IN THE SUPREME COURT OF FLORIDA
TALLAHASSEE, FLORIDA

IN RE

CASE NO.: 71,672

FLORIDA MEDICAL MALPRACTICE
PRESUIT SCREENING RULES

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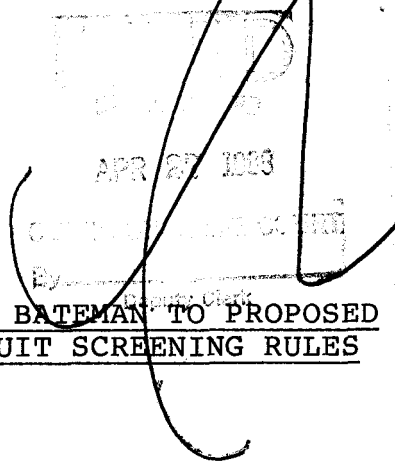

COMMENTS OF IDA BATEMAN AND CHAMP BATEMAN TO PROPOSED FLORIDA MEDICAL MALPRACTICE PRESUIT SCREENING RULES

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INTRODUCTION

These comments are offered on behalf of Ida Bateman and Champ Bateman, her husband, parties in an ongoing medical malpractice suit. The Batemans' comments are directed to Rule 3(b)(1) of the proposed Florida Medical Malpractice Presuit Screening Rules, which reads in pertinent part as follows:

> The parties may require other parties to appear for the taking of an unsworn statement. Such statements shall only be used for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party.

The above-quoted portion of the proposed Rule would appear to go beyond the intent of the statute, in that it would render undiscoveragle and inadmissible the statement of a party taken by the opposing party during informal discovery under Section 768.57(6), when the clear intent of the statute is to render undiscoverable and inadmissible statements and other work product generated internally by the insurer (or self-insurer) during the Section 768.57(3)(a) "pretrial screening procedure." A copy of Section 768.57 (1987), is attached hereto as Appendix A.

The Batemans' medical malpractice lawsuit arises out of injuries Mrs. Bateman suffered to her cerebal cortex during surgery to remove a benign pituitary tumor. The Complaint alleges that a bone drill which was supposed to disengage without harming brain tissue instead "plunged" into Mrs. Bateman's brain, through malfunction and/or misuse by the health care providers, causing serious and permanent injuries.

Pursuant to Section 768.57(6), the surgeon gave an unsworn statement to the Batemans' attorney. When later deposed under oath in the lawsuit, the surgeon's testimony materially

conflicted with his previous statement (which was transcribed by a certified court reporter) on several important issues concerning the surgery and the proper use of the Drill.

As set forth below, the Batemans contend that the provisions of subsection (5) where never intended to apply to information or statements given to an opposing party during informal discovery. The non-discoverability and inadmissibility provisions of subsection (5) are plainly intended to protect internal work product-type materials generated by the insurer or self-insurer under subsection (3)(a).

FIRST ARGUMENT

THE "PRESUIT SCREENING PROCESS" IN SUBSECTION (5) IS PLAINLY A REFERENCE TO THE INTERNAL "PRETRIAL SCREENING PROCEDURE" REQUIRED OF "EACH INSURER OR SELF-INSURER" BY SUBSECTION (3)(a), NOT THE INFORMAL DISCOVERY OF "DISCOVERABLE INFORMATION" BETWEEN OPPOSING PARTIES REQUIRED BY SUBSECTION (6).

Subsection (3)(a) of Section 768.57 mandates that upon receipt of an intent-to-sue notice "the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review and evaluation of claims during the 90 day period." The statute goes on to describe the methodology of such reviews by the insurer or self-insurer.

In a nutshell, subsection (3)(a) mandates an internal exposure/liability assessment by the exposed entity, the insurer or self-insurer, and provides 90 days of breathing room for this to occur. The obvious goal of the procedure is to encourage early settlement of cases which ought to be settled, rather than defended at great expense to the insurer or self-insurer, and ultimately, the insurance system as a whole.

The internal information generated during the course of this procedure is, of course, in the nature of work product, which would ordinarily be protected by the qualified work product privilege as codified in Fla.R.Civ.P. 1.280(b). However, subsection (5) goes on to render such information absolutely privileged:

> No statement, discussion, written document, report, or other work product generated by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party.

Subsection (5) plainly refers to the internal review procedure previously set forth in subsection (3)(a). Indeed, the last sentence of subsection (3)(a) refers to the internal investigations prescribed therein as "pretrial screening procedures..."

In contrast, subsection (6) mandates an informal discovery procedure between opposing parties which is entirely distinct in character from the internal investigation mandated by subsection (3)(a) and rendered absolutely privileged by subsection (5). Thus, subsection (6) requires the parties to "make discoverable information available..." to one another. Without a doubt the personal knowledge of a prospective defendant concerning the situation is "discoverable information" and, as in the Batemans' case, many parties utilize this provision to obtain unsworn statements from prospective defendants. The proposed Rules, in Section 3(b)(1), recognize and adopt this practice. However, the second sentence of Section 3(b)(1) illogically renders such discoverable information "not discoverable or admissible in any civil action for any purpose by any party." Thus, as the proposed Rule is currently worded, information which was once discoverable and was in fact discovered, is nevertheless deemed to be undiscoverable and inadmissible at trial.

This inconsistency comes about because the undiscoverability and inadmissibility provisions of Section 768.57(5) were never intended by the Legislature to apply to the discoverable information obtained from an opposing party during informal discovery. Instead, the plain intent of subsection

(5) is to protect the confidentiality of the preceding internal investigation conducted by or on behalf of the insurer or self-insurer.

Facts and information which have been discovered are not capable, within the limitations of time and space as we know them, of being undiscovered. In short, the absolute privilege created by the Legislature in subsection (5) cannot rationally apply and does not apply to the statement of an opposing party given to the opposing party during informal discovery under subsection (6). In contrast, a statement given by a prospective defendant to his or her insurer, pursuant to subsection (3)(a), is protected by the subsection (5) absolute privilege.

SECOND ARGUMENT

THERE ARE SUBSTANTIAL PUBLIC POLICY GROUNDS SUPPORTING A NARROWER INTERPRETATION OF THE SECTION 768.57(5) ABSOLUTE PRIVILEGE.

In Section 768.57(3)(a), the Legislature mandated an internal review and investigation of medical malpractice claims by the insurer, the entity which is financially responsible for defending and paying claims. Because one of the largest costs incurred in connection with medical malpractice claims are the costs of defending such claims in court, the Legislature sought to foster early recognition and compromise of valid claims, thereby avoiding unnecessary defense expenditures. One of the keys to a successful investigation is, of course, complete disclosure by the insureds of matters relating to their potential liability. Hence, the Legislature, in Section 768.57(5), rendered statements and other materials "generated

by the presuit screening process" both undiscoverable and inadmissible for any purpose, thereby transforming the qualified work product privilege into an absolute work product privilege.

In Section 768.57(6), the Legislature created an entirely different animal - informal discovery between opposing parties. This procedure is most frequently utilized by prospective plaintiffs in conducting the reasonable investigation required by Section 768.495, although prospective defendants can and do utilize the procedure.

It is apparent that a statement given by a prospective defendant to a prospective plaintiff bears none of the characteristics of the work product materials absolutely protected by subsection (5). Further, there is no discernible policy objective to be fulfilled by concealing such lawfully discovered information from the jury. Indeed, public policy considerations, as well as the interest of justice, virtually mandate that such statements be subject to use at trial. Otherwise, the statutory scheme would positively encourage prospective defendants to shade the truth, conceal information, lie, or otherwise endeavor to deceive prospective plaintiffs, hoping to avoid a lawsuit. This cannot be the Legislature's intent.

Plainly stated, as the Rule is presently worded, it will hinder, delay, and obstruct the efficient and timely administration of justice in medical malpractice cases, by encouraging prospective defendants to deceive prospective plaintiffs during informal discovery. A statement by a prospective defendant to its insurer or self-insurer should be undiscoverable and inadmissible. But a statement by a prospective

defendant to a prospective plaintiff must be admissible (it has already been discovered) if it is to have any meaning or purpose at all. The Batemans respectively submit that the Florida Legislature did not create a pointless procedure in Section 768.57(6).

CONCLUSION

For the foregoing reasons, the proposed Rule should be clarified or amended to indicate that the statement of an opposing party obtained during informal discovery pursuant to Section 768.57(6) is not subject to the undiscoverability/ inadmissability provisions of subsection (5).

Respectively submitted,

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APPENDIX

Section 765.57, Florida Statutes (1987).

3. The analysis of patient grievances which relate to patient care and the quality of medical services;

4. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of health care providers and health care facilities to report injuries and incidents; and

5. Auditing of participating health care providers to assure compliance with the provisions of the risk management program.

The fund shall establish a schedule of fee surcharges which it shall levy upon participating health care providers found to be in violation of the provisions of the risk management program. Such schedule shall be subject to approval by the department and shall provide an escalating scale of surcharges based upon the frequency and severity of the incidents in violation of the risk management program. No health care provider shall be required to pay a surcharge if it has corrected all violations of the provisions of the risk management program and established an affirmative program to remain in compliance by the time its next fee or assessment is due.

(h) *Nonavailability of coverage.*—The fund shall determine, no later than 7 days before the beginning of each fiscal year, whether the total amount of the membership fees to be charged for the fiscal year to health care provider applicants other than hospitals exceeds $5 million and whether the total amount of the membership fees to be charged to hospital applicants exceeds $12.5 million. If the total amount of the membership fees to be charged to health care provider applicants other than hospitals does not exceed $5 million, the fund shall return the membership fees collected from such providers and shall, not later than the day before the beginning of the fiscal year, notify all such providers, advising them that coverage will not be available from the fund. Thereafter, the fund may not issue coverage to any health care provider, including any hospital, for that fiscal year. If the total amount of the membership fees to be charged to hospital applicants for the fiscal year does not exceed $12.5 million, the fund shall return the membership fees collected from the hospitals and shall, not later than the day before the beginning of the fiscal year, notify such hospitals that coverage of hospitals will not be available from the fund. Thereafter, the fund may not issue coverage to any hospital for that fiscal year. If the fund ceases to provide coverage to hospitals, hospitals shall continue to meet the financial responsibility requirements of subparagraph (2)(c)1., subparagraph (2)(c)2., or subparagraph (2)(c)3. An application for fund membership for a particular fiscal year does not guarantee coverage for that year, and the fund is not liable for coverage of an applicant for any fiscal year in which the fund does not provide coverage in accordance with the provisions of this paragraph.

History.—s. 15, ch. 75-9; s. 3, ch. 76-168; s. 6, ch. 76-260; s. 4, ch. 77-64; s. 1, ch. 77-174; s. 1, ch. 77-457; s. 2, ch. 78-47; ss. 1, 2, ch. 79-178; ss. 1, 2, ch. 80-91; s. 1, ch. 80-328; ss. 2, 3, ch. 81-318; ss. 1, 2, 3, ch. 82-236; s. 809(2nd), ch. 82-243; ss. 80, 81, ch. 82-386; s. 2, ch. 82-391; s. 2, ch. 83-206; s. 50, ch. 83-215; ss. 1, 2, ch. 84-163; s. 67, ch. 85-62.

[1]**Note.**—Expires October 1, 1992, pursuant to s. 3, ch. 82-236, and is scheduled for review pursuant to s. 11.61 in advance of that date. Repealed effective October 1, 1992, by s. 809(2nd), ch. 82-243, and scheduled for review pursuant to s. 11.61 in advance of that date.

Note.—Section 768.48 was repealed by s. 68, ch. 86-160.

Note.—Former s. 627.353.

768.57 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; review.—

(1) As used in this section:

(a) "Claim for medical malpractice" means a claim arising out of the rendering of, or the failure to render, medical care or services.

(b) "Self-insurer" means any self-insurer authorized under s. 627.357 or any uninsured prospective defendant.

(c) "Insurer" includes the Joint Underwriting Association.

(2) Prior to filing a claim for medical malpractice, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical malpractice.

(3)(a) No suit may be filed for a period of 90 days after notice is mailed to the prospective defendant, except that this period shall be 180 days if controlled by s. 768.28(6)(a). Reference to the 90-day period includes such extended period. During the 90-day period, the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

2. Creation of a panel comprised of an attorney knowledgeable in the prosecution or defense of medical malpractice actions, a health care provider trained in the same or similar medical specialty as the prospective defendant, and a duly qualified claims adjuster;

3. A contractual agreement with a state or local professional society of health care providers, which maintains a medical review committee;

4. Any other similar procedure which fairly and promptly evaluates the pending claim.

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

(b) At or before the end of the 90 days, the insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer of admission of liability and for arbitration on the issue of damages. This offer may be made contingent upon a limit of general damages.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt shall

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be deemed a final rejection of the claim for purposes of this section.

(d) Within 30 days of receipt of a response by a prospective defendant, insurer, or self-insurer to a claimant represented by an attorney, the attorney shall advise the claimant in writing of the response, including:

1. The exact nature of the response under paragraph (b).

2. The exact terms of any settlement offer, or admission of liability and offer of arbitration on damages.

3. The legal and financial consequences of acceptance or rejection of any settlement offer, or admission of liability, including the provisions of this section.

4. An evaluation of the time and likelihood of ultimate success at trial on the merits of the claimant's action.

5. An estimation of the costs and attorney's fees of proceeding through trial.

[1](4) The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 90-day period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 90-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) No statement, discussion, written document, report, or other work product generated by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.

(6) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for dismissal of claims or defenses ultimately asserted.

(7) If a prospective defendant makes an offer to admit liability and for arbitration on the issue of damages, the claimant has 50 days from the date of receipt of the offer to accept or reject it. The claimant shall respond in writing to the insurer or self-insurer by certified mail, return receipt requested. If the claimant rejects the offer, he may then file suit. Acceptance of the offer of admission of liability and for arbitration waives recourse to any other remedy by the parties, and the claimant's written acceptance of the offer shall so state.

(a) If rejected, the offer to admit liability and for arbitration on damages is not admissible in any subsequent litigation. Upon rejection of the offer to admit liability and for arbitration, the claimant has 60 days or the remainder of the period of the statute of limitations, whichever period is greater, in which to file suit.

(b) If the offer to admit liability and for arbitration on damages is accepted, the parties have 30 days from the date of acceptance to settle the amount of damages. If the parties have not reached agreement after 30 days, they shall proceed to binding arbitration to determine the amount of damages as follows:

1. Each party shall identify his arbitrator to the opposing party not later than 35 days after the date of acceptance.

2. The two arbitrators shall, within 1 week after they are notified of their appointment, agree upon a third arbitrator. If they cannot agree on a third arbitrator, selection of the third arbitrator shall be in accordance with chapter 682.

3. Not later than 30 days after the selection of a third arbitrator, the parties shall file written arguments with each arbitrator and with each other indicating total damages.

4. Unless otherwise determined by the arbitration panel, within 10 days after the receipt of such arguments, unless the parties have agreed to a settlement, there shall be a 1-day hearing, at which formal rules of evidence and the rules of civil procedure shall not apply, during which each party shall present evidence as to damages. Each party shall identify the total dollar amount which he feels should be awarded.

5. No later than 2 weeks after the hearing, the arbitrators shall notify the parties of their determination of the total award. The court shall have jurisdiction to enforce any award or agreement for periodic payment of future damages.

(8) If there is more than one prospective defendant, the claimant shall provide the notice of claim and follow the procedures in this section for each defendant. If an offer to admit liability and for arbitration is accepted, the procedures shall be initiated separately for each defendant, unless multiple offers are made by more than one prospective defendant and are accepted and the parties agree to consolidated arbitration. Any agreement for consolidated arbitration shall be filed with the court. No offer by any prospective defendant to admit liability and for arbitration is admissible in any civil action.

(9) To the extent not inconsistent with this part, the provisions of chapter 682, the Florida Arbitration Code, shall be applicable to such proceedings.

(10) This section shall apply to any cause of action with respect to which suit has not been filed prior to October 1, 1985.

History.—s. 14, ch. 85-175; s. 9, ch. 86-287.

[1]**Note.**—As amended by s. 9, ch. 86-287; s. 16, ch. 86-287, provides in pertinent part that "the amendment to s. 768.57(4) . . . provided in this act shall operate retroactively to October 1, 1985."

[1]768.575 Court-ordered arbitration.—

(1) In an action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in [2]s. 768.50(2), the court may require, upon motion by either party, that the claim be submitted to nonbinding arbitration. Within 10 days after the court determines the matter will be submitted to arbitration, the court shall submit to the attorneys for each party the appropriate list of arbitrators prepared pursuant to subsection (2) and shall notify the attorneys of the date by which their selection of an arbitrator must be received by the court.

(2)(a) The chief judge of the judicial circuit shall prepare three lists of prospective arbitrators. A claimant's list shall consist of attorneys with experience in handling negligence actions who principally represent plaintiffs