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 AMERICAN HOSPITAL ASSOCIATION, ET AL. IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to and affordable for all Americans. AHA educates its members on healthcare issues and advocates on their behalf so that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of more than 1,000 tax-paying community hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, D.C., and Puerto Rico. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the Judiciary, media, academia, accrediting organizations, and the public.

The American Hospital Association and the Federation of American Hospitals are joined in this brief by a group of 24 state and regional hospital associations. These state and regional associations represent thousands of hospitals and health systems throughout the country, as well as other healthcare providers, including nursing homes, home health, hospice, and assisted

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[1] No counsel for any party authored this brief in whole or in part and no entity or person, aside from amici curiae, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

living facilities.[2] These associations are located in states with affidavit of merit laws similar to the Delaware law at issue here, and therefore have a particular interest in this case.

Amici's member hospitals and the doctors, nurses, and aides who practice in them are committed to providing the highest levels of patient care. Unfounded medical malpractice suits impede that goal, imposing substantial burdens on providers, patients, and the healthcare system as a whole. Amici therefore have a strong interest in protecting and preserving the tools that states use to screen and dispose of meritless malpractice claims, including affidavit of merit requirements like the Delaware law at the heart of this case. If this Court were to adopt Petitioner's request to hold such affidavit of merit requirements inapplicable in federal court, that holding would diminish the ability of state affidavit of merit

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[2] The state and regional hospital associations are: The Arizona Hospital and Healthcare Association, the Arkansas Hospital Association, the Connecticut Hospital Association, the Delaware Healthcare Association, the Florida Hospital Association, the Georgia Hospital Association, the Healthcare Association of Hawaii, the Illinois Hospital Association, the Iowa Hospital Association, the Kentucky Hospital Association, the Michigan Hospital Association, the Missouri Hospital Association, the New Jersey Hospital Association, the Healthcare Association of New York State, the Greater New York Hospital Association, the North Carolina Healthcare Association, the North Dakota Hospital Association, the Ohio Hospital Association, the Hospital and Healthsystem Association of Pennsylvania, the South Carolina Hospital Association, the Tennessee Hospital Association, the Texas Hospital Association, the Vermont Association of Hospitals and Health Systems, and the West Virginia Hospital Association.

requirements to reduce meritless malpractice claims and minimize the harms those claims inflict.

INTRODUCTION AND SUMMARY OF ARGUMENT

I. By the age of 65, the vast majority of physicians will have faced at least one medical malpractice claim. Anupam B. Jena, Seth Seabury, Darius Lakdawalla & Amitabh Chandra, *Malpractice Risk According to Physician Specialty*, 365 NEJM 629, 633 (2011). This high rate of claims does not reflect a high rate of medical negligence. When malpractice suits proceed to trial, providers prevail almost 90% of the time. José R. Guardado, *Medical Liability Claim Frequency Among U.S. Physicians*, AM. MED. ASS'N 2 (2023). And many more claims are dropped, denied, or dismissed before they ever reach trial. *Ibid*. The problem is therefore in the tort system, not the standard of care.

The problem is nonetheless a serious one for hospitals, physicians, and patients alike. Unfounded suits force hospitals and doctors to divert time and resources from patient care to litigation. One study concluded that physicians who practice for 40 years spend 11% of that time with open malpractice claims. See Seth Seabury, Amitabh Chandra, Darius Lakdawalla & Anupam B. Jena, *On Average, Physicians Spend Nearly 11 Percent of Their 40-Year Careers with an Open, Unresolved Malpractice Claim*, 32 HEALTH AFF. (MILLWOOD) 111 (2013). Such open claims siphon providers' attention from their medical practices and impose well-documented psychological and reputational harms.

Patients, in turn, suffer from the loss of physicians' time and access to needed medical care, as well as

from the defensive medicine that some providers are forced to practice out of fear of tort liability. A 2002 federal government survey found that physicians order more tests, recommend more invasive procedures, and prescribe more medicine than they believe is medically necessary when they are concerned about the threat of malpractice suits. U.S. Dep't of Health and Hum. Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* 4-5 (Jul. 24, 2002) (*HHS Report*).

Moreover, when medical malpractice suits proliferate, the cost of malpractice insurance increases and its availability decreases. Hospitals and physicians are forced to either charge higher rates or cease providing high-risk medical services. The true extent of this threat is well-illustrated by the medical malpractice insurance crisis that plagued the United States during the early 2000s. During that time, the proliferation of meritless malpractice suits contributed to such dramatically increased malpractice insurance costs that over one fifth of all hospitals were forced to curtail or completely discontinue a service, and some physicians stopped practicing altogether. Am. Hosp. Ass'n., *Medical Liability Insurance: Looming Crisis?* AHA TREND WATCH, June 2002, at 1 (*AHA Report*). For example, all twelve orthopedic surgeons in one Pennsylvania hospital group laid down their scalpels after insurance rates nearly doubled. *HHS Report*, *supra*, at 3.

II. Affidavit of merit requirements have proved to be a useful tool in combatting the harms inflicted by meritless malpractice suits, while preserving the ability of patients to vindicate meritorious claims.

Although the specific nature of these requirements varies across the almost thirty states that have adopted them, the Delaware law at the center of this case is representative: It imposes a substantive requirement on malpractice plaintiffs to support their claim with "[a]n affidavit of merit as to each defendant signed by an expert witness * * * stating that there are reasonable grounds to believe that there has been health-care medical negligence committed by each defendant." Del. Code Ann. tit. 18, § 6853(a)(1). By requiring plaintiffs to support their claims with an expert affidavit, the law limits the filing of unfounded claims and makes it easier for courts to dispose quickly of the meritless suits that are filed.

Affidavit of merit requirements like Delaware's are an important tool in combatting frivolous lawsuits. After Delaware and several other states adopted affidavit of merit requirements as part of tort reform packages in the early 2000s, the medical malpractice insurance crisis abated. And analysts have documented several specific instances in which a state's adoption of a tort reform package including an affidavit of merit requirement corresponded with a material drop in medical malpractice claims. For example, a 2014 report found that, after Ohio adopted its affidavit of merit requirement in 2003, the number of malpractice claims filed annually in that state declined by almost 50%. See *Ohio Medical Malpractice Claims Decline Again in 2012*, INS. J. (May 5, 2014), https://www.insurancejournal.com/news/midwest/2014/05/05/328287.htm.

III. Petitioner now invites this Court to weaken the force of affidavit of merit requirements by holding that they do not apply to any plaintiff who files a state

law medical malpractice claim in federal court. There is no sound basis for accepting that invitation. As respondents explain, under this Court's watershed decision in *Erie Railroad Co.* v. *Tompkins*, 304 U.S. 64 (1938), federal courts sitting in diversity must apply state substantive law. And in *Hanna* v. *Plumer*, 380 U.S. 460, 468 (1965), this Court further clarified that a state law is substantive for purposes of the *Erie* doctrine when it imposes an outcome-determinative rule that implicates *Erie*'s twin aims: avoiding forum shopping and ensuring the equitable application of the law. *Hanna* also clarified the interaction between the *Erie* doctrine and the Federal Rules of Civil Procedure—holding that where a Federal Rule of Civil Procedure governs a particular situation, that Rule applies instead of a conflicting state law unless the Federal Rule exceeds the boundaries of the Rules Enabling Act or the Constitution. *Id.* at 463-464.

Under these principles, Delaware's affidavit of merit requirement must be applied by state and federal courts alike. At the outset, there is no conflicting Federal Rule that governs the situation covered by Delaware's affidavit of merit requirement. Federal Rule of Procedure 11 specifically leaves room for such affidavit requirements, providing that pleadings do not need to be verified or accompanied by an affidavit "[u]nless a rule or statute specifically states otherwise"—as the Delaware affidavit of merit law does.

The affidavit of merit requirement is also plainly substantive for purposes of the *Erie* doctrine because it will be outcome-determinative in many cases, and unless federal courts apply the requirement, it will lead to forum shopping and exactly the kind of preferred treatment for out-of-state plaintiffs that *Erie*

was designed to prevent. Moreover, it would turn basic principles of federalism on their head if this Court were to hold that federal courts applying Delaware law can disregard a Delaware requirement specifically adopted by the Delaware legislature to combat harms to the Delaware healthcare system by the abuse of Delaware medical malpractice laws, all without pointing to a single conflicting federal rule or statute.

The Court should therefore affirm the decision of the court of appeals.

ARGUMENT

I. Meritless Medical Malpractice Claims Place Substantial Burdens On Providers, Patients, And Healthcare Systems As A Whole.

Meritless medical malpractice claims are a significant drain on hospitals and health systems. When such suits proliferate, they impede the ability of hospitals and physicians to provide care to their patients. And—by increasing the cost of medical malpractice insurance—they increase costs throughout the entire healthcare system, sometimes prohibitively so.

A. Providers And Patients Suffer From The Proliferation Of Meritless Medical Malpractice Claims.

For decades, commentators have recognized the problems posed by unchecked medical malpractice claims. See generally Michelle M. Mello, David M. Studdert & Troyen A. Brennan, *The New Medical Malpractice Crisis*, 348 NEJM 2281 (2003); Michelle M. Mello, Amitabh Chandra, Atul A. Gawande & David M. Studdert, *National Costs of the Medical Liability System*, 29 HEALTH AFF. (MILLWOOD) 1569 (2010). While malpractice liability can serve as an effective

means of compensating and deterring medical negligence, without proper limits on these state tort claims, the harms to providers and patients threaten to outweigh the benefits.

1. For healthcare providers, medical malpractice suits are an unfortunate fact of life. A 2011 study in the New England Journal of Medicine found that, by the age of 65, 75% of physicians in low-risk specialties, and *99%* of physicians in high-risk fields like surgery, will have been subject to a medical malpractice claim. Jena et al., *Malpractice Risk*, *supra*, at 633. A more recent study by the American Medical Association found that, of the 3,500 physicians who completed a 2022 survey, 31.2% had already faced a medical malpractice suit. Guardado, *supra*, at 2.

Many of these claims lack merit. For example, the American Medical Association study that found such high rates of malpractice claims also found that, of the claims that ultimately go to trial, a whopping 89% end in a verdict for the defendant. *Ibid*. Many more claims are dropped, dismissed, or withdrawn before trial: The AMA study put the percentage of dropped, dismissed, and withdrawn claims at 65%. *Ibid*. Another, earlier study found that 54% of the malpractice claims that do not settle are ultimately dismissed by the courts. Anupam B. Jena, Amitabh Chandra, Darius Lakdawalla & Seth Seabury, *Outcomes of Medical Malpractice Litigation Against US Physicians*, 172 JAMA INTERNAL MED. 892, 893 (2012).

Still, physicians and hospitals facing financial challenges face significant pressure to settle claims to reduce litigation costs. Berkeley Rice, *Malpractice: Why You May Be Forced to Settle*, 4 MED. ECON. 20 (Feb. 22, 2002). Indeed, from 2005 to 2009, 96.9% of all paid

claims reported in the National Practitioner Data Bank were settled out of court. Jessica B. Rubin & Tara F. Bishop, *Characteristics of Paid Malpractice Claims Settled In and Out of Court in the USA: A Retrospective Analysis*, BMJ OPEN, June 2013, at 3.

2. Moreover, regardless of whether the provider ultimately prevails, medical malpractice claims take a serious toll. Physicians, hospital employees, and others must take time away from the treatment of patients to respond to malpractice claims, even when they are unfounded. See Richard G. Roberts, *Understanding the Physician Liability Insurance Crisis*, 9 FPM 47 (2002). For example, a 2013 study found that, on average, a physician who practices for 40 years will spend 11% of that time facing an open medical malpractice claim. See Seabury et al., *supra*. The same study observed that, "[a]mong claims resolved with no payment, 72 percent of cases took six months or more to be resolved, 50 percent took one year or more, and 12 percent took three years or more." *Id.* at 113.

Medical malpractice claims also impose well-documented reputational and psychological harms on medical professionals. See Saba Fatima, *The Trauma of Malpractice Litigation*, HOSP. PEDIATR., June 2024, at 279. Several studies have linked malpractice claims to increased rates of physician burnout, depression, and suicide. Charles M. Balch et al., *Personal Consequences of Malpractice Lawsuits on American Surgeons*, 213 J. AM. COLL. SURG. 657, 667 (2011); see generally Richard Duszak, Jr. & Jeffrey D. Robinson, *Malpractice Litigation: The Elephant in the Reading Room*, 19 J. AM. COLL. RADIOL. 801 (2022). Indeed, the medical literature has begun to identify a phenomenon known as "medical malpractice stress syndrome,"

which consists of a constellation of physical and psychological effects a physician may experience as a result of malpractice litigation. See Bryan A. Liang, James Maroulis & Tim K. Mackey, *Understanding Medical Malpractice Lawsuits*, 54 STROKE 95, 95 (2023).

3. Nor are providers the only ones to suffer. Patients miss out when hospitals and physicians spend time in litigation rather than on patient care. And there is evidence that patients are also exposed to more tests and treatments ordered by physicians anxious to avoid malpractice claims. *HHS Report*, *supra*, at 4-5. According to a federal government survey performed in the early 2000s, when medical malpractice claims were proliferating, "79%" of surveyed physicians "said that they had ordered more tests than they would, based only on professional judgment of what is medically needed"; "51% ha[d] recommended invasive procedures such as biopsies to confirm diagnoses more often than they believed was medically necessary"; and "41% said that they had prescribed more medications, such as antibiotics, than they would based only on their professional judgment." *Ibid.*

B. Medical Malpractice Insurance Costs Burden The Healthcare System As A Whole.

Medical malpractice claims also take a heavy financial toll on the healthcare system writ large. While litigation costs and indemnity payments are typically covered by malpractice insurers, as the rate of malpractice litigation increases, so do insurance premiums, which "inevitably results in higher cost of medical care for all patients." Frank C. Spencer, *The Malpractice Crisis*, VIRTUAL MENTOR, Apr. 2005, at 1; see also Jean LeMasurier, *Physician Medical Malpractice*, 7 HEALTH CARE FIN. REV. 111, 111 (1985) (citing study showing that "for every 100-percent increase in premiums, physician fees are estimated to increase by 9.1 percent").

Hospitals are particularly affected. Hospitals typically supply medical malpractice insurance for the physicians they employ. Patrick V. Bailey, *Is There a Correlation between Physician Employment and Liability Premiums?*, 107 BULL. AM. COLL. SURG., Feb. 2022.[3] Thus, as premiums go up, hospital budgets get tighter. Further, many medical institutions, universities, and academic medical centers are self-insured, meaning they bear the brunt of higher claims more directly. *Ibid.* And when the rate of malpractice suits gets high enough, the cost of malpractice insurance of any kind can become prohibitive, driving providers out of the medical field altogether and reducing patient access to care.

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[3] Available at https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2022/02/is-there-a-correlation-between-physician-employment-and-liability-premiums/.

1. The medical malpractice crisis of the early 2000s is a powerful illustration of the problem. In the years leading up to that crisis, the cost of medical malpractice insurance had risen dramatically, so much so that hospitals and physicians in many states struggled to find malpractice coverage they could afford. See Mello et. al, *The New Medical Malpractice Crisis*, *supra*, at 2281; see also Am. Med. Ass'n, *America's Medical Liability Crisis: A National View* (2004) (designating "20 states in a full-blown medical liability crisis," and more showing signs of an impending crisis). In many areas across the country, insurance premiums rose by 25% to 30% in 2001 alone. Roberts, *supra*, at 47. And in 2002, one-third of all hospitals saw an increase of 100% or more in their insurance premiums. *AHA Report*, *supra*, at 1.

For healthcare providers in certain fields, such as obstetrics, emergency medicine, and general surgery, the crisis was particularly acute. In several states, insurance premiums in these specialized fields rose by 50% or more between 2001 and 2002, including increases as high as 80% in some areas. See Mello et al., *The New Medical Malpractice Crisis*, *supra*, at 2282; Roberts, *supra*, at 47. The crisis also hit harder in states without meaningful medical liability reforms in place. A 2003 American Hospital Association analysis showed that the liability costs per provider were $11,433 in states without reforms, as compared to $4,228 in other states. Stuart L. Weinstein, *Medical Liability Reform Crisis 2008*, 467 CLIN. ORTHOP. RELAT. RES. 392, 394 (2009).

The skyrocketing cost of malpractice insurance posed a grave threat to hospitals, physicians, and patients, particularly for those providing or receiving

care in high-cost areas or for high-risk conditions. As medical-liability insurance premiums rose precipitously, physicians were forced to close shop, and hospitals to shut down. See Mello et al., *The New Medical Malpractice Crisis*, *supra*, at 2281 (noting that hospitals in several states "temporarily closed or threatened to close emergency room, obstetrical, or other services."); Philip G. Peters, Jr., *On the Cusp of the Next Medical Malpractice Insurance Crisis*, 25 J. HEALTH CARE L. & POL'Y 133, 135 (2022) ("Many practitioners, both generalists and specialists, just can't afford the liability premiums, forcing them to retire early, limit their practice, or relocate."). To take just a few examples:

- In Nevada, "[t]he University of Nevada Medical Center closed its trauma center in Las Vegas for ten days" because "[i]ts surgeons * * * could no longer afford malpractice insurance" after "[t]heir premiums had increased sharply, some from $40,000 to $200,000." *HHS Report*, *supra*, at 2.
- In Pennsylvania, "all twelve active orthopedic surgeons" in one hospital group "decided to lay down their scalpels after their malpractice rates nearly doubled to $106,000." *Id.* at 3.
- In Mississippi, "[m]ost of the cities with populations under 20,000 * * * no longer [had] doctors who deliver[ed] babies," in part "because of the cost of insurance." *Ibid*.
- In New Jersey, "65% of the hospitals report[ed] that physicians [were] leaving because of increased premiums (over 250% over the last three years)." *Id.* at 4.

These are not mere anecdotes. In 2002, an American Hospital Association survey found that, because of increasing insurance premiums, over one-fifth of all hospitals had either curtailed or completely discontinued a service and almost 40% had experienced difficulty in obtaining physician coverage. *AHA Report*, *supra*, at 1. That same year, an article in the New York Times reported that, just over the course of the summer, "at least half a dozen hospitals ha[d] closed obstetric wards" and "a string of rural clinics ha[d] been temporarily shuttered" because of malpractice insurance costs. Joseph B. Treaster, *Rise in Insurance Forces Hospitals To Shutter Wards*, N.Y. TIMES (Aug. 25, 2002).

Indeed, in some states, not only physicians and hospitals, but medical-liability insurers themselves exited the market, as "several major carriers"—including St. Paul Companies (known today as Travelers), "the largest malpractice carrier in the United States" at the time—"stopped selling malpractice insurance." *HHS Report*, *supra* at 14.

2. Medical professionals, scholars, and policymakers alike recognized that costs associated with litigating frivolous medical malpractice claims were a significant contributor to the dramatic increase in insurance premiums, and the dramatic consequences it engendered. See, *e.g.*, Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Malpractice Litigation 'Crisis' Myth and the Factors Critical to Reform*, 108 DICK. L. REV. 1077, 1119-20 (2004).

As a witness representing the American Hospital Association told the Senate Judiciary Committee in 2004:

> [T]he effects of the medical liability crisis are well-known, but the bottom line is that patient care is jeopardized. In many areas physicians are packing up and leaving because they cannot afford the cost of liability premiums. Hospitals and other facilities are closing down or curtailing important services such as emergency rooms and obstetrical departments. Where these kinds of services are still available, not only are liability premiums driving up the cost of care, but defensive medicine, the ordering of extensive tests and other services equally drives up the cost of care.

The Medical Liability Crisis and Its Impact on Patient Care: Hearing Before the S. Comm. on the Judiciary, 108th Cong. 659, at 8-9 (Aug. 20, 2004) (statement of George Lee, Vice Pres., Medical Affairs, California Pacific Medical Center).[4]

The American Hospital Association was not alone in identifying these effects. In 2003, President George W. Bush also highlighted "frivolous and junk lawsuits" as the root cause of the prohibitively high insurance costs underlying the crisis. Doug Payne, *'Frivolous and Junk Lawsuits' Must End: Bush*, 39 MED. POST, Jan. 28, 2003, at 8. "The problem of those unnecessary costs isn't in the waiting room or the operating room. It's in the courtroom." *Ibid.*

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[4] Available at https://www.govinfo.gov/content/pkg/CHRG-108shrg96460/html/CHRG-108shrg96460.htm.

II. Affidavit Of Merit Requirements Are An Important Tool For Reducing Meritless Medical Malpractice Suits.

Affidavit of merit requirements play a key role in many states' efforts to reduce meritless medical malpractice suits. Delaware adopted the affidavit of merit requirement at issue here as part of its successful effort to combat the medical malpractice crisis of the early 2000s. Numerous other states have similarly adopted such requirements and experienced a decrease in medical malpractice claims as a result.

1. While the specifics vary across states, affidavit of merit requirements generally mandate that a plaintiff in a medical malpractice action provide an affidavit from a medical expert (or an attorney who has consulted with an expert) attesting to the reasonableness of the plaintiff's claim. See*, e.g.,* Del. Code Ann. tit. 18, § 6853(a)(1); 735 Ill. Comp. Stat. 5 / 2-622. For example, the Delaware law at stake in this case provides that "[n]o health-care negligence lawsuit shall be filed in this State unless the complaint is accompanied by * * * [a]n affidavit of merit as to each defendant signed by an expert witness * * * stating that there are reasonable grounds to believe that there has been health-care medical negligence committed by each defendant." Del. Code Ann. tit. 18, § 6853(a)(1). Almost thirty states now have some form of affidavit of merit requirement. Heather Morton, *Medical Liability/Malpractice Merit Affidavits and Expert*

Witnesses, Nat'l Conf. of State Legis. (last updated Aug. 11, 2021).[5]

The basic premise of these requirements is that, by imposing a minimal showing of merit on medical malpractice plaintiffs, states can deter the filing of unfounded suits and ensure that such suits are readily disposed of when they are filed. At the same time, because plaintiffs with meritorious claims can easily satisfy an affidavit requirement, malpractice suits can still serve their purpose in preventing and redressing medical negligence.

2. Unsurprisingly, then, an affidavit of merit requirement played an important role in Delaware's effort to combat the medical malpractice crisis of the early 2000s. The state adopted its affidavit of merit requirement in 2003. Del. Code Ann. tit. 18, § 6853. When it did so, the Delaware legislature acted against the backdrop of the existing crisis and the legislature's prior findings that a "tremendous increase in the cost of liability insurance coverage for health care providers in Delaware" would "endanger[] the ability of the citizens of Delaware to continue to receive quality health care as well as adequate and just compensation for negligent injuries." 60 Del. Laws ch. 373 pmbl. (1976). The affidavit of merit requirement was therefore designed to reduce the rising "number of suits and claims for damages * * * arising from professional patient care," which the legislature had previously

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[5] These states are Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New York, North Dakota, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and West Virginia.

identified as a leading cause of rising malpractice insurance costs. *Ibid.*

Other states have similarly adopted their affidavit of merit requirements to limit the rising tide of meritless medical malpractice suits. The Pennsylvania requirement, for example, was "designed and adopted to directly confront the crisis surrounding medical malpractice claims in th[e] Commonwealth." *Hoover* v. *Davila*, No. 03-10174, 2003 WL 23473920, at *455-56 (Pa. C.P. Nov. 20, 2003). New Jersey, too, employed its affidavit of merit statute to "weed out" meritless malpractice claims. *Galik* v. *Clara Maass Medical Center*, 771 A.2d 1141, 1147, (N.J. 2001). And "[t]he purpose behind" New York's affidavit of merit requirement, "as stated when the statute was enacted in 1986, is to deter the commencement of frivolous actions by counsel on behalf of their clients, and to thereby reduce the cost of medical malpractice litigation and medical malpractice insurance premiums." *Rabinovich* v. *Maimonides Medical Center*, 179 A.D.3d. 88, 91 (N.Y. App. Div. 2019) (citing 1985 N.Y. Sess. Laws 3022-27).

3. These and similar measures have played an important role in minimizing meritless medical malpractice suits and combatting the harms those suits inflict. See Nathanson, *supra*, at 1079 (affidavit of merit requirements have "proven effective in reducing insurers' litigation costs without significant social costs"). From 2007 to 2016, the number of medical liability claims writ large declined by an estimated 27%. *Medical Malpractice in America: A 10-Year Assessment with Insights*, CRICO STRATEGIES 4 (2018); see also Peters, *supra*, at 134 (noting that, as of 2022, the number of medical malpractice claims filed annually had "declined steadily for most of the last fifteen years").

In many states, that decline closely corresponded with the state's adoption of affidavit of merit requirements and other tort reforms. Ohio, for example, enacted its affidavit-of-merit requirement in 2005. *See* Ohio R. Civ. P. 10(D)(2) (2005) (see Staff Note). Between 2005 and 2012, the number of malpractice claims filed annually declined by almost 50%, reaching a new low in 2012. See *Ohio Medical Malpractice Claims Decline Again in 2012*, *supra*. Pennsylvania experienced a similar, 43.4% decline in annual medical-liability claims between the early 2000s and 2014. *Number of Med Mal Lawsuits in Pennsylvania Has Steadied, Data Show*, INS. J. (July 3, 2014), https://tinyurl.com/f6wctv8r. The Administrative Office of Pennsylvania Courts expressly attributed this improvement to the Pennsylvania Supreme Court's adoption of an affidavit of merit requirement. *Ibid.* And when Maryland enacted its affidavit of merit law, malpractice suits fell by 36% the next year. *The Maryland Survey: 1994-1995*, 55 MD. L. REV. 527, 907 (1996).

III. This Court Should Reject Plaintiffs' Attempt to Circumvent States' Efforts To Safeguard Their Healthcare Systems.

Petitioner now asks this Court to weaken the efficacy of affidavit of merit requirements by holding that they do not apply in federal court. This Court should reject that request. As respondents explain, Delaware's affidavit of merit requirement does not conflict with any of the Federal Rules of Procedure. To the contrary, Rule 11 expressly leaves room for the application of laws requiring affidavits. And Delaware's affidavit of merit law readily qualifies as a state substantive law that must be applied by a federal court

sitting in diversity under this Court's seminal decision in *Erie Railroad Co.* v. *Tompkins*, 304 U.S. 64 (1938).

1. As every first-year law student knows, *Erie* announced the fundamental principle of federalism under which federal courts sitting in diversity must apply state substantive law. Before *Erie*, federal courts sitting in diversity were permitted to apply federal rather than state common law. But this Court recognized that, under the Constitution, both Congress and the federal courts lack the "power to declare substantive rules of common law applicable in a State." 304 U.S. at 78.

The *Erie* Court further observed that the pre-*Erie* rule led to discrimination and forum shopping. Noncitizens—who could avail themselves of federal diversity jurisdiction when they sued in-state defendants—were able to choose a federal or state forum for their suits based on which court had more favorable law, a benefit in-state plaintiffs conspicuously lacked. *Id.* at 74-75. And permitting the application of federal rather than state law in federal courts also "prevented uniformity in the administration of the law of the State," as tort or contract rights within a state might vary depending on the forum in which those rights were vindicated. *Id.* at 75.

Erie restored the basic principles of federalism embedded in our Constitution and eliminated the fundamental problems that the pre-*Erie* system had engendered. But it gave rise to problems of its own as federal courts struggled with which rules to apply in the face of an apparent conflict between a state law and a Federal Rule of Civil Procedure. In theory, *Erie* and the Federal Rules should be able to peacefully co-exist because the latter are promulgated pursuant to the

Rules Enabling Act. 28 U.S.C. § 2072. That federal law empowers the Supreme Court (and by delegation, an Advisory Committee) to prescribe general rules governing the "practice and procedure" of federal district courts, and further provides that "[s]uch rules shall not abridge, enlarge or modify any *substantive* right." *Ibid.* (emphasis added). Thus, the decision as to which law to apply should be a straightforward one: *Erie* says that federal courts must apply state "*substantive* rules," 304 U.S. at 78 (emphasis added), and the Rules Enabling Act provides that federal courts should apply federal *procedural* rules.

2. In practice, however, courts have had difficulty deciding whether a particular rule qualifies as substantive or procedural. Thus, in *Hanna* v. *Plumer*, 380 U.S. 460 (1965), this Court offered several additional principles to guide federal courts sitting in diversity. The Court first observed that the question of whether a rule is substantive or procedural for purposes of the *Erie* doctrine should not be reduced merely to the question of whether the rule is "outcome-determinative," because even obviously procedural rules like filing deadlines can be outcome determinative when a plaintiff fails to comply with them. *Id.* at 468-469. The "'outcome-determination' test" must therefore be performed with "reference to the twin aims of the *Erie* rule: discouragement of forum-shopping and avoidance of inequitable administration of the laws." *Id.* at 468. Applying that inquiry, courts must consider whether the state law is likely to affect a plaintiff's decision as to where to file and whether the law inevitably leads to disparate results in some cases where the claims are indistinguishable. *Ibid.*

Hanna also explained how courts should approach a situation in which a party alleges that a Federal Rule should displace a state law. The Court observed that it had rejected such an argument in several cases because "the scope of the Federal Rule was not as broad as the losing party urged." *Id.* at 470. The Court explained, however, that if there is a "direct collision," *id.* at 472, then the reviewing court should determine whether the "Advisory Committee, this Court, and Congress erred in their prima facie judgment that the Rule in question" is procedural, in accordance with the commands of the Rules Enabling Act and the Constitution. *Id.* at 471.

3. This Court has consistently articulated and applied *Hanna*'s principles since that decision was announced. In *Walker* v. *Armco Steel Corp.*, 446 U.S. 740 (1980), for example, the Court reiterated that a Federal Rule will not displace a state law unless there is a "'direct collision'" between the two, such that the federal statute necessarily "control[s] the issue before the [c]ourt." *Id.* at 749 (quoting *Hanna*, 380 U.S. at 472). The Court then rejected petitioner's assertion that the Federal Rule in question displaced an Oklahoma statute, explaining that "'the scope of the Federal Rule [is] not as broad as the losing party urge[s].'" *Id.* at 750 (quoting *Hanna*, 380 U.S. at 470) (alterations in original).

Conversely, in *Burlington Northern* v. *Woods*, 480 U.S. 1 (1987), this Court applied *Hanna* to find that a federal appeals court had erred in applying an Alabama law penalizing parties who obtain a stay by executing a bond. The Court explained that there was a Federal Rule of Civil Procedure that applied to that situation and left "no room for the operation of" the

state law, and the Federal Rule in question represented a valid exercise of authority under the Constitution and the Rules Enabling Act. *Id.* at 5. And more recently, in *Shady Grove Orthopedic Associates, P.A.* v. *Allstate Ins. Co.*, 559 U.S. 393 (2010), a plurality of this Court applied *Hanna* to find that a New York state law barring the consolidation of class claims could not apply in federal court because the situation was governed by Federal Rule of Procedure 23, and that Rule comports with the relevant statutory and constitutional commands.

4. This is a straightforward case under *Erie* and *Hanna*. Petitioner cannot point to any Federal Rule of Civil Procedure that is in "direct collision" with Delaware's affidavit of merit requirement because the Federal Rules expressly leave room for such a law. Rule 11 provides that "[*u*]*nless a rule or statute specifically states otherwise*, a pleading need not be verified or accompanied by an affidavit." By its plain text, Rule 11 contemplates the existence and enforceability of state and federal laws like Delaware's, which require affidavits accompanying a pleading. And as respondents explain, Beebe Br. 15-18, in the face of this clear text, Petitioner's efforts to show that some *other* Federal Rule forecloses Delaware's affidavit of merit requirement ring hollow.

Petitioner is therefore left to argue that affidavit of merit requirements fall outside of *Erie*'s basic command that "in all matters except those in which some federal law is controlling, the federal courts exercising" diversity jurisdiction must "apply as their rules of decision the law of the State, unwritten as well as written." 304 U.S. at 72-73. Petitioner insists *Erie*'s rule does not apply because Delaware's law is

fundamentally "procedural." But as *Hanna* explained, whether a state statute may be deemed substantive for purposes of the *Erie* doctrine depends on the application of an "'outcome-determination' test" informed by "the twin aims of the *Erie* rule" of avoiding forum shopping and ensuring the equitable application of the law. 380 U.S. at 468.

A faithful application of that inquiry readily demonstrates that Delaware's affidavit of merit requirement is substantive. There is no question that the state law is outcome-determinative; if the requirement applies and a plaintiff cannot obtain the requisite affidavit from an expert, then she cannot succeed on the merits of her medical malpractice claim. Nor is a plaintiff's ability to satisfy the Delaware requirement simply a matter of following the steps prescribed by the law, as is the case with many purely procedural rules like filing deadlines. Whether a plaintiff can meet Delaware's requirement depends fundamentally on the underlying merits of the claim itself. See, *e.g.*, *Ellet* v. *Ramzy*, No. 04-CV-3201, 2004 WL 2240153, at *1 (Del. Super. Ct. Sept. 29, 2004) (finding that an "equivocal" affidavit was insufficient).

The Delaware law also implicates the "twin aims" of *Erie*—avoiding forum shopping and the inequitable application of the law. If federal courts decline to apply the Delaware affidavit of merit law, it will create a powerful incentive for plaintiffs to file in federal court to avoid the need to find expert support for their claims. And if the affidavit of merit requirement applies in state but not federal court, it will lower the barriers for success in diversity cases, increasing out-of-state plaintiffs' ability to pressure providers into settlement. Indeed, if the Court adopts Petitioner's

favored approach, it will arbitrarily make it easier to bring medical malpractice claims against hospitals and physicians located close to state borders, as well as those who provide specialty services or expert care, because those providers are the ones most likely to attract out-of-state patients. That kind of inequity is exactly what *Erie* was intended to prevent.

5. Finally, allowing plaintiffs to evade affidavit of merit requirements would undermine important State policy choices in an area—the health and well-being of its citizens—in which state interests are paramount. States like Delaware have adopted affidavit of merit requirements as an important safeguard against the proliferation of frivolous malpractice suits and the numerous harms those meritless suits impose on providers, patients, and state healthcare systems as a whole. It would contravene basic principles of federalism to displace this state policy choice embodied in a state statute in the absence of any conflicting federal statute or rule.

CONCLUSION

For the foregoing reasons, as well as those provided by Respondents, the Court should affirm the Third Circuit's decision.

Respectfully submitted,

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