

TIPPING THE SCALES?: MAINE ADOPTS THE
CONTINUING NEGLIGENT TREATMENT DOCTRINE
IN *BAKER V. FARRAND*

Michael P. Beers

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I. INTRODUCTION

In *Baker v. Farrand*,¹ the Maine Supreme Judicial Court, sitting as the Law Court, held that for a series of related negligent acts or omissions committed by a health care provider or practitioner, a single cause of action “accrues” under the Maine Health Security Act² (hereinafter MHSA) on the date of the last act or omission that contributed to the plaintiff’s injury.³ Hence, in situations where a physician provides continuing negligent treatment to a patient in which each and every one of the physician’s actions are negligent, the MHSA’s three-year statute of limitations does not begin to run until the last date of negligent care.⁴ Courts refer to this construction of the law as the “continuing negligent treatment doctrine.”⁵

In *Baker*, the plaintiff alleged that the defendant, his primary care physician, provided negligent care for a span of four years by failing to refer him to a urologist when diagnostic tests taken during this period indicated the possibility of prostate disease.⁶ After being diagnosed with adenocarcinoma of the prostate, the plaintiff filed suit, claiming that as a result of his delayed referral, his treatment options became limited.⁷ The Superior Court found that the MHSA’s statute of limitations prevented the plaintiff from bringing a claim for any acts that had occurred more than three years before he filed his suit.⁸

The Law Court reversed the Superior Court’s ruling by holding that for multiple acts or omissions that each individually contribute to an injury, the relevant date for statute of limitations purposes is the last date of negligent treatment.⁹ In doing so, the Law Court adopted the continuing negligent treatment doctrine and, consequently, allowed the plaintiff’s case to go forward.¹⁰ To recover for any acts or omissions that occurred outside the three-year limitations period, the plaintiff would have to establish that each act or omission “deviated from the applicable standard of care and, in combination with an act or omission that

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1. 2011 ME 91, 26 A.3d 806.

2. ME. REV. STAT. tit. 24, § 2902 (2010).

3. *Baker*, 2011 ME 91, ¶ 25, 26 A.3d 806.

4. *Id.*

5. See *Dickey v. Vermette*, 2008 ME 179, ¶ 25, 960 A.2d 1178 (Silver, J., dissenting).

6. *Baker*, 2011 ME 91, ¶¶ 3-4, 26 A.3d 806.

7. *Id.*

8. *Id.* ¶ 5.

9. *Id.* ¶ 24.

10. *Id.* ¶ 34.

occurred within the limitations period, contributed to and was a proximate cause of his harm.”¹¹

This Note begins, in Part II, by providing a background of statutes of limitations and the ability of courts to toll them in certain circumstances. Part III examines the different ways courts define “accrual” under medical malpractice statutes of limitations and reviews the Law Court’s past attempt of reconciling them with the MHSA. Part IV analyzes the Law Court’s rationale in finding the continuing negligent treatment doctrine consistent with the MHSA. Part V demonstrates that the Law Court correctly adopted the continuing negligent treatment doctrine, as opposed to other accrual methods, but unnecessarily limited the doctrine’s applicability. This Note concludes by maintaining that the MHSA allowed the Law Court to join the increasing number of states that have moved away from strict interpretations of statutes of limitations; however, the Law Court’s insistence that each act or omission must be negligent, as opposed to requiring negligent treatment overall, will prevent plaintiffs in similar circumstances from recovering for their injuries.

II. BACKGROUND

A. Statutes of Limitations

Statutes of limitations establish time limits for a party to bring an action, either in a criminal prosecution or a civil lawsuit.¹² Their primary purpose is to “protect defendant[s] against loss of witnesses and evidence and to protect his acts in reasonable reliance upon plaintiff’s inaction.”¹³ Most statutes of limitations “possess the same essential structure: they classify claims into groups, they assign each group of claims a limitation period of fixed duration, and they extinguish claims not filed before the limitation period expires.”¹⁴ In dealing with statutes of limitations, the timing of when the statutory period begins to run determines whether the claim is barred.¹⁵

In order to prescribe the period by which the statutory period begins to run, all statutes of limitations “use some sort of terminology to describe when the period of limitations commences, or as it is sometimes stated, . . . when the cause of action accrues.”¹⁶ Some statutes use specific terms such as “‘from the date of the act or omission complained of,’ ‘from the time the injury was done,’ and ‘when the damage resulting therefrom is sustained and is capable of ascertainment.’”¹⁷

11. *Id.*

12. See BLACK’S LAW DICTIONARY 1546 (9th ed. 2009).

13. Jennifer Wriggins, *Domestic Violence Torts*, 75 S. CAL. L. REV. 121, 172 (2001) (citing WILLIAM D. FERGUSON, *THE STATUTES OF LIMITATION SAVING STATUTES* 43 (1978)).

14. Andrew J. Wistrich, *Procrastination, Deadlines, and Statutes of Limitation*, 50 WM. & MARY L. REV. 607, 611 (2008).

15. See *id.* at 609-10.

16. 4 AM. JUR. TRIALS 456 (1966).

17. *Id.* As detailed in Part III, most courts have adopted various doctrines to determine the date the statute of limitations begins to run. The following state legislatures have created hybrid rules that combine elements from these doctrines to better define accrual: California, Iowa, Kansas, Montana, Nevada, New Hampshire, New York, Rhode Island, Texas, Vermont, Washington, and West Virginia.

Without such specificity, courts themselves must determine when a cause of action accrues, which has led to unpredictable results.¹⁸

Statutes of limitations are to be distinguished from statutes of repose in that the latter “extinguishes a cause of action after a fixed period of time . . . regardless of when the cause of action accrued.”¹⁹ In other words, statutes of repose establish “the maximum length of time available . . . that begins to run at a point . . . that may occur a substantial time after the alleged negligence.”²⁰ When the two are used simultaneously, a statute of limitations sets the date for when a cause of action accrues, while the statute of repose establishes an outer limit that prevents suits from being filed after a period of time from the date of the negligence.²¹

See CAL. CIV. CODE § 340.5 (West 2011) (statute begins to run either after the date of injury or when the plaintiff discovers the injury, whichever occurs first); IOWA CODE § 614.1.9.a (2011) (statute begins to run on the date the plaintiff knew or through reasonable diligence should have known, or received notice in writing of the injury, whichever comes first); KAN. STAT. ANN. § 60-513(c) (2011) (cause of action accrues at the time of the occurrence that caused the injury, unless the injury is not reasonably ascertainable, in which case the period of limitations should not commence until the injury becomes reasonably ascertainable); MONT. CODE ANN. § 27-2-205 (2011) (statute of limitations begins to run on the date of injury or when the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but statute of repose sets absolute limit); NEV. REV. STAT. § 41A.097 (2011) (statute begins to run on the earlier of the date of injury or when the plaintiff discovers, or through reasonable diligence should have discovered, the injury); N.H. REV. STAT. ANN. § 508:4 (2011) (statute begins to run upon injury, unless the injury was not reasonably discoverable, in which case the period begins when the plaintiff discovers, or reasonably should have discovered, the injury); N.Y. C.P.L.R. § 214-a (MCKINNEY 2011) (in the continuous treatment context the statute begins to run on the date of the last treatment that gave rise to the injury); R.I. GEN. LAWS § 9-1-14.1 (2011) (statute begins to run on the day of the injury, unless the injury could not have been discoverable with reasonable diligence, in which case the statute begins to run when the malpractice should have been discovered with reasonable diligence); TEX. CIV. PRAC. & REM. CODE ANN. § 74.251 (West 2011) (statute of limitations begins to run when the treatment that is the subject of the claim is complete); VT. STAT. ANN. tit. 12, § 521 (2011) (statute of limitations begins to run on the later of the date of the incident, or when the injury was discovered or reasonably should have been discovered); WASH. REV. CODE § 4.16.350 (2011) (statute of limitations begins to run on the later of the date of the act or omission or when the injury was discovered or reasonably should have been discovered); W. VA. CODE § 55-7B-4 (2011) (statute of limitations begins to run on the later of the date of the act or omission or when the injury was discovered or reasonably should have been discovered).

While these statutes do in fact provide more guidance, some ambiguity may still remain in trying to pinpoint the date of an injury in situations where treatment has occurred over the course of multiple years. *See* DAVID W. LOUISELL & HAROLD WILLIAMS, 2 *MEDICAL MALPRACTICE* § 13.05[1] (Gordon L. Ohlsson, ed., Matthew Bender 2011). Even with clearer language, “malpractice claims pose[] unique difficulties which require[] . . . modify[ing] the general statute of limitations.” *Caughell v. Group Health Coop. of Puget Sound*, 876 P.2d 898, 901 (Wash. 1994) (en banc) (as a result of ambiguity within the statute, the court adopted the continuing negligent treatment doctrine when appropriate).

18. *See* 4 AM. JUR. TRIALS 456 (1966).

19. 63 AM. JUR. 2D *Products Liability* § 1490 (2011).

20. Robin Miller, Annotation, *Timeliness of Action Under Medical Malpractice Statute of Repose, Aside from Effect of Fraudulent Concealment of Patient’s Cause of Action*, 14 A.L.R. 6th 301 (2006).

21. *See, e.g.*, CONN. GEN. STAT. § 52-584 (2011) (“No action to recover damages for injury to the person . . . caused by negligence . . . shall be brought but within two years from the date when the injury is first sustained or discovered or in the exercise of reasonable care should have been discovered, and except that no such action may be brought more than three years from the date of the act or omission complained of . . .”). Here, the two-year statute of limitations begins to run on date of the injury, its

B. Tolling the Statute of Limitations

Once the statute of limitations has run, the claim is extinguished, unless the party bringing the suit can “toll” the statutory period by “show[ing] facts which remove its bar of the action.”²² Generally, tolling occurs when the plaintiff has been prevented from asserting his or her rights through various circumstances such as legal disability, lack of information, or the inability to identify the defendant after exercising reasonable diligence.²³ In determining whether the statute of limitations should be tolled, courts look to the legislative intent behind the statute.²⁴ When consistent with the purpose of the statute, courts may toll the claim and remove it from the limitations period.²⁵ Often the legislature explicitly provides scenarios in which the statute of limitations should be tolled.²⁶

III. WHEN DOES AN INJURY “ACCRUE” UNDER MEDICAL MALPRACTICE STATUTES?

A. Traditional View

Under the traditional view, a cause of action for medical malpractice accrues at the time of the negligent act²⁷ or when the wrongful act results in a legal injury to the plaintiff.²⁸ Courts and legislatures recognize that a bright-line rule based on a strict accrual date favors the defendant and can produce harsh results for the plaintiff.²⁹ However, courts that “apply the rule justify their decision on the basis of the same reasoning that underpins all limitations, namely, that the lapse of time works to the disadvantage of the defendants in that witnesses die or become otherwise unavailable, and the production of necessary records becomes increasingly difficult.”³⁰

discovery, or when it should have reasonably been discovered; however, the statute of repose sets an absolute limit of three years after the negligence occurred, regardless of when it is discovered. *See id.*

22. 54 C.J.S. *Limitations of Actions* § 133 (2010). Courts differ as to whether a statute of repose may be tolled. *Compare* Rudenauer v. Zafirooulos, 837 N.E.2d 278, 281 (Mass. 2005) (statute of repose not subject to any form of tolling), *with* Witt v. St. Vincent’s Med. Ctr., 746 A.2d 753, 756-57 (Conn. 2000) (statute of repose may be tolled under certain circumstances).

23. 54 C.J.S. *Limitations of Actions* § 133 (2010).

24. *Id.*

25. *Id.*

26. *See id.* Courts sometimes also employ “equitable tolling” and toll the statute of limitations under extraordinary circumstances without clear direction from legislatures, so long as such tolling is consistent with the legislative scheme. *See id.* § 134. However, this practice is not universally accepted, as some courts only toll the statute of limitations when the legislature has granted them the power to do so. *See id.* § 133.

27. LOUISELL & WILLIAMS, *supra* note 17, § 13A.03[1].

28. *See, e.g., Ex parte Sonnier*, 707 So. 2d 635, 638 (Ala. 1997); *Kaminer v. Canas*, 653 S.E.2d 691, 695 (Ga. 2007); *Stuard v. Jorgenson*, 249 P.3d 1156, 1160 (Idaho 2011); *Rudenauer v. Zafirooulos*, 837 N.E.2d 278, 282 (Mass. 2005); *Solowy v. Oakwood Hosp. Corp.*, 561 N.W.2d 843, 845-46 (Mich. 1997).

29. LOUISELL & WILLIAMS, *supra* note 17, § 13A.03[1].

30. *Id.* It should be noted, however, that some courts in jurisdictions that apply this rule make an exception when a foreign object has been left inside the body of a surgical patient. *See id.* § 13A.03[2].

B. Continuous Treatment Doctrine

The continuous treatment doctrine (sometimes referred to as the termination of relationship doctrine)³¹ begins the running of the statute of limitations “upon the termination of the physician-patient relationship.”³² The rationale behind this rule is that as long as the relationship between the patient and physician exists, the latter has a continuing duty of care³³ and the cause of action should not accrue until the termination of the relationship.³⁴ Although more favorable to plaintiffs than the traditional view, courts that once employed the continuous treatment doctrine have since abandoned it as it sometimes may produce “the unconscionable result to [plaintiffs] who by exercising even the highest degree of care could not have discovered the cited wrong.”³⁵ Alternatively, it has been rejected as inconsistent with legislative intent behind the statute of limitations’ protection of defendants.³⁶

C. Continuous Course of Treatment Doctrine

Under the continuous course of treatment doctrine, a cause of action accrues upon the termination of the physician-patient relationship for the particular condition that gave rise to the injury.³⁷ Although sometimes also referred to as the continuous treatment doctrine,³⁸ the continuous course of treatment doctrine differs from the continuous treatment doctrine as described above in that it requires that the treatment following the act of negligence be “related to the same original condition or complaint,”³⁹ as opposed to the end of general treatment.⁴⁰ The rule has been justified in that it promotes physician-patient relationships by letting the patient wait to challenge the quality of the defendant’s care until the treatment has ended.⁴¹ Rather than force a patient to interrupt necessary treatment in order to avoid the running of limitations, “the rule protects a patient who trusts the physicians so much that he or she would not otherwise think to question the quality

31. See *Dickey v. Vermette*, 2008 ME 179, ¶ 23, 960 A.2d 1178 (Silver, J., dissenting).

32. *De Long v. Campbell*, 104 N.E.2d 177, 177 (Ohio 1952).

33. See *id.* at 178.

34. See *Weiss v. Rojanasathit*, 975 S.W.2d 113, 119 (Mo. 1998) (en banc).

35. *Oliver v. Kaiser Cmty. Health Found.*, 449 N.E.2d 438, 441 (Ohio 1983).

36. 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, 959-60 (discussing courts’ reasons for rejecting the continuous treatment doctrine).

37. See, e.g., *Lane v. Lane*, 752 S.W.2d 25, 26-27 (Ark. 1988); *Comstock v. Collier*, 737 P.2d 845, 849 (Colo. 1987); *Sherwood v. Danbury Hosp.*, 746 A.2d 730, 736 (Conn. 2000); *Harrison v. Valentini*, 184 S.W.3d 521, 524 (Ky. 2006); *Carter v. Haygood*, 892 So. 2d 1261, 1271 (La. 2001); *Johnson v. Winthrop Labs. Div. of Sterling Drug, Inc.*, 190 N.W.2d 77, 80 (Minn. 1971); *Smith v. Dewey*, 335 N.W.2d 530, 533 (Neb. 1983); *Borgia v. City of New York*, 187 N.E.2d 777, 778 (N.Y. 1962); *Horton v. Carolina Medicorp, Inc.*, 472 S.E.2d 778, 781 (N.C. 1996); *Liffengren v. Bendt*, 612 N.W.2d 629, 633 (S.D. 2000); *Metzger v. Kalke*, 709 P.2d 414, 417 (Wyo. 1985).

38. See *Dickey v. Vermette*, 2008 ME 179, ¶¶ 23-24, 960 A.2d 1178 (Silver, J., dissenting) (recognizing the difference between the two doctrines, but referring to both as the “continuous treatment doctrine”).

39. *Borgia*, 187 N.E.2d at 778.

40. See *Horton*, 472 S.E.2d at 781.

41. LOUISELL & WILLIAMS, *supra* note 17, § 13A.05[1].

of the doctor's care."⁴² Courts that have not adopted the continuous course of treatment doctrine criticize it as contrary to the purposes of the statute of limitations absent clear direction from the legislature.⁴³

D. Continuing Negligent Treatment Doctrine

For courts that use the continuing negligent treatment doctrine, accrual begins upon the last act of negligent treatment related to a single condition.⁴⁴ In effect, courts that have adopted this rule add a second requirement to the continuing course of treatment doctrine: the treatment following the original act of negligence must be *negligent*, rather than merely *related* to the negligent act.⁴⁵ As opposed to the continuous course of treatment doctrine, the statute of limitations is only delayed until the last negligent act or omission, instead of the end of the treatment for the condition that gave rise to the injury.⁴⁶ Courts that have added this requirement reason that in order for an injury to accrue on a date later than the initial negligent act, the entire treatment must constitute one continuing wrong.⁴⁷ Hence, in order to get the benefit of this doctrine, a plaintiff has the burden to show ongoing negligent treatment.⁴⁸

E. The Discovery Rule

Under the discovery rule, "the patient's action accrues when he or she discovers, or reasonably should have discovered, the existence of the essential elements to the cause of action."⁴⁹ The rule is sometimes codified,⁵⁰ but it has also been adopted in the absence of clear legislative intent.⁵¹ Even though the discovery

42. *Id.*

43. *See* *Cunningham v. Huffman*, 609 N.E.2d 321, 324 (Ill. 1993) (recognizing that courts have adopted the doctrine without direction from the legislature, but declining to do so).

44. *See* LOUISELL & WILLIAMS, *supra* note 17, § 13A.05[3].

45. *Ewing v. Beck*, 520 A.2d 653, 663 n.11 (Del. 1987); *Cunningham*, 609 N.E.2d at 325; *Farley v. Goode*, 252 S.E.2d 594, 599 (Va. 1979); *Caughell v. Group Health Coop. of Puget Sound*, 876 P.2d 898, 910 (Wash. 1994); *Tamminen v. Aetna Cas. & Sur. Co.*, 327 N.W.2d 55, 65 (Wis. 1982).

46. *See* LOUISELL & WILLIAMS, *supra* note 17, § 13A.05[3].

47. *See id.*

48. *See id.*

49. *Id.* § 13A.04(1). While this is a general characterization, other courts require that the plaintiff also discover that the source of the injury was caused by the defendant's conduct before the limitations period begins to run. *See Raymond v. Eli Lilly & Co.*, 371 A.2d 170, 172 (N.H. 1977).

50. *See Musculoskeletal Inst. Chartered v. Parham*, 745 So. 2d 946, 951 (Fla. 1999); *Yamaguchi v. Queen's Med. Ctr.*, 648 P.2d 689, 691-92 (Haw. 1982); *Rathje v. Mercy Hosp.*, 745 N.W.2d 443, 455, 457 (Iowa 2008); *Smith v. Sanders*, 485 So. 2d 1051, 1052 (Miss. 1986); *Wing v. Lorton*, 261 P.3d 1122, 1126 (Okla. 2011); *Gaston v. Parsons*, 864 P.2d 1319, 1321 (Or. 1994); *Strong v. Univ. of S.C. Sch. of Med.*, 447 S.E.2d 850, 851 (S.C. 1994); *Daniels v. Gamma W. Brachytherapy, LLC*, 221 P.3d 256, 265 (Utah 2009).

51. *See Pedersen v. Zielski*, 822 P.2d 903, 906 (Alaska 1991); *Walk v. Ring*, 44 P.3d 990, 994 (Ariz. 2002) (en banc) ("Use of the word 'accrues' ... permits judicial construction of the events of knowledge that will trigger accrual."); *Bussineau v. President & Dirs. of Georgetown Coll.*, 518 A.2d 423, 425 (D.C. 1986); *Booth v. Wiley*, 839 N.E.2d 1168, 1172 (Ind. 2005) ("If the discovery date is more than two years following the . . . malpractice, the claimant has two years after discovery . . . to initiate a malpractice action. But, if the discovery date is within two years . . . the statutory limitation period applies."); *Caravaggio v. D'Agostini*, 765 A.2d 182, 187 (N.J. 2001); *Roberts v. Sw. Cmty.*

rule could potentially extend the statute of limitations long beyond the end of treatment, courts justify extending the period in order to “avoid the harsh and illogical consequences of interpreting the statute [of limitations] in a manner that outlaws the plaintiff’s claim before he was or should have been aware of its existence.”⁵²

F. *The Law Court’s Pre-Baker Ruling*

In *Dickey v. Vermette*,⁵³ the Law Court declined to adopt either the continuous course of treatment or the continuing negligent treatment doctrines.⁵⁴ In *Dickey*, a dental hygienist noticed a dark spot on the x-ray of the plaintiff’s teeth, noting that it was odd, but not concerning.⁵⁵ In subsequent appointments, the same hygienist showed the spot to the defendant, a dentist, who remarked that that the office would “keep an eye on it.”⁵⁶ Five years later, a second x-ray was taken and revealed that the spot had grown.⁵⁷ The defendant then referred the plaintiff to an oral surgeon who diagnosed her with oral cancer.⁵⁸ The Law Court affirmed the lower court’s decision to bar the plaintiff’s claim under the MHSA’s three-year statute of limitations, ruling that the statute’s language prevented the adoption of the continuous course of treatment doctrine.⁵⁹ Because the plaintiff did not allege any negligence within the three-year limitations period, the Law Court declined to address whether the MHSA precluded the continuing negligent treatment doctrine.⁶⁰

Dissenting, Justice Silver argued that the facts of the case did not foreclose the adoption of the continuing negligent treatment doctrine because the proper inquiry should have been whether the treatment as a whole was negligent instead of determining if each individual act or omission was negligent.⁶¹ In support of this proposition, Justice Silver distinguished the proof required in an action for continuing negligent treatment and that involving a single negligent act.⁶² Although both necessitate a showing of duty, breach of duty, proximate cause, and damages, a plaintiff alleging a continuing course of negligent treatment need not prove which negligent act caused the injury as long as the “plaintiff proves that the continuing negligent treatment was the proximate cause of the injury.”⁶³

Health Servs., 837 P.2d 442, 451 (N.M. 1992); *Schanilec v. Grand Forks Clinic, Ltd.*, 599 N.W.2d 253, 255-56 (N.D. 1999); *Oliver v. Kaiser Cmty. Health Found.*, 449 N.E.2d 438, 443-44 (Ohio 1983); *Fine v. Checcio*, 870 A.2d 850, 859 (Pa. 2005); *Teeters v. Currey*, 518 S.W.2d 512, 517 (Tenn. 1974). For states that incorporate the discovery rule with additional elements, see *supra* note 17.

52. *Raymond*, 371 A.2d at 174.

53. 2008 ME 179, 960 A.2d 1178.

54. *Id.* ¶¶ 7-9.

55. *Id.* ¶ 2.

56. *Id.*

57. *Id.*

58. *Id.*

59. *Id.* ¶¶ 7-8.

60. *Id.* ¶ 9.

61. *Id.* ¶ 33 (Silver, J., dissenting).

62. *Id.* ¶ 31.

63. *Id.* ¶ 33 (quoting *Caughell v. Group Health Coop. of Puget Sound*, 876 P.2d 898, 907 (Wash. 1994)).

Accordingly, the fact that the plaintiff did not allege that each and every one of the defendant's acts or omissions was negligent should not have been fatal to her claim.⁶⁴

IV. THE *BAKER* DECISION

A. *Factual Background and Procedural History*

From 1987 through 2006, Dr. Merrill Farrand served as Philip Baker's primary care physician.⁶⁵ As a part of this care, Farrand annually tested Baker's prostate-specific antigen (PSA) levels from 1996 through 2006.⁶⁶ Any result above the normal test range of zero to four may suggest prostate disease.⁶⁷ Baker's tests revealed higher than normal PSA levels in every annual test from 2002 to 2006.⁶⁸ Only after receiving the October 2006 results, which indicated a PSA level of 7.7, did Farrand refer Baker to a urologist who, after performing a prostate biopsy, diagnosed Baker with adenocarcinoma of the prostate.⁶⁹

On September 14, 2007, Baker filed a notice of claim in accordance with the MHSA,⁷⁰ alleging that Farrand breached the applicable standard of care by failing to refer him to a urologist in 2003, 2004, and 2005.⁷¹ He claimed that as a result of not being referred to a urologist earlier, his diagnosis was delayed until after the cancer spread, which limited his treatment options.⁷² Farrand raised an affirmative defense that the action was barred by the statute of limitations before a prelitigation screening panel appointed by the court,⁷³ which ordered the parties to resolve the issue by motion with the Superior Court.⁷⁴

64. *Id.* ¶ 36.

65. *Baker v. Farrand*, 2011 ME 91, ¶ 3, 26 A.3d 806.

66. *Id.* PSA tests are used to identify potential prostate diseases, such as prostate cancer, prostate hypertrophy, and prostatitis. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. ME. REV. STAT. tit. 24, § 2853 (2010). Specifically, Baker filed a written notice with the Superior Court pursuant to section 2853(1)(b). *Baker*, 2011 ME 91, ¶ 3, 26 A.3d 806.

71. *Baker*, 2011 ME 91, ¶ 4, 26 A.3d 806. Although the complaint may have alleged the negligence began in 2003, the parties stipulated that the alleged negligent treatment began as early as 2002. *Id.* ¶ 4 n.1 (citation to footnote only).

72. *Id.* ¶ 4.

73. In accordance with the MHSA, the Chief Justice of the Superior Court recommends to each Superior Court clerk "the names of retired or active retired justices and judges, persons with judicial experience and other qualified persons to serve on screening panels . . ." ME. REV. STAT. tit. 24, § 2852(1) (2010). The clerk must also maintain lists of health care practitioners, health care providers and attorneys who would be able to serve on these panels. *Id.* When a claim is filed under the MHSA, the Chief Justice then chooses a person from the list to serve as chair of the panel to screen the claim. *Id.* § 2852(2)(A). The clerk then notifies this person of the Chief Justice's decision and provides him or her with the list of health care practitioners, health care providers, and attorneys. *Id.* § 2852(2)(B). The chair must then choose an attorney, as well as one health care practitioner, and potentially a second health care practitioner if there is more than one defendant accused of professional negligence, to serve on the panel. *Id.* The rationale for these panels is "[t]o identify claims of professional negligence which merit compensation . . . to encourage early resolution . . . and to encourage early withdrawal or dismissal of nonmeritorious claims." *Id.* § 2851(1) (2010).

In August 2009, Farrand moved for partial summary judgment on any alleged negligent acts or omissions that occurred before September 14, 2004, based on the MHSA's three-year statute of limitations,⁷⁵ which provides that "[a]ctions for professional negligence shall be commenced within 3 years after the cause of action accrues . . . [f]or purposes of this section, a cause of action accrues on the date of the act or omission giving rise to the injury."⁷⁶ In granting Farrand's motion, the Superior Court determined that the statute of limitations effectively barred any acts occurring more than three years before his filing notice of September 14, 2007.⁷⁷ The Superior Court found that Section 2902's use of "act" and "omission" in the singular (as opposed to "acts" or "omissions") indicated that each individual act must be considered on its own, separate from any other act or omission.⁷⁸ In doing so, the court declined to recognize the continuing negligent treatment doctrine, where the statute of limitations "would begin to run for 'a series of interrelated negligent acts that occurred during the course of treatment' on the date of the last act of negligence, 'as long as that act occurred within three years before the legal action was initiated.'"⁷⁹

In accordance with Rule 24 of the Maine Rules of Appellate Procedure, the parties filed an agreed-upon motion to report the case to the Law Court in order to review the partial summary judgment order and to determine the applicability of the continuing negligent treatment doctrine to the MHSA.⁸⁰ As an exception to the final judgment rule, Rule 24 allows parties to obtain review from the Law Court if "acceptance would be consistent with [the Law Court's] basic function as an appellate court [and not] improperly place [the Law Court] in the role of an advisory board."⁸¹ The Law Court determined that the issue of "whether a cause of action for professional negligence under the [MSHA] exists for acts or omissions committed during a continuing course of negligent treatment when some of the acts

Maine, as well as many other states, require this screening procedure in medical malpractice suits. See *Flanders v. Cooper*, 1998 ME 28, ¶ 12, 706 A.2d 589; LOUISELL & WILLIAMS, *supra* note 17, § 13A.02[2]. Other states have enacted voluntary review panels or require an affidavit from qualified experts to be filed with the complaint. See LOUISELL & WILLIAMS, *supra* note 17, § 13A.02[1], [3]. For more on the history of medical malpractice review panels, see *id.* § 13A.01.

74. *Baker*, 2011 ME 91, ¶ 4, 26 A.3d 806. Screening panels have no jurisdiction over affirmative defenses and are required to refer them to the Chief Justice of the Superior Court. ME. REV. STAT. tit. 24, § 2853(5); ME. R. CIV. P. 80M(e).

75. *Baker*, 2011 ME 91, ¶ 5, 26 A.3d 806.

76. ME. REV. STAT. tit. 24, § 2902 (2010).

77. *Baker*, 2011 ME 91, ¶ 5, 26 A.3d 806.

78. *Id.*

79. *Id.* (quoting *Dickey v. Vermette*, 2008 ME 179, ¶¶ 9, 25, 960 A.2d 1178 (Silver, J., dissenting)).

80. *Id.* ¶ 6. Rule 24(a) provides that the Superior Court may, where all parties appearing so agree, report any action to the Law Court if it is of the opinion that any question of law presented is of sufficient importance or doubt to justify the report, provided that the decision therefore would in at least one alternative finally dispose of the action.

ME. R. APP. P. 24(a).

81. *Liberty Ins. Underwriters, Inc. v. Estate of Faulkner*, 2008 ME 149, ¶ 6, 957 A.2d 94 (quoting *Morris v. Sloan*, 1997 ME 179, ¶ 7, 698 A.2d 1038) (internal quotation marks omitted).

or omissions occurred outside the limitations period” warranted Rule 24 treatment and accepted the case.⁸²

B. *Decision of the Law Court*

To determine when a cause of action for professional negligence “accrues,” the Law Court sought to first identify the MHSA’s meaning of “act or omission,” which the Act did not explicitly define.⁸³ To decipher the term’s meaning, the Law Court looked to the MHSA’s definition “professional negligence.”⁸⁴ Accounting for the four elements of every negligence claim,⁸⁵ the statute recognized a cause of action for medical malpractice when the “acts or omissions complained of constitute a deviation from the applicable standard of care . . . and . . . [t]here is a reasonable medical or professional probability that the acts or omissions . . . proximately caused the injury complained of.”⁸⁶

In construing the language of the MHSA this way, the Law Court determined that “a single cause of action may arise from multiple acts or omissions even if each independent act or omission, viewed in isolation from the other acts or omissions, constitutes an independent deviation from the applicable standard of care.”⁸⁷ Hence, in cases where there is a series of related acts or omissions, the key question becomes whether each act or omission on its own proximately caused the

82. *Baker*, 2011 ME 91, ¶ 7, 26 A.3d 806. The decision whether to accept a case under Rule 24 involves the related factors of whether

- (1) the question reported is of sufficient importance and doubt to outweigh the policy against piecemeal litigation; (2) the question might not have to be decided at all because of other possible dispositions; and (3) a decision on the issue would, in at least one alternative, dispose of the action.

Id. (internal citations and quotation marks omitted).

Finding the first factor, the existence of sufficient importance, met, the Law Court determined that this type of scenario was capable of frequent repetition and would affect patients’ ability to sue and health care practitioners’ liability exposure. *Id.* ¶ 9. As for the second factor, other possible dispositions, it ruled that the question raised addressed a threshold matter relating to the application of the statute of limitations, making other possible dispositions limited. *Id.* ¶ 10. If, however, a claim for negligence did not arise within the limitations period, the Law Court ruled that the statute of limitations would bar the action, making it unnecessary to address the reported question. *Id.* Because the parties stipulated that Baker suffered indeterminate or negligible harm during the limitations period, the only possible disposition of the action was to determine whether the continuing negligent course of treatment doctrine should be applied in this case. *Id.* ¶¶ 11-12. As for the third factor, whether a decision would dispose of the action, because the parties further stipulated that Baker would dismiss the action with prejudice unless the Law Court vacated the partial summary judgment, a decision affirming the Superior Court’s judgment would dispose of the action. *Id.* ¶ 13.

83. *Id.* ¶ 22.

84. *Id.* The MHSA states that “professional negligence” occurs when:

- A. There is a reasonable medical or professional probability that the acts or omissions complained of constitute a deviation from the applicable standard of care by the health care practitioner or health care provider charged with that care; and
- B. There is a reasonable medical or professional probability that the acts or omissions complained of proximately caused the injury complained of.

ME. REV. STAT. tit. 24, § 2502(7) (2010).

85. The four elements are duty, breach, proximate causation, and harm. *See Baker*, 2011 ME 91, ¶ 23, 26 A.3d 806.

86. *Id.* (quoting ME. REV. STAT. tit. 24, § 2502(7) (2010)).

87. *Id.* ¶ 24.

alleged injury.⁸⁸ If so, a single cause of action accrues from the date of the last act or omission that contributed to the injury because only at that point is the negligence complete.⁸⁹ Conversely, if only one act or omission in a series of acts or omissions was the cause of the injury, the “cause of action would accrue from the date of that act or omission, and not from the dates of any subsequent acts or omissions.”⁹⁰ Therefore, “in cases involving a continuing course of negligent treatment, the [MHSA] allows for the possibility that two or more negligent acts or omissions might combine to proximately cause a patient’s injury.”⁹¹ Under these circumstances, a plaintiff’s cause of action accrues for multiple negligent acts related to the same condition “on the date of the last act or omission by the health care provider or practitioner that contributed to the proximate causation of the patient’s harm.”⁹²

By reading the MHSA in this way, the Law Court recognized the continuing negligent treatment doctrine.⁹³ Turning to the facts of *Baker*, Farrand sought partial summary judgment for only acts or omissions that had occurred outside of the three-year limitations period.⁹⁴ Therefore, for the motion to be granted, Farrand would have to establish that no acts or omissions occurring before September 14, 2004, contributed to the proximate cause of the injury that Baker alleged continued into November 2006.⁹⁵ The Law Court found that a genuine issue of material fact existed as to whether the failure to refer Baker to a urologist in 2002 or 2003 was a part of the proximate cause of the delayed diagnosis of his prostate cancer, which affected his prognosis and treatment options.⁹⁶ Therefore, the Law Court vacated the partial summary judgment order and remanded the case, instructing the Superior Court that for Baker to recover for any negligence occurring outside the limitations period, he would have to show that each act or omission deviated from the applicable standard of care and contributed to the proximate cause of his harm.⁹⁷

88. *Id.* ¶ 24.

89. *Id.*

90. *Id.*

91. *Id.* ¶ 25.

92. *Id.* Baker could have in fact sued for the acts or omissions that occurred during the statutory period; however, because the damages suffered during this period were either indeterminate or negligible, monetary relief would presumably have been limited. *Id.* ¶ 6.

93. *Id.* ¶ 30.

94. *Id.* ¶ 32.

95. *Id.*

96. *Id.* ¶ 33.

97. *Id.* ¶ 34. In its analysis, the Law Court did not consider fraudulent concealment under title 14, section 859 of the Maine Revised Statutes, which provides that “[i]f a person, liable to any action mentioned, fraudulently conceals the cause thereof from the person entitled thereto, or if a fraud is committed which entitles any person to an action, the action may be commenced at any time within 6 years after the person entitled thereto discovers that he has just cause of action” ME. REV. STAT. tit. 14, § 859 (2010). Although Farrand did not commit fraud through any affirmative statements, “fraud is not limited to affirmative false statements of material facts,” and may be shown by “a failure to disclose or by silence when there is a duty to disclose.” *Dickey v. Vermette*, 2008 ME 179, ¶ 17, 960 A.2d 1178 (Alexander, J., dissenting). In order to prove fraudulent concealment that can toll the statute of limitations, a plaintiff must establish:

either (1) that defendants actively concealed materials facts from [the plaintiff] and that [the plaintiff] relied on their acts or statements to [his or her] detriment . . . or (2) that a

V. ANALYSIS

A. *A Matter of Statutory Construction*

Read literally, a cause of action “accrues” under section 2902 of the MHSA “on the date of the act or omission giving rise to the injury,”⁹⁸ which is easily applied in instances where one wrongful act or omission causes the injury.⁹⁹ The Law Court previously held that because the Legislature outlined the contours of the statute of limitations in section 2902, the Court had been divested of its ability to define accrual.¹⁰⁰ However, in cases such as *Baker*, where a combination of multiple acts or omissions caused the injury, there is no single discernible date for statute of limitations purposes.¹⁰¹ Due to this ambiguity, the Law Court fittingly assumed the role of defining accrual.¹⁰²

In *Baker*, the Law Court devoted a significant amount of time to explaining why “act or omission” could be read in the plural to include multiple acts or omissions.¹⁰³ The Superior Court interpreted the plain meaning of the MHSA to mean Baker’s cause of action accrued upon the occurrence of each negligent act and rationalized this as a basis for foreclosing any recovery for acts committed before 2004.¹⁰⁴ However, when not inconsistent with the plain meaning of the statute,¹⁰⁵ the Legislature provides that “[w]ords of the singular number may include the plural; and words of the plural number may include the singular.”¹⁰⁶ Therefore, the Law Court’s determination that the statute did not limit “act or omission” to the singular was consistent with the MHSA’s definition of professional negligence and allowed a series of related acts or omissions to create a single cause of action.¹⁰⁷ Without its lengthy discussion and conclusion that act or

special relationship existed between the parties that imposed a duty to disclose the cause of action, and the failure of defendants to honor that duty.

Harkness v. Fitzgerald, 1997 ME 207, ¶ 6, 701 A.2d 370. A fiduciary relationship fulfills the requirement of a special relationship. *Dickey*, 2008 ME 179, ¶ 18, 960 A.2d 1179 (Alexander, J., dissenting). Therefore, as the result of their physician-patient relationship, Baker and Farrand had a special and confidential relationship that required Farrand to disclose the PSA test levels to Baker. *See* 70 C.J.S. *Physicians & Surgeons* § 76 (2005) (“The patient has the right to assume that the physician will advise him or her properly in all matters pertaining to his or her ailment, including advice as to persons properly qualified to assist in his or her treatment.”). By not revealing the PSA test levels to Baker, Farrand potentially committed fraudulent concealment under title 14, section 859 of the Maine Revised Statutes that would have tolled the statute of limitations until six years after Baker discovered his cause of action. Hence, had the Law Court addressed this issue, it could have conceivably avoided the statute of limitations problem entirely.

98. ME. REV. STAT. tit. 24, § 2902 (2010).

99. *See* *Bolton v. Caine*, 541 A.2d 924, 925 (Me. 1988).

100. *See* *Dasha v. Me. Med. Ctr.*, 665 A.2d 993, 996 (Me. 1995).

101. *See* LOUISELL & WILLIAMS, *supra* note 17, § 13.05[1].

102. *See* *Dickey*, 2008 ME 179, ¶ 28, 960 A.2d 1179.

103. *See* *Baker v. Farrand*, 2011 ME 91, ¶¶ 22-29, 26 A.3d 806.

104. *Id.* ¶ 26.

105. ME. REV. STAT. tit. 1, § 71 (2010).

106. *Id.* § 71(9).

107. *Baker*, 2011 ME 91, ¶ 28, 26 A.3d 806. Illinois, another state that has adopted the continuing course of negligent treatment doctrine, interpreted its statute of limitations the same way. *See* *Cunningham v. Huffman*, 609 N.E.2d 321, 325 (Ill. 1993).

omission could be read in the plural, the Law Court would not have been able to accept the continuing negligent treatment doctrine without tolling the statute of limitations, which the court interpreted as an option the Legislature had foreclosed under the circumstances of this case.¹⁰⁸

B. *A Single Cause of Action?*

Going forward, *Baker* provides that in order for a combination of more than one act or omission to create a single cause of action, “each independent act or omission, viewed in isolation from the other acts or omissions [must] constitute[] an independent deviation from the applicable standard of care” and must contribute to the proximate cause of the injury.¹⁰⁹ Justice Silver, dissenting in *Dickey*, took a different approach and advocated that in instances of more than one negligent act, “proof of proximate cause and damages is not offered independently as to each of the acts or omissions in the series, *but rather as to the continuum of treatment as a whole.*”¹¹⁰ Under this interpretation, rather than proving that each act individually proximately caused the injury in some way, the plaintiff’s burden is to prove that the continuum of negligence as a whole proximately caused the injury.¹¹¹ The majority in *Dickey* rejected this proposition, holding that for the continuing negligent treatment doctrine to apply “every claim . . . [in the negligent treatment] requires proof of the four elements,”¹¹² a conclusion echoed in *Baker*.¹¹³ Thus, in order for Baker to recover on remand, he must demonstrate that “each of those acts or omissions deviated from the applicable standard of care and, in combination with an act or omission that occurred within the limitations period, contributed to and was a proximate cause of his harm.”¹¹⁴

Isolating each act or omission from the others runs contrary to the Law Court’s treatment of Baker’s claim as a single cause of action as opposed to four separate ones.¹¹⁵ The Law Court mandated that “*every claim for negligence* requires proof of duty, breach, proximate causation, and harm.”¹¹⁶ In this case, the Law Court concedes that Baker had a single claim that arose from multiple acts of negligence.¹¹⁷ If all of Farrand’s individual acts or omissions constituted a single cause of action, it logically follows that the proper inquiry should be whether the entire course of treatment as a whole was negligent, as opposed to requiring each and every act or omission to be negligent.¹¹⁸

108. See *Baker*, 2011 ME 91, ¶ 21 n.5, 26 A.3d 806 (citation to footnote only).

109. *Id.* ¶ 24.

110. *Dickey v. Vermette*, 2008 ME 179, ¶ 33, 960 A.2d 1179 (Silver, J., dissenting) (emphasis added).

111. See *id.* ¶ 34.

112. *Id.* ¶ 9 n.2 (majority opinion) (citation to footnote only).

113. See *Baker*, 2011 ME 91, ¶ 24, 26 A.3d 806.

114. *Id.* ¶ 34.

115. The four separate causes of action would be the failure to refer Baker to a urologist in 2002, 2003, 2004, and in 2005.

116. *Baker*, 2011 ME 91, ¶ 20, 26 A.3d 806 (emphasis added).

117. *Id.* ¶ 24.

118. See *Dickey v. Vermette*, 2008 ME 179, ¶ 33, 960 A.2d 1179 (Silver, J., dissenting).

This is further validated by the fact that it may be difficult in a course of treatment to prove which act or omission proximately caused the injury.¹¹⁹ *Baker* compounds this problem by requiring that plaintiffs show each act or omission proximately caused the harm complained of “to at least some demonstrable degree.”¹²⁰ Thus, in order to recover for injuries that occurred outside of the limitations period, Baker will need to prove that each failure of Farrand to refer him to a urologist proximately caused the injury in some demonstrable way,¹²¹ which necessarily involves proving at what point his cancer became sufficiently advanced to limit his treatment options, because any failure to refer him to a urologist after that time would not have caused any additional harm.

The differences in the approaches taken by the court in *Baker* and that of the *Dickey* dissent are illuminated by altering the facts in *Baker*. Had one of the test results between 2002 and 2006 been within the normal range, Farrand’s failure to refer Baker to a urologist at that juncture would not have been considered independently negligent, and consequently, the Law Court’s requirements would not be met.¹²² Thus, the continuing negligent treatment doctrine would be inapplicable and recovery for any negligence that occurred outside the three-year statutory period would be barred.¹²³ Yet, looking at the treatment as a whole, a course of treatment that had included one normal test amongst three high level tests could still be considered negligent and would not be barred.¹²⁴

C. Other Accrual Methods as Applied to the MHSA

In cases that involve repeated negligence, the traditional rule that ties accrual to the date of the negligence or when the plaintiff has a legal remedy becomes difficult to administer because accrual becomes ambiguous.¹²⁵ While the Law Court conceivably could have applied the traditional rule, it determined that “act or omission” could be read in the plural, consistent with the statutory definition of “professional negligence.”¹²⁶ By doing so, the Law Court joined the steady trend of states that have rejected the traditional rule as applied to situations such as these.¹²⁷

119. *See id.* This in turn reflects the ambiguity of defining accrual as “the date of the act or omission giving rise to the injury.” ME. REV. STAT. tit. 24, § 2902 (2010).

120. *Baker*, 2011 ME 91, ¶ 29, 26 A.3d 806.

121. *See id.* ¶ 34.

122. *See id.*

123. *See id.* ¶ 29.

124. *See Dickey*, 2008 ME 179, ¶ 33, 960 A.2d 1179 (Silver, J., dissenting). An argument could also be made that in a relationship such as that of a physician-patient, where the former is under a continued duty to provide non-negligent care, the failure to correct any prior negligence can constitute an act or omission because by not correcting prior negligence the physician is in fact contributing to the injury. Hence, not correcting prior negligence could in fact be considered a negligent act. The Law Court did not address this point. Nonetheless, it has been rejected in other jurisdictions. *See, e.g., Kaminer v. Canas*, 653 S.E.2d 691, 695 (Ga. 2007) (holding that any subsequent failures to diagnose a condition do not constitute new injuries for statute of limitations purposes).

125. *See LOUISELL & WILLIAMS, supra note 17, §13.05.*

126. *See ME. REV. STAT. tit. 24, § 2502(6) (2010).*

127. *See LOUISELL & WILLIAMS, supra note 17, §13.05.*

As for the continuous treatment and continuous course of treatment doctrines, in both *Dickey* and *Baker* the Law Court determined that the Legislature foreclosed its ability to adopt any method that tied accrual to the end of the doctor-patient relationship because it would involve tolling the statute of limitations.¹²⁸ This interpretation is consistent with the MHSA when only one act or omission causes the injury because accrual can unambiguously be tied to the date of that specific act or omission¹²⁹ and the general rule for statutes of limitations would apply.¹³⁰ But when multiple acts or omissions create a single cause of action, the only thing that meaningfully distinguishes the continuous treatment doctrine, the continuous course of treatment doctrine, and the continuing negligent treatment doctrine is a determination as to whether the treatment as a whole was negligent. If over a course of treatment a doctor commits both negligent and non-negligent actions, the inquiry should be whether the doctor's treatment, viewed as a whole and not as separate acts or omissions, constitutes negligent treatment. Hence, the end of the doctor-patient relationship would be relevant to determine the last negligent act, which under the Law Court's analysis is when the cause of action accrues.¹³¹

The Legislature stipulated that the discovery rule would apply to § 2902 when "the cause of action is based upon the leaving of a foreign object in the body, in which case the cause of action shall accrue when the *plaintiff discovers or reasonably should have discovered the harm.*"¹³² Hence, in foreign object cases, the Legislature allowed the discovery rule to toll the limitations period.¹³³ By specifically adopting the discovery rule in these situations, the Legislature presumably excluded its adoption in other situations.¹³⁴

VI. CONCLUSION

In *Baker v. Farrand*, the Law Court adopted the continuing negligent treatment doctrine in limited circumstances.¹³⁵ In doing so, Maine joined the increasing number of states that have moved away from the traditional rule that accrual occurs on the date of the injury,¹³⁶ which had not only led to unjust results for patients, but also had become unworkable in situations where treatment spans multiple acts or omissions because it is nearly impossible for a plaintiff to prove at what point the injury accrued.¹³⁷ While the MHSA's definition of professional negligence allows multiple acts or omissions to constitute a single cause of action, the Law Court significantly narrowed the doctrine's applicability by requiring that each individual act or omission be negligent, as opposed to determining whether the treatment as a whole was negligent.¹³⁸

128. See *Baker*, 2011 ME 91, ¶ 19, 26 A.3d 806; *Dickey*, 2008 ME 179, ¶ 7, 960 A.2d 1179.

129. See ME. REV. STAT. tit. 24, § 2902 (2010).

130. *Bolton v. Caine*, 541 A.2d 924, 925 (Me. 1988).

131. *Baker*, 2011 ME 91, ¶ 25, 26 A.3d 806.

132. ME. REV. STAT. tit. 24, § 2902 (emphasis added).

133. See *id.*

134. See *Dasha v. Me. Med. Ctr.*, 665 A.2d 993, 996 (Me. 1995).

135. *Baker*, 2011 ME 91, ¶ 24, 26 A.3d 806.

136. See LOUISELL & WILLIAMS, *supra* note 17, § 13.05[1].

137. See *Dickey v. Vermette*, 2008 ME 179, ¶ 33, 960 A.2d 1179 (Silver, J., dissenting).

138. See *Baker*, 2011 ME 91, ¶ 29, 26 A.3d 806.

A better approach would have been that proposed by the dissent in *Dickey*, whereby negligent treatment is determined by looking at the treatment in its entirety, as opposed to each act or omission individually.¹³⁹ The Law Court should have adopted a broader meaning of continuing negligent treatment that views the physician-patient relationship as a whole, and not through the lens of individual acts or omissions. In *Baker*, the continuing negligent treatment doctrine allowed the plaintiff's claim to proceed; however, future applications may result in hardships for patients who have been subjected to treatment that includes one or more non-negligent acts, but is negligent overall.

139. *Dickey*, 2008 ME 179, ¶ 33, 960 A.2d 1179 (Silver, J., dissenting).