

# Health Courts

## *Fair and Reliable Justice for Injured Patients*

*By Nancy Udell and David B. Kendall*

Blaming “junk lawsuits” for driving up doctors’ insurance fees, President Bush has urged Congress to pass strict limits on medical malpractice litigation. But while he is correct in considering our medical liability system broken, the president has failed to see the essential problem and has proposed the wrong cure.

The White House, along with a coalition of doctors and insurance companies, wants Congress to cap the non-economic damages that juries frequently award to severely injured patients for emotional pain and suffering. Some of those awards are indeed outrageous and undoubtedly contribute to the soaring malpractice insurance rates that are squeezing all doctors and driving some out of medicine altogether.

Democrats, meanwhile, focus blame for rapidly rising premiums on the malpractice insurance industry. Siding with trial lawyers and some consumer groups, they propose tighter regulation of the industry as the best solution to the malpractice insurance crisis.

But our medical liability system suffers from more fundamental defects: It does not give most injured patients access to justice, and it does not send clear signals about standards of care that would help health care providers avoid medical mistakes.

The headline-grabbing, big-money awards set by juries mask the fact that most patients do not receive any compensation at all for injuries

from negligence. According to studies of medical malpractice in several states, only 2 percent of patients injured by negligent care in a hospital file malpractice claims.<sup>1</sup> Elderly and low-income patients, in particular, are even less likely to sue.<sup>2</sup>

Injured patients usually do not know if they are victims of bad care or simply bad luck. Filing a malpractice claim can be an emotional, time-consuming ordeal. It entails confronting your doctor and spending countless hours in acrimonious legal proceedings. Only people with serious injuries and the potential for large awards are likely to find a lawyer to take their case because the legal costs involved are so high. Even for those with a serious injury (a disability lasting six months or more), the malpractice system compensates only one in 14 people.<sup>3</sup>

The problem is not simply a matter of greedy lawyers egging injured patients to sue. It is the inherent difficulty of distinguishing between malpractice and unavoidable injuries. That is the real reason why, for every valid claim, four unfounded claims are filed.<sup>4</sup>

Malpractice law has become so muddled that going to court is like rolling the dice. Juries

***“One person with a belief is a social power equal to ninety-nine who have only interests.”***

**—John Stuart Mill**

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hear confusing and conflicting testimony from expert witnesses about what constitutes a reasonable standard of medical care in a given situation, and then must decide whom to believe. Judges never tell them what the law is as they would in criminal matters. In the absence of any clear guidelines for determining if doctors are at fault, it is little wonder that jurors often let sympathy for severely injured patients guide their decisions.<sup>5</sup>

Similarly, many doctors do not trust the medical justice system because it makes inconsistent and often incorrect judgments about medical practice. Fearful of being sued, and shaken by mounting malpractice premiums, they often practice a false kind of professionalism—closing ranks, ordering

excessive tests, and shutting down frank discussion about failures and near misses.

Patients have the most to lose under the current system. Without clear signals from the courts about the steps doctors should take to prevent injuries, it should come as no surprise that between 48,000 and 98,000 patients die from medical mistakes in hospitals each year.<sup>6</sup> Patients are also losing access to doctors in high-risk specialties, such as obstetrics, particularly in states where malpractice insurance premiums are rising the fastest. Although many factors have pushed malpractice premiums higher, the biggest problem is the soaring costs of insuring against court decisions that are highly uncertain and lacking in common sense.

Yet, instead of grappling with the medical liability system’s fundamental flaws, the political

debate has centered on capping jury awards. Republicans say caps on damages for pain and suffering would lower insurance costs and thereby keep doctors from leaving their practices. Congressional Democrats argue that such caps, by making it harder for lawyers to recoup the high costs of pursuing malpractice cases, would deny injured patients access to justice. But Americans should not be forced to choose between access to medical care and access to justice.

The Progressive Policy Institute (PPI) proposes a Third Way: a new network of specialized health courts that would replace America's broken medical justice system.<sup>7</sup>

Malpractice claims should no longer be heard in civil courts. Instead, they could be handled in administrative processes overseen by the states. The system would be similar to the one that handles workers' compensation claims. This will give more injured patients access to quicker and less expensive justice.

Under workers' compensation systems, workers injured on the job could simply submit a claim form through their employer to an administrative law judge or board. If the judge or board determines that the injury occurred on the job, a worker receives compensation according to a schedule of benefits that takes into account the severity of the injury, the degree of disability, and the worker's age and pay. Injured workers cannot sue employers in a traditional court because workers' compensation provides an alternative system of justice, which the Supreme Court has upheld as constitutional.<sup>8</sup>

A health court system would be similar to the workers' compensation system in two important respects. First, there would be a schedule of benefits to compensate patients for medical injuries. Second, a health court system would be designed to provide quick, consistently fair damage awards.<sup>9</sup>

In a health court system, an injured patient would submit a simple claim form, available

through her health care provider, to a local health court review board. These boards would investigate claims and determine if they are clear, uncontestable cases of malpractice. In such cases, they would simply order the injured patient's health care provider to pay damages according to the schedule of benefits.

In making those determinations about clear, uncontestable cases of malpractice, review boards would refer to a catalogue of predetermined medical malpractice scenarios. Experts who have proposed and analyzed alternative schemes to our current system of medical justice have already identified an entire class of such scenarios, known as avoidable classes of events, or accelerated compensation events (ACEs). For example, a patient who suffers bleeding after colon surgery and requires additional surgery should not have to prove that malpractice has occurred; bleeding after colon surgery is a clear indication that the patient's surgical team did something wrong.<sup>10</sup>

In cases where a review board determines that a patient's injury is clearly *not* malpractice, or is too minor to merit an award, the board would dismiss the case. Patients or providers could appeal to a health court for a limited review of the case.<sup>11</sup> In cases where the circumstances of an injury are not cut and dry enough to qualify as an ACE, the review board would steer the case to the health court for a full trial.

In health court trials, as in civil trials, both parties would be represented by lawyers. But health court trials would be different from civil trials in several important respects. First,

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health courts would have specially qualified judges, whose decisions would help shape clear legal standards for medical practice. Second, there would be no juries. In the current system, juries have the impossible task of trying to

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discern legal standards when they should be deciding facts. Third, expert witnesses would be hired by the health courts, not by plaintiffs and defendants. Finally, in cases where judges find malpractice,

they would determine awards according to the schedule of benefits, taking into account both economic and non-economic factors, including health care expenses, legal expenses, income losses from disability, and pain and suffering.

For the start-up phase of a health court system, the schedule of benefits would be designed by a panel of independent experts to cover many common medical injuries. The experts would weigh injury awards commonly won in the current U.S. legal system against typical awards for similar injuries in other countries. In Britain, for example, damages paid for quadriplegia range from \$311,000 to \$387,000, depending on a patient's residual movement, pain, depression, and age.<sup>12</sup> There, a judicial panel sets guidelines to encourage uniform damages for medical injuries. In developing the schedule of benefits, experts would also consider objective economic analyses of the personal cost of injury.<sup>13</sup>

Over time, independent experts would systematically refine and expand the schedule of benefits to cover additional types of injuries in an annual review process.

Just as the schedule of benefits would evolve, so too would the list of ACEs that guide the

decisions of review boards, and the body of law that determines what does and does not constitute malpractice in more complicated cases. The rulings of health court judges would begin to establish new standards of practice to cover medical circumstances where common standards have not previously been agreed upon. The health court system would thus provide an essential benefit where our current system of medical justice fails: it would provide consistent, rational rulings that send clear signals to health care providers about what constitutes good medical practice. In so doing, it would help eliminate the uncertainty that encourages doctors to practice defensive medicine and contributes to medical errors.

The foundation for this new system of health courts should be built in the states, since states are already responsible for their own malpractice liability and insurance systems.<sup>14</sup> Yet the federal government also has a responsibility to regulate the malpractice system as a matter of interstate commerce, because federal programs like Medicare and Medicaid, along with big multistate employers, bear much of the initial brunt of soaring malpractice liability costs that providers pass on to payers and that payers ultimately pass on to consumers and taxpayers.

Those overlapping interests call for a cooperative policy solution.<sup>15</sup> Congress should provide start-up funding for states to create health courts, and it should set federal guidelines to ensure that health courts are similar from state to state in their designs and procedures, in the schedules of benefits they use, and in the standards of medical practice they recognize. Congress should also create a supporting system of federal health courts to arbitrate when health court decisions in different states are contradictory.

Federal guidelines for state health courts should include the following:

- Specialized judges who make rulings on standards of care as a matter of law;

- ❑ Experts hired by the court rather than hired guns for plaintiffs and defendants;
- ❑ A liberalized standard for negligence (a mistake or medical treatment falling outside a range of good practice, without need to show personal fault);
- ❑ Expedited proceedings and improved patient access;
- ❑ A schedule of limits on non-economic damages based on the severity of the injury, set by an independent commission created by Congress;
- ❑ Adjudication of claims against health plans for coverage decisions; and
- ❑ Public reporting of cases settled or adjudicated.

Trial lawyers undoubtedly will object to health courts on the grounds that they would deprive injured patients of the right to a jury trial. But the U.S. Constitution does not prohibit Congress or the states from creating new compensation rights or eliminating claims that were recognized by the common law so long as the change is part of a comprehensive administrative scheme and provides a benefit to claimants.<sup>16</sup> Similar reforms created the workers' compensation system, the National Labor Relations Board, (which settles labor disputes in arbitration rather than through litigation), and the Price Anderson Act, (which set up a system to compensate victims of nuclear accidents).

Not only does the idea of an administrative system of medical justice have many legal precedents, it has also been the subject of dozens of years of research and writing about the malpractice system and possible alternatives. Much of that work develops the idea of an administrative compensation system

for medical injury, including the 2002 Institute of Medicine report recommending demonstration projects at the state level.<sup>17</sup> Many European jurisdictions use administrative systems to compensate patients for medical errors, and substantial literature has examined that experience.<sup>18</sup>

This proposal for an administrative health court system adopts many of those ideas and also retains one important feature of a traditional judicial system: written rulings by judges to create a science-based common law that sends clear signals to doctors about what constitutes appropriate medical care in a given circumstance.

The federal start-up funds for health courts could come from a small assessment on medical malpractice insurance premiums. Over time, premiums would fall as compensation for injured patients becomes more predictable and the new system helps clarify standards of practice and reduce injuries. Initially, however, premiums would be about the same as they are now. Malpractice insurers would no longer pay any of the sizable awards that make headlines in the current

system, but they would more frequently pay limited compensation awards for injuries that receive nothing today.

Health courts would create a strong union between scientific evidence on the safety and effectiveness of health care and the legal precedents for settling difficult questions involving medical judgment. The current medical justice system is far too arbitrary and capricious to dispense fair and reliable justice.

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This paper critiques the current system, proposes a system of health courts as the solution, and lists the steps for implementation.

## What Is Wrong With the Current System of Medical Justice?

Patient safety expert Peggy O’Kane of National Committee for Quality Assurance (NCQA) has called the current malpractice system “broken.”<sup>19</sup> The Institute of Medicine has

recommended dismantling it.<sup>20</sup>

Public health expert Troyen Brennan of the Harvard School of Public Health says, “the legal system today is a string of ad-hoc decisions, jury by jury, with no

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rulings of right and wrong and no guidance on where to improve.”<sup>21</sup> But elected officials have not yet seriously challenged the status quo or its entrenched interests on all sides.<sup>22</sup>

Meanwhile, patients who are harmed by their health plans’ decisions to deny coverage for medically necessary care cannot receive any damages other than awards to cover the cost of the medical care they were denied. The current system fails in all-important areas and needs a complete overhaul. The following are some of the system’s most critical failures.

### **Compensation and Deterrence**

As noted previously, the medical justice system fails to compensate the vast majority of injured patients and does a poor job of preventing medical mistakes, according to in-depth studies of malpractice in four states.<sup>23</sup>

Patients cannot readily determine if their injuries are the result of bad care or bad luck, and they are unlikely to confront their doctors to find out. This lack of certainty leads lawyers to deluge courts with damage claims that are frequently of dubious validity. Only about one-third of malpractice claims produce a payment through a settlement or a trial, but that is enough to keep the tort business going strong.<sup>24</sup>

The cases that trial lawyers take to juries in hopes of winning big awards do not help determine legal standards of care for future cases. Juries do not explain their decisions, because they are supposed to be deciding fact, not making law about the standards of care. This ad-hoc decisionmaking process changes from case to case and leaves all parties without any basis for structuring future behavior.

Moreover, the current legal system is asking too much of jurors. In most cases, they do not have the necessary medical background to fully understand the relevant facts, and judges offer them no guidance on the standards of care.

Meanwhile, just as judges do not give juries clear guidelines, the judicial system offers only irrational signals to doctors. So, it is no surprise that there is little evidence the system deters medical mistakes.<sup>25</sup> The primary factor determining whether an injured person will receive compensation is the extent of the injury, not the extent of fault.<sup>26</sup> Claims against employer-sponsored health plans for injuries caused by denial of coverage involving medical judgment also have little deterrent effect. The federal Employee Retirement Income Security Act (ERISA) prohibits injured patients from suing for any damages other than the expense of care plus legal fees and other costs.

The mismatch between the occurrence of negligence, finding of liability, and awards of compensation is one the biggest downfalls of the current system. Instead of determining standards of care on an ad-hoc basis, the standards of care should be a consistent legal

standard subject to continuous updates as the science and skills of modern medicine advances. Today, however, neither juries nor judges have access to any independent, science-based research against which to gauge the testimony of expert witnesses.

### *Incentives for a Quality-Driven System*

The current system not only provides the wrong incentives, it actually deters improvements in the quality of medical care. Experts agree that frank, open discussion of mistakes and near misses is vital to quality improvement. But the randomness of the current legal system impedes such discussion.<sup>27</sup> In fact, only 5 percent of doctors and nurses say they are very comfortable talking about mistakes and near misses in the current legal environment.<sup>28</sup> Whether or not there are other reasons for this reticence, it is incompatible with quality improvement.

The Institute of Medicine and other leading researchers believe most medical mistakes are not caused by willful neglect on the part of an individual provider. Instead, they occur because small problems compound themselves in the complexity of modern medicine. For example, doctors and nurses do not always readily communicate about the medications each patient is taking, and thus may prescribe drugs with harmful interactions. Such so-called “systems errors” can be avoided with the sorts of internal checks and controls that are common in accounting, aviation, and banking.<sup>29</sup> Studies show that computerized systems could prevent anywhere from 28 percent to 95 percent of patient injuries resulting from improperly administered drug therapies.<sup>30</sup> But with its focus on individual negligence, the current medical justice system does not provide an incentive to reduce these risks.<sup>31</sup> No single doctor is accountable for all that happens to patients. So the only pressure for doctors to invest in these

computerized control systems comes from large employer coalitions like the Leapfrog Group, which consists of both public and private health care purchasers. Their demands that hospitals adopt them all at once have met with limited success.<sup>32</sup>

### *Expense and Efficiency*

Here, too, the current system gets failing marks. More than 50 percent of court awards go to court costs and lawyer fees,<sup>33</sup> nearly twice the overhead of a typical workers’ compensation system.<sup>34</sup> What little money does go to plaintiffs gets to them only after a very long time—often an agonizingly long time. Estimates of the average time

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between discovery of the alleged malpractice and payment of judgment or settlement range from three to five years, and some cases can take as long as eight to 10 years to resolve.<sup>35</sup>

The complexity of cases, the opportunities for delays by lawyers on both sides, and the appeals process all contribute to the slow progress. Studies show that patients are happy to avoid a lengthy malpractice trial if they have a less expensive and timelier alternative available.<sup>36</sup>

### *Fundamental Fairness*

Consistency in law and justice is one of the determinants of fairness. Law is supposed to treat similar cases alike, but nothing could be farther from the truth in medical malpractice cases today. Not only is there no guarantee that two people who suffer from the same mistake will both be compensated, studies show there is no

“horizontal equity” among awards; people with the same or similar injuries who do get

compensated can receive vastly different sums of money from the system—ranging from nothing to many millions of dollars.<sup>37</sup> Even among those who receive large jury awards, there is a great deal of variation in what plaintiffs actually receive; some exhaust their resources

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in order to win what amount to pyrrhic victories.<sup>38</sup> In addition, reasonable decisions are not reliably supported by the current court system. Two doctors who take the same reasonable course of action can be treated very differently by the system depending on the luck of the draw.<sup>39</sup>

### ***Accountability***

The current medical justice system fails to police the few truly bad doctors, hospitals, and other providers who develop a track record of poor safety. Studies show that even within a given specialty, and adjusting for other factors, a small number of providers account for the vast majority of the suits, awards, and settlement costs in their specialty areas.<sup>40</sup> The current system also fails to sort bad doctors from bad claims, as getting sued obviously does not make one a bad doctor. New research shows that doctors who get sued frequently tend to have high numbers of patient complaints, often relating to a doctor’s poor communication and interpersonal skills, not necessarily to incidents of malpractice.<sup>41</sup> State

licensing boards do not do any better at identifying bad doctors, because they, too, lack a reliable source for assessing negligent care.<sup>42</sup> The licensing board in Massachusetts has addressed this data gap by conducting its own reviews of doctors with three or more malpractice payments, but it could do even more if it had more reliable court judgments about malpractice.<sup>43</sup> Other attempts to create accountability have backfired. For example, hospitals that try to deny privileges to physicians with bad track records often get sued themselves.<sup>44</sup>

### ***Cost Containment***

With six straight years of double-digit premium hikes, the nation’s health care bill is becoming unaffordable. But in the absence of clear legal standards, it is only natural that doctors order extra tests to limit their exposure to lawsuits—a practice known as defensive medicine that adds unnecessary services to the health care bill. Under what circumstances is a CAT scan excessive or unnecessary testing? Is it ever okay not to do another test? The current medical justice system, with its lack of precedents and perverse incentives, simply cannot support rational, science-based cost containment measures. While reports differ on how widespread defensive medicine is,<sup>45</sup> studies and polls clearly document that it occurs routinely and adds costs in the range of \$38 to \$100 billion a year.<sup>46</sup>

## **A Third Way Solution: Fair and Reliable Health Courts**

The remedy to the deep-seated flaws of the current medical justice system is a system of health courts that is fair and reliable for patients and doctors alike. Health courts would fundamentally alter and improve the rights of injured patients. In a health court system, more injured patients would have

access to quicker and less expensive justice, and fewer would receive irrationally large awards.

A broad coalition of patient safety experts, medical school deans, consumer groups, medical professionals, and business leaders has come behind the need for such a system.<sup>47</sup> What follows is a detailed discussion of the key elements of a new health courts system to replace our medical liability system.

### ***Specialized Judges and Standards of Care***

Providers, patients, and society as a whole need consistent rulings on standards of care, as compliance with such standards is the critical issue in virtually every malpractice case. The legal system has failed to keep abreast of the growing complexity of medical science and looks for bright lines between good and bad medical practice at a time when health care quality depends more on statistics and weighing the strength of evidence. Without the consistent application of updated standards, the legal system contributes to uncertainty, waste, and often substandard care. Doctors do not know how to avoid lawsuits and health insurance companies do not have a clear or consistent idea of what treatments are “medically necessary,” which are the criteria health plan contracts typically use to define the services they will provide.

Health courts would have specialized judges, similar to the expert judges in federal tax court. Appointed by governors for long terms (10 years, for example), health court judges should have the background and training in science or medicine to enable them to define and interpret standards of care, based on the advice of experts. They could be lawyers, but could also be doctors, while that would not be necessary—just as U.S. Tax Court judges are lawyers, but not necessarily tax accountants, and Patent Court judges are lawyers, but not necessarily inventors. What

is most important is that health court judges develop a body of written rulings so that stakeholders understand the steps they should take to prevent injuries and avoid malpractice claims. Appeals should go first to a dedicated court of medical appeals at the state level, so that inconsistencies can be harmonized and standards clarified, and then to a federal health court if it is necessary to resolve substantial differences in ruling between states.

### ***Neutral Experts***

Health courts would use expert witnesses paid by the court, so they are not beholden to either the plaintiffs or the defendants. Access to impartial, unbiased expert testimony on the standards of care is essential for a reliable system. Establishing standards of medical care is remarkably complex. There may often be several courses of

treatment that fall within a range of reasonableness, rather than one acceptable course, depending on variables such as a patient’s health, age, or other circumstances.<sup>48</sup> Sometimes a widely used practice does not always constitute good

care.<sup>49</sup> And often medicine is as much an art as a science. In order to avoid what is sometimes called “cookbook medicine,” health courts would consider medical practice guidelines in the context of each case, according to the individual needs and characteristics of patients.

Expert testimony must help the court understand state-of-the-art treatments, and

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whether doctors' actions fall among the reasonable options in a given situation. Only then can expert testimony provide a meaningful foundation for rulings on standards of care that should become legal precedents. Patients and providers could possibly submit written expert testimony of their own in addition to court-appointed expert opinion, and the court could call for additional information if needed. But the cost of dueling experts is a principal driver of the escalating cost of malpractice litigation, and neutral, court-appointed experts could fill that role.

### ***Liberalized Standard for Liability***

A health court system would compensate patients who are injured by medical care as the result of an mistake that should have been prevented. This broader, more liberal standard of recovery goes beyond the current haphazard standard that is based on individual negligence. Health care quality experts generally agree that the focus on individual negligence in malpractice cases is too narrow and can be counter-productive given the growing complexity of the practice of health care. A team effort by all health professionals is necessary for state-of-the-art care. The Institute of Medicine's report in 2000 about reducing medical errors has solidified this consensus.<sup>50</sup>

Defining what constitutes a medical error will be challenging and may vary over time. For example, a patient who has a known health risk should not be compensated for an injury from surgery unless a clear error leads to that injury.<sup>51</sup> But determining exactly what is a "clear error" or a "known risk" requires first setting a legal precedent and then testing that precedent among a variety of health court judges and appeals. To ensure that the system is not overwhelmed with a large number of small claims, the overall cost of compensation will also have to be taken into account to determine what kinds of injuries can be compensated.

Liberalization of the liability standard should not go so far as to eliminate all accountability of individual providers, nor should it try to compensate for every injury or medical failure regardless of fault. For example, a baby born with cerebral palsy that occurred unavoidably at birth deserves our compassion, but the right way to help that family is through a social welfare system, such as a Medicaid disabilities program, not through the medical justice system. Injuries and illness will always occur, despite good medical care, or as the result of an acceptable and disclosed medical treatment risk.

### ***Expedited Proceedings and Lower Legal Fees***

For patients, a reliable system has to be one that can provide compensation for people wrongly injured by the medical system without years of legal wrangling and without costs that now consume roughly one-half of the awards. Patients whose cases do not promise large compensation often cannot obtain legal representation in the current system.<sup>52</sup> Patients should have easy access to compensation, perhaps with the assistance of patient advocates in hospitals.

A robust administrative level of service will be essential to ensure that a health court system delivers speedy, affordable justice. Local health court review boards, located in or near hospitals, would triage patients' injury claims. They would validate the facts of the claims by reviewing patients' medical charts and interviewing patients, doctors, and nurses. Based on those investigations, they would determine if an injury is on the list of ACEs and in those cases would order patients' health care providers to pay damages according to the schedule of benefits. Thus, many patients could avoid any further legal proceedings.

The list of ACEs in a health court system could be maintained in a computerized index that local review boards could use to efficiently

process patients' injury claims and identify those that qualify for expedited damage awards. The index could be systematically updated to include additional malpractice scenarios as experts identify them, as health courts produce consensus rulings, and as the scientific practice of medicine advances.

### ***Schedule of Benefits for Injured Patients***

The schedule of benefits that would determine damage awards in a health court system would cover both economic and non-economic damages. Economic damages include medical and legal costs, wages lost due to disability, and the like. The economic awards patients receive would vary on a case-by-case basis accordingly. Non-economic damages include compensation for pain and suffering that seek to make people whole. It is these non-economic damage awards that are so haphazard in our current system of medical justice. Rationalizing them will be one of the most important innovations in a health court system, and the key means of eliminating the runaway inflation in malpractice insurance costs that has caused doctors either to abandon their fields or practice defensive medicine.

The health court systems' schedule of benefits would be developed through a consensus process involving research on similar benefit schedules in the United States and abroad. Congress would establish an independent commission with members appointed by the president and Congress, reflecting diverse interests and perspectives, to write an initial schedule of benefits for health courts.<sup>53</sup> Once health courts are up and running, health court judges, in cooperation with other legal, medical, and economic experts, would at least annually recommend changes to the schedule of benefits. The commission would have final approval any changes. This same process would apply to the development and updating of the index of ACEs described above.

This approach is a better solution to the problem of huge jury awards than the idea of placing a rigid \$250,000 ceiling on non-economic damages for two reasons. First, a \$250,000 ceiling is simply too low for a patient facing a lifetime of pain and suffering. Second, today's arbitrary and capricious awards would be replaced with a schedule

of benefits proportional to harms that have been done. It would also ensure that different patients with similar injuries receive similar compensation. Most Western nations have

made a variety of explicit judgments about appropriate non-economic damages in medical cases. But none applies a rigid ceiling comparable to the \$250,000 cap for all injuries.<sup>54</sup>

States should have to make use of both the congressionally approved schedule of benefits and the index of clear-cut cases of medical malpractice in order to qualify for federal start-up funds for health courts.

### ***Adjudication of Medical Judgment Claims***

The prospect of a mind-boggling sum of malpractice jury awards has stymied reforms to make health maintenance organizations (HMOs) accountable for injuring patients. Advocates of the Patients' Bill of Rights<sup>55</sup> have proposed removing ERISA's legal shield, which protects employers and their health plans, including HMOs, from patients' lawsuits for injuries caused by a health plan decision involving medical judgment, such as denying payment for health care deemed medically necessary.

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But the Patients' Bill of Rights has stalled because employers and HMOs have successfully argued that lawsuits will drive up health insurance premiums, which are climbing at double-digit rates.

A well-functioning legal system should have the opposite effect. It should help hold down costs by supporting curbs against unnecessary care while punishing HMOs when they limit access to necessary care.

Health courts should handle the cases where patients are injured by health plan decisions that involve medical judgment. Currently, ERISA lumps together all non-malpractice claims against a health plan offered by an employer. That includes claims involving benefit administration issues, such as problems processing medical payments, and claims involving the more complex and far-reaching question of what is a medical necessity. Also, ERISA limits patients' awards to the costs of the medical services denied by a health plan plus legal fees and other costs. The Patients' Bill of Rights, which was never enacted by Congress, proposed to let injured patients file lawsuits in the same tort system that has handled malpractice cases so poorly.

Instead, injured patients should have the right to seek limited damages in a health court in ERISA cases involving medical judgments. But first, patients should be required to exhaust all other remedies, including a process known as external review, which provides a timely, independent medical review of whether health plans must pay for benefits in cases involving medical judgments by health plans. The federal government should set uniform and national guidelines for external review under the federal authority already established by ERISA. Health courts would handle these cases separately from malpractice cases, under the legal umbrella of ERISA, in order to maintain a national legal structure for providing employee benefits in multiple states. In other respects, such as

awarding only limited compensation, health courts would treat ERISA and malpractice cases similarly.

### *Improved Patient Safety*

Public reporting of health court cases would be an essential part of a new national patient safety strategy. Rulings of the health court system would replace ad-hoc decisionmaking based on testimony of dueling experts. Health court rulings would also completely replace the "locality rule," an increasingly archaic legal standard for medical malpractice that gives local doctors final control of standards of care, rather than using scientific, evidence-based medicine.<sup>56</sup> In cases involving medical circumstances not covered by the ACE index described above, health courts' neutral experts would rely on scientific literature and consider evidence-based guidelines listed in the National Guidelines Clearinghouse operated by the U.S. Agency for Healthcare Research and Quality (AHRQ).<sup>57</sup>

Experts should not be tied to rigid guidelines, however. They would advise the court on the range of appropriate care, recognizing that there often may be more than one appropriate course of action and, in many cases, multiple competing guidelines.<sup>58</sup> The national AHRQ should have the responsibility and additional resources to monitor rulings publicly reported by the health courts in order to pursue areas where additional research or clarification of research findings would be useful in settling court cases. Many cases will involve complex situations not covered by guidelines, and will be resolved by judges' decisions made in light of expert testimony about whether the provider's actions were within the range of reasonable actions given the circumstances.

Also, the system must encourage the reporting and discussion of medical mistakes

and near misses instead of driving that discussion underground by a fear of lawsuits. It should develop mechanisms to use performance information to improve the quality of care. Reporting such information should be kept separate from specifics about the proceedings of individual cases. Patient safety legislation approved by both the House of Representatives and the Senate offers such protection by recognizing the privacy of the providers who report the information.<sup>59</sup>

Once a judgment is made within the context of the health court system, the cases should be made public through the National Practitioner Data Bank, which currently includes all lawsuits against doctors without disclosing data about individual doctors or patients to the general public. Today, many doctors oppose disclosure because lawsuits do not accurately reflect how well they practice medicine, but that argument would no longer be valid for cases coming through a reliable system of health courts. A national database would augment what most states have already done in establishing public disclosure of malpractice cases.

Health courts would identify repeat offenders (including provider groups like hospitals with poor safety records) for remedial action by patient safety organizations and for inclusion in public reports on medical quality that are published on state or federal websites, and to help private consumer advocacy organizations, such as *Consumer Reports* magazine. Another important way to improve safety is by holding hospitals accountable for mistakes that happen in their facilities. Experts agree that makes sense because most mistakes are systems errors, not the fault of individual doctors.

Holding organizations as well as individual doctors accountable for patient safety would help catch recurring safety issues in hospital settings, such as infections and patient misidentification. It would also provide

reliable data for what is called “experience rating” of premiums, in which malpractice insurance rates for health care providers are set according to their records of malpractice. In the case of workers’ compensation, experience rating of premiums paid by employers has been more effective than regulations issued by the Occupational Safety Health Agency in improving workplace safety.<sup>60</sup>

In addition to public disclosure, the small minority of troublesome providers who slip through the cracks of medical review boards and licensing bodies should face tougher penalties.<sup>61</sup> Those providers too often escape oversight and discipline by filing lawsuits to intimidate state medical boards and hospitals that try to deny repeat offenders the opportunity to practice. A

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***“Court decisions should be public, while protecting patients’ privacy, so the medical community can learn from its mistakes and work to prevent them, and so the public can have accurate information about provider quality.”***

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reliable, consistent standard of oversight is needed and could be provided by a health court system. An adverse decision (or series of decisions) by the health court system should act as a bar against lawsuits when state medical boards and hospital privilege committees take action to sanction repeat offenders.

Finally, settlements in health court cases should not be sealed from public view. In today’s legal system, plaintiffs may agree to seal the terms of a settlement in exchange for a higher award or some other consideration. Under a health court regime, the schedule of benefits would prevent such backroom dealing. Court decisions should be public, while protecting patients’ privacy, so the medical community can learn from

its mistakes and work to prevent them, and so the public can have accurate information about provider quality.

## **Creating a National System of Health Courts**

The federal and state interests in creating an effective system of medical justice call for a cooperative policy solution. These key steps must be taken to create a system of health courts:

- 1) The federal government should set guidelines for states to follow in establishing state-level health courts. For example, one such guideline would provide that the standards of care is an issue of law for the administrative court, not an issue of fact for a jury. The government should also provide federal funds as an incentive for states to adopt health courts in the start-up phase.
- 2) The federal government would temporarily add a 0.5 percent fee to malpractice insurance premiums to finance state grants for creating a health court system. This fee would raise roughly \$133 million per year.<sup>62</sup> After a five year start-up period, states should be able to recover the ongoing costs of health courts from the traditional courts system. For example, instead of incurring the cost of juries, states would incur the costs of neutral experts. The Congressional Budget Office or General Accounting Office should undertake a thorough analysis of the costs and benefits of health courts as well as transition issues.
- 3) The U.S. Department of Health and Human Services (HHS) would establish a federal administrative health court to arbitrate when state health court decisions

interpret federal guidelines differently, and are thus contradictory.

- 4) The HHS would conduct an annual review of the effect of health courts on the number of cases in the system, the total claims submitted and paid, and the effect on malpractice insurance premiums paid by physicians and other health care providers.
- 5) After five years, the HHS should be required to assess the performance of the health court system, and either recommend modifications to the system or propose an alternative reform plan if the health court system is not providing fair and reliable justice to injured patients and clear standards of practice for health care providers. Specifically, the president and Congress may need to preempt state medical malpractice laws and establish federal health courts in states that choose to forgo federal start-up funds and avoid creating health courts on their own.<sup>63</sup>

The federal government would periodically provide funding to evaluate the performance of health courts throughout the country by examining a random sample of medical records. The research methodology for these process would be similar to the Harvard Malpractice Studies conducted in the 1980s and 1990s.<sup>64</sup>

## **Conclusion**

The existing medical malpractice system fails patients and health care providers. Patients who are injured do not receive just compensation, and all patients as a group are more likely to be injured because the malpractice system does not give health care professionals and institutions clear, consistent, or strong incentives to prevent injuries. Meanwhile, the current system is driving some

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good doctors out of business. Health courts would make the malpractice system swift and reliable for all.

Health courts should appeal to Democrats who have long fought to protect the interests of

patients. And they should also appeal to Republicans who have long argued for a less wasteful malpractice system. Now is the time for both sides to come together around reform that is both fair and efficient.

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## Endnotes

- <sup>1</sup> These findings were first made in the Harvard Medical Practice Study, first published in 1991, which was based on 1984 case records in hospitals in New York state. Brennan, T.A., L.L. Leape, M.M. Laird, L. Hebert, A.R. Localio, A.G. Lawthers, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study," *New England Journal of Medicine*, vol. 324, 1991, pp. 370-6 (hereinafter "Harvard Medical Practice Study"). The study was repeated in Colorado and Utah hospitals in 1991 with similar findings. Studdert, David M., Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E.J. Orav, and Troyen A. Brennan, "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care*, vol. 38, 2000, p. 253 (hereinafter, "Colorado-Utah Study"). Those findings mirrored findings in a similar California study conducted in 1977. D.H. Mills, ed., "Report on the Medical Insurance Feasibility Study," California Medical Association and California Hospital Association, 1977. By reviewing patient medical records, researchers were able to determine the frequency of "adverse events," defined as "injuries caused by medical management," and of the subgroup of such injuries that resulted from negligent or substandard care, to track the percentage of the adverse events caused by "negligence" and to track the number of claims filed as a result of these events. Published data indicate that there were no malpractice claims for 97 percent of New York and 97 percent of the Colorado-Utah incidents of negligent injuries. See also: Leape, Lucian, et al., "The Nature of Adverse Events in Hospitalized Patients," *New England Journal of Medicine*, vol. 324, 1991, pp. 377-84; Weiler, P.C., H.H. Hiatt, J.P. Newhouse, W.G. Johnson, T.A. Brennan, L.L. Leape, *A Measure of Malpractice*, Harvard University Press, 1993; Weiler, P.C., J.P. Newhouse, H.H. Hiatt, "Proposal for Medical Liability Reform," *Journal of the American Medical Association*, vol. 267, 1992, pp. 2355-8; Weiler, P.C., T.A. Brennan, J.P. Newhouse, L.L. Leape, A.G. Lawthers, H.H. Hiatt, et al., "The Economic Consequences of Medical Injuries," *Journal of the American Medical Association*, vol. 267, 1992, pp. 2487-92.
- <sup>2</sup> Studdert, David M., Troyen A. Brennan and Eric J. Thomas, "What Have We Learned Since the Harvard Medical Practice Study?" *Medical Error: What Do We Know? What Do We Do?*, Jossey-Bass, 2002.
- <sup>3</sup> The Harvard Medical Practice Study identified 5,396 cases where patients were injured by negligent care and suffered a disability lasting six months or more, but did not file a malpractice claim. By comparison, the study found only 415 cases where patients with any type of injury due to negligence filed a claim. Localio, A. Russell, et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *New England Journal of Medicine*, July 25, 1991.
- <sup>4</sup> Localio, A. Russell, et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *op. cit.*
- <sup>5</sup> Brennan, Troyen A., C. M. Cox, and H.R. Burstin, "Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *New England Journal of Medicine*, vol. 335, no. 26, December 26, 1996, pp. 1963-67.
- <sup>6</sup> Kohn, Linda T., Janet Corrigan, et al., eds., *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press, 2000.
- <sup>7</sup> This proposal represents one possible structure for a national system of health courts. A recent grant from the Robert Wood Johnson Foundation made jointly to Common Good and the Harvard School of Public Health provides funding for further exploration of how a health court system could operate. For example, there may be other ways to structure the administrative layer of the system than the design that is described in this paper.
- <sup>8</sup> *New York Central RR v. White*, 243 U.S. 188, 200 (1917); *Arizona Employers' Liability Cases*, 250 U.S. 400, 419-422 (1919).
- <sup>9</sup> Unlike workers' compensation, health courts would not compensate every injury. The role of the health court is to decide when things have gone wrong versus when injuries are simply the result of an acceptable, disclosed risk.
- <sup>10</sup> Studdert, David M., et al., "Medical Malpractice," *New England Journal of Medicine*, vol. 350, 2004, pp. 283-292.
- <sup>11</sup> In order to avoid overwhelming the system with too many small claims, not every case can go on for review by the health court. However, it is important that the system include checks and balances to be sure cases are not unfairly rejected.
- <sup>12</sup> Calculated using an exchange rate of .53 British pounds for every U.S. dollar; Bell, Justice, *Guidelines for the Assessment of General Damages in Personal Injury Cases*, Oxford University Press, 2002.
- <sup>13</sup> Objective economic analyses of the cost of pain and suffering have included such things as spending on safety equipment, and salaries and wages in risky professions.
- <sup>14</sup> For example: *Reliable Medical Justice Act*, 108th Congress, 1st sess., S. 1518, 2003.
- <sup>15</sup> Under the legal doctrine of cooperative federalism, Congress has the power to offer states the choice of regulating interstate activities according to federal standards, or having state law preempted by federal regulation. This arrangement has been replicated in numerous federal statutory schemes. For example: *Commodity Futures Trading Comm. v. Schor*, 478 U.S. 833 (1986).

- <sup>16</sup> *New York Central RR v. White*, *op. cit.*; *Arizona Employers' Liability Cases*, *op. cit.*
- <sup>17</sup> Corrigan, Janet M., Ann Greiner, and Shari M. Erickson, eds., "Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation," *Fostering Rapid Advances in Health Care*, Institute of Medicine, National Academies Press, 2002; Studdert, David M. and Troyen A. Brennan, "No-Fault Compensation for Medical Injury: The Prospect for Error Prevention," *Journal of the American Medical Association*, vol. 286, no. 2, July 11, 2001; Bovbjerg, Randall R. Laurence R. Tancredi, Daniel S. Gaylin, "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *Journal of the American Medical Association*, vol. 265, no. 21, June 5, 1991; Johnson, Kirk B., Carter G. Phillips, David Orentlicher, and Martin S. Hatlie, "A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims," American Medical Association, 1989.
- <sup>18</sup> For example: Danzon, Patricia M., "The Swedish Patient Compensation System: Lessons for the United States," *International Review of Law & Economics*, 1994; Grace, Elayne and Jean-Marc Queau, "What's Happening in Medical Malpractice Around the Globe?" presented at The Institute of Actuaries of Australia Sixth Accident Compensation Seminar, October 2002.
- <sup>19</sup> O'Kane, Peggy, conversation with Nancy Udell.
- <sup>20</sup> Corrigan, Janet M., Ann Greiner, and Shari M. Erickson, eds., "Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation," *op. cit.*
- <sup>21</sup> Brennan, Troyen A. and Philip K. Howard "Heal the Law, Then Health Care," *The Washington Post*, January 25, 2004.
- <sup>22</sup> Studdert, David M., et al, "Medical Malpractice," *op. cit.*
- <sup>23</sup> See studies cited in endnote 1.
- <sup>24</sup> Data Sharing Project, Physician Insurers Association of America, <http://www.thepiaa.org/services/research.htm>.
- <sup>25</sup> Studdert, David M., et al, "Medical Malpractice," *op. cit.*
- <sup>26</sup> Brennan, Troyen A., C.M. Cox, and H.R. Burstin, "Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *op. cit.*
- <sup>27</sup> Kohn, Linda T., Janet Corrigan, et al., eds., *To Err is Human: Building a Safer Health System*, *op. cit.*, p. 43. See also: Leape, Lucian L., "Can We Make Healthcare Safe?," *Reducing Medical Errors and Improving Patient Safety*, National Coalition of Health Care and the Institute for Healthcare Improvement, February 2000; Wu, Albert W., "Handling Hospital Errors: Is Disclosure the Best Defense?" *Annals of Internal Medicine*, vol. 131, no. 12, December 21, 1999, p. 971.
- <sup>28</sup> "Fear of Litigation Study," Harris Interactive, April 1, 2002.
- <sup>29</sup> Kohn, Linda T., Janet Corrigan, et al., eds., *To Err is Human: Building a Safer Health System*, *op. cit.*; Janet M. Corrigan, Ann Greiner, and Shari M. Erickson, eds., "Liability: Patient-Centered and Safety-Focused, Nonjudicial Compensation," *op. cit.*, and Leape, Lucian, et al, "The Nature of Adverse Events in Hospitalized Patients," *op. cit.*
- <sup>30</sup> "Reducing and Preventing Adverse Drug Events Decreases Hospital Costs," press release, Agency for Healthcare Research and Quality, April 11, 2001, <http://www.ahrq.gov/news/press/pr2001/adepr.htm>.
- <sup>31</sup> Liang, Bryan A. "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the HealthCare and Legal Systems," *Journal of Law, Medicine and Ethics*, no. 29, 2001, p. 347; Studdert, David M., Eric J. Thomas, Helen R. Burstin, Brett I.W. Zbar, E.J. Orav, and Troyen A. Brennan, *op. cit.*, p. 218.
- <sup>32</sup> Michael E. Porter & Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, p. 3.
- <sup>33</sup> Physician Insurers Association of America, *op. cit.*
- <sup>34</sup> "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," U.S. General Accounting Office, June 2003; Danzon, *op. cit.*; Grace, *op. cit.*
- <sup>35</sup> Kaminiski, Janet L., "Medical Malpractice—Massachusetts' Reform Initiative," Office of Legislative Research Report, Connecticut General Assembly, September 16, 2004, <http://www.cga.ct.gov/olr/medicalmalpracticeER.asp>. U.S. General Accounting Office, June 2003; for more information, please see endnote 17.
- <sup>36</sup> Liebman, Carol B. and Chris Stern Hyman, "A Mediation Skills Model To Manage Disclosure of Errors and Adverse Events To Patients," *Health Affairs*, July/August 2004.
- <sup>37</sup> Bovbjerg, Randall R., Frank A. Sloan, and James F. Blumstein, "Valuing Life and Limb in Tort: Scheduling 'Pain and Suffering,'" *Northwestern University Law Review*, vol. 83, 1989, pp. 919-928.
- <sup>38</sup> Hallinan, Joseph T., "Suit Wrinkle: In Malpractice Trials, Juries Rarely Have the Last Word—Large Awards Grab Attention But Often Aren't Paid Out," *Wall Street Journal*, November 30, 2004.
- <sup>39</sup> Brennan, T.A., L.L. Leape, M.M. Laird, L. Hebert, A.R. Localio, A.G. Lawthers, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study," *op. cit.*; Brennan, Troyen A., C.M. Cox, and H.R. Burstin, "Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation," *op. cit.*

- <sup>40</sup> Sloan, Frank F., E.M. Mergenhagen, B. Burfeild, et al., "Medical Malpractice of Physicians, Predictable or Haphazard," *Journal of American Medical Association*, vol. 262, 1989, pp. 3291-3297.
- <sup>41</sup> Hickson, Gerald B., Charles F. Federspiel, James W. Pichert, et al., "Patient Complaints and Malpractice Risk," *Journal of the American Medical Association*, 2002, 287: 2951-2957.
- <sup>42</sup> For example: Pear, Robert, "Panel Seeks Better Disciplining of Doctors," *New York Times*, January 4, 2005; "Even After Discipline, Doctors Finding Work," *Houston Chronicle*, March 23, 2004; Mullen, Frank X., Jr., "Special Report: State board doing little to stop reckless doctors," *Reno Gazette-Journal*, February 16, 2004; "The Peer Review Organizations and State Medical Boards: A Vital Link," Office of the Inspector General, U.S. Department of Health and Human Services, April 1993.
- <sup>43</sup> Pear, Robert, *op. cit.*
- <sup>44</sup> For example: Maxon, Terry, "Dallas doctor awarded \$366 million in damages," *Dallas Morning News*, August 28, 2004. The doctor at issue sued the hospital and two other cardiologists for numerous claims including federal antitrust violations (claims dismissed) and state law conspiracy and tort claims. The litigation went on for some years and is still subject to appeal.
- <sup>45</sup> For example: "Limiting Tort Liability for Medical Malpractice," Congressional Budget Office, January 8, 2004, p. 6.
- <sup>46</sup> Kessler, Daniel and Mark McClellan, "Do Doctors Practice Defensive Medicine?," *Quarterly Journal of Economics*, vol. 111, no. 2, May 1996, pp. 353, 354, 386.
- <sup>47</sup> See endorsers of the brochure, "An Urgent Call For Special Health Courts: America Needs A Reliable System of Medical Justice," Common Good, forthcoming, <http://www.cgood.org>.
- <sup>48</sup> Peters, Philip G. Jr., "Empirical Evidence and Malpractice Litigation," *Wake Forest Law Review*, vol. 37, 2002, p. 774 (quoting Mello, Michelle M., "Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation," *University of Pennsylvania Law Review*, vol. 149, 2001, p. 645); Eddy, David M., "The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?," *Journal of Health Politics, Policy & Law*, vol. 26, 2001, p. 396.
- <sup>49</sup> Eddy, *op. cit.*
- <sup>50</sup> Kohn, Linda T., Janet Corrigan, et al., eds., *To Err is Human: Building a Safer Health System*, *op. cit.*
- <sup>51</sup> Studdert, David M., et al., "Medical Malpractice," *op. cit.*, nn. 100 and 101.
- <sup>52</sup> Zimmerman, Rachel and Joseph T. Hallinan, "Limits on Awards for Suffering Create New Impediments," *Wall Street Journal*, October 8, 2004, p. A1.
- <sup>53</sup> The schedule of benefits would allow judges to exercise discretion in unusual cases.
- <sup>54</sup> For example: Bell, Justice, "Guidelines for the Assessment of General Damages in Personal Injury Cases," *op. cit.*; also see endnote 17.
- <sup>55</sup> *Bipartisan Patient Protection Act of 2003*, 107th Congress, 1st session, S. 1052.
- <sup>56</sup> See: Weiler, Paul C., *Medical Malpractice on Trial*, Harvard University Press, 1991, p. 21-22; Peters, Philip G. Jr., "Empirical Evidence and Malpractice Litigation," *op. cit.*, p. 759.
- <sup>57</sup> National Guideline Clearinghouse, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, <http://www.guideline.gov/>.
- <sup>58</sup> A 1994 review estimated that there were more than 1600 different guidelines at that time. The guidelines vary greatly in quality and scope. For more information, see Mello, *op. cit.*, p. 653.
- <sup>59</sup> *Patient Safety and Quality Improvement Act*, 108th Congress, 1st sess., H.R. 663 and S. 720.
- <sup>60</sup> Viscusi, W. Kip, "Job Safety," *The Concise Encyclopedia of Economics*, Liberty Fund, Inc., January 11, 2005. <http://www.econlib.org/library/Enc/JobSafety.html>.
- <sup>61</sup> For more information, see endnote 41.
- <sup>62</sup> "U.S. Tort Costs: 2004 Update," Tillinghast-Towers Perrin, p. 18.
- <sup>63</sup> Refer to endnote 11 on the legal doctrine of cooperative federalism.
- <sup>64</sup> Refer to endnote 1.