

# Annual Survey of Massachusetts Law

---

Volume 1972

Article 18

---

1-1-1972

## Chapter 15: Medical Malpractice

James W. Smith

Follow this and additional works at: <http://lawdigitalcommons.bc.edu/asml>

 Part of the [Health Law Commons](#)

---

### Recommended Citation

Smith, James W. (1972) "Chapter 15: Medical Malpractice," *Annual Survey of Massachusetts Law*: Vol. 1972, Article 18.

C H A P T E R 15

Medical Malpractice

JAMES W. SMITH

**§15.1. Introduction.** During the past decade there has been a considerable increase in medical malpractice litigation and a corresponding rise in interest in this area of the law. Previous editions of the SURVEY have extensively examined major developments in medical malpractice within the general context of tort law. The most notable recent example was the discussion of the Supreme Judicial Court's decision in *Brune v. Belinkoff*,<sup>1</sup> abolishing the community standard rule.<sup>2</sup>

The purpose of this article is to provide an overview of medical malpractice as a specialized field of law by focusing on four discrete problems: (1) consent of minors to medical treatment, (2) immunity, (3) statute of limitations, and (4) evidentiary uses of medical treatises and periodicals. While all of these issues ultimately go to the central question in medical malpractice, the liability of the physician or hospital, each deals with a different aspect of a typical medical malpractice case. The first two topics relate to statutory protection insulating the physician from liability; the third relates to the time in which the action must be brought, one of the most formidable procedural obstacles in medical malpractice suits; and the fourth relates to the burden of proving medical malpractice by expert opinion, still the most difficult and troublesome part of medical malpractice law. All four issues possess particular relevance because they have been the subjects of recent statutory or judicial action in Massachusetts. Moreover, they are continually developing areas, posing questions in need of further clarification or resolution.

**§15.2. Minors: Consent to medical treatment.** One of the most current problems in the legal-medical area involves the issue of minors' consent to medical treatment. At common law, minors are deemed incapable of giving consent with the result that the consent of the parent or legal guardian of the child is required before medical treatment can be administered.<sup>1</sup> This common law rule has proved unworkable with the dramatic increase in the incidence of drug abuse and venereal disease among minors. Since many young people were reluctant to re-

JAMES W. SMITH is a Professor of Law at Boston College Law School.

§15.1. <sup>1</sup> 354 Mass. 102, 235 N.E.2d 793 (1968).

<sup>2</sup> See 1968 Ann. Surv. Mass. Law §3.16.

§15.2. <sup>1</sup> See, e.g., *Reddington v. Clayman*, 334 Mass. 244, 134 N.E.2d 920 (1956) (unauthorized removal of a uvula during operation to remove tonsils and adenoids).

veal these types of medical problems to their parents, they failed to obtain parental consent to treatment and did not receive the care they needed. Similarly, physicians wishing to treat such minors did so at their own risk, perhaps committing a battery each time they proceeded without parental consent. This dilemma became particularly acute when such conditions gave rise to medical emergencies.

Massachusetts, like many other states,<sup>2</sup> has responded to this problem with new legislation. In 1954, the legislature enacted a statute<sup>3</sup> providing that a registered physician or surgeon, *acting under the authority of the Department of Public Health*, could examine and treat a minor for venereal disease without the consent of the parent or legal guardian provided the minor voluntarily appeared for examination and treatment. The statute was among the first of its kind, and it has never been amended. Perhaps for that reason, its language is somewhat more restrictive than comparable but more recent enactments in other jurisdictions which allow *private* doctors also to treat minors for venereal disease.<sup>4</sup> Even after the enactment of the 1954 statute, there remained, however, a need for new law to deal with drug abuse. In 1970, the legislature added Section 12E to Chapter 112 of the General Laws. This section provides that a minor twelve years of age or over who is found to be drug dependent by two or more physicians may give his consent to hospital and medical care related to the diagnosis or treatment of his drug dependency. In such cases, the consent of the parent or legal guardian is not required. The provisions of this statute do not, however, apply to methadone maintenance therapy.

Another special situation where the legislature has acted to expand the rights of minors to consent to medical procedures is in the area of surgery and treatment incident to the donation of a kidney. Under newly enacted legislation<sup>5</sup> a person of sound mind who is eighteen years of age or older may validly consent to giving a kidney for transplantation during his or her lifetime.<sup>6</sup>

<sup>2</sup> Most of this legislation has been enacted in the last five years. Only five states, Idaho, Tennessee, Vermont, West Virginia and Wyoming, have not provided for minor's consent to treatment for venereal disease. A majority of jurisdictions also provide for consent to treatment for drug abuse. See, e.g., Ga. Code Ann., §§74-104.1 through 74-104.3 (Supp. 1972). For a compilation of statutory material, see Pilpel, *Minors' Rights to Medical Care*, 36 Albany L. Rev. 462 (1972).

<sup>3</sup> G.L., c. 111, §117.

<sup>4</sup> Compare Va. Code Ann., §32-137 (Supp. 1972).

<sup>5</sup> G.L., c. 113, §8(a), as amended by Chapter 344 of the Acts of 1972.

<sup>6</sup> The statute also permits such a person to make a gift of all or any part of his body for specified medical purposes, such gift to take effect upon his death. G.L., c. 113, §8(b). The statute does not, however, deal with the matter of consent in the case of minors under the age of eighteen. The likelihood is that court approval of a proposed transplant would be required even where both the minor and his parents have consented to the transplant. In 1957 the Supreme Judicial Court issued three opinions, each permitting a minor to donate a kidney to a twin sibling. In each of these cases there was a finding that the minor under-

Probably the most far-reaching statute in this area is Chapter 112, Section 12F of the General Laws, passed in 1971. It provides that:

No physician shall be held liable for damages for failure to obtain consent of a parent or parents, guardian or guardians or other persons having custody or control of a minor child, or of the spouse of a patient, to emergency examination and treatment, including blood transfusions, when delay in treatment will endanger the life, limb, or mental well-being of the patient nor shall any hospital be liable for any such examination and treatment by a physician therein.

This statute most likely codifies what would have been the common law result in Massachusetts had such a case arisen. Its chief feature is that it assures non-liability for the physician faced with an emergency situation.

While Section 12F clearly applies in an emergency situation where the parents, guardian or spouse of the patient are not present or available to give consent to the needed treatment, an interesting question arises as to the statute's applicability where an emergency situation has arisen and the parent, guardian or spouse *refuses* on religious or other grounds to consent to the needed treatment. It is arguable that "failure to obtain consent" might be construed to include the situation where consent is refused. It is submitted, however, that such a construction was not intended by the legislature.<sup>7</sup> Were the question to arise before the courts in Massachusetts, the likelihood is, particularly in the case of minors, that the physician providing the emergency treatment would be protected as a matter of common law.<sup>8</sup>

---

stood the nature of the operation and its possible risks and consequences, and *in all of the cases the parents of the minors consented to the operation*. Further, in all of the cases, the Court made a finding based upon the testimony of a psychiatrist, that the operation was necessary for the medical well-being of the donor as well as the physical well-being of the donee. *Masden v. Harrison*, No. 68651 Eq., Mass. Sup. Jud. Ct., June 12, 1957; *Huskey v. Harrison*, No. 68666 Eq., Mass. Sup. Jud. Ct., Aug. 30, 1957; *Foster v. Harrison*, No. 68574 Eq., Mass. Sup. Jud. Ct., Nov. 20, 1957. The opinions in these cases were not published in the official reports of the Court. A discussion of these cases and their potential ramifications appears in Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U.L. Rev. 891 (1959).

While there are many unanswered questions in this area of the law, perhaps the most difficult at the present time are: (1) whether the court will allow such an operation where a minor, under eighteen years of age, who understands the nature of the operation and the risks involved, consents, but the parents refuse consent; and (2) whether the court will allow such an operation where the potential donor is a minor of insufficient age to understand the nature of the operation and the risks involved, and the parents give their consent. For a discussion of some of the problems in this area see Curran and Beecher, *Experimentation in Children*, 10 J.A.M.A. 77 (1969).

<sup>7</sup> If the legislature did intend to include refusal of consent situations, G.L., c. 112, §12F should be amended so as to clearly indicate such intent.

<sup>8</sup> While there are no Massachusetts cases on point, where parents have refused

A question which is likely to arise in Massachusetts in the future is the validity of a minor's consent to an abortion. The California Supreme Court in the case of *Ballard v. Anderson*<sup>9</sup> held that a minor's consent to a therapeutic abortion was valid and that parental consent was not required. In that case, however, the decision was based on a statute which permitted an unmarried, pregnant minor to give consent to the furnishing of hospital, medical, and surgical care related to her pregnancy.<sup>10</sup> The court, erroneously I believe, held that "surgical care related to her pregnancy" encompassed a therapeutic abortion despite the fact that the Therapeutic Abortion Act<sup>11</sup> was enacted 14 years after the statute in question. Three judges dissented, taking the position that the obvious legislative purpose of the consent statute was to preserve the unborn life, not to destroy it.<sup>12</sup> Massachusetts, as of this date, has no comparable statute. It is doubtful that the emergency treatment law, as currently worded, would be construed to insulate the physician from liability where he performs an abortion on a minor without obtaining parental consent. This point should be clarified by the legislature in the light of the recent Supreme Court pronouncements regarding abortion.<sup>13</sup>

---

on religious grounds to allow medical treatment to a minor, and such treatment was needed to save the child from death or serious bodily harm, courts in other jurisdictions have ordered compulsory treatment, usually by appointing the hospital administrator as temporary guardian of the child for the purpose of giving consent to the treatment. See *Matter of Brooklyn Hospital v. Torres*, 45 Misc. 2d 914, 258 N.Y.S. 2d 621 (Sup. Ct. Special Term 1965); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962). The Perricone opinion cited the language in *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944), where it was said that "[P]arents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." 37 N.J. 463, 473-474, 181 A.2d 751, 757 (1962).

While there is a difference between the situation where the court in effect orders the emergency treatment, despite the refusal of the parent to consent to it and the situation where the physician himself makes that determination, situations will no doubt arise where, due to the nature of the emergency, time is not available to seek even a speedy judicial determination of the matter. Since the courts have in the case of minors consistently ordered the needed medical treatment, where time prevents the obtaining of judicial approval, the courts would no doubt hold the physician who acts not liable in any subsequent litigations.

<sup>9</sup> 4 Cal. 3d 873, 484 P.2d 1345, 95 Cal. Rptr. 1 (1971).

<sup>10</sup> Cal. Civ. Code, §34.5 (West 1954).

<sup>11</sup> Cal. Health & Saf. Code, §§25950-25954 (West Supp. 1972). Prior to this statute abortions were permitted only in emergency situations when necessary to preserve the *life* of the mother.

<sup>12</sup> 4 Cal. 3d 873, 885, 484 P.2d 1345, 1354, 95 Cal. Rptr. 1, 10 (1971). The interpretation of the statute in the *Anderson* case related to a *therapeutic* abortion and would not appear to be authority in California where the abortion is not based upon preserving the health of the minor.

<sup>13</sup> *Roe v. Wade*,—U.S.—, 93 S. Ct. 705 (1973) and *Doe v. Bolton*,—U.S.—, 93 S. Ct. 739 (1973).

In addition to these "crisis" situations, there remains the general question of a minor's right to consent to ordinary medical treatment. Some states have enacted legislation allowing minors to consent to such treatment if they are living away from home.<sup>14</sup> In Massachusetts, it seems clear that in non-emergency situations the consent of the parent or legal guardian is required where the minor is incapable of understanding and appreciating the nature and likely consequences of medical treatment.<sup>15</sup> There are no Massachusetts cases which determine whether consent is required where the minor is of sufficient age and maturity to understand and appreciate the nature and likely consequences of the treatment,<sup>14</sup> and cases in other jurisdictions are divided.<sup>15</sup>

**§15.3. Immunity: Charities and emergency treatment.** Within the past decade, the Massachusetts legislature has acted upon two aspects of immunity relevant to medical malpractice. The results are most interesting because the General Court went in different directions on the two questions. By abolishing the doctrine of absolute charitable immunity, the path was paved for suits against hospitals based on the negligence of their staffs. Yet, statutory immunity was conferred upon physicians and nurses rendering emergency medical treatment, thus barring malpractice suits in those circumstances.

*Charitable organizations.* Since the 1876 decision of *McDonald v. Massachusetts General Hospital*,<sup>1</sup> most hospitals, as charitable organizations, enjoyed total immunity from liability in tort with respect to the conduct of their agents while engaged in charitable activities. The theory behind this doctrine was that funds donated for charitable purposes should not be diverted. Even when liability insurance became available at a relatively small cost, the doctrine of charitable immunity continued

<sup>14</sup> See, e.g., Cal. Civ. Code, §34.6, applying to minors fifteen years of age or older.

<sup>15</sup> See note 1, *supra*.

<sup>16</sup> In an opinion of the Attorney General, (Op. Atty. Gen. Feb. 9, 1966, p. 247) the view is expressed that "if a patient has not attained his majority and is unmarried, the consent of his parents, as natural guardians, is necessary."

<sup>17</sup> The conservative view is that the consent of the minor alone is insufficient, irrespective of the nature of the treatment or surgery and irrespective of the understanding of the minor. See, e.g., *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (consent by a boy of fifteen years to a skingrafting operation held invalid). The more liberal view holds that the consent of a minor approaching maturity to relatively simple treatment or surgery will be valid. See *Gulf & S.I.R. Co. v. Sullivan*, 155 Miss. 1, 119 So. 501 (1928) (consent by a seventeen year old minor to a vaccination held valid); *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956) (consent by eighteen year old plaintiff to a plastic surgery operation on her nose held valid). See Note, *Torts—Battery—Consent of Minor to Simple Operation as a Defense*, 10 Vand. L. Rev. 619 (1957) and Note, *Assault and Battery—Lack of Parental Consent to an Operation as a Basis for Liability*, 9 West. Res. L. Rev. 101 (1957) for discussions of the Lacey decision. There appear to be no cases dealing with the validity of consent by a minor to major medical treatment or surgery.

§15.3. 1 120 Mass. 432 (1876).

to be applied,<sup>2</sup> and became imbedded in the common law of Massachusetts.<sup>3</sup>

A major chink in the armor of charitable immunity appeared in 1969. In *Colby v. Carney Hospital*<sup>4</sup> the Supreme Judicial Court, while applying the doctrine of charitable immunity, stated that "we take this occasion to give adequate warning that the next time we are squarely confronted by a legal question respecting the charitable immunity doctrine it is our intention to abolish it."<sup>5</sup> This admonition, while putting potential charitable organization defendants on notice of an imminent change in the law, was also directed at the legislature. The subsequent enactment of Section 85K of Chapter 231 of the General Laws<sup>6</sup> made judicial abolition unnecessary.<sup>7</sup>

Section 85K provides that charitable organizations may be liable in tort. If the tort was committed in the course of any activity carried on to accomplish directly the charitable purposes of the organization, liability in any such cause of action may not exceed the sum of \$20,000, exclusive of interests and costs. The \$20,000 limitation does not apply if

<sup>2</sup> In fact the charitable immunity doctrine was applied even where the particular charity carried liability insurance and thus where recovery by the plaintiff would not have diverted funds held for charitable purposes. *McKay v. Morgan Memorial Co-op. Industries & Stores, Inc.* 272 Mass. 121, 172 N.E. 68 (1930).

<sup>3</sup> In 1958, in the case of *Simpson v. Truesdale Hospital, Inc.*, 338 Mass. 787, 154 N.E.2d 357 (1958) the Supreme Judicial Court stated: "While as an original proposition the doctrine might not commend itself to us today, it has been firmly imbedded in our law for three quarters of a century and we think that 'its termination should be at legislative, rather than at judicial, hands.'" *Id.* at 787-88, 154 N.E.2d at 358. This statement reflected an underlying consideration which was in conflict with the Court's desire to abolish the rule. Judicial abolition might have the effect of subjecting a charitable organization to tort liability for an act committed prior to the abolition but within the statute of limitations, where the charitable organization, having relied upon the charitable immunity doctrine, was uninsured. Abolition by the legislature, on the other hand, would operate prospectively.

<sup>4</sup> 356 Mass. 527, 254 N.E.2d 407 (1969).

<sup>5</sup> *Id.* at 528, 254 N.E.2d at 408.

<sup>6</sup> See Acts of 1971, c. 785, §1.

<sup>7</sup> It seems to have been assumed by some that the Colby decision abolished charitable immunity. For example, in the language declaring Chapter 785 of the Acts of 1971 to be an emergency measure, the purpose of the Act is set out as *limiting* the liability of charitable organizations, whereas in actuality the Act was creating liability up to twenty-thousand dollars. In a 1972 decision, *Ricker v. Northeastern University*, 1972 Mass. Adv. Sh. 299, 279 N.E.2d 671, the plaintiff sought recovery against a charity where the cause of action arose prior to the enactment of G.L., c. 231, §85K. The plaintiff claimed that he was entitled to recover under the following language of the Colby opinion: ". . . the next time we are squarely confronted . . . it is our intention to abolish it [charitable immunity]." The Court, applying the charitable immunity doctrine, held that the language in the Colby opinion did not by itself abolish the doctrine and that since the legislature had acted, judicial abolition was not warranted. The Court further held that there is no indication in the statute that it was intended to have retrospective effect.

the tort was committed in the course of activities primarily commercial in character even though carried on to obtain revenue to be used for charitable purposes.<sup>8</sup> Considering the proportional reduction in insurance premium costs as liability coverage increases, it is not clear why the legislature set a ceiling on the liability of charitable organizations rather than completely abolishing the doctrine; perhaps it was to protect self-insuring charitable organizations from financial ruination.

It should be noted that the \$20,000 limitation of liability is applicable to a *cause of action* rather than to a wrongful act. Thus, if several persons were injured as the result of a negligent act on the part of the agent of a charitable organization, the \$20,000 limitation would apply separately as to each plaintiff. Likewise, it would appear that if the negligent act of the agent of a charity caused injury to a person from which injury the person subsequently died, the \$20,000 limitation would apply separately to the count for pain and suffering and separately to the count for wrongful death these being severable and distinct harms.<sup>9</sup>

The abolition of the total immunity enjoyed by charitable organizations may make hospitals liable for the acts of their servants under the doctrine of *respondet superior*. It will be important to determine whether a physician treating a patient in a hospital should be treated as a servant of the hospital rather than an independent contractor;<sup>10</sup> whether the nurse or intern who assists the doctor in treating a patient is the servant of the hospital, the borrowed servant of the doctor or the servant or both,<sup>11</sup> or whether the X-ray technician is a servant or independent contractor.<sup>12</sup>

<sup>8</sup> This part of the statute merely codifies the common law. See *McKay v. Morgan Memorial Stores, Inc.*, note 2, *supra*, holding that a charity is liable for the negligence of its agents with respect to activities which are primarily commercial in character even though such activities are carried on to obtain revenue to be used for charitable purposes.

<sup>9</sup> While the executor or administrator maintains both actions, recovery for the decedent's pain and suffering prior to death becomes part of the decedent's estate, whereas recovery for wrongful death enures to the benefit of the statutory beneficiaries and is not part of the decedent's estate. See *Maltzman v. Hertz*, 336 Mass. 704, 147 N.E.2d 767 (1958). See also *Wall v. Massachusetts Northeastern Street Railway Co.*, 229 Mass. 506, 118 N.E. 864 (1918).

<sup>10</sup> For collected cases on the liability of a hospital for the negligence of a doctor see 69 A.L.R.2d. 305.

<sup>11</sup> See *Barrette v. Hight*, 353 Mass. 268, 230 N.E.2d 808 (1967), holding the defendant doctor, the chief of surgery at a hospital, not liable for the negligence of a resident in surgery even though at the time of the injury the resident was "somewhat" under the direction and control of the defendant-doctor. See also *Ramsland v. Shaw*, 341 Mass. 56, 166 N.E.2d 894 (1960), *Klucken v. Levi*, 293 Mass. 545, 200 N.E. 566 (1936), and *Guell v. Tenney*, 262 Mass. 54, 159 N.E. 451 (1928) holding the doctor not liable for injury resulting to his patient from the negligence of a hospital nurse. See also other cases collected in 14 A.L.R.3d 873, 880, 37 A.L.R.2d 1284, and 72 A.L.R.2d 408, 418.

<sup>12</sup> See 41 A.L.R.2d 329, 369. In *Withington v. Jennings*, 253 Mass. 484, 149 N.E. 201 (1925), the defendant doctor, who was in charge of the X-ray department of a hospital, was held not liable for the negligence of an X-ray technician.



*Emergency treatment.* Massachusetts follows the common law rule that, absent some special relationship between the parties which is regarded as sufficient to impose a duty to act,<sup>13</sup> a person is not liable for his failure to render assistance to prevent injury or death to another, irrespective of the slightness of the burden of rendering aid. This rule pertains whether the failure to render aid was inadvertent<sup>14</sup> or intentional.<sup>15</sup> It stems principally from a reluctance on the part of the courts to transform moral obligations into legal duties. It also reflects concern for the practical problems that would arise if recovery were generally allowed for nonfeasance.<sup>16</sup> On the other hand, a person who undertakes to render assistance to an injured or helpless person will be liable if, in rendering assistance or attempting a rescue, he fails to exercise ordinary care.<sup>17</sup>

---

The Court held that the technician was not the servant of the doctor but rather a fellow employee.

<sup>13</sup> See, e.g., *Newman v. Redstone*, 354 Mass. 379, 237 N.E.2d 666 (1968), wherein the Supreme Judicial Court assumed without deciding it would follow the rule of the *RESTATEMENT (SECOND) OF AGENCY* §512 (1957), imposing a legal obligation on an employer to exercise reasonable care to avert threatened harm to an employee, and, if the employee is hurt, to give first aid and care for him until he can be cared for by others. See also *Carey v. New Yorker of Worcester, Inc.*, 355 Mass. 450, 245 N.E.2d 420 (1969) and *Marra v. Botta Corporation*, 356 Mass. 569, 254 N.E.2d 418 (1970), involving the duty owed by the owner of a business establishment to prevent injury to one of its patrons, and *Brown v. Knight*, 1972 Mass. Adv. Sh. 1469, 285 N.E.2d 790, involving the duty of a paid custodian of a child to take affirmative protective steps to prevent injury to the child from the conduct of others.

<sup>14</sup> *Lacey v. United States*, 98 F. Supp. 219 (D.C. Mass. 1951).

<sup>15</sup> *Osterlind v. Hill*, 263 Mass. 73, 160 N.E. 301 (1928).

<sup>16</sup> One problem is assessing the degree of risk to which a rescuer must be subject before he could be legally excused from acting. Would a fair swimmer be obligated to effect the rescue of a person drowning a hundred yards offshore? If ten persons were present at the time of drowning which could have been prevented, would all ten be held liable? Would a person be liable if he was, through his fault, unaware of the victim's peril or unable to help him? For example, would an intoxicated person be held liable if, had he been sober, he could have rescued the victim?

<sup>17</sup> It is not entirely clear that Massachusetts accepts this common law rule. In an early case, *Griswold v. Boston & Maine Railroad*, 183 Mass. 434, 437, 67 N.E. 354, 356 (1903), the Court rejected the so called "Good Samaritan Rule" with the statement: "If it is law, no humane or gratuitous act could be done without subjecting the doer of it to an action on the ground that the defendant ought to have acted more quickly or with more judgment. It is a doctrine which would allow an action against a good Samaritan and let a priest and a Levite go free."

Yet in a later case, *Black v. New York, New Haven & Hartford R.R.*, 193 Mass. 448, 79 N.E. 797 (1907), the Court held the defendant railroad liable where its servants assisted an intoxicated passenger from the train but left him half way up a flight of stairs. The passenger subsequently fell and was injured. The Court stated: "They [the conductors] were under no obligation to remove him from the car, or to provide for his safety after he left the car. But they

These common law doctrines have placed physicians in a morally if not legally perplexing situation. The nature of their profession would appear to dictate that they assist someone in emergency conditions yet the potential threat of liability in negligence for being a "Good Samaritan" has caused doctors to hesitate to render such services. Many doctors have contended that since there is no legal obligation to provide any assistance, they should not be exposed to liability when voluntarily rendering emergency treatment.<sup>18</sup>

Any possibility of a medical boycott of emergency situations was drastically decreased by the enactment of G.L., c. 112, §12B in 1962. Under the present version of Section 12B:<sup>19</sup>

No physician duly registered . . . and no nurse duly registered . . . who, in good faith, as a volunteer and without fee, renders emergency care or treatment, other than in the ordinary course of his practice, shall be liable in a suit for damages as a result of his acts or omissions, nor shall he be liable to a hospital for its expenses if, under such emergency conditions, he orders a person hospitalized or causes his admission.

The statute is self-explanatory. Only the terms "in good faith"<sup>20</sup> and "other than in the ordinary course of his practice"<sup>21</sup> may require further

voluntarily undertook to help him from the car, and they were bound to use ordinary care in what they did that might affect his safety. Not only in the act of removal, but in the place where they left him, it was their duty to have reasonable regard for his safety in view of his manifest condition." *Id.* at 450, 79 N.E. at 798.

It is possible to distinguish the holding in the Black case from the Court's language in the *Griswold* opinion, as there is a difference between the negligent rendering of aid to an ill, injured or imperiled individual and the negligent act of taking a helpless person from a position of relative safety and placing him in a position of extreme danger.

<sup>18</sup> See Note, California Good Samaritan Legislation: Exemptions from Civil Liability While Rendering Emergency Medical Aid, 51 Cal. L. Rev. 816 (1963); W. PROSSER, *LAW OF TORTS* § , at 344 (4th ed. 1971).

<sup>19</sup> Since enacted in 1962 (Chapter 217 of the Acts of 1962) G.L., c. 112, §12B has been amended four times.

<sup>20</sup> If "good faith" refers to motive it is difficult to imagine someone rendering emergency treatment in bad faith. The term may refer to the absence of wilful and wanton conduct such as an abandonment of the victim.

<sup>21</sup> Presumably the language "other than in the ordinary course of practice" excludes emergencies occurring in a hospital or a doctor's office where the necessary equipment and assistance is available. It is not clear whether it would exclude an emergency call by a doctor to a heart attack victim at his home. The likelihood is that it would exclude such a visit, particularly since such calls are not normally performed gratuitously. The spirit of the language seems to encompass solely the situation where a doctor or nurse happens to be in a place, other than a hospital or doctor's office, when an emergency arises. For a discussion of the problem of interpretation of this type of statute see Comment, Good Samaritans and Liability for Medical Malpractice, 64 Col. L. Rev. 1301, 1308-1311 (1964).

clarification within the context of an actual case. To date, no cases have arisen in Massachusetts under this section.

Enactment of Section 12B was clearly warranted in light of the legislative policy to encourage physicians to aid people in dire need of expert medical treatment. Viewed as an exception to the Good Samaritan rule, the only remaining question is whether the legislature should not proceed to abrogate that doctrine in its entirety.<sup>22</sup>

**§15.4. Statute of limitations in medical malpractice cases.** In the case of *Capucci v. Barone*,<sup>1</sup> decided in 1929, the defendant-surgeon left a sponge in the plaintiff's abdominal cavity during an operation. The presence of the sponge was not discovered until two years following the operation. The Supreme Judicial Court held that the plaintiff's malpractice action against the surgeon was barred by the two year statute of limitations. G.L., c. 260, §4 then required a tort action for malpractice to be commenced "within two years next after the cause of action accrues."<sup>2</sup> That requirement was construed to mean two years from the date of the surgeon's misconduct or negligent act, namely the date of the surgery; it did not mean two years from the date that the foreign object was discovered in the plaintiff's body.<sup>3</sup>

In following years many other jurisdictions, deciding the issue under similar statutes, rejected the *Capucci* approach because it produced unjust results. Some jurisdictions have treated such an act by a doctor as a continuing negligence, holding that the cause of action accrued when the foreign object was removed. Other jurisdictions employed various fictions holding either that the surgical operation on the plaintiff may not be viewed as complete until the wound has been closed and all appliances used in the operation have been removed or that some constructive fraud tolled the running of the statute of limitations. More recently, some courts have simply taken the position that in medical malpractice cases the statute of limitations commences to run when the

<sup>22</sup> A few states have enacted statutes providing limited protection to all persons who render emergency care in good faith. Thus, a New Mexico statute (N.M. Stat. Ann. §12-12-3 (Repl. Vol. 3 1953)), provides in part: "No person who shall administer emergency care in good faith at or near the scene of an emergency . . . shall be held liable for any civil damages as a result of any action or omission by such person in administering said care, except for gross negligence; . . ."

Massachusetts recently extended the exemption from civil liability for good faith emergency treatment to members of a ski patrol duly registered in the National Ski Patrol system. See G.L., c. 231, §85I added by Chapter 349 of the Acts of 1970.

§15.4. <sup>1</sup> 266 Mass. 578, 165 N.E. 653 (1929).

<sup>2</sup> The two year statute of limitations for medical malpractice actions was first adopted by c. 319, §1 of the Acts of 1921, amending G.L., c. 260, §4. The critical amendment extending the period of limitation from two to three years was added in 1965 by c. 302 of the Acts of 1965.

<sup>3</sup> 266 Mass. at 580, 165 N.E. at 654-55.

plaintiff knows or, in the exercise of reasonable care, should know of his condition.<sup>4</sup>

Some states have dealt with this problem legislatively, by enacting statutes which combine a discovery rule with an outer limit.<sup>5</sup> Under this approach, the statute of limitations does not commence to run until the negligence has been discovered but the action must still be brought within a designated period of time from the date of medical treatment. Such a proposal came before the Massachusetts legislature in 1965. House Bill 530 would have amended G.L., c. 260, §4 to provide that "actions of contract or tort for malpractice, error or mistake . . . shall be commenced within two years next after the injured party has knowledge of the facts which give rise to a cause of action but only within five years after the cause of action accrues." This bill, with a "sliding scale discovery" rule and a five year "outer limit" was sent to the Senate with only one change: the five year "outer limit" was excised leaving only the two year "sliding scale discovery" rule. The Senate rejected that proposed amendment and adopted instead a substitute measure, Senate Bill 924. The Senate version merely republished G.L., c. 260, §4, but extended the statute of limitations for malpractice actions to three years.

Against this backdrop came *Pasquale v. Chandler*.<sup>6</sup> In that case, the defendant-surgeon left a Kelly clamp in the patient's abdominal cavity. A Kelly clamp is similar in appearance to a pair of scissors; it is approximately eight inches long, with curved serrated jaws and a ratchet type lock. The clamp was not discovered and removed from the patient until approximately six years after the operation at which time it was rusted and broken. The plaintiff died several months thereafter. The Supreme Judicial Court affirmed directed verdicts for the defendant-surgeon on counts for wrongful death and for pain and suffering because the two year statutes of limitations barred relief. The Court indicated that it might have been disposed to reconsider the rule set down in the *Capucci* decision were it not for the very recent legislative history of House Bill 530;<sup>7</sup> however, the legislature's rejection of a sliding scale rule, even with a five year outer limit, was viewed as an affirmation of the *Capucci* ruling. In that light, the Court believed it could not overrule *Capucci* without doing damage to fundamental notions of judicial self-restraint and deference to legislative policy-making

<sup>4</sup> For a collection of cases, see 80 A.L.R.2d 368.

<sup>5</sup> See, e.g., Ala. Code, tit. 7, §25[1] (Supp. 1972) and Conn. Gen. Stat. Ann. §52-584 (Supp. 1973).

<sup>6</sup> 350 Mass. 450, 215 N.E.2d 319 (1966).

<sup>7</sup> The Court in the *Pasquale* case held that a directed verdict was improperly granted on the count for pain and suffering against a second doctor-defendant, with respect to a claim of negligence on his part for failure to diagnose and treat the patient properly following his operation. Both the defendant-doctor and one other physician testified that examination by X-ray was the proper medical practice in diagnosing such complaints as *Pasquale's*. The defendant-doctor had failed to order an X-ray during the six year period.

functions. As a legal process problem, it appears reasonably clear that the decision of the Supreme Judicial Court in the *Pasquale* case is correct. Establishing the time for the accrual of a cause of action in a malpractice case is properly a legislative function. Certainly if G.L., c. 260, §4 expressly provided that such a cause of action shall accrue on the date of the defendant's negligence or misconduct, this language could not be ignored by the Court. Although Section 4 did not expressly provide to that effect, the legislative history suggested that interpretation.

Yet, this does not mean that the issue has been satisfactorily resolved. It now rests with the legislature. The General Court, as it has recently done in other areas of tort law,<sup>8</sup> should move to correct the unfair result which the Supreme Judicial Court was compelled to reach in *Pasquale*. There is no need for an absolute repose theory for the statute of limitations in this area. Proper legislation in this area should contain no outer limit in which the action must be brought. Rather, the plaintiff should be required to maintain his action within two years from the time that he knew of his injury.<sup>9</sup>

This rule would not work a manifest injustice upon the defendant-doctor. In the rare case where the plaintiff does not know of his injury until long after the operation, the absence of records or witnesses or the dimming of memories occasioned by long delay is more detrimental to the plaintiff who has the burden of establishing the physician's negligence than it is to the defendant-doctor. Since the plaintiff is unlikely to have independent evidence of the doctor's negligence, both parties will essentially rely upon hospital records, the testimony of hospital personnel, etc. In other words, the evidentiary burden will fall equally on plaintiff and defendant.

**§15.5. Evidentiary uses of medical treatises, periodicals, pamphlets, etc. in medical malpractice cases.** Despite some recent major developments in the area of medical malpractice<sup>1</sup> the greatest practical problem

<sup>8</sup> See, e.g., G.L., c. 231, §85K, enacted in 1971, abolishing the charitable immunity doctrine up to the first \$20,000 in damages; G.L., c. 231, §85L, enacted in 1971, changing the duty of a host driver to a guest to one of ordinary care; G.L., c. 106, §2-318, amended in 1971, holding manufacturers, sellers, and suppliers of goods liable in damages for breach of warranty despite the absence of privity between the plaintiff and defendant; and more recently, Acts of 1972, c. 665, amending G.L., c. 186, §19, substantially changing the duty owed by a landlord to his tenant relative to unsafe conditions of the premises.

<sup>9</sup> Language to the effect that the statute of limitations should commence to run when the plaintiff, *in the exercise of reasonable care*, should have known of his injury is not recommended. Such language has little practical significance when applied to a statute of limitations of this nature and is too indefinite a standard for the commencement of the running of the statute of limitations, at least in this situation.

<sup>1</sup> See, e.g., *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968) which abolished the community standard rule in malpractice cases. For a discussion of the *Brune* decision see 1968 Ann. Surv. Mass. Law §3.16.

in the field is the same as it was ten years ago: the difficulty in obtaining the testimony of expert witnesses. Massachusetts courts correctly maintain the rule that:

It is only in exceptional cases that a jury instructed by common knowledge and experience may without the aid of expert medical opinion determine whether the conduct of a physician toward a patient is violative of the special duty which the law imposes as a consequence of this particular relationship.<sup>2</sup>

All of the recent cases on point involved the question of whether expert testimony was necessary in the particular case to prove negligence or causation.<sup>3</sup>

<sup>2</sup> *Haggerty v. McCarthy*, 344 Mass. 136, 139, 181 N.E.2d 562, 565 (1962).

<sup>3</sup> For recent cases holding that no expert testimony was required see *Lipman v. Lustig*, 346 Mass. 182, 190 N.E.2d 675 (1963) (defendant-dentist dropped a reamer into the plaintiff's throat—stomach surgery was required); *Delaney v. Rosenthal*, 347 Mass. 143, 196 N.E.2d 878 (1964) (failure of defendant-doctor to properly treat an obviously infected thumb and allowing plaintiff's thumb to be treated principally by an inexperienced nurse's aid, resulting in serious complications); *Alexandridis v. Jewett*, 388 F.2d 829 (1st Cir. 1968) (failure of defendant-obstetrician to reasonably respond to plaintiff's telephone call that she was in labor, resulting in serious complications). In some cases the expert testimony was supplied by the defendant-doctor's admissions. *Manzoni v. Hamlin*, 348 Mass. 770, 202 N.E.2d 264 (1964); *Waters v. Dana*, 348 Mass. 796, 206 N.E.2d 87 (1965); *Pasquale v. Chandler*, 350 Mass. 450, 215 N.E.2d 319 (1966). For cases holding that expert testimony was required see *Erban v. Kay*, 342 Mass. 779, 174 N.E.2d 667 (1961) (cause of cardiac arrest during an operation); *Barrette v. Hight*, 353 Mass. 268 230 N.E.2d 808 (1967) (proper procedure for a "cutdown"); *Lyons v. Cambridge Clinic Inc.*, 355 Mass. 800, 247 N.E.2d 700 (1969) (removal of a tooth from a fractured jaw); *Civitarese v. Gorney*, 1971 Mass. Adv. Sh. 121, 266 N.E.2d 668 (causation-relation of postoperative bleeding, infectious hepatitis, and acute pyelonephritis to failure of defendant to take routine preoperative tests); *McCarthy v. Boston City Hospital*, 1971 Mass. Adv. Sh. 109, 266 N.E.2d 292 (administration of intensive radiation therapy treatments). The most interesting Massachusetts decision in this area is *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962). In the *Haggerty* case, the evidence at the trial showed that the defendant doctor performed an appendectomy upon the plaintiff. The defendant had some doubt as to whether he had been able to remove the entire appendix but failed to communicate that doubt to the plaintiff. Approximately eight years later the plaintiff, now living out-of-state, consulted a doctor complaining of pain. As a consequence of the plaintiff's telling this doctor that his appendix had been removed and the visible scar in the appendix area, the doctor omitted certain standard tests which would have shown an appendicitis. Later the plaintiff's appendix ruptured causing serious complications which would not have occurred had the appendix been timely removed. The plaintiff sued the first doctor claiming that his negligence in failing to inform him after the first operation that his appendix may not have been removed entirely was the cause of his subsequent harm. In a four to three decision the Supreme Judicial Court upheld a directed verdict for the defendant taking the position that it was incumbent on the plaintiff to show by expert medical testimony that an incomplete removal of the appendix in the circumstances created a definable and substantial medical risk and that this was known, or should have been known, to the surgeon.

In 1949 the Massachusetts Legislature, in an effort to ameliorate the difficulties inherent in obtaining expert testimony, enacted G.L., c. 233, §79C. In essence, Section 79C permitted the use of medical treatises and periodicals "in the discretion of the court," to supply evidence necessary for the plaintiff to avoid a directed verdict in a medical malpractice case. Section 79C required, however, that the court find that the evidence was relevant and "that the writer of such statement is recognized in his profession or calling as an expert on the subject. . . ."<sup>4</sup>

Fifteen years after its enactment, Section 79C was described as relatively ineffective in avoiding miscarriages of justice in medical malpractice cases caused by the absence of expert testimony.<sup>5</sup> The failure of Section 79C to achieve its purpose has been ascribed to the Supreme Judicial Court's restrictive view of how the plaintiff must establish to the court's satisfaction that the author is "'recognized in his profession or calling as an expert on the subject. . . .'"<sup>6</sup> The question raised, but never expressly answered by the Court, is whether the plaintiff must produce the testimony of a medical expert to vouch for the author's expertise. If so, the goal of the statute, to create alternatives to actual expert testimony, is perhaps fatally frustrated.

Where plaintiffs have attempted to utilize treatises pursuant to Section 79C without actually producing the testimony of a medical expert, they have failed. In *Reddington v. Clayman*,<sup>7</sup> the trial judge excluded a treatise which was offered under Section 79C because of lack of evidence that the author was recognized in his profession or calling as an expert on the subject. In approving the exclusion of this treatise, the Supreme Judicial Court considered and rejected several methods which would have obviated the need for expert testimony to vouch for the author's expertise. The biographical data in the front of the book could not be used to establish the author's expertise because such statements

<sup>4</sup> G.L., c. 233, §79C provides:

Statements of facts or opinions on a subject of science or art contained in a published treatise, periodical, book or pamphlet shall, in so far as the court shall find that the said statements are relevant and that the writer of such statements is recognized in his profession or calling as an expert on the subject, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, optometrists, hospitals and sanitarium, as evidence tending to prove said facts or as opinion evidence; provided, however, that the party intending to offer as evidence any such statements shall, not less than thirty days before the trial of the action, give the adverse party or his attorney notice of such intention, stating the name of the writer of the statements, the title of the treatise, periodical, book or pamphlet in which they are contained, the date of publication of the same, the name of the publisher of the same, and wherever possible or practicable the page or pages of the same on which the said statements appear.

<sup>5</sup> See Kehoe, *Massachusetts Malpractice Evidentiary Statute—Success or Failure?* 44 B.U.L. Rev. 10, 29 (1964).

<sup>6</sup> *Id.* at 21-29; 3 Ann. Surv. Mass. Law. §22.6 (1956).

<sup>7</sup> 334 Mass. 244, 134 N.E.2d 920 (1956).

are hearsay. The Court also rebuffed the plaintiff's attempt to establish the author's expertise through two other books, the *Directory of Medical Specialists* and an English edition of *Who's Who*. Judicial notice of these books was ruled out without discussion. The Court further suggested that these books would probably not be admissible under G.L., c. 233, §79B<sup>8</sup> as "[f]act statements published for persons in a particular occupation" in the absence of independent evidence that the compilation is used and relied upon by persons engaged in that occupation. *Reddington* thus appears to require *another expert witness* to establish the expertise of the author of the writing offered under Section 79C. To satisfy the court, this witness must testify that the author of the writing is an expert, or that the compilation sought to be admitted under Section 79B to prove that the author is an expert under Section 79C, is a compilation which is commonly used and relied upon by persons engaged in a particular occupation.

In *Ramsland v. Shaw*<sup>9</sup> the plaintiff attempted to introduce in evidence a treatise by Dr. R. R. MacIntosh, an English doctor, entitled *Lumbar Puncture and Spinal Analgesia*. He attempted to establish the expertise of Dr. MacIntosh by resort to Section 79B, using the 1957 edition of *Who's Who* together with the testimony of a city librarian. The trial court excluded the testimony of the city librarian and excluded the treatise despite the fact that the defendant-doctor himself gave evidence that would have warranted a finding that Dr. MacIntosh was a recognized expert in the field of anesthesia. On appeal, the Supreme Judicial Court affirmed the ruling of the trial judge that it was unnecessary to determine whether the book *Who's Who* was improperly excluded since the admissibility of the medical treatise was within the trial judge's discretion under the statute.<sup>10</sup> The Court found no abuse of discretion where the trial judge excluded the treatise by relying upon the locality rule.<sup>11</sup>

The interesting issue raised by *Reddington* and *Ramsland* is the relationship between Sections 79B and 79C of Chapter 233. The use of a collateral writing to vouch for the expertise of the author of a medical

<sup>8</sup> G.L., c. 233, §79B provides:

Statements of facts of general interest to persons engaged in an occupation contained in a list, register, periodical, book or other compilation, issued to the public, shall, in the discretion of the court, if the court finds that the compilation is published for the use of persons engaged in that occupation and commonly is used and relied upon by them, be admissible in civil cases as evidence of the truth of any fact so stated.

<sup>9</sup> 341 Mass. 56, 166 N.E.2d 894 (1960).

<sup>10</sup> A 1965 amendment to Section 79C deleted the language "in the discretion of the court" from the statute. See Acts of 1965, c. 425.

<sup>11</sup> The trial judge reasoned that since Dr. MacIntosh was an English physician and his treatise was published in England, his work should not be controlling because of possible differences in anesthesia techniques in England and in the locality involved in the case. The issue of whether the locality rule was to be incorporated by implication into Section 79C has been rendered moot by the decision in *Brune v. Belfinkoff*, note 1, *supra*.



writing under G.L., c. 233, §79C is hearsay unless it comes within the language of the statutory exception found in G.L., c. 233, §79B. Section 79B provides for the admissibility of “[s]tatements of fact of general interest to persons engaged in an occupation contained in a . . . compilation . . . if the court finds that the compilation is published for the use of persons engaged in that occupation and commonly is used and relied upon by them.” (Emphasis added).

The problems presented by the narrow scope and ambiguity of Section 79B can be illustrated by the *Ramsland* case. There the plaintiff attempted to establish the expertise of the author of the medical writing by offering *Who's Who* in support of such expertise, accompanied by the testimony of a librarian that *Who's Who* is commonly used and relied upon. There is considerable doubt as to whether a statement appearing in a general compilation such as *Who's Who*, attesting to the expertise of an author of a medical treatise, is a “statement of fact” within the contemplation of Section 79B. The question of the author’s standing within his calling or profession is more clearly a matter of expert opinion than it is a matter of fact. Even if this threshold obstacle is surmounted, there is a further question concerning the meaning and scope of the term “occupation.” Is it broad enough to embrace a librarian’s testimony that the compilation is commonly used and relied upon by librarians? When considered in relation to Section 79C, it is the author’s view that it clearly is not. What would be required is a doctor’s testimony that the compilation is used and relied upon by persons engaged in the medical field. Thus, even this route to admissibility requires a physician’s testimony.

Recent developments affecting the operation of G.L., c. 233, §79C, have not appreciably alleviated the difficulties in applying it. A 1965 amendment to Section 79C deleted the language “in the discretion of the court” from the statute.<sup>12</sup> Thus, the correctness of the trial judge’s exclusion of a medical treatise or periodical is no longer determined by the “abuse of discretion” standard. The same amendment also increased the time period for giving notice of an intention to use a treatise or periodical from three days to thirty days before the trial and required that the notice, wherever possible or practicable, specify the page or pages of the treatise or periodical containing the statements relied upon by the party.<sup>13</sup> The decision in *Brune v. Belinkoff*,<sup>14</sup> abolishing the “locality rule” in Massachusetts, meant that the author of the writing offered under Section 79C would not have to be qualified as an expert on the particular matter according to the standard of the community in which the defendant practiced medicine.

As mentioned in the beginning of this section, the apparent purpose

<sup>12</sup> See note 10, *supra*.

<sup>13</sup> See 1965 Ann. Surv. Mass. Law, §22.2.

<sup>14</sup> See note 1, *supra*.

<sup>15</sup> See Duarte, petitioner, 331 Mass. 747, 122 N.E.2d 890 (1954).

of G.L., c. 233, §79C was to provide a substitute for the expert medical witness in medical malpractice cases. Such substitute was deemed necessary because of the inability of plaintiffs, in medical malpractice cases, to obtain the testimony of fellow members of the profession relative to the defendant's negligence or misconduct. Twenty-three years after the enactment of Section 79C, it cannot definitively be stated that the statute has achieved its purpose.

Nor is there a strong likelihood that judicial decisions will increase the efficiency of the present statute. In the opinion of this author, it is highly unlikely that the Supreme Judicial Court will reverse its position in the *Reddington* decision and take judicial notice of either the expertise of the author of a medical treatise or of the accuracy and usage of any collateral writing which purports to vouch for the expertise of the author of a medical treatise or writing. It is doubtful whether the expertise of the author of a medical writing can ever be a matter of such notoriety as to warrant the use of judicial notice.<sup>15</sup> Even where the author's name has become a household word, his views may have subsequently become discredited or his conclusion disproved among his peers. With respect to a collateral writing, the issue is not so much whether the accuracy or use of the writing is a notorious fact but whether it actually purports to characterize the expertise of the author of the medical writing in question, and, if so, whether its author has the expertise to vouch for the expertise of the author of the medical writing. If the trial judge does not have the ability to determine by judicial notice that the author of a medical writing is an expert, how can such a matter be determined by the unknown author of a blurb appearing in *Who's Who*, the *Encyclopedia Britannica* or *Webster's Dictionary*? Where the collateral writing or compilation is itself a kind of medical treatise, the same arguments against the use of judicial notice apply to it as militated against use of judicial notice to vouch for the expertise of the author of the original writing.

Thus, once again, it may be up to the legislature to re-examine the purpose of Section 79C. If it concludes that its goal remains a worthwhile objective, then it might well ponder new legislation to implement it.

**§15.6. Conclusion.** These four topics are by no means exhaustive of the medical malpractice field. Indeed, this article has not discussed one of the most interesting and current problems in medical malpractice, the question of informed consent.<sup>1</sup> In informed consent cases, the doctor has allegedly obtained the patient's consent for certain medical treatment or surgery without having fully disclosed to the patient the risks involved in the treatment or surgery. The patient then falls victim to one of the undisclosed risks and sues the physician for malpractice. The principal issues in such cases are (1) whether the action sounds in battery for an

§15.6. <sup>1</sup> This article has deliberately omitted a detailed discussion of informed consent because the issue has not yet arisen in Massachusetts.

unconsented touching because the consent was not informed or in negligence because the doctor failed to exercise reasonable care in not disclosing all possible risks; and (2) whether expert testimony is required before a jury will be permitted to find liability. The majority view, drawn from recent cases in other jurisdictions, is that the proper cause of action is negligence and that expert testimony is required.<sup>2</sup> There appear to be sound theoretical and practical reasons supporting those conclusions.<sup>3</sup>

While special rules must occasionally be fashioned to deal with novel issues in medical malpractice such as informed consent, such questions can usually be satisfactorily analyzed by application of basic principles and underlying policies of medical malpractice law.

### STUDENT COMMENT

**§15.7. Planning for unplanned child litigation.** The use of birth control pills and voluntary sterilization as methods of contraception and family planning has increased greatly in recent years. To those relying

<sup>2</sup> On the negligence-battery issue see *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960); *DeFillippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967); *Kaplan v. Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967), *affirmed*, 51 N.J. 404, 241 A.2d 235 (1968). For a case treating the matter as a battery, see *Bang v. Charles T. Miller Hospital* 251 Minn. 427, 88 N.W.2d 186 (1958) (sterilization). See W. PROSSER, *LAW OF TORTS* §18, at 105-106, §32, at 165-166 (4th ed. 1971).

The need for expert testimony is illustrated in *Wilson v. Scott*, 412 S.W.2d 229 (Texas 1967) where the plaintiff was able to establish the standard by the testimony of the defendant-doctor. The defendant-doctor testified that it was standard procedure to inform the patient that there was a risk (about 1%) of the total hearing loss in a stapedectomy operation and that he told the plaintiff about the risk. The defendant's testimony established the standard despite the fact that the jury might disbelieve that the defendant complied with the standard in the particular case.

<sup>3</sup> The negligence theory appears to be the more accurate. Where a physician obtains the consent of a patient to surgery or other type of medical treatment by withholding information as to its potential risks but in no way deceives the patient as to the type of surgery or medical treatment itself, any fraud involved does not go to the essence of the touching and would therefore not appear to vitiate the consent. Furthermore, whether a particular patient, facing necessary and difficult surgery, should be informed of all the risks incident to such surgery is a question involving the exercise of reasonable care and sound medical judgment on the part of the doctor. Liability should not be automatically imposed upon a showing that the patient consented to the operation without being informed of the known risks incident thereto.

On the second issue, since the disclosure of risks incident to surgery or other medical treatment is a matter of professional judgment, expert testimony should normally be required to support a jury's finding of negligence. Only in rare circumstances where the failure to inform could be determined to be unreasonable based upon common knowledge and experience would expert evidence be unnecessary.

upon the effectiveness of birth control, the failure of these products and procedures to prevent conception and the subsequent birth of an unplanned child may be devastating. Years of family planning are wasted and great economic and social strain is placed upon already struggling couples. Single women must face the prospects of unwed motherhood, while single men are subject to paternity suits. The unplanned child may be the target of parental hostility. If his biological parents are not married, such a child must also endure the legal and social stigmas of illegitimacy. Given the socially undesirable consequences of birth control failure, it is important that the legal implications of such failure be known and understood.

The failure of birth control products and procedures has already resulted in legal action against physicians, pharmacists and manufacturers in other jurisdictions.<sup>1</sup> These decisions illustrate the need to create a sound medico-legal policy capable of balancing the competing public policies and private interests involved in "unplanned child litigation." While such disputes have not yet reached the courts of Massachusetts, they will eventually demand legal resolution. This Comment, then, will create a framework through which the problems inherent in unplanned child litigation can be viewed.

After beginning with a brief medical background and an analysis of possible plaintiffs and defendants, the article will discuss causes of action against physicians, pharmacists and manufacturers. Particular emphasis will be placed upon the problems of proof confronting plaintiffs and defendants alike. Assuming that courts may recognize these causes of action, this Comment will discuss elements of damages and how recovery should be measured. The conclusion will focus upon three questions that a trial court must consider in deciding whether or not relief should be granted: whether the plaintiff has suffered an injury that the law should compensate; whether public policy allows for such compensation; and whether the court is the proper institution to afford compensation.

## I. MEDICAL BACKGROUND

The vasectomy, or sterilization of the male, is a simple procedure which may be performed in thirty minutes in a doctor's office with the use of local anesthesia. The operation involves cutting and tying off the *vas deferens* so that sperm can no longer be ejaculated.<sup>2</sup> Due to its high

§15.7. <sup>1</sup> *Custodio v. Bauer*, 251 Cal. App.2d 303, 59 Cal. Rptr. 463 (1967) (action against a physician based upon pre-operative conduct and failure of tubal ligation); *Troppe v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971) (action against a druggist who delivered a tranquilizer instead of the prescribed oral contraceptive); and *Whittington v. Eli Lilly & Co.*, 333 F.Supp. 98 (S.D. W. Va. 1971) (action against a pharmaceutical company based upon the alleged failure of its oral contraceptive to prevent conception).

<sup>2</sup> Planned Parenthood League of Massachusetts, *The Operation of Vasectomy*, 1972 (available at the League's office in Newton, Mass.).

rate of success and relatively low cost,<sup>3</sup> the vasectomy has become the most popular form of voluntary sterilization. Because the patient may still be carrying live sperm cells in his seminal vesicle, he is advised to use contraception until laboratory tests confirm complete sterilization. The testing period may last from six to twelve weeks.<sup>4</sup> In rare cases the *vas deferens* may naturally fuse back together, thereby negating the effectiveness of the vasectomy. Vasectomies are generally irreversible, and surgical reversals have enjoyed only limited success.<sup>5</sup>

Tubal ligation, or sterilization of the female, blocks off the tubes which carry the egg from the ovary to the uterus. There are two basic methods of performing this operation. The older, salpingectomy, involves an abdominal incision through which the tubes are cut and tied.<sup>6</sup> Considered major surgery and requiring a week of hospitalization and several weeks for complete recovery, it is much more expensive than the vasectomy and recommended only when other types of surgery are to be performed at the same time. The newer method, laparoscopy, does not involve major surgery and is almost as inexpensive as the vasectomy. Through the use of special instruments a small piece of tube is removed and cauterized. The operation is performed under general anesthesia and requires only two small incisions near the navel.<sup>7</sup> Since the procedure is not considered major surgery, the patient may go home the next day. Tubal ligation is considered irreversible, and only rarely has surgical reversal been achieved. It is as effective as the vasectomy as a means of contraception.<sup>8</sup>

The birth control pill works in several ways to prevent conception. It may stop the release of the egg, change the lining of the womb to make it difficult for the egg to implant, or alter the rate of egg transport from the ovary to the uterus so it arrives too early or too late for implantation. There are two main types of birth control pill. The combination pill contains both estrogen and progesterone, while the sequential pill contains one or the other and must be taken alternately during the menstrual

<sup>3</sup> Consumer Reports, June, 1971, at 385. The chance of natural failure is about 0.5% and costs range from \$50 to \$175.

<sup>4</sup> Planned Parenthood League of Massachusetts, *The Operation of Vasectomy, 1972, and Vasectomy; Male Sterilization, 1972* (available at the League's office in Newton, Mass.).

<sup>5</sup> Comment, *Elective Sterilization*, 113 U. Pa. L. Rev. 415, 417 (1965); P. Tierney, *Voluntary Sterilization, A Necessary Alternative?*, 4 Family L.Q. 373 (1970). Two recent developments indicate that a reversible sterilization may soon be available. The first, the Bionyx Control, contains a microvalve which fits inside the sperm duct and may be turned to an "on" or "off" position, depending upon the user's desire to procreate. The second, the silicone plug, fits in the sperm duct, blocks the flow of sperm, and may be removed when the user desires to procreate. Both of these developments have been praised and subjected to criticism.

<sup>6</sup> Planned Parenthood League of Massachusetts, *Female Sterilization, 1972* (available at the League's office in Newton, Mass.).

<sup>7</sup> *Ibid.*

<sup>8</sup> *Ibid.*

cycle.<sup>9</sup> While both types are considered "almost completely effective,"<sup>10</sup> the combination pill is more highly recommended.<sup>11</sup> There are over twenty brands of oral contraceptives and physicians try to match patients with the product that physiologically is best suited to them. Of course, the ultimate effectiveness of the birth control pill depends on following the directions for its use.

## II. LEGALITY OF STERILIZATION AND ORAL CONTRACEPTIVES IN MASSACHUSETTS

Like most states Massachusetts has no specific law dealing with voluntary sterilization.<sup>12</sup> Despite the fact that sterilizations are performed regularly in the Commonwealth,<sup>13</sup> doubts about their legality continue to be expressed.<sup>14</sup> It has been suggested that sterilization is criminally punishable under the Mayhem Law.<sup>15</sup> Other jurisdictions with Mayhem statutes similar to the Massachusetts law have held that no criminal liability attaches to the physician performing a sterilization with the consent of the patient.<sup>16</sup> The rationale is that the statute requires malice, an element which cannot be proved in this situation, and that the purpose and previous application of the statute preclude its use as a basis for prosecution.<sup>17</sup> This reasoning should be controlling in Massachusetts.

It can also be argued that sterilization is punishable under anti-abortion statutes prohibiting unlawful attempts to procure miscarriage.<sup>18</sup> Case law indicates that the pregnancy of a woman is not an essential element of the offense.<sup>19</sup> However, the statute does require that the defendant act

<sup>9</sup> Planned Parenthood League of Massachusetts, *Choosing a Contraceptive: The Pill*, 1972 (available at the League's office in Newton, Mass.).

<sup>10</sup> Physician's Desk Reference (1972). The oral contraceptives of all manufacturers are listed as "almost completely effective." Planned Parenthood League literature describes the pill as 100% effective when taken as directed. See note 9, *supra*.

<sup>11</sup> Planned Parenthood League of Massachusetts, *Choosing a Contraceptive: The Pill*, 1972 (available at the League's office in Newton, Mass.).

<sup>12</sup> As of this writing only five states have specific legislation dealing with voluntary sterilization. See Ga. Code Ann. §§84-931 through 84-935 (Supp. 1972); Mont. Rev. Code Ann. §§69-6401 through 69-6406 (1970); N.C. Gen. Stat. §90-271 (Supp. 1971); Ore. Rev. Stat. §435.305 (1971); Va. Code Ann. §§32-423 *et. seq.* (Supp. 1972).

<sup>13</sup> The Planned Parenthood League has a referral list of 57 doctors performing sterilizations and several Boston hospitals also perform the operations.

<sup>14</sup> In *Hathaway v. Worcester City Hospital*, 341 F. Supp. 1385 (D. Mass. 1972), the court mentions that the City Solicitor of Worcester advised the hospital that performing a tubal ligation might be illegal under state law. However, the opinion did not state the legal basis for the City Solicitor's advice.

<sup>15</sup> G.L., c. 265, §14 (1958).

<sup>16</sup> *Jess'n v. County of Shasta*, 274 Cal. App.2d 737, 79 Cal. Rptr. 359 (1969).

<sup>17</sup> *Id.* at 747-48, 79 Cal. Rptr. at 365-66.

<sup>18</sup> G.L., c. 272, §19 (1968).

<sup>19</sup> *Commonwealth v. Cheng*, 310 Mass. 293, 37 N.E.2d 1010 (1941).

“with the intent to procure the miscarriage of a woman.”<sup>20</sup> Since the intent to sterilize is to prevent future conception, it can hardly be construed as an intent to procure a miscarriage. Furthermore, since no prosecutions have been brought under these statutes against persons performing sterilizations in Massachusetts, it appears that there are no operative criminal bars against the procedure in this Commonwealth.

Indeed, a Massachusetts woman recently claimed a constitutional right to have a tubal ligation performed in a city hospital. In *Hathaway v. Worcester City Hospital*,<sup>21</sup> the plaintiff sought a declaratory judgment and an order compelling the hospital to perform the operation. The federal district court for the district of Massachusetts dismissed the plaintiff's complaint on the ground that no constitutional right to have the city hospital perform tubal ligations existed, particularly where no such procedure had been previously performed in that facility. The court ruled that it could not justify ordering the hospital to perform tubal ligations under a statute directing city hospitals to receive “persons requiring relief during temporary sickness.”<sup>22</sup> The court could not attribute to the legislature an intent to make tubal ligations available because it viewed the operation as a “subject of grave political debate, as to which there is not even within the medical profession unanimity of view, and as to which the evidence shows Massachusetts hospitals have differing practices and policies.”<sup>23</sup> The question, therefore, was one for the legislature to decide.\*

The argument for the existence of a constitutional right to voluntary sterilization could be supported by reading *Griswold v. Connecticut*<sup>24</sup>

<sup>20</sup> G.L., c. 272, §19 (1968).

<sup>21</sup> 341 F. Supp. 1385 (D. Mass. 1972).

<sup>22</sup> G.L., c. 40, §5(20) (Supp. 1972).

<sup>23</sup> 341 F. Supp. at 1387.

<sup>24</sup> *Griswold v. Connecticut*, 381 U.S. 479 (1965).

<sup>25</sup> *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

\*On March 22, 1973 the United States Court of Appeals for the First Circuit ruled that Worcester City Hospital's refusal to perform voluntary sterilizations constituted a denial of equal protection in violation of the Fourteenth Amendment. 41 U.S.L.W. 2521 (April 3, 1973). This reversal of the District Court opinion discussed in this Comment appears to have been greatly facilitated by the United States Supreme Court decisions which permit abortion. *Roe v. Wade*, —U.S.—, 93 S. Ct. 705 (1973); *Doe v. Batton*, —U.S.—, 93 S. Ct. 739 (1973). The Court of Appeals found that there was no compelling state interest justifying the bar on voluntary sterilization. It also expressed doubt that there could be a rational basis for banning sterilization since performing the procedure involved no greater risk and required no special staff or equipment. The Court of Appeals noted that a fundamental interest, the decision to terminate the possibilities of any future pregnancies, was akin to the decision to terminate a particular pregnancy. Whatever state interests affecting the decision to abort were far less compelling in the decision to become sterile. Limiting the impact of its decision, the Court of Appeals indicated that it did not require the city or state to maintain the hospital, nor did it require the hospital to perform every therapeutic and non-therapeutic form of surgery. What it did require was that once the state under-

and *Eisenstadt v. Baird*<sup>25</sup> as applicable to several forms of birth control rather than to one form alone. Even if the reasoning in these cases is extended to voluntary sterilization, it does not require that the state make voluntary sterilization available in city hospitals. It would free the individual from governmental interference with his or her decision whether or not to procreate, but the individual would still have to obtain voluntary sterilization from a private medical source.

With regard to the legality of the use of oral contraceptives in Massachusetts it seems clear that the *Griswold* case protects their use by married persons and the *Eisenstadt* case extends this protection to unmarried persons.<sup>26</sup>

### III. PLAINTIFFS AND DEFENDANTS

Assuming the legality of the use of birth control products and procedures by married and unmarried persons, the next point of consideration is whether potential plaintiffs face any bars to recovery other than traditional defenses<sup>27</sup> raised by defendants. Married persons do not appear to face such bars. If the wife is a user of an oral contraceptive or has been sterilized, she may bring a personal injury action when the product or procedure fails. Her husband may bring a statutory claim for her medical expenses.<sup>28</sup> If the husband has had a vasectomy and the operation has failed, he may bring an action and his wife may also seek redress, since her unwanted pregnancy is well within the range of foreseeable consequences of the defendant's alleged wrongful conduct.<sup>29</sup>

---

took to provide general short term hospital care, it could not constitutionally distinguish between medically indistinguishable surgical procedures and impinge on a fundamental right. If the Court of Appeals decision stands, state and municipally operated hospitals will be obliged to perform voluntary sterilizations, as in the instant case. This affirmative duty could become burdensome if private hospitals balk at providing the operation, the demand for which will surely increase. It is unclear whether governmental hospitals are compelled by the decision to perform vasectomies, since the fundamental interest protected revolves around the woman's decision to prevent the possibility of future pregnancies. Whatever fundamental interest involved in the decision to have a vasectomy does not flow directly from *Roe v. Wade* and *Doe v. Batton*. Therefore, federal courts seeking to protect the decision to have a vasectomy will have to extend, rather than simply apply, *Hathaway v. Worcester City Hospital*.

<sup>26</sup> *Griswold* and *Eisenstadt* raise many questions about the existing state of contraceptive laws and are subject to a number of interpretations. The practical effect of *Eisenstadt* has been the extension of protection of use of birth control pills to unmarried persons. The Planned Parenthood League has also adopted the view that use of the pill is permissible in the case of married and unmarried persons.

<sup>27</sup> For the purpose of this Comment, statutes of limitations, contributory negligence greater than 50%, and affirmative defenses of due care would be traditional defenses.

<sup>28</sup> G.L., c. 231, §6A (1956).

<sup>29</sup> *Custodio v. Bauer*, 251 Cal. App.2d 303, 316-17, 59 Cal. Rptr. 463, 472 (1967).



Unmarried persons, however, must contend with the argument that their violation of fornication laws<sup>30</sup> bars their recovery in a civil action based upon the failure of birth control products and procedures. In Massachusetts, the plaintiff's violation of a criminal statute does not necessarily prevent his recovery:

Such violation is considered 'evidence of negligence' on the part of the violator, as to all consequences that the statute was intended to prevent. . . . If, however, his violation of law was merely a condition or an attendant circumstance of his injury, and not a proximate contributing cause, he may recover from the wrongdoer.<sup>31</sup>

Under this standard the question becomes whether the unmarried plaintiff's act of intercourse constitutes a "proximate contributory cause;" if it does, then the unmarried plaintiff will be barred from recovery.

Treating the act of intercourse as a "proximate contributory cause" and denying recovery to the unmarried plaintiff results in different legal outcomes in the cases of married and unmarried plaintiffs. In the case of married plaintiffs, the act of intercourse has been regarded as foreseeable conduct rather than as an independent intervening cause which relieves the defendant of liability.<sup>32</sup> In the case of unmarried plaintiffs, it appears that the opportunity to raise the foreseeability of intercourse as a fact allowing for recovery may be lost. However, there are several reasons for not applying the "evidence of negligence" standard to unmarried plaintiffs is unplanned child litigation. As a matter of justice between the parties the mere happenstance that the plaintiff is single should not preclude recovery. The state's interest in punishing the plaintiff is already vindicated by the criminal process, so further penalties such as a bar to civil recovery should not be imposed. Furthermore, the state's interest might be adversely affected by a denial of recovery to the unmarried plaintiff; a civil wrongdoer would be freed from legal responsibility to a large class of citizens, and the uncompensated mother and her child might well become an economic burden upon the state when the putative father is incapable of providing support.<sup>33</sup> Treating unmarried persons differently from married persons in this situation would also raise equal protection questions.<sup>34</sup>

It is also possible that where unmarried persons have produced an illegitimate child, the child will claim injury arising out of his status as an

<sup>30</sup> G.L., c. 272, §18 (1968).

<sup>31</sup> *Todd v. Traders & Mechanics Ins. Co.*, 230 Mass. 595, 598, 120 N.E.142, 144 (1918).

<sup>32</sup> *Custodio v. Bauer*, 251 Cal. App.2d 303, 59 Cal. Rptr. 463 (1967); *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

<sup>33</sup> In these circumstances a putative father might attempt to shift the burden of child support payments to a potential defendant.

<sup>34</sup> *Eisenstadt v. Baird*, 405 U.S. 438 (1972). The court might avoid this argument by stating that the differentiation is between plaintiffs who have committed a criminal act and those who have not.

illegitimate. The child plaintiff has numerous legal hurdles to clear before establishing a successful cause of action. The defendant may contend that the plaintiff was not a person when the birth control product or procedure failed and therefore cannot maintain an action. In Massachusetts, however, an injury to a non-viable fetus, later born alive but surviving only two and a half hours, enabled the child's administrator to sue under the Wrongful Death Act.<sup>36</sup> Non-viability at the time of the defendant's conduct, then, should not deprive the illegitimate plaintiff of standing to bring a claim once he is born and his illegitimate status attaches.<sup>37</sup>

Even if the child plaintiff establishes standing, defendants may contend that their legal responsibility extends only to the plaintiff's birth and not to his illegitimacy; since the plaintiff's biological parents may marry before his birth and thereby legitimate him, it is their conduct alone which determines the legal status of the plaintiff. The child plaintiff must counter that one who sells birth control products and services to unmarried persons should foresee that a breach of duty will result in the birth of *illegitimate children*. Therefore, attempts by defendants to characterize the child plaintiff or his injury as too remote from their wrong should fail. The defendant must take the child plaintiff as he finds him. The fact that the child's biological parents *could* have married and legitimized him does not relieve the defendant of liability to the child whose parents did not take that step.

After establishing standing to sue and a duty on the part of the defendant, the child plaintiff must satisfy the court that he has suffered an injury that should be compensated. He might point out the inequality under law between the legitimate child and himself as the basis of his injury.<sup>38</sup> Despite such a showing, courts could deny the existence of a legally cognizable injury by ruling that the birth of the plaintiff is a benefit, which, as a matter of law, outweighs any injury claimed.<sup>39</sup> Al-

<sup>35</sup> *Zepeda v. Zepeda*, 41 Ill. App.2d 240, 190 N.E.2d 849, *cert. den.* 379 U.S. 945 (1963); *Pinkney v. Pinkney*, 198 So.2d 52 (Fla. 1967). Illegitimate children brought actions against their putative fathers and claimed that illegitimate status constituted an injury for which compensation should be made.

<sup>36</sup> See *Torigian v. Watertown News Co., Inc.*, 352 Mass. 446, 225 N.E.2d 926 (1967).

<sup>37</sup> The court's reasoning in the *Zepeda* case should also be employed:

The plaintiff is a person now and he was a potential person with full capacity for independent existence at the time of the original wrong. As he developed biologically from potentiality to reality the wrong developed too. It progressed as did he, from essence to existence. When he became a person the nature of the wrong became fixed. From a moral wrong and a criminal act against the public it became a legal wrong and a tortious act against the individual. 41 Ill. App.2d at 253, 190 N.E.2d at 855.

In the *Zepeda* case the court also supported the view that a right of action existed by analogizing from other cases in which children recovered when wrongs were committed before their conception.

<sup>38</sup> See, e.g., *Labine v. Vincent*, 401 U.S. 532 (1971).

<sup>39</sup> *Shaheen v. Knight*, 11 Pa. D&C2d 41, 45, (C. P. Lycoming County, 1957).

ternatively, courts could defer the entire issue of recovery based upon illegitimacy to the legislature, reasoning that the legislature has been the traditional formulator of illegitimacy laws<sup>40</sup> and that lack of precedent further restricts judicial action.<sup>41</sup>

Defendants in unplanned child litigation will include physicians who perform sterilizations and prescribe birth control pills, lab technicians who test the effectiveness of sterilizations, pharmacists who receive and deliver prescriptions, and manufacturers of birth control pills. Because the conduct of potential defendants is often interwoven, plaintiffs would be well-advised to join all parties whose conduct might have led to their injury.<sup>42</sup> Defendants themselves may seek to mitigate or discharge their own liability by claiming that another party was legally responsible for the plaintiff's injury. For example, the physician who relies upon a laboratory test result when advising his patient that a vasectomy has been successful might claim that he performed the vasectomy carefully and that the lab technician negligently conducted the post-operative test. Since defendants are likely to attempt to shift liability to one another, it is important that each potential defendant become acquainted with the nature and extent of the legal duties of other potential defendants.

#### IV. LIABILITY OF PHYSICIANS, PHARMACISTS AND MANUFACTURERS

*Physicians.* The primary liability of the physician is derived from his performance of sterilizations. In order to insulate himself from suit in this area, the physician should follow several guidelines of conduct. Before performing a sterilization, he should inform the patient about the nature of the procedure, the possibility that it may not succeed, the consequences of its success, the existence of any medical and psychological side effects, and the availability of alternative methods of contraception. The patient and, if married, his or her spouse as well, should be asked to sign a consent form indicating an understanding of the operation and giving permission to the physician to perform it, and the form should be notarized.<sup>43</sup>

The sterilization itself should be performed in accordance with the physician's standard of care.<sup>44</sup> Translating this general standard into

<sup>40</sup> At common law the illegitimate child was "filius nullius" and had no rights unless legitimated by a special act of Parliament. Legislative enactments have slowly removed some of the inequities between legitimate and illegitimate children and the legislature appears to have developed an evolutionary policy of equalization.

<sup>41</sup> See *Jorgensen v. Mead Johnson Laboratories, Inc.*, 336 F. Supp. 961 (W.D. Okla. 1972). The District Court would not provide a remedy for a Mongoloid child born as a result of the mother's use of an oral contraceptive.

<sup>42</sup> See *Hackworth v. Hart*, 474 S.W.2d 377, 379 (Ky. Ct. App. 1971).

<sup>43</sup> Planned Parenthood League of Massachusetts, *The Operation of Vasectomy*, 1972 (sample form available at the League's office in Newton, Mass.).

<sup>44</sup> See *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968).

specifics for sterilization requires a step by step medical familiarity with the operation. Therefore, plaintiffs should rely upon medical treatises and expert testimony<sup>45</sup> in order to properly evaluate the correctness of the sterilization procedure. Establishing standards of care in the area of post-operative testing has also proved difficult. For example, in the Washington case of *Ball v. Mudge*,<sup>46</sup> the failure to conduct post-operative tests was established, but the plaintiff's complaint was dismissed because no community standard of post-operative testing could be presented to the jury.<sup>47</sup> More recently, in the Kentucky case of *Hackworth v. Hart*,<sup>48</sup> the defendant physician gave one post-operative test and a three test standard was presented; however, the issue of negligence was allowed to go to the jury.<sup>49</sup> The *Ball* case suggests that there may be a reluctance on the part of expert witnesses to testify against fellow physicians,<sup>50</sup> and the *Hackworth* case intimates that trial courts may be reluctant to direct verdicts for the plaintiff in a new matter that involves multiple defendants.<sup>51</sup>

Assuming that recognized standards of care will be developed in Massachusetts, the physician's failure to follow them may render him liable under several legal theories. Under the negligence theory the physician may be charged with improperly performing the sterilization operation, the post-sterilization tests, or both. Conception and birth by themselves do not conclusively establish a breach of the physician's duty to the plaintiff or the fact that such breach, if it did occur, was the proximate cause of the plaintiff's injury. Natural recanalization of the *vas deferens* may have occurred despite the physician's exercise of due care.<sup>52</sup> The plaintiff may have failed to use contraception during the post-operative testing period; even if the physician negligently ceased conducting post-operative tests, the plaintiff's prior negligent failure to use contraception might relieve him from liability.<sup>53</sup> Since conception and birth may be produced by causes other than negligent conduct of the defendant, the plaintiff may not employ a strict liability theory and instead must prove the negligence of the physician and its causal connection to the resulting injury.

In order to prove the physician's negligence the plaintiff must rely heavily upon expert testimony to establish the standard of care and show how the physician's conduct strayed from the standard and caused injury.

<sup>45</sup> *Haggerty v. McCarthy*, 344 Mass. 136, 139, 181 N.E.2d 562, 565 (1962); see also, G.L., c. 233, §79C (Supp. 1972).

<sup>46</sup> 64 Wash. 2d 247, 391 P.2d 201 (1964).

<sup>47</sup> *Id.* at 249, 391 P.2d at 203.

<sup>48</sup> 474 S.W.2d 377 (Ky. Ct. App. 1971).

<sup>49</sup> *Id.* at 381.

<sup>50</sup> See note 47, *supra*.

<sup>51</sup> See note 48, *supra*.

<sup>52</sup> Comment, Elective Sterilization, 113 U. Pa. L. Rev. 415, 417 (1965).

<sup>53</sup> Such conduct could be found by a jury to be 50% or more negligent, sufficient to bar recovery under the comparative negligence law.

In the case of the operation itself, the plaintiff may try to show that it was performed in such a way that recanalization was almost certain to occur.<sup>54</sup> In the case of post-operative testing, the plaintiff may contend that the physician failed to instruct him to use contraception during the post-operative testing period or prematurely advised him that the use of contraception was no longer necessary.<sup>55</sup>

Of course, the physician may avail himself of several defenses. He may raise a statute of limitations to bar the plaintiff's action completely.<sup>56</sup> Under the statute applicable to malpractice suits in tort or contract, the plaintiff must bring suit within a three year period which commences at the time the cause of action accrues.<sup>57</sup> The physician may also contend that he was not negligent in any respect or that the plaintiff was contributorily negligent and responsible for the unplanned pregnancy.<sup>58</sup>

Physicians may also face claims based upon a theory of negligent misrepresentation if they advise a patient that a sterilization will succeed or that intercourse without the use of contraception can be safely engaged in immediately after the operation. Since this conduct on the part of the defendant also gives rise to a negligence claim, which does not require proof of the plaintiff's justifiable reliance thereon, it is likely that the theory of negligent misrepresentation will be advanced sparingly.

Plaintiffs may also claim that the physician is liable for breach of contract. While physicians are generally held not to warrant a specific result or cure,<sup>59</sup> their conduct may overcome this presumption.<sup>60</sup> When a physician expressly guarantees to accomplish a result and fails to do so, liability will attach. However, few physicians will make such a guarantee in writing, if at all. Consequently the plaintiff generally bears the burden of proving the existence and the terms of the contract by parole evidence statements made by the defendant to his patient that the sterilization would be a complete success.<sup>61</sup> In deciding whether to give the words the effect of a binding promise, the law must distinguish between a formal and express guarantee and the everyday assurances given to relax the patient. The making of this distinction is usually left to the jury as a question of fact.<sup>62</sup> The test used is what a reasonable man would be-

<sup>54</sup> *Custodio v. Bauer*, 251 Cal. App.2d 303, 312 n.5, 59 Cal. Rptr. 463, 469 n.5 (1967).

<sup>55</sup> See *Hackworth v. Hart*, 474 S.W.2d 377 (Ky. Ct. App. 1971).

<sup>56</sup> G.L., c. 260, §4 (1970).

<sup>57</sup> *Id.*; In the case of sterilization, the cause of action accrues at the time of the operation and not when the damage occurs or is discovered. The statute has been construed in this manner by *Pasquale v. Chandler*, 350 Mass. 450, 215 N.E.2d 319 (1966).

<sup>58</sup> See note 53, *supra*.

<sup>59</sup> *Hunt v. Bradshaw*, 251 F.2d 103 (4th Cir. 1958).

<sup>60</sup> *Colvin v. Smith*, 276 App. Div. 9, 92 N.Y.S.2d 794 (1949).

<sup>61</sup> In this instance the hearsay rule may limit plaintiff's effort to sustain his burden of proof.

<sup>62</sup> See note 60, *supra*.

lieve after hearing the physician's words.<sup>63</sup> Unless the physician's conversation clearly states a guarantee of success, it is doubtful that the plaintiff can sustain his burden of proof. The presumption that physicians do not guarantee results aids the defendant physician greatly. Furthermore, if the plaintiff signed a consent form indicating his understanding that the sterilization might not succeed, then a second presumption will arise that the physician did not orally guarantee success. Given the great difficulty of proving the existence of an oral contract to sterilize and a guarantee of medical success, causes of action based upon contract will probably enjoy only limited success.

A second source of physician's liability would be the negligent transmittal of a prescription to the pharmacist. Prescriptions for the oral contraceptive are made by telephone or by written note. If the physician calls for a drug other than the one that he intends to prescribe then he becomes responsible for injury resulting from his negligent conduct. Plaintiffs will confront problems of proof where telephoned prescriptions are involved. The physician may honestly believe that he asked the druggist to supply the plaintiff with a specific oral contraceptive, and the druggist may assert just as adamantly that the physician told him to supply something else. The plaintiff would be wise to name both the physician and the druggist in his complaint when faced with such problems of memory and credibility. The defendants, of course, may contend that the plaintiff knew that the drug was supposed to be an oral contraceptive and should have known from the name and appearance of the drug whether or not it was the correct product. The success of this contention, of course, depends upon the facts of a given case.<sup>64</sup>

*Pharmacists.* The druggist delivers oral contraceptives to customers after receiving a written or telephoned prescription from the customer's physician. He should be certain that he understands the oral or written directions of the physician before filling the prescription. In Massachusetts the druggist who delivers a drug other than the one prescribed can be held liable for resulting injury on negligence grounds.<sup>65</sup> The Michigan decision of *Brown v. Marshall*<sup>66</sup> explains the policy behind the druggist's liability as well as the extent of his duty:

The case, it must be conceded, is one in which a very high degree of care may justly be required. People trust not merely their health but their lives to the knowledge, care and prudence of druggists, and in many cases a slight want of care is liable to prove fatal to some

<sup>63</sup> See C. SIMPSON, *CONTRACTS* 10 (1965).

<sup>64</sup> If the plaintiff were a new user of the product, she might not be held to know its name or appearance. The plaintiff was a new user in *Troppi v. Scarf*, 31 Mich. App.2d 240, 187 N.W.2d 511 (1971), and she did not confront the contention that she should have known the name or appearance of the birth control pill.

<sup>65</sup> *Nesci v. Angelo*, 249 Mass. 508, 144 N.E. 287 (1924); *Andreotala v. Gaeta*, 260 Mass. 105, 156 N.E. 731 (1927).

<sup>66</sup> 47 Mich. 576, 11 N.W. 392 (1882).

one. It is therefore proper and reasonable that the care required shall be proportioned to the danger involved.<sup>67</sup>

Given the existence of precedent and the policy of holding druggists liable for their mistakes, the druggist in Massachusetts who delivers a substance other than the prescribed oral contraceptive will probably be held responsible for his conduct.

Plaintiffs will have to prove that a misdelivery has occurred. In cases involving telephoned prescriptions, the plaintiff will encounter the problems previously mentioned under claims against physicians based upon negligent prescription. Where the prescription was in writing, it will be of little use if the patient or pharmacist has destroyed it. The plaintiff's best sources of proof are the drug and its container and the records of the physician and pharmacist.

The druggist's defenses are rather limited. He may set up the statute of limitations, claim that the physician prescribed the wrong drug, claim that the plaintiff should have known that the drug delivered was not the oral contraceptive prescribed, or claim that the plaintiff never used any of the drugs delivered and that the misdelivery was not causally related to the unplanned pregnancy.

*Manufacturers.* Manufacturers will face liability when the oral contraceptive fails to prevent conception. Claims may be based upon theories of negligence, breach of warranty, deceit and perhaps, strict liability. There are three elements of the plaintiff's case which must be proved regardless of what theory she pursues: the existence of a defective product; the defendant's responsibility for the defect; and the causal connection between the defect and the unwanted pregnancy.

Proving the existence of a product defect will not be a simple matter. When the pill has been ineffective for the plaintiff and no proof of a defect is presented other than the facts that the plaintiff used the pill and became pregnant, the plaintiff has not sustained her burden of proof under a theory of negligence. The injury to the plaintiff alone does not create an inference of product defectiveness.<sup>68</sup> If the plaintiff can check manufacturer's records and pharmacist's prescription records to determine who else has used pills from the same control group, she might be able to show that others have been injured and thereby strengthen the inference that the pills were defective. In order to defeat an inference of defectiveness the defendant can subject the pills in question to chemical testing and determine whether or not they conform to standards set for marketability. Since proof of defectiveness or effectiveness by such testing may be difficult and conclusive findings might not be achievable

<sup>67</sup> Id. at 583, 11 N.W. at 395.

<sup>68</sup> Absent other proof of a product defect, the injury to the plaintiff alone is not enough to establish a causal connection between the product and the injury. See *Jacquot v. Wm. Filene's Sons Co.*, 337 Mass. 312, 149 N.E.2d 635 (1958).

in all circumstances,<sup>69</sup> expert testimony and its credibility will play a determinative role in the development of product liability actions and defenses.

While the manufacturer's responsibility for a defect may be easily established, the causal connection between the defect, if established, and the plaintiff's unwanted pregnancy could be difficult to prove or disprove. Sustaining this burden of proof will call for expert testimony. In an area where expertise has not really developed, the plaintiff who must confront a well-trained staff of pharmaceutical house scientists and physicians is placed at a serious disadvantage. On the other hand, when a jury believes that a defect exists and sees that the plaintiff has conceived, it might rely more upon its common perceptions than upon its understanding of the defense's scientific arguments.

Even if the oral contraceptive is not deemed defective the manufacturer may have a duty to warn the public that it does not always work effectively. In some circumstances, the duty to warn will exist even though only a small number of users will be affected by product failure.<sup>70</sup> But a court may rule that because the pill is almost perfect and the number of persons affected is negligible, no duty to warn should be required. On the other hand, it might hold that brochure language like "virtually 100% protection,"<sup>71</sup> and Physician's Desk Reference language like "almost completely effective"<sup>72</sup> provide an adequate warning of the risk of failure.

Brochure phrases could conceivably constitute grounds for an action in deceit. These phrases intimate that the pill is completely effective when taken as directed. The average consumer may not be able to distinguish between "virtually 100% protection" and absolute protection in assessing the degree of risk of product failure associated with the pill. While the Physician's Desk Reference language, "almost completely effective"<sup>73</sup> more clearly expresses the possibility of product failure, it may not be reasonable for manufacturers to rely upon physicians to convey this information to patients, nor socially desirable to permit manufacturers to address vague or misleading language to the consumer. This vague language could easily *induce* the consumer to select the pill as a method of contraception. Any impact that this language might have as a warning is negated when the consumer reads the language as a statement of product effectiveness. In order to reduce claims based upon brochure language and provide the consumer with a more accurate and simple explanation of the risk of product failure, manufacturers should

<sup>69</sup> The plaintiff may have consumed all of the product alleged to be defective. It is debatable whether inferences may be drawn from testing other pills in the same prescription or control group.

<sup>70</sup> *Cornish v. Sterling Drug, Inc.*, 370 F.2d 82 (8th Cir. 1967).

<sup>71</sup> *Whittington v. Eli Lilly & Co.*, 333 F. Supp. 98, 100 (S.D. W.Va. 1971).

<sup>72</sup> *Physician's Desk Reference* 918 (1972).

<sup>73</sup> *Id.* at 918.



indicate the tested effectiveness of the pill and the circumstances under which the pill will fail to prevent conception. The fact that planned parenthood literature states that the pill is completely effective when taken as directed underscores the need for a change in brochure language.

The failure of the pill to prevent conception may result in an action based upon the manufacturer's breach of express and implied warranties of fitness for a particular purpose. In the first instance the court must determine whether or not an express or implied warranty of fitness exists. In *Whittington v. Eli Lilly & Co.*<sup>74</sup> it was held that a brochure stating, "when taken as directed, the tablets offer virtually 100% protection"<sup>75</sup> did not rise to an express or implied warranty of fitness. The court granted the defendant's motion for a summary judgment. Relying upon Webster's Dictionary, the court construed "virtually" as meaning "less than absolutely" in reaching the result that no warranty of complete effectiveness was extended. While stating that the pill was "clearly reasonably safe for use by the public as an oral contraceptive"<sup>76</sup> it cautioned, "in the very nature of things it cannot be totally and absolutely effective."<sup>77</sup> Given the ostensible impossibility of complete regulation of the reproductive process, the *Whittington* court indicated that the manufacturer should not be liable to a plaintiff whose physiological idiosyncrasies contributed to the product failure.<sup>78</sup>

If the brochure in *Whittington* did not create an express or implied warranty of absolute fitness for a particular purpose, what did it create? On one hand the language could be treated as a disclaimer limiting the manufacturer's warranty from absolute effectiveness to *almost* absolute effectiveness. On the other hand, it could be treated as the only type of warranty that a manufacturer can offer, assuming that it is currently impossible to completely regulate the reproductive process. Under either views the brochure would not extend a warranty of absolute effectiveness, as Mrs. Whittington alleged. Given the *Whittington* Court's emphasis on the unpredictability of the reproductive process, it undoubtedly adhered to the latter interpretation of the brochure language. If a Massachusetts Court differed on this factual issue and assumed that the pill would be 100% effective when taken as directed, then brochure language seeking to limit the manufacturer's warranty might be negated by section 2-316A of the Massachusetts Uniform Commercial Code.<sup>79</sup> Under this section consumer goods and services are not subject to warranty exclusions or modifications. If the pill is not treated as a consumer good then brochure language may be used as a disclaimer as well

<sup>74</sup> 333 F. Supp. 98 (S.D. W.Va. 1971).

<sup>75</sup> Id. at 100.

<sup>76</sup> Id.

<sup>77</sup> Id. at 100-01.

<sup>78</sup> Id. at 101.

<sup>79</sup> G.L., c. 106, §2-316A (Supp. 1972).

as an inducement to purchase the pill. Such a result would be contrary to a strong state consumer protection policy.<sup>80</sup>

If a Massachusetts court assumes, as in *Whittington*, that a warranty of absolute effectiveness cannot possibly be extended, it must then decide how relevant this assumption is to the issue of the manufacturer's liability. On one hand, the court could follow a line of cosmetic cases which draws a distinction between instances where the product is *ineffective* for a particular user and situations where it is *defective* under pharmaceutical standards.<sup>81</sup> The manufacturer is insulated from liability except in cases where the plaintiff proves the existence of a *defect* in the product and its *causal connection* to her injury. The unusually susceptible plaintiff will be denied recovery. On the other hand, the court could distinguish the cosmetic cases from the circumstance of contraceptive failure on the grounds that effectiveness is of greater importance to individual users who rely on the pill, and the potential harm resulting from the failure of the pill is much greater to society as a whole. If the pill is distinguishable, then the truth or falsity of the assumption that the pill cannot be completely effective becomes irrelevant. The court would be free to impose a strict liability based upon product *ineffectiveness* as well as *defectiveness*.

Strict liability presents many problems for manufacturers and an awareness of them might persuade the courts not to adopt a strict liability approach. On one hand, if it is technologically impossible to produce the perfect pill, then the manufacturer should not be liable for freak occurrences of failure that cannot be guarded against. If strict liability claims are allowed, plaintiffs need only allege that they took the pill as directed; proof of a defect would be unnecessary. Given its difficult burden of proving product misuse, manufacturers might confront fraudulent claims and be forced to absorb the extraordinary costs of large scale product liability litigation. Because little can be done to improve the present effectiveness of the pill, the manufacturer would have no chance to correct the conduct giving rise to liability. Under these circumstances, some manufacturers might be forced out of business or forced to curtail the development and improvement of its products.

There are also strong arguments in favor of imposing strict liability. The manufacturer profits from the pill, and may socialize the risk of loss through insurance. The cost of insurance would then be spread among consumers rather than requiring that a few persons bear the costs of product failure. While plaintiffs would not have to prove the existence of a defect they would still have to show causation, and that is by no means easy. The mere fact that fraudulent claims *might* be made has not barred recovery in other circumstances and should not do so

<sup>80</sup> See G.L., c. 106, §2-318 (Supp. 1972).

<sup>81</sup> The cosmetic cases distinguish between defective products and those causing injury to an unusually susceptible plaintiff. See, e.g., *Jacquot v. Wm. Filene's Sons Co.*, 337 Mass. 312, 149 N.E.2d 635 (1958).

here. If the court does consider treating the failure of the pill in strict liability fashion, it should at least take into account the above considerations in reaching its result.

## V. DAMAGES

Presuming for the moment that plaintiffs can successfully develop causes of action against potential defendants, it still remains for the trial court to formulate the measure of damages that may be recovered. Potential elements of recovery are the medical expenses surrounding an unplanned pregnancy and birth, pain and suffering, loss of earning capacity,<sup>82</sup> the husband's collateral claim for his wife's medical expenses, the cost of raising the unplanned child to the age of majority, and, if the parents are unmarried, the illegitimacy of the unplanned child. All but the last element have been successfully presented in unplanned child litigation,<sup>83</sup> and all but the last two elements have already been recognized as legitimate elements of injury in Massachusetts.<sup>84</sup>

The prospect of granting recovery for the cost of raising the unplanned child to the age of majority has raised signals of judicial distress. However, courts in California and Michigan have decided that recovery for this element of injury should not be disallowed, but rather, reduced by any benefit that the plaintiff may have received as a result of the birth of the unplanned child.<sup>85</sup> The reasoning behind this result is based upon an application of a "benefits rule:"

Where the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred upon the plaintiff a special benefit to the interest which was harmed, the value of the benefit conferred is considered in mitigation of damages, where this is equitable.<sup>87</sup>

The application of the benefits rule, praised extensively by commentators,<sup>88</sup> allows the jury to consider the full extent of the plaintiff's injuries while recognizing that the birth of an unplanned child is not devoid of measurable benefit in all circumstances. It is flexible enough to apply to a variety of plaintiffs whose injuries and benefits, if any, differ greatly. For example, the benefit received by the unmarried plaintiff, wealthy plaintiff and welfare plaintiff would differ, as would the injury suffered.

<sup>82</sup> *Shea v. Rettie*, 287 Mass. 454, 192 N.E. 44 (1934).

<sup>83</sup> See, e.g., *Custodio v. Bauer*, 251 Cal. App.2d 303, 59 Cal. Rptr. 463 (1967).

<sup>84</sup> Neither of the last two elements have ever been claimed in Massachusetts.

<sup>85</sup> *Hays v. Hall*, 477 S.W.2d 402, 406 (Tex. Civ. App. 1972) (dictum).

<sup>86</sup> *Custodio v. Bauer*, 251 Cal. App.2d 303, 59 Cal. Rptr. 463 (1967); *Troppi v. Scarf*, 31 Mich. App.2d 240, 187 N.W.2d 511 (1971).

<sup>87</sup> RESTATEMENT OF TORTS, §920 (1939).

<sup>88</sup> Note, *Damages—The Not So Blessed "Blessed Event,"* 46 N.C. L. Rev. 948 (1968); Note, *Unplanned Parenthood and the Benefits Rule*, 8 Wake Forest L. Rev. 159 (1971).

Despite its attractiveness, the benefits rule has been challenged by some commentators as inapplicable to unplanned child litigation.<sup>89</sup> It has been asserted that damages resulting from an invasion of one interest are not diminished by the showing of a benefit to another interest.<sup>90</sup> Since the benefits rule specifies that the benefit conferred must be to the interest harmed, no benefit accrues at all if it attaches to an uninjured interest of the plaintiff. While this reasoning may be appealing in theory, in practice, courts may find it difficult to separate the injury and benefit received by the plaintiff into different categories of interest. The task of separation may tend to invite semantic debate at the expense of the disposition of justice, but if courts can define the benefit accruing to the plaintiff and identify it with an injury suffered without resorting to semantic debate, then the benefits rule can work successfully.

A second objection to the benefits rule is the fact that when the plaintiff can prove that the benefit was unwanted, and hence, no benefit at all, he should be able to avoid the application of the rule completely.<sup>91</sup> There are references to the benefits rule in Massachusetts, but nothing which indicates that the plaintiff could avoid its application by this reasoning.<sup>92</sup> It therefore appears that if the benefits rule is applied in unplanned child litigation, defendants may use it to mitigate damages.

Defendants may attempt to mitigate damages in other ways as well. In order to completely bar, or, at least, reduce the plaintiff's recovery, they can allege that the plaintiff was contributorily negligent and his recovery should be barred or reduced in accordance with the comparative negligence law.<sup>93</sup> Defendants might also demand that the plaintiff take certain steps to reduce the damage suffered. For example, they might claim that the plaintiff should have an abortion or at least place the unplanned child for adoption. Such claims should fail on two counts. They ignore the fact that state policies encourage families to stay together rather than separate and that the doctrine of mitigation requires that plaintiffs use only *reasonable* means to mitigate damages.<sup>94</sup> In light of current laws and social values it is doubtful that courts would consider abortion and adoption within the realm of reasonable means.

## VI. CONCLUSION: RATIONALES FOR AND AGAINST ALLOWING RECOVERY

Although, as discussed, *supra*, plaintiffs may be able to fashion causes of action based upon common law and statutory concepts, they will recover nothing unless they can also convince the courts that they have

<sup>89</sup> A. Sheppard, *Negligent Interference with Birth Control Practices*, 11 S. Texas L.J. 229 (1970).

<sup>90</sup> Restatement of Torts, §920(b) (1939).

<sup>91</sup> Restatement of Torts, §920(f) (1939).

<sup>92</sup> See, e.g., *Magnolia Metal Co. v. Gale*, 189 Mass. 124, 75 N.E. 219 (1905).

<sup>93</sup> G.L., c. 231, §85 (Supp. 1972).

<sup>94</sup> *Quaranto v. Silverman*, 345 Mass. 423, 428, 187 N.E.2d 859, 863 (1963).

suffered injuries which the courts should compensate. Three rationales have been suggested as the basis for denying a judicial remedy to plaintiffs involved in unplanned child litigation: (1) recovery would be contrary to public policy;<sup>95</sup> (2) As a matter of law the birth of a healthy child is a benefit to the plaintiff which outweighs the alleged wrong;<sup>96</sup> and (3) any remedy should be formulated by the legislature.<sup>97</sup> A careful analysis of these three rationales will show whether any of them are persuasive with regard to one or more potential plaintiffs.

The denial of recovery on the grounds that recovery is contrary to public policy stems from the belief that the defendant should not have to pay for the cost of raising the unplanned child while the child's parents enjoy raising the child and use personally the funds supposedly designated for his support. It has been further contended that allowing recovery will disturb the traditional family values and structure and cause psychological harm to the unplanned child.<sup>98</sup> These contentions do not appear to be warranted. Parents, wed or unwed, when faced with the responsibility of the conception and birth of an unplanned child, may well need an award of damages to offset the expenses resulting from that conception and birth. Since many of these expenses are incurred before an award of damages is made, a substantial part of the award will probably be used to offset them. The fear that parents will squander an award intended for the benefit of the unplanned child is not a sufficient reason for denying recovery; however, where a court feels that such a fear is justified, it might impress a constructive trust for the benefit of the child on a portion of the damages to be designated for child support.

The belief that allowing recovery disturbs family life and the life of the unplanned child is arguably insupportable. The burden of the unplanned child upon married or unmarried parents is often severe. If an unplanned child is born, he may be resented by his parents or forced to endure the legal and social stigmas of illegitimacy. Allowing recovery in these situations could only ease some of the burdens that plaintiffs must bear. The unplanned child would not create as much financial or social strain for his parents, and he might be assured of a healthier family environment as a result.

The rationale that recovery in unplanned child litigation is against public policy is further undermined by the countervailing public policy position that a wrongdoer should pay for the wrong he has committed and that the injured party should be compensated for the injury suffered. Denying recovery could lead to a relaxation of professional standards

<sup>95</sup> *Shaheen v. Knight*, 11 Pa. D&C2d 41 (C.P. Lycoming County, 1957).

<sup>96</sup> *Id.*; *Hays v. Hall*, 477 S.W.2d 402, 406 (Tex. Civ. App. 1972) (dictum).

<sup>97</sup> *Zepeda v. Zepeda*, 41 Ill. App.2d 240, 190 N.E.2d 849, *cert. den.* 379 U.S. 945 (1963). The injury claimed in the *Zepeda* case is analogous to that claimed by the unplanned child. In *Zepeda* recognition of a remedy for this injury was deferred to the legislature.

<sup>98</sup> Note, 9 Utah L.J. 808 (1965).

among potential defendants once they realized that the law would insulate them from liability. Such a relaxation could result in a greater number of unplanned pregnancies and thus be inimical to private and public policies of family planning.<sup>99</sup>

Even if a court does not believe that public policy favors birth control, it should not manufacture public policy from its own social and moral views to defeat recovery as against public policy:

The right of a court to declare what is or is not in accord with public policy does not extend to specific economic or social problems which are controversial in nature and capable of solution only as a result of a study of various factors and conditions.<sup>100</sup>

Since it is arguable that birth control and recovery in unplanned child litigation are consonant with public policy and since the rationale that recovery is against public policy has been undermined, the court should not employ this rationale to defeat recovery by potential plaintiffs.

The second rationale that birth is a benefit as a matter of law is an insufficient basis for denying recovery to potential plaintiffs in unplanned child litigation. The notion that a parent could reap economic benefit from a child put to work in the factory or on the farm is generally inconsistent with modern reality. While parents may enjoy the love and affection of another child, this benefit is arguably outweighed by the economic and social problems of raising an unplanned child. Unmarried plaintiffs, faced with giving birth out of wedlock, paternity suits and forced marriages, certainly suffer greater damage than benefit when the unplanned child is conceived and born. Given these circumstances, the court should not decide against recovery as a matter of law; instead, it should submit the issue of recovery to the jury, taking into account the relevant circumstances of the parental plaintiffs.

The unplanned child might not overcome the argument that his birth is a benefit which outweighs the injury arising from his illegitimate status. If confronted with this benefits argument, he should claim that the benefit of birth and the injury of illegitimacy involve two different interests and that the benefit was an unwanted one which should not be used to defeat his recovery. If he cannot sidestep the application of the benefit rationale, then the illegitimate child plaintiff will not recover.

Applying traditional criteria for judicial deference to legislative ac-

<sup>99</sup> The state has an interest in its citizens' raising families within their means of support. When private efforts of family planning fail, the state interest suffers. More persons may be forced into welfare and a higher rate of illegitimacy may occur.

<sup>100</sup> *Mamlin v. Genoe*, 340 Pa. 320, 325, 17 A.2d 407, 409 (1941).

<sup>101</sup> Courts often defer decisions to the legislature for a number of reasons. In the absence of favorable precedent and cases which enable the application or reasonable expansion of previously developed principles to the instant case, the court may be reluctant to make what it believes to be new law. A court may also hesitate to decide a case when the decision requires it to infringe upon an area of law

tion<sup>101</sup> to the circumstances of unplanned child litigation indicates that courts need not deny relief to plaintiffs on the ground that the legislature is the only proper source of a remedy. A body of precedent in favor of recovery has been developed outside of Massachusetts where married persons have brought claims against physicians and pharmacists.<sup>102</sup> While these decisions are not binding authority in Massachusetts, they are persuasive and have been utilized by other courts that have subsequently decided in favor of recovery.<sup>103</sup> The case of *Whittington v. Eli Lilly & Co.*<sup>104</sup> denied recovery based upon the failure of a birth control pill to prevent conception. However, it should not be persuasive in Massachusetts. In West Virginia, where *Whittington* was decided, there was no Uniform Commercial Code provision like the Massachusetts provision which restricts a manufacturer's right to limit express and implied warranties on consumer goods.<sup>105</sup> If Massachusetts courts construe this provision as including birth control pills, then *Whittington* would not prevent recovery. Furthermore, *Whittington* is predicated upon a belief that the birth control pill is not 100% effective when taken as directed and that the manufacturer's brochure adequately conveyed this fact. Massachusetts courts are free to differ on one or both of these matters; they may even elect to hold the manufacturer strictly liable when the birth control pill is ineffective, rather than defective. Since Massachusetts courts are not bound by the reasoning of *Whittington*, they should not be ineluctably chained to its result.

Although no comparable precedents have been established with regard to unmarried plaintiffs, courts in Massachusetts should be free to formulate a policy favoring recovery. The right of the unmarried plaintiff to recover will generally depend upon the same set of facts that gives rise to the married plaintiff's right to recover. The legal theories upon which recovery can be based are also the same. While the policy supporting recovery for unmarried plaintiffs differs from that supporting the married plaintiff's recovery, it should be sufficiently strong to warrant the extension of a judicial remedy.

The illegitimate child seeking judicial relief faces several obstacles. Cases in other jurisdictions involving claims of illegitimacy as injury have

---

traditionally developed by the legislature. The court might believe that extended legislative debate and drafting are more conducive to the development of a remedy and an express public policy than judicial decision.

<sup>102</sup> See, e.g., *Custodio v. Bauer*, 251 Cal. App.2d 393, 59 Cal. Rptr. 463 (1967); *Troppe v. Scarf*, 31 Mich. App.2d 240, 187 N.W.2d 511 (1971).

<sup>103</sup> *Coleman v. Garrison*, 281 A.2d 616 (Del. Super. 1971).

<sup>104</sup> 333 F. Supp. 98 (S.D. W.Va. 1971).

<sup>105</sup> G.L., c. 106, §2-316A (Supp. 1972).

<sup>106</sup> Unmarried users of birth control products and procedures should be compensated when injured and civil wrongdoers should not be relieved of liability to so large a class of persons from whom they profit. The unplanned child should be supported by his parents or through an award of damages, but in any case, the burden of support should not fall upon the state.

deferred the granting of a remedy to the legislature.<sup>107</sup> Furthermore, claims of prenatal-postnatal physical injury resulting from the conduct of physicians and the products of manufacturers have also been deferred to the legislature.<sup>108</sup> Because a policy favoring recovery for these relatively unique injuries had not been established and precedents for recovery were not available, the courts did not elect to afford judicial relief.<sup>109</sup> Massachusetts courts would thus lack precedent upon which to base a decision granting recovery to the illegitimate plaintiff. They might further hesitate to grant recovery because laws relating to the rights of the illegitimate have been initially a matter for the legislature. Given this legal background, it is unlikely that Massachusetts common law will provide the illegitimate plaintiff with a remedy. Finally the broad social implications of making illegitimacy a compensable injury will reinforce the reluctance of the courts to provide recovery.

In the first instance, then, the trial court must decide if it is the proper body to address the questions presented by unplanned child litigation. If the trial court chooses to address these questions, it must decide if public policy favors full recovery, partial recovery or no recovery at all. If some form of recovery is in order, an assessment of the "benefits rule" should be made. The social impact of allowing recovery will be great. Defendant's insurance costs might rise and this increase passed on to the consumers of the birth control business. Hospitals seeking to limit liability might limit the availability of tubal ligation to cases of medical necessity and cases where the age-parity ratio<sup>110</sup> is satisfied. The unwillingness of the medical profession to sterilize single persons will undoubtedly increase. If the illegitimate child can recover on the basis of his status, then the legislature might be moved to remove the legal inequalities between legitimate and illegitimate children. Manufacturers might well be instructed to modify their birth control pill brochures so that the effectiveness of the product is clearly explained and the conditions under which the product will fail are clearly enumerated. Hopefully the legal process will develop a sound approach to these social and legal problems which arise in the context of unplanned child disputes.

ALAN D. MANDL

<sup>107</sup> See note 97, *supra*.

<sup>108</sup> See note 41, *supra*.

<sup>109</sup> *Id.*

<sup>110</sup> *McCabe v. Nassau County Medical Center*, 453 F.2d 698, 700 (2d Cir. 1971); See also P. Forbes, *Voluntary Sterilization of Women as a Right*, 18 DePaul L. Rev. 560 (1969).