

Report to Ontario Ministry of Health and Long Term Care
Re: Medical Liability Review

Dec 29, 2017

Hon. Stephen Goudge, Q.C

Table of Contents

	Page
PART I. INTRODUCTION	1
PART II. THE FACTUAL CONTEXT	5
Total Volume of Cases	6
Total Cost of Cases	8
Outcome Costs	9
Case Duration	13
PART III. RECOMMENDATIONS.....	15
Future Care Costs	16
Future Income Loss.....	25
Discount Rate.....	28
Gross Up	30
Management Fees	32
Subrogation.....	33
Pre-Judgment Interest.....	34
Guardianship Fees	36
Derivative Claims	39
Collateral Benefits	41
Likely Reduction in Medical Liability Protection Costs	42
Improving the Efficiency of the Civil Justice System in Respect of Medical Liability	44
The Advisory Committee	47
Risk Management	48
Future Considerations	50
Implementation Considerations	51
Future Considerations	54
PART IV. CONCLUSION	58
Schedule A – Summary of Recommendations.....	59
Schedule B – List of Those Consulted	65

Report to Ontario Ministry of Health and Long Term Care

Re: Medical Liability Review

PART I. INTRODUCTION

On March 9, 2016, the Ministry of Health and Long Term Care invited me to conduct a review of the Ontario civil justice system as it relates to cases of medical liability and their costs. I am to seek ways to reduce those costs and increase the efficiency of dealing with those cases, while ensuring that patients injured through medical mistake receive appropriate and timely compensation.

The need for such a review is driven primarily by two considerations. First, the Ministry directly or indirectly funds medical liability protection in Ontario for healthcare providers and institutions, including physicians and hospitals. Physicians are provided this protection by the Canadian Medical Protective Association (“CMPA”), which they pay for through their membership fees in the CMPA. Since 1987, the Ministry has funded this protection by reimbursing physicians annually for a very large proportion of their CMPA fees. The Ministry bears the cost of medical liability protection for hospitals and other healthcare providers through the funding it provides to them, which they then use to purchase medical liability insurance.

In essence, therefore, the Ministry pays for the medical liability protection of physicians, hospitals, and other healthcare providers in Ontario.

Second, as my Terms of Reference state, the cost of this medical liability protection has been rising significantly in recent years, due in large part to increased damages awards.

As medical liability costs rise, the cost of medical liability protection necessarily rises. This, and concerns about the length of time required for individuals to obtain compensation for injuries due to medical mistakes, suggest that changes to the medical liability aspect of the civil justice system may be needed to ensure the long term viability of the way medical liability protection is presently provided in Ontario.

It is important to emphasize that in seeking to make the civil justice system more efficient for these injured plaintiffs and in ensuring that they receive appropriate compensation, my mandate reflects the “Patients First” principle that guides the Ministry.

My Terms of Reference described the scope of my review as follows:

To examine the causes of the increased costs of medical liability protection and make recommendations to the Ministry respecting changes to the system to:

- (i) reduce medical liability protection costs; and
- (ii) improve the efficiency of the civil justice system in respect of medical liability;

to ensure that plaintiffs in cases where medical malpractice is found receive appropriate compensation in a timely manner, while ensuring that healthcare institutions and other healthcare providers are accorded fair processes.

My Terms of Reference also sought specific recommendations related to the following elements that contribute to medical liability cost and therefore the cost of medical liability protection:

- Cost of future care;

- Future income loss;
- Discount rate;
- Subrogation;
- Management fees;
- Guardianship fees;
- Gross up / tax implications; and
- Pre-judgment interest.

Lastly, my Terms of Reference direct me to consult widely, but particularly to consult with:

- The CMPA
- The Ontario Medical Association
- The Ontario Trial Lawyers Association
- The Health Care Insurance Reciprocal of Canada
- Canadian Defence Lawyers
- The Holland Access to Justice in Medical Malpractice Group
- The Canada Revenue Agency
- Other entities, as appropriate

I have done so extensively. A full list of those consulted is attached to my report. To all of those I have met with, many of them on a number of occasions, I express my appreciation for their openness and my thanks for sharing their experience and their views with me. Many of those consulted went to significant effort to gather and provide to me data and anecdotal information relevant to my task. While that took considerable

time, the results were of real value for my work. I am grateful to them, as well, for the many suggestions for change that they have provided to me.

My report begins by using that information to sketch the factual context that is relevant in addressing the questions put to me by the Ministry.

I have done so in large measure by using broad indicators such as orders of magnitude and trend lines rather than precise figures. That reflects both the paucity of relevant hard data and the basis upon which I acquired much of the information. In those instances where I have referenced specific data, I am grateful to those supplying it for permission to use it that way.

The balance of my report sets out the recommendations I make and the reasons for them. They constitute my best judgment about measures that can be taken to achieve the objectives set out in my Terms of Reference.

In the course of my task I have been ably assisted by two lawyers. In the first few months, Greg Ko was instrumental in setting the review on a productive path. Throughout my assignment, Tim Chapman-Smith has worked closely with me. His assistance has been invaluable. To both of them I owe enormous thanks.

In the end, I take full responsibility for all that follows, both the factual context and the recommendations I make. My hope is that my report will provide assistance to the Ministry and the civil justice system in dealing with questions of medical liability in ways that are fair, efficient and economically sustainable.

PART II. THE FACTUAL CONTEXT

A necessary prerequisite to any recommendations designed to address the challenges of cost and efficiency facing the medical liability aspect of the civil justice system is to understand as best we can what has been happening to it in recent years.

A variety of points of analysis are helpful in doing this. These include the total volume of cases; the total cost of cases, including damages and settlements paid to injured plaintiffs (which I will refer to collectively as outcome costs), and legal and expert costs in civil cases (which I will refer to collectively as transaction costs); various aspects of outcome costs; and case duration.

The information I have received has been very helpful. Much of it allows some comparisons to be made over a 25 year period from 1990 to 2015, and also between Ontario and three other provinces, Quebec, Alberta and British Columbia. While the information necessarily lacks some measure of precision, orders of magnitude and trend lines are apparent.

Total Volume of Cases

Total case volumes can be addressed by comparing the cases started annually over the 25 year period from 1990 to 2015. In Ontario, that number appears to be about the same in 2015 as it was in 1990. The number rose for several years early in this timeframe, but then declined, so that for the last 10 years it has been about where it was at the beginning of the period, despite an obviously increasing population.

It also appears that the trends in Quebec, Alberta and British Columbia are not dissimilar. In other words, Ontario does not seem unique on this score. However, it should be noted that Ontario typically does appear to have a significantly higher frequency of newly opened cases per 1,000 physicians than do Quebec, Alberta or British Columbia, something that is relevant to any interprovincial comparison of total medical liability costs.

Thus, it does not seem that rising medical liability costs in Ontario in recent years are due in any significant measure to more cases being commenced.

Case volumes can also usefully be addressed through the total number of cases closed each year by way of damages, settlements or dismissals, that is, cases that were concluded rather than abandoned.

In Ontario, that total appears to have risen very modestly over the 25 year timeframe. More importantly, while for a number of years the number of damage awards and settlements was significantly exceeded by the number of dismissals, the gap has closed

markedly in recent years. This experience appears to be shared in Quebec, Alberta and British Columbia.

This suggests that rising medical liability costs in Ontario in recent years may to a very modest extent be explained by a rising proportion of cases closed each year requiring damages or settlement payments.

Total Cost of Cases

The total cost of cases, including outcome costs and transaction costs incurred by defendants in medical liability cases shed light on the rise in medical liability costs in recent years.

In Ontario, a comparison over the 25 years from 1990 to 2015 of total case costs for cases closed each year shows an increase from the start to the end of the period of some 500% to 700%, unadjusted for inflation. This is not explained by the very modest increase in the number of cases closed annually requiring damage or settlement payments.

Translated into a per case average, it appears that a case closed at the end of this 25 year timeframe similarly carried, on average, a case cost of four to five times the cost of a case closed at the beginning of the period.

Comparisons with the experiences in Quebec, Alberta and British Columbia show trend lines in total case costs that are similar, although not rising quite as steeply. One striking aspect of this comparison, however, is how much higher in dollar value total case costs are in Ontario than in the other three provinces. For example, total case costs paid on behalf of physicians in 2015 was approximately \$188.3 million in Ontario. The Quebec total that year was about \$35.6 million, which was second among the other three provinces in that year.

In short, it appears that the significant rise in both total case costs and average case costs in Ontario over the last 25 years and the dollar value of those costs play an important part in the significant rise in medical liability costs in Ontario in recent years.

Outcome Costs

For the purposes of my review, several aspects of outcome costs must be kept in mind.

The first is total outcome costs. In Ontario, the trend line from 1990 to 2015 for total outcome costs paid each year in damages or settlements is very similar to the trend line for total case costs. From 1990 to 2015, total outcome costs increased some 500% to 700%, while in the same period the number of claims requiring payment rose only modestly.

Comparisons with Quebec, Alberta and British Columbia are rendered more difficult because of the significantly smaller number of cases in those provinces and the variation in those numbers year to year. This creates some volatility in the results in those provinces. However, the trend line for total annual outcome costs in these provinces, particularly Quebec and Alberta, is also rising, although not as steeply as in Ontario. Moreover, the dollar value of the annual outcome costs in Ontario exceeds that for the other three provinces by roughly the same order of magnitude as exists for total case costs.

Not only does it appear that the total of annual outcome costs paid in Ontario is a multiple of that in other provinces, but the typical case outcome cost appears considerably higher. By way of example, for the 12 months ending September 30,

2016, the median Ontario case outcome cost paid on behalf of physicians was more than double that anywhere else in the country.

A very important aspect of outcome costs is the extent to which total outcome costs have been made up of outcome costs in the quartile of cases with the highest outcome costs.

In Ontario, over the 25 years from 1990 to 2015, the total outcome costs paid to patients in the top quartile of cases comprises 87% of all outcome costs paid over those 25 years.

The experience in Ontario is typical of the other provinces, although the dollar values are much higher. For example, the 25 year average outcome cost paid for a case in Ontario appears to be about double that for a top quartile case in the other three provinces.

The conclusion is clear. In assessing the causes of increasing medical liability costs in Ontario, particular attention must be paid to this top quartile of cases that contributes so significantly to those costs.

Another aspect of outcome costs is the relationship between those cases determined by damages awards and those resolved by settlements. In Ontario, over the timeframe from 1990 to 2015, more than 90% of cases in which outcome costs were paid were concluded by settlement. While in most years, the average case outcome cost was higher for cases concluded by damage awards than by settlements, that appears not to have always been so. What is important is that there appears to be a close relationship

between the two. This is hardly surprising, since damage awards undoubtedly provide guidance in the settlement of cases. Thus, I think it is safe to use the components of outcome costs apparent in damage awards as a guide to estimating the components of settlements, something which may not be made explicit in every settlement.

The breakdown of outcome costs into those components is also important.

It is true that here hard empirical data is difficult to obtain. What follows is my assessment of the information I have been provided with. It is reassuring that what I heard anecdotally in my consultations was, almost without exception, entirely consistent with this assessment.

Not surprisingly, in Ontario, future costs, and within that future care costs, rather than future income loss, is by far the most dominant factor. Those costs commonly comprise 35% to 50% of total outcome costs in a given year. This has been particularly evident over the last decade.

That is consistent with the upper quartile information I have referred to. That quartile includes a small number of cases with very high outcome costs, most of which are future care costs. These are epitomised by compromised baby cases, of which there are not many each year, fortunately, but which carry very large future care costs.

The other components of outcome costs referenced in my mandate, while important in a variety of ways that I will discuss, are simply not of the same order of magnitude. While it is impossible to be precise, I would estimate that most would each comprise less than 5% of total annual outcome costs, although in individual cases individual components

may contribute a much higher percentage, and cumulatively they have a significant impact.

On the basis of the information I gathered, their apparent importance to total outcome costs, from most to least, appears to be as follows:

- Pre-judgment interest
- Subrogated claims
- Guardianship fees
- Management fees
- Gross up / tax implications

It is worth noting that the specific reference in my mandate to discount rates is not a reference to a specific component of outcome costs, although it obviously affects the calculation of other components and therefore needs to be addressed. Indeed, as I will discuss, a change in the discount rate can impact outcome costs very significantly.

The last aspect of outcome costs that can be referenced is the relationship over time between annual outcome costs and the transaction costs in those cases. While although once again the information available is less than scientific, it seems that transaction costs have borne about the same ratio or, for some health care institutions, a declining ratio to outcome costs over the last twenty-five years. Moreover transaction costs are a much smaller proportion of total case costs than outcome costs. It therefore seems that transaction costs are not leading the rise in medical liability costs in Ontario in recent years. Both for this reason and because my Terms of Reference focus on outcome costs, I have not dwelt on transaction costs.

Case Duration

The final point of analysis of the factual context necessary for my report concerns the duration of cases involving medical liability. This provides the backdrop for the discussion about improving the efficiency of the civil justice system as it deals with these cases. The reason for doing so is self evident. Patients injured through medical mistake deserve timely redress.

The information provided suggests that over the last 25 years in Ontario the average duration of cases resulting in dismissals has remained relatively constant, at approximately 40 months. The average duration of cases concluded by settlement appears to have been edging upward over the past few years to the range of 55 to 60 months. At least for physicians, the average duration of a case that is tried seems to have remained at about 80 months from start to finish.

The provincial comparison of note is with British Columbia, where the durations seem markedly less.

Once again, this information cannot be said to have full scientific rigour. However, my consultations all reflected experiences consistent with it. Undoubtedly, these timelines reflect the factual and evidentiary complexity that characterizes many cases of this nature. However, It also appears from my consultations that there are significant steps that could be taken, particularly in major centres where there are bottlenecks, to reduce these lengthy timelines to ensure that patients who are receiving appropriate compensation do so in a timely manner.

In summary, the factual context for my task can be described as follows. While the volume of medical liability cases has changed little over the years, the cost of those cases, including damages and settlement payments has risen significantly. By far the most costly of these cases are those in the top quartile of cases measured by cost. And of the various components of those costs, future care costs are a dominant contributor. Finally, the time these cases take is sufficiently significant that the concerns about delay appear justified.

PART III. RECOMMENDATIONS

The factual picture I have described clearly sustains the Ministry's assertion in my Terms of Reference that medical liability costs (and hence the cost of medical liability protection) in Ontario have been rising significantly in recent years, due in large part to increased damage awards and settlement payments.

In this context, my task is to make recommendations to the Minister about how medical liability protection costs could be reduced, and cases dealt with more efficiently, while ensuring appropriate compensation for those harmed by medical mistake, and at the same time providing fair processes for physicians, hospitals and other health care providers.

I will do so by first addressing each of the specific elements enumerated in my Terms of Reference, then several more general considerations and, finally, efficiencies that could be achieved in the way medical liability cases are dealt with in the civil justice system.

Future Care Costs

Patients injured through medical mistake are entitled to compensation reasonably expected to be required in the future as a result of the injuries. These future care costs are obviously important in light of their significant contribution to rising medical liability costs. In my view, there are a number of changes that could usefully be made to control these costs. The recommendations I would make are as follows:

First, criteria for determining future care in medical liability cases should be made explicit, perhaps by amendments to the *Courts of Justice Act* or other legislative means. Witnesses giving expert opinions about future care plans would be required to address them, and triers of fact would be required to consider them. This idea arose in a number of the consultations I held. It was advanced as an antidote to the creep in future care costs that many perceive to have been contributed to by a failure to consistently follow the relevant jurisprudential principles. It is particularly important in serious medical liability cases where future care costs can be very significant and run for a number of years.

I offer the following as examples of criteria that should be considered:

- (a) the future care plan must be an objective one, based on medical evidence;
- (b) there must be medical justification for the various components of the future care plan;
- (c) the future care plan must be reasonable in all the circumstances;

- (d) the future care must be provided by the lowest cost health care provider qualified either directly or by delegation to properly undertake any required controlled acts;
- (e) the future care plan must make allowance for the contingencies that could arise to render inaccurate the assumptions on which the plan was predicated; and
- (f) the future care plan should have some regard for the future care that would be provided by the public health care system for a similarly situated person whose condition was not caused by medical mistake, particularly since in both cases the care is publicly funded.

These criteria reflect the jurisprudential principles applicable to the determination of future care costs and also provide ways in which future care costs could be controlled without harming plaintiff experience.

I do not propose these criteria as an exhaustive list. The advisory committee I am recommending, comprised of judges, plaintiff lawyers and defence lawyers who do this kind of work would be ideally placed to offer advice in the beginning. But the criteria should also be considered a work in progress. Over time, and based on experience, they could and should be amended or refined with the help of the advisory committee.

There are a number of other aspects of future care that could well warrant development of additional criteria by this advisory committee. Attendant care, for example. It is a very important component of future care costs. Market rates for private care givers who

are not required to provide controlled acts vary by community. These care givers also vary by skill level. Providing what is reasonable on both these scores could be the subject of criteria to ensure that injured plaintiffs get the attendant care they need, but at the cost and skill level applicable to those needs.

A second example concerns accommodation changes that future care may require, also an important component of these costs. It may be useful to develop criteria concerning the relevance for those changes and their cost, of the incidental benefit that those changes may confer on those with whom the injured plaintiff may reside.

A second change that should be made to help reduce future care costs is to upgrade the quality of expert evidence about future care plans in these cases. My consultations reflected widespread concerns about the present inadequacies of this kind of evidence. The concerns include excessive advocacy from these witnesses, their frequent narrow expertise leading to extensive reliance on records and reports beyond that expertise, and a lack of standardized qualifications. Here, as well, the common perception is that these weaknesses have fueled the creep in future care costs.

My recommendation is that the Ministry consider proceeding to expand modestly the concept of independent evaluation centres, presently under consideration for auto insurance, to include the ability to give reliable future care plan evidence in medical liability cases.

Proceeding by way of this incremental addition will permit the inclusion of the relatively small number of medical liability cases that probably would not warrant the establishment of a capacity like this only for this kind of case.

The broad concept contemplates hospital-based centres. For medical liability cases, the future care plan evidence probably should be drawn particularly from university-based hospitals because of the highly specialized expertise required, for example, in compromised baby cases.

This should guarantee that future care needs in these cases would be addressed by the most qualified experts in the health care system. Indeed, in some ways, this would simply be an extension of the future care planning that is now done anyway in these hospitals following a medical mistake, or for patients suffering similar conditions not caused by medical mistake.

These teams should be funded by the Ministry of Health, in order to address the problem of excessive advocacy that may be partly caused today by expert witnesses giving this evidence being paid by one side of the case or the other.

Expert future care opinion evidence sourced in this way will, I think, avoid the problems of the perception of partisanship and lack of competence that plagued the designated assessment centre program discontinued by Ontario in 2006.

In short, multidisciplinary teams from university-based hospitals, paid for by the Ministry, should successfully address the difficulties of excessive advocacy, inadequate expertise and lack of standardized qualifications that appear to have contributed to the rise in future care costs in Ontario in recent years.

The use to be made of expert evidence sourced in this way must also be considered. I think that, in the beginning, its availability at no cost and its obvious attractiveness to the

court charged with setting future care plans should make litigants anxious to use it and mute their desire to call their own future care plan evidence, with the attendant problems that this evidence suffers from today. If, however, those problems persist because litigants continue to call their own experts, it may be necessary at some point to require that all future care plan evidence come from a university-based hospital centre in medical liability cases.

The third recommendation I make is driven by the reality that in virtually every case of significant future care costs in medical liability cases, a large portion of these costs will be by way of structured settlements, that is where funds from the damage award or the settlement are used to purchase an annuity to yield the periodic payments required for the care of the injured plaintiff. Section 116.1(1) of the *Courts of Justice Act* is specifically designed to facilitate structured settlements for future care costs in medical malpractice cases.

The limited number of life insurance companies currently willing to offer these products and the constraints they use to price them, mean that this component of future care costs is larger than it needs to be. The same of course is true of future income loss that is included in the structure.

The solution, in my view, is that there should be a government entity to hold the funds for future costs and administer the periodic payments required in these cases. Section 116.1(1) would be amended to permit this alternative.

Several such entities exist already that could take on this task. The Investment Management Corporation of Ontario manages investment funds for the broader public

sector. The Ontario Workplace Safety and Insurance Board (the WSIB), with its long experience investing funds and issuing cheques, would be another possibility. Either could be commissioned to provide this service, with very modest additional administrative costs.

The benefits of this arise in several ways. The significantly larger pool of funds available to manage the funds used to provide future care in these cases carries with it a greater ability to leverage the return on investment and allows higher discount rates to be used to calculate the funding necessary to provide future costs. Given the larger pool of funds, experience surpluses and deficits could more easily be absorbed, with surpluses being returned to the government entity. And since that entity would hold all structured settlement funds in those cases, the adverse selection risk posed by private insurance providers would be eliminated. Management fees on the funds providing future care would be eliminated. The discount rate for determining future costs awards could even be established by the fund manager based on the fund's investment experience, thereby eliminating the transaction costs now incurred to debate the applicable discount rate. The competitive advantage offered is clear.

In my consultations, Professor Douglas Hyatt, a well known economist at the University of Toronto, offered the following striking example.

A future cost of care of \$200,000 per year for a compromised male child, age 10 at trial, with a life expectancy of 65 years, has a present value of about \$7.4 million, based on the discount rates currently prescribed by the *Rules of Civil Procedure*. The present value of the same award using the discount rate applied by the WSIB, given its large

pool of funds, is approximately \$5.3 million, a difference of 40%, with no compromise to the periodic payments received by the injured child.

A fourth change that, in my view, would reduce the costs of future care in medical liability cases would be to establish a government agency, perhaps associated with the government entity just discussed, that would provide or purchase the future care services required by those injured through medical mistake, using the funds invested for that purpose.

This pooled purchasing leverage would allow the services called for in future care plans to be purchased at lower cost than would be available to a purchaser buying for a single individual. This leverage would apply to various costs of future care, such as specialized therapies, some specialized assistance devices, house modifications and, most importantly, attendant care. Guaranteeing individualized quality of service would be required as part of an RFP process that could be used to purchase these services. Lower cost future care services with no loss of quality would result. Again, the competitive advantage over private providers is clear.

An additional advantage of such a change is that this agency would be well positioned to gather data about outcomes achieved by various components of any future care plan. This data would be available to improve results in future cases and would fill an empirical gap that exists today as an impediment to providing better future care plans for injured plaintiffs in future cases.

A fifth change I recommend is to expand the use of the reference procedure under the *Rules of Civil Procedure* to allow it to be accessed more easily to determine the cost of future care in medical liability cases.

In my consultations, it became clear that this step should be taken. Particularly in cases that are seriously contested on the issue of liability, damages including those for future care costs are not often fully adjudicated but are determined by trade off. This has had two consequences for future care costs. First, there is a relative paucity of precedents in the case law to guide the future determinations of this head of damage. These precedents facilitate settlement in future cases. And, second, resolution by “saw off” has often resulted in upward pressure on future care costs.

The reference mechanism could easily be adapted to alleviate this situation. Rule 54.02(2) should be amended to permit a judge to direct a reference on this issue even if the parties do not consent. This process is designed to be a speedier, simpler and therefore less costly way of adjudicating an issue like future care costs than a trial could provide. Moreover, on agreement, persons like retired trial judges, many of whom have great expertise in this area, could be utilized as referees.

Such a process would promote a healthier development of precedent to guide future cases. The upward pressure on those costs caused by a relatively unguided trade off process would be reduced. And, if this head of damage ultimately needed to be adjudicated, a cheaper and efficient way of doing so would be available.

My sixth recommendation relates to the availability of congregate care centres, or community living residences as they are sometimes referred to.

My consultations made clear that there is a growing general shortage of these facilities. A recent report of the Ontario Ombudsman came to the same conclusion.

In cases of medical mistake, they could well be more beneficial for injured plaintiffs who wish to take advantage of them, than living independently in a residential home with one-on-one care. In such cases these alternatives would serve the best interests of the individual as the jurisprudence requires. This is often because of the benefits they bring of increased socialization and interaction with others or because of the challenge of aging parents losing their ability to assist with care giving.

The benefits are not just psychological and physical. The economic benefits can also be significant. The cost of retrofitting the home may be saved. More importantly, the saving in the cost of attendant care that comes with living for a period of years in shared cost settings, compared to the plaintiff's home, can be significant. So, if these facilities were available for cases where they would provide best care, not only would plaintiffs widely opt for them, they would benefit, and future care costs would be reduced.

Increasing the availability of this type of facility would require a policy decision by government. This is so whether the government provides the facilities or simply provides incentives for the private sector to do so. Either solution would help reduce future care cost.

Future Income Loss

There is no doubt that assessing the value of future income loss is an aspect of damage calculation in medical liability cases that is often speculative in a way that other components of medical liability costs are not. Particularly in cases involving young plaintiffs, such as compromised baby cases, that is inevitable.

Nonetheless, there are steps that could be taken to control or reduce the costs of future lost income in these cases while continuing to ensure that plaintiffs receive fair compensation.

First, the calculation of future income loss has to take account of future contingencies, both positive and negative, about what the future may have held, that would have affected that future income. If a clear and consistent way could be found in these cases to address these contingencies, that would mute the upward creep in this head of damage that the very uncertainty about how to approach the calculation of contingencies may contribute to. The advisory committee I propose should be tasked with developing guidelines that would remove that uncertainty.

A second way in which the calculation of future income loss appears on occasion to unduly increase this head of damage is the failure to make appropriate deductions for basic living expenses, where those expenses are provided for as part of the cost of future care in medical liability cases.

A third way is where the funding of future income loss is included in a structured settlement. In such cases future income loss should always be calculated on the basis of income net of tax, since the plaintiff pays no income tax with a structured settlement.

In my view, if judicial vigilance is not enough to achieve them, it would be desirable that both of these matters also be addressed in a legislated framework to assist in controlling this aspect of medical liability costs

The fourth recommendation I make concerning future income loss is in respect of the “lost years” doctrine. My consultations made clear that there is some controversy in the calculation of future income loss for years of life lost due to medical mistake. The controversy is over which of two methods is used to calculate the deduction from that future lost income of personal living expenses that would have been incurred by the plaintiff in those year. Both methods can be found in the case law. One results in lower deductions and, therefore, higher future income loss than the other. In my view, there should be a consistent approach based on which method provides appropriate compensation for the plaintiff. If both do so, the one that reduces the cost of future income loss can be preferred. That, as well, is an appropriate matter to ask the advisory committee to consider.

Finally, where the funding for future income loss is included in a structured settlement, I simply reiterate my earlier suggestion of a government entity to manage the settlement as a way of reducing its costs. I also reiterate the suggestion made above, namely that the loss should be calculated using the plaintiff’s net income, since there is no tax on

the income in the structured settlement. If that is not done, the cost of future income loss is higher than it should be to fairly compensate the plaintiff.

Discount Rate

Once a plaintiff's stream of future pecuniary loss (future care costs and future income loss) has been determined, the present value needed to be invested to provide that stream is calculated using a discount rate reflecting a reasonable rate of return on investment offset by the anticipated rate of inflation.

In Ontario, the *Rules of Civil Procedure* have provided a two-tier discount rate. For the first 15 years following the start of the trial, the calculation uses a complicated formula based on government of Canada bond rates fixed as of the year before the year the trial begins. Beyond 15 years, the discount rate is fixed at 2.5% per year.

While this was a well intentioned attempt to better approximate future real rates of return, the almost universal view among those I consulted was that, because of significant fluctuations in real return bond rates, that has not been the experience. In the last five years, the mandated discount rate up to 15 years appears to have been well below the actual rate of return available on investment, with the result that the cost of structured settlements has been higher than it should be.

The virtually unanimous recommendation I received was that the two-tier discount rate should be replaced by a single rate, at least in medical liability cases.

I agree.

Moreover, the discount rate should not be open, as it is today, to change in light of factors beyond investment and price inflation, such as postulated productivity changes, thereby reducing what can today be a significant upward pressure on transaction costs.

The advisory committee I propose should be invited to take on the task of recommending a single discount rate for incorporation in the *Rules of Civil Procedure*. In doing so, the committee can consider the basis on which it should be fixed; whether there are reasons to fix a particular discount rate for medical liability cases; whether there should be a separate discount rate for each of future care costs and future lost income (as there is in British Columbia); and whether, as I have suggested in the discussion of future care costs, if the structured settlement is invested by a large government entity the discount rate should reflect the experience of that entity.

Gross Up

In cases where structured settlements are not used to provide payments for future pecuniary loss, the alternative is to provide a lump sum award. Such an award has to include an amount to compensate the plaintiff for the tax liability on the income earned by the award. This gross up can commonly add 35% to 50% to the future pecuniary loss award. Structured settlements do not require this.

Thus, the cost reduction achieved by the increased use of structured settlements is significant. But structures also carry other advantages. With a structured settlement, the investment risk is transferred from the plaintiff to the entity holding the invested funds. That entity also assumes the risk that the plaintiff will have a longer than predicted life expectancy. The management fees that might be needed with a lump sum award are eliminated, and the risk of dissipation of the capital sum by the plaintiff is also eliminated.

If plaintiffs receiving lump sum awards could be exempted from tax on income earned from the award, the need for gross up would also be eliminated. However, that would require an amendment to the federal *Income Tax Act*. Rather than vainly seeking that solution, improving the process for providing periodic payments for future pecuniary loss through a structured settlement in the ways I have suggested is, in my view, a far more likely way to reduce medical liability costs while maintaining the compensation to plaintiffs that is both fair and appropriate.

If lump sum awards continue to be made, there is one step that could be taken that would reduce transaction costs in these cases. Ontario could standardize the

calculation of gross up, for example, by specifying in the *Courts of Justice Act* how it is to be done. This would at least eliminate the cost of contesting that issue at trial. Again, the advisory committee should be invited to recommend how best to do this for medical liability cases.

Management Fees

The anecdotal information I received in my consultations suggests that, in an increasing number of medical liability cases, courts are awarding significant damages for fees for the management of the property interests of plaintiffs arising from the litigation where they lack the expertise or experience to perform these functions. The data I gathered, though limited, seems to support that.

When viewed in the context of total annual outcome costs of medical liability cases, the amounts for management fees are not large. However, the trend line they appear to be on is an upward pressure on medical liability costs.

In my view, three steps can and should be taken in response.

First, it is appropriate that a plaintiff establish that, in the circumstances, it is reasonable that he or she receive management assistance. In this context, the ability of the plaintiff and the quantum involved would be relevant. The *Courts of Justice Act* could expressly provide for this, at least in medical liability cases.

Second, the management fee should be set by the court, taking into account the increased rate of return expected with professional assistance. This would tend to provide downward pressure on the fees awarded.

Third, it should be made clear what I think the case law provides, namely that no management fee is payable on structured settlements in these cases, perhaps through the *Courts of Justice Act*.

Subrogation

The *Ontario Health Insurance Act* requires plaintiff's counsel to pursue a subrogated claim on behalf of the Ontario Health Insurance Plan for the cost of past and expected future health care services provided under the Plan that are due to medical mistake.

As was made clear to me by virtually all those I consulted, the pursuit of OHIP's subrogated interest in medical liability cases, where the Ministry funds the medical liability protection costs of those paying the subrogated claims, represents a "circle of money" from which injured plaintiffs derive no benefit. To preserve those subrogated claims, transaction costs must be incurred, both on behalf of OHIP pursuing the claims, and on behalf of the Ministry by funding those who defend against the claims. Many I consulted suggested that pursuit of these subrogated claims in medical liability cases should simply be ended.

I agree. The elimination of those transaction costs would save some medical liability costs with no harm to injured plaintiffs. This could be accomplished simply and with no statutory amendment by the OHIP General Manager deciding not to pursue these claims and advising plaintiffs' counsel accordingly.

Pre-Judgment Interest

In Ontario, pre-judgment interest is paid on damages from the date the cause of action arose to the date of judgment.

Sections 127(1) and 128(1) of the *Courts of Justice Act* provide that the rate of pre-judgment interest to be paid is the rate established by the minimum rate at which the Bank of Canada makes short term advances to banks.

However, s.128(2) provides that prejudgment interest on non-pecuniary damages is excepted from this, but instead is determined by the *Rules of Civil Procedure*. Rule 53.10 sets the pre-judgment interest rate payable on non-pecuniary damages at 5% per year.

The exception was introduced in 1989 in order to avoid overcompensation, at a time when interest rates were significantly higher than 5%. However, interest rates have declined significantly over the years since then to the point that the pre-judgment interest rate for pecuniary damages is now well below 5%, but at a rate that reflects current interest rates and therefore compensates the plaintiff fairly for delay in receiving pecuniary damages.

The consequence is that pre-judgment interest currently paid on non-pecuniary damages in medical liability cases is more than it should be to compensate the plaintiff fairly for not receiving the non-pecuniary damage award when the cause of action arose and hence being without it until the date of judgment.

This anomaly has been corrected as of January 1, 2015 for pre-judgment interest payable on non-pecuniary damages arising from automobile accidents. In those circumstances, Rule 53.10 no longer applies. The pre-judgment interest rate set by the *Courts of Justice Act* applies to both pecuniary and non-pecuniary damages arising from an automobile accident. Most of those I consulted with suggest that the same change should be made for medical liability cases.

I agree. The application of Rule 53.10 for non-pecuniary damages in medical liability cases should be removed. This change would compensate injured plaintiffs fairly, would eliminate overcompensation, and would avoid unjustifiably different treatment, depending upon whether the injury was caused by an at fault driver or a medical mistake. This change is easily accomplished by a simple legislative amendment.

Guardianship Fees

A child receiving a damage award, who is incapable of managing that property, requires a guardian to be appointed under the *Children's Law Reform Act* (CLRA). For an incapable adult receiving a damage award, the appointment is made under the *Substitute Decisions Act* (SDA). There is no doubt that in either case the guardian serves an essential purpose to the benefit of the injured plaintiff. There is equally no doubt that the Public Guardian and Trustee (PGT) and the Office of the Children's Lawyer (OCL) play important roles in overseeing and performing the work of guardians in Ontario.

However, both the data made available to me and the anecdotal information I gathered appear to support the assertion I heard from a number of those I consulted, namely that, increasingly, courts are including in damage awards for medical liability cases significant compensation for guardians appointed to manage these interests of injured plaintiffs who lack the capacity to do so for themselves. This compensation typically includes both fees and associated legal and administrative expenses. It seems clear that this constitutes an upward pressure on medical liability costs. The medical liability cases where this is particularly true are those of badly injured plaintiffs who receive significant awards.

Addressing the challenge is a complex matter. Nonetheless, there are a number of aspects of the problem that should be investigated as possible ways of reducing this cost in a way that would not expose incompetent plaintiffs to risk. Some of these are as follows.

More guidance could be provided by courts in the awarding of guardianship fees in medical liability cases. Regulations under the SDA and the CLRA to guide courts in determining reasonable guardianship fees and expenses in these cases would help. There are now no such regulations under the SDA for guardians of the person or under the CLRA for guardians of property for children.

This guidance could ensure, for example, that these guardianship fees not be awarded for services provided by other components of a damage award, such as the costs of the future care plan. The guidance could also provide that guardianship fees be lowered where much of the damage award is in a structured settlement not requiring significant attention from the guardian.

More radically, as a way of containing guardianship costs, a government entity could be tasked with managing the property interests of incompetent plaintiffs in medical liability cases, whether or not a structured settlement was involved. That would undoubtedly provide security for those funds at a lesser cost than guardianship now requires.

There are also a number of things that should be explored to reduce the administrative costs incurred by guardians in these cases. In these cases, little if any benefits accrue to the plaintiff in return for these costs. These could include a reduction in the frequency with which accounts must be passed, especially where the damage award is not large or where the guardian of property is sophisticated, such as a financial institution.

Another change that should be explored would deem a guardian appointed in these cases under the CLRA to continue under the SDA when the child turns 18, where the

PGT has concluded that the plaintiff's incapacity continues. The PGT would also have to be satisfied with the management plan in place at that point and that it is viable.

In my view, each of these suggestions carries complexities that warrant further investigation. It would therefore be prudent for the Ministry to engage in discussions with the advisory committee I am recommending, the PGT and the OCL, and institutions that provide guardianship of property services. The objective, which should be achievable, would be to find ways to reduce the costs associated with guardianship in these cases without risk to plaintiffs who lack capacity.

Derivative Claims

The Ontario *Family Law Act* (FLA) permits certain members of the family of the injured plaintiff to make derivative claims not just for pecuniary losses they have suffered, but for non-pecuniary loss of care, guidance and companionship caused by the injury to the plaintiff.

The FLA defines the classes of eligible claimants as including spouses, children, grandchildren, parents and grandparents, and brothers and sisters of the injured person. It does not however impose a statutory upper limit on the non-pecuniary damages that can be awarded, although the applicable jurisprudence suggests a cap of \$100,000 adjusted for inflation. By comparison, other provinces have restricted the list of eligible claimants for such claims and have also imposed statutory limits on the quantum of non-pecuniary damages that can be received.

In my view, both steps ought to be considered in medical liability cases as steps that could be taken to reduce costs without adverse effect on the compensation received by injured plaintiffs and, indeed, without unfairness to family members.

For example, even if the list of eligible claimants were not restricted as other provinces have done, it would seem reasonable to require claimants other than spouses, children and parents to show a meaningful relationship with the injured plaintiff in order to receive non-pecuniary compensation. Moreover, it also seems reasonable for there to be statutory upper limits on derivative claims for non-pecuniary damages, not dissimilar to those found in other provinces. Non-pecuniary damages for plaintiffs have long been

limited by the governing jurisprudence. But the steps I suggest could also easily be accomplished by simple legislative change.

Collateral Benefits

Collateral benefits are those received by an injured plaintiff from a third party source, not the defendant. These are benefits such as private health insurance or income replacement programs. The applicable common law principle provides that to avoid the plaintiff receiving double recovery for the same loss (that is, recovering both from the third party and the defendant), collateral benefits are to be deducted from the damages award. The exception to this is if the injured plaintiff gave consideration for receipt of the third party benefit.

From my consultations, it appears that the common law principle has not been uniformly applied, resulting in inconsistent and unpredictable awards. In those cases where the principle has not been properly applied, medical liability costs are higher than they should be to produce fair compensation for plaintiffs.

In my view, the solution is straightforward. It could be done by legislation specific to medical malpractice as has been done for injuries from auto accidents. Or, the *Courts of Justice Act* could be amended. Either could provide that in medical liability cases any collateral benefits received from third parties should be deducted from any damage award unless the injured plaintiff has given some consideration in exchange for receipt of those benefits, as required by the relevant jurisprudence. Any such deduction should of course be made from the corresponding head of damage so that, for example, collateral income benefits would be deducted from the award for income loss.

Likely Reduction in Medical Liability Protection Costs

My Terms of Reference require me to make recommendations to reduce the costs of medical liability and therefore of medical liability protection, consistent of course with appropriate compensation to injured plaintiffs and fair processes to health care providers. I have proposed a number of such recommendations.

In my consultations, I explored with a number of those I dealt with the value of the cost reductions that could be expected from their suggestions. All acknowledged the difficulties that such a task presents, but a number made useful attempts.

Not surprisingly, in the end, it became clear that predicting the precise savings due to any of my recommendations would be next to impossible. However, I think several of the changes do allow for some very rough estimate of annual savings that may be possible.

For example, I think it is relatively safe to predict that the discount rate change I recommend could result in annual savings in medical liability costs in the tens of millions of dollars, with no adverse consequences for injured plaintiffs.

A second recommendation that could result in savings that may be more quantifiable than others is the change in pre-judgment interest rate. Those savings could well amount to several million dollars annually.

However, I think a safer way to approach the overall question of the value of cost reduction is by way of relative order of magnitude. Some of my recommendations will

be very important in reducing medical liability protection costs. Others will be of modest importance and still other of minor importance.

In my view, the various changes I propose concerning future care costs are the most important for cost savings. The example I have provided from Professor Hyatt of the magnitude of cost savings that could result from just one of the future care plan changes I propose, applied to only one case, gives a flavour of the dollars that could be saved.

Changes concerning future income loss and discount rates will also be very important in reducing medical liability protection costs.

Changes concerning subrogation, management fees, guardianship fees, and pre-judgment interest, I would categorize as of modest importance in creating reductions.

Finally, changes related to derivative claims and collateral benefits, although not to be ignored, seem to me to be of less importance in reducing substantially medical liability protection costs.

The most important thing, however, is to consider these changes as a package, which, taken together, would result in very significant reductions in these costs while preserving appropriate compensation for plaintiffs and fair processes for health care providers.

Improving the Efficiency of the Civil Justice System in Respect of Medical Liability

My Terms of Reference also direct me to make recommendations to improve the efficiency of the civil justice system in dealing with medical liability cases, because of concerns that have been raised about the length of time that it takes for plaintiffs to receive compensation after a civil claim is made.

Many of those I consulted share those concerns. The Commercial List in Toronto was often cited as a model of the efficiencies and advantages that can be achieved when resources specialized for a type of litigation are available at all stages of a legal proceeding of that type.

British Columbia was also cited as an example of the effective use of procedures, such as setting early trial dates, that appear to yield more expeditious results for medical liability cases than Ontario does.

In conducting this review, I have become even more acutely aware of the human and economic consequences of lengthy delays in the resolution of medical liability cases. I appreciate that the judges and lawyers engaged in these cases have to operate within a civil justice system that is subject to many demands and finite resources. They are clearly doing whatever they can.

I also recognize that medical liability cases almost always have features that tax expeditious disposition. The issues are complex and often highly specialized. The productions can be voluminous. The experts are frequently numerous. And skilled counsel on both sides battle hard because so much is at stake.

Nonetheless, I think there are a number of avenues that can and should be considered as ways of dealing with medical liability cases more efficiently. Four in particular deserve attention.

First, is the enhanced use of explicitly prescribed case management techniques tailored to medical liability cases. A standardized case management protocol should be established, providing for early engagement of a case management judge and the establishing of a timetable for the various stages of the litigation.

Second, the use of specialized judicial expertise in medical-legal matters wherever possible is important, both at pretrial and at trial. This is particularly so for the most complex of those cases, such as compromised baby cases.

Third, consideration should be given to the fixing of the trial date at an early stage of the litigation, perhaps as soon as pleadings are closed. This is possible in British Columbia, where a mandatory case planning conference then takes place immediately, to establish a timetable for the various steps in the litigation. Such a step could be of great assistance in focusing counsels' attention, reducing case durations and consequent transaction costs, and providing more timely compensation to plaintiffs in meritorious cases.

Fourth, consideration should be given to enhanced use of the reference procedure under the *Rules of Civil Procedure*, for discrete issues in these complex cases. I have already referred to this possibility in the context of determining future care costs. But other similar issues could be dealt with more efficiently if such a process were available to the case management judge or the trial judge on the request of one party.

In my view, the best way to explore these four avenues in detail is through the advisory committee I propose. It should be asked to make detailed recommendations to the Ministry on these possibilities. It is important that, so far as possible, pursuit of efficiencies in these ways proceed, informed by knowledgeable stakeholders, and with as much agreement as possible, rather than by imposition. If that is done, I am confident that the efficiency of the civil justice system in respect of medical liability cases can be significantly improved.

The Advisory Committee

I have put forward a number of recommendations to reduce medical liability protection costs and to more efficiently adjudicate medical liability cases that could be implemented through changes in legislation or in the *Rules of Civil Procedure*.

But I have also put forward a number of proposals for which the details would have to be developed prior to implementation. I have suggested an advisory committee for this role, made up of representative judges, plaintiffs' counsel and defence counsel who have extensive experience in medical liability cases. I discussed this suggestion with each of these groups during my consultations and all reacted very positively.

This committee would be able to provide the Ministry with invaluable advice to help bring my proposals to fruition. Where appropriate for implementation, the committee could be very useful in dialoguing with the Civil Rules Committee and the Ministry of the Attorney General.

The committee could also provide invaluable assistance by monitoring changes, once made, to suggest modifications and improvements in the light of experience.

And, finally, it would also be positioned, as the future unfolds, to identify new steps to be taken to advance the goals of cost reduction and greater efficiency.

This broad role of the advisory committee reflects an important reality, namely that the changes necessary to achieve the objectives set out in my Terms of Reference will inevitably be a work in progress. Many of those I consulted with indicated support for such a process and a great willingness to participate in it.

Risk Management

My Terms of Reference seek to reduce the costs of medical liability by focusing on changes that could be made to specific elements that make up those costs. The implicit assumption is that once a medical mistake has been made, the challenge is to reduce the costs that flow from it.

However, in reducing those costs it is at least as important to reduce the frequency of medical mistakes responsible for them. Indeed, the American experience suggests it is far more important for cost reduction, let alone patient wellbeing. Better risk management is vital to this task.

Even if my mandate had extended to it, I have not been able, given time and resource limitations, to engage in a detailed analysis of how well risk management is presently being done in Ontario's system or how it could be improved. But several points deserve to be made.

First, there does appear to be much going on in Ontario's health care system to address the managing of risk of medical mistake. Health care providers have access to continuing education sessions, to telephone advice lines and web-based assistance. Since 2016, the CMPA and HIROC have been sharing deidentified data and knowledge on key patient safety risks. And so on. But no one could deny that more can and should be done.

Second, since medical mistakes frequently occur in hospital settings, the risk management strategies of those institutions are critical. It is clear that both unit level

efforts and institutional level efforts are important. They must be part of an integrated strategy.

Experience in the United States, for example at the New York Weill Cornell Medical Center, or at Cincinnati Children's Hospital Medical Center, demonstrates the benefits of this approach. Relatively dramatic reductions in medical mistakes have resulted from it. Undoubtedly there are lessons to be learned from careful examination of how these reductions were achieved.

Third, the unit level component appears particularly important. It is there that the team approach to modern health care is most apparent. The analogy to "crew resource management" techniques used for safety by the airline industry appears increasingly apt. In Ontario, HIROC's successful experience with its Managing Obstetrical Risk Effectively Program is a pertinent example.

Fourth, American experience has also shown that what matters is the development of a robust culture of safety. This is not the product of how legal liability is attached, whether to the enterprise or to the individual health care provider. Rather, it depends on a collective commitment to safety and quality improvement processes using team work, structured communication, measurements of success and external peer review.

A graphic example of the success such an approach can achieve is that of the Labour and Delivery Unit of the Weill Cornell Centre at New York Presbyterian Hospital. The result there was damages payments from \$27.6 million in 2003 to 2006 to \$0.25 million in 2009.

Finally, the American experience has also shown that the most effective driver of enhanced risk management is the insurer of the health care institution or the health care provider. In Ontario that is the Ministry. The lesson, I think, is clear. The Ministry would do well to take a leading role by, for example, establishing an expert panel on risk management to advance the objective on a province-wide basis.

Implementation Considerations

In the preceding pages I have made a number of recommendations for systemic changes to reduce medical liability protection costs and improve the efficiency of the civil justice system in respect of medical liability. The objective is to ensure that plaintiffs injured by medical mistake receive appropriate compensation in a timely manner, while at the same time ensuring that health care providers and institutions receive fair process. That is my mandate from the Ministry.

Along the way, I have made reference to how particular recommendations might be implemented. However, there are undoubtedly different ways in which these recommendations could be brought about. In considering these various alternatives, I think there are some considerations that can usefully be kept in mind.

Most importantly, the review I have conducted was set up by the Ministry because of the serious challenges presented by the rising costs of medical liability protection and the concerning time that is often required for plaintiffs injured by medical mistake to receive appropriate compensation. The Ministry is responsible for the health care system and for the cost of the mistakes it makes. It must protect the interests of patients by ensuring the continued viability of an effective medical liability system. It must therefore address the serious challenges that caused my review to be established. It is these challenges that my recommendations target. Implementation specifically designed to ensure that these challenges are met is important.

I recognize that a number of the recommendations I make could be implemented, for example, through legislation of general application, giving rise to the possibility that the

civil justice system, more broadly, will be implicated. However, my mandate directed me to medical liability litigation, because of the serious challenges it presents to the Ministry and to those for whom it is responsible.

Focusing on implementation of my recommendations for medical liability litigation only can be justified in a number of ways.

First, medical liability litigation has the unique characteristic that the Ministry is ultimately responsible for payments to injured plaintiffs. It is the public purse that pays.

Second, many of these injuries are very serious, with consequences lasting years, so that appropriate and timely compensation is both very significant and very important to these plaintiffs, a number of whom are infants.

Third, unlike many other kinds of civil litigation where defendants can pay only to the extent they are privately insured, in medical liability litigation there are no policy limits. Appropriate compensation must always be fully paid, ultimately by the Ministry.

Fourth, the continuing viability of the system for dealing with medical liability litigation must be a high priority for the Ministry. It is an important public policy objective, deserving immediate attention. If implementation implicates the broader justice system, delay is inevitable.

Finally, there are useful precedents for implementing my recommendations in ways that specifically target medical liability litigation. For example, the *Courts of Justice Act*, R.S.O. 1990, c.43, though legislation with application to all civil litigation, specifically targets medical malpractice litigation in s.116.1. Another example of targeted

implementation is seen in the various provisions of the *Insurance Act*, R.S.O. 1990, c.I-8, which deals specifically with a number of aspects of motor vehicle accident litigation.

While I recognize that how it chooses to implement my recommendations is up to government, for the reasons I have given, I would hope that this can be done to target medical liability cases as far as possible. In my view, that will help to ensure that the serious challenges that caused my review to be established will be addressed.

Future Considerations

Over the course of my work, several matters arose that, while not within my mandate, have sufficient connection to it to warrant future consideration by the Ministry. I did not do so because I did not have the time or the resources necessary to gather the relevant information to ground sound recommendations.

The first of these is the actuarial basis used to determine the funding necessary to sustain payment of medical liability protection costs. For physicians, the CMPA uses an occurrence-based approach based on an estimate of possible medical mistakes made in the relevant year, that could result in claims, whether or not claims have been made. For hospitals, HIROC uses a claims-made approach, which requires funding only once a claim is indeed made, not from the earlier point when the medical mistake may be made.

Over time, the funding required for medical liability costs should be the same using either approach, if both are properly applied, although the claims-made approach relies less on predicting the future since the actuarial process for a case commences closer to the date of any payment. However, several of those I consulted suggested that if the CMPA were to switch to a claims-based approach, there would be a short term, one time saving in the funding needed for medical liability costs. How much and with what consequences, I am not in a position to say. However, it should also be noted that, in addition to possible cost saving, the claims-made approach may have significant advantages for enhanced risk management through better data provided on a more timely basis.

The second matter concerns the retainer arrangements used by each of HIROC and the CMPA in hiring lawyers to defend medical liability cases. In 2003, HIROC began to utilize the model of an overall cost agreement for a fixed period of time with its provider of legal services, based on projections of the work to be required. This replaced the more traditional fee for service model. The switch appears to have lowered HIROC's transaction costs with no loss of quality of service. While the CMPA has undertaken a number of steps to more effectively manage its legal costs, it continues to utilize a fee for service model. It may be that at some point a more detailed examination will be warranted of the arrangements through which health care providers and institutions obtain legal services to defend medical liability cases. The objective would be to see if the same value could be provided, but at lower cost.

The third matter concerns the contingency fee arrangement commonly used by lawyers for plaintiffs injured by medical mistake. These arrangements can provide for the lawyer to receive a significant percentage of the award to an injured plaintiff. It must also be said, however, that the highly sophisticated nature of these cases requires that injured plaintiffs receive the most expert legal assistance. The right balance between the cost of and the value added by this assistance is not easy to strike.

Moreover, the costs imposed by these arrangements are borne by plaintiffs, not the Ministry. However, if the health care received by those plaintiffs, because of medical mistakes, is less than it should be because of these fees, the shortfall in care may have to be made up by the public health care system. The cost of this may warrant the Ministry's attention at some point in the future.

A fourth matter that arose in several of my discussions concerned the degree to which, if at all, claims for compensation for medical mistake should be dealt with through a no fault system. My mandate did not extend to an examination of this issue. Indeed, my own view is that the present fault-based system provides fair and appropriate compensation, and carries advantages for risk management.

However, if the Ministry chose to pursue this possibility, I would suggest that it begin with a careful consideration of applying it first to compromised baby cases. These cases are fortunately few in number, but each requires very significant compensation. In addition, fault may not always be an issue. Several American states have chosen to follow this path, and their experience would be useful should the Ministry decide to explore this option.

Fifthly, a few of those I consulted with raised the issue of access to justice for plaintiffs with less serious injuries due to medical mistake. While this too was beyond my mandate, I can make several observations.

First, it is true that a great deal of the attention of all engaged in medical liability litigation focuses on the serious cases of individuals whose health is seriously compromised. Fortunately, these cases are limited in number, but all are complex, costly to litigate, and carry potentially very significant outcome costs to be paid.

Second, it may be true that these characteristics of compensation and litigation cost are inherent in any medical liability litigation because of the issues and interests involved. If so, it may present the access to justice problem I describe above.

While I saw nothing in considering this review that made me think an investigation of this possibility is urgent, it is an issue that the Ministry should continue to be alert to.

Finally, in my consultations some expressed the view that enterprise liability should be considered, to hold the hospital liable rather than the responsible individual health care provider for medical mistakes occurring in the hospital. The argument is that this would enhance risk management and possibly reduce transaction costs.

Again, my mandate did not extend to this possibility. However, should the Ministry wish examine it, I would urge some caution. I would hope that the root and branch change it represents would not get in the way of the more incremental and more immediately feasible suggestions I have made concerning risk management and cost control.

PART IV. CONCLUSION

In the end, my review leaves me persuaded that the dual premises of my Terms of Reference are correct. First, medical liability costs have been rising significantly in recent years due in large part to increased damage awards and, as a consequence, so has the cost of medical liability protection. Second, there are legitimate concerns about the length of time that it takes for plaintiffs to receive compensation after a civil claim of medical mistake is made.

Thus, changes that address these challenges are needed to ensure the long term viability of the way medical liability protection is presently provided in Ontario. It is vital, however, that these changes also ensure that those who suffer medical mistakes receive fair compensation and that they and health care providers are accorded fair process.

I have made a large number of recommendations that I hope provide a basis for achieving all these objectives. Some can be implemented immediately. Some require that further detail be developed. But they all begin to do what I think is necessary.

Finally, it is important that the way the civil justice system in Ontario deals with the consequences of medical liability should be thought of as a work in process. Only continuing attention to it and to the ways it can be improved will ensure that it continues to serve the best interests of the people of Ontario.

Schedule A

Summary of Recommendations

1. Future Care Costs

- (a) Provide explicit criteria for determining future care required in medical liability cases.
- (b) Develop multi-disciplinary teams of university-based hospital experts able to provide opinions on future care needs in medical liability cases.
- (c) Establish a government entity to hold and administer structured settlement funds in medical liability cases.
- (d) Establish a government entity to provide or purchase future care services in medical liability cases.
- (e) Expand the availability in medical liability cases of the reference procedure under the *Rules of Civil Procedure* for determining the cost of future care in medical liability cases.
- (f) Increase the availability of community living centres for those injured through medical mistake who wish to take advantage of them.

2. Future Income Loss

- (a) Develop clear guidelines to address contingencies in calculating future income loss in medical liability cases.
- (b) Ensure deductions from basic living expenses where these expenses are included in the cost of future care in medical liability cases.

- (c) Ensure deductions for income tax in calculating future income loss included in structured settlements in medical liability cases.
- (d) Develop a consistent approach to the “lost years” doctrine in medical liability cases.

3. Discount Rate

- (a) Replace the two-tiered discount rate in the *Rules of Civil Procedure* with a single rate in medical liability cases.

4. Gross Up

- (a) Establish a government entity to hold structured settlement funds thereby minimizing the need for gross up for tax in medical liability cases.
- (b) Standardize the calculation of gross up for medical liability cases.

5. Management Fees

- (a) Require a plaintiff to establish that, in the circumstances, it is reasonable to receive management assistance for the property interests received in medical liability cases.
- (b) Require that the increased rate of return expected with professional assistance is considered in calculating the appropriate management fee in medical liability cases.
- (c) Ensure that no management fee is payable on structured settlements in medical liability cases.

6. Subrogation

- (a) Subrogated claims in medical liability cases should be ended by having the OHIP General Manager advise counsel that these will not be pursued.

7. Pre-judgment Interest

- (a) Remove the application of Rule 53.10 in the *Rules of Civil Procedure* for non-pecuniary damages in medical liability cases.

8. Guardianship Fees

- (a) Create regulations under the *Substitute Decisions Act* (the SDA) and the *Children's Law Reform Act* (the CLRA) to guide courts in determining reasonable guardianship fees in medical liability cases.
- (b) Consider the establishment of a government entity to manage the property interests of an incapable plaintiff in medical liability cases, whether or not a structured settlement is involved..
- (c) In collaboration with the Public Guardian and Trustee and the Office of the Children's Lawyer, consider the reduction of administrative costs related to guardianship in medical liability cases.
- (d) Explore whether a guardian appointed in these cases under the CLRA should be deemed to continue under the SDA if incapacity continues.

9. Derivative Claims

- (a) Consider restructuring the list of claimants eligible under the *Family Law Act* to ensure that, for claimants other than spouses, children and parents, a meaningful relationship will be shown in medical liability cases.
- (b) Consider an upper limit on the quantum of non-pecuniary damages recoverable in medical liability cases by claimants under the *Family Law Act*, as has been done in other provinces

10. Collateral Benefits

- (a) Require deductions for collateral benefits unless the plaintiff has given consideration for those benefits in medical liability cases.

11. Improving the Civil Justice System in Respect of Medical Liability Cases

- (a) Enhance cases management in medical liability cases using a standardized protocol.
- (b) Use specialized judges with experience in medical liability cases wherever possible.
- (c) Implement early fixed trial dates for medical liability cases.
- (d) Enhance the use of the reference procedure under the *Rules of Civil Procedure*.

12. Advisory Committee

- (a) Create an advisory committee made up of experienced judges and counsel to work out details of these recommendations, monitor their implementation, and make ongoing suggestions for improvement.

13. Risk Management

- (a) Devote increasing resources to risk management initiatives and data sharing.
- (b) Enhance the focus on unit level risk management.
- (c) Learn from the experiences of leading American hospitals that have achieved dramatic reductions in medical mistakes.
- (d) The Ministry, as the effective insurer, should take the lead in driving enhanced risk management.

14. Future Considerations

- (a) Consider whether a claims-made actuarial approach is preferable to an occurrence-based actuarial approach in medical liability cases.
- (b) Consider the most cost effective retainer arrangements available for defendants in medical liability cases.
- (c) Consider the impact of contingency fees on medical liability protection costs.

- (d) Consider whether a no fault approach to medical liability cases should be explored.
- (e) Continue to be alert to whether access to justice could be an issue for plaintiffs with lesser injuries due to medical misake.
- (f) Consider whether enterprise liability is a concept that might have application in medical liability cases.

Schedule B
List of Those Consulted

- The Ontario Medical Association
- The Canadian Medical Protective Association
- The Ontario Trial Lawyers Association
- The Healthcare Insurance Reciprocal of Canada
- Canadian Defence Lawyers
- The Holland Access to Justice in Medical Malpractice Group
- Canada Revenue Agency
- The College of Physicians and Surgeons of Ontario
- Morris, Stoltz, Evans LLP
- Paul Harte, Paul Harte Professional Corporation
- The Judiciary: Justices Wilson, Wilkins, Platana, Hackland, Edwards, Turnbull
- Justice McSweeney, former Children's Lawyer
- The Public Guardian and Trustee
- The Office of the Children's Lawyer
- Aviva Insurance
- MOHLTC Senior Leadership: Dr. Robert Bell (DM), Lynn Guerriero (ADM), Phil Cooke (ADM)
- MOHLTC Subrogation Unit
- MOHLTC Counsel: Robert Maisey, Michelle Macdonald
- MOH Senior Staff: Kathryn Boone, Julie Ingo, Jake Ennis
- Professor Doug Hyatt, University of Toronto
- David Marshall
- Dr. Nizar Mahomed
- Randy Zettle, Borden Ladner Gervais LLP
- Hon. Coulter Osborne
- Lee Samis, Samis and Company
- Sandra Vellone
- Ralph Fenik, McKellar
- Dr. Andrew Armstrong
- MAG: Judy Hays, Linda Omagic