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AUSTRALIA'S "MOST EXTREME CASE": A NEW ALTERNATIVE FOR U.S. MEDICAL MALPRACTICE LIABILITY REFORM

Steven T. Masada[†]

Abstract: The United States currently confronts a severe increase in medical costs and a simultaneous decrease in the availability of health care services. A nearly identical situation recently emerged in the Commonwealth of Australia. This phenomenon, often labeled the "medical malpractice crisis," results in part from an increasing litigious trend spurred on by the appeal of potentially enormous damage awards. More lawsuits filed and increased award amounts raise the liability of health care providers and generate uncertainty in the medical malpractice insurance market. This in turn drives up the costs of insurance policy premiums and ultimately forces health care providers to diminish their delivery of health services. In response, many states implement reform initiatives that cap the maximum amount recoverable for an injured patient's non-economic loss. Australian jurisdictions, by contrast, take a more comprehensive approach to liability reform that incorporates a minimum loss requirement and a calculation scheme that proportions non-economic damage awards based on a hypothetical "most extreme case." The Australian approach not only limits the quantum of damages available to plaintiffs, but also produces more consistent damage awards than the U.S. cap approach. That is, Australian-style reform reduces the uncertainty posed to insurers in estimating their policyholders' liability. In turn, insurers can more accurately set rates.

The reform model followed by Australia is appropriate for the United States. If implemented, it would alleviate inefficiencies created by certain features unique to the U.S. legal system, including civil jury trials and contingency fee agreements. The regulation of non-economic damage awards in a manner consistent with Australia's reform thus presents a desirable model for U.S. policymakers, state legislatures, and the federal government to emulate in the current medical malpractice crisis.

I. INTRODUCTION

The "medical malpractice crisis" refers to the drastic upward surge in health care providers' liability insurance premiums that ultimately has encumbered patients' access to affordable health care.¹ Sometimes dubbed the "hidden defendants" in malpractice litigation,² insurance companies are

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¹ See Jerome Nates, *Damages*, in 2 MEDICAL MALPRACTICE ¶ 18.15 (David W. Louisell & Harold Williams eds., 2002). "Not surprisingly, public concern about the torts system ebbs and flows with the availability of liability insurance and accordingly, these crises are more aptly referred to as a crisis of the tort litigation/liability insurance system." Michael Mills, *Lessons from America: Professional Liability and Tort Reform*, AUSTRALIAN BAR REV., at *73, Dec. 20, 1994, available at LEXIS, News Library.

² See NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 80 (1995).

an indispensable party in an accurate analysis of the medical malpractice crisis.³ When payouts on insurance policies increase, insurance companies raise premium rates to secure adequate profits.⁴ Across the United States, medical malpractice insurance rates have escalated rapidly without evidence that patient care has deteriorated.⁵ Certain higher-risk practice areas, such as internal medicine, obstetrics/gynecology, and surgery face the most significant insurance increases.⁶ Consequently, emergency room doctors are walking off the job,⁷ physicians are closing their practices and moving to states with more favorable laws,⁸ and pregnant women cannot obtain prenatal care.⁹ The burden ultimately falls upon patients, who face higher costs and limited access to quality health care.¹⁰

In response to the ensuing public outcry, many state legislatures have limited the liability of health care providers to patients for non-economic losses—intangible harms, such as pain and suffering.¹¹ These states place a statutory maximum on the amount recoverable for non-economic losses.¹²

³ See Lee L. Bennett, *Defense Community Issues: New Liabilities and How to Respond to the Plaintiffs' Bar*, DEF. COUNS. J. 273, 283 (July 2002); Michael Mills, *Insurance and Professional Liability—The Trend of Uncertainty Or: Negligence and the High Court—A Practitioner's Perspective*, INS. L. J., at *13, November 2000, available at LEXIS, News Library. "Tort law and liability insurance enjoy a symbiotic relationship. Neither could exist without the other . . ." *Id.* at *13, n.21.

⁴ See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM* 12 (July 24, 2002); see also Mills, *supra* note 3, at *13.

⁵ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4.

⁶ See *id.*

⁷ See, e.g., Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?*, HEALTH LAWYER, December 2002, available at WESTLAW, News Library; Health Care Liability Alliance, *How Patients and Doctors are Suffering While Lawyers Profit from Litigation*, at <http://www.carh.net/pdfs/hcla.pdf> (last visited June 23, 2003); see also Stefanie Balogh & Andrew McGarry, *Doctors Push for Negligence Law Reform*, AUSTRALIAN, July 3, 2002, available at LEXIS, News Library (noting that 500 Queensland medics refused to work in protest of insurance costs).

⁸ See Health Care Liability Alliance, *supra* note 7; Rachel Zimmerman & Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice "Crisis"*, WALL ST. J., June 24, 2002, available at <http://www.pasenate.com/medmal/wsj.htm> (last visited Oct. 15, 2003).

⁹ See Zimmerman & Oster, *supra* note 8.

¹⁰ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES *supra* note 4; Nates, *supra* note 1.

¹¹ See *infra* note 124 and accompanying text.

¹² See *infra* note 124 and accompanying text. Damage awards for non-economic loss have been long recognized as a legitimate element in the American and English civil justice systems. See DAN DOBBS, *HANDBOOK ON THE LAW OF REMEDIES* 135-39 (1973). Compensatory damages, unlike punitive damages, are intended to compensate the injured patient for the losses incurred through the negligence of another. *Id.* These losses are further partitioned into two sub-categories: economic loss and non-economic loss. *Id.* While economic damage awards refer to financial costs incurred by the plaintiff as a result of injury, non-economic damage awards involve financial compensation for intangible losses. Oftentimes such damages are labeled simply as pain and suffering, but include damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. *Id.*

While insurance premiums continue to rise across the nation, states with such damage caps experience more moderate increases.¹³

A similar phenomenon also reached crisis levels in Australia.¹⁴ As in the United States, high insurance premiums caused physicians to walk off the job, eliminate risky practice areas, and relocate to less litigious jurisdictions.¹⁵ In response, state and territorial legislatures enacted, or are in the process of enacting, sweeping liability reform designed to limit the quantum of damages recoverable by any one plaintiff in a personal injury or wrongful death action.¹⁶ This Australian legislation, in addition to setting a maximum amount recoverable for non-economic losses, clearly delineates a damage calculation scheme and imposes a minimum loss requirement.¹⁷ Such comprehensive reform, in turn, significantly reduces health care providers' liability and enhances predictability and consistency for insurers. The state of New South Wales has pioneered the reform movement with its Civil Liability Act.¹⁸ Although Australian liability reform is in its early stages, early indications suggest that its regulation of damage awards will stabilize insurance markets and ensure the public's access to affordable health care.¹⁹

U.S. reform proponents, state legislatures, and the federal government should look abroad to Australia when reformulating the liability of health care providers in U.S. courts.²⁰ The Australian approach functions as an

Damages for non-economic losses constitute up to half of total damages paid in medical related injury suits. See PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 55 (1991).

¹³ See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 14-18.

¹⁴ The United States and Australia are being compared because both are industrialized nations with advanced health care systems and adversarial legal systems founded on the English common law paradigm. See Steven Mark, *Harmonization or Homogenization? The Globalization of Law and Legal Ethics—An Australian Viewpoint*, 34 VAND. J. TRANSNAT'L L. 1173, 1185 (2001) (noting that the similarities between U.S. and Australian society far outweigh the differences). Although this Comment only compares Australia and the United States, the dilemma over medical malpractice insurance is an international crisis.

¹⁵ See The Hon. Justice Michael Kirby, *Medical Malpractice – An International Perspective on Tort System Reforms*, Speech at the Conference of the Royal College of Physicians, (Sept. 11, 2000), available at http://www.hcourt.gov.au/speeches/kirbyj/kirbyj_tortsystem.htm (last visited Oct. 21, 2003) [hereinafter Kirby Speech].

¹⁶ See, e.g., Civil Law (Wrongs) Act, 2002 (Austl. Cap. Terr.); Personal Injuries (Liabilities and Damages) Act, 2003 (N. Terr.); Civil Liability Act, 2002 (Tas.); Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002 (Vict.); Civil Liability Act 2002 (W. Austl.); Personal Injuries Proceedings Act, 2002 (and Regulations) (Queensl.); Wrongs (Liability and Damages for Personal Injury) Amendment Act, 2002 (S. Austl.).

¹⁷ See *infra* Part IV.B.

¹⁸ Civil Liability Act, 2002 (N.S.W.).

¹⁹ See, e.g., Australian Medical Association, *AMA Report Card on State and Territory Tort Law Reform Activity* (Nov. 2002), available at [http://www.ama.com/au/web.nsf/doc/SHED-5FUJFW/\\$file/TLReform.pdf](http://www.ama.com/au/web.nsf/doc/SHED-5FUJFW/$file/TLReform.pdf) (last visited June 29, 2003) [hereinafter *AMA Report Card*].

²⁰ See, e.g., Jeffrey O'Connell & David F. Partlett, *An America's Cup for Tort Reform? Australia and America Compared*, 21 U. MICH. J.L. REFORM 443, 456 (1988) (beckoning Americans to look to

effective method, superior to the U.S. cap system, that moderates both the severity and uncertainty of potential medical malpractice damage awards.²¹ If implemented, reform styled after the Australian approach would advance the underlying goals pursued by U.S. reform proponents and minimize the effect of litigation-fostering elements imbedded in the U.S. legal system.

This Comment identifies the Australian approach to liability reform as a viable and sustainable alternative in the current U.S. medical malpractice crisis. Part II discusses the current medical malpractice crisis occurring in the United States and Australia. Part III addresses the factors contributing to the U.S. crisis and notes the legislative response prevalent in the individual states. Part IV focuses on Australia, noting that the Australian crisis arises from similar but not identical factors, leading the Commonwealth and individual states and territories to respond with different reform measures. Part V compares the drastically different approaches adopted by the United States and Australia in their respective reform movements, concluding that the Australian reform model is superior in achieving the underlying goal of stability in insurance markets. Finally, Part VI examines how Australian-style reform could operate within the U.S. legal system and recommends that policymakers consider adopting such an approach, especially in light of certain crisis-cultivating features unique to the U.S. legal system.

II. MEDICAL MALPRACTICE CRISIS DEFINED

A medical malpractice crisis develops when rising liability insurance ultimately hampers patients' access to health care. The availability of indemnity insurance coverage diminishes as insurance companies refuse to cover certain practice areas,²² opt to withdraw from the market entirely,²³ or

Australian initiatives in thinking about a reform agenda). American scholars often point to the systems of foreign countries as an alternative to the current system imposed in the United States. Cf. Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53 (Fall 1998); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001) (suggesting a switch to a "no-fault" system reminiscent of those in place in New Zealand and Sweden).

²¹ See *infra* Part V.

²² See Does Limitless Litigation Restrict Access to Health Care?: Oversight Hearing on Health Care Litigation Reform Before the House Subcommittee on Commercial and Administrative Law, 107 Cong. 161-63 (2002) (statement of the American Osteopathic Association), June 12, 2002 available at http://commdocs.house.gov/committees/judiciary/hju80193.000/hju80193_0.htm (last visited Oct. 21, 2003) [hereinafter Oversight Hearing].

²³ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 14. In December 2001, St. Paul Cos., the second largest medical malpractice insurer, discontinued that line of business, reporting a payout of US\$ 1.99 for every US\$ 1.00 collected through premiums. Michael Freedman, *The Tort Mess*, FORBES, May 13, 2002, at 92. British insurer Marketform warns it will pull out of Australia. Lisa Allen & Morgan Mellish, *Medical Insurer Threatens To Go*, AUSTRALIAN FIN. REV., October 12, 2002, available at

become insolvent.²⁴ Because, within the sphere of risk management, "profitability" depends on probability and predictability, coverage areas where potential liability is highly uncertain are susceptible to removal.²⁵ Insurers must consider not only adverse judgments, but also settlement amounts and other general legal costs.²⁶ Shrinking coverage areas create less competitive markets, which allow those remaining insurers to set rates at higher levels to hedge against the increased uncertainty.²⁷

Higher premiums compel health care providers to undergo a re-evaluation of their practice,²⁸ and reconsider those areas that offer the least likelihood of profitability. In 2001, U.S. doctors spent roughly US\$ 6.3 billion in insurance coverage.²⁹ Because many health care providers are either unable or unwilling to absorb these premiums, three options exist: limit the scope of practice by eliminating particularly expensive practice areas; relocate to a jurisdiction that offers lower insurance rates;³⁰ or abandon the medical profession altogether.³¹ Those remaining in the field simply apportion increased operating costs to all patients, which in turn burdens the affordability of, and access to, health services.³²

Sudden increases in insurance premiums struck the United States in the 1970s and 1980s.³³ California, for instance, endured a medical crisis in

LEXIS, News Library. St. Pauls Insurance pulled out of the Australian malpractice insurance market after reporting a 2001 loss of \$940 million in its global malpractice operation. Stewart Oldfield & Miranda McLachlan, *Mayne Faces Doubling Insurance Charges*, AUSTRALIAN FIN. REV., April 30, 2002, available at LEXIS, News Library.

²⁴ For example, HIH Insurance, the largest professional indemnity insurer in Australia, collapsed in March 2001. *Disaster*, AUSTRALIAN FIN. REV., May 12, 2001, available at LEXIS, News Library.

²⁵ See Oversight Hearing, *supra* note 22.

²⁶ See VIDMAR, *supra* note 2, at 60-61. Approximately 50% of costs incurred by malpractice litigation occurs during the pre-trial stage of lawsuits; reducing the sheer number of speculative claims significantly reduces the payouts borne by indemnity insurers. *Id.* at 61. Only 34% of malpractice premiums paid reached plaintiffs as direct compensation while 66% (approximately 46% litigation and 20% administration) was consumed by transaction costs. Californians Allied for Patient Protection, History of the Creation of MICRA, at <http://www.micra.org> (last visited June 25, 2003) [hereinafter Creation of MICRA].

²⁷ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4.

²⁸ *Id.*

²⁹ *Id.*

³⁰ For instance, states with statutory damage caps often offer lower insurance rates. See *id.*

³¹ See Oversight Hearing, *supra* note 22 (statement of the American College of Surgeons). For example, a Pennsylvania hospital announced it would cease delivering babies in June 2002, citing insurance costs. *Id.*

³² See, e.g., Patricia M. Danzon et al., *The Effects of Malpractice Litigation on Physicians' Fees and Incomes*, 80 AM. ECON. REV. 122, 125 (1990). Rising insurance premiums reach consumers through increased costs, higher taxes, reduced employer coverage, and, ultimately, limited access to quality care. See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4.

³³ Patricia M. Danzon, *Medical Malpractice Liability*, in LIABILITY: PERSPECTIVES AND POLICY 101, 101-02 (Robert E. Litan & Clifford Winston eds., 1988).

the mid-1970s similar to the crisis currently plaguing other states.³⁴ When the frequency of medical injury claims and the severity of jury awards peaked in 1975, two major California medical liability insurance carriers refused to renew medical indemnity coverage.³⁵ The remaining insurers significantly raised rates.³⁶ For example, Travelers' Indemnity Company raised its premiums to Los Angeles physicians by nearly 500%.³⁷ In response, many health care providers withheld medical services or simply refused to work until the government acted to remedy the situation.³⁸ Others practiced without insurance; an estimated 20% of California doctors were uninsured at the time.³⁹ Most health care providers merely passed the increased costs of premiums on to consumers by raising costs to individual patients,⁴⁰ as well as to employers and the government.⁴¹

Australia's health care system recently reached a similarly chaotic state as doctors, surgeons, and other health care providers closed their practices and cancelled certain procedures perceived as high-risk.⁴² Insurers raised premiums, or left the market altogether, causing unbearable burdens on health care providers seeking indemnity insurance.⁴³ At least two of Australia's largest medical insurers withdrew from the market.⁴⁴ As in the U.S. crisis, insurance rates escalated to unbearable levels and, as a result, health care suffered.⁴⁵

³⁴ Creation of MICRA, *supra* note 26.

³⁵ *Id.*

³⁶ *Id.*

³⁷ See Martin Ramey, *Putting the Cart Before the Horse: The Need to Re-Examine Damage Caps in California's Elder Abuse Act*, 39 SAN DIEGO L. REV. 599, 625-26 (2002).

³⁸ See Creation of MICRA, *supra* note 26.

³⁹ See Ramey, *supra* note 37, at 626.

⁴⁰ See *id.* at 627.

⁴¹ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4.

⁴² See Kirby Speech, *supra* note 15. This particularly affected Australia's large rural communities where the public relies on just a few health care providers for medical services. See, e.g., Mrs. Skinner, Health Care Liability Bill, Debate at the New South Wales ("NSW") Legislative Assembly, in HANSARD EXTRACT, June 21, 2001, available at <http://www.parliament.nsw.gov.au/prod/web/phweb.nsf/frames/hansard> (last visited Oct. 25, 2003).

⁴³ See, e.g., Allen & Mellish, *supra* note 23; *The Contagious Insurance Bug*, SYDNEY MORNING HERALD, August 5, 2002, available at LEXIS, News Library.

⁴⁴ United Medical Protection ("UMP"), a company that insures 32,000 doctors, constituting 90% of doctors in New South Wales and approximately 60% of the nationwide market, announced its liquidation. UMP executives point to the company's inability to cover the estimated AU\$ 450 million in claims outstanding, borne out of litigation costs, as the fundamental stimulus to the insurer's demise. Andrew Webster, *Australian Doctors Down Tools*, BBC News (April 30, 2002), at <http://news.bbc.co.uk/1/hi/world/asia-pacific/1959303.stm> (last visited June 23, 2003). UMP merely follows the trend set forth by HIH Insurance, the largest professional indemnity insurer in Australia, which filed for bankruptcy in March 2001. *Disaster*, *supra* note 24. "[W]ithdrawal of HIH from the market will cause a big rise in medical malpractice premiums in 2001 and subsequent years." *Id.*

⁴⁵ See Parliament of Australia, Current Issues Brief No. 10 2001-02, Liability Insurance Premium Increases: Causes and Possible Government Responses, March 19, 2002, available at

III. U.S. MEDICAL MALPRACTICE CRISIS: CONTRIBUTING FACTORS AND INDIVIDUAL STATE RESPONSES

In order to ensure access to affordable health care, policymakers at both the state and federal levels have focused on the factors that cause this crisis. In turn, many states have passed damage-capping legislation.

A. Factors Contributing to the Crisis

While many factors likely contribute to the U.S. medical malpractice crisis,⁴⁶ the most prevalent catalysts for increasing insurance premiums relate to a rise in medical malpractice litigation and certain inherent inefficiencies imbedded in the U.S. legal system.

1. Increases in Size of Awards and Number of Claims

The growing frequency of malpractice claims and rising severity of damage awards⁴⁷ directly affect insurance rates. The media, members of the medical and insurance industries, and the public often blame the tort system for rising health care costs.⁴⁸ Medical malpractice claims were rare in the

<http://www.aph.gov.au/library/pubs/CIB/2001-02/02cib10.pdf> (last visited June 29, 2003). Australia, unlike the United States, offers Medicare, a socialized health care system, to its citizens. See Gwen Gray, *Access to Medical Care Under Strain: New Pressures in Canada and Australia*, 23 J. HEALTH POL. POL'Y & L. 905 (1998). While the immediate burden of increased health care costs falls upon the government, consumers in Australia suffer from the limited availability of desired services and diminished quality of care, and contribute to the overburdening rise in insurance through higher taxes. *Id.*

⁴⁶ For instance, the events of September 11, 2001, decreasing investment returns, and higher reinsurance costs severely affected worldwide insurance markets. See Vandecruze, *supra* note 7; J. Robert Hunter & Joanne Doroshov, *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999) (blaming the insurance industry's mismanaged underwriting practices and reliance on investment returns for the recurrent insurance crises).

⁴⁷ "Frequency" refers to the total number of lawsuits. See Patricia M. Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413 (1987). "Severity" refers to the average amount per paid claim, including jury verdicts and out-of-court settlements. *Id.* See also Bennett, *supra* note 3, at 273. "The costs of the tort system are predicted to soon swamp the national economy, and already a national insurance crisis is ravaging the nation's essential health care system." Support H.R. 4600, the "Help Efficient, Accessible, Low-cost, and Timely Healthcare Act of 2002" (the HEALTH Act), available at http://www.neurosurgery.org/socioeconomic/medicalliability/0802_reasons_to_support_the_health_act%20I.pdf (last visited Oct. 25, 2003); see also Christopher S. Kozak, *A Review of Federal Medical Malpractice Tort Reform Alternatives*, 19 SETON HALL LEGIS. J. 599, 603-04 (1995).

⁴⁸ See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4. A recent poll conducted by the Health Care Liability Alliance confirmed that Americans are concerned about the frequency and severity of medical-related lawsuits. See *Four-in-Five Americans Concerned about Excess Litigation*, BOSTON GLOBE, June 12, 2002, available at <http://www.tala.com/AI/BG06-12-02.htm> (last visited June 23, 2003). The results appear to support a reduction in litigation: 78% of the Americans polled acknowledge that rising liability costs limit access to health care, 71% agree that litigation is a primary catalyst behind

United States until the late 1960s, when both the frequency of claims and the size of jury awards began to increase rapidly.⁴⁹ From 1975 to 1984, claims per physician rose an average rate of 10% a year, and between 1982 and 1986, claim frequency jumped from 13.5% to 17.2%.⁵⁰ A study found that only 8% to 13% of cases filed go to trial, and less than 2% result in a decision in favor of the plaintiff.⁵¹ Most claims—as many as 70%—result in no payment to the plaintiff.⁵² Still, insurers must bear the litigation expenses of defending malpractice claims.⁵³

Increases in the size of all awards are also a substantial contributor to the crisis.⁵⁴ Jury awards have grown 175% since 1994.⁵⁵ This rapid increase reflects the rising number of mammoth jury awards.⁵⁶ For example, before 1995, the state of Mississippi had never experienced an award in excess of US\$ 9 million. Since 1995, however, twenty-one jury verdicts topped that amount.⁵⁷ Although most cases never reach trial, the occasional huge jury award impairs insurance companies' ability to accurately assess risk, encourages lawyers and plaintiffs to litigate, and directly influences parties' willingness and ability to reach settlement.⁵⁸

Together, increases in the size of awards and the number of suits have devastated the predictability afforded to medical indemnity insurers.⁵⁹ Between 1999 and 2000, the median jury award increased 43%—seven times the rate of inflation—to about US\$ 3.5 million per plaintiff's verdict.⁶⁰ In turn, settlement amounts grew three-fold.⁶¹ Higher jury awards and settlements motivate more claims, as injured patients and attorneys attempt to "cash in," regardless of whether the harm was caused by substandard

skyrocketing insurance rates, and 73% support Congressional action to place reasonable limits on non-economic damages. *Id.* Only one of every three Delaware jurors polled believed that "most people who sue others in court have legitimate grievances," while four of every five agreed that "there are too many frivolous lawsuits today." Valerie Hans & William Lofquist, *Jurors' Judgments of Business Liability in Tort Cases: Implications for the Litigation Explosion Debate*, 26 L. & SOC'Y REV. 85, 94 (1992).

⁴⁹ See Danzon, *supra* note 33, at 101.

⁵⁰ See *id.* at 102-03.

⁵¹ U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 8.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ See Danzon, *supra* note 32, at 120.

⁵⁵ See Vandecruze, *supra* note 7.

⁵⁶ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 9.

⁵⁷ *Id.*

⁵⁸ *Id.* at 8. The average payment per paid claim increased from approximately US\$ 110,000 in 1987 to \$250,000 in 1999. *Id.* at 10.

⁵⁹ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 10; Danzon, *supra* note 33, at 120 (suggesting reform creating a schedule of compensation based on the age of the plaintiff and the severity of injury).

⁶⁰ See Oversight Hearing, *supra* note 22 (statement by the American Medical Association).

⁶¹ *Id.*

care.⁶² In addition, disposing of non-meritorious cases enlarges the costs borne by insurers. The average cost to defend meritless claims in 2001 was US\$ 22,967, while claims proceeding to trial but resulting in a defense verdict cost an average of US\$ 85,718.⁶³ The trend of rising litigation costs and decreasing profitability leaves the medical indemnity insurance market in a state of flux as insurers leave the market and future health care provider liability remains uncertain.

2. *Civil Juries and Contingency Fees: A Litigious Legal System*

The U.S. legal system itself contributes to the increased frequency in which parties resort to litigation.⁶⁴ The incentives created by a system that preserves the right to civil jury trials⁶⁵ and contingency fee agreements are substantial contributors to the current medical malpractice crisis.⁶⁶

a. *The U.S. Civil Jury System*

Civil juries have been identified by some as the "central villain in the illnesses of the American system of health care."⁶⁷ Use of the jury system adds to the growing litigiousness in the United States and exacerbates the medical malpractice crisis.⁶⁸ Juries add time and costs to the litigation process and augment the uncertainty of liability.⁶⁹ In civil litigation, juries have two primary tasks: assigning fault and assessing damages.⁷⁰ Inconsistency between juries with respect to both tasks often results in the

⁶² U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4 (blaming the legal system for medical malpractice crisis).

⁶³ See Oversight Hearing, *supra* note 22.

⁶⁴ See Lucille M. Ponte, *Reassessing the Australian Adversarial System: An Overview of Issues in Court Reform and Federal ADR Practice in the Land Down Under*, 27 SYRACUSE J. INT'L L. & COM. 335, 343-46 (2000); David E. Bernstein, *Procedural Tort Reform: Lessons from Other Nations*, CATO REV. OF BUS. & GOV'T, available at <http://www.cato.org/pubs/regulation/reg19n1e.html> (last visited June 29, 2003).

⁶⁵ U.S. CONST. amend. VII; see, e.g., *Dairy Queen v. Wood*, 369 U.S. 469 (1962). State constitutions guarantee similar rights. See, e.g., WASH. CONST. art. I, § 21; CAL. CONST. art. I, § 16.

⁶⁶ See, e.g., Bernstein, *supra* note 64; Ponte, *supra* note 64, at 335-43.

⁶⁷ See VIDMAR, *supra* note 2, at 4.

⁶⁸ *Id.* at 3 (noting "[c]ritics of that system . . . argue that the jury is the primary flaw in the legal procedures through which disputes over liability and compensation for injuries alleged to be caused by the negligence of another are resolved."). For example, physician groups have long argued that other physicians and health care providers are the most qualified individuals to decide liability. Kirk Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1379 (1989).

⁶⁹ See VIDMAR, *supra* note 2, at 185.

⁷⁰ See *id.* at 7-10.

assessment of significant damage awards without legal fault.⁷¹ This encourages plaintiffs with non-meritorious claims to file suit in the hopes that a jury may find in their favor or that an insurer may opt for settlement in lieu of risking an adverse jury verdict.⁷² All of these factors directly produce higher insurance premiums.

Many reform proponents claim that the arbitrariness of civil juries lies at the core of the uncertainty in damage awards.⁷³ Jury awards have risen dramatically over recent decades, out of proportion to the injuries actually sustained.⁷⁴ Plaintiffs' attorneys wield unlimited freedom when requesting damage amounts.⁷⁵ Juries, as a result, become more accepting of large awards:

Juries have become accustomed to huge award requests and they are more willing to reach into the deep pocket of malpractice insurers to compensate the victims generously—more willing than when they encounter the victims of automobile accidents, for in these cases the insurance premiums at risk are paid directly by the jurors themselves.⁷⁶

While quantifiable losses limit economic damages,⁷⁷ the nebulous categories of non-economic losses⁷⁸ provide for virtually limitless damage requests.⁷⁹

Studies show that legally insignificant factors significantly affect jurors' assessment of damages.⁸⁰ Juries award more when they perceive that the defendant can afford to pay more.⁸¹ For instance, a 1991 study noted

⁷¹ *Id.*

⁷² *Id.*; see also Kozak, *supra* note 47, at 619. High damage awards increase settlement amounts in other cases by setting a higher standard for compensation. See VIDMAR, *supra* note 2, at 3. This is crucial, considering that less than 10% of medical malpractice suits actually make it to trial. *Id.* at 5.

⁷³ VIDMAR, *supra* note 2, at 191-93; accord Peter H. Schuck, *Scheduled Damages and Insurance Contracts for Future Services: A Comment on Blumstein, Bovbjerg, and Sloan*, 8 YALE J. ON REG. 213, 221 (1991) (noting that, even if a strict scheduling damage scheme were adopted, difficulties will persist as long as the jury plays the central role in awarding damages.)

⁷⁴ See, e.g., VIDMAR, *supra* note 2, at 191 (between 1975 and 1985, jury awards increased nationwide 363% from US\$ 220,018 to US\$ 1,017,716); Health Care Liability Alliance, *supra* note 7 (average jury award rose 79% between 1993 and 1999).

⁷⁵ See WEILER, *supra* note 12, at 48.

⁷⁶ *Id.*

⁷⁷ See *supra* note 12 and accompanying text.

⁷⁸ See *supra* note 12 and accompanying text.

⁷⁹ See Nates, *supra* note 1, ¶ 18.01 [2].

⁸⁰ See generally, VIDMAR, *supra* note 2.

⁸¹ *Id.* at 191 ("What makes the damage awards in professional liability lawsuits particularly disconcerting is the fact that identical juries will command much higher recoveries in malpractice cases than in other tort suits. . .") (quoting American Medical Association (AMA) Specialty Society Medical

that an amputated leg resulted in a median jury award of US\$ 199,999 in automobile cases, while the same injury caused through physician malpractice led to a median award of US\$ 754,000.⁸²

The average juror lacks legal experience. Without clear guidance by legal principles, jurors may tend to revert to their emotions and sympathies in assigning fault and damage amounts.⁸³ A typical jury instruction offers virtually no guidance for how to assess non-economic damages:

The damages for pain and suffering should include such amounts as you find, by the greater weight of the evidence, is fair compensation for the actual physical pain and mental suffering which were the immediate and necessary consequences of the injury. There is no fixed formula for evaluating pain and suffering. You will determine what is fair compensation by applying logic and common sense to the evidence.⁸⁴

Erratic and unpredictable non-economic damage awards result because "juries are left with nothing but their consciences to guide them."⁸⁵ While non-economic damages are compensatory,⁸⁶ juries often augment pain and suffering awards in light of the defendant's conduct.⁸⁷ "Doing the right thing" in some situations may result in punishing bad actors, not a specific bad act.⁸⁸ As a result, a non-economic damage award may exceed its

Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System* (1988)); see also WEILER, *supra* note 12, at 48.

⁸² VIDMAR, *supra* note 2, at 191.

⁸³ See CLARK HAVIGHURST, *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* (1988). But see *Nelson v. Trinity Med. Ctr.*, 419 N.W.2d 886 (N.D. 1988) (holding that a court may remit a verdict where the jury was clearly influenced by sympathy and frustration with the provider's conduct).

⁸⁴ VIDMAR, *supra* note 2, at 189 (offering a typical jury instruction for pain and suffering).

⁸⁵ Victor E. Schwartz & Leah Lorber, *Twisting the Purpose of Pain and Suffering Awards: Turning Compensation into "Punishment"*, 54 S.C.L. REV. 47, 49 (2002); see also Danzon, *supra* note 33, at 120.

⁸⁶ RESTATEMENT (SECOND) OF TORTS § 903 (1979). It is reversible error if the jury does not make an award for pain and suffering. *American States Ins. Co. v. Audubon Country Club*, 650 S.W.2d 252 (Ky. 1983) (finding reversible error to accept a verdict for medical expenses with no recovery for pain and suffering); *Bowers v. Sprouse*, 254 Va. 428, 492 S.E.2d 637 (1997) (holding jury award for exact amount of economic damages is inadequate as a matter of law; plaintiff experienced pain, suffering, and inconvenience for which he is entitled compensation). See also Schwartz & Lorber, *supra* note 85.

⁸⁷ See generally, Schwartz & Lorber, *supra* note 85.

⁸⁸ *Id.* The temptation for jurors to disregard the preponderance of evidence presented at trial increases when they perceive the defendant as deserving punishment, regardless of whether the defendant caused the harm in this case. See Bernstein, *supra* note 64. "The jury system seems to show a desire for punitive [action] and retribution above and beyond the degree of injury—'let's get the rich doctor.'" Reported in United States Accounting Office (U.S. GAO), Report to Congressional Requesters, *Medical Malpractice: Case Study in North Carolina* (Dec. 1986) quoted in VIDMAR, *supra* note 2, at 4.

compensatory function to impose a punitive effect.⁸⁹

Jury awards are erratic and oftentimes unpredictable.⁹⁰ Given two injured patients with identical injuries, socioeconomic situations, and other material characteristics, two different juries are unlikely to arrive at comparable damage amounts.⁹¹ In a hypothetical situation, Defendant physician (“Dr. Defendant”) performs surgery on the knee of Plaintiff patient (“Patient”). Complications caused by Dr. Defendant’s negligent care result in Patient never regaining full range of motion in his knee. Dr. Defendant also negligently treats Patient’s neighbor for the same leg injury, with the same adverse result. Even assuming both plaintiffs possess identical material characteristics, (e.g., interests, income, status in society) the likelihood is slight that two independent juries comprised of individuals with different backgrounds and values would render similar verdict amounts.⁹² The jury system may award Patient a huge judgment while his neighbor receives a nominal award, or vice versa. This hypothetical demonstrates the disparate justice provided to injured patients as well as the unpredictability posed to health care providers and malpractice insurers in assigning premium amounts.

While injuries vary in severity, the U.S. cap system⁹³ does not accommodate for the fact that the most egregious medical errors are the least likely to occur.⁹⁴ Medical insurers must accommodate for the variability of juries and cannot reasonably estimate valuations for potential claims brought against their policyholders.⁹⁵

b. *The Contingency Fee Agreement*

Contingency fee agreements further fuel the legal backlog that increases litigation costs borne by insurers.⁹⁶ Such arrangements allow attorneys to provide legal services for a fee based on a percentage of the amount ultimately recovered by the client.⁹⁷ In theory, parties negotiate the

⁸⁹ See Schwartz & Lorber, *supra* note 85.

⁹⁰ See VIDMAR, *supra* note 2, at 7.

⁹¹ See *id.* at 191-93.

⁹² *Id.*

⁹³ See *infra* note 112 and accompanying text.

⁹⁴ See *infra* note 112 and accompanying text.

⁹⁵ See *infra* Part V.B.

⁹⁶ See Ponte, *supra* note 64, at 341-42.

⁹⁷ Victor E. Schwartz et al., PROSSER, WADE AND SCHWARTZ’S TORTS: CASES AND MATERIALS 543 (10th ed. 2000). Before the legal barriers gave way to competing social concerns, any fee arrangements based on the outcome were not only unethical but also illegal under the torts of champerty and maintenance. See Susan Lorde Martin, *Financing Plaintiffs’ Lawsuits: An Increasingly Popular (And Legal) Business*, 33 U. MICH. J.L. REFORM 57, 73 (2000). Champerty, a form of maintenance, refers to a

exact percentage. However, the common rate in the United States is as high as 40%.⁹⁸

While contingency fees comprise the backbone of U.S. civil litigation,⁹⁹ critics of these types of arrangements cite two fundamental flaws. First, contingency fees rarely result in a reasonable fee relative to the legal services provided.¹⁰⁰ Second, by investing their own financial interests in the case's outcome, the attorneys' interest may no longer mirror their clients' interests.¹⁰¹ Ultimately, an incentive arises for attorneys to pursue more speculative litigation with higher potential payouts.¹⁰² Health care providers and insurers incur more legal costs defending such claims.¹⁰³ The increasingly litigious trend in the United States in conjunction with a litigation-promoting legal system has injured the U.S. health care system and prompted states to seek legislative remedial measures.

B. *U.S. Legislative Response to the Medical Malpractice Crisis: Non-Economic Damages Caps*

Insurance companies assess the potential liability of policyholders and forecast potential payouts when setting premium rates.¹⁰⁴ Consequently, accurate risk assessment necessitates some level of predictability and certainty with regard to liability.¹⁰⁵ Many individual states address this need for stability and predictability by imposing legislative caps on patients' recoveries for injuries arising from medical negligence.¹⁰⁶

Endeavoring to fully compensate unquantifiable, non-economic losses

bargain between a stranger and a party to a lawsuit by which the stranger pursues the party's claim in consideration of receiving part of any judgment. See BLACK'S LAW DICTIONARY 93 (2d ed. 2001); Ponte, *supra* note 64, at 341-42.

⁹⁸ See Schwartz et al., *supra* note 97. MICRA also limits attorney contingency fees: 40% of the first US\$ 50,000; 33% of the next US\$ 50,000; 25% of the next US\$ 500,000; and 15% of any amount exceeding US\$ 600,000. CAL. BUS. & PROF. CODE § 6146 (West 2003).

⁹⁹ All U.S. states recognize such arrangements. See Kenneth A. Ewing, *Quantum Meruit in Ohio: The Search for a Fair Standard in Contingent Fee Contracts*, 18 U. DAYTON L. REV. 109, 110 (1992). See also Martin, *supra* note 97.

¹⁰⁰ Schwartz et al., *supra* note 97; U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 10.

¹⁰¹ U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 10.

¹⁰² A lawyer on a contingency fee has an incentive to develop a portfolio of cases, in hopes that at least one case results in a huge verdict. *Id.*; VIDMAR, *supra* note 2, at 169.

¹⁰³ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 10.

¹⁰⁴ See *id.* (noting payouts include adverse judgments, settlements, and other litigation costs).

¹⁰⁵ Danzon, *supra* note 47, at 417; James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171, 176 (1991).

¹⁰⁶ See Danzon, *supra* note 47, at 416 (finding the average impact of statutes limiting plaintiff's recovery has been to reduce average severity of awards by 23%).

is inefficient.¹⁰⁷ The burden placed on potential defendants reaches a level at which no one benefits.¹⁰⁸

“Every system of law must set some bounds to the consequences for which a wrongdoer must make reparation. If the burden is too great it cannot and it will not be met, the law will fall into disrepute and will be a disservice to those victims who might reasonably have expected compensation. In any state or society it is ultimately a question of policy to decide the limits of liability.”¹⁰⁹

Pain and suffering and other non-economic damages are ready targets due to the inherent arbitrariness in compensating intangible losses.¹¹⁰

In the 1970s, a sudden surge in medical malpractice insurance rates led Congress to convene an emergency hearing.¹¹¹ Congress, however, ultimately abstained, leaving the states to manage their respective crises.¹¹² Presently, many state legislatures are seeking to reduce health care providers' liability and provide stability to insurance markets through

¹⁰⁷ See Danzon, *supra* note 33, at 122; see also Angus Corbett, *A Reformulation of the Right to Recover Compensation for Medically Related Injuries in the Tort of Negligence*, 19 SYDNEY L. REV. 141, 176 (1997) (stating “while the notion of the right to obtain full compensation . . . is appealing it is an ultimately self defeating one.”).

¹⁰⁸ Mills, *supra* note 1, at *1; Danzon, *supra* note 33.

¹⁰⁹ Mills, *supra* note 1, at *1 n.1 (quoting Lord Hacking, debating civil liability in England).

¹¹⁰ See *supra* note 12 and accompanying text.

¹¹¹ See Ramey, *supra* note 37, at 625.

¹¹² *Id.* Recently, however, the federal government has plunged into the debate and Congress has entertained several health care reform bills that attempt to incorporate state damage-controlling measures into federal law. See Kristin Loiacono, *A Good Fight in the House over Medical Malpractice “Reform,”* TRIAL, May 2003, available at WESTLAW, News Library. The reform movement has continued to intensify since 1995, when then Speaker of the House Newt Gingrich pledged a conservative agenda outlined in the Contract with America. *Id.* The first bill to address medical malpractice reform independently, the Help Efficient, Accessible, Low Cost, Timely Health Care Act of 2002 (“HR 4600”), appeared in July 2002 and sought “[t]o improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.” See H.R. 4600, 107th Cong. (2d Sess. 2002). HR 4600 aspired to implement a nationwide cap on non-economic damages setting the maximum recovery for victims of medical negligence at US\$ 250,000, mirroring the provision in MICRA. *Id.*

In September 2002, HR 4600 received approval in the House of Representatives, but later floundered in the Senate. See Richard A. Oppel, Jr., *Bush Enters the Fray Over Malpractice*, N.Y. TIMES, Jan. 17, 2003, available at <http://www.consumerwatchdog.org/healthcare/nw/nw003162.php3> (last visited June 23, 2003). Since then, supporters of HR 4600 have introduced H.R. 5, a bill nearly identical to HR 4600. See Loiacono, *supra*. The bill, which also cites as its model California's MICRA, narrowly passed through the House. *Id.* The federal government continues to push for health care reform on the federal level; regardless of whether an initiative passes into law, the repeated attempts to mimic the MICRA provisions exemplify the United States' rooted adherence to the non-economic damage cap as the method to ameliorate the insurance crisis.

predetermined, rigid caps that limit damage awards but allow no flexibility for the circumstances of each case.¹¹³ While variations of legislative caps exist, the prevalent statutory paradigm mimics that first adopted by California in the mid-1970s.¹¹⁴

1. California's Medical Insurance Compensation Reform Act

In May 1975, then California Governor Jerry Brown called a special session of the legislature to resolve the crisis of skyrocketing medical malpractice premiums.¹¹⁵ The ensuing legislation, the Medical Insurance Compensation Reform Act ("MICRA"),¹¹⁶ radically modified the remedies available to injured patients.

MICRA, still in force today, imposes a bright-line US\$ 250,000 cap on non-economic damages in medical malpractice suits.¹¹⁷ The MICRA cap applies to all medical malpractice plaintiffs, regardless of the severity of the injury, the gravity of the loss, or the absence of other means for compensation.¹¹⁸ The statute requires trial judges to reduce any jury award in excess of the cap amount.¹¹⁹

Supporters claim that MICRA subdued California's rocketing insurance rates while simultaneously protecting access to courts and ensuring adequate recovery for legitimate claims.¹²⁰ Over MICRA's first twenty-five years, California insurance premiums increased at one-third the national rate—a 167% increase, compared to a 500% spike in rates for the rest of the country.¹²¹ California now boasts some of the lowest malpractice

¹¹³ See *supra* note 124 and accompanying text.

¹¹⁴ See *supra* note 124 and accompanying text.

¹¹⁵ See Ramey, *supra* note 37, at 625-26; Creation of MICRA, *supra* note 26.

¹¹⁶ Medical Insurance Compensation Reform Act, 1975 Cal. Stat. 3949.

¹¹⁷ CAL. CIV. CODE § 3333.2 (West 2003). MICRA, codified in part as California Civil Code § 3333.2, reads:

(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for non-economic losses exceed two hundred fifty thousand dollars (\$250,000).

Id. Consumer advocates have sought to raise this amount, claiming it is outdated in light of inflation and inadequate. See Ramey, *supra* note 37, at 628-29 (noting that US\$ 250,000 in 1975 only equates to US\$ 83,000 today).

¹¹⁸ *Id.*

¹¹⁹ *Id.*; see, e.g., Salgado v. County of Los Angeles, 19 Cal.4th 629, 967 P.2d 585 (1978).

¹²⁰ Health Care Liability Alliance, *supra* note 7.

¹²¹ See Loiacono, *supra* note 112; Physician Insurers Association of America, *Debunking the May 29, 2002 Malpractice Premium Analysis Published by the Center for Justice & Democracy*, June 27, 2002 cited in Washington State Medical-Education and Research Foundation, *The Impact of Medical Malpractice*

premiums in the United States.¹²² In turn, health care providers, especially those in high-risk specialty areas such as obstetrics and neurosurgery, are able to obtain reasonably-priced insurance.¹²³

2. *Other States Following the Success of MICRA*

Capping non-economic damage awards is now the standard model for American liability reform. Other states have recognized MICRA's success in California and followed suit by enacting identical or substantially similar measures.¹²⁴ While permutations of the MICRA model exist, the basic framework is consistent: a maximum cap on non-economic damage awards.¹²⁵ Some state supreme courts have invalidated such legislation on state constitutional grounds.¹²⁶ The fact that state legislatures continue to

Insurance and Tort Law on Washington's Health Care Delivery System, Sept. 2002, available at http://www.wsma.org/Tort_reform.pdf (last visited Oct. 25, 2003). Empirical analysis suggests that removing the \$250,000 non-economic cap could increase the cost of health care in California by more than \$6 billion per year. See Legislative Corner, *Hamm Report*, at http://www.capmpt.com/legislative_corner/hamm_report.html (last visited June 29, 2003); see also Ron Neupauer, Medical Underwriters of California, *2002 California Large Loss Trend Study: A Survey of California Malpractice awards and Settlements over \$1 Million*, available at <http://www.micc.com/largeloss/losstrend2002.htm> (last visited June 29, 2003).

¹²² Californians Allied for Patient Protection, *The California Story, MICRA: A Successful Model for Affordable and Accessible Health Care*, available at <http://www.micra.org> (last visited June 25, 2003) [hereinafter *California Story*]. In 1975, California physicians faced the highest medical malpractice rates in the nation; now, however, California remains in the lower third. See Vandecruze, *supra* note 7. MICRA's non-economic damages limits saved roughly US\$ 516 million in claim payments over ten years. See Ramey, *supra* note 37, at 633.

¹²³ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 2-4.

¹²⁴ See COLO. REV. STAT. § 13-64-302(1) (2001) (US\$ 250,000 limit on non-economic damages); FLA. STAT. ANN. §§ 766.207(7)(b), 766.209(4)(a) (West 2001) (capping non-economic damages at US\$ 350,000 per incident if the claimant rejects voluntary binding arbitration); HAW. REV. STAT. § 663-8.7 (2001) (US\$ 375,000 limit on damages for pain and suffering with certain classes of torts excepted); IDAHO CODE § 6-1603(1) (Michie 2001) (US\$ 400,000 cap on non-economic damages); KAN. STAT. ANN. § 60-1903(a) (2001) (US\$ 250,000 limit on non-economic damages in wrongful death action); ME. REV. STAT. ANN. tit., 24-A § 4313 (2001) (US\$ 400,000); MD. CODE ANN., CTS. & JUD. PROC. § 11-108(b)(2) (2001) (US\$ 500,000 limit on nonpunitive non-economic damages); MASS. ANN. LAWS ch. 231, § 60H (Law. Co-op. 2001) (US\$ 500,000 limit on non-economic damages with exceptions); MICH. COMP. LAWS § 600.1483(1) (2001) (US\$ 280,000 limit on non-economic damages with exceptions); MO. REV. STAT. § 538.210 (2001) (US\$ 350,000 cap per defendant on non-economic damages); MONT. CODE ANN. § 25-9-411(1) (2001) (US\$ 250,000 limit on non-economic damages in medical malpractice claim); N.D. CENT. CODE § 32-42-02 (2001) (US\$ 500,000 limit on non-economic damages); S.D. CODIFIED LAWS § 21-3-11 (Michie 2002) (US\$ 500,000 cap on non-economic damages); UTAH CODE ANN. § 78-14-7.1 (2002) (US\$ 400,000 limit on nonpunitive, non-economic damages); W. VA. CODE ANN. § 55-7B-8 (Michie 2001) (US\$ 1,000,000 limit on non-economic damages in medical malpractice action); WIS. STAT. § 893.55(4)(d) (2001) (US\$ 350,000 cap on non-economic damages).

¹²⁵ See *supra* note 124 and accompanying text.

¹²⁶ *E.g.*, *Williams v. Wilson*, 972 S.W.2d 260 (Ky. 1998); *Zoppo v. Homestead Ins. Co.*, 71 Ohio St.3d 552, 644 N.E.2d 397 (1994), cert. denied, 516 U.S. 809 (1995); *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *Condemarin v. Univ. Hosp.*, 775 P.2d 349 (Utah 1989); *Sofie v. Fibreboard*

mimic MICRA, however, evidences the prevalence and appeal of the method. In the current crisis, states with non-economic damage caps enjoy increased stability and controlled indemnity premiums.¹²⁷ In contrast, states lacking statutory reform face skyrocketing insurance rates, hesitant care providers, and a crisis in affordable access to health care.¹²⁸

3. States Lacking Damage Caps

States without an effective non-economic damage award limitation currently face the most severe problems with health care.¹²⁹ This group includes states such as Florida, where the state supreme court struck down MICRA-like legislation.¹³⁰

In recent years, multimillion-dollar jury awards have become more common, and states without non-economic damage caps leave health care providers subject to enormous liability.¹³¹ States that have no legislative mechanism to control non-economic damage awards encounter the largest medical malpractice premium increases.¹³² In one year, the average premium in states lacking legislative caps, such as Illinois, Ohio, Nevada, New York, and West Virginia, increased by as much as 44%, while states with non-economic damage caps between US\$ 250,000 and US\$ 350,000 experienced an average increase of 12% to 15%.¹³³

In states without caps, rising insurance rates significantly limit patient access to adequate health care.¹³⁴ In July 2002, the Trauma Unit at the Las Vegas University Medical Center, the only Level 1 trauma center in Nevada, closed for ten days.¹³⁵ Fifty-seven of fifty-eight orthopedic doctors resigned, citing sharp increases in their insurance premiums.¹³⁶ The Center reopened

Corp., 112 Wash.2d 636, 771 P.2d 711 (Wash. 1989); *Smith v. Dep't of Ins.*, 507 So.2d 1080 (Fla. 1987) (per curiam). Other states have upheld statutory caps on damages against constitutional challenges. *E.g.*, *Samsel v. Wheeler Transp. Servs., Inc.*, 246 Kan. 336, 789 P.2d 541 (1990); *Etheridge v. Med. Ctr. Hosps.*, 237 Va. 87, 376 S.E.2d 525 (1989); *Johnson v. Saint Vincent Hosp., Inc.*, 273 Ind. 374, 404 N.E.2d 585 (1980). See also Robert S. Peck, *Caps on Damages: Adding Injury to Injury*, TRIAL, at 22, Sept. 2002.

¹²⁷ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 14-17.

¹²⁸ *Id.* at 12-14; see also Mills, *supra* note 1, at *77-78; *California Story*, *supra* note 122.

¹²⁹ See, e.g., Symposium, Monique A. Anawis, *Tort Reform 2003*, 6 DEPAUL J. HEALTH CARE L. 309, 310 (2003); U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 12-14.

¹³⁰ See *supra* note 126 and accompanying text.

¹³¹ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note 4, at 6-11.

¹³² See *id.* at 12.

¹³³ *Id.* at 14.

¹³⁴ See Vandecruze, *supra* note 7.

¹³⁵ Anawis, *supra* note 129, at 311. Similarly, in January 2003, West Virginia surgeons took a 30-day leave of absence in protest of rising insurance premiums. *Id.* at 312.

¹³⁶ *Id.* at 311. Many of these Las Vegas doctors saw their medical malpractice insurance premiums increase between US\$ 40,000 and US\$ 200,000. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, *supra* note

only after some physicians agreed to become county employees, thereby receiving the protection of a US\$ 50,000 non-economic damage cap.¹³⁷

The U.S. cap approach to non-economic damage awards certainly addresses reform goals in that insurers no longer face the potential for unlimited payouts. Simply setting a predetermined cap, however, significantly differs from the liability reform movement of Australia.

IV. AUSTRALIAN MEDICAL MALPRACTICE CRISIS: CONTRIBUTING FACTORS AND UNIFORM LEGISLATIVE RESPONSE

Increases in litigation have created a crisis in the Australian insurance industry. Unlike the United States, Australia favors reform measures that incorporate a calculation scheme for non-economic damages that bases recovery on the loss incurred in a hypothetical “most extreme case.”

A. *Factors (Not) Contributing to Australia’s Crisis*

Australia, like the United States, has also experienced an increasingly litigious trend and inflated damage awards in connection with medical malpractice suits.¹³⁸ Reform proponents condemn Australia’s litigious course,¹³⁹ referring to it as the “Americanisation of the legal system.”¹⁴⁰

Despite sharing an English common law heritage, the Australian and U.S. legal systems differ in several important aspects.¹⁴¹ For instance, Australia does not use civil juries and attorneys are compensated according to an hourly wage—two features that help reduce litigation, judicial backlog, and the high costs associated with the American civil system.¹⁴²

In Australia, judges, not juries, generally assign fault and assess

4, at 2. Las Vegas patients depend on this trauma center; the next nearest Level 1 trauma center equipped to treat the most severely injured patients is five hours away by car. *Id.*

¹³⁷ See Vandecruze, *supra* note 7.

¹³⁸ See Kirby Speech, *supra* note 15; Premier Bob Carr, Civil Liability Amendment (Personal Responsibility) Bill, Address to the Legislative Assembly (Second Reading), in HANSARD EXTRACT, Oct. 23, 2002 available at <http://www.parliament.nsw.gov.au/prod/web/phweb.nsl/frames/hansard> (last visited Oct. 25, 2003).

¹³⁹ See, generally, *Naxakis v. West General Hospital*, (1999) 197 CLR 269 (twelve-year-old boy sued hospital for failing to conduct an angiogram, a procedure which may have diagnosed his head injury).

¹⁴⁰ See Carr, *supra* note 138. “If we look at the trends in the United States, it is clear that the writing is on the wall for us here in Australia, . . . [T]he American experience is a prediction of things to come in Australia and we would do well to take note.” Kirby Speech, *supra* note 15. “Overseas, the United States’ experience, in particular, shows what can happen if the legal system allows professional and occupational liability to go unchecked.” Mills, *supra* note 1, at *2.

¹⁴¹ See Ponte, *supra* note 64, at 339.

¹⁴² See Bernstein, *supra* note 64. The Australian legal system is inherently more procedurally and substantively efficient and consistent than that of the United States. See Ponte, *supra* note 64, at 340-41.

damages.¹⁴³ Using judges as finders of fact and law centralizes the decision-making power in those with the most expertise.¹⁴⁴ While average persons possess no legal training and may serve on a jury only a few times, judges wield a breadth of legal knowledge and experience gained from numerous lawsuits.¹⁴⁵ Judges determine damage awards with the familiarity of prior awards and similar claims.¹⁴⁶ In turn, judges are less prone to render decisions guided by sympathy or emotion and are less susceptible to misdirection by counsel in assessing damages.¹⁴⁷ Finally, whereas juries need not explain their reasoning or the method utilized in reaching a judgment or verdict amount,¹⁴⁸ judges must justify their findings in their opinions.¹⁴⁹ Final judgments, thus, bear more credibility and consistency.¹⁵⁰

In addition, the limitations Australia places on fees payable for legal services reduce the incentive for attorneys to pursue speculative claims.¹⁵¹ Unlike U.S. attorneys, most Australian attorneys¹⁵² are paid based on an hourly wage.¹⁵³ The majority of Australian states and territories, either through civil or criminal penalties, forbid fee agreements based on a successful outcome.¹⁵⁴ Three states have abolished such penalties, but still refuse to embrace contingency fees.¹⁵⁵ Instead, these Australian states and territories employ conditional fee agreements—a premium payment based

¹⁴³ See Ponte, *supra* note 64, at 340-41. For example, South Australia abolished jury trials in all civil lawsuits. See Michael Tilbury & Harold Luntz, *Punitive Damages in Australian Law*, 17 *LOY. L.A. INT'L & COMP. L. REV.* 769, 775-76 (1995).

¹⁴⁴ See VIDMAR, *supra* note 2, at 221 (noting that experienced judges will possess knowledge of other cases and can approximate the "going rate" for pain and suffering in certain classes of injury).

¹⁴⁵ See *id.*

¹⁴⁶ *Id.* Use of prior decisions in assessing damage awards is a basis for many scholarly approaches to reform. Schuck, *supra* note 73, at 216-17 (noting that "damage decisions by juries, . . . are more likely to be fair and accurate if they are based on reliable information about awards in prior cases."); cf. David Andrew Ipp et al., Review of the Law of Negligence: Final Report, 186-87, Sept. 2002 (recommending the implementation of a Tariff System, whereby counsel and court may consider awards of non-economic damages in prior cases) [hereinafter Ipp Report].

¹⁴⁷ Cf. Blumstein et al., *supra* note 105, at 177-78 (suggesting a most extreme measure—implementation of a schedule of damages, where injuries receive an amount prescribed by prior awards resulting from similar injuries.).

¹⁴⁸ Blumstein et al., *supra* note 105, at 175 (labeling jury deliberations as a proverbial "black box").

¹⁴⁹ See, e.g., *Pacific Dunlop Ltd. (T/as Dunlap Footwear) v. Rozina Krivec* (1996), __ N.S.W.L.R. __, available at http://www.austlii.edu.au/cgi-bin/disp.pl/au/cases/nsw/supreme_ct/95040172.html (last visited Oct. 29, 2003).

¹⁵⁰ See VIDMAR, *supra* note 2.

¹⁵¹ See Ponte, *supra* note 64, at 340-42.

¹⁵² In Australia, attorneys are often divided into two groups: solicitors and barristers. *Id.* at 342.

¹⁵³ *Id.* at 341; see also Martin, *supra* note 97, at 58; Mark, *supra* note 14, at 185.

¹⁵⁴ See Maintenance and Champerty Abolition Act, 1992, no. 88, 2 N.S.W. Stat. (1993) (N.S.W.); Criminal Law Consolidation Act, 1935, sched. 11 § 1(3) (S. Austl.); Crimes Act, 1958, pt. IA § 322A (Vict.); see also *supra* note 97 and accompanying text.

¹⁵⁵ See, e.g., Ponte, *supra* note 64, at 335-43.

on the attorney's hourly wage.¹⁵⁶ Because payment does not rely on the amount recovered, attorneys are disinclined to pursue claims based solely on potentially large payouts and insurers in turn face fewer speculative suits.¹⁵⁷

Although it has a legal system less susceptible to excessive insurer liability than the United States, Australia still experiences rising insurance premiums. This phenomenon supports the notion that non-economic damage awards play a significant role in the medical malpractice crisis.

B. Australia's Legislative Response: The "Most Extreme Case" Scheme

Throughout Australia, liability reform generally mirrors a model set forth in New South Wales. Non-economic damage awards are calculated according to each plaintiff's loss in relation to a hypothetical "most extreme case."

1. New South Wales and the Civil Liability Act

The state of New South Wales ("NSW") currently leads the Australian tort reform movement and is used by policymakers in other jurisdictions as a model for medical indemnity reform. This was not always so.¹⁵⁸ Prior to the adoption of recent legislation, NSW was recognized as the most litigious and plaintiff-friendly jurisdiction in Australia.¹⁵⁹ In response, the NSW government has since taken the lead in the tort reform movement.¹⁶⁰ NSW courts now uniformly address virtually all negligence-based personal injury or wrongful death claims, including medical-related injuries.¹⁶¹

NSW first addressed the medical malpractice crisis when the

¹⁵⁶ Conditional fees allow for payment of a premium amount upon the client's recovery, but base the fee upon a percentage of the attorney's normal hourly wage for the services provided. See, e.g., Ponte, *supra* note 64, at 335-43. For instance, in NSW, solicitors and barristers may legally enter cost agreements with clients providing that payment is contingent on the successful outcome of the legal matter; and, although the agreement may provide an amount more than the hourly wage, that premium is limited by statute to a maximum of 25% above normal costs. *Id.* In South Australia, the maximum premium permissible by statute is double the otherwise normal fees. Legal Profession Act, 1987, pt. 11, div. 3, (N.S.W.). Only in unique cases is it permissible for costs to be calculated as a proportion of, or vary according to, the amount recovered in the legal proceeding. *Id.*

¹⁵⁷ See Ponte, *supra* note 64, at 335-43.

¹⁵⁸ See AMA Report Card, *supra* note 19.

¹⁵⁹ In May 1996, Brendan Dooley, an Australian surgeon, stated: "Sydney is a cowboy town for medical litigation . . . second only to California." Greg J. Reinhardt, *Compensation and Professional Indemnity in Health Care - The Final Report of the Tito Committee*, TORTS L.J., at *1 (1996), available at LEXIS, News Library. See also Robert Gottlieb, *Tort Reform: Having Your Cake and Eating It*, AUSTRALIAN, Aug. 15, 2002, available at LEXIS, News Library.

¹⁶⁰ AMA Report Card, *supra* note 19.

¹⁶¹ Civil Liability Act, 2002, pt. 2, div. 1, § 11A (N.S.W.).

Australian Parliament passed the Health Care Liability Act ("HCLA") on June 29, 2001.¹⁶² The HCLA reformulated injured patients' right to recover compensation for medical-related injuries by instituting damage restrictions that substantially limited liability for malpractice claims based on negligence.¹⁶³ The reform package aimed to facilitate fair and sustainable compensation for persons suffering severe injuries, to keep costs of medical indemnity premiums at reasonable levels, and to maintain a full range of medical services for the community.¹⁶⁴

One year later, in response to a persistent outcry regarding a public liability crisis,¹⁶⁵ the NSW Parliament enacted the Civil Liability Act of 2002, which has since been amended by the Civil Liability (Personal Responsibility) Amendment (collectively, "CLA").¹⁶⁶ Drafters of the CLA noted the HCLA's effectiveness in stabilizing the turbulence of the medical indemnity crisis¹⁶⁷ and borrowed the provisions related to the calculation of damages almost verbatim.¹⁶⁸ The CLA provisions preempt the relevant portion of the HCLA with virtually identical language.¹⁶⁹ NSW lawmakers approach the reform initiative with the belief that there is a need for consistency.¹⁷⁰ That is, the lack of an objective standard guiding liability requires controlling the growth of the damage component.

The CLA provision relating to non-economic damages incorporates three distinct parts: (1) a ceiling amount recoverable for non-economic damages; (2) a strict method for calculating damage awards based upon a "most extreme case";¹⁷¹ and (3) a loss threshold below which non-economic losses are not recoverable.¹⁷² The relevant text of the CLA reads:

¹⁶² Health Care Liability Act, 2001 (N.S.W.)

¹⁶³ *Id.* at pt. 2.

¹⁶⁴ Mr. Knowles, Health Care Liability Bill, Address to the Legislative Assembly (Second Reading), in HANSARD EXTRACT, June 19, 2001 available at

<http://www.parliament.nsw.gov.au/prod/web/phweb.nsf/frames/hansard> (last visited Oct. 25, 2003).

¹⁶⁵ See, e.g., Parliament of Australia, *supra* note 45; Closure "Threat" to Australia's Beaches (May 14, 2002), at <http://www.news.bbc.co.uk/1/hi/world/asia-pacific/1986591.stm> (last visited June 23, 2003) (discussing possible of beach closing after injured swimmer was awarded AU\$ 3.75 million in damages).

¹⁶⁶ The CLA received royal assent on June 18, 2002; it applied retroactively to all suits commenced from March 20, 2002. Civil Liability Act, 2002, pt. 1, sect 2 (N.S.W.).

¹⁶⁷ John Della Bosca, Civil Liability Bill, Address to the Legislative Council (Second Reading), in HANSARD EXTRACT, June 4, 2002, available at

<http://www.parliament.nsw.gov.au/prod/web/phweb.nsf/frames/hansard> (last visited Oct. 25, 2003).

¹⁶⁸ Compare Civil Liability Act, 2002, pt. 2, div. 3, § 16 (N.S.W.) with Health Care Liability Act, 2001, pt. 2, div. 3, § 13 (N.S.W.).

¹⁶⁹ Civil Liability Act, sched. 2, Amendment of Acts (N.S.W.).

¹⁷⁰ See Knowles *supra*, note 164.

¹⁷¹ Civil Liability Act, 2002, pt. 2, div. 3, § 16(3) (N.S.W.); see also *infra* Part IV.A.1.

¹⁷² Civil Liability Act, 2002, pt. 2, div. 3, § 16(1) (N.S.W.).

Determination of damages for non-economic loss

- (1) No damages may be awarded to a claimant for non-economic loss unless the severity of the non-economic loss is at least 15% of a most extreme case.
- (2) The maximum amount of damages that may be awarded to a claimant for non-economic loss is \$350,000,¹⁷³ but the maximum amount is to be awarded only in a most extreme case.
- (3) If the severity of the non-economic loss is equal to or greater than 15% of a most extreme case, the damages for non-economic loss are to be determined in accordance with the following Table:

Table	
Severity of the non-economic loss (as a proportion of a most extreme case)	Damages for non-economic loss (as a proportion of the maximum amount that may be awarded for non-economic loss)
15%	1%
16%	1.5%
17%	2%
18%	2.5%
19%	3%
20%	3.5%
21%	4%
22%	4.5%
23%	5%
24%	5.5%
25%	6.5%
26%	8%
27%	10%
28%	14%
29%	18%
30%	23%
31%	26%
32%	30%
33%	33%
34% - 100%	34% - 100% respectively

- (4) An amount determined in accordance with subsection (3) is

¹⁷³ *But see infra* notes 183 and 184 and accompanying text.

to be rounded to the nearest \$500.¹⁷⁴

Even after establishing a defendant's liability, a malpractice victim does not necessarily qualify for non-economic damages.¹⁷⁵ The calculation of non-economic damages requires a three-step process:

Step 1: Determine the severity of the claimant's non-economic loss as a proportion of a most extreme case. The proportion should be expressed as a percentage.

Step 2: Confirm the maximum amount that may be awarded under this section for non-economic loss in a most extreme case. This amount is indexed each year under section 17.¹⁷⁶

Step 3: Use the Table to determine the percentage of the maximum amount payable in respect of the claim. The amount payable under this section for non-economic loss is then determined by multiplying the maximum amount that may be awarded in a most extreme case by the percentage set out in the Table.

Where the proportion of a most extreme case is greater than 33%, the amount payable will be the same proportion of the maximum amount.¹⁷⁷

The purpose is to avoid disproportionate and inconsistent awards and to provide efficient and adequate relief for those persons who suffer the most severe injuries.¹⁷⁸ For instance, minimal non-economic losses, those less than 15% of a "most extreme case," are not recoverable.¹⁷⁹ Losses of at least 15% severity are compensated according to a percentage of the AU\$ 350,000 maximum award amount.¹⁸⁰ Losses falling between 15% and 33% correspond to values set forth in a table determined by the

¹⁷⁴ Civil Liability Act, 2002, pt. 2, div. 3, § 16 (N.S.W.).

¹⁷⁵ *Id.* New Zealand and Sweden, countries that implement no-fault systems for medical-related injuries, similarly impose minimum "disability thresholds" before recovery is available. See Studdert & Brennan, *supra* note 20, at 232. In New Zealand, a person must spend fourteen days in the hospital or twenty-eight days with a significant disability; in Sweden, the threshold requires ten days of hospitalization or thirty sick days. *Id.*

¹⁷⁶ The amount in Section 17 is AU\$ 350,000, but has since been increased. See *infra* note 184.

¹⁷⁷ Civil Liability Act, pt. 2, div. 3, § 16, note (N.S.W.).

¹⁷⁸ Knowles, *supra* note 164.

¹⁷⁹ Civil Liability Act, pt. 2, div. 3, § 16(1) (N.S.W.).

¹⁸⁰ *Id.* § 16(3).

legislature.¹⁸¹ Losses 34% or greater are compensated according to that percentage.¹⁸² That is, an injury resulting in the 50% non-economic loss compared to a “most extreme case” will receive AU\$ 175,000 in non-economic damages. Section 17 of the CLA, however, provides for the indexing of the maximum recoverable amount.¹⁸³ Therefore, the statutory cap—AU\$ 350,000, as enacted—may be adjusted yearly to reflect current market conditions.¹⁸⁴

2. *The Commonwealth Government Supports Reform*

Australia has uniformly exhibited a commitment to the CLA’s treatment of non-economic damage awards on the federal and state levels. Developing concern over sharply increasing public liability prompted the Commonwealth government to initiate reform.¹⁸⁵ In May 2002, the Commonwealth appointed an expert panel (“Panel”) headed by Justice David Andrew Ipp¹⁸⁶ to review the current state of the law of negligence and inquire into a wholesale reform of tort law.¹⁸⁷ From the outset, the Panel assumed that escalating damage awards substantially contributed to the materialization of a liability crisis.¹⁸⁸

In regard to non-economic loss, the final report (“Ipp Report”) shares the terms and provisions imposed by NSW’s CLA and promotes the use of both a damage calculation scheme based on a hypothetical “most extreme case” and minimum loss thresholds.¹⁸⁹ While the CLA imposes an AU\$ 350,000 maximum on damages for non-economic loss, the Ipp Report recommends placing a ceiling at AU\$ 250,000,¹⁹⁰ but notes that each

¹⁸¹ *Id.* § 16(3).

¹⁸² *Id.*

¹⁸³ *Id.* § 17.

¹⁸⁴ *Id.* Amount declared for the purposes of Section 16(2) from October 1, 2002 is AU\$ 365,000. See NSW Dep’t of Commerce, 160 Government Gazette 8495, Jan. 10, 2002, available at <http://www.cms.dpws.nsw.gov.au/Gazette/Gazette.htm> (last visited Oct. 29, 2003).

¹⁸⁵ Ipp Report, *supra* note 146, at ix, Terms of Reference.

¹⁸⁶ Justice Ipp has been an Acting Judge of Appeal, Court of Appeal, Supreme Court of New South Wales, since 2001 and Justice, Supreme Court of Western Australia, since 1989. He was admitted to the Western Australian Bar in 1984 and appointed as a Queen’s Counsel in 1985. Ipp Report, *supra* note 146, at xiii (Panel of Eminent Persons).

¹⁸⁷ See Lynden Griggs, Comment, *Consumers and the Ipp Report into Negligence Reform*, COMPETITION & CONSUMER L.J., at *3-4, Sept. 21, 2002, available at LEXIS, News Library.

¹⁸⁸ The panel creating the Ipp Report set out under the presumption that “[t]he award of damages for personal injury has become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another....” Ipp Report, *supra* note 146, at ix, Terms of Reference.

¹⁸⁹ See *id.* at 188-95.

¹⁹⁰ *Id.* at 194.

jurisdiction should determine that amount for itself.¹⁹¹

If the Ipp Report recommendations are implemented, Australia's current patchwork of laws will converge to create a homogeneous body of negligence law that furthers the interests of consistency and uniformity.¹⁹² Although not binding, the Ipp Report carries persuasive value,¹⁹³ motivates state and territory governments to formulate legislative initiatives of their own, and confirms the nation's unified approach to liability reform.

3. *Other States and Territories Follow Suit*

The trend throughout the Australian states and territories evidences eagerness to subdue the liability crisis through legislation similar to the CLA.¹⁹⁴ The measures pursued by other Australian jurisdictions mirror the policy and framework of the Ipp Report and follow the substantive measures set forth by the CLA.¹⁹⁵ Reform proponents refer to the CLA as the most comprehensive reform statute in Australia¹⁹⁶ and "a triumph for common-sense."¹⁹⁷ Therefore, it is appropriate to look to the CLA as a reform measure representative of the unified reform movement in Australia. While a medical malpractice crisis hampers the Australian health care industry, Parliament and the individual states and territories have established a workable "most extreme case" solution.

¹⁹¹ *Id.* at 195.

¹⁹² See Griggs, *supra* note 187, at *6.

¹⁹³ For example, NSW government released the Civil Liability Amendment (Personal Responsibility) Bill, proposing the tort law reform recommendations of the Ipp Report, within forty-eight hours of its release. *Tort Law Reform Steaming in Australia*, DEF. COUNS. J., Oct. 2002, available at LEXIS, News Library.

¹⁹⁴ See *supra* note 16 and accompanying text.

¹⁹⁵ South Australia similarly imposes limitations of recovery available to plaintiffs, including a threshold barring non-economic losses and a maximum cap that affect both non-economic and economic damages. This practice diverges from the other jurisdictions in the manner of determining those benchmarks. South Australia implements a minimum threshold by rejecting the award of non-economic damages unless the injured person's ability to lead a normal life was significantly impaired for at least seven days or medical expenses of at least the prescribed minimum have been reasonably incurred in connection with the injury. See *Wrongs (Liability and Damages for Personal Injury) Amendment Act, 2002 (S. Austl.)* (effective December 1, 2002, amending the *Wrongs Act 1936*).

¹⁹⁶ See *AMA Report Card*, *supra* note 19; *Impact of the Civil Liability Act (NSW) 2002*, available at http://www.goldbergs.com.au/news_articles/THE%20IMPACT%20OF%20THE%20CIVIL%20LIABILITY%20ACT.pdf (last visited Oct. 25, 2003).

¹⁹⁷ See Carr, *supra* note 138.

V. THE AUSTRALIAN MODEL IS DESIRABLE BECAUSE IT REDUCES LIABILITY AND INCREASES PREDICTABILITY IN SETTING INSURANCE RATES

Although both Australia and the United States recognize the benefit of injecting some degree of regularity into damage assessment, each country approaches this phase of dispute resolution differently. The U.S. approach enforces a bright-line cap on non-economic damages, above which no amount is recoverable, but below which there can be great variability in each case.¹⁹⁸ Australia, on the other hand, employs a system that narrows the variability of damage amounts, thus improving insurers' ability to accurately set premium rates. From the standpoint of health care providers, insurance companies, and reform advocates, the Australian model is better equipped to achieve underlying reform goals than the U.S. cap system. The Australian approach significantly reduces health care providers' liability and achieves the consistency and predictability that insurance companies require in order to accurately set premium rates.

A. *The Australian Scheme Reduces Health Care Providers' Liability*

Both U.S. and Australian reforms limit individual liability of health care providers.¹⁹⁹ Australia, however, incorporates a calculation process—a scheme that reserves the maximum amount for only the most severely injured²⁰⁰—and a threshold requirement—a minimum amount of loss before recovery of non-economic damages is available.²⁰¹ These additional measures form a superior reform model that substantially reduces liability.

1. *Limiting Maximum Recovery to a "Most Extreme Case"*

Both U.S. and Australian reforms set forth a maximum amount for which health care providers, and their insurers, are liable.²⁰² Unlike the U.S. cap system, however, the Australian approach reserves the maximum

¹⁹⁸ See, e.g., *The City of Panama*, 101 U.S. 453, 464 (1879) (stating that "the result must be left to turn mainly upon the good sense and deliberate judgment of the tribunal"); *Botta v. Brunner*, 26 N.J. 82, 93, 138 A.2d 713 (1958) (stating "[n]o market place exists at which such malaise [pain and suffering] is bought and sold. . . . The varieties and degrees of pain are almost infinite.").

¹⁹⁹ But compare *supra* Part III.B with *supra* Part IV.B.

²⁰⁰ See *supra* Part IV.B.1.

²⁰¹ See *supra* Part IV.B.1.

²⁰² Compare *supra* Part III.B with *supra* Part IV.B.

amount for the most severe losses—a "most extreme case."²⁰³

In California, a jury is free to award any amount for pain and suffering, loss of enjoyment of life, or other intangible non-economic losses based upon the jury's independent deliberations and conclusions of fact.²⁰⁴ The assessment of damages is purely in the purview of the jury.²⁰⁵ After an amount is submitted, the statute mandates that the trial judge reduce any amount of non-economic damages to the statutory limit.²⁰⁶ Therefore, a patient suffering from any impairment, even relatively minor losses, may receive the maximum amount.

The Australian approach, on the other hand, is more controlled because the maximum amount is reserved only for the most serious injuries.²⁰⁷ For example, in NSW, non-economic damage awards are computed by evaluating the loss suffered by a particular plaintiff compared to the loss endured by a hypothetical "most extreme case." Once settled, that percentage of loss correlates to a value—a multiplier—set forth in the statutory table, which operates to reduce the non-economic damage award from the maximum amount. In short, the single, comprehensive process used in Australia, rather than the two-step process used in the United States—a jury award and a reduction by the trial judge—ensures that the maximum statutory amount is reserved for those who actually suffer the most severe harms.²⁰⁸

The difference between the two systems is best illustrated in application. Suppose Patient brought his malpractice suit in the United States where the MICRA model is followed. The jury may likely consider Patient's subjective suffering and the egregiousness of Dr. Defendant's conduct in returning an award amount for Patient's non-economic loss. If that amount exceeded the statutory cap, the trial judge must reduce that amount to the statutory cap. Patient, therefore, could receive any amount up to the cap amount in non-economic damages. If, however, Patient filed suit in Australia where the CLA model governs, the judge would first determine what a "most extreme case" entails—for example, the complete incapacitation of one's leg. Next, the judge would determine that the severity of Patient's loss caused by the reduced motion of his knee correlates

²⁰³ Compare *supra* Part III.B with *supra* Part IV.B.

²⁰⁴ See *supra* Part III.A.2.a; see also *supra* note 12 & 198 and accompanying texts.

²⁰⁵ See *supra* Part III.A.2.a; see also *supra* note 12 & 198 and accompanying texts.

²⁰⁶ See, e.g., Salgado, 19 Cal.4th at 645, 967 P.2d at 594 (reducing award).

²⁰⁷ See *supra* Part IV.B.1.

²⁰⁸ See, e.g., *Pacific Dunlop Ltd. (T/as Dunlap Footwear) v. Rozina Krivec* (1996), __ N.S.W.L.R. __, available at http://www.austlii.edu.au/cgi-bin/disp.pl/au/cases/nsw/supreme_ct/95040172.html (last visited Oct. 29, 2003).

to 30% of this “most extreme case.” The CLA Table compensates a 30% loss a damage award of 23% of the maximum amount recoverable.²⁰⁹ The judge would award Patient 23% of AU\$ 350,000, the maximum amount recoverable. Therefore, Patient would receive AU\$ 80,500.

2. *Profiting from the Minimum Loss Threshold*

The Australian approach further reduces the amount for which health care providers are liable in malpractice suits by imposing a minimum non-economic loss threshold.²¹⁰ The majority view in Australian jurisdictions, represented by the CLA and the Ipp Report, requires a non-economic loss of at least 15% of a “most extreme case” before recovery is available.²¹¹

Another hypothetical situation demonstrates the effect of imposing a loss threshold on health care providers' liability. Suppose that Patient's negligently treated knee equated to a 10% loss compared to a “most extreme case.” The statutory threshold would bar Patient's recovery of any non-economic damages from Dr. Defendant and his indemnity insurer. By comparison, a U.S. court, even one subject to MICRA-like reform, would permit non-economic damages up to the statutory cap amount.

The ultimate advantage of the Australian system extends beyond the simple reduction in payouts per claim. The U.S. damage cap affects severity and regulates the size of a single judgment, but is less effective in battling the costs incurred from the frequency of lawsuits.²¹² Australian reform, on the other hand, reduces insurers' litigation costs because fewer claims will be litigated due to the strict statutory limitations on damage awards. Eliminating “jackpot” awards and restricting the freedom in assessing non-economic damages removes incentives to sue.²¹³ Further, certain limited recovery not only deters speculative suits but also modifies the economic decision whether to pursue relatively minor injuries through tort. As a result, patients who have suffered redressable injuries due to the negligent conduct of their health care providers may opt out of litigation or pursue a more cost-efficient form of dispute resolution if their non-economic losses

²⁰⁹ Civil Liability Act, 2002, pt. 2, div. 3, § 16(3) (N.S.W.).

²¹⁰ *Id.* § 16(1).

²¹¹ *Id.* The threshold loss requirement does not affect recovery of economic losses. See Wrongs (Liability and Damages for Personal Injury) Amendment Act, 2002 (S. Austl.) (basing minimum loss of patients on other standards).

²¹² See Danzon, *supra* note 47, at 416 (severity is reduced by 23%, but frequency is reduced by 13%).

²¹³ See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERVICES *supra* note 4, at 8-11.

do not satisfy the threshold amount.²¹⁴

B. *The Australian Approach Improves Consistency and Predictability*

The Australian approach produces more consistent and predictable results than the U.S. cap system. As a result, insurers can more accurately set rates.²¹⁵ Caps act as a maximum amount awardable in any given case, but offer virtually no guidance in regard to consistency of damage awards.²¹⁶ Australian maximum amounts, on the other hand, act not only as a maximum, but also as the standard for assessing the actual amount recoverable. While non-economic damage awards freely fluctuate under the cap amount in the United States, strict adherence to the calculation of damages in Australia achieves horizontal equity.²¹⁷ For example, insurers can assume that less severe injuries will result in less severe awards.²¹⁸ In application, insurance companies can analyze common injuries to accurately assess the potential liability of the policyholder.

In the United States, the current system of calculating tort damages lacks standards for uniform assessment.²¹⁹ Too much discretion and too little information handed to layperson juries result in drastic variations between damage awards for injuries of similar severity.²²⁰ A proposed jury instruction from California evinces the lack of guidance handed to civil juries for non-economic losses:

Reasonable compensation for any pain, discomfort, fears,
anxiety and other mental and emotional distress suffered by the

²¹⁴ See Ron Heinrich, Paper given to AFR Insurance Summit 2002, *Public Liability: Slipping and Falling or Regaining Balance* (Nov. 29, 2002), at 12.

²¹⁵ See U.S. DEP'T OF HEALTH AND HUMAN SERVICES *supra* note 4.

²¹⁶ See Robert S. Peck & Ned Miltenberg, *Challenging the Constitutionality of Tort "Reform"*, ATLA'S LITIGATING TORT CASES § 29:20 (2003), available at WESTLAW, ATLA-tort.

²¹⁷ See Schuck, *supra* note 73, at 221. "Horizontal equity" refers to treating similarly situated people in a similar manner and implies similarity in damage awards for similar injuries. See *Dilts v. U.S.*, 845 F. Supp. 1505, 1510 (D. Wyo. 1994).

²¹⁸ For example, Vidmar separates the severity of malpractice injuries into five categories: (1) Emotional or Minor Injury (e.g., fright, temporary pain and suffering, lacerations, contusions, minor scars, rashes, no delays in recovery); (2) Temporary Disability (e.g., infection, miss set fracture, fall in hospital, burns, surgical material left in body, drug side effect, delayed recovery); (3) Permanent Partial Disability (e.g., loss of fingers, damage to organs, deafness, loss of one limb, eye, kidney, or lung); (4) Permanent Total Disability (e.g., paraplegia, blindness, loss of two limbs, brain damage, quadriplegia, lifelong care or fatal prognosis); and (5) Death. VIDMAR, *supra* note 2, at 50. Because a jury is free to award any amount it sees fit, the cap system fails to guarantee any correlation between severity of injury (or loss) and damage award. For example, a claim concerning a surgical sponge negligently left in the body, a injury under category two of the Vidmar scale, may result in the same award as a wrongful death action.

²¹⁹ See Schuck, *supra* note 73, at 221.

²²⁰ See VIDMAR, *supra* note 2, at 185-89.

plaintiff and caused by the injury [and for similar suffering reasonably certain to be experienced in the future from the same cause].

No definite standard [or method of calculation] is prescribed by law by which to fix reasonable compensation for pain and suffering . . . In making an award for pain and suffering you should exercise your authority with calm and reasonable judgment and the damages you fix must be just and reasonable in the light of the evidence.²²¹

Essentially, the only guiding principle presented by this instruction is that the amount should be “just and reasonable in light of the evidence.”²²² In contrast, the Australian model provides a detailed and defined calculation scheme that judges, or even jurors, can follow.²²³ By contrasting the lack of guidance provided by U.S. jury instructions to the Australian calculation scheme of non-economic damages, it is evident that the latter approach ensures the consistency and certainty that U.S. reform lacks.

VI. THE AUSTRALIAN SCHEME IS SUSTAINABLE IN THE UNITED STATES

Because reform legislation functions in conjunction with a broad matrix of other institutions and regulatory agents, the effect of statutory limits on recovery is properly understood within the appropriate structural and societal context.²²⁴ Yet, even in light of important differences between the U.S. and Australian legal systems, the Australian-style reform could stabilize U.S. malpractice insurance rates and alleviate the ongoing medical malpractice crisis.

A. *The Australian Scheme Could Remedy Inefficiencies Inherent in the U.S. Legal System*

The formulaic Australian approach could effectively reduce the litigious effect of certain unique features of the U.S. legal system and further the goals of American medical malpractice reform. Damage awards do not

²²¹ 2 CAL. JURY INSTR.— CIV. 14.13 (9th ed.)

²²² *Id.*

²²³ See *supra* Part IV.B.1.

²²⁴ See generally Angus Corbett, *The (Self) Regulation of Law: A Synergistic Model of Tort Law and Regulation*, 25 UNSW L.J. 616 (2003). The problem should not be too easily attributed to a single origin; rather, proper analysis should include the “broad matrix of institutional and legal concerns.” *Id.* at 617. The law of torts is a product of complex legal, social, historical, and economic factors.

operate in isolation within the legal system²²⁵ and certain elements that promote speculative litigation are simply nonexistent in Australia.²²⁶ Nonetheless, Australian-style reform is well-suited for the U.S. legal system. It could achieve stability in the insurance market, despite the United States' use of civil juries and contingency fee agreements.

1. *Reining in the U.S. Civil Jury*

The calculation scheme and threshold loss requirement promoted by Australian reform could stabilize the irregularity of damage awards and alleviate the drawbacks of the civil jury system. Because layperson juries can readily comprehend and apply this scheme, the quest for consistency and predictability argues in favor of adopting the Australian model.

The Australian damage scheme surpasses other reform initiatives designed to rein in juries because, as applied in the United States, it would maintain the jury's role while providing clear guidance in deliberation and concentrating attention on the victim-patients' harm, rather than the conduct of the defendant. In light of the problems accompanying the jury system, assessing non-economic damage awards as a function of a "most extreme case" is more consistent with the goals of American reformers than the cap system. Furthermore, by maintaining the determinative role of the jury and preserving some flexibility for subjective considerations, the Australian approach would be more amenable to consumer advocates than alternative reform measures, such as a "no fault"²²⁷ or damage scheduling system.²²⁸

The Australian damage scheme could also relieve the procedural hardships created by the jury system by increasing the consistency and predictability of damage awards and by reducing the quantum of damages. In the U.S. legal system, the Australian approach could guide juries to more consistent and predictable results. Instead of blindly rendering a dollar amount based on jurors' subjective notion of justice and fairness, juries could return a percentage reflecting a patient's non-economic loss as compared to a "most extreme case." The trial judge could then award the

²²⁵ See *id.* at 648-50 (expressing the need to develop a multi-dimensional model describing the interaction between tort law and other categories of law). The erroneous view that tort law acts independently of other regulatory factors furthers the view that promoting personal responsibility through tort reform will resolve the insurance crisis. *Id.* at 618.

²²⁶ See Ponte, *supra* note 64, at 335-43; Bernstein, *supra* note 64.

²²⁷ See, e.g., Studdert & Brennan, *supra* note 20, at 128 (recognizing that "no fault" systems compensate injured persons regardless of whether the harm was caused by the fault of another).

²²⁸ See, e.g., Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989). Damage scheduling generally refers to a system where a particular injury is compensated a set amount. *Id.* at 928-29.

actual dollar amount for non-economic damages by referring to a statutorily-defined table incorporating a legislatively-determined maximum amount for a "most extreme case." Alternatively, even if the jury rendered the non-economic damage award as a dollar amount, the clearly delineated calculation scheme would escort jurors through the assessment process and increase the likelihood of a fair and foreseeable amount. Unlike the ambiguous approach currently followed by U.S. courts,²²⁹ the Australian method would offer a tangible and specific method that would appeal to jurors' senses of objectivity and relativity. Determination of a damage award as a plaintiff's loss relates to a "most extreme case" would effectively limit the jury's freedom, thereby minimizing the possibility of a deviant award. For instance, it is unlikely that a jury would extend the title of "most extreme case" to the diminished range of motion in Patient's knee, but would consider amputation or complete loss of use as within this extremely narrow category.

The Australian calculation method, by basing the assessment of non-economic compensation on the loss compared to a "most extreme case," directs attention to the injury itself and consequently deflects the influence of subjective factors and emotional responses.²³⁰ Further, the reality of Dr. Defendant's negligent conduct plays a less significant role because jurors' attention focuses on the resulting harm, and not the particular injury-causing act or omission. Under the Australian approach, similar injuries should result in reasonably similar non-economic damage awards. In turn, health care providers and insurers are more able to accurately assess risk and appropriately set premium rates.

2. *Removing the Incentives of Contingency Fee Agreements*

Australian-style reform would further reduce health care provider liability by removing the incentives created by contingency fee agreements. A method of calculation that limits the freedom of civil juries in awarding damages significantly diminishes the incentive to pursue more speculative claims. Attorneys must assess the economic practicality of accepting cases and must independently evaluate each claim. If attorneys knew the standard of calculation and the value of a "most extreme case," they could more accurately assess the approximate value of their cases. An attorney could

²²⁹ See *supra* notes 84 and 221 and accompanying text.

²³⁰ See, e.g., Steve Cohen, *Malpractice: Behind a \$26-Million Award to a Boy Injured in Surgery*, NEW YORK, Oct. 1, 1990, at 41-49 reprinted in VIDMAR, *supra* note 2, at 101-03 (reflecting on the emotional testimony of a boy plaintiff that resulted in a US\$ 26 million verdict).

consider his client's harm and assign an approximation of the severity of loss in relation to a "most extreme case." Because the Australian damage scheme removes the potential for "jackpot" awards and makes potential payouts more foreseeable,²³¹ attorneys are discouraged from pursuing speculative litigation. In response to the diminished frequency of malpractice suits, medical insurers face an overall reduction in litigation expenses. Lower payouts and better estimations regarding claim validity will result in reduced premium rates.

B. Adequate Legal Recovery to U.S. Patients

The Australian damage assessment method also serves as a flexible model that will ensure fair compensation to negligently injured patients. Part of the reason for its success in Australia is due to the limited monetary recovery available to injured patients. Many groups, including consumer protection advocates, oppose damage-capping legislation and consider such legislation as substantially impinging on patients' rights.²³² For instance, caps deny wrongfully injured patients adequate compensation for harms caused by their health care provider's negligence.²³³ Australian-style reform could alleviate such concerns.

The Australian approach creates the potential for improved compensation, superior to the existing U.S. cap system or the alternative methods readily suggested by scholars and reform proponents. Scholars reject other reform measures, such as "no-fault" and strict damage schedule systems,²³⁴ criticizing the rudimentary nature by which awards are assigned.²³⁵ For example, these alternative reform approaches lack the comprehensiveness to accommodate certain variables, such as the victim's age and the duration of the injury.²³⁶ The Australian calculation scheme,

²³¹ See *supra* Part IV.B.

²³² See generally, *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980) (reasoning that damage limits fail to provide adequate compensation while not ensuring a reduction in the number of claims filed); see also *Hunter & Doroshov*, *supra* note 46; *Zimmerman & Oster*, *supra* note 8 (pointing at insurance companies' business practices and the insurance cycle as the prominent catalyst behind rapidly increasing insurance rates).

²³³ See generally, *Hunter & Doroshov*, *supra* note 46. While approximately 3% of hospital patients are victims of medical error, the Institute of Medicine estimates that between 44,000 and 98,000 patients die each year due to such mistakes. See Institute of Medicine, *To Err is Human: Building a Safer Health System*, Nov. 1999, available at http://www.nap.edu/html/to_err_is_human/reportbrief.pdf (last visited June 25, 2003).

²³⁴ See, e.g., *Schuck*, *supra* note 73, at 213-14 (suggesting scheduling damages as a better approach to tort reform).

²³⁵ See *id.* at 217.

²³⁶ *Id.*

however, strikes a balance between complete jury discretion and an imprecise categorization of injuries, and provides a flexible method whereby jurors can account for mitigating or augmenting factors.

The adoption of the Australian method lays the foundation for increased damage recovery for the most severely injured patients. Opponents to the statutory cap commonly point to certain cases where a patient's harm was particularly egregious and the jury's award was significantly reduced according to legislative mandate.²³⁷ However, because virtually any harm could result in a non-economic damage award at the cap amount, state legislatures must maintain a relatively conservative cap amount due to the variability and unpredictability of jury awards. Yet the adoption of a definitive calculation scheme and the reduction of the jury's freedom in assessing damages diminish the risk of unwarranted jackpot awards. With assurances in place that maximum awards are reserved for a "most extreme case," legislatures could adjust the maximum amounts available for non-economic loss. For example, a maximum award for non-economic loss could be elevated to US\$ 500,000, as long as the percentages set forth in the statute would reduce awards for less severe losses. In such a situation, the interests of negligently injured patients and medical insurers are satisfied. Although in certain circumstances the insurer will have to pay more than the current maximum amount, the reduced frequency and increased predictability of these large awards will create an overall reduction in insurer payouts.

VII. CONCLUSION

The Australian scheme, which bases recovery on a "most extreme case," exists as an alternative model for effective medical malpractice liability reform that the federal government and individual states should follow to alleviate the current medical malpractice crisis. The Australian approach is premised upon the goals of reducing health care providers' liability and increasing the certainty by which insurers assess risk and set rates. Limiting the maximum amount of damages through a legislatively-determined calculation scheme and deterring or barring plaintiffs from recovery of non-economic damages better serves reformers' underlying goals of achieving stability in the health care industry than the current U.S. cap system.

The Australian damage scheme further relieves the inefficiencies

²³⁷ *E.g.*, Hunter & Doroshov, *supra* note 46.

inherent in the U.S. legal system that also contribute to the crisis. By removing the potential for “jackpot” jury awards and limiting the vast uncertainty in health care providers’ liability, Australian-style reform would minimize the negative consequences of civil juries and contingency fee agreements. The Australian reformulation of non-economic damage awards minimizes uncertainty and effectively removes the existing motivations to pursue speculative litigation. Indeed, because Australia is devoid of many of the litigation-fostering features embedded within the U.S. system, the Australian-style reform measures may achieve even greater success in the United States. In the current medical malpractice crisis that plagues the U.S. health care industry, the Australian reform scheme presents a viable and desirable model for reform that should be considered as an alternative to the U.S. non-economic damage cap approach.

