DOCTOR MY DOCTRINE: MEDICAL MALPRACTICE AND THE IRREPRESSIBLE CONTINUING TORT

I. INTRODUCTION

Politics makes for interesting theater, and recent experience proves that the politics of health care is no exception. In the current political debate over the ramifications of health care reform, an age-old discussion has re-emerged near the forefront of the American political consciousness: the proper balance between patient rights and practitioner liability in medical malpractice.[1] While liability rules may serve mainly as a peripheral issue in the current policy-making struggle, these rules have been a favorite political target for many decades, always managing to assert their place in the broader discussion of health care policy.[2] The debate is often framed as addressing "tort reform," but this simple title belies the complexity of the issue. The term "tort reform" encompasses myriad policies

1. *See Tort Reform Back On Table In Health Care Debate*, KAISER HEALTH NEWS DAILY REPORT, Sept. 10, 2009, http:// www.kaiserhealthnews.org/ Daily-Reports/ 2009/ September/ 10/ Tort-reform. aspx? referrer= search.

2. *See* Michael Hiltzik, *Why Tort Reform is a Frivolous Diversion*, L.A. TIMES, Oct. 1, 2009, at B1.

including caps on punitive and non-economic damages,[3] caps on attorneys' fees, modification or elimination of joint and several liability rules,[4] elimination of collateral source restrictions,[5] and modifications to statutes of limitation.[6]

Statutes of limitation[7] have played a leading role in the ongoing tort reform drama, but no consideration of such statutes is complete without consideration of the policies that underlie them and the policies that sometimes circumvent the limitation of actions.[8] The tension between these policies often favors outcomes in the plaintiffs' favor at the expense of the defendants' repose.[9]

Statutes of limitation may have many purposes: "to promote repose, to reduce transaction costs, to protect reliance interests, or to reinforce . . . *status quo* bias."[10] Statutes of limitation may also serve an evidentiary function, maximizing the evidence available to a court while preventing judicial error that might result from a shrewd plaintiff preserving inculpatory evidence as an unwary defendant permitted the erosion of exculpatory evidence.[11] Naturally, these purposes are best served when courts strictly interpret statutes of limitation, but such strict adherence comes at the expense of other values. The most rigid limitations deny recovery to many plaintiffs, while the more flexible limitations do little to promote repose. Flexibility, in short, comes at the expense of the very certainty that statutes of limitation are meant to provide.[12] Legislatures and courts are left to balance the policies behind statutes of limitation with their own notions of fairness and justice. To avoid injustice in certain cases, courts employ

3. *See* Lee Harris, *Tort Reform as Carrot-and-Stick*, 46 HARV. J. ON LEGIS. 163, 173–74 (2009) (explaining the popularity of capping damages as an instrument of reform).

4. *See* BLACK'S LAW DICTIONARY 997 (9th ed. 2009). Joint and several liability is "[l]iability that may be apportioned either among two or more parties or to only one or a few select members of the group, at the adversary's discretion."

5. *See* 22 AM. JUR. 2D *Damages* § 392 (2003). The collateral source rule provides that "if an injured party received some compensation for injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor."

6. *See* Abigail R. Moncrieff, *Federalization Snowballs: The Need For National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 855 (2009).

7. *See* BLACK'S LAW DICTIONARY 1546 (9th ed. 2009) ("A law that bars claims after a specified period; specif., a statute establishing a time limit for suing in a civil case, based on the date when the claim accrued (as when the injury occurred or was discovered).").

8. *See* Congressman John Conyers, Jr., *Reparations: the Legislative Agenda*, 29 T. JEFFERSON L. REV. 151, 152 (2007). Even in a wildly different context—a discussion of reparations for American slavery—similar policies are mentioned together: "[T]here are the standard exceptions to statute of limitations law: the discovery rule . . . the equitable tolling of the statute . . . and the theory of a continuing tort . . . ." *Id.*

9. *See generally* Ehud Guttel & Michael T. Novick, *A New Approach to Old Cases: Reconsidering Statutes of Limitation*, 54 U. TORONTO L.J. 129 (2004) (describing statutes of limitations as a spectrum based on rigidity and arguing against repose as a purpose of limiting actions).

10. *Id.* at 173.

11. *See id.* at 129–30.

12. *See id.* at 135–36.

devices to circumvent strict rules, including the continuing tort doctrine.[13] For the purposes of this Note, the continuing tort doctrine refers to the idea that "in certain tort cases involving continuous or repeated injuries, the statute of limitations accrues upon the date of the last injury and that the plaintiff may recover for the entire period of the defendant's negligence, provided that an act contributing to the claim occurs within the filing period."[14]

This Note explores and discusses the continuing tort doctrine in the context of medical malpractice with a particular emphasis on the challenges that the doctrine may present to courts in the context of foreign object litigation. Part II discusses the history of the continuing tort doctrine and of medical liability reform, generally, while distinguishing the continuing tort doctrine from related rules; Part III discusses the current state of the continuing tort doctrine in medical malpractice law; Part IV describes the errors courts have made in discussing the doctrine; and Part V describes the uncertainty that flawed judicial reasoning has created for the future of the continuing tort doctrine and the potential liability for medical practitioners.

II. HISTORY

Medical practitioners have faced a turbulent market for medical malpractice insurance over the past several decades, with malpractice premiums increasing rapidly in cycles during the 1970s, 1980s, and again at the beginning of the new millennium.[15] In the 1970s, several private insurers left the medical malpractice insurance market in the face of rising claims, resulting in a shortage of malpractice insurance and higher rates for those who could still purchase coverage.[16] In response to these market conditions, states across the nation undertook reforms to their respective medical liability laws.[17] One of the most common reforms was to reduce the statute of limitations applicable in medical malpractice claims.[18] Simi-

13. *See* 54 C.J.S. *Limitations of Actions* § 194 (2005).

14. *Id.*

15. *See* U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 1 (2003), *available at* http:// www.gao.gov/ cgi-bin/ getrpt? GAO-03-836 (The General Accounting Office became the Government Accountability Office in 2004.).

16. *See* AM. MED. ASS'N, MEDICAL LIABILITY REFORM—NOW! 2 (2008), *available at* http:// www.ama-assn.org/ ama1/ pub/ upload/ mm/ -1/ mlrnow.pdf.

17. *See id.*

18. *See* Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 761 (1977) ("The most common legislative proposals include: (1) limiting either the amount of recovery by plaintiffs or the liability of individual health care providers; (2) reducing the statute of limitations applicable to medical malpractice actions; (3) abrogating the collateral source rule in medical malpractice actions; (4) establishing medico-legal screening panel plans; and (5) establishing either compulsory or voluntary arbitration plans.").

lar reforms followed the insurance rate increases of the 1980s; as a consequence of two decades of rapidly rising costs, every state enacted some sort of change to its medical liability laws designed to reduce medical malpractice premium rates.[19] However successful these reforms may have been, they have done little to silence the clamor for further reform, and medical practitioners continue to describe the litigation climate in which they must practice in terms of "crisis."[20] Notably, medical malpractice claims have continued to flourish, particularly in comparison to other torts, despite decades of political attention.[21]

There are a dizzying number and variation on both the kind of reforms that have been enacted and the kind of reforms that have yet to be enacted, and the process of reform does not end at the door of any legislature or town hall meeting. Whether in response to legislative action or inaction, courts must grapple daily with medical malpractice claims and the applicable temporal limitation schemes expressed in the statutes. The continuing tort doctrine, another consideration in the process of interpreting statutory limitation schemes, is a deceptively complex concept whose "contours and theoretical bases . . . are at best unclear."[22] Some scholars believe the doctrine developed in the context of employment discrimination suits in the 1960s as "an equitable method to avoid the 300–day time limit imposed by Title VII of the 1964 Civil Rights Act."[23] Courts applied the doctrine, referring to it as the "continuing violation" doctrine,[24] in "situations involving a pattern of ongoing discrimination in which the same person directed similar and continuous acts toward a specific individual."[25] According to this version of the story of the continuing tort's origin, the application of the doctrine eventually expanded into situations where an employer instituted a discriminatory policy that produced a continuing ill effect and later into situations in which an employee experienced present effects of past discrimination.[26] Other scholars believe the doctrine's ori-

19. *See* U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, *supra* note 15, at 11.

20. *See* AM. MED. ASS'N, *supra* note 16, at 2–5.

21. *See id.* at 5 ("Medical liability went from 5.8 percent of total tort costs in 1975 to 12.2 percent in 2006. Annual cost growth since 1975 has averaged 11.1 percent per year for medical liability, and 8.4 percent per year for other torts.").

22. Berry v. Bd. of Supervisors of L.S.U., 715 F.2d 971, 979 (5th Cir. 1983).

23. Brown Group Retail, Inc. v. State, 155 P.3d 481, 486 (Colo. App. 2006), *rev'd en banc*, 182 P.3d 687 (Colo. 2008).

24. *See id.*

25. Kelly Brechtel, Note, King v. Phelps Dunbar, LLP*: A Catch-22 for Louisiana Law Firms*, 60 LA. L. REV. 929, 931 (2000).

26. *See id. But see* United Air Lines, Inc. v. Evans, 431 U.S. 553, 558 (1977) (rejecting a continuing violation theory for present effects of past discrimination).

gins lie not in the interpretation of civil rights legislation, but in tort law,[27] perhaps specifically in the tort of trespass to land.[28]

Regardless of its origin, the continuing tort doctrine now has many recognized analogues outside of the context of employment discrimination and trespass: (1) a "continuation of events" theory applies in circumstances where "an undertaking . . . requires a continuation of services";[29] (2) a continuing violation exists upon continued collection of an unlawful tax;[30] (3) a continuing nuisance involves "a failure to physically remove or legally abate [a] condition, resulting in the physical invasion of another's property," even when the condition was created outside of the statutory period;[31] (4) a continuing tort can involve a course of harassing conduct where the acts that make up the conduct are sufficiently related;[32] and (5) the continued existence of a contaminating substance can support a continuing tort theory in the environmental contamination context.[33] The theories based on continuing harm visited upon a plaintiff are numerous, and the medical malpractice field is not immune from their influence.[34]

Although a disagreement may exist over how the continuing tort doctrine, as such, came into being, it is clear that the policy that animates the doctrine predates the Civil Rights Era and emerged in the medical malpractice field before federal courts began wrestling with employment discrimination questions.[35] In medical malpractice law, the continuing tort doctrine, a confusing concept in its own right, has been made infinitely more confusing by the judicial reasoning employed both to support and discredit it. Indeed, the confusion over how and when the doctrine should apply, as well as how it relates to other doctrines, has its own lengthy history.[36]

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27. *See* Dziura v. United States, 168 F.3d 581, 583 (1st Cir. 1999) ("'Continuing violation' jurisprudence is drawn from tort law.").

28. *See* Rogers v. Bd. of Rd. Comm'rs for Kent Cnty., 30 N.W.2d 358, 360 (Mich. 1947) ("Failure to remove the anchor stake upon expiration of the license to have it on defendant's land was a continuing trespass . . . .").

29. 54 C.J.S. *Limitation of Actions* § 113 n.2 (2005).

30. *See id.* at § 113 n.3.

31. *See* Lyons v. Twp. of Wayne, 888 A.2d 426, 431 (N.J. 2005).

32. *See* McCorkle v. McCorkle, 811 So. 2d 258, 264 (Miss. Ct. App. 2001).

33. *See* Nieman v. NLO, Inc., 108 F.3d 1546, 1560 (6th Cir. 1997) (holding that the continued existence of uranium contamination constituted a continuing tort, even if no new releases of uranium occurred).

34. This short list is by no means exhaustive. The premise of this comment is that the human imagination is the only meaningful limit on this common strain of theories based on continuing conduct. Consequently, it is impossible to describe every context in which the basic doctrine might apply.

35. *See* Gillette v. Tucker, 65 N.E. 865, 870 (Ohio 1902) ("[I]f we call malpractice a tort in this case, it is a tort growing out of a breach of contract which the law implies from the surgeon's employment and undertaking to perform the operation. We have seen that it was a continuous obligation, and recognized by the law, and it was alive and binding so long as the relation of physician and patient subsisted."), *overruled by* Oliver v. Kaiser Cmty. Health Found., 449 N.E.2d 438 (Ohio 1983).

36. *See Gillette*, 65 N.E. at 874 (Davis, J., dissenting) (reasoning that the existence of a foreign object did not constitute a continuing tort because it is improper to analogize between continuing

The precision that is so often lacking in judicial opinions that address the continuing tort doctrine is essential to analyzing the doctrine's relevance and applicability in medical malpractice law. This Note adheres to the definition of the continuing tort doctrine expressed in the *Corpus Juris Secundum*.[37] Commentators sometimes divide the continuing tort doctrine into two types: "pure" and "modified."[38] "[T]he first type . . . aggregates wrongs to permit recovery for harm suffered outside of the limitations period . . . . The second type . . . divides causes of action to create new claims and allow recovery for harms suffered within the limitations period."[39] This Note addresses the first type of continuing tort, the pure form. Because the pure form permits recovery for harms suffered outside of the limitations period, it conforms to the definition furnished by the *Corpus Juris Secundum*,[40] provides a more intuitive basis for analyzing the overall doctrine, and presents the greatest potential threat for medical practitioners.[41]

The continuing tort doctrine should not be confused with the continuous treatment rule—a concept that is both closely related to the continuing tort doctrine and inspired by the same notions of fairness—but that is nonetheless a distinguishable rule.[42] Although frequently treated by judges as interchangeable, the continuing treatment rule is not synonymous with the continuing tort doctrine.[43] Because either or both of the doctrines are applicable in many medical malpractice claims, the two doctrines are easily confused.[44] The continuous treatment rule is best expressed as follows:

> If the treatment by the doctor is a continuing course and the patient's . . . condition is of such a nature as to impose on the doctor a duty of continuing treatment and care, the statute does not com-

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trespasses and medical malpractice, but largely ignoring the majority's use of the doctor–patient relationship as the basis for a continuing duty).

37. *See* 54 C.J.S. *Limitations of Actions* § 194 (2005). *See also supra* note 14 and accompanying text.

38. *See* Kyle Graham, *The Continuing Violations Doctrine*, 43 GONZ. L. REV. 271, 282–83 (2008) (noting that few courts recognize that this distinction exists).

39. *Id.* at 283 (emphasis omitted).

40. *See supra* note 14 and accompanying text.

41. The pure form of the continuing tort doctrine represents a greater threat because it permits recovery for a longer period of conduct.

42. For a thorough discussion of the continuous treatment rule see Melanie Fitzgerald, *The Continuous Treatment Rule: Ameliorating the Harsh Result of the Statute of Limitations in Medical Malpractice Cases*, 52 S.C. L. REV. 955 (2001).

43. *See* Lane v. Lane, 752 S.W.2d 25, 27 (Ark. 1988) ("'Continuous treatment' is distinguishable from a 'continuing tort.'"). *See also* Wang v. Broussard, 96-2719 (La. App. 1 Cir. 2/20/98); 708 So. 2d 487, 492. ("'[I]nterruption of prescription by the continued existence of a professional relationship is not based on a [sic] continuous action constituting a continuing tort, but is based on the premise that the professional relationship is likely to hinder the patient's inclination to sue.'" (quoting Abrams v. Herbert, 590 So. 2d 1291, 1295 (La. Ct. App. 1991))).

44. *See infra* Part IV.A.

> mence running until treatment by the doctor for the . . . condition involved has terminated . . . .[45]

Whereas the continuous treatment rule allows a plaintiff to recover for injuries sustained outside of the statutory period because the doctor–patient relationship creates a continuing duty on the part of the doctor, the continuing tort doctrine is based on the idea that the ongoing tortious conduct is so closely related that a plaintiff cannot, in fairness, be expected to identify a single incident in a chain of tortious activity that caused the harm.[46] How could a plaintiff, for instance, identify when he sustained injury from a sponge left in his abdomen when that sponge did damage in his body every day until it was removed?[47] This is not the only justification offered for the continuing tort doctrine, but it is the justification with the most natural application in the field of medical malpractice.[48] The logic of the continuous treatment rule depends on the policy of preserving the trust and confidence patients are supposed to have with the professionals who administer their medical care.[49] The idea is that "if corrective treatment is necessary, it would be contrary to the patient's own interest in the patient's cure and recovery to disrupt the relationship by suing those caring for the patient."[50] The continuing tort doctrine does not share this rationale.[51] Moreover, while the continuous treatment rule is a function of a medical professional's duty to the patient, the continuing tort doctrine is a function of cause—tortious conduct that continues to cause injury to the patient.[52]

The precise distinction made here between the continuing tort doctrine and the continuous treatment rule is not recognized in every jurisdiction, and the definitions offered for the two doctrines are far from universal.[53] Recognizing the difference in the meaning of the doctrines is, however, quite important: the difficulty in pinpointing what the continuing tort doc-

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45. *Lane*, 752 S.W.2d at 26 (quoting 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 13.08 (1982)).

46. See Graham, *supra* note 38, at 288.

47. *See infra* Part V.A. The existence of a foreign object in the body of a patient is by no means a clear-cut application of the continuing tort doctrine.

48. *See* Graham, *supra* note 38, at 284–96 (explaining and criticizing the various justifications courts give for invoking the continuing tort doctrine).

49. *See* Langner v. Simpson, 533 N.W.2d 511, 520 (Iowa 1995).

50. *Id.*

51. Indeed, the continuous treatment rule is sometimes explained as a creature of the *contra non valentum* doctrine, rather than as a cousin to the continuing tort doctrine. *See* Ferguson v. Sugar, 2005-CA-0921 (La. App. 4 Cir. 6/25/08); 988 So. 2d 816, 828.

52. *But see* Kling Realty Co. v. Chevron USA, Inc., 575 F.3d 510, 519 (5th Cir. 2009) (reasoning that a continuing tort required a continuing duty and a continuing breach of that duty).

53. Even the Restatement and the Corpus Juris Secundum do not agree on the precise contours of the continuing tort doctrine. The language in the Restatement permits a continuing tort on the basis of continuing harm resulting from a past act, *see* RESTATEMENT (SECOND) OF TORTS § 899 cmt. c (1979), whereas the C.J.S. explicitly requires that "an act contributing to the claim [have occurred] within the filing period." 54 C.J.S. *Limitation of Actions* § 194 (2005).

trine means is precisely what creates fertile ground for creative litigators and potential pitfalls for judges. The resulting confusion also represents a frontier for even greater turbulence in the market for medical malpractice liability insurance, particularly if courts fail to note subtle interjurisdictional doctrinal differences, borrow faulty reasoning from past cases, and misapply otherwise sound reasoning from past cases.[54]

III. THE CURRENT STATE OF THE CONTINUING TORT DOCTRINE IN MEDICAL MALPRACTICE

Assessing the current state of the continuing tort doctrine in medical malpractice law is a fool's errand. The impossibility of accomplishing this task with acceptable precision is a function of the judicial errors in discussing the doctrine.[55] What is one to conclude about the state of the law in a jurisdiction, for instance, that claims to reject the continuing tort doctrine but argues in its favor?[56] The clarity with which the doctrine is discussed in the context of medical malpractice varies greatly, but jurisdictions generally fall into one of four groups: (1) expressly recognizing the doctrine in medical malpractice claims; (2) expressly rejecting the doctrine in medical malpractice claims; (3) recognizing the doctrine in other contexts but silent as to the doctrine's applicability to medical malpractice; or (4) rejecting the continuing tort doctrine in all contexts.[57]

In the first type of jurisdiction, expressly recognizing the continuing tort doctrine in the area of medical malpractice may involve using the exact term, "continuing tort doctrine," or may involve the express recognition of the doctrine without the term itself.[58] In the second type of jurisdiction, the express rejection of the continuing tort doctrine in the area of medical malpractice appears to foreclose any further discussion of the issue.[59] Like so many other issues in the law, however, what appears to be final is often still open for debate; it would be difficult to classify any legal theory as having been eradicated, especially a legal theory with as much potential for confusion and manipulation as the continuing tort.[60] In the

54. *See infra* Part V.

55. *See infra* Part IV.

56. *See infra* note 80 and accompanying text.

57. These neat divisions are based on what approaches courts claim to follow, not necessarily on reality. A close reading of the cases cited in this Part of the Note could easily be used to explain the errors in judicial reasoning discussed in Part IV. In the interest of simplicity, these divisions also do not distinguish between the two types of continuing tort doctrine discussed in note 38 and accompanying text, *supra*.

58. *See, e.g.*, Cunningham v. Huffman, 609 N.E.2d 321, 325 (Ill. 1993) ("When the cumulative results of continued negligence is the cause of the injury, the statute of repose cannot start to run until the last date of negligent treatment.").

59. *See, e.g.*, Charter Peachford Behavioral Health Sys. v. Kohout, 504 S.E.2d 514, 521 (Ga. Ct. App. 1998) ("The 'continuing tort' theory is inapplicable to actions for medical malpractice . . . .").

60. For a discussion of the confusion surrounding the doctrine as a cause for its continuing viabili-

third type of jurisdiction, although the doctrine has not yet been applied in the context of medical malpractice, no holdings or dicta restrain its application to medical malpractice either.[61] Medical practitioners should expect that a jurisdiction that embraces the policy behind the continuing tort doctrine in other contexts will embrace it in medical malpractice claims in due time. In the fourth type of jurisdiction, the continuing tort doctrine is, at the very least, paralyzed until such time as the state legislature or the state's highest court reverses course.[62] Refusing to follow in the steps of other courts that have recognized the doctrine is a remarkable act of judicial restraint, but no matter how steadfast a court remains, the argument will continue to resurface, forcing the court to exercise that restraint repeatedly.[63]

IV. THE ERRORS THE JUDICIARY MAKES IN DISCUSSING THE CONTINUING TORT DOCTRINE IN MEDICAL MALPRACTICE

Even in jurisdictions that have addressed the continuing tort doctrine in the context of medical malpractice directly, the judicial reasoning is often poor. This is no small matter: where judicial reasoning leaves loopholes and flexibility, later courts often exploit these conditions in the interest of fairness, but at the expense of those relying on previous judicial rulings.[64] Many states employ a discovery rule[65] for medical malpractice claims "under which the statute of limitations starts to run only when the plaintiff discovers, or in the exercise of reasonable diligence should have discovered, his injury."[66] The equitable nature of the discovery rule is, in itself, an invitation for courts to craft exceptions upon exceptions to temporal limitations,[67] so the importance of well-reasoned judicial opinions is

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ty in the medical malpractice context see Part IV, *infra*. For a discussion of the flexibility of the doctrine see Part V, *infra*.

61. *See, e.g.*, Stevens v. Lake, 615 So. 2d 1177, 1183 (Miss. 1993) ("It is true that continuing or repeated injuries can give rise to liability even if they persist beyond the limitations period for the initial injury."). There are no Mississippi cases on record in which the continuing tort doctrine has been applied to a medical malpractice claim, but there also appear to be no barriers to the doctrine's application to such a claim.

62. *See, e.g.*, Quality Optical of Jonesboro, Inc. v. Trusty Optical, L.L.C., 225 S.W.3d 369, 372 (Ark. 2006) ("As we have repeatedly stated, this court does not recognize a 'continuing tort' theory.").

63. *See id.*

64. *See* Guttel & Novick, *supra* note 9, at 157–64 (describing how lower courts have consistently evaded precedent aimed at tightening the discovery rule based on their own notions of fairness).

65. The discovery rule should not be confused with criminal procedure's "inevitable-discovery rule," defined as the rule "that evidence obtained by illegal means may nonetheless be admissible if the prosecution can show that the evidence would eventually have been legally obtained anyway." BLACK'S LAW DICTIONARY 355 (9th ed. 2009).

66. HENRY COHEN, CONG. RES. SERV., RS 22054, MEDICAL MALPRACTICE LIABILITY REFORM: H.R. 534, 109TH CONG. 5 (2005), *available at* http:// www.law.umaryland.edu/ marshall/ crsreports/ crsdocuments/ RS2205 40307 2005.pdf.

67. *See* Guttel & Novick, *supra* note 9, at 157 ("The logical poverty and minimal success of these

immensely important in this area of law. Perhaps the greatest danger lies in courts thinking they have dispensed with the continuing tort doctrine while inadvertently leaving it all too viable for future litigants in future courts. Errors made by courts in analyzing the continuing tort doctrine generally fall into five categories: (1) confusing continuing torts with continuous treatment, (2) being overly conclusory, (3) claiming to reject the doctrine while furnishing arguments that support continuing torts, (4) relying on statutes of repose as a backstop, and (5) relying on the discovery rule as a backstop.

A. Confusing Continuing Torts With Continuous Treatment

It is easy to conflate the continuing tort doctrine with the continuous treatment rule,[68] and many courts either fail to appreciate the difference between the doctrines or cannot resist the temptation to conveniently blend them. Within the same paragraph of the same opinion, courts will often blur any distinction between continuing torts and continuous treatment while purporting to address a single doctrine.

A typical opinion proceeds as follows: First, the court frames the plaintiff's argument to "adopt a continuous treatment tort rule for all medical malpractice cases"[69] while also characterizing the plaintiff's argument as a "continuous tort theory."[70] The use of the hybrid term "continuous treatment tort rule"[71] is a warning in itself that confusion will follow. Only a few lines later, and without any qualification or explanation, the court explains that under the continuous treatment rule, "'the running of the statute of limitations is tolled when a course of treatment that includes wrongful acts or omissions has run continuously and is related to the original condition or complaint.'"[72] As if this were not confusing enough, the opinion justifies this by explaining that the doctrine is based on the special relationship of trust between doctors and patients.[73] Based on this amalgamation of policies and rule sentences, what are lower courts to conclude about how the applicable statute of limitations is to be read in medical malpractice claims? Do continuing wrongful and related acts undergird the rule or must the plaintiff only establish that a doctor–patient relationship exists? A properly worded opinion would recognize that wrongful acts that

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exceptions suggest that they are not natural boundaries of the discovery rule but, rather, impositions upon it designed to correct its flaws.")

68. *See supra* Part II.

69. Carpenter v. Rohrer, 714 N.W.2d 804, 813 (N.D. 2006).

70. *Id.*

71. *Id.*

72. *Id.* (quoting 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 299 (2002)).

73. *See id.* Interestingly, the court's discussion of the continuing tort doctrine is not only wrong, it is unnecessary. The case was ultimately decided on other grounds, and the court never reached the question of the continuing tort doctrine's applicability to malpractice claims.

are repeated and related to one another would support a continuing tort theory, while an ongoing doctor–patient relationship, even without any additional wrongful acts, would support a theory founded in the continuous treatment rule.

Courts create greater vulnerability for medical malpractice insurance rates at the hands of future litigants by purportedly dealing with the continuing tort doctrine, when much of their reasoning is responsive to the continuous treatment rule instead.[74] This form of error allows future litigants to argue that the substance of the past decision—the reasoning—should rightly be elevated over the form—the terms used—and thus that the continuing tort doctrine remains a valid theory even if the continuous treatment rule is not.

B. Being Overly Conclusory

The continuing tort doctrine has the ring of equity, which helps explain its enduring appeal. Some opinions even expressly state that the continuing tort doctrine rests on the notion that "one should not be allowed to acquire a right to continue the tortious conduct ."[75] In spite of this natural appeal to a sense of justice and fairness, some courts reject the continuing tort doctrine in the context of medical malpractice simply because it has never been applied in that context in that jurisdiction before.[76] A rejection of the doctrine without any justification in law or policy might induce reliance on the part of potential defendants, but it is an insufficient means to restrain continuing torts from emerging in this field. The continuing tort doctrine had, after all, never been applied in the context of employment discrimination until the moment that it was.[77] The conclusory rejection of the continuing tort doctrine is especially flimsy in states that embrace the continuing tort doctrine in other contexts.[78] Where later courts are faced with arguments, on the one hand, for the continuing tort doctrine's inherent fairness and can only weigh, in the other hand, the fact that the doctrine has heretofore not been applied in medical malpractice, it seems likely that they will apply the doctrine.[79]

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74. *See, e.g.*, Aristide v. Jackson Mem'l Hosp., 917 So. 2d 253, 255 (Fla. Dist. Ct. App. 2005) (dispensing with a "continuing tort" theory because there was no ongoing doctor–patient relationship—a rationale unrelated to the continuing tort doctrine).

75. Ill. Cent. Gulf R.R. Co. v. Boardman, 431 So. 2d 1126, 1128 (Miss. 1983).

76. *See, e.g.*, *Aristide*, 917 So. 2d at 255 ("No Florida appellate court has applied the continuing tort doctrine to medical malpractice cases.").

77. *See supra* Part II.

78. *See* Halkey-Roberts Corp. v. Mackal, 641 So. 2d 445, 447 (Fla. Dist. Ct. App. 1994) ("The continuing torts doctrine is recognized under our state law.")

79. *See* Guttel & Novick, *supra* note 9, at 157. The discovery rule already opens the door to circumvent arguments ringing in equity, and exceptions to the statute of limitations proliferate in the face of poor judicial reasoning.

C. Furnishing Arguments That Support Continuing Torts

Merely confusing the language of the continuing tort doctrine and other related doctrines is bad enough, but rejecting the continuing tort doctrine in medical malpractice while at the same time furnishing arguments in its favor is much worse. This form of judicial error is essentially the reverse of confusing continuing torts and continuous treatment; here, rather than reasoning in a way that is unresponsive to the continuing tort doctrine, courts unwittingly reason in favor of the continuing tort doctrine. An opinion that rejects the continuing tort doctrine in medical malpractice might yet explain its adherence to the continuous treatment rule:

> [I]t would not be equitable to bar a plaintiff, who for example, has been subjected to a series of radiation treatments in which the radiologist negligently and repeatedly administered an overdosage, simply because the plaintiff is unable to identify the one treatment that produced his injury. Indeed, in such a situation no single treatment did cause the harm; rather it was the result of several treatments, a cumulative effect.[80]

This argument, while made in support of a continuous treatment rule, has much more to do with the underlying purpose of the continuing tort doctrine.[81] A plaintiff's inability to identify the specific conduct or event in a series of conduct or events that caused the plaintiff injury is a principal rationale behind the continuing tort doctrine, not the continuous treatment rule.[82] What about this rationale had anything to do with preserving a relationship of trust and confidence between doctors and patients? If the existence of a relationship between a doctor and a patient were sufficient to allow recovery for all harm suffered during the course of that relationship, then related harm flowing from related acts would be of no consequence. A court that explains its opinion in a medical malpractice case based on the rationale of the continuing tort doctrine should not be surprised when the doctrine continues to surface in medical malpractice cases.

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80. Forshey v. Jackson, 671 S.E.2d 748, 756 (W. Va. 2008) (quoting Lane v. Lane, 752 S.W.2d 25, 27 (Ark. 1988)). In fairness to the Forshey court, the opinion goes on to separately discuss the inapplicability of the continuing tort doctrine to the facts of the case while recognizing that the doctrine had been considered previously in a context similar to medical malpractice. *See id.* at 756–61.

81. *See* Graham, *supra* note 38, at 288.

82. *See id.*

D. Relying on a Statute of Repose as a Backstop

Many states have enacted statutes of repose to be read in tandem with the statute of limitations applicable to medical malpractice claims.[83] "A statute of repose extinguishes a cause of action after a fixed period of time . . . regardless of when the cause of action accrued . . . . [It] sets an outer boundary in time beyond which no cause of action may arise for conduct that otherwise would have been actionable . . . ."[84] While statutes of repose often appear ironclad and unforgiving in their certainty, they are still subject to judicial interpretation that often turns on legislative intent.[85] The continuing tort doctrine is a way to give life to legislative intent in a way that appears, at least on its face, contrary to the absolute quality of statutes of repose.[86] The argument runs that a legislature may have intended to create an outer boundary for the time when an action must be brought for an occurrence or act, but this outer boundary is meaningless in the face of a series of related occurrences or acts.[87] Where a series of occurrences or acts is sufficiently related, a court is free to regard the series as a single act; that is, after all, the very meaning of the continuing tort doctrine.[88]

Although statutes of repose are just as susceptible to attack from the continuing tort doctrine, some courts persist in using statutes of repose as their primary reason for rejecting the continuing tort doctrine in the medical malpractice context.[89] These courts treat the statute of repose as an analytical backstop, a convenient way of dispensing with an inconvenient argument. The danger in this method of reasoning lies in the ingenuity of future litigants and future courts to reinterpret the legislative intent underlying the statute of repose in a way that comports with the fairness of the continuing tort doctrine.[90] No statute of repose sufficiently restrains the continuing tort doctrine if a court is willing to read the statute in light of the fairness or justice that a legislature presumptively intends in all laws. Even courts that have thoroughly considered the contours and repercussions of the continuing tort doctrine in medical malpractice cases cannot reasonably believe that a statute of repose can adequately foreclose all future continuing tort theories.[91]

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83. *See generally* RICHARD E. SHANDELL & PATRICIA SMITH, THE PREPARATION AND TRIAL OF MEDICAL MALPRACTICE CASES § 3.08 (1981).

84. 51 AM. JUR. 2d *Limitation of Actions* § 31 (2000).

85. *See* Abend v. Klaudt, 531 S.E.2d 722, 726–27 (Ga. Ct. App. 2000) (reasoning that the Georgia legislature did not intend for the medical malpractice statute of repose to apply to continuing torts).

86. *See, e.g.*, Cunningham v. Huffman, 609 N.E.2d 321, 324–25 (Ill. 1993)

87. *See id.*

88. *See id.*

89. *See* Harrison v. Bevilacqua, 580 S.E.2d 109, 114 (S.C. 2003) (rejecting the continuing tort theory in the medical malpractice context because the statute of repose is intended as an absolute bar to recovery).

90. *See Cunningham*, 609 N.E.2d at 324–25.

91. *See In re* Med. Review Panel for Claim of Moses, 00-2643 (La. 5/25/01); 788 So. 2d 1173,

E. Relying on the Discovery Rule as a Backstop

Because so many states employ the discovery rule for medical malpractice claims, analysis of the discovery rule is often intertwined with analysis of the continuing tort doctrine.[92] Judges, in aiming to reject the continuing tort doctrine, will often reason that the continuing tort doctrine is simply supplanted by the discovery rule.[93] Some jurisdictions have very clearly enunciated how the continuing tort doctrine and the discovery rule should be read together in the medical malpractice context.[94] Many other jurisdictions have either not addressed the interplay between the two rules or have done so inconsistently, leading to different outcomes for similarly situated litigants.[95] It is no small wonder that "[t]he state of the law in this area has been described as 'vexing' and muddled."[96] "One court concluded that '[t]here is perhaps no subject of the law about which there is a greater conflict of judicial opinion.'"[97] At times, the confusion presents little difficulty, as when a plaintiff's discovery of his injury roughly coincides with the cessation of the defendant's tortious conduct. The difficulty arises when the decision over which doctrine applies—discovery rule or continuing tort doctrine—will affect which litigant succeeds on the statute of limitations question.

Consider a hypothetical case of a patient with sickle cell anemia who receives a series of blood transfusions in a clinic that uses a supply of blood that has not been properly screened.[98] The patient discovers that he has contracted HIV and, because of his sexual history and lack of exposure to any other foreign blood or bodily fluids, reasonably should con-

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1187 (wisely leaving open the question of whether the continuing tort doctrine can be invoked in the future to enlarge the statute of repose).

92. *See* COHEN, *supra* note 66.

93. *See, e.g.*, Stanbury v. Bacardi, 953 S.W.2d 671, 676 (Tenn. 1997). This case is a good example of both overreliance on the discovery rule and blending the continuous treatment rule with the continuing tort doctrine. The court claims to be recognizing that the discovery rule has abrogated the continuous treatment rule, but much of the precedent it cites relates to the continuing tort doctrine. *See id.* at 676–77.

94. *See* Monfort v. Colquitt County Hosp. Auth., 653 S.E.2d 535, 536–37 (Ga. Ct. App. 2007) (explaining Georgia's statutory recognition of both continuing torts and the discovery rule in medical malpractice).

95. *See* Case Comment, *Torts—Medical Malpractice—Statute of Limitations and the Discovery Rule in Tennessee*, 42 TENN. L. REV. 604, 611–13 (1975) (discussing the split of authority in reconciling the continuing tort doctrine and the discovery rule and noting Tennessee's irresolution of the matter).

96. Guttel & Novick, *supra* note 9, at 165 n.68 (quoting Galloway v. Gen. Motors Serv. Parts Operations, 78 F.3d 1164, 1165 (7th Cir. 1996)) (some internal quotations and citations omitted).

97. *Id.* (quoting St. Francis Levee Dist. v. Barton, 123 S.W. 382, 383 (Ark. 1909)).

98. This hypothetical is loosely based on *Sherwood v. Danbury Hosp.*, 746 A.2d 730 (Conn. 2000), in which a woman brought a medical malpractice claim against a hospital after the hospital gave her an HIV-tainted blood transfusion from a supply of blood that had allegedly not been tested for HIV antibodies. *See id.* at 733. Though the plaintiff's claim appeared time-barred, the Connecticut Supreme Court held that, under a continuous course of conduct theory, the statute of limitations could be tolled. *See id.* at 739.

clude that the transfusions were the source of this injury. The patient nonetheless continues to receive periodic blood transfusions from the same clinic a year after learning that he has HIV. The patient does not communicate with his physician; the physician does not intervene; and the patient's health is jeopardized with each tainted transfusion as his immune system is unable to respond to the various contagions being placed directly into his bloodstream. If the discovery rule governs, then the limitations period runs from the date on which the patient should have discovered his own injury and its source; the patient could easily be denied recovery for a long period of injuries if he fails to file a timely complaint. If, however, the continuing tort doctrine governs, the statute of limitations will not begin to run against the patient until the last transfusion, and he may be able to recover for all of the injuries sustained from the clinic's use of improperly screened blood product.[99]

It is easy to imagine many other cases in which a court might be faced with a choice between the discovery rule and a continuing tort theory. While the continuing tort doctrine may dovetail in some respects with the discovery rule, the two methodologies are not identical. "When courts tether the [continuing tort] doctrine to the plaintiff's awareness of a claim, they ignore a core differentiating element of this theory, namely, that some claims 'continue' even after the plaintiff becomes aware of the essential facts behind the grievance."[100] The distinctness of the two doctrines and the possibility that either or both might apply in a case necessitates some rule that determines how the doctrines will be reconciled. Whenever a court avoids confronting a continuing tort theory by invoking the discovery rule, it inadequately addresses the underlying issue: whether a continuing tort theory applies. In jurisdictions where the continuing tort doctrine remains a viable doctrine in medical malpractice claims, courts must directly address the relationship between the discovery rule and continuing torts or plead with the legislature to clarify the relationship between the two.

V. WHAT THE UNCERTAINTY MEANS FOR MEDICAL LIABILITY AND WHAT SHOULD BE DONE

While the continuing tort doctrine's application to medical malpractice claims is not yet widespread, it represents a lurking threat. The ongoing viability of the continuing tort doctrine in the context of medical malprac-

99. Arguably, the foreign blood causes new injuries daily as it moves throughout the patient's body and causes new mischief. Based on this reasoning, the limitations period should not begin to run as long as tainted blood remains in the patient's body. *See* Kling Realty Co. v. Chevron USA, Inc., 575 F.3d 510, 519 (5th Cir. 2009) (reasoning that cases of continuous physical invasion, such as a continuous leaking gas tank, constitute a continuing tort). *See also infra* Part V.A.

100. Graham, *supra* note 38, at 287.

tice presents an immense and unpredictable liability for medical practitioners, and the emergence of the doctrine as a popular tool to circumvent statutes of limitation would have an inflationary effect on malpractice liability rates.[101] Shortening the limitations period and establishing a strict outer boundary in the period for medical malpractice claims is one of the few "tort reforms" that has produced a statistically measurable reduction in the frequency of medical malpractice claims.[102] By lengthening the limitations period and making an outer boundary impossible, the continuing tort doctrine threatens to increase the number of medical malpractice claims, increase medical malpractice liability insurance premiums, and nullify any legislative reforms aimed at reducing the number of claims. While this ultimate effect is obvious, it can be accomplished in unobvious ways.[103]

A. The Possibilities

Even in jurisdictions that would ordinarily resolve statute of limitations questions in a medical malpractice claim through a different prism—for example, the continuous treatment rule or discovery rule, among others—foreign object[104] litigation is fertile ground for an intellectually-appealing argument based on the continuing tort doctrine. Even those states that have carved out a discrete exception to the statute of limitations for foreign object cases are susceptible to the logic of the continuing tort doctrine, particularly if that jurisdiction's courts have not dealt with the doctrine in a clear, consistent manner.[105] Foreign object litigation is by no means the only frontier for the continuing tort doctrine, but it represents an area where past judicial precedent in other areas of tort law can be applied in novel ways.[106]

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101. *See, e.g.*, Judith VandeWater, *Soaring Malpractice Insurance Has Doctors Retiring, Relocating; Losing Neurosurgeons Could Cost Patient Lives, Experts Say*, ST. LOUIS POST-DISPATCH, Sep. 22, 2003, at A1. The direct relationship between the length of the limitations period and medical malpractice liability is especially apparent in treating children, who ordinarily benefit from a longer limitations period or from a savings statute.

102. *See* Patricia M. Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413, 416 (1987) ("States that have adopted shorter statutes of limitations and set an outer limit on the time allowed to file a claim have experienced some reduction in claim frequency.").

103. The continuing tort doctrine's malleability makes it unfit for ad hoc response. A clear enunciation of the law is necessary to avoid novel applications of the doctrine. For further discussion see *infra* Part V.B.

104. *See* BLACK'S LAW DICTIONARY 720 (9th ed. 2009) ("An item that appears where it does not belong; esp., an item introduced into a living body, such as a sponge that is left in a patient's body during surgery.")

105. *See* NURSING MALPRACTICE 554 (Patricia W. Iyer ed., Lawyers and Judges Publishing Co. 2d ed. 2001). Many states have enacted an "exception to the statute of limitation if a foreign object is the subject of malpractice . . . ." *Id.*

106. *See supra* note 34.

Consider, for example, a case in which a doctor performs a hysterectomy on a patient and removes the sutures from the incision weeks after the surgery, inadvertently leaving a piece of rubber in the patient's abdomen that had previously enclosed a suture.[107] The patient then suffers repeated bouts of infection and cellulitis in her abdomen for over three years, requiring ongoing treatment, medication, and care.[108] In a state in which such an action "must be brought within one year of the alleged act or omission, or within one year of discovery of the alleged act or omission, provided in the latter case that the action is filed no more than three years from the date of the alleged act or omission,"[109] a claim for malpractice based on these facts and filed more than three years after the surgery would be time-barred unless the plaintiff could assert a theory to defeat the statute of limitations defense.[110] The continuing tort doctrine is a convenient theory on these facts: the rubber itself, by "migrating" through the patient's abdomen can be said to cause harm progressively, and the limitations period does not begin to run until it is removed.[111] Courts in some jurisdictions have accepted this very argument, opening the door for the continuing tort doctrine in foreign object litigation.

This application has been criticized as skirting the repose period for a single act of negligence—leaving a foreign object in a patient—and for basing the theory on continuing omissions and damages rather than continuing acts.[112] What these criticisms fail to appreciate, however, is both the nature of the continuing tort doctrine and its relationship to property law. A continuing tort in the property context can involve continuous "acts" by an inanimate object placed somewhere by a person.[113] The "acts" can include the physical movement of the object from one point to another, meaning that although no further human activity is involved, there are nonetheless continuing acts.[114] Why would an inanimate object left in a human being be treated any differently in the medical malpractice context?[115] By analogizing to case law in the property context, the critical dis-

107. *See* Bellard v. Biddle, 98-1502 (La. App. 3 Cir. 3/17/99); 734 So. 2d 733, 734. *But see infra* note 112 and accompanying text. This hypothetical case is based entirely on the facts of *Bellard*; the case provides a striking example of how expansive the continuing tort doctrine can become. The case has since been overruled, but remains a cautionary tale to other jurisdictions. *See In re* Med. Review Panel for Claim of Moses, 00-2643 (La. 5/25/01); 788 So. 2d 1173, 1187.

108. *See Bellard*, 734 So. 2d at 734.

109. *Id.*

110. Notice the layers of the statutory scheme: a one-year limitations period, a discovery rule, and a statute of repose. None of these layers was an effective restraint on the continuing tort doctrine.

111. *See Bellard*, 734 So. 2d at 735.

112. *See Claim of Moses*, 788 So. 2d at 1187.

113. *See* S. Cent. Bell Tel. Co. v. Texaco, Inc., 418 So. 2d 531, 533 (La. 1982) (holding that continuously leaking gas tanks constituted a continuing tort).

114. *See id.*

115. The court in *Claim of Moses* does not provide an explanation of why the property rationale does not have equal force in the medical malpractice context. Perhaps the court misunderstood that the court in *Bellard v. Biddle* based its reasoning not only on the doctor's omission, but also on the migra-

tinction should not be whether a doctor continues to introduce a foreign object into the patient's body over a period of time or merely introduces a foreign object once that remains in the patient's body over a period of time; the critical distinction should be whether the foreign object remains static, only producing continual harm from a single act, or whether the foreign object behaves in a way that could be construed as an act.[116] In other words, courts should ask whether the foreign object is more like a continuously seeping gas tank that causes new harm daily or a gas tank that once seeped and caused some harm that has not yet been remedied.[117] If the foreign object were more like the former, its presence would constitute a continuing tort; if it were more like the latter, then the limitations period would run from the time when the patient reasonably should have been aware of the harm and its cause.

To summarily conclude that the introduction of a foreign object involves a single act of negligence without any discussion of what the particular foreign object has done inside the patient bypasses an important question in continuing tort analysis. A single act may not support a continuing tort theory, but a court must necessarily determine whether any further acts have occurred or risk being overly conclusory.[118]

Without a meaningful way to distinguish between the property case law and medical malpractice, the continuing tort doctrine remains available to future litigants in the field of foreign object litigation.[119] In the broader field of medical malpractice, the doctrine remains viable because of erroneous judicial reasoning and total confusion in the way the doctrine is described and analyzed.[120]

B. The Solution

It is impossible to craft any judicial opinion that could anticipate the myriad ways in which the opinion's holding might be applied, construed, or misconstrued.[121] It is nonetheless desirable for judges to craft opinions

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tion of the piece of rubber in the patient's abdomen. *See Bellard*, 734 So. 2d at 735.

116. *See S. Cent. Bell*, 418 So. 2d at 533; *see also* Nieman v. NLO, Inc., 108 F.3d 1546, 1559–60 (6th Cir. 1997) (stating that the mere continuing presence of a contaminating substance was sufficient to support a continuing tort theory, but nonetheless noting that the existing contamination substance was seeping).

117. *See S. Cent. Bell*, 418 So. 2d at 533.

118. *See supra* Part IV.B.

119. *See In re* Medical Review Panel for Claim of Moses, 00-2643 (La. 5/25/01); 788 So. 2d 1173, 1187. The court chose to "leave open the question of whether the continuing tort doctrine can be invoked to enlarge the three-year repose period" while stating that the continuing tort doctrine required continuing "conduct on [the] defendant's part." *Id.* The holding is questionable as a statement of the existing decisional law in Louisiana, but even if taken at face value, it means little for the many other jurisdictions that have not dealt with this issue directly.

120. *See supra* Part IV.

121. *See* Stephen R. Perry, *Judicial Obligation, Precedent and the Common Law*, 7 OXFORD J.

that produce consistency and predictability in the law; in short, perfection should not be the enemy of good.[122] As long as a system of laws governs human interactions, the rule of law is necessary, and " [a] rule of law is only a rule of law if it is consistently applied so as to be predictable."[123] It is expected, and even desirable, that different versions of the continuing tort doctrine would emerge in different jurisdictions, but clarity ought to exist within a given jurisdiction.[124] Without clarity, unpredictability reigns, leading to greater instability in the market for malpractice liability insurance.[125]

A clear, comprehensive statement of the law of continuing torts could resolve much of the uncertainty that the doctrine creates. Even if such a statement did not eliminate the doctrine from this area of law, it would allow insurers to better predict outcomes in litigation.[126] Whether from the legislature or a jurisdiction's highest court, such a statement must necessarily involve describing whether the jurisdiction follows the continuing tort doctrine, and if so, what version of the doctrine is followed.[127] If the doctrine is only to be followed in certain areas of law or is to be applied differently in one area of law than in others, some logical reason must be given for this choice.[128] Like the very medical practitioners the doctrine affects, a clear statement of the law on the continuing tort doctrine must "above all, do no harm."[129] To avoid creating greater harm, a statement on the continuing tort doctrine must recognize the distinction between the continuing tort doctrine and the continuous treatment rule; explain the

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LEGAL STUD. 215, 240–41 (1987) (discussing the nature of the common law and the unforeseeable ways in which the meaning of precedent may change).

122. *See generally* LON L. FULLER, THE MORALITY OF LAW 152–59 (Yale Univ. Press rev. ed. 1969). The idea that law should be crafted and applied in a predictable, consistent manner is not universally accepted, but it is a common assumption of the American legal system.

123. Gabrielle Kaufmann-Kohler, *Arbitral Precedent: Dream, Necessity or Excuse?*, 23 ARB. INT'L 357, 374 (2007), *available at* http:// www.arbitration-icca.org/ media/ 0/ 12319 14308 7130/ 00950 001.pdf.

124. *See supra* Part IV.

125. *See* RAWLE O. KING, CONG. RES. SERV., RS 21461, MEDICAL MALPRACTICE LIABILITY INSURANCE AND THE MCCARRAN–FERGUSON ACT (2003), *available at* http:// www.law. umaryland.edu/ marshall/ crsreports/ crsdocuments/ RS214 61.pdf. The report discusses the argument that "the tort system functions unevenly and inequitably in resolving medical negligence cases" and that "[m]edical litigation . . . needs a predictable and consistent context" if medical practitioners are to enjoy a stable market for malpractice liability insurance. *Id.* at 3.

126. The doctrine, by its very nature, makes it impossible to set a clear outer boundary to the limitations period, but the uneven application of the doctrine eliminates any notion of boundaries. This Note does not take a position on whether jurisdictions should follow the continuing tort doctrine or eliminate it altogether. Rather, this Note illuminates the way in which the doctrine affects this area of law and offers a proposal in the interest of clarity and stability.

127. *See supra* notes 38–39 and accompanying text.

128. *See supra* Part V.A. A reason that distinguishes one area of law from another provides a check against unforeseeable analogies and cross-applications.

129. For a fascinating discussion of this well known maxim see Cedric M. Smith, *Origin and Uses of* Primum Non Nocere*—Above All, Do No Harm!*, 45 J. CLINICAL PHARMACOLOGY 371 (2005), *available at* http:// jcp.sagepub.com/ content/ 45/ 4/ 371. full.pdf +html.

policy behind the doctrine, including the preconditions for applying the doctrine; avoid vague reasoning that could be used in support of the doctrine or against it, depending on the objective of the litigant; explain the relationship between the doctrine and any relevant statute of repose; and explain the relationship between the doctrine and the discovery rule.[130]

Undoubtedly, even such a clear statement of the law would fail to bridle the imagination of litigators who see the continuing tort doctrine as a silver bullet for advancing the interests of clients whose claims are time-barred, but it would at least bring some measure of sanity to the discussion. While the continuing tort doctrine is more complex than it may first appear, its application and relation to other rules does not have to be "vexing," "muddled," or superlative in its degree of confusion.[131] Jurisdictions may reasonably choose rigidity or flexibility in their statutory limitation schemes, absolute limits or free-wheeling doctrines grounded in fairness, but it is hard to imagine a jurisdiction would consciously choose confusion. Instead, the present confusion surrounding the continuing tort doctrine has resulted from inadvertence and inattention from scholars and judges alike. In fields like medical malpractice, where analysis of the continuing tort doctrine has been especially scant, the doctrine creates special challenges and is deserving of more thorough treatment.[132]

VI. CONCLUSION

In the midst of a passionate national discussion of health care policy, including a discussion of laws affecting medical malpractice liability insurance rates, the history of reform goes largely unmentioned and unnoticed. Reform has been heaped on top of reform, but the drama continues, now with an increasingly assertive antagonist: the continuing tort doctrine. How meaningful the continuing tort doctrine's role becomes will depend on the receptiveness of courts and legislatures to the doctrine's underlying policy, the extent to which they understand its ramifications, and the clarity with which they define their position. A clear statement of the law is necessary to avoid unintended consequences and instability in the market for medical malpractice insurance.

Simon Turner Bailey[*]

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130. *See supra* Part IV.A–E.

131. *See supra* notes 894–97 and accompanying text.

132. *See* Robert J. David, *Continuing-Tort Doctrine and Three-Year Statute of Repose*, 49 LA. B.J. 333, 333 (2002) (referring to the application of the continuing tort doctrine to medical malpractice as a "'novel legal issue'" (quoting *In re* Medical Review Panel for Claim of Moses, 00-2643 (La. 5/25/01); 788 So. 2d 1173, 1174)).

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