded that the state's Medi-Cal program (comparable to Florida's Medicaid program) would face large cost increases along with the costs of total defense payments if the cap were eliminated or raised *id.*, 197. The Task Force found that the California reforms, including a cap on noneconomic damages reduced medical liability premium rates by 40 per cent over 1976 levels. The average premium dropped from $23,698 in 1976 to $14,107 in 2001.. (Numbers adjusted for inflation) California's premium rate had increased by less than 3 per cent per year. *id.*, 197 (citations omitted)

The Task Force found that Florida's medical malpractice rate and rate increase trends are substantially higher that nationwide rates. Physicians are abandoning their practices and hospitals are reducing or eliminating services. As a result, "the access of Florida residents, and visitors is being threatened."

The Legislative Function

Having considered the evidence upon the which the Task Force based its findings, the Court turns now to the legislative effort in enacting the legislation now challenged.

On July 14th and July 15th, 2003, hearings were conducted by the Florida Senate Committee on Judiciary on the issue of what to do about medical malpractice in the state. The Task Force Report had been in the legislature's possession since January of that year. It is unknown what use, if any, was made of the report.

The witnesses took the sworn testimony of officials of state government; it also heard from representatives of "stakeholders", a term used Task Force to designate those who favored or opposed the reforms that were discussed during the investigation; attorneys, on both sides of the issues including the president of the Florida Bar and the counsel for the Task Force. The

Committee on Judiciary also received 1600 sworn statements from physicians, who practiced in every area of medicine describing their own crisis which they attributed primarily to high premiums for malpractice insurance.

Steve Roddenberry, Deputy Director, Office of Insurance Regulation answered questions relating to the manner in which rates for medical malpractice are approved or denied by his office. When asked about the number of new companies coming into Florida his answer was that there were no new insurance companies coming into the state within the last two years. Committee on Judiciary Meeting, July 14, 2003, p.7 The Committee inquired as to closed claims, reserves and how reserves are identified by Mr Roddenbery's office; and frivolous law suits.

Dianne Orcutt, Deputy Director of Medical Quality Assurance for the Department of Health testified that at that time there were 38,000 active licenses in the department files. She stated that the actual number fluctuates from day to day. but that there were more licenses at that time than there were five years before..*id.*, 32,33. There is no requirement to notify the department when a physician retires or leaves the state.. *id.*,34. Ms. Orcutts' testimony regarding the number of physicians licensed in the state was expanded upon by the testimony of William Wells Large,, General Counsel for the Florida of Health and Executive Director for the Governor's Task Force on Healthcare Professional Liability Insurance. Mr. Large testified that it can't be said that more doctors are coming the Florida based on the numbers given by Ms. Orcutt. He explains that Florida has 46,000 licensed physicians but only 38,000 have a Florida address.. The numbers don't indicate how many of that number of physicians still admit patients to the hospital or whether they may be cutting back on certain procedures and eliminating high risk patients. Committee on Judiciary meeting July 15, 2003, p 314,323.

Elizabeth Dudek, Deputy Secretary for Health Quality Assurance at the Agency of Health Care Administration, testified that "....over the last several years....11 facilities have received exemptions to not provide certain emergency services." Neurosurgery was terminated in 5 facilities; orthopedic surgery in 3 facilities; otolaryngology in 4; plastic surgery in 4; ophthalmology in four; maxillofacial surgery in 2; thoracic surgery in1; gastroenterology in 1; gynecology in 1; pediatrics in 2; urological surgery in 1; cardiology in 1; and, pulmonary medicine in 1. Committee on Judiciary Meeting , July 14; 2003. p. 38.

The next witness was Robert White , President of First Professional Insurance Company. Inquiry was made regarding First Professional's relationship to the Florida Medical Association. Mr. White was asked if his company paid lobbyists to appear before the legislature in behalf of Florida Medical Association or pay to send advertising to the public regarding members of the legislature to which he answered in the negative. *id.*, p. 49. He testified that his company had paid Florida Medical Association $500,000 annually for the three years he had been President as an endorsement fee with possibility of an additional $3 million in the prior five year period. In consideration, the association recommended his company to doctors when inquiries were made concerning an insurance company. *id.*,p. 71-72.

Mr. White testified that the company had written no new business in Florida for the period May, 2002, until February, 2003. The company was attempting to maintain the same policyholder count as it had at the beginning of 2003 in order to maintain financial integrity. He stated that the company could not meet the demands on his company for, to do so, would place the company outside its capacity that it could write and still maintain its financial integrity. *id.*, p. 50.

Mr. White lay the blame on the crisis in the insurance rates to the lack of a cap on

noneconomic damages and to bad faith litigation. He believes that a $250,000 cap on noneconomic damages would provide more "predictable losses". *id.*, p.50, 85 When asked about the amount of the cap, he insisted that the $250,000 cap would help all doctors, even the 65 percent of doctors in Florida who are covered by $250,000 policies, who would receive no benefit from a higher cap such as one of $500.000 or more. *id.*, p.51. At the time, $250,000 coverage cost $65 or $70,000. *id.*, p.74 Mr. White supplemented his testimony by affidavit dated July 15, 2003. He reported that " ....the mature (5th year of practice) base rate of premium for a physician practicing in the specialty of obstetrics and gynecology in Dade County, Florida with a coverage limit of $250,000/$750,000 is $119.181.); and, that (Direct medical malpractice paid losses in Florida ....in .....2002 .... is....indemnity $44,823,1134 and allocated loss adjustment expense $24,375 954.)

As to bad faith litigation, Mr. White did not believe that Florida has a frivolous lawsuit problem, In his opinion, that problem was corrected by the 1988 legislation which addressed tort reform. According to him, the company pays non-meritorious law suits for concern about the bad faith provision of the law. *id.*, p.58,65,79, 85-86,94-95.

Jeff Scott, General Counsel for the Florida Medical Association testified generally about the association and its relationship to insurance companies and his knowledge of the malpractice problems. He was followed by the testimony of Sandra Mortham, CEO of Florida Medical Association. Ms. Mortham acknowledged that FMA was paid an endorsement fee by First Professional Insurance Company and noted that she had recently verified that similar associations in 30 other states endorsed insurance carriers which paid the association an endorsement fee. *id.*,119. She was questioned about the number of physicians leaving Florida. She was unable to

recite precise numbers but testified thar she was able to identify 300 doctors who had left the state. She explained that the each physician has an average patient load of 5000 each year. *id.*, 125-129. Ms. Mortham supplemented her testimony by affidavit on July 17, 2008 reflecting facts that further explain the inexact numbers of physicians who have left the state. .

Miles McGrane, President of the Florida Bar at the time of the hearing, was unable to furnish information on the malpractice problem confronting the legislature. One of the legislature's considerations, aside from tort reform, was physician discipline. He was able to respond to questions regarding attorney discipline.

Neil Ross, an attorney known and respected in the plaintiffs' bar, was examined extensively by the Committee. He testified that a cap of $250,000 on noneconomic damages would not be beneficial for either law firms that handle medical malpractice or for injured parties as well because of the economics of preparing the case for trial and for its trial. *id.*, 152-156. He denied that there was sufficient evidence to support the findings necessary to find the crisis which as that being considered. *id.*, 156-158. Mr. Roth expressed the opinion that "....the medical malpractice insurance fund that's in the Senate bill could solve the malpractice pricing problem. *id.*, 159 In addition, he testified as to the bad faith component of the proposed legislation *id.*, Committee on Judiciary meeting July 15,2003, 177-181,188-193, 198; expert witnesses, *id.*,183-188; arbitration, *id., 193-195.*

John M. Crump, a general surgeon with North Florida Surgeons, testified his group has 15 partners. He shares rotating with five of those partners at one hospital which is Baptist Hospital in Jacksonville. The other partners practice at different hospitals in the same city. His insurance policy is with Lloyds of London. Under that policy, the group is responsible for all defense costs

in case of a claim. The premium is $750,000 per year for $250,000 coverage for each incident. *id.*, 168. Prior to July 1st (presumably 2002), the groups insurance rate was $88,000 for $250,000 coverage. At that time, the rate went to $126,000 with a $25,000 deductible which the group found to be unaffordable. *id.* Dr. Crump testified that he had lost three partners because of the insurance crisis, one of which had never had a claim. He reported that there had been 39 claims made , 3 of which went trial in which the group prevailed and 17 which were settled favorably. He reported that the group had never lost a claim of the 20 which were closed. *Id.*, 170-173.

George Meros, an attorney represented the Florida College of Emergency Physicians, very aggressively, but not offensively, presented the case for his clients. *id.*, 234-285. His primary argument was that his clients work in an environment of making judgment decisions often with a patient that is unable to speak, is seriously injured, or near death, He questioned the ability of a jury to render a fair and reasonable verdict when the issue is whether the physician, who is now a defendant should have done something he failed to do when the exercise of his medical judgment based on his training and experienced , led him to the procedure he had followed. The practice of medicine is an imprecise science and judgment calls have to be made where there is no right nor wrong answer. *id.*, 242 Mr. Meros criticized some of the definitions used in jury instruction. He found the terms" reckless disregard to be meaningless and defined in the instruction as reckless negligence. *id.*, 251-252, 264. When asked about caps on noneconomic damages and amounts for a cap, he cited the California experience with $250,000. He justified his response by pointing out the California's 25 years of experience was unbeatable data. "....if there were a popular outcry about poor medical care, it would have been changed a long time ago" *id.*, 253. He stated that he agreed with " piercing the cap" on only egregious case, e.g., only when patient has suffered the

amputation of a wrong arm or leg or even more a physician operating while under the influence of alcohol. *id.*, 252-253, 262-263. He testified that, in seriously impaired patients, most of the compensation is actually economic damages, *id.*,262,267-270, because of the nature of the elements such as rehabilitation, out of pocket expenses, the cost of other services required as a result of the injury suffered, including future medical care and loss of income..

Mr. Meros also emphasized the fact of loss of specialists neurologists and obstreticians, who now decline to do back-up calls at emergency rooms, *and offered* 3 physicians who were in attendance and would testify if called. *id.*,279-283. The physicians were not called.

The next witness was Gerald Wester, representing five medical malpractice insurance companies in the state of Florida. Mr Wester previously served in a senior management position with the Florida Department of Insurance for thirteen years and, prior to his departure, he served as Deputy Insurance Commissioner for four years. His Testimony was directed to questions regarding bad faith legislation as applied to medical malpractice cases. *id.*, 287-291. He also addressed the need for HMO legislation to be included in proposed amendments to medical malpractice legislation in light of the new law on HMO liability with respect to how control should be defined .*id.*,291-295.297-299.

The testimony of one more witness should be examined; that of Williams Well Large, General Counsel for the Florida Department of Health, who served as Executive Director for the Governor's Task Force on Healthcare Professional Liability Insurance. Mr. Large explained how each member of the Task Force expressed reservation about a $250,000 cap as contained in the California legislation *id.*, 302-303, 334-338, 332-334, 338-339. He agreed that the Governor had recommended the amount to the group. He explained that he believed the determinative influence

was the testimony of First District Court of Appeal, Judge Robert Smith, Justice Grimes, and Barry Richard, an attorney. Judge Smith had heard the case of *Smith v. Department of Insurance* 507 So.2d 1080, the 1987, the case that struck down the $450,000 cap on noneconomic damages. The two prong test, established by *Kluger v. White*, 281 So.2d 1 (Fla. 1973) and the other Supreme Court cases following its application was discussed and explained by those witnesses as well other attorneys who had comments and arguments as well. *id.*,302-303. The Task Force was especially concerned about the second prong of the test, the alternative ground test. *id.*, 304

Regarding the amount of a proposed cap, in answer to a question, Mr. Large stated that the CPI index would be the sum of approximately $724,000 if compared to the 1975 amount of $250,000. *id.*,305.308-311. He was vigorously cross examined on the provision of setting an aggregate amount of $1,500,000. The Senate was concerned, in the light of *St. Mary's Hospital, Inc. v Phillipe, et. al.* 769 So.2d 961 (Fla. 2000), that the aggregate provision was not a per claimant provision as *St. Mary's* seems to direct *.id.,306-308,* He was asked about the number of physicians leaving the state and as to why. *id.*, 312-315; frivolous cases *id., 315-319;* whether there is a crisis *id., 319-324*; and, increase and number of claims. *id., 340-344.*

A survey of the activity of the House of Representatives revealed a report of Florida House Select Committee on Medical Liability Insurance, dated March,2003. The Select Committee consisted of nine members of the House appointed by House Speaker Johnnie Byrd. The Select Committee was charged with seeking potential solutions to the "rapidly escalating crisis" in the delivery of health care services for the people of the state. It held a series of meetings in Tallahassee and four hearings outside of the capital in Miami, Fort Lauderdale, Orlando ad Tampa. All hearings were taped and all materials were catalogued for review by the full House or other

interested bodies. The Select Committee also reviewed the ".....comprehensive" record of the Governor"s Select Task Force on Healthcare Professional Liability Insurance. See Executive Summary ps. 3-13, Report of House Select Committee on Medical Liability Insurance, March, 2003. In addition, it received hundreds of affidavits of emergency room physicians submitted by the Florida of Emergency Physicians, the Florida Hospital Association and NCH Healthcare System.

The Select Committee found that "the records of both the Governor's Task Force and the Select Committee are replete with anecdotal evidence of possible changes in behavior by medical practitioners, including institutional service provisions changes..." The report acknowledges a lack of information about specific cumulative changes in service availability or the direct impact on healthcare services due to a rise in premium costs for service providers. *id.*, 3,4. The Select Committee found ,however, that the record before the committee was clear that enough providers had discussed or taken the factors affecting availability of service as to "....raise serious concerns about the future of the delivery of services in many regions or specialties in Florida with reference to the hearings in four cities conducted by the committee. *id.*, p.5

A further examination of the actual report of the Select Committee, consisting of an additional 68 pages, reveals a thorough review and discussion of the four Supreme Court cases dealing with the constitutional issues of legislative change of past medical malpractice problems *id.*, 14-17[9].

The Select Committee report contains an analysis and discussion of various topics relating

[9]*Kluger v. White*, 281 So.2d 1 (Fla.1973); *Smith v. Department of Insurance*, 507 So.2d 1080 (Fla 1987); *University of Miami v. Echarte*, 618 So.2d 189 (Fla 1993), *St Mary's Hospital, Inc., v. Phillipe* 769 So.2d 961 (Fla. 2000)

to problems and solutions to the crisis, which it had found to exist in four categories of study. The four categories discussions are thorough, factual and informative, and are Medical Liability Insurance Historical Issues; Health Care Issues and Patient Safety and Options; Liability Issues; and, Insurance Issues.

As a required finding, the Select Committee considered proposed alternative methods of dealing with the crisis as required by *Kluger*.

> .....the Select Committee has had the cooperative and valuable assistance and input from an array of interested stakeholders and citizens. Each brought unique perspectives and differing toolboxes of solutions. ..... Prior state offers have, in retrospect, served as steps in a long process, applying a broad menu of options and prescriptions which have also been unknown in the degree of effectiveness at the time of passage. Just as there is no single cause of the crisis, so there is no single remedy. Prior programs enacted by the legislature should be viewed as partial solutions in a progression of options, each addressing specific remedies and each have varied levels of success or failure *id*,7

The most serious consideration was given to an implementation of the California initiative of a roll back of premiums and refunds for several insurance sectors. The method was ultimately rejected in consideration of the number of medical malpractice insurance companies which had stopped writing policies in the state as well as those which may leave the state if such roll backs should be utilized. Rate approval and review were noted as problems such as predatory pricing to gain market share only to fail to meet policy obligations, and other insurance reforms mentioned below which were incorporated into the legislation. It was noted that insurance companies are free to enter the market whereas healthcare providers are forced to choose between higher premium costs or going without coverage.

The section of the legislation dealing with tort reform is considered the most appropriate for the Court's consideration as dictated by the issues raised in this case It must not be thought that the Court considers the other reform measures issues to be unimportant--indeed they are. Each deals with a facet of what the Select Committee found to be issues the legislature should consider in providing relief in all troubled areas and not just on caps on noneconomic damages or any single remedy as stated in the report. Executive Summary, 8 .

THE COURT'S ANALYSIS

Having considered the evidence before the House and the Senate as found from a review of the Task Force report, the arguments made at hearing and in numerous memoranda and supplements, the Court finds that no further evidentiary hearing would assist the Court in its rulings. See *North Florida Health and Counseling Services, Inc v. State of Florida*, 866 So.2d 612, 627. This Court finds that there is substantial competent evidence below to perform what amounts to a *de novo* review of the legislative findings as required for appellate review of a trial court's findings. *id.* The right involved in the constitutional dispute is a fundamental right for which the standard employed is that of strict scrutiny with no presumption of validity. *id.*,625,626 It is well established that where a right of access to the courts to redress for a particular injury has been provided by statutory law predating the adoption of the Declaration if Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State pursuant to Fla. Stat. 2.01, the legislature is without power to abolish such a right without providing a reasonable alternative or is able to show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown. The seminal case is *Kluger v. White* 281 So.2d 1,4 (Fla. 1973).. The two pronged test set

forth by *Kluger* is mandatory as to both prongs. No matter how pressing the need to solve a public crisis found by the legislature, it must be found that no reasonable alternative method exists.

OVERPOWERING PUBLIC NECESSITY

The legislature made certain findings which preceded the substance of the legislation. Laws of Florida, Ch. 2003-416. In paragraphs numbered (11) through (14) the legislature clearly announced the findings of an overwhelming public necessity which is based upon findings made in paragraphs (1) through (10). In paragraph (15), the legislature finds that a cap on nonecnomic damages will substantially alleviate the high cost of medical malpractice insurance, and that there is no alternative measure of accomplishing that result without imposing even greater limits upon the ability of persons to recover damages for medical malpractice in (16). Paragraphs (17) and (18) announce the logical connection between the separate provisions of the legislation and the purpose of making quality health care available to citizens within the State and that each provision is necessary to alleviate the crisis relating to medical malpractice. *Kluger*, 4; *Smith Department of Insurance*, 507 So.2d 1080 1088 (Fla 1987); But see *dicta* in *University of Miami v. Echarte*, 618 So.2d 189 196,197 (Fla. 1993)

Plaintiff argues that the findings are not true findings of fact. Plaintiff relies upon statements made by several members of the Senate and statements contained in a summary to a report of the House Select Committee on Medical Liability Insurance dated March, 2003. The statements of the House members are found on page 12 of Plaintiff's Supplemental Memorandum on the Unconstitutionality Of Fla. Stat. 766.118. The statements generally are regarding the complexity of the issues of which there were found to be many; the amount of anecdotal evidence; the many points of view of opponents of the legislation; the impact of diminished physicians' fees

from government and private regulated reimbursements industries. and, a lack information available about specific cumulative totals of changes to service availability or the direct impact on health care services in Florida.

The Court considers that these and other similar problems were noted in the Executive Summary and that they were intended to demonstrate the difficulties and considerations in carrying out the Committees's charge. The statement was not intended to undermine the weight of the evidence upon which its findings are based. The reference to fees paid by Medicare and managed health programs on pages 4,5, of the Summary was made to illustrate that the relationship between rising insurance rates and fees paid is not as clear as a sole and primary cause. The practitioner may have to choose between receiving fees or paying his insurance premium.. Some practitioners elect to do neither, eliminate a specialty or high risk procedure, or retire. The Committee's effort was to attempt to solve both which is incorporated within the legislation by freezing rates until a standard of rate review is promulgated with additional reporting and other requirements placed upon the insurers. On page 5 of the Summary, it is stated that "While the quantity of practitioners terminating or reducing practices or the closing of specific hospital services cannot be calculated, using available data, it is clear from the record that enough providers have discussed or taken these actions to raise serious concerns about the future of service delivery in many regions or specialties in Florida." The Summary notes that from the hearings on two days in February, 2003, in four cities in Florida, the Committee's record was replete with references by healthcare providers "to the detrimental effect of either rising insurance costs or the cancellation of coverage in the current environment with the inability ....to secure adequate replacement coverage". Several examples of providers who testified regarding personal experience of loss of

practice or partners. Doctor William Barringer, a family practitioner had to retire prematurely due to " two malpractice cases .... settled by his insurer.... no ability to defend the cases.... settled to avoid litigation. ....With 20 years of patient history and over 100,000 visits he was forced to retire...." Doctor Charles Campbell, a surgeon, testified that, in his practice, 6 doctors had left the state, 2 retired early and one had transferred to Veterans Administration Hospital. He voiced deep concern that Florida is "losing quality doctors and 'the crisis is real'" Doctor Lipoff closed his practice when he received notice that his insurance would not be renewed. Doctor Bob Yelverton ceased giving mammography services after 25 years of claims free history due to potential liability exposure. Doctors Denise Baker, a surgeon and Doctor Douglas Sanders, a general practitioner, have either ceased to practice or have reduced the delivery of services. Doctor Barbara Sharpe expressed the view that there will be reduced or non-existent mammography services seriously affecting the access and availability of quality care. *id.*,5 Another example affecting a large segment of access and availability care is shown by the testimony of Doctor Michael Binder. a surgeon. He testified that he " had never had a malpractice case in all his years of practice" but that his insurance rates have increased 115% in the two years prior to his testimony. As a result, he has limited his practice to those patients who have full insurance coverage or those who are able to pay cash for his services. He no longer accepts or treats Medicare patients and has dropped his participation in managed care programs. *id.*6 Doctor George Banks, an obstetrician- gynecologist, testified that Pinellas County used to have 35 such practitioners and now has 13, with the prediction that there would be only 8-10 the following year. "He voiced a deep concern for the quality and availability of care"*id.*, 6. This Court agrees with an observation made the Summary of the report of the House Select Committee on Medical Liability Insurance:

> While the qualify of practitioners terminating or reducing practices or the closing of specific hospital services can not be specifically calculated, using current available data, it is clear from the record that enough providers have discussed or taken these actions to raise serious concerns about the future of service delivery in many regions or specialities in Florida. *id.*,5 The record of the public hearings conducted by the Select Committee on February 13th and 14th in 4 cities across the state is replete with references by healthcare providers to the detrimental impact of either rising insurance cost or the cancellation of coverage in the current environmental with the inability of service providers to secure adequate replacement coverage. *id.*,5

Turning to the statements made by made in the Senate hearings, as set forth in Plaintiff's argument, the Court finds that each of the individuals expressed concern about the lack of information available from state agencies. See: Plaintiffs' Supplemental Memorandum on the Unconstitutionality of Fla.. Stat. 766,118 (Caps on Noneconomic Damages) 13-18. With regard to the number of hospitals which have closed, Plaintiff argue that the hospitals that have closed are fifth or sixth hospitals of the same chain "in a given area", which was undefined. The same witness testified that, during the last several years, 11 hospitals had sought and obtained exemptions from certain procedures in emergency in their emergency rooms. The House had received hundreds of affidavits from emergency room physicians citing the impact on service in the hospitals which they served. The affidavits were sorted as to the affected counties in Florida.. A review of the 1600 affidavits provided the Senate Hearing on the judiciary cites many statements from practitioners who have curtailed services in the emergency rooms or had limited their services to hospital call in other ways. The testimony of George Meros, an attorney who represented the state emergency room physicians testified extensively as to the impact on insurance rates have had on their practice. Sworn testimony of George Meros, transcript of hearing, Hearing on Judiciary July 14, 2003, 279-283.

An argument raised by Plaintiffs is that the president of First Professionals Insurance Company in Florida testified that his company will succeed in Florida with or without tort reform and that there is no frivolous lawsuit problem in Florida. He also testified that his company had written no new coverage from May, 2002 until February, 2003, only months prior to his testimony. The company had starting writing again to keep the number of insureds at it what had been at the beginning of the year in order to maintain financial integrity. Robert White testimony, *Hearing on Judiciary*, July 14, 2003,5 He referred to frivolous lawsuits as non-meritorious claims and stated that such claims generally do not reach trial because they are settled without court action. He also testified that such claims are often settled for more than they are worth because a carrier fears bad faith or a run away jury. *id*, 58,65,79,85-86,94-95. Other witnesses testified similarly.

A last argument deserves comment: At least three Senators made specific mention on the floor of the Senate that the "findings" preceding the substance of Ch ,2003-416 were not really findings of fact that the Senate had discovered at all. This Court would have to agree that the Senate did little fact finding. Only two days of hearings were conducted by the Senate during which it heard from only one healthcare provider. It had received 1600 hundred affidavits from physicians around Florida which were not analyzed nor even referred to except for an announcement by the Chair that the affidavits had been received. Only four, or perhaps five, of the members of the committee ask questions at all during the hearings and it seemed obvious to the Court that they were attorneys who opposed the legislation. The Committee had adopted the report of the Governor's Select Task Force on Healthcare Professional Liability Insurance which contained the testimony of public hearings in 10 cities in Florida or the 4 days of public hearings in as many cities across the state. The Senate had adopted the findings supported by evidence that

the House Select Committee had conducted, including the hundreds of affidavits from emergency room physicians. All the evidence of the House was filed and presumably available to the Senate. If the Senate hearing members had examined all the evidence, it would have found sufficient facts to make the same findings as the House.

The Court is satisfied that a crisis of overwhelming public necessity crisis exists in the State of Florida for the reform measures contained in the legislation controlling the issues raised.

The question now before the Court is that of a compensating benefit to those deprived of full redress by the Court, and, if not, is there an alternative remedy which will be less burdensome than that proposed. The Task Force finds, after listing a number of benefits of the recommendations, that the plan as a whole constitutes sufficient benefit They cite *University of Miami vs. Echarte*, *supra,* as authority. The Court rejects that proposition and argument; that price is too heavy to bear and does not constitute a compensation. The Court finds that there is no compensatory benefit to the Plaintiffs who have lost the right affected by the legislation. Absent a compensation, the next question is; Was the evidence sufficient to make a finding that was. no less severe alternative which was reasonable ?

The Governor's Task Force considered roughly 100 proposals for an alternative method which would be acceptable. In addition the Select Committee of the House had considered a number of alternatives which were urged. Primary among them was the question of a roll back in rates as adopted by California in the same act of reform that established California's cap of $250,000 on noneconomic damages in medical malpractice cases. The argument was made that, indeed, the roll back on rates was the responsible factor in the success of that state's malpractice reform. The Task Force rejected the argument finding that the evidence cited above (Governor's

Task Force, 197 and citations) was convincing that the most significant factor was the $250,000 cap. The reform enacted by Florida which is under consideration froze rates until an effective date for rate determination by a newly imposed prescribed method could be established. Fla Stat. 627.062 The Task Force determined that, if adopted, roll back in rates would risk forcing one or more of the remaining four remaining of the nine insurance companies to flee the state. Five companies left the state during the period 2001- 2002. The Task Force determined that it was imperative that the state not lose additional carriers..

Other proposals were considered; some were incorporated into recommendations-some were not. Physician discipline and physician reporting were enacted together with insurance reporting requirements. new standards for insurance renewal rate review; creation of a self insurance entity, and others. Some of the proposals were to extinguish the right to jury trial or limiting the jurors to specialists only.

CONCLUSION

The standard of review utilized by the Court has been that of strict scrutiny which demands facts which would support a legislative finding. The Court believes that the review similar, if not identical, to an appellate review of an issue of possible judicial discretion as exercised by a trial judge. That is a *de novo* review in which after an appellate court reviews fact in the evidence and/or and if it is found that, from that review, it can be determined that reasonable men could differ over the issue, than the trial 's decision would be upheld.

> Discretion, in this sense, is abused when the judicial action is Arbitrary, fanciful, or unreasonable, which is another way of saying that discretion is abused only where no reasonable man would take the view adopted by the trial court. If reasonable men could differ as to the propriety of the action taken by the

trial court, then it cannot be said that the trial court abused its discretion. *Canakaris vs. Canakaris* 382 So.2d 1197, 1203

In reaching the conclusion below, the Court believes that no useful purpose would have been served by conducting an evidentiary hearing. Each of the parties would undoubtedly produce as many witnesses as the Court would allow. They would be stakeholder witnesses and expert witnesses from each side of the issue. No scenario of testimony could change the unalterable positions taken in this highly emotional dispute.

This Court finds that there was sufficient evidence for the Task Force to make a finding that no less severe alternative existed. The Task Force found "....and concludes that, without the inclusion of a cap on potential awards of non-economic damages in the package, no legislative reform plan can be successful in achieving a goal of controlling increases in healthcare costs and thereby promoting access to healthcare. Task Force report, 218. From an intensive review of the evidence and arguments, this Court is in agreement.

THE AGGREGATED DAMAGES ISSUE

Plaintiffs have challenged the validity of Fla.Stat. 766.118(3)(b)2(d) which limits noneconomic damages for all claimants to from all nonpractioners to the amount of $1,000,000. The jury awarded the claimant injured by the negligence $300,000 in past noneconomic damages and $2,000,000 for future noneconomic damages. for a total of $2,300,000. By applying the limits for noneconomic damages, this claimant would receive $1,500,000 for noneconomic damages pursuant to Fla. Stat. 766.118(3)(b). The husband, the second claimant, was awarded the amount of $1,000,000 for past noneconomic damages and $1,500,000 for future noneconomic damages. By applying the limitations of Fla. Stat. 766.118(3)(a) the husband would receive the amount of

$750,000.

The issue now before the Court is to examine the provisions of 766.118(3)(b)(d) in ligt of the equal protection argument and the holding of *St. Mary's Hospital vs. Phillipe*, 769 So.2d 961 (Fla. 2000). The facts of *St. Mary's* are dissimilar to the facts of this case as is the action which was a medical malpractice case brought under Fla. Stat. 766.207, the Voluntary Arbitration statute. That under 766.207(7)(b) contained a limiting provision of $250,000 per incident. The Supreme Court distinguished the holding of *Echarte, supra,* and held that each claimants damages are to evaluated separately and that any cap applies to each claimant individually. *St. Mary's*, 972

The issue classifications has not been raised however, it is an important consideration. In a class of claimants all must be treated equally. Fla. Stat.766.202(1) defines claimants as any person who has a cause of action based upon personal injury or wrongful death arising from medical negligence. As applied to the plaintiffs in this case they are both claimants. Each is entitled to an award of $750,000 as such. A further distinction is made between claimants however by 766.118(3)(b)1,2, and 3 by which the claimant (patient) who has been injured may receive up to $1,500.000 if certain other requirement relating to the severity of the injury are found by the evidence.

Based upon the foregoing analysis, the Court finds that as applied to the facts of this case, the injured claimant (patient), should receive the amount of $1,500,000 as and for her nonoeconomic damages. The claimant, husband should receive $750,000 for his noneconomic damages. The husband's award is based on the denial of equal protection as found in *St. Mary's'*, 972, and so is not valid on the facts of this case It may well be valid as to different facts with multiple claimants and differing amounts awarded. The Court further finds that such finding does

no harm to the goal and intent of the legislature's reform policy as set forth in this section of the legislation.

The court further finds without comment that other grounds; access to the courts, due process, trial by jury, separation of powers and Amendment 3 are without merit. It is therefore

ORDERED AND ADJUDGED:

1. Plaintiffs' Motion to Strike Fla. Stat. 766.118 is granted as it applies to Fla. Stat. 766.118(3)(b)(d).

2. Plaintiffs' Motion To Strike Fla. Stat. 766.118 as to all sections is denied.

DONE AND ORDERED this 17th day of October, 2003 in chambers at Jacksonville, Duval County, Florida.

JAMES L. HARRISON
SENIOR CIRCUIT JUDGE

cc; Counsel of Record