TASK FORCE ON NONECONOMIC DAMAGES

Report to the Legislature

STATE OF WASHINGTON

October 2005

This report can be found in its entirety at
http://www.ofm.wa.gov/rmd/index.htm

Task Force On Noneconomic Damages

October 2005

This letter transmits the final report from the Task Force on Noneconomic Damages. In 2004, the Washington State Legislature created this task force to "… prepare a study and develop, for consideration by the legislature, a proposed plan for implementation of an advisory schedule of noneconomic damages in actions for injuries resulting from health care." See Chapter 276, Laws of 2005, Section 118 (ESHB 2459).

Our multidisciplinary task force was comprised of representatives from virtually all relevant stakeholder groups. Early on in the task force proceedings, we commissioned a report and analysis of possible methods and means by which such an advisory schedule could be developed and implemented. We chose Drs. Michelle Mello and David Studdert, of the Harvard University, to provide us with this analysis and used their work as a foundation for further task force debate. Over the course of many meetings, we fully considered the options and alternatives presented by the Mello-Studdert report, as well as the advantages and disadvantages of such an advisory schedule.

One of the members of the task force (Gary Morse, Physicians Insurance) believes that discussion of advantages and disadvantages of an advisory schedule went beyond the scope of the legislative mandate by addressing the public policy question of whether an advisory schedule is a meaningful solution to perceived problems in health care liability. However, all of the remaining task force members considered discussion of pros and cons as an essential and integral part of the legislative charge. Therefore, our final task force report addresses both the logistical barriers and perceived policy concerns inherent in implementing such a schedule.

The task force offers this report as a path forward to implement an advisory schedule for noneconomic damages, should the Legislature wish to continue discussion on these issues. We believe the report that follows is an excellent summary of the issues that will need to be addressed and the options available to begin detailed development of an advisory schedule.

Thank you.

Patricia C. Kuszler, M.D., J.D., Chair
Task Force on Noneconomic Damages

Task Force Members:

The Honorable Dale E. Brandland, Washington State Senate
Ronald C. Dobson, MD, FACEP, Swedish Hospital
Judy Guenther, Consumer
The Honorable Bruce Hilyer, King Co. Superior Court Judge
Carol James, Consumer
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I. PREFACE

Legislative Charge

The 2004 Legislature established a task force, which was directed to

> "… prepare a study and develop, for consideration by the legislature, a proposed plan for implementation of an advisory schedule of noneconomic damages in actions for injuries resulting from health care under chapter 7.70 RCW."

The purposes behind the plan for an advisory schedule were to increase "the predictability and proportionality of settlements and awards" for noneconomic damages in medical malpractice cases. (See Appendix A, Chapter 276, Laws of 2004, Section 118; ESHB 2459.)

For those uninitiated to this topic, "noneconomic damages" are those damages that compensate a plaintiff in a legal action for pain, suffering, disfigurement, loss of companionship, and other harms arising from an injury that do not have direct financial consequences. They do not include punitive damages, nor the direct economic losses suffered by an injured individual. In Washington, as in many states, juries are provided only general guidance about how to calculate noneconomic damages. Debate has ensued over whether awards for noneconomic damages are rational or excessive in some cases.

The Legislature set out the composition of the task force in statute. The Governor appointed the nonlegislative members of the task force and selected a chair. The membership reflects diverse and informed views on this topic. (See Appendix B.)

The task force was directed by the Legislature to consider a set of elements relevant to the topic of noneconomic damages in health care cases, as follows:

- What information can most appropriately provide guidance to the trier of fact (jury or judge), giving consideration to past noneconomic damage awards for similar injuries or similar claims, considering the duration and severity of injuries and other appropriate factors.

- What is the most appropriate format in which to present the information to the trier of fact.

- When and how an advisory schedule should be used in dispute resolution settings and at trial.

In development of the implementation plan for an advisory schedule, the task force was to consider the elements noted above and to identify:

- The statutory, regulatory, or court rule changes necessary to implement an advisory schedule (and any other necessary documents).

- The time required to implement any schedule authorized by the Legislature.

Implementation of any plan developed by the task force was contingent on further statutory authorization by the Legislature. The task force was appropriated $75,000 for the work and given an October 31, 2005 deadline to prepare a plan for possible implementation of an advisory schedule for noneconomic damages.

II. EXECUTIVE SUMMARY

A. General Observations

The Task Force on Noneconomic Damages sought to fulfill the intent of the legislative charge to explore the feasibility and advisability of a statutorily imposed noneconomic damages schedule in medical malpractice cases. Preliminary research revealed that although several states have imposed caps on noneconomic and total damages, no state has developed a nuanced noneconomic scale or schedule such as that envisioned by the Legislature. Thus, the task force found itself in largely uncharted waters.

The task force ultimately sought expert help and identification of options from Drs. Michelle Mello and David Studdert from the Harvard School of Public Health, nationally known experts and scholars on the law and policy issues inherent in medical negligence. The resulting report concluded that such a damages schedule would best be created by aligning tiers of injuries to tiers of noneconomic losses and the subsequent assignment of dollar values to each tier. The former task could be accomplished by modifying and adapting an existing quantitative injury severity scale, such as that developed by the National Association of Insurance Commissioners (NAIC). The latter task, the dollar valuation of the tiered injuries, would require substantial data, much of it currently unavailable. This valuation process has virtually no analog and would require primary *de novo* development, a substantial but not insurmountable task. Once such a schedule is developed, its implementation will require substantial changes in legal procedure and process. The task force remains concerned that, depending on the manner in which an advisory schedule is implemented, it may function more often than not as a cap and be deemed impermissible under the Constitution of the state of Washington. See *Sofie v. Fibreboard Corp.* at Appendix H. Finally, in surveying the limited empirical information available with respect to malpractice incidence, actions and attendant costs, the task force concluded that an advisory noneconomic damages schedule would be only one of many needed steps to significantly ameliorate this complex problem.

B. Creating a Noneconomic Damages Schedule: Logistics and Data Issues

As noted in the Mello-Studdert report and the Data Subcommittee report, creation of a noneconomic damages schedule will require substantial work, input from a variety of stakeholders, and access to and development of several new data sets.

If the quantitative NAIC injury severity scale is adopted, it will require adaptation for malpractice cases. As noted in the Mello-Studdert report, establishment of the tiers will require input from a variety of experts and lay persons to fully and fairly characterize injuries caused by medical negligence and their complementary placement in tiers for noneconomic damages. This exercise will require substantial education and understanding of injury, its severity and long-term sequelae on the part of those involved in identifying, defining, and creating the tiers that will make up the schedule.

The second component of a noneconomic damages schedule will be the dollar valuation at each of the tiers. The lack of data is, by far, the most profound barrier to the establishment of a noneconomic damages schedule. The Data Subcommittee's report details the comprehensive data that will be required for valuation of noneconomic damages at each tier. The task force fully concurs with the Mello-Studdert analysis that precedential data is the most viable source for devising values for noneconomic damages. At minimum, detailed information on closed claims, open claims, and exposure data will be required. Much of the necessary data is not only publicly unavailable, but is simply non-existent. For example, many judgments do not reveal or document what amount was awarded for economic versus noneconomic damages. Much of the data related to amounts paid out, such as that held by malpractice insurers, hospital, and health care entities, is proprietary in nature. Obtaining and funding appropriate analysis of the necessary data will require legislative action.

C. Implementing a Noneconomic Damages Schedule: Changes in Legal Process

Assuming a noneconomic damages schedule was developed, use of the scale would require changes in legal process at several levels. First, legislative action must be taken to account and prescribe for the use of an advisory noneconomic damages schedule, provide for its maintenance and periodic revision, and address conflicts with other existing statutes. Second, the Legislature will need to provide guidance on both the preferred type of advisory schedule and the manner in which such an advisory schedule should be presented to juries and judges. The Legislature will need to define when it

might be appropriate and just to provide for exceptions, and how "outlier" cases – those presenting truly extraordinary circumstances or injury or gross negligence – may be dealt with by jury. Third, there is the issue of jury instructions, their development and use. Given that the schedule would be advisory only, it may be necessary to define the options open to the jury, to ensure the schedule is not viewed as prescriptive. This would result in the schedule functioning as a *de facto* cap, potentially leading to questions of constitutionality. These legal process issues will require input and buy-in from not only the Legislature, but also the judiciary and legal profession. Only after the Legislature defines a type of advisory schedule and the manner of its use can these more detailed implementation issues be fully developed. Thus, the task force recommendations in this area are of a most general nature.

D. Impact on Justice, Fair Compensation, and Deterrence of Malpractice

Both the Policy Subcommittee and the task force as a whole discussed the recommendation of the Mello-Studdert report at length. The task force concluded that implementation of an advisory schedule is feasible using the tiered classification of injuries and assignment of dollar values as described in the recommendations. As noted above, the development of the schedule will require significant assistance from a range of experts, as well as the development of currently unavailable data sets. This will be a lengthy development process that must be informed by analysis of the empirical evidence regarding the nature of the current alleged malpractice crisis and its underlying causes. This is particularly critical because, should the Legislature choose to further develop and implement an advisory noneconomic damages schedule, Washington will be the first state in the nation to do so and is likely to receive substantial national attention and scrutiny.

As the Legislature decides whether to develop and implement an advisory noneconomic damages schedule, there are a host of advantages and disadvantages that must be considered. These are discussed in more detail in the reports of the various subcommittees. The task force believes that it is essential that the schedule be advisory only, so that it does not function as a cap. In addition to the fact that a *de facto* cap would likely be unconstitutional in our state, it may also compromise justice, fairness, and deterrence – fundamental aims of the tort system and deeply held societal and cultural values.

The Mello-Studdert report details both theoretical and actual models of advisory schedules. The latter have been implemented in limited fashion in other nations, typically those with well-developed national, publicly funded health care systems. All are worthy of further study and consideration should the Legislature proceed to adopt an advisory noneconomic damages

schedule. Such a schedule should build upon states' and international experiences with caps or ceilings on damages. Thus, an advisory schedule could be viewed as a more sophisticated and sensitive approach to creating greater proportionality in damage awards. Because juries currently are unguided in their assessment of pain and suffering, a well-grounded schedule composed by both lay persons and experts could form the basis of more rational and educated awards. Greater access to justice may be a salutary added outcome. Disregarding the question of whether or not an advisory schedule addresses perceptions about the incidence and cost of malpractice, a schedule could advance the goal of greater rationality and proportionality in medical malpractice settlements and awards.

However, even a purely advisory noneconomic damages schedule will have an impact on justice for both injured parties and allegedly negligent health care providers that could be construed in a negative as well as positive light. While an advisory schedule would not deprive individuals of their right to a trial by jury, many fear that it may diminish respect for the individuality of the plaintiffs and fail to fully and fairly compensate them for their unique, nuanced injury. In this sense, plaintiffs in malpractice cases will be profoundly disadvantaged in comparison to plaintiffs in other personal injury torts where no such schedule exists. Is a disabling injury less worthy of full compensation because it resulted from medical negligence rather than a fall from a faulty staircase? A schedule, even an advisory schedule, may erode the right of the plaintiff to obtain compensation that will make him as "whole" as possible. Even with a schedule in place that is purely advisory, the task force agreed that a schedule must be flexible and permeable enough to accommodate extraordinary cases, based on these concerns.

Another fundamental aim of tort law is the deterrence of bad practice or negligence. An advisory schedule may function to limit damages and, as a result, may limit the role damages and liability play in deterring substandard practice. In addition, although health care providers may welcome such a schedule, the greater certainty with respect to noneconomic damages values may stimulate more plaintiffs to seek redress for their injuries. Plaintiffs who might abandon or seek settlement at lesser values because of uncertainty in noneconomic damages awards may now have an incentive to proceed to trial knowing that their injury is associated with a defined dollar damages value. There are opposing views on whether interest and willingness to use mediation or other alternative dispute resolution may be of more or less interest to plaintiffs when they have a damages yardstick, even if it is purely advisory. It is also possible that the advisory nature of the schedule will quickly cause the schedule to serve as a floor for damages and may inadvertently lead to boosting of the alleged economic damages.

In addition to the effects on justice, fairness, and deterrence summarized above, the task force debated whether imposition of an advisory

noneconomic damages schedule would have a positive impact on the cost and incidence of malpractice and on the cost of malpractice insurance. Whether an advisory schedule would succeed in effecting such a result is speculative at best. Research and tracking does not definitively support the allegation that the cost of malpractice insurance is in a crisis state or that malpractice judgments are the sole, or even primary cause, of insurance costs, although relevant stakeholders remain divided on this premise. The task force ultimately concluded that the Legislature must be aware that adoption of an advisory schedule is only one possible response to the complex and multifactorial problem of medical negligence and malpractice actions.

III. TASK FORCE PROCESS AND SCOPE OF WORK

A. Process and Organization

After appointment, the task force began its efforts in earnest in January 2005 and met periodically throughout the year, either as an entire group or within subcommittees. Three subcommittees were formed, consistent with the legislative direction:

- *Policy Subcommittee (Chair: Dr. Patricia Kuszler)*
  This group examined underlying advantages, disadvantages, and policy issues attendant to the development of a schedule.

- *Data Subcommittee (Chair: David Kennerud)*
  This group examined medical malpractice data that would need to be available to effectively construct an advisory schedule, data sources, and how data related to scheduling options.

- *Process Subcommittee (Chair: Mary Spillane)*
  This group examined statutory, court rule, and related topics that would need to be addressed should an advisory schedule be put in place.

B. Initial Scope of Work

The task force initially considered and discussed the legislative authorization and the challenges attendant to development of an actual advisory schedule. It was evident to the task force early on that creating such a schedule of damages was breaking new ground, and that there was no precedent for such a schedule in the United States. Some international models were available for review. The task force concluded that there was also a deficiency in available data, great complexity in creating any of the possible alternative schedules, and a lack of implemented models in the United States (in contrast to ceilings or "caps" on noneconomic damages). Consequently, it determined that the scope of its work should be to offer a reasonable implementation plan, should the Legislature make a policy choice to continue development of an advisory schedule for noneconomic damages. The task force determined that such a plan would set out options for damages schedules and identify processes that would need to be undertaken to develop a schedule. The task force thought it important to provide some discussion of the advantages and disadvantages presented by use of an advisory schedule in medical malpractice cases. Legislative members joining the task force after the 2005 legislation session confirmed and

reiterated their belief that this was the proper scope of work by the task force.

C. Use of Experts

In April 2005, after review of an array of literature on the topic of noneconomic damages, the task force approved the hiring of one or more experts to assist them in evaluating possible models or bases for calculating noneconomic damages. Drs. Michelle M. Mello and David M. Studdert of the Harvard School of Public Health were retained to advise the task force on current approaches to calculating noneconomic damages, to describe approaches that promised equitable and predictable compensation for noneconomic losses, and to make recommendations. Drs. Mello and Studdert met with the task force (via conference call) to discuss a draft of the report and possible recommendations. The full report, entitled *Options for Rational Scheduling and Valuation of Noneconomic Damages*, is set out in Section V of this report.

The task force uniformly found the Mello-Studdert report to be scholarly, instructive, and comprehensive in its assessment of available models or schedules for noneconomic damages. It is a key aspect of our recommendations and report to the Legislature.

The Mello-Studdert report will guide the Legislature through the purposes served by noneconomic damages, other state approaches to such damages, and the theory and mechanics of designing damage schedules. It sets out five possible approaches to the scheduling of noneconomic damages, considering the strengths and weaknesses of each. Recognizing that creation of a schedule is not a straightforward exercise, the report recommends an approach that the authors believe addresses the goals of equity, consistency, efficiency, and predictability of compensation for personal injury. The report also contains discussion of a number of policy and process considerations helpful to future efforts.

Relying on the Mello-Studdert report and through numerous discussions among the full task force and its subcommittees, the task force was able to gain consensus on a set of core recommendations. These form the basis of a plan by which the Legislature can move forward to create an advisory schedule if it so chooses. The work of the subcommittees, and their respective reports, further informs this legislative effort. The reports of the Policy, Data, and Process Subcommittees are set out at Sections VI, VII, and VIII, respectively.

IV. TASK FORCE CONCLUSIONS AND RECOMMENDATIONS

If the Legislature chooses to proceed with development of a schedule for noneconomic damages, the task force makes the following conclusions and recommendations:

Recommendation One:

Make a Considered Choice of a Damage Schedule Option

- The Mello-Studdert report offers the most comprehensive, current analysis of the options available for scheduling noneconomic damages. It should be relied upon and serve as key guidance on policy choices. Given the fact that the schedule will be advisory, the Legislature should review and consider all of the models in deciding on one that it believes can be the most rational, fair, and easy to use in the civil justice system, and then undertake development of the model in detail.

- The Legislature should adopt a schedule that is a blend of the quantitative tiering of injuries coupled with a dollar valuation at each tier, as recommended in the Mello-Studdert report. This basis for scheduling noneconomic damages offers the best guidance to juries, plaintiffs, and defendants, and does not suffer from the same limitations as other schedules discussed in the report. With the quantitative scale of severity, there are existing scales that form a reasonable bases upon which to proceed, subject to some improvements and modifications. The precedential approach to assigning dollar values to the tiers gives deference to the role of courts and juries. Although there are currently barriers to gathering data on previous decisions, legislative action could call for collection of needed data.

- The choice of a schedule and type of schedule requires legislation.

Recommendation Two:

Define the Nature and Manner of Use of a Damages Schedule

- Any schedule should be advisory and not prescriptive. The schedule should also be piloted and evaluated as to its usefulness in dispute resolution and for juries, and in reaching the legislative goals of predictability and proportionality. The schedule should not serve as a cap or ceiling on damages.

- The precise format in which to present the schedule to the jury should be subject to further policy debate, to more precisely define the meaning of "advisory." See Report of the Process Subcommittee, at Section VIII.

- If a schedule is adopted, even as an advisory model, it should be flexible enough to address extraordinary, unique, and compelling circumstances of individual cases.

- Any schedule must be maintained through an ongoing process of evaluation and adjustments, either by legislative action or by a body with delegated power to do so.

Recommendation Three:

Define a Specific Development Process

- The Legislature should establish a commission or panel to begin detailed development of the quantitative scale of injury and assignment of dollar values.

- Any commission or panel should include both experts and consumers. The task force uniformly agreed that both lay and expert opinion and input are essential to creation of a credible and fair damages schedule.

- The Legislature should define the process to be used by a commission or panel – does it take testimony, hold hearings, and the like? Given the complexity of that task, it is recommended there be some formal process for the panel to hear from experts, citizens, and those interested.

Recommendation Four:

Recognize the Timeframe for Developing an Advisory Schedule

- The timeframe for development of an advisory schedule should be realistic and could take two to five years, as the undertaking is complex and political. Numerous experts and interested stakeholder groups must be engaged in the process. Underlying data needs to be developed to support the valuation component of a schedule.

Recommendation Five:

Grant Authority to Gather Sufficient Data

- Lack of comprehensive medical malpractice data is a significant, but not insurmountable, barrier to use in a precedential approach of valuing tiers of injury in a damage schedule. Much of the needed data does not currently exist and will need to be developed *de novo.* Legislation or other steps that allow for collection of a broad array of medical malpractice data would be extremely advantageous, if not essential, in designing the valuation aspect of injury tiers in any advisory schedule. See Report of the Data Subcommittee, at Section VII.

Recommendation Six:

Consider Legal Issues Fully

- There should be further legal analysis of the implications of the *Sofie v. Fibreboard Corp.,* 112 Wn. 2d 636, 771 P.2d 711 (1989) in the context of an advisory schedule. This is an essential analysis in implementing the schedule in such a way that it will not be construed as or function as a cap. See discussion at Appendix G, Mello article, "Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation."

- Limiting the use of an advisory schedule to medical malpractice cases only, and not to all tort personal injury cases, presents additional legal and constitutional questions. Moreover, extrinsic to the legal questions, there are questions of fairness and justice inherent in carving out only one etiology of personal injury for special judicial treatment. There should be further legal analysis of the advisability of limiting the use of a schedule to only health care cases.

V. REPORT: OPTIONS FOR RATIONAL SCHEDULING AND VALUATION OF NONECONOMIC DAMAGES

OPTIONS FOR RATIONAL SCHEDULING AND VALUATION OF NONECONOMIC DAMAGES

Report to the

Washington State Noneconomic Damages Task Force

July 25, 2005

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Executive Summary

This report begins with a discussion of the goals of noneconomic damages for personal injuries, problems with current approaches to calculating them, and limitations of proposed reforms in this area. Next, we describe five alternative approaches that promise more considered, predictable, and equitable compensation for noneconomic losses. We outline the strengths and weaknesses of each approach, together with practical considerations for operationalizing them. Selected points from the report follow by chapter.

1. Background

- Noneconomic damages compensate plaintiffs for pain, suffering, disfigurement, loss of companionship, and other harms arising from an injury that do not have direct financial consequences.
- Noneconomic damages are intended to compensate victims by making them whole, and deter defendants from harmful behavior.
- Juries are usually given little guidance as to how to quantify these damages; as a result, similar injuries can lead to widely varying awards.
- These haphazard results lead to case-to-case inequities, uncertainty for stakeholders in the civil justice system, and higher costs of liability insurance.

2. Limiting Damages

- Most noneconomic damages awards are for relatively small amounts, but a minority are spread widely across very high amounts.
- Periodic medical malpractice crises have spurred calls from the highest levels of government for limits on noneconomic damages.
- More than half the states have passed legislation imposing ceilings or "caps" on noneconomic damages. Caps vary from state to state by amount, inflation adjustment mechanism, waiver provisions, types of injuries covered, whether caps are tied to life expectancy, and availability of tiers (higher caps for more serious injures).
- Criticisms of Caps:
    - Caps are often not adjusted for inflation and do not reflect present-day value.
    - Caps do not provide juries with any guidance as to calculation of awards; awards which do not trigger the cap may nonetheless be excessive given the injury.
    - The burden of caps falls on those with the most serious injuries.

3. Schedules: Theory and Mechanics

- A schedule would promote "vertical" and "horizontal" equity. Principles of vertical equity dictate that more severe injuries should receive higher compensation than less severe ones, and *vice versa*; principles of horizontal equity call for similar compensation for injuries of similar severity.

- Construction of a schedule requires two steps: (1) delineation of "tiers" (or levels) of severity, into which like injuries may be grouped; and (2) assignment of dollar values to the tiers.
- The key design choices in scheduling are:
    - What measure for noneconomic loss?
    - How many injury tiers?
    - Should injury tiers include age strata?
    - How should tiers be weighted against one another?
    - What process / decision makers should assign dollar values to tiers?
    - Should tiers have a single dollar value, multiple values, or value ranges?

4. Bases for Scheduling Damages

We review five alternative approaches to calculating noneconomic damages, and consider their strengths and weaknesses. The first approach addresses the valuation task; the second, third, and fourth approaches address the tiering task; and the fifth addresses both tasks.

Approach	Description	Strengths and Weaknesses
1. Precedential	Use of previous noneconomic damages awards in similar cases	*Strengths*: • Maintains credence in original source of decisions • Reduces "outlier" values and dispersion around the mean • Provides explicit guidance on dollar values *Weaknesses:* • To the extent inappropriate considerations drove original decisions, they are preserved albeit "dulled" • Problems in collecting precedential information • Does not provide basis for "clustering" cases
2. Quantitative Scale	Classifies noneconomic injuries using severity scales. The 9-tier NAIC scale is the key example.	*Strengths*: • Provides an explicit basis for grading injury severity • Process of slotting injuries into tiers of the scales is reasonably objective and reproducible *Weaknesses*: • Standard injury severity scales are biased toward physical manifestations of injury and may not adequately capture pain and suffering • Does not provide dollar values, just ranking and grouping. Dollar values would need to be overlaid by some other mechanism (e.g. precedential information)

3. Qualitative Scale	Looks to qualitative judgments and, potentially, expert determinations to scale injuries by severity of their accompanying losses. The leading example is the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* although the extent to which this captures noneconomic loss is questionable.	*Strengths*: • Avoids the perceived danger of trying to "quantify the unquantifiable" • If the decision making group is trusted and broadly representative and the process perceived as fair, some lack of explicitness about the scaling basis may be acceptable *Weaknesses*: • Basis for tiers remains obscure, as may the nature of the loss being scaled • Existing scales are grounded heavily in expert judgments about loss. However, clinical expertise carries no obvious primacy over lay perspectives for key parts of the scaling decision
4. Health Utilities Index	Uses empirical measurements of perceived decrements in quality of life to scale injuries. Scale values are grounded in preferences expressed by individuals about difficulties of living with different health states. Quality Adjusted Life Years (QALYs) are the leading example of this type of measure.	*Strengths:* • Potential to develop a scale based on a measure that appears to capture the concept of pain-and-suffering quite well • Underlying measure blends strands of subjective and objective valuations *Weaknesses*: • Health utilities scales remain relatively undeveloped for injuries • Does not provide dollar valuations
5. Hedonic Damages	Purport to compensate injured plaintiffs for the loss of quality of life or the value of life itself.	*Strengths:* • Provides a methodology for addressing both tiering and valuations • Concept of lost enjoyment of life may come close to notion of pain and suffering. *Weaknesses:* • Methodology is controversial and has been rejected by courts in many jurisdictions • Concept of hedonic damages may not capture pain and suffering

5. Operational Considerations

- Schedules may be mandatory, discretionary or presumptive; the presumptive approach is appealing as it has potential to preserve uniformity of awards as well as the jury's decision making function.
- Noneconomic damages are typically paid in a lump sum; they may also be structured as periodic payments, although there is no compelling reason to do so.
- Calculating noneconomic damages as a multiplier of economic damages is not rational.
- Any schedule should be periodically updated to reflect, *inter alia*, inflation and medical advances.
- Compensation in wrongful death cases may merit separate treatment

6. Conclusions and Recommendations

- On balance, quantitative scales are the best available basis for the tiering of injuries.
- A working group should consider how to improve upon existing quantitative scales.
- At this time, the precedential approach is a more expedient basis for valuation of injury tiers than the alternative, hedonic damages.
- A working group should make decisions about the range of previous awards to include in the valuations and the specific nature of the numerical values to be generated. It is probably desirable to limit the dataset to jury awards from the jurisdiction and to create ranges of dollar values that are anchored in median past awards for similar injuries.
- The schedule should be advisory in nature.
- Early versions of the schedule should undergo evaluation and reconsideration after a trial period.

1. Background: The Trouble with Noneconomic Damages

1.1. Calculation of Damages for Personal Injury

Compensation for personal injury consists of three conceptually distinct components. Economic damages cover direct financial losses, primarily health care costs and lost wages. Noneconomic damages compensate plaintiffs for pain, suffering, disfigurement, loss of companionship, and other harms arising from the injury that do not have direct financial consequences. Punitive damages aim to punish defendants, and are generally reserved for situations in which the defendant has demonstrated callous disregard for the plaintiff's well being.

To understand how each of these components are determined in the civil justice system, it is important to recognize that the majority of tort lawsuits—approximately 90% in the case of medical malpractice litigation—are resolved outside court. In settlement negotiations, plaintiff and defense lawyers often tender documentation about health care costs, lost wages, and severity of injury. However, the offers and counter-offers that precede out-of-court settlements seldom involve formal decomposition of the sums under negotiation into economic and noneconomic components.

For tort cases that proceed to trial, responsibility for quantifying damages almost always lies with juries. If the jury decides the defendant was negligent, it must determine the appropriate amount of damages by weighing testimony on the economic and health implications of the injury. Courts in some jurisdictions, such as California, compel juries to delineate the various components of their award. Although jury valuations of injuries occur in only a small minority of claims, they have a powerful sentinel effect; all bargaining takes place in their "shadow."[1]

Economic damages can be large, but because they are amenable to objective calculation, they tend to be relatively uncontroversial. Punitive damages are less objective and can be extremely large. Their appropriateness has been the subject of fierce debate within legal and policy communities.[2] However, business, fraud, and contract cases are the "heartland" of punitive damages; they are relatively rare in malpractice and most other types of personal injury litigation.[3] Hence, debate about the excessiveness of awards in cases involving physiologic injury tends to center on (ir)rationality of noneconomic damages.

Juries are generally given little guidance about how to calculate noneconomic damages. Consider, as a typical example, the model jury instruction from California: jurors are asked to consider awarding

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[1] Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L. J. 950 (1979).
[2] CASS R. SUNSTEIN ET AL., PUNITIVE DAMAGES: HOW JURIES DECIDE (2002).
[3] David M. Studdert & Troyen A.Brennan, *The Problems With Punitive Damages in Lawsuits Against Managed-Care Organizations*, 342 NEW ENG. J. MED. 280 (2000).

> Reasonable compensation for any pain, discomfort, fears, anxiety and other mental and emotional distress suffered by the 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. Nor is the opinion of any witness required as to the amount of such reasonable compensation. [Furthermore, the argument of counsel as to the amount of damages is not evidence of reasonable compensation.] 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.
>
> [This is non-economic damage.]
>
> [If you conclude that the plaintiff is entitled to recover compensation for future non-economic damages, you should determine that amount in current dollars, that is, the amount paid at the time of judgment that will compensate a plaintiff for future pain and suffering.
>
> The method you use in determining future economic losses need not be followed by you in your determination of future non-economic damages.][4]

Washington State provides no guidance beyond telling the jury to consider "the pain and suffering, both mental and physical, … experienced and with reasonable probability to be experienced in the future."[5]

Most jurisdictions allow litigants to request a jury instruction that provides a method of calculating noneconomic damages on a per diem basis.[6] Under the per diem method, the jury determines the noneconomic damages for a particular unit of time, such as one day, and then multiplies this amount by the number of days that the plaintiff's injury is expected to last. This method provides no guidance as to how to arrive at the unit valuation, however.[7] Some courts have explicitly rejected the per diem method on the basis that it lends a false air of quantitativeness to a determination that is inherently qualitative in nature.[8]

A second method has been allowed in some jurisdictions to assist juries in calculating so-called "hedonic damages." This method calls for jurors to determine a willingness-to-pay measure for the loss of life's pleasure that the plaintiff has incurred. The relationship between hedonic damages and noneconomic damages is murky; hedonic damages have been rejected in

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[4] Civil Committee On California Jury Instructions, *Measure Of Damages--Personal Injury--Pain And Suffering*, Cal. Jury Instr. Civ. 14.13 (2005).

[5] Washington Supreme Court Committee On Jury Instructions, *Measure of Damages--Elements of Noneconomic Damages—-Pain and Suffering, Etc.—Past and Future*, 6 Wash. Prac., Wash. Pattern Jury Instr. Civ. WPI 30.06 (5th ed. 2002). *See also* Washington Supreme Court Committee On Jury Instructions, *Measure of Economic and Noneconomic Damages—Personal Injury—No Contributory Negligence*, 6 Wash. Prac., Wash. Pattern Jury Instr. Civ. WPI 30.01.01 (5th ed. 2002) ("The law has not furnished us with any fixed standards by which to measure noneconomic damages. With reference to these matters you must be governed by your own judgment, by the evidence in the case, and by these instructions."); Washington Supreme Court Committee On Jury Instructions, *Noneconomic Damages—Definition*, 6 Wash. Prac., Wash. Pattern Jury Instr. Civ. WPI 30.01.03 (5th ed. 2002) ("(The committee recommends that no instruction be given on this subject.)").

[6] Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 CAL. L. REV 773, 782 (1995)

[7] *Id.*

[8] *Id.*, citing James O. Pearson, Jr., Annotation, *Per Diem or Similar Mathematical Basis for Fixing Damages for Pain and Suffering*, 3 A.L.R.4th 940 (1981).

many jurisdictions; and the use of this calculation methodology had been met with considerable judicial skepticism.[9] Nevertheless, because it is ambitious and innovative, we discuss this methodology in greater depth below.

1.2. Purposes of Noneconomic Damages

The broad objectives of noneconomic damages reflect those of tort law itself: to compensate individuals who have been harmed by negligent behavior and to deter and prevent such behavior in the future.[10] The traditional and dominant view is that the goal of compensation is to make the injured parties "whole" for their losses.[11] This view holds that the economic harm caused by an injury is, in principle, directly calculable and replaceable by money. Noneconomic harm, on the other hand, is, by definition, neither directly calculable nor replaceable by money, so money must substitute. The appropriate amount depends either on the injured party's subjective valuation of the loss or society's view of what constitute a reasonable amount of money for the loss. There is a lively debate in the academic community about which of these two perspectives in the correct one. In either case, the jury's award represents the court's (and, by proxy, society's) best guess of this valuation.

An alternative paradigm conceives of compensation as a form of social insurance.[12] Recognizing that society funds compensation, it draws on insurance theory to posit that coherent estimation of damages depends on comparisons of the marginal utility of money across pre- and post-injury states. Simply put, decisions about appropriate levels of payment from a compensatory perspective should turn on the sort of disability insurance choices individuals would make in well-functioning, actuarially fair markets.[13] Adoption of this perspective may or may not lead to levels of compensation that make successful claimants whole. Many law-and-economics commentators have used the insurance theory of damages to question whether noneconomic losses should be compensated at all.[14]

The second function of noneconomic damages is that payment of them, along with other types of damages, discourages or deters defendants (and others who might later be in a similar situation to the defendant) from engaging in the type of injurious behavior that led to the harm. There is no obvious relationship between the amount of damages required to achieve a socially optimal level of deterrence and the amount required to compensate the injured plaintiff appropriately. Indeed, where the money goes (other than out of the defendant's pocket) is not strictly relevant from a deterrence perspective. For example, if the Zed Corporation negligently caused a gas leak which harmed residents living nearby its plant, and the socially optimal level

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[9] *Id.*, citing Tina M. Tabacchi, Note, Hedonic Damages: A New Trend in Compensation? 52 Ohio St. L.J. 331, 342-48 (1991); Randall A. Bovbjerg, Frank A. Sloan, & James F. Blumstein, *Valuing Life and Limb: Scheduling "Pain and Suffering,* 83 NW. U. L. REV. 908, 927 (1989) (collecting cases).

[10] WILLIAM L. PROSSER ET AL., PROSSER AND KEETON ON THE LAW OF TORTS (5TH ED. 1998).

[11] GRAHAM DOUTHWAITE, JURY INSTRUCTIONS ON DAMAGES IN TORT ACTIONS (1993).

[12] GUIDO CALABRESI, THE COST OF ACCIDENTS (1970).

[13] *See* Steven P. Croley & Jon D. Hanson, *The Nonpecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law*, 108 HARV. L. REV. 1785, 1812-95 (1995).

[14] *See id.* at 1797-1804; Alan Schwartz, *Proposals for Products Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 363-65 (1988).

of monetary deterrence for this transgression was known to be $10 million, it would not matter from a deterrence perspective whether 1000 plaintiffs were compensated $1,000 each, one received $10 million, or all $10 million were used as kindling in a bonfire.

The main objective of a schedule for noneconomic damages is to improve the compensation function. To the extent that more predictable levels of damages send clearer signals about unacceptable wrongdoing, deterrence objectives may also be served, but these gains are somewhat incidental.

Specifically, a schedule would promote consistency and equity in compensation. The key indicators of internal consistency in damages awards have been conceptualized in terms of "vertical" and "horizontal" equity.[15] Principles of vertical equity dictate that more severe injuries should receive higher compensation than less severe ones, and *vice versa*; principles of horizontal equity call for similar compensation for injuries of similar severity.

A schedule would also improve the compensation function of tort damages by ensuring that the principle of absolute fairness in compensation is served. Damages awards meet the criterion of absolute fairness if they meet (and do not exceed) societal expectations about what constitutes appropriate compensation for the particular injury involved.[16] Schedules allow for a process of public deliberation to take place about these expectations outside the context of a particular plaintiff pressing a particular demand. They also ensure that those expectations are applied in a consistent fashion across cases.

1.3. Valuing Noneconomic Losses

Quantification of noneconomic losses represents a profound, longstanding, and seemingly intractable problem in the law.[17] The legal community has, for the most part, thrown its hands up and surrendered to the view that suffering is essentially unknowable in any objective terms. Consequently, as W. Kip Viscusi has noted, the problem has been turned back to juries, "in the apparent hope that jurors can fill the intellectual void left by the courts and legal scholars."[18] Courts give juries wide deference on the matter.[19]

Jurors struggle with the calculations. Survey data indicate that juries typically view the determination of damages as more difficult than the decision about liability.[20] In one jury simulation exercise conducted with 147 veniremen waiting to be called for jury selection outside a North Carolina courtroom, the participants

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[15] David M. Studdert et al., *Are Caps on Damages Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54, 55 (2004); Bovbjerg et al., *supra* note 9, at 924.
[16] *Id.*
[17] *See generally* Croley & Hanson, *supra* note 13; Geistfeld, *supra* note 6, at 775-76.
[18] W. KIP VISCUSI, REFORMING PRODUCTS LIABILITY 101 (1991).
[19] Edith Greene & Brian H. Borstein, *Precious Little Guidance: Jury Instructions on Damages Awards*, 6 PSYCH. PUB. POL. & L. 743 (2000).
[20] Shari S. Diamond, *What Jurors Think: Expectations and Reactions of Citizens Who Serve As Jurors*, *in* VERDICT: ASSESSING THE CIVIL JURY SYSTEM (Robert E. Litan, ed., 1993).

> uniformly commented on the difficulty of putting a price on pain and suffering and used different methods of calculating the awards. Some roughly split the difference between the defendant's and the plaintiff's suggested figures. One juror doubled what the defendant said was fair, and another said it should be three times medical expenses. One juror said, "Eight months of pain and suffering missing out of her teen years. She should receive no more than what most people make in a year" (awarded $50,000). A number of jurors assessed pain and suffering on a per month basis, such as $4000 or $5000, and multiplied by the eight months that the plaintiff was incapacitated. Other jurors indicated that they just came up with a figure that they thought was fair.[21]

It should not be surprising that the resultant valuations show an enormous amount of variance. Previous empirical research has found that although noneconomic damages awards by juries adhere reasonably well to the principle of vertical equity—that is, damages tend to climb with injury severity—horizontal equity is poor.[22] For example, a recent study of California malpractice verdicts found that noneconomic damages awards for injuries characterized by physician reviewers as "grave" ranged from about half a million dollars to over $6 million, with a mean of about $2 million.[23]

Research suggests that less than 50% of the variation in noneconomic damages can be explained by variation in the nature or extent of the injuries in question.[24] What explains the rest? One possibility is extraneous factors such as the plaintiff's gender, race, socioeconomic status, or physical appearance.[25] This is troubling, but a distinct possibility in light of research suggesting that the influence of such factors on jury decision making tends to increase with the vagueness of legal standards.[26]

1.4. The Costs of Unpredictability

The adverse effects of erratic compensation payments are felt throughout the civil justice system. They infect compensation systems with unpredictability and instability; increase the costs of liability insurance; undermine deterrence; allow case-to-case inequities to flourish; and weaken the credibility of injury compensation in the eyes of the media, the public, and policymakers.[27]

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[21] Neil J.Vidmar, *Empirical Evidence on the "Deep Pockets" Hypothesis: Jury Awards For Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L. J. 217 (1993).

[22] Studdert et al., *supra* note 15, at 58-59 (analyzing noneconomic damages awards in a sample of California medical malpractice cases from 1985 to 2002). *Cf.* Bovbjerg et al., *supra* note 9, at 920-25 (reporting similar findings from a study of total damages awards in 1973-1987 in a sample consisting of medical malpractice cases, product liability cases, auto injury cases, and cases against government defendants).

[23] Studdert et al., *supra* note 15, at 59.

[24] Bovbjerg et al., *supra* note 9, at 923; MICHAEL G. SHANLEY & MARK A. PETERSON, COMPARATIVE JUSTICE: CIVIL JURY VERDICTS IN SAN FRANCISCO AND COOK COUNTIES, 1959-1980 (1983).

[25] For illustrative empirical studies of the role of these factors in jury decisions, see the sources cited in Frederick S. Levin. Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie," 22 *U. Mich. J. L. Ref.* 303, 321 (1989).

[26] Martin Kaplan & L.E. Miller, *A Model of Cognitive Processes in Jurors*, 10 REP. RES. IN SOC. PSYCH. 48, 49 (1979), *cited in* Levin, *supra* note 25, at 321 n.68.

[27] Bovbjerg et al., *supra* note 9, at 908.

When damages awards are highly variable and insurers cannot predict them with precision, the cost of insurance rises.[28] Every malpractice insurance premium dollar includes an amount that represents the insurer's uncertainty about its exposure. The greater the uncertainty, the larger that amount will be. Where uncertainty is extreme and the potential exposure massive, some insurers may choose to withdraw from the market entirely,[29] or price some health care providers out of the market entirely.

Variability and unpredictability in damages awards also blur any deterrent signal that the tort system might send to potential defendants. Deterrence hinges on the ability of potential tortfeasors to understand what the economic sanctions associated with negligent behavior would be. Rational cost-benefit calculations around different levels of precaution taking cannot be performed with accuracy where the costs are not known with certainty. The result may be too much precaution taking (overdeterrence) or too little (underdeterrence).[30] In the medical malpractice context, this means that health care may suffer from the costs associated with defensive medicine or the suboptimal level of patient safety that results when providers are not motivated to take steps to prevent adverse events.

In addition to being costly, the present method of determining noneconomic damages results in inequitable treatment of plaintiffs. The lack of horizontal equity in the system runs contrary to the basic notion of a just system as one that treats similarly situated persons similarly.[31] For this reason, the absence of a coherent framework for evaluating noneconomic losses disrupts the social accountability of the legal system. Randall Bovbjerg, Frank Sloan, and James Blumstein have surmised, "At root, one's attitude about the liability system generally, and damage awards specifically, seems to depend a great deal on one's attitude concerning non-economic damages… ."[32] Rationalizing noneconomic damages would bring greater reliability, efficiency, justice, and legitimacy to the tort system.

2. Limiting Damages

2.1. Why Focus on Noneconomic Damages?

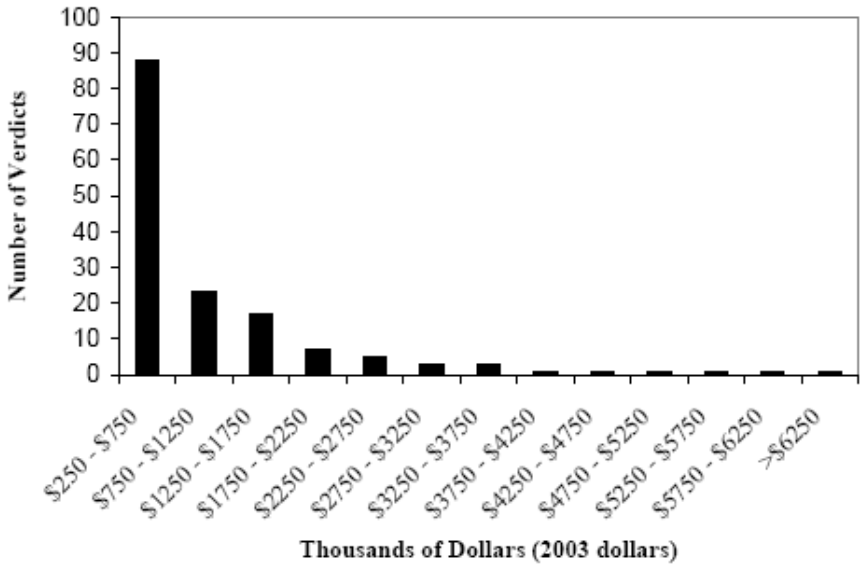
Periodic malpractice crises have led to enduring interest in limiting damages awards in malpractice cases. Noneconomic damages tend to be at the sharp edge of this push, for a variety of reasons: the lack of standards available for juries,[33] the controversial nature of noneconomic loss; the political unpopularity of suggesting that injured patients should not be fully compensated for their economic losses; the extreme variability in jury awards for noneconomic damages in ostensibly similar cases; and the public perception that "jackpot" noneconomic

[28] Patricia M. Danzon, *Medical Malpractice Liability*, *in* LIABILITY: PERSPECTIVES AND POLICY 101, 122 (Robert E. Litan & Clifford Winston, eds., 1988).
[29] Geistfeld, *supra* note 6, at 788; Bovbjerg et al., *supra* note 6, at 925.
[30] Geistfeld, *supra* note 6, at 786.
[31] Bovbjerg et al., *supra* note 9, at 924.
[32] *Id.* at 919.
[33] Geistfeld, *supra* note 6, at 781.

damages awards are the main driver of malpractice insurance premiums, which stems from media publicity about cases in which juries have made huge pain-and-suffering awards for seemingly trivial injuries.[34]

Available data on jury awards of noneconomic damages show that the awards are not normally distributed.[35] There is a pronounced positive skew to their distribution. In other words, most awards fall at the lower end of the distribution, but a smaller number of awards are dispersed widely across the upper end and involve very large dollar amounts. Figure 1 illustrates the distribution of noneconomic damages using data on 152 plaintiff verdicts in malpractice cases in which the noneconomic component of the award was $250,000 or greater.[36] (Inclusion of noneconomic awards of less than $250,000, which were not available in this analysis, would further accentuate the skewed distribution.) Plots of total damages in personal injury claims show more or less the same positively-skewed distribution.

Figure 1. Distribution of Noneconomic Damages in 152 California Medical Malpractice Jury Awards Over $250,000 in 1985-2002



To what extent is the overall skew driven by noneconomic damages? Noneconomic damages account for a significant proportion of awards—approximately 30% to 40% across all awards, and somewhere between 40% and 70% of large verdicts in medical malpractice and

[34] Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, __ J. L. MED. & ETHICS __, __ (2005) (forthcoming).
[35] Studdert et al., *supra* note 15; NICHOLAS M. PACE, DANIELA GOLINELLI, & LAURA ZAKARAS, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA (2004); Bovbjerg et al., *supra* note 9, at 920-25.
[36] These data are described more fully in Studdert et al., *supra* note 15.

other types of personal injury litigation.[37] There is a perception that the top-end payouts are driven by excessive noneconomic damages. The Bush Administration's linkage of concerns about "excessive payouts" in malpractice cases to caps on noneconomic damages caps as a reform illustrates this perception:

> Anybody who goes into court and wins their case ought to get full economic damages. At the same time, we must prevent excessive awards that drive up costs, encourage frivolous lawsuits, and promote drawn-out legal proceedings. And that is why we need a reasonable federal limit on non-economic damages awarded in medical liability lawsuits, and the reasonable limit in my judgment ought to be $250,000.[38]

There is some empirical support for the assertion that high total payouts are driven by large noneconomic damages awards and that such payouts have increased in recent years. According to the Physician Insurers Association of America, there has been a 60 percent increase in the average total award (unadjusted for inflation) from 1999 to 2003 and a doubling of the proportion of payouts that are $1 million or more during the 1997-2001 period.[39] Concern about this upsurge in total payouts has spurred efforts to limit damages; belief that noneconomic damages play an important role in driving up total payouts has focused this interest on the noneconomic component of awards.

Other countries, too, have pursued reforms with the objective of rationalizing noneconomic damages awards. Some have chosen a flat or tiered cap, while others have adopted more sophisticated scheduling approaches based on the severity of the injury. A sampling of foreign models is described in the Appendix to this report. Finally, ensuring that noneconomic damages adhere to a rational structure was also of major concern to the architects of the 9/11 victims' compensation fund; their concern appears to have been primarily that the awards would adhere to notions of horizontal equity.[40]

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[37] W. Kip Viscusi, *Pain and Suffering in Product Liability Cases: Systematic Compensation or Capricious Awards?*, 8 INT'L. REV. L. & ECON 203 (1988) (analysis of product liability cases); Bovbjerg et al., *supra* note 9; Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 ARIZ. L. REV. *849* (1998); AMERICAN LAW INSTITUTE, REPORTERS' STUDY: ENTERPRISE LIABILITY FOR PERSONAL INJURY (1991).

[38] George W. Bush, *President Proposes Major Reforms to Address Medical Liability Crisis* (visited June 23, 2005) <http://www.whitehouse.gov/news/releases/2002/07/20020725-1.html> (transcript of speech given at High Point University, Greensboro, NC, July 25, 2002).

[39] Physician Insurers Association of America, *Statement by the Physician Insurers Association of America, January 29, 2003* (visited June 23, 2005) <http://www.piaa.us/pdf_files/January_29_Piaa_Statement.pdf>.

[40] *See* KENNETH R. FEINBERG, CAMILLE S. BIROS, ET AL. FINAL REPORT OF THE SPECIAL MASTER FOR THE SEPTEMBER 11TH VICTIM COMPENSATION FUND OF 2001, VOLUME 1, AT 43 (visited June 26, 2005) <http://www.usdoj.gov/final_report.pdf> ("The Fund established the non-economic awards for physical injury victims based on the nature, severity and duration of the injury and the individual circumstances of the claimant. The Fund assured consistency by categorizing injuries so that claimants with like injuries (in terms of severity and duration) would receive a similar non-economic award. … (Of course, there were variations in the awards based on individual factors such as the necessity for surgery, or multiple injuries.)").

2.2. State Approaches to Noneconomic Damages Caps

As of June 2005, more than half the states have passed legislation imposing ceilings or "caps" on noneconomic damages (Figure 2). A review of these laws is helpful for understanding the theoretical and practical reasons to pursue the alternative approach of scheduling damages.

The prototypical form of the noneconomic damages cap is California's cap, adopted in 1975 as part of the Medical Injury Compensation Reform Act (MICRA).[41] The MICRA cap is a flat limit of $250,000 that is not adjusted for inflation over time. States adopting caps after California's pioneering initiative have generally looked to MICRA as a model; however, states have varied in their approaches to caps legislation in at least six respects (Figure 2).[42]

First, the absolute baseline amount of the cap varies. A few states have adopted California's $250,000 cutoff; more common are amounts between $250,000 and $500,000, and two states have ceilings above the $500,000 level. Second, some states allow an inflation adjustment and others do not. This can make a significant difference over the medium to long term: California's cap, for example, would have topped $900,000 in 2005 if it had been adjusted annually by the Consumer Price Index.[43]

Third, three states (Massachusetts, Florida, and Ohio) allow the judge or jury in a particular case to waive the cap if they feel the circumstances of the case warrant it. Fourth, some states restrict the cap to certain kinds of injuries—for example, Oklahoma's cap applies only to obstetrical and emergency cases, and the caps in Oregon and Maine apply only to wrongful death cases. Fifth, one state, Alaska, has calibrated the amount of the cap to the plaintiff's life expectancy. Alaska specifies a dollar amount that is to be multiplied by the plaintiff's estimated remaining years of life.[44]

Finally, some states employ a tiered rather than flat cap. That is, the legislation specifies two or three different dollar ceilings which apply to injuries of different levels of severity. For example, Maryland's cap is $812,500 for death cases and $650,000 for all other cases.[45] Michigan raises its $280,00 limit to $500,000 if the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, has permanently impaired cognitive capacity, or sustains permanent damage to a reproductive organ.[46] Similarly, Ohio's $350,000 ceiling is raised to $500,000 in cases of permanent physical or functional impairment;[47] and West Virginia's $250,000 cap increases to $500,000 when there is a permanent and substantial physical deformity, loss of use of a limb or bodily organ system, or a permanent physical or mental injury that prevents the person from being able to independently care for himself.[48]

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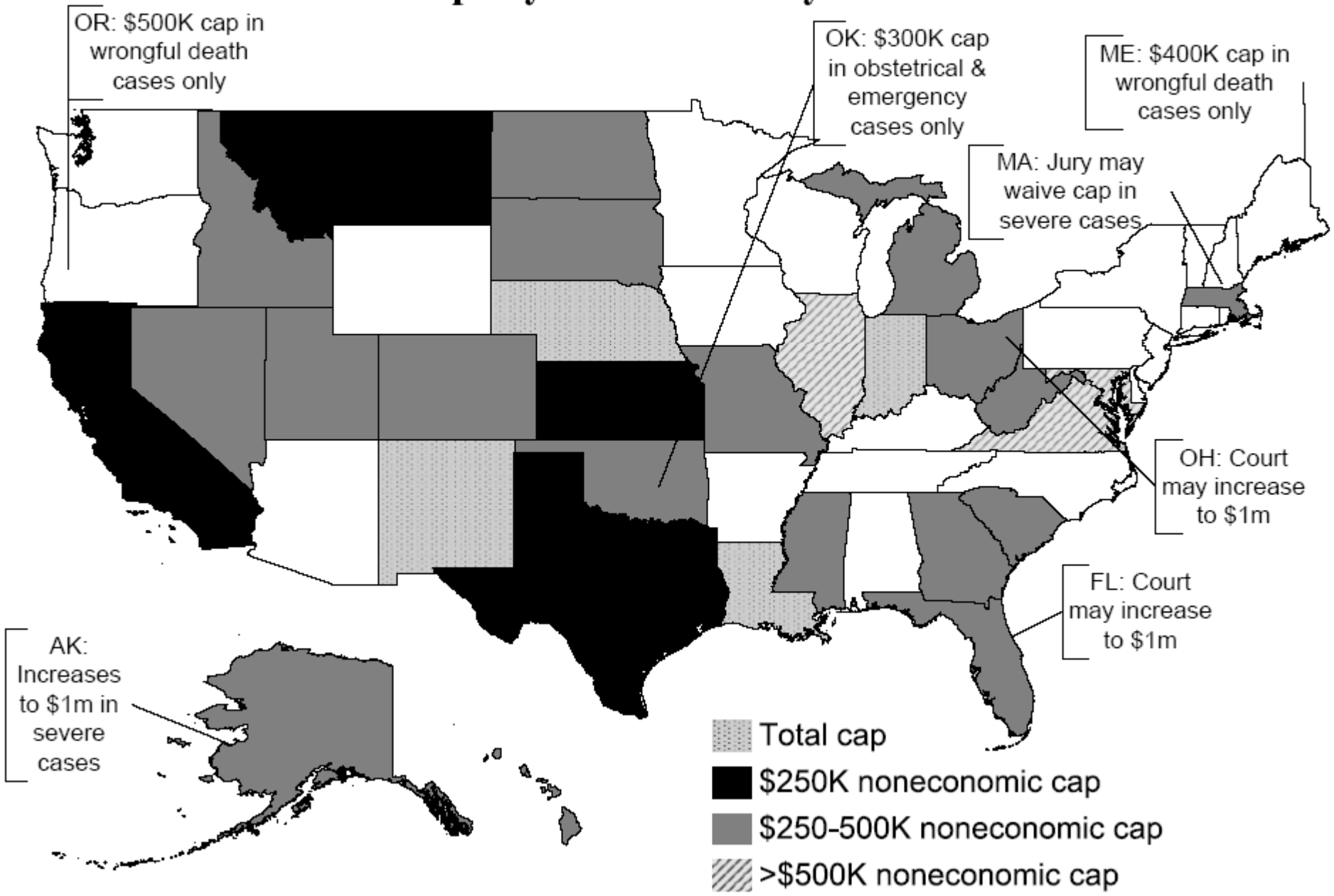
[41] CAL. CIV. CODE § 3333.2 (1975).
[42] A table describing caps laws in the U.S. states as of April 2005 is available in Kelly & Mello, *supra* note 34.
[43] To perform this calculation, see U.S. Department of Labor, Bureau of Labor Statistics. Inflation Calculator (visited June 22, 2005) < http://www.bls.gov/cpi/>.
[44] ALASKA STAT. § 09.17.010.
[45] Maryland Patients' Access to Quality Health Care Act of 2004, MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-09.
[46] MICH. COMP. L. § 600.1483.
[47] OHIO REV. CODE ANN. § 2323.43.
[48] W. VA. CODE § 55-7B-8.

Figure 2. Noneconomic and Total Damages Caps by State as of July 2005



2.3. Insights from States' Experiences With Caps

States' approaches to and experiences with noneconomic caps provide three key lessons. First, the selection of a dollar value for the cap should, in theory, represent a societal judgment about what constitutes reasonable but not excessive compensation for noneconomic loss. That judgment is made at a particular point in time; however, the value of dollars decreases over time. If the social valuation judgment is to have any enduring meaning, the cap should be adjusted annually for inflation in order to maintain its real value.[49]

Second, caps have not provided any substantive guidance to juries about appropriate awards. Indeed, juries are theoretically blinded to the existence of a cap; they certainly are not instructed as to its existence. Caps can help counteract very large noneconomic damages awards, but do nothing to address the problem of damages awards beneath the level of the cap that might nonetheless be considered excessive given the nature of the injury. Nor do they deal with the problem of inappropriately low awards, since they set no floors. "Thus any awards below the cap are subject to the same claims of arbitrariness and unfairness that plague the current system."[50]

Third, the gold-standard $250,000 flat cap has come under fire by consumer and attorney groups, as well as some scholarly commentators, who charge that it is fundamentally unfair. They argue that such caps inadequately compensate the most severely injured patients.[51] Further, they claim that the burden of caps falls disproportionately heavily on the shoulders of low wage earners, particularly women and the elderly, who rely on the noneconomic portion of damages awards to obtain compensation.[52]

Two empirical studies recently investigated these claims using data on California jury verdicts that were subject to the MICRA cap. Researchers at RAND Institute for Civil Justice analyzed 257 plaintiff verdicts handed down between 1995 and 1999 to ascertain whether the magnitude of reductions in total awards was significantly associated with the plaintiff's injury type, age, or gender.[53] They calculated both the absolute size of the reduction (in dollars) and the proportional reduction (the percentage reduction in the total award). They found that fatal

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[49] *Cf.* Danzon, *supra* note 28, at 123 ("The schedule should be indexed to the relevant measures (medical costs, wages) top revent either erosion or inflation of standards of compensation relative to real incomes.").
[50] Geistfeld, *supra* note 6, at 791.
[51] *See, e.g.*, W. Washington, *Lawyers Back Candidates, Lobbyists to Prevent Malpractice Award Cap*, *BOSTON GLOBE*, July 19, 2003 at A3; Edward Kennedy, Statement of Sen. Edward Kennedy in Opposition to the Medical Malpractice Amendment (July 26, 2002); American Law Institute, Reporters' Study. Enterprise Liability for Personal Injury 217-230 (1991); Geistfeld, *supra* note 6, at 776; Leo V. Boyle, *Are Malpractice Damage Caps Unfair to Patients?* PHYSICIAN'S WEEKLY, Mar. 18, 2002, <http:www.physweekly.com/pc.asp?issueid=12&questionid=12> (visited April 2, 2003).
[52] *See, e.g.*, Harvey Rosenfeld, Testimony of Harvey Rosenfield, The Foundation for Taxpayer and Consumer Rights, to the House Energy and Commerce Committee (Pennsylvania), February 10, 2003, Langhorne, Pensylvania; Maxwell J. Mehlman, *Resolving the Medical Malpractice Crisis: Fairness Considerations*, <http://medliabilitypa.org/research/ mehlman0603/> (visited June 22, 2005); Thomas Koenig and Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1 (1995).
[53] PACE ET AL., *supra* note 35

injuries had larger absolute and proportional reductions than non-fatal injuries.[54] Very serious injuries were the most likely to have their awards reduced, and emotional-only injuries were least likely.[55]

Researchers at the Harvard School of Public Health[56] examined 152 California malpractice cases from 1985 to 2002 in which juries returned verdicts with noneconomic damages above the MICRA cap. We found strong evidence that caps' impact was distributed inequitably across different types of injuries. In terms of the absolute size the reductions in awards, the burden climbed monotonically with severity of injury, except for deaths (Figure 3). This is troubling because other research suggests that plaintiffs with severe injuries are already at highest risk for inadequate compensation.[57] Caps put this vulnerable group in a kind of "double jeopardy."[58] The relationship between injury severity and absolute dollar reductions in the award persisted in a multivariate regression analysis that controlled for injury severity, age, and gender simultaneously.

In terms of proportional reductions, our analysis showed that the burden of caps tends to fall on injuries that cause chronic pain and disfigurement, but do not lead to the sort of declines in physical functioning that would generate large economic losses.[59] We found no statistically significant differences in the percentage reductions experienced by male and female plaintiffs, or elderly and nonelderly plaintiffs, in either the bivariate or the multivariate analyses.[60]

These studies buttress claims that the classic flat cap disproportionately burdens some vulnerable groups of plaintiffs, in particular the severely injured. Flat caps advance the goal of horizontal equity of compensation at the expense of vertical equity and absolute fairness.[61] Many states have manifested discomfort with this implication of a "one size fits all" cap by adopting a tiered cap that is tied to severity of injury.

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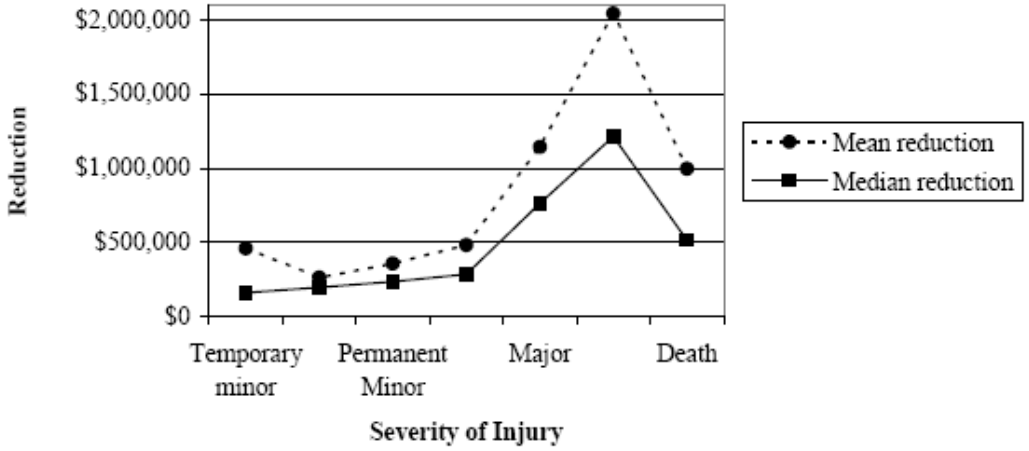
[54] *Id.* at xxi.
[55] *Id.* at xxii.
[56] Studdert et al., *supra* note 15.
[57] Frank.A. Sloan & C.R. Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 L. & SOC. REV. 601 (1990); Frank A. Sloan & Stephen S. van Wert, *Cost and Compensation of Injuries in Medical* Malpractice, 54 L. & CONTEMP. PROBS. 131, 133 (1991); Kenneth S. Abraham, Robert L. Rabin, & Paul C. Weiler, *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 SAN DIEGO L. REV. 333 (1993).
[58] Studdert et al., *supra* note 15, at 63; Michael M. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?* 140 U. PA. L. REV. 1147, 1218 (1992).
[59] Studdert et al., *supra* note 15, at 63.
[60] *Id.*
[61] *Id.* at 63-64.

Figure 3. Absolute Reductions in Noneconomic Damages Under MICRA Cap, by Severity of Injury



The shortcomings of laws imposing flat caps—together with the extreme political difficulty of passing caps legislation in some states—have stimulated interest in damages schedules as an alternative. Schedules respond to political demands for greater proportionality in damages awards than is possible under a flat cap. Scheduling proposals build on the existing model of the tiered cap, but differ from it in several respects: the number of tiers, the basis of the tiering, and the fact that schedules establish a floor as well as a ceiling for noneconomic damages in each tier. Schedules might be thought of as the next generation of tiered caps, more sophisticated, principled, and sensitive than their predecessors.

3. Schedules: Theory And Mechanics

Design of noneconomic damages schedules calls for a two-step process. First, a hierarchy or tiering system is created for purposes of categorizing injuries and creating a relative ranking according to some notion of severity. Second, one or more dollar values for noneconomic damages is assigned to each tier. We discuss each step in greater detail below.

The purpose of tiering is to group injuries that are considered similar, on the basis of some criterion, together into brackets. The underlying notion is that the appropriate level of noneconomic damages will be the same or similar for injuries within each bracket, and increase as the brackets climb in severity. An alternative approach would be to consider each injury individually but apply some kind of formula to calculate damages. For example, a disability weight could be generated for each kind of injury and then multiplied by some dollar value and the plaintiff's remaining life expectancy. This is a way of standardizing noneconomic damages, and achieves many of the same goals as scheduling, but is not scheduling in a strict sense. The

concept of scheduling is generally considered to refer to use of a matrix or table of damages. In order to limit the number of cells in the table, injuries must be combined into groups.

3.1. Creation of Tiers

The first and more complex of the two steps in scheduling damages is design of the injury tiers. Two core principles should guide the choice of design. In order to promote horizontal equity, the injuries grouped into each tier should be internally homogeneous with respect to the severity measure. To promote vertical equity, the groupings should be organized so that each tier represents an increase in severity relative to the one below it.

Another way of describing the vertical-equity mandate is to say that each tier has a quality-of-life "weight" attached to it and the weights increase as one travels up the tiers. Ideally, these weights would be quantified and explicitly stated. Assigning numerical weights, or "relative values,"[62] to each cell in the schedule permits comparison of injuries in different cells, which is useful for validating the scale. We can ask, for example, whether the loss of a foot really does strike us as four times as bad, in terms of noneconomic loss, as the loss of a finger.

The primary question in creating the tiers is what the severity measure should be. Noneconomic damages are meant to compensate plaintiffs for pain and suffering and decrements in quality of life. Standard classifications of injury severity, such as the nine-point scale created by the National Association of Insurance Commissioners,[63] use some proxy measure for these slippery and difficult-to-quantify constructs. For example, the NAIC scale refers to whether the disability is temporary or permanent and what level of disability is incurred during the period of disability (emotional disability only, insignificant, minor, major, significant, grave, or death). Even if such a scale was able to perfectly capture the nature of the injury, it must be remembered that the level of physical injury is not the same as the level of noneconomic loss. Injuries of a certain severity level may tend, on average, to be associated with a particular level of noneconomic loss, but there will be variance around this mean. Some plaintiffs who lose a finger will experience more pain and anguish than others; some will experience bigger impacts on their lifestyle than others. The process of creating injury tiers is perhaps best thought of as a process of choosing the least bad proxy measure of noneconomic loss.[64] In Section 4, we discuss various possibilities.

The basic tiers in a damages schedule represent severity; however, there is also the possibility of creating additional cells within each severity tier to represent different plaintiff age groups. One rationale is that, for permanent injury, plaintiffs with a longer remaining life expectancy will experience the noneconomic loss that flows from it for a longer period of time, and therefore should be compensated more than plaintiffs who with shorter life expectancy.

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[62] Bovbjerg et al., *supra* note 9,. at 944. Bovbjerg and colleagues provide an illustrative 45-cell schedule incorporating numerical weights. *Id.*

[63] NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MALPRACTICE CLAIMS: FINAL COMPILATION (M. Patricia Sowka, ed., 1980).

[64] *Cf.* Geistfeld, *supra* note 6, at 792 ("However, there is no test for objectively measuring an individual's pain and suffering, so injury categories will often improperly measure the severity of the plaintiff's injury.").

Another rationale is that different age groups may react to and "bounce back" from injuries differently.[65] The selection of cutoff points for the age groups is fairly arbitrary. The more finely age groups are divided, the more complex the schedule will be, but awards will more closely reflect the plaintiffs' estimated noneconomic losses.

3.2. Valuation of Tiers

The next step, assignment of dollar values or ranges of dollar values to each tier, defines the compensation gradient across ascending the injury levels. Vertical equity dictates only that the slope of the gradient is positive, at least up to cases involving death. The principle of absolute fairness guides the selection of the actual dollar values for each tier: the values should represent a social judgment about reasonable (not inadequate and not excessive) compensation for noneconomic loss for injuries within each tier.

This judgment is intensely political. There are a variety of processes that could be used to arrive at these decisions, and it is essential to select an approach that will have legitimacy among those who will be affected by the consequences of the decisions that result. One approach, discussed in greater depth below, is to base the values on jury awards or settlements in previous, similar cases. Advantages of this approach include the use of extant data and its representation of the views of the lay public. Key disadvantages are that it anchors the schedule in ad hoc judgments made by juries who received no guidance, and that it preserves the relatively high levels of noneconomic damages that exist in the status quo.[66]

A second approach would be to convene a body to deliberate about what is reasonable. The body could be a legislative committee or a commission that includes members of the public along with representatives of various stakeholder communities (e.g., the trial and defense bar, health care providers, patient advocacy organizations, liability insurers, and judicial organizations). The group could review existing data about jury awards and malpractice costs and weigh the competing values of cost control and generous compensation of those who have been injured by others' wrongful conduct. This approach frees the damages schedule from the tethers of existing jury awards and would likely have considerable political legitimacy,[67] but involves a potentially long and contentious process.

A third approach would be to appoint a group of experts with backgrounds in medicine, decision science, and law. Medical experts could present and evaluate information, derived from clinical and health services research, about the effects of various injuries and health conditions

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[65] Bovbjerg et al., *supra* note 9, at 941. Note that if older persons have a lesser degree of resilience, this would argue in favor of a higher noneconomic damages award for temporary injuries. However, the life-expectancy rationale would argue in favor of a lower noneconomic damages award for older plaintiffs. *See id.*

[66] *See, e.g., id.* at 792 ("If the system has been providing overy arbitrary pain-and-suffering awards, and if we have no method for determining the appropriate award in the first instance, why should we make prior awards the cornerstone of future awards? By doing so, we may ensure that like cases are treated alike in that all involve inappropriate damages awards.").

[67] Bovbjerg et al., *supra* note 9, at 967 ("Deciding upon such values is ultimately a matter of social choice that requires the balancing of many competing interests …. The entity with the greatest social legitimacy in making such broad trade-offs is the state legislature.").

on quality and enjoyment of life. Decision scientists could contribute information about empirical research into how the public weights various states of ill health and disability, as well as set research findings in a structured process for making policy decisions and value tradeoffs. Legal experts could contribute an understanding of how various choices would mesh or conflict with the way juries have traditionally thought about noneconomic damages, and with the expectations that litigants have when they go into a trial. This approach might make the best use of available empirical research, but may garner charges that the lay public is being excluded from the process.

Whoever the decision makers are, they will confront the choice of whether to assign one dollar value, multiple values, or a value range for each injury tier. Two or three values could be generated for "low end" and "high end" injuries within each tier; or a floor and ceiling for each tier could be specified. The fewer the number of values, the greater will be the potential for uniformity and predictability of awards. The greater the number of values, the greater will be the flexibility to address atypical cases (which may serve the goal of horizontal equity better than would strict equality of awards) and to ensure that the demands of absolute fairness are met for each plaintiff. Additionally, dollar ranges be the best way to preserve a role for jury discretion in determining damages, which may be important for constitutional reasons.

If the decision is to have only one dollar value for each tier, one method that has been proposed for arriving at the value is to multiply the relative weights by a "numeraire," or dollar multiplier.[68] The numeraire is chosen by one of the processes described above. This methodology is clearly very sensitive to the particular weights that were selected in the earlier stages of the schedule design.

The key decision points in designing a schedule of noneconomic damages are summarized in Figure 4.

Figure 4. Key Design Choices in Scheduling

1. Proxy measure for noneconomic loss
2. Number of injury tiers
3. Inclusion of age in the injury tiers
4. Assignment of relative weights to tiers
5. Process / decision makers for assigning dollar values to tiers
6. One dollar value, multiple values, or value range for each tier

[68] Bovbjerg et al., *supra* note 9, at 946.

4. Bases for Scheduling Damages

This section considers five general approaches to the scheduling of noneconomic damages: (1) use of prior precedents; (2) quantitative measures of injury severity; (3) qualitative measures of injury severity; (4) a health utilities approach; and (5) a hedonic damages approach. We describe each of these alternative approaches and their rationale and briefly consider the strengths and weaknesses of each approach. Where possible, we have tried to defer to Section 5 consideration of the details of how the resultant schedule would be incorporated into decision making about noneconomic damages.

4.1. Precedential Approaches

One strategy for rationalizing noneconomic damages involves use of precedent as a guide; specifically, consideration of previous noneconomic damages awards in similar cases. Bovbjerg and colleagues have proposed this type of approach.[69] Precisely how such precedent would collected, formatted, and incorporated depends on choices made in four areas, which we consider below.

4.1.1. Raw and Processed Precedent

Precedential information could be provided to noneconomic damages decision makers in raw form. Essentially, decision makers would receive little more than synopses of the injuries in previous similar cases together with the associated noneconomic damages awards. Provision of precedent in this form would demand a fair degree of activism on the part of the decision makers, who would have to sift through the different injuries described, compare them to the instant case, and decide how the respective dollar values should guide their decision.

Alternatively, the precedent could be provided in more processed form. By this method, not only would like cases be clustered before providing them to the decision makers, the specific injury descriptions themselves would also be distilled into a more generic description of the cluster. Hence, rather than wading through the specifics of every injury description in the cluster, the decision makers would work with a general description and the list or range of noneconomic damages amounts previous decisions gave to injuries within the relevant cluster.

Bovbjerg and colleagues have outlined a version of the processed approach in which jurors are presented with "valuation scenarios" to use as benchmarks. Standarized injury scenarios are created to provide hypothetical "descriptions of the prototypical circumstances of injury" [70] and appropriate damages for each; the jury would be given a range of scenarios from

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[69] Bovbjerg et al., *supra* note 9, at 953-56.

[70] *Id.* at 953. Bovbjerg and colleagues provide two examples of how a hypothetical arm injury could be described in a scenario: (1) "Permanent minor injury (level 5). Life expectancy 25 years. Mild persistent pain, usually controllabel with aspirin. Unable to engage in more than light housework." (2) "Plaintiff Peters has completely and permanently lost the use of her left arm. Her life expectancy is 25 years, according to standard life insurance tables.

relatively trivial to very severe injuries and would choose the one that most closely resembled the plaintiff's injury.

The precedential approach is already employed in some European jurisdictions. For example, the United Kingdom's Judicial Studies Board (JSB) publishes *Guidelines for the Assessment of Damages*,[71] a slim booklet now in its seventh edition, which sets forth a series of injury descriptions and provides a range of monetary awards for general damages based on previous awards. The JSB booklet, intended for judges and advocates, divides injuries into ten general groups ranging from "injuries involving paralysis" to "facial injuries" and "damage to hair"; these groups are further divided into 40 subgroups. The authors stress two caveats: "… the Guidelines are intended to reflect the general level of current awards; they do not reflect the views of [the authors] on what the levels should be. They are designed to provide the starting point for assessment of damages in any particular case."[72]

4.1.2. Defining the Precedent Measures

The JSB booklet provides information about noneconomic damages precedents in the form of a range of monetary values for each injury category.[73] However, there are a variety of ways in which the noneconomic damages data from previous awards might be specified for decision makers (in the processed method) or interpreted by them (in the raw method). The choice of measure is important because it may have a significant impact on the resultant award. We list four formats for measures below, roughly in ascending order of the degree of constraint they would be expected to place on the decision maker's latitude in arriving at the noneconomic damages award:

1. No specified parameters. The precedent would do no more than list a group of like cases and their noneconomic damages awards. How this information was used in relation to the instant case would be left to the discretion of the decision maker.

2. High-low parameters. The highest noneconomic damages award in previous like cases represents the upper bound on acceptable award, and the lowest noneconomic damages award represents the lower bound. The decision maker must fix the award amount somewhere in between these two points.

3. Mean-anchored high-low parameters. The mean of the noneconomic damages awards in like cases would be calculated, and parameters would then be set around the mean. For example, the upper bound and lower bounds might be two standard deviations above and below the mean.

Her arm throbs painfully most of the time, but the pain can usually be controlled with aspirin. She cannot do more than light housework." *Id*. at 954-55.

[71] JUDICIAL STUDIES BOARD, GUIDELINES FOR THE ASSESSMENT OF GENERAL DAMAGES IN PERSONAL INJURY CASES (2004).

[72] *Id.* at 2.

[73] The JSB booklet does not describe the precise mathematics of how this range is defined.

4. Mean or median. Either the mean or the median of the noneconomic damages awards in previous like cases would be the guide, providing a specific point value. Medians will generally be lower than means because of the right-tailed distribution of noneconomic damages awards—that is, a small number very high outlier awards will tend to pull the mean up.

4.1.3. Sources of Precedent

Policymakers face a number of choices regarding the sources of precedent used to establish the damages schedule. First, what types of noneconomic damages valuations are appropriately included? Should precedents be limited to jury determinations, or should settlement amounts also be included (setting aside, for the moment, the difficulty of delineating noneconomic damages in most settlements)? Viscusi and Bovbjerg and colleagues have argued that settlements should not be included because these amounts are determined by a variety of considerations (aversion to the risks of trial, attractiveness of witnesses, etc.) other than the magnitude of the noneconomic loss.[74]

Second, should the pool of precedents be confined to previous valuations from within the relevant jurisdiction, or is it reasonable to cast the net more widely? Except for the most populous states like California, New York, and Florida, the answer to this question might need to be "yes" if the response to the previous question is that precedent is limited to determinations at trial. Otherwise, too few awards would be available. Fewer than 1 in 10 malpractice claims proceed to jury verdict, and the plaintiff loses approximately 70% of those. Therefore, no more than 3% of a state's caseload is likely to provide useable statistics. Subdividing those into the 40 subgroups described by the JSB would mean that a minimum of 13,333 claims would be needed to produce ten previous awards in each subgroup. However, only about 45,000 malpractice claims are brought annually in the United States. The small-numbers problem is of particular concern if means rather than medians are used as the measure of damages, because the mean will be very sensitive to whether the sample includes any outlier values. The larger the sample, the closer the sample mean will be to a stable and true mean for the population of interest (i.e. all available jury valuations of for the relevant injury type).[75]

Third, what is the acceptable time period from which to sample previous cases? In theory, noneconomic damages awards from any time period should be eligible for inclusion, provided the appropriate inflation adjustment is applied to the year of the decision.[76] The sample-size problem noted above argues for long sampling periods. In practice, however, policymakers may have reasons for regarding valuations prior to certain dates as being "stale." For example, they may wish to limit a sampling period if valuations of noneconomic losses for given types of injury were changing steeply over time, or major tort reforms were enacted at

[74] Viscusi, *supra* note 37, at 214-15; Bovbjerg et al., *supra* note 9, at n.227.
[75] In technical terms, the central limit theorem states that given a distribution with a mean μ and variance σ^2, the sampling distribution of the mean approaches a normal distribution with a mean (μ) and a variance σ^2/N as N, the sample size, increases.
[76] Bovbjerg and colleagues and Studdert and colleagues both used the Consumer Price Index.

particular junctures and were perceived as marking a community change-of-attitude about appropriate valuations.

4.1.4. Precedent Clusters

The above discussion passes over what is probably the most crucial and difficult step in the arrangement of precedential information: how are cases clustered? What counts as an injury "class" for purposes of grouping previous cases and calculating the measure-of-choice? At a more fundamental level, the question is what criteria are used to define "similar" cases?

One answer is that similarity is defined by the perceptions of individuals or groups regarding which injuries "look" or "sound" like they are of comparable severity. But this is unsatisfactory. Aggregation is complex because no two injuries are the same. This is true in both the objective and the subjective sense. Consider two ostensibly identical injuries: two individuals suffer the loss of their index figure on their left hand. Person A experiences a clean cut and returns more-or-less to normal quite quickly, while person B, whose injury comes from a crushing incident, is plagued by infections, multiple surgeries, and hospital visits for years. The noneconomic loss of person B is much greater than that of person A, despite the similarity of their injury. Suppose A is left-handed and B is right-handed. Alternatively, suppose person A is a bedridden octogenarian and person B is a young woman with a passion for playing the piano. Both their age difference and the differential impact of the lost finger on their lives might prompt us to think differently about the extent of their noneconomic losses.

Schedules, by definition, involve a degree of aggregation and averaging, and no schedule will be able to respond to every idiosyncracy of every injury. Nonetheless, the nuances outlined above highlight what is at stake in the clustering enterprise. Sound schedules require an explicit and rational construct for clustering like injuries, and a defensible account of the criteria used (and foregone) in determining what counts as "like". Vertical and horizontal equity depend on it.

Unfortunately, the precedential approach cannot provide this construct. In this sense it is an incomplete basis for scheduling. It must be linked to some other method to achieve the clusters, for which it may then provide dollar valuations. A widely used severity-of-injury scale underpinned Bovbjerg and colleagues' precedential proposal. We consider this and other options for ranking and clustering injuries in the next section. But first, we conclude by summarizing the strengths and weakness of the precedential approach.

4.1.5. Strengths and Weaknesses

The strengths of the precedential approach are as follows:

- It preserves the source of the precedential decisions—the jury or judge, who speak in the name of the polity—as essential in defining the precedent measure.

- Despite turning back to previous decisions for guidance, it provides opportunities for constraining the influence of high-end awards (e.g. through choice of measures such as means, medians, mean-anchored high-low parameters). The resulting decisions may thus be more tightly distributed and predictable than the pool of previous decisions on which they are based.

- It provides explicit guidance about dollar values. With the exception of hedonic damages, the other bases for scheduling we will consider lead only to weights or scalar values to which dollar values must subsequently be applied.

The weaknesses of the precedential approach are threefold:

- Whatever heuristics surrounded the initial evaluations by the judge or jury remain embedded in future decisions. Hence, the schedule may trim the sharp edge of these heuristics, but it does not guarantee that the mean around which new decisions are converging is the correct one.[77]

- Information on previous noneconomic damages is not easy to acquire. Plaintiff verdicts in trials are not common. Moreover, courts in many jurisdictions do not break verdicts into their noneconomic and economic damages components. Settlements almost never do. Obtaining a reasonable number of previous noneconomic damages awards within injury categories will be challenging, and likely will require looking beyond single jurisdictions.[78]

- It does not provide a methodology for clustering similar cases. What defines similarity? The theoretical answer to this question is clear enough: noneconomic losses of similar magnitude. However, the precedential approach does not provide a mechanism for defining and drawing together similar cases.

4.2. Quantitative Approaches to Scaling Injury Severity

As noted above, the precedential approach is powerful in that it furnishes monetary values, but weak in the sense that it elides a central challenge in the scheduling enterprise—namely, devising the method by which injuries are ordered, lumped, and split into types. To the best of our knowledge, no approach for scaling noneconomic loss currently exists. In the absence of such a scale, policymakers and researchers have turned to other injury scales. Some

[77] See also the text accompanying note 66.

[78] Bovbjerg and colleagues suggest that a centralized database could be established and all jury verdicts reported to it, with detailed information about the damages award, the nature of the injury, and the plaintiff. James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. REG. 171,180-181 (1991). However, the tort scholar Peter Schuck has expressed concerns about the representativeness of any reporting system that does not gather information on settlements. Schuck also worries that populating a jury award database with the information Bovbjerg and colleagues desire would require that juries make much more detailed findings related to damages than they currently do, which could lead to more protracted jury deliberations and hung juries. Peter H. Schuck, *Scheduled Damages and Insurance Contracts for Future Services: A Comment on Blumstein, Bovbjerg, and Sloan*, 8 YALE J. REG. 213, 217-218 (1991).

of these have a clear focus on physical injuries; others are vaguer about what types of injury they are capturing.

The National Association of Insurance Commissioners' (NAIC) Severity of Injury Scale[79] is the best-known scale for classifying the severity of post-injury disability. An analysis of it highlights some of the strengths and weaknesses of the quantitative approach to arraying noneconomic injuries using existing severity scales.

The NAIC scale divides disability into nine levels, as shown in Table 1. It has been widely used in research[80] and has several strengths. First, its nine tiers allow reasonable stratification of injuries, but are not so particular as to require vast amounts of information about the clinical details of the injury in order to classify it. Second, the reliability of classifications on the NAIC scale—that is, the extent to which different people working independently to classify injuries will tend to make the same decisions as to which tier the injuries belong in—has been shown to be quite good.[81]

However, the scale has two significant shortcomings which make it less than ideal as a basis for ordering and clustering injuries by type. One shortcoming is that, although it is presented as an ordinal scale, certain design aspects undermine its ordinality. All emotional injuries that are not accompanied by physical injury are given a score of one, no matter how severe they are. This is problematic because emotional-only injuries are an internally heterogeneous group, ranging from slight, passing anxiety to permanent, severe emotional trauma. Additionally, many types of emotional injuries represent greater harms than physical injuries, especially minor physical injuries, yet all physical injuries are given a higher score.

Table 1. National Association of Insurance Commissioners' Injury Severity Scale

1	Emotional disability only: (e.g. fright; no physical damage)
2	Temporary insignificant: (e.g. lacerations, contusions, minor scars, rash; no delay in recovery)
3	Temporary minor: (e.g. infections, missed fracture, fall in hospital; recovery delayed)
4	Temporary major: (e.g. burns, surgical material left, drug side effect, brain damage; recovery delayed)
5	Permanent minor: (e.g. loss of fingers, loss or damage to organs, includes non-disabling injuries)
6	Permanent significant: (e.g. deafness, loss of limb, loss of eye, loss of one kidney or lung)
7	Permanent major: (e.g. paraplegia, blindness, loss of two limbs, brain damage)
8	Permanent grave: (e.g. quadriplegia, severe brain damage, lifelong care, fatal prognosis)
9	Death

[79] NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, *supra* note 63.
[80] Bovbjerg et al., *supra* note 9; PACE ET AL., *supra* note 35 ; Studdert et al., *supra* note 15.
[81] David M. Studdert et al., Geographic Variation in Informed Consent Law: Two Standards For the Disclosure of Treatment Risks Cite (June 28, 2005) (unpublished manuscript, on file with authors); Marie M. Bismark et al., Claiming Behaviour in New Zealand's No Fault System of Medical Injury Compensation: A Descriptive Analysis of Claimants and Non-Claimants (April 5, 2005) unpublished manuscript, on file with authors).

A similar problem occurs with temporary injuries, which are automatically ranked below permanent injuries on the scale. This arrangement is no doubt due to the importance of this distinction in workers compensation benefits, with insurers in this area being an important constituency for the NAIC. However, many temporary major injuries, and even temporary minor ones, may well exceed permanent minor injuries in their seriousness.

The other major shortcoming of the NAIC scale should already be evident from the preceding discussion. When discussing the NAIC scale, and others like it, it is easy to slip into the vernacular of physical injuries. Indeed, the scales steer one in that direction because they are designed primarily to deal with physical injuries. There is undoubtedly a strong correlation between an injury's physical severity and the noneconomic losses that accompany it. However, the correlation is not perfect, and for some injuries—scarring/disfigurement and loss of taste or smell, to take several classic examples—there may be very little correlation. In these circumstances, a scale based solely on physical attributes of the harm will provide a poor measure of the underlying noneconomic loss.

To summarize the foregoing, the strengths of the NAIC and other quantitative scales of injury severity are that (1) they provide an explicit basis for grading the severity of injury and (2) the process of slotting injuries into tiers of the scales is relatively objective and reproducible. One weakness is that it is not clear that standard injury severity scales, biased as they are toward physical manifestations of injury, constitute reasonable approximations of the pain and suffering associated with the injury. Another weakness is that the scales do not provide dollar values, only a mechanism for grouping and ranking injuries. Dollar values would need to be overlaid by some other mechanism, such as precedential information.

4.3. Qualitative Approaches to Scaling Injury Severity

Many commentators believe that noneconomic losses cannot be scaled in a quantitative, objective, or scientific way, regardless of the sophistication of methods employed. Noneconomic losses, they argue, are subjective and unquantifiable by definition. But schedules still demand some basis for delineating different tiers, preferably one that is rational, reproducible, and perceived as fair. One possible solution is to turn to qualitative judgments and group consensus for answers.

Two factors differentiate the qualitative approach to noneconomic damages valuations we are discussing here from the other better-known qualitative approach, jury verdicts. First, the judgments are made *ex ante,* and directed toward establishing tiers within a versatile scale rather than deciding damages for a particular case. Second, most examples of this approach involve panels of experts, not of lay decision makers, who tend to feed clinical experience and scientific data into the process, even though their final determination is not tethered in any rigid way to these underlying sources of "objectivity".

4.3.1. The AMA Guides

The American Medical Association's *Guides to the Evaluation of Permanent Impairment*[82] is the leading example of such a scale. The *Guides*' purpose is to grade permanent "impairment," defined as "a loss, loss of use, or derangement of any body part, organ system, or organ function."[83] Emily Spieler and colleagues have described the purpose in greater detail:

> The *Guides* is a tool to convert medical information about permanent impairments into numerical values. Each chapter focuses on a single organ system and provides a description of the diagnostic and evaluative methods for assessing specified impairments. Each impairment is assigned a rating, expressed as a percentage of loss of function for that system. Organ-based ratings are then translated into impairment ratings for the whole person, termed *whole person impairment* (WPI). For example, amputation of the index finger of either hand is considered a 20% impairment of the whole hand, an 18% impairment of the upper extremity, and an 11% WPI. Finally, the *Guides* combines multiple WPIs into a single rating by using the formula [A + B(1 - A)], where A is the rating for the first impairment and B is the rating for the subsequent impairment, thus creating an asymptotic curve toward 100%.[84]

The ratings are the product of clinical decision making at two levels.[85] First, the ratings themselves were set and are revised periodically by multiple panels of physicians with clinical expertise relevant to each organ system. The panels reportedly pay close attention to available clinical and scientific data about various injuries in reaching their conclusions about ratings. Second, a treating or examining physician must perform each specific evaluation, determining the impairment rating based on direct clinical examination of the individual being rated.

The *Guides* are used by workers compensation programs in more than forty states for the purpose of determining the amount and/or duration of workers' compensation permanent partial disability (PPD) benefits.[86] The assumption is that the impairment ratings provide a reasonable proxy for the extent of disability, even though the *Guides* states explicitly that the impairment ratings "are not intended for use as direct determinants of work disability."[87]

Do the ratings represent reasonable measures of noneconomic losses associated with injuries? Several features suggest that they may. The ratings are supposed to reflect the degree to which the impairment decreases the individual's ability to perform eight common activities of daily living (ADL): self-care/personal hygiene, communication, physical activity, sensory function, nonspecialized hand activities, travel, sexual function, and sleep.[88] Moreover, the

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[82] AMERICAN MEDICAL ASSOCIATION, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 5TH ED. (Linda Cocchiarella & Gunnar B.J. Andersson, eds., 2000).
[83] *Id.* at 2.
[84] Emily A. Spieler et al., *Recommendations to Guide Revision of the* Guides to the Evaluation of Permanent Impairment, 283 JAMA 519, 519 (2000).
[85] The process by which ratings are determined is described in depth in AMERICAN MEDICAL ASSOCIATION, *supra* note 82, at 18-22.
[86] Spieler et al., *supra* note 84, at 519.
[87] AMERICAN MEDICAL ASSOCIATION, *supra* note 82, at 5.
[88] Work is excluded for a variety of reasons. Specifically: "(1) work involves many simply and complext activities; (2) work is highly individualized, making generalizations inaccurate; (3) impairment percentages are unchanges for stable conditions; and (4) impairments interact with such other factors as the worker's age, education, and prior

ratings purport to recognize both objective manifestations of impairments (e.g., fracture) and subjective ones (e.g., fatigue and pain).

In fact, the *Guides* has been criticized for wandering beyond the stated focus on impairment into much broader conceptions of disability, which are influenced by the social, personal, and psychological consequences of the impairment.[89] To the extent that the *Guides* has done this, its measurements may indeed stand as reasonable proxies for noneconomic loss.

Sandra Sinclair and John Burton investigated this question by comparing ratings under the *Guides* with a "purer" measure of noneconomic loss, quality of life measures (see next section).[90] They used data from a survey of 12,000 permanently impaired workers in Ontario, Canada, who were asked to rate the decrements in quality of life associated with 78 benchmark conditions. Their quality-of-life ratings were then compared to the ratings of these injuries under the *Guides*. The study found that less than only 60% of the variation in quality-of-life measures could be explained by the *Guides*' impairment ratings. Systematic divergences occurred at both ends of the spectrum. The AMA ratings that were too low when quality of life ratings were low, which the investigators interpreted as a "sanctity of body image effect." On the other hand, the AMA ratings appeared to systematically overvalue quality-of-life losses associated with the most severe injuries. Thus, arguments that the *Guides* measure something more than mere impairment notwithstanding, the empirical evidence suggests that these ratings are no better than fair measures of how laypersons perceive the effects of different injuries on quality of life.

The strengths of the *Guides* are that it is publicly available, widely accepted in workers compensation programs, created by authoritative experts under the auspices of a respected medical organization, and periodically updated by those experts.[91] Indeed, a state that based its damages schedule on the *Guides* would not need to conduct any maintenance or updating of the injury tiers at all; it could simply adopt the changes represented in each successive edition of the *Guides* (although the state would still have to update the dollar values of the damages assigned to each injury type).

The main weaknesses of the *Guides* are its internal validity and reliability problems.[92] Some of these problems have already been mentioned. Another dimension of the validity problem is that the approach to pain is considered inconsistent across parts of the *Guides*.[93] The *Guides* has also been criticized for the validity of its impairment ratings on the basis that it emphasizes certain activities, functions, and tasks over others without justifying these choices.[94]

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work experience to determine the extent of work disability." AMERICAN MEDICAL ASSOCIATION, *supra* note 82, at 5.

[89] Spieler et al., *supra* note 84, at __.

[90] Sandra Sinclair & John F Burton, *Measuing Non-Economic Loss: Quality-of-Life Values Versus Impairment Ratings*, WORKERS' COMP. MONITOR, Jul.-Aug. 1994, at 1; Sandra Sinclair & John F Burton, *A Response to the Comments by Doege and Hixson*, WORKERS' COMP. MONITOR, Jul.-Aug. 1997, at 13.

[91] Spieler et al., *supra* note 84, at __.

[92] Spieler and colleagues, *id.*, review many such criticisms and cite to relevant sources.

[93] *Id.* at __.

[94] Ellen S. Pryor, *Flawed Promises: A Critical Evaluation of the American Medical Association's* Guides to the Evaluation of Permanent Impairment, 103 HARV. L. REV. 964, 964-973 (1990) (reviewing AMERICAN MEDICAL ASSOCIATION, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 3D ED. (1988)). Pryor argues that one nuance of some of the judgments made in the *Guides* is gender bias. *Id.* at 969-972.

Another shortcoming of the *Guides* is its incompleteness: some states of impairment are not represented, including all temporary impairments and some permanent impairments that may be fairly common among malpractice claims, such as headaches.[95] Thus, even this broadly used injury scale has encountered some resistance from the medicolegal community.

4.3.2. Scandinavian Damages Panels

In Sweden and Denmark, expert panels are entrusted with the task of scaling noneconomic losses associated with various injuries. Their valuations are used as the basis for determining noneconomic damages in both the civil justice and no-fault compensation systems in these countries.[96] The panels' products resemble the JSB booklet described above, with generic injury descriptions accompanied by a percentage disability rating. The percentage disability rating is used in conjunction with a maximum compensation amount, set annually by the governments, to calculate noneconomic damages for permanent injuries.

The unavailability of primary source materials in English limits our ability to evaluate the Scandinavian injury scales, but a few observations may be made. One strength of the Scandinavian approach, like other qualitative scales, is that it avoids the perceived danger of trying to "quantify the unquantifiable." A second potential strength is political legitimacy. If the decision-making group is trusted and broadly representative, some lack of explicitness in how the scale is established may be accepted based on the perception that a fair process led to their derivation.

On the other hand, the Scandinavian approach is grounded heavily in expert judgments about loss. Even if the expert group is trusted, a question arises as to whether clinical experts are the appropriate parties to value noneconomic loss. A number of commentators have argued that in valuations of noneconomic losses clinical expertise may be useful but carries no obvious primacy over lay perspectives.[97] This criticism also applies, of course, to the AMA *Guides*.

Finally, the basis for the different ratings or tiers in the Scandinavian scales remains somewhat obscure, as does the nature of the actual loss being ranked. In theory, the scales represent degrees of disability, or perhaps only functional impairment. Certainly, they do not

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[95] Spieler et al., *supra* note 84, at __.

[96] The Swedish patient insurance scheme, an administrative, no-fault compensation system for medical injuries, provides two kinds of noneconomic damages: a "pain and suffering payment" to compensate patients for the pain they feel during the acute period of the injury, and a "disability payment" that is available for permanent or chronic injuries after the acute period ends. The disability payment might be considered a payment for lost quality of life in that it compensates for permanent functional impairment above and supplements what the patient receives from other social insurance sources to cover his economic losses. Pain and suffering payments are determined by a schedule that tops out at 5000 Swedish kroners (approximately $640) per month for hospitalization for a serious injury (there are some supplementary payments available for special treatments such as hospitalization in an intensive care unit). The schedule is set by the Traffic Injuries Board and approved by the courts. *See generally* Patricia Danzon, *The Swedish Patient Compensation System: Lessons for the United States*, 15 J. LEG. MED. 199,2, 203 (1994). The Danish system is patterned after the Swedish approach, and is described in the Appendix to this report.

[97] Spieler et al., *supra* note 84.

attempt to capture pain and suffering as Americans would understand that concept, nor do they attempt to measure some broader notion of quality of life.

4.4. Health Utilities Index

Quality-of-life measures were mentioned briefly in the previous section as the benchmark against which Burton and Sinclair tested the AMA *Guides*' impairment ratings as measures of noneconomic loss. In this section we delve more deeply into these measures as a standalone basis for scaling noneconomic damages.

4.4.1. Health Utility Weights

Significant gains have been made over the past thirty years in developing quality-of-life measures for assessing the utility losses associated with different health states.[98] These measures are designed to scale personal preferences (or lack of preferences) for various health states, without attempting to assign monetary values to them. In short, the measures provide a way of ranking illnesses against one another, according to how willing people say, hypothetically, they would be prepared to live with them. These preferences are understood to signify the perceived loss in quality of life that a compromised health state, such as living for a month as a paraplegic or with malaria, would entail.

The resulting rankings could be used as a basis for grouping together injuries of similar magnitude into tiers in a damages schedule. Again, dollar values for each of the groups would have to be generated through some other mechanism.

Health utility weight approaches are grounded in the theory of welfare economics and make several basic assumptions about utility preferences, namely: they depend only on health consequences, and not on other personal characteristics or the risk involved; they can be derived through preference elicitation techniques (such as surveys); and they are amenable to aggregatation and averaging.[99] A variety of preference-based utility scales have been developed and calibrated through physician and general population surveys.[100]

4.4.2. QALYs

Operationalization of these scales involves linking utility weights to specific illnesses and then summing over time to derive "preference-adjusted life years," of which quality-adjusted life

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[98] MICHAEL F. DRUMMOND ET AL., METHODS FOR THE ECONOMIC EVALUATION OF HEALTH CARE PROGRAMMES (1987); George W. Torrance, *Measurement of Health State Utilities For Economic Appraisal: A Review*, 5 J. HEALTH ECON. 1 (1986).
[99] James K. Hammitt, *QALYs Versus WTP*, 22 RISK ANALYSIS 983 (2002).
[100] MARSHA R. GOLD ET AL., COST-EFFECTIVENESS IN HEALTH AND MEDICINE (1996).

years (QALYs) are the most widely-used metric. QALYs have been widely used in health services research to compare the health gains associated with alternative clinical and policy choices. For example, do HIV-positive patients fare better on drug regimen A or regimen B? Does an African population derive greater total health gain from spending $10,000 on water purification or immunizations? There has been some use of QALYs (and their close cousins, disability-adjusted life years, or DALYs) in the economic evaluation of injury-related outcomes.[101] Recently, there have also been some initial attempts to use quality-of-life measures to value injuries in the civil justice system, including injuries due to assaults,[102] consumer product defects,[103] and drunk driving.[104]

To the best of our knowledge, no detailed QALY- or DALY-based scale currently exists for grading losses across a range of specific personal injuries. We believe development of such as scale would provide a very promising basis on which to schedule noneconomic losses. QALYs and other similar health utilities measures may come remarkably close to the concept of "pain and suffering." They capture the two dimensions that are pivotal to valuation of noneconomic injury for compensation purposes: subjective, multidimensional assessments of loss severity and the length of time for which the loss will endure.

One methodological limitation is that the preferences embedded in health utility scales are not obviously "net" of economic considerations. Concerns about the direct financial consequences of certain health states may factor into individuals' utility preferences. Whether they actually do is largely an unresearched and unsettled question among decision scientists.

4.4.3. Scale Construction and Use

The formal construction of a scale for a damages schedule would proceed in four steps. First, a group of injuries would be selected to constitute the "corner" conditions in the damages schedule. Ideally, the selected injuries would be distributed across the spectrum of injury severity (from low to high) and would capture some of the injury types most commonly seen in malpractice cases.

Second, utility weights would be assigned to each selected injury. The weights could be derived from existing surveys and literature, or could be generated anew through focus groups or surveys within the jurisdiction adopting the damages schedule. The weights would represent the value assigned to living with the associated injury for a year.

Third, a full scale of noneconomic losses would be generated by slotting in other injuries around the corner conditions. Weights would be assigned to injuries between corner conditions

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[101] Ted R. Miller & David T. Levy, *Cost-Outcome Analysis in Injury Prevention and Control: Eighty-Four Recent Estimates for the United States*, 38 MED. CARE 562 (2000); CHRISTOPHER J. L. MURRAY & ALAN D. LOPEZ, EDS., THE GLOBAL BURDEN OF DISEASE (1996).
[102] TED R. MILLER ET AL., VICTIM COSTS AND CONSEQUENCES—A NEW LOOK (1996).
[103] TED R. MILLER ET AL., THE CONSUMER PRODUCT SAFETY COMMISSION'S REVISED INJURY COST MODEL: FINAL REPORT (1998).
[104] Stan V. Smith, *Jury Verdicts and the Dollar Value of Human Life*, 13 J. FORENSIC ECON. 169 (2000).

through a statistical smoothing process. Conditions would be arrayed according to the ranking of their weights, as judged by a panel with some clinical and decision-science expertise represented. The final product, consisting of a detailed list of injury types with associated weights, would constitute the injury tiers in the damages schedule.

In a particular malpractice case, the jury's role would be to pair the injury under consideration with the one most like it on the schedule. Expert evidence presented at trial about the likely duration of the injury would then be combined with the weight in a simple formula to calculate the number of QALYs associated with the injury.

The final step would be to assign dollar values to different QALY levels. Conceptually, a number of approaches could be used to achieve this. A precedential approach or any other other method could be used. Arguably the simplest and most logical would be to determine the maximum amount obtainable for noneconomic loss, then assign that amount to the injury with the highest weighting over the longest feasible duration (e.g., 78 years). All other injuries would be scaled accordingly. A flexible single figure of dollars-per-QALY figure could be derived, or one could return to each of the injuries list in the scale and calculate a dollar figure, which would represent the value of noneconomic loss associated with living with that injury for one year.

4.4.4. Strengths and Weaknesses

The health utilities approach has two major strengths. It has the potential to yield a scale that orders a broad range of injuries according to criteria that actually address the value of noneconomic losses, as opposed to scales that use percentage impairment, level of physical injury, or some other proxy for those losses. Second, it effectively blends subjective and objective valuations of noneconomic loss. The measures it uses have a subjective component because they are grounded in individuals' stated preferences concerning the health states associated with different injuries. The measures are objective in the sense that the preferences are not those of the injured party, but averaged preferences expressed by groups of unaffected individuals, with weights derived from these preferences then applied uniformly to successive cases.

One major weakness of this approach, from a political perspective, is its complexity. Concepts such as QALYs and utility preferences are not easily grasped, and may be seen as compromising the jury's independence. It may be a difficult proposal to sell in the legislature. Another problem is that QALY and DALY scales remain relatively undeveloped for injuries, especially injuries that tend to be the subject of malpractice claims, so architects of a damages schedule would likely have to develop the scale from scratch. Finally, as we have noted, this approach provides a tiering system but does not provide dollar valuations for the levels of injury represented on the scale. That task must again be achieved by another method, and another set of difficult choices.

4.5. Hedonic Damages Approach

Courts have long awarded damages for "loss of enjoyment of life." But when recognized, damages for this loss were usually counted as a strand of noneconomic loss more generally, alongside pain, mental anguish, disfigurement, loss of consortium, and so on. Hence, they formed part of a single lump-sum payment made for noneconomic losses. Beginning in the mid-1980s,[105] courts began considering loss of enjoyment of life as a separate component of damages under the name "hedonic damages." Hedonic damages purport to compensate injured plaintiffs for the loss of quality of life or the value of life itself.

A minority of states recognize hedonic damages, but the number appears to be growing.[106] The nub of the controversy over hedonic damages is whether they are subsumed by standard damages for pain and suffering. Most jurisdictions, including Kansas, Nebraska, New York, Ohio, Pennsylvania, California, Texas, and Minnesota have ruled that they are. Others, such as Maryland, New Mexico, South Carolina, Washington, and Wyoming have allowed recovery of hedonic damages as a separate element of damages.[107] Many state supreme courts have not yet ruled on the issue. Even among courts that have permitted separate recovery of hedonic damages, most agree that expert testimony as to their magnitude is not permitted, especially in the wake of the *Daubert* decision,[108] and hedonic damages are generally not available in wrongful death or survival actions.

In a recent review, Schwarz and Silverman criticized hedonic damages on four counts:[109] (1) they are duplicative because the losses they purport to compensate overlap with those that are the focus of general damages awards;[110] (2) they provide a means of avoiding established liability rules, such as limits on punitive damages and the "cognitive awareness" requirement that has long been a requirement of noneconomic damages; (3) the basis of their calculation is scientifically unsound; and (4) the totals reached are too vague as to permit meaningful appellate review.

Why are hedonic damages relevant to this review of approaches to rationalizing valuation of noneconomic damages? Although hedonic damages are controversial, and the "expert" methods used to calculate them even more so, proponents of hedonic damages have outlined a specific methodology for their calculation. This methodology is ambitious in that it provides both features of the noneconomic damages schedule: tiers and dollar values for those tiers.

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[105] *See, e.g.,* Sherrod v. Berry, 629 F.Supp. 159 (N.D. Ill. 1985), *aff'd*, 827 F.2d 1985 (7th Cir. 1987), *vacated on other grounds and remanded*, 835 F.2d 1222 (7th Cir. 1988) (allowing expert testimony on hedonic damages in a civil rights action for wrongful death).

[106] Victor E. Schwartz & Cary Silverman, *Hedonic Damages: The Rapidly Bubbling Cauldron*, 69 BROOKLYN L. REV. 1037, 1039, 1046 (2004).

[107] *Id.* at 1046.

[108] *See, e.g.,* Saia v. Sears Roebuck, 47 F. Supp. 2d 141 (D. Mass 1999). *See also id.* at 1064-65; Reuben E. Slesinger, *The Demise of Hedonic Damages Claims in Tort Litigation*, 6 J. LEG. ECON. 17, 23-26 (1996).

[109] Schwartz & Silverman, *supra* note 106, at 1044-69.

[110] *See also* Kyle R. Crowe, *The Semantical Bifurcation of Noneconomic Loss*, 75 IOWA L. REV. 1275 (1990).

4.5.1. Tiers: The Lost Pleasure of Life Scale

The Lost Pleasure of Life (LPL) Scale,[111] used to rank and weight hedonic losses, is based on the scale used by mental health professionals to assess patients' degree of functioning and severity of stress.[112] The scale ranges from zero to 100, with zero signifying no loss of functioning and 100 signifying that the individual has no meaningful functioning and cannot derive pleasure from life. Table 2 provides some illustrative examples for LPL scores ranging from low to high.

Table 2. Lost Pleasure of Life Scale[113]

Degree of Loss		Examples
None	0	Normal functioning
Minimal	1-17%	Person is involved in automobile accident and misses some days of work; family functioning and relationships disrupted for days. Person returns to "pre-injury" level of functioning.
Mild	17-33%	Person breaks arm which results in a permanent inability to participate in recreational activities. Person has infrequent occurrences of mild depression. All other aspects of practical, emotional, social and occupational functioning are at a pre-injury level.
Moderate	33-50%	Person loses leg in car accident which affects his practical functioning on a daily basis; recreational activities are restricted and he suffers infrequent occurrences of mild depression.
Severe	50-67%	Person is burned in a fire and experiences significant scarring. Social functioning substantially reduced, person experiences significant loss of self-worth and frequent periods of depression. Practical and occupational functioning remain at pre-injury level.
Extreme	67-83%	Person is quadriplegic and requires attendant care on a daily basis. Practical, social and occupational functioning are significantly diminished. Person experiences severe depression and a loss of some sense of self worth.
Catastrophic	83-100%	Person is bedridden requiring daily nursing care. All aspects of practical, emotional and social functioning are substantially reduced. Person is unable to work

To arrive at the score, the mental health professional must compare the individual's pre- and post-injury states in four domains of functioning: (1) practical functioning; (2) emotional/psychological functioning; (3) social functioning; and (4) occupational functioning

[111] *See* Edward P. Berlá et al., *Hedonic Damages and Personal Injury: A Conceptual Approach*, 3 J. FORENSIC ECON. 1 (1990).
[112] AMERICAN PSYCHOLOGICAL ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 11, 18-19 (2000)
[113] Reprinted from Berlá et al., *supra* note 111.

(which refers not to lost wages, but to a person's ability to engage in the career of their choice and derive non-monetary pleasure from it).[114] The individual receives a percentage score in each domain.

The score represents the clinician's judgment of the specific injury and its probable effect on that the injured individual's future life. The percentage need not be static. Taking into account the time elapsed after the injury and the age of the individual, the rater may downgrade the percentage over time. For example, the impact of a debilitating leg injury sustained by fifty-year-old will change as he moves into higher age brackets where he would be expected to have limited mobility for other reasons.

4.5.2. Valuations: Willingness-to-Pay Measures

To determine hedonic damages, the mental health professional's scorecard is submitted to a forensic economist for conversion to dollar estimates of damages. The monetary measures applied come from "contingent valuation studies"[115]—investigations of people's preferences for health risks of varying degrees, which in turn come from both direct elicitation (i.e., questionnaires) and studies of "revealed preferences" in populations.

These valuations are commonly referred to as "willingness-to-pay" measures, because they essentially ask people how much they are prepared to pay (or receive) to avoid (or accept) exposure to certain risks. Researchers focus on risks about which they know two things: (1) the risk's magnitude at the population level (for example, the probability of an automobile crash, and the probability that an airbag will save the occupant in the event of such a crash); and (2) how much it costs to avoid the risk (e.g., the price of the airbag option in an automobile purchase). Combining this information, researchers have estimated the value of a statistical life.

The valuations come from a number of settings: consumption studies (the airbag situation is a good example of this), labor market studies (the estimated "premium" added to the salaries of workers in dangerous occupations, such as window-washing), and studies analyzing the cost and impact of regulations imposed by government agencies.[116] These methodologies have provided estimates of the value of a statistical life, which range from $450,000 to $7 million. Averaging these estimates, economists have tended to arrive at figures in the $2-4 million range.

An alternative valuation method that has been proposed is to compute the implicit value of a statistical life from jury awards for nonfatal injuries. Mark Cohen and Ted Miller analyzed noneconomic damages awards in jury verdicts reported from products liability and physical, non-

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[114] *Id.* at __.
[115] Stan V. Smith, *Evaluating the Loss of Enjoyment of Life - Hedonic Damages*, *in* ANALYSIS, UNDERSTANDING AND PRESENTATION OF CASES INVOLVING TRAUMATIC BRAIN INJURY (Charles N. Simkins, ed. 1993).
[116] Schwartz & Silverman, *supra* note 106, at 1061-62.

sexual assault cases from the 1980-1995 period and estimated the implied value of a statistical life at between $1.4 million and $3.8 million in 1995 dollars.[117]

Once the value of a statistical life is determined, the value of a nonfatal injury or health condition can be calculated by multiplying the value of a statistical life by the percentage loss in pleasure of life resulting from the injury or condition.[118]

4.5.3. Strengths and Weaknesses

One advantage of the hedonic damages approach is that it provides a methodology for addressing both requirements of noneconomic damages scale: creation of tiers and valuation of the tiers. Additionally, the concept of lost enjoyment of life probably comes closer than simple measures of physical injury severity to the broader notion of pain and suffering that noneconomic damages are supposed to capture.

Again, a weakness of this relatively sophisticated approach to valuing noneconomic loss is the difficulty of explaining it in a way that laypersons can appreciate. Loss of enjoyment of life is a concept that will be readily understood, but the intricacies of contingent valuation studies are less so. A further problem is that hedonic damages have been rejected by courts in several jurisdictions, and the approach (especially the willingness-to-pay valuation method) remains controversial even among jurisdictions that have recognized them. Finally, several academic criticisms of willingness-to-pay studies have been lodged; among these are that the studies are of limited use because they tend to measure only small risks; that they often use data collected for other purposes the calculate the value of a statistical life; and that the studies have produced widely varying estimates of the value of a statistical life.[119]

4.6. Additional Considerations

The approaches outlined above focus almost exclusively on the magnitude of noneconomic loss as the basis for determining the tiers of a noneconomic damages schedule. However, we note that a number of case-specific characteristics are known to be correlated with the magnitude of the loss. Stratification by these characteristics within whatever severity strata are chosen will provide greater sensitivity to the specific characteristics of each case.

Incorporation of such additional dimensions of the injury or injured individual will have the effect of transforming the schedule into a matrix. Addition of within-severity-level strata

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[117] Mark A. Cohen & Ted R. Miller, *"Willingness to Award" Nonmonetary Damages and the Implied Value of Life from Jury Awards*, 23 INT'L REV. L. & ECON. 165 (2003). The paper describes the methodology for performing this valuation in detail.

[118] *Id.* at 171.

[119] *See* Dennis C. Taylor, *Your Money or Your Life? Thinking About the Use of Willinness-to-Pay Studies to Calculate Hedonic Damages*, Note, 51 WASH. & LEE L. REV. 1519, 1546-51 (1994) (briefly summarizing some of the academic literature). For a more technical review of the criticisms, see Richard Raymond, *The Use, or Abuse, of Hedonic Value-of-Life Estimates in Personal Injury and Death Cases*, 9 J. LEG. ECON. 69 (1999-2000).

will complicate the matrix quickly. For example, a ten-level scale with six age brackets would present decision makers with sixty cells within which to classify injury. Adding another three-level variable would create 180 cells.

4.6.1. Age and Duration of Injury

The trial lawyer, Melvin Belli, was famous for asking jurors to consider the severity of his client's suffering for a small time interval, decide on an appropriate noneconomic damages figure for that interval, and then arrive at a total noneconomic award by multiplying that amount over the seconds, minutes, hours, days, and years the victim would be forced to bear the injury.[120] Although many courts today would frown on such theatrics, most jurisdictions do permit jurors to calculate noneconomic damages award using the per-diem method, discussed above in Section 1.1.[121] Indeed, the duration of the plaintiff's injury seems quite important for thinking about the magnitude of the noneconomic loss associated with the injury.

For permanent injuries, duration of injury can be addressed as a component of the injury tiers in a damages schedule by reference to the injured individual's age, as we previously discussed.[122] Subtracting age from life expectancy will provide an approximate estimate of the injury's duration. Downward adjustments to this difference may be needed if co-morbidities or the injury itself have lowered life expectancy in the instant case.

For temporary injuries, a more precise estimate of the injury's duration will be necessary. Because this determination is scientific, not value-based, experienced insurance adjusters or physicians with training and experience in rehabilitative medicine are likely to be the best decision makers, providing they do not have a financial stake in the damages determination.

Should age-related considerations, independent of the duration of the injury, be relevant to the noneconomic damages calculation? Should we value, for example, ten years of extreme pain and suffering more highly for a woman in her childbearing years than for a man in old age? Several surveys have shown public preferences for giving lifesaving treatments to young adults over older adults and young children.[123] The same preferences may extend to valuations of noneconomic losses. Architects of a schedule would need to decide whether age weighting was appropriate. This is a value-based judgment, not the province of experts.

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[120] VISCUSI , *supra* note 18, at 100.
[121] See *supra* text accompanying notes 6-8.
[122] See *supra* text accompanying note 65.
[123] Magnus Johanneson & Per-Olov Johannson, Is the Valuation of a QALY Gained Independent of Age? 16 J. HEALTH ECON. 589 (1997); P.A. Lewis & M. Charney, Which of Two Individuals Do You Treat When Only Their Ages Are Different and You Can't Treat Both? 15 J. MED. ETHICS. 28 (1989); Erik Nord, *The Person-Trade-Off Approach To Valuing Health Care Programs*, 15 MED. DECISION MAKING 201 (1995).

4.6.2. Gender

Some have hypothesized that noneconomic losses may differ by gender. Women, for example, are sometimes believed to be better able to cope with pain than men. However, reanalysis of our data on California jury verdicts showed no support for this hypothesis.[124] After controlling for severity of injury and age, gender did not predict the size of noneconomic damages awards. Moreover, differential valuation of noneconomic loss by gender is likely to be difficult to defend politically and legally.

5. Operational Considerations

5.1. Use by the Jury

A damages schedule could be utilized by juries in at least three different ways. First, juries could be required to select an amount for noneconomic damages that falls within the amounts scheduled for the applicable injury tier.[125] As discussed, this could be a single value or a "floor to ceiling" range. The advantages of this type of mandatory schedule are uniformity of awards for similar injuries (horizontal equity), proportionality of awards according to injury severity (vertical equity), strong cost control, and maximal predictability of awards for parties to litigation and liability insurers. The primary drawback is that juries have little or no ability to adjust awards for truly exceptional cases;[126] there may also be state-law barriers to imposing a binding schedule on juries (for example, it may be deemed to abridge the right to jury trial).

A second approach would be to make the schedule purely discretionary or advisory in nature. It could be submitted to juries as part of their jury instructions along with a notice that they are free to use or disregard it as they choose. The advantages and disadvantages of this approach are the reverse of the above: it allows juries wide latitude to ensure that their awards reflect absolute fairness and would involve fewer legal and political complexities; however, the goals of horizontal and vertical equity, predictability, and cost control may be only weakly served, depending on how frequently juries chose to depart from the schedules.

A middle-ground approach would be to use a presumptive schedule. The schedule would be presumptively applied unless strong justification was established for an upward or downward departure. Litigants might be required to justify a departure through testimony at trial, or juries could be instructed that they should award an amount within the prescribed range (or close to the

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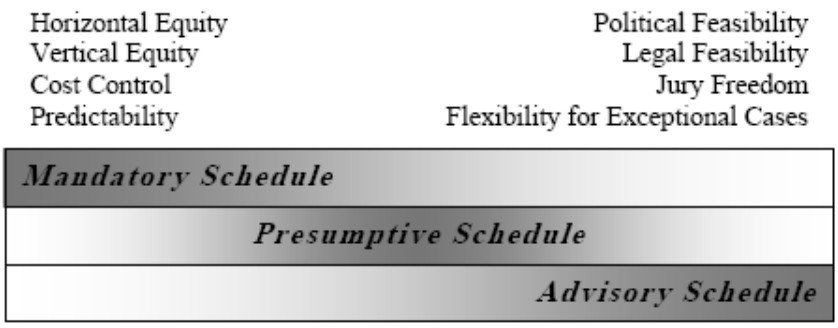
[124] The data are described in Studdert et al., *supra* note 15. The reanalysis was performed as part of the preparation of this report and is not reported in that article.

[125] Bovbjerg et al., *supra* note 9, at 946, advocates the mandatory approach.

[126] Bovbjerg and colleagues have suggested that a post-trial process could be created in whch plaintiffs would have the opportunity to argue their case should be considered atypical and given a supplementary damages award. They suggest that the process could be administrative in nature, rather than require the plaintiff to pursue a full judicial appeal. *Id.* at 948.

prescribed amount) unless they made a specific finding that an upward or downward departure was justified. There is some precedent for the presumptive approach: Massachusetts, for example, permits juries to waive its noneconomic damages cap if they feel justice demands it.[127] The presumptive approach strikes a balance between the competing values[128] described above (Figure 5).

Figure 5. Values Served by Different Uses of a Damages Schedule



5.2. Approaches to Payment

Once the noneconomic loss associated with the injury has been valued and an award amount determined, the question then arises how best to pay out the damages. The two basic alternatives are lump-sum payments and periodic payments. Lump-sum payments are paid out all at once upon arriving at a settlement or verdict. A lump-sum noneconomic damages payment represents a judgment about both the value of the economic loss and the amount of time that the plaintiff will experience that loss, which is proxied by the plaintiff's remaining life expectancy or estimated period of disability.

Periodic payment involves paying out compensation for losses as they accrue over time (for example, on an annual basis). Many states, including Washington, have passed tort-reform laws mandating periodic payment of damages in malpractice suits. Such laws typically are confined to periodic payment of economic damages, but at least one refers also to noneconomic damages.[129] The advantages of periodic payment of economic damages are threefold. First, it responds to the considerable uncertainty that may exist about a plaintiff's future condition, experiences, and needs by paying for only those costs that she actually incurs. This protects the

[127] MASS. GEN. LAWS ch. 231, § 60H.
[128] *Cf.* Bovbjerg et al., *supra* note 9, at 964 (highlighting the need to determine "the relative importance of doing justice in individual cases versus arriving at fair results across cases").
[129] *See, e.g.*, ALASKA STAT. § 09.55.548 (Michie 1996) (specifying periodic payment of damages for future medical treatment, care or custody, loss of future earnings, and loss of bodily function); CAL. CODE CIV. PROC. § 667.7.

plaintiff against erroneously low jury estimates of her needs, and defendants against overly conservative estimates of the plaintiff's needs. Second, it helps ensure that the plaintiff does not squander or lose through unfortunate investments funds that she will need later in life.[130] Third, it enables the defendant and his insurer to save money by purchasing an annuity for the damages award that costs less than a lump-sum payment of damages would cost.[131]

There is no strong theoretical reason why periodic payment cannot also be used for noneconomic loss. Once an annualized estimate of noneconomic loss is generated by reference to the damages schedule, the court could order that the noneconomic damages component of the award be paid on an annual basis, as the plaintiff "incurs," or experiences, the decreased quality of life.

However, the justification for employing periodic payment is weaker for noneconomic than for economic loss. With regard to the first advantage, the problem of uncertainty about the plaintiff's future experience is not actable in the same way as for economic damages. That is, the plaintiff cannot quantify her actual losses by submitting receipts every December. The second advantage does apply equally to noneconomic damages.

The third advantage, however, generally will not apply. For economic damages awards, the gross value of the award for future economic loss to paid over the life of the plaintiff can be significantly more than the present value of that award.[132] This is not generally true for noneconomic damages awards, which are expressed as the present value of the plaintiff's future loss of quality of life. The cost of an annuity purchased to pay the periodic payments for noneconomic damages typically will equal the jury's present value award; there is no cost savings to the defendant. California's MICRA legislation contemplates that there may be exceptional cases in which the calculation looks different, and does allow defendants to request periodic payment for noneconomic damages if they feel there would be an advantage to doing so.[133]

One disadvantage of periodic payments relates to deterrence. If the plaintiff happens to die prematurely, the defendant benefits from a lower total payout.[134] In such cases, defendants will be somewhat insulated from the full financial consequences of their negligence. This cuts against the notion that the tort system will encourage optimal levels of precaution-taking by imposing an economic sanction for substandard levels.

5.3. Relationship to Special Damages

The noneconomic damages schedule we have described is completely untethered to special (economic) damages. The jury is instructed to consider noneconomic damages separately

[130] National Conference of Commissioners on Uniform State Laws, *Uniform Periodic Payment of Judgments Act* (visited June 23, 2005) < http://www.nccusl.org/nccusl/uniformact_summaries/uniformacts-s-uppoja.asp>,
[131] *Id.*
[132] Pacific West Law Group LLP. *What Is MICRA?* (visited June 23, 2005) <http://www.pacificwestlaw.com/physicians/micra.htm>.
[133] *Id.*
[134] Danzon, *supra* note 28, at 123.

from its calculation of economic damages, and is not instructed to use economic damages as a benchmark for thinking about noneconomic loss. This is not the only possible approach; indeed, at least one state has adopted noneconomic damages caps that make the ceiling a multiplier of the economic damages in the case. Ohio limits noneconomic damages to the greater of $250,000 or three times the amount of economic loss, up to $350,000 per plaintiff and $500,000 per occurrence.[135] However, there is no principled reason why noneconomic loss should be conceived of as a function of the magnitude of the economic loss.[136] It is preferable to keep the two determinations separate.

5.4. Management and Updating of Schedule

Damages schedules require regular review and updating of both the tiering structure and the dollar values of the tiers. Updating the dollar values is relatively straightforward, and could consist of a simple annual adjustment for inflation.[137] Over the long term, policymakers may wish to reconsider the real value of the amounts associated with each tier, to account for changes in the social valuation of various states of ill health and disability.

Depending on the particular method chosen for creating the injury tiers, it may be advisable to periodically revisit the structure of the tiers. For example, if lists of physical injuries or conditions that fall within each tier are used, clinical experts should be consulted at regular intervals to determine whether advancements in treatment have materially changed the pain, suffering, and quality-of-life decrements associated with those conditions. Some conditions may require reclassification to a lower tier. Other methods of designing the tiers have other implications in terms of maintenance and updating; the specifics have been discussed above in the descriptions of each method.

5.5. The Special Case of Wrongful Death

The proposals we have outlined contemplate the typical medical malpractice case in which the injured patient files suit seeking damages for his own injury. Wrongful death cases brought by the patient's family present special challenges for thinking about noneconomic damages, especially where the patient died instantaneously and personally experienced no pain and suffering. In such cases, the relevant noneconomic injury is the emotional anguish and loss of consortium suffered by the family of the decedent.

Some of the scheduling approaches we have described are amenable to including a special tier for this type of injury. It is similar in kind, though perhaps not in intensity, to the emotional anguish experienced by patients who, for example, have a delayed diagnosis of cancer. Both types of emotional-only injury can be scheduled. Alternatively, policymakers may opt to

[135] OHIO REV. CODE ANN. § 2323.43.
[136] Geistfeld, *supra* note 6, at 786.
[137] Bovbjerg et al., *supra* note 9, at 963.

carve wrongful death cases out from the damages schedule and allow juries to make noneconomic awards in such cases on an ad hoc basis.

6. Conclusion & Recommendations

Creating a schedule for noneconomic damages that is rational, perceived as fair, and easy for decision makers in the civil justice system to use is not a straightforward exercise. Appreciation of the complexities involved helps to explain the traditional gravitation of policymakers toward flat dollar caps. Although the flat-cap solution may be appealing in its simplicity, it rides roughshod over fairness principles. A coherent schedule promises to better honor principles of vertical and horizontal equity, and improve the absolute fairness, consistency, efficiency, and predictability of compensation for personal injury.

The two central tasks in designing a schedule are (1) the creation of tiers that group injuries with similar levels of noneconomic loss and (2) assignment of dollar values to those tiers. With the exception of the hedonic damages approach, no single approach among the five we outlined addresses both tasks. We do not recommend pursuing the hedonic damages approach, for reasons outlined below. Consequently, a blended approach is needed.

6.1. Tiers

The first task requires identification of a scale that appropriately captures and grades noneconomic losses. No perfect scale exists. Existing scales based on quantitative and qualitative judgments have three main shortcomings. First, they tend to be focused on severity of physical injury. While this is undoubtedly correlated with the extent of noneconomic loss in most injuries, it is not synonymous with it. For some injuries, the two concepts may diverge sharply, leading to gross over- or undervaluation of the noneconomic loss. Second, there are some problems with the existing scales' ordinality—that is, their ability to correctly rank order injuries in ascending order of severity. Third, their construction is heavily driven by expert judgments, perhaps too heavily, given the relevance of at least some lay input into understanding the severity of noneconomic losses associated with personal injury.

The health utilities index presents an intriguing opportunity for combating all three shortcomings of existing scales. The focus of health utilities analysis—quality of life—appears much closer to the loss noneconomic damages are supposed to address than does the focus of conventional severity scales. The health utilities index treats seriously the problem of ordinality, and it explicitly provides roles for lay and expert judgments in arriving at the final utility weights. We believe that the health utilities methodology is more sophisticated that the scaling component of the hedonic damages approach (Lost Pleasure of Life Scale), and that ultimately, it would be easier to operationalize.

However, the health utilities index has two important limitations from a policy perspective. First, it remains relatively undeveloped, especially so in the realm of personal injuries. Additional theoretical work and validity testing may be required before policymakers

feel that "proof of concept" has been established. Second, its methodological foundations are complex, somewhat controversial, and may not easy for the public, legislators, and other key stakeholders in the civil justice system to understand or accept. Therefore, we flag a health utilities scale as perhaps the most promising approach for the future, but recognize that at this time its adoption as the basis of a schedule is likely to prove infeasible.

We therefore return to the quantitative scale of severity and, on balance, recommend this approach for the tiering of noneconomic losses. We find the existing scales, despite their shortcomings, to be a reasonable basis on which to proceed. However, it is desirable to make improvements to them, and very feasible to do so with relatively little time and effort.

To accomplish this, we recommend establishment of a panel consisting of lay persons, medical experts, and insurance adjusters with experience in assessing severity and tracking injuries over time. The panel could start with existing scales, such as the NAIC scale, and modify these to address noneconomic losses specifically. The structure of the resulting scale could be quite simple. Beside each tier, however designated, it would be helpful to have descriptive examples of injuries which panel members agree tend to have associated noneconomic losses that fall within that severity level. It would be particularly useful if those examples meshed with some of the most prevalent types of injury seen in malpractice litigation. In many ways, the work of this panel would replicate the activities of the Swedish and Danish panels we discussed in section 4.3.2, and further understanding of the constitution and approaches of those panels may help to inform the process.

6.2. Valuations

Only two of the approaches—the precedential approach and hedonic damages—articulate a mechanism for assigning dollar values to tiers. We recommend the precedential approach. Its chief advantage is the deference it pays to the role of courts and juries. Its chief weakness, the various challenges associated with gathering sufficient data on previous decisions, is probably surmountable if there is reasonable flexibility about the range of permissible data sources and the time periods from with previous determinations may be drawn.

The hedonic damages approach, through creative, has a checkered history in the courts. We believe it is too controversial, both inside and outside legal circles, to warrant serious consideration at this point.

With the choice of the precedential approach come some important subsidiary decisions. Answers to these questions are essentially political in nature. Though input from scientific research may be useful, a sense of the distribution of jury awards and how far mean values diverge from median ones—the answers to these subsidiary questions are ultimately normative determinations that should reflect community values and expectations about the proper workings of the civil justice system. We offer some recommendations as a starting point for these political discussions.

The first subsidiary question is what sources of precedent are considered acceptable. Should settlement data be obtained from insurers in the state, or should only jury verdicts be used? Further, should award data be drawn from within the jurisdiction only, or are awards from other jurisdictions also of interest? If ensuring fidelity and deference to the views of juries and the local community is considered very important, we recommend basing valuations on jury awards from the jurisdiction only. However, for some rare (or rarely litigated) injury types, it may be informative to provide decision makers with data from jury awards in other jurisdictions (using award amounts before application of any damages caps in place in the state).

Second, should the valuation consist of a single dollar amount or a range of values? We recommend using a range of values in recognition of the fact that not all cases that fall within a particular severity tier will appear to juries to be equal in terms of the associated losses. It is desirable to give the jury the ability to account for idiosyncratic characteristics of particular cases (e.g., the fact that the plaintiff who lost a finger was a pianist) without having to discard the schedule entirely.

Third, what form should the numerical measures take? For example, should the "anchor" for a range of dollar values be the mean past award, or the median? Should high and low outlier values in past awards be discarded, and if so, how great an outlier need an award be to be disqualified? We recommend the use of medians over means, due to the skewed distribution of awards. If means are preferred, we recommend that a "raw" mean be calculated including all awards, and then an "adjusted" mean be calculated based on a subset of awards that excludes those that fall beyond one standard deviation of the raw mean. The adjusted mean should be used as the anchor value.

6.3. Use by the Jury

Damages schedules may be purely advisory, presumptive, or mandatory. Where the primacy of jury decision making is valued either for political or for constitutional reasons, a relatively nonbinding schedule is preferred. Decisions about the use of the schedule by the jury are best made by local legal experts, following review of relevant constitutional precedents concerning due-process and jury-trial rights and consideration of feasible jury instructions for courts of that jurisdiction. Even within the realm of purely advisory schedules, it may be possible to use jury instructions to put relatively greater or lesser emphasis on the social value and advantages of adhering to the schedule.

6.4. Concluding Comments

Despite the challenges and complexity of the tasks associated with creating a schedule of noneconomic damages, we believe that schedules represent a very significant advancement over existing efforts to limit noneconomic awards. The challenges can feasibly be addressed through a process that defines substantial and appropriate roles for both expert and lay input.
Importantly, the process should be conceived as ongoing. Initial versions of the schedule should

be piloted and evaluated for their uptake by juries, effect on award costs, and acceptability to jurors and the public. In this way, the efficacy, rationality, and legitimacy of the schedule can be assured.

Appendix: Selected Foreign Models for Valuation of Noneconomic Loss

Country	Description of Scheme	Key Features
Australia	1. South Australia Workers Rehabilitation and Compensation Act provides for a lump sum award for noneconomic injures. Generally the award is calculated by multiplying a "prescribed sum" ($62,000 in 1985, adjusted upward based on the Consumer Price Index) by a percentage disability taken from a table of maiming injuries. Some examples from the table include: • Total and incurable paralysis of the limbs: 100% • Total loss of hearing: 75% • Loss of foot: 75% • Loss of thumb: 35%[138] If an injured worker sues, his recovery for nonpecuniary loss is limited to 1.4 times the amount calculated above.[139] 2. Victoria Transport Accident Act provides that only those with a "serious injury" have recourse to the common law. Serious injury is defined to include serious long-term impairment or loss of a body function, serious long-term disfigurment, severe long-term mental or severe long-term behavioral disturbance or disorder, or loss of a fetus; alternatively, an injury with a degree of impairment of 30% or more is presumed to be a serious injury. If total damages are assessed at less than $30,520, then no damages will be awarded for either pecuniary loss or pain and suffering. Pain and suffering damages are capped at $302,520; pecuniary damages are capped at $686,840. Total damages in wrongful death cases are capped at $500,000.[140] 3. South Australian Civil Liability Act provides that no damages may be awarded for noneconomic losses due to traffic accidents unless the injury significantly impairs the person's ability to lead a normal life for a period of at least 7 days or resulted in medical expenses above a prescribed minimum ($2750 in 2002, adjusted upward based on the Consumer Price Index). If these thresholds are satisfied, then, noneconomic losses are awarded pursuant to the following statutory formula: (a) the injured person's total non-economic loss is assigned a numerical value (the "scale	Schedules with disability percentage Caps Floors

[138] South Australian Workers Rehabilitation and Compensation Act of 1986, pt. 4, div. 5, § 43 & Schedule 3.
[139] Jeffrey O'Connell & David Partlett, *An America's Cup for Tort Reform? Australia and America Compared*, 21 U. MICH. J. L. REF. 443, 468 (1988).
[140] Victoria Transport Accident Act of 1986, pt. 6, div. 1, § 93.
[141] South Australian Civil Liability Act of 1936, pt. 8, § 52.

	value") from 0 to 60 (the scale reflecting 60 equal gradations of noneconomic loss, from a case in which the noneconomic loss is not severe enough to justify any award of damages to a case in which the injured person suffers noneconomic loss of the gravest conceivable kind); (b) for injuries arising from accidents that occurred in 2002, the damages for noneconomic loss are calculated by multiplying the scale value by $1,710; (c) for injuries arising from accidents that occurred in 2003, the damages for noneconomic loss are calculated as follows: (i) scale value ≤ 10: multiply scale value by $1,150; (ii) scale value > 10 but ≤ 20: add to $11,500 an amount calculated by multiplying the number by which the scale value exceeds 10 by $2,300; (iii) scale value > 20 but ≤ 30: add to $34,500 an amount calculated by multiplying the number by which the scale value exceeds 20 by $3,450; (iv) scale value > 30 but ≤ 40: add to $69,000 an amount calculated by multiplying the number by which the scale value exceeds 30 by $4,600; (v) scale value > 40 but ≤ 50: add to $115,000 an amount calculated by multiplying the number by which the scale value exceeds 40 by $5,750; (vi) scale value > 50 but ≤ 60: add to $172,500 an amount calculated by multiplying the number by which the scale value exceeds 50 by $6,900.[141]	
Belgium	Experts assess percentage points of invalidity and disability; however, it is left to the expert's discretion to decide which scale he or she uses. There is no legislative table. Judges award compensation for any losses which have been established, but they have discretion as to amount of award. Great importance has been attached to previous awards, for consistency's sake. Judges, with the help of academics, lawyers and insurers) have drawn up a "National Indicative Table" (the "Table") for quantification of damages, first adopted in 1997. The Table appears to be based on prior awards. It is a starting point and is not binding. Some elements of the Table: • Day rates set out for periods of temporary disability • For permanent disability, the Table suggests certain sums per percentage point of invalidity. These sums decrease as the age of the victim increases	Day Rates Precedent Award Tables Severity scale with dollar values

[142] _____, ____, *in* PERSONAL INJURY COMPENSATION IN EUROPE 60-64 (Marco Bona and Philip Mead, eds., 2003).

	• For disfigurement, the table suggests amounts of compensation according to a severity scale: Minimal (€247.89-€750); Minor (€743.65-€1,500); Slight (€1487.36-€2,250); Medium (€2231.04-€8,750); Serious (€8676.27-no maximum); Very Serious (€14,873.61-no maximum); Catastrophic (€24,789.35-no maximum). [142]	
Canada	Canadian courts have chosen a "functional approach" when assessing noneconomic damages. The functional approach holds that nonpecuniary damages should compensate for additional physical arrangements, above and beyond those related to the injury, which make life more endurable. What will it cost for the victim to live comfortably under these circumstances? Two other possible approaches considered by Canadian courts (in the case of *Andrews v. Grand and Toy Alberta*) have been: (1) the conceptual approach: treat each injury as a proprietary asset with an objective value (e.g., a schedule); and (2) the personal approach: value injury in terms of lost human happiness.[143] "Minor Injury Cap" law: a new law provides that those who suffer a "minor injury" in a car accident are limited to $4000 non-pecuniary damages. "Minor injury" is essentially a soft tissue injury which does not cause long term functional impairment. Diagnosis is to be made in reference to specific publications.[144]	Floors Caps
Denmark	In Denmark, non-pecuniary damages are assessed in two components: 1. Acute phase: Damages for pain and suffering are fixed at €18 per day of illness, with a maximum of €6,900. This is a fixed amount with no adjustments for particularly severe injuries. This rate covers the period from the time of injury until the time of recovery, or until it is established that the injury is permanent. Return to work does not necessarily stop payments. 2. Permanent disability: Once permanent disability has been established, the following rules are applied to assess additional noneconomic damages: • The percentage disability is multiplied by a certain amount (€800 in 2002). A victim can receive up to 120% in special cases. A minimum of 5% is imposed. • If the victim is over age 40, damages are reduced by 1% per year, and by an additional 1% per year if over 60. The reduction cannot exceed 40%	Day Rates Floors Schedules with disability percentage Award tables

[143] Andrews v. Grand and Toy Alberta Ltd., 2 S.C.R. 229, 261 (Can. 1978).
[144] Barbara Billingsley, *Legislative Reform and Equal Access to the Justice System*, 42 ALBERTA L. REV. 711 (2005).
[145] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 87-91.

	• Degree of disability is determined under a table created by the National Board of Industrial Injuries, subject to continual updates. The table addresses many categories of injury, including disfigurement and sexual injury. • Reduction of life expectancy and spoiled holiday are not compensable. Judges do not have much discretion. They may reduce damages if the person dies before damages have been calculated, but otherwise may not deviate from these rules. It is possible to reopen the case and recalculate in the event of serious deterioration in the claimant's condition.[145]	
Finland	The Traffic Accident Board has created the following scale method to compensate aesthetic injuries. This table is used for various types of compensation cases. Minor cosmetic damage – FIM 4,000-10,000 Slight cosmetic damage – FIM 10,000 – 25,000 Moderate cosmetic damage – FIM 25,000 – 50,000 Severe cosmetic damage – FIM 50,000 – 100,000 Extremely severe cosmetic damage – FIM above 100,000 (€1 = 5.95 FIM)[146]	Severity scale with dollar values
France	For "prejudice physiologique" (permanent reduction in the victim's physical, psychological or intellectual functions which affects his everyday life), there is a two-step process for evaluating damages: 1. First, experts quantify the injury. There is no compulsory schedule; however, many experts use the "Bareme Rousseau" which lists various disabilities and suggests a disability rate or scale of rates for each injury. It is unclear how the Bareme Rousseau is created or updated. 2. Second, judges use the method of "le calcul au point," in which they multiply the disability rate by a certain corresponding value that is calculated by reference to previous awards in similar cases. The value tends to decrease with age. For disfigurement and physical pain (apparently a separate head of damages), damages are assessed on a seven-degree scale based on prior awards (no information was available on this scale). Judge may award either a lump sum or periodic payments.[147]	Schedules with disability percentage Precedent Periodic Payments

[146] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 163.

Hong Kong	Pain-and-suffering awards are "imprecise and intuitive" but appear to follow a three-step process: 1. Court first should assess damages by reference to comparable cases 2. Court then looks to "special features" of the case which might influence the award. 3. Then, the court should cross-check its award against a set of guidelines established by the Hong Kong Court of Appeal in the case of *Lee Ting Lam v. Leung Kam Ming*, [1980] HKLR 657. These guidelines have been adjusted upward for inflation. The guidelines are meant to be only a general description, not hard and fast rules. They are meant to encourage consistency. The guidelines are: a. "Serious Injury": The lowest category, covering cases in which the injury leaves a disability which disrupts general activities and enjoyment of life, but allows reasonable mobility to the victim—for example, the loss of a limb replaced by a satisfactory artificial device, or bad fractures leaving recurrent pain. Range of awards as of 2002: HK$400,000-$540,000 b. "Substantial Injury": Injuries requiring treatment in hospital for many months that leave the victim with a much reduced degree of mobility—for example, a leg amputated from the thigh, so that an artificial leg cannot be used satisfactorially; or multiple injuries which leave a chronic condition requiring regular treatment. Range of awards as of 2002: HK$540,000-$660,000 c. "Gross Disability": Injuries that leave the victim with very restricted mobility or cause serious mental disability or behavioral changes. Includes paraplegics. Range of awards as of 2002: HK$660-1,000,000. d. "Disaster": Injuries that leave the victim in need of constant care and attention, incapable of ever leading an independent adult life. Includes paraplegics and those in a persistent vegetative state or left with the mental age of a child. Awards as of 2002: HK $1,000,000 upwards.[148]	Precedent Severity scale with dollar values

[147] Suzanne Galand-Carval, *Non-Pecuniary Loss Under French Law, in* DAMAGES FOR NON-PECUNIARY LOSS IN A COMPARATIVE PERSPECTIVE 90, 100 (W.V. Horton Rogers, ed., 2001); _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 197.
[148] RICK GLOFCHESKI, TORT LAW IN HONG KONG 321-324 (2002).

Italy	The procedure for evaluating noneconomic damages is as follows: 1. Medical experts establish the percentage of invalidity using medical scales called "baremes," which appear to be drafted by medical experts. 2. Judges then use tables, based on case law experience, to assess the monetary value (or range thereof) per percentage point of invalidity. Many of the tables are local and inconsistent with each other. There has been some movement to standardize the tables into a National Indicative Table. Noneconomic damages are awarded in 3 categories: 1. "Danno Biologico": Loss of physical/mental integrity; includes loss of sexual function, loss of earning capacity, and aesthetic damages. The tables mentioned above are intended to assess Danno Biologico. 2. "Danno Moral": Moral and physical suffering, pain, mental and emotional distress. Award is usually ¼ to ½ the Danno Biological award. 3. "Danno Esistenziale": Alteration of daily life. These damages are discretionary, awarded based on "fairness."[149]	Schedules with disability percentage Award tables Precedent
Netherlands	Experts have a limited role in deciding noneconomic damages. They generally use the AMA guidelines to determine the percentage disability. Assessment of damages is left to the judge, who decides "on the grounds of equity." Judges compare their case to past cases. Abstracts are published in a special edition of the review of Traffic Law. There are no tables or judicial guidelines for appropriate award levels. [150]	Schedules with disability percentage Precedent
UK	Courts have set a figure for the worst case (€333,000) and then constructed a "tariff" working down from that, making assumptions about the relative seriousness of different injuries. Brackets are very wide. They are generally based on the *Guidelines for the Assessment of General Damages in Personal Injury Cases* (the "Guidelines").[151] The Guidelines are intended to reflect the general level of current damage awards (*i.e.*, not the Guidelines' authors' views of the desirable award levels). The Guidelines divides injuries into ten	Periodic Payments Ranked injuries with dollar values Precedent

[149] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 319-323.
[150] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 372-373.
[151] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 132.
[152] JUDICIAL STUDIES BOARD, *supra* note 71, at 2.
[153] _____, _____, *in* PERSONAL INJURY COMPENSATION IN EUROPE, *supra* note 142, at 132.

	sections: injuries involving paralysis, head injuries, psychiatric damage, injuries affecting the senses, injuries to internal organs, orthopedic injuries, facial injuries, scarring to other parts of the body, damage to hair, and dermatitis. Within these sections, injuries are ranked into tiers and a range of awards is provided for each tier. For example, Chapter 1, Injuries Involving Paralysis, provides for the following awards: (a) Quadriplegia: £175,000 to £220,000. The level of the award within the bracket will be affected by the following considerations: (i) the extent of any residual movement; (ii) the presence and extent of pain; (iii) depression; (iv) age and life expectancy. The top of the bracket will be appropriate only where there is significant effect on senses or ability to communicate. It will often involve significant brain damage. (b) Paraplegia: £120,000 to £155,000. The level of award within the bracket will be affected by the following considerations: (i) the presence and extent of pain; (ii) the degree of independence; (iii) depression; (iv) age and life expectancy. The presence of increasing paralysis or the degree of risk that this will occur, for example, from syringomyleia, might take the case above this bracket. The latter might be the subject of a provisional damages order.[152] Periodic payments are allowed with consent of the parties. [153]	

VI. REPORT OF POLICY SUBCOMMITTEE

The Policy Subcommittee examined many of the advantages and disadvantages to implementation of the use of an advisory schedule for noneconomic damages in medical malpractice cases. The discussion in that group reflected the larger group discussion about the advisability of a noneconomic damages schedule. We are confident that the Mello-Studdert report comprehensively identifies the methods by which such a schedule could be constructed. The task force concurs with their recommendation that a quantitative tiering of injuries be devised and that each tier be assigned a dollar valuation based on data drawn from precedential malpractice cases. This represents a reasoned, fair, and fact-based approach to develop a noneconomic damages schedule. If the Legislature were to adopt this recommendation, significant research, development, and data resources would need to be invested to create what would be the first noneconomic damages schedule in the United States.

However, neither the Policy Subcommittee nor the task force as a whole was able to reach a consensus on the underlying question of whether a schedule should be adopted. We believe that the advantages are counterbalanced by disadvantages. The subcommittee and the task force thought it important to give the Legislature a sense of the debate and issues identified during the course of the task force's deliberations. Issues that were discussed among the subcommittee members and the task force are set forth below along with accompanying statements of the advantages and disadvantages flowing from each issue.

Identified Issues, Advantages, and Disadvantages

Issue 1: Unprecedented nature of an advisory schedule for noneconomic damages	
Advantages	Theoretical models, such as those catalogued and proposed by Mello and Studdert could be operationalized. Models in other disciplines that guide judicial processes could be used as examples. These include workers compensation or child support scales. The legal and judicial community is capable of using and administering similar guidelines in both civil and criminal contexts.
Disadvantages	Development and use of a schedule for noneconomic damages, advisory or not, is unprecedented in the United States. No other state has sought or attempted to develop a nuanced schedule to put a dollar value on the subjective concept of pain and suffering. A few other nations have such schedules, but these function within completely different legal systems and social, economic, and cultural constructs. There is no example upon which to model such a schedule and no data to provide a reliable starting point for defining and valuing noneconomic damages.
Issue 2: Technical complexity of creation of a schedule	
Advantages	With a substantial investment of time and resources, several theoretical models are available upon which to create tiers of injuries and apply values to them. (See Mello-Studdert report.) There is substantial flexibility not only in how to design a schedule, but also in defining how a jury could utilize a schedule.
Disadvantages	Given the fact that an advisory schedule for noneconomic damages exists in theory, but has not been operationalized in any U.S. jurisdiction, development of a schedule would be a complex and expensive undertaking, with no empirical evidence to support a positive outcome. A long period of time may be required to amass the data necessary to support the valuation of injuries contemplated in the Mello/Studdert report.

Issue 3: Access to justice	
Advantages	Delineating noneconomic damages in a schedule may increase predictability and settlements, and give injured parties that might not otherwise seek redress an incentive or basis to go forward with their claim.
Disadvantages	Injured parties have the right to a trial by jury unencumbered by constraints and limitations imposed by the government. A schedule, unless purely advisory, may defeat this right.
Issue 4: Respect for the individual nature of the injured person's claim and damages	
Advantages	A schedule could be purely advisory and not limit a jury to the suggested values, protecting the exceptionally damaged plaintiff and unique claims.
Disadvantages	The current system protects individuality of plaintiffs' claims and their uniqueness. A schedule could erode this bedrock principle of tort liability for negligent acts.
Issue 5: Flexibility of a noneconomic damages schedule as opposed to a cap	
Advantages	A schedule does not suffer from the same deficiencies as a "flat cap" or ceiling on damages and can be viewed as a more sophisticated, principled, and sensitive approach to managing damages. A schedule can give "ranges" of values to various injuries and can, over time, be adjusted for exceptional cases. Criteria could be developed to guide juries in such situations as well.
Disadvantages	To be effective, a schedule can have only a limited number of "cells" of injuries to which dollar values are assigned. This may make it difficult to include tiers of injuries and values that are both nuanced and broad enough to compensate the unique individual or aspects of a case that increase the pain and suffering beyond a "normal" range. It may be construed as prescriptive and function as a *de facto* cap.

Issue 6: Alternative dispute resolution issues	
Advantages	A schedule might address those cases of more minor injury, which under current systems, often go uncompensated (also an access to justice issue). If a schedule were combined with available arbitration and mediation processes, more claims would likely be settled at lower costs.
Disadvantages	Fear of unknown potential damages at trial currently can drive reasonable settlements by defendants and serves to decrease the number of cases and ultimately the societal costs of litigation. A schedule may have the effect of taking such an incentive away, resulting in more trials rather than early resolution of disputes.
Issue 7: Inequity between medical malpractice versus other personal injury torts	
Advantages	As part of a solution to widespread criticism of medical malpractice case outcomes, a schedule could be a helpful, and innovative development be piloted and, if successful, become a model for the nation. It is a rational response to a critical problem.
Disadvantages	A schedule that is applicable only to medical malpractice cases creates a different approach than that for all other personal injury tort cases. This may raise constitutional issues and questions. For example, is it rational to limit a schedule to only one particular type of tort when the injuries may be similar? When two plaintiffs have suffered similar injuries, should they be protected differently under the law and by the courts merely because one sustained their injury from medical negligence while the other sustained it from a car accident?
Issue 8: Effect on medical malpractice insurance rates	
Advantages	A schedule is one tool, when used in combination with others, which could increase predictability of settlements and judgments and, accordingly, help the insurance market remain stable and make more insurers willing to provide coverage.
Disadvantages	It is unclear whether adoption of a schedule would have any effect on ameliorating rates or addressing a “crisis” that some believe exists in medical practice coverage.

Issue 9: Effectiveness of tort remedies generally	
Advantages	A schedule may be an incentive for more claimants to seek fair recovery for injuries due to negligent acts in health care settings. (This is an access to justice issue as well.)
Disadvantages	Use of a schedule will not address the failure of the tort system to provide compensation to those injured by acts of negligence. Only a small percentage (1-5 percent) of patients injured by medical negligence seek redress. A schedule would not further incentives to deter bad practice.
Issue 10: Transparency of quality assurance and patient safety	
Advantages	Use of a schedule, particularly combined with a process to collect medical malpractice data, could assist in analysis of trends and significant problem areas. In the long term, this could allay medical community fears that liability will result from quality assurance efforts and systematic attempts to address patient safety.
Disadvantages	Use of a schedule would not address transparency with respect to quality assurance and patient safety. It would not encourage public disclosure or sharing of information necessary to focus on corrective action or advances in patient safety or systems improvements.
Issue 11: Fair compensation to plaintiffs and counsel	
Advantages	A schedule, even if advisory, can increase predictability, promote settlement, and avoid undervaluation of a plaintiff's injury.
Disadvantages	Some believe a schedule would unfairly reduce levels of compensation to plaintiffs and their counsel. A schedule may reduce settlements, and parties may be more willing to take risks and incur costs associated with trial. Uncertainty with respect to possible verdicts drives settlements and limits litigation and all its attendant costs.

Issue 12: Impact of a noneconomic damages on the jury process and system	
Advantages	Juries may need more guidance on damage awards, especially with respect to assessing noneconomic damages. The judges on the task force indicated that juries would welcome more definitive guidance.
Disadvantages	Most people think the jury system works well and they trust juries to fairly evaluate cases.
Issue 13: Impact of a noneconomic damages schedule on other damages	
Advantages	A noneconomic damages scale may foster more careful and precise analysis of the economic damages, because noneconomic damages will be less likely to be used to substitute for difficult-to-calculate economic damages.
Disadvantages	Adoption of a schedule might have the unintended consequence of increasing the scope and cost of economic damages. More often it simply is not clear what percentage of total damages is noneconomic, so awards may still be large.

In conclusion, the Policy Subcommittee concurs that the model recommended by the Mello-Studdert report offers the best option for a schedule that might provide guidance to plaintiffs, defendants, and juries. However, the subcommittee is unable to conclude that the advantages of a schedule clearly outweigh the disadvantages. The Legislature will need to fully explore the impact of such an advisory schedule on justice, fairness, and deterrence. We urge the Legislature to fully and rigorously examine empirical data and underlying causes of medical error and resulting malpractice actions. It seems unlikely that implementation of an advisory noneconomic damages schedule alone is sufficient to address the multifaceted and complex issues inherent in medical negligence and malpractice litigation.

VII. REPORT OF DATA SUBCOMMITTEE

The Data Subcommittee identified a number of data issues that will need to be resolved should the Legislature decide to implement an advisory schedule of noneconomic damages. These issues have been divided into three major categories:

1. Drafting of statutes authorizing collection of necessary data;
2. Defining the data elements to be collected; and
3. Commissioning special studies to obtain supplemental data and provide additional analysis of medical malpractice experience.

A. Background

The creation of a schedule for noneconomic damages will require the availability of a variety of data on medical malpractice claims. The Mello-Studdert report (Section V) identifies the following key decision points in designing a schedule:

1. Proxy measure for noneconomic loss
2. Number of injury tiers
3. Inclusion of age in the injury tiers
4. Assignment of relative weights to tiers
5. Process/decision makers for assigning dollar values to tiers
6. A single dollar value, multiple values, or value range for each tier

The existence of a robust database of medical malpractice claim data can help with many of these steps. For example:

- The volume of data and specific data elements collected will influence the number of tiers that can be reasonably used and whether age can be used.
- Historical claim data can assist in assigning weights, dollar values, or ranges to tiers.

It is primarily the second item, assigning values, where a historical database can provide assistance. The task force does not suggest that historical claim data is the only source for informing these decisions, but strongly believes that a comprehensive database of historical claim data can provide invaluable assistance in the decision-making process. In addition, even if the ultimate decision were not to proceed with construction of a schedule for noneconomic damages, the existence of such a database would prove to be valuable to Washington State.

B. Legislation Needed to Collect Necessary Data

Currently, there is not a single state agency with the authority to collect comprehensive medical malpractice data. The Office of the Insurance Commissioner (OIC) has at least some authority to collect data from primary insurance companies. The Washington State Department of Health (DOH) has, or could be granted legislatively, the authority to collect claims data from the regulated health care providers and facilities.

Many self-insurers are reluctant to submit data to any state agency for a variety of reasons, citing the need to confidentiality as a primary reason. However, we understand that other state agencies, such as the Employment Security Department and the Department of Revenue, routinely collect data considered confidential, so precedent exists for collecting confidential data.

The OIC has recently collected ten years of data on medical malpractice claims from primary insurance companies, and plans to seek legislative authority to collect additional data. We understand that the OIC has encountered difficulties in collecting data, as the various companies do not collect the same data elements and, even when they do, they may collect data in different formats.

The OIC reports on medical malpractice claims can be found in Appendix C.

LEGISLATIVE DECISION POINTS

- Determine which agency or agencies should be assigned the responsibility and given the authority to collect data.
  - Instead of a state agency, a neutral third party could be used to collect, de-identify, and aggregate the data.
- Define entities that will be required to submit data to the selected state agency.
  - Possibilities include primary insurance companies, self-insurers, surplus lines insurance companies, and others.
- Define the procedure for collection data, either as a part of enabling legislation or through action by the agency or entity collecting data to define.
  - Define whether penalties will be exacted for failure to submit required data.
- Define protections to ensure confidentiality of data, both with respect to patients and the entities supplying data.

TASK FORCE RECOMMENDATIONS
1. The OIC is best suited to be the state agency tasked with collecting data. The DOH may also be an appropriate choice, particularly if the Legislature does not wish to grant the OIC authority to collect data from self-insurers and other entities not normally regulated by the OIC. 2. Data should be collected from as broad an array of entities as possible. However, care should be taken to avoid unnecessary duplication of effort between entities (e.g., a self-insurer and their excess insurance carrier). 3. The Legislature or a delegated body should work with the entity tasked with collecting data and the entities supplying data to define data collection procedures. 4. The Legislature or a delegated body should work with the entity tasked with collecting data and the entities supplying data to develop agreeable standards for protecting data confidentiality.

C. Definition of Data Elements to be Collected

It would be advantageous for the state to begin collecting a broad array of medical malpractice data to aid in addressing a variety of possible noneconomic damage scheduling models. Also, it would provide data that could be used by the state more broadly in analyzing trends in medical malpractice experience.

The main types of data that are typically considered for collection are broken down into the following three main categories:

- *Closed Claim Data:* Data on closed claims is probably the easiest data to obtain, as well as the most objective data available. With few exceptions, once closed, the dollar amounts associated with these claims do not change. However, it is also important to recognize a key disadvantage to using only closed claim data. Since there can be significant lag time between the reporting of a claim and the final closure of a claim, closed claim data can be very slow to react to changes in trends. Nevertheless, closed claim data represents an excellent starting point for analysis of medical malpractice experience.

- *Open Claim Data:* As mentioned above, a disadvantage of using only closed claim data is the potentially long lag time between reporting of a claim and the

final closing of a claim. Inclusion of data for open claims would provide more up-to-date information on current trends in medical malpractice claims. We note that for the purposes of creating a schedule of damages for noneconomic losses, it may not be appropriate to use open claim data. For example, if a precedential approach is chosen to determine values for a schedule, it may be more appropriate to use only data for closed claims. However, even in such circumstances, open claim data may be helpful in recognizing more quickly what, if any, changes to historical trends may be occurring.

- *Exposure Data*: Something that is often not addressed in studies of medical malpractice experience is the degree to which the volume and type of exposure is changing over time. While exposure issues may not directly relate to issues surrounding noneconomic damage schedules, we believe the state would find it useful to have such data at its disposal for a variety of analytical purposes.

As noted in the prior section, the OIC encountered difficulty collecting data from insurance companies. The various companies collect data in different formats, and it was difficult to develop a reporting format that each reporting entity could handle. This problem is likely to be exacerbated with the addition of self-insurers and other entities. It is also important to note that, particularly with open claim data, confidentiality is likely to be a critical issue for entities supplying data.

LEGISLATIVE DECISION POINTS

- Define the specific data elements that should be collected.
  - Determine whether only claim-related data should be collected, or whether exposure data should be collected as well.
  - Determine whether data should be collected for both closed claims and also for open claims.
  - Determine whether data from other states, if available, should be considered. Determine whether data for other types of tort claims should be considered.
- Define the manner in which the confidentiality of data will be protected, both with respect to patients and the entities supplying data.
- Determine whether data should be collected through legislatively authorized pilot projects.

TASK FORCE RECOMMENDATIONS

1. A broad range of data should be collected, including data for closed claims, open claims, and exposure data.

2. The Legislature or a delegated body should work with the entity tasked with collecting data and the entities supplying data to precisely define the specific data elements and develop agreeable standards for protecting data confidentiality. A pilot project involving a selection of insurance companies and self-insured companies may help identify specific problem areas that will need to be addressed.

3. The collected elements should include the following types of information:

   Claims Data

   - The date of the event that resulted in the claim
   - The date the claim was reported to the insuring entity, self-insurer, facility, or provider
   - The date of suit, if filed
   - The date the claim was closed
   - The county or counties in which the event that resulted in the claim occurred
   - The claimant's age and sex
   - The following information on the judgment or settlement:
     - Whether the claim was resolved due to a judgment, arbitration, or mediation
     - Whether the resolution occurred before or after trial
   - For claims that result in a verdict or judgment that itemizes damages:
     - Economic damages
     - Noneconomic damages
     - Allocated loss adjustment expenses (e.g., defense costs)
   - For claims that result in a verdict or judgment that does not itemize damages:
     - Total damages
     - Allocated loss adjustment expenses (e.g., defense costs)

- Expected future payments for:
  - Total damages
  - Allocated loss adjustment expenses (e.g., defense costs)
- For claims that resolve without judgment or settlement:
  - The reason for final disposition
- The reason for the medical malpractice claim:
  - This coding should use the same coding of reason for malpractice claims as those used for mandatory reporting to the national practitioner data bank.
- Classification of injury using the National Association of Insurance Commissioner's injury severity scale

Exposure Data

- For physicians and other healthcare providers:
  - Specialty
  - Number of years in practice
  - County of practice
  - Full-/part-time status
- For hospitals and other facilities:
  - Acute care patient days
  - Intensive care patient days
  - Physical rehabilitation patient days
  - Psychiatric care patient days
  - Number of births
  - Outpatient visits
- Emergency room visits

D. Supplemental data and studies discussion

Once data has been collected, analysis can take place to aid in the construction of a schedule. The data elements and sources identified above are intended to address the "precedential" approach for determining schedule values, discussed in the Mello-Studdert report. Depending on the ability to collect historical data, it may be some years before a sufficient volume of data is available. For some items, such as how damages are apportioned between economic and noneconomic damages, historical data will likely be very limited.

While the focus on data collections rightly belongs on Washington State specific data, there also may be value in examining what data is available from other states and for other types of tort claims. The data available for Washington State medical malpractice history alone may be insufficient to provide helpful guidance. Some examples of areas that other data could be helpful with are:

- Analyzing the split of total losses into economic and noneconomic damage portions
- Analyzing the relationship of losses between tiers
- Analyzing the spread of losses within tiers

In addition, the items identified in the above section will not by themselves be sufficient to fully address the scheduling options in the Mello-Studdert report. Following is a brief discussion of the different options they present, and the additional information that would be needed for each.

- **Quantitative Scale:** The data items and sources identified above would provide the necessary information for using the precedential approach to assigning values to the NAIC scale. If alternative scales were desired, that data would need to be added to the lists above.

- **Qualitative Scale:** The data items and sources above would not provide the information for this option. If such a scale were chosen, appropriate data items would need to be identified and added to the lists above. Then the data could be useful in assigning values to the chosen scale.

- **Health Utilities Index:** The data items and sources above would not provide the information for this option. If this option were chosen, it is likely special studies would be necessary to assign index values to historical claims. Once this was done, the historical data could be useful in assigning dollar values to different health utility loss levels.

- **Hedonic Damages:** The data items and sources above would not provide the information for this option. If this option were chosen, it is likely special studies would be necessary to assign lost pleasure of life values to historical claims. Once this was done, the historical data could be useful in assigning dollar values to different lost pleasure of life levels.

In addition to assisting with the construction of a schedule of damages, the data items we have identified should allow for a broad range of studies that can help shed light on emerging trends in medical malpractice claims. The OIC has begun performing an annual analysis of closed claim experience, which provides some insight into emerging trends. However, as noted by the OIC in their reports, they have a limited ability to gather data, so their reports provide an incomplete picture of the current state of medical malpractice claims in Washington.

LEGISLATIVE DECISION POINTS

- Determine whether special data studies should be conducted to provide supplemental information, including whether data from other states and other types of tort claims should be considered.
- After determining the most viable or preferable option for scheduling damages, determine whether precedential data should be used to determine the schedule parameters.
- Consider legislatively authorized pilot projects.
- Consider commissioning reports to provide analysis and recommendations based on the data collected and determine if such studies should be conducted by a state agency (e.g., OIC), or an independent consultant.

TASK FORCE RECOMMENDATIONS

1. Prior to development of a damages schedule, the Legislature should consider funding a retrospective closed claim study or detailed review to estimate the split between economic and noneconomic damages in cases closed with payment in Washington. It would be advantageous to also include a review of similar information that may already exist for other states.
2. The Legislature should authorize regular studies of medical malpractice experience in order to provide greater insight into trends in medical malpractice experience, and to regularly compile and review studies performed for other states.

VIII. REPORT OF PROCESS SUBCOMMITTEE

The Process Subcommittee has identified the following process issues that will need to be resolved should the Legislature decide to implement an advisory schedule of noneconomic damages. These issues have been divided into three major categories:

1. Necessary statutes
2. Construction of the advisory schedule
3. Development of jury instructions

A. Necessary Statutes

LEGISLATIVE DECISION POINTS

- The actual advisory schedule or guidelines should either be placed in statute (like the sentencing guidelines and child support schedule) or be published elsewhere pursuant to legislative authorization (like the Insurance Commissioner's mortality tables, per RCW 48.02.160).
- The guidelines will need to be drafted by some entity, such as a new panel or commission (e.g., Sentencing Guidelines Commission), or by the Legislature itself. If a separate commission is authorized, the Legislature should address some of the broader issues in the statute, such as specifying which bases for scheduling damages should be utilized.
- Determine the manner in which periodic revisions of the new guidelines will be undertaken.
  - By legislative action or separate panel or commission.
- Determine whether the statute should specify anything about what the jury should be told about the guidelines.
  - This may be sufficiently procedural in nature that it could be addressed in a court rule.
  - The details of drafting jury instructions could be left to the Washington Pattern Jury Instruction Committee.
- Define existing statutes that need to be amended in order to reflect the use of these advisory guidelines.

TASK FORCE RECOMMENDATIONS

1. The Legislature should identify the model or type of schedule that it believes can be the most rational, fair, and easy to use in the civil justice system and that will meet the underlying policy goals, then take steps to develop the model in detail.

2. After identifying the type of schedule the Legislature wishes to implement, it should establish a working group or panel to examine existing or theoretical scales that define injury tiers and associated values and to develop schedule details.

   a. Any work group should include both experts and consumers. The task force uniformly agreed that both lay and expert opinion and input are essential to creation of a credible and fair damages schedule.

   b. The Legislature should define the process to be used by a work group – does it take testimony, hold hearings, and the like? Given the complexity of that task, it is recommended there be some formal process for the panel to hear from experts, citizens, and those interested.

   c. Any schedule must be maintained through an ongoing process of evaluation and adjustments.

B. Construction of the Advisory Schedule

Data issues: The Data Subcommittee report addresses these issues.

Tiering and valuation issues: The Legislature will need to determine which of the available models of scheduling damages should be developed for further implementation. The level of detail the Legislature wishes to describe as far as tiering of injuries and valuation approaches is within its discretion. Some level of detail can be left to a panel or commission, should that be the policy choice of the Legislature.

TASK FORCE RECOMMENDATIONS
1. The Mello-Studdert report offers the most comprehensive, current analysis of the options available for scheduling noneconomic damages. It should be relied upon and serve as key guidance on policy choices.

C. Development of Jury Instructions

Considerations:

Drafting of instructions can be left to the Washington Pattern Jury Instruction Committee or addressed directly by the Legislature. The instructions will need to make clear that the guidelines are advisory. The jury will need to be instructed that they are not bound by the guidelines.

Policy decisions will need to be made as to how much jurors need to be told about the meaning of "advisory" or when they can or should deviate from the schedule. In addition to telling jurors that the guidelines are "advisory," the instruction could suggest or state the circumstances under which the jury would be justified in awarding an amount that is outside the guidelines. As the Mello-Studdert report notes, the term "advisory" admits of many different degrees. For example, quite different messages are conveyed with the following alternatives (ranging from least binding on jurors to most binding):

- "You are free to disregard the guideline range in making your decision."
- "You may use the guideline range as your starting point. You may award noneconomic damages that fall above or below the range depending on the evidence in the case."
- "If you believe that the evidence supports an amount of noneconomic damages that is above or below the guideline range, you may award such an amount."
- "You *should* use the guideline range as your starting point, but you may award noneconomic damages that fall above or below the range depending on the evidence in the case."
- "Under extraordinary circumstances, you may award noneconomic damages in an amount that is above or below the guideline range."

(If the Legislature weighs in on these particulars, it should be aware that the more directive this language is may have a bearing on *Sofie* issues, i.e., whether the guidelines intrude on the jury's deliberation process in a manner that violates the constitutional right to a jury trial.)

The Washington Pattern Jury Instruction Committee would likely take a considerable amount of time in drafting these instructions, given that nobody else in the country uses guidelines of this nature and there are no established instructions to use as a beginning point.

TASK FORCE RECOMMENDATIONS

1. Any schedule should be advisory and not prescriptive. The Legislature should define, or provide guidance, as to the meaning of "advisory" and how a schedule should be used by a jury. The schedule should also be piloted and evaluated as to its usefulness for juries and in reaching the legislative goals of predictability and proportionality. The schedule should not serve as a cap or ceiling on damages.

2. The Legislature should define the circumstances under which juries can or should deviate from a schedule, as necessary, given its advisory nature.

3. Drafting of jury instructions should be delegated to the Washington Pattern Jury Instruction Committee.

IX. CONCLUSION

The Task Force on Noneconomic Damages appreciates the opportunity to forward these observations and recommendations to the Legislature. The task force offers this report as a path forward to implement an advisory schedule for noneconomic damages, should the Legislature wish to continue discussion on these issues. While we have fully debated the advantages and disadvantages of such a damages schedule, we believe this report is an excellent summary of the issues that will need to be addressed and the options available to begin detailed development of an advisory schedule.

APPENDICES

Appendix A

Chapter 276, Laws of 2004, Section 118

(ENGROSSED SUBSTITUTE HOUSE BILL 2459)

Sec. 118. 2003 1st sp.s. c 25 s 128 (uncodified) is amended to read as follows:

FOR THE OFFICE OF FINANCIAL MANAGEMENT (in pertinent part)

General Fund-State Appropriation (FY 2005)…….. $12,860,000

The appropriations in this section are subject to the following conditions and limitations:

(4)(a) $75,000 of the general fund--state appropriation for fiscal year 2005 is provided solely for a task force on noneconomic damages. On or before October 31, 2005, the task force shall prepare a study and develop, for consideration by the legislature, a proposed plan for implementation of an advisory schedule of noneconomic damages in actions for injuries resulting from health care under chapter 7.70 RCW. Implementation of any proposed plan is contingent upon statutory authorization by the legislature.

(b) The task force shall develop a proposed plan for use of an advisory schedule of noneconomic damages, as defined in RCW 4.56.250, that will increase the predictability and proportionality of settlements and awards for noneconomic damages in actions for injuries resulting from health care. The task force shall consider:

(i) The information that can most appropriately be used to provide guidance to the trier of fact regarding noneconomic damage awards, giving consideration to past noneconomic damage awards for similar injuries, considering severity and duration of the injuries, and other factors deemed appropriate by the task force; past noneconomic damage awards for similar claims for damages; and such other information the task force finds appropriate;

(ii) The most appropriate format in which to present the information to the trier of fact; and

(iii) When and under what circumstances an advisory schedule should be utilized in alternative dispute resolution settings and presented to the trier of fact at trial.

(c) A proposed implementation plan shall include, at a minimum:

(i) The information developed under subsection (b) of this section;

(ii) Identification of statutory, regulatory, or court rule changes necessary to implement the advisory schedule, as well as forms or other

(ENGROSSED SUBSTITUTE HOUSE BILL 2459 cont.)

documents necessary to implement the schedule; and

(iii) Identification of the time required to implement an advisory schedule authorized by the legislature.

(d) The task force is composed of fourteen members, as follows: (i) One member from each of the two largest caucuses in the senate, to be appointed by the president of the senate, and one member from each of the two largest caucuses in the house of representatives, to be appointed by the speaker of the house of representatives; (ii) one health care ethicist; (iii) one economist; (iv) one actuary; (v) two attorneys with expertise or significant experience in medical malpractice actions, one representing the plaintiff's bar and one representing the insurance defense bar; (vi) two superior court judges; (vii) one representative of a hospital; (viii) one physician; (ix) one representative of a medical malpractice insurer; and (x) two consumers. The governor shall appoint the nonlegislative members of the task force and select a chair.

(e) Legislative members of the task force shall be reimbursed for travel expenses under RCW 44.04.120. Nonlegislative members of the task force shall be reimbursed for travel expenses as provided in RCW 43.03.050 and 43.03.060.

(f) The office of financial management shall provide support to the task force with the assistance of staff from the administrative office of the courts, the house of representatives office of program research, and senate committee services.

Appendix B

Composition and Members of the Task Force

Represented Interest	Name	Title/Business
Ethicist CHAIR	Patricia C. Kuszler, M.D., J.D.	Professor and Director of Multidisciplinary Initiatives University of Washington School of Law Seattle, WA
Economist	Paul Sommers	Professor, Institute of Public Service and Albers School of Business Seattle University Seattle, WA
Actuary	David Kennerud, FCAS, MAAA	Milliman Inc. Seattle, WA
Attorney (2)	Reed Schifferman	Stritmatter Kessler Whelan Withey Colluccio Seattle, WA
	Mary Spillane	Williams, Kastner & Gibbs Seattle, WA
Judge (2)	Craig Matheson	Superior Court Judge Benton County Superior Court Kennewick, WA
	Bruce Hilyer	Superior Court Judge King County Superior Court Seattle, WA
Hospital	Mark Judy	Chief Executive Officer Valley General Hospital Monroe, WA
Physician	Ronald C. Dobson, M.D. F.A.C.E.P.	Director, Emergency Services Swedish Hospital Seattle, WA
Insurer	Gary L. Morse, J.D.	Senior Vice President and General Counsel Physicians Insurance Seattle, WA
Consumers (2)	Judy Guenther	Chehalis, WA
	Carol James	Kirkland, WA
Senators (2)	Adam Kline	Washington State Senate Olympia, WA
	Dale E. Brandland	Washington State Senate Olympia, WA
Representatives (2)	Lynn Kessler	House of Representatives Olympia, WA
	Skip Priest	House of Representatives Olympia, WA

Appendix C

OFFICE OF THE INSURANCE COMMISSIONER

OIC Web Page: www.insurance.wa.gov

First and Second Annual Medical Malpractice Insurance Reports:

First Annual (2004) – issued March 1, 2005

http://www.insurance.wa.gov/news/dynamic/newsreleasedetail.asp?offset=30&rcdNum=437

Second Annual (2005) – issued October 4, 2005

http://www.insurance.wa.gov/news/dynamic/printNews.asp?rcdNum=470

Appendix C

OIC News Release

Mike Kreidler
Washington Insurance
Commissioner

News Release

For More Information, Contact:
Public Affairs: (360) 725-7055
Office of Insurance Commissioner

Web Page: www.insurance.wa.gov

3/1/2005

Medical malpractice insurance report released

TUMWATER, Wash. — The Office of the Insurance Commissioner (OIC) released the results of a survey today that analyzes trends in medical malpractice claims for a 10-year period.

The top five medical malpractice insurers, which comprise over 90 percent of the regulated market for physicians and surgeons, were asked to supply specific closed claim information to the OIC for a 10-year period beginning July 1, 1994 and ending June 30, 2004. The survey, or data call, collected information on compensation for injuries and the related expenses of defending physicians. Surplus lines carriers and self-insurers that provide malpractice coverage for physicians, such as health care facilities and medical cooperatives, are not regulated by the OIC and did not participate in the data call.

The participating insurers closed 10,073 medical malpractice claims over the 10-year period.

Among the key findings:

- The number of medical malpractice claims increased at an annual rate of 4.9 percent.
- The average amount of compensation per claim increased at an annual rate of 4.1 percent.
- Twenty-seven percent of the claims were closed with an indemnity (compensation) payment to a claimant.
- Sixty-one percent of the claims were closed with defense costs, such as attorney or expert witness fees.
- 3,248 claims were closed without any compensation payments or defense costs.
- Two percent of the total paid claims resulted in compensation payments of over $1 million.

- Claims with defense costs increased at an annual rate of 5.3 percent.
- Defense costs increased at an annual rate of 6.4 percent.
- Sixty-seven percent of the claims that incurred defense costs resulted in no compensation payment.
- Of the 10,073 claims, 50 were decided by a jury in favor of the plaintiff.

"Currently, no claims or settlement reporting requirements exist for medical malpractice insurers," said Insurance Commissioner Mike Kreidler. "It's clear from our experience in conducting this limited survey that we need more reliable claims and settlement information from all of the parties providing medical malpractice coverage. With more accurate and consistent information, we'd be better equipped to assess the health of the market and could make public policy based on facts rather than anecdotes."

The complete malpractice survey results can be found at www.insurance.wa.gov.

Appendix C

OIC News Release

Mike Kreidler
Washington Insurance
Commissioner

News Release

For More Information, Contact:
Public Affairs: (360) 725-7055
Office of Insurance Commissioner

Web Page: www.insurance.wa.gov

10/4/2005

Second Annual Medical Malpractice Insurance Report Released

Olympia, Wash. — The second annual medical malpractice insurance survey was released today by Insurance Commissioner Mike Kreidler. The survey, or data call, analyzes trends in medical malpractice claims for a 10-year period beginning July 1, 1995 and ending June 30, 2005.

In last year's data call, the top five medical malpractice insurers comprising over 90 percent of the regulated market for physicians and surgeons were asked to supply specific closed claim information to the Insurance Commissioner's Office for a 10-year period. This year's report includes the most recent year of data on compensation for injuries and the related expenses of defending physicians. Surplus lines carriers and self-insurers that provide malpractice coverage for physicians are not regulated by the Insurance Commissioner and did not participate in the data call.

The participating insurers closed 10,212 medical malpractice claims over the 10-year period. Among the key findings:

- The number of paid medical malpractice claims increased at an annual rate of 3.5 percent.
- The average amount of compensation per claim increased at an annual rate of 3.2 percent.
- Twenty-seven percent of the claims were closed with an indemnity (compensation) payment to a claimant.
- 3,178 claims were closed without any compensation payments or defense costs.
- Less than two percent of the total paid claims resulted in compensation
- Of the 10,212 closed claims, 45 claims – or less than one percent – were decided by a jury and resulted in a payment to a plaintiff.

- Sixty-two percent of the claims were closed with defense costs, such as attorney or expert witness fees.
- Sixty-seven percent of the claims that incurred defense costs resulted in no compensation payment.
- The number of claims with defense costs increased at an annual rate of 3.5 percent.
- Average defense costs increased at an annual rate of 7 percent.

“The results of this survey suggest that medical malpractice claim payments have stabilized over the last few years, which should be good news for physicians and surgeons – at least in the near term,” said Commissioner Kreidler.

“However, we still lack the authority to require specific information that could shine a light on the real trouble areas in the medical malpractice market,” he added. “Now is the time to develop clear and consistent requirements for reporting claim and settlement information. It’s time to move from policy decisions based on anecdotes to decisions based on data that can really solve problems. I intend to push for legislation again in 2006 that would give my office the authority we need to better assess the health of the medical malpractice market.”

The study limitations include:

- Use of historical paid claim data cannot predict future trends in medical malpractice insurance rates.
- Participating insurers represent a limited share of the medical malpractice insurance market. Current laws do not allow the Commissioner to obtain data from surplus lines insurers (which sell insurance to high risk providers or specialties) or self-insurers (such as health care facilities and medical cooperatives).
- Claims information by type of specialty is unreliable due to differences in the way insurers collect data.

The complete malpractice survey results can be found at www.insurance.wa.gov/special/wic/MedMalDataCallOct2005.pdf.

Appendix D

U.S. GENERAL ACCOUNTING OFFICE (GAO): MEDICAL MALPRACTICE INSURANCE – MULTIPLE FACTORS HAVE CONTRIBUTED TO PREMIUM RATE INCREASE (GAO-04-128T): TESTIMONY

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 2:00 p.m. EDT
Wednesday, October 1, 2003

MEDICAL MALPRACTICE INSURANCE

Multiple Factors Have Contributed to Premium Rate Increases

Statement of

Richard J. Hillman, Director
Financial Markets and Community Investment

Kathryn G. Allen, Director
Health Care - Medicaid and Private Health Insurance Issues

GAO-04-128T

Appendix D

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our work examining recent increases in premium rates for medical malpractice insurance and the effect of certain tort reform laws on premium growth. Since the late 1990s, medical malpractice insurance rates have increased dramatically for physicians in certain specialties in some states. These increases have heightened concerns that some health care providers may no longer be able to afford malpractice insurance, resulting in shuttered practices and reducing access to high-risk services. In response, some states have recently revised or have considered revising their tort laws, sometimes placing caps on damages in malpractice lawsuits, and the Congress is considering similar legislation.[1]

Our testimony today will focus on the factors that have contributed to the recent increases in insurance premium rates and the differences in rates among states that have passed varying levels of tort reform laws. Our findings are based on two reports we recently issued addressing various aspects of the recent increases in medical malpractice insurance rates.[2] Recognizing that the medical malpractice market varies considerably across states, as part of these reviews we judgmentally selected a number of states and conducted more in-depth reviews in each of those states.[3] Both our analyses and our conclusions are based in part on data and information we received from the states we visited and in part on analyses of national data from various sources.

In summary, multiple factors have contributed to the recent increases in medical malpractice premium rates in the states we analyzed. First, since 1998, insurers' losses on medical malpractice claims have increased rapidly in some states. We found that the increased losses appeared to be the greatest contributor to increased premium rates, but a lack of

[1]For example, on March 13, 2003, the House of Representatives passed the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (H.R. 5); on June 27, 2003, a similar version (S.11) of this bill was introduced in the Senate.

[2]U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, D.C.: June 27, 2003), and *Medical Malpractice: Implications of Rising Premiums on Access to Health* Care, GAO-03-836, (Washington, D.C.: Aug. 8, 2003).

[3]The states we visited were, for GAO-03-702, California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas; and for GAO-03-836, California, Colorado, Florida, Minnesota, Mississippi, Montana, Nevada, Pennsylvania, and West Virginia.

comprehensive data at the national and state levels on insurers' medical malpractice claims and the associated losses prevented us from fully analyzing the composition and causes of those losses. For example, data that would have allowed us to analyze claim severity at the insurer level on a state-by-state basis or to determine how losses were broken down between economic and noneconomic damages were unavailable. Second, from 1998 through 2001, medical malpractice insurers experienced decreases in their investment income[4] as interest rates fell on the bonds that generally make up around 80 percent of these insurers' investment portfolios. While almost no medical malpractice insurers experienced net losses on their investment portfolios over this period, a decrease in investment income meant that income from insurance premiums had to cover a larger share of costs. Third, during the 1990s, insurers competed vigorously for medical malpractice business, and several factors, including high investment returns, permitted them to offer prices that, in hindsight, did not completely cover the ultimate losses some insurers experienced on that business. As a result, some companies became insolvent or voluntarily left the market, reducing the downward competitive pressure on premium rates that had existed through the 1990s. Fourth, beginning in 2001, reinsurance rates for medical malpractice insurers also increased more rapidly than they had in the past, raising insurers' overall costs.[5] In combination, all of these factors have contributed to the movement of the medical malpractice insurance market through hard and soft phases—similar to the cycles experienced by the property-casualty insurance market as a whole—and premium rates have fluctuated with each phase.[6] Cycles in the medical malpractice market tend to be more extreme than in other insurance markets because of the longer period of time required to resolve medical malpractice claims, and factors such as changes in investment income and reduced competition can exacerbate the fluctuations.

[4]In general, state insurance regulators require insurers to reduce their requested premium rates in line with expected investment income. That is, the higher the expected income from investments, the more premium rates must be lowered.

[5]Reinsurance is insurance for insurance companies. They routinely use reinsurance as a way to spread the risk associated with the insurance they sell.

[6]Some industry officials have characterized hard markets as periods of rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and the withdrawal of insurers from certain markets. Soft markets are characterized by relatively flat or slow rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers.

In an attempt to constrain increases in medical malpractice premium rates, states have adopted various tort reform measures.[7] Of particular focus recently have been tort reform measures that include placing caps on monetary awards for noneconomic damages—such as pain and suffering—that may be paid to plaintiffs in a malpractice lawsuit. Available data, while somewhat limited in scope, indicate that rates of premium growth have been slower on average in states that have enacted tort reforms with noneconomic damage caps than in states with more limited reforms. Premium rates reported for three specialties—general surgery, internal medicine, and obstetrics and gynecology—were relatively stable on average in most states from 1996 through the late 1990s and then began to rise, but more slowly, in states with certain noneconomic damage caps. For example, from 2001 through 2002 average premium rates rose approximately 10 percent in the four states with noneconomic damage caps of $250,000 but approximately 29 percent in states with more limited tort reforms. As we have discussed, premium rate increases are influenced by multiple factors, and our analyses did not allow us to determine the extent to which the differences premium rate increases at the state level could be attributed to tort reform laws or to other factors.

Overall, adequate data do not exist that would allow us and others to provide definitive answers to important questions about the market for medical malpractice insurance, including an explanation of the causes of rising losses over time and the precise effect of tort reforms on premium rates. This lack of data is due, in part, to the nature of regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency. However, comprehensive data on individual awards actually paid in malpractice cases are also lacking, as are data on conditions in the health care sector that might affect the incidence and severity of medical malpractice suits.

Background

Nearly all health care providers buy medical malpractice insurance to protect themselves from potential claims that could otherwise cause financial distress or even bankruptcy. Under a malpractice insurance

[7]Medical malpractice lawsuits are generally based on principles of tort law. A tort is a wrongful act or omission by an individual that causes harm to another individual. To reduce malpractice claims payments and insurance premiums and for other reasons, some have advocated changes to tort laws, such as placing caps on the amount of damages or limits on the amount of attorney fees that may be paid under a malpractice lawsuit. These changes are collectively referred to as "tort reforms."

contract, the insurer agrees to investigate claims, to provide legal representation for the health care provider, and to accept financial responsibility for payment of any claims up to a specified monetary level during an established time period. The insurer provides this coverage in return for a fee—the medical malpractice premium. The most common physician policies provide coverage limits of $1 million per incident and $3 million per year.

Since 1999, medical malpractice premium rates for physicians in some states have increased dramatically. Among the states that we analyzed, however, we found that both the extent of the increases and the premium levels varied greatly not only from state to state but across medical specialties and even among areas within states. For example, the largest writer of medical malpractice insurance in Florida increased premium rates for general surgeons in Dade County by approximately 75 percent from 1999 to 2002, while the largest insurer in Minnesota increased premium rates for the same specialty by about 2 percent over the same period. The resulting 2002 premium rate quoted by the insurer in Florida was $174,300 a year, more than 17 times the $10,140 premium rate quoted by the insurer in Minnesota. In addition, the Florida insurer quoted a rate of $89,000 a year for the same coverage for general surgeons outside Dade County, or about half the rate it quoted inside Dade County.

In order to improve the affordability and availability of malpractice insurance and to reduce pressure on providers who could be faced with heavy liabilities, all states have adopted varying types of tort reform legislation. Tort reforms are generally intended to limit the number of malpractice claims or the size of payments in an effort to reduce malpractice costs and insurance premiums. Among the various types of tort reform measures adopted by states during the past three decades, caps on noneconomic damage awards have been the focus of particular interest. They have also been an issue of some debate.[8] Noneconomic

[8]Other tort reform measures adopted by states include placing caps on economic and punitive damages; abolishing the "collateral source rule" that prevents a defendant from introducing evidence that the plaintiff's losses and expenses have been paid in part by other parties such as health insurers or prevents damage awards from being reduced by the amount of any compensation plaintiffs receive from third parties; abolishing "joint and several liability" to ensure that damages are recovered from defendants in proportion to each defendant's degree of responsibility, not each defendant's ability to pay; placing limits on fees charged by plaintiffs' lawyers; imposing stricter statutes of limitations that shorten the time injured parties have to file a claim in court; and establishing pretrial screening panels to evaluate the merits of claims before proceeding to trial.

damages are awarded to plaintiffs in a medical malpractice suit to compensate for harm that is not easily quantifiable, such as pain and suffering. Proponents of caps believe that such limits can help reduce the rate of growth in malpractice insurance premiums by, among other things, helping to prevent excessive awards and overcompensation and by ensuring more consistency in jury verdicts. In contrast, opponents of these caps believe that factors other than award amounts affect malpractice insurance premiums and that caps can result in undercompensation for severely injured persons. Congress is currently considering federal tort reform legislation that includes several of the measures states have adopted, including placing caps on noneconomic and punitive damages.

Multiple Factors Have Contributed to the Increases in Medical Malpractice Premium Rates

Among the factors that have contributed to increases in medical malpractice premium rates are insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates. We found that increased losses appeared to be the greatest contributor to premium rate increases, but a lack of comprehensive data at the national and state levels on claims and associated losses prevented us from fully analyzing the composition and causes of those losses at the insurer level.

Rising Paid Losses Increase Insurers' Expectations of Required Premiums

In the long term the price insurers need to charge for their premiums is the sum of actual paid losses and expenses, plus a reasonable return in a competitive market.[9] Paid losses, one of the two ways that insurers define losses, are the cash payments insurers make in a given year, irrespective of the year in which the claim giving rise to the payments occurred or were reported. Most payments made in any given year are for claims that were reported in previous years. Medical malpractice insurers saw these losses begin to rise rapidly in 1998.

Short-term changes in rates—from year-to-year—are affected by incurred losses, which, in contrast to paid losses, reflect an insurer's expectations of the amounts it will have to pay on claims reported in that year and any adjustments, whether up or down, to the amounts the company expects to

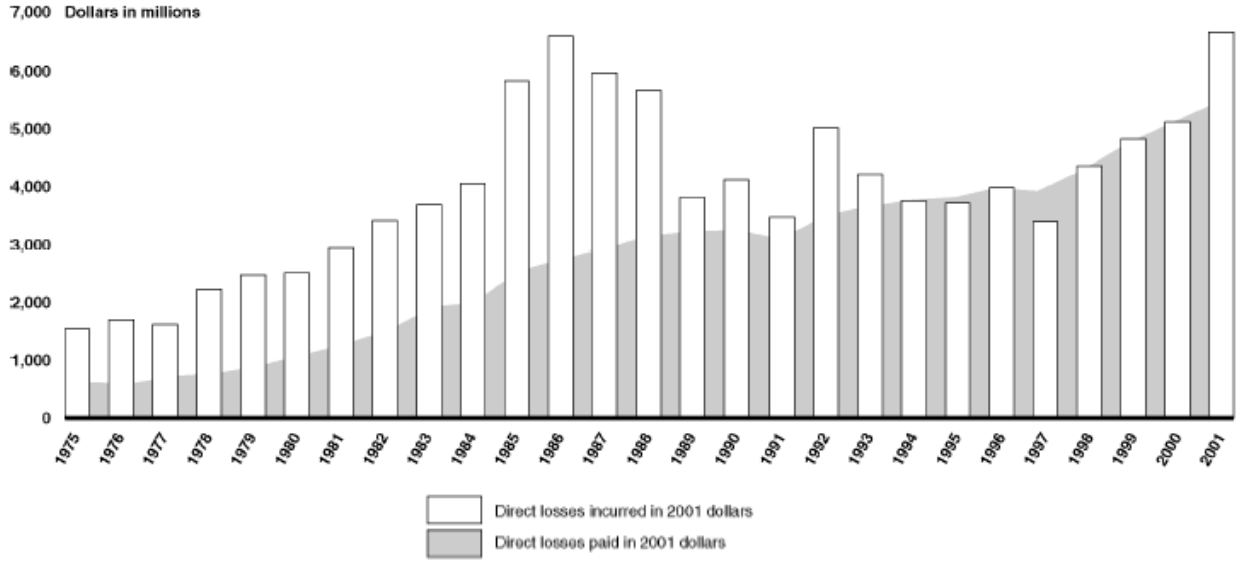
[9] We identified several factors suggesting that this market was not anticompetitive. That is, these factors suggested that insurers in this market were not charging premium rates that were inconsistent with expected losses.

pay out on claims from previous years that are still pending.[10] Incurred losses are the largest component of medical malpractice insurers' costs. For the 15 largest medical malpractice insurers in 2001—whose combined market share nationally was approximately 64.3 percent—incurred losses (including both payments to plaintiffs to resolve claims and the costs associated with defending claims) accounted for around 78 percent, on average, of the insurers' total expenses.

Figure 1 helps illustrate the relationship between incurred and paid losses and between short-term and long-term determinants of changes in premium rates. The figure shows paid and incurred losses for the national medical malpractice market from 1975 to 2001, adjusted for inflation. After adjusting for inflation, we found that the average annual increase in paid losses from 1988 to 1997 was approximately 3.0 percent but that this rate rose to 8.2 percent from 1998 through 2001. Inflation-adjusted incurred losses decreased by an average annual rate of 3.7 percent from 1988 to 1997 but increased by 18.7 percent from 1998 to 2001.

[10] That is, as more information becomes available on a particular claim, the insurer may find that the original estimate was too high or too low and must make an adjustment. If the original estimate was too high, the adjustment will decrease incurred losses, but if the original estimate was too low, the adjustment will increase them.

Figure 1. Inflation-Adjusted Paid and Incurred Losses for the National Medical Malpractice Insurance Market, 1975–2001 (Using the CPI, in 2001 dollars)



Source: GAO analysis of A.M. Best data.

The recent increases in both paid and incurred losses among our seven sample states[11] varied considerably, with some states experiencing significantly higher increases than others. From 1998 to 2001, for example, paid losses in Pennsylvania and Mississippi increased by approximately 70.9 and 142.1 percent, respectively, while paid losses in Minnesota and California increased by approximately 8.7 percent and 38.7 percent, respectively.

According to actuaries and insurers contacted with, increased losses affect premium rates in several ways. First, increasing levels of paid losses on claims reported in current or previous years can increase insurers'

[11]For analysis of the medical malpractice insurance market, we visited seven states—California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas. We selected these states because they contained a mix of characteristics, including the extent of any recently reported increases in premium rates, status as a "crisis" state according to the American Medical Association, presence of caps on noneconomic damages, state population, and aggregate loss ratios for medical malpractice insurers within the state.

estimates of what they expect to pay out on future claims. Insurers then raise premium rates to match their expectations. In addition, large losses on even one or a few individual claims can make it harder for insurers to predict the amount they might have to pay on future claims. Some insurers and actuaries we spoke with told us that when losses on claims are hard to predict, insurers will generally adopt more conservative expectations regarding losses—that is, they will assume losses will be toward the higher end of a predicted range of losses. Further, large losses on individual claims can raise plaintiffs' expectations for damages on similar claims, ultimately resulting in higher paid losses for both claims that are settled and those that go to trial. As described above, this tendency in turn can lead to higher expectations of future losses and thus to higher premium rates. Finally, an increase in the percentage of claims on which insurers must make payments can also increase the amount that insurers expect to pay on each policy, resulting in higher premium rates. That is, insurers expecting to pay out money on a high percentage of claims may charge more for all policies in order to cover the expected increases.

Declining Investment Income Has Affected Premiums

State laws restrict medical malpractice insurers to conservative investments, primarily bonds. In 2001, the 15 largest writers of medical malpractice insurance in the United States[12] invested, on average, around 79 percent of their investment assets in bonds, usually some combination of U.S. Treasury, municipal, and corporate bonds. While the performance of some bonds has surpassed that of the stock market as a whole since 2000, annual yields on selected bonds have decreased steadily since 2000. We analyzed the average investment returns of the 15 largest medical malpractice insurers in 2001 and found that the average return fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002. However, none of the companies experienced a net loss on investments at least through 2001, the most recent year for which such data were available. Additionally, almost no medical malpractice insurers overall experienced net investment losses from 1997 to 2001. We roughly estimated that, all else held constant, the 1.6 percent decrease in average investment return from 2000 to 2002 would have resulted in an increase in premium rates of approximately 7.2 percent over the same period.

[12]As reported by A.M. Best. These insurers included a combination of commercial companies and non-profit physician-owned insurers. Some of these insurers sold more than one line of insurance, and changes in returns on investments might not be reflected equally in the premium rates of each of those lines.

Medical malpractice insurers are required by state insurance regulations to reflect expected investment income in their premium rates. That is, insurers are required to reduce their premium rates to consider the income they expect to earn on their investments. As a result, when insurers expect their returns on investments to be high, as returns were during most of the 1990s, premium rates can remain relatively low because investment income will cover a larger share of losses on claims. Conversely, when insurers expect their returns on investments to be lower—as returns have been since around 2000—premium rates rise in order to cover a larger share of losses on claims. During periods of relatively high investment income, insurers can lose money on the underwriting portion of their business but still make a profit. Although losses from medical malpractice claims and the associated expenses may exceed premium income, income from investments can still allow the insurer to operate profitably. Insurers are not allowed to increase premium rates to compensate for lower-than-expected returns on past investments but must consider only prospective income from investments.

Downward Pressure on Premium Rates Has Decreased as Profitability Has Declined

Since 1999, the profitability of the medical malpractice insurance market as a whole has declined—even with increasing premium rates—causing some large insurers to pull out of the market in some states or even nationwide. With fewer insurers offering this insurance, there is less price competition and thus less downward pressure on premium rates. According to some industry and regulatory officials in our seven sample states, premium rates were kept from rising between 1992 and 1998, in part, by price competition, even though losses generally did rise. In some cases, premium rates actually fell. For example, during this period premium rates for obstetricians and gynecologists covered by the largest insurer in Florida—a state where these physicians are currently seeing rapid premium rate increases—actually decreased by approximately 3.1 percent. Some industry participants we spoke with told us that, in hindsight, premium rates charged by some insurers during this period might have been lower than they should have been. As a result, the premium increases that began in 1998 were actually bringing premiums more in line with insurers' losses on claims. Some industry participants also pointed out that the pricing inadequacies of the 1990s were to some extent masked by insurers' adjustments to expected losses on claims reported during the late 1980s and by their high investment income.

According to industry participants and observers, as the competitive pressures on premium rates decreased, insurers apparently were able to raise premium rates to a level more in line with their expected losses

relatively quickly and easily. That is, absent the competitive pressure that may have caused insurers to keep premium rates lower, insurers were able to raise premium rates to match their loss expectations.

Reinsurance Premium Rates Have Increased

The rising cost of reinsurance was an additional reason for the recent increases in medical malpractice premium rates in our seven sample states. Insurers in general purchase reinsurance to protect themselves against large unpredictable losses. Medical malpractice insurers, particularly smaller insurers, depend heavily on reinsurance because of the potentially high payouts on medical malpractice claims.

The Medical Malpractice Market Moves through Hard and Soft Insurance Cycles

The medical malpractice insurance market appears to roughly follow the same "hard" and "soft" cycles as the overall property-casualty insurance market. However, the cycles tend to be more volatile—that is, the swings are more extreme—because of the length of time involved in resolving medical malpractice claims and the volatility of the claims themselves. Hard markets are generally characterized by rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and often by the departure of some insurers from the market. In the medical malpractice market, some market observers have characterized the period from approximately 1998 to the present as a hard market. (Previous hard markets occurred during the mid-1970s and mid-1980s.) Soft markets are characterized by slowly rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers. The medical malpractice market from 1990 to 1998 has been characterized as a soft market.

States with Tort Reforms that Include Certain Noneconomic Damage Caps Had Lower Recent Growth in Malpractice Insurance Premium Rates

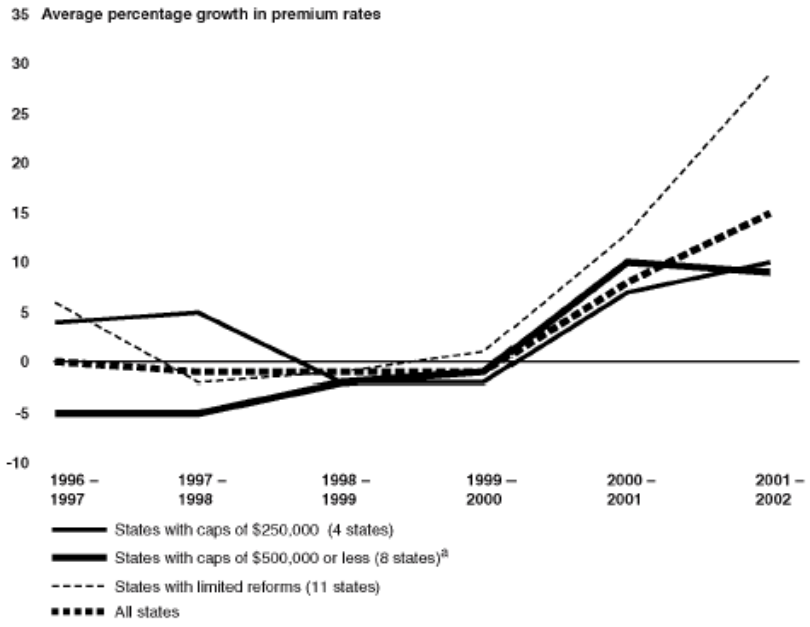
In order to constrain the rate of growth in malpractice insurance premiums, states have adopted various tort reform measures, some of which include placing caps on monetary awards for noneconomic damages. Premium rates reported for the physician specialties of general surgery, internal medicine, and obstetrics and gynecology—the only specialties for which data were available—were relatively stable on average in most states from the mid- to late 1990s and then began to rise, but more slowly among states with certain noneconomic damage caps.[13] From 1996 to 2000, average premium rates for all states changed little, as did average premium rates for states with certain caps on noneconomic damages and states with limited reforms, increasing or decreasing annually by no more than about 5 percentage points on average.[14] After 2000, premium rates began to rise across most states on average, but more slowly among states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared with 29 percent in the states with limited reforms (see fig. 2).[15]

[13]Premium rate data are reported by the Medical Liability Monitor (MLM). MLM is a private research organization that annually surveys professional liability insurance carriers in 50 states and the District of Columbia to obtain their base premium rates for the specialties of internal medicine, general surgery, and OB/GYN.

[14]We focused our analysis on those states with noneconomic damage caps as a key tort reform because such caps are included in proposed federal tort reform legislation and because published research generally finds these caps to have a greater impact on medical malpractice premium rates and claims payments than some other tort reform measures.

[15]Because research suggests that any impact of tort reforms on premiums can be expected to follow the implementation of the reforms by at least 1 year, we grouped states into their respective categories based on reforms in place as of 1995 and reviewed premium rate data for the period 1996 through 2002. Four states had noneconomic damage caps of $250,000 (California, Colorado, Montana, Utah), 8 states had noneconomic damage caps of $500,000 or less (Hawaii, Louisiana, Massachusetts, Michigan, Missouri, North Dakota, South Dakota, and Wisconsin), and 11 states had limited reforms, defined as no damage caps of any type or collateral source reforms (Arkansas, District of Columbia, Kentucky, Mississippi, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, Vermont, and Wyoming). We categorized the remaining 28 states as "other reforms" for analysis purposes, indicating they had a noneconomic or total damage cap greater than $500,000, any punitive damage cap, or any collateral source rule reform.

Figure 2: Premium Rates for Three Physician Specialties Rose After 2000, but to a Lesser Extent in States with Noneconomic Damage Caps



Source: MLM.

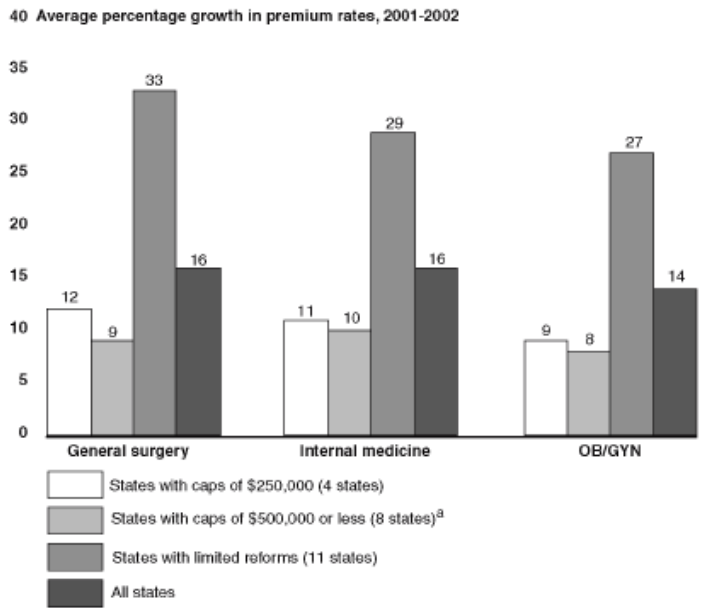
Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

The recent increases in premium rates were also lower for each reported physician specialty in the states with these noneconomic damage caps. From 2001 to 2002, the average rates of premium growth for each specialty in the states with these noneconomic damage caps were consistently lower than the growth rates in the limited reform states (see fig. 3).

Figure 3: Recent Premium Growth Was Lower for Three Physician Specialties in States with Noneconomic Damage Caps



Source: MLM.

Note: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

Other studies have found a relationship between direct tort reforms that include noneconomic damage caps and lower rates of growth in premiums.[16] For example, in a recent analysis of malpractice premiums in states with and without certain medical malpractice tort limitations, the Congressional Budget Office (CBO) estimated that certain caps on damage awards in combination with other elements of proposed federal tort reform legislation would effectively reduce malpractice premiums on average by 25 to 30 percent over the 10-year period from 2004 through

[16]Direct reforms are limits on amounts that can be recovered in a malpractice action including caps on noneconomic or total damages, abolition of punitive damages, collateral source rule reforms, and abolition of mandatory prejudgment interest.

2013.[17] A 1997 study that assessed physician-reported malpractice premiums from 1984 through 1993 found that direct reforms, including caps on damage awards, lowered the growth in malpractice premiums within 3 years of their enactment by approximately 8 percent.[18]

Differences in malpractice premiums across states are influenced by several factors other than noneconomic damage caps. First, the manner in which damage caps are administered can influence the ability of the cap to restrain claims and thus premium costs. Some states permit injured parties to collect damages only up to the specified level of the cap regardless of the number of defendants, while other states permit injured parties to collect the full cap amount from each defendant named in a suit. Malpractice insurers informed us that imposing a separate cap on amounts recovered from each of several defendants increases total claims payouts, which can hinder the effectiveness of the cap in constraining premium growth. Second, tort reforms unrelated to caps can also affect premium and claims costs. For example, California tort reform measures include not only a $250,000 cap but also allow other collateral sources to be considered when determining how much an insurer must pay in damages and allow periodic payment of damages rather than requiring payment in a lump sum, among other measures. Malpractice insurers told us that these provisions, in addition to the cap, have helped to constrain premium growth in that state. In contrast, while Minnesota has no caps on damages, it has experienced relatively low growth in premium rates. Trial attorneys say this development is the result of mandatory prescreening requirements that have reduced claim costs, and thus premiums, by preventing some meritless claims from going to trial. Third, state laws and regulations unrelated to tort reform, such as premium rate regulations, vary widely and can influence premium rates. Finally, insurers' premium pricing decisions are affected by their losses on medical malpractice claims and income from investments, and other market conditions as we previously discussed. Because of these various factors, we could not determine the extent to which differences in premium rates across states were attributable solely to damage caps or also to these additional factors.

[17]U.S. Congress, Congressional Budget Office, *Cost Estimate: H.R. 5 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 2003).

[18]Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *Law and Contemporary Problems*, vol. 670, no. 1 (1997): 81-106.

Comprehensive Data on the Composition and Causes of Increased Losses Were Lacking

A lack of comprehensive data at the national and state levels on medical malpractice claims filed against various insurers and the losses associated with these claims prevented us from answering important questions about the market for medical malpractice insurance, including exactly why losses are rising over time and, as just noted, the extent to which tort reforms may have affected premium rates. For example, comprehensive data that would have allowed us to fully analyze the frequency and severity of medical malpractice claims at the insurer level on a state-by-state basis did not exist. As a result, we could not determine the extent to which increased losses were the result of an increased number of claims, larger claims, or some combination of both. In addition, data that would have allowed us to analyze how losses were divided between settlements and trial verdicts or between economic and noneconomic damages were not available. Insurers do not submit information to the National Association of Insurance Commissioners on the portion of losses paid as part of a settlement and the portion paid as the result of a trial verdict, and no other comprehensive source of such information exists. As a result, we could not analyze the effect of certain tort reforms on noneconomic losses, and thus on premium rates.

While more complete data on the insurance industry would help provide better answers to questions about how the medical malpractice insurance market is working, other data are equally important to analyzing the underlying causes of rising malpractice losses and associated costs. These data relate to factors outside the insurance industry, such as policies, practices, and outcomes in both the medical and legal arenas. However, collecting and analyzing such data were beyond the scope of our reviews.

Conclusions

As we have discussed, multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in our sample states. However, we found that losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run. And while losses for the entire industry have shown a persistent upward trend, insurers' loss experiences have varied dramatically across our sample states, resulting in wide variations in premium rates. In addition, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market.

We have also seen that the severe premium rate increases of the last few years followed a period of relatively stable premium rates in the early 1990s, when insurers had excess reserves and sufficient investment

income to keep rates low. But by the mid- to-late 1990s, as insurers exhausted their excess reserves and investment income fell below expectations, the profitability of malpractice insurance had declined. Regulators found that some insurers were insolvent, and in 2002 one of the two largest medical malpractice insurers, which had been selling insurance in almost every state, stopped selling medical malpractice insurance altogether. Other companies reduced the amount of insurance they sold and consolidated their markets, resulting in large rate increases in many states. It remains to be seen whether these increases will be found to have exceeded those necessary to pay for future claims losses, as they did in the 1980s.

Tort reforms, particularly those that limit noneconomic damages, have frequently been proposed as a means of controlling increases in medical malpractice insurance premium rates. While the limited available data indicate that premium rates have grown more slowly in states with tort reform laws that include certain caps on noneconomic damages, a lack of comprehensive data prevented us from determining the exact effects of these laws on premium rates. Tort reforms and other actions that reduce insurer losses below what they otherwise would have been should ultimately slow the increase in premium rates, if all else holds constant. But several years may have to pass before insurers can quantify and evaluate the effect of the laws on losses from malpractice claims and before an effect on premium rates is seen.

More time is also needed before we can determine whether the medical malpractice insurance market will continue its cycle from the current hard to a soft phase and thus are better able to understand the part the cycle itself has played in the rise in premium rates. However, any evaluation of the effect of tort reforms and cyclical behavior on premium rates requires sufficient data. In order for Congress and others to better understand conditions in the medical malpractice market and the effects of the actions that have already been or will be taken, better data need to be collected, including more comprehensive data on insurers' losses, jury verdicts in malpractice cases, and conditions in the medical industry that might affect the incidence and severity of medical malpractice suits. Without question, the absence of such data complicates the ability of insurers, regulators, and the Congress to understand current market conditions and to formulate effective, sustainable solutions.

Mr. Chairman, this concludes our prepared statement. We would be pleased to answer any questions you or other members of the subcommittee may have at this time.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Richard J. Hillman at (202) 512-8678 or Kathryn G. Allen at (202) 512-7059. Individuals from our Financial Markets and Community Investment team making key contributions to this testimony include Lawrence Cluff, Patrick Ward, Melvin Thomas, and Andrew Nelson. Individuals from our Health Care team making key contributions to this testimony include Randy DiRosa and Corey Houchins-Witt.

Appendix D

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Appendix D

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Appendix E

ARTICLE FROM *THE JOURNAL OF LAW, MEDICINE & ETHICS*
Volume 33.3 – Fall 2005

"Managing Malpractice Crises," Michelle M. Mello, pages 414-415.

PREFACE

Managing Malpractice Crises

Michelle M. Mello

As this Symposium issue goes to press, reports are trickling in from the insurance industry that the first medical malpractice "crisis" of the twenty-first century may be winding down. After five years of distress, liability insurers are reporting gradual progress toward profitability on the heels of repeated premium increases, liability-limiting tort reforms, improved investment returns, and an overall stabilization of most sectors of the insurance market. For health care providers and their insurers, the pain of the malpractice crisis may shortly begin to recede. But if history offers any lessons, it is that the pain stems from a chronic, not an acute, disease. This is the third malpractice crisis in thirty years, and there is every reason to suspect there will be a fourth. It is timely, while the wounds of this crisis are healing but still fresh, to consider why the disease is so difficult to manage. The articles in this Symposium provide a number of insights from experience in the U.S. and abroad.

One Man's Policy Window is Another Man's Crisis

Academic researchers and others who have long decried the performance of the medical liability system and advocated far-reaching reform heralded the recent crisis as a "teachable moment," or "policy window," to use John Kingdon's term. Policymakers were ready to listen. Policy summits drew large crowds of legislative staffers and reporters struggling to understand what was happening and how we might get out of it.

However, it quickly became apparent that despite legislators' commitment to the issue, making good policy in the middle of a crisis is extremely difficult. Powerful interest groups brought enormous pressures to bear, and demands to "do something – now!" in many cases drowned out thoughtful deliberation and weighing of options. The result has been a fairly limited and conventional set of policy responses, as the article by Carly Kelly describes. Fiona Tito Wheatland explains that the Australian experience has been strikingly similar: an atmosphere of crisis contributed to the adoption of reforms that were not well supported by the available data about the causes of the problem.

In the U.S., no group has called more loudly for action than physicians. The past four years have seen work stoppages, emergency department closures, and demonstrations in the streets by high-risk specialists straining under the weight of double-digit insurance premium increases. As Allen Kachalia and his colleagues colorfully detail, physicians' responses to this malpractice crisis have been unprecedented in their variety, ingenuity, and aggressiveness. Although the effects of the crisis on access to care have dominated the policy debate, it seems clear that the earliest casualty of the malpractice crisis was the physician-patient relationship, as distrust and defensive behavior grew.

For physicians, the crisis is not just a business matter. A 2002 promotional brochure from a physician-owned insurance company read, "THIS IS PERSONAL. For every physician, every surgeon, every nurse, every hospital administrator, from routine checkups to emergency procedures, LIABILITY KNOWS NO BOUNDS." A button distributed by the Pennsylvania Orthopedic Society proclaimed Pennsylvania specialty physicians to be an "ENDANGERED SPECIES," suggests that trial lawyers were destroying doctors' ecosystem. Indeed, physicians had much to complain about. But the urgency of their claims and the rapid distillation to a single-minded focus on caps on non-economic damages as the only acceptable policy response has forced other ideas off the table. The question now is whether the policy window will remain open for consideration of reform alternatives as the insurance market cools. In their article, Randy Bovbjerg and Larry Tancredi compellingly establish the reasons it is important that it does.

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Nevermind the Solution, What's the Problem?

Fights over the basic facts of the problem have been at the center of the malpractice policy debate. What is a "malpractice crisis?" Are we in one? If so, why, and can we get out of it without policy action?

From an academic's perspective, if there is one silver lining to the recent problems, it is the plethora of important new scholarly articles sorting through the evidence on these points. In this Symposium issue, Tom Baker contributes a careful analysis of the insights from the Harvard Medical Practice Study, which continues to be the most-cited study in policy debates about the performance of the malpractice system. He highlights the ways in which the study has been used and abused by those seeking to advance a reform agenda. Fiona Tito Wheatland tackles the thicket of factual issues around the drivers of Australia's medical liability crisis; echoes of the debates over the causes of the U.S. crisis. Finally, Kay Wheat's exposition of the controversy over clinical negligence in Britain and Dean Harris and Chien-Chang Wu's analysis of the Chinese situation raise and answer the more fundamental question of what a "medical malpractice crisis" is and how we recognize one when we see it. In particular, has all the focus on the frequency and costs of malpractice litigation diverted attention from a more profound "malpractice crisis" – the prevalence of medical error and the lack of strong regulation from within or outside the health care industry to address it?

Fights over the facts of the malpractice crisis have been a significant barrier to achieving consensus about policy solutions. It is perhaps a waste of ink to say that legislative responses to a policy problem ought to bear some relationship to the actual causes of the problem, but this seems to have gotten lost in many legislatures. At root, the gap between empirical evidence concerning causation and proposed solutions may have less to do with a disregard for the facts than with the disagreement about what the facts are. In the absence of evidentiary clarity, legislators may pick the solution that is urged by the loudest voices, or the one that is most familiar.

As we look back on the crisis with, if not 20/20 hindsight, at least a much greater visual acuity than we had two or three years ago, we can see that no interest group's genesis story was wholly correct. Rising claims costs, insurance market cycles, greater public and attorney awareness of the prevalence of medical error, ill-advised insurer business decisions, and idiosyncratic legal and insurance arrangements probably all played a role in leading us into crisis. Such complexity is not easily communicated, nor does it suggest clear and realizable solutions. But perhaps in the next crisis, we can at least agree that both the problem and the solution are likely to be multifaceted.

The Oil and Vinegar Problem

Much has been made of the fact that this malpractice crisis, unlike previous ones, coincides with the rise of a vigorous patient safety movement. It was hoped that the confluence of these two forces would inspire creative legislation that tackled both rationalization of medical injury compensation and reduction of medical error. Unfortunately, tort reform and patient safety have proved to be like oil and vinegar: you can put them in the same jar, but getting them to intermix requires that you shake things up quite a bit. Legislators thus far have not been willing or able to do this.

The past three years have seen the passage of combination tort reform and patient safety bills in many state legislatures. Without exception, these bills have simply bundled the two kinds of reforms together rather than truly integrating them. For example, venue reform might be paired with requirements to disclose adverse events to patients; caps might be accompanied by a new statewide reporting system for adverse events. These bills pay homage to the need for increased safety but not to the fact that the tort system and liability-limiting reforms do little to advance, and indeed may impede, that goal. Fiona Tito Wheatland, Kay Wheat, and Dean Harris and Chien-Chang Wu note that other countries face similar problems. Randy Bovbjerg and Larry Tancredi have a good deal to say about the shortcomings of the current legislative approach and the need for a more fundamental restructuring of medical injury compensation.

The Appeal of Simple Fixes

In summary, a range of forces have pushed legislatures during this malpractice crisis toward conventional solutions such as damages caps. The urgent need for cost control has obscured the roles that more nebulous principles such as equity, fairness to patients, access to reliable justice, and improvement of healthcare safety should play in reform. Political pressures have been paramount; as Carly Kelly intimates, also influential may have been concerns about the constitutionality of far-reaching reforms and a desire to stick to measures that have previously passed muster in the courts.

The hope that a simple treatment for this malpractice crisis will be found is a profoundly human – and probably deeply mistaken – sentiment. In contemplating policy responses to this malpractice crisis and the next, we would do well to heed the words of Albert Einstein: "Everything should be made as simple as possible, but not simpler."

Appendix F

ARTICLE FROM *THE JOURNAL OF LAW, MEDICINE & ETHICS*

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"Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" are a Key Improvement," Randall R. Bovbjerg and Laurence R. Tancredi, pages 478-509.

Liability Reform Should Make Patients Safer: "Avoidable Classes of Events" are a Key Improvement

Randall R. Bovbjerg and Laurence R. Tancredi

Too many patients are injured in the course of medical care. This truth is as distressing now as it was four years ago when it began an article in this journal's last similar symposium.[1] Many or most injuries seem preventable. Yet today's systems of care and of oversight of care too often fail to prevent them, despite generations of increasing legal intervention. Few injuries are litigated, even fewer addressed through medical peer review or state disciplinary authorities.[2] The Institute of Medicine's (IOM's) landmark report *To Err Is Human*[3] brought patient safety to national attention when released in late 1999. Half a decade later, significant reduction of injury remains a distant prospect, despite some apparent progress.[4]

Slow progress is usually attributed to shortfalls in leadership and in financing.[5] This article addresses a different and underappreciated problem – the patient-safety movement's failure to promote better compensation for legitimately injured patients along with better injury prevention. Reformers understandably shy away from courtroom-driven compensation because they seek to replace the legal culture of blame with a safety culture of problem solving. Alas, the public face of patient safety thus has not been friendly to injured patients: reformers seek to shield safety information from legal discovery, block any use of caregiver apologies in litigation, and cut patient compensation through tort reform.[6] These policy positions have allowed pro-tort advocates to garner much public support by arguing that safety comes from raising legal obligations, not lowering them.[7]

Far too much energy has gone into such attempts to cut back or cordon off injury compensation from safety improvement. A better stance is to seek out positive alternatives – making it easier for patients to recognize injuries and quickly receive reasonable compensation, making results more consistent across cases, and making the entire process less threatening to caregivers and more congruent with patient safety efforts. Providing for just compensation through a just process should help win social acceptance for emphasizing patient safety over today's ineffective blame-finding. This arti-

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cle discusses four reforms that combine compensation and safety objectives, focusing most on the useful roles that "avoidable classes of event" lists may play.

The Need for Reform

Medical injury is a significant policy problem. Injuries due to medical care are rare as a percentage of patient encounters, but large in numbers. If medical injury were a disease, as David Shapiro has noted, it would have its own Institute at NIH.[8] The high incidence of medical injury has long been documented,[9] yet medical injury captured national attention only after *To Err Is Human* and the ensuing blitz of journalism, legislative hearings, and administrative reaction.[10] The scope of injuries goes far beyond the numbers of cases addressed through any existing system of oversight and remediation.

The Promise and Problems of Liability

Tort law admirably promises to compensate negligent injuries, so as to deter negligence and prevent injury, while providing justice to litigants.[11] Tort's practical shortcomings for medicine have long been recognized[12] and merit only brief mention. Compensation is poor because few injured patients sue and fewer collect, payouts are slow and somewhat erratic, and overhead costs are very high. Deterrence is the main rationale for tort, as the duty to compensate theoretically targets negligence; prevention and compensation of injuries are two sides of the same coin. Yet injury prevention is piecemeal rather than systematic.[13] The system resolves individual disputes better than often appreciated.[14]

However, standards of fault and causality are vague and inconsistent, experts routinely disagree, results are unpredictable, deterrence signals are confounded by liability insurance, and high rates of preventable error and injury persist.[15] Individual justice is offered in the form of procedural fairness for litigants – that is, full opportunity to make their best case. But system justice is poor: the legal process omits most injuries, resolves disputes slowly and somewhat haphazardly, and pays out hugely variable amounts in similar cases-hardly attributes of a fair injury-resolution system.[16] Some litigants have been found to be satisfied,[17] but others are very critical of the legal process.[18] These deep-seated, severe, and ongoing problems with tort are much stronger policy grounds for reform than are periodic and impermanent liability insurance crises. The early-2000s crisis, for example, appears to be receding as of early 2005.[19]

The Promise and Problems of Patient Safety

The patient safety movement is the most hopeful development to date in injury policy. Patient safety methods address the central rationale of liability-keeping patients safe. Moreover, safety methods offer much more timely, direct, and thoroughgoing improvements in care than distant liability courtrooms can ever muster. Safety mechanisms directly effect improvements, whereas liability merely wields a big stick, after the fact. Successes of patient safety pioneers in numerous settings suggest that it is feasible to avoid many medical injuries through better monitoring and feedback into improved clinical and administrative processes.[20]

Yet patient safety is hard to implement fully in the shadow of liability. Candid reporting and investigation of problems are needed to learn how to improve safety, both within and across medical settings, and many support disclosure of adverse events to patients.[21] However, "no one loves a whistle blower,"[22] and fear of litigation tends to drive information underground.[23] According to quality leader Donald Berwick, "the tort system poisons the openness and honesty that are preconditions to safety improvement."[24] Patient safety advocates, most prominently the IOM, have thus sought to create a new blame-free culture of safety, insulated from the finger-pointing side of the liability coin.

The patient safety movement is the most hopeful development to date in injury policy. Yet patient safety is hard to implement fully in the shadow of liability.

To limit caregivers' legal disincentives to report problems for safety investigation, *To Err Is Human* endorsed new legal confidentiality protections for most patient safety information, so that it would not be discoverable or admissible in legal actions. Today, safety reformers' top legislative priority is to implement this suggestion to keep safety investigations secret from liability-compensation process.[25] Unfortunately, patient safety reformers have not focused on compensation. That mainly leaves patients reliant on the conventional liability system that reformers find so counterproductive. In a parallel development, reformers also seek to shelter any apologies or expressions of sympathy made by a practitioner from any use in litigation.[26]

One committee report for the IOM and a white paper of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have called for some form of fundamental liability reform,[27] as have researchers[28] and some new commentators.[29] Yet, especially during

liability crisis, the top priority for medical reformers has always been tort reform to limit the existing system of liability,[30] not creating a better system. Even those seeking a better system often give the tort reform agenda higher priority.

The safety-reform movement has thus positioned itself to favor internal openness, largely surrounded by an external wall to shut out injured patients and their lawyers. This is an understandable posture given the current legal system, but morally questionable. It is especially unseemly because all of the patient safety movement's publicity about medical errors has led public opinion to favor more legal sanctions against physicians, not less blaming.[31]

To their credit, many patient-safety supporters also promote disclosure by hospitals of certain patient injuries, and surveys show some progress in implementing processes for doing so.[32] Yet disclosure remains essentially voluntary and seems very likely to fall short, especially if disclosers face unlimited tort liability.[33] *To Err Is Human* flirted with the idea that compensation based on adversarial litigation and fault should be replaced by a system of non-fault-based, non-judicial compensation, but the IOM committee sidestepped taking a position.[34] If one is to take seriously the book's urgent representations that a culture of blame is inimical to patient safety, then some serious legal reform seems a prerequisite to progress.

To Err Is Human also had the misfortune to arrive just before the first malpractice insurance crisis in fifteen years. Concerns over finding and affording liability insurance in an era of limited medical fees has understandably tended to preoccupy practitioners and medical leaders and has probably also heightened provider fears of lawsuit.[35] Legal fears and the fiscal stress on providers has slowed progress in patient safety.[36] Another impediment is the lack of consistent motivation to reduce injuries. Harms are easy to hide from people other than the caregivers directly involved, and safety savings largely accrue to payers and patients, not to the medical institutions that make improvements. Also to their credit, the Joint Commission and the Leapfrog Group of businesses are promoting patient safety through private regulation and incentives,[37] although they are hard put to monitor progress.

A Shared Problem

A bedrock principle of managing for improvement is that if you can't measure it, you can't manage it.[38] A significant problem for both liability and patient safety is that medical injury is not an objective, measurable phenomenon like low birth-weight or death under anesthesia. Instead, it is a subjective judgment about care and its aftermath, reached using implicit standards and often only after expending considerable resources and time-whether through root-cause analysis, peer review, licensure hearing, or jury trial.[39] Very often, reasonable people disagree.[40] A better metric is badly needed.[41]

Why Compensation Matters

In today's injury and liability debates, medical safety reformers should encourage medical tort reformers to give increased safety at least equal billing with reduced legal remedies.[42] For the future, more fundamental improvement in approaches to compensation is important, both in its own right and because of its relation to safety.

The current neglect of injury compensation is not benign but harmful in several ways: First, it alienates many patient advocates who should be natural supporters of patient safety. Not all patient advocates sound just like plaintiffs' attorneys. One fine new book of advocacy, *The Wall of Silence*, eloquently supports safety and learning from injuries-but vehemently opposes tort reforms that reduce injured patients' remedies.[43] Most of the public sympathizes with injured patients and perceives that liability is important,[44] and safety reformers should do more to support help for injured individuals.

Second, shortchanging patient compensation cedes the moral high ground to opponents who produce uncompensated victims before legislative committees and eventually before judges in test cases on the validity of reforms. Patient safety has a good case that as a statistical matter, it can do more to prevent injury than does the liability system.[45] Safety advocates could also argue that every injured patient produced is more evidence of the failures of the current legal system to deter injury. However, ability to save "statistical lives" does not weigh heavily with juries who must decide whether and how much to compensate flesh-and-blood individual claimants.[46]

Third, ignoring compensation forgoes the helpful stimulus to safety that could be created by having unsafe providers pay more than safe ones. Safety reformers appreciate the value of the fiscal carrots of government grants or higher health plan reimbursement, but they undervalue the fiscal stick of having to pay for injuries. Improving deterrence through compensation assumes, however, that responsibility can be more appropriately determined than it has been in liability courtrooms.

Finally, patient-safety reformers should heed a cautionary note about the future of liability: the level of claiming today is low relative to the estimated level of injuries. Both standards of care and levels of claiming could readily rise as claimants, judges, and juries come to recognize the improved capabilities of patient-safety mechanisms to prevent injury.[47] Tort-imposed respon-

sibilities are not fixed, but rather constantly evolving, with new duties and new standards of care. Meeting those responsibilities is not like running the hurdles but like the pole vault – they keep raising the bar. New capabilities and, especially, new written rules are a major source of liability standards.[48] Better capabilities in patient safety, new standards like those of the Leapfrog Group and new process requirements like those of the JCAHO for conducting root cause analyses – all these could help support claims that injury resulted from failure to meet a safety standard or to implement a recommendation from a prior safety analysis.[49]

Patient-safety reformers should heed a cautionary note about the future of liability: the level of claiming today is low relative to the estimated level of injuries.

The nightmare scenario for medical defendants is that patient safety will help lawyers transform medical institutional liability into something more like corporate products liability, with lawsuits based on performance in entire classes of care, seeking discovery about all similar prior cases, and vastly increasing the number of injuries litigated.[50] This scenario represents the worst case; it is also possible that better injury prevention will reduce the incidence of injuries and hence of claiming.[51] Still, things could get much worse from a defense perspective, and medical and safety leaders should work to improve compensation before tort law developments do so in their own way.

Moving Reform Beyond the Conventional Debate

Despite the urgent need for improved safety, medical reformers mainly seek conventional tort reforms like caps on awards.[52] Such restrictions reduce liability payouts – especially to seriously injured people[53] – and the cost of providers' insurance.[54] However, they leave in place the same legal system about which providers have long complained. Conventional cutbacks in claimants' legal privileges do nothing to promote disclosure[55] or patient safety[56] and do little to make compensation or justice fairer.[57] Beyond tort limitations, the other main medical injury reform sought is federal legislation to keep safety analyses confidential, lest better information allow more people to sue and further deter even internal acknowledgment of injuries.[58] Treating patients as adversaries and elevating secrecy to national policy is a very unfortunate byproduct of mistrust of the legal system.

A more appealing fundamental goal of reform is to make patients better off, safer when they undergo medical treatment and more reliably compensated if things go wrong.[59] Today's litigation-based liability system is underperforming, but the reform battle is missing that entirely. The plaintiffs' lawyers want to maintain or expand current rights to litigate, while the doctors want to keep tort process, too, just with lower payouts. Amazingly, doctors often argue fiercely that the current system is broken, that it causes defensive medicine, that it does not help patients – but then imply that things will be just fine if only litigation has caps.

The biggest problem is preventable injury, but the big battle is over whether to impose caps. This is a very narrow debate in the short run. In the long run, caps seem unlikely to be sustained if they are perceived as being unfair takeaways. Judges and jurors will likely find ways to circumvent such caps, and eventually legislators will vote them out.[60] A better system would focus on preventing injury and making payments fairer, faster, less costly to deliver, more predictable, and more congruent with patient-safety efforts. Perhaps interest in more fundamental change will grow if political gridlock continues over federal tort reform or if appreciation spreads that tort reform does not banish all dispiriting effects of liability.[61]

Better Reform: Fairer Compensation with More Patient Safety

Medical injury reform should be friendly to injured patients and to patient safety analysis alike. It is important to address the two key goals together: (a) making compensation more readily available and distributing it more fairly and (b) promoting patient safety.[62] The most thoroughgoing approach is to reintegrate accountability for injury prevention with accountability for compensating patients with preventable injuries. To the extent feasible, both forms of accountability should apply at the level of medical institutions, which have the systems capable of managing safety and preventing injuries, that is, hospitals, large physician group practices, and integrated delivery systems.[63] The reform vision is to create a better performing prevention/compensation system, not merely to contract or expand the current system, as today's battling physicians and plaintiffs' attorneys would do.

The balance of this article presents four alternatives that could increase fairness and promote both compensation and safety:[64] (i) voluntarily increased disclosure of injuries by caregivers within the existing tort system; (ii) encouraging disclosure by allowing potential defendants who make an "early offer" of injury compensation to pay only limited damages; (iii) total re-

placement of tort with a more accessible, administrative system of compensation; and (iv) using expert, advance listings of "avoidable classes of events" (ACEs) as the basis for compensation.

ACE listings are a key tool for improving compensation and safety, either as the centerpiece of reform or as a way to make other reforms work better. ACEs can shortcut the current need of injured people to "blame and claim," reduce caregivers' traditional incentives to remain silent about adverse events, routinize the resolution of injuries once discovered, and make the entire process more consistent in application.

Broad Disclosure and Compensation Under Today's Tort System

More "transparent" disclosure of injuries to patients and their families would combine compensation and safety goals, on a voluntary basis, with no need for any legislative or contractual reform. Disclosure "surfaces" many new problems for patient safety analysis that have traditionally been hidden.[65] Disclosure improves compensation when it includes settlement offers, which it may not. Full disclosure with compensation would constitute a marked change from traditional practices of both caregivers and claims managers, who were traditionally advised not to discuss any potential case with anyone but their liability insurer or attorney. However, disclosure appears to have significant support among commentators, patient safety leaders, and regulators, if not yet among practitioners.[66]

Most commentators seem to favor disclosure as a principle of moral obligation,[67] and some see it as good medical practice for enhancing patient-provider trust.[68] The American Medical Association (AMA) has for a decade recognized a form of disclosure of injuries as an ethical duty. This duty is part of a general stricture to "at all times deal honestly and openly with patients," telling them "all the facts necessary to ensure understanding of what has occurred," with the goal that they be "able to make informed decisions regarding future medical care."[69] Many commentators have noted that fear of liability compounds traditional reluctance to discuss errors or problems,[70] even though the AMA provision specifies that "[c]oncern regarding legal liability... should not affect the physician's honesty with a patient." Similarly, the JCAHO starting in 2001 called for hospitals to inform patients of "outcomes of care, including unanticipated outcomes."[71]

Neither the AMA nor JCAHO specifies just what information or conclusions a disclosure should disclose, in particular whether a physician or hospital should acknowledge error or legal responsibility, much less offer compensation.[72] Patients clearly value disclosure more than physicians do.[73] Physicians often say they would "be very careful about how I phrase my statements,"[74] and medical groups, along with others, have promoted legislation to assure that any apologies or "benevolent gestures" they make after an injury are not admissible as evidence of liability, although candor about fault typically remains admissible.[75]

Some observers favor disclosure as a practical risk management approach.[76] As yet, it is unclear whether disclosing is costly because it alerts patients to their right to sue or, instead, affordable because patients treated right are more grateful than vengeful. Many anecdotes cite informed patients who did not sue or who accepted moderate settlements, but contrary accounts also exist.[77] Patient surveys have had similarly mixed findings.[78] As to actual experience, several studies of litigants have found that non-disclosure was one factor predisposing them to sue.[79] But a broad literature review found only a single published study of the converse, that is, the effect of disclosures on propensity to sue.[80] That article described the success of full disclosure at a Veteran's Hospital, including notice of the right to seek compensation; claims rose slightly but costs dropped significantly because cases were easier and cheaper to resolve.[81]

JCAHO and others see disclosure as a helpful component of a culture of openness about problems that supports patient safety analysis and improvements.[82] There are some indications that hospitals are complying with JCAHO's directive to create disclosure standards and processes.[83] Yet the extent of actual disclosures is unclear, both as to frequency and as to amount of information and compensation. Information disclosure alone seems unlikely to reduce litigiousness for very costly injuries like many newborn cases. Here, substantial recompense seems likely to be needed to forestall suit, yet even here enhanced trust might facilitate early settlements, allow more structured awards and periodic payouts that can benefit both sides, and avoid the legal and emotional costs of protracted disputes. Still, some commentators and many providers seem to fear that many forms of disclosure will simply facilitate lawsuits.[84] Moreover, responsible defendants who disclose adverse events and pay compensation will bear costs that their secretive competitors do not – a bad outcome for social policy. Accordingly, stronger rewards for disclosers merit consideration.

Encouragement of Disclosure and Compensation Through "Early Offer" Reform

One way to reward disclosures is to limit damages when defendants quickly offer to help those they have injured. This "early offer" approach would allow providers who promptly disclose injuries and promise compen-

sation to avoid liability claims for full tort-style damages.[85] An offer would have to be made within 120 days of an adverse event, and it would have to promise to pay all future economic losses when incurred, net of receipts from other insurance and not including any allowance for non-pecuniary losses like "pain and suffering."[86] Uncertainty about future damages is sidestepped by making compensation payable as losses accrue, without having to guess about the future. Patients could still reject an offer and sue, but not for nonpecuniary losses. Lawsuits like today's for non-monetary damages would be possible only where the early offer involved a case of egregious misconduct, proven by the higher standard of clear and convincing evidence. Changing damages law in this mandatory way requires legislation, although voluntary disclosures with early offers of compensation could well be attractive to patients and foreclose lawsuits, as discussed above.

This model has major advantages. It is easy to implement because it requires so little change in law and settlement process. It bars no one from recovery, indeed encourages early compensation when injured patients really need help – much faster than litigation. It offers a clear *quid pro quo* for the curtailment of tort remedies and pain and suffering damages. Defendants are encouraged to make more offers because they can only receive the benefit of offering by acting quickly, before providers can know for sure whether an offeree would otherwise sue. Patients are motivated to accept because the compensation is reasonable; it comes without the need for long, uncertain and expensive litigation, including high attorneys' fees; and it protects against changes in future circumstances, unlike the "lump sum" payouts of conventional litigation. Early-offer settlements presuppose prompt disclosure. Indeed, the plan's author explains, an early-offers statute could require a health care provider after settlement to meet with patients and fully discuss the circumstances surrounding the adverse result. The plan thus promotes "understanding, cooperation and swift compensation rather than contentious, hostile and dilatory proceedings."[87]

There are also shortcomings. Champions of full damages (for winning claimants) can argue that early offer coerces patients by taking away accustomed legal remedies. Further, the proposal relies on voluntary provider acknowledgement of responsibility, and providers are not guaranteed to make more offers than now. Defendants might try to "game" the reform by making offers only to badly injured people believed to be litigious. Moreover, the system might work too well, in that the large number of cases not now dealt with would have to be paid for. This makes defense interests uneasy. Additionally, early offer reform would leave tort in place, so legal fears would continue as well. Early offer's creation of ongoing responsibility to pay net future losses also creates new risk for defendants akin to selling health and disability coverage; this is a cost of protecting defendants against runaway verdicts and claimants against outliving a tort award.

Finally, until recently, the model had little political support. However, in 2002 the Bush administration praised it as "a new set of balanced incentives to encourage doctors to make offers, quickly after an injury, to compensate the patient for economic loss, and for patients to accept." The administration promised to promote demonstrations of its effectiveness, including for care provided by federal programs.[88] In 2003, an IOM committee endorsed a different form of experimentation as well.[89] In 2004, a limited federal demonstration of a much-modified version was announced for certain federal care.[90]

Compensation by Administrative Agency

The best known non-tort compensation method is an administrative compensation system that completely replaces tort.[91] Such systems simplify determinations of responsibility for paying compensation, limit damage allowances, especially for non-monetary damages, and avoid adversary judicial process. They are thus designed to cover more cases, faster, more efficiently, and more predictably than tort – so as to improve compensation. They can also generate more injury information than tort, rely more on experience rating, and build in more technical expertise – all expected to improve safety, as Workers Compensation has done.[92]

Social reformers and students of medical liability have long promoted at least experimentation with alternatives to judicial rules and process.[93] Such alternatives are often called "no fault," a name that misleadingly connotes reduced accountability.[94] To the contrary, thoroughgoing administrative compensation would likely improve accountability for both compensation and safety, relative to today's underperforming liability processes.

Existing Examples

Two versions already exist in U.S. health care.[95]

(a) The National Childhood Vaccine Injury Act of 1986 created a federal compensation program covering injuries from children's' vaccinations.[96] The law responded to concerns that open-ended tort liability was driving too many pharmaceutical manufacturers out of the vaccine business.[97] The program departed from fault as the basis of eligibility and created a new mechanism to simplify determinations, without a new agency: Claimants are automatically compensated if their injury is one of the recognized side effects listed in

the Vaccine Injury Table (shown on the program web page). Otherwise, a claimant must specifically prove that a vaccine caused their adverse condition or significantly aggravated a pre existing condition – without regard to fault. Claims must be made within 24 months of a death or 36 months of an injury. Allowable compensation includes up to $250,000 for death or, for injuries, all past and future otherwise unreimbursed medical expenses, custodial and nursing home care, loss of earned income, and up to $250,000 for pain and suffering. Reasonable attorneys' fees and costs are reimbursable for any claims brought in good faith, regardless of outcome. Any disputes are resolved before a federal court special master, and decisions are appealable. Claimants who are rejected or who reject the compensation may sue, but only in federal court.

Administrators believe that their program has stabilized the vaccine market, encouraged safer vaccines, and provided a more efficient and less adversarial alternative. Outside analysts largely agree.[98] One analysis, however, found results on pertussis vaccine claims inconsistent with epidemiological knowledge.[99] The program has lately faced numerous claims for autism from Thimerosal, of which only a few have been resolved, all by dismissal.[100]

(b) Two states have enacted administrative compensation for certain severe newborn injuries, Virginia in 1987 and Florida in 1988.[101] The laws sought to remove expensive and unpredictable "bad baby" cases from the courts, replacing tort with faster, less costly administrative resolution using non-fault-based standards. Claims for other childbirth related injury remained in court.[102] Both programs narrowly limited eligibility but provided broad benefits. Eligibility is limited to infants born live with severe, birth-related neurological injury due to oxygen deprivation or mechanical injury. Benefits are meant to meet all monetary needs, including special housing and transportation, net of other sources of compensation. Determinations of eligibility are made administratively and benefits are paid out as expenses accrue; payments are secondary to all other available sources of compensation.

A comprehensive evaluation of eight years of experience[103] found that the new programs kept obstetrical liability coverage available and reduced premiums. Other positive findings included that administrative costs (overhead) were very low, only 10.3% of average payouts. Tort cost five times more, 46.9%, mainly because of attorneys' fees. Administrative compensation to families was very similar to comparable tort cases. Parental satisfaction was also very similar under the two systems. Fewer than expected claims were filed, however, particularly for cerebral palsy. This prevented the unaffordable cost overruns predicted by some opponents of reform, but kept the programs too small to conduct patient safety analysis or to implement any loss-prevention mechanisms. Such improvements would need a larger base of information and fiscal support.

Administrative claims resolution was found to be very fast once claims were filed, but pre-filing delay was the same as under tort because claimants used lawyers to decide whether to claim in court or the administrative agency. Claimants also reported that their physicians had not disclosed the existence of the program, that they learned about the compensation only from their attorneys – which suggests that defendants continue to fear the legal system. Administratively, the Florida program in particular suffered "leakage" of cases to tort because of the survival of judicial remedies and judicial interpretation of administrative authority, a finding confirmed by subsequent scholarship.[104]

A subsequent legislative evaluation in Virginia was also positive about performance, although concerned about adequacy of future funding.[105] These two programs are a proven alternative or adjunct to conventional tort reform. They merit much more attention from policy makers than they have received.

One major concern about this administrative compensation model is its political feasibility. Tort reform has proven a hard sell in many states and nationally, and this model contemplates far greater changes to the status quo, albeit ones that provide a clear *quid quo pro* for injured patients.

Broader Implementation, Starting with Demonstrations

The operations of these non-fault programs provide concrete evidence that it is feasible to operate administrative compensation for medical injuries. These particular systems were not targeted at injury prevention-not in their definitions of compensable event, in the scope of their operations, or in their disconnect between funding obligations and incidence of problems. There have long been policy proposals to move to a non-judicial, non-fault-based system that does target prevention.[106]

Typically, broader versions of this model define the compensable event as any preventable injury, a standard that would include more cases than negligent injury, and eligibility for compensation would be determined case by case by expert administrators. Administration would resemble that of Workers Compensation, but unlike workers comp, the system would cover only preventable injuries. Proposals would also typically limit awards: in place of uncertain but possibly large awards for some claimants, they offer faster, more predictable, but lesser amounts. Proponents also typically urge that hospitals or other institutions be the locus of responsibility. Such enterprise responsibility is congruent with systems safety precepts and similar to the workers compensation model.[107]

This reform model relies on both public and private action. Public functions include setting rules on eligibility, benefits and the like; adjudicating claims not settled privately; and possibly overseeing an insurance pool for smaller entities. Private functions include bearing risk, by self-insurance or experience-rated coverage for larger entities; negotiating settlements; and running risk reduction/injury prevention programs.

Affordability of the reform is a concern, as shifting from an eligibility standard of fault to one of preventability would broaden the number of injuries that constitute legitimate claims, which could raise costs. A more objective system, however, would also pay fewer non-legitimate claims, although case-by-case variation could still persist. Claims settlement and adjudication costs would fall relative to tort, but would still remain significant because of the need for case-by-case decisions. The percentage loading would probably be higher than for Workers Compensation, given the greater need for expert medical testimony.

One set of proposals would maintain provider responsibility to fund the system through private premiums, as now. They would keep overall premiums for the new arrangement affordable by eliminating minor claims (below a "disability threshold," e.g., of 10 hospital days or 30 sick days), having other payers like health plans pay first, and dropping payment for pain and suffering.[108] Making administrative compensation a secondary payer to other health and disability insurance programs may be even more important now than the 1970s when similar "collateral offset" reforms were first proposed. Medical benefits costs have grown very fast relative to other costs since that time. Collateral source offset and pain and suffering limits seem even more important today than when first proposed, given the escalation in malpractice awards seen since the mid-1990s.[109] Some commentary suggests the possibility of broader funding in order to support broader coverage and reduce providers' disinclination to disclose problems.[110] Additional public funding seems merited where it would achieve the broader social goal of improving safety for all patients.

One major concern about this administrative compensation model is its political feasibility. Tort reform has proven a hard sell in many states and nationally, and this model contemplates far greater changes to the status quo, albeit ones that provide a clear *quid quo pro* for injured patients. Since Workers Compensation programs were enacted a century ago, only automobile no-fault has been tried on a broad scale, and that has never been enacted in its original form as a full replacement for tort, but only in "watered down" forms. Actual enactments often only duplicated tort recovery or allowed tort claims in all serious cases or even moderately serious ones.[111] Another concern is the potential that disclosure and claiming could remain low (a counter measure is discussed in the next section). Finally, narrowing eligibility by imposing minimum thresholds for recovery reduces the number of covered events and hence the usefulness of the reform for compensation and as a source of safety information; administrators might seek to require inclusion of even below-threshold events in safety analyses.

Proponents of non-fault-based programs understand their potential shortcomings and their difficulty of implementation and accordingly seek to move in that direction through controlled testing rather than by universal mandate. An IOM committee recently recommended testing a statewide administrative resolution model.[112] To encourage testing and to guard against the possibility of underfunding by premiums, the IOM panel recommended federal support through reinsurance to backstop states that volunteer themselves as social laboratories for testing administrative compensation.

Models Using Advance Lists of Avoidable Events

Better compensation and safety require more disclosure or discovery of preventable injuries. One shortcoming of all three models just discussed is that all rely on claimants to recognize injuries or on caregivers to disclose voluntarily. These may be insufficient to overcome entrenched patterns of underclaiming and underdisclosure. Another concern is that all claims must be separately investigated and settled or adjudicated, case by case, which raises overhead costs and can lead to inconsistent results across cases.

A very promising alternative that facilitates discovery and prompt resolution of cases is to establish avoidable classes of events, or ACEs, in advance.[113] ACEs are injuries that experts agree are generally preventable. Once listed, ACEs can be compensated almost auto-

matically through an insurance process rather than a legal one. ACEs institutionalize disclosure of legitimate claims because an accessible list allows patients and families to recognize problem outcomes. An open list also reduces the temptation of caregivers to remain silent.

The most thoroughgoing ACE-based reform would replace tort entirely by compensation for ACEs plus a residual non-tort mechanism for preventable non-ACE injuries. Short of a total system replacement, ACE lists could also be implemented as adjuncts to either fault-based early offer or non-fault-based administrative compensation – which would make those reforms fairer and more efficient.[114] ACEs would constitute a significantly new and different way to make determinations for compensation, although the vaccine-compensation list of compensable events is similar.

Expert construction of the listings helps assure consistent and fair compensation. ACEs' standardization facilitates claims resolution through a simpler, less adversarial, and less costly process than case-by-case decision making under either today's tort processes or administrative compensation.[115] Standardized decisions would also speed payouts, so ACEs have also been called "accelerated-compensation events."[116] Costs of defensive medicine could also decline because event lists would be professionally validated and applied non-litigiously (unlike liability resolutions, even after tort reform). Additional positive efforts to reduce defensive behavior would remain desirable[117] and would be facilitated by ACE-based data.

As for safety, ACEs' emphasis on preventability and using ACE data to improve makes them an early forerunner of today's patient-safety thinking. Payment based on ACEs would be much more consistent with patient safety reporting and analysis than are today's fault-based determinations. ACE experience would also likely provide relatively objective and consistent indicators of problems for safety analysis within and even across institutions.

Creating Lists of ACEs

ACEs are defined classes of adverse outcomes that are professionally agreed in advance to be generally preventable. ACEs do not cover all bad outcomes, only events that should seldom occur, given good medical care. There are three main criteria for being listed as an ACE:[118]

(1) *Avoidability:* Events are medically caused and moderately or highly preventable as a class (e.g., 70% or more, relative to not good care). This criterion is central both to making claims legitimate and to making ACE recognition part of prevention and patient safety.

(2) *Detectability:* Each ACE class is readily specified and recognized when it occurs, with clear boundaries that exclude similar non-ACEs.

(3) *Absence of undesirable incentive effects:* Listing an event as an ACE does not distort medical decision making, for example by making a bad outcome for condition X compensable if it occurs after treatment alternative A but not after alternative B.[119]

The standard for being listed as an ACE is statistical avoidability, as in epidemiology. It is not individual error or "smoking gun" noncompliance with some standard, generally articulated after the fact, as in peer review or liability law.[120]

Prior research created ACEs for three specialties – obstetrics-gynecology, orthopedic surgery, and general surgery.[121] The ACEs were specialty-based because of the need for expert input, and these three were chosen because they were then the three top-ranking physician specialties in rates of claims.[122] For practical implementation, however, ACEs should cover all care provided on an equal basis, without regard to what specialty of personnel provided or oversaw the care. Having different standards of compensability according to choice of personnel could skew medical decision making. Sample ACE listings related to childbirth illustrate the spectrum of events previously created (Fig. 1). The full OB-Gyn listing created 48 events for research purposes.

ACEs have thus proven quite feasible to create, contrary to objections made by some early critics that one cannot differentiate medically caused injury from naturally occurring adverse outcomes.[123] Clinical agree-

Figure 1

Sample ACEs Related to Childbirth

- Paralysis of part(s) of body to mother following anesthesia
- Hyaline membrane disease, nutritional disturbances and/or other complications, including death, to infant(s) within a few days of iatrogenic (treatment induced) prematurity.
- Structural deformaties of penis, urinary tract obstructions and/or other complications to infant(s) following circumcision requiring reparative surgery.
- Neurological disturbances, physical handicaps and/or other complications to infant(s) of post-maturity, in the absence of evidence that the fetus is in good condition, to mothers under prenatal care. Post-maturity is defined as 42 weeks (and beyond) from accurately dated gestation. (Includes neurological disturbances and physical handicaps.)
- Blood disorders, physical disturbances and/or other complications to infant (or mother) following non-detection of Rh problems in mother.

Source: ACE's for Obstetrics and Gynecology.© 1992 Laurence R. Tancredi

ment on listings was readily achieved in the late 1970s[124] and again in the late 1980s.[125] Constructing lists would seem even more feasible today, as patient-safety advances have promoted systems-based, epidemiological thinking about injury.

A related early critique was that ACEs could at best cover narrow, clear cases of liability.[126] This simply misperceived the epidemiological nature of the avoidability standard, which is not based on individual error but on preventability of entire classes of events, without considering the idiosyncrasies of each one. Nor are ACEs limited to what lawyers call "res ipsa" cases, the small share that do not even require medical testimony to show negligence.[127] To the contrary, ACE descriptions cover a broad variety of circumstances (Figure 1).

"Never Events" and ACEs

In March 2002, The National Quality Forum announced a list of 27 "serious reportable events in healthcare" that experts agreed should be publicly tracked as safety indicators.[128] These "never events" include wrong-site surgeries, patient deaths or disability from the use of contaminated drugs or devices, deaths from medication errors, and the discharge of an infant to the wrong family. Subsequently, never events were adopted for safety tracking purposes in Minnesota and Pennsylvania.[129] Reporting based on an event list offers hope of making reports more objective and more consistent across reporting entities, which first-generation public safety reporting has failed to do.

The lists of never events echo the ACE approach by listing problem occurrences in advance. The nomenclature may imply that the events should literally never occur, but a more realistic reading is that they should never go un-investigated. Never events resemble ACEs, but ACEs are much more specific avoidable outcomes worthy of compensation. The acceptance of never events could well facilitate acceptance of not dissimilar ACEs.

Like ACEs, never events are created in advance by experts concerned about avoiding injury. Both emphasize classes of events that should be handled consistently, in sharp contrast with piecemeal, slow, and inherently erratic fault-based determinations. However, never events were created merely as safety "flags," useful indicators of potential problems for further analysis and safety intervention. ACEs need to be more carefully delineated to justify automatic compensation and avoid undesirable incentive effects. Moreover, the descriptions of several never events focuses heavily on process, which introduces many issues about the appropriateness of the medical procedures used in treatment. For example, "Patient death or serious disability associated with the use or function of a device in patient care in which the device used or functions other than as intended" requires a determination of the degree of association between the use of the device and disability or death and the extent to which the specific device was used in an inappropriate way.

Figure 2

ACEs cover a majority of severe injuries
(1980s hospital obstetrical claims)

	emotional only	temporary	permanent		
ACEs	24%	56%	66%	52%	52%
Non-ACEs	76%	44%	34%	48%	48%

ACEs account for most system spending
(thousands of 1989 $)

	no. cases	average payout + expenses	total aggregate cost	% share of aggregate
ACEs	148	$273	$40,404	88%
Non-ACEs	137	$39	$5,343	12%
total	285	$161	$45,747	

Computed from data in Bovbjerg, Tancredi and Gaylin (1991)

The next generation of ACEs needs to go beyond never events and also beyond the three specialties of care already addressed. These specialties' existing sets of ACEs need to be updated across specialties for all practitioners providing a given type of care. The next step toward reform could be to develop listings applicable to all surgery, for example. This process could draw on certain never events that can be sharpened to serve as ACEs. A similar method would be applied to internal medicine and the medical subspecialties. This process would expand ACEs to cover much or most medical care.[130]

Evidence on ACE Incidence and Costs

The major relevant ACE study applied the obstetrical ACE listings to a large sample of hospital obstetrical claim files from the 1980s. Fully half of cases constituted ACEs (Figure 2). Two thirds of permanent injuries (the most expensive category per case) were ACEs. Finally, ACEs accounted for fully 88% of total liability system cost, combining payouts plus adjustment expenses – the administrative "overhead" costs of investigation, settlement, and defense.[131] This obstetrics study and earlier application to another closed claims sample[132] suggest that ACEs are broadly applicable in medical care, making them a powerful tool. Indeed,

some assert that ACEs would cover too many cases, and that an ACE-based system would therefore be unaffordable.[133] Yet covering more cases than today's underperforming system is a strength, both for compensation and for prevention.

How many injuries not now in the liability system would ACEs "surface" and make subject to fairer compensation and better prevention? That depends in part on one's estimate of the number of injuries not helped by the liability system, in part on the final eligibility and compensation rules of an ACE-based system, and in part on the extent to which better prevention would reduce the pool of injuries. Better data are needed, and the authors' desire for better estimates is one reason that we, like many others, support gradual implementation through demonstrations, on which more below.

Yet some evidence already suggests that ACE listings would not bring forward as many new cases as some commentators fear. In the obstetrical study just noted, 45% of all claims files were closed without any claimant's coming forward. Such files were opened when a potential liability claim was reported by insured potential defendants. These cases without claimants represent the population from which new claims might emerge under ACEs. The study found that 49% of such cases were ACEs and hence eligible for compensation – much more than the 4% actually paid by the liability system. However, the "new" cases that would be paid as ACEs typically featured only temporary injuries (median severity of 3 on a 9 point scale), whereas claimant-brought cases had permanent injuries. The average paid claim for permanent injury was 100 times greater than for temporary injury.[134]

These ACE analyses also answered another early criticism, that ACE listings once constructed would be difficult and costly to apply in practice.[135] ACEs were successfully applied to samples of the NAIC near-census of mid-1970s liability claims[136] and to hospital liability claims files through the late 1980s.[137] The former application was effectuated by senior physician-lawyers involved in the creation of the listings, which left in question ACEs' general applicability by less-motivated, less expert reviewers. Contract nurse-claims investigators applied the ACE lists in the obstetrical study. They found that ACE determinations were almost always clear-cut, and in the unusual difficult cases, the three investigators could quickly reach consensus through discussion among themselves.[138]

ACEs' simplified injury compensation can be expected to substantially reduce the very high transaction costs of tort, which consume well over 50% of total spending. It is possible to object that the tort system already settles cases of obvious liability without lengthy process or high costs,[139] and economic theory suggests that strong cases on liability should settle, but practice shows otherwise. Even cases that defendants consider indefensible can go to jury verdict,[140] and parties can have many motives for holding out for a trial.[141] In the obstetrical ACE study, 100% of jury determinations involved ACEs (there were 4 verdicts among 77 paid claims, a rate of jury resolution similar to the rest of malpractice). Moreover, tort's administrative costs for ACEs were nearly three times higher than non-ACEs. Both of these factors suggest that resolving ACEs quickly through an insurance process would achieve large savings.[142]

ACE Systems Design

ACE-based and other alternative systems can be more or less costly depending on the rules they embody on eligibility, benefits, and the like.[143] The same holds true for any other tort reform, insurance policy, or public benefits program. Full discussion of appropriate rules and operational details is well beyond the scope of any short article, but basic considerations need sketching.[144]

DESIGN OF ELIGIBILITY

Eligibility is based on listing as an ACE. Non-ACEs found to be preventable in an individual case should also be covered. How to determine eligibility in practice is sufficiently complex to warrant separate discussion under operations, below.

DESIGN OF BENEFITS

ACE benefits (that is, covered services) should generally resemble what well-insured Americans finance for themselves in health and disability coverage. Covering less than every service includable in a tort claim is defensible on the ground that ACEs offer certain, immediate payment, whereas the liability system pays only about 30% of claims, on average almost five years after injury. Conceptually, ACEs' standard of preventability falls between the tort system's fault criterion and the mere causation of workers compensation or auto no-fault coverage. An intermediate level of allowable benefits is likewise appropriate for ACEs.

Some standardization of benefits is appropriate because one goal of moving to ACEs is to make compensation more predictable and similar across similar cases. A key concern is making allowance for future costs – wage loss, medical and rehabilitative services, and custodial care. Determinations are easier if payments are made only as losses accrue, as under the Virginia and Florida programs or the early-offer proposal. Even so, wage losses can only be estimated, as the course of an unfollowed career is unknowable. Such losses should be consistently estimated, whether paid

in advance or over time. It would be reasonable to set wage allowances at a median level (as Virginia did) or to assure that the top and bottom allowances not range as widely as under tort.[145] Today's approach of arguing out each case as unique and then individualizing all awards is not only very costly in disputation but also inevitably creates unfair differentials across cases.

Future medical costs are typically even larger than future wage losses, and they are knowable with more precision if paid as incurred. Some standards of cost containment should apply to submissions of medical bills – again, standards adapted from typical practice under well-insured Americans' health or disability plans. Paying benefits only at the time of need protects medical providers from having to pay windfall awards and protects injured people against underestimation of future needs. Alternatively, if an implementing state or private entity decides to make lump-sum payments as in tort, some standardization of future benefits is appropriate and the possibility of arrangements resembling annuities should be explored. Such arrangements give injured patients better protection while allowing ACE-risk-bearers to manage risks of future losses.[146]

ACE payouts should probably include some allowance for pain and suffering, a "non-monetary" but quite real loss.[147] After all, people are willing to pay money themselves to reduce non-monetary risks from injury, although private insurance never includes such losses because of the moral hazard involved in valuation. Payouts should be modest relative to tort because ACEs are not grounded in fault and are not needed to fund high legal fees as under tort. Allowances should be structured to avoid moral hazard and to assure proportionality across cases (meaning that more severe cases always receive more than less severe and that similar claimants receive similar amounts).

A key design issue is whether and how to coordinate benefits with other private insurance or public programs that also cover injuries. Coordination should occur to improve both fiscal efficiency and quality management, but which payment source should be primary? Tort law makes liability payments primary, although "collateral source" reforms alter this traditional practice.[148] Reducing the share of cost borne by the injury compensation mechanism reduces fiscal deterrence but also decreases administrative costs because other coverages have much lower overheads. An ACE program would have low overhead, too, so that the latter rationale has less force.

Our own balancing of this difficult issue suggests that ACE payment be secondary to other sources. To shift all injury costs at once to a new system would create major uncertainty about costs and might make program financing infeasible. Some other payers might object to paying for medical injuries,[149] but they are doing so now; they just are unaware of its extent. Moreover, the new ACE system will also benefit other insurers by promoting safety and reducing injury rates over time, to the benefit of all. Thus, financing of the new broader system would combine provider premiums and other funding sources, as the injury "system" does now.

DESIGN OF ACE OPERATIONS

Comprehensive replacement of tort with an ACE-based alternative requires four key operational mechanisms: first, a mechanism to determine ACE eligibility and compensation; second, a residual, non-tort mechanism to resolve disputes over ACE application and non-listed injuries; third, a statute or set of contracts that bar continued access to tort through binding legal rules; and fourth, a determination of whether the ACE alternative should cover all medical care or only participating providers or certain subsets of care.

1. *Medical providers should disclose injuries and routinely compensate patients injured with an ACE.* Voluntary acceptance of patient eligibility and compensation should be the normal rule under ACEs, not the exception as under tort. Enhanced disclosure is desirable for all the reasons already discussed (first reform above), and it is far more workable with ACE lists and changed rules than under tort. Some verification of information would be necessary, and some disputes would arise, but the process should not normally be adversarial. Most ACE resolutions should resemble the operations of health or disability insurance rather than liability insurance.

2. *A non-judicial dispute-resolution process like mediation followed by binding arbitration should resolve disagreements* over whether a case constitutes an ACE. Such disputes should be rare but will occur. The same process should also determine the compensability of non-listed injuries, also using a standard of preventability, but applied case by case rather than in advance.[150] This recommendation is a shift from prior ACE writing, which contemplated that non-ACE cases would remain in tort.[151] However, we now support a complete departure from judicially driven determinations of fault. One reason for our shift is that having systems that are part tort and part alternative has proved quite troublesome for the Virginia and Florida impaired-infant programs. Costs rise and settlements slow when tort operates alongside and competes with an alternative to tort. Moreover, a partly fault-based system cannot achieve the speed and consistency sought through reform.

Another reason for avoiding residual tort liability is the detrimental impact of judicial process on organized patient-safety efforts, which were not occurring at the

time of earlier ACE proposals. Today, safety will suffer if a partial carve-out reform leaves in place much of the blame-based culture that safety experts decry. Fully non-judicial processes are needed to make case resolutions more expert and provider cooperation more likely. Faster, non-tort resolution of all cases also gives patient-safety managers more timely information and facilitates early rehabilitation and safety investigation of all injuries. Having a pending lawsuit, especially for very large damages, makes it harder for medical providers to develop and implement improvements to avoid similar injuries in the future, lest change make prior practice look faulty.[152] Prosecuting a lawsuit for years also denies injured patients needed support for rehabilitation in the meantime and undercuts their incentive to rehabilitate themselves lest their injuries seem less consequential at trial.[153]

Receiving ACE payment should not typically require making an adjudicatory claim or hiring an attorney. Access to lawyers, however, does provide protection against unfairness if disputes arise about payment eligibility or amounts, particularly for permanent and severe injury. An ACE system should pay reasonable attorneys fees in any good-faith dispute, but hours and hourly rates should be controlled. The vaccine compensation program and the Virginia and Florida impaired infants programs offer useful precedents, and there are many others in administrative practice.

3. *Legally binding strictures are needed to make ACE-based compensation exclusive,* created either by statute or by contract. The most familiar way to accomplish this is through reform legislation, as for administrative compensation. A statute could require the creation of ACE lists, require medical providers to compensate listed events automatically, and establish public review to resolve eligibility and other disputes (or set standards for private resolution). A statute is the only way to cover all providers, all patients, and all care within the enacting jurisdiction. Legislation is the easiest course of action for reformers to describe and recommend.[154] Safety incentives would then be created as under Workers Compensation, with experience-rated premiums or self-insured retentions for large institutions. (If non-ACEs were resolved by an administrative compensation agency, this approach would closely resemble the ACE-enhanced version of the administrative model, discussed next.)

Early writing about ACEs assumed statewide applicability through legislation.[155] This remains a viable option, one approach supported by the IOM committee that proposed reform demonstrations. Here too, however, we have come to believe that a different approach may be preferable. Especially since the emergence of the patient safety movement and its highlighting of the importance of systems in protecting patients, we think that ACE implementation would be more productive if it followed institutional lines and capabilities in health care rather than state jurisdictional lines in law. The Workers Compensation model does not fit health care as well as factories, because medicine remains so much a cottage industry as well as a corporate one. Physicians, the most important medical decision makers, are not normally employees of hospitals, the key institution. This lack of integration is partly responsible for the halting progress in patient safety and injury policy generally.

Accordingly, ACE reform may be most successful if implemented within sizeable medical entities like medical-center hospitals and large physician groups, particularly if they integrate responsibility for care across providers and modalities of service. These are the institutions capable of improving safety; different entities differ greatly in their degree of capabilities; and ACEs to be successful will need to relate to institutional safety management. We have also become skeptical that any complex, comprehensive replacement to tort can be successfully legislated as a coherent package without modifications that undercut its effective functioning.[156]

4. *Private contracts could also implement ACEs,* institution by institution, rather than statewide.[157] Medical groups that are organized into effective operational systems, such as a large hospital-based medical center, an integrated medical delivery system, or a large physician group practice, would agree to run an alternate safety-compensation system. Private design and implementation would avoid the delays and compromises inherent in legislation, but would forgo statutory consumer protection. It would thus be very important for

The ACE-based health plan alternative could be the exclusive remedy, elected at the beginning of the year. Safety-compensation contracts could also operate like preferred provider arrangements, allowing patients at the time of care to decide whether to stay with a preferred provider or instead go elsewhere and get the conventional legal system, with all of its costs and benefits.

private parties to provide public documentation that the new alternative was preferable to tort in the ways discussed above.

This form of accountability could avoid the types of challenges made to mandatory arbitration and might also attract patients. Assurances could also be bargained for by organized patients, possibly acting through their employment-based health plans. Another way to reassure patients is to create qualifying standards through state legislation, an approach recommended by a committee of the IOM,[158] but one also subject to the difficulties of passing coherent legislation. Our judgment is that moving ahead with workable reform is more important than assuring the same approach statewide by statute.

The contracts could be made between patients and medical providers, and they should provide for the type of automatic compensation described above. Such contracts would be most defensible for non-urgent care or continuing care from a patient's usual course of care. Obstetrics is a good area for patient-provider agreements because patients typically have substantial lead time before birth and are not unfairly pressured to agree right away. It is desirable to promise prospective patients that covered providers will make early offers of compensation for all listed ACEs and will arbitrate any disputes over ACEs and over all other medical injuries. Thus, the alternative is implemented privately, and used consistently, but patients would retain a choice: patients not in need of urgent care and wanting to stay in the tort system could seek out other providers. It would likely be difficult to persuade a court that a contract signed with a new provider immediately before urgent care was freely entered into. Here, permissive legislation could prove useful.

A promising variant of contracting would go beyond provider-patient contracts to involve health plans, too, and employer groups that arrange for coverage. At the times that a patient signs up for a health care plan and providers agree to participate in the plan, those contracts would include a better safety-compensation system. Enrollee-patients would agree to alternative, better compensation through ACEs when choosing their health plan – thus, well before the need for urgent care. Health plans now routinely designate some medical providers as "preferred" or "centers of excellence" based on fiscal and quality criteria. A better system for medical injury could be part of the reason for those designations. Where created as a benefit under an employee benefit plan, the new payment system could enjoy federal preemption from state tort litigation.[159]

The ACE-based health plan alternative could be the exclusive remedy, elected at the beginning of the year. Safety-compensation contracts could also operate like preferred provider arrangements, allowing patients at the time of care to decide whether to stay with a preferred provider or instead go elsewhere and get the conventional legal system, with all of its costs and benefits. The preferred provider approach would add choice at the cost of adding complexity. A private alternative has partly been tried – through the arbitration agreements sometimes used by large prepaid group practices in California and elsewhere. The best known example is that of some Kaiser health plans, whose arbitration in California suffered from delays and lack of transparency. That experience illustrates some of the benefits that would derive from the openness in claims settlement that would accompany ACEs.[160]

Many implementing details could vary by location and by the desires of the contracting parties. The foregoing describes the basic parameters. A related implementation issue is the extent of coverage of ACEs. In order to create a consistent framework for compensation and safety, it is most important that all similar medical care face the same standards. Thus, an ACE-based alternative should cover all childbirths or none. Ideally, all care within an institution would operate under the same compensation-safety system. Otherwise, competing systems will send mixed signals and undercut reform; for example, if different standards applied to surgeons operating on a pregnant or delivering woman as against another patient. An issue for further discussion with potential implementers is whether it might be feasible to phase in ACE reform, starting with parts of medical care and expanding to others over time. Our intuition is that a hospital or provider group would find it difficult to simultaneously maintain both fault and non-fault cultures. On the other hand, incremental change may be easier to manage than a "big bang" of complete upheaval. Moreover, even thoroughgoing change would have to be incremental in the sense that cases arising from prior time periods would have to remain under prior law until the statute of limitations has expired.

ACEs as Adjuncts to Other Reforms

The transparency and objectivity of ACEs would enable them to improve upon the other reforms discussed above. The basic elements of each reform would remain in place, but ACEs would improve their operations in practice.

ACEs would most add value to administrative compensation reform. The reforms mesh well because both ACEs and administrative compensation seek to determine eligibility by preventability of injury rather than fault, and both seek to regularize benefits and payout rules. ACEs would address a key weakness in workers comp-style reform-relying on patients to bring

claims, as does the tort system now. Not only would the public availability of listings help potential claimants recognize legitimate claims, but the administrative agency and private risk bearers could also use the lists to make prompt settlements for all ACEs. Case-by-case adjudication would not be needed, which would speed resolutions and reduce administrative expense.

This article has argued that safety reform is vital but would be better recognized as a form of accountability if it were conjoined with fairer compensation of injury.

ACEs can also make early-offer reform fairer to injured patients. A key weakness of early-offer is the prospect of gaming by providers – strategic rather than systematic disclosure of injuries: Medical institutions or insurers might decide to make early offers only for cases of very large damage that are likely to be discovered without disclosure rather than to routinely offer compensation, for example. ACE listings could be a check on any such provider behavior. For example, JCAHO or another safety regulator could monitor whether providers were failing to make disclosures and offers for cases qualifying as ACEs.[161] Alternatively, an early-offer system allowing providers to limit damages with an offer could require providers to make offers in all cases listed as ACEs.[162]

The Importance of Demonstrations

Many variables and uncertainties attend implementation of full-scale alternatives to tort. The best approach would therefore be demonstrations that document the performance of alternatives before full implementation. Demonstrations were suggested by prior scholarship and by the IOM committee. The IOM committee creatively also suggested that the federal government use the promise of federal fiscal reinsurance to encourage demonstrations of malpractice alternatives that closely resemble the models of administrative compensation and ACE-based reform presented here. Current federal fiscal circumstances and other considerations make this a very unlikely prospect.

For ACE-based contracts, a good first step would be to conduct a "virtual demonstration" within an interested medical institution. This means using the institution's existing risk-management, utilization, and quality data to estimate the existing incidence of ACEs and to project likely costs of compensation under different possible approaches. Grant funding would almost certainly be needed to encourage the effort, which would be considerable relative to the benefit to any one institution. "Rolling out" the new model would await those results, much in the way that prudent companies pretest a new product externally or new information systems internally. Advances in internal medical risk management and patient-safety reporting have improved the feasibility of undertaking virtual demonstrations since demonstrations were proposed in the early 1990s.[163]

Feasibility of contract depends on private willingness to do better, but does not face the difficulties of shepherding legislative bills through to passage without being diverted from the original goals. Contracts can expect to face challenges in court asserting that traditional rights are abridged. Consequently, it is vital to make clear that the new system will make patients better off through easier compensation, more consistent decisions, lower overhead cost, and more safety systems improvement than is possible today.

Blameworthy Conduct, Medical Discipline, and Systems Reform

Any non-fault-based alternative like ACEs or administrative compensation needs to address the small subset of cases involving behavior that is universally castigated as faulty.[164] Accordingly, a narrowly defined alternative remedy must address egregious misconduct that borders on criminal behavior or repeated acts of simple negligence showing reckless disregard for safety. This remedy would act as a "safety valve" for troublesome cases not addressed by non-fault processes. A similar concern has arisen under Workers Compensation[165] and was also addressed in the early-offer proposal.[166] The latter included higher compensation or punitive damages for egregious misconduct, but only if proven by a preponderance of evidence, a higher standard than that of ordinary negligence cases.

Keeping this exception narrow is important, and it is desirable not to litigate exceptions in courtrooms. If a judge or jury may grant tort compensation in lieu of non-tort compensation in exceptional cases, over time the exception could "swallow the rule," as lawyers say. The expected monetary or other rewards to claimants and their attorneys could be so much larger in court than outside that more and more claims would be channeled back into tort, as appears to have happened to some extent in Florida and Virginia's administrative compensation for severely injured newborns. This danger would probably be lessened if courts perceive that the alternative system treats claimants fairly. Another reason for not trying individual cases in court on an exceptions basis is that courts lack a firm basis for decid-

ing just how egregious a particular case is because they lack knowledge of what is typical.

A new, non-tort preventability system should determine what conduct is egregious administratively or through private dispute resolution instead. Administrators are better placed than courts to note whether a particular medical institution has developed a pattern of blameworthy conduct, which could trigger an administrative sanction. Courts are also ill-suited to administer such ongoing oversight; they sometimes appoint special masters to oversee problem institutions or agencies, but even these ongoing overseers lack comparative perspective.

Similarly, safety advocates should support some enhanced form of medical discipline. Some problem physicians and other caregivers simply cannot or will not comply with improved safety procedures.[167] Protecting patients from clearly noncompliant physicians, at least the extreme outliers, is important in its own right and also to garner public support for safety-oriented compensation reform. Such practitioners need to have their practice restricted in order to protect patients, whether through medical peer review, state medical discipline, or another mechanism.[168] Sub-par practitioners are a long-standing and seemingly intractable problem,[169] and continuing failure to address them satisfactorily is a serious political obstacle to implementing other reforms. The reason is that defenders of the status quo can readily point to such disciplinary failures as a reason for retaining fault-based lawsuits,[170] which are a recognizable "big stick" and are popularly believed to discipline such practitioners.

Opinion polling shows that the public recognizes medicine's current safety shortcomings, but thinks the appropriate response is tougher litigation and discipline of physicians and other medical providers.[171] Systems safety approaches are not yet popularly recognized as more potent, despite the efforts of patient safety reformers.

The dangers of ignoring discipline were illustrated again during the November 2004 election in Florida. A plaintiffs' lawyers' counteroffensive against tort-reform limits on contingency fees passed overwhelmingly.[172] The initiative added a "three strikes and you're out" amendment to the state constitution that will automatically revoke the medical license of any doctor with three malpractice judgments.[173] The provision may prompt more lawsuits and will certainly raise physicians' willingness to settle cases before trial, probably at higher levels of payment. Also approved was a constitutional right for patients to obtain copies of medical providers' internal safety records.[174] Both of these provisions will likely undercut safety initiatives.

To avoid such backlash, safety reformers should also support better disciplinary mechanisms. No mechanism to date (including tort law) has generated much enforcement.[175] The overall system's ability to identify and constrain more low-quality practitioners should be enhanced. Enhancement seems to call for stronger relationships between state medical licensure boards and other quality monitors as well as with caregivers, who have the best information about low performers but who are not motivated to speak up because they fear and resent what they see as the haphazard blame finding of today's disciplinary and liability processes. ACEs could also give credentialing and licensing bodies better data on a doctor's practice record than do the tort claims that state boards are increasingly taking into account.

However it is accomplished, better discipline is important. Without improvements in discipline, opponents of compensation-safety reform will retain one of their best arguments for resisting improvements over tort.

Conclusion

Today's tort liability system has laudable goals – deterrence of faulty, substandard care through just legal process to compel compensation to those wrongfully injured. If it demonstrably met those goals, the liability system would be worth its cost in premiums of about a percentage point and a half of overall health care spending.[176] However, it falls well short in practice. Medical and safety reformers have emphasized cutting back on legal process and awards, and have unduly ignored the importance of improving compensation by covering more avoidable injuries at more measured and predictable levels.

This article has argued that safety reform is vital but would be better recognized as a form of accountability if it were conjoined with fairer compensation of injury. More preventable injuries should be discovered and disclosed both to patients and to patient safety managers. Such improvements might be possible within the current legal system if proponents of full disclosure of injuries to patients are successful in improving the amount of reporting of problems and the number of injured patients reasonably assisted with their losses. Disclosure might be further encouraged within the tort system by allowing those who make reasonable "early offers" of compensation to avoid tort-style, very large pain and suffering awards.

Larger changes to liability rules and processes would probably be more effective. The time has come to experiment with non-tort alternatives, which have worked for limited aspects of medicine. One often-promoted option is to totally supplant tort with a new public system of administrative compensation akin to

Workers Compensation. Such a major shift would be difficult to legislate as a coherent package, and even if successfully implemented as intended, it would remain a case-by-case adversarial system, likely with low claims rates and substantial administrative costs. We believe that a preferable alternative is to list avoidable classes of events (ACEs) in advance, so that compensability is clearer. ACEs could be paid promptly through an insurance process rather than adjudication. Non-listed events would be resolved through private alternatives, including mediation and arbitration. Such a system could be implemented on its own through private contracts, or the listings could be used to improve disclosure and case finding within administrative-compensation or early-offer reform.

Such a system that improved cost and safety might cost more than the underperforming tort system, but avoiding more injuries would be very valuable. Better safety engineering might well also lead to better processes and higher quality care or more efficient care for uninjured patients as well.

A paradoxically hopeful sign for broader reform is the increasing dissatisfaction of providers and even with large health payers with the current system, along with some possibility that changes in legal doctrine and lawyers' access to information on providers' safety records could lead to an upsurge in claims or awards. Similarly threatening legal developments were one spur to the enactment of Workers Compensation laws a century ago. Perhaps the 21st century may see new reforms as well.

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65. J. Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984); Gibson and Singh, *supra* note 18.
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67. J. Banja, "Moral Courage in Medicine – Disclosing Medical Error," *Bioethics Forum* 17, no. 2 (2001): 7-11; National Patient Safety Foundation, "Talking to Patients about Health Care Injury: Statement of Principle," November 14, 2000, *available at* <http://www.npsf.org/html/statement.html> (last visited June 23, 2005).
68. A. W. Wu, T. A. Cavanaugh, S. J. McPhee, B. Lo and G. P. Micco, "To tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients," *Journal of General Internal Medicine* 12 (1997): 770-5.
69. American Medical Association Council on Ethical and Judicial Affairs and Southern Illinois University School of Law, Code of Medical Ethics, Patient Rights Standards RI. 2.90 & RI 12, and Current Opinions of the Council on Ethical and Judicial Affairs, Opinion E-8.12: Patient Information (1994), *available at* <www.ama-assn.org/ama/pub/category/8497.html> (last visited June 23, 2005).
70. Katz, *supra* note 66, Gibson and Singh, *supra* note 18.
71. JCAHO, *supra* note 32 (Standard). This newer standard builds upon requirements evolved since 1996 that hospitals conduct "root cause" safety analysis of "sentinel events," that is, severe unanticipated events, see, e.g., JCAHO, "Our Commitment to Patient Safety," March 2004, *available at* <http://www.jcaho.org/general+public/patient+safety/index.htm#Sentinel%20Event%20Policy> (last visited June 23, 2005); see generally American Society for Healthcare Risk Management, "Disclosure of Unanticipated Events: The Next Step in Better Communication with Patients," (part 1 of 3) Chicago, IL: American Hospital Association, May 2003, *available at* <http://www.hospitalconnect.com/ashrm/resources/files/Disclosure.Pt1.pdf> (last visited June 23, 2005).
72. N. LeGros and J. D. Pinkall, "The New JCAHO Patient Safety Standards and the Disclosure of Unanticipated Outcomes," *Jour-*

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nal of Health Law 35, no. 2 (2002): 189-210; L. F. Brott and K. Thomas, "Disclosure of Unanticipated Outcomes," *Health Systems Risk Management Advisor* (2001), *at* <www.pronational.com/news/hsriskrv/outcomedisc4Q2001.htm> (last visited June 24, 2005).

73. T. H. Gallagher, A. D. Waterman, A. G. Ebers, V. J. Fraser and W. Levinson, "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors," *JAMA* 289, no. 8 (2003): 1001-1007.
74. Specific quotation from B. Rice, "Medical Errors: Is Honesty Ever Optional?" *Medical Economics* 79, no. 19 (2002): 63-6, 72; similar findings came from physician focus groups, T. H. Gallagher et al., *supra* note 73.
75. E.g., California Evidence Code, Division 9, Chapter 3, §1160(a); J. R. Cohen, "Legislating Apology: The Pros and Cons," *University of Cincinnati Law Review* 70 (2002): 819-895; J. R. Cohen, "Toward Candor after Medical Error: The First Apology Law," *Harvard Health Policy Review* 5, no.1 (2004): 21-24.
76. American Society for Healthcare Risk Management of the American Hospital Association, "Disclosure: What Works Now and What can Work Even Better," (part 3 of 3) (February 2004), *available at* <http://www.hospitalconnect.com/ashrm/resources/files/Disclosure.Part3.0204.pdf> (last visited June 24, 2005).
77. Compare W. R. Boyte, "Casey's Legacy: Finding Generosity when Admitting to an Error in Judgment," *Health Affairs* 20, no.2 (2001): 250-4 (young doctor forgiven by parents after apology in wake of child's death) with Wachter and Shojania, *supra* note 20, at 296 (apologizing "profusely" did not prevent lawsuit nearly two years later).
78. Compare A. B. Witman, D. M. Park and S. B. Hardin, "How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting," *Archives of Internal Medicine* 156, no. 22 (1996): 2565-9 (12% of patients would sue if informed promptly, versus 20% if uninformed) with K. M. Mazor, S. R. Simon, R. A. Yood, B. C. Martinson, M. J. Gunter, G. W. Reed and J. H. Gurwitz, "Health Plan Members' Views about Disclosure of Medical Errors," *Annals of Internal Medicine* 140, no. 6 (2004): 409-18 (in all but one scenario, "percentage of patients indicating that they would seek legal advice was relatively high even with full disclosure").
79. M. L. May and D. B. Stengel, "Who Sues Their Doctors? How Patients Handle Medical Grievances," *Law & Society Review* 24 (1990):105-120; C. Vincent, M. Young and A. Phillips, "Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action," *Lancet* 8913, no. 343 (1994): 1609-13; G. B. Hickson, E. W. Clayton, P. B. Githens and F. A. Sloan, "Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries," *JAMA* 267, no. 10 (1992): 1359-63.
80. A. Kachalia, K. G. Shojania, T. P. Hofer, M. Piotrowski and S. Saint, "Does full Disclosure of Medical Errors Affect Malpractice Liability? The Jury is Still Out," *Joint Commission Journal on Quality and Safety* 10 (2003): 503-11. See also K. M. Mazor, S. R. Simon and J. H. Gurwitz, "Communicating with Patients about Medical Errors: a Review of the Literature," *Archives of Internal Medicine* 164, no. 15 (2004):1690-7 ("insufficient empirical evidence to support conclusions about the disclosure process or its consequences").
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82. J. Morath, T. Hart, "Partnering with Families: Disclosure and Trust," *Spotlight on Solutions: Patient Safety Initiative 2000* (Chicago, IL: National Patient Safety Foundation, 2001): 247-251, *available at* <http://www.npsf.org/download/Morath.pdf> (last visited June 24, 2005); P. M. Schyve, "Address to National Summit on Medical Errors and Patient Safety Research, Senior Vice President of JCAHO," September 11, 2000, *at* <http://www.jcaho.org/news+room/on+capitol+hill/schyve_statement+.htm> (last visited June 24, 2005); "Medical Mistakes: Tell Patients, Families Say Risk Managers in National Survey," *QRC Advisor* 16, no. 11 (2000): 12.
83. R. M Lamb, D. M. Studdert, R. M. Bohmer, D. M. Berwick and T. A. Brennan, "Hospital Disclosure Practices: Results of a National Survey," *Health Affairs* 22, no. 2 (2003): 73-83.
84. R. Zimmerman, "Doctors' New Tool To Fight Lawsuits: Saying 'I'm Sorry'; Malpractice Insurers Find Owning Up to Errors Soothes Patient Anger: 'The Risks Are Extraordinary,'" *Wall Street Journal*, May 18, 2004, at A1; B. A. Liang, "A System of Medical Error Disclosure," *Quality & Safety in Health Care* 11 (2002): 64-68; see also R. R. Bovbjerg, "Patient Safety and Physician Silence," *Journal of Legal Medicine* 25 (2004): 505-516.
85. J. O'Connell, "Offers That Can't Be Refused: Foreclosure of Personal Injury Claims By Defendants' Prompt Tender of Claimants' Net Economic Losses," *Northwestern University Law Review* 77 (1982): 589-632; J. O'Connell, "Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives," *Law and Contemporary Problems* 49 (1986): 125-141; J. O'Connell and P. B. Bryan, "More Hippocrates, Less Hypocrisy: 'Early Offers' as a Means of Implementing the Institute of Medicine's Recommendations on Malpractice Law," *Journal of Law and Health* 15, no. 1 (2000-2001): 23-51.
86. The originally proposed time period of 90 days has been extended to 120; see sources cited *ibid.*
87. J. O'Connell, quoted in "HHS Report Endorses Tort Reform Concept that could Speed Resolution of Medical Malpractice Claims," *University of Virginia News*, August 22, 2002, *at* <http://www.virginia.edu/topnews/releases2002/hhs-aug-22-2002.html> (last visited June 24, 2005).
88. ASPE (DHHS, Office of the Assistant Secretary for Planning and Evaluation), *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, Washington, DC: US Dept. of Health & Human Services/ASPE, July 24, 2002, *available at* <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf> (last visited June 24, 2005).
89. Corrigan et al., IOM, *supra* note 27.
90. The federal model differs substantially from the early-offer approach described in text. Under the demonstration, government (defense) and claimants may both communicate their offers in confidence to a trusted intermediary. The government promises that any offer will be for its estimate of the present value of economic losses, but there is no provision for coverage of losses as they occur. If the claimant makes an overlapping offer, indicating willingness to accept the same or higher offer, the intermediary announces a settlement at the average of the two. If either chooses not to make offer, litigation proceeds, and neither side has had to reveal any perceived weakness in its case through open offers. See USDHHS, Office of the Secretary, General Counsel, Notice Regarding...Alternative Settlement Process for Certain Administrative Claims Under the Federal Tort Claims Act, *Federal Register* 69, no. 185 (2004): 57294-57297, Friday, September 24, *available at* <http://www.premierinc.com/advocacy/issues/108/04/liability/early-offers-program-0904.pdf>(last visited June 28, 2005).
91. See, e.g., P. C. Weiler, *Medical Malpractice on Trial* (Cambridge, MA: Harvard University Press,1991); Bovbjerg and Sloan *supra* 13; Studdert and Brennan, *supra* note 59 *JAMA* (2001).
92. See Bovbjerg and Sloan, *supra* note 13.
93. See *id.* at 53-85 (history of no-fault and lessons for medical no-fault from Workers Compensation and auto no-fault); for a recent restatement of the case for administrative compensation, see Studdert and Brennan, *supra* note 60 (No-Fault *JAMA*).
94. We owe this observation to William M. Sage. Sage was a contributor to the IOM committee report that avoided "no fault" in favor of "Patient-Centered and Safety-Focused, Nonjudicial Compensation," chapter 6 in Corrigan et al., IOM, *supra* note 27. One earlier article referred to "selective" no fault, R. R. Bovbjerg, L. R. Tancredi and D. S. Gaylin, "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *JAMA* 265 (1991): 2835-2842.
95. Many more administrative systems that cover medical injuries exist in other countries. See D. M. Studdert et al. "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" *Law & Contemporary Problems* 60, no. 2 (1997): 1-34; Studdert and Brennan, *supra* note 59, *JAMA* (2001).
96. National Childhood Vaccine Injury Act of 1986, Title III of Pub-

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lic Law 99-660, 42 USC Sec. 300aa-1 et seq.
97. Health Resources and Services Administration, DHHS. National Vaccine Injury Compensation Program home page <http://www.hrsa.gov/osp/vicp/INDEX.HTM> (last visited June 24, 2005).
98. W. K. Mariner, "The National Vaccine Injury Compensation Program," *Health Affairs* 11, no. 1 (1992): 255-65; D. Ridgway, "No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program," *Journal of Health Politics, Policy and Law* 24 (1999): 59-90.
99. D. Ridgway, "Disputed Claims for Pertussis Vaccine Injuries under the National Vaccine Injury Compensation Program," *Journal of Investigative Medicine* 46, no. 4 (1998): 168-74.
100. National Vaccine Injury Compensation Program, "Post-1988 Monthly Statistics Report," August 13, 2004, *available at* <http://www.hrsa.gov/osp/vicp/monthly_stats_post.htm> (last visited June 24, 2005).
101. J. A. Henderson, "The Virginia Birth-Related Injury Compensation Act: Limited No-Fault Statutes as Solutions to the 'Medical Malpractice Crisis,'" in V. P. Rostow and R. J. Bulger, eds., *Medical Professional Liability and the Delivery of Obstetrical Care*, vol. 2 (Washington, DC: IOM, 1989): 194-212; T. R. Tedcastle and M. A. Dewar, "Medical Malpractice: A New Treatment for an Old Illness," *Florida State University Law Review* 16 (1988): 535-590; K. V. Heland and P. Rutledge, "No-Fault Compensation for Neurologically Impaired Infants: The Virginia Experience," *Current Opinion in Obstetrics & Gynecology* 2 (1992): 58-65; Academic Task Force for Review of the Insurance and Tort Systems, Medical Malpractice Recommendations (unpublished report to governor and legislature) November 6, 1987.
102. R. R. Bovbjerg, F. A. Sloan and P. J. Rankin, "Administrative Performance of 'No-Fault' Compensation for Medical Injury," *Law and Contemporary Problems* 60, no. 2 (1997): 71-115; Bovbjerg and Sloan, *supra* note 13.
103. All aspects of the study were summarized in Bovbjerg and Sloan, *supra* note 13. Other publications included: Bovbjerg et al., *supra* note 102; K. Whetten-Goldstein et al., "Compensation for Birth-Related Injury: No-Fault Programs Compared with Tort System," *Archives of Pediatric and Adolescent Medicine* 153, no. 1 (1999): 41-8; F. A. Sloan, K. Whetten-Goldstein and G. B. Hickson, "The Influence of Obstetric No-Fault Compensation on Obstetricians' Practice Patterns," *American Journal of Obstetrics and Gynecology* 179, no. 3, Pt. 1 (1998): 671-6; F. A. Sloan et al., "No-Fault System of Compensation for Obstetric Injury: Winners and Losers," *Obstetrics and Gynecology* 91 (1998): 437-443.
104. D. M. Studdert, L. A. Fritz and T. A. Brennan, "The Jury Is Still in: Florida's Birth-Related Neurological Injury Compensation Plan after a Decade," *Journal of Health Politics, Policy and Law* 25 (2000): 499-526.
105. Joint Legislative Audit and Review Commission of the Virginia General Assembly, *Review of the Virginia Birth-Related Neurological Injury Compensation Program* January 15, 2003, *at* <http://jlarc.state.va.us/Reports/Rpt284.pdf> (last visited June 24, 2005).
106. See sources cited in *supra* notes 13, 30, 60.
107. See Bovbjerg and Berenson, *supra* note 47, also discussed in note 63.
108. E.g., W. G. Johnson et al., "The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan," *JAMA* 267 (1992): 2487-92; Studdert et al., *supra* note 95, *Law & Contemporary Problems* (1997); D. M. Studdert and T. A. Brennan, "Toward a Workable Model of 'No-Fault' Compensation for Medical Injury in the United States," *American Journal of Law & Medicine* 27, nos. 2-3 (2001): 225-52.
109. Bovbjerg 2005 (Crisis), *supra* note 6; on the merits of collateral source offset, see also notes 148 & 149, infra.
110. Bovbjerg and Sloan, *supra* note 14; K. S. Abraham, "Medical Liability Reform; A Conceptual Framework," *JAMA* 260 (1988): 68-72.
111. Bovbjerg and Sloan, *supra* note 13.
112. Corrigan et al., (IOM), *supra* note 27.
113. Havighurst and Tancredi, *supra* note 12; J. R. Boyden and L. R. Tancredi, "Identification of Designated Compensable Events (DCEs)," in American Bar Association Commission on Medical Professional Liability. *Designated Compensable Event System: A Feasibility Study* (Chicago, IL: ABA, 1979):11-51; L. R. Tancredi and R. R. Bovbjerg, "Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, a Malpractice and Quality Reform Ripe for a Test," *Law and Contemporary Problems* 54, no.2 (1991): 147-178.
114. In the early 1990s, the authors propose a demonstration for private contractual implementation of mandatory early offers for obstetric ACEs, but their proposal did not receive funding from the Robert Wood Johnson Foundation because at the time no actual implementation could be promised, although one HMO had agreed to participate in a "virtual" demonstration (see text at note *infra* 163). R. R. Bovbjerg, L. R. Tancredi, and K. V. Heland, "Injury Monitoring, Avoidance, and Resolution: 'ACEs' for Quality and Malpractice Reform," unpublished proposal to the Robert Wood Johnson Foundation, Washington, DC: The Urban Institute, August 30 1993. In early 2005, a group of researcher/reformers at the Harvard School of Public Health and Common Good were funded by the Robert Wood Johnson Foundation to develop a practical administrative compensation plan that uses the equivalent of ACEs as well. "Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System," press release, January 10, 2005, *at* <http://www.hsph.harvard.edu/press/releases/press001102005A.html.html> (last visited June 24, 2005).
115. Tancredi and Bovbjerg, *supra* note 113.
116. L. R. Tancredi and R. R. Bovbjerg, "Advancing the Epidemiology of Injury and Methods for Quality Control: 'ACEs' as an Outcomes-Based System for Quality Assurance," *Quality Review Bulletin: Journal of Quality Assurance* 18, no. 6 (1992): 201-209.
117. R. R. Bovbjerg, "Medical Malpractice: Folklore, Facts, and the Future," *Annals of Internal Medicine* 117 (1992): 788-791.
118. L. R. Tancredi and R. R. Bovbjerg, "Creating Outcomes-Based Systems for Quality and Malpractice Reform: Methodology of Accelerated-Compensation Events (ACEs)," *Milbank Quarterly* 70 (1992): 183-216; Boyden and Tancredi, *supra* note 113.
119. In parallel fashion, some safety experts recommend tracking "balancing measures" to assure that changes meant to improve one aspect of safety are not causing new problems in other areas. Institute for Healthcare Improvement, Measures, Safety: General *at* <http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Measures/> (last visited June 24, 2005).
120. L. R. Tancredi, "Identifying Avoidable Adverse Events in Medicine," *Medical Care* 12 (1974): 935-943; L. R. Tancredi, "Designated Compensable Events: A No-Fault Approach to Medical Malpractice," *Law, Medicine and Health Care* 10 (1982): 200-203, at 215; Tancredi and Bovbjerg, *supra* note 118.
121. *Ibid.*
122. U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984 (Washington, DC: Government Accountability Office, April 1987, pub. no. GAO/HRD-87-55), *available at* <http://161.203.16.4/d214/132815.pdf> (last visited June 24, 2005).
123. E.g., R. E. Keeton, "Compensation for Medical Accidents," *University of Pennsylvania Law Review* 121 (1973): 590-605.
124. Boyden and Tancredi, *supra* note 113.
125. Tancredi and Bovbjerg, *supra* note 118.
126. P. M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, MA: Harvard University Press, 1985): at 217.
127. Danzon thus concluded, without evidence, that ACEs "would not account for a significant fraction of claims," *id.* at 218.
128. Serious Reportable Events in Healthcare: A National Quality Forum Consensus Report (Washington, DC: National Quality Forum, March 22, 2002); Executive Summary *available at* <http://www.qualityforum.org/neverteaser.pdf> (last visited June 24, 2005).
129. A. Robeznieks, "Minnesota, Pennsylvania to Launch Error-Reporting Systems," *American Medical News*, October 6, 2003, (accessed online September 24, 2004 from now-proprietary

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site); D. Mandernach, "A Better System for Monitoring and Preventing Medical Errors," *Minnesota Medicine* 87, no. 4 (2004): 40-2.

130. Various routes could lead to further development, including additional research projects or national consensus panels, like the one that developed never events. Given the breadth of medical expertise contemplated by developing ACEs to cover all inpatient care or all medical care, it seems more feasible to stay with smaller research groups of experts to develop and test event lists in the context of moving to an actual demonstrations, as discussed more below.
131. Bovbjerg et al., *supra* note 94.
132. Boyden and Tancredi *supra* note 113.
133. Mills et al. *supra* note 11; 1978, Epstein 1978
134. Bovbjerg et al., *supra* note 94.
135. G. Calabresi "The Problem of Malpractice: Trying to Round Out the Circle" 233-243 in S. Rottenberg, ed, *The Economics of Medical Malpractice* (Washington, DC: American Enterprise Institute, 1978); R. A. Epstein, Medical Malpractice: Its Cause and Cure," 245-267 in *ibid.*; and W. B. Schwartz and N. K. Komesar, "Doctors, damages, and deterrence," *N. Engl. J. Med.* 298 (1978): 1282-1289.
136 Boyden and Tancredi, *supra* note 113.
137. Bovbjerg et al., *supra* note 94.
138. Other defined events in health care have also proved feasible to operationalize, notably including the vaccine-compensation table of events and the definitions of severe neurological birth-related injuries used in Virginia and Florida.
139. Danzon, *supra* note 126, at 218.
140. Taragin et al., *supra* note 14.
141. T. B. Metzloff, "Resolving Malpractice Disputes: Imaging the Jury's Shadow," *Law and Contemporary Problems* 54, no. 1 (1991): 43-131.
142. Bovbjerg et al., *supra* note 94.
143. Bovbjerg and Raymond, *supra* note 16.
144. Tancredi and Bovbjerg, *supra* note 113 offers a longer discussion.
145. The Special Master who resolved death claims administratively after the September 11th atrocities decided to reduce top allowances and raise the bottom, "so that there's a rough equal[ity]," University of Virginia School of Law, "9/11 Fund's Special Master Recounts Experiences," summary of Kenneth Feinberg's lecture of September 21, 2004, webposted September 22, 2004, *at* <http://www.law.virginia.edu/home2002/html/news/2004_fall/feinberg.htm> (last visited June 10, 2005).
146. See extended discussion in J. F. Blumstein, R. R. Bovbjerg, and F. A. Sloan, "Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injuries," *Yale Journal on Regulation* 8, no. 1 (1991): 171-212.
147. See generally R. R. Bovbjerg, F. A. Sloan and J. F. Blumstein, "Valuing Life and Limb in Tort: Scheduling 'Pain and Suffering,'" *Northwestern University Law Review* 83 (1989): 908-976 (issues in tort context). The 9-11 Special Master decided that "Everybody gets the same formula on non-economic loss." Univiversity of Virginia, *supra* note 145; and the Florida infant compensation program makes allowances up to a ceiling of $100,000, almost always at that ceiling, Bovbjerg et al. 1997, *supra* note 102 (no fault admin).
148. In practice, the main payers are non-liability sources like health and disability insurance and government programs, which provide far more compensation than tort. From this perspective, the tort system is the payer that is truly "collateral" in the sense of secondary or supportive rather than principal. See D. R. Hensler et al., *Compensation for Accidental Injuries in the United States* (Santa Monica, CA: Rand Corporation, 1991, R-3999-HHS/ICJ).
149. One major insurer announced in late 2004 that it would no longer pay for medical care that resulted in a "never event." *Associated Press*, "Health Insurer Says It Won't Cover Mistakes," *Houston Chronicle*, October 7, 2004, at B3. C. Snowbeck, "Minnesota Health Plan won't Pay Hospitals for Medical Errors: Plan begins in January," Pittsburgh Post-Gazette, December 9, 2004, *available at* <http://www.post-gazette.com/pg/04344/423960.stm> (last visited June 13, 2005).
150. Overseas programs, notably in Sweden, routinely make individual determinations of preventability. So would all cases under a Workers Comp style administrative reform. ACE-like rules of thumb tend to emerge from repeated case adjudication. E.g., Studdert et al., *supra* note 108.
151. Tancredi and Bovbjerg, *supra* note 113, at 152 (notes possibility of fault-based administrative agency or fault-based arbitration); see also Havighurst and Tancredi, *supra* note 12.
152. Practices can readily meet existing negligence standards, yet be easy to improve. A major advantage of patient safety is that it actively seeks to make care safer, not just to avoid demonstrably substandard practices.
153. Cf. J. D. Cassidy et al., "Effect of Eliminating Compensation for Pain and Suffering on the Outcome of Insurance Claims for Whiplash Injury," *N. Engl. J. Med.* 342, no. 16 (2000):1179-86 (non-fault auto reform that elimined compensation for pain and suffering was associated with lower incidence of whiplash claims and improved prognosis of whiplash injury), comment in R. A. Deyo, "Pain and Public Policy," *N. Engl. J. Med.* 342, no. 16 (2000):1211-3.
154. The statute could be federal, but injuries are traditionally resolved under state law.
155. Havighurst and Tancredi, *supra* note 12.
156. See discussion *supra* at note 111, on difficulties legislating the administrative compensation model.
157. C. C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (Washington, DC: AEI Press, 1995).
158. Corrigan et al., IOM, *supra* note 27.
159. ERISA (the Employee Retirement and Income Security Act of 1974), preempts state law relating to employee benefit plans, a point that cannot be fully elaborated here. For a recent discussion in context of Supreme Court decision, see T. S. Jost, "The Supreme Court Limits Lawsuits against Managed Care Organizations," *Health Affairs* July-December (2004 Suppl, Web Exclusives): W4-417-26.
160. E. S. Rolph, E. Moller, J. E. Rolph, "Arbitration Agreements in Health Care: Myths and Reality," *Law and Contemporary Problems* 60, no. 1 (1997):153-184; M. Nieto and M. Hosel, "Arbitration in California Managed Health Care Systems," California Research Bureau, California State Library, December 2000, CRB-00-009, *available at* <http://www.library.ca.gov/crb/00/09/00-009.pdf> (last visited June 24, 2005).
161. One reviewer noted that disclosure could be motivated by a penalty on providers for meritorious cases that were not disclosed or offered compensation prior to litigation or adjudication. How accurately such legal processes determine merit of cases is open to question, especially among medical providers. Using expert ACEs as a yardstick would arguably improve consistency and acceptance of any such sanction.
162. This could be done in the enabling act where early-offer is established by statute. Or, if tort-based early offer used private contracts to limit recoveries after qualifying offers, providers could bind themselves to make offers for all ACEs as a way to assure fairness and win judicial approval in any litigation to invalidate early offers.
163. W. Wadlington, "Medical Injury Compensation. A Time for Testing New Approaches," *JAMA* 265, no. 21 (1991):2861; Tancredi and Bovbjerg, *supra* note 113, *Law and Contemporary Problems* (1991); Bovbjerg et al., *supra* note 114, unpublished proposal (1993).
164. Wachter and Shojania *supra* note 20.
165. A. Larson and L. K. Larson, *Larson's Workers' Compensation Law*, vol.6, § 103.03 (Albany, NY: LexisNexis Matthew Bender, 2000) (requiring actual intent to harm worker for worker to sue an employer outside of workers comp), but see *Delgado v. Phelps-Dodge Chino Mines*, 34 P.3d 1148, 2001-NMSC-034 (S.Ct. NM) (also willful misconduct with reasonable expectation of death or serious injury), *available at* <http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=nm&vol=01sc-034&invol=2> (last visited June 24, 2005).
166. J. O'Connell, article cited in note 85 *supra*.

167. Wachter, *supra* note 164; R. C. Derbyshire, "What Should the Profession do about the Incompetent Physician?" *JAMA* 194, no. 12 (1965): 1287-90.
168. C. F. Ameringer, *State Medical Boards and the Politics of Public Protection* (Baltimore, MD: Johns Hopkins,1999); T. A. Brennan, R. I. Horwitz, F. D. Duffy, C. K. Cassel, L. D. Goode and R. S. Lipner, "The Role of Physician Specialty Board Certification Status in the Quality Movement," *JAMA* 292 (2004):1038-43; T. S. Jost, "Legal Issues in Quality of Care Oversight in the United States: Recent Developments," *European Journal of Health Law* 10, no. 1 (2003):11-25.
169. Derbyshire *supra* note 167; T. A. Brennan, "The Role of Regulation in Quality Improvement," *Milbank Quarterly* 76, no. 4 (1998): 709-31, at 512.
170. E.g., Public Citizen, "Medical Malpractice Briefing Book: Challenging the Misleading Claims of the Doctors' Lobby," *Congress Watch Review*, August 2004, *available at* <http://www.citizen.org/documents/MedMalBriefingBook08-09-04.pdf> (last visited June 24, 2005); S. Wolfe, "A Free Ride for Bad Doctors," *New York Times*, March 4, 2003 [op-ed], accessible as HRG Publication #1655, *at* <http://www.citizen.org/publications/release.cfm?ID=7232> (last visited June 24, 2005).
171. E.g., Blendon et al., *supra* note 7.
172. The three-strikes initiative passed by 71% to 29%; the right to safety records initiative passed 81% to 19%. Florida Department of State, Division of Elections, "November 2, 2004 General Election - Official Results, Constitutional Amendment," *available at* <http://election.dos.state.fl.us/elections/resultsarchive/Index.asp> (last visited June 24, 2005).
173. [Florida] Department of State, Initiative no. 8, "Public Protection from Repeated Medical Malpractice," Constitutional Amendment, Article X, Section 20, in Proposed Constitutional Amendments to Be Voted on November 2, 2004, *available at* <http://election.dos.state.fl.us/initiatives/pdf/ProposedAmendenglish.pdf> (last visited June 24, 2005); see also, e.g., Associated Press, "Florida Passes Three-Strikes Malpractice Law," *New York Times*, November 26, 2004, *available at* <http://www.nytimes.com/2004/11/26/national/26malpractice.html> (last visited June 24, 2005).
174. Initiative 4, passed in November 2004, created a "constitutional right for a patient or potential patient to know and have access to records of a health care facility's or provider's adverse medical incidents, including medical malpractice and other acts which have caused or have the potential to cause injury or death," see sources cited in *supra* notes 172 and 173.
175. T. A. Brennan, *supra* note 169. See also sources cited in note 2 *supra*.
176. Premiums, including self-insurance and similar premium-like spending, totaled some $25 million in 2002, compared with $1.6 billion in medical spending. Bovbjerg, *supra* note 6 (clinics, 2005); the comparable figure during the last crisis era of the mid-1980s was about one percent, J. R. Posner, "Trends in Medical Malpractice Insurance, 1970-1985," *Law and Contemporary Problems* 49, no. 2 (1986): 37-56.

Appendix G

ARTICLE FROM *THE JOURNAL OF LAW, MEDICINE & ETHICS*

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"Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation," Carly N. Kelly and Michelle M. Mello, pages 515-534.

Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation

Carly N. Kelly and Michelle M. Mello

The United States is in its fifth year of what is now widely referred to as "the new medical malpractice crisis." Although some professional liability insurers have begun to report improvements in their overall financial margins,[1] there are few signs that the trend toward higher costs is reversing itself – particularly for doctors and hospitals. In 2003-2004, the presidential election and tort reform proposals in Congress brought heightened public attention to the need for some type of policy intervention to ease the effects of the crisis.

The darling of tort reformers at both the federal and state levels has been legislation to limit, or "cap," damages awarded to plaintiffs in malpractice cases. Health care provider groups, liability insurers, and the Bush Administration have all seized on the example of California's MICRA law, which since 1975 has capped noneconomic damages in malpractice cases at a flat $250,000, as the path to financial recovery. Caps proposals were even taken direct-to-public in 2004 with voter referenda in several states. As states around the country, and the Congress, continue to propose and debate proposals for caps, one recurrent question with which they must grapple is whether hard-fought battles for caps legislation may result in Pyrrhic victories, as courts rule that caps violate state or federal constitutional provisions.

The constitutionality issue, largely dormant since the late 1980s, resurfaced in 2004 with legal challenges to caps laws in West Virginia, Florida, Ohio, and Utah.[2] In November 2004, the Utah Supreme Court upheld the state's $400,000 (previously $250,000) noneconomic damages cap against a barrage of constitutional challenges.[3] Litigation against the noneconomic damages caps laws in West Virginia, Florida, and Ohio is still pending.

The constitutionality of damages caps is an important issue for all those affected by the malpractice crisis. Policymakers expect liability insurers to respond to the passage of caps by reducing premiums in response to their improved risk exposure and ability to predict their payouts. However, the experience of California and other early adopters of caps demonstrates that although caps are typically passed as an emergency response to a malpractice crisis that has reached critical levels, if

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there is uncertainty as to whether they will be upheld in the courts, liability insurers may not move immediately to reduce premiums. Rather, the relief doctors and hospitals expect may be delayed until constitutionality questions are settled.

In this article, we address this uncertainty by reviewing existing case law concerning the constitutionality of medical malpractice damages caps passed by state legislatures. After providing some basic information about the nature of damages caps and existing state laws, we analyze the five most common constitutional challenges that caps legislation has faced: claims based on access to courts provisions, right to jury-trial provisions, equal protection guarantees, due process protections, and separation of powers principles.[4] We conclude that damages caps passed as a response to documented strains in the liability insurance market are generally upheld against constitutional challenges, except in a small minority of states in which they are judged to implicate interests important enough to trigger heightened judicial scrutiny. We note that most state courts have been hesitant to overturn damages caps, even in the face of judicial doubt about their efficacy. This underscores the important responsibility that state legislators have to thoroughly evaluate the evidence supporting damages caps before adopting legislation, since state courts are not likely to assume this role.

We focus our analysis on challenges to state caps legislation. In the concluding section of the paper, however, we briefly comment on the constitutional issues that a federal cap would raise. At the time of this writing (April 2005), the prospects for passage of a federal cap, previously bleak, appear to have been buoyed by the Republicans' gain of 4 Senate seats and President Bush's vocal commitment to pursuing tort reform in his second term. However, the legislation continues to face the prospect of a Democratic filibuster, and most of the legislative action continues to be in the states. In addition to focusing on state litigation, we focus our analysis on caps on noneconomic damages, for reasons articulated below.

Malpractice Damages Awards

Medical malpractice verdicts are composed of three types of damages. First, compensatory ("economic") damages cover the patient's economic losses, such as lost wages (both past and future), medical expenses, and long-term care. Economic damages are intended to put the plaintiff in the same financial position as he would have been in had the malpractice not occurred.

The second component, noneconomic damages, are intended to compensate the plaintiff for the non-pecuniary harm caused by the malpractice, such as pain and suffering, inconvenience, loss of consortium (i.e., marital companionship), and decreased quality of life. There is no clear method for determining the amount of noneconomic damages; they are generally left to the complete discretion of the jury, which seeks again to "make the plaintiff whole." Although they vary widely from case to case, on average noneconomic damages comprise about one third of malpractice awards.

Punitive ("exemplary") damages are the final component of a medical malpractice award. Punitive damages are meant to punish the defendant for wrongful conduct and to deter others from engaging in similar behavior. As such, they are not tethered to the severity of the plaintiff's injury, but to the culpability of the defendant's conduct. Many states have enacted laws that restrict punitive damages in all types of personal injury cases, including medical malpractice actions. For example, North Carolina only allows punitive damages to be awarded in tort actions upon a showing of fraud, malice, or willful and wanton misconduct.[5] Other states have restricted the availability of punitive damages in medical malpractice cases specifically. In Oregon, for example, punitive damages may not be awarded against a licensed or registered health care professional acting within the scope of their employment and without malice.[6] In practice, punitive damages are very rarely awarded in medical malpractice cases, even in states without such laws. A review of empirical studies determined that punitive damages are awarded in less than 1.5 percent of malpractice verdicts, less than a third the rate at which they are awarded in other tort cases.[7]

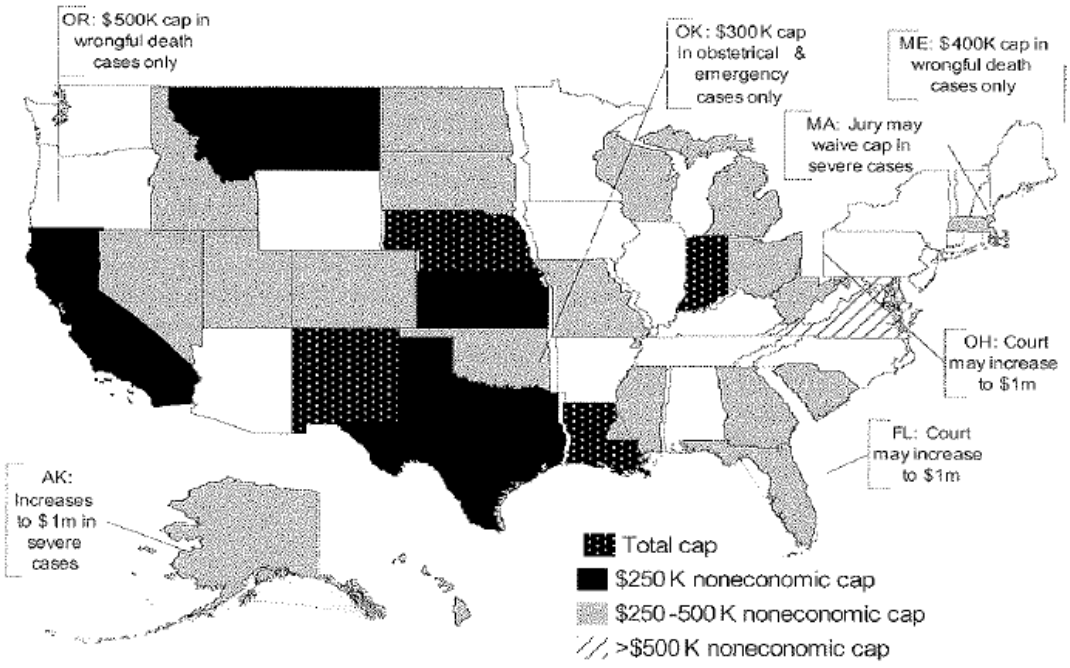
Damages Caps Strategies

Damages caps are applied in malpractice cases by allowing the jury to calculate damages in the usual way and then reducing jury awards that exceed the ceiling of the cap. Juries are theoretically "blinded" as to the existence of the cap – they are not informed of it, and may be instructed not to consider it if they are aware of it. However, jurors may be well aware that components of their awards will be reduced by the judge, and may compensate by awarding higher damages in components (such as economic damages) that are not subject to a cap.[8]

As of April 2005, more than half the states had passed legislation imposing some kind of limit on noneconomic damages awards (Figure 1). Noneconomic damages have been the primary target of cap initiatives for a variety of reasons. It is politically unpopular to suggest that injured persons should not be fully compensated for their economic losses, even though in some of the highest-value cases, such as those involving devastating injury to newborns, it is economic damages that make up the majority of the award. Noneconomic damages are also an easier focus because of the intangible

Figure 1

Noneconomic and Total Damages Caps by State



[1] Where applicable, state dollar amounts have been adjusted for inflation as required by state law. This chart does not reflect states that waive damages caps in cases involving intentional harm and/or willful and wanton misconduct.

nature of noneconomic losses and the difficulties in valuation. The lack of anchoring guidelines for juries has led to wide heterogeneity in noneconomic awards in cases of similar injury, raising questions of horizontal equity.[9] Some critics assert that noneconomic damages awards are heavily influenced by juror emotion, and thus frequently result in unfairly large awards.[10] Medical liability insurance companies point to excessively large verdicts as the primary reason for increasing malpractice insurance premiums, and most of the lay public tends to associate "jackpot" awards with high noneconomic damages awards, due in no small part to media publicity about cases involving relatively trivial injuries but huge pain-and-suffering awards.

While the primary area of legislative concern has been noneconomic damages, some states have taken other approaches (Table 1). Some limit only punitive damages; some limit a plaintiff's total damages, including economic losses; some limit the liability of each defendant named in a case; and some impose a cap on all elements of damages except medical expenses and related expenses.

States also vary in the flexibility of the caps they adopt. Most states impose an absolute ceiling on damages that does not change over time. For example, in California, noneconomic damages in health care malpractice actions have been capped at $250,000 since 1975,[11] even though the real value of that amount has declined to about $70,000 over the last 30 years. Similarly, in Arkansas, punitive damages in medical malpractice lawsuits are capped at $1 million.[12] In response to concerns about inflation, some states have elected to automatically adjust their cap upwards on an annual basis. For example, Idaho adjusts its $250,000 noneconomic damages cap yearly based on average annual wage data.[13]

Damages caps are frequently criticized because of their potential to deny compensation to severely injured patients who may deserve money in excess of the cap. To address this critique, several states have tried to build some flexibility into their damages caps to distinguish among injuries of varying severity. Alaska caps noneconomic damages at the greater of $400,000 or $8,000 times the plaintiff's life expectancy years, but in cases of severe permanent physical impairment, the cap is increased to the greater of $1 million or $25,000 times the plaintiff's life expectancy years.[14] Other states, such as Massachusetts and Nevada, allow the judge or jury to waive the damages cap whenever aggravating circumstances exist to justify a higher award.[15]

Some states have given physicians, rather than patients, the added protection from the costs of severe malpractice injuries. In Nevada, for example, noneconomic damages can never exceed the amount of money remaining under the defendant's professional liability policy after economic damages are awarded to the plaintiff.[16] Indiana has enacted an even more extreme protection by capping total medical liability damages (compensatory, noneconomic, and punitive) at $1.25 million.[17] Paradoxically, this means that the patients with the largest compensatory damages claims will be the least likely to collect anything for their pain and suffering, and in some extreme situations these patients may even be denied the full amount of their actual medical expenses and lost wages.

At the federal level, there has been interest in capping both noneconomic and punitive damages, but legislators have shied away from the idea of a cap that would limit economic damages either explicitly or implicitly (by capping total damages). In 2003, legislation that would have imposed a federal cap of $250,000 on noneconomic and punitive damages in malpractice cases passed the U.S. House of Representatives,[18] but stalled in the Senate.[19] A new version of the legislation was introduced in 2004 and passed the House, but it too faltered in the Senate.[20] Similar bills have been introduced in the 109th Congress.[21]

Constitutional Attacks on Damages Caps Laws

The different structures of state damages caps, and particularly the preference for capping only noneconomic or punitive damages, can to some extent be attributed to legislative attempts to draft laws that will withstand state constitutional attack. Caps legislation has been subject to constitutional challenge in at least twenty-five states. Most of these lawsuits have been based on state rather than federal constitutional provisions. Interestingly, damages caps have been upheld under some state constitutions, while at the same time being struck down in other states with almost identical constitutional provisions. This lack of uniformity may pose difficulties for state legislators trying to predict the likelihood that proposed caps legislation would survive legal challenge and could impact the willingness of multistate medical liability insurance companies to reduce premium rates even after tort reform legislation is enacted.

At this point, it is useful to remember that the U.S. Supreme Court will not review state supreme court decisions on questions of state law.[22] Unless a state malpractice law is alleged to violate the U.S. Constitution or another federal law, the U.S. Supreme Court has no authority to review the state court's decision. Although state malpractice reforms are occasionally challenged using the Fourteenth Amendment due process and equal protection guarantees or Seventh Amendment right to jury-trial provisions, the U.S. Supreme Court has never granted certiorari to review a state medical malpractice decision. Thus, federal jurisprudence offers little structure or guidance to state judges struggling to interpret the equal protection and due process provisions in their own state constitutions.

There have been five major constitutional grounds for challenging medical liability reform at the state level. We discuss these in order of importance. First, damages caps have been challenged using the open-courts guarantee contained in many state constitutions. Second, damages caps have been said to violate the right to trial by jury. Third, damages caps have been alleged to violate both federal and state equal protection guarantees. Fourth, damages caps have been challenged using federal and state due process provisions. Finally, damages caps are occasionally challenged under a separation of powers theory.

Access to Courts

Thirty-nine state constitutions contain a provision guaranteeing citizens access to the court system for civil lawsuits.[23] The Missouri Constitution provides a typical example of the wording of this guarantee: "[t]hat the courts of justice shall be open to every person, and certain remedy afforded for every injury to person, property or character, and that right and justice shall be administered without sale, denial or delay."[24] There is no equivalent open-courts provision in the U.S. Constitution. (Some commentators have argued that state open-courts provisions are analogous to federal due process guarantees, but challenges under the open-courts provisions of state constitutions should be viewed as a distinct constitutional strategy.[25])

Although open-courts provisions in state constitutions tend to be worded similarly, there are considerable differences in interpretation among state courts. Some state courts have construed them as simple procedural guarantees of the availability of a judicial process. Damages caps have been upheld against open-courts challenges in these states because they do not actually prevent litigants from filing their case.[26] Alternatively, courts may characterize them as a mere modification to an existing cause of action, which is a constitutionally-permissible legislative act in most states.[27]

In other states, courts have interpreted the open-courts guarantee as imposing substantive constraints on the legislature's discretion to restrict established causes of action and remedies.[28] The balancing analysis that courts conduct in considering the reasonableness of such restrictions also varies. The toughest open-courts challenges have been in states where case law

requires courts to inquire into the public necessity for a statute that limits access to courts, or whether the statute provides plaintiffs with some replacement remedy or "commensurate benefit," or both.

To date, noneconomic damages caps have been upheld against open-courts challenges in 6 states (Table 2). As we discuss below, one of these states, Florida, upheld a cap that was part of a statute encouraging arbitration of malpractice claims, but struck down another that was not connected to an alternative remedy. Caps on total damages have been subjected to open-courts challenges in 7 states and have survived in 4 (Table 2).

The majority approach of state courts has been to define the rights protected by open-courts provisions relatively narrowly and hold that they are not significantly impinged by damages caps. For example, in *Adams v. Children's Mercy Hospital*,[29] the Missouri Supreme Court held that open-courts provisions barred legislatures from erecting procedural barriers to accessing the judicial process, but did not affect their ability to modify or even eliminate causes of action. Damages caps plainly fall within the latter category of legislative actions, and thus, in the court's view, were not unconstitutional. Further, because the open-courts guarantee did not implicate substantive rights, the legislature was not obliged to offer a replacement remedy or other offsetting benefit to those whose recovery it chose to limit.

Cases from Texas and Florida are illustrative of the minority position that caps violate open-courts provisions. In 1986, a federal district court, adjudicating claims under the U.S. and Texas constitutions, held that a Texas law capping a provider's liability for malpractice damages other than medical expenses at $500,000 violated the open-courts provision of the Texas constitution because it denied catastrophically injured patients the right to collect their full damages award without creating any replacement remedy.[30] Two years later, the Texas Supreme Court reached a similar decision in *Lucas v. United States*.[31] The court's analysis in that case emphasized two major considerations: First, was an adequate substitute remedy provided to those whose right to recover damages had been limited? Second, how effective was the cap likely to be in achieving its intended purpose?

In considering the substitute remedy question, the court declined to consider the potential benefits of caps to society as evidence of a countervailing benefit of the statute. It required a particularized showing of offsetting benefits to claimants themselves, citing as an example the creation in other states of a patient compensation fund through which patients could obtain redress for malpractice injuries. Thus, the Texas court considered it crucial to provide an individual "quid pro quo" to claimants when limiting rights held at common law – an approach the dissent in Lucas claimed was unsupported by judicial precedent.[32]

The Texas court further criticized the law as both arbitrary and unreasonable because it limited severely injured patients' ability to recover damages based on speculative data that damages caps might reduce malpractice insurance rates.[33] Although it acknowledged that a malpractice insurance crisis existed in Texas, the court closely scrutinized the evidence that caps would be efficacious in stabilizing insurance rates. It noted that even the legislature that passed the law expressed uncertainty about whether caps would have an effect, and cited an independent study finding that caps would affect less than 1% of all malpractice claims filed in Texas. It concluded that caps were "a speculative experiment" that imposed impermissible burdens on the severely injured.

Lucas is an unusual case, in terms of the level of constitutional scrutiny applied, because the court was not

Table 2
Constitutional Litigation Outcomes Tally

Claim	Caps on Noneconomic Damages†		Caps on Total Damages‡	
	No Violation	Violation	No Violation	Violation
Access to courts	AK, FL (arbitration statute), KS, MO, UT, WV	FL	ID, IN, LA, NE	KS, SD, TX
Right to jury trial	AK, CA, FL, ID, KS, MD, MI, MO, UT, WV, WI	AB, OH, OR (n/a to wrongful death cases)	CO, IN, LA, NE, VA	AB, KS, SD
Equal protection	AK, CA, FL (arbitration statute), MI, MO, OH, UT, WI, WV	AB, NH	CO, ID, IN, LA, NE, VA	AB, IL, ND, SD, TX
Due process	AK, CA, CO, FL (arbitration statute), MD, MO, UT, WV, WI	OH	CO, ID, IN, LA, NE, TX, VA	ND, SD
Separation of powers	AK, ID, IL, UT, WV	--	NE, VA	--

† Including caps on general damages.
‡ Including caps on all damages other than medical expenses.

presented with a legislative finding that caps were effective. Indeed, the Texas legislature had made no such finding. However, the court was willing to disturb the legislature's overall judgment that, notwithstanding the uncertainty about the effectiveness of caps, the legislation was worth a try. The key issue in the case appears to have been the lack of an adequate substitute remedy.

Texas citizens unhappy with the *Lucas* ruling passed Proposition 12 in 2003, amending the state constitution to expressly permit the legislature to limit noneconomic damages in actions against health care providers.[34] This measure paved the way for the adoption of a $250,000 cap in 2004.[35]

An interesting line of cases in Florida further illustrates the tough scrutiny applied in the minority approach to open-courts cases.[36] Case law from the 1970s established that the Florida state constitution's access to courts provision[37] prohibited the legislature from abolishing rights to access judicial redress for particular injuries that were in existence at the time of adoption of the Declaration of Rights of the Florida state constitution, unless the legislature provided a reasonable replacement remedy or showed "an overpowering public necessity" for its action and the unavailability of any alternative means of meeting that necessity.[38] In 1986, in response to a crisis in the property and casualty insurance market, Florida passed a general tort reform act that capped noneconomic damages for all tort claimants at $450,000.[39] The statute was subsequently challenged on a variety of constitutional grounds. In adjudicating the access to courts claim, the Florida Supreme Court reaffirmed the need for the state to make the showing described above and concluded that the state had not even attempted to do so.[40]

Caps were revived in Florida in 1988, when the legislature adopted limitations on noneconomic damages in medical malpractice cases in which the claim was arbitrated or in which the defendant had offered to go to arbitration and the plaintiff had refused.[41] This statute, too, was challenged, with an open-courts claim forming the backbone of the case. Applying the same standard as before, the state supreme court reached a different conclusion: it upheld the statute because it offered claimants a commensurate benefit in conjunction with the retraction of their right to recover unlimited damages[42] and was the only method likely to be effective in addressing a matter of overwhelming public necessity, the medical malpractice insurance crisis of the mid-1980s. The commensurate benefit lay in the advantages of arbitration for plaintiffs, which included a relaxed evidentiary standard and mechanisms for ensuring the prompt payment of damages. With regard to public necessity, the court noted that the legislature had made specific factual findings, supported by the work of a special task force on the malpractice crisis, that insurance costs had risen sharply, were driving up health care costs, and had left some physicians unable to find insurance at any price. The court deferred to the legislature's conclusion that other possible reforms would not address these problems effectively.

This line of cases suggests that in states in which courts have interpreted open-courts provisions to impose substantive restrictions on legislatures' ability to restrict common law rights, defenders of caps legislation must make a persuasive showing that damages caps are effective in achieving their intended purpose of reducing insurance costs – or at least that they are more effective than alternative reforms. They must establish, first, that a serious problem exists in the state's insurance markets (not a difficult showing to make in most states that are seriously considering caps); second, that the instability in the market has direct adverse effects on plaintiffs or potential plaintiffs; and third, that the caps legislation addresses those effects and provides affirmative benefits to plaintiffs. In states such as Florida that do not require physicians to carry liability insurance, one line of argument on the benefits side is that caps will constrain the growth of insurance premiums, thereby encouraging physicians to insure themselves and make funds available to compensate injured patients. In states where all physicians do carry insurance, because the state and/or hospital credentialing processes require it, the benefits argument would need to be couched in terms of ameliorating the effects of the liability crisis on the supply and cost of health services in the state.

We emphasize, however, that in most states this showing of effectiveness will not be required. The majority approach continues to view open-courts guarantees as procedural guarantees only, leaving legislatures free to limit or abolish remedies and causes of action. West Virginia, where a constitutional challenge to caps legislation is now pending, is one such state. This underscores the important responsibility that state legislatures have to thoroughly investigate the potential effectiveness of the tort reform measures that they enact.

Right to Trial by Jury

The right to trial by jury is frequently invoked in efforts to invalidate medical malpractice damages caps. The Seventh Amendment to the U.S. Constitution guarantees a jury trial in suits at common law.[43] It also guarantees that no fact tried by a jury can be re-examined in any court. The U.S. Supreme Court has declined to make the Seventh Amendment binding on states.[44] However, forty-eight states have comparable jury trial guarantees in their own constitutions.[45]

Jury-trial challenges have been brought against

noneconomic damages caps laws in 14 states, and the claim has failed in 11 of those (Table 2). In 8 states, litigants have brought jury-trial challenges to laws capping total damages. Their success rate has been somewhat higher, but still poor: the cap survived in 5 of 8 cases (Table 2).

When damages caps are challenged under state jury-trial provisions, courts typically apply the precept that such provisions preserve jury-trial rights in cases in which such a right existed at common law at the time the state constitution was adopted. In some cases, judges have focused on whether the cause of action at issue existed at the time of constitutional adoption. For example, the Oregon Supreme Court held that the state's $500,000 cap on noneconomic damages could be applied to statutorily-created causes of action such as wrongful death suits, but not to common law medical malpractice personal injury claims, which were in existence in 1857 when the state's constitution was adopted.[46]

In other cases, courts have focused more on the scope of the jury-trial right as it was understood at the time of constitutional adoption. In *Etheridge v. Medical Center Hospitals*, for example, the Virginia Supreme Court upheld legislation capping total damages at $750,000 on the basis that the jury-trial right never contained an implied right to unlimited damages.[47] The jury's function is limited to fact-finding, the court held, and while this includes damages determinations, caps are applied only after the jury has completed its damages assessment. Thus, caps lay safely outside the boundary of the jury-trial guarantee.

Crucial to the holding in *Etheridge* was the court's characterization of the application of damages caps as a matter of law rather than fact. "Once the jury has ascertained the facts and assessed the damages," the court opined, "the constitutional mandate is satisfied. Thereafter, it is the duty of the court to apply the law to the facts. The [damages cap] does nothing more than establish the outer limits of a remedy provided by the General Assembly. A remedy is a matter of law, not a matter of fact."[48] The Utah Supreme Court has expressed a similar view, analogizing damages caps to jury instructions and noting that juries are always "guided and constrained by the court" in carrying out their duties.[49] Certain other state courts, such as Missouri's and Idaho's, take the view that caps do not implicate the jury-trial right because they are applied after the jury's verdict,[50] or because caps simply modify a common law cause of action, something that legislatures have well-established authority to do.[51]

Other courts, however, such as Alabama's, appear to find it problematic to hold that juries must be permitted to determine an appropriate damages award but their determinations need not be given legal effect.[52] Interestingly, the jury-trial provisions of the Alabama and Missouri constitutions are identically worded.[53] The Washington Supreme Court, too, has struck down a cap on noneconomic damages pursuant to a jury-trial challenge, holding that the jury's province includes not only the factual assessment of their amount, but also the actual awarding of damages.[54] Thus, although the general approach of state courts to jury-trial challenges to caps is similar – look to the scope of claimants' rights at the time of constitutional adoption – there are variations in how this analysis plays out, and the outcomes cannot be predicted from the breadth of the jury-trial provision on its face. This circumstance has not escaped judges' notice: a majority in the key Washington case and dissenters in the recent Utah case noted that in "states that have found the damages limit unconstitutional, the operative language of the right to jury trial provisions in those states' constitutions is nearly identical to our own."[55]

Interestingly, some state courts have upheld statutory damages caps by justifying them as a form of pre-established remittitur.[56] Remittitur is a procedure through which a judge may reduce the amount of damages awarded on the basis that it is grossly excessive.[57] A trial judge may remit the jury's verdict, or an appellate court may remit a trial court judge's verdict. In *Dimick v. Schiedt*, the U.S. Supreme Court held that remittitur did not violate the Seventh Amendment right to jury trial because judicial reduction of excessive damages awards was practiced at the time of the adoption of the federal Constitution.[58] However, the Court cautioned that remittitur should be applied on a case by case basis, and should only be used to reduce jury verdicts that are palpably and grossly excessive.[59] Although state courts are not obligated to follow *Dimick* when interpreting their own constitutions, the Supreme Court's discussion about the proper use of remittitur could potentially influence state court decisions about the constitutionality of damages caps. *Dimick* also creates a potential platform for defending a federal damages cap, should one ever be enacted by Congress.

Equal Protection

The Fourteenth Amendment to the U.S. Constitution prohibits states from denying citizens equal protection under the law.[60] Most state constitutions also contain a similar provision. In general, any state law that has the effect of dividing people up into different "classifications" will be susceptible to an equal protection challenge. Courts are more likely to find that a state law violates equal protection if it creates divisions based on a "suspect" class, such as race, or if the classification involves a "fundamental" right, such as voting.[61]

Challenges to damages caps based on equal protection principles assert that caps laws create one or more of three types of classification systems.[62] First, when damages caps are applied only to medical malpractice cases, they effectively divide all personal injury plaintiffs into two classes: medical malpractice plaintiffs and all others. Second, caps offer persons sued for medical negligence a unique form of damages protection that is not available to other types of tort defendants. Third, caps divide malpractice plaintiffs into two groups, allowing those whose injuries are valued below the cap to collect their full damages, while barring those with damages in excess of the cap (typically the most severely injured) from recovering a portion of their losses.

Most state courts follow the federal framework when evaluating equal protection challenges that are brought under their state constitution. Under federal equal protection doctrine, classifications are examined using one of three levels of review: strict scrutiny, intermediate or "heightened" scrutiny, or rational-basis review. The level of review is based on the nature of the classification and the type of rights involved in the division. Under rationality review, a state law will be upheld as long as the classification has a rational relationship to a legitimate government objective.[63] Laws subject to this level of review are almost always upheld, even if the classification is not the best method for accomplishing the law's stated goal.[64]

State supreme courts are not, however, required to apply the federal review framework when analyzing equal protection challenges brought exclusively under the state's constitution. This was demonstrated in the 1985 case of *Sibley v. Board of Supervisors of Louisiana State University*, in which the Louisiana Supreme Court formulated its own intermediate standard of review to evaluate a cap on total damages in malpractice cases under the state's equal protection clause, noting, "The federal three level system is in disarray and has failed to provide a theoretically sound framework for constitutional adjudication."[65] This difference in review standards makes it theoretically possible for a state caps law to withstand a federal equal protection challenge while still failing a challenge under an analogous state constitutional provision, or vice versa.

State courts have evaluated damages caps using rational-basis review, holding that these laws do not involve a fundamental right or a suspect class. A minority of jurisdictions have applied a higher level of scrutiny that most closely resembles the intermediate category. As in other areas of equal protection law, the choice of scrutiny level tends to be dispositive.

The type of cap at issue also tends to predict the outcome in equal protection cases. Noneconomic damages caps have been challenged on equal protection grounds in 11 states and have survived in all but 2. Challenges to caps on total damages have been brought in 11 states, but total caps have been upheld in only 6 of those states (Table 2). We discuss some illustrative cases.

The California Supreme Court's decision in *Fein v. Permanente Medical Group*, upholding California's Medical Injury Compensation Reform Act ("MICRA"), is one of the earliest and most frequently cited opinions to address the classifications created by medical liability damages caps.[66] The plaintiff in *Fein* was awarded total damages of $1,287,783, including $500,000 for noneconomic losses.[67] After the verdict, the trial court reduced the noneconomic award to $250,000 to comply with the MICRA cap.[68] The plaintiff subsequently challenged MICRA on federal and state equal protection grounds, arguing that the cap created a discriminatory classification between medical malpractice victims and other tort victims, and between medical malpractice victims with claims above and below the statutory limit.[69]

In a decision that blended the federal and state claims together, the California Supreme Court held that the MICRA caps did not violate the plaintiff's equal protection rights.[70] The court concluded that there was no fundamental property right to collect an unlimited amount of tort damages, so rational-basis review was the correct standard to apply.[71] The Court held that the MICRA caps met this standard, noting that the legislature was responding to a medical malpractice insurance crisis and that it was "obvious" that a $250,000 noneconomic damages cap was rationally related to the legitimate state interest of reducing the malpractice costs of providers and their insurers.[72] Based on this conclusion, the court dismissed the plaintiff's state and federal equal protection claims.[73] Notably, the U.S. Supreme Court dismissed the appeal in the *Fein* case for want of a substantial federal question.[74] One might infer from this disposition that the Supreme Court found no federal equal protection infringement by the MICRA caps.[75]

Aside from making California one of only two states to uphold damages caps at the time, the *Fein* decision is notable for the cursory nature of the court's inquiry into the statute's means/ends fit. Other courts have also employed the rational-basis standard but have engaged in a more meaningful review of the legislative record in support of the caps law. For example, in the 2004 Utah case, the court catalogued a series of reports by government agencies, academic researchers, and nongovernmental organizations attesting to the effects of high malpractice insurance costs on the availability of health care, the effects of high-end jury awards in driving up insurance costs, and the efficacy of caps in addressing the problem of the unpredictability of dam-

ages. The opinion in that case evinces the court's skepticism as to the accuracy and prudence of the legislature's judgments – it noted, for example, that there was "little indication" in the record that Utah was suffering health care availability problems due to liability costs, that the influence of large damages awards on health care costs was "debatable," and that the court had "concerns about the wisdom of depriving a few badly injured plaintiffs of full recovery."[76] However, as is appropriate under rational-basis analysis, the court did not view these concerns as erecting a constitutional barrier to the legislature's action.

In other states, courts have explicitly or implicitly applied a higher standard of scrutiny. In the 1991 case of *Moore v. Mobile Infirmary Association*, the Alabama Supreme Court invalidated a $400,000 cap on noneconomic damages based on the conclusion that the state had failed to show a reasonable means/ends fit between caps and the asserted purpose of alleviating the effects of the mid-1980s malpractice crisis. The court formally declined to state what standard of review it was applying, but its analysis goes beyond typical rational-basis review. Reviewing available empirical studies, the court held that there was insufficient evidence that the enactment of medical malpractice damages caps leads to a decrease in insurance premiums or an improvement in the availability of health care services.[77] Relying heavily on a U.S. General Accounting Office report that showed a remote connection between damages caps and the total cost of health care, the court held that there was no rational reason for denying relief to the most catastrophically injured patients, while still allowing those who were less severely injured to receive full compensation.[78] The court was also troubled that damages caps created a form of negligence protection for health care providers that was not generally available to other types of tortfeasors.[79]

In *Carson v. Maurer,* the New Hampshire Supreme Court applied this heightened scrutiny more explicitly to invalidate a noneconomic damages cap for medical malpractice plaintiffs.[80] In rejecting the rational-basis standard, the *Carson* court held that although no fundamental right or suspect class was implicated, the rights affected by damages caps were of sufficient importance that any classifications created by damages caps must be "reasonable" and must have a "fair and substantial" relation to the object of the legislation.[81] The court recognized that medical malpractice damages caps serve an important societal goal, but held that it was still "unfair" to force a class of the most severely injured patients to support the entire medical industry through a reduction in damages awards.[82] Moreover, it expressed skepticism that caps could achieve their intended purpose of stabilizing insurance risks and premiums. Rather than examining evidence concerning statistical associations between caps and premiums, the court simply made the commonsense observation that premiums were influenced by factors other than claims payouts and that only a small proportion of cases would have damages high enough to implicate the cap. Further, it noted, caps did not address the problem of nonmeritorious malpractice cases.

Overall, the case law suggests that damages caps will survive equal protection challenges where the court employs a true rational-basis analysis, which will nearly always be the case. The evidence that caps reduce claim severity and have a modest stabilizing effect on premiums is almost certainly sufficient to support a judicial holding under rational-basis review that a reasonable legislature could have concluded that caps would advance an objective of stabilizing insurance premiums.[83] Caps are vulnerable, however, in the few jurisdictions in which heightened scrutiny is applied, because it is less clear that the empirical evidence shows the required "substantial" connection.

Due Process

Due process challenges have been brought against noneconomic damages caps in 10 states, and against total damages caps in 9 states. Courts have rejected these claims in 9 of the 10 noneconomic caps cases and 7 of the 9 challenges to total damages caps.

Due process challenges come in two flavors. First, caps can be challenged as a violation of procedural due process guarantees. The procedural due process argument rests on the assumption that plaintiffs have a vested property interest in whatever damages award a jury delivers, and that the application of a standard damages cap deprives them of this full amount without any opportunity to present evidence as to why the full award amount is justified. For example, in the Virginia case of *Etheridge vs. Medical Center Hospitals*, the plaintiff contended that Virginia's $750,000 damages cap deprived her of an effective opportunity to be heard, since the damages cap purported to "preordain the result of the hearing" and created "a conclusive presumption that no plaintiff's damages exceed $750,000."[84]

The procedural due process theory has never been successfully used to defeat damages caps legislation in any federal or state court. The theory that damages caps unconstitutionally deprive plaintiffs of their property has been rejected by state courts. As explained by the Virginia Supreme Court in *Etheridge:* "Procedural due process guarantees a litigant the right to reasonable notice and a meaningful opportunity to be heard. The procedural due process guarantee does not create constitutionally-protected interests; the purpose of the guarantee is to provide procedural safeguards against

a government's arbitrary deprivation of certain interests."[85] This sentiment was echoed by the Colorado Supreme Court in *Scholz v. Metropolitan Pathologists, P.C.:* "The constitutional guarantee of due process is applicable to rights, not remedies. Although a vested cause of action is property and is protected from arbitrary interference, [appellants have] no property, in the constitutional sense, in any particular form of remedy; all that [they are] guaranteed...is the preservation of their substantial rights to redress by some effective procedure."[86]

A second avenue of attack is to assert a substantive due process violation. When damages caps are challenged as a violation of substantive due process, they are usually evaluated with the same framework as equal protection questions. As explained earlier, this typically consists of a rational-basis analysis in which the court will evaluate whether the cap is rationally related to a legitimate legislative purpose.[87] It is not uncommon for a state court decision to blend the equal protection and substantive due process questions into a single reasonableness test in order to dispense with both questions in the same analysis.[88]

As in equal protection discussions, state courts will normally uphold damages caps against substantive due process challenges as long as there is some evidence that the caps were enacted to address a malpractice crisis in the state. However, there is some variation in outcomes even among cases in which the rational-basis test was employed. One distinctive case is the Ohio Supreme Court's decision in *Morris v. Savoy.*[89] The court explicitly applied rational-basis review, yet found insufficient evidence in the legislative record to sustain Ohio's general damages cap against a due process challenge. The legislature had made no specific, explicit findings about the efficacy of caps. Moreover, it had asked the state insurance commissioner to prepare a report on the effectiveness of 15 of 36 specific malpractice reforms the state had adopted in decreasing malpractice insurance premiums, but had not listed caps among the 15. The court inferred that caps were not "among the statutes that the legislature obviously believed would have an impact on insurance premiums."[90] This inference is difficult to credit: why would the legislature have passed malpractice caps, if not to calm insurance rates? The court also considered external reports and the Texas Supreme Court's decision in the *Lucas* case in concluding that the evidence was not sufficient even to satisfy the rational basis standard. Morris is unusual in that the legislature failed to document its findings about caps, but is an important case because it remains the law in Ohio, where a constitutional challenge to a newly adopted cap is pending.

One due process question that remains unresolved in many states is the "quid pro quo" or "replacement remedy" question that has also arisen in the context of open-courts analyses.[91] When the U.S. Supreme Court declined to review the Fourteenth Amendment questions raised in the California Supreme Court decision in *Fein,* Justice White wrote a spirited dissent urging the Court to resolve the question of whether federal due process requires a substitute quid pro quo compensation scheme in order to implement a cap on tort damages.[92] Justice White noted that this question was left unresolved by the Court's decision in *Duke Power Co. vs. Carolina Environmental Study Group, Inc.,* where the Court upheld the provisions of a federal statute that placed a dollar limit on the liability that would be incurred by power plants in the event of a nuclear accident. One of the objections raised against the liability limitations discussed in *Duke Power* was the contention that the limited liability provisions violated due process by failing to provide those who were severely injured by a nuclear accident with any remedy to replace the law's elimination of the common law right to sue.[93] Although the U.S. Supreme Court upheld the liability limitations in *Duke Power,* the Court expressly declined to resolve the quid pro quo question.[94] As Justice White urged: "Whether due process requires a legislatively enacted compensation scheme to be a quid pro quo for the common-law or state-law remedy it replaces, and if so, how adequate it must be, appears to be an issue unresolved by this Court...Moreover, given the continued national concern over the 'malpractice crisis,' it is likely that more States will enact similar types of limitations, and that the issue will recur."[95]

The procedural due process theory has never been successfully used to defeat damages caps legislation in any federal or state court.

As alluded to by Justice White, state supreme courts have struggled with the quid pro quo question in the due process context, leading several states to resolve the substitute remedy issue using other constitutional arguments. For example, in *Arneson v. Olson,* the North Dakota Supreme Court expressed some doubt that a quid pro quo is required in order to enact damages caps. However, the court ultimately opted to resolve the due process questions raised by the litigants from a more "procedural" due process angle, holding that the elimination of a preexisting right may not be arbitrarily imposed.[96] Notably, when state courts discuss a quid pro quo requirement, it is more frequently done in the open-courts context, rather than on due process

grounds.[97] In fact, no damages caps opinion within the past 15 years has even addressed the quid pro quo issue in the due process context, leading one to question whether the issues that Justice White raised in 1985 have now become irrelevant to the states. Thus, it appears that the "split" in judicial opinion that worried Justice White may have resolved itself as the majority of state courts continue to reject any quid pro quo requirement in the due process context.

Separation of Powers

Finally, medical malpractice legislation is occasionally challenged under a separation of powers theory. Many state constitutions contain provisions that vest judicial powers exclusively in the court system, similar to Article III of the U.S. Constitution.[98] Arguably, the legislative branch infringes on judicial power and "determine[s] judicial controversies" when it enacts laws that alter or affect court or jury procedures.[99] For example, the Illinois Supreme Court concluded that the Illinois legislature had unconstitutionally encroached on the judiciary's remittitur powers by passing a $500,000 cap on noneconomic damages in tort actions.[100] This type of reasoning has led some legal scholars to conclude that policies and procedures related to jury verdicts should only be created by judges and members of the bar, rather than by state legislatures.[101]

From another perspective, one could argue that damages caps are a larger public policy problem, rather than a question of legal procedure. If this is the case, then tort reform measures would be in the constitutional province of the legislative branch. Most state courts have adopted this view, holding that damages caps are an extension of the legislature's right to modify or eliminate a common law cause of action, rather than an unconstitutional encroachment on the courts' right to administer justice.[102] As the Utah Supreme Court has explained, "[t]he power to declare what the law shall be is legislative. The power to declare what is the law is judicial."[103]

Some scholars have gone further by arguing that state lawmakers are in the best position to evaluate the wisdom of damages caps, since unlike judges, legislators are able to hold public hearings and can collect and analyze data on the potential effects of damages caps before voting on legislation.[104] Judges who endorse this separation of powers philosophy may be less likely to scrutinize the legislature's justifications for enacting damages caps in the context of equal protection and due process challenges as well.

It is important to stress that even if a court rules that it is constitutionally proper to entrust the legislature to enact statutes that cap tort damages, it is still a violation of the separation of powers doctrine for a legislature to take away the court's jurisdiction over individual medical malpractice cases. This became an issue in Ohio, where the legislature tried to circumvent judicial review of a damages caps law by entirely removing the court's jurisdiction over cases involving damages in excess of the cap. The Ohio Supreme Court invalidated this law, holding that a legislature may not limit a court's jurisdiction if the only motivation behind the law is a desire to circumvent the court's ability to overturn the legislation.[105] However, this case was unique in that it involved a wholesale revocation of jurisdiction rather than a limitation on remedies.

Overall, separation of powers arguments have been a uniformly unsuccessful strategy for challenging damages caps. Courts have rejected such claims in all cases, whether they involve caps on noneconomic damages or total damages (Table 2).

Implications for State and Federal Tort Reform

Our review of the outcomes of state litigation suggests that caps on noneconomic damages have generally been upheld. Constitutional challenges have been successful in a handful of states in which courts have applied heightened levels of judicial scrutiny, but the overall scorecard, as described in Table 2, shows that most challenges fail. Caps on total damages have been struck down more often – likely one reason such caps have not been pursued in the latest round of tort reform.

The outcomes of the pending cases in Ohio, Florida, and West Virginia are uncertain, but some predictions might be ventured. Although the Ohio Supreme Court struck down a previous damages cap in the state in the *Morris* case, there would seem to be ample opportunity for the current cap to survive challenge, because the *Morris* decision appeared to turn on the legislature's failure to document its findings about the effectiveness of caps. This is a mistake the legislature is unlikely to have repeated. The Ohio Supreme Court applied rational-basis analysis in *Morris*, and it will likely do so again, but with different results.

There is nothing in the West Virginia case law to suggest that its newly adopted cap will be held invalid. The new law caps damages at a much lower level than the $1 million cap that was previously upheld (Table 1), and the court in the earlier constitutional challenge was careful to limit its holding to the $1 million cap. Indeed, it explicitly acknowledged that: "A reduction of non [economic] damages to a lesser cap at some point would be manifestly so insufficient as to become a denial of justice."[106] However, given the prevalence of $250,000 caps among the states today, it seems very unlikely that the court would consider a cap at that level to be grossly insufficient.

The prospects in Florida are more uncertain, in part because its constitutional guarantee of access to courts is atypically strong. Florida requires a showing of "overpowering public necessity" in order to abolish a common law right without providing an adequate substitute remedy.[107] Making this showing will presumably involve proof both that the high malpractice insurance rates in Florida are affecting the availability of health care and that the cap Florida has adopted will be efficacious in stabilizing insurance rates. Both of these claims are hotly contested, and the Florida court has already shown itself to be more likely than many state courts to actively scrutinize the evidence supporting different types of medical malpractice reform.

Although our review of litigation outcomes leads us to conclude that noneconomic damages caps are generally deemed constitutional, it is important to note that there is a degree of selection bias in examining the constitutionality of caps through the lens of litigation. States in which caps are patently unconstitutional have not passed caps legislation at all, and therefore are not represented in our analysis of litigation.

The most prominent example of such a state is Pennsylvania, one of the states hit hardest by rising liability costs over the past several years. All parties to the debate over malpractice reform in Pennsylvania understand that legislation capping damages cannot be passed unless the state first amends its constitution to allow it. Article 3, section 18 of the Pennsylvania constitution prohibits the General Assembly from enacting any law that would limit the amount to be recovered for injuries resulting in death, or for injuries to persons or property.

This can easily become an onerous (and often impossible) process. For example, Pennsylvania requires a proposed state constitutional amendment to be passed in two consecutive legislative sessions, followed by voter approval in a statewide referendum.

In Wyoming and Arizona, too, caps initiatives have been precluded by a clear constitutional mandate. In November 2004, Wyoming citizens considered and narrowly rejected "Amendment D," a ballot measure that would have amended the state constitution to permit the legislature to pass a law capping noneconomic damages in malpractice cases. Article 10, section 4 of the Wyoming constitution bars laws that limit damages in actions for wrongful death or personal injury. Arizona citizens did the same in 1994 by a much larger margin, rejecting "Proposition 103," which would have removed the constitutional prohibition on laws limiting the damages one may recover for personal injury or death. Texas has demonstrated that constitutional amendments are possible given the right combination of amendment procedures and political will, but reformers in other states, such as Florida, are extremely pessimistic about the prospects.

Owing in no small measure to state constitutional problems, provider groups and other tort reform advocates have turned their efforts in recent years towards the enactment of federal damages caps. It is not our purpose to comprehensively evaluate the prospects for such legislation before the federal courts, but a few observations can be briefly made. A federal cap would be subject to constitutional challenges only under the U.S. Constitution. Federal action in this area could be challenged as an impermissible exercise of the national government's commerce-clause authority, though such a challenge would be unlikely to succeed. On the other hand, because some state constitutional provisions on which challenges to state caps have been based have no analogs in the U.S. Constitution, the range of constitutional claims available against a federal cap would be somewhat narrower.

The HEALTH Acts of 2003 and 2004 both contained provisions specifying that the federal law would preempt conflicting state laws, unless the state law provided greater liability protection for health care providers or specified a different damages limit.[108] Thus, an enterprising state legislature that wanted to bypass the effects of the HEALTH Act and preserve a full range of remedies for malpractice plaintiffs presumably could pass a damages cap in an extremely high amount. For example, a one billion dollar state cap on noneconomic damages, although basically meaningless, would still allow a state to circumvent the $250,000 HEALTH Act cap.

Constitutional concerns aside, there are some prudential reasons to question a federal tort reform law. Bills such as HEALTH depart from the tradition, dating back to the earliest days of medical negligence litigation in the U.S., that personal injury actions for malpractice are a matter of state law. The rationales for keeping the locus there are compelling: providers' litigation risk varies dramatically from state to state (quite independent of whether there are tort reforms in place), and so does the salience of medical malpractice as a public issue. Interest groups, insurance markets, the supply of health care providers, and public views about lawsuits and compensation of injured persons also vary widely. Furthermore, much of health care quality regulation, such as licensure and provider disciplinary proceedings, is conducted at the state level. Medical malpractice is not an area that cries out for federal regulation either because state-level regulation is inefficient or because state legislatures have failed to act on an important issue.

Of course, one drawback to having the medical liability issue resolved at the state level is the persistent

uncertainty, whether realistic or not, about whether medical malpractice damages caps are constitutional. Although caps have survived constitutional litigation in the majority of states where they have been challenged, the political volatility of this issue undoubtedly leaves many lawmakers and liability insurers with doubts about the stability of caps legislation. As some scholars have pointed out, state court judges are elected officials in many states, and therefore may be more susceptible to political and public influence when rendering decisions on ambiguous constitutional questions.[109] Without the protection of life tenure, some critics have questioned whether state judges are even equipped to take minority interests into account when rendering judicial decisions on controversial issues.[110] Additionally, as was recently seen in Texas, the state constitution itself can be a fluid document, particularly in "referendum" states where a single state-wide election can change the legality of damages caps literally overnight based on the political whim of voters.[111] These factors, among others, make the entire body of state constitutional law more unstable than its federal counterpart.

In her study of state constitutional decisions, Helen Hershkoff observed that state court judges seem more likely than federal judges to take localized concerns into account when ruling on the constitutional propriety of legislation. Hershkoff speculated that this may be partly due to the fact that, unlike federal judges, state court judges do not have to worry about the potential nationwide impact of their decisions.[112] This could help explain why some state courts, such as Utah's, have been willing to uphold damages caps legislation, even after expressing some doubt about whether caps are an effective way to resolve the problems associated with the medical liability insurance market.

Hershkoff argued that state court judges play a unique and important role as "common law generalists" with broad experience at articulating constitutional frameworks for state legislators to use in resolving complex social and economic issues.[113] She explained: "[I]n difficult cases, the state court's most appropriate stance may be to acknowledge openly the limits of the judicial process – to 'face up to indeterminacy' – and to use its power of review to encourage the coordinate branches to work together to develop conditional responses to constitutional questions. The state court can [do this by] encouraging, and insisting upon, the gathering of information, the testing of methods, and the 'learning by monitoring' that commentators associate with improved decisionmaking."[114]

Proponents of a federal damages cap might argue that the instability of state constitutional law offers a compelling reason for enacting national-level reform legislation. However, given the local nature of both the health care delivery system and the medical liability insurance industry, it is logical to expect that states would approach these issues in different ways. Rather than focusing on the judicial branch, perhaps a more important issue is whether state legislators are thoroughly evaluating the potential effectiveness of damages caps before enacting legislation.

One potential compromise, proposed by James Blumstein, would be to enact federal legislation authorizing states to conduct "pilot programs" to address the medical liability problems in their state. This legislation could include a provision preempting conflicting state laws, so as to avoid the constitutional barriers currently plaguing states like Pennsylvania. This approach to reform would have an advantage over a national damages cap in that it would continue to allow individual state legislatures to draft reform laws that were specifically tailored to the insurance market problems and health care quality concerns unique to the state.[115] A "states as laboratories" approach to the medical liability crisis has the added benefit of allowing states to experiment with new and innovative solutions to reform that, if successful, could be replicated in other states.

In conclusion, constitutional concerns have been a bugaboo for damages caps legislation in the past. In California and other states, the hoped-for effects of caps legislation on insurance premiums were delayed for years as constitutional challenges worked their way through the courts. Constitutional challenges continue to be brought against caps passed as part of the latest round of tort reform; however, reformers can face those challenges with greater confidence today. Over the years, the scales in state courts have increasingly tipped toward upholding noneconomic damages caps. Legislatures have also learned to avoid the more problematic caps on total damages and to make and document findings about the effects of high liability insurance costs on health care in their state and the effectiveness of caps in stabilizing those costs. Some states, like Pennsylvania, remain barred from adopting damages caps due to constitutional provisions that explicitly prohibit them. But others face a much clearer path than was the case during previous malpractice crises. For them, the primary obstacle to implementing caps is not legal but political.

The now-widespread judicial acceptance of caps should not be interpreted as proof that they are efficacious, or good public policy. Rational-basis review sets the bar very low. The evidence about the caps' effectiveness remains mixed, and concerns about their equity implications persist.[116] Our review suggests that these matters ought to be scrupulously considered by legislatures, for they will not be by the courts.

Appendix G

Table 1

Damages Caps Laws and Constitutional Challenges†

State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
Alabama	No limits	$400,000 limit on noneconomic damages was held to violate equal protection and the right to a jury trial. *Moore v. Mobile Infirmity Ass'n*, 592 So. 2d 156 (Ala. 1991). $1 million limit on total damages was also struck down as violating equal protection and the right to a jury trial. *Smith v. Schulte*, 671 So. 2d 1334 (Ala. 1995).
Alaska	Noneconomic damages are capped at $400,000, or $8,000 times the years of the plaintiff's life expectancy, whichever is greater. In cases of severe permanent physical impairment or severe disfigurement, damages are limited to the greater of $1 million or $25,000 times the years of the plaintiff's life expectancy. Alaska Stat. § 09.17.010. Punitive damages in most cases are limited to the greater of three times the award of compensatory damages or $500,000. 50% of punitive damages awards must be paid to the state treasury. Alaska Stat. § 09.17.020.	Medical malpractice damages caps did not violate the right to a jury trial, the right to equal protection, or the right to substantive due process in the state or federal constitutions, the separation of powers doctrine, or the right of access to the courts, or the ban on "special legislation" in the state constitution. *Evans v. State*, 56 P.3d 1046 (Alaska 2002).
Arizona	No limits	Article 2, § 31 of the Arizona constitution prohibits the enactment of any law limiting the damages one may recover for personal injury or death.
Arkansas	Punitive damages are capped at $1 million in medical malpractice and personal injury lawsuits. Ark. Code § 16-55-208.	Unchallenged on constitutional grounds
California	Noneconomic damages in medical liability cases are limited to $250,000. Cal. Civ. Code § 3333.2.	The $250,000 limit on noneconomic damages in medical liability actions does not violate the equal protection or due process provisions of the state or federal constitutions. *Fein v. Permanente Med. Group*, 695 P.2d 665 (Cal. 1985), appeal dismissed, 474 U.S. 892 (1985).
Colorado	$1 million limit for total damages (including past and future damages and noneconomic damages) against a hospital or physician, unless court finds clear justification to exceed, of which no more than $300,000 can be for noneconomic damages ($250,000 for cases before July 1, 2003). Colo. Rev. Stat. § 13-64-302. Punitive damages may not exceed the amount of actual damages awarded. Colo. Rev. Stat. § 13-21-102.	The $250,000 limit on noneconomic damages in medical liability actions is constitutional and does not violate equal protection or due process guarantees. *Scholz v. Metropolitan Pathologists, P.C.*, 851 P.2d 901, 906-907 (Colo. 1993).
Connecticut	No limits	N/A
Delaware	Punitive damages may only be awarded if the medical injury was maliciously intended or the result of wanton and willful misconduct. Del. Code tit. 18, § 6855.	Unchallenged on constitutional grounds
District of Columbia	No limits	N/A
Florida	Noneconomic damages awards for physician malpractice are capped at $500,000, but this cap may be increased to $1 million at the court's discretion. Fla. Stat. § 766.118. If a plaintiff rejects a physician's offer to use binding arbitration in lieu of a trial, then noneconomic damages are capped at $350,000. Fla. Stat. § 766.209. Noneconomic damages are capped at $250,000 in arbitration proceedings. Fla. Stat. § 766.207. Punitive damages may not be awarded by arbitration panels. Fla. Stat. § 766.107.	Capping noneconomic damages at $250,000 in binding arbitration hearings for medical malpractice claims did not violate the equal protection, due process, or takings provisions of the state or federal constitutions, nor did it violate the right to jury trial, single subject requirement, or nondelegation doctrine under the Florida constitution. *Univ. of Miami v. Echarte*, 618 So. 2d 189 (Fla. 1993). An earlier law capping noneconomic damages for all tort claimants at $450,000 was held unconstitutional under the Florida constitution's open-courts provision (Art. I, § 21). Unlike in Echarte, the state had not made a colorable argument that the caps law offered a commensurate benefit to claimants or was the only available means of responding to an overpowering public necessity. *Smith v. Dep't of Insurance*, 507 So. 2d 1080 (Fla. 1987).

† Current as of April 2005. We do not include caps that apply only to the liability of government-employed health care providers.

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State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
		A constitutional challenge to the recently adopted $500,000 cap (Fla. Stat. § 766.118) is pending. *Berges v. Lambkin-Alexander* (Fla. Cir. Ct., no citation available).
Georgia	General law limiting punitive damages in all tort actions to $250,000 unless defendant acts with specific intent to harm or demonstrates other aggravating circumstances that would justify a higher award. Ga. Code § 51-12-5.1. In 2005, the state passed a $350,000 cap on noneconomic damages ($700,000 if judgment involves more than one medical facility). Ga. Code § 51-13-1.	Unchallenged on constitutional grounds
Hawaii	General law placing a $375,000 limit on pain and suffering awards in tort actions. Cap does not apply to intentional torts. Haw. Rev. Stat. § 663-8.7.	Unchallenged on constitutional grounds
Idaho	$250,000 cap on noneconomic damages per claimant in personal injury and wrongful death actions. Cap adjusted annually based on average annual wage data. Cap does not apply to injuries caused by willful or reckless misconduct, or felonious actions. Idaho Code § 6-1603. Punitive damages in personal injury actions are capped at the greater of $250,000 or three times compensatory damages. Idaho Code § 6-1604.	Cap on noneconomic damages in personal injury and wrongful death actions did not violate the right to jury trial, constitute special legislation, or violate the separation of powers doctrine under the state constitution. *Kirkland v. Blaine Co. Med. Ctr.*, 4 P.3d 1115 (Idaho 2000).
Illinois	No punitive damages are allowed in tort or contract cases arising from medical, hospital or other healing art malpractice. 735 Ill. Comp. Stat. 5/2-1115.	Prior law capping noneconomic damages in tort actions to $500,000 was held to violate the special legislation and separation of powers provisions in the Illinois constitution. *Best v. Taylor Machine Works, Inc.*, 689 N.E.2d 1057 (Ill. 1997). Previous cap on total damages was held to violate the Illinois equal protection provision. *Wright v. Central Du Page Hosp. Assoc.*, 347 N.E.2d 736 (Ill. 1976). Current cap on punitive damages in medical malpractice cases remains unchallenged on constitutional grounds.
Indiana	The total amount recoverable in medical liability cases is limited to $750,000 for acts that occurred before July 1, 1999, and to $1,250,000 for acts that occurred after July 1, 1999. Defendant healthcare providers are responsible for paying the first $250,000 of the damage award. Any amount in excess of this limit is paid from the Indiana Patient's Compensation Fund. Ind. Code Ann. § 34-18-14-3.	Cap on total damages does not violate equal protection, due process, or right to trial by jury under either the federal or Indiana constitutions. *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980), aff'd, *Indiana Patient's Compensation Fund v. Wolfe*, 735 N.E. 2d 1187 (Ind. Ct. App. 2000).
Iowa	No limits. The Iowa House and Senate passed a $250,000 cap on noneconomic damages in 2004 (HB 2440) but the measure was vetoed by Governor Tom Vilsack.	N/A
Kansas	Noneconomic damages in personal injury cases are capped at $250,000. Kan. Stat. Ann. § 60-19a02.	An earlier Kansas statute that established a total damages cap of $1 million in medical malpractice actions was held to violate the right to jury trial and right to remedy (open-courts) provisions of the Kansas constitution. *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988). However, the Kansas Supreme Court has upheld the current statute as constitutional based on the fact that the $250,000 cap is limited to noneconomic damages. *Samsel v. Wheeler Transport Serv., Inc.*, 789 P.2d 541 (Kan. 1990) (holding that the cap does not violate state constitutional guarantees of jury trial and open-courts); see also *Leiker v. Gafford*, 778 P.2d 823 (Kan. 1989) (holding that a similar $100,000 cap on non-pecuniary losses in wrongful death actions did not violate the equal protection, due process, or right to jury trial provisions of the federal or Kansas constitutions).
Kentucky	No limits	Article 54 of the Kentucky constitution prohibits the legislature from passing any law that would limit recovery in a personal injury or wrongful death action.

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State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
Louisiana	The total amount of damages for injuries or death due to medical malpractice is capped at $500,000. Each provider is liable for $100,000, and the state's patient compensation fund pays any excess award above that level. La. Rev. Stat. Ann. § 1299.42.	$500,000 cap in medical liability actions did not violate the equal protection provisions of the state or federal constitutions. *Butler v. Flint Goodrich Hosp. of Dillard Univ.*, 607 So.2d 517 (La. 1989).
Maine	$400,000 noneconomic damages cap applies to wrongful death cases only. 24-A M.R.S.A. § 4313.9.	Unchallenged on constitutional grounds
Maryland	In December 2004, the Maryland legislature passed the "Maryland Patients' Access to Quality Health Care Act of 2004" (H.B. 2) which capped noneconomic damages in medical malpractice actions at $812,500 if they involve a patient's death, and at $650,000, in all other cases. The legislation was vetoed by Governor Robert Ehrlich, but the Maryland legislature subsequently overrode this veto in January 2005.	The medical liability legislation has not been challenged on constitutional grounds. In an earlier decision, the Maryland Supreme Court held that a statute capping damages in personal injury cases did not violate the right to jury trial or due process clauses in the Maryland constitution. *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992).
Massachusetts	In a medical malpractice case, the jury is not to award the plaintiff more than $500,000 for noneconomic damages unless it determines that the loss or impairment is so severe that the damages cap would deprive the plaintiff of just compensation for the injuries sustained. Mass. Gen. Laws ch. 231, § 60H.	Unchallenged on constitutional grounds
Michigan	Noneconomic damages are capped at $280,000, adjusted annually for inflation. The noneconomic damages cap is increased to $500,000 in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, where the plaintiff has permanently impaired cognitive capacity, or where the plaintiff has permanent damage to a reproductive organ. Mich. Comp. Laws § 600.1483.	There are no Michigan supreme court cases ruling on the constitutionality of these caps. One Michigan appellate court ruled that the caps were constitutional and did not infringe on the right to jury trial or right to equal protection. *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002). Subsequent decisions have followed Zdrojewski in applying the cap, but at least one Michigan appellate court issued an opinion which strongly criticized this earlier holding. *Wiley v. Henry Ford Cottage Hosp.*, 668 N.W.2d 402, 509 (Mich. Ct. App. 2003).
Minnesota	No limits	N/A
Mississippi	Noneconomic damages are limited to $500,000 in cases involving malpractice or breach of the standard of care. In all other cases, noneconomic damages are capped at $1,000,000. Miss. Code Ann. § 11-1-60. Punitive damages are only awarded upon a showing of actual malice or gross negligence. Miss. Code Ann. § 11-1-65.	Unchallenged on constitutional grounds
Missouri	Noneconomic damages in tort actions based on improper healthcare are capped at $350,000. This amount is adjusted annually based on inflation data. Punitive damages are only awarded upon a showing of willful, wanton, or malicious conduct. Mo. Ann. Stat. § 538.210.	Noneconomic damages caps do not violate the due process, equal protection, right to jury trial, or open-courts provisions of either the federal or Missouri constitutions. *Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898 (Mo. 1992).
Montana	Noneconomic damages in medical malpractice actions are limited to $250,000. Mont. Code Ann. § 25-9-411. Punitive damages are capped at the lesser of $3 million or three percent of the defendant's net worth. Mont. Code Ann. § 27-1-220.	Unchallenged on constitutional grounds
Nebraska	The total amount recoverable by a plaintiff in a medical liability action may not exceed $1,750,000. Provider liability is capped at $500,000; damages above this amount are paid from the state's Excess Liability Fund. Neb. Rev. Stat. § 44.2825.	Caps on total damages do not violate the right to trial by jury, equal protection, separation of powers or open-courts provisions of the Nebraska constitution. *Gourley v. Neb. Methodist Health Sys., Inc.*, 663 N.W.2d 43 (Neb. 2003); see also *Prendergast v. Nelson*, 256 N.W.2d 657 (1977) (upholding the total damages cap against equal protection and due process challenges).
Nevada	$350,000 cap on noneconomic damages is applied to medical malpractice actions unless the defendant's conduct constitutes gross malpractice, or the court determines by clear and convincing evidence that a higher award is justified. Noneconomic damages may not exceed the amount of money remaining under the	Unchallenged on constitutional grounds

Appendix G

State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
	defendant's professional liability insurance policy after subtracting the economic damages awarded to the plaintiff. Nev. Rev. Stat. § 41A.031.	
New Hampshire	Punitive damages may not be awarded in any action unless specifically provided by statute. N.H. Rev. Stat. Ann. § 507:16.	A prior $250,000 cap on noneconomic damages in medical liability cases was held to violate the equal protection provision in the New Hampshire constitution. *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980). A similar $875,000 cap on noneconomic damages in personal injury accidents was also held to violate state equal protection law. *Brannigan v. Usitalso*, 587 A.2d 1232 (N.H. 1980).
New Jersey	Punitive damages in civil actions are capped at the greater of five times the compensatory damages or $350,000. N.J. Stat. Ann. § 2A:15-5.14.	Unchallenged on constitutional grounds
New Mexico	$600,000 cap on all medical malpractice damages, excluding punitive damages and medical care and related costs. Healthcare providers are liable for $200,000. Awards in excess of this amount are paid from the state patient compensation fund. N.M. Stat. Ann. § 41-5-6.	Unchallenged on constitutional grounds
New York	No Limits	N/A
North Carolina	Punitive damages are only awarded for acts of fraud, malice, or willful or wanton conduct. N.C. Gen. Stat. § 1D-15. Punitive damages are capped at the greater of $250,000 or three times compensatory damages. N.C. Gen. Stat. § 1D-25.	Statute capping punitive damages did not violate the right to a jury trial, separation of powers principle, open-courts guarantee, prohibition against special legislation, or the principles of due process, equal protection or the right to enjoy the fruits of one's labor under the state constitution, and was not void for vagueness. *Rhyne v. K-Mart Corp.*, 594 S.E.2d 1 (N.C. 2004).
North Dakota	Noneconomic damages in healthcare malpractice actions are capped at $500,000. N.D. Cent. Code § 32-42-02.	Current law unchallenged on constitutional grounds. However, a prior North Dakota cap on total damages (later repealed) was held to be a violation of the equal protection and substantive due process rights guaranteed in the North Dakota constitution. *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).
Ohio	Noneconomic damages in medical liability cases are capped at the greater of $250,000 or three times the amount of economic loss, up to $350,000 per plaintiff and $500,000 per occurrence. This cap is increased to $500,000 per plaintiff and $1 million per occurrence when permanent physical or function deformities are involved. Ohio Rev. Code Ann. § 2323.43.	An earlier law capping general damages in medical liability actions was held to be unconstitutional under the due process clause of the Ohio constitution. *Morris v. Savoy*, 576 N.E.2d 765 (Ohio 1991). An earlier cap on punitive damages was also held to violate the jury trial provision of the Ohio constitution. *Crowe v. Owens Corning Fiberglass*, 718 N.E.2d 923 (Ohio 1999). More than a dozen cases challenging the current cap are pending at the trial court level.
Oklahoma	Noneconomic damages are capped at $300,000 in medical malpractice cases involving pregnancy or emergency care. Okla. Stat. tit. 63, § 1-1708.1F. The cap also applies to other malpractice cases if the defendant made a settlement offer and the verdict awarded to the plaintiff is less than 1.5 times the amount of the final offer. Okla. Stat. tit. 63, § 1-1708.1F-1. Punitive damages are limited to $100,000 in cases of reckless disregard of the rights of others. In cases of intentional and malicious acts, they are limited to the greater of $500,000, twice compensatory damages, or the benefit derived by defendant from his conduct. If the judge finds beyond a reasonable doubt that the intentional and malicious act threatened human life, then the cap does not apply. Okla. Stat. Ann. tit. 23, § 9.1.	Unchallenged on constitutional grounds
Oregon	Noneconomic damages are capped at $500,000 in civil lawsuits that are based on statutorily-created causes of action. Or. Rev. Stat. § 31.710. Punitive damages are only allowed upon a showing of malice or reckless and outrageous indifference to a highly unreasonable risk of harm. Or. Rev. Stat. § 31.730. Punitive damages may not be	$500,000 cap on noneconomic damages was found to violate the right to trial by jury in the Oregon constitution. *Lakin v. Senco Products*, 987 P.2d 463 (Or. 1999). However, the court stipulated that this case did not overrule an earlier case which upheld the constitutionality of the cap when applied to wrongful death cases, since the wrongful death statute was a creation of the legislature and not based on Oregon common law as it existed at

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State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
	awarded against licensed or registered healthcare professionals acting within the scope of their employment. Or. Rev. Stat. § 31.740.	the time the Oregon constitution was enacted. *Greist v. Phillips*, 906 P.2d 789 (Or. 1995).
Pennsylvania	No limits	Art. 3, § 18 of the Pennsylvania constitution prohibits the General Assembly from enacting any law that would limit the amount to be recovered for injuries resulting in death, or for injuries to persons or property.
Rhode Island	No Limits	N/A
South Carolina	As of July 1, 2005, noneconomic damages are capped at $350,000 per provider; plaintiff may recover no more than $1.05 million in noneconomic damages in cases involving multiple defendants. Cap is adjusted annually for inflation. Cap does not apply if defendant was grossly negligent. S.C. Code § 15-32-320.	Unchallenged on constitutional grounds
South Dakota	General (noneconomic) damages in medical malpractice actions may not exceed $500,000. There is no limit on the total of special (economic) damages. S.D. Codified Laws § 21-3-11.	A prior version of this statute provided for a cap of $1,000,000 on all damages, whether economic or noneconomic. This law was found to violate the substantive due process, equal protection, jury trial, and open-courts guarantees in the South Dakota constitution. *Knowles v. U.S.*, 544 N.W.2d 183 (S.D. 1996). The current version of the cap, which is limited to noneconomic damages, has not been challenged on constitutional grounds.
Tennessee	No Limits	N/A
Texas	Noneconomic damages in medical malpractice actions are capped at $250,000 per physician. Noneconomic damages are also capped at $250,000 per hospital, with an additional cumulative hospital liability cap of $500,000 when multiple hospitals are involved. Tex. Civ. Pract. & Rem. § 74.301. Punitive damages in all tort cases are limited to the greater of $200,000 or two times the amount of economic damages, plus any noneconomic damages up to $750,000. Tex. Civ. Prac. & Rem. § 41.008.	The Texas Supreme Court held a prior version of the medical malpractice damages cap to be unconstitutional, except when applied to wrongful death cases. *Lucas v. U.S.*, 757 S.W.2d 687 (Tex. 1988) (holding medical malpractice damages caps violated the open-courts provision of the Texas constitution); see also *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990) (holding caps could be applied to causes of action not based in common law, such as an action for wrongful death). In order to ensure that the current legislation will be upheld, Texas voters passed Proposition 12 in 2003, which amended the Texas constitution to expressly permit the legislature to limit noneconomic damages in actions against healthcare providers. Tex. Const. art. 3, § 66.
Utah	Noneconomic damages in medical malpractice actions are capped as follows: (1) actions arising prior to July 1, 2001 at $250,000; (2) actions arising after July 1, 2001, and before July 1, 2002 at $400,000; and (3) actions arising after July 1, 2002 at $400,000, adjusted annually for inflation. Utah Code Ann. § 78-14-7.1.	Caps do not violate state constitutional guarantees of open-courts, equal protection, due process, jury trial, or separation of powers. *Judd v. Drezga*, 103 P.3d 135 (Utah 2004).
Vermont	No limits	N/A
Virginia	Total damages in medical liability actions were capped at $1.5 million in 2000. This cap increases $50,000 annually through 2007, until it reaches a final cap of $2 million in 2008. Va. Code Ann. § 8.01-581.15. Punitive damages in tort actions are capped at $350,000. Va. Code Ann. § 8.01-38.1.	Total damages cap does not violate right to jury trial, due process, separation of powers, prohibition against special legislation, or the federal equal protection clause. *Etheridge v. Med. Ctr. Hosps.*, 376 S.E.2d 525 (Va. 1989). Punitive damages limits do not violate the due process provisions in either the state or federal constitutions. *Wackenhut Applied Tech. Ctr. v. Sygnetron Prot. Sys.*, 979 F.2d 980 (4th Cir. 1992).
Washington	A cap on noneconomic damages for personal injury and wrongful death claims remains on the books. Wash. Rev. Code § 4.56.250. However, this provision has been declared unconstitutional and is no longer enforced.	Although a cap on noneconomic damages remains on the books, this statute was found to violate the right to trial by jury and was declared unconstitutional. *Sofie v. Fireboard Corp.*, 771 P.2d 711 (Wash. 1989).

Appendix G

State	Damages Caps Applicable to Medical Malpractice Cases	Constitutional Challenges
West Virginia	In medical liability actions, noneconomic damages are capped at $250,000 per occurrence. This cap increases to $500,000 when there is a permanent and substantial physical deformity, loss of use of a limb or bodily organ system, or a permanent physical or mental injury that prevents the person from being able to independently care for himself. These limits are adjusted annually for inflation, and only apply to defendants who have at least $1,000,000 per occurrence in medical liability insurance. The statute also stipulates that if the limits are found to be unconstitutional, then the cap on noneconomic damages will automatically increase to $1 million. W.Va. Code § 55-7B-8.	A prior $1 million cap on noneconomic damages in medical malpractice actions was held to be constitutional and not in violation of equal protection, substantive due process, jury trial, or right to remedy guarantees in the state constitution. *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877 (W.Va. 1991). A constitutional challenge to the current cap is pending. *Boggs v. Camden-Clark Mem'l Hosp.* (W.Va. S. Ct., no citation available).
Wisconsin	Noneconomic damages are limited to $350,000, adjusted annually for inflation. Wis. Stat. § 893.55. In wrongful death cases, the noneconomic damages limit is increased to $500,000 for the death of a child and $350,000 for the death of an adult. Wis. Stat. § 895.04.	There are no Wisconsin Supreme Court decisions ruling on the constitutionality of this legislation. However, a Wisconsin appellate court held that the $350,000 cap on noneconomic damages did not violate the right to trial by jury, separation of powers, equal protection, or due process provisions of the state constitution. *Guzman v. St. Francis Hosp., Inc.*, 623 N.W.2d 776 (Wis. Ct. App. 2000).
Wyoming	No Limits	Article 10, § 4 of the Wyoming constitution prohibits the legislature from enacting any law that would cap damages in an action involving wrongful death or personal injury.

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2. *Berges v. Lambkin-Alexander* (FL. Cir. Ct., no citation available); *Boggs v. Camden-Clark Mem'l Hosp.* (W. VA. S. Ct., no citation available); T. Albert, "Challenges in State Courts: New Tort Reforms Under Fire," *amednews.com* November 1, 2004 *at* <http://www.ama-assn.org/amednews/2004/11/01/prl11101.htm> (last visited June 21, 2005).
3. *Judd ex rel. Montgomery v. Drezga*, 103 P.3d 135 (Utah 2004).
4. Claims have also been brought alleging that caps legislation violates state constitutional provisions prohibiting "special laws," or laws that apply to only particular persons or things of a class. See, e.g., *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988). Such challenges have not been successful.
5. N.C. GEN. STAT. § 1D-15 (2004).
6. OR. REV. STAT. § 31.740 (2003).
7. D. M. Studdert and T. A. Brennan, "The Problems with Punitive Damages in Lawsuits Against Managed-Care Organizations," *N. Engl. J. Med.* 342 (2000): 280-284.
8. D. M. Studdert, Y. T. Yang and M. M. Mello, "Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California," *Health Affairs* 23 (2004): 54-67.
9. See Studdert, Yang and Mello, *supra* note 8.
10. P. V. Niemeyer, "Awards for Pain and Suffering: The Irrational Centerpiece of Our Torts System," *Virginia Law Review* 90 (2004): 1401-1421, at 1403.
11. CAL. CIV. CODE § 3333.2 (2004).
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13. IDAHO CODE § 6-1603 (2004).
14. ALASKA STAT. § 09.17.010 (2004).
15. MASS. GEN. LAWS ch. 231, § 60H (2004) (allows the jury to waive a $500,000 cap on noneconomic damages if it determines that the patient's injuries are so severe that the cap would deprive the patient of just compensation); NEV. REV. STAT. § 41A.031 (2004) (allows the judge to waive a $350,000 cap on noneconomic damages in cases of gross malpractice or where the court determines by clear and convincing evidence that an award in excess of $350,000 is justified).
16. NEV. REV. STAT. § 41A.031 (2004).
17. BURNS IND. CODE ANN. § 34-18-14-3 (2004).
18. Help Efficient, Accessible, Low-Cost Timely Healthcare (HEALTH) Act of 2003, H.R. 5.
19. Patients First Act of 2003, S. 11.
20. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. This bill was subsequently attached to H.R. 4279, which passed the House on May 12, 2004.
21. A bill to 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, S. 354, 109th Cong.; A bill to 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, H.R. 534, 109th Cong.
22. U.S. CONST. art. III § 2 restricts the federal courts (including the U.S. Supreme Court) to appellate review of cases involving questions of federal law.
23. D. Schuman, "The Right to a Remedy," *Temple Law Review* 65 (1992): 1197-1227, at 1201.
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25. P. J. Chupkovich, Comment, "Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for Obtaining Affordable Health Care?" *Journal of Contemporary Health Law and Policy* 9 (1993): 337-375, at 364.
26. See *Evans v. State*, 56 P.3d 1046, 1056 (Alaska 2002).
27. See *Gourley v. Nebraska Methodist Health Sys.*, 663 N.W.2d 43, 74 (Neb. 2003); *Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898, 905 (Mo. 1992).
28. Lucas, 757 S.W.2d, at 715 (Culver, J., concurring).
29. Adams, 832 S.W.2d, at 905.
30. *Waggoner v. Gibson*, 647 F. Supp. 1102 (N.D. TX. 1986).
31. Lucas, 757 S.W.2d, at 690.
32. *Id.* at 696-699 (Gonzalez, J., dissenting).
33. *Id.* at 691.
34. TEX. CONST. art. 3, § 66.
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36. Governor's Select Task Force on Healthcare Professional Liability Insurance, *Report and Recommendations* (Florida: Governor's Office, 2003): at 201-211.
37. FL. CONST. Art. I, § 21.

38. *Kluger v. White*, 281 So.2d 1 (Fla. 1973); *Lasky v. State Farm Ins. Co.*, 296 So.2d 9 (FL. 1974).
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40. *Smith v. Dep't of Insurance*, 507 So.2d 1080 (FL. 1987).
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42. *University of Miami v. Echarte*, 618 So. 2d 189 (FL. 1993).
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44. *Minneapolis & St. Louis R.R. v. Bombolis*, 241 U.S. 211 (1916).
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46. *Lakin v. Senco Prods., Inc.*, 987 P.2d 463, 475 (OR. 1999).
47. *Etheridge v. Med. Ctr. Hosps.*, 376 S.E.2d 525, 529 (VA. 1989).
48. *Id.*
49. Judd, 103 P.3d, at 143.
50. Adams, 832 S.W.2d, at 907.
51. *Kirkland v. Blain Co. Med. Ctr.*, 4 P.3d 1115, 1119-1120 (ID 2000).
52. *Moore v. Mobile Infirmary Assoc.*, 592 So.2d 156, 164 (AL. 1992).
53. *Id.* at 164. The Alabama and Missouri constitutions both guarantee that the right of a jury trial shall remain "inviolate." See MO. CONST. art. I, § 22(a) and ALA. CONST. art. I, § 11.
54. *Sofie v. Fibreboard Corp.*, 771 P.2d 711, 720-23 (Wash. 1989).
55. *Id.* at 723, quoted in Judd, 103 P.3d, at 146.
56. *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251, 260; but see Evans, 56 P.3d, at 1055 (Alaska Supreme Court holding that damages caps are not remittur, but a constitutionally-allowable limitation of a cause of action).
57. L. Hunter Dietz et al., "Availability of New Trial or Remittitur," 57B Am. Jur. 2d Negligence § 1093 (2004).
58. *Dimick v. Schiedt*, 293 U.S. 474, 486 (1935).
59. *Id.*
60. U.S. CONST. amend. XIV § 1.
61. See *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978) (holding demonstrates the Supreme Court's analysis of suspect classifications based on race); *Harper v. Va. Bd. of Elections*, 383 U.S. 663 (1966) (holding invalidating a poll tax demonstrates a law that infringed on the fundamental right to vote).
62. M. A. Willis, Comment, "Limitation on Recovery of Damages in Medical Malpractice Cases: A Violation of Equal Protection?" *University of Cincinnati Law Review* 54 (1986): 1329-1351, at 1334.
63. *U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166 (1980).
64. *Minn. v. Clover Leaf Creamery Co.*, 449 U.S. 456 (1991); but see *U.S. Dept. of Agric. v. Moreno*, 413 U.S. 538 (1973) (striking down federal food stamp program rule that defined "household" as a group of related persons on grounds that it was "irrationally" related to the government's objective of promoting nutrition).
65. *Sibley v. Bd. of Supervisors of LA. State Univ.*, 477 So.2d 1094, 1107 (LA. 1985).
66. *Fein v. Permanente Med. Group*, 695 P.2d 665, 682 (CA. 1985).
67. *Id.* at 670.
68. *Id.* at 671 (citing Medical Injury Comprehensive Reform Act, CAL. CIV. CODE § 3333.2).
69. *Id.* at 679.
70. *Id.* at 684.
71. *Id.* at 679.
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74. *Fein v. Permanente Med. Group*, 474 U.S. 892 (1985).
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76. Judd, 103 P.3d, at 142.
77. Moore, 592 So.2d, at 156.
78. *Id.* at 169.
79. *Id.*
80. *Carson v. Maurer*, 424 A.2d 825, 830 (N.H. 1980).
81. *Id.* at 831.
82. *Id.* at 837.
83. D. M. Studdert, M. M. Mello and T. A. Brennan, "Medical Malpractice," *N. Engl. J. Med.* 350 (2004): 283-292.
84. Etheridge, 376 S.E.2d, at 530.
85. *Id.*
86. *Scholz v. Metropolitan Pathologists*, P.C., 851 P.2d 901, 907 (CO. 1993).
87. As with equal protection challenges, some state courts have opted to use a higher standard of review. See *Knowles v. U.S.*, 544 N.W.2d 183, 189 (S.D. 1996) (holding that the damages caps must bear a "real and substantial relation" to the objective to be attained).
88. See Evans, 56 P.3d, at 1055 (holding that the substantive due process question was dispensed with once the court found that the damages caps did not violate equal protection guarantees).
89. *Morris v. Savoy*, 576 N.E.2d 764 (Ohio 1991).
90. *Id.* at 770.
91. See Bell, 757 P.2d, at 259; Lucas, 757 S.W.2d, at 690 (holding that statutory caps were unreasonable under the state open-courts provision of the Texas constitution because they failed to provide a substitute redress for the victim).
92. Fein, 474 U.S., at 892.
93. *Duke Power Co. v. Carolina Environmental Study Group, Inc.*, 438 U.S. 59 (1978).
94. *Id.* at 88.
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96. *Arneson v. Olson*, 270 N.W.2d 125, 134-135 (N.D. 1978).
97. Lucas, 757 S.W.2d, at 690-691; Smith, 507 So.2d, at 1089-1090; Judd, 103 P.3d, at 138-140.
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99. Judd, 103 P.3d, at 145.
100. *Best v. Taylor Mach. Works, Inc.*, 689 N.E.2d 1057, 1078-1080 (Ill. 1997).
101. Scherlinck, *supra* note 98, at 340.
102. For example, see Kirkland, 4 P.3d, at 1121 (holding that a noneconomic damages cap did not violate separation of powers because the Idaho constitution allows the legislature to "modify or abolish common law causes of action"); *Pulliam v. Coastal Emergency Servs. of Richmond, Inc.*, 509 S.E.2d 307, 319 (VA. 1999) (holding that a medical malpractice damages cap did not violate separation of powers, because the legislature "has the power to provide, modify, or repeal a remedy"); *Verba v. Ghaphery*, 552 S.E.2d 406, 411 (W.Va. 2001) (holding that a medical malpractice damages cap did not violate separation of powers because the legislature has the power to limit common law remedies).
103. Judd, 103 P.3d, at 145, quoting *Ritchie v. Richards*, 47 P. 670, 675 (UT. 1896) (Bartch, J., concurring).
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107. Kluger, 281 So.2d, at 4.
108. HEALTH Act of 2003, § 11(c); HEALTH Act of 2004, § 1011(c).
109. H. Hershkoff, "State Courts and the 'Passive Virtues': Rethinking the Judicial Function," *Harvard Law Review* 114 (2001): 1833-1922, at 1888.
110. *Id.*
111. H. Hershkoff, "Postive Rights and State Constitutions: The Limits of Federal Rationality Review," *Harvard Law Review* 112 (1999): 1131-1195, at 1162-1163.
112. *Id.* at 1168.
113. *Id.* at 1181.
114. *Id.* at 1182.
115. J. F. Blumstein, "A Perspective on Federalism and Medical Malpractice," *Yale Journal on Regulation* 14 (1996): 411-427, at 425-426.
116. Studdert, Mello and Brennan, *supra* note 83; Studdert, Yang and Mello, *supra* note 8.

Appendix H

***SOFIE V. FIBREBOARD CORP.*, 112 Wn. 2d 636, 771 P.2d 771 (1989)**

[No. 54610–0. En Banc. April 27, 1989.]

AUSTIN SOFIE, ET AL, *Appellants*, v. FIBREBOARD CORPORATION, ET AL, *Respondents*.

[1] Statutes — Validity — Presumption — Economic Legislation. A court will apply every reasonable presumption in favor of upholding the constitutionality of economic legislation.

[2] Jury — Right to Jury — Civil Proceeding — Constitutional Provisions. The right to trial by jury in a civil proceeding in this state is guaranteed solely by article 1, section 21 of the state constitution. The seventh amendment to the United States Constitution does not apply.

[3] Jury — Right to Jury — Scope — Applicability — Historical Analysis. In determining the scope of the right to trial by jury guaranteed by Const. art. 1, § 21, as well as the particular actions to which it applies, a court will look initially to the right as it existed at the time the constitution was adopted in 1889.

[4] Damages — Jury — Right to Jury — Scope — Determination of Damages. A plaintiff in a civil action has a right under Const. art. 1, § 21 to have the jury determine the factual issue of the amount of damages sustained.

[5] States — Legislature — Authority — Jury's Determination of Damages. The Legislature has no authority to intrude upon the constitutional jury function of determining the amount of a plaintiff's damages.

[6] Constitutional Law — Construction — Form and Substance. A court may not bypass a constitutional protection by allowing it to exist in form but taking away its intended function.

[7] Torts — Damages — Tort Reform Act — Limitation on Damages — Noneconomic Damages — Validity. RCW 4.56-.250, which requires a trial judge to apply a formula based on age to reduce the noneconomic damages awarded by a jury to a personal injury or wrongful death plaintiff, violates a plaintiff's right to a jury guaranteed by Const. art. 1, § 21.

[8] Courts — Judicial Discretion — Abuse — What Constitutes. A judicial decision constitutes an abuse of discretion only if no reasonable judge would have made the same decision.

[9] Torts — Joint Tortfeasors — Joint and Several Liability — Statutory Restriction — Exceptions — Hazardous Substances. Under RCW 4.22.070(3)(a), statutory restrictions on joint and several liability established by the 1986 tort reform act do not apply to an action relating to a hazardous substance, regardless of whether the substance pollutes the environment. [*Dictum.*]

ANDERSEN, J., concurs by separate opinion; CALLOW, C.J., and DOLLIVER and DURHAM, JJ., dissent by separate opinions.

Nature of Action: A former pipefitter afflicted with lung cancer sought damages from asbestos manufacturers.

Superior Court: The Superior Court for Kitsap County, No. 87–2–00407–6, James I. Maddock, J., on October 30, 1987, entered a judgment in favor of the plaintiff. The court reduced the jury's award of noneconomic damages in accordance with the formula set forth in RCW 4.56-.250.

Supreme Court: Holding that RCW 4.56.250 violates the state constitutional right to trial by jury, that the trial court had not abused its discretion in making several decisions, and that the statutory restriction of joint and several liability did not apply to the named defendants, the court *affirms* the liability determination, *reverses* the trial court's reduction of the noneconomic damages, and *reinstates* the damage award in the verdict.

Schroeter, Goldmark & Bender, William Rutzick, Janet L. Rice, and *Kirk I. Mortensen; Stritmatter, Kessler & McCauley* and *Paul Stritmatter,* for appellants.

Gibson, Dunn & Crutcher, by *Steven T. Johnson, Kent T. van den Berg, Gary C. Grotz,* and *Mark Hughes,* for respondents Fibreboard, Celotex, Owens–Illinois, and Keene Corporations.

Williams, Kastner & Gibbs, by *William H. Mays, Mary H. Spillane,* and *Elizabeth A. Christianson,* for respondent Eagle–Picher Industries.

McKay & Gaitan, by *Linda E. Blohm,* for respondent Raymark Industries.

Bryan P. Harnetiaux and *Robert H. Whaley* on behalf of Washington State Trial Lawyers Association; *Daniel F. Sullivan* and *Jeffrey Robert White* on behalf of Association of Trial Lawyers of America; *Richard H. Robblee* on behalf of United Association of Journeymen and Apprentices, amici curiae for appellants.

Kenneth O. Eikenberry, Attorney General, Michael E. Tardif, Senior Assistant, and *Michael Madden, Assistant; Bertha B. Fitzer* and *F. Ross Burgess* on behalf of Washington Defense Trial Lawyers Association and Defense Research Institute; *Jeffrey I. Tilden* and *Rex C. Browning* on behalf of the Liability Reform Coalition, amici curiae for respondents.

[As amended by order of the Supreme Court September 27, 1989.]

UTTER, J.—Austin and Marcia Sofie challenge the constitutionality of RCW 4.56.250. This statute, part of the 1986 tort reform act, places a limit on the noneconomic damages recoverable by a personal injury or wrongful death plaintiff. The Sofies brought a direct appeal to this court after the trial judge in their tort action, under the direction of the statute, reduced the jury's award of noneconomic damages. The respondents subsequently cross–appealed to the Court of Appeals, raising several issues of trial court error, issues we consider here.

The Sofies argue that RCW 4.56.250 violates their constitutional rights to trial by jury, equal protection, and due process. We find that the statute's damages limit interferes with the jury's traditional function to determine damages. Therefore, RCW 4.56.250 violates article 1, section 21 of the Washington Constitution, which protects as inviolate the right to a jury. Because the statute is unconstitutional on this basis, we do not consider its constitutionality under the latter two doctrines raised by appellants, although we briefly survey the equal protection issues. Respondents' arguments concerning trial court error are without merit.

The Washington Legislature passed RCW 4.56.250 in 1986 partly as a response to rising insurance premiums for liability coverage. The damages limit that the statute creates operates on a formula based upon the age of the plaintiff.[1] As a result, the older a plaintiff is, the less he or

[1]RCW 4.56.250 states:

"(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

she will be able to recover in noneconomic damages. The trial judge applies the limit to the damages found by the trier of fact. If the case is tried before a jury, the jury determines the amount of noneconomic damages without knowledge of the limit. The jury goes about its normal business and the judge reduces, according to the statute's formula and without notifying the jury, any damage verdicts that exceed the limit.

In September 1987, the Sofies sued Fibreboard Corporation and other asbestos manufacturers for the harm caused to Mr. Sofie by their asbestos products. Mr. Sofie, then aged 67, was suffering from a form of lung cancer—mesothelioma—caused by exposure to asbestos during his career as a pipefitter. At trial, Mr. Sofie's attorneys presented evidence of the extreme pain he experienced as a result of the disease. The testimony indicated that Mr. Sofie spent what

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"(a) 'Economic damages' means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

"(b) 'Noneconomic damages' means subjective, nonmonetary losses, including, but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, and destruction of the parent–child relationship.

"(c) 'Bodily injury' means physical injury, sickness, or disease, including death.

"(d) 'Average annual wage' means the average annual wage in the state of Washington as determined under RCW 50.04.355.

"(2) In no action seeking damages for personal injury or death may a claimant recover a judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent–child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

"(3) If a case is tried to a jury, the jury shall not be informed of the limitation contained in subsection (2) of this section."

remained of his life waiting for the next "morphine cocktail," for the next hot bath, for anything that would lessen his consuming physical agony.

At the end of the trial, the jury found the defendants at fault for Mr. Sofie's disease. They returned a verdict of $1,345,833 in favor of the Sofies. Of this amount, $1,154,592 went to compensate noneconomic damages: $477,200 for Mr. Sofie's pain and suffering and $677,392 for Mrs. Sofie's loss of consortium. While the trial judge specifically found the jury's finding of damages reasonable, he indicated he was compelled under the damages limit to reduce the noneconomic portion of the verdict to $125,136.45, resulting in a total judgment of $316,377.45.

I

Appellants argue that RCW 4.56.250 violates their right to equal protection under the law as guaranteed by Const. art. 1, § 12. This constitutional provision states:

> No law shall be passed granting to any citizen, class of citizens, or corporation other than municipal, privileges or immunities which upon the same terms shall not equally belong to all citizens, or corporations.

Although the language of article 1, section 12 differs from the fourteenth amendment to the federal Constitution, this court has generally followed the federal tiered scrutiny model of equal protection analysis originally developed by the United States Supreme Court. *See, e.g., Daggs v. Seattle,* 110 Wn.2d 49, 55, 750 P.2d 626 (1988). We have followed this approach because a separate analysis focusing on the language and history of our state constitution has not been urged. In one of their briefs, appellants point out that this court initially used an analysis based upon the different language of our own constitution. *See, e.g., State v. Carey,* 4 Wash. 424, 30 P. 729 (1892). They argue that it is appropriate to consider both the tiered scrutiny model of equal protection analysis as well as a language–specific analysis similar to the one developed by the Oregon Supreme Court. *See, e.g., State v. Clark,* 291 Or. 231, 630

P.2d 810 (1981); *State v. Edmonson,* 291 Or. 251, 630 P.2d 822 (1981).

In the context of tiered scrutiny, appellants argue that this court should review the noneconomic damages limit under the midlevel scrutiny followed in *State v. Phelan,* 100 Wn.2d 508, 671 P.2d 1212 (1983) and *Hunter v. North Mason High Sch. & Sch. Dist. 403,* 85 Wn.2d 810, 539 P.2d 845 (1975). They contend that Mr. Sofie belongs to a "semi-suspect class"—discrete but not suspect—of severely injured plaintiffs. Citing *Hunter,* they also claim that the damages limit affects an important right: the right to be indemnified for personal injuries. Under such a midtier analysis, this court generally requires that the challenged law further a substantial state interest. *Daggs,* 110 Wn.2d at 55.

Respondents contend that intermediate scrutiny should not apply because the damages limit amounts to economic legislation. Such legislation, they maintain, is reviewed under the deferential rational basis test. In support of this they cite, among other cases, *Duke Power Co. v. Carolina Envtl. Study Group,* 438 U.S. 59, 57 L. Ed. 2d 595, 98 S. Ct. 2620 (1978) (upholding the Price-Anderson Act).

Courts in some other states have struck down similar tort damage limits on equal protection grounds. *See, e.g., Carson v. Maurer,* 120 N.H. 925, 424 A.2d 825, 830 (1980) (striking limit on noneconomic damages after finding right to recover for personal injuries an "important substantive right,") (citing *Hunter*); *Arneson v. Olson,* 270 N.W.2d 125, 132 (N.D. 1978) (applying heightened scrutiny to flat damages limit); *see also* Comment, *Constitutional Challenges to Washington's Limit on Noneconomic Damages in Cases of Personal Injury and Death,* 63 Wash. L. Rev. 653 (1988); *Development in the Law: The 1986 Washington Tort Reform Act,* 23 Willamette L. Rev. 211 (1987). Other courts, however, have upheld limits, analyzing the legislation under the rational basis test. *See, e.g., Fein v. Permanente Med. Group,* 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, *appeal dismissed,* 474 U.S. 892, 88 L. Ed. 2d

215, 106 S. Ct. 214 (1985); *see also Boyd v. Bulala,* 647 F. Supp. 781 (W.D. Va. 1986) (finding that damages limit passes the rational basis test under equal protection analysis but violates the right to a jury trial).

As for the analysis based on the language of our privileges and immunities clause, this question must wait for another case.[2]

II

The dispositive issue of this case is the right to a jury trial.

[1] This court has long approached the review of legislative enactments with great care. The wisdom of legislation is not justiciable; our only power is to determine the legislation's constitutional validity. *Petstel, Inc. v. County of King,* 77 Wn.2d 144, 151, 459 P.2d 937 (1969); *State ex rel. Bolen v. Seattle,* 61 Wn.2d 196, 198, 377 P.2d 454 (1963); *Smith v. Centralia,* 55 Wash. 573, 576, 104 P. 797 (1909). In

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[2]Article 1, section 20 of the Oregon Constitution states:

"No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

Under the Oregon court's analysis, no statute can survive merely by showing a rational relationship between the classification and the purpose; it must leave legal entry to a class open and must operate with consistently applied objective criteria. *See State v. Clark,* 291 Or. 231, 630 P.2d 810 (1981); *State v. Edmonson,* 291 Or. 251, 630 P.2d 822 (1981). The court inquires into whether the challenged state action affects a "privilege or immunity"—that is, "some advantage" to which a person "would be entitled but for a choice made by a government authority". *Salem v. Bruner,* 299 Or. 262, 269, 702 P.2d 70, 74 (1985). The next step is to determine whether the action or statute was performed under lawful authority. The court then considers whether the statute or action affects a true class (one with characteristics that set it apart regardless of the statute), or a pseudo-class (one created by the statute), or an individual. To determine whether the statute represents impermissible discrimination, the court has devised different tests for each of these classifications.

For an in-depth analysis of the Oregon court's method for construing its privileges and immunities clause, *see* Schuman, *The Right to "Equal Privileges and Immunities": A State's Version of "Equal Protection",* 13 Vt. L. Rev. 221 (1988). For a privileges and immunities analysis of noneconomic tort damage cap legislation, *see* Note, *Challenging the Constitutionality of Noneconomic Damage Caps: Boyd v. Bulala and the Right to a Trial by Jury,* 24 Willamette L. Rev. 821, 836–38 (1988).

matters of economic legislation, we follow the rule giving every reasonable presumption in favor of the constitutionality of the law or ordinance. *Shea v. Olson,* 185 Wash. 143, 152, 53 P.2d 615, 111 A.L.R. 998 (1936).[3] We employ this caution to avoid substituting our judgment for the judgment of the Legislature. *See State Pub. Employees' Bd. v. Cook,* 88 Wn.2d 200, 206, 559 P.2d 991 (1977), *adhered to on rehearing,* 90 Wn.2d 89, 579 P.2d 359 (1978); *Fritz v. Gorton,* 83 Wn.2d 275, 283, 517 P.2d 911, *appeal dismissed,* 417 U.S. 902 (1974); *Jones v. Jones,* 48 Wn.2d 862, 868, 296 P.2d 1010, 54 A.L.R.2d 1403 (1956); *see also* Utter, *Freedom and Diversity in a Federal System: Perspectives on State Constitutions and the Washington Declaration of Rights,* 7 U. Puget Sound L. Rev. 491, 522–23 (1984).

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[3]The dissent of Dolliver, J., is correct in pointing out, at page 677, that *Shea* contains language setting a reasonable doubt standard in favor of the constitutionality of a statute. By citing *Shea,* we incorporate the burden of proof stated in that opinion. In the final analysis, the language quoted by the dissent is merely a different way of stating the rule we cite above. One need only to look at the many cases in which this principle is enunciated to see the different combinations of words used to express it. *State v. Ide,* 35 Wash. 576, 77 P. 961 (1904), which *Shea* cites for authority, puts it this way:

> [I]t is settled by the highest authority that a legislative enactment is presumed to be constitutional and valid until the contrary clearly appears. In other words, the courts will presume that an act regularly passed by the legislative body of the government is a valid law, and will entertain no presumptions again [*sic*] its validity. And, when the constitutionality of an act of the legislature is drawn in question, the court will not declare it void unless its invalidity is so apparent as to leave no reasonable doubt upon the subject. . . .

35 Wash. at 581; *see also Litchman v. Shannon,* 90 Wash. 186, 189, 155 P. 783 (1916); *Chas. Uhden, Inc. v. Greenough,* 181 Wash. 412, 420–21, 43 P.2d 983, 98 A.L.R. 1181 (1935) ("an act of the legislature will be presumed to be valid unless there is no reasonable doubt as to its validity"); *McDermott v. State,* 197 Wash. 79, 83, 84 P.2d 372 (1938) ("Every reasonable presumption must be indulged in favor of the constitutionality of this statute, and the burden rests upon appellant to establish clearly its invalidity"); *Spokane v. Coon,* 3 Wn.2d 243, 246, 100 P.2d 36 (1940) ("every presumption is in favor of the constitutionality of a law or ordinance"). *Brewer v. Copeland,* 86 Wn.2d 58, 542 P.2d 445 (1975), describes the standard twice, each time with different words. At page 61 this court stated that the plaintiff "must overcome the presumption of constitutionality beyond a reasonable doubt"; at page 69, we put it another way: "if any state of facts can reasonably be conceived to uphold the legislation including the classification made therein, the legislation will be upheld."

Other courts, faced with unconstitutional tort damage limits, have adhered to similar principles when reviewing those legislative actions. The Kansas Supreme Court put it well:

> "This court is by the Constitution not made the critic of the legislature, but rather, the guardian of the Constitution." The constitutionality of a statute is presumed, and all doubts must be resolved in favor of its validity. Before a statute may be stricken down, it must clearly appear the statute violates the Constitution. Moreover, it is the court's duty to uphold the statute under attack, if possible, rather than defeat it, and if there is any reasonable way to construe the statute as constitutionally valid, that should be done.

(Citations omitted.) *Kansas Malpractice Victims Coalition v. Bell,* 243 Kan. 333, 340, 757 P.2d 251, 256–57 (1988).

[2] To determine the extent of the right to trial by jury as it applies here, we must first identify the source of the constitutional protection. The seventh amendment to the United States Constitution does not apply through the Fourteenth Amendment to the states in civil trials. *Minneapolis & St. L. R.R. v. Bombolis,* 241 U.S. 211, 60 L. Ed. 961, 36 S. Ct. 595 (1916); *Walker v. Sauvinet,* 92 U.S. 90, 23 L. Ed. 678 (1876). The right to jury trial in civil proceedings is protected solely by the Washington Constitution in article 1, section 21. Therefore, the relevant analysis must follow state doctrine; our result is based entirely on adequate and independent state grounds.[4]

Article 1, section 21 states:

> The right of trial by jury shall remain inviolate, but the legislature may provide for a jury of any number less than twelve in courts not of record, and for a verdict by nine or more jurors in civil cases in any court of record, and for waiving of the jury in civil cases where the consent of the parties interested is given thereto.

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[4]Even if the federal constitution were to apply in this case, following the nonexclusive criteria set out in *State v. Gunwall,* 106 Wn.2d 54, 720 P.2d 808 (1986), we would still base our decision on the Washington Constitution.

[3] Our basic rule in interpreting article 1, section 21 is to look to the right as it existed at the time of the constitution's adoption in 1889. *State ex rel. Goodner v. Speed,* 96 Wn.2d 838, 840, 640 P.2d 13, *cert. denied,* 459 U.S. 863 (1982); *In re Ellern,* 23 Wn.2d 219, 224, 160 P.2d 639 (1945); *State ex rel. Mullen v. Doherty,* 16 Wash. 382, 384–85, 47 P. 58 (1897). We have used this historical standard to determine the scope of the right as well as the causes of action to which it applies. These two issues, scope and the applicable causes of action, merit separate discussion.

State ex rel. Mullen v. Doherty, supra, being close in time to 1889, provides some contemporary insight on the scope issue. In *Mullen,* we cited section 248 of the Code of 1881, in force at the time of the constitution's passage, to determine the jury's role in the constitutional scheme: "either party shall have the right in an action at law, upon an issue of fact, to demand a trial by jury." *Mullen,* 16 Wash. at 385. Subsequent cases underscore the jury's fact finding province as the essence of the right's scope. *See, e.g., State v. Strasburg,* 60 Wash. 106, 110 P. 1020 (1910); *In re Ellern, supra.*

[4] At issue in the present case is whether the measure of damages is a question of fact within the jury's province. Our past decisions show that it is indeed. The constitutional nature of the jury's damage–finding function is underscored by *Baker v. Prewitt,* 3 Wash. Terr. 595, 19 P. 149 (1888). In that case, the territorial Supreme Court stated:

> Sections 204 and 289 of the [territorial] Code seem to require that in all actions for the assessment of damages the intervention of a jury must be had, save where a long account may authorize a referee, etc. This statute is mandatory, and we are satisfied that where the amount of damages is not fixed, agreed upon, or in some way liquidated, a jury must be called, unless expressly waived.

Baker, at 597–98. If our state constitution is to protect as inviolate the right to a jury trial at least to the extent as it

existed in 1889, then *Baker*'s holding provides clear evidence that the jury's fact–finding function included the determination of damages. This evidence can only lead to the conclusion that our constitution, in article 1, section 21, protects the jury's role to determine damages.

The present case is not the first time we have recognized the constitutional nature of the jury's damage–determining role. In *James v. Robeck,* 79 Wn.2d 864, 869, 490 P.2d 878 (1971), we stated: "To the jury is consigned under the constitution the ultimate power to weigh the evidence and determine the facts—and the amount of damages in a particular case is an ultimate fact." *See also Dacres v. Oregon Ry. & Nav. Co.,* 1 Wash. 525, 20 P. 601 (1889) (Act of 1883, creating a scheme for determining the value of train–killed animals by appraisers, was unconstitutional because it denied the right to a jury trial); *Worthington v. Caldwell,* 65 Wn.2d 269, 273, 396 P.2d 797 (1964) ("Questions of damages should be decided by the jury . . ."); *Anderson v. Dalton,* 40 Wn.2d 894, 897, 246 P.2d 853, 35 A.L.R.2d 302 (1952); *Kellerher v. Porter,* 29 Wn.2d 650, 189 P.2d 223 (1948); *Walker v. McNeill,* 17 Wash. 582, 592–95, 50 P. 518 (1897).

The jury's role in determining noneconomic damages is perhaps even more essential. In *Bingaman v. Grays Harbor Comm'ty Hosp.,* 103 Wn.2d 831, 835, 699 P.2d 1230 (1985), the husband of a woman who died painfully 35 hours after giving birth, the result of medical malpractice, brought a wrongful death and survival action. The only issue before this court was whether the trial judge had properly reduced the jury's damage verdict of $412,000 for the woman's pain and suffering. In resolving the issue in the plaintiff's favor, we stated: "The determination of the amount of damages, *particularly in actions of this nature,* is primarily and peculiarly within the province of the jury, under proper instructions . . ." (Italics ours.) 103 Wn.2d at 835. *See also Lyster v. Metzger,* 68 Wn.2d 216, 224–25, 412 P.2d 340 (1966) (issue of damages, here primarily noneconomic, is within the jury's province); *Power v. Union Pac. R.R.,* 655

F.2d 1380, 1388 (9th Cir. 1981) (under Washington law, damages for loss of companionship determined by trier of fact).

United States Supreme Court jurisprudence on the Seventh Amendment's scope in civil trials, while not binding on the states, also provides some insight. In *Dimick v. Schiedt,* 293 U.S. 474, 79 L. Ed. 603, 55 S. Ct. 296, 95 A.L.R. 1150 (1935), the Court used historical analysis to determine whether the Seventh Amendment allowed additur. Citing cases and treatises dating from the time of the amendment's adoption, the Court found that determining damages, as an issue of fact, was very much within the jury's province and therefore protected by the Seventh Amendment. The Court also indicated that a judge should give more deference to a jury's verdict when the damages at issue concern a noneconomic loss. The Court quoted the English case of *Beardmore v. Carrington,* 2 Wils. 244, 248, 95 Eng. Rep. 790, 792 (K.B. 1764):

> ". . . There is great difference between cases of damages which [may] be certainly seen, and such as are ideal, as between *assumpsit, trespass for goods* where the sum and value may be measured, and actions of *imprisonment, malicious prosecution, slander and other personal torts,* where the damages are matter of opinion, speculation, ideal . . ."

293 U.S. at 479. The Court clarified the implications of the difference between these two classes of actions by quoting from J. Mayne, *Damages* (9th ed. 1920) at page 571: "'in cases where the amount of damages was uncertain their assessment was a matter so peculiarly within the province of the jury that the Court should not alter it.'" 293 U.S. at 480.

Respondents and certain amici contend that *Tull v. United States,* 481 U.S. 412, 95 L. Ed. 2d 365, 107 S. Ct. 1831 (1987), renders null the above analysis from *Dimick.* Using historical analysis, the *Tull* Court found that a defendant in an enforcement proceeding under the federal clean water act had the right to a jury trial but not to have

the jury determine the amount of the civil penalty. The distinction, however, between damages in a tort action and a civil penalty in a regulatory enforcement case is fundamental. Therefore, *Tull* is irrelevant on the issue before the court. Ultimately, however, because the Supreme Court's civil trial Seventh Amendment jurisprudence is not binding on the states, state courts can look on this area as educational rather than coercive: the federal cases may assist us, but they do not compel the result we reach. We find the noneconomic damages limit unconstitutional on adequate and independent state grounds. While we do this, we will examine federal cases which provide the most informative analysis on the issues we must decide. *Dimick* provides that analysis; *Tull* does not.

As our past decisions have shown, Washington has consistently looked to the jury to determine damages as a factual issue, especially in the area of noneconomic damages. This jury function receives constitutional protection from article 1, section 21.

The second issue we must address is the determination of which causes of action the right to trial by jury attaches to. We have held in the past that the right attaches to actions in which a jury was available at common law as of 1889 and to actions created by statutes in force at this same time allowing for a jury. *See, e.g., State ex rel. Mullen v. Doherty, supra* (as of 1889, quo warranto proceedings were not heard by a jury, therefore right did not attach); *In re Ellern, supra; see also* Trautman, *Right to Jury Trial in Washington—Present and Future,* 34 Wash. L. Rev. 401 (1959).

Amici in favor of respondents' position suggest that the right to a jury does not apply to causes of action that did not exist at the time of the constitution's adoption. A fundamental problem exists with this argument. If the right to a jury trial applies only to those *theories of recovery* accepted in 1889—rather than the types of actions that, at common law, were heard by a jury at that time—then the constitutional right to a jury will diminish over time. As a

method of construing a lasting constitutional right, this makes little sense.

As respondents themselves point out, this court stated in *Hunter v. North Mason High Sch. & Sch. Dist. 403,* 85 Wn.2d 810, 539 P.2d 845 (1975), that constitutional analysis is not completely frozen in time. It would defeat the intention of our constitution's framers to interpret an essential right so that it slowly withers away. An interpretation more consistent with the intended longevity of a constitutional right adapts the application of that right according to developments in the law over time. As long as the scope and nature of the right are adequately defined—and for that we can turn to a stricter historical analysis—a more flexible historical approach for determining when the right attaches will better achieve the intent of the framers.

A method of historical analysis used by the United States Supreme Court in *Tull v. United States, supra,* provides further insight. The *Tull* Court looked for proceedings analogous to the enforcement action under the federal clean water act which were contemporary with the Seventh Amendment's adoption. Finding that the common law proceeding of debt, in which the litigants had a right to a jury, was analogous to the clean water act enforcement action, the Court applied the Seventh Amendment right to the modern action. Without stretching the analogy as far as the Supreme Court did, it is logical to apply the more recent tort theories by analogy to the common law tort actions that existed in 1889. We note again that we reach our result today on adequate and independent state grounds. The holding in *Tull,* like all United States Supreme Court precedent in the civil trial area of the Seventh Amendment, is not binding on the states and merely serves as an example to us. It does not compel the result we reach.

Ultimately, there is not even an issue whether the right to a jury attaches to the Sofies' case. While they asserted "newer" tort theories in their complaint, the heart of the appellants' cause of action centered on negligence and willful or wanton misconduct resulting in personal injury. See

Plaintiff's Summons and Complaint, at 4–5. These basic tort theories are the same as those that existed at common law in 1889. *See, e.g., Columbia & P.S. R.R. v. Hawthorne,* 3 Wash. Terr. 353, 19 P. 25 (1888) (worker injured by falling pulley, defect known to employer), *rev'd on other grounds,* 144 U.S. 202 (1892); *Sayward v. Carlson,* 1 Wash. 29, 23 P. 830 (1890) (plaintiff, injured at work due to employer's negligence, while on the way to the bathroom, was not contributorially negligent). Subsequent cases and statutes have recognized newer theories of recovery within the framework of these basic tort actions, but the basic cause of action remains the same. Therefore, the right to trial by jury—with its scope as defined by historical analysis—remains attached here.

III

Respondents argue that the Legislature has the power to alter the functions of civil trials, such alterations often affecting the role of the jury. They cite a number of cases in which our courts have upheld such changes against challenges based on the right to trial by jury. *See, e.g., State v. Mountain Timber Co.,* 75 Wash. 581, 135 P. 645 (1913), *aff'd,* 243 U.S. 219, 61 L. Ed. 685, 37 S. Ct. 260 (1917) (upholding the workers' compensation statute); *State ex rel. Clark v. Neterer,* 33 Wash. 535, 74 P. 668 (1903) (upholding constitutionality of fees and time limits for requesting jury); *Bellingham v. Hite,* 37 Wn.2d 652, 225 P.2d 895 (1950) (certain municipal cases may be tried without a jury provided there is right to jury trial on appeal); *Christie–Lambert Van & Storage Co. v. McLeod,* 39 Wn. App. 298, 693 P.2d 161 (1984) (upholding mandatory arbitration statute). Respondents argue that the Legislature may, in fact, do away with causes of action altogether, replacing them with procedures such as workers' compensation which, at the initial stage at least, do not allow for a jury at all. In short, respondents contend, the Legislature can determine the "law of recovery."

[5] The Legislature has power to shape litigation. Such power, however, has limits: it must not encroach upon constitutional protections. In this case, by denying litigants an essential function of the jury, the Legislature has exceeded those limits.

A review of the decisions cited by respondents provides insight into the limits of legislative power. These decisions show that the Legislature cannot intrude into the jury's fact–finding function in civil actions, including the determination of the amount of damages.

In the case of workers' compensation, this court in *State v. Mountain Timber Co., supra,* did not engage in the historical analysis regarding the right to a jury trial. Our analysis instead centered on the State's police power to abolish causes of action and replace them with a mandatory industrial insurance scheme. Because the use of such power was done for the public health and welfare and a comprehensive scheme of compensation was inserted in its place, the abolition of the cause of action was not unconstitutional.[5] 75 Wash. at 583.

The United States Supreme Court, in affirming our decision, found that the statute did not violate the Seventh Amendment as it would apply to trials in federal court. The Court stated:

> So far as private rights of action are preserved, [the Seventh Amendment applies]; but with respect to those we find nothing in the act that excludes a trial by jury. As between employee and employer, the act abolishes all right of recovery in ordinary cases, and therefore leaves nothing to be tried by jury.

Mountain Timber, 243 U.S. at 235. In other words, if the cause of action is completely done away with, then the right to trial by jury becomes irrelevant. Since the right attaches to civil trials, there can be no right—and no constitutional violation—if no civil trial is available.

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[5]We note here that while the Legislature has the power to abolish a civil cause of action, *Mountain Timber* establishes that such a legislative act must have its own independent constitutional foundation.

Respondents Eagle–Picher imply, without direct authority, that the Legislature's greater power to abolish causes of action includes the lesser power to alter jury functions, including that of determining damages. They cite the workers' compensation scheme as an example of the greater power. As part of this assertion, respondents refer to *Shea v. Olson*, 185 Wash. 143, 53 P.2d 615, 111 A.L.R. 998 (1936)—which upheld the automobile "guest statute"—for the proposition that "[a] person has no vested interest in any rule of the common law." 185 Wash. at 156.

While respondents cite *Shea* correctly, its holding is not applicable here. The scope of the right to trial by jury may be defined by the common law through a historical analysis, but the right itself is protected by the state constitution. As the United States Supreme Court stressed in *Dimick v. Schiedt*, 293 U.S. 474, 79 L. Ed. 603, 55 S. Ct. 296 (1935), the common law is a flexible body of doctrine, but fundamentally different from a constitutional provision which looks to the common law at a specific point in time for definition. 293 U.S. at 487. Constitutional protections are not directly subject to common law changes. Because of the constitutional nature of the right to jury trial, litigants have a continued interest in it—it simply cannot be removed by legislative action. As long as the cause of action continues to exist and the litigants have access to a jury, that right of access remains as long as the cause of action does. Otherwise, article 1, section 21 means nothing.

The other cases cited by respondents affect access to the jury in procedural ways. They do not deprive the jury of any of its essential functions. Washington's mandatory arbitration law does not supplant the jury in civil litigation. Rather, it provides for proceedings under a certain jurisdictional amount to be disposed of at a lesser expense to the parties and to the state. As made clear by the Court of Appeals in *Christie–Lambert Van & Storage Co. v. McLeod, supra*, the availability of a jury trial de novo to redetermine the arbitrator's conclusions preserved the right protected by article 1, section 21. The court stated:

> [a]ll that is required is that the right of appeal for the purpose of presenting the issue to a jury must not be burdened by the imposition of onerous conditions, restrictions or regulations which would make the right practically unavailable.

39 Wn. App. at 306, quoting *Smith Case,* 381 Pa. 223, 231, 112 A.2d 625 (1955). The court found that the procedures created in the Washington statute, notably placing on the losing party costs and fees in a frivolous appeal, were not an unreasonable burden on the parties and left the ultimate right to a jury intact.

The municipal trial at issue in *Bellingham v. Hite, supra,* was not unconstitutional for essentially the same reasons discussed in *Christie–Lambert.* The City of Bellingham gave a police judge jurisdiction to try certain municipal offenses—here driving while intoxicated. Like the mandatory arbitration plan, a jury trial de novo was available on appeal. Therefore, the scheme did not violate the right to trial by jury. *Bellingham v. Hite, supra* at 657.

The procedural directives at issue in *State ex rel. Clark v. Neterer, supra,* did not at all encroach upon the jury's province. In *Clark,* we found that article 1, section 21 allowed for waiver of a jury "'where the consent of the parties interested is given thereto". Such consent could be express or implied; therefore filing fees and deadlines, not being unreasonable, could direct the expression of consent within the bounds of the constitution. 33 Wash. at 541.

The issues in the preceding cases are fundamentally different from the legislative damage limit. Respondents do not contend that these previous cases directly infringed upon the jury's role to find the facts. Rather, the Legislature directed parties' access to the jury, often providing for more streamlined procedures to fulfill a state interest. At issue in the Sofies' case is a statute that directly changes the outcome of a jury determination. The statute operates by taking a jury's finding of fact and altering it to conform to a predetermined formula. Such a statutory operation is beyond the scope of the cases that respondents cite.

Respondents also argue that the trial court has the power to lower a jury's damages finding under the doctrine of remittitur, setting a precedent applicable to the legislative damage limit. While trial judges do have this power, remittitur functions very differently from the tort reform act.

First, remittitur is wholly within the power of the trial judge. Within the guidelines of the doctrine, the judge makes the legal conclusion that the jury's damage finding is too high. This judicial finding—arrived at with judicial care—is fundamentally different from a legislatively imposed "remittitur" that operates automatically. Appellants, indeed, argue that this legislative "remittitur" violates the doctrine of separation of powers. As we held in *Tacoma v. O'Brien,* 85 Wn.2d 266, 534 P.2d 114 (1975), any determination calling for a legal conclusion is constitutionally within the province of the judiciary, not the Legislature. Any legislative attempt to mandate legal conclusions would violate the separation of powers. 85 Wn.2d at 271. The judge's use of remittitur is, in effect, the result of a legal conclusion that the jury's finding of damages is unsupported by the evidence. The Legislature cannot make such case–by–case determinations. Therefore, the legislative damages limit is fundamentally different from the doctrine of remittitur. Although we do not decide the case on this basis, the limit may, indeed, violate the separation of powers as indicated by *O'Brien.*

Second, a judge can implement remittitur only under well developed constitutional guidelines. As discussed in cases like *Lyster v. Metzger,* 68 Wn.2d 216, 412 P.2d 340 (1966) and *Martin v. Foss Launch & Tug Co.,* 59 Wn.2d 302, 367 P.2d 981 (1962), the jury's constitutionally protected role is that of the finder of fact and part of this role is to determine the amount of damages in a given case. Because these matters are within the jury's province, there is a strong presumption in favor of their validity. This presumption is codified in statute: RCW 4.76.030. A judge can only reduce a jury's damages determination when it is, in light of this strong presumption, wholly unsupported by the

evidence, obviously motivated by passion or prejudice, or shocking to the court's conscience.

Third, the opposing party in cases of remittitur has the choice of accepting the reduction or seeking a new trial. RCW 4.76.030. The tort reform legislation does not allow parties this choice. All three of the discussed strictures surrounding the doctrine of remittitur are lacking in the tort reform act's damages limit. Indeed, the former and the latter operations are fundamentally different.[6]

[6] Respondents also contend that the damages limit affects only the judgment as entered by the court, not the jury's finding of fact. This argument ignores the constitutional magnitude of the jury's fact–finding province, including its role to determine damages. Respondents essentially are saying that the right to trial by jury is not invaded if the jury is allowed to determine facts which go unheeded when the court issues its judgment. Such an argument pays lip service to the form of the jury but robs the institution of its function. This court will not construe constitutional rights in such a manner. As we once stated: "'The constitution deals with substance, not shadows. Its inhibition was leveled at the thing, not the name. . . . If the inhibition can be evaded by the form of the enactment, its insertion in the fundamental law was a vain and futile proceeding.'" *State v. Strasburg,* 60 Wash. 106, 116, 110 P. 1020 (1910), quoting *Cummings v. Missouri,* 71 U.S. (4 Wall.) 277, 325, 18 L. Ed. 356 (1866).

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[6]If imposing a legislative limit on damages violates the jury's province, one may wonder whether the concept of trebling a jury's finding of damages, as in the Consumer Protection Act, does the same thing. Within the historical method of analysis used by this court, however, these two operations are different. A jury's role to determine damages in a common law action contemporaneous with the constitution's adoption is protected by article 1, section 21. A negligence action, including the later theories of recovery analogous to it, is such an action. The Consumer Protection Act, on the other hand, is a cause of action specifically created by the Legislature to fulfill a public policy. Part of that public policy is to allow treble damages where appropriate. But because the act is a legislatively created cause of action and was created well after 1889, under the historical analysis used by this court, it is outside of the strict purview of article 1, section 21.

[7] Finally, the plain language of article 1, section 21 provides the most fundamental guidance: "The right of trial by jury shall remain inviolate". The term "inviolate" connotes deserving of the highest protection. *Webster's Third New International Dictionary* 1190 (1976), defines "inviolate" as "free from change or blemish: pure, unbroken . . . free from assault or trespass: untouched, intact . . ." Applied to the right to trial by jury, this language indicates that the right must remain the essential component of our legal system that it has always been. For such a right to remain inviolate, it must not diminish over time and must be protected from all assaults to its essential guaranties. In Washington, those guaranties include allowing the jury to determine the amount of damages in a civil case.

The potential impact of the constitution's language was not lost on the Legislature. During the floor debates on the tort reform act, the legislators were warned of the possible constitutional problems with their new legislation. Senator Talmadge stated:

> The Constitution of this state in Article I, Section 21, talks about the right to trial by jury being inviolate, not being something that we can invade as members of the Legislature, and when you start to put limitations on what juries can do, you have, in fact, invaded the province of the jury and have not preserved the right to a trial by jury inviolate.

Senate Journal, 49th Legislature (1986), at 449.

IV

A number of other jurisdictions have stricken tort reform legislation that places a limit on the jury's ability to determine damages in a given case. A smaller number of courts have upheld such legislation against right–to–jury based challenges. The methods all of these courts have used are instructive through their similarities and differences to the present case and in their modes of analysis.

In *Boyd v. Bulala*, 647 F. Supp. 781 (W.D. Va. 1986), *reh'g denied*, 672 F. Supp. 915 (1987), a federal district court, applying both Virginia and federal constitutional

law, determined that Virginia's legislative damage limit—which placed a flat limit on noneconomic damages—was an unconstitutional violation of the right to trial by jury. The court developed insightful distinctions between what the Legislature can and cannot do:

> Unquestionably, the legislature may pass measures which affect the way a jury determines factual issues. The legislature may prescribe rules of procedure and evidence, create legal presumptions, allocate burdens of proof, and the like. Just as certainly, the legislature may abolish a common law right of action and, if it desires, replace it with a compensation scheme. The legislature may even make rules concerning the type of damages recoverable and the way in which damages are paid. But the legislature may not preempt a jury's findings on a factual issue which has properly been submitted to the jury.

(Footnotes omitted.) 647 F. Supp. at 789–90. To make matters clear, the *Bulala* court held that both the Seventh Amendment and the Virginia State Constitution provided the right to have a jury determine the extent of damages as well as liability. 647 F. Supp. at 788.

In *Kansas Malpractice Victims Coalition v. Bell,* 243 Kan. 333, 757 P.2d 251 (1988), the Kansas Supreme Court struck down its state's noneconomic damages limit—another flat limit—as violative of the Kansas constitution's protection of the right to trial by jury. After determining that the jury's function to determine damages was constitutionally protected, the court stated: "It would be illogical for this court to find that a jury, empaneled because monetary damages are sought, could not then fully determine the amount of damages suffered." 757 P.2d at 343. *See also Duren v. Suburban Comm'ty Hosp.,* 482 N.E.2d 1358 (Ohio C.P., Cuyahoga Cy. 1985) (striking limit on a number of constitutional grounds); *Smith v. Department of Ins.,* 507 So. 2d 1080 (Fla. 1987) (flat limit violates right to jury); *Lucas v. United States,* 757 S.W.2d 687 (Tex. 1988) (citing *Smith* and *Boyd,* finds limit on damages invades jury's

fact–finding province); Comment, *Challenging the Constitutionality of Noneconomic Damage Caps: Boyd v. Bulala and the Right to a Trial by Jury,* 24 Willamette L. Rev. 821 (1988).

Respondents contend that the limits in the above cases are distinguishable from the one in the Washington statute because they generally limited the damages to a fixed amount. Washington's limit, on the other hand, follows a formula based upon age. In terms of invading the province of the jury, however, the nature of the mechanism itself makes little difference. Whether the limit is fixed or follows a formula, if it restricts the jury's ability to reach its damages verdict, it invades the jury's province.

It is highly persuasive that in Kansas, Texas, Ohio, and Florida, states that have found the damages limit unconstitutional, the operative language of the right to jury trial provisions in those states' constitutions is nearly identical to our own. *See* Kan. Const. Bill of Rights § 5 ("The right of trial by jury shall be inviolate"); Tex. Const. art. 1, § 15 ("The right of trial by jury shall remain inviolate"); Ohio Const. art. 1, § 5 ("The right of trial by jury shall be inviolate"); Fla. Const. art. 1, § 22 ("The right of trial by jury shall be secure to all and remain inviolate").

Cases upholding damage limits either have not analyzed the jury's role in the matter or have not engaged in the historical constitutional analysis used by this court in construing the right to a jury. Two cases from California cited by respondents are essentially irrelevant to the jury issue here. In *Fein v. Permanente Med. Group,* 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, *appeal dismissed,* 474 U.S. 892, 88 L. Ed. 2d 215, 106 S. Ct. 214 (1985), the California Supreme Court upheld its state's damage limit provision in medical malpractice cases. In that case, however, the issue of whether the limit infringed on the right to trial by jury was not discussed. The court upheld the limit on due process and equal protection grounds. However, in *American Bank & Trust Co. v. Community Hosp. of Los Gatos–Saratoga, Inc.,* 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr.

671 (1984), the California court upheld the same act's provision for periodic payment of "future damages" against a challenge based on the right to jury trial. Based on a historical analysis much less detailed than the one employed by this court, the California court found that the periodic payment provision did not represent impairment of the substantial features of a jury trial. 683 P.2d at 680. The case, however, is fundamentally different from the one now before us. It did not deal with the ultimate issue of directly invading the jury's fact–finding province.

In *Johnson v. St. Vincent Hosp., Inc.*, 273 Ind. 374, 404 N.E.2d 585 (1980), the Indiana Supreme Court upheld a flat limit on damages against challenges that it violated the right to a jury. In reaching its conclusion, the court cited the legislature's power to restrict causes of action through statutes of limitation and procedural rules. From these legislative powers, the court concluded: "It is the policy of this Act that recoveries be limited to $500,000, and to this extent the right to have the jury assess the damages is available." 273 Ind. at 401. Essentially, although it gave no clear reasons, the Indiana court did not recognize the jury's role to determine damages. It is also notable that the court did not undertake any historical analysis to reach its conclusion. This lack of analysis minimizes the impact of the similarity between the Indiana constitution's jury provision and our own. *See also Prendergast v. Nelson*, 199 Neb. 97, 256 N.W.2d 657 (1977) (mandatory prerequisite submission of malpractice claims to panel does not violate right to jury because jury ultimately is the finder of fact).

The weight of authority from other states, both numerically and persuasively, supports the conclusion that Washington's damages limit violates the right to trial by jury.

V

The dissenters raise several points to which we now respond. Justice Dolliver's dissent, at page 677, states that "[a] moment's reflection" will reveal that the real issue in this case is not whether the determination of damages is a

question of fact within the jury's province but whether this function "extends to the remedy phase." This statement simply recasts the formulation of a principle in an attempt to make it into something else. The issue must remain an inquiry into what is contained within the jury's fact–finding province. Because that province includes finding damages, as a matter of course the remedy phase is affected, just as any finding of fact can affect a trial's outcome.

Justice Dolliver cites with approval the recent case of *Etheridge v. Medical Ctr. Hosps.*, ___ Va. ___, 376 S.E.2d 525 (1989), but ignores the greater number of cases from other jurisdictions that support our position. In making this oversight, Justice Dolliver also omits the fact that four courts whose decisions support our holding—Texas, Kansas, Ohio, and Florida—base their decisions on state constitutions with operative language nearly identical to our own. Moreover, the Virginia Constitution, upon which *Etheridge* is based, contains language quite different from ours or of the other states mentioned above. The *Etheridge* opinion is also poorly reasoned. After conceding that the "jury's fact–finding function extends to the assessment of damages", the court finds that a "trial court applies the remedy's limitation only *after* the jury has fulfilled its fact–finding function." *Etheridge*, 376 S.E.2d at 529. Thus, supposedly, the limitation does not impinge on the jury's function. *Etheridge*, 376 S.E.2d at 529.

As this court stated in *State v. Strasburg*, 60 Wash. 106, 110 P. 1020 (1910), a case which Justice Dolliver fails to mention: "'The constitution deals with substance, not shadows. Its inhibition was leveled at the thing, not the name. . . .'" 60 Wash. at 116, quoting *Cummings v. Missouri*, 71 U.S. (4 Wall.) 277, 325, 18 L. Ed. 356 (1866). In other words, a constitutional protection cannot be bypassed by allowing it to exist in form but letting it have no effect in function. The *Strasburg* principle is the undoing of *Etheridge*'s reasoning.

Strasburg also deflates Justice Dolliver's accusation, at page 683, that this court's "entire analysis" boils down to a

few sentences "with no authority cited." We cite *Strasburg* plainly enough. The impact of *Strasburg* on this case is worth repeating: because the jury's province includes determining damages, this determination must affect the remedy. Otherwise, the constitutional protection is all shadow and no substance.

Justice Dolliver's dissent also attempts to construct an issue out of a trial judge's power to reduce the amount of a jury's award. As we state above, the remittitur doctrine is part and parcel of the constitutional right to a jury. Justice Dolliver's assertion at page 681 that the Code of 1881 contained no provision for remittitur—apparently implying that the doctrine did not apply to the right to a jury at the time of our constitution's adoption—ignores the fact that remittitur existed at common law. *Walker v. McNeill,* 17 Wash. 582, 50 P. 518 (1897), cited by Justice Dolliver for its act of reducing excessive damages, is a near–contemporary example. For a discussion of the common law roots of remittitur, *see Dimick v. Schiedt,* 239 U.S. 474, 79 L. Ed. 603, 55 S. Ct. 296, 95 A.L.R. 1150 (1935). In his repeated reference to remittitur, Justice Dolliver fails to mention that this function is solely within the province of the trial judge—that it is entirely separate from a legislative operation which reduces a jury's damages finding. In so doing, he does not address the separation of powers problems implicit in his conclusion.

Contrary to the assertion in Chief Justice Callow's dissent at page 670, this court does not hold that today's juries are constitutionally bound to "determine the same issues which were determined by juries in 1889." Rather, we use historical evidence as an aid to determine what the drafters meant by keeping the right to a jury trial "inviolate." We agree with Chief Justice Callow, and held in *Hunter v. North Mason High Sch. & Sch. Dist. 403,* 85 Wn.2d 810, 539 P.2d 845 (1975), that the construction of a constitutional protection is not frozen in time. The contemporary relevance of the provision in light of changes in the law, the

construction given to it over time as well as the construction given to it immediately after its adoption—by jurists intimate with the drafting of the provision—are also tools to divine its contours. All of these factors point to the constitutional protection of the jury's function to determine damages. Thus, Chief Justice Callow's reference to "no authority" and "no sound policy reasons" applies to something that we do not hold.[7]

Perhaps the most serious problem with Chief Justice Callow's dissent is that it fails to address the constitutional language itself: "The right of trial by jury shall remain inviolate". While Chief Justice Callow agrees that the right does exist, he provides no mechanism for determining the content of the right and for protecting that content. His construction is open to the form–over–content problems this court identified in *State v. Strasburg, supra.* The word "inviolate" carries with it a strong command: the right—as it existed in the minds of the framers and as it is relevant today—must exist "free from assault or trespass: untouched, intact . . ." *Webster's Third New International Dictionary* 1190 (1976).

The dissenters make much out of their citation to *Tull v. United States,* 481 U.S. 412, 95 L. Ed. 2d 365, 107 S. Ct. 1831 (1987). As we state above, the conclusion in *Tull* has no bearing on this court because we base our decision on adequate and independent state grounds. Since 1889, Washington's jurisprudence on the right to a jury in civil trials has always been based on the state constitution. *Tull* and *Dimick v. Schiedt, supra,* may provide material for our analysis, but they do not direct us.

Chief Justice Callow's advocation of *Tull* conceptually distorts the rule we developed in *State v. Gunwall,* 106 Wn.2d 54, 720 P.2d 808 (1986), which in turn relied on the

[7]Nowhere do we advocate a wholesale adoption of the Code of 1881. To make such a claim misconstrues the techniques of state constitutional interpretation. The legislative process of passing statutes differs markedly from that of drafting a constitution. The constitution's lasting and foundational nature must be respected when we undertake the task of interpreting it.

concurring opinion of Justice Handler in the New Jersey decision of *State v. Hunt,* 91 N.J. 338, 450 A.2d 952 (1982). Chief Justice Callow relies on *Gunwall* and *Hunt* to support his implication that this court should defer to Supreme Court interpretation of a comparable federal provision unless an analysis of the six *Gunwall* criteria indicate that we should take an independent course. Callow, C.J., dissenting, at 673.

This implication is contrary to the reasoning of Justice Handler and was specifically rejected by him in *Hunt.* In footnote 3 of his opinion, he stated, "To the extent that Justice Pashman suggests in his concurring opinion that this approach establishes a presumption in favor of federal constitutional interpretations, *supra* at 355, no decision of this Court has recognized such a presumption, and nothing in this opinion or in the majority opinion, as I read it, calls for or encourages the establishment of such a presumption." *Hunt,* at 367 n.3.

After criticism that the *Gunwall* criteria could be misinterpreted to support the view now espoused by the dissent,[8] this court clarified the test in *State v. Wethered,* 110 Wn.2d 466, 472, 755 P.2d 797 (1988). In *Wethered,* we reemphasized the statement that the *Gunwall* factors were nonexclusive and added that they were to be used as interpretive principles of our state constitution.

At any rate, *Tull* does not even apply to civil damages actions. The second opinion in *Boyd v. Bulala,* 672 F. Supp. 915 (W.D. Va. 1987), which the dissenters fail to cite, reaffirmed that court's previous holding that the Virginia damages limit violated the Seventh Amendment, stating: "Unlike the assessment of civil penalties discussed in *Tull, supra,* the assessment of damages has always been a matter 'peculiarly within the province of the jury.'" 672 F. Supp. at 920, quoting *Virginia Mid. R.R. v. White,* 84 Va. 498, 508, 5 S.E. 573 (1888). *Boyd* has not been overruled.

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[8]*See* Note, *Federalism, Uniformity, and the State Constitution—State v. Gunwall,* 62 Wash. L. Rev. 569 (1987).

To his credit, Justice Dolliver concedes that our State's jurisprudence contains cases squarely stating that a jury's role to determine damages is of constitutional proportions. At page 681 he admits that *James v. Robeck,* 79 Wn.2d 864, 490 P.2d 878 (1971), "does describe damages determination as a constitutionally consigned jury function." Justice Dolliver makes this concession because he must. The principle in *James* is inescapable: that case has not been limited or overruled.

Justice Dolliver's treatment of other Washington precedent attempts to limit the cases to their facts and ignore the principle that underlies them. For example, *Baker v. Prewitt,* 3 Wash. Terr. 595, 19 P. 149 (1888), did hold, as his dissent suggests, that a jury determined damages in default judgments at the time our constitution was adopted. Nonetheless, the underlying principle in *Baker* is that a jury determines damages, period. *Baker* links sections 204 and 289 of the Code of 1881, which outline the jury's fact–finding function generally and its role in determining damages specifically in default actions, respectively. If the court had intended to limit its holding to its facts, it would not have cited to section 204 and it would not have stated: "in *all* actions for the assessment of damages the intervention of a jury must be had . . ." (Italics ours.) 3 Wash. Terr. at 597. Although *Dacres v. Oregon Ry. & Nav. Co.,* 1 Wash. 525, 20 P. 601 (1889), does base its holding on the Seventh Amendment, that does not diminish that case's contemporary relevance for construing our state's constitutional provision. What we are concerned with is the conception of the scope of the right to a jury trial at the time of our constitution's adoption, not how United States Supreme Court precedent 98 years after that case affects the territorial court's conclusion.

On page 683, Justice Dolliver's dissent claims:

> Contrary to the majority's bold conclusion, this court has never constitutionalized the jury's right to determine damages. Even conceding this point, however, there is no

> precedent for extending the scope of this right to the remedy phase.

This statement ignores the plain language of *James* as well as the impact of *Strasburg*. Indeed, this argument can only be made by ignoring or mischaracterizing these cases.

Justice Dolliver also misconstrues the nature of the Legislature's power to create and eliminate causes of action and the attachment of the jury right to these actions. When the Legislature abolishes a cause of action, it does so explicitly, as it did when it created the workers' compensation scheme. Thus, Justice Dolliver's claim, on page 686, that the Legislature has "eliminated, in effect, any cause of action in which the damages are above the amount allowed in the act", cannot be taken seriously. If RCW 4.56.250 "partially" abolished a cause of action, then the Legislature certainly wasn't aware of it. Only if this court saw itself as a super–Legislature could we make up such legislative acts after the fact.

The dissenters' arguments regarding comparative negligence in product liability actions, punitive damages, and treble damages are unpersuasive. The absence of punitive damages in our state is a reflection of policies contemporary with our constitution's adoption. As with remittitur, this is incorporated into the jury right. *Spokane Truck & Dray Co. v. Hoefer,* 2 Wash. 45, 25 P. 1072 (1891), in abolishing punitive damages, did not discuss the impact of Const. art. 1, § 21. That the constitutional argument was neither made nor considered suggests a contemporary understanding that awarding punitive damages was not one of the essential jury functions envisioned by the framers to remain "inviolate." *Spokane Truck*'s treatment of the jury question contrasts markedly with the clear statements in cases such as *James v. Robeck, supra.* Therefore, it does not provide the constitutional evidence provided in the cases upon which we rely. Additionally, the nonconstitutional status of punitive damages may have been intimately understood by the judges on the court at that time, three of whom had served as drafters at the constitutional convention 2 years earlier.

See Journal of the Washington State Constitutional Convention 1889, at 465, 470, 485 (B. Rosenow ed. 1962); 2 Wash. iii (1892) (list of judges).

Justice Dolliver's discussion, on pages 684–85, of the effect of RCW 4.22.005 on *Seay v. Chrysler Corp.*, 93 Wn.2d 319, 609 P.2d 1382 (1980), focuses only on the results of the operation, not the process of it. It is entirely within the Legislature's power to define parameters of a cause of action and prescribe factors to take into consideration in determining liability. This is fundamentally different from directly predetermining the limits of a jury's fact–finding powers in relevant issues, which offends the constitution.

As for the "gratuitous holding" regarding the Consumer Protection Act discussed by Justice Dolliver's dissent at page 687, we have not reached such a fundamental conclusion. We are unable to because the Consumer Protection Act is not an issue in this case. We cannot decide cases not before us. Further, Chief Justice Callow's contrasting suggestion that our holding today renders the Consumer Protection Act unconstitutional shows again that this court is unable to speculate on cases not presented and which have not been adequately briefed.

While the dissenting opinions make interesting reading, they do not alter the fact that we have never overruled *James v. Robeck, supra. James,* quite simply, describes damages determination as a constitutionally consigned jury function. As for other states faced with similar issues, all but one with constitutional provisions similar to ours have stricken damages limits as violative of the right to a jury.

VI

Respondents contend that the trial judge erred in the following ways: applying joint and several liability instead of apportionment of fault, allowing juror misconduct, permitting cumulative testimony, excluding a key witness, and refusing to grant motions for remittitur or a new trial. We find no merit in these arguments.

[8] As for the issues of juror misconduct, cumulative testimony, witness exclusion and motions for remittitur, these matters are committed to the trial court's discretion. This court will not reverse trial court rulings in these areas unless we see a clear abuse of discretion. *See, e.g., Gardner v. Malone,* 60 Wn.2d 836, 376 P.2d 651, 379 P.2d 918 (1962) (juror misconduct); *Braack v. Bailey,* 32 Wn.2d 60, 62, 200 P.2d 525 (1948) (cumulative testimony); *Maehren v. Seattle,* 92 Wn.2d 480, 488, 599 P.2d 1255 (1979) (admission or refusal of testimony), *cert. denied,* 452 U.S. 938 (1981). A judge abuses his discretion when no reasonable judge would have reached the same conclusion. *Byerly v. Madsen,* 41 Wn. App. 495, 704 P.2d 1236, *review denied,* 104 Wn.2d 1021 (1985). With regard to remittitur, not only is this matter within the trial judge's discretion, but the judge must, under our state constitution, give great deference to the jury's finding of fact, including the determination of damages. *See, e.g., Bingaman v. Grays Harbor Comm'ty Hosp.,* 103 Wn.2d 831, 699 P.2d 1230 (1985). Because the trial judge in the present case did not come close to abusing his discretion, petitioners' arguments here are without merit.

Respondents point out that the trial judge instructed the jury, under RCW 4.22.070(3), to apply joint and several liability to the defendants. This statutory provision operates as an exception to the Legislature's restriction of joint and several liability in the 1986 tort reform act. RCW 4.22.070-(3)(a) states:

> Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

The trial judge interpreted the exception to include causes of action relating to asbestos because the judge found—and respondents conceded—that asbestos is a "hazardous substance."

Respondents argue that the trial judge read the term "substances" out of context. They contend that the statute, when read as a whole, applies only to problems relating to

hazardous waste and environmental pollution. They further assert, through citations to floor debates in the Senate during the bill's passage, that the exception was intended to avoid interference with the Legislature's proposed "superfund" toxic cleanup bill. In support of these assertions, they cite an early version of the exception:

> The defendants shall be jointly and severally liable if the cause of action involves a violation of any state or local law relating to solid wastes, hazardous wastes or substances, air, water, or high or low level radioactive wastes or substances. If legislation is enacted in 1986 creating joint and several liability for causes of action relating to solid wastes or hazardous wastes or substances, then this subsection shall be null and void.

Senate Journal, 49th Legislature (1986), at 467. Respondents quote further remarks from the amendment's sponsor, Senator Talmadge, that the amendment was indeed intended to address environmental issues. Senate Journal, *supra*. In relation to their interpretation, respondents contend that the exception in RCW 4.22.070 was intended to apply to causes of action under RCW 70.105 (Hazardous Waste Management Act).

[9] In interpreting a statute, this court looks first to the plain and ordinary meaning of the words used by the Legislature. *State v. Theilken,* 102 Wn.2d 271, 684 P.2d 709 (1984); *Hewson Constr., Inc. v. Reintree Corp.,* 101 Wn.2d 819, 685 P.2d 1062 (1984). Regardless of respondents' arguments about context, the simple use of the word "or" in the statute at issue indicates that the exception operates to each of the nouns in the sentence. That includes "hazardous substances," wherever they may be found. If the Legislature intended the exception to be limited to environmental litigation, it would or should have stated so explicitly.

Respondents' reliance on legislative history only appears to show that the Legislature intended a broader application for RCW 4.22.070(3)(a). The remarkable differences between the early and final versions of the statute further

indicate that the exception was not limited to environmental cases. In addition, the words "any cause of action" in section (3)(a) mean, in simple and plain terms, that the exception is not limited to any specific RCW section. Based on the foregoing analysis, then, the trial judge properly interpreted this statute.

The real issue here, however, is not a choice between joint and several liability or apportionment of fault, as posited by respondents. It is, rather, a choice between joint and several liability for the named defendants alone or joint and several liability for named defendants along with possible liability for unnamed defendants as well. RCW 4.22.070(1)(b) retains joint and several liability against named defendants in cases where the plaintiff is not at fault:

> If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimants total damages.

The special verdict form from the trial shows that the jury found the plaintiffs in this case not at fault. Clerk's Papers, at 393. In addition, defendants had alleged at trial that other, unnamed entities were also at fault. Because the exception in RCW 4.22.070(3)(a) applies, the defendants in this case are liable jointly and severally for the entire amount regardless of the possible relative fault between them and unnamed entities.

VII

For the reasons we have developed above, the limit on noneconomic damages in RCW 4.56.250 is unconstitutional. This damages limit, then, is no longer operative. Because the trial court specifically found that the jury's award of damages was reasonable and supported by the evidence, we reinstate that award.

BRACHTENBACH, DORE, PEARSON, and SMITH, JJ., concur.

ANDERSEN, J.—I concur on the basis that RCW 4.56.250 violates Const. art. 1, § 21.

CALLOW, C.J. (dissenting)—I disagree with the majority's determination that Const. art. 1, § 21 affords a tort litigant an absolute right to have a jury determine noneconomic damages in a tort action. This constitutional provision should be interpreted to require only that a jury determine such facts as the Legislature may choose to incorporate into a cause of action.

The majority's right–to–jury argument can be stated as two propositions. First, the majority asserts that a litigant has a constitutional right to trial by jury with respect to all actions in which a jury was available at the time the constitution was adopted. *See, e.g., State ex rel. Goodner v. Speed,* 96 Wn.2d 838, 840, 640 P.2d 13, *cert. denied,* 459 U.S. 863 (1982). A jury was available in negligence actions at the time the constitution was adopted. *See, e.g., Sayward v. Carlson,* 1 Wash. 29, 23 P. 830 (1890). Because the plaintiff's action sounds primarily in negligence, plaintiff is entitled to a jury trial. I agree.

Second, the majority asserts that in such cases a litigant has the constitutional right to have the jury determine the same issues which were determined by juries in 1889. Majority, at 645. Because juries determined the measure of damages, including noneconomic damages, in all civil actions in 1889, the majority concludes that a contemporary litigant has the constitutional right to have a jury determine the measure of noneconomic damages. Majority, at 646. I disagree.

The majority offers *no authority* and *no sound policy reasons* in support of the premise that our constitution requires contemporary juries to determine all issues which juries determined in 1889. In fact, this court has never adopted a historical standard to determine the "scope" of the right to a jury trial, and there are good reasons why we should not do so now.

Most of the majority's cited authority and discussion focuses on the minor premise—that the amount of damages have historically been determined by a jury.[9] Thus, *Baker v. Prewitt,* 3 Wash. Terr. 595, 19 P. 149 (1888), does show that in 1889 "the jury's fact–finding function included the determination of damages." Majority, at 646. Similarly, the court in *James v. Robeck,* 79 Wn.2d 864, 869, 490 P.2d 878 (1971) spoke historical truth when it said that "the amount of damages in a particular case is an ultimate fact." Majority, at 646. In *Bingaman v. Grays Harbor Comm'ty Hosp.,* 103 Wn.2d 831, 835, 699 P.2d 1230 (1985), we held that an appellate court could not alter the jury's determination of noneconomic damages, because the determination of noneconomic damages had been left to the discretion of the jury. *See also Dimick v. Schiedt,* 293 U.S. 474, 79 L. Ed. 603, 55 S. Ct. 296, 95 A.L.R. 1150 (1935).

These cases prove that juries historically have determined the amount of damages, including noneconomic damages, in civil actions. But they only prove that juries *historically* have determined noneconomic damages, not that juries *constitutionally* must do so. The majority errs by equating historical fact with constitutional necessity.

No case cited by the majority shows that this court has ever used a strict historical standard for determining the scope of the right to a jury trial. For example, the majority states that *State ex rel. Mullen v. Doherty,* 16 Wash. 382, 384–85, 47 P. 58 (1897) provides "contemporary insight on the scope issue." Majority opinion, at 645. In *Mullen,* the court cited section 248 of the Code of 1881 to show that at the time the constitution was adopted, the right to a jury trial extended only to "actions at law." Because a quo warranto proceeding is not an action at law, the court determined that the defendant had no right to a jury trial. *Mullen,* at 385. *Mullen* is merely an early example in which

[9]I note that even in 1889, juries did not have unlimited discretion to award economic damages. Section 717 of the Territorial Code of 1881 limited to $5,000 the damages a jury could award in a wrongful death action.

the court used a historical standard to determine whether the right to a jury trial attached *at all*. It simply does not address the "scope" issue. Similarly, the court in *In re Ellern*, 23 Wn.2d 219, 160 P.2d 639 (1945) held that the right to a jury trial attached to insanity commitment proceedings because a jury heard such proceedings in 1889. *Ellern* does not address the "scope" issue.

The only case the majority cites which directly addresses the "scope" issue is *State v. Strasburg*, 60 Wash. 106, 110 P. 1020 (1910). In *Strasburg*, six judges held that a criminal defendant had a due process right to bring the question of his sanity before a jury. Because this right antedated the adoption of the constitution, three judges found that a statute which purported to deny the jury the opportunity to consider this issue also violated Const. art. 1, § 21. The plurality in *Strasburg* thus determined that the right to a jury trial included the right to have the jury determine the issue of the defendant's sanity.

Strasburg is distinguishable from the case before us. In *Strasburg*, the defendant had an *independent* constitutional right to have his sanity made a factual issue. Const. art. 1, § 21 therefore required that the factual issue be determined by the jury. In the present case, however, the plaintiff has no independent constitutional right to have the determination of noneconomic damages be a factual issue. Accordingly, the plaintiff has no Const. art. 1, § 21 right to have the amount of noneconomic damages determined by a jury.

The majority errs by summarily dismissing *Tull v. United States*, 481 U.S. 412, 95 L. Ed. 2d 365, 107 S. Ct. 1831 (1987). The majority dismisses *Tull* on the grounds that the Seventh Amendment does not apply to the states. Majority, at 648. I agree that the federal supremacy clause does not compel us to apply *Tull* to this case. However, "[t]he opinions of the Supreme Court, while not controlling on state courts construing their own constitutions, are nevertheless important guides on the subjects which they squarely address." *State v. Gunwall*, 106 Wn.2d 54, 60–61,

720 P.2d 808 (1986), quoting *State v. Hunt,* 91 N.J. 338, 363, 450 A.2d 952 (1982) (Handler, J., concurring).

Before this court will determine whether our State constitution affords wider protection than the United States Constitution, a litigant must adequately present and argue the issues to us, using at a minimum the criteria set out in *Gunwall. State v. Wethered,* 110 Wn.2d 466, 472–73, 755 P.2d 797 (1988). However, the majority today interprets Const. art. 1, § 21 to afford wider protection than the Seventh Amendment without presenting any reasons for doing so. Majority, at 644–45; footnote 4. We articulated *Gunwall*'s interpretive criteria precisely in order to avoid this "all sail, no anchor" approach to state constitutional law. *Gunwall,* 106 Wn.2d at 60.

In *Tull,* the Court concluded that the common law right of trial by jury did not include the right to have a jury determine the amount of the remedy. Therefore, the Court held that the Seventh Amendment permitted Congress to assign the determination of the amount of a civil penalty to the trial judge. *Tull,* 481 U.S. at 426–27. The analysis set forth in *Tull* bears directly on the "scope" issue.[10] We should not ignore *Tull,* and we cannot legitimately do so.

Because the majority chooses to disregard *Tull,* the applicability of the tort reform act may now depend upon the forum, federal or state, in which an action is heard. The Seventh Amendment controls federal courts sitting in diversity cases. *Byrd v. Blue Ridge Rural Elec. Coop., Inc.,*

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[10]The majority cites *Boyd v. Bulala,* 672 F.2d 915 (W.D. Va. 1987) for the proposition that "*Tull* does not even apply to civil damages actions" (majority, at 663), as if the opinion of a single federal district judge were dispositive of the issue. Compare *Franklin v. Mazda Motor Corp.,* 704 F. Supp. 1325 (D. Md. 1989) (Maryland cap on economic damages does not violate the Seventh Amendment).

In fact, the court in *Boyd* acknowledged that *Tull* "provides some guidance." 672 F. Supp. at 920. The court ultimately determined that the Seventh Amendment required juries to determine that the right to trial by jury guaranteed by the Virginia Constitution is *stronger* than the right secured by the Seventh Amendment. 672 F. Supp. at 922. The Virginia Supreme Court subsequently held that the Virginia Constitution does not require juries to determine the amount of damages. *Etheridge v. Medical Ctr. Hosps.,* ___ Va. ___, 376 S.E.2d 525 (1989). *Boyd*'s predictive value is weak.

356 U.S. 525, 2 L. Ed. 2d 953, 78 S. Ct. 893 (1958). Because the Seventh Amendment does not require that a jury determine the amount of the remedy, *Tull,* the tort reform act does not violate federal right–to–jury guaranties and therefore may still apply to tort litigation in federal court. Compare *Boyd v. Bulala,* 647 F. Supp. 781, 788 (W.D. Va. 1986), *reconsideration denied,* 672 F. Supp. 915 (W.D. Va. 1987); *Etheridge v. Medical Ctr. Hosps.,* ___ Va. ___, 376 S.E.2d 525 (1989). Even in our state courts, the act will still apply to litigants who waive their right to a jury trial, intentionally or otherwise. *See* CR 38(d).

Other absurd results will necessarily follow from the adoption of a historical standard for determining the "scope" of the right to a jury trial. For example, the majority cites *Baker v. Prewitt,* 3 Wash. Terr. 595, 19 P. 149 (1888), to establish the fact that juries in 1889 determined the amount of damages in all civil actions. Majority opinion, at 645–46. However, *Baker* also holds that a jury must determine the amount of damages before a court can enter a *default* judgment. 3 Wash. Terr. at 598. *Baker*'s holding was in effect overruled by *Johansen v. United Truck Lines,* 62 Wn.2d 437, 383 P.2d 512 (1963). However, because the majority holds that a jury must determine all issues which juries determined in 1889, a default judgment entered at variance with this obsolete procedure logically violates a defendant's Const. art. 1, § 21 right to a jury trial.

The majority's analysis also inexorably results in a Const. art. 1, § 21 right to have the jury assess punitive damages in wrongful death actions. The Territorial Code of 1881, § 8, provides in part that: "In every [wrongful death] action the jury may give such damages, pecuniary *or exemplary,* as, under all the circumstances of the case may to them seem just." (Italics mine.) *See also Graetz v. McKenzie,* 3 Wash. 194, 28 P. 331 (1891). Because juries had the right to award punitive damages in wrongful death actions in 1889, Const. art. 1, § 21 will now require that juries be permitted to determine appropriate punitive damage awards in wrongful death actions today.

Indeed, this court did not generally prohibit punitive damage awards until 1891. *Spokane Truck & Dray Co. v. Hoefer,* 2 Wash. 45, 25 P. 1072 (1891). In *Spokane Truck,* the court clearly indicated that it was rejecting the majority common law rule which permitted the jury to award such damages.[11] 2 Wash. at 50–51. If the drafters of our state constitution intended Const. art. 1, § 21 to perpetuate a litigant's common law right to have a jury determine the amount of noneconomic damages, surely they also intended to perpetuate a litigant's common law right to have the jury determine appropriate punitive damages.

While the majority's holding resurrects much obsolete remedy law (which I submit is ill advised), the holding (if consistent) should also eliminate other more recent provisions. For example, the majority asserts that the Consumer Protection Act's damages provisions are not affected by its analysis because they are part of "a cause of action specifically created by the Legislature to fulfill a public policy." Footnote 6. However, the Legislature also specifically created the tort reform act's damage provisions to further a public policy. Laws of 1986, ch. 305, § 100. Under the majority's "flexible historical approach" (majority, at 649), the right to a jury trial would presumably attach to Consumer Protection Act actions because they are analogous to actions heard by a jury at common law, such as fraud, misrepresentation, or deceit. Therefore, if consistently applied, the majority's analysis renders the CPA's treble damages provisions unconstitutional.

For these reasons, I believe the majority errs by adopting a historical standard for determining the "scope" of the right to a jury trial. As the majority acknowledges at page 649, the constitution is not a static document and constitutional analysis should not be completely frozen in time.

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[11]The majority attempts to distinguish the punitive damage issue by asserting that "the nonconstitutional status of punitive damages may have been intimately understood by the judges on the court [in 1891], three of whom had served as drafters at the constitutional convention 2 years earlier." Majority, at 665. I submit that this is speculation.

Hunter v. North Mason High Sch. & Sch. Dist. 403, 85 Wn.2d 810, 539 P.2d 845 (1975). This is *exactly* what the majority's historical standard does.

I would apply a more flexible standard to determine the scope of the right to trial by jury. I would hold that Const. art. 1, § 21 does not restrict the power of the Legislature to alter or amend the elements of a common law cause of action. *Tull; see also Shea v. Olson,* 185 Wash. 143, 53 P.2d 615, 111 A.L.R. 998 (1936). Rather, this provision serves to check the power of the judiciary, by preventing a judge from substituting his or her judgment for that of the jury. *Bingaman; James.* Compare Const. art. 4, § 16. Accordingly, I would hold that the challenged provisions of the tort reform act do not violate Const. art. 1, § 21.

DOLLIVER, J., concurs with CALLOW, C.J.

DOLLIVER, J. (dissenting)—The majority finds RCW 4.56.250 violates Const. art. 1, § 21 ("[t]he right of trial by jury shall remain inviolate") and thus is unconstitutional. While I might agree with the public policy result crafted by the majority, I cannot agree the statute violates plaintiffs' right to trial by jury and, so, I dissent. The majority limits its discussion to the trial by jury question and refuses to consider the equal protection and due process issues raised by plaintiffs. Since I also believe the trial by jury issue is the most important issue before the court and further believe RCW 4.56.250 does not violate either equal protection or due process, I too confine my dissent to the issue of trial by jury.

I begin by referring to the test this court must use in determining whether a statute is constitutional. The majority correctly cites *Shea v. Olson,* 185 Wash. 143, 53 P.2d 615, 111 A.L.R. 998 (1936) in delineating the standard. Its paraphrase of the holding in *Shea,* however, tends to mislead. The majority states:

> In matters of economic legislation [a limitation not expressed in *Shea*], we follow the rule giving every reasonable presumption in favor of the constitutionality of the law or ordinance.

Majority, at 642–43. The rule is not, however, as indicated by the majority, "every reasonable presumption". As the court in *Shea* goes on to state: "[T]he rule in this state is that the court will not declare a law unconstitutional unless its invalidity is so apparent as to leave no reasonable doubt on the subject." *Shea,* at 152. We affirmed this test in a recent case: "A statute should not be declared unconstitutional unless it appears unconstitutional beyond a reasonable doubt." *Haberman v. WPPSS,* 109 Wn.2d 107, 139, 744 P.2d 1032, 750 P.2d 254 (1987). The test is not that there is a reasonable presumption to uphold legislation against constitutional attack. Rather, any finding of unconstitutionality must be beyond a reasonable doubt. The burden is on the one attacking the statute, here the plaintiffs. I examine the statute in question with that test in mind. One of the difficulties with the approach of the majority is that it is not only a weak rendition of the test for constitutionality but it also implicitly shifts the burden to the defendants to show the statute is not unconstitutional.

The opinion of the majority rests on the proposition that "the measure of damages is a question of fact within the jury's province." Majority, at 645. A moment's reflection, however, will demonstrate that this statement is not the real issue. The real question, of course, is whether the jury's fact–finding function to measure damages extends to the remedy phase. In other words, is the jury's authorized measurement of damages necessarily translated, without limitation, into the legal remedy finally given. *See Etheridge v. Medical Ctr. Hosps.*, ___ Va. ___, 376 S.E.2d 525 (1989) (statutory limit on damages in medical malpractice claims does not violate right to trial by jury—remedy is a matter of law, not a matter of fact).

The majority does not attempt to deny that the finding of damages by a jury may be subject to a legal determination as to the final award given by the court. It gives a number of examples to illustrate this point. While not denying this proposition, however, the position of the majority appears to be that the particular kinds of limitations on the jury finding pointed out by the defendants are different than the limitation under RCW 4.56.250. Throughout its discussion, however, the majority does not challenge, but indeed implicitly accepts, the general principle that the jury is not plenary in determining the amount of the judgment. Thus, in its own analysis the majority demonstrates that the question before the court is not whether the jury is the sole fact finder in the determination of whether any damages should be assessed. It clearly is. Rather, the question is whether the particular limitation which stands between the fact–finding power of the jury and the remedy of the court is constitutional.

Parenthetically, I observe that the "facts" a jury may consider are severely limited by the rules of evidence. The jury is not plenary in deciding what "facts" may be reviewed in determining damages. *See* James, *Sufficiency of the Evidence and Jury–Control Devices Available Before Verdict,* 47 Va. L. Rev. 218 (1961). I also note that in the early part of the 19th century it was thought juries had the legal and moral *right* to decide questions of law. Juries continue, of course, to have the *power* to decide the law in returning a general verdict. *See* Note, *The Changing Role of the Jury in the Nineteenth Century,* 74 Yale L.J. 170 (1964). This view of the power of the jury is no longer the rule in any American jurisdiction and has never been the rule in this state. Even so, it serves to remind that the final award which is made or remedy which is granted involves a question of law as well as simply a determination of facts.

The distinction between the fact–finding power of the jury and the remedy granted by the court is well illustrated by the case of *Tull v. United States,* 481 U.S. 412, 95 L.

Ed. 2d 365, 107 S. Ct. 1831 (1987); *cf. Dimick v. Schiedt*, 293 U.S. 474, 490–94, 79 L. Ed. 603, 55 S. Ct. 296, 95 A.L.R. 1150 (1935) (Stone, J., dissenting) (Seventh Amendment does not restrict the court's control of the jury verdict—Hughes, C.J., Brandeis, and Cardozo, JJ., concurring in the dissent). The majority finds *Tull* "irrelevant on the issue before the court" because *Tull* involved a civil penalty in a regulatory case rather than damages in a tort action. Majority, at 648. However, by holding the right to jury trial extends to a clean water act regulatory enforcement action, did not the Court say there is no distinction between tort actions and regulatory actions?

The real issue and the relevant issue is succinctly stated by the Court:

> The Seventh Amendment is silent on the question whether a jury must determine the remedy in a trial in which it must determine liability. The answer must depend on whether the jury must shoulder this responsibility as necessary to preserve the "substance of the common–law right of trial by jury." Is a jury role necessary for that purpose? We do not think so.

(Footnote and citation omitted.) *Tull*, at 425–26.

The Court goes on to explain in footnote 9:

> Nothing in the Amendment's language suggests that the right to a jury trial extends to the remedy phase of a civil trial. Instead, the language "defines the kind of cases for which jury trial is preserved, namely 'suits at common law.'" *Colgrove v. Battin*, 413 U.S. 149, 152[, 37 L. Ed. 2d 522, 93 S. Ct. 2448] (1973). Although "'[w]e have almost no direct evidence concerning the intention of the framers of the seventh amendment itself,' the historical setting in which the Seventh Amendment was adopted highlighted a controversy that was generated . . . by fear that the civil jury itself would be abolished." *Ibid.* (footnote and citation omitted). We have been presented with no evidence that the Framers meant to extend the right to a jury to the remedy phase of a civil trial.

Tull, at 426 n.9.

Nor has any such evidence been presented regarding Const. art. 1, § 21. While the majority insists this is a case

to be determined on state grounds, it does not indicate how the words of the Seventh Amendment, "the right of trial by jury shall be preserved" differ in substance from Const. art. 1, § 21, "[t]he right of trial by jury shall remain inviolate". Furthermore, it gives no principled reason why this court ought to interpret Const. art. 1, § 21 differently from the Seventh Amendment. The historical dissertation by the majority of the power of the jury to determine damages, while informative, does not provide any analytical basis for extending this power to the remedy phase.

The judiciary and the Legislature have in the past made policy choices which have stood between the damages found by the jury and the ultimate remedy, *i.e.*, punitive damages, immunity, and treble damages. The majority attempts to distinguish these examples through its 1889 analysis as to what causes of action the right attaches. Even conceding the application of this analysis to recent tort theories, it begs the question. Whether the right to trial by jury attaches to a cause of action does not determine whether this right extends to the remedy phase. Why is the alteration of the jury's determination of damages in this case different from other allowable alterations? The majority never says why; it simply says it is so.

Not only does the majority not address the real issue, the cases relied on by the majority do not even establish as a historical fact that the right to jury trial in 1889 extended to damages determinations. The court in *Baker v. Prewitt*, 3 Wash. Terr. 595, 19 P. 149 (1888) held that a jury should have determined the damages attendant to a default judgment. The court relied on sections 204 and 289 of the territorial code. Section 204 stated that "[a]n issue of fact shall be tried by a jury . . ." Section 289(2) provided that a trial court "may order the damages to be assessed by a jury" in actions in which "the defendant fail[ed] to answer to the complaint". Code of 1881, §§ 204, 289. What *Prewitt* held, therefore, was only that under the existing statutes, a right to have a jury determine damages existed in default judgments. The case has not been extended, before now, as

authority for a right to a jury determination of damages in other contexts. Arguably, *Prewitt*'s interpretation of section 289 was incorrect in any event, as the provision uses the permissive "may" rather than the mandatory "shall". However, even if *Prewitt* correctly interpreted the territorial code and the *Prewitt* rule applies outside the default judgment context, are all of the more than 40 sections of the territorial code describing jury functions and procedures now to be accorded constitutional stature? Given the predilections of the majority, it would seem so.

The other cases the majority cites are equally unpersuasive as authority to derive the right to jury determined damages. *James v. Robeck,* 79 Wn.2d 864, 869–70, 490 P.2d 878 (1971), which leads off the majority's recitation, does describe damages determination as a constitutionally consigned jury function. However, although *James* overturned a trial court's order reducing a jury–determined damage award, it noted that such a reduction would not be improper in all cases. *James,* at 871. In this respect, *James* refutes the majority's contention that the scope of the constitutional jury right is equivalent to the scope of jury powers under the territorial code. Section 276 of the Code of 1881 provided that when the jury returns "[e]xcessive damages, appearing to have been given under the influence of passion or prejudice", a new trial may be had. The provision does not authorize the trial court simply to reduce the damages as an alternative to a new trial, as *James* and the cases it cites allow.

Similarly, *Dacres v. Oregon Ry. & Nav. Co.,* 1 Wash. 525, 20 P. 601 (1889) is not persuasive to the majority's position. The statute at issue was held violative of the Seventh Amendment jury trial right, not the state constitutional provision. Moreover, *Dacres* did not say the statute offended the federal jury trial right because it prevented a jury determination of damages. Even if it had, it would have been proved wrong by *Tull.*

The remaining Washington cases the majority claims recognize "the constitutional nature of the jury's damage–

determining role" (majority, at 646), ultimately rely either on *Walker v. McNeill,* 17 Wash. 582, 50 P. 518 (1897) or *Martin v. Foss Launch & Tug Co.,* 59 Wn.2d 302, 367 P.2d 981 (1962). The *Anderson* and *Kellerher* cases describe damages determinations simply as "a jury function", *Anderson v. Dalton,* 40 Wn.2d 894, 897, 246 P.2d 853, 35 A.L.R.2d 302 (1952), and "primarily the province of the jury", *Kellerher v. Porter,* 29 Wn.2d 650, 666, 189 P.2d 223 (1948), and both substantively rely only on *Walker v. McNeill, supra. Walker* noted the advantages of having a jury determine damages, but in the end reduces as excessive the damages the jury had determined in the case.

Worthington v. Caldwell, 65 Wn.2d 269, 273, 369 P.2d 797 (1964), *Bingaman v. Grays Harbor Comm'ty Hosp.,* 103 Wn.2d 831, 835, 699 P.2d 1230 (1985), and *Lyster v. Metzger,* 68 Wn.2d 216, 224–25, 412 P.2d 340 (1966) all rely either directly on *Martin v. Foss Launch & Tug Co., supra,* or on cases citing *Martin* as precedent. Interestingly, *Martin* first cites a legislative statute, RCW 4.76.030, for the proposition that there is a statutory presumption that the jury verdict is correct. *Martin,* at 303. Next, *Martin* cites *Anderson v. Dalton, supra,* for the maxim that "the determination of damages is primarily a jury function." *Martin,* at 303. Finally, *Martin* cites *Scobba v. Seattle,* 31 Wn.2d 685, 198 P.2d 805 (1948), which states that the trial court has inherent discretion to relieve a party of an excessive verdict by giving the prevailing party the option to accept a smaller amount or submit to a new trial. *See also Ticknor v. Seattle–Renton Stage Line,* 139 Wash. 354, 358, 247 P. 1, 47 A.L.R. 252 (1926) ("[I]t is within the discretion of the trial judge to require an acceptance of a less amount than the verdict, or a new trial will be granted."). Whether the award is reduced by consent or a new trial is granted, there is an underlying power to limit the damages found by the jury. If the jury's determination of damages translated automatically, by constitutional fiat, into the legal remedy, how could such a common law rule be constitutional?

The majority also cites *Worthington v. Caldwell, supra,* for the proposition that "'[q]uestions of damages should be decided by the jury. . .'". Majority, at 646. Following the line of cases cited by *Worthington* leads only to precedent which allows a trial judge to reform an irregular verdict in accordance with the jury's intent. *See Weihs v. Watson,* 32 Wn.2d 625, 630, 203 P.2d 350 (1949); *Richey & Gilbert Co. v. Northwestern Natural Gas Corp.,* 16 Wn.2d 631, 651, 134 P.2d 444 (1943); *Bobst v. Hardisty,* 199 Wash. 304, 306, 91 P.2d 567 (1939); *City Bond & Share, Inc. v. Klement,* 165 Wash. 408, 411, 5 P.2d 523 (1931); *Beglinger v. Shield,* 164 Wash. 147, 153, 2 P.2d 681 (1931); *Gosslee v. Seattle,* 132 Wash. 1, 2–4, 231 P. 4 (1924); *Buffington v. Henton,* 70 Wash. 44, 47–48, 126 P. 58 (1912); *Casety v. Jamison,* 35 Wash. 478, 480, 77 P. 800 (1904). Contrary to the majority's bold conclusion, this court has never constitutionalized the jury's right to determine damages. Even conceding this point, however, there is no precedent for extending the scope of this right to the remedy phase.

The entire analysis of the majority on the relevant issue, with no authority cited, is found on page 655 of its opinion:

> Respondents also contend that the damages limit affects only the judgment as entered by the court, not the jury's finding of fact. This argument ignores the constitutional magnitude of the jury's fact–finding province, including its role to determine damages. Respondents essentially are saying that the right to trial by jury is not invaded if the jury is allowed to determine facts which go unheeded when the court issues its judgment. Such an argument pays lip service to the form of the jury but robs the institution of its function. This court will not construe constitutional rights in such a manner.

In essence this is the opinion of the majority. It is a conclusion with no support. Unasked by the majority and unanswered by its opinion is the question as to why this particular limitation in RCW 4.56.250 would rob the jury of its function if other limitations, such as treble damages and remittitur, do not? How does one know the jury is robbed

of its function when the majority has not delineated the scope of that function?

Certainly, the jury is entitled to determine the facts which will lead to its assessment of damages and ultimately to the imposition of a remedy by the court. This is a constitutional right which is and must remain inviolate. This does not mean, nor has it ever meant, that the jury's determination of what it believes to be the damages is a constitutional absolute which may not be changed by action of law. It seems to me the majority, with its all or nothing analysis and its failure to distinguish between the damages a jury finds and the judgment which the court grants, *i.e.*, the remedy, needlessly, improperly, and harmfully puts the Legislature, and this court, in a doctrinal straitjacket. To say the Legislature may eliminate the cause of action but not limit the remedy neither accords with common sense nor does it necessarily flow from the constitutional right to trial by jury.

Not only are the facts which a jury may consider limited, it has never been the rule in this state that a jury may assess damages as it chooses from the facts which are presented to it. For example, we have long refused to allow juries to assess compensatory or punitive damages, regardless of whether the facts before the jury might persuade it otherwise. *Spokane Truck & Dray Co. v. Hoefer*, 2 Wash. 45, 25 P. 1072 (1891); *Barr v. Interbay Citizens Bank*, 96 Wn.2d 692, 649 P.2d 827 (1981). Although this is a common law limitation, other examples can be given where legislative action has altered the effect of a jury's determination of damages: RCW 4.22.005, reversing *Seay v. Chrysler Corp.* 93 Wn.2d 319, 609 P.2d 1382 (1980) (see discussion of *Seay v. Chrysler Corp., infra*); RCW 19.86.090 (authorization of treble damages by court in consumer protection action); RCW 79.01.756 (treble damages for cutting or manufacturing timber without authorization).

The most closely analogous legislative action, unmentioned by the majority, is contained in *Seay v. Chrysler Corp., supra.* In *Seay,* we refused to apply comparative

negligence in product liability actions. Product liability actions were judicially created. *See Seay v. Chrysler Corp.*, at 325 (Utter, C.J., dissenting). Thus, in product liability cases in which there was in fact negligence by the plaintiff, since comparative negligence would not apply, there would be higher verdicts and settlements. In *Seay* we held the comparative negligence statute (former RCW 4.22.010) applied only to actions based on negligence and did not apply to causes of action for strict product liability which is based on a no–fault concept. The following year the Legislature enacted RCW 4.22.005, which reversed *Seay* and applied the doctrine of comparative negligence to strict liability cases.

The effect of this legislative action can be seen by taking two hypothetical cases where the facts were identical, the finding of damages by the jury was identical, and there was the same degree of contributory negligence by the plaintiff. Prior to RCW 4.22.005, the plaintiff would have received the *entire* amount of the jury determination of damages. Following RCW 4.22.005, the damages would be reduced by the percentage of the comparative negligence of plaintiff. The doctrine of strict liability would remain the same, the factual basis on which the jury measured damages would remain the same, and the damages for the injury would remain the same. But, by the operation of law, the *recovery* which, say yesterday would be $1,000, would today be $1,000 *minus* any contributory negligence by plaintiff. From an analytical standpoint, I fail to see any difference between my hypothetical case in which the finding of damages by the jury in a common law cause of action is reduced by statute so the *recovery* is less and the case before the court whereby statute the recovery is also less even though the "damages" found by the jury would be a greater amount.

The Legislature has also consistently removed common law causes of action by providing immunity or defenses for the actions. RCW 4.24.200–.210 (immunity from liability of

owner of land or water used for recreation), upheld in *Riksem v. Seattle,* 47 Wn. App. 506, 736 P.2d 275, *review denied,* 108 Wn.2d 1026 (1987); RCW 4.24.300 (immunity from liability of persons rendering emergency care); RCW 4.24.400 (immunity from liability of building warden assisting evacuation or attempting to control hazard); RCW 4.24.410 (immunity from liability of dog handler using police dog in line of duty); RCW 5.40.060 (absolute defense to an action for personal injury or wrongful death when influence of liquor or drugs was a proximate cause of the injury or death); RCW 7.68 (crime victims' compensation act), upheld in *Haddenham v. State,* 87 Wn.2d 145, 550 P.2d 9 (1976); former RCW 46.08.080 (motor vehicle guest statute) (repealed by Laws of 1974, 1st Ex. Sess., ch. 3, p. 2) upheld in *Shea v. Olson,* 185 Wash. 143, 53 P.2d 615, 111 A.L.R. 998 (1936); RCW 68.50.400(3) (immunity from liability of person donating anatomical parts); RCW 70.136-.050 (immunity from liability of persons in agencies rendering aid in hazardous materials incidents).

The majority agrees the Legislature has the power to remove causes of action altogether. If the statute is examined from this perspective, it appears the Legislature in enacting RCW 4.56.250 has eliminated, in effect, any cause of action in which the damages are above the amount allowed in the act. If, as the majority states, when a cause of action is "completely done away with, then the right to trial by jury becomes irrelevant" (majority, at 651) it is, in fact, describing the essence of the statute before the court. By operation of law there can be no cause of action which would have damages in excess of the statutory formula. Within the statutory amounts (*i.e.,* the allowable causes of action) the jury may determine damages as it finds them under the facts of the case.

Rather than analyze why the lesser power to limit recovery is not included within the greater power to abolish causes of action, the majority proceeds with a talismanic incantation of the right of trial by jury. The majority

essentially makes up arguments to distinguish the noneconomic loss situation from the workers' compensation and treble damages situations which clearly illustrate limitations on the jury function in determining remedies. Most troublesome about the majority discussion on this question is the gratuitous holding that there is no right to trial by jury for Consumer Protection Act claims. The reasoning behind this conclusion is woefully inadequate, especially when the majority lectures so strongly about applying a "flexible historical approach" (majority, at 649) to determine when the jury right attaches.

The Legislature perceived a problem in our tort law and believed reform was necessary. Laws of 1986, ch. 305, § 100, p. 1354. It enacted comprehensive tort law revisions which it stated were "to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance." We may question the efficacy of the legislation (*see* Priest, *The Current Insurance Crisis,* 96 Yale L.J. 1521, 1587–90 (1987)). Nonetheless, the Legislature took action which it hoped and believed would remedy or partially remedy the problem. While we may wish it had acted otherwise, we are bound to uphold the statute unless it can be shown to be unconstitutional beyond a reasonable doubt. The plaintiffs have not met their burden. Therefore, I dissent.

CALLOW, C.J., concurs with DOLLIVER, J.

DURHAM, J. (dissenting)—I concur in Justice Dolliver's dissent. There are a few additional comments that I feel should be made, however.

First, Section I of the majority opinion is pure dicta. The court does not decide in this case any issue requiring construction of Const. art. 1, § 12. Thus, the majority's gratuitous discussion of how the Oregon Supreme Court has interpreted a similarly worded provision of Oregon's constitution is irrelevant and inappropriate. A variety of forums

is available to members of the court who have settled opinions on the meaning of our state constitution. This is not the time or the place.

Second, I am astonished to learn from the majority that the methodology we developed in *State v. Gunwall,* 106 Wn.2d 54, 720 P.2d 808 (1986), for ascertaining when a state constitutional provision may be relied upon as an independent source of right, was "clarified" in *State v. Wethered,* 110 Wn.2d 466, 755 P.2d 797 (1988). This simply is not so. In *Wethered,* we declined to engage in analysis of Const. art. 1, § 9, because counsel had not adequately addressed the *Gunwall* criteria. Far from altering *Gunwall*'s methodology, in *Wethered* we had no occasion even to consider it.

Not only is *Wethered* now called a "clarification" of *Gunwall,* it also is cast as a response to criticism in a Washington Law Review case note. This is again a mischaracterization. *Wethered* says nothing about the *Gunwall* criteria other than that any argument favoring independent analysis of a state constitutional provision must address them. Thus, *Wethered* expresses no opinion on, and is in no way responsive to, any criticisms of the analytic methodology we described in *Gunwall.*

More simple means are available to refute the "implication" by Chief Justice Callow that the majority finds troublesome. *See State v. Reece,* 110 Wn.2d 766, 778, 757 P.2d 947 (1988) ("There is no presumption of adherence to federal constitutional analysis."). The majority's distortion of *Wethered* for this purpose is unnecessary and inappropriate.

Third, the majority's discussion of how its ruling affects the trebling of damages in Consumer Protection Act actions is dangerously confusing. The majority attempts to save treble damages by a swift and discursive "historical analysis" which concludes that causes of action under the Consumer Protection Act are "outside of the strict purview of article 1, section 21." Footnote 6. Later, responding to Justice Dolliver's criticism of this conclusion as a "gratuitous

holding" based on "woefully inadequate" reasoning, dissent of Dolliver, J., at 687, the majority recants:

> As for the "gratuitous holding" regarding the Consumer Protection Act discussed by Justice Dolliver's dissent at page 687, we have not reached such a fundamental conclusion. We are unable to because the Consumer Protection Act is not an issue in this case. We cannot decide cases not before us.

Majority, at 666.

This is rhetoric over reason. The majority's opinion leaves only two possibilities for the validity of the Consumer Protection Act's treble damages provisions. Either treble damages are unconstitutional, or there is no right to a jury trial in actions under the Consumer Protection Act. In light of the majority's gratuitous analysis on this issue, and notwithstanding its disclaimer, lower courts will feel constrained to choose the latter option. How sad that "such a fundamental conclusion" is so carelessly determined.

Finally, it is remarkable the way the majority skirts around a decision upholding the workers' compensation scheme. Though this decision was not supported by "historical analysis", the majority nevertheless affirms it, apparently on the basis that a competing constitutional concern justified the legislative action.

I cannot understand why the Legislature can remove damages determinations from the jury as part of the workers' compensation scheme, but it cannot do so in other actions. The "independent constitutional foundation" that the majority apparently believes saves the workers' compensation scheme was nothing other than the state's general police power. *See State v. Mountain Timber Co.*, 75 Wash. 581, 135 P. 645 (1913), *aff'd*, 243 U.S. 219 (1917). As described in *Mountain Timber*, this police power is broad enough to justify the noneconomic damages cap. Where's the distinction? And why is a "detailed historical analysis" not necessary for workers' compensation, when it is so essentially dispositive here?

The majority's only answer is to hold that the Legislature can eliminate the jury right by abolishing a common law cause of action, but it cannot do so merely by limiting or redefining causes of action. "Otherwise, article 1, section 21 means nothing." Majority, at 652. Otherwise, the majority says, the jury right is form but not substance. As Justice Dolliver so well observes, there is just no sense in this. Under the majority's reasoning, the form of the legislative action—whether it supplants a cause of action, or merely imposes limits on it—is ultimately dispositive on the constitutional issue. *That* is form over substance.

CALLOW, C.J., and DOLLIVER, J., concur with DURHAM, J.

After modification, further reconsideration denied September 27, 1989.

Appendix I

REFERENCE AND SUPPORTING DOCUMENT AVAILABILITY

All materials available upon request, including Task Force Member Reed Schifferman's comments, as well as other supporting documents used throughout the process.