IN THE SUPREME COURT OF FLORIDA

ALEX GUP, M.D., and THE
MEDICAL CENTER CLINIC,

Petitioners,

vs. CASE NO. 74,848

KATHERINE COOK and
ERNEST A. COOK, Wife
and Husband,

Respondents.

INITIAL BRIEF ON THE MERITS OF

PETITIONERS ALEX GUP, M.D., and THE MEDICAL CENTER CLINIC

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TABLE OF CONTENTS

LIST OF CITATIONS

FLORIDA STATUTES

I. INTRODUCTION

Petitioners, The Medical Center Clinic and Dr. Alex Gup, were defendants at the trial level, and were appellants before the First District Court of Appeal. They will be referred to by name in this brief--"Dr. Gup" and "the Clinic".

Respondents, Katherine Cook and Ernest Cook, were plaintiffs at the trial level, and were appellees before the First District Court of Appeal. They will be referred to by name--"Mr. and Mrs. Cook".

References to the Record on Appeal will be in the form of "R. _____". References to the Transcript will be in the form of "T. _____".

References are also made to depositions. Depositions are indexed as a separate item in the Record, and are filed in four separate volumes--I through IV. Each deposition is assigned a letter designation--A through U. Reference to the depositions will cite "Depo.", with the volume number, the letter designation, the last name of the deponent, and the pages cited. For example: (Depo. Vol. III, N, Smith pp 28-29).

This brief cites two Mercy Hospital cases. Both cases involved the same parties, on appeal twice for different issues. They will be referred to as Mercy Hospital I and Mercy Hospital II. Mercy Hospital, Inc. v. Menendez, 371 So.2d 1977 (Fla. 3d DCA 1979) (Mercy Hospital I) was cited by the First District Court of Appeal as being in conflict with its decision, because it requires the plaintiff, not the defendant, to join the Fund

as a defendant. Mercy Hospital, Inc. v. Menendez, 400 So.2d 48 (Fla. 3d DCA 1981) (Mercy Hospital II) was relied on by the trial court in requiring a $100,000.00 per claim escrow account.

A copy of the Opinion of the First District Court of Appeal is attached as the Appendix to this brief.

II. STATEMENT OF THE CASE

This case arises out of a claim for medical malpractice. The case was tried before a jury on June 14-16, 1986. A verdict was returned in favor of the plaintiffs Cook on June 16, 1986.

The defendants, Dr. Gup and the Medical Center Clinic, appealed on two issues to the First District Court of Appeal. On September 20, 1989, the First District Court of Appeal rendered its decision. The First District Court of Appeal reversed the trial court on one issue, but affirmed on the second issue. However, in affirming the second issue, the First District Court of Appeal certified that its decision was in conflict with Mercy Hospital, Inc. vs. Menendez, 371 So.2d 1077 (Fla. 3d DCA 1979) (Mercy Hospital I). The opinion of the First District Court of Appeal on the issue now before this court was a 2 to 1 decision, with The Honorable Anne Booth dissenting.

On October 5, 1989, Dr. Gup and the Medical Center Clinic filed their Notice to Invoke Discretionary Jurisdiction of the Supreme Court, pursuant to Fla.R.App.P. 9.030(a)(2)(A)(vi).

III. STATEMENT OF FACTS

This case arises out of a claim for medical malpractice. We will divide the Statement of the Facts into "Background Facts", and "Specific Facts", with the latter statement reciting those specific facts which relate to the pending issues.

BACKGROUND FACTS

The original claim for malpractice alleged that Dr. Alex Gup, a urologist, failed to timely diagnose a cancerous tumor in Mrs. Cook's bladder. The claim against the Medical Center Clinic, of which Dr. Gup was a member, was that Dr. Gup and other employees of the Clinic, including Dr. Thomas Wyatt, an obstetrician, failed to inform Mrs. Cook of her need to return for follow-up care, thereby contributing to the delayed diagnosis of cancer. They were treating Mrs. Cook for urinary tract problems in late 1977 and early 1978 when Mrs. Cook was pregnant with her third child.

Mrs. Cook last saw Dr. Gup on December 17, 1977. According to the allegations in the Complaint the claim against Dr. Gup and the Clinic had existed on or before that date. On that date there was only one claim pending against the Clinic--Rotenberry v. Wilhoit and Medical Center Clinic filed on April 14, 1977. (R. 442-444, 601) Two other claims were filed against the Clinic during the time Mrs. Cook was continuing to see Dr. Wyatt.

During that entire time there were no claims pending against Dr. Gup.

On April 3, 1978, Mrs. Cook was admitted to the hospital and delivered her third child. (T. Vol. IV, p. 644) Upon discharge, Dr. Wyatt told her she had a urinary tract infection and there was blood in her urine. He gave her a prescription. (T. Vol. III, p. 392; T. Vol. IV, p. 673) Mrs. Cook saw Dr. Wyatt again on May 15, 1978, for her six-week postpartum examination. The examination at that time was entirely normal. Dr. Wyatt did not tell Mrs. Cook to return to Dr. Gup, nor that she needed any further examinations to be done. (T. Vol. III, p. 394; T. Vol. IV, pp. 682, 724)

Mrs. Cook had no further urinary problems until August, 1979, fifteen months after her normal examination by Dr. Wyatt. At that time, she once again discovered blood in her urine. She visited another urologist who, after performing a cystoscopy and infusion pyelogram, diagnosed her as having a tumor in her bladder. (T. Vol. III, p. 395) Mrs. Cook then went to see still another urologist, Dr. Howell Martin, who confirmed that diagnosis. Dr. Martin then performed a transurethral resection and removed all of the tumor, which was found to be malignant. He subsequently removed all of Mrs. Cook's bladder in order to keep the cancer from recurring.

Mrs. Cook and her husband sued Dr. Gup and the Medical Center Clinic for negligence in failing to perform diagnostic

tests in 1977 and 1978, and in failing to diagnose the cancer at that time. (R. 1-3) Later, the Cooks joined Dr. Martin as a defendant, alleging that he was negligent in unnecessarily removing her bladder, and in failing to secure her informed consent to that operation. (R. 30-34)

The case was tried on June 14-16, 1986. The jury found that Dr. Gup, the Clinic, Mrs. Cook and Dr. Martin were all negligent. After ruling that the statute of limitations had run against Dr. Martin, the jury assessed the responsibility as follows:

Alex Gup, M.D.	15%
Medical Center Clinic by its agents and employees other than Alex Gup, M.D.	70%
Catherine Cook	15%
TOTAL	100%

(R. 302-303)

SPECIFIC FACTS

Among other post-trial motions, Dr. Gup and the Medical Center Clinic filed a motion to limit their liability to $200,000.00 ($100,000.00 each) on the grounds that they were members of the Florida Patients' Compensation Fund at the time of the incidents in question, and that the plaintiffs had failed to join the Fund in the case. The Motion to Limit Liability was filed in accordance with §768.54(2)(b), Florida Statutes, (1977). In pertinent part, that statute provided:

> A health care provider shall not be liable for an amount in excess of $100,000.00 per claim for claims covered under sub-section (3) in this state if, at the

time the incident giving rise to the cause of the claim occurred, the health care provider:

1. Had:

* * *

b. Proved financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the board of governors of the fund through the establishment of an appropriate escrow account.

Dr. Gup and the Clinic had paid the required fees and assessments for membership in the Florida Patients' Compensation Fund for the period from July 1, 1977, to June 30, 1978, during which time the incident in question occurred. (R. 309-310; T. Vol. VIII, C, p. 12) Certificates of membership had been issued to them. (R. 309-310; T. Vol. VIII, C, p. 12)

The following evidence was presented to show that they were in compliance with the requirements of the statute, and were not liable for an amount in excess of $100,000.00 for each claim.

Charles Portero, Claims Manager for the Florida Patients' Compensation Fund, testified by affidavit and by deposition. Mr. Portero stated that he had researched the records of the Fund, and had determined that Dr. Gup and the Medical Center Clinic paid the fees and all assessments required by the Fund for the years commencing July 1, 1976, and ending July 1, 1978, and that certificates reflecting their Fund membership were issued to them. Mr. Portero further testified that Dr. Gup and the Clinic did all things necessary to comply with §768.54(2)(b), and that upon payment of their obligation of $100,000.00 each, the Florida Patients' Compensation Fund would have been liable for any

judgment in excess of $200,000.00 of damages, had it been timely joined as a defendant. (R. 341; Depo. Vol. IV, R. Portero, pp. 11-15)

Charles Portero, the Claims Manager, further testified that the Clinic provided documentary proof of their accounts receivable, that the Clinic was a partnership with seventy partners who would be personally liable for any judgment entered against the Clinic or any of the doctors, and that the $100,000.00 escrow account was being maintained. Portero testified that those documents and records demonstrated financial responsibility of the Clinic and its members to the satisfaction of the Board of Governors of the Florida Patients' Compensation Fund. (Depo. Vol. IV, R, Portero, pp. 13-14)

Similar testimony regarding the fiscal year July 1, 1977, to June 30, 1978, was offered by John Odem. Mr. Odem was Claims Manager and Assistant General Manager of the Fund in 1977, and later became General Manager of the Fund. Mr. Odem testified that the Medical Center Clinic and Dr. Gup were in compliance with the requirements of the Florida Patients' Compensation Fund during the 1977-1978 fiscal year, and that the Florida Patients' Compensation Fund had previously paid a claim arising during that period where the Fund had been timely joined as a party. (Depo. Vol. IV, T, Odem, pp. 9-10)

Mr. Odem testified that the financial responsibility required by §768.54(2)(b) was demonstrated to the satisfaction of the Fund's Board of Directors through the $100,000.00 escrow

account, plus the financial statements regarding the assets of the partnership and the assets of the individual partners at the time, which showed total assets on the balance sheet for 1976 of $9,801,170.41. (Depo. Vol. IV, T, Odem, pp. 17, 22, Def. Ex. 2)

In order to demonstrate "financial responsibility to the satisfaction of the Board of Governors of the Florida Patients' Compensation Fund", the Clinic placed the sum of $100,000.00, plus accumulating interest, in an escrow account. In addition to that escrow account, at the request of the Fund and the Department of Insurance, the Clinic furnished the Department of Insurance a financial statement evidencing accounts receivable for 1975 of $6,896,265.98, and for the year 1976 of $9,167,689.20. (Depo. Vol. IV, R, Portero, p. 13) Further, the Clinic furnished additional proof of its financial responsibility, including a $1,000,000.00 line of credit, which was available to pay the initial $100,000.00 per claim. (R. 342) The Florida Department of Insurance acknowledged that Gup and the Medical Center Clinic had complied with the statute. (R. 342; Depo. Vol. III, P, Wester, pp. 21-26)

Cathy Sims, Administrative Manager for the Florida Patients' Compensation Fund from 1979 to 1985, testified from a complete review of their files that the Medical Center Clinic had demonstrated the requisite financial responsibility to the Florida Patients' Compensation Fund for the years in question. (Depo. Vol. III, Q, Sims, p. 36)

Hunt Wester, who was head of the risk management section of the Florida Department of Insurance, was instrumental in drafting the statute creating the Florida Patients' Compensation Fund, had served on the board of the Fund, and served as General Manager of the Florida Patients' Compensation Fund. He personally handled the details of assuring compliance by the Clinic and its physicians with the requirements of §768.54. (Depo. Vol. III, P, Wester, pp. 3-5) In evaluating financial responsibility, Wester testified that the financial stability of the Clinic partnership was strong, with each partner being liable for the actions of the partnership, and by the pledging of over $7,000,000.00 in accounts receivable. (Depo. Vol. III, P, Wester, pp. 25-28) Those accounts receivable were pledged against claims that may arise, in case there were multiple claims arising during a period of time, so that their escrow would never reduce below $100,000.00. (Depo. Vol. III, P, Wester, p. 28) Mr. Wester testified that a claim against the Clinic and one of its physicians, in which the Fund was made a party, which arose during the membership year in question, had been paid by the Fund. (Depo. Vol. III, P, Wester, p. 10) Mr. Wester testified that if the Fund had been joined as a party in the Cooks' suit, the Fund would have paid the judgment in excess of the underlying $200,000.00 owed by the Clinic and Dr. Gup. (Depo. Vol. III, P, Wester, p. 10)

Luther Smith, who had served as the General Manager of the Medical Center Clinic for 35 years, testified that in addition to

the $100,000.00 in escrow, the assets and accounts receivable of the partnership were available to prove financial responsibility (Depo. Vol. IV, U, Smith, p. 28), that the Medical Center Clinic had a $1,000,000.00 line of open credit which was a source available to meet claims (Depo. Vol. IV, U, Smith, p. 44), that the Insurance Commissioner and later the Board of Governors of the Fund accepted the $100,000.00 escrow as adequate, and that the Clinic did everything requested of it by the Department of Insurance or the Fund to fully comply with the statute. (Depo. Vol. IV., U, Smith, pp. 19-22) Additionally, the administrator of the Clinic testified that each time the statute was amended, the Clinic asked the Fund if they were in compliance, and each time the answer came back affirmative. (Depo. Vol. IV, U, Smith, pp. 28-29)

The plaintiffs failed to join the Florida Patients' Compensation Fund in this suit. The statute of limitations ran against the Fund (prior to the verdict) and therefore the Fund has no obligation to pay any part of the verdict. In order to avoid the effects of their failure to join the Fund, Plaintiffs opposed the Motion to Limit the Judgment by arguing that, notwithstanding the testimony of the Fund's administrators, and the Fund's interpretation of the statute, the statute required Gup and the Clinic to post an escrow account of $100,000.00 per claim. Failing that, Plaintiff argued Gup and the Clinic were not in technical compliance with the statute and could not limit the judgment. Plaintiffs contended that three claims were

pending during the pertinent time period, so that the Clinic and Dr. Gup were not in compliance of the statute, and therefore they were liable for the full amount of the judgment.

The trial court construed the statute in accordance with the plaintiffs' arguments, and denied the Motion to Limit Judgment. (R. 708-709)

The trial court based its decision on Mercy Hospital, Inc., v. Menendez, 400 So.2d 48 (Fla. 3d DCA 1981), (Mercy Hospital II), holding that in order to be in full compliance with the statute, the Clinic needed to have $100,000.00 in escrow for each pending claim.

The First District Court of Appeal affirmed the trial court's decision, but did so on other grounds. Specifically, the First District Court of Appeal stated:

> We need not decide whether the trial court's above rationale was correct because the court's denial of the limitation motion is affirmable for another, more basic, reason under the recent holding of this court in Tallahassee Memorial Regional Medical Center v. Meeks, 543 So.2d 770 (Fla. 1st DCA 1989).

Meeks held that the limitation provisions of §768.54(2)(b) were applicable only to the parties to the Fund contract, i.e., the health care provider and the Fund, and did not preclude the plaintiff from recovering directly from the health care providers the excess over $100,000.00. Meeks held that it is a misconstruction of §768.54(3)(e) to require that the plaintiff - as contrasted with the health care provider - join the Fund as a party defendant.

In Meeks, the First District Court of Appeals had certified conflict with Mercy Hospital, Inc., v. Menendez, 371 So.2d 1077 (Fla. 3d DCA 1979), (Mercy Hospital I), which held that "the plaintiffs have the burden of making the Fund a party in any suit where recovery is sought against a health care provider in excess of $100,000.00..." (371 So.2d at 1079) The First District Court of Appeal in the instant case likewise certified its conflict with Mercy Hospital I.

IV. ISSUES

ISSUE I.

WHETHER A HEALTH CARE PROVIDER WHO IS A MEMBER OF THE PATIENTS' COMPENSATION FUND, AND WHO HAS MET THE STATUTORY REQUIREMENTS FOR THE LIMITATION OF ITS LIABILITY SET FORTH IN §768.54(2)(b), FLORIDA STATUTES (1977) IS ENTITLED TO A LIMITATION OF LIABILITY TO $100,000.00 WHERE PLAINTIFFS FAILED TO JOIN THE FUND AS A PARTY DEFENDANT?

ISSUE II.

WHETHER THE TRIAL COURT ERRED IN CONSTRUING §768.54(2)(b), FLORIDA STATUTES (1977), TO REQUIRE A $100,000.00 ESCROW ACCOUNT PER CLAIM, WHERE THE HEALTH CARE PROVIDER HAD PROVED FINANCIAL RESPONSIBILITY IN THE AMOUNT OF $100,000.00 PER CLAIM TO THE SATISFACTION OF THE BOARD OF GOVERNORS OF THE FUND?

V. SUMMARY OF THE ARGUMENT

ISSUE I.

A health care provider who is a member of the Florida Patients' Compensation Fund, and who has met the statutory requirements for the limitation of its liability set forth in §768.54(2)(b), Florida Statutes (1977), is entitled to a limitation of liability to $100,000.00, where plaintiffs failed to join the Fund as a party defendant. The First District Court of Appeal erred in finding that the defendant/health care provider has the burden to sue the Fund.

The First District Court of Appeal relied on the case Tallahassee Memorial Regional Medical Center, Inc., v. Meeks, 543 So.2d 770, (Fla. 1st DCA 1989). Meeks is now before the Supreme Court of Florida for review, based on a certified conflict with existing case law on this same issue.

The decision of the First District Court of Appeal, holding that the health care provider, not the plaintiff, has the burden of suing the Fund, should be reversed for the following reasons:

1. §768.54(3)(e)1. states that the person filing the claim shall not recover against the defendant unless the Fund was named as a defendant in the suit. Under the Florida Rules of Civil Procedure, only a plaintiff can name a "defendant" in a lawsuit.

2. To require the defendant/health care provider to join the Fund as a defendant (or even as a third-party defendant), imposes upon the health care provider a duty which is in direct conflict with another specific duty imposed by the statute.

Specifically, the statute requires the health care provider to "provide an adequate defense" for the Fund, and states specifically that a "fiduciary relationship" exists toward the Fund with respect to any claim affecting the Fund. The First District Court's ruling creates a conflict between the health care provider and the Fund.

3. At least since 1979, when Mercy Hospital I was decided, the Fund, health care providers, and plaintiffs' attorneys, have known that plaintiffs have the burden of making the Fund a party in any suit where recovery is sought against a health care provider in excess of $100,000.00. Mercy Hospital I made that exact ruling, and stated that its decision was reached upon a consideration of the terms of the legislative act and the court's understanding of the legislative intent of that act.

4. Requiring the defendant/health care provider, rather than the plaintiff, to sue the Fund creates a potential for an unavoidable loss of "coverage" by the health care provider. A plaintiff who sues a health care provider shortly before the statute of limitations expires, is able to join the Fund as a party-defendant, as the statute requires. On the other hand, a health care provider who is sued shortly before the running of the statute of limitations, may be unable to sue the Fund before the statute of limitations expires against the Fund. It is clear, therefore, that the decision of the First District Court of Appeal in the case at bar and in Meeks, is contrary to the statute, for those decisions permit an unavoidable forfeiture of

"coverage" by the health care provider without the health care provider being able to prevent it.

5. An interpretation of the statute which requires the health care provider to join the Fund in the case is contrary to the plain language of the statute. If the legislature had intended that result, it could have easily stated that requirement, in plain English. The legislature did not do so.

ISSUE II.

The court erred in construing §768.54(2)(b), Florida Statutes (1977), to require a $100,000.00 escrow account per claim, where the health care provider had proved financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the Board of Governors of the Fund. That ruling should be reversed for the following several reasons:

1. Four persons who had served in various offices helping administer the Florida Patients' Compensation Fund testified that the Clinic and Dr. Gup were in full compliance with the statute, because they had proved financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the Board of Governors of the Fund.

2. At the request and direction of the Fund and the Department of Insurance, the Clinic had posted a $100,000.00 escrow account; they had furnished the Fund with financial statements showing assets in excess of $9,000,000.00; they had shown proof of a $1,000,000.00 open line of credit which was

available for paying claims, and they had provided verification that the Clinic was a general partnership, wherein each of the doctors (over 70 at that time) were individually liable for any judgment entered against any doctor or the Clinic. The Clinic was told by the Fund that it had complied with the statute.

3. The administrators of the Fund testified that had the Fund been properly joined by the plaintiff in the suit, the Fund would have paid the entire verdict in excess of $200,000.00 (representing the $100,000.00 underlying liability for each of the two certificate holders--Dr. Gup and the Clinic).

4. A reviewing court must defer to the interpretation of a statute given to it by a state-created agency which is charged with interpreting and applying the statute, as long as that interpretation is consistent with legislative intent and is supported by substantial, competent evidence. (Public Employees Relations Commission v. Dade County Police Benevolent Association, 467 So.2d 987 (Fla. 1985). The trial court failed to follow this important rule of statutory construction. Instead, the trial court made the error of accepting Mercy Hospital II as controlling authority. Mercy Hospital II interpreted the statute to mean that a $100,000.00 per claim escrow account is essential. Mercy Hospital II was not controlling, however, because in Mercy Hospital II there was no evidence that the health care provider had given to the Fund other financial information proving, to the satisfaction of the Board of Governors of the Fund, the provider's financial

responsibility. The ruling in Mercy Hospital II, therefore, cannot be regarded as a rejection of the rule of law which requires a court to defer to an agency's interpretation and application of the statute. The trial court in the instant case mis-applied Mercy Hospital II, because in the instant case the record was replete with testimony that the Fund never required or requested that the Clinic establish a $100,000.00 escrow for each claim, but on the contrary requested financial information from the Clinic, and then informed the Clinic that the financial information proved "financial responsibility to the satisfaction of the Board of Governors of the Fund".

5. Finally, a careful reading of the statute, shows that if the legislature intended to require a bond or escrow account in the amount of $100,000.00 per claim, regardless of other evidence of "financial responsibility", there is no logical purpose for the language "proved financial responsibility. . . to the satisfaction of the Board of Governors of the Fund". The decision of the trial court makes that language "nugatory" and "surplusage". The Fund's interpretation of the statute is reasonable and proper, and the court should have deferred to that interpretation.

The decision of the trial court on this issue should be reversed.

VI. ARGUMENT

ARGUMENT--ISSUE I.

A HEALTH CARE PROVIDER WHO IS A MEMBER OF THE FLORIDA PATIENTS' COMPENSATION FUND, AND WHO HAS MET THE STATUTORY REUIREMENTS FOR THE LIMITATION OF ITS LIABILITY SET FORTH IN §768.54(2)(b), FLORIDA STATUTES (1977), IS ENTITLED TO A LIMITATION OF LIABILITY TO $100,000.00 WHERE PLAINTIFFS FAILED TO JOIN THE FUND AS A PARTY DEFENDANT.

The case of Tallahassee Memorial Regional Medical Center, Inc. v. Meeks, 543 So.2d 770 (Fla. 1st DCA 1989), cited above, is now before the Supreme Court of Florida for review, based on a certified conflict with existing case law on this same issue.

The decision of the First District Court of Appeal, following Meeks, held that the health care provider, not the plaintiff, has the burden of suing the Florida Patients' Compensation Fund. The decision of the First District Court of Appeal was a 2 to 1 decision, with The Honorable Anne Booth dissenting. Judge Booth's short dissenting opinion indicates that she agreed with Gup and the Clinic on both issues now before this Court. The court's majority decision in the instant case, and in the Meeks case, should be reversed for the following several reasons:

1. Section 768.54(3)(e)1. states:

> Any person may file an action against a participating health care provider for damages covered under the fund, except that the person filing the claim shall not recover against the fund . . . unless the fund was named as a defendant in the suit. (emphasis added)

The opinion of the First District Court of Appeal would require the defendant health care provider to join the Fund as a

defendant in the lawsuit. The Florida Rules of Civil Procedure do not permit such an action. Only the plaintiff in a lawsuit can join any party as a defendant. Under the Florida Rules of Civil Procedure, the defendant health care provider could only join the Fund as a third-party defendant. Procedurally, a third-party defendant is altogether different from a defendant, and the grounds for asserting a cause of action against the two are completely different. Yet, the statute uses the term "defendant" in its requirement that the Fund be named as a party in the lawsuit.

2. The First District Court of Appeal has attempted to re-write the statute in order to reach a result which was not contemplated by the statute. That is contrary to the fundamental rules of statutory construction. Courts cannot re-write the law. State v. City of Fort Pierce, 88 So.2d 135 (Fla. 1956). Courts may not invade the province of the legislature and add words to a statute which change its meaning. Metropolitan Dade County v. Bridges, 402 So.2d 411 (Fla. 1981). Courts cannot amend or complete statutes to supply relief where the legislature has not supplied it. Dade County v. National Bulk Carriers, 450 So.2d 213 (Fla. 1984). Courts cannot judge the wisdom of legislation, as long as the legislation itself is constitutional. State v. Boles, 343 So.2d 9 (Fla. 1977). Courts must give effect to the legislation as written, despite any personal opinions as to its wisdom or efficacy. This is the most firmly embedded principle in the constitutional system of separation of powers and checks

and balances. Holly v. Auld, 450 So.2d 217 (Fla. 1984), Moore v. State, 343 So.2d 601 (Fla. 1977). The First District Court of Appeal has violated all of these rules of construction.

3. To require the defendant health care provider to join the Fund as a defendant (or even as a third-party defendant), imposes upon the health care provider a duty which is in direct conflict with another specific duty imposed by the statute:

> It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed which potentially affects the fund, with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in a fiduciary relationship toward the fund with respect to any claim affecting the fund." (F.S. §768.54(3)(e)2.)

It is a logical impossibility for the health care provider to provide an adequate defense for the Fund, and act in a fiduciary relationship toward the Fund, but on the other hand take an action against the Fund which imposes liability that otherwise would not exist. At the very least, the First District Court's ruling creates a conflict between the health care provider and the Fund, which was never contemplated in the statute, and which is contrary to both the letter and the spirit of the entire statute.

4. This exact issue was considered by the Third District Court of Appeal in Mercy Hospital, Inc., v. Menendez, 371 So.2d 1077 (Fla. 3d DCA 1979)(Mercy Hospital I). The Third District Court of Appeal made the following statements concerning that issue:

> . . . We hold that plaintiffs have the burden of making the Fund a party in any suit where recovery is sought against a health care provider in excess of $100,000.00, and that upon the plaintiff's failure to make the Fund a party, the trial court may, within the time allowed by Florida Rule of Civil Procedure 1.530, enter an order for the limitation of the judgment in accordance with Section 768.54(2)(b), Florida Statutes (1977).
>
> This decision is reached upon a consideration of the terms of the legislative act and our understanding of the legislative intent of that act. Legislative intent may be determined from a reading of the act in its entirety. (371 So.2d at page 1079)

Mercy Hospital I, not the opinion of the court in the instant case, correctly follows the language and intent of the statute on this point.

5. The First District Court of Appeal ruled, by reference to Meeks, that the health care provider also had the duty to assert the limitation of liability as an affirmative defense. Mercy Hospital I also considered that argument, and rejected it. The court stated:

> The plaintiffs' suggestion that the limitation provided should be treated as a "set-off" that must be pled by the defendant simply is not supported by the language of the statute. The provision in the statute is one of limitation of judgment upon the performance of conditions specified.
>
> * * *
>
> Because the obligation of the Fund is not secondary and is not a set-off, it must be joined and have a right to defend. Nor do we think that the obligation of the Fund may be said to be an affirmative defense of the health care provider. To be such a defense the limitation of liability would need to be conditioned on a notice or pleading. Such an intention cannot be gathered from the statute. Perhaps that would have been a better way to have written the limitation but the wisdom of legislation is not within our province. (371 So.2d at 1079)

6. Requiring the defendant health care provider to bring the Fund into the case creates a potential for an unavoidable loss of "coverage" by the health care provider. This would occur if the health care provider is sued at or near the end of the applicable statute of limitations period. It is, of course, the filing of the complaint which tolls the statute of limitations period, or which must be filed within a certain period of time following the administrative claim. A plaintiff could sue a health care provider shortly before the running of the statute of limitations, and by the time the defendant is served, and has a reasonable opportunity to join the Fund, the statute of limitations has run against the Fund.

On the other hand, it is the plaintiff who governs the date on which he or she sues the health care provider. Such a plaintiff can, on that date, join the Fund in the claim, whether or not he has determined that the health care provider was a member of the Fund. If it is subsequently determined that the health care provider was not a member of the Fund, then the Fund can be dismissed from the suit. This is frequently done. There is no reason for the plaintiff to establish that the health care provider was or was not a member of the Fund before he files his suit. If, however, the health care provider is required to join the Fund after he or she is sued, then by the time the provider has notice of the suit, any right he or she had against the Fund could be lost. It is, therefore, clear that the decision of the First District Court of Appeal in the case at bar and in Meeks,

is contrary to the statute, for those decisions permit an unavoidable forfeiture of coverage by the health care provider without the health care provider being able to prevent it.

7. The Meeks rationale of requiring the health care provider, not the plaintiff, to sue the Fund was never raised by the Plaintiffs at the trial level, in the appellate briefs, or in oral argument. Thus the court was never given an adequate opportunity to consider the many consequences of its action.

8. There is a logical inconsistency in holding that a health care provider can limit its exposure to $100,000.00 only by joining the Patients' Compensation Fund to the suit. It is logically inconsistent because if the Fund is joined in the case, there is no reason to file a motion and obtain a "limitation of liability", since in that event the Fund would be duty-bound to pay, up to its contractual limits, any verdict in excess of the underlying $100,000.00 per member. In that event, where the Fund is in the case, the problem of limiting the liability of the health care provider to $100,000.00 does not even arise. If, therefore, the question of limiting the liability of the health care provider to $100,000.00 arises only in a case where the Fund has not been joined, it cannot logically be said that there can be no limitation of liability solely because the health care provider did not join the Fund.

9. Finally, an interpretation of the statute which requires the health care provider to join the Fund in the case overlooks the fact that if the legislature intended that result,

it could have easily stated the requirement, in plain English. The legislature did not do so. Instead, the legislature used language which numerous courts and the administrators of the Fund have always interpreted, until Meeks was decided, to mean that the statute requires the plaintiff, not the defendant, to join the Fund, and that if the Fund is not joined, the health care provider shall not be liable for an amount in excess of $100,000.00 per claim. Taddiken v. Florida Patient's Compensation Fund, 478 So.2d 1078 (Fla. 1985). At the trial level and on appeal, the Plaintiffs in the instant case never once argued that Gup and the Clinic had the duty themselves to join the Fund.

ARGUMENT--ISSUE II.

THE COURT ERRED IN CONSTRUING §768.54(2)(b), FLORIDA STATUTES (1977) TO REQUIRE A $100,000.00 ESCROW ACCOUNT PER CLAIM, WHERE THE HEALTH CARE PROVIDER HAD PROVED FINANCIAL RESPONSIBILITY IN THE AMOUNT OF $100,000.00 PER CLAIM TO THE SATISFACTION OF THE BOARD OF GOVERNORS OF THE FUND.

This issue was briefed by the parties before the First District Court of Appeals. An Amicus Curiae brief was filed by the Florida Patients' Compensation Fund on the side of Gup and the Clinic. It was also argued at oral argument. However, the First District Court of Appeal made no ruling on this point, choosing instead to affirm on other grounds; namely, on the authority of Tallahassee Memorial Regional Medical Center, Inc. v. Meeks, 543 So.2d 770 (Fla. 1st DCA 1989). (See Issue I.) Specifically, the court stated:

> We need not decide whether the trial court's above rationale was correct because the court's denial of the limitation motion is affirmable for another, more basic, reason under the recent holding of this court in Tallahassee Memorial Regional Medical Center v. Meeks, 543 So.2d 770 (Fla. 1st DCA 1989).

Notwithstanding that fact, since both Meeks and the instant case have been certified by the First District Court of Appeal as being in conflict with existing case law, this court has jurisdiction to resolve this issue, even though the First District Court of Appeal made no ruling on it. See Bankers Multiple Line Insurance Co. v. Farish, 464 So.2d 530 (Fla. 1985), and Dania Jai-Alai Palace, Inc., v. Sykes, 450 So.2d 1114 (Fla. 1984), citing Bould v. Touchette, 349 So.2d 1181 (Fla. 1977).

Section 768.54(2)(b), Florida Statutes (1977) states:

(b) Each health care provider shall not be liable for an amount in excess of $100,000.00 per claim for claims covered under subsection (3) in this statute if, at the time the incident giving rise to the cause of the claim occurred, the health care provider:

1. HAD:

a. Posted bond in the amount of $100,000 per claim;

b. Proved financial responsibility in the amount of $100,000 per claim to the satisfaction of the board of governors of the fund through the establishment of an appropriate escrow account;

c. Obtained medical malpractice insurance in the amount of $100,000 or more per claim from private insurers or the Joint Underwriting Association established under subsection 627.351(7); or

d. Obtained self-insurance as provided in s. 627.357, providing coverage in an amount of $100,000 or more per claim, and

2. Had paid, for the year in which the incident occurred for which the claim was filed, the fee required pursuant to subsection (3).

The Clinic and Dr. Gup were proceeding under subsection 1.b. According to the Fund, as shown by the testimony of Portero, Odem, Wester, Sims, and Luther Smith, the Clinic and Dr. Gup were in full compliance with the statute. Specifically, at the request and direction of the Fund and the Department of Insurance, the Clinic had posted a $100,000.00 escrow account; they had furnished the Fund with financial statements of assets in excess of $9,000,000.00; they had shown proof of a $1,000,000.00 open line of credit, and provided verification that

the Clinic was a general partnership, wherein each of the doctors (over 70 at that time) were individually liable for any judgment entered against them. The Fund administrators testified that that financial information "proved financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the Board of Governors of the Fund".

The administrators of the Fund also testified that had the Fund been properly joined by the plaintiff in the suit, the Fund would have paid the entire verdict in excess of $200,000.00, (representing the $100,000.00 underlying liability for each of the two certificate holders--Dr. Gup and the Medical Center Clinic). In fact, the administrators testified that the Fund had paid a claim which was settled during the certificate period involved in the instant case. In that case, the Fund had been properly joined in the case by the plaintiff.

Since Cook had failed to join the Fund in the instant case, and the applicable statute of limitations had run, Cook sought to avoid the limitation of judgment by arguing that the Clinic and Dr. Gup were not in full compliance with the statute. In spite of the testimony from the Fund administrators, the trial court found that the Clinic and Dr. Gup were not in full compliance. Specifically, the trial court found that F.S. §768.54(2)(b)1.b. required a separate escrow account containing $100,000.00 for each of three claims pending at the time of the alleged incident.

In reaching that decision, the trial court found that Mercy Hospital, Inc., v. Menendez, 400 So.2d 48 (Fla. 3d DCA 1981),

(Mercy Hospital II) was controlling. The trial court's decision to apply Mercy Hospital II was incorrect for the following reasons:

1. In Mercy Hospital II, there was no evidence from the Fund administrators as to whether the Fund regarded Mercy Hospital as being in compliance with the statute. There was no indication that the Fund administrators testified concerning the Fund's interpretation and application of the applicable statutory language. In the case at bar, however, four different Fund representatives/administrators explained in detail how they interpreted and applied the statute, and explained in detail how and why the Clinic and Dr. Gup were considered to be in compliance with the statute.

In Mercy Hospital II there was no indication of the hospital's proof of "financial responsibility", which could serve to qualify Mercy Hospital under subparagraph (b) of the statute. In the case at bar, at the request of the Fund and the Department of Insurance, the Clinic submitted financial information showing accounts receivable of $6.8 million dollars in 1975 and over $9,000,000.00 in 1976. Plus, they submitted evidence of a $1,000,000.00 open line of credit, the existence of a $100,000.00 escrow account, and proof that the Clinic was a general partnership, in which each member was individually liable for any verdict rendered against the group or any of its members.

The Fund administrators testified that that financial information was accepted by the Board of Governors of the Fund,

so that Fund-membership certificates were issued to the Clinic and to Dr. Gup for the years in question.

Further, the Fund administrators testified that the Fund had paid its share of a settlement arising in the certificate-year in question, because the Fund had been joined by the plaintiff in that suit. The administrators testified that if the Fund had been joined in this case, the Fund would have paid.

2. According to the decision in Mercy Hospital II, the court was not confronted with such evidence (See Mercy Hospital, Inc., v. Menendez, 371 So.2d 1077 (Fla. 3d DCA 1979) (Mercy Hospital I) for a full discussion of the facts.) The court in Mercy Hospital II did not consider, and was not required to consider the following, important rule of statutory interpretation:

> COURTS MUST DEFER TO THE INTERPRETATION OF A STATUTE GIVEN TO IT BY A STATE-CREATED AGENCY WHICH IS CHARGED WITH INTERPRETING AND APPLYING THE STATUTE IF THE AGENCY'S INTERPRETATION IS REASONABLE, AND SUPPORTED BY THE EVIDENCE.

In the case at bar, the trial court should have applied that rule of statutory construction, but failed to do so.

In Public Employees Relations Commission v. Dade County Police Benevolent Association, 467 So.2d 987 (Fla. 1985) this court articulated the rule of law on this point. The court stated:

> . . . The commission [Public Employees Relations Commission] has the principal responsibility of

> interpreting the statutory provisions consistent with the legislature's intent and objectives. [Citations omitted]. . . Further, we agree that a reviewing court must defer to an agency's interpretation of an operable statute as long as that interpretation is consistent with legislative intent and is supported by substantial, competent evidence. . . (467 So.2d at 989) (emphasis added)

Department of Insurance v. Southeast Volusia Hospital District, 438 So.2d 815 (Fla. 1983), applied this rule of law to the Florida Patients' Compensation Fund. The court stated specifically:

> . . . The administrative construction of a statute by the agency charged with its administration is entitled to great weight. We will not overturn an agency's interpretation unless clearly erroneous. (Citing State ex rel. Biscayne Kennel Club v. Board of Business Regulation, 276 So.2d 823, 828 (Fla. 1973) (438 So.2d at 820).

3. There is an important practical reason for the court to defer to the interpretation and application placed on the statute by the Patient's Compensation Fund and its administrators. The Fund administrators communicate directly with Florida health care providers who paid their fees and assessments to obtain "insurance coverage" from the Fund, through the program set up by the state legislature. The health care providers rely upon the Fund administrators to tell them exactly what needs to be done, including payment of fees, proving financial responsibility, posting bonds, or setting up escrow accounts, in order to obtain the benefits and protections of the Florida Patient's Compensation Fund.

The evidence was clear in the case at bar that the Clinic and Dr. Gup did in fact rely on the Fund administrators, and complied fully with each and every demand and request given to them by the Fund. Having done that, it is only reasonable, and it is only fair, that these health care providers be able to obtain the limitation of judgment which the statute contemplated. A great injustice results to them if they are denied the limitation of liability only because they did not post two additional escrow accounts of $100,000.00, when the Fund administrators had told them they had qualified under subsection (b), by having proved financial responsibility to the satisfaction of the Board of Governors.

If a state agency, established by the legislature to interpret and apply a statute, deals with Florida citizens and tells them how to comply with the statute, and that what they have done does comply, it is a good and reasonable rule of law that courts should defer to those interpretations and applications, unless they are "clearly erroneous".

4. In Mercy Hospital II, the court was free to apply its own interpretation, without the advantage (or disadvantage) of evidence telling the court what interpretation the Fund applied in its dealings with health care providers across the State of Florida. Its ruling, therefore, cannot be regarded as a rejection of the rule of law which requires a court to give "great weight" to such an interpretation, and to defer to the agency's interpretation. The trial court in the instant case

mis-applied Mercy Hospital II, because in the instant case the record was replete with testimony, uncontradicted, that the Fund never required or requested that the Medical Center Clinic establish a $100,000.00 escrow for each claim, because the Fund had accepted the financial statements from the Clinic as solid proof of "financial responsibility".

It is absurd to think that the Clinic, with $9,000,000.00 per year in accounts receivable, a $1,000,000.00 line of credit, and with members who were facing individual liability, would not have set up the $100,000.00 escrow accounts if the Fund had requested it. In the face of that testimony, which was not present in Mercy Hospital II, Mercy Hospital II should not have been accepted as controlling authority. It was, in that sense, "limited to its facts", and the facts were very much different from the case at bar.

5. The interpretation placed on F.S. §768.54(2)(b) by the Fund was reasonable and proper. In fact, the interpretation placed upon the statute by the Fund and its administrators is far more reasonable, and consistent with proper statutory interpretation, than that placed upon it by the trial court.

In Lusker v. Guardianship of Lusker, 434 So.2d 951 (Fla. 2d DCA 1983) the court stated: "A statute is to be construed so that it is meaningful in all of its parts." (434 So.2d at page 953) A statute is to be interpreted so that any one part does not become nugatory or surplusage. A statute is to be interpreted so that its language is given its "plain meaning".

Southeastern Fisheries Association, Inc. v. Department of Natural Resources, 453 So.2d 1351 (Fla. 1984).

In the instant case, if subsection (b)1.b. was intended to require a $100,000.00 escrow account per claim, notwithstanding other proof of financial responsibility, the legislature would have said so in plain language. Subsection (b)1.a. reads: "[Had] posted bond in the amount of $100,000.00 per claim". If subsection (b)1.b. was intended to mean "[Had] established an escrow account in the amount of $100,000.00 per claim", the legislature would have stated the requirement in that language, identical in form to subsection (b)1.a., which immediately preceded it. Instead, the legislature used the following language:

> [Had] proved financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the Board of Governors of the Fund through the establishment of an appropriate escrow account. (emphasis added)

Most of the language in that subsection would be "surplusage" or "nugatory", if it actually meant that an escrow account of $100,000.00 per claim must be established. If that were its meaning, there is no logical purpose for the language "proved financial responsibility . . . to the satisfaction of the Board of Governors of the Fund".

Further, if the legislature intended that the health care provider must establish an escrow account of $100,000.00 per claim, regardless of the proof of "financial responsibility", it could have combined sub-sections (2)(b)1.a. and b. to read: "[Had] posted a bond or established an escrow account in the

amount of $100,000.00 per claim." The legislature did not do so, because the language "proof of financial responsibility to the satisfaction of the Board of Governors of the Fund" was intended to have meaning. The interpretation given to that language by the Fund administrators, as proved in this case, gives that language a reasonable meaning. The interpretation and the decision of the trial court makes that language "nugatory" and "surplusage". The decision of the trial court should be reversed.

The Fund, according to the testimony of its administrators, did not interpret subsection (b) to require an escrow of $100,000.00 per claim. The Fund interpreted and applied that statute as allowing other "proof of financial responsibility in the amount of $100,000.00 per claim to the satisfaction of the Board of Governors of the Fund". Logically, and in line with time-honored rules of statutory interpretation, the Fund administrators have properly interpreted and applied the statute. The interpretation placed on the statute by the trial court in the instant case, was the interpretation which is erroneous, and which leaves words in the statute "nugatory" and "surplusage".

6. Even if §768.54(2)(b) had required the placing of $100,000.00 per claim into an escrow account, the Clinic and Dr. Gup were in compliance with even that stricter interpretation of the statute. Plaintiff was first seen by Dr. Gup on November 8, 1977, and was last seen by Dr. Gup on December 17, 1977. During that time period the Clinic had only only claim pending against

it, and there were no claims pending against Dr. Gup. Therefore, "at the time the incident giving rise to the cause of the claim occurred" the Clinic had $100,000.00 in escrow for each pending claim.

For all the reasons outlined above, it is erroneous to require the health care provider to have an escrow of $100,000.00 per claim, when the statute clearly does not require it, and the Fund itself has never required it from its members.

VII. CONCLUSION

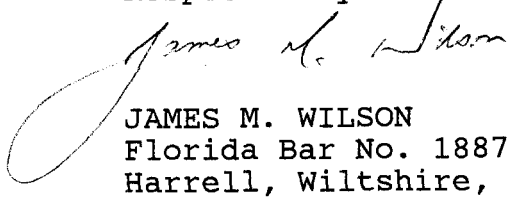
The First District Court of Appeal held that a plaintiff need not join the Fund as a defendant in the suit in order to collect a judgment in excess of the underlying $100,000.00. It held that if the health care provider desires to limit its liability for the judgment in excess of $100,000.00, it has the duty to sue the Fund. Those holdings are contrary to the plain language of the statute, and should be reversed.

On the second issue, the court should reverse the trial court's decision that the Clinic and Dr. Gup were not in compliance with the statute, since they did not set up a $100,000.00 escrow account for each pending claim. That interpretation is contrary to the wording of the statute and interpretation and application of that statute by the Florida Patient's Compensation Fund administrators.

For the reasons stated above, the Court should reverse the First District Court of Appeal in the instant case on these issues and hold that Dr. Gup and the Clinic are entitled to a limitation of their liability to $100,000.00 each as the statute provides.

The Court is reminded that the First District Court of Appeal ruled in favor of petitioners Gup and the Clinic on a different issue, relating to the amount of damages awarded. That part of the First District Court of Appeal's opinion should be left intact. This Court's decision should specify that the other issue is not affected by it.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing has been furnished by U.S. Mail to Robert J. Mayes, Esquire, 226 South Palafox Street, Pensacola, FL and William C. Baker, Jr., Esquire, 300 East Government Street, Pensacola, FL, and to Marguerite H. Davis, Esquire, 215 South Monroe Street, First Florida Bank Building, Suite 400, Tallahassee, FL 32301, this 6th day of November, 1989.

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