University of Dayton Law Review
Winter, 1999

Comment

***349** THE LOSS OF CHANCE DOCTRINE: LEGAL RECOVERY FOR PATIENTS ON THE EDGE OF SURVIVAL

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***350** I. Introduction

With the advent of evermore sophisticated medical technology, physicians have been able to detect and treat illnesses and diseases with increasing success. In light of these advanced lifesaving techniques, the public has started to look upon physicians as miracle workers. When some aspect of the healing process goes wrong, the effects are no less devastating when the initial chances for survival are less than optimistic. Despite continuing medical advances, doctors are not infallible, and incidents still arise when a physician overlooks obvious symptoms or fails to perform routine tests in a timely manner to detect potentially fatal or debilitating illnesses.

It is in light of the public's high expectations that the loss of chance doctrine has developed to compensate individuals who have a less than fifty percent chance of survival or recovery and are further injured by a physician's negligence. [FN1] When a patient with a less than fifty percent chance of recovery from an illness has that chance further diminished by a physician's negligence, he or she will generally be unable to recover monetary damages for this "loss of chance." Under a traditional negligence analysis, recovery is usually denied because of uncertainty as to whether the illness or the physician's later negligence caused the patient's ultimate injury. [FN2] The loss of chance doctrine was developed in an attempt to compensate these patients for their losses at the hands of negligent physicians. While some jurisdictions have refused to adopt the loss of chance doctrine, others are divided between a "relaxed causation" approach derived from the Restatement (Second) of Torts, or a pure loss of chance approach. [FN3]

This Comment argues that marginal patients should be permitted to recover for the loss of any chance of survival due to the negligence of a physician. Such recovery does not necessitate abandonment or dilution of traditional rules of causation if the recovery is limited to the actual injury suffered-the loss of a small probability of survival. This, of course, requires an approach to the calculation of damages that will award plaintiffs only a proportion of the damages they now frequently claim. Among the diverse approaches to this issue noted above, only the "pure" ***351** loss of chance approach can achieve those goals. However, some limitations on the current "pure" loss of chance doctrine seem justified. Loss of chance claims should only be available to marginal patients, and then only in survivorship actions rather than wrongful death actions. With those limitations, the loss of chance doctrine achieves an equitable and practical compromise in the effort to provide just compensation without undue liability.

As background, the next section of this Comment outlines the various approaches taken by courts faced with loss of chance claims and explains the policy considerations underlying each. [FN4] This Comment then demonstrates that a limited "pure" loss of chance approach seems the most equitable and practical solution to the plight of marginal patients. [FN5]

II. Background

The premise of the loss of chance doctrine is that while cures cannot be absolutely guaranteed when physicians undertake the diagnosis or treatment of a patient, a possibility of recovery does exist when physicians employ standard and reasonable care. [FN6] In a loss of chance claim, the plaintiff is trying to establish that his or her chance for survival or recovery was greater

prior to the physician's negligence. [FN7] Some courts have found that, if traditional rules of negligence are to be retained, such loss of chance claims must be rejected. Other courts have been more receptive to such claims, but have differed on the legal requirements necessary to sustain the claim.

The lost chance doctrine stems from Hicks v. United States, a case in which a personal representative of the decedent's estate brought a wrongful death suit alleging medical malpractice. [FN8] The decedent had complained of intense abdominal pain and constant vomiting. [FN9] The physician misdiagnosed the condition as minor, but the woman ultimately died of a serious intestinal disorder. [FN10] The following passage from the court's ***352** opinion has served as the catalyst for development of the loss of chance doctrine in medical malpractice cases:
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. If there was any substantial possibility of survival and the defendant destroyed it, he is answerable. [FN11]

Since Hicks, courts in many jurisdictions have recognized causes of action for loss of chance in medical malpractice suits when a patient's chance of recovery or survival is less than fifty percent. [FN12] However, states have not adopted a uniform stance to the loss of chance doctrine. Instead three different approaches have developed based upon traditional causation rules: the "all or nothing" approach, a "relaxed causation" approach derived from the Restatement (Second) of Torts § 323, and a third approach known as "pure" loss of chance.

A. Rejecting Loss of Chance Claims Under Traditional Negligence Rules

1. Traditional Malpractice Law and the Marginal Patient

In a traditional malpractice case, the plaintiff's claim is generally founded on negligence, and the plaintiff must prove: (1) the physician owed a duty to the plaintiff; (2) a breach of this duty occurred; (3) the breach was the cause in fact of the injury; (4) the breach was the proximate cause of the injury; and (5) the plaintiff suffered damage from the physician's conduct. [FN13] Under traditional cause in fact inquiries, the plaintiff must establish that the injury would not have occurred without, or "but for," the defendant's conduct. [FN14] When two or more forces combine to cause an injury, however, the traditional "but for" causation rule is abandoned. [FN15] Instead, a plaintiff is required to prove that the defendant's ***353** conduct was a substantial factor in causing the plaintiff's injury to fulfill the cause in fact element. [FN16] Because the plaintiff bears the burden of proving causation, he must show that it was more probable than not that the defendant caused his injuries. [FN17] It must be shown that the patient's chances for recovery were greater than fifty percent and, but for the physician's negligence, the patient lost some chance of survival. [FN18] Therefore, because patients are frequently treated for underlying illnesses, diseases, or injuries, it is important to distinguish the natural end result of the patient's condition from the actual injury, the loss of chance, that is the subject of the suit. [FN19]

One might, for example, imagine a patient whose physician failed to detect a terminal illness in a timely manner because he or she did not run standard tests. The evidence establishes that the patient would have had a seventy percent chance of survival if the disease had been detected in its early stages. However, because the doctor failed to order routine tests, the patient's chances of survival upon the eventual detection of the disease were decreased to forty percent. The patient ultimately dies. In the subsequent malpractice action, if the plaintiff uses a traditional negligence theory, he or she must establish that the physician breached a duty of care by failing to order the tests, as well as establish the causal connection between the physician's conduct and the patient's injury. In other words, the plaintiff must show that the defendant's conduct was the cause of the lost chance of recovery. [FN20]

In cases where the patient suffers from an injury or illness that is potentially terminal, the plaintiff's case often fails because there is generally too great a question as to whether the disease or the physician's negligence caused the patient's death. [FN21] Where medical evidence tends to establish that it was more likely than not that the medical affliction would have killed the patient rather than the physician's negligence, the disease or injury becomes the cause in fact of the patient's death, entitling the physician to judgment. Under these circumstances, the traditional negligence analysis essentially allows the physicians to escape liability.

***354** 2. The "All or Nothing Approach" and the Traditional Negligence Analysis

Use of a traditional negligence analysis is classified as the "all or nothing" approach in the loss of chance context. Jurisdictions utilizing this approach do so because they generally fear that adoption of a more liberal approach will stray too

far from the time-honored rules requiring proof of causation in a malpractice action. [FN22] For example, in Cooper v. Sisters of Charity of Cincinnati, Inc., the Ohio Supreme Court reasoned:
Lesser standards of proof are understandably attractive in malpractice cases where physical well being, and life itself, are the subject of litigation. The strong intuitive sense of humanity tends to emotionally direct us toward a conclusion that in an action for wrongful death an injured person should be compensated for the loss of chance for survival, regardless of its remoteness. However, we have trepidations that such a rule would produce more injustice than justice. [FN23]

A plaintiff in a jurisdiction adhering to the traditional approach must prove that a physician's negligence "probably" caused the patient's injury. [FN24] Plaintiffs showing a greater than fifty percent chance of survival have a better chance to succeed under this approach because in this situation there is not as much question as to whether the disease or the physician's negligence injured the patient. Because this approach adheres to traditional standards of causation, a plaintiff who can only show a less-than-even chance of survival (less than fifty percent) will be completely barred from recovery. [FN25] For this reason the traditional approach is known as the "all or nothing" approach. [FN26] A number of jurisdictions still adhere to this approach, [FN27] although that number is gradually diminishing. [FN28]

***355** Texas is one such jurisdiction. In Kramer v. Lewisville Memorial Hospital, the patient experienced gynecological problems and, despite visiting various doctors and undergoing several tests, her symptoms worsened. [FN29] When cervical cancer was finally diagnosed, it had spread throughout her body. [FN30] The Texas Supreme Court refused to adopt loss of chance, stating:
We acknowledge that in searching for the truth, the law does not, and should not require proof of an absolute certainty of causation or any other factual issue. It always settles for some lower threshold of certainty . . . [[[[but] [b]elow reasonable probability, however, we do not believe that a sufficient number of alternative explanations and hypotheses for the cause of harm are eliminated to permit a judicial determination of responsibility. [FN31]

Thus, while conceding that causation does not need to be proven with perfect accuracy, courts that refuse to adopt loss of chance refuse on the ground that the doctrine simply stretches the causation element of the claim too thin to be valid.

A patient who loses a less than fifty percent chance of recovery will most likely not be compensated for that loss because it would not appear likely that the patient would have recovered with proper care. [FN32] If the patient is able to recover any damages at all, the damages would most likely depend on the extent to which the illness or injury killed the patient sooner than it would have with timely diagnosis and treatment. [FN33] Damages may also depend on whether the plaintiff could prove that the delayed diagnosis aggravated the patient's condition. [FN34]

***356** B. The "Relaxed Causation" Approach

An alternative approach that attempts to soften the harshness of the "all or nothing" rule bases recovery upon the approach to duties and causation taken by the Restatement (Second) of Torts § 323: [FN35]
One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
(a) his failure to exercise such care increases the risk of such harm . . . . [FN36]

This "relaxed causation" approach views the underlying injury, the patient's illness or death, as the ultimate injury for which the patient is compensated. [FN37] With this approach a plaintiff must show that the defendant's acts or omissions increased the risk of harm to the patient. [FN38] This approach allows the case to go to the jury upon a finding that the defendant negligently deprived the patient of a "substantial" or "appreciable" chance of survival or recovery. [FN39] A prima facie case for liability is established when a plaintiff produces expert medical testimony showing to a reasonable degree of medical certainty that the defendant's conduct increased the degree of the risk of harm to the patient. [FN40]

Courts employing the "relaxed causation" approach feel that it establishes a more procedurally-oriented response to loss of chance claims. [FN41] Under the Restatement (Second) of Torts § 323 approach, a plaintiff's showing of negligence and a substantial or increased risk of harm permits the question to go to the jury with a less than normal ***357** threshold level of proof. [FN42] Specifically, the plaintiff can take a negligence claim to the jury by merely showing that the physician increased the risk of harm to the patient, instead of showing that the physician was the cause in fact of the patient's injury. At this point, the jury is permitted to determine whether medical malpractice was a substantial factor in causing the harm the patient suffered. [FN43] Proponents argue that traditional rules of causation are in fact satisfied under this approach, [FN44]

because the increased harm or substantial lost chance is treated as a concurring cause of the ultimate result. [FN45]

In Herskovits v. Group Health Cooperative, [FN46] the Washington Supreme Court followed the lead set forth in Hamil v. Bashline. [FN47] Applying relaxed causation to a case in which a physician failed to timely diagnose a patient's lung cancer, the court reasoned that "to decide [against loss of chance] would be a blanket release from liability for doctors and hospitals any time there was less than a fifty percent chance of survival, regardless of how flagrant the negligence." [FN48] Similarly, in McKellips v. St. Francis Hospital, Inc., the Oklahoma Supreme Court also applied the relaxed causation approach. [FN49] In that case the patient experienced chest pains, and went to the hospital only to be told that he suffered from gastritis and was sent home. [FN50] Later that evening, he went into cardiac arrest and died. [FN51] The court explained its adoption of the loss of chance doctrine:
[I]n those situations where a health care provider deprives a patient of a significant chance for recovery by negligently failing to provide medical treatment, the health care professional should not be allowed to come in after the fact and allege that the result was inevitable inasmuch as that person put the patient's chance beyond the possibility of realization. Health care ***358** providers should not be given the benefit of the uncertainty created by their own negligent conduct. [FN52]

Under the "relaxed causation" approach, damages are calculated on the basis of the full amount of damages generally awarded in a wrongful death action, and the court or jury is generally given unfettered discretion to determine the appropriate damages. [FN53] These damages are based on those losses caused directly by the patient's premature death, such as lost earnings and additional medical expenses. [FN54] Because this method for calculating damages involves no mathematical calculations, and it permits the jury to use its own judgment, there is the possibility of overcompensation. [FN55]

C. Pure Loss of Chance

Rather than determine whether the patient's physical injury was caused by the physician's negligence, courts adopting the "pure" loss of chance doctrine examine whether the physician was probably responsible for the patient's lost chance for survival. [FN56] This lost chance then becomes the injury for which damages are sought, rather than the actual physical injury or death the patient suffered. [FN57] Because pure loss of chance recognizes a lost chance of recovery, however small, as the compensable interest, traditional rules for proving causation are preserved: the plaintiff must prove that the physician was the cause in fact of the patient's injury or lost chance of recovery. [FN58] The Nevada Supreme Court in Perez v. Las Vegas Medical Center applied pure loss of chance to a case involving a prisoner who died of a massive brain hemorrhage after physicians made no attempt to diagnose his persistent headaches. [FN59] In utilizing pure loss of chance, the court indicated that defendants would no longer be able to ***359** dodge liability simply by claiming that the patient would have died regardless of their efforts. [FN60]

Jurisdictions following this approach reject the "relaxed causation" approach as confusing and overcompensatory. [FN61] Instead, they retain traditional causation rules and adopt a percentage probability test to more accurately calculate damages. [FN62] The probability of long-term survival is reflected in the amount of damages awarded for the lost chance. [FN63] For example, where a patient had a forty percent chance of survival with timely diagnosis and proper care, under pure loss of chance the plaintiff would recover damages equal to the percent of the chance lost (forty percent) multiplied by the total amount of damages ordinarily allowed in a wrongful death action. [FN64] The value placed on the patient's life reflects factors such as age, health, and earning potential. [FN65] Jurisdictions using this formula believe it more accurately allocates damages. [FN66]

D. Hybrid Approaches

Some states have arrived at their own version of the loss of chance doctrine. [FN67] Ohio, for example, accepts the causation approach espoused by the Restatement (Second) of Torts § 323, allowing a plaintiff to maintain an action for the loss of chance of recovery or survival when he or she presents expert medical testimony showing that the health care provider's negligence increased the risk of harm to the patient. [FN68] Ohio, however, parts ways with the Restatement by incorporating the proportional approach of ***360** the "pure" loss of chance. [FN69] Under Ohio's hybrid approach, damages are awarded in direct proportion to the chance of survival or recovery the patient lost. [FN70] This, it is thought, apportions damages consistently with the defendant's degree of fault. [FN71]

Another hybrid approach refines the "substantial factor" causation standard into a three-prong test applied on a case by case basis. Under this test, the plaintiff must prove that: (1) the omitted treatment was intended to prevent the very harm that resulted; (2) plaintiff would have submitted to the treatment; and (3) it is more probable than not that the treatment could

have lessened or avoided plaintiff's injury if rendered. [FN72] Satisfaction of this test is said to establish a nexus that shows that the physician's alleged negligence was a substantial factor in causing the harm. [FN73] This test is intended to curtail frivolous lawsuits because it is believed there will be little financial incentive to bring a loss of chance case to trial when damages would be dramatically reduced by a pre-existing condition. [FN74]

III.Analysis

At the heart of the debate about loss of chance lies the question: Should the well-grounded rules for proving causation give way to a dying or ailing patient's right to recover for a physician's negligence that diminishes the patient's chance of recovery? While the loss of chance doctrine attempts to eliminate the inequities that can result from the traditional negligence analysis, many believe it alters the time-honored rules regarding causation in medical malpractice cases. [FN75] Specifically, the loss of chance doctrine allows a plaintiff to recover damages when he or she cannot prove that the physician's negligence was the cause of the patient's injury beyond a reasonable medical doubt. [FN76] Proponents of traditional causation requirements face criticism because it almost always bars a patient with a less-than-even chance of survival from recovering damages for a physician's negligence in failing to treat or diagnose his or ***361** her illness in a timely manner. The hybrid approaches do little to resolve the dispute, confusing the issue further as mere restatements of the traditional negligence analysis or the pure loss of chance approach.

A. Liability Concerns Raised by the Lost Chance Doctrine

Upon examination of the various loss of chance approaches, liability concerns lie at the root of the most heated issues. While traditional causation analysis often precludes plaintiffs from a remedy, relaxed causation tends to allow plaintiffs to recover damages for the loss of chance of survival, no matter how small. The third alternative, pure loss of chance, represents a compromise between the above approaches but employs statistical evidence that could be confusing to the jury. The loss of chance doctrine should be applied so that plaintiffs recover damages in proportion to the physicians' negligence, and its use should be limited to only those cases in which the physician's error is especially serious and egregious.

1. The "All or Nothing" Approach Produces Inequitable Results

Jurisdictions that continue to adhere to the "all or nothing" approach do so based on the rationale that the loss of chance doctrine is at odds with "the requisite degree of medical certitude necessary to establish a causal link between the injury of a patient and the tortious conduct of a physician." [FN77] This reasoning is based on the idea that liability cannot be assigned based on the mere possibility that the defendant's negligence was the cause of the harm. [FN78] However, while the "all or nothing" approach preserves traditional causation rules, this standard's rigidity poses unacceptable hurdles for loss of chance plaintiffs.

Requiring a plaintiff to show that the physician was the cause of the patient's injury beyond a reasonable medical probability creates the potential for unfair results. Innocent victims who originally had a less than fifty percent chance of recovery are generally unable to make the reasonable medical probability showing and are, therefore, unable to recover damages for a physician's negligence. [FN79] However, basic notions of ***362** fairness should entitle a plaintiff to recover damages for situations in which the caregiver does indeed reduce the patient's chances for survival. Denying plaintiffs recovery in these cases produces inequitable results, making "[t]he innocent patient . . . the loser while the health care provider escapes liability despite his or her negligence." [FN80]

The "all or nothing" approach also invites courts to manipulate traditional causation standards, lowering them in order to avoid harsh results. [FN81] Warping causation requirements that have been the cornerstone of negligence theories, [FN82] results in decisions that stem from emotional reactions to tragic situations rather than sound jurisprudence. Where courts simply bend or dispense with causation requirements to compensate plaintiffs for their losses, no matter how small a showing of negligence they make, [FN83] they risk a litigation explosion in which litigants, with emotionally appalling factual scenarios, attempt to recover damages.

The "all or nothing" approach is prone to extreme results with the plaintiff receiving all of the possible damages or none. Enforcing traditional causation requirements in cases involving patients with less-than-even chances for survival will either completely bar recovery at one end of the spectrum, or compel courts to manipulate causation rules at will, causing chaotic results in the effort to afford some compensation to plaintiffs.

2. The Restatement (Second) of Torts § 323 Approach Confuses Traditional Rules of Causation

Proponents of the "relaxed causation" approach urge that health care providers who deprive patients of significant chances for recovery should not be able to excuse their conduct after the fact by alleging that the patient's final medical condition or death was an inevitable consequence of the underlying illness or injury despite the defendant's negligence. [FN84] However, a fear persists that this approach, with its lower causation standards, may lead to verdicts based on speculation and bad case law. At ***363** a more extreme level, critics envision the relaxed causation standard causing a much larger problem: unfettered litigation as plaintiffs rush to take advantage of charitable causation standards in an attempt to collect damages on even the smallest lost chances of recovery.

The fears that stem from the "relaxed causation" approach are similar to those associated with the "all or nothing" approach. A significant possibility exists that the "relaxed causation" approach would permit cases to go to the jury on insufficient evidence, and would lead to imposing liability on the basis of sheer speculation. [FN85] Relaxed causation could potentially allow cases to go to the jury powered more by emotion than by an actual showing of a causal connection between the physician's negligence and the patient's final medical condition. The reality of a relaxed causation standard is that the process for proving a causal connection ultimately becomes a guessing game. Specifically, the jury is required to guess what the patient's initially poor prognosis would have been if the physician had not acted negligently.

This speculative causation standard could kindle a chain reaction. Once a plaintiff has prevailed in a cause of action that is submitted to the jury based on speculation, subsequent claims of the same nature could be based on a shaky causation standard. The more frequently a negligence claim arises from a patient who initially had a less-than-even chance of survival, the farther removed these claims will become from an actual negligence theory. Eventually, it would be possible for the causation requirement to become stretched so thin that claims would no longer be based on a negligence theory, but on something else that really has no sound basis in tort law. [FN86]

Diluting the causation requirements in this manner could potentially create "open season" on physicians. With a lowered causation standard, many critics fear that utilizing this approach will open the floodgates of litigation, bringing in its wake numbers of malpractice claims that are lacking on the merits. [FN87] While relaxing causation requirements may have begun with the noble intention of allowing plaintiffs who ultimately suffered fatal or debilitating injuries to recover damages for their physicians' negligence, it could eventually pave the way for plaintiffs with less compelling claims to inch their way in. For example, one can easily see the potential for claims brought against a physician merely because a ***364** patient did not respond favorably enough to proper treatment. These types of actions would all but force physicians to become insurers of their patients, while overburdening court dockets at the same time. [FN88] Ultimately, the combination of high emotions caused by the loss of a loved one plus a physician's negligence could contribute to a litigation explosion. [FN89]

3. Pure Loss of Chance Maintains Traditional Causation Rules, but Is Confusing to the Jury

Courts employing pure loss of chance maintain the traditional rule for proving causation. They do, however, recognize the lost chance of recovery as a compensable interest. [FN90] This approach thus avoids the controversy associated with a relaxed or manipulated causation standard. Even though a plaintiff may not be able to prove beyond a preponderance of the evidence that a defendant denied a patient a chance of recovery, he or she may be able to show beyond a preponderance of the evidence that the patient was deprived of a certain percentage of a chance of recovery without disregarding traditional causation standards. [FN91] Examination of this proportional approach, however, reveals practical problems lurking below its surface. [FN92]

Extensive reliance on statistical evidence that measures the extent to which a chance of recovery was diminished could ultimately prove confusing for juries. It is possible for statistics to be misused and manipulated by expert witnesses and attorneys. [FN93] Some argue that statistical data, though relevant, should not be used by itself to prove causation. [FN94] These critics also assert that in addition to statistical data, the plaintiff should have to demonstrate that the patient would have been a part ***365** of the group whose chance of survival would have been increased by early diagnosis. [FN95]

Such an approach could narrow the field of plaintiffs who might attempt to bring a loss of chance claim when faced with the obligation to meet these narrow and specific criteria. However, requiring this individualized information about each patient would likely exacerbate the problem presented by reliance on statistical evidence rather than clarify it. If complicated statistical data would not be enough to make a juror's eyes glaze over, the potentially endless stream of experts who could testify on the patient's membership in a group that would have responded favorably to early diagnosis or treatment would

probably finish the job. Adding such requirements to the statistical evidence would place an even higher premium on each party's search for willing expert witnesses. [FN96]

Even setting the confusion issue aside, the requirement of showing that a patient would have been part of a group that would have responded favorably to early diagnosis or treatment is really an afterthought. When the statistical evidence regarding the extent to which the patient lost a chance of recovery is at issue, asking whether the patient would have responded favorably to early treatment is redundant. Loss of chance, in theory, already presumes that the patient would have responded favorably to earlier treatment or diagnosis.

In examining the possibilities for establishing the causation element in a loss of chance case, it is clear that each approach has its fair share of compelling reasons for its application in addition to its glaring weaknesses. These conflicts must be reconciled in order to lend any legitimacy and consistency to the doctrine.

B. Concerns Surrounding Damages Calculation

The two approaches that courts have taken to calculate damages in loss of chance cases have come under fire for different reasons. The traditional valuation approach for calculating damages can overcompensate plaintiffs in the event that they actually prevail on their claim. Conversely, the proportional valuation approach employs a seemingly callous and mechanical method for calculating damages that either undercompensates or overcompensates the plaintiff by definition.

***366** 1. The Traditional Valuation Approach Tends to Overcompensate

An approach that awards the full amount of damages typically allowed in a traditional negligence case may overcompensate loss of chance plaintiffs. [FN97] A patient who already has a less than fifty percent chance of survival should not be permitted to recover full damages just as if he or she had a greater than fifty percent chance for survival. [FN98] The patient who might have died because of the illness itself, not the physician's negligence, should not be permitted to recover damages for negligence. [FN99]

Juries are typically permitted to rely on their own intuition and experience in calculating damages in negligence cases, making it possible for them to award full damages to a loss of chance plaintiff even though the defendant may have only been responsible for part of the harm. [FN100] This approach for calculating damages could be especially confusing if used in conjunction with a "relaxed causation" liability standard. A combination of jurors' intuition and a lower liability standard creates a risk that monetary damages will not accurately reflect the harm caused by the negligent physician. [FN101]

2. The Proportional Approach Both Overcompensates and Undercompensates

A proportional calculation of damages, which compensates plaintiffs in proportion to the effect of a physician's negligent conduct, is a more accurate approach, but it is still imperfect. Inevitably, the proportional approach will both overcompensate and undercompensate a loss of chance plaintiff.

The proportional damages approach fails to assess the actual quality of life a patient with a less than fifty percent chance of recovery will face if he or she does in fact recover. [FN102] When the patient's post- negligence ***367** quality of life has little value, the lost chance of recovery has a correspondingly smaller value. [FN103] Extension of liability in such cases is unjustified since it overcompensates plaintiffs who have lost very little. [FN104]

The proportional damages approach, however, fails to address the true loss to plaintiffs and can appear callous to plaintiffs who have lost loved ones or to patients who have suffered debilitating injuries. There is no difference between losing a thirty percent and an eighty percent chance of recovery to a plaintiff who has suffered permanent injury or lost a parent, spouse, or child forever. [FN105] From this perspective, damages calculated mechanically according to a mere percentage that a court believes accurately represents the value of the patient's lost recovery would not adequately compensate these individuals. In this regard, the proportional approach undercompensates plaintiffs.

Damages are calculated proportionally to protect negligent doctors at the expense of plaintiffs. [FN106] Essentially, this approach to damages valuation is a compromise. Plaintiffs are permitted to recover some monetary damages for their debilitating injuries, or the loss of their loved one, while physicians are shielded from excessive liability by paying only damages attributable to their own fault when the patient originally faced a less than fifty percent chance of recovery.

C. Hybrid Approaches Only Confuse the Loss of Chance Issue

Upon closer examination of the current hybrid approaches adopted by some states, it becomes clear that these approaches are not really what they purport to be. What hybrid courts claim to adopt and what they actually adopt are different.

In Roberts v. Ohio Permanente Medical Group, the Ohio Supreme Court claimed to combine the relaxed causation approach derived from the Restatement (Second) of Torts with a proportional damages calculation approach. [FN107] The court really adopted a pure loss of chance standard by ***368** discounting the plaintiff's award of damages to the extent that the patient lost a chance of recovery. [FN108] This appears to be a hybrid approach, but in reality is an application of pure loss of chance because the proportional damages calculation compensates the plaintiff for the lost chance at recovery, not the increased risk of harm to the plaintiff.

In Ehlinger v. Sipes, the Wisconsin Supreme Court purported to reject the relaxed causation and pure loss of chance approaches, in favor of a "substantial factor" test. [FN109] Closer scrutiny of this test indicates that this test is really a reformation of the traditional "all or nothing" approach. By requiring the plaintiff to show that the omitted treatment was intended to prevent the harm that occurred, the test really requires that the plaintiff establish the physician's breach of duty. [FN110] The second and third prongs of the test-that the patient would have submitted to the treatment and the treatment could have avoided the harm-merely proves cause in fact. However, the third element is difficult, if not impossible, for plaintiffs to prove in cases in which the patient had a less than fifty percent chance of survival. This element of the test has the effect of turning the substantial factor test into the traditional negligence analysis.

By resorting to this confusing rhetoric, the Ehlinger court appears hesitant to completely disregard the traditional negligence analysis in the loss of chance context. This could be an example where a court developed law driven by sympathy for the patient, because the court articulated a standard that is similar to traditional negligence, but awarded damages to the plaintiffs under loss of chance.

The mixed terminology employed by these so-called "hybrid" courts does not create a new and improved loss of chance approach. It merely confuses the issue and will only lead to inconsistent application of the loss of chance doctrine.

D. Limited Pure Loss of Chance Is the Most Feasible Solution

The arguments in favor of the loss of chance doctrine are persuasive in theory. It is painful enough to lose a loved one who may have had a chance of surviving an illness. Precluding recovery for a physician's negligence in failing to timely diagnose a potentially fatal illness compounds this pain and frustration. While the pure loss of chance ***369** approach has some difficulties, they are not insurmountable. [FN111] Minor modifications in its application would negate many of the criticisms of the doctrine and effectuate a fair compromise between the patients' interest in recovering damages for their loss of chance and the physicians' interest in protecting themselves from extensive liability when the patients already face poor prognoses.

1. Implications on the Health Care Field

While the pure loss of chance approach attempts to provide a fair and proportional amount of compensation for patients whose chance of recovery or survival has been lessened by a physician's negligence, there are concerns that loss of chance will generally place extreme financial burdens on the health care field. [FN112] Specifically, some fear that this doctrine will constitute one more step in making doctors the insurers of their patients, imposing liability for injuries even if physician negligence did not necessarily cause the injuries. [FN113] There is already an enormous tendency to lay blame when a physician fails to find a remedy for the medical problem; this may only be compounded by loss of chance. [FN114] In addition, if physicians are subjected to extensive liability in loss of chance cases, a possibility exists that physicians will not be willing to treat dying patients. [FN115] Physicians might alter the nature and extent of their practices to escape mounting costs associated with acquiring negligence coverage or defending themselves in lawsuits that may have little merit. [FN116] Physicians would have little incentive to place their careers at risk where the chances for successful treatment of patients is unlikely. [FN117]

However, it is important to remember that in a pure loss of chance analysis, causation is not the only element that the plaintiff must prove. ***370** Before reaching the causation element of the analysis, the plaintiff must prove that the physician fell below a certain standard of care when treating the patient. [FN118] Recovery doctrines need not be applied in a manner that promotes sub-professional performance levels for physicians. Moreover, pure loss of chance need not be viewed as an

opportunity to assign the role of insurer to physicians because they undertake a duty of care for patients, merely because this is a function that sometimes produces unpredictable results. [FN119] Pure loss of chance does not change this liability standard. Rather, like the traditional negligence standard, it requires doctors to employ the standard and reasonable methodsof treatment available to them. Pure loss of chance only requires physicians to be held proportionately liable for cases in which they fail to meet this standard and their actions reduce a patient's chance of recovery.

2. Loss of Chance Provides a Counterbalance for Managed Health Care

While many fear that loss of chance in any form may inhibit physicians from freely practicing medicine, it presents different concerns regarding managed health care systems currently in place in this country. By imposing limitations on the tests and treatments physicians may order for their patients, managed health care systems raise liability concerns relevant to the loss of chance doctrine.

Lifesaving testing and treatment procedures can involve the participation of dozens of health care professionals, which in turn necessitates cost containment measures to keep rising medical costs under control. [FN120] Under managed health care systems, third-party payers have developed alternative reimbursement plans that penalize physicians financially for providing unnecessary tests or treatment. [FN121] Thus, third-party payers influence the manner in which physicians administer tests and treatment by shifting financial risk of loss to the physician by either punishing or rewarding him or her. [FN122] For example, a third-party payer can penalize a physician by reducing capitation, a set fee paid to the physician per patient, thereby causing the physician to lose profit whenever he or she ***371** orders inappropriate tests or treatments. [FN123] This, in turn, increases the possibility for undertreatment. [FN124] With such financial incentives at stake, it may become increasingly acceptable for physicians to forgo standard but expensive treatments in cases involving patients with poor prognoses based on the rationale that the patients would probably die anyway.

Pure loss of chance is one possible counterbalance to the potential for undertreatment. Potential liability to the patient, calculated in proportion to the physician's negligence, may prevent patients with a less-than-even chance of survival from falling prey to such cost-cutting measures. A physician will likely order standard but expensive tests or treatment if he or she fears being subjected to a lawsuit for failing to do so. Adopting pure loss of chance would effectively encourage the physicians to administer necessary treatment for their patients. [FN125] With the prevalence of managed health care, pure loss of chance is especially important. In a time when it could be profitable for physicians to overlook the needs of patients with less than favorable prognoses, pure loss of chance serves to protect the patients from undertreatment.

3. Application of Pure Loss of Chance Should Be Narrow in Scope

One suggestion for combating the potential litigation explosion problem that could result from implementation of pure loss of chance is to implement the doctrine only when medical science is more knowledgeable about disease or more sophisticated in detection and treatment of diseases. [FN126] This application is impractical and unfair. As we await medical progress, patients with poor prognoses will still suffer from illnesses, and will still lose chances for recovery at the hands of negligent physicians. Even as medical science gains more information about known diseases, new diseases and disorders will inevitably develop, posing new puzzles for medicine. Procrastination will not solve the loss of chance conundrum or make the application of loss of chance any easier; it will however, leave those patients who depended on physicians for proper care with no remedy.

***372** Pure loss of chance serves a useful purpose in the world of negligence actions. It represents a compromise, allowing patients with poor prognoses to recover for lost chance at the hands of negligent doctors, while at the same time, holding physicians liable only for their part in causing the harm. To avoid abuse, however, loss of chance should be applied narrowly.

Loss of chance claims should be barred in cases in which the plaintiff had a greater than fifty percent chance of survival and seeks damages because he or she desired a better result from the treatment. [FN127] This requirement would weed out the frivolous claims many critics of the doctrine fear. [FN128] Such plaintiffs could bring a possibly successful claim under the traditional negligence formulation, and therefore, should not be allowed to disguise such claims as loss of chance to avoid an adverse decision.

Likewise, pure loss of chance claims should not be brought in conjunction with wrongful death claims. [FN129] Wrongful death actions provide a cause of action that benefits spouses, parents, and children of the deceased person. [FN130] A pure loss of chance claim is not proper in such an action because these wrongful death beneficiaries sue in their own right, not as

representatives of the deceased person's estate. [FN131] Essentially, loss of chance claims are inconsistent with wrongful death actions because the wrongful death beneficiaries did not lose the chance of recovery. Further, pure loss of chance is fundamentally at odds with a wrongful death action because it is intended to compensate for the lost chance of recovery, not the actual death. [FN132] Therefore, disallowing wrongful death claims premised on pure loss of chance would provide for a more consistent application of the doctrine.

***373** Plaintiffs would still have the option of bringing survivorship actions to recover damages. [FN133] These actions are generally provided for by statute and are brought by the decedent's personal representative. A survivorship action is more appropriate than a wrongful death action in the loss of chance context because the proceeds from the action are paid to the decedent's estate. Thus, the decedent's estate is compensated for the loss of chance. Though it is likely that the decedent's survivors will eventually receive these proceeds, this method is more appropriate within the loss of chance context than paying loss of chance proceeds directly to spouses, parents, or children.

IV.Conclusion

Pure loss of chance should not be completely rejected. Physicians do occasionally make errors so egregious that they diminish a patient's chance for recovery, and loss of chance is a practical theory that allows plaintiff- patients to recover damages when that chance of recovery is reduced by a physician's negligence. At the same time, it protects physicians from undue liability. Loss of chance need not result in a flood of litigation or imposition of physician insured results. Courts can and should limit the doctrine's application to only the most serious and egregious cases of negligence.

By leaving the causation requirements of the negligence analysis unaltered, focusing on the lost chance of recovery as the compensable injury, and adding an inquiry into whether the treatment in question could have actually made a difference, a compromise is reached. On one hand, physicians are protected from extensive liability because they are only held responsible for the injury or loss of chance that is attributable to them. On the other hand, patients who have lost a chance at recovery because of a physician's negligence are allowed the opportunity to be made whole and to recover damages for their losses. In the end, the time-tested negligence analysis used in medical malpractice cases remains unsullied.

[FNa1]. Production Editor, 1998-99, University of Dayton Law Review. J.D. expected, May 1999, University of Dayton School of Law; B.S. Ed., 1994, Ohio University.

[FN1]. See generally Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 Yale L.J. 1353 (1981) (describing inequities that result from application of the traditional negligence analysis to this scenario).

[FN2]. See generally Stephen F. Brennwald, Proving Causation in "Loss of Chance" Cases: A Proportional Approach, 34 Cath. U. L. Rev. 747 (1985) (stating that the causation requirement has produced the greatest judicial controversy).

[FN3]. King, supra note 1, at 1353.

[FN4]. See infra notes 6-74 and accompanying text.

[FN5]. See infra notes 75-133 and accompanying text.

[FN6]. Steven E. Pegalis & Harvey F. Wachsman, 1 American Law of Medical Malpractice 2d 225, 239 (1992).

[FN7]. Beth Clemens Boggs, Lost Chance of Survival Doctrine: Should the Courts Ever Tinker with Chance?, 16 S. Ill. U. L.J. 421, 424 (1992).

[FN8]. 368 F.2d 626 (4th Cir. 1966); see King, supra note 1, at 1353 n.53.

[FN9]. Hicks, 368 F.2d at 626.

[FN10]. Id.

[FN11]. Id. at 632. Many commentators have criticized the use of this passage as the basis of the lost chance doctrine because they claim that Hicks was not a lost chance case. See Lisa J. Perrochet et al., Lost Chance Recovery and the Folly of

Expanding Medical Malpractice Liability, 27 Tort & Ins. L.J. 615, 619 (1992).

[FN12]. See infra notes 46-55 and accompanying text.

[FN13]. W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 30, at 164-65 (5th ed. 1984).

[FN14]. Id. at 266.

[FN15]. Id.

[FN16]. Hamil v. Bashline, 392 A.2d 1280, 1284 (Pa. 1978). Proximate cause invokes legal policies that aim to limit defendants to those whose conduct was the cause in fact of the harm. See Brennwald, supra note 2, at 748. Therefore, the law limits the chain of causation to those causes that are fairly "proximate." Id.

[FN17]. Robert S. Bruer, Note, Loss of Chance as a Cause of Action in Medical Malpractice Cases, 59 Mo. L. Rev. 969, 971 (1994).

[FN18]. Id.

[FN19]. Pegalis & Wachsman, supra note 6, at 225.

[FN20]. Joseph H. King, Jr., The Law of Medical Malpractice in a Nutshell 195 (1977) [hereinafter Malpractice in a Nutshell]. Injury in this context refers to the reduction in chance for survival.

[FN21]. See id. at 227; see also Mayhue v. Sparkman, 653 N.E.2d 1384, 1387 (Ind. 1995).

[FN22]. Boggs, supra note 7, at 426; see Bruer, supra note 17, at 981 (indicating that reasonable medical probability means that the plaintiff must prove causation by a greater than fifty percent chance); see also Cooper v. Sisters of Charity of Cincinnati, Inc., 272 N.E.2d 97 (Ohio 1971) (refusing to apply loss of chance to a case in which the physician failed to examine a boy's head after he suffered head injuries as the result of being hit by an automobile), overruled by Roberts v. Ohio Permanente Med. Group, Inc., 668 N.E.2d 480 (Ohio 1996) (reversing Cooper's application of the traditional negligence analysis in cases in which the patient had a less than fifty percent chance of survival).

[FN23]. Cooper, 272 N.E.2d at 103.

[FN24]. Id. "Probability is most often defined as that which is more likely than not." Id. at 104.

[FN25]. Id.

[FN26]. Id.

[FN27]. See, e.g., Murdoch v. Thomas, 404 So. 2d 580 (Ala. 1981); Abille v. United States, 482 F. Supp. 703 (N.D. Cal. 1980) (applying Alaska law); Dumas v. Cooney, 235 Cal. App. 3d 1593 (1989); Gooding v. University Hosp. Bldg., Inc., 445 So. 2d 1015 (Fla. 1984); Hilden v. Ball, 787 P.2d 1122 (Idaho 1989); Walden v. Jones, 439 S.W.2d 571 (Ky. 1968); Wright v. Clement, 190 N.E. 11 (Mass. 1934); Cornfeldt v. Tongen, 295 N.W.2d 638 (Minn. 1980); Clayton v. Thompson, 475 So. 2d 439 (Miss. 1985); Wollen v. DePaul Health Ctr., 828 S.W.2d 681 (Mo. 1992); Horn v. National Hosp. Ass'n, 131 P.2d 455 (Or. 1942); Sherer v. James, 351 S.E.2d. 148 (S.C. 1986); Blondel v. Hays, 403 S.E.2d 340 (Va. 1991).

[FN28]. See generally Roberts v. Ohio Permanente Med. Group, Inc., 668 N.E.2d 480 (Ohio 1996). "The time has come to discard the traditionally harsh view we previously followed and to join the majority of states that have adopted the loss-of-chance theory." Id. at 484 (emphasis added).

[FN29]. 858 S.W.2d 397 (Tex. 1993).

[FN30]. Id. at 397-98.

[FN31]. Id. at 405.

[FN32]. King, supra note 1, at 1363-64.

[FN33]. Id. at 1364.

[FN34]. Id.

[FN35]. Short v. United States, 908 F. Supp. 227, 236 (Vt. 1995).

[FN36]. Restatement (Second) of Torts § 323 (1965).

[FN37]. Boggs, supra note 7, at 432. The origins of this theory can be traced to Hamil v. Bashline, 392 A.2d 1280 (Pa. 1978). In that case, the plaintiff took her husband, who was having severe chest pains, to the hospital. Id. at 1283. An EKG was ordered, but when the first machine did not work and a replacement was not found, the patient ultimately died in a doctor's office without ever receiving the ordered tests. Id.

[FN38]. Id. at 1288.

[FN39]. Kramer v. Lewisville Mem'l Hosp., 858 S.W.2d 397, 401 (Tex. 1993) (stating that either computation will allow liability to be imposed whenever the fact-finder determines that loss of a substantial chance to avoid harm was a substantial factor in causing the ultimate harm).

[FN40]. Hamil, 392 A.2d at 1288-89.

[FN41]. Mayhue v. Sparkman, 653 N.E.2d 1384, 1388 (Ind. 1995). The procedural response that the court refers to involves the plaintiff proving negligence and an increase in the risk of harm to the patient, which in turn, allows the jury to determine whether the physician's conduct was a substantial factor in causing the harm to the plaintiff. Id.

[FN42]. Bruer, supra note 17, at 975-76. Because of this lower threshold of proof, this approach as been dubbed "relaxed causation." Id.

[FN43]. Mayhue, 653 N.E.2d at 1388.

[FN44]. Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 592 (Nev. 1991) (allowing the estate of a man who would have faced life as a quadriplegic, if he had survived a brain hemorrhage, to recover damages for his lost chance of survival).

[FN45]. See Kramer v. Lewisville Mem'l Hosp., 858 S.W.2d 397, 401 (Tex. 1993)

[FN46]. 664 P.2d 474 (Wash. 1983).

[FN47]. 392 A.2d at 1288.

[FN48]. Herskovits, 664 P.2d. at 477. In applying the relaxed causation standard, however, the court opted to calculate the damages on a proportional basis. See infra notes 102-06 and accompanying text.

[FN49]. 741 P.2d 467, 469 (Okla. 1987).

[FN50]. Id. at 470.

[FN51]. Id.

[FN52]. McKellips, 741 P.2d at 474.

[FN53]. Delaney v. Cade, 873 P.2d 175, 187 (Kan. 1994). Some courts have elected to combine the "relaxed causation" approach and Professor Joseph H. King's proportional method for calculating damages. See Roberts v. Ohio Permanente Med. Group, Inc., 668 N.E.2d 480, 484 (Ohio 1996). However, plaintiffs are not necessarily entitled to total recovery under this formulation. Herskovits, 664 P.2d at 479.

[FN54]. Herskovits, 664 P.2d at 479.

[FN55]. Id.

[FN56]. United States v. Cumberbatch, 647 A.2d 1098, 1102 (Del. 1994).

[FN57]. King, supra note 1, at 1363-64.

[FN58]. Bruer, supra note 17, at 980.

[FN59]. 805 P.2d 589, 590 (Nev. 1991).

[FN60]. Id. at 593.

[FN61]. See Thompson v. Sun City Community Hosp., 688 P.2d 605 (Ariz. 1984); DeBurkarte v. Louvar, 393 N.W.2d 131 (Iowa 1986); Roberson v. Counselman, 686 P.2d 149 (Kan. 1984); Perez v. Las Vegas Med. Ctr., 805 P.2d 589 (Nev. 1991); Scafidi v. Seiler, 574 A.2d 398 (N.J. 1990).

[FN62]. See King, supra note 1, at 1382-84. King has also authored texts on basic medical malpractice law. See Malpractice in a Nutshell, supra note 20.

[FN63]. King, supra note 1, at 1382-84.

[FN64]. Id.

[FN65]. Id. This calculation is based on the ordinary damages awarded in negligence cases. Id.

[FN66]. See Bruer, supra note 17, at 983.

[FN67]. See Roberts v. Ohio Permanente Med. Group, Inc., 668 N.E.2d 480 (Ohio 1996) (reversing the decision that refused to recognize loss of chance in Cooper v. Sisters of Charity of Cincinnati, Inc., 272 N.E.2d 97 (Ohio 1971)); see also Delaney v. Cade, 873 P.2d 175 (Kan. 1994) (applying Restatement (Second) of Torts § 323 relaxed causation standard and the proportional calculation of damages and calling this damages calculation approach the most accurate approach because it assesses damages in direct relation to the harm caused); McKellips v. St. Francis Hosp., Inc., 741 P.2d 467 (Okla. 1987) (applying a hybrid approach of relaxed causation and proportional damages because the proportional damages approach produces more predictable results).

[FN68]. Roberts, 668 N.E.2d at 484.

[FN69]. Id.

[FN70]. Id.

[FN71]. See id.; see also id. at 486 (Cook, J., dissenting) (noting the inconsistency between the loss of chance doctrine, which aims to compensate the victim, and a statutory cause of action, which seeks to compensate the victims' survivors).

[FN72]. Ehlinger v. Sipes, 454 N.W.2d 754,761-62 (Wis. 1990).

[FN73]. Id. at 763.

[FN74]. Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 592 (Nev. 1991).

[FN75]. Roberts, 668 N.E.2d at 486 (Cook, J., dissenting).

[FN76]. Id.

[FN77]. Jones v. Owings, 456 S.E.2d 371, 374 (S.C. 1995) (quoting Kirkpatrick v. Bryant, 686 S.W.2d 594, 602 (Tenn.

1993)) (declining to apply loss of chance doctrine to a case in which a physician failed to treat a lung abnormality that turned out to be lung cancer).

[FN78]. Id. (emphasis added).

[FN79]. Roberts, 668 N.E.2d at 483.

[FN80]. Id. at 484.

[FN81]. See Boggs, supra note 7, at 429.

[FN82]. Roberts, 668 N.E.2d at 486 (Cook, J., dissenting).

[FN83]. See generally Holton v. Memorial Hosp., 679 N.E.2d 1202, 1220-22 (Ill. 1997) (Heiple, C.J., concurring) (expressing the fear that imposition of liability will be based on speculation).

[FN84]. McKellips v. St. Francis Hosp., Inc., 741 P.2d 467, 474 (Okla. 1987). This court reasoned that enabling health care providers to benefit from uncertainty created by their negligent conduct would effectively allow them to escape liability for their negligent conduct in situations where the patient would not necessarily have recovered even though the possibility existed. Id.

[FN85]. Holton, 679 N.E.2d at 1221.

[FN86]. See Roberts, 668 N.E.2d at 486 (Cook, J., dissenting). "[B]y awarding the estate a percentage of the total damages because it cannot show causation by a preponderance of the evidence, the court obviates time-honored principles underlying the right to compensation in tort, including the basic concept of assessing fault." Id.

[FN87]. See Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 592 (Nev. 1991).

[FN88]. See generally Holton, 679 N.E.2d at 1222 (explaining that a physician becomes the insurer of his or her patient when held liable for the patient's injuries, even if negligence was not necessarily the cause of those injuries).

[FN89]. Herskovits v. Group Health Coop., 664 P.2d 474, 491 (Wash. 1983) (Brachtenbach, J., dissenting) (stating relaxed causation would open up litigation system to untold abuses).

[FN90]. Bruer, supra note 17, at 982. This is a different approach to relaxed causation because relaxed causation compensates for the final medical condition, usually death.

[FN91]. King, supra note 1, at 1363-64.

[FN92]. See Perez, 805 P.2d at 598 (Steffen, J., dissenting) (opposing loss of chance because of the fear that the doctrine will encourage a proliferation of frivolous lawsuits).

[FN93]. Id. Judge Steffen indicates that our court system is premised upon the public's confidence in cross-examination to protect against abuse of evidence. Id. It is also urged that attorneys be able to explain the true significance of statistical data to keep it in its proper perspective. Id. The dissent in Herskovits expressed a concern over the use of statistical evidence. 664 P.2d at 491 (Brachtenbach, J., dissenting).

[FN94]. Perez, 805 P.2d at 598.

[FN95]. Herskovits, 664 P.2d at 490-91 (Brachtenbach, J., dissenting).

[FN96]. Bruer, supra note 17, at 984.

[FN97]. In wrongful death actions, juries tend to base the measure of damages on several factors that determine the value of lost life, including the age of the deceased and lost earning potential. Delaney v. Cade, 873 P.2d 175, 187 (Kan. 1994).

[FN98]. Roberts v. Ohio Permanente Med. Group, 668 N.E.2d 480, 484 (Ohio 1996).

[FN99]. Id.

[FN100]. See Delaney, 873 P.2d at 187.

[FN101]. Boggs, supra note 7, at 432-36.

[FN102]. Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 595 (Nev. 1991). In this case, a man who died of a massive brain hemorrhage that was left untreated in a county detention center, faced life on a respirator or as a quadriplegic if he survived. Id.

[FN103]. Id. In light of the facts stated in the preceding footnote, the dissenting judge did not believe the patient really "lost" anything worth compensating when faced with such a poor quality of life if he survived. Id.

[FN104]. Id.

[FN105]. See generally King, supra note 1, at 1378 (analogizing loss of chance to a defendant who destroys a raffle ticket. The defendant not only destroys the ticket, but along with it any chance of ever knowing whether the ticket would have won the drawing). Under a proportional method of awarding damages, the plaintiff is ultimately left with only a consolation prize. Id.

[FN106]. See supra notes 61-66 and accompanying text.

[FN107]. 668 N.E.2d 480 (Ohio 1996).

[FN108]. Id. at 484.

[FN109]. 454 N.W.2d 754, 763 (Wis. 1990).

[FN110]. Id.

[FN111]. King, supra note 1, at 1365. Pure loss of chance adheres to traditional rules of causation because the plaintiff attempts to show the causal connection between the physician's negligence and the lost chance. Id. Therefore, it is possible that the physician's negligence caused the loss of chance beyond a reasonable medical probability. Id.

[FN112]. Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 595-96 (Nev. 1991).

[FN113]. See Holton v. Memorial Hosp., 679 N.E.2d 1202, 1222 (Ill. 1997) (Heiple, C. J., concurring). On the opposite side of the coin, the majority states that there is nothing new about requiring health care professionals to compensate those negligently injured while under their care. Id. at 1213.

[FN114]. Herskovits v. Group Health Coop., 664 P.2d 474, 489 (Wash. 1983) (Brachtenbach, J., dissenting) (stating that this is an important reason for not abandoning established requirements of proximate cause).

[FN115]. Perez, 805 P.2d at 595.

[FN116]. Id.

[FN117]. Id.

[FN118]. See supra notes 13-17 and accompanying text.

[FN119]. Herskovits, 664 P.2d at 489.

[FN120]. Vernellia R. Randall, Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries, 17 U. Puget Sound L. Rev. 1, 3-4 (1997).

[FN121]. Id. at 6. These plans are an alternative to past reimbursement plans that rewarded physicians for ordering expensive or unnecessary treatment. Id.

[FN122]. Id. at 30-31.

[FN123]. Id. at 31-32.

[FN124]. Id.

[FN125]. See Holton v. Memorial Hosp., 679 N.E.2d 1202, 1213 (Ill. 1997). Disallowing recovery because a patient is already too ill to survive could become a disincentive for health care providers to treat critically ill patients. Id.

[FN126]. Herskovits v. Group Health Coop., 664 P.2d 474, 488 (Wash. 1983) (predicting that until that time arrives, formulas for liability could be founded on speculation).

[FN127]. Weymers v. Khera, 563 N.W.2d 647, 654-55 (Mich. 1997); see Roberts v. Ohio Permanente Med. Group, Inc., 668 N.E.2d 480, 490 (Ohio 1996) (Moyer, C.J., concurring) (stating that this holding should not be extended to cases in which the patient did not respond favorably to treatment or recovery was either slower or less complete than it would have been without the negligence). Other courts have opted to extend the loss of chance doctrine only to cases in which the patient suffered death or debilitating injury. See Perez v. Las Vegas Med. Ctr., 805 P.2d 589, 592 (Nev. 1991). Loss of chance should not be applied in this manner because the traditional negligence analysis, a more difficult standard, does not impose such a requirement.

[FN128]. Herskovits, 664 P.2d at 488.

[FN129]. United States v. Cumberbatch, 647 A.2d 1098, 1102 (Del. 1994).

[FN130]. Id.

[FN131]. Id. See e.g., Del. Code Ann. tit. 10, § 3721 (1975 & Supp. 1996). See also Roberts, 668 N.E.2d at 486. Compensation for lost chance on the other hand, appears to benefit the patient.

[FN132]. Roberts, 668 N.E.2d at 486.

[FN133]. See Wollen v. DePaul Health Ctr., 828 S.W.2d 681, 686 (Mo. 1992). These claims that benefit the decedent's estate would fit more consistently with pure loss of chance which attempts to compensate for the patient's lost chance of survival.

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