



THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location

302 Senate Office Building

Mailing Address

404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/2/17	SM	Unfavorable
	JU	
	CA	
	RC	

January 2, 2017

The Honorable Joe Negrón
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 16** – Senator Greg Steube
HB 6527 – Representative Shawn Harrison
Relief of Charles Pandrea by the North Broward Hospital District

SPECIAL MASTER'S FINAL REPORT

BASED ON A JURY AWARD OF \$808,554.78 AGAINST THE NORTH BROWARD HOSPITAL DISTRICT, THIS CONTESTED CLAIM FOR LOCAL FUNDS ARISES FROM THE DEATH OF JANET PANDREA, WHO RECEIVED NEGLIGENT MEDICAL TREATMENT FOR CANCER, WHICH DISEASE (A POSTMORTEM EXAM REVEALED) SHE DID NOT HAVE.

CURRENT STATUS:

On November 21, 2008, John G. Van Laningham, an administrative law judge from the Division of Administrative Hearings, serving as a Senate special master, held a de novo hearing on a previous version of this bill, SB 50 (2009). After the hearing, the judge issued a report containing findings of fact and conclusions of law and recommended that the bill be reported UNFAVORABLY. The 2009 report was reissued for SB 28 (2012), the most recent version of the claim bill for which a report is available. The 2012 report is attached as an addendum to this status report.

Due to the passage of time since the hearing, the Senate President reassigned the claim to me, Thomas C. Cibula. My responsibilities were to review the records relating to the claim bill, be available for questions from the members, and

SPECIAL MASTER'S FINAL REPORT – SB 16

January 2, 2017

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determine whether any changes have occurred since the hearing, which if known at the hearing, might have significantly altered the findings or recommendation in the previous report.

According to counsel for the parties, no changes have occurred since the hearing which might have altered the findings and recommendations in the report. Additionally, the prior claim bills on which the attached special master report is based, is effectively identical to claim bill filed for the 2016 Legislative Session.

Respectfully submitted,

Thomas C. Cibula
Senate Special Master

cc: Secretary of the Senate

Attachment



**THE FLORIDA SENATE
SPECIAL MASTER ON CLAIM BILLS**

Location

402 Senate Office Building

Mailing Address

404 South Monroe Street

Tallahassee, Florida 32399-1100

(850) 487-5237

DATE	COMM	ACTION
12/2/11	SM	Unfavorable

December 2, 2011

The Honorable Mike Haridopolos
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 28 (2012)** – Senator Ellyn Setnor Bogdanoff
Relief of Charles Pandrea

SPECIAL MASTER'S FINAL REPORT

BASED ON A JURY AWARD OF \$808,554.78 AGAINST THE NORTH BROWARD HOSPITAL DISTRICT, THIS CONTESTED CLAIM FOR LOCAL FUNDS ARISES FROM THE DEATH OF JANET PANDREA, WHO RECEIVED NEGLIGENT MEDICAL TREATMENT FOR CANCER, WHICH DISEASE (A POSTMORTEM EXAM REVEALED) SHE DID NOT HAVE.

FINDINGS OF FACT:

On January 7, 2002, Janet Pandrea, 65, saw her primary care physician, Dr. Martin Stone, because she had been coughing for two weeks. Dr. Stone prescribed an antibiotic and some cough medicine and instructed Mrs. Pandrea to return for a follow-up visit in three months. Her symptoms did not improve, however, and so she saw Dr. Stone again one week later. This time, the doctor ordered a chest X-ray.

The X-ray, taken on January 14, 2002, revealed a mass in Mrs. Pandrea's chest, which the radiologist suspected was cancerous. Based on the abnormal chest X-ray, Dr. Stone ordered a computed tomography (CAT) chest scan with contrast. The CAT scan was performed on January 17,

2002. The study showed an encapsulated anterior mediastinal mass, measuring six centimeters by four centimeters, with signs of calcification. Upon learning this, Dr. Stone ordered a fine-needle biopsy, which was performed on January 24, 2002. The specimen, consisting of three "cores," plus three tiny tissue fragments, was fixed in formalin (preserved in a formaldehyde solution) and sent to the pathologist for interpretation.

Dr. Peter A. Tsivis is a pathologist who was, at all relevant times, an employee of the North Broward Hospital District (District). (The District operates the Coral Springs Medical Center, a public facility where Dr. Tsivis worked.) Dr. Tsivis received Mrs. Pandrea's tissue specimen on January 24, 2002. After examining the specimen, Dr. Tsivis prepared a Surgical Pathology Report, which contained the following findings:

SPECIMEN DEMONSTRATE[S]
MALIGNANT NEOPLASM CONSISTENT
WITH MALIGNANT NON-HODGKIN'S
LYMPHOMA (SEE MICROSCOPIC).

To explain, "malignant neoplasm" is the medical term of art for cancer. Non-Hodgkin's lymphoma (NHL) is a categorical description which denotes a variety of different cancers, approximately 30 in number, that originate in the lymphatic system. (In other words, NHL is not a particular cancer, but a particular spectrum of cancers.) Thus, Dr. Tsivis interpreted the specimen (unconditionally) as being positive for cancer, and he found that the cancer he had seen was "consistent with" diseases falling under the category NHL. But Dr. Tsivis pointedly did not state that Mrs. Pandrea's cancer was NHL, nor did he attempt to classify the type of NHL that he believed the disease might be.

Dr. Tsivis further qualified his "pathology diagnosis" with a "microscopic description" providing, in pertinent part, as follows:

The microscopic features [of the specimen] are interpreted as consistent with a malignant non-Hodgkin's lymphoma. However, the material in this specimen is insufficient for any

confirmatory studies such as immunohistochemistry.

Additional tissue for further light microscopy possible immunoperoxidase and for flow cytometry studies is suggested for further evaluation if clinically indicated.

(Emphasis added.)

In view of Dr. Tsivis's findings, Dr. Stone referred Mrs. Pandrea to Dr. Abraham Rosenberg, an oncologist, whom she first saw on January 30, 2002. On Dr. Rosenberg's orders, an abdominal CAT scan and a positron emission tomography (PET) scan were performed on February 2, 2002. The CAT scan showed no evidence that the cancer had spread into Mrs. Pandrea's abdominal organs. The PET scan, however, produced a less encouraging result.

The doctor who interpreted Mrs. Pandrea's PET scan corroborated Dr. Tsivis's finding of an abnormality "consistent with" a malignant lymphoma. The PET scan added a new datum, namely that the tumor's metabolic characteristics suggested the cancer was a relatively non-aggressive one.

The PET scan prompted Dr. Rosenberg to move forward with his treatment plan. He saw Mrs. Pandrea on February 6, 2002, and performed a bone marrow test, which was negative for cancer. Also on that date, Dr. Rosenberg called Dr. Tsivis and requested that immunohistochemistries (or "stains") be made on the existing biopsy specimen, to look for certain proteins in the tissue which could help differentiate the type of cancer involved.

Despite having requested that Dr. Tsivis perform these "stains," Dr. Rosenberg decided on February 6, 2002, to begin giving Mrs. Pandrea chemotherapy. He chose a regimen appropriate for treating "B-cell" lymphomas. Dr. Rosenberg believed (and hoped) that Mrs. Rosenberg had B-cell lymphoma because that particular cancer is more common than T-cell lymphoma (the next likeliest possibility in his opinion) and is more responsive to treatment than the T-cell disease.

Mrs. Pandrea had her first round of chemotherapy on February 7, 2002. Mrs. Pandrea did not tolerate the treatment well. She became nauseous, began vomiting, and had a seizure, all of which ultimately sent her to the hospital on February 10, 2002. It was determined that she probably had developed an adverse reaction to one of the chemotherapy agents. Dr. Rosenberg decided to discontinue the use of that drug and substitute another agent.

Meantime, on February 14, 2002, Dr. Tsivis performed the immunostaining that Dr. Rosenberg had requested. The result was *inconsistent* with a B-cell lymphoma, the putative condition for which Mrs. Pandrea was being treated. But the findings, Dr. Tsivis wrote in his Surgical Pathology Addendum Report, were "insufficient for further diagnostic evaluation of [the] specimen." Dr. Tsivis's bottom line remained the same as before: malignant neoplasm (cancer) consistent with malignant NHL.

Dr. Rosenberg should have changed his treatment plan based on Dr. Tsivis's Addendum Report, which at a minimum cast doubt on Dr. Rosenberg's working assumption that Mrs. Pandrea had a B-cell lymphoma. Dr. Rosenberg did *not* make any adjustments, however, because *he never saw the addendum*, which for reasons unknown was not delivered to Dr. Rosenberg, though Dr. Tsivis had sent it to him in the usual manner according to his routine practice. Despite having not received, within a reasonable time, the results of the pathology tests he had ordered, Dr. Rosenberg never followed up to find out what the "stains" had shown, which was his responsibility.

On February 27, 2002, Mrs. Pandrea underwent a second round of chemotherapy. She soon began having more medical problems, including muscle weakness and pain, secondary to the chemotherapy. On March 6, 2002, Dr. Rosenberg prescribed an antibiotic because Mrs. Pandrea's white blood cell count was low. The antibiotic triggered a serious side effect: rhabdomyolysis, which is characterized by the rapid breakdown of muscle tissue. On March 18, 2002, Mrs. Pandrea was admitted into the hospital, where her condition worsened dramatically over the next two weeks. She experienced respiratory failure on March 21, 2002, which led to emergency abdominal surgery

on March 27. Following the surgery, Mrs. Pandrea developed an infection, and then sepsis. She died on April 2, 2002.

A postmortem examination revealed that Mrs. Pandrea did not have cancer after all. The mediastinal mass was actually a benign thymoma, which in all likelihood could have been removed without endangering Mrs. Pandrea's life, had an accurate and timely diagnosis of her condition been made.

* * *

The issues of ultimate fact in dispute here are (1) whether Dr. Tsivis was negligent in interpreting the biopsy specimen as he did, and (2) whether Dr. Tsivis's negligence (if he were negligent) was the *proximate cause* of Mrs. Pandrea's injury (death). If it is determined that Dr. Tsivis's negligence was the proximate cause of Mrs. Pandrea's death, then a third issue arises, namely: What percentage of the fault should be assigned to Dr. Tsivis (and through him, to the District)?

The question of whether Dr. Tsivis was negligent is a close one, and the evidence is in conflict. To review, he interpreted the biopsy specimen as positive for cancer, suspicious for NHL, but insufficient as a basis for confirming the existence of NHL, much less the specific type of NHL. The autopsy proved that Dr. Tsivis was wrong in finding "cancer," and it is undisputed that he was mistaken in this regard. This does not mean, however, that his interpretation fell below the standard of care.

Claimant's expert pathologist (Dr. Harris) testified that, in her opinion, the standard of care required Dr. Tsivis to state that there was not enough tissue in the specimen to conclude whether the mass was benign or malignant. In other words, according to *Claimant's* expert, Dr. Tsivis was not required to diagnose a benign thymoma, but rather he should have said that the specimen was inconclusive, and left it at that.

The difference between Dr. Tsivis's actual report and the "reasonable report" described by Dr. Harris is largely a matter of degree, not of kind. Dr. Tsivis's report committed (erroneously) to a diagnosis of "cancer," and offered a tentative diagnosis of NHL, but made clear that additional information would be needed to make and confirm a

definitive diagnosis. In Dr. Harris's "reasonable report," the suspected cancer (based on the chest X-ray) would be neither confirmed nor ruled out. Hence both reports, at bottom, are of the same kind (inconclusive). One (Dr. Tsivis's) is merely less so than the other.

It is determined, therefore, that although Dr. Tsivis was mistaken in finding that Mrs. Pandrea had cancer, he was not negligent in doing so. That said, however, even if Dr. Tsivis were found to have been negligent, the outcome would be the same, based on the additional (and alternative) findings that follow.

Claimant contends that but for Dr. Tsivis's negligence, Mrs. Pandrea would not have been treated for a cancer she didn't have, and thus would not have developed the complications secondary to such treatment which ultimately led to her death. Whether this is true, as a matter of fact, is far from clear, however. Conceivably, the outcome would have been the same *regardless* of Dr. Tsivis's negligence, due to the actions of others that would have taken place anyway. The undersigned nevertheless gives the benefit of the doubt to Claimant on this issue, and finds that Dr. Tsivis's negligence was a cause-in-fact of the injury.

For legal liability to attach to negligent conduct, it is necessary, but not sufficient, that the negligent conduct have been a cause-in-fact of the plaintiff's injury. In addition to this necessary "but for" causal connection, the negligence must also be regarded as the legal or "proximate" cause of the injury. The outcome determinative question here thus becomes whether Mrs. Pandrea's death was the foreseeable consequence of Dr. Tsivis's negligence, foreseeability being the touchstone of proximate cause.

With this question in view, the undersigned does not see much, if any, *operational* difference between what Dr. Tsivis wrote in his report, on the one hand, and what Dr. Harris (Claimant's expert) testified he should have written, on the other. That is, in terms of the reasonably foreseeable practical effects of one pathologic interpretation versus the other, nothing really distinguishes between them. This is because the evidence overwhelmingly establishes (and it is found) that Dr. Tsivis's report was not "diagnostic," meaning that it was neither specific enough nor definitive enough to

support a reasonable decision to commence treatment. His report reasonably required that further diagnostic tests be run—just as Dr. Harris's hypothetical "reasonable report" would have done.¹

Thus, even assuming Dr. Tsivis were negligent, the fact is, it was *not* reasonably foreseeable that his pathology report would form the basis for a decision to start treating Mrs. Pandrea for NHL. What was foreseeable, rather, was that the physician responsible for Mrs. Pandrea's diagnosis and treatment would order another biopsy so that a definitive pathologic diagnosis could be obtained. This is what Dr. Rosenberg should have done on receipt of Dr. Tsivis's report, according to the applicable standard of care. But instead Dr. Rosenberg breached the standard of care by starting Mrs. Pandrea on chemotherapy before confirming that she had a specific type of NHL. Dr. Tsivis could not reasonably have foreseen that such negligence would occur based on his (Dr. Tsivis's) pathology report.

To elaborate on this finding, it is the undersigned's determination, based on the evidence presented, that Dr. Tsivis's negligence did not set in motion a chain of events leading to Mrs. Pandrea's death. In a broad sense, the "ball was rolling" before Dr. Tsivis became involved. After all, prior to the biopsy and Dr. Tsivis's interpretation of the specimen, Mrs. Pandrea had sought medical treatment, and a chest X-ray had been taken, which the radiologist had found was suspicious for cancer. It was not Dr. Tsivis's report, therefore, that started Mrs. Pandrea down the road to medical care.

In a narrower sense, it is fair to say that, in fact, by the time Dr. Tsivis came into the case, the *diagnostic* ball was rolling along due to the previous actions of others. Put another way, the diagnostic chain of events was already in play. Dr. Tsivis's negligence neither started this chain *nor stopped it*. The latter finding is crucial. If Dr. Tsivis had made a diagnosis that was "actionable" vis-à-vis treatment, he would have (negligently) stopped the diagnostic ball and started the *treatment* ball rolling, initiating a new chain of events. Instead, however, he kept the diagnostic ball rolling, which is exactly what, the undersigned finds (based largely on Claimant's expert's testimony), he should have done.

When Dr. Rosenberg prematurely and negligently started Mrs. Pandrea on chemotherapy, he broke the diagnostic chain of events and started the *treatment* ball rolling. Dr. Tsivis's negligence did not start this chain of events which led to Mrs. Pandrea's death; it merely provided the occasion for Dr. Rosenberg's *intervening and superseding* negligence, which led to Mrs. Pandrea's untimely death.

Dr. Tsivis's negligence thus can be regarded as the proximate cause of Mrs. Pandrea's death only if Dr. Rosenberg's negligence was itself a reasonably foreseeable (i.e. a probable, and not merely possible) consequence of Dr. Tsivis's conduct.

On the question of foreseeability, there is no evidence establishing that Dr. Tsivis had actual knowledge that patients have died (or suffered serious injury) as a result of negligence similar to his in this instance. Nor is there any proof that the type of harm which Mrs. Pandrea suffered has so frequently resulted from negligence such as Dr. Tsivis's that the same type of harm may be expected again. On the contrary, Mrs. Pandrea's death under the instant circumstances strikes the undersigned as highly unusual and far outside the scope of any fair assessment of the "danger" created by Dr. Tsivis's negligence.

It is the undersigned's determination, therefore, that, as a matter of fact, Dr. Tsivis's negligence was not the proximate cause of Mrs. Pandrea's death. That being the case, he was not at fault here, and therefore neither was the District.

LEGAL PROCEEDINGS:

In December 2002, Charles Pandrea, as the personal representative of his late wife's estate, brought a wrongful death action against the District and a host of others, including Drs. Stone and Rosenberg. The action was filed in the Broward County Circuit Court.

The case was tried before a jury in May 2005 against the following defendants, who remained parties to the suit: The District, Drs. Stone and Rosenberg, and University Hospital Medical Center ("Hospital"). The jury returned a verdict awarding Mr. Pandrea, who was 75 years old at the time, a total of \$8,072,498.08 in damages, broken down as follows: (a) \$3 million for past pain and suffering; (b) \$5 million for future pain and suffering; and (c) \$72,498.08 for funeral

expenses. The jury apportioned the fault for Mrs. Pandrea's death as follows: Dr. Rosenberg, 50 percent; the Hospital, 28 percent; Dr. Stone, 12 percent; and the District, 10 percent.

The District paid Mr. Pandrea \$200,000 under the sovereign immunity cap, leaving unpaid the sum of \$608,554.78, which represents the excess portion of the judgment against the District. Mr. Pandrea has settled with all of the private defendants, some of whom paid and were released from further liability before the civil trial, recovering a total of \$4.77 million from them. Thus, Mr. Pandrea has collected, to date, nearly \$5 million on the wrongful death claim.

CLAIMANT'S ARGUMENTS:

The District is vicariously liable for the negligence of its employee, Dr. Tsivis, who misinterpreted the biopsy specimen, rendering a "false positive" diagnosis of cancer, which set in motion the chain of events leading to Mrs. Pandrea's untimely death. Mr. Pandrea is entitled to recover from the District the entire portion of damages for which the jury found the District responsible, namely \$808,554.78.

RESPONDENT'S ARGUMENTS:

It was not reasonable for Dr. Rosenberg to start Mrs. Pandrea on chemotherapy based on Dr. Tsivis's "non-diagnostic" pathology report—and such negligence on Dr. Rosenberg's part was not a reasonably foreseeable consequence of Dr. Tsivis's conduct. Thus, Dr. Tsivis's negligence, if any, was not the proximate cause of Mrs. Pandrea's death. Further, in the alternative, the award of \$8 million was excessive and probably reflected a desire to punish the defendants, sympathy for Mr. Pandrea, or a combination of these, none of which is a proper consideration. There is no compelling reason to enact the instant claim bill.

CONCLUSIONS OF LAW:

As provided in s. 768.28, Florida Statutes (2010), sovereign immunity shields the District against tort liability in excess of \$200,000 per occurrence. See Eldred v. North Broward Hospital District, 498 So. 2d 911, 914 (Fla. 1986)(§ 768.28 applies to special hospital taxing districts); Paushter v. South Broward Hospital District, 664 So. 2d 1032, 1033 (Fla. 4th DCA 1995).

Under the doctrine of respondeat superior, the District is vicariously liable for the negligent acts of its agents and

employees, when such acts are within the course and scope of the agency or employment. See Roessler v. Novak, 858 So. 2d 1158, 1161 (Fla. 2d DCA 2003). Dr. Tsivis was an employee of the District and was acting in the course and scope of his employment when interpreting Mrs. Pandrea's biopsy specimen. Accordingly, Dr. Tsivis's negligence in connection with the interpretation of this specimen, if any, is attributable to the District.

The fundamental elements of an action for negligence, which the plaintiff must establish in order to recover money damages, are the following:

(1) The existence of a duty recognized by law requiring the defendant to conform to a certain standard of conduct for the protection of others including the plaintiff;

(2) A failure on the part of the defendant to perform that duty; and

(3) An injury or damage to the plaintiff proximately caused by such failure.

Stahl v. Metro. Dade Cnty., 438 So. 2d 14, 17 (Fla. 3d DCA 1983).

There is no question that Dr. Tsivis owed Mrs. Pandrea a legal duty to exercise reasonable care in interpreting the biopsy specimen. The first element of the claim, therefore, is satisfied.

As for the second element, however, it is the undersigned's primary determination of ultimate fact that Dr. Tsivis's conduct did not fall below the applicable standard of care. To repeat for emphasis, the undersigned finds, as a matter of fact, that Dr. Tsivis did not fail to perform the legal duty he owed Mrs. Pandrea. The second element of this claim, therefore, is not met.

Additionally, however, and in the alternative, even if Dr. Tsivis did breach the duty of reasonable care he owed Mrs. Pandrea, his negligence, the undersigned finds, was not, as a matter of fact, the proximate cause of Mrs. Pandrea's

death. The third element of this claim, therefore, is not met in any event.

"Proximate cause" is an involved legal concept. The "proximate cause" element of a negligence action embraces not only the "but for," causation-in-fact test, but also fairness and policy considerations, usually focusing on whether the consequences of the negligent act were foreseeable in the exercise of reasonable prudence. See, e.g., Stahl, 438 So. 2d at 17-21.

The issue of causation is complicated in this case by the involvement of multiple defendants, each of whose negligence allegedly combined to produce the sole injury (death) for which Claimant sought (and seeks) to recover (and for which he has recovered a substantial sum). In situations such as this, where there were several wrongs but one injury, the negligent actors are referred to as "joint tortfeasors." See, e.g., D'Amario v. Ford Motor Co., 806 So. 2d 424, 435 n.12 (Fla. 2001).

Generally speaking, each joint tortfeasor whose negligence was a proximate cause of the plaintiff's injury is liable for his or her share of the damages, under comparative fault principles. In this case, for instance, the jury apportioned the fault between the four defendants who remained in the suit at trial, assigning to each a percentage of responsibility for Mrs. Pandrea's death. (The District, recall, was found by the jury to have been 10 percent at fault, due to the actions of Dr. Tsivis.)

A negligent party is *not* liable for someone else's injury, however, if a separate force or action was "the active and efficient intervening cause, the sole proximate cause or an independent cause." Dep't of Transp. v. Anglin, 502 So. 2d 896, 898 (Fla. 1987). Such a supervening act of negligence so completely disrupts the chain of events set in train by the original tortfeasor's conduct that any negligence which occurred before the supervening act is considered too remote to be the proximate cause of any injury resulting from the supervening act. On the other hand, if the intervening cause were foreseeable, which is a question of fact for the trier to decide, then the original negligent party may be held liable. Id. In circumstances involving a foreseeable intervening cause, the original tortfeasor sometimes is said

to have "set in motion" the "chain of events" that resulted in the plaintiff's injury. See Gibson v. Avis Rent-a-Car System, Inc., 386 So. 2d 520, 522 (Fla. 1980).²

In this case, the question arises whether the negligence of Dr. Rosenberg was an unforeseeable intervening cause which so profoundly and unexpectedly changed the course of events as to sever any reasonable causal connection between Dr. Tsivis's negligence and Mrs. Pandrea's death. Concerning the question of foreseeability as it arises in the context of an "intervening cause" case, the Florida Supreme Court has explained:

[T]he question of whether to absolve a negligent actor of liability is more a question of responsibility [than physical causation]. W. Prosser, *Law of Torts*, § 44 (4th Ed. 1971); L. Green, *Rationale of Proximate Cause*, 14270 (1927); Comment, 1960 Duke L.J. 88 (1960). If an intervening cause is foreseeable the original negligent actor may still be held liable. The question of whether an intervening cause is foreseeable is for the trier of fact.

* * *

Another way of stating the question whether the intervening cause was foreseeable is to ask whether the harm that occurred was within the scope of the danger attributable to the defendant's negligent conduct. A person who creates a dangerous situation may be deemed negligent because he violates a duty of care. The dangerous situation so created may result in a particular type of harm. The question whether the harm that occurs was within the scope of the risk created by the defendant's conduct may be answered in a number of ways.

First, the legislature may specify the type of harm for which a tortfeasor is liable. See *Vining v. Avis Rent-A-Car*, above;

Concord Florida, Inc. v. Lewin, 341 So.2d 242 (Fla. 3d DCA 1976) cert. denied 348 So.2d 946 (Fla. 1977). Second, it may be shown that the particular defendant had actual knowledge that the same type of harm has resulted in the past from the same type of negligent conduct. See Homan v. County of Dade, 248 So.2d 235 (Fla. 3d DCA 1971). Finally, there is the type of harm that has so frequently resulted from the same type of negligence that "'in the field of human experience' the same type of result may be expected again." Pinkerton-Hays Lumber Co. v. Pope, 127 So.2d 441, 443 (emphasis in original).

Gibson, 386 So. 2d at 522-23 (citations omitted).

As the trier of fact, the undersigned finds that the negligence of Dr. Rosenberg in prematurely commencing to treat Mrs. Pandrea with chemotherapy was not within the "scope of the risk" created by Dr. Tsivis's negligence in issuing a pathology report that was less inconclusive than it should have been. Dr. Rosenberg's negligence was, as a matter of fact, an unforeseeable, active, and efficient intervening cause; as such, it relieved Dr. Tsivis of liability.

Claimant makes an argument concerning foreseeability that is clever and plausible on its face, but ultimately unpersuasive. The argument invokes the "rule of complete liability of initial tortfeasors." This rule holds that a tortfeasor is responsible for all of the reasonably foreseeable consequences of his actions—even injuries caused downstream by a subsequent tortfeasor (provided the subsequent negligence was reasonably foreseeable). D'Amario, 806 So. 2d at 435-36. Thus, in a multi-wrong, multi-injury scenario, the *initial* tortfeasor can potentially be held responsible for *all* of the plaintiff's damages.

Before going forward with this discussion, an important distinction must be made between *joint* tortfeasors, on the one hand, and *initial/subsequent* tortfeasors, on the other. When several wrongs combine to cause a single injury, the plaintiff can sue the joint tortfeasors together; the fact-finder

will apportion the fault among the negligent parties, who will be liable for their respective shares of the damages. In contrast, when several wrongs independently cause *several* separate injuries, the plaintiff can either sue the independent tortfeasors separately and attempt to recover damages from each for the distinct injury caused by the particular negligent party named in each suit, or he can sue the *initial* tortfeasor alone and potentially recover, exclusively from that original negligent party, all of his damages in the one suit; in that case, however, the negligence of the initial tortfeasor is not compared to that of the subsequent tortfeasor because, unlike a case involving joint tortfeasors, each one's actions were independent of the other and caused separate injuries. Id. at 435.

To make this clearer, consider a common initial/subsequent tortfeasor scenario, which starts with an accident (a car crash, say) in which the plaintiff, in consequence of another's negligence, suffers bodily injuries requiring medical attention, and ends with the plaintiff suffering additional injuries at the hands of his negligent doctor. The person whose negligence caused the initial accident and the doctor who later committed medical malpractice are not *joint* tortfeasors; they are *initial* and *subsequent* tortfeasors. Thus, they cannot be sued together (and have their negligent acts compared). Instead, they must be sued separately in independent actions wherein each might be held responsible for the injuries caused by his own acts of negligence.

Alternatively, under the complete-liability rule, the plaintiff in the above described scenario could sue the initial tortfeasor and seek to recover for *all* of his injuries, even the ones caused by his negligent doctor. Moreover, although "[t]ypically, the question of whether an intervening cause [wa]s reasonably foreseeable is for the jury, . . . an exception exists when subsequent medical negligence in treating the initial injury is involved." Letzter v. Cephas, 792 So. 2d 481, 485 (Fla. 4th DCA 2001). Under this exception, which applies "when one who is negligent injures another causing him to seek medical treatment," id., "negligence in the administration of that medical treatment *is* foreseeable [*i.e.* is deemed foreseeable as a matter of law] and will not serve to break the chain of causation," id. (Emphasis added). As the Letzter court explained further,

Where one who has suffered personal injuries by reason of the negligence of another exercises reasonable care in securing the services of a competent physician or surgeon, and in following his advice and instructions, and his injuries are thereafter aggravated or increased by the negligence, mistake, or lack of skill of such physician or surgeon, the law regards the negligence of the wrongdoer in causing the original injury as the proximate cause of the damages flowing from the subsequent negligent or unskillful treatment thereof, and holds him liable therefor.

Id. (quoting Stuart v. Hertz Corp., 351 So. 2d 703, 707 (Fla. 1977)). The court added, finally, that:

When the rule in Stuart v. Hertz applies, the initial tortfeasor's remedy against the succeeding negligent health care provider lies in an action for subrogation. See Underwriters at Lloyds v. City of Lauderdale Lakes, 382 So. 2d 702, 704 (Fla. 1980). The foreseeability rule of Stuart v. Hertz has expressly been held to apply even when the initial tortfeasor is a physician as well. See Davidson v. Gaillard, 584 So. 2d 71, 73-74 (Fla. 1st DCA 1991), disapproved on other grounds by Barth v. Khubani, 748 So. 2d 260 (Fla. 1999).

Id.

To summarize, then, when an initial tortfeasor injures the plaintiff, causing him to seek medical treatment during which a subsequent tortfeasor further injures the plaintiff, the plaintiff can seek to recover damages for all of his injuries from the initial tortfeasor, under the complete-liability rule; in such an action, moreover, the plaintiff need not prove that the medical negligence was foreseeable because the law regards the first injury as the proximate cause of the second.

Pointing to the foregoing principles, Claimant contends that Dr. Rosenberg's negligence was, as a matter of law, the foreseeable consequence of Dr. Tsivis's negligence. For this to be true, Dr. Tsivis would need to be regarded, not as a *joint* tortfeasor whose negligence combined with that of Dr. Rosenberg and others to cause Mrs. Pandrea's death, but as an *initial* tortfeasor whose negligence injured Mrs. Pandrea in some distinct way, causing her to seek medical treatment, during which, due to the negligence of *subsequent* tortfeasors, she died.

In trying to fit this case into the initial/subsequent tortfeasor mold, Claimant relies on Davidson v. Gaillard, 584 So. 2d 71 (Fla. 1st DCA 1991). In that case, the decedent, Mrs. Davidson, had been treated in 1981 for Hodgkin's Disease, which as a result had gone into remission. Mrs. Davidson began having worrisome symptoms in the summer of 1983, however, and consequently her doctor ordered a CAT scan, which was performed by a radiologist named Dr. Gaillard. Reviewing the results, Dr. Gaillard saw no abnormal mass or tumor and concluded that Mrs. Davidson's cancer had not returned. Based on Dr. Gaillard's diagnosis that the CAT study was negative for cancer, Mrs. Davidson did not immediately receive treatment. Id. at 72.

Mrs. Davidson continued to experience symptoms and returned to her doctor a few months later. It was eventually determined that Mrs. Davidson's cancer had indeed come back and, worse, had spread to her stomach. In April 1984, much of her stomach and some of her pancreas were removed. A second surgery was then performed to remove a tumor that was obstructing Mrs. Davidson's bowel. During this surgery, her bowel was perforated, causing a massive infection which proved fatal. Id.

Mrs. Davidson's husband brought separate lawsuits for negligence against, respectively, Dr. Gaillard for his failure to diagnose Mrs. Davidson in October 1983, and the physicians who treated her in 1984, after the cancer was belatedly found. (The Davidson case under discussion deals solely with the claim against Dr. Gaillard.) At trial, the parties' experts generally agreed that, if Mrs. Davidson had been diagnosed correctly in October 1983, her prognosis would have been reasonably good; with immediate treatment, the cancer likely would have gone into remission. The defense

maintained, however, that the primary cause of Mrs. Davidson's death was not Dr. Gaillard's initial, negligent failure to detect the tumor, but rather the subsequent malpractice of the doctors who treated her for cancer. The jury agreed with the defense, finding that Dr. Gaillard's negligence was not a legal cause of Mrs. Davidson's death. Id. at 72-73.

On appeal, the plaintiff argued that the trial court had erred in denying the plaintiff's motion for directed verdict on proximate causation. The plaintiff relied on the complete-liability rule (discussed at length above), which holds that an initial tortfeasor is liable not only for the injuries he, himself, negligently caused, but also, as a matter of law, for the additional injuries resulting from the negligent medical treatment of the initial injuries. The appellate court agreed with the plaintiff and reversed. Id. at 73-74.

While Davidson might appear at first blush to be analogous to the instant case, closer study shows that it is distinguishable. Unlike this case, Davidson plainly involved a multi-injury situation. Indeed, the plaintiff there (unlike Claimant here) brought two lawsuits, one against the "initial" tortfeasor (Dr. Gaillard) and another against the "subsequent" tortfeasors (the treating physicians). To cut to the chase, it is simply incorrect to assert, as Claimant does, that just as Dr. Gaillard's negligence was held to be the proximate cause of Mrs. Davidson's death, *even though (so Claimant contends) Dr. Gaillard's negligence did not physically injure Mrs. Davidson*, so too should Dr. Tsivis's negligence be regarded as the proximate cause of Mrs. Pandrea's death, though he caused her no physical harm. This assertion is incorrect because, in fact, Dr. Gaillard's negligence *did* cause a physical injury: his negligence delayed an accurate diagnosis and treatment for about six months, during which time Mrs. Davidson's cancer spread into her stomach and other organs. Thus, the radiologist's negligence (in giving a false negative diagnosis) *aggravated* Mrs. Davidson's disease, causing her (probably treatable, not imminently fatal) lymphoma to become a metastatic cancer of the stomach, pancreas, and bowels—the separate (and obviously much worse) bodily injury that caused her to seek medical treatment, which was (allegedly) negligently provided.

In this case, it is Claimant's theory that Dr. Tsivis negligently rendered a false *positive* diagnosis, causing Mrs. Pandrea to seek treatment for a disease that she did not actually have. Unlike the situation in Davidson, however, where the radiologist's false *negative* diagnosis *itself* led to an aggravation of the patient's condition (*i.e.*, a separate injury), here Dr. Tsivis's negligence (assuming he were negligent) did not *itself* cause any cognizable injury (emotional distress from a wrong diagnosis not being an issue in this case), but rather caused an injury (if at all) only in combination with the negligence of Dr. Rosenberg, without which negligence Mrs. Pandrea would not have been treated for a nonexistent cancer. In short, Dr. Tsivis (unlike Dr. Gaillard in Davidson) cannot be considered an "initial" tortfeasor under any reasonable view of the allegations or facts; at best (from Claimant's standpoint) he was a *joint* tortfeasor. (*That, i.e.* as a joint tortfeasor, is how the District was sued, and how the plaintiff's case was presented to the jury, in the civil action that preceded this legislative proceeding.) Thus, the medical negligence of Dr. Rosenberg was not, as a matter of law, the foreseeable consequence of Dr. Tsivis's negligence.

The bottom line is that Dr. Tsivis's negligence was not the proximate cause of Mrs. Pandrea's death, as a matter of fact. The District, therefore, is not legally responsible for this tragic occurrence.

LEGISLATIVE HISTORY:

This is the fourth year that this claim has been presented to the Florida Legislature.

ATTORNEYS FEES:

Section 768.28(8), Florida Statutes, provides that "[n]o attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement." "Claimant's law firm, Krupnick Campbell Malone Buser Slama Hancock Liberman & McKee, P.A., has agreed to limit its fees to the "maximum amount permitted under the law." Claimant's attorneys represent that they have incurred approximately \$480,000 in litigation costs. The undersigned presumes that most (or all) of the expenses have been paid out of the nearly \$5 million Claimant already has received. Information concerning the amount of attorney's fees paid to date is unavailable.

Claimant has retained Lance J. Block to lobby in favor of this bill. The contract between Claimant and Mr. Block calls for a

contingency fee of six percent. Mr. Block has attested via affidavit, however, that his fee will be in compliance with any limitations that the bill places on fees and costs.

In its current form, the instant claim bill provides that the "total amount paid for attorney's fees, lobbying fees, costs, and other similar expenses relating to the adoption of this act may not exceed 25 percent of the total amount awarded under this act." Claimant and his attorneys appear to be willing to abide by this limitation.

GENERAL CONCLUSIONS:

Mrs. Pandrea's death should not have happened and would not have occurred but for the medical negligence of Dr. Rosenberg and others besides the District. These other responsible parties have paid substantial sums in damages as a result of their negligent actions—nearly \$5 million in gross. Indeed, the District itself has paid \$200,000, even though, in the undersigned's judgment (based solely on the evidence presented in this proceeding and made in obedience to the applicable law), the District was not at fault. Thus, Claimant has received substantial compensation for his profound loss.

RECOMMENDATIONS:

For the reasons set forth above, I recommend that Senate Bill 28 (2012) be reported UNFAVORABLY.

Respectfully submitted,

John G. Van Laningham
Senate Special Master

cc: Senator Ellyn Setnor Bogdanoff
Debbie Brown, Interim Secretary of the Senate
Counsel of Record

¹ Indeed, ironically, Dr. Tsivis's "negligent" report, which was ultimately right (more tests are needed) for reasons that were not entirely correct (the patient has cancer of some kind), would tend to increase the likelihood that further testing would be done, as compared to Dr. Harris's "reasonable report," which appears to pose a greater risk (than Dr. Tsivis's report) of causing the patient or her doctor to *forego* further testing or treatment in the near term. Cf. Sunderman v. Agarwal, 750 N.E.2d 1280 (Ill.App. 2001)(pathology report stating that specimen was "inconclusive for malignancy" allegedly caused delay in diagnosis and treatment of decedent's lung cancer; summary judgment in pathologist's favor affirmed because, despite inconclusive pathology report, treating physician believed patient had cancer and recommended treatment accordingly, and thus pathology report not proximate cause of delay).

² In contrast, where the intervening cause was not the foreseeable consequence of the original negligent party's conduct, the latter, who is not liable for the resulting injury to the plaintiff (because his negligence was not the proximate cause thereof), may be found to have "provided the occasion" for the later negligence which harmed the plaintiff—but not to have set in motion the injurious chain of events. Anglin, 502 So. 2d at 899.