IN THE
DISTRICT OF COLUMBIA COURT OF APPEALS

Appeal No. 24-CV-0942

MEDSTAR GEORGETOWN MEDICAL CENTER, INC., *ET AL.*,

Appellants

v.

DAVID S. KAPLAN

Appellee

Appeal from the Superior Court for the District of Columbia
(The Honorable Ebony Scott)
Case No. 2021 CA 004820 M

BRIEF OF APPELLANTS

Larry D. McAfee (Bar No. 457226)
Rachel I. Viglianti (Bar No. 984340)
Gleason, Flynn, Emig & McAfee
11 North Washington Street, Suite 400
Rockville, Maryland 20850
(301) 294-2110
lmcafee@gleason-law.com
rviglianti@gleason-law.com

*Janet A. Forero (Bar No. 422014)
Derek M. Stikeleather (Bar No. 997292)
Goodell, DeVries, Leech & Dann, LLP
One South Street, 20th Floor
Baltimore, Maryland 21202
Telephone: (410) 783-4000
Fax: (410) 783-4040
jforero@gdldlaw.com
dstikeleather@gdldlaw.com

Attorneys for Appellants,
MedStar Georgetown Medical Center, Inc., and MMG-GI at Lafayette Center
d/b/a/ MedStar Medical Group II, LLC

RULE 28(a)(2) LIST OF PARTIES AND COUNSEL

The parties and their counsel in this matter are:

Parties	**Counsel**
MedStar Georgetown Medical Center, Inc., and MMG-GI at Lafayette Center d/b/a/ MedStar Medical Group II, LLC *Appellants*	Janet A. Forero (Bar No. 422014) Derek M. Stikeleather (Bar No. 997292) Goodell, DeVries, Leech & Dann, LLP One South Street, 20th Floor Baltimore, Maryland 21202 Telephone: (410) 783-4000 Larry D. McAfee (Bar No. 457226) Rachel I. Viglianti (Bar No. 984340) Barry Harris (Bar No. 1601214) Gleason, Flynn, Emig & McAfee 11 North Washington Street, Suite 400 Rockville, Maryland 20850 (301) 294-21100
David S. Kaplan *Appellee*	Catherine D. Bertram (Bar No. 425052) Bertram Law Group, PLLC 601 Pennsylvania Ave, NW Washington, DC 20004 Telephone: (202) 803-5800 Alfred F. Belcuore (Bar No. 181560) Law Offices of Alfred F. Belcuore 336 Constitution Avenue, N.E. Washington, DC 20002 Telephone: (301) 367-2992

Carrie J. Williams (Bar No. 90014710) appeared in the Superior Court in this action on behalf of Appellants, MedStar Georgetown Medical Center., Inc. and MMG-GI at Lafayette Center d/b/a/ Medstar Medical Group II, LLC. No other

parties or counsel appeared in the Superior Court in this action. *See* D.C. Court of Appeals Rule 28 (a)(2)(B). Counsel further certifies that no individual has filed an amicus brief in connection with this appeal.

These representations are made so that the judges of this Court may evaluate possible disqualification or recusal.

Dated: January 29, 2025

Respectfully submitted,

/s/ *Derek M. Stikeleather*
Janet A. Forero (Bar No. 422014)
Derek M. Stikeleather (Bar No. 997292)
Goodell, DeVries, Leech & Dann, LLP
One South Street, 20th Floor
Baltimore, Maryland 21202
Telephone: (410) 783-4000
Fax: (410) 783-4040
jforero@gdldlaw.com
dstikeleather@gdldlaw.com

Larry D. McAfee (Bar No. 457226)
Rachel Viglianti (Bar No. 984340)
Gleason, Flynn, Emig & McAfee
11 North Washington Street, Suite 400
Rockville, Maryland 20850
(301) 294-21100
lmcafee@gleason-law.com
rviglianti@gleason-law.com

Attorneys for Appellants, MedStar Georgetown Medical Center, Inc., and MMGGI at Lafayette Center d/b/a/ MedStar Medical Group II, LLC

RULE 28(a)(2) CORPORATE DISCLOSURE STATEMENT

MedStar Georgetown Medical Center, Inc. is a not-for-profit corporation with no corporate subsidiaries. It is wholly owned by MedStar Health, Inc. MMG-GI at Lafayette Center d/b/a/ MedStar Medical Group II, LLC is a non-profit organization with no corporate subsidiaries, and it is wholly owned by MedStar Health, Inc. *See* D.C. Court of Appeals Rule 28 (a)(2)(B).

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STATEMENT OF JURISDICTION

This appeal is from a final judgment that disposes of all parties' claims. *See* D.C. Court of Appeals Rule 28 (a)(5).

ISSUES PRESENTED

1. Did the trial court abuse its discretion by allowing a verdict sheet that encouraged the jury to award duplicative damages?

2. Was it an abuse of discretion for the trial court to refuse to deliver a curative instruction and subsequently refuse to grant a new trial after Mr. Kaplan's counsel conflated "safety" with the standard of care and anchored damages at $4 million during closing argument?

3. Did the trial court abuse its discretion in refusing to reduce the excessive $4 million judgment?

STATEMENT OF THE CASE

Appellee, David Kaplan, filed personal injury claims against Appellants MedStar Georgetown University Hospital (the "Hospital") and MMG-GI at Lafayette Center d/b/a/ MedStar Medical Group II, LLC (together, "Medstar Providers") alleging negligent medical treatment and failure to obtain informed consent related to his treatment for Crohn's disease. (Joint Appendix ("App.") 1875). In April 2024, a jury found the MedStar Providers liable under both theories and awarded Plaintiff $4 million in non-economic damages. (App. 1872-73). On September 26, 2024, the Superior Court denied the MedStar's post-trial motions for judgment notwithstanding the verdict, a new trial, and remittitur. (App. 1874-1908). The MedStar Providers timely noted this appeal. (App. 4).

RELEVANT FACTS

A. David Kaplan's diagnosis of Crohn's disease

David Kaplan began experiencing gastrointestinal symptoms in late summer 2018, when he was 34 years old. (App. 46-47, 719). He first sought treatment from gastroenterologist Dr. James Frank[1] on September 13, 2018. (App. 412-43). Based on the results of a sigmoidoscopy and Mr. Kaplan's report of symptoms, Dr. Frank diagnosed Mr. Kaplan with Crohn's disease, which is essentially "an inflammatory disorder of the GI tract." (App. 149-50, 412-15, 721).

Dr. Frank prescribed prednisone, a steroid, to alleviate the symptoms and ordered follow-up tests. (App. 722). Although Mr. Kaplan did not recall being informed of the risk of avascular necrosis (AVN), also known as aseptic necrosis, Dr. Frank's contemporaneous notes indicate that it was discussed as a potential side effect of steroid use. (App. 722-23, 421-22, 1912). Mr. Kaplan testified that during the time he was under Dr. Frank's care he "wasn't doing well at all," was "in a lot of pain," and had lost 24 pounds in two weeks. (App. 722).

In late September, Mr. Kaplan transferred his care to Dr. Mark Mattar[2] at the Georgetown IBD Clinic (the "Clinic"). (App. 724-27, 1916-18). At Mr. Kaplan's first visit on October 3, 2018, Dr. Mattar said he agreed with Dr. Frank's diagnosis

[1] There are no allegations of negligence against Dr. Frank. (App. 47).

[2] Dr. Mattar is stipulated to be an employee of the MedStar Providers. (App. 950)

of Crohn's disease, gave Mr. Kaplan instructions for tapering down the prednisone dosage by 5 milligrams per week, and prescribed mesalamine in the hopes of achieving remission. (App. 164, 333). Dr. Mattar discussed the possible need for biologic therapy with Mr. Kaplan if the mesalamine was unsuccessful in reducing the symptoms. (App. 333). To prepare for the potential need for biologic treatment, Dr. Mattar instructed Mr. Kaplan to choose a primary care physician and obtain blood work, a chest X-ray, a TB test, and a pneumonia vaccine. (App. 167, 249-50, 1125-27).

B. Mr. Kaplan's mesalamine treatment and ultimate transition to biologics.

Per Dr. Mattar's instructions, Mr. Kaplan reduced his prednisone dose from 60 mg to 40 mg on October 3, 2018. (App. 162-64, 1917). When he tried to reduce to 35 mg, however, he reported new onset of bloody stool, and the providers at the Clinic advised him to return to the 40 mg dosage. (App. 164-65, 2777).

On November 7, 2018, Mr. Kaplan obtained the chest X-ray and follow-up blood work but by November 16th had still not gotten the pneumonia vaccine. (App. 2657, 2660). Mr. Kaplan also reported that he was still taking 40 mg of prednisone because his attempts to taper had been unsuccessful. (App. 2660). Ten days later, after eight weeks on mesalamine, Mr. Kaplan successfully tapered to 35 mg with no increase in symptoms. (App. 2787).

For the next month, Mr. Kaplan was able to taper to 25 mg of prednisone and then to 15 mg. (App. 2793). On December 27, 2018, he emailed the Clinic to report that he was experiencing an increase in leakage and overnight bowel movements. (*Id.*). On January 2, 2019, Nurse Practitioner Aimee LeStrange[3] advised Mr. Kaplan to schedule an appointment to discuss next steps. (App. 2796).

At a January 23, 2019 appointment, Nurse Practitioner LeStrange discussed the risks and benefits of Stelara (a biologic) and anti-TNF medications with Mr. Kaplan. (App. 2664-65). Based on Mr. Kaplan's family history of lymphoma, the decision was made to proceed with Stelara injections. (App. 2665-66, 2676). After receiving insurance approval, the first injection was scheduled for February 18th. (App. 2682). Because Mr. Kaplan became dizzy and hypotensive due to a vasovagal reaction, the initial Stelara attempt was discontinued. (App. 2693, 2696-97). His first successful infusion occurred on March 7, 2019. (App. 2700). Mr. Kaplan reported immediate symptom relief and was then able to taper off the prednisone completely. (App. 775-76).

C. Mr. Kaplan developed AVN and received a bilateral hip replacement

Around June 26, 2019, Mr. Kaplan developed severe hip pain. (App. 776-77). His orthopedic surgeon diagnosed Mr. Kaplan with bilateral avascular necrosis, a

[3] Ms. LeStrange is stipulated to be an employee of the MedStar Providers. (App. 950)

rare but recognized side effect of steroid use. (App. 778-79, 2316, 2462). Ultimately, Mr. Kaplan underwent two hip replacement surgeries, one in July 2020 and the other in November 2020. (App. 781, 783).

D. Mr. Kaplan sued his providers, alleging medical negligence and lack of informed consent.

In December 2021, Mr. Kaplan sued the MedStar Providers alleging they breached the standard of care by delaying Mr. Kaplan's transition to a biologic treatment and failing to inform him of the risk of AVN. (App.1875). The breach, Mr. Kaplan alleged, caused his AVN and led to bilateral hip replacements. (*Id.*)

1. Trial evidence of negligence and causation.

Mr. Kaplan called two standard of care experts at trial. Both testified that steroid use is recommended for short-term alleviation of symptoms of Crohn's disease, but that the standard of care required a complete taper by three months. (App. 162, 639). According to Mr. Kaplan's experts, Dr. Mattar breached the standard of care by not transitioning Mr. Kaplan to a biologic treatment by early to mid-November. (App. 180-82, 206, 238-39, 644-45). Had Dr. Mattar done this, the experts testified, Mr. Kaplan would have discontinued steroid use within three months, as they claimed the standard of care required. (App. 206-07, 645).

Mr. Kaplan's experts also testified that the standard of care required Dr. Mattar to inform Mr. Kaplan that the longer he was on prednisone, the higher the risk of developing AVN. (App. 197-98, 619-20, 645-46). While they agreed that

Dr. Frank advised Mr. Kaplan that AVN was one of the side effects associated with steroid use, they opined that a second warning was required some months later. (App. 197-98, 619-20).

The Medstar Providers' standard of care expert testified that it was within the standard of care for a newly diagnosed Crohn's patient to be on prednisone for up to a year while identifying an appropriate maintenance medication. (App. 1296-97). He also testified that, given Mr. Kaplan's report of improved symptoms, it was within the standard of care to continue him on mesalamine and attempt to taper the prednisone. (App. 1314-17, 1339-40).

As to causation, Mr. Kaplan's orthopedic expert testified that steroid use was the most likely cause of his AVN. (App. 475-76). The expert acknowledged that there was no "set point" at which a patient develops AVN due to steroids use, and it could develop after one or two months of taking 40 mg of steroids daily. (App. 529, 535-36). Thus, Mr. Kaplan's expert acknowledged Mr. Kaplan could have already developed AVN by October 21st or November 21st, well before his experts claim the standard of care required a complete taper. (App. 536). In other words, the steroids taken at the inception of Mr. Kaplan's treatment –which are not criticized by his experts – could have independently caused Mr. Kaplan's AVN.

Mr. Kaplan's expert also testified that symptoms of AVN typically take between five and seven months to manifest. (App. 537). Mr. Kaplan reported hip

pain to his orthopedic surgeon on June 26, 2019, so Plaintiff's AVN likely developed between late November 2018 and late January 2019. (App. 777, 2465). This means that, even under Mr. Kaplan's experts' standard of care, his AVN still would have developed when he was tapering.

The MedStar Providers' experts testified that Mr. Kaplan's AVN was caused by several factors including prednisone and Crohn's disease, which increase the risk of AVN. (App. 984, 991). Because of these associations, nothing would have changed had Mr. Kaplan discontinued prednisone a few weeks earlier, the expert testified. (App. 994-95).

2. Trial evidence of Mr. Kaplan's damages.

Mr. Kaplan testified that he had hip pain from July of 2019 through recovery from his hip surgeries in November 2020. (App. 780-84). Afterwards, Mr. Kaplan testified, his level of pain was "night and day," and he is "very grateful." (App. 788). His left hip is "phenomenal," and his right hip is "pretty good too[.]" (App. 787).

The evidence established that Plaintiff has no limitations on his activities of daily living—he can walk, drive, work, travel, and go to the farmer's market. (App. 788-89). Mr. Kaplan can exercise and play sports; he testified that he rows, bikes, and uses an elliptical machine. (App. 789-90). Other than high intensity running and competitive soccer, Mr. Kaplan can do everything he did before his hip surgeries. (App. 789-90).

Mr. Kaplan testified that rowing, biking, and the elliptical are "not the same" as competitive soccer and running, and he found it "hard to replace" those things that were very important to him. (App. 790). He also testified that he had "some embarrassment" when explaining his hip replacements to his girlfriend and that it impacted "intimate activities" with his girlfriend "a little bit." (App. 791).

In terms of lasting physical effects, Mr. Kaplan said that he cannot cross his legs very well, and he gets sore more quickly than before the surgeries. (App. 891). According to his experts, Mr. Kaplan's hip replacements will likely last approximately 25 years. He may need revision surgery when he is in his late 50's or early 60's. (App. 502, 545). However, Mr. Kaplan's treating orthopedic surgeon and defense expert opined that his hip replacements will likely last the rest of his life. (App. 905-906).

E. The trial court approved a verdict form with two lines for non-economic damages.

Mr. Kaplan sought no economic damages at all, only non-economic damages. Yet the verdict sheet approved by the trial court over the MedStar Providers' objection instructed the jury to consider two awards — one for "past and future physical injury" and another for "past and future emotional distress." (App. 1873).

Counsel for the MedStar Providers explained why having two lines for what amounts to one award for "pain and suffering" was improper and prejudicial to them. Pain and suffering, counsel explained, is defined in the jury instructions and each

element of "pain and suffering," such as physical injury, future effects on physical well-being, and past and future emotional distress are part and parcel of a single category of damages. (App. 1727-29). Asking the jury to parse out a single category of damages "five different times or three different times or even two different times" prejudices defendants. (App. 1728).

The trial court overruled the objection of the MedStar Providers and included two lines for a single category of damages.

F. Mr. Kaplan's counsel emphasized safety during closing argument and anchored damages at $4 million.

Mr. Kaplan's closing arguments repeatedly referred to the "safe" use of corticosteroids, the MedStar Providers' alleged failure to "protect" Mr. Kaplan, and direct appealed to the jury's own safety interests. (App. 1763-69). Mr. Kaplan's counsel characterized the intent of the guidelines she claimed constituted the national standard of care as helping doctors "who are treating patients like David do it safely and well. And that is what the national standard of care is." (App. 1761).

Counsel continued the theme a few moments later, stating:

> It's Dr. Mattar's job to protect this patient. Dr. Mattar knows this is dangerous and he only has limited time to move.
>
> ***
>
> You're almost halfway through your safety zone, and he's still on 40 milligrams. This is the last chance.
>
> ***
>
> So had they done what they needed to do to protect David, he would have gone on these biologics in November. And you heard Dr. Schoen say the earlier you go on and get off those—and try to get off those

> steroids, the easier it is to get off them and the quicker you can get down and get off and be safe and stay within the safety zone. And that's what's important, but that's what they didn't do. They didn't protect David, and David didn't know.

(App. 1764-65, 1767-68).

She continued, saying, "David was on steroids for seven months continuously, more than double the safe time," and "[t]he science determines what's safe, what the safe window is. And you don't go outside it. Because you don't want to be a statistic and you don't want to get to an unsafe place because we don't know where that line is[.]" (App. 1769, 1778).

In response to the MedStar Providers' objection, the trial court found the repeated references to safety improper because "the jury instruction" on standard of care "doesn't use the word 'safety.'" (App. 1845-46, 1847-49). The court declined to give a curative instruction however, and instead, only reminded the jury that the standard of care is defined in the jury instructions. (App. 1849, 1855).

In addition to conflating the standard of care with "safety," Mr. Kaplan's counsel employed a recognized heuristic known as "anchoring."[4] Counsel's very last comment during initial closing argument was that it was up to the jury "as a collective group" to determine the value of Mr. Kaplan's injuries. (App. 1788).

[4] As explained in Argument Section II.C, humans tend to estimate value by assigning an initial value and adjusting up or down from there. When the initial value is "anchored" at a higher number, the result tends to be biased in favor of that number.

"Some of you might think it's worth $4 million. Some of you might think it's three. Some might think it's worth six. It's completely up to you, ladies and gentlemen. David Kaplan trusts you to decide." (App. 1788).

The MedStar Providers objected to counsel's anchoring and asked the court to instruct the jury to disregard any suggestion of a specific amount of damages. (App. 1846). The trial court acknowledged that some trial court judges "have determined that anchoring is inappropriate" and that suggesting a range of damages "does in fact anchor" but declined to deliver a curative instruction. (App. 1849-51).

G. The jury awarded Mr. Kaplan $4 million in damages, the first number in counsel's anchored range.

The jury found in favor of Mr. Kaplan and awarded him $2.5 million in damages for "past and future physical injury" and $1.5 million for "past and future emotional distress." (App. 1866-67).

H. The trial court denied the MedStar Providers' post-trial motions.

The MedStar Providers filed post-trial motions seeking judgment notwithstanding the verdict, a new trial, or, in the alternative, a remittitur of damages. They argued that Mr. Kaplan's closing was improper, the evidence was insufficient to prove breach of the standard of care and causation, the verdict sheet created the likelihood of duplicative damages, and the damages were excessive. The

trial court denied the motions in an omnibus order dated September 26, 2024. (App. 1874-1908). The MedStar Providers noted a timely appeal.

SUMMARY OF THE ARGUMENT

This Court should vacate the judgment because the trial court abused its discretion. *First*, the trial court allowed the use of a verdict sheet with separate lines for "past and future physical injury" and "past and future emotional distress," rather than a single line for this indivisibly intertwined category of damages. In so doing, the trial court promoted duplicative damages. The trial court's refusal to order a new trial or reduce the duplicative $1.5 damages is error.

Second, Mr. Kaplan's counsel delivered an inflammatory and misleading closing argument, tantamount to a golden rule argument, by urging the jury to penalize the MedStar Providers for failing to "protect" Mr. Kaplan and to keep him "safe." The argument conflated "safety" with the national standard of care, to the detriment of the MedStar Providers.

Third, Mr. Kaplan also improperly "anchored" the jury to $4 million in non-economic damages in his closing argument, and the jury gave precisely that amount. The trial court erroneously refused to issue curative instructions or order a new trial.

The verdict is excessive, and the trial court abused its discretion in refusing to vacate or reduce it.

ARGUMENT

I. The trial court abused its discretion when it provided the jury a verdict sheet that encouraged duplicative damages.

Mr. Kaplan sought only non-economic damages. That is, he did not claim economic losses, such as lost wages or unpaid medical bills. He asked the jury to compensate him only for the intangible distress caused by his AVN and bilateral hip replacement. Although he sought a single category of damages, Mr. Kaplan urged the court to draft a verdict sheet that included separate monetary awards for specific subsets of non-economic damages, like disfigurement and scarring. (App. 1726).

The trial judge declined to include a line for disfigurement but said she would follow the standard jury instruction on damages and provide a line for "past and future physical injury" and a separate line for "past and future emotional distress." (App. 1733). Over the objection of the MedStar Providers, this damages question on the verdict form was submitted to the jury:

> 5. What amounts do you find would fully and fairly compensate David Kaplan for the following elements of his damages?
>
> Past and Future Physical Injury $_____
>
> Past and Future Emotional Distress $_____

(App. 1873).

Under the circumstances of this case, it was an abuse of the trial court's discretion to instruct the jury to separate monetary damages for "physical injury"

and "emotional distress." Parsing out closely intertwined damages likely resulted in a duplicative award.

A. Non-economic damages are a single category for purposes of a monetary award.

Colloquially referred to as "pain and suffering," non-economic damages are comprised of a group of imprecise and overlapping categories, such as "pain, mental anguish, anxiety, emotional distress, and nervous shock." Noah Lars, *Comfortably Numb: Medicalizing (and Mitigating) Pain-and-Suffering Damages*, 42 U. Mich. J.L. Reform 431, 432 (2009).

Because these concepts are inextricably intertwined, courts have generally "not attempted to draw distinctions between the elements of 'pain' on the one hand, and 'suffering' on the other," instead referring to the "unitary concept" of "pain and suffering" to allow for recovery "not only for physical pain but for fright, nervousness, grief, anxiety, worry, mortification, shock, humiliation, indignity, embarrassment, apprehension, terror or ordeal." *Capelouto v. Kaiser Found. Hosps*., 500 P.2d 880, 883 (Cal. 1972). "Suffering," as one court has pointed out, "means distress, whether physical or emotional." *Marxmiller v. Champaign-Urbana Mass Transit Dist.*, 90 N.E.3d 1064, 1075 (Ill. App. 4th 2017). "Emotional distress or mental anguish is a component of suffering, not an element of damages unto itself." *Id*.

B. Allowing separate awards for physical and emotional damages on the verdict sheet was an abuse of discretion.

While the format and language of the verdict form is within the trial judge's discretion, a reviewing court must examine the verdict sheet holistically to determine '"whether submission of the issues to the jury was fair, and whether the ultimate questions of fact were clearly submitted to the jury."' *Benjamin v. Sparks*, 986 F.3d 332, 346-47 (4th Cir. 2021) (quoting *Horne v. Owens-Corning Fiberglass Corp.*, 4 F.3d 276, 284 (4th Cir. 1993)).

Here, parsing out the "unitary concept" of pain and suffering into separate damages awards for "physical pain" and "emotional distress" invited duplicative damages and was an abuse of discretion. The Illinois Supreme Court's analysis in *Powers v. Ill. C. G. R. Co*., 438 N.E.2d 152, 156 (Ill. 1982) is persuasive. The court held that a verdict sheet "invited a duplicating recovery" where it asked the jury to award damages for: 1) the nature and extent of the injury; 2) disability resulting from the injury; 3) "pain and suffering" caused by the injury; and 4) lost wages. *Id*. "Any award for elements such as disability, pain and suffering, or disfigurement will of necessity involve and be based upon the jury's examination of and assessment of the nature, extent and duration of the injury." *Id*. *Accord S. Covington & C. S. R. Co. v. Vanice*, 278 S.W. 116, 120 (Ky. 1925) (allowing damages for injuries to plaintiff's person as well as "damages for physical and mental suffering, and for the permanent

impairment of [plaintiff's] power to earn money" "necessarily authorizes the assessment of double damages").

The same is true here. The jury was asked to determine the monetary value of Mr. Kaplan's "past and future physical injury" and then separately determine the monetary value of Plaintiff's "past and future emotional distress." Under the circumstances of this case, it would be impossible for the jury to untangle the compensation for Mr. Kaplan's physical injury from his compensation for emotional distress. Emotional pain is inextricably tied to the physical pain of injury. They are indivisible. By instructing the jury to award monetary damages for physical injury and emotional distress, the verdict sheet "necessarily authorize[d] the assessment of double damages." *S. Covington*, 278 S.W. at 120.

C. Instructing on the elements of damages is not the same as instructing the jury to deliver a separate award for each element.

When drafting the verdict sheet, the trial judge analyzed whether separate damages for physical injury and emotional distress is "consistent with [D.C. Pattern Jury Instruction]13.01." (App. 1731). The judge ruled that "past and future physical injury" and "past and future emotional distress" "tracks 13.01." (App. 1733).

Although it is true that D.C. Civil Pattern Jury Instruction 13.01 lists "the extent and duration of any physical injuries" and "any physical pain and emotional distress" as separate elements, instructing the jury on the elements of damages is not

the same as instructing the jury to make a separate award of damages for each element. *See Powers*, 438 N.E.2d at 156 (finding reversible error where the verdict form "told the jury in effect to enter a separate amount for each element of damage"). Allowing separate damages awards based on the individual elements of § 13.01 leads to impermissible duplication of damages. That is what happened here.

D. The likelihood of duplicate damages requires the award to be reduced by the duplication or the case remanded for a new trial on damages.

The jury awarded Mr. Kaplan $2.5 million for past and future physical injury and $1.5 million for emotional distress. As argued in Section III, below, this award is excessive and beyond any reasonable calculation of Mr. Kaplan's damages. It is also further evidence that the award for physical injury encompassed emotional distress, rendering the $1.5 million for emotional distress duplicative.

The evidence was that Mr. Kaplan had minimal physical injury. He experienced serious hip pain for approximately a year, from June 2019 through his bilateral hip replacement surgeries in 2020. Post-surgery, he returned to full hip mobility, with little pain and minimal limitations on his activities. (App. 876-80). Mr. Kaplan did not claim economic damages for past or future medical treatment, and no expert testified regarding the cost of future surgeries.

Notwithstanding this evidence, the jury awarded Mr. Kaplan $2.5 million for past and future physical injury. This award bears no relation to the evidence of Mr.

Kaplan's physical injuries and demonstrates that the jury was unable to parse out non-economic damages for emotional distress from damages for physical injury Mr. Kaplan's $2.5 million award for physical pain and suffering must necessarily include the emotional aspect of that pain and suffering. The $1.5 million award is duplicative.

If a jury has "actually awarded, or arguably awarded," duplicate damages, the proper remedy is to "reduce the judgment by the amount of duplication." *Cobb v. Wash. Metro. Area Transit Auth*., Case No. 20-cv-3522, 2021 U.S. Dist. LEXIS 129809, at *11 (D.D.C. July 13, 2021). At a minimum, this Court should reduce Mr. Kaplan's award by the duplicative $1.5 million. If this Court does not believe it can determine the extent to which the jury's verdict is duplicative, then it should vacate the judgment and award a new trial on damages.

II. It was an abuse of discretion for the trial court to refuse to deliver a curative instruction or grant a new trial after Mr. Kaplan's improper closing argument.

Scattered throughout Mr. Kaplan's closing argument were ten separate references to "safety" or "protection," designed to mislead the jury into believing the standard for liability was whether Mr. Kaplan was kept "safe" and "protected," rather than whether the MedStar Providers breached the national standard of care. Then, at the very end of closing, Mr. Kaplan improperly "anchored" the jury to an award of $4 million in damages, precisely the amount that the jury ultimately

awarded. The closing enflamed and misled the jury to the detriment of MedStar Providers, yet the trial court refused to deliver a curative instruction or grant a new trial. This was an abuse of discretion that warrants reversal of the judgment and remand for a new trial.

A. References to "safety" and "protecting" patients misstate the standard for liability and violate the prohibition against "golden rule" closing arguments.

Mr. Kaplan's closing repeatedly referenced the "safe" use of corticosteroids, MedStar Providers' alleged failure to "protect" Mr. Kaplan, and encouraged the jury to consider its own safety interests. (App. 1763)The closing discussed safely and timely transitioning to a biologic and said Dr. Mattar's "job" was to "protect" Mr. Kaplan from the dangers of steroids. (App. 1761, 1763, 1764). Mr. Kaplan made four references to the "safety zone," "safe time," and "safe window" of steroid usage and criticized Dr. Mattar for veering outside of that "safety zone." (App. 1764-65, 1767-68).

Arguments referencing safety and the protection of patients are improper because they confuse the standard for assessing liability and violate the prohibition against "golden rule" arguments. A "golden rule argument" is one that explicitly or subtly '"asks the jury to place themselves in the shoes" of an injured party or "appeals to the jury's own interests." *Beckwitt v. State*, 249 Md. App. 333, 385 (2021), *aff'd on other grounds by Beckwitt v. State*, 477 Md. 398 (2022). Golden

rule arguments imply that the jurors should render the verdict they would want awarded if they personally had been injured. Thus, these arguments are universally forbidden because they invite jurors to "depart from neutrality" and decide the case based on inappropriate considerations such as emotion, personal interest, bias, or prejudice. *Moore v. Hartman*, 102 F. Supp. 3d 35, 161 (D.D.C. 2015) (quoting *Caudle v. District of Columbia*, 707 F.3d 354, 360-61, (D.C. Cir. 2013)); *accord Ins. Co. of N. Am. v. U.S. Gypsum Co*., 870 F.2d 148, 154 (4th Cir. 1989)).

When plaintiff's counsel in a medical malpractice case argued that the jury must decide "if you want safe or unsafe medicine," and criticized the defendant for breaking the "rules of safe medical practice" and failing to "err on the side of safety," the Supreme Court of Kansas had no trouble concluding that "the comments were error." *Castleberry v. DeBrot*, 424 P.3d 495, 506-08 (Kan. 2018). That court explained that those statements "invited the jury to determine whether [the defendant's] conduct met the standard of care based on whether it desired 'safe or unsafe medicine,' instead of the evidence and the law." *Id*. at 508. Mr. Kaplan's counsel's remarks in this case accomplished the same improper goal.

B. Mr. Kaplan's "golden rule" arguments improperly influenced the jury and the trial court's refusal to deliver a curative instruction or grant a new trial was an abuse of discretion.

Reversal is required where the improper comments of counsel "left the jurors with wrong or erroneous impressions, which were likely to mislead, improperly

influence, or prejudice them to the disadvantage" of the appellant. *President & Dirs. of Georgetown Coll. v. Wheeler*, 75 A.3d 280, 292 (D.C. 2013). Although a single golden rule argument is improper, "[w]here a party makes repeated appeals to the juror's emotional sympathies, the error is heightened and may warrant a new trial even where the court has provided curative instructions." *Moore*, 102 F. Supp. 3d at 161. (D.D.C. 2015).

In this case, there were multiple appeals to the jurors' sympathies that were likely to improperly influence and unfairly prejudice the jury against the MedStar Providers. Mr. Kaplan's counsel's comments encouraged the jury to abandon the appropriate standard of care analysis and instead decide whether Dr. Mattar kept Mr. Kaplan "safe" and "protected." Counsel then slipped her argument into the second person, inviting the jurors to imagine that "[y]ou're now another two weeks in[,] [y]ou're almost halfway through your safety zone" and even though "this is the last chance," Dr. Mattar chose not to transition to a biologic. (App. 1765). Later, Mr. Kaplan's counsel was even more explicit, arguing that "the science determines what's safe" and "you don't go outside it. Because you don't want to be a statistic and you don't want to get to an unsafe place[.]" (App. 1778).

By the end of Mr. Kaplan's closing argument, the jurors were primed to decide this case based not on whether Mr. Kaplan proved that MedStar Providers breached the standard of care and that breach caused Mr. Kaplan's injuries, but on whether

the jurors would want to be kept safe or be a "statistic." (App. 1778). Yet despite recognizing that counsel's comments were improper because "the jury instruction" on standard of care "doesn't use the word 'safety,'" the trial court refused to deliver a curative instruction and simply referenced the standard of care jury instructions in its final charge to the jury. (App. 1849, 1855). The trial court later denied MedStar Providers' motion for a new trial, finding that Mr. Kaplan's counsel did not "cross the line" into "golden rule" territory and that "any perceived prejudice" was cured by the trial court's reminder to follow the jury instructions. (App. 1895-96).

Given the pervasiveness of Mr. Kaplan's remarks, the trial court's refusal to deliver a curative instruction and denial of a new trial was an abuse of discretion. *See Wheeler*, 75 A.3d at 292 (a trial court's conclusions about the scope of closing argument are reviewed for abuse of discretion). An abuse of discretion has occurred if, after considering "the entire argument, the context of the remarks, the objection raised, and [any] curative instruction," the reviewing court determines that the comments "impair[ed] gravely the calm and dispassionate consideration of the case by the jury." *Cote v. R.J. Reynolds Tobacco Co.*, 909 F.3d 1094, 1103 (11th Cir. 2018). Such an impairment occurred here.

C. Mr. Kaplan improperly "anchored" the jury to a particular amount of damages, which deprived the MedStar Providers of a fair trial.

Golden rule arguments were not the only improper comments made by Mr. Kaplan's counsel during closing argument. The very last thing Mr. Kaplan's counsel did in her initial closing was to "anchor" the amount of damages to $4 million, the exact amount of damages the jury ultimately awarded. Counsel said:

> So when you fill out that form—it's not my job, and I can't tell you what numbers to put in. But what I can tell you is that it's up to you as a collective group to decide what you think the value of that is. Some of you might think that it's worth $4 million. Some of you might think it's worth three. Some might think it's worth six. It's completely up to you, ladies and gentlemen. David Kaplan trusts you to decide. Thank you.

(App. 1788).

The MedStar Providers objected to the anchoring and asked the trial court to instruct the jury that it was to disregard any suggestion of a specific amount of damages that might be appropriate. (App. 1846). The court acknowledged that some Superior Court judges "have determined that anchoring is inappropriate" but declined to deliver a curative instruction. (App. 1850). This was an abuse of discretion.

1. "Anchoring" is a proven psychological phenomenon.

Fifty years ago, researchers Amos Tversky and Daniel Kahneman identified three heuristics human beings employ to reduce the mental effort of decision

making. Amos Tversky & Daniel Kahneman, *Judgment Under Uncertainty: Heuristics and Biases*, 185 Science 1124 (1974). Tversky and Kahneman coined the heuristic used when people estimate value "Adjustment and Anchoring." When estimating value, humans tend to assign an initial value, then adjust it by increasing or decreasing as necessary. Dan Pilat & Sekoul Krastev, *Why Do We Take Mental Shortcuts?* (2021), https://thedecisionlab.com/biases/heuristics, *available* at https://thedecisionlab.com/biases/heuristics (last visited Jan. 28, 2025). But research shows that people "often get stuck on that initial value," which is referred to as "anchoring," and the result is that the "adjusted value is biased in favor of the initial value[.]" *Id.*

The anchoring effect has been proven time and again in scientific studies. Tversky and Kahneman showed participants one of two numbers: 10 or 65. Then they asked them to guess the percentage of African countries in the United Nations. The median estimate of the group shown the number 10 was 25, while the median guess from the group that saw 65 was 45.8. *Id.* In another study, participants were asked to write the last two digits of their social security number at the top of a piece of paper and then asked whether they would pay more or less than that number for various products. Roman Buric, *Anchoring Bias – Everything You Need to Know*, InsideBE, Mar. 24, 2022, https://insidebe.com/articles/anchoring-bias/ (last visited Jan. 28, 2025). The participants with social security numbers ending in a sum above

50 were willing to pay, on average, twice as much as those with numbers ending in a sum under 50. *Id.* Yet another study had judges roll dice that landed on 3 or 9 and then decide whether they would sentence a woman convicted of shoplifting to more or fewer months in prison than the number on the dice. Judges who rolled a 3 averaged a 5-month period of incarceration, while judges who rolled a 9 averaged an 8-month sentence. *Id.*

2. Anchoring in closing arguments should be prohibited under the rule against seeking a specified amount in damages.

It is easy to see how prejudicial the anchoring phenomenon can be when used by a tort plaintiff in closing argument. Non-economic damages are amorphous, making them particularly susceptible to anchoring. And plaintiffs, of course, always deliver their closing arguments first, giving them the opportunity to provide the anchoring number.

As the trial court noted when ruling on the MedStar Providers' objection to Mr. Kaplan's anchoring, this Court in *District of Columbia v. Colston*, 468 A.2d 954, 957 (D.C. 1983), acknowledged that it is improper for the parties "to suggest to the jury that it award a specific dollar amount," but refused to find per se improper an argument that offers a range of amounts while making clear that the amount of damages is up to the jury. Several cases decided after *Colston* have followed suit. *See Howard Univ. v. Roberts-Williams*, 37 A.3d 896, 912 (D.C. 2012) (declining to

find error where counsel asked the jury to determine whether plaintiff's professional reputation was worth "$300,000, $500,000, [or] $800,000" where jury did not award non-economic damages); *Hechinger Co. v. Johnson*, 761 A.2d 15, 22 (D.C. 2000) (finding no reversible error under *Colston* to say to the jury, regarding damages, "I can't tell you if it is a million dollars, if it is two million dollars, or if it is three million dollars. That is for you to decide.").

Importantly, however, this Court in *Colston* considered only whether counsel's argument was an improper golden rule argument or whether counsel asked for a "specific dollar amount." *Colston*, 468 A.2d at 957-58. So too in *Hechinger*. There the Court considered whether plaintiff's closing argument resulted in the jury awarding damages for future medical expenses and lost wages, in contravention to the court's instructions. *Hechinger*, 761 A.2d at 21. This Court has never squarely addressed whether allowing plaintiff to offer a range of specific damages figures is impermissible for the same reason that seeking one specific amount is prohibited—because it triggers the anchoring phenomenon and causes the defendant irreparable prejudice.

In fact, identifying a range of damages is improper for the same reason that counsel is prohibited from asking for a specific damages award. In *Colston*, this Court cited *Purpura v. Pub. Serv. Elec. & Gas Co.*, 147 A.2d 591, 594 (Super. Ct. App. Div. 1959), as support for the statement that it is "improper for counsel to

suggest to the jury that it award a specified dollar amount." 468 A.2d at 957. The *Purpura* Court, in turn, explained why asking for a specific dollar amount is improper: '"In cases where the damages are unliquidated and incapable of measurement by a mathematical standard, statements by plaintiffs' counsel as to the amount claimed or expected are not to be sanctioned, because they tend to instill in the minds of the jury impressions not founded upon the evidence."' *Purpura*, 147 A.2d at 594 (quoting *Botta v. Brunner*, 138 A.2d 713, 722 (N.J. 1958)) (emphasis added). "In other words, the prejudice arises not from the acceptance by the jury of the suggested figures, but from the influences upon the minds of the jurors." *Id*.

One of the cases cited by the New Jersey Supreme Court in *Botta* was *Stein v. Meyer*, 150 F.Supp. 365, 366 (E.D. Pa. 1957). In that case, the federal district court found the following closing argument "highly improper": "How much would you pay to be afflicted with a condition that you couldn't hold cups or saucers, something that is going to be permanent? Would you take it for $ 5,000? Would you take it for $ 50,000?" *Id*. While it is true that "no definite amount was mentioned," the court held, plaintiff's counsel's comment "suggested the amount to the minds of the jury almost as clearly as if counsel had stated a definite number of thousands." *Id*.

Fifteen years before Tversky and Kahneman published their ground-breaking work on heuristics, the New Jersey Supreme Court and the Eastern District of Pennsylvania understood that allowing plaintiff's counsel to suggest a range of

damages amounts was as improper and prejudicial as a request for a definite number. This Court adopted the prohibition against requesting a specific dollar amount and has twice cited to *Purpura* when doing so. *Colston*, 468 A.2d at 957; *Hechinger*, 761 A.2d at 21. This case offers the Court an opportunity to adopt the principle of *Purpura* in full and hold that the reference to any specific monetary amount in closing is improper because it improperly "anchors" the jury to those amounts.

D. The $4 million damages award is evidence that Mr. Kaplan's golden rule arguments and "anchoring" caused unfair prejudice to the MedStar Providers.

An excessive damages award is one indication that a jury was enflamed and unfairly prejudiced by improper closing arguments. *Christopher v. Florida*, 449 F.3d 1360, 1368 (11th Cir. 2006). The jury in this case awarded Mr. Kaplan $4 million for non-economic damages resulting from his bilateral hip replacements. As argued in Section III, this amount is excessive and shocks the conscience.

The jury awarded Mr. Kaplan $4 million, the very first number his counsel suggested to the jury. The jury's damages award was untethered to any reasonable calculation of Mr. Kaplan's non-economic damages and is evidence that 1) the jury was enflamed and awarded damages based on passion and emotion rather than the evidence and law; and 2) just as Mr. Kaplan's counsel intended, the jury "anchored" to the first number they heard, which caused the damages to be inflated and the MedStar Providers to be unfairly prejudiced.

III. The $4 million judgment is excessive, and the trial court abused its discretion in refusing to reduce it.

A verdict is excessive and warrants a new trial or remittitur if: 1) it "is 'beyond all reason, or . . . is so great as to shock the conscience.'" *Scott v. Crestar Fin. Corp.*, 928 A.2d 680, 688 (D.C. 2007) (quoting *Wingfield v. Peoples Drug Store, Inc.*, 379 A.2d 685, 687 (D.C. 1977)); or 2) it "is so inordinately large as to obviously exceed the maximum limit of a reasonable range within which the jury may properly operate." *Nyman v. FDIC*, 967 F. Supp. 1562, 1571 (D.C. 1997).

When determining whether a verdict is excessive, trial courts should consider that "an award of damages 'must strike a balance between ensuring that important personal rights are not lightly disregarded and avoiding extravagant awards that bear little or no relation to the actual injury involved.'" *Campbell-Crane & Assocs. v. Stamenkovic*, 44 A.3d 924, 945 (D.C. 2012) (quoting *Phillips v. District of Columbia*, 458 A.2d 722, 726 (1983). At bottom, the award "must be proportional to the harm actually suffered." *Id*. This Court reviews the denial of a request for remittitur for abuse of discretion. *George Wash. Univ. v. Violand*, 940 A.2d 965, 979 (D.C. 2008).

The trial court abused its discretion in this case because the jury's $4 million award bears no relation to Mr. Kaplan's actual injury. Mr. Kaplan had hip pain from June of 2019 through recovery from his hip surgeries in July and November of 2020. (App. 777-84). Afterwards, Mr. Kaplan testified, his level of pain was "night and

day" and he is "very grateful." (App. 787-88). His left hip is "phenomenal," Plaintiff said, and his right hip is "pretty good too[.]" (App. 788).

Mr. Kaplan has no limitations on his activities of daily living and has few restrictions on his ability to exercise and play sports. (App. 788-90). Other than high intensity running and competitive soccer, Plaintiff can do everything he did before his hip surgeries. (App. 789-90). Mr. Kaplan's only lasting effects are that he cannot cross his legs very well and he gets sore more quickly than he used to before the surgeries. (App. 891).

Mr. Kaplan testified that he missed playing competitive soccer and running, and he found it "hard to replace" those things that were very important to him. (App. 790). He also testified that he had "some embarrassment" when explaining his hip replacement to his girlfriend and that it impacted "intimate activities" with his girlfriend "a little bit." (App. 791). Nothing in this evidence justifies $4 million in non-economic damages.

George Washington Univ. v. Lawson, 745 A.2d 323 (D.C. 2000), is instructive. There, the jury awarded just under $2 million for non-economic damages after finding the hospital negligently amputated the upper portion of plaintiff's ring finger which led to tendon damage and limited use of her remaining three fingers. *Id*. at 330. Plaintiff testified that she was left with "feelings of emptiness and loss" that had affected her daily life, including her ability to work and be intimate. *Id*.

The trial court found the $2 million judgment "well out of proportion to the permanent physical and emotional injuries" sustained by the plaintiff and reduced it to $1 million. *Id*. at 331. That conclusion was affirmed by this Court. *Id*. "Admittedly an amputation of any kind is a severe injury," the Court recognized, but it said the trial court was within its discretion in reducing a judgment that was "more than four times the size of the special damages" plaintiff incurred. *Id*.

That same year, this Court found no abuse of discretion where a trial court refused to reduce a $2 million verdict for a plaintiff who sustained severe and permanent injuries, including "significant brain damage, loss of intelligence, memory and psychological and physical problems[.]" *Hechinger Co.*, 761 A.2d at 26. It was within the trial court's discretion to find that $2 million was not excessive where the plaintiff "experienced seizures, incontinence, bizarre behavior and loss of self-esteem, among other problems." *Id*.

The $2 million awards in *Lawson* and *Hechinger* are the equivalent of $3,715,023.70 in April 2024 dollars. That award was excessive for a plaintiff who, unlike Mr. Kaplan, had permanent loss of function in her fingers and impairment of her daily activities. And the award was proportionate for a plaintiff who was left with permanent and severe brain damage that dramatically affected his daily living.

An award of $4 million for a little over a year of pain followed by two surgeries that left Mr. Kaplan with no more permanent injury than a reduced ability

to cross his legs and increased soreness and inability to participate in competitive soccer and high-intensity running is "beyond all reason" and obviously exceeds "the maximum limit of a reasonable range within which the jury may properly operate." The trial court abused its discretion in refusing to reduce the judgment to an amount that is rationally related to the actual damages incurred.

CONCLUSION

For the reasons stated above, the MedStar Providers respectfully request that this Court vacate final judgment grant a new trial or reduce the judgment by $1.5 million.

Dated: January 29, 2025

Respectfully submitted,

/s/ *Derek M. Stikeleather*
Janet A. Forero (Bar No. 422014)
Derek M. Stikeleather (Bar No. 997292)
Goodell, DeVries, Leech & Dann, LLP
One South Street, 20th Floor
Baltimore, Maryland 21202
Telephone: (410) 783-4000
Fax: (410) 783-4040
jforero@gdldlaw.com
dstikeleather@gdldlaw.com

Larry D. McAfee (Bar No. 457226)
Rachel Viglianti (Bar No. 984340)
Gleason, Flynn, Emig & McAfee
11 North Washington Street, Suite 400
Rockville, Maryland 20850
(301) 294-21100
lmcafee@gleason-law.com
rviglianti@gleason-law.com

Attorneys for Appellants,
MedStar Georgetown Medical Center, Inc.,
and MMG-GI at Lafayette Center d/b/a/
MedStar Medical Group II, LLC

CERTIFICATE OF SERVICE

I CERTIFY that, on this 29th day of January 2025, a copy of the Appellants' Brief was electronically filed and served via the Court's electronic filing system upon:

Catherine D. Bertram (DC Bar #425052)
Bertram Law Group, PLLC
20 F Street, NW, 7th Floor
Washington, DC 20001
Telephone: (202) 803-5800
Counsel for Appellee

Alfred F. Belcuore (DC Bar #181560)
Law Offices of Alfred F. Belcuore
336 Constitution Avenue, N.E.
Washington, DC 20002
Telephone: (301) 367-2992
Counsel for Appellee

/s/ Derek M. Stikeleather
Derek M. Stikeleather (DC Bar #997292)

District of Columbia
Court of Appeals

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5. Any names of victims of sexual offenses except the brief may use initials when referring to victims of sexual offenses.

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Appeal No. 24-cv-0942
Case Number(s)

Derek M. Stikeleather
Name

January 29, 2025
Date

dstikeleather@gdldlaw.com
Email Address

Judgment under Uncertainty: Heuristics and Biases

Biases in judgments reveal some heuristics of thinking under uncertainty.

Amos Tversky and Daniel Kahneman

Many decisions are based on beliefs concerning the likelihood of uncertain events such as the outcome of an election, the guilt of a defendant, or the future value of the dollar. These beliefs are usually expressed in statements such as "I think that . . . ," "chances are . . . ," "it is unlikely that . . . ," and so forth. Occasionally, beliefs concerning uncertain events are expressed in numerical form as odds or subjective probabilities. What determines such beliefs? How do people assess the probability of an uncertain event or the value of an uncertain quantity? This article shows that people rely on a limited number of heuristic principles which reduce the complex tasks of assessing probabilities and predicting values to simpler judgmental operations. In general, these heuristics are quite useful, but sometimes they lead to severe and systematic errors.

The subjective assessment of probability resembles the subjective assessment of physical quantities such as distance or size. These judgments are all based on data of limited validity, which are processed according to heuristic rules. For example, the apparent distance of an object is determined in part by its clarity. The more sharply the object is seen, the closer it appears to be. This rule has some validity, because in any given scene the more distant objects are seen less sharply than nearer objects. However, the reliance on this rule leads to systematic errors in the estimation of distance. Specifically, distances are often overestimated when visibility is poor because the contours of objects are blurred. On the other hand, distances are often underestimated when visibility is good because the objects are seen sharply. Thus, the reliance on clarity as an indication of distance leads to common biases. Such biases are also found in the intuitive judgment of probability. This article describes three heuristics that are employed to assess probabilities and to predict values. Biases to which these heuristics lead are enumerated, and the applied and theoretical implications of these observations are discussed.

The authors are members of the department of psychology at the Hebrew University, Jerusalem, Israel.

Representativeness

Many of the probabilistic questions with which people are concerned belong to one of the following types: What is the probability that object A belongs to class B? What is the probability that event A originates from process B? What is the probability that process B will generate event A? In answering such questions, people typically rely on the representativeness heuristic, in which probabilities are evaluated by the degree to which A is representative of B, that is, by the degree to which A resembles B. For example, when A is highly representative of B, the probability that A originates from B is judged to be high. On the other hand, if A is not similar to B, the probability that A originates from B is judged to be low.

For an illustration of judgment by representativeness, consider an individual who has been described by a former neighbor as follows: "Steve is very shy and withdrawn, invariably helpful, but with little interest in people, or in the world of reality. A meek and tidy soul, he has a need for order and structure, and a passion for detail." How do people assess the probability that Steve is engaged in a particular occupation from a list of possibilities (for example, farmer, salesman, airline pilot, librarian, or physician)? How do people order these occupations from most to least likely? In the representativeness heuristic, the probability that Steve is a librarian, for example, is assessed by the degree to which he is representative of, or similar to, the stereotype of a librarian. Indeed, research with problems of this type has shown that people order the occupations by probability and by similarity in exactly the same way (*1*). This approach to the judgment of probability leads to serious errors, because similarity, or representativeness, is not influenced by several factors that should affect judgments of probability.

Insensitivity to prior probability of outcomes. One of the factors that have no effect on representativeness but should have a major effect on probability is the prior probability, or base-rate frequency, of the outcomes. In the case of Steve, for example, the fact that there are many more farmers than librarians in the population should enter into any reasonable estimate of the probability that Steve is a librarian rather than a farmer. Considerations of base-rate frequency, however, do not affect the similarity of Steve to the stereotypes of librarians and farmers. If people evaluate probability by representativeness, therefore, prior probabilities will be neglected. This hypothesis was tested in an experiment where prior probabilities were manipulated (*1*). Subjects were shown brief personality descriptions of several individuals, allegedly sampled at random from a group of 100 professionals—engineers and lawyers. The subjects were asked to assess, for each description, the probability that it belonged to an engineer rather than to a lawyer. In one experimental condition, subjects were told that the group from which the descriptions had been drawn consisted of 70 engineers and 30 lawyers. In another condition, subjects were told that the group consisted of 30 engineers and 70 lawyers. The odds that any particular description belongs to an engineer rather than to a lawyer should be higher in the first condition, where there is a majority of engineers, than in the second condition, where there is a majority of lawyers. Specifically, it can be shown by applying Bayes' rule that the ratio of these odds should be $(.7/.3)^2$, or 5.44, for each description. In a sharp violation of Bayes' rule, the subjects in the two conditions produced essen-

tially the same probability judgments. Apparently, subjects evaluated the likelihood that a particular description belonged to an engineer rather than to a lawyer by the degree to which this description was representative of the two stereotypes, with little or no regard for the prior probabilities of the categories.

The subjects used prior probabilities correctly when they had no other information. In the absence of a personality sketch, they judged the probability that an unknown individual is an engineer to be .7 and .3, respectively, in the two base-rate conditions. However, prior probabilities were effectively ignored when a description was introduced, even when this description was totally uninformative. The responses to the following description illustrate this phenomenon:

> Dick is a 30 year old man. He is married with no children. A man of high ability and high motivation, he promises to be quite successful in his field. He is well liked by his colleagues.

This description was intended to convey no information relevant to the question of whether Dick is an engineer or a lawyer. Consequently, the probability that Dick is an engineer should equal the proportion of engineers in the group, as if no description had been given. The subjects, however, judged the probability of Dick being an engineer to be .5 regardless of whether the stated proportion of engineers in the group was .7 or .3. Evidently, people respond differently when given no evidence and when given worthless evidence. When no specific evidence is given, prior probabilities are properly utilized; when worthless evidence is given, prior probabilities are ignored (*1*).

Insensitivity to sample size. To evaluate the probability of obtaining a particular result in a sample drawn from a specified population, people typically apply the representativeness heuristic. That is, they assess the likelihood of a sample result, for example, that the average height in a random sample of ten men will be 6 feet (180 centimeters), by the similarity of this result to the corresponding parameter (that is, to the average height in the population of men). The similarity of a sample statistic to a population parameter does not depend on the size of the sample. Consequently, if probabilities are assessed by representativeness, then the judged probability of a sample statistic will be essentially independent of sample size. Indeed, when subjects assessed the distributions of average height for samples of various sizes, they produced identical distributions. For example, the probability of obtaining an average height greater than 6 feet was assigned the same value for samples of 1000, 100, and 10 men (*2*). Moreover, subjects failed to appreciate the role of sample size even when it was emphasized in the formulation of the problem. Consider the following question:

> A certain town is served by two hospitals. In the larger hospital about 45 babies are born each day, and in the smaller hospital about 15 babies are born each day. As you know, about 50 percent of all babies are boys. However, the exact percentage varies from day to day. Sometimes it may be higher than 50 percent, sometimes lower.
>
> For a period of 1 year, each hospital recorded the days on which more than 60 percent of the babies born were boys. Which hospital do you think recorded more such days?
>
> ► The larger hospital (21)
> ► The smaller hospital (21)
> ► About the same (that is, within 5 percent of each other) (53)

The values in parentheses are the number of undergraduate students who chose each answer.

Most subjects judged the probability of obtaining more than 60 percent boys to be the same in the small and in the large hospital, presumably because these events are described by the same statistic and are therefore equally representative of the general population. In contrast, sampling theory entails that the expected number of days on which more than 60 percent of the babies are boys is much greater in the small hospital than in the large one, because a large sample is less likely to stray from 50 percent. This fundamental notion of statistics is evidently not part of people's repertoire of intuitions.

A similar insensitivity to sample size has been reported in judgments of posterior probability, that is, of the probability that a sample has been drawn from one population rather than from another. Consider the following example:

> Imagine an urn filled with balls, of which ⅔ are of one color and ⅓ of another. One individual has drawn 5 balls from the urn, and found that 4 were red and 1 was white Another individual has drawn 20 balls and found that 12 were red and 8 were white. Which of the two individuals should feel more confident that the urn contains ⅔ red balls and ⅓ white balls, rather than the opposite? What odds should each individual give?

In this problem, the correct posterior odds are 8 to 1 for the 4 : 1 sample and 16 to 1 for the 12 : 8 sample, assuming equal prior probabilities. However, most people feel that the first sample provides much stronger evidence for the hypothesis that the urn is predominantly red, because the proportion of red balls is larger in the first than in the second sample. Here again, intuitive judgments are dominated by the sample proportion and are essentially unaffected by the size of the sample, which plays a crucial role in the determination of the actual posterior odds (*2*). In addition, intuitive estimates of posterior odds are far less extreme than the correct values. The underestimation of the impact of evidence has been observed repeatedly in problems of this type (*3*, *4*). It has been labeled "conservatism."

Misconceptions of chance. People expect that a sequence of events generated by a random process will represent the essential characteristics of that process even when the sequence is short. In considering tosses of a coin for heads or tails, for example, people regard the sequence H-T-H-T-T-H to be more likely than the sequence H-H-H-T-T-T, which does not appear random, and also more likely than the sequence H-H-H-H-T-H, which does not represent the fairness of the coin (*2*). Thus, people expect that the essential characteristics of the process will be represented, not only globally in the entire sequence, but also locally in each of its parts. A locally representative sequence, however, deviates systematically from chance expectation: it contains too many alternations and too few runs. Another consequence of the belief in local representativeness is the well-known gambler's fallacy. After observing a long run of red on the roulette wheel. for example, most people erroneously believe that black is now due, presumably because the occurrence of black will result in a more representative sequence than the occurrence of an additional red. Chance is commonly viewed as a self-correcting process in which a deviation in one direction induces a deviation in the opposite direction to restore the equilibrium. In fact, deviations are not "corrected" as a chance process unfolds, they are merely diluted.

Misconceptions of chance are not limited to naive subjects. A study of the statistical intuitions of experienced research psychologists (*5*) revealed a lingering belief in what may be called the "law of small numbers," according to which even small samples are highly

representative of the populations from which they are drawn. The responses of these investigators reflected the expectation that a valid hypothesis about a population will be represented by a statistically significant result in a sample—with little regard for its size. As a consequence, the researchers put too much faith in the results of small samples and grossly overestimated the replicability of such results. In the actual conduct of research, this bias leads to the selection of samples of inadequate size and to overinterpretation of findings.

Insensitivity to predictability. People are sometimes called upon to make such numerical predictions as the future value of a stock, the demand for a commodity, or the outcome of a football game. Such predictions are often made by representativeness. For example, suppose one is given a description of a company and is asked to predict its future profit. If the description of the company is very favorable, a very high profit will appear most representative of that description; if the description is mediocre, a mediocre performance will appear most representative. The degree to which the description is favorable is unaffected by the reliability of that description or by the degree to which it permits accurate prediction. Hence, if people predict solely in terms of the favorableness of the description, their predictions will be insensitive to the reliability of the evidence and to the expected accuracy of the prediction.

This mode of judgment violates the normative statistical theory in which the extremeness and the range of predictions are controlled by considerations of predictability. When predictability is nil, the same prediction should be made in all cases. For example, if the descriptions of companies provide no information relevant to profit, then the same value (such as average profit) should be predicted for all companies. If predictability is perfect, of course, the values predicted will match the actual values and the range of predictions will equal the range of outcomes. In general, the higher the predictability, the wider the range of predicted values.

Several studies of numerical prediction have demonstrated that intuitive predictions violate this rule, and that subjects show little or no regard for considerations of predictability (*1*). In one of these studies, subjects were presented with several paragraphs, each describing the performance of a student teacher during a particular practice lesson. Some subjects were asked to *evaluate* the quality of the lesson described in the paragraph in percentile scores, relative to a specified population. Other subjects were asked to *predict*, also in percentile scores, the standing of each student teacher 5 years after the practice lesson. The judgments made under the two conditions were identical. That is, the prediction of a remote criterion (success of a teacher after 5 years) was identical to the evaluation of the information on which the prediction was based (the quality of the practice lesson). The students who made these predictions were undoubtedly aware of the limited predictability of teaching competence on the basis of a single trial lesson 5 years earlier; nevertheless, their predictions were as extreme as their evaluations.

The illusion of validity. As we have seen, people often predict by selecting the outcome (for example, an occupation) that is most representative of the input (for example, the description of a person). The confidence they have in their prediction depends primarily on the degree of representativeness (that is, on the quality of the match between the selected outcome and the input) with little or no regard for the factors that limit predictive accuracy. Thus, people express great confidence in the prediction that a person is a librarian when given a description of his personality which matches the stereotype of librarians, even if the description is scanty, unreliable, or outdated. The unwarranted confidence which is produced by a good fit between the predicted outcome and the input information may be called the illusion of validity. This illusion persists even when the judge is aware of the factors that limit the accuracy of his predictions. It is a common observation that psychologists who conduct selection interviews often experience considerable confidence in their predictions, even when they know of the vast literature that shows selection interviews to be highly fallible. The continued reliance on the clinical interview for selection, despite repeated demonstrations of its inadequacy, amply attests to the strength of this effect.

The internal consistency of a pattern of inputs is a major determinant of one's confidence in predictions based on these inputs. For example, people express more confidence in predicting the final grade-point average of a student whose first-year record consists entirely of B's than in predicting the grade-point average of a student whose first-year record includes many A's and C's. Highly consistent patterns are most often observed when the input variables are highly redundant or correlated. Hence, people tend to have great confidence in predictions based on redundant input variables. However, an elementary result in the statistics of correlation asserts that, given input variables of stated validity, a prediction based on several such inputs can achieve higher accuracy when they are independent of each other than when they are redundant or correlated. Thus, redundancy among inputs decreases accuracy even as it increases confidence, and people are often confident in predictions that are quite likely to be off the mark (*1*).

Misconceptions of regression. Suppose a large group of children has been examined on two equivalent versions of an aptitude test. If one selects ten children from among those who did best on one of the two versions, he will usually find their performance on the second version to be somewhat disappointing. Conversely, if one selects ten children from among those who did worst on one version, they will be found, on the average, to do somewhat better on the other version. More generally, consider two variables X and Y which have the same distribution. If one selects individuals whose average X score deviates from the mean of X by k units, then the average of their Y scores will usually deviate from the mean of Y by less than k units. These observations illustrate a general phenomenon known as regression toward the mean, which was first documented by Galton more than 100 years ago.

In the normal course of life, one encounters many instances of regression toward the mean, in the comparison of the height of fathers and sons, of the intelligence of husbands and wives, or of the performance of individuals on consecutive examinations. Nevertheless, people do not develop correct intuitions about this phenomenon. First, they do not expect regression in many contexts where it is bound to occur. Second, when they recognize the occurrence of regression, they often invent spurious causal explanations for it (*1*). We suggest that the phenomenon of regression remains elusive because it is incompatible with the belief that the predicted outcome should be maximally

representative of the input, and, hence, that the value of the outcome variable should be as extreme as the value of the input variable.

The failure to recognize the import of regression can have pernicious consequences, as illustrated by the following observation (*1*). In a discussion of flight training, experienced instructors noted that praise for an exceptionally smooth landing is typically followed by a poorer landing on the next try, while harsh criticism after a rough landing is usually followed by an improvement on the next try. The instructors concluded that verbal rewards are detrimental to learning, while verbal punishments are beneficial, contrary to accepted psychological doctrine. This conclusion is unwarranted because of the presence of regression toward the mean. As in other cases of repeated examination, an improvement will usually follow a poor performance and a deterioration will usually follow an outstanding performance, even if the instructor does not respond to the trainee's achievement on the first attempt. Because the instructors had praised their trainees after good landings and admonished them after poor ones, they reached the erroneous and potentially harmful conclusion that punishment is more effective than reward.

Thus, the failure to understand the effect of regression leads one to overestimate the effectiveness of punishment and to underestimate the effectiveness of reward. In social interaction, as well as in training, rewards are typically administered when performance is good, and punishments are typically administered when performance is poor. By regression alone, therefore, behavior is most likely to improve after punishment and most likely to deteriorate after reward. Consequently, the human condition is such that, by chance alone, one is most often rewarded for punishing others and most often punished for rewarding them. People are generally not aware of this contingency. In fact, the elusive role of regression in determining the apparent consequences of reward and punishment seems to have escaped the notice of students of this area.

Availability

There are situations in which people assess the frequency of a class or the probability of an event by the ease with which instances or occurrences can be brought to mind. For example, one may assess the risk of heart attack among middle-aged people by recalling such occurrences among one's acquaintances. Similarly, one may evaluate the probability that a given business venture will fail by imagining various difficulties it could encounter. This judgmental heuristic is called availability. Availability is a useful clue for assessing frequency or probability, because instances of large classes are usually recalled better and faster than instances of less frequent classes. However, availability is affected by factors other than frequency and probability. Consequently, the reliance on availability leads to predictable biases, some of which are illustrated below.

Biases due to the retrievability of instances. When the size of a class is judged by the availability of its instances, a class whose instances are easily retrieved will appear more numerous than a class of equal frequency whose instances are less retrievable. In an elementary demonstration of this effect, subjects heard a list of well-known personalities of both sexes and were subsequently asked to judge whether the list contained more names of men than of women. Different lists were presented to different groups of subjects. In some of the lists the men were relatively more famous than the women, and in others the women were relatively more famous than the men. In each of the lists, the subjects erroneously judged that the class (sex) that had the more famous personalities was the more numerous (*6*).

In addition to familiarity, there are other factors, such as salience, which affect the retrievability of instances. For example, the impact of seeing a house burning on the subjective probability of such accidents is probably greater than the impact of reading about a fire in the local paper. Furthermore, recent occurrences are likely to be relatively more available than earlier occurrences. It is a common experience that the subjective probability of traffic accidents rises temporarily when one sees a car overturned by the side of the road.

Biases due to the effectiveness of a search set. Suppose one samples a word (of three letters or more) at random from an English text. Is it more likely that the word starts with r or that r is the third letter? People approach this problem by recalling words that begin with r (road) and words that have r in the third position (car) and assess the relative frequency by the ease with which words of the two types come to mind. Because it is much easier to search for words by their first letter than by their third letter, most people judge words that begin with a given consonant to be more numerous than words in which the same consonant appears in the third position. They do so even for consonants, such as r or k, that are more frequent in the third position than in the first (*6*).

Different tasks elicit different search sets. For example, suppose you are asked to rate the frequency with which abstract words (thought, love) and concrete words (door, water) appear in written English. A natural way to answer this question is to search for contexts in which the word could appear. It seems easier to think of contexts in which an abstract concept is mentioned (love in love stories) than to think of contexts in which a concrete word (such as door) is mentioned. If the frequency of words is judged by the availability of the contexts in which they appear, abstract words will be judged as relatively more numerous than concrete words. This bias has been observed in a recent study (*7*) which showed that the judged frequency of occurrence of abstract words was much higher than that of concrete words, equated in objective frequency. Abstract words were also judged to appear in a much greater variety of contexts than concrete words.

Biases of imaginability. Sometimes one has to assess the frequency of a class whose instances are not stored in memory but can be generated according to a given rule. In such situations, one typically generates several instances and evaluates frequency or probability by the ease with which the relevant instances can be constructed. However, the ease of constructing instances does not always reflect their actual frequency, and this mode of evaluation is prone to biases. To illustrate, consider a group of 10 people who form committees of k members, $2 \leqslant k \leqslant 8$. How many different committees of k members can be formed? The correct answer to this problem is given by the binomial coefficient $\binom{10}{k}$ which reaches a maximum of 252 for $k = 5$. Clearly, the number of committees of k members equals the number of committees of $(10 - k)$ members, because any committee of k

members defines a unique group of $(10 - k)$ nonmembers.

One way to answer this question without computation is to mentally construct committees of k members and to evaluate their number by the ease with which they come to mind. Committees of few members, say 2, are more available than committees of many members, say 8. The simplest scheme for the construction of committees is a partition of the group into disjoint sets. One readily sees that it is easy to construct five disjoint committees of 2 members, while it is impossible to generate even two disjoint committees of 8 members. Consequently, if frequency is assessed by imaginability, or by availability for construction, the small committees will appear more numerous than larger committees, in contrast to the correct bell-shaped function. Indeed, when naive subjects were asked to estimate the number of distinct committees of various sizes, their estimates were a decreasing monotonic function of committee size (*6*). For example, the median estimate of the number of committees of 2 members was 70, while the estimate for committees of 8 members was 20 (the correct answer is 45 in both cases).

Imaginability plays an important role in the evaluation of probabilities in real-life situations. The risk involved in an adventurous expedition, for example, is evaluated by imagining contingencies with which the expedition is not equipped to cope. If many such difficulties are vividly portrayed, the expedition can be made to appear exceedingly dangerous, although the ease with which disasters are imagined need not reflect their actual likelihood. Conversely, the risk involved in an undertaking may be grossly underestimated if some possible dangers are either difficult to conceive of, or simply do not come to mind.

Illusory correlation. Chapman and Chapman (*8*) have described an interesting bias in the judgment of the frequency with which two events co-occur. They presented naive judges with information concerning several hypothetical mental patients. The data for each patient consisted of a clinical diagnosis and a drawing of a person made by the patient. Later the judges estimated the frequency with which each diagnosis (such as paranoia or suspiciousness) had been accompanied by various features of the drawing (such as peculiar eyes). The subjects markedly overestimated the frequency of co-occurrence of natural associates, such as suspiciousness and peculiar eyes. This effect was labeled illusory correlation. In their erroneous judgments of the data to which they had been exposed, naive subjects "rediscovered" much of the common, but unfounded, clinical lore concerning the interpretation of the draw-a-person test. The illusory correlation effect was extremely resistant to contradictory data. It persisted even when the correlation between symptom and diagnosis was actually negative, and it prevented the judges from detecting relationships that were in fact present.

Availability provides a natural account for the illusory-correlation effect. The judgment of how frequently two events co-occur could be based on the strength of the associative bond between them. When the association is strong, one is likely to conclude that the events have been frequently paired. Consequently, strong associates will be judged to have occurred together frequently. According to this view, the illusory correlation between suspiciousness and peculiar drawing of the eyes, for example, is due to the fact that suspiciousness is more readily associated with the eyes than with any other part of the body.

Lifelong experience has taught us that, in general, instances of large classes are recalled better and faster than instances of less frequent classes; that likely occurrences are easier to imagine than unlikely ones; and that the associative connections between events are strengthened when the events frequently co-occur. As a result, man has at his disposal a procedure (the availability heuristic) for estimating the numerosity of a class, the likelihood of an event, or the frequency of co-occurrences, by the ease with which the relevant mental operations of retrieval, construction, or association can be performed. However, as the preceding examples have demonstrated, this valuable estimation procedure results in systematic errors.

Adjustment and Anchoring

In many situations, people make estimates by starting from an initial value that is adjusted to yield the final answer. The initial value, or starting point, may be suggested by the formulation of the problem, or it may be the result of a partial computation. In either case, adjustments are typically insufficient (*4*). That is, different starting points yield different estimates, which are biased toward the initial values. We call this phenomenon anchoring.

Insufficient adjustment. In a demonstration of the anchoring effect, subjects were asked to estimate various quantities, stated in percentages (for example, the percentage of African countries in the United Nations). For each quantity, a number between 0 and 100 was determined by spinning a wheel of fortune in the subjects' presence. The subjects were instructed to indicate first whether that number was higher or lower than the value of the quantity, and then to estimate the value of the quantity by moving upward or downward from the given number. Different groups were given different numbers for each quantity, and these arbitrary numbers had a marked effect on estimates. For example, the median estimates of the percentage of African countries in the United Nations were 25 and 45 for groups that received 10 and 65, respectively, as starting points. Payoffs for accuracy did not reduce the anchoring effect.

Anchoring occurs not only when the starting point is given to the subject, but also when the subject bases his estimate on the result of some incomplete computation. A study of intuitive numerical estimation illustrates this effect. Two groups of high school students estimated, within 5 seconds, a numerical expression that was written on the blackboard. One group estimated the product

$$8 \times 7 \times 6 \times 5 \times 4 \times 3 \times 2 \times 1$$

while another group estimated the product

$$1 \times 2 \times 3 \times 4 \times 5 \times 6 \times 7 \times 8$$

To rapidly answer such questions, people may perform a few steps of computation and estimate the product by extrapolation or adjustment. Because adjustments are typically insufficient, this procedure should lead to underestimation. Furthermore, because the result of the first few steps of multiplication (performed from left to right) is higher in the descending sequence than in the ascending sequence, the former expression should be judged larger than the latter. Both predictions were confirmed. The median estimate for the ascending sequence was 512, while the median estimate for the descending sequence was 2,250. The correct answer is 40,320.

Biases in the evaluation of conjunctive and disjunctive events. In a recent

study by Bar-Hillel (*9*) subjects were given the opportunity to bet on one of two events. Three types of events were used: (i) simple events, such as drawing a red marble from a bag containing 50 percent red marbles and 50 percent white marbles; (ii) conjunctive events, such as drawing a red marble seven times in succession, with replacement, from a bag containing 90 percent red marbles and 10 percent white marbles; and (iii) disjunctive events, such as drawing a red marble at least once in seven successive tries, with replacement, from a bag containing 10 percent red marbles and 90 percent white marbles. In this problem, a significant majority of subjects preferred to bet on the conjunctive event (the probability of which is .48) rather than on the simple event (the probability of which is .50). Subjects also preferred to bet on the simple event rather than on the disjunctive event, which has a probability of .52. Thus, most subjects bet on the less likely event in both comparisons. This pattern of choices illustrates a general finding. Studies of choice among gambles and of judgments of probability indicate that people tend to overestimate the probability of conjunctive events (*10*) and to underestimate the probability of disjunctive events. These biases are readily explained as effects of anchoring. The stated probability of the elementary event (success at any one stage) provides a natural starting point for the estimation of the probabilities of both conjunctive and disjunctive events. Since adjustment from the starting point is typically insufficient, the final estimates remain too close to the probabilities of the elementary events in both cases. Note that the overall probability of a conjunctive event is lower than the probability of each elementary event, whereas the overall probability of a disjunctive event is higher than the probability of each elementary event. As a consequence of anchoring, the overall probability will be overestimated in conjunctive problems and underestimated in disjunctive problems.

Biases in the evaluation of compound events are particularly significant in the context of planning. The successful completion of an undertaking, such as the development of a new product, typically has a conjunctive character: for the undertaking to succeed, each of a series of events must occur. Even when each of these events is very likely, the overall probability of success can be quite low if the number of events is large. The general tendency to overestimate the probability of conjunctive events leads to unwarranted optimism in the evaluation of the likelihood that a plan will succeed or that a project will be completed on time. Conversely, disjunctive structures are typically encountered in the evaluation of risks. A complex system, such as a nuclear reactor or a human body, will malfunction if any of its essential components fails. Even when the likelihood of failure in each component is slight, the probability of an overall failure can be high if many components are involved. Because of anchoring, people will tend to underestimate the probabilities of failure in complex systems. Thus, the direction of the anchoring bias can sometimes be inferred from the structure of the event. The chain-like structure of conjunctions leads to overestimation, the funnel-like structure of disjunctions leads to underestimation.

Anchoring in the assessment of subjective probability distributions. In decision analysis, experts are often required to express their beliefs about a quantity, such as the value of the Dow-Jones average on a particular day, in the form of a probability distribution. Such a distribution is usually constructed by asking the person to select values of the quantity that correspond to specified percentiles of his subjective probability distribution. For example, the judge may be asked to select a number, X_{90}, such that his subjective probability that this number will be higher than the value of the Dow-Jones average is .90. That is, he should select the value X_{90} so that he is just willing to accept 9 to 1 odds that the Dow-Jones average will not exceed it. A subjective probability distribution for the value of the Dow-Jones average can be constructed from several such judgments corresponding to different percentiles.

By collecting subjective probability distributions for many different quantities, it is possible to test the judge for proper calibration. A judge is properly (or externally) calibrated in a set of problems if exactly Π percent of the true values of the assessed quantities falls below his stated values of X_Π. For example, the true values should fall below X_{01} for 1 percent of the quantities and above X_{99} for 1 percent of the quantities. Thus, the true values should fall in the confidence interval between X_{01} and X_{99} on 98 percent of the problems.

Several investigators (*11*) have obtained probability distributions for many quantities from a large number of judges. These distributions indicated large and systematic departures from proper calibration. In most studies, the actual values of the assessed quantities are either smaller than X_{01} or greater than X_{99} for about 30 percent of the problems. That is, the subjects state overly narrow confidence intervals which reflect more certainty than is justified by their knowledge about the assessed quantities. This bias is common to naive and to sophisticated subjects, and it is not eliminated by introducing proper scoring rules, which provide incentives for external calibration. This effect is attributable, in part at least, to anchoring.

To select X_{90} for the value of the Dow-Jones average, for example, it is natural to begin by thinking about one's best estimate of the Dow-Jones and to adjust this value upward. If this adjustment—like most others—is insufficient, then X_{90} will not be sufficiently extreme. A similar anchoring effect will occur in the selection of X_{10}, which is presumably obtained by adjusting one's best estimate downward. Consequently, the confidence interval between X_{10} and X_{90} will be too narrow, and the assessed probability distribution will be too tight. In support of this interpretation it can be shown that subjective probabilities are systematically altered by a procedure in which one's best estimate does not serve as an anchor.

Subjective probability distributions for a given quantity (the Dow-Jones average) can be obtained in two different ways: (i) by asking the subject to select values of the Dow-Jones that correspond to specified percentiles of his probability distribution and (ii) by asking the subject to assess the probabilities that the true value of the Dow-Jones will exceed some specified values. The two procedures are formally equivalent and should yield identical distributions. However, they suggest different modes of adjustment from differcent anchors. In procedure (i), the natural starting point is one's best estimate of the quantity. In procedure (ii), on the other hand, the subject may be anchored on the value stated in the question. Alternatively, he may be anchored on even odds, or 50-50 chances, which is a natural starting point in the estimation of likelihood. In either case, procedure (ii) should yield less extreme odds than procedure (i).

To contrast the two procedures, a set of 24 quantities (such as the air dis-

tance from New Delhi to Peking) was presented to a group of subjects who assessed either X_{10} or X_{90} for each problem. Another group of subjects received the median judgment of the first group for each of the 24 quantities. They were asked to assess the odds that each of the given values exceeded the true value of the relevant quantity. In the absence of any bias, the second group should retrieve the odds specified to the first group, that is, 9 : 1. However, if even odds or the stated value serve as anchors, the odds of the second group should be less extreme, that is, closer to 1 : 1. Indeed, the median odds stated by this group, across all problems, were 3 : 1. When the judgments of the two groups were tested for external calibration, it was found that subjects in the first group were too extreme, in accord with earlier studies. The events that they defined as having a probability of .10 actually obtained in 24 percent of the cases. In contrast, subjects in the second group were too conservative. Events to which they assigned an average probability of .34 actually obtained in 26 percent of the cases. These results illustrate the manner in which the degree of calibration depends on the procedure of elicitation.

Discussion

This article has been concerned with cognitive biases that stem from the reliance on judgmental heuristics. These biases are not attributable to motivational effects such as wishful thinking or the distortion of judgments by payoffs and penalties. Indeed, several of the severe errors of judgment reported earlier occurred despite the fact that subjects were encouraged to be accurate and were rewarded for the correct answers (*2, 6*).

The reliance on heuristics and the prevalence of biases are not restricted to laymen. Experienced researchers are also prone to the same biases—when they think intuitively. For example, the tendency to predict the outcome that best represents the data, with insufficient regard for prior probability, has been observed in the intuitive judgments of individuals who have had extensive training in statistics (*1, 5*). Although the statistically sophisticated avoid elementary errors, such as the gambler's fallacy, their intuitive judgments are liable to similar fallacies in more intricate and less transparent problems.

It is not surprising that useful heuristics such as representativeness and availability are retained, even though they occasionally lead to errors in prediction or estimation. What is perhaps surprising is the failure of people to infer from lifelong experience such fundamental statistical rules as regression toward the mean, or the effect of sample size on sampling variability. Although everyone is exposed, in the normal course of life, to numerous examples from which these rules could have been induced, very few people discover the principles of sampling and regression on their own. Statistical principles are not learned from everyday experience because the relevant instances are not coded appropriately. For example, people do not discover that successive lines in a text differ more in average word length than do successive pages, because they simply do not attend to the average word length of individual lines or pages. Thus, people do not learn the relation between sample size and sampling variability, although the data for such learning are abundant.

The lack of an appropriate code also explains why people usually do not detect the biases in their judgments of probability. A person could conceivably learn whether his judgments are externally calibrated by keeping a tally of the proportion of events that actually occur among those to which he assigns the same probability. However, it is not natural to group events by their judged probability. In the absence of such grouping it is impossible for an individual to discover, for example, that only 50 percent of the predictions to which he has assigned a probability of .9 or higher actually came true.

The empirical analysis of cognitive biases has implications for the theoretical and applied role of judged probabilities. Modern decision theory (*12, 13*) regards subjective probability as the quantified opinion of an idealized person. Specifically, the subjective probability of a given event is defined by the set of bets about this event that such a person is willing to accept. An internally consistent, or coherent, subjective probability measure can be derived for an individual if his choices among bets satisfy certain principles, that is, the axioms of the theory. The derived probability is subjective in the sense that different individuals are allowed to have different probabilities for the same event. The major contribution of this approach is that it provides a rigorous subjective interpretation of probability that is applicable to unique events and is embedded in a general theory of rational decision.

It should perhaps be noted that, while subjective probabilities can sometimes be inferred from preferences among bets, they are normally not formed in this fashion. A person bets on team A rather than on team B because he believes that team A is more likely to win; he does not infer this belief from his betting preferences. Thus, in reality, subjective probabilities determine preferences among bets and are not derived from them, as in the axiomatic theory of rational decision (*12*).

The inherently subjective nature of probability has led many students to the belief that coherence, or internal consistency, is the only valid criterion by which judged probabilities should be evaluated. From the standpoint of the formal theory of subjective probability, any set of internally consistent probability judgments is as good as any other. This criterion is not entirely satisfactory, because an internally consistent set of subjective probabilities can be incompatible with other beliefs held by the individual. Consider a person whose subjective probabilities for all possible outcomes of a coin-tossing game reflect the gambler's fallacy. That is, his estimate of the probability of tails on a particular toss increases with the number of consecutive heads that preceded that toss. The judgments of such a person could be internally consistent and therefore acceptable as adequate subjective probabilities according to the criterion of the formal theory. These probabilities, however, are incompatible with the generally held belief that a coin has no memory and is therefore incapable of generating sequential dependencies. For judged probabilities to be considered adequate, or rational, internal consistency is not enough. The judgments must be compatible with the entire web of beliefs held by the individual. Unfortunately, there can be no simple formal procedure for assessing the compatibility of a set of probability judgments with the judge's total system of beliefs. The rational judge will nevertheless strive for compatibility, even though internal consistency is more easily achieved and assessed. In particular, he will attempt to make his probability judgments compatible with his knowledge about the subject matter, the laws of probability, and his own judgmental heuristics and biases.

Summary

This article described three heuristics that are employed in making judgments under uncertainty: (i) representativeness, which is usually employed when people are asked to judge the probability that an object or event A belongs to class or process B; (ii) availability of instances or scenarios, which is often employed when people are asked to assess the frequency of a class or the plausibility of a particular development; and (iii) adjustment from an anchor, which is usually employed in numerical prediction when a relevant value is available. These heuristics are highly economical and usually effective, but they lead to systematic and predictable errors. A better understanding of these heuristics and of the biases to which they lead could improve judgments and decisions in situations of uncertainty.

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Rural Health Care in Mexico?

Present educational and administrative structures must be changed in order to improve health care in rural areas.

Luis Cañedo

The present health care structure in Mexico focuses attention on the urban population, leaving the rural communities practically unattended. There are two main factors contributing to this situation. One is the lack of coordination among the different institutions responsible for the health of the community and among the educational institutions. The other is the lack of information concerning the nature of the problems in rural areas. In an attempt to provide a solution to these problems, a program has been designed that takes into consideration the environmental conditions, malnutrition, poverty, and negative cultural factors that are responsible for the high incidences of certain diseases among rural populations. It is based on the development of a national information system for the collection and dissemination of information related to general, as well as rural, health care, that will provide the basis for a national health care system, and depends on the establishment of a training program for professionals in community medicine.

The continental and insular area of Mexico, including interior waters, is 2,022,058 square kilometers (*1*, *2*). In 1970 the population of Mexico was 48,377,363, of which 24,055,305 persons (49.7 percent) were under 15 years of age. The Indian population made up 7.9 percent of the total (*2*, *3*). As indicated in Table 1, 42.3 percent of the total population live in communities of less than 2,500 inhabitants, and in such communities public services as well as means of communication are very scarce or nonexistent. A large percentage (39.5 percent) of the economically active population is engaged in agriculture (*4*).

The country's population growth rate is high, 3.5 percent annually, and it seems to depend on income, being higher among the 50 percent of the population earning less than 675 pesos ($50) per family per month (*5*). The majority of this population lives in the rural areas. The most frequent causes of mortality in rural areas are malnutrition, infectious and parasitic diseases (*6*, *7*), pregnancy complications, and accidents (*2*). In 1970 there were 34,107 doctors in Mexico (*2*). The ratio of inhabitants to doctors, which is 1423.7, is not a representative index of the actual distribution of resources because there is a great scarcity of health professionals in rural areas and a high concentration in urban areas (Fig. 1) (*7*, *8*).

In order to improve health at a national level, this situation must be changed. The errors made in previous attempts to improve health care must be avoided, and use must be made of the available manpower and resources of modern science to produce feasible answers at the community level. Although the main objective of a specialist in community medicine is to control disease, such control cannot be achieved unless action is taken against the underlying causes of disease; it has already been observed that partial solutions are inefficient (*9*). As a background to this new program that has been designed to provide health care in rural communities, I shall first give a summary of the previous attempts that have been made to provide such care, describing the various medical institutions and other organizations that are responsible for the training of medical personnel and for constructing the facilities required for health care.

The author is an investigator in the department of molecular biology at the Instituto de Investigaciones Biomédicas, Universidad Nacional Autónoma de México, Ciudad Universitaria, México 20, D.F. This article is adapted from a paper presented at the meeting on Science and Man in the Americas, jointly organized by the Consejo Nacional de Ciencia y Tecnologia de México and the American Association for the Advancement of Science and held in Mexico City, 20 June to 4 July 1973.

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ARTICLE: COMFORTABLY NUMB: MEDICALIZING (AND MITIGATING) PAIN-AND-SUFFERING DAMAGES

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Author: Lars Noah*

* Professor of Law, Univ. of Florida. An earlier version of this Article was presented to the faculty at Vanderbilt, and I would like to thank those in attendance for their feedback. My title alludes to a well-known song of that name from Pink Floyd's album The Wall (Columbia Records 1979). Cf. Alex B. Long, Insert Song Lyrics Here: The Uses and Misuses of Popular Music Lyrics in Legal Writing, *64 Wash. & Lee L. Rev. 531, 540, 570 (2007)* (noting the relative dearth of references to Pink Floyd).

Highlight

It has been said, "time heals all wounds." I do not agree. The wounds remain. In time, the mind, protecting its sanity, covers them with scar tissue and the pain lessens. But it is never gone.

- Rose F. Kennedy (1974)

Text

[*431]

I. Introduction

Among the compensatory damages that a plaintiff may recover in tort litigation, awards for pain and suffering have attracted the most attention. Attorneys, judges, legislators, and scholars from various disciplines long have struggled to measure and make sense of this aspect of compensation for tortiously caused injuries. With the steady expansion of what falls within the rubric of nonpecuniary damages and in the types of claims eligible for such awards, to say nothing of the growth in the absolute and relative size of this portion of compensatory awards, pain-and-suffering damages have become increasingly controversial.

Although it canvasses the competing arguments about this subject and accompanying proposals for reform, this Article ultimately sidesteps much of the debate in order to offer a fairly modest set of suggestions for better understanding and perhaps more sensibly cabining monetary damages for pain and suffering. A perspective rooted in medical practice might help to clarify the purposes and, in turn, the proper magnitude of such awards. Once we come to understand emotional distress as just another type of injury partially responsive to therapeutic interventions, the avoidable consequences rule, which obligates victims to take reasonable steps to mitigate their harm, should provide clearer parameters for fixing pain-and-suffering damages.

[*432]

II. Pain and Suffering (and Such)

This Article asks a fairly fundamental but rarely explored question: why do courts invariably treat awards for pain and suffering as "noneconomic" damages, distinguishing them from awards for medical expenses and other types of economic damages? Before, however, trying to formulate an answer in Part III, this Article summarizes the debate over pain-and-suffering damages and introduces a handful of the more interesting proposals for reform.

A. Distinguishing Economic and Noneconomic Damages

Noneconomic damages encompass a variety of overlapping (and imprecise) categories such as pain, mental anguish, anxiety, emotional distress, and nervous shock. [1] Loss of enjoyment of life (a.k.a. "hedonic" damages), which might be understood as the deprivation of the normal pleasures of living (the opposite of pain), also represents a compensable type of nonpecuniary harm. [2] Finally, various derivative claims, such as loss of consortium, companionship, and society (essentially for the deprivation of the positive emotional support previously received from the injured victim), fall within the domain of noneconomic damages. [3]

By compensating plaintiffs for their medical expenses and lost earnings, courts treat the physical and economic aspects of bodily injury as pecuniary damages, but the emotional aspects of such injuries **[*433]** remain within the category of nonpecuniary damages. Courts routinely draw a distinction between "special" and "general" damages, the former denoting economic harms (e.g., past medical expenses) and requiring specific proof. [4] General

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[1] See, e.g., Capelouto v. Kaiser Found. Hosps., 500 P.2d 880, 883 (Cal. 1972) (explaining that "pain and suffering" is a "unitary concept" that "has served as a convenient label under which a plaintiff may recover not only for physical pain but for fright, nervousness, grief, anxiety, worry, mortification, shock, humiliation, indignity, embarrassment, apprehension, terror or ordeal"); Clohessy v. Bachelor, 675 A.2d 852, 862 n.12 (Conn. 1996) (using these various descriptors interchangeably); Pearson v. Interstate Power & Light Co., 700 N.W.2d 333, 347 (Iowa 2005); see also Dan B. Dobbs, The Law of Torts 1050 (2000) ("The pain for which recovery is allowed includes virtually any form of conscious suffering, both emotional and physical." (footnotes omitted)).

[2] See, e.g., Overstreet v. Shoney's, Inc., 4 S.W.3d 694, 715-17 (Tenn. Ct. App. 1999) (distinguishing between pain and suffering, permanent impairment/disfigurement, and loss of enjoyment, and referring to the prescription of antidepressants for the treatment of post-traumatic stress disorder as some evidence supporting the jury's noneconomic damage award of $ 1.75 million after a serious eye injury); see also Kyle R. Crowe, Note, The Semantical Bifurcation of Noneconomic Loss: Should Hedonic Damage Be Recognized Independently of Pain and Suffering Damage?, 75 Iowa L. Rev. 1275, 1277 (1990) (explaining that many jurisdictions treat loss of enjoyment of life as a subset of pain and suffering rather than as a freestanding category of noneconomic damages). For more on the debate over hedonic damages, see infra note 190.

[3] See Nancy Levit, Ethereal Torts, 61 Geo. Wash. L. Rev. 136, 146-47 (1992) ("As emotional harms attained legitimacy during the past decade, tort law increasingly acknowledged another manifestation of psychic injury - the harm to relational interests.").

[4] See, e.g., Pexa v. Auto Owners Ins. Co., 686 N.W.2d 150, 156-57 (Iowa 2004); Veazey v. State Farm Mut. Auto. Ins., 587 So. 2d 5, 8-9 (La. Ct. App. 1991); Jackson v. Brumfield, 458 So. 2d 736, 737 (Miss. 1984) (bills for prescription drugs); Anderson v. A.P.I. Co. of Minn., 559 N.W.2d 204, 210 (N.D. 1997); Overstreet, 4 S.W.3d at 702-06 (lost earning capacity); see also ***DaFonte v. Up-Right, Inc., 828 P.2d 140, 144 (Cal. 1992)*** ("The important distinction between "economic' and "non-economic' damages is carefully defined by the statute."); Thibeaux v. Trotter, 883 So. 2d 1128, 1130 (La. Ct. App. 2004) ("General damages [as contrasted with special damages] are speculative in nature and, thus, incapable of being fixed with any mathematical certainty."); Flannery v. United States, 297 S.E.2d 433, 435 (W. Va. 1982) (distinguishing between "liquidated" and "unliquidated" damages). See generally ***Restatement (Second) of Torts § 904*** cmts. b & c (1979).

damages, in contrast, have an entirely open-ended quality to them, [5] and courts may even constrain the sometimes creative efforts of plaintiffs' lawyers to "prove" the nature of such harms. [6]

In its Restatement of the Law of Torts, the American Law Institute (ALI) has struggled to make sense of these characterizations. The Second Restatement offered the following explanation:

The sensations caused by harm to the body or by pain or humiliation are not in any way analogous to a pecuniary loss, and a sum of money is not the equivalent of peace of mind. Nevertheless, damages given for pain and humiliation are called compensatory. They give to the injured person some pecuniary return for what he has suffered or is likely to suffer. There is no scale by which the detriment caused by suffering can be measured and hence there can be only a very rough **[*434]** correspondence between the amount awarded as damages and the extent of the suffering. [7]

In the course of revising the Second Restatement, the ALI split the subject into different parts, including one volume designed to address "liability for physical harm." [8] Initially, the reporters planned to carve out emotional harms for separate treatment, even while conceding that the expansion of claims for mental distress had muddied the line. [9] In the end, the ALI decided to include emotional harms within the ambit of this volume. [10]

As one commentator noted, "the line between pecuniary and nonpecuniary harms is fuzzy." [11] In contexts where plaintiffs may recover only economic damages (as in the case of many wrongful death statutes), the question of

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[5] See *Duncan v. Kansas City Ry., 773 So. 2d 670, 682 (La. 2000); Botta v. Brunner, 138 A.2d 713, 718 (N.J. 1958)* ("For hundreds of years, the measure of damages for pain and suffering following in the wake of personal injury has been "fair and reasonable compensation.' This general standard was adopted because of universal acknowledgement that a more specific or definitive one is impossible."); *id. at 718-19* ("The varieties and degrees of pain are almost infinite. Individuals differ greatly in susceptibility to pain and in capacity to withstand it."); *id. at 720* ("Pain and suffering have no known dimensions, mathematical or financial."); see also infra note 38 and accompanying text (discussing jury instructions).

[6] See Joseph H. King, Jr., Counting Angels and Weighing Anchors: Per Diem Arguments for Noneconomic Personal Injury Tort Damages, *71 Tenn. L. Rev. 1, 10-11, 13-18 (2003);* Jessica M. Silbey, Judges as Film Critics: New Approaches to Filmic Evidence, *37 U. Mich. J.L. Reform 493, 526-31, 561-69 (2004)* (discussing the admissibility of "day in the life" videos); see also infra note 56 (discussing the judicial treatment of expert testimony concerning hedonic damages); *Miss. Code Ann. § 11-1-69(1)* (2007) (prohibiting expert testimony about the monetary value of pain and suffering damages). See generally Danny R. Veilleux, Annotation, Necessity of Expert Testimony on Issue of Permanence of Injury and Future Pain and Suffering, *20 A.L.R.5th 1* (1994 & Supp. 2007).

[7] ***Restatement (Second) of Torts § 903*** cmt. a; see also id. § 905 & cmt. i.

[8] Restatement (Third) of Torts: Liability for Physical Harm (Proposed Final Draft No. 1, 2005); see also Martha Chamallas, Removing Emotional Harm from the Core of Tort Law, *54 Vand. L. Rev. 751, 752-60 (2001)* (criticizing this decision to marginalize non-physical injuries). Previous volumes of the Third Restatement had addressed matters of apportionment and products liability.

[9] See Restatement (Third) of Torts (Proposed Final Draft No. 1) § 4 cmt. d; see also *Molien v. Kaiser Found. Hosps., 616 P.2d 813, 817-21 (Cal. 1980).*

[10] See Restatement (Third) of Torts: Liability for Physical and Emotional Harm ch. 8 (Tentative Final Draft No. 5, 2007).

[11] Margaret Jane Radin, Compensation and Commensurability, *43 Duke L.J. 56, 69 n.23 (1993)* ("For example, loss of a wife's consortium was historically thought of as an economic harm to her husband, because the law focused on the services she owed him; but in a modern understanding, the emotional component of the loss is more important."); see also id. (adding that psychotherapy can help both "to make the victim functional again as a worker" and to promote "emotional satisfaction," but deciding to "ignore the difficulty of drawing the line between pecuniary and nonpecuniary harms, as well as what we can learn from this difficulty"); Ellen Smith Pryor, The Tort Law Debate, Efficiency, and the Kingdom of the Ill: A Critique of the Insurance Theory of Compensation, *79 Va. L. Rev. 91, 125-36 (1993); id. at 95* (challenging "the ability to categorize the vast and complex

characterization becomes tremendously important. [12] It also has federal tax implications because Congress excluded from "gross income" only those compensatory **[*435]** damages awarded "on account of personal physical injuries or physical sickness." [13]

More generally, the division between economic and noneconomic damages replicates the largely discredited Cartesian dichotomy between body and mind. [14] It also parallels an increasingly criticized distinction in medicine between curative and palliative care. [15] Physicians must do more than fix broken bodies - they should strive to alleviate their patients' pain and suffering even if unable to root out the underlying cause of such symptoms. [16] Indeed, some health care professionals have come to regard chronic pain as a disease process in its own right. [17]

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spectrum of losses into a dichotomy between pecuniary and nonpecuniary losses"); Neil Vidmar & Leigh Anne Brown, Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy, *22 Miss. C. L. Rev. 9, 28 (2002)* (cautioning that "these lines of demarcation are often indistinct").

[12] For example, wrongful death statutes historically allowed recoveries for only pecuniary losses. See *Liff v. Schildkrout, 404 N.E.2d 1288, 1292 (N.Y. 1980);* John Fabian Witt, From Loss of Services to Loss of Support: The Wrongful Death Statutes, the Origins of Modern Tort Law, and the Making of the Nineteenth-Century Family, *25 Law & Soc. Inquiry 717, 735, 741-43 (2000);* see also infra note 192 (discussing workers' compensation). Nonetheless (and putting aside subsequent legislative reforms), some courts stretched the characterization to allow recovery for the loss of companionship in such cases. See, e.g., *Sea-Land Servs., Inc. v. Gaudet, 414 U.S. 573, 586-88 (1974); Reiser v. Coburn, 587 N.W.2d 336, 339-42 (Neb. 1998); Green v. Bittner, 424 A.2d 210, 215-16 (N.J. 1980);* see also Andrew J. McClurg, Dead Sorrow: A Story About Loss and a New Theory of Wrongful Death Damages, *85 B.U. L. Rev. 1, 22-27 (2005).*

[13] *26 U.S.C. § 104*(a)(2) (2000) (emphasis added); see also id. § 104(a) ("Emotional distress shall not be treated as a physical injury or physical sickness. The preceding sentence shall not apply to an amount of damages not in excess of the amount paid for medical care … attributable to emotional distress."); *Murphy v. IRS, 493 F.3d 170, 174-76 (D.C. Cir. 2007); Lindsey v. Comm'r, 422 F.3d 684, 687-89 (8th Cir. 2005);* F. Patrick Hubbard, Making People Whole Again: The Constitutionality of Taxing Compensatory Tort Damages for Mental Distress, 49 Fla. L. Rev. 725, 744-45 (1997).

[14] See Levit, supra note 3, at 191 ("Despite the cumulative and trenchant evidence in psychology, sociology, biology, medicine, and psychopharmacology dispelling ancient concepts of mind-body dualism, the mental-material distinction persists in tort law."); see also Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders xxx (4th ed., text rev. 2000) ("The term mental disorder unfortunately implies a distinction between "mental' disorders and "physical' disorders that is a reductionist anachronism of mind/body dualism."); cf. Youndy C. Cook, Comment, Messing with Our Minds: The Mental Illness Limitation in Health Insurance, *50 U. Miami L. Rev. 345, 348-64 (1996)* (explaining that, when interpreting insurance policies that provide less generous coverage in cases of mental illnesses, courts have focused on either the nature of the symptoms, the course of treatment, or the underlying cause).

[15] See Eric J. Cassell, The Nature of Suffering and the Goals of Medicine, 306 New Eng. J. Med. 639, 640 (1982) ("The split between mind and body that has so deeply influenced our approach to medical care was proposed by Descartes to resolve certain philosophical issues… . An anachronistic division of the human condition into what is medical (having to do with the body) and what is nonmedical (the remainder) has given medicine too narrow a notion of its calling."); Ben A. Rich, A Prescription for the Pain: The Emerging Standard of Care for Pain Management, *26 Wm. Mitchell L. Rev. 1, 24 (2000)* ("Since pain and suffering, understood as sensation and emotion, are quintessentially subjective human experiences, they lie outside of the acceptable parameters of the curative model."); *id. at 18* ("Modern medicine has been shaped by the Cartesian dualism of mind and body … [, so] the responsibility for dealing with pain and suffering [experienced by the mind] has necessarily been removed from the physician's job description [of treating the body]."); *id. at 18 n.115* (noting that "the transition from a biomedical to a biocultural model of pain, which takes into account the nonphysiological aspects of the pain experience, blurs earlier distinctions between pain [directly traceable to tissue injury] and suffering").

[16] See Council on Ethical & Judicial Affairs, Am. Med. Ass'n, Code of Medical Ethics: Current Opinions with Annotations, Opinion 2.20, at 76 (2006) ("Physicians have an obligation to relieve pain and suffering … ."); Cassell, supra note 15, at 639 ("The obligation of physicians to relieve human suffering stretches back into antiquity."); Edmund D. Pellegrino, Emerging Ethical Issues in Palliative Care, 279 JAMA 1521, 1521 (1998) ("Not to relieve pain optimally is tantamount to moral and legal malpractice.").

This nosological debate aside, recognizing **[*436]** pain and suffering as more than, in turn, a symptom of physical injury and an associated emotional response may help to illuminate the possible contingency of the well-entrenched doctrinal line between pecuniary and nonpecuniary damages.

Courts regard medical expenses as a species of pecuniary damages, though some commentators have questioned this characterization insofar as the physical injury itself does not deprive the victim of an asset. [18] Even so, because the rule of avoidable consequences obligates the tortfeasor to reimburse the victim's reasonable mitigation efforts, [19] and because physicians can correct many physical injuries without any lasting disability (thus, making the victim "whole"), it makes perfect sense to understand these awards as economic damages. [20] Even absent the possibility of correcting a physical injury, health insurance policies pay for interventions designed solely to diminish pain and suffering, for instance by covering analgesia [21] and, to a lesser extent, mental **[*437]** health services. [22]

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[17] See Michael Finch, Law and the Problem of Pain, *74 U. Cin. L. Rev. 285, 286-87, 318-26 (2005); id. at 305* ("The distinction between "physical' and "mental' aspects of illness may be a heuristic device rather than an ontological divide."); Jean Marx, Prolonging the Agony, 305 Science 326, 326 (2004); Mary Carmichael, The Changing Science of Pain, Newsweek, June 4, 2007, at 40, 42-43 (quoting Will Rowe, executive director of the American Pain Foundation, as saying that ""there's a growing awareness that pain is a disease of its own,"' and explaining that it represents "an overactivity of the nervous system"); id. at 40 ("Chronic pain is one of the most pervasive and intractable medical conditions in the United States, with one in five Americans afflicted."). At a minimum, health care providers should chart pain as a vital sign (along with temperature, pulse, respiration, and blood pressure). See Laurie Tarkan, New Efforts Against an Old Foe: Pain, N.Y. Times, Dec. 26, 2000, at F1; see also William J. Donnelly, Taking Suffering Seriously: A New Role for the Medical Case History, 71 Acad. Med. 730 (1996).

[18] See Steven P. Croley & Jon D. Hanson, The Nonpecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law, *108 Harv. L. Rev. 1785, 1914-15 (1995)* ("Medical insurance, which proponents of the conventional wisdom offer as the primary example of pecuniary-loss insurance, should be, according to their own definition, classified as nonpecuniary-loss insurance."); see also *id. at 1858 n.239* ("Much of modern medical care is designed to relieve pain and suffering, but for reasons that are not clear to us, nobody claims that those aspects of medical care are for the nonpecuniary aspects of an injury."). The point seems even clearer when a collateral source already has paid for the victim's medical expenses. See, e.g., *Bynum v. Magno, 101 P.3d 1149, 1155-63 (Haw. 2004).*

[19] See infra Part III.A.

[20] See Pryor, supra note 11, at 129 & n.123 (explaining that, "if the replaceability test is applied to the original loss as a whole, then even those losses addressed by basic medical care are not pecuniary unless the medical care is completely restorative," but noting that "virtually every insurance theory analyst mentions basic medical expenses as an example of a pecuniary loss"); see also Ellen S. Pryor, Rehabilitating Tort Compensation, *91 Geo. L.J. 659, 669-76, 691-93 (2003)* (arguing that, rather than viewing compensatory damages as an effort to return victims to their pre-injury state, courts should focus on what benefits an inevitably transformed individual can derive from rehabilitative efforts); *id. at 664* ("In recent years, the meaning of compensation itself has become more contested as a matter of theory and doctrine."); *id. at 665* (referring to the rising "fragmentation" and "contestability" of compensatory damage categories).

[21] On occasion, however, insurers may scrimp on such coverage. See, e.g., Barnaby J. Feder, Aetna to End Payment for a Drug in Colonoscopies, N.Y. Times, Dec. 28, 2007, at C2 (discussing recent decisions by major health insurers to classify propofol, a powerful anesthetic that has facilitated colon cancer screening, as "medically unnecessary" in most cases).

[22] See Richard G. Frank et al., Will Parity in Coverage Result in Better Mental Health Care?, 345 New Eng. J. Med. 1701 (2001); Maria A. Morrison, Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation, *45 S.D. L. Rev. 8 (2000);* Brian D. Shannon, Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?, *68 U. Colo. L. Rev. 63, 68-69, 102-03 (1997);* Richard E. Gardner, III, Comment, Mind over Matter?: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage, *49 Emory L.J. 675, 677 (2000)* ("Health plans normally include less coverage for mental health care than for medical and surgical services; however, both states and the federal government have begun to require that these services be covered in the same way."); Chris Jenkins, Law Equalizes Coverage for Mental, Physical Care: "Milestone" Measure Could Expand Treatment Services, Wash. Post, Oct. 10, 2008, at B1. Unless one interprets the less generous coverage for mental health care as reflecting

Courts treat awards for such items as economic rather than noneconomic damages. [23] In short, compensation for medical expenses helps to cover past and future expenditures necessitated by an injury, and these damages are no less "pecuniary" when a court awards future medical expenses (in lieu of the lost earning capacity associated with an alleged disability) to a victim who does not intend to spend the award on mitigation efforts.

Separately, and within the category of pecuniary damages, the line between medical expenses and lost wages has shifted over time as previously untreatable and disabling traumas now respond to advanced surgical and other interventions. Thus, awards that once compensated victims for their lost earning capacity nowadays instead may go to pay for health care treatments and rehabilitation. Along similar lines, and in light of improvements in the treatment of pain and suffering, this Article argues that courts should recast as medical expenses at least some of the sums that they traditionally have allowed as nonpecuniary damages.

B. Claims for Nothing Other Than Emotional Distress

Pain and suffering may occur even without physical injury, but courts only gradually came to allow compensation when tortious behavior caused purely emotional harm. The tort of negligent infliction of emotional distress emerged during the second half of the twentieth century in part because psychiatry had improved its understanding of the nature of such injuries. [24] Previously, judges **[*438]** had declined to recognize emotional distress claims lacking any physical trigger or manifestation, out of a suspicion that such harms were too easily feigned. [25] Growing acceptance of psychiatric testimony that the plaintiff suffered from a diagnosable mental illness provided some reassurance of legitimacy. [26]

Even when plaintiffs have satisfied the various other prerequisites for bringing these tort claims, some courts continue to demand medical evidence to support allegations of severe emotional distress. [27] For instance, several courts have allowed recoveries based on a diagnosis of post-traumatic stress disorder (PTSD). [28] Some critics

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consumer preferences against paying premiums for such services, the failure to ensure sufficient access might strengthen the case for offering tort compensation for out-of-pocket costs not reimbursed by a collateral source.

[23] See infra note 116.

[24] See *Molien v. Kaiser Found. Hosps., 616 P.2d 813, 817, 821 (Cal. 1980);* *Corgan v. Muehling, 574 N.E.2d 602, 608-09 (Ill. 1991);* Julie A. Davies, Direct Actions for Emotional Harm: Is Compromise Possible?, *67 Wash. L. Rev. 1, 25 (1992)* ("Numerous commentators and courts have observed that developments in science enable experts to adequately distinguish between trivial and non-trivial emotional distress without reliance on physical consequences of harm."). Conversely, new views about the nature and persistence of pain had led some commentators to question the long-standing willingness of courts to award damages for this type of harm. See, e.g., Cornelius J. Peck, Compensation for Pain: A Reappraisal in Light of New Medical Evidence, 72 Mich. L. Rev. 1355, 1395-96 (1974); id. at 1365 ("Pain is a social and psychological as well as physiological phenomenon."); id. at 1369 ("The new medical evidence provides an additional argument for limiting or excluding such awards, at least in cases in which no physiological basis for pain exists."); cf. id. at 1371-72 & n.81 (conceding that awards for mental suffering are another matter).

[25] See *Bowen v. Lumbermens Mut. Cas. Co., 517 N.W.2d 432, 437 (Wis. 1994);* John J. Kircher, The Four Faces of Tort Law: Liability for Emotional Harm, *90 Marq. L. Rev. 789, 807-08, 838-39 (2007);* Levit, supra note 3, at 172.

[26] See Virginia E. Nolan & Edmund Ursin, Negligent Infliction of Emotional Distress: Coherence Emerging from Chaos, 33 Hastings L.J. 583, 604-05, 616 n.187 (1982); see also infra notes 146 & 167 (discussing negligent infliction of emotional distress claims).

[27] See, e.g., *Bass v. Nooney Co., 646 S.W.2d 765, 772-73 (Mo. 1983);* *Camper v. Minor, 915 S.W.2d 437, 446 (Tenn. 1996);* *Hegel v. McMahon, 960 P.2d 424, 431 (Wash. 1998);* *Stump v. Ashland, Inc., 499 S.E.2d 41, 53 (W. Va. 1997).*

[28] See, e.g., *Gough v. Natural Gas Pipeline Co. of Am., 996 F.2d 763, 767 (5th Cir. 1993);* *Berthelot v. Aetna Cas. & Sur. Co., 623 So. 2d 14, 22 (La. Ct. App. 1993);* *Giamanco v. Epe, Inc., 619 So. 2d 842, 845-46 (La. Ct. App. 1993);* *Sullivan v. Boston Gas Co., 605 N.E.2d 805, 811 (Mass. 1993);* *Henricksen v. State, 84 P.3d 38, 54-55 (Mont. 2004);* *Nichols v. Busse, 503*

argue, however, that a PTSD diagnosis inappropriately certifies the genuineness of an emotional distress complaint. [29] Furthermore, **[*439]** the failure to seek out treatment after securing such a diagnosis would seem to cast doubt on the seriousness of the alleged harm, especially if the recommended intervention carried no significant risk. [30] In any event, by recognizing emotional distress claims, judges countenance awards of solely nonpecuniary damages; plaintiffs would have to prove special (pecuniary) damages only if they also alleged that their suffering resulted in lost wages or required expenditures for medical care.

C. Controversy over Awards for Pain and Suffering (and Distress)

As the California Supreme Court noted more than two decades ago, "thoughtful jurists and legal scholars have for some time raised serious questions as to the wisdom of awarding damages for pain and suffering in any negligence case." [31] In part, fundamental disagreements exist about the purposes served by nonpecuniary damage awards:

An economic loss can be compensated in kind by an economic gain; but recovery for noneconomic losses such as pain and suffering and loss of enjoyment of life rests on the legal fiction that money damages can compensate for a victim's injury… . **[*440]** We accept this fiction, knowing that although money will neither ease the pain nor restore the victim's abilities, this device is as close as the law can come in its effort to right the wrong. We have no hope of

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N.W.2d 173, 180 (Neb. 1993); see also Edgar Garcia-Rill & Erica Beecher-Monas, Gatekeeping Stress: The Science and Admissibility of Post-Traumatic Stress Disorder, 24 U. Ark. Little Rock L. Rev. 9, 16-28 (2001) (summarizing the medical literature); Edward J. Hickling et al., The Psychological Impact of Litigation: Compensation Neurosis, Malingering, PTSD, Secondary Traumatization, and Other Lessons from MVAs, 55 DePaul L. Rev. 617, 619 (2006) (estimating that "twenty-five percent of the population of injured car crash victims will develop this disorder"); id. at 627 ("Due to its link to a causal factor and subsequent psychological distress, PTSD has increasingly become a diagnosis with the potential for legal recourse and financial compensation.").

[29] See Lars Noah, Pigeonholing Illness: Medical Diagnosis as a Legal Construct, 50 Hastings L.J. 241, 270-71 & n.108 (1999); David F. Partlett, Tort Liability and the American Way: Reflections on Liability for Emotional Distress, 45 Am. J. Comp. L. 171, 180-83 (1997) (book review); see also Benedict Carey, Most Will Be Mentally Ill at Some Point, Study Says, N.Y. Times, June 7, 2005, at A18 (reporting that some experts question the growth in these sorts of diagnoses). When a treating (as opposed to testifying) physician renders such a diagnosis, it normally coincides with a recommendation for treatment. Cf. Noah, supra, at 303-04, 307 (discussing the possibility of junk diagnoses provided solely for forensic purposes); id. at 248-49, 298-99 & n.225 (explaining that mental health professionals may work backward from the apparently successful treatment of nonspecific symptoms when making a diagnosis).

[30] See Hetzel v. County of Prince William, 89 F.3d 169, 171-73 (4th Cir. 1996); Robinson v. United States, 330 F. Supp. 2d 261, 294-95 (W.D.N.Y. 2004) (rejecting plaintiff's allegations of sleeplessness and depression where he never sought any treatment for these complaints); cf. Metro-North Commuter R.R. v. Buckley, 521 U.S. 424, 445 (1997) (Ginsburg, J., concurring in judgment in part) (noting that the plaintiff "sought no professional help to ease his distress, and presented no medical testimony concerning his mental health"); Spina v. Forest Preserve Dist. of Cook County, 207 F. Supp. 2d 764, 771-76 (N.D. Ill. 2002) (ordering remittitur to $ 300,000 for nonpecuniary damages awarded in a sexual harassment case); id. at 775 ("The Court cannot uphold a $ 3 million verdict for a plaintiff who has never sought mental health treatment, whose own expert witness opined that she does not require such treatment, and who still retains her position with her employer."). Conversely, and without regard to efforts at attaching a diagnostic label to the victim's complaints, "a prescription for medicine or a visit to a doctor can lend support to a claim for emotional distress." Miner v. City of Glens Falls, 999 F.2d 655, 663 (2d Cir. 1993). If, however, plaintiff underwent a treatment that carried little or no risk, then such conduct may be less probative of the genuineness of the alleged emotional injury. See infra notes 157-58 and accompanying text.

[31] Fein v. Permanente Med. Group, 695 P.2d 665, 680 (Cal.), appeal dismissed, ***474 U.S. 892 (1985);*** see also id. at 681 n.16 (quoting Justice Traynor's dissent in Seffert v. L.A. Transit Lines, 364 P.2d 337, 345 (Cal. 1961)); Borer v. Am. Airlines, Inc., 563 P.2d 858, 862-63 (Cal. 1977) (declining to recognize derivative claims for persons other than spouses); Philip L. Merkel, Pain and Suffering Damages at Mid-Twentieth Century: A Retrospective View of the Problem and the Legal Academy's First Responses, 34 Cap. U. L. Rev. 545, 566-79 (2006).

evaluating what has been lost, but a monetary award may provide a measure of solace for the condition created … . [32]

In addition to providing a form of consolation, [33] nonpecuniary damages may serve a symbolic purpose in expressing society's acknowledgement of (and respect for) the victim's right to bodily integrity and disapproval of the harm caused by the tortfeasor, [34] they may promote loss avoidance goals by sending a fuller deterrent signal, [35] and they may help to cover the plaintiff's attorneys fees. [36]

[*441] The controversy has intensified in recent years, [37] in part because, whatever the theoretical justifications, the only guidance that juries get often resembles the following:

No definite standard [or method of calculation] is prescribed by law by which to fix reasonable compensation for pain and suffering. Nor is the opinion of any witness required as to the amount of such reasonable compensation. [Furthermore, the argument of counsel as to the amount of damages is not evidence of reasonable compensation.] In making an award for pain and suffering you should exercise your authority with calm and reasonable judgment and the damages you fix must be just and reasonable in the light of the evidence. [38]

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[32] *McDougald v. Garber, 536 N.E.2d 372, 374-75 (N.Y. 1989)* (citations omitted) (internal quotation marks omitted); see also *id. at 376* (explaining that the calculation "involves no mathematical formula" but represents a "murky process"); Joseph H. King, Jr., Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law, *57 SMU L. Rev. 163, 171-201 (2004);* *id. at 164* ("Pain and suffering damages and the policy goals of modern tort law are conceptually and operationally incompatible."); W. Kip Viscusi, Pain and Suffering: Damages in Search of a Sounder Rationale, 1 Mich. L. & Pol'y Rev. 141, 169 (1996) ("The appropriate levels of pain and suffering awards vary substantially depending on whether our objective is to make the victim whole, provide optimal insurance, provide optimal deterrence, or foster some other objective.").

[33] See Heidi Li Feldman, Harm and Money: Against the Insurance Theory of Tort Compensation, *75 Tex. L. Rev. 1567, 1588-89 (1997)* (explaining that a monetary award may allow the victim to flourish in new ways); see also Emily Sherwin, Compensation and Revenge, *40 San Diego L. Rev. 1387, 1393 (2003)* ("The common practice of awarding lump sums for future pain and suffering without discounting to present value confirms that these awards are not seriously understood to conform to actual loss.").

[34] See Jody Lynee Madeira, Regarding Pained Sympathy and Sympathy Pains: Reason, Morality, and Empathy in the Civil Adjudication of Pain, *58 S.C. L. Rev. 415 (2006)* (responding to objections of subjectivity and irrationality - and defending the role of compassion - in evaluating claims for pain-and-suffering damages in personal injury litigation); Steven D. Smith, The Critics and the "Crisis": A Reassessment of Current Conceptions of Tort Law, *72 Cornell L. Rev. 765, 788-89 (1987);* see also *id. at 783-85* (arguing that the dispute resolution process itself serves to remedy the victim's "sense of injustice"); John C.P. Goldberg, Two Conceptions of Tort Damages: Fair v. Full Compensation, *55 DePaul L. Rev. 435, 443-47, 462-65 (2006)* (explaining that the now-dominant "make whole" understanding of compensatory damages as a remedy for a loss conflicts with an earlier conception that focused on offering some redress (satisfaction) for interference with a legal right).

[35] See *Kwasny v. United States, 823 F.2d 194, 197-98 (7th Cir. 1987)* (Posner, J.) (ordering 50% remittitur of a pain-and-suffering damage award to the estate of a frail patient who died after negligence); Robert Cooter, Hand Rule Damages for Incompensable Losses, *40 San Diego L. Rev. 1097, 1116 (2003).*

[36] See Stephen D. Sugarman, A Comparative Law Look at Pain and Suffering Awards, *55 DePaul L. Rev. 399, 401, 419 (2006);* Viscusi, supra note 32, at 157-58; see also Stephen Daniels & Joanne Martin, The Strange Success of Tort Reform, *53 Emory L.J. 1225, 1244-46 (2004)* (explaining that contingency fee lawyers may shy away from cases with little prospect for noneconomic damages).

[37] See, e.g., Richard Abel, General Damages Are Incoherent, Incalculable, Incommensurable, and Inegalitarian (but Otherwise a Great Idea), *55 DePaul L. Rev. 253 (2006).*

[38] Cal. Jury Instructions: Civil 14.13 (2007). Jury instructions in other jurisdictions follow this general pattern. See *Johnson v. Scaccetti, 927 A.2d 1269, 1283 (N.J. 2007);* Ronald W. Eades, Jury Instructions on Damages in Tort Actions § 6.22 (5th ed.

Although admirable for their candor, such unhelpful jury instructions have led critics to lodge both conceptual and practical objections to the award of nonpecuniary damages: they lack any economic meaning as reflected by the absence of a market for first party insurance, [39] standardless instructions inevitably mean inconsistency among jury awards, [40] the awards may be out of proportion **[*442]** to the seriousness of the injury (which would inefficiently overdeter and spread excessive costs among other users), [41] their unpredictability complicates efforts at settlement and sends confused deterrent signals, [42] and they largely escape appellate scrutiny. [43] These characteristics have prompted some scholars to go so far as to raise procedural due process objections. [44]

2008); Roselle L. Wissler et al., Instructing Jurors on General Damages in Personal Injury Cases: Problems and Possibilities, 6 Psychol. Pub. Pol'y & L. 712, 718 (2000); see also id. at 736 (calling such instructions "breathtakingly unhelpful"); David W. Leebron, Final Moments: Damages for Pain and Suffering Prior to Death, 64 N.Y.U. L. Rev. 256, 265 (1989) ("The response of the legal system to the doctrinal and factual complexity of pain and suffering has been to make the awarding of this element of damages procedurally simple but analytically impenetrable. The law provides no guidance, in terms of any benchmark, standard figure, or method of analysis, to aid the jury in the process of determining an appropriate award."); cf. Thomas C. Galligan, Jr., The Tragedy in Torts, 5 Cornell J.L. & Pub. Pol'y 139, 172 (1996) (applauding such instructions for inviting attention to the particulars of the victim's injuries); Neil Vidmar, Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases, 43 Duke L.J. 217, 254-55 (1993) (finding that mock jurors reported a wide variety of ways that they arrived at nonpecuniary awards).

[39] See, e.g., 2 Am. Law Inst., Reporters' Study on Enterprise Responsibility for Personal Injury: Approaches to Legal and Institutional Change 206 (1991) ("When tort doctrine is pictured in this way - as a port of entry into an insurance program paid for and provided by members of the community for themselves - the claim of pain and suffering to any, let alone full, compensation appears shaky."); Robert Cooter, Towards a Market in Unmatured Tort Claims, 75 Va. L. Rev. 383, 391-92 (1989); George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 Yale L.J. 1521, 1547, 1553 (1987). For responses to this conventional wisdom, see Ronen Avraham, Should Pain-and-Suffering Damages Be Abolished from Tort Law?: More Experimental Evidence, 55 U. Toronto L.J. 941, 977 (2005); Croley & Hanson, supra note 18, at 1914-17 (summarizing their conclusions).

[40] See, e.g., Mark A. Geistfeld, Due Process and the Determination of Pain and Suffering Tort Damages, 55 DePaul L. Rev. 331, 340-46 (2006); Sugarman, supra note 36, at 416-17 (finding "the median [pain-and-suffering] awards for quadriplegia, loss of an arm (all types), loss of a leg (all types), and loss of a finger, were $ 3.5 million, $ 1.5 million, $ 1 million, and $ 137,000, respectively," with "ratios of more than twenty to one for several of the injuries"). But see Rosselle L. Wissler et al., Decisionmaking About General Damages: A Comparison of Jurors, Judges, and Lawyers, 98 Mich. L. Rev. 751, 812-17 (1999) (finding little variability in awards and recommending only modest procedural reforms to reduce it further).

[41] See John E. Calfee & Paul H. Rubin, Some Implications of Damage Payments for Nonpecuniary Losses, 21 J. Legal Stud. 371, 402 (1992); King, supra note 32, at 190; Alan Schwartz, Proposals for Products Liability Reform: A Theoretical Synthesis, 97 Yale L.J. 353, 362-77, 408-15 (1988); Victor E. Schwartz & Leah Lorber, Twisting the Purpose of Pain and Suffering Awards: Turning Compensation into "Punishment," 54 S.C. L. Rev. 47, 70 (2002); Too Much Suffering, Nat'l L.J., June 28, 1993, at 8 (noting that "pain and suffering awards appear to have cost consumers tens of billions of dollars per year").

[42] See King, supra note 32, at 166-67, 185-92, 196-97.

[43] See David Baldus et al., Improving Judicial Oversight of Jury Damages Assessments: A Proposal for the Comparative Additur/Remittitur Review of Awards for Nonpecuniary Harms and Punitive Damages, 80 Iowa L. Rev. 1109, 1120, 1128-29, 1132-33 (1995); Geistfeld, supra note 40, at 344; Paul V. Niemeyer, Awards for Pain and Suffering: The Irrational Centerpiece of Our Tort System, 90 Va. L. Rev. 1401, 1401-04, 1416-17 (2004); cf. Ronald J. Allen & Alexia Brunet, The Judicial Treatment of Noneconomic Compensatory Damages in the 19th Century, 4 J. Empirical Legal Stud. 365, 397 (2007) (finding that, before the twentieth century, courts "kept a tight control over jury damage awards, notwithstanding the proposition of significant jury discretion").

[44] See Ronald J. Allen et al., An External Perspective on the Nature of Noneconomic Compensatory Damages and Their Regulation, 56 DePaul L. Rev. 1249, 1274-75 (2007); id. at 1276 ("The transfer of assets without a factual basis violates due process, and the articulation of the factual basis must come from somewhere if the practice of awarding noneconomic compensatory damages can be justified."); Paul DeCamp, Beyond State Farm: Due Process Constraints on Noneconomic

It takes little effort to find reports of jury verdicts for pain and suffering that would strike most observers as at least mildly perplexing. [45] For instance, a recent medical malpractice case included an award of $ 100 million for pain and suffering that the trial judge **[*443]** reduced to $ 1.8 million, [46] while a different personal injury verdict included over $ 50 million in nonpecuniary damages that survived on appeal. [47] In another case, a New York jury awarded almost $ 9 million for pain and suffering to an inebriated dishwasher who lost his arm when he fell under a subway train. [48] A Mississippi jury awarded $ 10 million to each of ten patients who had used the drug **[*444]** Propulsid,

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Compensatory Damages, *27 Harv. J.L. & Pub. Pol'y 231, 257-68, 290-97 (2003);* see also Lars Noah, Civil Jury Nullification, *86 Iowa L. Rev. 1601, 1626, 1645-48 (2001);* infra note 177 (discussing the use of punitive damage ratios).

[45] See DeCamp, supra note 44, at 265-67; Schwartz & Lorber, supra note 41, at 64-65 (providing several recent examples); see also Mathias Reimann, Liability for Defective Products at the Beginning of the Twenty-First Century: Emergence of a Worldwide Standard?, 51 Am. J. Comp. L. 751, 809 (2003) (finding "no jurisdiction outside of the United States where a plaintiff can currently recover more than about $ 300,000 for non-pecuniary damages, even in the most catastrophic cases"); Sugarman, supra note 36, at 418 ("The amounts awarded for pain and suffering in the American cases we examined are vastly greater than the predicted awards in Europe."). See generally What's It Worth: A Guide to Current Personal Injury Awards and Settlements (LexisNexis Matthew Bender 2007) (annual compilation organized by type of harm).

[46] See *Evans v. St. Mary's Hosp. of Brooklyn, 766 N.Y.S.2d 577, 577-78 (App. Div. 2003)* (affirming this remittitur, which also included a substantially reduced award for past and future medical expenses of almost $ 4 million, in a case involving permanent brain damage); Graham Rayman, Woman Gets $ 114M in Malpractice Suit, Newsday, Nov. 24, 2001, at A15; see also *Palanki v. Vanderbilt Univ., 215 S.W.3d 380, 384, 387-88 (Tenn. Ct. App. 2006)* (affirming remittitur of noneconomic damages from $ 15 million to approximately $ 6 million where a young child lost much of his bladder after medical malpractice and required corrective surgeries, but declining to order further reduction even though there was little evidence of any lasting pain, untreatable suffering, or inability to lead a fairly normal life); *id. at 388* (Plaintiff's expert "testified that if future psychological issues arose, the issues could be managed in six to twelve counseling sessions."); cf. Buell-Wilson v. Ford Motor Co., *46 Cal. Rptr. 3d 147, 154, 167-72 (Ct. App. 2006)* (invalidating as excessive a verdict that included $ 105 million in noneconomic damages to an SUV driver left paraplegic after a rollover accident, even after the trial judge had remitted that portion to approximately $ 65 million, unless the plaintiff accepted a further remittitur to $ 18 million, which her attorney originally had suggested to the jury as the appropriate amount), vacated on other grounds, ***127 S. Ct. 2250 (2007)*** (to reconsider the punitive damage award); *Philip Morris Inc. v. French, 897 So. 2d 480, 485-87, 492 (Fla. Dist. Ct. App. 2004)* (affirming a jury verdict of $ 5.5 million for pain and suffering that the trial judge remitted to $ 500,000 to a flight attendant who developed chronic sinusitis from exposure to second-hand smoke).

[47] See *Ritter v. Stanton, 745 N.E.2d 828, 832-33, 850-58 (Ind. Ct. App. 2001)* (economic damages totaled almost $ 1.3 million for a victim who survived after getting crushed by a truck and undergoing more than fifty surgeries); see also *Velarde v. Ill. Cent. R.R., 820 N.E.2d 37, 54-57 (Ill. App. Ct. 2004)* (affirming $ 49 million awarded for pain and suffering to three occupants of a vehicle who suffered serious head injuries after getting hit by a train); *Kresin v. Sears, Roebuck & Co., 736 N.E.2d 171, 174-75, 178 (Ill. App. Ct. 2000)* (rejecting an excessiveness objection to a $ 16.5 million verdict, which included approximately $ 400,000 for medical expenses, $ 1 million for caretaking expenses, $ 6 million for pain and suffering, $ 7 million for disability, and $ 2 million for disfigurement, in a case where an employee's negligence in operating a vehicle severely injured a 73-year-old customer in the store's parking lot, requiring multiple surgeries and resulting in serious disabilities).

[48] See Calvin Sims, $ 9 Million Won for Loss of Arm in Drunken Fall, N.Y. Times, Sept. 21, 1990, at B3 (reporting that the verdict included $ 8.6 million for future pain and suffering as against $ 200,000 for past pain and suffering and $ 17,055 for medical expenses (plus more than $ 530,000 in lost earnings), and explaining that the plaintiff alleged the token clerk had failed to alert police that he posed a risk to himself). After the judge ordered a new trial and the plaintiff prevailed again (though instead emphasizing inadequate lighting on the platform and recovering less than $ 3 million total for his pain and suffering), the appellate courts reversed for lack of evidence of either breach or proximate causation. See *Merino v. N.Y. City Transit Auth., 639 N.Y.S.2d 784, 788-89* (App. Div.), aff'd, ***675 N.E.2d 1222 (N.Y. 1996).*** For an illustrative case that survived on appeal, see *Leon v. J&M Peppe Realty Corp., 596 N.Y.S.2d 380, 389 (App. Div. 1993)* (affirming a jury verdict in favor of a carpenter injured by a circular saw (resulting in partial amputation of three fingers and causing him to seek psychiatric care for PTSD), which included $ 14,000 for medical expenses, $ 100,000 for past pain and suffering, and $ 1.5 million for future pain and suffering (running for 40 years), though the judge cut the latter award in half); *id. at 387* (holding that the jury should have allocated at least 15% of responsibility to the plaintiff for comparative negligence).

[49] but the state supreme court reversed the judgment on grounds of improper joinder after emphasizing that the jury's verdict had ignored the very different circumstances of the plaintiffs, including the fact that their claimed medical expenses ranged from zero to $ 100,000. [50]

D. Some Proposed Reforms

Notwithstanding the wide range of views about the desirability of awarding noneconomic damages, most observers seem to accept the need for some type of reform. [51] Only a few of the most strident critics would abolish these awards altogether, and only a few of the most ardent defenders find absolutely no room for improvement. One recommendation for reducing variability among noneconomic damage awards would create a binding schedule of values (derived from past jury verdicts, subject to various adjustments) dependent on the severity of the physical injury and the age of the victim. [52] **[*445]** Although this idea has received a great deal of attention from other scholars, [53] it has had little evident impact on decisionmakers. [54]

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[49] See Schwartz & Lorber, supra note 41, at 67-68; Melody Petersen, Jury Levies $ 100 Million Award Against Heartburn Drug Maker, N.Y. Times, Sept. 30, 2001, § 1, at 32.

[50] See *Janssen Pharm., Inc. v. Bailey, 878 So. 2d 31, 48 (Miss. 2004)* (noting that, although the trial judge had remitted nine of the awards (to range from $ 2.5 million to $ 7.5 million), the ratio between medical expenses and the total award for each plaintiff still varied dramatically). In the settlement of other class action claims, parties have hired experts to allocate nonpecuniary awards to different victims according to various criteria. See Stephanie Simon, Putting a Price on Pain, L.A. Times, Jan. 28, 2005, at A1.

[51] See, e.g., *Jutzi-Johnson v. United States, 263 F.3d 753, 758-59 (7th Cir. 2001);* Randall R. Bovbjerg et al., Valuing Life and Limb in Tort: Scheduling "Pain and Suffering," *83 Nw. U. L. Rev. 908, 936 (1989)* ("The problem with non-economic damages is, in sum, not that they are inappropriate or unreal, but rather that they are extremely difficult to consistently monetize in the absence of quantitative standards."); id. ("Although non-economic damages are real and should be compensable in a fault-based system, this conclusion does not support totally unstructured decisionmaking about the appropriate levels of awards."); *id. at 924-27* (elaborating on the problems caused by variability in awards); Mark Geistfeld, Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries, *83 Cal. L. Rev. 773, 840-43 (1995).*

[52] See Bovbjerg et al., supra note 51, at 939-49, 975; id. at 945-46 ("Severity and age as classifying measures are intuitively and empirically related to the subjective assessments of the extent of pain and suffering likely to have been experienced, yet they are sufficiently objective to facilitate their application in particular cases and to avoid "gaming' by the parties."); id. at 947 ("Subjective and case-specific matters cannot be accommodated within a point-value matrix, which accepts some degree of "leveling' of potentially legitimate variation in order to achieve simplicity, ease of administration, and consistency of results."); id. at 938 ("Scheduling can provide rational standards - heretofore unavailable - for valuation, thus improving the tort system's current approach, rather than abolishing or arbitrarily limiting nonpecuniary damages."). Under this proposal, distress without underlying physical injury got lumped together in a single category and assigned the lowest rank on the severity scale. Id. at 920 n.76; see also id. at 942 n.158 (suggesting a further refinement "by distinguishing between short-and long-term "emotional only' injuries"); id. at 963-64 n.237 (noting schedules do not address derivative claims such as loss of consortium).

[53] See Ronen Avraham, Putting a Price on Pain-and-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change, *100 Nw. U. L. Rev. 87, 87 & n.1 (2006);* Wissler et al., supra note 40, at 817; see also Oscar G. Chase, Helping Jurors Determine Pain and Suffering Awards, *23 Hofstra L. Rev. 763, 777-90 (1995)* (recommending instead use of a nonbinding approach); Edward J. McCaffery et al., Framing the Jury: Cognitive Perspectives on Pain and Suffering, *81 Va. L. Rev. 1341, 1398-402 (1995)* (suggesting that the variance in observed awards may have more to do with the nature of the tort than the severity of the physical injury); *id. at 1402* ("Our studies show that pain and suffering is an inherently under-specified concept, and we believe that society may want consciously to specify it differently in different contexts."); Frederick S. Levin, Note, Pain and Suffering Guidelines: A Cure for Damages Measurement "Anomie," *22 U. Mich. J.L. Reform 303 (1989)* (recommending a system modeled on criminal sentencing guidelines for use by juries in setting awards for noneconomic damages).

Other commentators have looked to the economics literature on "willingness to pay" (WTP) for guidance about the appropriate valuation of nonpecuniary damages in tort litigation. An expert could derive these numbers from surveys asking people the maximum amount that they would spend to avoid a small risk of a fatal injury ("contingent valuation" methodology) or from wage premiums demanded for riskier lines of work or the extent of consumer demand for safety features that increase the price of goods and services ("revealed preferences" methodology). [55] After calculating the value of a statistical life (VSL), an expert might opine about noneconomic damages in a case based on the degree to which an injury has deprived the victim of life's pleasures. [56] Alternatively, **[*446]** jurors might try to decide how much an individual would pay in order to avoid a non-fatal risk of the sort encountered by a plaintiff (focusing perhaps only on the risk of experiencing pain and suffering) in the course of extrapolating noneconomic damages. [57]

In health care economics (and regulatory arenas involving public health), quality-adjusted life years (QALYs) have become a popular measure of outcomes. [58] Researchers calculate QALYs by first assigning some number

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[54] See Joseph Sanders, Why Do Proposals Designed to Control Variability in General Damages (Generally) Fall on Deaf Ears? (And Why This Is Too Bad), *55 DePaul L. Rev. 489, 507-15 (2006).* In contrast, several other countries have used such approaches. See Sugarman, supra note 36, at 423-27 (discussing legislation in New South Wales (Australia), judicial precedent in Canada, and the practice in Italy, France, England, and Germany); see also id. at 430-34 (recommending a similar approach in the United States coupled with fee shifting, but recognizing that politically it would stand little chance of success).

[55] See W. Kip Viscusi, Fatal Tradeoffs: Public and Private Responsibilities for Risk 34-74 (1992); Ted R. Miller, Willingness to Pay Comes of Age: Will the System Survive?, *83 Nw. U. L. Rev. 876, 879, 891-907 (1989);* see also Cooter, supra note 35, at 1112-15, 1120; id. at 1102 ("Many incompensable losses correspond to compensable risks. For example, a person will only spend so much to reduce the small risk that his child will die in an automobile accident, but no amount of money will compensate for the child's death."); id. at 1099 ("Assume that a reasonable person would spend $ 100 to reduce the probability of accidental death by 1/10,000… . Courts should award damages of $ 1 million for wrongful death."). But see Adi Ayal, Can We Compensate for Incompensable Harms?, *40 San Diego L. Rev. 1123, 1128-29 (2003)* ("We cannot use data on people's actual expenditures in order to achieve a true assessment of their subjective valuation of the harm they would suffer if the risk materialized. Monetary investments in risk reduction are subject to numerous [cognitive] effects, biasing different individuals' choices in similar directions.").

[56] See Dennis C. Taylor, Note, Your Money or Your Life?: Thinking About the Use of Willingness-to-Pay Studies to Calculate Hedonic Damages, *51 Wash. & Lee L. Rev. 1519, 1526-31 (1994).* Courts have, however, generally rejected the admission of such expert testimony. See, e.g., *Mercado v. Ahmed, 974 F.2d 863, 869-71 (7th Cir. 1992);* *Saia v. Sears Roebuck & Co., 47 F. Supp. 2d 141, 144-50 (D. Mass. 1999);* *Loth v. Truck-A-Way Corp., 70 Cal. Rptr. 2d 571, 576-79 (Ct. App. 1998);* *Montalvo v. Lapez, 884 P.2d 345, 365-66 (Haw. 1994);* see also W. Kip Viscusi, The Flawed Hedonic Damages Measure for Wrongful Death and Personal Injury Compensation, 21 J. Forensic Econ. (forthcoming 2008) (pts. v-vi); Joseph A. Kuiper, Note, The Courts, Daubert, and Willingness-to-Pay: The Doubtful Future of Hedonic Damages Testimony Under the Federal Rules of Evidence, *1996 U. Ill. L. Rev. 1197, 1229-30, 1241-42, 1244-45* (discussing decisions to exclude the testimony); *id. at 1254* (disparaging this work as "pop-economics").

[57] See Geistfeld, supra note 51, at 842-43 (offering a hypothetical jury instruction that contained the following language: "What is the maximum amount of money that a reasonable person would have been willing to pay to eliminate the 1-in-10,000 risk of ending up with an injury as severe as the plaintiff's pain-and-suffering injury? … If you multiply the amount by 10,000, you will get the amount of money that would fairly compensate the plaintiff … ."); Geistfeld, supra note 40, at 350-57 (elaborating on this idea, and explaining that, outside of the instances where the parties have transacted (such as consumer product purchases), the test asks instead how much a potential victim would have demanded in order to be willing to accept such a risk of injury); see also Frank A. Sloan et al., Alternative Approaches to Valuing Intangible Health Losses: The Evidence for Multiple Sclerosis, 17 J. Health Econ. 475, 490 (1998) (finding WTPs - based on a contingent valuation study and after making adjustments - ranging from $ 350,000 to $ 880,000 to avoid the noneconomic consequences of MS).

[58] See Matthew D. Adler, QALYs and Policy Evaluation: A New Perspective, *6 Yale J. Health Pol'y L. & Ethics 1, 1-6 (2006);* Arti Kaur Rai, Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care, *72 Ind. L.J. 1015, 1048-52, 1065-67, 1070-72, 1075-76 (1997).*

between zero (worst) and one (best) to reflect a patient's overall health-related quality of life after hospital discharge, which they then use to discount the estimated life-years gained. Although typically used across large patient populations, this technique assumes that an individual would prefer to secure a short but higher quality of life (e.g., two years multiplied by 0.8 = 1.6 QALYs) than linger in a poor state of health for an extended period of time (e.g., five years multiplied by 0.3 = 1.5 QALYs). Such a technique has any number of flaws, [59] to say nothing of the further (and far more contested) question about the upper threshold for justified spending on efforts to extend life, [60] but it does have the advantage **[*447]** of providing a common metric for comparing different types of medical interventions without the difficulty encountered in cost-effectiveness analysis of assigning a monetary value to lives saved.

Courts resolving tort litigation could invert this analysis and ask to what extent the defendant has reduced the victim's quality of life. [61] Although absolute reductions in life expectancy generally do not entitle the victim to damages apart from any associated loss of earning capacity, [62] jurors could decide that the quality of that remaining life expectancy also has declined. [63] Thus, if the plaintiff had a fifteen-year life expectancy, and the

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[59] See Allan S. Detsky & Andreas Laupacis, Relevance of Cost-effectiveness Analysis to Clinicians and Policy Makers, 298 JAMA 221, 223 (2007); Maurice McGregor, Cost-Utility Analysis: Use QALYs Only with Great Caution, 168 Can. Med. Ass'n J. 433 (2003); John La Puma & Edward F. Lawlor, Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers, 263 JAMA 2917 (1990).

[60] See, e.g., Lee Goldman, Editorial, Cost-Effectiveness in a Flat World - Can ICDs Help the United States Get Rhythm?, 353 New Eng. J. Med. 1513, 1513 (2005) (pegging "the usually accepted threshold" at $ 35,000-50,000 per QALY); Peter A. Ubel et al., What Is the Price of Life and Why Doesn't It Increase at the Rate of Inflation?, 163 Archives Internal Med. 1637, 1628-39 (2003) (arguing that these thresholds are too low and inflexible); Ross Kerber, We're Extending Our Lives, but at What Price?, Boston Globe, Sept. 26, 2005, at E1 (reporting that "healthcare economists often use $ 100,000 per added year of life as the maximum benefit worth paying by" Medicare).

[61] Cf. Mark A. Cohen & Ted R. Miller, "Willingness to Award" Nonmonetary Damages and the Implied Value of Life from Jury Awards, 23 Int'l Rev. L. & Econ. 165, 171-72, 179 (2003) (using QALY techniques to derive a VSL of $ 1.9 million from past jury awards in consumer product cases, and suggesting that these techniques could be used to create a schedule of pain-and-suffering damages for future cases). See generally Margaret A. Sommerville, Pain and Suffering at Interfaces of Medicine and Law, 36 U. Toronto L.J. 286, 286 (1986) (suggesting that pain-and-suffering damages be understood "as compensation for reduction in the plaintiff's quality of life"); id. at 289 (asking "whether the concept of quality of life could function as a possible unifying and organizing principle underlying all the approaches taken with respect to deciding whether to award damages for non-pecuniary loss … [and] to quantifying these damages"); id. at 302 ("This type of analysis may cause these two types of injury, that is, physical and mental injury, to be seen as more analogous and, as a consequence, equally worthy of compensation.").

[62] See Lars Noah, An Inventory of Mathematical Blunders in Applying the Loss-of-a-Chance Doctrine, *24 Rev. Litig. 369, 373 n.16 (2005);* cf. *Durham v. Marberry, 156 S.W.3d 242 (Ark. 2004)* (joining a handful of courts that allow such an award). Some research has suggested that reductions in quality of life may shorten life expectancy. See, e.g., Kim T.J.L. Ensinck et al., Is There an Increased Risk of Dying After Depression?, 156 Am. J. Epidemiology 1043, 1046-47 (2002); Lawson R. Wulsin, Editorial, Does Depression Kill?, 160 Archives Internal Med. 1731 (2000); see also Sheldon Cohen et al., Psychological Stress and Disease, 298 JAMA 1685 (2007); Ilan S. Wittstein et al., Neurohumoral Features of Myocardial Stunning Due to Sudden Emotional Stress, 352 New Eng. J. Med. 539, 540, 546-47 (2005) (investigating the association between stressful events and potentially fatal cardiovascular responses).

[63] See Adler, supra note 58, at 49-50 (comparing different health classification systems); id. at 69 ("Many, perhaps most, health conditions lack a single contingent-valuation or revealed preference study. By contrast, … QALY surveys have been conducted for a large number of conditions."); Mauro V. Mendlowicz & Murray B. Stein, Quality of Life in Individuals with Anxiety Disorders, 157 Am. J. Psychiatry 669, 678-79 (2000) (discussing various instruments used to measure relative decrements in quality of life across types of emotional distress, and noting that "PTSD may exert a heavier toll on quality of life than other anxiety disorders"). But cf. George Loewenstein et al., Projection Bias in Predicting Future Utility, 118 Q.J. Econ. 1209, 1212 (2003) ("Nonpatients' predictions of the quality of life associated with serious medical conditions are lower than actual patients' self-

tortfeasor caused the **[*448]** victim's overall quality of life to decline from 0.9 to 0.85, [64] then the defendant would have deprived the plaintiff of 0.75 QALYs; if (borrowing from the WTP research) experts persuade the jury that each QALY has a value of $ 100,000, [65] then the nonpecuniary award would amount to $ 75,000.

III. Avoidable Consequences and Emotional Injury

Plaintiffs generally have a duty to mitigate their damages, though courts have shown some reluctance when applying the mitigation requirement to nonphysical harms. With advances in the treatment of both pain and suffering, however, this judicial hesitancy may make less sense today. If nothing else, application of the avoidable consequences rule to claims seeking noneconomic damages might provide a firmer basis for monetizing these awards, even if many aspects of emotional harm remain beyond the therapeutic capabilities of health care professionals.

A. Basic Contours of the Duty to Mitigate

The avoidable consequences doctrine limits recovery for an injury to its likely severity after the victim makes reasonable efforts to mitigate damages, and it separately authorizes recovery for expenditures **[*449]** made in pursuit of mitigation. [66] Indeed, some courts have allowed claims seeking nothing other than the recovery of reasonable (anticipatory) mitigation expenses. [67] The doctrine has less, however, to do with encouraging plaintiffs

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reported quality of life."); Laura J. Damschroder et al., The Impact of Considering Adaptation in Health State Valuation, 61 Soc. Sci. & Med. 267, 267-68 (2005); infra note 149 (discussing research on "hedonic adaptation").

[64] Cf. FDA, Final Rule, Patient Examination and Surgeons' Gloves: Test Procedures and Acceptance Criteria, 71 Fed. Reg. 75,865, 75,874 (Dec. 19, 2006) ("According to one measurement scale of well-being, reduced mental lucidity, depression, crying, lack of concentration, or other signs of adverse psychological sequelae may detract as much as 8 percent from overall feelings of well-being."); Kenneth J. Smith & Mark S. Roberts, The Cost-Effectiveness of Sildenafil, 132 Annals Internal Med. 933, 934-36 (2000) (assuming that erectile dysfunction results in an average disutility of 0.13). See generally Matthew D. Adler, Fear Assessment: Cost-Benefit Analysis and the Pricing of Fear and Anxiety, 79 Chi.-Kent L. Rev. 977 (2004); id. at 1029-30 (citing contingent valuation studies involving pain, depression, and anxiety); id. at 1043-50 (explaining that QALY estimates for these sorts of conditions could be converted into dollars using the VSL); Adler, supra note 58, at 57-60 (discussing QALY-to-dollar conversions, and illustrating with analyses conducted by the FDA that monetized the avoidance of functional disability as well as pain and suffering associated with heart disease).

[65] See Adler, supra note 58, at 67 ("[A] conversion factor of $ 100,000 per QALY looks closer to optimal, and lower factors such as $ 50,000 or even $ 10,000 should be considered."); Margaret M. Byrne et al., Willingness to Pay Per Quality-Adjusted Life Year in a Study of Knee Osteoarthritis, 25 Med. Decision Making 655, 656, 662 (2005) (finding a WTP of no more than $ 6,000 per QALY to avoid a nonfatal condition); see also Cass R. Sunstein, Essay, Lives, Life-Years, and Willingness to Pay, 104 Colum. L. Rev. 205, 228-31, 245-49 (2004); David A. Fahrenthold, Cosmic Markdown: EPA Says Life Is Worth Less, Wash. Post, July 19, 2008, at A1. This approach is more structured (and constrained) than per diem arguments.

[66] See, e.g., Preston v. Keith, 584 A.2d 439, 441-43 (Conn. 1991); McWilliams v. Wilhelm, 893 P.2d 1147, 1148-49 (Wyo. 1995); see also Restatement (Third) of Torts: Apportionment § 3 cmt. b (2000); ***Restatement (Second) of Torts § 918(1)*** ("One injured by the tort of another is not entitled to recover damages for any harm that he could have avoided by the use of reasonable effort or expenditure after the commission of the tort."); id. cmt. b ("The damages for the harm suffered are reduced to the value of the efforts he should have made or the amount of the expense he should have incurred, in addition to the harm previously caused."); id. § 919(2) ("One who has already suffered injury by the tort of another is entitled to recover for expenditures reasonably made … in a reasonable effort to avert further harm.").

[67] See, e.g., Sutton v. St. Jude Med. S.C., Inc., 419 F.3d 568 (6th Cir. 2005) (holding that the plaintiff had standing to pursue a class action lawsuit for medical monitoring expenses on behalf of cardiac bypass patients who had received an allegedly defective aortic connector and faced an increased risk of injury); see also Kenneth S. Abraham, Liability for Medical Monitoring and the Problem of Limits, 88 Va. L. Rev. 1975, 1977 (2002) (drawing the parallel to mitigation); David M. Studdert et al., Medical Monitoring for Pharmaceutical Injuries: Tort Law for the Public's Health?, 289 JAMA 889 (2003). But see Paz v. Brush Eng'd Materials, Inc., 949 So. 2d 1, 6-7 (Miss. 2007) (canvassing the division of authority in other jurisdictions); Sinclair v. Merck

to minimize avoidable consequences than it serves as a mechanism for quantifying the appropriate scope of future damages and forcing the victim to internalize the costs associated with any unreasonable failure to mitigate. [68] If victims know in advance that they will not profit from allowing their injuries to go uncorrected, then (as the cheapest loss avoider) they will have every reason to take reasonable steps to minimize their damages. [69] Because the avoidable consequences **[*450]** rule operates as an affirmative defense, the burden of proof falls on the defendant. [70]

In applying the mitigation requirement in the torts context, courts usually address the obligation to undergo surgical interventions, tending to conclude that victims need not subject themselves to such procedures if they pose more than minimal risk. [71] Reasonable people also might decline medical treatments that have little chance of success or that present significant practical difficulties (such as inconvenience and expense). Less frequently do questions arise in connection with noninvasive treatments. [72] Nonetheless, because prescription drugs often pose a risk of potentially serious side effects, [73] courts will have to decide whether a reasonable person would accept those risks given the anticipated therapeutic benefits. [74]

& Co., 948 A.2d 687 (N.J. 2008) (declining to recognize such claims); Victor E. Schwartz et al., Medical Monitoring: The Right Way and the Wrong Way, *70 Mo. L. Rev. 349 (2005)* (criticizing courts for allowing such claims).

[68] See *Lawson v. Trowbridge, 153 F.3d 368, 377 (7th Cir. 1998)* ("An obvious example would be a person who, when cut by a defective product, fails to take antiseptic measures, thereby allowing the wound to become infected. The injured person may recover damages from the tortfeasor, but only for the harm that he would have suffered had he exercised reasonable care."); Charles T. McCormick, Avoiding Injurious Consequences, 37 W. Va. L.Q. 331, 331-34, 340-41 (1931). In most cases, victims already have an incentive to minimize avoidable consequences because of their preference for limiting the severity of an injury coupled with the uncertainty about their ability to shift any or all damages to the tortfeasor. Indeed, the doctrine also may reflect principles of proximate causation insofar as the defendant could not have foreseen the victim's intervening decision to decline subsequently recommended treatment, which may become a superseding cause that cuts off the defendant's obligation to pay for any aggravation of the original injury.

[69] The Americans with Disabilities Act (ADA) also imposes something of a mitigation requirement by determining whether an impairment substantially limits a major life activity after taking into account the availability and use of any corrective measures. See Jill Elaine Hasday, Mitigation and the Americans with Disabilities Act, *103 Mich. L. Rev. 217, 219 & n.8, 229-66 (2004)* (arguing that this inquiry properly includes any unreasonable failures to use corrective measures); cf. Sarah Shaw, Comment, Why Courts Cannot Deny ADA Protection to Plaintiffs Who Do Not Use Available Mitigating Measures for Their Impairments, *90 Cal. L. Rev. 1981, 2006-20, 2027-39 (2002)* (disputing this interpretation).

[70] See, e.g., *Willis v. Westerfield, 839 N.E.2d 1179, 1187-88 (Ind. 2006); Greenwood v. Mitchell, 621 N.W.2d 200, 205-07 (Iowa 2001); Monahan v. Obici Med. Mgmt. Servs., Inc., 628 S.E.2d 330, 336-37 (Va. 2006); Hawkins v. Marshall, 962 P.2d 834, 838-39 (Wash. Ct. App. 1998).*

[71] See, e.g., *Chancellor v. Taylor, 711 P.2d 660, 661-62 (Ariz. Ct. App. 1985)* (dictum); *McDonnell v. McPartlin, 708 N.E.2d 412, 420 (Ill. App. Ct. 1999); Couture v. Novotny, 211 N.W.2d 172, 174-76 (Minn. 1973); Automatic Merchandisers, Inc. v. Ward, 646 P.2d 553, 555 (Nev. 1982).*

[72] See W.E. Shipley, Annotation, Duty of Injured Person to Submit to Nonsurgical Medical Treatment to Minimize Tort Damages, *62 A.L.R.3d 70* (1975 & Supp. 2007).

[73] See Lars Noah, Law, Medicine, and Medical Technology 290-94, 321-36 (2d ed. 2007).

[74] See, e.g., *Keans v. Bottiarelli, 645 A.2d 1029, 1031 (Conn. App. Ct. 1994)* (affirming conclusion that the plaintiff's failure to take prescribed antibiotics represented a failure to mitigate damages associated with the need for hospitalization after a negligent tooth extraction); *Herring v. Poirrier, 797 So. 2d 797, 806-07 (Miss. 2000)* (upholding mitigation instruction where, among other things, the plaintiff had neglected to tell his physician that he discontinued a prescribed course of pain medication because it had caused drowsiness). Even when the benefits unmistakably outweigh the risks, patients far too often neglect to complete a prescribed course of treatment. See Amy Dockser Marcus, The Real Drug Problem: Forgetting to Take Them, Wall

B. Judicial Hostility to Psychiatric Mitigation

Although rarely litigated, courts have shown some hesitancy in applying a duty to mitigate pain and suffering. [75] In 1973, in one of **[*451]** the earliest reported opinions to discuss the issue squarely, a Louisiana appellate court affirmed a judgment in favor of a pedestrian who had been struck by a vehicle in a parking lot and received an award of $ 40,000 for lost wages (past and future), $ 18,000 for pain and suffering, and more than $ 2,400 for medical expenses. [76] Although the victim had recovered from his physical injuries, he continued to complain of pain, leading to a psychiatric referral and diagnosis of depression. [77] After unsuccessfully treating the plaintiff with antidepressants and tranquilizers, the psychiatrist recommended electroshock therapy. [78] Notwithstanding the psychiatrist's explanation that the treatment was highly effective (purportedly working in 80-90% of cases) and that the risks related to the induction of seizures were minimal relative to some of the hazards commonly associated with pharmaceutical and surgical interventions, the plaintiff declined to undergo this treatment. [79]

The appellate court in Dohmann v. Richard rejected the defendants' argument that the plaintiff had failed to mitigate damages by declining the electroshock therapy recommended by his psychiatrist. After explaining that it could find no precedent for a psychiatric mitigation requirement, the court suggested a fundamental difference between widely accepted treatments for physical injuries and treatments designed to alter personality. [80] (Of course, the premise underlying the plaintiff's claim was that the defendant's **[*452]** negligence had adversely affected his personality, causing him ongoing pain and suffering that made it impossible for him to return to work.) In addition, the court emphasized the social stigma attached to such treatments: "we bear in mind that our society has not progressed to a point in which it accepts mental illnesses, and particularly the drastic treatment thereof by such measures as

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St. J., Oct. 21, 2003, at D1; Andrew Pollack, Take Your Pills, All Your Pills: Drug Makers Nag Patients to Stay the Course, N.Y. Times, Mar. 11, 2006, at C1.

[75] See Shipley, supra note 72, at 97 ("In most of the few cases involving a claim that plaintiff should have submitted to psychiatric treatment to mitigate damages, the courts have shown a reluctance to rule that damages be diminished because of the failure to undergo such treatment."); see also Restatement (Third) of Torts: Liability for Physical and Emotional Harm ch. 8, at 2 (summarizing the reasons why courts historically restricted recovery for emotional distress, including that, "while mitigation may be important in minimizing this harm, there is little a legal system can do to encourage or enforce mitigation").

[76] See *Dohmann v. Richard, 282 So. 2d 789, 789-92, 794 (La. Ct. App. 1973).*

[77] See *id. at 792* (explaining that "obviously his physical injuries were not overly serious and should have been of a moderate duration").

[78] See *id. at 792-93.*

[79] See *id. at 793* ("The plaintiff and his family were extremely frightened of the prospect of electro-shock treatments.").

[80] See id. ("Plaintiff is not being asked to have a fractured bone placed in a cast, a hernia repaired, or any other conventional form of surgery. Instead it is proposed that he subject himself to electro-shock, a form of treatment designed to work a change in his personality."). At one point in its discussion, the court also seemed unpersuaded by the reassuring picture painted by the plaintiff's treating psychiatrist, even though it pointed to no evidence in the record that cast doubt on his optimistic risk-benefit analysis. See id. ("We are dealing with what is perhaps the most misunderstood field of medicine, i.e. treatment of the mind."). Later in the same paragraph, however, it hastened to add that "we do not intend to in any way demean the value of such treatments or to question the effectiveness with which they are generally credited within the medical profession, but refer only to the attitudes held towards them by the public at large." *Id. at 794* ("As testified to by Dr. McCray the treatment is of undoubted value and benefit in many cases and may very well be so in the case at bar."). If electroconvulsive therapy remained genuinely "experimental," then a reasonable patient could decline it, but the court had only alluded to this possibility. Cf. *Moore v. Baker, 989 F.2d 1129, 1133 (11th Cir. 1993)* (explaining that the duty to disclose alternatives does not include any obligation to advise patients of the availability of experimental treatments); *Schiff v. Prados, 112 Cal. Rptr. 2d 171, 182-84 (Ct. App. 2001)* (same). See generally Lars Noah, Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy, *28 Am. J.L. & Med. 361 (2002).*

shock therapy, with the same tolerance that it now regards physical surgery or treatment." [81] The court concluded its discussion of the avoidable consequences issue by emphasizing that "we are not prepared to hold at this time that psychiatric therapy of this sort falls within the spirit, or the letter, of that line of jurisprudence which requires injured persons to mitigate their damages." [82]

One decade later, the Supreme Court of Louisiana addressed the same basic issue, and it reached a similar conclusion, though on different grounds and without citing Dohmann. [83] In Jacobs, the plaintiff's car collided with a negligently operated city bus, allegedly resulting in severe and disabling anxiety. [84] The trial judge awarded her $ 100,000, half of which reflected pain-and-suffering damages, but rejected a further claim for lost future wages after concluding that the plaintiff had failed to mitigate her emotional injuries by undergoing additional psychotherapy; the appellate court disagreed with that finding and ordered additur of almost $ 160,000. [85] The state supreme court concurred, emphasizing that none of the medical witnesses had testified that continued psychiatric treatment would have reduced her anxiety enough to allow the plaintiff to return to work. [86] Unlike Dohmann, then, the issue **[*453]** did not turn on whether the plaintiff had acted reasonably in declining to undergo treatment - even if the decision to ignore the advice of her doctors was entirely unreasonable, it did not proximately cause any more severe an injury (for which the defendants should escape an obligation to pay). [87]

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[81] *Dohmann, 282 So. 2d at 794* ("Accordingly we cannot disregard the effect that such treatment, given the present attitudes of our society, is likely to have on plaintiff's future relations with his peers.").

[82] Id. (emphasis added); see also *Tortorice v. Capital Brickwork Constr., Inc., 251 A.2d 812, 813-14 (Pa. Super. Ct. 1969)* (same, in worker's compensation case). In contrast, many years earlier an English court found a failure to mitigate after the plaintiff had declined to undergo electroshock treatments. See Marcroft v. Scruttons, Ltd., [1954] 1 Lloyd's List L.R. 395, 399 (C.A.). Decades later, and in spite of further research and improvements, this form of therapy remains underutilized. See Max Fink & Michael Alan Taylor, Electroconvulsive Therapy: Evidence and Challenges, 298 JAMA 330 (2007); Sarah H. Lisanby, Electroconvulsive Therapy for Depression, 357 New Eng. J. Med. 1939 (2007).

[83] See *Jacobs v. New Orleans Pub. Serv., Inc., 432 So. 2d 843, 846 (La. 1983).*

[84] The dissent noted, however, that initially "there was no claim for or evidence of a psychological disability related to the accident." *Id. at 847* (Lemmon, J., dissenting) ("The psychiatric testimony in the first trial, which was introduced solely to corroborate plaintiff's claim that her fear of needles justified her refusal of a myelogram, was evidence in support of her claim for damages resulting from a back injury.").

[85] See *id. at 844-45.* As the Louisiana Supreme Court explained, the appellate court failed to recognize that the trial judge already had awarded $ 50,000 for lost earning capacity. See *id. at 846-47.*

[86] See *id. at 846;* see also ***Zerilli v. N.Y. City Transit Auth., 973 F. Supp. 311, 323 (E.D.N.Y. 1997)*** (denying the defendant's motion for a new trial or a judgment notwithstanding the verdict in an employment discrimination case, which resulted in an award of $ 95,000 for emotional distress, after finding no evidentiary foundation to support a requested jury instruction on the duty to mitigate where the employee allegedly declined to attend a psychological counseling program at the worksite: "even assuming a duty on the part of a plaintiff to mitigate such damages - a duty for whose existence [defendant] provides no authority - … it would have been an invitation to sheer speculation to have allowed the jury to consider, without any testimony on the question, the extent to which the psychological counseling would have alleviated Ms. Zerilli's condition had she agreed to engage in it"); *Gulf Oil Corp. v. Slattery, 172 A.2d 266, 270 (Del. 1961)* (affirming plaintiffs' verdict where the jury had received a mitigation instruction, and rejecting the defendant's argument that it should have received a partial directed verdict on the claim for traumatic neurosis (anxiety) where an automobile accident victim had declined to undergo belatedly recommended psychiatric treatment of doubtful efficacy); *Jackson v. Kansas City, 947 P.2d 31, 36 (Kan. 1997).*

[87] The court separately noted that the plaintiff had discontinued psychotherapy for financial reasons. See *Jacobs, 432 So. 2d at 846.* Although impecunity might have excused her decision, see *Garcia v. Wal-Mart Stores, Inc., 209 F.3d 1170, 1174-75 (10th Cir. 2000),* that would not prevent a court from awarding damages to cover these expenses in the future (and, thereby, reduce its award for future lost wages or pain and suffering), except again for the lack of evidence that it would have helped this patient

One decade ago, a trio of federal district courts encountered questions about psychiatric mitigation. Two of these cases arose under the Federal Tort Claims Act (FTCA), [88] and, because the judgments emerged from bench trials, the judicial opinions contain detailed summaries of the evidentiary record. As elaborated in the paragraphs that follow, the plaintiffs in all three cases had fairly minor lasting physical injuries but offered diagnoses of serious emotional distress, and they underwent psychological counseling but declined to use some or all of the medications prescribed by their psychiatrists. In all three cases, the courts agreed with the defendants' arguments that the mitigation requirement applied to the claims for nonpecuniary damages, but they decided that each plaintiff had acted reasonably in declining to use the recommended psychotropic drugs.

The first case, arising from a catastrophic accident involving a commercial airliner that resulted from admitted negligence by the air traffic controllers, focused on what damages to award to one of **[*454]** the flight attendants who had survived the crash. [89] The plaintiff's physical injuries had healed and he did not seek any award for past medical expenses, but, because of the lasting emotional trauma associated with the accident (diagnosed as PTSD with depression), [90] the court awarded almost $ 31,000 for future medical expenses in light of the continuing need for psychological counseling and psychiatric evaluation. [91] In addition, after explaining the difficulty encountered in trying to monetize pain-and-suffering damages, the court awarded $ 220,000, [92] only to increase that amount a few months later to $ 300,000 in response to the plaintiff's motion for reconsideration. [93] In rejecting the government's mitigation defense, the court simply found that the plaintiff's "choice not to take antidepressant medications is not a wholly unreasonable choice. He has, instead, made major efforts in other ways and obviously declined the reliance on medication based on the same attitude of self-reliance and determination that have brought him this far in his recovery." [94] Perhaps, as in Jacobs, the **[*455]** court did not believe that the additional use of psychotropic drugs would have made much of a difference, but it never explained its conclusion in causation terms.

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return to work or at least limit her future suffering. Although the opinion failed to mention the nature of the recommended psychiatric treatment, and the reported opinions of the lower courts did not clarify the matter, it appears that the trial judge also had awarded $ 8,000 to cover future medical (presumably psychiatric) expenses. See *Jacobs v. New Orleans Pub. Serv., Inc., 374 So. 2d 167, 168 (La. Ct. App. 1979)* (Beer, J., concurring).

[88] *28 U.S.C. §§1346*(b), 2402, 2671-80 (2000).

[89] See ***In re Air Crash at Charlotte, 982 F. Supp. 1101, 1103-05 (D.S.C. 1997).***

[90] See ***id. at 1106-08 & n.5.*** The defendant's psychiatric witness, a recognized expert in PTSD, had recommended that the plaintiff "should consider the use of medications, which plaintiff has rejected to this point." ***Id. at 1107;*** see also ***id. at 1107-08*** (adding that this expert also thought that the plaintiff already could return to some form of work and, with proper treatment, could return to his previous position within two years). The court evidently found that expert's prognosis unduly optimistic. See ***id. at 1108-09; id. at 1110*** ("While no one disputes that the post traumatic stress syndrome that plaintiff has suffered will remain with him for the rest of his life, there are significant questions as to the degree to which the plaintiff will be able to learn to cope with this trauma.").

[91] See ***id. at 1110*** ("Plaintiff will continue to need routine sessions with the treating psychologist on a weekly basis in the near future, decreasing to monthly and, eventually, to rarely although possibly having some need, off and on, for the remainder of his life."). In addition, the court awarded almost $ 270,000 for lost earning capacity. See ***id. at 1108-10.***

[92] See ***id. at 1110-11*** (claiming also to approach this task with a fair degree of skepticism about the genuineness of allegedly debilitating emotional injuries); ***id. at 1112-13*** ("Damages for emotional distress are perhaps the most difficult damages to quantify. They are unique to each plaintiff, requiring careful inquiry into the event experienced, the plaintiff's reaction to those events, and the plaintiff's prospects for recovery."). Although it did not separate the figure, the court suggested that much of this amount covered past nonpecuniary damages. See ***id. at 1110*** ("The most significant pain and suffering in the present case is severe emotional suffering over the more than two year period since the time of the crash.").

[93] See ***id. at 1114-15.***

[94] ***Id. at 1112*** ("Therefore, the court does not find this personal choice to be a failure to mitigate damages under the present circumstances."). The other "major efforts" included buying and repairing a house, going back to college (notwithstanding difficulties in concentrating), getting engaged (notwithstanding fears of abandonment), and taking flights as a passenger (notwithstanding extreme anxiety). See ***id. at 1105-08.*** Of course, in addition to crediting this evidence that the plaintiff was

The second case arose from an automobile accident caused by the negligent driving of a federal employee. [95] The plaintiff suffered only minor physical injuries in the collision, but she subsequently experienced anxiety and worsening depression, and her continuing physical complaints suggested a somatoform disorder (i.e., unconscious exaggeration of symptoms). [96] At the time of trial, the plaintiff was under the care of several different specialists, and she was taking a number of different prescription medications, including a mood stabilizer (Tegretol(R)) and an antidepressant (Zoloft(R)). [97] More than three years earlier, however, she had refused a different psychiatrist's recommendation to take precisely these sorts of medications, and, at the time of trial, the plaintiff continued to decline the earlier recommendation also to take an antipsychotic drug. [98]

In light of this record (and having conceded negligence), the government relied on a mitigation defense at trial, arguing that the "plaintiff should not be awarded any damages after November 1993, when she refused to take the combination of three psychiatric **[*456]** medications recommended by Dr. Dickinson." [99] In considering this issue, the court explained that it could find only a single decision from New York that addressed psychiatric mitigation, [100]

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toughing it out and making other attempts to cope with his undoubted emotional trauma, the court's award of future medical expenses (and its finding that he eventually would manage to return to some form of gainful employment) assumed that the plaintiff would continue to seek the assistance of mental health care specialists and experience further improvement. See ***id. at 1110*** ("The court concludes that plaintiff will recover in significant ways over time."). Thus, in the sense that it decided to award less than the full pecuniary and nonpecuniary damages sought by the plaintiff, see ***id. at 1103 & n.1,*** the court did apply the avoidable consequences rule, see ***id. at 1112*** ("The court has taken these [mitigation] factors into account in reaching its above stated award.").

[95] See *Salas v. United States, 974 F. Supp. 202, 203-04 (W.D.N.Y. 1997).*

[96] See *id. at 204-10; id. at 206* ("As to the plaintiff's psychiatric state, various labels have been applied [also including PTSD, borderline personality, and schizo-affective disorder], but all of the doctors do agree that the motor vehicle accident triggered a psychiatric condition."); *id. at 207* ("In sum, the medical testimony demonstrated that … the minor trauma of the automobile accident triggered a major psychiatric deterioration which totally disabled the plaintiff.").

[97] See *id. at 205.*

She has been on and off antidepressants in the past, but chose not to take them on a long-term basis, apparently because of side effects. For instance, the record disclosed that the plaintiff took Pamelor, a tricyclic antidepressant, for more than one year following the accident, and it did make her feel less depressed. However, she claims that it made her allergic to the sun and she stopped taking it.

Id. (adding that, "three weeks prior to trial, she began taking Zoloft, one of the new generation of antidepressants known as selective serotonin[] reuptake inhibitors").

[98] See *id. at 207.* It took almost two years before the plaintiff began taking the mood stabilizer and fully three years before taking the antidepressant. See *id. at 212* (adding that the plaintiff's treating psychiatrist had disagreed with the earlier recommendation to use an antipsychotic).

[99] *Id. at 211.* The defendant offered a variety of other arguments (including comparative negligence) that the court also found unpersuasive. See *id. at 207-13.* For instance, the government insisted that, given her longstanding psychiatric problems, the plaintiff eventually would have deteriorated even in the absence of this accident. See *id. at 209-10.* The court rejected this argument because it depended on the testimony of the government's expert witness, which the court found less credible than the plaintiff's witnesses in part because Dr. Dickinson had abandoned the plaintiff for declining to comply with her recommended course of psychotropic drug treatment. See *id. at 210-11.*

[100] See *id. at 211.* In that case, the tenant of a public apartment complex claimed that negligent maintenance gave an intruder access to the building and resulted in her rape. See *Skaria v. State, 442 N.Y.S.2d 838, 839-40 (Ct. Cl. 1981).* After a bench trial, the court held for the plaintiff, but it declined to award any damages for pain and suffering (including phobias linked to the trauma) experienced after January 1, 1979, because, after relocating six months prior to that date, she had failed to locate another therapist as recommended by the psychologist who initially had treated her. See *id. at 841-42;* see also ***Gardner v.***

which it distinguished because the victim there had declined treatment altogether rather than just "a particular course of treatment." [101] Nonetheless, the court accepted the proposition that a plaintiff would have a duty to mitigate emotional injury.

The court offered a number of reasons, however, for concluding that this plaintiff had not failed to mitigate. First, it questioned Dr. Dickinson's favorable prognosis in the case of treatment, [102] which **[*457]** meant that the defendant had not established that any arguable failure to mitigate caused an aggravated injury. Second, the court noted that psychiatric experts testifying for both parties conceded that patients may have legitimate reasons for rejecting psychotropic medication, including bothersome side effects. [103] Third, the court recognized that the victim's underlying emotional injury or cognitive impairment could excuse her failure to act in an objectively reasonable way. [104] Although in the end it found no failure to mitigate in this case, the court's award of future compensatory damages assumed that the combination of psychotherapy and prescribed medications would allow the plaintiff to improve gradually and recover fully within five years. [105]

Federated Dep't Stores, Inc., 717 F. Supp. 136, 139-42 (S.D.N.Y. 1989) (affirming $ 150,000 awarded for past pain and suffering where the victim of a false arrest alleged extreme anxiety, but ordering remittitur of $ 500,000 award for future pain and suffering to $ 10,000 because he had never sought out psychiatric care), aff'd in relevant part, *907 F.2d 1348, 1354 (2d Cir. 1990);* *Tucker v. Town of Branford, No. CV-960252918S, 1998 Conn. Super. LEXIS 1139, at 13-15, 22-23* (Apr. 23, 1998) (awarding, after a bench trial, $ 1,050 for past psychiatric expenses and $ 12,000 for pain and suffering to the driver of an automobile who developed PTSD after a collision with a negligently operated police vehicle that caused her car to become submerged, but declining to award future damages (including an estimated $ 3,900 for additional psychiatric treatment) because the plaintiff had refused further psychotherapy or the use of anti-anxiety drugs); *Fox v. Evans, 111 P.3d 267, 270-71 (Wash. Ct. App. 2005)* (affirming jury verdict that reduced damages by 22% for failure to mitigate where an auto accident victim had refused to accept a diagnosis of depression and had discontinued prescribed antidepressants and psychotherapy); *Casimere v. Herman, 137 N.W.2d 73, 77-78 (Wis. 1965)* (reversing an award of $ 4,500 for future pain and suffering where the plaintiff's psychologist had testified that her emotional injury could be treated but failed to specify the likely duration or cost of psychotherapy).

[101] *Salas, 974 F. Supp. at 211;* see also *id. at 212* ("The plaintiff readily agreed to undergo psychiatric assessment upon the recommendation of one of her physicians. In fact, since the accident, plaintiff has consistently seen many doctors and for the most part followed their medical advice."); id. ("She has also consistently engaged in psychotherapy with Dr. Mostert and others, which is a recognized, conventional form of treatment for somatoform disorder.").

[102] See *id. at 212* ("The prognosis of every other physician who examined the plaintiff was much more guarded… . Dr. Dickinson's prognosis for a virtually assured and complete recovery is not supported by the record."). On this point, then, the evidence in this case fell somewhere in between the two earlier Louisiana cases, one that had uncontroverted testimony about the high likelihood of efficacy with electroshock therapy (but rejected the mitigation defense on other grounds) and the other that found no evidence whatsoever to suggest that psychotherapy would have helped the plaintiff.

[103] See *id. at 211-12;* *id. at 210* ("Dr. Dickinson did concede that some patients are legitimately concerned about the side-effects of medication and that many patients do refuse medications.").

[104] See *id. at 212* ("The plaintiff believes her cognitive difficulties stem from a brain injury and that her other physical symptoms are also causally related to the motor vehicle accident. Thus, the plaintiff could have reasonably believed that her condition was physiological, rather than psychiatric, in nature."); see also *Templeton v. Chicago & N.W. Transp. Co., 628 N.E.2d 442, 453-54 (Ill. App. Ct. 1993);* *Cannon v. New Jersey Bell Tel., 530 A.2d 345, 351-52 (N.J. Super. Ct. App. Div. 1987);* *Botek v. Mine Safety Appliance Corp., 611 A.2d 1174, 1177 n.2 (Pa. 1992).*

[105] See *Salas, 974 F. Supp. at 213-14;* *id. at 214* ("Considering the testimony of the experts, whose estimates as to plaintiff's ability to return to work ranged from soon to never, I believe that [with continued treatment] the plaintiff's pain and suffering can be eliminated and she can be returned to work in five years."); id. (awarding pain and suffering on an annually declining schedule, for a total of almost $ 90,000); see also Neal v. Dir., D.C. Dep't of Corrections, No. 93-2420, 1995 WL 517249, at 15 (D.D.C. Aug. 9, 1995) (reducing, after a bench trial for equitable relief under Title VII, the future lost earnings requested by the victim of sexual harassment because experts had testified that her major depression and anxiety likely would improve with Prozac(R) or a comparable drug even though she previously had declined medication because of concerns about side effects, but not reducing for failure to mitigate the back pay requested because the plaintiff's psychotherapist had concurred with her

[*458] In a third case from the late 1990s, based on a misdiagnosis of the plaintiff as HIV positive that caused him lasting depression (even though subsequent retesting had given the patient a clean bill of health), a federal district court entered judgment on a verdict that included an award of $ 285,000 for pain and suffering as well as $ 5,000 for expenses that included mental health care. [106] In rejecting the defendant's motion for a new trial, the court found no merit in objections lodged against the jury instructions concerning the mitigation requirement, [107] and it explained that the plaintiff had received some psychiatric counseling, but, without further elaboration, the court concluded that "his desire not to take medication, standing alone, does not support [the defendant's] argument. The jury could have reasonably concluded that Baker did what he could to alleviate his distress … ." [108] In short, these federal courts applied the mitigation requirement to claims for nonpecuniary damages but, for various reasons, appeared to do so in a more lenient manner than normally happens in the case of treatments for physical injuries.

Religious objections to mental health treatments might pose a stronger version of the stigma concern expressed in Dohmann and perhaps implicit in the federal cases decided in the late 1990s. For instance, adherents of Scientology vigorously denounce modern psychiatry, [109] and they have mounted publicity campaigns attacking psychotropic drugs. [110] Putting aside longstanding questions about whether the Church of Scientology qualifies as a bona fide religion, [111] courts generally have rejected the argument that tort victims **[*459]** need not accept reasonable medical interventions that might offend their religious scruples. [112] Judges do not, of course, thereby

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decision), rev'd on other grounds sub nom. *Bonds v. District of Columbia, 93 F.3d 801, 813 (D.C. Cir. 1996).* In support of this approach for setting pain-and-suffering damages, the Salas court cited a much older FTCA case involving an automobile collision, which also included a limited discussion of the psychiatric mitigation issue. See *Letoski v. FDA, 488 F. Supp. 952, 953-57 (M.D. Pa. 1979)* (finding that the plaintiff's minor orthopedic injuries triggered a severe anxiety neurosis, which he belatedly and unsuccessfully tried to treat with tranquilizers and antidepressants); *id. at 960* (observing that the "plaintiff has not received optimal treatment up to this point, largely because of his own unwillingness to cooperate manifested in some degree by his quickness to indicate inability to tolerate any drug regimen"); *id. at 961* (rejecting, however, the government's argument that he had failed before trial to mitigate psychiatric damages); *id. at 960-62* (concluding that intensive psychotherapy and behavioral therapy would allow the plaintiff to return to work within five years, and awarding compensatory damages accordingly, including future psychiatric expenses of $ 16,000 and future pain and suffering of $ 85,000); see also *Browning v. United States, 361 F. Supp. 17, 24 n.5, 28-29 (E.D. Pa. 1973)* (engaging in a similar analysis of a claim brought under the Public Vessels Act).

[106] See Baker v. Dorfman, No. 1:97 *Civ. 7512, 1999 U.S. Dist. LEXIS 4451, at 10-14* (S.D.N.Y. Apr. 6, 1999), aff'd, *239 F.3d 415, 422 (2d Cir. 2000).* The award, which emerged after successful malpractice litigation against an attorney who had missed deadlines for filing the negligent misdiagnosis claim, also included $ 70,000 for lost wages and $ 25,000 in punitive damages.

[107] See id. at 16-18.

[108] Id. at 17. The appellate court noted that the defendant had not pressed his mitigation argument. See *239 F.3d at 418 n.1.* In contrast, one court held that a trial judge had committed error in declining to use a defendant's requested jury instruction that focused on the plaintiff's failure to undergo psychotherapy. See *Tabieros v. Clark Equip. Co., 944 P.2d 1279, 1315-17 (Haw. 1997)* (emphasizing, however, the fact that the general mitigation instruction had failed to specify the impact of the avoidable consequences rule).

[109] See Timothy Bowles, Scientology Ethics and Psychiatric Injustice, *27 Tex. Tech L. Rev. 1011 (1996)* (offering a true believer's views on the subject); Daniel Ruth, Funny? Yes, and Quite Weird, Too, Tampa Trib., Mar. 22, 2007, at B1.

[110] See Thomas M. Burton, Medical Flap: Anti-Depression Drug of Eli Lilly Loses Sales After Attack by Sect, Wall St. J., Apr. 19, 1991, at A1; Michael Tackett, Scientologist Campaign Shakes Drug Firm, Advertising Industry, Chi. Trib., June 30, 1991, at 17.

[111] See Paul Horwitz, Scientology in Court: A Comparative Analysis and Some Thoughts on Selected Issues in Law and Religion, *47 DePaul L. Rev. 85, 102-10, 145-54 (1997);* Mark Oppenheimer, Weird, Sure. A Cult, No, Wash. Post, Aug. 5, 2007, at B2; Janet Reitman, Inside Scientology, Rolling Stone, Mar. 9, 2006, at 55.

[112] See, e.g., *Munn v. Algee, 924 F.2d 568, 573-75 (5th Cir. 1991)* (holding that the plaintiff had a duty to mitigate by accepting a blood transfusion even if, as a Jehovah's Witness, she had a religious objection); see also Gary Knapp, Annotation, Refusal of

force plaintiffs to accept these objectionable treatments, [113] but they also do not obligate the tortfeasor to subsidize the victim's arguably unreasonable choice. [114] Thus, a psychiatric mitigation rule would not force someone with religious (or other) objections to accept, for instance, psychotropic drugs, but it also would not allow the victim of emotional injuries to seek recovery for more than the amount it typically would have cost to treat such a condition, putting aside for the moment questions about what to do with untreatable pain and suffering.

Other courts have taken what one might call half-steps toward a psychiatric mitigation requirement. For instance, where simple surgery could have corrected a physical injury, courts may limit the recovery for future pain and suffering associated with that uncorrected underlying condition. [115] Moreover, in situations where the plaintiff has attempted to mitigate emotional injury (even if not compelled to do so by virtue of the avoidable consequences doctrine), recoveries will include expenditures for treatment. [116] In fact, **[*460]** where victims commit suicide because of an inability to cope with their plight, courts may award wrongful death damages. [117] Although no one would argue that the avoidable consequences doctrine demands that victims take their own lives in order to minimize the duration of intolerable pain and suffering, [118] courts that allow wrongful death claims in such

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Medical Treatment on Religious Grounds As Affecting Right to Recover for Personal Injury or Death, 3 A.L.R.5th 721 (1992 & Supp. 2007).

[113] Indeed, courts routinely reverse judges who disregard patients' religious preferences when hospitals seek court orders to compel blood transfusions. See, e.g., Stamford Hosp. v. Vega, 674 A.2d 821, 831-32 (Conn. 1996); In re Dubreuil, 629 So. 2d 819, 828 (Fla. 1993); id. at 824-25 n.8 (canvassing case law).

[114] See Kenneth W. Simons, The Puzzling Doctrine of Contributory Negligence, 16 Cardozo L. Rev. 1693, 1730 (1995) ("Although the decedent's decision to honor her religious beliefs is not unreasonable, defendant has no duty to subsidize her choice to sacrifice her life in the name of religion."). But see Anne C. Loomis, Comment, Thou Shalt Take Thy Victim as Thou Findest Him: Religious Conviction as a Pre-Existing State Not Subject to the Avoidable Consequences Doctrine, 14 Geo. Mason L. Rev. 473, 493-511 (2007).

[115] See, e.g., Verrett v. McDonough Marine Serv., 705 F.2d 1437, 1444 (5th Cir. 1983) (denying any recovery for future pain where plaintiff declined routine surgery for a ruptured disc); Lawrence v. City of Shreveport, 948 So. 2d 1179, 1189 (La. Ct. App. 2007) (agreeing that plaintiff should not receive pain-and-suffering damages during the eleven month delay in undergoing recommended knee surgery). In addition, courts may harbor suspicions about plaintiffs who do not even bother to seek out medical treatment for an allegedly painful condition. See Olmstead v. Miller, 383 N.W.2d 817, 821-22 (N.D. 1986).

[116] See Spears v. Jefferson Parish Sch. Bd., 646 So. 2d 1104, 1107-08 (La. Ct. App. 1994) (affirming an award of more than $ 7,500 for psychotherapy plus $ 100,000 in general damages for residual pain and suffering); Tracy v. Parish of Jefferson, 523 So. 2d 266, 274-76 (La. Ct. App. 1988) (upholding an award of $ 20,800 for future psychiatric expenses for intensive therapy and possible hospitalization in addition to, among other items, $ 350,000 for physical pain and suffering and $ 250,000 for mental anguish); Brookshire Grocery Co. v. Goss, 208 S.W.3d 706, 720-23 (Tex. Ct. App. 2006) (upholding an award of $ 400,000 for future medical expenses primarily to treat pain and anxiety associated with a back injury plus $ 25,000 for residual future pain and suffering); see also King, supra note 6, at 2 n.3, 45 & n.225; cf. Musa v. Jefferson County Bank, 607 N.W.2d 349, 352 n.7 (Wis. Ct. App. 2000) (reciting a jury instruction in an intentional tort case on the duty to mitigate emotional distress damages, but reversing an award for $ 4,000 in mental health treatment expenses), rev'd, 620 N.W.2d 797 (Wis. 2001). A few commentators have suggested, however, that psychotherapy is a rehabilitation cost that courts would treat as an aspect of general damages rather than as medical expenses. See Avraham, supra note 39, at 965, 969 n.75; cf. Pryor, supra note 20, at 664-65 & n.20, 676-78 (noting that medical expenses can include rehabilitation costs); Viscusi, supra note 32, at 151-52 (calling this view a misapprehension).

[117] See Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 4 illus. 3; ***Restatement (Second) of Torts § 455***; Gregory G. Sarno, Annotation, Liability of One Causing Physical Injuries As a Result of Which Injured Party Attempts or Commits Suicide, 77 A.L.R.3d 311 (1977 & Supp. 2007).

[118] Cf. Abel, supra note 37, at 267 (noting facetiously that "a defense lawyer could callously answer that the living can always mitigate damages - by suicide"); infra note 155 (discussing drug-induced coma and terminal sedation). Recently, one of my Torts

circumstances grant the victim's estate a measure of damages that reflects the proximate economic (and perhaps other) consequences of the profound mental anguish that the tortfeasor had inflicted on the victim. [119]

C. Medicine's Take on Pain and Suffering

In the aggregate, pain-and-suffering damages account for more than half of the monetary value of all tort awards. [120] By way of comparison, expenditures on mental health services amount to far less **[*461]** than ten percent of overall medical expenditures. [121] Although the latter figure fails to count non-psychiatric measures designed to alleviate pain and suffering, [122] and undoubtedly also reflects a longstanding problem of undertreatment, [123] no one thinks that the health care system should devote well over half of its available resources to addressing these

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students asked whether a plaintiff who had suffered a catastrophic leg injury certain to cause her continuing agony should have to mitigate by amputation.

[119] Separately, most courts predicate an award for nonpecuniary damages on some consciousness by the victim. See, e.g., *Keene v. Brigham & Women's Hosp., Inc., 775 N.E.2d 725, 737-39 (Mass. App. Ct. 2002),* modified on other grounds, *786 N.E.2d 824, 826 (Mass. 2003); McDougald v. Garber, 536 N.E.2d 372, 375 (N.Y. 1989);* see also *Capelouto v. Kaiser Found. Hosps., 500 P.2d 880, 883 (Cal. 1972)* (holding that infants can recover for pain and suffering); *Choctaw Maid Farms, Inc. v. Hailey, 822 So.2d 911, 925-34 (Miss. 2002)* (Cobb, J., concurring in part and dissenting in part) (identifying numerous jurisdictions that decline to award damages for past pain and suffering if the victim has died before judgment); cf. *Molzof v. United States, 502 U.S. 301, 304, 312 (1992)* (rejecting argument that loss-of-enjoyment claim brought on behalf of comatose patient amounted to a request for punitive damages barred by FTCA). Although sometimes criticized, and physicians may struggle to define varying degrees of awareness, see Rob Stein, "Vegetative" Woman's Brain Shows Surprising Activity: Tests Indicate Awareness, Imagination, Wash. Post, Sept. 8, 2006, at A1, such a requirement makes perfect sense if linked to the notion that the award makes resources available for the treatment of that emotional harm.

[120] See Sugarman, supra note 36, at 422 n.21; Neil Vidmar et al., Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards, *48 DePaul L. Rev. 265, 296 (1998).*

[121] See Tami L. Mark et al., Mental Health Treatment Expenditure Trends, 1986-2003, 58 Psychiatric Servs. 1041, 1042 (2007) (finding that "mental health expenditures fell from 8% of all health expenditures in 1986 to 6% of all health expenditures in 2003"); see also Benjamin G. Druss, Rising Mental Health Costs: What Are We Getting for Our Money?, 25 Health Aff. 614 (2006).

[122] Patterns of prescription drug usage, which accounts for approximately 10% of overall health care spending, may offer a better perspective. In 2007, physicians issued more prescriptions for antidepressants than for any other therapeutic class of drugs, with narcotic analgesics ranked third and benzodiazepines (anti-anxiety agents) ranked tenth overall, but combining the raw numbers for these three classes accounted for only 13 percent of all prescriptions issued. See IMS National Prescription Audit, 2007 Top Therapeutic Classes by U.S. Dispensed Prescriptions, *http://www.imshealth.com/deployedfiles/imshealth/Global/* Content/Document/Top-Line%20Industry%20Data/2007%20Top%20Therapeutic%20Classes %20by%20RXs.pdf; see also id., 2007 Top Therapeutic Classes by U.S. Sales, http:// *www.imshealth.com/deployedfiles/imshealth/Global/Content/Docume* nt/Top-Line%20 Industry%20Data/2007%20Top%20Therapeutic%20Classes%20by%20Sales .pdf (finding that antidepressants ranked fourth in sales, behind statins and proton pump inhibitors, while narcotic analgesics and benzodiazepines did not even crack the top ten, presumably because of the widespread availability of cheaper generic versions). These figures, of course, offer only a crude means of comparison: some of these prescriptions may have absolutely nothing to do with efforts to treat pain and suffering (e.g., abuse and diversion of opioids); conversely, physicians occasionally may prescribe drugs from other therapeutic classes (e.g., anticonvulsants and antipsychotics) in order to treat pain and suffering.

[123] See C. Stratton Hill, Jr., Editorial, When Will Adequate Pain Treatment Be the Norm?, 274 JAMA 1881 (1995); Kenneth B. Wells & Jeanne Miranda, Editorial, Reducing the Burden of Depression, 298 JAMA 1451 (2007); Ronald Melzack, The Tragedy of Needless Pain, Sci. Am., Feb. 1990, at 27-28, 33; Kathleen Fackelmann, New Standard Calls for "Whole" Cancer Care; Patients Also Need Social Services, USA Today, Oct. 24, 2007, at *7*D (reporting that the Institute of Medicine has issued recommendations "calling for a new standard of care in which all oncologists routinely screen patients for mental distress"). But see Shankar Vedantam, Criteria for Depression Are Too Broad, Researchers Say: Guidelines May Encompass Many Who Are Just Sad, Wash. Post, Apr. 3, 2007, at A2 (noting concerns about the overprescribing of antidepressants).

problems. Yet the pattern of awards from tort litigation would have one believe that the emotional sequelae of accidental injuries dwarf the costs associated with efforts undertaken to correct the associated physical harms.

Awards for pain and suffering in cases involving unintentional torts date at least as far back as the early nineteenth century, [124] predating basic advances in analgesia such as the synthesis of aspirin **[*462]** and the development of surgical anesthesia. [125] Treatments for pain have, of course, become increasingly sophisticated since then. [126] Patients now enjoy access to a new generation of opioid analgesics, [127] more refined delivery methods such as infusion pumps, [128] nerve blocking agents, [129] various non-narcotic drugs, [130] devices for stimulating nerves, [131] and a range of other techniques. [132] More generally, **[*463]** with the growing recognition of the importance of

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[124] See *Samsel v. Wheeler Transp. Servs., Inc., 789 P.2d 541, 551-52 (Kan. 1990);* Jeffrey O'Connell & Rita James Simon, Payments for Pain & Suffering: Who Wants What, When & Why?, 1972 U. Ill. L.F. 1 app. at 83, 93-99. From the beginning, courts declined to draw any distinction between the pain associated with an injury and accompanying suffering. See *Fantozzi v. Sandusky Cement Prods. Co., 597 N.E.2d 474, 484-85 (Ohio 1992)* (citing decisions dating as far back as 1872).

[125] See David B. Jack, One Hundred Years of Aspirin, 350 Lancet 437, 438 (1997); Martin S. Pernick, The Calculus of Suffering in Nineteenth-Century Surgery, Hastings Ctr. Rep., Apr. 1983, at 26, 28.

[126] See Patrick Wall, Pain: The Science of Suffering 109-20 (2000). See generally Handbook of Pain Management (Ronald Melzack & Patrick D. Wall eds., 2003). In addition, methods of verifying and measuring pain continue to improve. See Adam J. Kolber, Pain Detection and the Privacy of Subjective Experience, *33 Am. J.L. & Med. 432, 434 (2007)* ("Despite many conceptual and technological challenges, neuroimaging may someday play a critical role in the evaluation of pain claims."); see also Erika Kinetz, Is Hysteria Real? Brain Images Say Yes, N.Y. Times, Sept. 26, 2006, at F1.

[127] See David E. Joranson et al., Trends in Medical Use and Abuse of Opioid Analgesics, 283 JAMA 1710, 1710 (2000) (explaining that "the use of opioids in the class of morphine is the cornerstone of pain management"); Lars Noah, Challenges in the Federal Regulation of Pain Management Technologies, *31 J.L. Med. & Ethics 55, 58 & n.53, 61-62 (2003).* If laypersons share the "opiophobia" that inhibits aggressive pain management by physicians, see Joseph J. Fins, Public Attitudes About Pain and Analgesics: Clinical Implications, 13 J. Pain & Symptom Mgmt. 169, 171 (1997), then judges and jurors may not find any fault in victims' failure to make use of such drugs.

[128] See Mona Momeni et al., Patient-Controlled Analgesia in the Management of Postoperative Pain, 66 Drugs 2321 (2006); Patricia C. Crowley, Comment, No Pain, No Gain? The Agency for Health Care Policy & Research's Attempt to Change Inefficient Health Care Practice of Withholding Medication from Patients in Pain, *10 J. Contemp. Health L. & Pol'y 383, 395 (1994)* (describing federal guidelines that call for preventative rather than "as needed" administration of drugs to treat post-operative pain); *id. at 391 n.59, 392-93 n.69* (discussing the advantages of patient-controlled analgesia).

[129] See Diane E. Hoffmann, Pain Management and Palliative Care in the Era of Managed Care: Issues for Health Insurers, *26 J.L. Med. & Ethics 267, 268 (1998)* (adding that these treatments can cost many thousands of dollars).

[130] These might include muscle relaxants (e.g., Soma(R)) and anticonvulsants (e.g., Neurontin(R)). See Roger Chou et al., Comparative Efficacy and Safety of Skeletal Muscle Relaxants for Spasticity and Musculoskeletal Conditions: A Systematic Review, 28 J. Pain & Symptom Mgmt. 140, 141 (2004); Morris Maizels & Bill McCarberg, Antidepressants and Antiepileptic Drugs for Chronic Non-Cancer Pain, 71 Am. Fam. Physician 483 (2005). In addition, consumers can purchase an increasing number of analgesics without a prescription. See Lars Noah, Treat Yourself: Is Self-Medication the Prescription for What Ails American Health Care?, *19 Harv. J.L. & Tech. 359, 369-71 & n.68 (2006).*

[131] See El-sayed A. Ghoname et al., Percutaneous Electrical Nerve Stimulation for Low Back Pain: A Randomized Crossover Study, 281 JAMA 818 (1999); Tara Parker-Pope, Pain Relief for Some, with an Odd Tradeoff, N.Y. Times, Jan. 8, 2008, at F6 (spinal cord stimulation).

[132] See Hoffmann, supra note 129, at 277-81, 288 n.94. These include behavioral therapy, strength training, dietary changes, and acupuncture. See, e.g., Michael Haake et al., German Acupuncture Trials (GERAC) for Chronic Low Back Pain, 167 Archives Internal Med. 1892, 1896-98 (2007); Jeremy Laurance, Are We Really Born to Suffer?, Times (London), Jan. 27, 1997, at 18. Even if unconventional treatments do not work in the manner promised, they may unleash a powerful placebo effect. See

treating pain, [133] health care providers have begun to embrace the need for a multidisciplinary approach to analgesia. [134]

Treatments for suffering also have become increasingly sophisticated in recent years. Among antidepressants, we have moved over the course of the last half century from tricyclics (e.g., Elavil(R) (amitriptyline)) and tetracyclics (e.g., Desyrel(R) (trazadone)), and then the monoamine oxidase (MAO) inhibitors (e.g., Parnate(R) (tranylcypromine)), to selective serotonin reuptake inhibitors (SSRIs) such as Prozac(R) (fluoxetine). [135] Although the widespread use of the newest generation of antidepressants has attracted criticism, [136] they represent an unmistakable advance over the older pharmacological options.

For the treatment of anxiety (and associated insomnia), patients need no longer rely on the old and sometimes troublesome stand-bys such as benzodiazepines (including Valium(R), Halcion(R), and Xanax(R)) now that they can try SSRIs and the newer sleep aids (Ambien(R), Lunesta(R), and Rozerem(R)). [137] In addition, various **[*464]** non-pharmaceutical mental health interventions may offer relief. [138] Next on the horizon, patients with depression

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Kathleen M. Boozang, The Therapeutic Placebo: The Case for Patient Deception, 54 Fla. L. Rev. 687, 718 (2002) ("Those with the most to gain are patients whose pain remains unresolved by conventional treatment methods."); id. at 691 (observing that "many physicians believe that alternative practitioners are particularly effective at evoking the placebo response"); id. at 711 ("Changing people's expectations regarding pain, depression or anxiety can change their experiences … ."); id. at 713 ("Stimulation of endorphins may be instrumental in achieving placebo analgesic effect as well as reduction in depression … .").

[133] See Debra B. Gordon et al., American Pain Society Recommendations for Improving the Quality of Acute and Cancer Pain Management, 165 Archives Internal Med. 1574 (2005); Ann M. Martino, In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?, *26 J.L. Med. & Ethics 332, 333-41 (1998).*

[134] See Marcia L. Meldrum, A Capsule History of Pain Management, 290 JAMA 2470, 2473-74 (2003); Carmichael, supra note 17, at 46-47.

[135] See Jeffrey A. Lieberman et al., Drugs of the Psychopharmacological Revolution in Clinical Psychiatry, 51 Psychiatric Servs. 1254, 1256-57 (2000); J. John Mann, The Medical Management of Depression, 353 New Eng. J. Med. 1819, 1821-25 (2005); Erica Goode, Antidepressants Lift Clouds, but Lose "Miracle Drug" Label, N.Y. Times, June 30, 2002, § 1, at *1*.

[136] See, e.g., David Brent, Editorial, Antidepressants and Suicidal Behavior: Cause or Cure?, 164 Am. J. Psychiatry 989 (2007); Erick H. Turner et al., Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy, 358 New Eng. J. Med. 252 (2008); Gardiner Harris, Debate Resumes on the Safety of Depression's Wonder Drugs, N.Y. Times, Aug. 7, 2003, at A1; Shankar Vedantam, Youth Suicides Increased As Antidepressant Use Fell, Wash. Post, Sept. 6, 2007, at A1. Insofar as they work for only some patients, psychotropic drugs are no different from pharmaceutical treatments for other medical conditions. See Lars Noah, The Coming Pharmacogenomics Revolution: Tailoring Drugs to Fit Patients' Genetic Profiles, *43 Jurimetrics J. 1, 2, 4-7 (2002);* see also Lars Noah, Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community, *44 Ariz. L. Rev. 373, 383-85, 387-88, 393-94, 422 & n.211, 428 & n.240, 447-49 (2002)* (discussing the ineffectiveness of other medical interventions).

[137] See Gregory Fricchione, Generalized Anxiety Disorder, 351 New Eng. J. Med. 675, 676-79 (2004); Michael H. Silber, Chronic Insomnia, 353 New Eng. J. Med. 803, 805-08 (2005); see also Robert L. DuPont & Caroline M. DuPont, The Treatment of Anxiety: Realistic Expectations and Risks Posed By Controlled Substances, 22 J.L. Med. & Ethics 206, 207, 209-10 (1994) (benzodiazepines); Stephanie Saul, Sleep Drugs Found Only Mildly Effective, but Wildly Popular, N.Y. Times, Oct. 23, 2007, at F4.

[138] See Jonathan R.T. Davidson, Recognition and Treatment of Posttraumatic Stress Disorder, 286 JAMA 584, 585-86 (2001); Hickling et al., supra note 28, at 620-21, 632-33 (explaining that cognitive behavioral interventions outperformed supportive psychotherapy in treating PTSD in victims of motor vehicle accidents, but adding that neither approach entirely cures a patient); Benedict Carey, For Psychotherapy's Claims, Skeptics Demand Proof, N.Y. Times, Aug. 10, 2004, at F1; Shankar Vedantam, Most PTSD Treatments Not Proven Effective: Scientists Find That One Therapy Is Shown to Help Disorder; Evidence of Drugs' Benefits Inconclusive, Wash. Post, Oct. 19, 2007, at A3. Talk therapies are not, however, always benign. See Sharon Begley, Get Shrunk at Your Own Risk, Newsweek, June 18, 2007, at 49 (discussing research that found negative outcomes in grief

that fail to respond to SSRIs or psychotherapy may benefit from the implantable vagus nerve stimulator, [139] and PTSD sufferers some day might undergo "memory dampening" treatments. [140]

The undertreatment of pain potentially exposes health care professionals to tort liability. [141] Similarly, reliance on psychotherapy alone and the failure to offer antidepressant medications may provide the basis for negligence claims against mental health institutions. [142] In short, reasonable health care providers must offer their patients available mechanisms for minimizing pain and suffering. **[*465]** Although regard for personal autonomy means that patients generally remain free to decline such interventions, it hardly follows that other tortfeasors must pay for the full (untreated) consequences of their negligence when victims unreasonably decline options for relieving some of their pain and suffering.

D. Making the Case for Mitigation

The academic literature reveals almost no discussion of the psychiatric mitigation issue. [143] A pair of recently published pieces address the question, though primarily in connection with negligent infliction of emotional distress claims as opposed to pain-and-suffering damages more generally, [144] and, while they arrived at divergent

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counseling and "stress debriefing" for PTSD patients, adding that experts "estimate that 10 to 20 percent of people who receive psychotherapy are harmed by it").

[139] See Miriam Shuchman, Approving the Vagus-Nerve Stimulator for Depression, 356 New Eng. J. Med. 1604 (2007) (reporting, however, that doubts about its efficacy persist); see also Shankar Vedantam, Magnetic Relief for Depression?, Wash. Post, Nov. 11, 2008, at F1 (reporting that the FDA just approved a transcranial magnetic stimulation device). In addition, the Internet may offer powerful social outlets for the disabled. See Rob Stein, Real Hope in a Virtual World: Online Identities Leave Limitations Behind, Wash. Post, Oct. 6, 2007, at A1.

[140] See Adam J. Kolber, Therapeutic Forgetting: The Legal and Ethical Implications of Memory Dampening, *59 Vand. L. Rev. 1561, 1574-77 (2006);* Peter Gorner, Drug Eases Pain of Bad Memories, Chi. Trib., Mar. 3, 2006, at A1; Rob Stein, Is Every Memory Worth Keeping? Controversy over Pills to Reduce Mental Trauma, Wash. Post, Oct. 19, 2004, at A1 (describing experiments using the hypertension drug propranolol, which appears to block the action of stress hormones on the amygdala and thereby blunt the etching or reconsolidation of painful memories); Rick Weiss, On Ecstasy, Consensus Is Elusive, Wash. Post, Sept. 30, 2002, at A7 (reporting about research into MDMA's possible efficacy as a treatment for PTSD); see also Rick Weiss, "Ecstasy" Use Studied to Ease Fear in Terminally Ill, Wash. Post, Dec. 27, 2004, at A11 ("MDMA[] has been referred to by psychiatrists as an "empathogen,' a drug especially good at putting people in touch with their emotions. Some believe it [as well as another psychedelic drug, psilocybin] could help patients come to terms with the biggest emotional challenge of all: the end of life.").

[141] See, e.g., *Gaddis v. United States, 7 F. Supp. 2d 709, 717 (D.S.C. 1997);* see also Barry R. Furrow, Pain Management and Provider Liability: No More Excuses, ***29 J.L. Med. & Ethics 28 (2001);*** Rima J. Oken, Note, Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain, *23 Cardozo L. Rev. 1917, 1977-81 (2002).*

[142] See, e.g., *O'Sullivan v. Presbyterian Hosp., 634 N.Y.S.2d 101, 103 (App. Div. 1995);* see also Gerald L. Klerman, The Psychiatric Patient's Right to Effective Treatment: Implications of Osheroff v. Chestnut Lodge, 147 Am. J. Psychiatry 409 (1990) (discussing the settlement of a high-profile malpractice claim); cf. *Gowan v. United States, 601 F. Supp. 1297, 1300-01 (D. Or. 1985)* (finding no merit to such allegations of psychiatric malpractice); ***Paddock v. Chacko, 522 So. 2d 410, 417-18 (Fla. Dist. Ct. App. 1988)*** (same).

[143] See Eugene Kontorovich, Comment, The Mitigation of Emotional Distress Damages, *68 U. Chi. L. Rev. 491, 500-01 (2001)* ("Despite the ubiquitous use of mitigation in determining damages, courts have neglected to apply the rule to emotional distress… . Commentators appear to have wholly ignored the issue."); see also McCaffery et al., supra note 53, at 1403 ("There has been little research about the meaning or measurement of non-pecuniary damages, although such damages play a central role in our practical tort system, which in turn plays a central role in the regulation of all activities in our society.").

[144] See Kevin C. Klein & G. Nicole Hininger, Mitigation of Psychological Damages: An Economic Analysis of the Avoidable Consequences Doctrine and Its Applicability to Emotional Distress Injuries, *29 Okla. City U. L. Rev. 405 (2004);* Kontorovich,

conclusions about the desirability of applying the avoidable consequences rule in this context, neither article offered a terribly convincing argument. A student piece published in 2001 recognized that a mitigation requirement might help to reduce the moral hazard created in tort litigation when a victim realizes that any effort he or she takes to minimize the severity of the injury will inure to the benefit of the tortfeasor by reducing the ultimate award, [145] **[*466]** but the author concluded that it would make more sense for courts to restrict the availability of emotional distress claims altogether (for instance, by resurrecting the actual impact and physical manifestation requirements that courts previously had used to ensure the genuineness of the plaintiff's alleged distress). [146]

Mr. Kontorovich argued that a psychiatric mitigation requirement would pose special difficulties, which "may explain why courts have avoided the issue." [147] First, he correctly dismissed the idea that plaintiffs would have to use their "willpower" to manage a traumatic experience (in effect, to "tough it out"). [148] Although some victims will show more resilience than others, and the extent to which any one plaintiff has successfully coped with a traumatic experience presumably would result in a reduced damage award, courts should not penalize victims who fail to cope as well as others might under similar circumstances. Even so, research suggests (and courts should recognize) that individuals who suffer serious injuries do not invariably report dramatic reductions in their well-being. [149] (This research also finds that lottery winners do not enjoy **[*467]** lasting improvements in well-being, [150] which suggests that large noneconomic damage awards may do little to offset a plaintiff's pain and suffering. [151])

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supra note 143, at 491. An earlier article, which focused on Social Security disability insurance and workers' compensation programs, included a brief discussion of the mitigation rule's likely application in chronic pain cases. See Ellen Smith Pryor, Compensation and the Ineradicable Problems of Pain, *59 Geo. Wash. L. Rev. 239, 286-88 (1991)* (doubting that it would have much consequence given the ineffectiveness of then-available treatments for such patients, and contrasting these cases with the use of the rule to evaluate choices about conventional medical care for physical illness and injury).

[145] See Kontorovich, supra note 143, at 491 ("If psychiatric treatment might reduce or eliminate a plaintiff's emotional distress, the plaintiff might nonetheless forgo such treatment if he knows that the defendant will be liable for the full, unmitigated level of distress."); id. at 507 ("The de facto exemption of emotional distress from the mitigation rule creates moral hazard, resulting in systematic overcompensation of plaintiffs. Applying the mitigation rule would, ideally, be the first response to this problem."). Mr. (now Professor) Kontorovich added that the problem might become even greater when courts require proof of "severe" distress, see id. at 491, but this incorrectly assumes that such a threshold showing relates to the seriousness of the emotional harm at the time of trial, and it directly contradicts his later argument that uninjured plaintiffs could commit fraud by pointing to their use of antidepressants to confirm their alleged distress, see id. at 511 (suggesting that "plaintiffs might assert emotional distress damages and claim to fully "mitigate' nonexistent distress by taking the antidepressants they would want to take anyway").

[146] See id. at 518-20; id. at 492 ("The best way for courts to control moral hazard would be to return to the recently disfavored approach of allowing recovery only in categories of cases where objectively verifiable circumstances, such as a crippling wound, allow courts to infer severe emotional distress with a high degree of confidence."). There may, of course, be other legitimate grounds for criticizing the uneven expansion of doctrine in this area, including the impact, zone of danger, and foreseeable bystander categories. See, e.g., *Consol. Rail Corp. v. Gottshall, 512 U.S. 532, 545-49, 557 (1994);* *Camper v. Minor, 915 S.W.2d 437, 440-46 (Tenn. 1996);* John C.P. Goldberg & Benjamin C. Zipursky, Unrealized Torts, *88 Va. L. Rev. 1625, 1668-71 (2002).* Kontorovich failed to explain, however, why the moral hazard concern (in this particular context) justifies foregoing the benefits that others have found in recognizing at least some of these types of claims. See Restatement (Third) of Torts: Liability for Physical and Emotional Harm §§46-47; supra Part II.B. His solution also does nothing to combat the problem when distress (pain and suffering) damages arise in connection with a tortiously caused physical injury, though he did recognize the weaknesses associated with common responses to such awards (e.g., statutory caps). See Kontorovich, supra note 143, at 515-18.

[147] Kontorovich, supra note 143, at 507.

[148] See id. at 512-13 (arguing that such a requirement would be nearly impossible to apply); cf. Goldberg & Zipursky, supra note 146, at 1681-88 (explaining that this general notion underlies doctrinal limitations on emotional distress claims); id. at 1683 ("The default rule against recovery for emotional harm reflects a judgment that the maintenance of one's emotional well-being in the face of adversity is something for which a plaintiff ordinarily must take responsibility.").

[149] See Samuel R. Bagenstos & Margo Schlanger, Hedonic Damages, Hedonic Adaptation, and Disability, *60 Vand. L. Rev. 745, 749-50, 760-69 (2007);* Paul Menzel et al., The Role of Adaptation to Disability and Disease in Health State Valuation: A

Second, Kontorovich suggested that demanding mitigation of emotional distress would pose a greater threat to personal autonomy, [152] but the mitigation rule only requires that victims accept reasonable treatments, and the autonomy concerns seem no greater in this context than in connection with pharmaceutical or surgical interventions for any number of physical injuries. [153] He **[*468]** recognized that drugs used in connection with surgery might have similar modes of action (presumably an allusion to anesthetic agents), but he argued that long-term use of antidepressants would "have more durable and pronounced effects on the personality." [154] In emphasizing that their mode of action alters brain chemistry, [155] however, Kontorovich misses the point. Unlike symptomatic

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Preliminary Normative Analysis, 55 Soc. Sci. & Med. 2149 (2002); Pryor, supra note 11, at 114 ("The narrative, sociological, and psychological literature of disability makes clear that loss often forces reexamination, reconceptualization, and the alteration of values, attitudes, beliefs, and desires."); id. at 116 ("The transformative potential of disability has at least this implication: even a fully informed, nondevaluative pre-injury judgment is a questionable basis for conclusions about the nature and quality of postinjury life … ."); Shankar Vedantam, Is Great Happiness Too Much of a Good Thing?, Wash. Post, Oct. 1, 2007, at A9; see also Cass R. Sunstein, Willingness to Pay vs. Welfare, 1 Harv. L. & Pol'y Rev. 303, 327-28 (2007) (warning that "duration" or "projection bias" may lead juries to assume continuing pain and suffering even though the "psychological immune system" ensures that victims will adapt to physical injuries after a short time and without being dramatically worse off than before); Childhood Traumas Rarely Trigger Disorder, Wash. Post, May 8, 2007, at A11 (noting that a study found "emotional resiliency in children"); cf. Adler, supra note 64, at 997 ("Many people are dispositionally anxious; they tend to find something or other to be anxious about, and their overall level of anxiety remains pretty much the same, with different objects rationalizing an ongoing anxiety state.").

[150] See Bagenstos & Schlanger, supra note 149, at 761; Jeremy A. Blumenthal, Law and the Emotions: The Problems of Affective Forecasting, *80 Ind. L.J. 155, 167 (2005);* see also Shankar Vedantam, C'mon, Get Happy? It's Easier Said Than Done, Wash. Post, Jan. 7, 2008, at A10.

[151] Cf. O'Connell & Simon, supra note 124, at 19-22, 26-28 (finding that most accident victims did not understand their entitlement to recover for pain and suffering, in many cases even after they already had received an award that included this item of damages); id. at 48 ("On the basis of our findings, it would appear that auto accident victims do not feel "a sense of continuing outrage,' nor do damages for pain and suffering "wipe out' any sense of outrage.").

[152] See Kontorovich, supra note 143, at 509-10 ("Psychiatric mitigation also differs from other medical mitigation because the side effects express themselves in the mind and mood of the patient, and thus can be seen as greater usurpations of autonomy."). In support of the proposition that antidepressants might result in profound alterations in a person's mind or emotional state, he cited a popular press book published eight years earlier that had assailed the growing use of SSRIs. See id. at 509 n.91 (citing Peter D. Kramer, Listening to Prozac (1993)); see also id. at 510 (drawing a parallel to electroshock treatments). Critics of SSRIs surely exaggerate for the sake of emphasis when they suggest that these drugs amount to a "chemical lobotomy." See Joseph Glenmullen, Prozac Backlash: Overcoming the Dangers of Prozac, Zoloft, Paxil, and Other Antidepressants with Safe, Effective Alternatives 8 (2000). As discussed previously, the latest medical research offers a generally favorable account of the relative risks and benefits of currently available psychotropic drugs. See supra Part III.C; see also supra note 82 (referencing current medical views about electroconvulsive therapy).

[153] For example, widely accepted treatments for cardiovascular problems, diabetes, epilepsy, organ failure, and even orthopedic injuries carry risks of adversely affecting a patient's personality or cognitive abilities. See, e.g., Bernadette Tansey, Doctors Warned of Drugs' Danger: Anti-Epilepsy Medications Tied to Risk of Suicide, S.F. Chron., Feb. 1, 2008, at C1. Kontorovich pointed out that courts resolving "wrongful pregnancy" or "wrongful birth" cases (though he incorrectly characterizes these as "wrongful life" claims) generally do not demand abortion or adoption as forms of mitigation. See Kontorovich, supra note 143, at 509 & n.89; see also Lars Noah, Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation, *55 Fla. L. Rev. 603, 639, 643 & n.168 (2003)* (discussing these issues). Deciding to try an antidepressant hardly seems to present an individual with an equally profound choice. In addition, some courts have applied the avoidable consequences rule to some fairly dramatic lifestyle changes recommended by a treating physician (some of which the use of SSRIs may facilitate). See, e.g., *Gideon v. Johns-Manville Sales Corp., 761 F.2d 1129, 1138-39 (5th Cir. 1985)* (smoking cessation); *Tanberg v. Ackerman Inv. Co., 473 N.W.2d 193, 196 (Iowa 1991)* (weight loss).

[154] Kontorovich, supra note 143, at 510 n.94 ("Psychiatric mitigation would have a far greater effect on a plaintiff's mental state. Unlike drugs administered in surgery, whose effects on personality are incidental, antidepressants and their ilk are taken over a long period of time … .").

treatments that might help to dull or mask an emotional injury, which itself bespeaks some undesirable alteration of the victim's original brain chemistry allegedly triggered by the defendant's tortious act, SSRIs and other psychotropic drugs aim (in theory at least) to reset to normal the neurotransmitter channels damaged by a traumatic event. [156] The fact that psychoactive drugs have become more effecttive **[*469]** in their mechanism of action argues in favor of rather than against application of the avoidable consequences doctrine.

Third, Kontorovich speculated that a psychiatric mitigation rule might create a "second-order" moral hazard insofar as plaintiffs would tend to overuse antidepressants. [157] Let me try to make his point more forcefully: a psychiatric mitigation rule might encourage the recreational use of powerful narcotics by tort victims alleging severe pain. In neither case, however, would it increase whatever risk of such behavior already exists: even without a mitigation rule, plaintiffs could use such drugs in the hopes of proving a dubious emotional distress or pain-and-suffering claim (and having the defendant pay the costs of this course of drug treatment). [158] Moreover, to the extent that it

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[155] See id. ("Indeed, unlike other medications that can affect mood, Prozac and similar drugs are specifically designed to change the patient's brain chemistry so as to cause substantial changes in his consciousness and day-to-day personality."). Another student author went even further when he wondered (in passing) whether a seriously injured victim would have to mitigate severe pain and suffering by undergoing what amounts to a drug-induced coma. See Daniel J. Gabler, Comment, Conscious Pain and Suffering Is Not a Matter of Degree, 74 Marq. L. Rev. 289, 312 n.154 (1991); see also id. at 319-20 (arguing that, even though the unconscious victim then would lose the right to recover any further damages for pain and suffering, courts should award loss-of-enjoyment-of-life damages for this interval of time). Such mitigation would not, of course, be expected if regarded as unreasonable, and physicians typically use barbiturates to induce coma only in cases of traumatic brain injury or prolonged seizures. If, however, the victim's injuries meant imminent death, physicians may offer "terminal sedation" even though it might hasten death. See Bernard Lo & Gordon Rubenfeld, Palliative Sedation in Dying Patients, 294 JAMA 1810, 1812-15 (2005); Gina Castellano, Note, The Criminalization of Treating End of Life Patients with Risky Pain Medication and the Role of the Extreme Emergency Situation, *76 Fordham L. Rev. 203, 211-12 (2007);* see also Sidney H. Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look, 320 New Eng. J. Med. 844, 847 (1989) ("The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering, even to the point of unconsciousness.").

[156] See Richard A. Friedman, Like Drugs, Talk Therapy Can Change Brain Chemistry, N.Y. Times, Aug. 27, 2002, at F5. Chronic pain also disrupts normal brain chemistry, which suggests that successful treatments may have a similar mechanism of action. See John D. Loeser & Ronald Melzack, Pain: An Overview, 353 Lancet 1607, 1609 (1999); Melanie Thernstrom, Pain, the Disease, N.Y. Times, Dec. 16, 2001, § 6 (Magazine), at 66. In addition, to the extent that illnesses (e.g., brain tumors) adversely affect behavior, effective non-pharmacological interventions would achieve a similar (and desirable) alteration in personality. Cf. Kolber, supra note 140, at 1604 ("It is, thus, not at all clear why we ought to revere the selective rewriting of our lives that we do without pharmaceuticals, yet be so skeptical of pharmaceutically-assisted rewriting."). Lastly, drugs used chronically in order to treat non-psychiatric conditions also may have lasting (and perhaps undesirable) impacts on personality. See Gardiner Harris, F.D.A. Requiring Suicide Studies in Drug Trials, N.Y. Times, Jan. 24, 2008, at A1 ("Medicines to treat acne, hypertension, high cholesterol, swelling, heartburn, pain, bacterial infections and insomnia can all cause psychiatric problems … ."); Shankar Vedantam, Prescription for an Obsession? Gambling, Sex Manias Called Surprise Risks of Parkinson's Drugs, Wash. Post, Mar. 19, 2006, at A1 (reporting that dopamine agonists (e.g., Mirapex(R) and Requip(R)) may turn some patients into obsessive pleasure seekers).

[157] See Kontorovich, supra note 143, at 510-11 (calling this the "problem of the merry mitigator"). He referred to "cosmetic" uses of antidepressants, suggesting both recreational (enhanced "sense of well-being") and frivolous uses (e.g., treating premenstrual syndrome), see id. at 510-11 n.99; see also Colleen Cebuliak, Life As a Blonde: The Use of Prozac in the '90s, 33 Alta. L. Rev. 611, 612-13, 619-25 (1995), but he failed to recognize that similar problems might arise with so-called "lifestyle" (though non-psychoactive) drugs or cosmetic surgical procedures used in connection with alleged efforts to mitigate a physical injury. Moreover, insofar as he conceded that psychotropic agents may have non-psychiatric applications, it cuts against his earlier argument because victims with physical injuries that trigger secondary effects treatable by such drugs (e.g., discomfort causing an inability to sleep) would be expected to use them unless a court decided that a reasonable patient might decline to do so given the risks of side effects (whether physical or cognitive). In short, the mitigation rule (with its reasonableness inquiry) should focus on the nature of the intervention rather than the nature of the injury subject to treatment. Perhaps, given current knowledge about existing psychotropic agents, courts would conclude as a matter of law (as they have in the case of abortion, see supra note 153) that mitigation never requires the use of such drugs (or, more plausibly, a subset of such drugs), whether for treating a physical or emotional injury.

attempts to monetize future pain and suffering, the avoidable consequences doctrine would look to expert testimony about treatment and prognosis rather than past patterns of (over)use.

Fourth, Kontorovich worried that a psychiatric mitigation rule would threaten patient confidentiality, [159] but this makes little sense: the plaintiff already has decided to put his or her mental state into **[*470]** issue, [160] any additional stigma associated with the use of psychiatric medications seems minor, [161] and, at least as applied to limit future emotional harms (and to estimate future medical expenses), the mitigation rule would not require that the plaintiff actually make use of (much less reveal to the public) any embarrassing treatments. [162] In short, after initially deciding that a psychiatric mitigation rule might have some merit, the author offered entirely unpersuasive arguments for dismissing the idea and preferring instead his more radical solution of resurrecting some decidedly old-fashioned (and generally discredited) doctrinal limitations on negligent infliction of emotional distress claims. [163]

An article published in 2004 by a pair of newly minted lawyers advocated extending the mitigation rule to emotional harms. [164] Apart from arguably overstating the degree of judicial hostility to the idea, their article suffers from a number of limitations that detract from its central thesis. The authors purported to offer an economic analysis that demonstrated the desirability of applying **[*471]** the duty to mitigate in these cases, [165] but their admittedly oversimplified comparison between persons who make prompt use of antidepressants and those who refuse

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[158] See supra note 30. Some commentators had made similar (and equally unpersuasive) arguments to justify less generous insurance coverage for mental health treatments. See Lawrence R. Landerman et al., The Relationship Between Insurance Coverage and Psychiatric Disorder in Predicting Use of Mental Health Services, 151 Am. J. Psychiatry 1785, 1789 (1994) (finding little foundation for such concerns).

[159] See Kontorovich, supra note 143, at 512.

[160] See *Doe v. Oberweis Dairy, 456 F.3d 704, 718 (7th Cir. 2006)* ("If a plaintiff by seeking damages for emotional distress places his or her psychological state in issue, the defendant is entitled to discover any records of that state."); *Henricksen v. State, 84 P.3d 38, 48-49, 51 (Mont. 2004);* Kenneth S. Broun, The Medical Privilege in the Federal Courts: Should It Matter Whether Your Ego or Your Elbow Hurts?, *38 Loy. L.A. L. Rev. 657, 670-75 (2004);* Ellen E. McDonnell, Note, Certainty Thwarted: Broad Waiver Versus Narrow Waiver of the Psychotherapist-Patient Privilege After Jaffee v. Redmond, *52 Hastings L.J. 1369, 1375-90 (2001)* (criticizing the majority approach).

[161] See Anne Hudson Jones, Mental Illness Made Public: Ending the Stigma?, 352 Lancet 1060 (1998). Or at least no worse than the stigma one might associate with other widely used medications that a plaintiff might take in order to mitigate a physical condition (e.g., erectile dysfunction drugs). In addition, the use of pain medications and sleep aids would not carry even the residual stigma allegedly associated with psychotropics. In any event, this argument conflicts with Kontorovich's prior argument that plaintiffs without genuine emotional distress might inappropriately make (and prove) use of antidepressants.

[162] In fact, the victim may have less fear of embarrassing disclosure than when relying on employer-provided first-party insurance to cover such interventions. Cf. Theo Francis, Medical Dilemma: Spread of Records Stirs Patient Fears of Privacy Erosion, Wall St. J., Dec. 26, 2006, at A1; Brian Krebs, Extortion Used in Prescription Data Breach: FBI Investigating Threat Against Express Scripts Customers, Wash. Post, Nov. 8, 2008, at D1; Ellen Nakashima, Prescription Data Used to Access Consumers: Records Aid Insurers but Prompt Privacy Concerns, Wash. Post, Aug. 4, 2008, at A1; Robert O'Harrow, Jr., Plans' Access to Pharmacy Data Raises Privacy Issues: Benefit Firms Delve into Patient Records, Wash. Post, Sept. 27, 1998, at A1.

[163] Kontorovich presumably would applaud a decision such as *Fournell v. Usher Pest Control Co., 305 N.W.2d 605, 606-07 (Neb. 1981),* which summarily denied an emotional distress claim for the lack of any physical manifestation notwithstanding the fact that a psychiatrist had treated the victim for depression over an extended period of time (and had even hospitalized her three times). Nebraska subsequently liberalized its rules. See *Hamilton v. Nestor, 659 N.W.2d 321, 325-29 (Neb. 2003).*

[164] See Klein & Hininger, supra note 144, at 431 ("Due to the fact that the common law is increasingly willing to recognize psychological damages, courts should impose an affirmative duty to take reasonable steps to minimize psychological injuries.").

[165] See id. at 433-38.

treatment failed to take into account the drug expenditures avoided by the latter group or the possibility that the expenditures incurred by the former group might fail to speed recovery. [166]

The authors also offered several unconvincing hypotheses to explain the common law's differential treatment of physical and psychological harms in applying the avoidable consequences doctrine, including the relative recency of the recognition of emotional distress claims, [167] and the tactical choices of defense counsel, [168] while completely ignoring the more likely explanation based on recent changes in the external environment (i.e., improved interventions, enhanced insurance coverage for mental health services, and reduced stigma). [169] Lastly, by focusing narrowly on claims for negligent infliction of emotional distress absent **[*472]** physical injury (and the use of antidepressants), the authors failed to consider the broader consequences of their proposed mitigation requirement, including the possibility that such a rule would have the effect of altering the "noneconomic" characterization of a large portion of tort awards and also might help to mollify some critics of pain-and-suffering damages. [170]

At least one scholar has advocated this broader notion of fundamentally recharacterizing nonpecuniary damages, [171] though, strangely enough, he did so without making any reference to the rule of mitigation. [172] In addition,

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[166] In contrast, in an earlier hypothetical, the authors imagined an emotional injury valued at $ 50,000, which the victim could cut in half by undergoing treatment costing $ 5,000. See id. at 431-32. Although such a course of action would seem to make perfect sense from the perspective of the sufferer, it hardly follows that (as the authors blithely assume) these also represent "societal costs" (of $ 50,000 or $ 25,000) and that the treatment (which clearly does entail a societal cost of $ 5,000) represents the efficient outcome ($ 5,000 + $ 25,000 < $ 50,000). As critics of pain-and-suffering awards have argued, see supra note 39, noneconomic damages lack any real meaning in the marketplace.

[167] See Klein & Hininger, supra note 144, at 425 (placing the date in the 1980s). Apart from entirely ignoring the long history of awarding damages for pain and suffering that accompany a physical injury, this misdates the recognition of emotional distress claims by several decades. See *Consol. Rail Corp. v. Gottshall, 512 U.S. 532, 547 nn.6 & 8, 554-55 (1994);* Levit, supra note 3, at 141-46; id. at 144 ("By the middle of the twentieth century, there was a substantial reversal of the general proposition of the previous century regarding compensation for emotional pain alone."). The authors also suggested that courts routinely demand a diagnosis of emotional distress. See Klein & Hininger, supra note 144, at 413-14, 426; see also supra notes 27-28. In fact, a number of jurisdictions require no such medical evidence to corroborate claims of noneconomic injury. See, e.g., *Chizmar v. Mackie, 896 P.2d 196, 205 (Alaska 1995);* *Gammon v. Osteopathic Hosp. of Maine, Inc., 534 A.2d 1282, 1283, 1286 n.9 (Me. 1987).*

[168] See Klein & Hininger, supra note 144, at 425. In fact, a failure-to-mitigate argument would help to reinforce (rather than undermine) a defendant's preferred contention denying that the plaintiff suffered any emotional injury, as the authors belatedly recognized. See id. at 429 ("If a plaintiff does not seek psychological treatment, it stands to reason that he or she has not suffered psychological harm.").

[169] Instead, the authors expressed a decidedly ahistoric confidence in psychopharmacology and easy access through managed care plans. Contrast id. at 415-16, 426, 430, with Donald P. Hay & Linda K. Hay, Diagnosing and Treating Depression in a Managed Care World, *42 St. Louis U. L.J. 55, 56 (1998)* ("Up until recently, the only antidepressant medications that were available to treat depression had significant medical side effects … ."); *id. at 57* ("Often a closed [drug] formulary does not include the new and improved alternatives as they are generally more expensive."). In fact, some of the earlier decisions rejecting a duty to mitigate psychological harm (but not cited by the authors) arose during the era of electroshock therapy. See supra notes 76-86 and accompanying text.

[170] Indeed, they did just the opposite in calling for little more than internal consistency. See Klein & Hininger, supra note 144, at 428 ("The idea of attaching a numeric value to psychological injuries is problematic, … but if courts are willing to award damages based on a problematic formula, they must be willing to reduce those damages using the same formula."); id. at 439.

[171] See Stanley Ingber, Rethinking Intangible Injuries: A Focus on Remedy, *73 Cal. L. Rev. 772, 803-05 (1985);* *id. at 809* ("Damages should be limited to the extent that these [intangible] injuries have caused or are anticipated to cause transferable, out-of-pocket expenses. Such pecuniary damages are likely limited and capable of relatively firm proof. They, consequently, are less subject to plaintiff fabrication and jury abuse."); *id. at 782* ("Pain and suffering and emotional distress may result in costs

when he suggested this idea more than two decades ago, [173] the treatments available for various forms **[*473]** of pain and suffering remained fairly primitive by today's standards, which meant that his proposal effectively would have denied most damages for victims complaining of emotional distress. [174] (If, instead, the proposal had invoked the avoidable consequences doctrine, then, for the same technological reasons, it would have done little to cabin awards for pain and suffering.) Given fairly dramatic improvements in the safety and effectiveness of treatments for, among other things, chronic pain and depression, such a doctrinal recharacterization of these nonpecuniary damages might enjoy greater traction at this time. [175] In other words, with advances in technology, a rule limiting

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that are as quantifiable and transferable as those that exist in any other injury. Suffering can disable, leading to lost income, the need for medical attention, therapy, or drugs."); *id. at 783-84* ("Society has sufficiently acknowledged the victim's right to bodily and emotional security by granting damages for the economic ramifications of his injury - his cost of coping and of being rehabilitated. The remaining injury is arguably only that which is truly nonquantifiable and nontransferable and, therefore, best borne by the victim."). Ingber qualified his proposal to limit nonpecuniary damages in various ways: excluding willful torts, *id. at 791,* and shifting attorneys' fees, *id. at 812.*

[172] As a consequence, he failed to address any of the objections lodged against psychiatric mitigation, focusing instead on rebutting objections to any proposal that would have the effect of stringently limiting the magnitude of nonpecuniary awards. Ingber had, however, hinted at a mitigation requirement in his discussion of intangible damages in defamation cases. See *id. at 835-36* (arguing that, if the defendant refuses to issue a retraction and the plaintiff fails to secure an opportunity to publish a refutation without cost, the defendant should finance the plaintiff's effort to issue a reply designed to restore reputation). Even critics of such an approach seem to be oblivious to the mitigation issue. See Davies, supra note 24, at 27 n.131 ("While persons suffering from severe emotional distress may benefit from medical attention, they may not seek it."); id. at 29 ("Given the stigma still attached to treatment of mental disorders, many individuals may be reluctant to seek substantial medical treatment.").

[173] For still earlier proposals to limit recovery to the pecuniary costs of nonpecuniary injuries (though also without making any reference to a mitigation requirement and usually offered only as aspects of more sweeping reforms), see Richard S. Miller, The Scope of Liability for Negligent Infliction of Emotional Distress: Making "the Punishment Fit the Crime," 1 U. Haw. L. Rev. 1, 39-42 (1979); Clarence Morris, Liability for Pain and Suffering, 59 Colum. L. Rev. 476, 476-77 (1959); Jeffrey O'Connell, A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees, 1981 U. Ill. L. Rev. 333, 348-53; id. at 349 n.47 ("Thus if psychic loss leads to pecuniary loss - as in the need for psychiatric services or inability to work because of sheer pain - such loss is payable under the above provision as pecuniary loss."); id. at 368 ("Pain so severe as to cause the tort victim to miss work or purchase analgesics does represent economic loss and, as such, will be compensated under the proposed reforms. Apart from such direct economic loss, damages for pain and suffering seem to serve no economic function."). In recent years, a couple of commentators have made passing references to this idea. See Abel, supra note 37, at 323 (tossing it in at the very end of a lengthy critique of nonpecuniary damages); King, supra note 32, at 168, 173, 205-09 (focusing on expenditures for pain management); id. at 164 (making these recommendations "tentatively and preliminarily"); see also *Jutzi-Johnson v. United States, 263 F.3d 753, 758 (7th Cir. 2001)* (Posner, J.) ("Various solutions, none wholly satisfactory, have been suggested, such as … estimating how much it would cost the victim (if he survived) to obtain counseling or therapy to minimize the pain and suffering, Law Commission, Damages for Personal Injury: Non Pecuniary Loss 8 (Consultation Paper No. 140, 1995); Andrews v. Grand & Toy Alberta Ltd., (1978) 83 D.L.R. (3d) 452, 476-77 (Can. S. Ct.) … ."); Peter Cane, Atiyah's Accidents, Compensation and the Law 354 (6th ed. 1999) ("When all has been done to minimize the pain and suffering by medical means, any residual pain and suffering cannot be shifted; it remains with the victim, no matter what compensation is paid to that person by others.").

[174] See Ingber, supra note 171, at 783 ("Restricting damages for intangible injuries to their tangible ramifications clearly leaves part, if not a significant part, of the injury to be borne by the … plaintiff alone."). Conversely, with such a damage limitation in place, Ingber would have allowed recovery by a broader class of emotional distress victims. See id. at 817-19; see also *Miller, supra* note 173, at 39-40. *Contrast Kontorovich, supra* note 143, at 492, 518-20 (favoring further restrictions on emotional distress claims given the difficulty of imposing a psychiatric mitigation requirement).

[175] See Kolber, supra note 140, at 1594 ("As mental health treatments become more effective, however, a plaintiff's failure to use them may appear more unreasonable, and courts may become more willing to penalize plaintiffs who fail to mitigate emotional damages."); cf. Martin V. Totaro, Note, Modernizing the Critique of Per Diem Pain and Suffering Damages, *92 Va. L. Rev. 289, 310-19 (2006)* (focusing on cognitive-behavioral treatments for pain, and contending that their availability undermines the assumption of relatively constant and unremitting agony behind requests for future nonpecuniary damages based on time-

recovery to the medical expenses associated with mitigating pain and suffering might **[*474]** converge at least partially with existing awards for nonpecuniary damages. [176]

A psychiatric mitigation requirement would, of course, fail to account for some types of pain and suffering. In the context of nonpsychiatric mitigation, victims may not recover entirely from their physical injuries, and the common law allows damages for the economic consequences of these lasting disabilities in the form of lost earning capacity. Similarly, in the context of psychiatric mitigation, victims may not recuperate entirely from their emotional injuries, and the courts presumably would continue to award damages for both the economic and noneconomic consequences of intractable (i.e., untreatable) pain and suffering.

Even so, applying the avoidable consequences doctrine in this setting may have a number of desirable effects. First, expenditures for psychiatric mitigation could provide a more precise baseline from which to calculate total noneconomic damages; [177] in practice, when parties settle, economic damages (and medical expenses in particular) currently serve this purpose. [178] Indeed, one commentator **[*475]** recently proposed that juries use a

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unit arguments); *id. at 323* ("Courts permitting the per diem argument have not incorporated advances in the field of pain and suffering into their analyses."); infra note 194 (drawing a parallel to the legal impact of advances in antipsychotic medications). In making such a proposal more than a quarter of a century ago, one scholar noted that "since World War II there have been dramatic innovations in treatment for the relief of pain, not only through analgesics but through more novel devices, including the application of electric signals to the nervous system to block the feeling of pain." O'Connell, supra note 173, at 349 n.47. As explained in Part III.C above, these technological advances have continued apace and extend beyond simple pain relief to offer promising treatments for other forms of suffering.

[176] Those commentators who recommend eliminating noneconomic damages altogether would force plaintiffs to prove psychiatric expenses as "special" damages; in contrast, applying the mitigation requirement more rigorously would mean that the burden of proof remains with the defendant and also would continue to allow recoveries for the unmitigable portion of pain-and-suffering damages. The intermediate option that I urge would obligate the plaintiff to provide evidence of mitigation efforts by revising jury instructions to require some proof of pain and suffering (and explaining that an award for noneconomic damages seeks to cover only those harms that the plaintiff could not have treated successfully). At a minimum, juries should differentiate between past and future nonpecuniary damages.

[177] Perhaps juries could select from a sliding scale of multipliers (e.g., 5-25) based on their assessment of the severity of the untreatable injury. In one of the cases described previously, the final award reflected a ratio of almost 10:1. See ***In re Air Crash at Charlotte, 982 F. Supp. 1101, 1110-11 (D.S.C. 1997)*** (awarding nearly $ 31,000 for future psychiatric expenses and $ 300,000 for pain and suffering). Although the court did not make any mention of such a ratio, it did reject the defendant's suggestion to use prior awards (and the relationship between the awards for physical and emotional injuries) as a guide. See ***id. at 1112-13 & n.9;*** cf. *Feld v. Merriam, 461 A.2d 225, 229, 234-35 (Pa. Super. Ct. 1983)* (affirming an award of $ 8,900 for past psychiatric expenses and almost $ 3 million for pain and suffering), rev'd on other grounds, *485 A.2d 742, 747-48 (Pa. 1984).* Along roughly similar lines, the U.S. Supreme Court has suggested some outer limits on the ratio between punitive and compensatory damages. See *State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 425 (2003)* (noting that "few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process").

[178] See Ingber, supra note 171, at 779 ("To avoid the risk and uncertainty of a jury verdict, … defendants often settle claims for noneconomic loss by offering a fixed multiple of more easily provable economic loss, for example, medical expenses."); O'Connell, supra note 173, at 334 ("[Liability] insurers start with a multiple of a claimant's medical bills and wage loss: every dollar of pecuniary loss is worth, say, three dollars for pain and suffering."); id. at 342 & n.20 (adding that the multiplier serves only as a handy "starting point"); Neil Vidmar & Jeffrey J. Rice, Assessments of Noneconomic Damage Awards in Medical Negligence: A Comparison of Jurors with Legal Professionals, *78 Iowa L. Rev. 883, 894 (1993)* ("Judges and attorneys in North Carolina frequently speak of an informal guideline that suggests that noneconomic damages should be between three and seven times the amount of economic damages."); Wissler et al., supra note 40, at 812-13 n.179 (noting that "the rule of thumb some lawyers use to come up with a figure for general damages for purposes of settlement negotiations [is] multiplying medical specials by three"); Peter Passell, The Health Care Plan Could Worsen Injury-Claim Abuses, N.Y. Times, Oct. 14, 1993, at D2 ("The cost of medical treatment is generally used as a benchmark of injury severity in calculating out-of-court settlements for "pain and suffering.' Hence a $ 4,000 medical bill can be used to leverage … another two or three times the $ 4,000 payment for pain and suffering."); see also Stephen Daniels & Joanne Martin, It Was the Best of Times, It Was the Worst of Times: The

multiplier, [179] even though the severity of the physical injury does not invariably correlate to the severity of the emotional injury. [180] One could draw a parallel to the methodological disputes in the willingness-to-pay context, [181] though particularized in this setting: expenditures for psychiatric mitigation would offer concrete evidence of victims' revealed preferences as a basis for judging the severity of their reported pain and suffering, [182] which would have obvious advantages over the **[*476]** contingent valuation alternative of asking jurors how much a reasonable person would have been willing to pay to avoid the risk of the injury experienced by the victim. [183]

Precarious Nature of Plaintiffs' Practice in Texas, *80 Tex. L. Rev. 1781, 1807 n.61 (2002)* (reporting that the multiplier had declined from about 3.1 to 1.7).

[179] See Avraham, supra note 53, at 110-19 (proposing "a system of nonbinding age-adjusted multipliers"); id. at 111 (offering for illustrative purposes a range of multipliers from 0.5 for medical expenses not exceeding $ 100,000 up to 1.25 for medical expenses above $ 1 million); id. at 110-11 n.116 ("It seems intuitive that people with more severe injuries (reflected in higher health costs) suffer proportionally more from their injuries."); see also Marcus L. Plant, Damages for Pain and Suffering, 19 Ohio St. L.J. 200, 211 (1958) (suggesting that noneconomic damages not exceed 50% of medical expenses); cf. *Jones v. Wal-Mart Stores, Inc., 870 F.2d 982, 988 (5th Cir. 1989)* ("Once it has been proved by objective evidence that the [physical] injury will continue adversely to affect the plaintiff, the jury may not give a take nothing verdict for future pain, suffering, and mental anguish."); *id. at 989* (conceding, however, that the plaintiff was "an extremely stoic and cheerful person"); *Healy v. Bearco Mgmt., Inc., 576 N.E.2d 1195, 1203 (Ill. App. Ct. 1991); Am. States Insur. Co. v. Audubon Country Club, 650 S.W.2d 252, 254-55 (Ky. 1983)* (suggesting that future pain-and-suffering damages should be awarded whenever there are future medical expenses); Todd R. Smyth, Annotation, Validity of Verdict Awarding Medical Expenses to Personal Injury Plaintiff, but Failing to Award Damages for Pain and Suffering, *55 A.L.R.4th 186* (1987 & Supp. 2007).

[180] See supra note 149. Any such correlation would, of course, be entirely absent in claims for the infliction of emotional distress alone, at least unless that distress triggers some physical manifestation.

[181] See Adler, supra note 64, at 1030-34; see also supra notes 55-57 and accompanying text.

[182] See O'Connell & Bailey, supra note 124, at 104 (observing that plaintiffs' lawyers may draw attention to prescriptions for analgesics and other records of treatment for pain). Along similar lines, in an investigation of whether the prospect for recovering pain and suffering damages alters the behavior of injury victims, one group of researchers looked at patterns of pharmaceutical usage rather than rely on subjective reports about pain. See Cornelius J. Peck et al., The Effect of the Pendency of Claims for Compensation upon Behavior Indicative of Pain, 53 Wash. L. Rev. 251, 260-61 (1978) ("Data concerning the use of prescribed analgesic drugs are presumably the best indicators of pain and pain behavior. There are, however, many types of analgesic drugs of varying strength, and reduction to common units for measurement is necessary if comparisons are to be made. Accordingly, narcotic and barbiturate equivalency tables were prepared for the various types of drugs … ."); id. at 268-70 (finding that workmen's compensation claimants with "third-party [tort] claims engaged in behavior indicative of pain at a statistically significantly higher rate than the control group [with respect to] the use of prescribed pain-relieving drugs," but discounting this result); see also id. at 274 ("Because of its sensitivity as a measure of pain and its importance in types of pain behavior, the data concerning drug usage deserve comment."). But cf. Jennifer S. Labus et al., Self-Reports of Pain Intensity and Direct Observations of Pain Behavior: When Are They Correlated?, 102 Pain 109, 119-21 (2003) (cautioning against undue reliance on non-verbal cues, though focusing on pain behaviors other than taking medication); Dennis C. Turk & Herta Flor, Pain > Pain Behaviors: The Utility and Limitations of the Pain Behavior Construct, 31 Pain 277 (1987) (same).

[183] In a study designed to evaluate the variability of monetary awards for general damages, a group of researchers used a survey instrument that evidently failed to include any references to psychiatric interventions. See Wissler et al., supra note 40, at 819 (providing examples of injury descriptions used in their survey); see also id. at 764 ("We did not include cases in which … the plaintiff suffered only emotional distress unaccompanied by physical injury."). As a more flexible option than a proposed scheduling approach, one group of authors suggested that judges could give juries a series of valuation scenarios, which would include references to additional factors reflective of pain and loss of functioning. See Bovbjerg et al., supra note 51, at 954 (suggesting that "one might use fairly simple descriptors, such as the strength of drug needed to control pain"); id. at 955 (illustrating with a scenario that included the following information: "Her arm throbs painfully most of the time, but the pain can usually be controlled with aspirin."); see also McCaffery et al., supra note 53, at 1380-81 (discussing a survey question that had asked about approaches to measuring damages for pain and suffering, and noting that some of the answers "talked of simple heuristics, such as referring to the cost of anesthesia as an estimate of the "price' of pain").

Second, courts would encourage victims to take reasonable steps to minimize the severity of these consequences. Communicating an expectation of psychiatric mitigation may have a salutary impact by counterbalancing the often anti-therapeutic effects of tort litigation. [184] If plaintiffs understood that judges and juries would have more of an interest in evidence of their rehabilitative efforts than persistent complaints about their unmitigated agony, then victims might sooner seek out the help that they (claim that they) need. [185] **[*477]** The danger, of course, is that plaintiffs then might incur charges for psychiatric interventions more easily than they would run up other types of medical expenses. [186]

Third, focusing on treatable pain and suffering as a medical expense may promote clarity in thinking about the nature and purpose of what remains in the category of noneconomic damages: acute (past) pain and suffering, which the victim would have experienced before having any opportunity to seek out medical intervention; [187] pain and suffering that fail to respond to reasonable treatment efforts; [188] and the loss of enjoyment of life, which some courts have characterized as the noneconomic aspects of the permanent disability suffered by the victim. [189] It also

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[184] For instance, PTSD sufferers may find themselves retraumatized by the litigation process. See Hickling et al., supra note 28, at 630-31; see also J. David Cassidy et al., Effect of Eliminating Compensation for Pain and Suffering on the Outcome of Insurance Claims for Whiplash Injury, 342 New Eng. J. Med. 1179, 1184-85 (2000) (finding lower reported levels of pain and depression when traffic accident victims could no longer seek to recover noneconomic damages); Richard Mayou et al., Prediction of Psychological Outcomes One Year After a Motor Vehicle Accident, 158 Am. J. Psychiatry 1231, 1237 (2001) ("Litigation is a continuing reminder of the accident that may interfere with a natural tendency toward symptom resolution."); cf. Bagenstos & Schlanger, supra note 149, at 785-87 (making a similar argument against awarding hedonic damages); id. at 787 ("Damages that compensate for the out-of-pocket costs of rehabilitation … would not cause these disempowering effects; they are in fact means of empowerment.").

[185] See Ingber, supra note 171, at 808 ("A system that awards damages for the pecuniary losses associated with intangible injuries - but refuses general damages - would demonstrate societal concern for the victim's plight while emphasizing rehabilitative needs rather than suffering. Thus, the system's focus would be positive - on healing - rather than negative - on disability."); id. at 782 ("When dealing with those affected by emotional distress, such damages may encourage sufferers to seek professional assistance and rehabilitation. Without such encouragement, these individuals might not pursue therapy due to feelings of shame or fear of stigma from acknowledging "emotional instability."' (footnote omitted)); Pryor, supra note 20, at 681-82; cf. Peter A. Bell, The Bell Tolls: Toward Full Tort Recovery for Psychic Injury, 36 U. Fla. L. Rev. 333, 375-76 (1984); id. at 396 (arguing that emotional distress "damages may enable and encourage plaintiffs to obtain professional psychological assistance soon after the onset of the traumatic injury").

[186] See Kontorovich, supra note 143, at 510-11; cf. supra notes 157-58 and accompanying text (summarizing and responding to these concerns). Similarly, commentators suspect that plaintiffs might incur unnecessary diagnostic expenses even if they would not undergo more dangerous therapeutic interventions. See Avraham, supra note 53, at 115 ("While a plaintiff may strategically go to excessive doctor's visits or get unnecessary X-rays, she will not volunteer to go through an operation merely to receive higher pain-and-suffering compensation down the road."). Limitations on insurance coverage for mental health care, see supra note 22, may help to counteract this tendency, and estimates of future psychiatric expenses would, of course, depend on expert testimony rather than a pattern of prior utilization.

[187] See, e.g., *Wellborn v. Sears, Roebuck & Co., 970 F.2d 1420, 1428 (5th Cir. 1992); Beynon v. Montgomery Cablevision Ltd., 718 A.2d 1161, 1169-79, 1183-85 (Md. 1998); Oliveira v. Jacobson, 846 A.2d 822, 827-28 (R.I. 2004);* see also Leebron, supra note 38, at 260-70, 279-88.

[188] See, e.g., *Helleckson v. Loiselle, 155 N.W.2d 45, 49-50 (Wis. 1967)* (explaining that, in calculating pain-and-suffering damages, the jury should consider the extent to which the patient experienced only incomplete relief from narcotic painkillers and tranquilizers that he had received in the hospital).

[189] See, e.g., *LeBleu v. Safeway Ins. Co., 824 So. 2d 422, 426 (La. Ct. App. 2002)* (explaining that "an award for disability may include compensation for limitations on activities outside the workplace," and rejecting the defendant's objection that this conflicted with the failure to award future pain and suffering damages); *Golden Eagle Archery, Inc. v. Jackson, 116 S.W.3d 757, 763-72 (Tex. 2003)* (discussing damages for "physical impairment"); see also Pryor, supra note 11, at 151-52; id. at 121 n.102 (suggesting a "rehabilitated self" standard that "might articulate those functions, abilities, and activities that are deemed basic to

might help to focus the debate over such hedonic damages, [190] drawing **[*478]** closer attention to this feature of the award without the need to carve it out as a freestanding category of nonpecuniary damages and the accompanying risk of duplicative recovery. For instance, once the victim has made all reasonable efforts to manage the distress caused by the defendant, the parties could use experts to help the jury engage in a QALY-based analysis.

Finally, though this proposal seeks to improve the consistency of awards for pain and suffering as well as to limit their magnitude, plaintiffs need not necessarily fear such a change. As legislatures increasingly constrain noneconomic damages, [191] shifting some nonpecuniary harms into the category of economic damages as medical expenses can only serve to maximize the payout received in a case where, for instance, a cap or ratio otherwise would reduce the award. [192] Of course, nothing currently prevents plaintiffs from **[*479]** making such a tactical choice. [193] In smaller cases where a damages cap would not come into play, however, the movement of erstwhile

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a meaningful quality of life and then resolve issues of compensability in light of these judgments"); id. at 129-31 (arguing that it makes more sense to look at "component aspects of the loss, rather than to the loss as a whole," because otherwise one "would count as nonpecuniary even those losses that could be largely corrected by basic medical care," but also cautioning against the potential expansiveness of such a particularized approach).

[190] See, e.g., *McGee v. AC&S, Inc., 933 So. 2d 770, 774-80 & n.3 (La. 2006)* (noting conflict among jurisdictions); *id. at 780-84 & n.2* (Victory, J., dissenting) (same); *Smallwood v. Bradford, 720 A.2d 586, 592-95 (Md. 1998); Banks v. Sunrise Hosp., 102 P.3d 52, 61-64 (Nev. 2004);* see also Bagenstos & Schlanger, supra note 149, at 748-49, 755-59, 774-97; Feldman, supra note 33, at 1591-94; King, supra note 32, at 205 ("I disagree with those who have suggested that damages include a sum for purchasing surrogate pleasures or to pay for new activities, all to serve as substitutes for the former pleasures and satisfactions that the post-accident condition and limitations have now placed out of reach."); Susan Poser et al., Measuring Damages for Lost Enjoyment of Life: The View from the Bench and the Jury Box, 27 Law & Hum. Behav. 53 (2003); Victor E. Schwartz & Cary Silverman, Hedonic Damages: The Rapidly Bubbling Cauldron, *69 Brook. L. Rev. 1037 (2004).* Hedonic damages may, however, refer more narrowly only to the nonpecuniary value of life in the case of a fatal injury, which also presents the issue in stark terms insofar as the victim would have had no occasion for recovering future pain-and-suffering damages. See *Durham v. Marberry, 156 S.W.3d 242, 245-48 (Ark. 2004);* Andrew Jay McClurg, It's a Wonderful Life: The Case for Hedonic Damages in Wrongful Death Cases, *66 Notre Dame L. Rev. 57, 60-61 n.9 (1990).*

[191] See, e.g., *Ohio Rev. Code Ann. § 2323.43* (West 2007) (limiting, subject to various exceptions, noneconomic damages in medical malpractice cases to the greater of $ 250,000 or three times economic damages up to a maximum of $ 350,000); *Preston v. Dupont, 35 P.3d 433, 440-42 (Colo. 2001)* (holding that a statutory cap on noneconomic damages did not limit recoveries for "physical impairment or disfigurement"); *Barlow v. N. Okaloosa Med. Ctr., 877 So. 2d 655, 658 (Fla. 2004)* (explaining that the $ 500,000 cap applicable to medical malpractice cases sought to address the size and unpredictably of noneconomic damage awards); see also F. Patrick Hubbard, The Nature and Impact of the "Tort Reform" Movement, *35 Hofstra L. Rev. 437, 490-91 & n.257, 496-99 (2006).*

[192] In worker's compensation, claimants already do something comparable. This non-tort remedy for occupational injuries increasingly recognizes mental distress claims but continues to award only pecuniary damages. See Thomas S. Cook, Workers' Compensation and Stress Claims: Remedial Intent and Restrictive Application, *62 Notre Dame L. Rev. 879, 896-912 (1987);* Emmanuel S. Tipon, Annotation, Right to Workers' Compensation for Emotional Distress or Like Injury Suffered By Claimant as Result of Nonsudden Stimuli - Compensability Under Particular Circumstances, ***108 A.L.R.5th 1*** (2003 & Supp. 2007). Claimants may recover expenses associated with drug treatment and psychiatric counseling. See, e.g., *Zebco Motorguide v. Briggs, 881 P.2d 103, 104 (Okla. Civ. App. 1994); Wade v. Aetna Cas. & Sur. Co., 735 S.W.2d 215, 220 (Tenn. 1987); Roller v. Dep't of Labor & Indus., 117 P.3d 385, 388-89 (Wash. Ct. App. 2005);* see also 5 Arthur Larson, *Larson's Workers' Compensation Law § 94.03*[3][b] (2007) ("Psychiatric medical benefits are now routinely awarded in appropriate cases."). Mental distress claimants also may seek lost wages for their alleged disability. See, e.g., *Saylor v. Lakeway Trucking, Inc., 181 S.W.3d 314, 320-24 (Tenn. 2005);* see also Pryor, supra note 144, at 241 (explaining that these programs "do not compensate for pain independently; rather, they largely compensate lost-earning capacity").

[193] See Avraham, supra note 53, at 100 ("Plaintiff lawyers may "itemize' noneconomic damages by looking for economic justification for them, in order to move those "itemized' damages into the noncapped economic losses."); see also Catherine M. Sharkey, Unintended Consequences of Medical Malpractice Damages Caps, *80 N.Y.U. L. Rev. 391, 429-44, 493-95 (2005)*

nonpecuniary harms into economic damages may well result in a smaller payout on the assumption that expenditures for psychiatric mitigation will increase the amount for medical expenses by far less than the decrease achieved in the award for pain and suffering. As with additional medical expenses that serve to reduce the degree of lost earning capacity, application of the avoidable consequences doctrine will reduce the size of awards where justified by principles of joint cost-minimization. In the context of psychiatric mitigation, the doctrine may have the additional benefit of helping to structure and constrain the assessment of the residual lost (non-earning) capacity to enjoy life.

IV. Conclusion

Pain and suffering long ago became synonymous with noneconomic damages, and recoveries for emotional distress claims quite naturally followed that approach. Courts may need to revisit their choice of characterization. Just as it would make no sense to equate physical injuries solely with economic damages, it makes no sense to treat emotional harms as invariably noneconomic, at least not nowadays. Physical and mental injuries have both pecuniary and nonpecuniary consequences, but doctrine continues to reflect long-discredited notions about the **[*480]** nature of emotional harms. In addition, judicial hostility to psychiatric mitigation emerged at a time when available treatment options were decidedly primitive. As interventions have become safer and more effective, and as the social stigma associated with their use has largely dissipated, courts should revisit the issue. [194] Applying the doctrine of avoidable consequences in cases of emotional injury should result in a recharacterization of some pain-and-suffering damages as medical expenses, whether or not the plaintiff chooses to make such use of an award in the future, and it might help to confine what remains under the banner of noneconomic damages.

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(describing "crossover effects," though not using proof of expenditures for psychiatric mitigation as an example); cf. *Musa v. Jefferson County Bank, 620 N.W.2d 797, 800-02, 804-05 (Wis. 2001)* (declining to extend a limitation applicable to the recovery of emotional distress damages for intentional interference with contractual relationships to an award for mental health treatment expenses in such a case); *id. at 806* (Sykes, J., dissenting) (criticizing this characterization); Adam Liptak, Pain-and-Suffering Awards Let Juries Avoid New Limits, N.Y. Times, Oct. 28, 2002, at A14 ("As all sorts of limitations have recently been placed on punitive damages, creative lawyers have shifted their attention to pain and suffering, a little-scrutinized form of compensation for psychic harm."). Even without caps, differential tax treatment, see supra note 13, might make plaintiffs (though perhaps not their attorneys) better off if they could characterize part of their pain-and-suffering damage awards as medical expenses. In any event, juries already might engage in such recharacterization. See *Green v. Franklin, 235 Cal. Rptr. 312, 322-23 (Ct. App. 1987)* (observing that an instruction on a cap "would only serve to increase the possibility that a jury may simply label damages that otherwise would have been denominated noneconomic as economic losses"); Noah, supra note 44, at 1616-18.

[194] Along similar lines, judges have shown a growing willingness to order treatment of schizophrenic patients. See Douglas Mossman, Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis, *39 San Diego L. Rev. 1033, 1128-29 (2002);* id. at 1156 ("The last decade's advances in psychopharmacology require courts and legal scholars to re-evaluate the role and value of antipsychotic drugs without being misled by distorted and increasingly outdated views found in existing case law and secondary legal sources.").