CHALLENGING THE COST OF CLINICAL NEGLIGENCE

THE CASE FOR REFORM

CONTENTS

FOREWORD

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CEO

As the leading provider of professional protection to more than 30,000 health professionals in South Africa and 300,000 worldwide, MPS has a unique insight into the nature of clinical negligence claims.

These are undoubtedly challenging times for healthcare professionals, and I understand that increases in the cost of membership subscriptions can be painful, and have a significant impact on some. I am keen that MPS plays its part in the debate about reform needed to tackle the escalation of costs associated with clinical negligence, whilst respecting the desire of society to ensure that patients who experience clinical negligence are appropriately cared for. In this paper we raise ideas to help address some of the factors contributing to this situation.

The good news is that this debate is already happening and there have been significant strides forward. Minister for Health, Aaron Motsoaledi, is actively confronting this issue due to his concerns about the escalating 'crisis'[1].

I congratulate the Minister for Health for his work so far on this, as well as the work of the Department of Justice and the South African Law Reform Commission, and I hope that our paper will be one contribution among many to this important and increasingly relevant debate.

I recognise the important role MPS must play as well. We will continue to support our members and promote safe practice in medicine and dentistry by helping to avert problems in the first place. Crucially, we advocate open disclosure. When organisations embrace open disclosure it benefits all involved. Above all, it is the ethical thing to do.

We also recognise that human error in healthcare cannot be completely eradicated. However, as an organisation at the heart of healthcare, we see our role as supporting our members and helping them to identify and implement ways of managing risk.

1 Health 24, SA's Shocking Medical Malpractice Crisis, 10 March 2015

ABOUT **MPS**

The Medical Protection Society Limited ("MPS") is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership are discretionary as set out in the Memorandum and Articles of Association.

When we assist a member with a claim, we can manage it from first notification to conclusion, and can take care of all the legal costs and compensation payments.

Our claims handling philosophy aims to provide an expert, supportive and efficient claims handling service to members who are faced with claims in clinical negligence. MPS seeks to identify the issues early, respond to them and move matters to appropriate resolution, be that settlement or successful defence. 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 impact of claims on MPS's wider membership as well as the personal impact on those involved in the claim.

An efficient and cost effective legal system that works for patients and their families, as well as for healthcare professionals, is crucial to the work that we do and the important support we provide to our members.

EXECUTIVE SUMMARY

There is growing recognition of the need for legal reform in regards to clinical negligence in South Africa. Not only to reduce mounting costs that are becoming a burden for the public purse, but also to create a system that both ensures reasonable compensation for patients and allows for a fair and robust defence where necessary.

In our experience, over the last six years, there has been a deterioration in the overall claims environment for both medical and dental members.

Our data indicates that between 2009 and 2015, there has been an escalation in the likely value of claims being brought against doctors, with claim sizes increasing by over 14% on average, each year, during that period. The average likely increase of claim size for dentists per year during this period was similar at just under 14%. Our data also indicates that the estimation of the long-term average claim frequency for doctors in 2015 is around 27% higher than that in 2009.

Our concern is that this trend may continue, with increasing claim sizes forcing us to raise subscription costs.

> **“MPS DOES NOT BELIEVE THAT THE DETERIORATING CLAIMS ENVIRONMENT IN RECENT TIMES REFLECTS A DETERIORATION IN PROFESSIONAL STANDARDS”**

For obstetricians in particular, the subscription rate that MPS has had to charge members continues to rise due to the increasing uncertainty of the future cost of providing protection for obstetric risk on an occurrence basis. Recognising the concern that this is causing, MPS introduced a choice in professional protection for private obstetricians and gynaecologists who manage pregnancies after 24 weeks gestation. This new protection is called ‘claims-made’[2] protection.

For some specialities, the claims experience risks threatening the sustainability of private practice. If this causes a shift in the workload to the public sector, it could increase pressure on public services and affect important health sector reforms, such as the universal coverage for all.

Our concerns were echoed by Health Minister Aaron Motsoaledi at the Summit in March 2015 where he is understood to have similar concerns about the public sector’s clinical negligence experience. In March 2015 it was reported that he said: ‘the nature of the crisis is that our country is experiencing a very sharp increase - actually an explosion in medical malpractice litigation - which is not in keeping with generally known trends of negligence or malpractice’.[3] He further commented that in his view ‘the number of claims increased substantially’.[4]

MPS does not believe that the deteriorating claims environment in recent times reflects a deterioration in professional standards. However, we do believe that there is greater scope for standardisation of treatments, and processes could ensure a more consistent approach to healthcare. MPS recognises the important role that organisations such as the Office of Health Standards Compliance will play in this regard. Recent developments are most certainly a step in the right direction.

2 MPS claims-made protection, like our traditional occurrence-based protection, is underpinned by the flexibility of discretion and can provide protection against a clinical negligence claim. For further information please visit our site https://mpsclaimsmade.org/home/

3 Health 24, SA’s shocking medical malpractice crisis, 10 March 2015

4 ibid

There are potentially a multitude of complex factors, some of them positive, that are contributing to the current claims experience including:

- The lack of a patient-centered and robust complaints system is leaving many patients with litigation as the only viable avenue for redress;
- 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, with no parties benefitting;
- The cost of settling a claim increases as time goes on. A protracted legal process can have a significant impact on the final costs of settling a claim, as it means legal bills continue to mount and compensation can increase in size;
- Amendments to the provisions of the Road Accident Fund Act potentially resulting in attorneys refocusing their area of interest towards personal injury claims, and in particular, clinical negligence;
- Increased patient awareness of their rights under the Constitution as well as the Consumer Protection Act;
- Increasing patient expectations with many patients now expecting greater involvement in – and understanding about – their healthcare.

Alongside our concerns about cost, we believe that the clinical negligence litigation system does not facilitate the efficient and fair resolution of disputes. Instead, the system is unnecessarily adversarial with frequent 'trial by ambush'.[5] It also lacks transparency and is time consuming and expensive.

Recognising that key government departments have acknowledged and taken steps to address this challenge, in this paper we propose reform that could begin to tackle some of the problems that have contributed to the current claims environment. We believe such reform could help to make the system faster and more efficient for patients and their families, highlighting the importance of a patient-centred complaints system to address concerns without the need to resort to litigation.

> **"WE HOPE OUR PROPOSALS WILL HELP TO FURTHER IGNITE THE DEBATE AROUND THE POLICY OPTIONS AVAILABLE FOR REFORM IN SOUTH AFRICA"**

Whilst the deterioration in the claims experience may not continue at its current pace, the experience to date merits deep consideration of legal reform.

These proposals should be debated and explored at a public policy level. We hope that this paper will be one contribution among many to support future reform.

In Australia following the crisis in medical indemnity provision in the early 2000s, we believe the 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 contrast to the South African experience in recent times.

MPS is keen to be part of the debate about what reform is needed. We recognise that we are only one voice and our reform proposals are not exhaustive. However, we hope our proposals will help to further ignite the debate around the policy options available for reform in South Africa. MPS is willing to share its experiences, together with other stakeholders, so as to make reform a priority. MPS applauds the Minister of Health, and institutions such as the South African Law Reform Commission, for their recognition of this priority and for progress made so far.

5 It is not unusual for parties to wait until the last minute to amend their pleadings or serve expert witness

MAIN PROPOSALS

Complaints process

- MPS proposes the development of a consistent, efficient, aligned and patient-centred complaints process that allows for local resolution

Frequency of claims

- MPS proposes that a Certificate of Merit be introduced
- MPS proposes further consideration of ways to encourage alternative dispute resolution

Pre-litigation resolution framework

- MPS proposes the introduction of a pre-litigation resolution framework

Procedural Changes

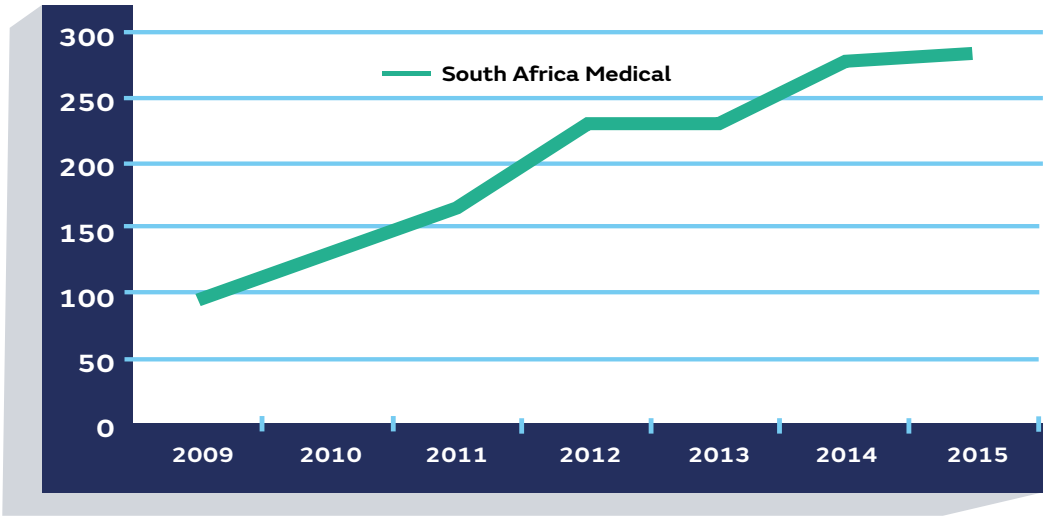
- MPS proposes procedural change to ensure:
  - The exchange of factual witness statements
  - Early exchange of expert notices and summaries
  - Mandatory early experts meetings

Limiting damages awards
(general and special)

- MPS proposes that a tariff of general damages is created in statute
- MPS proposes a limit on general damages
- MPS proposes a limit on future care costs
- MPS proposes a limit on claims for loss on future earnings

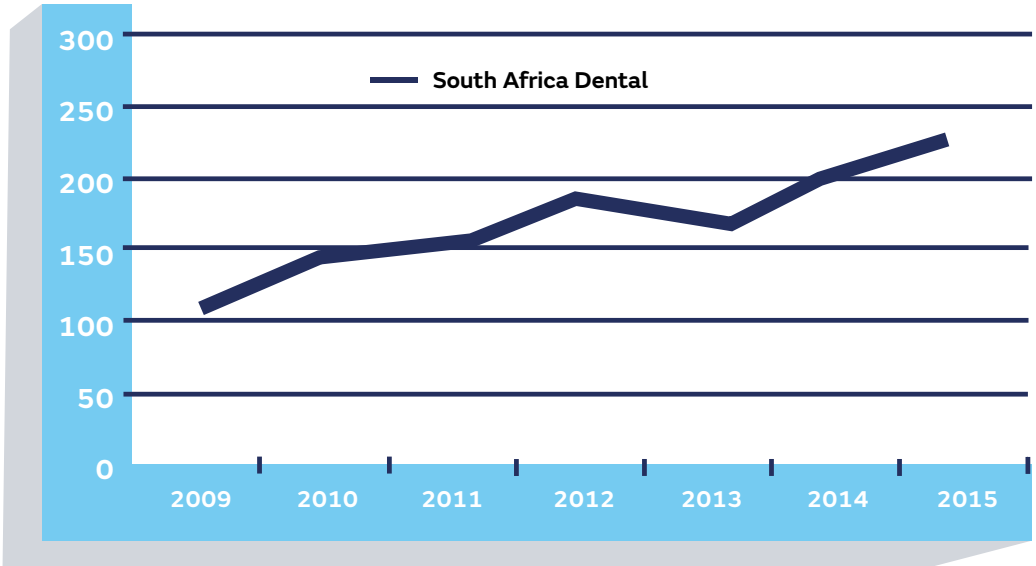
The nature of clinical negligence claims means that it can often be years before a case is brought and fully resolved. The graphs below show the increasing trend in the average estimated actuarial indemnity cost per member. This is based on detailed and robust actuarial work, assessing trends in the size of claims and the likelihood of claims for each area of practice.

MPS Membership; Average Estimated Actuarial Indemnity Cost per Member; South Africa Medical 2009-2015 with 2009 as base year



Relative Values 2009 = 100

MPS Membership; Average Estimated Actuarial Indemnity Cost per Member; South Africa Dental 2009-2015 with 2009 as base year



Relative Values 2009 = 100

WHY **PATIENT CONCERNS** BECOME CLAIMS

We recognise that human error in healthcare cannot be completely eradicated, mistakes happen and risks and complications can occur. Our advice to members is to have full and open communication with patients as soon as possible. An explanation may be all that is needed to reassure the patient and avoid unnecessary escalation.

When considering the current claims environment, the first consideration must be how we prevent patient concerns unnecessarily escalating into a claim in the first place.

THE NEED FOR A PATIENT-CENTRED COMPLAINTS SYSTEM

While there are meritorious claims where the patient understandably pursues financial compensation, in many cases patients are simply seeking answers, an apology, and reassurance that necessary changes have been made by the healthcare professional involved. The priority must therefore be to develop a robust, efficient and, above all, patient-centred complaints system to address patient concerns as an alternative to litigation. Such a system should also allow for effective, local resolution in the first instance.

MPS acknowledges and welcomes the fact that some progress has been made towards the development of an efficient, patient-centred complaints system, such as that envisaged by the Office of Health Standards Compliance and its Ombud, and that there are small-scale complaints systems instituted by private practices in some areas. However, we are concerned that such systems are not standardised and robust enough to compete with litigation as a means to resolve concerns.

Patients and their families deserve an explanation when a treatment or procedure does not go as planned, or when there is an adverse outcome. The lack of an efficient and standardised complaints service means that many patients and their families may feel they have little option but to pursue a clinical negligence claim. This results in expense and delay for patients and their families, as well as anxiety for the healthcare professional. A full explanation accompanied by a meaningful apology as an expression of regret or sorrow (where appropriate) can be a key factor in determining whether a patient brings a claim.

Whilst a patient-centred complaints system, such as that envisaged by the Office of Health Standards Compliance and its Ombud, will allow patients to have their say and feel heard, complaints also provide an opportunity for invaluable feedback and self-reflection on an individual's performance, and a chance to consider lessons learned to inform better practice in the future, even if a complaint is without justification.

> **"THE PRIORITY MUST BE TO DEVELOP A ROBUST, EFFICIENT AND, ABOVE ALL, PATIENT-CENTRED COMPLAINTS SYSTEM TO ADDRESS PATIENT CONCERNS AS AN ALTERNATIVE TO LITIGATION"**

Without the opportunity to make a complaint through a transparent complaints system, a dissatisfied patient is likely to consider other options to express their concerns. This may be reporting a doctor to the HPCSA or instructing an attorney to make a claim for clinical negligence, or both. Both options involve lengthy processes and delay, and inevitably involve added emotional stress for the doctor, and also the patient. This is particularly the case if the complaint is not upheld or if the claim is successfully defended.

INCREASE IN THE FREQUENCY MPS MEDICAL MEMBERS ARE BEING SUED

Our data indicates that the estimation of the long-term average claim frequency for doctors in 2015 is around 27% higher than that in 2009. While there has been a plateau in our estimates of the long-term average claim frequency for dental members, this situation may be temporary and a reflection of the successful implementation of a dental mediation service by the South African Dental Association (SADA). Without the mediation service we suggest our dental claims experience could be worse.

There are likely to be a number of complex and interrelated causes of the increase in the frequency of medical claims. For this reason, the factors explored below may not be exhaustive and MPS welcomes discussion on any further contributory causes.

An important and positive influence behind this increase may be a greater empowerment and involvement of people in their healthcare. It is thought that patients have an increased awareness of their rights under the Constitution as well as the Consumer Protection Act. Alongside this, we believe patient expectations are increasing.

However, there are other potential contributing factors that are much less positive. We believe that the lack of a standardised, patient-centered complaints system is one crucial factor, but we believe there are others including:

- Amendments to the provisions of the Road Accident Fund Act potentially resulting in attorneys refocusing their area of interest towards other forms of personal injury claims, in particular clinical negligence;
- A civil court system that could do more to discourage unmeritorious claims.

While there are claims that arise after patients have suffered avoidable harm, and for which they should legitimately receive reasonable compensation, the present legal system appears not to do enough to discourage unmeritorious claims from the outset.

SUMMARY

It is important that patients have access to justice, but it is in the interests of all parties that patient concerns about care can be addressed early and through alternative routes where possible. Pursuing clinical negligence claims in South Africa can be a lengthy and costly process for plaintiffs, defendants and the State.

CLINICAL NEGLIGENCE CLAIMS IN SOUTH AFRICA – THE JOURNEY OF A CLAIM

To illustrate problems in the current legal system and where the focus for reform should be, this section compares what MPS considers a more cost effective and efficient claims journey with the current one, and highlights the challenges faced by plaintiffs and defendants. The key differences in this 'ideal journey' are explored in the proposals in the section on Proposals (from page 18).

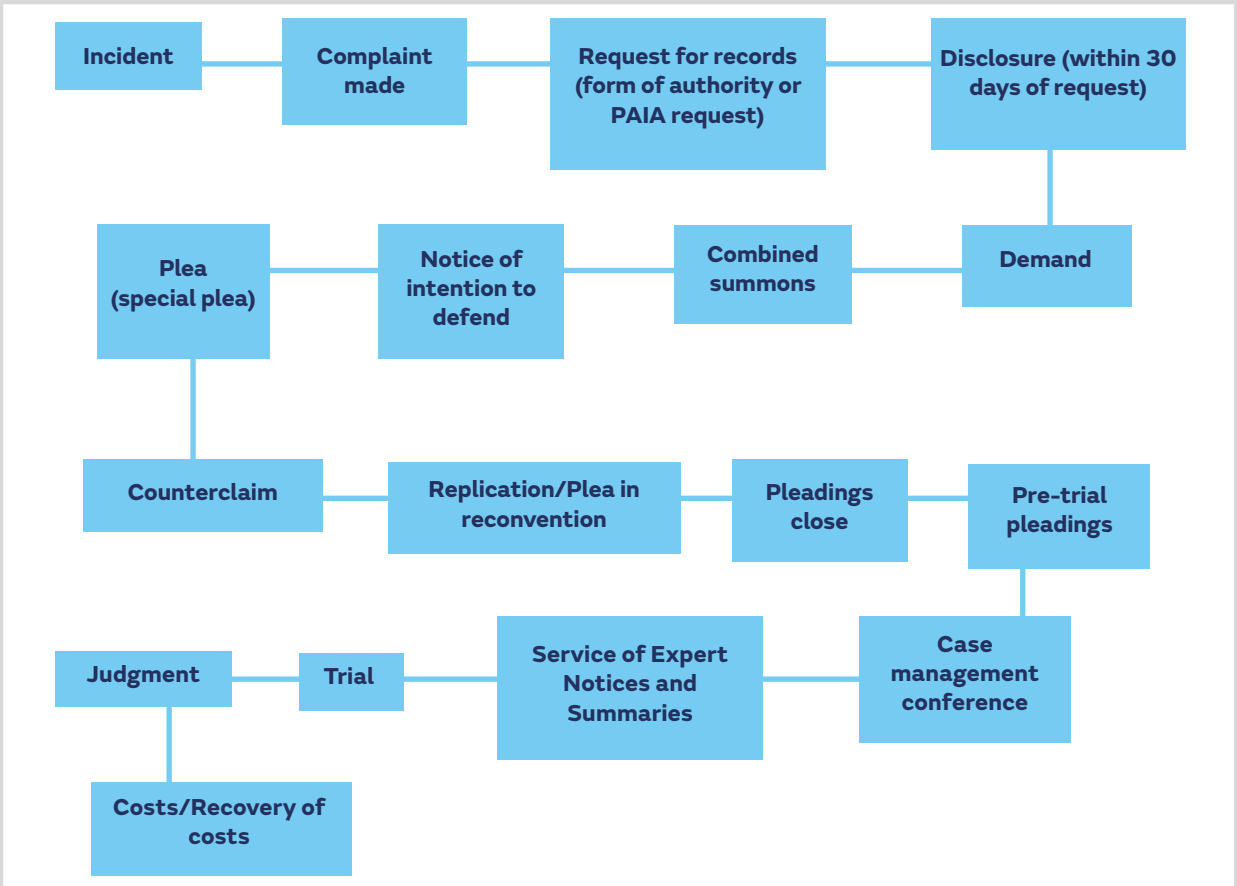
We believe the 'ideal' journey set out on page 12 would save patients and healthcare professionals time and money as well as reduce unnecessary anxiety. At the same time we also believe it would ensure that patients and families with meritorious claims receive the compensation that they are entitled to, without delay.

It is MPS's experience that the claim journey is made onerous due to incidents not being reported when they occur, late investigation of claims, court procedural systems that can be inefficient and the lack of opportunity to resolve cases early. This results in an increase in costs and delay, as well as anxiety on the part of patients and defendants.

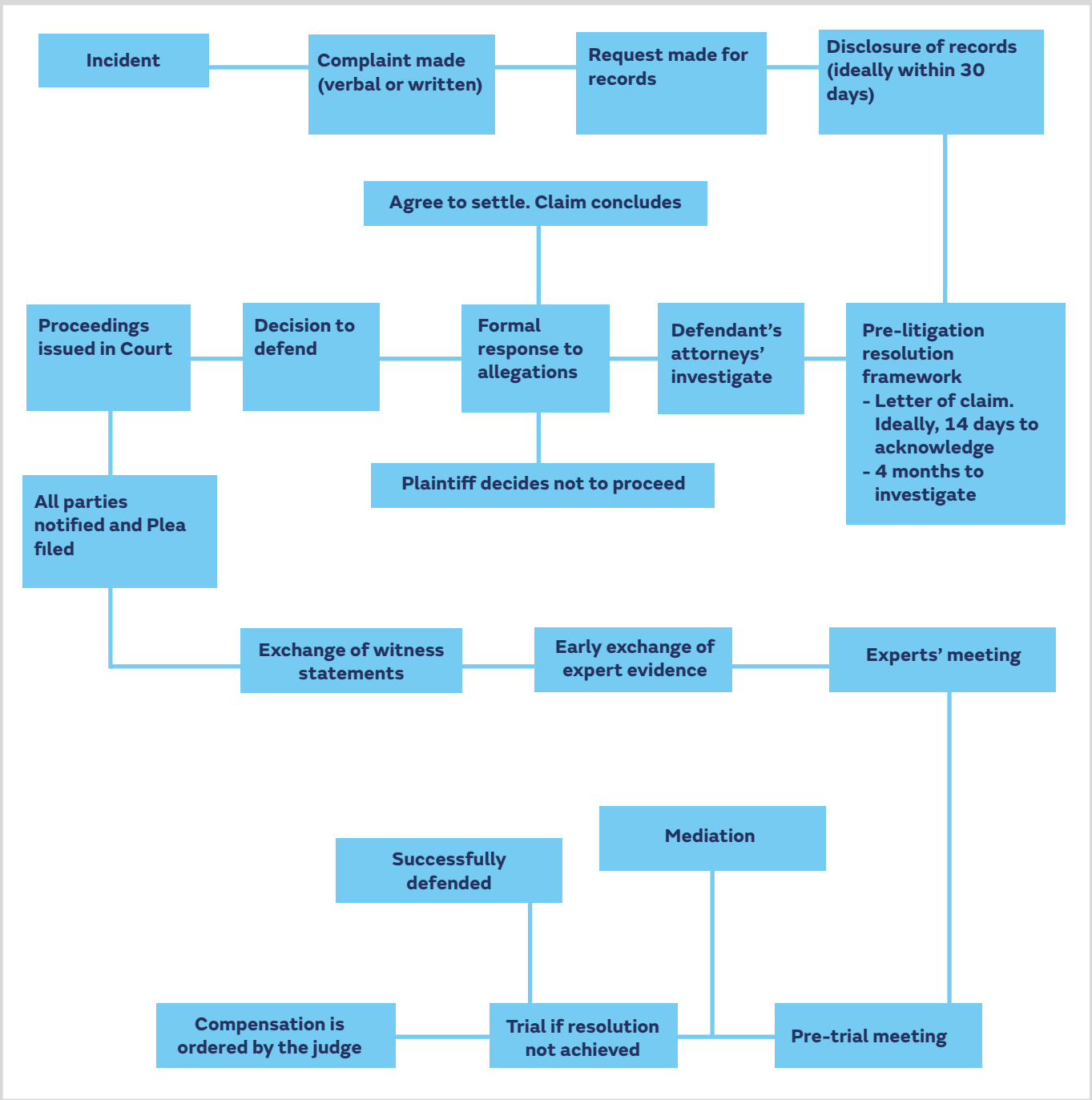
The system also lacks transparency. Although this seems harsh, at present, without any pre-litigation framework, the defendant is often at a disadvantage in the pre-litigation stage as they are wholly reliant on the plaintiff's co-operation to begin investigating the merits of a potential claim prior to formal proceedings being issued.

Once litigation commences, both patients and defendants are faced with delay and costs as there are few procedural mechanisms in place to advance the litigation. Those that are in place are, in our experience, cumbersome, costly, and in some instances result in even further delay in the resolution of the matter.

AT PRESENT THE CLAIM JOURNEY LOOKS LIKE THIS:



THE IDEAL JOURNEY OF A CLAIM



CHALLENGES AT EACH STAGE OF THE JOURNEY

PRE-LITIGATION

NO ADVANCE NOTIFICATION OF CLAIMS

The lack of a requirement for advance notification of a claim, except for claims made against the State, puts the plaintiff at an unfair advantage from the start. This 'head-start' allows the plaintiff to pick from a limited pool of experts as well as investigate the potential claim in a timeframe that suits them. This means that the defendant is precluded from an early understanding of the plaintiff's case, so that any decision about whether to settle or defend a potential claim cannot be taken before formal action is commenced.

LITTLE INCENTIVE TO REACH A RESOLUTION BEFORE PROCEEDINGS ISSUED

In the absence of a pre-litigation procedure to mandate plaintiffs and defendants to seek and provide information to each other about a prospective case in an open and transparent way, there is understandably very little appetite for plaintiffs, or ability for defendants, to resolve cases quickly without resorting to costly court proceedings.

It is MPS's experience in other international jurisdictions that pre-litigation procedures can encourage early and full exchange of information about a case. This enables plaintiffs and defendants to investigate and resolve claims without the need to issue formal legal proceedings. Pre-litigation procedures are particularly effective where compliance is encouraged by cost penalties against parties who ignore or fail to meaningfully engage with the procedures.

Further, in cases where a claim cannot be resolved pre-action, such a framework supports the efficient management of the proceedings by the early exchange of information and by narrowing the issues in dispute. This also means that cases may be more amenable to resolution by mediation or other forms of alternative dispute resolution at this stage.

ACTION

COMMENCEMENT OF PROCEEDINGS

MPS is of the view that current practice at this stage in the claim journey is unsatisfactory for both the plaintiff and the defendant. This is because neither party is in a position at the commencement of proceedings to engage in an open and transparent way, for the reasons explored in the 'pre-litigation' stage.

The system therefore encourages an adversarial approach by both parties, with parties unwilling to 'disclose their hand' until obliged to by court rules. In MPS's experience, the more open the parties can be early in proceedings, the greater the chance that the claim can be resolved early to the benefit of both the patient and defendant.

It is MPS's experience that often the Particulars of Claim[6] do not contain enough information about the events that led to the claim, the allegations of negligence, the extent to which each allegation of negligence caused the loss sustained, as well as full details about the damages claimed, in order to make an early assessment of the claim.[7]

Presented with limited Particulars of Claim, a defendant has little choice but to pay the costs of an application to compel the plaintiff to provide details of the pleadings. This results in delay and an overall increase in costs, especially if the application is opposed.

In addition, the court rules do not require the plaintiff to disclose the records in their possession at the time they serve the Particulars of Claim. The defendant then must formally notify the plaintiff that such disclosure is necessary for the defendant to make their plea.[8] Again this adds to further delay and costs.

SERVICE OF THE PLEA

Due to time constraints, as well as the possible absence of a full set of records and expert opinion, defendants often have no choice but to serve a Plea in which they simply deny all the allegations. Consequently the opportunity for the parties to understand the other's case, to narrow the issues in dispute, or resolve the case is missed.

JUDICIAL CASE-FLOW MANAGEMENT

Notwithstanding the significant strides that have been made following the implementation of judicial case management in response to concerns about excessive court delay around the country, it is MPS's overall experience that there are still a number of challenges which need addressing across the High Court divisions.

Whilst there can be no doubt that overall there has been a significant improvement in the waiting times for trial dates, MPS would support continuous judicial control over cases from issue of proceedings. Judges should be able to set time limits for each step in the process of a case along with strict control of adjournments, coupled with the ability to impose sanctions on non-compliant parties.

The current court rules do not require the parties to exchange factual witness statements.[9] As the purpose of witness statements is to understand the factual basis for a claim and the defence of it, the opportunity to limit issues and assess the veracity of each other's case is lost. This is even more acute in cases where the issue of a lack of informed consent is alleged, where factual evidence is key.

6 *A legal document that sets out the basis of the plaintiff's claim and the losses which are said to be consequent of the negligence alleged*

7 *The Rules of Court set out the information which must be contained in the Particulars of Claim so that the defendant knows the case that they have to meet*

8 *The Plea is the defendant's response to the facts and law contained in the Particular of Claim*

9 *A record of the evidence of a person in his/her own words about a set of facts which is then signed by that person confirming that the contents of the statement are true*

NO REQUIREMENT FOR EXPERTS TO MEET

Currently, the court rules do not mandate experts' meetings or experts joint minutes as part of the claims process. However, experience has shown that this is possible. In the absence of judicial case-led management, it is up to the parties to try and reach an informal agreement as to whether such meetings will in fact take place.

MPS is keen to explore whether the claims process could be improved by the introduction of early experts' meetings. In MPS's experience, in other jurisdictions, they are beneficial as they encourage definitive decisions to be made, such as defendants to settle early or, alternatively, for the plaintiff to abandon the case. It has the advantage of saving time and costs for plaintiffs and defendants as well as protecting the resources of the already overburdened civil justice system. Lastly, it improves the quality of the expert evidence given in court as it can be narrowed down to what is truly in dispute. Again, this is to the benefit of both defendants and plaintiffs.

EXPERT EVIDENCE IS EXCHANGED TOO LATE IN THE PROCESS

Whilst the court rules provide for time periods by which expert notices and summaries must be served, it is our experience that the expert evidence, on both sides, is exchanged far too late in the court process.

The effect of this is that the plaintiff's attorney may only finalise their expert evidence shortly before trial, leading to last minute amendments to pleadings and changing the basis of the allegations of negligence or increasing the value of the claim. It is not uncommon to see the value of a case increase substantially in the run up to trial. In a recent cerebral palsy case MPS was involved in, the plaintiff amended the compensation claim - doubling it - in the weeks before trial.

Defendants are faced with the difficult decision of having to consider whether they should postpone the matter and accept the wasted costs or to try and revise their own evidence quickly to meet the amended case. The early exchange of expert evidence in conjunction with early experts' meetings well in advance of a trial date is beneficial to all parties. This would stop last minute amendments to the Particulars of Claim, allow both sides to review and consider their respective cases, assist in narrowing the issues in dispute and facilitate earlier settlement of cases or, if the expert evidence no longer supports the claim, for the plaintiff to discontinue.

This would mean that fewer cases go to trial and would assist in the proper and fair allocation of scarce court resources.

DAMAGES

It is against this backdrop that MPS has over the past six years seen an increase in the estimates of the size of medical and dental claims. Our data indicates that between 2009 and 2015, there has been an escalation in the likely value of claims being brought against doctors, with claim sizes increasing by over 14% on average, each year, during that period. The average likely increase of claim size for dentists per year during this period was similar at just under 14%.

In particular, in our experience, special damages (for loss of future earnings and care, medical and hospital expenses) have increased considerably. This is especially true in high value catastrophic claim[10] cases.

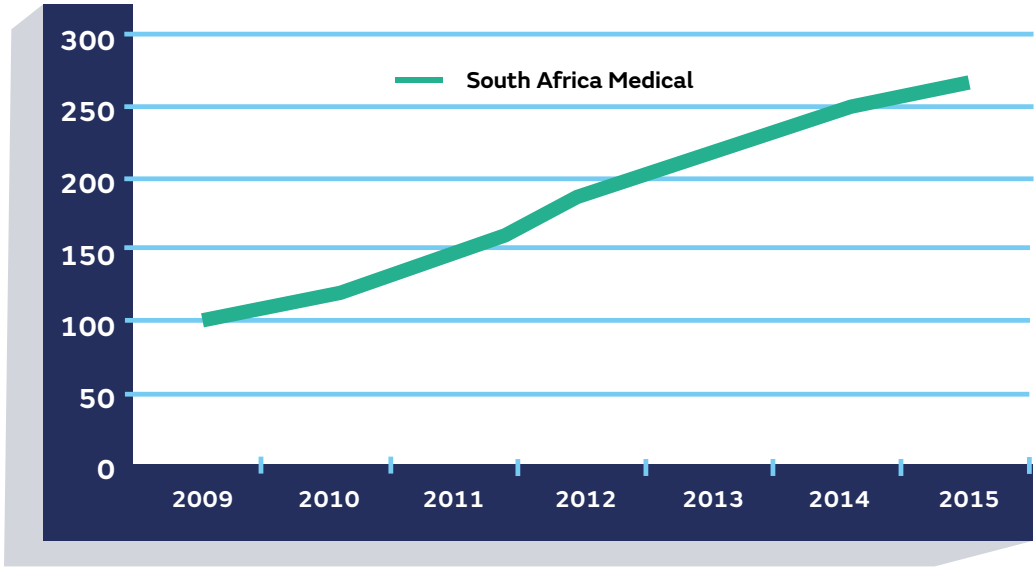
There can be little doubt that the current litigation framework poses a number of challenges for patients and their families as well as the healthcare professionals. In order to best serve South African citizens, we need a system that promotes the minimising of unnecessary expenditure, conserves court resources and ensures that the parties are on an equal and fair footing from the start.

10 *Injuries that impact enormously on the lives of the individual affected often with serious and long-term effects often requiring them to have lifelong assistance and on-going rehabilitation. Common examples are spinal cord injuries, serious head trauma, amputation, neurological disorders and birth injuries resulting in paralysis, paraplegia and quadriplegia*

The graphs below illustrates this increasing trend in the cost of clinical negligence for both medical and dental members.

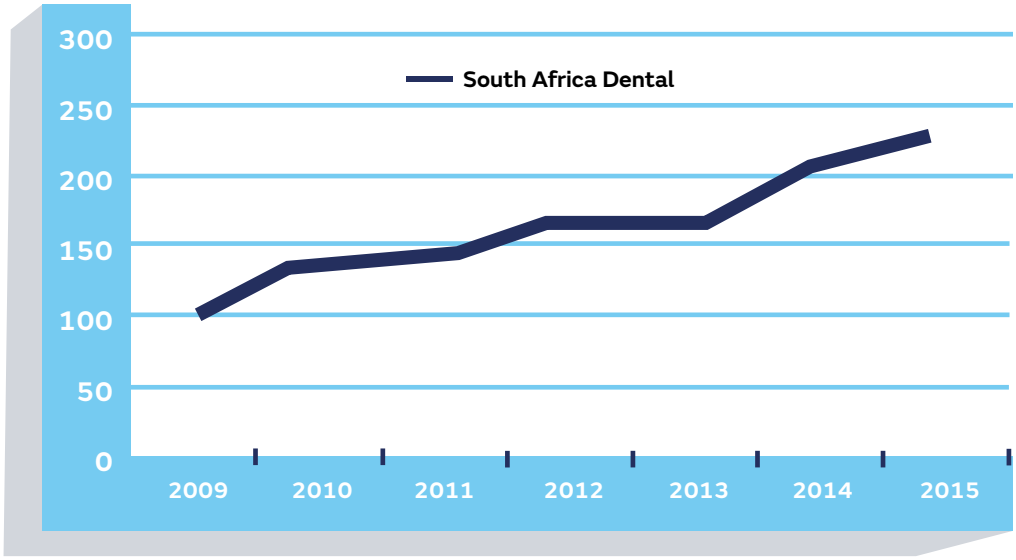
The nature of clinical negligence claims means that it can often be years before a case is brought and fully resolved. The graphs below show the increasing trend in the estimated likely claim size. This is based on detailed and robust actuarial work, assessing trends in the size of claims and in the likelihood of claims for each area of practice.

Severity Trend - South Africa Medical 2009-2015 with 2009 as base



Relative Values 2009 = 100

Severity Trend - South Africa Dental 2009-2015 with 2009 as base



Relative Values 2009 = 100

POST ACTION

COSTS

When comparing costs in South Africa with other jurisdictions, costs are not, generally speaking, disproportionate to the damages claimed. Whilst this is positive, MPS has noticed an overall increase in litigation costs and there are still unnecessary costs in the system. MPS believes it is the current legal procedural framework which adds costs to the claim process.

Another significant driver for higher costs is counsel fees, which are high. In MPS's experience, plaintiff lawyers are reliant on the services of counsel; in particular they are often reluctant to negotiate settlements without a Senior Counsel's input, again driving up the cost of claims. It is not unusual for the Senior Counsel to have a junior advocate who is entitled to compensation equivalent to two thirds of the Senior Counsel's fee, notwithstanding that the plaintiff may also be represented by experienced attorneys.

MPS has attempted to argue that such fees should not be allowed but when challenged, the courts have allowed both Senior and Junior Counsel's fees to be recovered, adding to the cost of litigation.

Advocates are permitted to charge not only a first day fee (or a portion of the fee) but also collapse fees by prior agreement[11]. This is in addition to their trial fee in the event that a case is settled just before the trial date or soon after the trial commences. This too adds to the high cost of litigation.

> **"WHILE THERE HAVE BEEN SIGNIFICANT STRIDES FORWARD, SUCH AS THE IMPLEMENTATION OF JUDICIAL CASE MANAGEMENT, WE BELIEVE THAT THERE IS MORE THAT COULD BE DONE"**

At the beginning of this section we outlined what MPS would consider to be the ideal journey of a claim. We believe that the ideal journey would save patients and healthcare professionals time and costs and reduce unnecessary anxiety that prolonged litigation can cause. At the same time it would also ensure that patients and families with meritorious claims quickly receive the compensation that they are entitled to.

However, as this section has explored, the current framework does not yet support the efficient management of claims. This leads to delays, lack of transparency, an adversarial culture and a loading of unnecessary costs. The current system does not benefit either the healthcare profession or patients and their families.

While there have been significant strides forward, such as the implementation of judicial case management, we believe that there is more that could be done alongside these recent and effective improvements.

11 By agreement, the advocate is entitled to charge a fee in addition to the first day fee for those days that the advocate has set aside for the hearing but have been lost due to the case being settled or postponed

PROPOSALS

In our experience, over the last six years, there has been a deterioration in the overall claims environment for both medical and dental members.

For some specialities, the claims experience 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 and affect important health sector reforms, such as the universal coverage.

We believe that legal and procedural reforms are required to begin to tackle some of the factors that have led to this claims experience and ensure a fairer and more efficient system for all parties. Added to this, a patient-centred, standardised complaints system should be developed to ensure that patient concerns are addressed, where possible, before they become a claim.

MPS recognises that the proposals in this paper are not exhaustive. However, we aim to contribute to the ongoing debate which has been stimulated by the recent and welcome Department of Health Medical Negligence Summit where the Health Minister Aaron Motsoaledi referred to the "crisis" in medical malpractice claims faced by everybody in the healthcare profession - both public and private. The leadership shown by the Minister in tackling the challenge head-on is to be welcomed. MPS also applauds the work that has been embarked on by the South Africa Law Reform Commission and the commitment from the Department of Justice shown during the Summit.

Many stakeholders who attended this summit drew on the experience of other nations when dealing with similar concerns. The recommendations below are influenced by the experiences of Australia and the US – as detailed in the annexes – and aim to streamline the clinical negligence claims process to reduce costs and delays, and save both healthcare professionals and the public purse money. We also noted earlier the positive impact similar reforms had on subscription rates for professional protection in Australia. These proposals are not intended to be prescriptive; MPS acknowledges these proposals should be explored further, and others considered. Rather we hope that they will add to the debate.

1. COMPLAINTS PROCESS

- **MPS proposes the development of a consistent, efficient, aligned and patient-centred complaints process that allows for local resolution**

To address patient questions and concerns before they escalate to a claim, MPS recommends the development of a consistent, efficient, aligned and, above all, patient-centred complaints process. Such a process should allow for local resolution in the first instance.

A good complaints handling service can give patients an opportunity to be heard, an acknowledgement when things go wrong, to receive an explanation and lessons to be learned, in a much less adversarial forum than litigation. Investing in such a system is in everyone's best interests.

MPS would like to see the development of a complaints system that allows for local resolution in the first instance as the 'tier one' for complaints. That way a strengthened 'tier two' complaints system at the level of the Office of Health Standards Compliance, its Ombud and the HPCSA would ensure that patients and their families have an effective alternative to litigation.

2. FREQUENCY OF CLAIMS

- **MPS proposes that a Certificate of Merit be introduced**

We explored earlier some of the multifactorial reasons why our estimation of the long-term average claim frequency for doctors in 2015 is higher than that in 2009.

In response to a similar challenge, many US and Australian states introduced a Certificate of Merit, or similar. This certificate requires the patient's lawyer to confirm, before the start of the case, that it has merit. If, once the case has concluded, the judge decides that this is not the case, the existence of the certificate permits a party to claim the costs of proceedings from the other side's lawyer if it is established that there was no basis for the issue of proceedings or service of a defence.

As further leverage, some Australian states have in addition introduced minimum thresholds for general awards, and caps on lawyer's fees. For example, in New South Wales, there can be no general damages for injury below 15% of 'a most extreme case'.[12]

In addition to a Certificate of Merit, MPS supports the introduction of financial penalties to discourage the prolonged pursuit of unmeritorious claims and the continued defence of meritorious claims. We suggest that such financial penalties could be awarded against the attorneys who bring the claim, rather than the patient.

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

3. ALTERNATIVE DISPUTE RESOLUTION

- **MPS proposes further consideration of ways to encourage alternative dispute resolution**

In a legal system that can at times be unduly complex and potentially inaccessible, MPS can see the value of exploring alternative dispute resolution. The South African legal system already uses alternative dispute resolution fruitfully in the fields of family and labour law.

MPS fully appreciates that whilst not every case is suitable for conciliation or mediation, we believe that with judicial case management the parties should at every stage be encouraged to consider alternative dispute resolution as an alternative to formal proceedings.

Not only would this help to alleviate the pressure on the present court system and save money for the public purse, it would also potentially provide a more time and cost effective means of resolving a matter to the benefit of both plaintiff and defendant.

Some have recommended the appointment of a Medical Ombud similar to that of the Office of the Ombud to deal with not only complaints, but adjudicate over matters with the power to mediate and settle claims outside of the formal court process.

Again MPS welcomes any mechanism that will facilitate the early resolution of meritorious claims. This is in the best interests of patients, their families and healthcare professionals.

4. PRE-LITIGATION RESOLUTION FRAMEWORK

- **MPS proposes the introduction of a pre-litigation resolution framework**

MPS proposes the adoption of a pre-litigation resolution framework similar to those adopted in other jurisdictions. Such a system provides a mechanism for parties to obtain sufficient information and understanding of their respective cases early. This allows them to investigate claims efficiently and, where appropriate, resolve them before a case becomes a litigated claim.

In the United Kingdom, for example, medical negligence cases are dealt with under the Pre-Action Protocol for the Resolution of Clinical Disputes.[13] This regulates the conduct of the parties by providing a reasonable timetable for the exchange of information, an acceptable standard for the content and quality of the correspondence exchanged, as well as guidance on what is acceptable conduct between the parties in pre-action negotiations.

A framework encourages early resolution, be that settlement or successful defence of claims. Faster resolution of an issue can lead to considerable savings. The parties are also encouraged to consider alternative dispute resolution. The protocol is backed up by cost sanctions if the parties fail to engage with the protocol.

MPS believes that the implementation of such a framework will ease the burden on the courts as cases will be resolved sooner. This could potentially save public money.

13 The Protocol is a procedural framework which aims to maintain/restore the patient/doctor relationship as well as resolve disputes without the need for litigation. Further information on the UK protocol can be found here: https://www.justice.gov.uk/courts/procedure-rules/civil/protocol

5. PROCEDURAL CHANGES

- **MPS proposes procedural change to ensure:**
  - **The exchange of factual witness statements**
  - **Early exchange of expert notices and summaries**
  - **Mandatory early expert's meetings**

As explored earlier, we are concerned that the control of the pace of litigation rests with the parties involved. There is no clear, independent timetable which leads to inefficient use of the scarce commodity of court time.

In MPS's experience, the current model can mean that parties have the opportunity to use expense and delay to gain an unfair advantage, which obstructs the resolution of issues in a time and cost-efficient manner. To mitigate this, MPS would like to see active judicial oversight from the commencement of proceedings.

As the legal issues in medical negligence cases can be complex and are heavily reliant on expert evidence, MPS proposes robust case management to ensure efficient and cost effective progression of the case by both parties. This is especially the case with high value catastrophic injury claims where the costs of running such matters can be in the millions of Rand for both plaintiffs and defendants.

The exchange of factual witness statements

The introduction of factual witness statements will allow the parties an opportunity for early review of each other's factual evidence in order to more accurately assess the veracity of their respective cases and limit the issues being contested.

Expert witnesses would then be able to provide expert opinions based on all the facts, ensuring an objective view. This will assist with the resolution of meritorious claims and the abandonment of unmeritorious claims far sooner in the litigation process. This will save time and money as well as ensuring patients and their families get a resolution to their case as soon as possible.
As a witness statement must be in the words of the litigant and contain a statement of truth, it will discourage litigants with poor prospects from pursuing cases unnecessarily.

Early exchange of expert notices and summaries

The benefit of early exchange of expert evidence is that the parties then know the strengths and weaknesses of their respective cases, thereby facilitating early settlement negotiations or withdrawal of the action.

If the parties still believe that the case needs adjudication, it assists in limiting the issues in dispute. The other benefit is that where a party has been unable to secure expert evidence, they cannot continue with the case to the doors of court in the hope of securing some form of settlement.

For these reasons, early exchange of such notices and summaries improves transparency and can allow for cases to be settled earlier to everyone's benefit.

We also consider that the obligation to exchange expert evidence should extend to the exchange of evidence to support the quantification of claims. This will avoid late amendments to quantum pleadings and to encourage earlier settlements.

Mandatory early experts' meetings

Once it has been established that expert evidence is to be exchanged early, it should also be mandated that experts' meetings of a like discipline are held early following the sharing of expert evidence so that they can identify and discuss issues and, where possible, reach agreement.

Early experts' meetings will allow parties to assess whether the expert evidence is objective and balanced, and will determine if the experts tasked to comment on the facts have the relevant expertise. This will ensure that the correct experts are retained which will save time and cost.

6. LIMITING DAMAGES AWARDS
(GENERAL[14] AND SPECIAL[15])

As discussed, in recent years MPS has seen an increase in the severity of claims. In particular, special damages have increased considerably.

There is precedent in South Africa for a limit on damages. In particular we point to the recent changes to the legal landscape in respect of road accident claims with the introduction of the Road Accident Fund Amendment Act 2008.

This Act was introduced in response to on-going concerns about the sustainability of the compensation scheme in the face of an increase in the size and frequency of claims. The Fund addressed these concerns by setting financial limits on the Fund's liability in certain circumstances.

Notably the Fund has:

- Capped claims for loss of income and support regardless of actual loss, adjusted quarterly to account for inflation.
- Payment of general damages is limited to instances where a 'serious' injury has been sustained, i.e. 30% or more impairment of the Whole Person as per the US Guide (subject to certain exceptions).

According to those running the Fund, the result has been a limit on wastages in the compensation scheme and a curtailment in abuse by claimants and their lawyers. Furthermore, it has limited the Fund's exposure to claims by non-South African citizens by limiting its liability for loss of income and support.[16]

Despite constitutional challenge, the provisions of the Amendment Act have been upheld, introducing far reaching changes to the compensation scheme for the victims of road accidents.

14 Non-pecuniary loss such as pain and suffering, loss of amenities, disfigurement and injury to personality

15 Pecuniary loss such as loss of income and medical expenses

16 Road Accident Fund "Legal Framework" 1.1.2.7.2 Limitation of Liability in terms of the RAF Amendment Act

GENERAL DAMAGES

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

Tariff of general damages

The quantification of general damages remains difficult to determine with a degree of consistency in spite of case law and textbooks on the subject.

It is this unpredictability that can be problematic when it comes to settling cases quickly. It also increases the chances of over-settlement, which in the long-term drives up costs. It is not just the awards in high value catastrophic injury 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.

In order to achieve greater predictability and control costs, MPS proposes the creation of a tariff of general damages in statute and a limit on general damages.

In Australia, six states have adopted a threshold for general damages awards where no general damages are payable unless the injury is equivalent to 15% of a most extreme case and are assessed as a percentage of the capped maximum award.[17] This is similar to the provisions of the Road Accident Fund Amendment Act 2008 where general damages are only payable for 'serious' injuries expressed as a percentage. In Queensland, Australia, injuries are assessed on a '100 point scale' and reference similar injuries in earlier cases.[18] In South Australia, damages are calculated by reference to a scale value reflecting gradations of non-economic loss.[19]

Limit on general damages

The annexes explore the wide use of 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.

The South African Law Reform Commission, or a similar body, could, as part of their work on this topic, bring together an independent group of specialists to develop a tariff on general damages, and decide on the level of a limit. Queensland and Victoria have a limit based on three times the average weekly earnings.[20] This is another possibility to explore.

This group could also decide whether there needs to be an inflationary uplift on such a limit on an annual basis.

Thought must be given as to how to ensure that lawyers and judges do not orchestrate the system, as it has been suggested some do in Australia.[21] Only if this is thoroughly considered will these limits be successful.

17 Annex A and B

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

19 ibid

20 ibid

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

SPECIAL DAMAGES

- **MPS proposes a limit on future care costs**
- **MPS proposes a limit on claims for loss on future earnings**
- **MPS proposes that an independent commission establishes specific guidelines for the determination of life expectancy in the South African context**
- **MPS proposes that an independent group of experts annually considers medical inflation**

Future care costs

In representing its members, MPS recognises the importance to society for fair compensation following clinical negligence. However, this must be balanced against society's ability to meet the level of compensation required.

In recent years MPS has seen an increase in the amount of special damages claimed by plaintiffs particularly high value catastrophic injury claims.

While it is important that plaintiffs receive an award that provides them with the care they need, there can be an enormous differential between costings proposed by care experts for the plaintiff and those for the defendant. Defendants 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 for the costs incurred in care.

MPS proposes that the South African Law Reform Commission investigates the establishment of an independent review body to, as part of their current mandate, define a care package that provides an appropriate standard of care for all patients with a particular injury, regardless of the cause, and set an ultimate limit. This will have the benefit of allowing local care experts to give advice and make recommendations on the criteria for an appropriate care package for a particular injury.

Future earnings

MPS supports placing a limit on future earnings and earning capacity as an important tool in lowering costs in the system and to introduce greater parity in the size of awards plaintiffs receive.

The limits imposed by Road Accident Fund Amendment Act 2008 in respect of a claim for future loss of earnings to the sum of R234 360 per annum,[22] are in keeping with the Australian approach detailed in Annex A. In some Australian states a claim for loss of earnings is limited to a multiple of two to three times average weekly earnings.

There is a significant issue of fairness here. In many cases, the costs associated with an expensive clinical negligence system are felt by society. Yet some plaintiffs receive significantly higher special damages awards than others – 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.

Life expectancy

Intertwined with the issue of an appropriate care package is the issue of life expectancy. At present, the plaintiff and defendant have to rely on an extremely limited pool of experts from outside South Africa to advise them on the critical issue of life expectancy as there are currently no local comparable studies. This also results in an increase in costs.

MPS proposes that the same independent body discussed above establishes specific guidelines for the determination of life expectancy in the South African context.

Medical inflation

Medical inflation has the potential to add millions of Rand to claims for care costs. To ensure that what is claimed is accurate, MPS supports the creation of an independent group of experts to consider the issue of medical inflation. On an annual basis they could make recommendations on the appropriate discount rate to be used to calculate the costs of future care within special damages.

22 GN 141 of GG 39025, 24/07/2015, 105

7. OTHER RECOMMENDATIONS

- **MPS proposes a pilot of a specialist clinical negligence court**

Specialist Court

Parliament has established specialist courts for various matters, including Labour Courts, the Land Claims Court and the Special Income Tax and Electoral Court for the purpose of handling specific areas or types of cases. In some cases these courts have exclusive jurisdiction.

Whilst MPS recognises that the creation of a specialist court to handle clinical negligence cases might be too expensive for some jurisdictions at the present time, MPS would like to add support for the recommendation made at the recent Summit that the State should consider piloting the creation of specialist clinical negligence courts in the same provinces that it piloted judicial case-flow management.

- **MPS proposes that practices of 'funding companies' be investigated**

Litigation Funding

Since their inception, contingency fee agreements have been a matter of contention. There have been on-going concerns regarding the legality of common law contingency fee agreements after the enactment of the Contingency Fees Act 1997 which appears to have been recently decided by in two full bench decisions.[23] However, at the time of going to print these are still subject to appeal.

Whilst it is not MPS's intention to debate the merits or otherwise of contingency fee agreements, it is against this backdrop that MPS has noticed the emergence of companies that assist with the administration and funding of claims. Such companies, sometimes referred to as 'funding companies', in many ways offer the same service a plaintiff lawyer would. Yet these companies are not regulated by the Law Society.

MPS would welcome the inclusion of the matters of non-law firms and funding arrangements offered to possible plaintiffs into the mandates of the Law Reform Commission, the Law Society and the Financial Services Board. It is important to ensure there are adequate safeguards in place to protect plaintiffs from unethical practices.

- **MPS proposes a review into damages paid to patients from abroad**

Patients from abroad

MPS proposes that there is a review into the payment of clinical negligence damages to patients from abroad. Currently there are provisions in the Road Traffic Accident Act requiring damages to be paid in Rand and based on the costs of treatment and care in South Africa, in cases where foreign patients have been injured. We would like to see consideration as to whether this should be applied to clinical negligence cases as well. We are concerned that the current situation may mean that foreign patients receive considerably more in compensation than South African citizens.

23 Ronald Bobroff and Partners Inc v De La Guerre; South African Association of Personal Injury Lawyers v Minister of Justice and Constitutional Developments (CCT 122/13, CTT 123/13 [2014] ZACC 2; 2014 (3) SA 134 (CC); 2014 (4) BCLR 430 (CC) (20 February 2014)

ALTERNATIVE REFORMS

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 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 compensated.' [24]

While the criticisms raised are in relation to the NHS and the UK tort system, the principles are transferable to South Africa.

Others have raised concerns that such a system would also make healthcare professionals less accountable to their patients and that the focus will be on the consequences of a mistake and not learning from the causes.

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

24 Health Select Committee – sixth report, complaints and litigation, 22 June 2011

CONCLUSIONS

In representing its members, MPS recognises the importance to society for fair compensation following clinical negligence. However, this must be balanced against society's ability to meet the level of compensation required. Added to this, investing in an efficient patient-centred complaints process, which addresses concerns before they become a claim, would benefit both patients and the healthcare profession.

While the recommendations made in this paper are not exhaustive, they aim to contribute to the growing debate about whether society can continue to afford the mounting cost of clinical negligence and whether the current legal system could be improved.

MPS has considered the experience of other countries and how it is possible to learn from these to help us to develop a fairer and more efficient system. While the experience of reform in Australia and the US has been mixed, there have been many advances too.

We believe, based on our research and our experience in other international jurisdictions, that if the proposals in this paper are implemented they could begin to make a difference to the cost of clinical negligence. Even more importantly, reform could make the legal system quicker, fairer and more efficient for defendants, plaintiffs and their patients and reduce the burden on the public purse.

Prevention is better than cure, and we encourage healthcare professionals to be open and honest with patients when things go wrong. MPS has a crucial role supporting and advising members to embrace open disclosure. Our whole philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this through our workshops, E-learning, publications, conferences, lectures and presentations. We are committed to continuing this important work.

ANNEX A

INTERNATIONAL EXPERIENCE – AUSTRALIA

A REVIEW OF TORT LAW REFORM IN AUSTRALIA AS AT SEPTEMBER 2014 BY MARK DOEPEL, PARTNER, SPARKE HELMOREAND 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"[25].

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 reform.[26] 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 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

25 Reynolds v. Katoomba RSL All Services Club Ltd (2001) 53 NSWLR 43 at [26]

26 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

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 jurisdictions[27] 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 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 jurisdictions[28], 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

27 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

28 Not in the Northern Territory and, in South Australia, in a modified form

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 publicity.[29] 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.

29 For a rare example, see: *Lemoto v. Able Technical Pty Ltd* (2005) 63 NSWLR 300

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 Australia[30] 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 opthalmic 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 materialised[31], 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 of the plaintiff's surgery, because it found that the warnings understated the magnitude of the risk[32]; 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 remote[33]; 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 size[34] 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

30 *Wallace v. Kam* (2013) 297 alr 383

31 *Rogers v. Whitaker* (1992) 175 CLR 479; 109 ALR 625

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

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

34 *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

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;

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
Duty and standard of care A person is not negligent for failing to take precautions against a foreseeable risk unless: a. it is "not insignificant" and b. 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
Obvious risks 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.	Yes	Yes	Modified	Modified	Modified	No	No	Modified
Professionals 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.	Yes	Yes	Yes	Yes	Modified (health care profes-sionals only)	Modified	No	Yes
Recreational Services There should be no liability for personal injury or death for the manifestation of an obvious risk.	Yes	Yes	Modified	Modified	Yes	Modified	No	Modified
Contributory negligence 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: a. probability of harm b. seriousness of harm c. burden of taking precautions and d. social utility of the activity in question. Courts should be entitled to reduce damages on account of contributory negligence by up to 100%	Yes	Yes	Modified	Yes	Modified	Modified	No	Yes

Tort reform area	Australian responses							
	NSW	Qld	Vic	SA	WA	ACT	NT	Tas
Causation The plaintiff bears the onus of establishing both: a. factual causation; and b. the scope of liability (including both legal and "common sense" causation, foreseeability and remoteness).	Yes	Yes	Yes	Modified	Yes	Yes	No	Yes
Proportionate Liability Joint and several liability should be retained for personal injury claims.	Modified	Modified	Modified	Modified	Modified	Modified	Modified	Modified
Liability for Mental Harm There should be no liability unless the mental harm is a recognised psychiatric illness. It must have been reasonable to foresee mental harm in a person of normal fortitude, with reference to: a. whether the injury arose from witnessing a shocking incident or its aftermath b. whether there was a pre-existing relationship between the plaintiff and the defendant and c. the nature of the relationship between the plaintiff and the person who was injured or killed in the incident.	Modified	No	Yes	Yes	Yes	Yes	No	Modified
Limitation period A nationally consistent limitation period should be introduced, being a period of 3 years with a long-stop 12 year period, discretion to extend and extended period for minors. Time should commence from the date on which the plaintiff knew or should have known that an injury had occurred, the cause of which was attributable to the defendant and that the injury was sufficiently serious to warrant proceedings.	Yes	Modified	Modified	Yes	Yes	Modified	No	Modified
Thresholds for non-economic loss awards No general damages should be payable unless the injury is equivalent to 15% of a most extreme case and general damages should be assessed as a percentage of the capped maximum award.	Yes	No	Modified	Modified	Modified	Modified	Modified	Modified

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 Association[35] 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.*'[36]

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."[37] 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.*'[38]

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.[39] 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 law-suits.[40]

It is difficult to draw irm 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 cautiously[41]", 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".[42]

Despite this, a separate CBO paper found "evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted then they would be otherwise".[43]

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"[44]. Furthermore "MICRA was intended to, and has been successful in, stabilizing liability costs".[45]

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 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".[46]

35 www.atra.org/issues/medical-liability-reform, Viewed on 18 August 2014

36 ibid

37 www.ama-assn.org/ama/pub/news/news/sgr-letter-22feb2010.page Viewed on 22 August 2014

38 ibid

39 H.R.5 Help, Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003, Congressional Budget Office Cost Estimate, March 2003

40 President Barack Obama, State of Union Address, January 25 2011

41 ibid

42 ibid

43 Limiting Tort Liability for Medical Malpractice, The Congress of the United States Congressional Budget Office, January 2004

44 www.micra.org viewed on 2 October 2014

45 www.micra.org viewed on 2 October 2014

46 www.tapa.info/about-us.html

The most significant areas of reform have been:

1. Limitation periods

All states have statutes of limitation for clinicalnegligence claims.[47] 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.

2. 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".[48] 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%.[49]

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.[50]

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 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.[51]

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".[52]

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.

47 www. ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-statutes-of-limitation.aspx

48 The Effects of Tort Reform: Evidence from the States, The Congress of the United States Congressional Budget Office, June 2004

49 ibid

50 ibid

51 ibid

52 www.cmanet.org/news/detail?article=appeals-court-upholds-constitutionality-of viewed 22 August 2014

3. **Tackling frivolous claims**

According to the National Conference of State Legislatures, 28 states, such as Iowa, introduced a Certificate of Merit.[53] 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.[54] 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.[55]

4. **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.[56] 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' [57]

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.

53 www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-merit-affidavits-and-expert-witnesses.aspx viewed on 19 August 2014

54 www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx

55 The Effects of Tort Reform: Evidence from the States, The Congress of the United States Congressional Budget Office, June 2004

56 www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx

57 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)

Data taken from the PIAA chart on 'State enactments of selected health care liability reform' as of 9/15/2014, available at http://www.piaa.us

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