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***568 THE CASE FOR ACROSS-THE-BOARD APPLICATION OF THE LOSS-OF-CHANCE
DOCTRINE**

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It makes jurisprudential and public policy sense for the doctrine to apply to better-than-even chance cases when plaintiffs cannot prove causation

NEGLIGENCE law traditionally has required that findings of liability be predicated on a showing that defendants were the cause in fact of plaintiffs' harm. To prevail, plaintiffs had to show that "but for" defendants' negligence, the injury complained of would not have occurred.

In certain sub-sets of negligence law, application of the traditional rule had harsh consequences. Particularly in medical malpractice cases in which a physician's failure to diagnose a patient's pre-existing disease or condition allowed that disease or condition to progress, plaintiffs were barred from recovery in cases where their chance of a better outcome, absent negligence, was less than 51 percent. Recovery was denied because they were unable to prove that their injuries would not have taken place if proper diagnosis and treatment had been provided.

In response to the perceived inequity of denying recovery in these cases, courts during the last 20 years have developed what has come to be known as the loss-of-chance doctrine. The specific nature of the doctrine varies by jurisdiction. Some courts relax causation requirements simply by accepting a lower threshold of proof. [FN1] Others view the lost chance itself, rather than the ultimate outcome, as the compensable injury. [FN2] Still others appear to recognize a hybrid of the first two approaches. [FN3]

In general, the doctrine has been successful in facilitating compensation for injured plaintiffs, and it now is the majority rule. [FN4] As currently applied in almost all jurisdictions, however, the loss-of-chance doctrine results in significant inequities for defendants. Virtually all courts that recognize the loss-of-chance doctrine apply it only in those situations where the patient had less than a 50 percent chance of recovery or survival absent negligence (known as "not-better-than-even" cases), refusing to extend the doctrine to cases where the lost chance exceeded 50 percent (known as "better-than-even" cases). As a result, a plaintiff with a 51 percent chance of recovery *569 or survival who is able to establish negligence by a preponderance of the evidence is allowed to recover full damages for the ultimate injury suffered, notwithstanding the fact that there is a 49 percent chance that the injury would have occurred even if a proper diagnosis had been rendered and appropriate care given.

In short, the equities have never been in balance in this area of tort law. Prior to the development of the loss-of-chance doctrine, large numbers of deserving plaintiffs failed because of their inability to make out a prima facie case of negligence, resulting in a windfall for culpable defendants. Today, the pendulum of compensation has traveled to the opposite end of the spectrum, and defendants are routinely held liable in damages for injuries that they did not cause, resulting in the systematic overcompensation of plaintiffs.

It is strange that this problem has received virtually no attention in the courts or from commentators. [FN5] This fact is doubly surprising, given that a broader application of the loss-of-chance doctrine would allow defendants to limit damages to those actually flowing from their negligence, while at the same time allowing courts to reach results that intellectually are more credible.

In refusing to extend the loss-of-chance theory to all cases in which plaintiffs cannot establish causation under traditional

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principles, courts confuse the probabilities associated with claimants' health and survival with the preponderance of the evidence standard, ignore the common law and academic context within which the theory originally developed, and achieve results that are at cross-purposes with current judicial and legislative efforts to curb the perceived excesses of the tort system, particularly as related to medical malpractice litigation.

NATURE OF THE PROBLEM

A. "What" and "How"

A significant number of loss-of-chance cases involve alleged acts of medical negligence--often omissions--that combine with a patient's pre-existing disease or condition to produce injury or death. Because of this and because both the patient's chances of a better outcome and the evidence establishing negligence often are expressed in percentage terms, courts frequently confuse the probabilities associated with plaintiffs' health and survival with the preponderance of the evidence standard. [FN6] As one commentator has observed, courts fail "to distinguish between what is to be proved and how it is to be proved." [FN7]

The "what" that must be proven focuses on damages--namely, that the negligence alleged deprived the patient of a chance of recovery or survival, with that chance expressed almost invariably in percentage terms. The "how" centers on the preponderance of the evidence standard--that at least 51 percent of the evidence produced must persuade the fact finder that the defendant caused the harm.

The result of confusing these two variables is that courts typically conclude that if the patient had a better-than-even chance of recovery absent negligence, and if negligence is established by a preponderance of the evidence, then the physician was the cause in fact of the patient's entire injury and is liable for all associated damages.

This conclusion is analytically incorrect, in large part because a traditional negligence case does not involve a pre-existing condition, and therefore the agent or instrumentality of injury or death is not in question. The single uncertainty is whether that *570 agent or instrumentality worked harm on the plaintiff because of the defendant's negligence.

In contrast, a loss-of-chance action by definition involves multiple uncertainties, and the fact that negligence is proved by a preponderance of the evidence is not the equivalent of proving that the negligence was the cause of the patient's ultimate harm. In an absolute sense, causation for a patient's ultimate injury in a loss-of-chance case can be established only by considering the mathematical product of the evidence establishing negligence, together with the patient's original chance for a better outcome.

Because most courts do not apply the loss-of-chance theory to better- than-even cases, a defendant theoretically could be liable for wrongful death in a situation in which it was shown only that there was a 26 percent likelihood that the defendant's negligence was the actual cause of death.

The problem is best illustrated by the following examples comparing a traditional negligent injury or wrongful death case with a case in which a patient suffers harm as a result of a negligent diagnosis.

Example A: Negligence resulting in wrongful death. A healthy plaintiff is killed when struck by a negligent automobile driver. To prevail, the decedent's representative must establish two variables--first, that the vehicle was the cause in fact of the death (Variable 1), and second, that a preponderance of the evidence establishes that the vehicle was being operated negligently (Variable 2). Since Variable 1 can be established to a certainty, this example can be illustrated mathematically as follows:

Variable 1 (cause of death) = 100% = 1.00

Variable 2 (evidence establishing negligence) = 51% = .51

(Variable 1) x (Variable 2) = causation establishing defendant's liability for death

(1.00) x (.51) = .51 = 51%

Here, liability is established because it has been shown that it is more likely than not that the defendant's negligence was the cause in fact of the death. Of course, the mathematical product establishing liability could be significantly higher, to the extent that more than 51 percent of the evidence establishes negligence.

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Example B: Lost chance of survival resulting from misdiagnosis. The plaintiff has a disease from which, at the time he sought treatment, he would have had a 51 percent chance of survival had he been properly diagnosed and treated. Unlike Example A, here a determination of liability involves a number of variables. Variable 1 is the likelihood that the disease would have caused the patient's death irrespective of the negligent diagnosis (100 percent - 51 percent = 49 percent). Variable 2 is the likelihood that the disease caused death possibly in combination with the misdiagnosis (100 percent). Therefore, Variable 3 is the only absolutely quantifiable harm resulting from the misdiagnosis--namely, the loss of a 51 percent chance of survival (100 percent - 49 percent = 51 percent). Variable 4 again is the preponderance of the evidence establishing the alleged negligence.

Mathematically, this example can be illustrated as follows:

Variable 3 (chance of survival lost = 51% = .51

Variable 4 (evidence establishing negligence) = 51% = .51

(Variable 3) x (Variable 4) = causation establishing the defendant's liability for death

(.51) x (.51) = .26 = 26%

Here, virtually all courts would find the physician liable for the patient's death, although it can be established that there is a 26 percent likelihood that the negligence was the cause in fact of the death. In so doing, these courts treat the better-than-even chance as though it had materialized or was certain to do so--in other words, not as a chance, but as a certainty. [FN8]

*571 Having concluded that the physician's negligence was the cause in fact of the patient's death, courts typically assess damages for the full value of the patient's life, as is the action were one for wrongful death. Again, as in Example A, the mathematical product establishing liability for death could be significantly higher than 26 percent, to the extent that more than 51 percent of the evidence establishes negligence.

B. What To Do

On a theoretical, but not necessarily practical, level, this problem could be addressed in two ways that would yield a more analytically credible result. The first method would approach the problem only from the standpoint of causation, whereas the second would focus on how the injury is valued and apportion damages accordingly.

1. Causation

Under the causation approach, it could be argued that whenever the mathematical product of the lost chance (Variable 3 in Example B above) and the preponderance of the evidence (Variable 4 in Example B above) is less than 51 percent, the defendant should prevail on the question of liability for the ultimate injury.

This approach, while perhaps correct in a purely theoretical sense, is unlikely to work. First, it is analytically complicated and courts are unlikely to warm to the idea that the rights and liabilities of plaintiffs and defendants can be established with mathematical precision. Second, it would be difficult to apply. While juries are directed to determine, after hearing expert testimony, the precise chance of recovery or survival that the plaintiff lost as a result of negligence, they are not asked to identify, as an exact percentage, how much weight they accorded the evidence in concluding that negligence was established by a "preponderance." Third, this approach would likely be viewed as perpetuating the inequities the loss-of-chance theory was intended to eliminate. In Example B above, a plaintiff who lost a 70 percent chance of survival and put forth evidence establishing negligence to a 70 percent certainty still could not prevail, since the resulting product of these variables would be only 49 percent.

2. Damages

An alternative for resolving the problem is to view the lost chance as a separately compensable injury and apportion damages according to the percentage of chance lost in all cases where the plaintiff cannot establish cause-in-fact according to traditional standards.

In fact, this is the approach followed by a number of courts in not-better- than-even cases, [FN9] and an approach which relies for support on the same case law and academic antecedents that they frequently cite with approval. It is, therefore, surprising that these courts openly endorse this methodology when a plaintiff can show a lost chance of 49 percent or less, but allow full recovery for the total injury suffered when a plaintiff shows a lost chance of only 51 percent, since the two

cases are practically the same.

ORIGINS

A. Professor King's Theory

Although virtually all courts and many commentators have implicitly or explicitly concluded that the loss-of-chance theory should be applied only to cases in which the patient lost a not-better-than-even chance of recovery or survival, a review of the theory's academic and common law antecedents does not support such a limitation. The theory in its modern form is most often associated with the seminal 1981 article by Professor Joseph King, cited at footnote 8, in the Yale Law Journal.

*572 King criticized the traditional rules of causation on a variety of grounds, including (1) that application of traditional causation principles leads to arbitrary and unfair results because full recovery is afforded to plaintiffs who can prove any better-than-even lost chance, while recovery is denied altogether to those who can show only a 50 percent or less lost chance; (2) that because it is the defendant's own negligence that prevents the fact finder from knowing whether the patient would have recovered in the absence of negligence, principles of fundamental fairness dictate that the cost of this uncertainty be imposed on the tort-feasor and not the victim; (3) that the traditional rule undermines the loss allocation and deterrence functions of tort law by failing to assign the loss of not-better-than-even chances to their tortious causes; and (4) that chances of survival have value, a reality largely ignored by traditional causation principles.

King argued that the actual injury was not the ultimate outcome but rather that the actual chance lost was the compensable injury. He also suggested that courts view loss-of-chance cases as involving issues of valuation, as opposed to causation, and that damages should be apportioned according to the percentage of chance lost.

Significantly, however, King also argued that his theory should apply across-the-board to all cases in which a plaintiff could not establish that the defendant's negligence was the cause-in-fact of the entire harm suffered. He devoted only three paragraphs to the subject of better-than-even chances, assuming, in all likelihood, that once a court accepted his concept of loss-of-chance, it would necessarily apply the theory to cases both above and below the 50 percent line. Indeed, the theory makes little sense when applied in a lop-sided fashion.

Inexplicably, while numerous courts have quoted King at length--and at times in reverential tones--they are silent on the theory's application to better-than-even cases.

B. Case Law Antecedents

In addition to the King article, the development of modern loss-of-chance theory is most often credited to a series of three cases decided between 1966 and 1983. However, a review of the case law underlying the development of the theory fails to lead to the conclusion that it was intended to be limited to not-better-than-even cases.

In *Hicks v. United States*, [FN10] a physician failed to diagnose an intestinal obstruction from which the patient died. The Fourth Circuit rejected the argument that the failure to diagnose was not the cause of death, noting the uncontradicted testimony of an expert that the decedent would have survived if operated on promptly. In language subsequently quoted widely, the court stated: "If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable." (Emphasis supplied.) It is important to note that the court's oft-quoted reference to the value of a "substantial possibility" of survival was made in a context in which the patient's lost chance of survival, while perhaps speculative, was held to be almost a certainty.

A similar result was reached in *Hamil v. Bashline*, [FN11] which, like *Hicks*, involved a patient whose lost chance was decidedly better-than-even. The physician failed to diagnose a myocardial infarction, from which the patient died shortly after reaching the hospital. An expert opined that if the physician had employed appropriate diagnostic and treatment methods, the decedent would have had a 75 percent chance of surviving. Reversing the trial court's directed verdict for the defendant, the Pennsylvania Supreme Court relied on [Section 323\(a\) of the Restatement \(Second\) of Torts](#), which imposes liability for negligence resulting in an increased risk of harm. Again, as in *Hicks*, the *Hamil* court's purported "relaxed" standard of causation *573 was employed in the context of a case in which the decedent had a substantially better-than-even chance of survival.

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The progenitor of the modern loss-of-chance theory is *Herskovits v. Group Health Cooperative of Puget Sound*, [FN12] in which the plaintiff alleged that the failure of the defendants to make an early diagnosis of her husband's lung cancer reduced his chances of survival from 39 percent to 25 percent--a net loss-of-chance of 14 percent.

The Washington Supreme Court made two important observations. First, it expressly took notice of the fact that both *Hamil* and *Hicks* involved patients whose chances of survival were greater than 50 percent," concluding that the theory could "apply equally to cases such as the present one, where the original survival chance is less than 50 percent." Second, with respect to damages, both the main and plurality opinions recommended some form of apportionment. The main opinion stated that causing a reduction of the opportunity to recover "does not necessitate a total recovery against the negligent party for all damages caused by the victim's death." The plurality opinion went even further, quoting King's view that damages in loss-of-chance cases should be discounted to reflect the actual value of the chance lost, rather than total damages for wrongful death.

The court's reasoning here is significant. First, it is clear that the court did not view itself as inventing some new theory of recovery, but rather, as borrowing an established theory from better-than-even cases and applying it to new facts. Second, and more important, neither the *Herskovits* main opinion nor the plurality intimated that loss-of-chance theory should be limited to not- better-than-even cases or that damages should be apportioned only in such cases. In fact, the specific scope of *Herskovits* recently was clarified by the Washington Court of Appeals, and again no such limitation was suggested:

... [I]f *Herskovits* stands for anything beyond its result, we believe the plurality represents the law on a loss of chance of survival. The plurality would allow instructions on a loss of a chance of survival ... only if the evidence shows (1) a substantial reduction in the chance of survival, and (2) the negligence of the defendant caused the reduction. [FN13]

Given the reliance in *Herskovits* on *Hicks*, *Hamil* and the views of King, it follows that a "substantial reduction" in the context of a loss-of-chance action also must include lost chances in excess of 50 percent. In short, there is no authority for the proposition that *Herskovits* created a loss-of-chance cause of action limited to not-better-than-even cases. This conclusion merely is a fiction that has been developed by courts in other jurisdictions applying permutations of the theory.

ACROSS-THE-BOARD APPLICATION IS THE MOST EQUITABLE

The arguments for restricting application of the loss-of-chance theory to not-better-than-even cases are unpersuasive. Restricting the doctrine, moreover, is not consistent with current judicial and legislative efforts to curb the perceived excesses of the tort system, particularly as related to medical malpractice. An across-the-board application of the doctrine is more equitable to all litigants--better, for instance, than other methods of containing damages, such as damages caps.

Continuing tort reform initiatives illustrate the need, be it real or perceived, to place certain restrictions on the operation of the tort system. Of the various initiatives that have been proposed and enacted at the state level, the two measures that appear to have taken hold in the most widespread fashion are shortened statutes of limitation for actions against health care providers *574 and caps on damages, typically noneconomic damages. From a political standpoint, caps on damages certainly have some symbolic value, since they are most often called for or justified in the wake of perceived "runaway verdicts." Increasingly, however, they are have been subjected to court challenges, and several state statutes have been struck down.

In the wake of new state laws enacted in 1986 aimed at medical malpractice reform, the American Bar Association Commission to Improve the Tort Liability System recommended that statutory caps on noneconomic damages be abolished. [FN14] The commission's report was particularly unforgiving in its criticism of the arbitrariness of damages caps. The ABA's criticism of damages caps has been echoed by several state courts. [FN15]

A comprehensive review of the advantages and disadvantages of damages caps is beyond the scope of this article, but two points are clear. First, the ostensible purpose of damages caps is to reduce damage awards in an effort to contain malpractice insurance premiums and maintain affordable access to health care. Second, to the extent that damages caps have, at least in part, fallen into disfavor, the chief criticism is that they are inherently arbitrary--that is, they fail to create a match between the harm caused and the compensation awarded in damages. In view of this, it seems clear that courts should seek out forms of judicial relief that promise some containment of damage awards while ensuring, to the fullest extent possible, that deserving plaintiffs are equitably compensated for their injuries.

An across-the-board application of the loss-of-chance theory is one such judicial solution. The underlying premise of that theory is that medical malpractice defendants should be liable for only the harm they caused. This principle seems

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considerably more equitable, as a means of containing damage awards, than more draconian devices, such as a damages cap. In astutely recognizing the implications of loss-of-chance theory on the economics of health care, one court noted: "A rule of law that more precisely confines physicians' liability for negligence to the value of the interest damaged should have a salutary effect on the cost and availability of medical care." [FN16]

JUDICIAL APPROACHES

An across-the-board application of the loss-of-chance theory would both be consistent with the theory's academic and case law antecedents and would serve the interests of individual litigants as well as the malpractice liability system. Nevertheless, almost no jurisdictions have extended the theory to situations where the plaintiff lost more than a 50 percent chance of a better outcome.

One jurisdiction that has extended the theory is New Jersey. In a series of well-reasoned opinions, New Jersey courts have demonstrated that the logic and fundamental fairness of the loss-of-chance theory obtains equally both above and below the 50 percent line. In contrast, Kansas represents a state that originally applied the theory to better-than-even cases and then retreated. A comparison of the decisions of in these states should assist defense counsel seeking an expanded application of the theory in understanding the practical context within which the theory is applied.

A. New Jersey Approach

New Jersey courts have demonstrated *575 their awareness of the proper application and the legitimate boundaries of the loss-of-chance theory.

In *Scafidi v. Seiler*, [FN17] the New Jersey Supreme Court was presented with a case in which the plaintiff alleged that a physician's failure to properly treat her premature labor caused the premature birth and death of her infant child. According to expert testimony, a timely administration of tocolytic therapy would have been 75-80 percent effective in arresting her premature labor. The trial court ruled that if the jury found that the defendant's negligence was a proximate cause of the infant's premature birth and death, then the defendant would be liable for all the plaintiff's damages.

This conclusion was reversed by the intermediate appellate court, which was affirmed by the New Jersey Supreme Court.

The supreme court held that a defendant whose negligence aggravates a plaintiff's preexisting condition should be liable only for the amount of harm actually caused by the negligence. Significantly, it recognized that this approach of awarding proportional damages is an "essential complement" to the lower standard of proof of causation applicable to plaintiffs in loss-of-chance cases. "It should be a self-evident principle of tort law," the court stated, "that valuation of allowable damages 'is animated by a premise similar to that underlying causation: that a tortfeasor should be charged only with the value of the interest he destroyed.'" [FN18]

The court justified its result on precedent and public policy grounds. With respect to precedent, it observed that its holding was consistent with the principles underlying both New Jersey's comparative negligence and joint tortfeasor contribution statutes--both of which require that damages be awarded in proportion to a party's fault. Regarding public policy, the court noted that a legal rule that more accurately matches physician liability with the harm caused "should have a salutary effect on the cost and availability of medical care."

The court placed two important restrictions on its holding to ensure that the rule would operate equitably for both plaintiffs and defendants. First, it required that a defendant in a loss-of-chance case seeking to apportion damages bear the burden of proof in segregating those damages attributable to negligence from those caused by the preexisting condition. Second, to protect defendants, the court emphasized that in loss-of-chance cases the court and not the jury should reduce the verdict to match the percentage of chance lost.

The rule announced in *Scafidi* was applied next by a New Jersey intermediate appellate court in *Del Tufo v. Township of Old Bridge*, [FN19] a case brought by the executor of a decedent's estate who claimed that the failure of police officers to summon emergency medical assistance for the decedent, who was in police custody following his arrest, resulted in his death from cardiac failure. Expert testimony established that during the half hour prior to the onset of cardiac distress, the decedent would have had a 50-75 percent chance of survival, depending on when help was summoned.

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Holding that the police department had a duty to provide necessary medical treatment, the court concluded that the decedent was deprived of a "substantial prospect of recovery" within the meaning of Scafidi and concluded that the department should be liable in damages to the extent that its negligence was a substantial factor in diminishing the chance of recovery. The court did not, however, apportion the damage award consistent with Scafidi because the alleged acts of negligence occurred prior to Scafidi.

A similar issue arose later in the New Jersey Supreme Court in *Fischer v. Canario*. [FN20] That case primarily involved the procedural question whether Scafidi's damages apportionment methodology should *576 apply retroactively to cases still pending at the time Scafidi was handed down. Although procedural in nature, *Fischer* nevertheless is significant because the court again indicated that it would not limit the loss-of-chance doctrine to situations where the patient lost a not-better-than-even chance.

Expert testimony in *Fischer* indicated that the defendants' failure to diagnose the decedent as suffering from lung cancer resulted in a lost chance of survival of exactly 50 percent. The court cited Scafidi with approval for the proposition that principles of fundamental fairness "dictate that a physician's liability in a medical malpractice action be limited to the value of the lost chance for recovery attributable to the physician's negligence."

The New Jersey Supreme Court has not expressly articulated the distinction between less-than-even and better-than-even cases. Nevertheless, taken together, the analyses and consistency of Scafidi, *Del Tufo* and *Fischer* clearly indicate that New Jersey courts will apply the theory to all cases in which plaintiffs cannot establish under traditional causation principles that the failure to diagnose or treat a preexisting medical condition was the cause in fact of the ultimate harm suffered.

In a 1996 decision, the New Jersey Supreme Court clarified an important limitation on the application of the loss-of-chance theory. In *Anderson v. Picciotti*, [FN21] a patient sued her physician, claiming that he mistakenly amputated her toe following an erroneous diagnosis of osteomyelitis, which diagnosis resulted from the failure to perform a bone scan as required by the applicable standard of care. In determining that the defendant physician failed to establish that any pre-existing condition of the patient combined with the physician's own negligence to produce the injury, the *Anderson* court held that the loss-of-chance theory is inapplicable to "traditional" medical malpractice cases where a plaintiff's allegations do not suggest increased risk from the failure to diagnose or treat a pre-existing condition but rather only implicate a physician's professional judgment as departing from the standard of care.

This limitation is important, because one of the criticisms that has been raised against an across-the-board application of loss-of-chance theory is that it could allow loss-of-chance to entirely "swallow" causation in all medical malpractice cases. [FN22] *Anderson* illustrates that such fears are unfounded and that informed courts are perfectly capable of discerning which cases are candidates for evaluation under a loss-of-chance methodology and which should be decided under traditional principles of causation.

B. Kansas Experience

The experience of the Kansas courts is typical of jurisdictions that have attempted to justify a limited application of the theory. In an effort to escape the reach of federal district court decisions extending the theory to better-than-even cases, Kansas state courts have adopted a confused posture of retrenchment.

Kansas first recognized the loss-of-chance doctrine in *Roberson v. Counselman*, [FN23] a medical malpractice action alleging failure to diagnose symptoms of acute heart attack and failure to refer to an appropriate specialist. Conflicting expert testimony was presented on the issue of causation. One cardiologist stated that with proper treatment the decedent would have had an 81 percent chance of survival, whereas without treatment, his chances of survival were reduced to 75 percent. This expert then apparently "netted" the two figures to conclude that the defendant's negligence deprived the decedent of a 6 percent chance of survival. The second expert stated that the decedent would have had only a 40 percent chance of survival even with proper treatment; without such treatment, the chances of survival were zero.

*577 The Kansas Supreme Court, without discussing the conflicting expert testimony, concluded that it was sufficient to create a jury question and reversed the trial court's grant of summary judgment. In so doing, the court held that the question of causation in a case involving negligent treatment of a potentially fatal condition is generally a matter to be determined by the jury when evidence has demonstrated that the decedent lost an "appreciable chance" to survive and the defendant's negligence was a substantial factor in the decedent's death.

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Roberson represents a fairly superficial analysis. The court primarily quoted at length the opinions of courts in other jurisdictions, concluding in summary fashion that Kansas would adopt the loss-of-chance theory but ultimately leaving many questions unanswered. Besides not defining what it viewed as an "appreciable loss," the court did not indicate whether it viewed the compensable injury to be the decedent's death or the value of the chance lost. In addition, the court nowhere discussed how damages should be calculated in a loss-of-chance case.

The court also was silent on the fact that, based on the testimony of the first expert, Roberson could fairly be characterized as a better-than-even case. The fact that the first expert's "netting" approach resulted in a figure less than 50 percent is immaterial. The critical fact is that a patient with a better than even chance (either 81 or 75 percent, depending on when the chance was measured) died following a negligent medical omission. Therefore, a court opposed to extending the loss-of-chance theory to better-than-even cases likely would have treated Roberson as a traditional wrongful death action.

The rule adopted in Roberson was applied next in a Kansas federal district court case, *Boody v. United States*, [FN24] in which the plaintiff sued for the wrongful death of his wife, alleging negligent failure to diagnose cancer. Boody is particularly significant because expert testimony established that with proper diagnosis and treatment, the decedent had a 51 percent chance of survival for five years. The Boody court relied on Roberson in applying the loss-of-chance theory, despite the fact that the decedent in Boody indisputably had a better-than-even chance. Like the court in Roberson, however, the Boody court did not mention the distinction between less-than-even and better-than-even cases.

The same year the same federal district court decided *Borgren v. United States*, [FN25] in which the plaintiff, who survived, sued under the Federal Tort Claims Act, alleging negligent failure to diagnose cancer and claiming that the physician's malpractice reduced her chance of a better recovery by 30- 57 percent over a 10-year period. Borgren therefore can fairly be characterized as a better-than-even case.

The district court again analyzed the case under the loss-of-chance framework, concluding that a 30-57 percent lost chance over a 10- year period was an "appreciable loss" within the meaning of Roberson. Again, the Borgren court was silent as to any distinction between less-than-even and better-than- even cases.

This distinction was first recognized in Kansas in *Donnini v. Quano*, [FN26] a case in which the Kansas Court of Appeals expressly sought to limit application of the theory to not-better-than-even cases. The plaintiff sued a physician for failing to diagnose cancer in her husband, from which he ultimately died. The jury found that the decedent's chances of survival, had he received proper medical care, were 55 percent, and that he had no chance of survival under the care actually given. From this the court reasoned that the jury found that it was more likely than not that the doctor's conduct was a "substantial factor" in bringing about the harm," and it flatly concluded that a "cause of action in which the patient had a greater than 50 percent chance of *578 surviving does not fall under the loss of chance doctrine."

The Donnini court sought to escape Boody's extension of the theory to a better-than-even case on the ground that the Boody decedent was deprived of a 51 percent chance of living five years, whereas the jury's finding in Donnini on percentage was not limited to five years. The court nowhere explained why this purported distinction should make a difference, and, in fact, it does not. The basis on which the court sought to distinguish Boody is specious for two reasons.

First, both Boody and Donnini involve the question whether loss-of-chance theory should be applied to cases where the patient had a better-than-even chance of avoiding an undesirable outcome. The fact that the particular undesirable outcome might be somewhat different--for example, deprivation of survival for five years versus deprivation of survival altogether--should not change the analysis.

Second, and more important, the court misunderstood entirely the expert testimony on the issue of survival. In fact, the chance that each of the two decedents lost was almost identical, making the cases virtually indistinguishable. The Donnini court purported to distinguish Boody on the ground that the Boody decedent's chances of recovery were expressed with reference to a five-year survival rate, whereas expert testimony in Donnini made no such five-year reference. This distinction is not meaningful, because the five-year reference is simply a medical term of art, used in lieu of words like "cure." [FN27] The Donnini court, however, interpreted it literally to mean that, at best, the decedent would have lived only for another five years. This point previously had been clarified in Borgren, so it is unclear why the Donnini court apparently misinterpreted it. Even more surprisingly, the Donnini court in a later portion of its opinion appeared to recognize the true meaning of the five-year reference, stating that "a patient living for five years is probably cured of the tumor for which he has been treated."

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There was no meaningful factual difference between the decedents in Boody and Donnini; both were deprived of a better-than-even chance of a "cure"--for example, survival for five years--and any difference between them is purely semantic. Since the Donnini court attempted to distinguish Boody only on a factual rather than a legal basis and since that purported distinction fails, Donnini's conclusion that loss-of-chance theory does not apply to better-than-even cases is analytically un-supportable.

The Kansas experience is fairly representative of those jurisdictions that limit application of the theory to not-better-than-even cases. Most of these states fall into three groups: (1) states that are silent altogether on the issue of whether the theory may be applied to better-than-even cases; (2) states that conclude without explanation that the theory does not apply to better-than-even cases; or (3) states, like Kansas, which purport to limit application of the theory, but whose justifications for the limitation prove analytically problematic.

EXPANDING LOSS-OF-CHANCE TO BETTER-THAN-EVEN CASES

In order to make an effective case for an across-the-board application of the loss-of-chance theory, the question is where to begin. Jurisdictions likely to be the most amenable to arguments advocating an across-the-board application are those whose current formulation of the doctrine parallels the theory as originally proposed by King and that view the lost chance itself, rather than the ultimate outcome, as the compensable injury, apportioning damages according to the chance lost.

*579 In fact, a number of jurisdictions follow this approach. [FN28] Many already may have decisions that implicitly invite arguments for an expanded application of the theory. By way of example, the Missouri Supreme Court in its opinion adopting King's version of the loss-of-chance theory made a number of statements that could be interpreted as friendly to an across-the-board application of the theory.

In *Wollen v. DePaul Health Center*, [FN29] the Missouri Supreme Court, in adopting loss-of-chance theory, concluded that a plaintiff who cannot satisfy traditional causation principles cannot bring an action for wrongful death but must instead sue for loss-of-chance. The court offered three hypothetical situations which suggest that Missouri might apply loss-of-chance to better-than-even cases:

... Case 1 (this case): An allegation of wrongful death in which the statistics show a 30 percent chance of survival if the disease had been properly diagnosed. Case 2: A wrongful death petition in which the statistics show a 70 percent chance of survival. Case 3: A petition filed under [[Missouri's survivorship statute]....

Assuming for the sake of argument that all three cases are based on a lost chance of recovery, the question is which causes of action are allowable under Missouri law....

[R]egardless of whether the lost chance of survival is greater than or less than 50 percent, it is impossible to prove that decedent's death resulted from the failure to properly diagnose and treat. Thus, neither of the wrongful death actions (cases 1 and 2) are allowed under the wrongful death statute; and only the action filed under the survivorship statute (case 3) is allowed as a matter of Missouri law. [FN30]

The implications of the court's language are significant. First, in stating that Cases 1 and 2 cannot be brought under the wrongful death statute, the court does not appear to distinguish between better-than-even cases (Case 2) and not-better-than-even cases (Case 1). This point is underscored by the fact that the court's hypothetical Case 3 makes no reference to a percentage chance of survival, implying that either case 1 or case 2, if filed under the survivorship statute, would be allowable as a loss-of-chance action. More significant, by stating that it is impossible to infer causation merely because the patient had a greater than 50 percent chance of survival if properly diagnosed and treated, the court implies that the only remedy available to a plaintiff in this situation is a loss-of-chance action.

Other less direct statements in *Wollen* also may be read to suggest that the court did not intend to limit loss-of-chance theory to not-better-than-even cases. In describing its rationale for adopting the theory, the court stated:

The traditional yes-no view of the world in causation theory does not match the "maybe" view of the world found in probability, statistics, and everyday life. To both the statistician and the patient seeking care from a doctor, there is no meaningful difference between a 50.001 percent and a 49.999 percent chance of recovery. [FN31]

The court's refusal to allow a bright-line rule to bar recovery for patients whose chances of recovery are below 50 percent also may reflect the view that plaintiffs should not be allowed to recover full damages simply because their original chances of recovery or survival exceeded 50 percent.

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The Wollen court's language and hypothetical illustrations provide a reasonable basis from which to argue that loss-of-chance theory should apply across-the-board in all cases where a plaintiff cannot establish that negligence was the cause in fact of the ultimate injury suffered. In advocating an expanded application of the theory, defense counsel should seek out opinions like Wollen, which may indicate a court's willingness to apply the theory to better-than-even cases.

*580 CONCLUSION

There are many sound justifications for extending the loss-of-chance theory to cases of medical malpractice where the patient was deprived of a better- than-even chance of a better outcome. As a matter of fundamental fairness, it seems elemental that tortfeasors should be required to compensate their victims only for the harm caused. As a matter of legal doctrine, applying the theory across-the-board to all malpractice cases where the patient is unable to satisfy traditional standards of causation is both logical and entirely consistent with the theory's origins as developed both by academics and in the courts.

Applying the theory to better-than-even cases also makes sense from the standpoint of facilitating sound judicial and public policy and in curbing, at least in some measure, the perceived excesses of the malpractice liability system.

Arguments for restricting the theory to not-better-than-even cases--whether advanced by commentators or by courts--are uniformly unpersuasive. In order to ensure parity for malpractice defendants, defense counsel should seek out opportunities to advocate vigorously for an across-the-board application of the loss-of-chance theory.

[FN1]. See, e.g., *O'Brien v. Stover*, 443 F.2d 1013, 1018 (8th Cir. 1971) (evidence of 30 percent chance of survival absent negligence was sufficient to create jury question on causation); *Roberson v. Counselman*, 686 P.2d 149, 160 (Kan. 1984) (evidence that plaintiff had 40 percent chance of surviving heart attack if given proper care created jury question as to whether defendant's negligence was "substantial factor" in causing plaintiff's death); *Kallenberg v. Beth Israel Hosp.*, 357 N.Y.S.2d 508 (App.Div. 1st Dep't 1974) (20-40 percent chance of survival created jury question on proximate cause).

[FN2]. See, e.g., *Falcon v. Memorial Hosp.*, 462 N.W.2d 44, 52 (Mich. 1990); *DeBurkarte v. Louvar*, 393 N.W.2d 131, 137 (Iowa 1986).

[FN3]. See e.g., *Scafidi v. Seiler*, 574 A.2d 398, 408 (N.J. 1990); *McKellips v. St. Francis Hosp.*, 741 P.2d 467, 474-77 (Okla. 1987).

[FN4]. See *Kramer v. Lewisville Memorial Hosp.*, 858 S.W.2d 397, 400-01 (Tex. 1993) (collecting cases and noting that only eight states have clearly rejected doctrine).

[FN5]. But see Lori R. Ellis, Note, *Loss of Chance as Technique: Toeing the Line at Fifty Percent*, 72 TEX. L. REV. 369 (1993) (recognizing arguments for extending loss-of-chance theory but advocating continued restriction to not-better-than-even cases) [hereinafter Ellis].

[FN6]. See *Donnini v. Quano*, 810 P.2d 1163 (Kan. App. 1991) (jury determination of negligence where patient had 55 percent chance of survival was tantamount to jury finding that negligence was cause of patient's death).

[FN7]. John Makdisi, *Proportional Liability: A Comprehensive Rule to Apportion Tort Damages Based on Probability*, 67 N.C.L. REV. 1063 (1989).

[FN8]. See Joseph H. King Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1387 (1981) [hereinafter King].

[FN9]. See, e.g., *Wollen v. DePaul Health Center*, 828 S.W.2d 681 (Mo. 1992); *Scafidi*, 574 A.2d 398; *McKellips*, 741 P.2d 467.

[FN10]. 368 F.2d 626 (4th Cir. 1966).

[FN11]. 392 A.2d 1280 (Pa. 1978).

[FN12]. 664 P.2d 474 (Wash. 1983).

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[FN13]. *Zueger v. Public Hosp. Dist. No. 2 of Snohomish County*, 789 P.2d 326, 329 (Wash.App. 1990) (emphasis supplied).

[FN14]. See generally Report of the Action Commission to Improve the Tort Liability System 10-15 (1987).

[FN15]. *Lucas v. United States*, 757 S.W.2d 687 (Tex. 1988); *Kansas Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988); *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *Morris v. Savoy*, 576 N.E.2d 765 (Ohio) 1991); *University of Miami v. Echarte*, 585 So.2d 293 (Fla.App. 1991). See also Carol A. Crocca, Annotation, *Validity, Construction and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245 (1995 and Supp. 1996).

[FN16]. *Scafidi*, 574 A.2d at 498.

[FN17]. 574 A.2d 398 (N.J. 1990).

[FN18]. *Id.* at 408, citing *King*, supra note 8, at 1356.

[FN19]. 650 A.2d 1044 (N.J.Super. 1995).

[FN20]. 670 A.2d 516 (N.J. 1996).

[FN21]. 676 A.2d 127 (N.J. 1996).

[FN22]. See *Ellis*, supra note 5, at 400.

[FN23]. 686 P.2d 149 (Kan. 1984).

[FN24]. 706 F.Supp. 1458 (D. Kan. 1989).

[FN25]. 723 F.Supp. 581 (D. Kan. 1989).

[FN26]. 810 P.2d 1163 (Kan.App. 1991).

[FN27]. As a matter of technical terminology, cancer survival is never expressed in terms of a "cure." Rather, cancer statistics are based on various "survival rates," which represent the length of time that victims have survived after a given date, such as the date of diagnosis or the beginning of treatment. For most types of cancer, five-year studies are conducted. See American Joint Committee on Cancer, *Manual for Staging of Cancer* 11-21 (2d ed. 1983).

[FN28]. See *Kramer*, 858 S.W.2d at 402 (collecting cases). See also *Ellis*, supra note 5 at 370, n.7-10.

[FN29]. 828 S.W.2d 681 (Mo. 1992).

[FN30]. *Id.* at 685-86 (emphasis added).

[FN31]. *Id.* at 684 (emphasis added).

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