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NICA - Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why This Malpractice Reform Must Be Eliminated

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I. INTRODUCTION

The Florida Birth-Related Neurological Injury Compensation Act[1] was part of the Florida Legislature's efforts to manage both the spiraling medical malpractice costs and diminishing liability insurance availability during the 1970s and 1980s.[2] During that period, medical liability insurance had become so expensive that, although "technically available", it was "functionally unavailable."[3] In trying to ferret out the causes of the malpractice situation, the legislature determined that there was an identifiable group of physicians that disproportionately accounted for medical liability claims, both in number of claims and amount of payout.[4] There were multiple specialties in this group, but it was not hard to realize that obstetrician-gynecologists ("ob-gyns") were important contributors.[5] Therefore, in 1986,

1. FLA. STAT. § 766.301–.316 (2001).
2. *See generally* Thomas R. Tedcastle & Marvin A. Dewar, *Medical Malpractice: A New Treatment for an Old Illness*, 16 FLA. ST. U. L. REV. 535 (1988).
3. *Id.* at 547 n.90.
4. *Id.* at 552.
5. *Id.* (noting that these physicians paid claims that were two to three times as high as the remainder of physicians). Obstetricians are defined as physicians (medical doctors or osteopathic physicians) who diagnose, care, and treat pregnancy and associated disorders.

the legislature created a special academic task force to study the Florida malpractice problem and to assist the ob-gyns in particular.[6]

The task force evaluated the rising insurance costs. It reported that "litigation costs and attorney's fees" had increased from 1975–1986, yet there was no particular change in the relevant substantive law to account for it.[7] While it was true that the tort environment had shifted in favor of the plaintiff with the change to a national medical standard and the use of *res ipsa loquitur*, these changes alone should not have accounted for the increases.[8] As the marketplace would allow, the skyrocketing medical liability insurance costs were being partly passed on to increasingly dissatisfied patients and their insurance companies.[9]

Cost alone was not the sole problem. Some patients became nearly disenfranchised as physicians resisted treating high-risk patients; in fact, physicians resisted practicing in certain high-risk specialties altogether.[10] The more litigious patients became even more disillusioned with medical care, possibly as a result of poor medical performance of physicians or hospitals, and possibly, it was suggested, as a result of "incompetence or

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DAN J. TENNENHOUSE, ATTORNEYS MEDICAL DESKBOOK § 6:13 (3d ed. 1993). Their specialty includes birth control and sterility problems. *Id.* These physicians perform major surgery, and their specialty is usually combined with gynecology (ob-gyn). *Id.* Their training generally includes one year of internship and three years of obstetrics and gynecology specialty training, which occurs after the usual four years of medical school. *Id.*

6. Tedcastle, *supra* note 2, at 544.

7. *Id.* at 550.

8. *Id.* at 550–51. *Res ipsa loquitur* is a tort doctrine whereby the plaintiff need only prove that the defendant had exclusive control of the instrumentality that caused the injury and that the type of accident is one that would not ordinarily occur in the absence of negligence on the part of the party in control of that instrument. McDougald v. Perry, 716 So. 2d 783, 785 (Fla. 1998) (proving a defendant's negligence regarding a wayward automobile wheel by using the doctrine of *res ipsa loquitur*). Because *res ipsa loquitur* allows for a common sense inference of negligence where hard evidence is wanting, it is self-evident that it is a plaintiff-friendly doctrine.

9. Tedcastle, *supra* note 2, at 554. Physicians who practiced or trained in that era recall that it was a difficult time. Interview with Harvey Schoenbrum, M.D., Board Certified Urologist, in Palm Beach County, Fla., (June 20, 2001). Patients blamed physicians for their skyrocketing fees, and physicians blamed the insurance companies for their rapidly increasing premiums. *Id.* Physicians were angry that the insurance companies were happy to collect premiums in Florida when there was no malpractice crisis, but leave the state when times got tough. *Id.*

10. Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 CORNELL L. REV. 170, 173 (1988); Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN'S L.J. 1, 14 (1997).

inattentiveness, negligence or neglectfulness, faulty diagnosis or faulty equipment."[11] The stage was set. There were increased medical care costs, increased liability insurance costs,[12] "overly generous jury awards,"[13] and difficulties in obtaining insurance.[14] Patients and physicians were angry and, irrespective of where one wanted to place the blame, what had started as a malpractice epidemic had become a malpractice crisis.[15]

The ob-gyns were a dramatic part of the malpractice crisis. Astonishingly, in 1985, ob-gyns in Florida paid an average medical malpractice liability premium of $185,460, compared to a national average of $23,300.[16] The Florida Legislature correctly realized that ob-gyns were a subset of physicians that had a disproportionate, if not unbearable insurance liability, but without whom our society would not function.[17] They also believed that the newborn was a subset of these physicians' patients who were apt to be injured catastrophically, and because of them, they decided to delve into what could only be called a medicolegal, insurance *experiment.*[18]

The Florida Birth-Related Neurological Injury Compensation Act, ("NICA"), was Florida's contribution to the idea of a hybrid no-fault and tort medical liability system. This comment will first develop the historical perspective that led to this legislation. It will next review the NICA statute and goals in detail. From there, it will focus on whether NICA has met its stated and implied goals, and discuss some of the problems involved in reaching those conclusions. Lastly, this comment will analyze four important issues that NICA has faced. It will detail how it faced those issues and further explain why these four miscues, along with its marginal success, prove that this malpractice reform law should be repealed.

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11. Gellhorn, *supra* note 10, at 170.

12. Malpractice insurance rates for ob-gyns reportedly increased 113% during the four-year period from 1982–86, and there were more lawsuits involving these specialists than any other. Falker, *supra* note 10, at 1–2.

13. Matthew K. Richards, *The Utah Medical No-Fault Proposal: A Problem-Fraught Rejection of the Current Tort System,* 1996 BYU L. REV. 103, 104 (1996).

14. B. Richard Young, *Medical Malpractice in Florida: Prescription for Change,* 10 FLA. ST. U. L. REV. 593, 593 (1983). More than twenty medical liability insurers withdrew from the Florida market in the 1970s. *Id.*

15. David M. Studdert et al., *The Jury Is Still in: Florida's Birth-Related Neurological Injury Compensation Plan After a Decade,* 25 J. HEALTH POL. POL'Y & L. 499, 500 (2000).

16. Gellhorn, *supra* note 10, at 173.

17. FLA. STAT. § 766.301 (2001) (indicating the legislative findings and intent for the NICA statute).

18. *Id.* NICA has been called the "most significant experiment with compensation for medical injury yet undertaken in the United States." Studdert, *supra* note 15, at 500.

II. NICA IS BORN

The academic task force, along with outside recommendations, ultimately recommended NICA as a solution to the uniquely severe situation of the ob-gyns.[19] The legislature found that ob-gyns were a high-risk, essential specialty that had suffered rapid advances in their malpractice liability costs.[20] They found that any birth of a child that did not go well would usually be accompanied by litigation.[21] One should realize, however, that there is not necessarily a *quid pro quo* between a physician's errors and litigation. For example, in a traditionally low insurance risk medical specialty like dermatology, although it is self-evident that skin cancer patients unfortunately suffer iatrogenic injuries, they sue relatively infrequently; therefore, dermatologists enjoy relatively low insurance premiums.[22] The reasons are speculative, but possibly the generally older group of patients the dermatologist treats may have a greater tolerance and patience for error or poor result. One might infer also that obstetrical injuries are worse, although not every obstetrical error is expected to be horrible. Regardless of the reason, the Florida Legislature intended to stabilize, or possibly reduce, the ob-gyn's insurance premiums.[23] They concluded that the birth-related neurologically injured were an especially high risk and expensive tort subset, and they therefore required a dramatic new mechanism to deal with that problem.[24] Their solution was to carve out these claims and provide compensation irrespective of fault.[25]

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19. Tedcastle, *supra* note 2, at 556–57.

20. *Id.* at 583.

21. *Id.* The medical consumer appears to have very little tolerance for obstetrical accidents. Every mother expects a "perfect" baby, and when an adverse birth happens, litigation frequently results. When a neurologically injured newborn is delivered, nearly all will sue, independent of whether their doctor was at fault.

22. Bruce L. Allen, M.D. & Josef E. Fischer, M.D., *Caps on Malpractice Awards: Update*, HIGHLIGHTS BULL. AM. C. SURGEONS, June 1999, *available at* http://www.facs.org/dept/hpa/proliab/0699a.html (generally showing the relationship of dermatology malpractice fees to other medical specialty fees). For example, dermatology malpractice fees for the State of Florida ($1 million/$3 million coverage) is quoted as $35,440 per year compared to ob-gyn which is quoted as $140,346 per year. *Id.*

23. Insurance premiums amounted to an average of eleven and six-tenths of one percent of gross practice revenues in 1986–87 for physicians in general, but they amounted to twenty-three and one-tenth percent of gross practice revenues for ob-gyns in the same time period. Tedcastle, *supra* note 2, at 553 n.122.

24. *Id.* at 557.

25. *Id.*

The legislature decided "to provide [a] compensation [plan], on a no-fault basis, for a limited class of catastrophic injury that result[ed] in unusually high costs for custodial care and rehabilitation."[26] The situation had become so severe, that in addition to that laudable goal, part of the legislative goal was to stabilize or reduce insurance costs to ensure that ob-gyns would not be forced out of practice due to the malpractice crisis.[27]

Toward their goal, the Florida Legislature's first foray into no-fault compensation, NICA, was narrowly written to include only birth-related neurological injuries.[28] This was not the only option available in terms of malpractice reform, however. For example, the legislature could have plunged medical negligence *in toto* into a no-fault, workers' compensationlike system.[29] Instead, the not yet functioning "Virginia Plan" became the model upon which NICA was patterned, and this plan was and still is limited to the birth-related neurologically injured.[30]

III. THE NICA STATUTE

Both the Virginia Plan[31] and NICA were to be strict liability workers' compensation type plans, where the claimant did not need to establish fault and the claim was taken out of the tort system and managed administra-

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26. FLA. STAT. § 766.301(2) (2001).

27. Fla. Birth Related Neurological v. Fla. Div. of Admin. Hearings, 664 So. 2d 1016, 1020 (Fla. 5th Dist. Ct. App. 1995), *certifying question to* 686 So. 2d 1349 (1997). *See* Gellhorn, *supra* note 10, at 173 (showing that medical malpractice premiums rose sufficiently to cause some doctors to stop practicing). *See also* Mary A. Cavanaugh, *Bad Cures for Bad Babies: Policy Challenges to the Statutory Removal of the Common Law Claim for Birth-Related Neurologic Injuries*, 43 CASE W. RES. L. REV. 1299, 1320 (1993).

28. § 766.302(2).

29. Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 76–79 (1998). Workers' compensation exclusively provided compensation to those workers who suffered a disabling injury or illness on the job. *Id.* at 76. Most states (forty-seven) require employers to purchase or self-insure. *Id.* Workers may be unhappy with the relatively low compensation as opposed to that available in tort. *Id.* at 78. Therefore, workers have frequently tried to circumvent the exclusivity provision. *Id.* Other problems include the real or perceived lack of high quality care in some cases due to the various plan limitations. *Id.* *See* Richards, *supra* note 13, at 103 (describing a 1996 Utah tort reform plan that calls for wholesale abandonment of the existing tort system in favor of no-fault).

30. Tedcastle, *supra* note 2, at 582. *See also* Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. § 38.2-5000–5021 (Michie 1999).

31. The Virginia Plan became the country's first malpractice reform effort that adopted the no-fault method of compensation. Bovbjerg, *supra* note 29, at 56.

tively.[32] In reality, there was a significant difference between NICA and workers' compensation. With workers' compensation, if the employee was injured on the job, he did not need to prove anything else in order to obtain compensation.[33] With NICA, the claimant not only needed to have been injured during birth, but he also had to prove that the injury was related to oxygen deprivation or mechanical failure.[34] The definition under the NICA was as follows:

> "Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams . . . at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.[35]

Reading the statute, one can appreciate its restrictive details.[36] For example, an obstetrician delivering an injured baby physically outside of a hospital could fall outside the criteria.[37] Similarly, a "bad baby"[38] that

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32. Tedcastle, *supra* note 2, at 590. The similarities between workers' compensation plans and NICA were that in both of these plans, purportedly in return for a relatively assured compensation handled through an administrative solution, the injured party gave up his common law tort rights. Bradford v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 667 So. 2d 401, 403 (Fla. 4th Dist. Ct. App. 1995).

33. Tedcastle, *supra* note 2, at 590 n.424.

34. *Id.* Because of this proof requirement, NICA was neither pure tort nor pure no-fault.

35. FLA. STAT. § 766.302(2) (2001).

36. Studdert, *supra* note 15, at 519.

37. This is not inconceivable. Although no cases of this nature are yet reported, an expectant mother might deliver a catastrophically injured baby at home or on the way to the hospital. The issue might arise whether the obstetrician who had delivered prenatal care is eligible to receive NICA protection, or whether he or she loses that benefit because the mother failed to make it to the hospital. In a related scenario, there is an issue as to whether an ob-gyn would receive the benefit of NICA protection if he or she cared for a pregnant woman who negligently abused illicit drugs or alcohol during the pregnancy and unexpectedly delivered at home.

But see Fluet v. Fla. Birth-Related Neurologic Injury Comp. Ass'n, 788 So. 2d 1010 (Fla. 2d Dist. Ct. App. 2001). In *Fluet*, a mother of a neurologically injured baby who died was denied NICA benefits by the administrative law judge because she was delivered by a midwife, and her ob-gyn was not physically in the hospital when he ordered medication for her telephonically. *Id.* at 1010–11. The appellate court reversed, finding there was no specific

weighed 2400 grams or an infant that was the result of a genetic accident would not be covered, yet potentially are just as injured.[39] NICA was meant to be the sole and exclusive remedy for an infant who satisfies the above criteria of a birth-related neurologically injured infant.[40] A hospital and

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mandate that the physician be physically present in the delivery room. *Id.* at 1013. The holding discussed the difference between delivering the baby and the delivery of obstetrical services and concluded that NICA refers to the delivery of obstetrical services. *Id.* The statement of facts, however, do not tell if the physician was present in the hospital or out of the hospital when he telephoned his medication order. *Id.* This too may influence a court.

Also, consider the situation where a NICA-participating physician emergently delivers a mother in a migrant labor camp situation rather than in a hospital, and that mother has not had the benefit of prenatal care. While the statute provides for *no notice* in a situation like this, it does not speak directly to the "out of hospital" instance. This physician, who fully paid his or her assessment, might not be covered in the event of a birth-related neurological injury. If that same infant weighed slightly less than 2500 grams at birth, the ob-gyn would not be covered despite the fact that he paid his or her assessment into the program and notified the pregnant patient that he participated in NICA. These hypotheticals make the hazards of NICA's restrictive statutory definition clear.

38. A "bad baby" is medical jargon for an obstetrical accident that results in a neurologically defective infant. *See generally* Cavanaugh, *supra* note 27, at 1299–1300 n.3 (giving a graphic example and discussion of the "bad baby" syndrome).

39. In order for an infant to be covered, the infant must meet the statute's criteria. If a newborn infant is neurologically impaired, there may be questions as to whether the infant's impairment resulted from hypoxemia (oxygen deprivation) or mechanical injury, and therefore covered, versus undiagnosed genetic injury or even maternal drug use, and therefore not covered. The no-fault aspect is already suspect since it will be a "my expert says this versus your expert says that" argument from the beginning. It has the potential to resemble traditional tort actions in medical negligence. Cavanaugh, *supra* note 27, at 1312–13 (describing the uncertain and complex interrelationship between events during pregnancy and perinatal events that lead to neurologically injured infants). It is not always certain whether the physician's actions caused the injuries. *Id.* *See* Studdert, *supra* note 15, at 519–21; Bovbjerg, *supra* note 29, at 53–123 (discussing in detail the "no-fault" alternative to the medical malpractice crisis and propounding it as a substitute for the current system in tort). They explain in general that the central premise of no-fault is to "make third-party insurance for medical injuries more like first-party health or disability insurance." Bovbjerg, *supra* note 29, at 64.

40. Cavanaugh, *supra* note 27, at 1321.

> The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies . . . against any person or entity directly involved with the labor, delivery, or immediate postdelivery resuscitation during which such injury occurs, arising out of or related to a medical malpractice claim with respect to such injury[.]

FLA. STAT. § 766.303(2) (2001). The same subsection of the statute also states that one may pursue a tort action if there is clear and convincing evidence of bad faith or malice on the part of the provider. *Id.*

physician must provide specific and timely notification to their pregnant patients in order to claim the protection of NICA's no-fault benefits,[41] except in certain defined emergent circumstances. The statute initially provided that when a claimant filed a claim, it was to be reviewed by a panel of physicians selected by the Division of Workers' Compensation.[42] That nonbinding, advisory panel is composed of three appropriately skilled physicians whose review determines whether the infant meets NICA's statutory criteria.[43] If the infant's injuries are found to be noncompensable, then the claimant may pursue her remedy in tort. On the other hand, if the infant has suffered compensable injuries, NICA provides for as much as $100,000 in damages to the parents, plus actual expenses for medically reasonable bills related to the infant's medical care, rehabilitative care, training, and custodial care.[44] Excluded from these listed covered expenses

41. Cavanaugh, *supra* note 27, at 1320. The *Florida Statutes* state that each hospital that has a participating physician and each participating physician shall:

> provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.002(9)(b) or when notice is not practicable.

FLA. STAT. § 766.316 (2001).

42. Cavanaugh, *supra* note 27, at 1320–21. Due to dissatisfaction with claims handling, the Division of Workers' Compensation was replaced by the Division of Administrative Hearings in May 1993. Bovbjerg, *supra* note 29, at 87.

43. Cavanaugh, *supra* note 27, at 1320–21. Section 766.308(1) of the *Florida Statutes* states:

> Each claim filed with the division under ss. 766.301–766.316 shall be reviewed by a medical advisory panel of three qualified physicians appointed by the Insurance Commissioner, of whom one shall be a pediatric neurologist or a neurosurgeon, one shall be an obstetrician, and one shall be a neonatologist or a pediatrician. The panel shall file its report, with its recommendation as to whether the injury for which the claim is filed is a birth-related neurological injury, with the division at least 10 days prior to the date set for the hearing. . . . The administrative law judge shall consider, but not be bound by, the recommendation of the panel.

FLA. STAT. § 766.308(1) (2000). It is the administrative law judge of compensation claims of the Division of Workers' Compensation that makes the final determination. FLA. STAT. § 766.309(1) (2001).

44. FLA. STAT. § 766.31(1)(b)1. (2001).

are various payments made to the claimant, such as from the government, various health care plans, or other insurance policies.[45]

The Act provides for attorneys' fees as well,[46] although the restrained attorneys' fees under NICA will not be as attractive as the usual contingency tort fee.[47] Additionally, section 766.306 of the *Florida Statutes* state that "[t]he statute of limitations with respect to any civil action that may be brought by, or on behalf of, an injured infant allegedly arising out of, or related to, a birth-related neurological injury shall be tolled by the filing of a claim."[48] Strictly read, it would appear that this provision grinds civil actions to a halt while the administrative action is settled, allowing time for the claimant to pursue her common law remedy later should the injuries prove to be noncompensable under NICA. However clear this language appears, in *Humana of Florida, Inc. v. McKaughan*,[49] the court found and discussed the uncertainties that it perceived.[50]

IV. HAS NICA BEEN SUCCESSFUL?

Gauging the success of a program like NICA is not easy. First of all, in general, it is hard to agree as to which parameters indicate success. The stated legislative goal was "provid[ing] compensation, on a no-fault basis, for a limited class of catastrophic injur[y] that result[ed] in unusually high costs for custodial care and rehabilitation;"[51] this goal has no easily monitored and quantifiable parameters. In general, it is problematic to be highly confident in the value and interpretation of physician oriented information due to medical and legal complexities.[52] Additionally, Studdert

45. § 766.31(1)(a)1.–4.

46. § 766.31(1)(c). *But cf.* Fla. Birth-Related Neurological Injury Comp. Ass'n v. Carreras, 633 So. 2d 1103 (Fla. 3d Dist. Ct. App. 1994) (showing that an attorney's fee of $300 per hour was excessive and that any time the attorney spent in researching whether the patient's claim should be filed in tort was not compensable as an attorney's expense).

47. Studdert, *supra* note 15, at 521 (noting that plaintiffs' attorneys have an economic incentive to go around NICA and file in tort).

48. § 766.306.

49. 652 So. 2d 852 (Fla. 2d Dist. Ct. App. 1995), *certifying question to* 668 So. 2d 974 (Fla. 1996).

50. This ambiguity meant to this court that when a malpractice defendant invokes NICA as an affirmative defense, the malpractice action did not necessarily automatically abate. *Id.* at 861.

51. § 766.301(2).

52. Ann Stewart, Comment, *Physician Profiles: Consumer Protection or Excessive Exposure?* 25 FLA. ST. U. L. REV. 957, 957–59 (1998).

noted how hard it is to isolate the forces that account for any causal change given the complexity of the medical malpractice arena.[53] Thus, no real clarity evolves out of any method of gauging NICA's success.

For example, one might realize it would not be difficult to measure the cost of today's medical malpractice premiums and compare them in relative dollars to the premiums ob-gyns paid during the height of the malpractice crisis. However, the factors that may have affected those premiums are practically impossible to quantify given the dramatically changing health care climate over the relevant period.[54] Consider that prior to the Clinton presidency, it would have been a rare American who understood what "managed care" was. Today, to the contrary, managed care is pervasive,[55] and it would be a rare American who does not know what an HMO is. Any change in either the malpractice premiums,[56] the availability of insurance, or the generally quieter malpractice climate might have resulted from any cause or combination of causes. However, it is at least as likely that the natural progression of managed care, rather than the effects of NICA, has been most influential. The end result is that NICA proponents will rave about NICA, and managed care proponents will rave about managed care.

Stewart notes just how difficult it is to understand malpractice trends and relates a relevant example.[57] A slight alteration of her example would compare two physicians with different policy limits, one at $200,000 and

53. Studdert, *supra* note 15, at 500.

54. *Id.*

55. Judith E. Orie, Comment, *Economic Credentialing: Bottom-Line Medical Care*, 36 DUQ. L. REV. 437, 447 (1998).

56. Whether the premiums are inflating, deflating, or stable, any statistical analysis would be hard pressed to accurately interpret the dramatic health care delivery changes that have coincidentally accompanied the birth and adolescence of NICA.

57. Stewart, *supra* note 52, at 977–78. In the Stewart scenario, there are two physicians, one with $1,000,000 and one with $200,000 in malpractice insurance policy limits. *Id.* Stewart hypothesizes that where there is a nuisance suit (non-negligent physician) of $200,000, the insurer for the $1,000,000 holder will be willing to settle because litigation costs will exceed that amount. *Id.* at 978. When the other physician clearly commits an act of malpractice, his or her insurer will be quick to settle to the policy limit knowing that their client will probably lose. *Id.* The question posed is how will these similar insurer settlement actions be classified for analysis. *Id.* In one case, the payment compared to coverage ratio is twenty-five percent; in the other, it is 100%. *Id.* Therefore, this frequently used ratio provides little analyzable data: both cases settled, one physician was negligent, and the ratio does not indicate who it is. *Id.* Stewart also points out that effective classification may be obfuscated because it might be analyzed in terms of the type of injury or the type of physician. *Id.* She convincingly shows that use of these statistics may not be probative. *Id.*

one at $1,000,000. Even nonculpable conduct on the part of the physician with the lower policy limit might cause his or her insurer to settle because defending against the claim might cost more that the policy limit. On the other hand, the high policy limit holder's insurer might defend "to the hilt" even culpable conduct, and bring in the crème de la crème of defense attorneys in order to avoid a judgment. A certain number of these high policy limit cases are going to be won, while the lower policy limit cases will be settled out of court. The result is a skewed and irrational view of malpractice trends, depending on the particular variable studied. Consequently, if physicians by chance or design over the relevant time period decide to increase or reduce their policy limits, then this might confound the understanding of the results of malpractice trend curves. Thus, one sees how medical and legal complexities may make one less confident in the integrity of possible causative parameters.

In addition, the Florida malpractice climate had calmed, and more insurers were looking to reenter the Florida market. The reality was, though, malpractice premiums had stabilized and decreased around the *entire* country over the time period NICA has been in effect, not just in Florida.[58] Even administrators from the Florida Department of Insurance, like William Bodiford, admit that it is thereby unreasonable to attribute this improved malpractice climate as one of NICA's successes.[59] As Richards noted, "[t]he effectiveness of these limited [no-fault] plans . . . is dubious—both in their ability to adequately compensate injured newborns and in restoring insurance coverage to obstetricians."[60] Nevertheless, there was additional access to health care in Florida during the 1990s, even though "there is no empirical evidence that no-fault caused these improvements."[61] More recently, though, medical malpractice insurance is once again difficult to come by and increasing in cost.[62] These data suggest that

58. Richards, *supra* note 13, at 109 n.39; Studdert, *supra* note 15, at 500 (commenting that it is hard to isolate the forces that account for any change given the complexity of the medical malpractice insurance market).

59. Richards, *supra* note 13, at 109 n.39 (detailing a telephone interview between Richards and Bodiford where Bodiford himself opined that Florida's "'social insurance program' [was] not deserving of any 'rave reviews'").

60. *Id.* at 109.

61. Bovbjerg, *supra* note 29, at 110.

62. Letter from Jenan L. Ariff, Vice President Aon Healthcare Practice, to Sandy Martin, M.D. (July 17, 2001) (explaining the generally worsening malpractice insurance situation and expected premium increases, as part of a mailing to all physician clients renewing medical malpractice insurance). The letter also notes mergers along with the pullouts. *Id.* This type of consolidation is rarely market friendly. *Id.*

even with NICA in existence for over a decade, there may be another medical malpractice crisis in the near future.

The absolute number or relative trend of malpractice suits for birth-related neurologically injured patients might be an appropriate measure of NICA success.[63] Proponents might argue that if NICA does an excellent job, there would be fewer NICA claims and fewer payouts than anticipated. Detractors might look at the same data and lament that NICA is not doing its share or that the advisory panel is refusing to certify appropriate injuries. Other proponents might look to the reduced frequency and size of obstetrical malpractice suits in general and claim victory for NICA since it occurred since NICA's inception. However, this improvement can hardly be attributed to NICA,[64] and even the improvement appears to be waning.[65]

While it is difficult to arrive at a number, studies suggest that NICA should have approximately twenty-seven to fifty-three certified claims per year.[66] Yet, from 1989 through 1997, a total of eighty-six claims were approved.[67] The reasons for this are not clear, but it is not likely to be because of a sudden improvement in health care itself.[68] Perhaps it may have had something to do with a reduced "claiming behavior"[69] pattern or that some of these cases are simply just "los[t] to tort."[70]

Studdert conducted a statistical, empirical investigation and concluded that with respect to data as of 1998, "the annual frequency of tort claims did not undergo a statistically significant change after 1989 in either the $250,000+ or $500,000+ group of cases."[71] Given that there are weaknesses with the statistical data, Studdert admits anyway that high cost tort claims, of

63. *See generally* Studdert, *supra* note 15, at 503–20.

64. *Id.* at 516. The authors note, however, that NICA has been relatively efficient at distributing the money it did distribute (approximately $12,000,000 of $15,700,000 went to the injured and their parents during the 1989–1997 interval). *Id.* at 503–04. Also, NICA's staff has been a source of advice and counsel, as well as money, to its beneficiaries. Yet, a significant number of patients who were denied compensation under NICA did receive compensation in tort, several at levels beyond the $1,000,000 level. *Id.* at 515. This leaves one with the gnawing question as to why the statute did not forseeably include these birth-related injuries. *Id.* at 503.

65. Ariff, *supra* note 62.

66. Studdert, *supra* note 15, at 504.

67. *Id.* at 503–04.

68. *Id.* at 504–05.

69. *Id.* at 505. For example, Plaintiff's attorneys may have steered their clients away from NICA given the sparse attorney remuneration compared to tort recovery; or, for example, even some confusion as to NICA's role. *Id.*

70. *Id.* at 506.

71. Studdert, *supra* note 15, at 509.

the type that the no-fault NICA was designed to eliminate, persist.[72] Ultimately, if there is a persistence of the type of high cost malpractice claim that NICA is designed to eliminate, then absent an increased number of actions of this kind, NICA's benefit is less than convincing.

In some articles, investigators seemed to have concluded that a firm indicator of NICA's success might be efficiency, defined as speed of resolution and level of administrative cost compared to tort.[73] When these parameters were evaluated, as best as they could be, the authors concluded that NICA was a resounding success.[74] Unfortunately, the devil is in the details. They note that while the program was intended to be restrictive, it is more narrow than intended; that there are still tort remedies leading to a manipulation of the program based on "perceived benefits" to both the claimants and their attorneys; and that a small program such as this leads to inefficiencies that perhaps could be overcome by a larger program.[75] Some might claim that the exceptions defeat the conclusion, particularly when just about the same number of high claim injured infant tort actions occur now as before NICA.[76]

V. THE REALITY OF NICA HAS NOT MET ITS EXPECTATION

There are expected advantages of a no-fault system. For example, one would expect reduced lawyer costs, one of the highest of overhead costs of the tort medical malpractice system; presumably less time delay in monetary recovery and time involvement by the defendants; and less need for the practice of defensive medicine due to the strict liability nature of the harm.[77] The reality of the system, however, does not seem to have matched

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72. *Id.* (noting the "lively persistence" of these high cost tort claims).

73. Randall R. Bovbjerg et al., *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60 LAW & CONTEMP. PROBS. 71, 73 (1997).

74. *Id.* at 106–08.

75. *Id.*

76. Studdert, *supra* note 15, at 517.

77. Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1374 (1989); Bovbjerg et al., *supra* note 73, at 84. "Defensive medicine" refers to the practice of physicians ordering many tests and procedures that they would ordinarily not consider necessary, all because they consciously or subconsciously realize that they may be sued and have to take the witness stand to defend why they didn't perform that esoteric test. *See generally* Michael C. Thornhill et al., *Health Care Reform: Perspectives from the Clinton Campaign*, 15 WHITTIER L. REV. 3, 7–8 (1993) (relating that physicians on a panel discuss the amount of defensive medical care they administered during their previous twelve-hour shift). The result of this is a general increase

the promise, at least in Florida.[78] Studies show that there is over a three-fold increase in Florida tort activity with respect to the types of claim NICA is designed to compensate, as compared to Virginia, where the other no-fault birth-related neurologically injured program is in effect.[79]

The reasons for the increased litigious nature of the Florida patient are speculative, but practicing Florida physicians intuitively sense that Florida is a different type of medical environment. The older patient relocates from "up north" where they have spent their lives with a given set of physicians. They are suddenly faced with the situation of securing a new team of physicians to guide them through many of life's most difficult problems. They are at a point in their lives when more medical problems develop, problems that never occurred when they were "up north" and younger. Maybe because it is human nature to search for a cause for these new problems, they often blame their Florida physicians. Also, perhaps they may be agitated into malpractice action by the plethora of attorney advertising on television, on the radio, and on the front and back covers of their local "Yellow Pages." Obviously, as a group, they do sue,[80] but the preceding speculation more accurately pertains to the elderly than it does to the younger obstetric group, who are more or less twenty or thirty-something. How the older group influences the obstetrical group toward their proclivity to sue in tort is ill defined; but even at twenty or thirty-something, it is not unreasonable to believe that they have acquired their parents' and relatives' opinions concerning their health care and their physicians. Then, if something goes awry, they are ready to pull the malpractice trigger. It is a fact that even among no-fault claimants, the large majority does not believe that the cause of their medical injury was accidental, but rather name a "provider"[81] as being at fault.[82]

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in the costs of medical care and occasionally morbidity. *See also* Cynthia J. Dollar, Note, *Promoting Better Health Care: Policy Arguments for Concurrent Quality Assurance and Attorney-Client Hospital Incident Report Privileges*, 3 HEALTH MATRIX 259, 261–62 (1993) (noting that the "proliferation of medical malpractice suits, which began in the 1980s, has caused physicians, nurses, and other hospital personnel to practice defensive medicine . . . to ward off potential liability"). More tests and procedures along with more paperwork which occupy a greater percentage of health care time are all incident to this. *Id.*

78. Frank A. Sloan et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, 60 LAW & CONTEMP. PROBS. 35, 48 (1997).

79. *Id.*

80. Stewart, *supra* note 52, at 979 (explaining the litigious nature of the Florida patient).

81. In defining a "provider," the *Florida Statutes* state:

It is interesting to note that in a 1989 article, during the height of the malpractice crisis, proponents of an alternative fault based system of tort reform said that their proposed alternative "responds directly to the flaws in the current [tort] system . . . [and would] permit more injured parties to be compensated than does the current system."[83] If one considers this a laudable goal of tort reform, there is no evidence that the no-fault NICA has been able to reach this goal. The authors also looked forward to an enhanced predictability of claim compensation,[84] but there is no evidence that this goal, as applied to NICA, has been reached. After all, it is nearly impossible to predict whether a neonate will be adjudicated to be both physically *and* mentally impaired, as is required by the statute's definition.[85] The authors thought that their alternative no-fault based system would lead to a larger number of meritorious claims because recovery would not be limited to those claims that were high enough to attract a contingency paid attorney.[86] Once again, if one assumes that this is a laudable goal, NICA has not reached it. Parents and guardians will generally seek out the assistance of counsel when a "bad baby" situation arises. The first goal of counsel is going to be to prove that this baby did not meet the restrictive criteria of NICA, in order that he can go forward in tort.[87] The authors of the article believe that a NICA type of no-fault plan "offend notions of justice and

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> The term "health care providers" means physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, optometrists licensed under chapter 463, dentists licensed under chapter 466, chiropractic physicians licensed under chapter 460, pharmacists licensed under chapter 465, or hospitals or ambulatory surgical centers licensed under chapter 395.

FLA. STAT. § 766.101(2)(b) (2001).

This term insidiously entered the insurance vernacular in the late 1970s and early 1980s, as physicians began to receive insurance letters that began: "Dear Provider" instead of "Dear Doctor." Most practicing physicians abhorred that tendency to depersonalize their professional lives, but they could do nothing. It may have represented the beginning of the managed care "push," where physicians became interchangeable commodities as patients purchased health care plans rather than made appointments for personal physicians. Patients were no longer life-long patients of their doctor, but were consumers of their insurance plans' products.

82. Sloan, *supra* note 78, at 48.

83. Johnson, *supra* note 77, at 1389–90.

84. *Id.* at 1390.

85. § 766.302(2).

86. Johnson, *supra* note 77, at 1390.

87. Humana of Fla., Inc., v. McKaughan, 652 So. 2d 852 (Fla. 2d Dist. Ct. App. 1995) (presenting just such a case where the claimant's goal was to prove he was not eligible for NICA).

individual accountability by imposing liability on health care providers even when they have done everything humanly possible to treat a patient but were unable to prevent a bad outcome."[88] Although this article was not directly analyzing NICA, it is applicable because it was nevertheless discussing fault versus no-fault principles.

Perhaps NICA has excelled in other areas that outweigh its lukewarm performance in claims management. For example, in addition to the goal of compensation, Cavanaugh states that another goal of tort law that a no-fault program should attempt to accomplish is to deter poor medical practice.[89] If the no-fault NICA program were to be completely successful, it would be successful at reducing the frequency and severity of birth related injuries, but that implies that these variables are within the control of the physician.[90] Some variables are within the physician's control, such as the clumsy obstetrician who drops the neonate and breaks its spine or incorrectly uses extraction forceps and causes neurological damage. However, it is intuitive that a no-fault system would not deter poor medical practice in the same way a tort system would, where the accused physician sits in the courtroom and listens to the zealous advocacy of the plaintiff's attorney as he or she describes in embarrassing detail his or hers each and every mistake. This ego deflating fear is what deterrence is about. A no-fault system simply cannot address this with equal force.

The above analysis shows that while there have been some successes to NICA, the reality is that NICA simply has not lived up to its expectation. Whether it has been harmful is speculative. Perhaps it has been harmful because it has deterred consideration of a more meritorious plan.

During its evolution, NICA has faced four legal hurdles that have molded the statute, its construction, and effectiveness. The following four sections of this comment will present and analyze each of these legal problems in detail. The first section concerns the nature of NICA's funding mechanism. Both claimants and nonparticipating physicians, whether obgyns or nonobstetrical physicians, dislike the funding mechanism, although the funding has been adjudicated constitutional.[91] It fails to meet the most basic tenet of an assessment of any kind, which is to allow the payer to see and reap the benefit of the tax. The second section concerns the notice requirement, which is burdensome and unfriendly to both the patient and physician. The notice requirement was added to avoid constitutional

88. Johnson, *supra* note 77, at 1376.
89. Cavanaugh, *supra* note 27, at 1338.
90. *Id.*
91. Bovbjerg, *supra* note 29, at 98 n.224.

weakness, yet it may ultimately lead either the patient or the physician to inadvertent loss of benefit. The third section of this comment will look at the ongoing jurisdictional struggle between the judiciary and the legislature. This comment will provide insight into how that struggle parallels the plaintiff and defense bars' struggle for tort versus no-fault causes of action. The last section of this comment will analyze how the narrow medical definition of the potential claimant has often times eliminated the very party most in need of assistance.

A. *The Oppressive Nature of NICA's Funding*

Section 766.314 of the *Florida Statutes* defines the assessments to the NICA program. It provides that all licensed physicians, exclusive of participating physicians,[92] shall pay an initial assessment of $250 per year.[93] If the physician became licensed after January 1, 1989, the physician would not be able to get away with a lower initial assessment since he or she would need to pay an initial assessment equal to the most recent assessment.[94] With respect to those physicians who deliver obstetrical services, if the physician elected to become a participating physician, then the physician would pay an initial assessment of $5000,[95] as well as the various annual

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92. "Participating physician" means:

> a physician licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part time and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth-related neurological injury compensation plan for the year in which the injury occurred. Such term shall not apply to any physician who practices medicine as an officer, employee, or agent of the Federal Government.

§ 766.302(7).

93. § 766.314(4)(b)(1).

94. § 766.314(4)(b)(3).

95. Before December 1, 1988, physicians who wish to participate:

> shall pay an initial assessment of $5,000. However, if the physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule, and is supervised by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the Board of Regents who has paid the assessment required by this paragraph and paragraph (5)(a), and any certified nurse midwife supervised by such employee. Participating physicians include any certified nurse midwife who has paid 50 percent of the physician assessment required by this paragraph and paragraph (5)(a) and who is supervised by a participating physician who has paid the assessment required by this paragraph and

assessments indicated above. There are exceptions to the assessments, which include certain classes of physicians such as residents in training, those who work for the Veterans Administration, and those with limited licenses.[96]

The *Florida Statutes* also provided that each hospital had to pay an assessment that was equal to fifty dollars per infant delivered in the hospital during the previous calendar year.[97] The statute also provides for additional assessments to the hospital entities, if needed.[98]

In addition to the above, in order to maintain the plan on "an actuarially sound basis,"[99] the statute also provides that up to $20,000,000 in additional money may be transferred from the Insurance Commissioner's Regulatory Trust Fund and, in certain instances, from casualty companies.[100]

A source of contention from the receipt of the first NICA assessment, Florida physicians, in a class action, challenged the constitutionality of the funding mechanism.[101] The class of physicians that did not practice

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> paragraph (5)(a). Supervision shall require that the supervising physician will be easily available and have a prearranged plan of treatment for specified patient problems which the supervised certified nurse midwife or physician may carry out in the absence of any complicating features. Any physician who elects to participate in such plan on or after January 1, 1989, who was not a participating physician at the time of such election to participate and who otherwise qualifies as a participating physician under ss. 766.301–766.316 shall pay an additional initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

§ 766.314(4)(c).

96. § 766.314(4)(b)4.a.–f.

97. § 766.314(4)(a).

98. § 766.314(7)(a). These are based upon actuarial calculations and valuations, provided that at no time the premium shall be greater than one quarter of one percent of the net direct written premiums. *Id.*

99. McGibony v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 564 So. 2d 177, 178 (Fla. 1st Dist. Ct. App. 1990).

100. § 766.314(5)(b). "If the assessments collected . . . are insufficient to maintain the plan on an actuarially sound basis, there is hereby appropriated for transfer to the association from the Insurance Commissioner's Regulatory Trust Fund an additional amount of up to $20 million." *Id.*

> Taking into account the assessments collected pursuant to subsection (4) and appropriations from the Insurance Commissioner's Regulatory Trust Fund, if required to maintain the plan on an actuarially sound basis, the Department of Insurance shall require each entity licensed to issue casualty insurance as defined in s. 624.605(1)(b), (k), and (q) to pay into the association an annual assessment in an amount determined by the department pursuant to paragraph (7)(a), in the manner required by the plan of operation.

§ 766.314(5)(c)(1).

101. *McGibony*, 564 So. 2d at 178.

obstetrics argued that they were no more likely to receive a benefit from this assessment than any other member of the general public.[102] They maintained that their rights to due process and equal protection under both the Florida and Federal Constitutions were violated.[103] They saw the assessment as nothing more than an ill-conceived tax against the profession in general.[104] The class asserted that there was "no rational basis for singling [them] out" to pay this tax, [105] except based upon an arbitrary and discriminatory action.[106]

Because the Supreme Court of Florida agreed that "[o]nly clear and demonstrated usurpation of power will authorize judicial interference with legislative action," the burden was on the class to prove that there was no conceivable basis to support the disliked tax.[107] Unfortunately for the plaintiff physicians, their class was not a protected class,[108] and the court stated that the tax would be constitutional so long as the state had a rational basis for its taxation decision and the decision was not arbitrary.[109]

Nonparticipating, nonobstetrical physicians (the majority of the physicians in Florida) complained, in effect, that it was unfair to lay a tax upon them selectively when all they did to "deserve" the tax was be a physician.[110] One can assume from the class action that those that never delivered obstetrical services or had anything to do with labor and delivery could not believe that it was fair, or constitutional, to force them to selectively finance a malpractice problem in which they had no specific interest. By way of example, if a colo-rectal surgeon had a malpractice problem or indeed if colo-rectal surgeons as a group had a malpractice problem, the ob-gyns were not offering to pay toward their increased insurance premiums.[111] This feeling amongst physicians became a near

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102. *Id.* at 179.

103. *Id.* at 178.

104. *Id.*

105. *Id.* at 179.

106. *McGibony*, 564 So. 2d at 179.

107. *Id.*

108. To fall within the construction of the equal protection provision of the Florida Constitution, "a 'suspect class' is any group that has been the traditional target of irrational, unfair and unlawful discrimination." Coy v. Fla. Birth-Related Neurological Comp. Plan, 595 So. 2d 943, 945 (Fla. 1992).

109. *McGibony*, 564 So. 2d at 179.

110. *Id.*

111. Interview with Harvey Garber, M.D., Board Certified Colo-Rectal Surgeon, in Palm Beach Co., Fla. (June 30, 2001).

revolt, as nearly 17,000 physicians did not pay their NICA assessment early in NICA's history.[112]

The court studied the legislative intent of the Florida Legislature and determined that there was a malpractice crisis in Florida and a severe stress on the efficient delivery of health care, which ultimately affected all physicians in the state.[113] They relied upon the concept of a team approach to medicine, and thus the court held that the legislature's decision to selectively tax all physicians, but not the public at large, was not arbitrary, unreasonable or capricious and was therefore constitutional.[114] The court used the syllogism that all doctors rely upon efficiently operated hospitals, and when the delivery of obstetrical care is disrupted as a result of the malpractice crisis, hospitals will not be efficiently operated.[115] As a result, all physicians will be negatively impacted. Thus, physicians alone should pay the assessment.[116]

To the dismay of the nonobstetrical physicians, the court stated precisely the opposite of what the Florida physicians had been thinking: "[w]e are convinced that all physicians, regardless of whether they practice obstetrics, derive a benefit from this legislation that is greater in degree than that derived by the general public."[117] Thus, in general

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112. *Coy*, 595 So. 2d at 945.

113. *McGibony*, 564 So. 2d at 179.

114. *Id.* In addition, the *Coy* court was extremely concerned about the system-wide disruption that could ultimately befall the citizens, hospitals and physicians of Florida as a result of the malpractice crisis. *Coy*, 595 So. 2d at 946. The following exchange occurred:

> Question: "Hypothetically, let's assume for a moment that all of the obstetrical physicians on that staff, because of malpractice premiums and because of—frankly, because of the problems associated with malpractice, including having to come to the courthouse and testify, and so forth, decided they had had enough. And they had decided that they have had enough so much that they decided to stop either treating indigent patients, which are sometimes a common problem pregnancy, or otherwise just stop practicing OB. Based on that hypothetical I gave you and your small knowledge of Jackson, would that have an effect on that hospital's operations?"
>
> Answer: "It would be disastrous."
>
> Question: "That disaster would permeate that hospital; wouldn't it?"
>
> Answer: "I presume, yes."

Id.

115. *Coy*, 595 So. 2d at 946.

116. *Id.* at 946–47.

117. *Id.* at 947.

constitutional terms, the legislature's methods were rationally related to legitimate governmental objectives and were constitutional, and, not being a protected group, the physicians would have to pay a tax they considered spiteful. It was a close four to three decision,[118] and the dissent echoed the feelings of every one of those 17,000 physicians who did not pay their assessment.

Speaking for the dissent, Justice Kogan wrote, "I can find no rational basis for imposing much of the burden of this program primarily on physicians as a class . . . particularly . . . in light of the fact that obstetricians are not obliged to join the plan, and many have exercised this option."[119] He said that this was nothing more than a "status tax" based on one's station in life, and, unless there was a nexus between that status and the goal the tax was designed to achieve, it would not pass even rational basis scrutiny.[120] He believed that imposing this tax denied equal protection because similarly situated persons were not being treated similarly.[121] Also, in this case, there was no *quid pro quo*—the nonobstetrical physicians were paying a tax and they received no specific benefit that the public at large did not receive.[122]

A different consideration was accepted without challenge by all of the justices. This consideration was whether the assessment was a tax at all or was it a user fee.[123] That the justices agreed the assessment was a tax allowed them to rapidly decide that rational basis, or severe deference, would be appropriate.[124] Had the court instead decided that the assessment was a user fee, this jump would not have been so clear.[125] For example, a user fee is one in which the fee is collected for a specific benefit, and thus the collecting entity must show that the fee fairly approximates the benefit received.[126] Based upon this, some critics, however, have disagreed with the tax interpretation.[127] They point out that although the assessment superficially resembles a tax, the court presented an analysis that was more along

118. *Id.* at 948.

119. *Id.*

120. *Coy*, 595 So. 2d at 948.

121. *Id.* at 947.

122. *Id.*

123. Sharon Liebman, Comment, *State-Enforced Fees For Special Benefits Conferred: Taxes or User Fees?* (Coy v. Birth-Related Neurological Injury Compensation Plan, 595 So. 2d 943 (Fla. 1992)), 45 FLA. L. REV. 325 (1993).

124. *Id.* at 329.

125. *Id.* at 333.

126. *Id.* at 329.

127. *Id.* at 331–33.

the lines of a "benefits-received" analysis.[128] The absolute value of the difference between what the obstetrical physicians had to pay as opposed to the nonobstetrical physicians was meant to indicate the legislature's construction as to the difference in value ($250 versus $5000) between the two groups.[129] The ob-gyns were to receive this value benefit for their pecuniary burden, and it was appropriate for them to pay more.[130] Other courts, however, have found that "benefits-conferred" principles did not govern taxes but were appropriate instead for user fees or special assessments, thereby creating a constitutional question as to the funding mechanism.[131]

Therefore, they opined, where assessments were for specific government provided services, the assessment was not a tax, but a special assessment or a user fee.[132] "Similarly, the physician's fee is not a tax . . . [and] [t]he court should have looked beyond the literal tax definition because a charge which superficially satisfies the definition might still be governed by [user fee] principles."[133] Therefore, it was concluded that the court incorrectly applied user fee principles and labeled the physician assessment as a tax.[134] This is an important observation. With such a narrow majority and new members of the court, should this issue come before the court again they might find this assessment a user fee. In that case, the statute would not be presumptively valid, and the extreme deference accorded the legislature would not be automatic.[135]

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128. Liebman, *supra* note 123, at 331–33.

129. *Id.* at 331.

130. *Id.*

131. *Id.* at 332. *See also* Alamo Rent-A-Car, Inc. v. Sarasota-Manatee Airport Auth., 906 F.2d 516, 518 (11th Cir. 1990) (following the reasoning that for a user fee to not violate the commerce clause, it must be a fair approximation of the value of the benefit conferred); City of Naples v. Moon, 269 So. 2d 355, 358 (Fla. 1972) (differentiating ad valorem taxes and special assessments); State *ex rel.* Clark v. Henderson, 188 So. 351, 354 (Fla. 1939) (explaining that a tax and a special assessment are similar, but a special assessment is an enforced contribution that is imposed on a segment of the community as a result of special or peculiar benefit).

132. Liebman, *supra* note 123, at 332.

133. *Id.*

134. *Id.*

135. *Id.* at 335.

B. *The Notice Requirement or How Not to Win Friends and Influence People*

The NICA statute requires that each hospital with a participating physician and each participating physician shall give notice to their patients.[136] The notice will advise the patient that a limited no-fault compensation program covers their provider in the event of severe neurological birth-related injury and the provisions of this insurance represent their only remedy in the event of a severe birth-related injury.[137] The features of the notice requirement include that it shall be clear and concise;[138] that the notice shall be given on a specific NICA-provided form;[139] that the providers may elect to have the patients sign a receipt indicating they signed the form (in order to benefit from the rebuttable presumption clause that notice has been given);[140] and that notice need not be given in the event of an emergency that meets the State of Florida's statutory definition or when it is not practicable.[141] If the physician or hospital fails to provide such notice, neither they nor the claimant will obtain the benefit of NICA protection in the event of birth-related neurological injury.[142]

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136. FLA. STAT. § 766.316 (2001). The full text is as follows:

> Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.092(9)(b) or when notice is not practicable.

Id.

137. § 766.303(2).

138. § 766.316.

139. *Id.*

140. *Id.*

141. *Id.*

142. Braniff v. Galen of Fla., Inc., 669 So. 2d 1051, 1053 (Fla. 1st Dist. Ct. App. 1995), *certifying question to* 696 So. 2d 308 (Fla. 1997).

In *Braniff v. Galen of Florida, Inc.*,[143] the plaintiff filed a malpractice action and alleged that the negligent delivery of their daughter led to a severe neurological birth-related injury.[144] The defendant claimed that he gave proper and adequate notice but that in any case, the statute did not mandate *pre-delivery* notice and that the exclusivity feature was not conditional upon pre-delivery notice.[145] The trial court agreed and dismissed the civil malpractice action holding that the plaintiff could not recover any more than what the administrative action allowed.[146]

The appellate court reversed, however, finding that the defendant had not properly given notice to the plaintiff.[147] The defendant had not been successful in proving that the purpose of the notice requirement was just to inform patients of the procedures they needed to go through in order to file a claim.[148] Had this been the legislative intent of the notice requirement, it would have made sense to be able to provide this notice even postdelivery.[149] However, the court noted that the statute's language speaks of "the limited no fault *alternative*" which indicates a choice between health care alternatives (limited no-fault vs. traditional tort); hence, the intent of the notice was more than simple claim procedure.[150] At the same time, the court stated that it made even less sense to have a pre-delivery notice requirement if that notice was not a condition precedent to benefiting from the exclusivity of a NICA lawsuit.[151]

The court of appeal found that notice only became an issue when the defendant sought to shield himself against a tort claim.[152] As a result of this ruling, the case was remanded for jury trial because there was a factual disagreement as to whether notice was actually given. Because the court considered this issue to be of great public importance, it certified the following question to the Supreme Court of Florida: "WHETHER SECTION 766.316, FLORIDA STATUTES (1993), REQUIRES THAT HEALTH CARE PROVIDERS GIVE THEIR OBSTETRICAL PATIENTS

143. *Id.*

144. *Id.* at 1052.

145. *Id.*

146. *Id.*

147. *Braniff*, 669 So. 2d at 1052.

148. *Id.*

149. *Id.* at 1052–53.

150. *Id.* It would not have made sense to discuss alternatives in a notice when the patient might have already received the medical service and could no longer effectively choose an alternative. It only made sense that the notice was a predelivery notice. *Id.*

151. *Id.*

152. *Braniff*, 669 So. 2d at 1053 n.2.

PRE-DELIVERY NOTICE OF THEIR PARTICIPATION IN THE FLORIDA BIRTH RELATED NEUROLOGICAL INJURY COMPENSATION PLAN AS A CONDITION PRECEDENT TO THE PROVIDERS' INVOKING NICA AS THE PATIENTS' EXCLUSIVE REMEDY?"[153]

The Supreme Court of Florida held that in order for the provider to claim NICA as the exclusive remedy for his or her obstetrical patient's catastrophic delivery, the provider must have given predelivery notice in a reasonable time in advance of the required obstetrical services, where practicable.[154] The court stated that what would constitute reasonable advance notice and "when practicable" would vary from circumstance to circumstance.[155] The court reviewed the legislative history of the NICA statute and found that the academic task force that originally recommended the adoption of a limited no-fault compensation plan was concerned that the Virginia Plan did not have a notice requirement.[156] The cause for the concern was that patients who elected to be treated by an ob-gyn participating in the Virginia Plan had ostensibly given up their ability to sue in tort, perhaps without adequate due process.[157] The task force, therefore, included the notice requirement in the Florida law to avoid any such question of unconstitutionality.[158]

"The Task Force obviously believed that because not all health care providers [were] required to participate in the NICA plan, fairness require[d] that the patient be made aware that she has limited her common law remedies by choosing a participating provider."[159] If limiting one's remedies was an unacceptable method of dealing with the malpractice crisis, the legislators could have avoided the whole issue by mandating the limited no-fault plan to all providers and therefore all patients. With the composition of the Supreme Court of Florida at the time, it is likely that they would have found that action rationally related to a legitimate Florida interest. Instead, they saddled another bureaucratic burden on providers, which left another loophole through which either the physician or the claimant could find himself or herself unwittingly uncovered. Most distressing was the uncertainty, because after the physician or hospital had paid their increased assessment to provide NICA coverage, they could find themselves "bare" to

153. *Id.* at 1053.
154. Galen of Fla., Inc. v. Braniff, 696 So. 2d 308, 309 (Fla. 1997).
155. *Id.* at 310.
156. *Id.*
157. *Id.*
158. *Id.*
159. *Braniff*, 696 So. 2d at 310 n.1.

face a malpractice action in common law tort anyway.[160] The logic of the Supreme Court of Florida, which mandated pre-delivery notice, is less than compelling when compared to the logic of the dissent in another important case, *Bradford v. Florida Birth-Related Neurologic Injury Compensation Ass'n.*[161]

In *Bradford*, the parents of a birth-related neurologically injured child were successful in their "end run" around NICA.[162] They applied for NICA administrative benefits and then claimed that because their physician had not complied with the notice requirement, they were not eligible for NICA benefits.[163] Although the trial judge disagreed, the Fourth District did agree with the parents. Judge Klein's dissent is more lucid and logical and may yet hold the day. He stated that when the legislature intends to make a statutory provision a condition precedent, it does so with clarity.[164] He gives the example of the medical malpractice statute pre-suit provision.[165] After the prospective plaintiff complies with the provision, he is given explicit directions on how to notify the soon-to-be defendant. This includes when to notify the defendant, the mandated use of certified return receipt mail, and what must be included in the notice.[166] In the NICA notice section, on the other hand, the hazy procedure is only generally stated and does not say when the notice must be given.[167]

Judge Klein also makes an excellent point as to the meaning of the statutory definition of "participating physician." He notes that the statute defines participating physician as:

> a physician licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part time and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth-

160. *Id.* at 312.

161. 667 So. 2d 401, 402–04 (Fla. 4th Dist. Ct. App. 1995).

162. *Id.* Studdert, *supra* note 15, at 520 (discussing the concept of the "end run" around the no-fault program).

163. *Bradford*, 667 So. 2d at 401-02 (implying they were not limited to an administrative solution by NICA but could pursue their common law remedy in tort).

164. *Id.* at 403.

165. *Id.*

166. *Id.*

167. *Id.*

> related neurological injury compensation plan for the year in which the injury occurred.[168]

The judge said that from his point of view, any physician who would read that definition would properly think that all they would need to do to be completely covered would be to elect to participate.[169] It would then be within reason for the physician to discontinue their malpractice coverage for this type of event.[170]

Generally accepted canons of statutory construction suggest that it is unreasonable to make the notice requirement a condition precedent if the legislature did not expressly indicate it.[171] Judge Klein stated that courts should be reluctant to add words to statutes unless the word has obviously been omitted, the context of the statute is clear and unequivocal, and adding the word will assist the intent.[172] As to the notice provision, there are no missing words (i.e., condition precedent) and none should be added.[173]

The notice provision can be onerous or burdensome in a number of ways. If a parent has a child that fits the statutory definition of birth-related neurologically injured, but there has been no common law negligence, the parent would be able to collect from NICA, if the provider remembered to supply predelivery notice.[174] If a negligent physician had absentmindedly allowed his liability insurance to lapse, with a suitable injury the parent could be covered by NICA, but only if the physician remembered to give predelivery notice. If a child suffers an obstetrical injury of a suitable type, one can argue the parent might not receive NICA benefits if the physician did not provide the prescribed NICA form. If a child suffers a qualifying injury and the physician did not give notice, there is uncertainty as to whether the parent could waive her right to notice.[175] Also, if a NICA physician without liability insurance failed to give adequate notice, and negligently caused such an obstetrical injury, one might wonder if his or her entire career could be jeopardized. The Supreme Court of Florida apparently thought so.

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168. *Bradford*, 667 So. 2d at 403.
169. *Id.*
170. *Id.*
171. *Id.* at 403–04.
172. *Id.* at 404.
173. *Bradford*, 667 So. 2d at 402.
174. *Id.*
175. *E.g.*, O'Leary v. Fla. Birth-Related Neurological Injury Comp. Ass'n, 757 So. 2d 624 (Fla. 5th Dist. Ct. App. 2000).

C. *The Jurisdictional Squabble: From* McKaughan *to* O'Leary

NICA threatened to self implode because of other matters beyond the funding and notice issues. The issue of jurisdiction is an important example. It was critical to clarify whether it was the courts or the administrative framework of NICA or some combination of both that was to determine the inclusion or exclusion of various types of birth-related neurological injuries.[176] Failure to do so would leave NICA in even more confusion. In one convoluted case, a plaintiff found themselves being forced to prove their child did not meet NICA requirements in order to prevail in their civil malpractice action.[177] The confusion over NICA's jurisdictional underpinnings brought that case all the way to the Supreme Court of Florida.[178]

In *McKaughan*, the infant son was the product of a breech delivery, at which time the infant was intubated.[179] The child suffered injuries that eventuated in the filing of a medical malpractice lawsuit.[180] The defendants answered affirmatively that the exclusive remedy provision of NICA covered the birth-related injuries.[181] The parents did not believe that their son's injuries fit the narrow definition of NICA-injured.[182] The circuit court ordered the malpractice action stayed while the parents sought an administrative determination by the Division of Administrative Hearings ("DOAH") as to whether the child was covered or not.[183] Hence, the parents filed a petition to prove that their son was *not covered* because the injury did not occur "in the course of labor, delivery, or resuscitation in the immediate postdelivery period."[184]

The parents asked DOAH to send the case back to the circuit court since they were not truly "claimants" seeking NICA benefits.[185] DOAH held that the parents had not filed a claim suitable for administrative resolution

176. Studdert, *supra* note 15, at 517–18.

177. Humana of Fla., Inc. v. McKaughan, 652 So. 2d 852, 857 (Fla. 2d Dist. Ct. App. 1995).

178. Fla. Birth-Related Neurological Injury Comp. Ass'n v. McKaughan, 668 So. 2d 974 (Fla. 1996).

179. Respondent's Answer Brief at 3, Fla. Birth-Related Neurological Injury Comp. Ass'n v. McKaughan, 668 So. 2d 974 (Fla. 1996) (Nos. 85,445; 85,447; 85,469 consolidated).

180. *McKaughan*, 668 So. 2d at 976.

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. *McKaughan*, 668 So. 2d at 976.

and, in fact, dismissed the parent's petition, sending the case back to the circuit court.[186] DOAH stated that the health care providers should not have the ability to force administrative resolution on the plaintiff.[187] On appeal, the district court agreed and certified a question of great public importance which in essence was what "procedure to follow or . . . [what the] hearing officer's duty [is] when a claimant who *denies* having a NICA-covered injury is forced by the circuit court into the administrative forum."[188]

Things were topsy-turvy with NICA. Instead of parents seeking coverage by NICA, they were trying to figure out how to prove that their child was *not* covered by NICA. Instead of NICA protecting the physician that paid an assessment for coverage, the DOAH was saying that these parents were not claimants so there could be no coverage and DOAH could have no jurisdiction. Just who had jurisdiction over the whole situation remained to be clarified.

The Supreme Court of Florida agreed that NICA legislation did not hold that the administrative hearing officer had exclusive jurisdiction to decide whether an injured infant was to be covered under NICA, a question that would arise when NICA is being used as a shield to a medical malpractice action.[189] So, the administrative judge was correct, at least temporarily, when he determined that he did not have jurisdiction and sent the case back to the courts for further action.[190] The court saw no clear legislative intent to prevent a plaintiff who believed their birth-related injury

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186. *Id.*

187. *Id.*

188. Respondent's Answer Brief, *supra* note 178, at 4. The full text of the certified question was:

> DOES AN ADMINISTRATIVE HEARING OFFICER HAVE THE EXCLUSIVE JURISDICTION TO DETERMINE WHETHER AN INJURY SUFFERED BY A NEWBORN INFANT DOES OR DOES NOT CONSTITUTE A "BIRTH-RELATED NEUROLOGICAL INJURY" WITHIN THE MEANING OF THE FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN, SECTIONS 766.301–.316, FLORIDA STATUTES (1993), SO THAT A CIRCUIT COURT IN A MEDICAL MALPRACTICE ACTION SPECIFICALLY ALLEGING AN INJURY OUTSIDE THE COVERAGE OF THE PLAN MUST AUTOMATICALLY ABATE THAT ACTION WHEN THE PLAN'S IMMUNITY IS RAISED AS AN AFFIRMATIVE DEFENSE PENDING A DETERMINATION BY THE HEARING OFFICER AS TO THE EXACT NATURE OF THE INFANT'S INJURY?

McKaughan, 668 So. 2d at 975.

189. *McKaughan*, 668 So. 2d at 978.

190. *Id.* at 977.

fell outside of NICA, even if incorrect, to prevent them from litigating their complaint in court.[191]

Now NICA was squarely open for the courts to second-guess the administrative law judge's compensability decisions,[192] making things somewhat of a free-for-all. Therefore, the legislature faced their prior miscue and changed the law.[193] The significant change was that now the administrative law judge had the exclusive jurisdiction to determine whether an injured infant satisfied the NICA statute or not.

The 2000 case of *O'Leary v. Florida Birth-Related Neurological Injury Compensation Ass'n*[194] concerned an emergency obstetrical delivery of a pregnant woman who had been in an automobile accident.[195] The baby was delivered but had complications and suffered neurological defects.[196] The baby died a little over two years later, and the parents filed a malpractice

191. *Id.*

192. Studdert, *supra* note 15, at 518.

193. Section 766.301(1)(d) of the *Florida Statutes* (1993) was amended in 1998 to read:

> The Legislature makes the following findings:
>
> The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault. The issue of whether such claims are covered by this act must be determined exclusively in an administrative proceeding.

FLA. STAT. § 766.301(1)(d) (2001). *But cf.* FLA. STAT. § 766.301(1)(d) (Supp. 1988) (showing that the last sentence was not in the original language). Similarly, section 766.304 of the *Florida Statutes* (Supp. 1988)) was amended as follows:

> The administrative law judge shall hear and determine all claims filed pursuant to ss. 766.301-766.316 and shall exercise the full power and authority granted to her or him in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge *has exclusive jurisdiction* to determine whether a claim filed under this act is compensable. No civil action may be brought until the determinations under s. 766.309 have been made by the administrative law judge. If the administrative law judge determines that the claimant is entitled to compensation from the association, no civil action may be brought or continued in violation of the exclusiveness of remedy provisions of s. 766.303. If it is determined that a claim filed under this act is not compensable, the doctrine of neither collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law.

FLA. STAT. § 766.304 (2001) (emphasis added). The original statute read: "The deputy commissioner shall hear and determine all claims filed pursuant to ss. 766.301–766.316 and shall exercise the full power and authority granted to him with respect to workers' compensation claims, as necessary, to carry out the purposes of such sections." FLA. STAT. § 766.304 (Supp. 1988).

194. 757 So. 2d 624 (Fla. 5th Dist. Ct. App. 2000).

195. *Id.*

196. *Id.* at 624–25.

action.[197] The defendants sought to abate the malpractice action while the plaintiffs sought a determination from the administrative judge as to whether NICA benefits applied or not, although they maintained they had not received adequate NICA notice.[198] The administrative law judge ruled that the issue of whether notice had been given was not in his jurisdiction and dismissed it back to the circuit.[199] The defendant physicians appealed, which was the basis of this action.[200]

The Fifth Circuit took note of the 1998 amendments to the NICA statute, done in recognition of the dual jurisdiction issue left open in *McKaughan*.[201] Under the new law, the administrative law judge had exclusive authority to determine whether the injury was compensable under NICA and that any medical malpractice action was stayed until such time as the decision was made.[202] The court reversed the administrative law judge's decision (that he lacked authority) and remanded back to him for determination of whether notice was given or waived.[203]

It was a long road from *McKaughan* to *O'Leary*, but the final jurisdictional chapter may not yet be written in this battle between the judiciary and the legislature. However, there has already been one acceptance of *O'Leary* during the current year (2001). In *University of Miami v. M.A.*,[204] the court denied the medical malpractice defendant's request to abate the civil action while the administrative judge made his NICA determination so the defendants appealed.[205] The district judge found that the trial judge erred in denying their motion to abate because now the administrative judge had exclusive jurisdiction to determine the compensability under the amended sections of the *Florida Statutes*.[206]

The jurisdictional confusion spills over to both attorneys' bars. Previous to NICA, plaintiff attorneys essentially had one obstacle to overcome. They had to prove that a preponderance of the evidence showed that their client was injured and these defendants negligently caused that injury. With NICA, a new dimension is added, that of having to prove that

197. *Id.* at 625.
198. *Id.*
199. *O'Leary*, 757 So. 2d at 625.
200. *Id.*
201. *Id.* at 626.
202. *Id.*
203. *Id.* at 628.
204. 793 So. 2d 999 (Fla. 3d Dist. Ct. App. 2001).
205. *Id.* at 999–1000.
206. *Id.* at 999–1000 (citing to *O'Leary*, 757 So. 2d 624). The amended subsections were 766.301 and 766.304 of the *Florida Statutes* (1993).

their client does *not* have a NICA injury that would literally suck the claim out of tort and into no-fault. Similarly, defense attorneys who previously concentrated on proving their clients were not negligent or the plaintiff was not injured, now make every gasp at proving that the plaintiff *was* injured—and injured badly enough to be covered by NICA. This extra layer of bureaucracy would all be fine, if the end result was an improved system with reduced costs, and better coverage for all. However, the evidence above does not show that to be the case.

D. *The Swiss Cheese Narrow Medical Definition*

In *McKaughan* and in *M.A.*, the underlying issue upon which the jurisdictional tangle operated was whether the injured infants met the narrow statutory definition of injury.[207] In both of these cases, the plaintiffs were anxious to show that their injured child did *not* meet it. It is not difficult to imagine the situation where a defendant might not have adequate malpractice insurance (to cover multiple incidents, for example) and where the narrow definition precludes coverage for a family because their child, although severely neurologically injured, is not physically injured as well.[208]

Studdert contends that the criterion used to determine whether an injured infant will be covered by NICA are restrictive, and their study provides both direct and indirect evidence.[209] For example, they show that there is a high rate of dismissal of NICA claims.[210] They proved their point by showing that fifteen of eighteen NICA dismissed claims ended successfully for the plaintiffs in tort, thus demonstrating the relative restrictiveness of NICA.[211] They acknowledge that since a portion of these claims were settled as opposed to tried by a jury, their evidence that NICA criteria are stricter than negligence criteria is somewhat "circumstantial."[212]

However, they also looked at the clinical information; based upon that, twice as many claimants met negligence criteria as met NICA criteria.[213] As they noted, this clinical disparity helps explain the indirect results noted

207. *See* discussion *supra* note 39.

208. The definition requires that the injured child be both mentally *and* physically impaired. Therefore a child who was substantially mentally impaired due to birth-related trauma but who did not have a substantial degree of physical impairment would not qualify.

209. Studdert, *supra* note 15, at 519.

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

above. On a more practical basis, it is clear that there are catastrophically injured claimants who are not qualifying for the restrictive NICA definition and whose providers were found to be not negligent. If the stated intent of the program is to "to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries,"[214] it is surprising that these catastrophically injured patients should be left out.

When one says that the statute is restrictive or narrow, it is hard to envision how damaging that can be upon a family. A heartbreaking example is found in *Florida Birth Related Neurological v. Florida Division of Administrative Hearings*,[215] where the infant was a product of a difficult labor and delivery complicated by asphyxia that led to damage to the basal ganglia area of the brain.[216] The ob-gyn was a NICA participating physician.[217] The infant, Eric, did not develop normally. He had severe physical problems, which led to tongue problems and inability to talk; by four and one-half years of age, he was unable to stand, walk or crawl.[218] Experts believed he would never be able to clothe, feed or toilet himself.[219] Tests showed, however, that despite the profound physical defects, measurements of his cognitive skills surprisingly were not much below average and the school board anticipated placing him in a mainstream class.[220] The cause of his injuries was an umbilical cord wrapped around his neck at birth causing asphyxiation, hypoxemia and brain damage.[221]

NICA found that this child did not suffer a compensable injury because his mentation was fairly good despite the profound and catastrophic birth-related neurologic and physical injury that he suffered.[222] The family appealed and the administrative hearing officer disagreed with NICA.[223] His argument sounded like an English lesson concerning how the word "or" and how the word "and" should and could be construed.[224] First of all, the hearing officer states that although NICA wants the statute construed narrowly because the statute is in derogation of common law rights, the

214. FLA. STAT. § 766.301(2) (2001).

215. 664 So. 2d 1016 (Fla. 5th Dist. Ct. App. 1995), *certifying question to* 686 So. 2d 1349 (Fla. 1997).

216. *Id.* at 1017.

217. *Id.*

218. *Id.* at 1018.

219. *Id.*

220. *Fla. Birth Related Neurological*, 664 So. 2d at 1018.

221. *Id.* at 1019.

222. *Id.*

223. *Id.*

224. *Id.* at 1020.

family wants the statute construed liberally because it is remedial.[225] The hearing officer concludes the statute should be construed to maximize the legislative intent, and the statute reads that an injury is one "caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired."[226] The hearing officer then delves into a Clintonesque interpretation of whether "and" really means "and" or does it mean "or:"

> In ascertaining the meaning and effect to be given in construing a statute the intent of the legislature is the determining factor. Although in its elementary sense the word 'or' is a disjunctive participle that marks an alternative generally corresponding to 'either' as 'either this or that;' a connective that marks an alternative. There are, of course, familiar instances in which the conjunctive 'or' is held equivalent to the copulative conjunction 'and,' and such meaning is often given the meaning 'or' in order to effectuate the intention of the parties to a written instrument or the legislative intent in enacting a statute when it is clear that the word 'or' is used in the copulative and not in the disjunctive sense.[227]

He considered the policy reasons for NICA and stated that if the policy was to cover "catastrophic injuries that result in unusually high costs for custodial care and rehabilitation" in order to reduce insurance costs, there was no suggestion that even if this infant was more mentally impaired that the costs of care could possibly be any higher.[228] He concluded by saying that sometimes "[c]ircumstances may require courts to construe the word 'and' to mean 'or' whenever such a conversion is mandated by the context of the words" or where it is needed to make legislative intent clear, as in this case.[229]

The court recognized the severe impact this would have on NICA, so they certified a question of great public importance to the Supreme Court of Florida.[230] The question essentially asked whether the NICA injury must include physical and mental defects or may either defect alone suffice.[231]

225. *Fla. Birth Related Neurological*, 664 So. 2d at 1019.
226. *Id. See* FLA. STAT. § 766.302(2) (2001).
227. *Fla. Birth Related Neurological*, 664 So. 2d at 1020.
228. *Id.*
229. *Id.* at 1021.
230. *Id.*
231. *Id.*

The Supreme Court of Florida made a hash of the whole matter by agreeing that the child suffered a NICA compensable injury, but by that, they meant that this child was, in fact, both physically and mentally injured as a result of his catastrophic delivery.[232] The court reasoned the circuit court did not take certain factors into consideration. For example, "Eric will not be able to translate his cognitive capabilities into adequate learning in a normal manner. Moreover, as a direct consequence of his injuries, Eric's social and vocational development have been drastically impaired. Consequently, it is concluded that Eric is permanently and substantially mentally and physically impaired . . . ."[233] However, as far as interpreting "and" as "or," the court was having nothing to do with that.[234]

The court stated "[t]he Statute is written in the conjunctive and can only be interpreted to require permanent and substantial impairment that has both physical and mental elements."[235] This slams a door in the face of certain catastrophic birth-related neurological injuries or at the least requires the family to run the gauntlet of litigation—precisely what the no-fault benefit was supposed to avoid.

VI. CONCLUSION

The Florida Birth-Related Neurological Injury Compensation Act, section 766.301–.316 of the *Florida Statutes*, was born in an era of rapidly accelerating malpractice costs and was specifically designed "to provide compensation, on a no-fault basis, for a limited class of catastrophic injury that resulted in unusually high costs for custodial care and rehabilitation."[236] Its underpinning was to insure that ob-gyns were not forced out of business by these excessively high insurance costs. It was designed to carve out the most severe of the birth-related neurologically injured patients, in part so that malpractice insurance companies would not be so fearful of doing business in a litigious Florida environment. This comment has presented evidence that shows that NICA has been only moderately successful in reaching its stated goals and cannot be credited with the

232. Fla. Birth-Related Neurological Injury Comp. Ass'n, v. Fla. Div. of Admin. Hearings, 686 So. 2d 1349, 1353 (Fla. 1997).

233. *Id.*

234. *Id.* at 1355–56.

235. *Id.* at 1356. The conjunctive operationally means that it is requires both physical and mental injuries. *Id.* The alternative was called the disjunctive and would have been an "either/or" condition. *Id.* at 1355.

236. FLA. STAT. § 766.301(2) (2001).

generally improved malpractice climate that some physicians now enjoy. In fact, there is evidence that the malpractice environment is once again hardening despite NICA's existence. In addition, there is a high rate of NICA claim dismissal that will end up in tort anyway.[237] Lawyers game the no-fault system by doing an "end-run" around NICA when it serves their purposes.[238]

Early on, the state's physicians challenged the funding mechanism but as of this writing, it is constitutional. Yet it depends on the correctness of the interpretation by the Supreme Court of Florida that the assessment to all nonobstetrical physicians is a tax and not a hidden user fee. This is dubious because there is very little correlation between the amount paid and the benefit received. In the best of circumstances, nonobstetrical physicians resent paying a fee for the benefit of one particular specialty without their consent, when the rest of Florida's population is exempt. In the worst of circumstances, it is illegal taxation.

The statute has had two severe structural difficulties that undermined the faith one might have developed in the program. First, predelivery notice was written into Florida's version of limited obstetrical no-fault in the hopes that NICA could survive a due process attack. Erstwhile, it puts the provider's family and livelihood on the line, directly contradicting one of the main legislative intents. Second, the narrow, restrictive definition of birth-related injury also threatens the very beneficiaries it was ostensibly designed to assist. The exceptions to coverage poke so many holes in NICA's availability that the coverage ends up resembling Swiss cheese. It invites litigation where some of the primary benefits of a partial no-fault system *viz a viz* NICA is to avoid litigation and speed up solutions.

Jurisdictional infighting between the judiciary and the legislature is even today not resolved. As discussed, the Supreme Court of Florida put its foot down and showed that there was concurrent, contingent jurisdiction.[239] However, the legislature was not to be outdone, and they amended the statute to provide that the administrative law judge would have exclusive jurisdiction in NICA determinations and that no civil actions would proceed until this was resolved. This has been followed in the Third Circuit recently, but the judiciary may not yet have fired their final salvo.

A statute that is written to correct a specific problem and that fails to accomplish its stated goal after more than ten years is one that should be examined closely. In particular, where a statute has significant flaws—such

237. Studdert, *supra* note 15, at 519.

238. *Id.* at 520.

239. *Id.* at 517–18.

as its funding mechanism, its notice requirements, its limiting definitions, and its jurisdictional authority—it should be more than examined closely, it should, in fact, be repealed. Limited no-fault liability for obstetrical catastrophes is an idea whose time has come and gone.

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