IN THE SUPREME COURT OF FLORIDA

CASE NO. SC09-1771

WILLIAM COX and MARTHA COX,

Petitioners,

vs.

ST. JOSEPH'S HOSPITAL,
ERIC CASTELLUCCI, M.D.,
and EMERGENCY MEDICAL
ASSOCIATION OF FLORIDA, LLC,

Respondents.
_____/

ON DISCRETIONARY REVIEW FROM THE DISTRICT
COURT OF APPEAL OF FLORIDA, SECOND DISTRICT

PETITIONERS' BRIEF ON THE MERITS

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I. STATEMENT OF THE CASE AND FACTS

A. An overview.

At the age of 69, William Cox suffered a stroke, caused by a blood clot.[1/] He was rushed to St. Joseph's Hospital by emergency medical personnel and came under the care of Dr. Eric Castellucci. Although he arrived in the emergency room within minutes of suffering the stroke -- well within the three-hour window for the administration of a tissue plasminogen activator drug (tPA), which dissolves blood clots -- neither the Hospital nor Dr. Castellucci bothered to determine the time of onset, and he was never given the drug as a result. The consequences were devastating. In a medical malpractice action brought by Mr. and Mrs. Cox against the Hospital, Dr. Castellucci and the doctor's LLC, the jury found that both the Hospital and Dr. Castellucci had acted in "reckless disregard" of Mr. Cox's health, and that their disregard caused Mr. Cox considerable damage.

Both defendants appealed to the District Court of Appeal, Second District. They did not challenge, and the district court did not disturb, the jury's finding of "reckless disregard." Based entirely upon a single decade-old study of the efficacy of tPA therapy -- the "NINDS study," a study in which the rate of success was 31% -- the defendants challenged the sufficiency of the evidence to support the jury's finding of fact that the defendants' reckless disregard of Mr. Cox's health

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[1/] This introductory "overview" is taken from the face of the district court's decision. *St. Joseph's Hospital v. Cox*, 14 So.3d 1124 (Fla. 2d DCA 2009) (A. 1-5).

caused him damage. And based exclusively upon that decade-old study, the district court agreed with the defendants, disregarded expert medical opinion testimony proving a *prima facie* case of causation, reversed Mr. Cox's judgment, and ordered entry of a judgment in the defendants' favor.

The district court acknowledged that Mr. Cox presented the opinion testimony of two highly qualified experts -- an internationally recognized expert in the treatment of stroke patients, and the on-call neurologist who would have administered tPA to Mr. Cox if he had been called on time. And the district court acknowledged that both experts opined that, "to a high degree of medical probability" and "more likely than not," had Mr. Cox been given tPA treatment, he would have had a very good recovery.

The district court also acknowledged several of its own decisions holding that an expert opinion satisfying the "more likely than not" standard was sufficient to defeat a motion for directed verdict on the issue of causation, but declined to follow them because "the plaintiff's expert testimony on causation [in those cases] was not constrained by statistical evidence revealing success rates of less than fifty percent, as in this case" (A. 4). In addition, although the district court possessed no medical expertise on the subject itself, and actually set out in its opinion a number of the facts upon which one of the experts based her opinion, it declared the experts' causation opinions "speculative" because unsupported by sufficient "facts" upon which the opinions were based.

As we will demonstrate in the argument that follows, these conclusions are in express and direct conflict with decisions of this Court and other district courts of appeal on at least two, and more likely four, questions of law. These conclusions are also erroneous as a matter of law. Initially, however, we will detail the facts underlying the issues presented here.[2/]

B. The defendants' "reckless disregard."

On the morning of January 19, 2001, 69-year old William Cox visited a used car dealership owned by a friend, Maria Rendon, to work on a model airplane (T. 669, 1179-82, 1326-27). Another friend of Ms. Rendon's, Julio Devilla, also visited the lot that morning; he spoke to Mr. Cox for several minutes, and Mr. Cox appeared normal to him at that time (T. 1182, 1210-12). Less than 15 minutes later, Mr. Devilla discovered Mr. Cox slumped over, appearing intoxicated, and unable to speak or walk (T. 1183-84, 1212-13, 1225-26, 1231, 1237). He immediately called 911 -- at 11:15 -- and Tampa Fire Rescue was dispatched to the scene (T. 637, 1213). Lt. Terry Oliver, the responding paramedic, arrived on scene at 11:21, evaluated Mr. Cox as a stroke patient, and learned from Mr.

[2/] Because the jury returned a verdict in favor of the plaintiffs, we will state the facts in a light most favorable to the verdict, with all conflicts resolved and all reasonable inferences drawn in the plaintiffs' favor -- as we are entitled to do. *See Goldberg v. Florida Power & Light Co.*, 899 So.2d 1105, 1110 (Fla. 2005); *Irven v. Dept. of Health & Rehabilitative Services*, 790 So.2d 403, 406 n. 2 (Fla. 2001). Although the district court purported to view the facts in a light most favorable to the plaintiffs, it will be apparent as we proceed that the district court wandered across this line in several respects.

Devilla that the stroke had occurred between 11:00 and 11:15 (T. 629-37, 640, 649, 671-72, 1225-26, 1232). He departed the scene with Mr. Cox at 11:33, radioed a "stroke alert" to the Hospital, and delivered Mr. Cox to the Hospital's emergency room at 11:39 (T. 496-98, 632-40).

The triage of Mr. Cox was delayed until 11:50, and for some reason that is not adequately explained by the evidence, the triage nurse wrote on Mr. Cox's "primary triage assessment" that the stroke was of "unknown onset" (T. 500-10, 1329-30).[3/] It is undisputed on the record that "unknown" does not mean "unknowable," and that the single most important piece of information that must be gathered when a stroke patient arrives in an emergency room is the time of onset of the stroke (T. 484, 489, 503-05, 590, 698, 710-14, 735-36, 818-20, 866-73, 980, 1014, 1747-56).

This information is of critical importance because there is a three-hour window for intravenous administration of a tissue plasminogen activator drug (tPA), a clot-busting drug that is often effective in reversing the effects of a stroke (T. 811-14, 987, 1564-65). And because this information is so critical, neither an

[3/] Mr. Cox's chart does not itself explain where this information came from (T. 510, 596). Lt. Oliver had no memory of telling the triage nurse that the onset of the stroke was unknown, but conceded that he might have; and he conceded that he might not have reported the information he had received from Mr. Devilla, but stated that, had anyone asked him if he had learned additional information from which the time of onset might be determined, he would have elaborated upon his conversation with Mr. Devilla (T. 641, 666-68, 671-73). The triage nurse also had no memory of where she obtained the information, but assumed it had been

ER physician nor ER nurses can accept "unknown onset" as the last word; rather, they simply must seek out the information from every possible source available to them -- from family, from friends, and especially from anyone who might be in the waiting room (T. 492-95, 503-05, 513-16, 530-31, 590-93, 701-02, 818-25, 832-33, 853, 866-68, 916, 937-43, 976-79, 991, 1005).

Well within the three-hour window for the administration of tPA, there were five people who knew the time of onset, four of whom were actually at the emergency room. Lt. Oliver did not leave the emergency room until 12:31, 52 minutes after his arrival (T. 640-41). Although he had reported that Mr. Cox had been found by a "worker" five minutes before his arrival, and this information was in Mr. Cox's chart in Dr. Castellucci's own handwriting, he was not questioned about his conversation with Mr. Devilla (T. 509-14, 533-34, 641, 721-23, 832). He also could have been reached by radio after he left the hospital, but he was not contacted (T. 641).

Mr. Devilla had also told Ms. Rendon and Mrs. Cox about his normal conversation with Mr. Cox less than 15 minutes before he called 911 at 11:15, and all three of them were in the emergency room's waiting room for extended periods of time -- but were never questioned as to what they knew about the time of onset (T. 1189-94, 1208, 1214-15, 1223, 1371-73, 1375-76, 1431). Indeed, Mrs. Cox arrived at noon and remained there throughout the remainder of the three-hour

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provided by Lt. Oliver (T. 1331).

window of opportunity, but Dr. Castellucci never talked to her (T. 1370, 1375-76, 1408-14, 1418). Mr. Cox's adult son had also been given the same information and was at home, available by telephone, but no one sought the information from him either (T. 1267-69).

According to the emergency room nurse assigned to Mr. Cox's primary care, there was no need for her to seek out information from these persons because the "onset was already assessed" (T. 725). And because the triage nurse's assessment was "unknown onset," Mr. Cox was not treated as a "stroke alert" patient; rather, he was simply treated as a stroke patient -- one who, because the time of onset was not known, was not a candidate for tPA (T. 528-29, 543-45, 606-07, 730-33, 754-55, 843).

Although Dr. Castellucci testified that a CT scan of Mr. Cox's brain should have been ordered within 10 minutes and its results returned within 45 minutes after the patient's arrival in the emergency room, he was not notified to see the patient for 36 minutes, and did not see Mr. Cox until 12:15 (T. 498, 505-06, 546). At 12:30, 51 minutes after Mr. Cox's arrival in the emergency room, Dr. Castellucci wrote orders for several tests, including a CT scan, which is critical to determine if the patient is a candidate for tPA -- and ordered that Dr. Kotwal be called (T. 520-25, 602-05, 829, 1149-53, 1171). Although Dr. Kotwal was an internist, the Hospital's protocol required that he be called to make the decision as to whether to bring in a neurologist, who was the only specialist qualified to order

administration of tPA (T. 477, 563-65, 814).

It took the nursing staff another 23 minutes to request a CT scan; the order was finally "taken off" at 12:53 (T. 524-554). The three-hour window for administration of tPA closed between 2:00 and 2:15 (T. 841). The results of the CT scan were not faxed to the emergency room until 2:58, nearly two and one-half hours after Dr. Castellucci had ordered it -- a delay that one of the plaintiffs' experts characterized as "unconscionable" (T. 527-28, 837-39). Dr. Kotwal was not called until 4:00, three and one-half hours after Dr. Castellucci ordered that he be called, and he was not reached; he was called again at 4:15 and returned the call at 4:24 (T. 1158-62). The on-call neurologist, Dr. Berges, was finally reached at 5:53 -- much too late for tPA to be given to Mr. Cox (T. 477, 1165-66).

All of the test results that were ultimately returned to Dr. Castellucci -- including the CT scan -- were essentially normal, and the *only* thing in Mr. Cox's chart that would have prevented Mr. Cox from obtaining tPA was the triage nurse's initial assessment that the onset of the stroke was "unknown" (T. 528-29, 543-45, 602-07, 974, 1058-64, 1567). The consequences of this neglect were devastating (T. 811) -- but because the defendants raised no challenge below to the amounts of the jury's damage awards, we will spare the Court the tragic details.

At trial, Dr. Castellucci himself was highly critical of the conduct of the Hospital's nurses (T. 503-05, 514-15, 526-28, 531, 618). And as the Court might expect, there was abundant, highly-qualified expert opinion testimony establishing

that the conduct of both Dr. Castellucci and the Hospital's nurses rose to the level of "reckless disregard" for the health and welfare of Mr. Cox (T. 810-11, 832-33, 843-44, 941-49, 976-79, 991, 1005). The defendants did not challenge the sufficiency of the evidence to support the jury's finding of "reckless disregard," but they did challenge the jury's additional finding that their "reckless disregard" of Mr. Cox's health and welfare was a cause of damage. The evidence supporting the jury's finding of causation came from two sources, Dr. Nancy Futrell and Dr. Eddy Berges.

C. Dr. Nancy Futrell.

Dr. Futrell obtained her medical degree from the University of Utah Medical School; did an internship in internal medicine there; did an additional year of neurology there; and then went to the University of Miami where she finished her neurology training and did a stroke fellowship (T. 1037). From there, she practiced neurology and stroke care at Henry Ford Hospital (T. 1038). Subsequently, she was director of the stroke center at Creighton University; she started a stroke center at the Medical College of Ohio, and became chairperson of its neurology department (T. 1038-39). She then returned to Utah where she started the Intermountain Stroke Center in Salt Lake City (T. 1040).

She is board certified in the following specialities: neurocineology (ultrasound of the blood vessels and brain); neuroimaging (reading CT scans and MRI scans of the brain); and vascular neurology (stroke specialist), and she was

instrumental in establishing a certification program for this specialty (T. 1041-43). She has written a practice test book for the vascular neurology certification examination (T. 1044). And she has performed as a "CT Scan Images Analysis Contracts Investigator" in two multi-center national clinical trials, analyzing between 900 and 1100 CT scans of stroke patients (T. 1044-46).

She has served on the editorial boards of the following journals: "Stroke, a Journal of Cerebral Circulation"; "Surgical Neurology," an international journal; "The Journal of Stroke and Cerebral Diseases," where she was also an editor (T. 1046-47). She is currently serving on the editorial board of Europe's premier journal, "Cerebral Vascular Diseases" (T. 1047-48). She has lectured on the treatment of strokes at major institutions in the United States and in Europe at least 40 or 50 times, and does so several times a year (T. 1048). And she is a member of the board of directors of two organizations that certify MRI scanning facilities and CT scanning facilities (T. 1049-51).

The defendants did not challenge Dr. Futrell's qualifications to testify as an expert. She gave the following opinions on the causation issue in the case:

> Q. Before we find out how you got to your conclusions, tell us what your conclusions were.
>
> A. Well, my conclusions were that Mr. Cox arrived at the emergency room in the appropriate time window to receive T.P.A., that he was an appropriate candidate for T.P.A. and that all of the indications we have from his clinical status in the emergency room and the CT in the emergency room suggests that he probably would have

had a very good outcome had he received the medication.

. . . .

Q. . . . Dr. Futrell, after you've reviewed all the records, reviewed the depositions, the transcripts, reviewed the facts of this case about Mr. Cox, do you have an opinion *more likely than not within a reasonable degree of medical probability* whether had Mr. Cox been given T.P.A. under the circumstances of this case, whether he would have gained a benefit and whether or not his stroke would have resolved or been significantly lessened as a result of the use of T.P.A.?

A. I believe *to a high degree of medical probability that Mr. Cox, had he received T.P.A., would have had a very good recovery and have minimal or no neurologic deficit.*

. . . .

Q. . . . Now ma'am, you've also told this jury that it's your opinion that if the patient had been given this, he would have made an almost complete recovery or very minimal problems; is that correct?

A. Yes.

(T. 1052-53, 1076-77, 1097; emphasis supplied). There were no objections to this opinion testimony.

The defendants' principal contention at trial was that Mr. Cox was not a candidate for tPA because he had had a subdural hematoma two and one-half years before his stroke, and a prior subdural hematoma was listed as a

"contraindication" for the use of tPA in the manufacturer's package insert approved by the FDA. In a subsequent subsection of our statement, we will elaborate upon this defense by detailing the abundant evidence supporting the jury's rejection of it, but we mention it here because Dr. Futrell addressed it in some detail in explaining how and why she reached the conclusion she did.

To begin with, she testified that she was not sure if Mr. Cox had ever had a prior subdural hematoma, because the report of one CT scan said he did, and the report for a CT scan taken six weeks later said he did not -- facts that were also established by the physician who had treated Mr. Cox two and one-half years earlier (T. 1053, 1633, 1643-44, 1649). She then testified that she reviewed the CT scan taken of Mr. Cox's brain after his stroke and could see no sign that there had ever been a significant subdural hematoma -- nothing, no sign of any damage in his brain whatsoever -- nothing that would relate to any risk of administering tPA (T. 1054).

Mr. Cox's CT scan was then displayed to the jury and explained in considerable detail. Dr. Futrell testified that the scan revealed a brain that looked much younger than Mr. Cox's stated age; that there was no sign of any fresh bleeding in the brain; that there was no sign whatsoever that Mr. Cox had had a prior bleed into his brain; and that the scan showed nothing to suggest that tPA treatment should be withheld (T. 1055-60). Indeed, based upon her analysis of the CT scan, Dr. Futrell described Mr. Cox's brain as "super normal," and stated that

he was a "great candidate" for tPA. She also testified that she had treated 40-50 patients with tPA -- three of whom had things listed as "contraindications," and that all three of them had gone back to work (T. 1067, 1137).

Finally, Dr. Futrell explained how she reached her opinion that Mr. Cox "would have had a very good recovery and had minimal or no neurological deficit":

> Q. How can you tell us that?
>
> A. Well, there are a number of things and it's a combination of what we can find in the medical literature and clinical experience that I have from having given the drug and seeing which patient it works on and, of course, we have the additional resource of our colleagues that we know what's happened to their cases. We also discuss our good outcomes and our bad outcomes and we hone each other's skills that way. And basically the data are that in patients who are given T.P.A. within the three-hour window who are appropriate candidates, the best study that kept mostly good, kept the protocol violators out was from Canada and it was written by a guy name[d] Alastair Bookman. He was able --
>
> [An objection was sustained at this point]
>
> Q. (By Mr. Brennan [counsel for plaintiffs]) I asked a too open-en[d]ed question and I apologize. From all you know and all you've seen about this case, is it your opinion T.P.A. would have worked on Mr. Cox had he been given it?
>
> A. Yes.

(T. 1077-78).

D. Dr. Eddy Berges.

Dr. Berges was the on-call neurologist who would have determined whether tPA treatment of Mr. Cox was warranted. On April 17, 2003 -- almost a year and one-half after suit had been filed and more than three and one-half years before the trial commenced, Dr. Berges provided plaintiffs' counsel with a letter in which he expressed his expert opinions on the case (R. 1; T. 1, 1558-63, 1586-87, 1594).[4/] In that letter he opined that, within a reasonable degree of medical probability, if he had been called within the three-hour window, he would have treated Mr. Cox with tPA, and more likely than not, Mr. Cox would have benefitted and his neurodeficits would have resolved and been reversed (T. 1569-70). In a deposition taken by the defendants eight days before trial, Dr. Berges reaffirmed the opinions he had previously held, based on the information he had at the time, but recanted the opinions on the ground that he now knew that Mr. Cox had a prior subdural hematoma (T. 1, 1557, 1567, 1571, 1587, 1594, 1606).

On cross-examination during the deposition, plaintiffs' counsel established that Dr. Berges had staff privileges at the defendant-Hospital; that, after he had provided his opinion letter in this case, he had been sued for giving tPA to a patient in another case; and that he had changed his opinion in this case after he

[4/] The letter itself was excluded from evidence; it was marked PX2 for ID, and can be found at R. 2627-29 (T. 1628-30). Portions of the letter were disclosed to the jury through the deposition testimony read at trial.

was sued (T. 1592-93). The defendants' principal defense below was bottomed upon Dr. Berges' recantation. At an appropriate place in our argument, we will explain why the jury was entitled to believe Dr. Berges' initial opinion and reject his recantation. For the moment, we will explain why the jury was entitled to reject the defendants' principal defense, even if it believed the recantation.

E. The "subdural hematoma" defense.

The defendants' principal defense was that Mr. Cox was not a candidate for tPA because he had had a subdural hematoma two and one-half years before his stroke, and a prior subdural hematoma was listed as a "contraindication" for the use of tPA in the manufacturer's package insert approved by the FDA. This was an interesting "after-the-fact" defense, of course, since neither Dr. Castellucci nor the Hospital's nurses knew of Mr. Cox's medical history in the three-hour window available to them, and did not bother to find out -- and Dr. Berges, the neurologist on call for Mr. Cox testified that, based on the information he had at the time of Mr. Cox's hospitalization (which did not include a history of prior subdural hematoma -- T. 562-63), tPA therapy for Mr. Cox would have been applicable (T. 1567).

The defense also required the jury to accept the probability of several events which, because of the defendants' reckless disregard of Mr. Cox's welfare, never happened. It would have required the jury to find as a fact that, if Dr. Berges had been called within the three-hour window, he would have found Mrs. Cox and

asked her if her husband had ever had a subdural hematoma, and that Mrs. Cox -- whose native language was Spanish and whose English was halting, and who thought that her husband had had only had a "bruise" to his brain (T. 1346-51, 1413-14, 1426-30, 1439-40, 1444-45) -- would have stated that he had had a subdural hematoma two and one-half years ago.

Even Dr. Berges admitted that, if he had been called in time, and if he had asked, and if Mrs. Cox had not told him of the prior subdural hematoma, he would probably have given Mr. Cox tPA (T. 1581, 1588-89, 1599-1600). Given the speculative nature of this string of events that never happened -- three "ifs" and a "maybe," as it were -- we believe the jury could have rejected the defense for its speculative nature alone, and relied instead on Dr. Berges' testimony that, based on the information the Hospital and Dr. Castellucci *did* have at the time, tPA therapy was applicable.

But the speculative nature of the defense was not the only reason the jury rejected it. To begin with, as we have previously noted, Dr. Futrell reviewed Mr. Cox's CT scan, and testified that it was highly doubtful that Mr. Cox had suffered a prior subdural hematoma (T. 1053-59). There was also expert testimony establishing that the "contraindication" on the manufacturer's package insert was *not* absolute -- and that tPA therapy was *not* "contraindicated" in Mr. Cox's case. For example, one expert testified that manufacturers typically list almost any sort of "contraindication" in an effort to protect themselves from liability (T. 899).

And the evidence established that the *only* reason that prior subdural hematoma was listed as a "contraindication" was that patients with prior subdural hematomas had been excluded from the drug trials conducted on stroke patients in which the manufacturer obtained FDA approval to market the drug (T. 890-91, 1809-10, 1817).

Moreover, and curiously, although the drug is injected intravenously and therefore goes to the brain when treating conditions other than strokes, subdural hematoma was *not* listed as a "contraindication" for use in treating a clot causing a heart attack -- a fact that underscores the point that the only reason prior subdural hematoma is listed as a "contraindication" for stroke patients is that the drug was not tested on patients with prior subdural hematomas (T. 971-72, 1007-09, 1136-37, 1818-19). And one of the plaintiffs' experts testified that he had successfully given tPA to a cardiac patient with a prior subdural hematoma (T. 975).

There was also abundant expert testimony that the "indications" and "contraindications" listed by the manufacturer were not absolute -- that they were merely "guidelines" or "recommendations" requiring clinical judgment in balancing the benefits of the drug's use against its risks in particular patients (T. 559, 890, 894, 975, 1015-16, 1066-67, 1084-86, 1128-32, 1574-75, 1592, 1811). And there was expert testimony that the use of tPA on patients with a two and one-half year old subdural hematoma that had resolved itself, as reflected by the "super normal" CT scan of Mr. Cox's brain that the Hospital finally delivered to Dr.

Castellucci after the three-hour window had expired, was perfectly appropriate (T. 973-75, 1015-17, 1052-64).

Indeed, there was expert testimony that tPA is in fact given to stroke patients with prior subdural hematomas in appropriate cases -- and given aggressively (T. 894-95, 905-08, 934, 975). And for good measure, the nurse manager at Tampa General Hospital, who had been a charge nurse in its emergency room for 12 years, testified that she had actually given tPA to stroke patients with a prior history of subdural hematoma three to five times (T. 930-34, 951, 962). All of this evidence provided ample support for the jury's rejection of the defendants' highly speculative three "ifs" and a "maybe" defense.

F. The "NINDS" study defense.

The district court did not bottom its reversal on the defendants' three "ifs" and a "maybe" defense. Rather, it determined that the defendants were entitled to judgment in their favor because, in its opinion, a decade-old study of the efficacy of tPA therapy conclusively trumped the plaintiffs' experts' opinion testimony on the issue of causation. The study itself was not in evidence. And the evidence upon which the district court bottomed its reversal covers a mere three pages of the 2,149-page trial transcript:

> Q. (By Mr. Lamb [counsel for the Hospital]): Now ma'-am, you've also told this jury that it's your opinion that if the patient had been given this, he would have made an almost complete recovery or very minimal problems; is that correct?

A. Yes.

Q. You know, do you not, that the best data we have on that issue -- well, let me do it this way. You know that there was a famous study known as the NINDS study published back in 1995 by "The New England Journal of Medicine" and it is only on the basis of that study that around the country people --

. . .

Q. (By Mr. Lamb) Are you familiar with the NINDS study?

A. We call it N-I-N-D-S or the "NINS." We're all talking about the same thing.

Q. And that was [the] study that established satisfactorily for the first time some efficacy with T.P.A. so that people around the country starting using it?

A. You're correct.

Q. That first happened in 1995?

A. That's correct and, as you said, it was the first study.

Q. Yes, ma'am. And we know, don't we, that for people who met the criteria for that study, and this gentleman would not have met the criteria for that study because he had had that prior subdural hematoma; right?

[An objection was sustained at this point]

Q. (By Mr. Lamb) The NINDS study indicated, did it not, Doctor, with it's [sic] data that for every patient that made almost a full recovery or the kind of recovery you described to this jury as being more likely than not this is

the thing that's going to happen to Mr. Cox, for every patient that made that kind of recovery, the NINDS study said one of eight patients you gave the medication would make that kind of recovery; right, one of every eight?

A. That's not exactly what, that's a distortion of the NINDS study.

Q. You said that's a distortion, but what's not a distortion is the study said that 20 percent of the people made that kind of recovery without any medication and that when you gave T.P.A., that number went up to 31 percent. That's what it said; right?

A. It said that, yes.

Q. And you know if you do the mathematical calculation that that means you['ve] got to give this medication to eight people to get one that makes the kind of recovery you say Mr. Cox is going to get; isn't that true?

A. No, that's not true.

Q. Why isn't it?

A. Well, first of all, the categories that Mr. Cox would go to would be either of the two. The NINDS study had one category that was for complete recovery and the NIN[D]S had the next category that was for very good recovery or minimal neurological deficit and then there were other categories of moderate deficit, severe deficit and death and there are various ways you can add those numbers together. But the worst number in the NINDS that there was over a 30 percent, it was like 36 percent improvement from other problems and that was including all the people in trial that had bad prognostic factors so that the data have, unfortunately, been excluded in subsequent papers. What you're quoting is a

> paper that later looked at the NINDS data and tried to say that T.P.A. wasn't that good. That number didn't come from the NINDS trial at all.
>
> Q. Did you send Mr. Brennan any information where it was suggested that you'd have to give T.P.A. to eight patients to get one patient to make this kind of recovery?
>
> A. I sent him the paper to which you are referring to show him the way that some folks are distorting the trial data and I sent him [sic] it to him for that explicit purpose.

(T. 1097-1101). This testimony seems far more equivocal than the absoluteness attributed to it by the district court; but because we will demonstrate that, even if absolute, it did not trump the plaintiffs' experts' opinion testimony, we will not belabor the point. With the facts now stated in the proper light, we turn to the district court's application of the law to those facts.

II. ISSUE ON REVIEW

> WHETHER THE DISTRICT COURT OF APPEAL ERRED IN CONCLUDING THAT THE DEFENDANTS WERE ENTITLED TO JUDGMENT IN THEIR FAVOR BECAUSE THE PLAINTIFFS FAILED TO PRESENT A PRIMA FACIE CASE ON THE ISSUE OF PROXIMATE CAUSATION.

III. SUMMARY OF THE ARGUMENT

The plaintiffs presented expert opinion testimony from two experts that the defendants' reckless disregard of Mr. Cox's health and welfare caused him damage, "to a high degree of medical probability" and "more likely than not."

According to *Wale v. Barnes*, 278 So.2d 601 (Fla. 1973), and its extensive progeny, an expert opinion on the issue of medical causation is *direct* evidence on the issue, sufficient to defeat a motion for directed verdict. The district court acknowledged this line of decisions, but then purported to "distinguish" them on the ground that "the plaintiff's expert testimony on causation [in those cases] was not constrained by statistical evidence revealing success rates of less than fifty percent, as in this case." As we explain in the argument that follows, this attempt to "distinguish" *Wale v. Barnes* and its progeny confuses the general with the specific and rests upon a logical fallacy.

Gooding v. University Hospital Building, Inc., 445 So.2d 1015 (Fla. 1984), did not require a different conclusion, and it was misapplied by the district court. In *Gooding*, unlike the plaintiffs' experts in this case, the plaintiff's expert did *not* testify that the chances of the decedent's survival were "more likely than not." *Absent* such testimony, this Court concluded that there was no cause of action for a mere "loss of a chance" to survive and that the defendant was therefore entitled to a directed verdict. In the instant case, the plaintiffs' experts testified that, "to a high degree of medical probability" and "more likely than not," Mr. Cox would have benefitted from tPA treatment. And that is precisely what the *Gooding* decision requires to present a *prima facie* case on the issue of causation. Plaintiffs' experts therefore provided the evidence that was missing in *Gooding*, and that evidence should have been sufficient to withstand the defendants' motion

for directed verdict.

Apparently uncomfortable with its conclusion that the plaintiffs' experts' opinions could be disregarded entirely because "constrained" by a decade-old study of a random sample of stroke patients, the district court went on to declare the experts' opinions "speculative" because unsupported by sufficient "facts." We disagree with the district court's declaration that the opinions were unsupported by sufficient "facts." Both experts had the benefit of all the tests run on Mr. Cox's brain and vascular system -- tests that were specifically designed to determine whether he was an appropriate candidate for tPA therapy, including the CT scan that revealed his "super normal" brain. And, of course, both brought their extensive experience and training to bear upon the opinions they ultimately reached. But we need not belabor these points because, even if the record were entirely devoid of the "facts" upon which the experts based their opinions, the district court's conclusion rests upon a misapprehension of the law governing the issue.

As authority for its conclusion, the district court relied upon a decision of this Court decided half a century ago. That decision is no longer the law, however. Florida's Evidence Code, enacted more than a quarter century ago, now permits an expert to give a competent opinion without disclosing the underlying "facts." Because there is no longer any requirement that the facts underlying an expert opinion be admitted into evidence in order to establish the basis of the

opinion, the district court plainly erred in concluding that it could entirely disregard the plaintiffs' experts' opinions because they were unsupported by sufficient "facts."

The district court's decision also conflicts with other settled principles of the law governing the sufficiency of the evidence in medical malpractice cases. For example, in *Atkins v. Humes*, 110 So.2d 663 (Fla. 1959), this Court established that, except in rare cases, neither a court nor a jury of lay persons can be permitted to decide whether a medical practitioner's treatment or lack thereof was a cause of damage to a patient -- that expert medical testimony is required to establish a fact of that nature. It is also settled that the sufficiency of the facts required to form an opinion must normally be decided by the expert himself because neither trial judges nor appellate judges are in a position to determine precisely which facts are dispensable and which are essential to the validity of the opinion reached.

Yet, that is what the district court did. Although the issue of causation in the case was clearly beyond the capability of lay jurors and judges to decide, and expert medical opinion testimony on the issue was therefore plainly required, a panel of three judges (whom we must assume have no real medical expertise, not to mention any expertise in the treatment of stroke victims and their prospects for recovery from tPA treatment) have told an internationally recognized stroke expert and the neurologist who would have treated Mr. Cox had he been called in time that they did not know what they were talking about -- and told them that, as a

matter of law! Most respectfully, it was legally impermissible for the district court to reject the experts' opinions and decide those facts itself. Determination of the facts belonged to the trier of fact in this case. The district court's decision should be quashed, and the cause should be remanded with directions to affirm the plaintiffs' judgment.

IV. ARGUMENT

THE DISTRICT COURT OF APPEAL ERRED IN CONCLUDING THAT THE DEFENDANTS WERE ENTITLED TO JUDGMENT IN THEIR FAVOR BECAUSE THE PLAINTIFFS FAILED TO PRESENT A PRIMA FACIE CASE ON THE ISSUE OF PROXIMATE CAUSATION.

A. The expert opinion testimony.

As a predicate for what follows, we remind the Court that the plaintiffs presented expert opinion testimony that the defendants' reckless disregard of Mr. Cox's health and welfare caused him damage, "to a high degree of medical probability" and "more likely than not." Although only one of these opinions was necessary to present a *prima facie* case on the issue of causation, there were, in fact, two expert opinions to that effect: (1) one from Dr. Futrell and one from Dr. Berges. Dr. Futrell certainly gave such an opinion. There was no objection to her qualifications to give the opinion; no objection to the opinion itself; and no objection that the opinion should be excluded from evidence as "speculative." Dr. Futrell's opinion is therefore a given here.

Dr. Berges also gave such an opinion, based on what Dr. Castellucci and the Hospital knew during the three-hour window that was available in which he could have and *would have* administered tPA therapy to Mr. Cox. There was no objection to his qualifications to give the opinion; no objection to the opinion itself; and no objection that the opinion should be excluded from evidence as "speculative." The district court discounted this opinion because Dr. Berges recanted it eight days before trial based on a (disputed) medical condition that no one knew about until it was discovered during the course of the litigation. Most respectfully, it was not the district court's function to discount the initial opinion; that function belonged exclusively to the jury impaneled to find the facts in this case.

It is thoroughly settled that a jury is not required to believe or reject the entirety of a witness's testimony. Rather, juries are entitled to accept some parts of a witness's testimony and reject others. *See Goldstein v. Walters*, 126 So.2d 759, 764 (Fla. 2d DCA 1961) (" . . . in the instant case, the jury could properly accept or reject portions of the husband's testimony"); *Haislet v. Crowley*, 170 So.2d 88, 93 (Fla. 2d DCA 1964) (" . . . the acceptance of a part of the plaintiff's testimony and the rejection of another part . . . is within the exclusive province of the jury"); *Marks v. Delcastillo*, 386 So.2d 1259, 1266 (Fla. 3d DCA 1980) (same); *Wynne v. Adside*, 163 So.2d 760, 763-64 (Fla. 1st DCA 1964) (same).

And where a witness has recanted, a jury is not bound to accept the

recantation; rather, it is free to believe the witness's original testimony:

> The logical conclusion of appellant's argument is that juries must believe all or none of a particular witness's testimony. The fallacy of this conclusion is self-evident. Obviously, a witness can tell the truth about some matters and lie about others. In this case, to reach a verdict of guilty, the jury had to believe Ms. Williams' original testimony and disbelieve her recantation. It is not this Court's function to reweigh the evidence, but only to ensure its legal sufficiency.

Burr v. State, 466 So.2d 1051, 1053 (Fla. 1985). *See also Walker v. Fla. Dept. of Business & Professional Regulation*, 705 So.2d 652, 655 (Fla. 5th DCA 1998) ("[T]he trier of fact is never bound to believe any witness, even a witness who is uncontradicted"); *Roach v. CSX Transportation, Inc.*, 598 So.2d 246 (Fla. 1st DCA 1992) (similar).

Given this settled law, the jury was entitled to believe that Dr. Berges changed his opinions in this case because he was angry at being sued, perhaps fearful of losing his staff privileges at the Hospital if he cooperated with the plaintiffs, or perhaps simply in an effort to let a fellow physician off the hook. And the jury was entitled to believe his initial opinions and reject his recantation. And if it did that (and we believe we are entitled to that presumption, given the jury's favorable verdict), Dr. Berges' initial opinion is also a given here.

B. **The sufficiency of the opinion testimony to present a *prima facie* case.**

The district court's decision conflicts with decisions holding that an expert

opinion that a medical defendant's conduct, "to a high degree of medical probability" or "more likely than not," caused a patient damage is direct evidence on the issue, sufficient to defeat a motion for directed verdict.

The leading decision is, of course, *Wale v. Barnes*, 278 So.2d 601, 605 (Fla. 1973), in which this Court squarely held that an expert opinion on the issue of medical causation is *direct* evidence on the issue, sufficient to defeat a motion for directed verdict. And this decision has been the polestar guiding the lower courts ever since. There are numerous decisions that follow *Wale v. Barnes* on this point -- all of which squarely conflict with the decision sought to be reviewed here.[5/] Indeed, we have been unable to find a single decision after *Wale v. Barnes* in which a Florida appellate court has ever held that a verdict can be directed in favor of a medical defendant in the face of expert medical testimony presenting a *prima facie* case on the issue of causation, and we challenge the defendants to find one.

In fact, until the decision in this case, the Second District has faithfully followed this principle of *Wale v. Barnes* every time the issue has arisen there. *See, e. g., Hughes v. Slomka*, 807 So.2d 98, 100 (Fla. 2d DCA 2002) (expert's "more likely than not" opinion "sufficed to withstand a motion for directed verdict on causation"); *Lawrinson v. Bartruff*, 600 So.2d 22, 23 (Fla. 2d DCA 1992)

[5/] The following are representative: *Harris v. Gandy*, 18 So.3d 569 (Fla. 1st DCA 2009); *Olsten Health Services, Inc. v. Cody*, 979 So.2d 1221 (Fla. 3d DCA 2008); *Hancock v. Schorr*, 941 So.2d 409 (Fla. 4th DCA 2006); *McQueen v. Jersani*, 909 So.2d 491 (Fla. 5th DCA 2005); *Singleton v. West Volusia Hospital Authority*, 442 So.2d 235 (Fla. 5th DCA 1983).

(expert's "more likely than not" opinion "created enough of a conflict in the evidence to overcome [the defendant's] motion for directed verdict"); *Mezreh v. Bevis*, 593 So.2d 1214, 1214 (Fla. 2d DCA 1992) (rejecting a defendant's claim of entitlement to a directed verdict because "[t]here was competent expert testimony . . . that had defendants not breached the standard of care, plaintiff's breast cancer 'more likely than not' would have been completely cured"); *Zack v. Centro Espanol Hospital, Inc.*, 319 So.2d 34, 36 (Fla. 2d DCA 1975) ("When considering the expert opinions as direct evidence, the plaintiffs made a prima facie case on the issue of causation, which issue was properly submitted to the jury"; *citing Wale v. Barnes*).

The district court acknowledged this line of decisions in its opinion, but then purported to "distinguish" them on the ground that "the plaintiff's expert testimony on causation [in those cases] was not constrained by statistical evidence revealing success rates of less than fifty percent, as in this case." Most respectfully, this attempt to "distinguish" *Wale v. Barnes* and its progeny on the point confuses the general with the specific and rests upon a logical fallacy.

The study involved stroke patients with various degrees of impairment, some much more serious than the symptoms with which Mr. Cox presented to the emergency room within minutes after his stroke. The issue presented to the jury was whether *Mr. Cox* would have benefitted from tPA treatment, not how many patients in a random sample of stroke victims would benefit from tPA treatment.

And even then, the study demonstrated that at least 31 out of every 100 stroke patients *will* benefit from tPA treatment (which, of course, is why the treatment is available to the right patients). The task faced by the medical experts in this case was to determine, based on all the evidence available to the defendants at the time, whether *Mr. Cox* would have been one of the 31 patients who would benefit from the therapy or one of the 69 who would not.

Both experts testified, in effect, that Mr. Cox, "to a high degree of medical probability" and "more likely than not," fell into the category of those 31% who would benefit from the therapy, not into the category that would not. The decade-old "statistics" certainly presented a conflict in the evidence, since they would have supported a jury finding that Mr. Cox would not "more likely than not" have benefitted from the therapy, but the "statistics" were not *dispositive* of the issue. At most, they simply presented a conflict in the evidence that it was the jury's function to resolve. And because the plaintiffs' experts provided direct evidence on the issue of whether the defendants' reckless disregard caused *Mr. Cox* damage, that evidence was sufficient to prevent a directed verdict in the defendants' favor.

The point can be made in perhaps a different way, closer to home. Law School Aptitude Test (LSAT) scores run the gamut from poor to outstanding -- and statistically at least, the chances of scoring in the top quarter are only 25%, and the chances of scoring in the bottom three-quarters are 75%. By the district

court's logic in this case, a law school admissions committee should reject all applicants because the chance that any one of them scored in the top quartile was only one in four. That would not happen, of course, because each applicant has an *individual* score, so each applicant can be placed in the quartile belonging to that test score, and those who scored in the top quartile can be admitted.

But that is precisely the point that the district court failed to appreciate -- that *Mr. Cox's* chances of benefitting from tPA therapy have to be tied to his *individual* chances -- not to the chances of a random sampling of others whose chances may have varied from zero to 100. And that is what the plaintiffs' experts did. Most respectfully, *Wale v. Barnes* and its numerous progeny cannot fairly be "distinguished" in the manner in which the district court finessed the plaintiffs' experts' opinion testimony in this case.

Gooding v. University Hospital Building, Inc., 445 So.2d 1015 (Fla. 1984), did not require a different conclusion, and it was misapplied by the district court. In *Gooding*, unlike the plaintiffs' experts in this case, the plaintiff's expert did *not* testify that the chances of the decedent's survival were "more likely than not": "Dr. Bailey, however, failed to testify that immediate diagnosis and surgery more likely than not would have enabled Mr. Gooding to survive." 445 So.2d at 1017. *Absent* such testimony, this Court concluded that there was no cause of action for a mere "loss of a chance" to survive and that the defendant was therefore entitled to a directed verdict.

In the instant case, if the plaintiffs' experts had testified that *Mr. Cox* had only a 31% chance of benefitting from tPA treatment, then the district court's reversal of the plaintiffs' judgment would be correct. But that is not what the plaintiffs' experts said. They offered their expert medical opinion that, "to a high degree of medical probability" and "more likely than not," Mr. Cox would have benefitted from tPA treatment. And that is precisely what the *Gooding* decision requires to present a *prima facie* case on the issue of causation: "The plaintiff must show that the injury more likely than not resulted from the defendant's negligence in order to establish a jury question on proximate cause." 445 So.2d at 1020.

The plaintiffs' experts therefore provided the evidence that was missing in *Gooding*, and that evidence should have been sufficient to withstand the defendants' motion for directed verdict. Most respectfully, the conflict with *Wale v. Barnes* and its progeny is undeniable -- and the district court plainly erred in ordering the entry of a judgment in the defendants' favor in the face of the *prima facie* case presented by the opinion testimony of the plaintiffs' experts.

C. The impropriety in declaring the opinion testimony "speculative."

Apparently uncomfortable with its conclusion that the plaintiffs' experts' opinions could be disregarded entirely because "constrained" by a decade-old study of a random sample of stroke patients, the district court went on to declare the experts' opinions "speculative" because unsupported by sufficient "facts." At the outset, we disagree with the district court's declaration that the opinions were

unsupported by sufficient "facts." Both experts had the benefit of all the tests run on Mr. Cox's brain and vascular system -- tests that were specifically designed to determine whether he was an appropriate candidate for tPA therapy, including the CT scan that revealed his "super normal" brain. And, of course, both brought their extensive experience and training to bear upon the opinions they ultimately reached. "Experts routinely form medical causation opinions based on their experience and training." *Marsh v. Valyou*, 977 So.2d 543, 548 (Fla. 2007) (quoting three additional decisions to the same effect). And, as we will note in the next subsection of our argument, both were far more qualified to determine the sufficiency of the "facts" they had to reach an opinion than the district court was. But we need not belabor these points because, even if the record were entirely devoid of the "facts" upon which the experts based their opinions, the district court's conclusion rests upon a misapprehension of the law governing the issue.

As authority for its conclusion, the district court relied upon a decision of this Court decided half a century ago: *Harris v. Josephs of Greater Miami, Inc.*, 122 So.2d 561 (Fla. 1960). The problem with this reliance is that *Harris* is no longer the law. Florida's Evidence Code, enacted more than a quarter century ago, now permits an expert to give a competent opinion without disclosing the underlying "facts": "Unless otherwise required by the court, an expert may testify in terms of opinion or inferences and give reasons without prior disclosure of the underlying facts or data." Section 90.705(1), Fla. Stat.

And if there were any doubt about the continuing validity of *Harris*, this Court put that doubt to rest 15 years ago:

> Although the proponent of an expert opinion may choose to disclose the basis for the opinion, such disclosure is not required prior to eliciting the opinion. If the cross-examiner inquires about the basis of the opinion, the expert must disclose the facts or data upon which the opinion is based and the court in its discretion may require such disclosure. §90.705(1), Fla. Stat. (1991). However, *there is no requirement that the facts or data underlying an expert opinion be admitted into evidence in order to establish the basis of the opinion*. *See* §§90.704, .705, Fla. Stat. (1991).

Jackson v. State, 648 So.2d 85, 91 (Fla. 1994) (emphasis supplied). *Accord Florida Department of Transportation v. Armadillo Partners, Inc.*, 849 So.2d 279, 287-88 (Fla. 2003).

Other district courts have announced the same rule: *Fried v. State Farm Mutual Automobile Ins. Co.*, 904 So.2d 566, 569 (Fla. 3d DCA 2005) ("Under sections 90.704 and 90.705, Florida Statutes, an expert may state his or her opinion without setting forth the basis for that opinion"); *Myron v. South Broward Hospital District*, 703 So.2d 527, 530 (Fla. 4th DCA 1997) ("Under section 90.705, Florida Statutes (1993), an expert may testify in the form of an opinion without disclosing the underlying facts on which the opinion is based"); *City of Hialeah v. Weatherford*, 466 So.2d 1127, 1129 (Fla. 3d DCA 1985) ("Thus, the statute [§90.705] eliminates the requirement formerly placed on the party calling

an expert witness to present underlying data and factual support for expert testimony").

Most respectfully, the district court's conclusion that it could entirely disregard the plaintiffs' experts' opinions because they were unsupported by sufficient "facts" undeniably conflicts with each of these decisions applying §90.705(1), Fla. Stat. -- and the district court plainly erred in ordering the entry of a judgment in the defendants' favor in the face of the *prima facie* case presented by the opinion testimony of the plaintiffs' experts.

D. The district court's usurpation of the jury's function.

The district court's decision also conflicts with other settled principles of the law governing the sufficiency of the evidence in medical malpractice cases. For example, in *Atkins v. Humes*, 110 So.2d 663, 666 (Fla. 1959), this Court established that, except in rare cases, neither a court nor a jury of lay persons can be permitted to decide what is or is not a proper diagnosis or an acceptable method of treatment of a human ailment, or whether a medical practitioner's treatment or lack thereof was a cause of damage to a patient -- that expert medical testimony is required to establish facts of that nature. *Accord Sims v. Helms*, 345 So.2d 721 (Fla. 1977).

The following proposition is also settled: " . . . The sufficiency of the facts required to form an opinion must normally be decided by the expert himself because neither trial judges nor appellate judges are usually in a position to

determine precisely which facts are dispensable and which are essential to the validity of the opinion reached." *Quinn v. Millard*, 358 So.2d 1378, 1382 (Fla. 3d DCA 1978). *Accord Centex-Rooney Construction Co., Inc. v. Martin County*, 706 So.2d 20, 27-28 (Fla. 4th DCA 1997); *Lopez v. State*, 478 So.2d 1110, 1110-11 (Fla. 3d DCA 1985); *Gershanik v. Department of Professional Regulation*, 458 So.2d 302, 305 (Fla. 3d DCA 1984); *H. K. Corp. v. Estate of Miller*, 405 So.2d 218, 219 (Fla. 3d DCA 1981).

Yet, that is what the district court did. Although the issue of causation in the case was clearly beyond the capability of lay jurors and judges to decide, and expert medical opinion testimony on the issue was therefore plainly required, a panel of three judges (whom we must assume have no real medical expertise, not to mention any expertise in the treatment of stroke victims and their prospects for recovery from tPA treatment) have told an internationally recognized stroke expert and the neurologist who would have treated Mr. Cox had he been called in time that they did not know what they were talking about -- and told them that, as a matter of law!

Most respectfully, where expert testimony is required to prove the facts in a medical malpractice case because judges and juries are not competent to decide those facts themselves, it was impermissible for the district court to reject the experts' opinions and decide those facts itself. *See Golden Hills Turf & Country Club, Inc. v. Buchanan*, 273 So.2d 375, 376 (Fla. 1973) (disapproving a district

court decision rejecting unchallenged expert opinion testimony as unpractical and without foundation; reiterating that a judgment should be affirmed if supported by competent evidence, notwithstanding that an appellate court might have reached a different conclusion had it been the trier of fact).

In conclusion, we respectfully suggest that it would be appropriate for this Court to reiterate its "directions to the appellate courts of this state":

> We initiate this analysis by articulating three incontrovertible premises of law which are relevant to our disposition of this case. First, it is not the function of an appellate court to reevaluate the evidence and substitute its judgment for that of the jury. . . . Second, if there is any competent evidence to support a verdict, that verdict must be sustained regardless of the District Court's opinion as to its appropriateness. . . . Finally, the question of whether defendant's negligence was the proximate cause of the injury is generally one for the jury unless reasonable men could not differ in their determination of that question.

Welfare v. Seaboard Coast Line Railroad Co., 373 So.2d 886, 888-89 (Fla. 1979), *quoting Helman v. Seaboard Coast Line Railroad Co.*, 349 So.2d 1187, 1189 (Fla. 1977). Most respectfully, the district court plainly erred in ordering the entry of a judgment in the defendants' favor in the face of the *prima facie* case presented by the opinion testimony of the plaintiffs' experts.

V. CONCLUSION

In short, there was expert opinion testimony supporting the plaintiffs' verdict on the issue of causation sufficient to withstand the defendants' motion for

directed verdict. The district court could not legitimately declare the expert testimony "constrained" and "speculative" simply because only 31 of 100 randomly selected stroke patients benefitted from tPA treatment in a decade-old study. And unless this Court is prepared to accept that decade-old "statistics" of a random sample can conclusively trump the competent testimony of highly qualified medical experts, specialists in their field, the district court's decision should be quashed, and the cause should be remanded with directions to affirm the plaintiffs' judgment.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 9.210(a)(2)

I hereby certify that the type style utilized in this brief is 14 point Times New Roman proportionally spaced.

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CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true copy of the foregoing was mailed this 21st day of January, 2010, to: Edward M. Copeland IV, Esq., Rissman, Weisberg, et al., One North Dale Mabry Highway, 11th Floor, Tampa, FL 33609, *Counsel for EMAF and Castellucci*; Roland J. Lamb, Esquire, Morgan, Lamb, Goldman & Valles, P.A., 500 North Westshore Blvd., Suite 820, Tampa, FL 33609, *Counsel for St. Joseph's Hospital*; Irene Porter, Esq., Hicks & Kneale, P.A., 799 Brickell Plaza, Ninth Floor, Miami, FL 33131; and to Kimberly A. Ashby, Esq., Akerman Senterfitt, 420 South Orange Avenue, Suite 1200 (32801), Post Office Box 231, Orlando, FL 32802, *Counsel for St. Joseph's Hospital*.

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