



THE LAW REFORM COMMISSION

TORT REFORM

CONSULTATION PAPER

Caps on Non-Economic Damages and Reducing the Limitation Period

22nd October, 2010

The Law Reform Commission

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INTRODUCTION

1. The issue of tort reform was referred to the Law Reform Commission by the Hon. Attorney General on May 13, 2010. This referral originated from the Hon. Minister of Health, Environment, Youth, Sports and Culture by way of a Ministry Briefing Note on Medical Malpractice Indemnity Fees.¹
2. The objective of this consultation by the Law Reform Commission is to invite submissions on that aspect of tort reform which deals with (i) the placement of legislative caps on the award of non-economic damages in cases of personal injury with a particular focus on medical malpractice and (ii) the reduction of the limitation periods applicable to claims for damages for personal injury.
3. The Law Reform Commission has been requested to conduct wide stakeholder consultation in order to seek input on proposals to-
 - (i) amend the Torts (Reform) Law (1996 Revision), using Chapter 74 of the Civil Practice and Remedies Code of Texas² (“the Texas model”) as a guide in order to limit non-economic damages awards to a maximum of CI\$500,000;
 - (ii) amend section 13 of the Limitation Law (1996 Revision) to reduce the limitation period after knowledge of injury to one year and to extend this amendment to infants after they have reached the age majority;
 - (iii) amend section 13 of the Limitation Law to reduce the limitation period for personal injury from three years or, as is the approach in the State of Florida, specifically carve out actions for medical malpractice or wrongful death and reduce the limitation period for those actions to two years; and
 - (iv) amend section 15 of the Limitation Law to reduce the ultimate limitation period from fifteen years to ten years and to make that section applicable to all negligence actions including personal injury actions governed by section 13.
4. The Commission will provide the Government with a report which will set out and analyze the responses to the issues highlighted in this paper and provide the Commission’s final recommendations thereon.

SUMMARY OF RECOMMENDATIONS FOR CONSULTATION

5. The statements and recommendations made in this consultation paper are provisional. The final recommendations of the Law Reform Commission (LRC) will be made after consultation with stakeholders and the general public and upon consideration of the submissions received.
6. **The following reflect the provisional recommendations of the Law Reform Commission-**

¹ Forwarded to the Hon. Attorney General under cover of memorandum dated May 11, 2010.

² Texas Statutes, Title 4 Chapter 74, Sec. 74.301, 302.

- The LRC does not recommend the imposition of legislative caps on the ability of the court to exercise its jurisdiction in the assessment and award of non-economic damages in personal injury actions.(paras. 138 - 139)
- The LRC recommends for consideration the following options as a means to ameliorate any impact of medical malpractice litigation-
 - (a) Legislative Reform Options:
 - (i) Introducing a standard of care in medical negligence. (paras. 141–146)
 - (ii) Establishing an expert witness rule. (paras. 147-148)
 - (iii) Alternative dispute resolution. (paras. 149 – 152)
 - (b) Quasi-Legislative Reform Options:
 - (i) Require periodic payment of awards. (para. 154)
 - (ii) Pre-trial screening panels. (para. 155)
 - (iii) Review medical negligence reporting systems. (para. 156)
 - (iv) Review medical guidelines. (paras. 157 - 158)
 - (v) Government operated medical malpractice liability coverage. (para. 159)
 - (vi) Government patient compensation programmes. (para. 160)
 - (vii) Government subsidies to health care providers. (para. 161)
 - (viii) Clinical Indemnity Schemes. (paras.162 – 168)
 - (ix) Captive Insurance Schemes. (paras. 169 - 172)
- The LRC does not recommend reducing the limitation period applicable to personal injury actions from three to two years. (paras. 195 - 217)
- The LRC is of the view that the accrual and knowledge rule should continue to be the standard applied in determining the period from which a limitation period should commence. (paras. 218 - 228)
- The LRC does not recommend reducing the ultimate limitation period from fifteen to ten years. (paras. 229 - 239)
- The LRC recommends the introduction of an ultimate limitation period of thirty years to be made applicable to personal injury claims. This period is to be qualified by providing the court with a discretion to exclude the thirty year period based on the circumstances of the case. (paras. 240 - 248)
- The LRC believes it to be in the public interest that as a general rule, the limitation period should run against a minor only after he has attained the age of majority and that the period should be set at either three or six years after the date of knowledge. (paras. 249 - 259)

- The LRC recommends that consideration be given towards permitting persons to enter into agreements to reduce or extend either the basic limitation period or ultimate limitation period in the event of personal injury litigation. (paras. 260 - 264)

BACKGROUND

7. Concerns have been raised by the Cayman Islands Medical and Dental Society (CIMDS) in relation to the intention of the Medical Protection Society (MPS) to increase subscription rates for practising Obstetricians and Gynaecologists (OBGYN).

8. This issue of increased subscription rates came to prominence in 2006. As will be further discussed since that time MPS subscription rates have increased over the five year period, though there was a marginal reduction in 2010.

Description of the Medical Protection Society

9. The MPS³ has been described as a medical defence organisation which provides, amongst other services, comprehensive professional indemnity cover to doctors and other health care professionals within Europe, Asia and the Caribbean. It is a mutual, not-for-profit organisation offering its extensive membership⁴ assistance with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.⁵

10. The MPS is owned by its members who in turn form a collective group in order to share the risk of the legal problems faced in their clinical practice. It seeks to ensure that risks are shared fairly between members by collecting an appropriate sum from each individual after taking into account their professional status, clinical specialty and the extent of the indemnity required from the MPS.

11. Membership in the MPS is offered on an occurrence based model. Indemnity protection based on the occurrence of an incident presupposes that the indemnity arrangements existed at the time the incident occurred. Accordingly, with such a facility, MPS members would be able to continue to seek assistance in claims arising from incidents during the currency of their membership.

12. This approach to indemnity coverage differs from the claims model in that such models specify that in order to be eligible for assistance, the policy holder should be paying a premium both at the time of the incident and at the time any potential claim is reported. With this model, changing insurers may leave medical professionals and their patients exposed since the practitioner is required to retain an insurance policy to ensure that his protection is current. This issue appears to be critical when dealing with the medical profession having regard to statutes of

³ <http://www.medicalprotection.org>.

⁴ Over 260,000 medical practitioners.

⁵ <http://www.medicalprotection.org>.

limitation which permit an injured party to bring claims from the date of knowledge of the incident. Claims of this nature, it has been contended, are the most substantive.

13. It was pointed out that MPS subscription rates are usually established at relatively low levels and any subsequent change in those rates generally reflects changes in the medico-legal environment. Although occurrence based indemnity is the more prominent standard for professional protection, pricing such indemnity has been viewed as difficult to predetermine. Therefore, the approach of the MPS is to annually seek to ensure that a sufficient amount in subscription income is generated in each country in which it operates to meet all future costs incurred as a result of events occurring in that year.

Concerns of the Cayman Islands Medical and Dental Society

14. In 2006, the representations emerging from the CIMDS suggested that the MPS was reluctant to continue to offer indemnity coverage to its medical practitioner subscribers at the premium rates which existed. A four hundred percent increase in annual premiums had been proposed by the MPS. The justification for this increase was based on local judgment award precedents in personal injury cases. As an example, the case of *Panton v. Seymour*⁶ was cited in which the court awarded the plaintiff approximately \$KYD 5.8 million in general damages for the injuries he sustained in a motor vehicle accident.⁷ Reference was also made to unresolved malpractice claims pending in the courts of the Cayman Islands arising from the mismanagement of new born deliveries. The documents we reviewed suggested that three such claims were in existence, one being against an obstetrician and reportedly valued at \$KYD 3 million.

15. Having regard to the apparent decisions of the court above, the contention is that the MPS is concerned about the impact that judicial decisions of the type described will have on the operational costs that it would be required to absorb in cases of negligent conduct committed by its medical subscribers. The point was made that its membership is in what can be regarded as a high risk profession in terms of the exposure to professional malpractice litigation. Therefore, the desire is to act preemptively by guarding against that exposure through the increase of premiums to such levels that would not affect the viability of the MPS. In the alternative, it was proposed to exclude the high risk group of medical practitioners from their coverage and continue to offer coverage to lower risk groups at sustainable premium rates.

16. The contention of the CIMDS was that any increase in premiums, especially at the rate proposed by the MPS, may ultimately result in its membership having to discontinue its specialist practices. It argued that the cost of coverage would be placed at unattainably high levels which may go beyond the reach of practitioners, given the size of the Cayman Islands population that such practitioners are required to serve. This in turn will adversely affect the provision of medical care to the Islands especially in the area of obstetrics and gynaecology. The suggestion was that premium increases are likely to result in the few specialists in, for example, obstetrics and gynaecology having to either find an alternative insurer or be forced out of private practice in the Islands.

⁶ [2006 CILR, 91]

⁷ In *Bodden v. Solomon* [2008 CILR 385] the Grand Court made an award comprising special and general damages for a personal injury claim for \$KYD 2.5 million.

17. In response to these concerns, representations were made to the then Government by the Health Practice Commission Sub-Committee on Medical Malpractice. This Sub-Committee was established in 2006 pursuant to instructions coming from the then Hon. Minister of Health. The Sub-Committee made several recommendations to prevent the proposed increases, the primary one being tort reform.

18. It recommended that any element of tort reform should include matters such as placing a cap on non-economic damages and reducing the statute of limitations period. In the case of the former, the proposal was that a cap of Two Hundred and Fifty Thousand Cayman Islands Dollars (\$KYD 250,000)⁸ should be placed on the non-economic damages capable of being awarded for injuries suffered as a result of medical malpractice. The rationale for this suggestion was that a legislative framework which includes such a provision would prevent an increase in MPS premiums and may in fact reduce those premiums. This in turn, it was posited, would facilitate the retention of medical professionals in the Cayman Islands.

19. In the case of the applicable limitations period, it was recommended that the tort reform initiatives should also extend to a reduction of the statute of limitations to two years for medical cases and that special consideration be given to the time frame within which children injured at birth should be barred from making a claim. The Sub-committee reasoned that such a measure may result in less awards and lower premiums.⁹

MPS SUBSCRIPTION RATES

The calculation of MPS subscription rates in the Cayman Islands

20. In evaluating the concerns raised by the CIMDS as it relates to an increase in premiums it might first be useful to give an indication of the rates charged by the MPS. The research documentation we reviewed reflects that it is not possible to derive credible statistics for obstetric claims in the Cayman Islands since the numbers of claims are too few. Further, providing an accurate prediction from the data as to how many obstetric claims arise in any given period presents a difficulty. It was indicated that the approach adopted is to examine similar jurisdictions from which adequate data could be extrapolated. The comparison is usually made between the Cayman Islands gross domestic product per capita and that of the UK. In arriving at 2006 rates, examined were the number of births per annum in the UK, the successfully claimed incidents and the average award. Those statistics were applied to the Cayman Islands to arrive at premiums of KYD\$405,000 for the six obstetricians practicing in the Cayman Islands at the time. This gave a net annual premium of KYD \$67,500.

21. In 2006 when this assessment was provided, the subscription rates at the time for the obstetricians in the Islands was KYD \$35,800. This rate seems to have reflected a subsidised amount, hence the reduction from KYD\$67,500. It was pointed out that the MPS had charged

⁸ The proposal as reflected in the Ministry Briefing Note on Medical Malpractice Indemnity Fees was that CI\$500,000 limit be placed on non-economic damage awards.

⁹ The other recommendations of the Sub-Committee include: limiting legal fees, consulting medical experts, setting a discount rate based on affordability, providing physicians with less coverage, requesting government intervention in the form of subsidies and captive insurance.

subscription rates in the Cayman Islands for obstetricians that were subsidised by the subscriptions paid by other hospital based specialties. This approach was felt to be justified in order to avoid distortions in the recruitment to the obstetric practice. The argument was presented that if the MPS aimed to make a profit it would set subscription rates for obstetricians, neurosurgeons and orthopedic surgeons that would result in few, if any, such specialties subscribing to the MPS.

22. The LRC has been unable to determine whether the method described above for calculating MPS subscription rates in 2006 has continued to apply.

MPS OBGYN Subscription Rates from 2006 to 2010

23. In the Cayman Islands, the medical specialties which are covered by the MPS include obstetrics, gynaecology, cosmetics, neurosurgery, plastic and reconstructive surgery, spinal surgery, orthopedic, cardiothoracic surgery and urology.

24. Given that the OBGYN profession is the primary focus of the concerns, we have sought to reflect in the table below the relevant MPS Subscription rates¹⁰ in US dollar terms at September 2010 exchange rates for persons practicing in the obstetrics and gynaecology specialties in the Cayman Islands. By way of comparison the rates across the Caribbean region are also reflected. It is to be noted that our interpretation and presentation of the data is subject to correction.

MPS OBGYN ANNUAL SUBSCRIPTION RATES 2006-2010 \$US

	2006	2007	2008	2009	2010
Antigua	\$3,532	\$4,453	\$5,775	\$6,298	\$18,360
Bahamas	\$42,802	\$55,636	\$87,930	\$108,155	\$150,000
Barbados	\$8,148	\$10,618	\$13,805	\$16,705	\$24,055
Bermuda	\$34,430	\$51,768	\$77,135	\$94,875	\$150,000
BVI	\$29,216	\$37,962	\$56,475	\$69,476	\$86,400
Cayman Islands	\$44,721	\$58,149	\$93,039	\$157,397	\$153,649
East Caribbean	\$3,772	\$4,920	\$6,154	\$6,708	\$10,800
Jamaica	\$4,607	\$5,989	\$7,985	\$8,943	\$11,385
St Lucia	\$4,373	\$5,247	\$8,389	\$9,143	\$10,518
Trinidad & Tobago	\$8,449	\$10,981	\$14,379	\$18,405	\$24,259

25. From the data, it would be observed that over the last five years the subscription rates in the Cayman Islands have been higher than those in comparable jurisdictions. While the rates in the Cayman Islands did in fact decrease during the current 2010 subscription period, they nevertheless remained higher than those of other jurisdictions within the region. Of note is that the rates in the Bahamas and Bermuda are similarly on the higher end of the scale.

¹⁰ See <http://www.medicalprotection.org>

Observations in relation to the subscription rates data

26. As indicated earlier, the contention in 2006 was that the MPS was planning to increase its rates by as much as 400 per cent and that there was a fear that such an increase would adversely impact the OBGYN medical specialty. Our findings reflect that those rates did in fact increase over a five year period but from our examination of the data, the increases do not appear to be at the levels that were anticipated.

27. The LRC in seeking to ascertain which medical specialties have been affected over the last 5 years in terms of loss of services due to these increases was tentatively advised that none were adversely impacted. We have not however been able to confirm whether the MPS subscription rate increases that have occurred over the five year period have in fact affected the availability of medical practitioners and in particular the OBGYN specialists.

28. Further, the LRC takes note that in 2006 the formula used to calculate the subscription rates for the Cayman Islands was based on the experience in the UK. We have however been unable to determine whether the formula remains relevant and whether it bears a correlation to the medical dynamics concerning the Cayman Islands medical profession.

29. It was earlier pointed that the data reflects that the MPS subscription rates in the Bahamas and Bermuda when compared to the Cayman Islands are equally substantial in amount. In this regard, a question which will be addressed later is whether there are any policies or recommendations to engage in tort reform in any other jurisdiction across the region in which the medical profession is serviced by the MPS.

WHAT IS TORT REFORM?

30. Notwithstanding the LRC's preliminary observations based on the concerns of the CIMDS, it is nevertheless critical within the scheme of this discussion to examine the essence of the tort reform proposal.

31. The proposal of stakeholders seems to be that tort reform is the most suitable panacea to the concerns surrounding medical malpractice litigation and the commensurate increase in medical indemnity fees.

32. The LRC believes that an understanding of tort reform requires a conceptual understanding of a tort.¹¹ A tort may be defined broadly as a civil wrong involving a breach of duty fixed by law, such duty being generally owed to all persons. In another sense, it is an act that is illegal, but not necessarily criminal.

33. Physical injury to a person, physical damage to property, injury to reputation or damage to economic interests are all torts, a breach of which is remedied primarily by an action for damages. Monetary damages is the usual remedy for a tort. The other important remedy is the grant of an injunction, which is a court order forbidding the defendant from doing or continuing to do a wrongful act. Whether the plaintiff is claiming damages or applying for an injunction, he

¹¹ See Gilbert Kodilinye, *Commonwealth Caribbean Tort Law*, 3rd Ed.

must first prove that the defendant has committed a recognised tort since the law of torts does not cover every type of harm caused by one person to another.

34. The plaintiff in a tortious action may seek compensation reflecting special damages and general damages. Special damages are awarded in order to compensate the plaintiff for the quantifiable monetary losses suffered. Damages of this nature must be specially proved and are awarded in respect of out of pocket expenses and loss of earnings actually incurred down to the date of the trial. These damages are generally capable of exact calculation or approximation and include the economic costs of an injury such as medical expenses and loss of income.

35. General damages cover loss of future earnings as well as compensate the claimant for the non-monetary aspects of the specific harm suffered. Damages in this category are incapable of precise mathematical calculation and are implied by the law. As a result, no pleading is required. General damages usually fall under the heads of loss of future income and “non-economic” loss such as pain and suffering, loss of amenities and enjoyment of life.

36. Although there are several¹² other components involved, tort reform in most jurisdictions revolves around setting limits, or caps, on awards for “non-economic damages”¹³ which arise when a tort has been committed or reducing the time limit within which an action can be placed before the court for adjudication.

37. In other words, the primary objective of modern tort reforms seem to place focus on enacting legislation which will bring about substantial changes to the law of negligence. This is achieved by reducing the quantum of damages available to plaintiffs who are injured by negligent defendants while at the same time also reducing the time limit within which a victim is allowed to enforce a cause of action.¹⁴

38. The reduction which is the subject of our examination stems from (i) the placement of caps on the non-economic damages awarded for items such as severe pain, physical and emotional distress, disfigurement, loss of the enjoyment of life that an injury has caused, loss of sterility, loss of sexual organs, physical impairment and loss of a family member and (ii) the imposition of reduced limitation periods within which compensation may be sought for those resulting intangibles.

39. Cynics have referred to the notion of tort reform as tort “deform”¹⁵ given that it is often felt that laws purporting to reform the law of tort do not actually reform the legal system, but rather shift the balance of the scales of justice.

¹² Other components of tort reform include limits on punitive damages, elimination of joint and several liability, proportionate liability, changes to the collateral source rule, shortened statutes of limitation, prejudgment interest, periodic payments, medical malpractice standards, product liability and contingent fees.

¹³ Also known as “quality of life damages”.

¹⁴ Mullany, Nicholas J - “Tort Reform and the Damages Dilemma” [2002] UNSW Law JI 56; (2002) University of New South Wales Law Journal 876.

¹⁵ “What is Tort Reform: A User-Friendly Guide to the Civil Justice System” – <http://whatistortreform.com>.

WHAT ARE THE OBJECTIVES OF THE TORT LIABILITY SYSTEM?

40. In general, the tort liability system has a threefold objective. It seeks to compensate victims, deter accidents and place the responsibility for compensation upon negligent parties. The system rests on the premise that substantive tort liability depends on whether the defendant breached a duty of care and thereby caused an injury that is fairly part of the risk the defendant undertook.

41. The classical principle of the modern law of tort is derived from the judgment of Lord Atkin in *Donoghue v. Stevenson*¹⁶: “*You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour.*” The principle enunciated in that dictum highlights that each individual owes a duty of care to his neighbour. If that duty is breached and injury results due to another person’s negligent conduct, then the aggrieved party is entitled to compensation. This is the primary justification for a system of tortious liability. It is regarded as just and reasonable that a person who suffers injury as a result of negligence should be compensated for medical expenses, out of pocket expenses and critically, for pain and suffering.

42. Further, tort liability provides an incentive, or, in another sense, a threat, to compel safe behaviour by potential tortfeasors. The law of tort seeks to deter negligent behaviour and to encourage appropriate steps to be taken in ensuring that the safety of others will not be affected by negligent or reckless conduct. Emphasis upon liability for negligence results in persons becoming more aware of their obligations under the law and the prospect of substantive negligence awards tends to result in fewer lives damaged or lost by avoidable injuries.

43. Finally, under the tort liability system, the costs of negligently inflicted harm are distributed amongst those who undertake risky activities. The intention is to remove the financial burden from the person injured. In this regard, the tort system operates to shift the burden of losses from innocent plaintiffs to negligent defendants and allows the loss to be distributed through insurance policies amongst persons who participate in otherwise risky but socially valuable activities.

44. The risk of injury or loss is inherent in our daily lives. However the tort liability system provides incentives for individuals and entities to take appropriate care, compensate those who are harmed, spread risk and serves the purposes of punishment or retribution. In economic terms those various purposes can be related to the social goals of efficiency and equity.

LIMITING NON-ECONOMIC DAMAGES AWARDS

45. The first part of our terms of reference requires that we examine the proposal to amend the Torts (Reform) Law (1996 Revision), using the Texas model as a guide in order to limit non-economic damages awards to a maximum of C\$500,000.

¹⁶ [1932] AC 562.

46. Though different types of tort reform measures have been adopted in several jurisdictions, in examining this proposal we give consideration as to whether caps on non-economic damages contradict the underlying purpose behind the tort liability system.

47. A cap is a maximum amount of damages that can be awarded by courts in any claim brought by the complainant. The approaches to tort reform and in particular the control of non-economic damages awards as they relate to medical malpractice, vary from jurisdiction to jurisdiction.

48. These approaches tend to involve the imposition of outright caps on non-economic damages, a mix of capping of non-economic damages and threshold limitations, establishment of a no-fault tort compensation scheme, the application of rule of law principles and the stipulation of guidelines in the award of damages.

The Capping Approach

49. The jurisdiction in which caps feature prominently given the litigious and “multi-million dollar” award predisposition is the United States of America (US). Several states have introduced a cap on the amount of compensation that victims are entitled to receive in their medical malpractice claims. The amount of the cap and what is capped, varies state by state.

Texas

50. In Texas tort reform legislation established a three-tiered system for awarding non-economic damages in medical malpractice cases. In an action for a medical malpractice claim when final judgment is rendered against a single health care provider or a single health care institution, the cap on civil liability for non-economic damages is limited to an amount not exceeding \$250,000 for each claimant, regardless of the number of separate causes of action on which the claim is based.

51. In an action on a medical malpractice claim when final judgment is rendered against more than one health care institution, or more than one health care provider, or any combination thereof, the limit of civil liability for non-economic damages for each health care institution and each health care provider is limited to an amount not exceeding \$250,000 for each claimant.

52. The third tier places a limit on civil liability for non-economic damages for all health care institutions and health care providers. The amount is limited to \$500,000 for each claimant.

53. From all indications, despite the legislative changes in Texas, insurers initially requested rate hikes. Texas insurers lowered rates only after being forced to do so. In 2007, the *Texas Observer* found:

“The campaign’s promise, that tort reform would cause doctors to begin returning to these state’s sparsely populated regions, has now been tested for four years. It has not proven to be true. Those doctors are following the Willie Sutton model: They’re going, understandably, where the better-paying jobs and career opportunities are, to the

*wealthy suburbs of Dallas and Houston, to growing places with larger, better-equipped hospitals and burgeoning medical communities.”*¹⁷

54. At the time, a national medical liability insurer explained that it planned to raise its premiums an additional 19 per cent in Texas despite the fact that Texas had approved non-economic damage caps. The provider justified the premium increase by explaining that savings due to damage caps would only account for a small percentage of its payouts.¹⁸

55. One commentator pointed out that the Texas reform caps are set in nominal terms and do not increase to reflect the effects of inflation. As time passes damage awards will be substantially reduced. Compared with \$250,000 in 2003, for example, a damage award of \$250,000 in 2009 is worth only \$216,800 since inflation would have reduced the value of \$250,000 by more than 15 per cent.

56. The view held by some is that while patients in Texas lost significant legal rights and many unsafe health care providers are now unaccountable, rural communities that were exploited during the “tort reform” campaign have seen no improvement in access to physicians. Medical malpractice insurers are charging doctors at rates that are not much different than any other state in the country, irrespective of tort reforms.¹⁹

57. In summary, tort reform was adopted in Texas to pursue a symptom of medical malpractice. In so doing, it reduced compensation to the severely injured. The reform has however done nothing to treat the underlying problem of medical malpractice. Lowering medical malpractice insurance premiums for doctors and other service providers through tort reform does not appear to have provided any benefit to patients in Texas.

58. The reforms, it was suggested, ignore the genuine and more fundamental problem of medical malpractice and is said to encourage it by reducing negligence costs of doctors.

Florida

59. In 2003, the Florida legislature introduced caps on non-economic damages in medical malpractice lawsuits. The law established caps on recoverable non-economic damages in medical malpractice cases.²⁰ This statutory cap applies only to medical malpractice cases. Under the law a claim brought against a medical practitioner, including physicians and surgeons, for non-economic damages shall be limited to \$500,000 or \$1 million if death results or the victim is in a permanent vegetative state. In the case of a non-practitioner (hospital and other non-physicians), the damages limit is \$750,000 or \$1.5 million if death results or the victim is in a permanent vegetative state.

¹⁷ Suzanne Batchelor, “Baby, I Lied; Rural Texas is still waiting for the doctors tort reform was supposed to deliver,” *Texas Observer*, October 19, 2007. <http://www.texasobserver.org/article.php>.

¹⁸ Jerome M. Staller, *Statistical Analysis; Medical Malpractice Law & Strategy*, Medical Malpractice Law & Strategy vol. 22, no. 3, p. 1 (January 10, 2005).

¹⁹ “True Risk: Medical Liability, Malpractice Insurance and Health Care Principal Contributors”: J. Robert Hunter, Gillian Cassell-Stiga.

²⁰ Florida Statutes, Title XLV Chapter 766.118.

60. Non-economic damages awards against an emergency services practitioner are limited to \$150,000 or \$300,000 for all claimants in the same cause of action. Whereas the liability of an emergency services non-practitioner is limited to \$750,000 or \$1.5 million for all claimants in the same cause of action.

61. In examining the Florida experience, it appears that physicians have viewed the passage of this tort reform measure as having positive benefits in the form of lower medical malpractice insurance rates and a reduction in the number and severity of claims.²¹ At the same time however, commentators²² have argued that while the legislature contended that the cap would prevent spiraling malpractice insurance rates, thus far, doctors have yet to see any meaningful changes in those rates.

62. It was pointed out that medical malpractice insurance companies in Florida applied for rate hike requests in 2003 shortly after the insurance industry lobbied the legislature for the caps on damages and other tort reform measures. On the question of whether caps on damages would ever have any significant impact on the rates insurers charge doctors, a spokesman for Florida's insurance industry suggested that it could take several years before any tangible results were achieved.²³

63. Though unsuccessful, attention should be drawn to the fact that caps on non-economic damages have been challenged in the Florida court system on the grounds of constitutionality.²⁴

64. An independent insurance-rating agency published a report²⁵ concerning the performance of the medical malpractice insurance industry. The report found that between 1991 and 2002 states with caps on non-economic damages saw physician premiums increase 48.2 percent; whereas, states without caps saw only a 35.9 percent increase in premiums. The study further indicates that premium increases were more commonplace in states with caps as compared to those without caps.²⁶

65. Regardless of whether non-economic damage caps have a positive impact, malpractice premiums seem to have risen in Florida. Surveys indicate that rates continued to climb in 2003 with a majority average increase falling between 10 and 49 per cent. This increase occurred

²¹ "Recent Challenges to Caps on Non-Economic Damages" By Robert E. White, Jr.

²² "Legislature Fails to Defuse Med-Mal Crisis", The Business Journal – Tampa Bay, November 13, 2003.

²³ Statement attributed to Sam Miller, vice president for public affairs and communication with the Florida Insurance Council in Tallahassee.

²⁴ In *Nadine Raphael vs. James Shecter & Emergency Physician* the jury returned an award for the plaintiff in the amount of \$9,500,000 in non-economic damages. The lawyer for the physician defendant petitioned the trial judge to apply the non-economic damage cap to the verdict. The plaintiff's lawyer argued to the trial judge that the cap was unconstitutional and urged the judge to not to apply the cap. The judge ruled that the \$150,000 non-economic damage cap governing emergency room cases was constitutional.

²⁵ Weiss Ratings, Inc "Medical Malpractice Caps, The Impact of Non-Economic Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage, 2003".

²⁶ The Physician Insurers Association of America (PIAA) released a response to the Weiss study criticising it as based upon unreliable methodology and foundational data. The response points out that no attempt was made to evaluate the effectiveness of caps at various levels and that Weiss simply lumped all states with any sort of cap together for comparison to non-cap states.

during the period in which all states engaged in damages reform, including eleven states with non-economic caps of \$500,000 or less.²⁷

66. The position in Florida suggests that the varied results and conclusions in many reports and studies point to the fact that the true impact tort reform is having on malpractice premiums is difficult to determine with complete accuracy. There is a divergence of opinions concerning the interpretation of the data that is presently available. This appears to be due to a lack of comprehensive data of the type that would allow proper analysis of the medical malpractice insurance market, including the frequency, severity and causes of insurer losses.²⁸

The Threshold Approach

67. In Australia tort reform changes can be broadly categorised into changes to the law relating to liability, changes to the amount of damages paid to an injured person and changes to claims procedures including time limits. The reforms were implemented by introducing caps and thresholds on general non-economic damages.

68. A threshold is a barrier to the access of damages resulting in the receipt of compensation only if a victim satisfies a minimum level in terms of monetary value or permanent impairment.

69. Australian tort law reforms had the stated objectives of limiting increases in insurance premiums, curbing excessive insurance payouts, limiting small claims for non-economic loss, limiting large claims for non-economic loss and limiting large claims for loss of earnings.

70. In New South Wales, under the Civil Liability Act, 2002²⁹, the concept of general damages assessed at large has been converted into non-economic loss that consists of pain and suffering and loss of amenities of life. Small claims are set at a 15 per cent threshold for non-economic losses. This means that no damages can be awarded unless the severity of the non-economic loss is at least 15 per cent of a most extreme case.

71. The damages are based on a sliding scale upon which damages are scaled down where the severity of the non-economic loss is assessed as being between 15 and 32 per cent of the most extreme case. Once the severity is assessed as being greater than 32 per cent, the full proportion of non-economic loss is awarded. The reasoning behind the scaling down in the lower ranges is to eliminate minor claims and produce monetary savings that can be applied towards the more severely injured.

72. The maximum amount of damages that may be awarded for non-economic loss is \$350,000. However, that maximum amount can only be awarded in a most extreme case. If the severity of the non-economic loss is equal to or greater than 15 per cent of a most extreme case, the damages for non-economic loss are to be determined in accordance with prescribed formula

²⁷ “A Review of Tort Reform’s Impact on Malpractice Premiums: Is It the Answer?” *Group Practice Journal* by Matthew G. Pletcher, 2004.

²⁸ *Ibid.*

²⁹ Section 16.

and the amount determined is to be rounded to the nearest indexation of the maximum amount relating to non-economic damages.

73. In Victoria³⁰ damages for non-economic losses are capped at \$371,380 and are only recoverable where a claimant has sustained a significant injury which is defined in the Act. In this regard, a process is implemented so that the plaintiff can determine whether he is entitled to general damages. The threshold approach does not apply to sexual offences.

74. In the case of injury other than psychiatric injury or impairment, the loss must be more than 5 per cent of the normal functioning of the body and in the case of psychiatric injury or impairment the loss must be more than 10 per cent of normal mental ability, otherwise there is no entitlement. In each case impairment must be permanent to qualify.

75. Queensland has not implemented a threshold approach. Injuries are assessed on a 100% point scale and by reference to similar injuries in earlier proceedings. However, the maximum awardable amount on damages for non-economic damages is capped at \$250,000.

The No-Fault Approach

76. New Zealand has adopted a no-fault approach to dealing with damage awards. In New Zealand the health system is funded by the Ministry of Health and administered by District Health Boards. Each Board is responsible for providing services in a particular geographic region. This public health service coexists with a parallel system of private insurance and private hospitals. Both systems are underpinned by a no-fault accident compensation scheme which provides coverage for personal injury regardless of fault or cause, and at the same time bars the right to sue for compensatory damages covered by the scheme.

77. The no-fault injury compensation scheme³¹ replaced the common law system for accident victims. The scheme is administered by the Accident Compensation Corporation (ACC), which operates under the Injury Prevention, Rehabilitation and Compensation Act, 2001 (IPRCA). ACC is responsible for preventing injury, determining whether claims for injury are covered, providing entitlements including compensation, buying health services to treat and rehabilitate the injured, and advising the Government.

78. Under the IPRCA an eligible person is covered for a personal injury provided it falls within one of eleven statutory categories, which include accident, medical misadventure and disease or infection that is due to medical misadventure. Personal injury is statutorily defined as death, physical injury, mental injury consequent on physical injury, or damage to dentures or prostheses. The term “physical injury” is not precisely defined, but courts consider it to mean any condition involving harm to the human body including sickness or disease.

79. Under the scheme, every citizen who suffers a loss of earnings for longer than seven days as a result of injury is entitled to be compensated. The amount of compensation is, in the first instance, 80 per cent of the earnings lost, but this is subject to abatement if the victim is able to

³⁰ Wrongs Act, 1958.

³¹ The scheme came into operation on 1st April, 1974.

engage in paid employment. The compensation is also subject to a maximum and minimum rate. Those who are injured and incapacitated before entering the workforce and hence do not have a pre-injury rate of earnings are entitled to compensation at a rate equivalent to the minimum wage at the time of the injury. A victim may also be entitled to a lump sum payment for permanent impairment.

80. The IPRCA prohibits independent proceedings, whether under any rule of law or enactment, in any court in New Zealand, for damages arising directly or indirectly out of any covered injury. Therefore, a person may not sue for compensatory damages for any personal injury that is covered by the scheme. The purpose of the bar is to prevent any duplicitous compensation.

81. The benefits³² of coverage under the scheme include medical treatment, social and vocational rehabilitation, weekly compensation during incapacity, lump-sum compensation for permanent impairment, weekly compensation for the spouse and dependants of a deceased claimant, childcare payments, survivors' grants, and funeral grants.

The Rule of Law Approach

82. In Canada, like other jurisdictions, general damages are awarded for intangible injuries such as pain and suffering, loss of companionship, emotional distress, loss of enjoyment of life, the loss of expectation of life, and for the egregious conduct of a defendant in some circumstances.

83. However, damages falling in this category are currently capped at CDN\$100,000 and indexed to inflation. Thus, the maximum award currently allowable is approximately CDN\$325,000. Irrespective of how serious or catastrophic an injury to a plaintiff may be, Canadian courts cannot award in excess of the maximum stipulated amount unless exceptional circumstances arise.³³

84. This cap on general damages in Canada is established by way of a rule of law which originated in three cases decided by the Supreme Court of Canada: (a) *Arnold v. Teno*³⁴, (b) *Andrews v. Grand & Toy*³⁵ and (c) *Thornton v. Prince George*³⁶. These cases established a cap on non-economic damages in order facilitate national consistency in damage awards.

³² The New Zealand scheme has both advantages and disadvantages. The advantages include speedy and simple settlement of claims, universal and consistent access for all and the 'no fault' provision. The disadvantages include limitations on claims for mental injury and trauma, and limitations on the allowances payable to non-income earners who are limited to an independence allowance, medical and rehabilitation costs, poor compensation payments, not all illnesses are compensated, major overlap between inter-agency work and the hospitals are no safer or more dangerous than Western hospitals.

³³ "Medical Malpractice Liability in Canada", June 2009, Stephen F. Clarke, Senior Foreign Law Specialists.

³⁴ *Arnold v. Teno*, [1978] 2 S.C.R. 287.

³⁵ *Andrews v. Grand & Toy Limited*, [1978] 2 R.C.S. (S.C.C.).

³⁶ *Thornton v. Prince George School District No. 57*, [1978] 2 S.C.R. 267.

85. The issue of whether or not, and under what circumstances, a trial judge may exceed the upper limit for general damages was dealt with in the case of *Lindal v. Lindal*³⁷. In that case the Court ruled that it was inappropriate to compare the nature of injuries among different plaintiffs to determine whether or not they were more or less seriously injured. Rather, the amount of the award in any case should be based on its ability to ameliorate the condition of the victim considering his particular circumstances. The trilogy of cases only sets a cap for the most catastrophic of injuries and the significant damage awards that can arise in those cases. In other words, the cap is simply an upper limit established in the interest of maintaining consistency, uniformity and predictability and cannot be exceeded. The cap may however be increased in response to economic conditions, in particular, a decline of purchasing power as a result of inflation.

86. The Supreme Court of Canada, in the 1995 decision of *ter Neuzen v Korn*,³⁸ stated that the cap is no longer a procedural issue but rather, “rule of law.” In the British Columbia Court of Appeal’s 2005 decision in *Lee v Dawson*³⁹ the court determined that it could not overturn the cap set by the Supreme Court of Canada in the trio of cases, despite compelling reasons to do so. Leave from the Supreme Court of Canada was denied without reasons. Until the Supreme Court of Canada decides to grant leave on the issue of whether the cap should be modified or removed, the cap will continue to limit the amount of general damages received by a plaintiff who suffers personal injury. While the cap on general damages is approximately \$325,000 that maximum amount is only paid to the most catastrophically injured victims, such as persons who suffered from quadriplegia, severe brain damage and similar injuries.

87. In essence, while there are no caps specifically targeted at medical malpractice claims in Canada, the Supreme Court of Canada has created a cap that applies to non-economic awards for personal injury claims.

The Judicial Guidelines Approach

88. In the United Kingdom, the Judicial Studies Board prepared guidelines for the assessment of general damages in personal injury cases known as Guidelines for the Assessment of General Damages in Personal Injury Cases⁴⁰. The Guidelines contain upper and lower limits of awards of non-economic damages in relation to many types of injuries such as those involving paralysis, head injuries, psychiatric damage, injuries affecting the senses, injuries to internal organs, orthopaedic injuries, facial injuries, scarring and dermatitis.

89. According to the Guidelines, these indicative upper and lower limits broadly reflect current consensus about appropriate awards for the different types of injuries and are arrived at by combining the decisions in reported cases with the practical effects of the injuries sustained.

³⁷ *Lindal v. Lindal*, [1981] 2 S.C.R. 629.

³⁸ *ter Neuzen v. Korn* (1995), 11 B.C.L.R. (3d) 201, [1995] 3 S.C.R. 674.

³⁹ *Lee v. Dawson*, [2003] B.C.J. No. 1532 (S.C.), aff’d (2006), 267 D.L.R. (4th) 138 (B.C.C.A.).

⁴⁰ Compiled for the Judicial Services Board by Mr. Justice Mackay; Martin Bruffell, Solicitor; John Cherry, QC; Alan Hughes, Solicitor, Michael Tillett QC, Eight Edition.

90. The Guidelines seek to promote consistency and certainty in the assessment of general damages in individual cases. They are, however, not intended to fetter the discretion of the individual judgment which must be brought to bear upon the unique features of each particular case. In other words, it is not the purpose of the Guidelines to freeze the scale of damages whether absolutely or in relative terms as between different categories of loss. The research points to the fact that these Guidelines are relied upon by all judges in the UK courts who are concerned with the assessment of general damages in personal injury cases. Judges are at liberty to take full account of the amount of damages awarded in earlier cases.

91. It is also useful to bring attention to the UK National Health Service Redress Act, 2006 or the NHS Redress Act, 2006, as it is commonly termed. From all indications, this Act is not yet in force and regulations are required to bring it into operation. The NHS Redress Act, 2006 aims to provide a more consistent and open response to a patient's problems when they occur by placing emphasis on correcting the problem. In particular, it makes provision for the establishment of a scheme designed to provide redress for liability in tort in connection with services provided as part of the health services in England or Wales, thereby removing the need to pursue civil proceedings.

92. The intention is that the scheme will be administered by the National Health Service Litigation Authority ("NHSLA"). Access to such an authority removes the need to go to court. The scheme will require its members to consider whether the case being investigated or reviewed involves liability and if it appears that it does, to take steps towards redress.

93. The Act provides for a redress package where there has been clinical negligence in the hospital. The redress package must include an offer of compensation, explanation, apology and a report of action, proposed or implemented, to prevent similar occurrences. The redress package may include care or treatment. It may be accepted with waiver of the right to sue, or rejected.

94. The redress scheme is a consensual process, not a judicial process; therefore redress is offered not awarded. Proceedings under the redress scheme are voluntary and they are mutually exclusive to civil legal proceedings. Legal rights under the redress system are suspended but remain intact during the redress process when legal liability is assessed. Legal liability is not adjudicated upon by the scheme's procedure since it is not a tribunal type process. Rather, legal rights are determined if any offer is made and accepted as part of a compromise agreement.

95. It is also the intention that the scheme will provide for financial compensation to be offered, and will specify an upper limit on the total amount of financial compensation that may be included in an offer under the scheme. It is currently intended that this limit will initially be set at £20,000. The Act does not affect any private law rights but rather focuses on the process of compensation in a procedural and not substantive way.

ASSESSMENT OF NON-ECONOMIC DAMAGES

Approach of the Courts in the Cayman Islands

96. Under the Torts (Reform) Law (1996 Revision) there are no provisions which place a ceiling on damages (whether they be economic or non-economic) that can be awarded by the court to a victim. The Grand Court has an inherent jurisdiction to determine damage awards. This is borne out under the Grand Court Rules (O.37, R.1) which provides that the assessment of damages falls within the strict purview of the Judge.

97. Damages awards are classed into special damages and general damages. The items covered under special damages include loss of salary and medical expenses. These damages must be specifically pleaded. As indicated in our earlier remarks, general damages include the non-economic losses arising from pain and suffering and loss of amenities.

98. In assessing damages for pain, suffering and loss of amenities, the judge in the exercise of his jurisdiction relies on the United Kingdom Judicial Studies Board Guidelines for the Assessment of General Damages in Personal Injury Cases⁴¹ and English case law. The UK Guidelines establish upper and lower monetary limits attributable to different types of injuries. Any determined amount is increased in order to take into account the higher cost of living in the Cayman Islands.⁴²

99. Another tool utilised in the Cayman Courts is the Actuarial Tables with explanatory notes for use in Personal Injury and Fatal Accident Cases, commonly referred to as the “Ogden Tables”. The Ogden Tables are statistical tables which contain information for use in court cases in the UK. Their purpose is to simplify the calculation of future losses in personal injury and fatal accident cases. The tables take into account life expectancy and provide a range of discount rates. The most recent edition⁴³ of the tables makes changes to methods for calculating loss of earnings to take into account contingencies other than mortality.

100. The impetus behind the call for tort reform in the shape of placing caps on non-economic damages is that the increase in the rates of the MPS have been propelled by the quantum of damages awarded for non-economic losses in the courts of the Cayman Islands.

101. The LRC in its research of this issue has not been able to identify specific cases decided over the last 10 years in which the court has awarded non-economic damages for medical malpractice. As stated in the background to this paper, alluded to were malpractice claims involving obstetricians and also complaints against medical practitioners. However, we have not been able to confirm the particulars of those claims. It is possible that either the cases are unreported or are the subject of out of court resolution. In this regard, it is instructive to again note that in 2006 it was pointed out that it is not possible to derive credible statistics for obstetric claims in the Cayman Islands as the numbers of claims are too few.

⁴¹ *Ibid.*

⁴² *Archer v. UBS (Cayman Islands) Limited*, Grand Court, (Quin, J.): September 23rd, 2009.

⁴³ 6th Edition, *ante*.

102. Further, the learned justices⁴⁴ of the Grand Court from whom guidance was sought indicated that, based on their knowledge and experience, the non-economic damages awarded in the Islands for items such as pain and suffering usually represent a very small portion of the total award in personal injury cases. The view shared was that the greatest item in the overall amount of such awards is likely to be the economic loss, that is, the cost of past and future medical and other care and the loss of past and future earnings. The position in the Cayman Islands is perhaps in contrast to the approach in the US courts where non-economic damages often times are very substantive.

103. The cases that we have been able to identify in the Cayman Islands Law Reports tend to support the view of the learned justices. Three of these cases involve personal injury and one concerns an allegation of medical negligence which was not proved.

Panton v. Seymour, [2006 CILR 91]

104. The damages awarded in the case of *Panton v. Seymour*⁴⁵ was highlighted as the primary basis for possible increases in MPS subscription rates. In that case, the plaintiff brought an action against the defendant to recover damages in respect of personal injuries and losses sustained as a result of a road accident caused by the defendant's negligence. The plaintiff, suffered extensive injuries, including brain damage which left him with the mental capacity of a 2-year-old and physically unable to feed, bathe, or clothe himself. The Court awarded the plaintiff special damages totaling \$968,512 and this covered loss of salary, medical and other expenses.

105. The general damages awarded to the plaintiff totaled \$5,865,945 and were broken down as follows-

• Pain suffering and loss of amenities	\$ 350,000
• Future loss of earnings	\$1,147,104
• Future cost of care	\$3,432,557
• One-off future cost of care	\$ 19,104
• Future loss of profit share	\$ 882,400
• Interest	\$ 34,780

106. Arguably the non-economic damages of \$350,000 awarded for pain and suffering would have been quite reasonable having regard to the extent of the injury to the plaintiff and the degree of his incapacity. Note that the amount would be well within the \$500,000 limit that is being proposed as an option for reform. The Court relied on the Odgen Tables in the calculation of the costs for future care which resulted from the pain and suffering that the plaintiff has suffered. While that figure represents a substantial portion of the general damages it can equally be argued that the amount was justified.

⁴⁴ Hon. Justice Charles Quin and Hon. Justice Angus Foster.

⁴⁵[2006 CILR 91] *Panton v. Seymour*, Grand Court (Levers, J.): March 21st, 2006.

E v. H [2000 CILR 347]

107. Another case is that of *E v. H*⁴⁶ where the plaintiff brought an action to recover damages for personal injury sustained in a road accident caused by the defendant's negligence. The plaintiff suffered immediate pain in the muscles of her left shoulder and upper arm and parathesias in her left hand. The plaintiff claimed general damages for pain, suffering and loss of amenity, special damages including, inter alia, medical expenses and loss of earnings, damages for future loss of income and loss of prospects in employment.

108. The Court found that the accident had predisposed the plaintiff to a pattern of chronic non-restorative pain for which the defendant was liable. Accordingly, the court awarded damages in the sum of CI\$30,000 for pain, suffering and loss of amenity. It was reasoned that the award of general damages recognised the discomfort which the plaintiff experienced daily and the life-long restrictions imposed by the rehabilitative regime which was essential to prevent further deterioration in her health.

Bodden v. Solomon [2008 CILR 385]

109. In *Bodden v. Solomon*⁴⁷ the plaintiff sought damages for personal injuries caused by the defendant's negligent driving. He was hit by the defendant's car while out walking and suffered severe injuries, including the loss of his left leg, a blood clot, a ventral hernia and brain damage. As a result of those injuries, the plaintiff was left permanently incapacitated, with decreased executive dysfunction and learning and language difficulties, and was therefore in need of constant care.

110. The case reports do not reflect any award in this case for the non-economic damages for pain and suffering. However, the substance of the award consists of \$631,981 in respect of loss of future earnings and cost of future care of \$2,180,245.

Archer v. UBS, [2009 CILR 531]

111. The only case involving medical negligence that the LRC has been able to identify is that of *Archer v. UBS*⁴⁸. That case dealt with an allegation of employer liability and medical negligence. The plaintiff slipped on the stairs at her workplace and sustained injuries to her back. She consulted a neurosurgeon about her continuing pain and he carried out a spinal fusion operation. The operation left the plaintiff completely disabled and unable to work, with no likelihood of her condition improving.

112. The court found that her medical treatment, though premature, did not automatically break the chain of causation and would only do so when it was so grossly negligent to be a completely inappropriate response to the injury. Accordingly, the conduct of the surgeon was found not to be deliberate or unreasonable. The doctor was therefore not guilty of negligence in the performance of his operation on the plaintiff. However, since the defendant employer was

⁴⁶ [2000 CILR 347] *E v. H*. (Smellie, C.J.: September 5th, 2000.

⁴⁷ [2008 CILR 385] *Bodden v. Solomon*, Grand Court (Henderson, J.): September 5th, 2008.

⁴⁸ [2009 CILR 531] Grand Court (Quin, J.): September 23rd, 2009.

negligent the plaintiff was awarded damages for her injuries. In assessing damages for pain, suffering and loss of amenities, the court relied on the English case law and the Guidelines from the Judicial Studies Board. The plaintiff was accordingly awarded CI\$65,000 as general damages for pain, suffering and loss of amenities and CI\$282,718.96 for special damages.

113. It is arguable that in all the cases identified, and in particular *Panton v. Seymour*, the amounts awarded for non-economic damages were justified. In fact, the view could be put forward that on the face of it, in some instances, the awards were arguably too low given the extent of the injuries suffered by the plaintiff. This however clearly speaks to the conservative approach of the courts in the Cayman Islands in assessing non-economic damages based on strict guidelines balanced against the specific circumstances of the victim and the justice of the case.

Approach of the Courts within the Caribbean Region

114. The LRC in its research examined the approach adopted in the assessment of non-economic damages in those jurisdictions in the region in which the MPS has a membership. These include the Bahamas, Bermuda, Barbados and Jamaica.

115. The LRC found that the approach in these jurisdictions is similar to that of the Cayman Islands. The courts place reliance on the UK Judicial Studies Board Guidelines and judicial precedent in the assessment of damages.⁴⁹

116. Additionally, the LRC is not aware of any legislative steps or policy directives in those jurisdictions to engage in tort reform along the lines of capping non-economic damages or reducing the limitation period.

SHOULD NON-ECONOMIC DAMAGES BE CAPPED?

117. In the light of the discussion above and the approaches to dealing with non-economic damages, the critical question is whether non-economic damages should indeed be capped along the lines suggested in the proposal for reform or at all.

118. In the debate on whether or not to cap non-economic damages and the approach to be adopted, it is usual for several stakeholders to be involved. These are-

- patients who expect high-quality health care;
- individuals who pay premiums and out-of-pocket health care costs;
- employers who pay for private-sector financed health care coverage;
- medical professionals who provide health care services;
- attorneys who represent patients seeking damages;
- the insurance industry that writes policies for medical practitioners and provides health care insurance to groups and individuals;
- hospitals and health systems that employ medical professionals, treat patients and often are self-insured; and

⁴⁹ In Jamaica the Courts also rely on the “Assessment of Damages for Personal Injuries”, Harrison and Harrison.

- governments that bear the financial burden of public sector health care programs.

119. Each stakeholder is a vital part of any health care system and will therefore be impacted by any tort reform measure.

120. The arguments as to whether caps on non-economic damages for medical malpractice are meritorious have found their place in several jurisdictions, including some of those which have been previously identified in this consultation paper and in which the common law system of recovery for torts bring the legal and medical profession into litigious conflict. The debates tend to involve constitutional, legal, commercial social and ethical issues.

121. For instance, the legal profession tends to focus primarily on seeking to obtain a remedy for its client who complains about an injury as a result of the negligent provision of health care service. The desired remedy usually consists of procuring full compensation from the medical insurance system in order to afford an element of loss distribution in favour of the client.

122. On the other hand, for the medical practitioners, the issue is not distributive justice but one of individual justice, including that for the health care professional involved. It is argued that the allegation of professional negligence is not only potentially costly but also disproportional.⁵⁰

123. In forming an opinion on the conflicting view points as to whether legislative caps on non-economic damages should be imposed, one should bear in mind the objectives of tort law and the tort liability system as earlier articulated. These are providing compensation, serving as a deterrent and imposing responsibility.

CONSTITUTIONALITY OF CAPS ON NON-ECONOMIC DAMAGES

Separation of Powers and Due Process

124. The LRC takes note of the contending view points emerging from the US jurisdictions as to the constitutionality of placing caps on the power of the judiciary to award non-economic damages.

125. Advocates of tort reform contend that damages caps are a public policy issue rather than a question of legal procedure. Therefore, tort reform measures would be in the constitutional province of the legislative branch, given that caps on damages 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 court's right to administer justice.

126. However, it is conversely argued that caps on non-economic damages are unconstitutional given that they seek to move the protected right of the judiciary to determine the question of liability and the quantum of damages in the award of tort cases. It is seen as a violation of the principle of separation of powers when the legislature attempts to impose what

⁵⁰ The Hon Justice Michael Kirby AC CMG, "Medical Malpractice - An International Perspective of Tort System Reforms."

are regarded as arbitrary damage caps on the independent judicial arm of government. Even if it is determined to be constitutionally proper to entrust the legislature to enact statutes that cap tort damages, it is arguable that it is still a violation of the separation of powers doctrine for a legislature to whittle away the jurisdiction of the court over any case involving the award of damages for tortious liability.⁵¹

127. Also contended is that caps go against due process by violating procedural due process guarantees. The procedural due process argument rests on the assumption that a plaintiff has a vested property interest in the determined damages that are awarded. Therefore, the application of standard damages caps deprives the plaintiff of this full amount without being afforded an opportunity to present evidence as to why the full award is justified.

Non-Discrimination

128. It is argued that caps on non-economic damages have a significant adverse impact on women. This is in light of the fact that women tend to recover more in non-economic damages because a greater proportion of their total damages are for non-economic losses which involve certain injuries that primarily affect women. These injuries include sexual or reproductive harm, pregnancy loss, impaired fertility, sexual functioning, incontinence, trauma associated with sexual relationships, scarring or disfigurement.

129. Losses of the type described are not based on the economic wage earning aspects of life. Consequently, any cap on non-economic damages will deprive women of a much greater proportion of a just award than men in these circumstances. This in turn, commentators have argued, amounts to a form of discrimination against women and contributes to unequal access to justice or unfair compensation for women.

130. The elderly, particularly elderly women, as well as children who suffer the ultimate injury of death may also be disproportionately disadvantaged by a cap on non-economic damages. The view is that they will lose a greater percentage of their total compensatory awards. This limitation on death recoveries will amount to a ceiling on recovery and prevent the families of the deceased from seeking redress and recognition through the tort system.

131. The prevailing argument is that it goes against the grain of fairness and equality in a civil justice system, as laws capping non-economic damages perhaps signal that women, the elderly, and the parents of deceased children should not seek to access the process of the court.

OTHER STAKEHOLDER ARGUMENTS ON NON-ECONOMIC DAMAGES CAPS

132. In the international debate, the following arguments in support of and against the capping non-economic damages and in particular those damages relating to medical malpractice litigation have been derived from the studies and papers reviewed.

⁵¹ This question of whether the legislative branch infringes on judicial power and determines judicial controversies when it enacts laws that alter or affect the awards of a court was the subject of deliberation in the March 2010 landmark US decision in the case *Atlanta Oculoplastic, P.C. v. Nestlehurst*.⁵¹ The Georgia Supreme Court unanimously held that a statutory cap on non-economic damages in medical malpractice cases is unconstitutional. The decision was in relation to the award issued by a jury verdict.

Arguments in Support of Caps on Non-Economic Damages

- The premiums for medical insurance coverage have increased as a result of increased litigation. Medical malpractice lawsuits are driving up the costs of liability insurance for physicians to the point that some of them are restricting their practices. Caps on non-economic damages will therefore discourage litigation and assist in reducing malpractice insurance costs.
- Caps protect qualified doctors from exorbitant judgments that may result in them deciding to terminate their practice.
- Caps on the non-economic damages attributable to malpractice proceedings positively impact the medical practice environment by making a particular jurisdiction more attractive for the purposes of practising medicine.
- Capping non-economic damages increases the number of insurers in the relevant insurance market.
- The threat of litigation leads doctors to practise defensive medicine and engage in a practice of ordering unnecessary tests and procedures to avoid lawsuits. This in turn increases medical bills.
- Increased costs to the medical profession will result in those costs being transferred to the recipients of health care, thereby making the provision of health care unaffordable to the underprivileged.
- The imposition of caps are advantageous to the quality of health care in that they assist in controlling the severity of claims filed against doctors and help to ensure accessible quality health care.
- Medical specialists are more likely to accept complex cases when the threat of a significant award is minimised.
- The tort system which holds parties liable for intangible non-economic injuries is inefficient and arbitrary. The non-economic losses of, for example, pain and suffering and loss of consortium are not easily valued. Although the purpose of non-economic damages is to compensate for injuries that are less real and less tangible they are not physically verifiable and not readily quantified according to monetary measures set by the marketplace. As a result, awards for non-economic loss do not “make whole” in the sense of restoring a person’s ability to work in the way that wage replacement or medical cost damages do, and as such are arbitrary, subjective and unpredictable.
- Caps on non-economic damages which are in the form of thresholds limit the number of small or minor claims for non-economic damages and more efficiently re-directs the pool of available funds to the seriously injured.

- The transaction costs of the tort liability system and in particular attorneys' fees are excessive.
- Removal of the possibility of permitting exorbitant awards discourages "ambulance chasers" and some malpractice lawyers who may be less than ethical or opportunistic in their practices.
- Caps remove the more frivolous or overly ambitious malpractice suits, so that only the legitimate cases are pursued in court.
- The assessment of fair compensation for victims of medical malpractice is limited by frivolous lawsuits and excessive awards of non-economic damages, which increases the likelihood of bankruptcy for medical insurance companies.
- The justice system tends to be biased against large corporate defendants in favor of individual plaintiff tort suits. Placement of a ceiling on the amount of non-economic damages would remove this bias.
- In circumstances where one excessive award is permitted to stand that award becomes a precedent for other larger awards. Unbridled, spiralling, excessive judgments therefore impose a huge cost on society.
- The class-action mechanism in which many claims that cover similar factual grounds are combined into a single larger case is too easily abused by plaintiffs and attorneys. Caps on non-economic damages will prevent this abuse.

Arguments in Opposition to Caps on Non-Economic Damages

- The view is held that a lack of consistent evidence pointing to the benefits and costs of tort liability and in particular caps on non-economic damages have made tort reforms an arbitrary exercise. There is, it is argued, limited data to reflect that the costs of the tort system are excessive. In fact, opponents of reform contend that even if the costs are excessive, those costs, to the extent that they exist, are justified by the role of the tort system in compensating victims and ensuring that negligent parties face the total costs of their conduct and take the appropriate steps to improve safety.
- In cases where damage caps produce a reduction in insurer payouts, caps do not always induce insurance companies to reduce the premiums they charge doctors. In fact some tend to raise their rates. There is evidence that some jurisdictions with caps experienced a greater increase in the annual premiums in high-risk medical specialties such as internal medicine, general surgery and obstetrics/gynecology than states without caps. Caps therefore benefit insurance companies by increasing their profits, while producing no benefit for doctors, and causing a detriment to the victims of negligent conduct, in particular women and the elderly.

- Insurance premium cycles are driven by insurance capacity and this is influenced by economic cycles in equity markets, interest rates, global claims and competition. Tort reforms do not fix market cycles; rather, they provide temporary subsidies to mask the consequences of market inefficiency, corporate incompetence and occasionally outright dishonesty. In other words, damage caps are not likely to alter market cycles that affect premium rates and insurance availability. Caps are concerned with an illusory search for relief from market-driven premium policies of insurance companies because there is no empirical evidence that caps on non-economic damages will have any significant effect on insurance rates.
- Reforms to limit non-economic damages make consumers worse off. Although in some cases insurance premiums may fall and those reductions are passed onto consumers in full, this gain is offset by the increased risk that victims will be forced to bear because of the uninsurable risk.
- In Texas it was pointed out by the Supreme Court in the case *Lucas v. United States*⁵², that while doctors may be facing higher insurance premiums, there is no relationship between insurance rates and caps on damages.
- Caps create a “one size fits all” mentality to resolving medical malpractice claims. Awards of general damages should reflect economic realities and compensate those injured for the whole of the remainder of their lives.’’
- Imposing a legislative cap on non-economic damages does not meet the procedural justice requirement of accountability. When legislatures impose caps on non-economic damages, no distinction is made among the cases. Although an injured party may receive his day in court, a portion of his remedy is pre-determined without any regard for the serious or egregious nature of the injury. Thus there is no proportionality because there is no rational differentiation between the cases. Imposing caps on non-economic damages therefore violates the ethical principle of procedural justice.
- Tort reform legislation thus reduces malpractice insurance premiums for doctors, but it does so by reducing damage awards to the patients who are harmed by malpractice and as there is no adjustment for inflation the value of the maximum damage award will steadily decline over time. The greater point is that the focus on reducing malpractice insurance premiums treats only a symptom of malpractice and does not address the underlying problem of negligent medical treatment.⁵³
- Caps on damages increase insurance company profits while making it cheaper to catastrophically injure patients. Significantly, tort restrictions do not address the mechanisms to improve patient safety.

⁵² 757 S.W. 2d 687 (Tex. 1988).

⁵³ Roger Sherman and Geraldine Szott Mookr, “Medical Malpractice Tort Reform in Texas, Treating Symptoms Rather than Seeking a Cure, *Journal of Consumer and Commercial Law*”, p. 144.

- Caps on non-economic damages do not address the issues of regulation of the medical profession in terms of governance, best practices, recruitment and qualifications.
- Though medical practice premiums for malpractice insurance are costly doctors are financially rewarded to sufficiently cover these premiums. Medical malpractice premiums are expensive because of the risk involved. When the risk is high and the costs of error are high, the price for insuring against such a risk is naturally high. It is therefore a misleading premise to argue that because insurance premiums are costly there is a crisis which should be dealt with by restricting access to the courts.
- The argument that physicians respond to premium increases by moving to lower-premium jurisdictions or by retiring is not easy to answer because of the difficulty of tracking the movements of the thousands of patients and physicians in “real time.”
- Tort law reforms that limit claims for non-economic loss make it difficult for risk averse consumers to buy insurance at a fair value.
- Caps on non-economic damages increase the complication rate for newborn deliveries and tend to trigger the use of more expensive procedures. This is due to the fact that, limitation of liability makes it easier for physicians to pursue riskier procedures that are more remunerative while offering minimal or no offsetting benefits to patients.
- Caps are unfair to the patients with the most extensive injuries, that would be entitled to damages that exceed the statutory cap if one was imposed.
- In instances where caps on non-economic damages are combined with thresholds, injured individuals become ineligible for compensation for pain and suffering in circumstances where community standards may suggest that they deserve financial recompense. In other words, thresholds place an unjust limit on when an injured party may be entitled to recover damages for the losses sustained.
- Caps are unjust in that they prevent physicians who make mistakes from being held fully accountable for their errors.
- Thresholds are unethical given that to rule out recovery for non-economic loss fails to appropriately recognise that personal capacities such as sight, touch and mental equilibrium lie at the core of what it is to be human.
- Thresholds are used to arbitrarily determine whether a person should be compensated for their injuries without any regard to the impact of an injury on a person’s way of life. This is compounded by the inconsistencies between the different thresholds in personal injury schemes and a failure to distinguish between the personal circumstances of claimants.
- It is offensive to assume that persons with an injury that falls below the threshold are suffering from trivial or superficial conditions which do not deserve compensation.

- Thresholds produce inequitable consequences, such as permitting a certain level of negligence to become free from financial liability to the negligent party. As a result, safety standards are likely to decrease.
- Thresholds on non-economic damages have a greater impact on stay-at-home parents, the elderly, unemployed persons and children. For persons such as these, whose claims for economic loss are usually lower than that for full-time workers, the loss of non-economic damages can make it practically impossible to bring an action.
- Attorneys are less willing to bring suits acknowledged to be meritorious unless they cross a certain threshold of non-economic loss damages. This position obtains despite how devastating the injury might be or how compelling the proof of negligence or medical error.
- Evaluating claims made about the benefits of tort reform is complicated. Studies that support reform tend to deal with broad tort reforms and their evidence may not apply to malpractice cases. In the area of medical malpractice, an accurate evaluation requires an assessment of claimed benefits against the lost compensation to those injured by malpractice. That is, a cost benefit analysis is required.
- Proponents of caps have given minimal consideration to what their effects might be on the ability of injured individuals to find legal representation and gain access to the civil justice system. This is due to the fact that caps make it less likely that certain types of injuries will be redressed through the courts, given that claims with low economic loss recovery value but high non-economic loss value would not be worthwhile pursuing.
- Caps tend to mean that awards for injuries such as deafness, numbness, disfigurement, chronic pain and the like, which may not greatly impair physical functioning or cause wage loss or high health care costs, will be adversely affected by caps because they attract relatively small economic damage awards.
- While non-economic damage awards cannot provide full restitution for all consequences of an injury, especially where the injury has resulted in the loss of bodily or cognitive functions, these non-economic damage awards do provide additional monetary support to make life more endurable for the plaintiff. Capping non-economic damages makes it difficult to maximize the benefits of that monetary support.
- The measurement of non-economic damages is not an arbitrary and subjective exercise. The aspects of injury that are compensated through non-economic loss damages are real and often devastating, and the elements of life compensated by these damages are often those we cherish most. Debilitating pain or depression that severely diminishes the quality of life is only one element compensated through non-economic loss damages. Reproductive health, fertility, sexual enjoyment, intimacy,

caring for and enjoying loved ones are all priceless facets which are valued and protected through the tort system. Caps therefore devalue these intangibles.

- Capped non-economic damages impact the most seriously injured people more in that they recover less of their compensatory awards, because it is in the more serious injury, higher damage cases where the amount awarded is most likely to exceed the statutory cap.
- Cap laws which place a ceiling on recovery for certain types of injuries disproportionately experienced by women will depress the recovery value of these injuries and attorneys may be increasingly unwilling to represent victims in certain types of cases. The civil justice system therefore increasingly becomes an unavailable option for plaintiffs and as a result a greater burden will be placed on society to absorb the medical and lost productivity costs flowing from these serious injuries.
- Caps will result in a lost opportunity for tort suits to bring chronic problems or abuses to public and regulatory attention.
- The fiscal impact of caps on awards is distributed inequitably across different types of injuries. The plaintiffs with the most severe injuries appear to be at highest risk for inadequate compensation so those worst-off may suffer a form of “double-jeopardy” under caps.

133. The arguments in support of or against caps on non-economic damages are numerous. The impact of reforms which place caps on non-economic damages has had differing results, depending upon the type and meaningfulness of the reforms, as well as whether the reforms have withstood constitutional scrutiny.

134. Whether or not such reforms have had a significant effect on insurance premiums may not conclusively pass judgment on the overall functioning of the tort system in terms of efficiency and equity. For instance, whether non-economic damages caps reduce litigation does not necessarily lead to the conclusion that it is more efficient or equitable to discourage tortious litigation.

135. While all stakeholders seem to be making valid and cogent arguments and voicing reasonable perspectives, recommendations however must be based on sound empirical data and on legal and ethical footing.⁵⁴

THE LRC POSITION ON CAPPING NON-ECONOMIC DAMAGES

136. The LRC has assessed the bases articulated for the proposal to impose caps on non-economic damages, including the risk posed to accessing OBGYN specialists. The various legislative and non-legislative approaches adopted when seeking to impose limits on non-

⁵⁴ The Hon Justice Michael Kirby AC CMG, *ibid*.

economic damages have been examined and the arguments for and against the imposition of caps on non-economic damages have been considered. The LRC has taken note of the decided cases in the Cayman Islands and the quantum awarded by the courts for non-economic damages in personal injury claims. As has been pointed out, the local awards for non-economic damages represent a small portion of the total damages usually awarded in personal injury cases. While the cases we have examined do not necessarily relate to personal injury claims as a result of medical malpractice they may however perhaps reflect an accurate picture of the conservative approach of the courts when dealing with the issue on non-economic damages.

137. In this regard, the LRC takes note of the apparent absence of identifiable cases in the Cayman Islands dealing specifically with medical malpractice claims. This may well call into question the rationale for seeking to change our legal system to such a degree that it may have an adverse impact on the distribution of justice. Further, the LRC is of the view that the assessment of MPS subscription rates do not appear to represent the indemnification risk in terms of the number of medical practice cases before the court and the approach of the courts in awarding non-economic damages.

138. Accordingly, it is the recommendation of the LRC that non-economic damages for personal injury claims including those relating to medical malpractice should not be the subject of any form of legislative caps at this time. Any assessment of non-economic damages for personal injury generally and specifically relating to medical malpractice cases should continue to remain within the strict jurisdiction of the court. It is the belief of the LRC that the courts of the Cayman Islands continue to be the more appropriate arbiters in terms of assessing and awarding damages based on principles of justice and having regard to the specific circumstances of each case.

139. The findings of the LRC do not support what may be construed as a proposal to implement a fundamental change in the legal system of the Cayman Islands.

REFORM OPTIONS FOR CONSIDERATION

140. Having regard to the public interest concerns surrounding reasonable access to medical expertise, the LRC recommends for consideration other options which perhaps may merit exploration in more detail. These options may be classified into legislative and quasi-legislative options for reform.

Legislative Reform Options

Introducing a standard of care in medical negligence

141. Issues relating to the standard of care in medical negligence cases may arise in relation to medical treatment and to the giving of information about treatment. The issue that tends to cause controversy in regard to the standard of care applicable to the treatment of patients is whether the court should be the ultimate arbiter of the standard of care or whether it should defer to some designated body of opinion within the medical profession.⁵⁵

⁵⁵Review of the Law of Negligence Report; August 2002 (“The Ipp Report”), Commonwealth of Australia 2002.

142. The rule dealing with this issue is known as the Bolam⁵⁶ rule. It provides that “a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act merely because there is a body of opinion that would take a contrary view”. This approach requires a court to defer to responsible medical opinion, so that if the defendant acted in accordance with a responsible body of expert opinion, the court cannot decide that the defendant acted without reasonable care.

143. An objection to the Bolam rule is that it places too much emphasis on opinions that may be extreme and held by only a few experts or by practitioners who may work in the same institution and as a result are unrepresentative of the views of the larger body of practitioners. The application of the Bolam rule has, however, been tempered in the Australian jurisdiction in that the rule has been modified to reflect that a defendant would not be held liable where the court is satisfied that the conduct in question was in accordance with an opinion “widely held by a significant number of respected practitioners in the relevant field”.

144. In this formulation, the requirement that the opinion be widely held is designed to prevent reliance being placed on practices that develop in isolation from the mainstream of professional activity. The Australian modification further reposes jurisdiction in the court by adding the proviso that “unless the court considers that the opinion was “irrational”.”⁵⁷ Therefore, even if the medical opinion points in one direction, the Court is still provided with a discretion to exercise its jurisdiction if it believes the medical opinion lacks reasonable basis.

145. The LRC believes that this approach to assessing medical liability may provide the medical profession with protection in the public interest, while at the same time facilitating the court in its protection of the plaintiff’s interest.

146. The LRC accordingly recommends that the test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient, should, unless the court considers the opinion to be irrational, be based on whether the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field.

Establishing an expert witness rule

147. The position in several US jurisdictions is that a plaintiff is precluded from establishing a case of medical negligence unless he is supported by a qualified medical expert who is in a position to determine whether the defendant deviated from standard medical practices. The rules enacted in the US seek to establish objective standards that recognise professional qualifications and experience of expert witnesses. Some of the rules state that an expert is required to be a licensed physician, board certified, practice a similar specialty, be currently practising or practising within a set time frame from the date of injury and be certified by the court as an expert.

⁵⁶ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

⁵⁷ This proviso follows the law as laid down by the English House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232.

148. To the extent that this rule does not feature in the decision making process in the courts, the LRC recommends it for consideration.

Alternative Dispute Resolution

149. An alternative dispute resolution scheme is designed to either remove cases out of the tort system altogether or assess the merits of a claim before it is placed within the jurisdiction of the court. Schemes of this nature attempt to provide fairer, faster, and less expensive routes to a resolution for all parties.

150. An arbitration program is one such method of alternative dispute resolution. It offers resolution to medical liability litigation without involving the court system. An arbitration program catering for medical malpractice claims would typically consist of a panel comprising an attorney, a health care provider and a lay person.

151. The panel, rather than a judge, hears the merits of a case and makes a decision on fault and patient compensation. These programs are typically voluntary, and the decisions are binding. The benefits of arbitration are that it takes less time to come to resolution and costs less for both sides to defend.

152. Accordingly, the LRC recommends for consideration alternative dispute resolution in the form of arbitration proceedings as a method of resolving medical malpractice litigation.

Quasi - Legislative Reform Options

153. The LRC recommends the following quasi-legislative options for consideration-

Require periodic payment of awards

154. Traditionally, awards are made in one lump-sum payment, even when the amount awarded is intended to cover future medical expenses and lost earnings. A periodic payment of an award would pay the award over a period of time in installments instead of in one lump sum. Periodic payments would allow the injured party to receive payments over their lifetime or for the duration of the injury. This approach in turn ensures that funds are available for future medical expenses, lost wages and living expenses. Periodic payments may also help bring stability to the insurance market by giving more predictability of future payments and preventing overpayment.⁵⁸

Pre-trial screening panels

155. A pre-trial screening panel is essentially a select group which will include an attorney, a physician and a lay person. This group will hear the merits of the case before it goes to trial and arrive at either a binding or non-binding determination on the merits of the case. In theory, pre-

⁵⁸ Uniform periodic payment of judgment Acts Approved by the American Bar Association Seattle, Washington, February 12, 1991.

trial screening panels help to eliminate and discourage frivolous claims that burden the justice system. Some common elements of a pre-trial screening panel include: findings of the panel may or may not be allowed into evidence at trial, findings of the panel are either binding or non-binding, findings before a case may proceed to trial must be unanimous or claims above a certain amount may be subject to a pre-trial screening.⁵⁹

Review medical negligence reporting systems

156. Medical boards are the traditional institutions to which negligence is reported. In cases where there is no requirement for providers to voluntarily report their own errors to their respective boards, this should be made mandatory.

Review medical guidelines

157. Medical guidelines as they relate to risk management protocols and practice parameters for specialists in obstetrics/gynaecology, emergency medicine, anesthesia and radiology or other high risk areas should be reviewed. Physicians who can demonstrate that they followed the practice criteria set out in the guidelines will have a defence against medical malpractice claims. The thinking is that if the court determines that the physician followed the published guidelines, he will not be subject to legal proceedings. In turn, doctors agree to limit their use of defensive medicine because of concerns about malpractice liability.⁶⁰ In theory, guidelines should improve outcomes and reduce injuries without the need for legislation.⁶¹

158. Also systems dealing with the provision of information to the public about health care provider quality and action taken against problematic doctors should be reviewed.⁶²

Government operated medical malpractice liability coverage

159. An insurance fund may be established by the Government from which doctors can purchase insurance if there is no other insurance carrier on the market. The benefit of this type of fund is that it deals with any shortage of available insurance or unaffordable insurance.⁶³

Government patient compensation programmes

160. A patient compensation fund is designed to spread the cost of high awards. Such a programme requires that the Government establish a fund that pays a portion of a judgment or settlement against a health care provider if the award exceeds a stipulated amount. The fund in

⁵⁹ Medical Malpractice Pretrial Screening Panels, Jerome Harleston, Senior Attorney, April 29, 2003.

⁶⁰ Ruslan Novik, Risk Management Information “Medical Malpractice” available at: <http://www.ucalgary.ca/MG/inrm/industry/Professional/med/med.htm>.

⁶¹ Maine established the Medical Liability Demonstration Project as an experiment to lower treatment costs and reduce malpractice claims. Doctors who volunteer for the program agree to limit their use of “defensive medicine” in exchange for being able to cite practice parameters when defending against malpractice claims. The Project developed practice parameters or guidelines in four medical specialties: obstetrics and gynecology, radiology, emergency medicine and anesthesiology.

⁶² *Ibid* at p. 148

⁶³ “Issue Brief Health Policy Studies Division Contact:” Emily V. Cornell, December 5, 2002.

turn pays the remainder of the award or it may stipulate a maximum amount. The health provider will be responsible for awards beyond the funds maximum. Financing of the funds is done through an annual surcharge assessed against health care providers that participate in the fund and such participation can be mandatory or voluntary.⁶⁴ The advantage is that patient compensation funds help to spread the risk more broadly and assist in the maintenance of medical malpractice insurance.

Government subsidies to health care providers

161. A Government mechanism could be established in order to subsidise all or a portion of the health care provider's insurance premium. Subsidies could be made available to all providers, to a select group of providers who practise in high-risk specialties, or to providers in a select medically underserved specialty. Subsidies of this nature could be justified on the basis of public policy interest.⁶⁵

Clinical Indemnity Schemes

162. The experience in Ireland was that the most frequent medical claims in the courts were in relation to obstetrics and gynaecology.⁶⁶ As a result, insurance premiums doubled and the number of practitioners reduced.

163. The Clinical Indemnity Scheme (CIS) was therefore established because commercial insurers either withdrew from offering insurance cover to obstetricians/gynaecologists or were not in a position to obtain cover at affordable rates. This was due to the escalation in the size of court awards and associated costs in cases of birth-related injury.⁶⁷

164. Under the CIS, the State assumes responsibility for the indemnification and management of clinical negligence claims arising from the diagnosis, treatment and care of patients. The Scheme, is managed by the State Claims Agency (SCA) and each enterprise assumes legal liability for the alleged clinical negligence of its employees. The Scheme does not cover general practitioner services, except where such services are provided on behalf of a participating enterprise.

⁶⁴ Cheye Calvo, "State Patient Compensation Funds" (Washington, D.C.: National Conference of State Legislatures, 2002). Seven states operate voluntary systems- Indiana, Louisiana, Nebraska, New Mexico, North Dakota, South Carolina, and Virginia and three states operate mandatory programs- Kansas, Pennsylvania, and Wisconsin.

⁶⁵ Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas, and Washington have tried this approach in the past to solve an immediate crisis. These programs were established in the late 1980s and abandoned as the liability crisis abated.

⁶⁶ Learning extracted from Medical Negligence and MRSA Claims: Is the Law of Tort Efficient Enough? Bridget Kelleher, Dublin Institute of Technology, 2009.

⁶⁷ www.stateclaims.ie/ClinicalIndemnityScheme/introduction.html. The CIS was established in 2002 which transferred all medical indemnity arrangements to the State. The scheme which is managed by the State Claims Agency (SCA) ensures that 'the State assumes all responsibility for the indemnification and management of all clinical negligence claims'. The scheme only covers claims alleging medical negligence or clinical negligence and so does not cover Employer's Liability or Public Liability.

165. The Scheme covers only claims alleging medical malpractice or clinical negligence and does not cover private hospitals with the exception of obstetric/gynaecological services offered at specified hospitals.

166. Typically the CIS covers the following:

- All health service executive facilities, public hospitals and other agencies providing clinical services.
- Non-consultant hospital doctors, nurses and other clinical staff employed by health agencies whether permanent, locum or temporary.
- Consultant hospital doctors are covered with effect from February 1st 2004 in respect of alleged clinical negligence incidents on or after that date.
- Clinical support staff in pathology and radiology services.
- The clinical activities of public health doctors, nurses and other community-based clinical staff.
- Dentists providing public practice.

167. Public doctors are not required to contribute monetarily to the CIS and doctors who treat private patients in public hospitals are also covered by the CIS without having to contribute.

168. However, doctors who treat private patients in private hospital or clinics are not covered by the CIS and have their own indemnity arrangements, primarily with the Medical Protection Society. However, over a certain level (e.g. €500,000 for some specialities), the Government will bear the costs of medical malpractice cases.⁶⁸

Captive Insurance Schemes

169. In a captive insurance company those insured have direct involvement and influence over the captive's operations, including underwriting, claims management, and investments. This direct involvement often means that the insured can reduce its insurance costs. However, as a self-funded mechanism, if a captive does not properly plan and reserve for losses, the parent organisation's financial position can be significantly impaired.⁶⁹

170. A captive may be classed as a pure captive whereby a parent company, for example a hospital or medical practice, forms an insurance company to insure its own risks. It can also be classed as a group captive in which multiple, non-related organisations form or participate in an insurance company to insure risks common to the group.

⁶⁸ Statements attributed to Susan Moriarty, Solicitor Head of Claims (CIS) State Claims Agency, Treasury Building, Grand Canal Street, Dublin 2.

⁶⁹ Medical Malpractice Captive Insurance Company, Janet Brierton, Associate Legislative Attorney, April 26, 2004. Captives also present certain disadvantages. For example, a captive must cover all claims if it is not backed by reinsurance. As a self-funded mechanism, if a captive does not properly plan and reserve for losses, the parent organization's financial position can be significantly impaired. Captives are not protected by state guaranty or insolvency funds. In addition, forming a captive may require a substantial capital outlay for start up and maintenance costs.

171. To form a captive⁷⁰, a hospital or group of other health care professionals need to select a domicile in which to incorporate. Captives have several options when selecting a domicile. A captive may incorporate on-shore in a jurisdiction with legislation that permits captives or off-shore in a country that permits captives. A captive must however comply with the laws and regulations of its domicile.⁷¹

172. The common benefits of forming a captive are the ability to: (i) control premium and capital investments, (ii) design loss prevention and claims handling policies for specific insurance needs, (iii) reduce the impact of the insurance industry underwriting cycle, (iv) reduce regulatory requirements, (v) have direct access to the reinsurance market, (vi) provide broader coverage than may be available in the commercial market, and (vii) provide a self-funding mechanism for claims, which may have tax benefits.

REDUCING THE STATUTE OF LIMITATION PERIODS

173. The second part of our terms of reference requires that consideration be given towards the following-

- amending section 13 of the Limitation Law (1996 Revision) to reduce the limitation period after knowledge of injury to one year and to extend this amendment to infants after they have reached the age majority; and
- amending section 13 of the Limitation Law to reduce the limitation period for personal injury from three years, or, as is the approach in the State of Florida, specifically carve out actions for medical malpractice or wrongful death and reduce the limitation period for those actions to two years.

What is a statute of limitations?

174. Before any consideration given to a reduction in the limitation period it would perhaps be useful to define the statute of limitations concept.

175. The time within which a person must commence an action to enforce a right is called the “limitation period”. The purpose of limitations legislation is to ensure that civil actions are brought in a timely fashion while affording the plaintiff a reasonable opportunity to seek legal advice, consider a settlement, and if necessary, initiate legal proceedings. A claim that is not brought within the applicable basic limitation period is vulnerable to a limitations defence which,

⁷⁰ www.captive.com

⁷¹ States can regulate captives to varying degrees depending on the domicile and type of captive formed. According to the National Association of Insurance Commissioners (NAIC), there are 23 states that permit captive insurance companies to domicile in their jurisdiction: Arizona, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maine, Montana, Nevada, New York, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, and West Virginia. These 23 states regulate the captives through their captive insurance company laws, which generally include provisions on: captive formation, minimum capital and surplus requirements, taxation, financial statements, reporting, and investments, among other miscellaneous requirements.

if successful, will result in the defendant being immune from liability despite the merits of the claim.

176. In other words, if proceedings are commenced after the expiration of the limitations period specified for a particular kind of claim at issue, the defendant may plead as a defence that the proceedings are “statute-barred.” In such a situation, a decision is not able to be determined on its merits and the claim would accordingly be defeated by operation of the limitation period.⁷² The length of the limitation period generally depends on the nature of the claim.

Classification of Limitation Legislation

177. Legislation dealing with limitation periods typically falls into two categories. These are procedural or substantive. The distinction between procedural and substantive limitation periods is based on the effect of the expiration of the limitation period.

Procedural

178. Legislation is classed as procedural where the expiration of the limitation period does not extinguish the right on which the claim is based.⁷³ Procedural limitation provisions usually state that an action shall not be brought after the relevant limitation period has expired. Legislation expressed in these terms has the effect, after the limitation period has expired, of cutting off access to the courts for enforcement of a claim. It bars access to a remedy which may have been available if litigation were successful. The rights of the plaintiff however still remain.

Substantive

179. A substantive limitation provision generally operates to automatically extinguish the right on which a claim is based once the limitation period for bringing proceedings to enforce the right has expired.⁷⁴ The reason for enacting legislation which has this effect is that, given that the purpose of a limitation statute is to prevent claimants from suing after the specified period of time has elapsed, it is logical for the legislation to provide that the right no longer exists after the limitation period has expired, rather than to merely bar the remedy.

180. The distinction between procedural and substantive limitation periods is important for several reasons. First, if the limitation law is procedural, the onus is on a defendant to plead that an action is statute-barred. If the defendant makes no such pleading the action may proceed even though it is out of time. On the other hand, if the limitation period is substantive, compliance is an essential element of the plaintiff’s case and it should be for the plaintiff to plead compliance and to establish that the action was brought within time.

⁷² Brady and Kerr, *The Limitation of Actions*, 2nd ed. (1994), pp.1–41.

⁷³ *McKain v RW Miller & Co (SA) Pty Ltd* (1991) 174 CLR 1 per Mason CJ at 19.

⁷⁴ New South Wales Law Reform Commission, Report No 3: *Report on the Limitation of Actions* 22 (October 1967) para 14.

181. Secondly, if the limitation period is procedural, the defendant may waive the right to rely on the limitation defence.⁷⁵ However, if the limitation period is substantive, it would appear to be a precondition to the existence of the court's jurisdiction that the action be brought within time. Accordingly, the expiration of the limitation period would be incapable of being waived by the defendant.⁷⁶

182. A defendant may be estopped from relying on the expiration of a procedural limitation period if for example, the defendant's conduct leads the plaintiff to assume that the defendant will not rely on a limitation defence.⁷⁷ However, if the limitation period is substantive the defendant cannot be estopped from relying on a limitation defence.

183. In the case of a procedural limitation period an application for extension of the limitation period may be made after the original limitation period has actually expired. This may occur if, for example, the plaintiff has suffered latent injury which does not manifest itself until after the expiration of the limitation period. However, if the limitation period is substantive, expiration of the limitation period extinguishes the right with the result that there is no remaining right to be enforced even if the period is extended.⁷⁸

184. The Cayman Islands Limitation Law may be construed as being procedural since the provisions permit the court to exercise a discretion as it relates to extending⁷⁹ or excluding⁸⁰ a limitation period. These provisions will later be discussed in more detail.

Purpose of limitation periods

185. The imposition of limitation periods has been justified on a number of grounds including fairness, closure, efficiency and public policy.

Fairness to the parties

186. The argument based on fairness is that it is unreasonable that a potential defendant should be subject to an indefinite threat of being sued. Delay in bringing proceedings may unfairly prejudice a defendant's ability to contest the plaintiff's claim.⁸¹

187. The longer the time which elapses before the action is commenced, the harder it will be for a defendant to contest the plaintiff's allegations. Evidentiary problems are likely to increase as time passes and it may not be possible to trace witnesses, or those who can be found may no longer have a sufficiently clear recollection of events. Further, written records may have been lost or destroyed.⁸²

⁷⁵ *Commonwealth of Australia v Verwayen* (1990) 170 CLR 394 per Mason CJ at 405-406.

⁷⁶ Australian Torts Reporter, Vol 1 at 10,103.

⁷⁷ *Commonwealth of Australia v Verwayen* (1990) *supra*.

⁷⁸ *Limitation Act 1969* (NSW) s 61, *Commonwealth of Australia v Mewett* (1995) 59 FCR 391 per Cooper J at 403 and per Lindgren J at 421.

⁷⁹ Section 38.

⁸⁰ Section 39.

⁸¹ *Thompson v. Eastwood* (1877) 2 App Cas 215, 248 per Lord Hatherley.

⁸² UK Law Commission, Consultation Paper No 151: *Limitation of Actions* (October 1997) 11-12.

188. Although a plaintiff may also be affected by deterioration of evidence over the passage of time, it can be argued that a potential defendant is in a more vulnerable position than a plaintiff. It is the plaintiff who decides when to commence proceedings and can use the time before the claim is brought to collect evidence, while the defendant may not even be aware that he is at risk of being sued and is therefore unlikely to take the necessary steps to preserve evidentiary material. It can also be argued that, because it is the plaintiff whose interests have been harmed, the plaintiff is likely to have a clearer recollection of events and hence stand a better chance succeeding based on the facts.⁸³ A limitation period serves to minimise these occurrences by introducing fairness to the proceedings.

Facilitating closure to a cause of action

189. Limitation periods are justified on the basis that parties should be entitled to have legal disputes resolved in a timely manner. The law serves not merely to resolve disputes but also to provide security to litigants. In this regard, it has been said that “long dormant claims have more served the ends of cruelty rather than justice.”⁸⁴ It can therefore be asserted that open-ended threats of liability are inimical to security and that limitation periods serve to provide that security.

Facilitating economic activity through closure of a cause of action

190. If a limitation period does not exist, the burden of insuring against and defending unlimited claims will inevitably be passed on to potential defendants through higher insurance premiums and on to consumers in general through increased costs for goods and services. The imposition of a limitation period therefore permits more accurate assessments of potential liability.

Judicial efficiency and public policy

191. It is generally recognised that the public has an interest in resolving disputes as quickly as possible. Society provides a judicial system to assist its members in the orderly resolution of disputes. This system should not be burdened with dated disputes which could reasonably have been settled at some point in the past. Limitation periods ensure that claims do not exist indefinitely by permitting the slate to be wiped clean from time to time.⁸⁵

Adverse effects of limitation periods

192. Despite the reasons for enacting limitation legislation, the result may be unfair for some plaintiffs where the delay in commencing the action is not due to any fault on the part of the plaintiff. For example, the plaintiff may not have been aware of the existence of the injury or of its severity within the relevant limitation period.

⁸³ Ireland Law Reform Commission, Consultation Paper on the Statutes of Limitation: Claims in Contract and Tort in Respect of Latent Damage (Other Than Personal Injury), 1998.

⁸⁴ *A' Court v. Cross* (1825) 3 Bing 329, 332 per Best CJ, 130 ER 540, 541.

⁸⁵ Law Commission, Consultation Paper No 151: *Limitation of Actions* (October 1997) 13.

193. In this regard, the limitation period should be sufficiently long to allow plaintiffs to recognise and consider a cause of action, to take legal advice and to attempt to negotiate a settlement with defendants. A limitation period which leads to the plaintiff's claim becoming statute barred before the plaintiff is, or could reasonably be, aware of the existence of a claim is unjust to a plaintiff.⁸⁶

194. Limitation periods may also have a negative impact on the administration of justice. The interests of society will not be served if plaintiffs are obliged to institute proceedings before they have had an opportunity to explore the possibility of settlement. Therefore, as will be further discussed, a reduction of a limitation period must take these effects into consideration.

Reduction of the limitation period from three to two years

195. The Limitation Law (1996 Revision), section 13⁸⁷ provides *inter alia* that any action for negligence, nuisance or breach of duty where the damages claimed by the plaintiff for the negligence, nuisance or breach of duty consist of or include damages in respect of personal injuries to himself or any other person shall be brought within three years from (a) the date on which the cause of action accrued or (b) the date of knowledge (if later) of the person injured.

196. If the person injured dies before the expiration of the three year limitation period the personal representatives of his estate may bring an action within three years from (a) the date of death or (b) the date of the personal representative's knowledge, whichever is the later.

197. The proposal is that the limitation period for personal injury claims should be reduced from three to two years. The LRC supports the view⁸⁸ that in encouraging the timely resolution of disputes, a limitation system must strike a proper balance among the interests of potential claimants, potential defendants and society at large.

198. The setting of a limitation period should take account of the need to do justice to the plaintiff in all causes of action. A limitation period must allow the plaintiff sufficient time, once the relevant facts are known, to consider his position, to take legal advice, investigate the claim and to attempt to reach a negotiated settlement with the defendant before instituting proceedings. It would therefore be unjust to set an unreasonably short limitation period.

199. However, at the same time, it is an important function of limitation periods to encourage the plaintiff to start proceedings against the defendant without undue delay. Therefore, a limitation period which is too long will fail to provide the plaintiff with any incentive to move quickly against the defendant and by extension, this would be prejudicial to the defendant.

200. It is reasonable to presume that when the period of three years was considered and subsequently incorporated into our Limitation Law, the justifications reflected above for setting the period were taken into account and that this accordingly led to the three year limitation

⁸⁶ *Ibid* at p. 15.

⁸⁷ Section 13.

⁸⁸ Alberta Law Reform Institute, Report No 55: *Limitations* (December 1989) 16.

stipulation. The thinking obviously being that a period of three years was thought to have struck a fair balance which protected the interests of the plaintiff and that of the defendant.

201. The LRC is not aware of any legal issues which would suggest that the plaintiff or defendant was prejudiced as a result of the application of the three year period in personal injury cases falling under section 13. Neither has the LRC in its research been able to identify any medical malpractice cases in which the limitation period was at issue.

202. The question therefore is whether any legislative amendment from three years to two years would serve any meaningful purpose. It is unclear whether a period of two years has significant advantages over the three years period and a period of one year would in the opinion of the LRC be too short a time within which to institute legal proceedings. Essentially, there appears to be no data in the Cayman Islands to conclusively state that the legal position of the parties would have changed had the limitation period been two rather than three years.

203. Limitation periods of three years are not unusual. In the United Kingdom, the Limitation Act 1980 contains a separate time limit for actions in respect of personal injuries (three years from the date of accrual or the date of knowledge of the person (if later)), plus a discretionary exclusion of time limit.

204. In New South Wales,⁸⁹ the limitation period for a personal injury action is three years, but there is a discretionary extension for latent injury where the plaintiff did not know the injury had been suffered, was unaware of the nature or extent of the injury, or was unaware of the connection between the injury and the defendant's act or omission.

205. In Alberta⁹⁰ the Limitations Act was considered to be a significant departure from the traditional approach to this area of the law. Its basic structure is that all claims must be brought within 2 years of reasonable discovery, with a long-stop of 10 years from when the claim arose.⁹¹

206. In Ontario⁹², there is a basic limitation period of two years for all proceedings from the date on which the claim was discovered. An action against a medical professional or hospital must therefore be commenced within two years of the date that the plaintiff knew or ought to have known of the negligence alleged. This limitation period does not apply to minors until they attain the age of majority (18) or to persons who are not mentally competent.

207. In Texas⁹³ a health care liability claim must be commenced within two years from the occurrence of the breach or tort or from the completion of treatment or hospitalisation. If the actual date of the tort cannot be ascertained, time would be measured from the last date of a course of treatment.

⁸⁹ Limitation Act, 1969.

⁹⁰ Limitations Act, 1996.

⁹¹ Alberta Law Reform Institute. The law came into force on 1 March 1999 and is based on recommendations in a 1989 report by the Alberta Law Reform Institute.

⁹² Ontario Limitations Act, 2002.

⁹³ Tex. Civ. Prac. & Rem. Code. § 74.251(a) (Westlaw 2007).

208. In Florida⁹⁴ the statute of limitations for medical malpractice is two years from when the patient or sometimes a particular family member or guardian, either knew, or should have known with the exercise of reasonable diligence, that the injury has occurred and there is a reasonable possibility that the injury was caused by medical malpractice. Florida also has an accompanying rule called the statute of repose.

209. This rule says that unless there is fraud, concealment or misrepresentation, under no circumstances may a health care provider be sued for medical malpractice more than four years after the actual incident of malpractice. So even if the patient or family does not know about the malpractice, they may not bring the claim more than four years after the malpractice occurs under most circumstances.

210. In British Columbia section 8 of the Limitation Act⁹⁵ provides that a six year period is applicable to an action based on negligence against a hospital or a hospital employee acting in the course of employment, or an action against a medical practitioner, based on professional negligence or malpractice.

211. In the jurisdictions serviced by the MPS such as Bermuda⁹⁶ and the British Virgin Islands⁹⁷ the limitation period for personal injury claims is 6 years. In the Bahamas⁹⁸ on the other hand, the limitation period for personal injury claims is three years.

212. As would be gleaned, the various legislative models seem to set limitation periods at two, three or six years. From all indications, the stipulated periods are a matter of policy rather than a deliberate mathematical calculation which was based on verifiable statistics. The element of probability seems to have been the greatest influence.

213. Even if it is felt that the two year period is more ideal to meet the circumstances of the Cayman Islands, section 39 of the Limitation Law should be borne in mind. As alluded to earlier, that section provides the court with a discretion to exclude the limitation period in circumstances where its application may prejudice either the plaintiff or defendant.

214. Section 39 provides that in determining whether to exercise the discretion, the court should consider all the circumstances of the case, including the length of, and reasons for, delay on the part of the plaintiff; the extent to which, having regard to the delay, there is or is likely to be prejudice to the defendant; the nature of the plaintiff's injury; the position of the defendant; the conduct of the defendant which resulted in the harm of which the plaintiff complains; the conduct of the defendant after the cause of action arose, the duration of any disability of the plaintiff; and the extent to which the plaintiff acted properly and reasonably in the circumstances once the injury became discoverable.

⁹⁴ Florida Statutes 95.11, F.S.

⁹⁵ Limitation Act [RSBC 1996] Chapter 266, section 8.

⁹⁶ Limitation Act, 1984 (1989 Revision).

⁹⁷ Limitation Act, 1961.

⁹⁸ Limitation Act, Chapter 83.

215. This discretionary approach has been objected to in the Australian jurisdiction. The Law Reform Commission of Western Australia in its 1997 report on limitation periods⁹⁹ stated that the major objections to such a discretion are that it would generate uncertainty and it might make liability insurance expensive and difficult to obtain. The Commission further indicated that the possibility existed that it would lead to divergent approaches among judges in the exercise of the discretion and undermine the effectiveness of a fixed limitation period as a means of encouraging plaintiffs not to promptly exercise their rights.

216. The LRC is however of the view that the discretion as currently exists in section 39 of the Limitation Law is a flexible alternative which allows judges to balance the numerous factors involved in a cause of action and the relative hardships to the plaintiff and the defendant in arriving at a just decision. A discretion of this nature is especially useful in cases involving claims for damages which remain undiscoverable until after the ultimate limitation period has expired and in cases where factors other than the latency of the injury prevents the plaintiff from bringing the action within the limitation period.¹⁰⁰

217. Accordingly, the LRC does not recommend the reduction of the basic limitation period for personal injury claims from three to two years. We are of the view that the current three year period applicable to personal injury claims is appropriate, especially since there is no evidence to suggest that it is or has been prejudicial to litigants and it does not represent a departure from modern existing legislative trends dealing with limitation periods. Further, the LRC is not of the opinion that a distinct limitation period for medical professionals and institutions can be justified on the basis that the Limitation Law has had an adverse effect on medical malpractice litigation.

When should the limitation period commence?

218. Within the context of reducing the limitation period, it might be useful to consider an opinion which appears to be calling for the re-examination of the provision in our Limitation Law which requires that the limitation period in personal injury cases commence from date of

⁹⁹ Law Reform Commission of Western Australia, Project No 36 Part II: *Report on Limitation and 408 Notice of Actions* (January 1997) 123.

¹⁰⁰ In England, the Law Commission also considered the advantages and disadvantages of a judicial discretion to allow an action to be commenced notwithstanding that the limitation period has expired. It pointed out that the advantage of including a judicial discretion to disapply or exclude the initial limitation period is that it allows flexibility. A discretion to disapply or exclude the limitation period running from the date of discoverability enables the court to take into account factors other than those allowed for in the definition of the date of discoverability which have prevented the plaintiff from bringing proceedings before the expiry of the limitation period. Though the plaintiff may have had full knowledge of the facts giving rise to the proceedings, there may, perhaps, be circumstances where the plaintiff's conduct in not bringing proceedings before the end of the limitation period was excusable. The existence of a judicial discretion enables the court to prevent injustice to plaintiffs in such a position.

See also Queensland Law Reform Commission, Working Paper No 50: *Review of the Limitation of 427 Actions Act 1974 (Qld)* (December 1997) 69: The Queensland Law Reform Commission in its discussion paper pointed out that the discretion to extend the limitation period in the interests of justice should be exercised only in exceptional cases; where the prejudice to the defendant in having to defend an action after the normal limitation period has expired, and the general public interest in the finality of litigation, are outweighed by other factors.

knowledge. The contention is that allowing a plaintiff three years within which to pursue a claim for personal injury after knowledge is illogical.

219. The Limitation Law provides that the three year period for the basic limitation period commences from the date on which the action accrued or from the date of knowledge of the injured person, if that period is later in time.

220. By date of accrual is meant the date on which it is presumed the injury occurred or manifested itself. In contrast, the date of discovery is the date from which the person actually becomes aware that the injury suffered was caused by the negligent act.

221. Most limitation periods run from one of two dates- the date on which the cause of action accrues or the date on which the cause of action is first reasonably discoverable by the plaintiff.¹⁰¹ It is often contended that limitation periods which operate based on accrual or discovery serve to adversely affect defendants.

222. Reform in this area usually revolves around three options for determining the commencement period for a limitation period. These are date of discoverability, accrual or date of act or omission.

Date of discoverability of the cause of action

223. Under this option, time would not start to run until the plaintiff knows, or ought reasonably to know that he has a cause of action. The date of discoverability responds to the injustice to a plaintiff of the limitation period running before the plaintiff knew, or could reasonably have known, that he or she had a cause of action. Discoverability has been recommended as the basic test for limitation periods by other law reform bodies. For example, the Alberta Law Reform Institute,¹⁰² the Ontario Limitations Act Consultation Group¹⁰³ and the Law Reform Commission of Western Australia.¹⁰⁴ The Law Commission of New Zealand proposed the date of the act or omission giving rise to the cause of action should be the date of commencement of the limitation period.¹⁰⁵

224. Discoverability may be regarded as having the principal merit of producing greater justice to plaintiffs by overcoming the “latent damage” problem under which a plaintiff might lose his action before he could reasonably have known of it. It might however be thought to carry the disadvantage of uncertainty in that the date of discoverability may vary from case to case depending on the particular plaintiff in question. It may require resolution through oral evidence and discoverability of documents which will affect the length and cost of hearings.

¹⁰¹ See para 3.29 (Personal Injuries); para. 3.88 (Latent Damage); para 3.101 (Actions under the Consumer Protection Act 1987).

¹⁰² Limitations, Report No. 55 (1989).

¹⁰³ Recommendations for a New Limitations Act, Report of the Limitations Act Consultation Group (1991).

¹⁰⁴ Report on Limitation and Notice of Actions, Project No 36 - Part II (1997). See also the proposals of the Law Reform Commission of Ireland, “Report on the Statute of Limitations: Claims in Respect of Latent Personal Injuries,” LRC 21 (1987).

¹⁰⁵ Report No 6, Limitation Defences in Civil Proceedings, NZLC R6 (1988).

Date of accrual of the cause of action

225. The date that the cause of action arose is the date that it “accrues.” Under the common law, a plaintiff’s cause of action is said to “accrue” when all of the elements that constitute the action are present and the cause of action is complete. Limitation laws have traditionally adopted the date of accrual as the logical point to commence the running of time under the limitation period.

226. The accrual based system has several advantages.¹⁰⁶ It provides some certainty, in the sense that the rules as to when the cause of action accrues are generally well settled. However, at the same time, the rules do not always make it possible to determine exactly when the cause of action accrued on the facts of a particular case. Problems such as these raise doubts as to whether a limitation system based on such a rule can meet the objectives of certainty and fairness.¹⁰⁷ There are cases where, because of the difficulty in establishing precisely when the cause of action accrued, reliance on the accrual rules creates uncertainty.¹⁰⁸

Date of the act or omission giving rise to the cause of action

227. Under this option, time would run from the date of the negligent act or omission irrespective of when damage is caused. This approach may be thought objectionable in principle in that the initial limitation period might run before the accrual of the cause of action and hence before the plaintiff could sue.

228. The LRC believes that these options have their advantages and disadvantages. Our view however is that an option which combines the accrual rule with that of discoverability is appropriate. The current provisions in our Law strike a balance by allowing the discoverability concept to take precedence over the accrual concept if the cause of action is discovered later. Accordingly, the LRC does not recommend any change to the date of accrual or discoverability rule as it applies to the period from which the limitation period should be calculated.

REDUCING THE ULTIMATE LIMITATION PERIOD AND APPLYING AN ULTIMATE LIMITATION PERIOD TO PERSONAL INJURY CLAIMS

229. The third part of our terms of reference requires that consideration be given to amending section 15 of the Limitation Law (1996 Revision) in order to reduce the ultimate limitation period from fifteen years to ten years and to make that section applicable to all negligence actions including personal injury actions governed by section 13.

¹⁰⁶ Law Reform Commission of Western Australia, Project No 36 Part II: Report on Limitation and Notice of Actions, (January 1997) 96-97.

¹⁰⁷ Alberta Institute of Law Research and Reform, Report for Discussion No 4: Limitations 219, (September 1986) 88-89.

¹⁰⁸ Law Reform Commission of Western Australia, Project No 36 Part II, *supra*.

Reducing the ultimate limitation period

230. Section 15 provides that an action for damages for negligence shall not be brought after the expiration of 15 years from the date on which the act or omission occurred. However, this provision does not apply to actions in which the negligent act has resulted in personal injury. In other words, the “ultimate limitation period” or long-stop period” as it is sometimes termed, does not apply to personal injury cases. As a result, the period within which a claim can be brought for a personal injury action is indefinite. Our law in theory permits a claim to be in abeyance provided that the plaintiff is unaware of a cause of action.

231. The issue therefore is whether this is a tenable situation generally and in particular as it relates the medical profession.

232. The Ultimate Limitation Period (ULP) is the period beyond which a claim can no longer be brought. In other words, the action is fully extinguished. The ULP sets an outside time limit for asserting a claim, even where one or more of the provisions would otherwise apply to extend the running of time.

233. A number of legal systems have a general period of limitation which provides a final time barrier for all types of legal claims. Traditionally this was, in many jurisdictions, 30 years¹⁰⁹ but in recent years this period has, in some systems, been reduced to 15 or 10 years.¹¹⁰

234. The ULP proposals which have been made by law reform bodies in several common law jurisdictions and in some cases enacted are as follows:

- (i) A period of 30 years from the day of the act or omission on which the claim is based for the majority of claims, reduced to 10 years for most cases against health facilities or health facility employees.¹¹¹
- (ii) A period of 15 years after the act or omission giving rise to the cause of action.¹¹²
- (iii) A period of 10 years from the act or omission or breach of legal duty on the part of the defendant giving rise to a claim.¹¹³

¹⁰⁹ Jolowicz, 1972.

¹¹⁰ Hondius, 1995.

¹¹¹ Ontario Limitations (General) Bill 1992, s15. See Ontario Limitations Act Consultations Group, Recommendations for a New Limitations Act, Report of the Limitations Act Consultation Group (1991), recommendation 13 and recommendation 15 (pp 34 - 38)

¹¹² New Zealand Law Reform Commission, Model Limitations Bill, 1988 s 5 (except in cases of fraudulent breach of trust by a trustee, or where there has been deliberate concealment by the defendant, or where the act or omission occurs where the plaintiff is an infant); Law Reform Commission of Western Australia, *Report on Limitation and Notice of Actions*, Project No 36 Part II (1997) paras 7.30 and 7.54; and Alberta Law Reform Institute, Model Limitations Act 1989, s 3(1) and s 3(3). (This was reduced to 10 years by the Limitations Act c L-15.1, passed by the Alberta Provincial Legislature in May 1996, but not yet in force). But it should be noted that the Law Reform Commission of Western Australia also recommends that the court should have a discretion to override the long-stop limitation period in exceptional cases (see para. 7.55).

¹¹³ Extended to 30 years from that date in the case of fraud, fraudulent breach of trust and cases of deliberate concealment by the defendant. Law Reform Commission of British Columbia, *Report on the Ultimate Limitation Period: Limitation Act, Section 8* (1990), pp 67 - 68.

235. The argument for a ULP of 10 or 15 years is that it would significantly reduce the risk that defendants would be obliged to litigate extremely stale claims, at a time when they have no evidence with which to defend themselves given that records may have been destroyed, witnesses' memories may have faded, or indeed the witnesses themselves may be untraceable.

236. The LRC understands the concern about escalating subscription insurance rates in the medical field. This raises the issue of whether reducing the ULP from 15 to 10 years as is proposed would significantly reduce litigation and incidentally reduce costs on defendants through rising insurance rates.

237. The experience in Canada was that the reduction in the number of claims was inconsequential given that there were not many claims in existence. This flows from the fact that the majority of cases were either settled, abandoned, completed without reference to the limitation law or subject to a limitations defence under the basic limitation period.¹¹⁴ It was not the case, therefore, that insurance rates would reduce considerably as a result of a reduction in the number of cases that may emerge under a 10 year ULP.

238. It is argued that changes to the cost of insurance are affected far more by aspects of litigation other than the limitation period. In a Special Report prepared by the Canadian Medical Protective Association, it was pointed out that the significant change affecting medico-legal costs in the high risk area of obstetrics is the growing size of court awards and settlements in a few cases each year.¹¹⁵ It was further stated that replacing the 15 year ULP with a 10 year ULP would not affect insurance costs to the extent that it would not impact the level of awards in individual cases.¹¹⁶

239. The LRC therefore does not recommend a reduction in the ULP from 15 to 10 years. As in the case of the basic limitation of 3 years, a reduction is not likely to achieve any meaningful result, especially against the background that we are not aware of cases in the court involving medical malpractice where the length of the ULP served to prejudice the defendant. Furthermore, the current 15 year limit does not deviate in any significant way from modern legislative trends.

Applying the ultimate limitation period to personal injury claims

240. On the issue of extending the ULP to personal injury claims, the LRC is of the view that such an option should be explored.

241. Our research shows that when dealing with personal injury claims, excessively long limitation periods are not acceptable in modern legislation much less no limitation period as in the case of the Cayman Islands. The LRC understands the policy reasons behind the exclusion

¹¹⁴ Alberta Institute of Law Research and Reform, *supra*, n. 11 at 156.

¹¹⁵ Canadian Medical Protective Association, "Special Report," at 1, online: <http://www.cmpa.org/cmpaweb/public/english/tort/reform-e.pdf>.

¹¹⁶ Thomas, W.D.S. "A Physician's Foresight, A Profession's Pride - A History of The Canadian Medical Protective Association 1901-2001" at 40, online: <http://www.cmpa.org/cmpaweb/publications/english/misc/history-e.pdf>.

of personal injury claims from the ULP having regard to the issue of latent damages. However the indefinite nature of the ULP is questionable.

242. The LRC agrees that plaintiffs who have suffered personal injury can be regarded as meriting special concern simply on the ground that personal injury is a more extreme type of harm than property damage or economic loss. We particularly have in mind those who suffer from medical conditions where the symptoms may not become apparent for decades after the negligent medical conduct.

243. In British Columbia, the ULP is 30 years. Our research shows that the BC experience is that the basic ULP of 30 years is excessive. Due to its long duration it was thought the ULP would have little practical effect with regard to protecting defendants from stale claims. It was felt that ULP allowed too much time to pass before proceedings are instituted, making it difficult for defendants to assemble evidence and witnesses. This in turn created the risk that defendants may be found liable when evidence, which would otherwise have provided protection, is lost or deteriorated due to the passage of time.

244. The LRC also supports the view that it is in the public interest that there be timely finality to the potential threat of litigation and that an indefinite ULP does not bring about an end to the risk of litigation within a reasonable period. In some cases access to protective insurance may be elusive as a professional person may be susceptible to liability long after retirement, but may not be able to obtain insurance coverage or may only be able to do so at great expense.

245. The fact that matters cannot be treated as “closed” also creates an element of uncertainty about potential future financial costs. As a result, defendants may be unwilling to enter into long-term arrangements and future transactions. This can be detrimental to the commercial and indeed the insurance sector as a whole.

246. The LRC therefore agrees that justice in personal injury claims does require some element of finality. However, the LRC is concerned that the application of the ULP at 15 years or 10 years as proposed would fail to protect persons suffering from personal injury with a long latency period. In some cases, the consequences of medical negligence may not develop within a ULP of 15 years from the date of the act or omission of the defendant.¹¹⁷ To prevent such plaintiffs from bringing an action against defendants by subjecting their claims to a ULP of 15 years or less would risk serious injustice. It is in our view more appropriate to give increased protection to personal injury claims, as opposed to claims for property damage or pure economic loss given that they are the more serious claims. While the argument that a period longer than 10 or 15 years would not always protect plaintiffs is accepted, a balance has to be struck in order to protect those who could not reasonably know of their injury.

¹¹⁷ As would have been the case in *Guidera v NEI Projects (India) Limited* (unreported, 30 January 1990) (CA), where the plaintiff did not develop symptoms of asbestosis until 23 years after he had been exposed to asbestos dust.

247. A possible compromise is to permit the court a discretion to exclude the ULP if its application is likely to prejudice the defendant.¹¹⁸ Such judicial discretion is likely to prevent injustice both to the plaintiffs and defendants.

248. Accordingly, the LRC is of the view that an indefinite limitation period as it relates to personal injury claims may place an unfair burden on defendants. The uncertainty inherent in an indefinite period weakens the limitations system. The LRC recommends that the ULP for personal injury claims be set at 30 years from the date of the act or omission. This period is believed to be more appropriate for personal injury claims since it is likely to enable most, if not all, cases of latent personal injury to proceed. At the same time, it is recommended that the 30 year period be coupled with a judicial discretion to exclude the ULP if the circumstances so require.

APPLYING A ONE YEAR LIMITATION PERIOD TO MINORS AFTER AGE OF MAJORITY

249. The final part of our terms of reference requires that consideration be given to applying the limitation period to infants after they have reached the age of majority and that a limitation period of one year be given to such minors after the date on which they became aware of the cause of action.

250. Under the common law, there is a presumption that a minor is not competent to make a reasoned judgment about decisions relating to a claim. As a result, limitation periods are generally suspended in favour of minors or persons with a disability. In fact, the Limitation Law is silent on the issue as to whether it applies to minors.

251. It is useful to note that section 32 of the Law deals with the issue of disability, in that it excludes from its application any person who is under a disability. However, after the disability ceases, the individual has 6 years within which to pursue his claim.

252. Provisions of this nature are incorporated in limitations legislation because it is felt to be unjust to provide for the running of limitation periods against children or persons with a disability. In many jurisdictions, limitations legislation makes provision for delaying the commencement of the limitation period until the minor has attained the age of majority.

253. The concern however is that delaying the commencement of the limitation period until the plaintiff has attained his majority exposes a potential defendant to legal proceedings over an extended period. For example, in Queensland, an action alleging that the plaintiff's injuries were caused at birth by the negligence of a medical practitioner may be brought up to twenty-one years after the birth. This obviously has several implications. It is almost inevitable that in such a situation, the quality of the available evidence will have deteriorated.

¹¹⁸ As is the case with the current discretion afforded to the courts under s33 of the UK Limitation Act 1980, which permits the courts to take into account the plaintiff's lack of awareness of their legal remedy, or a supervening disability.

254. Further, in light of increased medical indemnity fees there is concern that doctors will be unwilling to enter or remain in certain fields of practice given the length of time for which potential liability can continue. Our research reflects that in instances where the limitation period does not apply to minors, it creates difficulties for professional indemnity insurers due to that fact that they are unable to properly forecast claims by minors and assess premiums. Also affected are obstetricians who may possibly face claims, sometimes 30 years or more after the relevant event.

255. However, the LRC is of the view that any possible prejudice to potential defendants which results from suspension of the limitation period is outweighed by the risk that a minor plaintiff might be deprived of the right to seek compensation because proceedings are not initiated on the minor's behalf within the limitation period.

256. In some jurisdictions, the commencement of the limitation period is postponed only if the plaintiff is not in the custody of a parent. The onus of proof is on the plaintiff to prove the absence of parental custody.¹¹⁹

257. The LRC would therefore support the proposal that where the claimant is a minor, the primary limitation period should start to run when he has reached the age of eighteen. The justification for this flows from the adoption of a date of knowledge test, that is, a minor below a certain age may be incapable of having actual or constructive knowledge. Although this will not be true in all cases, preserving the general rule protects all minors while they are unable to bring proceedings on their own behalf, and prevents further disputes between the parties as to the age at which the minor properly "knew" the relevant facts.

258. The LRC does not however support the proposal to limit to one year the period within which a minor child should be required to pursue his claim after attaining the age of majority. The LRC sees no reason to deviate from the current regime that applies to adults. In this regard, two periods are available which will be consistent with the current provisions. A three year basic period could be imposed as provided in section 13. In the alternative, if we construe a minor as being under a form of disability, a period of six years could be set which would be consistent with section 32 of the Law which relaxes the strict application of limitation periods for persons suffering from a disability.

259. Accordingly, the LRC believes it to be in the public interest, that as a general rule, the limitation period should run against a minor only after he has attained the age of majority and that period should be set at either three or six years after the date of knowledge.

AGREEMENTS TO CHANGE THE LIMITATION PERIOD

260. An option worth considering in the dealing with the issue of limitation periods is that of agreements to modify the relevant period.

¹¹⁹ *Limitation Act 1974* (Tas) s 26(6), but note that this provision applies only to personal injury actions.

261. The Limitation Law is silent on the issue of whether it is possible for parties to contract out of a statutory limitation period by agreeing to extend or shorten any applicable period. Arguably, it is not in the interests of the public or the legal system for disputes to be brought years after the events giving rise to a claim arose.

262. However, unless the agreed extension is considerably greater than the statutory limitation period, there may be no adverse implications for the public interest. Agreements may assist the parties to a dispute to extend a limitation period sufficiently to allow for further negotiations to settle a dispute and to avoid incurring the costs associated with litigation unless it becomes necessary. Moreover, it may be argued that the defendant's agreement to an extension of time in such a manner that there is no obvious unfairness to him in allowing the action to proceed outweighs any public interest in ensuring a fair trial.

263. The New Zealand Law Commission in addressing this issue saw no reason why parties to a dispute should not be able effectively to agree that a limitation defence not be taken for a particular period.¹²⁰

264. Accordingly, the LRC recommends that consideration be given towards permitting the parties to enter into agreements to reduce or extend either the basic limitation period or ULP.

CONCLUSION

265. The research suggests that legislatures facing proposals on the capping of non-economic damages and reducing limitation periods should consider not only whether there is any solid empirical evidence that such measures will alleviate the problems in the insurance markets, but also the effect of caps and limitation periods on the tort liability systems and ultimately access to justice. Essentially, the appropriate approach should strike a balance between responding to the concerns of reasonable critics about civil law remedies whilst affording relief to those who suffer as a result of serious and perhaps avoidable mistakes in the provision of health care.

266. The Commission is therefore seeking your feedback in assessing the issues identified in this paper and the recommendations highlighted in paragraph 6. Unless marked to the contrary, the Commission will assume that comments received are not confidential, and that respondents consent to our quoting from, or referring to, their comments and attributing their comments to them, and to the release or publication of their submissions. Requests for confidentiality or anonymity will be respected to the extent permitted by the Freedom of Information Law.

Submissions should be submitted in writing no later than 19th November, 2010 to the Director, Law Reform Commission, c/o Government Administration Building and may be posted, delivered by hand to the offices of the Commission on 3rd Floor Anderson Square or emailed to cheryl.neblett@gov.ky.

¹²⁰ Report No 6, Limitation Defences in Civil Proceedings, NZLC R6 (1988), para 266.

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