

CHALLENGING THE COST OF CLINICAL NEGLIGENCE THE CASE FOR REFORM



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FOREWORD



With nearly 300,000 members worldwide and more than 16,000 medical and dental members in Ireland, MPS has an in-depth knowledge of the medicolegal environment for healthcare professionals. This

knowledge and experience, coupled with our international expertise, provides us with a strong insight into the deteriorating claims environment in Ireland.

These are unquestionably challenging times and I understand that the increase in our subscription rates, caused by the rise in the cost of clinical negligence, are painful and are having a significant impact. In this paper we make bold but achievable recommendations to government, to address the factors contributing to this unsustainable situation.

We recognise the important role we must play. We commit in this paper to trialling a pre-action protocol to help make the system more efficient. But more importantly, we will continue to encourage and support our members to embrace open disclosure. In our experience this can help ensure that patients and their families are provided with the answers they need and avoid unnecessary escalation.

A handwritten signature in black ink that reads "Simon Kayll". The signature is written in a cursive, flowing style with a horizontal line underneath the name.

Simon Kayll
CEO

EXECUTIVE SUMMARY

Our claims handling philosophy aims to provide an expert, supportive and efficient claims handling service to members who are faced with claims. MPS seeks to identify the issues early, respond to them and move matters to appropriate resolution, be that settlement or successful repudiation. Where there is a good defence to a claim, MPS is robust in pursuing it. Where there is no defence, and it is clear that a claim will be pursued, MPS will try to effect settlement on fair terms as early as possible. MPS prides itself in taking an ethical, fair and straight forward approach to claims handling and reducing the financial and reputational impact of claims on MPS's wider membership.

The deterioration in the claims environment has been happening for a number of years, and significantly so in the last two years, in some areas of practice. For example, earlier this year when considering the claims environment for private hospital consultants in particular, the actuarial estimates of the cost of indemnity for claims per member had increased by over 90% over the last two years.

This is a result of large increases in both the rate at which private hospital consultants are being sued and the average size of those claims. As a consequence, we had to increase our subscription rates.

As a responsible not-for-profit organisation owned by members, we have an obligation to ensure that we collect sufficient subscription income to meet the expected future costs of claims against members so we can be in a position to defend their interests long into the future.

THE STATE CLAIMS AGENCY

The current cost of clinical negligence claims to the public purse is also significant. "At end 2013 the State Claims Agency (SCA) had 3,061 clinical claims under management, with an estimated liability of €1 billion, compared with 2,652 active claims at end 2012"¹. "The SCA resolved 419 personal injury (clinical) claims during 2013 at a cost of €63 million".²

The SCA comments in the National Treasury Management Agency Annual report, that the average cost of personal injury (clinical) claims resolved in 2013 increased and that alongside an increase in claims that fell under their remit in 2004:

*"An additional factor in the higher average cost per claim was the High Court decision, in a 2009 precedent case, to increase by 38.5 per cent the level of general damages in catastrophic injuries cases from €325,000 to €450,000. Legal fee costs have increased in conjunction with award/settlement costs"*³.

However, the impact of the deteriorating claims environment is felt differently by MPS than the SCA. This is because MPS has to fund itself on a prospective or pre-funded basis - collect the money now for incidents which occur in that year but for which claims may occur many decades in the future.

REFERENCES

1. National Treasury Management Agency Annual report and midyear 2013 update, p20-21 <http://www.ntma.ie/news/annual-report-2013-and-midyear-2014-update>
2. *ibid*
3. *ibid*

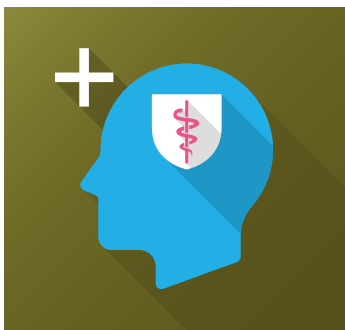


MPS PRIDES ITSELF IN TAKING AN ETHICAL, FAIR AND STRAIGHT FORWARD APPROACH TO CLAIMS HANDLING AND REDUCING THE FINANCIAL AND REPUTATIONAL IMPACT OF CLAIMS ON MPS'S WIDER MEMBERSHIP



MPS does not believe that the recent claims experience (increase in both the actuarial estimates of frequency and severity) in Ireland reflects a deterioration of professional standards. We believe that there are a multitude of complex factors contributing to this including:

- The lack of an efficient and predictable legal process for handling clinical negligence claims allows the size of claims to increase, and makes delays endemic. This has far reaching consequences; for both patients and healthcare practitioners who have to endure a great deal more stress while they wait for a resolution, and the final costs of settling the claim becomes much more expensive.



- The cost of settling a claim increases as time goes on. For example, the cost of settling a claim that should have been resolved in 2011 can be significantly greater to settle in 2014. In keeping with many other countries in our experience the level of claims inflation in Ireland far outstrips that of retail or consumer price inflation. This takes its toll on all involved. A protracted process can have a significant impact on the final cost of settling a claim, as it means legal bills continue to mount and compensation can increase in size. High plaintiff costs also contribute to the increasing cost of claims. In our experience, plaintiffs' costs are amongst the highest in any country in which we have members.

- Patients' expectations are increasing and many patients now expect greater involvement in – and understanding about – their healthcare. An increasing challenge for doctors is to manage these expectations and we are here to help them.

- The economic downturn, with claimants pursuing cases that they may not consider when the economy is more buoyant, and potentially may have pushed some claimant lawyers to seek alternative and more attractive sources of income.
- Lack of a speedy and transparent system, leads to a pressure to settle claims in circumstances where we would not do so elsewhere in the world.

We recognise that some progress has been made by both government and the judiciary towards an efficient and predictable legal process for handling clinical negligence claims, but much more needs to be done.

Whilst the deterioration in the claims experience against private hospital consultant members we have seen over the last two years may not continue at such a pace, the experience to date merits deep consideration of tort and procedural reform.

In this paper we make bold recommendations that we believe will begin to tackle some of the problems that have contributed to the current claims environment.

In Australia, following the crisis in medical indemnity provision in the early 2000s, we believe that tort reforms, similar to those that we recommend in this document, had a beneficial impact on the claims environment – and therefore the cost of professional protection. For example, the change in the subscription rates for certain of the larger surgical specialities in a large Australian State, between 2003/2004 and 2013/2014 was -0.2% and for others -0.9%. This is in stark contrast to the recent Irish experience.

We know that the recommendations in this paper are not exhaustive. Our aim is to stimulate this important debate.

This paper is broken down into four main sections.

1. The first section is an analysis of the current claims experience, from MPS's perspective, illustrated by 'the journey of a claim'. This section outlines what an effective and efficient claims journey should look like and compares this with the current claims litigation process.
2. Section two puts forward our recommendations for a Bill that would define the tort of clinical negligence. Further recommendations are also made to curtail solicitors' fees and reduce limitation periods. We believe this package of recommendations could begin to improve the claims environment.

We believe government should consider as a priority a Bill that:

- Provides a definition of the tort of clinical negligence
- Will require that a tort is only established when both breach of duty of care and causation of injuries is proven
- Reiterates that the burden of proof to establish the tort of clinical negligence rests with the plaintiff
- Allows for the creation of a tariff of general damages to assist judges in assessing compensation in clinical negligence cases.

Alongside this Bill, government should also introduce:

- A limit on general damages
 - A limit on claims for future earnings
 - A 'Certificate of Merit' for legal proceedings
 - A cap on lawyers' fees for smaller value cases
 - Full implementation of the recommendation of the 2011 Law Reform Commission review on limitation.
3. Before the concluding section, we also discuss important procedural reform. This section discusses how MPS wishes to be instrumental in the piloting and implementation of a pre-action protocol.

Furthermore, in this section we explore the powerful impact open disclosure can have in reducing the escalation of complaints.

4. The annexes contain a high level review of the tort reform experience of other nations and the lessons we can learn. Mark Doepel, Partner at Sparke Helmore Solicitors in Australia and tutor at the University of Sydney, has kindly guest authored the first part of this annex, reviewing the Australian experience so far. We also consider tort reform in the US.

MPS considers itself a core part of the medical and dental community and is committed to supporting and serving that community. We are acutely aware of the many difficulties the professions face now and are likely to face in the coming years and we hope that this paper will bring about the change that will help to mitigate some of these challenges.

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CLINICAL NEGLIGENCE AND TORT LAW IN IRELAND – THE JOURNEY OF A CLAIM

This section compares this ‘ideal’ with the real journey of a claim in Ireland and the numerous challenges that plaintiffs and defendants face.

This journey can be blighted by endemic delay and increased costs caused by inefficiencies. The defendant can be put at a disadvantage from the start due to the lack of transparency in the process, making it hard to successfully defend some cases.

There is also a negative impact for the plaintiff. Delays mean that plaintiffs may not have the early closure on a case that

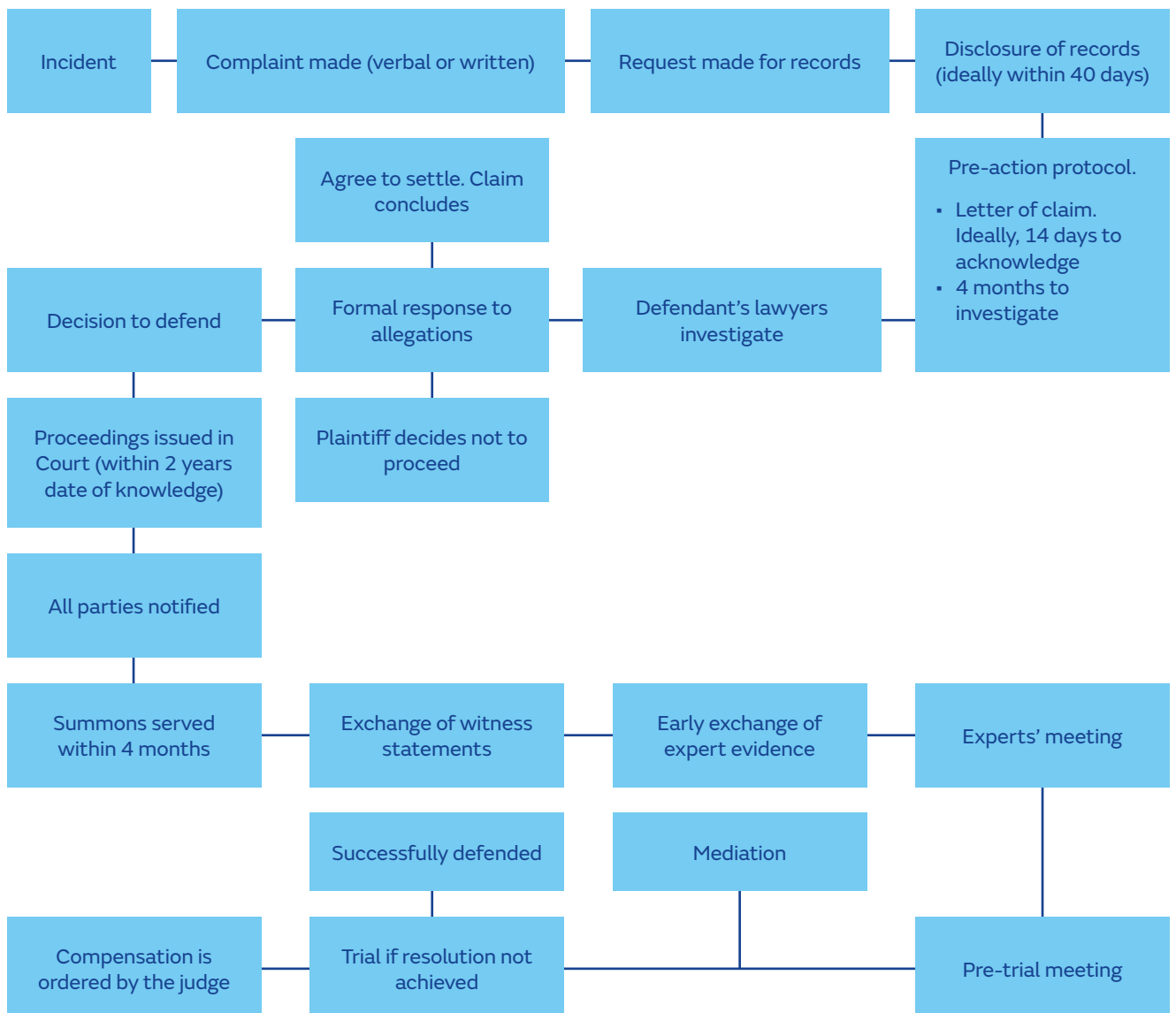
they deserve and those plaintiffs with meritorious claims may suffer financial hardship while they wait for compensation.

In this section we also consider why there is greater pressure to settle claims in circumstances where MPS would not do elsewhere in the world and why plaintiff costs and damages for less severe injuries are so high.

A theme that runs throughout this journey is the increase in recent years in the rate at which MPS medical members have been sued, which we explore below.

The ‘Journey of a Claim’ should look like this:

THE IDEAL JOURNEY OF A CLAIM



Increase in the rate at which MPS medical members have been sued

The causes of this increase in the frequency of claims are complex and the reasons provided below may not be exhaustive.

The graph below illustrates this recent increasing trend in contrast with the experience of other territories where MPS has members.

Some commentators suggest that there is a growing “compensation culture” in Ireland and that the economic downturn is a contributing factor, with claimants pursuing cases that they may not consider when the economy is more buoyant. Added to this it may lead some claimant lawyers to seek alternative sources of income.

Patient expectations are increasing. Sometimes these increased expectations are based on what can be reasonably delivered, other times not. Either way, we offer members support to deal with this challenge.

We also believe that there may have been an increase in capacity in private healthcare and the number and risk profile of procedures happening in the private sector.

However, there are other factors contributing to this trend that need to be tackled.

While there are claims that arise after patients have suffered avoidable harm, and for which patients should receive reasonable compensation, the Irish legal system does not do enough to discourage unmeritorious claims, for example when the plaintiff’s lawyers are unable to get solid expert support for their claim.

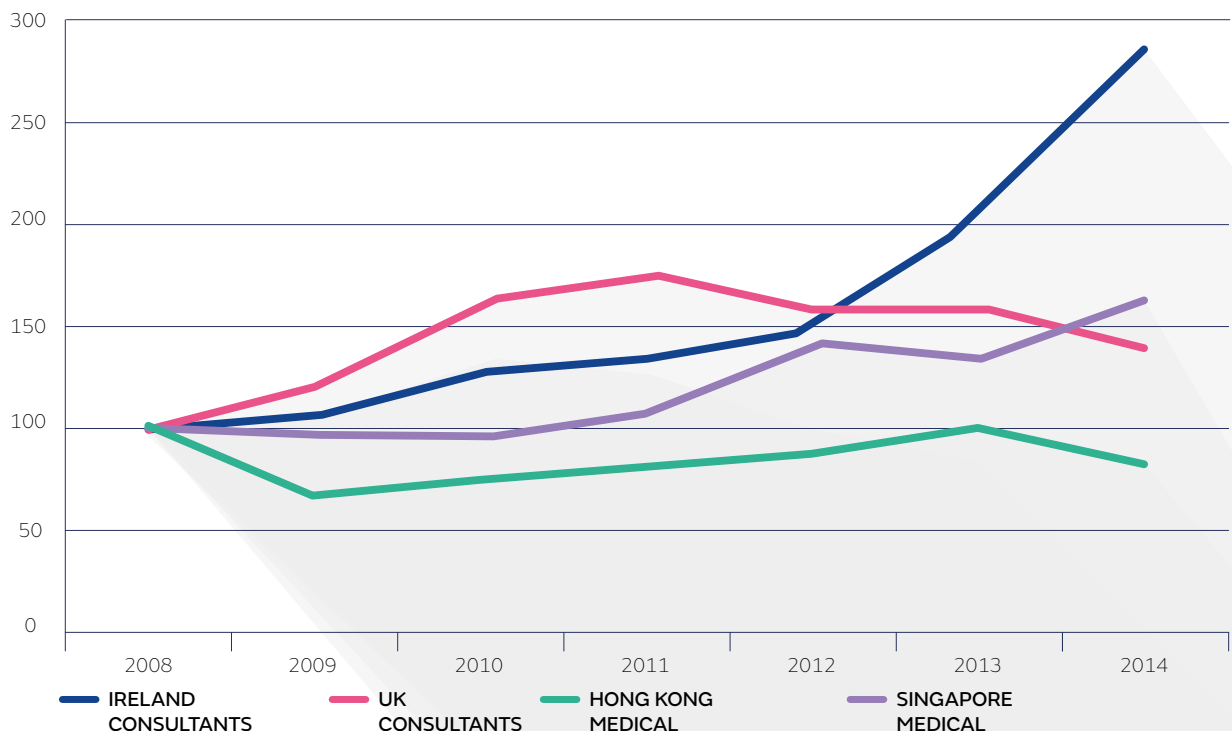
For healthcare professionals, a system that does not discourage unmeritorious claims means that they are at constant risk of needing to defend their actions and decisions through legal proceedings.

Added to this, without active judge-led case management, the civil justice system allows cases to drag on for many years. In our experience the courts are reluctant to

REFERENCES

- 4. Excludes liabilities relating to De Puy class action cases. This graph reflects changes in Average Estimated Actuarial Claims Cost per Member which are reflective of medicolegal experience in different countries where the mix of practice may be different.

MPS MEMBERSHIP; AVERAGE ESTIMATED ACTUARIAL CLAIMS COST PER MEMBER; (FREQUENCY AND SEVERITY) IRELAND VS OTHERS 2008-2014 WITH 2008 AS BASE YEAR



RELATIVE VALUES : 2008 = 100

strike-out cases even when the plaintiff's lawyers have failed to progress their client's claim. Expert evidence does not have to be served until very late in the proceedings, which means that defendants may not know the strength of the expert support for the plaintiff until after Notice of Trial is served.

Furthermore, our experience is that a small number of plaintiff lawyers may be prepared to run cases without strong expert support until the last moment in the hope that the defendant will make an offer to settle at the door of the court, to avoid the costs of trial. Neither the plaintiff nor the defendant benefits from this.

Challenges at each stage of the journey

1. Late notification of claims

It is not unusual to see late notification of claims. The Civil Liability and Courts Act 2004 reduced limitation in personal injuries claims from three years to two years from the date of incident to date of knowledge. Unfortunately, this has not had the expected impact of reducing the number of claims. This is possibly because potential litigants may be quick to consult lawyers. However, a more significant factor is that even after the issue of a personal injury summons there is no requirement to serve it for a period of a year (a claim form must be served within four months under the English Civil Procedure Rules), and it can be extended by a further period of six months. This effectively still gives plaintiffs at least three years to investigate their claim.

MPS often sees late notification of claims involving catastrophic injuries. One of MPS's highest current open Irish claims, was reported to MPS more than 20 years after the incident took place.

Late notification can mean that:

- Records may have been lost or destroyed; hospitals and other institutions are unable to provide records
- Medical staff may have retired, died or cannot be traced
- Medical staff may have little recollection of the facts of the case

Even when proceedings are issued the

litigation can fall into long periods of inaction; in our experience judges can be reluctant to strike-out cases. In one MPS case the notification of claim was made in 1995 and the proceedings were served in 1996; the claim was not listed for trial until 2013 when it finally settled. Despite many years of inactivity on the plaintiff's lawyers' part, the judge was reluctant to strike-out the case. This means that it can be many years before the healthcare professional knows if proceedings will go ahead against them, leaving them, and the plaintiff, in limbo.

Late notification of claims contributes towards both delay and higher costs. This is because the longer the delay between the incident and the claim the greater the opportunity there is for claims inflation to increase levels of damages. These increases can vastly exceed inflation rates experienced in other sectors of the economy. Again this is of great concern to MPS as it is funded on an occurrence basis and has to collect enough subscription income to fund these unpredictable awards into the future.

2. Little incentive to reach a resolution before proceedings issued

MPS acknowledges and strongly supports the considerable work that has been done by the Working Group on Medical Negligence and Periodic Payments, which was established in 2010 by the then President of the High Court, Mr Justice Quirke and subsequently chaired by Ms Justice Mary Irvine. Included in the reforms recommended by the Working Group's Report (March 2012) are pre-action protocols⁵. MPS would support the implementation of the groups' recommendation to introduce a pre-action protocol and anticipates seeing change soon.

However, there is currently no pre-action protocol included in the civil procedure rules. A pre-action protocol encourages openness and transparency, and provides the opportunity to investigate a claim and resolve it prior to issuing proceedings. A protocol will set out what information parties must provide to the other side, and in England and Wales there are financial penalties if parties do not attempt to resolve the case in this way before issuing proceedings.

REFERENCES

5. Report on the Working Group on Medical Negligence and Periodic Payments March 2012

There is no such arrangement in Ireland, which means there is little opportunity to resolve cases quickly without court proceedings, and before allowing legal costs to build up:

- There is no requirement for a detailed letter of claim prior to the issuing of proceedings. Such a letter would set out allegations and details of the alleged injury caused to the patient, which means that the defendant's lawyer is able to fully commence investigations. A typical letter of claim in Ireland (as required by S8 CLCA 2004) will state that the solicitor has been instructed to investigate a claim of negligence against a doctor and request that the doctor admit liability within 14 days, without providing details of relevant dates, allegations or injuries.
- There is limited exchange of information. Solicitors acting on behalf of the plaintiff are often slow to disclose clinical records at the pre-action stage. As a result there are limited means for the defendant to obtain the patient's clinical records, despite the obvious prejudice to the defendant, who is unable to investigate early and loses an opportunity to achieve a pre-proceedings settlement.

3. Commencement of proceedings – defendant at a disadvantage from the start

The current system can put the defendant at a significant disadvantage because there are no requirements on the plaintiff to disclose their clinical records early, even when proceedings are issued. The defendant is required to respond to the claim, and will be hampered without this information. Added to this, it is often necessary for defendants to incur the costs of a court application to gain access to this information, further increasing delay and costs. It also means that the defendant is left in a position where he/she is unable to make an early offer to reduce costs. Further concerns include:

- A Personal Injuries Summons is required to be served within 12 months of the date of issue (the date the court accepts the claim document). This will, in most cases, be the first time that the defendant's lawyers receive detailed information on the allegations of negligence.

The Summons should include the following:

- Detailed descriptions of the allegations of negligence
 - A full explanation of each instance of negligence
 - The injuries alleged
 - Full particulars of all items of special damage.
- The plaintiff then has 21 days from service of the

Summons to confirm that the information contained in the pleadings is truthful and accurate. During this time, the plaintiff is still not required to disclose his or her clinical records.

- The defendant is then required to deliver a defence within eight weeks of the Summons being served. This is prior to any requirement to disclose the clinical records. This means that a defence may have to be delivered prior to sight of the relevant records and in the absence of any expert evidence. This is prejudicial to the defendant's ability to assess the merits of the claim early.

4. Absence of judge-led case management

Given the lack of proactive case management by the court, there is little incentive for the plaintiff's lawyers to proceed expeditiously, which can lead to delays and thus increase costs:

- There are no directions hearings in order to ensure compliance with the court rules for the progression of the case.
- There may be significant delays in disclosing a complete set of clinical records until after the defence has been served.
- There is no requirement to exchange factual witness statements which encourages 'trial by ambush' as each party is unclear on the other side's factual position until he or she is giving evidence at the trial. This impacts on the investigation process and length of trial since the issues in dispute are not narrowed in advance of the trial.

5. No requirement for experts to meet

There is no court requirement for experts to meet. In England and Wales the experts' meeting is critical in allowing clarification and narrowing of the issues in dispute. This is beneficial for a number of reasons:

- Any concessions made in meetings by experts may lead the defendant to settle early or for the plaintiff to abandon the case
- Saves time and costs
- Saves the resources of the civil justice system
- It improves the quality of the evidence given in court.

6. Expert evidence is exchanged too late in the process

MPS has experienced many cases where expert evidence is exchanged too late. While the Rules state that the Plaintiff is obliged to serve their 'Schedule of Witnesses' and 'Witness Reports' within one month of the date of service of the 'Notice of Trial', to be followed by the defendant reciprocating within seven

days (and thereafter to exchange their witness reports within the following seven days), in the absence of case management the reality is that this deadline is rarely, if ever, adhered to.

The practice has effectively evolved where expert reports are exchanged well after the Notice of Trial is served, sometimes up to and during the trial itself. They can also effectively alter or add to the allegations previously made or injuries already pleaded. This may require additional reports to be taken up when there is extremely limited time available to the defendant to do so. This also means that defendants can only

really assess the strength of the plaintiff's expert support late in proceedings.

In a recent case pleaded at €1,000,000, the plaintiff was allowed to lodge five new expert reports two days before the commencement of the trial. This additional evidence was allowed by the trial judge despite it adding a new dimension to the claim and each report having been obtained by the plaintiff's lawyers three months earlier. MPS had previously obtained supportive expert evidence and planned to defend the claim to trial. The trial was postponed but MPS lawyers were unable to obtain supportive expert evidence to

THE JOURNEY OF A CLAIM – THE CHALLENGES



counter the new evidence and MPS had a no alternative but to settle the claim.

Earlier service of this evidence would have meant that MPS would have been able to settle the claim much sooner and have avoided the additional legal costs incurred as a result of this delay.

7. Lack of scrutiny of causation arguments

In order to establish negligence it is necessary for the plaintiff to prove that the practitioner has breached the duty of care, but also that this breach caused the patient an avoidable injury. The need to establish causation is often a challenge for plaintiffs, as the injury may be difficult to distinguish from an underlying disease for which they were seeking treatment in the first place, or where a plaintiff has suffered an injury during a procedure that cannot be explained by any breach of duty on the part of the doctor.

It is a concern to MPS that Irish courts sometimes appear reluctant to scrutinise causation arguments once breach of the duty of care is established.

8. Timings of lodgments/tenders into court

Procedural rules also limit opportunities for a defendant to make an early offer (lodgement/tender). This allows defendants the ability to make an early and without prejudice offer with cost consequences for the plaintiff should they unreasonably refuse within a set time period. In England and Wales, a costs protective offer can be made at any time but the Irish procedural rules only allow offers to be made within a restricted period of time.

An offer (lodgement/tender) can be made either at the time of delivery of defence or four months from the date of Notice of Trial. In Ireland lodgements can be made at other times and in certain circumstances require an application to court and the appearance of counsel. Obviously, this step increases costs for the defence.

Increased cost in the system

The challenges in the civil justice system

explored earlier in the section, which add cost and cause significant delays, compound the increasing size of damage levels and disproportionately high plaintiff costs.

1. Damages - special and general - are often high and unpredictable

General damages are disproportionately high in comparison to other countries. We estimate - when considering awards for relatively modest injuries – that based on awards set down in the Judicial College Guidelines⁶, general damages can be double those in England and Wales. In a recent case, general damages were ordered by a judge at €300,000 in circumstances where MPS was advised that damages should reasonably have been assessed at €150,000.

In our experience special damages claimed by plaintiffs have increased in recent years. A significant component of special damages relates to loss of earnings, yet these claims may include little by way of evidential support and, at worst, will be speculative. It also allows some plaintiffs – those who are high earners or are able to persuade a judge that they may have been - to win much larger awards than others.

Damages awards can be inconsistent. General damages are set by judges, in principle by reference to case authority. The judge rightly has discretion to set the level of damages and of course will be influenced by the plaintiff's own circumstances. However, as a minority of cases are decided by judges there is little up to date case law on quantum and, as a result, there is a large degree of unpredictability for general damage awards.

An example is a recent case involving a facial scarring, where the UK's Judicial Studies Board 2012⁷ would indicate an award on the basis of an injury of "less significant scarring" at between €3,505-€12,665.⁸ There is no case law or written guidance on what a court might consider to be reasonable in such a case and MPS was advised that a reserve of €60,000 was appropriate, many times the reserve for a similar claim in the UK.

Defendant lawyers are wary of allowing damage awards to be assessed by a

IN ORDER TO ESTABLISH NEGLIGENCE IT IS NECESSARY FOR THE PLAINTIFF TO PROVE THAT THE PRACTITIONER HAS BREACHED THE DUTY OF CARE, BUT ALSO THAT THIS BREACH CAUSED THE PATIENT AN AVOIDABLE INJURY.

REFERENCES

6. Guidelines for the Assessment of General Damages in Personal Injury Cases, Judicial College, formally the Judicial Studies Board (JSB)
7. Guidelines for the Assessment of General Damages in Personal Injury Cases, Judicial Studies Board 2012
8. Correct at date

judge, preferring to negotiate settlements. However, negotiations can be protracted as it can be difficult to pitch a reasonable offer, given the lack of case law, and because the plaintiff may have high expectations of the compensation they think they will receive. In our experience, some plaintiff lawyers can take a very broad-brush approach to valuing the case, often being unwilling to approach valuation of the case on a forensic basis, which again can make negotiations challenging.

As a result of the adverse environment for defendants, the huge cost consequences of a trial, compounded by the lack of a speedy and transparent procedural system, there is significant pressure on defendants to settle in circumstances where they would not do so elsewhere in the world.

Added to this, doctors and dentists are often reluctant to fight cases in court because of the high level of media attention clinical negligence cases attract in Ireland.

2. Plaintiff costs are disproportionately high

Plaintiff costs are exceptionally high. Few law firms charge with reference to hourly rates for work undertaken. This means there is little transparency on bills offered as part of the settlement of a claim; plaintiffs' lawyers seek payment of a lump sum "professional fee" to reflect the work undertaken. It is usually necessary for us to commission the services of an expert costs draftsman who will scrutinise the bill and provide advice as to whether the plaintiff lawyer's fees are reasonable, and who will then negotiate the bill with the plaintiff's lawyer. It is not unusual for the bill to be reduced by 20-30% following negotiation; however, the cost of this service also adds to the overall cost.

The only other recourse for the defendant will be to take the case to the Taxing Master; however, the 8% levy charged for this service means that it is only worth doing this in very high value cases. This deterrent to proceeding to tax bills was acknowledged by Taxing Master Declan O'Neill in his judgment assessing the legal costs of the plaintiff in *Isabelle Sheehan -v- David Corr*, November 2012⁹, when professional fees were drastically reduced.

The Legal Services Regulation Bill 2011 aims to reduce exceptionally high legal fees. This Bill creates a Legal Costs Adjudicator (LCA). The aim is that the LCA will determine a fair and reasonable charge for work undertaken by solicitors. This Bill also requires that solicitors will have to provide their clients with a clear statement of the legal costs they expect to charge. If this is likely to change as the case progresses, they have to inform their clients. Solicitors will also have

to produce a detailed Bill at the end of the case, which outlines how the costs were incurred.

Whilst we very much welcome these upcoming changes, there appears to be scepticism in the legal community that it will produce the desired results. We are therefore reliant on the taxing masters continuing to probe the costs and set guidelines, as in the *Sheehan* decision.

Another significant driver for high costs is barristers' fees, which are exceptionally high in Ireland. In our experience, plaintiff solicitors are very reliant on the services of barristers; in particular they are often reluctant to even negotiate settlements without a senior counsel input, again driving up the cost of claims.

A senior barrister's brief fee for a short trial in Ireland can easily be set at €30,000, which is twice the figure we would pay to a Queen's Counsel in England. The high fees are further distorted by the attempts by some plaintiffs' lawyers to argue that junior counsel should receive 50% of the fee of senior counsel, regardless of work undertaken. Again, the judgment of Taxing Master O'Neill in *Sheehan -v- David Corr*¹⁰ is a clear indication that this custom is not accepted as valid (although the costs of junior counsel were allowed at one half of the fee of senior counsel). MPS has for some time declined to pay fees on this basis but it is illustrative of the high cost regime.

Conclusion

At the beginning of the chapter we outlined the ideal journey of a claim. However, as this section explored, what we have is a civil justice system for clinical negligence undermined by delays, a lack of transparency and unnecessary costs. Defendants can be unfairly disadvantaged and feel under pressure to settle claims. Damages awards and plaintiff costs are disproportionate and the frequency of claims is increasing.

This has contributed to a necessary and unavoidable increase in MPS subscription rates for some specialities, which risks threatening the sustainability of some areas of private practice. The repercussions this could have on access to, and quality of, healthcare provision has the potential to be significant.

Furthermore, the current lack of an effective pre-action protocol and efficient civil litigation system can mean that plaintiffs with meritorious claims may have to wait many years before receiving fair compensation.

REFERENCES

9. *Sheehan -v- David Corr*, November 2012 (An infant, suing by her mother and next friend, Catherine Sheehan)

10. *ibid*

RECOMMENDATIONS

Whilst the deterioration in the claims experience against private hospital consultant members we have seen over the last two years may not continue at such a pace, the experience to date merits deep consideration of tort and procedural reform.

For some specialties, the claims experience (and therefore the cost of protection) risks threatening the sustainability of some areas of private practice. If this causes a shift in the workload to the public sector, it could increase pressure on public services. Added to which there is a risk that specialised private provision could be lost and some people's healthcare needs may not be met as a result.

While procedural changes are required – such as the urgent introduction of a pre-action protocol – we believe that appropriate and wide ranging tort reform could begin to tackle the increase in both the frequency and the severity of claims, and rebalance the economic fairness between claimants and defendants.

We recognise that these recommendations are not exhaustive. However, we have aimed to be bold in order to initiate debate and create momentum for change. We argue in this section for a Bill that defines the tort of clinical negligence and introduces a tariff of general damages. We also make recommendations to help ensure only cases with merit are pursued.

The recommendations below are drawn from the experiences of Australia and the US – as detailed in the annexes – and aim to streamline the clinical negligence claims process, improve the claims environment and save both healthcare professionals and the public purse money. We noted earlier the positive impact similar reforms had on subscription rates for professional protection in Australia.

The following section also considers procedural reform, which seeks to make the civil justice system more efficient.

Ultimately, we believe that this package of reform could benefit both defendants and plaintiffs.

1. GENERAL DAMAGES

- MPS recommends that a tariff of general damages is created in statute
- MPS recommends a limit on general damages.

2. SPECIAL DAMAGES

- MPS recommends a limit on future earnings and that future financial losses are limited to proven earnings
- MPS recommends a limit on future care costs

3. FREQUENCY OF CLAIMS

- MPS recommends a 'Certificate of Merit' be introduced
- MPS recommends a cap on lawyers' fees in smaller value cases to introduce proportionality

4. DEFINITION OF CLINICAL NEGLIGENCE

- MPS recommends that government introduces a Bill that defines the tort of clinical negligence and confirms that a tort is established by both breach of duty and that breach must have caused the injury. It would also assert that the burden of proof is placed on the plaintiff

5. LENGTH OF LIMITATION PERIODS

- MPS recommends full implementation of the recommendation of the 2011 Law Reform Commission review on limitation
- MPS recommends an ultimate limitation period of ten years

1. GENERAL DAMAGES

- MPS recommends that a tariff of general damages is created in statute
- MPS recommends a limit on general damages.

As explored earlier, awards for general damages¹¹ are often much higher than in England and Wales. An illustration of this would be a recent MPS case where we were advised that the general damages for unsatisfactory plastic surgery would be likely to be assessed by a court at €200,000, whereas the Judicial College Guidelines¹² suggests that an appropriate award for a similar injury in England would be between €50,800 and €101,460¹³.

There is a large degree of unpredictability about the size of the award and this makes it difficult to settle cases quickly. It also increases the chances of over-settlement, which in the long-term drives up costs. It is not just the exceptionally high awards in catastrophic cases where this is a concern, but also the increasing number of cases that should attract a more modest award and the cumulative impact of these.

MPS recommends that a tariff of general damages is created in statute

To achieve greater predictability, MPS recommends the introduction of a Bill that allows for the creation of a tariff of general damages. This tariff, which could be created in a similar way to the England and Wales Judicial College Guidelines, would provide a range of damages for an extensive list of specific injuries, from catastrophic brain injuries to dental damage.

This guide must be created in statute to ensure that it is referenced by the judiciary. The Injuries Board published a Book of Quantum in 2004¹⁴. This aimed to provide a quick reference guide for personal injury claims settled by the Injuries Board. It has not been updated and are not referenced by judges in their assessment of damages.

The new guide should include contributions

from specialist lawyers and judges. This group would collate levels of damages and set tariffs on injury types. The damages range should be reviewed annually to take into account reported decisions and inflation.

As detailed in Annex A and B, some Australian states operate systems that reflect this principle. In Queensland injuries are assessed on a '100 point scale' and reference similar injuries in earlier cases.¹⁵ In South Australia damages are calculated by reference to a scale value reflecting gradations of non-economic loss.¹⁶

MPS recommends a limit on general damages

The annexes explore the wide use of these limits in both the US and Australia. Research suggests such limits contributed to a reduction in the number of claims, the value of awards and insurance costs.

Further consideration is needed as to the level of such a limit. If we were to draw comparison with the often used \$250,000 limit in the US, we would be looking at a limit of around €187,237.¹⁷ In Queensland and Victoria, they have a limit based on three times the average weekly earnings.¹⁸ This is another possibility to explore.

Government should bring together an independent group of specialists, similar to that suggested to develop the tariff on general damages, to decide on the level of the limit. This group would also decide whether there needs to be an inflationary uplift on this limit.

Thought must be given as to how to ensure that lawyers and judges approach the limit on damages in the spirit with which it was introduced as it has been suggested might not always have been the case in Australia¹⁹. Only if this is thoroughly considered will these limits be successful.

REFERENCES

11. Damages for the bodily or psychological injury referred to as non-economic damages elsewhere
12. Guidelines for the Assessment of General Damages in Personal Injury Cases, Judicial College, formally the Judicial Studies Board (JSB)
13. Correct at date
14. Book of Quantum, Personal Injuries Assessment Board, June 2004
15. A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006
16. *ibid*
17. Correct at date
18. A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006
19. Annex A, International experience, A review of tort law reform | Australia as at September 2014

2. SPECIAL DAMAGES

- MPS recommends a limit on future earnings and that future financial losses are limited to proven earnings
- MPS recommends a limit on future care costs

In our experience special damages²⁰ claimed by plaintiffs have increased in recent years. MPS will be robust in investigating special damages claims, although to do so may involve delay and additional costs, for example, necessitating the instruction of forensic accounting experts.

Some Australian states placed limits on loss of earning capacity. Mark Doepel notes in annex A that the cap is typically at a multiple of two or three times average weekly earnings. Tasmania puts a limit on loss of earning capacity at 4.25 times the adult average weekly earnings.²¹

A significant component of awards relates to loss of earnings but these claims may have little by way of evidential support and, at worst, may be speculative - based on property investments and planned, but unexecuted, business ventures.

There is a significant issue of fairness here. As identified earlier, the costs associated with an expensive and inefficient clinical negligence system are felt by society in a number of ways. Yet some plaintiffs receive significantly higher special damages awards than others - a cost that society then bears - purely because they are very high earners, or because they are able to persuade a judge that they might have been a high earner in the future.

MPS recommends a limit on future earnings and earning capacity and that future financial losses are limited to proven earnings

In line with the Australian approach detailed in annex A, we believe there should be a limit on future earnings and earning capacity as an important tool

for lowering costs in the system, and to introduce greater parity in the size of awards plaintiffs receive.

Evidential support for claims should be required such as wage slips and tax returns.

MPS recommends a limit on future care costs

MPS has begun to see UK based experts providing care reports for Irish plaintiffs based on their knowledge of UK care regimes. This may be contributing to an increase in annual care awards. In a recent case, a care expert advised a care regime at €210k rising to €250k²² per annum in circumstances where our own expert advised a care regime at around €100k per annum, based on her knowledge of home-based care in Ireland.

While it is crucial that plaintiffs receive an award that provides them with the care they need there can be enormous differential between costings proposed by care experts for the plaintiff and the defendant.

We have very little knowledge of how plaintiffs choose to arrange for their care once they have received compensation. For example, an award may be based on qualified nursing care but the plaintiff may opt to employ unqualified carers at lower cost or employ two carers instead of three. Whilst it is right that plaintiffs should be free to utilise their awards in any way which best meets their needs, there is unfairness if in fact they are over compensated. A limit on future care costs, based on the realities of providing home based care in Ireland, could ensure that patients receive the care they need without upward escalation of care costs.

Such a limit could be based on HSE pay scales to ensure they accurately reflect the true cost of care in Ireland. These limits would need to be regularly reviewed to take into account pay rises and inflation. Further consideration will be required as to what this limit could be.

REFERENCES

20. Incurred financial losses as a result of the incident

21. A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006

22. Correct at date

3. FREQUENCY OF CLAIMS

- MPS recommends a 'Certificate of Merit' be introduced
- MPS recommends a cap on lawyers' fees in smaller value cases to introduce proportionality

The bulk of smaller claims contribute to the deteriorating claims environment alongside the disproportionately large ones. Earlier, some of the complex reasons why the frequency of claims is increasing were explored.

Many US and Australian States have introduced versions of a Certificate of Merit to tackle small, frivolous claims. However, while Mark Doepel (annex A) states that this is a useful tool, defendant lawyers need to make full use of it to ensure it has significant impact²³. Some Australian States coupled this with the introduction of minimum thresholds for general awards, and caps on lawyers' fees, making smaller cases less lucrative. For example, in New South Wales, there can be no general damages for injury below 15% of 'a most extreme case'.²⁴

MPS recommends a 'Certificate of Merit' be introduced

To ensure lawyers have an interest in only bringing forward meritorious cases, a Certificate of Merit, along with to tough financial penalties for contravention of the rule, should be introduced.

Learning lessons from both Australia and the US²⁵, we recommend that this Certificate of Merit requires a commitment from the solicitor that the case has merit, and is supported by independent expert opinion to affirm that he or she believes there has been a breach in the duty of care and that this breach caused the injury.

MPS recommends a cap on lawyers' fees in smaller value cases to introduce proportionality

Plaintiff costs can be exceptionally high. As described in section two, there can be

THE LAW REFORM COMMISSION CONCLUDED IN ITS 2011 REPORT ON THE LIMITATION OF ACTIONS THAT TIGHTER, CORE LIMITATION PERIODS COULD HAVE THE EFFECT OF REDUCING THE COST OF INSURANCE

limited ability to scrutinise plaintiff costs.

A method to cut legal costs, and potentially reduce the number of small unmeritorious value claims, would be the introduction of a cap on lawyers' costs for smaller value cases. Costs in smaller value cases - where costs can be easily disproportionate to compensation - could be capped at 20% of the value of the claim.

Some Australian States have placed a cap on lawyers' fees.²⁶ New South Wales caps fees dependent on the size of the award, Queensland limits fees when the award is below \$30,000, and then again between \$30,000 and \$50,000, the Northern Territory caps are dependent on award of damages in relation to the final offer with a sliding scale and in Australian Capital Territory (ACT), where if the award is less than \$50,000 the lawyer can be paid no more than 20%.²⁷

REFERENCES

23. Also in A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006

24..ibid

25. Annex A, International experience, A review of tort law reform I Australia as at September 2014

26. A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006

27. Explored in annexes A-C

4. DEFINITION OF CLINICAL NEGLIGENCE

- MPS recommends that government introduces a Bill that defines the tort of Clinical Negligence and confirms that a tort is established by both breach of duty and that breach must have caused the injury. It would also assert that the burden of proof is placed on the plaintiff

In Australia, the 2002 report 'Review of the Law of Negligence: final report'²⁸ known as the 'Ipp Report', recommended extensive reform of tort in Australia. One chapter explored the issue of causation and recommended a legal definition of tort, which confirms on what grounds a tort is established and also places the burden of proof on the plaintiff. While these recommendations were not pursued at a federal level, a number of states implemented this recommendation.

MPS recommends that government introduces a Bill that defines the tort of professional negligence and confirms that a tort is established by both breach of duty and that breach must have caused the injury. It would also assert that the burden of proof is placed on the plaintiff

Causation is the essential second limb of tort of clinical negligence. Some plaintiff lawyers may continue to pursue cases in the knowledge that the causation argument is weak.

A legal definition, where this is expressly acknowledged, will ensure that defendants could be confident they would receive a fair trial and clarify for plaintiffs what factors they need evidence of before making a claim.

5. LENGTH OF LIMITATION PERIODS

- MPS recommends full implementation of the recommendation of the 2011 Law Reform Commission review on limitation
- MPS recommends an ultimate limitation period of ten years

The Civil Liability and Courts Act 2004 reduced the limitation period in personal injuries claims from three years to two years from the date of incident to date of knowledge. Disappointingly, this has not had the expected impact of reducing the frequency of claims.

MPS often sees late notification of claims involving catastrophic injuries. Late notification means that doctors are less likely to have a recollection of events and/or that records may be missing.

The Law Reform Commission concluded in its 2011 Report on the Limitation of Actions²⁹ that tighter, core limitation periods could have the effect of reducing the cost of insurance. Reform here could limit the adverse effects on the cost of professional protection. It recognised that there is a balance between the rights of plaintiffs and defendants, but also noted that there was public interest in ensuring that claims are not delayed.

MPS recommends full implementation of the recommendation of the 2011 Law Reform Commission review on the Limitation of Actions

REFERENCES

28. Review of the Law of Negligence: final report, 2002, Ipp, Cane, Sheldon and Mactintosh
29. Limitation of Actions; Report, Law Reform Commission December 2011

The Commission made 26 recommendations, which have the ultimate aim of streamlining the law and providing greater clarity. The most pertinent are:

- (5.06) There should be a basic limitation period of two years, which would apply to the common law actions defined in the report. This commences from the date of knowledge of the plaintiff.
- (5.08) Determining a person's knowledge under the 'date of knowledge test' for the commencement of the basic limitation period should include both actual and constructive knowledge.
- (5.09) Constructive knowledge should be defined as the knowledge that a person might reasonably have been expected to acquire from facts observable or ascertainable by him or her or from facts ascertainable by him or her with the help of professional expert advice.
- (5.14, 5.15 and 5.16) There should be an ultimate limitation period of 15 years which should run from the date of the act or omission giving rise to the cause of action.
- (5.23) In respect of a person who was under the age of 18 and who was in the custody of a parent or guardian, the parent or guardian should be presumed competent and presumed to be conscious of his or her responsibilities, and therefore capable of commencing proceedings on behalf of such a potential plaintiff.³⁰

This legislation should be implemented as a priority.

MPS recommends an ultimate limitation period of ten years

An ultimate limitation period is the cut-off point for all legal proceedings commencing after the date of the act or omission. These limits provide certainty and fairness, and can limit adverse effects on the cost of professional protection.

The Law Reform Commission recommended an ultimate limitation period of 15 years, but MPS does not think that this goes far enough. There are huge challenges in defending claims many years after the alleged incident. Defendants may not have access to evidence relating to the case or may not be able to recall the circumstances.

In Australia, some States operate a long-stop period. This is 12 years in South Australia, Western Australia and New South Wales. Mark Doepel argues in annex a that these limitations mean that doctors can be reasonably confident that when treating a person aged 18 or more, that when 12 years have passed, there will be no further risk of a claim being made as a result of that treatment.³¹

MPS WILL CONTINUE TO OFFER ITS MEMBERS HIGH QUALITY AND TAILORED EDUCATION PROGRAMMES SUCH AS THE HUGELY SUCCESSFUL MATERCLASS WORKSHOPS

REFERENCES

30. Limitation of Actions; Report, Law Reform Commission December 2011
31. A Comprehensive Guide to Tort Law Reform throughout Australia, Mark Doepel and Chad Downie, Kennedys, 2006

ALTERNATIVES TO TORT REFORM

A revised and improved tort system is the most cost effective system for clinical negligence claims. More importantly, in the absence of proper systems of accountability, tort law often provides patients with the explanations and answers that they are seeking, above financial compensation, which alternative systems may not.

Two alternative systems for pursuing clinical negligence claims have been put forward, but our concern is that neither may be effective. The first is to extend the remit of the Injuries Board to include clinical negligence claims. These are currently specifically excluded. The second is the introduction of a 'no fault compensation' system.

1. The Injuries Board

In recent years there has been consideration of the possibility of extending the remit of the Injuries Board, to cover clinical negligence claims as a way of reducing the costs of these claims and the current delays in the system. However, we believe this is unlikely to offer a faster or more cost effective way of improving the claims experience for patients or the healthcare profession.

The claims that the Injuries Board currently handles are relatively uncomplicated personal injury claims, many of which will have previously been notified to insurers and where liability is unlikely to be in dispute. Clinical negligence claims are less straight forward. We understand that the Injuries Board expects a defending insurance company to respond to a claim within 90 days of notification. This would be very unlikely to happen in a clinical negligence case for the following reasons:

- In clinical negligence cases complete sets of medical records are required, often being held by doctors or hospitals who are not the subject of the claim. Full disclosure of notes can take months.
- Issues of liability can be complicated
- Almost without exception cases will require expert evidence in order to establish breach of duty
- Even where breach of duty is established, causation of injuries is required to be proven.

Added to the practical difficulties, there is also a concern that extending the Injuries Board's remit in this way would lead to an unmanageable flood of cases that would otherwise never be notified to defence organisations or the SCA.

This is because the bar to lodge a claim with the Injuries Board is so low, it can be expected that many more plaintiffs will lodge cases which they would not pursue if they had to engage with a solicitor directly.

While MPS fully supports the need for patients to have access to advice and compensation where appropriate, this change would open the way to a surge of unmeritorious claims.

No fault compensation

MPS has closely followed debates around alternatives to the current clinical negligence compensation system. As an international organisation, MPS has experience of no fault schemes in other countries, particularly in New Zealand, which has operated a no fault system since 1972.

We understand the appeal of the no fault principle. Yet experience in other countries shows that no fault schemes do not incentivise improvements in patient safety, may result in lower compensation levels, and may impose significant costs on the taxpayer.

In 2011 the House of Parliament's Health Select Committee considered the costs and benefits of a no fault compensation system in the UK. They reported that:

'The Committee has heard in evidence that "no-fault" compensation schemes could increase the costs of settling claims against the NHS by between 20% and 80%. Furthermore, as claims would increase at a time when NHS resources are already under strain, the "pot" of compensation would be likely to be fixed, meaning that the amount payable to the most severely injured persons would be less than at present.

The evidence suggests that "no-fault" compensation schemes may increase the volume of cases seeking compensation from the NHS whilst reducing the compensation

available to those most in need. The Committee believes that the existing clinical negligence framework based on qualifying liability in tort offers patients the best opportunity possible for establishing the facts of their case, apportioning responsibility for errors, and being appropriately compensated³².'

While the criticisms raised are in relation to the NHS and the UK tort system, they are relevant to Ireland.

Bearing these issues in mind, further research into the complexities of no fault compensation is required.

REFERENCES

32. Health Select Committee – sixth report, complaints and litigation, 22 June 2011, available at <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/786/78610.htm#a18>

THE ROLE OF MPS

A PRE-ACTION PROTOCOL AND THE IMPORTANCE OF OPEN DISCLOSURE

MPS recognises the important role it too must play. In this paper we are committing to forge ahead with trialling procedural reform before it is introduced in statute. MPS will be writing to major law firms in Ireland that represent plaintiffs, to ask them to co-operate with us in trialling a pre-action protocol.

Section two of this paper explored some of the problems with the current system, which come about because there is currently no pre-action protocol. Such a protocol, along with other reform, may go some way to reducing the legal costs associated with clinical negligence claims.

It should also make the system more efficient for both plaintiffs and defendants.

Alongside pre-action protocols, we would also like to see the creation of a specialised High Court list comprising clinical negligence actions presided over by a High Court Judge, who will also handle case management - particularly for catastrophic and high value claims applications - and ensure compliance with the directions of the High Court.

We understand that there is widespread support for a pre-action protocol. However, without embedding it in regulations with effective cost penalties we can do little to persuade all plaintiff lawyers to adopt this approach. We hope to see such a protocol introduced soon.

Added to this above commitment, MPS will continue to offer its members high quality and tailored education programmes, such



as the hugely successful MasterClass workshops, clinical risk assessments and GP conferences. Between 2009 and 2014 MPS has facilitated clinical risk self-assessments for general practices, workshops such as medical records for primary care and mastering communication skills workshops. In addition we have delivered numerous lectures at major conferences and study days, most of which were provided free of charge to members. We have formed excellent relationships with partner organisations such as HSE and the Irish College of General practitioners and delivered numerous lectures at partnership events. The MPS philosophy is to work with members to reduce their risk.

MPS has a crucial role supporting and advising its members to embrace open disclosure. MPS has long supported and advised members to be open with patients when something has gone wrong, regardless of fault. Above all, MPS believes that it is the ethical thing to do. When organisations embrace open disclosure it benefits all involved. It results in safer doctors and greater levels of patient satisfaction.

MPS experience has seen many complaints arise from poor communication following an adverse outcome. Our advice to all members is to have full and open communication with the patient once sufficient facts have been established, as soon as possible. An explanation may be all that is needed to reassure a service user and avoid unnecessary escalation.

MPS developed the A.S.I.S.T framework model to help doctors undertake discussions with patients and their relatives following an adverse outcome. We are pleased that the model has been incorporated into the HSE Open Disclosure guidelines³³.

REFERENCES

33. Open Disclosure; national Guidelines; communicating with service users and their families following adverse events in healthcare, HSE, SCA, October 2013

CONCLUSIONS

There is no room for complacency. The recommendations made in this paper are not exhaustive. However, they aim to initiate debate about the need for change and the benefits of this to healthcare professionals and society.

MPS is concerned that if some healthcare professionals find the cost of practising in the private sector in Ireland unsustainable, more doctors may consider working abroad. The impact this may have on Irish society is likely to be damaging.

If services are not offered in the private sector they will inevitably be sought in the public sector, where liability for any claims for clinical negligence would lie with the SCA in their entirety, impacting on the public purse.

MPS has considered the experience of other countries and how we can learn from these to help us develop a better, fairer system in Ireland. While the experience of tort reform in Australia and the US has been mixed, there have been many advances.

We believe, based on our research in this paper, and our experience in Ireland and other jurisdictions, that if the recommendations in this paper are

implemented appropriately, they will make a difference to the frequency and severity claims, and ultimately the amount professionals will have to pay for their professional protection. Even more importantly, it will make the system quicker, fairer and more efficient for defendants, plaintiffs and their patients and benefits the public purse.

As a priority, government must introduce a new Bill that provides a clear definition of tort of clinical negligence. There are simple steps government can take such as, the full implementation of the Law Reform Commission's proposals on limitation.

Finally, while we are willing and able to play an important role trialling procedural reform, the support of the government is essential to make it happen.

ANNEX A

INTERNATIONAL EXPERIENCE – AUSTRALIA

A REVIEW OF TORT LAW REFORM IN AUSTRALIA AS AT SEPTEMBER 2014 BY MARK DOEPEL, PARTNER, SPARKE HELMORE AND TUTOR AT THE UNIVERSITY OF SYDNEY

Introduction

Australian tort law reform commenced in the early 2000s against the international backdrop known as the “liability crisis”. By 2002, the Chief Justice of New South Wales (NSW) was describing the law of negligence in Australia as “...the last outpost of the welfare state”³⁴.

The impetus for reform began in the health care sector. In 1999/2000, many Australian medical defence organisations were obliged to ask members to pay significantly more for their indemnity. The exponential rise in premiums – particularly for obstetricians – began to reduce the availability of some types of medical services.

Eventually, calls for reform percolated out to the broader community as liability insurance became less affordable and harder to obtain, particularly following the collapse of the HIH insurance group in March 2001. That group had been writing high volumes of liability insurance in return for unsustainable premiums and provided reinsurance to some Australian medical defence organisations. Many charities and community organisations could not obtain affordable liability insurance anywhere and began to cancel or curtail their public activities.

The Australian Federal Government established the Ipp Committee to examine possible reforms to tort law. The Committee released its two reports in August and September 2002, outlining 61 reform recommendations, chief amongst which was that all Australian jurisdictions should take a consistent approach to tort reform.

However, by November 2002 it was apparent that the Australian States and Territories would not be able to agree on

a nationally consistent framework for tort law reforms. And so the governments of the eight Australian States and Territories each launched – separately – into tort law reform. This paper will examine those reforms and, almost a decade and a half on, look at how effective they have been, particularly with reference to the medical profession.

The general Australian reforms

The table in (Annex b) summarises the main Ipp Committee recommendations, with the exception of those relating specifically to medical negligence (considered later), and the various Australian legislative implementations of tort reform³⁵. Notably, the reforms enacted included some areas that were not amongst the recommendations in the Ipp Report:

- A. Apologies and expressions of regret. An apology does not now amount to an admission of (and may not be called as evidence of) liability or fault;
- B. Proportionate liability, which is now applicable in claims for property damage and economic loss, but not in claims for bodily / personal injury which were the sole concern of the Ipp Committee; and
- C. Procedural changes, particularly in relation to:
 - Personal injury claims. In Queensland, the Australian Capital Territory and the Northern Territory, the parties must now explore the possible resolution of claims before commencing litigation or face possible costs penalties. The Ipp Report recommended that advance notice of claims should be required before litigation but did not take procedural issues any further than that; and
 - Requirements for solicitors, when commencing any proceedings claiming damages, or any defence, to certify that, based on the information available at the time, there is a proper basis for the claim or defence. Solicitors who file such a certificate without proper basis may be required to pay the costs of the proceedings personally, without passing those

REFERENCES

34. *Reynolds v. Katoomba RSL All Services Club Ltd* (2001) 53 NSWLR 43 at [26]
35. Table A sets out the current state of the law in each jurisdiction. However, the reforms were not all introduced simultaneously so some have been in force in some relevant jurisdictions longer than others

costs onto their clients.

The main benefits that general tort reform was intended to bring to the medical profession lay in:

- A. Its efforts to clarify how questions of causation of loss should be approached, against a common law background where defendants were increasingly being found liable for very remote consequences of their own negligence. However, it remains to be seen whether the legislation has in fact clarified this difficult legal area;
- B. Reductions in limitation periods applicable to personal injury claims, so that the limitation period expires on the earliest of the following two dates (with exceptions for minors and those under other legal disabilities):
 - Three years from the “discovery date”, being a date 3 years after the plaintiff knew, or should have known, that:
 - death or personal injury had occurred;
 - it was caused by the defendant’s fault; and
 - it was sufficiently serious to warrant bringing proceedings for damages; or
 - 12 years after the date of the act or omission occurred.

All but one of the Australian jurisdictions adopted these recommendations, although most did so in a modified form. As a result, Australian medical practitioners (with the exception of those in the Northern Territory) can be reasonably confident when treating a person aged 18 or more, that when 12 years have passed, there will be no further risk of a claim being made as a result of that treatment. The reforms also mean that most claims will be brought at a time when the defendant still has his or her records about the treatment and may still have a reasonable recollection of the relevant events;

- C. The capping of legal fees, providing a disincentive for lawyers to get involved in claims involving only minor injuries and an incentive for lawyers who do get involved to reach a prompt settlement,

thus reducing both settlement and legal costs for defendants;

- D. The protection given to rescuers and “good Samaritans”;
- E. A reduction in higher-end awards of damages, mainly because:
 - Awards for loss of earnings and earning capacity are capped (typically, at a multiple of two or three times average weekly earnings) so that awards for high-earning plaintiffs are reduced by way of a formula that is not susceptible to judicial manipulation;
 - Awards of future damages (loss of earnings and / or medical care) are subject to a higher discount rate (5%) than the Ipp Committee recommended (3%). Although that will do much to curtail the large-end verdicts, it has given rise to criticisms that the higher discount rates adopted uniformly across Australia severely undermine the compensation paid to seriously injured plaintiffs. A push by plaintiff lawyer associations to reduce the discount rate is likely; and
 - Structured settlements are available to seriously injured plaintiffs requiring long-term care.

Australian reforms directed specifically at medical indemnity including insurance arrangements

The responses of each of the Australian jurisdictions³⁶ to the Ipp recommendations about professional indemnity issues were slower than those relating to the general law of negligence. Most of the States and Territories began by introducing professional standards legislation that allowed members of specific occupational and professional groups to cap the civil liability of their groups’ members, but those reforms did not apply to claims for personal injury damages and were not applicable to the medical profession.

In November 2003 concerns were raised in the New South Wales Parliament that medical professionals were resorting to “defensive medicine” because they feared the legal consequences of making errors. That is, they were either performing unnecessary services to assure patients

REFERENCES

- 36. Although the reforms were enshrined in a number of enactments in each jurisdiction, the main Act(s) which comprised those reforms were: in the Australian Capital Territory, the Civil Law (Wrongs) Act 2002; in New South Wales, the Civil Liability Act 2002; in the Northern Territory, the Personal Injuries (Civil Claims) Act 2003 and the Personal Injuries (Civil Claims) Act 2003; in Queensland, the Personal Injuries Proceedings Act 2002 and the Civil Liability Act 2003; in Victoria, amendments to the Wrongs Act 1953; and in Western Australia, the Civil Liability Act 2002

that they had considered everything, or they were avoiding treating high-risk patients.

The main Australian tort reforms directed specifically at the medical profession were:

- A. The *Bolam* principle was returned to the law in most jurisdictions³⁷, meaning that medical practitioners themselves, not the Courts, determine the appropriate standard of care, although the Courts can disregard medical opinion if it considers it to be irrational. However, the Northern Territory has not adopted this recommendation;
- B. The duty to inform patients of matters relevant to their decision to undergo treatment, including warnings, was reformed to some extent. However, there is little consistency between the various jurisdictions:
 - In New South Wales, Victoria, South Australia and Western Australia, the *Bolam* principle does not extend to failure to provide information / warn;
 - In Queensland patients must be informed about risks associated with medical treatment if:
 - a reasonable person would require it to make an informed decision about the treatment; and / or
 - the doctor knows or should know that he or she expects the advice to be given; and
 - In Tasmania, medical practitioners are protected if they need to act promptly to avoid serious risk to a patient's life or health;
- C. Public health authorities now have immunity from suit for matters arising from the exercise of their "special statutory powers" unless they are exercised so perversely as to miscarry. Whilst the term "special statutory powers" is undefined in this context, the immunity would almost certainly apply to situations like a decision to detain (or not to detain) a person under mental health legislation; and
- D. New South Wales and Victoria legislated to preclude the recovery, in actions for wrongful birth, of damages to compensate the plaintiff for the cost of raising the child and/or income lost

whilst so doing.

The Australian experience since tort reform

The most obvious difficulty with the Australian reforms is the lack of any national consistency – and indeed, the substantial diversity - between them. Whilst most of the States and Territories have models that are at least superficially similar, the devil lies in the detail of their differences. Queensland, the Australian Capital Territory and the Northern Territory adopted a completely new procedural approach to personal injury claims. Entities with an interest in tort issues nationally, including liability insurers, must therefore modify their approach to the extent of their duty of care and to any alleged breaches thereof differently in different jurisdictions.

The reforms appear to have had an impact on the number of Court filings. However, the early statistics may have been skewed by reason of a rush by plaintiff lawyers to file proceedings in advance of law reform, meaning that filings were up immediately prior to reforms and down immediately after them. The Australian Competition and Consumer Commission publishes an annual report into its monitoring of public and professional liability insurance issues and reported an 11% decrease in the average size of claims between about December 2003 and June 2004. However, the ACC reported that the average size of professional indemnity claims increased by 21% in the same period, indicating that much more remained to be done to reform the law of professional negligence.

Some of the reforms do not appear to be working in the manner intended. In particular:

- A. General damages in most jurisdictions are subject to a cap at their upper end (see item 11 in Table A). Anecdotal evidence suggests that:
 - Some Judges approach the scale of general damages by determining what figure they wish to award and then assessing the injury as the corresponding percentage of the worst case, rather than approaching the question from the opposite direction; and

- Some plaintiff lawyers have become particularly innovative in their pleadings with a view to bypassing the cap. For instance:
 - There were efforts to plead cases under the Trade Practices Act 1974 (Cth), although the Federal Government curtailed that practice by making modifications to the Act to prevent it giving rise to civil actions for damages for personal injury; and
 - Some plaintiff lawyers have included nervous shock damages claims in cases that may previously have been conducted on the basis of pure physical injuries, with a view to increasing the plaintiff's percentage assessment;

- B. There is an apprehension that Judges will increase verdicts so as to avoid the cap on legal fees. Some defendant lawyers believe that it may be impossible to settle small claims for less than the applicable threshold without also agreeing to pay something towards legal fees, so that claims which should have been settled are proceeding to trial;
- C. Plaintiffs' solicitors may initially have been more careful about the allegations made within pleadings when certifying that they had a reasonable basis for those pleadings, but there have been relatively few cases in which solicitors have been found personally liable for costs as a result of an inappropriate certification, and those cases have received relatively little publicity³⁸. Even when a Judge does not believe a plaintiff's evidence about the basis for a case, it may be difficult for a defendant to satisfy the Judge that the plaintiff's solicitor should also have disbelieved it from the outset. The apparent return to imaginative pleadings referred to above suggests that the threat of personal costs orders is having relatively little impact.

Other of Commissioner Ipp's recommended reforms are not working, simply because they have not been adopted, or have been too substantially modified by those jurisdictions that did adopt them. For instance:

- A. Only one Australian jurisdiction introduced a threshold for non-economic loss awards in the way recommended;
- B. None of the jurisdictions capped non-economic loss awards at the number recommended; and
- C. The cap on legal fees in small claims was only introduced in half of the Australian jurisdictions. Each that did introduce it substantially modified the recommendation.

Looking more specifically at the medical indemnity field:

- A. One of the most important planks of the professional indemnity reforms related to the introduction of proportionate liability, so that a wrongdoer could only be found liable for a loss to which various wrongdoers contributed to the extent just and reasonable. However, those reforms did not apply to claims for personal injury and are of no assistance to medical practitioners who will still be jointly and severally liable for the whole of any loss to which they contribute, albeit with rights to claim contribution from other wrongdoers;
- B. There is some room for optimism in relation to the duty to inform / warn, following a 2013 decision by the High Court of Australia³⁹ which exonerated a neurosurgeon from any liability to a plaintiff who, in the primary Judge's findings, would have undergone surgery even if he had been warned of the relevant risk. That case reversed an alarming earlier trend in claims for failure to warn:
 - In 1992, the High Court found an ophthalmic surgeon responsible for the plaintiff's loss of vision in her left eye by reason of his failure to warn her of a remote risk (1 in 14,000) which in fact materialised⁴⁰, notwithstanding a body of professional evidence to the effect that no warning was necessary in the circumstances;
 - In 1996, the District Court of Western Australia found an orthopaedic surgeon responsible for the results

REFERENCES

- 37. Not in the Northern Territory and, in South Australia, in a modified form
- 38. For a rare example, see: *Lemoto v. Able Technical Pty Ltd* (2005) 63 NSWLR 300
- 39. *Wallace v. Kam* (2013) 297 alr 383
- 40. *Rogers v. Whitaker* (1992) 175 CLR 479; 109 ALR 625

of the plaintiff's surgery, because it found that the warnings understated the magnitude of the risk⁴¹; and

- In 2000, the High Court found a dental surgeon responsible for surgical complications despite recognising that it is difficult to accept a plaintiff's retrospective evidence that he or she would not have undergone the surgery if properly warned, when the problem which the surgery was designed to address was acute and the risk was remote⁴²; and

C. In 2013 the New South Wales Court of Appeal exonerated a radiologist from the consequences of failing to detect an aneurism during a 2003 scan. The aneurysm was detected 3 years later and ruptured during surgery to remove it. Had it been detected earlier, the surgical intervention required would have been substantially less risky. The radiologist was not liable because:

- The harm suffered was the result of the materialisation of an "inherent" risk (that is, the risk of intra-operative rupture), being one that could not be avoided by the exercise of reasonable care and skill (including the care and skill of those who later treated the plaintiff);
- The risk was unavoidable, even if the harm that manifested was not;
- The radiologist did not perform the surgery which led to the rupture and there was no good reason of public policy to extend his liability to cover the consequences of surgery performed by someone else. It was not the radiologist's role to avoid the risk created by the later surgery;
- Even though earlier surgery would have been less risky, it would not have been entirely without risks so that early diagnosis would not of itself have avoided the risk; and
- Duties in relation to diagnosis are not analogous to duties to inform / warn and should not be expanded by reference to notional decisions patients might have taken not to undergo proposed treatment.

However, it is alarming to note that a survey conducted in 2009, albeit on the basis of a relatively small sample size⁴³ concluded that many medical practitioners in New South Wales remained unaware of tort reforms some 7 years after they were enacted and continued to practice defensive medicine with a view to protecting themselves against litigation. Without better understanding of the reforms by the medical profession, they will not achieve their important aim of improving the standard of and access to medical care in Australia without compromising the interests of those responsible for providing it.

As we approach a benchmark of 15 years since the reforms began to be introduced, we see that a great deal of good legislative intent may have gone awry due

to the haste of the various Australian jurisdictions to introduce their own tort reforms, rather than waiting to explore the possibility of national consistency, due to discrepancies between the Ipp recommendations and the regimes introduced in each Australian State and Territory, and due to some liberal judicial interpretation of the reforms in lower courts. There can be no doubt that the reforms were of benefit to those who may be defendants in negligence actions, including professional negligence actions, but it is very difficult to conclude that they went far enough to address the imbalance which led to their enactment.

Other common law jurisdictions considering tort reform would do well to consider what we have learned in Australia:

- A. In any federated country, national consistency must not be sacrificed in a race to introduce reforms;
- B. Professional negligence – and particularly medical negligence – has its own issues which must be addressed in the framework of broader negligence law reform. Legislation should enshrine professionals' right to be assessed on the basis of accepted peer conduct at the relevant time and should extent that assessment to issues of failure to provide information / warn;
- C. Legislative reform must apply comprehensively to all statutes that may confer individual rights of action for personal damages to avoid imaginative pleadings by plaintiff lawyers;
- D. Similarly, although the availability of personal costs orders against plaintiff lawyers who falsely certify a case's prospects is a useful tool, defendants must make judicious but regular use of the tool if they want the reform to have any effect on the commencement of speculative or unmeritorious cases; and
- E. Whilst caps on damages for economic and non-economic loss and on the ability to recover legal costs in small claims is very helpful in restricting settlement costs for defendants, legislation should be drafted with an eye to avoiding the possible future benevolent interpretation of thresholds by sympathetic judges;

REFERENCES

41. *Roberts v. Hardcastle* [2002] WADC 149

42. *Rosenberg v. Percival* (201) 178 ALR 577

43. *Defensive medicine in general practice: Recent trends and the impact of the Civil Liability Act 2002 (NSW)*, Omar Salem and Christine Forster, (2009) 17 JLM 235.

ANNEX B

TABLE A

THE MAIN IPP RECOMMENDATIONS AND THE VARIOUS AUSTRALIAN MODELS

| Tort reform area | Australian responses | | | | | | | |
|--|----------------------|-----|----------|----------|---|----------|----|----------|
| | NSW | Qld | Vic | SA | WA | ACT | NT | Tas |
| <p>Duty and standard of care</p> <p>A person is not negligent for failing to take precautions against a foreseeable risk unless:</p> <ol style="list-style-type: none"> it is “not insignificant” and a reasonable person in the same position would have taken precautions, with regard to the probability and likely seriousness of the risk, the burden of taking precautions and the social utility of the risk-creating activity. | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| <p>Obvious risks</p> <p>A person is not liable for failure to warn of any risk that is obvious to a reasonable person, including matters that are patent or matters of common knowledge. A risk may be obvious even if it is of low probability.</p> | Yes | Yes | Modified | Modified | Modified | No | No | Modified |
| <p>Professionals</p> <p>The standard of care required of persons who hold themselves out as possessing a particular skill should be determined by reference to what could reasonably be expected of a person professing that skill as at the date of the alleged negligence, unless the Court considers that professional opinion as to those reasonable expectations is irrational.</p> | Yes | Yes | Yes | Yes | Modified (health care professionals only) | Modified | No | Yes |
| <p>Recreational Services</p> <p>There should be no liability for personal injury or death for the manifestation of an obvious risk.</p> | Yes | Yes | Modified | Modified | Yes | Modified | No | Modified |
| <p>Contributory negligence</p> <p>The test should be whether a reasonable person in the plaintiff’s position would have taken precautions against the risk of harm, having regard to what the plaintiff knew or reasonably knew taking into consideration the:</p> <ol style="list-style-type: none"> probability of harm seriousness of harm burden of taking precautions and social utility of the activity in question. <p>Courts should be entitled to reduce damages on account of contributory negligence by up to 100%</p> | Yes | Yes | Modified | Yes | Modified | Modified | No | Yes |

| Tort reform area | Australian responses | | | | | | | |
|---|----------------------|----------|----------|----------|----------|----------|----------|----------|
| | NSW | Qld | Vic | SA | WA | ACT | NT | Tas |
| Caps on non-economic loss awards Maximum award should be capped at \$250,000 (with ongoing indexation) | Modified | Modified | Modified | Modified | Modified | No | Modified | No |
| Loss of earning capacity Should be capped at twice the average full time adult ordinary earnings | Modified | Modified | Modified | Modified | Modified | Modified | Modified | Modified |
| Discount rate The discount rate for lump sum damages for future economic loss should be 3% | Modified | Modified | Modified | Modified | No | No | Modified | Modified |
| Interest on non-economic loss No interest should be recoverable on general damages and/or damages for gratuitous services | Yes | Modified | No | Yes | No | Yes | Modified | No |
| Exemplary and punitive damages Should be abolished for negligence claims | Yes | Modified | No | No | No | No | Yes | No |
| Gratuitous services threshold Damages should only be awarded if gratuitous attendant home care services were provided for more than six hours per week for more than 6 months, at an hourly rate linked to full time adult ordinary wages | Modified | Yes | Modified | Modified | Modified | No | Modified | Modified |
| Legal costs threshold No legal costs should be recoverable if damages are less than \$30,000 and should be capped to no more than \$2,500 for awards between \$30,000 and \$50,000 | Modified | Modified | No | No | No | Modified | Modified | No |
| Protection for rescuers, good Samaritans and not for profit organisations Rescuers / good Samaritans should not be liable for providing assistance in an emergency if exercising all reasonable care and skill. Not for profit organisations should not be liable for personal injury or death caused by negligence in the provision of emergency services. | Modified | Modified | Modified | Modified | Modified | Modified | Modified | Modified |

ANNEX C

INTERNATIONAL EXPERIENCE – UNITED STATES

During the most recent US medical liability crisis, the American Tort Reform Association⁴⁴ painted a picture of US states where there was no tort reform, which has some resonance with the current picture in Ireland:

‘In state civil justice systems that lack reasonable limits on liability, multi-million dollar jury awards and settlements in medical liability cases have forced many insurance companies to either leave the market or substantially raise costs. Increasingly, physicians in these states are choosing to stop practising medicine, abandon high-risk parts of their practices, or move their practices to other states.’⁴⁵

The debate about tort reform, both in relation to medical negligence and wider areas of tort law, grew rapidly in the mid-1980s and again in the early 2000s. Many US states have implemented tort reform in different ways. One of the main drivers has been the significant increase in insurance premiums as well as concerns about access to healthcare.

The American Medical Association (AMA), as well as many of the American medical colleges and other associations, is a supporter of tort reform for clinical negligence. AMA said “We know that effective medical liability reform will help lower health care costs and keep physicians caring for patients.”⁴⁶ They argue that such reform works well in California and Texas but also support less traditional reforms:

‘Incentives for States to pursue a wide range of alternative reforms including, health courts, administrative determination of compensation, early offers, and safe harbours for the practice of evidence-based medicine.’⁴⁷

These suggested reforms are largely untested and there is debate amongst tort reform supporters as to whether or not they would be effective.

Since 2003 the US Congress has repeatedly introduced the ‘Help Efficient, Accessible Low-cost, Timely Healthcare (HEALTH) Act, which generally received the designation of H.R. 5, which sought to

limit damages in medical negligence cases as well as restrict lawyers’ fees and reduce the statute of limitations on claims.

The Congressional Budget Office (CBO) estimated that the HEALTH Act would lower premiums nationwide by an average of 25% to 30% from the levels likely to occur under current law.⁴⁸ A similar Bill was also pursued in 2011 but again failed to become law. However, President Obama committed in a State of the Union speech to look again at limiting frivolous lawsuits.⁴⁹

It is difficult to draw firm conclusions about the impact tort reform has had. A 2004 CBO report States that despite a number of reviews into the effectiveness of tort reform in various US States, “the findings should be interpreted cautiously⁵⁰”, because data are limited and tort reform is enacted differently in each state. For this reason “distinguishing among the effects of different types of tort reforms can be difficult”.⁵¹

Despite this, a separate CBO paper found “evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise”.⁵²

California and Texas are seen as the US States that are the most advanced and successful at tort reform. Californians Allied for Patient Protection, an alliance of doctors, dentists, hospitals, nurses, and other health care professionals, states that “MICRA (Medical Injury Compensation Reform Act) saves the health care system billions of dollars each year and increases patients’ access to health care by keeping doctors, nurses and other health care providers in practice and hospitals and clinics open”⁵³. Furthermore “MICRA was intended to, and has been successful in, stabilizing liability costs”.⁵⁴

A similar organisation in Texas, Texas Alliance for Patient Access (TAPA), argues that:

“Because of reforms doctors are flocking to Texas in record number, returning to the emergency rooms, taking complex cases and establishing practices in medically

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46. www.ama-assn.org/ama/pub/news/news/sgr-letter-22feb2010.page Viewed on 22 August 2014
47. *ibid*
48. H.R.5 Help, Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003, Congressional Budget Office Cost Estimate, March 2003
49. President Barack Obama, State of Union Address, January 25 2011
50. *ibid*
51. *ibid*
52. Limiting Tort Liability for Medical Malpractice, The Congress of the United States Congressional Budget Office, January 2004
53. www.micra.org viewed on 2 October 2014
54. www.micra.org viewed on 2 October 2014
55. www.tapa.info/about-us.html
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underserved areas of the state. This has allowed more patients to get the timely and specialized care they need closer to home. Since the passage of reforms, nursing homes have been able to find and afford liability coverage. Hospitals have re-invested their liability savings into new technology, patient care and patient safety and have increased charity care by more than \$100 million dollars annually".⁵⁵

The most significant areas of reform have been:

1. Limitation periods

All states have statutes of limitation for clinical negligence claims.⁵⁶ California has introduced a statute of limitation whereby commencement of legal action should never exceed three years unless paused for a specific reason.

In New York the 'discovery rule' works differently and only applies to situations where a foreign object was left in the patient's body. In these circumstances a claim must be filed within one year of the date of discovery. A normal claim must be lodged within two years and six months of the alleged incident.

The rules in Tennessee are also stricter. Here, claims must be filed within one year of the date the injury is discovered, but no more than three years after the date the injury occurred.

In many US states, if the injured person is a minor they have a longer time period within which to claim. However, not that many states are as generous as Ireland, where the statute of limitations for a minor (two years) only begins once that person turns 18. For example, in Indiana, if the minor was younger than six years old when the incident happened, the parents or other guardians have until the child turns eight to sue.

In some states the statute of limitation takes into account the 18th birthday of the claimant. In Idaho if someone is under 18 years of age or lacks capacity, the statute of limitations is paused until the person reaches 18 or regains their mental capacities. However, even in these circumstances, regardless of the plaintiff's

age or mental state, the statute of limitations cannot be paused for more than six years.

1. Limits on non-economic damages and other damages

Twenty-nine US states have a limit on damages. Limits on non-economic damages can range from \$250,000 in California to \$750,000 per incident in Tennessee and Wisconsin.

Some states place limits on both non-economic and other damages together, such as Virginia where the limit is \$2.15 million and is scheduled to climb to \$3 million in 2031.

The purpose of these limits is to tackle unpredictable and extreme damages awards. Proponents of limits argue it is difficult to place a value on pain and suffering, which means that awards without limits become unpredictable. By placing a ceiling on the amount juries can award for such subjective damages, errors or biases can be curtailed. Additionally it was thought that if the economic benefits of a claim can be reduced, fewer cases may be brought.

The 2004 CBO paper found that "the most consistent finding in the studies that CBO reviewed was the caps on damage award reduced the number of lawsuits filed, the value of awards and insurance costs".⁵⁷ Browne and Puelz's research found limits on non-economic damages could be associated with a 19% decline in the average value of non-economic claims. Limits on non-economic damages decreased the average probability that a case would be brought from 4% to 1.4%.⁵⁸

Kessler and McClennan found that tort reform generally led to fewer clinical medical negligence cases and reforms, which limited awards, and led to a decrease in the number of claims, the number of claims incurring legal expenses and the time it took to resolve claims.⁵⁹

Patricia Born and W Kip Viscusi found that limits on damages, and other tort reform, reduced insurance companies' costs and the premiums they charged. Kenneth Thorp in 2004 had produced

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similar findings. In states where limits on non-economic damages were in place, loss ratios for insurance firms were 11.7% lower and overall premiums were 17.1% lower. He found that limits on non-economic damages were the only reform that was associated with this impact on insurance.⁶⁰

California introduced a cap of \$250,000 on non-economic damages in 1975 through the Medical Injury Compensation Reform Act (MICRA). The California Medical Association believes that the “cap on noneconomic damages has proven to be an effective way of limiting meritless lawsuits and keeping health care costs lower”.⁶¹

However, these limits are controversial. Seven states have had their state Supreme Courts rule such caps unconstitutional. In a recent case in Florida (*Estate of McCall v. United States*, __ Fla. __ (2014)), the state High Court ruled that such limits are unconstitutional under specific circumstances, but strongly suggested that it would invalidate the cap under all circumstances if the right case were brought before it. The debate in the US continues.

2. Tackling frivolous claims

According to the National Conference of State Legislatures, 28 states, such as Iowa, introduced a Certificate of Merit.⁶² This certificate confirms the claim has been reviewed by an expert (definitions differ) and certifies that the care provided failed to reach appropriate standards. This certificate offers a filter for frivolous claims.

Seventeen jurisdictions also require that medical negligence cases be heard by a screening panel before trial.⁶³ These panels are often made up of doctors and lawyers. The aim is to encourage early settlement but also to put potential claimants off pursuing frivolous claims. In some states the panels are mandatory, in others they are not.

Browne and Puelz found that sanctions of this kind led to a decrease in the value of both economic and noneconomic claims and in the number of lawsuits filed for car-related torts.⁶⁴

3. Limits on Attorneys' fees

Some states limit contingent fees (a fee based on a percentage of the award the attorney wins for the plaintiff). In 2011 it was reported that 28 states limit attorneys' fees in some way.⁶⁵ These fees are thought to incentivise lawyers to take on a large number of cases that have a limited chance of success, to subsidise unsuccessful cases with the successful ones.

The HEALTH Act proposed further federally imposed limits on attorney fees. The Act proposed that:

'Attorney fees would be restricted as follows:

- 40 percent of the first \$50,000 of the award,
- 33.3 percent of the next \$50,000 of the award,
- 25 percent of the next \$500,000, and
- 15 percent of that portion of the award in excess of \$600,000'⁶⁶

This replicates the rules enacted in California in 1975 as part of MICRA. Below is a grid that illustrates the reforms made in ten US states.

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65. www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx
66. H.R.5 Help, Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003, Congressional Budget Office Cost Estimate, March 200

STATE ENACTMENTS OF SELECTED CARE LIABILITY REFORMS

| State | Limits on non-economic damages | Limits on contingent attorney fees | Statute of Limitations |
|------------|--|--|---|
| California | \$250,000 non-economic damages cap UPHELD Civ. §3333.2 (1975) | Sliding scale Bus. & Prof. §6146 (1987) | 3 yrs or 1 yr from discovery, maximum of 3 yrs; 1 yr FO Civ. Proc. §340.5 (1975) |
| Florida | \$500,000 cap on non-economic damages per physician/ claimant; \$1 million max \$750,000 cap on non-economic damages per entity/claimant; \$1.5 million max EXCEPTIONS - \$150,000 cap on non-economic damages per emergency provider/claimant; \$300,000 max §766.118 (2003) Ruled UNCONSTITUTIONAL in wrongful death cases involving multiple claimants (3/2014) | After costs, 30% of first \$250,000, 10% of anything over \$250,000 FL Const. Art. I, Sec. 26 (Effective 11/2004) | 2 yrs or 2 yrs from discovery; 4 yr maximum §95.11 (1975) |
| Hawaii | \$375,000 for non-economic damages §663-8.7 (1986) | Court approval §607-15.5 (1986) | 2 yr from discovery; 6 yr maximum §657-7.3 (1986) |
| Idaho | \$324,478 cap on non-economic damages (adjusted annually to average wage index on 7/1) §6-1603 (Effective 7/1/2004) | None | 2 yr; 1 yr FO §5-219 (1971) |
| Indiana | \$250,000 cap on total damages per provider; \$1,250,000 cap on total damages for all providers and state fund: UPHELD §34-18-14-3 (1999) | 15% max if paid out of patient compensation fund; otherwise none §34-18-18-1 (1999) | 2 yrs from act or discovery UPHELD §34-18-7-1 (1999) |
| Louisiana | \$100,000 cap per provider/ incident, with \$500,000 cap on total damages, (difference paid by PCF), plus future medical costs 40:1299.42 (1991) | None | 1 yr; 1 yr from discovery; 3 yr max. UPHELD 9:5628 (1975) |
| Nevada | \$350,000 non-economic damages cap NRS 41A.035 (Effective 11/23/2004) | Sliding scale NRS 7.095 (Effective 11/23/2004) | After Oct. 1, 2002, 3 yrs from date of injury, 1 year from date of discovery NRS §41A.097 (Effective 11/23/2004) |
| Ohio | Greater of \$250,000 or 3 times economic damages up to max of \$350,000/plaintiff, \$500,000/ occurrence (\$500,000/plaintiff and \$1 million/occurrence in catastrophic cases) §2323.43 (2003) | Capped at amount of non-economic damages unless otherwise approved by the court §2323.43(F) (2003) | 1 yr from discovery; 4 yr statute of repose §2305.113 (Effective 4/7/2005) |
| Tennessee | \$750,000 cap on non-economic damages per incident with exceptions up to \$1 million. TN Code Ann. 29-39-102 (effective for injuries occurring after 10/1/2011) | 33.3% of damages awarded UPHELD §29-26-115 (1976) | 1 yr from discovery; 3 yr maximum (FO exception) §29-26-116 (1976) |
| Texas | \$250,000 cap on non-economic damages per physician/claimant \$250,000 cap on non-economic damages per Institution (up to 2) Civ. Prac. & Rem. Code §74.301 (2003) | None | 2 yrs; 10 yr maximum Civ. Prac. & Rem. Code §74.251 (2003) |

THE MEDICAL PROTECTION SOCIETY

33 CAVENDISH SQUARE
LONDON, W1G 0PS
UNITED KINGDOM

E: SARA.HIGHAM@MPS.ORG.UK

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