SUPREME COURT OF KENTUCKY
No. 2018-SC-276-DG

ASHLAND HOSPITAL CORPORATION
D/B/A KING'S DAUGHTERS MEDICAL CENTER — APPELLANT

v. ON DISCRETIONARY REVIEW FROM THE COURT OF APPEALS
No. 2015-CA-1750

PAUL WESLEY LEWIS, M.D. AND
DAVID SHACKELFORD — APPELLEES

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND KENTUCKY MEDICAL ASSOCIATION IN SUPPORT OF DR. PAUL WESLEY LEWIS AND ASHLAND HOSPITAL CORPORATION

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Certificate of Service

I hereby certify that on January 7, 2019, a copy of this brief was sent via U.S. Mail to Sam Givens, Clerk, Kentucky Court of Appeals, 360 Democrat Drive, Frankfort, KY 40601; David F. Latherow and Kenneth Williams, Jr., WILLIAMS HALL & LATHEROW, LLP, P.O. Box 2008, Ashland, KY 41105; W. Mitchell Hall, Jr. and Alexis O. Gonzalez, VANANTWERP ATTORNEYS, LLP, P.O. Box 1111, Ashland, KY 41105; A. David Blankenship, KINNER & PATTON, 245 Main Street, Paintsville, KY 41240; and Hon. George W. Davis, III, Judge, Boyd Circuit Court, P.O. Box 688, Catlettsburg, KY 41129-1196.

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INTRODUCTION

This is an appeal of the Court of Appeals' reversal of a trial court's grant of summary judgment in favor of a physician and hospital after a plaintiff failed to present expert evidence showing the medical providers' alleged delay in detecting and responding to signs of a stroke caused the plaintiff's injuries. The Court of Appeals erred in holding that expert testimony is unnecessary to show causation in a complex medical negligence case and improperly found that "common knowledge" can establish this critical element of a claim.

STATEMENT OF POINTS AND AUTHORITIES

PURPOSE AND INTEREST OF *AMICI CURIAE*

Amici curiae, the American Medical Association and Kentucky Medical Association, collectively represent hundreds of thousands of doctors in Kentucky and across the nation. This *amicus curiae* brief explains why relieving plaintiffs of the need to present expert testimony supporting their medical negligence claims is likely to result in juries deciding claims based on hindsight bias and speculation, not medical science. Expert testimony is critical to the ability of a jury to properly evaluate whether a patient's injuries were caused by an underlying medical condition, a known risk or complication of treatment, or a deviation from the standard of care. *Amici* urge the Court to find that gaps in expert testimony cannot be filled by a lay juror's "common knowledge" or application of *res ipsa loquitur*. The brief shows why the Court of Appeals ruling, if not reversed, will result in unwarranted liability for healthcare providers and encourage costly defensive medicine.

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including Kentucky, and in every medical specialty.

The Kentucky Medical Association (KMA) is the only statewide association representing every physician specialty in Kentucky. Initially organized in 1851, the

KMA was first incorporated in 1929. It is a Kentucky, non-profit, non-stock, membership corporation organized under KRS Chapter 273. Among its purposes is the enforcement of just medical laws, the protection of its members against unjust encroachments on their professional care of patients, and the enlightenment of public opinion with regard to matters of great import to Kentucky physicians and their patients. Kentucky physicians are personally and directly impacted by the outcome in this matter. As the voice of Kentucky physicians, the KMA offers a unique and critical perspective on health care laws affecting its members.

The AMA and KMA appear on their own behalf and as representatives of the AMA Litigation Center. The Litigation Center is a coalition among the AMA and the medical societies of every state. The AMA Litigation Center is the voice of America's medical profession in legal proceedings across the country. The mission of the Litigation Center is to represent the interests of the medical profession in the courts. It brings lawsuits, files *amicus* briefs and otherwise provides support or becomes actively involved in litigation of general importance to physicians.

STATEMENT OF THE CASE

This case involves whether expert testimony is necessary to establish that a physician deviated from the standard of care in monitoring for signs of a stroke following a medical procedure, and, if so, the extent of damage caused by any delay attributed to the physician's negligence. The briefs of the Appellants detail the factual and procedural history of this case with ample references to the record. *Amici* adopt their Statements of the Case and highlight information that is particularly relevant to this *amicus* brief.

Plaintiff, David Shackelford, presented at King's Daughters Medical Center (KDMC) for a cerebral angiogram to assist in diagnosing the cause of his chronic headaches. Dr. Lewis, a radiologist, performed the angiogram without complications. After the procedure, Shackelford reported a headache and seeing "floaters," symptoms that are not uncommon after an angiogram. Plaintiff did not report weakness, slurred speech, or facial palsy, which may indicate a stroke. He was given medication for his symptoms, kept for observation for eight hours (even as expert testimony indicated the typical monitoring period following an angiogram is four hours), and reported improvement before he was discharged at approximately 7:30 p.m. After exhibiting disoriented behaviors following his discharge, Plaintiff returned to KDMC the following morning at 8 a.m. An MRI revealed signs of a recent stroke.

Plaintiff filed a complaint alleging negligent medical care. He does not allege that any healthcare provider's negligence caused the stroke itself, which is a known risk of an angiogram. Rather, he alleges that had Appellants detected the stroke earlier, he would not have suffered the extent of harm he attributes to the stroke. Specifically, Plaintiff asserts that Appellants should have conducted an MRI while he was in recovery and admitted him for overnight hospitalization.

Plaintiff's expert witness, Dr. Michael Khoury, could not affirmatively answer whether, within a reasonable degree of medical probability, Dr. Lewis's post-procedure care was a substantial factor in causing Plaintiff's harm. Dr. Khoury indicated that it is "impossible to tell . . . whether or not [Plaintiff's] stroke, and its neurologic deficit would be any different had he been hospitalized versus going home."

Due to the lack of expert testimony indicating that any action or inaction on the part of the defendants caused Plaintiff's harm, the trial court granted summary judgment and dismissed Plaintiff's claims. The Court of Appeals reversed, holding that a plaintiff could present these complex issues of causation to a jury without the aid of expert testimony. The court acknowledged that a plaintiff must ordinarily present proof of causation in a medical negligence action through expert testimony. Yet, the court excused the need for expert testimony here, finding that the importance of promptly identifying and treating a stroke is "common knowledge." The court also indicated that *res ipsa loquitur* may excuse the typical need for expert testimony in such circumstances.

While the basic principle that early detection of a stroke (or other condition) is beneficial to patients may be true, it does not speak to whether a physician's treatment decisions departed from the standard of care and caused harm to a patient. The Court of Appeals' reasoning exposes healthcare providers to liability for harms resulting from underlying medical conditions and known risks that they did not cause. It will spur unnecessary defensive medicine, as physicians will feel compelled to order tests and admit patients solely to protect themselves from adverse outcomes, regardless of the accepted standard of care. The AMA and KMA urge the Court to reaffirm the well-established requirement that a plaintiff must present expert testimony supporting a claim that a physician's deviation from the applicable standard of care caused the plaintiff's alleged injury.

ARGUMENT

I. Unless expert testimony indicates that a healthcare provider's treatment decisions resulted in a patient's condition, doctors will be subject to hindsight bias and liability for harm they did not cause.

Expert testimony is critical for providing jurors with a basis for determining whether a medical professional took the proper steps to evaluate a patient based on his or her condition and, if not, whether any delay in detecting or treating a health issue caused a patient harm. Permitting juries to evaluate such complex medical decisions based on "common knowledge," as the Court of Appeals' decision allows, is a recipe for imposing liability for harm that a physician did not cause and could not have prevented based on the accepted standards of care.

Physicians regularly care for people with significant health problems. A patient's health may decline following a medical procedure due to the underlying medical condition or a known risk of treatment, including complications. The challenge in fairly deciding medical liability litigation is to "differentiate between adverse events and medical errors." David Sohn, *Negligence, Genuine Error, and Litigation*, 6 Int'l J. Gen. Med. 49, 50 (2013). According to a Harvard Public Health Study, only about 27 percent of adverse events are caused by negligence. *See* Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 New Eng. J. Med. 370, 371 (1991), https://www.nejm.org/doi/pdf/10.1056/NEJM199102073240604. Physicians must not face liability simply because a patient experiences an unfortunate outcome. Otherwise, the resulting strict liability will create "a chilling effect on treating complex conditions or performing difficult procedures." Sohn, 6 Int'l J. Gen. Med. at 50.

As this Court has recognized, "[m]ost medical malpractice claims involve issues of science and professional skill outside the ordinary experiences and range of knowledge

of typical jurors and judges." *Adams v. Sietsema*, 533 S.W.3d 172, 179 (Ky. 2017). Expert testimony assists the jury in determining both the standard of care and whether a departure from that standard was a proximate cause of the damage claimed by a patient. *See id.* Most medical liability cases cannot proceed without such expert evidence. *See id.* This case is no exception.

Without expert testimony, juries are naturally predisposed to viewing an adverse outcome as stemming from negligent care. Jurors understandably seek to "find someone to blame" for an adverse event so that they may provide compensation to a sympathetic plaintiff. David P. Sklar, *Changing the Medical Malpractice System to Align with What We Know About Patient Safety and Quality Improvement*, 92 Acad. Med. 891, 891 (2017). As medical liability claims arise only after an adverse event takes place, jurors are particularly susceptible to hindsight bias. *See* Hal R. Arkes, *The Consequences of the Hindsight Bias in Medical Decision Making*, 22 Current Directions in Psychol. Sci. 356, 358 (2013), https://www.researchgate.net/publication/258127985_The_Consequences_of_the_Hindsight_Bias_in_Medical_Decision_Making (observing that jurors may be prone to think that a physician "should have easily been able to make the correct diagnosis").

"Hindsight bias" refers to the "human tendency to look back upon past events and view them as being expected or obvious." Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 Tort & Ins. Prac. L.J. 895, 905 (2007). Hindsight bias leads those who know the outcome (good or bad) to view the level of medical care provided in the same manner. *See* Eric J. Thomas & Laura A. Petersen, *Measuring Errors and Adverse Events in*

Health Care, 18 J. Gen. Intern Med. 61, 63 (2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494808/pdf/jgi_20147.pdf (recognizing that medical conferences used to review adverse events as well as medical liability claims are subject to hindsight bias). Hindsight bias makes it "difficult for finders of fact to evaluate fairly (e.g., without reference to whether the decision, in retrospect, turned out to be the right choice)." Haskel, 42 Tort & Ins. Prac. L.J.at 905. When a patient experiences a poor outcome, medical care that is "second guessed by a hindsightful observer" may appear to result from "incompetence, folly, or worse." *Id.* at 906 (quoting Baruch Fischhoff, *Hindsight ≠ Foresight: The Effect of Outcome Knowledge on Judgment Under Uncertainty*, 1 J. Experimental Psych.: Hum. Perception & Performance 288 (1975), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743746/pdf/v012p00304.pdf).

Expert testimony is critical to the ability of juries to overcome hindsight bias. When jurors lack a proper medical grounding, they may improperly fill the voids by presuming that a physician's action or inaction caused a patient's alleged harms. The requirement that a plaintiff proffer expert medical testimony establishing medical negligence, proximate cause, and injury provides a basic safeguard against unmeritorious cases proceeding beyond a motion for summary judgment and ending in a verdict based on hindsight rather than science. *See* Haskel, 42 Tort & Ins. Prac. L.J.at 908-09.

The Court of Appeals' ruling allows lay jurors to use "common knowledge" to fill gaps in medical evidence. The ruling will feed hindsight bias aimed at compensating sympathetic plaintiffs regardless of a physician's fault. Basing liability on the rudimentary observation that early detection of an illness or other medical condition is better for patient results is not a medically sound standard. Strokes are not the only type

of medical condition where it is "common knowledge" that patients benefit from early detection and treatment. The same is true of cancer, Alzheimer's disease, infectious diseases, and many other conditions. Excusing the need for expert testimony to show that a physician's departure from the standard of care caused or exacerbated a patient's injury would expose physicians to liability based on speculation, not medical science.

II. *Res ipsa loquitur* has no place in establishing causation in complex medical liability cases.

The doctrine of *res ipsa loquitur* has no place in evaluating complex questions of medical judgment and the level of harm caused by a deviation from the standard of care.

Res ipsa loquitur, meaning, "the thing speaks for itself," originated in situations in which an unusual or bizarre occurrence—a barrel of flour rolling out of a warehouse window and falling on a pedestrian—indicates no other explanation for a plaintiff's injury than a defendant's negligence. *See* W. Page Keeton et al., Prosser & Keeton on Torts § 39, at 243 (5th ed. 1984). This doctrine is misused when it is applied to answer questions concerning the standard of care for detecting a medical condition, whether any delay in a diagnosis exacerbated a plaintiff's harm, and, if so, how much harm stemmed from the underlying condition and how much harm can be attributed to a physician's negligence.

Cases in which courts apply *res ipsa* often involve facts and injuries that are "freakish and improbable." *Id.* at 245. Injuries that occur frequently enough without anyone's fault are not those for which negligence is the most likely explanation and thus *res ipsa loquitur* does not apply. *Id.* at 246 (using a staph infection following an operation as one such example). When a surgeon leaves a sponge or a tool in a patient or removes an incorrect arm or leg, courts have found that those may be instances where the

"thing speaks for itself" and have allowed juries to find negligence without expert testimony. *See id.* at 256-57. Kentucky law is consistent with this principle. *See Nazar v. Branham*, 291 S.W.3d 599, 604-05 (Ky. 2009) (finding jury may infer through *res ipsa* approach, but is not required to find, negligence when a surgical item is left in patient's body).

The case at bar, though, is far removed from these scenarios. As Dean Prosser recognized:

> [T]here is usually not enough in a mistaken diagnosis alone, or the unfortunate choice of the wrong method of treatment, or the kind of accident or undesirable result which happens in spite of all reasonable precautions, to show the necessary lack of skill or care. What this means is that ordinary laymen are not qualified to say a good doctor would not go wrong, and that expert testimony is indispensable before any negligence can be found.

Prosser & Keeton on Torts § 39, at 256 (citations omitted). To this end, this Court has recognized that *res ipsa* may permit a jury to decide a medical liability case without expert testimony only in rare circumstances. *See Adams v. Sietsema*, 533 S.W.3d 172, 179 (Ky. 2017). The case must be one in which "the jury may reasonably infer both negligence and causation from the mere occurrence of the event and the defendant's relation to it." *Id.* (quoting *Blankenship v. Collier*, 302 S.W.3d 665, 670 (Ky. 2010)). The injury must be one that "could not have occurred but for the negligence of [a physician]." *Id.*; *see also Love v. Walker*, 423 S.W.3d 751, 757 (Ky. 2014) (finding *res ipsa* did not apply, and expert testimony was required, to show whether a doctor performed a surgery in a negligent manner that caused paralysis of plaintiff's vocal cord).

Other state high courts have similarly recognized that *res ipsa* has a highly limited role in medical liability cases. As the Pennsylvania Supreme Court observed:

> Courts sitting in medical malpractice cases require detailed expert testimony because a jury of laypersons generally lacks the knowledge to determine the factual issues of medical causation; the degree of skill, knowledge, and experience required of the physician; and the breach of the medical standard of care. In contrast, plaintiffs in *res ipsa loquitur* cases rely on the jury to fill in the missing pieces of causation and negligence, inherent in their cases, with the jury's common experience. . . .
>
> *Res ipsa loquitur* must be carefully limited, for to say whether a particular error on the part of a physician reflects negligence demands a complete understanding of the procedure the doctor is performing and the responsibilities upon him at the moment of injury. . . . [M]edicine being an applied science, the realm of reasonable choice is best defined by those engaged in the practice, and expert medical testimony on this issue is required. As aptly noted by the Justices of the Supreme Court of New Mexico, "The cause and effect of a physical condition lies in a field of knowledge in which only a medical expert can give a competent opinion . . . . [Without experts] we feel that the jury could have no basis other than conjecture, surmise or speculation upon which to consider causation."

Toogood v. Owen J. Rogal, D.D.S., P.C., 824 A.2d 1140, 1149 (Pa. 2003) (quoting *Woods v. Brumlop*, 377 P.2d 520, 523 (N.M. 1962)).

Plaintiffs must not be able to rely on *res ipsa* in medical liability actions merely because they have difficulty securing expert testimony supporting their claims; this situation, as here, may indicate there was no malpractice. *See* O.C. Adamson, II, *Medical Malpractice; Misuse of Res Ipsa Loquitur*, 46 Minn. L. Rev. 1043, 1051 (1962). When courts apply *res ipsa* to complex medical liability determinations, physicians become subject to liability "for a bad result unless the jury may choose to exonerate him." *Id.* at 1055.

Here, Plaintiff was aware that stroke is a risk of a cerebral angiogram. The questions in this case involve whether he suffered a stroke while in observation at the hospital or after discharge, whether his physician should have ordered additional testing such as an MRI before his release or admitted Plaintiff overnight, and, whether any of

these actions would have reduced Plaintiff's injury and, if so, how much. These are not issues suitable for application of *res ipsa*, but include complex determinations of medical judgment, the ability and speed at which a physician should detect and diagnose a medical condition, and causation.

III. The Court of Appeals' decision, if affirmed, will spur unnecessary and costly defensive medicine.

Because of the Court of Appeals' decision, patients may be subject to more medical tests, which could have risks and costs without any corresponding benefit. The decision sends a message to practitioners that they should direct patients to undergo medical tests, such as MRIs, and order overnight hospitalizations, even when a patient's symptoms do not indicate the need for such measures. If physicians do not engage in such defensive medicine, the Court of Appeals decision suggests that they will expose themselves to liability for later-developed complications that earlier tests or observation could not have prevented.

Fear of lawsuits can affect the way physicians practice. It can cause them to order tests that are unnecessary or have minimal utility in an effort to reduce the chance that a patient will attribute an adverse outcome to a doctor's care. For example, research indicates that when physicians are concerned about the potential for a lawsuit, they are significantly more likely to order diagnostic tests or advanced imaging for patients who complain about common conditions that can stem from benign underlying causes. *See* Emily R. Carrier et al., *High Physician Concern About Malpractice Risk Predicts More Aggressive Diagnostic Testing in Office-Based Practice*, 32 Health Aff. 1377, 1386 (2013), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0233. Researchers observe that physicians use defensive medicine—testing for every possible diagnosis no

matter how unlikely—as a method of counteracting hindsight bias. Arkes, 22 Current Directions in Psychol. Sci. at 358.

These tests and longer hospital stays may avoid liability, but they may not be beneficial to patients. Testing itself (as Plaintiff's angiogram here so starkly illustrates) comes with its own risks.

Unnecessary tests and hospital admissions also come at substantial cost to patients, insurers, and taxpayers. For example, Plaintiff here alleges that healthcare providers should have conducted an MRI following his procedure and admitted him for overnight observation, based only on a reported headache during recovery (which he experienced chronically) and floaters in his vision. Should an MRI become standard practice after a cerebral angiogram, it would add more than $2,500 to the cost of each procedure.[1] In addition, each day of inpatient care costs thousands of dollars.[2] While these costs may appear warranted in hindsight, doctors must evaluate whether tests and hospitalization are warranted based on each individual patient's condition at the time.

While it is difficult to estimate the total cost of defensive medicine, evidence indicates that treating patients in this manner adds billions of dollars to the nation's

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[1] *See* Anne Saker, *Cheap MRIs Give Patients More Options*, Cincinnati Enquirer, Nov. 22, 2014, https://www.cincinnati.com/story/news/2014/11/22/cheap-mris-proliferate-even-groupon/19431111/ (reporting that the average cost of an MRI in Kentucky in 2014 was $2,530, not including the cost of the radiologist's report); Lacie Glover, *Why Does an MRI Cost So Darn Much?*, Money, July 16, 2014, http://time.com/money/2995166/why-does-mri-cost-so-much/ (indicating that the equipment and suite that houses an MRI machine costs millions of dollars, which is factored into the cost of an MRI along with the radiologist fee, the contrast dyes, and the cost of the procedure itself).

[2] *See* Henry J. Kaiser Family Found., *State Health Facts, Hospital Adjusted Expenses Per Inpatient Day by Ownership* (2016), https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day-by-ownership/ (estimating the average cost incurred by Kentucky hospitals to provide a day of inpatient care from $1,720 to $1,898 in 2016 depending on hospital ownership).

annual healthcare bill. A 2003 U.S. Department of Health and Human Services (HHS) report placed the cost of defensive medicine at between $70 billion and $126 billion per year. *See* Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Servs., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care 11 (2003), https://aspe.hhs.gov/system/files/pdf/72871/medliab.pdf. A more recent and conservative estimate put the 2008 cost of defensive medicine at $45.6 billion. *See* Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 Health Aff. 1569, 1574 (2010), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2009.0807.

The Court of Appeals decision, by permitting lawsuits alleging a delay in diagnosing a condition without the support of an expert, is especially likely to foster more defensive medicine. Claims alleging that a healthcare provider did not diagnose a condition quickly enough are among the most common bases for lawsuits. *See* Diederick Healthcare, 2018 Medical Malpractice Payout Analysis (2018), https://www.diederichhealthcare.com/wordpress_content/uploads/2018/03/infographic.pdf (reporting that 34% of medical liability claims related to a diagnosis and that the average payout in a Kentucky medical liability claim rose 17% between 2016 and 2017).

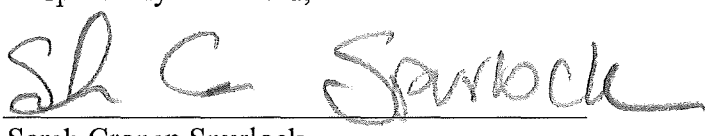
In sum, early detection of a medical condition—whether it is cancer, an infection, or a stroke—can often improve a patient's odds of recovery. This "common knowledge" does not negate the need for a physician to use his or her professional medical judgment based on an individual patient's reported symptoms at the time to determine what testing or course of treatment is warranted. When a patient experiences an adverse event, juries must decide whether what occurred stemmed from an underlying medical condition or a

known risk of treatment, or whether it resulted from a healthcare provider's negligence in not conducting additional tests, requiring lengthier observation, or admitting the patient. Only a qualified physician can evaluate whether there was a deviation from the standard of care and, critically here, if so, whether a delay in detecting a medical condition caused a patient to experience avoidable harm. A jury's decision making in medical liability cases must be based on scientific evidence, not speculation that is prone to hindsight bias.

CONCLUSION

For these reasons, the American Medical Association and Kentucky Medical Association respectfully request that this Court reverse the Court of Appeals and reinstate the trial court's issuance of summary judgment and dismissal of Plaintiff's claim.

Respectfully submitted,



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