Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 9 (Fall 2018)

Weekly Summary

We already looked at the duty and breach elements of medical malpractice. Now we turn to causation and damages.

Money Damages

A medical malpractice lawsuit may result in a range of consequences for the defendant, including: credentialing with their hospital and third-party payers, licensing, and reports to the NPDB. But the primary objective of the plaintiff is to obtain monetary compensation. Most money damages are economic compensatory (mostly lost wages and medical expenses). Some damages are non-economic compensatory (pain & suffering). These are often capped by statute. Rarely, plaintiffs recover nominal damages (e.g. for a purely offensive non-harmful battery) or punitive damages (for intentional or wanton conduct).

Causation

Traditional "but for" causation is sufficient in every jurisdiction. The plaintiff must establish that in the absence of the defendant's negligence she probably (>50.01%) would not be injured. Because their illnesses or injuries mean that medicine can offer only limited benefits, many plaintiffs cannot establish but for causation. Therefore, in an increasing number of jurisdictions (including Minnesota), "lost chance" causation is an alternative. Lost chance causation requires reframing the injury as the "lost chance" itself rather than the physical harm. This reframing changes the calculation of damages. For example, negligence that deprives the patient of a 10% chance of avoiding a $100,000 injury would be compensated at $10,000.

Reading

All the following materials are collected into a single PDF document:

- Valadez v. Newstart (Tenn. App. 2008)
- Mohr v. Grantham (Wash. 2011)
- Diederich, Medical Malpractice Payout Analysis (2018)

Objectives

By the end of this week, you will be able to:

- Distinguish traditional "but for" causation from "lost chance" causation (4.8).
- Analyze and apply legal principles concerning how economic, non-economic, and punitive money damages are calculated and statutorily limited (4.9).

IN THE COURT OF APPEALS OF TENNESSEE
AT JACKSON
AUGUST 20, 2008 Session

PEDRO AND GRISELDA VALADEZ, Individuals and as parents and next Friends of FATIMA VALADEZ, a minor v. NEWSTART, LLC, ET AL.

Direct Appeal from the Circuit Court for Shelby County
No. CT-007286-04 Donna M. Fields, Judge

No. W2007-01550-COA-R3-CV - Filed November 7, 2008

In this appeal we are asked to reverse the trial court's grants of summary judgment to Appellees and adopt a loss of chance theory of recovery, thus allowing Appellants to recover for Appellees' alleged failure to timely notify them that their unborn child was afflicted with spina bifida such that they could participate in a clinical trial. Because our supreme court has expressly stated that Tennessee does not recognize a cause of action for loss of chance, we affirm.

Tenn. R. App. P. 3; Appeal as of Right; Judgment of the Circuit Court Affirmed

ALAN E. HIGHERS, P.J.,W.S., delivered the opinion of the court, in which DAVID R. FARMER, J., and HOLLY M. KIRBY, J., joined.

Tim Edwards, Memphis, TN, for Appellants

Darrell E. Baker, Jr., Peter B. Winterburn, Memphis, TN, for Appellees Newstart, LLC, and Carl Pean, M.D.

Jerry E. Mitchell, Justin E. Mitchell, Memphis, TN, for Appellee Ericka Lee Gunn-Hill, M.D.

OPINION

I. FACTS & PROCEDURAL HISTORY

In early 2003 the National Institute of Child Health and Human Development (NICHD) commenced a study to compare two approaches to treating babies with spina bifida, a condition where a baby's spine remains exposed in the mother's uterus. The study, known as the Management of Myelomengocele Study (MOMS), was limited to three clinical centers, including Vanderbilt University. Persons interested in participating in the study were sent an information packet and were required to consent to both an evaluation of their medical records and consultation with their doctor, if necessary. After eligibility was confirmed, participants were assigned to one of the three clinical centers, where a final screening was performed.[1] Upon enrollment in the study, women were assigned to one of two groups: the intrauterine surgical group (prenatal surgery group), in which surgery was performed on the fetus's spine while in the uterus, or the standard care group (postnatal surgery group), in which surgery was performed after birth, typically within 48 hours. Assignment to either group was randomly "made by a central computer system" and [n]either the MOMS Center staff nor the woman [was] able to choose which group she [was] assigned to." Thus, each participant "had a 50-50 of either being in the [intrauterine surgery] study group or in the [postnatal surgery] group."

Griselda Valadez ("Appellant" or "Ms. Valadez"), was a patient of Dr. Carl Pean ("Appellee"), for prenatal care. However, during Ms. Valadez's pregnancy Dr. Pean was called to serve on active military duty, and his patients were treated by Dr. Ericka Gunn-Hill. In January 2004, at approximately twenty-one weeks pregnant, Ms. Valadez underwent an ultrasound examination, administered by the Flinn Clinic. Appellants allege that the results of the examination, which showed Ms. Valadez's unborn child was afflicted with spina bifida, were promptly relayed to Appellees; however, Appellees failed to notify Appellants of the results until March 2004.

On December 30, 2004, Pedro and Griselda Valadez (collectively, "Appellants") filed a Complaint for Medical Malpractice and for Breach of Contract against Newstart, LLC, Carl Pean, M.D., and Ericka Gunn-Hill, M.D. (collectively, "Appellees").[2] Appellants claimed that Appellees were notified by the Flinn Clinic of the results of the ultrasound, but failed to timely notify Appellants. This failure, Appellants claimed, prevented Ms. Valadez from qualifying for the MOMS study, whereby she could have potentially received the intrauterine surgery, as women must qualify for the study by the twenty-fifth week of pregnancy.

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[1] According to the MOMS website, "[t]he [final screening] is quite extensive and includes: [a] complete obstetrical ultrasound (sonogram)[;] [a]n MRI of the fetus's head [;] [a] physical examination of the mother and clearance for surgery by an anesthesiologist and an obstetrician [;] [a] social work evaluation [;] [t]eaching about spina bifida and the medical problems associated with this condition [;] [t]eaching about what the prenatal surgery will involve, what to expect after surgery and what type of care will be needed between the prenatal surgery and delivery [;] [a] review of medications which may be necessary before, during and after the prenatal surgery [; and a] thorough review of the risks and benefits of participating in the study. If the evaluation confirms that a woman is eligible and she chooses to participate in the study, she will be asked to sign an informed consent form and the father will complete a brief psychosocial questionnaire." MOMS, http://www.spinabifidamoms.com/english/overview.html (last visited Sept. 18, 2008).

[2] Appellants' original Complaint named Newstart, LLC, Carl Pean, M.D., John Doe, M.D., and Jane Roe, M.D. However, Ericka Lee Gunn-Hill, M.D. was specifically named in an Amended Complaint, filed April 28, 2005.

On January 11, 2007, Appellees filed motions for summary judgment claiming that Appellants would "not be able to establish their claims to a reasonable degree of medical certainty in that there is no more than a 50% chance that Griselda Valadez would have been included in the fetal surgery side of a randomized study[.]" The trial court granted Appellees' Motions in a Memorandum Opinion and Order, filed July 3, 2007, holding that "this is a 'lost opportunity' case within the meaning of Kilpatrick v. Bryant, 868 S.W.2d 594 (Tenn. 1993)" and thus the "case must be dismissed."

II. ISSUE PRESENTED

Appellants have timely filed their notice of appeal and present the following issue for review:

1. Whether Tennessee should adopt a loss of chance theory of recovery.

For the following reasons, we affirm the decision of the circuit court.

III. STANDARD OF REVIEW

In the instant case, we are asked to review the trial court's grant of summary judgment to a defendant. Thus, we are bound by the following standard of review:

Summary judgment is appropriate when "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Tenn. R. Civ. P. 56.04. Ruling on a motion for summary judgment does not involve disputed issues of fact, but only questions of law. ***Owner-Operator Indep. Drivers Ass'n v. Concord EFS, Inc.***, 59 S.W.3d 63, 68 (Tenn. 2001). Thus, our standard for reviewing a grant of summary judgment is *de novo* with no presumption of correctness as to the trial court's findings. ***See Webber v. State Farm Mut. Auto. Ins. Co.***, 49 S.W.3d 265, 269 (Tenn. 2001). The evidence must be viewed "in the light most favorable to the nonmoving party," and all reasonable inferences must be drawn in the non-moving party's favor. ***Staples v. CBL & Assocs.***, 15 S.W.3d 83, 89 (Tenn. 2000).

IV. DISCUSSION

On appeal, Appellants argue that this Court should reverse the trial court's grant of summary judgment to Appellees and adopt the "loss of chance" doctrine in this medical malpractice case. Our Supreme Court dealt with the "loss of chance" doctrine in *Kilpatrick v. Bryant*, 868 S.W.2d 594 (Tenn. 1993). In *Kilpatrick*, a doctor who was sued for failing to detect breast cancer was granted summary judgment after alleging, in his motion, that the plaintiffs failed to establish the necessary elements of a medical malpractice action as outlined in Tennessee Code Annotated section 29-26-115:

> (a) In a malpractice action, the claimant shall have the burden of proving by evidence . . . :

> (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred;
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> (2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and
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> (3) *As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.*

Tenn. Code Ann. § 29-26-115 (Supp. 2007) (emphasis added). Our Supreme Court noted that our state's medical malpractice "statute codifies the common law elements of negligence - duty, breach of duty, causation, proximate cause, and damages," ***Kilpatrick***, 868 S.W.2d at 598 (citing *Cardwell v. Bechtol*, 724 S.W.2d 739, 753 (Tenn. 1987); *Dolan v. Cunningham*, 648 S.W.2d 652, 654 (Tenn. Ct. App. 1982)) and that "no claim for negligence can succeed in the absence of any one of these elements." ***Id.*** (citing *Bradshaw v. Daniel*, 854 S.W.2d 865, 869 (Tenn. 1993)). It further stated that "[c]ases involving the 'loss of chance' theory of recovery necessarily focus on the elements of causation and proximate cause." ***Id.*** (citing *Kramer v. Lewisville Mem'l Hosp.*, 858 S.W.2d 397 (Tex. 1993)). The Court then explained that causation is a two-step process. First, courts must determine whether causation (cause in fact) has been established–whether "'the event would not have occurred but for the conduct.'" ***Id.*** (citing *McKellips v. Saint Francis Hosp.*, 741 P.2d 467, 470 (quoting Prosser and Keeton, *The Law of Torts* 266 (5th ed. 1984))). If cause in fact is established, courts must then determine proximate cause–whether the cause is sufficiently related to the result to impose liability. ***Id.***

"The critical issue in this appeal, as in all loss of chance cases, is whether the Plaintiffs have failed, as a matter of law, to establish the existence of causation, i.e., that the purported medical malpractice actually caused the harm complained of." ***Id.*** (citing *McKellips*, 741 P.2d at 470-71). "This question dominates because the rule requiring causation be proven by a preponderance of the evidence dictates that Plaintiffs demonstrate the negligence *more likely than not* caused the injury." ***Id.*** at 598-99 (citing *Lindsey v. Miami Dev. Corp.*, 689 S.W.2d 856, 861 (Tenn. 1985)).

In deciding whether to recognize the "loss of chance" cause of action in Tennessee, our Supreme Court considered the doctrine's history. The "loss of chance" doctrine emerged in *Hicks v. United States*, 368 F.2d 626 (4th Cir. 1966), where the Fourth Circuit, in dicta, stated:

> 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 is any substantial possibility of survival and the defendant has destroyed it, he is answerable.

Kilpatrick, 868 S.W.2d at 599 (quoting *Hicks*, 368 F.2d at 632). Relying on that language, some courts began adopting the "loss of chance" doctrine, as discussed below. ***Id.*** However, in *Hurley v. United States*, 923 F.2d 1091, 1093 (4th Cir. 1991), the Fourth Circuit reviewed *Hicks* and stated that the "dicta . . . [has] precipitated misunderstanding throughout the courts." ***Id.*** "The court in *Hurley* held that *Hicks* was not intended to change traditional notions of causation in medical malpractice cases, and rejected the loss of chance doctrine as a viable cause of action - thereby negating the widely held view of *Hicks*." ***Id.*** (citing *Hurley*, 923 F.2d at 1095, 1099). Instead, the Fourth Circuit "reinstated the traditional standard for proving causation which requires a showing of probability of survival or recovery of greater than 50 percent absent the defendant's negligence." ***Id.***

The jurisdictions that have considered whether to adopt the "loss of chance" doctrine have typically chosen one of three approaches: (1) pure loss of chance, (2) loss of a substantial chance, and (3) the traditional approach. ***Kilpatrick***, 868 S.W.2d at 600 (citation omitted). Under the pure loss of chance theory, a patient may recover if the defendant deprives him or her of *any* possibility of a better result. ***Id.*** "Thus, . . . a patient who faced a 95 percent chance of dying even with appropriate medical care would still have a cause of action against the physician who negligently deprived him of the 5 percent chance of survival." ***Id.*** At least fourteen jurisdictions have adopted the pure loss of chance approach.[3]

Between the pure loss of chance and the traditional approach lies the loss of substantial chance approach. Under this approach, "the [defendant's] negligence [must] be shown to have reduced a 'substantial chance' or 'substantial possibility' or 'appreciable chance' of a favorable end result given appropriate medical treatment." ***Id.*** "This approach is apparently designed to prohibit claims where the plaintiff does not have a realistic basis for a favorable outcome even absent the defendant's negligence." ***Id.*** at 600-01. While, at the same time, preventing a health care provider from avoiding liability for negligence "simply by saying that the patient would have died anyway, when that patient had a reasonable chance to live." ***Kilpatrick***, 868 S.W.2d at 600 (quoting *Perez v. Las Vegas Med. Ctr.*, 805 P.2d 589, 593 (Nev. 1991)). Under this approach, the "impaired or destroyed opportunity" itself, is considered the injury. ***Id.*** at 601 (citing *Falcon v. Mem'l Hosp.*, 462

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[3] Although it is sometimes difficult to classify a jurisdiction's adoption of the "loss of chance" theory as pure loss of chance or loss of a substantial chance theory, it seems that fourteen states have adopted the former. *See Thompson v. Sun City Cmty. Hosp.*, 688 P.2d 605, 616 (Ariz. 1984); *James v. United* States, 483 F. Supp. 581, 586 (N.D. Cal. 1980) (applying California law); *Richmond County Hosp. Auth. v. Dickerson*, 356 S.E.2d 548, 550 (Ga. Ct. App. 1987); *DeBurkarte v. Louvar*, 393 N.W.2d 131, 137 (Iowa 1986); *Delaney v. Cade*, 873 P.2d 175, 211 (Kan. 1994); *Wollen v. DePaul Health Ctr.*, 828 S.W.2d 681, 685 (Mo. 1992) (en banc); *Aasheim v. Humberger*, 695 P.2d 824, 828 (Mont. 1985); *Scafidi v. Seiler*, 574 S.2d 398, 408 (N.J. 1990); *Roberts v. Ohio Permanente Med. Group, Inc.*, 668 N.E.2d 480, 488 (Ohio 1996) (*overruling Cooper v. Sisters of Charity Cincinnati, Inc.*, 272 N.E.2d 97 (Ohio 1971)); *Hamil v. Bashline*, 392 A.2d 1280, 1286 (Pa. 1978); *Voegeli v. Lewis*, 568 F.2d 89, 94 (8th Cir. 1997) (applying South Dakota law); *Herskovits v. Group Health Coop. of Puget Sound*, 664 P.2d 474, 479 (Wash. 1983); *Thornton v. CAMC, Etc.*, 305 S.E.2d 316, 324-25 (W. Va. 1983); *Ehlinger v. Sipes*, 454 N.W.2d 754, 763 (Wis. 1990).

N.W.2d 44, 53-54 (Mich. 1990), *superseded by statute*, Mich. Comp. Laws Ann. § 600.2912a (West 2000), *as recognized in Blair v. Hutzel Hosp.*, 552 N.W.2d 507 (Mich. Ct. App. 1990)). Thus, the plaintiff must establish by a preponderance, only that the defendant's negligence was the cause in fact of the impaired opportunity, not that it was the cause in fact of the harmful medical result. ***Id.*** At least five jurisdictions have adopted the loss of substantial chance approach.[4]

Other jurisdictions which have considered whether to adopt the "loss of chance" doctrine have instead adopted the traditional approach. Under this approach, "recovery is disallowed unless it can be shown that the plaintiff would not have suffered the physical harm but for the defendant's negligence, i.e., that it is more probable than not (greater than 50 percent) that but for the negligence of the defendant the plaintiff would have recovered or survived." ***Id.*** at 602 (citing *Falcon*, 462 N.W.2d at 47 (Riley, C.J., dissenting)). At least nineteen jurisdictions, including Tennessee, have adopted the traditional approach, refusing to recognize the "loss of chance" doctrine.[5] In adopting the traditional approach and refusing to adopt the "loss of chance" doctrine, our Supreme Court stated:

> [P]roof of causation equating to a "possibility," a "might have," "may have," "could have," is not sufficient, as a matter of law, to establish the required nexus between the plaintiff's injury and the defendant's tortious conduct by a preponderance of the evidence in a medical malpractice case. Causation in fact is a matter of probability, not possibility, and in a medical malpractice case, such must be shown to a reasonable degree of medical certainty.

Kilpatrick, 868 S.W.2d at 602 (citing *White v. Methodist Hosp. S.*, 844 S.W.2d 642, 648-49 (Tenn. Ct. App. 1992)). Furthermore, our Supreme Court held:

> [W]e are persuaded that the loss of chance theory of recovery is fundamentally at odds with the requisite degree of medical certitude necessary to establish a casual like between the injury of a patient and

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[4] *See Daniels v. Hadley Mem'l* Hosp., 566 F.2d 749, 757-58 (D.C. Cir. 1977); *McBride v. United States*, 462 F.2d 71 (9th Cir. 1972) (applying Hawaii law) ("[T]he absence of positive certainty [that the treatment would have successfully prevented the plaintiff's injury] should not bar recovery if negligent failure to provide treatment deprives a patient of a significant improvement in his chances for recovery."); *Perez v. Las Vegas Med. Ctr.*, 805 P.2d 589, 592 (Nev. 1991); *Kallenburg v. Beth Israel Hosp.*, 45 A.D.2d 177, 179-80 (N.Y. App. Div. 1974) (per curiam); *McKellips v. Saint Francis Hosp.*, 741 P.2d 467, 475 (Okla. 1987).

[5] *See* Mich. Comp. Laws Ann. § 600.2912a (West 2000); *Finn v. Phillips*, No. COA 01-1317, 2002 WL 31133192, at *2 (Ark. Ct. App. Sept. 25, 2002); *Grody v. Tulin*, 365 A.2d 1076, 1079-80 (Conn. 1976); *U.S. v. Cumberbatch*, 647 A.2d 1098, 1099 (Del. 1994); *Gooding v. Univ. Hosp. Bldg., Inc.*, 445 So. 2d 1015, 1021 (Fla. 1984); *Watson v. Med. Emergency Sev.*, 532 N.E.2d 1191, 1196 n.2 (Ind. Ct. App. 1989); *Walden v. Jones*, 439 S.W.2d 571, 576 (Ky. 1968); *Philips v. Eastern Maine Med. Ctr.*, 565 A.2d 306, 308 (Me. 1989); *Fennell v. S. Maryland Hosp. Ctr., Inc.*, 580 A.2d 206, 215 (Md. 1990); *Fabio v. Bellomo*, 504 N.W.2d 758, 762 (Minn. 1993); *Ladner v. Campbell*, 515 So. 2d 882, 888-89 (Miss. 1987); *Pillsbury-Flood v. Portsmouth Hosp.*, 512 A.2d 1126, 1130 (N.H. 1986); *Alfonso v. Lund*, 783 F.2d 958, 964-65 (10th Cir. 1986) (stating that "we believe that New Mexico would not apply the 'lost chance' theory . . . [as] New Mexico courts have remained firm in requiring that proximate cause be shown as a probability."); *Horn v. Nat'l Hosp. Ass'n*, 131 P.2d 445 (Or. 1944); *Kramer v. Lewisville Mem'l Hosp.*, 858 S.W.2d 397, 407 (Tex. 1993); *Jones v. Owings*, 465 S.W.2d 371, 374 (S.C. 1995); *Blondel v. Hays*, 403 S.E.2d 340, 344-45 (Va. 1991).

> the tortious conduct of a physician. . . . [A] plaintiff in Tennessee must prove that the physician's act or omission more likely than not was the cause in fact of the harm. *Lindsey* [*v. Miami Dev. Corp.*], [6]89 S.W.2d [856,] 861 [(Tenn. 1985)]. This requirement necessarily implies that the plaintiff must have had a better than even chance of surviving or recovering from the underlying condition absent the physician's negligence. [Tenn. Code Ann. section] 29-26-115(a)(3) plainly requires that the plaintiff suffer injury "which would not otherwise have occurred." This statutory language is simply another way of expressing the requirement that the injury would not have occurred but for the defendant's negligence, our traditional test for cause in fact. . . . [W]e hold that a plaintiff who probably, i.e., more likely than not, would have suffered the same harm had proper medical treatment been rendered, is entitled to no recovery for the increase in the risk of harm or the loss of a chance of obtaining a more favorable medical result. . . . We decline to relax traditional cause in fact requirements and recognize a new cause of action for loss of chance.

Id. at 602-03.[6]

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[6] The *Kilpatrick* court also noted Michigan Supreme Court Chief Justice Riley's dissent in *Falcon*, 462 N.W.2d at 61, 64-68, wherein she stated:

> The 'lost chance of survival' theory urged by plaintiff represents not only a redefinition of the threshold of proof for causation, but a fundamental redefinition of causation in tort law.
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> . . . .
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> Relaxing the causation requirement might correct a perceived unfairness to some plaintiffs who could prove the possibility that the medical malpractice caused an injury but could not prove the probability of causation, but at the same time could create an injustice. Health care providers could find themselves defending cases simply because a patient fails to improve or where serious disease processes are not arrested because another course of action could possibly bring a better result. No other professional malpractice defendant carries this burden of liability without the requirement that plaintiffs prove the alleged negligence probably rather than possibly caused the injury. We cannot approve the substitution of such an obvious inequity for a perceived one.
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> The lost chance of survival theory does more than merely lower the threshold of proof of causation; it fundamentally alters the meaning of causation.
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> The most fundamental premise upon which liability for a negligent act may be based is cause in fact. ([c]itation omitted)[.] An act or omission is not regarded as a cause of an event if the particular event would have occurred without it. ([c]itation omitted)[.] If the defendant's acts did not actually cause the plaintiff's injury, then there is no rational justification for requiring the defendant to bear the cost of the plaintiff's damages.
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> . . . .

(continued...)

"Once the Tennessee Supreme Court has addressed an issue, its decision regarding that issue is binding on the lower courts." ***Davis v. Davis***, No. M2003-02312-COA-R3-CV, 2004 WL 2296507, at *6 (Tenn. Ct. App. Oct. 12, 2004) (citing *State v. Irick*, 906 S.W.2d 440, 443 (Tenn. 1995); *Payne v. Johnson*, 2 Tenn. Cas. (Shannon) 542, 543 (1877)). "The Court of Appeals has no authority to overrule or modify [the] Supreme Court's opinions." ***Bloodworth v. Stuart***, 428 S.W.2d 786, 789 (Tenn. 1968) (citing *City of Memphis v. Overton*, 392 S.W.2d 86, 97 (Tenn. Ct. App. 1964); *Levitan v. Banniza*, 236 S.W.2d 90, 95 (Tenn. Ct. App. 1950)); *see also* ***Barger v. Brock***, 535 S.W.2d 336, 340-41 (Tenn. 1976). Accordingly, because Appellants cannot show a greater than fifty percent chance of receiving the intrauterine surgery even absent Appellees' negligence, we must affirm the trial court's decision to grant Appellees' motions for summary judgment.

V. CONCLUSION

For the aforementioned reasons, we affirm the decision of the circuit court. Costs of this appeal are taxed to Appellants, Pedro and Griselda Valadez, and their surety, for which execution may issue if necessary.

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ALAN E. HIGHERS, P.J., W.S.

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[6](...continued)

> I believe it is unwise to impose liability on members of the medical profession in such difficult circumstances as those now before this Court. Rather than deterring undesirable conduct, the rule imposed only penalizes the medical profession for inevitable unfavorable results. The lost chance of survival theory presumes to know the unknowable.

Kilpatrick, 868 S.W.2d at 603 (quoting *Falcon,* 462 N.W.2d at 61, 64-68), *superseded by statute*, Mich. Comp. Laws Ann. § 600.2912a (West 2000), *as recognized in Blair v. Hutzel Hosp.*, 552 N.W.2d 507 (Mich. Ct. App. 1990)).

172 Wash.2d 844

Linda J. MOHR and Charles L. Mohr, her husband, Appellants,

v.

Dale C. GRANTHAM, M.D., and Jane Doe Grantham, and their marital community; Brian J. Dawson, M.D., and Jane Doe Dawson, and their marital community; Brooks Watson II, M.D., and Jane Doe Watson, and their marital community; Kadlec Medical Center, a Washington corporation; and Northwest Emergency Physicians, Inc., a Washington corporation, Respondents.

No. 84712–6.

Supreme Court of Washington, En Banc.

Argued Feb. 8, 2011.

Decided Oct. 13, 2011.

Background: Patient who suffered a trauma-induced stroke and was permanently disabled brought action against hospital and physicians, alleging that negligent treatment by diminished her chances of avoiding or greatly minimizing her disability. The Superior Court, Benton County, Vic L. Vanderschoor, J., entered summary judgment in favor of defendants. Patient appealed.

Holdings: The Supreme Court, En Banc, Owens, J., held that:

(1) there is a cause of action in the medical malpractice context for the loss of a chance of a better outcome;

(2) a lost chance cause of action applies to medical malpractice claims where the ultimate harm is some serious injury short of death;

(3) the loss of a chance is the compensable injury in a cause of action for a lost chance;

(4) fact questions regarding breach and causation precluded grant of summary judgment; and

(5) fact question regarding apparent agency precluded summary judgment in favor of hospital.

Reversed and remanded.

Madsen, C.J., dissented and filed opinion.

J.M. Johnson, J., dissented and filed opinion, in which Alexander, J., concurred.

OWENS, J.

846 ¶ 1 Linda Mohr suffered a trauma-induced stroke and is now permanently disabled. She and her husband, Charles, claim that negligent treatment by her health care providers diminished her chances of avoiding or greatly minimizing her disability. In other words, they claim that negligence caused Mrs. Mohr a loss of the chance of a better outcome. In *Herskovits v. Group Health Cooperative* 847 *of Puget Sound*, 99 Wash.2d 609, 611, 614, 664 P.2d 474 (1983) (Dore, J., lead opinion), this court recognized the lost chance doctrine in a survival action when the plaintiff died following the alleged failure of his doctor to timely diagnose his lung cancer. This case compels consideration of whether, in the medical malpractice context, there is a cause of action for a lost chance, even when the ultimate result is some serious harm short of death. We hold that there is such a cause of action and, accordingly, reverse the order of summary judgment.

FACTS

¶ 2 In Richland, Washington, on the afternoon of August 31, 2004, Mrs. Mohr suffered a hypoglycemic event that caused her to run her car into a utility pole at approximately 45 m.p.h. She was taken by ambulance to the emergency room at Kadlec Medical Center (KMC). Having visible lacerations on her face from the car accident, Mrs. Mohr was given a neurological assessment upon arrival, at around 4:00 p.m., and a computerized tomography (CT) scan of her brain about an hour later. These tests were overseen or authorized by Dr. Dale Grantham, who was charged with Mrs. Mohr's care at KMC on August 31. The results were normal.

¶ 3 Following those neurological tests, however, Mrs. Mohr reported and was observed to have neurological symptoms, including being wobbly on her feet and having severe pain after being administered pain medication.[1] Dr. Grantham informed one of Mrs. Mohr's physician sons, Dr. Brandt Mohr, by phone that he would carry out another neurological assessment before dis-

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Cheryl Rani Guttenbe Adamson, Attorney at Law, Kennewick, WA, for Appellants.

Christopher Holmes Anderson, Fain Anderson VanDerhoef PLLC, Mary H. Spillane, Williams Kastner & Gibbs, Donna Maria Moniz, Johnson Graffe Keay Moniz & Wick LLP, Seattle, WA, Jerome R. Aiken, Attorney at Law, Yakima, WA, for Respondents.

Bryan Patrick Harnetiaux, Attorney at Law, Spokane, WA, George M. Ahrend, Ahrend Law Firm PLLC, Moses Lake, WA, amicus counsel for of Washington State Association for Justice Foundation.

1. The Mohrs also allege that Mrs. Mohr reported some numbness but that it was not recorded until the following day, when the hospital records indicate that "some numbness in her left hand ... has persisted." Clerk's Papers (CP) at 122.

charging her. He did not. Instead, he prescribed a narcotic, Darvocet, and sent Mrs. Mohr home with her husband. At that point, Mrs. Mohr [848] could not walk herself to or from the car and had to be carried to bed by her husband when they arrived home. The Mohrs were not given discharge instructions that included specific information about head injuries.

¶ 4 Mrs. Mohr was again transported to KMC by ambulance just after 7:00 a.m. on September 1, 2004, because her husband was concerned that she remained very lethargic through the night. Dr. Brian Dawson was the attending emergency room physician that morning. By around 9:30 a.m., Mrs. Mohr was diagnosed as having a stroke. Specifically, she was first found to have an "evolving infarct ... in the right middle cerebral artery territory," Clerk's Papers (CP) at 119, which relates to a cause of a stroke.[2] A magnetic resonance imaging (MRI) examination, performed shortly after 9:30 a.m., confirmed that Mrs. Mohr was in fact having a stroke.[3] However, Dr. Dawson did not provide any anticoagulant or antithrombotic treatment or therapy. Around 11:30 a.m. Mrs. Mohr was transferred to the intermediate care unit, under the care of Dr. Brooks Watson.

¶ 5 Before the transfer, Mrs. Mohr's two physician sons had arrived at KMC to be by her side. They tried to get both Dr. Dawson and then, after her transfer, Dr. Watson to order a CT angiogram. A CT angiogram was not done until 2:30 p.m., after the Mohr sons had Dr. Watson repeatedly paged. Then, although the results were available at 3:27 p.m., Dr. Watson was not located or informed until 4:50 p.m. that the CT angiogram showed a dissected carotid artery. He still did not order anyone to administer anticoagulant therapy, antiplatelet agents, or any other treatment. Dr. Watson had [849] prescribed aspirin around 2:00 p.m. but did not order its immediate administration.

¶ 6 Mrs. Mohr's sons finally arranged a transfer and transport to Harborview Medical Center. Dr. Watson signed the transfer form as a formality. Only shortly before her transport at 6:00 p.m. on September 1, 2004, was Mrs. Mohr finally given aspirin, though it had to be administered in suppository form because, by then, she could no longer swallow.

¶ 7 Mrs. Mohr is now permanently brain damaged; a quarter to a third of her brain tissue was destroyed. In particular, the portions of her brain that were damaged are involved with motor control, sensation, and spatial reasoning.

¶ 8 Mrs. Mohr and her husband filed suit, claiming that Mrs. Mohr received negligent treatment, far below the recognized standard of care. They argue that the doctors' negligence substantially diminished her chance of recovery and that, with nonnegligent care, her disability could have been lessened or altogether avoided. The Mohrs' claim relies, at least in part, on a medical malpractice cause of action for the loss of a chance. In support of their claim, the Mohrs presented the family's testimony, including her two sons who are doctors, and the testimony of two other doctors, Kyra Becker and A. Basil Harris. The testimony included expert opinions that the treatment Mrs. Mohr received violated standards of care and that, had Mrs. Mohr received nonnegligent treatment at various points between August 31 and September 1, 2004, she would have had a 50 to 60 percent chance of a better outcome. The better outcome would have been no disability or, at least, significantly less disability.

¶ 9 On April 16, 2009, the Benton County Superior Court granted summary judgment for the defendants on the basis that the Mohrs did not show "but for" causation and

2. An "infarct" is "an area of coagulation necrosis in a tissue ... resulting from obstruction of the local circulation by a thrombus [(blood clot)] or embolus [(foreign particle circulating in the blood)]." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1157 (2002). A known cause of strokes is "formation of an embolus or thrombus that occludes an artery." TABER'S CYCLOPEDIC MEDICAL DICTIONARY 1847 (18th ed. 1997).

3. Mrs. Mohr's medical records indicate that the "MRI ... revealed a right frontoparietal CVA." CP at 123. "CVA" is an abbreviation for a "cerebrovascular accident," also known as a stroke. Taber's, *supra,* at 350.

the hesitancy of the court to expand *Herskovits* to the facts of 850this case. The Mohrs appealed, and the Court of Appeals certified the case for our review.

ISSUES

¶ 10 1. In the medical malpractice context, is there a cause of action for a lost chance of a better outcome?

¶ 11 2. Did the trial court properly grant summary judgment for all defendants under CR 56(c)?

ANALYSIS

1. *Lost Chance of a Better Outcome*

[1, 2] ¶ 12 The medical malpractice statute requires the same elements of proof as traditional tort elements of proof: duty, breach, injury, and proximate cause. RCW 7.70.040. Whether there is a cause of action for a lost chance of a better outcome in the medical malpractice context is a question of law, which we review de novo. *Berger v. Sonneland,* 144 Wash.2d 91, 103, 26 P.3d 257 (2001). The standard formulation for proving proximate causation [4] in tort cases requires, "first, a showing that the breach of duty was a cause in fact of the injury, and, second, a showing that as a matter of law liability should attach." *Harbeson v. Parke–Davis, Inc.,* 98 Wash.2d 460, 475–76, 656 P.2d 483 (1983). In a medical malpractice case, for example, a plaintiff would traditionally seek to prove "cause in fact" by showing "that he or she would not have been injured but for the health care provider's failure to use reasonable care." *Hill v. Sacred Heart Med. Ctr.,* 143 Wash.App. 438, 448, 177 P.3d 1152 (2008) (citing *McLaughlin v. Cooke,* 112 Wash.2d 829, 837, 774 P.2d 1171 (1989)). However, as the plurality noted in *Herskovits,* "[t]he word 'cause' has a notoriously 851elusive meaning (as the writings on legal causation all agree)." 99 Wash.2d at 635 n. 1, 664 P.2d 474 (Pearson, J., plurality opinion). For this reason, and in service of underlying tort principles, this court and others have recognized some limited exceptions to the strict tort formula, including recognition of lost chance claims. *See, e.g., id.* at 619, 664 P.2d 474 (Dore, J., lead opinion), 634–35 (Pearson, J., plurality opinion).

¶ 13 *Herskovits* involved a survival action following an allegedly negligent failure to diagnose lung cancer. Over the course of a year, Leslie Herskovits repeatedly sought treatment for persistent chest pains and a cough, for which he was prescribed only cough medicine. *Id.* at 611, 664 P.2d 474 (Dore, J., lead opinion). When he finally sought another medical opinion, Herskovits was diagnosed with lung cancer within three weeks. *Id.* His diagnosing physician testified that the delay in diagnosis likely diminished Herskovits's chance of long-term survival from 39 percent to 25 percent. *Id.* at 612, 664 P.2d 474. Less than two years after his diagnosis, then 60 years old, Herskovits died. *Id.* at 611, 664 P.2d 474. The trial court dismissed the case on summary judgment on the basis that Herskovits's estate, which brought suit, failed to establish a prima facie case of proximate cause: it could not show that *but for* his doctor's negligence he would have survived because he "*probably* would have died from lung cancer even if the diagnosis had been made earlier." *Id.* Though divided by different reasoning, this court reversed the trial court, finding that Herskovits's lost chance was actionable.

¶ 14 The lead opinion, signed by two justices, and the concurring opinion, which garnered a plurality, agreed on the fundamental bases for recognizing a cause of action for the loss of a chance. The lead opinion explained:

> To decide otherwise would be a blanket release from liability for doctors and hospitals any time there was less than a 50 percent chance of survival, regardless of how flagrant the negligence.

Id. at 614, 664 P.2d 474. The plurality similarly noted that traditional all-or-nothing causation in lost chance cases " 'subverts the 852deterrence objectives of tort law.' " *Id.* at

4. To answer the question of whether there is a cause of action for a loss of a chance of a better outcome, we focus on the injury and proximate cause elements. At the outset, however, we note that, in order to prevail in a medical malpractice claim, a plaintiff still also bears the exacting burden to prove that a health care provider breached the standard of care.

634, 664 P.2d 474 (Pearson, J., plurality opinion) (quoting Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences,* 90 YALE L.J. 1353, 1377 (1981)). Both opinions found that "the loss of a less than even chance is a loss worthy of redress." *Id.* With emphasis, the lead opinion agreed, stating that " '[*n*]*o matter how small that chance may have been—and its magnitude cannot be ascertained—no one can say that the chance of prolonging one's life or decreasing suffering is valueless.*' " *Id.* at 618, 664 P.2d 474 (Dore, J., lead opinion) (quoting *James v. United States,* 483 F.Supp. 581, 587 (N.D.Cal.1980)).

¶ 15 The lead and plurality opinions split over *how,* not whether, to recognize a cause of action. Drawing from other jurisdictions, especially the Pennsylvania Supreme Court's holding in *Hamil v. Bashline,* 481 Pa. 256, 392 A.2d 1280 (1978), the lead opinion held that the appropriate framework for considering a lost chance claim was with a "substantial factor" theory of causation. The court summarized that

> once a plaintiff has demonstrated that the defendant's acts or omissions have increased the risk of harm to another, such evidence furnishes a basis for the jury to make a determination as to whether such increased risk was in turn a substantial factor in bringing about the resultant harm.

Herskovits, 99 Wash.2d at 616, 664 P.2d 474 (additionally noting the *Hamil* court's reliance on the *Restatement (Second) of Torts* § 323 (1965), which provides that one who renders services to another, necessary for the protection of that person, is liable if "his failure to exercise [reasonable] care increases the risk of [physical] harm").[5] The "substantial factor test" is an |853 exception to the general rule of proving but for causation and requires that a plaintiff prove that the defendant's alleged act or omission was a substantial factor in causing the plaintiff's injury, even if the injury could have occurred anyway. *Fabrique v. Choice Hotels Int'l, Inc.,* 144 Wash.App. 675, 684, 183 P.3d 1118 (2008).

¶ 16 Rather than looking to the causation element, the plurality opinion in *Herskovits* focused instead on the nature of the injury. *Herskovits,* 99 Wash.2d at 634, 664 P.2d 474 (Pearson, J., plurality opinion) ("[T]he best resolution of the issue before us is to recognize the loss of a less than even chance as an actionable injury."). The plurality noted among its concerns about the "all or nothing" traditional tort approach to recovery that it "creates pressure to manipulate and distort other rules affecting causation and damages in an attempt to mitigate perceived injustices." *Id.* In part, this characterizes what the *Herskovits* lead opinion does by prescribing that causation in *all* lost chance cases is to be examined under the substantial factor doctrine. The plurality found it more analytically sound to conceive of the injury as the lost chance. *Id.*

¶ 17 Though this court has not reconsidered or clarified the rule of *Herskovits* in the survival action context or, until now, considered whether the rule extends to medical malpractice cases where the ultimate harm is something short of death, the *Herskovits* majority's recognition of a cause of action in a survival action has remained intact since its adoption. "Washington recognizes loss of chance as a compensable interest." *Shellenbarger v. Brigman,* 101 Wash.App. 339, 348, 3 P.3d 211 (2000); *see Zueger v. Pub. Hosp. Dist. No. 2,* 57 Wash.App. 584, 591, 789 P.2d 326 (1990) (finding that the *Herskovits* "plurality represents the law on a loss of the chance of survival"); 16 DAVID K. DEWOLF & KELLER W. ALLEN, WASHINGTON PRACTICE: TORT LAW AND PRACTICE § 4. 10, at 155–56, § 15.32, at 488 (3d ed. 2006) ("Washington courts recognize the doctrine of 'loss of a chance' as an exception to a strict application of the |854 but-for causation test in medical malpractice cases."). In *Shellenbarger,* the Court of Appeals reversed summary judgment of a medical malpractice claim of negli-

5. While recognizing the lost chance doctrine, the most recent *Restatement* asserts that the reliance by many courts on § 323 of the *Restatement (Second)* as support for the doctrine is misplaced. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 26 cmt. n (2010). The reporter's note explains that § 323 addressed affirmative duties, not causation or the nature of injury.

gent failure to diagnose and treat lung disease from asbestos exposure in its early stages. 101 Wash.App. at 342, 3 P.3d 211. Expert witnesses testified that had Shellenbarger received nonnegligent testing and early diagnosis, which would have led to treatment, he would have "had a 20 percent chance that the disease's progress would have been slowed and, accordingly, he would have had a longer life expectancy." *Id.* at 348, 3 P.3d 211. The court concluded, "We find no meaningful difference between this and *Herskovits'* lost chance of survival." *Id.* at 349, 3 P.3d 211.

¶ 18 Washington courts have, however, generally declined to extend *Herskovits* to other negligence claims. *See, e.g., Daugert v. Pappas,* 104 Wash.2d 254, 260–62, 704 P.2d 600 (1985) (declining to apply *Herskovits* in a legal malpractice claim); *Fabrique,* 144 Wash.App. at 685, 183 P.3d 1118 (following *Daugert* and finding "no authority supporting the application of the 'substantial factor' definition of proximate cause to a negligence or strict liability action involving a contaminated food product"); *Sorenson v. Raymark Indus., Inc.,* 51 Wash.App. 954, 957, 756 P.2d 740 (1988) (distinguishing *Herskovits* from an asbestos exposure claim that the plaintiff's risk of cancer was increased). Such limitation is common: "[T]he courts that have accepted lost opportunity as cognizable harm have almost universally limited its recognition to medical-malpractice cases." RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 26 cmt. n at 356–57 (2010).

¶ 19 *Herskovits* has been widely cited as an authority by other state courts and in journal articles for recognizing a cause of action in lost chance cases. *See, e.g., Matsuyama v. Birnbaum,* 452 Mass. 1, 16, 890 N.E.2d 819 (2008); *McMackin v. Johnson County Healthcare Ctr.,* 2003 WY 91, ¶¶ 16–17, 73 P.3d 1094, 1100, *adhered to on reh'g,* 2004 WY 44, 88 P.3d 491; Tory A. Weigand, *Loss of Chance in Medical Malpractice: The* 855 *Need for Caution,* 87 Mass. L.Rev. 3, 9 (2002). Since *Herskovits,* the majority of states that have considered the lost chance doctrine have adopted it, although with varying rationales. *Matsuyama,* 452 Mass. at 10 n. 23, 890 N.E.2d 819 (listing 20 states and the District of Columbia that have recognized the lost chance doctrine); *see* Weigand, *supra,* at 7–10. Several states have rejected the doctrine. *Matsuyama,* 452 Mass. at 10 n. 23, 890 N.E.2d 819 (listing 10 states that have declined to adopt the doctrine). And others have not yet reviewed the issue or have declined to reach the question. *Id.*

[3] ¶ 20 The rationales underpinning the lost chance doctrine have generally been applied the same in wrongful death claims and medical malpractice claims where the ultimate harm is something short of death. *See, e.g., Shellenbarger,* 101 Wash.App. at 349, 3 P.3d 211. In *Delaney v. Cade,* 255 Kan. 199, 873 P.2d 175 (1994), the Kansas Supreme Court recognized a cause of action for loss of chance of a better outcome. The court observed that

> many jurisdictions are like Kansas, in that the issue has only come up in a loss of survival case or a loss of a better recovery case. . . .
>
> We have found no authority or rational argument which would apply the loss of chance theory solely to survival actions or solely to loss of a better recovery actions and not to both.

Id. at 209–10, 873 P.2d 175. *But cf. Weymers v. Khera,* 454 Mich. 639, 653, 563 N.W.2d 647 (1997) ("we reject scrapping causation (the bedrock of our tort law) in negligence cases where the injury alleged by the plaintiff is something less than death").[6] We find no *persuasive* rationale to distinguish *Herskovits* from a medical malpractice claim where the facts involve a loss of chance of avoiding or minimizing permanent disability 856 rather than death. To limit *Herskovits* to cases that result in death is arbitrary; the same underlying principles of deterring negligence and compensating for injury apply when the ultimate harm is permanent disability.

6. The *Restatement* characterizes the *Weymers* holding as "without any good explanation." RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 26 Reporter's Note cmt. n at 375.

¶ 21 We note that, significantly, nothing in the medical malpractice statute precludes a lost chance cause of action. In relevant part, chapter 7.70 RCW provides that, in order to prove "that injury resulted from the failure of the health care provider to follow the accepted standard of care," a plaintiff must establish:

> (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;
>
> (2) Such failure was a proximate cause of the injury complained of.

RCW 7.70.040. The chapter does not define "proximate cause" or "injury." RCW 7.70.020.

¶ 22 The principal arguments *against* recognizing a cause of action for loss of a chance of a better outcome are broad arguments, similar to those raised when *Herskovits* was decided: concerns of an overwhelming number of lawsuits and their impact on the health care system; distaste for contravening traditional tort law, especially regarding causation; discomfort with the reliance on scientific probabilities and uncertainties to value lost opportunities. *See* Joseph H. King, Jr., *"Reduction of Likelihood" Reformulation and Other Retrofitting of the Loss–of–a–Chance Doctrine,* 28 U. MEM. L.REV. 491, 506 (1998); *Matsuyama*, 452 Mass. at 15, 890 N.E.2d 819 (noting criticisms of the doctrine, namely that it "upends the long-standing preponderance of the evidence standard; alters the burden of proof in favor of the plaintiff; undermines the uniformity and predictability central to tort litigation; results in an expansion of liability; and is too complex to administer") However, none of these arguments [857] effectively distinguish the Mohrs' claim from *Herskovits* and seem instead to agitate for its overruling. Now nearly 30 years since *Herskovits* was decided, history assures us that *Herskovits* did not upend the world of torts in Washington, as demonstrated by the few cases relying on *Herskovits* that have been heard by Washington appellate courts.

[4] ¶ 23 We hold that *Herskovits* applies to lost chance claims where the ultimate harm is some serious injury short of death. We also formally adopt the reasoning of the *Herskovits* plurality. Under this formulation, a plaintiff bears the burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome. This reasoning of the *Herskovits* plurality has largely withstood many of the concerns about the doctrine, particularly because it does not prescribe the specific manner of proving causation in lost chance cases. Rather, it relies on established tort theories of causation, without applying a particular causation test to *all* lost chance cases. Instead, the loss of a chance is the compensable injury.

¶ 24 The significant remaining concern about considering the loss of chance as the compensable injury, applying established tort causation, is whether the harm is too speculative. We do not find this concern to be dissuasive because the nature of tort law involves complex considerations of many experiences that are difficult to calculate or reduce to specific sums; yet juries and courts manage to do so. We agree that

> [s]uch difficulties are not confined to loss of chance claims. A wide range of medical malpractice cases, as well as numerous other tort actions, are complex and involve actuarial or other probabilistic estimates.

Matsuyama, 452 Mass. at 18, 890 N.E.2d 819. Moreover, calculation of a loss of chance for a better outcome is based on expert testimony, which in turn is based on significant practical experience [858] and "on data obtained and analyzed scientifically . . . as part of the repertoire of diagnosis and treatment, as applied to the specific facts of the plaintiff's case." *Id.* at 17, 890 N.E.2d 819. Finally, discounting damages responds, to some degree, to this concern.

¶ 25 In *Herskovits*, both the lead and concurring opinions discussed limiting damages. 99 Wash.2d at 619, 664 P.2d 474 (Dore, J., lead opinion), 635 (Pearson, J., plurality opinion). This is a common approach in lost chance cases, responsive in part to the criticism of holding individuals or organizations

liable on the basis of uncertain probabilities. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 26 cmt. n at 356 ("Rather than full damages for the adverse outcome, the plaintiff is only compensated for the lost opportunity. The lost opportunity may be thought of as the adverse outcome discounted by the difference between the ex ante probability of the outcome in light of the defendant's negligence and the probability of the outcome absent the defendant's negligence."). Treating the loss of a chance as the cognizable injury "permits plaintiffs to recover for the loss of an opportunity for a better outcome, an interest that we agree should be compensable, while providing for the proper valuation of such an interest." *Lord v. Lovett*, 146 N.H. 232, 236, 770 A.2d 1103 (2001). In particular, the *Herskovits* plurality adopted a proportional damages approach, holding that, if the loss was a 40 percent chance of survival, the plaintiff could recover only 40 percent of what would be compensable under the ultimate harm of death or disability (i.e., 40 percent of traditional tort recovery), such as lost earnings. *Herskovits*, 99 Wash.2d at 635, 664 P.2d 474 (Pearson, J., plurality opinion) (citing, King, *supra*, 90 YALE L.J. at 1382). This percentage of loss is a question of fact for the jury and will relate to the scientific measures available, likely as presented through experts. Where appropriate, it may otherwise be discounted for margins of error to further reflect the uncertainty of outcome even with a nonnegligent standard of care. *See* King, *supra*, 28 U. MEM. L.REV. at 554–57 ("conjunction principle").

859 ¶ 26 We find that the *Herskovits* plurality has withstood the broad policy criticisms raised against it and comports with the medical malpractice statute. We find no meaningful basis to distinguish permanent disability from death for the purposes of raising a loss of chance claim. Accordingly, we hold that *Herskovits* applies to medical malpractice cases that result in harm short of death and formally adopt the rationale of the plurality opinion that the injury is the lost chance. For the reasons discussed next, as it relates to the facts of this case, we reverse the order of summary judgment.

2. *Summary Judgment*

[5, 6] ¶ 27 An order granting summary judgment is reviewed de novo. *Rivas v. Overlake Hosp. Med. Ctr.*, 164 Wash.2d 261, 266, 189 P.3d 753 (2008). Summary judgment "shall be rendered forthwith if ... there is no genuine issue as to any material fact and ... the moving party is entitled to a judgment as a matter of law." CR 56(c). We review the evidence in the light most favorable to the nonmoving party. *Miller v. Jacoby*, 145 Wash.2d 65, 71, 33 P.3d 68 (2001).

[7] ¶ 28 Interpreting the facts in the light most favorable to the Mohrs, they have made a prima facie case under the lost chance doctrine that, on August 31 and September 1, 2004, the respondents breached the recognized standard of care for treating a head trauma victim with Mrs. Mohr's symptoms and that their breaches caused Mrs. Mohr a diminished chance of a better outcome. The Mohrs presented the expert testimony of doctors Becker and Harris. Their testimony included opinions regarding breaches of the standard of care: that once given a narcotic, Mrs. Mohr should not have been discharged but observed overnight; that, had Mrs. Mohr been held overnight, her neurological deficits would have been earlier discovered to be a stroke; and that anticoagulants, antiplatelet agents, and general brain protective care reduce the damage caused by strokes. The expert testimony also included information regarding causation,860 including Dr. Becker's opinion that had Mrs. Mohr "received anti-thrombotic therapy there's at least a 50 to 60 percent chance that things could have had a better outcome.... Less disability, less neglect, less ... of the symptoms of right hemispheric stroke." CP at 225–26. Dr. Harris testified that had Mrs. Mohr received nonnegligent treatment at various points between August 31 and September 1, 2004, she would have had a 50 to 60 percent chance of a better outcome. This included the possibility, according to Dr. Harris, that Mrs. Mohr may have had no disability if she had been properly treated. We find, on this evidence, a prima facie showing of duty,

breach, injury in the form of a lost chance, and causation.

¶ 29 Respondents also argue that the case cannot go forward because the Mohrs have not proved damages. This is a misconception of the requirements of medical malpractice tort law. *See* RCW 7.70.040. The Mohrs have made a prima facie case of injury: lost chance of a better outcome.

[8, 9] ¶ 30 Finally, KMC separately asserts that the trial court's order of summary judgment in its favor should be affirmed because it is not vicariously liable for the negligence of the codefendant physicians.[7] However, the Mohrs' and KMC's competing contentions regarding apparent agency and resulting vicarious liability present a question of fact that is not disposable on summary judgment as a matter of law. We therefore reverse the order of summary judgment as to KMC.

[10, 11] ¶ 31 Under apparent authority, an agent (e.g., a doctor) binds a principal (e.g., a hospital) if objective manifestations of the principal "cause the one claiming apparent authority to actually, or subjectively, believe that the agent has authority to act for the principal" and such belief is objectively reasonable. *King v. Riveland*, 125 Wash.2d 500, 507, 886 P.2d 160 (1994). A finding of apparent agency can [861] subject a hospital to vicarious liability for the negligence of contractor physicians or staff working at the hospital. *See, e.g., Adamski v. Tacoma Gen. Hosp.*, 20 Wash.App. 98, 107–08, 579 P.2d 970 (1978).

¶ 32 KMC and the Mohrs dispute whether the Mohrs could and did reasonably believe that any of the codefendant physicians were employees or agents of KMC. The Mohrs signed a form that included the following language:

> Patient care is under the control of the patient's attending physician who: is an independent provider and not an employee or agent of the hospital: May request other physicians to provide services during hospitalization (i.e. pathologists, anesthesiologists, radiologists).

CP at 107. Without considering the clarity of this language, we note that there are other relevant considerations, including: discharge instructions from the "[KMC] Emergency Department" that included information about treatment by Dr. Grantham at KMC; physician name tags that included KMC with the doctors' names; billing statements from KMC; and identification of Dr. Watson as a " 'Hospitalist' " for KMC. *Id.* at 108, 268–70, 579 P.2d 970. It is also informative that KMC's emergency room is an essential part of its operation. *See Adamski*, 20 Wash.App. at 115, 579 P.2d 970.

¶ 33 In *Adamski*, the Court of Appeals considered several factors that it found relevant to the question of whether an independent-contractor physician was an apparent agent of the hospital. *Id.* at 115–16, 579 P.2d 970. It stated that "courts generally look to all of the facts and circumstances to determine if the hospital and doctor enjoy such a 'significant relationship' that the rule of respondeat superior ought to apply." *Id.* at 108, 579 P.2d 970. Similarly, the published model jury instructions enumerate seven relevant factors for the determination of apparent agency in the hospital and independent-contractor physician context. 6 WASHINGTON PRACTICE: WASHINGTON PATTERN JURY INSTRUCTIONS: CIVIL 105.02.03 (5th ed. 2005). One factor is "[w]hether the hospital made any representations [862] to the patient, verbally or in writing, regarding their relationship with the physician." *Id.* However, "no one of [the factors] is controlling." *Id.* Thus, the notice that the Mohrs received disclaiming an agency relationship between KMC and the treating physicians is but one factor to consider.

¶ 34 KMC argues that even if there is apparent agency, the hospital is not liable for negligent acts of physicians that it could not control. *Cf. McLean v. St. Regis Paper Co.*, 6 Wash.App. 727, 729–30, 496 P.2d 571 (1972). However, the negligence alleged here concerns the provision of medical services and is well within the scope of the apparent agency relationship alleged be-

7. This court may sustain a trial court ruling on any correct ground. *Nast v. Michels*, 107 Wash.2d 300, 308, 730 P.2d 54 (1986).

tween the physicians and KMC. As in *Adamski*, we find that a hospital may be, depending on the facts found by a jury, liable for the negligence of its contractor doctors, who are held out to be agents of the hospital. Accordingly, we reverse the order of summary judgment.

CONCLUSION

¶ 35 We hold that there is a cause of action in the medical malpractice context for the loss of a chance of a better outcome. A plaintiff making such a claim must prove duty, breach, and that there was an injury in the form of a loss of a chance caused by the breach of duty. To prove causation, a plaintiff would then rely on established tort causation doctrines permitted by law and the specific evidence of the case. Because the Mohrs made a prima facie case of the requisite elements of proof, we reverse the order of summary judgment and remand to the trial court for further proceedings.

WE CONCUR: CHARLES W. JOHNSON, TOM CHAMBERS, MARY E. FAIRHURST, DEBRA L. STEPHENS, and CHARLES K. WIGGINS, Justices.

MADSEN, C.J. (dissenting).

¶ 36 A central tenet of tort liability for medical malpractice is that a plaintiff must |863prove a physician's acts or omissions caused a patient's actual physical or mental injury before liability will attach. The lost chance doctrine adopted by the majority punishes physicians for negligent acts or omissions that cannot be shown to have caused any *actual* physical or mental harm. Because traditional tort justifications for imposing liability are missing, we should not extend a cause of action for a lost chance of a better outcome as a form of medical malpractice claim beyond its current application.

¶ 37 Black letter negligence law requires proof on a more probable than not basis that the injury was caused by the negligence of another. The majority holding rests on the fiction that the "injury" is actually the loss of a chance of a better outcome. This is semantic pretense. No matter how the cause of action is described, at the end of the day liability is based on no more than the mere *possibility* that the physician's negligence has caused harm, a result that conflicts with black letter law that "negligence in the air" is not actionable.

¶ 38 The majority claims that the tort principles of deterrence and compensation are served by adopting the doctrine. It is incorrect. Deterrence of negligence that does not cause actual harm is a meaningless proposition, and there can be no compensation of injury because the actual injury that occurs may be the result of the preexisting condition. Compensating plaintiffs for preexisting harm is not a legitimate goal of the tort system.

¶ 39 The majority's holding is also contrary to RCW 7.70.040. If the lost chance doctrine is to be accepted in this state, it should be through action of the legislature, which can consider the numerous public policy questions implicated by the doctrine that the majority never considers and, indeed, is not suitably in a position to consider.

¶ 40 The lost chance doctrine is also uniquely unfair because only the health care profession is exposed to liability under it. This court, like others, has refused to apply the basic doctrine against members of any other profession. If a |864lawyer is sued for malpractice, the plaintiff must prove proximate causation of real harm, but this is not true under the lost chance doctrine when a plaintiff sues a physician for negligent treatment that cannot be shown to have proximately caused real harm. The inequity is obvious.

Analysis

¶ 41 It is a fundamental principle that in a medical malpractice action the plaintiff must prove causation of the plaintiff's actual physical (or mental) injury before tort liability will be imposed. To avoid the difficulty posed by this requirement, the majority recognizes a cause of action for which the plaintiff does not have to prove that "but for" the physician's negligence, the injury would not have occurred. Majority at 493 (citing *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wash.2d 609, 619, 664 P.2d 474 (1983) (Dore,

J., lead opinion); *id.* at 634–35, 664 P.2d 474 (Pearson, J., plurality)). That is, because the majority finds the traditional causation-of-injury requirement to be an insurmountable obstacle, it employs a different concept to anchor a lost chance claim. Majority at 496. The majority simply redefines the injury as the lost chance. With this semantic leap—essentially a fiction—the causation problem is fixed.

¶ 42 But in reality the problem remains. No matter how the lost chance cause of action is characterized, the plaintiff is freed of the requirement of proving causation because, no matter how the action is described, the end result is that liability is imposed based on *possibilities* and not on probabilities. *See, e.g., Jones v. Owings,* 318 S.C. 72, 77, 456 S.E.2d 371 (1995) ("[l]egal responsibility in this approach is in reality assigned based on the mere *possibility* that a tortfeasor's negligence was a cause of the ultimate harm"); *Pillsbury–Flood v. Portsmouth Hosp.,* 128 N.H. 299, 305, 512 A.2d 1126 (1986) (rejecting plaintiff's reliance on the "loss of a chance" doctrine expressed in *Hicks v. United States,* 865 368 F.2d 626 (4th Cir.1966); the *Hicks* rule that allows relaxation of the causation requirement where the defendant increased the risk of harm is ill advised; "[c]ausation is a matter of probability, not possibility").

¶ 43 The lost chance doctrine contravenes the long-standing rule that a verdict in a medical malpractice action must not rest on " 'conjecture and speculation.' " *Douglas v. Bussabarger,* 73 Wash.2d 476, 505, 438 P.2d 829 (1968) (internal quotation marks omitted) (quoting *Glazer v. Adams,* 64 Wash.2d 144, 148, 391 P.2d 195 (1964)). A " 'possibility' " is not enough. *Id.*

¶ 44 Trying to skirt this obstacle by saying that "a plaintiff would still have to establish the loss of chance by a preponderance of the evidence," as the plaintiff argued in *Crosby v. United States,* 48 F.Supp.2d 924, 931 (D.Alaska 1999), is not an acceptable excuse because it leads to unacceptable results. As the court in *Crosby* correctly responded, "[i]f a plaintiff's chance of recovery was reduced from 20 percent to 10 percent, then permitting recovery for that 10 percent loss enables a plaintiff to recover damages even when the plaintiff's actual physical injury was *not* more likely than not caused by a defendant's alleged negligence." *Id.* (emphasis added).

¶ 45 The majority tries to justify the lost chance doctrine on the ground that it serves the tort principles of deterring negligence and compensating for injury when "the ultimate harm is permanent disability." Majority at 495. But as the majority itself explains, these justifications rest on *actual* physical harm to the plaintiff, "permanent disability" in the majority's own words. But a *chance* of a better outcome, by definition, is not the same as an *actual* better outcome because there is no way to establish that any physical harm in fact resulted from the negligent act or omission of the physician. Not only does the doctrine not require proof of "but for" causation, "but for" causation *cannot* be proved in any event.

866 ¶ 46 The "deterrence" justification identified by the majority is in fact unrelated to preventing harm-causing negligence. As Benjamin Cardozo famously explained long ago, " 'negligence in the air' " is not actionable.[1] Physicians, and indeed individuals involved in thousands of actions, are negligent every day without legal consequence because, despite the involvement or presence of others, their acts *do not actually cause harm* to the other persons.

¶ 47 The Texas Supreme Court aptly observed, when it "reject[ed] the notion that the enhanced deterrence of the loss of chance approach might be so valuable as to justify scrapping [the] traditional concepts of causation," that *"[i]f deterrence were the sole value to be served by tort law, we could dispense with the notion of causation altogether and award damages on the basis of negligence alone." Kramer v. Lewisville Mem'l Hosp.,* 858 S.W.2d 397, 406 (Tex.1993) (emphasis added). By rejecting the traditional causation in favor of the possible deterrent effect of the lost chance doctrine, the majority im-

1. *Palsgraf v. Long Island R.R. Co.,* 248 N.Y. 339, 341, 162 N.E. 99 (1928) (quoting FREDERICK POLLOCK, THE LAW OF TORTS 455 (5th ed. 1920)).

poses liability for damages based on negligence alone—"negligence in the air."

¶ 48 Moreover, the goal of compensation is not served, either, because there is no way to prove a physician's acts or omissions in fact caused the actual physical harm, rather than the actual harm resulting from the preexisting condition. In fact, under this theory of liability, plaintiffs may be compensated where they suffer absolutely no physical injury as a result of the physician's conduct. Indeed, the Maryland high court has determined that the lost chance doctrine does not result in accurate compensation for any plaintiff's injuries (when the lost chance is less than 50 percent). *Fennell v. S. Maryland Hosp. Ctr., Inc.,* 320 Md. 776, 789–90, 580 A.2d 206 (1990).[2]

867 ¶ 49 Of perhaps greater importance, in a practical sense, the lost chance doctrine does not conform to RCW 7.70.040. Under this statute, a plaintiff in a medical malpractice action must prove:

> (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;
>
> (2) Such failure was a proximate cause of the injury complained of.

RCW 7.70.040.[3] Expert testimony is generally required to establish the standard of care and causation. *Putman v. Wenatchee Valley Med. Ctr.,* 166 Wash.2d 974, 988, 216 P.3d 374 (2009); *Berger v. Sonneland,* 144 Wash.2d 91, 110–11, 26 P.3d 257 (2001); *Harris v. Robert C. Groth, M.D., Inc.,* 99 Wash.2d 438, 449, 663 P.2d 113 (1983). To remove the issue of cause in fact "from the realm of speculation, the medical testimony must at least be sufficiently definite to establish that the act complained of 'probably' or 'more likely than not' caused the subsequent disability." *O'Donoghue v. Riggs,* 73 Wash.2d 814, 824, 440 P.2d 823 (1968) (quoting *Ugolini v.* 868 *States Marine Lines,* 71 Wash.2d 404, 407, 429 P.2d 213 (1967)).

¶ 50 The statute provides that a plaintiff must prove the health care provider failed to exercise the requisite degree "of care, skill, and learning" and this failure "was a proximate cause of the injury complained of." RCW 7.70.040. "Injury" in the statute undoubtedly reflects prevailing law stated in *O'Donoghue,* 73 Wash.2d at 824, 440 P.2d 823, that the failure to exercise the required degree of care must be a proximate cause of "the subsequent disability." In other words, the legislature meant an actual physical disability resulting from the failure to exercise proper care, not an amorphous "lost chance" that may well involve no actual disability at all.

¶ 51 In considering the comparable Alaska statute, which like ours requires a plaintiff to prove the health care provider failed to exercise the proper standard of care and as a "proximate result of this" failure "the plaintiff suffered injuries that would not otherwise

2. In *Fennell,* 320 Md. at 789, 580 A.2d 206, the court, noting that loss of chance recovery is based on statistical probabilities, examined "the statistical probabilities of achieving a 'just' result with loss of chance damages." Drawing from Stephen F. Brennwald, Comment, *Proving Causation in "Loss of a Chance" Cases: A Proportional Approach,* 34 CATH. U.L.REV. 747, 779 n.254 (1985), the Maryland court described a hypothetical example involving 99 cancer patients, each with a 1/3 chance of survival (the example can also be applied to facts involving a chance of a better outcome, rather than survival), each of whom received negligent treatment, and all of whom died. *Fennell,* 320 Md. at 789, 580 A.2d 206.

Statistically, if all had received proper treatment, 33 would have lived and 66 would have died. *Id.* Under the lost chance doctrine, all would be permitted recovery of 33 1/3 percent of the normal value of the case. *Id.* at 789–90, 580 A.2d 206. However, the 33 who would have survived with proper care would be compensated by only 33 1/3 percent of the appropriate damages for the actual injury, i.e., a recovery one-third that which would be necessary to compensate for the actual harm. *Id.* In the other 66 cases, where the decedents died as a result of the preexisting cancer and not as a result of the negligence, the patients would be overcompensated for actual injury to the extent of the entire one-third recovery. *Id.*

The result, the Maryland court said, is that the lost chance doctrine results in errors in compensation for actual injury in all 99 cases. *Id.*

3. The statute was amended in 2011 to be gender neutral. Laws of 2011, ch. 336, § 251. The substantive provisions were not changed.

have been incurred," Alaska Stat. § 09.55.540(a)(3), the federal court in *Crosby,* 48 F.Supp.2d at 931, concluded that "the 'loss of chance' theory disrupts traditional causation principles set forth by statute." The court said "AS 09.55.540 clearly and unambiguously requires plaintiffs to establish that a defendant's alleged negligence was more likely than not the cause of injury." *Id.* The federal court aptly said that, "[t]he statute rejects any presumption of negligence." *Id.* The court concluded that "[r]ecognizing a 'loss of chance' theory under the circumstances of this case would enable plaintiff to recover even when her injury was not proximately caused by the defendant" and contravene the statute. *Id.*

¶ 52 Similarly, the Vermont Supreme Court reached the same conclusion in connection with its comparable state statute, observing that the statutory elements traditionally required that plaintiff produce evidence of a " 'reasonable probability or reasonable degree of medical certainty' that the defendant's conduct caused the injury." *Smith v.* [869] *Parrott,* 2003 VT 64, 175 Vt. 375, 380, 833 A.2d 843 (2003) (quoting *Greene v. Bell,* 171 Vt. 280, 285, 762 A.2d 865 (2000)). The court said that the "loss of chance theory of recovery is thus fundamentally at odds with the settled common law" codified in the statute. *Id.*

¶ 53 The same is true in Washington. Our statute setting out the elements that a plaintiff must prove in a medical malpractice action does not permit a presumption of negligence. It requires proof of proximate cause, not as to a *chance* of malpractice resulting in *possible* injury, but as to actual physical injury to the plaintiff.

¶ 54 If there is to be any change in this law, it should come from the legislature, after appropriate hearings, collection of data, and consideration of competing interests. Only the legislature has the authority to amend the statute.

¶ 55 Moreover, the legislature is best positioned to consider the myriad of public policy matters implicated by the lost chance doctrine. Among them are concerns about the potential impact on the practice of medicine, the costs of medical malpractice insurance, the costs of medical care, and the costs to society as a whole of compensating an entirely new class of plaintiffs who formerly had no claim under the common law. *See Smith,* 175 Vt. at 381, 833 A.2d 843; *Fennell,* 320 Md. at 792–95, 580 A.2d 206. As one court mentioned, "society is wallowing near the water line with the burdensome and astronomical economic costs of universal healthcare and medical services." *Kemper v. Gordon,* 272 S.W.3d 146, 152 (Ky.2008). Malpractice insurance costs are rising and are a part of this financial burden. *Id.* At the same time, medical science and technology are advancing at a phenomenal pace and our expectations based upon these advancements rise as they advance. *Id.* But humans must still effectuate the advances, and there are no guarantees notwithstanding our expectations.

¶ 56 The lost chance doctrine also gives rise to other questions. "For instance, what is a 'late diagnosis'? Does a diagnosis missed this week, but made next week, rise to the [870] level of diminished chance?" *Id.* What about a case where experts could present "evidence ... that an MRI misread on Monday, but accurately discerned on Friday, perhaps gives rise to an infinitesimal loss of a chance to recover. Yet, under this doctrine, even a small percentage of the value of human life could generate substantial recovery and place burdensome costs on healthcare providers" that would ultimately be passed on to each person in the jurisdiction. *Id.*

¶ 57 What about in the very case before this court, where we are not considering the passage of weeks, or even days, but of hours?

¶ 58 In addition, even courts rejecting the doctrine have noted " 'appealing' " arguments exist in favor of the lost chance doctrine, *e.g., id.* (quoting *Smith,* 175 Vt. at 381, 833 A.2d 843), and these, too, should be considered by the legislature.

¶ 59 The ramifications of the majority's opinion are unknown but potentially far-reaching. The majority opinion has the potential to alter health care in this state, as physicians would have to contemplate whether to provide an unprecedented level of care to avoid liability for even a slightly diminish-

ed *chance* of a better outcome. As noted, even a small percentage of chance can equal a substantial award. At the same time, it is no secret that health care insurance coverage is already strained, for those who even have such insurance, and adopting this doctrine cannot help but impact the nature and extent of insurance reimbursement for potential tests and treatments ordered as an eventual result of the majority's decision to expand liability to an unprecedented degree in this state.

¶ 60 All of these matters are public policy considerations for the legislature.

¶ 61 Another issue is the inequity of applying the lost chance doctrine in the medical field. As in other states, this court has declined to extend the lost chance of survival doctrine, the specific form set out in *Herskovits,* to permit |871 suits against other professionals. *See Daugert v. Pappas,* 104 Wash.2d 254, 704 P.2d 600 (1985) (refusing to extend lost chance doctrine to legal malpractice actions). Courts have questioned the inconsistent application of the doctrine depending upon whether the action is for medical malpractice or other professional malpractice. *Smith,* 175 Vt. at 381, 833 A.2d 843; *Gooding v. Univ. Hosp. Bldg., Inc.,* 445 So.2d 1015, 1019–20 (Fla.1984) ("[h]ealth care providers could find themselves defending cases simply because a patient fails to improve or where serious disease processes are not arrested because another course of action could possibly bring a better result" while "[n]o other professional malpractice defendant carries this burden of liability without the requirement that plaintiffs prove the alleged negligence probably rather than possibly caused the injury").

¶ 62 This basic inequity weighs against extension of the doctrine, yet the majority never considers it. In fact, the majority declines to fully consider any of the many reasons why the doctrine should not be accepted. Instead, the majority says that they simply mirror concerns addressed in *Herskovits,* that *Herskovits* has not caused any problems, and for the same reasons favoring *Herskovits,* the lost chance doctrine should be adopted where the ultimate harm is injury short of death.[4]

¶ 63 I do not share the majority's view that *Herskovits* has caused no serious harm and therefore it is unlikely that the majority's present opinion will. Nor do I agree that because the majority can find no reason to distinguish the rationale for the decision in *Herskovits,* this court's hands are essentially tied and we must reach a similar conclusion here.

¶ 64 First, we have no idea what the impact of *Herskovits* has been. We do not know how often the case is followed, |872 how often actions brought under it have been settled, or what cases were decided but not appealed. Second, whatever the effect of *Herskovits,* it is impossible to conclude that effects of the present case will be comparable. If nothing else, the added burdens to society presented by this case will be cumulative to any produced by *Herskovits.* But in any event, and regardless of *Herskovits,* we are simply not in a position to casually conclude that there will be little discernible negative impact. We simply do not know, and the court does not represent the branch of government with the capability of weighing all of the policy arguments and other considerations that should be weighed.

¶ 65 Rather than assume that the issue before us is essentially already determined, as the majority does, this case presents issues and concerns that should be carefully examined before extending the lost chance doctrine and effecting such a sweeping change in the law. The court should not just apply *Herskovits* to injury short of death, but should instead take the opportunity to examine the issue much more closely.[5] At the end

4. Curiously, the majority couches this at one point in its opinion as "some serious injury short of death." Majority at 496. Whatever this means, it is not explained or supported by any analysis in the opinion. If it means that the doctrine is to apply where "serious" versus "something less serious" harm actually results, even more questions arise.

5. The majority effectively treats *Herskovits* as binding precedent because although a six-member majority of the court disagreed on *how* the lost chance doctrine should be applied in a case where death ensued, it agreed that the doctrine should be adopted. Majority at 493. More than a minor disagreement in *Herskovits* is involved, however. The two-member lead opinion in *Her-*

of the examination, the court's conclusion should be that extending the lost chance doctrine is incompatible with RCW 7.70.040 [6] and |873that whether the doctrine should be adopted is a question that must be decided by the legislature.

¶ 66 Given that the decision whether to extend the lost chance doctrine should belong to the legislature, it is my hope that the legislature will examine this issue. If the legislature concludes that the doctrine should become a part of our state law, then it will be doing so as a duly informed representative body. If not, or if the legislature determines that a different version of the doctrine should be adopted, the legislature can effectively abrogate the majority's holding by amending RCW 7.70.040.[7]

¶ 67 For the reasons stated in this opinion, I dissent.

J.M. JOHNSON, J. (dissenting).

¶ 68 The majority improperly extends *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wash.2d 609, 664 P.2d 474 (1983) to create a cause of action for Mrs. Linda Mohr and her husband against the emergency professionals and hospital that provided for her care after she crashed her own car. These medical professionals did not proximately cause the ultimate, sad injury Mrs. Mohr suffered—namely, a distal |874dissection of her right internal carotid artery and loss of brain tissue. Proximate cause is a required element under Washington's liability law (RCW 7.70.040). Because the majority creates a speculative cause of action that is beyond the express legislative mandate of RCW 7.70.040, I dissent.

FACTS

¶ 69 Mrs. Mohr crashed her car into a utility pole at approximately 45 miles per hour after running into four other vehicles during an accident in which she was driving alone. The Richland Fire Department responded. Mrs. Mohr was treated by emergency medical personnel (EMPs) and brought by ambulance [1] to the emergency room at Kadlec Medical Center (KMC) at 3:44 p.m. on August 31, 2004.

¶ 70 Mrs. Mohr was seen in the emergency room by Dr. Dale Grantham. Dr. Grantham and nursing staff noted that Mrs. Mohr had suffered injuries to her head, face, mouth, right forearm, and left leg due to the acci-

skovits would alter the standard of proof. The four-member plurality would alter the characterization of the harm. The two positions were not and are not the same. A plaintiff meeting the lower standard of causation would not necessarily satisfy the "more probable than not" standard adhered to in the plurality. Rather, a plaintiff could prevail by introducing evidence that a physician's conduct increased the risk of harm and the harm in fact was sustained, with the jury then taking a permissible step from increased harm to causation and the conclusion that increased risk was a substantial factor in bringing about the resultant injury (death). *See Herskovits*, 99 Wash.2d at 615–17, 664 P.2d 474 (Dore, J., lead opinion). To prevail under the plurality's theory, the plaintiff could establish a prima facie issue of proximate causation only if the plaintiff produced evidence that the defendant probably caused a substantial reduction in the decedent's chance of survival. *Id.* at 634–35, 664 P.2d 474 (Pearson, J., plurality).

6. This statute was not considered in *Herskovits*.

7. The South Dakota legislature expressly abrogated the state supreme court's adoption of the lost chance doctrine. South Dakota Codified Laws § 20–9–1.1 provides:

> The Legislature finds that in those actions founded upon an alleged want of ordinary care or skill the conduct of the responsible party must be shown to have been the proximate cause of the injury complained of. The Legislature also finds that the application of the so called loss of chance doctrine in such cases improperly alters or eliminates the requirement of proximate causation. Therefore, the rule in *Jorgenson v. Vener*, 2000 SD 87, 616 N.W.2d 366 (2000) is hereby abrogated.

Similarly, the Michigan legislature effectively rescinded *Falcon v. Memorial Hospital*, 436 Mich. 443, 462 N.W.2d 44 (1990), when it enacted Michigan Compiled Laws § 600.2912a(2), which provides:

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

1. Mrs. Mohr has not sued the Richland Fire Department, ambulance, or the EMPs.

dent. Dr. Grantham and nursing staff also noted that Mrs. Mohr suffered from diabetes, that her blood sugar was low upon rescue by the EMPs at the crash site, and that she had not been ambulatory at the scene of the accident.

¶ 71 Dr. Grantham performed a physical exam. During the exam, Mrs. Mohr did not report or demonstrate any acute distress, swelling of the head, numbness, or neck pain. She did not exhibit any motor or sensory deficits. Dr. Grantham ordered blood samples, a finger stick glucose sample, and had Mrs. Mohr taken for x-rays. He also ordered a computerized tomography (CT) scan of her head. The x-rays and CT scan came back normal; they did not show any broken bones, fractures, dislocations, or intracranial injury.

¶ 72 Mrs. Mohr suffered lacerations to her right eyelid and right hand as a result of her accident. Dr. Grantham |875sutured these lacerations at 6:36 p.m. He also fed her at this time and noted that she was alert and able to walk to the bathroom, albeit "slightly wobbly on foot." Clerk's Papers (CP) at 91, 94. Another finger stick glucose sample was taken, and a nurse applied antibacterial ointment and dressed Mrs. Mohr's leg wound.

¶ 73 Dr. Grantham returned at 7:56 p.m. to speak with Mrs. Mohr and her husband. She reported a pain level of "7" on a scale of 1 to 10. Dr. Grantham prescribed Darvocet, a pain medication, and warned Mr. and Mrs. Mohr about its sedative effect. Dr. Grantham noted that Mrs. Mohr was in "good condition, stable condition and improved condition." *Id.* at 94. The doctor proceeded to give Mrs. Mohr and her husband discharge instructions, telling them to return or contact their physician immediately if her condition worsened or changed unexpectedly, if she did not improve, or if other problems arose. The Mohrs left for their home at 8:20 p.m.

¶ 74 At 6:32 a.m. the following morning, Mr. Mohr called the Richland Fire Department. Mrs. Mohr was experiencing weakness, a lack of coordination, and nausea. The fire department transported Mrs. Mohr to the emergency room at the same hospital (KMC). She was admitted at 7:11 a.m.

¶ 75 Mrs. Mohr was seen by Dr. Brian Dawson at 7:16 a.m. She reported weakness and difficulty walking, but no numbness or tingling.[2] Dr. Dawson was aware of Mrs. Mohr's history and performed a physical exam. Dr. Dawson noted that she was somnolent (drowsy), had normal speech, and had weakness on her left side. He ordered a CT scan, which was performed between 8:10 a.m. and 8:19 a.m.

¶ 76 The results of this CT scan, which came back before 9:30 a.m., were not normal. Instead, it revealed findings that the radiologist thought "may be secondary to evolving |876infarct which is in the right middle cerebral artery territory." [3] The radiologist recommended a magnetic reasoning imaging (MRI) examination. Mrs. Mohr was transported to receive the MRI at 9:30 a.m.

¶ 77 The results of the MRI, which came in by 10:32 a.m., led to the discovery of a dissected right internal carotid artery. Dr. Dawson discussed the situation with Dr. Brooks Watson II, and they agreed upon a treatment plan. Mrs. Mohr was transferred to the intermediate care unit at 11:46 a.m., and Dr. Watson prescribed aspirin around 2:00 p.m.

¶ 78 An urgent ultrasound was performed to rule out carotid dissection in the common carotids, but that procedure could not assess the distal internal carotid artery. For this, a CT angiogram was ordered. The CT angiogram was performed at 2:30 p.m. and confirmed that Mrs. Mohr had a distal dissection of the right internal carotid artery. The

2. Mrs. Mohr did not report numbness in her left hand to a medical professional until she was seen by Dr. Brooks Watson II, the third doctor to attend her, at approximately 2:00 p.m. on September 1, 2004. CP at 122.

3. CP at 119. An "infarct" is an area of coagulation necrosis in tissue resulting from obstruction of the local circulation by a thrombus (blood clot) or embolus (foreign particle circulating in the blood). WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1157 (2002). An infarct is not, however, the medical equivalent of a "stroke." It is thus inaccurate to state that Mrs. Mohr was diagnosed as having a stroke at that point in time. *Cf.* majority at 492.

findings were discussed with Dr. Watson at 4:50 p.m.

¶ 79 Dr. Watson discussed the situation with Harborview Medical Center after trying to attempt "neurosurgical input locally." [4] He connected with Dr. Jerry Jurkovitz of Harborview, who agreed to accept Mrs. Mohr and to assume care. It was arranged for Mrs. Mohr to be "life-flighted" to Harborview Medical Center. Dr. Watson ordered intravenous heparin (an anticoagulant) for stabilization. However, he did not administer that drug because her physician sons and the neurosurgeons at Harborview requested that medication be withheld. The doctors at Harborview were not, however, opposed to Dr. Watson's providing aspirin therapy. Aspirin was administered to Mrs. Mohr that evening by a nurse, at the direction of Mrs. Mohr's sons. Some time |877 afterward, Mrs. Mohr was transported to Harborview, where various doctors provided her care.[5]

¶ 80 One of Mrs. Mohr's sons, a fifth-year resident in diagnostic radiology at the University of Washington, testified at deposition that Mrs. Mohr had lost between one-quarter and one-third of her brain tissue in the period following the accident on August 31, 2004.[6] The record does not indicate the numerous patients Drs. Grantham, Dawson and Watson cared for in the emergency room during the time period in question, nor does it detail events after Mrs. Mohr was taken to Harborview.

ANALYSIS

¶ 81 This case boils down to statutory interpretation. Because RCW 7.70.040 does not provide the cause of action the majority creates, its analysis and result are incorrect. Our legislature has simply not required the impossible of medical caregivers: to guarantee the best possible outcome for patients they help.

A. Standard of Review

¶ 82 Statutory interpretation is a question of law that this court reviews de novo. *Berger v. Sonneland*, 144 Wash.2d 91, 104–05, 26 P.3d 257 (2001); *cf.* majority at 493 (citing *Berger*, 144 Wash.2d at 103, 26 P.3d 257). If a statute is plain and unambiguous, its meaning must be derived from the wording of the statute itself. *Berger*, 144 Wash.2d at 105, 26 P.3d 257. Plain words do not require construction. *Id.* Instead, courts assume the legislature means exactly what it says. *Id.* Courts should not force a given construction by imagining a variety of alternative interpretations. *See id.* (quoting *W. Telepage, Inc. v. Dep't of Financing*, 140 Wash.2d 599, 608, 998 P.2d 884 (2000)).

|878 *B. Respondents Are Entitled to Judgment as a Matter of Law: the Mohrs Have Not Established the Statutorily Required Element of Proximate Cause*

¶ 83 The language of RCW 7.70.040 is plain and unambiguous. With respect to the issue raised in this motion for summary judgment, the health care provider's alleged failure to exercise the acceptable standard of care must be a "proximate cause of the injury complained of" before that health care provider may be subject to liability under chapter 7.70 RCW. Proximate cause is a necessary element of proof. RCW 7.70.040.

¶ 84 A "proximate cause" of an injury is defined as a cause that, in a direct sequence, unbroken by any new, independent cause, produces the injury complained of and without which the injury would not have occurred. *Stoneman v. Wick Constr. Co.*, 55 Wash.2d 639, 643, 349 P.2d 215 (1960). To establish proximate cause, the plaintiff must show both "cause in fact" (that the injury would not have occurred but for the act in question) and "legal causation." *Ayers v. Johnson & Johnson Baby Prods. Co.*, 117 Wash.2d 747, 753, 818 P.2d 1337 (1991). "Legal causation" depends on considerations of " 'logic, common sense, justice, policy, and precedent.' " *King v. City of Seattle*, 84 Wash.2d 239, 250, 525 P.2d 228 (1974) (quoting 1 THOMAS ATKINS STREET, THE FOUNDA-

4. CP at 329.

5. Mrs. Mohr has not sued Harborview or the doctors at Harborview.

6. *See* CP at 183.

TION OF LEGAL LIABILITY 110 (1906)). It involves the "determination of whether liability *should* attach as a matter of law given the existence of cause in fact." *Hartley v. State*, 103 Wash.2d 768, 779, 698 P.2d 77 (1985).

¶ 85 The injury complained of in this case is the distal dissection of Mrs. Mohr's right internal carotid artery, which led to a loss of brain tissue. The appellants offer no evidence or testimony, however, that Drs. Grantham, Dawson or Watson caused this injury. They have not established cause in fact. Consequently, the appellants have not made a showing sufficient to establish the existence of an element essential to their case, and on which they will 879 bear the burden of proof at trial: proximate cause. *See Young v. Key Pharm., Inc.*, 112 Wash.2d 216, 225, 770 P.2d 182 (1989) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986)). Thus, there can be no "genuine issue as to any material fact," and the respondents are entitled to a "judgment as a matter of law." CR 56(c); *Celotex*, 477 U.S. at 322, 106 S.Ct. 2548.

CONCLUSION

¶ 86 We should affirm the trial court and answer the question certified to us in the negative. The nonbinding plurality opinion in *Herskovits* should not be extended to rewrite the medical malpractice statutory scheme adopted by the legislature. Our application of the separation of powers doctrine is not a one-way street.

¶ 87 Recovery on the basis of "a lost chance of a better outcome" from these targeted medical care providers is highly speculative and places an impossible burden on doctors and hospitals.[7] Order of Certification at 1. This is not a compensable injury under Washington law. I dissent.

I CONCUR: GERRY L. ALEXANDER, Justice.

38 Cal.3d 137

211 Cal.Rptr. 368

Lawrence FEIN, Plaintiff and Appellant,

v.

PERMANENTE MEDICAL GROUP, Defendant and Appellant.

S.F. 24336.

Supreme Court of California, In Bank.

Feb. 28, 1985.

Rehearing Denied April 4, 1985.*

Patient brought medical malpractice action against medical group alleging that he was injured by failure of group to promptly diagnosis impending heart attack.

KAUS, Justice.

In this medical malpractice action, both parties appeal from a judgment awarding plaintiff about $1 million in damages. Defendant claims that the trial court committed reversible error during the selection of the jury, in instructions on liability as well as damages, and in failing to order that the bulk of plaintiff's award be paid periodically rather than in a lump sum. Plaintiff defends the judgment against defendant's attacks, but maintains that the trial court, in fixing damages, should not have applied two provisions of the Medical Injury Com-

pensation Reform Act of 1975 (MICRA): Civil Code section 3333.2, which limits noneconomic damages in medical malpractice cases to $250,000, and Civil Code section 3333.1, which modifies the traditional "collateral source" rule in such litigation. Plaintiff's claims are based on a constitutional challenge similar to the challenges to other provisions of MICRA that we recently addressed and rejected in *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 204 Cal.Rptr. 671, 683 P.2d 670, *Barme v. Wood* (1984) 37 Cal.3d 174, 207 Cal.Rptr. 816, 689 P.2d 446, and *Roa v. Lodi Medical Group, Inc.* (1985) 37 Cal.3d 920, 211 Cal.Rptr. 77, 695 P.2d 164. We conclude that the judgment should be affirmed in all respects.

I

On Saturday, February 21, 1976, plaintiff Lawrence Fein, a 34-year-old attorney employed by the Legislative Counsel Bureau of the California State Legislature in Sacramento, felt a brief pain in his chest as he was riding his bicycle to work. The pain lasted a minute or two. He noticed a similar brief pain the following day while he was jogging, and then, three days later, experienced another episode while walking after lunch. When the chest pain returned again while he was working at his office that evening, he became concerned for his health and, the following morning, called the office of his regular physician, Dr. Arlene Brandwein, who was employed by defendant Permanente Medical Group, an affiliate of the Kaiser Health Foundation (Kaiser).

Dr. Brandwein had no open appointment available that day, and her receptionist advised plaintiff to call Kaiser's central appointment desk for a "short appointment." He did so and was given an appointment for 4 p.m. that afternoon, Thursday, February 26. Plaintiff testified that he did not feel that the problem was so severe as to require immediate treatment at Kaiser Hospital's emergency room, and that he worked until the time for his scheduled appointment.

When he appeared for his appointment, plaintiff was examined by a nurse practitioner, Cheryl Welch, who was working under the supervision of a physician-consultant, Dr. Wintrop Frantz; plaintiff was aware that Nurse Welch was a nurse practitioner and he did not ask to see a doctor. After examining plaintiff and taking a history, Nurse Welch left the room to consult with Dr. Frantz. When she returned, she advised plaintiff that she and Dr. Frantz believed his pain was due to muscle spasm and that the doctor had given him a prescription for Valium. Plaintiff went home, took the Valium, and went to sleep.

That night, about 1 a.m., plaintiff awoke with severe chest pains. His wife drove him to the Kaiser emergency room where he was examined by Dr. Lowell Redding about 1:30 a.m. Following an examination that the doctor felt showed no signs of a heart problem, Dr. Redding ordered a chest X-ray. On the basis of his examination and the X-ray results, Dr. Redding also concluded that plaintiff was experiencing muscle spasms and gave him an injection of Demerol and a prescription for a codeine medication.

Plaintiff went home but continued to experience intermittent chest pain. About noon that same day, the pain became more severe and constant and plaintiff returned to the Kaiser emergency room where he was seen by another physician, Dr. Donald Oliver. From his initial examination of plaintiff Dr. Oliver also believed that plaintiff's problem was of muscular origin, but, after administering some pain medication, he directed that an electrocardiogram (EKG) be performed. The EKG showed that plaintiff was suffering from a heart attack (acute myocardial infarction). Plaintiff was then transferred to the cardiac care unit.

Following a period of hospitalization and medical treatment without surgery, plaintiff returned to his job on a part-time basis in October 1976, and resumed full-time work in September 1977. By the time of trial, he had been permitted to return to virtually all of his prior recreational activi-

ties—e.g., jogging, swimming, bicycling and skiing.

In February 1977, plaintiff filed the present action, alleging that his heart condition should have been diagnosed earlier and that treatment should have been given either to prevent the heart attack or, at least, to lessen its residual effects. The case went to judgment only against Permanente.

At trial, Dr. Harold Swan, the head of cardiology at the Cedars-Sinai Medical Center in Los Angeles, was the principal witness for plaintiff. Dr. Swan testified that an important signal that a heart attack may be imminent is chest pain which can radiate to other parts of the body. Such pain is not relieved by rest or pain medication. He stated that if the condition is properly diagnosed, a patient can be given Inderal to stabilize his condition, and that continued medication or surgery may relieve the condition.

Dr. Swan further testified that in his opinion any patient who appears with chest pains should be given an EKG to rule out the worst possibility, a heart problem. He stated that the symptoms that plaintiff had described to Nurse Welch at the 4 p.m. examination on Thursday, February 26, should have indicated to her that an EKG was in order. He also stated that when plaintiff returned to Kaiser late that same night with his chest pain unrelieved by the medication he had been given, Dr. Redding should also have ordered an EKG. According to Dr. Swan, if an EKG had been ordered at those times it could have revealed plaintiff's imminent heart attack, and treatment could have been administered which might have prevented or minimized the attack.

Dr. Swan also testified to the damage caused by the attack. He stated that as a result of the attack a large portion of plaintiff's heart muscle had died, reducing plaintiff's future life expectancy by about one-half, to about 16 or 17 years. Although Dr. Swan acknowledged that some of plaintiff's other coronary arteries also suffer from disease, he felt that if plaintiff had been properly treated his future life expectancy would be decreased by only 10 to 15 percent, rather than half.

Nurse Welch and Dr. Redding testified on behalf of the defense, indicating that the symptoms that plaintiff had reported to them at the time of the examinations were not the same symptoms he had described at trial. Defendant also introduced a number of expert witnesses—not employed by Kaiser—who stated that on the basis of the symptoms reported and observed before the heart attack, the medical personnel could not reasonably have determined that a heart attack was imminent. Additional defense evidence indicated (1) that an EKG would not have shown that a heart attack was imminent, (2) that because of the severe disease in the coronary arteries which caused plaintiff's heart attack, the attack could not have been prevented even had it been known that it was about to occur, and finally (3) that, given the deterioration in plaintiff's other coronary arteries, the heart attack had not affected plaintiff's life expectancy to the degree suggested by Dr. Swan.

In the face of this sharply conflicting evidence, the jury found in favor of plaintiff on the issue of liability and, pursuant to the trial court's instructions, returned special verdicts itemizing various elements of damages. The jury awarded $24,733 for wages lost by plaintiff to the time of trial, $63,000 for future medical expenses, and $700,000 for wages lost in the future as a result of the reduction in plaintiff's life expectancy.[1] Finally, the jury awarded $500,000 for "noneconomic damages," to compensate for pain, suffering, inconvenience, physical impairment and other intangible damages sustained by plaintiff from the time of the injury until his death.

After the verdict was returned, defendant requested the court to modify the

1. Plaintiff did not claim that the heart attack would reduce his earning capacity during his lifetime.

award and enter a judgment pursuant to three separate provisions of MICRA: (1) Civil Code section 3333.2—which places a $250,000 limit on noneconomic damages, (2) Civil Code section 3333.1—which alters the collateral source rule, and (3) Code of Civil Procedure section 667.7—which provides for the periodic payment of damages. The trial court, which had rejected plaintiff's constitutional challenge to Civil Code sections 3333.2 and 3333.1 in a pretrial ruling,[2] reduced the noneconomic damages to $250,000, reduced the award for past lost wages to $5,430—deducting $19,303 that plaintiff had already received in disability payments as compensation for such lost wages—and ordered defendant to pay the first $63,000 of any future medical expenses not covered by medical insurance provided by plaintiff's employer, as such expenses were incurred. At the same time, the court declined to order that the award for future lost wages or noneconomic damages be paid periodically pursuant to Code of Civil Procedure section 667.7, determining that the statute was not "mandatory" and that "under the unique facts and circumstances of this case" a periodic payment award of such damages would "defeat[ ] rather than promote[ ]" the purpose of section 667.7.

As noted, both parties have appealed from the judgment. Defendant maintains that the trial court committed reversible error in (1) excusing all Kaiser members from the jury, (2) instructing on the duty of care of a nurse practitioner, (3) instructing on causation, (4) permitting plaintiff to recover wages lost because of his diminished life expectancy, and (5) refusing to order the periodic payment of all future damages. Plaintiff argues that the judgment in his favor should be affirmed, but asserts that the court erred in upholding the MICRA provisions at issue here. Since defendant's claims go to the basic validity of the judgment in favor of plaintiff, we turn first to its contentions.

2. Plaintiff had anticipated the possible application of sections 3333.2 and 3333.1 before trial and had requested the court to declare the statutes unconstitutional at that time. After full briefing, the court rejected the constitutional attack. The court also ruled at that time that in order to avoid possible confusion of the jury, it would not inform them of the $250,000 limit and that—since the amounts of the collateral source benefits were not disputed—it would simply reduce the verdict by such benefits; neither party objected to the court's decision to handle the matter in this fashion.

negligence.[9] Taken as a whole, the instructions did not suggest that defendant could be held strictly liable.

V

Defendant next argues that the trial court erred in permitting the jury to award damages for the loss of earnings attributable to plaintiff's so-called "lost years," i.e., the period of time by which his life expectancy was diminished as a result of defendant's negligence. (See generally Fleming, *The Lost Years: A Problem in the Computation and Distribution of Damages* (1962) 50 Cal.L.Rev. 598 [hereafter *The Lost Years*].)

[9] We believe that this was clearly a proper element of plaintiff's damages. As the United States Supreme Court explained in *Sea-Land Services, Inc. v. Gaudet* (1974) 414 U.S. 573, 594, 94 S.Ct. 806, 819, 39 L.Ed.2d 9: "Under the prevailing American rule, a tort victim suing for damages for permanent injuries is permitted to base his recovery 'on his prospective earnings for the balance of his life expectancy at the time of his injury *undiminished by any shortening of that expectancy as a result of the injury.*' 2 Harper & James[, The Law of Torts (1956)] § 24.6, pp. 1293–1294 (emphasis in original)." (See also Rest.2d Torts, § 924, coms. d, e, pp. 525–526.)[10] Although, to our knowledge, the lost years issue has not been previously decided in California, recovery of such damages is consistent with the general rule permitting an award based on the loss of future earnings a plaintiff is likely to suffer "because of inability to work *for as long a period of time in the future as he could have done had he not sustained the accident.*" (Italics added.) (*Robison v. Atchison, Topeka, & S.F. Ry. Co.* (1962) 211 Cal.App.2d 280, 288, 27 Cal.Rptr. 260.)

Contrary to defendant's contention, plaintiff's recovery of such future lost wages will not inevitably subject defendant to a "double payment" in the event plaintiff's heirs bring a wrongful death action at some point in the future. In *Blackwell v. American Film Co.* (1922) 189 Cal. 689, 700–702, 209 P. 999, we held that in a wrongful death case, a jury was properly instructed that in computing damages it should consider the amount the decedent had obtained from defendant in an earlier judgment as compensation for the impairment of his future earning capacity. Similarly, in the *Sea-Land Services* case, the Supreme Court recognized that an appro-

9. For example, just before reading the instructions on causation, the court read the following instructions: "A plaintiff who was injured as a proximate result of some negligent conduct on the part of a defendant is entitled to recover compensation for such injury from that defendant. [¶] Thus, *the plaintiff is entitled to a verdict in this case if you find, in accordance with my instructions: 1. That defendant was negligent; and 2. That such negligence was a proximate cause of injury to the plaintiff.*

"In this action, the plaintiff has the burden of establishing by a preponderance of the evidence all of the facts necessary to prove the following issues: 1. *The negligence of the defendant.* 2. That such negligence was the proximate cause of injury to plaintiff. 3. The nature and extent of plaintiff's damages...." (Italics added.)

10. The comments in the Restatement state: "*d. Loss or impairment of earning capacity for the future.* The extent of future harm to the earning capacity of the injured person is measured by the difference, viewed as of the time of trial, between the value of the plaintiff's services as they will be in view of the harm and as they would have been had there been no harm. This difference is the resultant derived from reducing to present value the anticipated losses of earnings during the expected working period that the plaintiff would have had during the remainder of his prospective life, but for the defendant's act. (On the determination of the prospective length of life, see Comment *e.*) Accordingly, the trier of fact must ascertain, as nearly as can be done in advance, the difference between the earnings that the plaintiff would or could have received during his life expectancy but for the harm and the earnings that he will probably be able to receive during the period of his life expectancy as now determined.... [¶] *e. The determination of length of life.* In the case of permanent injuries or injuries causing death, it is necessary, in order to ascertain the damages, to determine the expectancy of the injured person's life at the time of the tort.... [¶] If the person harmed is alive at the time of trial, ordinarily the opinion of experts on the probable diminution of the plaintiff's life expectancy as a result of the tort is admissible as bearing upon the impairment of future earning capacity...." (*Ibid.*)

priate set-off may be made in the later wrongful death action. (*Sea-Land Services, Inc. v. Gaudet, supra,* 414 U.S. at pp. 592–594 & fn. 30, 94 S.Ct. at pp. 818–819 & fn. 30.)

[10] Defendant alternatively argues that the jury should have been instructed to deduct from plaintiff's prospective gross earnings of the lost years, the "saved" cost of necessities that plaintiff would not incur during that period. Although there is some authority to support the notion that damages for the lost years should be assessed on the basis of plaintiff's "net" loss (see *The Lost Years, supra,* 50 Cal.L.Rev. 598, 603 & fn. 23), we need not decide that issue in this case because defendant neither requested such an instruction at trial nor presented any evidence of anticipated cost savings that would have supported such an instruction. Under these circumstances, the trial court did not err in failing to instruct on the point. (See *LeMons v. Regents of University of California* (1978) 21 Cal.3d 869, 875, 148 Cal.Rptr. 355, 582 P.2d 946.)

VI

After the jury returned its verdict, defendant requested the trial court to enter a judgment—pursuant to section 667.7 of the Code of Civil Procedure—providing for the periodic payment of future damages, rather than a lump-sum award. Although the trial court rejected plaintiff's constitutional challenge to the periodic payment provision—a conclusion consistent with our recent decision in *American Bank*—it nonetheless denied defendant's request, interpreting section 667.7 as affording a trial court discretion in determining whether to enter a periodic payment judgment and concluding that on the facts of this case the legislative purpose of section 667.7 "would be defeated rather than promoted by ordering periodic payments rather than a lump sum award." Defendant contends that the trial court misinterpreted the statute and erred in failing to order periodic payment of all future damages.

[11] We agree with defendant that the trial court was in error insofar as it interpreted section 667.7 as "discretionary" rather than "mandatory." The statute provides that "[i]n any [medical malpractice action], a superior court *shall,* at the request of either party, *enter a judgment ordering that money damages* or its equivalent *for future damages* of the judgment creditor *be paid in whole or in part by periodic payments rather than by a lump-sum payment* if the award equals or exceeds fifty thousand dollars ($50,000) in future damages." (Italics added.)[11] Al-

11. Section 667.7 provides in relevant part: "(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor. [¶] (b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor. [¶] (2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees. [¶] (c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support,

though in some contexts the use of the term "shall" may be consistent with a "discretionary" rather than a "mandatory" meaning (see, e.g., *Estate of Mitchell* (1942) 20 Cal.2d 48, 50–52, 123 P.2d 503), the legislative history of section 667.7 leaves little doubt that here the Legislature intended to impose a mandatory duty on the trial court to enter a periodic payment judgment in cases falling within the four corners of the section.[12]

[12] Nonetheless, for several reasons relating to the specific facts of this case, we conclude that the trial court judgment should not be reversed on this ground. To begin with, although the court formally rejected defendant's motion for a periodic payment order, its judgment did provide for the periodic payment of the damages which the jury awarded for plaintiff's future medical expenses, directing the defendant to pay such expenses "as [they] are incurred up to the amount of $63,000."

Second, with respect to the award of noneconomic damages, we find that defendant is in no position to complain of the absence of a periodic payment award. As noted, defendant did not move for a periodic payment award until after the jury had returned its special verdicts. Although the trial court had requested the jury to return a special verdict designating the total amount of its noneconomic damage award—to facilitate the application of Civil Code section 3333.2, whose constitutionality we discuss below—the jury was not instructed to designate the portion of the noneconomic damage award that was attributable to future damages, and it did not do so. Instead, it returned an undifferentiated special verdict awarding noneconomic damages of $500,000. Because of defendant's failure to raise the periodic payment issue earlier, plaintiff was deprived of the opportunity to seek a special verdict designating the amount of "future noneconomic damage." Furthermore, as we have seen, the trial court, acting pursuant to Civil Code section 3333.2, reduced the $500,000 noneconomic damage verdict to $250,000. Given the facts of this case, the $250,000 might well reflect the noneconomic damage sustained by plaintiff up until the time of the judgment. Under the circumstances, we conclude that the interests of justice would be served by affirming the lump-sum noneconomic damage award. (See *American Bank & Trust Co. v. Commu-*

as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision. [¶] (d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.... [¶] (f) It is the intent of the legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment."

12. As originally introduced, the bill which ultimately became section 667.7 provided that a trial court "may," and at the request of either party "shall," provide for periodic payments. (Assem. Bill No. 1 (1975–1976 Second Ex.Sess.) June 6, 1975, § 26.) Thereafter, the bill was amended to provide simply that a court "may" provide for periodic payments. (Assem. Amend. to Assem. Bill No. 1 (1975–1976 Second Ex.Sess.) June 12, 1975, § 26.) Before enactment, however, the bill was again amended to delete the permissive "may" language and to insert the mandatory "shall" language that appears in the current statute. (Sen. Amend. to Assem. Bill No. 1 (1975–1976 Second Ex.Sess.) June 25, 1975, § 26.)

nity Hospital, supra, 36 Cal.3d 359, 378, 204 Cal.Rptr. 671, 683 P.2d 670.)

Third and finally, there is the question of the $700,000 award for lost future earnings. Although in general lost future earnings are a type of future damage particularly suitable to a periodic payment judgment, this case presents a somewhat unusual situation because the damages awarded are solely attributable to the earnings of plaintiff's lost years. If the trial court had ordered such damages paid periodically over the time period when the loss was expected to be incurred, the damages would have been paid in their entirety *after* plaintiff's expected death, and thus—if the life expectancy predictions were accurate—plaintiff would not have received *any* of this element of damages. Had defendant presented evidence by which the jury could have determined what proportion of the lost years' earnings would likely be spent for the support of plaintiff's dependents rather than plaintiff himself (see *The Lost Years, supra,* 50 Cal.L.Rev. 598, 613), and had it raised the periodic payment issue in a timely fashion so that the jury could have made special findings on that question, there might well be a strong argument that the dependents' share of the lost years' earnings should be subject to periodic payment. In the absence of any such apportionment, however, we conclude that the trial court properly determined that section 667.7 did not call for the periodic payment of this element of plaintiff's award.

Thus, in sum, we conclude that none of the defendant's contentions call for a reversal of the judgment.

VII

We now turn to plaintiff's contentions.

As noted, although the jury by special verdict set plaintiff's noneconomic damages at $500,000, the trial court reduced that amount to $250,000 pursuant to Civil Code section 3333.2.[13] Plaintiff challenges this ruling, contending that section 3333.2 is unconstitutional on a number of grounds. In many respects, plaintiff's argument tracks the constitutional objections to other provisions of MICRA that we have recently rejected in *American Bank, Barme* and *Roa.*

We begin with the claim that section 3333.2 denies due process because it limits the potential recovery of medical malpractice claimants without providing them an adequate quid pro quo. In rejecting a similar challenge to the periodic payment provision at issue in *American Bank,* we explained that "*[i]t is well established that a plaintiff has no vested property right in a particular measure of damages, and that the Legislature possesses broad authority to modify the scope and nature of such damages.* (See, e.g., *Werner v. Southern Cal. etc. Newspapers* (1950) 35 Cal.2d 121, 129 [216 P.2d 825]; *Feckenscher v. Gamble* (1938) 12 Cal.2d 482, 499–500 [85 P.2d 885]; *Tulley v. Tranor* (1878) 53 Cal. 274, 280.) Since the demise of the substantive due process analysis of *Lochner v. New York* (1905) 198 U.S. 45 [25 S.Ct. 539, 49 L.Ed. 937], it has been clear that the constitutionality of measures affecting such economic rights under the due process clause does not depend on a judicial assessment of the justifications for the legislation or of the wisdom or fairness of the enactment [i.e., the 'adequacy' of the quid pro quo]. So long as the measure is rationally related to a legitimate state interest, policy determinations as to the need for, and the desirability of, the enactment are for the Legislature." (Italics added.) (*American Bank, supra,* 36 Cal.3d 359, 368–369, 204 Cal.Rptr. 671, 683 P.2d 670.)

[13] It is true, of course, that section 3333.2 differs from the periodic payment provision in *American Bank* inasmuch as the periodic payment provision—in large

13. Section 3333.2 provides in relevant part: "(a) In any [medical malpractice] action ... the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage. [¶] (b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000)."

measure—simply postpones a plaintiff's receipt of damages whereas section 3333.2 places a dollar limit on the amount of noneconomic damages that a plaintiff may obtain.[14] That difference, however, does not alter the applicable due process standard of review. As our language in *American Bank* itself suggests, our past cases make clear that the Legislature retains broad control over *the measure*, as well as *the timing*, of damages that a defendant is obligated to pay and a plaintiff is entitled to receive, and that the Legislature may expand or limit recoverable damages so long as its action is rationally related to a legitimate state interest. In *Werner v. Southern Cal. etc. Newspapers, supra*, 35 Cal.2d 121, 216 P.2d 825, for example, our court applied the "rational relationship" standard in dismissing a due process attack on a statute—Civil Code section 48a—which permitted a plaintiff who brought a libel or slander action against a newspaper generally to obtain only "special damages," largely eliminating the traditional right to obtain "general damages" that such a plaintiff had enjoyed before the statute.[15]

In light of our discussion of the legislative history and purposes of MICRA in *American Bank*, *Barme* and *Roa*, it is clear that section 3333.2 is rationally related to legitimate state interests. As we explained in those decisions, in enacting MICRA the Legislature was acting in a situation in which it had found that the rising cost of medical malpractice insurance was posing serious problems for the health care system in California, threatening to curtail the availability of medical care in some parts of the state and creating the very real possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments. In attempting to reduce the cost of medical malpractice insurance in MICRA, the Legislature enacted a variety of provisions affecting doctors, insurance companies and malpractice plaintiffs.

[14] Section 3333.2, like the sections involved in *American Bank*, *Barme* and *Roa*, is, of course, one of the provisions which made changes in existing tort rules in an attempt to reduce the cost of medical malpractice litigation, and thereby restrain the increase in medical malpractice insurance premiums. It appears obvious that this section—by placing a ceiling of $250,000 on the recovery of noneconomic damages—is rationally related to the objective of reducing the costs of malpractice defendants and their insurers.

There is no denying, of course, that in some cases—like this one—section 3333.2 will result in the recovery of a lower judgment than would have been obtained before the enactment of the statute. It is worth noting, however, that in seeking a means of lowering malpractice costs, the Legislature *placed no limits whatsoever on a plaintiff's right to recover for all of the economic, pecuniary damages—such as medical expenses or lost earnings—resulting from the injury*, but instead confined the statutory limitations to the recovery of *noneconomic damages*, and—even then—permitted up to a $250,000 award for such damages. Thoughtful jurists and legal scholars have for some time raised serious questions as to the wisdom of awarding damages for pain and suffering in any negligence case, noting, inter alia, the inherent difficulties in placing a monetary value on such losses, the fact that money damages are at best only imperfect

14. One feature of the periodic payment provision upheld in *American Bank*—terminating payments for future damages, other than damages for loss of earnings, on the plaintiff's death—clearly does operate to reduce the amount of damages ultimately recovered.

15. The "general damage/special damage" distinction drawn by section 48a is similar to the "noneconomic damage/economic damage" distinction established by section 3333.2. Section 48a defines "general damages" as "damages for loss of reputation, shame, mortification and hurt feelings" and defines "special damages" as "all damages which plaintiff alleges and proves that he has suffered in respect to his property, business, trade, profession or occupation, including such amounts of money as the plaintiff alleges and proves he has expended as a result of the alleged libel, and no other."

compensation for such intangible injuries and that such damages are generally passed on to, and borne by, innocent consumers.[16] While the general propriety of such damages is, of course, firmly imbedded in our common law jurisprudence (see, e.g., *Capelouto v. Kaiser Foundation Hospitals* (1972) 7 Cal.3d 889, 892–893, 103 Cal.Rptr. 856, 500 P.2d 880), no California case of which we are aware has ever suggested that the right to recover for such noneconomic injuries is constitutionally immune from legislative limitation or revision. (See, e.g., *Werner v. Southern Cal. etc. Newspapers, supra,* 35 Cal.2d 121, 126–128; fn. 15, 216 P.2d 825, *ante.* See generally Morris, *Liability for Pain and Suffering* (1959) 59 Colum.L.Rev. 476 [urging legislative revision of rules relating to damages for pain and suffering].)

Faced with the prospect that, in the absence of some cost reduction, medical malpractice plaintiffs might as a realistic matter have difficulty collecting judgments for *any* of their damages—pecuniary as well as nonpecuniary—the Legislature concluded that it was in the public interest to attempt to obtain some cost savings by limiting noneconomic damages. Although reasonable persons can certainly disagree as to the wisdom of this provision,[17] we cannot say that it is not rationally related to a legitimate state interest.[18]

16. Justice Traynor, in a dissenting opinion in *Seffert v. Los Angeles Transit Lines* (1961) 56 Cal.2d 498, 511, 15 Cal.Rptr. 161, 364 P.2d 337, observed: "There has been forceful criticism of the rationale for awarding damages for pain and suffering in negligence cases. (Morris, *Liability for Pain and Suffering,* 59 Columb.L.Rev. 476; Plant, *Damages for Pain and Suffering,* 19 Ohio L.J. 200; Jaffe, *Damages for Personal Injury: The Impact of Insurance,* 18 Law and Contemporary Problems 219; Zelermyer, *Damages for Pain and Suffering,* 6 Syracuse L.Rev. 27.) Such damages originated under primitive law as a means of punishing wrongdoers and assuaging the feelings of those who had been wronged. [Citations.] They become increasingly anomalous as emphasis shifts in a mechanized society from ad hoc punishment to orderly distribution of losses through insurance and the price of goods or of transportation. Ultimately such losses are borne by a public free of fault as part of the price for the benefits of mechanization. [Citations.] [¶] Nonetheless, this state has long recognized pain and suffering as elements of damages in negligence cases [citations]; *any change in this regard must await reexamination of the problem by the Legislature.*" (Italics added.)

17. In its comprehensive report on the medical malpractice insurance crisis, the American Bar Association's Commission on Medical Professional Liability recommended that no dollar limit be imposed on recoveries for economic loss, but expressly "[took] no position on whether it is appropriate to place a ceiling on the recovery of non-economic loss." (Rep. of Com. on Medical Professional Liability (1977) 102 ABA Ann.Rep. 786, 849.) The commission explained its conclusions as follows: "When liability has been demonstrated, the first priority of the tort system is to compensate the injured party for the economic loss he has suffered. While it is legitimate in the Commission's view to deduct payments to or for the benefit of the plaintiff by collateral sources, it is unconscionable to preclude a plaintiff, by an arbitrary ceiling on recovery, from recovering all his economic damages, even though some lowering of medical malpractice premiums may result from the enactment of such a ceiling. [¶] The Commission has taken no position, however, on whether it is appropriate to place a statutory ceiling on the recovery of non-economic loss. The arguments in favor of limiting non-economic loss are that a ceiling on general damages would contain jury awards within realistic limits, reduce the exposure of insurers (which reductions could be reflected in lowered premiums), lead to more settlements and less litigation, and enable insurance carriers to set more accurate rates because of the greater predictability of the size of judgments. [¶] The arguments against limiting non-economic loss are that medical malpractice should not be distinguished from other areas of professional malpractice or personal injury actions which have no ceiling on general damages, that general damages are as real to the plaintiff as economic loss, that a wrongdoer should pay for all the losses he has caused, including pain and suffering, and that the general damages portion of an award provides a fund out of which the plaintiff's attorney's fees can be deducted without leaving the plaintiff economically undercompensated. In addition, it is argued that no immediate cost or premium savings will be generated by a ceiling on non-economic losses because questions regarding the constitutionality of such statutes would have to be finally resolved before the insurance companies would reflect any potential savings in their rates; and because the ceiling might prove to be the norm." (*Ibid.*)

18. Indeed, even if due process principles required some "quid pro quo" to support the stat-

A number of state courts have invalidated statutory provisions limiting damages in medical malpractice actions on a variety of theories (see, e.g., *Wright v. Central Du Page Hospital Assn.* (1976) 63 Ill.2d 313, 347 N.E.2d 736; *Arneson v. Olson* (N.D. 1978) 270 N.W.2d 125, 135–136; *Carson v. Maurer* (1980) 120 N.H. 925, 424 A.2d 825, 836–836; *Baptist Hosp. of Southeast Texas v. Baber* (Tex.Ct.App.1984) 672 S.W.2d 296, 297–298); others have upheld such limitations. (See, e.g., *Johnson v. St. Vincent Hospital, Inc.* (1980) 273 Ind. 374, 404 N.E.2d 585, 600–601; *Prendergast v. Nelson* (1977) 199 Neb. 97, 256 N.W.2d 657, 668–672 [plurality opinion].) With only one exception, all of the invalidated statutes contained a ceiling which applied to both pecuniary and nonpecuniary damages, and several courts—in reaching their decisions—were apparently considerably influenced by the potential harshness of a limit that might prevent an injured person from even recovering the amount of his medical expenses. (See *Anderson v. Wagner* (1979) 79 Ill.2d 295, 37 Ill.Dec. 558, 402 N.E.2d 560, 564 [explaining decision in *Wright, supra*]; *Arneson v. Olson, supra,* 270 N.W.2d 125, 135.)[19] Section 3333.2, of course, could have no such effect. In any event, as we have explained, we know of no principle of California—or federal—constitutional law which prohibits the Legislature from limiting the recovery of damages in a particular setting in order to further a legitimate state interest. (See, e.g., *Cory v. Shierloh* (1981) 29 Cal.3d 430, 437–440, 174 Cal.Rptr. 500, 629 P.2d 8 [upholding statute eliminating liability of persons who provide alcohol to drunk driver]; *Duke Power Co. v. Carolina Env. Study Group, supra,* 438 U.S. 59, 98 S.Ct. 2620, 57 L.Ed.2d 595 [upholding statutory limit on liability in the event of a nuclear accident].) Accordingly, we conclude that section 3333.2 does not violate due process.

Plaintiff alternatively contends that the section violates the equal protection clause, both because it impermissibly discriminates between medical malpractice victims and other tort victims, imposing its limits only in medical malpractice cases, and because it improperly discriminates within the class of medical malpractice victims, denying a "complete" recovery of damages only to those malpractice plaintiffs with noneconomic damages exceeding $250,000.

[15] With respect to the first contention, it should be evident from what we have already said that the Legislature limited the application of section 3333.2 to medical malpractice cases because it was responding to an insurance "crisis" in that particular area and that the statute is rationally related to the legislative purpose. *American Bank, Barme* and *Roa* make clear that under these circumstances, plaintiff's initial equal protection claim has no merit. (See *American Bank, supra,* 36 Cal.3d 359, 370–374, 204 Cal.Rptr. 671, 683 P.2d 670; *Barme, supra,* 37 Cal.3d 174,

ute, it would be difficult to say that the preservation of a viable medical malpractice insurance industry in this state was not an adequate benefit for the detriment the legislation imposes on malpractice plaintiffs. As the United States Supreme Court observed in upholding the provisions of the Price-Anderson Act which placed a dollar limit on total liability that would be incurred by a defendant in the event of a nuclear accident: "'It should be emphasized ... that it is collecting a judgment, not filing a lawsuit, that counts.... [A] defendant with theoretically "unlimited" liability may be unable to pay a judgment once obtained.'" (*Duke Power Co. v. Carolina Env. Study Group* (1978) 438 U.S. 59, 89–90, 98 S.Ct. 2620, 2638–2639, 57 L.Ed.2d 595 [quoting from legislative history].)

Although we do not suggest that the Legislature felt that section 3333.2 alone—or for that matter any other single provision of MICRA—was essential to the survival of the medical malpractice insurance system, there is surely nothing in the due process clause which prevents a legislature from making a number of statutory changes which, in combination, provide the requisite benefit to justify the enactment.

19. The one exception is *Carson v. Maurer, supra,* in which the New Hampshire court struck down a provision which imposed a limit only on noneconomic damages, a statute apparently modeled on section 3333.2. As we noted in *Roa* (37 Cal.3d at p. 932, fn. 9, 211 Cal.Rptr. 77, 695 P.2d 164), the *Carson* court—in invalidating a variety of provisions of its medical malpractice legislation—applied an "intermediate scrutiny" standard of review that is inconsistent with the standard applicable in this state.

181–182, 207 Cal.Rptr. 816, 689 P.2d 446; *Roa, supra,* 37 Cal.3d 920, 930–931, 211 Cal.Rptr. 77, 695 P.2d 164.)

[16] As for the claim that the statute violates equal protection because of its differential effect within the class of malpractice plaintiffs, the constitutional argument is equally unavailing. First, as we have already explained, the Legislature clearly had a reasonable basis for drawing a distinction between economic and noneconomic damages, providing that the desired cost savings should be obtained only by limiting the recovery of noneconomic damage. (See pp. 383–384 of 211 Cal.Rptr., pp. 680–681 of 695 P.2d, *ante.*) The equal protection clause certainly does not require the Legislature to limit a victim's recovery for out-of-pocket medical expenses or lost earnings simply because it has found it appropriate to place some limit on damages for pain and suffering and similar noneconomic losses. (See, e.g., *Werner v. Southern Cal. etc. Newspapers, supra,* 35 Cal.2d 121, 126–128, 216 P.2d 825.)

[17] Second, there is similarly no merit to the claim that the statute violates equal protection principles because it obtains cost savings through a $250,000 limit on noneconomic damages, rather than, for example, through the complete elimination of all noneconomic damages. Although plaintiff and a supporting amicus claim that the $250,000 limit on noneconomic damages is more invidious—from an equal protection perspective—than a complete abolition of such damages on the ground that the $250,000 limit falls more heavily on those with the most serious injuries, if that analysis were valid a complete abolition of damages would be equally vulnerable to an equal protection challenge, because abolition obviously imposes greater monetary losses on those plaintiffs who would have obtained larger damage awards than on those who would have recovered lesser amounts. Just as the complete elimination of a cause of action has never been viewed as invidiously discriminating within the class of victims who have lost the right to sue, the $250,000 limit—which applies to all malpractice victims—does not amount to an unconstitutional discrimination.

[18] Nor can we agree with amicus' contention that the $250,000 limit is unconstitutional because the Legislature could have realized its hoped-for cost savings by mandating a fixed-percentage reduction of all noneconomic damage awards. The choice between reasonable alternative methods for achieving a given objective is generally for the Legislature, and there are a number of reasons why the Legislature may have made the choice it did. One of the problems identified in the legislative hearings was the unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses. The Legislature could reasonably have determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates. Furthermore, as one amicus suggests, the Legislature may have felt that the fixed $250,000 limit would promote settlements by eliminating "the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble." Finally, the Legislature simply may have felt that it was fairer to malpractice plaintiffs in general to reduce only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases. Each of these grounds provides a sufficient rationale for the $250,000 limit.

In light of some of the dissent's comments, one additional observation is in order. Contrary to the dissent's assertion, our application of equal protection principles in *American Bank, Barme, Roa* and this case is not inconsistent with the principles enunciated in *Brown v. Merlo* (1973) 8 Cal.3d 855, 106 Cal.Rptr. 388, 506 P.2d 212, *Cooper v. Bray* (1978) 21 Cal.3d 841, 148 Cal.Rptr. 148, 582 P.2d 604, or like cases. As *Cooper* explains, under the traditional, rational relationship equal protection standard, what is required is that the court

"conduct '*a serious and genuine judicial inquiry* into the correspondence between the classification and the legislative goals.' " (21 Cal.3d at p. 848, 148 Cal.Rptr. 148, 582 P.2d 604 [quoting *Newland v. Board of Governors* (1977) 19 Cal.3d 705, 711, 139 Cal.Rptr. 620, 566 P.2d 254, italics added in *Cooper*].) We have conducted such an inquiry in all of these cases, and have found that the statutory classifications are rationally related to the "realistically conceivable legislative purpose[s]" (*Cooper, supra,* 21 Cal.3d at p. 851, 148 Cal.Rptr. 148, 582 P.2d 604) of MICRA. We have not invented fictitious purposes that could not have been within the contemplation of the Legislature (see *Brown v. Merlo, supra,* 8 Cal.3d at p. 865, fn. 7, 106 Cal.Rptr. 388, 506 P.2d 212) nor ignored the disparity in treatment which the statute in realistic terms imposes. (*Id.* at p. 862, 106 Cal.Rptr. 388, 506 P.2d 212.) But *Brown* and *Cooper* have never been interpreted to mean that we may properly strike down a statute simply because we disagree with the wisdom of the law or because we believe that there is a fairer method for dealing with the problem. (See *Cory v. Shierloh, supra,* 29 Cal.3d 430, 437–439, 174 Cal.Rptr. 500, 629 P.2d 8.) Our recent decisions do not reflect our support for the challenged provisions of MICRA as a matter of policy, but simply our conclusion that under established constitutional principles the Legislature had the authority to adopt such measures. As Justice Traynor explained in *Werner v. Southern Cal. etc. Newspapers, supra,* 35 Cal.2d 121, 129, 216 P.2d 825: "[A] court cannot eliminate measures which do not happen to suit its tastes if it seeks to maintain a democratic system. The forum for the correction of ill-considered legislation is a responsive legislature."

Accordingly, we conclude that section 3333.2 is constitutional. The trial court did not err in reducing the noneconomic damage award pursuant to its terms.

VIII

[19] For similar reasons, plaintiff's constitutional challenge to Civil Code section 3333.1—which modifies this state's common law "collateral source" rule—is also without merit.

Under the traditional collateral source rule, a jury, in calculating a plaintiff's damages in a tort action, does not take into consideration benefits—such as medical insurance or disability payments—which the plaintiff has received from sources other than the defendant—i.e., "collateral sources"—to cover losses resulting from the injury. (See, e.g., *Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 84 Cal.Rptr. 173, 465 P.2d 61.) Section 3333.1 alters this rule in medical malpractice cases.[20] Under section 3333.1, subdivision (a), a medical malpractice defendant is permitted to introduce evidence of such collateral source benefits received by or payable to the plaintiff; when a defendant chooses to introduce such evidence, the plaintiff may introduce evidence of the amounts he has paid—in insurance premiums, for example—to secure the benefits. Although section 3333.1, subdivision (a)—as ultimately adopted—does not specify how the jury should use such evidence, the Legislature apparently assumed that in most cases the jury would set plaintiff's

20. Section 3333.1 provides in relevant part: "(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence. [¶] (b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant."

damages at a lower level because of its awareness of plaintiff's "net" collateral source benefits.[21]

In addition, section 3333.1, subdivision (b) provides that whenever such collateral source evidence is introduced, the source of those benefits is precluded from obtaining subrogation either from the plaintiff or from the medical malpractice defendant. As far as the malpractice plaintiff is concerned, subdivision (b) assures that he will suffer no "double deduction" from his tort recovery as a result of his receipt of collateral source benefits; because the jury that has learned of his benefits may reduce his tort award by virtue of such benefits, the Legislature eliminated any right the collateral source may have had to obtain repayment of those benefits from the plaintiff. As for the malpractice defendant, subdivision (b) assures that any reduction in malpractice awards that may result from the jury's consideration of the plaintiff's collateral source benefits will inure to its benefit rather than to the benefit of the collateral source.

In our recent case of *Barme v. Wood, supra*, 37 Cal.3d 174, 207 Cal.Rptr. 816, 689 P.2d 446, we addressed a constitutional challenge to section 3333.1, subdivision (b) brought by a "collateral source" whose subrogation rights against a malpractice defendant had been eliminated by the statute. In upholding the section's constitutionality, we explained that a collateral source has no vested due process right to subrogation and that section 3333.1, subdivision (b) is rationally related to the purposes of MICRA since it reduces the costs imposed on medical malpractice defendants by shifting some of the costs in the area to other insurers.

This case is not controlled by *Barme*, because here plaintiff challenges the validity of subdivision (a), rather than subdivision (b), and contends that the statute violates the rights of a malpractice plaintiff, rather than the rights of a collateral source. Nonetheless, plaintiff's constitutional challenge is still without merit.

[20] Again, we begin with the due process objections to the statute. Although, by its terms, subdivision (a) simply adds a new category of evidence that is admissible in a medical malpractice action, we recognize that in reality the provision affects the measure of a plaintiff's damage award,

21. As we noted in *Barme* (37 Cal.3d at p. 179, fn. 5, 207 Cal.Rptr. 816, 689 P.2d 446): "Earlier drafts of section 3333.1, subdivision (a) required the trier of fact to deduct such collateral source benefits in computing damages, but—as enacted—subdivision (a) simply provides for the admission of evidence of such benefits, apparently leaving to the trier of fact the decision as to how such evidence should affect the assessment of damages."

In this case, it is not clear from the record whether the parties and the trial court recognized that section 3333.1, subdivision (a) simply authorizes the reduction of damages on the basis of collateral source benefits, but does not specifically mandate such a reduction. As noted earlier (see p. 374, fn. 2 of 211 Cal.Rptr., p. 671, fn. 2 of 695 P.2d *ante*), after rejecting plaintiff's pretrial constitutional challenge to this statute, the trial court indicated that in order to avoid any confusion of the jury and because the amount of collateral source benefits was not in dispute, the evidence would not be admitted at trial and the court would simply reduce the jury award by the amount of such benefits. Plaintiff did not object to this procedure and raises no claim with respect to this aspect of the court's ruling on appeal.

Plaintiff does raise a minor contention, however, which is somewhat related to this matter. In awarding damages applicable to plaintiff's future medical expenses, the trial court indicated that defendant was to pay the first $63,000 of such expenses *that were not covered by employer-provided medical insurance.* Plaintiff, pointing out that he may not be covered by medical insurance in the future, apparently objects to any reduction of future damages on the basis of potential future collateral source benefits. Under the terms of the trial court's judgment, however, defendant's liability for such damages will be postponed only if plaintiff does in fact receive such collateral benefits; thus, it is difficult to see how plaintiff has any cause to complain about this aspect of the award. Indeed, if anything, the trial court may have given plaintiff more than he was entitled to, since it did not reduce the jury's $63,000 award by the collateral source benefits plaintiff was likely to receive, but instead imposed a continuing liability on defendant to pay up to a total of $63,000 for any noncovered medical expenses that plaintiff may incur in the future as a result of the injury. Defendant has not objected to this portion of the judgment.

permitting the jury to reduce an award on the basis of collateral source benefits of which—but for the statute—the jury would be unaware. Nonetheless, as we have already explained in our discussion of section 3333.2, a plaintiff has no vested property right in a particular measure of damages. Thus, the fact that the section may reduce a plaintiff's award does not render the provision unconstitutional so long as the measure is rationally related to a legitimate state interest.

Because section 3333.1, subdivision (a) is likely to lead to lower malpractice awards, there can be no question but that this provision—like section 3333.2—directly relates to MICRA's objective of reducing the costs incurred by malpractice defendants and their insurers. And, as we have seen, the Legislature could reasonably have determined that the reduction of such costs would serve the public interest by preserving the availability of medical care throughout the state and by helping to assure that patients who were injured by medical malpractice in the future would have a source of medical liability insurance to cover their losses.

Moreover, the Legislature clearly did not act irrationally in choosing to modify the collateral source rule as one means of lowering the costs of malpractice litigation. In analyzing the collateral source rule more than a decade ago in *Helfend v. Southern Cal. Rapid Transit District, supra,* 2 Cal.3d 1, 84 Cal.Rptr. 173, 465 P.2d 61, we acknowledged that most legal commentators had severely criticized the rule for affording a plaintiff a "double recovery" for "losses" he had not in reality sustained,[22] and we noted that many jurisdictions had either restricted or repealed it. (*Id.* at pp. 6–7, & fns. 4, 5 & 6, 84 Cal.Rptr. 173, 465 P.2d 61.) Although we concluded in *Helfend* that a number of policy considerations counseled against judicial abolition of the rule, we in no way suggested that it was immune from legislative revision, but, on the contrary, stated that the changes proposed by legal commentators "if desirable, would be more effectively accomplished through legislative reform." (*Id.* at p. 13, 84 Cal.Rptr. 173, 465 P.2d 61.) In the mid-1970's, California was only one of many states to include a modification of the collateral source rule as a part of its medical malpractice reform legislation (see Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis* (1975) Duke L.J. 1417, 1447–1450), and the American Bar Association's Commission on Medical Professional Liability also recommended abolition of the rule as one appropriate response to the medical malpractice "crisis." (See Rep. of Com. on Medical Professional Liability, *supra,* 102 ABA Ann.Rep. 786, 849–850.) Under the circumstances, we think it is clear that the provision is rationally related to a legitimate state interest and does not violate due process.

Plaintiff's equal protection challenge to section 3333.1 is equally without merit. As with all of the MICRA provisions that we have examined in recent cases, the Legislature could properly restrict the statute's application to medical malpractice cases because the provision was intended to help meet problems that had specifically arisen in the medical malpractice field.

Accordingly, the trial court did not err in upholding section 3333.1.[23]

22. See, e.g., 2 Harper and James, The Law of Torts (1968 Supp.) section 25.22, at page 52; Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law* (1966) 54 Cal.L.Rev. 1478; James, *Social Insurance and Tort Liability: The Problem of Alternative Remedies* (1952) 27 N.Y.U.L.Rev. 537; Schwartz, *The Collateral Source Rule* (1961) 41 B.U.L.Rev. 348; West, *The Collateral Source Rule Sans Subrogation: A Plaintiff's Windfall* (1963) 16 Okla.L.Rev. 395; Note, *Unreason in the Law of Damages: The Collateral Source Rule* (1964) 77 Harv.L.Rev. 741.

23. The majority of out-of-state cases that have passed on the issue have upheld the validity of provisions modifying the collateral source rule in medical malpractice cases. (See, e.g., *Eastin v. Broomfield* (1977) 116 Ariz. 576, 570 P.2d 744, 751–753; *Rudolph v. Iowa Methodist Medical Ctr.* (Iowa 1980) 293 N.W.2d 550, 557–560; *Pinillos v. Cedars of Lebanon Hospital Corp.* (Fla.

IX

The judgment is affirmed. Each party shall bear its own costs on appeal.

BROUSSARD, GRODIN and LUCAS, JJ., concur.

BIRD, Chief Justice, dissenting.

With today's decision, a majority of this court have upheld, in piecemeal fashion, statutory provisions that require victims of medical negligence to accept delayed payment of their judgments (*American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 204 Cal.Rptr. 671, 683 P.2d 670 [hereafter *American Bank*]), that prohibit them from paying the market rate for legal representation (*Roa v. Lodi Medical Group* (1985) 37 Cal.3d 920, 211 Cal.Rptr. 77, 695 P.2d 164), that deprive them of compensation for proven noneconomic damages greater than $250,000 (maj. opn., *ante*, at pp. 382–385 of 211 Cal.Rptr., at pp. 679–682 of 695 P.2d), and that divest them of the benefit of their own insurance policies (*id.*, at pp. 387–390 of 211 Cal.Rptr., at pp. 684–687 of 695 P.2d).

While the majority have considered the cumulative *financial* effect of these provisions *on insurers* to support their conclusion that MICRA might have some desirable impact on insurance rates (see maj. opn., *ante*, at p. 384, fn. 16 of 211 Cal.Rptr., at p. 681, fn. 16 of 695 P.2d), they have insisted upon assessing the *human* impact of each provision *on injured victims* in isolation. However, it is no longer possible to ignore the overall pattern of the MICRA scheme. In order to provide special relief to negligent healthcare providers and their insurers, MICRA arbitrarily singles out a few injured patients to be stripped of important and well-established protections against negligently inflicted harm.

Crisis or no crisis, this court is duty bound to apply the constitutional guarantee against irrational and invidious legislative classifications. Today's majority opinion represents a sad departure from this court's previously proud tradition of fulfilling that important duty.

By now, the story of MICRA is a familiar one. (See generally, *American Bank, supra*, 36 Cal.3d at p. 364, 204 Cal.Rptr. 671, 683 P.2d 670.) Enacted in 1974 amidst a nationwide "medical malpractice crisis," it includes a number of provisions that seek to relieve healthcare providers and their insurers from some of the costs of medical malpractice litigation. Victims of medical negligence—especially those afflicted with severe injuries—have been singled out to provide the bulk of this relief. These plaintiffs have been deprived of the benefit of various general rules that normally govern personal injury litigation. (See, e.g., Code Civ.Proc., § 667.7 [exception to general rule requiring immediate lump sum payment of a judgment]; Bus. & Prof.Code § 6146 [special restrictions on attorney fees]; Civ.Code, § 3333.2 [special limit on noneconomic damages];[1] § 3333.1 [abrogation of collateral source rule].)

As political scientist Paul Starr has observed, "[a] crisis can be a truly marvelous mechanism for the withdrawal or suspension of established rights, and the acquisition and legitimation of new privileges." (Quoted in Jenkins & Schweinfurth, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge* (1979) 52 So.Cal.L.Rev. 829, 935 [hereafter *California's MICRA*].) However, now that the medical malpractice "crisis" is fading into the past, courts around the country are taking a closer look at medical malpractice legislation. At the time of this court's first MICRA decision, only three courts had invalidated medical malpractice legislation on equal protection grounds. (*American Bank, supra*, 36 Cal.3d at p. 370, fn. 10, 204 Cal.Rptr. 671, 683 P.2d 670.) In the past year alone, that number has doubled. (See *Austin v. Litvak* (Colo.1984) 682 P.2d 41; *Baptist Hosp. of Southeast Texas v. Baber* (Tex.Ct.App. 1981) 403 So.2d 365, 367–368. Contra, *Carson v. Maurer, supra*, 424 A.2d 825, 835–836.)

1. Henceforth, all statutory references are to the Civil Code unless otherwise specified.

1984) 672 S.W.2d 296; *Kenyon v. Hammer* (1984) 142 Ariz. 69, 688 P.2d 961.)

Unfortunately, a majority of this court today decline to join this growing trend. Instead, they continue to defer to the Legislature's resolution of the "crisis," with dire consequences both for victims of medical negligence and for well-established principles of constitutional law.

The problems of this approach are rapidly becoming apparent as the courts begin to confront its human consequences. Less than one year ago, this court rejected the first MICRA challenge, upholding the periodic payment provision. (See *American Bank, supra,* 36 Cal.3d 359, 204 Cal.Rptr. 671, 683 P.2d 670.) Already, that provision has been severely limited. In *American Bank* itself, this court mandated special procedures to offset the provision's worst effects (*id.,* at pp. 376, 377, fn. 14, 204 Cal.Rptr. 671, 683 P.2d 670) and declined to apply it to the case at bar. (*Id.,* at p. 378, 204 Cal.Rptr. 671, 683 P.2d 670.) Today, in "the interests of justice," this court approves the trial court's refusal to apply the provision to all but a small portion of the present plaintiff's award. (Maj. opn., *ante,* at p. 382 of 211 Cal.Rptr., at p. 679 of 695 P.2d.)

While the majority have upheld the various provisions of MICRA out of deference to the Legislature, it is unlikely that such *ad hoc* judicial adjustments to the act will ultimately produce a result that is more respectful of the Legislature than a clear-cut constitutional invalidation followed by a *legislative* revision of the scheme. The majority's well meaning attempt at "deference" serves only to perpetuate a fundamentally unjust statutory scheme.

I.

For the first time, this court is confronted with a provision of MICRA that directly prohibits plaintiffs from recovering compensation for proven injuries. In contrast to the provisions so far upheld by this court, there is no pretense that the $250,000 limit on noneconomic damages affects only windfalls (compare *American Bank, supra,* 36 Cal.3d at p. 369, 204 Cal.Rptr. 671, 683 P.2d 670), that it protects plaintiffs' awards (compare *ibid; Roa v. Lodi Medical Group, supra,* 37 Cal.3d at p. 933, 211 Cal.Rptr. 77, 695 P.2d 164), or that it discourages nonmeritorious suits (compare *id.,* at pp. 931–932, 211 Cal.Rptr. 77, 694 P.2d 164.) The statute plainly and simply denies severely injured malpractice victims compensation for negligently inflicted harm.

Also for the first time, the weight of authority from other jurisdictions *supports* the constitutional challenge. A substantial majority of the courts of the nation that have addressed the constitutionality of medical malpractice damage limits have *invalidated* the challenged provisions. (See *Wright v. Central Du Page Hospital Association* (1976) 63 Ill.2d 313, 347 N.E.2d 736, 743; *Carson v. Maurer* (1980) 120 N.H. 925, 424 A.2d 825, 838 [hereafter *Carson*]; *Arneson v. Olson* (N.D.1978) 270 N.W.2d 125, 136; *Baptist Hosp. of Southeast Texas v. Baber, supra,* 672 S.W.2d at p. 298; *Simon v. St. Elizabeth Medical Center* (Ohio Ct.Comm.Pleas 1976) 355 N.E.2d 903, 906–907 (dictum); cf. *Jones v. State Board of Medicine* (1976) 97 Idaho 859, 555 P.2d 399, 416, cert. den., 431 U.S. 914, 97 S.Ct. 2173, 53 L.Ed.2d 223 [remanding for factual determination on whether a medical malpractice crisis actually existed]; but see *Johnson v. St. Vincent Hospital, Inc.* (1980) 273 Ind. 374, 404 N.E.2d 585, 601.)

In *Carson, supra,* 424 A.2d at page 838, the New Hampshire Supreme Court struck down a damage limit identical to the present one. The court explained that "[i]t is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation." (*Id.,* at p. 837.)[2]

2. The majority attempt to distinguish *Carson* on the grounds that the New Hampshire Supreme Court applied an "intermediate" form of equal protection scrutiny, which is not appropriate under the California Constitution. (See maj. opn., *ante,* at p. 385, fn. 19 of 211 Cal.Rptr. at p.

The majority suggest that, with the exception of *Carson*, the decisions of other jurisdictions are factually distinguishable from the present case. It is argued that the invalidated statutes were more oppressive than the present one since they restricted recovery for all types of injury. (See maj. opn., *ante*, at p. 385 of 211 Cal. Rptr., at p. 682 of 695 P.2d.) However, in *Baptist Hosp. of Southeast Texas v. Baber, supra*, 672 S.W.2d 296, a Texas appellate court invalidated a $500,000 limit that applied only to damages other than medical expenses. Also, in *Simon v. St. Elizabeth Medical Center, supra*, 355 N.E.2d 903, an Ohio appellate court stated in dictum that a $200,000 limit on "general" damages, similar to the limit on "noneconomic" damages involved in the present case, violated the United States and Ohio Constitutions. These provisions were not markedly more severe than MICRA's $250,000 limit on noneconomic damages.

Moreover, for many plaintiffs the present limit may be no less harsh than the $500,000 limit on total damages struck down by the Illinois Supreme Court in *Wright v. Central DuPage Hospital Association, supra*, 347 N.E.2d at page 741. Depending on the relative size of a particular plaintiff's economic and noneconomic damages, the present limit might produce more or less harsh results than the Illinois statute. Only the North Dakota and Ohio statutes imposed substantially more stringent restrictions. (See *Arneson v. Olson, supra*, 270 N.W.2d at p. 135 [$300,000 limit on total damages]; *Jones v. State Board of Medicine, supra*, 555 P.2d at p. 410 [$150,000 limit on total damages].)

The burden on medical malpractice victims is no less real by virtue of the fact that it is "noneconomic" injury which goes uncompensated. Noneconomic injuries include not only physical pain and loss of enjoyment, but also "fright, nervousness, grief, anxiety, worry, mortification, shock, humiliation, indignity, embarrassment, apprehension, terror or ordeal." (*Capelouto v. Kaiser Foundation Hospitals* (1972) 7 Cal.3d 889, 892–893, 103 Cal.Rptr. 856, 500 P.2d 880.)

For a child who has been paralyzed from the neck down, the only compensation for a lifetime without play comes from noneconomic damages. Similarly, a person who has been hideously disfigured receives only noneconomic damages to ameliorate the resulting humiliation and embarrassment.

Pain and suffering are afflictions shared by all human beings, regardless of economic status. For poor plaintiffs, noneconomic damages can provide the principal source of compensation for reduced lifespan or loss of physical capacity. Unlike the attorney in the present case, these plaintiffs may be unable to prove substantial loss of future earnings or other economic damages.

At first blush, $250,000 sounds like a considerable sum to allow for noneconomic damages. However, as amici California Hospital Association and California Medical Association candidly admit, most large recoveries come in cases involving permanent damage to infants or to young, previously healthy adults. Spread out over the expected lifetime of a young person, $250,000 shrinks to insignificance. Injured infants are prohibited from recovering more than three or four thousand dollars per year, no matter how excruciating their pain, how truncated their lifespans, or how grotesque their disfigurement. Even this small figure will gradually decline as inflation erodes the real value of the allowable compensation.

The majority are able to cite only a single decision upholding a limit on medical malpractice damages.[3] In *Johnson v. St. Vin-*

682, fn. 19 of 695 P.2d). However, the *Carson* court's conclusion that it was "unreasonable" to require the most severely injured victims of medical negligence to support the medical care industry is no less relevant under a lower form of scrutiny. The *Carson* court found no rational basis for the fixed limit.

3. The majority erroneously cite a second case, *Prendergast v. Nelson* (1977) 199 Neb. 97, 256 N.W.2d 657, as upholding a damage limit. In *Prendergast* a three-justice *plurality* of the Ne-

cent Hospital, Inc., supra, 404 N.E.2d 585, 601, the Indiana Supreme Court upheld a $500,000 limit on total damages. However, the Indiana statute did more than restrict malpractice victims' recoveries. In order to obtain the benefits of the limit, health care providers were required to contribute to a state-run compensation fund. (*Id.*, at p. 601; Ind.Code, tit. 16, art. 9.5, ch. 2–1.)

By contrast, the present limit is not linked to any public benefit. Insurers and health care providers are free to retain any savings for private use. Moreover, the Legislature had before it *no* evidence that the immense sacrifices of victims would result in appreciable savings to the insurance companies. In the years preceding the enactment of MICRA, an insignificant number of individuals (at maximum, 14 in a single year) received compensation of over $250,000 in noneconomic and economic damages *combined.* (See Cal. Auditor General, The Medical Malpractice Insurance Crisis in California (1975) p. 31 [hereafter *Report of the Auditor General*].) Further, it does not appear that the Legislature had access to any data specifically relating to noneconomic damages. (*Id.*, at pp. 30–31; see generally, *California's MICRA, supra,* at p. 951.)

As in *American Bank* and *Roa,* this court is urged to apply a heightened level of equal protection scrutiny. (Cf. *Carson v. Maurer, supra,* 424 A.2d 825.) However, I do not find it necessary to address that issue, since the limit cannot survive any " 'serious and genuine judicial inquiry into the correspondence between the classification and the legislative goals.' " (*Cooper v. Bray* (1978) 21 Cal.3d 841, 848, 148 Cal.Rptr. 148, 582 P.2d 604, quoting *Newland v. Board of Governors* (1977) 19 Cal.3d 705, 711, 139 Cal.Rptr. 620, 566 P.2d 254.)

Only one legitimate purpose is advanced in support of the statute: that of preserving medical malpractice insurance so that plaintiffs will be able to collect on the unrestricted portions of their judgments. (Maj. opn., *ante,* at p. 383 of 211 Cal.Rptr., at p. 680 of 695 P.2d.) Admittedly, the objective of preserving insurance is legitimate. And, the Legislature might reasonably have determined that special relief to medical tortfeasors and their insurance companies would effectuate that purpose. (See *American Bank, supra,* 36 Cal.3d at p. 372, 204 Cal.Rptr. 671, 683 P.2d 670.)

However, it is not enough that the statute as a whole might tend to serve the asserted purpose. Each statutory classification " 'must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike.' " (*Brown v. Merlo* (1973) 8 Cal.3d 855, 861, 106 Cal.Rptr. 388, 506 P.2d 212; see also *Cooper v. Bray, supra,* 21 Cal.3d at p. 848, 148 Cal.Rptr. 148, 582 P.2d 604; *Newland v. Board of Governors, supra,* 19 Cal.3d at p. 711, 139 Cal.Rptr. 620, 566 P.2d 254.)

There is no logically supportable reason why the most severely injured malpractice victims should be singled out to pay for special relief to medical tortfeasors and their insurers. The idea of preserving insurance by imposing huge sacrifices on a few victims is logically perverse. Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. (See generally, Keeton, Basic Insurance Law (1960) p. 484.) In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals.

braska Supreme Court expressed their view that a $500,000 limit on damages should be upheld. (*Id.*, 256 N.W.2d at p. 669.) An equal number contended that the limit was unconstitutional. (*Id.*, at pp. 675–677 (conc. & dis.opn. of White, J.), (dis.opn. of McCown, J.), (dis. opn. of Boslaugh, J.).) The seventh justice expressed no opinion on the merits of the constitutional challenge, but dissented from the result and pointed out that the plurality opinion did not decide the constitutional questions. (*Ibid.* (dis.opn. of Clinton, J.).)

In short, four out of seven justices concluded either that the limit was unconstitutional or that the question of its constitutionality was not justiciable.

The result is a fundamentally arbitrary classification. Under the statute, a person who suffers a severe injury—for example loss of limbs or eyesight—late in life may receive up to $250,000 for the resulting loss of enjoyment during his or her final years. An infant with identical injuries is limited to the same compensation for an entire lifetime of blindness or immobility.

Such arbitrary treatment cannot be justified with reference to the purpose of the statute. Without speculating on the wisdom of the possible alternatives, it is plain that the Legislature could have provided special relief to health care providers and insurers without imposing these crushing burdens on a few arbitrarily selected victims. Most obviously, the burden could have been spread among all of the statute's beneficiaries—health care consumers or, more broadly, the taxpayers. Alternately, the Legislature could have reduced all noneconomic damage awards in medical malpractice actions by a pro rata amount. (See *California's MICRA, supra,* 52 So. Cal.L.Rev. at p. 952.)

The majority suggest three rationales for singling out the most severely injured plaintiffs to bear the burden. First, it is suggested that "[t]he Legislature could reasonably have determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates." (Maj. opn., *ante,* at p. 386 of 211 Cal.Rptr., at p. 683 of 695 P.2d.) However, the same could be said of *any* restriction on recoveries, regardless of the existence or nature of classifications among tort victims. In effect, this rationale ignores the fact that plaintiff is challenging a classification among tort victims.

Next, the majority hypothesize that "the Legislature may have felt that the fixed $250,000 limit would promote settlements by eliminating 'the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble.'" (Maj. opn., *ante,* at p. 386 of 211 Cal.Rptr., at p. 683 of 695 P.2d.) Again, *any* restriction on recoveries might make plaintiffs less willing to face the risk of litigation. Like the "stability" rationale, this theory fails to address the nature of the classifications among plaintiffs.

Finally, it is suggested that "the Legislature simply may have felt that it was fairer to malpractice plaintiffs in general to reduce only the very large noneconomic damage awards, rather than to diminish the more modest recoveries for pain and suffering and the like in the great bulk of cases." (Maj. opn., *ante,* at p. 386 of 211 Cal.Rptr., at p. 683 of 695 P.2d.) The notion that the Legislature might have concentrated the burden of medical malpractice on the most severely injured victims out of considerations of fairness certainly has the advantage of originality.

While many courts have concluded that fixed malpractice damage limits are grossly unfair (see cases cited *ante,* at p. 391 of 211 Cal.Rptr., at p. 688 of 695 P.2d), none has suggested the possibility of fairness as a legitimate basis for such a limit. If "fairness" can justify the present limit, it is hard to imagine a statute that could be invalidated under the majority's version of equal protection scrutiny.

The majority's acceptance of rationales so broad and speculative that they could justify virtually any enactment calls attention to the implications of the MICRA cases for equal protection doctrine in this state. In *American Bank, supra,* 36 Cal.3d at page 398, 204 Cal.Rptr. 671, 683 P.2d 670 (dis. opn. of Bird, C.J.), I joined a majority of this court in rejecting the notion of "intermediate" equal protection scrutiny. However, I conditioned that rejection on the belief—grounded in the past practice of this court—that the alternative was a two-tier system with a meaningful level of scrutiny under the lower tier. (*Id.,* at pp. 398–401, 204 Cal.Rptr. 671, 683 P.2d 670; see also *Hawkins v. Superior Court* (1978) 22 Cal.3d 584, 607–610, 150 Cal.Rptr. 435, 586 P.2d 916 (conc. opn. of Bird, C.J.).)

In particular, I relied on *Brown v. Merlo, supra,* 8 Cal.3d 855, 106 Cal.Rptr. 388, 506 P.2d 212. In *Brown,* this court conducted a serious and sensitive inquiry into the nature and purposes of the automobile

guest statute. The court demanded not only that the enactment might tend to serve some conceivable legislative purpose, but also that each classification bear a fair and substantial relationship to a legitimate purpose. (*Id.*, at p. 861, 106 Cal.Rptr. 388, 506 P.2d 212.) The guest statute failed to pass this level of scrutiny since the classification of all automobile guests bore an insufficiently precise relation to the asserted purposes. For example, the classification was held to be overinclusive with regard to the purpose of preventing collusive suits. (*Id.*, at p. 877, 106 Cal.Rptr. 388, 506 P.2d 212.) *Brown* was subsequently followed in *Cooper v. Bray, supra,* 21 Cal.3d 841, 148 Cal.Rptr. 148, 582 P.2d 604.

If applied in the present case, the mode of analysis used in *Brown* and *Cooper* would compel invalidation of the $250,000 limit, which is *grossly* underinclusive by any standard. Millions of healthcare consumers stand to gain from whatever savings the limit produces. Yet, the entire burden of paying for this benefit is concentrated on a handful of badly injured victims—fewer than 15 in the year MICRA was enacted. (See *Report of the Auditor General, supra,* at p. 31.) Although the Legislature normally enjoys wide latitude in distributing the burdens of personal injuries, the singling out of such a minuscule and vulnerable group violates even the most undemanding standard of underinclusiveness.

However, the MICRA majority opinions have made no attempt to assess the over- or under-inclusiveness of the legislative classifications at issue. *American Bank, Barme,* and *Roa* could arguably be distinguished from *Brown* and *Cooper* on the ground that the MICRA provisions at issue did not directly deny malpractice victims compensation for negligently inflicted harm. However, if *Brown* and *Cooper* retain any vitality today, their analysis must be applied in the present case.

At a bare minimum the court should honestly confront the existence of *Brown* and *Cooper.* In my view, it is remarkable that neither of these decisions—previously considered to be leading opinions on the application of equal protection analysis in the personal injury area—is capable of being distinguished in any MICRA majority opinion.

In conclusion, there is no rational basis for singling out the most severely injured victims of medical negligence to pay for special relief to health care providers and their insurers. Hence, the $250,000 limit on noneconomic damages cannot withstand any meaningful level of judicial scrutiny.

II.

Plaintiff also challenges section 3333.1, which deprives medical malpractice victims of the benefits of the longstanding collateral source rule.[4]

The collateral source rule bars the deduction of collateral compensation, such as insurance benefits, from a tort victim's damage award. (See *Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 729, 94 Cal.Rptr. 623, 484 P.2d 599; see generally, Schwartz, *The Collateral-Source Rule* (1961) 41 B.U.L. Rev. 348, 354.) The effect of the rule is to prevent tortfeasors and their insurers from reaping the benefits of collateral source funds, which "are usually created through the prudence and foresight of persons other than the tortfeasor, frequently including the injured person himself." (*Gypsum Carrier, Inc. v. Handelsman* (9th Cir.1962) 307 F.2d 525, 534–535.)

As this court has observed, the collateral source rule embodies "the venerable concept that a person who has invested years of insurance premiums to assure his medical care should receive the benefits of his thrift. The tortfeasor should not garner the benefits of his victim's providence." (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 9–10, 84 Cal.Rptr. 173, 465 P.2d 61 [hereafter *Helfend*].) In

4. For the relevant text of section 3333.1, see the majority opinion, *ante,* at p. 387, fn. 20 of 211 Cal.Rptr., at p. 684, fn. 20 of 695 P.2d.

the present case, the plaintiff collected workers' compensation, which he earned indirectly from his employment.

It is not disputed that section 3333.1 must be reviewed under the rational relationship test. That test requires that legislative classifications bear a rational relationship to a legitimate state purpose to pass constitutional muster. (See *Brown v. Merlo, supra,* 8 Cal.3d at p. 882, 106 Cal. Rptr. 388, 506 P.2d 212; *Cooper v. Bray, supra,* 21 Cal.3d at p. 848, 148 Cal.Rptr. 148, 582 P.2d 604.)

The proponents of section 3333.1 have suggested that it serves two purposes. First, it seeks to eliminate double recoveries by victims. (See Keene, *California's Medical Malpractice Crisis,* in A Legislator's Guide to the Medical Malpractice Issue (Warren & Merritt edits. 1976) p. 31.) However, there is no apparent reason why legislation enacted for this purpose should be limited to medical malpractice victims. (See *Graley v. Satayatham* (Ohio Ct. Common Pleas 1976) 343 N.E.2d 832, 836–838.)

Moreover, as this court has recognized, the collateral source rule "does not actually render 'double recovery' for the plaintiff." (*Helfend, supra,* 2 Cal.3d at p. 12, 84 Cal. Rptr. 173, 465 P.2d 61.) Tort victims are not fully compensated for their injuries by their judgments alone. The jury is directed to award damages only in the amount of the plaintiff's injuries. Yet, plaintiffs must pay attorney fees and costs out of their recoveries. Generally, fees and costs account for a substantial proportion of the recovery in medical malpractice actions. (See U.S. Dept. of Health, Ed. & Welf., Rep. of Sect.'s Com. on Medical Malpractice (1973) p. 32.)

The collateral source rule enables the plaintiff to recover some of these costs from collateral sources. Hence, the rule "will not usually give him 'double recovery,' but partially provides a somewhat closer approximation to full compensation for his injuries." (*Helfend, supra,* 2 Cal.3d at p. 13, 84 Cal.Rptr. 173, 465 P.2d 61.) Section 3333.1 will prevent many tort victims from obtaining this relatively full compensation simply because they were injured by a doctor instead of some nonmedical tortfeasor.

Furthermore, while supposedly eliminating victims' "windfalls," section 3333.1 provides a windfall to negligent tortfeasors. Under section 3333.1, negligent healthcare providers obtain a special exemption from the general rule that negligent tortfeasors must fully compensate their victims. "No reason in law, equity or good conscience can be advanced why a wrongdoer should benefit from part payment from a collateral source.... If there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer...." (*Grayson v. Williams* (10th Cir.1958) 256 F.2d 61, 65; see also *Helfend, supra,* 2 Cal.3d at p. 10, 84 Cal.Rptr. 173, 465 P.2d 61.)

The second purpose advanced to justify section 3333.1 is that of reducing the cost of medical malpractice insurance, the overall goal of MICRA. (See Stats.1975, Second Ex.Sess. 1975–1976, ch. 2, § 12.5, p. 4007.) It is argued that the Legislature rationally singled out medical malpractice actions in order to alleviate a "crisis" in medical malpractice insurance rates.

However, the relationship between section 3333.1 and the reduction of malpractice insurance premiums is entirely speculative. There is no requirement that physicians' insurers pass on their savings in the form of lowered premiums. Hence, insurance companies may simply retain their windfall for private purposes. Further, section 3333.1 operates only as a rule of evidence. Juries may choose not to offset collateral compensation. Hence, "a degree of arbitrariness may frustrate the relationship between this provision and attainment of MICRA's goal." (*California's MICRA, supra,* 52 So.Cal.L.Rev. at p. 949.)

The courts of other jurisdictions have had occasion to address the constitutionality of similar provisions. In *Arneson v. Olson, supra,* 270 N.W.2d 125, 137, the North Dakota Supreme Court unanimously invalidated a statute that effectively abolished the collateral source rule in medical

malpractice cases. The court found that there was no " 'close correspondence between [the] statutory classification and [the] legislative goals' " (*Id.*, at pp. 133, 137), and noted that the provision gave the tortfeasor "the benefit of insurance privately purchased by or for the tort victim...." (*Id.*, at p. 128.)

Similarly, in *Carson v. Maurer, supra*, 424 A.2d at pages 835–836, the New Hampshire Supreme Court unanimously overturned a kindred provision, reasoning that it "arbitrarily and unreasonably discriminate[d] in favor of the class of health care providers." And, in *Graley v. Satayatham, supra*, 343 N.E.2d at page 836, the court struck down a requirement that collateral benefits be listed in medical malpractice complaints, reasoning that it unconstitutionally discriminated against medical malpractice victims.

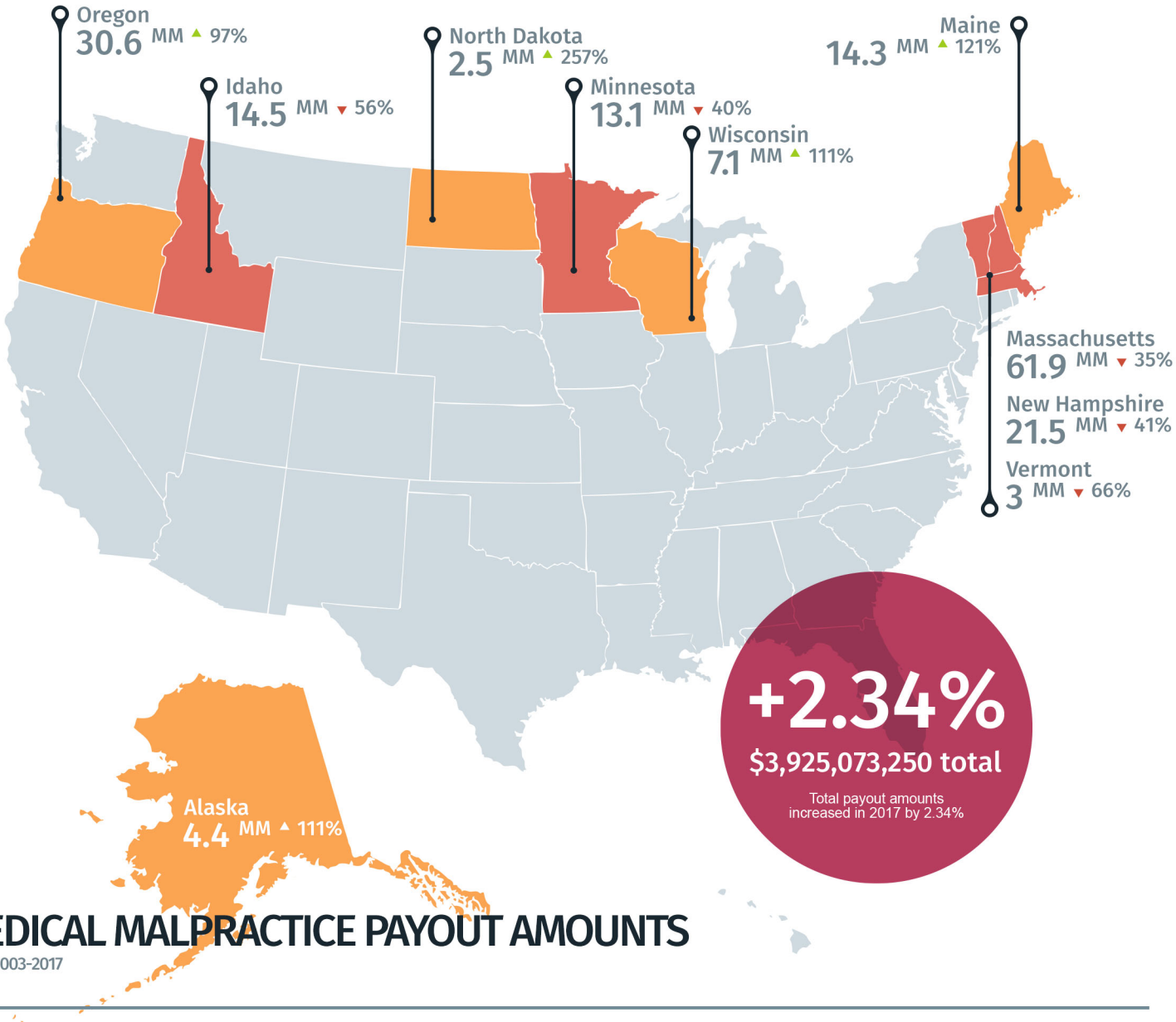
Some jurisdictions have upheld similar provisions. (See *Eastin v. Broomfield* (1977) 116 Ariz. 576, 570 P.2d 744, 751–753; *Pinillos v. Cedars of Lebanon Hospital Corp.* (Fla.1981) 403 So.2d 365, 367–368; *Rudolph v. Iowa Methodist Medical Center* (Iowa 1980) 293 N.W.2d 550, 552–560.) Two of these decisions were made by sharply divided courts. (See *Pinillos, supra*, 403 So.2d at pp. 369–371 (dis. opn. of Sundberg, C.J.); *Rudolph, supra*, 293 N.W.2d at pp. 561–568 (dis. opn. of Reynoldson, C.J.).) Moreover, the decisions reflect a highly deferential approach that is not consistent with the California courts' rigorous application of the rational relationship test to classifications affecting tort victims. (See, e.g., *Brown v. Merlo, supra*, 8 Cal.3d 855, 106 Cal.Rptr. 388, 506 P.2d 212; *Cooper v. Bray, supra*, 21 Cal.3d 841, 148 Cal.Rptr. 148, 582 P.2d 604; *Monroe v. Monroe* (1979) 90 Cal.App.3d 388, 153 Cal. Rptr. 384; *Ayer v. Boyle* (1974) 37 Cal. App.3d 822, 112 Cal.Rptr. 636.)

In conclusion, section 3333.1 permits negligent healthcare providers and their insurers to reap the benefits of their victims' foresight in obtaining insurance. This departure from the general rule prohibiting the deduction of collateral source benefits from a judgment is not rationally related to any legitimate state purpose. Hence, section 3333.1 should be declared unconstitutional.

* Assigned by the Chairperson of the Judicial Council.

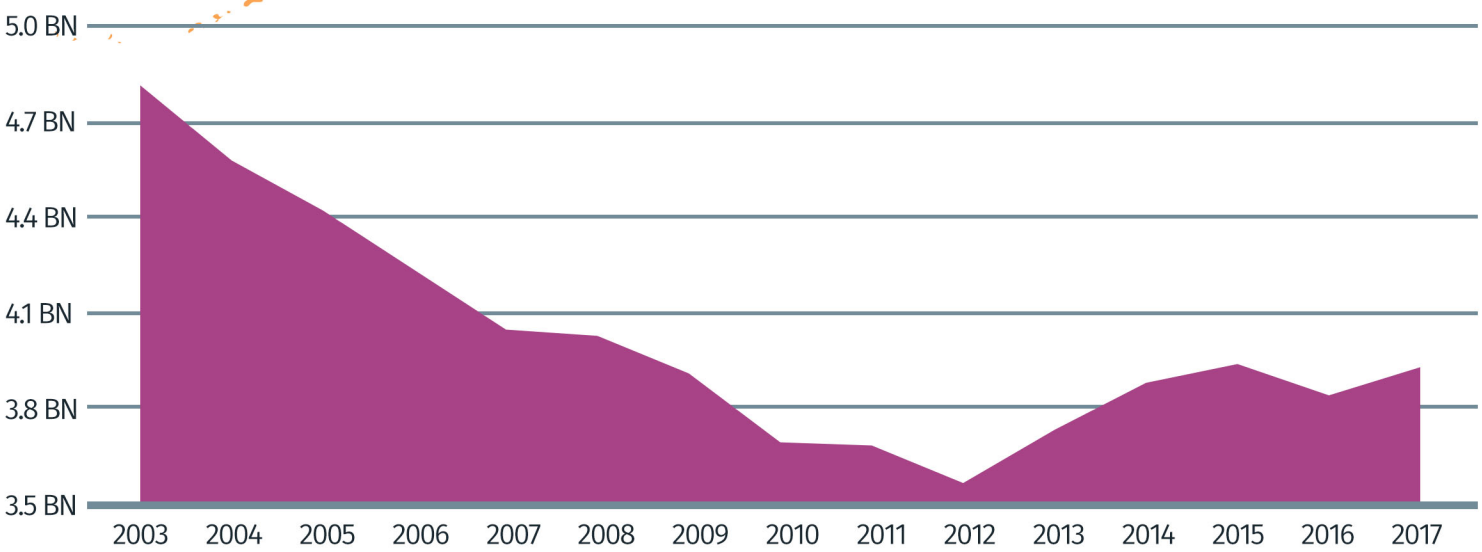
2018 MEDICAL MALPRACTICE PAYOUT ANALYSIS

Presented by Diederich Healthcare



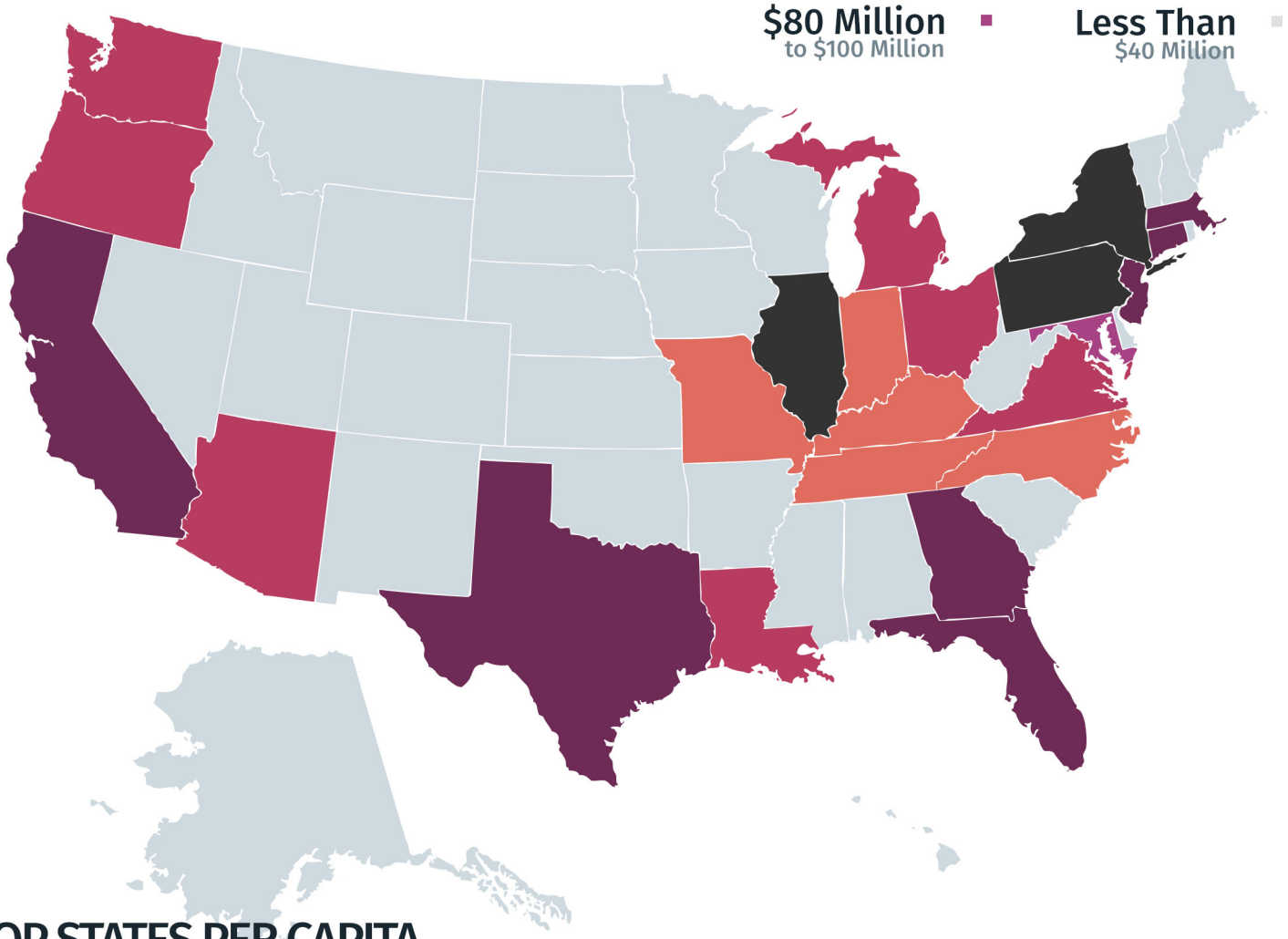
MEDICAL MALPRACTICE PAYOUT AMOUNTS

From 2003-2017



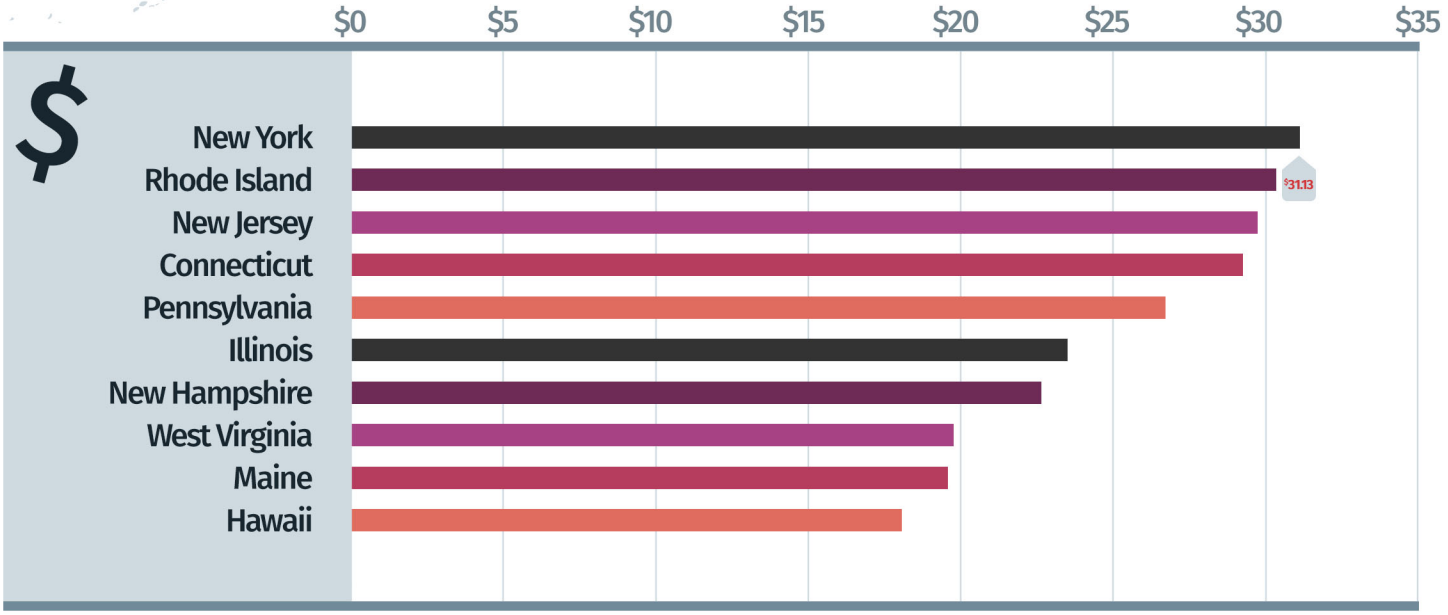
TOTAL PAYOUT AMOUNTS BY STATE

Payout amounts for the United States of America by the million.



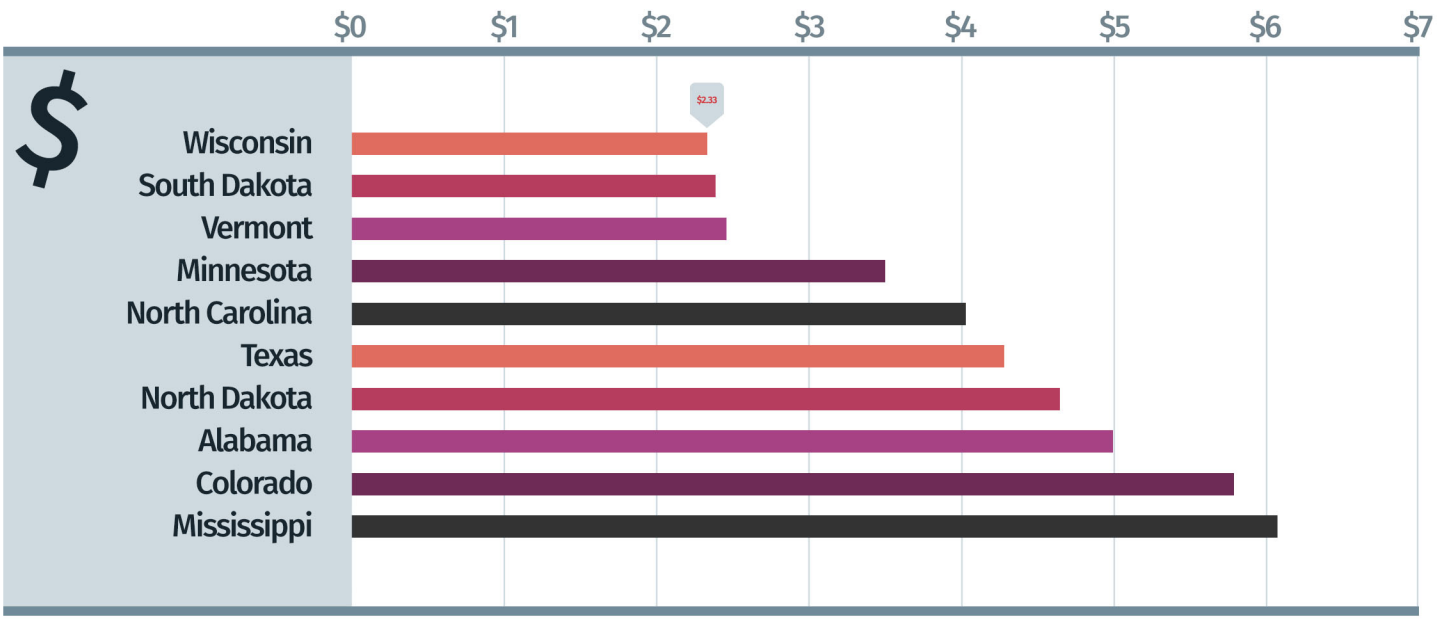
TOP STATES PER CAPITA

Total paid out per person residing in the state. Population estimates are taken from the US Census Bureau (see references).



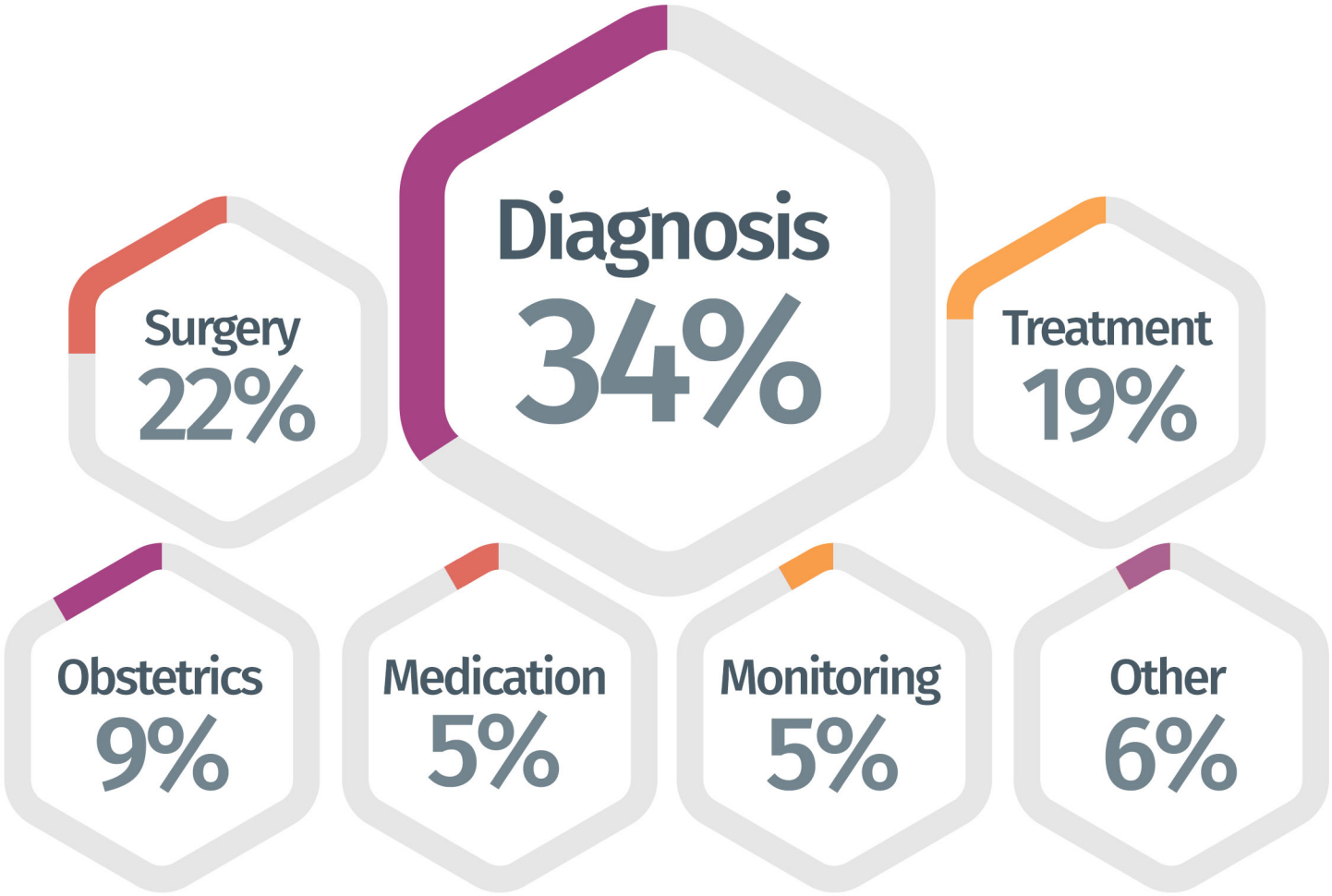
BOTTOM STATES PER CAPITA

Total paid out per person residing in the state. Population estimates are taken from the US Census Bureau (see references).



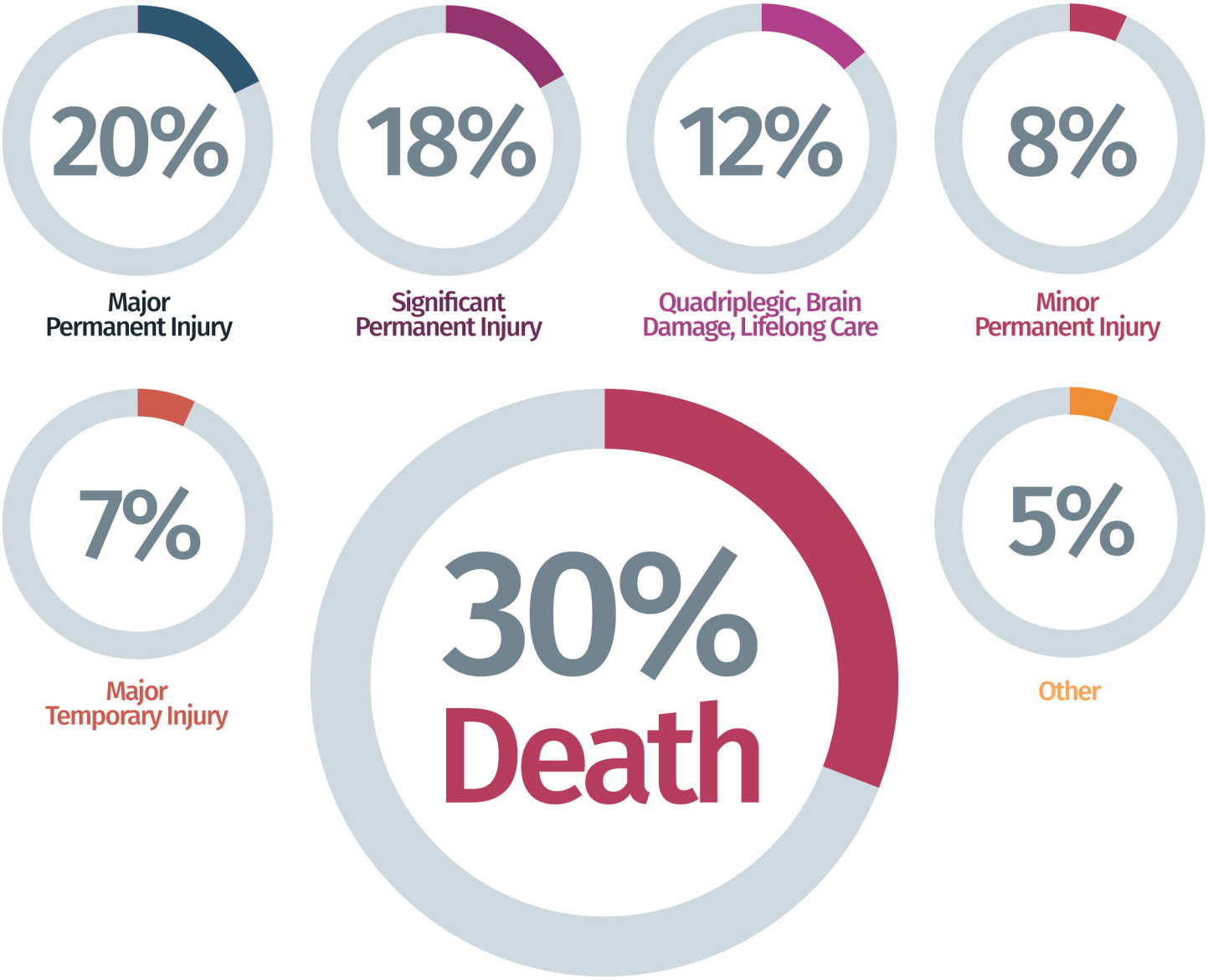
PAYMENT AMOUNTS BY MALPRACTICE ALLEGATION

Percentages rounded.



SEVERITY OF OUTCOME

Percentage of payment amounts by severity of the alleged outcome.



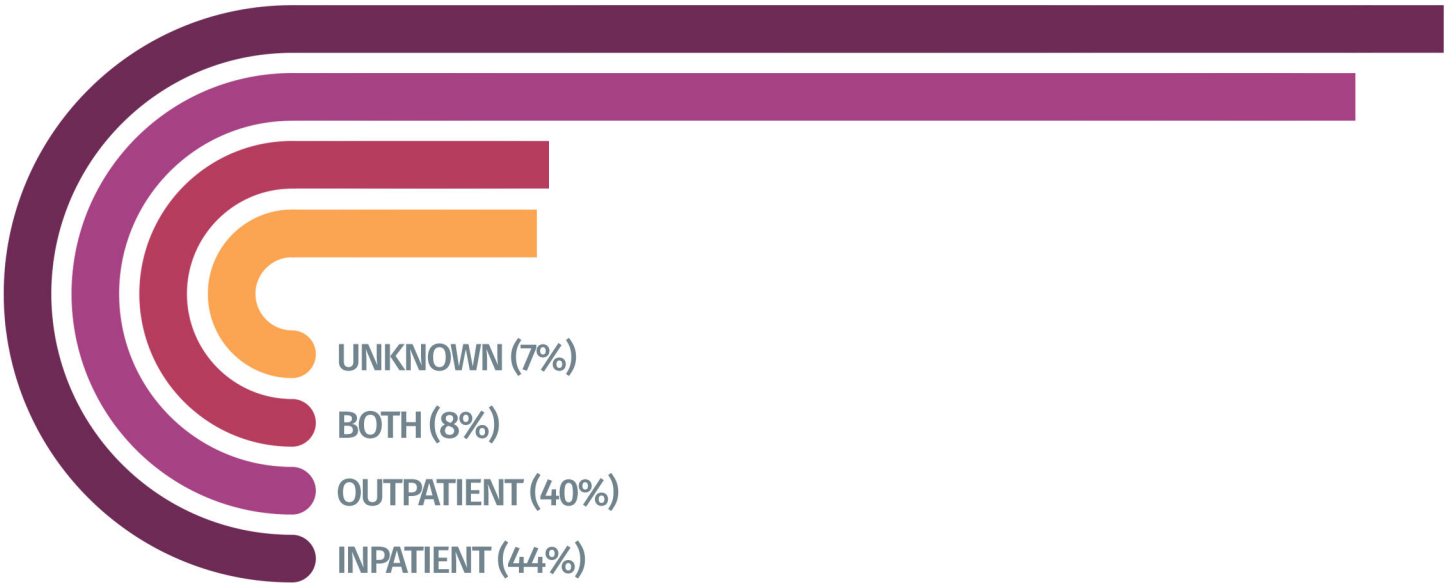
AVERAGE PAYMENT AMOUNTS

Payment amount by severity of the alleged outcome.

QUADRIPLEGIC, BRAIN DMG, LIFE CARE	$ 1,029,105
MAJOR PERMANENT INJURY	$ 600,797
SIGNIFICANT PERMANENT INJURY	$ 424,645
DEATH	$ 374,530
MINOR PERMANENT INJURY	$ 236,057
MAJOR TEMPORARY	$ 214,407
CANNOT BE DETERMINED	$ 109,583
EMOTIONAL INJURY	$ 91,678
MINOR TEMPORARY	$ 72,850
INSIGNIFICANT INJURY	$ 34,333

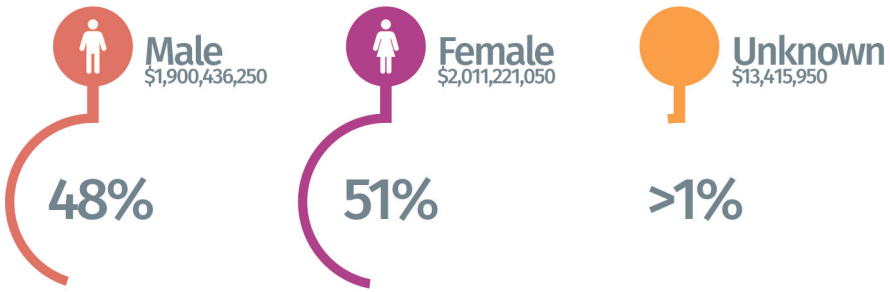
PATIENT TYPE

Total payment amount by patient type.



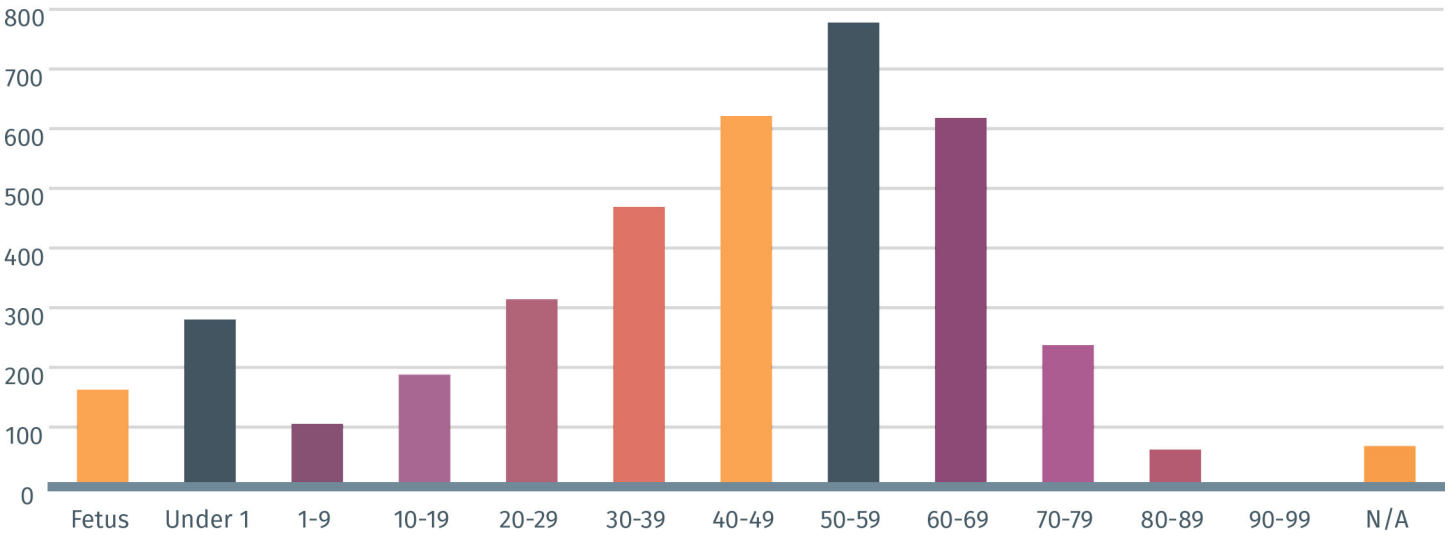
PATIENT GENDER

Percentage of total payment amount by patient gender.



PATIENT AGE

Total payment amount by patient age. Y axis represents millions of dollars.



NORTHEASTERN UNITED STATES

Taking a closer look at the northeastern United States of America, in regard to medical malpractice payouts.

CONNECTICUT TOTAL PAYOUT AMOUNT: $104,766,250 | PER CAPITA: $29.20 | +67.64% IN TOTAL PAYOUTS FROM 2016

DELAWARE TOTAL PAYOUT AMOUNT: $8,253,250 | PER CAPITA: $8.58 | +35.95% IN TOTAL PAYOUTS FROM 2016

DISTRICT OF COLUMBIA TOTAL PAYOUT AMOUNT: $11,498,500 | PER CAPITA: $16.57 | +78.72% IN TOTAL PAYOUTS FROM 2016

MAINE TOTAL PAYOUT AMOUNT: $26,112,000 | PER CAPITA: $19.55 | +121.38% IN TOTAL PAYOUTS FROM 2016

MARYLAND TOTAL PAYOUT AMOUNT: $86,585,550 | PER CAPITA: $14.31 | -6.3% IN TOTAL PAYOUTS FROM 2016

MASSACHUSETTS TOTAL PAYOUT AMOUNT: $117,461,500 | PER CAPITA: $17.12 | -34.51% IN TOTAL PAYOUTS FROM 2016

NEW HAMPSHIRE TOTAL PAYOUT AMOUNT: $30,348,000 | PER CAPITA: $22.60 | -41.43% IN TOTAL PAYOUTS FROM 2016

NEW JERSEY TOTAL PAYOUT AMOUNT: $267,913,250 | PER CAPITA: $29.75 | -10.3% IN TOTAL PAYOUTS FROM 2016

NEW YORK TOTAL PAYOUT AMOUNT: $617,973,000 | PER CAPITA: $31.13 | -11.72% IN TOTAL PAYOUTS FROM 2016

PENNSYLVANIA TOTAL PAYOUT AMOUNT: $342,093,300 | PER CAPITA: $26.71 | +8.4% IN TOTAL PAYOUTS FROM 2016

RHODE ISLAND TOTAL PAYOUT AMOUNT: $32,152,250 | PER CAPITA: $30.34 | +10.53% IN TOTAL PAYOUTS FROM 2016

VERMONT TOTAL PAYOUT AMOUNT: $1,536,500 | PER CAPITA: $2.46 | -65.87% IN TOTAL PAYOUTS FROM 2016

41.95%

The total payout amount for the northeast in 2017 was 41.95% of the United States ($1,646,693,350).

$25.66

The northeast had $25.66 paid out for every individual residing in the region in 2017. This number is almost 3 times greater than the next highest region (the midwest).

50%

Half of the states in the northeast had payout amounts that were greater than the previous year, while the other half decreased in payout amounts.

MIDWESTERN UNITED STATES

Taking a closer look at the midwestern United States of America, in regard to medical malpractice payouts.

ILLINOIS TOTAL PAYOUT AMOUNT: $300,790,050 | PER CAPITA: $23.50 | +11.49% IN TOTAL PAYOUTS FROM 2016

INDIANA TOTAL PAYOUT AMOUNT: $57,382,000 | PER CAPITA: $8.61 | -27.11% IN TOTAL PAYOUTS FROM 2016

IOWA TOTAL PAYOUT AMOUNT: $23,060,000 | PER CAPITA: $7.33 | +9.68% IN TOTAL PAYOUTS FROM 2016

KANSAS TOTAL PAYOUT AMOUNT: $25,279,500 | PER CAPITA: $8.68 | +0.38% IN TOTAL PAYOUTS FROM 2016

MICHIGAN TOTAL PAYOUT AMOUNT: $77,072,200 | PER CAPITA: $7.74 | +21.13% IN TOTAL PAYOUTS FROM 2016

MINNESOTA TOTAL PAYOUT AMOUNT: $19,496,000 | PER CAPITA: $3.50 | -40.18% IN TOTAL PAYOUTS FROM 2016

MISSOURI TOTAL PAYOUT AMOUNT: $54,644,750 | PER CAPITA: $8.94 | -20.72% IN TOTAL PAYOUTS FROM 2016

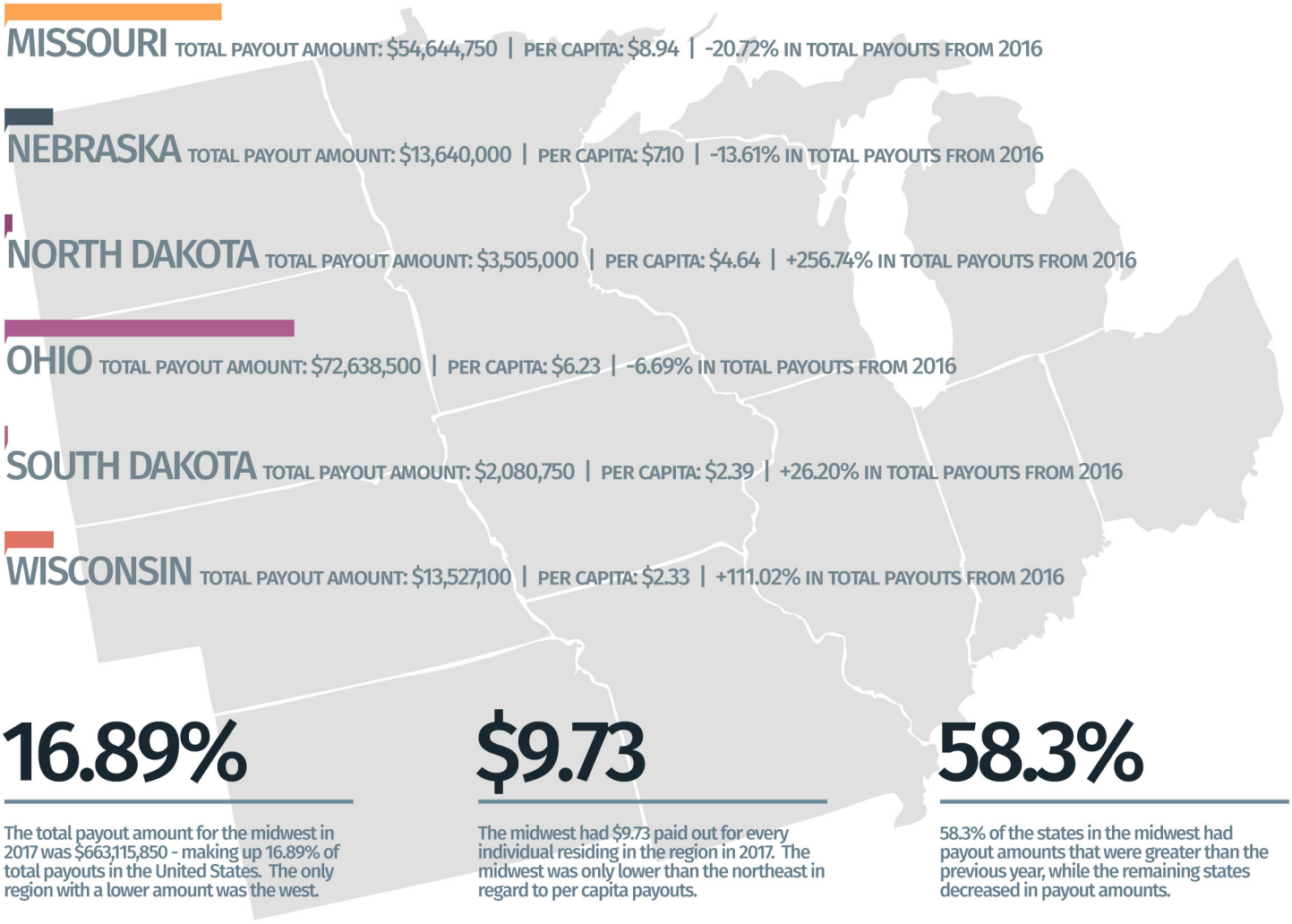
NEBRASKA TOTAL PAYOUT AMOUNT: $13,640,000 | PER CAPITA: $7.10 | -13.61% IN TOTAL PAYOUTS FROM 2016

NORTH DAKOTA TOTAL PAYOUT AMOUNT: $3,505,000 | PER CAPITA: $4.64 | +256.74% IN TOTAL PAYOUTS FROM 2016

OHIO TOTAL PAYOUT AMOUNT: $72,638,500 | PER CAPITA: $6.23 | -6.69% IN TOTAL PAYOUTS FROM 2016

SOUTH DAKOTA TOTAL PAYOUT AMOUNT: $2,080,750 | PER CAPITA: $2.39 | +26.20% IN TOTAL PAYOUTS FROM 2016

WISCONSIN TOTAL PAYOUT AMOUNT: $13,527,100 | PER CAPITA: $2.33 | +111.02% IN TOTAL PAYOUTS FROM 2016



16.89%

The total payout amount for the midwest in 2017 was $663,115,850 - making up 16.89% of total payouts in the United States. The only region with a lower amount was the west.

$9.73

The midwest had $9.73 paid out for every individual residing in the region in 2017. The midwest was only lower than the northeast in regard to per capita payouts.

58.3%

58.3% of the states in the midwest had payout amounts that were greater than the previous year, while the remaining states decreased in payout amounts.

SOUTHERN UNITED STATES

Taking a closer look at the southern United States of America in regard to medical malpractice payouts.

ALABAMA TOTAL PAYOUT AMOUNT: $24,330,000 | PER CAPITA: $4.99 | -6.89% IN TOTAL PAYOUTS FROM 2016

ARKANSAS TOTAL PAYOUT AMOUNT: $19,649,050 | PER CAPITA: $6.54 | -28.62% IN TOTAL PAYOUTS FROM 2016

FLORIDA TOTAL PAYOUT AMOUNT: $260,480,550 | PER CAPITA: $12.41 | +17.01% IN TOTAL PAYOUTS FROM 2016

GEORGIA TOTAL PAYOUT AMOUNT: $148,249,800 | PER CAPITA: $14.21 | +24.80% IN TOTAL PAYOUTS FROM 2016

KENTUCKY TOTAL PAYOUT AMOUNT: $43,399,100 | PER CAPITA: $9.74 | +17.11% IN TOTAL PAYOUTS FROM 2016

LOUISIANA TOTAL PAYOUT AMOUNT: $68,145,250 | PER CAPITA: $14.55 | +56.03% IN TOTAL PAYOUTS FROM 2016

MISSISSIPPI TOTAL PAYOUT AMOUNT: $18,070,250 | PER CAPITA: $6.06 | -24.02% IN TOTAL PAYOUTS FROM 2016

NORTH CAROLINA TOTAL PAYOUT AMOUNT: $41,342,000 | PER CAPITA: $4.02 | +33.17% IN TOTAL PAYOUTS FROM 2016

OKLAHOMA TOTAL PAYOUT AMOUNT: $33,430,800 | PER CAPITA: $8.50 | -15.35% IN TOTAL PAYOUTS FROM 2016

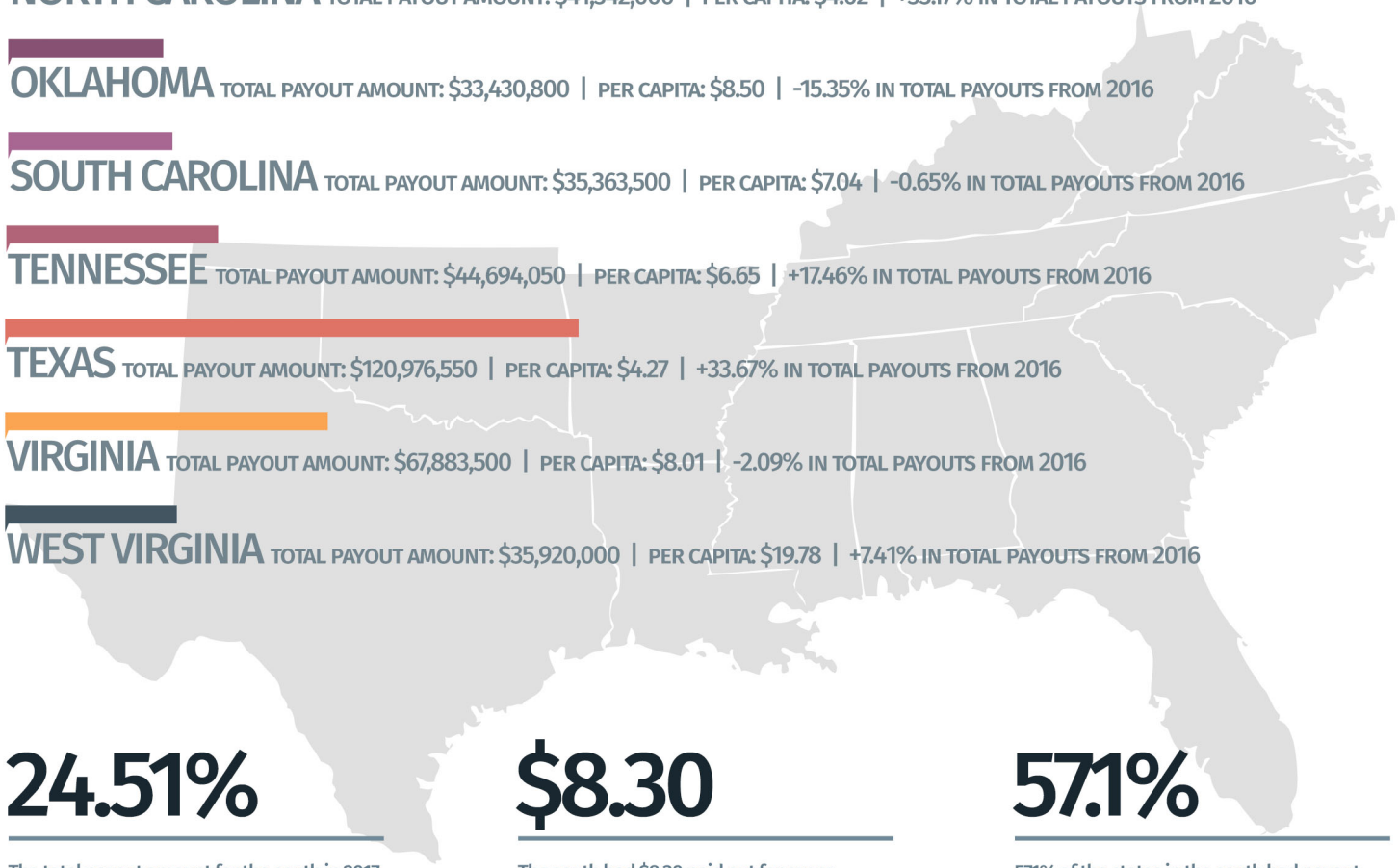
SOUTH CAROLINA TOTAL PAYOUT AMOUNT: $35,363,500 | PER CAPITA: $7.04 | -0.65% IN TOTAL PAYOUTS FROM 2016

TENNESSEE TOTAL PAYOUT AMOUNT: $44,694,050 | PER CAPITA: $6.65 | +17.46% IN TOTAL PAYOUTS FROM 2016

TEXAS TOTAL PAYOUT AMOUNT: $120,976,550 | PER CAPITA: $4.27 | +33.67% IN TOTAL PAYOUTS FROM 2016

VIRGINIA TOTAL PAYOUT AMOUNT: $67,883,500 | PER CAPITA: $8.01 | -2.09% IN TOTAL PAYOUTS FROM 2016

WEST VIRGINIA TOTAL PAYOUT AMOUNT: $35,920,000 | PER CAPITA: $19.78 | +7.41% IN TOTAL PAYOUTS FROM 2016



24.51%

The total payout amount for the south in 2017 was $961,934,400 - making up 24.51% of total payout amounts in the United States for 2017.

$8.30

The south had $8.30 paid out for every individual residing in the region in 2017.

57.1%

57.1% of the states in the south had payout amounts that were greater than the previous year, while the remaining states decreased in payout amounts.

WESTERN UNITED STATES

Taking a closer look at the western United States of America in regard to medical malpractice payouts.

ALASKA TOTAL PAYOUT AMOUNT: $8,270,000 | PER CAPITA: $11.18 | +111.1% IN TOTAL PAYOUTS FROM 2016

ARIZONA TOTAL PAYOUT AMOUNT: $71,970,550 | PER CAPITA: $10.26 | +16% IN TOTAL PAYOUTS FROM 2016

CALIFORNIA TOTAL PAYOUT AMOUNT: $260,668,400 | PER CAPITA: $6.59 | +10.48% IN TOTAL PAYOUTS FROM 2016

COLORADO TOTAL PAYOUT AMOUNT: $32,402,500 | PER CAPITA: $5.78 | -5.4% IN TOTAL PAYOUTS FROM 2016

HAWAII TOTAL PAYOUT AMOUNT: $25,755,750 | PER CAPITA: $18.04 | +95.75% IN TOTAL PAYOUTS FROM 2016

IDAHO TOTAL PAYOUT AMOUNT: $11,478,750 | PER CAPITA: $6.69 | -55.82% IN TOTAL PAYOUTS FROM 2016

MONTANA TOTAL PAYOUT AMOUNT: $18,436,500 | PER CAPITA: $17.55 | +80.66% IN TOTAL PAYOUTS FROM 2016

NEVADA TOTAL PAYOUT AMOUNT: $22,084,000 | PER CAPITA: $7.37 | +2.65% IN TOTAL PAYOUTS FROM 2016

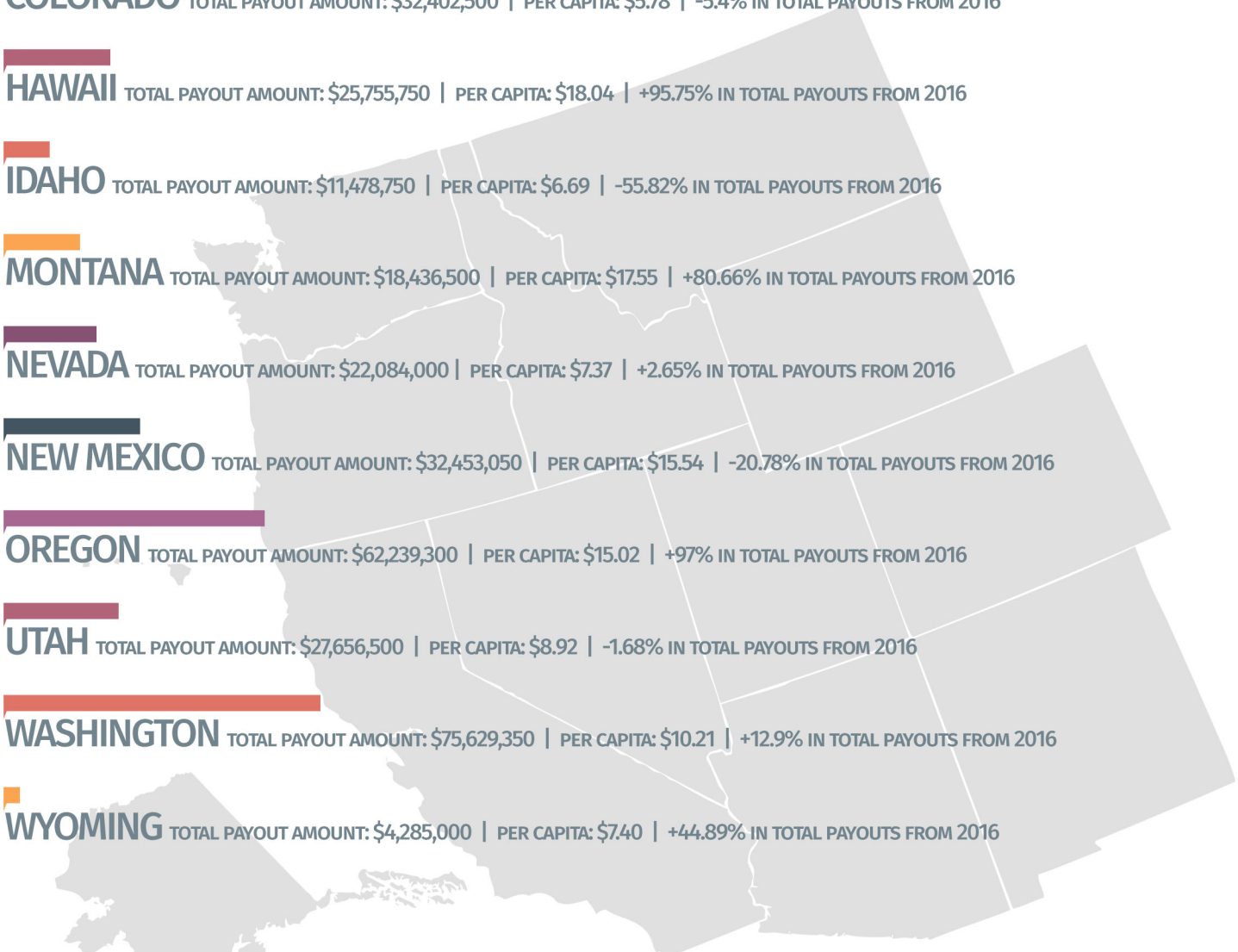
NEW MEXICO TOTAL PAYOUT AMOUNT: $32,453,050 | PER CAPITA: $15.54 | -20.78% IN TOTAL PAYOUTS FROM 2016

OREGON TOTAL PAYOUT AMOUNT: $62,239,300 | PER CAPITA: $15.02 | +97% IN TOTAL PAYOUTS FROM 2016

UTAH TOTAL PAYOUT AMOUNT: $27,656,500 | PER CAPITA: $8.92 | -1.68% IN TOTAL PAYOUTS FROM 2016

WASHINGTON TOTAL PAYOUT AMOUNT: $75,629,350 | PER CAPITA: $10.21 | +12.9% IN TOTAL PAYOUTS FROM 2016

WYOMING TOTAL PAYOUT AMOUNT: $4,285,000 | PER CAPITA: $7.40 | +44.89% IN TOTAL PAYOUTS FROM 2016



16.65%

The total payout amount for the west in 2017 was $653,329,650 - making up 16.65% of total payouts in the USA.

$8.44

The west had $8.44 paid out for every individual residing in the region in 2017.

69.2%

69.2% of the states in the west had payout amounts that were greater than the previous year, while the remaining states decreased in payout amounts.

REFERENCES & NOTES

Where the data came from and how it was analyzed.

"National Practitioner Data Bank Public Use Data File"
September 1, 1990 - December 31, 2017
U.S. Department of Health and Human Services

All data not pertaining to the 50 United States of America and the District of Columbia were removed for the purposes of this analysis.

State data was determined by evaluating Work State (workstat), Home State (homestat) and Licensure State (licnstat), in that order.

Figures used for the 'per capita' statistics are based on July 2017 population estimates from the U.S. Census Bureau:

> Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2017 (NST-EST2017-01)
> Source: U.S. Census Bureau, Population Division
> Release Date: December 2017

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Diederich Healthcare's network of over two-hundred contracted insurance affiliates assures healthcare clients greater portability, market accessibility, and effective consultation. Diederich Healthcare provides comprehensive medical malpractice insurance and consulting services to over 13,000 healthcare providers throughout the United States , Guam , and Puerto Rico . Through Diederich's 13 U.S. regional offices and multiple sales and service centers, the company strives to provide superior client services. As a leader in the industry for almost 40 years, our goal is to deliver cost-effective quality insurance to our physician clients. To obtain a quote for medical malpractice insurance, please call us at 800-457-7790 or complete a quote form at:

http://www.diederichhealthcare.com/get-a-quote/