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 AMICI CURIAE INSURANCE COMPANIES, TRADE ASSOCIATIONS, AND NON-PROFIT ORGANIZATION WITH AN INTEREST IN PRESERVING ACCESS TO QUALITY, AFFORDABLE HEALTHCARE IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE[1]

The following insurance providers, trade associations, and non-profit organization with an interest in medical liability reform ("Amici") file this brief:

Insurance Companies, which collectively write over 20% of medical negligence policies nationwide.[2]

- CNA Insurance
- COPIC Insurance Company
- Curi Malpractice Insurance
- The Doctors Company
- Physicians Insurance
- ProAssurance

Trade Associations, which collectively represent the interests of the medical professional liability insurance industry nationwide.

- American Property and Casualty Insurance Association
- The Medical Professional Liability Association
- National Association of Mutual Insurance Companies

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[1] Pursuant to Rule 37.6, Amici state that no party, counsel for any party, or any person other than Amici and their counsel authored this brief or made any monetary contribution for its preparation or submission.

[2] These carriers are competitors and are collectively Amici solely for this brief.

Non-Profit Organization, American Tort Reform Association, which is dedicated to reforming the civil justice system, including medical liability.

These Amici have a strong interest in enforcing laws like the affidavit of merit statute at issue here. By reducing meritless lawsuits, these statutes preserve access to quality, affordable healthcare. The substantive protections and rights these statutes afford should be available to all physicians, not only those sued in state court. Any other rule endangers the healthcare these statutes protect. Amici therefore respectfully urge this Court to hold that Delaware's affidavit of merit statute applies in diversity jurisdiction cases in federal court.

INTRODUCTION AND SUMMARY OF ARGUMENT

A clear majority of states (twenty-eight) have affidavit of merit statutes.[3] John D. North, *Tort Reform-Certificate of Merit*, 9 BUS. & COM. LITIG. FED. CTS. § 103:31 (5th ed. 2021). These statutes embody important state interests and policies. They grant physicians substantive protection from meritless medical negligence claims by imposing a prerequisite that must be satisfied before a litigant can pursue a claim.

[3] States with analogous statutes require either an expert or practitioner in the field to provide an affidavit or a certificate of merit or review. Amici refer to these statutes interchangeably as affidavit of merit statutes or certificate of review statutes.

Whether these statutes apply in federal court turns on the rule the Court adopts here. Amici urge this Court to clarify that *Shady Grove Orthopedic Associates, P.A. v. Allstate Insurance Co.*, 559 U.S. 393 (2010), represented a straightforward application of the rule set forth in *Hanna v. Plumer*, 380 U.S. 460, 472 (1965), and applied in *Walker v. Armco Steel Corp.*, 446 U.S. 470, 749 (1980), and *Burlington Northern Railroad Co. v. Woods*, 480 U.S. 1, 4–5 (1987)—namely, that a federal rule controls over a state requirement only if there is a "direct collision" or "clash" between the two displacing the state requirement.

ARGUMENT

State affidavit of merit statutes like 18 Del. C. § 6853 are not a pleading standard or any other procedural rule. They are substantive laws embodying important state interests and policies—specifically to grant physicians substantive protection from meritless medical negligence claims by requiring a prerequisite before those claims can proceed. *See* 18 Del. C. § 6853(a)(1)–(2). States passed these laws, among other reforms, to protect against exceedingly costly medical negligence claims and judgments that threatened both physicians and this country's medical insurance industry in the latter half of the 20th century. The risk against which these statutes protect—that healthcare will become expensive and scarce—remains a threat today.

Amici urge this Court to affirm that the direct collision rule from *Hanna* and its progeny applies.

This allows affidavit of merit statutes to continue protecting the important interests they serve—no matter the forum where litigation occurs.

I. State Legislatures Enacted Affidavit of Merit Statutes to Prevent Meritless Lawsuits That Threaten the Availability of Quality, Affordable Healthcare.

Affidavit of merit statutes are far from a procedural rule. They embody important state interests and policies intended to protect physicians from meritless medical negligence claims. This, in turn, assures access to quality, affordable healthcare.

A. The Rise of "Nuclear" Verdicts Awarding Excessive Noneconomic Damages for Pain and Suffering Incentivized Meritless Lawsuits and Created an Insurance Crisis.

Historically, noneconomic damages awards for pain and suffering were modest and did not eclipse a plaintiff's economic damages. *See* Ronald J. Allen & Alexia Brunet, *The Judicial Treatment of Noneconomic Compensatory Damages in the 19th Century*, 4 J. EMPIRICAL LEGAL STUD. 365, 397–98 (2007), https://doi.org/10.1111/j.1740-1461.2007.00092.x (concluding that "no tort case prior to 1900" permitted a non-economic compensatory damages award that exceeded $450,000 in current dollars). Prior to 1900, courts "maintained substantial control over damage awards, keeping them remarkably in line." *Id.* at 398 (observing that as noneconomic damage awards increased, so too did the probability of reversal).

This trend began to shift in the 1950s. Victor E. Schwartz & Cary Silverman, *The Case in Favor of*

Civil Justice Reform, 65 EMORY L.J. ONLINE 2065, 2066 (2016). Plaintiffs' lawyers developed strategies for increasing noneconomic damages awards. *See* Melvin M. Belli, *The Adequate Award*, 39 CAL. L. REV. 1 (1951) (detailing tactics for increasing non-economic damages and advocating for less judicial review and revision of jury awards). Among these tactics were demonstrative evidence, such as graphic pictures or other visual aids, to invoke a jury's sense of empathy toward a plaintiff and outrage against the defendant. Schwartz & Silverman, *supra* at 2066. As a result, the size of pain and suffering awards increased "from modest amounts to six-figure awards that sometimes reached millions of dollars." *Id.*; *see also* Phillip L. Merkel, *Pain and Suffering Damages at Mid-Twentieth Century: A Retrospective View of the Problem and the Legal Academy's First Responses*, 34 CAP. U.L. REV. 545, 560–65 (2006) (describing history of post-World War II pain and suffering awards and jurisprudence).

By the 1970s, noneconomic damages were the largest component of jury awards in personal injury cases. Merkel, *supra* at 565. It became a "well-known fact of courtroom life that in personal injuries litigation the intangible factor of 'pain, suffering, and inconvenience' constitutes the largest single item of recovery, exceeding by far the out-of-pocket 'specials' of medical expenses and loss of wages." *Nelson* v. *Keefer*, 451 F.2d 289, 294 (3d Cir. 1971). These large, multi-million-dollar verdicts are called "nuclear" because the "verdict can have devastating impacts on businesses, entire industries, and society at large[.]" Cary Silverman & Christopher E. Appel, *Nuclear Verdicts: An Update on Trends, Causes, and Solutions*,

U.S. Chamber of Com. Ins. for Legal Reform at 2 (May 30, 2024), https://instituteforlegalreform.com/wp-content/uploads/2024/05/ILR-May-2024-Nuclear-Verdicts-Study.pdf.

Around the same time, attorney advertising, which had historically been prohibited, was permitted. *See Bates v. State Bar of Ariz.*, 433 U.S. 350, 382–83 (1977). This allowed attorneys to advertise large jury verdict awards with the hopes of attracting similarly situated clients desiring the same result. *See*, *e.g.*, Silverman & Appel, *supra* at 39–40 (explaining how allowing attorney advertising has inundated the public and jury pool with ads "touting nuclear verdicts").

The negative effect this trend had on healthcare—and more specifically the cost and availability of medical malpractice insurance—was devastating. Physicians and their insurers faced a crisis. Plaintiffs were filing meritless lawsuits and juries were awarding excessive verdicts, requiring medical liability insurers to pay greater defense costs and indemnity payments.

This drove up insurance premiums and caused many physicians to lose insurance coverage. Insurance premiums increased as much as 400% and some carriers refused to extend coverage to some physicians. A detailed survey of the medical malpractice insurance market written in the early 1970s reported:

> The cost of a constant level of medical malpractice insurance coverage increased sevenfold for physicians, ten-fold for surgeons, and five-fold for hospitals between 1960 and 1972. The areas which showed the greatest

> increase in the cost of constant coverage over these years were California and New York City which increased over twenty-five percent faster than the nation.

James R. Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 J. LAW & CONTEMP. PROBS., no. 2, Spring 1986, at 38 (quoting Mark Kendall & John Haldi, *The Medical Malpractice Insurance Market*, U.S. Dep't of Health, EDUC. & WELFARE, REPORT OF THE SEC'Y'S COMM'N ON MEDICAL MALPRACTICE & APP. at 494 (1973)).

In what would become a historic moment, in May of 1975, a group of 307 northern California anesthesiologists refused to renew their insurance policies or practice without coverage. Instead, they simply walked off their jobs. *Medicine: Crisis in California*, TIME, May 19, 1975, https://time.com/archive/6878482/medicine-crisis-in-california/. Operating rooms at over forty-five hospitals in the San Francisco Bay Area were "unusually quiet" while all but essential procedures screeched to a halt. *Id.* Patient care suffered for the next month. *Id.*

B. State Legislatures Enacted Statutory Reforms to Address This Crisis and Protect Access to Quality, Affordable Healthcare.

This nearly month-long physician strike resulted in the California Legislature enacting the Medical Injury Compensation Reform Act ("MICRA"), a first-of-its-kind law. *See Am. Bank & Tr. Co. v. Cmty. Hosp. of Los Gatos-Saratoga, Inc.*, 683 P.2d 670, 672 (Cal. 1984) ("In May 1975, the Governor—citing serious problems that had arisen throughout the state as a

result of a rapid increase in medical malpractice insurance premiums—convened the Legislature in extraordinary session to consider measures aimed at remedying the situation.").

MICRA is characterized as "the gold standard for medical liability insurance reform" by the American Medical Association ("AMA"). AMA, Tanya Albert Henry, *California's MICRA law modernized after nearly 50 years* (Jun 7, 2022), https://www.ama-assn.org/practice-management/sustainability/california-s-micra-law-modernized-after-nearly-50-years. MICRA, through its various statutory provisions, "helps provide predictability for insurers, and in turn, creates a more stable and affordable medical liability insurance market for physicians[.]" *Id*. Consequently, MICRA "helps maintain patient access to high-quality physician care." *Id*.

State legislatures nationwide quickly enacted similar statutory reform schemes embodying the same state interests and policy decisions. The Delaware General Assembly was among them, passing its initial medical malpractice statute in 1976. 60 Del. Laws ch. 373 § 1 (1976). Delaware's amended medical malpractice statute, enacting its affidavit of merit provision, went into effect in 2003. *See* 18 Del. C. § 6853 (hereafter "§ 6853"). Its intent is to fulfill the same promise of stability as prior reform statutes and "reduce the filing of meritless medical negligence claims" in Delaware. *Beckett v. Beebe Med. Ctr., Inc.*, 897 A.2d 753, 757 (Del. 2006).

Other states enacted similar statutes for the same purpose. *See, e.g.*, *Rasor v. Nw. Hosp., LLC*, 403 P.3d 572, 576–77 (Ariz. 2017) (explaining Arizona's affidavit of merit statute is intended to "lead[] to prompt

resolution of meritless [medical negligence] cases without unnecessarily wasting time or resources"); *Kukral v. Mekras*, 679 So.2d 278, 284 (Fla. 1996) (observing Florida's statute is intended to "alleviate the high cost of medical negligence claims through early determination and prompt resolution of claims").

These statutes require some form of certificate of merit or review from a qualified expert be provided to the trial court before or shortly after a medical malpractice action is filed. Typically, the failure to comply with these requirements is fatal. *See*, *e.g.*, Ariz. Rev. Stat. § 12-2603; Colo. Rev. Stat. § 13-20-602; Conn. Gen. Stat. § 52-190a; Fla. Stat. § 766.104; Ga. Code § 9-11-9.1; Haw. Rev. Stat. § 671-12.5; 735 Ill. Comp. Stat. 5/2-622; Iowa Code Ann. § 147.140; Ky. Rev. Stat. § 411.167; Md. Code § 3-2A-04; Mich. Comp. Laws § 600.2912d; Minn. Stat. Ann. § 145.682; Miss. Code § 11-1-58; Mo. Rev. Stat. § 538.225; Nev. Rev. Stat. § 41A.071; N.J. Stat. Ann. § 2A:53A-27; N.Y. C.P.L.R. § 3012-a; N.C. R. Civ. Proc. 9(j); N.D. Cent. Code § 28-01-46; Ohio Rev. Code § 2323.451; S.C. Stat. § 15-36-100; Tenn. Code Ann. § 29-26-122; Tex. Civ. Prac. & Rem. Code § 74.351; Va. Code Ann. § 8.01-20.1; W. Va. Code § 55-7B-6.

C. Meritless Claims Remain a Problem These Statutes Prevent.

These types of professional review statutes continue to serve an important purpose in the current medical liability system. A 2023 AMA research paper found 31% of all physicians have been sued in their careers and that claim frequency increased for general surgeons, obstetrician/gynecologists, and male physicians. Jose R. Guardado, *Medical Liability Claim Frequency*

Among U.S. Physicians, AMA ECON. & HEALTH POLICY RSRCH. 7–8 (2023), https://www.ama-assn.org/system/files/policy-research-perspective-medical-liability-claim-frequency.pdf. "It seems to be just a matter of time, or more specifically, of longer exposure before a physician is sued." *Id*. at 7.

This high frequency of claims does not mean these physicians are practicing bad medicine. Many of these lawsuits are meritless. Between 1988 and 2022, approximately 64% of medical professional liability claims were dropped, withdrawn, or dismissed without any payment to the plaintiff "because they lacked merit." Michael C. Stinson, *Medical Professional Liability: Trends in Claims and Legislative Responses*, PHYSICIAN LAW: EVOLVING TRENDS & HOT TOPICS 2025, at 114–15 & fig. 6 (Wes M. Cleveland ed., American Bar Association 2025); *see also* AMA, *Medical Liability Reform Now! 2025*, at 4 (2025) (hereafter "*Reform Now!*") (citing a Medical Professional Liability Association ("MPLA") 2019 study with data showing consistent percentages from 2016-2018). This means that "nearly two-thirds of all claims filed each year eat up valuable resources that could be used to compensate truly injured patients, but instead were simply wasted." Stinson, *supra*, at 114 (estimating expense per claim to be approximately $24,000).

The AMA confirms how frequently claims of alleged medical negligence are meritless. The AMA evaluated the findings of several studies on the subject. It observed first that a 2011 study published in the New England Journal of Medicine concluded 78% of claims did not result in an indemnity payment. *Reform Now!*, *supra* at 2 (citing Anupam B. Jena, et al., *Malpractice risk according to physician specialty*,

365 N. ENGL. J. MED. 629, no. 7 (August 18, 2011), https://www.nejm.org/doi/10.1056/NEJMsa1012370). It then observed that another study found 54% of litigated claims (*i.e.*, claims in which defense costs were incurred) were dismissed by the court and that only 55% of claims qualified as "litigated" at all. *Id.* (citing Anupam B. Jena, et al., *Outcomes of medical malpractice litigation against U.S. physicians*, 172 ARCH. INTERN. MED. 892, no. 11 (June 11, 2012), https://www.doi.org/10.1001/archinternmed.2012.1416).

Affidavit of merit statutes likely contributed to these outcomes because they help to weed out meritless claims "without having to go through the initial, and expensive, stages of litigation." Stinson, *supra* at 120. Put simply, these statutes work. *See* Amanda Wagner, *Malpractice Consult: Affidavits of merit and why they matter*, UROLOGY TIMES J., v. 50 No. 4 (April 7, 2022), https://www.urologytimes.com/view/malpractice-consult-affidavits-of-merit-and-why-they-matter (noting "the amount of medical malpractice cases has decreased since states began enacting this reform measure"); Pamela Valenza, *Certificates of merit – a means to reduce frivolous lawsuits*, INT'L J. OF ACADEMIC MEDICINE (Jan.-Jun. 2017), https://www.doi.org/10.4103/IJAM.IJAM_91_16 (recommending nationwide policy "along the lines of certificate of merit legislation" to reduce meritless lawsuits).

D. Meritless Medical Malpractice Claims Are Harmful to the Provision of Quality, Affordable Healthcare.

Medical liability is a threat to and "imposes rising costs on the nation's health care system." Kevin B. O'Reilly, *1 in 3 physicians has been sued; by*

age 55, 1 in 2 hit with suit, AMA, Jan. 26, 2018. If meritless lawsuits can proceed in federal court because the safeguard of state affidavit of merit statutes does not apply, physicians and the availability of quality, affordable healthcare will suffer.

1. Negative Effects on Physicians.

The "fear of liability hangs like a cloud over physicians." *Reform Now!*, *supra* at 2. This environment influences how and where physicians practice. In states with reform statutes, like § 6853, physician supply is higher and access to care is greater. *Id.*; *see also* Carol Kane & David W. Emmons, *The Impact of Liability Pressure and Caps on Damages in the Healthcare Market: An Update of Recent Literature*, AMA POLICY RESEARCH PERSPECTIVES No. 2007-1 (2007). The reason is obvious: physicians are more willing to practice in states where the liability environment is stable and less costly.

If, as Petitioner invites, there is no threshold merit determination in federal court, physicians will have greater reasons to fear liability—not because their care is negligent, but because without this safeguard any plaintiff may hold them hostage in a lawsuit that lacks any reasonable basis in science or fact. *See*, *e.g.*, *Questions of law or fact*, 3 AM. LAW MED. MALP. § 20:15 (June 2025 Update) (explaining causation remains a question of fact in medical malpractice actions in all but the most limited circumstances). This is particularly true given how modern medicine is practiced—frequently over state lines, via internet or phone. Section V, *infra*.

These risks present extreme consequences for physicians. Physicians must report all medical mal-

practice payments resulting from a written claim or judgment to the National Practitioner Data Bank ("NPDB"), which the U.S. Department of Health and Human Services operates. 45 C.F.R. § 60.7(a). This includes settlement payments. *Id*. The failure to make these reports subjects the physician to civil monetary penalties. § 60.7(c). This information is available to hospitals, healthcare entities, and boards of medical examiners, among others, for purposes of making decisions as to licensure, clinical privileges, professional society membership, DEA-controlled substance registrations, and exclusions from Medicare, Medicaid, and other federal healthcare programs.

While a settlement payment "shall not be construed as creating a presumption that medical malpractice has occurred," § 60.7(d), the practical reality is that NPDB reports significantly affect a physician's reputation, licensure, and credentialing. Many state medical boards, for example, query the NPDB as part of their licensure and credentialing process—as Delaware does here. *See* Delaware Division of Professional Regulation, Board of Medical Licensure and Discipline–*Physician Licensure*, https://dpr.delaware.gov/boards/medicalpractice/physlicense/ (explaining that all applicants for physician licensure "must submit . . . [a] self-query report from the [NPDB] website").

Physicians with a lengthier history of settlement payments may be viewed as greater liabilities—even if the payments reported were low-value settlements to resolve meritless claims. And the same problems permeate credentialing decisions for hospitals and insurability and premium decisions by insurance carriers—the greater the number of settlement payments, the greater the possibility of perceived risk.

This places physicians in the untenable position of fighting meritless claims through trial to mitigate against these adverse consequences. But this too creates problems for access to quality, affordable healthcare.

2. Increased Healthcare Costs.

As a matter of pure economics, when an insurer is called to defend a lawsuit, the costs incurred in managing the claim increase. Data from the MPLA shows that between 2016 and 2018, the average defense cost for settled claims was $77,117. *Reform Now!*, *supra* at 4 (citing MPLA Data Sharing Project, *MPL Closed Claims 2016-2018 Snapshot* (2019)). For claims tried to verdict, the costs ranged between $158,843 (defense victory) and $236,519 (plaintiff victory)—more than twice the average cost to settle a case. *Id*. These costs add up. The AMA, relying on data from the National Association of Insurance Commissioners, calculates that defense costs in 2022 alone were $2.9 billion. *Reform Now!*, *supra* at 4.

These costs have a direct effect on the cost of healthcare because they increase the cost to keep hospital and clinic doors open. *See* U.S. Gen. Acct. Off., *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, at 22 (2003) (concluding that even a single large payout could increase premiums to account for similar risks in the future). This, in turn, increases healthcare costs for patients and the public. *See* Katherine Baicker, et al., *Malpractice Liability Costs and the Practice of Medicine in the Medicare Program*, 26 HEALTH AFFS. 841, no. 3 (May/June 2007), https://doi.org/10.1377/hlthaff.26.3.841 (finding that a 60% increase in mal-

practice premiums from 2000 to 2003 was associated with an increase in Medicare spending of more than $16 billion).

Most communities cannot absorb these increases. And they ultimately result in adverse effects on the availability of quality healthcare.

3. Decreased Access to Quality Healthcare.

Maternal care is often hardest hit. Obstetricians' insurance premiums are already near the highest of all physicians, as are the number of claims made over the duration of an obstetrician's practice. *Reform Now!*, *supra* at 1–2 (citing Guardado, *supra*).

The risk is particularly acute for rural obstetric care, which services large Medicaid and Medicare populations. These federal programs offer low reimbursement rates, leaving rural clinics operating on a razor's margin. When costs increase and these clinics cannot absorb them, they close. The result is one of the largest public health crises facing rural America today: the increasing number of maternity care deserts. *See, e.g.*, March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.*, 2024 Report, https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf.

A maternity care desert is defined as any county without a hospital or birth center offering obstetric care and without any obstetric providers. *Id.* at 8, 45. Thirty-five percent—or one in three—U.S. counties qualify as maternity care deserts. *Id.* at 5. The more than 2.3 million women of reproductive age in these counties are 13% more likely to give birth preterm—

a particularly disturbing statistic, as fertility rates in rural counties and maternity care deserts "are higher than urban and full access counties and are decreasing at a slower pace." *Id.*

Fear of a lawsuit—even a meritless one—also affects how physicians practice. This phenomenon—known as defensive medicine—is "often motivated by concerns about litigation and malpractice claims rather than by patients' best interests, potentially decreasing the quality while increasing the costs of patient care." Junyao Zheng, et al., *Prevalence and determinants of defensive medicine among physicians: a systematic review and meta-analysis*, 35 INT'L J. FOR QUALITY IN HEALTH CARE, no. 4, November 30, 2023, https://doi.org/10.1093/intqhc/mzad096. This occurs in one of two ways. Either the physician provides more care to reduce liability risk (positive defensive medicine) or the physician avoids high-risk procedures or patients to reduce the risk (negative defensive medicine). *Id.* Both reduce the quality of care patients receive.

Moreover, the mere existence of a lawsuit removes a physician from patient care and places them in a courtroom. A study of 40,916 physicians covered by a single nationwide insurer estimated that the average physician spends 50.7 months—or almost 11%—of an assumed forty-year career with an unresolved, open malpractice claim. Seth Seabury, et al., *Physicians Spend Nearly 11 Percent of Their 40-Year Careers with an Open, Unresolved Malpractice Claim*, 32 HEALTH AFFS. 111, no. 1 (January 2013), https://doi.org/10.1377/hlthaff.2012.0967. This is a "time period similar to that spent in medical school." *Id.* And notably, claims that did not result in payment

"accounted for more than 70 percent of the time physicians spent with open claims." *Id.* These are likely the very type of meritless claims affidavit of merit statutes like § 6853 are designed to address.

This time away from practice "affects physicians through added stress, work, and reputational damage, as well as loss of time dealing with the claim instead of practicing medicine." *Id.* While physicians can purchase insurance to protect against judgments, this does not protect against the "psychological costs of being involved in litigation, including the stress and emotional toll." Michelle M. Mello, et al., *National costs of the medical liability system*, 29 HEALTH AFFS. 1569, no. 9 (September 2010), https://doi.org/10.1377/hlthaff.2009.0807.

There is "no evidence that this stress and anxiety improve the quality of care." *Id.* (observing these costs are "impossible to quantify"). To the contrary, anxiety and stress are symptoms of burnout, which is associated with sub-optimal patient care. Emer Ryan, et al., *The relationship between physician burnout and depression, anxiety, suicidality and substance abuse: A mixed methods systemic review*, 11 FRONTIERS IN PUBLIC HEALTH, at 2 (Mar. 30, 2023), http://doi.org/10.3389/fpubh.2023.1133484. In 2023, the AMA reported that 45.2% of physicians—nearly half—reported at least one symptom of burnout. AMA, *Measuring and addressing physician burnout*, May 15, 2025, https://www.ama-assn.org/practice-management/physician-health/measuring-and-addressing-physician-burnout.

For these reasons, the substantive protection statutes like § 6853 provide from meritless medical negligence claims should apply in all lawsuits, without

regard to whether the case is brought in state or federal court.

II. This Court Should Affirm That *Shady Grove* Represents a Straightforward Application of *Hanna*, *Walker*, and *Burlington*.

Petitioners characterize *Shady Grove* as a stark break with this Court's precedents going back at least sixty years to *Hanna*. Under Petitioner's reading, a state statute does not apply in federal court if a federal rule operates parallel with state law. Pet. Br. 12–21. In effect, Petitioner advances a blanket-preemption reading of *Shady Grove* where the state law cannot apply if there is **any** "overlap" with the federal rule. Pet. Br. 34. Amici urge a different reading.

Petitioner's approach is inconsistent with *Hanna*, which sets forth the "familiar" framework applicable here. *Shady Grove*, 559 U.S. at 398. *Hanna* held that the federal rule for service of process directing how process "shall" be served controlled over the conflicting state requirement that service "shall" be "by delivery in hand." 380 U.S. at 461–62, 470–71. The Court determined that the two provisions resulted in an "unavoidable" "clash" and that the federal rule was "in direct collision with" the state provision because of Rule 4's "unmistakable clarity—that in[-]hand service is not required in federal courts." *Id.* at 470, 472.

Fifteen years after *Hanna*, *Walker* held that a state law requiring service of process to toll the statute of limitations controlled to determine when a "civil action is commenced rather than Rule 3." The Court explained that its holding was consistent with *Hanna* because *Hanna* was "premised on a 'direct collision' between the Federal Rule and the state

law." 446 U.S. at 749 (quoting *Hanna*, 380 U.S. at 472). Through this lens, and interpreting Rule 3 according to its plain meaning, the Court determined that there "is no indication that the Rule was intended to toll a state statute of limitations, much less that it purported to displace state tolling rules for purposes of state statutes of limitations." *Id.* at 750–51 (footnote omitted); *see also id.* at 750 n.9. Rule 3 was not "sufficiently broad to control the issue before the Court." *Id.* at 749–50. For these reasons, the Court concluded that both Rule 3's direction on when a civil action commences and the seemingly contrary state provision for statute of limitations purposes could "exist side by side . . . each controlling its own intended sphere of coverage without conflict." *Id.* at 752.

Seven years later, *Burlington* held that Rule 38 of the Federal Rules of Appellate Procedure, which provides for discretionary damages and costs for frivolous appeals, displaced a state statute mandating payment of a 10% penalty plus fees on appeal to the losing appellant. 480 U.S. at 3, 7–8. *Burlington* summarized *Hanna*'s first step determining "whether, when fairly construed, the scope of [the] Rule . . . is 'sufficiently broad' to cause a 'direct collision' with the state law or, implicitly, to 'control the issue' before the court, thereby leaving no room for the operation of that law." *Id.* at 4–5 (citations omitted). Applying this direct collision approach, the mandatory penalty "unmistakably conflict[ed]" with the "plenary discretion" afforded to federal appellate courts through Rule 38's "discretionary mode of operation." *Id.* at 7. The Court confirmed its *Hanna* analysis by noting that the pur-

poses to be achieved by Rule 38—along with Rule 37—were "sufficiently coextensive with the asserted purposes of" the state law "so as to preclude" the state law's application. *Id.* at 7, n.5.

Here, the better reading of *Shady Grove*—against the backdrop of *Hanna*, *Walker*, and *Burlington*—is that the portion of the decision that commanded a 5–4 majority (Parts I and II–A) synthesized this Court's previous precedents to find a "clash" or "collision" between Rule 23 and the state statute. The majority opinion in *Shady Grove* makes this clear, explaining that "[t]he framework for our decision is familiar." 559 U.S. at 398. Further, the majority concluded that the state law provision did not apply only after finding, "as in *Hanna*," that "a collision [was] unavoidable." *Id.* at 406 n.8 (citation omitted).

This interpretation of *Shady Grove* also accords with the plain text of the Rules Enabling Act. 28 U.S.C. § 2072(a) provides this Court with authority to prescribe "general rules of practice and procedure and rules of evidence for cases in the United States district courts . . . and courts of appeals." Congress was silent on the question of whether the Act was intended to fully displace state law just because it operates in the same general sphere as a federal rule but does not directly collide with it.

Applying the longstanding direct collision approach to § 6853, it can easily "exist side by side" with the Federal Rules. *Walker*, 466 U.S. at 752.

III. State Affidavit of Merit Statutes Do Not—And Cannot—Directly Collide with the Federal Rules of Civil Procedure Because They Provide Substantive Law.

State affidavit of merit statutes like § 6853 grant physicians substantive protection from meritless medical negligence claims. This conclusion flows directly from the well-established direct collision rule Amici urge this Court to affirm here.

A. The State Legislative Policy Decisions Bound Up in Certificate of Merit Statutes Apply Equally in Federal Court.

While this case presents a novel issue before this Court, other courts examining the issue have reached the outcome Amici urge here. The Tenth Circuit, analyzing Colorado's certificate of review statute under *Erie* and its progeny, applied the direct collision rule and concluded there was no conflict between Federal Rule of Civil Procedure 11 and Colo. Rev. Stat. § 13-20-602. *Trierweiler v. Croxton & Trench Holding Corp.*, 90 F.3d 1523, 1540 (10th Cir. 1996). "The question," the Tenth Circuit explained, "is not whether the federal and state rules overlap." *Id.* at 1539. Rather, it is whether there is a direct collision with the state law. *Id.* at 1539 (quoting *Burlington*, 480 U.S. at 4–5; citing *Hanna*, 380 U.S. at 471–72). While both Rule 11 and the Colorado law demonstrated "an intent to weed unjustifiable claims out of the system," there was no "direct collision" between the two. *Id.* at 1540. Rule 11 targeted the attorney, whereas § 13-20-602 imposed a substantive prerequisite on the claim itself. *Id.*

Moving to *Erie*'s second step, the court acknowledged its reluctance to "graft a state-created procedure onto cases appearing in federal court for fear of encroaching on 'the constitutional power of the federal government to determine how its courts are operated.'" *Id.* (quoting Charles Alan Wright, LAW OF FEDERAL COURTS § 59, at 410 (5th ed. 1994)). Characterizing the imposition on a federal court to accept "one additional filing" as "relatively minor," it concluded the "essential characteristics" of the federal system would not be altered if the state statute applied. *Id.*

In contrast, "[b]y declining to apply the statute in federal court, [the court] would create a rule of law likely to produce substantially different results in state and federal court." *Trierweiler*, 90 F.3d at 1540. Specifically:

> A plaintiff alleging professional negligence is likely to seek a forum without the certificate of review hurdle either to avoid extra cost, to give himself or herself more time to build a meritorious case, or to increase the settlement value of his or her claims once litigation begins. If the certificate of review requirement applies in state but not federal court, the inequitable result would be a penalty conferred on state plaintiffs but not on those in federal court.

Id. at 1541.

The court additionally noted that the policy embodied in § 13-20-602 was to "expedite the litigation process in cases filed against licensed professionals and to prevent the filing of frivolous actions in this area." *Id.* (quoting *Martinez v. Badis*, 842 P.2d 245,

251 (Colo. 1992)). This policy "seems 'bound up with state-created rights and obligations.'" *Id.* (quoting *Byrd v. Blue Ridge Rural Elec. Co-op, Inc.*, 356 U.S. 525, 535 (1958) (cleaned up)); *cf. Shady Grove*, 559 U.S. at 420 (noting that "in some instances" the state law may be "so bound up with the state-created right or remedy that it defines the scope of that substantive right or remedy" (Stevens, J., concurring in part and concurring in the judgment)). The "balance of interests apparent in the legislative scheme convinces us that the Colorado certificate of review statute manifests 'a substantive decision by that State.'" *Trierweiler*, 90 F.3d at 1541 (quoting *Walker*, 446 U.S. at 751). The statute therefore "should apply to professional negligence actions brought in federal court under diversity jurisdiction." *Id.*

The policy decisions "bound up" in § 6853 and similar statutes are of great importance to Amici and should be enforced in federal court. The substantive interests § 6853 and its brethren protect should not be disregarded as mere procedural formalities that yield in federal court. There is simply no analogous Federal Rule of Civil Procedure that does—or even could—directly collide with these statutes to afford the same safeguards from meritless medical negligence claims. As *Trierweiler* lays bare, the inequities that will result from denying physicians the protection of affidavit of merit statutes in federal court (or perhaps framed differently, the penalty that will be inflicted on state-court plaintiffs) presents reason alone to affirm the Court of Appeals' judgment.

The very substantive harm against which these statutes protect—the increased costs, decreased quality, and unavailability of healthcare described above—

find no analogous protection in the Federal Rules of Civil Procedure. The direct collision test should apply in determining whether these statutes are applicable in federal court. Any other holding will result in the very harm about which *Trierweiler* warns: an influx of meritless medical malpractice claims brought in federal court to maximize settlement value while avoiding any obligation to show that a reasonable basis exists for the lawsuit. This result, Amici urge, would be simply untenable and work immeasurable harm to an already beleaguered healthcare system.

B. Any Alleged Collision Between § 6853 and the Federal Rules Is Manufactured.

Amici urge this Court to reject Petitioner's attempt to manufacture conflicts between § 6853 and the Federal Rules of Civil Procedure.

Fairly construed, there simply is no "collision" between § 6853 and the Federal Rules. *Shady Grove*, 559 U.S. at 406; *Burlington*, 480 U.S. at 5 (quoting *Walker*, 446 U.S. at 749, and *Hanna*, 380 U.S. at 471–72). As the discussion above on *Trierweiler* makes clear, Rule 11 and § 6853 do not clash. This fact is made even more evident by Rule 11's plain language, which specifically envisions that a statute, like § 6853, may require a complaint be accompanied by an affidavit. Fed. R. Civ. P. 11(a). Further, Rule 1 directs that the Federal Rules "should be construed, administered, and employed . . . to secure the just, speedy, and inexpensive determination of every action and proceeding."

Next, contrary to Petitioner's argument, there is no direct collision with Rule 8. Rule 8 provides three elements that a complaint "must contain." Rule 8 is

therefore a pleading standard. Delaware's affidavit of merit statute, by contrast, is not a pleading standard. It provides substantive, sworn information that a claimant must provide under state law to proceed with the claim. And this information is not required to be provided in the complaint. *See* 18 Del. C. § 6853(a)(1). Further, Rule 8 does not, by its terms, prohibit claimants from providing additional information. Whereas the federal rule in *Shady Grove*, Rule 23, provides that "[a] class action may be maintained," 559 U.S. at 398 (quoting Rule 23), Rule 8 sets forth only what "must" be included in a complaint. Put differently, Rule 23's text provides sufficient conditions for a class action to proceed, while Rule 8's text specifies the necessary contents of a complaint. There is no "collision"—direct or otherwise—or "clash" between § 6853 and Rule 8.

Although Rule 9 may apply additional requirements to certain pleadings, there is still no collision or clash with § 6853. The two can "coexist in peace." *Shady Grove*, 559 U.S. at 401; *see also Walker*, 446 U.S. at 752 (state service requirement and Rule 3 "can exist side by side"). Rule 9 does not apply to medical malpractice cases, while § 6853 does. There can be no clash when Rule 9 does not even apply.

The same rationale applies to Rule 12. Rule 12 provides a procedural "housekeeping" mechanism for dispensing with claims that fail as a matter of law. *Hanna*, 380 U.S. at 473. By contrast, § 6853 determines the law on what is required for a medical malpractice lawsuit to be viable.

In this respect, § 6853 is nearly indistinguishable from 18 Del. C. § 6856, which provides the statute of limitations for medical negligence claims. A certificate

of review statute is like a statute of limitations. *Trierweiler*, 90 F.3d at 1540. Statutes of limitations are deemed substantive because "they have the capacity to bar recovery altogether in state court, while not applying them in federal court could lead to the opposite result." *Id.* (citing *Guar. Tr. Co. of N.Y. v. York*, 326 U.S. 99, 109 (1945)). Like statutes of limitations, failure to comply with a certificate of review statute bars recovery altogether. *Id.* Determining the former is substantive and applies in federal court while concluding the latter is merely a procedural formality reserved to state courts would be based on irreconcilable logic. *See, e.g.*, *Jinks v. Richland Cty.*, 538 U.S. 456, 465 (2003) (Scalia, J.) ("For purposes of *Erie* . . . statutes of limitations are treated as substantive."); *Sawyer v. Atlas Heating & Sheet Metal Works, Inc.*, 642 F.3d 560, 562 (7th Cir. 2011) (Easterbrook, J.) ("[T]he statute of limitations . . . is substantive." (citations omitted)).

Because there is no direct conflict or clash, § 6853 does not conflict with any Federal Rules and should be applied in federal court.

Of course, if there were any direct conflict, the Federal Rules may not preempt the substantive rights and protections statutes like § 6853 bestow to physicians because the Rules Enabling Act prohibits Federal Rules that "abridge, enlarge or modify **any** substantive right." 28 U.S.C. § 2072(b) (emphasis added).

IV. Applying Affidavit of Merit Statutes Is Straightforward and Unlikely to Be "Mangled" in Federal Court.

Petitioner admonishes this Court not to "mangle . . . state provisions in the process" of applying state law. He then trots out a (short) parade of horribles that reflects nothing more than federal courts giving effect to state substantive law. Pet. Br. 11.

Amici are confident, that federal judges are able to apply the plain terms of affidavit of merit statutes and the state case law interpreting them, just as federal judges apply any state statute and applicable state case law when sitting in diversity jurisdiction. For example, in *Young v. United States*, Judge Easterbrook took a tailored approach, after closely considering the matter, by implementing the "rule of substance" in Illinois's affidavit of merit statute through Federal Rule 56's summary judgment mechanism. 942 F.3d 349, 351 (7th Cir. 2019). Recognizing that "Illinois wants insubstantial medical-malpractice suits resolved swiftly," the court achieved that goal through summary judgment, demonstrating that "the state substantive goal and the federal procedural system thus can exist harmoniously." *Id.* at 351–52.

In any event, federal court decisions interpreting state law do not bind state courts. *See, e.g.*, *Chris Eldredge Containers, LLC v. Crum & Foster Specialty Ins. Co.*, 335 A.3d 1216, 1220 (Pa. Super. Ct. 2025) (holding "state courts are not bound by a federal court's interpretation of state law"). And when state judicial interpretations of a state law rule of decision change, federal courts must apply that change. *See Comm'r of Internal Rev. v. Bosch's Estate*, 387 U.S. 456, 465 (1967); *Nolan v.*

Transocean Air Lines, 365 U.S. 293, 295–96 (1961) (per curiam). Thus, to the extent Petitioner is concerned that federal courts will not properly apply state affidavit of merit statutes, state courts can resolve any errors as they see fit.

More fundamentally, the holding that would most damage state goals and laws—even the ones that are most simple and straightforward to apply—is a flat refusal to apply state affidavit of merit statutes across the entire country. That is not the role that a "federal court adjudicating a state-created right solely because of the diversity of citizenship of the parties" should undertake when it is "in effect, only another court of the State." *York*, 326 U.S. at 108. "When a State chooses to use a traditionally procedural vehicle as a means of defining the scope of substantive rights or remedies, federal courts must recognize and respect that choice." *Shady Grove*, 559 U.S. at 420 (Stephens, J., concurring in part and concurring in the judgment) (citing *Ragan v. Merchants Transfer & Warehouse Co.*, 337 U.S. 530, 533 (1949)).

V. Insulating Federal Plaintiffs from State Affidavit of Merit Statutes Invites Forum Shopping.

It is important not to "clear away a fence just because we cannot see its point." *Artis v. Dist. of Columbia*, 583 U.S. 71, 92 (2018) (Gorsuch, J., dissenting). State affidavit of merit statutes act as a "fence" to promptly dispose of meritless medical negligence claims. In many instances—as here—the determination of whether the State statute applies directs the outcome of the case. If this were not true, Petitioner would not have received a final judgment necessary to provide standing to pursue his appeal.

See Hollingsworth v. Perry, 570 U.S. 693, 705 (2013) (requiring parties seeking appellate review to have standing).

The outcome-determinative nature of these statutes means that this Court, if it holds for Petitioner, would invite a wave of forum shopping in the federal courts. For example, if a plaintiff cannot find an expert to attest that "there are reasonable grounds to believe that there has been health-care medical negligence committed by each defendant," that plaintiff need only march to the federal courthouse to avoid prompt disposition of the case. 18 Del. C. § 6853. That is just the type of forum shopping *Erie* intended to guard against:

> *Swift v. Tyson* introduced grave discrimination by noncitizens against citizens. It made rights enjoyed under the unwritten 'general law' vary according to whether enforcement was sought in the state or in the federal court; and the privilege of selecting the court in which the right should be determined was conferred upon the noncitizen. Thus, the doctrine rendered impossible equal protection of the law. In attempting to promote uniformity of law throughout the United States, the doctrine had prevented uniformity in the administration of the law of the state.

Erie, 304 U.S. at 74–75 (footnote omitted); *see also Hanna*, 380 U.S. at 469 (explaining that the difference between the state and federal rule "would be of scant, if any, relevance to the choice of a forum" in holding that the federal rule applied).

And in any event, a plaintiff is still "likely to seek a forum without the certificate of review hurdle either to avoid extra cost, to give himself or herself more time to build a meritorious case, or to increase the settlement value of his or her claims once litigation begins." *Trierweiler*, 90 F.3d at 1541.

The threat of strategic forum selection in medical malpractice cases by out-of-state plaintiffs is all too real. The incentives for plaintiffs are clear: filing in federal court would present the clear avenue for meritless lawsuits aimed at extracting a nuisance settlement, thereby negatively impacting healthcare for state citizens.

Medical professional liability claims are particularly likely to result in diversity-jurisdiction cases. A recent study by the Centers for Disease Control and Prevention's ("CDC") National Center for Health Statistics ("NCHS") notes the growth of telemedicine use among physicians from 15.4% in 2019 to 86.5% in 2021. Kelly L. Myrick, et al., *Telemedicine Use Among Physicians by Physician Specialty: United States, 2021*, CDC NCHS, Data Brief, No. 493, at 1 (Feb. 2024), https://perma.cc/HAH3-NWV2. Telemedicine is particularly prevalent for physicians that practice in a medical specialty area. *Id.* at 1, fig.1.

On the other side of the ledger, 37% of adults reported using telemedicine in the past year for data collected in 2021. Jacqueline W. Lucas, et al., *Telemedicine Use Among Adults: United States, 2021*, CDC NCHS, Data Brief, no. 445, at 1 (Oct. 2022), https://perma.cc/5ZVQ-LCFN; *see also* Ctrs. for Medicare & Medicaid Servs., *Medicare Telehealth Trends Report* at 5–6, https://perma.cc/7M63-SKYE (showing nearly seven million Medicare recipients used

telehealth services in 2023 and that telehealth usage remained relatively steady from 2022 through 2024). Patients' most frequent reasons for using telemedicine include improved outcomes, preference over face-to-face visits, ease of use, low costs, improved communication, and elimination of travel time. Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, 49 PRIM. CARE 517 (Dec. 2022), https://perma.cc/DXR9-E3KK.

The obvious implication: telemedicine removes what otherwise might be an unsurmountable geographical difference—potentially across state lines—to connect patients with physicians and other medical providers. With more cross-state medical practice through telemedicine, the diversity of state citizenship between patient and physician increases.

Even without telemedicine, medical care for trauma and other acute care benefits from regionalization, *i.e.*, when patients are sent to larger medical centers for certain types of care. *See, e.g.*, Nathan T. Walton & Nicholas M. Mohr, *Concept Review of Regionalized Systems of Acute Care: Is Regionalization the Next Frontier in Sepsis Care?*, 3 J. AM. COLL. EMERGENCY PHYSICIANS OPEN (Feb. 2022), https://perma.cc/2CQB-RQVP. Regionalized care is most often provided for trauma, burns, neonatal intensive care and obstetrics, stroke, and heart attack. *Id.* In regionalized systems, patients are often taken from smaller rural hospitals to hospitals located in one of the nearest large metropolitan areas, which may well be in a different state. Urban areas are also likely to see cross-state border care. Delaware a good case in point: Delaware's largest city (Wilmington) is just thirty miles from Philadelphia, Pennsylvania, seventy

miles from Baltimore, Maryland, and sits just across the Delaware River from New Jersey. Further, interstate metropolitan areas abound east of the Mississippi River, including D.C.–Maryland–Virginia, Connecticut–New Jersey–New York, and Indiana–Illinois–Wisconsin.

Not only does forum selection threaten to deal a serious blow to fairness interests for defendants and in-state plaintiffs, but the additional case load in already overburdened federal courts can likewise be avoided by holding for Respondents here. Medical malpractice cases do not wind up in federal court solely under diversity jurisdiction. They also arise under supplemental jurisdiction to federal question claims as well as under the Federal Tort Claims Act. *See, e.g.*, *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 *York*, 326 U.S. at 109)); *Gipson v. United States*, 631 F.3d 448, 451–53 (7th Cir. 2011) (finding that Indiana law requiring expert evidence on the standard of care in medical malpractice cases, except under certain circumstances, was applicable in Federal Tort Claims Act case).

In the end, this Court should avoid a rule that encourages forum shopping and does "violence to the principle of uniformity within a state upon which [*Erie*] is based." *Klaxon Co. v. Stentor Elec. Mfg. Co.*, 313 U.S. 487, 496 (1941). To do so, this Court only need make clear that *Shady Grove* did not change the direct

collision rule set forth at least as early as *Hanna* and applied in cases like *Walker* and *Burlington*.

CONCLUSION

Amici respectfully urge this Court to affirm the judgment of the Court of Appeals.

Respectfully submitted,

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