

## Lost Chances, Felt Necessities, and the Tale of Two Cities

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*It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair, we have everything before us, we had nothing before us . . . .*

*A Tale of Two Cities*, Charles Dickens

### I. INTRODUCTION

Courts have been increasingly asked to expand physician liability for loss of statistical chances of survival or better outcome.<sup>2</sup> The request has been made pursuant to the perceived right of the judiciary to conform the common law to the changing needs or the “felt necessities of the time.”<sup>3</sup> The loss of chance doctrine raises fundamental questions as to the appropriate limits of judicial policymaking in the area of physician liability. Indeed, recognition of loss of chance as either a theory of causation or a cognizable harm marks a notable judicial expansion of physician liability with significant ramifications for both tort law and health care in general.<sup>4</sup>

The two state supreme courts to have last addressed the issue reached polar

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2. See generally *Groover v. Johnston*, No. 1071143, 2009 WL3152211 (Ala. Sept. 30, 2009); *Gooding v. University Hosp. Bldg., Inc.*, 445 So.2d 1015 (Fla. 1984); *Kemper v. Gordon*, 272 S.W.3d 146 (Ky. 2008); *Matsuyama v. Birnbaum*, 890 N.E.2d 819 (Mass. 2008); *Renzi v. Paredes*, 890 N.E.2d 806 (Mass. 2008); *Fennell v. Southern Md. Hosp. Ctr. Inc.*, 580 A.2d 206 (Md. 1990); *Rankin v. Stenton*, 749 N.W.2d 460 (Neb. 2008); *Alberts v. Schultz*, 975 P.2d 1279 (N.M. 1999); *Roberts v. Ohio Permanente Med. Group, Inc.*, 668 N.E.2d 480 (Ohio 1996); *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467 (Okl. 1987); *Joshi v. Providence Health Sys. of Or. Corp.*, 149 P.3d 1164 (Ore. 2006); *Hamil v. Bashline*, 392 A. 2d 1280 (Pa. 1978); *Jorgensen v. Vener*, 616 N.W.2d 366 (S.D. 2000), *aff'd on reh'g*, 640 N.W.2d 485 (S.D. 2002) *superseded by statute* S.D. Codified Laws § 20-9-1.1, 1.2 (2002); *Kramer v. Lewisville Mem. Hosp.*, 858 S.W.2d 397 (Tex. 1993); *Smith v. Parrott*, 833 A. 2d 843 (Vt. 2003); *Herskovits v. Group Health Coop. of Puget Sound*, 664 P.2d 474 (Wash. 1983); *McMackin v. Johnson County Healthcare, Ctr.*, 73 P.3d 1094 (Wyo. 2003), *aff'd on reh'g*, 88 P.3d 491 (Wyo. 2004).

3. OLIVER WENDELL HOLMES, JR., *THE COMMON LAW* 1 (1881).

4. See *Gregg v. Scott* [2005] 2 A.C. 176, 198 (H.L.) (U.K.) (“[A] wholesale adoption of possible rather than probable causation as the criterion liability would be so radical a change in our law as to amount to a legislative act”); *RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM* §26 com. n. (Proposed Final Draft No. 1, 2005).

opposite conclusions despite strikingly similar facts and medical issues.<sup>5</sup> While the two decisions are perhaps a poor comparison to Dickens's masterful Aeschylean tragedy, set amid the fortunes and misfortunes of Paris and London in 1775, they do depict "a tale of two cities" as to physician liability. Reduced to their core, the decisions represent the divergent views of the judiciary's common-law authority and demonstrate the debate over the proper limits to judicial expansion of physician liability based on the "public policy" auspices of the common law.<sup>6</sup>

Parts II and III of this article provide an overview of the fundamental components of the common-law tradition and their application to physician tort liability. They focus on the forces of stability and flexibility underlying the debate as to judicial policymaking, represented by the competition between the desire to ensure the common law conforms with the times and the prudential concerns underlying the separation of powers. Part IV discusses the need for courts, in considering whether to abrogate existing rules and expand liability, to expressly address and recognize their institutional limitations, as well as to limit any such abrogation or expansion to only those instances where existing precedent is "intolerable" and there is a true societal consensus as to changing needs. Part V overviews loss of chance, and the existing judicial and legislative treatment of the doctrine. Part VI examines loss of chance in terms of the state of the relevant medical science, societal consensus, and the underlying policy debate. Finally, Parts VII and VIII compare the two recent state supreme court decisions in Kentucky and Massachusetts which capture the divergent views on judicial policymaking as to loss of chance and expansion of tort liability in general.

## II. THE COMMON LAW TRADITION AND "THE FELT NECESSITIES OF THE TIME"

The common-law tradition describes the judiciary's practice of adjudicating disputes based on prior court announcements, as distinguished from legislative enactments, codes, or texts.<sup>7</sup> This judge made law<sup>8</sup> has been said to "embrace that great body of unwritten law founded upon general custom, usage, or

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5. *Kemper v. Gordon*, 272 S.W.3d 146 (Ky. 2008) (rejecting "lost or diminished" chance doctrine); *Matsuyama v. Birnbaum*, 890 N.E.2d 819 (Mass. 2008) (permitting loss of chance recovery in medical malpractice action).

6. *See Kemper v. Gordon*, 272 S.W.3d 146 (Ky. 2008); *Matsuyama v. Birnbaum*, 890 N.E.2d 819 (Mass. 2008).

7. BLACK'S LAW DICTIONARY 293 (8th Ed. 2004); Daniel Farber & Philip Frickey, *The New Public Law: In the Shadows of the Legislature: The Common Law in the Age of New Public Law*, 89 MICH. L. REV. 875, 875-76 (1991) (noting legislatures make "ex ante rules to achieve public policies" while courts "administer ex post justice in disputes between private parties.").

8. Richard A. Posner, *THE PROBLEMS OF JURISPRUDENCE* 247 (1990) (explaining common law "is any body of law created primarily through judges by their decisions rather than by the framers of statutes or constitutions").

common consent, and based upon natural justice or reason.”<sup>9</sup> According to the famous passage by Holmes:

The life of the law has not been logic: it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed and unconscious, even the prejudices which judges share with their fellow men, have more to do than the syllogism in determining the rules by which men should be governed.<sup>10</sup>

The common law has thus held to many a somewhat exalted status as

[i]t is not a codification of exact or inflexible rules for human conduct, for the redress of injuries, or for protection against wrongs, but is rather the embodiment of broad and comprehensive unwritten principles, inspired by natural reason and an innate sense of justice, and adopted by common consent for the regulation and government of human affairs.<sup>11</sup>

Other commentators are more subdued stating that “the common law does not possess some enduring or essential core that transcends its historical elaboration; there is nothing more (or less) to the common law than the on-the-move and seat-of-the-pants workings of its own development.”<sup>12</sup>

Not surprisingly, in considering new extensions of tort law, courts state their public policy obligation expressly: assessing and determining “contemporary attitudes and public policy.”<sup>13</sup> Public policy considerations thus drive and determine how any particular case is decided. Not only are tort law’s fundamental components of duty of care, causation, and damages all matters heavily imbued with public policy but generally and “more than any other branch of the law, the law of torts is a battleground of social theory” and policy.<sup>14</sup> The imposition of new tort liability, and allowing for the award of

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9. *Samsel v. Wheeler Transport Servs., Inc.*, 789 P.2d 541, 550 (Kan. 1990).

10. *See* Holmes, *supra* note 3, at 1.

11. 15A Am. Jur. 2d, Common Law §1; *see also* MICHAEL EISENBERG, *THE NATURE OF THE COMMON LAW* 5, 15 (1988) (arguing “socially desirable that the courts should act to enrich the supply of legal rules that govern social conduct” and that “the task of the common law is not to determine what constitutes an injury or a right but to explore, on an ongoing basis, the extent to which actions that are perceived by the community as inflicting wrongful injuries should give rise to remedies at law”).

12. ALLAN C. HUTCHINSON, *EVOLUTION AND THE COMMON LAW* 276 (2005).

13. *Remy v. MacDonald*, 801 N.E.2d 260, 267 (2004).; *see also* M. Stuart Madden, *The Vital Common Law: Its Role In A Statutory Age*, 18 U. ARK. LITTLE ROCK L. REV. 555, 588 (1996) (“[B]y trial, error, experiment, expansion, and correction, the common law has hewn to an objective of advancing the public welfare.”).

14. W. PAIGE KEETON ET AL., *PROSSER AND KEETON ON TORTS*, §3 at 15 (5th ed. 1984); *see* Lababedy v. Gisla, No. C057863, 2009 WL 2217760 (Cal. Ct. App. July 27, 2009) (positing “duty is simply a shorthand expression for the sum total of policy considerations favoring a conclusion that the plaintiff is entitled to legal protection.”) (*quoting* *Adams v. City of Fremont*, 68 Cal. App. 4th 243, 265 (1998)).

damages never before recognized, thus inevitably involves the weighing of interests and policy.<sup>15</sup> While the public policy function of the judiciary in common-law tort adjudication is undeniable, its sources and boundaries are ill-defined and illusive. This is due, in part, to the fact that identifying and defining the underlying policy considerations in individual cases is the inventive part of the common-law decision.

The common-law tradition evolved to include the judicial practice of deciding issues of first impression by drawing upon past and present judicial experience and other sources for resolution.<sup>16</sup> Many common-law courts of highest resort have declared that they have the power and duty to modify, overrule, or change existing common law to conform to the changing conditions of society.<sup>17</sup> They declare that when the common law is out of step with the times, they have the responsibility to change that law, particularly where the legislative branch has been silent on the issue.<sup>18</sup> “[T]he common law

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15. See *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 342 (Cal. 1976). The *Tarasoff* court held that duty determination includes assessment of

the foreseeability of the harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant’s conduct and the injury suffered, the moral blame attached to the defendant’s conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved.

*Id.*

16. See generally *Plains Commerce Bank v. Long Family Land & Cattle Co.*, 491 F.3d 878, 892 (8th Cir. 2007) (discussing courts’ latitude to shape common law in response to cases before them); *Tenneco Oil Co. v. Clevenger*, 363 So. 2d 316, 318 (Ala. Civ. App. 1978) (stating progress of common law is marked by many cases of first impression); *Jews for Jesus, Inc. v. Rapp*, 997 So.2d 1098, 1103 (Fla. 2008) (noting in cases of first impression look to common-law principles and public policy considerations).

17. See *Brannigan v. Raybuck*, 667 P. 2d 213, 218 (Ariz. 1983); *Bland v. Scott*, 112 P.3d 941, 948 (Kan. 2005); *Matsuyama*, 890 N.E.2d at 837 (citing *Sullivan v. Boston Gas Co.*, 605 N.E.2d 805, 808 (Mass. 1993)); see also *Washington v. Resolution Trust Corp.*, 68 F.3d 935, 939 (5th Cir. 1995) (explaining common law evolves “in light of the changing conditions and circumstances of society.”); *Nunnally v. Artis*, 492 S.E.2d 126, 129 (Va. 1997) (describing duty to develop the orderly evolution of common law); *Thomas v. Mallett*, 701 N.W. 2d 523, 557 (Wis. 2005) (reasoning “common law developed to adapt to changing needs of society.”).

18. See, e.g., *Ontiveros v. Borak*, 667 P.2d 200, 204 (Ariz. 1993) (recognizing “[t]he common law, which is judge-made and judge-applied, can and will be changed when changed conditions and circumstances establish that it is unjust or has become bad public policy”); *County Sanitation Dist. No. 2 v. L.A. County Employees*, 669 P.2d 835, 848-49 (Cal. 1985) (noting need to redefine, modify or abolish common-law rules when demanded by reason or equity); *Giulani v. Guiler*, 951 S.W.2d 318, 321 (Ky. 1997) (stating when common law out of step, court responsible for conforming common law); see also *Hilen v. Hays*, 673 S.W.2d 713, 717 (Ky. 1984) (illustrating “[c]ommon law is not a stagnant pool, but a moving stream. It seeks to purify itself as it flows through time”); “*Jones v. Maryland*, 486 A.2d 184, 188 (Md. 1985) (explicating “this Court has manifested a willingness to change common-law rules which have become unsound in the circumstances of modern life”); *Harrison v. Montgomery County Bd. Of Educ.*, 456 A.2d 894, 903 (Md. 1983) (holding “the common law is not static, its life and heart is its dynamics, its ability to keep pace with a world while constantly searching for just and fair solutions to pressing societal problems”); *Surratt v. Thomson*, 183 S.E.2d 200, 202 (Va. 1971) (quoting *State v. Culver*, 129 A.2d 715, 721 (N.J. 1957) (noting “[t]here is not a rule of common law in force today that has not evolved from some earlier rule of common law . . . leaving the common law of

today is not a frozen mold of ancient ideas, but such law is actual and dynamic and thus changes with the times and growth of society to meet its needs”<sup>19</sup> and “principles of law which serve one generation well may, by changing conditions, disserve a later one.”<sup>20</sup> Thus, the common law evolves because “the need for stability in law must not be allowed to obscure the changing needs of society or to veil the injustice resulting from a doctrine in need of reevaluation.”<sup>21</sup>

The changing needs or, as Holmes called them, the “felt necessities of the time” is, at once, the most intriguing and most concerning component of the common-law analysis. This component necessitates judicial assessment of the state of social needs and customs as well as, at times, science and technology. It stems from the notion that rooting the common law to existing standards “provides an added and needed source of legitimacy”<sup>22</sup> and that while the “[common] law must be stable . . . it cannot stand still.”<sup>23</sup> Accordingly, where

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today when compared with common law centuries ago as different as day is from night”); *Hay v. Med. Ctr. Hosp. of Vt.*, 496 A.2d 939, 944 (Vt. 1985) (declaring “It is the role of this Court to adapt the common law to the changing needs and conditions of the people of this state”); *McDavid v. United States*, 584 S.E.2d 226, 230 n.4 (W. Va. 2002) (explaining “[c]ourts retain the power to change the common law”); *Theama v. City of Kenosha*, 344 N.W.2d 513, 519 (Wis. 1984) (reasoning “[t]he rule denying recovery for loss of society and companionship was created by the courts and not the legislature, and it is, therefore, as much our duty as the legislature’s to change the law if it no longer meets society’s needs”); see also Stanley Mosk, *The Common Law and The Judicial Decision-Making Process*, 11 HARV. J.L. & PUB. POL’Y 35, 36 (1988) (stating “vitality of the common law can flourish if the courts remain alert to their obligation and have the opportunity to change it when reason and equity so demand”).

19. *State v. Guess*, 715 A.2d 643 (Conn. 1998) (quoting *Perkins v. State*, 251 N.E.2d 30, 33 (Ind. 1969)); see also Oliver Wendall Holmes, Jr., *The Path of The Law* reprinted in *The Path of the Law After One Hundred Years*, 110 HARV. L. REV. 991, 1001 (1997) (“It is revolting to have no better reason for a rule than that so it was laid down in the time of Henry IV. It is still revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past.”).

20. BENJAMIN CARDOZO, *THE NATURE OF THE JUDICIAL PROCESS* 151-52 (1921) (quoting *Dwy. v. Conn. Co.*, 89 Conn. 74, 99 (1915)).

[T]hat court best serves the law which recognizes that the rule of law which grew up in a remote generation may, in the fullness of experience, be found to serve another generation badly, and which discards the old rule when it finds that another rule represents what should be according to the established and settled judgment of society . . . .”

*Id.*

21. See *Alvis v. Ribar*, 421 N.E.2d 886, 896 (Ill. 1981); see also *Ontiveros v. Borak*, 667 P.2d 200, 205 (Ariz. 1983). The *Ontiveros* Court held that

[I]nherent in common law is a dynamic principle which allows it to grow and to tailor itself to meet changing needs within the doctrine of stare decisis which, if correctly understood, was not static and did not forever prevent the courts from reversing themselves or from applying principles of common law to new situations as the need arose. If this were not so, we must succumb to a rule that a judge should let others long dead and unaware of the problems of the age in which he lives, do his thinking for him.

667 P.2d at 205.

22. Eisenberg, *supra* note 11, at 10.

23. ROSCOE POUND, *INTERPRETATION OF LEGAL HISTORY* 1 (1923).

tort law is no longer compatible with the realities or attitudes of modern society or in keeping with the advances of science or technology, adoption of a new rule or change in existing precedent has been found to be warranted if otherwise consistent with tort principles.<sup>24</sup>

The difficulty is that one may reasonably question whether it is a court's role to proclaim that there has been a societal change mandating judicial alteration of law.<sup>25</sup> A judicial assessment and conclusion as to the status of societal customs, needs, and changes for purposes of addressing whether the common law is out of step with the times can result in unwarranted judicial policymaking. Assessment of the efficacy or consensus of medical advances and technology in the confines of a lawsuit between discreet parties may not be fairly done. The fundamental limitations of the common-law time continuum remain principles underlying the separation of powers.

The separation of powers embodies the principle of judicial restraint. It recognizes the inability and undesirability of the judiciary substituting its notions of a correct policy for those of a popularly elected legislature.<sup>26</sup> Courts are not to legislate under the guise of interpretation, are to give great weight to the rule of law, and are to defer to the elected branches except when the branches act unconstitutionally.<sup>27</sup> This principle recognizes the institutional and functional limitations of the judiciary. It recognizes that the legislature is the policymaking arm of the government, especially where expansion of liability raises serious social consequences. It forms, at least in theory, an important limitation upon the judicial public policy power including physician liability expansion under the common law.

The institutional limitations of the judiciary underpinning separation of powers principles are substantial.<sup>28</sup> Judges and the case specific adjudicatory system are poorly designed for broad policymaking.<sup>29</sup> "Asking judges to make and implement broad social policy is a little bit like using your lawn mower to

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24. See Madden, *supra* note 13, at 571 (noting "common law has sometimes developed a right or remedy that has yet to command significant public approval" while at other times "worked in seeming conflict with the development of progressive jurisprudence").

25. See Bissen v. Fujii, 466 A. 2d 429, 431 (Haw. 1970) ("We should recognize that although courts at times arriving at decisions have taken into consideration social needs and policy it is the paramount role of the legislature as a coordinate branch of our government to meet the needs and demands of changing times and legislate accordingly."); Krise v. Gillund, 184 N.W. 2d 405, 409 (Neb. 1971) (holding where change is of far reaching effect such a change should be by the legislature).

26. See Robert P. Young, Jr., *A Judicial Traditionalist Confronts The Common Law*, 8 TEX. REV. L. & POL. 299, 300 (2004) (stating legislature serves as "people's lawgiver in matters of public policy"); see also Mass. Const., pt. I art. xxx. (mandating separation of executive, judicial and legislative departments). See generally Victor Schwartz et al., *Toward Neutral Principles of Stare Decisis in Tort Law*, 58 S.C. L. REV. 317 (2002) (noting courts' lack of in-depth consideration of separation of powers limitations on common-law adjudication and general disagreement on issue otherwise).

27. See generally Thomas M. Reavley, *The Rule of Law for Judges*, 30 PEPP. L. REV. 79 (2002).

28. See Young, *supra* note 26, at 304.

29. *Id.* (arguing "the artifact of our adversarial system further undermines the ability of courts to make sensible public policy choices").

cut your hedge.”<sup>30</sup> Indeed, “[t]he first thing the courts have to learn is how little they know.”<sup>31</sup> This has been a longstanding objection with one of its most notable proponents stating:

[The judicial process] is also too remote from conditions, and deals case by case, with too narrow a slice of reality. It is not accessible to all the varied interests that are in play in any decision of great consequence. It is, very properly, independent. It is passive. It has difficulty controlling the stages by which it approaches a problem. It rushes forward too fast, or it lags; its pace hardly ever seems just right. For all these reasons it is, in a vast complex, changeable society, a most unsuitable instrument for the formation of policy.<sup>32</sup>

The gist of the position is that the legislative process encompasses a broad range of information with input from any and all interested parties, while the judiciary is “severely challenged . . . to make sound public policy decisions.”<sup>33</sup> Hearings, data, testimony, and evidence from a variety of experts and others can be gathered without the constraints of relevancy and probative value of a single lawsuit.<sup>34</sup> Courts, on the other hand, are charged with adjudicating specific disputes between named litigants. It is only the specific litigants’ factual dispute and specific information as to that singular dispute that is available. Even though many non-parties have a very substantial stake in the outcome, they have no say or input. While the legislative process is rife with political compromise, it is far more inclusive and is subject to direct accountability.<sup>35</sup>

Legislative function and power coupled with notions of judicial restraint would seem to comprise a forceful, if not ultimate, limitation on judicial common-law authority. The difficulty is that the force such principles have as to statutory issues is considered by many not to be transferable to common-law adjudication. Courts generally consider themselves the stewards of the

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30. Lillian R. Bevier, Transcript, *The Goldwater Institute and the Federalist Society: Federalism and Judicial Mandates*, 28 ARIZ. ST. L.J. 17, 171 (1996); see also Lillian R. Bevier, *Judicial Restraint: An Argument from Institutional Design*, 17 HARV. J. L. & PUB. POL’Y 7, 9-11 (1994) (comparing judiciary’s task of resolving individual disputes to legislatures task of broad policy making); Joshua Dunn, *The Perils of Judicial Policy Making: The Practical Case for Separation of Powers*, The Heritage Foundation, Sept. 23, 2008, <http://www.heritage.org/Research/thought/fp20.cfm>.

31. Richard A. Posner, *Against Constitutional Theory*, 73 N.Y.U. L. REV. 1, 18 (1998).

32. ALEXANDER M. BICKEL, *THE SUPREME COURT AND THE IDEA OF PROGRESS* 175 (1978).

33. See Young, *supra* note 27, at 304 (expressing belief judiciary challenged when making policy choices).

34. See *Smith v. Parrot*, 833 A.2d 843, 848 (Vt. 2003) (indicating advantages in leaving policy to legislature).

35. See generally *Alvis v. Ribar*, 421 N.E.2d 886 (Ill. 1981) (Underwood, J., dissenting) (“[P]olicy choices such as those invoked here are . . . best left to the judgment of a General Assembly staffed and equipped to explore, consider, and resolve simultaneously these many faceted questions.”); see also *Bissen v. Fujii*, 466 A. 2d 429, 431 (Haw. 1970) (noting policy concerns “paramount role” of legislature).

common law and believe that this authority, in turn, expressly authorizes judicial law making. The resultant judicial policymaking is thus deemed compatible with legislative policy making absent express constitutional prohibition or legislative preemption. To others, however, even leaving aside the constitutional dimension, separation of powers considerations must operate more broadly as a substantial prudential limitation on judicial law making.<sup>36</sup>

The prudential limitations embedded in the separation of powers include the notion of conservancy and precedent. A common-law court relies on prior decisions of adjudicated disputes as a guide in finding and applying the law to resolve cases. *Stare decisis* is to be given great weight for purposes of maintaining certainty and predictability as well as avoiding usurpation of the legislative function.<sup>37</sup> Case precedent likewise allows litigants to understand and assess their respective rights or duties as well as restricting the scope of litigation. *Stare decisis* is, in fact, arguably a vital means of preserving the judiciary's legitimacy under the Constitution.<sup>38</sup> Although not without some debate, fidelity to precedent fosters certainty and equality, as well as judicial efficiency, restraint, and impartiality. As to the latter, homage to precedent fulfills the fundamental precept behind the separation of powers—that we live under the governance of laws, not of men.<sup>39</sup>

The rule of law, or fidelity to precedent, precept has led some to argue that where a court considers a radical or substantial change in existing policy in the name of the common law, the source of that policy (legislative or judicial) should not matter.<sup>40</sup> Once established and rooted such policy becomes a rule of conduct and any change arguably requires legislative action. Indeed, the Supreme Court has stated that “the fact that a rule of law has become ‘embedded’ in our ‘national culture’ argues strongly against overruling [it].”<sup>41</sup> Regardless, at the very least, precedent and the rule of law serve as a “brake upon [judicial] legal change.”<sup>42</sup> “In the exercise of proper self-restraint the

36. See Reavley, *supra* note 27, at 79; Young, *supra* note 26, at 304.

37. 1000 Va. Ltd., P'ship v. Vertecs Corp., 146 P.3d 423, 438 (Wash. 2006) (reasoning “*stare decisis* helps make the system of justice one of unity, assuring that the decisions of the courts of last resort are reliable and binding”); see also Randall v. Sorrell, 548 U.S. 230, 243-44 (2006) (noting importance of *stare decisis*); Vasquez v. Hillery, 474 U.S. 254, 265-66 (1986) (emphasizing doctrine).

38. See Thomas Healey, *Stare Decisis as a Constitutional Requirement*, 104 W. VA. L. REV. 43, 106-07 (2001).

39. MASS. CONST., pt. I, art. XXX; see also Stephen Presser, *The Development and Application of Common Law*, 8 TEX. REV. L. & POL. 291, 294 (2004) (noting Blackstone's conclusion that judicial activism results in loss of liberty); Reavley, *supra* note 27, at 79 (“[J]udges should be constrained by the rule of law, by its letter and by its traditions, and they may not substitute preference—right or wrong, popular or unpopular for the law that rules them also.”).

40. See e.g., Earl Matz, *The Nature of Precedent*, 66 N.C. L. REV. 367, 390-91 (1988) (discussing argument that common-law precedent should have “same force as precedents interpreting statutes” in order to force legislatures to effect public interest).

41. Leegin Creative Leather Prods., Inc. v. PSKS, Inc., 551 U.S. 877, 926 (2007) (Breyer, J., dissenting) (quoting *Dickerson v. United States*, 530 U.S. 428, 443-44 (2000)).

42. *Adams v. Buffalo Forge Co.*, 443 A. 2d 932, 935 (Me. 1982) (quoting *Amoskeag Trust Co. v. Trs. of*

courts should leave it to the people, through their elected representatives in the [legislature], to say whether or not it should be revised or discarded.”<sup>43</sup> As such, advocates for restraint contend that where a long-standing common-law rule is the subject of challenge, the notions underlying separation of powers require refraining from judicial alteration absent a history of inconsistent application and “Herculean need.”<sup>44</sup>

Principles of coherence and principled distinctions are fundamental requirements of common-law adjudication.<sup>45</sup> As one court explained:

To be acceptable the [common] law must be coherent. It must be principled. The basis on which one case, or one type of case is distinguished from another has to be transparent and capable of identification. When a decision departs from principles normally applied, the basis for doing so must be rational and justifiable if the decision is to avoid the reproach that hard cases make bad law.<sup>46</sup>

Accordingly, while there should not be blind allegiance to precedent, central to prudential concerns is the need for sound reasoning including coherence and principled distinctions from past precedent.<sup>47</sup> The difficulty remains, however, that “[a] commitment to principled adjudication does not dictate the choice between competing principles.”<sup>48</sup> Indeed, many authorities note the importance of approaching a request to expand common law with “canny caution” respecting “the difficulties . . . which can grow out of letting a concept’s seeming corollaries take over without reference to the sense of the situation.”<sup>49</sup> Even where the common law must diverge from precedent, it should do so narrowly to avoid broad proclamations and adverse consequences.<sup>50</sup> “Negligence law is not suitable to sweeping pronouncements, and as experience indicates, a revised or expanded tort principle is better left to case-by-case development.”<sup>51</sup>

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Dartmouth Coll., 200 A. 786, 788 (N.H. 1938)).

43. *Rogers v. Florence Printing Co.*, 106 S.E.2d 258, 261-62 (1958).

44. *Young*, *supra* note 26, at 306.

45. *Vasquez v. Hillery*, 474 U.S. 254, 265 (1980).

46. *Fairchild v. Glenhaven Funeral Servs. Ltd.*, [2003] 1 A.C. 32, 68 (H.L.); see Sarah Green, *Coherence of Medical Negligence Cases: A Game of Doctors and Purses*, 14 MED. L. REV. 1 (2006).

47. See *Payne v. Tennessee*, 501 U.S. 808, 828 (1990) (explaining *stare decisis* not an inexorable command or mechanical formula but a principle of policy).

48. Richard A. Posner, *The Meaning of Judicial Self-Restraint*, 59 IND. L.J. 1, 9 (1984).

49. KARL LLEWELLYN, *THE COMMON LAW TRADITION: DECIDING APPEALS* 281 (1960); see also Antonin Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175, 1177 (1986) (common law system develops through fact specific pronouncements).

50. See Scalia *supra* note 49, at 1177.

51. *Coombes v. Florio*, 877 N.E. 2d 567, 580 (Greaney, J., concurring in part and dissenting in part); see also *In re Roche*, 411 N.E.2d 466, 476 (1980) (common law incremental and requires refraining from “overly broad generalizations”).

A further prudential consideration (as well as source) is legislative enactments or positive law. Legislatures proclaim public policy through statutes. A statute applicable to a particular issue displaces any common-law rule.<sup>52</sup> A legislative enactment or scheme is a primary source of a policy choice made by the elected officials of government. Moreover, a statute need not be expressly on point to provide a fundamental source of policy in common-law adjudication.<sup>53</sup> To some, a court should not make any ruling based on public policy unless there can be reference to an express source of that policy in a statute, statutory rule, or constitutional provision.<sup>54</sup> While courts often refer to, and rely upon, the rules or policies set forth in precedent of other jurisdictions, “even more, a court should heed the policy pronouncements of its own jurisdictions’ legislature.”<sup>55</sup> At a minimum, the legislature is “an appropriate potential player in any common-law policymaking dispute, not simply another government agency from which disappointed litigants seek relief.”<sup>56</sup> Moreover, “[a]lthough common law evolves with the changing times, it is not fashioned solely in that context, but is shaped consistent with the policy considerations set forth by [the] legislature.”<sup>57</sup>

### III. APPLICATION TO PHYSICIAN LIABILITY AND MODERN MEDICINE

Tort law, as it applies to physician liability, is primarily common law that has undergone incremental and steady expansion, largely through the public policy auspices. Early liability was premised on the contractual undertaking between physician and patient and it was an actionable wrong if the physician failed to provide medical care as agreed.<sup>58</sup> Liability progressed from notions of

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52. See Harvey S. Perlman, *Thoughts on the Role of Legislation in Tort Cases*, 36 WILLAMETTE LAW REV. 813, 814 (2000).

53. See *Moragne v. States Marine Lines, Inc.*, 398 U.S. 375, 376 (1970) (reasoning statutes in majority of jurisdictions allowing wrongful death shows policy shift favoring recovery). The *Moragne* Court concluded that “this legislative establishment of policy carries significance beyond the particular scope of each of the statutes involved.” *Id.*

54. See Hans A. Linde, *Courts and Torts: “Public Policy” Without Public Politics?*, 28 VAL. U. L. REV. 821, 853-54 (1994).

55. See Perlman, *supra* note 52, at 814. But see Harlan Stone, *The Common Law in the United States*, 50 HARV. L. REV. 4, 15 (1936) (arguing a statute is not “an alien intruder in the house of the common law”).

56. Perlman *supra* note 52; see also Stone, *supra* note 55, at 13 (stating “I can find in the history . . . of the common law no adequate reason for our failure to treat a statute much more as we treat a judicial pronouncement, as both a declaration and a source of law, and as a premise for legal reasoning”). But see Madden *supra* note 13, at 556 (noting much authority suggesting common law in “retreat” due to the rise of statutory enactments rendering “common law background music for a modern statutory lyric”)

57. *Rettig v. Town of Woodbridge*, No. X10UWYCV075005102S, 008 WL 2345145, at \*6 (Conn. Super Ct. May 14, 2008); see also *Bartom v. Adjustment Bureau, Inc.*, 618 N.E.2d 1, 7 (Ind. 1993) (“[While] Indiana courts should not hesitate to modify common law rules when their existence cannot be justified in light of the realities of modern life, such determinations should be consonant with the evolving body of public policy adapted by the General Assembly.”); Madden, *supra* note 13, at 611 (“[A] partner with statutory law in that system of social justice our common law is more than a legacy of jurisprudence. Progressive, protean and dynamic, American common law is a reflection of our society’s better self.”)

58. KANT PATEL & NARK RUSHEFSKY, *HEALTH CARE POLITICS & POLICY IN AMERICA* 267 (Angela

contract<sup>59</sup> to legally imposed tort and fiduciary<sup>60</sup> duties as well as duties of informed consent<sup>61</sup> and maintenance of confidences.<sup>62</sup> Consistent with tort policies in general, the central tenets of physician liability are: (a) imposing the duty of care to conform to the accepted medical practice and standards applicable to the average qualified physician practicing in the same circumstances; (b) awarding damages for cognizable harm caused by a breach of this duty of care; and (c) requiring imposition of liability to be supported by “experts” under the more probable than not standard. Virtually all common-law courts determine and define duties of care and their contours, including duties of medical providers, “by reference to existing social values and customs and appropriate social policy.”<sup>63</sup>

Common-law courts have usually maintained healthy adherence to the principle that the standard of care is that of the “ordinary” or “reasonable” qualified physician practicing in that specialty. The standard is not one of perfection, and it is not enough to show that another doctor might have undertaken a different course of treatment.<sup>64</sup> Nonetheless, the standard has expanded, with many courts still permitting liability based on such concepts as “the Captain of the Ship” in surgical cases<sup>65</sup> and ostensible authority or partnership by estoppel.<sup>66</sup> Liability has also been extended to encompass harm

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Pilioras ed., M.E. Sharpe 3d ed. 2006).

59. See *Sullivan v. O'Connor*, 296 N.E.2d 183, 186 (Mass. 1973); see also 3 William Blackstone Commentaries on The Law of England 122, 163 (1825) (noting professionals held to implied contractual undertaking to render their service with “integrity, diligence and skill”); *Patel & Rushefsky*, *supra* note 58, at 267.

60. See generally *Warsofsky v. Sherman*, 93 N.E.2d 537 (Mass. 1952); *Korper v. Weinstein*, 783 N.E.2d 877 (Mass. App. Ct. 2003).

61. See generally *Harnish v. Children’s Hosp. Med. Center*, 439 N.E.2d 240 (Mass. 1982).

62. See generally *Alberts v. Levine*, 479 N.E.2d 113 (Mass. 1993).

63. See *Cremins v. Clancy*, 612 N.E.2d 1183, 1185 (Mass. 1993).

64. See, e.g., *Leech v. Bralliar*, 275 F. Supp. 897, 899 (D.C. Ariz. 1967) (prolotherapy for whiplash injury recognized as proper treatment by a small minority of physicians); *Wasfi v. Chaddha*, 588 A.2d 204 (Conn. 1991) (holding medical malpractice action fails as diagnosis and treatment at issue subject to two schools of thought); *Jones v. Chidester*, 610 A.2d 964, 969 (Pa. 1992) (liability turns on whether physician followed course of treatment advanced by considerable number of recognized and respected professionals); *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977) (standard for malpractice not poll of medical profession but rather if physician undertakes form of treatment which a reasonable and prudent member of profession would take, under the same or similar circumstances, not subject to liability).

65. The Captain of the Ship doctrine is the common-law rule that a surgeon is responsible for all negligent conduct in the operating room. See *McConnell v. Williams*, 65 A.2d 243 (Pa. 1949); see also *Truhitte v. French Hosp.*, 180 Cal. Rptr. 152, 160 (Cal. Ct. App. 1982) (tracing Captain of the Ship doctrine to need to afford recovery in face of hospital immunity); Stephen H. Price, *The Sinking of the Captain of the Ship: Reexamining the Vicarious Liability of an Operating Surgeon for the Negligence of Assisting Hospital Personnel*, 10 J. LEG. MED. 323 (1989).

66. See *York v. Rush-Presbyterian-St. Luke’s Med. Ctr.*, 854 N.E.2d 635, 662 (Ill. 2006) (holding hospital may be vicariously liable for negligence of non-employee physician under doctrine of apparent agency); *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 795 (Ill. 1993); see also *Mejia v. Comty. Hosp. of San Bernadino*, 99 Cal. App. 4th 1448, 1455 (2002). But see *Garcia v. Kent*, No. B176081, 2007 WL 273960, at \*19 (Cal. Super. Ct. Feb. 1, 2007) (rejecting malpractice claim against non-treating physician with names on medical group appointment card and office door); *Impasto v. Girolamo*, 459 N.Y.S.2d 512, 515 (1983) (holding

to third parties for patient medication risks<sup>67</sup> and otherwise eroded “curbside” consults.<sup>68</sup> On a more subtle level, causation has developed wherein “but for cause in fact” is many times no longer required or is otherwise defined in terms of nebulous “substantial contributing factor” language with damages evolving from physical harm to include emotional harm and non-economic and hedonic damages.

In the context of physician liability, the central tort aims include deterring violations of basic standards of physician conduct as to medical care and treatment of patients;<sup>69</sup> protecting patients from harm caused by unreasonable conduct through the creation of enforceable rights; and awarding compensation for the harms caused. The common-law duty has long roots and has been expressed as “ordinary skill,” “reasonable care,” and “reasonable skill.” As will be seen, both duty and harm are directly impacted by medical advances and science.

Judicial policymaking due to “changing needs” or the “felt necessities of the time” is very much a part of physician tort liability. For instance, it was the advent of modern transportation, means of communication and access to medical facilities and experience that drove the common law to discard “the same locality rule” in favor of the general standard of reasonable care in medical malpractice actions.<sup>70</sup> The locality rule provided that “a medical man has the obligation to his patient to possess and employ such reasonable skill and care as is commonly had and exercised by reputable, average physicians in the same general system or school of practice in the same or similar locality.”<sup>71</sup> The rule was designed to protect the rural or small town physician who did not have access to the latest medical knowledge, facilities or experience as his or

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no liability by partnership by estoppel where physician does not represent physician as partner).

67. See *McKenzie v. Hawaii Permanente Med. Group, Inc.*, 47 P.3d 1209, 1220-22 (Haw. 2002); *Coombes v. Florio*, 877 N.E.2d 567, 572 (Mass. 2008); *Joy v. Eastern Me. Med. Ctr.*, 529 A.2d 1364, 1366 (Me. 1987); see also *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 345-46 (Cal. 1976) (imposing duty on psychiatrist to foreseeable victims of psychiatry patients); Thomas J. Leonardo, Comment, *Extending Physician's Duty of Care To Third Parties for Breach of Duty Owed To Patient--Coombes v. Florio*, 877 N.E. 2d 567 (Mass. 2007), 42 SUFFOLK U. L. REV. 277 (2008) (discussing various views as to physician liability to third parties for medication risks).

68. A “curbside consult” refers to informal consultations where the physician is consulted in the hallway or by other means informally where a brief recitation of the patient’s history, clinical status and test results are summarized or mentioned. In such consultations, the physician consulted does not know the patient’s name, has never met the patient, and does not bill for the consult. See *Oliver v. Brock*, 342 So. 2d 1, 4 (Ala. 1976); *Bienz v. Central Suffolk Hosp.*, 557 N.Y.S.2d 139, 139-40 (1990). See generally Kimberly Baker, *A Doctor's Legal Duty-Erosion of the Curbside Consult*, FDCC QUARTERLY (Spring 2002) (collecting and discussing cases addressing curbside consult).

69. See RESTATEMENT (SECOND) OF TORTS § 901 (1979) (setting forth various purposes of tort law); WILLIAM BUCKLEY, TORTS AND PERSONAL INJURY LAW 5 (Thomson 3d ed. 2003) (discussing same).

70. See *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968).

71. Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 408-11 (1969); John K. Gohagan, Michelle H. Lewis & Daniel J. Merenstein, *The Locality Rule and The Physician's Dilemma*, 297 JAMA 2633 (2007).

her urban counterparts.<sup>72</sup> Eventually, limiting the standard of care to the standard of other doctors in similar communities was deemed “unsuited to present day conditions.”<sup>73</sup>

The most fertile fodder for expansion of physician liability under the “changed societal conditions” or “circumstances” rubric centers on medical science and technology.<sup>74</sup> Courts, in fact, in articulating the “ordinary” or “reasonable” physician standard of liability inject a scientific timeliness element into the definition. That is, the physician’s conduct is to be considered with “regard for the advanced state of medical science at the time.” The difficulty is that medicine is a rapidly evolving science subject to constant technological innovations or purported advances, not all of which have been proven to be efficacious. Not surprisingly, the incremental expansion of physician liability in tort law has progressed against a backdrop of meteoric advances in medical science and technology.<sup>75</sup> In fact, the history of medical malpractice closely parallels the development of technology.<sup>76</sup> By the 1830s, for example, doctors had developed sufficient medical techniques “that allowed them to save rather than amputate limbs and that allowed patients and juries to judge imperfect results against prevailing standards.”<sup>77</sup> Similarly, between 1820 and 1850, lawsuits against physicians were fueled by advances in treating bone fractures.<sup>78</sup> The advent of the X-ray led to lawsuits regarding radiology and orthopedics.<sup>79</sup> The suits claimed excess exposure to radiation and failure to interpret films properly.<sup>80</sup>

More recently, examples of the direct tie between malpractice suits and the advent and diffusion of technology include surgery, breast cancer, and

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72. See Waltz, *supra* note 71, at 410.

73. *Id.* at 415-17 (locality rule in place by at least 1880 and abolished in Massachusetts in 1968); see also Gilbert v. Sycamore Mun. Hosp., 622 N.E. 2d 788, 795-96 (Ill. 1993) (reasoning liability based on apparent authority supported by “two realities of modern hospital care,” i.e., hospital increase advertising and holding out to public to provide health care services and patients many times unaware of technical employment status of health care providers at hospital). *But see* Nestrowich v. Ricotta, 767 N.E.2d 125, 128 (N.Y. 2002) (retaining locality rule for physician liability).

74. As historian Kenneth DeVille has noted, “The development and implementation of new technologies and procedures have played a consistent and central role throughout the history of malpractice litigation.” Kenneth DeVille, *Medical Malpractice in Twentieth Century United States; The Interaction of Technology, Law & Culture*, 14 IN’T J. TECH. ASSESSMENT IN HEALTH CARE 197, 197 (1998).

75. See Kemper v. Gordon, 272 S.W.3d 146, 152-53 (Ky. 2008); see also *Health Disparities: Genetics Play Important Role in Cancer Detection, Prognosis Among Minorities*, Medical News Today (April 2008), <http://www.medicalnewstoday.com/articles/104251.php> (explaining racial disparities in breast cancer care).

76. Peter Jacobson, *The Project on Medical Liability in Pennsylvania: Medical Liability and the Culture of Technology*, 6-7, 16 (2004), [http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/News/Press\\_Releases/Medical\\_liability/med\\_mal\\_092204.pdf](http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/News/Press_Releases/Medical_liability/med_mal_092204.pdf).

77. Patel & Rushefsky, *supra* note 58, at 269; see also Allen Speigel & Florence Kavalier, *America’s First Medical Malpractice Crisis, 1835-1865*, 22 J. of Community Health 283 (1997).

78. Jacobson, *supra* note 76, at 12.

79. *Id.*

80. *Id.* at 6-7; see also Patel & Rushefsky, *supra* note 58, at 271.

neurologically impaired infants.<sup>81</sup> For surgeries the technology implication is laparoscopic techniques and the claim of surgical error;<sup>82</sup> for breast cancer it is diagnostic and therapeutic techniques and therapies; and for neurologically impaired infants the failure to use or properly interpret new monitoring devices.<sup>83</sup>

Similarly, “the advent of molecular biology with its enormous implications for the biological sciences (the sequencing of the human genome), sophisticated new imaging techniques, and advances in bioinformatics and information technology have contributed to an explosion of scientific information that has fundamentally changed the way we define, diagnose, treat, and prevent disease.”<sup>84</sup> These advances now allow access to “the innermost parts of the cell and provide a window to the most remote recesses of the body.”<sup>85</sup>

The difficulty remains that medical advances and new technology in the area of medical science does not necessarily equate to better outcomes. In many instances, the medical technology is widespread before there is any true assessment of its efficacy. For example, while electronic fetal monitoring is widely used, the efficacy of predicting and preventing prenatal injury has been substantially challenged and widely rejected. Indeed, in 2006, researchers declared that monitoring fetal oxygenation with continuous electronic fetal monitoring was a worthless enhancement.<sup>86</sup> As one commentator observed, “the prudent obstetrician often sees no alternative but to monitor electronically. At the same time, the use of EFM reinforces the public misconception that a physician has the tools to adequately predict the effects of perinatal asphyxia to

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81. See Jacobson, *supra* note 76, at 26-27; see also Executive Summary, *Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology*, ACOG (2009) [http://www.acog.org/from\\_home/Misc/neonatalEncephalopathy.cfm](http://www.acog.org/from_home/Misc/neonatalEncephalopathy.cfm) (noting 70% of cerebral palsy in newborns results from factors undetectable during labor and “use of nonreassuring fetal heart rate patterns to predict subsequent cerebral palsy had a 99% false-positive rate”).

82. See, e.g., *Mercker v. Abend*, 561 S.E.2d 351 (Ga. Ct. App. 2003); *Lucas v. Collins*, 743 N.E.2d 847 (Mass. App. Ct. 2001); *Oakden v. Roland*, 988 P.2d 1057 (Wyo. 1999).

83. See *Tavares v. N.Y. City Health & Hosp. Corp.*, 2003 N.Y. Misc. LEXIS 1217 (N.Y. Sup. Ct. 2003); *Cruz v. Northeastern Hosp.*, 810 A. 2d 602, 606 (Pa. Super 2002); see also Jacobson, *supra* note 76, at 26-27; *South Carolina Cerebral Palsy Lawsuit Results in \$4.4 Million Verdict Over Missed Fetal Heart Monitor*, AboutLawsuits.com, Feb. 16, 2009, <http://www.aboutlawsuits.com/south-carolina-cerebral-palsy-lawsuit-over-misread-fetal-heart-monitoring-28031>.

84. ANTHONY S. FAUCI ET AL., *HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 1* (2009); see also ROY PORTER, *BLOOD AND GUTS: A SHORT HISTORY OF MEDICINE 1* (2004) (“[T]he war between disease and doctors out in the battleground of the flesh has a beginning and a middle but no end.”).

85. FAUCI ET AL., *supra* note 84, at 1.

86. Amy Romano, *Improving Electronic Fetal Monitoring: Rearranging the Deck Chairs on the Titanic*, Science & Sensibility, Jun. 5, 2009, <http://www.scienceandsensibility.org/?p=212>. (noting in 2006 researchers declared monitoring fetal oxygenation with continuous EFM was a worthless enhancement); see also Stephen Thacker, *The Impact of Technology Assessment and Medical Malpractice on the Diffusion of Medical Technologies*, in *MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE, VOLUME II: AN INTERDISCIPLINARY REVIEW 12* (Roger J. Bulger & Victoria P. Rostow eds., 1989)

the degree that he or she may be held legally accountable.”<sup>87</sup>

Similarly, as to cancer screening technology, while the American Cancer Society recommends screening for prostate cancer with the prostate specific antigen (PSA) test every year beginning at age fifty, there are substantial differences of professional opinion regarding what to recommend to patients because there are no studies showing the test reduces mortality. As for breast cancer and mammography, there is similar substantial debate whether it is of any benefit for women age fifty or under. As one author recently noted, “despite the broad appeal and acceptance of mammography and other cancer screening tests, there is lingering concern about the scientific justification for their use.”<sup>88</sup> Moreover, as will be seen with loss of chance, the advent of screening technologies has led to the use and reference to “survival statistics,” which are widely misused and misunderstood.

In general terms, medical advances and diagnostic technology in common use may not improve medical outcomes but, instead, “paradoxically contribute[] to a higher legal standard of care.”<sup>89</sup> This results since the duty of care turns on the customs and practices of the qualified practitioner which is directly impacted by what the trial experts testify to as to the use, availability, and efficacy of particular technology.<sup>90</sup> The standard of care is likewise impacted by societal expectations which may well not be properly founded.

Concomitant to the “changing needs” and tort aim components of the question whether to expand physician liability is the need to address social consequences. It is notable that the issue of expanding common-law liability, either as a matter of first impression or in the context of reevaluating an existing common-law rule, is usually framed in terms of providing redress and furthering deterrence. Nonetheless, a cost benefit analysis as to the proposed rule including examination of the social consequences especially the impact on the physician-patient relationship and the practice of medicine, increased costs and expanded litigation, lack of coherency or predictability, and lack of consensus is manifest.<sup>91</sup>

For example, courts in recent times have grappled with whether physician liability under the common law should be expanded to include harm caused to a third party stemming from the physician’s failure to warn a patient of the effects of treatment.<sup>92</sup> Courts have disagreed over whether to impose such a

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87. Thacker, *supra* note 86, at 20.

88. ROBERT KAPLAN, *DISEASE, DIAGNOSIS, & DOLLARS* 47 (2009).

89. Jacobson, *supra* note 76, at 57.

90. *Id.*

91. *See, e.g.,* Coombes v. Florio, 877 N.E. 2d 567, 583 (Mass. 2007) (Marshall, C.J., dissenting) (“[T]he contrasting opinions issued today suggest just how widely and thoroughly reasonable minds may differ on this matter of broad social import.”); Schofield v. Merrill, 435 N.E.2d 339, 342 (Mass. 1982) (noting “lack of such consensus makes abolition of the common law rule unworkable”). “”

92. *See, e.g.,* Cheeks v. Dorsey, 846 So. 2d 1169, 1173 (Fla. Dist. Ct. App. 2003); McKenzie v. Haw. Permanente Med. Group, 47 P.3d 1209 (Haw. 2002); Kirk v. Michael Reese Hosp. & Med. Ctr., 513 N.E.2d

duty on physicians to third parties, with some finding that “sound public policy” favors such a duty; that the “costs” of imposing such a duty are limited “as existing tort law already imposes on a doctor a duty to warn a patient of the adverse side effects of medications”;<sup>93</sup> and that the “benefits of such warnings” are significant.”<sup>94</sup> Conversely, others find that imposing such a duty as to third parties “significantly shrinks the essential and protected space within which a doctor and patient can freely move together;”<sup>95</sup> impedes and threatens confidentiality policy as to physician-patient communications; invites and increases litigation; and potentially adversely modifies physician behavior toward patients.<sup>96</sup> Among these judges, it has been noted that, given the divergent views, judicial expansion of liability was inappropriate.<sup>97</sup> This view sees such consequences, actual and potential, as well as the lack of consensus as to competing policies as either outweighing tort principles of deterrence and compensation or necessitating judicial restraint.<sup>98</sup>

As to modern medical practice, the social consequence or cost-benefit assessment encompasses, in many cases, defensive medicine. Defensive medicine is defined as those tests, procedures, referrals, hospitalizations, or prescriptions ordered by physicians out of fear of being sued. To be sure, the extent of defensive medicine has been debated.<sup>99</sup> However, there is abundant

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387 (Ill. 1987); *Calwell v. Hassan*, 925 P. 2d 422 (Kan. 1996); *Joy v. E. Maine Med. Ctr.*, 529 A.2d 1364, 1366 (Me. 1987); *Coombes v. Florio*, 877 N.E.2d 567 (Mass. 2007).

93. *Coombes v. Florio*, 877 N.E.2d 567, 573 (Mass. 2007) (“The duty described here does not impose a heavy burden because it requires nothing from a doctor that is not already required by his duty to his patient.”).

94. *Id.*

95. *Id.* at 581 (Marshall, C.J., dissenting).

96. *Id.* at 587-88, n. 5 (Cordy, J., dissenting) (stating “a decision to impose a [new] duty [upon physicians] is at heart a decision about values and social policy, including the value of limiting or expanding the possibility of litigation under given circumstances”); *see also id.* at 581 (Marshall, C.J., dissenting). According to Chief Justice Marshall of the Massachusetts Supreme Judicial Court, where physician liability is expanded to a new class of potential claimants: “one need not be clairvoyant to understand the inevitable result of today’s enlargement of liability; a significant increase in third party litigation against doctors and an attendant increase in expenses at a time when our health care system is already overwhelmed with collateral costs.” *Id.*

97. *Coombes v. Florio*, 877 N.E.2d at 587-88. (Cordy, J., dissenting).

98. *See generally*, *Pegram v. Herdich*, 530 U.S. 211, 221 (2000) (quoting *Pasty v. Bd. of Regents of Fla.*, 457 U.S. 496, 513 (1982)) (explaining policies pertaining to HMO’s involve policy judgments about socially acceptable medical risk and given the policy considerations and the lack of judicial competence compared to the legislature “suggest that legislative and not judicial solutions are preferable”).

99. *See HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK HARVARD MEDICAL PRACTICE STUDY*, ch. 10, at 2-3 (1990) (noting although physicians reported the threat of lawsuits, did not find a strong relationship threats and litigation and medical costs); Daniel Kessler & Mark McKellan, *Do Doctors Practice Defensive Medicine?*, Q. J. ECON., May 1996, at 353-390 (estimating that states with restrictions such as cap on damages, prohibitions of punitive damages, no automatic prejudgment interest and of-sets for collateral sources lowered spending for in-patient care); *see also* Jacob Goldstein & Dionne Searcey, *Tangible and Unseen Health Care Costs*, WALL ST. J., Sept. 3, 2009, at A13, available at <http://online.wsj.com/article/SB125193312967181349.html> (noting difficulty in determining actual costs caused by defensive medicine); Posting of Tim Foley to Health Care Blog, *Defensive Medicine: The Truth is Out There*, [http://healthcare.change.org/blog/view/defensive\\_medicine\\_the\\_truth\\_is\\_out\\_there](http://healthcare.change.org/blog/view/defensive_medicine_the_truth_is_out_there) (Jan. 23, 2009,

evidence suggesting it is real and significant. In a recent study by the Massachusetts Medical Society, 83 percent of physicians polled reported practicing defensive medicine and that an average of 18 to 28 percent of tests, procedures, referrals, and consultations and 13 percent of hospitalizations were ordered for defensive reasons.<sup>100</sup> The Massachusetts study estimated the cost of such practices conservatively at \$1.4 million while another 2000 study estimated the cost at \$70 billion.<sup>101</sup> Another related study found that an average of 44 to 48 percent of the physicians in Massachusetts reported that they alter or limit their practices because of the fear of being sued.<sup>102</sup> Similarly, an earlier nation-wide study by the American Medical Association revealed that “seventy-nine percent of physicians reported that the ‘fear of being sued’ caused them to order more tests because of concerns of potential medical liability lawsuits.”<sup>103</sup>

The result of defensive medicine is an increase in health care costs and ineffective and counterproductive medical care. Healthcare costs in the United States are crippling. Moreover, such practices only increase malpractice risk through either the establishment of a higher standard of care or a violation of the standard of care—a proverbial “damned if you do, damned if you don’t” scenario.<sup>104</sup> No profession should feel it needs to diverge from the applicable standard of care or alter reasonable judgment and practice for fear of being sued.

The difficulty with cost-benefit and social consequences considerations is

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16:06 PST); Kevin Pho, *Wasted Medical Dollars*, USATODAY.COM, Apr. 22, 2008, <http://blogs.usatoday.com/oped/2008/04/wasted-medical.html>.

100. *MMS Urges Special Study of Defensive Medicine*, MASSACHUSETTS MEDICAL SOCIETY, June 23, 2009,

<http://www.massmed.org/AM/Template.cfm?section=ltomeb&Template=/cm/contentDisplay.cfm&COTENDID=30633> (discussing two recent proposed legislative bills asking for establishment of task force to investigate issues related to defensive medicine).

101. *Id.*

102. *Id.*; see also Abigail Jeffries, *New Study Points to the Cause and Cure of Defensive Medicine*, 6 HEALTH CARE LEDGER 4, 4-10 (2009).

103. See James Comodeca & Margaret Maggio, *Killing The Golden Goose By Evaluating Medical Care Through The Retroscope: Tort Reform from The Defense Perspective*, 31 U. DAYTON L. REV. 207, 213 (2006) (citing Am. Med. Assn., *Medical Liability Reform—Now, A Compendium of Facts Supporting Medical Liability Reform and Debunking Arguments Against Reform*, <http://www.ama-assn.org/ana/pub/upload/mm/378/mlrnwoct192005.pdf> (updated Oct. 19, 2005)); see also Jones v. Mesrobian, No. 04-3146, 2006 WL 618890, at \*22 n.4 (C.D. Ill. 2006) (noting the practice of defensive medicine); *Ferdon v. Wis. Patients Comp. Fund*, 701 N.W. 2d 440 (Wis. 2005) (citing U.S. CONGRESS JOINT ECONOMIC COMMITTEE, *LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE* (2003), available at <http://www.house.gov/jec/tort/05-06-03.pdf>) (noting state legislature found medical providers engage in defensive medicine); Jacobson, *supra* note 76, at 24 (noting “practicing defensive medicine because of the fear of litigation may have a greater impact on the continued use of electronic fetal monitoring in clinical practice”). But see Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premise Behind Tort Reform*, 5 YALE J. HEALTH POL’Y, L. & ETHICS 357, 360-61 n.17 (2005); Daniel P. Kessler & Mark B. McClellan, *Do Doctors Practice Defensive Medicine?* 111 Q. J. ECON. 353 (1998).

104. Comodeca & Maggio, *supra* note 103, at 214.

that they are often regarded by some courts as the “least of any concern.”<sup>105</sup> Seldom, if ever, is there available or presented evidence or data regarding these future consequences, given the non-existence or limited availability of such information due, at least in part, to the effect of a rule not yet in place. It likewise is rare that such empirical data would be allowed to be presented in the context of a malpractice or negligence suit between discreet parties. Such empirical data and evidence is more readily presented and available to legislatures with their subpoena and investigative resources, ability to collect data, conduct research, and take and hear evidence from a variety of sources.<sup>106</sup>

As to positive law, state legislatures are no strangers to regulation of physicians. It is fundamental that states have a duty to protect the health, safety, and welfare of their citizens. Pursuant to this responsibility, and very early on, states passed licensure enactments and formed medical boards to oversee physician licensure and competency.<sup>107</sup> Not only have all state legislatures enacted wrongful death, survival, and comparative or contributory negligence statutes, but they have all likewise enacted a multitude of statutes specifically regulating a wide spectrum of issues pertaining to physician liability. Some states have, in fact, opted to statutorily codify the fundamental principles of common-law tort liability including such elements as burden of proof, standard of care, and proximate cause, all in an apparent (if not express) effort to legislatively insulate liability from further common law expansion.<sup>108</sup>

Legislative enactments have capped damages,<sup>109</sup> eliminated punitive damages,<sup>110</sup> implemented repose provisions,<sup>111</sup> required pre-trial screening,<sup>112</sup>

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105. *Hay v. Med. Ctr. Hosp. of Vt.*, 496 A.2d 939, 946 (Vt. 1985) (citing *Ueland v. Reynolds Metals Co.*, 691 P.2d 190, 195 (Wash. 1984)).

106. *See Pegram v. Herdrich*, 530 U.S. 211, 221 (2000) (noting legislature’s superiority to judiciary regarding policy judgment as to socially acceptable medical risks.).

107. *See THE PHYSICIAN’S PERSPECTIVE ON MEDICAL LAW* 296 (Howard H. Kaufman & Jeff L. Lewin, eds., 1997) (noting first modern medical practice act was passed in Texas in 1873 and by 1905 thirty-nine states were licensing physicians).

108. *See, e.g.*, N.H. Rev. Stat. Ann. § 507-E (2009); *see also* Alabama Medical Liability Act, Ala. Code §§ 6-5-480 to 541 (2009); *Crutcher v. Williams*, 12 So. 3d 631, 647 (Ala. 2009) (explaining the Alabama Medical Liability Act applies “in any action for injury or damages or wrongful death, whether in contract or in tort, against a health care provider for breach of the standard of care”).

109. *See, e.g.*, *Arbino v. Johnson & Johnson*, 880 N.E.2d 420, 445 (Ohio 2007) (upholding constitutionality of certain legislative damage limitations stating “issues such as the wisdom of damages limitations and whether the specific dollar amount available under them best serve the public interest are not for us to decide”). *But see Ferdon v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005) (holding \$350,000 cap on non-economic damages unconstitutional).

110. *See, e.g.*, 735 Ill. Comp. Stat. 5/2 – 1115.1 (2007). The Illinois statutory cap was held unconstitutional in *Best v. Taylor Machine Works*, 689 N.E.2d 1057, 1077-78 (Ill. 1997); *see also* Pa. Stat. Ann. tit. 40, §1303.505(d) (2009) (establishing punitive damage against a physician cannot exceed 200 percent of compensatory award absent intentional misconduct).

111. *See, e.g.*, Mass. Gen. Laws. ch. 231, § 60D (2009); Conn. Gen. Stat. Ann. § 51-584 (West 2009) (creating three-year statute of repose); Or. Rev. Stat. § 12.110(4) (2009) (establishing five-year statute of repose).

112. *See, e.g.*, Alaska Stat. § 09.55.536 (2009) (requiring review of filed cases by expert panel appointed by courts with finding admissible at trial).

altered the collateral source rule,<sup>113</sup> provided peer review protection,<sup>114</sup> required that future damages over a certain amount be paid in periodic installments, and altered prejudgment interest calculation.<sup>115</sup> Additional legislative activity includes enacting “apology” protection,<sup>116</sup> expert witness standards,<sup>117</sup> mandatory reporting of malpractice claims to licensing boards with public disclosure,<sup>118</sup> elimination or modification of joint and several liability,<sup>119</sup> and limits on attorney’s fees.<sup>120</sup> Legislatures have likewise authorized task forces or subcommittees to study medical malpractice insurance as well as, more recently, the shortage of physicians.<sup>121</sup>

While the dynamic is usually the legislature responding to a perceived or actual malpractice, tort, or insurance “crisis” under “tort reform,” the result remains a robust legislative presence in the area of physician liability and regulation. This presence reflects a desire to redirect and control some of the common law expansions and to otherwise inject a legislative presence as to physician tort liability.<sup>122</sup> At the very least, legislative presence provides an

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113. See, e.g., Mass. Gen. Laws ch. 231, § 60G (2009) (legislating collateral source rule as to medical expenses does not apply to medical malpractice action in that medical expenses paid by third party subject to deduction); Pa. Stat. Ann. tit. 40, § 1303.508 (2009) (mandating no plaintiff recovery for past medical expenses or past lost earnings that were covered by any public or private benefit received prior to trial); Tenn. Code Ann. § 29-26-119 (2009) (defining payments by government programs or employer sponsored insurance as collateral sources that will offset a jury award, but amounts paid by insurance paid directly by plaintiff do not count to reduce jury award).

114. See, e.g., Tenn. Code Ann. § 63-6-219 (2009); Or. Rev. Stat. § 41.675(1) (2009); Tex. Title 63, 1-1709 (2009).

115. See NATIONAL CONFERENCE OF STATE LEGISLATURES, NCSI COMMITTEE REPORT, MEDICAL MALPRACTICE TORT REFORM (noting that in 2005 forty-eight state legislatures had before them 400 bills concerning medical care liability).

116. Massachusetts was the first state to adapt apology legislation in 1986. See Mass. Gen. Laws ch. 233, § 23D (2009); see also Pennsylvania Senate Bill 208 (Session 2009-2010) (February 19, 2009).

117. See, e.g., Ariz. Rev. Stat. Ann. § 12-2604(A) (2009); *Seisinger v. Siebel*, 203 P.3d 483 (Ariz. 2009) (upholding statute providing for minimum qualification for expert testimony in medical malpractice action).

118. See generally Colo. Rev. Stat. § 10-1-120 (2009).

119. See, e.g., Iowa Code § 668.4 (2009) (establishing if medical malpractice claim plaintiff found without fault then each defendant jointly and severally liable); Neb. Rev. Stat. § 25-21, 185.10 (2009) (barring application of joint and several liability in recovery of noneconomic damages); Ohio Rev. Code Ann. § 2315.33 (2009) (barring applicability of joint and several liability in recovery of all damages from defendants found to be less than 50 percent liable).

120. See Medical Malpractice Directory-Attorneys’ Fees by State, [www.medical-malpractice-directory.com/info/malpractice-attorney-fees.htm](http://www.medical-malpractice-directory.com/info/malpractice-attorney-fees.htm) (last visited Jan. 4, 2010).

121. See, e.g., H.R.J. Res. 643, 2007 Sess. (Va. 2007); see also *The Online News Hour: States Face Shortage of Primary Care Doctors* (PBS television broadcast Jan. 6, 2009), transcript available at [http://www.pbs.org/newshour/bb/health/jan-june09/doctors\\_01-06.html](http://www.pbs.org/newshour/bb/health/jan-june09/doctors_01-06.html). (noting universal healthcare, educational loans, low wages and fights with insurance companies causing shortage of primary care doctors); Robert Pear, *Shortage of Doctors an Obstacle to Obama Goals*, N.Y. TIMES, Apr. 26, 2009, at A1, available at <http://www.nytimes.com/2009/04/27/health/policy/27care.html>; Association of American Medical Colleges, Workforce, *Current Evidence Suggests That the United States is Headed Toward an Aggregate Shortage of Physicians*, <http://www.aamc.org/workforce/> (last visited Jan. 4, 2010).

122. See Farber & Frickey, *supra* note 7, at 888 (noting view of “legislature as an appropriate potential player in any common law policy making dispute and not simply another government agency from which disappointed litigants can seek relief”).

important judicial source and anchor to common-law jurisprudence in the realm of healthcare liability.<sup>123</sup> This judicial source is not limited to express statutory enactments directly on point but can include legislative policy evident in related enactments, as well as the fundamental role of the legislature to make policy decisions—especially those with far-reaching social consequences.<sup>124</sup> The longstanding legislative presence in the regulation of physicians, the institutional limitations of the courts, and the social ramifications of enlarging significantly physician liability all form a proper boundary to common-law tort liability expansion upon physicians.

#### IV. JUDICIAL POLICY MAKING: BALANCING FLEXIBILITY AND RESTRAINT

As set forth above, some legal scholars view the true “genius” of the common law as the unrestricted ability to change and comply with modern conditions,<sup>125</sup> “or the felt necessities of the time,” while to others it is the duty to honor and apply the rule of law and defer to the legislature in matters of policy.<sup>126</sup> The intersection of these two forces suggest that common-law tort adjudication as to physician liability necessitates more than rote application of the tort aims of deterrence, compensation, and vindication of rights; but rather requires consideration, in the first instance, of the court’s institutional limits. Further, a court must consider whether existing precedent is intolerable and there exists a true consensus as to the need for the requested expansion.

##### A. Recognition of Institutional Limitations

Where the judiciary is determining, in the context of a singular dispute between discreet litigants, whether to expand tort liability based on the “changing needs” or “realities” of “modern society,” such an inquiry requires serious pause due to the institutional limits of the court.<sup>127</sup> This is particularly

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123. *Fahy v. Fahy*, 630 A.2d 1328, 1332 (1993) (stating “we have previously used statutes as a useful source of policy for common law adjudication”).

124. *See, e.g., Krise v. Gillund*, 184 N.W.2d 405, 409 (N.D. 1971) (“[W]here the change is of such far reaching effect as the adoption of a comparative negligence rule which would take the place of contributory negligence, we believe it would be desirable that such a change be made by Legislative Assembly and not by the courts.”); *Baab v. Shockling*, 399 N.E.2d 87, 88 (Ohio 1980) (refusing to judicially adopt form of comparative negligence as it should be for legislature given far reaching social consequences); *see also Alvis v. Robar*, 421 N.E.2d 886 (Ill. 1988) (Underwood, J., dissenting) (maintaining choice to adopt comparative negligence best left to General Assembly)..

125. *See Barnes v. Indep. Auto. Dealers Ass’n of Cal. Health and Welfare Benefit Plan*, 64 F.3d 1389, 1394 (9th Cir. 1995) (quoting *PM Group Life Ins. Co. v. Western Growers Assurance Trust*, 953 F.2d 543, 546 (9th Cir.1992)) (reasoning “inherently incremental in nature; the very genius of the common law is that it proceeds empirically and gradually, testing the ground at every step”); *Brooks v. Robinson*, 284 N.E.2d 794, 797 (Ind. 1972) (“[T]he strength and genius of the common law lies in its ability to adapt to the changing needs of society it governs.”); “”

126. *See Scalia, supra* note 49, at 1177 (1989).

127. *Young, supra* note 26, at 301-02 (arguing common law’s warrant for judicial policymaking “should make any self-confessed judicial traditionalist extremely uncomfortable”).

true with medical liability given the ever-changing technological advances and their rapid diffusion into practice, the complexity of medicine, and the vitally important role and impact the provision of medical care and services play in modern society.

It seems fair to require courts to expressly examine whether they are, in the first instance and with specific reference to the case at hand, capable and sufficiently informed to adjudicate the liability expansion requested. What is the evidence and source of changing social needs, circumstances or developments before the court? If technology based, is the technology or science fully and reliably before the court, and sufficiently irrefutable for the court to judicially declare a new rule of liability that will govern not just the dispute before it, but all similar disputes in the future? At a minimum, it would seem that the “changing needs,” “realities” of “modern society,” “community attitudes,” “the felt necessities of the time,” or “modern medical science” or practice must be squarely identified and sufficiently and reliably before the court. This necessitates, in turn, a court fairly considering its own limitations to assess the abilities and limits of medical science and technology at issue, as well as assessing the quality and breadth of the scientific, technological, or changing societal needs evidence before it. Any material shortcomings in the quality and scope of the information militate strongly for judicial restraint as to abrogation of long-standing law. At its core, it requires recognition by the court that it has profound institutional shortcomings in adjudicating matters of broad policy import.<sup>128</sup>

### *B. True Consensus, Intolerability, and Degree of Social Import*

It is certainly understandable to adopt a new rule where the old rule is no longer compatible with modern society or in keeping with the advances of science or medicine. “Precedents drawn from the days of travel by stage coach do not fit the conditions of travel today.”<sup>129</sup> In such cases, as with the abrogation of the locality rule, the prior precedent is largely obsolete and not subject to serious debate.<sup>130</sup> However, if there has been no “‘overwhelming’ change in current society,”<sup>131</sup> or there remains any reasonable vitality to the

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128. See Young, *supra* note 26, at 306. Young argues, “It is only when a jurist is willing to be a conservator that is, willing to be humble enough to recognize how ill-equipped he is to engage in the vast, complicated considerations of the policy implicated in any change of the common law--that he can avoid the most egregious, however well-intentioned excesses and errors of judicial lawmaking.” *Id.*

129. *MacPherson v. Buick Motor Co.*, 111 N.E. 1050, 1053 (1916).

130. See *Parrish v. Russell*, 569 So. 2d 328, 331 (Ala. 1990) (citing *Zills v. Brown*, 382 So.2d 528, 532 (Ala. 1980)) (recognizing “distinctions in the degree of care and skill to be exercised by physicians . . . based upon geography can no longer be justified in light of the presently existing state of transportation, communication, and medical education and training”); *Capitol Hill Hosp. v. Jones*, 532 A.2d 89 (D.C. 1987) (rejecting application of locality rule).

131. *In re Parentage of A.B. v. S.B.*, 837 N.E.2d 965, 971 (Ind. 2005); see also *Leegin Leather Prods., Inc., v. PSKS*, 551 U.S. 877 (2000) (stating “the fact that a rule of law has become ‘embedded’ in our ‘national

prior precedent, common-law courts should be more restrained as to abrogation or departure based on their perception of changing societal needs, circumstances, or developments.<sup>132</sup> According to the Supreme Court, there should be no judicial alteration of established common law unless “the rule has proven to be intolerable simply in defying practical workability” and “related principles of law have so far developed as to have left the old rule no more than a remnant of abandoned doctrine.”<sup>133</sup>

Similarly, if there is no true consensus as to the intolerability of the existing precedent, the need for the new rule of expansion, or the specific medical or scientific issue, judicial abrogation is unjustified.<sup>134</sup> This is necessary in that the common law is not supposed to serve as a vehicle in which courts can advance or impose social policies or values that are not firmly and unequivocally accepted and entrenched.<sup>135</sup> While it functions to keep pace with apparent and accepted societal changes, such changes must be clear and

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culture’ argues strongly against overruling it”).

132. See Promulgation of Rules Regarding Protection of Confidential News Sources, 479 N.E.2d 154 *passim* (Mass. 1985) (declining adopt confidential news sources rule due to lack of consensus among lawyers, media and legislature); see also Schwartz, *supra* note 26, at 367 (contending courts should be wary of departing from precedent where there is a reasonable basis for existing precedent). *But see* Madden, *supra* note 13, at 566 (“[T]he common law judge is not encumbered by any political need that a critical mass of public concern have been before justice can be entered in an individual case. The common law judge must consider and resolve a societal conflict when presented early in its maturation.”)

133. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 854-55 (1992); see also Montejou v. Louisiana, 129 S. Ct. 2079, 2094 (2009) (Stevens, J., dissenting) (citing Payne v. Tennessee, 508 U.S. 808, 827-28 (1991)) (noting while stare decisis not “an inexorable command”, it is “preferred course because it promotes the evenhanded predictable, and consistent development of legal principles, fosters reliance on judicial decisions and fosters the active and perceived integrity of the judicial process”); Midlock v. Apple Vacations West, Inc., 406 F.3d 453, 457 (7th Cir. 2005) (“[T]he essence of stare decisis is that the mere existence of certain decisions becomes a reason for adhering to their holdings in subsequent cases.”); B.T. v. Santa Fe Pub. Schls. 506 F. Supp.2d 718, 724 (D. N.M. 2007) (citing *Casey* standard).

134. See Coombes v. Florio, 877 N.E. 2d 567, 583 (Mass. 2007) (Marshall, C.J., dissenting) (advocating rejection of expanding physicians’ tort liability given how reasonable minds may differ on the issue); Schofield v. Merrill, 435 N.E.2d 339, 342 (Mass. 1982) (“lack of such consensus makes abolition of the common law rule unworkable”); Promulgation of Rules Regarding Protection of Confidential News Sources, 395 Mass. 464 *passim* (1985) (noting lack of consensus precluding court rule making); Badillo v. Am. Brands, 16 P.3d 435, 441 (Nev. 2001) (lack of consensus as to medical monitoring militates toward rejecting judicial expansion of the common law); Crum v. Lambe, 1987 WL 26336, at \*1 (Ohio Ct. App. 1987) (deciding issue to expand common-law liability subject to legitimate debate left to legislature); see also Reavley, *supra* note 27, at 90 (“the law is allowed to change through the rational consideration of social utility, but rights and standards are determined by consensus on law . . .”);

135. See Presser, *supra* note 39, at 296-97 (discussing proper role for judges). Presser argues,

You recognize that your job is to preserve the past, with its core system of values. You defer to the other institutions of republican government when it comes to policy making, and you conceive of your job primarily as the protection of property and person as that protection has been traditionally understood. You do not redistribute wealth. That is not your job.

*Id.*; see also *In re* Parentage of A.B. v. S.B., 837 N.E.2d 965, 970 (Ind. 2005) (holding modification of common law by courts appropriate “to reflect clearly established, widespread social changes, not to advance or favor one movement over another”).

unequivocal. After all “common law” is premised on “universal traditions and long standing practice.”<sup>136</sup>

The consequences and tension between flexibility, restraint, and judicial versus legislative policymaking are certainly debated. On one side, there is the perceived greater protection of patients with increased physician accountability. On the other side, there is uncertainty as to standards of care, increased defensive medicine, and concerns regarding potential or resulting increased transactional, insurance premium, and overall healthcare costs.

In the end, the limits to common-law authority include the ability and obligation of the judiciary to exercise self-restraint, at times, as to a request for common-law expansion of liability even when faced with what seems, in the context of the singular dispute before the court, a grievous or potential injustice.<sup>137</sup> It is the very exercise of self-restraint in the face of substantial tort policies of deterrence and compensation for perceived wrongs favoring expansion of liability that gives the separation of powers, and their underlying prudential concerns, vitality in common-law adjudication. Not only is such self-restraint consistent with the notion that “[i]t does not lie within the power of any judicial system to remedy all human wrongs,”<sup>138</sup> but it is also fundamental to democratic government.<sup>139</sup>

The power of the court is great indeed, but it is not a power to be confused with evangelic illusions of legislative and political primacy. If this is true, then self-restraint by the courts in lawmaking must be their greatest contribution to the democratic society.<sup>140</sup>

Whatever view, the contours, sources, and limits of the policymaking role are subject to much debate and are the backdrop upon which loss of chance has emerged.<sup>141</sup>

## V. LOSS OF CHANCE

The loss of chance doctrine permits a claimant to recover where a physician’s breach of the standard of care has caused the loss of a statistical chance of survival or of a better outcome.<sup>142</sup> Absent special treatment or

136. Presser, *supra* note 39, at 294 (quoting Blackstone Commentaries).

137. See generally *Bissen v. Fujii*, 466 P.2d 429 (Haw. 1970). The *Bissen* court held “[w]e should recognize that, although courts, at times, in arriving at decisions have taken into consideration social needs and policy it is the paramount role of the legislature as a coordinate branch of our government to meet the needs and demands of changing times and legislate accordingly.” *Id.* at 431.

138. W. PAIGE KEETON ET AL., *supra* note 14, at 23.

139. Farber & Frickey, *supra* note 7, at 893 (explaining “courts also need to be sensitive to the danger that common-law doctrines can undermine legislative policy judgments”).

140. Charles D. Breitel, *The Lawmakers*, 65 COLUM. L. REV. 749, 777 (1965).

141. See Farber & Frickey, *supra* note 7, at 876.

142. See generally David A. Fischer, *Tort Recovery for Loss of Chance in Medical Malpractice*, 36 WAKE

recognition of this purported loss, a claimant would not be able to meet his or her burden of proof as to causation as it was “more likely than not” (greater than 50 percent) that the underlying condition or disease caused the harm, as the law does not impose liability for loss of possibilities.

Proponents of the doctrine assert that it alleviates the unfairness of the more probable than not standard which they derisively refer to as the “all or nothing rule.”<sup>143</sup> Where the claimant’s chance of survival is less than 50 percent, any reduction in that chance by any subsequent negligence does not, under traditional notions of causation, proximately cause any injury. By definition, it is more probable than not that the pre-existing condition rather than the delayed diagnosis caused the injury.

The origins of the loss of chance doctrine are difficult to pinpoint, but appear to include certain maritime<sup>144</sup> and early contract cases.<sup>145</sup> In the 1911 English contract case, *Chaplin v. Hicks*,<sup>146</sup> for instance, the plaintiff was one of fifty competitors for an acting contract but was not considered for one of the twelve finalist positions due to the defendant’s alleged failure to provide notification. Although the claimant did not have a better than 50 percent chance of winning the contest, the court found that the plaintiff had lost “the opportunity of competition” which had monetary value.<sup>147</sup> Such contract-based claims have been generally rejected by American courts due to concerns of impermissible speculation.<sup>148</sup>

Notably, more recent American state court decisions have frequently cited to a 1981 article from the Yale Law Journal by Professor Joseph King, for support in adopting loss of chance as a cognizable claim.<sup>149</sup> There, King asserted that the traditional more probable than not standard barring recovery when the chance of recovery is under 50 percent is arbitrary and contrary to the

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FOREST L. REV. 605 (2001); Joseph H. King Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981) [hereinafter *King I*]; Tory A. Weigand, *Loss of Chance in Medical Malpractice: The Need for Caution*, 87 MASS. L. REV. 3 (2002); Stephen F. Brennald, Comment, *Proving Causation in “Loss of Chance” Cases: A Proportional Approach*, 34 CATH. U. L. REV. 747 (1985); Robert A. Reising Jr., Note, *The Loss of Chance Theory in Medical Malpractice Cases: An Overview*, 13 AM. J. TRIAL ADVOC. 1163 (1990); George J. Zilich, Note, *Cutting Through the Confusion of the Loss-of-Chance Doctrine Under Ohio Law: A New Cause of Action or a New Standard of Causation?*, 50 CLEV. ST. L. REV. 673 (2002-2003).

143. See King I, *supra* note 142, at 1376-77; see also *Matsuyama*, 890 N.E.2d at 829-30; *Herskovits*, 664 P.2d at 478.

144. See generally *Gardner v. Nat’l Bulk Carriers, Inc.*, 310 F.2d 284 (4th Cir. 1962); *Zinnel v. U.S. Shipping Bd. Emergency Fleet Corp.*, 10 F.2d 47 (2nd Cir. 1925).

145. See generally *Chaplin v. Hicks*, [1911] 2 A.C. 786 (K.B.); *Kan. City, M. & O. Ry. Co. v. Bell*, 197 S.W. 322 (Tex. 1917).

146. [1911] 2 A.C. 786 (K.B.).

147. *Id.* at 793.

148. See *Phillips v. Pantages Theatre Co.*, 300 P. 1048, 1049 (Wash. 1931); *Collatz v. Fox Wis. Amusement Corp.*, 300 N.W. 162, 164 (Wis. 1941).

149. King I, *supra* note 142, at 19; see also Joseph H. King, *Reduction of Likelihood Reformulation and Other Retrofitting of the Loss of Chance Doctrine*, 28 U. MEM. L. REV. 491 (1998) [hereinafter *King II*].

objectives of tort law because it denies recovery for statistical demonstrable losses resulting from negligent acts.<sup>150</sup> He contended that the traditional rule is unfair as “the imponderables of chance” must be grappled with only because of the defendants’ conduct.<sup>151</sup> Professor King’s articulation of the duty to protect against chances of a better outcome does not limit the duty to medical malpractice and provides that risk of future consequences caused by negligent conduct is not recoverable until the harm actually materializes.<sup>152</sup>

### A. *Judicial Treatment*

Recognition of the loss of chance doctrine in medical negligence actions first firmly emerged in the United States in the early 1970s and 1980s,<sup>153</sup> although there are some earlier traces.<sup>154</sup> As it presently stands, approximately eighteen states have recognized the doctrine in some form, while approximately thirteen states have rejected it.<sup>155</sup> Federal court decisions are likewise mixed,<sup>156</sup> and

150. King I, *supra* note 142, at 1356.

151. *Id.* at 1378.

152. See King II, *supra* note 149, at 495-96.

153. See, e.g., *Deburkarte v. Louvar*, 393 N.W.2d 131 (Iowa 1986); *Aeshiem v. Humberger*, 695 P.2d 824, 828 (Mont. 1985); *Herskovits v. Health Coop. of Puget Sound*, 664 P. 2d 474, 476-77 (Wash. 1983); *Hamil v. Bashline*, 392 A.2d 1280, 1288 (Pa. 1978); see also *United States v. Hicks*, 368 F.2d 626 (4th Cir. 1966).

154. See *Kuhn v. Banker*, 13 N.E.2d 242 (Ohio 1938); see also *Hicks*, 368 F.2d at 632. The *Hicks* Court held

[w]hen a defendant’s negligent action or inaction has effectively terminated a person’s chance of survival, it does not lie in the defendant’s mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable.

368 F.2d at 632.

155. See *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 829 n.23 (Mass. 2008) (noting those courts adopting or rejecting loss of chance doctrine). Since 2003, the highest courts of five states have addressed the issue. *Id.* Four have rejected the doctrine (Vermont, Kentucky, Nebraska and Oregon), while two have adopted it (Massachusetts and Wyoming). *Id.* In May 2008, the Nebraska Supreme Court reaffirmed its 1994 ruling that it did not recognize loss of chance. See *Rankin v. Stenton*, 749 N.W.2d 460 (Neb. 2008) (citing and affirming *Steinke v. Share Health Plan*, 518 N.W.2d 904 (Neb. 1994)). Delaware, Oregon, and Maryland courts have held that loss of chance is not cognizable under their respective wrongful death statutes, while otherwise leaving the issue open as to non-death claims. See *United States v. Cumberbatch*, 647 A.2d 1098 (Del. 1994); *Weimer v. Hetrich*, 525 A.2d 643 (Md. 1987); *Joshi v. Providence Health Sys. of Or. Corp.*, 149 P.3d 1164 (Ore. 2006). In 2000, South Dakota judicially adopted loss of chance in medical malpractice actions only to have it abolished by statute. See *Jorgensen v. Vener*, 616 N.W.2d 366 (S.D. 2000), *aff’d on reh’g*, 640 N.W.2d 485 (S.D. 2002), *superseded by statute*, S.D. Codified Laws § 20-9-1.1, 1.2 (2009). The Michigan Supreme Court also judicially adopted the doctrine over a strenuous dissent by the court’s Chief Justice, but the legislature subsequently responded to abolish it. See *Falcon v. Memorial Hosp.*, 462 N.W.2d 44 (Mich. 1990), *superseded by statute*, Mich. Comp. Laws Ann § 600.2912a(2) (2009).

As it stands, those states that have judicially adopted the loss-of-chance doctrine include Arizona, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Washington, Wisconsin, and Wyoming. Those states judicially rejecting loss of chance include Alaska, California, Idaho, Kentucky, Maryland, Minnesota, Mississippi, Nebraska, Tennessee, Texas, South Carolina, Vermont and Texas. West Virginia has adopted a statute recognizing loss of chance so long as the loss of chance is greater than 25 percent. W. Va. Code § 55-7B-3 (2003). Arkansas has

California has so far rejected the doctrine through decisions of its intermediary appellate courts.<sup>157</sup> At least three states have abolished or limited the doctrine by statute.<sup>158</sup> The highest courts of Canada and England have rejected the doctrine in medical malpractice actions with Australian appellate courts currently split on the issue.<sup>159</sup> Further, the American Law Institute (ALI), one of the nation's most venerable legal scholarly organizations and publisher of the highly regarded "Restatements" of law, has taken no position on the issue, last stating it would leave the issue to further development by the courts while noting that liability for lost chances would mark a "drastic" expansion of traditional tort liability principles.<sup>160</sup>

Even among those courts which have adopted loss of chance, there is substantial disagreement. Some courts have adopted a "relaxed causation" approach centering on whether there was an "increased risk of harm."<sup>161</sup> Once a claimant presents evidence that the physician's negligence "increased the risk of harm," the jury then proceeds to consider and value the claim (i.e., the ultimate harm or injury).<sup>162</sup> Under this view, the causation element is "relaxed" as any decrease in the chance of survival or better outcome can constitute an increased risk of harm even if plaintiff's chances of survival or better outcome was less than 50 percent before the negligence.<sup>163</sup> Courts adopting this approach vary as to what constitutes a sufficient reduction, with some requiring that it either be "appreciable" or "substantial," while others hold that "any" reduction is compensable.<sup>164</sup>

Other courts hold that loss of chance claims do not relax the causation element but should constitute a compensable injury.<sup>165</sup> There is no "relaxation"

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so far rejected loss of chance but stated it was "not closing the door to future adoption." *Holt v. Wagner*, 43 S.W.3d 128, 132 (Ark. 2001).

156. See *United States v. Hicks*, 368 F.2d 626 (4th Cir. 1966); see also *Hurley v. United States*, 923 F.2d 1091, 1093, 1099 (4th Cir. 1991) (clarifying and limiting *Hicks* decision); *DePass v. United States*, 721 F.2d 203, 208 (7th Cir. 1983); *United States v. Crosby*, 48 F. Supp. 2d 924 (D. Alaska 1999).

157. See *Marsolino v. Patel*, No. E041922, 2009 WL 1299041, \*67 (Cal. Ct. App. May 11, 2009) (citing *Dumas v. Cooney*, 1 Cal. Rptr. 2d 584 (Cal. Ct. App. 1991)); *William v. Wraxall*, 39 Cal. Rptr. 2d 658 (Cal. Ct. App. 1995); *Bromme v. Pavitt*, 7 Cal. Rptr. 2d 608 (Cal. Ct. App. 1992).

158. MICH. COMP. LAWS § 600.2912a(2) (2009); S.D. CODIFIED LAWS § 20-9-1.1, 1.2 (2009); W. VA. CODE §55-7B-3 (2003).

159. *Gregg v. Scott* [2005] 2 A.C. 176, 198 (H.L.) (U.K.); *Lawson v. Laferriere*, [1991] 1 S.C.R. 541 (Can.). Compare *Gett v. Tabet*, (2009) 254 A.L.R. 504 (Austl.) (declining to recognize loss of chance), with *Rufo v. Hosking* (2004) 61 N.S.W.L.R. 678 (Austl.) (recognizing loss of chance).

160. See RESTATEMENT (THIRD) OF TORTS § 26 (2005).

161. See, e.g., *Scafidi v. Seiler*, 574 A.2d 398, 406 (N.J. 1990); *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467, 475 (Okla. 1987).

162. See, e.g., *Scafidi v. Seiler*, 574 A.2d 398, 406 (N.J. 1990); *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467, 475 (Okla. 1987).

163. See *Brennald*, *supra* note 142, at 761 (outlining substantial factor test of causation).

164. See *Weigand*, *supra* note 142, at 8 n.75 (comparing differing interpretations of sufficient reduction).

165. See *Deburkarte v. Louvar*, 393 N.W.2d 131, 137 (Iowa 1986); *Lord v. Lovett*, 770 A.2d 1103, 1105-06 (N.H. 2001); *Jorgensen v. Vener*, 616 N.W.2d 366 (S.D. 2000), *aff'd on reh'g*, 640 N.W.2d 485 (S.D. 2002), *superseded by statute*, S.D. CODIFIED LAWS § 20-9-1.1, 1.2 (2009).

of the burden of proof as to causation with the loss of chance becoming the compensable interest rather than the ultimate injury or death.<sup>166</sup> The physician is not liable for the ultimate harm or outcome, but for the lost chance alone.<sup>167</sup>

Under this view, a claimant who faced a 90 percent chance of death (or other injury) would have a claim to recover for the purported 10 percent deprivation.

Courts likewise vary as to whether the loss of chance is cognizable where the chances at the time of the asserted negligence were less than 50 percent and whether a loss of chance claim is actionable where the ultimate harm or injury has not occurred.<sup>168</sup> Courts disagree on how to quantify or award damages for the loss of chance as well.<sup>169</sup> They either allow recovery for the value of the ultimate injury or the value of the loss of chance.<sup>170</sup> Where the loss of chance is the compensable interest, some courts have utilized different discounting methods while other have left it to the discretion of the jury.<sup>171</sup>

American courts have so far limited the doctrine to medical malpractice actions although some question the justification for limiting its application.<sup>172</sup> While commentators generally favor adopting loss of chance in legal malpractice actions,<sup>173</sup> courts have not been receptive.<sup>174</sup> There has been

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166. *Lord v. Lovett*, 770 A.2d at 1105-06 (discussing burden of proof with loss of chance).

167. *Id.* at 1106.

168. *See Mead v. Adrian*, 670 N.W. 2d 174, 187-89 (Iowa 2003) (Cady, J., concurring). *Compare Renzi v. Paredes*, 890 N.E.2d 806, 812 (Mass. 2008), with *Donning v. Quianno*, 810 P.2d 1163, 1168 (Kan. App. 1991) and *Wilson v. Brown*, No. 07CA13, 2008 WL 1062183, at \*1 (Ohio Ct. App. Apr. 9, 2004).

169. *Compare Thompson v. Sun City Cmty. Hosp., Inc.* 688 P.2d 605, 615-16 (Ariz. 1984), with *Cahoon v. Cummings*, 734 N.E.2d 535, 540 (Ind. 2000) and *McKellips v. St. Francis Hosp.*, 741 P.2d 467, 475-77 (Okla. 1987).

170. *See supra* note 169.

171. *See Smith v. State Dep't of Health & Hosp.*, 676 So.2d 543, 546-47 (La. 1996); *see also Todd S. Aagaard, Identifying and Valuing Injury in Lost Chance Cases*, 96 MICH. L. REV. 1335, 1348 (1998). Courts have likewise disagreed over whether a claim for loss of chance has to be established in an exact percentage to be submitted to a jury. *Compare Geesaman v. St. Rita's Med. Ctr.*, 917 N.E.2d 867, 874 (Ohio Ct. App. 2009), with *Hess v. A.I. Dupont Hosp.*, No. 08-0229, 2009 WL 595602, at \*13 (E.D. Pa. Mar. 5, 2009).

172. *See Bach v. Trident Steamship Co.*, 920 F.2d 322 (5th Cir. 1997) (explaining loss of chance doctrine confined to medical malpractice and refusing to extend); *Frey v. AT&T Mobility L.L.C.*, No. 07-CV-468-TCK-FHM, 2008 WL 4415328, at \*10 (N.D. Okla. Sept. 23, 2008) (indicating loss of chance not cognizable outside of medical malpractice); *Stroud v. Arthur Andersen & Co.*, 37 P.3d 783, 792 n.38 (Okla. 2001) (declining to address whether loss of chance applies outside medical malpractice); *Beacon Bowl, Inc. v. Wisconsin Elec. Power Co.*, 501 N.W.2d 788, 806 (Wis. 1993) (refusing to extend doctrine); *see also Fischer, supra* note 142, at 611-12. *But see Blinzler v. Marriot In't Inc.*, 81 F.3d 1148, 1153 (1st Cir. 1996) (recognizing loss of chance of action for loss of chance outside of medical malpractice); *Pelas v. Golden Rule Ins. Co.*, No. Civ.A. 97-3779, 1999 WL 438478 (E.D. La. June 28, 1999) (allowing extension of doctrine); *Recent Cases: Tort Law-Loss of Chance Doctrine-Massachusetts Supreme Judicial Court Accepts Loss of Chance in Medical Malpractice Actions*, 122 HARV. L. REV. 1247, 1251-54 (2009) (arguing *Matsuyama* court wrongfully limited loss of chance to medical malpractice).

173. *See John Leubsdorf, Legal Malpractice and Professional Liability*, 48 RUTGERS L. REV. 101, 149-150 (1985) (arguing for importing doctrine into legal malpractice actions as a less costly alternative); Polly A. Lord, Comment, *Loss of Chance in Legal Malpractice*, 61 WASH. L. REV. 1479 (1986) (supporting use of loss of chance in some legal malpractice claims). *But see Doll v. Brown*, 75 F.3d 1200, 1205-07 (7th Cir. 1996) (discussing loss of chance theory in employment discrimination); John C.P. Goldberg, *What Clients Are Owed: Cautionary Observations on Lawyers and Loss of a Chance*, 52 EMORY L.J. 1201, 1208-13 (2003) (warning

sporadic recognition of the doctrine in other areas, as well as commentary suggesting its adoption in class actions,<sup>175</sup> education malpractice,<sup>176</sup> employment discrimination,<sup>177</sup> contractual disputes including lost profits<sup>178</sup> and other matters.<sup>179</sup> Loss of chance rationale is purportedly appropriate in medical negligence actions, particularly as to failure to diagnose cancer cases, because the survivability statistics that are available establish the loss of chance with sufficient certitude to justify liability and compensation,<sup>180</sup> a medical care provider's duty of care includes the understanding that "the physician will take every reasonable measure to obtain optimal outcome for the patient;"<sup>181</sup> and failure to recognize loss of chance in medical malpractice forces the least culpable party to bear the loss.<sup>182</sup>

### B. Legislative Treatment

To date, seven states have enacted loss of chance legislation. In all instances, the legislation has arisen in response to the state's highest court adopting the doctrine as part of that state's common law. The usual result has pitched medical societies, associations, and insurers against the plaintiff trial bar.

Michigan's legislature was the first to enter the fray. In 1990, the Michigan Supreme Court adopted the loss of chance doctrine in *Falcon v. Memorial Hospital*<sup>183</sup> over the searing dissent of the court's then Chief Justice Riley.<sup>184</sup>

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courts to use caution before importing loss of chance doctrine into legal malpractice).

174. See *Daugat v. Pappas*, 764 P.2d 609 (Wash. 1985) (considered the leading case rejecting loss of chance in legal malpractice action); see also *Elibee v. Fox*, 2006 U.S. Dist. LEXIS 71727, at \*20 (D. Kan. 2006) (rejecting loss of chance as to legal malpractice); *Hardy v. Southwestern Bell Tel. Co.*, 910 P.2d 1024 (Okla. 1994) (rejecting loss of chance in ordinary negligence action).

175. See generally Paul Speaker, *The Application of the Loss of Chance Doctrine in Class Actions*, 21 REV. LITIG. 345 (2002).

176. See generally Jennifer C. Parker, *Beyond Medical Malpractice: Applying the Lost Chance Doctrine to Cure Causation and Damages Concerns with Educational Malpractice Claims*, 36 U. MEM. L. REV. 373 (2006).

177. See *JPMorgan Chase & Co. Sec. Litig.*, No. 06-C-4674, 2009 WL 537062, at \*15 (N.D. Ill. Mar. 3, 2009) (suggesting application of loss of chance theory to merger); see also Paul M. Secunda, *A Public Interest Model for Applying Lost Chance Theory to Probabilistic Injuries in Employment Discrimination Cases*, 3 WIS. L. REV. 747-794 (2005).

178. See Jeremy L. Pryor, Comment, *Lost Profit or Lost Chance: Reconsidering the Measure of Recovery for Lost Profits in Breach of Contract Actions*, 19 REGENT U.L. REV. 561 (2006).

179. See, e.g., *Frey v. AT&T Mobility L.L.C.*, No. 07-CV-468-TCK-FHM, 2008 WL 4415328, at \*10 (N.D. Okla. Sept. 23, 2008) (alleging defendant's failure to provide last call details resulted in lost chance of rescue).

180. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 834-35 (Mass. 2008) (noting expert evidence establishing loss of chance more likely available in medical malpractice).

181. *Id.* (citing KENNETH S. ABRAHAM, *THE FORMS AND FUNCTIONS OF TORT LAW* 117-118 (3d ed. 2007)).

182. *Matsuyama*, 890 N.E.2d at 834-35 (citing RESTATEMENT (THIRD) OF TORTS § 26 cmt. n (2005)).

183. 462 N.W.2d 44 (Mich. 1990), *superseded by statute*, MICH. COMP. LAWS § 600.2912(a)(2) (2009).

184. See *id.* at 58-68 (Riley, C.J., dissenting).

The majority of the Court held that the wrongful death claimant's loss of a 37.5 percent chance of survival due to medical negligence was cognizable, because it was "hardly the kind of opportunity that any of us would willingly allow our healthcare providers to ignore."<sup>185</sup> Under the court's view, the loss of opportunity claim accrued not when the patient died, but at the moment the claimant went from a 37.5 percent chance of survival to zero chance.<sup>186</sup> According to Chief Justice Riley's dissent, recognition of loss chance "eviscerates" the principles underlying tort law and that "[r]ather than deterring undesirable conduct, the rule imposed only penalizes the medical profession for inevitable unfavorable results."<sup>187</sup> The more probable than not standard was not viewed as inequitable or arbitrary but "the very foundation of the tort system." According to Chief Justice Riley:

Imperfect as it may be, our legal system attempts to ascertain facts to arrive at the truth. To protect the integrity of that goal, there must be some degree of certainty regarding causation before a jury may determine as fact that a medical defendant did cause the plaintiff's injury and should therefore compensate the plaintiff in damages. To dispense with this requirement is to abandon the truth seeking function of the law.<sup>188</sup>

Within three years of the high court's adoption of the doctrine, the state legislature enacted a provision seeking to limit it. The provision provides:

In an action allowing medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50 percent.<sup>189</sup>

This legislation was enacted in direct response to the state supreme court's decision in *Falcon*. The meaning and intent of the provision, however, were unclear. Subsequent appellate decisions grappled with whether the provision, in referencing 50 percent, required a showing that the initial opportunity to survive before the alleged malpractice was greater than 50 percent or whether it instead required a showing that the lost opportunity reduced by the alleged malpractice was greater than 50 percent.<sup>190</sup> The Michigan Supreme Court

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185. *Id.* at 52.

186. *Id.*

187. *Falcon*, 462 N.W.2d at 67-68 (Riley, C.J. dissenting).

188. *Id.* at 66 (Riley, C.J., dissenting)

189. MICH. COMP. LAWS § 600.2912(a)(2) (2009).

190. *See generally* *Fulton v. William Beaumont Hosp.*, 655 N.W.2d 569 (Mich. Ct. App. 2002).

recently addressed the issue, yet rendered a split decision in *Stone v. Williamson*.<sup>191</sup> Three of the seven justices found that the statutory prohibition was “substantially incomprehensible” and thus unenforceable.<sup>192</sup> To these justices there were “multiple, contradictory interpretations” and that “[c]hoosing between them can only be a guess.”<sup>193</sup> As such, the provision “cannot be judicially enforced because doing so requires the [c]ourt to impose its own prerogative as an act of the [l]egislature.”<sup>194</sup> These justices concluded that they understood the legislature to have effectively overruled the state supreme court’s decision adopting loss of chance and to have “reinstated the traditional elements of medical malpractice claims.”<sup>195</sup>

Four of the court’s justices believed the statutory language was not incomprehensible or unenforceable. These justices viewed the legislative amendment, not as a rejection of the loss of chance doctrine in its entirety, but as establishing a 50 percent threshold.<sup>196</sup> Three of these four justices believed that the loss of opportunity under the statute is to be determined by subtracting the pre-negligence chance from the post negligence chance,<sup>197</sup> while the fourth justice construed the provision more elaborately to require that the loss of chance be determined by subtracting the post negligence chance from the pre negligence chance, the post negligence chance then subtracted from one hundred, “the former number must be divided by the latter number, and then this quotient must be multiplied by one hundred to obtain [the] percentage.”<sup>198</sup> Not surprisingly, three of the seven justices concluded that “given [the] montage of issues and positions created by the language of [the] statute, it would be helpful for the [l]egislature to reexamine its goal and the policies it wishes to promote and strive to better articulate its intent in that regard.”<sup>199</sup>

West Virginia’s highest court adopted loss of chance in medical malpractice actions as part of its common law in 1983.<sup>200</sup> In 1986, the West Virginia Legislature enacted various provisions pertaining to medical professional liability, including setting forth statutory “elements of proof,”<sup>201</sup> namely requiring a deviation from the care expected “of a reasonable, prudent health care provider” and proximate cause for imposition of liability.<sup>202</sup>

Legislative activity as to loss of chance did not occur until 2003, however,

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191. 753 N.W.2d 106 (Mich. 2008); see also *Taylor v. Kent Radiology*, No. 286078, 2009 WL4936485 (Mich. Ct. App., Dec. 22, 2009) (explaining *Stone* opinion in detail).

192. *Stone*, 753 N.W.2d at 161.

193. *Id.* at 160.

194. *Id.* at 161.

195. *Stone*, 753 N.W.2d at 161.

196. *Id.* at 169 (Cavanagh, J., concurring).

197. *Id.*

198. *Id.* at 186 (Markman, J., concurring).

199. *Stone*, 753 N.W.2d at 164-65.

200. See generally *Thornton v. CAMC*, 305 S.E.2d 316 (W.V. 1983).

201. W. VA. CODE R. § 55-7B-3 (2009).

202. *Id.*

following the state's medical malpractice crisis. In 2002, insurance companies were pulling out of West Virginia and physicians were striking in protest of rapidly increasing medical malpractice premiums. The legislature responded with statutory tort reform, including a provision addressing the loss of chance doctrine. The two original House and Senate bills expressly noted the dramatic increase in insurance coverage and acknowledged that "it is the duty and responsibility of the [l]egislature to balance the rights of our individual citizens to adequate and reasonable compensation with the broad public interest in the provision of services by qualified healthcare providers and facilities . . . ." <sup>203</sup> It also noted the need for "reforms in the common law."

Both bills' loss of chance provisions provided that in any claim asserting a deprivation of a chance of recovery or causing an increased risk of harm to the patient, such a claim must be established "by clear and convincing evidence that the treatment rendered or which should have been rendered would have resulted in a substantial probability, greater than fifty percent chance, the patient would have had an improved recovery or would have survived."<sup>204</sup> By the time of actual enactment, the clear and convincing standard and 50 percent prerequisite were dropped and replaced by the "reasonable degree of medical probability standard" and a 25 percent threshold. The 25 percent threshold was likely derived through political compromise rather than some medical reasoning or methodology. The provision provides:

(b) If the plaintiff proceeds on the loss of chance theory, i.e., that the health care provider's failure to follow the accepted standard of care deprived the patient of a chance of recovery or increased the risk of harm to the patient which was as substantial factor in bringing about the ultimate injury to the patient, the plaintiff must prove, to a reasonable degree of medical probability, that following the accepted standard of care would have resulted in a greater than twenty-five percent chance that the patient would have had an improved recovery or would have survived.<sup>205</sup>

The provision has not been the subject of any appellate decision since its enactment.

Similar to Michigan, New Hampshire has experienced a vigorous interplay between the judicial and legislative branches regarding its loss of chance doctrine. In 1986, the New Hampshire Legislature enacted tort reform due to concern about the "very real and very difficult current problem—the availability and affordability of liability insurance for . . . New Hampshire . . . professional people."<sup>206</sup> The legislature felt that liability and insurable risk had

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203. H.B. 2124, 78th Leg. (W. Va. 2003).

204. W. VA. CODE R. § 55-7B-3(c) (2009).

205. *Id.*

206. *See* Lord v. Lovett, 770 A.2d 1103, 1109 (N.H. 2001) (Broderick, J., concurring) (citing N.H.S. Jour.

expanded and required “stabilization” and “predictability.”<sup>207</sup> The resulting statutory enactment included, *inter alia*, statutorily setting forth the standard and traditional burden of proof in medical negligence and informed consent cases as well as defining medical injury.

In 2001, the New Hampshire Supreme Court adopted the loss of chance doctrine, despite this legislative backdrop, in *Lord v. Lovett*.<sup>208</sup> *Lovett* involved a woman who had fractured her neck and was paralyzed as a result of a car accident.<sup>209</sup> She claimed that medical personnel failed to immobilize her correctly and failed to provide her with needed steroid therapy, lessening her chances of a better outcome.<sup>210</sup> It was conceded that the claimant’s expert could not quantify the degree of better chance lost.

On appeal, the New Hampshire Supreme Court adopted loss of chance or opportunity doctrine holding that it was a cognizable injury. Although it recognized the legislative efforts in 1986 regulating “medical injury actions,” the court found that loss of chance fit well within the legislative requirement and intent of “medical injury.”<sup>211</sup> According to the court, it was not straining the statutory terms or intent declaring: “We do not drag it from the shadows of the common law but draw it from the light of the legislative enactment.”<sup>212</sup>

In a concurring opinion, Judge Broderick observed that the adoption of loss of chance by the court was “ironic” in that it sprung from a statute enacted as part of comprehensive tort reform “which was intended to preempt the common law and bring predictability and stability.”<sup>213</sup> He further remarked that it was not clear whether the legislature intended to codify the then recognized common law causes of action for medical malpractice “and subject them to uniform and more rigorous standards,” or whether it intended to “cast a wide net to capture any possible claims of medical malpractice, whether or not then recognized in the common law.”<sup>214</sup>

The legislature soon responded to the high court’s infusion of loss of chance into the state’s common law. In June 2003, it added the following text to the statutory scheme:

The requirements of this section [medical injury] are not satisfied by evidence

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190 (1986)).

207. *Id.*

208. 770 A.2d. 1103, 1107 (N.H. 2001).

209. *Id.* at 1104.

210. *Id.*

211. N.H. REV. STAT. ANN. § 507-E:1 (2009) (defining medical injury as “any adverse, untoward or undesired consequence arising out of or sustained in the course of professional services rendered by a medical care provider, whether resulting from negligence, error, or omission in the performance of such services . . . from failure to diagnose . . . or otherwise arising out of or sustained in the course of such services).

212. *Lovett*, 770 A.2d at 1107.

213. *Id.* at 1109 (Broderick, J. concurring).

214. *Id.* at 1110.

of loss of opportunity for a substantially better outcome. However, this paragraph shall not bar claims based on evidence that negligent conduct by the defendant medical provider or providers proximately caused the ultimate harm, regardless of the chance of survival or recovery from an underlying condition.<sup>215</sup>

If the wording left any doubt of the legislative intent to abrogate loss of chance or its intent regarding the 1986 statutory scheme, those doubts were fully eradicated by the legislature's express statement of its purpose in the June 2003 amendment:

Availability and affordability of insurance against liability for medical injury is essential for the protection of patients as well as assuring availability of and access to essential medical and hospital care. This act reaffirms the intent of the general court [legislature] to contain the costs of the medical injury reparations system and to promote availability and affordability of insurance against liability for medical injury by codifying the law applicable to recovery of damages for medical injury in RSA 507-E. The decision [by the Supreme Court of New Hampshire] . . . departed from that intent by broadening the opportunity to recover damages in medical injury cases through recognition of the so-called "loss of opportunity" doctrine. This act is intended to overrule that decision as well as to restate the legislative policy that this judicial broadening of the opportunity to recover damages in medical injury cases is contrary to the intent of the general court in enacting RSA 507:E.<sup>216</sup>

South Dakota's Supreme Court adopted loss of chance as a compensable interest in 2000 in *Jorgesen v. Vener*,<sup>217</sup> only to have the state's legislature abrogate the ruling soon thereafter.<sup>218</sup> *Jorgesen* is noteworthy for the added wrinkle it brought to the table. The claim that made its way to the South Dakota Supreme Court was on behalf of a man who had broken his leg requiring placement of pins and external fixation.<sup>219</sup> He claimed that the physician failed to diagnose a chronic infection or refer him to an infectious disease specialist.<sup>220</sup> At a deposition, the plaintiff testified that given the chances and rigors of available treatments (painful grafts) he would have chosen amputation.<sup>221</sup>

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215. N.H. REV. STAT. ANN. § 507-E:2 (III) (2009).

216. *Id.*; S.B. 119, 158th Leg., 1st Sess. (N.H. 2009).

217. 616 N.W.2d 366 (S.D. 2000), *aff'd on reh'g*, 640 N.W.2d 485 (S.D. 2002), *superseded by statute*, S.D. CODIFIED LAWS § 20-9-1.1 (2009).

218. S.D. CODIFIED LAWS § 20-9-1.1 (2009).

219. *Jorgensen I*, 616 N.W.2d at 366-67.

220. *Id.* at 367.

221. *Jorgensen II*, 640 N.W.2d at 489 (Gilbert, C.J., dissenting). He testified that even if his chances of success would have been 75 percent instead of 60 percent, he would not have chosen the treatment: "Probably not . . . I don't have [two and half years] to be there and I don't want bone grafts, operations, and still probably

The Supreme Court of South Dakota held that “the loss of chance doctrine properly balances the competing concerns of a patient who receives negligent treatment, against those of a doctor who practices in the inherently inexact science of medicine.”<sup>222</sup> It recognized that the loss of chance placed “medical malpractice on a different plane of liability compared to other types of malpractice” but was justified due to the “availability of statistical probabilities in the field of medical science” not available elsewhere.<sup>223</sup> In a concurring opinion, Justice Amundson suggested that a loss of chance, while actionable if under 50 percent, still had to be “substantial” to be actionable.<sup>224</sup> As to the fact that the claimant testified he would not have opted for the treatment even if made available, the Court summarily and curiously stated it was not dispositive but for the jury.<sup>225</sup>

As with the Michigan decision initially adopting loss of chance, the South Dakota decision was also accompanied by a strongly worded dissent which found that the adoption “unfairly targets the medical profession by needlessly creating a new formula to expand damage awards and a new class of plaintiffs to sue for them.”<sup>226</sup> In considering the majority’s determination that the recovery was not otherwise barred by the fact the claimant would have opted for amputation anyway, given the limited chance and ardor of the graft treatment, the dissent remarked:

The plaintiff here can both disclaim a medical remedy and sue for not having been denied it. Thus a patient’s own decisions about courses of treatment become wholly irrelevant. The doctor must pay for not giving a patient a choice the patient would never have chosen. The expansion of liability here is breathtaking. Medical malpractice law now becomes a Pickwickian parlor game. There will be compensation for loss, even if only illusory, a product of statistics, conjured up and displayed in so many pixels. All a jury needs to do is count them, and, of course, add dollar signs.<sup>227</sup>

The state legislature swiftly enacted an express statutory abrogation of the judicial ruling and loss of chance in South Dakota. An initial bill was proposed adopting the substantial loss of chance formulation of Justice Amundson, which was then dropped. Notably, the revised bill did not refer to the loss of chance as a compensable injury as declared by the South Dakota Supreme Court, treating it instead as an alteration of causation. As enacted, the statute

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lose my leg. Plus it would have been a fused ankle with a rocker bottom shoe, so I still would have been crippled.” *Id.*

222. *Jorgensen I*, 616 N.W.2d at 371.

223. *Id.* at 371.

224. *Id.* at 374 (Amundson, J. concurring).

225. *Id.* at 374-75 (Konenkamp, J., dissenting).

226. *Jorgensen I*, 616 N.W.2d at 374 (Konenkamp, J., dissenting).

227. *Jorgensen II*, 640 N.W. 2d at 491 (Konenkamp, J. dissenting).

provides that “the Legislature . . . finds that the application of the so called loss of chance doctrine in such cases improperly alters or eliminates the requirement of proximate causation. Therefore the rule in *Jorgensen v. Veneer* . . . is hereby abrogated.”<sup>228</sup> It likewise expressed its intent of “returning the common law . . . to its status immediately prior to the court’s decision.”<sup>229</sup>

There has also been legislative activity as to loss of chance in Wyoming and Montana, although it has been markedly less successful in altering or affecting the judicial adoption of the doctrine by those states’ high courts. In Wyoming, the state supreme court adopted loss of chance and rejected the assertion that no such recognition could be made given the language of the state’s wrongful death statute.<sup>230</sup> “The argument presented conjures up a statutory hurricane from which we are asked to pluck a wind-borne feather. We are unable to spot a hurricane in that argument and are thus unwilling to grasp for the feather.”<sup>231</sup>

In reaction to the case, proposed legislation ensued in Wyoming in 2004, 2005, 2007 and 2008. The proposed bills in each of these years sought to utilize the same outright abrogation language as that proposed and adopted in South Dakota. In 2008, the bill’s language was amended providing that “[T]he loss of chance doctrine is hereby abrogated . . . for any person unable to establish a loss of chance of twenty-five (25 percent) or more,” and codifying that any such damage award would be proportional.<sup>232</sup> The bill subsequently died in committee.<sup>233</sup>

In 1985, Montana’s high court was one of the first state supreme courts to address and adopt the doctrine utilizing the increased harm approach.<sup>234</sup> Under this version, recovery of full damages for the ultimate outcome is permitted. In 2005, the legislature enacted a statute “limiting” damages to the difference between the pre and post negligence chance of recovery multiplied by the total damages when the chance of recovery before the negligence was not more likely than not (less than 50 percent). Full damages are recoverable when the chance of recovery was “more likely than not.”<sup>235</sup>

Most recently, the Massachusetts Medical Society (MMS) proposed a bill in Massachusetts following that state’s recent adoption of loss of chance as a compensable injury in medical malpractice actions, as well as an earlier ruling expanding physician liability to third parties injured by patient due to inadequate warnings as to medication. The MMS description of the proposed bill states that the bill intended to “clarify” that physicians are not responsible

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228. S.D. CODIFIED LAWS § 20-9-11.1 (2009).

229. S.D. CODIFIED LAWS § 20-0-1.2 (2009).

230. *McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094 (Wyo. 2003), *aff’d*, 88 P. 3d 491 (Wyo. 2004).

231. *McMackin*, 88 P. 3d at 493.

232. H.B. HBO118, 2008 Leg. (Wyo. 2008).

233. See <http://legisweb.state.wy.us/2008/Digest/HBO118.htm> (last visited June 21, 2009).

234. *Aashein v. Humberger*, 695 P.2d 824, 828 (Mont. 1985).

235. MONT. CODE ANN. § 27-1-739 (2009).

for the acts of their patients beyond the *Tarasoff* case.<sup>236</sup> In addition, it would “clarify that physicians are not liable for the loss of chance of a better outcome but only for their negligence which actually causes the death of a patient who has a better than 50 percent chance of survival.”<sup>237</sup> The wording of the actual proposed bill, however, does not expressly reference or use the phrase “loss of chance” nor does it reference the Massachusetts Supreme Judicial Court’s decision in *Matsuyama* and it is highly questionable that the proposed enactment, as currently worded, alters the ruling.<sup>238</sup>

The legislative activity as to loss of chance has all been in response to judicial adoption of the doctrine. There is no evidence that loss of chance legislation either for or against adoption has ever been proposed absent prior judicial recognition. The legislative effort has also been largely part of “tort reform.” Of the seven states discussed above, the legislative effort has failed once (Wyoming); resulted in a statutory requirement of a certain threshold (West Virginia); resulted in modification of full damages to proportionate damages (Montana); resulted in a judicial dispute as to whether loss of chance is abrogated or allows for recovery where greater than 50 percent (Michigan); and been outright abrogated (South Dakota; New Hampshire). In the seventh state, Massachusetts, the legislation has only recently been proposed and it is questionable that, even if enacted, it would affect the judicial adoption of loss of chance.

The dynamic of the legislative response to the judicial adoption of the loss of chance doctrine fuels a common law/public policy view of the court’s responsibility and role. It is a repeated mantra that, absent legislation on point, the common-law court is free and obligated to develop new common-law rules based on “social mores,” “public policy,” and/or “principles of tort law.” Under this view, if the legislature does not like the common-law rule adopted, it can then initiate “tort reform” to change it.<sup>239</sup> Courts that adhere to this common law/public policy view fail to recognize the legislature as a source of policy absent a directly controlling enactment, and fail to even discuss the institutional boundaries and limitations of the courts regarding broad policy making as to a vigorously disputed social issue.

This justification for common-law authority ignores the separation of powers and institutional limitations of the courts. These principles and realities should

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236. Massachusetts Medical Society, MMS-Filed State Legislative Status Report: 2009-2010 Session 1 (2009), <http://massmed.org> (click “MMS advocacy tab, then find legislative status reports under “State Advocacy” heading) (last visited Jan. 4, 2010).

237. *Id.*

238. H.B. 1519, 2009 Leg. (Ma. 2009). The relevant proposed statutory language is that a claimant bears the burden of proving that “[a]s a direct and proximate result of the defendant’s negligent act or omission, the plaintiff suffered injuries which would have not have otherwise occurred.” *Id.*

239. *Coombes v. Florio*, 877 N.E.2d 567, 583 (Marshall, C.J., dissenting) (arguing “it is for the court to proceed incrementally with the expansion of common-law tort principles, and for the Legislature to initiate, if chooses the policy process of comprehensive tort reform”).

cause such courts to at least pause to consider and define their authority before announcing liability rules of far reaching social consequences. It is no retort that the common law has been marked by decisional law of first impression, as it remains for the courts to always consider and recognize judicial function and limitations. As a practical matter, legislatures should not have to foresee and then preempt a specific area, such as loss of chance, in order for a common-law court to even contemplate deferring to the legislative process. They likewise should not have to be regulated to a role of overseeing the judicial branch and having to so correct unwarranted judicial expansion of liability under the guise of “tort reform.”

It is notable that the courts in New Hampshire, West Virginia, and Michigan adopted loss of chance even though those states had codified pre-existing burden of proof standards and/or specifically defined medical injury ostensibly to limit further judicial expansion and/or provide legislative oversight or involvement. The New Hampshire Supreme Court, for example, adopted loss of chance under a statutory scheme specifically enacted to reign in physician liability<sup>240</sup>. The legislature was then forced to act again to abrogate the judicial action and to expressly state that the statutory scheme was intended to preempt common law expansion.<sup>241</sup> That the court felt no need to even consider the intent and purpose of the statute in the first instance demonstrates how entrenched courts can be in their perceived power to develop and adjudicate tort liability under the common-law authority. Similarly, just because there is not an enactment directly on point does not mean that legislative policy cannot be derived from other related enactments or goals, or that judicial deference is not warranted. Indeed, it would seem that due to the degree and extent of the legislative regulation of healthcare and physician liability and insurance, the issue is worthy of at least some discussion and consideration, if not outright deference, anytime a significant expansion of liability is being sought. Moreover, the absence of a clear direction or established traditions may well militate for, not against judicial restraint.

It is troubling that courts adopting loss of chance usually do not identify or articulate the boundaries of their common-law judicial function vis-à-vis the legislative function. There is an absence of articulation and uniformity of application of principled criteria as to (a) the issue of whether judicial deference is mandated given the particular dispute and legal and social implications and/or (b) the “public policy,” “social mores,” and/or principles of tort law underlying the common-law power to determine whether or not to expand existing liability.

To be sure, the effectiveness and thoroughness of the legislative process as to loss of chance is not without substantial doubt or shortcomings. Based on

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240. See generally *Lord v. Lovett*, 770 A.2d 1103 (N.H. 2001).

241. See N.H. REV. STAT. ANN. 507-E:2 (2009).

the available data, it is difficult to identify and assess the information or depth the legislative process assessed the loss of chance issue. In virtually all states that have experienced, or will experience, legislative action, professional medical societies and insurers are pitched against the trial bar. However, whether and to what degree, such issues as the status of modern medicine, cancer diagnosis and treatment, survival statistics, defensive medicine, physician judgment, insurance claims, insurance costs, healthcare and tort law goals and functions as to physician liability are discussed and evaluated is impossible to discern. Whatever the shortcomings of legislative action, however, it would still appear to be a superior means of evaluating the issue and its social ramifications than the confines and limited scope of a court adjudicating a singular dispute between discreet litigants in an area of complexity, uncertainty, and ever changing knowledge and science.

#### VI. LOST CHANCES: THE COMPETING POLICIES, CONSENSUS AND SCIENCE

Primary among the policy arguments favoring the loss of chance doctrine is that life is precious and the loss, through medical negligence, of any chance of cure, survival, or better outcome is worthy of recognition and protection. Equally compelling is the argument that acts of negligence as to patients with poor prognosis should not go unredressed and that it is fundamentally unfair to permit recovery where the negligence had a 51 percent possibility of producing harm but denying any recovery where the proof is 50 percent or less possibility.<sup>242</sup> The more probable than not standard is deemed unfair as it is an “all or nothing” rule which fails to deter medical negligence by immunizing “whole areas of medical practice from liability.”<sup>243</sup> Other policies identified as favoring the doctrine include tort law’s dual purposes of providing compensation to victims of negligence and deterring negligent conduct.<sup>244</sup> Courts have likewise noted that the doctrine prevents physicians from taking advantage of any uncertainty in outcome when such uncertainty is deemed to have been caused by their negligence,<sup>245</sup> and, that without loss of chance recovery, healthcare providers would be less inclined to perform a full spectrum of testing in less than optimistic cases.<sup>246</sup>

The most pronounced of the supporting policies for judicial adoption of loss of chance as a compensable harm is the assumption that modern medical

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242. See King I, *supra* note 142, at 1377 (discussing negative effects of all or nothing rule).

243. *McMackin v. Johnson County*, 73 P.3d 1094, 1099. *But see In re Winship*, 397 U.S. 358, 370 (1970) (Harlan, J., concurring) (noting that more probable than not standard is effort to establish degree of confidence society should have in making factual findings); *Kramer v. Lewisville Mem. Hosp.*, 858 S.W.2d 397 (Tex. 1993) (declining to adopt loss of chance doctrine and retaining more probable than not standard).

244. See *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 830 (Mass. 2008) (discussing policy considerations behind adoption of doctrine).

245. See *id.* at 831 (citing *Hicks v. United States*, 368 F.2d 626, 632 (4th. Cir. 1966)).

246. See *Crosby v. United States*, 48 F. Supp. 2d 924, 931 (D. Alaska 1999).

science is now capable of accurately determining a person's prognosis to a reasonable degree of medical certainty.<sup>247</sup> Unlike all other professions, compensation for lost chances is deemed ideally suited for medical negligence claims given the assertion that it is the obligation of the medical provider to use all reasonable measures to optimize a person's recovery; medical advances; and the belief that survival statistics are a routine tool of medicine.<sup>248</sup> Consequently, as a matter of medical science and perceived societal consensus, the abrogation of the more probable than not standard and the imposition of liability for lost chances is deemed necessary to meet the "felt necessities of the times" or changing needs. It is upon closer inspection that this perceived consensus and its scientific underpinning loses much of its luster.

As noted earlier, the incremental expansion of physician liability in tort has a direct correlation to the perceived advances in medicine and technology and leads to the public perception of the increased capability of medicine. As to lost chances, the medical advance and technology at work is the continued development of diagnostic technology and therapeutic treatments as well as the generation of "survival statistics." Both serve as fundamental underpinnings to recognition of loss of chance claims and are consistent with the long-standing intuition as to the benefits of early detection. Courts adopting loss of chance have either implicitly or expressly accepted the propriety and scientific reliability of both propositions with little question and with little discussion of the state of the actual efficacy of the science.<sup>249</sup>

With ever new technology comes increased expectations and demands including the sense of infallibility of technology and ability of medicine to cure or curtail all disease and ills.<sup>250</sup> These expectations fueled the long-standing "intuition" that early detection and treatment is always better. This is particularly true with cancer diagnosis and treatment, which has been accompanied by the public mantra that "early" detection equates to better outcome. The "vast new armamentarium of diagnostic techniques" which "sections" and images patients in "exquisite anatomical detail" detecting

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247. *Matsuyama*, 890 N.E.2d at 837 (holding "now that medical science has developed credible means of quantifying the extent to which the malpractice damaged the patient's prospects of survival . . . loss of chance of survival rightly assumes a place in our common law").

248. *Id.* at 835; *see also* *Cooper v. City of Harford*, No. 3:07-CV-823 (JCH), 2009 WL 2163127, at \*29 (D. Conn. July 21, 2009) (explaining loss of chance not applicable beyond "peculiar" circumstances of medical malpractice).

249. *See, e.g., Roberts v. Ohio Permanente Med. Group, Inc.*, 668 N.E.2d 480, 488 (Ohio 1996) ("[O]ver the years medical technology has improved and advances have been made in the treatment of many areas of medicine, including cancer. However, these medical strides are meaningless unless early detection is practiced diligently by those in health care field."); *Evers v. Dollinger*, 471 A.2d 405, 419-21 (N.J. 1984) (Handler, J., concurring) (discussing propriety of taking judicial notice that delay in cancer diagnosis results in poorer prognosis).

250. *Jacobson*, *supra* note 76, at 56-59 (discussing technology's effect on liability); *see also* *MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE: VOLUME II, AN INTERDISCIPLINARY REVIEW 20-21* (1989) (discussing "dramatic impact" of social and political pressures upon use of technology).

abnormalities before they would be detected clinically, only fuels the “early diagnosis is better” outcome precept.<sup>251</sup>

A substantial and authoritative body of science and research demonstrates that the true state of modern medicine exhibits much controversy and debate about whether early detection results in better outcome for many chronic diseases, including many forms of cancer. What is deemed “early” detection is biologically late.<sup>252</sup> There is, in fact, substantial authority that many times early detection is not better and that, in fact, intervention and treatment cause more harm than good. As recently stated by Robert Kaplan in his book *Disease, Diagnosis & Dollars*:

We have failed to recognize that most important chronic diseases evolve over decades in a person’s body. By the time they come to medical attention, they are well entrenched and not subject to cure. Treatment may alleviate some of the suffering from these conditions, but may also cause problems that harm our overall level of well being.<sup>253</sup>

[I]t is commonly believed that bad health outcomes usually result from failure to detect disease early. Certainly, this is true in some cases. Yet, in other cases early detection is of little value. For example, early detection of a disease that will not eventually result in death, disability, or symptoms may be of little importance. Similarly, detection of a disease for which there is no effective treatment cannot lead to a remedy that will make the patient better.<sup>254</sup>

Five-year survival rates for a wide range of cancer types are frequently reported as a measure of progress and the efficacy of early detection and treatment.<sup>255</sup> However, it was recently reaffirmed that “the five-year survival

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251. William Black & H. Gilbert Welch, *Advances in Diagnostic Imaging and Overestimation of Disease Prevalence and the Benefits of Therapy*, 328 NEW ENG. J. MED. 1237, 1237-1243 (1993).

252. See generally Franco Berrino, Roberta De Angelis, & Milena Sant, *Cancer Survival Statistics Should Be Viewed With Caution—Author’s Reply*, 8 THE LANCET ONCOLOGY 1053, 1053-54; Alvan R. Feinstein, D.M. Sosin & CK Wells, *The Will Rogers Phenomenon: Stage Migration and New Diagnostic Techniques as a Source of Misleading for Survival for Cancer*, 312 NEW ENG. J. MED. 1604, 1605 (1985); King II, *supra* note 149, at 550; C. Barber Mueller, *Stage II Breast Cancer Is Not Simply a Late Stage I*, 104 SURGERY 631 (1988); H. Gilbert Welch, Lisa M. Schwartz & Steven Woloshin, M.D., *Are Increasing 5-Year Survival Rates Evidence of Success Against Cancer?*, 283 JAMA 2975-78 (2000); Don Coburn, *Cases, Deaths and Survival Rates: Judging Success or Failure of the War on Cancer is Difficult*, WASH. POST, Dec. 3, 1991, at Z12; Gina Kolata, *Cancer ‘Prevention’ is a Big Seller, But Medical Experts Are Divided*, N.Y. TIMES, Jan. 11, 2004, § 1, at 1; Posting of David Gorski to Sciencebasedmedicine.org, *The Early Detection of Cancer and Improved Survival: More Complicated Than Most People Thought*, <http://www.sciencebasedmedicine.org/?p=116> (May 12, 2008).

253. KAPLAN, *supra* note 88, at 4.

254. *Id.* at 35.

255. See Black & Welch, *supra* note 251 (discussing length bias in comparisons adjusted for rate of progression of disease); Barnett S. Kramer, Jennifer M. Crosswell, *Cancer Screening: The Clash of Science and Intuition*, 60 ANN. REV. MED. 125 (2009); Gorski, *supra* note 252 (discussing common assumptions related to early detection of cancer).

rate is the world's most misleading number."<sup>256</sup> There is a serious "clash" between "science and intuition" in that "[d]espite the strength of the messages transmitted to the public about the value of cancer screening, cancer mortality statistics remain sobering."<sup>257</sup> It has long been recognized that the "the more we search for cancer, the more cancer we find" and that the public perception of the benefits of early screening or diagnosis is not consistent with the true experience with cancer.<sup>258</sup> The natural history of cancer is largely unknown, with existing knowledge equating to the tip of an iceberg:

There is a tendency to assume that cancers picked up by screening efforts necessarily behave in the same manner as cancers diagnosed by symptomatic presentation. The development of cancer is a lengthy (years or decades) and complex process, the hallmark of which is unrepaired genetic instability leading to distinct, heterogeneous subpopulations of abnormal cells. As such, cancer can be envisioned as an iceberg of disease, in which the visible tip above the waterline comprises the most aggressive lesions—those that produce symptoms and clinical disease. The majority of our body of knowledge concerning the natural histories of malignancies comes from observations of these symptomatic lesions. Underneath the water's surface, however, there are multiple subpopulations of cells, ranging from those with genetic and epigenetic changes with to those with phenotypic abnormalities. Some of these subpopulations will look like typical cancers to a trained pathologist. However, a static snapshot may not reflect a dynamic cellular behavior. Early detection methods, by definition, attempt to dip below the waterline and pick up silent lesions; but the natural history of these asymptomatic lesions has not been observed and is simply unknown. In fact, because of the geometry of the iceberg, even a modestly sensitive screening test may detect more cancers whose natural history is not known than whose natural history is known.<sup>259</sup>

The true state of modern science and cancer is that the natural course of cancer is highly variable and a dynamic process that may proceed in many different ways.<sup>260</sup> Cancers may proceed at different speeds, different lethalties, and may even regress or be stopped by the body's immune system.<sup>261</sup> This heterogeneity in the natural history of cancer demonstrates its complexity and uncertainty, and how it is difficult to know what is "early" and whether "early"

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256. H. GILBERT WELCH, *SHOULD I BE DIAGNOSED FOR CANCER: MAYBE NOT AND HERE'S WHY* 126 (2004). See generally Joel Kauffman, *MALIGNANT MEDICAL MYTHS* (2006).

257. Kramer & Croswell, *supra* note 255, at 125-37.

258. *Id.*; see also KAPLAN, *supra* note 88, at 47-69 (discussing misleading nature of screening and purported survival statistics).

259. *Id.* at 127.

260. WELCH, *supra* note 256, at 9.

261. *Id.* (explaining "some [cancers] may grow very fast, others may grow very slowly and a few may even go away").

detection and treatment alters outcomes.<sup>262</sup> Indeed, this is the reason cancer statistics can be so misleading.<sup>263</sup>

The reality is that courts adopting loss of chance have a poor understanding of the true state of modern medicine and the true nature of “survival statistics.”

Because five-year survival is affected by the timing of diagnosis and who is diagnosed, it is an unrealistic statistic for drawing conclusions about the quality of medical care across time. But that doesn't stop people from making faulty comparisons based on five-year survival and promoting those comparisons as evidence of the value of cancer research and early detection.<sup>264</sup>

The traditional five or ten-year survival statistics, derived as they are from observational studies and different screening modalities, can be severely skewed due to a number of inherent biases which, in turn, reveal the true unknowns and complexity of cancer.<sup>265</sup> Courts adopting loss of chance frequently equate survival statistics with outright cure when there is no such equivalency. Most survival statistics do not take into account the means of diagnosis (screening vs. clinical). Lead time and length time biases as well as over-diagnosis, pseudo-disease, and stage migration or the Will Rogers Phenomenon have significantly inflated survival statistics and the efficacy of new screening technologies.<sup>266</sup>

Lead time bias is the most well known and confirms that advancing the time of diagnosis with screening or through new technologies always increases survival.<sup>267</sup> For example, assume a particular cancer results in death 100 percent of the time within four years of diagnosis. The resulting five-year survival rate is 0 percent. If through a new technology, the cancer is detected earlier, for example, five years before clinical diagnosis was possible, the five-year survival would be 100 percent, even though nothing is done in altering the disease or death.<sup>268</sup>

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262. See Gina Kolata, *Early Detection of Cancer: Nothing is Black and White*, N.Y. TIMES, Dec. 24, 2002, at F1.

263. *Id.*

264. WELCH, *supra* note 256, at 137.

265. See, e.g., KAPLAN, *supra* note 88, at 47-69; D.A. Berry, *The Screening Mammography Paradox: Better When Found, Perhaps Better Not to Find*, 98 BRIT. J. CANCER 1729 (2008); William C. Black & Alexander Ling, *Is Earlier Diagnosis Really Better? The Misleading Effects of Lead Time and Length Biases*, 155 AM. J. ROENTGENOLOGY 625 (1990); Feinstein, Sosin & Wells, *supra* note 252; Brian Kay & David White, *The Impact of Cancer Biology, Lead Time Bias, and Length Time Bias in the Debate About Cancer Screening Tests*, 23 J. INS. MED. 102 (1991); Kramer & Croswell, *supra* note 255; Mueller, *supra* note 252; Gordon C. Wishart et al., *Screen-Detection vs. Symptomatic Breast Cancer: Is Improved Survival Due to Stage Migration Alone?* 98 BRIT. J. CANCER 1741 (2008); H. Gilbert Welch, Steven Woloshin & Lisa M. Schwartz, *Essay, How Two Studies on Cancer Screening Led to Two Results*, N.Y. TIMES, Mar. 13, 2007.

266. See Feinstein, Sosin & Wells, *supra* note 252; Kramer & Croswell, *supra* note 255.

267. See KAPLAN, *supra* note 88, at 50.

268. See Kramer & Croswell, *supra* note 255, at 129.

Length time bias refers to the fact that early diagnostic tools are more likely to pick up less aggressive cancer than rapidly growing or aggressive cancer.<sup>269</sup>

The slower growing, less aggressive cancers have a longer preclinical period than more rapidly fatal cancers. As such the screening tool had a greater likelihood of detecting these lesions than tumors that grow and spread quickly. Attempts to compare outcomes between screen-detected and symptom detected cancers are thus inherently biased.<sup>270</sup>

Accordingly, length time refers to the pre-symptomatic period when the cancer is technologically detectable, for example, a mammogram for breast cancer. Through screening, longer times and slower growing tumors are preferentially selected, resulting in length time bias as to survival.

Over-diagnosis is a form of length time bias and represents the tendency to detect abnormalities, pre-cancer or cancer, but due to reasons unknown these abnormalities may never have progressed to a life threatening disease if left undetected and untreated. The Will Rogers Phenomenon, or stage migration, is where new technologies lead to discovering tumor spread that would not have been found in another patient diagnosed with another method or earlier technology.<sup>271</sup> The Will Rogers name comes from a famous line from a Will Rogers joke: “When the Okies left Oklahoma and moved to California they raised the average intelligence level in both states.” Similarly, because of technology, patients migrate from one stage to another for purposes of classification. Because the new technology discovers additional disease that would not have been detected in the past, the patient is classified in a different stage. This results in the statistical effect of making the survival rate in both groups appear better, without any change in overall survival of the group as a whole. The patient that migrates to a higher stage tends to have lesser, or less aggressive, disease than the average patient in that stage, thus improving the group’s overall survival rate. Conversely, the survival rate of the original group improves as the worst of the patients in that group, who usually have poorer results, are now in the other stage or group.

In fundamental terms, early detection, in many instances, makes it appear that fewer people die of disease, even if treatment has no effect on the disease.

Lead time and length time biases pertain not only to changes that lower the threshold for detecting disease, but also to new treatments that are applied at the same time. Whether or not new therapy is more effective than old therapy, patients given diagnoses with the use of lower detection thresholds will appear

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269. KAPLAN, *supra* note 88, at 51-51.

270. *Id.* at 131

271. See Feinstein, Sosin & Wells, *supra* note 252; see also P.W. Dickman & H.O. Adami, *Interpreting Trends in Cancer Survival*, 260 J. INTERNAL MED. 103, 110 (2006); Gorski, *supra* note 252.

to have better outcomes than their historical controls because of these biases. Consequently, new therapies often appear promising and could even replace older therapies that are more effective or have fewer side effects. Because the decision to treat or to investigate the need for treatment further is increasingly influenced by the results of diagnostic imaging, lead time and length biases increasingly pervade medical practice.<sup>272</sup>

These principles explain why survival statistics show an increase in survival at the same time mortality from cancer has remained largely unchanged in the last forty years. This is not an argument that there are no true advances and treatment in the care of cancer. Without question, there are. However, “the question of sorting out ‘real’ effects on cancer survival attributable to new treatments being tested from spurious effects due to these biases is more complicated than it first seems.”<sup>273</sup> Absent statistics from randomized and controlled studies, survival statistics are misleading, and cannot reasonably serve as a basis for constituting “harm” for purposes of physician tort liability.<sup>274</sup> The fact that they represent “naked” statistics, which, without particular proof, cannot provide a basis to say how any person would have done, is also troubling. More fundamentally, survival statistics reflect both the complexity of cancer and the fact that the earlier is better precept is not remotely universally true and is, at best, complicated based on the modern state of science and medicine.<sup>275</sup>

When you add to the mix the fact that it is only at the time of diagnosis that a cancer can be staged (and thus stamped by a claimant with corresponding survival statistics), the loss of chance “harm” becomes even more problematic. There is simply no acceptable scientific methodology or process to truly determine what stage a cancer was at any time other than diagnosis.<sup>276</sup> Absent

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272. Black & Welch, *supra* note 251.

273. Gorski, *supra* note 252; *see also* Kramer & Croswell, *supra* note 255.

274. Kramer & Croswell, *supra* note 255.

275. A further dynamic not mentioned in any loss of chance decision to date is the role of false negatives. If the loss of a statistical chance of survival is a legally protectable interest, then statistical deduction for false negatives would be required. *See* Weigand, *supra* note 142, at 20 (citing King II, *supra* note 149, at 555). For instance, if the claim is that a mammogram and then biopsy should have been undertaken, the statistical rates for false negatives for these tests need to be factored into the statistical loss. *Id.* A mammogram carrying a 10 to 15 percent false negative rate would thus reduce any proffered statistical loss of chance as would the statistical false negative rate of biopsy. *Id.*

276. *See* Holy Cross Inc. v. Marrone, 816 So. 2d 1113 (Fla. Dist. Ct. App. 2001) (reasoning while staging assists physicians in identifying treatment options, not intended to determine when cancer spread); *see also* Kardos v. Harrison, 980 A.2d 1014, 1019 (Del. 2009) (holding defendant physician entitled to judgment as a matter of law even though claimant’s expert testified that 30 percent of patients like decedent responded to treatment, as expert could not say beyond speculation that decedent within 0 to 30 percent statistical group); Anthony v. Chambless, 500 S.E.2d 402, 406 (Ga. Ct. App. 1998) (holding summary judgment properly granted where 50 percent loss of chance did not consider age, state of health, and post-operative complications). *But see* Crosby v. Myhra-Bloom, No. A08-1128, 2009 WL 911664, at \*9-14 (Minn. Ct. App. Apr. 7, 2009) (rejecting *Daubert* challenge to TNM staging opinion on stage of cancer at time of negligence based on x-ray taken at that time).

clinical examination, imaging and pathological work-up, a cancer cannot be staged. Yet loss of chance as a compensable harm for medical malpractice assumes such staging can be done, and does not otherwise consider any “back-staging” difficulties sufficient to prevent adoption of this new physician liability doctrine. Accordingly, “the lost of chance of survival theory presumes to know the unknowable.”<sup>277</sup> These infirmities with survival statistics transcend simply the unreliability of certain proof or evidence of loss of chance harm, but also reflect the countervailing policies and lack of consensus surrounding loss of chance as a compensable harm in medical practice.

Aside from the lack of consensus on modern medicine capability, there are additional policy considerations that call into question the existence of consensus and social need for lost chance liability.

Prior to recent times in medical malpractice actions, loss of chance or possible outcome has rarely been a cognizable harm in tort. Tort law has long recognized that there is no liability where the harm or loss would have occurred anyway, and chances or possibilities are usually deemed too speculative and uncertain to serve as a basis for imposing legal responsibility. The concern with speculative or uncertain damage is imposing liability for harms not caused by the defendant’s wrongful conduct. In fact, the rule against recovery where damage is uncertain is directed against uncertain causation rather than uncertain extent or measure. Accordingly, while a defendant’s wrongful conduct may well have played a role in the uncertainty of outcome, so did the underlying disease, and the law has traditionally resolved questions of uncertainty with the more probable than not burden of proof. The law thus does not require certainty for liability only that it be more certain than not.<sup>278</sup>

While many courts find that treating loss of chance as a distinct “injury” alleviates the problems inherent in treating it as a causation theory, this distinction is not particularly compelling.<sup>279</sup> Permitting a fact finder to determine whether a harm occurred on proof there was a 20 percent loss of chance of a better outcome is not much different than stating the issue as: “more probably than not, the wrongful conduct caused a 20 percent loss of chance of a better outcome.” The central issue in either formulation remains permitting tort liability based on lost possibilities. As one court observed: “[w]hen the dew leaves the rose it is still a rose, the reasonable probability of a chance of survival is still just a possibility.”<sup>280</sup>

Defining and valuing the lost chance of harm in terms of proportionality does not save the nature of the asserted loss from its difficulties or remove it from the policy debate. Reconceptualizing harm as loss of opportunity is still

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277. *Falcon v. Memorial Hosp.*, 462 N.W.2d 44, 68 (Mich. 1990) (Riley, C.J., dissenting).

278. *Gregg v. Scott* [2005] 2 A.C. 176 (H.L.)(U.K.).

279. *Kemper v. Gordon*, 272 S.W.3d 146, 151-52 (Ky. 2008).

280. *Id.*; see also *Dumas v. Cooney*, 235 Cal. App. 3d 1593, 1610 (1991) (“[R]edefining loss of chance as a new form of injury simply does not diminish that the theory radically alters the meaning of causation.”).

an allowance of recovery for the outcome of physical harm discounted by the probability that the physician's negligence did not cause the harm. Moreover, one may reasonably question how the value of a claimant's lost chances of recovery is necessarily equal to some specific percentage value of the ultimate harm. It amounts to applying a proportional numerical value based on estimates, which is then applied to estimates of general damages that never occurred to yield a value of the lost chance.<sup>281</sup> More fundamentally, "a proportionate award . . . would not exemplify the basic negligence rule and its behavioral norm. The award would instead project a very different and seemingly perverse legal rule: courts will hold the defendant liable, notwithstanding the possibility [if not probability] that he or she [caused] no [actual harm]. The behavioral norm embodied in this rule is not one of care and safety."<sup>281</sup>

Further, imposing liability based on statistical affiliation has long been a controversial area of the law. Traditionally, courts have held that it is not "enough that mathematically the chances somewhat favor a proposition."<sup>282</sup> The law's tolerance for reliance on and use of statistics, however, has grown.<sup>283</sup> Yet, it is not often that the statistical proffer constitutes both the harm and the measure of harm and it remains a reasonable principle that liability should not be imposed based on naked statistics alone absent particularized proof.<sup>284</sup> This

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281. Charles Nesson, *The Evidence or the Event? On Judicial Proof and the Acceptability of Verdicts*, 98 HARV. L. REV. 1357, 1383 (1985); see also Richard W. Wright, *Liability for Possible Wrongs: Causation, Statistical Probability, and the Burden of Proof*, 41 LOY. L.A. L. REV. 1295, 1296 (2008) (positing loss of chance does not "constitute an actual setback to another's equal external freedom through an invasion of the other's rights in his [or her] person . . . as is required for an interactive justice wrong").

282. *Smith v. Transport*, 58 N.E.2d 754, 755 (Mass. 1945) (denying imposition of liability as "the most that can be said of the evidence . . . is that perhaps the mathematical chances somewhat favor the proposition . . . the defendant caused the accident"); see also, e.g., *Spencer v. Baxter Int'l.*, 163 F. Supp. 2d 74, 80 (D. Mass. 2001); *Okazaki v. Dep't of Children & Families*, No. 407-cv-496-SPM, 2008 Westlaw 4525333, at \*7 (N.D. Fla. Oct. 3, 1998) (statistics without analytical foundation are meaningless and must be supported by appropriate valuation for admissibility); *Lanigan v. Huran Valley Hosp., Inc.*, 766 N.W.2d 896, 899 (Mich. Ct. App. 2009) (holding proffered 70 percent ten-year mortality statistic only "marginally relevant" as rate was not limited to those similarly situated as plaintiff); *Wosinski v. Cohn*, 713 N.W. 2d 16, 21 (Mich. Ct. App. 2005) (refusing to recognize bald statistics as valid evidence of negligence and or relevant to informed consent in medical malpractice action); *McCloud v. Commonwealth*, 609 S.E.2d 16, 25 (Va. 2005) (recognizing evidence of raw numbers without description of circumstances can be misleading).

283. Oliver Wendall Holmes, Jr., *The Path of The Law* reprinted in *The Path of the Law After One Hundred Years*, 110 HARV. L. REV. 991, 1001 (1997) ("For the rational study of the law the black-letter man may be the man of the present, but the man of the future is the man of statistics and the master of economics."); see also Barrett S. Moore, Comment, *Health Law—Informed Consent—Trust Me, I Do This All the Time: Comparative Provider Statistics and Informed Consent in Arkansas*, 31 U. ARK. LITTLE ROCK L. REV. 609 (2009) (discussing debate over imposing liability as to informed consent on comparative provider statistics); Aaron D. Twerski & Neil B. Cohen, *Comparing Medical Providers: A First Look at the New Era of Medical Statistics*, 58 BROOK. L. REV. 5, 34 (1992) (asserting that statistical methodology will develop to a level of statistical accuracy that medical statistics become an inseparable part of medical liability).

284. *Martin v. Citibank, N.A.*, 762 F.2d 212, 219 (2d Cir. 1985) (noting although statistics admissible in disparate treatment case involving single plaintiff statistical evidence alone not sufficient to make prima facie evidence); *DeLuca v. Bank of Tokyo Mitsubishi*, 249 F.R.D. 123 (S.D.N.Y. 2008) (noting same); *Bussey v. Phillips*, 419 F. Supp. 569 (S.D.N.Y. 2000) (noting same).

principle is based upon the fundamental notion that “liability [including cognizable harm] should be grounded upon what the wrongful act caused as to the particular individual rather than statistical affiliation.” To impose liability based on statistical affiliation absent particularized proof not only results in more errors than the traditional rules, but is also an inescapably broad policy determination. The individualized adjudicatory function of the court as to the specific individuals before the court is transformed to permitting awards based on statistical chances lost by a similar group not before the court. The result allows an award for something to the majority of the claimants who are entitled to nothing, to ensure that the minority of the claimants receive compensation to which they are entitled. This is a fundamental policy decision, and arguably the province of the legislature.

Additionally, imposing liability upon physicians for any statistical loss of a better outcome can only fuel defensive medicine.<sup>285</sup> Loss of chance courts have, in fact, equated the standard of care of the average qualified physician to the duty of a physician to take “every reasonable measure to obtain an optimal outcome for the patient.”<sup>286</sup> Reformulating the duty in this fashion, in light of the ever-increasing technology being pushed upon physicians and the public, places a significant burden upon the physician and subjects the physician to significant second-guessing for purposes of a civil lawsuit. Moreover, if statistical chances, no matter how small, are the basis for liability, why wouldn’t healthcare providers simply order any and all testing and procedure regardless of efficacy? In a profession like medicine, which is experiencing a shortage of members, and which is the centerpiece of the national debate over our healthcare system, these issues should be especially concerning and deserving of consideration in the common-law public policy rubric as to loss of chance.<sup>287</sup>

On a more fundamental level, recognition of loss of chance as either a new rule of causation or as a new injury would mark a significant expansion of liability upon physicians in a time of ever-rising health care costs as well as represent a marked reconceptualization of harm in tort law—imposing liability for risk.<sup>288</sup> Liability would no longer be about outcomes, but rather about risk of avoiding an outcome. The ramifications of such a rule in modern medical practice and universal healthcare efforts require careful assessment and

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285. See *Fennell v. Southern Md. Hosp. Ctr. Inc.*, 580 A.2d 206, 215 (Md. 1990) (holding recognition of loss of chance would cause increase in litigation); see also Weigand, *supra* note 142, at 15 (discussing policy arguments against adoption of doctrine).

286. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 835 (Mass. 2008) (quoting RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM §26’ com. n. (Proposed Final Draft No. 1, 2005)).

287. See *Dumas v. Cooney*, 235 Cal. App. 3d 1593 (1991) (rejecting loss of chance in medical malpractice in part due to concern of defensive medicine).

288. See *id.* at 1610 (“[R]edefining loss chance as a new form of injury simply does not diminish that the theory radically alters the meaning of causation.”); *Jones v. Owings*, 456 S.E.2d 371, 374 (S.C. 1995) (holding loss of chance “is contrary to the most basic standards of proof which undergird the tort system.”).

valuation before adoption. A loss of chance claim presupposes that a purpose of tort law is compensation for lost chances, similar to principles underlining lotteries and insurance policies; a purpose that has never before been accepted in any other context.<sup>289</sup> It is a substantial argument that it is an unprincipled and unfair imposition of a liability upon one segment of society (medical providers), while having been rejected for other professions.<sup>290</sup> From a purely statistical point of view, loss of chance produces more errors than traditional causation/damage principles.<sup>291</sup>

More practically, if under loss of chance a claimant can recover 30 percent of the value of his or her injury or life where the negligence caused a loss of a 30 percent chance of a better result, then a patient who had a 51 percent chance of cure or better outcome is limited to 51 percent of the value of the injury, instead of full value available under traditional law.<sup>292</sup> Virtually all courts that have adopted the doctrine fail to address this logical application or, in some cases, limit loss of chance recovery to only claimants with a less than 50 percent chance of better outcome.<sup>293</sup> There is no remote justification not to apply the same rule to physicians in cases of liability over 50 percent and have the harm measured accordingly. The result is proportional recovery in all cases.<sup>294</sup> Further, one may reasonably conclude that if physician liability is expanded to include loss of chance, then a physician will have to defend against both an assertion that the negligence caused the injury or death or, in the alternative, the loss of chance to avoid the injury or death, resulting in the imposition of a daunting burden to defend, as it is easy to simply conclude that

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289. See *Lawson v. Laferriere*, [1991] 1 S.C.R. 541, 156 (Can.) (holding “not prepared to conclude that particular medical conditions should be treated for purposes of causation as the equivalent of diffuse elements of pure chance, analogous to the non-specific factors of fate or fortune which influence the outcome of a lottery”); *Falcon v. Memorial Hosp.*, 462 N.W.2d 44, 66 (Mich. 1990) (Riley, C.J., dissenting) (decrying application of lottery and insurance principles to tort law).

290. See *Kramer v. Lewisville Mem. Hosp.*, 858 S.W.2d 397, 406 (Tex. 1993) (“[I]t is doubtful that there is any principled way we could prevent [the loss of chance doctrine’s] application to similar actions involving other professions.”); see also Fischer, *supra* note 142, at 611-12 (recognizing no principled reason not to apply loss of chance to lack of informed consent cases, failure to warn regarding products, legal malpractice, and other areas); Recent Cases, *supra* note 172, at 1251-54 (discussing inevitable extension of scope of doctrine); Kenneth S. Abraham, *Stable Divisions of Authority*, 44 WAKE FOREST L. REV. 963, 976-77 (2009) (noting loss of chance doctrine not reasonably limitable to cases of medical negligence).

291. See *Fennell v. Southern Md. Hosp. Ctr. Inc.*, 580 A.2d 206, 213 (Md. 1990) (comparing doctrines rate of statistical error to other theories).

292. See generally Jonathan P. Kieffer, *The Case for the Across the Board Application of the Loss of Chance Doctrine*, 64 DEF. COUNSEL J. 568 (1997); King I, *supra* note 142, at 1386.

293. See, e.g., *Donning v. Quianno*, 810 P.2d 1163, 1168 (Kan. Ct. App. 1991); *Wilson v. Horton*, No. C-040193, 2004 WL2913562, at \*3 (Ohio Ct. App. Dec. 17, 2004) (holding directed verdict for defendant on loss of chance claim as lost chance of survival does not apply where decedent had a greater than 50% chance of survival”); *Liotta v. Rainey*, No. 77396, 2000 WL1738355, at \*5 (Ohio Ct. App. Nov. 22, 2000) (holding trial court properly granted directed verdict where patient had a better than even chance of survival).

294. See Abraham, *supra* note 290, at 977 (noting logic of loss of chance leads to wholesale regime of proportional liability).

there must have been a loss of at least a chance.<sup>295</sup>

In the end, loss of chance imposes liability for possibilities, not probabilities, and does so amidst the uncertainty and complexity of predicting outcomes for individuals afflicted with pre-existing health ailments, including complex and uncertain disease such as cancer. It makes the medical provider responsible, not just for causing a particular outcome, but for any loss of chance of avoiding that outcome. It places a higher social value on an individual's statistical lost chance that was not likely to occur over a medical practitioner's right not to be subject to liability and compensation obligation when the outcome was more probable than not the result of disease, not the physician's care. It does so without requiring any particularistic proof and, in cancer cases, based on application of generic survival statistics that are considered by many "the world's most misleading figures," directly reflective of the true complexity and unknowns of cancer treatment and screening efficacy. The new theory of causation or harm is equally reflective of the unduly high expectation of medicine's diagnostic and therapeutic capacity.<sup>296</sup> Given the vigorous policy debate and lack of consensus, one may reasonably question whether the judiciary, in the confines of a singular dispute, is either equipped or otherwise the appropriate instrument to impose liability for lost chances on such a vital segment of society in a profession that is rife with uncertainty and complexity and the subject of unwarranted expectation.<sup>297</sup>

## VII. KENTUCKY AND MASSACHUSETTS

Within weeks of each other in 2008, the highest courts of Kentucky and Massachusetts addressed the viability of loss of chance claims against physicians.<sup>298</sup> Both cases involved failure to timely diagnose gastric cancer. Both patients died of gastric cancer with their respective estate's bringing medical malpractice claims for wrongful death. Both alleged failure to more timely diagnose and treat, and that this failure resulted in the asserted loss of a statistical chance of survival.

### A. Kentucky: "Wings for Angels, Feet For Men"

In *Kemper v. Gordon*,<sup>299</sup> a thirty-eight year-old mother was seen and treated

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295. See, e.g., *Gregg v. Scott* [2005] 2 A.C. 176 (H.L.) (U.K.) (Baroness Hale) (arguing "reformulating that damage in this way could lead to some liability in almost every case").

296. David Plotkin & Francis Blankenburg, *Breast Cancer--Biology & Malpractice*, 14 AM. J. CLIN. ONCOL. 254 (1991) (arguing "until we correct the unduly high expectation of our diagnosis and therapeutic capacity in this field all of us will suffer the social consequences").

297. See, e.g., *Joslyn v. Chang*, 837 N.E.2d 1107, 1112-13 (Mass. 2005) (requiring deference to legislature amid debate over concerns over rising medical malpractice insurance).

298. *Kemper v. Gordon*, 272 S.W.3d 146 (Ky. 2008); *Matsuyama v. Birnbaum*, 890 N.E.2d 819 (Mass. 2008).

299. 272 S.W.3d 146 (Ky. 2008).

for periodic complaints of severe nausea, dizziness and chest pain.<sup>300</sup> She experienced these symptoms first in February 1996 and then again in April 1996.<sup>301</sup> The defendant physician saw her in April 1996 and ordered a CT scan of the abdomen which was read as normal.<sup>302</sup> In December 1996, Ms. Gordon was found to have enlarged lymph nodes and was diagnosed with Grade III adenoma carcinoma.<sup>303</sup> She died in January 1998.<sup>304</sup>

Her estate asserted that the patient went from a 30 percent to a 5 percent statistical “chance of recovery,” as a result of the purported negligent failure to more timely diagnose and treat gastric cancer.<sup>305</sup> It was contended that recovery should be allowed for 25 percent of total wrongful death damages.<sup>306</sup> The trial court refused to instruct the jury on loss of chance and, after a defense verdict, the plaintiff appealed.

On appeal, the Kentucky Court of Appeals held that a new trial was necessary as the trial court erred in not providing the jury with a loss of chance instruction.<sup>307</sup> It proceeded to hold that based on “public policy” the adoption of loss of chance in Kentucky, and allowing for an award of proportional damages based on that lost chance, was warranted.<sup>308</sup> According to the court: “[p]roportionate recovery would better comport with traditional notions of fairness and justice, than the all or nothing rule that would leave the patient without a remedy.”<sup>309</sup> It did note that the loss of chance rule would not apply to cases where the statutory chance of survival went from above 50 percent to below 50 percent—these cases would be adjudicated under the traditional rule.<sup>310</sup>

On further appeal, the Supreme Court of Kentucky reversed the Court of Appeals decision.<sup>311</sup> In so doing, the high court rejected the assertion that earlier Kentucky cases had “la[id] the groundwork for a natural progression into accepting the lost or diminished chance method of recovery.”<sup>312</sup> Eschewing any mention or construction of Kentucky’s wrongful death statute, the court likewise rejected the assertion that “public policy reasons” required recognition of the doctrine.<sup>313</sup> It did so, in rather direct and eloquent terms:

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300. *Id.* at 148.

301. *Id.*

302. *Id.*

303. *Kemper*, 272 S.W.3d at 149.

304. *Id.*

305. *Id.* at 150.

306. *Id.*

307. *See id.* at 148-150.

308. *Id.* at 152.

309. *Gordon v. Kemper*, No. 2002-CA-001983-MR, 2002-CA-002043-MR, 005 WL 678535 (Ky. Ct. App. Mar 25, 2005) (opinion removed at court’s request, only citation available).

310. *Id.*

311. *Kemper*, 272 S.W.3d at 152.

312. *Id.* at 150.

313. *Id.* at 152.

We are fully appreciative of the [claimant's] point that the standard of proof in the lost or diminished chance doctrine would still be anchored in the requirement of probabilities. It is argued that a plaintiff would still be required to show, within a reasonable probability, that the negligence caused the loss of the chance of survival. However, a close look at the semantics of this argument makes it clear that this amounts to a concept chasing its own tail. When the dew leaves the rose, it is still a rose. The reasonable probability of a chance of survival is still just a possibility.

We further take issue with the Court of Appeals' determination that public policy reasons support the recognition of lost or diminished chance of recovery as a distinct and compensable injury in tort law. Even as we write this opinion, our society is wallowing near the water line with the burdensome and astronomical economic costs of universal healthcare and medical services. Rising malpractice insurance premiums for physicians are undoubtedly a part of that financial burden. Medical science and technology are advancing at a dizzying and sometimes seemingly miraculous rate. Our expectations as recipients of these modern day blessings ride upon the tail of this comet. We must acknowledge, however, that in spite of seemingly miraculous cures and mind-boggling technology that allow us to both examine and evaluate the human body, the diagnosis must still be seen by human eyes, analyzed by human minds, and treatment offered by human hands. That is why there remains great wisdom in ensuring that our laws offer redress for those wronged by medical malpractice based on reasonable probabilities and substantial cause, not on chance or mere possibility. Perfection is not part of human nature, and rarely does wisdom say one thing and nature another—wings for angels and feet for men.

We are troubled by the potential financial burden that might be spread upon the shoulders of millions of people if we adopt this new concept of lost or diminished chance of recovery. Further, we see many difficulties in adopting the lost or diminished chance doctrine. For instance, what is a "late diagnosis"? Does a diagnosis missed this week, but made next week, rise to the level of diminished chance? A whole new and expensive industry of experts could conceivably be marched through our courts, providing evidence for juries that an MRI misread on Monday, but accurately discerned on Friday, perhaps gives rise to an infinitesimal loss of a chance to recover. Yet, under this doctrine, even a small percentage of the value of a human life could generate substantial recovery and place burdensome costs on healthcare providers. This additional financial load would be passed along to every man, woman, and child in this Commonwealth.<sup>314</sup>

The Court referenced and relied upon *Smith v. Parrot*,<sup>315</sup> a 2003 Vermont

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314. *Id.* at 151-52.

315. 833 A.2d 843 (Vt. 2003).

Supreme Court decision, which had likewise rejected the doctrine.<sup>316</sup> In that case, the Vermont Supreme Court held that the loss of chance doctrine, while “appealing,” represented a significant departure from established tort law, and that the potential expansion of liability upon the medical profession in Vermont “involves significant and far-reaching policy concerns more properly left to the Legislature, where hearings may be held, data collected, and competing interests heard before a wise decision is reached.”<sup>317</sup>

In conclusion, the Kentucky court declined the invitation to judicially legislate “in a matter of such far reaching consequence to [Kentucky] citizens.”<sup>318</sup>

*B. Massachusetts: “Evolving Life of the Commonwealth”*<sup>319</sup>

Just six weeks after the *Kemper* decision, the Massachusetts Supreme Judicial Court reached a contrary conclusion in *Matsuyama v. Birnbaum*.<sup>320</sup> In *Matsuyama*, the decedent, a forty-six year-old man, had made a number of generalized gastric related complaints on and off over a three to four year period.<sup>321</sup> No gastro-intestinal or endoscopic work-up was done. He was subsequently diagnosed with infiltrative gastric adenoid carcinoma, signet ring cell type, and subsequently died within two years of diagnosis.<sup>322</sup>

In asserting that the delay had resulted in her husband’s death, the claimant relied upon staging and five-year survival statistics.<sup>323</sup> The jury determined that the decedent had stage II gastric cancer at the time of the alleged negligence with a 37.5 percent chance of surviving five years, and stage IV gastric cancer at the time of diagnosis and treatment with a 0 to 5 percent chance of survival for five years.<sup>324</sup> At trial, the jury was permitted to award damages for the value of the decedent’s life and determined the statistical loss of chance to be 37.5 percent.<sup>325</sup> The court then awarded damages equating to 37.5 percent of the value of the decedent’s life.<sup>326</sup>

The issue on appeal was whether loss of chance claims were cognizable in Massachusetts and, specifically, whether they were actionable under the Massachusetts wrongful death statute.<sup>327</sup> The court held that loss of chance

316. *Kemper*, 272 S.W.3d at 152.

317. *Smith v. Parrot*, 833 A.2d at 848.

318. *Kemper v. Gordon*, 272 S.W.3d 146, 152-53 (Ky. 2008).

319. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 837 (Mass. 2008).

320. *Id.* (holding recovery for loss of chance part of wrongful death statute).

321. *Id.* at 824-26.

322. *Id.* at 826.

323. *Matsuyama*, 890 N.E.2d at 826-27.

324. *Id.* at 828.

325. *Id.* at 827-28.

326. *Id.*

327. *Matsuyama*, 890 N.E.2d at 823; see MASS. GEN. LAWS ch. 229, §2 (2009) (creating liability for death caused by negligence).

claims were actionable, and that Massachusetts was joining the majority of states that have endorsed the doctrine.<sup>328</sup> According to the court, it was doing so “to ensure that the fundamental aims and principles of our tort law remain fully applicable to the modern world of sophisticated medical diagnosis and treatment.”<sup>329</sup> It found that the traditional and longstanding rule that once a defendant’s negligence is shown to more probably than not have caused injury or death the claimant is entitled to recover 100 percent of the value of the loss, was “inadequate to advance the fundamental aims of tort law.”<sup>330</sup> For the first time in any reported case, it referred to the more probable than not burden of proof derisively as the “all or nothing standard.”<sup>331</sup>

The court recognized that there were “serious” countervailing policy reasons militating against adoption of the doctrine.<sup>332</sup> It, nonetheless, found that the benefits of recognizing loss of chance as a theory of injury outweighed such concerns.<sup>333</sup> It summarily concluded that physicians “routinely use [survival] statistics as a tool of medicine;” that “medical science has progressed to the point that physicians can gauge a patient’s chance of survival to a reasonable degree of medical certainty;” and that “[r]eliable modern techniques of gathering and analyzing medical data have made it possible for fact finders to determine based on expert testimony . . . whether a negligent failure to diagnose a disease injured a patient by preventing the disease from being treated at an earlier stage, when prospects were more favorable.”<sup>334</sup> Not only did the Massachusetts Supreme Judicial Court proclaim that survival statistics were a routine tool of medicine, but, without explanation or citation to any support, declared that “the relevant standard for gastric cancer” was the five-year survival rate.<sup>335</sup> It equated five-year and ten-year survival rates with cures and reasoned that the particular “metric” (five or ten year) was a “question on which the law must inevitably bow to some extent to the shape of the available medical evidence in each particular case.”<sup>336</sup>

The court went on to hold that loss of chance was actionable under the wrongful death statute.<sup>337</sup> Although the statute was enacted by the legislature and imposed liability on anyone who “by his negligence causes the death of a person,” the court held that loss of chance injury was “akin” to death.<sup>338</sup> It found that, despite its terms, the wrongful death statute regulated only the

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328. *Matsuyama*, 890 N.E.2d at 828-29.

329. *Id.*

330. *Id.* at 830.

331. *Id.* at 829-30.

332. *Matsuyama*, 890 N.E.2d at 831.

333. *Id.*

334. *Id.* at 832, 834.

335. *Id.* at 838.

336. *Matsuyama*, 890 N.E.2d at 838-39.

337. *Id.* at 837-38.

338. *Id.* at 837.

remedy and procedures for wrongful death actions, while the right to sue for wrongful death was one of common-law origin and thus for the court to determine.<sup>339</sup> Further, the opinion stated that “our common law of wrongful death evolves to meet changes in the evolving life of the Commonwealth”<sup>340</sup> and:

Now that medical science has developed credible methods of quantifying the extent to which the malpractice damaged the patient’s prospects for survival, and in light of the strong public policy favoring compensation for victims of medical malpractice and the deterrence of deviations from appropriate standards of care, loss of chance rightly assumes a place in our common law of wrongful death, and we so hold.<sup>341</sup>

The court concluded by limiting loss of chance to medical malpractice and finding that loss of chance “remedies the illogical and harsh results of a rule that would permit a person who had a pre-negligence chance of survival of 51 percent to recover full damages while denying all recovery to the person whose pre-negligence chance of survival was 49 percent.”<sup>342</sup> According to the court, loss of chance was particularly well-suited to medical malpractice due to the availability of statistics; the fact that negligence that harms the patient’s chances of a better outcome “contravenes the expectation at the heart of the doctor-patient relationship ‘that the physician will take every reasonable measure to obtain an optimal outcome for the patient’;” and that the shortcomings of the all or nothing rule are particularly acute as “it is not uncommon for patients to have a less than even chance of survival or achieving a better outcome when they present for diagnosis.”<sup>343</sup>

It held that any loss of chance was cognizable no matter how small and reserved until another day the issue of whether a claimant can bring such a claim where the underlying injury has not occurred.<sup>344</sup> As to the measure of damages, the *Matsuyama* court opted to adopt the proportionate method where monetary damages are calculated based on “the percentage probability by which the defendants tortious conduct diminished the likelihood of achieving some more favorable outcome.”<sup>345</sup>

Notably, in *Renzi v. Paredes*,<sup>346</sup> a companion failure to diagnose breast cancer case decided the same day as *Matsuyama*, the court held that a loss of chance claim is cognizable whether or not the statistical chances at the time of

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339. *Id.* at 838.

340. *Matsuyama*, 890 N.E.2d at 837.

341. *Id.* at 837-38.

342. *Id.* at 838.

343. *Id.* at 835.

344. *Matsuyama*, 890 N.E.2d at 835 n.33.

345. *Id.* at 839 (quoting King I, *supra* note 142, at 1382).

346. 890 N.E.2d 806 (Mass. 2008).

negligence were less than, or greater than, 50 percent.<sup>347</sup> In *Renzi*, a woman died of inflammatory breast cancer at age fifty-four.<sup>348</sup> Her husband, as administrator of her estate, brought claims against her primary care physician and a radiologist for failure to diagnose the cancer earlier.<sup>349</sup> The plaintiff settled with the primary care physician prior to trial, but the claim against the radiologist proceeded to judgment.

The claim against the radiologist was that he failed to properly interpret a routine mammogram causing a severe delay in diagnosis.<sup>350</sup> The plaintiff's causation expert opined that the delay caused the cancer to progress from either a stage IIB or IIIA to a IIIB in the seven intervening months, resulting in a 28 percent generic loss of statistical chance of survival of ten years (reduced from 58 percent to 30 percent).<sup>351</sup>

The Massachusetts Supreme Judicial Court reiterated the rule in *Matsuyama* and expanded it to cases where the chances of survival go from above 50 percent to below 50 percent. In so holding, the court stated that, to not recognize any injury for loss of chance when the chances go from above to below 50 percent, "would be arbitrary and inappropriate in light of the contemporary realities of medical practice."<sup>352</sup> The court emphatically stated that "it would defy logic, to say nothing of fairness, to absolve a physician from liability when his or her malpractice reduces a plaintiff's chances of survival from greater than even to less than even."<sup>353</sup> It likewise reiterated that loss of chance was sufficiently "akin" to wrongful death to be actionable under the wrongful death statute, but that they were sufficiently distinct in that causing a death is not the same as causing a loss of chance of survival.<sup>354</sup> It is notable that the proffer as to both the wrongful death and statistical loss of chance claim was the above to below reduction in ten-year survival.<sup>355</sup> The court upheld the jury's finding that the negligence caused a loss of chance of survival but remanded back for a new determination of damages under the formula adopted in *Matsuyama*.<sup>356</sup>

#### VIII. LOSS OF STATISTICAL CHANCE: LEGISLATIVE OR JUDICIAL POLICY DETERMINATION

The *Kemper* and *Matsuyama* decisions capture the debate over whether medical malpractice liability should be expanded to include responsibility for

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347. *Id.* at 809.

348. *Id.* at 810.

349. *Id.*

350. *Renzi*, 890 N.E.2d at 810.

351. *Id.* at 810-11.

352. *Id.* at 812.

353. *Id.*

354. *Renzi*, 890 N.E.2d. at 812.

355. *Id.*

356. *Id.*

lost chances of a better outcome, as well as the divergent views as to the appropriate role and limits to judicial power and policymaking as to physician liability. In *Kemper*, the court determined that judicial recognition of loss of chance would constitute impermissible judicial legislation and that any recognition or adoption was for the legislature. The Kentucky Supreme Court recognized its institutional limits and exercised judicial restraint over the expansion of liability. Implicit in the *Kemper* decision was the recognition that adoption of loss of chance would be like “stepping into a conceptual slippery slope” with the risk of “sliding all the way down to a system of proportional liability in all cases.”<sup>357</sup> The Massachusetts Supreme Judicial Court in *Matsuyama*, however, had no such concern, determining that judicial adoption of the loss of chance doctrine was in keeping with its right to judicially develop the common law consistent with the “evolving life of the Commonwealth.”

Neither court expressly addressed the appropriate scope of judicial policymaking. Identifying any clearly announced demarcation in either jurisdiction is, in fact, no easy endeavor. Both states’ courts generally state the basis of their purported judicial authority to determine whether to impose a new tort duty of care or to otherwise expand existing common law. In Kentucky, courts have formulated that “[t]he examination is focused to determine whether a duty is owed and consideration is given to public policy as well as statutory and common-law theories, in order to determine whether a duty existed in a particular situation.”<sup>358</sup> Moreover, Kentucky courts have stated, “if the common law is out of step with the times, this Court has the responsibility to change it”<sup>359</sup> and the principle of stare decisis “does not commit to us the sanctification of ancient fallacy.”<sup>360</sup> Massachusetts courts have, in turn, stated that duties of care under tort law are to be determined “by reference to existing social values, customs, and considerations of policy,”<sup>361</sup> as well as “changed social conditions”, “existing social values and customs,” or “the evolving life of the Commonwealth.”<sup>362</sup>

The difficulty with these formulations is not so much the existence of the power but the failure of the courts to identify any limits to the power and the sources of the “emerging social values,” or “public policy” justifying judicial

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357. Abraham, *supra* note 290, at 977.

358. T&M Jewelry, Inc. v. Hicks, 189 S.W.3d 526, 531 (Ky. 2006) (quoting Grand Aerie Fraternal Order of Eagles v. Careyhan, 169 S.W.3d 840, 849 (Ky. 2005)); see also Giulani v. Guiler, 951 S.W.2d 318, 326 (Ky. 1997) (Cooper, J., dissenting) (arguing that public policy determinations are for legislative branch and court cannot usurp such function through common-law authority).

359. Giulani v. Guiler, 951 S.W.2d 318, 319 (Ky. 1997).

360. Hilen v. Hays, 673 S.W.2d 713, 717 (Ky. 1984).

361. Luoni v. Berube, 729 N.E.2d 1108, 1110 (Mass. 2000) (setting forth that duty or liability expansion turns on existing social values, customs, and considerations of policy).

362. Coombes v. Florio, 877 N.E.2d 567, 570 (Mass. 2008); see also Cremins v. Clancy, 612 N.E.2d 1183 (Mass. 1993); Sullivan v. Boston Gas Co., 605 N.E.2d 805 (Mass. 1993) (explaining “sound principles of common law evolve out of the interaction of the infinite variety of new patterns of human activity with principles crafted in response to already experienced situations”).

expansion of existing liability. While the common law may be considered by many to be the child of the judiciary, it is not exclusively judicial. Moreover, it is constrained by its institutional limitations and by prudential concerns underlying the separation of powers.

These institutional limitations have merit as to the issue of whether to expand physician liability to include loss of statistical chances. Regarding the pertinent science and medicine as to cancer diagnosis and treatment, the *Matsuyama* court accepted as absolute truth that earlier diagnosis equates to better outcome; that “medical science has progressed to the point that physicians can gauge a patient’s chances of survival to a reasonable degree of medical certainty;” that the use of survival “statistics as a tool of medicine” is routine; and that the staging of cancer and the use of survival statistics derived there from is an appropriate basis to seek to impose liability upon a physician.<sup>363</sup> These are not absolutes and are subject to debate as matters of both science and medicine.<sup>364</sup> For seven justices to make such a broad policy statement and declaration on the state of modern medicine and societal consensus, based on the limited information presented, cuts to the core of judicial, institutional, and prudential limitations and concerns.

The *Matsuyama* court heard cryptic and generalized testimony as to staging and statistics from paid experts. There was no medical or scientific basis offered as to how anyone, including a testifying physician “expert,” could opine what stage a cancer was in at any point in the past, which is an absolute prerequisite in identifying any statistical loss, even assuming the statistics’ reliability, and applicability to the particular claimant, his or her particular cancer, and its specific biology. The court, in its steadfast determination to announce a new rule of physician liability for lost chances based on tort principles of deterrence and redress, ignored the fact that the defendant’s expert oncologist testified that it was not scientifically possible or reasonable to state what stage the cancer was at anytime prior to diagnosis, never mind seven months earlier.<sup>365</sup> The court likewise never addressed the contention that the proffered statistics were not shown to pertain to the decedent’s signet ring cell biology type of gastric cancer. There was no general garnering of data and testimony as to “the modern status of medicine,” defensive medicine, cancer prognosis, staging and survival statistics, or whether they should constitute an appropriate basis to impose liability and award damages. There was no testimony or study of the sources of these statistics, their reliability, and whether they can ever be an appropriate basis to impose liability as to a particular case or person. The fact there is substantial authority that five-year survival statistics are “the world’s most misleading statistics”<sup>366</sup> required, at

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363. *Matsuyama v. Birnbaum*, 890 N.E. 2d 819, 834 (Mass. 2008).

364. See *supra* notes 278-79 and accompanying text (discussing staging and statistics).

365. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 827 (Mass. 2008).

366. See WELCH, *supra* note 256, at 126.

least, pause from the court before drastically changing the Massachusetts standard.

The Massachusetts court was unfazed by the well-recognized biases in survival statistics, stating that it would be for a trial court, in any particular case, to ensure their reliability.<sup>367</sup> This ignores the fact that these biases reflect the tremendous unknowns and biological natural history of cancer and that “earlier is better” is not universally true. Not only must the jury evaluate standards of medical practice, but now they must also sort through and appraise statistical data amidst the complexity and uncertainty of cancer prognosis. Moreover, how does one determine and apply statistics when the person is alive at the time of trial, is in remission, or in any other type of loss of chance claim when the ultimate harm has not occurred? Under the Massachusetts Supreme Judicial Court’s reasoning, loss of chance is separate and distinct from the ultimate harm.<sup>368</sup> If this is so, then it does not matter if the ultimate outcome occurs, so long as at the time of negligence there was “a chance.”<sup>369</sup>

To award damages, or to statistically quantify any “loss of chance,” under such circumstances seems highly questionable. If the ultimate outcome has not occurred, how has the claimant lost a chance of avoiding that outcome? Conversely, if loss of chance is the true injury, then it should not matter whether the outcome happens or not. The *Matsuyama* court avoided the issue by referencing, in a footnote, that it was leaving that issue undecided.<sup>370</sup> The main concern with this unsettled principle is that the judicial development of common law should be coherent and principled.<sup>371</sup> “The basis on which one case . . . is distinguished from another should be transparent and capable of identification.”<sup>372</sup> Allowing recovery for loss of chance where the ultimate harm has occurred but not when the ultimate harm has not or allowing it in both circumstances is neither coherent nor principled. Similarly, limiting loss of chance to the medical profession, or not otherwise allowing physicians to reduce their damage exposure by the same proportionality approach, is equally unprincipled.<sup>373</sup> It is the piecemeal adjudication of such intricate social issues based on perceived injustices that erodes coherence in the law and invites the

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367. *Matsuyama*, 890 N.E.2d at 834.

368. *Renzi v. Paredes*, 890 N.E.2d 806, 813 (Mass. 2008) (explaining jury awards for wrongful death and loss of chance are distinct).

369. *See Fennell v. Southern Md. Hosp. Ctr. Inc.*, 580 A.2d 206, 213 (Md. 1990) (“[I]f courts are going to allow damages solely for the loss of chance of survival, logically there ought to be recovery for loss of chance regardless of whether the patient succumbs to the unrelated pre-existing medical problem or miraculously recovers despite the negligence and unfavorable odds.”).

370. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 835 n.33 (Mass. 2008).

371. *Fairchild v. Glenhaven Funeral Servs., Ltd.*, [2002] 1 A.C. 32, 36 (U.K.) (Lord Nicholls of Birkenhead, concurring).

372. *Id.*

373. *See Gett v. Tabet* [2009] NSWCA 76 (adopting loss of chance on grounds it avoids potential injustice of all or nothing rule not compelling as it would apply beyond medical malpractice).

reproach that “hard cases make bad law.”<sup>374</sup>

The *Matsuyama* Court did not acknowledge, —nor did they have the ability and means to conduct research, learn about or collect relevant data on, —the potential impact such an expansion of liability may have on healthcare costs or the practice of medicine. The legislative process would, at least, allow reasonable assessment and discourse as to whether such an expansion of liability would encourage the practice of defensive medicine; would otherwise constitute an impediment to medical practice and physician judgment; or would significantly impact costs associated with medical care and insurance, including universal healthcare. Moreover, given the number of care providers practicing in Massachusetts, and the importance of healthcare and the education of healthcare providers in Massachusetts, the legislative process is arguably a better and more inclusive forum in which to address and resolve such an important issue.<sup>375</sup>

Aside from the institutional limitations, the “public policy” or “changing needs” rubric in determining whether to expand or not expand existing liability can be a troublesome standard. The judicial “public policies” are not well identified and can be selective. For example: What “public policy,” “social mores,” or “community attitudes” should courts consider? As to the “evolving life of the Commonwealth” or “changing needs” referenced by the *Matsuyama* court: whose evolving life? Certainly not the tens of thousands of medical providers living and practicing in Massachusetts. Can it be truly said that the more probable than not standard has become “intolerable” in medical malpractice actions, or conversely, that there is a true societal consensus that loss of statistical chances must be compensated either as a matter of science or social thought? Is there a true consensus that earlier diagnosis means better outcome to the extent that a judicially created rule expanding liability is to be adopted and applicable to all medical malpractice cases?

Even if the legislature has not addressed the precise issue, this does not mean that policy reflected in other enactments is not influential.<sup>376</sup> The legislature is no stranger to the common law,<sup>377</sup> and is a significant public policy source in any common-law analysis, regardless of any enactment directly on point.<sup>378</sup> For instance, the Massachusetts Legislature has made general efforts to control malpractice actions and insurance premiums. It has enacted statutes of repose, mandated tribunal screening, carved out an

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374. *Gregg v. Scott* [2005] 2 A.C. 176, 198 (H.L.) (U.K.).

375. *See, e.g., “Joslyn v. Chang*, 837 N.E.2d 1107, 1112-13 (Mass. 2005) (requiring deference to legislature amid debate over concerns over rising medical malpractice insurance); *Goodridge v. Dept. of Pub. Health*, 789 N.E.2d 941, 1004 (Mass. 2003) (Cordy, J., dissenting) (“[S]o long as the question is at all debatable, it must be the Legislature that decides.”)

376. *See generally Gett v. Tabet* [2009] NSWCA 76 (noting definition of harm for purposes of tort reform across Australia does not include a risk of physical or mental injury).

377. *See Stone, supra* note 55, at 12-16.

378. *See supra* notes 27-35 and accompanying text (discussing legislation as public policy source).

exception to the collateral source rule for medical malpractice claims, and limited certain damages, all in a concerted effort to control insurance and litigation costs.<sup>379</sup> It is significant that the legislature opted not to adopt a pure comparative negligence statute.<sup>380</sup> If a plaintiff's contributory negligence is greater than the defendant's, recovery is not proportional but barred.<sup>381</sup> The decision not to adopt a pure comparative negligence statute and instead cutting off all liability where a claimant is 51 percent negligent, reflects the legislature's policy choice that the 50 percent demarcation is significant and does strike the proper balance as to the imposition of liability. Allowing recovery for a "loss of chance" under a proportional damage approach, regardless of this demarcation, is fundamentally at odds with this legislative effort. Moreover, there is no principled reason not to apply it "across the board" and allow recovery in proportion to the physician's negligence whether above or below 50 percent.<sup>382</sup>

The court in *Matsuyama* too easily dispatched the exclusive language and policy of the wrongful death statute.<sup>383</sup> Despite any questions about whether the right to sue for wrongful death is of common-law origin or a statutory right in abrogation of the common law, the reality is that legislative control over wrongful death has been present in Massachusetts for over a century. The statute and its legislative progression over time represents substantial policy choices by the elected legislature, such as establishing recovery under the statute was for "death," setting forth who, when, and how such suits can be brought, and for what damages. Prior to *Matsuyama*, the high court had repeatedly conceded that arguments concerning the propriety of the public policy surrounding the wrongful death statute are "best left for the Legislature,"<sup>384</sup> and that the court has "no right to conject what the Legislature would have enacted if they had foreseen the occurrence of a case like this."<sup>385</sup>

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379. See MASS. GEN. LAWS ch. 231, § 60C (1976); MASS. GEN. LAWS ch. 231, § 60B (2006); MASS. GEN. LAWS ch. 231, § 60F (1986) MASS. GEN. LAWS ch. 231, § 60H (1986).

380. See MASS. GEN. LAWS ch. 231, § 85 (1973).

381. *Id.*

382. See generally Lori R. Ellis, *Loss of Chance Technique: Toeing the Line at Fifty Percent*, 72 TEX. L. REV. 369 (1993); King I, *supra* note 142, at 1386; Kieffer, *supra* note 294. But see *Boone v. William Backus Hosp.*, 864 A.2d 1, 18 (Conn. 2005) (holding loss of chance claim only available where claimant had at least 51 percent chance of survival prior to negligence).

383. See *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 835-35 (Mass. 2008); see also MASS. GEN. LAWS ch. 229, §2 (2009).

384. *Schultz v. Grojean*, 548 N.E.2d 180, 182 (Mass. 1990); *United States v. Cumberbatch*, 647 A.2d 1098, 1104 (Del. 1994) (holding loss of chance not cognizable under state wrongful death statute); *Joshi v. Providence Health Sys. of Or. Corp.*, 149 P.3d 1164, 1170 (Or. 2006) (holding same as to Oregon wrongful death statute); *McMackin v. Johnson County Healthcare Ctr.*, 88 P. 3d 491 (Wyo. 2004) (holding loss of chance is actionable under Wyoming wrongful death statute).

385. *King v. Viscoloid Co.*, 106 N.E. 988, 989 (Mass. 1914); see *Cato v. Craighead Circuit Ct.*, No. 09-4, 2009 WL1564462, at \*13 (Ark. June 4, 2009) (holding "matters of public policy are the purview of the legislature" and "resolution of the question of policy is addressed in a democracy to the policymaking branch of the government . . . it is not for the courts to make a statute to say something it does not").

The legislative requirement that the negligence actually cause death was deserving of consideration given the legislature's longstanding and preemptive status as to any preexisting common-law authority as to the "right" for wrongful death.<sup>386</sup> The holding that "loss of chance" was a new compensable injury, separate and distinct from death, but yet "akin" to death for purposes of the statute, was a judicial attempt to force a square peg into a round hole. By definition, loss of a less than probable *chance* of living a certain amount of years is not death and is not "akin" to death. Further, even accepting the Massachusetts Supreme Judicial Court's view that the right to recover for wrongful death was solely the province of the common law unaffected by the statute's express language of "negligence that causes death," the court should not have ignored the statutory provisions identifying who may sue for wrongful death and the recoverable damages. Indeed, under the wrongful death scheme adopted by the Legislature, it is the loss of the value of the decedent to the specific statutory beneficiaries that is recoverable, not the loss of life or enjoyment of life suffered by the decedent.<sup>387</sup> The loss of chance damage or injury is not set forth in the statute and is not an injury or damage suffered by the statutory beneficiaries. That the *Matsuyama* Court opted to place a monetary value on the loss of chance by awarding 37.5 percent of total death damages did not save it from the statute's mandatory remedial requirements or its purpose. An award of a statistical percentage of death damages to the statutory beneficiaries is not an injury that was either death or a legislatively designated damage suffered by the statutory beneficiaries.

Even more broadly, the Massachusetts Supreme Judicial Court previously held that the separation of powers "recognizes the inability and the undesirability of the judiciary substituting its notions of a correct policy for that of a properly elected Legislature."<sup>388</sup> Nonetheless, the *Matsuyama* Court held recovery for the loss of a statistical chance of a better outcome—specifically an asserted loss of a raw statistical 37.5 percent chance of surviving five years—was "akin" to death and thus encompassed by the "death" statute. The judicially created demarcation between right and remedy for wrongful death in Massachusetts was compromised, as: loss of chance was not an item of damage or loss set forth in the statute; loss of chance is not a loss suffered by the statutory beneficiaries; and the award of 37.5 percent of total death damages for a 37.5 percent chance of surviving five years is simply mathematically incorrect.<sup>389</sup>

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386. See, e.g., *Justus v. Atchinson*, 568 P.2d 122, 127-28 (Cal. 1977) (recognizing intent of legislature in adopting wrongful death statute was to preempt common law).

387. MASS. GEN. LAWS ch. 229, § 2 (2009).

388. *Joselyn v. Chang*, 837 N.E.2d 1107, 1113 (Mass. 2005); see also *Schultz v. Grojean*, 548 N.E.2d 180, 182 (Mass. 1990) (arguing propriety of public policy surrounding wrongful death statute best left to the legislature).

389. Arguably, a 37.5 percent loss of chance of living five years is not rationally related to awarding 37.5 percent of the total death damages. Under this view, any proportional computation would at least require

The court's reference to either five-year or ten-year survival as a "metric," and, for purposes of wrongful death, equivalent to cure, is problematic. In fact, the court equated five-year survival with cure when the evidence presented never equated five-year survivability as to Stage II gastric cancer with cure. The court seriously miscited and misunderstood the limited testimony from decedent's treating oncologist.<sup>390</sup> It is one thing for the court to conclude the evidence in a particular case was sufficient for a jury to find equivalency to cure, it is quite another to announce (based on *one* physician out of three that testified) an unqualified principle that survival statistics are a "metric" equivalent to cure for purposes of wrongful death. Survival rates are not cure rates. The time intervals represent only those reported periods for which the patients in the study were followed. For instance, people diagnosed with breast cancer continue to die five, ten, even twenty years after diagnosis and treatment.<sup>391</sup> The *Matsuyama* court further compromised its own reasoning by stating that its adoption of proportional damages based on statistical reduction found by the jury was in keeping with the wrongful death statute's dictate that

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determination of what percentage of the claimant's life expectancy the five-year period represented. *See Borgren v. United States*, 716 F. Supp. 1378, 1382 (D. Kan. 1989) (calculating expected life span when awarding loss of chance damages). *But see* Lars Noah, *An Inventory of Mathematical Blunders in Applying the Loss of Chance Doctrine*, 24 REV. LITIG. 369 (2005) (contending that loss of chance valuation should be based on "attributable risk.") For instance, according to Noah, if a loss of survival went from 85 percent to 65 percent then the negligence increased the risk of dying from 15 percent to 35 percent. *Id.* at 382. This equates to a "relative risk" of 2.33 (.35/.15) or an "attributable risk" of more than 57 percent (.35-.15/.35). *Id.* The centerpiece of this approach is to view the statistical loss not as chances of survival but as risk of mortality. In the above example, the 57 percent attributable risk would meet the traditional causation standard. *Id.*

390. The *Matsuyama* court quoted a portion of the treating oncologist's testimony as follows:

"[t]he metric in cancer is at five years, what fraction, what percentage are alive . . . [I]f they're alive in five years, we typically say that they're cured or that the cancer is unlikely to come back."

*Matsuyama v. Birnbaum*, 890 N.E.2d 819, 827 n.16, (Mass. 2008).

Based on this description, the court held that there was sufficient evidence for the jury to find that the five-year statistics equated to cure and that the decedent lost the "probability of a cure" thereby justifying an award of death damages. This was a highly questionable citation. The omitted testimony from the above quotation is telling in that as to "cure" he was testifying about Stage I gastric cancer, the earliest form of gastric cancer, not decedent's Stage II. The *complete* portion of the testimony was as follows, with the pertinent part of the omitted portion highlighted:

Well, certainly longer survival, but the other issue is the metric in cancer at five years, what fraction, what percentage are alive. *For a patient with Stage I*, there are patients who are still alive, but five years in general, if they're alive in five years, we typically say they're cured or that the cancer is unlikely to come back.

Trial Transcript, July 27, 2004 (Day 2) at 52 (on file with author) (emphasis added).

The complete testimony makes clear that only the five-year statistics of Stage I had any relation to cure or avoiding death. Indeed, decedent's own expert never testified that the five-year survival statistics he proffered as to Stage II were related to cure.

391. *See Breast Cancer: Statistics on Incidence, Survival, and Screening*, IMAGINIS, Jan. 23, 2008, <http://www.imaginis.com/breasthealth/statistics.asp>.

damages were to be awarded based on the degree of the defendant's culpability.<sup>392</sup> This reference is odd in that the damages based on degree of fault aspect of the wrongful death statute had long been repealed by the legislature.<sup>393</sup>

The *Kemper* and *Matsuyama* decisions depict the nebulous and seemingly selective nature of the judicial "public policy," "changing needs," "evolving life" rubric. In *Kemper*, the policies and interests noted were: the drastic expansion of liability upon a vitally important segment of society; the rapidly changing state of medical science and technology amid a profession that, in the end, requires human judgment; the difficulties in reformulating tort injury to include lost chances; the likelihood of increased litigation; and the potential to significantly impact the costs of healthcare including universal healthcare.

The *Matsuyama* court, on the other hand, noted no such policies or interests. Instead, it relied upon: tort law concepts of deterring wrongful conduct and compensating victims for harms caused by that conduct; the court's belief that the ability to determine lost chances was well established and accepted in medical science, with any particular reliability issues to be addressed by the court in a given case; that no matter how small the asserted lost chance it was worthy of compensation; and that the more probable than not standard was an unfair "all or nothing" rule, requiring amelioration in medical malpractice actions. The tort principles of deterrence and compensation are nowhere to be found in *Kemper*, while the policies of judicial restraint and the potential impact on medical practice and costs are nowhere to be found in *Matsuyama*.

The selective nature of the public policy rubric is also demonstrated by the fact that the Massachusetts Supreme Judicial Court, only one year prior to its decision in *Matsuyama*, and again under the auspices of its power to expand liability of physicians based on "public policy," could not agree as to whether, and under what standard, a physician is liable to a third party injured by the patient's physician due to an alleged failure to warn about the side effects of medicine.<sup>394</sup> Certain judges noted that the "public policy" in determining whether or not to expand liability requires consideration of whether such expansion would increase litigation and/or increase the costs of healthcare.<sup>395</sup> Indeed, Chief Justice Marshall, who authored the *Matsuyama* opinion, — emphatically stated in *Coombes v. Florio*: "One need not be clairvoyant to

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392. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 838 (Mass. 2008) (setting forth "the development of our law of wrongful death to encompass loss of chance of survival is entirely consistent with this courts holding in *Gaudette* that the wrongful death statute will be viewed in part as requiring that damages recoverable for wrongful death be based upon the degree of the defendant's culpability").

393. See *Guy v. Johnson*, 448 N.E.2d 1142, 1143 (Mass. App. Ct. 1983) (noting "since the coming of a basic statutory reform in 1973 . . . the damages for wrongful death are no longer expressed in terms of the degree of culpability of the tortfeasor, but rather as the fair value of the decedent to those entitled to recover").

394. *Coombes v. Florio*, 877 N.E.2d 567 (Mass. 2007) (concurring in judgment, but failing to agree upon standard for physician liability to third parties).

395. *Id.* at 587 (Cordy, J., dissenting).

understand the inevitable result of today's enlargement of liability: significant increase in third-party litigation against doctors and an attendant increase in expenses at a time when our health care system is already overwhelmed with collateral costs."<sup>396</sup> She, however, makes no mention of such a concern in *Matsuyama* when such policy concerns were equally applicable.

Similarly, to justify its holding by reference that it was joining the "majority" is selective. The difference between the number of courts which have adopted the doctrine and those who have not is not large—eighteen to thirteen—not including the states that have limited or abrogated the doctrine by statute. This is not compelling authority that the more probable than not standard is obsolete and intolerable in light of modern times. This is not evidence of a true consensus or an "intolerable" rule that is "no more than a remnant of abandoned doctrine."<sup>397</sup> Given the reasonable debate, judicial restraint is warranted.

The Massachusetts Supreme Judicial Court made no mention of the *Kemper* decision decided just a month before *Matsuyama*, nor did it reference a Nebraska Supreme Court decision rendered two months previously, which reaffirmed that Nebraska does not recognize loss of chance as to medical malpractice actions.<sup>398</sup> The selective nature of the "majority" rationale is further demonstrated by the facts that (1) the Massachusetts rule that the wrongful death statute only governs the remedy, not the right, as to wrongful death is a minority position, and (2) the Court has, in other cases, stated that any trend in other state courts is not determinative on whether to adopt a new rule of liability.<sup>399</sup>

To be sure, a *Matsuyama* type court would view the *Kemper* court's approach as a shirking of its judicial obligation to develop the common law, which includes deciding important cases, regardless of policy implications. The *Matsuyama* court would likely sour at the suggestion of legislative deference as to a common-law issue, stating that it is the obligation of the judiciary to develop the common law, and to keep the common law in step with changing conditions of society; that it is the responsibility of the court to balance competing interests and allocate losses arising out of human activities; and that it is for the legislature to initiate tort reform. As to lost chances, it was a logical incremental step for the common law to make, given the compensatory and deterrence goals of tort law; the uncertainty in outcome created by the physician's negligence; and the "unfairness" of the "all or nothing" burden of proof. As for the larger question about the appropriate role

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396. *Id.* at 583 (Marshall, C.J., dissenting).

397. *Planned Parenthood of Se. Pa v. Casey*, 505 U.S. 833, 854-55 (1992).

398. *Rankin v. Stetson*, 749 N.W.2d 460, 469 (Neb. 2008) (citing *Steineke v. Share Health Plan of Neb.*, 518 N.W.2d 904 (Neb. 1994)).

399. *See Diaz v. Eli Lilly Co.*, 302 N.E.2d 555, 561 (Mass. 1972) (noting trend of other state court decisions on issue but decision not reached by "following the crowd.").

of the judiciary, it would undoubtedly remind its critics that “[a]ll law is policy. Every application of law is an implementation of policy.”<sup>400</sup> For a *Matsuyama* type court, whatever shortcomings the judiciary has in this regard, it is just as good as the legislature and, even if not, the legislature can overturn the decision through legislation or tort reform. In the end, according to such a court, the “felt necessities of the time” mandate judicial recognition of lost chances as compensable harm for physician negligence.

A *Kemper* type court, in turn, would respond that the common law is not a boundless judicial hallowed ground and must be subject to principles of restraint; that the legislative branch is the elected public policy making arm of the government; and that courts are institutionally deficient in making far-reaching policy decisions. As to lost chances, it would be concerned with jettisoning the more probable than not standard under the auspices of being “all or nothing” when it represents a minimum, bedrock standard demarcating between possibilities and probabilities. “What we lack is knowledge and the law deals with that lack of knowledge by the concept of the burden of proof.”<sup>401</sup>

A *Kemper* court would be concerned with its ability to broadly expand liability based on assumptions of the modern state of “medical science” and advances presented within the limited confines of a medical malpractice action between discreet litigants and the lack of true societal consensus on the issue. It would note and discuss the complexities and uncertainties of cancer based on the present state of modern medicine and ask whether the court truly has sufficient knowledge, information, and resources to fully and fairly decide such an issue. Further, such a court would ask about the impact such an expansion might have on the practice and cost of medicine and the modern debate over healthcare.

As to the larger question about the appropriate role of the judiciary, a *Kemper* court would likely note the robust legislative presence in the area of healthcare and wrongful death, and recognize that courts cannot legitimately usurp the legislative’s policy function through the auspices of the common law. It would certainly note that the decision to expand physician liability for an entirely new class of plaintiffs and jettisoning full damages for negligently caused outcomes in lieu of proportionate damage for lost chances is one of pure policy. It would likely add that physician liability for lost chances, amidst significant debate and lack of consensus as to the true efficacy of the medical science at issue, is likewise a decision of policy, given the competing values. It would respond to its critics that the judiciary must, at times, exercise restraint in the first instance especially where the liability expansion question is encased with vigorous social and policy debate with far-reaching consequences and

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400. Richard S. Kay, *Judicial Policy Making and the Peculiar Function of the Law*, 40 CONN. L. REV. 1261, 1264 (2008).

401. *Gregg v. Scott*, [2005] 2 A.C. 176, 196 (H.L.) (U.K.).

where liability expansion is being sought upon a large and vital segment of society.

#### IX. CONCLUSION

*It is a far, far better thing I do, than I have ever done; it is a far, far better rest that I go to, than I have ever known.*

Charles Dickens, *A Tale of Two Cities*

The imposition of common-law liability upon physicians for loss of statistical chances has steadily been accepted even though it marks a drastic expansion and reformulation of liability. The allowance of recovery for loss of statistical chances, no matter how small or remote the loss, has significantly transformed physician tort liability, from liability for more probable than not actual outcomes to compensation for lost chances and possibilities. The law has moved from harm based to risk based.

It remains to be seen whether the trend toward adoption of this doctrine will continue. It may be that the notion of judicial restraint is the exception rather than the rule, and that recognition of liability for lost chances is the inevitable destiny of modern tort law. Legislative efforts to respond to the adoption of the doctrine have been mixed, invoked only after judicial adoption. Yet, one may be reasonably concerned with courts declaring the status of “modern science and medicine” and then broadly declaring a new liability and injury upon a single segment of society within the limited confines of a single malpractice suit. In the end, the *Matsuyama* and *Kemper* decisions tell a “tale of two cities” and exemplify the longstanding debate over the limits to judicial policymaking. They reveal that this entrenched debate is not limited to constitutional issues, but permeates the trodden ground of the common law, and otherwise demonstrates the profound power of common-law courts to shape physician liability through declarations of “public policy” and the “felt necessities of the time.”

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