

Matsuyama v. Birnbaum
890 N.E.2d 819 (Mass. 2008)

MARSHALL, C.J. We are asked to determine whether Massachusetts law permits recovery for a "loss of chance" in a medical malpractice wrongful death action, where a jury found that the defendant physician's negligence deprived the plaintiff's decedent of a less than even chance of surviving cancer. We answer in the affirmative. As we later explain more fully, the loss of chance doctrine views a person's prospects for surviving a serious medical condition as something of value, even if the possibility of recovery was less than even prior to the physician's tortious conduct. Where a physician's negligence reduces or eliminates the patient's prospects for achieving a more favorable medical outcome, the physician has harmed the patient and is liable for damages. Permitting recovery for loss of chance is particularly appropriate in the area of medical negligence. Our decision today is limited to such claims.

The case before us was tried before a jury in the Superior Court. In response to special questions, the jury found the defendant physician negligent in misdiagnosing the condition of the decedent over a period of approximately three years. They found as well that the physician's negligence was a "substantial contributing factor" to the decedent's death. They awarded \$160,000 to the decedent's estate for the pain and suffering caused by the physician's negligence, and \$328,125 to the decedent's widow and son for the decedent's loss of chance. The defendants appealed, asserting, among other things, that loss of chance was not cognizable under the Massachusetts wrongful death statute, see G. L. c. 229, §§ 2 and 6, or otherwise. We granted their application for direct appellate review.

We conclude that recognizing loss of chance in the limited domain of medical negligence advances the fundamental goals and principles of our tort law. We also conclude that recognizing a cause of action from loss of chance of survival under the wrongful death statute comports with the common law of wrongful death as it has developed in the Commonwealth. *See Gaudette v. Webb*, 362 Mass. 60, 71 (1972) (recognizing common-law origin of wrongful death actions in Commonwealth). The application of the doctrine to the evidence in this case supported the jury's findings as to loss of chance liability. Finally, although we determine that some portions of the jury instructions do not conform in all respects to the guidelines we set out below, they were broadly consistent with our decision today. Accordingly, we affirm.

1. Background. On the record before us, the jury could have found the following: the defendant, Dr. Neil S. Birnbaum, a board-certified internist and president of the board of the codefendant, Dedham Medical Associates, Inc. (Medical Associates), became the primary care physician of the decedent, Kimiyoshi Matsuyama, in July, 1995, when the forty-two year old Matsuyama presented himself for a routine physical examination. Matsuyama's medical records at the time of his initial visit to Birnbaum disclosed complaints of gastric distress dating back to 1988. The records also indicated that in 1994 Matsuyama's previous physician had noted that Matsuyama might need an upper

gastrointestinal series or small bowel follow-through further to evaluate his symptoms. [Birnbaum followed Matsuyama as a patient between 1995-99. The facts suggest that Birnbaum failed to view certain symptoms, such as Matsuyama's severe stomach pain and skin moles, as warranting concern over cancer.]

When Matsuyama . . . appeared in Birnbaum's office in November, 1998, for a routine checkup and followup, Birnbaum noted that the patient "was feeling better" and had no "significant symptoms" of gastric distress. Such was not the case on May 3, 1999, when Matsuyama went to Birnbaum complaining of epigastric pain, vomiting, sudden weight loss, and premature feelings of fullness after eating. Birnbaum ordered a gastrointestinal series and an abdominal ultrasound, which revealed a two-centimeter mass in Matsuyama's stomach. Subsequent medical procedures confirmed the presence of infiltrative gastric adenoid carcinoma, signet ring cell type. Matsuyama then began treatment with specialists. He succumbed to gastric cancer the following October, leaving his wife and his minor son.

In June, 2000, the plaintiff filed suit against Birnbaum and Medical Associates. Her complaint, as amended, alleged wrongful death, breach of contract, and negligence against both defendants. Trial began in the Superior Court in July, 2004. The jury heard testimony from, among others, the plaintiff's expert witness, Dr. Stuart Ira Finkel, a gastroenterologist. Finkel testified that, in his opinion, Birnbaum breached the applicable standard of care in evaluating and treating Matsuyama, resulting in Matsuyama's death. Specifically, Finkel opined that, in light of Matsuyama's complaints, symptoms, and risk factors, including the presence of *H. pylori*, his Japanese ancestry, his having lived in Japan or Korea for extended periods, his smoking history, and other well-known risk factors, an internist exercising the expected standard of care would have ordered an upper gastrointestinal series X-ray or an endoscopy, or referred Matsuyama to a specialist for endoscopy, beginning in 1995. The expert also testified that the appearance of Matsuyama's seborrheic keratosis in September, 1997, "could have and should have" triggered a suspicion of stomach cancer "right then and there." Finkel told the jury that if Birnbaum had ordered the appropriate testing on Matsuyama in 1995, the cancer "would have been diagnosed" and "treated in a timely fashion when it might still have been curable." As a result of Birnbaum's failure to make a timely diagnosis, Finkel opined, the cancer metastasized to an advanced, inoperable phase, resulting in Matsuyama's premature death.

In the course of his testimony, Finkel offered an extensive discussion of the tumor-lymph nodes-metastasis (TNM) method for classifying gastric cancer into separate "stages," from stage 0 to stage 4, with each higher stage signaling a more advanced cancer and carrying a statistically diminished chance for survival, as measured by the standard gastric cancer metric of five years cancer free after treatment. Patients with stage 0, in which the cancer is confined to the stomach lining, have a better than 90% survival rate, Finkel averred; at stage 1, the survival rate drops to between 60% and 80%; at stage 2, between 30% and 50%; at stage 3, between 10% and 20%; and at stage 4, less than 4%. Finkel opined that, as a result of Birnbaum's breach of the standard of care,

Matsuyama lost the opportunity of having gastric cancer "diagnosed and treated in a timely fashion when it might still have been curable."

Dr. Mark Peppercorn, a gastroenterologist, testified as an expert for the defense. He testified that Birnbaum did not deviate from the accepted standard of care over the course of his treatment of Matsuyama; that Matsuyama's type of stomach cancer had "a different biology, a different characteristic from garden variety, if you want to use that poor term, cancer"; and that his type of cancer did not manifest symptoms until it was in an advanced stage. Peppercorn testified that staging of cancers is done by oncologists for treatment, not actuarial, purposes, with the following presumed five-year survival rates: at stage 1, from 60% to 90%; at stage 2, 25% to 40%; at stage 3, up to 10%; and at stage 4, "practically zero; less than [5%], probably."

In addition to the medical expert testimony, the jury heard testimony from the plaintiff's forensic economist . . . [who testified that] had Matsuyama attained his full work life and life expectancies, he would have contributed \$623,460 to his household. . . .

After a six-day trial, the case went to the jury. In response to special questions, the jury found Birnbaum negligent in Matsuyama's treatment, but found him not grossly negligent. They also found that Birnbaum's negligence was a "substantial contributing factor" to Matsuyama's death, and awarded Matsuyama's estate \$160,000 for pain and suffering caused by the negligence. Then, in response to a special jury question . . . the jury awarded damages for loss of chance, which they calculated as follows: they awarded \$875,000 as "full" wrongful death damages, and found that Matsuyama was suffering from stage 2 adenocarcinoma at the time of Birnbaum's initial negligence and had a 37.5% chance of survival at that time. They awarded the plaintiff "final" loss of chance damages of \$328,125 (\$875,000 multiplied by .375). Judgment entered against the defendants, jointly and severally, on the negligence- wrongful death count in the amount of \$328,125, later amended to \$281,310. A separate judgment entered against the defendants, jointly and severally, for damages in the amount of \$160,000 on the counts for conscious pain and suffering.

2. Loss of chance. Although we address the issue for the first time today, a substantial and growing majority of the States that have considered the question have indorsed the loss of chance doctrine, in one form or another, in medical malpractice actions.²³ We join that majority to ensure that the fundamental aims and principles of our

²³ The highest courts of at least twenty States and the District of Columbia have adopted the loss of chance doctrine. See *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597 (1984); *Ferrell v. Rosenbaum*, 691 A.2d 641 (D.C. 1997); *Holton v. Memorial Hosp.*, 176 Ill. 2d 95 (1997); *Cahoon v. Cummings* 734 N.E.2d 535 (Ind. 2000); *DeBurkate v. Louvar*, 393 N.W.2d 131 (Iowa 1986); *Delaney v. Cade*, 255 Kan. 199 (1994); *Hastings v. Baton Rouge Gen. Hosp.*, 498 So. 2d 713, 720-722 (La. 1986); *Wollen v. DePaul Health Ctr.*, 828 S.W.2d 681 (Mo. 1992); *Aasheim v. Humberger*, 215 Mont. 127 (1985); *Perez v. Las Vegas Med. Ctr.*, 107 Nev. 1 (1991); *Evers v. Dollinger*, 95 N.J. 399 (1984); *Alberts v. Schultz*, 126 N.M. 807 (1999); *Roberts v. Ohio Permanente Med. Group, Inc.*, 76 Ohio St. 3d 483 (1996); *McKellips v. Saint Francis Hosp., Inc.*, 741 P.2d 467 (Okla. 1987); *Hamil v. Bashline*, 481 Pa. 256 (1978); *Jorgenson v. Vener*, 616 N.W.2d 366 (S.D. 2000); *Brown v. Koulizakis*, 229 Va. 524 (1985); *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wash. 2d 609 (1983); *Thornton v. CAMC*, 172 W. Va. 360

tort law remain fully applicable to the modern world of sophisticated medical diagnosis and treatment.

The development of the loss of chance doctrine offers a window into why it is needed. The doctrine originated in dissatisfaction with the prevailing "all or nothing" rule of tort recovery. See generally King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, Yale L.J. 1353, 1365-1366 (1981) (King I). Under the all or nothing rule, a plaintiff may recover damages only by showing that the defendant's negligence more likely than not caused the ultimate outcome, in this case the patient's death; if the plaintiff meets this burden, the plaintiff then recovers 100% of her damages. Thus, if a patient had a 51% chance of survival, and the negligent misdiagnosis or treatment caused that chance to drop to zero, the estate is awarded full wrongful death damages. On the other hand, if a patient had a 49% chance of survival, and the negligent misdiagnosis or treatment caused that chance to drop to zero, the plaintiff receives nothing. So long as the patient's chance of survival before the physician's negligence was less than even, it is logically impossible for her to show that the physician's negligence was the but-for cause of her death, so she can recover nothing. Thus, the all or nothing rule provides 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." *Herskovits v. Group Health Coop. of Puget Sound*, 99 Wash. 2d 609, 614 (1983).

(1983); *Ehlinger v. Sipes*, 155 Wis. 2d 1 (1990); *McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094 (Wyo. 2003), S.C., 88 P.3d 491 (Wyo. 2004). One additional State's high court recognized loss of chance, *Falcon v. Memorial Hosp.*, 436 Mich. 443 (1990), but the Legislature subsequently amended its medical malpractice statute to state that a "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%." Mich. Comp. Laws Ann. § 600.2912a(2) (West), as amended by 193 Mich. Pub. Acts 78, § 1, (effective April 1, 1994). See also *Boone v. William W. Backus Hosp.*, 272 Conn. 551 (2005) (adopting loss of chance doctrine, but also apparently retaining requirement that decedent "had at least a 51 percent chance of survival" prior to negligence).

Ten States' high courts have, in contrast, refused to adopt the loss of chance doctrine. See *Gooding v. University Hosp. Bldg., Inc.*, 445 So. 2d 1015 (Fla. 1984); *Manning v. Twin Falls Clinic & Hosp., Inc.*, 830 P.2d 1185 (Idaho 1992); *Fennell v. Southern Md. Hosp. Ctr., Inc.*, 320 Md. 776 (1990); *Fabio v. Bellomo*, 504 N.W.2d 758, 762 (Minn. 1993) ("We have never recognized loss of chance in the context of a medical malpractice action, and we decline to recognize it in this case"); *Ladner v. Campbell*, 515 So. 2d 882 (Miss. 1987); *Pillsbury-Flood v. Portsmouth Hosp.*, 512 A.2d 1126 (N.H. 1986); *Kilpatrick v. Bryant*, 868 S.W.2d 594, 602-603 (Tenn. 1993); *Kramer v. Lewisville Memorial Hosp.*, 858 S.W.2d 397, 402-407 (Tex. 1993); *Jones v. Owings*, 318 S.C. 72 (1995); *Smith v. Parrott*, 175 Vt. 375 (2003). Two other States' high courts have held that loss of chance claims are incompatible with their States' wrongful death statutes, but have not decided whether loss of chance claims are otherwise actionable. See *United States v. Cumberbatch*, 647 A.2d 1098, 1102-1104 (Del. 1994); *Joshi v. Providence Health Sys. of Or. Corp.*, 342 Or. 152 (2006).

Other States' high courts have not addressed the issue or have explicitly left the question open. See, e.g., *Holt v. Wagner*, 344 Ark. 691 (2001) ("not closing the door to the future adoption of one of the versions of lost chance of survival" when issue is properly presented). The Draft Restatement, *supra* at § 26 comment n, discusses loss of chance but "takes no position on this matter, leaving it for future development and future Restatements."

As many courts and commentators have noted, the all or nothing rule is inadequate to advance the fundamental aims of tort law. . . . Fundamentally, the all or nothing approach does not serve the basic aim of "fairly allocating the costs and risks of human injuries," *O'Brien v. Christensen*, 422 Mass. 281, 288 (1996), quoting *Vertentes v. Barletta Co.*, 392 Mass. 165, 171 (1984) (Abrams, J., concurring). See *King I*, supra at 1377 (all or nothing rule places loss of chance losses "outside tort law," thereby "distort[ing] the loss-assigning role of tort law"). The all or nothing rule "fails to deter" medical negligence because it immunizes "whole areas of medical practice from liability." *McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094, 1099 (Wyo. 2003), S.C., 88 P. 3d 491 (Wyo 2004). It fails to provide the proper incentives to ensure that the care patients receive does not slip below the "standard of care and skill of the average member of the profession practising the specialty." *Brune v. Belinkoff*, 354 Mass. 102, 109 (1968). And the all or nothing rule fails to ensure that victims, who incur the real harm of losing their opportunity for a better outcome, are fairly compensated for their loss

Courts adopting the loss of chance doctrine also have noted that, because a defendant's negligence effectively made it impossible to know whether the person would have achieved a more favorable outcome had he received the appropriate standard of care, it is particularly unjust to deny the person recovery for being unable "to demonstrate to an absolute certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass." *Hicks v. United States*, 368 F.2d 626, 632 (4th Cir. 1966).

Despite general agreement on the utility of the loss of chance doctrine, however, courts adopting it have not approached loss of chance in a uniform way.²⁸ See Annot., *Medical Malpractice: "Loss of Chance" Causality*, 54 A.L.R.4th 10 (1987 & Supp. 2008) (encyclopedic discussion of cases adopting distinct approaches). The unsettled boundaries of the doctrine have left it open to criticisms similar to those that the defendants have leveled here: that the loss of chance doctrine 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. . . . While these objections deserve serious consideration, the doctrine of loss of chance, when properly formulated, survives these criticisms.

Addressing the specific arguments advanced by the defendants is useful for delineating the proper shape of the doctrine. The defendants argue that the loss of chance

²⁸ Some courts have relied on § 323 of the Restatement (Second) of Torts (1965) in recognizing loss of chance. See, e.g., *DeBurkate v. Louvar*, 393 N.W.2d 131, 135 (Iowa 1986); *McKellips v. St. Francis Hosp., Inc.*, 741 P.2d 467, 474-475 (Okla. 1987); *Hamil v. Bashline*, 481 Pa. 256 (1978). We are in accord with the position taken by the Draft Restatement, supra at § 26, Reporters' Note to comment n, that this reliance is misplaced. Section 323 of the Restatement (Second) imposes a duty of reasonable care on the part of those who "undertake[], gratuitously or for consideration, to render services to another," and imposes liability on such persons for "harm resulting" when "failure to exercise such care increases the risk of such harm." *Id.* However, § 323 is silent on the question whether loss of chance itself is a form of harm. The placement of § 323 in Topic 7, "Duties of Affirmative Action," rather than in a topic concerning harm or causation, illustrates that § 323 is not an appropriate source for the doctrine of loss of chance. *Id.*

doctrine "lowers the threshold of proof of causation" by diluting the preponderance of the evidence standard that "has been the bedrock of the Massachusetts civil justice system." Some courts have indeed approached the issue of how to recognize loss of chance by carving out an exception to the rule that the plaintiff must prove by a preponderance of the evidence that the defendant "caused" his injuries. See, e.g., *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597, 607-608 (1984) (adopting rule that "permits the case to go to the jury on the issue of causation with less definite evidence of probability than the ordinary tort case," and requiring jury to "find for the defendant unless they find a probability that defendant's negligence was a cause of plaintiff's injury" [emphasis in original]). We reject this approach. "It is fundamental that the plaintiff bears the burden of establishing causation by a preponderance of the evidence." *Johnson v. Summers*, 411 Mass. 82, 91 (1991). Therefore, in a case involving loss of chance, as in any other negligence context, a plaintiff must establish by a preponderance of the evidence that the defendant caused his injury.

However, "injury" need not mean a patient's death. Although there are few certainties in medicine or in life, progress in medical science now makes it possible, at least with regard to certain medical conditions, to estimate a patient's probability of survival to a reasonable degree of medical certainty. . . . That probability of survival is part of the patient's condition. When a physician's negligence diminishes or destroys a patient's chance of survival, the patient has suffered real injury. The patient has lost something of great value: a chance to survive, to be cured, or otherwise to achieve a more favorable medical outcome. See *Herskovits v. Group Health Coop. of Puget Sound*, supra at 618, quoting *James v. United States*, 483 F. Supp. 581, 587 (N.D. Cal. 1980) ("no one can say that the chance of prolonging one's life or decreasing suffering is valueless"). Thus we recognize loss of chance not as a theory of causation, but as a theory of injury. .

Recognizing loss of chance as a theory of injury is consistent with our law of causation, which requires that plaintiffs establish causation by a preponderance of the evidence. See *Johnson v. Summers*, supra at 91. See also *Woronka v. Sewall*, 320 Mass. 362, 365 (1946). In order to prove loss of chance, a plaintiff must prove by a preponderance of the evidence that the physician's negligence caused the plaintiff's likelihood of achieving a more favorable outcome to be diminished. That is, the plaintiff must prove by a preponderance of the evidence that the physician's negligence caused the plaintiff's injury, where the injury consists of the diminished likelihood of achieving a more favorable medical outcome The loss of chance doctrine, so delineated, makes no amendment or exception to the burdens of proof applicable in all negligence claims.

We reject the defendants' contention that a statistical likelihood of survival is a "mere possibility" and therefore "speculative." The magnitude of a probability is distinct from the degree of confidence with which it can be estimated. A statistical survival rate cannot conclusively determine whether a particular patient will survive a medical condition. But survival rates are not random guesses. They are estimates based on data obtained and analyzed scientifically and accepted by the relevant medical community as part of the repertoire of diagnosis and treatment, as applied to the specific facts of the

plaintiff's case. . . .Where credible evidence establishes that the plaintiff's or decedent's probability of survival is 49%, that conclusion is no more speculative than a conclusion, based on similarly credible evidence, that the probability of survival is 51%.

The defendants also point out that "[t]he cause, treatment, cure and survivability related to cancer is tremendously uncertain and complex," and argue that loss of chance is "rife with practical complexities and problems." Such 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. Wrongful death claims, for example, often require, as part of the damages calculation, an estimate of how long the decedent might have lived absent the defendant's conduct. The calculation of damages in a claim for lost business opportunities may be similarly complex. See, e.g., *Roblin Hope Indus., Inc. v. J.A. Sullivan Corp.* (No. 2), 11 Mass. App. Ct. 76, 79 (1980).

The key is the reliability of the evidence available to the fact finder. In earlier periods, Massachusetts courts grappling with what we would now call loss of chance claims often lacked reliable expert evidence of what the patient's chances of survival or recovery would have been absent the alleged negligence. See, e.g., *Wright v. Clement*, 287 Mass. 175, 176 (1934) (affirming directed verdict for defendant despite evidence of negligent failure to diagnose scarlet fever and negligence in moving decedent from maternity ward because "there is nothing to show any probability that [the patient] would have recovered or lived longer or suffered less, if due care had been used"). More recently, as we noted above, at least for certain conditions, medical science has progressed to the point that physicians can gauge a patient's chances of survival to a reasonable degree of medical certainty, and indeed routinely use such statistics as a tool of medicine. Reliable modern techniques of gathering and analyzing medical data have made it possible for fact finders to determine based on expert testimony -- rather than speculate based on insufficient evidence -- whether a negligent failure to diagnose a disease injured a patient by preventing the disease from being treated at an earlier stage, when prospects were more favorable. . . .The availability of such expert evidence on probabilities of survival makes it appropriate to recognize loss of chance as a form of injury. . . .Through appropriate expert evidence, a plaintiff in a medical malpractice case may be able to sustain her burden of showing that, as a result of defendant's negligence, a decedent suffered a diminished likelihood of achieving a more favorable medical outcome.

We are unmoved by the defendants' argument that "the ramifications of adoption of loss of chance are immense" across "all areas of tort." We emphasize that our decision today is limited to loss of chance in medical malpractice actions. Such cases are particularly well suited to application of the loss of chance doctrine. See Restatement (Third) of Torts: Liability for Physical Harm § 26 comment n (Proposed Final Draft No. 1, 2005) comment n (Draft Restatement). First, as we noted above, reliable expert evidence establishing loss of chance is more likely to be available in a medical malpractice case than in some other domains of tort law. *Id.* Second, medical negligence that harms the patient's chances of a more favorable outcome contravenes the expectation

at the heart of the doctor-patient relationship that "the physician will take every reasonable measure to obtain an optimal outcome for the patient." *Id.* See K.S. Abraham, *Forms and Functions of Tort Law* 117-118 (3d ed. 2007) (discussing argument that "health care providers undertake to maximize a patient's chances of survival, [and so] their failure to do so should be actionable. Ordinary actors who negligently risk causing harm have not undertaken such a duty"). Third, it is not uncommon for patients to have a less than even chance of survival or of achieving a better outcome when they present themselves for diagnosis, so the shortcomings of the all or nothing rule are particularly widespread. Finally, failure to recognize loss of chance in medical malpractice actions forces the party who is the least capable of preventing the harm to bear the consequences of the more capable party's negligence. See Draft Restatement, *supra* at 326 comment n.

In sum, whatever difficulties may attend recognizing loss of chance as an item of damages in a medical malpractice action, these difficulties are far outweighed by the strong reasons to adopt the doctrine

4. Damages. Our conclusion that loss of chance is a separate, compensable item of damages in an action for medical malpractice does not fully resolve the issues on appeal. We must consider, among other things, how the loss of the likelihood of a more favorable outcome is to be valued. The first question is what is being valued. In this case, the patient's prospects for achieving a more favorable outcome were measured in terms of the patient's likelihood of surviving for a number of years specified by the relevant medical standard: for gastric cancer, the five- year survival rate. There is no single measure that will apply uniformly to all medical malpractice cases. . . . Precisely what yardstick to use to measure the reduction in the decedent's prospects for survival -- life expectancy, five-year survival, ten-year survival, and so on -- is a question on which the law must inevitably bow to some extent to the shape of the available medical evidence in each particular case. See *McMackin v. Johnson County Healthcare Ctr.*, 73 P.3d 1094, 1100 (Wyo. 2003) (noting that "no clear-cut rule" can govern all measures of damages in loss of chance cases).

A second, more challenging issue is how to calculate the monetary value for the lost chance. Courts adopting the loss of chance doctrine have arrived at different methods for calculating such damages. See generally *Mead v. Adrian*, 670 N.W.2d 174, 187- 189 (Iowa 2003) (Cady, J., concurring specially). The most widely adopted of these methods of valuation is the "proportional damages" approach. See *Cahoon v. Cummings*, 734 N.E.2d 535, 541 (Ind. 2000), and cases cited (holding that proportional damages is "the better approach"). . . . Under the proportional damages approach, loss of chance damages are measured as "the percentage probability by which the defendant's tortious conduct diminished the likelihood of achieving some more favorable outcome." *King I*, *supra* at 1382. The formula aims to ensure that a defendant is liable in damages only for the monetary value of the portion of the decedent's prospects that the defendant's negligence destroyed. In applying the proportional damages method, the court must first measure the monetary value of the patient's full life expectancy and, if relevant, work life expectancy as it would in any wrongful death case. But the defendant must then be held liable only for the portion of that value that the defendant's negligence destroyed

To illustrate, suppose in a wrongful death case that a jury found, based on expert testimony and the facts of the case, that full wrongful death damages would be \$600,000 (step 1), that the patient had a 45% chance of survival prior to the medical malpractice (step 2), and that the physician's tortious acts reduced the chances of survival to 15% (step 3). The patient's chances of survival were reduced 30% (i.e., 45% minus 15%) due to the physician's malpractice (step 4), and the patient's loss of chance damages would be \$600,000 multiplied by 30%, for a total of \$180,000 (step 5)

[F]or the reasons we have stated above, the judge did not commit reversible error in instructing on the viability of loss of chance as an item of damages, and he correctly chose to apply the proportional method to determine damages for Matsuyama's loss of chance. In conformity with the formula we have set out supra, he also required on the special jury questions that the jury determine full wrongful death damages and the percentage of Matsuyama's chances of survival but for Birnbaum's negligence. We recognize that the judge did not complete the proportional instruction we outlined above. As the defendants point out, the judge did not require the jury to determine Matsuyama's chance of survival as a result of Birnbaum's negligence, and to subtract that figure from Matsuyama's chance of survival prior to the negligence. In terms of the formula discussed supra, the judge correctly instructed the jury as to step 1 and step 2, but omitted steps 3 and 4. This compelled the jury to assume that Birnbaum's negligence (if any) reduced Matsuyama's chances of survival to zero: \$875,000 multiplied by (.375 minus 0) equals \$328,125, the damages awarded for loss of chance. In fact, the conflicting testimony at trial was that as a result of Birnbaum's negligence, Matsuyama had anywhere from 0 to a 5% chance of survival. The judge should not have removed from the jury's consideration the question whether and to what extent Birnbaum's negligence left Matsuyama with any chance of survival, both critical factors in valuing Matsuyama's lost chance. . . .

However, a remand will not be necessary. The record before us shows that both prior to and after the jury instructions, the defendants objected to question 6, not on the ground of the judge's apportionment formula but on more general, and wholly different, grounds. This lack of a specific objection on point is fatal to their detailed objection on appeal

Judgment affirmed.

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NOTES AND QUESTIONS

1. *Matsuyama* offers a more nuanced defense of restricting loss of a chance to the medical malpractice context than *Falcon*. Review the four reasons offered by the Massachusetts court for this limitation. Isn't the fourth reason true for many familiar tort contexts (especially products liability)?

2. In note 28 the court rejects Section 323 of the Restatement (Second) as a basis for its loss of a chance argument. Is this consistent with its endorsement of Prof. Abraham's comment that "health care providers undertake to maximize a patient's chances of survival, [and so] their failure to do so should be actionable?"

3. For more on *Matsuyama*, see Prof. Sebok's commentary about this case at:

<http://writ.news.findlaw.com/sebok/20080805.html>