

**Whose Loss Is It Anyway? Effects of the “Lost-Chance”
 Doctrine on Civil Litigation and Medical Malpractice
 Insurance***

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INTRODUCTION

The provision and financing of medical care in the United States has been a controversial topic of debate for decades, the intensity of

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which has escalated recently. On Capitol Hill and elsewhere throughout the country, congressional representatives and their constituents are seeking answers to various difficult policy questions: Is medical care a right or a privilege? Is it the government's responsibility to provide medical care to all of its citizens? How necessary is the concept of patient choice in implementing comprehensive changes to our current system? Ultimately, these issues all come down to money: Who is going to pay for any changes once implemented, and—perhaps more importantly—why are we paying so much for our current system?

A frequently identified cause of our medical care system's rising costs is the need for doctors to charge their patients progressively more money in order to keep up with their own increasing operating costs, among which are the costs of obtaining malpractice insurance.¹ This cause-and-effect relationship is illustrated by Doug Hiller, M.D., who was elected as president of the Hawaii Medical Association in early 2008.² As an orthopedic surgeon who had been practicing in Hawaii for nearly twenty years, Hiller experienced the crunch between rising medical malpractice insurance premiums and stagnant wages.³ Malpractice insurance premiums for orthopedic surgeons cost about \$44,000 per year, while the annual salary for such a surgeon in Hawaii is typically between \$100,000 and \$150,000.⁴ Instead of accepting the presidency and continuing to practice in Hawaii, Dr. Hiller decided to move to Wyoming.⁵ In a sense of exasperation, Dr. Hiller commented on the situation in an interview: “‘I work harder and harder every year and make the same amount of money every year.’”⁶ He noted, “‘I’ve been practicing medicine in the islands for

1. See, e.g., U.S. GEN. ACCOUNTING OFFICE, MEDICAL LIABILITY: IMPACT ON HOSPITAL AND PHYSICIAN COSTS EXTENDS BEYOND INSURANCE, REPORT TO THE CHAIRMAN, COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES 1 (1995) (“[H]ospitals and physicians incur and pass on to consumers additional expenses that directly or indirectly relate to medical liability.”); see also Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care* 3 (Nat’l Bureau of Econ. Research, Working Paper No. 10709, 2004) (“[T]he expected payouts [for medical malpractice claims] faced by insurers are likely to have a first-order effect on malpractice premiums.”).

2. *Malpractice Insurance Costs Behind Hawaii Doctor Shortage*, INS. J., Oct. 6, 2008, available at <http://www.insurancejournal.com/news/west/2008/10/06/94339.htm>.

3. Rebecca Vesely, *Deserting Island: Orthopedic Surgeons Leave Hawaii Practices*, MODERN PHYSICIAN, Oct. 20, 2008, available at <http://www.modernphysician.com/article/20081020/modernphysician/310199995/-1/mparchives2008> (on file with the North Carolina Law Review).

4. *Id.*

5. *Malpractice Insurance Costs Behind Hawaii Doctor Shortage*, *supra* note 2.

6. Vesely, *supra* note 3.

20 years and I feel horrible, absolutely horrible about leaving my patients, my friends and my home.’”⁷ But, as he went on to acknowledge, “[a]t some point, your income and costs hit a crossroads. I’m there now. I would love to stay here, but I can’t.”⁸

As Dr. Hiller’s comments suggest, beneath the surface of any discussion concerning medical malpractice insurance simmers the source of its need in the first place—the medical malpractice lawsuit. Intuitively, the amount of money that doctors must pay for medical malpractice insurance is related to the number of medical malpractice lawsuits filed against them.⁹ To those who argue that reforming our tort system is a necessary first step in controlling medical care costs, curbing the proliferation of medical malpractice lawsuits frequently serves as a visceral rallying point for their cause.¹⁰ In the eyes of tort-

7. *Malpractice Insurance Costs Behind Hawaii Doctor Shortage*, *supra* note 2.

8. *Id.*; *cf. Pa. Doctors Drop Boycott Threat*, CNN.COM, Jan. 1, 2003, <http://archives.cnn.com/2002/HEALTH/12/31/medical.malpractice/index.html> (“Doctors in eastern Pennsylvania who were threatening to walk off the job Wednesday because of high malpractice costs will work as usual, thanks to a \$220 million bailout proposal”); *W. Va. Doctors Strike Over Insurance Costs*, CNN.COM, Jan. 1, 2003, <http://www.cnn.com/2003/HEALTH/01/01/medical.malpractice/index.html> (“At least 39 surgeons walked off the job at four hospitals in West Virginia on Wednesday to protest rising medical malpractice insurance costs, officials said.”).

9. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, REPORT TO CONGRESSIONAL REQUESTERS 4 (2003) [hereinafter GAO], available at <http://www.gao.gov/new.items/d03702.pdf> (finding that losses resulting from amounts paid to satisfy malpractice claims are the “greatest contributor” to rising malpractice insurance rates); *cf. Daniel Eisenberg & Maggie Sieger, The Doctor Won’t See You Now*, TIME, June 9, 2003, at 46, 49 (indicating that malpractice insurers, “worried by a rise in malpractice awards by juries,” have stopped doing business in Illinois). Additionally, certain doctors believe that, with regard to increasing malpractice premium rates, “the main problems are frivolous lawsuits and multimillion-dollar judgments.” *Id.* at 50. In spite of this natural, common-sense understanding that malpractice insurers increase premium rates solely to cover increases in malpractice lawsuits (in terms of dollars or number of lawsuits being filed), substantial evidence exists to the contrary. *See infra* Part III.B for a discussion of other factors playing a role in the increase of malpractice insurance rates.

10. *See, e.g.*, Philip K. Howard, *Why Medical Malpractice Is off Limits*, WALL ST. J., Sept. 29, 2009, at A25 (“[A] reliable medical malpractice system that patients, doctors and the general public can trust . . . is the one reform Washington will not seriously consider. That’s because the trial lawyers, among the largest contributors to the Democratic Party, thrive on the unreliable justice system we have now.”); Charles Krauthammer, Editorial, *Health-Care Reform: A Better Plan*, WASH. POST, Aug. 7, 2009, at A21 (expressing the opinion that a first step toward reforming health care would be to prevent “lay juries [from] giving away lottery prizes at the behest of the liquid-tongued John Edwardes who pocket a third of the proceeds” from the damages awarded to the plaintiff). Tort-reform efforts may indeed help to reduce health care costs. *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Orrin G. Hatch, Senator, U.S. Senate (Oct. 9, 2009), available at http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf

reform proponents, any new rule or legal cause of action that may lead to expanded liability for doctors represents a step in the wrong direction in terms of fixing the country's medical care system.¹¹

One such rule is the "lost-chance" doctrine, which has been described as "the most pernicious example of a new tort action resulting in expanded liability."¹² The lost-chance doctrine—a cause of action unique to medical malpractice litigation—permits a patient-turned-plaintiff to recover damages from a doctor-turned-defendant without even needing to establish that the doctor was probably (i.e., more likely than not) responsible for the patient's alleged injury.¹³ At first glance, the lost-chance doctrine may indeed seem to create an expanded risk of liability for those in the medical profession and, accordingly, may seem to hinder medical care cost-control efforts.¹⁴

Even beyond the perceived effect on medical care costs, the lost-chance doctrine seemingly thwarts our civil litigation system's presumption that a defendant should not be held liable unless the plaintiff demonstrates that the defendant *more likely than not* caused

(indicating that adoption of certain tort-reform proposals could potentially reduce health care spending by \$11 billion). However, costs associated with medical malpractice represent only a fraction of total health care expenditures. *See id.* (estimating that costs related to medical malpractice account for two percent of total health care expenditures); *see also* Dionne Searcey & Jacob Goldstein, *Tangible and Unseen Health-Care Costs: Spending by Doctors Extends Beyond Insurance as Many Take Steps to Protect Themselves; Patients' Wishes Push up Bills, Too*, WALL ST. J., Sept. 3, 2009, at A13 (estimating that medical malpractice-related costs account for slightly over one percent of total health care costs). While an opportunity to cut billions of dollars in costs should certainly not be taken lightly, implementing tort-reform efforts is by no means a cure-all for fixing our health care system. Searcey & Goldstein, *supra* (estimating that medical malpractice-related spending in 2007 was \$30 billion, whereas overall health care-related spending totaled \$2.2 trillion).

11. *See, e.g.*, Krauthammer, *supra* note 10 (proposing, as a first step toward reforming health care, to "abolish the entire medical-malpractice system"); *cf.* Larry Weiss, *Tort Reform: Our Permanent Issue*, COMMON SENSE (Am. Acad. of Emergency Med., Milwaukee, Wis.), July/Aug. 2008, at 1, 4, *available at* <http://www.aem.org/commonsense/commonsense0708.pdf>.

12. Weiss, *supra* note 11, at 4. In addition to the terminology of "lost-chance" referred to by Dr. Weiss, courts, legislatures, and the media also refer to the doctrine as "loss of a chance," "loss of chance," or "lost opportunity." While these phrases all refer to the same concept, this Comment refers to the doctrine as "lost-chance" for the sake of consistency.

13. *Id.* at 4 ("Here, a plaintiff only has to prove loss of a chance of a better outcome.").

14. *See* Lisa Perrochet, Sandra J. Smith & Ugo Colella, *Lost Chance Recovery and the Folly of Expanding Medical Malpractice Liability*, 27 TORT & INS. L.J. 615, 625 (1992) ("Public policy considerations caution against relaxing standards of causation or recognizing the deprivation of a chance as a compensable injury. This is because lost chance liability exacerbates the problem of defensive medicine in the current climate of attempts at cost containment.").

the plaintiff's injury.¹⁵ To hold a defendant liable in any other instance, opponents of the doctrine argue, is to "undercut the truth-seeking function of the courts."¹⁶ The question that naturally arises, then, is if the lost-chance doctrine is indeed so "pernicious" and runs counter to the "truth-seeking function" of our civil litigation system, what purpose does the doctrine actually serve?

The lost-chance doctrine's potential role in medical malpractice litigation is illustrated by the plight of Allen Lord. Upon experiencing blurred vision, Mr. Lord scheduled an appointment with his ophthalmologist, who sent Mr. Lord to get an MRI.¹⁷ The radiologist who read Mr. Lord's MRI found no abnormalities or irregularities that could account for Mr. Lord's symptoms.¹⁸ Despite this good news, Mr. Lord's vision continued to deteriorate rapidly over the next few days, at which point Mr. Lord's ophthalmologist sent him to see a specialist in neuro-ophthalmology.¹⁹ The specialist did not examine him. Instead, two residents conducted the examination and noted that Mr. Lord's previous MRI seemed normal to them.²⁰ One week later, when the specialist finally looked at Mr. Lord's MRI, he immediately was able to diagnose Mr. Lord with a debilitating ocular disease.²¹ Once diagnosed, Mr. Lord began treatment, but he ultimately suffered substantial loss of vision.²²

Mr. Lord filed a malpractice suit against the doctors who misread his MRI and, allegedly, caused his loss of vision by their delay in diagnosis.²³ He filed suit in North Carolina, a state that has neither acknowledged nor disavowed the lost-chance doctrine.²⁴ In spite of the highly suggestive chain of events, Mr. Lord's case was dismissed because he was only able to produce evidence that it was "possible," but not probable, that the delay in diagnosis cost him his vision.²⁵

15. See, e.g., *Cooper v. Sisters of Charity, Inc.*, 272 N.E.2d 97, 103 (Ohio 1971) ("Traditional proximate cause standards require that the trier of the facts, at a minimum, must be provided with evidence that a result was more likely than not to have been caused by an act . . ."); RESTATEMENT (SECOND) OF TORTS: BURDEN OF PROOF § 433B cmt. A (1965) ("[I]n civil cases, the plaintiff . . . must make it appear that it is more likely than not that the conduct of the defendant was a substantial factor in bringing about the harm.").

16. Tory A. Weigand, *Loss of Chance in Medical Malpractice: A Look at Recent Developments*, 70 DEF. COUNS. J. 301, 311 (2003).

17. *Lord v. Beerman*, 191 N.C. App. 290, 291, 664 S.E.2d 331, 333 (2008).

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.* at 292, 664 S.E.2d at 333.

22. *Id.*

23. *Id.* at 292, 664 S.E.2d at 333–34.

24. See *infra* note 58 and accompanying text.

25. *Lord*, 191 N.C. App. at 300, 664 S.E.2d at 338.

While the record in Mr. Lord's case did not develop fully enough to determine whether his claim might have been cognizable under the lost-chance doctrine, his situation is indicative of those in which the doctrine may be applicable. Instead, Mr. Lord has lost most of his vision, and the doctors who misread his MRI presumably continue to practice without being held accountable for their inaction.²⁶

Both Mr. Lord's plight and Dr. Hiller's dilemma are representative of the competing policy considerations inherent in the lost-chance doctrine. On one side, tort-reform proponents and medical professionals seek to curb skyrocketing malpractice insurance and litigation costs.²⁷ On the other side, injured patients and plaintiffs' attorneys seek to hold negligent doctors accountable for the undue harm they inflict upon patients.²⁸ Two recent state supreme court decisions illustrate the lost chance doctrine's relevance to these competing policy interests. Both of these cases were largely decided on the public policy concerns surrounding the doctrine.

In *Matsuyama v. Birnbaum*,²⁹ the Supreme Judicial Court of Massachusetts ruled on the lost-chance doctrine for the first time and concluded that "recognizing loss of a chance in the limited domain of medical negligence advances the fundamental goals and principles of our tort law."³⁰ In response to the defendants' argument that adoption of the lost-chance doctrine would open up the floodgates for future tort litigation, the court stated, "[w]e are unmoved by the defendants' argument that the ramifications of adoption of the loss of chance are immense across all areas of tort. . . . [N]egligence that harms the patient's chances of a more favorable outcome contravenes the expectation at the heart of the doctor-patient relationship"³¹

26. *Cf. McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094, 1099 (Wyo. 2003) ("A tortfeasor should not get off scot free because instead of killing his victim outright he inflicts an injury that is likely though not certain to shorten the victim's life." (quoting *DePass v. United States*, 721 F.2d 203, 208 (7th Cir. 1983) (Posner, J., dissenting))).

27. *See Eisenberg & Sieger, supra* note 9, at 55, 57 ("President Bush and other Republicans, whose campaigns are supported by doctors and insurance firms, endorse [tort-reform] legislation . . .").

28. *See id.* at 57 (indicating that "plaintiffs' lawyers" were lobbying Congress to hinder Republican-backed tort-reform efforts); *cf. David E. Frank, Doctor Can Be Sued for Patient's Lost Chance of Survival*, MASS. MED. L. REP., Autumn 2008, at 1, 15, available at <http://mamedicalaw.com/wp-files/edition/mmlr-autumn-2008-3.pdf> ("As long as physicians practice appropriately within the standard of care, they have nothing to worry about." (quoting a physician interviewed in the article)).

29. 890 N.E.2d 819 (Mass. 2008).

30. *Id.* at 823.

31. *Id.* at 834–35 (internal quotations omitted); *see also Frank, supra* note 28, at 15 ("I don't anticipate that we're going to see a barrage . . . of stand-alone loss of chance cases apart from the wrongful-death medical-malpractice claims that have always been

The second recent decision addressing the lost-chance doctrine occurred in Kentucky, in which the state supreme court refused to adopt the doctrine.³² Alluding to fears similar to those of Dr. Larry Weiss and the medical community as a whole, the court stated in *Kemper v. Gordon*³³:

[A]s 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. . . . 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.³⁴

While the *Matsuyama* and *Kemper* courts came to opposite policy conclusions regarding the wisdom of adopting the lost-chance doctrine in medical malpractice lawsuits,³⁵ neither court based its decision on any empirical or statistical evidence.³⁶ The *Matsuyama* court merely stated that adoption of the lost-chance doctrine would not create an influx of new medical malpractice claims, while the *Kemper* court said that doing so would create that exact problem. Although the lost-chance doctrine itself is not a novel concept,³⁷ with twenty-two states adopting the doctrine prior to *Matsuyama*³⁸ and sixteen others rejecting it prior to *Kemper*,³⁹ no research has been

allowed.” (quoting Joseph L. Doherty, an attorney at Boston’s Doherty & Quill who was interviewed in the article)).

32. *Kemper v. Gordon*, 272 S.W.3d 146, 148 (Ky. 2008) (“[W]e reject the adoption of the ‘lost or diminished chance’ doctrine of recovery . . .”).

33. 272 S.W.3d 146 (Ky. 2008).

34. *Id.* at 152.

35. Compare *Matsuyama*, 890 N.E.2d at 834 (downplaying the potential ramifications of adopting the lost-chance doctrine), with *Kemper*, 272 S.W.3d at 152 (emphasizing the financial costs associated with adopting the lost-chance doctrine).

36. See *Kemper*, 272 S.W.3d at 150–53 (overturning the appellate court’s adoption of the lost-chance doctrine and making a policy analysis, without pointing to any data); *Matsuyama*, 890 N.E.2d at 828–35 (summarizing evolution of the lost-chance doctrine, indicating which states have adopted it, and ultimately adopting it for Massachusetts, all without pointing to any data).

37. Before courts expressly acknowledged the lost-chance concept as a distinct cause of action, various court decisions hinted at its underlying logic. See, e.g., *Hicks v. United States*, 368 F.2d 626, 632 (4th Cir. 1966) (“When 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.”).

38. See *infra* note 56 and accompanying text.

39. See *infra* note 57 and accompanying text.

done to confirm or dispel the notion that a state's adoption of the doctrine significantly contributes to either that state's court docket congestion or to its malpractice insurance costs.

This Comment seeks to put the lost-chance doctrine in its appropriate context, both in terms of its overall impact on a state's court docket and its resulting financial impact on medical malpractice insurance. In doing so, this Comment will argue that a state's adoption of the lost-chance doctrine has no significant impact on either court docket congestion or medical malpractice insurance costs. As such, the *Matsuyama* court's decision to adopt the doctrine is more favorable than the *Kemper* court's decision to reject the doctrine.

Part I of this Comment gives a brief historical overview of the lost-chance doctrine's evolution and its current status among the fifty states. Part II analyzes how the lost-chance doctrine fits into the wider scheme of civil litigation generally, into medical malpractice litigation specifically, and into various tort-reform efforts taken by numerous states. Through the use of statistical data, Part III seeks to refute any connection between a particular state's adoption of the lost-chance doctrine and either increased court docket congestion or malpractice insurance costs. Part IV provides an analysis of how states that have adopted the lost-chance doctrine have been able to rely upon conventional rules of evidence to prevent the doctrine from leading to an influx of meritless litigation. This Comment concludes that a state's adoption of the doctrine does not exacerbate that state's court docket congestion or that state's medical malpractice insurance issues, and finally, it argues that the *Matsuyama* decision is superior to the *Kemper* decision.

I. HISTORICAL OVERVIEW OF THE LOST-CHANCE DOCTRINE

A. *Proof of Causation in a Medical Malpractice Case*

In order to recover damages in a typical tort action, the plaintiff must show by a preponderance of the evidence that the defendant's negligence was the proximate cause of the plaintiff's injury.⁴⁰ While causation may essentially be a non-issue in many tort lawsuits (such as a car wreck in which the cause of the plaintiff's injury was the collision), causation in medical malpractice litigation plays a critical

40. RICHARD A. EPSTEIN, *CASES AND MATERIALS ON TORTS* 393 (8th ed. 2004) ("Once the plaintiff has established that the defendant has engaged in some wrongful conduct, she must link that conduct to her harm.").

role.⁴¹ A plaintiff's injury⁴² (his or her adverse medical outcome, whether it be the loss of a limb, organ function, or even life) may be the result of a doctor's misdiagnosis, performance of a medical procedure, a patient's genetic predisposition, unhealthy lifestyle, or any combination of innumerable other factors. Consequently, it is often difficult, if not impossible, to determine that *the* proximate cause of a plaintiff's injury was a doctor's negligence.

Since a plaintiff may have difficulty proving that the doctor's negligence was more likely than not the cause of her injury, she must typically provide expert testimony supporting the proposition that other similarly situated patients who were treated correctly (non-negligently) generally enjoy a better medical outcome than that experienced by the plaintiff.⁴³ An expert witness's testimony is typically given in terms of what the plaintiff's odds of recovery would have been in the absence of the defendant doctor's negligence compared to what the plaintiff's odds of recovery actually were in the presence of the doctor's negligence, with both odds being based on similarly situated patients.⁴⁴ If the judge in the case is convinced that

41. Lawyers' Guide to Med. Proof (MB) § 903.01 ("Medical causation is the causal relationship between a precipitating event and a person's injury. The relationship between harm and legal responsibility is complex.")

42. The lost-chance doctrine applies only to injuries that have already occurred. Joseph H. King, Jr., "Reduction of Likelihood" Reformulation and Other Retrofitting of the Loss-of-a-Chance Doctrine, 28 U. MEM. L. REV. 491, 496 (1998) ("Where the defendant's tortious conduct created a risk of future consequences, the operation of the loss-of-a-chance doctrine should be suspended until the harmful effects actually materialize."). For instance, if a plaintiff's chance of recovering from terminal cancer has been reduced from forty percent to ten percent because of a defendant's negligence, courts recognizing the lost-chance doctrine will not allow the plaintiff to pursue a lost-chance cause of action based merely on the increased risk of not recovering. Only once the plaintiff has suffered the ultimate injury (in this example, death) would a lost-chance cause of action be recognized (in this example, by a survivor of the patient). See, e.g., *Perez v. Las Vegas Med. Ctr.*, 805 P.2d 589, 592 (Nev. 1991) ("Of course, the plaintiff or injured person cannot recover merely on the basis of a decreased chance of survival or of avoiding a debilitating illness or injury; the plaintiff must in fact suffer death or debilitating injury before there can be an award of damages."). While some courts do recognize an "increased risk" theory of recovery in which the plaintiff may recover damages based merely upon the heightened likelihood of developing or having a recurrence of an adverse medical outcome in the future, this is distinct from the lost-chance doctrine. See King, *supra*, at 496 (articulating the differences between the increased-risk theory and lost-chance theory).

43. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 318 (2002) ("In a medical malpractice case, the patient generally must prove by use of expert testimony both that the diagnosis or treatment complained of constitutes negligence and that it is the proximate cause of the patient's injuries.")

44. See, e.g., *Alexander v. Scheid*, 726 N.E.2d 272, 277 (Ind. 2000) ("Although an act of malpractice may reduce a patient's chances for survival or for obtaining a better result,

the expert witness's testimony could provide a reasonable basis for a jury to conclude that the defendant doctor's negligence was more likely than not the cause of the plaintiff's injury, then the case is permitted to go to the jury.⁴⁵ For instance, if a plaintiff's odds of recovery from cancer with a timely diagnosis would be seventy percent, but because of the doctor's negligent misdiagnosis, her odds of recovery were only ten percent once the cancer was finally discovered, this evidence could provide a basis for allowing a jury to decide the case.⁴⁶

Complications arise, however, when a plaintiff's odds of recovery are already less than fifty percent *before* the defendant doctor's negligent act. For example, if the patient in the previous example had only a forty percent chance of recovery at the time of the doctor's negligent misdiagnosis, it would be mathematically impossible to prove that the doctor's negligence was the proximate cause of the patient's injury: even had the patient's cancer been diagnosed in a timely, non-negligent manner, her odds of recovery would still be less than fifty percent, making it impossible to prove that the doctor's negligence was more likely than not the proximate cause of her injury. Because of the difficulty in proving causation in these instances, courts began considering alternative formulations of causation.

this is simply a statistical proposition based on the known experience of a group of persons thought to be similarly situated . . .").

45. *See, e.g.*, *Turner v. Duke Univ.*, 325 N.C. 152, 162, 381 S.E.2d 706, 712 (1989) ("Proximate cause is ordinarily a jury question.").

46. The lost-chance doctrine is typically utilized in cases where statistical percentages are available to accurately determine what the plaintiff's lost chance of recovery actually was. *King, supra* note 42, at 541 ("In approving the loss-of-a-chance doctrine, the court noted, 'In the failure-to-diagnose case, the fact pleaded to show causation often has to be a statistic.' " (quoting *Wollen v. DePaul Health Ctr.*, 828 S.W.2d 681, 682 (Mo. 1992) (en banc))). While not stated in express terms, a vague form of the lost-chance doctrine has been applied in cases where, although the plaintiff's expert testimony could not be established in statistical terms, the court nevertheless believed that the facts and circumstances of the plaintiff's injury warranted sending the case to the jury. *See, e.g.*, *Felts v. Liberty Emergency Serv., P.A.*, 97 N.C. App. 381, 390, 388 S.E.2d 619, 624 (1990) (upholding admission of plaintiff's expert witness's testimony that stated it would have been "possible" for plaintiff's heart attack to have been prevented with an earlier diagnosis). This rationale, similar to the way that *res ipsa loquitur* allows a plaintiff to send her case to the jury even in the absence of proof of the defendant's negligence, was utilized long before the official recognition of the lost-chance doctrine. *See, e.g.*, *Hicks v. United States*, 368 F.2d 626, 633 (4th Cir. 1966) ("[Various courts] have similarly held that if the victim might have been saved by a precaution which the defendant negligently omitted, the omission is deemed to have caused the harm, even though it is not possible to demonstrate conclusively that the precaution would in fact have saved the victim.").

B. *The Modern Lost-Chance Doctrine and the Proportional Approach*

Acknowledging that the traditional preponderance of the evidence/more-likely-than-not rule of proving causation would continuously allow certain medical professionals to escape liability for their negligent acts, some courts began recognizing claims in which a plaintiff's odds of recovery were already less than fifty percent prior to a defendant doctor's negligence.⁴⁷ Many of these courts adopted a "proportional approach" in calculating damages, a concept whose innovation is generally credited to Dr. Joseph King.⁴⁸ Whereas permitting defendant doctors to go entirely unaccountable did not serve policy goals, allowing a plaintiff to collect the entire amount of damages from a defendant doctor whose negligent act was less likely than not the cause of the plaintiff's injury created similar shortcomings.⁴⁹ Applying Dr. King's proposed approach to the previously used example, a plaintiff with a forty percent chance of recovery who, because of the defendant doctor's negligent act, had her chance of recovery reduced to only ten percent, could collect thirty percent (forty minus ten) of her total damages from the defendant doctor.⁵⁰ By holding a defendant liable for a proportional amount of the plaintiff's injury, Dr. King's approach effectively provided both an appropriate level of deterrence for otherwise unaccountable medical professionals, and at the same time, enabled plaintiffs to collect some damages for injuries that would otherwise go uncompensated. This proportional approach became what is now termed the "lost-chance" doctrine.⁵¹

Courts in the 1980s began applying Dr. King's proportional approach to medical malpractice cases. *Herskovits v. Group Health*

47. *Hamil v. Bashline*, 392 A.2d 1280 (Pa. 1978), and *Herskovits v. Group Health Cooperative of Puget Sound*, 664 P.2d 474 (Wash. 1983) (en banc), are generally considered the first cases to formally recognize a lost-chance cause of action. See, e.g., Zaven T. Saroyan, *The Current Injustice of the Loss of Chance Doctrine: An Argument for a New Approach to Damages*, 33 CUMB. L. REV. 15, 24 (2002) ("Among the first cases to explicitly adopt [the lost-chance doctrine] was *Hamil v. Bashline* In 1983, the Washington Supreme Court announced what was to become the seminal decision in the recognition of the loss of chance doctrine.").

48. See Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1382 (1981); see also Lars Noah, *An Inventory of Mathematical Blunders in Applying the Loss-of-a-Chance Doctrine*, 24 REV. LITIG. 369, 370–72 (2005) (crediting Dr. King's article as influential in the formulation of the proportional approach to the lost-chance doctrine).

49. See King, *supra* note 48, at 1367.

50. *Id.* at 1382.

51. See Noah, *supra* note 48, at 370–72.

*Cooperative of Puget Sound*⁵² is generally cited as the first decision to apply the official lost-chance methodology.⁵³ Although the Supreme Court of Washington did not expressly apply Dr. King's proportional approach, the decision is significant in that it permitted a plaintiff to recover damages when the evidence in the case indicated that the defendant's negligence was less likely than not the proximate cause of the plaintiff's injury.⁵⁴ Since *Herskovits*, Dr. King's proportional approach has been cited in numerous subsequent decisions and has served as a basis for more than twenty states' adoption of the lost-chance doctrine.⁵⁵

C. *Current Status of the Lost-Chance Doctrine Throughout the Fifty States*

The disparate conclusions of the *Matsuyama* and *Kemper* courts in 2008 reflect the general distribution among the fifty states; while twenty-two states have adopted the doctrine,⁵⁶ a roughly equal

52. 664 P.2d 474 (Wash. 1983) (en banc).

53. See, e.g., Noah, *supra* note 48, at 372.

54. See *Herskovits*, 664 P.2d at 476–77 (“Is a 36 percent (from 39 percent to 25 percent) reduction in the decedent’s chance for survival sufficient evidence of causation to allow the jury to consider the possibility that the physician’s failure to timely diagnose the illness was the proximate cause of his death? We answer in the affirmative. To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence.”). While cited for its primacy in adopting the lost-chance doctrine, the *Herskovits* opinion has also been questioned for its rationale of holding the defendant liable for a thirty-six percent decrease of plaintiff’s chance of survival (thirty-nine down to twenty-five proportionally), rather than a fourteen percent decrease (thirty-nine down to twenty-five absolutely). See, e.g., Noah, *supra* note 48, at 372–75.

55. See, e.g., *McKellips v. St. Francis Hosp., Inc.*, 741 P.2d 467, 476 (Okla. 1987) (“The amount of damages recoverable is equal to the percent of chance lost multiplied by the total amount of damages which are ordinarily allowed in a wrongful death action.”); see also *Perez v. Las Vegas Med. Ctr.*, 805 P.2d 589, 592 (Nev. 1991) (“[T]he damages are to be discounted to the extent that a preexisting condition likely contributed to the death or serious debilitation.”).

56. Those states include: **Arizona**, *Thompson v. Sun City Cmty. Hosp., Inc.*, 688 P.2d 605, 616 (Ariz. 1984) (en banc) (“We hold, therefore, that . . . the jury may be allowed to consider the increase in the chance of harm on the issue of causation.”); **Delaware**, *United States v. Anderson*, 669 A.2d 73, 77 (Del. 1995) (“[T]he loss of a chance of avoiding an adverse consequence . . . should be viewed as an injury and be compensable.”); **Illinois**, *Holton v. Mem’l Hosp.*, 679 N.E.2d 1202, 1213 (Ill. 1997) (“We therefore reject the reasoning . . . that plaintiffs may not recover for medical malpractice injuries if they are unable to prove that they would have enjoyed a greater than 50% chance of survival or recovery absent the alleged malpractice of the defendant.”); **Indiana**, *Mayhue v. Sparkman*, 653 N.E.2d 1384, 1389 (Ind. 1995) (“While the policy arguments for each position are strong . . . [adopting the lost-chance doctrine] is most consistent with Indiana law”); **Iowa**, *DeBurkarte v. Louvar*, 393 N.W.2d 131, 137 (Iowa 1986) (“We believe the better approach is to allow recovery . . . for the lost chance of survival.”); **Kansas**,

number have disavowed it (sixteen)⁵⁷ or have deferred on deciding the issue (six).⁵⁸ In six other states, the highest court has not yet

Roberson v. Counselman, 686 P.2d 149, 160 (Kan. 1984) (“The reasoning of the district court [rejecting the lost-chance doctrine] declares open season on critically ill or injured persons as care providers would be free of liability . . . if the patient had only a fifty-fifty chance of surviving the disease or injury even with proper treatment.”); **Louisiana**, Smith v. State Dep’t of Health & Hosps., 95-0038, p.5 (La. 6/25/96), 676 So. 2d 543, 547 (“[I]n a medical malpractice case seeking damages for the loss of a less-than-even chance of survival . . . the plaintiff must prove . . . that the tortfeasor’s action or inaction deprived the victim of all or part of that chance”); **Massachusetts**, Matsuyama v. Birnbaum, 890 N.E.2d 819, 838 (Mass. 2008) (“Our method . . . remedies the illogical and harsh results of a rule that would permit a person who had a prenegligence chance of survival of 51% to recover full damages while denying all recovery to the person whose prenegligence chance of survival was 49%.”); **Missouri**, Wollen v. DePaul Health Ctr., 828 S.W.2d 681, 685 (Mo. 1992) (en banc) (“[T]his Court chooses to recognize a cause of action for lost chance of recovery in medical malpractice cases.”); **Montana**, Aasheim v. Humberger, 695 P.2d 824, 828 (Mont. 1985) (“We feel that including ‘loss of chance’ within causality recognizes the realities inherent in medical negligence litigation.”); **Nevada**, Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 592 (Nev. 1991) (“By defining the injury as the loss of chance of survival, the traditional rule of preponderance is fully satisfied.”); **New Jersey**, Scafidi v. Seiler, 574 A.2d 398, 400 (N.J. 1990) (“We hold [that] plaintiffs’ damages will be limited to the value of the lost chance for recovery attributable to defendant’s negligence.”); **New Mexico**, Alberts v. Schultz, 1999-NMCA-15, ¶ 40, 126 N.M. 807, 816, 975 P.2d 1279, 1288 (“We recognize the legitimacy of the lost-chance concept in New Mexico, as set forth in this opinion.”); **New York**, Kallenberg v. Beth Israel Hosp., 357 N.Y.S.2d 508, 510–11 (N.Y. App. Div. 1974) (per curiam), *aff’d*, 37 N.Y.2d 719 (N.Y. 1975) (permitting recovery where plaintiff had only a twenty to forty percent chance of survival prior to defendant’s negligence); **North Dakota**, VanVleet v. Pfeifle, 289 N.W.2d 781, 784 (N.D. 1980) (“We think . . . the doctors should not be able to escape liability simply because the cancer would eventually have resulted in [plaintiff’s] death even if it were discovered sooner.”); **Ohio**, Roberts v. Ohio Permanente Med. Group, 668 N.E.2d 480, 484 (Ohio 1996) (“[W]e recognize the loss-of-chance theory and follow the [proportional] approach”); **Oklahoma**, McKellips v. St. Francis Hosp., Inc., 741 P.2d 467, 474 (Okla. 1987) (“Today’s pronouncement adopts the loss of a chance doctrine in Oklahoma”); **Pennsylvania**, Hamil v. Bashline, 392 A.2d 1280, 1288 (Pa. 1978) (“We agree with [the lost-chance doctrine] and hold that once a plaintiff has demonstrated that defendant’s acts or omissions . . . have increased the risk of harm to another, such evidence furnishes a basis for [recovery].”); **Washington**, Herskovits v. Group Health Coop. of Puget Sound, 664 P.2d 474, 477 (Wash. 1983) (en banc) (“To decide [against the lost-chance doctrine] would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence.”); **West Virginia**, Mays v. Chang, 579 S.E.2d 561, 566 (W. Va. 2003) (per curiam) (“[A] jury could conclude that the [defendant’s] allegedly negligent inactions contributed to [plaintiff’s] lost chance of early detection and treatment, and conclude that if the [defendant] had complied with the standard of care, the harm . . . would not have occurred.”); **Wisconsin**, Ehlinger by Ehlinger v. Sipes, 454 N.W.2d 754, 763 (Wis. 1990) (“We disagree with the court of appeals’ conclusion . . . that in a case of this nature Wisconsin law follows the ‘all or nothing’ approach.”); **Wyoming**, McMackin v. Johnson County Healthcare Ctr., 73 P.3d 1094, 1100 (Wyo. 2003) (“We hold that the doctrine of ‘loss of chance’ is cognizable in Wyoming”).

57. Those states include: **Alabama**, McAfee v. Baptist Med. Ctr., 641 So. 2d 265, 267 (Ala. 1994) (“If, as the defendants suggest, the plaintiffs are in fact asking this Court to abandon Alabama’s traditional rules of proximate cause and to recognize the ‘loss of

chance doctrine,' we decline to do so."); **Connecticut**, *Boone v. William W. Backus Hosp.*, 864 A.2d 1, 18 (Conn. 2005) ("[I]n order to satisfy the elements of a lost chance claim, 'the plaintiff must [first] prove that *prior to* the defendant's alleged negligence, the [decedent] had a chance of survival of at least 51 percent.'" (quoting *Drew v. William W. Backus Hosp.*, 825 A.2d 810, 815 (Conn. 2003))); **Florida**, *Gooding v. Univ. Hosp. Bldg., Inc.*, 445 So. 2d 1015, 1020 (Fla. 1984) ("We . . . hold that a plaintiff in a medical malpractice action must show more than a decreased chance of survival because of a defendant's conduct."); **Idaho**, *Manning v. Twin Falls Clinic & Hosp., Inc.*, 830 P.2d 1185, 1190 (Idaho 1992) ("Our review of the cases that have considered the rationale of the doctrines of 'increased risk of harm' or 'lost chance' convinces us to reject both doctrines."); **Kentucky**, *Kemper v. Gordon*, 272 S.W.3d 146, 148 (Ky. 2008) ("[W]e reject the adoption of the 'lost or diminished chance' doctrine of recovery . . ."); **Maryland**, *Fennell v. S. Md. Hosp. Ctr., Inc.*, 580 A.2d 206, 211 (Md. 1990) ("We are unwilling to relax traditional rules of causation and create a new tort allowing full recovery for causing death by causing a loss of less than 50% chance of survival."); **Minnesota**, *Fabio v. Bellomo*, 504 N.W.2d 758, 762 (Minn. 1993) ("We have never recognized loss of chance in the context of a medical malpractice action, and we decline to recognize it in this case."); **Mississippi**, *Clayton v. Thompson*, 475 So. 2d 439, 445 (Miss. 1985) (en banc) ("This Court concludes, therefore, that Mississippi law does not permit recovery of damages because of mere diminishment of the 'chance of recovery.'"); **Nebraska**, *Steineke v. Share Health Plan of Neb., Inc.*, 518 N.W.2d 904, 907 (Neb. 1994) ("We decline to adopt the loss of chance doctrine in this case . . ."); **New Hampshire**, N.H. REV. STAT. ANN. § 507E:2 (2009) (superseding *Lord v. Lovett*, 770 A.2d 1103, 1106 (N.H. 2001)); **Oregon**, *Joshi v. Providence Health Sys. of Or. Corp.*, 149 P.3d 1164, 1170 (Or. 2006) ("We cannot accept plaintiff's invitation to adopt [the lost-chance] theory in actions brought under [Oregon's wrongful death statute]."); **South Carolina**, *Jones v. Owings*, 456 S.E.2d 371, 374 (S.C. 1995) ("After a thorough review of the 'loss of chance' doctrine, we decline to adopt the doctrine and maintain our traditional approach."); **South Dakota**, S.D. CODIFIED LAWS § 20-9-1.1 (2004) (superseding *Jorgenson v. Vener*, 2000 SD 87, ¶20, 616 N.W.2d 366, 372); **Tennessee**, *Kilpatrick v. Bryant*, 868 S.W.2d 594, 603 (Tenn. 1993) ("Accordingly, we hold that a plaintiff who . . . more likely than not would have suffered the same harm had proper medical treatment been rendered, is entitled to no recovery for . . . the loss of a chance of obtaining a more favorable medical result."); **Texas**, *Kramer v. Lewisville Mem'l Hosp.*, 858 S.W.2d 397, 407 (Tex. 1993) ("[W]e do not adopt the loss of chance doctrine as part of the common law of Texas."); **Vermont**, *Smith v. Parrott*, 2003 VT 64, ¶¶ 12 & 14, 833 A.2d 843, 848–49, 175 Vt. 375, 381 ("The loss of chance theory of recovery is thus fundamentally at odds with the settled common law standard Accordingly, we hold that the trial court correctly rejected plaintiff's claim for recovery under the loss of chance doctrine.").

58. Those states include: **Alaska**, *Parson v. Marathon Oil Co.*, 960 P.2d 615, 620 (Alaska 1998) ("[W]e need not address . . . whether Alaska should adopt the loss-of-chance doctrine."); **Arkansas**, *Holt ex rel. Holt v. Wagner*, 43 S.W.3d 128, 132 (Ark. 2001) ("We recognize that lost chance of survival is a complex legal theory that has taken various shapes and forms in other states. We are not closing the door to the future adoption of one of the versions of lost chance of survival."); **Colorado**, *Kaiser Found. Health Plan of Colo. v. Sharp*, 741 P.2d 714, 718 n.5 (Colo. 1987) (en banc) ("[W]e express no opinion on whether we would apply [the lost-chance doctrine] in a proper case."); **Maine**, *Phillips v. E. Me. Med. Ctr.*, 565 A.2d 306, 308 (Me. 1989) ("[W]e conclude that the jury could rationally determine that the plaintiffs satisfied even the more stringent requirement [of more-likely-than-not causation]."); **Michigan**, *Stone v. Williamson*, 753 N.W.2d 106, 114–15 (Mich. 2008) (indicating that legislative enactment made in response to the court's earlier adoption of lost-chance doctrine is ambiguous and that, as a result, the status of the doctrine in the state is unclear); **Rhode Island**, *Contois v. Town of W. Warwick*, 865 A.2d 1019, 1025 (R.I. 2004) ("Although we may revisit the loss of chance

addressed the issue.⁵⁹ While some opponents of the doctrine may see it as “pernicious”⁶⁰ or as “undercut[ting] the truth-seeking function”⁶¹ that courts serve, the relative lack of attention paid to the doctrine by a noticeable number of state supreme courts may itself be indicative of the overall effect (or lack thereof) that the doctrine actually has in medical malpractice litigation.⁶²

Similarly, the doctrine’s lack of effect on malpractice litigation is evident in the distribution of states that have chosen to adopt it. Due to the doctrine’s potential to expand tort liability—the wisdom of which is a major point of contention⁶³—it should follow that a state’s acceptance or rejection of the lost-chance doctrine would be based on political grounds. This logical assumption, however, is evidently not the case. For instance, Vermont,⁶⁴ California,⁶⁵ Oregon,⁶⁶ and Rhode

doctrine under an appropriate factual scenario, we hold that for the reasons set forth here the facts presented in this case are inadequate . . .”).

59. Those states include: **California**, *Bird v. Saenz*, 103 Cal. Rptr. 2d 131, 138 n.3 (Cal. Ct. App. 2001), *rev’d on other grounds*, 51 P.3d 324 (Cal. 2002) (“The California Supreme Court apparently has not yet addressed the lost chance doctrine Inasmuch as the doctrine, in any formulation, has not been approved by our courts, . . . we are loathe to set out to define it.”); **Georgia**, *Richmond County Hosp. Auth. v. Dickerson*, 356 S.E.2d 548, 550 (Ga. Ct. App. 1987) (“Proximate cause is not eliminated by merely establishing by expert opinion that the patient had less than a fifty percent chance of survival had the negligence not occurred.”); **Hawaii**, *Yamane v. Pohlson*, 137 P.3d 980, 986 (Haw. 2006) (indicating that plaintiff had filed a lost-chance complaint but not addressing the merits of the doctrine); **North Carolina**, *White v. Hunsinger*, 88 N.C. App. 382, 386, 363 S.E.2d 203, 206 (1988) (“Proof of proximate cause in a malpractice case requires more than a showing that a different treatment would have improved the patient’s chances of recovery.”). *But see* *Shumaker v. United States*, 714 F. Supp. 154, 163–64 (M.D.N.C. 1988) (“The statement [in *Hunsinger*] that proof of proximate causation requires more than a showing that different treatment would have improved the chances of recovery can, but need not, be construed as inconsistent with recognizing lost possibility as a compensable loss.”) (citation omitted). Other states include: **Utah**, *Andersen v. Brigham Young Univ.*, 879 F. Supp. 1124, 1129–30 (D. Utah 1995) (“The Supreme Court of Utah has not directly spoken to loss of chance as a possible separate and new cause of action [T]his Court is not inclined to make an ‘eerie guess’ that the Supreme Court of Utah will do so.”); **Virginia**, *Straus v. McDonald*, 67 Va. Cir. 116, 120 (Va. Cir. Ct. 2005) (declining to apply lost-chance methodology without prior approval from state supreme court).

60. *See* Weiss, *supra* note 11, at 4.

61. *See* Weigand, *supra* note 16, at 311.

62. *See generally* *Lord v. Beerman*, 191 N.C. App. 290, 664 S.E.2d 331 (2008) (upholding summary judgment for defendant). For a description of the lost-chance doctrine’s potential role in the case, see *supra* text accompanying notes 17–26.

63. *See* Eisenberg & Sieger, *supra* note 9, at 50 (indicating a partisan split concerning tort-reform efforts, with Republicans, doctors, and insurance companies on one side and Democrats and plaintiffs’ attorneys on the other side); Howard, *supra* note 10 (suggesting that efforts to reform medical malpractice litigation are thwarted by Democrats and those who contribute to the party).

64. As of 2009, Vermont’s State House of Representatives consists of ninety-four Democrats, forty-seven Republicans, five Progressives, and three Independents. The Vermont Legislature, Legislative Directory, <http://www.leg.state.vt.us/lms/legdir/alpha.asp>

Island,⁶⁷ all fairly liberal states,⁶⁸ have failed to adopt the doctrine.⁶⁹ On the other hand, Oklahoma,⁷⁰ Arizona,⁷¹ Wyoming,⁷² and Kansas,⁷³ all fairly conservative states, have adopted the doctrine.⁷⁴

?Body=H (last visited Jan. 2, 2010). Its State Senate consists of twenty-three Democrats/Progressives and seven Republicans. The Vermont Legislature, Legislative Directory, <http://www.leg.state.vt.us/lms/legdir/alpha.asp?Body=S> (last visited Jan. 2, 2010).

65. As of 2009, California's State Assembly consists of fifty Democrats and twenty-eight Republicans. Assembly Member Roster, http://www.assembly.ca.gov/clerk/member_information/memberdir_1.asp (last visited Jan. 2, 2010). Its State Senate consists of twenty-five Democrats and fifteen Republicans. Senate Member List, <http://www.leginfo.ca.gov/sen-addresses.html> (last visited Jan. 2, 2010). Because the California Supreme Court has not addressed the lost-chance doctrine yet, a California appellate court has indicated that it is "loathe to set out to define" the adoption of the doctrine. *Bird v. Saenz*, 103 Cal. Rptr. 2d 131, 138 n.3 (Cal. Ct. App. 2001), *rev'd on other grounds*, 51 P.3d 324 (Cal. 2002).

66. As of 2009, Oregon's State House of Representatives consists of thirty-five Democrats and twenty-four Republicans. Oregon State Legislature, House of Representatives, <http://www.leg.state.or.us/house> (follow "State Representatives - Democrats" and "State Representatives - Republicans" hyperlinks) (last visited Jan. 2, 2010). Its State Senate consists of seventeen Democrats and twelve Republicans. Oregon State Legislature, Oregon State Senate, <http://www.leg.state.or.us/senate> (follow "State Senators - Democrats" and "State Senators - Republicans" hyperlinks) (last visited Jan. 2, 2010).

67. As of 2009, Rhode Island's State House of Representatives consists of sixty-eight Democrats, six Republicans, and one Independent. State of Rhode Island General Assembly, <http://www.rilin.state.ri.us/Email/RepEmailListDistrict.asp> (follow "Bio" hyperlinks) (last visited Jan. 2, 2010). Its State Senate consists of thirty-three Democrats, four Republicans, and one Independent. Rhode Island State Legislature, <http://www.rilin.state.ri.us/Email/SenEmailListDistrict.asp> (last visited Jan. 2, 2010).

68. Characterizing a state as "liberal" or "conservative" based solely upon party affiliation of its state's legislators is obviously a generalization. While state legislators do have the ability to ratify laws that would affect the lost-chance doctrine's applicability, a more accurate gauge of any correlation between the lost-chance doctrine and partisan ideology could be attained by analyzing the party affiliations of a state's supreme court members at the time of its decision to adopt or renounce the doctrine. The comparison of the four "liberal" states with the four "conservative" states is meant to serve only as an indication of a lack of correlation. There are some who believe, however, that Democrats have hamstrung Republican-prompted tort-reform efforts at the federal level. *See, e.g., Eisenberg & Sieger, supra* note 9, at 59 ("[P]laintiffs' lawyers, who contribute heavily to the campaigns of Democrats, are lobbying their friends in the Senate, and national 'tort reform' may remain more of a rallying cry than a real prospect."). Presumably, a Republican-dominated state legislature (in Oklahoma, Arizona, Wyoming, or Kansas, for example) would have no such problems in passing tort-reform legislation, which could repeal any judicially created lost-chance cause of action.

69. *See supra* notes 57–59.

70. As of February 2009, Oklahoma's State House of Representatives consists of sixty-one Republicans and thirty-nine Democrats. Oklahoma Legislature, <http://www.lsb.state.ok.us> (follow "House Home Page" hyperlink; then follow "House Membership" hyperlink to "Current House Membership" hyperlink) (last visited Jan. 2, 2010). Its State Senate consists of twenty-six Republicans and twenty-two Democrats. Oklahoma Legislature, <http://www.lsb.state.ok.us> (follow "Senate Home Page" hyperlink;

The only notable geographic trends are that most midwestern and plains states (including Ohio, Indiana, Illinois, Wisconsin, Iowa, Missouri, Kansas, and Oklahoma) *have* adopted the doctrine,⁷⁵ while most southern and southeastern states (including South Carolina, Florida, Tennessee, Mississippi, Alabama, Arkansas, and Texas) have *not* adopted it.⁷⁶ While geographic proximity to an adopting or non-adopting state may have *some* effect on whether a particular state decides to adopt the doctrine or not, many of the state supreme court decisions seem to be based more upon the strength of the claimant's case in which the state supreme court addresses the issue.⁷⁷

II. THE LOST-CHANCE DOCTRINE IN CONTEXT

By lowering the threshold of causation necessary for a plaintiff to collect damages from a defendant, the lost-chance doctrine, on its face, may seem to present the possibility of a litigation influx. Its potential effect, however, must be put into the appropriate context. Doing so requires analyzing how much of a typical state's court docket might actually be susceptible to the lost-chance methodology. While the doctrine itself is, indeed, a judicially-created remedy and its

then follow "Senators" hyperlink; then follow "Printable Directory" hyperlink) (last visited Jan. 2, 2010).

71. As of 2009, Arizona's State House of Representatives consists of thirty-five Republicans and twenty-five Democrats. Arizona State Legislature, Member Roster, <http://www.azleg.gov/MemberRoster.asp> (last visited Jan. 2, 2010). Its State Senate consists of eighteen Republicans and twelve Democrats. *Id.*

72. As of 2009, Wyoming's State House of Representatives consists of forty Republicans and nineteen Democrats. Legislature, <http://legisweb.state.wy.us/LegislatorSummary/LegislatorList.aspx?strHouse=H&strStatus=N> (last visited Jan. 2, 2010). Its State Senate consists of twenty-three Republicans and seven Democrats. State of Wyoming Legislature, <http://legisweb.state.wy.us/LegislatorSummary/LegislatorList.aspx?strHouse=S&strStatus=N> (last visited Jan. 2, 2010).

73. As of 2009, Kansas's State House of Representatives consists of seventy-six Republicans and forty-nine Democrats. Kansas House of Representatives, <http://www.kslegislature.org/legsrv-house/searchHouse.do> (last visited Jan. 2, 2010). Its State Senate consists of thirty-one Republicans and nine Democrats. Kansas Senate, <http://www.kslegislature.org/legsrv-senate/searchSenate.do> (last visited Jan. 2, 2010).

74. *See supra* note 56.

75. *Id.*

76. *See supra* notes 57–58.

77. *Compare* Smith v. Parrott, 2003 VT 64, ¶¶ 6 & 14, 833 A.2d 843, 845, 848, 175 Vt. 375, 377, 381 (refusing to adopt doctrine when plaintiff's expert witness was indecisive as to whether defendant's negligence was more likely than not the cause of plaintiff's injury), *with* Aasheim v. Humberger, 695 P.2d 824, 825, 828 (Mont. 1985) (adopting doctrine in a case where defendant doctor's failure to take X-rays of plaintiff's knee on four separate occasions resulted in untimely discovery of a "giant cell" tumor). *But see* Alberts v. Schultz, 1999-NMCA-15, ¶ 40, 126 N.M. 807, 816, 975 P.2d 1279, 1288 (adopting doctrine but refusing to allow recovery in instant case because of plaintiff's lack of proof of causation).

use could be subject to a particular court's whims on a particular day, state legislatures have the ability to overrule judicial decisions adopting the doctrine. Thus, an analysis of how various state legislatures have dealt with the doctrine is also necessary to put the lost-chance doctrine in its appropriate context. Perhaps most important in placing the doctrine in context, however, is an inquiry into the logistics of how the lost-chance methodology would actually play out in a particular lawsuit.

A. *Civil Litigation Trends Generally and Medical Malpractice Litigation Specifically*

The lost-chance doctrine would only affect a particular state's *civil* caseload. A study commissioned by the National Center for State Courts and the Bureau of Justice Statistics ("State Court Study") indicated that in 2006, civil litigation represented only 16.9 percent of the total combined caseloads of courts throughout all fifty states.⁷⁸ Far more prevalent were traffic cases, representing 54.3 percent of all cases filed during the study,⁷⁹ and slightly more prevalent were criminal cases, which represented 21.1 percent of the cases filed during the same time period.⁸⁰ Admittedly, civil litigation often is much more complex and time consuming than a court appearance for a speeding ticket, but the fact that civil litigation represents a smaller portion of court dockets than criminal cases is important to consider before reaching the knee-jerk conclusion that adoption of the lost-chance doctrine will necessarily lead to an overwhelming influx of new litigation.

While civil litigation represents only 16.9 percent of the total state court caseloads nationwide, medical malpractice lawsuits in particular make up only part of this number. The State Court Study indicated that "[a]utomobile cases clearly dominate the tort landscape, representing more than half of the tort cases handled by

78. COURT STATISTICS PROJECT, BUREAU OF JUSTICE STATISTICS & NAT'L CTR. FOR STATE COURTS, EXAMINING THE WORK OF STATE COURTS 13 (2007) [hereinafter STATE COURT STUDY], available at http://www.ncsconline.org/D_Research/csp/2007_files/Examining%20Final%20-%202007%20-%201%20-%20Whole%20Doc.pdf (revealing 17,300,000 civil cases out of a total 102,400,000 cases filed). Medical malpractice claims may also be filed in federal court, which is often the case when the defendant is a federal employee in a veterans' hospital or on a military base. While these lawsuits are governed by state law and would therefore also be susceptible to the particular state's stance on the lost-chance doctrine, the vast majority of medical malpractice claims are filed in state court. *Id.*

79. *Id.* (reporting 55,600,000 traffic cases out of 102,400,000 total cases filed).

80. *Id.* (showing 21,600,000 criminal cases out of 102,400,000 total cases filed).

state general jurisdiction courts. In contrast, medical malpractice and product liability cases, which receive the most attention from legislators and the media, collectively accounted for just seven percent of tort caseloads.⁸¹ In fact, medical malpractice cases make up only three percent of all civil cases brought in state courts.⁸² Thus, out of all the cases in a typical state's court docket (civil, criminal, traffic, domestic relations, and juvenile matters), cases which might potentially be conducive to a lost-chance methodology⁸³ (medical malpractice within civil litigation) comprise approximately one-half of one percent of the total docket.⁸⁴

Because medical malpractice cases comprise only a small portion of a typical state court docket, no discernable difference exists in terms of overall civil caseload between those states that have adopted the lost-chance doctrine and those that have refused to do so. For instance, the number of 2006 medical malpractice cases filed in Kansas (eleven cases per 100,000 residents), Iowa (nine cases per 100,000 residents), and Arizona (eight cases per 100,000 residents)⁸⁵—all states that have adopted the doctrine⁸⁶—are relatively similar to the number of cases filed in Tennessee (eleven cases per 100,000 residents), Mississippi (ten cases per 100,000 residents), and Rhode Island (eight cases per 100,000 residents)⁸⁷—all states that have failed to adopt the doctrine.⁸⁸ Seemingly, factors other than the acceptance or rejection of the lost-chance doctrine play a role in determining a state's court caseload.⁸⁹ Admittedly, these data do not prove that a state's adoption of the lost-chance doctrine has no effect whatsoever on the number of medical malpractice lawsuits filed in that state, but any resulting increase that might exist is insufficient to distinguish the adopting states from the non-adopting states.

81. *Id.* at 22. The State Court Study used statistics for medical malpractice claims from only nine of the fifty states in arriving at this conclusion.

82. *Id.* The same nine-state qualification applies to this conclusion as well.

83. For a discussion of why the lost-chance doctrine may not necessarily be conducive to—or even permissible in—all medical malpractice lawsuits, see *infra* Parts II.C and IV.B.

84. 16.9% (civil cases comprising a court's total caseload) multiplied by 3% (medical malpractice cases comprising a court's civil caseload) equals 0.507%.

85. STATE COURT STUDY, *supra* note 78, at 24.

86. *See supra* note 56.

87. STATE COURT STUDY, *supra* note 78, at 24.

88. *See supra* notes 57–58.

89. *See infra* Part III.B for a more in-depth discussion on other factors.

B. *Tort-Reform Efforts Addressing (and Failing to Address) the Lost-Chance Doctrine*

Many states have taken steps to reform their tort systems, which (perhaps reflective of medical malpractice's disproportionate amount of media attention) have included efforts to curb medical malpractice litigation.⁹⁰ In spite of these efforts, however, very few legislatures have actually addressed the issue of the lost-chance doctrine.⁹¹ A 2007 study that analyzed the effects of state tort-reform efforts indicated that the most prevalent types of reforms were those related to damage caps, venue restrictions, expert witness certification requirements, and stricter statutes of limitations for filing a malpractice claim.⁹² No mention was made of any state disavowing the lost-chance doctrine or whether any such actions may have had an alleviating effect on that state's medical malpractice litigation burden.⁹³ Similar studies conducted by the United States General Accounting Office have likewise failed to pinpoint any legislative efforts to overturn a judicially created lost-chance cause of action.⁹⁴ While certainly not conclusive of the lost-chance doctrine's lack of overall significance, its complete lack of mention in such malpractice-cost-containment studies is telling.

Only five state legislatures have made any discernable effort to address the lost-chance doctrine, all with differing attitudes and levels of success. In 2003, the New Hampshire legislature overturned a two-year-old court decision in which the state's supreme court had

90. Teresa M. Waters, et al., *Impact of State Tort Reforms on Physician Malpractice Payments*, 26 HEALTH AFF. 500, 500 (2007) ("Medical malpractice reform is a hot topic for state and federal legislatures. The National Conference of State Legislatures (NCSL) reports that in 2005, forty-eight states considered medical malpractice law changes, which more than thirty states adopted.").

91. See *infra* notes 95–108 and accompanying text (describing the treatment of the lost-chance doctrine by the New Hampshire, Michigan, South Dakota, and Wyoming state legislatures).

92. See Waters et al., *supra* note 90, at 501 (noting as significant the fact that several states made changes in "apportioning liability," but failing to note any issues regarding the lost-chance doctrine's proportional approach).

93. See *id.*

94. See generally U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003), <http://www.gao.gov/new.items/d03836.pdf> (failing to address any connection between a state's stance on the lost-chance doctrine and its medical malpractice expenses); GAO, *supra* note 9 (noting that a lack of comprehensive data makes it impossible to ascertain the impact of such tort-reform efforts). In addition to the efforts identified in Waters et al., *supra* note 90, the GAO study indicated that limits on joint and several liability and penalties for filing a bad faith claim were two key areas of legislative reform. GAO, *supra* note 9, at 51–54.

expressly adopted the lost-chance doctrine.⁹⁵ The Supreme Court of New Hampshire, in *Lord v. Lovett*,⁹⁶ stated that “we fail to see the logic in denying an injured plaintiff recovery against a physician for the lost opportunity of a better outcome on the basis that the alleged injury is too difficult to calculate, when the physician’s own conduct has caused the difficulty.”⁹⁷ Nevertheless, the state legislature amended its medical malpractice statute to overrule this decision because it was contrary to legislative intent.⁹⁸ The South Dakota state legislature undertook a similar effort in 2002. In response to the state’s adoption of the lost-chance doctrine two years earlier, the legislature found that the doctrine “improperly alters or eliminates the requirement of proximate causation.”⁹⁹ No substantial data exist to determine whether the legislative decisions in New Hampshire and South Dakota have had any effect on the states’ respective medical malpractice expenses, but such legislation’s lack of impact in the medical profession may be somewhat of an indicator.¹⁰⁰

The Michigan legislature made a similar, though less successful, effort to overrule the lost-chance doctrine. The Supreme Court of Michigan initially adopted the lost-chance doctrine in 1990 in *Falcon v. Memorial Hospital*.¹⁰¹ Three years later, the state legislature amended its medical malpractice statute in an apparent attempt to overrule the *Falcon* decision, but the amended statute’s convoluted wording indicates that a lost-chance cause of action is both still

95. An Act Relative to Medical and Hospital Liability Insurance, 2003 N.H. Laws 208 (codified at N.H. REV. STAT. ANN. § 507E:2 (2009)) (“The requirements of this section are not satisfied by evidence of loss of opportunity for a substantially better outcome.”); Melissa A. Wojtylak et al., *Recent Developments in Medicine and Law*, 39 TORT & INS. L.J. 597, 600–01 (2004) (“On July 8, 2003, New Hampshire Governor Craig Benson signed Senate Bill 119, effectively eliminating future loss-of-opportunity claims in medical malpractice actions in the state.”).

96. 770 A.2d 1103 (N.H. 2001).

97. *Id.* at 1108.

98. 2003 N.H. Laws 208 (“This act is intended to overrule [*Lord v. Lovett*], 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 general court.”).

99. S.D. CODIFIED LAWS § 20-9-1.1 (2004)

100. Concededly, asserting that the lost-chance doctrine has no significant effect on civil litigation simply because most state legislatures have not addressed the issue is a tenuous argument. It is nevertheless curious, if the lost-chance doctrine is indeed so “pernicious” and disruptive to so many systems (courts, insurance, the practice of medicine), why so many state legislatures have failed to address the doctrine for such a long time. While outside the scope of this Comment, further research could be done to determine why more state legislatures have not followed in the footsteps of the New Hampshire and South Dakota legislatures to statutorily overturn a state supreme court’s adoption of the lost-chance doctrine.

101. 462 N.W.2d 44, 56–57 (Mich. 1990).

permitted *and* that it is not permitted.¹⁰² In a 2008 decision, the Supreme Court of Michigan concluded tentatively that the most likely meaning of the amended statute was that a lost-chance cause of action would only be allowed in situations where the plaintiff initially had a greater than fifty percent chance of recovery.¹⁰³ However, as the court indicated, “[e]ven if [the legislature] was trying to create a remedy for the ‘injury’ of a reduction in chances following medical malpractice, by imposing the threshold of greater than fifty percent it may well have eliminated most of the cases that might benefit from such a rule.”¹⁰⁴ The confusion between the Michigan courts and legislature surrounding the lost-chance doctrine indicates that courts may be in a better position to selectively apply the lost-chance concept on a case-by-case basis, rather than to have a legislative body attempt to pass a blanket prohibition that may cause more harm than good. Furthermore, the fact that fifteen years separated the legislative amendment and the court’s attention to the issue is a strong indicator that lost-chance causes of action had not permeated the Michigan court system.

Wyoming’s legislature also made a half-hearted attempt to statutorily overturn a state supreme court decision adopting the lost-chance doctrine.¹⁰⁵ The Supreme Court of Wyoming adopted the doctrine in *McMackin v. Johnson County Healthcare Center*,¹⁰⁶ and shortly thereafter, members of the state legislature introduced bills directed at overturning the case.¹⁰⁷ In spite of this initial effort, the bill introduced in the state House of Representatives died in committee discussion, and the Senate voted down a similar bill.¹⁰⁸ While the initial efforts of the Wyoming legislature may have been indicative of

102. See *Stone v. Williamson*, 753 N.W.2d 106, 114 (Mich. 2008) (“It is confounding to attempt to ascertain just what the Legislature was trying to do with this amendment.”).

103. *Id.*

104. *Id.*

105. S. File 165, 58th Leg., Reg. Sess. (Wyo. 2005), available at <http://legisweb.state.wy.us/2005/Introduced/SF0165.pdf>; H.B. 115, 58th Leg., Reg. Sess. (Wyo. 2005), available at <http://legisweb.state.wy.us/2005/Introduced/HB0115.pdf>; see also Chenoa C. Allen, *Loss of Chance in Wyoming: Alive, But for How Long?*, 6 WYO. L. REV. 533, 552 (2006) (“Although Wyoming may have been justified in adopting loss of chance as an expansion of existing case law, the fact it did so has not been without controversy.”).

106. 73 P.3d 1094, 1100 (Wyo. 2003).

107. Allen, *supra* note 105, at 552 (“During the 2005 legislative session, both the Wyoming House of Representatives and the Senate introduced legislation in response to *McMackin*.” (citing Wyo. S. File 165; Wyo. H.B. 115)).

108. *Id.* (citing 2005 General Session Journal Digest for H.B. 115, <http://legisweb.state.wy.us/2005/digest/HB0115.htm> (last visited Jan. 2, 2010); 2005 General Session Journal Digest for S. File 165, <http://legisweb.state.wy.us/2005/digest/SF0165.htm> (last visited Jan. 2, 2010)).

a concerted effort to overturn the lost-chance doctrine, the lack of urgency and solidarity in both houses of the legislature speaks to the doctrine's relative lack of importance when compared to more pressing issues, both inside and outside the medical malpractice realm.

In contrast to New Hampshire and South Dakota (and to a lesser extent Michigan and Wyoming), Missouri's legislature has actively approved of the lost-chance doctrine.¹⁰⁹ The state's supreme court adopted the doctrine in *Wollen v. DePaul Health Center*¹¹⁰ in 1992. One year later, while revamping the state's medical malpractice statutes, the legislature allowed for court appointment of a plaintiff ad litem for lost-chance causes of action when the original plaintiff had already died.¹¹¹ Whereas the lost-chance doctrine may in many cases fly under a state legislature's radar screen when it goes about enacting tort-reform measures, the same cannot be said about Missouri. Following its 1993 efforts, the Missouri legislature in 2005 enacted tort-reform legislation that put caps on punitive damage awards, limited the use of joint and several liability, and imposed venue restrictions, but did nothing to rein in the scope of lost-chance causes of action.¹¹² As the legislature was distinctly aware of the lost-chance doctrine during its 2005 reform efforts when it decided to leave the doctrine in place, the legislature presumably was unable to trace any burdensome tort-related expenses back to the doctrine that would have warranted overturning it. Perhaps this absence of burdensome expenses was a function of certain checks inherent in how the doctrine is typically applied.

C. *The Self-Policing Nature of the Lost-Chance Doctrine*

In response to the Supreme Court of Massachusetts's ruling in *Matsuyama*,¹¹³ Joseph L. Doherty, a medical malpractice defense attorney, stated, "I don't anticipate that we're going to see a barrage... of stand-alone loss of chance cases apart from the wrongful-death medical-malpractice claims that have always been allowed."¹¹⁴ Doherty's statement is insightful, and it serves to

109. John L. Roark, *Loss of Chance Revisited*, MO. ORG. DEF. LAW., Winter 2005, at 1, 9, available at <http://www.humanspan.com/uploads/archives/4914/modlwinter05.pdf> ("[T]he Missouri Legislature has likewise addressed who may assert this type of claim.")

110. 828 S.W.2d 681, 685 (Mo. 1992) (en banc).

111. MO. REV. STAT. § 537.021 (2008); Roark, *supra* note 109, at 9 n.4.

112. Christopher Brown, *Missouri Malpractice Claims Decrease Following 2005 Tort Reform, Report Shows*, 16 HEALTH L. REP. 1185, 1186 (2007).

113. *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 823 (Mass. 2008).

114. Frank, *supra* note 28, at 15.

illustrate how the lost-chance methodology actually fits into a particular medical malpractice lawsuit. The typical patient who is injured, ostensibly, by medical negligence is unlikely to know whether his particular state recognizes the lost-chance doctrine. As such, the likelihood that this patient would initiate contact with a plaintiff's attorney based even partly on the potential for a lost-chance cause of action is low. Similarly, a plaintiff's attorney would have difficulty using the lost-chance doctrine as a way to drum up business because—even assuming adoption of the doctrine does in fact lead to a more plaintiff-friendly jurisdiction—a particular patient's "lost chance" is actually calculated once a case has proceeded to the discovery phase and expert witnesses examine the patient.¹¹⁵ By this point in the litigation, the parties should be able to determine whether or not the plaintiff has a colorable claim, regardless of the lost-chance doctrine's availability. Thus, to suggest that a particular patient or plaintiff's attorney might exploit the lost-chance doctrine as a means of bringing a frivolous lawsuit is to ignore some significant logistical hurdles that plaintiffs would have to overcome before the doctrine could be used in such a way.¹¹⁶

Furthermore, the lost-chance doctrine itself is, to a certain extent, self-policing. The Supreme Court of Nevada illustrated this concept when it adopted the doctrine in *Perez v. Las Vegas Medical Center*,¹¹⁷ dismissing the dissenting opinion's "opening-the-floodgate" fears by stating:

115. 61 AM JUR. 2D *Physicians, Surgeons, and Other Healers* § 318 (2008) ("In a medical malpractice case, the patient generally must prove by use of expert testimony both that the diagnosis or treatment complained of constitutes negligence and that it is the proximate cause of the patient's injuries.").

116. Of course, this presupposes that plaintiffs' attorneys will only pursue claims that they believe to have merit, which may be somewhat naïve. Various studies have documented the frequency with which lawsuits are filed in which the doctor was not negligent, claims are paid when the doctor was not negligent, or would-be meritorious claims are never filed. *See, e.g.,* David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2030 (2006) (finding that, out of a study sampling 1,452 malpractice claims, thirty-seven percent of the claims involved no negligence and, out of this thirty-seven percent, twenty-eight percent resulted in payment); *see also* REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK: PATIENTS, DOCTORS, AND LAWYERS; MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6 (1990) (estimating that for every malpractice lawsuit filed, eight patients suffered an injury due to negligence and did not file suit). Thus, while much of the analysis in this Comment assumes an efficiently and ethically working tort system, in reality, things may be quite different.

117. 805 P.2d 589 (Nev. 1991).

In order to create a question of fact regarding causation in [lost-chance] cases, the plaintiff must present evidence . . . that some negligent act or omission by health care providers reduced a substantial chance of survival given appropriate medical care [W]e need not now state exactly how high the chances of survival must be in order to be “substantial.” We will address this in the future on a case by case basis. There are limits, however, and we doubt that a ten percent chance of survival as referred to in the example in the dissenting opinion would be actionable. Survivors of a person who had a truly negligible chance of survival should not be allowed to bring a case fully through trial. *Perhaps more importantly, in cases where the chances of survival were modest, plaintiffs will have little monetary incentive to bring a case to trial because damages would be drastically reduced to account for the preexisting condition.*¹¹⁸

Thus, while the basic logistics of pursuing a medical malpractice lawsuit make a standalone lost-chance claim unlikely and limit the doctrine’s potential for abuse, the *Perez* court further illustrates the economic futility of filing a lost-chance claim in which the chance that was “lost” is truly negligible.¹¹⁹

III. ANALYZING THE EFFECTS (OR LACK THEREOF) OF A STATE’S ADOPTION OF THE LOST-CHANCE DOCTRINE

Admittedly, even once the lost-chance doctrine is put into the appropriate context and its self-policing aspects are considered, the conclusion does not necessarily follow that a particular state’s decision to adopt the doctrine has *no* effect on medical malpractice within that state. Any such effect—if it exists—likely would be observable in one of two ways: (1) a spike in the overall number of medical malpractice lawsuits filed in a particular state in the years following that state’s adoption of the lost-chance doctrine; or (2) a spike in the per-doctor premium rates paid for medical malpractice insurance in the years following that state’s adoption of the doctrine. While raw data consisting of either the per-state number of

118. *Id.* at 592 (emphasis added).

119. *Id.* In spite of the appealing rationale of the *Perez* court, it should be noted that a state supreme court decision in Kansas permitted recovery when the patient’s chances of recovery were reduced by only ten percent (from a ten percent chance of survival to zero). *Pipe v. Hamilton*, 56 P.3d 823, 829 (Kan. 2002) (“[Plaintiff] contends a 10 percent chance of survival is more than a trifling matter and is something that Kansas public policy supports as being recognized as substantial. We agree. As a matter of law, a 10 percent loss of chance cannot be said to be token or de minimis.”).

malpractice lawsuits filed or the per-doctor insurance premium rates of a particular state are difficult to obtain, the data that are available give no indication that a state's adoption of the lost-chance doctrine has an effect on either of these two facets.¹²⁰

A. *Effect of Adopting the Doctrine on the Number of Malpractice Claims Filed*

While data indicating the number of medical malpractice lawsuits filed per state, per year would provide the most ideal means of analyzing the effects of a state's decision to adopt the lost-chance doctrine, such data are not readily accessible.¹²¹ Instead, the most comprehensive database capable of providing helpful information regarding the prevalence of medical malpractice lawsuits consists of the number of claims paid by malpractice insurers.¹²² This database, termed the "National Practitioner Data Bank" ("NPDB"), is compiled, updated, and maintained by the United States Department of Health and Human Services ("DHHS").¹²³ Federal law mandates that each time a medical malpractice insurer pays a claim on behalf of one of its insureds, the insurer must report the payment and the identity of the insured to DHHS.¹²⁴ Beginning in 1990, DHHS has compiled these reported claims payments into NPDB, thereby

120. See *infra* notes 122 and 135 and accompanying text. Ideally, the best data for such analyses would be a state-by-state, year-by-year account of the number of medical malpractice claims filed in court, and an account of the per-doctor dollar amounts of malpractice insurance payments made per year. Surprisingly, both types of information are scarce, and the information that is available is more of a snapshot of a few selected states or a few selected years rather than longitudinal data compiled and organized annually. As such, many of the conclusions in this Comment are based upon inferences from data that were compiled for a purpose other than analyzing the lost-chance doctrine. Another potential source of imprecision may arise from the fact that when a particular state decides to adopt the lost-chance doctrine, it may take years for any potential increase of lost-chance medical malpractice claims to be filed, litigated, adjudicated, and ultimately paid by an insurer. While the analysis in this Comment assumes a delay period of approximately two or three years between a state's adoption of the lost-chance doctrine and any suspected increase in claims filed or premium rates, this is only a rough estimate.

121. Given the lack of relevant statewide data, a more effective means of measuring the effect of a state's adoption of the lost-chance doctrine might be to analyze selected counties (or other relevant districts) within the particular state. For instance, comparing the number (or even type) of medical malpractice claims brought in Suffolk County (Boston) in the wake of the *Matsuyama* decision with the number (or type) of claims brought prior to the decision might be a more accurate method of discerning any cause-and-effect relationship.

122. National Practitioner Data Bank, <http://www.npdb-hipdb.hrsa.gov/> (last visited Jan. 2, 2010).

123. *Id.*

124. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784, 3788 (codified as amended in scattered sections of 42 U.S.C.).

providing a source for the number and dollar amounts of claims paid by state, by year.¹²⁵

Sorting through the data in NPDB provides a rough idea of whether a state's adoption of the lost-chance doctrine creates a spike in the number of medical malpractice claims being paid. Two states appropriate for such an inquiry are Ohio and Illinois. Both states have relatively large populations and adopted the lost-chance doctrine in the mid-1990s.¹²⁶ Ohio's supreme court adopted the lost-chance doctrine in 1996.¹²⁷ NPDB reports 773 claims paid in 1994, 790 claims paid in 1995, 803 claims paid in 1996, 734 claims paid in 1997, 512 claims paid in 1998, 983 claims paid in 1999, 976 claims paid in 2000, 731 claims paid in 2001, and 613 claims paid in 2002.¹²⁸

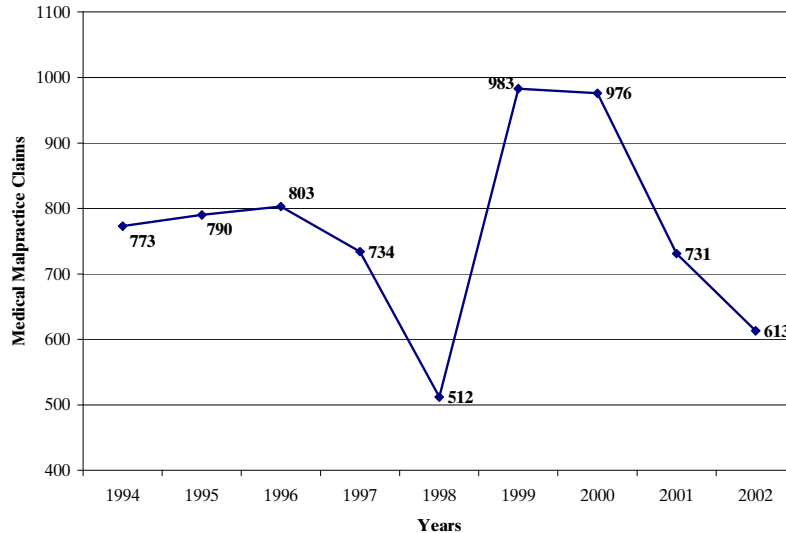
125. National Practitioner Data Bank, *supra* note 122.

126. While NPDB data are available from 1990 through 2008, data for the beginning years and ending years are markedly sparser than for the middle years, indicating that all paid claims have likely not been reported or accounted for. Similarly, while Iowa, New Mexico, and Indiana are three other states that adopted the lost-chance doctrine in the mid-to-late 1990s and would otherwise be appropriate for this analysis, NPDB reports no claims information in these states for the years 1996 through 2003. Thus, although many studies cite the NPDB as a key authority for their findings, and NPDB may be the best available source for relevant malpractice claims data, it is far from perfect. *See generally* U.S. GEN. ACCOUNTING OFFICE, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY (2000), available at <http://www.gao.gov/new.items/d01130.pdf> (indicating various flaws in NPDB's reporting processes).

127. *Roberts v. Ohio Permanente Med. Group*, 668 N.E.2d 480, 484 (Ohio 1996) (“[W]e recognize the loss-of-chance theory and follow the [proportional] approach . . .”).

128. Data available for download at NPDB Web site: <http://www.npdb-hipdb.hrsa.gov/publicdata.html>.

Figure 1. Reported Medical Malpractice Claims in Ohio, 1994–2002



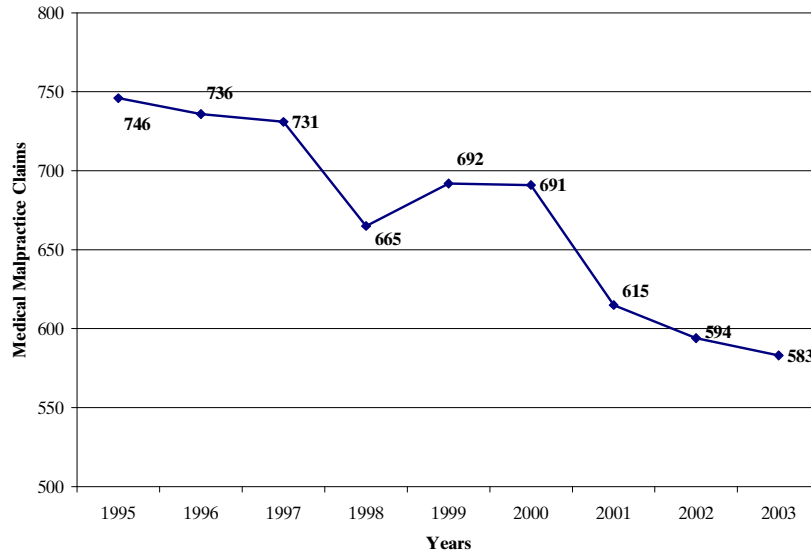
Even assuming that the jump in paid claims during 1999 and 2000 was directly attributable to the court's adoption of the lost-chance doctrine, one would expect this level to continue afterward. Instead, the number of paid claims decreased in 2001 and 2002. The volatility of the number of claims paid per year indicates that more significant factors, rather than merely Ohio's adoption of the lost-chance doctrine, are dictating the prevalence of medical malpractice claims in the state.

Similar to Ohio, the Supreme Court of Illinois adopted the lost-chance doctrine in 1997.¹²⁹ NPDB reports 746 claims paid in 1995, 736 claims paid in 1996, 731 claims paid in 1997, 665 claims paid in 1998, 692 claims paid in 1999, 691 claims paid in 2000, 615 claims paid in 2001, 594 claims paid in 2002, and 583 claims paid in 2003.¹³⁰

129. *Holton v. Mem'l Hosp.*, 679 N.E.2d 1202, 1213 (Ill. 1997) (“We therefore reject the reasoning . . . that plaintiffs may not recover for medical malpractice injuries if they are unable to prove that they would have enjoyed a greater than 50% chance of survival or recovery absent the alleged malpractice of the defendant.”).

130. Data available for download at NPDB Web site: <http://www.npdb-hipdb.hrsa.gov/publicdata.html>.

Figure 2. Reported Medical Malpractice Claims in Illinois, 1995–2003



While likely coincidental, the number of claims paid in Illinois in the years following its adoption of the lost-chance doctrine actually *decreased*. Nevertheless, it stands to reason that any affirmative link between Illinois' adoption of the lost-chance doctrine and an increase in medical malpractice litigation would not result in *fewer* claims actually being paid.

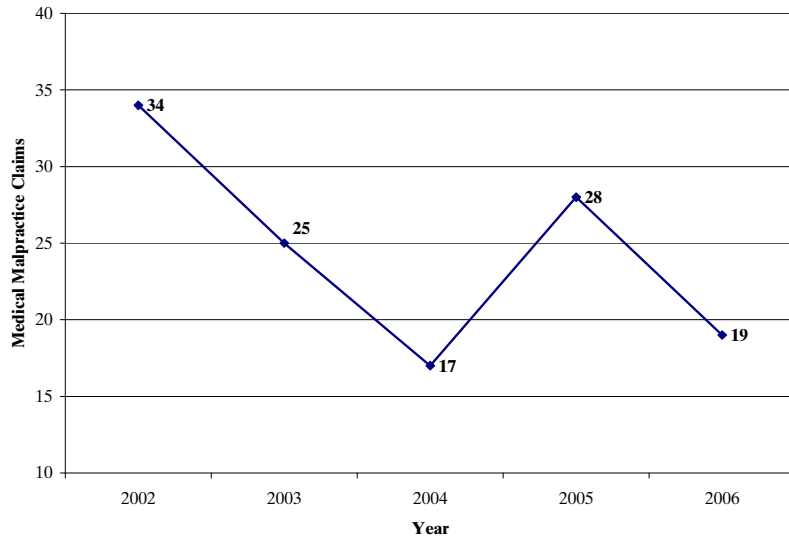
In its own annual report in 2006 based upon NPDB data, DHHS listed the number of reported claims paid by state for the years 2002 through 2006.¹³¹ After the Supreme Court of Wyoming adopted the lost-chance doctrine in 2003,¹³² the DHHS Report indicated that in Wyoming, there were thirty-four claims paid in 2002, twenty-five claims paid in 2003, seventeen claims paid in 2004, twenty-eight claims paid in 2005, and nineteen claims paid in 2006.¹³³

131. U.S. DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK: 2006 ANNUAL REPORT 72 (2006), available at http://www.npdb-hipdb.hrsa.gov/pubs/stats/2006_NPDB_Annual_Report.pdf [hereinafter DHHS ANNUAL REPORT]. As mentioned previously, the number of reported claims in the more recent years of available NPDB data is lower on a per-state basis than the number reported in earlier years. *Id.* This is likely due to a lag in reporting time and incomplete information, rather than an actual decrease in claims paid. As such, the data should be interpreted with this in mind.

132. *McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094, 1100 (Wyo. 2003) (“We hold that the doctrine of ‘loss of chance’ is cognizable in Wyoming . . .”).

133. DHHS ANNUAL REPORT, *supra* note 131, at 72.

Figure 3. Reported Medical Malpractice Claims in Wyoming, 2002–2006



Although Wyoming has a substantially lower population than Illinois or Ohio, and its fluctuation of reported claims is greater percentage-wise, no discernable jump and plateau exists that could potentially be connected with the state's adoption of the lost-chance doctrine.

The data reported by DHHS in NPDB suggest that a particular state's adoption of the lost-chance doctrine has no apparent effect on the number of claims being paid with medical malpractice insurance funds in that particular state. To be sure, this determination does not inevitably lead to the conclusion that adoption of the doctrine likewise has no effect on the number of malpractice lawsuits being *filed*. But, an effect (or lack thereof) on the number of claims paid is likely indicative of the same effect on the number of lawsuits filed.

B. Effect of Adopting the Doctrine on Doctors' Malpractice Insurance Rates

While the volatility of claims paid per year is substantial, an analysis of malpractice insurance premium payments in several states that addressed the lost-chance doctrine in the mid-1990s indicates that the economic effect of such an adoption can be nothing more than a proverbial drop in the bucket.

The supreme courts of Delaware and Louisiana adopted the lost-chance doctrine in 1995 and 1996, respectively.¹³⁴ In 1996, the year following Delaware's adoption of the doctrine, malpractice insurance providers wrote \$17.3 million in premiums for medical professionals within the state.¹³⁵ By 2004, this number had increased to \$38.3 million, more than doubling in less than a decade.¹³⁶ Similar to Delaware, malpractice insurance providers in Louisiana wrote \$67.8 million in premiums for medical professionals within the state in 1997, the year following Louisiana's adoption of the lost-chance doctrine.¹³⁷ By 2004, this figure had increased to \$120.5 million, nearly double the amount eight years prior.¹³⁸ At first glance, the spike in written premiums in Delaware and Louisiana might seem to correspond with each state's adoption of the lost-chance doctrine (assuming that the first lost-chance claims took several years to be litigated, for claims to be paid by insurance providers, and for insurance providers to adjust their rates charged to medical professionals accordingly).

An analysis of two other states, however, negates any apparent connection between a state's adoption of the lost-chance doctrine and a rise in malpractice insurance premium rates for doctors within that state. The supreme courts of Nebraska and Tennessee also addressed the lost-chance doctrine in the mid-1990s, but contrary to Delaware and Louisiana, these two states rejected the doctrine.¹³⁹ In spite of its rejection, the amount of malpractice insurance premiums written in Nebraska increased from \$18.8 million in 1996 to \$34.1 million in 2004,¹⁴⁰ an increase roughly comparable to that experienced in Delaware, which chose to adopt the lost-chance doctrine. Likewise, premiums written by malpractice insurance providers in Tennessee increased from \$156 million in 1997 to \$340 million in 2004,¹⁴¹ far exceeding the rate of increase in Louisiana—which chose to adopt the doctrine—in this same time period. Thus, factors other than a state's

134. *United States v. Anderson*, 669 A.2d 73, 77 (Del. 1995); *Smith v. State Dep't of Health & Hosps.*, 95-0038, p. 5 (La. 6/25/96), 676 So. 2d 543, 550.

135. NAT'L ASS'N OF INS. COMM'RS, COUNTRYWIDE SUMMARY OF MEDICAL MALPRACTICE INSURANCE, CALENDAR YEARS 1991-2008, at 22, (Sep. 1, 2009) [hereinafter NAIC SUMMARY], http://www.naic.org/documents/research_stats_medical_malpractice.pdf.

136. *Id.*

137. *Id.* at 26.

138. *Id.*

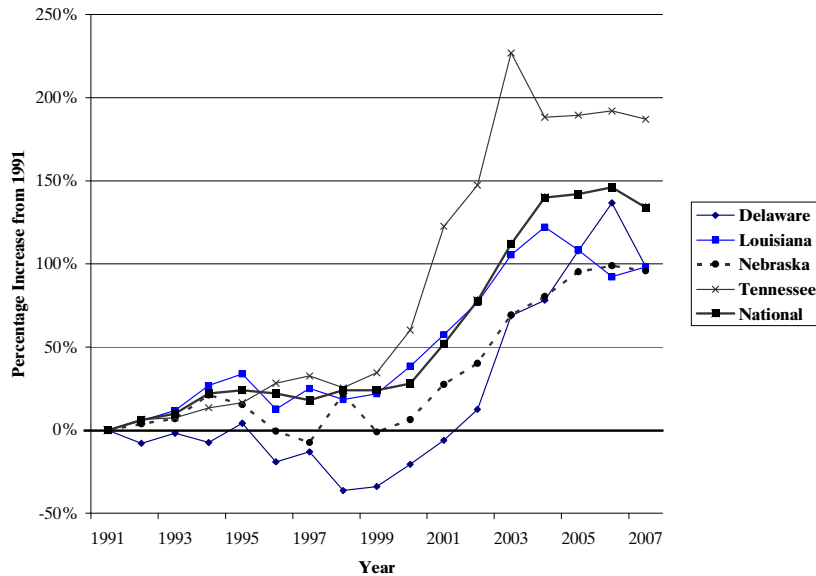
139. Nebraska's supreme court rejected the doctrine in 1994. *Steineke v. Share Health Plan of Neb., Inc.*, 518 N.W.2d 904, 907 (Neb. 1994). Tennessee's supreme court rejected the doctrine in 1993. *Kilpatrick v. Bryant*, 868 S.W.2d 594, 603 (Tenn. 1993).

140. NAIC SUMMARY, *supra* note 135, at 29.

141. *Id.* at 34.

adoption or rejection of the lost-chance doctrine seemingly dictate premium rates for medical malpractice insurance.¹⁴²

Figure 4. Annual Malpractice Insurance Premiums Written as a Percentage of Payments Paid in 1991¹⁴³



Indeed, NAIC's data indicate that malpractice insurance premium rates rose dramatically nationwide during the late 1990s and early 2000s, nearly doubling between 1999 and 2004.¹⁴⁴ Some states felt this nationwide increase more dramatically, causing the American Medical Association to label certain states as "full-blown crisis" states

142. This comparison simply illustrates that larger factors are at play and that, if adoption of the doctrine has *any* effect, it is dwarfed by these larger factors, as will be discussed further in this Part.

143. Figure 4 compares total annual medical malpractice premiums paid in the four states with each other and with the nationwide trend. The actual dollar amounts of each state's (and the national) premiums written are too disparate to provide a meaningful graphical comparison of the dollar-amount increases per year. Instead, the graph represents each state's (and the national) absolute percentage increase in premiums written per year when compared to the dollar amount written in 1991, the first year for which NAIC data are available. For instance, the total dollar amount of premiums written nationally in 2000 was approximately 30 percent higher than in 1991. In 2004, it was approximately 130 percent higher than in 1991.

144. NAIC data indicate that, nationally, medical malpractice insurers wrote \$6.2 billion in premiums in 1999, compared with \$12.0 billion in 2004. NAIC SUMMARY, *supra* note 135, at 1.

due to their drastic increases in premium rates.¹⁴⁵ The root causes of these increases, however, are not clear-cut. Whereas the American Medical Association and other tort-reform proponents point to the most intuitively obvious cause—medical malpractice litigation—evidence exists to indicate that litigation-related costs play a relatively small role in escalating malpractice insurance premium rates.¹⁴⁶

A 2004 study conducted by Dartmouth University professors Katherine Baicker and Amitabh Chandra (“Dartmouth Study”) sought to answer the specific question: “[A]re increases in [malpractice claim] payments responsible for increases in medical malpractice premiums?”¹⁴⁷ The Dartmouth Study used data from two sources: the NPDB and the Medical Liability Monitor (“MLM”),¹⁴⁸ an organization that collects and publishes information pertaining to medical malpractice insurance premium rates.¹⁴⁹ By analyzing NPDB’s malpractice claims data in tandem with MLM’s malpractice insurance premium data, the Dartmouth Study was able to conduct a comprehensive analysis of how malpractice claims affect malpractice insurance rates.¹⁵⁰ “Surprisingly,” the Dartmouth Study concluded, “there seems to be a fairly weak relationship between malpractice payments (for judgments and settlements) and premiums.”¹⁵¹ Although the study did indicate that “[w]hile premiums do respond to increases in [malpractice claim] payouts, they do not increase dollar

145. Am. Med. Ass’n, Medical Liability Reform: Q&A, http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_tp.pdf (last visited Jan. 2, 2010).

146. See *infra* notes 150–53 and accompanying text.

147. Baicker & Chandra, *supra* note 1, at 2.

148. *Id.* at 9–10.

149. Welcome to Medical Liability Monitor, <http://www.medicalliabilitymonitor.com/about.html> (last visited Jan. 2, 2010). Medical Liability Monitor (“MLM”) touts itself as “the only independent source of consistent, reliable coverage and fresh perspectives on medical professional liability insurance and risk management.” *Id.* It provides subscribers with “the latest information on medical liability insurance rates and trends, tort reform, significant jury verdicts, and what’s happening with liability insurers around the nation.” *Id.*

150. Baicker & Chandra, *supra* note 1, at 8–14. As with any attempt to discern common trends from complex and interrelated factors, the Dartmouth Study acknowledged several shortcomings in its data sources and its analysis that might have affected the accuracy of the study’s conclusions. *Id.* at 21–24. In particular, the study indicated that, with respect to raising premium rates in response to an increase in malpractice claims payments, some states that were experiencing “crises” in 2000 to 2001 may have responded more directly to these malpractice claims payments than was the general trend throughout the decade-long study. *Id.* at 21–22. Further, the study indicated that it was difficult to identify an accurate lag time between when insurers noticed an increase in malpractice claims payments and when they reacted by raising premium rates. *Id.* at 22.

151. *Id.* at 13.

for dollar, suggesting that other factors are at work as well.”¹⁵² The study indicated as an aside that “[o]ur analysis suggests that indirect and anecdotal evidence on the size of these effects may be quite misleading.”¹⁵³

Thus, although the Dartmouth Study did not conclude that malpractice claims have *no* effect on malpractice insurance rates, it did conclude that the link between the two was “fairly weak” and that “other factors are at work.”¹⁵⁴ A few of these factors, as identified by the study, include a decline in the portion of insurers’ income typically made from investing, decreased competition among insurers, and increasing reinsurance rates.¹⁵⁵

To ensure that an insurance company remains financially capable of paying claims on policies that it has written, states regulate how much of a typical insurance company’s assets may be tied up in investments at any given time and the types of products in which the company may invest.¹⁵⁶ Although these products are primarily low-risk investment vehicles, at times, the returns on the insurance company’s investments fail to meet the company’s projections.¹⁵⁷ When the company suspects it may fail to meet its investment income projections, a state will require the company—again, with the purpose of ensuring the company’s continued financial viability—to raise premium rates in order to compensate for the income the company expected to earn from its investments.¹⁵⁸ Because the majority of an insurance company’s assets are tied up in investments (as opposed to the immediate day-to-day premium-writing and claim-paying side of its business), even a small decrease in investment expectations may result in the company needing to increase its premium rates by a noticeable amount.¹⁵⁹

152. *Id.* at 14.

153. *Id.* at 2.

154. *Id.*

155. *Id.*

156. GAO, *supra* note 9, at 24–25.

157. *Id.* This was the case in the early 2000s when the bond market—the primary investment source for insurance companies—failed to produce the returns that investors expected. *Id.*

158. *Id.* at 25. The opposite is true as well. When insurance companies exceed their investment projections, states require them to decrease their premium rates. *Id.* In fact, an insurance company may actually lose money on the underwriting portion of its business but earn enough from its investments so that it makes a total net profit for the relevant time period. *Id.* at 25–26.

159. *Id.* at 26. The GAO provides an example of an insurance company with \$100,000 in investment assets that collected \$25,000 in premiums for a particular year. As the ratio between investment income and premium income is four to one, a one percent decrease in

If selling medical malpractice insurance in a particular state ceases to be profitable for an insurance company, it may stop providing it.¹⁶⁰ If the company making this decision is large enough to the point where its exit from the market leaves a void that the remaining companies cannot fill, the remaining companies may not need to be as competitive with each other in terms of providing insurance with low premiums.¹⁶¹ Accordingly, the remaining companies may increase their premium rates due to the lack of competition. Another explanation may be that the remaining companies are prohibited from filling the void.¹⁶² Once again, in order to ensure that a particular company remains financially capable of paying the claims that may arise from the policies it writes, states limit the amount of insurance a particular company can sell in relation to the company's net assets.¹⁶³ Thus, if the remaining insurance companies in a particular state are relatively small in size, they might not be permitted to provide low-premium insurance even if they wanted to.¹⁶⁴

The third factor identified by the Dartmouth Study as a driving force behind rising medical malpractice insurance premiums is the reinsurance industry.¹⁶⁵ Insurance companies themselves purchase insurance from various entities (reinsurers) in order to mitigate the risk of writing a medical malpractice policy that becomes particularly unprofitable (i.e., the insurance company must pay a claim where the dollar amount far exceeds the premium amount collected from the policyholder).¹⁶⁶ In anticipation of such a situation, an insurance company may have purchased a reinsurance contract from a reinsurer in which the reinsurer promises to reimburse the insurance company for any dollar amount on a particular claim that exceeds a certain threshold.¹⁶⁷ If medical malpractice insurers treat the need to purchase reinsurance as part of their operating costs, and reinsurance

investment assets will require the insurer to raise its premium rates by four percent in order to satisfy state requirements. *Id.*

160. *Id.* at 31.

161. *Id.*

162. *Id.*

163. *Id.*

164. *See id.*

165. *See* Baicker & Chandra, *supra* note 1, at 3.

166. GAO, *supra* note 9, at 32.

167. For instance, an insurance company may have a reinsurance contract that takes effect only once it has paid \$300,000 toward a particular medical malpractice claim. In the same way a deductible works with personal health insurance, the insurance company must pay up to \$300,000 toward the claim but then gets reimbursed by the reinsurance company for any amount over \$300,000. *Cf. id.* at 32 (discussing a perceptible increase in reinsurance premium rates).

companies raise the rates they charge to provide reinsurance, the medical malpractice insurers will likely have to recoup these extra costs somewhere—most likely by charging higher premiums on the malpractice policies they sell.¹⁶⁸ Thus, when purchasing reinsurance becomes more expensive for medical malpractice insurance providers, these additional costs are passed along to those purchasing malpractice policies, regardless of whether the increased cost of providing and purchasing reinsurance was a result of more medical malpractice claims being paid.¹⁶⁹

As described in the Dartmouth Study, various factors other than medical malpractice claims themselves appear to be the driving force behind the malpractice insurance premium rates that medical professionals must pay. It should go without saying, then, that a particular state's adoption of the lost-chance doctrine is even more tangentially related to any potential effect that medical malpractice claims may have on malpractice insurance rates in that particular state. Indeed, the comparison of two adopting states and two non-adopting states indicates no discernable difference in the premium amounts being paid in light of the states' respective court decisions concerning the lost-chance issue. While not definitive proof of the doctrine's complete lack of effect on malpractice insurance rates, any connection is seemingly negligible and is likely dwarfed by other more significant factors. Accordingly, without this intermediate connection between the lost-chance doctrine's adoption and an increase in malpractice insurance rates, the arguments that suggest an ultimate connection between the doctrine's adoption and an increase in overall health care costs seems even more unfounded.

168. *Id.*

169. The GAO study indicates two primary reasons for the increase in reinsurance rates: first, the reinsurance industry suffered immense financial setbacks and, as a result, became more conservative in its underwriting policies in the wake of the September 11, 2001, terrorist attacks. *Id.* Second, the amount of reinsurance claims being filed by malpractice insurers has increased. *Id.* Admittedly, this second reason seemingly detracts from the argument that increased medical malpractice claims are not the cause of increased medical malpractice insurance premiums.

IV. USING JUDICIAL DISCRETION AND RULES OF EVIDENCE TO LIMIT THE LOST-CHANCE DOCTRINE'S SCOPE

A. *Confining the Lost-Chance Doctrine to Medical Malpractice Litigation*

Much of the apprehension concerning the lost-chance doctrine is that a court's acceptance of the concept as a cause of action in medical malpractice cases will inevitably lead to its adoption in other types of cases, whether it be legal malpractice, personal injury tort claims, or breach of contract cases.¹⁷⁰ While there are no logical impediments prohibiting a court from allowing the expansion of the doctrine into other areas,¹⁷¹ courts that have adopted the lost-chance doctrine thus far have only applied it to medical malpractice claims and have steadfastly refused to apply it elsewhere.¹⁷²

When the Supreme Court of Missouri adopted the lost-chance doctrine in *Wollen v. DePaul Health Center*,¹⁷³ the court made expressly clear that "this Court chooses to recognize a cause of action for lost chance of recovery in *medical malpractice cases*."¹⁷⁴ Five years later, a Missouri appellate court refused to apply the lost-chance doctrine to a civil action in which a defendant prison guard had deprived the plaintiff inmate of his epilepsy medication.¹⁷⁵ In doing so, the appellate court stated, "[w]e are unable to conclude that

170. Weigand, *supra* note 16, at 301 ("In theory, loss of chance is applicable to any type of case in which the chances of a better outcome have been diminished, although it has received limited acceptance in non-medical malpractice actions."). Several other articles also address the potential for expansion into different areas of civil litigation, such as legal malpractice. See, e.g., Benjamin H. Barton, *Do Judges Systematically Favor the Interests of the Legal Profession?*, 59 ALA. L. REV. 453, 494-96 (2008) (arguing that judges, in order to protect their profession, are averse to expanding the lost-chance doctrine outside of medical malpractice and into legal malpractice); John C. P. Goldberg, *What Clients Are Owed: Cautionary Observations on Lawyers and Loss of a Chance*, 52 EMORY L.J. 1201, 1201-13 (2003) (illustrating potential for expansion of the lost-chance doctrine into legal malpractice but indicating various potential complications associated with doing so). For a particularly interesting article written by a defense attorney in favor of "across-the-board" utilization of the lost-chance doctrine, see Jonathan P. Kieffler, *The Case for Across-the-Board Application of the Loss-of-Chance Doctrine*, 64 DEF. COUNS. J. 568 (1997). In spite of the potential for future application in other areas of law, this Comment focuses solely on the effect that adoption of the lost-chance doctrine has in medical malpractice cases.

171. See generally Kieffler, *supra* note 170 (proposing that a proportional approach to calculating damages in civil litigation be applied "across-the-board").

172. See, e.g., *Kemp v. Balboa*, 959 S.W.2d 116, 119 (Mo. Ct. App. 1997) (refusing to apply the lost-chance doctrine when plaintiff sued a non-medical professional for depriving him of medication).

173. 828 S.W.2d 681 (Mo. 1992) (en banc).

174. *Id.* at 685 (emphasis added).

175. *Kemp*, 959 S.W.2d 116.

Wollen opened the door to ‘lost chance of recovery’ claims in every tort action in which a plaintiff contends that his physical injuries may have shortened his life. [Plaintiff’s] action was not a medical malpractice action.”¹⁷⁶ As the dividing line between a medical malpractice action and a non-medical malpractice action is unambiguous and often defined by state statute, the ability of the Missouri courts to restrict the lost-chance doctrine to medical malpractice cases is indicative of the ease with which other courts are capable of doing the same.

B. Continuing to Require Expert Testimony in Lost-Chance Cases

Even within the limited scope of medical malpractice litigation, courts in states that have adopted the lost-chance doctrine have been able to control its use and potential misuse by continuing to require that plaintiffs provide reliable expert testimony indicating the actual chance that has been lost. The Supreme Court of Illinois, for example, adopted the lost-chance doctrine in 1997 in *Holton v. Memorial Hospital*.¹⁷⁷ Six years later, the court refused to grant relief under the lost-chance rationale to a plaintiff who had not provided expert testimony regarding causation. In *Snelson v. Kamm*,¹⁷⁸ the court made expressly clear that *Holton* did “not set aside the requirement that a plaintiff present expert testimony asserting that a defendant hospital deviated from the standard of care and that *that deviation* was the proximate cause of the plaintiff’s injury.”¹⁷⁹ The Supreme Court of Illinois’ decision in *Snelson* is important because it exemplifies the fact that the lost-chance doctrine does not compromise any traditional evidentiary requirements and that, when applied in tandem with these requirements, the doctrine does not necessarily open the courthouse doors to an influx of new litigation.

The Supreme Court of Illinois’ decisions are by no means the exception to the rule. Numerous other states that have adopted the lost-chance doctrine have been able to control the doctrine’s spread and to prevent plaintiffs from using the doctrine to skirt the rules of evidence. The Supreme Court of Ohio adopted the doctrine in

176. *Id.* at 119.

177. 679 N.E.2d 1202, 1213 (Ill. 1997) (“We therefore reject the reasoning of cases which hold, as a matter of law, that plaintiffs may not recover for medical malpractice injuries if they are unable to prove that they would have enjoyed a greater than 50% chance of survival or recovery absent the alleged malpractice of the defendant.”).

178. 787 N.E.2d 796 (Ill. 2003).

179. *Id.* at 821.

*Roberts v. Ohio Permanente Medical Group*¹⁸⁰ in 1996, effectively overturning a longstanding decision in which the court had expressly disavowed the doctrine.¹⁸¹ Subsequently, the Supreme Court of Ohio has clarified the applicable scope of its lost-chance doctrine. In *Dobran v. Franciscan Medical Center*,¹⁸² the plaintiff's chance of recovery prior to the defendant's negligent misdiagnosis was over fifty percent.¹⁸³ In denying the plaintiff's lost-chance claim, the court stated that "*Roberts* contemplates those plaintiffs who had a 'less-than-even chance of recovery or survival' that was diminished even further by the defendant's negligence. [Plaintiff] has not been diagnosed with metastatic cancer, and consequently cannot claim that his chance of survival is less than fifty percent."¹⁸⁴

The *Dobran* decision illustrates the fact that the lost-chance doctrine is, by its own nature, limited in applicability to cases in which the plaintiff's odds of recovery prior to the defendant doctor's negligence were already less than fifty percent. A recent appellate decision in Ohio applied *Dobran's* logic in denying a plaintiff's lost-chance claim. In *Haney v. Barringer*,¹⁸⁵ the plaintiff was unable to provide a qualified expert witness to testify regarding causation.¹⁸⁶ Instead of withdrawing her claim, the plaintiff amended her complaint and added a lost-chance cause of action as well.¹⁸⁷ On appeal, the court dismissed the plaintiff's lost-chance claim, holding:

[A] medical malpractice plaintiff cannot simply rely on a loss-of-chance theory if some problem arises with respect to proving proximate cause. In effect, the plaintiff must either prove traditional proximate cause, or prove that traditional notions of proximate cause do not apply because the chance of survival or recovery was less than [fifty percent] at the time of defendant's negligence.¹⁸⁸

The *Dobran* and *Haney* decisions in the Ohio courts effectively address the concerns that the lost-chance doctrine might circumvent

180. 668 N.E.2d 480 (Ohio 1996).

181. *Id.* at 484 ("In revisiting [prior caselaw], we recognize that our court has traditionally acted as the embodiment of justice and fundamental fairness. Rarely does the law present so clear an opportunity to correct an unfair situation as does this case before us.").

182. 102 Ohio St. 3d 54, 2004-Ohio-1883, 806 N.E.2d 537.

183. *Id.* at 56 n.1, 2004-Ohio-1883 ¶ 8 n.1, 806 N.E.2d at 538 n.1.

184. *Id.*

185. No. 06MA141, 2007 Ohio App. LEXIS 6306 (Ohio Ct. App. Dec. 27, 2007).

186. *Id.* at *3-4.

187. *Id.* at *3-4.

188. *Id.* at *9-10.

traditional evidentiary requirements for bringing a malpractice action. The doctrine does not allow a plaintiff with a lack of evidence regarding causation to recover under a “fallback” cause of action. When applied appropriately, it merely enables a plaintiff who has reliable statistical evidence of *some* causal connection in the generality of similar cases to get to the jury when the plaintiff’s pre-negligence odds of recovery were already less than fifty percent.

C. *Continued Threshold of Reliability Necessary for Admitting Evidence*

Several courts have reiterated the need for reliable statistical evidence. Perhaps the best example of this is *Alberts v. Schultz*,¹⁸⁹ the decision in which the Supreme Court of New Mexico adopted the lost-chance doctrine.¹⁹⁰ The plaintiff in *Alberts* lost his leg after the defendant doctor’s untimely diagnosis of a blood-flow problem.¹⁹¹ After a thorough analysis of the lost-chance doctrine in other jurisdictions throughout the nation, the court expressly adopted the doctrine in New Mexico.¹⁹² Nevertheless, the court went on to conclude that “[i]n this specific case, the Alberts’ are not entitled to compensation under that theory because they did not prove that the alleged malpractice proximately caused [the patient’s] lost chance for a better result.”¹⁹³ While the *Alberts* court accepted the plaintiffs’ argument that the doctor should have diagnosed the abnormality earlier, the court indicated that the plaintiff had not provided any evidence indicating that *if* the abnormality had been identified at an earlier time, the plaintiff’s leg would have had a better chance of being saved.¹⁹⁴ The *Alberts* decision is exemplary because it illustrates the fact that even in a lost-chance cause of action, the plaintiff still must provide valid evidence of causation.

Similar to *Alberts*, when the Supreme Court of Missouri adopted the lost-chance doctrine in *Wollen*, the court clarified that “the lost chance must also be statistically significant within applicable statistical standards.”¹⁹⁵ Thus, the statistical evidence on which the plaintiff’s expert testimony is based must be reliable enough to eliminate speculation and guessing from the calculation of what

189. 1999-NMCA-15, 126 N.M. 807, 975 P.2d 1279.

190. *Id.* ¶ 40, 126 N.M. at 816, 975 P.2d at 1288.

191. *Id.* ¶ 4, 126 N.M. at 809, 975 P.2d at 1281.

192. *Id.* ¶ 40, 126 N.M. at 816, 975 P.2d at 1288.

193. *Id.*

194. *Id.*

195. *Wollen v. DePaul Health Ctr.*, 828 S.W.2d 681, 685 n.3 (Mo. 1992) (en banc).

chance of recovery the plaintiff actually lost. This is key to understanding the effect of the doctrine, as it does not eliminate, or even relax, the standard for the *quality* of evidence that needs to be presented.¹⁹⁶

As a whole, courts in states that have adopted the lost-chance doctrine have shown an ability to confine the doctrine's scope and overall effect on civil litigation. This has been accomplished by expressly limiting the doctrine to medical malpractice cases only, refusing to relax expert testimony requirements, continuing to require valid statistical evidence, and refusing to apply the doctrine in situations where traditional but-for causation is more appropriate. Thus, while opponents of the doctrine may have fears that the lost-chance concept will lead to unwanted consequences, judges have thus far been able to apply the doctrine carefully and appropriately.

CONCLUSION

While the lost-chance doctrine may be seen by some as “the most pernicious example of a new tort action resulting in expanded liability,”¹⁹⁷ the concept itself is neither new nor pernicious when put in its appropriate context. Courts have formally recognized the doctrine for nearly thirty years¹⁹⁸ and have applied similar logic for decades prior to its formal recognition.¹⁹⁹ In fact, nearly every identifiable indicator points to the doctrine's non-effect on the various systems (civil litigation, healthcare, insurance) that opponents of the doctrine argue it destroys.

Indicative of the doctrine's non-effect is that it was not until 2008 that the supreme courts of Massachusetts and Kentucky finally addressed the doctrine for the first time. Although the Supreme Judicial Court of Massachusetts in *Matsuyama*²⁰⁰ and the Supreme Court of Kentucky in *Kemper*²⁰¹ reached opposing conclusions

196. See, e.g., *Matsuyama v. Birnbaum*, 890 N.E.2d 819, 841 (Mass. 2008) (“Our decision today [adopting the lost-chance doctrine] should not be construed to limit a defendant's right or ability vigorously to challenge the statistical evidence.”).

197. Weiss, *supra* note 11, at 4.

198. See *supra* notes 47–55 and accompanying text.

199. See, e.g., *Hicks v. United States*, 368 F.2d 626, 632 (4th Cir. 1966) (“When 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.”); see also Saroyan, *supra* note 47, at 21 (“In 1966, although still implicit, *Hicks v. United States* was the first case to recognize the doctrine of loss of chance as a cause of action under tort law.”).

200. 890 N.E.2d 819 (Mass. 2008).

201. 272 S.W.3d 146 (Ky. 2008).

whether to adopt the lost-chance doctrine—with neither court providing much support for its policy-based decision²⁰²—the evidence that is available supports the decision to adopt the doctrine reached by the Massachusetts court in *Matsuyama*. The apprehensions the *Kemper* court vaguely articulated are largely representative of those that opponents of the lost-chance doctrine have in general: adoption of the lost-chance doctrine undermines the traditional means of determining liability; adoption of the doctrine will lead to an influx of medical malpractice litigation and overburden court dockets; adoption of the doctrine will further increase malpractice insurance rates, thereby further complicating health care reform efforts; and adoption of the doctrine in medical malpractice cases will inevitably lead to its spread into *other* areas of the law.

The fact that these two states have just recently addressed the issue of lost-chance in 2008 is indicative of the doctrine's limited utility to plaintiffs. Presumably, if plaintiffs' attorneys viewed the doctrine as a potential avenue of success for each and every medical malpractice case they litigated, the adopt-or-refute question would have been decided by these states' high courts or precluded by legislative efforts long ago. This is not the case, and in fact to this day, several states have still not addressed the issue at all.²⁰³

The lack of attention paid to the lost-chance doctrine by various state courts and numerous state legislatures can likely be explained by its limited role within a state's court system in general. Civil litigation comprises roughly only seventeen percent of the cases on state court dockets nationwide, with a larger portion consisting of criminal matters.²⁰⁴ Furthermore, within this seventeen percent, medical malpractice cases make up only three percent of all civil cases.²⁰⁵ So while medical malpractice claims receive disproportionate attention in general, both in the media and by state legislators, when compared with other areas of law that comprise a court's docket, the portion of a typical state's total court docket that these claims comprise is small.²⁰⁶ Accordingly, when comparing the dockets of states that have adopted the lost-chance doctrine with states refusing to do so, no difference in the amount of medical malpractice claims being filed among these states is apparent.²⁰⁷ Even when state legislators do take

202. See *supra* note 36 and accompanying text.

203. See *supra* note 59 and accompanying text.

204. See STATE COURT STUDY, *supra* note 78, at 12.

205. See *supra* note 82 and accompanying text.

206. See *supra* notes 81–84 and accompanying text.

207. See *supra* notes 85–89 and accompanying text.

medical malpractice reform efforts, the lost-chance doctrine is rarely addressed at all and is occasionally even given tacit approval.²⁰⁸

Within medical malpractice litigation specifically, the lost-chance doctrine is only conducive to certain types of claims. Any claim in which the plaintiff had a more-likely-than-not chance of recovery prior to the defendant's negligence still falls under the traditional causation standard.²⁰⁹ The lost-chance doctrine merely permits plaintiffs whose chances of recovery were less than even at the time of the defendant's negligence to recover a *proportional* amount of damages.²¹⁰ Furthermore, the doctrine itself is somewhat self-policing because, as a potential plaintiff's "lost chance" of recovery gets smaller, the marginal utility of filing a lawsuit becomes smaller as well.²¹¹

A particular state's decision to adopt the lost-chance doctrine has no clear connection to an increase in the number of malpractice claims filed in that state,²¹² or to an increase in malpractice insurance premium rates in that state.²¹³ Although the data sources analyzed in this Comment were admittedly incomplete and tangentially related to the issues at hand, the lack of any definitive connection lends support to the argument that the lost-chance doctrine does not have a deleterious effect on either court docket congestion or the medical malpractice insurance market.

While opponents of the doctrine fear that courts may expand its application into other areas of the law, this has not yet happened. In fact, many courts choosing to adopt the doctrine have made clear that its application is to be specifically limited to medical malpractice litigation.²¹⁴ In addition to limiting its threshold applicability, courts adjudicating an actual lost-chance claim are capable of applying rules of procedure and evidence to ensure that the doctrine does not become a shortcut through the traditional means of proving causation. Courts that have adopted the doctrine still require plaintiffs to provide reliable expert medical testimony, still allow the defendant to question the credibility of these experts and their

208. See *supra* Part II.B.

209. See *supra* Part IV.B.

210. See *supra* notes 47–51 and accompanying text.

211. See *supra* Part II.C. *But see* *Pipe v. Hamilton*, 56 P.3d 823, 829 (Kan. 2002) (“As a matter of law, a 10 percent loss of chance cannot be said to be token or de minimis”).

212. See *supra* Part III.A.

213. See *supra* Part III.B.

214. See *supra* Part IV.A.

supporting statistical evidence, and still require a jury to ultimately determine liability.²¹⁵

Thus, while a reflexive response to the lost-chance doctrine may be to see it as “pernicious”²¹⁶ or as “undercut[ting] the truth-seeking function of the courts,”²¹⁷ once the doctrine is placed in its appropriate context and its effects are measured, these fears appear unfounded. Accordingly, states adopting the lost-chance doctrine have effectively provided their citizens with an adequate remedy for unique instances of medical negligence, while at the same time affording an appropriate level of deterrence for otherwise unaccountable medical professionals. Until evidence is presented that indicates the lost-chance doctrine’s harmful effect on civil litigation, malpractice insurance costs, or health care reform efforts in general, the commonly espoused negative reactions to the doctrine are inadequate to outweigh the public benefits that the doctrine provides.

STEVEN R. KOCH

215. See *supra* Part IV.B–C.

216. Weiss, *supra* note 11, at 4.

217. Weigard, *supra* note 16, at 311.