1994

When Your Doctor Says, You Have Nothing to Worry About, Don't Be So Sure: The Effect of Fabio v. Bellomo on Medical Malpractice Actions in Minnesota

David W. Feeder II

Comment

When Your Doctor Says, "You Have Nothing to Worry About," Don't Be So Sure: The Effect of *Fabio v. Bellomo* on Medical Malpractice Actions in Minnesota

David W. Feeder II

In 1984[1] Dr. James Bellomo examined Deloras Fabio, his long-time patient, and discovered a lump in her left breast.[2] Instead of ordering a mammogram or biopsy of the lump, Dr. Bellomo dismissed it as a "fibrous mass," and told Fabio "not to worry about it."[3] Subsequently, Dr. Bellomo found the same lump during a 1986 examination; again he failed to take any action, assuring Fabio that she had nothing to worry about.[4] Several months later, a different doctor diagnosed Fabio with breast cancer. By that time, the cancer had already metastasized to four lymph nodes.[5] Fabio subsequently filed a medical malpractice suit against Dr. Bellomo for his failure to properly diagnose and treat her breast cancer in 1986. Fabio later attempted to amend her complaint to include charges of malpractice based on the 1984 examination.[6] Dr. Bellomo moved for summary judgment and contested Fabio's attempted amendment based on Minnesota's two-year statute of limitations on

1. The plaintiff failed to establish the exact date of this examination, stating only that it occurred sometime between 1982 and 1984. Because the lower court disposed of the case on summary judgment, however, the court of appeals viewed all questions of fact in the light most favorable to the plaintiff. For that reason, the parties and the reviewing courts consistently state that this examination occurred in 1984. This Comment does likewise.

2. Fabio v. Bellomo, 504 N.W.2d 758, 760 (Minn. 1993). Dr. Bellomo became Fabio's primary care physician in 1977, and he continued in that capacity until his retirement in June of 1986. Fabio v. Bellomo, 489 N.W.2d 241, 242 (Minn. Ct. App. 1992), *aff'd*, 504 N.W.2d 758 (Minn. 1993).

3. *Fabio*, 504 N.W.2d at 760.

4. *Id.*

5. *Id.* Fabio underwent a modified radical mastectomy to remove her left breast and then underwent nine months of chemotherapy which neutralized the cancer. *Fabio*, 489 N.W.2d at 243.

6. Fabio v. Bellomo, 504 N.W.2d 758, 760 (Minn. 1993).

medical malpractice actions.[7] The trial court denied Fabio's motion to amend her complaint[8] and granted summary judgment in favor of Dr. Bellomo because Fabio failed to establish a sufficient causal relationship between the delay in treatment and any harm to herself.[9] The Minnesota Court of Appeals affirmed.[10] On appeal, the Minnesota Supreme Court held that, as a matter of law, Dr. Bellomo's examinations of Fabio's breast in 1984 and 1986 did not constitute a continuing course of treatment. Thus, the two year statute of limitations began to run in 1984. The court affirmed the summary judgment, finding that Fabio failed to establish causation and damages with regard to the 1986 examination.[11]

Fabio v. Bellomo raises two important medical malpractice issues: whether multiple misdiagnoses of a latent disease constitute a continuing course of treatment for purposes of tolling the Minnesota medical malpractice statute of limitations, and whether a misdiagnosed cancer patient who maintains "at least a 50-50 chance" of long-term survival can show causation and damages necessary to sustain a medical malpractice suit in Minnesota.

This Comment examines the effect of *Fabio v. Bellomo* on medical malpractice actions in Minnesota. Part I discusses medical malpractice causes of action, with emphasis on the legislative restrictions on these claims and Minnesota's medical malpractice statute of limitations. Part II analyzes the Minnesota Supreme Court's holding and reasoning in *Fabio*. Part III discusses the effect of *Fabio* on medical malpractice actions in Minnesota, particularly with regard to the continuing course of treatment exception to the two-year statute of limitations, and to medical malpractice causation and damages law. This Comment asserts that *Fabio* unnecessarily upsets the balance of interests maintained by medical malpractice actions in favor of physicians, and that the Minnesota legislature should act to reverse this result and clarify this area of the law. This Comment concludes by proposing a framework for legislative action, including a model medical malpractice statute of limitations which

7. *Id.* at 760-61; *see* MINN. STAT. ANN. § 541.07(1) (1992).

8. *Fabio*, 489 N.W.2d at 243. The trial court determined that Dr. Bellomo's treatment of Fabio's breast with regard to the 1984 examination ended after that examination; the two year statute of limitations thus barred any action based on the 1984 examination. *Id.*

9. *Id.*

10. *Id.* at 246-47.

11. *Fabio*, 504 N.W.2d at 762-63.

more equitably balances the significant competing interests—those of individual patients and the medical profession.

I. RESTRAINTS ON MEDICAL MALPRACTICE ACTIONS: CHECKING THE VITAL SIGNS

A. MEDICAL MALPRACTICE

Physicians[12] can be liable in tort[13] for professional malpractice[14] when patients sustain injuries while under their care. Generally, patients sue physicians in negligence.[15] A negligence action can arise from a physician's action[16] or inaction.[17] Malpractice law protects patients' rights,[18] balancing their concerns

12. This Comment uses "physicians" broadly to refer to all health care professionals. Many state statutes that govern malpractice actions specify in broad and sometimes lengthy terms the wide range of health care professionals covered by the regulations. *See, e.g.*, HAW. REV. STAT. § 657-7.3 (Supp. 1992) ("chiropractor, clinical laboratory technologist or technician, dentist, naturopath, nurse, nursing home administrator, dispensing optician, optometrist, osteopath, physician or surgeon, physical therapist, podiatrist, psychologist, or veterinarian").

13. W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 32, at 185-93 (5th ed. 1984). The doctor-patient relationship, however, rarely supports a patient's action in contract. *Id.* at 186 (stating that doctors only incur contract liability when they expressly contract to cure a patient or accomplish a particular result).

14. Malpractice is defined as "[p]rofessional misconduct or unreasonable lack of skill." BLACK'S LAW DICTIONARY 959 (6th ed. 1990). For a thorough discussion of professional malpractice in the medical field see generally, DAVID M. HARNEY, MEDICAL MALPRACTICE (2d ed. 1987); 2 J. D. LEE & BARRY A. LINDAHL, MODERN TORT LAW § 25 (Rev. ed. 1988); 1 DAVID W. LOUISELL & HAROLD WILLIAMS, MEDICAL MALPRACTICE (1992).

15. To establish a prima facie case of negligent care and treatment against a physician, a plaintiff must normally prove several elements: the standard of care recognized by the medical community as applicable to the particular defendant; that the defendant departed from that standard; and that the defendant's departure was a direct cause of the plaintiff's injuries. *See* Plutshack v. University of Minn. Hosp., 316 N.W.2d 1, 5 (Minn. 1982).

16. *See, e.g.*, City of Sommerset v. Hart, 549 S.W.2d 814 (Ky. 1977) (holding surgeon negligent for a scalpel blade found in patient's bladder after surgery to remove a kidney stone); Conrad v. Lakewood Gen. Hosp., 410 P.2d 785 (Wash. 1966) (holding surgeon who left hemostat inside patient's body negligent as a matter of law).

17. *See, e.g.*, Baloney v. Carter, 387 So. 2d 54 (La. Ct. App. 1980) (holding physicians negligent for failing to diagnose and treat patient's fractured pelvis and fractured right leg when patient suffered four additional days of pain and inconvenience as a result of the delay in treatment); Mehlman v. Powell, 378 A.2d 1121 (Md. 1977) (holding physicians negligent for failing to correctly interpret electrocardiogram when patient consequently died from pulmonary embolism). These cases, involving negligent omissions or diagnostic failures, provide the common law support for many of the arguments in this Comment.

18. "[T]he tort lawsuit is the system which our society has evolved for help-

against those of physicians[19] and providing a vital check on physicians' broad power and discretion.[20]

---

ing people who have been caused to suffer physical and/or mental injury through no fault of their own." LOUISELL & WILLIAMS, *supra* note 14, ¶ 1.04, at 1-11. In addition, malpractice also allocates the risk of loss in society:

> The law of torts, then, is concerned with the allocation of losses arising out of human activities; and since these cover a wide scope, so does this branch of the law. . . . ["]The purpose of the law of torts is to adjust these losses, and to afford compensation for injuries sustained by one person as the result of the conduct of another."

PROSSER & KEETON, *supra* note 13, at 6 (quoting Cecil A. Wright, *Introduction to the Law of Torts*, 8 CAMBRIDGE L.J. 238, 238 (1944)).

19. *See* LOUISELL & WILLIAMS, *supra* note 14, ¶ 1.02, at 1-6.

> Society has a significant interest in the just disposition of malpractice claims. Success of ill-founded, albeit honestly made, claims can have harmful effects in thwarting reasonable innovations in medical practice and genuine progress of the healing arts. Failure of sound claims—particularly when it results from denial of the substance of the right to a fair hearing—fosters continuation of malpractice.

Id. Achieving a proper balance of these interests is vital to society: "Too many unfounded and unsupportable lawsuits could, conceivably, lead to the discouragement of the medical experimenters on the one hand, and the young legal lions on the other, both of whom must flourish in order to assure the proper and balanced development of our society." *Id.* ¶ 1.01, at 1-5. Evidence suggests, however, that the present "balance" has shifted significantly in favor of physicians. *See* Kenneth Jost, *Fault-Free Malpractice*, 80 A.B.A. J. 46, 47-48 (1994) (citing recent Medical Practice Study directed by Harvard Law School professor Paul Weiler). Injury and death caused by negligent medical treatment is more prevalent than previously recognized. *Id.* Few patients—about one in eight—file malpractice claims, and only one in sixteen patients who do file claims receive any compensation. *Id.* at 48.

20. Physicians wield considerable power and authority in American society:

> [T]he magnitude of the influence exerted by many physicians upon their patients is at times awesome. What "the doctor said" is still regarded by some as an inviolable order, to be followed or trusted until specifically changed by the physician himself. It is surprising how naive, how unquestioning a non-medical person, even one of superior intelligence and education, often appears to be in relation to orders or advice from a physician. Whether regarded as a god-like creature or simply an educated person whose presumed superior knowledge and judgment are not to be doubted by a mere "layman," the physician usually is in a position directly or indirectly to control factors which are vital to his patient's physical and mental well-being.

LOUISELL & WILLIAMS, *supra* note 14, ¶ 2.02, at 2-9. Deloras Fabio, the plaintiff in *Fabio v. Bellomo*, also echoed these notions during her deposition:

> [Q. Was your husband concerned about the lump in your breast?]
> A. No, because Dr. Bellomo had told me it was nothing. He's our doctor and we relied on him.
> Q. Did you ever talk to anyone else about the lump; a friend or another doctor?
> A. You don't when your doctor tells you it's nothing. You don't tell somebody else you have got this lump.
> Q. Would it be would [sic] fair to say that you kind of put it out of your mind at that time?

Most physicians have significant concerns over potential malpractice liability, particularly in light of the rapidly advancing bio-medical technologies and the large number of patients treated.[21] Today, medical practice requires malpractice insurance as much as it does a stethoscope.[22] During the 1970s, a significant rise in the number of malpractice claims and recoveries against physicians[23] caused malpractice insurance rates to increase dramatically.[24] The increase in claims and recoveries, in turn, forced physicians to purchase greater levels of insurance protection.[25] Many physicians struggled and some failed to obtain malpractice insurance.[26] This development, widely described as a medical malpractice insurance "crisis," carries with it real, perceived, and predicted corresponding impacts on the health care profession and its ability to provide affordable services to the public.[27] Consequently, state courts and legislatures

---

A. Right.

Brief for Amicus Curiae Minnesota Trial Lawyers Assoc. at 1, Fabio v. Bellomo, 504 N.W.2d 758 (Minn. 1993) (No. C6-91-2542) [hereinafter MTLA Amicus Brief] (quoting deposition of Deloras Fabio at 32). Similar themes run throughout popular culture as well. *Cf.* MALICE (Columbia Pictures 1993) (Physician charged with malpractice, played by Alec Baldwin, when asked during a deposition whether he had a "god complex," the notion that physicians become intoxicated by the power to heal and save lives, responded, "I am god.").

21. "A major reason that today's care is so hazardous is that advances in medical science have made possible bolder interventions (and more favorable outcomes), often in more fragile patients. Therefore, the consequences of errors are likely to be far more serious." Paul C. Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2355 (1992).

22. In 1990, the average jury verdict in medical malpractice cases was $1.2 million. Sarah Glazer, *Whatever Happened to the Malpractice Insurance Crisis?* WASH. POST J. MED. HEALTH SCI. & SOC'Y, July 9, 1991, at 11 (citing survey by Jury Research Inc.). That same year, however, the average malpractice claim paid by St. Paul Fire & Marine Insurance Co. of Minnesota, the largest malpractice underwriter in the country, was $36,400, reflecting the large number of out-of-court settlements and the tendency of judges to reduce jury awards. *Id.* Even with this reduced pay-out figure, physicians who do not purchase malpractice insurance risk bankruptcy in the event of even one successful claim.

23. *See* Patricia M. Danzon, *The "Crisis" in Medical Malpractice: A Comparison of Trends in the United States, Canada, the United Kingdom and Australia*, 18 LAW, MED. & HEALTH CARE 48, 48-49, 49 fig.1, 51 fig.2 (1990) (discussing and diagramming the increase in medical malpractice claim frequency and severity between 1974 and 1986).

24. *See id.* at 49, 52 fig.3 (detailing and diagramming the increase in medical malpractice insurance costs between 1978 and 1984).

25. *See id.* at 49 & n.11 ("The percentage of physicians carrying at least $1 million in coverage increased from 21 percent in 1976 to 41 percent in 1983.").

26. Mitchell S. Berger, Note, *Following the Doctor's Orders—Caps on Non-Economic Damages in Medical Malpractice Cases*, 22 RUTGERS L.J. 173, 175 & n.15 (1990).

27. Numerous commentators have analyzed the "medical malpractice cri-

took action to help alleviate the "crisis" by restricting its perceived cause—medical malpractice claims.

B. Responses to the "Crisis"—"Tort Reform" and Statutes of Limitations

In response to the medical malpractice insurance "crisis," nearly every state enacted some measure of "tort reform."[28] Tort reform represents an ongoing policy, one that politicians continue to debate and discuss.[29] Indeed, tort reform currently merits serious consideration as politicians, the media, and interest groups address the issues of health care reform and medical costs.[30] Tort reformers generally seek to reduce physicians' liability exposure and risk. To this end, they have pursued a vari-

---

sis" from many perspectives. *See, e.g., id.* at 174-80 (reviewing the "crisis" and the legislative responses to it and specifically examining caps on non-economic damages in medical malpractice claims); James R. Posner, *Trends in Medical Malpractice Insurance 1970-1985*, 49 Law & Contemp. Probs. 37, 37-47 (1986) (reviewing the "crisis" and the legislative responses to it from the perspective of the insurance industry); *cf.* Danzon, *supra* note 23 (reviewing trends in medical malpractice claims, awards, and insurance costs in a cross-cultural comparison); U.S. Gen. Accounting Office, Medical Malpractice—No Agreement on the Problems or Solutions (1986) [hereinafter GAO Report I] (reviewing the U.S. medical malpractice situation and examining views of health care providers, consumers, and attorneys). *But see* Michael J. Saks, *Do We Really Know Anything About The Behavior Of The Tort Litigation System—And Why Not?*, 140 U. Pa. L. Rev. 1147 (1992) (challenging the validity of any conclusions which are based on previous or current data on the tort system). For a thorough historical review of the "crisis" and the legislative responses to it, see generally Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 Law & Contemp. Probs. 5 (1986).

28. GAO Report I, *supra* note 27, at 2. Tort reform seeks reduction of liability exposure and risk for physicians as its primary objective. Ultimately, however, legislatures must balance this goal against the greater interests of society, particularly the rights and interests of medical malpractice victims.

29. *See, e.g.*, U.S. Gen. Accounting Office, Medical Malpractice—A Framework For Action (1987) [hereinafter GAO Report II]; GAO Report I, *supra* note 27 (discussing and analyzing the issue without any recommendations for reform). Indeed, President Bush and Vice-President Quayle made tort reform a focus of their unsuccessful 1992 re-election campaign, blaming villainous trial lawyers who wear "tasseled loafers" for the medical malpractice crisis. *See Transcript of the '92 Vice Presidential Debate (Part 1), reprinted in* Wash. Post, Oct. 14, 1992, at A15, A16 (remarks of Vice President Dan Quayle) ("Medical malpractice legislation has been before the Congress of the United States and you [Al Gore] tried to convince the American people that Bill Clinton is for tort reform? The biggest campaign contributors to your campaign are the trial lawyers of America. . . . Bill Clinton is not for tort reform.").

30. *See, e.g.*, Weiler et al., *supra* note 21 (discussing medical malpractice liability reform); Jeffrey O'Connell & Michael Horowitz, *The Lawyer Will See You Now: Health Reform's Tort Crisis*, Wash. Post, June 13, 1993, at C3 (discussing the issue of tort reform as it relates to health care reform). For a broad

ety of strategies: establishing limitations on damage recoveries,[31] restricting the "collateral source rule,"[32] requiring review by medical boards,[33] and increasing restrictions, such as statutes of limitations, on plaintiffs seeking to bring medical malpractice actions.

Of these reforms, statutes of limitations[34] constitute the most prevalent restrictions on plaintiffs seeking to bring medical malpractice suits. These statutes require plaintiffs to bring claims within a specified time period, barring any action that fails to comply.[35] Statutes of limitations protect both defendants and the judicial system from the hardship of litigating stale claims.[36] In practice, this focus on defendants and judicial resources overshadows the concerns of plaintiffs, often to their detriment.[37] The limitation period normally begins to "run" as the

---

discussion of tort reform issues, see Symposium, *Tort Reform: Will It Advance Justice in the Civil System*, 32 VILL. L. REV. 1211 (1987).

31. *See, e.g.*, Berger, *supra* note 26; Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11 (1991).

32. The collateral source rule provides that if the patient recovers certain elements of damage from a source other than the tortfeasor (i.e. insurance), that amount does not reduce the tortfeasor's liability. *See* LOUISELL & WILLIAMS, *supra* note 14, ¶ 12.14, at 12-56.

33. *See, e.g.*, Richard Boyle, *Medical Malpractice Screening Panels: A Judicial Evaluation of Their Practical Effect*, 42 U. PITT. L. REV. 939 (1981) (arguing that medical malpractice panels provide a sound solution to medical malpractice crisis); Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990) (advocating legislation providing for screening panels as a means to address the medical malpractice problem).

34. Legislatures alone create statutes of limitations; the common law imposes no such restrictions. *See* Fabio v. Bellomo, 504 N.W.2d 758, 763 (Minn. 1993) (Gardebring, J., joined by Wahl & Page, JJ., dissenting) (citing Robert Muscara, Note, *Tort Law—Federal Tort Claims Act—Accrual of Medical Malpractice Actions, United States v. Kubrick, 444 U.S. 111 (1979)*, 4 W. NEW. ENG. L. REV. 155, 158 (1981)).

35. *See generally*, *Developments in the Law—Statutes of Limitations*, 63 HARV. L. REV. 1177 (1950) [hereinafter *Developments*] (seminal discussion on statutes of limitations).

36. *See id.* at 1185-86 (discussing purposes of statutes of limitations).

> The primary consideration underlying [statutes of limitations] is undoubtedly one of fairness to the defendant. There comes a time when he ought to be secure in his reasonable expectation that the slate has been wiped clean of ancient obligations, and he ought not to be called on to resist a claim when "evidence has been lost, memories have faded, and witnesses have disappeared."

Id. at 1185 (quoting Order of R.R. Telegraphers v. Railway Express Agency, Inc., 321 U.S. 342, 349 (1944)) (footnotes omitted).

37. *See id.* at 1205 ("As between the duly diligent plaintiff and the wrong-

result of an objective or discernable act or event, such as the date of an incident or injury.[38] Injuries sustained from acts of medical malpractice, however, often fail to fully manifest themselves and evade discovery for many years.[39] Thus, the point at which the limitations period commences is extremely significant for medical malpractice claims.

All states have enacted statutes of limitations governing tort actions, and a majority of states have enacted statutes that specifically restrict medical malpractice claims.[40] Medical mal-

---

doer, the courts have been unnecessarily sympathetic towards the latter, in shortening the period in which it is likely that the plaintiff will bring an action or in entirely depriving the plaintiff of a practical remedy.").

38. *See id.* at 1200-19 (discussing commencement of the statutory period).

39. *See* Susan S. Septimus, *The Concept of Continuous Tort as Applied to Medical Malpractice: Sleeping Beauty for Plaintiff, Slumbering Beast for Defendant*, 22 TORT & INS. L.J. 71, 78 & n.41 (detailing latent diseases and injuries). Undetected cancer is a paradigm of these cases, and "[b]reast cancer in women is probably the malignancy most often involved in these [failure to detect cancer medical malpractice] cases." HARNEY, *supra* note 14, at 109. Breast cancer is a very serious, complex, and unique disease. *See* W. Russell Corker, *Legal Aspects of Breast Cancer*, TRAUMA Aug. 1991, at 59; Harold L. Hirsh, *The Emotional Assault of Breast Cancer*, TRAUMA Aug. 1992, at 55.

40. Thirty-one states have enacted a separate statute of limitations specific to medical malpractice actions: Alabama, ALA. CODE § 6-5-482 (1993); Arkansas, ARK. CODE ANN. § 16-114-203 (Michie Supp. 1993); California, CAL. CIV. PROC. CODE § 340.5 (West 1982); Colorado, COLO. REV. STAT. § 13-80-102.5 (Supp. 1993); Delaware, DEL. CODE ANN. tit. 18, § 6856 (1989); Georgia, GA. CODE ANN. § 9-3-71 (Michie Supp. 1993); Hawaii, HAW. REV. STAT. § 657-7.3 (Supp. 1992); Illinois, ILL. ANN. STAT. ch. 735, para. 5/13-212 (Smith-Hurd 1992); Indiana, IND. CODE ANN. § 34-4-19-1 (Burns 1986); Louisiana, LA. REV. STAT. ANN. § 9:5628 (West 1991); Maine, ME. REV. STAT. ANN. tit. 24, § 2902 (West 1990); Maryland, MD. CTS. & JUD. PROC. CODE ANN. § 5-109(a) (1989); Michigan, MICH. COMP. LAWS ANN. § 600.5838a (West 1989); Mississippi, MISS. CODE ANN. § 15-1-36 (Supp. 1993); Missouri, MO. ANN. STAT. § 516.105 (Vernon Supp. 1993); Montana, MONT. CODE ANN. § 27-2-205 (1993); Nebraska, NEB. REV. STAT. § 44-2828 (1988); Nevada, NEV. REV. STAT. ANN. § 41A.097 (Michie Supp. 1993); New Mexico, N.M. STAT. ANN. § 41-5-13 (Michie 1989); New York, N.Y. CIV. PRAC. L. & R. 214-a (McKinney 1990); Oklahoma, OKLA. STAT. ANN. tit. 76, § 18 (West 1989); South Carolina, S.C. CODE ANN. § 15-3-545 (Law. Co-op. Supp. 1992); South Dakota, S.D. CODIFIED LAWS ANN. § 15-2-14.1 (1984); Tennessee, TENN. CODE ANN. § 29-26-116 (1980); Texas, TEX. REV. CIV. STAT. ANN. art. 4590i (West 1994); Utah, UTAH CODE ANN. § 78-14-4 (1992); Vermont, VT. STAT. ANN. tit. 12, § 521 (Supp. 1993); Washington, WASH. REV. CODE ANN. § 4.16.350 (West Supp. 1993); West Virginia, W. VA. CODE § 55-7B-4 (Supp. 1993); Wisconsin, WIS. STAT. ANN. § 893.55 (West 1983); Wyoming, WYO. STAT. § 1-3-107 (Supp. 1993).

In addition, the following states have enacted a scheme in which a general statute of limitations provision makes specific reference to medical malpractice actions: Arizona, ARIZ. REV. STAT. ANN. § 12-542(1) (1992); Connecticut, CONN. GEN. STAT. ANN. § 52-584 (West 1991); Florida, FLA. STAT. ANN. § 95.11(4)(b) (West 1982); Idaho, IDAHO CODE § 5-219(4) (1990); Iowa, IOWA CODE ANN.

practice statutes of limitations have two essential components: the actual limitations period and the point at which the cause of action accrues. These statutes vary little with respect to time periods, as nearly all states require plaintiffs to bring suit within one to three years of the accrual of the cause of action, with the vast majority adopting a two year limitation.[41] Courts and legislatures, however, recognize tolling doctrines, which postpone the harsh effects of these statutes.[42] Nevertheless, many states have enacted statutes of repose,[43] which establish

§ 614.1(9) (West Supp. 1993); Kansas, KAN. STAT. ANN. § 60-513(a)(7), (c) (1983); Kentucky, KY. REV. STAT. ANN. § 413.140(1)(e),(2) (Michie/Bobbs-Merrill 1992); Massachusetts, MASS. ANN. LAWS ch. 260, § 4 (Law. Co-op. 1992); Minnesota, MINN. STAT. ANN. § 541.07(1) (West Supp. 1993); North Carolina, N.C. GEN. STAT. § 1-15(c) (1983); North Dakota, N.D. CENT. CODE § 28-01 to 18(3) (1991); Ohio, OHIO REV. CODE ANN. § 2305.11(B) (Anderson Supp. 1992); Oregon, OR. REV. STAT. § 12.110(4) (1988); Rhode Island, R.I. GEN. LAWS § 9-1 to 14.1 (Supp. 1993); Virginia, VA. CODE ANN. § 8.01-243(A),(C) (Michie 1992).

Only five states apply a general civil tort statute of limitations to medical malpractice actions: Alaska, ALASKA STAT. § 9.10.070 (1983); District of Columbia, D.C. CODE ANN. § 12-301(8) (1989); New Hampshire, N.H. REV. STAT. ANN. § 508:4 (Supp. 1993); New Jersey, N.J. STAT. ANN. § 2A:14-2 (West 1987); Pennsylvania, 42 PA. CONS. STAT. ANN. § 5524(2) (Supp. 1993). For a detailed comparison of these statutes, see *infra* Appendix I (graphically summarizing statutes of limitations of all fifty states and the District of Columbia).

41. Notably, the following states provide a one year limitation period for medical malpractice claims: Kentucky, Louisiana, Ohio, and Tennessee. *See* statutes cited *supra* note 40. At the opposite extreme, California, the District of Columbia, Maine, Massachusetts, Montana, New Hampshire, New Mexico, North Carolina, Rhode Island, South Carolina, and Washington provide a three year limitation. *See* statutes cited *supra* note 40. New York's limitation period is two years, six months. *See* statutes cited *supra* note 40. In Maryland, Nevada, Vermont, and Wisconsin, the time limitation varies depending on the accrual of the action: In Maryland, plaintiffs must bring actions five years from the date of the act, or three years from discovery, whichever occurs earlier; Vermont requires action within three years from the date of the act, or two years from discovery, whichever occurs later; and Wisconsin's limitation period is three years from the date of the act, or one year from discovery, whichever occurs later. *See* statutes cited *supra* note 40. All other states provide two-year limitation periods. *See* statutes cited *supra* note 40.

42. Tolling doctrines delay the running of statutes of limitations. *See Developments*, *supra* note 35, at 1220-37 (discussing various doctrines).

43. The operative feature of a statute of repose is that it cuts off a cause of action, regardless of whether the individual is aware that the cause of action exists. *See* Christopher J. Trombetta, Note, *The Unconstitutionality of Medical Malpractice Statutes of Repose: Judicial Conscience Versus Legislative Will*, 34 VILL. L. REV. 397, 401 (1989) ("If the statutory period commences upon the occurrence of an event, regardless of when the injury occurs, at a time when the plaintiff may or may not be aware of an injury, the statute is properly termed a statute of repose."). In a state (i.e. Minnesota) that does not recognize the discovery rule, *see infra* notes 45-48 and accompanying text, a statute of limitations that runs from the date of the act functions identically to a statute of repose. Trombetta, *supra* at 401-02. Alabama's statutory repose language is

an absolute time limitation for medical malpractice claims and effectively negate tolling doctrines or delayed accrual mechanisms.[44]

Determinations of when a cause of action accrues, however, vary widely by state. Generally, in tort cases, causes of action accrue at the time of injury, which usually coincides with the act causing the injury. In medical malpractice cases, however, the manifestation of the injury can occur many years after the act. Cases involving failure to diagnose a latent disease are particularly troublesome. A statute of limitations that begins to run at the date of the incident can lead to highly unfair results because patients almost always discover the injury well after the limitation period has run. In response to this manifest unfairness, courts developed the "discovery rule" doctrine, which tolls the statute of limitations until the plaintiff discovers, or reasonably should have discovered, the injury.[45] The discovery rule is based on the fundamental notion of fairness to plaintiffs,[46] and

typical. *See* ALA. CODE § 6-5-482(a) (1993) (providing "that in no event may the action be commenced more than four years after such act"). Faced with constitutional challenges to statutes of repose—both on due process and equal protection grounds—state courts are divided. *Compare* Trombetta, *supra with* Josephine Herring Hicks, Note, *The Constitutionality of Statutes of Repose: Federalism Reigns*, 38 VAND. L. REV. 627 (1985).

44. The following states incorporate statutes of repose that run from the date of the incident into their statute of limitations: Alabama (four years); California (three years); Colorado (three years); Connecticut (three years); Delaware (three years); Florida (four years); Georgia (five years); Hawaii (six years); Illinois (four years); Iowa (six years); Kansas (four years); Kentucky (five years); Louisiana (three years); Massachusetts (seven years); Michigan (six years); Montana (five years); Nebraska (ten years); Nevada (four years); North Carolina (four years); North Dakota (six years); Ohio (four years); Oregon (five years); South Carolina (six years); Tennessee (three years); Utah (four years); Vermont (seven years); Washington (eight years); West Virginia (ten years); Wisconsin (five years). *See* statues cited *supra* note 40.

45. The discovery rule doctrine, a significant change in malpractice law, generally provides that the limitations period does not begin to run "until the patient discovers, or in the exercise of reasonable care and diligence should have discovered," the injury. *See* LEE & LINDAHL, *supra* note 14, § 25.83. Indeed, the Supreme Court has recognized the discovery rule as applicable to malpractice cases brought against the government under the Federal Tort Claims Act. *See* United States v. Kubrick, 444 U.S. 111 (1979).

46. The unfairness caused by strict application of statutes of limitations, without regard to whether the patient has discovered the injury, is obvious, and has received wide discussion:

> [I]n 'situations . . . where no injury or damage becomes apparent contemporaneously with the negligent act, the application of the general rule that a cause of action exists from the time the negligent act was committed would lead to the unconscionable result that the injured party's right to recovery can be barred by the statute of limitations before he is even aware of its existence.'

the few states that do not recognize it provide poignant examples of the injustice that results in its absence.[47] Consequently, nearly every state embraces at least the basic notion behind the discovery rule.[48]

In addition to the discovery rule, several states make special allowances for situations in which a continuing course of treatment with a physician effectively prevents a patient from acting on or discovering an injury until the treatment or relationship ceases.[49] States that recognize the "continuing course

---

LEE & LINDAHL, *supra* note 14, at 370 (quoting Wyler v. Tripi, 267 N.E.2d 419 (Ohio 1971) (footnote omitted)). "The obvious injustice that so often flowed from the application of the old rule disturbed the conscience and the sense of fairness in both legislators and the judiciary." LOUISELL & WILLIAMS, *supra* note 14, ¶ 13.07, at 13-20.

47. *See, e.g.*, Francis v. Hansing, 449 N.W.2d 479 (Minn. Ct. App. 1989). The defendant physician inserted a "Safety Coil IUD" into the plaintiff in April 1967, and subsequently in May of the same year inserted a "Lippies Loop IUD" into the plaintiff, assuming the first IUD had been "expelled." *Id.* at 480. In the spring of 1987, an ultrasound revealed the presence of the coil IUD in the plaintiff's uterus, and it was subsequently surgically removed. *Id.* Despite the fact that the plaintiff was unaware of the injury for nearly 20 years, the court dismissed the suit based on the statute of limitations, refusing to apply the discovery rule. *Id.* at 480-82.

48. The following states, a strong majority, make some provision for discovery of the injury in determining when the cause of action accrues in their medical malpractice statute of limitations: Alabama, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. *See* statutes cited *supra* note 40. In the following 13 of the 19 jurisdictions in which the legislature has not incorporated the discovery rule in the statute of limitations, the judiciary nonetheless reads the doctrine into the statutes: Alaska, Pedersen v. Sielski, 822 P.2d 903 (Alaska 1991); Arizona, Leech v. Bralliar, 275 F. Supp. 897 (D. Ariz. 1967); District of Columbia, Stager v. Schneider, 494 A.2d 1307 (D.C. 1985); Georgia, Whitaker v. Zirkle, 374 S.E.2d 106 (Ga. Ct. App. 1988), *cert. denied*, 188 Ga. App. 913 (Ga. Nov. 23, 1988); Idaho, Johnson v. Stoddard, 526 P.2d 835 (Idaho 1974); Indiana, Utley v. United States, 624 F. Supp. 641 (S.D. Ind. 1985); Maine, Black v. Ward, 549 A.2d 371 (Me. 1988); Massachusetts, Riley v. Presnell, 565 N.E.2d 780 (Mass. 1991); New York, Harkin v. Culleton, 544 N.Y.S.2d 432 (N.Y. Sup. Ct. 1989); Ohio, Oliver v. Kaiser Community Health Found., 449 N.E.2d 438 (Ohio 1983); Pennsylvania, Morgan v. Johns-Manville Corp., 511 A.2d 184 (Pa. Super. Ct. 1986); Texas, Gatling v. Perna, 788 S.W.2d 44 (Tex. Ct. App. 1900); and Virginia, Dessi v. United States, 489 F. Supp. 722 (E.D.Va. 1980). Thus, the vast majority of states recognize the discovery rule to some extent.

49. *See* LEE & LINDAHL, *supra* note 14, § 25.84. In addition, many courts and legislatures recognize other significant, but less popular tolling doctrines: fraudulent concealment; cases in which a foreign object has been left in a patient's body; and infancy, minority, or incompetency of the patient at the time of the injury. *See, e.g.*, COLO. REV. STAT. § 13-80-102.5(3)(a) (concealment), (3)(b)

of treatment" doctrine do so to encourage trust in the physician-patient relationship.[50] The continuing course of treatment doctrine alleviates the same concerns as the discovery rule, providing an alternate protection for plaintiffs against the unfairness caused by undiscovered injuries.[51] Although only three states formally recognize the doctrine in their medical malpractice statutes of limitations,[52] courts in seventeen other states have adopted the rule.[53]

(foreign object), (3)(d)(I) (infancy/minority), (3)(d)(II) (disability) (Supp. 1993). Disability, as defined in the relevant statute, includes both minority and mental incompetency. COLO. REV. STAT. § 13-81-101 (1987).

50. *See, e.g.*, Swang v. Hauser, 180 N.W.2d 187, 189-90 (Minn. 1970) ("A policy reason [for the continuing treatment doctrine] is that the patient must repose reliance upon his physician in the completion of the course of curative treatment . . . ."); McDermott v. Torre, 437 N.E.2d 1108, 1112 (N.Y. 1982) ("The policy underlying the continuing treatment doctrine seeks to maintain the physician-patient relationship in the belief that the most efficacious medical care will be obtained when the attending physician remains on a case from onset to cure.").

51. *See* Fabio v. Bellomo, 504 N.W.2d 758, 764 (Minn. 1993) (Gardebring, J., joined by Wahl & Page, JJ., dissenting) ("The 'continuing course of treatment' doctrine has evolved as a compromise to ameliorate potential unfairness resulting from delayed discovery of an injury." (footnote omitted)).

52. The three states are New York, North Carolina, and Texas. *See* statutes cited *supra* note 40.

53. Alabama, Moore v. Averi, 534 So.2d 250 (Ala. 1988); Arkansas, Taylor v. Phillips, 801 S.W.2d 303 (Ark. 1990); Colorado, Comstock v. Collier, 737 P.2d 845 (Colo. 1987); Connecticut, Connell v. Colwell, 571 A.2d 116 (Conn. 1990); Indiana, Ferrell v. Geisler, 505 N.E.2d 137 (Ind. Ct. App. 1987); Michigan, Amrhein v. Philip Petachenko, D.C., P.C., 435 N.W.2d 10 (Mich. Ct. App. 1988); Minnesota, Schmit v. Esser, 236 N.W. 622 (Minn. 1931); Missouri, Green v. Washington Univ. Medical Ctr., 761 S.W.2d 688 (Mo. Ct. App. 1988); Nebraska, Ourada v. Cochran, 449 N.W.2d 211 (Neb. 1989); New Jersey, Fleishman v. Richardson-Merrell Inc., 226 A.2d 843 (N.J. Super. Ct. App. Div. 1967); North Carolina, Callahan v. Rogers, 365 S.E.2d 717 (N.C. Ct. App. 1988); Ohio, Wells v. Johenning, 578 N.E.2d 878 (Ohio Ct. App. 1989); South Dakota, Wells v. Billars, 391 N.W.2d 668 (S.D. 1986); Virginia, Justice v. Natvig, 381 S.E.2d 8 (Va. 1989); Washington, Adams v. Allen, 783 P.2d 635 (Wash. Ct. App. 1989); Wisconsin, Robinson by Robinson v. Mount Sinai Medical Ctr., 402 N.W.2d 711 (Wis. 1987); Wyoming, Metzger v. Kalke, 709 P.2d 414 (Wyo. 1985). In addition, some states that specifically reject continuing course of treatment as a tolling doctrine nonetheless allow application of the doctrine within their medical malpractice schemes. *See, e.g.*, Ewing v. Beck, 520 A.2d 653, 659-62 (Del. 1987) (rejecting continuing course of treatment as a tolling doctrine, but allowing a cause of action for "continuous negligent medical treatment" where the cause of action accrues at termination of treatment); Cunningham v. Huffman, 609 N.E.2d 321, 324-25 (Ill. 1993) (specifically rejecting continuing course of treatment as a tolling doctrine, but interpreting the statutory language regarding accrual of the cause of action—at "occurrence" causing injury—to allow examination of continuing course of treatment).

C. MINNESOTA'S RESPONSES—JUDICIAL AND LEGISLATIVE RESTRICTIONS OF MEDICAL MALPRACTICE ACTIONS

The judiciary restricts medical malpractice actions primarily through its construction and interpretation of the common law. Although medical malpractice is based on the tort of negligence,[54] courts often treat these actions distinctly. In Minnesota, in order for plaintiffs to establish causation, and thus a prima facie case of medical malpractice, they must prove that it is more probable than not that the injury was a result of the physician's negligence.[55] Moreover, when the issues involved in proving causation are not within the common knowledge of lay persons, plaintiffs must present expert testimony to prove this element.[56] In medical malpractice actions the issues of causation and damages are often the most important, perplexing, and difficult aspects of the case.[57] Unfortunately, Minnesota courts often confuse the issues of causation, damages, injuries, "theories of recovery," and "causes of actions" by inaccurately interchanging or substituting one word or phrase for another, and thus furthering error and misunderstanding in the law.[58]

The Minnesota legislature has also restricted medical malpractice claims,[59] mandating that plaintiffs commence "all actions against physicians, surgeons, dentists, other health care professionals . . . hospitals, [and] sanatoriums, for malpractice, error, mistake or failure to cure, whether based on contract or

54. *See supra* note 15 and accompanying text.

55. Leubner v. Sterner, 493 N.W.2d 119, 121 (Minn. 1992) (citing Plutshack v. University of Minn. Hosps., 316 N.W.2d 1 (Minn. 1982) and Cornfeldt v. Tongen, 295 N.W.2d 638, 640 (Minn. 1980)). "[T]he ["more probable than not"] standard in this state is both well settled and well grounded in considerations of both equity and public policy." *Id.*

56. *Leubner*, 493 N.W.2d at 121 (citing Smith v. Knowles, 281 N.W.2d 653, 656 (Minn. 1979) and *Cornfeldt*, 295 N.W.2d at 640); Harvey v. Fridley Medical Ctr., P.A., 315 N.W.2d 225, 227 (Minn. 1982).

57. *See* HARNEY, *supra* note 14, at 419-27 (arguing that proof of causation in medical malpractice actions is difficult and that because of the complexities and uncertainties of medicine the required quantum of proof in such actions should be less than in ordinary personal injury cases).

58. *See, e.g.*, Fabio v. Bellomo, 504 N.W.2d, 758, 762-63 (Minn. 1993) (interchanging "damages" and "theories of recovery" and later equating "theory of recovery" with "cause of action"); *see also infra* part III.B (discussing *Fabio's* confusion of medical malpractice causation and damages law).

59. A full discussion of all legislative restrictions on medical malpractice actions is beyond the scope of this Comment, which focuses predominantly on statutes of limitations. For a broader discussion of Minnesota legislative restraints and tort reform actions, see, e.g., Charles E. Spevacek, *Tort Reform in Minnesota—The Impact of the 1986 Legislative Enactments on General Civil Litigation*, 10 HAMLINE L. REV. 461 (1987).

tort" within two years.[60] Medical malpractice plaintiffs may commence actions only "after the cause of action accrues,"[61] yet the legislature failed to statutorily define when this moment occurs. Furthermore, Minnesota's medical malpractice statute of limitations does not recognize a discovery rule, a continuous treatment provision, or any other tolling doctrine.[62]

Moreover, the Minnesota judiciary has shown great hesitancy in developing tolling doctrines, generally adhering instead to the principle that "[c]ourts have no power to extend or modify statutory limitation periods."[63] The courts have recognized only two tolling doctrines for medical malpractice actions. First, Minnesota courts recognize that "fraudulent concealment" by the physician tolls the limitations period.[64] To substantiate a claim of fraudulent concealment, a plaintiff must prove two elements: that acting with reasonable diligence she could not have discovered the concealment sooner and that her own negligence did not cause the concealment; and that the concealment was fraudulent or intentional.[65] This doctrine is firmly rooted in both fairness[66] and equity.[67]

In addition, Minnesota courts embrace the continuing

60. MINN. STAT. ANN. § 541.07(1) (West Supp. 1994).

61. MINN. STAT. ANN. § 541.01 (West 1988).

62. *See* MINN. STAT. ANN. § 541.07(1) (West Supp. 1994); *see also supra* notes 45-53 and accompanying text (discussing tolling doctrines). *But cf.* MINN. STAT. ANN. §§ 541.073, 541.075 (West Supp. 1994) (incorporating discovery rule in statute of limitations governing actions for damages due to sexual abuse and actions seeking remedies in environmental actions, respectively).

63. Johnson v. Winthrop Lab. Div. of Sterling Drug, Inc., 190 N.W.2d 77, 81 (Minn. 1971).

64. Schmuckering v. Mayo, 235 N.W. 633, 633 (Minn. 1931) (holding that in cases of fraudulent concealment the statute of limitations commences when the cause of action is discovered or might have been discovered by the exercise of diligence). *Id.* at 633.

65. *See* Wild v. Rarig, 234 N.W.2d 775, 795 (Minn. 1975), *cert. denied*, 424 U.S. 902 (1976); Collins v. Johnson, 374 N.W.2d 536, 541 (Minn. Ct. App 1985).

66. *Schmuckering*, 235 N.W. at 633 ("In the presence of a fiduciary and confidential relation the fraud may more readily be perpetrated. The relation of physician and patient of itself begets confidence and reliance on the part of the patient." (citation omitted)).

67. The *Schmuckering* court discussed two equitable reasons for the fraudulent concealment doctrine. *Id.* at 634. First, "one who cannot assert his right because the necessary knowledge is improperly kept from him is not within the mischief the statute [of limitations] was intended to remedy . . ." and second, "a person should not be permitted to shield himself behind the statute of limitations where his own fraud has placed him." *Id.* The court concluded its opinion with a simple (yet subsequently often quoted) summary of the rationale behind the doctrine: "Fraud is bad, it should not be permitted to go unchecked anywhere, and justice should always be able to penetrate its armor." *Id.*

course of treatment exception.[68] In *Schmit v. Esser*,[69] the Minnesota Supreme Court clearly stated that continuing treatment tolls the statute of limitations,[70] yet subsequent Minnesota case law inconsistently characterizes the doctrine.[71] In determining when treatment has ceased, Minnesota courts traditionally examine three factors: whether a relationship exists between the physician and the patient with regard to the illness, whether the physician is examining and attending the patient, and whether there is something more to be done by the physician in order to

68. *See, e.g.*, Grondahl v. Bulluck, 318 N.W.2d 240 (Minn. 1982); Schmit v. Esser, 236 N.W. 622, 624-25 (Minn. 1931). The *Schmit* court stated, "[w]e think the treatment and employment [of the physician] should be considered as a whole, and, if there occurred therein malpractice the statute of limitations begins to run when the treatment ceases." *Id.* at 624 (citing and quoting Schmitt v. Esser, 226 N.W. 196, 197 (1929)). Subsequent courts and commentators generally credit the 1931 *Schmit* court with establishing the continuing treatment doctrine. The 1929 *Schmitt* court, however, hearing the defendant's appeal after the trial court overruled his demurrer to the plaintiff's complaint, actually adopted the rule first. The 1929 *Schmitt* court affirmed the trial court's order and remanded the case for trial. After a jury verdict for the plaintiff, the defendant appealed, asking for a new trial. The 1931 *Schmit* court, in reversing the trial court's order, granted a new trial based on errors that occurred during the trial, but reaffirmed the 1929 *Schmitt* court's statement of the continuing treatment rule. *Id.* at 624-25. Courts also refer to the doctrine as the "termination of treatment" rule in recognition of the event that triggers the statute of limitations. *See, e.g.*, Fabio v. Bellomo, 489 N.W.2d 241, 244 (Minn. Ct. App. 1992), *aff'd*, 504 N.W.2d 758 (Minn. 1993) (referring to the doctrine in this way).

69. 236 N.W. 622 (Minn. 1931).

70. *Id.* at 624 ("[T]he statute of limitations begins to run when the treatment ceases.").

71. The courts seem to use the notions of "when the statute of limitations begins to run" and "when the cause of action accrues" interchangeably in subsequent cases. *See, e.g.*, *Fabio*, 504 N.W.2d at 762 ("Generally *the cause of action accrues* when the physician's treatment for the particular condition ceases." (citing Johnson v. Winthrop Lab. Div. of Sterling Drug, Inc., 190 N.W.2d 77, 80 (Minn. 1971) and Schmit v. Esser, 236 N.W. 622, 624-25 (Minn. 1931)) (emphasis added)); *Johnson*, 190 N.W.2d at 79-81 (*"[T]he event which starts the period of limitation running* against a medical malpractice action is the termination of treatment . . . ." (citing *Schmit*, 236 N.W.2d at 622) (emphasis added)).

The lack of a discovery provision in either the accrual of the cause of action or the commencement of the limitations period, and the fact that the statute of limitations period runs from the accrual of the action mitigates this inconsistency. Under these circumstances, the same result occurs regardless of whether the continuing treatment doctrine affects the accrual of the cause of action or the running of the statute of limitations. This seemingly academic distinction, however, may be crucial when analyzing statutes of limitations in other jurisdictions. Indeed, some courts have ruled specifically on this issue. *See, e.g.*, Dana David Peck, Comment, *The Continuing Treatment Doctrine: A Toll on the Statute of Limitations for Medical Malpractice in New York*, 49 ALB. L. REV. 64, 66 n.11 (1984) (stating that continuing treatment doctrine tolls the New York medical malpractice statute of limitations).

effect a cure.[72] An exception exists, however, in cases in which the alleged malpractice consists of a "single act."[73] If the parties dispute questions of material fact regarding whether the statute of limitations bars a plaintiff's claim, a jury decides this issue.[74] Both pragmatism[75] and policy[76] provide a strong foundation for the continuing course of treatment doctrine. Despite recognition of the fraudulent concealment and continuing course of treatment tolling doctrines, however, Minnesota courts continually have refused to adopt the discovery rule.[77]

II. *FABIO v. BELLOMO*: THE PULSE WEAKENS

In *Fabio v. Bellomo*,[78] Deloras Fabio brought a malpractice action against Dr. James Bellomo, who served as her primary care physician from 1977 until his retirement in 1986.[79] During

72. Grondahl v. Bulluck, 318 N.W.2d 240, 243 (Minn. 1982) (citing *Schmit*, 236 N.W. at 625).

73. *See* Murray v. Fox, 220 N.W.2d 356 (Minn. 1974) (single act of surgery); Swang v. Hauser, 180 N.W.2d 187 (Minn. 1970) (same). The courts have developed a test for this exception: The alleged malpractice must consist of a single act of negligence, the act must be complete at a precise time, the act must be incapable of being cured or relieved by a continued course of treatment, and the plaintiff must actually be aware of the facts upon which the claim is based. Crenshaw v. Saint Paul Ramsey Medical Ctr., 379 N.W.2d 720, 721 (Minn. Ct. App. 1986) (citing *Swang*, 180 N.W.2d at 189-90; *Murray*, 220 N.W.2d 356; Collins v. Johnson, 374 N.W.2d 536 (Minn. Ct. App. 1985)).

74. Noland v. Freeman, 344 N.W.2d 419, 420 (Minn. 1984); *Grondahl*, 318 N.W.2d at 243 (citing *Schmit*, 236 N.W. at 624 and Sheets v. Burman, 322 F.2d 277, 278 (5th Cir. 1963)).

75. *See Swang*, 180 N.W.2d at 189 ("A practical reason for [the continuing course of treatment] rule is that the actionable treatment does not ordinarily consist of a single act or, even if it does, it is most difficult to determine the precise time of its occurrence.").

76. *See id.* at 189-90 ("A policy reason [for the continuing course of treatment doctrine] is that the patient must repose reliance upon his physician in the completion of the course of curative treatment, a relationship of trust which inhibits the patient's ability to discover acts of omission or commission constituting malpractice.").

77. *See, e.g.*, Johnson v. Winthrop Lab. Div. of Sterling Drug, Inc., 190 N.W.2d 77, 81 (Minn. 1971). "Thus, in the absence of fraud, ignorance of the existence of the cause of action does not toll the statute of limitations." *Id.*

78. 504 N.W.2d 758 (Minn. 1993).

79. *Id.* at 760. Fabio's records show that she saw Dr. Bellomo at least 58 times between 1982 and June 1986 alone. Appellant's Opening Brief at 5-6, Fabio v. Bellomo, 504 N.W.2d 758 (Minn. 1993) (No. C6-91-2542) [hereinafter Appellant's Brief]. Fabio clearly stated in her deposition that Dr. Bellomo was her primary and sole provider of general health care:

> Q. Did Dr. Bellomo perform annual exams, your pelvic exams, or did you see a gynecologist for that sort of thing?
>
> A. I had no gynecologist. Dr. Bellomo was my doctor.

a physical examination in 1984, Dr. Bellomo discovered a lump in Fabio's left breast.[80] Dr. Bellomo dismissed the lump as a "fibrous mass" and instructed Fabio not to worry about it.[81] During a physical examination in 1986, Dr. Bellomo again noticed the lump in Fabio's left breast. He again diagnosed the lump as a fibrous mass, telling her "not to worry about it."[82] After Dr. Bellomo's retirement, another physician examined Fabio, discovered the lump, and immediately ordered a mammogram.[83] A biopsy revealed the presence of two malignant tumors and confirmed that the cancer had metastasized to four lymph nodes.[84]

After completing treatment for the cancer,[85] Fabio sued Dr. Bellomo for medical malpractice based on his failure to diagnose and treat her condition during the 1986 examination.[86] On the day of trial, Fabio moved to amend her complaint to add an action for negligence based on Dr. Bellomo's failure to properly treat her during the 1984 examination.[87] The trial court denied Fabio's motion to amend her complaint, rejecting her argument that a continuing course of treatment tolled the statute of limitations and concluding that the claim was time barred.[88] The trial court also granted summary judgment in favor of Dr. Bel-

---

MTLA Amicus Brief, *supra* note 20, at 14 (quoting deposition of Deloras Fabio at 19).

80. *Fabio*, 504 N.W.2d at 760.

81. *Id.* At least one commentator concludes that, due to the importance of early detection and the comparative ease of breast lump diagnosis, whenever a physician discovers a lump in a woman's breast, "[a]t a minimum, a mammogram should be performed." Corker, *supra* note 39, at 59.

82. *Fabio*, 504 N.W.2d at 760.

83. *Id.*

84. *Id.*

85. Fabio underwent a modified radical mastectomy to remove her left breast and the four lymph nodes into which the cancer had metastasized; following the surgery, Fabio received nine months of chemotherapy. Fabio v. Bellomo, 489 N.W.2d 241, 243 (Minn. Ct. App. 1992). Interestingly, the supreme court described Fabio's medical consequences quite dryly, stating simply that, "[t]he tumor was subsequently excised, and Fabio underwent chemotherapy treatment." *Fabio*, 504 N.W.2d at 760. Fortunately, the treatments succeeded, and Fabio has had no signs of recurrence. *Fabio*, 489 N.W.2d at 245.

86. 504 N.W.2d at 760. Fabio claimed that Dr. Bellomo failed to palpate the lump or order a mammogram when he noticed it in 1986. *Id.* Fabio argued three theories of damages: (1) the delay in treatment due to Dr. Bellomo's failure to diagnose caused her to undergo chemotherapy; (2) the delay resulted in a "loss of chance" of life expectancy and an increased risk of cancer recurrence; and (3) the delay negligently aggravated her preexisting cancerous condition. *Id.* at 761.

87. *Id.* at 760.

88. *Id.* at 761.

lomo regarding the 1986 examination.[89] The court of appeals affirmed these rulings.[90] On appeal, the Minnesota Supreme Court considered whether the trial court properly dismissed Fabio's motion to amend her complaint.[91] The court also considered whether Fabio met her burden of production with respect to causation and damages.[92] The court affirmed the judgments of the lower courts, rejecting each of Fabio's theories of recovery[93] and ruling that Dr. Bellomo's examinations of Fabio's breast were not part of a continuing course of treatment.[94]

The court began its analysis of the lower courts' denials of Fabio's motion to amend the complaint by reviewing the basis of the trial court's determination that Dr. Bellomo did not undertake a continuing course of treatment with regard to Fabio's breast.[95] Next, the court examined the medical malpractice statute of limitations and acknowledged the continuing course of treatment rule as a tolling doctrine.[96] The court then immediately decided that, *as a matter of law*, Dr. Bellomo's examination of Fabio's breast did not fall within a continuing course of treatment, therefore time barring her claim based on the 1984 examination.[97] Although the parties strongly emphasized the importance of the continuing course of treatment issue,[98] the court cited no authority, performed no legal analysis, and devoted only three cursory sentences to the issue:

---

89. *Id.*

90. Fabio v. Bellomo, 489 N.W.2d 241 (Minn. Ct. App. 1992), *aff'd*, 504 N.W.2d 758 (Minn. 1993).

91. *Fabio*, 504 N.W.2d at 761. This examination necessitates an analysis of the scope of the continuing course of treatment doctrine: "Whether the trial court abused its discretion by denying the amendment, therefore, turns on whether it was correct that there was no continuing course of treatment." *Id.* at 762.

92. *Id.* at 761.

93. *Id.* at 762-63; *see also infra* notes 105-108 and accompanying text (detailing the court's analysis of Fabio's theories of damages).

94. *Fabio*, 504 N.W.2d at 762.

95. *Id.* at 761. The trial court found that Dr. Bellomo's treatment of Fabio ceased when he determined that she had no condition of her breasts requiring further treatment on his part. *Id.* Thus, the trial court denied the motion to amend because it determined that the statute of limitations barred the allegation. *Id.* at 761-62.

96. *Id.* at 762.

97. *Id.*

98. Both parties fully briefed the issue. Indeed, continuing course of treatment was the first issue addressed in both appellant's and respondent's briefs, and it was extensively addressed in the oral arguments. Both the Minnesota Trial Lawyers Association and the Minnesota Medical Association submitted amicus briefs in support of the arguments on both sides of the issue, also demonstrating the issue's importance.

> When Dr. Bellomo examined Fabio's breast between 1982 and 1984, he did not recommend any further treatment. His treatment of her condition ceased at the time he told her not to worry about it. We therefore hold that the trial court was correct to rule that Dr. Bellomo's examinations of Fabio's breast that occurred between 1982 and 1984 are barred by the statute of limitations, because these examinations were not part of a continuing course of treatment.[99]

In a dissenting opinion, however, three justices expressed disagreement with the court's conclusion.[100] The dissent examined the continuing course of treatment doctrine,[101] analyzed the relationship between Fabio and Dr. Bellomo,[102] and concluded that the continuing course of treatment doctrine applied.[103]

---

99. *Fabio*, 504 N.W.2d at 762.

100. *Id.* at 763-67 (Gardebring, J., joined by Wahl & Page, JJ., dissenting).

101. The dissent first noted the importance of the continuing course of treatment doctrine, pointing out that "[it] has evolved as a compromise to ameliorate potential unfairness resulting from delayed discovery of an injury." *Id.* at 764 (footnote omitted). The dissent then listed the three factors the court has established to determine whether a continuing course of treatment existed: "(1) whether there is a relationship between physician and patient with regard to the illness; (2) whether the physician is attending and examining the patient; and (3) whether there is something more to be done [by the physician in order to effect a cure]." *Id.* at 765 (quoting Grondahl v. Bullock, 318 N.W.2d 240, 243 (Minn. 1982)). The dissent concluded that the facts satisfied the second and third factors. The dissent, however, was troubled by the first factor: whether a relationship existed between Fabio and Dr. Bellomo with regard to the illness. *Id.* at 765.

102. The dissent performed a thorough and detailed analysis of the issue. First, the dissent examined the relationship between Fabio and Dr. Bellomo, specifically reviewing the act of "diagnosis" by a physician as "treatment." *Id.* at 765. Justice Gardebring preliminarily concluded that, "[i]f Dr. Bellomo, through his physician/patient relationship with Fabio, was "treating" her by examining the lump in her breast with an eye to diagnosis, I can only conclude that there was a continuing course of treatment during this time." *Id.* The dissent then reviewed three New York decisions—Fonda v. Paulsen, 363 N.Y.S.2d 841 (N.Y. App. Div. 1975), McDermott v. Torre, 437 N.E.2d 1108 (N.Y. 1982), and Shumway v. DeLaus, 543 N.Y.S.2d 777 (N.Y. App. Div. 1989), *appeal dismissed*, 554 N.E.2d 1281 (N.Y. 1990)—which addressed the issue of whether multiple misdiagnoses triggered the continuing course of treatment exception. *Id.* at 765-66. Based on the reasoning of these cases, the dissent articulated a framework for analyzing the question:

> A physician's diagnosis that nothing further is necessary does not end "treatment" if the physician is subsequently given notice within a reasonable time that the initial diagnosis was wrong. Treatment by omission can toll the statute of limitations if the subsequent misdiagnosis occurred within a reasonable time after the initial diagnosis, and there was a relationship between the physician and the patient.

Id. at 767.

103. In the dissenters' opinion, "whether the physician was put on notice, through the actions of her patient or herself, that an abnormal condition existed" constitutes the key inquiry in analyzing this issue. *Id.* at 767. Applying this analysis to the facts in *Fabio*, the dissent concluded that a continuing

The court then turned to the issue of whether Fabio could prove damages attributable to Dr. Bellomo's 1986 examination. The court noted the Minnesota rule of causation in medical malpractice actions: plaintiffs must present expert testimony that establishes that it is more probable than not that damages resulted from the doctor's malpractice.[104] The court explored Fabio's three theories of damages—chemotherapy, "loss of chance," and "negligent aggravation of a preexisting condition"—and rejected all three.[105] The court flatly rejected Fabio's first argument, that undergoing chemotherapy injured her, because she admitted in oral argument that chemotherapy would have been necessary even if Dr. Bellomo had diagnosed the cancer in 1986.[106] Addressing Fabio's second theory of recovery, "loss of chance," the court concluded that, "[w]e have never recognized loss of chance in the context of a medical malpractice action, and we decline to recognize it in this case."[107] Finally, the court disallowed Fabio's "negligent aggravation of a preexisting condition" theory of recovery, relying on a recent decision which it claimed rejected this theory.[108]

---

course of treatment existed, because "Dr. Bellomo certainly possessed such knowledge." *Id.*

104. *Fabio*, 504 N.W.2d at 762.

105. *Id.* at 762-63.

106. *Id.* at 762.

107. *Id.* The court distinguished the two cases that Fabio cited to support the theory of loss of chance recoveries in traditional tort actions: *Dunshee v. Douglas*, 255 N.W.2d 42, 47 (Minn. 1977) and *Mack v. McGrath*, 150 N.W.2d 681, 684 (Minn. 1967). *Id.* at 762-63. In *Mack* and *Dunshee*, the court allowed recovery for potential damages from initial injuries caused by the defendants. *Id.* at 763. The court noted that in these cases, "the future effects flowed directly from the initial injuries, the initial injuries were the sole cause of the future effects, and the probabilities of their occurrence were proven with reasonable medical certainty." *Id.* The court then distinguished Fabio's claim, concluding that her cancer did not result from Dr. Bellomo's misdiagnosis and that the misdiagnosis could not have been the sole cause of any future injuries or ill effects. *Id.* The court also reasoned that, even if it adopted the "loss of chance" theory of recovery, Fabio could not recover under that theory because her physician testified that she had "at least [a] 50-50" chance of survival and thus did not meet the "more probable than not" causation requirement. *Id.*

108. 504 N.W.2d at 763 (citing Leubner v. Sterner, 493 N.W.2d 119, 122 (Minn. 1992)).

III. AFTER *FABIO*: DIAGNOSIS = CRITICAL CONDITION; PRESCRIBED TREATMENT = IMMEDIATE LEGISLATIVE ACTION

A. *Fabio's* Unwarranted Narrowing of the Continuing Course of Treatment Doctrine

Fabio is a troublesome decision that severely undermines Minnesota's continuing course of treatment doctrine. The court's three short conclusory sentences and minimal legal analysis of the continuing course of treatment issue demonstrate a disturbing disregard for the importance of the issue and for the fact that its result upsets the balance maintained by medical malpractice even further in favor of physicians.[109]

1. Ignoring the Patient's Perspective and Eliminating the Objective Restraint on Physicians

In addressing the continuing course of treatment issue, the *Fabio* court performed virtually no legal analysis and failed to articulate the basis for its decision.[110] In concluding that Dr. Bellomo's treatment ceased when he told Fabio "not to worry about" the lump in her breast, the court only noted that he did not recommend any further treatment at the time of the examination. Because the court dispensed with explicit reasoning and explanation, the basis of its decision must be surmised. The court most likely based its decision on two of the three traditional continuing course of treatment factors: whether there was a relationship between Dr. Bellomo and Fabio with regard to the illness, or whether there was something more to be done by Dr. Bellomo in order to effect a cure.[111] Because of the court's focus on "further treatment," this Comment assumes that the court based its decision on whether there was something more to be done.[112]

In determining whether a continuing course of treatment existed, Minnesota courts prior to *Fabio* specifically examined

---

109. *See supra* notes 18-20 and accompanying text.

110. *See supra* note 99 and accompanying text.

111. *See supra* text accompanying note 72 (listing traditional continuing course of treatment factors).

112. *But cf. Fabio*, 504 N.W.2d at 765-67 (Gardebring, J., joined by Wahl & Page, JJ., dissenting) (focusing on whether there was a relationship between Fabio and Dr. Bellomo with regard to her illness). This assumption, however, does not significantly affect this Comment's analysis. The analysis in this section focuses on the fact that the court ignored the patient's perspective in making its decision. This criticism applies regardless of which factor the court actually analyzed.

whether the patient's injury *objectively* required additional attention from the physician in order to effect a cure.[113] An objective analysis requirement ensured the adoption of a neutral perspective, rather than the sole perspective of the treating physician. The *Fabio* court eliminated objective review, however, and adopted a "purely-physician" perspective when it ruled that Dr. Bellomo's treatment of Fabio's breast ceased on *his* determination that she required no further treatment.[114] In reality, Dr. Bellomo was badly mistaken; Fabio's breast contained malignant lumps that required significant and immediate action to effect a cure. The continuing course of treatment doctrine evolved to protect the interests of patients and to protect against the inherent unfairness that occurs when latent injuries remain undiscovered.[115] Thus, any decision involving the continuing course of treatment doctrine must examine the patient's perspective,[116] which the *Fabio* decision failed to address.[117]

After *Fabio*, a physician terminates the treatment and triggers the statute of limitations with regard to that examination or diagnosis by making a purely subjective determination that the patient requires no medical attention. Hence, an unacceptable anomaly occurs: the physician reduces the likelihood that the patient will seek another examination by assuring the patient that she has nothing to worry about, and in turn, with the same assurance, minimizes the threat of objective accountability[118] due to the increased likelihood that the statute of limitations will bar a civil action. In order to protect both society's and the patient's interests, however, the legal system must hold phy-

113. *See* Grondahl v. Bulluck, 318 N.W.2d 240, 243-44 (Minn. 1982) ("Whether something more could be done for Mrs. Grondahl, who continually suffered from symptoms requiring treatment, is a question to be evaluated in light of expert medical testimony.").

114. *See Fabio*, 504 N.W.2d at 761-62.

115. *See supra* notes 46, 51 and accompanying text (discussing the discovery rule, the continuing course of treatment doctrine, and their common purpose of protecting patients' rights).

116. Courts should examine decisions involving the continuing course of treatment doctrine either solely from the patient's perspective or from a "joint" perspective which includes the concerns of both physicians and patients. While the patient's perspective is crucial and must be examined, this Comment fully endorses a "joint" perspective approach which ensures that the competing interests can be appropriately examined and balanced; *see infra* part III.C. (proposing model statute and implicitly recommending a joint perspective by allowing juries to examine the understanding or belief of both physicians and patients).

117. The court's ruling as a matter of law to remove the issue from the jury creates a particularly onerous effect. *See infra* part III.A.2.

118. *See supra* note 20 (discussing notion that medical malpractice suits provide a check on the wide discretion possessed by physicians).

sicians accountable when their actions fall below the objective professional standard of care.[119]

2. Removing the Question From the Jury

The *Fabio* court decided, as a matter of law, that the moment Dr. Bellomo told Fabio "not to worry about" the lump in her breast, he ceased to treat her condition.[120] Thus, Dr. Bellomo triggered the statute of limitations with respect to his 1984 examination of Fabio's breast merely by uttering a reassuring statement and by recommending no further treatment. Prior to *Fabio*, the jury determined whether the facts of the particular case constituted a continuing course of treatment; indeed, the court articulated factors to help guide the jury in this evaluation.[121] After *Fabio*, at least in the case of periodic breast examinations by a physician, courts must now remove the question of continuing treatment from the jury whenever the physician follows Dr. Bellomo's example and "terminates the treatment" by telling the patient "not to worry."

This result ignores the reality that every physician-patient relationship is unique, and that such relationships depend a great deal on variables such as the individual patient and doctor, the length and nature of the relationship, and the nature of the ailment treated. Reducing this complex interrelation to a few words and phrases inappropriately prejudices patients because it gives physicians the exclusive, unilateral power to define, alter, and limit their relationships with patients. Moreover, when a court removes important issues from the jury's domain, it should only do so after carefully analyzing all aspects of the issue and explicitly articulating its reasoning. The *Fabio* court failed to follow this careful process of analysis.

3. Ignoring the Rationale Behind the Doctrine

Fabio ignores the primary policy rationale behind the continuing course of treatment doctrine, the need for and encouragement of trust in physician-patient relationships.[122] *Fabio*, however, allows physicians to trigger the statute of limitations

119. *Cf.* Fabio v. Bellomo, 504 N.W.2d 758, 767 (Minn. 1993) (Gardebring, J., joined by Wahl & Page, JJ., dissenting) ("A physician's diagnosis that nothing further is necessary does not end 'treatment' if the physician is subsequently given notice within a reasonable time that the initial diagnosis was wrong.").

120. *Id.* at 762.

121. *See supra* notes 72, 74 and accompanying text.

122. *See supra* notes 50, 76 and accompanying text.

after an examination merely by recommending no additional treatment and assuring the patient that she has nothing to worry about. Thus, after *Fabio*, patients seeking to protect their rights regarding a possible cause of action against their physician should obtain a second opinion whenever their physicians recommend no further treatment of a condition and conclude the examination by saying, "you have nothing to worry about." Contrary to the rationale of encouraging trust between physicians and patients, *Fabio* fosters distrust and second-guessing within the relationship, eviscerating the bases on which the continuing course of treatment doctrine rests.

Moreover, by ignoring the many variables involved in physician-patient relationships, *Fabio* works serious harm in the case of an ongoing physician-patient relationship. Many physician-patient relationships mirror the relationship between Dr. Bellomo and Fabio: the physician exclusively provides primary general health care services for the patient for a lengthy time period. Such relationships necessarily involve strong trust and reliance, and society holds an equally strong interest in maintaining their viability.[123] The suspicion and distrust which *Fabio* generates are most severe and damaging in this situation.[124]

4. Increasing the Unfairness to Medical Malpractice Plaintiffs

Minnesota, notwithstanding *Fabio*, imposes some of the harshest restrictions on medical malpractice actions in the country.[125] The courts' staunch refusal to adopt the discovery rule[126] renders the continuing course of treatment exception the only protection for plaintiffs with injuries which do not manifest

123. Indeed, patients are less likely to get a second opinion regarding routine examination and care, normally provided by a general health care provider, than they are for a serious or unusual injury, one which may be treated by a specialist. The current debate over health care reform, in which many citizens continually express concern over whether they will be able to keep their present doctors, clearly illustrates the importance of these relationships.

124. Long-term physician-patient relationships admittedly increase long-term liability concerns of physicians, if, for example, a physician may be liable for any and all procedures or examinations conducted during the relationship. *Fabio*, however, fails to balance these concerns against the equally strong concerns of society and patients for their rights.

125. *See supra* notes 60-77 and accompanying text (detailing Minnesota's medical malpractice statute of limitations); *see also infra* Appendix I (graphically summarizing and comparing statutes of limitations of all fifty states and the District of Columbia).

126. *See supra* note 77 and accompanying text.

themselves for a long period of time after the misdiagnosis. Courts and commentators have noted, however, that the law must provide plaintiffs with some protection in these cases to maintain the balance of interests between plaintiffs and physicians, and it is questionable whether a state can eliminate protection to plaintiffs with regard to latent injuries.[127]

Moreover, *Fabio's* unfairness has a disproportionately severe impact on women.[128] In *Fabio*, the Minnesota Supreme Court ignored the importance[129] and the uniqueness[130] of breast cancer, jeopardizing women's ability to recover for misdiagnosis and mistreatment of this highly discriminatory disease.[131] If courts continue to recognize the continuing course of treatment doctrine, they must interpret it to provide meaningful protection to plaintiffs.[132] At a minimum, the courts should give this issue serious, not cursory, consideration.

B. *Fabio's* Continued Confusion of Medical Malpractice Causation and Damages

In addition to tightening the statute of limitations restric-

127. *See supra* note 46 and accompanying text (discussing concerns of fundamental fairness).

128. *Fabio* establishes a direct precedent for cases involving breast cancer, a disease which is virtually exclusive to women. Once physicians learn to administer the "Dr. Bellomo assurance" ("you have nothing to worry about") at the end of each examination, it will be very difficult for patients to distinguish their cases from *Fabio*.

129. *See* Corker, *supra* note 39, at 59 ("Any lump in the female breast must be viewed as a potentially life-threatening problem, owing to the high incidence of death associated with breast cancer.").

130. *See* Hirsh, *supra* note 39 (detailing the numerous psychological and emotional injuries that breast cancer inflicts upon women). "Female breast cancer is not a simple disease with simple solutions. Rather it is a complex disease entity with multiple problems and uncertainties involving prevention, diagnosis and treatment, provoking, in addition to physical alterations, intense fears and emotional disturbances." *Id.* at 85.

131. Ironically, the Minnesota judiciary has professed a primary and ongoing concern over the issue of fairness to women within the legal system and indeed claims to be progressing in this area. *See* Hon. A.M. Keith, *The State of the Judiciary*, BENCH & BAR OF MINNESOTA, Sept. 1992, at 20, 22-23 ("Women are coming to feel taken care of by this system, and I think we're making progress."). *Fabio* represents a significant step backwards in the process of assuring fairness to women within the legal system.

132. *Fabio* exemplifies the tendency of Minnesota courts to focus on the specific treatment of a specific injury or ailment and essentially results in a significant, albeit implicit, expansion of the "single act" exception. *See supra* note 73 and accompanying text. This focus, however, ignores the realities of medical practice, particularly in the case of long-term treatment by a physician who provides all or substantially all medical care to a patient.

tion on medical malpractice actions, *Fabio* also rejected several theories of recovery for cases of negligent omission, such as cancer misdiagnosis. To establish a prima facie medical malpractice cause of action in Minnesota, plaintiffs must show that damages resulted more probably than not from the malpractice.[133] The court firmly rejected Fabio's "loss of chance" theory of recovery[134] and also rejected her "negligent aggravation of a preexisting condition" theory of recovery, purporting to reaffirm its recent decision in *Leubner v. Sterner*.[135]

The court, however, incorrectly interpreted and applied *Leubner*, blurring the issues of damages and causation. *Leubner*, a well-reasoned decision, reversed the appellate court's creation of a *cause of action* for negligent aggravation of a preexisting condition.[136] The *Leubner* court, however, analyzed and correctly characterized the notion of aggravation of a preexisting condition, concluding that it is a *"measure of damages, not a theory of liability . . . ."*[137] Properly read, *Leubner* disallows an explicit *cause of action* for negligent aggravation but does not preclude recovery of *damages* for such negligence under an allowable "theory."

---

133. *See supra* note 55 and accompanying text.

134. 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."). *But see* Corker, *supra* note 39, at 62 (arguing that because of the medical complexities involved and general lack of adequate scientific data, "[t]he loss-of-a-chance theory is critical for representing a plaintiff in a failure to timely diagnose and treat breast cancer case").

135. 504 N.W.2d at 763 (citing Leubner v. Sterner, 493 N.W.2d 119, 122 (Minn. 1992)). *Leubner* involved a malpractice negligence case dealing with the failure to diagnose and treat breast cancer. 493 N.W.2d at 120. The trial court granted summary judgment for the defendants, ruling that the plaintiff's offer of proof failed to prove causation under the more probable than not required standard. *Id.* The court of appeals affirmed summary judgment on several counts, but *sua sponte* ruled that the plaintiff established a prima facie "cause of action for negligent aggravation of a preexisting disease . . . ." *Id.* at 120-21. The supreme court reversed, emphasizing that the plaintiff ultimately failed to prove causation under the required "more probable than not" standard. *Id.* at 122.

136. 493 N.W.2d at 120 ("We hold there is no such thing as a medical malpractice cause of action for 'negligent aggravation of a preexisting condition,' and reverse the court of appeals.").

137. *Id.* at 122 (emphasis added). Indeed, the court concluded, *"[o]ne can think of medical malpractice cases where there would be damages for aggravation of a preexisting condition*; but, particularly in malpractice cases, the plaintiff cannot use the fact her condition has worsened as proof the defendant doctor made it worse." *Id.* (emphasis added). Thus, *Leubner* merely affirms the well-established notion that plaintiffs must always prove *causation* under the "more probable than not" standard, which the plaintiff in *Leubner* failed to do.

The *Fabio* court erred in its use and application of *Leubner*. The court first referred to Fabio's "theories of recovery"—chemotherapy, "loss of chance," and "negligent aggravation of a preexisting condition"—characterizing them as "*forms of damages*."[138] The court, however, later equated the negligent aggravation "theory of recovery" with "cause of action" and relied on *Leubner* to disallow recovery.[139] If negligent aggravation is a form of damages as *Leubner* (and *Fabio* initially) characterizes it, however, then *Leubner* alone does not support summary judgment in favor of Dr. Bellomo. Causation and damages are related, yet separate considerations, and *Fabio* wrongly merges the two notions, furthering confusion and inconsistency in the law.[140]

Fabio's conflation of causation and damages essentially engrafts the "more probable than not" requirement on the proof of damages.[141] Increased hardship and unfairness[142] results, particularly in cases of negligent omission such as cancer misdiagnosis, especially when this result is viewed in conjunction with *Fabio's* restriction of the continuing course of treatment doctrine. First, the court effectively states that unless patients have lost more than a fifty percent chance of survival, they have not sustained compensable injuries.[143] In addition, only a select

138. *Fabio*, 504 N.W.2d at 762 (emphasis added).

139. *Id.* at 762-63. "This *theory* [negligent aggravation of a preexisting condition] was recently rejected by this court, under very similar circumstances." *Id.* at 763 (citing *Leubner*, 493 N.W.2d at 122) (emphasis added).

140. Indeed, the courts often fail to clearly articulate the distinctions between causation and damages, and thus the law and the bar are mired in confusion and uncertainty. The briefs of the two parties in *Fabio* clearly reveal the problem; each side, relying on the law, characterized the issues of causation and damages in an entirely different manner. *See* Appellant's Brief, *supra* note 79, at 25 ("[T]he issues raised by this case are not issues of causation, but rather, issues of damages."); Respondent's Brief at 26, Fabio v. Bellomo, 504 N.W.2d 758 (Minn. 1993) (No. C6-91-2542) ("The issue is whether Fabio's offer of proof as to causation is sufficient under Minnesota law to state a prima facie case of medical malpractice.").

141. *See Fabio*, 504 N.W.2d at 763. The court noted that even if it accepted the loss of chance theory, Fabio could not recover under that theory because her physician testified that she had at least a "50-50" chance of long-term survival; a 50% chance of survival does not meet the "more probable than not" damage requirement. *Id.*

142. *See* Corker, *supra* note 39, at 60 (arguing that fairness demands malpractice protection in cases of breast cancer misdiagnosis and mistreatment). "Because early detection of breast cancer offers the best opportunity for cure, a patient whose breast cancer has been negligently misdiagnosed should be fairly compensated." *Id.*

143. The imprecision inherent in these medical predictions heightens this unfairness. A physician testifying in a malpractice case could respond to a question regarding the likelihood of recovery by saying either "about 50-50" or

group of cancer patients can now recover in malpractice for negligent diagnosis or treatment: only those patients who lost at least fifty-one percent chance of survival and also discovered the injury within two years of the negligent act. Thus, *Fabio* permits recovery in malpractice solely based on chance or, in a very jaded sense, the patient's "good fortune" of sustaining and discovering *serious* injury. Medical malpractice actions protect the rights of patients and society, and this protection is not intended to hinge, nor should it hinge, on mere fortuity. This Comment urges the judiciary to reconsider the results which follow from *Fabio* and to clearly articulate its reasoning and analysis when addressing the issues of causation and damages in future medical malpractice actions.

C. Recommendation: Don't Call 911 for an Ambulance, Call The Legislature for an Amendment

In light of *Fabio*, the Minnesota legislature must act to restore the balance in medical malpractice law. This issue involves two equally strong, competing concerns: Minnesota's ongoing concern of attracting, encouraging, and supporting medical practice and technology development; and Minnesota's concern, consistent with its progressive reputation, of protecting and securing the rights of its citizens, particularly those that have wrongfully sustained serious injury. In the case of medical malpractice, the judiciary has shifted the balance of these concerns markedly in favor of physicians; the legislature must now restore the balance. The legislature should remedy this problem by amending the medical malpractice statute of limitations.[144]

"a little less than 50-50," and quite possibly intend the same meaning. Thus, a plaintiff's recovery depends solely on whether her physician was properly "coached" to respond "49%" or "less than 50%" versus "about 50%." Moreover, seriously ill patients who have less than a 50% chance of survival when first treated by physicians have absolutely no recourse for any negligent omissions, regardless of how severe the negligence might be.

144. Specifically, the medical malpractice statute of limitations should be amended to codify the continuing course of treatment exception as a tolling doctrine. To date, courts have presumed the existence of the rule as a tolling doctrine within the statutory scheme.

> Minn.Stat. [sic] § 541.07 has been amended several times since the termination of treatment rule was set forth in *Schmitt* in 1929.... We therefore conclude the legislature has presumptively adopted the termination of treatment rule for determining the time when a medical malpractice claim accrues and the two-year statute of limitation period begins to run.

Willette v. Mayo Found., 458 N.W.2d 120, 122 (Minn. Ct. App. 1990).

This Comment proposes a model statute and articulates a framework for legislative action.

Fabio muddied the state of the continuing course of treatment doctrine by taking a very narrow reading of it,[145] and by establishing a rule of law for negligent omission cases.[146] The legislature should abrogate the effect of *Fabio* by reasserting the doctrine as a protection for medical malpractice plaintiffs.[147] Specifically, the legislature should amend the statute of limitations, returning to the framework established in *Grondahl v. Bulluck*,[148] and allowing the jury to resolve questions of continuing treatment. The following proposed model medical malpractice statute of limitations embodies this framework and reflects a realistic and acceptable compromise for Minnesota legislators on this issue:[149]

> NOTE: Statutory language *not* denoted in italics is borrowed from the present statute of limitations in § 541.07(1).
> PROPOSED MINN. STAT. ANN. § 541.076. MEDICAL MALPRACTICE STATUTE OF LIMITATIONS
>
> All actions against physicians, surgeons, dentists, other health care professionals as defined in § 145.61, and veterinarians as defined in chapter 156, hospitals, or sanitariums for malpractice, error, mistake or failure to cure, whether based on contract or tort, *must be commenced within two years of the accrual of the cause of action;* provided that a counter-claim may be pleaded as a defense to any action for services brought by a physician, surgeon, dentist or other health care professional or veterinarian, hospital or sanatorium, after the limitations herein described notwithstanding it is barred by the provisions of this chapter, if it was the property of the party pleading it at the time it became barred and was not barred at the time *the action accrued,* but no judgment thereof except for costs can be rendered in favor of the party so pleading it. *For purposes of this section, "physician" refers generally to all individuals and entities listed above. For purposes of this section, an action accrues at the time of the act or incident which is the subject matter of the claim. If there is a continuing course of treatment between a physician and a patient with regard to an injury or*

145. *See supra* part III.A.4.

146. *See supra* part III.A.2.

147. This Comment, however, makes no recommendation as to retroactive application of any such enactment. For a detailed discussion of the validity of retroactive legislation that affects statutes of limitations, see Patrick T. Murphy, Note, *Section 27A of the SEA: An Unplugged* Lampf *Sheds No Constitutional Light*, 78 MINN. L. REV. 197 (1994) (analyzing the constitutionality of retroactive federal statute of limitations legislation).

148. *See supra* note 72 and accompanying text.

149. This recommendation assumes that the Minnesota legislature will continue to impose a two-year statute of limitations, reaffirm its commitment to both the continuing course of treatment and fraudulent concealment tolling doctrines, and also continue to distinguish itself from the vast majority of states by refusing to adopt a form of the widely accepted discovery rule.

ailment, the limitation period herein described will be tolled until the time at which such treatment ceases. Whether there was a continuing course of treatment is a question for the jury to consider in light of the following factors: (1) whether there is a relationship between the physician and patient with regard to the illness; (2) whether the physician is attending and examining the patient; (3) whether there is objectively something more to be done by the physician in order to effect a cure; (4) the length and nature of the physician-patient relationship; (5) the nature of the injury, ailment or disease involved; (6) the understanding or beliefs of both the physician and the patient; and (7) any other evidence which might be relevant or useful in this determination. If a physician prevents a patient from discovering a cause of action by fraudulent concealment, the limitation period herein described will be tolled until the patient discovers, or with reasonable diligence should have discovered, the cause of action. Whether there was fraudulent concealment is a question for the jury. This section shall be interpreted broadly.

The legislature should enact a separate medical malpractice statute of limitations to increase clarity and to symbolize the importance of the issue. The statute should establish a limitations period of two years and provide details specifying which health care professionals and claims are governed by the statute. The statute should also specify that a medical malpractice cause of action accrues at the time of the act or incident that caused the injury.

In addition, the statute should specifically list and explain the circumstances that will toll the statute of limitations. First, the statute should recognize and define the continuing course of treatment exception as a tolling doctrine. This description should specify that a jury must decide the question of continuing course of treatment in a given case, listing the factors the jury should consider in making this determination. These factors should include and broaden those listed in *Grondahl v. Bulluck*[150] to allow consideration of more evidence, consistent with an expansive interpretation of the doctrine.

Next, the statute should recognize and define the fraudulent concealment exception as a tolling doctrine, similarly specifying that a jury must decide the question of fraudulent concealment in a given case. Finally, the statute should mandate a broad interpretation of these factors. This framework eliminates confusion and ambiguity by clearly articulating the crucial aspects of the statute of limitations and restores the balance of interests by broadening the scope of the continuing course of treatment doctrine.[151]

150. *See supra* note 72 and accompanying text.

151. It should be noted, however, that there are many possible alternative solutions to the problem. This Author by no means wishes to discourage explo-

CONCLUSION

In *Fabio v. Bellomo*, the Minnesota Supreme Court held that, as a matter of law, no continuing course of treatment existed between a physician and patient when the physician examined the patient's breast twice during a two year period, twice found a lump, and after each examination recommended no further treatment and told the patient "not to worry about" the lump. Furthermore, the court rejected the plaintiff's theories of recovery, concluding that she failed to state a cause of action in medical malpractice.

The supreme court's ruling shifts the balance of interests maintained by medical malpractice actions significantly in favor of physicians, and confuses the already muddled areas of malpractice causation and damages law. The ruling also undermines the continuing course of treatment doctrine and its validity as a toll on the two-year medical malpractice statute of limitations. This Comment urges the Minnesota legislature to amend the medical malpractice statute of limitations to clarify and stabilize this area of the law, and proposes a model medical malpractice statute of limitations and a framework for legislative action to serve this end.

---

ration of creative solutions and compromises to obtain a more equitable balance between the competing interests involved. Oklahoma provides an example of such ingenuity, incorporating both the discovery rule and a modified statute of repose into its statutory scheme. *See* OKLA. STAT. ANN. tit. 76, § 18 (West 1989) (providing that plaintiffs must bring medical malpractice suits within two years of discovery, but also providing that plaintiffs who bring such an action more than three years after the date of the injury, rather than being barred as is the case with a normal statute of repose, may only recover actual medical and surgical expenses incurred or to be incurred as a direct result of the injury). This approach strikes an inventive balance between the rights of patients and society, and the equally significant concerns of physicians.

APPENDIX I

The following table summarizes the medical malpractice statutes of limitations in all fifty states and the District of Columbia, which are listed in the first column. The second column describes the type of the statute of limitations: a statute specific to medical malpractice ("S"), a generally applicable statute ("G"), or a general statute that specifically addresses medical malpractice ("G/S"). The third column lists the limitations period. The fourth column indicates whether the cause of action accrues at the date of the act or omission. The fifth column denotes whether the statute allows discovery of the injury, either in the accrual of the cause of action or as a toll on the limitations period. Any period noted in parentheses represents the time within which a patient is required to file suit after the date of discovery. The sixth column indicates whether the statute recognizes the termination of treatment doctrine, either in the accrual of the cause of action or as a toll on the limitations period. The seventh column describes any qualifications or unique features within the statute, primarily regarding accrual of the limitations period and the information outlined in columns four and five. The eighth column lists the length of any repose period explicitly or implicitly established by the statute. The ninth column indicates whether the statute recognizes the presence of a foreign object in the patient's body as a toll on the limitations period. Any period noted in parentheses represents the time within which a patient is required to file suit after discovery of any such object. The tenth column indicates whether the statute recognizes fraudulent concealment of the act, omission, or injury by the physician as a toll on the limitations period. Any period noted in parentheses represents the time within which a patient is required to file suit after discovery of such fraudulent action.

STATE	GENERAL v. SPECIFIC	SOL PERIOD	DATE OF ACT	DISCOVERY	TERMINATION OF TREATMENT	QUALIFICATION	REPOSE PERIOD	FOREIGN OBJECT	FRAUDULENT CONCEALMENT
AL	S	2 yrs	X	X(6 mos.)			4 yrs		
AK	G	2 yrs	X						
AZ	G/S	2 yrs	X						
AR	S	2 yrs	X					X (1 yr)	
CA	S	3 yrs	X	X(1 yr)		a.	3 yrs	X	X
CO	S	2 yrs		X		if no disc, no SOL	3 yrs	X (2 yrs)	X (2 yrs)
CT	G/S	2 yrs	X	X		2 yrs from act or discovery	3 yrs		
DE	S	2 yrs	X	X			3 yrs		
DC	G	3 yrs	X						
FL	G/S	2 yrs	X	X		2 yrs from act or discovery	4 yrs		X (2 yrs, 7 yr repose)
GA	S	2 yrs				2 yrs from occurrence of injury	5 yrs	X	
HI	S	2 yrs		X			6 yrs		X
ID	S	2 yrs	X			explicitly precludes tolling for discovery or continuous treatment		X (1 yr)	X (1 yr)
IL	S	2 yrs		X			4 yrs		
IN	S	2 yrs	X						
IA	G/S	2 yrs		X			6 yrs	X	
KS	G/S	2 yrs	X	X		2 yrs from act unless injury not discovered	4 yrs		
KY	G/S	1 yr		X			5 yrs		
LA	S	1 yr	X	X		1 yr from act or discovery	3 yrs		
ME	S	3 yrs	X					X	
MD	S	—	X (5 yrs)	X(3 yrs)		a.			X
MA	G/S	3 yrs				b.	7 yrs	X	
MI	S	2 yrs	X	X(6 mos.)		2 yrs from act or 6 mos. from disc, whichever is later	6 yrs	X (6 mos.)	X (6 mos.)
MN	G/S	2 yrs	X						
MS	S	2 yrs		X		2 yrs from discovery			
MO	S	2 yrs	X					X (2 yr disc, 10 yr repose)	
MT	S	3 yrs	X	X		c.	5 yrs		X
NE	S	2 yrs	X	X(1 yr)		2 yrs from act or 1 yr from discovery	10 yrs		
NV	S	—	X (4 yrs)	X(2 yrs)		a.	4 yrs		X
NH	G	3 yrs	X	X		c.			

STATE	GENERAL v. SPECIFIC	SOL PERIOD	DATE OF ACT	DISCOVERY	TERMINATION OF TREATMENT	QUALIFICATION	REPOSE PERIOD	FOREIGN OBJECT	FRAUDULENT CONCEALMENT
NJ	G	2 yrs				b.			
NM	S	3 yrs	X						
NY	S	2 yrs, 6 mos.	X		X	from act or last treatment		X (1 yr)	
NC	G/S	3 yrs		X (1 yr)	X (last act of defendant)	3 yrs from last act or 1 yr from discovery, whichever occurs later	4 yrs (from last act of defendant)	X (1 yr, 10 yr repose)	
ND	G/S	2 yrs				b.	6 yrs		X
OH	G/S	1 yr				b. (SOL pd may be extended 180 days if claimant gives notice within the 1 yr pd,)	4 yrs		
OK	S	2 yrs		X		modified statute of repose	e.		
OR	G/S	2 yrs		X			5 yrs		X (2 yrs)
PA	G	2 yrs							
RI	S	3 yrs	X	X		c.			
SC	S	3 yrs	X	X (3 yrs)		c.	6 yrs	X (2 yrs)	
SD	S	2 yrs	X						
TN	S	1 yr	X	X		1 yr from act or discovery	3 yrs	X (1 yr)	X (1 yr)
TX	S	2 yrs	X		X	2 yrs from act or completion of treatment			
UT	S	2 yrs		X			4 yrs	X (1 yr)	X (1 yr)
VT	S	—	X (3 yrs)	X (2 yrs)		d.	7 yrs	X (2 yr)	X
VA	G/S	2 yrs				b.		X (1 yr, 10 yr repose)	X (1 yr, 10 yr repose)
WA	S	3 yrs	X	X (1 yr)		d.	8 yrs	X	X
WV	S	2 yrs	X	X		d.	10 yrs		X
WI	S	—	X (3 yrs)	X (1 yr)		d.	5 yrs	X (1 yr)	X (1 yr)
WY	S	2 yrs	X	X		d. (if the malpractice is discovered during the second yr of the 2 yr SOL, the SOL pd is extended 6 mos.)			

a. Whichever occurs earlier (act v. discovery)
b. From accrual
c. 3 yrs from act or discovery
d. Whichever occurs later (act v. discovery)
e. Doesn't bar action. If suit is brought more than 3 yrs after date of act, recovery is limited to actual expenses incurred as direct result of injury.