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**IN THE SUPREME COURT OF PENNSYLVANIA, WESTERN DISTRICT**

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NO. 55 WAP 2017

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**LANETTE MITCHELL,**

APPELLEE,

V.

**EVAN SHIKORA, D.O., UNIVERSITY OF PITTSBURGH PHYSICIANS D/B/A WOMANCARE ASSOCIATES AND MAGEE WOMENS HOSPITAL OF UPMC**

APPELLANTS.

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# BRIEF OF *AMICI CURIAE* THE PENNSYLVANIA ASSOCIATION FOR JUSTICE AND AMERICAN ASSOCIATION FOR JUSTICE IN SUPPORT OF APPELLEE TO AFFIRM THE JUDGMENT OF THE SUPERIOR COURT

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Appeal from the Order and Opinion of the Superior Court entered on May 5, 2017 at No. 384 WDA 2016, vacating the judgment on the Verdict entered in the Court of Common Pleas of Allegheny County on February 22, 2016 at G.D. No. 13-023436, and remanding for a new trial.

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## INTEREST OF *AMICI CURIAE*

The Pennsylvania Association for Justice ("PAJ"), formerly Pennsylvania Trial Lawyers Association, is a non-profit organization comprised of 2,000 members of the trial bar of the Commonwealth of Pennsylvania. For nearly 50 years, PAJ has promoted the rights of individual citizens by advocating the unfettered right to trial by jury, full and just compensation for innocent victims, and the maintenance of a free and independent judiciary. The organization opposes, in any format, special privileges for any individual, group, or entity. Through its *Amicus Curiae* Committee, PAJ strives to maintain a high profile in the state and federal courts of the Commonwealth by promoting, through advocacy, the rights of individuals and the goals of its membership.

The American Association for Justice ("AAJ") is a national voluntary bar association founded in 1946 to safeguard the right of all Americans to seek legal recourse for wrongful injury. AAJ's trial lawyer members primarily represent individual plaintiffs in personal injury actions, workplace injury and employee rights cases, consumer protection actions, and other civil suits. Its members practice law in every state of the Union, including Pennsylvania. Throughout its 70-year history, AAJ has served as a leading advocate of the right to access to the courts for legal redress for wrongful injury.

This case is of acute interest to *amici curiae* as it involves the identification of medical errors and patient safety within the Commonwealth of Pennsylvania and the fundamental fairness of the judicial system. No person or entity other than the *amici curiae*, its members, and its counsel authored this brief in whole or in part. No person or entity other than *amici curiae*, its members, and its counsel, contributed money that was intended to fund the preparation or submission of this brief.

## SUMMARY OF ARGUMENT

In holding that "the risks and complications evidence was immaterial to whether Defendants' treatment of Mitchell met the standard of care", the Superior Court appropriately applied this Court's prior precedent, including *Brady v. Urbas*, 111 A.3d 1155 (Pa. 2015). Generic and unsubstantiated claims that an injury could have occurred in the absence of negligence, are not relevant to the determination of whether a medical professional's care of an injured patient fell below the standard of care in a medical negligence case. Even in the limited circumstances where it may be relevant, such relevance is outweighed by the risk of prejudice, confusion of the issue, or the likelihood that it would mislead the jury.

The assertion that a medical procedure necessarily has risks should never insulate a healthcare provider from exercising reasonable care. The fact that harm may occur to a patient, which can theoretically be anticipated, causes confusion as to whether a healthcare provider has met a reasonable standard of care. The admission of testimony and argument that "known risks and complications can occur absent negligence" is improper and creates a qualified immunity for medical professionals as it misleads jurors into believing that simply because a risk and complication is known, it does not occur as a result of negligence. The standard of care requires healthcare

providers to minimize or eliminate these risks, and the use of the term "complication" gives the impression that such an injury can occur regardless of whether or not reasonable care was provided to a patient. Much like the now prohibited "error in judgment" charge, such evidence and testimony must be restricted and the focus of the jury must be limited to whether the standard of care was met based upon the facts of the particular case.

Furthermore, none of the *amici* supporting Appellants have raised valid or relevant public policy arguments in support of reversal. There is no merit to the arguments that the Superior Court's decision will result in higher insurance premiums, an increase in frivolous lawsuits, or a mass departure of physicians from Pennsylvania, and these claims are unsupported by evidence. Instead, the decision below is consistent with Pennsylvania's goal to compensate wrongfully injured patients, correctly identify medical errors, and recognize and prevent juror bias and confusion. Finally, the decision below is consistent with decisions from other jurisdictions, which have held that evidence of risks and complications should not be admitted in medical negligence cases and tend to mislead the jury.

*Amici* urges that the Superior Court's grant of a new trial be affirmed.

## COUNTER STATEMENT OF THE CASE

*Amici* accept and adopt Appellee's Counter Statement of the Case. However, *amici* highlight the following facts, which are salient to this *Amici Brief*.

In May 2012, Appellee Lanette Mitchell was scheduled to undergo a non-emergent laparoscopic hysterectomy at Magee Women's Hospital of UPMC with her physician, Dr. Shikora. (R. 726a; 795a-96a). A resident, Karen Hansen, was tasked to perform portions of the surgery under Dr. Shikora's supervision. (R.726a; 796a). At that time, Dr. Hansen had completed less than five laparoscopic hysterectomies. (R. 729a).

During the initial stages of the procedure, the surgeons cut through Ms. Mitchell's skin and fascia to expose the peritoneum—the sheath covering the internal organs. (R. 733a-34a). While the peritoneum is not transparent, it is translucent with some ability to see through it. *Id.* Prior to cutting through the peritoneum, the surgeons "tented" or pulled up on "what they thought was" the peritoneum. (R. 733a). However, when Dr. Hansen made cut, she severely lacerated Ms. Mitchell's intestine. *Id.* Dr. Hansen and Dr. Shikora claim that they unknowingly lifted and cut part of Ms. Mitchell's bowel. (R 736a). Because Dr. Hansen was still in training, Dr. Shikora was responsible for her conduct as the supervising surgeon and he signed the operative

report indicating that there had been an "inadvertent large bowel injury." (R. 726a-28a; 734a; 770a). Ms. Mitchell filed this lawsuit in negligence only.

Prior to trial, relying on this Court's decision in *Brady v. Urbas*, Ms. Mitchell filed a motion *in limine* to exclude consent-related evidence of risks and complications as such evidence was not relevant, unfairly prejudicial, and would confuse and mislead the jury. (R. 181a-91a). Counsel for Defendants argued that general complications evidence was always relevant and should be admitted. (R. 192a-214a). The trial court permitted the introduction of testimony and argument that Ms. Mitchell's bowel injury was a known risk and complication of the procedure, but precluded any evidence or testimony that Ms. Mitchell was told about these risks. (R. 215a).

At trial, Ms. Mitchell's expert, Dr. Morozov, testified that the failure to properly identify Ms. Mitchell's anatomy before cutting into her bowel was not merely a complication, but was a breach of the standard of care. (R. 653a-59a). Dr. Morozov testified that the standard of care requires a surgeon to not only "tent" or clamp and pull up on the peritoneum, but also to inspect or "transvisualize" by moving the blunt end of the scissors under the peritoneal sheath to ensure that only the peritoneum is clamped. (R. 653a). At that point, the surgeon should make a "tiny cut." *Id.* In Ms. Mitchell's surgery, there was no evidence that there was any inspection of the peritoneum

before the surgeon cut. (R. 656a). Furthermore, the large size of the cut to Ms. Mitchell's intestines indicated that the surgeon did not take proper steps to avoid injury with a small cut, but rather made an aggressive cut that severed the bowel nearly in half. (R. 664a-66a). Dr. Morozov testified, the surgeon violated the standard of care because "[t]hat transvisual step was actually designed and developed specifically to avoid what happened in this case." (R. 715a).

Rather than rebut Dr. Morozov's explanation of the specific standard of care and the need to inspect and make a small cut, Defendants instead made repeated claims that Ms. Mitchell's injury was a "known risk" and "complications can happen," which they argued relieved Defendants of any liability. (R. 594a; 1211a; 1215a-19a). Their own expert, Dr. Ascher-Walsh, admitted that "merely because a patient suffers a colon injury, that doesn't really tell us whether the doctor was negligent…" and "in fact, the bowel injury itself doesn't really tell us much about the standard of care…" (R. 1181a).

The jury found no negligence, and the trial court denied Ms. Mitchell's request for a new trial. (R. 1426a). On appeal, the Superior Court determined that the testimony and argument regarding known risks and complications should have been excluded, and Ms. Mitchell was entitled to a new trial. *Mitchell v. Shikora,* 161 A.3d 970 (Pa. Super. 2017).

## ARGUMENT

Never before has this Court created a bright-line rule governing the admission of known risks and complication evidence. At best, the *Brady* Court acknowledged that such evidence *could* be relevant in certain limited situations. *Id.* at 1161, N5. In reversing the lower court's decision to admit the evidence, the Superior Court recognized the liberal threshold to determine relevance, but emphasized that the evidence must nevertheless be probative of whether Defendants' treatment of Mitchell fell below the standard of care. *Mitchell v. Shikora,* 161 A.3d 970, 975 (Pa. Super. 2017)(citing *Brady,* 111 A.3d at 1162). Because evidence of the known risks and complications was not relevant to the determination of whether the doctor deviated from the standard of care, admission of such evidence would do nothing more than "mislead and/or confuse the jury." *Id.* (citing *Brady*, 11 A.3d at 1163).

Appellants and *amici*, misconstruing the holding in *Brady,* argue that risk and complication evidence should *always* be admitted by trial courts in general malpractice cases. Not only does this position contradict *Brady,* it ignores the gate keeping function of every trial court to admit or exclude evidence. Despite Appellants' mischaracterization, the Superior Court's holding in *Mitchell* is consistent with *Brady,* keeping open the possibility that

this type of evidence may be admitted in some limited circumstances, none of which were present in this case.

### A. INFORMATION ABOUT KNOWN RISKS AND COMPLICATIONS IS NOT RELEVANT TO THE JURY'S DETERMINATION OF WHETHER A PHYSICIAN OR SURGEON VIOLATED THE STANDARD OF CARE.

When determining whether to admit or exclude evidence, a court must first assess whether such evidence is relevant. Even if evidence is relevant, it may be excluded where there is a risk of prejudice, confusion, or where it may mislead the jury. The Superior Court did not make a broad-sweeping relevance determination precluding introduction of risk and complication evidence in *all* negligence cases, but rather determined that the specific evidence presented here was not relevant to the ultimate issue—whether the standard of care was met. *Mitchell*, *161 A.3d at 975-76*.

#### 1. Evidence of risks and complications is not generally relevant.

When a patient suffers an adverse event resulting in an injury, whether or not that injury was a "known risk" does not make it more or less likely that the medical professional met, or violated, the standard of care. "Evidence is relevant if: (a) it has any tendency to make a fact more or less probable than it would be without the evidence; and (b) the fact is of consequence in determining the action." Pa.R.E. 401. "Evidence that is not relevant is not admissible." Pa.R.E. 402.

"[M]edical malpractice can be broadly defined as the unwarranted departure from the generally accepted standards of medical practice resulting in injury to a patient…" *Toogood v. Owen J. Rogal, D.D.S., P.C.* 824 A.2d 1140, 1145 (Pa. 2003). "To prevail on a claim of medical negligence, the plaintiff must prove that the defendant's treatment fell below the appropriate standard of care." *Brady v. Urbas*, at 1161 (citing *Scampone v. Highland Park Care Ctr.,* 57 A.3d 582, 593 (Pa. 2012); *see also Toogood,* 824 A.2d at 1145). The central focus of the jury must be to determine what the standard of care requires, and whether or not the defendant satisfied that requirement. "A physician must have the same knowledge and skill and use the same care normally used in the medical profession. A physician whose conduct falls below this standard of care is negligent." *Passarello v. Grumbine,* 87 A.3d 285, 297 (Pa. 2014)(citing Pa. SSJI (Civ) 14.10 (4th ed. 2011)).

In *Brady*, this Court recognized:

> [T]he fact that a patient may have agreed to a procedure in light of the known risks does not make it more or less probable that the physician was negligent…[p]ut differently, there is no assumption-of-the-risk defense available to a defendant physician which would vitiate his duty to provide treatment according to the ordinary standard of care.

*Brady,* 111 A.3d at 1162. Thus, in a medical negligence trial—one that does not include a lack of informed consent claim—evidence that a patient agreed in spite of the risks is irrelevant and should be excluded because it has no relevance to the standard of care and creates an improper impression that a patient consented to the resultant injury. *Id.* at 1162-63. While the Court recognized that there may be instances where this information is relevant to the standard of care, such as when the standard of care differs between geographic regions or the standard of care requires that a doctor discuss certain risks,[1] this information would not be relevant to whether a physician deviated from the applicable standard of care, resulting in the particular injury to the patient.

For every medical procedure, there are a substantial amount of adverse outcomes that can, and historically have, occurred. There are few, if any, "unknown risks" of procedure. In order to be considered a "known risk," an injury only has to occur in a recognizable amount of patients. However, absent a malpractice lawsuit, there is rarely a determination of whether an injury was caused by the substandard care of one or more medical professionals. To that end, wrong-site surgeries occurred with enough frequency that many hospitals now have procedures in place that

[1] *Brady*, 111 A.3d at 1162, N.5.

require surgeons to mark surgical sites in the presence of the patient. A patient who undergoes a surgery in the wrong location clearly sustains an adverse event or "complication," and it is obviously a known risk as it has occurred with enough frequency to create procedures and protocols, which the surgeon clearly failed to meet. Infections can occur during the normal course of treatment and recovery, or they can occur due to substandard care. In both situations—wrong-site surgeries and infections—the central issue is not whether the patient sustained a "known complication," but rather whether the physician or surgeon employed appropriate methods in performing the procedure to eliminate or minimize these risks. The present case was illustrative of this, as Appellants' own expert admitted that the injury Ms. Mitchell sustained had no bearing on whether there was a violation of the standard of care.

**2. <u>The Superior Court correctly held that the risks and complication evidence was not relevant in this case.</u>**

To establish the standard of care applicable to a laparoscopic surgery, Ms. Mitchell was required to obtain expert testimony. *Hightower-Warren v. Silk,* 698 A.2d 52, 54 (Pa. 1997)(citing *Mitzelfelt v. Kamrin*, 584 A.2d 888, 891 (Pa. 1990)). Ms. Mitchell's expert, Dr. Morozov, explained that the standard of care requires a surgeon to both inspect or "transvisualize" the anatomy, and after doing so, to then make a small incision through the

peritoneum and, using the blunt end, move the scissors beneath the peritoneum to ensure that no other organs were present and only the peritoneum would be cut. Here, the surgeon made an aggressive cut through Ms. Mitchell's peritoneum, nearly severing her bowel in half.

Appellants' expert Dr. Ascher-Walsh, did not rebut Dr. Morozov's testimony or explanation of the steps required by the standard of care to identify the anatomy and prevent injuries. Dr. Ascher-Walsh instead only offered that this was the riskiest part of the procedure and that this was a known risk; he did nothing to explain what steps the surgeon had taken to avoid such an injury. Furthermore, Dr. Ascher-Walsh admitted that, simply because Ms. Mitchell suffered a known complication, did not make it any more or less likely that the surgeon was negligent in severing Ms. Mitchell's bowel, nor did it offer any guidance regarding whether the technique met the standard of care.

By Appellants' own expert's admission, the fact that Ms. Mitchell sustained a known complication was not relevant, because it had no bearing on whether the surgeons met or violated the standard of care. While Appellants have claimed that there are examples where such evidence could be relevant—such as in a *res ipsa locquitur* claim or if there is a claim that falls within the "two schools of thought" doctrine—neither of these were

involved in the present case. This evidence had no bearing to the central issue before the jury and the Superior Court correctly determined that "the risks and complications evidence was immaterial to the issue of whether Defendants' treatment of Mitchell met the standard of care." *Mitchell*, 161 A.3d at 975.

### B. Even if such evidence is relevant, any such relevance is outweighed by the potential to prejudice, confuse, and mislead the jury

While the Superior Court determined that the risks and complication evidence should not have been admitted in this case, it recognized that even if it were relevant, it would nevertheless be inadmissible. The Superior Court held:

> [R]elevant evidence may be excluded 'if its probative value is outweighed by a danger of one or more of the following: unfair prejudice, confusing the issues, misleading the jury, undue delay, wasting time, or needlessly presenting cumulative evidence.'

*Mitchell,* 161 A.2d at 972-73, citing *Brady,* 111 A.3d at 1161 and Pa.R.E. 403.[2] Both the *Mitchell* Court and the *Brady* Court recognized the substantial risks of admitting evidence and permitting argument that is not relevant to the standard of care, as it has the tendency to improperly mislead jurors to

[2] Unlike F.R.E. 403, which requires the probative value to be "substantially outweighed," Pa.R.E. 403 eliminates the word "substantially." Pa.R.E. 403 Comment. In addition, '"Unfair prejudice" means a tendency to suggest decision on an improper basis or to divert the jury's attention away from its duty of weighing the evidence impartially.' *Id*.

excuse the conduct of the medical professional. *See Passarello v. Grumbine,* 87 A.3d 285 (Pa. 2014).

In *Passarello,* this Court found that "error in judgment" charge, coupled with defense counsel's argument that the defendant used her best intentions and judgment, improperly focused the jury's attention on the defendant doctor's state of mind, and "[i]n so doing, counsel used the error in judgment rule not as a measure of whether [defendant doctor] deviated from the standard of care in any specific act or omission, but as a measure of [defendant doctor's] character as a professional." *Passarello v. Grumbine*, 87 A.3d 285, 305–06 (Pa. 2014)(internal citations omitted). The Court held:

> [Defense] counsel's argument skillfully suggest[ed]…that regardless of the objective standard of care, [the defendant], in an exercise of continued self-sacrifice, acted with the best intentions and made judgements for which she could not be faulted, in part, because they were judgments and a physician cannot warrant care.

*Id.* at 306. Based upon the numerous arguments from defense counsel in *Passarello* and similar cases[3], the Court determined that the "error in

[3] The Court favorably cited and discussed the *en banc* opinion of the Superior Court in *Pringle v. Rapaport,* 980 A.2d 159 (Pa. Super. 2009) appeal denied, 987 A.2d 162 (Pa. 2009) (holding that "the "error in judgment" charge wrongly suggests to the jury that a physician is not culpable for one type of negligence, namely the negligent exercise of his or her judgment. This is simply untrue since in all medical malpractice actions '[t]he proper focus is whether the physician's *conduct* (be it an action, a judgment, or a decision) was within the standard of care…If, on one hand, a physician's conduct violates the standard of care, then he or she is negligent regardless of the nature of the conduct at

judgment" jury instruction posed a palpable and substantial risk of confusing juries and should no longer be given in medical malpractice cases. *Id.* Though *Pasarello* involved the now prohibited "error in judgment" charge, the reasoning is applicable to the present case.

In the present case, defense counsel sought to focus the jury's attention not on whether the surgeons met the standard of care, but instead that "complications are a part of life and a part of medicine." In both these cases, the conduct and claims of defense counsel focused not on whether there was a violation of the standard of care, but rather, that "errors in judgment" or "known complications" can occur, and that jurors should excuse the conduct of the doctor because medical professionals are not the guarantors of a cure.

Just as a plaintiff's expert would be precluded from offering testimony that, "in past experiences he or she has repeatedly seen this type of injury occur as a result of negligence," so should a defense expert be precluded from opining that such an injury can occur absent negligence. Similarly, even though it may be relevant to admit evidence of prior lawsuits against a defendant, or prior instances where patients sustain similar injuries in a

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issue...the "error in judgment" instruction neither defines nor clarifies the applicable standard of care, and may likely mislead the jury during its deliberations." *Id.* at 173-74.)

hospital or medical facility, this type of evidence would never be allowed because of the risk of prejudice and because it focuses the jury's attention away from the particular events involved in the case at hand. To allow evidence of known risks and complications to be admitted simply because relevance is a low standard would greatly expand the bounds of relevance and admissibility—including discovery of prior similar events or lawsuits at hospitals—and the Superior Court properly determined that such evidence should have been excluded based upon the facts of this case.

Should the Court permit the type of testimony that was elicited by Appellants at trial, and argued as the central theme of the case[4], it obfuscates the central issue and essentially creates a qualified immunity as long as the harm a patient suffers may be characterized as a complication that is a known risk. The Superior Court, citing *Brady*, correctly noted 'that evidence of risks and complications could confuse the jury and cause it to "lose sight of the central question pertaining whether defendant's actions conformed to the governing standard of care."' *Mitchell*, 161 A.3d at 975 (citing *Brady,* 111 A.3d at 1163).

[4] Specifically, Appellants argued that "Dr. Shikora should be judged by his management of the complication, which was excellent, and Dr. Ascher-Walsh…said complications—it can happen," "complications are a part of medicine and a part of life," and "complications can occur despite the best possible care." (R. 588a-89). "The complication we intend to show was both unpredictable and unfortunately unavoidable." (R. 588a).

## C. THE SUPERIOR COURT'S DECISION PROTECTS INDIVIDUALS IN PENNSYLVANIA, HELPS DEFEAT INSTANCES OF JURY CONFUSION, AND IS CONSISTENT WITH THE HOLDINGS IN SIMILAR MEDICAL NEGLIGENCE CASES IN OTHER JURISDICTIONS.

### 1. The Superior Court's decision is consistent with and reinforces the public policy of Pennsylvania's civil justice system to compensate wrongfully injured patients and identify medical errors.

*a. The Superior Court's decision is consistent with Pennsylvania's public policy.*

A driving public policy and goal of Pennsylvania's civil justice system is to protect and compensate wrongfully injured patients and correctly identify medical error. Pennsylvania's Medical Care Availability and Reduction of Error Act ("MCARE Act") states that "[e]very effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety." 40 P.S. § 1303.102(5). In the same vein, Pennsylvania's Rules of Evidence state that "[t]hese rules should be construed so as to administer every proceeding fairly, eliminate unjustifiable expense and delay, and promote the development of evidence law, *to the end of ascertaining the truth and securing a just determination*." Pa.R.E. 102 (emphasis added). These goals are imperative. Medical errors were recently found to be the third leading cause of death in the United States. Martin A. Makary and Daniel Michael, *Medical error—the third leading cause of death in the US,* 353 BMJ 2139 (2016).

The Superior Court correctly focused on ensuring patient safety as an overarching goal in Pennsylvania, finding evidence of general risks and complications of a procedure irrelevant to whether a surgeon's conduct fell below the standard of care in a negligence case. *Mitchell v. Shikora*, 161 A.3d at 973.

Appellants, however, want irrelevant evidence of risks and complications of a surgical procedure to be admissible to prove that a physician was *not negligent*. *See, generally*, Brief of Appellants ("Appellants' Br."); Brief *Amicus Curiae* of the America Medical Association, et. al ("AMA Br."); Brief for *Amicus Curiae* The Pennsylvania Orthopaedic Society ("Ortho Br."); Brief of *Amicus Curiae* The Hospital & Healthsystem Association of Pennsylvania ("Hospital Br."). This suggestion, if implemented, would not result in the elimination of medical errors. Instead, it would cloud medical negligence cases with so much irrelevant evidence – evidence of every possible risk or complication of every procedure – that medical errors would be nearly impossible to identify, thereby undermining the purpose of Pennsylvania's civil justice system. *See* 40 P.S. § 1303.102(5).

*b. Appellants' and amici's policy arguments are improper for this Court and have no basis in law or fact.*

Instead of focusing on patient safety and the correct identification of medical errors, Appellants and *amici* argue for a complete overhaul of

medical malpractice in Pennsylvania, and attempt to make this case about insurance premiums, frivolous lawsuits, and the mass departure of physicians. *See* Ortho Br. 12-14; AMA Br. 14-15; Hospital Br. 11; Appellants' Br. 25-48. Though unsupported by the evidence, Appellants' *amici* also suggest that there is or will be a "medical malpractice crisis" as a result of this case. *See* Ortho Br. 12-14. These arguments and statistics have no place here, especially because this Court declined to grant review on broader policy issues. *See* Supreme Court of Pennsylvania, Western District, Order entered November 20, 2017. Nevertheless, Appellants and *amici* advance numerous policy issues outside of the discussion surrounding whether the Superior Court's holding conflicts with *Brady v. Urbas*.

Moreover, the statistics cited by Appellants and *amici* are outdated, irrelevant, and simply do not make sense. For example, the claim that medical malpractice litigation was or is full of frivolous cases (Hospital Br. 9-10) is not only irrelevant, but is false. *See* David M. Studdert, *et al.*, *Claims, errors, and compensation payments in medical malpractice litigation*, N Engl J Med 2006; 354, 2024-33 (May 2006) ("…the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter.").

In fact, Pennsylvania has gone to great lengths to ensure that only the most meritorious medical negligence cases ever make it to the lawsuit stage. For example, the Pennsylvania Rules of Civil Procedure require that "In any action based upon an allegation that a licensed professional deviated from an acceptable professional standard" the plaintiff or plaintiff's attorney must obtain a certificate of merit. Pa.R.C.P. No. 1042.3(a)(1)-(3). This certificate must state that "an appropriate licensed professional has supplied a written statement that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm," or that the claim is based on allegations of other licensed professionals or does not otherwise require expert testimony. *Id*. Thus, plaintiffs in Pennsylvania are already required to bring only cases in which a certificate of merit can be produced. *Id*.

Similarly, arguments regarding insurance premiums and a potential "mass departure of physicians" are inaccurate and improper. Insurance premiums do not rise because of medical negligence cases. *See* Americans for Insurance Reform, *Stable Losses/Unstable Rates 2002* (Oct. 2002) (finding that medical insurance premiums over the last 30 years in

Pennsylvania have not corresponded to increases/decreases in payouts, but have instead risen and fallen in concert with the economy). *See also* Americans for Insurance Reform, *Stable Losses/Unstable Rates 2016* (Nov. 2016). In addition, studies show that there is no link between malpractice premiums and physicians relocating out of state. *See* Neil Vidmar, *A report for the Pennsylvania Bar Association*, Medical Malpractice Litigation in Pennsylvania, 3, 36-41 ("Despite claims that Pennsylvania is losing doctors to other states as a result of high liability insurance premiums, official statistics from the American Medical Association and from the Federation of State Licensing Boards show an actual per capita increase in treating physicians"); Y. Tony Yang, *et. al.*, *A longitudinal analysis of the impact of liability pressure on the supply of obstetrician-gynecologists*, 5 J. Empirical Legal Stud. 21 (March 2008) (finding that the number of available OB/GYNs had no significant statistical association with insurance premiums).

Appellants' and *amici*'s unsupported policy arguments, especially regarding non-meritorious claims and insurance premiums, have no place here and should not be considered by this Court.

### 2. The decision below advances the important objective of protecting jurors from confusing and prejudicial evidence.

The Superior Court's decision in this case helps to eliminate occasions of jury confusion in medical negligence cases, and minimizes the damage potentially caused by this issue.

Pennsylvania courts have discussed the issues of jury confusion and prejudicial evidence at length. *See generally*, *Shinal v. Toms, M.D.*, 162 A.3d 429, 433 (Pa. 2017); *Drum v. Shaull Equipment and Supply Co.*, 787 A.2d 1050 (Pa. Super. 2001); *Sutch v. Roxborough Memorial Hospital*, 151 A.3d 241 (Pa. Super. 2016); *Commonwealth v. Rich*, 167 A.3d 157 (Pa. Super. 2017). This Court has specifically addressed its interest in protecting juries from confusion, for example by holding that "error in judgement" jury instructions pose palpable and substantial risks of confusing juries with respect to the issue of standard of care, and therefore should not be given in medical malpractice cases. *Passarello*, 87 A.3d at 301-04; *see also Pringle v. Rapaport*, 980 A.2d at 173-74. Moreover, court rules, such as Pennsylvania Rule of Evidence 403, are meant to quell instances of jury confusion. *See* Pa.R.E. 403.

Despite attempts to decrease instances of jury confusion, medical malpractice verdicts in Pennsylvania still overwhelmingly favor defendants.

*See Medical Malpractice Jury Verdicts: January 2016 to December 2016*, The Unified Judicial System of Pennsylvania, prepared August 30, 2017, *available at* http://www.pacourts.us/assets/files/setting-771/file-6329.pdf?cb=8929e6 (finding that over 80% of verdicts were in favor of the defense in 2016, and even more if the results from Philadelphia are not considered). This is especially concerning in light of a conclusion by a New England Journal of Medicine national study which found that "Although the number of claims without merit that resulted in compensation was fairly small, the converse form of inaccuracy—claims associated with error and injury that did not result in compensation—was substantially more common. One in six claims involved errors and received no payment." Studdert, *supra* pp. 18-19.

Nonetheless, Appellants argue that the jury needs to have the "entire picture." *See* Appellants' Br. 31-32. This is simply not the case. A jury, as addressed by the Superior Court, needs only to have information that is probative of the standard of care; the jury does not need information beyond this. *Mitchell*, 161 A.3d at 975. The information that Appellants are trying to introduce is *not* probative of the standard of care, thus is irrelevant and would serve *only* to confuse the jury. For example, as explained by the Virginia Supreme Court in *Holley v. Pambianco*, such evidence can be "…so

misleading that, for all the jury could determine, each of the [injuries] contained in the statistics may have been due to a physician's negligence. In that event, the jury could infer the direct opposite of defense counsel's argument: That perforations occur only where the physician is negligent." 613 S.E.2d 425, 428 (Va. 2005).

If evidence of potential risks and complications is allowed in medical negligence cases in Pennsylvania, it would undoubtedly increase the chance of juror confusion these cases. The Superior Court's decision recognizes that jury confusion is a problem, and helps prevent it from happening in complicated medical negligence cases.

### 3. Rulings from other jurisdictions support the Superior Court's decision to exclude evidence of risks and complications from medical negligence cases.

The Superior Court's decision is consistent with the Virginia Supreme Court's ruling in *Holley v. Pambianco*, 613 S.E.2d at 428. In *Holley*, the plaintiff underwent a colonoscopy, during which polyps were found and removed using "hot biopsy forceps." *Id*. Five days later, the plaintiff was determined to have a perforated colon, necessitating a colostomy and thereafter a colostomy bag. *Id*. The plaintiff brought a medical malpractice action against the doctor and medical group. *Id*. at 183. At trial, the defendant introduced testimony, over the plaintiff's objections, regarding risks of similar

procedures and frequency of colon perforations as a result thereof. *Id*. at 184. However, the statistics introduced contained "no breakdown between those cases involving perforations caused by negligence and those that did not." *Id*.

The Virginia Supreme Court granted review, in part on the issue of "[w]hether the trial court erred by admitting evidence of the risks of perforation of the colon during a colonoscopy and polypectomy and permitting defense counsel to argue to the jury, in a case in which informed consent was not in issue, that such risks were normal." *Id* at 183. The court found that the admission of this evidence was an error, explaining that "the argument was based upon a premise unsupported by the evidence: That perforations are just as likely to occur in the absence of negligence as in its presence," and noting that the statistical evidence was misleading to the jury. *Id*. The court concluded that "such raw statistical evidence is not probative of any issue in a medical malpractice case and should not be admitted." *Id*.

The Virginia Supreme Court's holding in *Holley* is directly applicable to this case. Here, Appellants want to introduce evidence of risks and complications in laparoscopic hysterectomies to support the idea that it is *more* probable that Dr. Shikora conformed to the proper standard of care. Appellant's Br. 25. Appellants specifically seek to introduce testimony that in

laparoscopy procedures the greatest *risk* is in the initial incision, and during the initial incision is the most common time for *complications* to occur. Appellant's Br. 10-13. The testimony, however, includes no breakdown of how many of these cases involved negligence, and instead improperly assumes that none do. The testimony is simply that these injuries are "common," without regard to whether they are "common" due to negligence. Theoretically, 100% of these "common" injuries could be due to negligence. The information alleged by Appellants does not make it more likely than not that this injury was not a result of negligence. As the Virginia Supreme Court highlighted in *Holley*, evidence of risks of procedures is irrelevant in a medical malpractice case, and should not be admitted. *Holley* at 185.

In addition to *Holley*, it is well-settled throughout states that, generally, assumption of risk is not a valid defense to a medical negligence action as a matter of public policy. *See, for example*, *Baird v. Owczarek*, 93 A. 3d 1222, 1232 (2014); *Schwartz v. Johnson*, 49 A. 3d 359 (Ct. App. Md. 2012); *Marty ex rel. Marty v. Malin*, 2012 WL 3139862 at *2 (Nev. July 31, 2012) ("…the physician-patient relationship is not one where because of inherent risks, the patient has agreed that the physician no longer owes her a duty of care"); *Spar v. Cha*, 907 N.E.2d 974, 982 (Ind. 2009) (explaining that assumption of risk "has little legitimate application in the medical malpractice context" and

that “there is virtually no scenario in which a patient can consent to allow a healthcare provider to exercise less than ‘ordinary care’.”). Moreover, evidence of risk/complications discussions between a doctor and patient are typically inadmissible in these cases, as this information has little to no probative value and is likely to confuse the jury. *See Wright v. Kaye*, 267 Va. 510, 529 (2004) (explaining that evidence of discussion concerning the risks of surgery is neither relevant nor material to the issue of the standard of care and could only serve to confuse the jury); *Baird v. Owczarek*, 93 A.3d 1222, 1231 (Delaware 2014); *Ehrlich v. Sorokin*, 165 A.3d 812, 820 (N.J. Super. App. Div. 2017).

While these and other state court decisions are not binding on this Court, they are persuasive for the idea that evidence of risks and complications is not relevant to whether a physician conformed to the proper standard of care. Moreover, they illustrate how easily this evidence can mislead and/or confuse the jury by leading them to believe that any injuries were the result of the risks and complications, and highlight the importance of excluding this type of evidence to avoid this harmful result.

## CONCLUSION

The Superior Court did not err in holding that testimony and argument regarding "known risks and complications" was not relevant to whether the surgeons in this case violated the standard of care. Appellants' own expert admitted that the injury that Ms. Mitchell suffered did not offer any indications of whether or not the standard was met. Moreover, the Superior Court properly determined that such evidence carried a substantial risk of prejudice and may mislead the jury. As such, the Superior Court's grant of a new trial and exclusion of such evidence was completely consistent with this Court's prior holdings in *Brady v. Urbas* and *Passarello v. Gumbine*.

Respectfully submitted,


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## CERTIFICATE OF COMPLIANCE

1. The undersigned, Joseph R. Froetschel, is licensed to practice law in the Commonwealth of Pennsylvania, and is in good standing.

2. This Brief complies with the type-volume limitations of Appellate Rule 531 and does not exceed 7,000 words, as it contains 6,225 words.

3. This Brief complies with the typeface requirements of Appellate Rule 124(a)(4) because this Brief has been prepared in a proportionally spaced typeface using *Microsoft Word,* in Arial, 14 point font.

4. I certify that this filing complies with the provisions of the *Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts* that require fling confidential information and documents differently than non-confidential information and documents.

Dated: March 9, 2018

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## PROOF OF SERVICE

I hereby certify that this 9th day of March 2018, I am serving this Brief *Amici Curiae* for the Pennsylvania Association of Justice and American Association for Justice in Support of the Appellees upon the persons below via electronic service, which satisfies the requirements of Pa. R.A.P. No. 121:

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