No. 24-440

IN THE

# Supreme Court of the United States

HAROLD R. BERK,
*Petitioner*,

v.

WILSON C. CHOY, ET AL.,
*Respondents*.

**On Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

## BRIEF OF THE DRI CENTER FOR LAW AND PUBLIC POLICY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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## BRIEF OF THE DRI CENTER FOR LAW AND PUBLIC POLICY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

## INTEREST OF *AMICUS CURIAE*[1]

The DRI Center for Law and Public Policy is the public policy "think tank" and advocacy voice of DRI, Inc.—an international organization of more than 16,000 attorneys who represent businesses in civil litigation, including attorneys who represent physicians, medical providers, clinics, and hospitals, in defense of malpractice cases nationwide. DRI's mission includes enhancing the skills, effectiveness, and professionalism of defense lawyers; promoting appreciation of the role of defense lawyers in the civil justice system; and anticipating and addressing substantive and procedural issues germane to defense lawyers and the fairness of the civil justice system. The Center participates as an *amicus curiae* in this Court, federal courts of appeals, and state appellate courts in an ongoing effort to promote fairness, consistency, and efficiency in the civil justice system.

## INTRODUCTION AND SUMMARY OF ARGUMENT

Affidavit of merit statutes reflect the fundamental premise that expert support is required to prevail on a medical malpractice claim. That is, it is universally required that to get a medical malpractice claim to a decision by the factfinder, the plaintiff must present

[1] Pursuant to Rule 37.6, Amicus affirms that no counsel for any party authored this brief in whole or in part, and no person or entity, other than amicus, its members, or its counsel has made a monetary contribution to its preparation or submission.

expert support that a violation of the standard of care occurred and caused the plaintiff's injury. Affidavit of merit statutes reflecting this reality are critical components of a state's medical malpractice cause of action. Such requirements embody the state's efforts to promote access to justice and healthcare and to reduce costs by decreasing meritless litigation. The expectation among those who defend medical malpractice cases is that a case is reviewed *and supported* by an expert *before* a lawsuit is filed, whenever possible. Requirements such as affidavit of merit statutes comport with this understanding and practice.

Similar to other state law that defines who can bring a medical malpractice claim, when it can be brought, what must be proven, and what damages are recoverable, affidavit of merit statutes are not pleading requirements, and they do not conflict with the Federal Rules of Civil Procedure. Rather, they are substantive requirements of state law designed to weed out meritless claims.

Applying affidavit of merit and similar statutes in federal court better protects professionals from the ill-effects of being haled into court for frivolous lawsuits. With respect to medical professionals, this also protects public health by giving effect to a state's response to issues such as physician shortages, availability and affordability of liability insurance, and access to healthcare. Taking into consideration an appropriate sensitivity and deference to state law and promoting the critical principles of federalism and separation of powers, this Court should affirm.

## ARGUMENT

### I. Proper Application of this Court's Precedent Compels Affirmance, Giving Effect to Federalism Principles.

The briefs of respondents and other *amici* aptly describe the correct application of *Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938), and its progeny. To support those arguments and provide context for the court's analysis, The Center focuses on the substantive nature of affidavit of merit statutes, their background, and purpose. The Center argues that affidavit of merit requirements must be applied by federal courts in this case and cases like it. In this case, when the requirement is applied, it is evident the plaintiff has no claim under state law for medical malpractice and that should not differ because of the forum.

### II. Contextualizing Delaware's Affidavit of Merit Requirement Against the Background of Medical Liability Reform.

#### A. The challenges to healthcare and the medical community that affidavit of merit statutes address.

To understand the nature of affidavit of merit requirements, it is helpful to start by understanding why states enact them in the first place. That inquiry begins with the challenges facing the medical profession and our healthcare system because those concerns are directly linked to the medical liability system. The provision of healthcare is unique in that it touches everyone at some point in their life. *Nat.*

*Fedn. of Indep. Businesses v. Sebelius*, 567 U.S. 519, 590-91, (2012) ("Unlike the market for almost any other product or service, the market for medical care is one in which all individuals inevitably participate.") (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

Physicians provide quality healthcare to their patients, often in unideal or complex circumstances. The provision of medical care is further complicated by the reality that in many circumstances, undesirable and adverse outcomes cannot be avoided even with the best care. The result is that many medical malpractice lawsuits are filed even when no malpractice occurred. Anupam B. Jena, *et al. Outcomes of Medical Malpractice Litigation Against US Physicians*, 172:11 Archive of Internal Med. 892, 893 (2012); *See* Fred J. Hellinger & William E. Encinosa, *The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures*, 96 Am. J. of Pub. Health 1375, 1375 (2006) (noting that only 2% of negligent medical injuries resulted in a claim and only 17% of malpractice claims involved injuries caused by negligence).[2]

Physicians today face a different and changing climate with respect to the public perception of doctors, healthcare, how care is delivered and paid for,

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[2] In the simplest of terms, that means that in *most* cases there is no expert support for the proposition that the physician's care fell below the standard of care and caused harm. Lack of expert support is even more prevalent in cases where the plaintiff is proceeding *pro se*. This case is no outlier. Cases where the plaintiff is unrepresented command a substantial use of judicial and defense resources, exacerbating these issues, especially where the claims are often unfounded.

and their own personal liability risks. Many of today's physicians can expect to be sued during their careers. Anupam B. Jena, *et al*, *Malpractice Risk According to Physician Specialty*, 365 N. Engl. J. Med. 629, 629-636 (2011).

The personal and professional toll that litigation has on an accused physician cannot be understated. For example, consider the testimony of Dr. Carrie Miles before the Oregon Legislature detailing her personal experience as a defendant in a nearly $47 million lawsuit which arose from a 20-minute visit with the plaintiff's mother. *Hearing on HB 2014 Before the S. Comm. on Judiciary*, 80th Sess. (Or. 2019) (statement of Dr. Carrie Miles). Even though the jury found for the defense, the potential for tens of millions in liability and resulting stress on the doctor, her partners, patients, and family was "terrifying," and she considered leaving the state and the practice of medicine. *See, also*, Michelle M. Mello, *et al.*, *National Costs of the Medical Liability System,* 29:9 Health Affairs 1569, 1574 (2010) (discussing the reputational and emotional toll on clinicians).

Regardless of merit, it takes significant resources to evaluate and defend malpractice claims, even those that are unfounded. Jose Guardado, *Medical Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition 2006-2015*, AMA Policy Research Perspectives, 1, 4 (2018).

The liability climate contributes to rising medical liability premium rates, causing further problems for access to healthcare. Allen Hardiman, *Upward Trajectory of Medical Liability Premiums Persists for Sixth Year in a Row*, AMA Policy Research Perspectives, 1, 2 (2025) ("The overall picture is a clear upward trend in medical liability premiums

since 2019."); Jose Guardado, *Medical Professional Liability Insurance Premiums: An Overview of the Market 2009-2018,* AMA Policy Research Perspectives 1, 4 (2019) (In 2009 nearly thirty six percent of premiums rates decreased, in 2018 only five percent decreased. Conversely, the number of rates that increased in 2018 was double the number that increased in 2009.).

Tort liability has expanded significantly, increasing the risk of exposure for medical professionals. In the 1960s, tort liability came to be viewed as the third-party insurer of society, compensating injured parties that did not or could not acquire insurance themselves. In the 1970s the medical liability insurance industry experienced a period of crisis when several private insurers left the market due to rising claims and inadequate rates. American Medical Association, *Medical Liability Reform Now!, 7* (2025). This exodus created an availability and affordability crisis for medical providers. *Id*. at 7-8.

In the 1980s there were reports of extraordinary changes in commercial casualty insurance markets. *See* George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 Yale L.J. 1521 (1987). This crisis, characterized by a lack of affordability, shook the medical liability market as claim frequency and severity increased. AMA, *MLR* at 8. Premiums increased drastically for some products and services and, for some, insurers even refused to offer coverage at any premium. Priest, *supra*, at 1521.

The affordability crisis had a dramatic effect on physicians. Those in specialities such as obstetrics and gynecology cut back on high-risk procedures and

high-risk patients to reduce risk and temper their premiums. Physicians in high risk, high premium locales even closed their practices. AMA, *MLR* at 8. The insurance crisis rippled across the country, creating great concern, and prompting assessment and action. In part because the risk of liability continues to increase, there are physician shortages throughout the country. Shortages are especially pronounced for rural areas and for underserved populations.[3] The omnipresent cloud of potential liability impacts where physicians decide to practice, their chosen specialty, what procedures they will perform, and in certain cases even *if* they will practice at all. Brenda E. Sirovich, MD, MS, Steven Woloshin, MD, MS, & Lisa M. Schwartz, MD, MS, *Too Little? Too Much? Primary Care Physicians' Views on US Health Care*, 171:17 Archive of Internal Med., 1582 (2011); *see also* Massachusetts Medical Society, *Massachusetts Medical Society's 2013 Physician Workforce Study Shows Physician Shortages, Difficulty in Recruiting* (2013).

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[3] There are nationwide shortages that adversely affect the delivery and quality of care. *See* William F. Rayburn, MD, MBA, FACOG, *The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications, 2017*, Am. Coll. Of Obstetricians and Gynecologists, 4 (2017) (half of the counties in the United States already do not have any obstetrician-gynecologists). Shortages often occur in areas and ways that affect the most vulnerable populations. For example, the shortage of OBGYNs and family practice physicians greatly affects access to healthcare for women and underserved communities. Shortages increase with increased risk for liability. Eric Helland & Mark H. Showalter, *The Impact of Liability on the Physician Labor Market*, 52:4 J. of L. and Econ. 635, 655 (2009).

In 1986, the U.S. Department of Justice issued a "*Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability*," attributing the crisis to modern tort law's expansion of corporate liability. Priest, *supra,* at 1523. The Justice Department Report analyzed the "veritable explosion of tort liability," related changes in the law, and the "explosive growth" in damages awards, particularly with respect to noneconomic damages. DOJ, *Report*, at 200-01. The report included specific data about the increases with respect to medical malpractice premiums and verdicts. *Id.* at 220, 234-35.

As a result, within 18 months, "on the basis of the Department's and other attributions of the crisis to tort law, forty-two states [had] enacted tort reform or insurance legislation." Priest, *supra*, at 1523;. *see* Nat'l Conf. of State Legislatures, *Selected State Legislative Action Re: Affordability and Availability of Liability Insurance* (August 4, 1986). State affidavit of merit requirements, like ceilings on noneconomic damages, the elimination of no-fault joint liability in favor of several liability or limits on attorneys' contingent fees to a sliding scale, are all examples of substantive state legislation aimed at reform and enforceable in federal court.

Still again, in the early 2000s, liability premiums skyrocketed and access to care was threatened. At the height of this crisis 45% of hospitals reported that it affected their provision of emergency services and loss of physicians. AMA, *MLR* at 8. The American College of Obstetricians and Gynecologists reported that the lack of affordable coverage resulted in 70% of its physicians' making changes to their practices. *Id.*

The crisis also affected medical students, influencing their choice of speciality. *Id.* Lack of access is a public health crisis, one that is worsened when limits on liability are eliminated. Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Servs., *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care,* 11 (2003).

Challenges to access and affordability of healthcare continue, as do the calls for medical liability reform.[4] Given these challenges, it is no surprise that state legislatures enact reforms, like Delaware's affidavit of merit statute, to address their concerns and the significant cost to public health from meritless litigation. *See* Deanna Arpi Youssoufian, *The Rules of the Malpractice Game: Affidavit of Merit Statutes, Erie, and the Cautionary Tale of an Overbroad Application of Rule 11*, 87 Brook. L. Rev. 1459, 1462 (2022); Michelle Mello, et al., *National Costs of the Medical Liability System*, 29 Health Aff. (Mill-wood) 1569, 1574 (Sept. 2010); U.S. Congress,

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[4] For example, there is growing concern over the prevalence of "nuclear verdicts," and how they can be addressed. A nuclear verdict is a verdict of more than $10 million. Nuclear verdicts are being awarded with more frequency across the country. *See Nuclear Verdicts, An update on Trends, Causes, and Solutions*, Cary Silverman and Christopher E. Appel, Shook, Hardy & Bacon LLP (2024). Such verdicts are often reduced post-trial or on appeal. *Id.* Nuclear verdicts have a negative effect on society and the civil justice system. They result in instability in industries in which they occur, distort the public's view of the civil tort system, undermine the rule of law, result in increased premiums for insurance coverage or lack of availability of the same, perpetuate unreasonable settlement demands, and result in prolonged litigation and unnecessary appeals. *Id.*

Joint Economic Committee Study: *Liability for Medical Malpractice: Issues and Evidence*, 2 (May 2003).

### B. Responding to the challenges: medical liability reform.

For patients to be able to receive quality healthcare and for our healthcare system to continue functioning, there must be reasonable limits on liability. State law, historically and currently, imposes and defines those limits.

Affidavit of merit requirements are adopted by states in furtherance of efforts at medical liability reform. The intended result is to decrease the number of unsubstantiated lawsuits against physicians in favor of affordable liability insurance, thereby reducing physician shortages and healthcare costs and increasing access to quality care for patients. *See e.g., Cichos v. Dakota Eye Inst., P.C.*, 933 N.W.2d 452, 461–62 (N.D. 2019) ("Section 28-01-46, N.D.C.C., was 'enacted to prevent an actual trial in such cases where a medical malpractice plaintiff cannot substantiate a basis for the claim.' *Pierce v. Anderson*, 912 N.W.2d 291, 295 (N.D. 2018). The purpose is an 'attempt[ ] to minimize frivolous claims by requiring the plaintiff to produce an expert opinion to support the allegations of the negligence in the early stages of litigation.' *Cartwright v. Tong*, 896 N.W.2d 638, 642 (N.D. 2017)"); *Stroud v. Hennepin Cnty. Med. Ctr.*, 556 N.W.2d 552, 555 (Minn. 1996) ("The Minnesota legislature enacted Minn. Stat. § 145.682 for the purpose of eliminating nuisance medical malpractice lawsuits by requiring plaintiffs to file affidavits verifying that their allegations of malpractice are well-founded. *Oslund v. United States,* 701 F.Supp. 710, 712 (D.Minn. 1988).").

Twenty-eight states have enacted some type of affidavit of merit requirement. *See* Ariz. Rev. Stat. Ann. § 12-2603; Colo. Rev. Stat. § 13-20-602; Conn. Gen. Stat. § 52-190a; Del. Code Ann. tit. 18, § 6853; Fla. Stat. Ann. § 766.104; Ga. Code Ann. § 9-11-9.1; Haw. Rev. Stat. Ann. § 671-12.5; 735 Ill. Comp. Stat. Ann. § 5/2-622; Md. Code Ann., Cts. & Jud. Proc. §3-2A-04; Mich. Comp. Laws Ann. § 600.2912d; Minn. Stat. Ann. § 145.682; Miss. Code Ann. § 11-1-58; Mo. Ann. Stat. § 538.225; Nev. Rev. Stat. Ann. § 41A.071; N.J. Stat. Ann. § 2A:53A-27; N.Y. C.P.L.R. 3012-a; N.D. Cent. Code Ann. § 28-01-46; Ohio Rev. Code Ann. § 2323.451; Okla. Stat. tit. 12, § 19.1 (held unconstitutional by *John v. Saint Francis Hospital, Inc.*, 405 P.3d 681 (Okla. 2017)); Pa. R. Civ. P. No. 1042.3; S.C. Code Ann. § 15-36-100; Tenn. Code Ann. §29-26-122; Tex. Civ. Prac. & Rem. Code Ann. § 74.351; Utah Code Ann. § 78B-3-423; Vt. Stat. Ann. tit. 12, § 1042; Va. Code Ann. § 8.01-20.1; Wash. Rev. Code Ann. § 7.70.150 (Repealed by Wash. Laws 2023, ch. 102, § 10, eff. July 23, 2023); W. Va. Code Ann. § 55-7B-6. Several states require that the affidavit or certification of merit be filed toward the beginning of the lawsuit, at the time the complaint is filed, or within a few months of initiation of the lawsuit, as in Delaware. *See* Fla. Stat. Ann. § 766.104; Mich. Comp. Laws Ann. § 600.2912d; Minn. Stat. Ann. § 145.682; Miss. Code Ann. 11-1-58; S.C. Code Ann. § 15-36-100; Va. Code Ann. § 8.01-20.1; W. Va. Code Ann. § 55-7B-6. Other statutes require the plaintiff to file the affidavit with initial discovery disclosures while others require it to be filed when the defendant files an answer. *Compare* Ariz. Rev. Stat. Ann. § 12-2603 *with* N.J. Stat. Ann. § 2A:53A-27. Still others have other prelitigation requirements, such as medical panels that must be consulted before litigation can be

filed. *See e.g.*, Idaho Code Ann. § 6-1001; N.M. Stat. Ann. § 41-5-15; Haw. Rev. Stat. Ann. § 671-12.

### C. Medical malpractice affidavit of merit laws are an integral part of state substantive policy governing healthcare access, affordability, and quality.

State statutes governing malpractice actions and providing who can recover, how, when, and for what, are a critical part of the state's response to concerns about affordability and accessibility of healthcare for its citizens. The idea that states are laboratories of innovation is particularly true in healthcare. States work on innovative ways to enact reform in efforts to curtail the unpredictability of expansive tort liability. Failing to defer to state substantive law defining a medical malpractice cause of action does not give proper deference to the state's prerogative. States must be allowed to continue to do this work, and it must be given effect, if our healthcare system is going to adapt and improve.

States differ in what type of medical malpractice claims they permit. For example, some states permit claims for "loss of chance," where the plaintiff claims their injury is a lost opportunity for a better outcome rather than a physical injury. *Smith v. Providence Health & Servs.—Oregon,* 393 P.3d 1106, (Or. 2017) (recognizing a claim where plaintiff alleges defendant did not cause his stroke but caused him not to receive treatment in a timely fashion that caused loss of an opportunity for a better recovery from the stroke); *See* Lauren Guest, David Schap, and Thi Tran, *The "Loss of Chance" Rule as a Special Category of Damages in Medical Malpractice: A State-by-State Analysis,* 21 J. Legal Econ. 53, 58-60 (2015) (reviewing case law as of

2014 and concluding that 41 states had addressed loss of chance, with 24 states having adopted some version of the theory).

A few states even allow claims for "wrongful life," meaning a claim by a child that they were born with a certain defect or disease that had it been diagnosed in utero, they would not have been born. *See e.g.*, *Tomlinson v. Metro. Pediatrics, LLC*, 412 P.3d 133, 147 (Or. 2018) (refusing to recognize a medical malpractice claim for wrongful life and explaining that "[t]he vast majority of courts that have considered the question have refused to recognize such claims. *See Willis v. Wu*, 607 S.E.2d 63, 68-69 (S.C. 2004) (Twenty-seven states, by judicial opinion, statute, or both, have either refused to recognize or limited a wrongful life action. Three states * * * have allowed such a cause of action.')." States also differ on the outer limits of tort liability for medical malpractice, for example, in areas of vicarious liability and agency or whether a third party to a physician-patient relationship can sue for malpractice.

However, the universal and fundamental requirement to sustain a medical malpractice case is the requirement of medical expert support. *Coleman v. United States*, 912 F.3d 824 (5th Cir. 2019) (Federal Rule of Evidence 601 requires federal courts to apply state rules to determine expert witness competency in medical malpractice claims that turn on questions of substantive state law); Heather Morton, *Medical Liability/Malpractice Merit Affidavits and Expert Witness*, Nat'l Conf. of State Legislatures, (Aug. 11, 2021). The need for expert support goes to the heart of any claim. For those defending these claims, it is expected that a claim will be reviewed by an expert, and supported by an expert, before a lawsuit is ever

filed. There is no good faith basis for a medical malpractice claim unless it has been reviewed and validated by a qualified medical expert, save in very narrow circumstances. Delaware's affidavit of merit statute, for example, makes an exception for cases that traditionally fall under the *res ipsa loquitur* doctrine and would not need an expert for a plaintiff to prevail on them. Del. Code Ann. tit. 18, § 6853(e). This includes, for example, cases that involve left-behind surgical instruments or an operation on the wrong body part.

In every other medical malpractice case, a plaintiff is required to put forth their evidence, in the form of the testimony of experts, to support their claims that the defendant breached the standard of care and caused the harm. Whether the expert is of the right type such that they are qualified to testify about the school of medicine invoked by the care or procedure at issue, whether their credentials are sufficient, and what they testify to are not "satellite" issues, rather they go to the crux of the allegations and the ultimate issues the factfinder will decide: negligence and causation. Expert support is determinative. An affidavit of merit statute is one way a state requires the plaintiff to answer the ultimate question of whether they can prove their case.

This is not a barrier to otherwise meritorious claims nor is it a surprise to the attorneys who practice in this area. A prospective plaintiff can access their medical records, for any reason. HIPAA Privacy Rule, 45 C.F.R. § 164.524 (2024). Obtaining the pertinent medical records and having them reviewed is often the first task of the lawyer agreeing to evaluate the case. That is the expectation and the

standard practice. The fact that some states require expert support, a fundamental aspect that goes to the merits of the case, to be secured and communicated at the outset, rather than at summary judgment, for example, is the state's prerogative to decide and is not in conflict with the Federal Rules. It is not a special or heightened pleading requirement, it is a tool used by the state to ensure the claim is supported and to weed out those that are not, before they drain more resources from an overburdened system.

Regardless of state variances, a typical medical malpractice case involves substantive questions of state law, such as:

- Does the duty of the defendant to meet the standard of care extend to this plaintiff? (E.g., can the defendant physician be held liable to people *other* than their patients for professional negligence).
- What are the standards of proof for negligence and causation?
- Does a state immunity statute preclude imposing liability on the defendant? *See e.g.*, *Cederberg v. Legacy Health*, No. 3:18-CV-02044-HZ, 2020 WL 5809991 (D. Or. Sept. 28, 2020) *aff'd*, No. 20-35907, 2022 WL 832067 (9th. Cir. Mar. 21, 2022).
- Are there state privileges that apply, e.g., peer review or quality assurance privilege?
- Is there comparative or contributory fault, is it joint or several, who is on the verdict form, and how is fault allocated?
- How far does vicarious liability extend? (E.g., is a hospital liable for the negligence

of an independent physician member of the medical staff? What are the rules for apparent agency, is it a "captain of the ship" state?).

- What damages are recoverable? (E.g., standards for noneconomic damages, punitive damages, collateral source rules).

Federal courts look to state law to supply answers to those questions. The answers reflect how a state imposes boundaries on tort liability, and its policy and efforts to control healthcare costs and ensure availability and access to quality healthcare for their citizens. Just as a damages cap or rejecting joint liability in favor of several liability is a policy decision of a state with respect to its tort law, so are affidavit of merit requirements.[5]

## III. Medical malpractice claims in federal court.

State medical malpractice claims arrive in federal court in a variety of ways. As here, federal courts are the forum when there is diversity. They are also the

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[5] States with limits on noneconomic damages enjoy a positive impact among surgical and support specialists locating in rural counties. David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 36:2 J. Legal Stud. Univ. of Chicago Press, 36:2, 143-182 (2007) (for surgical and support specialties, rural counties in states with limits had about 10 percent more physicians per capita than rural counties in states without limits). Allen Kachalia, MD, JD & Michelle M. Mello, JD, PhD, *New Directions in Medical Liability Reform*, 364 N. Engl. J. Med. 1564, 1566 (2011) (studies of limits on noneconomic damages have nearly uniformly found limits are an effective means of reducing the size of indemnity payments).

forum in federal question[6] cases in which the state malpractice claim is pendent to a federal claim,[7] and for malpractice claims against the federal government under the Federal Tort Claims Act (FTCA).[8] When federal entities are providing healthcare via a Veteran's Administration hospital, in a correctional institution or at a Federally Qualified Health Center, for example, claims filed under the FTCA must be in federal court.[9] The federal district courts regularly

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[6] When a district court exercises pendent jurisdiction over state claims pursuant to 28 U.S.C. § 1367, it applies state law as if deciding a diversity case. *See Felder v. Casey*, 487 U.S. 131, 151 (1988) ("[W]hen a federal court exercises diversity or pendent jurisdiction over state law-claims, 'the outcome of the litigation in the federal court should be substantially the same, so far as legal rules determine the outcome of a litigation, as it would be if tried in a State court.'" (quoting *Guaranty Trust Co. v. York*, 326 U.S. 99, 109 (1945))).

[7] Litigants, often those that are *pro se*, attach state medical malpractice claims to other claims arising under myriad federal statutes, including, *e.g.*, the Emergency Medical Treatment and Labor Act (EMTALA) 42 U.S.C. § 1395dd (2018) and the Health Insurance Portability and Accountability Act (HIPAA) 42 U.S.C. § 1320d (2018). Notwithstanding such federal statutes do not provide for a private cause of action, plaintiffs nonetheless use them as access points to federal court and once there, the district courts often retain jurisdiction of the state law medical malpractice claims even when other claims are dismissed.

[8] 28 U.S.C. §§1346(b).

[9] "Generally, sovereign immunity prevents the United States from being sued without its consent." *Iverson v. United States*, 973 F.3d 843, 846 (8th Cir. 2020) (cleaned up). "Congress waived the United States' sovereign immunity for claims arising out of torts committed by federal employees." *Ali v. Fed. Bureau of Prisons*, 552 U.S. 214, 217–18 (2008). "The applicable tort law is 'the law of the place where the act or omission occurred.'" *Wright v. United States*, 892 F.3d 963, 966 (8th Cir. 2018) (quoting 28 U.S.C. § 1346(b)(1)).

and routinely adjudicate these claims, looking to and applying state substantive law.

Tort law generally and healthcare regulation specifically are traditional state functions. Medical, legal, and insurance practices are highly localized. Physicians often practice in a single state, licensed by their state medical board. Liability insurers write state-specific, or even locale-specific policies, and jurisdictional rules limit plaintiffs to the forum in which they were allegedly injured. Accordingly, medical malpractice falls within the states' jurisdiction and sovereignty. *See* Gary T. Schwartz, *Considering the Proper Federal Role in American Tort Law*, 38 Ariz. L. Rev. 917, 922 (1996). The requirements to bring a medical malpractice claim, what is needed to prevail, who can be held liable, and what damages are recoverable, to name a few, are all dictated by state substantive law.

## IV. Consistent with the *Erie* doctrine, applying state affidavit of merit statutes in federal court ensures uniformity and gives effect to federalism principles.

The Tenth Amendment guarantees to the states the function of defining the requirements for state law causes of action. U.S. Const. amend. X; *Erie*, 304 U.S. at 78-79. The outcome the petitioner seeks would impair the state's ability to perform that function reserved to it by the constitution. Concluding that Delaware's affidavit of merit statute has no application in federal court would involve ignoring "a requirement imposed by a separate sovereign in its effort to fashion a state cause of action that strikes the right balance between insurance costs and affordable healthcare[.]" *Pledger v. Lynch*, 5 F.4th 511, 528 (5th

Cir. 2021) (Quattlebaum, J., concurring in part and dissenting in part). That cannot be the correct answer.

The *Erie* doctrine requires a federal court sitting in diversity jurisdiction to apply state substantive law and federal procedural law. *Erie*, 304 U.S. 77-79 (1938). "There is no federal general common law." *Id.* at 78. This doctrine "preserves the autonomy and independence of the states" and ensures that the outcome of the case will not differ because of the forum. *Id.*

The Third Circuit concluded that Delaware's section 6853 did not conflict with FRCP 8, 9, 11, or 12. *Berk v. Choy*, Case No. 23-2620, 2024 WL 3534482, at *2-3 (3d Cir. Jul. 25, 2024). The Third Circuit was correct; there is no conflict with the Federal Rules. It can exist side by side with the Federal Rules. The statute is substantive, and it should be applied in this federal court action

Regardless of whether a plaintiff brings a medical malpractice action in state or federal court, it should be governed by the substantive components of the state cause of action and the outcome should be the same. *See Hanna v. Plummer*, 380 U.S. 460, 471-472 (1965) ("The *Erie* rule is rooted in part in a realization that it would be unfair for the character of result of a litigation materially to differ because the suit had been brought in a federal court."). It undermines *Erie* to allow a cause of action that would be dismissed if filed in state court to continue if filed in federal court.

Concluding that Delaware's affidavit of merit requirement should not be enforced in federal court would lead to improper forum shopping. This concern is particularly keen because, although physicians may

practice in a single state, those located near interstate borders may find themselves sued in federal court to avoid a state's more stringent affidavit of merit requirement than that of a neighboring state. In contrast, giving effect to an affidavit of merit statute serves the twin aims of *Erie* by prohibiting unfair forum shopping and promoting federalism concerns. *Id.* at 468.

Concluding that Delaware's affidavit of merit statute conflicts with the Federal Rules and therefore is inapplicable in federal court would effectively invalidate similar statutory requirements in an end-run around the judgments of state policymakers on matters of substantive state law. "Supervision over either the legislative or the judicial action of the states is in no case permissible except as to matters by the constitution specifically authorized or delegated to the United States. Any interference with either, except as thus permitted, is an invasion of the authority of the state, and, to that extent, a denial of its independence. *Erie*, 304 U.S. at 78-79 (cleaned up). In these matters, the voice of the state "should utter the last word." *Id.* at 79.

## CONCLUSION

For these reasons, and those stated by respondents, the decision of the Court of Appeals should be affirmed.

Respectfully submitted,

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