IN THE SUPREME COURT OF THE STATE OF OREGON

JOSEPH L. SMITH,
Plaintiff- Appellant,
Petitioner on Review,

v.

PROVIDENCE HEALTH SERVICES – OREGON, dba Providence Hood River Memorial Hospital, dba Providence Medical Group; LINDA L. DESITTER, MD; MICHAEL R. HARRIS, MD; HOOD RIVER EMERGENCY PHYSICIANS, LLC; and HOOD RIVER MEDICAL GROUP, PC,
Defendants-Respondents
Respondents on Review,

And

PROVIDENCE MEDICAL GROUP, fka Hood River Medical Group, PC; and HOOD RIVER MEDICAL GROUP, PC,
Defendants.

Multnomah County Circuit Court
Case No. 1302-02067

CA A155336

SC S063358

BRIEF ON THE MERITS OF *AMICI CURIAE* OREGON MEDICAL ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION

On Review of the Decision of the Court of Appeals, April 18, 2015
Before Devore, J., Ortega, P.J., and Garrett, J.
In an Appeal from Judgment of Dismissal of the Circuit Court for Multnomah County Entered September 24, 2013
Honorable Nan G. Waller

December 2015

Stephen C. Hendricks, OSB #792653
Hendricks Law Firm PC
1425 SW 20th Ave., Suite 201
Portland, OR 97201
503-241-5629
schendricks@hendrickslawfirm.com
Attorney for Petitioner on Review
Joseph L. Smith

Jay W. Beattie, OSB #871631
Lindsay Hart LLP
1300 SW 5th Ave., Suite 3400
Portland, OR 97201
503-226-7677
jbeattie@lindsayhart.com
Attorney for Respondents on Review
Linda L. Desitter MD and
Hood River Emergency Physicians LLC

Lindsey H. Hughes, OSB #833857
Hillary A. Taylor, OSB #084909
Keating Jones Hughes PC
1 SW Columbia St., Suite 800
Portland, OR 97258
503-222-9955
lhughes@keatingjones.com
htaylor@keatingjones.com
Attorneys for Respondents on Review
Michael R. Harris MD and
Hood River Medical Group

George Steven Pitcher, OSB #963982
Rachel A. Robinson, OSB #084550
Lewis Brisbois Bisgaard
888 SW Fifth Ave., Suite 600
Portland, OR 97204
971-712-2803
george.pitcher@lewisbrisbois.com
rachel.robinson@lewisbrisbois.com
Attorneys for Respondent on Review
Providence Health Services -- Oregon

Travis Eiva, OSB #052440
Zemper Eiva Law
72 W Broadway, Suite 201
Eugene, OR 97403
541-636-7480
travis@zempereiva.com
Attorney for Amicus Curiae
Oregon Trial Lawyers Association

Roy Pulvers, OSB #833570
Holland & Knight LLP
2300 US Bancorp Tower
111 SW Fifth Avenue
Portland, OR 97204
503-243-2300
roy.pulvers@hklaw.com
Attorney for Amici Curiae
Oregon Medical Association
and American Medical Association

Michael T. Stone, OSB #935499
Brisbee & Stockton LLC
139 NE Lincoln St.
P.O. Box 567
Hillsboro, OR 97123
503-648-6677
mts.@brisbeeandstockton.com
Attorney for Amicus Curiae Oregon Association of Defense Counsel

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The Oregon Medical Association ("OMA") and the American Medical Association ("AMA") (referred to together as "OMA/AMA" or as "*Amici*") respectfully submit this brief on the merits as *amici curiae*, pursuant to ORAP 8.15.[1] *Amici* accept respondents' statement of the case and set forth below their argument in support of the respondents.

I. Argument

A. Introduction

The OMA/AMA appear as *amici curiae* due to a serious concern about physicians being singled out for a unique and consequential form of new professional negligence liability. Indeed, this Court's case law is clear that well-established common law principles of causation and injury should not be changed based on the policy arguments that plaintiff has put forward to support his claim.

Importantly, the parameters for 'loss of chance' data such as relied on in plaintiff's generalized allegations in this case may have little or no bearing on the actual individual case. Indeed, it would be *contrary to fact* and thus legally incorrect to simply assume or infer that an allegation of the general statistical

[1] The AMA is appearing on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is an association of the AMA and the State Medical Societies, organized to represent the viewpoint of the medical profession in the courts.

results of a study translates into any meaningful number with respect to an individual plaintiff.

Notably, plaintiff's position also would result in recognition of a new cause of action that is contrary to legislative policy choices already expressed in statutes. Plaintiff's position is that 'loss of chance' would be a legally-cognizable injury. That would trigger the statute of limitations for medical patients who suffer an "injury," under ORS 12.110(1), (4) (two-year statute of limitations for any "injury" in a medical negligence case). However, this Court already has rejected an argument that 'loss of chance' is a legally-cognizable injury for lawyers' clients. *Drollinger v. Mallon*, 350 Or 652, 260 P3d 482 (2011). Thus 'loss of chance' does *not* trigger the same statute of limitations for any "injury" for a legal negligence claim under ORS 12.110(1). Further, the legislature has not manifested any policy of disparate treatment favoring lawyers as professionals over doctors as professionals with respect to 'loss of chance' liability. In other words, the statutory term "injury" in the statute of limitations cannot and should not be interpreted differently depending upon whether the plaintiff is a doctor's patient or a lawyer's client.

Importantly, and in addition, the legislature already has legislated in the area of risk of adverse outcomes to medical patients. ORS 677.097 codifies the duty underlying a cause of action for the injury from adverse patient outcomes

where there is a lack of informed patient consent to risks of treatment. The legislature did not, however, go so far as to authorize a speculative cause of action for 'loss of chance' of a better outcome.

The OMA/AMA, as organizations of medical professionals, are well-placed to inform the Court about significant systemic ramifications for the medical standard of care and the costs and delivery of health care that a decision to recognize 'loss of chance' as a new basis for liability can engender. Moreover, having played an active role in state and federal legislative policy-making around issues of medical tort liability and health care policy, the OMA/AMA seek to underscore that direct or indirect policy-making around issues involving medical standard of care, public health, and the costs and delivery of health care services properly should be left to the legislature and the professional community. Absent an unequivocal and unmistakable doctrinal imperative in the common law, which does not exist here, this Court should not recognize new singular areas of liability for physicians, especially when that may materially impact the standard of medical care and the costs and delivery of health care services.

B. Plaintiff seeks common law change without the requisite justification

1. Plaintiff seeks a changed and diminished standard for common law causation without justification

Plaintiff has affirmatively alleged that it is considerably more likely than not that defendants *did not cause him any physical harm*. Indeed, even giving plaintiff *arguendo* the benefit of an allegation that he did not make and could not make (*viz*., that the 33% 'loss of chance' statistic that he relied on actually applied to his individual case), plaintiff has affirmatively alleged that it is *twice* as likely that defendants' alleged negligence *did not cause him any physical harm* (67% to 33%). In all other cases, the well-established common law requires a plaintiff to establish that her physical injury was more likely than not caused by a doctor's failure to meet the standard of care; it is plaintiff's burden of proof to establish a likelihood greater than 50%. *E.g.*, *Joshi v. Providence Health Sys. Of Or. Corp.*, 342 Or 152, 158-59, 149 P3d 1164 (2006).

Plaintiff's argument for a lesser quantum of causation for 'loss of chance' claims against a physician thus is manifestly an argument to change the established common law of causation. Incapable of meeting the established standard for causation, plaintiff asks the court to modify the common law to recognize a claim based on a different, ill-defined and lesser causation standard.

Plaintiff's argument to change the established common law of causation for this one category of medical negligence claims is based solely on a policy argument that the courts should open their doors to such claims, so that plaintiff can be compensated for the effects of a stroke that the physician did not cause and for the "wondering" that plaintiff has been left to do about what might have been. However, this Court has decided that a party's policy arguments will not provide a cognizable basis for the Court to modify well-established common law principles. *See Brownstone Homes Condo Assn v. Brownstone Forest Hts*, 358 OR 223, 236, ___ P3d ___ (2015) (court will seek to correct an incorrect prior common law decision); *G.L. v. Kaiser Foundation Hospitals, Inc.*, 306 Or 54, 59, 757 P2d 1347 (1988) (setting out conditions, excluding policy choices, for changing established common law).

2. Plaintiff seeks to redefine legally-cognizable injury without justification

Plaintiff's contention that the Court should recognize 'loss of chance' as a legally-cognizable injury is somewhat different than the causation argument but ultimately leads to the same conclusion. That is not surprising since the injury argument is a transparent attempt to gut the well-established causation requirement in the guise of recognizing a new form of injury.

The Oregon Supreme Court has rejected new 'loss of chance' contentions in the parallel contexts of a professional negligence claim against a lawyer, *Drollinger v. Mallon*, *supra*, and a wrongful death action against a physician, *Joshi v. Providence*, *supra*. The Court also has rejected the notion that there is a material difference in the common law formulation of the elements of professional negligence claims that would depend on the precise profession of the practitioner, whether a lawyer or doctor, architect or accountant, *etc*.. *E.g.*, *Conway v. Pacific Univ.*, 324 Or 231, 239-40, 924 P2d 818 (1996) (physicians and lawyers share a duty of care based on the reliance that patients and clients place on them). The common law question presented here thus arguably was squarely decided by this Court in *Drollinger* in 2011, when the Court categorically rejected a 'loss of chance' claim against a lawyer.[2]

The stakes can be high both in medicine and in the law. And this Court should not distinguish in the elements of a common law professional negligence claim between claims that may involve a person's health with respect to medical professionals, on the one hand, and claims that may involve a person's financial survival, the right to practice a person's chosen profession, or a criminal defendant's personal freedom (including even life-and-death in some cases), as

[2] *Drollinger* also was decided *after Lowe v. Phillip Morris*, 344 Or 403, 413, 183 P3d 181 (2008), which had suggested that the question presented here was an open question.

examples, with respect to legal professionals. *See Conway*, 324 Or at 239-40 (physicians and lawyers share a duty of care based on reliance).

It is clear that plaintiff's argument for the Court to recognize a new 'loss of chance' injury in claims against physicians is again an attempt to change established common law without any attendant attempt by plaintiff to address, much less satisfy, the predicates required by *Brownstone Homes* and *G.L. v. Kaiser* for a change in the common law. Indeed, plaintiff's argument here calls to mind the plaintiff's failed attempt to convince this Court to recognize a 'need for medical monitoring' as a new legally-cognizable injury in *Lowe v. Phillip Morris*, 344 Or 403, 183 P3d 181 (2008).

In *Lowe*, this Court affirmed the dismissal of plaintiff's claim that years of smoking had given rise to an injury in the form of a 'need for medical monitoring.' In *Lowe*, the plaintiff effectively sought to eliminate the physical injury requirement for a legally-cognizable injury at common law. In so doing, the plaintiff effectively advocated replacing the existing harm-based paradigm for tort compensation with an inherently speculative system that instead would compensate for risk of harm. Here, similarly, plaintiff seeks to substitute statistical speculation for physical injury, and to supplant the established common law causation requirement.

Plaintiff's position also would artificially divide the common law of professional negligence among the professions, holding physicians liable for the same 'loss of chance' injury claims that this court has held must be dismissed against a lawyer. Courts should not make professional negligence common law that favors lawyers over doctors and patients over clients. Indeed, insofar as tort claims are supposed to serve as a deterrent, there is no special need to deter physicians from conduct that could lead to a 'loss of chance' claim; physicians are dedicated to achieving the best possible health outcome for their patients.

The plaintiff's contention in *Lowe* and plaintiff's contention here share another important similarity, in that, the plaintiffs effectively were and are asking this Court to impose a new standard of care on the medical profession and impose a rule of law that would have or could have significant ramifications for the costs, delivery and allocation of health care resources. Only an unequivocal and unmistakable common law imperative, which did not exist in *Lowe* and which does not exist here, should push this Court down a road so fraught with fundamental changes in medical liability that have significant health care policy implications.

C. The realities of 'loss of chance' claims

1. 'Loss of chance' allegations cannot properly survive motions to dismiss

The law should not permit a claim based on a bare allegation of loss of a statistical chance, such as the one in this case, to survive a motion to dismiss. Like plaintiff's complaint here -- which he was given an opportunity to amend and did not -- such claims purport to rely on study data that lacks a quantifiable relationship to the particular plaintiff and her/his health and circumstances. Put differently, the parameters for a study may have little or no bearing on the individual case.

Accordingly, it would be *contrary to fact* to simply assume or infer that an allegation of study data translates into any meaningful number with respect to the individual plaintiff. For purposes of a motion to dismiss, a court may assume that a study did find a certain general statistical result on the study's own terms. Without more, however, it would be contrary to fact, legally improper, and scientifically incorrect to further assume or infer that an allegation of generalized study data has any quantifiable correlation to the circumstances of a particular plaintiff patient. *See* Tory A. Weigand, *Lost Chances, Felt Necessities, and The Tale of Two Cities*, 43 Suffolk U Law Rev 327, 365-73 (2010) (detailing this

point and concluding (at p. 370) that "'naked' statistics…, without particular proof, cannot provide a basis to say how any person would have done").[3]

Thus, to use something like the instant case as an example, efficacy studies for stroke treatment typically may be done with narrow specified protocols in institutions with frequent treatment, with results then reflecting conditions significantly different from those encountered by a patient who did not participate in the study. For example, a stroke efficacy study at a major medical institution might have imaging available to be done in less than 30 minutes after an event, a stroke specialist able to stratify the patient acutely, and a neuro-radiologist available to read the imaging acutely. Such a study also would take into account data that the administration of medications that may be helpful in some cases may lead to increased harm or even death in others, depending on the patient's other characteristics and the nature of the stroke. (For example, medicine that may help when a stroke is caused by a clot may be dangerous to administer when a stroke is caused instead by a hemorrhage.) However, the type of diagnosis and treatment availability noted in the study parameters above is not present in most real-world circumstances. And thus an individual's actual loss of chance in most

[3] The Weigand article is an exceptionally thoughtful, well-researched, comprehensive treatment of the subject of 'lost chance' claims including analysis of case law, medical studies and statistics, medical practice, jurisprudential considerations, health care policy, and legislation.

circumstances would not correlate to the general statistical results in the study. In other words, the risk of harm measured in the study would not apply to an individual patient who faced different circumstances.

The point here is that it would be legally incorrect to permit a complaint to proceed past a motion to dismiss when the only allegation, as in this case, is that there is some general percentage loss of chance that applies as derived from some medical research data. Even if the Court were to recognize a claim for 'loss of chance,' which it should not, there would have to be at a minimum an additional allegation linking the results of a study to the individual's case. The Court should not recognize a new cause of action based merely on a statistical supposition, with liability disengaged from the actual patient and doctor in the case.

Of critical note in this case, plaintiff alleged that he lost a 33% chance of an outcome with *reduced or no* symptoms. Presumably that means that he alleges that he lost a chance of some percentage of reduced symptoms and also some percentage of no symptoms, either or both of which could well be significantly less than the alleged sum of 33%.

Would an allegation, for example, that plaintiff lost a 5% chance of an outcome with no symptoms, have survived a motion to dismiss even under the standards promoted by plaintiff and by OTLA? And, if not, does that allegation

of a 5% lost chance of no symptoms somehow nonetheless become a viable allegation by coupling it to some other result?

Moreover, the possible range of "reduced" symptoms ultimately is patient-specific in any given case. Some patients will have some symptoms, of varying importance, but not others. That fact means that there may be little correlation between an overall statistical number for the full range of potential reduced symptoms and any given individual case. If an individual plaintiff who did not receive treatment did not in fact suffer a hearing loss, then it is meaningless that 5%, for example, of patients who received treatment also did not suffer a hearing loss. Why should a plaintiff who suffered no hearing loss be entitled to allege (and thus presumably recover for) 33% percent of the overall range of "better" outcomes (reduced symptoms or no symptoms) when a certain percentage of those "better" outcomes necessarily does not apply to that plaintiff?

Furthermore, every medical treatment also has the potential for harm. In the treatment of stroke, for example, the distinction between a hemorrhage and a clot causing a stroke is not always readily apparent, and the administration of a blood-thinning medication intended for a clot may be dangerous if the cause of a stroke instead is a hemorrhage. And if study data show that a particular course of treatment has a statistical risk of adverse outcomes that were avoided by a lack

of treatment, why shouldn't those statistics have to be factored in to reduce the percentage 'loss of chance' that a plaintiff alleges?

The science of predictions and outcomes is far from perfect, to say the least. *See* Weigand, 43 Suffolk U L Rev at 365-71 (discussing how reliance on cancer 'survival studies,' for example, is "misleading," "unrealistic" and "unreliab[le]"). Which is why the existing system of adjudication properly demands proof that a physician's negligence caused *this plaintiff patient's physical injury, not some abstract statistical injury* embedded in the theory of 'loss of chance' recovery. The Court should not permit a claim to proceed on an allegation that is inherently speculative and predicated on an unjustifiable inference that generalized study data correlates in any meaningful way to the outcome in an individual case.

2. 'Loss of chance' cases are legally and factually confusing

Attention must be paid to the inherent legal and factual confusion that a jury would confront in deciding a 'loss of chance' case. Without some significant degree of certainty that a court would be giving the jury a job that can be done properly and fairly under the law, the claim should not be recognized.

As a practical matter, it may help to try to imagine jury instructions that a lay person reasonably could understand for such a case. Plaintiff's burden is to prove what exactly? To prove by a preponderance that there was a 'loss of

chance' or perhaps a substantial 'loss of chance'? If so, what are the rational guideposts needed by juries? Is this 'loss of chance' the element of injury or the element of causation, or both, and which comes first? And if it is only one of the two, then how is the other one defined? Compound these problems with the fact that lawyers typically argue for an all-or-nothing position to the jury at trial, not some middle ground. And turning to damages, what are the rational guideposts needed to allow juries to factually determine damages? These are all very real problems and the net result is inevitably going to be confusing to a jury and unlikely to lead to a decision applying the law properly to the facts, which is supposed to be the point of the exercise.

A cause of action that hinges on generalized data also poses a serious risk that jurors will be unduly persuaded by a statistical veneer for generalized predictions, which may be treated by jurors as scientific truth. In similar contexts, this Court properly has exercised caution. In *State v. Brown*, 297 Or 404, 442, 687 P2d 751 (1984), the court prohibited the use of polygraph evidence because of a concern that juries would over-rely on that "scientific" evidence and give it more credence in an individual case than was justified. That same caution should apply here and preclude recognition of a new cause of action in individual cases based on generalized statistics in the inherently speculative realm of predictions and outcomes.

There is one other trial point to be noted. Oregon does not permit defendants in medical negligence cases to simply obtain pre-trial discovery from a plaintiff's secondary physicians or experts. This discovery and evidence is particularly important in 'loss of chance' cases, where the plaintiff's subsequent treating doctors and experts are often the plaintiff's primary witnesses. Moreover, the experts' testimony on 'loss of chance' likely will be based principally on study data that itself is not admissible in evidence at trial. Recognizing a new claim of liability, without permitting defendants access to discovery that is especially critical to such claims, is a jurisprudential reason not to recognize such a claim.

3. 'Loss of chance' and the delivery of medicine

As briefly discussed above, one of the more notable aspects of the plaintiff's claim for 'medical monitoring' in *Lowe v. Philip Morris* was that it effectively called for a court-ordered change in the medical standard of care and health care costs and resources in Oregon, in the guise of a simple tort claim. The plaintiff was asking the Court to recognize a need for and order medical monitoring in the form of annual spiral CT scans for hundreds of thousands of current and former smokers in Oregon who had not been diagnosed with lung cancer. However, annual spiral CT scans were not the accepted medical standard

of care for such individuals in Oregon, and it was not negligence for a doctor not to order annual spiral CT scans for all such smokers.

The plaintiff's claim thus would have effectively changed the medical standard of care and required the purchase of countless extremely expensive spiral CT machines along with training and employment of technicians and physicians. It also would have necessarily ordered the reallocation of existing personnel and resources from other health care areas to that program to accommodate the tests, radiological reports and follow-up for hundreds of thousands of spiral CT scans each year in Oregon. And that is not to mention all of the additional health care testing, services and use of resources that then would have been generated from the number of 'false positives' that any test such as the spiral CT scan inevitably generates.

It was not necessary for the Court to grapple with those realities expressly in *Lowe* – because, like here, there was no legal justification for eliminating the common law requirement of physical injury and replacing harm with risk as the basis for tort recovery. It is nonetheless true that the courts should be extremely wary of taking on the responsibility of making substantial changes in the health care system in the context of common law decision-making, especially when the court is being asked to change the legal *status quo*.

Here, as in *Lowe*, plaintiff's attempt to introduce a claim for 'loss of chance' into the Oregon common law governing claims against physicians carries with it not only the prospect of a judicial revision of the medical standard of care but also the potential for a significant effect on the costs and delivery of health care resources. Such a judicial revision would run counter to local and national professional and legislative health care policy reform that is attempting to strategically increase access to quality health care while at the same time reducing the costs of that health care.

Breast cancer diagnosis is an example where the medical community tries to balance benefits from early detection, harms from unnecessary tests and interventions and false positives, overall health care costs and resource management, and that decisions need to be made in real time based on an individual patient's profile and history. The risk inherent in plaintiff's position is that 'loss of chance' liability may indirectly push the professional standard of care into demanding greater testing and more interventions (the practice of so-called 'defensive medicine') than the medical professional community might otherwise recommend and adopt.

Indeed, the medical research literature recognizes and establishes that the potential for legal liability does lead to an increase in the practice of defensive medicine. Weigand, 43 Suffolk U Law Rev at 342-43, 373 (citing to and

discussing studies containing "abundant evidence" of that result). *Amici* also concur that this will be true in Oregon should claims for 'loss of chance' be recognized. Rather than the accepted practice of medicine informing and defining the medical standard of care, the prospect of 'loss of chance' claims effectively can drive the medical standard of care into a world of tests and medications that would not otherwise be ordered.

D. Plaintiff's proposed change in the common law is not supported by existing statutes, and health care policy is properly left to the legislature and the profession

This case thus presents a good example of a claim by a plaintiff in an individual tort case that could have major systemic ramifications on both the medical standard of care as well as on the costs and delivery of health care resources. While plaintiff may not purport to be explicitly asking the Court to make a policy decision, the Court is most definitely being asked by the plaintiff to make that policy decision indirectly, as a direct and necessary consequence of the change that plaintiff argues for in the standard for causation and the scope of a legally-cognizable injury.

Those policy choices here include not only the medical ones discussed above. They also include fundamental jurisprudential, economic and equitable policy choices surrounding whether to allow compensation to -- and hold physicians liable for -- a majority of claimants who admittedly suffered no

physical injury as a result of the alleged negligence. *See Stevens v.* Bispham, 316 Or 221, 229, 851 P2d 556 (1993) ("[T]he choice of what constitutes legally cognizable harm is a policy choice.").

It is axiomatic that the making of public policy decisions is a legislative function. *Amici* also recognize the reality that some common law judicial decisions inevitably have some public policy consequences. And even courts that purport to steer clear of public policy considerations to the extent possible in the text of their common law decisions, nonetheless cannot be and should not be blind to those consequences. That means that the courts must be capable of distinguishing between judicial decisions with significant public policy implications like this one and those with little or none.

Thus, in *Stevens v. Bispham*¸ this Court recognized that whether to permit a claim for professional negligence against a lawyer without a criminal defendant having been granted post-conviction relief and acquittal was a policy question, on which deference to the legislature therefore was appropriate. *Id*. Accordingly, the court looked to various statutes to try to ascertain how the legislature's related policy choices could inform its decision in that case. 316 Or at 229-31. Moreover, the court endeavored to hew as closely as possible to the policy that the court could infer from other legislative choices in that context. *Id*.

Consideration of the value and efficacy of the changes attendant upon recognition of 'loss of chance' claims is fundamentally a policy matter. And thus reference should be made to existing statutes to see what they may disclose about the choice presented in this case.

The existing common law causation standard reasonably allocates risk and costs between physicians and patients. It has done so for a century. The well-established, existing causation standard permits patients to recover *full damages* for injuries where they can establish a simple probability, *greater than 50%*, that a physician's negligence caused a patient's physical injury. The legislature has accepted this formulation without change over the course of a century.

The legislature has employed the same statutory term, "injury," as the trigger for the statute of limitations for *all* negligence claims, including medical negligence claims pursuant to ORS 12.110(1), (4). The single statutory term is not divisible; it cannot mean one thing for professional negligence claims against lawyers (where 'loss of chance' is not a legally-cognizable "injury") but the opposite for physicians (wherein plaintiff contends that 'loss of chance' should constitute a legally-cognizable "injury").

Importantly and in addition, the legislature already has actively legislated in the area of risk of harm to patients from adverse medical outcomes. The legislature codified a statutory 'informed consent' requirement, ORS 677.097.

The attendant cause of action covers circumstances in which a patient suffered physical injury from a treatment risk without the patient's informed consent. The legislature, however, did not go further and recognize a cause of action for 'loss of chance' related to an alleged statistical potential for a better outcome. Pursuant to *Stevens v. Bispham*, this Court should honor the policy choices inherent in these legislative decisions and should not gut the common law causation standard or create a new cause of action for 'loss of chance' as a legally-cognizable injury.

The legislature also has demonstrated the capacity to deal with issues allocating fault more generally in the tort law. *E.g.*, ORS 30.600 (comparative fault). To the extent that 'loss of chance' similarly is an attempt to change the causation standards for recovery or to redefine the scope of a legally-cognizable injury, it likewise is a proper subject for legislative consideration.

Indeed, the legislature and the initiative process have considered a variety of 'tort reform' proposals over the years. That includes the legislature's recent adoption of an Early Discussion and Resolution system (with the active participation of both OMA and OTLA) to try to bring about early negotiated resolutions of patients' complaints and concomitant institutional changes to address concerns that may arise from those patients' communications and resolutions. ORS 31.250.

That is the way that systemic public policy properly should be made. Here, relevant statutes do not support plaintiff's policy position for a change in the common law. And there most certainly is no unequivocal and unmistakable imperative in the common law for the radical change that plaintiff seeks. The decision of the Court of Appeals correctly states and applies the law, and it should therefore be affirmed.

Respectfully submitted this 10th day of December, 2015.

HOLLAND & KNIGHT LLP

s/ Roy Pulvers
Roy Pulvers, OSB #833570
Attorney for *Amici Curiae*
Oregon Medical Association
and American Medical Association

CERTIFICATE OF COMPLIANCE WITH BRIEF LENGTH AND TYPE SIZE REQUIREMENTS

Brief Length

I certify that (1) this brief complies with the word-count limitation ORAP 5.05(2)(B) and (2) the word-count of this brief (as described in ORAP 5.05(2)(a)) is 4,861 words.

Type size

I certify that the size of the type in this brief is not smaller than 14 point for both the text of the brief and footnotes as required by ORAP 5.05(4)(f).

Respectfully submitted this 10th day of December, 2015.

HOLLAND & KNIGHT LLP

s/ Roy Pulvers
Roy Pulvers, OSB #833570
Attorney for *Amici Curiae*
Oregon Medical Association
and American Medical Association

CERTIFICATE OF FILING AND SERVICE

I hereby certify that on December 10, 2015 I caused to be electronically filed the foregoing BRIEF ON THE MERITS OF *AMICUS CURIAE* OREGON MEDICAL ASSOCIATION with the Supreme Court Administrator through the eFiling system and served on the parties or attorneys for parties identified herein, in the manner set forth below:

Will be notified via the court's electronic filing system:

Stephen C. Hendricks
Hendricks Law Firm PC
1425 SW 20th Ave., Suite 201
Portland, OR 97201
schendricks@hendrickslawfirm.com

Jay W. Beattie
Lindsay Hart LLP
1300 SW 5th Ave., Suite 3400
Portland, OR 97201
jbeattie@lindsayhart.com

Lindsey H. Hughes
Hillary A. Taylor
Keating Jones Hughes PC
1 SW Columbia St., Suite 800
Portland, OR 97258
lhughes@keatingjones.com
htaylor@keatingjones.com

George Steven Pitcher
Rachel A. Robinson
Lewis Brisbois Bisgaard
888 SW Fifth Avenue Suite 600
Portland, OR 97204
george.pitcher@lewisbrisbois.com
rachel.robinson@lewisbrisbois.com

Travis Eiva
Zemper Eiva Law
72 Broadway, Suite 201
Eugene, OR 97403
travis@zempereriva.com

Michael T. Stone
Brisbee & Stockton LLC
139 NE Lincoln St.
P.O. Box 567
Hillsboro, OR 97123
mts.@brisbeeandstockton.com

s/ Roy Pulvers
Roy Pulvers, #833570
Attorney for *Amicus Curiae*
Oregon Medical Association
And American Medical Association