

Winter 2006

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Kaycee Hopwood

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Recommended Citation

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“FOR IT’S ONE, TWO, THREE STRIKES, YOU’RE OUT. . .”¹

KAYCEE HOPWOOD*

I. INTRODUCTION

The United States is currently in the midst of a medical malpractice² crisis.³ Physicians nationwide claim that they are being forced to desert their practices due to soaring medical malpractice insurance premiums.⁴ However, this malpractice

* J.D. Candidate, May 2006, The John Marshall Law School. The author would like to thank her family for their constant support. The author would also like to give a special thanks to her husband, Greg Hopwood, for his encouragement and unending patience throughout the last three years.

1. JACK NORWORTH, TAKE ME OUT TO THE BALL GAME (York Music Co. 1927), available at http://www.baseball-almanac.com/poetry/po_stmo.shtml (last visited Oct. 6, 2004).

2. Black’s Law Dictionary defines “malpractice” as [f]ailure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them.

BLACK’S LAW DICTIONARY 959 (6th ed. 1990). See also NGA CENTER FOR BEST PRACTICES, ADDRESSING THE MEDICAL MALPRACTICE INSURANCE CRISIS 1 (Dec. 5 2002), available at <http://www.nga.org/cda/files/1102MEDMALPRACTICE.pdf> (defining medical malpractice) [hereinafter NGA BRIEF]. In order to avoid being forced to personally compensate victims of medical malpractice, physicians protect themselves by obtaining malpractice insurance. Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live With Inefficient Doctors?*, 94 W. VA. L. REV. 11, 54 (1991) (explaining why physicians purchase medical malpractice insurance as well as the probability that malpractice will occur).

3. Valerie Witmer, *A Patient Perspective: Focusing on Compensating Harm*, 13 ANNALS HEALTH L. 589, 590 (2004) (dispelling the myth that uncontrollable litigation is to blame for the current medical malpractice crisis).

4. Leo Boyle, *The Truth About Medical Malpractice*, TRIAL, Apr. 2002, available at <http://www.vanosteen.com/news/medical-malpractice.asp>. See also Ken Thomas, *Bush: ‘We’re Not Going to Let This Issue Lie’ Governor Urges Malpractice Awards Reform*, TALLAHASSEE DEMOCRAT, Apr. 1, 2003 (on file with author) (discussing doctors’ contentions that they may be compelled to desert their practices due to high insurance costs). Specifically, physicians argue that because of the soaring premiums, they are being forced to choose

madness is not a novel concept to the United States since the nation experienced similar crises first in the 1970s and again in the 1980s.⁵

Physicians and critics of the current tort system⁶ specifically blame their plights on excessive noneconomic damage awards,⁷ large contingency fees,⁸ and an abundance of frivolous lawsuits.⁹ However, out-of-control medical liability litigation is not the cause.¹⁰ Instead, the crux of the crisis is the disturbing frequency

between relocation or premature retirement. Amanda Craig, *A Physician's Perspective on the Medical Malpractice Crisis*, 13 ANNALS HEALTH L. 623, 624-25 (2004) (discussing physicians' alleged options when faced with soaring insurance premiums). In addition, many physicians are threatening to quit doing high-risk procedures, such as delivering babies. NGA Brief, *supra* note 2, at 1. However, physicians seem to ignore their exceptionally good fortune. Jamie Court, *Sued a Physician, Did You? The Doctor Won't See You Now; Ethics collapse over malpractice insurance cost*, L.A. TIMES, June 13, 2004. In fact, a Medical Economics Magazine survey indicated that in 2002, even after paying medical malpractice insurance and other deductible expenses, OB/GYNs still averaged \$220,000, whereas invasive cardiologists made in the range of \$360,000. *Id.*

5. Michael D. Maves, *Disappearing Doctors: The Medical Liability Crisis*, American Medical Association, <http://www.medicine.osu.edu/alumni/disappearingdocs.ppt#1> (last visited Nov. 10, 2005). The first medical malpractice crisis has been described as a crisis of availability. *Id.* Unlike in the 1970's, the second crisis in the 1980's has been portrayed as an affordability crisis. *Id.* Although the 1990's did not see such a dilemma, the third and most current crisis developed at the onset of the twenty-first century. *Id.*

6. The tort system provides a primary vehicle to resolve incidents of medical negligence. NGA Brief, *supra* note 2, at 4. Theoretically, the purpose of the tort system is to compensate the injured and to prevent injuries from occurring in the future. *Id.*

7. Richard W. Stevenson, *President Asks Congress for Measures Against Frivolous Suits*, N.Y. TIMES, Jan. 17, 2003. President Bush argues that without a \$250,000 cap on noneconomic damages, "excessive jury awards will continue to drive up insurance costs, will put good doctors out of business or run them out of your community, and will hurt communities like Scranton, Pa." *Id.*

8. MIMI MARCHEV, THE MEDICAL MALPRACTICE INSURANCE CRISIS: OPPORTUNITY FOR STATE ACTION 16 (2002), available at http://www.nashp.org/Files/gnl48_medical_malpractice.pdf. (last visited Oct. 6, 2004). As a result, physicians in the state of Florida recently proposed an amendment to the state's constitution which would cap the amount that lawyers can earn from a medical malpractice lawsuit. Siobhan Morrissey, *Med-Mal War Hits the Ballot*, 3 A.B.A. J. E-REPORT 30 (2004).

9. Marc Levy, *Malpractice Crisis May be More Complex Than Blaming Lawyers*, ASSOCIATED PRESS NEWSWIRES, May 11, 2003, available at <http://www.phillyburbs.com/pb-dyn/news/103-05122003-87311.html>. See also *Politics Keeps Real Remedies for Medical Errors Off Radar*, USA TODAY, Sept. 13, 2004, at 19A [hereinafter *Politics*] (discussing President Bush's contention that "junk lawsuits" are to blame for the current medical malpractice crisis).

10. Witmer, *supra* note 3, at 590. See also *Medical Liability Issues: Hearing Before the H. Energy and Commerce Comm.: S. Comm. On Health,*

with which medical malpractice occurs.¹¹ As a result, caps on noneconomic damages and contingency fees, and a reduction of frivolous lawsuits are not the solution.

According to a 1999 study conducted by the Institute of Medicine, as many as 98,000 people die annually due to medical errors that could have been avoided.¹² In fact, more people die from medical malpractice each year than from automobile accidents, AIDS, and breast cancer.¹³ Interestingly, the National Practitioner Data Bank ("NPDB")¹⁴ reports that only a minority of physicians are responsible for a majority of malpractice awards.¹⁵

108th Cong. (2003) [hereinafter Rosenfield] (statement of Harvey Rosenfield: TLC Foundation for Taxpayer and Consumer Rights) (reasoning that the current medical malpractice crisis is not due to malpractice litigation). *But see* Craig, *supra* note 4, at 626-27 (arguing that the litigation system is behind the recent crisis).

11. Boyle, *supra* note 4.

12. HEALTH GRADES QUALITY STUDY, PATIENT SAFETY IN AMERICAN HOSPITALS 1 (2004), available at http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf. Every six months, patient safety related incidents claim more lives in America than the Vietnam War did. *Id.* If medical errors were considered to be a "cause of death" by the CDC, these errors would rank number six. *Id.* at 2. Although the statistics regarding fatalities due to medical errors are shocking, they do not take in to account the countless people whose lives are shattered because of medical malpractice. Harvey F. Wachsman, *Lawsuits Protect Public*, USA TODAY, Sept. 13, 2004, at 19A.

13. Maves, *supra* note 5.

14. Pursuant to the Health Care Quality Improvement Act of 1986, Congress created the NPDB. AMA-ASSN.com, National Practitioner Data Bank, <http://www.ama-assn.org/ama/pub/category/4543.html> (last visited Aug. 31, 2004). Specifically, "[t]he National Practitioner Bank (NPDB) is an electronic repository of all payments made on behalf of physicians in connection with medical malpractice settlements or judgments as well as adverse peer review actions against licenses, clinical privileges, and professional society memberships of physicians and other health care practitioners." *Id.* Federal law mandates that in addition to information on specific adverse actions, all information regarding medical malpractice payments is required to be conveyed to the NPDB. *Id.* Unfortunately, the public does not have access to the information contained in the Data Bank. Joseph T. Hallinan, *Doctor Is Out: Attempt to Track Malpractice Cases Is Often Thwarted*, WALL ST. J., Aug. 27, 2004, at A1. As a result, if a physician has paid a malpractice award or settlement, that physician's patients have no way of knowing. *Id.* See also NGA Brief, *supra* note 2, at 10 (discussing the functions of the National Practitioner Data Bank).

15. See Citizen.org, *Stopping Repeat Offenders: The Key to Cutting Medical Malpractice Costs*, http://www.citizen.org/print_article.cfm?ID=8308 (last visited Sept. 12, 2004) (providing statistical information regarding the percentage of physicians who are largely responsible for most of the medical malpractice that occurs in the United States) [hereinafter *Stopping Repeat Offenders*]. According to Public Citizen's Dr. Sidney Wolfe, "[a] relatively small percentage of docs are causing injury and death to patients, and not being disciplined for it." Scott Finn, *State Ranks 2nd in Multiple-Payout Doctors Database May Be Flawed*, Cabell Senator Says, CHARLESTON GAZETTE

As a result, the most logical solution to this recurrent crisis is to drastically reduce the astronomical number of medical malpractice incidents that occur each year,¹⁶ a solution that can be achieved by stopping the repeat offenders who are responsible for the bulk of all medical liability litigation.¹⁷

Part I of this Comment will chronicle the origins of malpractice litigation and explain the role of state medical licensure boards. It will also discuss the ramifications of inefficient physicians, and expose the detrimental consequences that occur when repeat medical malpractice offenders are allowed to continue to practice medicine. Part II will discuss and subsequently dispel the various solutions to the medical malpractice crisis proposed by physicians and critics of the tort system. Finally, Part III will offer a uniform, practical solution to the so-called “med-mal” war.

II. BACKGROUND

A. *The Origins*

The first account of medical liability litigation dates back to 1375, where in *Stratton v. Cavendish*, a surgeon was held liable by the King’s Bench for negligently performing hand surgery.¹⁸ The first American case arose approximately four hundred years later in *Cross v. Guthery*, where a plaintiff successfully brought an action for damages against a surgeon who unskillfully amputated his wife’s breast, which ultimately caused her death.¹⁹

(West Virginia), Jan. 17, 2003, at 1C.

16. Rosenfield, *supra* note 10, at 32. See also *Malpractice Reform Must Focus on Reducing Patient Injury, Not Just Limiting Awards, Says the Commonwealth Fund*, U.S. NEWSWIRE, Jan. 5, 2004 (reasoning that in order to resolve the current crisis, medical injury must be reduced) [hereinafter *Malpractice Reform Must Focus on Reducing Patient Injury*].

17. See Paul Flemming, *Health Care Rules Heading to Court*, THE NEWS-PRESS (Florida), May 13, 2004, at 3B (explaining the ramifications of a proposed amendment to Florida’s constitution which would target repeat medical malpractice offenders).

18. Maves, *supra* note 5. To rationalize its decision, the King’s Bench compared the injured patient to a horse injured by a blacksmith, and reasoned that in the latter instance, the blacksmith would be responsible for the horse’s injuries. *Id.*

19. *Cross v. Guthery*, 2 Root 90 (Conn. Super. Ct. 1794). See Maves, *supra* note 5 (discussing that *Cross* was the first recorded American case). See also John Fabian Witt, *From Loss of Services to Loss of Support: The Wrongful Death Statutes, the Origins of Modern Tort Law, and the Making of the Nineteenth-Century Family*, 25 LAW & SOC. INQUIRY 717, 732-33 (2000) (discussing the first wrongful death actions allowed in the United States); Douglas W. Taylor, *Assessment and Plan for Medical Malpractice: Quality Improvement Through Mediation*, 6 DEPAUL J. HEALTH CARE L. 343, 346 (2003) (discussing the United State’s lengthy medical malpractice history).

Nearly a century after *Cross, Dent v. West Virginia* gave the states power to regulate who could practice medicine.²⁰ In *Dent*, a West Virginia statute provided the following three different methods by which one could obtain a valid medical license: (1) graduation from a “reputable medical college,” (2) continuous practice of medicine in the State of West Virginia for a ten-year period prior to March 8, 1881, or (3) successful completion of the state Board of Health examination.²¹ The defendant was ultimately precluded from practicing medicine when members of the Board of Health concluded that the defendant did not receive his diploma from a “reputable” medical school.²² The Supreme Court of the United States affirmed the board’s decision, reasoning that “[t]he power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud.”²³ This holding delegated the power to regulate the medical profession to the states,²⁴ granting the states a great deal of freedom to implement and enforce medical licensing laws.²⁵

B. Delegation of Regulatory Duty

Although the Supreme Court in *Dent* granted states the power to regulate the medical profession, the states uniformly delegated their authority to state medical licensure boards.²⁶ The duties of these licensure boards include the investigation of claims

20. Phyllis Coleman & Ronald A. Shellow, *Restricting Medical Licenses Based on Illness Is Wrong-Reporting Makes It Worse*, 9 J.L. & HEALTH 273, 278 (1994).

21. *Dent v. West Virginia*, 129 U.S. 114, 115-17 (1889). See also Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage For Health Care Delivery*, 12 HEALTH MATRIX 239, 245-46 (2002) (discussing the *Dent* decision); Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 215 (1999) (discussing the three ways a person in West Virginia could become licensed to practice medicine).

22. *Dent*, 129 U.S. at 118. See also Richards, *supra* note 21, at 216 (discussing the statute’s requirement that an applicant receive his or her diploma from a “reputable” medical college”); McLean *supra* note 21, at 246 (discussing the board’s decision that the defendant did not obtain his diploma “from a reputable medical school”).

23. *Dent*, 129 U.S. at 122.

24. See McLean, *supra* note 21, at 245-46 (discussing the power of the states to regulate medical licensure).

25. See Richards, *supra* note 21, at 218 (discussing the deference given to states regarding medical licensure).

26. Coleman, *supra* note 20, at 278. These boards are usually comprised of governor-appointed public and physician members. NGA Brief, *supra* note 2, at 9.

of unprofessional or incompetent conduct on the part of a physician and disciplining a physician when such a claim is proved to be true.²⁷ Among their disciplinary powers are the rights to implement and enforce probation, as well as to suspend or even revoke a physician's medical license.²⁸ Although state licensure boards have broad powers under state law, these boards rarely resort to disciplinary action.²⁹ In fact, state medical boards only took a mere 2,708 serious disciplinary actions in 2001.³⁰

In addition to their reluctance to discipline physicians, there are numerous other reasons why state medical licensure boards are not effective.³¹ For example, because states independently set their own criteria that physicians must meet, state A may punish conduct that state B deems acceptable.³² Moreover, because medical licensure boards only have jurisdiction in the state where the board is located, disciplinary actions invoked by these boards only have limited effects since a physician who has been disciplined in one state can resume practicing in another state in which he or she holds a valid medical license.³³ "Physician

27. Timothy S. Jost et al., *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 HEALTH MATRIX 309, 309 (1993) (discussing the jobs of state medical licensure boards).

28. *Id.* at 310.

29. Kathleen L. Blaner, *Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse than the Disease*, 37 CATH. U.L. REV. 1073, 1080 (1988) (discussing the roles that licensure boards and peer review groups play in physician discipline).

30. *Stopping Repeat Offenders*, *supra* note 15.

31. See Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 693-94 (1991) (discussing the ineffectiveness of state medical licensure boards). Particularly limited budgets restrict a great deal of boards, and as a result, a few contested disciplinary actions can deplete all of their resources. *Id.* at 694. Furthermore, few state licensure boards gather medical malpractice data, and even when it is accessible, this information is almost never used as a foundation for disciplinary proceedings. *Id.* at 696. Last, board members find it difficult to judge their colleagues, and this uneasiness is only heightened when the physician subject to review is a friend. *Id.* at 693-94. See also NGA Brief, *supra* note 2, at 9 (reasoning that medical boards are frequently condemned for not investigating claims quickly enough, for being too lenient, and for not adequately notifying the public about accused and disciplined physicians).

32. Blaner, *supra* note 29, at 1079-80. The lack of federal involvement has led to "complete state sovereignty." *Id.*

33. *Id.* at 1074. Despite disciplinary actions taken by state medical licensure boards, so-called "rogue" physicians merely circumvent the system by leaving the jurisdiction in which they were disciplined and resuming their practice somewhere else. Adler, *supra* note 31, at 691. In fact, according to the General Accounting Office, although a specific state medical licensure board disciplined 122 practitioners in 1984, at least 49 of these physicians, or over 40%, continued to practice medicine after merely moving to different states. *Id.* at 691-92. Although it is suspected that an additional 43 of the abovementioned 122 physicians may have also evaded the system by merely

licensing boards . . . are sometimes similar to the incompetent physicians they try to discipline. From time to time they do a good job, but they often are ineffective."³⁴

1. An Ohio Case Study

A study depicted in HEALTH MATRIX: JOURNAL OF LAW-MEDICINE analyzed the way in which the Ohio State Medical Board reacted to complaints closed by the board in 1990.³⁵ Upon receipt of the complaint, the Board ultimately registered it and affixed each one to a routing form.³⁶ Subsequently, the secretary and the supervising member jointly determined how to deal with the complaint.³⁷ Interestingly, most cases did result in review or investigation.³⁸ However, despite the fact that board staff or board investigators did indeed evaluate most of the complaints sampled, the Board dismissed a disturbing 75% of these complaints immediately after this initial assessment.³⁹ Shockingly, the Board only took formal disciplinary action in a mere 2.5% of the complaints investigated.⁴⁰ Even more appalling is that 26% of complainants never received any response to the complaints that they filed.⁴¹ As the results of this study indicate, state licensure boards are relatively ineffective at identifying and eliminating incompetent physicians.⁴²

C. Inefficient Physicians

A substantial accumulation of data confirms that inefficient physicians pose a significant threat; however, despite this evidence, little has been done in the United States to address the problem.⁴³ "Grave human tragedies invariably flow from allowing

moving to different states, the General Accounting Office was unable to confirm their locations. *Id.* at 692. The devastation caused by these "rogue" physicians has been documented in numerous highly publicized cases. *Id.*

34. Blaner, *supra* note 29, at 1111.

35. Jost et al., *supra* note 27, at 311, 326. This particular portion of the study was derived from a random sample of 200 closed cases initially generated by public complaints. *Id.* at 313.

36. *Id.* at 326.

37. *Id.* at 327.

38. *Id.* Specifically, ninety-two percent of the complaints sampled were referred for investigation or for review. *Id.*

39. *Id.* at 330.

40. *Id.* See also Adler, *supra* note 31, at 692 (discussing the small and unimpressive number of disciplinary actions actually taken by state medical licensure boards against physicians).

41. Jost et al., *supra* note 27, at 333. In fact, only seven individualized letters out of the original two hundred complaints studied were sent to complainants in reply to their particular claims. *Id.* The majority of complainants merely received standard form letters. *Id.*

42. Adler, *supra* note 31, at 692.

43. *Id.* at 690-91. In fact, a quick glance at the news most often reveals

inefficient doctors to exist in the medical profession.”⁴⁴ For example, in May 2002, doctors diagnosed forty-six year-old Linda McDougal with a very aggressive type of breast cancer and recommended that she undergo a double mastectomy.⁴⁵ Luckily, Linda’s doctors later informed her that she in fact did not have cancer, and that her diagnosis had been the result of a lab test result mix-up.⁴⁶ Unfortunately, Linda received this information days after she underwent surgery for the removal of both of her breasts.⁴⁷ The medical director at the hospital where this tragic mistake occurred declined to reveal the identity of the pathologist responsible for this mix-up; however, he did confirm that the doctor continues to work at the hospital.⁴⁸

When thirty-two year-old Stephanie Valdez decided to have more children, this single mother of two underwent surgery to have her prior tubal ligation reversed.⁴⁹ After the surgery, Stephanie began to experience acute abdominal pain. Her surgeon responded by removing a fallopian tube, as well as an ovary.⁵⁰ Unfortunately, the surgeon failed to notice a roll of surgical gauze in Stephanie’s pelvic cavity that he left behind during the initial surgery.⁵¹ As a result of this oversight, the gauze festered inside of Stephanie’s body for almost a year and caused a rampant infection that nearly killed her before a twelve-hour surgery spared her life.⁵²

These stories are only a few accounts of the nightmares that occur as a result of doctors’ incompetence. As a result, inefficient

numerous instances of situations involving incompetent doctors. *Id.* at 690.

44. Cleckley, *supra* note 2, at 62.

45. CBSNEWS.com, *Mastectomy Mistake Fuels Debate*, Jan. 21, 2003, <http://www.cbsnews.com/stories/2003/01/18/health/main537085.shtml>.

46. *Id.*

47. *Id.* Remembering the day that her doctor revealed to her what had occurred, Linda recalled, “[s]he didn’t know how to tell us other than to just tell us, and immediately I thought I was dying, and she told me I didn’t have cancer.” *Id.* As a further consequence of this lab test result mix-up, a woman who actually had an aggressive type of breast cancer received Linda McDougal’s cancer-free results. *Id.* However, according to Dr. Daniel Foley, the hospital’s medical director, this woman has since been notified and treated. *Id.*

48. *Id.* “If you’re right 99.999 percent of the time, you don’t want to be that .01 percent because the consequences are serious and we have to be right 100 percent of the time,” Dr. Foley commented. *Id.*

49. Christina Cheakalos et al., *Medical Nightmares*, PEOPLE, June 2, 2003.

50. *Id.* The surgeon who removed Stephanie’s fallopian tube and ovary blamed her abdominal discomfort on cysts. *Id.*

51. *Id.*

52. *Id.* Ironically, the surgery that Stephanie underwent to allow her to have more children subsequently left her infertile. *Id.*

physicians who are unable to improve their performance should be barred from practicing medicine.⁵³

D Repeat Offenders

Although the number of people that die each year in the United States as a result of medical malpractice is rightfully alarming, surprisingly, the majority of all medical malpractice is committed by a minority of physicians.⁵⁴ In fact, since 1990, a mere five percent of physicians are responsible for a shocking fifty-four percent of medical malpractice settlements and awards.⁵⁵

Based on information obtained by Public Citizen from the National Practitioner Data Bank, between the years 1988 and 1993, a New Jersey physician was involved in thirty-three medical malpractice suits in which he either lost or settled,⁵⁶ while between the years of 1990 and 1997, a Texas physician was involved in thirteen malpractice actions which he also either lost or settled.⁵⁷ Similarly, between the years of 1989 and 2001, a Pennsylvania physician made twenty-four malpractice payments.⁵⁸

Since compelling evidence indicates that the majority of medical malpractice is committed by a few "bad-apple doctors," it only seems logical that the medical profession would prohibit these repeat offenders from practicing medicine; however, that is not the case.⁵⁹ Thus, although physicians claim that the United States is currently in the midst of a crisis that is causing their medical malpractice insurance premiums to soar, "[t]he true crisis is an epidemic of medical malpractice."⁶⁰

III. ANALYSIS

A. "Problem" Solutions

Physicians and opponents of the tort system who blame out-of-control medical liability litigation for the present medical malpractice insurance crisis uniformly propose several

53. Blaner, *supra* note 29, at 1073.

54. *Stopping Repeat Offenders*, *supra* note 15.

55. Dr. William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 471-72 (2004) (discussing that a small percentage of physicians are to blame for a large percentage of malpractice awards). Statistics show that only a small percentage of doctors (4.8%) have made multiple malpractice payments to injured patients. *Stopping Repeat Offenders*, *supra* note 15. In fact, only 1.7% of physicians have made more than two payments, for a total sum of \$11 billion. *Id.*

56. *Stopping Repeat Offenders*, *supra* note 15.

57. *Id.*

58. *Id.*

59. Boyle, *supra* note 4.

60. Wachsman, *supra* note 12.

reoccurring, yet ineffective solutions to the dilemma, including caps on noneconomic damage awards,⁶¹ caps on contingency fees,⁶² and a reduction of frivolous lawsuits.⁶³

1. Caps on Noneconomic Damage Awards

Damages in medical malpractice cases generally fall into two different categories:

economic damages for the actual monetary losses due to negligence such as medical expenses, lost wages, rehabilitation costs or any other economic out of pocket loss suffered as the result of a health care injury; and *non-economic damages* for things such as pain and suffering, disfigurement, and loss of companionship.⁶⁴

The majority of the debates concerning caps center on noneconomic rather than on economic damages,⁶⁵ and there are numerous explanations why capping noneconomic damages is not the solution to the current medical malpractice crisis.⁶⁶ Most importantly, the three basic goals of tort law are essentially

61. Stevenson, *supra* note 7.

62. Marchev, *supra* note 8.

63. Levy, *supra* note 9.

64. NGA Brief, *supra* note 2, at 5; see also CBO.gov, Limiting Tort Liability for Medical Malpractice, Jan. 8, 2004, <http://www.cbo.gov/showdoc.cfm?index=4968&sequence=0> [hereinafter CBO] (defining economic and noneconomic damages). See also Marchev, *supra* note 8 (differentiating between the two types of damages).

65. NGA Brief, *supra* note 2, at 5. Advocates of noneconomic damage caps argue that these caps are the solution to the current medical malpractice crisis; however, evidence suggests that health-care costs as a whole are unlikely to be impacted by these caps. Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 781, 800 (2004) (discussing the relatively small impact that a national damage cap would have on health-care costs in general). Insurance costs associated with medical malpractice only represent a very small portion of total health-care costs. *Id.* at 800. More specifically, in 1992, the total cost of health-care in the United States stretched over \$800 billion, whereas only between five and six billion dollars were paid by doctors in the form of premiums. *Id.*

66. See Witmer, *supra* note 3, at 595 (arguing that caps will deny patients their right to be fully compensated for the their injury). However, proponents of noneconomic damage caps maintain that these restrictions are necessary since these damages have a tendency to be unpredictable. NGA Brief, *supra* note 2, at 5. Advocates also argue that noneconomic damage awards are extremely subjective, and difficult to quantify and calculate. *Id.* In spite of the complaints regarding the unpredictability of noneconomic damage awards, intangible losses, such as pain and suffering, are rightful components of damages, and are essential to making the victim "whole" again. Witmer, *supra* note 3, at 597. Damage caps "are an overly simplistic superficial way of addressing these very serious problems that are taking place today in America." Robert A. Clifford et al, *Anatomy of a Malpractice Case From a Litigator's Perspective*, 6 DEPAUL J. HEALTH CARE L. 279, 292 (2003).

negated by statutes that cap noneconomic damage awards.⁶⁷ In other words, these caps deny complete compensation to the injured, fail to discipline wrongdoers, and promote possibly dangerous behavior.⁶⁸

First, caps on noneconomic damages deny victims of medical malpractice full compensation for their injuries.⁶⁹ Even though a specific objective of tort law is to make a winning plaintiff "whole,"⁷⁰ patients who need an amount in excess of the capped figure in order to be made "whole" again are ultimately denied complete recovery.⁷¹ Thus, caps on noneconomic damages place excessive and undue burdens on those victims who are the most tragically injured.⁷² For example, when a jury awards a medical malpractice victim noneconomic damages in the amount of \$1 million, and that figure is then drastically reduced to \$250,000 as a result of a damage cap, that victim is not being fully compensated.⁷³

The unfairness that flows from caps on noneconomic damages is a concept that is all too familiar to Gilford Tyler, who lost his leg due to a medical error.⁷⁴ In response to Tyler's tremendous loss and for the pain and suffering that he would be forced to tolerate because of his indefinite disfigurement, the jury awarded Tyler noneconomic damages in the amount of \$4.5 million; however, this amount was drastically reduced to merely \$515,000 in conformity with the state's noneconomic damage cap.⁷⁵ In response to the significant reduction, the trial judge stated, "[t]he thought that the injuries sustained by the Plaintiff are, in any way, compensated by \$515,000 is, facially abhorrent."⁷⁶ It is evident from Tyler's story

67. Cleckley & Hariharan, *supra* note 2, at 49-50.

68. *Id.*

69. Witmer, *supra* note 3, at 595. See Phillip H. Corboy et al., *Illinois Courts: Vital Developers of Tort Law as Constitutional Vanguard, Statutory Interpreters, and Common Law Adjudicators*, 30 LOY. U. CHI. L.J. 183, 213 (1999) (reasoning that an Act which requires that noneconomic damages be capped at \$500,000 only hurt those individuals who needed more than the amount provided for by the cap in order to be fully compensated).

70. See Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 NW. U.L. REV. 908, 909-10 (1989) (discussing that returning the plaintiff to "whole" is one of tort law's primary objectives); Gunnar, *supra* note 55, at 478.

71. Witmer, *supra* note 3, at 595.

72. *Id.* See Corboy et al., *supra* note 69, at 213 (reasoning that pursuant to an Act which capped noneconomic damages at \$500,000, "the more severely a plaintiff was injured, the greater the disparity and distortion wrought by the cap").

73. Witmer, *supra* note 3, at 598.

74. Gfell, *supra* note 65, at 775.

75. *Id.*

76. *Id.*

that caps on noneconomic damages punish the most tragically injured victims.⁷⁷

Unfortunately, noneconomic damage caps also negatively impact those who are “economically disadvantaged,” as well as children.⁷⁸ For example, *economic* damage awards guarantee much more comfort and security to victims with yearly incomes of over \$300,000 than they do to victims who only earn minimum wage or to children who are unable to predict their “future potential earning capacity as a corporation president.”⁷⁹ As a result, children who face indefinite pain and suffering and victims who receive limited *economic* damage awards are the ones who feel the devastating ramifications of caps on noneconomic damages.⁸⁰

Furthermore, capping noneconomic damages also negatively affects women and the elderly.⁸¹ For example, take into account the story of a housewife who developed brain damage as the result of medical negligence.⁸² Her injury will require constant care and assistance, yet as a housewife, she will receive no economic damages in the form of lost wages.⁸³ Also consider the story of an elderly woman who, due to a medical error, lost both legs.⁸⁴ Since she is retired, the damages that she will receive in the form of lost

77. See Witmer *supra* note 3, at 595 (reasoning that caps on noneconomic damages affect the most tragically hurt victims).

78. See Kathleen E. Payne, *Linking Tort Reform to Fairness and Moral Values*, 1995 DET. C.L. MICH. ST. U.L. REV. 1207, 1228-29 (1995) (discussing the classes of people who are the most significantly affected by caps on noneconomic damages). Steven Oleson’s story is a prime example of how caps on noneconomic damages adversely affect children. *Id.* at 1228. A jury awarded this severely handicapped child noneconomic damages in the amount of \$7 million; however, this award that was intended by the jury to compensate Steven for things such as pain and suffering was drastically reduced to \$250,000 pursuant to a statutory cap on noneconomic damages. *Id.*

79. *Id.* at 1229.

80. Witmer, *supra* note 3, at 598.

81. *Medical Malpractice: Caps on Non-Economic Loss Damages Would Adversely Impact Women, Elderly*, WOMEN’S HEALTH WEEKLY, Aug. 14, 2003 (discussing the adverse affects that noneconomic damage caps have on both the elderly and on women). Unlike men, women experience gynecological medical malpractice and various forms of reproductive harm. *Id.* The emotional distress and other consequences that follow such injuries are not compensated through economic damage awards. *Id.* Lucinda Finley, a tort reform expert, said “[m]any of these more precious, indeed priceless, aspects of human life are virtually worthless in the market, and they are compensated through non-economic damages.” *Id.* Finley further argued that since injured retirees receive no economic damages in the form of lost wages, noneconomic damage caps unfairly punish the elderly. *Id.* See also Witmer, *supra* note 3, at 598 (reasoning that elderly patients and housewives feel the majority of the effects stemming from caps on noneconomic damages).

82. Witmer, *supra* note 3, at 598.

83. *Id.*

84. *Id.*

wages will be insignificant, as will her damages for future medical expenses, since she will not need long-term care after the surgery.⁸⁵ Even though these victims did not experience significant economic losses, their lives were drastically and disastrously altered, and they will suffer continuously.⁸⁶ It is indisputable that a noneconomic damage award capped at \$250,000 will in no way provide these victims with the complete compensation that they rightfully deserve.⁸⁷

In addition to denying victims of medical malpractice full compensation, caps on noneconomic damages also fail to discipline wrongdoers,⁸⁸ since these caps permit them to avoid paying substantial amounts to their injured victims.⁸⁹ Last, noneconomic damage caps promote possibly dangerous behavior.⁹⁰ These caps remove incentives for physicians to minimize error by eliminating the risk of significant noneconomic damage awards.⁹¹ As a result, physicians who engage in negligent conduct are permitted to practice medicine, yet they are not subject to any significant penalty.⁹²

2. Caps on Contingency Fees

Caps on contingency fees are not the answer to the current medical malpractice crisis, since these caps make it difficult for victims of medical malpractice, who have complicated, yet legitimate claims, to retain an attorney.⁹³ When contingency fees are capped, the only victims who are able to obtain legal representation are those with clear-cut cases and extremely serious injuries.⁹⁴

Most plaintiffs' attorneys who take on medical malpractice cases work on a contingency fee basis.⁹⁵ Under this fee

85. *Id.*

86. *Id.*

87. *Id.*

88. Cleckley, *supra* note 2, at 49-50.

89. Witmer, *supra* note 3, at 600.

90. Cleckley, *supra* note 2, at 49-50.

91. Witmer, *supra* note 3, at 595.

92. *Id.*

93. See CBO, *supra* note 64 (discussing the potential inefficiency that could result as a consequence of capping contingent fees). See also Jennifer Heldt Powell, *Less Pain, Suffering for Docs; Calif. Law reduces malpractice awards, fees*, BOSTON HERALD, July 13, 2004 (stating that critics argue that caps that limit lawyer fees make it hard for victims with justified claims to obtain legal counsel). Several efforts have been made by various states to limit lawyer fees. NGA Brief, *supra* note 2, at 6. For example, some states have implemented "sliding scales," whereas other states allow the court to fix attorney fees at a "reasonable" sum. *Id.*

94. Rosenfield, *supra* note 10, at 20.

95. NGA Brief, *supra* note 2, at 6. Ironically, proposed reforms in no way limit defense lawyers' hourly fees. Jean Hellwege et al., *Slay the Beast of*

arrangement, not only is the client not required to pay the attorney upfront, but the attorney only receives payment from the client if the case ends in some form of an economic award.⁹⁶ As a result, a plaintiff whose attorney works on a contingency fee basis does not experience any monetary loss, despite the outcome of the case.⁹⁷

When a suit ultimately produces a jury award or ends in a settlement, an attorney working on contingency usually receives one third of that award;⁹⁸ however, it can cost an attorney anywhere from \$35,000 to \$50,000 to bring an injured victim's suit to trial.⁹⁹ Contrary to physicians' beliefs that the prospect of large jury awards encourages plaintiffs' attorneys to represent fruitless claims, in reality, an attorney working on a contingency fee basis is compelled to choose only those cases that are legitimate and are likely to compensate the plaintiff.¹⁰⁰ More specifically, since a plaintiff's attorney only receives compensation for his hard work when the case ends in a settlement or a jury award in favor of his client, the contingency fee arrangement actually deters attorneys from bringing frivolous claims.¹⁰¹

Last and perhaps most importantly, contingency fees provide those who have limited resources with a place to seek redress for their injuries,¹⁰² thus allowing anyone who is injured, despite their economic status, to bring an action.¹⁰³ In his testimony before the House Energy and Commerce Committee in 2003, Harvey Rosenfield stated, "[a] contingency fee system is a poor patient's only hope of affording an attorney to challenge a negligent physician. Undermining such a system through caps on fees that

'Reform' Rhetoric, TRIAL, July 2004, at 24, 29 (discussing facts surrounding contingency fees).

96. NGA Brief, *supra* note 2, at 6.

97. Gunnar, *supra* note 55, at 479.

98. *Id.* See also NGA Brief, *supra* note 2, at 6 (stating that a lawyer who works on a contingency fee basis receives a percentage of the plaintiff's award). In fact, professional rules require that lawyers only charge fees that are reasonable. Hellwege, *supra* note 95, at 29. Usually, when a case ends early, or when a case only requires that a lawyer do a small amount of work, the lawyer will not charge the entire fee. *Id.* A typical proposal would cap attorney contingency fees at a mere ten percent. *Id.* An attorney working on this basis would be forced out of business if he or she took cases that did not promise a large damage award. *Id.*

99. Gunnar, *supra* note 55, at 479.

100. *Id.* Actually, both the Model Rules of Professional Conduct and the Model Code of Professional Responsibility support contingency fees. *Id.*

101. *Id.* In fact, plaintiffs' attorneys assume all litigation costs, fully aware that settlements or jury awards in favor of plaintiffs only occur in twenty-eight percent of all malpractice actions. *Id.* Furthermore, the contingency fee system also makes it less likely that litigation will be prolonged by attorneys, since they must absorb pre-trial expenses. Hellwege, *supra* note 95, at 29.

102. NGA Brief, *supra* note 2, at 6.

103. Marchev, *supra* note 8, at 10.

reduce incentives for attorneys to take malpractice cases, gives dangerous doctors . . . a license to be negligent in poor neighborhoods."¹⁰⁴

3. *A Reduction of Frivolous Lawsuits*

A frivolous lawsuit is characterized as one "presenting no debatable question to the court."¹⁰⁵ In response to the medical malpractice crisis, President George W. Bush recently reasoned that "[t]here are too many lawsuits filed against doctors and hospitals without merit. And one thing the American people must understand is even though the lawsuits are junk lawsuits, and they have no basis, they're still expensive."¹⁰⁶

Interestingly, there is no statistical support for the contention that the amount of frivolous lawsuits is increasing.¹⁰⁷ In fact, a Harvard study indicated that out of every eight people who are victims of medical malpractice, only one ever brings an action.¹⁰⁸ Furthermore, plaintiffs' attorneys who most often work based on contingency fee arrangements have no motivation for pursuing baseless claims.¹⁰⁹ Dr. Harvey F. Wachsman, a New York attorney and neurosurgeon, best summed up the debate surrounding frivolous lawsuits when he stated, "[t]hose who attack lawyers and demand radical changes to the legal system are blaming the messengers and trying to punish the victims. Lawsuits are the only protection the public has against negligent physicians."¹¹⁰

In conclusion, "[t]he malpractice crisis is not about lawyers and lawsuits. It is about the tremendous amount of malpractice being committed."¹¹¹ Therefore, caps on noneconomic damages and contingency fees and a reduction of frivolous lawsuits are not the solution to the dilemma.

104. Rosenfield, *supra* note 10, at 21.

105. Association of Trial Lawyers of America, *'Frivolous' Lawsuits Resource Center*, http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/frivolous/frivolous.aspx (last visited Sept. 16, 2004) [hereinafter *Frivolous Lawsuits*].

106. Kathy A. Gambrell, *Bush Seeks Medical Malpractice Reform*, UNITED PRESS INT'L (Washington D.C.), Jan. 16, 2003. See also Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS, Jan. 21., 2004, at 6 (reasoning that very few victims of medical malpractice actually file claims).

107. *Frivolous Lawsuits*, *supra* note 105. In fact, research indicates that infamous accounts of frivolous lawsuits are actually extremely embellished or even bogus. *Id.*

108. Gfell, *supra* note 65, at 779.

109. *Frivolous Lawsuits*, *supra* note 105.

110. Wachsman, *supra* note 12.

111. *Id.*

B. MICRA and the HEALTH Act

In 1975, California passed the Medical Injury Compensation Reform Act (MICRA) in an effort to satisfy striking doctors.¹¹² Two of the key provisions in MICRA (1) “[p]lace a \$250,000 cap on the amount of compensation paid to malpractice victims for their ‘non-economic’ injuries”¹¹³ and (2) “[e]stablish a sliding scale for attorneys fees which discourages lawyers from accepting serious or complicated malpractice cases.”¹¹⁴ However, after the Act’s passage in 1975, premiums only escalated, and twelve years later, medical malpractice premiums were 190% higher than they were prior to MICRA.¹¹⁵

In the spring of 2003, the U.S. House of Representatives passed the Help, Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act,¹¹⁶ which was fashioned after MICRA.¹¹⁷ Similar to the California statute, the HEALTH Act limits

112. Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors’ Medical Malpractice Rates in California: And How Malpractice Caps Failed*, Mar. 7, 2003 at 2 [hereinafter *How Malpractice Caps Failed*].

113. Rosenfield, *supra* note 10, at 25. Interestingly, the cap’s existence is not revealed to juries, and without their knowledge, jury verdicts are decreased. *How Malpractice Caps Failed*, *supra* note 112, at 2.

114. Rosenfield, *supra* note 10, at 25.

115. *Id.* at 3. In 1988, Proposition 103 was passed by Californians in reaction to soaring insurance rates. *How Malpractice Caps Failed*, *supra* note 112, at 2. The legislation “rolled back insurance rates for most policyholders, including doctors, froze premiums and refunded millions of dollars to doctors to compensate for excessive past premiums.” *Id.* at 2. Proposition 103, not MICRA, is credited with lowering insurance premiums in California. Rosenfield, *supra* note 10, at 6. Seventeen years after he signed MICRA, Jerry Brown, the former governor of California, admitted that he would not advocate a national form of the MICRA legislation because he “witnessed yet another insurance crisis and found that insurance company avarice, not utilization of the legal system by injured consumers was responsible for excessive premiums.” ConsumerWatchDog.com, *Five Dangerous Myths About California’s Medical Malpractice Restrictions*, <http://www.consumerwatchdog.org/malpractice/fs/?postId=993&pageTitle=Five+Dangerous+Myths+About+California%27s+Medical+Malpractice+Restrictions> [hereinafter *Five Dangerous Myths*] (last visited Oct. 6, 2004). See *FTCR Says Bush Should Blame Insurers Not Medical Malpractice Victims, Says Reform is Answer to Malpractice Crisis*, U.S. NEWSWIRE, Jan. 15, 2003 (reasoning that Proposition 103 lowered malpractice premiums in California).

116. Bob Gatty, *Insurers’ Losses Are ‘Greatest Contributor’ to Rising Rates*, DERMATOLOGY TIMES, Nov. 1, 2003, available at <http://www.dermatologytimes.com/dermatologytimes/article/articleDetail.jsp?id=76865>. See Sharon Worcester, *Medical Groups Call for Senate Passage of Liability Reform*, CLINICAL PSYCHIATRY NEWS, Feb. 1, 2004 (discussing several of the components of the HEALTH Act). See also *Tort Reform Bill Dies in Senate*, CONTEMPORARY OB/GYN, Aug. 1, 2003 (discussing Democrats’ negative perception of the HEALTH Act, as well as two reasons why some say the bill did not pass).

117. Craig, *supra* note 4, at 630.

noneconomic damages to \$250,000 and limits attorney contingency fees.¹¹⁸ As expected, both the American Medical Association (AMA)¹¹⁹ and President Bush are strong advocates of the legislation.¹¹⁹ Fortunately, the Act has not yet been passed by the Senate,¹²⁰ since MICRA, the original model, proved not to be the solution to California's malpractice dilemma.¹²¹

IV. PROPOSAL

The current malpractice dilemma calls for a nationwide remedy.¹²² Fortunately, this objective can be achieved by implementing a law at the federal level that would prohibit repeat medical malpractice offenders from practicing medicine anywhere in the United States.¹²³ This proposal will concentrate on a recent amendment to the state of Florida's Constitution termed "Public Protection from Repeat Medical Malpractice"¹²⁴ and will advocate that similar legislation should be fashioned after the Florida amendment and subsequently implemented at the federal level.

A. *The Pattern Exists, Yet It Is Ignored*

Medical malpractice litigation has been likened to "a giant 'lottery,' in which lawsuits are purely random events bearing no

118. *Id.* at 630-31.

119. *Id.* at 632.

120. Bob Gatty, *Impact of Patient Lawsuit Limits Ruling Far Reaching: Patients' Bill of Rights, Federal Malpractice Insurance Legislation in the Senate May Be Influenced*, DERMATOLOGY TIMES, Aug. 1, 2004. See Mary Ellen Schneider, *Physicians Push for Liability Caps*, CLINICAL PSYCHIATRY NEWS, Aug. 1, 2004 (reasoning that even though the United States House of Representatives passed legislation that would impose noneconomic damages caps, the legislation has not yet passed in the Senate).

121. See Craig, *supra* note 4, at 632 (stating that critics of MICRA argue that it has not been effective in combating the malpractice crisis and the prevention of justice).

122. Maves, *supra* note 5. Simplistic reasoning that does not have long-term effects is not the solution to the current dilemma. See Monique Anawis, *Presentation: Tort Reform*, 6 DEPAUL J. HEALTH CARE L. 309, 309 (2003) (reasoning that a solution with short-sighted reasoning will not remedy the medical malpractice dilemma). Furthermore, medical malpractice reform cannot be undertaken single-handedly by any county or state association. Maves, *supra* note 5.

123. See Jim Saunders, *Amendments Get Voter Support*, DAYTONA BEACH NEWS, Nov. 3, 2004, available at <http://www.news-journalonline.com/NewsJournalOnline/News/Headlines/03NewsHEAD03110304.htm> (discussing the amendment to Florida's Constitution which would preclude a doctor who has committed medical malpractice on three or more occasions from practicing medicine in that state).

124. Floridians for Patient Protection, *Amendment 8: Public Protection From Repeated Medical Malpractice*, <http://www.local6.com/politics/3848419/detail.html> [hereinafter *Amendment 8*] (last visited Nov. 7, 2005).

relationship to the care given by a physician.”¹²⁵ However, as previously mentioned, a majority of all malpractice awards are generated by only a minority of physicians.¹²⁶ In fact, this distribution is not random at all, rather, it is extremely similar to “drunk driving recidivism.”¹²⁷ Motor vehicle bureaus recognize drunk driving patterns, and in anticipation, they suspend and revoke drivers licenses in order to discourage and prevent those individuals who are inclined to drive drunk from doing so.¹²⁸ Ironically, state medical boards do not utilize their power to regulate the medical profession with similar force.¹²⁹

B. Florida's Response

In 2003, relying on suggestions that a minority of physicians were to blame for a massive amount of malpractice, Floridians began to question the state system's ability to discipline repeat medical malpractice offenders.¹³⁰ In fact, research conducted by Public Citizen established that about half of the medical malpractice in Florida is committed by approximately six percent of physicians,¹³¹ data that is strikingly similar to national statistics on the subject.¹³² In what has been called “a clash of the titans,”¹³³ attorneys and physicians took their malpractice differences to the Florida ballot.¹³⁴ The end result was several amendments that were proposed to the state's constitution,¹³⁵ one of which (Amendment 8) recently gave Florida voters the opportunity to

125. *Stopping Repeat Offenders*, *supra* note 15.

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.*

130. *Efforts to Curb Medical Errors Faltering; Consumers Remain Frustrated at the Lack of Notice Given Towards Physician Disciplinary Issues*, SARASOTA HERALD-TRIBUNE, Apr. 6, 2003 [hereinafter *Efforts to Curb Medical Errors Faltering*].

131. *Keep Malpractice Fight Out of State Constitution*, PALM BEACH POST, Oct. 7, 2004, at 18A [hereinafter *Out of State Constitution*]. The general consensus is that most malpractice is committed by only a few physicians, even if the precise percentage is disputed. *Id.*

132. See Gunnar, *supra* note 55, at 471-72 (reasoning that merely five percent of physicians are responsible for roughly fifty-four percent of awards and settlements resulting from malpractice lawsuits).

133. Morrissey, *supra* note 8.

134. *Voters Approve All Three Medical Malpractice Issues*, ASSOCIATED PRESS NEWSWIRES, Nov. 3, 2004, available at http://staugustine.com/stories/110304/sta_2681578.shtml [hereinafter *Voters Approve All Three*].

135. Andi Atwater & Associated Press, *Malpractice Changes Already in the Courts: Lee Memorial Says It Won't Comply Yet*, NEWS-PRESS, Nov. 4, 2004, available at <http://www.newspress.com/apps/pbcs.dll/article?AID=/20041104/NEWS01/411040440/1075/NEWS0107> [hereinafter *Atwater*].

prohibit physicians who continually commit medical malpractice from practicing medicine in the state.¹³⁶ Proponents of Amendment 8 call it the “‘three-strikes-and-you’re-out’ solution to the problem of bad doctors.”¹³⁷

The Ballot Summary for Amendment 8, Public Protection from Repeated Medical Malpractice, stated: “Current law allows medical doctors who have committed repeated malpractice to be licensed to practice medicine in Florida. This amendment prohibits medical doctors who have been found to have committed three or more incidents of medical malpractice from being licensed to practice medicine in Florida.”¹³⁸ On November 2, 2004, Amendment 8 was passed.¹³⁹ An amazing 1,922,568 Floridians, or seventy percent of voters, supported the Amendment.¹⁴⁰

C. Follow the Leader

In order to resolve the existing medical malpractice dilemma, it is essential to drastically reduce the astronomical number of medical malpractice incidents that occur each year.¹⁴¹ Patients deserve increased protection,¹⁴² and a national law modeled after Florida’s Amendment 8 will provide this protection by keeping incompetent physicians from harming innocent patients.¹⁴³ Specifically, Amendment 8 provides that “[n]o person who has

136. Sarah Skidmore, *Amendment 8 Lets Voters Set Punished Doctors’ Fate*, FLORIDA TIMES-UNION, Oct. 30, 2004, at B-2.

137. *Out of State Constitution*, *supra* note 131.

138. *Amendment 8*, *supra* note 124.

139. See Bob Lamendola, *Medical Malpractice Debate Rages on Post-Election*, HERALD TODAY, Nov. 5, 2004, <http://www.bradenton.com/mld/bradenton/news/local/10103548.htm> (last visited May 1, 2003) (stating that by a ratio of 4-1, Amendment 8, Public Protection from Repeated Malpractice, was passed by Florida voters).

140. Associated Press, *Florida Voters Decide on Three Medical Malpractice Issues*, Nov. 2, 2004, available at http://www.redwoodsgroup.com/dental_quicknews_detail.asp?fname=Floridavotersdecideonthreemedicalmalpracticeissues (last visited Nov. 3, 2004). In fact, only 819,284 Florida voters actually opposed the amendment and voted against it. *Id.*

141. *Malpractice Reform Must Focus on Reducing Patient Injury*, *supra* note 16.

142. Ray Weiss, *Hospital Backs Challenges to Amendments 7 and 8*, DAYTONA BEACH NEWS, available at <http://www.news-journalonline.com/NewsJournalOnline/News/WestVolusia/03WV01WEST02EFPOLFL110404.htm> (last updated Nov. 4, 2004).

143. See Wesh.com, *Learn About 8 Proposed Amendments*, <http://www.wesh.com/print/3880019/detail.html?use=print> (last updated Nov. 1, 2004) [hereinafter *Proposed Amendments*] (stating that proponents of the amendment maintain that it will shield patients from the harm caused by physicians who are incompetent); see also Skidmore, *supra* note 136 (discussing advocates’ arguments that the number of incompetent physicians in Florida will be limited by the amendment).

been found to have committed three or more incidents of medical malpractice shall be licensed or continue to be licensed by the State of Florida to provide health care services as a medical doctor.”¹⁴⁴ In order to overcome the problems that medical licensure boards encounter because of their limited jurisdiction,¹⁴⁵ the proposed federal legislation should implement an even stricter limitation, and prohibit a physician who is found guilty of medical malpractice on three or more occasions from practicing in *any* state in America.

1. Clarification

Adopting federal legislation similar to Florida’s Amendment 8 would not affect physicians who merely have multiple claims filed against them,¹⁴⁶ since the language of the amendment specifically requires that the physician be “found to have committed” medical malpractice on three or more occasions.¹⁴⁷ In an effort to clarify the exact meaning intended by the phrases “medical malpractice” and “found to have committed,” the drafters of the Florida amendment included the following subsections:

- i) The phrase “medical malpractice” means both the failure to practice medicine in Florida with that level of care, skill, and treatment recognized in general law related to health care providers’ licensure, and any similar wrongful act, neglect, or default in other states or countries which, if committed in Florida, would have been considered medical malpractice.
- ii) The phrase “found to have committed” means that the malpractice has been found in a final judgment of a court or law, final administrative agency decision, or decision of binding arbitration.¹⁴⁸

Like the Florida amendment, the proposed federal legislation should similarly require that physicians be “found to have committed” multiple instances of medical malpractice and should also include explanatory and clarifying language comparable to that contained in Amendment 8.¹⁴⁹

144. *Amendment 8, supra* note 124.

145. Blaner, *supra* note 29, at 1074.

146. See David Fuller, *Letters to the Editor*, TAMPA TRIBUNE, Nov. 1, 2004 (reasoning that a claim is different from an adverse judgment by a jury).

147. *Amendment 8, supra* note 124. See Flemming, *supra* note 17 (reasoning that a physician can only receive a strike from “a final court judgment, a final administrative agency decision or the result of binding arbitration”).

148. *Amendment 8, supra* note 124.

149. See *id.* (defining the terms “medical malpractice” and “found to have committed”).

2. High-Risk Areas

It is contended that due to the inherent risks involved in certain procedures, obstetricians, neurosurgeons, and a minority of other specialists are more inclined to be sued.¹⁵⁰ It is further argued that as a result of Amendment 8, these physicians will be reluctant to take complex and high-risk cases.¹⁵¹ In response to these well-founded apprehensions, it is necessary that the proposed federal legislation set a separate and slightly higher threshold for those physicians practicing in enumerated high-risk areas; however, the decision as to which specialties qualify and the specific number of "strikes" allotted these few areas are decisions best determined by the legislature. It must be noted, however, that these specific specialties should not be entirely exempt from the law.¹⁵²

3. Bad Physicians Punish Good Physicians

Typically, a physician's past malpractice litigation history does not affect his or her insurance premium rates;¹⁵³ thus, repeat malpractice offenders do not experience adequate rises in their insurance rates proportionate to their malpractice litigation records.¹⁵⁴ Alternatively, the threat created by these repeat offenders is distributed among physicians in like areas.¹⁵⁵ Thus, a federal law that prohibits repeat medical malpractice offenders from practicing medicine would lower premium rates, since good physicians would no longer be forced to pay for other physicians who are repeatedly incompetent.¹⁵⁶

V. CONCLUSION

Out-of-control medical liability litigation is not to blame for the current medical malpractice crisis,¹⁵⁷ and caps on noneconomic damages and contingency fees, as well as a reduction in frivolous

150. Skidmore, *supra* note 136. For example, every two and a half years, physicians who specialize in high-risk areas such as neurosurgery or obstetrics receive one claim against them. Maves, *supra* note 5.

151. *Three-Strikes Amendment Would Wreck Medical Care*, TAMPA TRIBUNE, Nov. 4, 2004.

152. *But see* Fuller, *supra* note 146 (arguing that Amendment 8's provisions should not apply to certain physicians).

153. Adler, *supra* note 31, at 695; *see* Gunnar, *supra* note 55, at 471 (reasoning that a physician's malpractice premium rates are typically not influenced by that particular physician's past malpractice litigation record, overall settlement payments, or any disciplinary action taken against the physician).

154. Gunnar, *supra* note 55, at 472.

155. *Id.*

156. *See* Boyle, *supra* note 4 ("[G]ood doctors – and far too many innocent patients who are injured or killed – pay for bad doctors").

157. Witmer, *supra* note 3, at 590.

lawsuits, are not the solutions to the dilemma.¹⁵⁸ Instead, the key to reducing medical liability litigation is to drastically lower the number of malpractice incidents that occur each year,¹⁵⁹ a solution that can be achieved by implementing a national and slightly modified version of Florida's Amendment 8.

158. Gfell, *supra* note 65, at 780. "The reforms advanced by tort reform proponents, purportedly in the public interest, are actually in the interests of the thousands of physicians who will be allowed to practice bad medicine, undetected, undeterred, and untroubled by their conscience." Dr. Harvey F. Wachsman, *Individual Responsibility and Accountability: American Watchwords for Excellence in Healthcare*, 10 ST. JOHN'S J. L. COMMENT. 303, 324 (1995). Dr. Wachsman further argues that Americans "need reforms that protect the public, not reforms that blame the injured, the disabled, and victims of medical ineptitude and neglect." *Id.*

159. Rosenfield, *supra* note 10, at 23.