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

Mary I. Coombs

University of Miami School of Law, mcoombs@law.miami.edu

Follow this and additional works at: https://repository.law.miami.edu/fac_articles

Recommended Citation

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

Mary Coombs

INTRODUCTION

Malpractice reform has been a subject of scholarly attention and efforts to reform the law for at least thirty years. While there have been efforts to put malpractice reform on the federal legislative agenda, none have succeeded. Significant changes have occurred, how-

† With thanks to Patrick Gudridge, Lili Levi, 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 Library. 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.

1 “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) (citations omitted).

2 H.R. 229, 104th Cong. § 7 (1995); H.R. 1091, 105th Cong. § 204 (1997);
ever, at the state level. The vast majority of this change occurred through legislative action, typically in the form of bills seeking to institute various changes in the malpractice system. Some legislation, following the model of California’s Medical Injury Compensation Reform Act (“MICRA”), focused on 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, patients. Other statutes expanded their focus to deal directly with the malpractice insurance industry, or to reduce the level of patient-harming behavior by enhancing physician discipline or supporting the patient safety movement.

Some reform, however, has occurred through the citizen initiative. While they are sometimes in the form of a more wide-ranging,
How Not to Do Medical Malpractice Reform

In addition to the Florida initiatives discussed herein, voters in five other states faced initiatives dealing with malpractice issues in the years between 2000 and 2006:

<table>
<thead>
<tr>
<th>Year</th>
<th>State</th>
<th>Kind</th>
<th>Number</th>
<th>Subject</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>Texas</td>
<td>Constitutional</td>
<td>Proposition 12</td>
<td>Noneconomic damage limit</td>
<td>Pass</td>
</tr>
<tr>
<td>2004</td>
<td>Nevada</td>
<td>Statutory</td>
<td>Question 3</td>
<td>Limit Contingency Fees, plaintiff recovery</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>Nevada</td>
<td>Constitutional</td>
<td>Question 4</td>
<td>Control Insurance Rates</td>
<td>Fail</td>
</tr>
<tr>
<td></td>
<td>Nevada</td>
<td>Constitutional</td>
<td>Question 5</td>
<td>Penalize lawyers for frivolous suits</td>
<td>Fail</td>
</tr>
<tr>
<td></td>
<td>Oregon</td>
<td>Constitutional</td>
<td>Measure 35</td>
<td>Noneconomic damage limit</td>
<td>Fail</td>
</tr>
<tr>
<td></td>
<td>Wyoming</td>
<td>Constitutional</td>
<td>Amendment C</td>
<td>Mandatory pre-suit panel review or arbitration</td>
<td>Pass</td>
</tr>
<tr>
<td></td>
<td>Wyoming</td>
<td>Constitutional</td>
<td>Amendment D</td>
<td>Authorize limits for noneconomic damages</td>
<td>Fail</td>
</tr>
<tr>
<td>2005</td>
<td>Washington</td>
<td>Statutory</td>
<td>Initiative Measure Number 330</td>
<td>Noneconomic damage limit; Contingency Fee Limit; Shorter stat. limitations</td>
<td>Fail</td>
</tr>
<tr>
<td>2005</td>
<td>Washington</td>
<td>Statutory</td>
<td>Initiative Measure Number 336</td>
<td>Malpractice ins. reg; License revocation; Limit number of expert witnesses</td>
<td>Fail</td>
</tr>
</tbody>
</table>

legislative-like approach, initiatives are designed by the particular entities that put them on the ballot. Most are thus very narrow, designed for specific purposes, and they are not subject to legislative reformulation. In this paper, I present a detailed case study of one such malpractice reform by initiative.

In Florida in 2004, three constitutional initiatives dealing with malpractice reform were on the ballot. Amendment Three severely restricted attorney 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 to have committed an act of malpractice three times. All passed easily. Two of these amendments have been largely undermined by subsequent events which, in effect, returned the situation to something close to the status quo ante. The direct impact of those two initiatives on the law surrounding malpractice and malpractice litigation is thus likely to be minimal. Amendment Seven, however, was re-affirmed in a 2008 decision. The Florida Supreme Court gave full effect to Amendment Seven, significantly changing prior Florida law.

We can learn something about the process by which malpractice reform occurs through 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.


8 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. For example, statutory initiatives in California may not be amended or repealed except by another initiative. Cal. Const. art. II § 10(c). In contrast, Washington has a provision for initiatives to the legislature, in which the legislature may counter with its own proposal. The electorate then has the opportunity to choose which becomes law., WASH. CONST. art. II, sec. 1. See generally Kristen L. Fraser Method, Procedure, Means, and Manner: Washington's Law of Law-making. 39 GONZ. L.REV. 447, 454-56 (2003/04).

HOW NOT TO DO MEDICAL MALPRACTICE REFORM

In Part One, I describe the Florida story: the 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 Two, 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. Last, I provide a brief conclusion.

I. THE FLORIDA STORY

A. The Initiative Process

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 physicians and trial lawyers used the initiative system 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 in the early part of the twentieth century, when the legislature was seen as captive to special interests. The forces behind initiatives were a confluence of populists, working to advance the interests of farmers and workers, and progressives, who sought a means to combat corruption. In contrast, Florida added the citizen initiative during the 1968 revision of its constitution. Although the drafters adopted a well-established tool of governance, they adopted a rather unusual variant of it. They seem to have been responding to a quite different problem, the perception that prior constitutions had been "larded with special interest amendments." Thus the goal was to add a variety of means to amend the constitution, including the citizen initiative. There is no evidence the drafters considered a provision for statutory initiatives.

---

11 Evans v. Firestone, 457 So. 2d 1351, 1358 (Fla. 1984) (McDonald, J., concurring).
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 a sufficient number of voters’ signatures.\(^\text{14}\) The initiative is placed on the ballot at the next regularly scheduled election, and becomes law if it receives a sufficient affirmative vote.\(^\text{15}\)

There are three aspects of Florida’s initiative process that make it unusual. Each seems related to the fact that initiatives are only available to amend the constitution. First, the Florida Supreme Court reviews proposed initiatives before they are placed on the ballot. Once the proponents obtain ten percent of the required signatures and notify the Secretary of State, they may request that the Secretary of State submit the amendment to the Attorney General, who then petitions the Supreme Court for an advisory opinion.\(^\text{16}\) Both proponents and opponents of the amendment may brief and argue to the court.\(^\text{17}\) The advisory opinion issued by the Florida Supreme Court addresses two issues: whether the petition satisfies the Constitutional single subject requirement,\(^\text{18}\) and whether the ballot title and summary are clear and unambiguous.\(^\text{19}\) This procedure avoids, in most cases, the particular

\(^{13}\) See TALBOT D’ALEMBERTE, THE FLORIDA STATE CONSTITUTION: A REFERENCE GUIDE 147-48 (1991) (stating that “the possibility that constitutional initiative can be used for statutory initiative” has not been addressed). As D’Alemberte notes, the citizenry can in effect force the legislature to act by placing in the constitution a provision that states some specific provisions shall be binding “until changed by law.” Id. at 148. see FLA. CONSTIT. art II, § 8 (i) (the ethics in government provision, added by initiative in 1976).

\(^{14}\) 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. FLA. CONSTIT. art. XI § 3. See Div. of Elections, Fla. Dep’t of State, Initiative Procedures, http://election.dos.state.fl.us/initiatives/init.shtml (last visited Feb. 11, 2008), for the processes for qualifying a proposed amendment in Florida.

\(^{15}\) In 2006, legislatively-proposed Amendment 3 passed, raising the required vote from a simple majority to sixty percent. See FLA. CONSTIT. art. XI, § 5.

\(^{16}\) FLA. STAT. § 15.21, § 16.061 In any event, this review must occur before the initiative is placed on the ballot.

\(^{17}\) FLA. CONSTIT. art. IV, § 10; Art. V, § 3(b)(10).

\(^{18}\) FLA. CONSTIT. art. XI, § 3.

\(^{19}\) See FLA. STAT. ANN. § 101.161 (West Supp. 2008), for these requirements. See generally Advisory Opinion to the Att’y Gen. Re The Medical Liability Claimant’s Compensation Amendment, 880 So. 2d 675, 676 (Fla. 2004) (setting out the scope of review for these issues). Some critics have noted that there is no provision
counter-majoritarian difficulty inherent when a court rejects a proposal already approved by the majority of the voting citizens.\footnote{20}

Second, while many states' laws indicate that initiatives must deal with only a single subject, the Florida Supreme Court has taken this requirement very seriously.\footnote{21} It has provided several rationales for this close review. First, because initiatives are constitutional, it is seen as important "to insulate Florida's organic law from precipitous and cataclysmic change."\footnote{22} Second, since citizen initiatives lack opportunity for the kind of debate or 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."\footnote{23} Finally, reflecting the nature of the proposal as both citizen initiative and, if adopted, constitutional text, the initiative should not "substantially alter or perform the functions of multiple branches" of government,\footnote{24} or affect multiple sections of the constitution in a way that is not clear to the electorate.\footnote{25}

Legal 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., \textit{The Operation and Jurisdiction of the Supreme Court of Florida}, 29 NOVA L. REV. 431, 491 (2005).

\footnote{20} 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. \textit{See} Patrick O. Gudridge, Complexity and Contradiction in Florida Constitutional Law and cases discussed therein (manuscript on file with author).

\footnote{21} "[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, \textit{Florida Constitutional Theory (For Clifford Alloway)}, 48 U. MIAMI L. REV. 809, 816 (1994).

\footnote{22} \textit{In re Advisory Opinion to Attorney General - Save Our Everglades Trust Fund}, 636 So. 2d 1336, 1339 (Fla.1994).

\footnote{23} 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. \textit{See} Peter Schrag, \textit{Paradise Lost: California's Experience, America's Future} 217-18 (1998).

\footnote{24} \textit{In re Advisory Opinion to Attorney General-Save Our Everglades}, \textit{supra} note 22 (italics in original).

\footnote{25} \textit{Fine}, 448 So. 2d at 989. For a subtle and incisive analysis of the Florida single-subject rule requirement, see Gudridge \textit{supra} note 21, at 893-901 (concluding
scholars have disputed the desirability of both the current procedures for judicial review, and the jurisprudence the Supreme Court has applied in these cases. The pre-election procedure seems particularly useful given the intense scrutiny Florida courts use when deciding if the proposed change comports with the single subject rule. The assurance that the proposal is clear may also serve as a partial substitute for the provision that many other states have for a voter pamphlet. These pamphlets provide each voter, well before the election date, a relatively neutral description of each proposed initiative, sometimes together with summary arguments of proponents and opponents.

B. The 2004 Initiative Battle

Understanding the 2004 initiative battle requires a bit of historical context. The Florida Medical Association leadership's 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, particularly acute in Florida, Governor Bush convened a Task Force in 2002, which held hearings around the state, invited expert testimony, and produced a report proposing a number of reforms. The one it presented as most likely to ameliorate the perceived problem was a $250,000 "hard" cap on non-damages. The Governor pressed the legislature to enact these

---

26 See Jameson & Hosack, supra note 12, at 453-56.
27 Cf. FLA. STAT. ANN. § 101.171 (West Supp. 2008) (indicating that Florida only has the obligation to ensure that copies of constitutional amendments are posted or available in booklet form at polling places on the day of election).
28 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 M I A M I L. REV. 1285,1287 (2004)
30 See id. 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."). The Task Force explicitly modeled its cap on non-economic damages after a parallel provision in California's Medical Injury Compensation Reform Act of 1975. Id. at 193. The report set out sixty different recommendations, under these five headings: healthcare quality, physician discipline, tort compensation, alternative dispute resolution, and insurance code reform. Id. at v-xvi. The presentation of the hard cap as
reforms, both in the regular session, and in four special session he called to deal specifically with malpractice reform. While the House was an eager ally, the Senate was recalcitrant. The general perception was that the trial lawyers had more influence in the Senate, while the health care industry was the dominant influence in the House and the Governor's mansion. The legislature finally passed a bill, but it reflected the conflicting agendas of the different stakeholders. The most disappointing feature to the doctors and hospitals was the liability cap: it was $500,000 for physicians and $750,000 for hospitals, and 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), (transcript at 2) (referring to University of Miami v. Echarte, 618 So. 2d 189, 196 (1993) holding that a limit on malpractice litigation passed in response to an earlier crisis was constitutional under this test).

Oddly, although the malpractice insurers and FMA fought hard for this proposal, both in the task force process 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. Interview with Bob White, President, FPIC Ins. Group, Inc., in Jacksonville Fla. (Dec. 15, 2006) (transcript at 1, on file with author). Cf. Kathryn Zeiler, et al., Physicians' Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990-2003, 36 J. OF LEGAL STUDIES 59 (2007) (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).

See Horenkamp, supra note 28, at 1290.

See, e.g., Interview with the professional leadership of the Academy of Florida Trial Lawyers in Tallahassee, Fla., (Dec. 4, 2006) [hereinafter AFTL interview] (transcript, 3 on file with author); Interview with Dr. Carl Lentz, the President of the FMA in 2004-05 in Daytona Beach, Fla. (Dec. 14, 2006) (transcript at 2 on file with author) (claiming that "it was pretty obvious that [the recalcitrant Republican Senators] had had some dealings with a trial lawyer . . . and some threats").

See 2003 Fla. Laws ch. 416 (passing a 94-page statute that 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; requiring that patients receive information relevant to patient safety by ordering the Department of Health to create a practitioner profile, which was to include records of malpractice actions, and have it publicly accessible; and including provisions on 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, of the Florida Defense Lawyers Association in Miami, Fla. (Nov. 30 2006) (transcript at 2).
these limits were subject both to doubling in some specified circumstances and to a judicial override in others.\(^3\)

The leaders of the Florida Medical Association ("FMA"), both the professional staff and the incoming and outgoing elected leaders, were unwilling to accept this result. At the annual FMA convention, only days after the end of the last special session of the Florida legislature, those leaders decided it was time for war. The new President of the FMA, 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."\(^3\) The FMA planned to 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 sought a cap on attorney's contingency fees in malpractice actions.\(^3\) The shift from damage caps to fee caps has been explained in different ways. Some suggested that attorney fee caps were 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.\(^3\) Others suggested that a cap on damages would be less attractive to voters, and thus less likely to pass.\(^3\) Finally, the FMA, after consulting with the

---

34 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."

35 Interview with Dr. Carl Lentz, supra note 32, (transcript at 3).

36 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." Fla. Const., art I § 26.

37 See, e.g., Interview with Gail Parenti, supra note 33, (transcript at 4); Interview with Sandra Mortham, Jeff Scott and John Knight, the professional leadership of the Florida Medical Association in Tallahassee, Fla. (Dec. 4, 2007) [hereinafter FMA interview] (transcript 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, but its constitutionality was never determined because at the time it was challenged as unconstitutional, the court adopted the same schedule as a court rule for all personal injury actions. See Fla. Bar re Amendment to the Code of Prof'l Responsibility (Contingent Fees), 494 So. 2d 960, 961-62 (Fla. 1986).

38 Interview with Dr. Carl Lentz, supra note 32, (transcript at 4) (noting that arguments over the amount of a damage cap are complicated and the contingency fee cap "sells better to the public").
head of the largest malpractice insurer in Florida, concluded 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.  

The trial lawyers were already prepared for the possibility of such
a battle. In 1988 the physicians had placed a constitutional amend-
ment imposing a $250,000 hard cap on non-economic damages on the
ballot. The trial lawyers expended millions of dollars in order to de-
feat the proposal. After the fight ended, the leadership of the Acad-
emy of Florida Trial Lawyers (the “Academy”) vowed that they
would never again be the only ones at risk in an election. They chose
to create a stockpile of weapons, and had drafted, tested and redrafted
a number of possible initiatives, which were ready for use. The
Academy described this strategy as “a policy similar to the mutual
assured destruction policy” between the US and the USSR; the pri-

39 Interview with Bob White, supra note 30, transcript at 2-3; Interview
with Dr. Carl Lentz, supra note 32, transcript at 4; Interview with Mark Delegal,
lobbyist for insurers, in Tallahassee, Fla. (Dec. 4, 2006) (transcript at 3) (the attorney
fee cap will “take the fuel away from the engine” of malpractice litigation); FMA
interview, supra note 37, transcript at 2.

40 AFTL interview, supra note 32, transcript at 3. Amendment 10, entitled
“Limitation of Non-Economic Damages in Civil Actions,” lost; 56.6% votes against it
and 43.4% votes for it. See Div. of Elections, Fla. Dep’t of State, Initiatives/Amendments/Revisions, http://election.dos.state.fl.us/initiatives/initiativelist.asp
(last visited Feb. 11, 2008) (query “Year: 1988” and “Status: 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, General Counsel, Fla. Hosp. Ass’n, in Tallahas-
see, Fla. Dec. 4 2006 (transcript at 2). The unattractiveness of the constitutional
amendment route may have been influenced by the hostile response of the AFTL.
AFTL interview, supra note 32, transcript at 2.

41 The Academy has since changed its name to the Florida Justice Associa-
tion. http://www.floridajusticeassociation.org/aboutAFL.asp (last visited Oct, 22,
2008). In this article I continue to use the name of the organization at the relevant
time.

42 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.” Interview with Dr. Carl Lentz, supra note 32, transcript at 5.

43 These were designed to threaten the interests of those, such as the insur-
ance industry and the business community, who might ally with physicians and hospi-
tals and provide funding for anti-trial lawyer proposals. AFTL interview, supra note 32,
transcript at 2-3. This strategy was not unique to the organized trial bar in Flor-
da. Trial lawyers in California similarly “employed a counter proposition strategy” to
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).

44 AFTL interview, supra note 32, transcript at 2.
mary goal was not to have the proposals enacted, but to use them as a threat to dissuade others from pressing for initiatives the trial lawyers saw as attacks. The potential weapons at this time included initiatives more closely regulating insurance rates, imposing an obligation on health care providers to charge no patient more than the lowest rate they charged Medicaid and health insurance plans, 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."

Using the proposals as threats, the Academy leadership tried to persuade the FMA not to go forward, but were rebuffed. The Academy also took their arguments to a variety of other stakeholders: Associated Industries of Florida, the Florida Chamber of Commerce, the Florida Association of Health Plans and the Florida Insurance Council. 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. The FMA, however, refused their entreat-


46 See id. (query “Year: 2008” and “Status: Active”), for Floridians for Patient Protection’s “Physician Shall Charge the Same Fee for the Same Health Care Service to Every Patient,” which is still listed as “active” in 2010.

47 See id. (query “Year: 2004” and “Status: Passed”), for the outcomes and full text of each amendment.

48 Interview with Carl Lentz, supra note 32, (transcript at 5-6). AFTL tried unsuccessfully to negotiate with physicians outside FMA through county and specialty medical societies. AFTL interview, supra note 32, (transcript at 5).

49 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. Interview with Bill Bell, supra note 40, (transcript at 2-3).

50 See Letter from Associated Industries, Florida Chamber of Commerce, Florida Insurance Council and Florida Association of Health Plans to Florida Medical Association (Nov. 19, 2003) (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. Interview with Bob White supra note 30, (transcript at 4). Delegal, the FPIC lobbyist, describes the proposed amendment as “bullets and guns pointing at our heads”, Interview with Mark Delegal, supra note 39, (transcript 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 guts to move forward on our proposal,” John Knight, FMA interview, supra note 37, (transcript at 2).
The Academy 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. In return, the Academy agreed not to go forward with any proposal other than Amendments Seven and Eight.

The battle between trial lawyers and doctors was now joined. The Florida Supreme Court approved all three proposals in its pre-election review. All the proposals obtained the necessary signatures. The

Letter from Florida Medical Association to Associated Industries, Florida Chamber of Commerce, Florida Insurance Council and Florida Association of Health Plans (Nov. 24, 2003) (on file with author). See generally interview with Dr. Carl Lentz, supra note 32, (transcript at 5). Delegal described the negotiations between coalition members and FMA as involving "shouting matches" and reported a comment by Lentz that "these lawyers are terrorists and they need to be treated like terrorists and we don’t negotiate with terrorists." Interview with Mark Delegal, supra note 39.

Associated Industries also sent a letter to each physician in Florida urging them not to support the amendment. Letter to Florida physicians from Associated Industries (Jan. 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 37, (transcript at 4).

As they described it the other proposals remain available as bullets for another day. AFTL interview, supra note 32, (transcript at 5-6).

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. Advisory Opinion to the Att’y Gen. re The Medical Liability Claimant’s Compensation Amendment, 880 So. 2d 675, 682 (Fla. 2004). 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 “impede[e] a citizen’s access to the courts and that citizen’s right and ability to secure representation for a redress of injuries"” Id. at 683. The Court unanimously concluded that Amendment Seven 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 Att’y Gen. re Patients’ Right to Know About Adverse Medical Incidents, 880 So. 2d 617 622 (Fla. 2004). Finally, the Court majority found no defect in Amendment Eight, despite arguments that it was misleading. Advisory Opinion to the Att’y Gen. re Pub. Prot. from Repeated Med. Malpractice, 880 So. 2d 667, 673-74 (Fla. 2004). In dissent, Justice Bell contended that the summary was misleading by stating that “[c]urrent law allows medical doctors who have committed repeated malpractice to [remain licensed].” Id. at 674-75. While Justice Bell argued that this could suggest that there was no mechanism under current law to revoke licenses in such situations, id. at 675,
FMA proudly pointed out that they had obtained most of their signatures by having doctors keep petitions in their offices where they urged patients to sign them. The election campaign was quite expensive. One public interest organization estimated the total spending exceeded $8.5 million by the proponents of Amendment Three, and $25 million by its opponents.

Almost all the efforts by both sides focused on Amendment Three, because polling indicated strong voter support for Amendments Seven and Eight. The editorials in the state's major newspapers were overwhelmingly negative towards all three amendments. It made no difference to the voters. The polling was accurate and Seven and Eight both passed easily. 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. The proponents' story line was clear and easy

the majority concluded that the amendment, as suggested by the summary, would impose a stricter limitation than under current law. Id. at 672 (majority opinion).

FMA interview, supra note 37, (transcript at 13) ("we did not do what the trial bar did which was go out and buy them all"). Its 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 the FMA. AFTL interview, supra note 32, (transcript at 6).

This data is calculated from a Ballot Initiative Strategy Center's report. See DANIEL SMITH, BALLOT INITIATIVE STRATEGY CTR., MONEY TALKS: BALLOT INITIATIVE SPENDING IN 2004 at 8 (2006), available at http://www.ballot.org/ (search for "Money Talks"); then follow the "Money Talks: The 2004 Buyer's Guide" hyperlink). 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 efforts to avoid the election campaign. AFTL interview, supra note 32, (transcript at 6).

"No one fought for 7 & 8; ... it just passed," Interview with Mark Delegal, supra note 39, (transcript 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. Interview with Dr. Carl Lentz, supra note 32, (transcript at 6).

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). Interview with William Large, supra note 30, (transcript at 5).

Amendment Seven received 81.2% of the votes and Amendment Eight received 71.2%. See Div. of Elections, supra note 40 (query: "Year: 2004" and "Status: Passed").

See id. (passing with a 63.6% vote). Ironically, the legislatively proposed super-majority initiative itself obtained only 57.8% of the vote. See id. (query "Year:
to understand: You, the plaintiff, were injured. You, the plaintiff, not your greedy lawyer, should receive the lion’s share of the damages.61 The counter-arguments are more complex, in part because they require focusing the voter’s attention not simply on what the amendment said, but on the real-world consequences of enacting it.62

So, on November 2, 2004, three new provisions became part of 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,63 had they taken effect in precisely the way their proponents intended (and, presumably, as the voters might have assumed they would). Two of them certainly will not; the third may do so, but it is still too early to make an entirely accurate assessment. We now separate our story into three strands, looking at the post-enactment story of each of the amendments.

C. Amendment Three

Even before Amendment Three passed and became Art. I, Section 26 of the Florida Constitution, the Academy, representing the trial lawyers, considered how it might be interpreted to do the least damage to their interests.64 The conclusion many of them seemingly reached

61 That story line “sells pretty easily,” Interview with Dr. Carl Lentz, supra note 32, (transcript at 4). See also FMA interview, supra note 37, (transcript 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.”)

62 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 37, (transcript 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 ‘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.” Interview with Gail Parenti, supra note 33, (transcript at 6).

63 These questions are considered in Section III, infra.

64 In addition to the technique described in the 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 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 32, (transcript at 9). In their briefs to the Supreme Court during the post-Amendment Three struggle, trial lawyers had suggested that it would trump any subrogation or hospital lien claims insofar as they would reduce what the plaintiff re-
was that this constitutional right of clients, like other constitutional rights, such as the right to a jury trial, could be waived.\textsuperscript{65} Trial lawyers proceeded to ask new clients, in at least some cases, to do so and thus to agree to a higher fee, though still within the fee limits set by the ethics rules of the Florida Bar.\textsuperscript{66} The proponents of Amendment Three were, to put it mildly, not happy.\textsuperscript{67} To some extent, they were trapped by their own political choices. The caps on attorneys' contingency fees in other states are drafted as a limit on how much attorneys may charge their clients.\textsuperscript{68} In contrast, Article I, § 26 is written in

\begin{footnotesize}
\begin{itemize}
\item[66]{Under the Florida rules of 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. \textit{Rules Regulating the Fla. Bar R. 4-1.5(f)(4)(B)(ii)} (2008), available at http://www.floridabar.org/DIVCOM/PI/WebNodes.nsf/Nodes/D4775989DE9COC8A852565FEF005FD840. 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. \textit{Id}.}
\item[67]{Bob White of FPIC 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. Interview with Bob White, \textit{supra} note 30, (transcript 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. Letter from Associated Industries of Florida, Florida Insurance Council, Florida Chamber of Commerce, and Florida Association of Health Plans to Florida Medical Association, \textit{supra} note 50, 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. Interview with William Large, \textit{supra} note 30, (transcript at 7). See also FMA interview, \textit{supra} note 37, (transcript at 7). Cf. \textsc{Elisabeth R. Gerber, et al.}, \textit{Stealing the Initiative: How State Government Responds to Direct Democracy} 13 (2001) (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”).}
\end{itemize}
\end{footnotesize}
terms of the percentage of the recovery that "the claimant is entitled to receive." The possibility of waiver is built into the language 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 FMA 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. The Court referred the issue to the Florida Bar to study it and report back. The Bar in turn created a Special Committee which held hearings and drafted a proposed rule, which the Bar approved. 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 procedures described in the rule, and the waiver must track a form included therein.

After an additional comment period, the Florida Supreme Court issued an opinion in which it adopted the Bar's proposed rule with

---

69 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. Comments and Objections To Proposed Amendment to Rule 4-1.5(f)(4)(B) of the Trial Lawyer Section of the Florida Bar, at 5 (Submitted to Supreme Court of Florida in connection with Case No. SC05-1150).


71 Notice of Filing at 1, In re Amendments to the Rules Regulating the Fla. Bar – Rule 4-1.5(f)(4)(B) of the Rules of Prof'l Conduct, 939 So. 2d 1032 (Fla. 2006) (No. SC05-1150). The Court references this filing in its final opinion of the matter. 939 So. 2d at 1037.

72 Notice of Filing, supra note 71, at 1-2, Exhibit C (providing text of the proposed rule).

73 During both the stage after the initial petition was filed and after the Bar filed its proposed rule, the Supreme Court received hundreds of comments. See 939 So. 2d 1032, 1037 n. 2.
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 direct benefit of a medical malpractice claimant," and that such a right, like other fundamental constitutional rights could be waived. The Court then rejected the arguments that a judicial hearing was required for the contract to be effective; they deemed it sufficient that clients know they could request such a hearing if they wished.

The ultimate result of Amendment Three and the corresponding ethics rule is unclear. 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

---

74 Id. at 1037, 1039.
75 Id. 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, 1039. The broader interests asserted by opponents 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. See Comments of American Medical Ass'n and Mississippi State Medical Ass'n in Support of the Petition at 7-8, In re Amendment to the Rules Regulating the Fla. Bar—Rule 4-1.5(f)(4)(B) of the Rules of Prof'l Conduct, 939 So. 2d 1032 (Fla. 2006) (No. SC05-1150).
76 939 So. 2d at 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 reviews under the prior rule are ex parte and thus "in effect, a form over substance requirement." Id. at 1040 n.4 (quoting Notice of Filing, supra note 71, at 4). See Gary Blankenship, Med Mal Fee Waiver Procedures Argued, FLA. B. NEWS, July 1, 2006, http://www.floridabar.org/DIVCOM/JN/JNNews01.nsf/Articles?OpenView&Start=4 4.15&Count=30&Expand=444#44 (describing the oral arguments). 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. See id. 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 id.
77 See 939 So. 2d at 1040. Since the client is always free not to agree to a waiver and the attorney is always free not to agree to represent the client absent a waiver, a non-mandatory pre-contractual judicial review is a rather meaningless gesture.
the case at the constitutionally set fee limit. On the other hand, the head of FPIC, the largest malpractice insurer in Florida, and the executive leadership of the FMA claim that the amendment continues to have the effect its proponents sought. They say that some lawyers have withdrawn from the field, moving out of Florida, or shifting their practice away from medical malpractice. 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.

Footnotes:
78 Interview with Lincoln Connolly, Plaintiffs’ Attorney, in Miami, Fla. (Dec. 18, 2006) (transcript at 12 on file with author) (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 32 (transcript 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. Interview with Mark Delegal, supra note 39, (transcript at 7).
79 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 37, (transcript at 7). See also Interview with Bob White, supra note 30, (transcript at 5). Large said that “ethical lawyers” will not seek waivers. Interview with William Large, supra note 30, (transcript 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 members to have patients sign a waiver stating that they will not sue their doctor for more than $250,000 in noneconomic damages.” Jordana Mishory, Medmal Plaintiffs Can Waive Fee Caps, DAILY BUSINESS REVIEW A1, A16 (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, e.g., 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. Dist. Ct.App. 1991). Presumably the FMA would argue that there are no strong public policy needs to ensure access to the essential service of a malpractice attorney.
80 Interview with Mark Delegal, supra note 39, (transcript at 7) (some lawyers moved a medical malpractice practice to Georgia).
81 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. Interview with Lincoln Connolly, supra note 78, (transcript at 6). Another pointed to the non-economic damage caps, FLA. STAT. ANN. § 766.118 (West Supp. 2008), and the near-elimination of the bad faith claims against insurance companies, § 766.1185, which 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 section 768.81 as more significant impediments. Telephone conversation with Scott McMillen in Miami, Fl. (March 15 2007). The 2003 legislation also tightened
D. Amendment Eight

Amendment Eight, which became Art. X, Section 26, of the constitution, has been referred to as “Three Strikes and You’re Out.”82 As written, it would seem to require that a physician’s license be revoked on the occurrence of the third 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.83

Bills were quickly pre-filed for the 2005 session of the Florida legislature to “fix” the problems with Amendment Eight.84 With relative ease, a bill doing just that passed.85 Under the statute, a number
of limits were included on what could count as a strike for purposes of Art X, Section 26. First, the act of alleged malpractice must have occurred after Nov. 2, 2004. Second, no matter how many claims were brought, one act, or series of related acts, could never count for more than one strike. Third, and most important, the legislature determined that Amendment Eight was not meant to change the constitutional right of doctors to be sanctioned by the State only under a clear and convincing evidence standard. Thus, if there were a finding by a court or arbitration panel based on 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. Only if the Board concluded that the evidence clearly and convincingly demonstrated malpractice would there be a strike. 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.

new section 456.50. See 2005 Fla. Laws ch. 266.


87 § 456.50(1)(d) (defining "incident").

88 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 ..

89 See § 456.50(2). The relevant amended administrative rules went into effect on January 3, 2007. E-mail from Ed Tellechea, Legal Counsel, Bd. of Med., to Mary Coombs, Professor of Law, Univ. of Miami Sch. of Law (Apr. 2, 2007, 10:31 EST) (on file with Health Matrix) (the Board itself reviews the transcripts in cases that arise under this provision. As of the date of the e-mail, only one case had come before the board in which there was discipline constituting a strike. Id.

90 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
E. Amendment Seven

The meaning of Amendment Seven, the “Patient’s Right to Know” proposal, which became Article X, Section 25 of the Constitution, was very much in contention until the recent Florida Supreme Court decision in Florida Hospital Wateman v Buster, and is still not entirely clear. 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. It would seem to 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, 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 provided 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, “[t]he 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, supra note 32 (transcript at 13).

91 984 So. 2d 478 (2008)

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, 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.
and the amendment was largely described to the public as providing exactly that.\(^9\) In fact, the provision has overwhelmingly been used in the context of malpractice lawsuits or, rarely, investigative journalism.\(^4\) Almost as soon as the election results were in, lawyers for the Florida Hospital Association sought an injunction prohibiting enforcement of Amendment Seven.\(^5\) Meanwhile, trial lawyers with pending malpractice cases cited Amendment Seven in requests for various documents related to peer review of adverse incidents involving the defendants.\(^6\) 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 should be construed so as not to abrogate existing statutes protecting peer review from discovery and admissibility. The earliest reported court decisions ruled for the physicians and hospitals.\(^7\)

\(^{93}\) "[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., Interview with Lincoln Connolly, supra note 78, (transcript 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 is 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 in Miami, Fla. (March, 30 2007). 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." Interview with Bill Bell, supra note 40, (transcript at 9).

\(^{95}\) FHA v. Fla. Agency for Healthcare Admin. and Fla. Dep't 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).


\(^{97}\) See Bridgman v. Health Mgmt. Assocs., Inc., No. 51-04-CA-59-ES, 2005 WL 900630 (Fla. Cir. Ct. Jan. 14, 2005) (holding that Amendment Seven does not conflict with the federal constitution or federal law, but is not self-executing); Richardson v. Nash, 2005 WL 408132 (Fla. Cir. Ct. Jan. 18 2005)(amendment intended to change existing law, but not self-executing, not retroactive); Rusiecki, 2005 WL 408133 at *7 (holding that the amendment is neither retroactive, nor self-
Meanwhile, organizations of hospitals and physicians sought protection from the Florida legislature. In the 2005 session, the legislature "implemented" Article X Section 26. 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 documents relating to adverse incidents which occurred after passage of Amendment Seven. 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. Patient-requesters were only entitled to records of an incident involving the same condition, treatment or diagnosis as their own. Finally, the statute reiterated that any information a pa-

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, No. 052003CA054153, 2005 WL 900744, at **4-5 (Fla. Cir. Ct. Feb. 28, 2005).


99 Like the legislation on Amendment 8, the bill passed overwhelmingly, 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." Interview with David Simmons, supra note 98, (transcript 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) (2007) (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 See § 381.028(3)(j).

102 § 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 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 Gary Blankenship, House Works on Med Mal Amendment Implementation, FLA. B. NEWS, Apr 1, 2005 at 20, available at
Litigation continued. Three cases that came down while the legislation was under consideration took three different approaches. *Michota v. Bayfront Medical Center* held that Amendment Seven was intended to provide access to documents that had been protected under existing law. It also concluded that the provision was self-executing, but not retroactive, and therefore granted the plaintiff’s motion to compel only insofar as it sought documents created after Nov. 2, 2004. *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. *Brown v. Graham* held that Amendment Seven was not self-executing, and not retroactive, and thus granted the motion for a protective order. It also held that courts should read Amendment Seven narrowly, so as not to interfere with the operation of existing laws that provide confidentiality to various records, and the processes that created them, and that protect them from discovery or admissibility; particularly in light of the significant public policy behind these laws. In its discussion of whether Amendment Seven was self-executing, the Brown court 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.”

http://www.floridabar.org/DIVCOM/JN/JNNews01.nsf/Articles?OpenView&Start=86.1&Count=30&Expand=86#86 (then-Representative Jeff Kottkamp (now Lieutenant Governor) is quoted as saying this provision was “limiting the constitution with a statute and I’m not really convinced that is permissible.”)

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, focusing on the date of the reports requested rather than the date of the incident that was the subject of the report.


107 No. 501999CA007754, 2005 WL 900722, at *4-6 (Fla. Cir. Ct. Mar. 18, 2005).

108 *Id.* at *3-4.

109 *Id.* at *5.
After this legislation passed, litigation also focused on 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 by the Legislature to restrict constitutional rights? Again courts took somewhat different positions on these issues. *Notami Hospital of Florida, Inc. v. Bowen* held that the constitutional provision was self-executing, and that the statute that purported to implement it instead conflicted with it. The court noted that the statute "drastically limits discovery of records the amendment expressly states are discoverable, and limits the ‘patients’ qualified to access those records," and was thus unconstitutional. Finally, the court ruled that Amendment Seven was intended to be retrospective as to existing records.

*Florida Hospital Waterman v. Buster* agreed only in part with the *Notami* court’s analysis. The intermediate appellate court in *Florida Waterman* determined that the Amendment “preempts the statutory privileges” of peer review insofar as it allows such records to be discovered in litigation. 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, finding support for its conclusion in the Supreme Court’s advisory opinion.

---

110. The implementing legislation in regard to both Amendments Seven and Eight was signed into law by the governor on June 20, 2005. Melissa Morgan Hawkins, *Amendments 7 and 8 Update: Legislation Enabling the Patients’ Right to Know Act and Three Strikes Rule*, TRIAL ADVOC. Q., Spring 2006, at 7.

111. 927 So. 2d 139, 144 (Fla. Dist. Ct. App. 2006) (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 to effectively nullify the will of the people), aff’d sub nom. *Fla. Hosp. Waterman, Inc. v. Buster*, Nos. SC06-688, SC06-912, 2008 WL 596700 (Fla. Mar. 6, 2008). Later that year, the 4th District Court of Appeals, in *North Broward Hospital District v. Kroll*, 940 So. 2d 1281 (Fla. Dist. Ct. App. 2006) followed *Notami* and rejected *Florida Waterman*.

112. *Notami*, 927 So. 2d at 142-43.

113. *Id.*

114. *Id.* at 144-45 (relying on the language allowing access to “any record relating to any adverse incident” and extending the right to patients who had received treatment prior to the date of enactment).


116. *Id.* 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.

117. *Id.* at 353. The statute was also unnecessary, since the court found that the amendment was self executing. *Id.* At 355.

118. *Id.* 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 in-
ever, Florida Waterman, in contrast to Notami, held that the Amendment was not intended to be retroactive, and that retroactive application would be constitutionally impermissible.

The Florida Supreme Court granted review on May 5, 2006. There were three issues before it: whether Amendment Seven preempts existing statutory privileges for peer review, whether it is self-executing, and if it should be applied retroactively. The importance of these issues to the trial bar and hospitals and physicians organizations was demonstrated in part by the number of amicus briefs.

The Florida Supreme Court's decision, issued on March 6, 2008, was an almost complete triumph for the plaintiffs. It first concluded that the Amendment is self-executing. It provides a "sufficiently vestigations, proceedings, and records of the peer review panel from discovery. . . Indeed, this is a primary purpose of the amendment." Advisory Opinion to the Att'y Gen. re Patients' Right to Know About Adverse Med. Incidents, 880 So. 2d 617, 620-21 (Fla. 2004).

Id. 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.

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

Fla. Hosp. Waterman, Inc. v. Buster, 926 So. 2d 1269 (Fla. 2006). Apparently, the opinion from the Fifth District Court of Appeals 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. See Wellner v. E. Pasco Med. Ctr., Inc., No. 2D05-2079, 2007 WL 866003, at *2 (Fla. Dist. Ct App. Mar. 23, 2007) at 2. The briefs all refer to Florida Waterman. See, e.g., id. Apparently Kroll settled, since the Supreme Court opinion refers only to Florida Waterman and Notami Hospital. Florida Hospital Waterman, v. Buster, 984 So. 2d 478, 478 (Fl. 2008)

Id. 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, Florida Hospital Waterman, Inc. v. Buster, No. SC06-688 (July 5, 2006), 2006 WL 2302682.

Amicus briefs were filed by the Florida Hospital Association, the Florida Defense Lawyers Association, the Academy of Florida Trial Lawyers, and Floridians for Patient Protection. See Fla. Hosp. Waterman, Inc., v. Buster, Nos. SC06-688, SC06-912, 2008 WL 596700 (Fla. Mar. 6, 2008), for downloadable versions of most amicus briefs (follow "Briefs and Other Related Documents" hyperlink). 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 32, (transcript at 14).

cient rule” for courts to follow.125 Furthermore, it held, the amendment’s “language makes evident that it was intended to effect an immediate change in the law governing access to medical records without the need for legislative action,”126 and that a contrary decision could frustrate the will of the people.127

The Court then examined the question of whether the Amendment authorized access to records in existence on the date it took effect and whether it could validly do so.128 It stressed that “the amendment was intended to provide immediate access to existing records.”129 It then held that the statutory provisions protecting these records did not create a substantive, vested right.130

Finally, the Court found that numerous provisions of the statute conflicted with the Amendment and were thus invalid.131 While the Court did not invalidate the entire statute, the portions left standing were of far less substantive significance.132

If the Florida Supreme Court had concurred with the arguments of the defendants, then Amendment Seven would have changed little in Florida law. However, the justices construed the constitutional provision broadly and found key provisions of the statute unconstitutional. This suggests that reports of the results of most peer review activities--reports that had once been kept confidential--will now apparently be open to public view.133

---

125 984 So. 2d at 485, quoting Gray v Bryant, 125 So. 2d 846, 851 (Fla. 1960). As it noted later, the legislature was free to act, as long as the purpose of any statute was “to give force and effect to [the Amendment’s] provisions.” Id. At 492
126 984 So. 2d at 486.
127 Ibid., citing Gray v Bryant, 125 So. 2d 846, 852 (Fla. 1960)
128 984 So. 2d. at 486-87.
129 984 So. 2d at 487.
130 984 So. 2d at 490-92. The court noted that the precise content of these privileges had changed over time and was never absolute. “[A]t most, medical providers received an expectancy that legislative policy favored only limited access and use of [certain] records.” Id. At 491. Justice Lewis dissented from this portion of the majority opinion. 984 So. 2d at 494
131 984 So. 2d at 493-94 (finding unconstitutional provisions limiting discovery a) to final reports, b) to reports dealing with a same or similar condition as suffered by requesting patients, c) to records of a facility or provider of which requestors are patients and d) to records generated after November 2, 2004, and indicating that e) existing privilege statutes are unchanged, and f) existing laws regarding discoverability and admissibility into evidence of records are unchanged.
132 984 So. 2d at 493 (finding unproblematic the definitional section, and provisions identifying who is responsible for identifying relevant medical records and limiting the allowable fees for production of such records.
133 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.
F. The Current Florida Malpractice Landscape

In total, it is unlikely that much direct benefit or harm will come from Amendments' Three or Eight. There is almost certainly no risk to 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 Seven, given the Florida Supreme Court's ruling, may be significant but it is too early to assess. 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.1 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.135

One reason for this lack of focused attention to malpractice recently may be that malpractice claims experience substantially improved since 2004 from the perspective of health care practitioners, hospitals and their insurers.136 The number of claims has fallen.137 The

Note however, that federal law may provide substantial protections for peer review, regardless of the outcome of Florida Waterman. See text at note 207, FLA. ST. ANN. § 768.81 (West 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 proponents to focus on this bill despite knowing that the trial lawyers would be working to defeat it. Interview with Mark Delegal, supra note 39, (transcript at 5).

Interview with William Large, supra note 30, (transcript at 8); see also Interview with Robert Wychulis, CEO of Florida Association of Health Plans, Tallahassee, Fla. (Dec. 5, 2006) (transcript at 8) ("I don't believe any of those constitutional amendments were implemented in a way in which they were intended by the parties").

See Brian Bandell, Study: Hospital Malpractice Losses Down 10%, S. FLA BUS. J., Oct. 25 2006, http://southflorida.bizjournals.com/southflorida/stories/2006/10/23/dailyl5.htm (discussing report from Aon Consulting that shows the number of claims against hospitals fell 26% over the course of five years).

The number of claims against hospitals fell 26% over five years. Id. "Newly reported claims and incidents were down 29% for 2004" at FPIC. quoted by
The frequency of claims per physician has fallen. The severity of claim per physician has fallen, or been flat. According to a report from the Commissioner of the Florida Office of Insurance Regulation, incurred losses and the pure loss ratio dropped steeply from 2002-2005, while the number of practitioners who were forced into the joint underwriting residual market declined as eighteen new companies entered the market. As a result, malpractice insurance rates are declining or flattening. While malpractice insurance rates around the country also declined during this period, the rates in Florida declined less than the Florida Insurance Consumer Advocate suggested was appropriate given the declines in insurance companies’ loss ratios. While there is no consensus, and no reliable research-based

138 The number of claims per physician declined from 13.6% in 2001 to 10.7% in 2005. Bandell, supra note 136.
139 Severity of a claim per physician was $135,000 in 2003, whereas in 2004 and 2005 it was $108,000. Id. 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 HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMIN., NATIONAL PRACTITIONER DATA BANK, 2005 ANNUAL REPORT TABLE 13 AT 70.
140 The 2007 report is available at http://www.floir.com/DataReports/DataReports.htm#Pro%20and%20Cas%20-%20Reports
141 Id. at Figures at pp. 4 & 6. Each flattened during 2006.
142 Id. at 3.
evidence explaining this change,\textsuperscript{145} the change itself erodes pressure 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 seriously to revisit the issue until those reforms prove inadequate in the eyes of at least some major stakeholders.\textsuperscript{146}

II. THE IMPACT OF FLORIDA’S INITIATIVES

The effects of the malpractice amendments and of the process leading up to them on the legal landscape, and the political will necessary to engage these issues is a complex question, one beyond the scope of this story. However, it is worth considering the particular measures as voters passed them, as examples of malpractice reforms. This story might help us think about how -- 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 imposed by most law reviews with nothing but a single footnote citing the literature on this question. To say that we cannot agree on the “good” does not mean, however, that we cannot agree on what constitutes the “bad.” As I hope to demonstrate below, each of these reforms, as adopted, was likely to make matters worse for patients, the ultimate touchstone for malpractice and for health care reform generally.

\textsuperscript{145} 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.” Bandell, \textit{supra} note 136. The Insurance Commissioner’s Report references both the legislative reform and the constitutional amendments without attempting to parse out chains of causality. \textit{See} 2006 \textit{ANNUAL REPORT, supra} note 143. Arguably, Florida’s malpractice insurance rates simply mirror a national trend. \textit{See id.} at 1 (stating that the fifteen insurance firms comprising 80% of Florida’s medical malpractice market also experienced comparable loss and expense ratios in other major markets across the country).

\textsuperscript{146} However, if scholars are correct that a key indicator of increasing malpractice rates is the insurance cycle, driven by declines in market returns, another malpractice crisis may be looming. \textit{See}, e.g., Paul C. Weiler, Reforming Medical Malpractice in a Radically Moderate – and Ethical Fashion, \textit{54 DePaul Law Rev.} 205, 209-11)(2005).
Each of the reforms seems to suffer from the problems one would expect given their origins. Amendment Three was modeled on caps on attorney fees that were part of the law elsewhere, beginning with California’s MICRA in 1975. By 2006, a substantial minority of states had adopted such caps. No other state except Delaware, however, had set the cap as low as that in Amendment Three.

Some scholars have argued 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. There has

---

147 See 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 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 Dwyer, supra note 68, at 615-17 & nn. 20-25 (asserting 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). Dwyer even includes Oregon, which applies its cap only to punitive damages in medical malpractice cases, and Indiana, which applies only when the state’s patient’s compensation fund represents the defendant. Id. at 616 n.22.

149 See DEL. CODE ANN. tit.18 § 6865 (1999) (limiting attorneys’ fees to 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.

<table>
<thead>
<tr>
<th>Total Recovery</th>
<th>$250,000</th>
<th>$500,000</th>
<th>$1,000,000</th>
<th>$3,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Att'y Fee: Calif</td>
<td>$74,200</td>
<td>$136,700</td>
<td>$221,700</td>
<td>$521,700</td>
</tr>
<tr>
<td>Att'y Fee: Florida</td>
<td>$75,000</td>
<td>$100,000</td>
<td>$150,000</td>
<td>$450,000</td>
</tr>
</tbody>
</table>

also been heated debate over whether contingency fees are excessive.\textsuperscript{152}

The move to cap attorney contingency fees in malpractice cases evokes many of the same arguments. The proponents of fee caps, in Florida as elsewhere, indicated that their goal was to reduce the number of claims, particularly "frivolous" claims\textsuperscript{153} and thus the financial impact on physicians.\textsuperscript{154} One can certainly argue that reducing the

\textsuperscript{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 generally Lester Brickman, \textit{The Market for Contingent 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, \textit{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 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 begin to compete with them, since barriers to entry within the legal profession are low. See, e.g., Alexander Tabarrok and Eric Helland, \textit{Two Cheers for Contingent Fees} (AEI Press 2005). 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, \textit{supra} note 32, (transcript 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. \textit{Patricia M. Danzon, New Evidence on the Frequency and Severity of Medical Malpractice Claims} (Rand Corporation 1986); Patricia M. Danzon & Lee A. Lillard, \textit{Settlement Out of Court: The Disposition of Medical Malpractice Claims}, 12 J. LEG. STUDIES 345 (1983).

\textsuperscript{153} See, e.g., Comments of American Medical Ass'n & Mississippi State Medical Ass'n in Support of Petition at 6, \textit{In re Amendment to the Rules Regulating the Fla. Bar} Rule 4-1.5(f)(4)(B) of the Rules of Prof'l Conduct, 939 So. 2d 1032 (Fla. 2006) (No. SC05-1150) (asserting that Amendment Three "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 \textit{Tom Baker, The Medical Malpractice Myth} 83-85 (2005).

\textsuperscript{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. Olson, \textit{supra} note 151, at 49 (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,
HEALTH MATRIX

volume of claims, and thus lowering malpractice insurance rates, re-
dounds 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, rather
than a more random subset of existing claims, both weak and clearly
valid ones.

One study that focused specifically on contingent fees in malprac-
tice cases was triggered by Amendment Three itself. After the initia-
tive 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. Perhaps unsurprisingly, the
report concluded that caps on contingency fees were unwarranted,
though it did suggest some procedural reforms to empower clients to
negotiate with attorneys over fee arrangements. One point it rather
gleefully made, repeated to me by leaders of the AFTL, is that wit-
tesses before the Florida legislature who had claimed that frivolous
lawsuits drove the need for reform were unable to “cite a single ex-
ample of a frivolous lawsuit” when put under oath.

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).

statute of limitations and, in effect, a four year statute of repose except for claims by
minors for medical malpractice actions).

AMERICAN BAR ASSOCIATION TORT TRIAL & INSURANCE PRACTICE
SECTION, REPORT ON CONTINGENT FEES IN MEDICAL MALPRACTICE LITIGATION
(2004).

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.

Id. at 43-45.

AFTL interview, supra note 32, (transcript at 3).

AMERICAN BAR ASSOCIATION TORT TRIAL & INSURANCE PRACTICE
SECTION, supra note 157, at 21. 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 56 (Fla. 2003) [hereinafter Medical Malpractice
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 the lawyers of the cases that fail. 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 some cases, such as auto accident claims, seems particularly inapt for medical malpractice. Other 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 is costly because it requires extensive attorney time and hiring experts, both to evaluate the case and to prepare for trial. Assuming the plaintiff's attorney can make a reasonable prediction of the strength of a case, she is unlikely to take a weak one. 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 to which the contingency fee represents a risk premium. Critics of malpractice litigation argue that because such a high percentage of the cases 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 suggests that the malpractice attorney's hourly-equivalent income will be lower, all else being equal, than that of a lawyer bringing other kinds of personal injury cases.

\[\text{\textfootnote{Hearing [on file with author].}}\]

\[\text{\textsuperscript{162} Bernstein, supra note 151, at 10, citing Walter Olson.}\]

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

\[\text{\textsuperscript{164} "It can take tens to hundreds of thousands of dollars -- and sometimes more -- to prepare a complex medical malpractice action," Gary Blankenship, Dueling Amendments Pass, FLORIDA BAR NEWS, Nov. 15, 2004 http://goliath.ecnext.com/coms2/summary_0199-3445913_ITM (quoting Florida Bar President Kelly Overstreet Johnson). If the case is dropped without an indemnity payment or lost at trial, as a practical matter the plaintiff's attorney must absorb all these costs.}\]

\[\text{\textsuperscript{165} One attorney estimated that at his firm, "we probably don't take 90%-95% of the malpractice cases that come through our door." Interview with Lincoln Connolly, supra note 78, (transcript at 10).}\]

\[\text{\textsuperscript{166} Brickman's argument that contingency fees are too high because lawyers prevail in 70-90% of their cases is likely a false generalization. Contra Brickman, supra note 152, at 80. The argument is wildly false if applied to malpractice litigation.}\]
A contingency fee cap will deter attorneys from taking some cases that they otherwise would 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.\textsuperscript{167} But the cap will also deter attorneys from taking cases without enough damages. Even without state-imposed caps on contingent fees, a very large percentage of instances of actual malpractice never lead to a lawsuit.\textsuperscript{168} Many of these are situations where the harm to the plaintiff is insufficient to be worth the attorney's time, even where liability could be proven relatively easily.\textsuperscript{169} As suggested in the table in footnote 150, a cap will, definitionally, raise the floor of predicted recovery 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.\textsuperscript{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.\textsuperscript{171} Contingency fee caps are an inefficient way of reducing the extent of frivolous claims, and the more stringent the cap, the more harm it does in limiting valid claims relative to the benefit of deterring frivolous ones.

\textsuperscript{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, \textit{supra} note 81.

\textsuperscript{168} \textit{Paul C. Weiler, Medical Malpractice on Trial} (1991).

\textsuperscript{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.

\textsuperscript{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.

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 adequate discipline.\textsuperscript{172} It is difficult to know how effective Florida's Board of Medicine is, either absolutely or in comparison to other states, at the task of discovering which doctors fail to do their work properly and then imposing appropriate sanctions.\textsuperscript{173} The Board of Medicine reported that there were 276 disciplinary proceedings in the 2005-06 fiscal year.\textsuperscript{174} The Federation of State Medical Boards Annual Report for 2005 showed that there were 872 prejudicial actions in Florida, against 815 physicians.\textsuperscript{175} Public Citizen showed that there were 182 serious Board actions during 2005.


\textsuperscript{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 (instead of determinations not to issue a Florida license), and does not include citations, which are typically based on failure to document continuing education credits and are considered penalties rather than disciplinary actions (unless the behavior is repeated). \textit{See} e-mail from Larry McPherson, Executive Dir., Fla. Bd. of Med., to Mary Coombs, Professor of Law, Univ. of Miami Sch. of Law (Apr. 17, 2007, 10:24 EST) (on file with Health Matrix). It does, however, provide detail regarding the kinds of discipline and the types of violations. \textit{Id.} The Annual Report of the Federation of State Medical Boards (FSMB) is presented as calendar year data, includes actions taken through both the licensure and disciplinary process, and includes citations. \textit{Id.} Florida's Board will no longer forward non-disciplinary citations to the FSMB as of next year. \textit{Id.} As a result, it will appear that Florida is disciplining fewer physicians. \textit{See} id. Finally, Public Citizen includes only the more severe forms of discipline, so that their data will indicate fewer physicians are being disciplined than the FSMB data across all states. \textit{Id.}

\textsuperscript{174} \textit{PROSECUTION SERVICES UNIT, FLA. DEP'T OF HEALTH, SUMMARY OF PROSECUTION AND DISCIPLINARY ACTIVITY FOR FISCAL YEAR 2005-6} 9 (2005) (on file with author). These totals had ranged in the five prior years from 200 to 279. \textit{Id.}

\textsuperscript{175} \textit{FED'N OF STATE MED. BDS., TRENDS IN PHYSICIAN REGULATION} 22 (2006), \textit{available at} http://www.fsmb.org/pdf/PUB_FSMB_Trends_in_Physician_Regulation_2006.pdf. A seeming large increase in the number of actions between 2003 and 2004 may be an artifact of a recent law affecting continuing medical education (CME) requirements for initial licensure and a corresponding bump in citations. \textit{See} id. (illustrating the increase in board actions against physicians).
and calculated that the number of serious actions per 1000 physicians ranked Florida 32nd in the nation.\footnote{PUBLIC CITIZEN RANKINGS, supra note 172. Another difficulty with reconciling the sources is their variant data regarding the denominator. For example, the Public Citizen study shows 51,025 Florida physicians in 2004, id., while 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. FED’N OF STATE MED. BDS., supra note 175. The Board of Medicine report does not include this data, BOARD OF MEDICINE REPORT, supra note 174, but the Annual Report of the Florida Department of Health Division of Medical Quality Assurance for 2005-06 shows 39,016 medical doctors, in addition to a few hundred in specialty categories that include limited license and critical need area, 2005-2006 Fl. Dep’t of Health Div. of Med. Quality Assurance Ann. Rep. 27. The difference between the two latter numbers may simply be an artifact of using calendar year rather than fiscal year data. The Public Citizen data must include physicians with Florida licenses but not practicing in-state.}

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 that are related tangentially, if at all, to incompetence.\footnote{The lengthy list of sanctionable behaviors is set out in Fla. Stat. § 456.079 (2007) and in the Discipline and Licensure Restrictions of the Florida Administrative Code, Fla. Admin. Code Ann. r. 64B8-8.001 (1986 & Supp. 2007). The Board of Medicine Report indicated that 156 of the disciplinary violations in 2005-06 were for patient care issues. BOARD OF MEDICINE REPORT, supra note 174. One study showed that only a modest portion of sanctions nationwide were based on the codes most clearly linked to malpractice; a substantial 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, Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards, 32 J. Health Politics, Pol’y & L. 867, 875-76 & tbl. 2(2007) (18.8% of the sanctions reported by the Public Citizen were for “substandard care, incompetence, [and] negligence;” and 12.2% reported by the Federation of State Medical Boards were 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 GEN., DEPT. OF HEALTH AND HUMAN SERVS., MED. LICENSURE AND DISCIPLINE: AN OVERVIEW 13 (1986); DERBYSHIRE, supra note 176 at 78 (listing the common causes for medical disciplinary actions in 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 125 (1979).} Meanwhile, the Board had the authority to consider malpractice judgments as part of its assessment of whether discipline was appropriate even prior to the changes wrought by Amendment Eight. Under Florida law, physicians must
forward information on closed malpractice claims to the Office of Insurance Regulation, which then informs the Department of Health.\textsuperscript{178} In turn, the Department of Health 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 that it should submit the file to the Board of Medicine for possible discipline.\textsuperscript{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.\textsuperscript{180} Observers have suggested that state boards of medicine frequently lack sufficient resources to investigate thoroughly even all the situations brought to their attention.\textsuperscript{181} And these

\textsuperscript{178} FLA. STAT. ANN. § 456.049 (West 2007).
\textsuperscript{179} FLA. STAT. ANN. § 456.073(1) (West 2007). This provision tracked the language of 456.072(2)(i), 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. FLA. DEPT. OF HEALTH DIV. OF MEDICAL QUALITY ASSURANCE, ANNUAL REPORT: JULY 1, 2005 – JUNE 30, 2006, 38 (2006). 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.

\textsuperscript{180} A frequent source of criticism is that boards of medicine repeatedly sanction the same physicians; 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 “[s]ix percent of the doctors in Florida are responsible for half the malpractice,” yet the licensing board has not been effective in reducing malpractice. PUBLIC CITIZEN, BAD DOCTORS, supra note 172; see also Grant & Alfred, supra note 177, at 877-78 & tbl.3. The authors analyze Federation of State Medical Boards data and show that those who have been sanctioned once are disproportionately likely to be sanctioned again. Using other data sets, they show a similar pattern in malpractice judgments. Id. at 878-81 & tbl.4. In contrast, a typical system for dealing with human error is a form of progressive discipline; a large percentage of those disciplined once will not get into trouble again. The fact that there is recidivism indicates a weakness in the malpractice disciplinary system, at least insofar as there is an alternative system that could have predicted with reasonable accuracy which among the pool of first offenders would turn out to be incapable of rehabilitation and used that knowledge to determine appropriate sanctions.

\textsuperscript{181} See R. John Kinkel & Norma C. Josef, Disciplining Doctors: How Medical Boards are Dealing with Problem Physicians in the Midwest, 9 Res. in the Soc. of Health Care 207, 211-12 (1991); OFFICE OF INSPECTOR GEN., DEP’T. OF HEALTH AND HUMAN SERVICES, REGION I, MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW
boards may well be inhibited from acting by the kind of professional
courtesy that affects all professional self-regulation.\textsuperscript{182}

This does not necessarily translate, however, into a 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 currently lead to disciplinary action, in
Florida or elsewhere.\textsuperscript{183} But on reflection, it is also obvious that they
should not. Most automobile accidents, even if one of the drivers was
at fault, do not lead to license revocation or even suspension. Is revo-
cation, however, the appropriate answer for "repeat offenders"? The
answer may often be yes. Surely the doctors who are the topic of Pub-
lic Citizen's horror 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.\textsuperscript{184} But license revo-
cation is not always the correct response. Consider the problem of

\textsuperscript{182} See, e.g., \textsc{Stanley J. Gross}, \textit{Of Foxes and Hen Houses: Licensing and
the Health Professions} (1993); \textsc{Robert A. Adler}, \textit{Stalking the Rogue
Physician: An Analysis of the Health Care Quality Improvement Act}, 28
\textsc{Am. Bus. L. J.} 683, 691 (1991); \textsc{Mark Crane}, \textit{Why Did It Take So Long
To Nail This Crooked Doctor?} 66 \textsc{Med. Econ.} 54 (March 20 1989).
Similar criticisms have been made regarding the
effectiveness of lawyer discipline, which also 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 are subject to disbarment, the most serious punishment,
an additional 133-155 were suspended. \textit{Medical Malpractice Hearing, supra}
note 161, at 134-37 (statement of Miles McGrane).

\textsuperscript{183} \textsc{Grant} and \textsc{Alfred} indicated that the total number of annual sanctions of all
types for all behaviors nationwide during the period from 1992 to 2004 ranged from
3370 to 6212. \textsc{Grant \\& Alfred, supra} note 177, at 874 tbl.I. Meanwhile, the Institute
of Medicine has estimated that there were between 44,000 and 98,000 annual hospital
deaths due to medical error. \textsc{Comm. on Quality Health Care in Am., Inst. of Med.
To Err Is Human: Building a Safer Health System 1} (Linda T. Kohn et al. eds,
2000) [hereinafter IOM 2000]. The MQA data cited in n.179 \textit{supra} indicates a similar
gap.

\textsuperscript{184} See \textit{Public Citizen, Bad Doctors, supra} note 172, at 7-9. See also
\textsc{Timothy Stoltzfus Jost}, \textit{The Necessary and Proper Role of Regulation to Assure the
Quality of Health Care}, 25 \textsc{Hous. L. Rev.} 525 (1988); \textit{See generally} \textsc{Timothy
Stoltzfus Jost, Oversight of the Quality of Medical Care: Regulation, Management, or
the Market?} 37 \textsc{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 \textsc{Derbyshire, supra} note 176 at 88;
sources cited in \textsc{Adler, supra} note 182, at 690 n.26.
disentangling cause and effect. We know that most incidents of avoidable adverse events, or even malpractice, do not lead to lawsuits.\textsuperscript{185} For a variety of reasons, patients do not sue.\textsuperscript{186} A doctor who has been sued once, however, is considerably more likely to be sued again.\textsuperscript{187} One explanation: he is an incompetent physician who needs to be removed. Another: he is arrogant and rude and his patients are consistently more willing to sue him when things go wrong. The doctor might be well-insured or have substantial assets that could be reached to satisfy a malpractice judgment.\textsuperscript{188} Plaintiffs’ attorneys are more likely to bring suit against a physician with past malpractice judgments because the likelihood of a good settlement is higher. 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 repeatedly than are dermatologists or gastroenterologists of equal skill.\textsuperscript{189}

\textsuperscript{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).

\textsuperscript{186} According to one source, “[t]he number of medical errors reported by Florida hospitals exceeds the number of medical malpractice claims filed each year by 6 to 1.” PUBLIC CITIZEN, BAD DOCTORS, supra note 172.

\textsuperscript{187} Id. at 6-7. 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 in an area with a large Medicaid population. John E. Rolph, John L. Adams, & Kimberly A. McGuigan, Identifying Malpractice-Prone Physicians, 4 J. EMPIRICAL LEGAL STUDIES 125 (2007).

\textsuperscript{188} Leaders at the University of Miami Medical School have regularly decried the perceived effects of defendants’ resources when the plaintiff is deciding whom to sue in a malpractice action. See e-mail from John G. Clarkson, Former Dean, Univ. of Miami Miller Sch. of Med., to Mary Coombs, Professor of Law, Univ. of Miami Sch. of Law (Oct. 4, 2007, 12:45 EST) (on file with Health Matrix). Physicians associated with the university have the university’s deep pockets available to them, whereas Jackson Memorial Hospital, which is where many of these physicians practice, is funded by a public trust and is thus insulated by sovereign immunity. See id.

\textsuperscript{189} In addition, mere randomness would mean that some physicians would be the subject of more than one claim, and almost by definition, they would contribute disproportionately to the total payouts. It is unclear if these theories can fully account for data such as that in a study of physicians in Washington, D.C. which showed 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 2 (2005), available at http://www.citizen.org/documents/WDC2005malpracticeanalysis.pdf
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. Nonetheless, to the extent there is a core of dangerous doctors, the disciplinary system should remove them. And doing so may respond to an understandable public desire for retribution against “bad apples.” Much of the general population also apparently believes that suspending the licenses of health professionals who make mistakes is among the “very effective” solutions to medical error. The language

---

190 The patient safety movement is built around the 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 & Steven Garber, Reducing Medical Malpractice by Targeting Physicians Making Medical Malpractice Payments, 4 J. EMPIRICAL LEGAL STUD. 185, 198-202 (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, because 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 of that study.

191 Timothy Stolzfus 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. Jost, Oversight of the Quality of Medical Care: Regulation, Management, or the Market?, supra note 184, at 841. Even where a physician is substantially 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 When asked whether various measures would be very effective, twenty-three percent of the public selected “increasing lawsuits for malpractice,” and fifty percent selected “suspending the licenses of health professionals who make medical errors;” unsurprisingly only three and one percent respectively of doctors surveyed selected these as effective options. Robert J. Blendon, et al. Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med. 1933, 1938 tbl.4 (2002). Contrast that with 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 TIMES, July 21, 2004, available at http://www.sptimes.com/2004/07/21/State/Few_doctors_will_pay_.shtml. It is impossible to know if the public 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.
of "three strikes and you're out" with which Amendment Eight was promoted fed into these public views.\footnote{\textsuperscript{193}}

All this, however, is based on a narrow and static view of what Amendment Eight would have done. Its primary effect would have been to make incurring even a second malpractice judgment in Florida highly dangerous to a physician's livelihood. Physicians would feel forced to settle any case where there was even a small chance that they might lose at trial.\footnote{\textsuperscript{194}} Plaintiffs' attorneys would be encouraged to bring more and weaker cases.\footnote{\textsuperscript{195}} Malpractice insurance rates would rise.\footnote{\textsuperscript{196}} Physicians would make additional efforts to avoid being sued. While some of these results 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 or patient populations, and not locating one's practice in Florida, are not.\footnote{\textsuperscript{197}}

\footnote{\textsuperscript{193} It also, of course, evoked an analogy between bad doctors and the career criminals to whom the phrase had earlier been applied.}
\footnote{\textsuperscript{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." Interview with William Large, supra note 30, (transcript at 7). See also Chaires, supra note 85.}
\footnote{\textsuperscript{195} Indeed, the one group that would seem clearly to benefit from the passage of Amendment Eight was its sponsor, the plaintiffs' trial bar, whose bargaining position would be enhanced.}
\footnote{\textsuperscript{196} Chaires, supra note 85, at 3; see also Randall R. Bovbjerg & 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.").}
\footnote{\textsuperscript{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. Medical Malpractice Hearing, supra note 161, at 96-97, 101 (statement of Jeff Scott, FMA counsel), 125-30 (statement 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), 2005-2006 FL. DEP'T OF HEALTH DIV. OF MED. QUALITY ASSURANCE ANN. REP., AT 27; 47,805 in 2003-04 (17,849 out of state), 2003-2004 FL. DEP'T OF HEALTH DIV. OF MED. QUALITY ASSURANCE ANN. REP., AT 24; and 43,517 in 2001-02 (when the report did not break out out-of-state Florida licensed doctors), 2001-2002 FL. DEP'T OF HEALTH DIV. OF MED. QUALITY ASSURANCE ANN. REP., AT 41. Annual reports are 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. HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL CENTER FOR HEALTH WORKFORCE ANALYSIS: U.S. HEALTH WORKFORCE PERSONNEL FACTBOOK, tbl.222,
The most difficult reform to assess is Amendment Seven. On its face, it seems to provide a very broad right of access to records. 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."

Depending on whether proof of a concrete plan to seek care were required, this definition might not exclude anyone. 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.

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,

http://bhpr.hrsa.gov/healthworkforce/reports/factbook.htm. Interestingly, Florida was disproportionately low in the number of primary care physicians, a category at a relatively low risk of malpractice claims. See id. It is quite 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 Medical Malpractice Hearing, supra note 161, at 125-7 (Mortham statement)).
quality assurance, credentials, or similar committee, or any representative of any such committees.\textsuperscript{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.\textsuperscript{203} Furthermore, as an attorney who represents hospitals noted, absent limiting legislation, it might require, in addition to the 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.\textsuperscript{204} The law would create substantial burdens, particularly on health care facilities, to keep the relevant documents,\textsuperscript{205} access them when requested, and redact any patient-identifying information.\textsuperscript{206}

Even after the voiding of many of the provisions of the "implementing legislation," the impact of Amendment Seven may turn out to be 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.\textsuperscript{207} Second,

\begin{itemize}
\item \textsuperscript{202} Fl. Const. Art. X, § 25(c)(3).
\item \textsuperscript{203} See Florida Hospital Waterman v Buster, 984 So. 2d 478, 492 (2008) (rejecting statutory limit to "final reports").
\item \textsuperscript{204} Interview with Gail Parenti, supra note 33, (transcript at 8).
\item \textsuperscript{205} It was this concern that led the hospitals to request 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). The Florida Supreme Court rejected the first limitation and has not spoken to the validity of the latter. Florida Hospital Waterman v Buster, 984 So. 2d 478, 492-94 (2008)
\item \textsuperscript{207} "[P]atient safety work product shall be privileged and shall not be . . . subject to discovery in connection with a . . . State . . . civil or administrative proceeding." Patient Safety and Quality Improvement Act (PSQIA) of 2005, 42 U.S.C. § 299b-22(a) (Supp. 2007). "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
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, they hope, bringing the records within the attorney-client privilege. Finally, it is possible, especially if the ill-effects that physicians and hospitals foresee come to pass, that the Amendment might be repealed. The Florida state Representative most involved in the drafting and passage of the statute, David Simmons, said that in that situation he would "push to have the Legislature place a measure on the ballot to repeal [the] Amendment."  

If Amendment Seven has the impact that its text suggests, the benefits may well be less and the costs higher than its proponents and the voters assumed. Amendment Seven 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 that information would be to consumers depends both on its accuracy and usability and on the sources of information otherwise available. 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, actions by hospitals regarding clinical privileges and professional society actions is the National Practitioner Data Bank; however, this is not accessible to the general public. Florida does have a state level web resource, the Practitioner Profile. Anyone can look up a licensed practitioner by name or license number. The profile includes information on education, staff privileges, reported financial respons-

information for reporting to or by a patient safety organization." Id. § 299b-21(6). The FMA leadership indicated that the Act "might lend itself to a form where you could shelter things," FMA interview, supra note 37, (transcript at 17). In effect, insofar as the kinds of reports otherwise subject to discovery under Fl. Const. Art. X, § 25 are prepared for provision to patient safety organizations, they will instead be privileged. Indeed, the FMA sought to invoke the preemptive effect of PSQIA in Florida Hospital Assoc. v. Viamonte, No. 4:08cv312 (N.D. Fla, filed July 10, 2008).

208 FMA interview, supra note 37, (transcript at 10).

209 Dan Lynch & Harris Meyer, Revealing Discovery, DAILY BUS. REV. A1, (Sept. 28 2005). Doctors and hospitals might also seek federal legislation or regulation expanding the federal protective umbrella of PSQIA. See note 207, supra.

210 The only exception is that a plaintiff or his attorney may access the data bank if they have sued a hospital and seek to show that the hospital did not, as required, query the data bank in the course of granting or continuing a physician's credentials. See NATIONAL PRACTITIONER DATA BANK, FACT SHEET FOR ATTORNEYS. http://www.npdb-hipdb.hrsa.gov//pubs/fs/Fact_Sheet.pdf.

sibility, legal actions, board final disciplinary actions taken against the
doctor, and liability claims against the practitioner above a dollar
threshold ($100,000 for physicians). In theory, this resource should
provide essentially all the information that would be available through
the NPDB. However, much of the information is self-reported and
thus important negative information may not appear.\footnote{212}

There are also public 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 the site includes national and statewide averages
as a benchmark.\footnote{213} The U.S. Department of Health & Human Ser-
vices also has a website that allows the user to compare hospitals.\footnote{214}
The HHS 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 in-
formation provided is substantial and the sites are easily navigated to
find reasonably comprehensive, comparative information about spe-
cific hospitals.

It seems doubtful that there is much additional consumer value in
being able to obtain the information that is made available via
Amendment Seven. Depending on the scope of the request, it could

\footnote{212} Among the items of information subject to Department of Health verifica-
tion 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, resig-
nations from or revocation of such privileges; and liability claims. \textit{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. \textit{See} Jacob Goldstein,
\textit{State’s Files on Doctors Fall Short}, \textit{MIAMI HERALD}, Dec. 10 2006, at 1A. Some other
information, such as malpractice claims history, could be verified, since this data is
independently reported to the Department of Health by the Office of Insurance Regu-
lation,

\footnote{213} Fla. Agency for Health Care Admin., Connecting Florida with Health Care
Information, \url{http://www.floridahealthfinder.gov/CompareCare/SelectChoice.aspx}
(last visited Feb. 23, 2008). Legislation in 2006 requires hospitals to provide this
information and the agency to make it publicly available. \textit{See} FLA. STAT. ANN. §§
408.05(3)(k), 408.061 (West Supp. 2008).

\footnote{214} U.S. Dep’t of Health & Human Servs., Hospital Compare,
\url{http://www.hospitalcompare.hhs.gov/Hospital/Static/About-Overview.asp?dest=NAV|Home|About|Overview#TabTop} (last visited Feb. 18,
2008).
readily result in too much information for effective decision making.\(^{215}\) 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 that the various websites provide on how to assess the data. 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 a commitment to patient safety, which might be manifested by more self-scrutiny and thus more reports.\(^{216}\)

A distinct use of Amendment Seven -- probably the one most desired by its proponents -- is as a tool for malpractice litigation.\(^{217}\) The records themselves are inadmissible, and the proponents concede that Amendment Seven would not change that.\(^{218}\) But the records might lead to admissible evidence by pointing the plaintiff to potential wit-
nesses who might be willing to speak, and by providing a road map for questioning defendants. Counsel for both plaintiffs and defendants see such records as extremely useful for plaintiffs. 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." An attorney who represents hospitals said that "the availability of material like this in a suit has a dramatic impact on the settlement dynamic." There is no neutral objective point from which to assess whether this would ultimately be good or bad for patients.

The most significant likely impact of Amendment Seven will be on the peer review system, and thus on the processes of patient safety. Essentially all of these processes are privileged; the processes are to be treated as confidential, participants may not testify about them, and the documentation created is neither discoverable nor admissible under statutory law 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.

Doctors 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.

There is apparent unanimous agreement that patient safety measures are socially desirable, and that the system to develop such meas-

---

219 Information that has been presented to a medical review committee is not privileged if it is also available from some other source. Mount Sinai Med. Ctrs. of Greater Miami, Inc v. Bernstein, 645 So. 2d 530, 532 (Fla. Dist. Ct. App. 1994) (citation omitted). 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 Cmty. Hospital v. Jones, 584 So. 2d 220 (Fla. Dist. Ct. App. 1991).

220 Lynch and Meyer, supra note 209.

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


ures depends on a sufficiently reliable system for reporting errors.\textsuperscript{224} 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.\textsuperscript{225} 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.\textsuperscript{226} Effectively promoting patient safety is seen as requiring a focus on systems, rather than a culture of blaming; punishing those whose errors are reported is thus counter-productive.\textsuperscript{227} Health care personnel are generally viewed as reluctant to report errors, whether theirs or their colleagues, for a variety of reasons.\textsuperscript{228} Some empirical data confirms these claims.\textsuperscript{229}

One of the perceived impediments to open reporting of errors in the health-care setting is the risk of blame through the malpractice system.\textsuperscript{230} Thus patient safety advocates often support measures to narrow, or even displace that system.\textsuperscript{231} Others, by contrast, insist on

\textsuperscript{224} William Sage and his co-authors refer to “the political ascendancy of ‘patient safety.’” Sage, et al., \textit{supra} note 216, 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, \textit{supra} note 183, at 87; \textit{see e.g.}, Randall R. Bovbjerg, \textit{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).


\textsuperscript{228} \textit{See, e.g.}, Bovbjerg, \textit{supra} note 224, at 6; Furrow, \textit{supra} note 225, at 192; ATUL GAWANDE, \textit{Complications: A Surgeon’s Notes On An Imperfect Science} 94-97 (2002) (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).

\textsuperscript{229} \textit{See} studies cited in Sage, et al. \textit{supra} note 216, at 1289 nn. 79-80.

\textsuperscript{230} \textit{See} Bovbjerg \& Tancredi, \textit{supra} note 196, at 497 (quoting quality improvement advocate Donald Berwick, “[T]he tort system poisons the openness and honesty that are preconditions to safety improvement.”); \textit{see also} IOM Report 2000, \textit{supra} note 183, at 109-110.

\textsuperscript{231} \textit{See} Bovbjerg, \textit{supra} note 224, 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.” IOM 2000, \textit{supra} note 183, at 111.
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.\textsuperscript{232} Other scholars argue that the reporting that patient safety advocates insist is essential is not dependent on confidentiality or protection from the risk of malpractice litigation.\textsuperscript{233} 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.\textsuperscript{234} And even with protections, the level of reporting, whether voluntary or "mandatory," is frequently too low to serve its purposes.\textsuperscript{235}

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 promote patient safety, the answer is unclear.\textsuperscript{236} 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."\textsuperscript{237} Indeed, the opponents of those using patient safety as an argument to support "tort reform" note that the biggest patient safety success story has been in anesthesiology,\textsuperscript{238} and a major impetus for that project was the extremely high malpractice risks and malpractice insurance rates anesthesiologists had been experiencing.\textsuperscript{239}

\textsuperscript{232} See, e.g., BAKER, supra note 153; 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).

\textsuperscript{233} Cf. Susan O. Scheutzow, State Medical Peer Review: High Cost but No Benefit - Is It Time for a Change? 25 Am. J. L. & MED. 7, 9-12 (1999) (noting a study showing that confidentiality protections are not correlated with greater use of the peer review process).


\textsuperscript{235} See Furrow, supra note 225, at 203; Maxine M. Harrington, Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?, 15 Health Matrix 329, 351-52 (2005). Harrington notes the strikingly disparate number of adverse incident reports in New York and Florida, and suggests one possible reason is substantially different rates of under-reporting. Id. at 364-65.

\textsuperscript{236} As noted in Sage, et al., supra note 216, at 1271, there is a tension between the needs of improvement and accountability in terms of the availability of information about medical error.

\textsuperscript{237} Hyman & Silver, supra note 234, at 893.

\textsuperscript{238} Id. at 917; see GAWANDE, supra note 228, at 64-69.

\textsuperscript{239} 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.
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 Amendment Seven is to promise that the reports one makes and other documentation of one’s participation in various forms of peer review can readily become public, evoking all the reasons people are reluctant to make such reports.

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

CONCLUSION

The changes wrought by Amendments Three, Seven and Eight, 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 Amendment was designed by a single stakeholder, trial lawyers (Seven and Eight) or physicians (Three). The primary purpose seemed to be to harm, or threaten to harm, the interests of other stakeholders, trial lawyers (Three) or physicians and hospitals (Seven and Eight), although the amendments 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 suffi-

240 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.

241 Two of the strongest opponents of the argument that malpractice liability 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 into place.” David A. Hyman & Charles Silver, Speak Not of Error: Does Legal Fear Increase the Risk of Medical Error?, Regulation, Spring 2005, at 52, 55.
ciently appealing to the electorate. 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 amendments to 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. In fact, even constitutional initiatives can serve as one stage in a complex governance process. But expectations of the various stakeholders may run the risk of making further governance changes harder, even if experience shows the undesirability of the provisions as enacted. It may also evoke cynicism if the citizenry feels that their wishes, as embodied in the amendments, are frustrated by legislatures or courts.

This story also, I hope, demonstrates the value of such storytelling. Legal scholarship has traditionally been analytic, whether it is done at the level of specific doctrine, or is more conceptual and theoretical. Critical race theory and critical feminist theory led the way to the addition of narrative as an explicit 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 explored in traditional scholarship. 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, it now seems to have been accepted as a legitimate

242 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 Amendments Seven and Eight 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 32, (transcript at 15).

243 They could not have the complexity of legislation and they had to be written to appeal to the average voter, who might base his or her vote on a brief review of the title and summary.

244 Some of the most prominent and most influential works in the field have been collected within the anthologies edited by Richard Delgado and Jean Stefancic, see, e.g., The Cutting Edge (2000), and been the subject of discussions of the field in the works cited in the sources in note 245, infra. The term has sometimes also included the use of explicitly fictional writings to illuminate limitations in dominant scholarship or political understandings. Among 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).

245 See, e.g., DANIEL FARBER & SUZANNA SHERRY, BEYOND ALL REASON: THE RADICAL ASSAULT ON TRUTH IN AMERICAN LAW 5 (1997) and Richard Delgado, On Telling Stories in School: A Reply to Farber and Sherry, 46 VAND. L. REV. 665 (1993). There are also less contentious approaches to these questions. See, e.g., Jane
part of the universe of legal scholarship. 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 most obscured by traditional scholarship. Law, particularly the common law, is shot through with stories. There does not appear to be the same narrative urge within legal scholarship for the "back stories" of legislation. It is sometimes 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 operated to produce outcomes and lay the groundwork for ongoing processes of conflict, cooperation, or cooption. It may help us understand the contingency of legal change and the importance 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.

---


246 For a very thoughtful contemporary example of and reflection on 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).

247 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. See, e.g., Lucie E. White, Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G., 38 BUFL. L. REV. 1 (1990); Anthony V. Alfieri, Impoverished Practices, 81 GEO. L.J. 2567 (1993) (introducing his article with a short narrative in which an indigent client sought legal services from the article's author).

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 at http://www.westacademic.com/Professors/ProductLines.aspx?tab=1

248 Political theorists and political journalists, and the occasional law professor, have generally provided such closer studies of the political process. 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); SCHRAG, supra note 23 (focusing on the processes and effects of the citizen initiative in California); MICHAEL J. GRAETZ & IAN SHAPIRO, DEATH BY A THOUSAND CUTS: THE FIGHT OVER TAXING INHERITED WEALTH (2005).