Causation and Loss of a Chance: The Issues Yet to Be Addressed in Medical Negligence Claims in Thailand

Khajorndej Direksoonthorn*

I. INTRODUCTION .............................................................................................................. 32

II. THE CURRENT LEGAL FRAMEWORK FOR MEDICAL NEGLIGENCE IN THAILAND ........................................................................................................ 35

III. THE CAUSATION PROBLEM IN THAI MEDICAL NEGLIGENCE CASES.... 38

IV. LOSS OF A CHANCE: IS IT FAIR TO BE USED IN THE THAI MEDICAL NEGLIGENCE CONTEXT?.................................................................................. 43
   A. Introduction to the Loss of a Chance Doctrine ................................................. 43
   B. Applying the Loss of a Chance Doctrine Against a Backdrop of the Supreme Court’s Decisions................................................................. 44

V. CONSIDERATIONS FOR ADOPTING THE NOTION OF LOSS OF A CHANCE IN THAILAND ....................................................................................... 48
   A. The Standard of Proof: Not Statistical Confidence but Factfinders’ Confidence........................................................................................................ 48
   B. Proportional Recovery for Loss of a Chance: Compensation by Belief Probability? .................................................................................. 50
   C. Arguments against Loss of a Chance: Cases in the United Kingdom and Australia................................................................................................ 51
   D. Deterministic versus Indeterministic Causal Process .................................... 55
   E. Epidemiological Evidence .................................................................................. 57

VI. SHOULD THAILAND ADOPT THE LOSS OF A CHANCE DOCTRINE IN MEDICAL NEGLIGENCE? ................................................................. 62

VII. CONCLUSION ............................................................................................................. 65

I. INTRODUCTION

In Thailand, many physicians criticize the legal framework governing medical negligence litigation as being unfair. They primarily

* Judge in the Research Justice Division, Court of Appeal, Thailand. M.D. (First Class Honors, Chulalongkorn University, Thailand), LL.M. (Rector’s Award for Academic Excellence, Assumption University, Thailand), LL.M. (Harvard Law School, the United States), Master of Health and Medical Law (The University of Melbourne, Australia). The Author would like to thank the editors of the Asian-Pacific Law and Policy Journal for their editorial assistance. The views expressed in this article are those of the Author and should not be attributed to any other member of the Thai judiciary.
argue that the procedural framework is biased toward patient plaintiffs. Additionally, however, as this paper will highlight, the lack of analyses of causation may also be a source of unfairness toward physicians in medical negligence claims.

In terms of procedural fairness, the governing provisions are in the Consumer Case Procedure Act.\(^1\) Under the current statutory scheme, physicians bear the burden of proof in medical negligence claims in Thailand regardless of whether they practice in public hospitals or the private sector. The most recent high-profile medical negligence case decided by the Thai Supreme Court was decided in 2016. The decision provoked severe criticism from the Thai medical community\(^2\) for being perceived as unfair to medical professionals and echoes earlier cases that received similar criticism. In that case, the Court held that a doctor was negligent in delaying the diagnosis of a pediatric patient with tuberculous meningitis thereby causing their permanent disability.\(^3\) The then-President of the Thai Medical Council\(^4\) criticized judges for lacking rudimentary medical knowledge and allowing empathy and sympathy to overshadow the truth and law.\(^5\) Some legal scholars responded that the then-President lacked knowledge of the law and was biased toward the doctor.\(^6\) Since the 2016 case, medical professionals have attempted to propose a new procedural law that would work more to their advantage.\(^7\) The medical professionals'
justifications for revamping the procedural rules for medical negligence cases may sound familiar, i.e., doctors contemplating quitting their career, excellent medical students discouraged from entering the profession, and doctors practicing more and more defensive medicine.

Another potential source of unfairness in medical negligence cases is in the analyses under substantive law. The Thai Supreme Court’s medical negligence decisions lack in-depth discussion on the element of causation, as parties fail to argue the issue and the Supreme Court is unable to raise issues the parties do not first introduce. It is undisputed that causation is a major element of the common law tort of negligence and the civil law’s delict or wrongful act. In fact, the Australian High Court once announced that causation was “a matter of common-sense.” In Thailand, however, parties and courts do not analyze the element of causation in-depth in the context of medical negligence claims, to the effect that other possible outcomes of many cases were never realized. In several high-profile cases, medical professionals may have prevailed had the issue of causation been analyzed thoroughly. Therefore, further analysis of the causation element may assuage physicians' concerns that medical negligence decisions are decided unfairly. It is the Author’s aim to encourage defendant doctors to make such arguments in court, especially since courts are generally prohibited from raising and analyzing issues which the parties did not argue.

One way that some well-known cases in Thailand could have been resolved differently is if the courts considered the loss of a chance doctrine, a legal theory that evaluates causation and damages. The loss of a chance doctrine has attracted a fair amount of scholarly interest and has been considered by the judiciary in several countries. Indeed, the United Kingdom (“UK”) House of Lords and the Australian High Court have settled the issue in their respective jurisdictions and have rejected the doctrine. To the best of the Author’s knowledge, the loss of a chance doctrine has not been directly raised in the Thai courts in medical negligence claims nor have the courts addressed the doctrine.

---


10 See Civil Procedure Code § 142 (Thai.).


13 The underlying reasons as to why the parties in these cases failed to raise the issue of loss of a chance in court warrant further empirical analysis or in-depth discussion elsewhere.
The article will first provide an overview of the current legal framework for medical negligence litigation in Thailand. Section III will then discuss the absence of in-depth analyses of the element of causation by Thai courts and a Thai Supreme Court judgment will be used to contextualize the discussion. Section IV will discuss the potential application of the loss of a chance doctrine in Thailand and survey the loss of a chance doctrine applied in UK and Australian case law in order to provide some insight into its application. The discussion will also include how to fit the loss of a chance doctrine into the existing Thai legal framework, as well as arguments for and against the adoption of the loss of a chance doctrine in Thailand. The article will conclude by suggesting the improvement of the causation element analysis in medical negligence claims in Thailand and how to appropriately apply the notion of loss of a chance in the Thai legal context.

II. THE CURRENT LEGAL FRAMEWORK FOR MEDICAL NEGLIGENCE IN THAILAND

Health law in Thailand is still in its infancy. Many complex and relevant issues often discussed in Western countries, such as health data governance and informed consent, have not been comprehensively considered or deliberated.14 Unlike many other countries, it is difficult to say whether health law is even considered a discipline in and of itself in Thailand.15 Few health law textbooks written in the Thai language exist.16 Similarly, very few precedents from the Supreme Court of Thailand are ascertainable to guide the trial judges in adjudicating health law cases.17 Differences between Thai and Western cultures, a lack of economic resources, and a shortage of medical personnel may contribute to the underdevelopment of health law in Thailand.18 These factors are further compounded by Thai patients’ lack of knowledge about their legal rights and an unwillingness to institute legal proceedings generally, let alone


15 See Nathan Cortez, Recalibrating the Legal Risks of Cross-Border Health Care, 10 YALE J. HEALTH POL’Y L. & ETHICS 1, 43 (2010).

16 Id. at 43 n.305.

17 Id.

against doctors or hospitals who are perceived as having superior power.\textsuperscript{19} Therefore, patient claims arising out of medical malpractice disputes are rarely brought before the Thai judiciary. Of the claims filed, most involve simple issues of medical negligence arising out of alleged negligent medical procedures and treatments.\textsuperscript{20}

In addition to the underutilization of health law claims, there are also barriers to studying the limited existing case law. Only select judgments of the Thai Supreme Court have been published and disseminated to the general public,\textsuperscript{21} making the analyses for academic purposes much more difficult than that of common law countries, such as the United States, the UK, and Australia, where all court opinions are publicly available. Furthermore, the decisions selected for publication are not released in their entirety but are instead summarized for conciseness, making the study of precedent even more difficult. It is important to note that Thailand is a civil law country, meaning that Supreme Court decisions are not strictly legally binding like in common law countries. Nevertheless, the Supreme Court’s opinions are exceedingly persuasive for all courts in Thailand.\textsuperscript{22}

One specific act governs the current legal procedure for medical negligence litigation in Thailand, the \textit{Consumer Case Procedure Act, B.E. 2551} (2008) (“Act”), as opposed to the general \textit{Civil Procedure Code}, which governs most other areas of civil disputes.\textsuperscript{23} The Act first came into effect in 2008 and provides for special court proceedings for a “Consumer Case”.\textsuperscript{24} A “Consumer Case” is defined as “a case between a consumer or a person having the power to file a lawsuit on the consumer’s behalf” and a

\begin{itemize}
  \item \textsuperscript{19} Id. at 226.
  \item \textsuperscript{21} The Thai Bar Association and the Office of the Judiciary are the two publishing entities of Thai Supreme Court decisions. Each organization selects and summarizes for publication only those judgments it considers interesting and important. The Author was a former member of the Office of the Judiciary team that operated such a task. The public can search for these judgments via the internet at http://deka.supremecourt.or.th.
  \item \textsuperscript{22} See Thanin Kraivichien & Apichon Chantarase, \textit{Advice for Law Students} 91–92 (4th ed. 2005).
  \item \textsuperscript{23} See Consumer Case Procedure Act, B.E. 2551 (2008) (Thai.).
  \item \textsuperscript{24} Id. § 2
\end{itemize}
“Business Operator” having a dispute in relation to a legal right or obligation related to consumption of goods or service. The President of the Court of Appeal handed down several decisions affirming that a plaintiff patient is in fact a consumer within the meaning of the Act, and a defendant doctor, whether working in public hospitals or private practice, is considered a “Business Operator.”

The Act confers several procedural advantages to consumer litigants (i.e., the patient in medical negligence claims) that did not exist under the previously controlling general Civil Procedure Code. For example, under Section 29 of the Act, the burden of proof is often shifted to the defendant doctor to prove the operations, procedures, or treatments given to the patient were in accordance with those of other doctors, whereas previously the burden rested with the plaintiff patient. In addition, the plaintiff patient can now bring a medical malpractice lawsuit without paying court fees. The plaintiff patient also benefits from the lengthy limitation period under the Act, which allows the case to be brought before the court within three years instead of within just one year under the prior scheme. By the same token, the Act arguably imposes a heavier burden on defendant doctors than when medical malpractice claims had been governed by the Civil Procedure Code.

---

25 Id. § 3
26 Id. § 8 (asserting that the President of the Court of Appeal is the authoritative figure in deciding whether a case is a consumer case).
28 Section 29 of the Act states as follows:

Any point in dispute needs to be proved as to fact relating to the manufacture, assembly, design, or component of the goods, services, or any undertaking which the court is of an opinion that such fact is only known to the party who is the Business Operator, the burden of proof in such point in the dispute shall fall on the party who is the Business Operator.

29 Id. § 18.
30 Id. § 13 (“[T]he Consumer must exercise the right to claim within three years as from the date of knowing of such damage and the liable Business Operator…”).
31 CIVIL AND COMMERCIAL CODE § 448 (Thai.) (“[T]he claim for damages arising from a wrongful act is barred by prescription after one year from the day when the wrongful act and person bound to make compensation became known to the injured person…”).
32 See CIVIL PROCEDURE CODE § 84/1 (Thai.); Consumer Case Procedure Act, B.E. 2551 § 29 (2008) (Thai.). According to Section 84/1 of the Civil Procedure Code,
dissent over the legal procedure framework that presently governs medical negligence cases.\footnote[33]{Medical malpractice actions, including medical negligence actions, are substantively evaluated as “wrongful acts” under the general provision of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}}}

Medical malpractice actions, including medical negligence actions, are substantively evaluated as “wrongful acts” under the general provision of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}} Section 420 of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}} Medical malpractice actions, including medical negligence actions, are substantively evaluated as “wrongful acts” under the general provision of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}}

Medical malpractice actions, including medical negligence actions, are substantively evaluated as “wrongful acts” under the general provision of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}} Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}}

Section 420 of the \textit{Thai Civil and Commercial Code} governing all wrongful acts or delict.\footnote[34]{Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}}

Section 420 of the \textit{Thai Civil and Commercial Code} states: “A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom.”\footnote[35]{This general provision is the equivalent of tort in common law countries and was adopted word-for-word from Section 823 of the \textit{German Civil Code (BGB)}.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}}

Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[37]{Section 420 of the \textit{Thai Civil and Commercial Code} is usually the applicable law for medical negligence in Thailand, however, breach of contract claims may also be brought to recover damages in such cases.\footnote[38]{To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}}}

To be clear, although wrongful acts in Thailand are comprised of both intentional and negligent acts,\footnote[39]{for the purposes of this article, only medical malpractice claims arising out of negligent acts of the medical professional will be addressed.}

### III. \textsc{The Causation Problem in Thai Medical Negligence Cases}

Section 420 of the \textit{Thai Civil and Commercial Code} lists the elements of wrongful acts\footnote[40]{The elements of wrongful acts under Thai law are, namely, the relevant act is unlawful, either commission or omission may constitute the act, the act can be conducted either deliberately or negligently, there is damage done to other persons’ certain specified classes of rights, and a causal link between such the act and the damage having been done can be established. See \textit{Paijit Punyapan}, คำอธิบายประมวลกฎหมายแพ่งและพาณิชย์หลักเกณฑ์ละเมิด (2016).} and does not expressly list causation as an

The party that alleges any fact in support of its pleading shall be required to prove the fact. CIVIL PROCEDURE CODE § 84/1 (Thai.). By comparison, Section 29 of the Act shifts the burden of proof to the party who is the Business Operator, i.e., the defendant doctor or the relevant institution. Consumer Case Procedure Act, E. 2551 § 29 (2008) (Thai.).

Section 29 of the Act shifts the burden of proof to the party who is the Business Operator, i.e., the defendant doctor or the relevant institution. Consumer Case Procedure Act, E. 2551 § 29 (2008) (Thai.).

### References

- [Cherdchoo Ariyarsiwattana], \textit{Should Medical Service Fall under the Consumer Case Procedure?}, MGR ONLINE (June 16, 2016), https://mgronline.com/daily/detail/9590000060203.
- Paijit Punyapan, \textit{คำอธิบายประมวลกฎหมายแพ่งและพาณิชย์หลักเกณฑ์ละเมิด} (2016).
element. Thai jurisprudence nonetheless acknowledges that causation is an essential element for all wrongful acts. To illustrate, in Thai legal textbooks, causation is described as a necessary condition of wrongful acts. When most Thai textbooks describe the causation element of wrongful acts, they do so by using the condition theory and the theory of adequate causation.

The condition theory is the equivalent of the “but for” test of causation in common law, that is, but for the defendant's negligent conduct, the damage suffered by the plaintiff would not have occurred. The theory of adequate causation states that negligent conduct must be reasonable or appropriate for causing the alleged damage. Adequate causation theory dictates that a defendant is responsible only if the intervening act was a foreseeable one. Legal scholars say that this theory softens what would have been the outcome of the case under condition theory, including the conclusion of whether the damage occurred because of an intervening act.

Although the concepts embodied in the above-mentioned theories have been clearly accounted for in Thai legal scholarship, it is worth noting that Thai courts have never explicitly invoked either theory in a decision. Rather, to indicate the successful establishment of the causation in cases,

---

41 SANANKORN SOTTIPAN, คำอธิบายบทกฎหมายลักษณะละเมิด จัดกระบวนเบื้องต้น สมมติฐานได้ [TREATISE ON WRONGFUL ACTS] 112 (9th ed. 2020).


45 SANONGCHART, supra note 42.

46 PENG PENGNITI, คำอธิบายประมวลกฎหมายแพ่งและพาณิชย์ว่าด้วยละเมิด พระราชบัญญัติความรับผิดละเมิดของเจ้าหน้าที่ พ.ศ. 2539 และกฎหมายอื่นที่เกี่ยวข้อง [TREATISE ON WRONGFUL ACTS, LIABILITY FOR WRONGFUL ACT OF OFFICIALS ACT B.E. 2539, AND RELEVANT LAWS] 94 (8th ed. 2013); WATJANASAWASDI, supra note 43, at 349.

47 PENGNITI, supra note 46, at 93–96.

the court uses a unique “direct consequence” approach.\textsuperscript{49} Under this approach, if the damage was a direct consequence of the negligent conduct, the causation element has been established.\textsuperscript{50} If the damage is a “but for” consequence of the negligence but the courts deem the causal link as being too weak, or the consequence is very unlikely given the relevant negligent act, the courts will hold that it is not a direct consequence of the negligence.\textsuperscript{51} At times, it is difficult to extract the reasoning behind the establishment of the causation element as the analysis is very brief. This article will not delve into whether or how causation can be successfully established in some exceptional or specific cases since it is irrelevant to the point the Author wishes to make.\textsuperscript{52}

Oftentimes, the defendant doctor’s defense and the court’s analysis focus on whether their conduct constitutes negligence rather than whether the negligent act caused the injury.\textsuperscript{53} Based on the Author’s own experience, it is difficult to say whether the Thai courts’ tendency to lightly weigh the causation element in their decisions, has, as a result, influenced defendant doctors’ arguments in court. Most of the time, parties’ arguments are limited to the presence or absence of negligence, even when the causation element can play an important role in the outcome of their case. It is the Author’s aim to encourage defendant doctors to make such arguments in court, especially since courts are prohibited from raising and analyzing issues which the parties did not argue.\textsuperscript{54} Under-analyzing the causation element can result in the court overlooking potential causes or significant considerations, for instance, a patient’s preexisting condition that may have merely been exacerbated or otherwise caused the harm, notwithstanding the doctor’s actions.\textsuperscript{55} If the Thai courts were to provide in-depth analyses of

\textsuperscript{49} Id.

\textsuperscript{50} Direksoonthorn, Informed Consent in Thailand, supra note 14, at 27.


\textsuperscript{52} This includes any variants in establishing causation under the Thai law, which may be gleaned from academic textbooks or relevant court cases. For an in-depth discussion on establishing causation under various circumstances in light of the Supreme Court’s decisions, mostly outside the medical context, see CHITTI TINGSAPAT, ค.ค.อ.ก.ก. (1953) Thai. Sup. Ct. No. 131/2496.

\textsuperscript{53} See CIVIL PROCEDURE CODE § 142 (Thai).


the causation element, it may assuage the concern of the Thai medical community over the unfairness of the current statutory regime.

One example of a medical negligence case that likely would have been decided differently if causation had been thoroughly analyzed is the Supreme Court’s decision in Judgment No. 6092/2552 (2009).\(^\text{56}\) In that case, it was alleged that the defendant doctor’s conduct was the cause of a pregnant patient’s vision loss, suffered during their last admission to the hospital.\(^\text{57}\) The plaintiff patient had a history of premature uterine contractions and, during two previous hospital visits, the defendant doctor prescribed the medication Bricanyl (an anti-contraction medication).\(^\text{58}\) The patient was admitted to the hospital a third time with the same symptoms and the doctor ordered a nurse by phone to administer Bricanyl.\(^\text{59}\) The patient soon after developed a severe allergic reaction causing permanently impaired vision.\(^\text{60}\) The Court concluded that Bricanyl had caused the allergic response and that the doctor was negligent in determining that it was the appropriate drug and ordering the nurse over the phone without seeing the patient face-to-face.\(^\text{61}\) The doctor argued that the damage suffered by the patient was not directly caused by the alleged negligent conduct.\(^\text{62}\) The Court discussed the causation element briefly and held that because the patient was not experiencing any symptoms of a severe allergic reaction before the Bricanyl injection, the alleged allergic reaction was a direct consequence of the Bricanyl prescription.\(^\text{63}\) They further reasoned that the doctor’s negligent action was failing to see the patient in person prior to ordering the administration of the drug, and held that this was the cause of the plaintiff's injury.

That conclusion, however, overlooks the fact that the doctor would have prescribed the Bricanyl even if they saw the patient in person, a detail that would thereby break the causal chain between the doctor's negligent conduct and the patient's vision loss. The patient in this case had been


\(^{57}\) \textit{Id.}

\(^{58}\) \textit{Id.}

\(^{59}\) \textit{Id.}

\(^{60}\) \textit{Id.}

\(^{61}\) \textit{Id.}

\(^{62}\) \textit{Id.}

\(^{63}\) \textit{Id.}
administered Bricanyl at least twice before she finally developed a severe allergic reaction during the third administration of the drug.\textsuperscript{64} Even if the doctor had not been negligent and had seen the patient in person, the doctor still may have prescribed Bricanyl, as they had done twice before without consequence.\textsuperscript{65} Thus, the allergic reaction would have likely occurred regardless of the wrongful conduct specified by the court. Under such an analysis, the negligent action (i.e., ordering Bricanyl by phone instead of seeing the defendant \textit{without other} negligent conduct) did not cause the damage (i.e., allergic drug reaction).\textsuperscript{66}

Some may argue that the repeated exposure to the drug could have culminated in a more serious drug reaction in the administration at issue rather than the two former administrations.\textsuperscript{67} But there is no such discussion in the Court’s judgment.\textsuperscript{68} In any event, this argument would not yield a different result considering the negligent action at issue.\textsuperscript{69} It follows that the damages (2 million Thai baht or approximately 67,000 US dollars plus pre-judgment interest) should not have been awarded in this case.

\textsuperscript{64} \textit{Id.}

\textsuperscript{65} \textit{See id.}

\textsuperscript{66} Even though some may argue that if the doctor had come to see the patient in person, the patient might not have suffered from the drug allergy due to the effect of the different time it was administered, that argument is quite a stretch and unfounded. Even if there is high chance of the patient not suffering from the drug allergy if the drug (more accurately, any drug) is administered in different times, the patient always bears the same risk of drug allergy every time the drug is administered. \textit{See Paul v Cooke [2012] NSWSC 840; see also Sarah Green, Coherence of Medical Negligence Cases. A Game of Doctors and Purses, 14 MED. L. REV. 1, 14–15 (2006) (warning against confusing “statistically independent events with events that are dependent on one another (since it does not appear to recognise that, although the chance of the same injury occurring on a different day is small, it is no smaller than the day on which it did occur)”}).

\textsuperscript{67} If such an argument is made, it will be decided on the evidence adduced. For example, if other doctors would prescribe Bricanyl in treating the patient because the fact that ordering Bricanyl twice without any allergic reaction having occurred to the patient makes allergic reaction on the third occasion extremely rare, especially compared with ordering a brand-new drug without any prior information about this patient’s reaction to the drug. On the contrary, one may argue that the repeated exposure to a drug could culminate in a more serious drug reaction as compared with administering a different new drug even though such an argument does not sound very plausible since a serious and life-threatening drug reaction (anaphylaxis) could also occur on a first occasion the new drug is administered. \textit{See generally Bruce S. Bochner & Lawrence M. Lichtenstein, Anaphylaxis, 324 NEW ENG. J. MED. 1785 (1991); Alfred I. Neugut, Anita T. Ghatak & Rachel L. Miller, Anaphylaxis in the United States: An Investigation Into Its Epidemiology, 161 ARCHIVES OF INTERNAL MEDICINE 15 (2001).}

\textsuperscript{68} \textit{See คาพิพักษ์ศาลฎีกาที่ ๖๐๙๒/๒๕๕๒ (2009) Thai. Sup. Ct. No. 6092/2552.}

\textsuperscript{69} \textit{See id.}
IV. LOSS OF A CHANCE: IS IT FAIR TO BE USED IN THE THAI MEDICAL NEGLIGENCE CONTEXT?

A. Introduction to the Loss of a Chance Doctrine

The aforementioned case demonstrates the causation problem in Thai medical negligence cases and highlights the need for an in-depth causation analysis. The loss of a chance doctrine in medical negligence revolves around the elements of damage and causation and is inextricably intertwined with causation. As Professor Joseph H. King, who “wrote the first scholarly article in the United States dealing with the loss of chance,” aptly explained:

[T]he loss-of-a-chance doctrine relies on a broader analysis beyond causation that encompasses the valuation sphere. Instead of viewing the loss exclusively in all-or nothing terms of ultimate outcomes, the concept of loss has been more broadly conceived to include the loss of a chance of achieving a more favorable outcome. The importance of this approach lies in the fact that it may support damages for lost opportunities or reduced prospects when it is not possible to prove that it was more likely than not that but for the defendant's tortious conduct the ultimate injury would have been averted or that some more favorable outcome would have been achieved. This approach has gained support during the past fifteen years, especially in medical malpractice actions. Thus, a plaintiff may receive damages if he can prove that the defendant caused the loss of a chance of avoiding the ultimate injury despite the fact that the chance or likelihood of achieving a better outcome was not better than even. Damages should reflect the value of the lost chance or the extent of its reduction, usually by estimating the percentage by which the defendant's tortious conduct reduced the likelihood of achieving some more favorable result. Some courts limit application of the loss-of-a-chance doctrine to 'substantial' chances.

The jurisdictions that allow loss of a chance claims acknowledge the notion that “chance has value.” Although the concept that “chance has value” is a way plaintiff’s lower the causation establishment hurdle, as it

---


allows claims that would not otherwise be considered, the damages awarded are arguably more fair to physicians, as it limits damages to a certain causal probability where the Plaintiff previously would have received full damages.\(^{73}\) To what extent the physician’s conduct caused the loss of a chance of a more favorable outcome for purposes of medical negligence, is necessary for analysis.

The typical situation in which a patient plaintiff may raise the loss of a chance doctrine is a patient plaintiff who cannot prove, on the balance of probabilities, that the damage was directly caused by the alleged negligence. If they can prove as such, the patient plaintiff may be granted full damages. In contrast, under the loss of a chance doctrine, the damages amount is discounted by the probability it can prove to the court. Accordingly, loss of a chance claims proponents contend that allowing loss of a chance will not radically change the legal landscape, since the plaintiff in other kinds of cases is not interested in commencing legal proceedings by a loss of a chance claim to reduce their own damages.\(^{74-75}\) Loss of a chance in medical negligence claims in Thailand, however, can result in a fairer system from the medical profession’s perspective since they can invoke this doctrine to reduce the damages awarded to the plaintiff patient. The following section highlights case examples that may have been decided differently if the loss of a chance doctrine had applied.

B. Applying the Loss of a Chance Doctrine Against a Backdrop of the Supreme Court’s Decisions

Previously we have discussed Thai Supreme Court cases as currently decided without an in-depth causation analysis or consideration of the loss of a chance. A number of court cases may have been decided differently, in the physician’s rather than the patient's favor, if the loss of a chance had been raised before the court and the causation element thereby analyzed in depth. In 2011, for example, the Supreme Court of Thailand handed down a decision that was heavily criticized by the medical profession (the “AFE case”).\(^{76}\) The criticism of the AFE case focused on the

\(^{73}\) Id. at 618.

\(^{74}\) For example, the German courts shift the burden of proof to the doctor where the gross errors are involved. See Marc S. Stauch, Medical Malpractice and Compensation in Germany, in MEDICAL MALPRACTICE AND COMPENSATION IN GLOBAL PERSPECTIVE 179, 196 (Ken Oliphant, Richard W. Wright & Kinga Bączyk-Rozwadowska eds., 2013). “Under the [German] existing rules, the patient generally is already better placed, at least where he can show an actual or hypothetical gross error by the treating side: in such a case he will normally achieve full recovery, even where the likelihood that the error played a part in his injury is quite small.” Id.


Court’s lack of reliance on the Thai Medical Council’s opinion in deciding contrary to the Medical Council’s decision and against the defendant’s acquittal. In medical negligence cases in Thailand, patients can directly bring their cases before the court without the involvement of the Medical Council. However, in this case there had been a disciplinary action against the defendant doctors before being brought before the Court. The Court deemed the Medical Council’s decision to be a piece of evidence, but ultimately decided that the Medical Council did not submit any detailed reasoning for their acquittal to the Court. As a matter of fact, the extent of their disciplinary proceedings was for the Medical Council’s committee members to cast a vote on whether to convict or acquit the doctors. The majority voted to acquit the doctors, reasoning that the doctors provided good faith medical practice. Nonetheless, a few committee members testified at the trial court that they did not agree with the majority, that the doctors’ conduct was below the standards of good medical practice, and that they had resigned from their posts after the Medical Council’s vote.

In this case, the decedent’s husband sued two defendant doctors: an anesthetist and an obstetrician. The patient had been in labor and requested that the anesthetist administer epidural anesthesia. After that, the obstetrician intentionally ruptured the amniotic membrane. The two doctors then tended to other patients, but shortly thereafter, the patient suffered from an amniotic fluid embolism (“AFE”) resulting in her death and the death of her baby. The Court ruled that the doctors were negligent in failing to closely tend to the patient after administering epidural anesthesia and rupturing the amniotic membrane. The Court was rather light in their causation analysis as they failed to discuss the impact of the fact that both parties agreed that an AFE normally has a mortality rate of 80%. Five years later, one of the country’s most infamous malpractice cases in recent times was adjudicated by the Thai Supreme Court (the “TB Meningitis case”). This case has become renown for the Court’s questionable reliance upon the plaintiff’s expert witness who was a general practitioner, not a specialist, in ruling against the defendant doctor. There, the plaintiff patient was a minor who commenced the proceedings after suffering permanent disability from tuberculous meningitis. The plaintiff patient claimed that the doctor delayed the diagnosis of tuberculosis, should have suspected the disease a few days earlier, and that the result of the delayed diagnosis was permanent brain damage. The then-President of the

---

77 Id.
78 Id.
79 ค ำพิพำกษำศำลฎีกำที่ ๑๒๔๙๘/๒๕๕๘ (2016) Thai. Sup. Ct. No. 12498/2558. This decision was announced to the parties in 2016.
80 Id.
81 Id.
Thai Medical Council gave testimony as an expert witness for the defense.\textsuperscript{82} The Court merely stated that the negligence of the doctor caused the damage to the patient without any further analysis as to whether the consequence in question could have occurred regardless of the negligent action of the doctor.\textsuperscript{84}

The two aforementioned cases demonstrate the causation problem in Thai medical negligence cases and show instances where the loss of a chance doctrine could potentially resolve or mitigate the problem. In the AFE case, the parties agreed that an AFE causes death in more than 80\% of all cases, and that patients die \textit{immediately} in 25\% of those cases.\textsuperscript{85} However, the court did not consider that fact in their decision because they did not analyze causation.\textsuperscript{86} A potential missed causation argument, may have been that, even if the defendant doctors had tended to the patient more closely, she would have died from AFE anyway since it was more likely than not that the patient would have died even without anyone's negligence. Had the court analyzed causation, the outcome may have been different.

In the AFE case, the defendant doctors might have explicitly raised the issue and argued that even if they had attended to the decedent closely, the AFE would have probably developed anyway and caused the decedent’s death. In addition, no other negligent conduct on the part of the doctors had been established. The similarly-situated prospective plaintiff may commence proceedings against the doctor by contending that the doctor’s negligence deprived the decedent’s chance of survival. In other words, the doctor’s negligent conduct, that is, not attending to the decedent, deprived the decedent of a 20\% chance of a better outcome, which is the decedent’s survival. They may argue that the court should award 20\% of the damages they would obtain from the traditional approach.

The TB meningitis case would likewise have been determined differently if the loss of a chance had been argued. The expert witness in that case maintained that the slight delay in diagnosis of tuberculosis and proper treatment did not contribute to additional adverse effects to the plaintiff.\textsuperscript{87} Based on the Author’s own research using a systematic review and meta-analysis that the risk of death of this disease was 19.3\% and

\textsuperscript{82} See \textit{id}. He was also the President of Asian Society for Pediatric Infectious Diseases at the time of testifying.

\textsuperscript{83} See \textit{id}.

\textsuperscript{84} \textit{Id}.


\textsuperscript{86} See \textit{id}.

“among survivors, risk of neurological sequelae was 53.9%.”\footnote{88} Accordingly, it may be argued that a few days’ delay in diagnosis did not contribute to neurological sequelae. The disease’s survivors are probable to suffer neurological sequelae, which is the damage at issue. If this information can negate the causation altogether, the loss of a chance argument could have a major role to play, especially to the plaintiff’s advantage. Specifically, the plaintiff would have the ability to bring a lawsuit alleging the doctor deprived them of a chance to enjoy a better outcome.

Similarly, under the circumstances of the TB meningitis case, the similarly-situated prospective defendant may successfully argue that a few days’ delay in diagnosis does not result in more adverse neurological sequelae in any respect. By means of epidemiological evidence, however, the plaintiff may invoke the loss of a chance purporting that the delay in diagnosis caused them to lose the chance of a better medical outcome (i.e., without any neurological sequelae). Among the survivors of TB meningitis, it has been found that the risk of neurological sequelae is 53.9\%\footnote{89}; therefore, the negligent delay in diagnosis deprived them of a 46.1\%chance of a better outcome. Utilizing those statistics, the plaintiff patient can plausibly assert that the defendant should compensate them accordingly.

Some argue, however, that such outcomes would have been unfair to the patient by preventing them from obtaining compensation when the doctor acted negligently. Further, such an outcome might fail to sufficiently deter doctors from engaging in negligent conduct. Lord Nicolls’s dissenting opinion in \textit{Gregg v. Scott}, the United Kingdom’s landmark case regarding loss of a chance, clearly stated this counterargument:

\begin{quote}
The patient could recover damages if his initial prospects of recovery had been more than 50\%. But because they were less than 50\%he can recover nothing. This surely cannot be the state of the law today. It would be irrational and indefensible. The loss of a 45\%prospect of recovery is just as much a real loss for a patient as the loss of a 55\%prospect of recovery. In both cases the doctor was in breach of his duty to his patient. In both cases the patient was worse off. He lost something of importance and value. But, it is said, in one case the patient has a remedy, in the other he does not.\footnote{90}
\end{quote}

\footnote{88} Silvia S. Chiang et al., \textit{Treatment Outcomes of Childhood Tuberculous Meningitis: A Systematic Review and Meta-Analysis}, \textit{14 LANCET INFECTIOUS DISEASES} 947, 947 (2014). The paper’s authors defined neurological sequelae as any motor, sensory, cognitive, or hypothalamic impairment that emerged during the illness and persisted through treatment completion. \textit{Id.}

\footnote{89} Chiang et al., \textit{supra} note 88.

\footnote{90} Gregg v. Scott, [2005] UKHL 2, 3.
There is also “the concern that if a doctor could show that the correct treatment provided only a less than 50% chance of recovery, then there was no recovery. This would leave a doctor’s duty of care to his or her patient ‘hollow’.”\(^9^1\) Loss of a chance comes into play when the patient can reformulate the claim in that the doctor’s negligence deprived them of the chance of a more favorable outcome. If those arguments can successfully persuade the court, the outcome would again be different.

As mentioned above, health law in Thailand is nascent and the Author anticipates that the concern and dismay of medical professionals over the current Thai medical litigation regime will be discussed in Thailand soon.\(^9^2\) The following section evaluates different considerations that courts should consider when evaluating whether to apply the loss of a chance doctrine in future medical negligence claims.

V. CONSIDERATIONS FOR ADOPTING THE NOTION OF LOSS OF A CHANCE IN THAILAND

A. The Standard of Proof: Not Statistical Confidence but Factfinders’ Confidence

Loss of a chance claims are designed to relax the standard of proof for establishing causation in civil cases and allow the damages award to consider the probability.\(^9^3\) The current standard of proof for civil cases is a balance of probabilities,\(^9^4\) which requires the bearer of the burden of proof to prove their cases to the threshold where it is more likely (than not) or probable.\(^9^5\)

This means that, if the tribunal is not satisfied that the case of the plaintiff is more probable than the case of the defendant, then it must find for the defendant. However, being satisfied that the plaintiff’s case is more probable than the defendant’s will not in itself suffice, as the court might consider both parties’ cases to be improbable. To succeed, the plaintiff must satisfy the court that its case is more

---

\(^{91}\) JONATHAN HERRING, MEDICAL LAW AND ETHICS 126 (8th ed. 2020).

\(^{92}\) See เสนอ สธ ยุติกำรท ำร่ำง พ.ร.บ.วิธีจดเกิดกล่าวคำแกร่ง รัฐบาล, ผู้มีอำนาจมีคำสั่งให้ส่ง [Proposal to the Ministry of Public Heath Demanding the Withdrawal of the Obsolete Medical Litigation Bill: Shifting the Burden of Proof to Patients], HFOCUS (Mar. 7, 2018), https://www.hfocus.org/content/2018/03/15524.


\(^{94}\) See Marta Infantino, Causation Theories and Causation Rules, in COMPARATIVE TORT LAW: GLOBAL PERSPECTIVES 264, 279 (Mauro Bussani & Anthony J. Sebok eds., 2d ed. 2021). In the United States, the standard of proof is a preponderance of the evidence. Id.

\(^{95}\) TURTON, supra note 136, at 83.
probable than not.\(^96\)

In contrast, under the loss of a chance doctrine, to prove that the delay in, for example, diagnosis of TB meningitis caused the permanent disability, the plaintiff only must prove that the negligence caused them the loss of a chance of achieving a better outcome and avoiding the permanent disability.

Nevertheless, that does not necessarily mean that the loss of a chance works to the medical profession’s disadvantage. In fact, loss of a chance in medical negligence claims in Thailand can result in a fairer system, even from the medical profession’s perspective, since they can invoke this doctrine to reduce the damages awarded to the plaintiff patient, while retaining the status quo in Thailand medical negligence jurisprudence. As has been discussed, court cases may have been increasingly decided in the medical profession’s favor, or at least for reduced damages, if causation and loss of a chance had been raised before the court and analyzed in depth.

There is a difficulty, however, in determining the exact probability for causation in both loss of a chance claims and the current standard of proof. One way that courts in different nations have measured probability is with numerical percentages, however, in practice, they do not greatly affect a case outcome. In the previous example, the evidence that less than 50% of TB meningitis patients can avert the neurological sequelae of TB meningitis may not have overcome the hurdle of the current plaintiff’s standard of proof in civil cases under the articulated burdens in western countries, including Thailand. However, the standard of proof in practice for negligence cases is essentially the factfinders level of belief or confidence in the adduced evidence, whether they are judges or jurors, rather than objective numerical percentages.\(^97\) In other words, even if the evidence objectively shows that patients are likely to suffer a particular injury in 90% of cases without negligence, the factfinders can elect not to believe that evidence by discounting it on any reasonable grounds, such as the reliability or the applicability to a particular case, thereby shifting the standard of proof.\(^98\) Therefore, using the statistical figures below or above 50% (fact probability)\(^99\) may not reliably or consistently satisfy the factfinders

\(^{96}\) Jeremiy Gans et al., Uniform Evidence 508 (3d ed. 2019).


\(^{98}\) See Chris Miller, Causation in Personal Injury: Legal or Epidemiological Common Sense?, 26 LEGAL STUD. 544, 551 (2006). For example, if every witness in a case testifies that the murderer drove a yellow cab, and 90% of all cabs in that city were yellow, that does not necessarily mean there is a 90% chance that a person who drives a yellow cab was the murderer.

\(^{99}\) David W. Barnes, Too Many Probabilities: Statistical Evidence of Tort Causation, 64 LAW & CONTEMP. PROBS. 191, 191–92 (2001). Barnes explains that “the belief probability relates to evidentiary requirements imposed by the law, and the fact
standard of proof (belief probability). To satisfy the standard of proof is to adequately satisfy the belief of the factfinders in order to establish causation. Interestingly, the factfinders themselves are not able to agree upon the appropriate number of their belief probability:

In one survey [in the US], 80 out of 255 judges refused to specify a probability sufficient for a 'preponderance of the evidence' finding. Of the judges who were willing to do so, only about three-fifths chose a probability of 50 to 55%; about two-fifths chose a probability of 60% or greater, almost one-fifth a probability of 70% or greater, one-tenth a probability of 80% or greater, and one-twentieth a probability of 90 to 100%.\textsuperscript{100}

In other words, the standard of proof will not consistently be described numerically, as the determination is up to the subjective interpretation of the factfinder. Therefore, the difficulty in choosing the appropriate number to award damages, according to proportional recovery inherently accompanied by adopting the loss of a chance, is not unique to the loss of a chance doctrine. If the allegedly wrong percentages are fatal to adoption of loss of a chance, it is not less fatal to the conventional standard of proof. However, the supposedly wrong percentages for loss of a chance are at least based on some scientific method, while the other is primarily based on the subjective interpretation of the factfinder.

B. Proportional Recovery for Loss of a Chance: Compensation by Belief Probability?

The plaintiff deploys loss of a chance as a cause of action to circumvent the ordinary burden of proof, on a balance of probabilities, and to establish that the damage was caused by the alleged negligence by transforming the traditional damage, such as personal injury, into the loss of a chance.\textsuperscript{101} As mentioned earlier, the standard of proof of "on a balance of probabilities" denotes a level of the factfinder’s belief or confidence in the evidence adduced to prove the fact at issue. Loss of a chance claims are usually accompanied by proportional recovery or damages\textsuperscript{102} and it follows that damages awarded to the plaintiff should be reduced to reflect the chance of better outcomes having been lost to negligence. To permit loss of a chance claims is to supplant the traditional causation approach—the all-or-

\textsuperscript{100} Wright, supra note 93 at 201 (citing Catherine M.A. McCauliff, Burdens of Proof: Degrees of Belief, Quanta of Evidence, or Constitutional Guarantees, 35 VAND. L. REV. 1293, 1325–31 (1982)).


nothing rule—with proportional recovery representing the extent to which factfinders believe in the causal link has been shown in that case. Many scholars believe the loss of a chance doctrine provides a fairer solution, prevents underdeterrence of negligence, and better serves the tort law’s compensatory goal, as far as the plaintiff’s genuine loss is concerned, than the traditional all-or-nothing rule.  

It appears that the loss of a chance doctrine is applied only to cases where the initial probability of achieving better outcomes is less than even. If the chance of getting better outcomes is higher than 50%, the patient will get full damages rather than discounted damages. However, such an approach may result in the overdeterrence of medical malpractice, an effect that aggravates the popular claim that negligence has any meaningful deterrent effect on medical practice. If, from the outset, the chance of achieving better outcomes is only 60%, the plaintiff should be awarded damages in accordance with that chance having been lost, not full damages as it gets in the traditional approach. Some may even argue that if the lost chance really has its own value, the patient should be compensated when the doctor negligently treats them even though they do not suffer any tangible injury or worse outcome. However, in those cases, it is hard to say the patient has lost any chance of better medical outcomes.

C. Arguments against Loss of a Chance: Cases in the United Kingdom and Australia

The landmark loss of a chance cases rejecting the loss of chance doctrine in the UK and Australia are Gregg v. Scott and Tabet v. Gett, respectively.

In Gregg, a majority of the House of Lords rejected the application of the loss of a chance to medical negligence claims and personal injury claims. In this case, Mr. Gregg, the patient plaintiff, consulted Dr. Scott, his

---


105 I.M. Kennedy, The Fiduciary Relationship - Doctors and Patients, in WRONGS AND REMEDIES IN THE TWENTY-FIRST CENTURY 116, 116 (Peter Birks ed., 1996). According to Professor Kennedy, “the most significant feature of the negligence action is to make the good doctor nervous.” Id.


general care practitioner and the defendant doctor, about a lump in his arm. Dr. Scott initially diagnosed it as benign with no further examination or follow-up. Months later, Mr. Gregg then consulted another general practitioner who referred him to a hospital as they determined the lump was a cancerous lesion of a lymph node requiring the administration of chemotherapy.

Mr. Gregg brought a lawsuit against Dr. Scott, asserting that the nine-month delay in receiving treatment, as a result of Dr. Scott’s negligence, deprived him of the chance to live disease-free for ten years. The House of Lords rejected that claim on the basis that the delay in treatment, according to the trial judge’s evaluation of the expert evidence, only reduced the chance of living disease-free for ten years from 42% to 25%. Under the balance of probabilities test, which is the test for causation in the UK, the Court must be satisfied that the occurrence of an event was more likely than not. In this case then, it was not established that Dr. Scott’s negligence had caused the alleged damages because the chance Mr. Gregg had of living disease-free for ten years, from the outset and even without any negligence on Dr. Scott’s part, was less than 50%. The Court also emphasized that deciding otherwise would mean radically changing the standard of proof. The Court added that to effect such a radical change is a function of Parliament, not the Court.

In the Australian High Court’s decision, the patient plaintiff, Tabet, was six-years-old and suffering from a large brain tumor. Tabet was being treated by the defendant pediatrician, Dr. Gett. Dr. Gett offered a provisional diagnosis of chickenpox (the disease from which Tabet had just recovered before paying a visit), meningitis, or encephalitis. Tabet then developed a seizure. After a CT scan was performed, the tumor was detected. The tumor removal procedure itself was performed perfectly.

---

110 Id.
111 Id. at [61].
112 Id. at [5].
113 Id. at [91], [191], [227].
114 Id. at [90].
115 Id. at [227].
116 Id. at [90].
117 Id.
119 Id. at 547.
120 Id. at 548.
and without negligence by Dr. Gett.\textsuperscript{121} Nevertheless, Tabet suffered a permanent disability as a result of the surgery and the tumor itself.\textsuperscript{122}

The trial court ultimately determined that Dr. Gett’s negligent action was ordering a delayed CT scan of the patient.\textsuperscript{123} At first instance, the trial judge found that the negligence deprived Tabet of a 40\% chance of a better medical outcome and awarded Tabet compensation accordingly. The case was later overturned by the New South Wales Court of Appeal. Tabet appealed the decision to the High Court. The High Court rejected the loss of a chance doctrine by holding that to accept the loss of a chance as a form of actionable damage would be a radical change to the law of negligence which should not be adopted. Justice Hayne and Justice Bell held:

To accept that the appellant’s loss of a chance of a better medical outcome was a form of actionable damage would shift the balance hitherto struck in the law of negligence between the competing interests of claimants and defendants. That step should not be taken. The respondent should not be held liable where what is said to have been lost was the possibility (as distinct from probability) that the brain damage suffered by the appellant would have been less severe than it was.\textsuperscript{124}

Justice Kiefel also remarked:

Expressing what is said to have been lost as the loss of a chance was said by Gonthier J in Laferrière to divert attention from the proper connection between fault and damage. It is artificial and breaks the causal link. I respectfully agree. One commentator to whom his Honour referred suggests that in cases of the kind in question what is involved is in truth not a loss of a chance. The factors present in that chance have played themselves out when physical injury or death occurs. What is in issue is a past event.\textsuperscript{125}

Justice Crennan stated that:

The present requirement of proof of causation in personal injury cases results in boundaries being drawn which differ from those which are relevant to liability for pure economic loss. Policy considerations which tell against altering the present requirement of proof of causation in cases of medical

\textsuperscript{121} Id.
\textsuperscript{122} Id. at 576.
\textsuperscript{123} Id. at 548.
\textsuperscript{124} Id. at 564.
\textsuperscript{125} Id. at 586–87.
negligence include the prospect of thereby encouraging defensive medicine, the impact of that on the Medicare system and private medical insurance schemes and the impact of any change to the basis of liability on professional liability insurance of medical practitioners. From the present vantage point, the alteration to the common law urged by the appellant is radical, and not incremental, and is therefore the kind of change to the common law which is, generally speaking, the business of Parliament.\textsuperscript{126}

In sum, the highest courts of these major world powers in the common law world have repudiated the loss of a chance claim in medical negligence.\textsuperscript{127}

On the contrary, “the adoption by most [U.S.] state courts of the loss of a chance doctrine is perhaps the most significant development in damages rule relating to malpractice cases.”\textsuperscript{128} Requiring a plaintiff to prove that it is more probable than not that the negligence caused death or physical harm, in medical negligence cases where patients have less than a 50\% chance of avoiding physical harm or survival before negligence, necessarily means that the patients will receive no recovery. The U.S. courts, therefore, deem loss of the chance to avoid death or physical harm as compensable injury.\textsuperscript{129}

In \textit{Falcon v. Mem’l Hosp.}, the Michigan Supreme Court regarded the patient’s loss of a 37.5\% opportunity of survival as the loss of \textit{substantial} opportunity of avoiding physical harm meriting compensation.\textsuperscript{130} It saw “the injury resulting from medical malpractice as not only, or necessarily, physical harm, but also as including the loss of opportunity of avoiding physical harm. A patient goes to a physician precisely to improve his opportunities of avoiding, ameliorating, or reducing physical harm and suffering.”\textsuperscript{131} The US courts adopting this approach maintain that the proof of such causation requires the same standard of proof, that is, a preponderance of the evidence, i.e., it is more likely than not that the negligence caused the plaintiff the loss of a chance of more favorable outcome.\textsuperscript{132} If such standard has been met, the damages award will be

\hspace{1cm} \textsuperscript{126} \textit{Id.} at 575.
\textsuperscript{127} See \textit{id.}; \textit{Gregg v. Scott} [2005] UKHL 2.
\textsuperscript{131} \textit{Falcon v. Mem’l Hosp.}, 462 N.W.2d 44, 52 (Mich. 1990).
calculated according to the reduced chance of a more favorable outcome.\textsuperscript{133} The Supreme Judicial Court of Massachusetts elucidated this in \textit{Matsuyama v. Birnbaum}:

The doctrine originated in dissatisfaction with the prevailing “all or nothing” rule of tort recovery. Under the all or nothing rule, a plaintiff may recover damages only by showing that the defendant's negligence more likely than not caused the ultimate outcome, in this case the patient's death; if the plaintiff meets this burden, the plaintiff then recovers 100% of her damages. Thus, if a patient had a 51% chance of survival, and the negligent misdiagnosis or treatment caused that chance to drop to zero, the estate is awarded full wrongful death damages. On the other hand, if a patient had a 49% chance of survival, and the negligent misdiagnosis or treatment caused that chance to drop to zero, the plaintiff receives nothing. So long as the patient's chance of survival before the physician's negligence was less than even, it is logically impossible for her to show that the physician's negligence was the but-for cause of her death, so she can recover nothing. Thus, the all or nothing rule provides a "blanket release from liability for doctors and hospitals any time there was less than a 50% chance of survival, regardless of how flagrant the negligence."\textsuperscript{134}

Thai courts ought to consider these established systems when deciding how to evaluate future medical negligence cases.

D. Deterministic versus Indeterministic Causal Process

Some scholars differentiate between the deterministic causal process and indeterministic causal process in considering whether the loss of a chance approach should apply to a particular case.\textsuperscript{135}

In a deterministic process there is no objective probability of something occurring — either it will or it will not and theoretically this can be predicted with certainty. So when probability is used to describe the chance of such an event, the probability is not objective but epistemological; it is an expression of the likelihood of an event given the limited


\textsuperscript{134} Matsuyama v. Birnbaum, 890 N.E.2d 819, 829-830 (Mass. 2008).

knowledge that is available.\textsuperscript{136}

The proponents of this theory contend that loss of a chance should be reserved for the situation where the causal process is truly random or has an objective chance, and was not already deterministic at the time of negligence:

Within a deterministic framework, probability is relative to our beliefs and knowledge, having no connection with the objective world, since if we knew everything, we would have no need of probabilities. Given deterministic assumptions, every proposition is either true or false, and probability is purely a means of managing our lack of knowledge and thus an epistemological concept.\textsuperscript{137}

“In contrast, if a process is indeterministic it occurs randomly and cannot be predicted even with unlimited knowledge. Reece explains that in an indeterministic process, probability is an objective concept. The likelihood of a future event occurring has an objective probability that is a property of the natural world.”\textsuperscript{138}

For example, in \textit{Hotson v. East Berkshire Area Health Authority}\textsuperscript{139}, a case of the UK House of Lords, the court used a deterministic causal process. A child hurt his leg falling from a tree.\textsuperscript{140} As a result, avascular necrosis\textsuperscript{141} of his hip joint ensued due to insufficient blood supply to the area.\textsuperscript{142} The court held that the defendant doctor was negligent in not ordering an X-ray that would have revealed the condition, causing a delay in proper treatment for five days.\textsuperscript{143} The plaintiff argued that the delay in diagnosis and treatment caused the damage of the boy’s hip.\textsuperscript{144} The trial judge believed that the chance of avascular necrosis, without any

\textsuperscript{136} Gemma Turton, \textit{Evidential Uncertainty in Causation in Negligence} 142 (2016).

\textsuperscript{137} Reece, \textit{supra} note 135, at 193.

\textsuperscript{138} Turton, \textit{supra} note 136, at 141–42.

\textsuperscript{139} Hotson v. East Berkshire Area Health Auth. [1987] 2 AC 750 (HL).

\textsuperscript{140} Id.

\textsuperscript{141} Avascular necrosis is defined as the “necrosis of bone tissue due to impaired or disrupted blood supply (as that caused by traumatic injury or disease) and marked by severe pain in the affected region and by weakened bone that may flatten and collapse.” Avascular necrosis, Merriam-Webster.com, https://www.merriam-webster.com/dictionary/avascular%20necrosis#medicalDictionary (last visited Nov. 24, 2021).

\textsuperscript{142} Hotson v. East Berkshire Area Health Auth. [1987] 2 AC 750, 752 (HL).

\textsuperscript{143} Id.

\textsuperscript{144} Id.
negligence, was 75%.\textsuperscript{145} Hence, at first instance the plaintiff was awarded 25% of full damages as a result of loss of a chance of the better outcome.\textsuperscript{146} Nevertheless, the House of Lords later rejected the claim on the grounds that the plaintiff was unable to prove, on the balance of probabilities, that the disability was caused by the alleged negligence.\textsuperscript{147}

This case’s circumstances reflect the deterministic causal process in the sense that when the plaintiff suffered the injury, he had only one fate awaiting: whether there was sufficient blood supply or insufficient blood supply, which would determine the development of avascular necrosis regardless of the doctor’s conduct. In other words, the chance the boy would suffer the disability was not random.

\textbf{E. Epidemiological Evidence}

Epidemiology is involved in medical negligence cases involving disease and creates certain confusions in the element of causation analysis. To be clear, the factfinders’ power to discount evidence showing statistical figures based on epidemiology that negates causation does not mean that epidemiological evidence does not play any role in determining causation.\textsuperscript{148} Epidemiological evidence is used in both the loss of a chance doctrine jurisdictions and jurisdictions that use alternate theories of causation. Notably, many medical negligence cases in many developed countries rely upon epidemiological evidence as exemplified via case law in certain common law countries.\textsuperscript{149} For instance, in \textit{Gregg v. Scott},

\begin{itemize}
\item \textsuperscript{145} \textit{Id.}
\item \textsuperscript{146} \textit{Id.}
\item \textsuperscript{147} \textit{Id.} at 755.
\item \textsuperscript{148} See Marc Stauch, \textit{Causation, Risk, and Loss of Chance in Medical Negligence}, 17 OXFORD J. LEGAL STUD. 205, 219 (1997). Professor Stauch contends:

\begin{quote}
[W]hereas statistics derived systematically from our previous experience of similar cases, provide us with a very accurate probability-weighting for each candidate, the balance of probabilities test attempts to perform the same operation by appealing crudely to what we feel the likely cause to have been. The relevant feeling must, once again, derive from our previous experience of similar cases, but this time in its rawest form.
\end{quote}


epidemiological statistics were used in court to ascertain the prognosis of the patient of the lymphoma’s subtype suffered by Mr. Gregg.150

Nevertheless, the difficulty with the interpretation of the evidence is worrisome. In Gregg, Professor Goldstone, an expert witness, had initially overlooked new research on lymphoma151 resulting in a poorer prognosis of the cancer’s subtype Mr. Gregg suffered.152 He changed his prior analysis given the new research and came up with a new number for Mr. Gregg’s ten-year survival prognosis.153 That number was discussed by the UK courts in the case to ascertain the likelihood of Mr. Gregg’s ten-year survival.154 Difficulties with the interpretation of the epidemiological evidence was compounded by the fact that a delay in diagnosis does not always contribute to a worse prognosis.155

To highlight the difficulty of working with epidemiological evidence, the author offers the example of evaluating cancer prognoses and causation. When a diagnosis is made early, and a patient is classified under Stage I the patient may progress to Stage II in a matter of months with or without any treatment.

Imagine that a patient with Stage II lung cancer will die within thirty months on average, while that same type of patient, diagnosed six months earlier (at Stage I), will die within thirty-six months on average—the earlier diagnosis does not improve the prognosis except in the sense that the patient learns of his or her ultimate fate sooner.156

In other words, early diagnosis does not necessarily mean a better prognosis for the patient; they may just learn of sickness earlier. This situation is oftentimes referred to as “lead time bias.”157

151 Brunangelo Falini et al., Lymphomas Expressing ALK Fusion Protein(s) Other Than NPM-ALK, 94 BLOOD 3509, 3509 (1999).
153 Claire McIvor, The Use of Epidemiological Evidence in UK Tort Law, in FORENSIC EPIDEMIOLOGY IN THE GLOBAL CONTEXT 55, 76 (Sana Loue ed., 2013). McIvor also remarked: “Professor Goldstone’s subsequent revisions to his estimates of Mr. Gregg’s statistical chances are further indicative of a general lack of scientific rigour.” Id.
Therefore, using only epidemiological evidence may be problematic in loss of a chance claims. To illustrate, in the usual loss of a chance claims, it has often been suggested that delayed diagnosis and a patient's cancer development from Stage I into Stage II reduces the chance of survival of the patient. The epidemiological evidence shows that patients with advanced stages of cancer have less chance of survival. However, that is not always due to negligence. Rather, the supposedly poorer prognosis may very well have resulted from “lead time bias”. The solution may call for evidence of the comparison between a patient group that has not been given treatment (i.e., watchful waiting) and a group that has been given prompt treatment. Such an experiment, however, may be unethical for many diseases.

Further, some scholars contend that medical doctors cannot reliably interpret epidemiological evidence accurately and correctly. They argue that epidemiologists rather than medical doctors should be the ones to interpret and guide the court in cases requiring such evidence since the medical doctor, unfamiliar with epidemiology, cannot fully appreciate and interpret all the figures and potential implications within the context of the specialized discipline. Unfortunately, this practice is not a viable one in the Thai context. Thailand has encountered a severe shortage of epidemiologists, and the situation is unlikely to change in the near future. That epidemiologists interpret the figures to educate the courts in Thailand is perhaps at present too onerous a demand.

Another problem with using epidemiological evidence in loss of a chance claims is that the court must determine the relevant epidemiological evidence to use when quantifying of damages. There is a bewildering array of relevant numbers in interpreting the epidemiological evidence to choose from.

If, for example, a patient's chance for survival was 40% with proper treatment and 20% after malpractice, the same facts may be expressed in several other ways. It may be said that malpractice caused a 50% decrease in the patient's prospects for survival or that proper treatment would have improved the patient's prospects by 100%. It may also be said that malpractice increased the patient's chances of dying from 60% to 80%, and thus caused a 33% increase in the chance of dying. Proper treatment may also be said to have offered

158 Noah, supra note 156.
159 Claire McIvor, Debunking Some Judicial Myths about Epidemiology and Its Relevance to UK Tort Law, 21 MED. L. REV. 553, 585–86 (2013).
160 See generally McIvor, supra note 153.
the patient a 25% reduction of the chance of death.\footnote{162}

Some courts may choose the figure of 40% to represent the lost chance and calculate the damages by awarding only 40% of full damages to the plaintiff. Some other courts may use 20% (40-20) instead in their calculation. Other courts may utilize one of the other figures listed above in their estimation of damages to be awarded. In fact, it has been noted that the chance of the plaintiff having enough blood supply to the femoral epiphysis after the alleged negligence estimated at 20% in \textit{Hotson}\footnote{163} derived from the trial judge choosing the average of conflicting expert witnesses.\footnote{164}

Each number would have significant implications both for the establishment of causation and for quantification of damages under a loss of chance doctrine in particular, and different jurisdictions reach different conclusions based on their interpretation of the numbers. The problem of epidemiological numbers may pose more of a challenge to the adoption of the loss of a chance doctrine than to the traditional theory of establishing causation. Factfinders must unavoidably specify a certain number in order to calculate a damages award as a form of proportional recovery according to the loss of a chance theory, whereas they do not need to provide a specific number in the traditional causation. In other words, if the standard of proof (a balance of probabilities or preponderance of the evidence) has been met, the damages will be awarded in full; otherwise, none will be awarded.

To illustrate the competing conclusions of causation, in the Thai TB meningitis case, one study showed that the risk of death of this disease was 19.3\% and “among survivors, risk of neurological sequelae was 53.9 [percent].”\footnote{165} If the court was forced to choose one number to estimate the damages awarded in percentage points of the total damages incurred, which figure should the court pick? Some may argue that 46.1\% represents the loss of the plaintiff’s chance because the negligence deprived the plaintiff of 46.1\% of the better outcome, that is, not suffering from neurological sequelae.\footnote{166} However, the more accurate method would be to calculate damages by accounting for the number or the statistic that represents the probability of patients not suffering from neurological sequelae even after negligence, since not all the patients would suffer from neurological sequelae as a consequence of a few days’ delay in diagnosis.

\begin{itemize}
\item \footnote{163} Hotson v. East Berkshire Area Health Auth. [1987] AC 750 (HL).
\item \footnote{164} TURTON, supra note 136, at 125.
\item \footnote{165} Chiang et al., supra note 88.
\item \footnote{166} This approach was taken by the trial judge in \textit{Tabet v Gett}, to award the 40\% lost chance of the better outcome of Tabet not suffering from brain damage. See \textit{Tabet v Gett} (2010) 240 CLR 537 (Austl.).
\end{itemize}
Even if a few days’ delay in diagnosis occurs, the patient still would have a chance of 20% of neurological intactness. The actual loss of such a chance is only 26.1% (46.1–20), not 46.1%. Should we convert the figures to the increased risk and award greater damages rather than just the difference between the risk with medical negligence and without? As Lars Noah contends:

[E]ven if [the courts in jurisdictions permitting loss of a chance’s claims] would not award full damages to a patient whose chances of survival declined from, let us say, 99% to 95% and then died, it still makes more sense to convert these figures to the increased risk and award 80% damages \((.05 - .01)/.05\) rather than award only 4% damages based on either the absolute or relative chance lost.\(^{167}\)

Other scholars propose an entirely different approach, the double-risk approach, to satisfy the legal standard of proof and establish causation.\(^{168}\) The double-risk approach concludes that, if the negligence doubles the risk of injury incurred, the negligence is more likely than not to cause the injury.\(^{169}\) For example, in Gregg\(^{170}\) the evidence showed that the delay in treatment probably reduced the chance of ten years’ disease-free survival from 42 to 25%. This means that the negligence increased the risk of death (or whatever the opposite of ten years’ disease-free survival) from 58 to 75%. It follows that the negligence did not double the risk \((75/58 = 1.29\)\). The commentators who support this theory would conclude that the negligence is not more likely than not to be a cause of the alleged damage.\(^{171}\)

However, other scholars contend that the double-risk approach cannot function as a tool to establish causation in medical negligence.\(^{172}\) It is just one statistic epidemiologists employ in their work.\(^{173}\) This is reminiscent of the need for epidemiologists, as expert witnesses, to interpret the data in court instead of physicians.

A final concern specific to the adoption of the loss of a chance claim in Thailand is based on another aspect of epidemiological evidence. Apart from the tropical disease endemic to Thailand, epidemiological data for Thailand are still lacking. Most research data referenced is derived from

---

\(^{167}\) Noah, supra note 156, at 399.  
\(^{168}\) See id. at 398–99.  
\(^{171}\) Noah, supra note 156, at 394–96.  
\(^{172}\) McIvor, supra note 159, at 572.  
\(^{173}\) Id. at 573 (citing KENNETH J. ROTHMAN, EPIDEMIOLOGY: AN INTRODUCTION 24–56 (2002)).
textbooks of western countries, randomized controlled trials, and studies conducted in other, mostly western, countries. When using those data, especially for establishing causation of the medical negligence affecting Thai patients, highly plausible arguments may exist against the applicability of such data to the Thai legal context. Among the Thai survivors of TB meningitis, risk of neurological sequelae may be only 30% rather than 53.9% as above-mentioned, thereby easily succeeding in establishing causation of the doctor’s negligence. Relying upon epidemiological evidence in establishing causation and valuation of damages appears to be questionable, especially in countries lacking in dependable epidemiological statistics and epidemiologists like Thailand.

VI. Should Thailand Adopt the Loss of a Chance Doctrine in Medical Negligence?

Under the current Thai legal framework, the loss of a chance doctrine could be incorporated without much difficulty. Section 420 of the *Civil and Commercial Code* is broad enough to construe loss of a chance as damage to a right of another person. Damage to any right of another person can be compensable under the Thai law. In addition, the Thai law also recognizes non-pecuniary damage:

A person may be held liable for willful or negligent injury to another’s right even in the absence of pecuniary damage. In the case of injury to the body or health of another, or in the case of deprivation of liberty, the wrongdoer is liable for non-pecuniary damages, i.e., he must compensate the victim for the damages which are not readily quantified or valued in money, such as physical pain, suffering, loss of enjoyment of life, and disfigurement.

Generally speaking, no statutory provisions dictate the standard of proof in civil cases. However, Section 84/1 of the Thai *Civil Procedure Code* reads: “Where a party alleges any fact in support of his pleading, the

---


175 CIVIL AND COMMERCIAL CODE § 420 (Thai.). A person who, willfully or negligently, unlawfully injures the life, body, health, freedom, property or any other right of another is bound to compensate him for any damage arising therefrom. *Id.*

176 PUNYAPAN, supra note 42, at 34–35.

177 ALESSANDRO STASI, ELEMENTS OF THAI CIVIL LAW 114 (2016).

178 CIVIL PROCEDURE CODE § 104 (Thai.). The court has full power and discretion to decide whether the evidence adduced by parties is relevant and sufficient to convince the court, and the court shall adjudicate the case accordingly. *See id.*
burden of proof of such fact falls on the party alleging it….” Accordingly, the party which bears the burden of proof has to prove any fact it alleges to the courts. The facts must be proven to be more likely to be true than not. Consequently, the standard of proof in civil cases is believed to be the preponderance of the evidence. Some decisions of the Thai Supreme Court have reaffirmed that theory. If the plaintiff can prove, by the preponderance of the evidence, that the negligence caused them loss of a chance, Thai courts may award damages accordingly. Indeed, extrapolating from the Supreme Court’s decisions having been discussed so far, the loss of a chance claims should succeed because in those cases the Court awarded the damages to the plaintiffs although the causation element appears to be highly equivocal. As a result, it may be argued that the prospective plaintiff in Thailand may not be attracted to the loss of a chance claim since they can receive full damages without any discount under the current statutory regime. However, if the defendant argues that, despite its negligent conduct, the damage incurred was just the loss of a chance, the court cannot avoid the analysis of the issue. Accordingly, the discussion must now turn to the question of whether Thai courts ought to allow the loss of a chance claims.

The loss of a chance doctrine comes with theoretical inconsistency and several practical difficulties when applied to the Thai context, as previously discussed. It has been said that:

Treating the risk exposure as the legal injury, but only when the risked harm actually occurs and only in the problematic causation situations, is an ad hoc solution that, among other problems, fails to explain why recovery is contingent on the actual occurrence of the risked harm and why the damages are based on the ex post actual harm rather than the ex ante expected harm.

Additionally, it is difficult to find limiting principles to constrain its use. Although, some scholars argue that plaintiffs in other cases would not be interested in loss of a chance claims as they can obtain full and non-discounted damage awards.
Probabilistic proof is not logically restricted to the causation issues. A court could allow probabilistic proof of any element of any cause of action including, for example, the duty and breach issues in a negligence action. Use of probabilistic proof has the potential to dramatically change the legal system in ways that most people would probably not approve.185

Some scholars have proposed for the court to award another different type of damages to the plaintiff in loss of a chance claims that are not based upon proportional recovery. They contend that the loss of a chance is deemed as damage to the plaintiff’s right to patient autonomy and self-determination, therefore, the distinct form of damages can be independently awarded.186 Such an approach is appealing if the court adopts it in a way that still safeguards the right to patient autonomy and self-determination.187 However, patient autonomy and self-determination are not deeply ingrained in Thai society.188 Many patients still rely on their families’ and doctors’ interests and emotions when making their own medical decisions.189

Fortunately, Thai courts have quite broad discretion in awarding damages in wrongful act cases. According to Section 438 of the Thai Civil and Commercial Code, “The court shall determine the manner and the extent of the compensation according to the circumstances and the gravity of the wrongful act.”190 The court can frame the loss of a chance as a type of compensable damage without the need to explicitly attach it to the right of patient autonomy and self-determination. Then, the court can award damages without resorting to one number chosen from a wide range of bewildering figures. The court can also lay the foundation that only substantial loss of a chance can be compensated if they wish to do so.191

In the Thai AFE case, the Supreme Court granted the plaintiff full damages. If, instead, the defendant doctors had argued for the loss of a chance doctrine, the damages incurred in the case may have been discounted.

185 Fischer, supra note 72, at 616.
186 Perry, supra note 135, at 289; TURTON, supra note 136, at 145–58.
187 Fischer, supra note 72, at 625.
190 CIVIL AND COMMERCIAL CODE § 438 (Thai.).
191 See, e.g., Falcon v. Mem’l Hosp., 462 N.W.2d 44 (Mich. 1990); Hicks v. United States, 368 F.2d 626 (4th Cir. 1966). According to those decisions, the Supreme Court of Michigan and the US Court of Appeals for the Fourth Circuit require a “substantial” loss of an opportunity in order to grant loss of a chance damages. See Falcon, 462 N.W2d at 44; Hicks, 368 F.2d at 626.
or, if the Court had elected to adopt it, the damages valuation may have been different. The Court might grant partial damages in light of the loss of a chance notion, without the need to specify the exact figure. This may assuage the fear and concern of Thai medical professionals over the medical litigation scheme. As a matter of fact, the Michigan Supreme Court encountered a similar case where a patient had died from an amniotic fluid embolism although it granted merely the partial damages (37.5%, as the lost chance, of the full damages for wrongful death). By the same token, as for the Thai TB meningitis case, the Court could award partial damages for a few days’ delay in diagnosis of the disease with already high mortality, morbidity, and disability rates.

VII. CONCLUSION

The causation element of medical negligence in Thailand has been largely overlooked in Thai court decisions, as parties fail to argue them sufficiently. A more thorough analysis of causation could result in completely different outcomes of many cases of this kind. Parties and courts may place a much higher emphasis on whether the doctor’s conduct was negligent or not (breach of duty element in common law), especially given the complexity of proving the standard of care in those cases.

Additionally, the loss of a chance in medical negligence cases also merits discussion of whether and how it should be employed in medical negligence litigation in Thailand. As discussed, the full adoption of such notion may be somewhat problematic. A dearth of epidemiological evidence and epidemiologists are one of several considerations against taking this approach. The inconsistency and asymmetry when applied in situations where the initial chance of better outcomes is less than 50%, and practical difficulties when applied in Thailand also militate against the full implementation of the loss of a chance. Proportional recovery, if to be used generally, is radical and it is difficult to choose the most appropriate number to discount damages. Thai laws have never explicitly prescribed the standard of proof for civil cases; the courts have been afforded full discretion and authority. Parliament plays no role in this realm and, after all, the standard of proof effectively reflects the court’s extent or level of confidence and belief in the evidence adduced. The Thai courts have never

---

192 *Falcon*, 462 N.W.2d at 56–57 (“We are persuaded that loss of a 37.5% opportunity of living constitutes a loss of a substantial opportunity of avoiding physical harm. We need not now decide what lesser percentage would constitute a substantial loss of opportunity. In the instant case, while Nena Falcon's cause of action accrued before her death, she did not suffer conscious pain and suffering from the failure to implement the omitted procedures between the moment that the medical accident occurred and the time of her death a few minutes later -- she was sedated throughout the entire time period. In this case, 37.5% times the damages recoverable for wrongful death would be an appropriate measure of damages.”).

193 *Wichitcholchai*, *supra* note 181, at 558.
expressed their belief in numbers. Fortunately, the current statutory provisions leave room for partially implementing the loss of a chance doctrine. Partial damage awards can be granted to the plaintiff without the need to adhere to the proportional recovery by specifying the number representing the loss of a chance in percentage points. This way, together with the clearer causation element, the Thai medical litigation scheme would be fairer to both the medical professional and the patient. It should also allay the medical profession’s fears, concerns, and criticism that the court prioritizes sympathy over the truth to decide a case.

\[\text{CHITTI TINGSAPAT, Considerations of Weighing Evidence and Writing Court Judgments} 26 (4th ed. 2009).\]