CHAPTER 16

The Supreme Court and Medical Malpractice Law

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I. INTRODUCTION

Calling physicians to account for errors is nothing new. More than four thousand years ago, the Code of Hammurabi decreed, "If the doctor has treated a gentleman with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has caused the loss of the gentleman's eye, one shall cut off his hands." Although Roman law replaced such retribution with compensation, it had long recognized claims for mala praxis, or "bad practice," and this theory of liability was carried forward into the English common law, which resolved the first known negligence suit against a physician in 1374.[1] The term *malpractice* can be traced to Sir William Blackstone's seminal 1768 text *Commentaries on the Laws of England*, which defines the term as a "great misdemeanor and offence at common law."[2]

In the United States, claims for medical malpractice began appearing with some regularity in the early 1800s. By midcentury, such claims had dramatically increased due to a number of factors, including an increase in all types of litigation that accompanied America's rapid industrialization, an increased focus on personal responsibility that slowly replaced notions of religious fatalism, and antielite sentiments against physicians and other professionals that marked the populism of Jacksonian democracy.[3] Whatever the cause, the effect was clear: the number of medical malpractice cases on appeals courts' dockets grew a remarkable 950 percent between 1840 and 1860.[4] One scholar noted in 1860 that most of the oldest physicians in almost every part of the country had by then been either sued or threatened with suit.[5]

Pennsylvania was at the leading edge of the rising tide of medical malpractice litigation. By 1850, perhaps only New York saw more malpractice suits.[6] This trend continued for approximately a century, until the 1960s, when a wholesale expansion of tort law spurred a

further increase in the volume of such suits. Consequently, for more than a century and a half, the Pennsylvania Supreme Court has been called on to adopt and apply traditional tort concepts to medical malpractice litigation, often in novel circumstances. This chapter recounts the Court's important work in this regard. It begins with a discussion of how the common-law elements of negligence—duty, breach, causation, and damages—have been defined and applied in suits against healthcare providers to develop the unique body of medical malpractice law we recognize today. It next addresses the Court's review of statutes governing medical malpractice litigation and the promulgation of procedural rules specifically governing such litigation. Finally, the chapter reviews the Court's ongoing efforts to track medical malpractice filings and verdicts and to inform the public about the evolution of the litigation by publishing detailed statistics on its official website. As a whole, the chapter assesses the Court operating in four distinct capacities—as a common-law court, constitutional- and statutory-review court, rulemaking body, and research and public information bureau.

II. THE COURT'S COMMON-LAW DECISIONS ON MEDICAL MALPRACTICE

The Court has demonstrated a sophisticated approach to medical malpractice issues when acting as a common-law court, with its first such decision dating before the Civil War. While the common-law negligence elements of duty, breach, causation, and damages are commonly understood in tort litigation generally, they raise complicated issues when applied to the unusual circumstances of medical malpractice cases.

A. Duty

The Supreme Court's frequent and most important malpractice cases have defined the scope of a healthcare provider's duty of care to a patient. The earliest of these decisions, *McCandless v. McWha* in 1853,[7] addressed the fundamental question of whether a physician who has not acted negligently can be liable for a bad outcome experienced by a patient. On the one hand, an ancient strain of legal theory held physicians liable for any untoward result (a patient's death or the loss of an eye, punishable in the Code of Hammurabi), regardless of whether the physician did anything wrong. On the other hand, the common law largely supplanted this concept of strict liability with the fault-based precept that because bad results happen even when due care is provided, physicians should not be held liable in the absence of negligence. *McCandless*, the first Pennsylvania decision to use the term *malpractice*, involved a claim "for malpractice in setting a broken leg of the plaintiff."[8] Reflecting the older concept of strict liability, the trial court charged the jury that the physician could be held liable if the broken leg failed to heal straight and equal with the uninjured leg. The jury found for the plaintiff and the defendant appealed.

The Supreme Court vacated the verdict on the basis that the trial court had allowed the defendant to be found liable regardless of fault. According to the Court, a contract for medical services did not include a warranty of cure, a mere bad outcome without corresponding negligence does not constitute malpractice, and a surgeon's duty is only to provide reasonable skill and diligence "such as thoroughly educated surgeons ordinarily employ."[9] To be sure, the Court explained, "the law has no allowance for quackery," but it simply "demands *qualification* in the profession practiced—not extraordinary skill such as belongs only to a few men of rare genius and endowments, but that degree which ordinarily characterizes the profession."[10] A physician "is bound to be up to the improvements of the day" and "must apply himself with all diligence to the most accredited sources of knowledge" because the patient "is entitled to the benefit of these increased lights."[11] But liability can attach only if the physician is negligent.[12] This foundational statement of a physician's duty of care remains the law today.

The Court also spent considerable effort addressing whether a physician's standard of care is defined by local custom and practice, known as the "locality rule," or by the broader standards of the medical profession as a whole. The "locality rule" had taken hold in the eighteenth century and endured well into the following century as courts recognized that many physicians practiced in rural communities without ready access to cutting-edge medical advancements, and it was therefore unfair to subject them to a standard of care that reflected the more sophisticated practice in large cities.[13] At first, the Supreme Court embraced the "locality rule." In its 1959 decision in *Donaldson v. Maffucci*, the Court explained that a physician who is not a specialist "is required to possess and employ in the treatment of a patient the skill and knowledge usually possessed by physicians *in the same or similar locality*."[14]

Twelve years later, however, in its 1971 decision in *Incollingo v. Ewing*,[15] the Court rejected local custom as a valid component of a physician's duty to patients. In *Incollingo*, the defendant physician invoked the locality rule and argued that he was not negligent because his failure to pay attention to written warnings associated with a drug and his prescribing the drug over the telephone without having seen the patient was an accepted practice among local physicians. The Court rejected the argument that the medical profession may set its own standard of conduct by establishing a local custom of practice. Quoting Justice Oliver Wendell Holmes of the US Supreme Court, the Court stated, "What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is usually complied with or not."[16]

Instead, henceforth, the standard of care of physicians in Pennsylvania would be an objective one—that is, "the statement that 'A physician is required to exercise only such reasonable skill and diligence as is ordinarily exercised in his profession' . . . is not to be taken in isolation, and in disregard of the admonition to give due regard to the advanced state of the profession and to exercise the care and judgment of a reasonable man in the exercise of medical skill and knowledge."[17] In a concurring opinion, Justice Samuel J.

Roberts voiced his agreement that in light of the modern state of medicine and the national dissemination of medical information, the locality rule was no longer sound:

> During the period of its original formulation in the middle and late nineteenth century the "locality rule" was plausibly expedient. The law was arguably wise in indulging in the assumption that medical knowledge, skill and care varied considerably from community to community. . . .
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> Present day conditions, however, cast much doubt upon the rule. Modern systems of transportation and communication, the proliferation and widespread dissemination of medical literature, and the prevalence and availability of seminars and postgraduate courses make it both possible and desirable for *all* practitioners to be reasonably familiar with current medical advances. Furthermore, the major source of a physician's professional expertise is not the particular locality in which he practices but initially the institutions in which he received his education and professional training.
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> In light of the foregoing, the locality rule is an anachronism. . . . The standard of care required of a specialist or general practitioner should be that of a reasonable specialist or general practitioner in similar circumstances practicing medicine in light of present day scientific knowledge.[18]

In 1981, ten years after *Incollingo*, the Supreme Court's application of an objective, "reasonable man" standard of care was incorporated into Pennsylvania's standard jury instructions. That basic instruction remains in effect today: "A physician must have the same knowledge and skill and use the same care normally used in the medical profession. A physician whose conduct falls below this standard of care is negligent."[19]

In addition to defining physicians' duties in the negligence context, the Court began to develop and enunciate the physician's duty to obtain a patient's informed consent. In its 1966 decision in *Gray v. Grunnagel*, the Court stated that in "the absence of an emergency, the consent of the patient is 'a prerequisite to a surgical operation by his physician' and an operation without the patient's consent is a technical assault."[20] The Court explained further that "it will be no defense for a surgeon to prove that the patient had given his consent, if the consent was not given with a true understanding of the nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results."[21] More recently, in its 2008 decision in *Fitzpatrick v. Natter*, the Court expanded the ability to sue for lack of informed consent by holding that a patient "need not show that she would have chosen differently had she possessed the missing information, but only that the missing information would have been a substantial factor in this decision."[22]

In addition to recognizing this new duty to obtain informed consent, the Court also expanded traditional tort duties by imposing liability on surgeons for the acts of others under their supervision in the operating room and requiring hospitals to be responsible

for malpractice that occurs within their walls. First, in its 1949 decision in *McConnell v. Williams*, the Court ruled that surgeons can be vicariously liable for the negligent actions of nurses or interns in the operating room.[23] *McConnell* involved a hospital intern who improperly introduced silver nitrate into the eye of a young child in the operating room, rendering her blind.[24] Finding that the surgeon could be held liable, the Court explained, "It can readily be understood that in the course of an operation in the operating room of a hospital, and until the surgeon leaves that room at the conclusion of the operation . . . he is in the same complete charge of those who are present and assisting him as is the captain of a ship over all on board."[25] Ever since, the "captain of the ship" doctrine has been a recognized basis on which surgeons can be liable for the acts of others in the operating room. In two subsequent decisions, *Shull v. Schwartz* and *Scacchi v. Montgomery*, both decided in 1950, the Court clarified that the "captain of the ship" doctrine is limited to events that occur *inside* the operating room and during the course of an ongoing operation.[26]

The Court also expanded the liability of hospitals. Traditionally, hospitals were nonprofit endeavors that were run by religious or other charitable organizations. Because they were charitable, hospitals were generally protected from civil liability under the theory that recovery of a judgment by one patient would deplete resources that could be used to treat other patients. This protection was known as "charitable immunity." However, by the mid-twentieth century, medicine was increasingly seen as a business, and for-profit interests began to acquire and operate hospitals. As this occurred, the traditional rationale for protecting charitable resources gave way to the recognition that hospitals, even ones that remained affiliated with religious or other charitable groups, were professionally managed, multi-million-dollar enterprises that should be subject to the same rules and liabilities as other such enterprises.

In 1965, in *Flagiello v. Pennsylvania Hospital*, the Court considered whether the time had come to abolish charitable immunity and subject hospitals to civil liability.[27] While the Court was divided on whether the public policy considerations for and against continuing immunity should be balanced by the legislature rather than the judiciary, the Court finally concluded that the issue involved a legal question that it was duty bound to resolve. "[W]e have a duty to perform," the Court reasoned, "and that is to see that justice, within the framework of law, is done."[28] Having resolved to decide the question, the Court had little doubt that charitable immunity as "an instrument of injustice . . . long ago outlived its purpose if, indeed, it ever had a purpose consonant with sound law."[29] *Flagiello*, which presaged the widespread abolition of charitable immunity in the United States in the decade that followed, enabled plaintiffs to bring suits against not only individual medical professionals but also the nonprofit institutions that employed them.

The duties of hospitals were further expanded in 1991, when the Court rendered its landmark decision in *Thompson v. Nason Hospital*.[30] Even after the abolition of charitable immunity in *Flagiello*, hospitals were not themselves viewed as healthcare providers that could be subject to medical malpractice liability. Instead, such liability could be asserted

only against physicians, nurses, and other professionals. Hospitals could be subjected to liability only on agency principles like *respondeat superior*. They could not be sued directly in negligence for deficient or nonexistent policies and procedures governing medical practice within their walls. This changed with *Thompson*'s recognition of a cause of action for "corporate negligence," which provided that hospitals owe duties directly to patients to (1) use reasonable care in the maintenance of safe and adequate facilities and equipment, (2) select and retain only competent physicians, (3) oversee all persons who practice medicine within its walls as to patient care, and (4) formulate, adopt, and enforce adequate rules and policies to ensure quality care for the patients.[31] In 2012, in *Scampone v. Highland Park Care Ctr., LLC*, the Court extended *Thompson*'s theory of corporate negligence to nursing homes as well.[32]

Finally, during the 1990s, the Court confronted complicated issues regarding whether healthcare providers owe duties to people other than their patients, including the public at large. In *Goryeb v. Commonwealth Department of Public Welfare*, the Court imposed a duty of care on mental health professionals to victims who were shot by a discharged mental patient because the victims "could foreseeably be affected" if the discharge of the patient was improper.[33] The Court further extended this duty in *Sherk v. County of Dauphin*, holding that under the logic of *Goryeb*, a police officer shot by a released mental patient could recover from the hospital for its negligent release of the patient.[34]

The Court limited this duty to third parties in *Estate of Witthoeft v. Kiskaddon*. In that case, an ophthalmologist knew through an examination that his patient's corrected eyesight did not meet the 20/70 standard required for a driver's license in Pennsylvania.[35] The ophthalmologist failed to report the patient's deficient eyesight to state authorities, and the patient later struck and killed a bicyclist while driving. The Court declined to create a private cause of action against the defendant, explaining, "[I]t is an unreasonable extension of the concepts of duty and foreseeability to broaden a physician's duty to a patient and hold a physician liable to the public at large within the factual scenario of this case."[36]

The Court's reluctance to impose additional duties on healthcare professionals was further seen in *Althaus v. Cohen*, in which a psychiatrist diagnosed and treated a child for sexual abuse by her parents. The child was removed from the family home and the parents were arrested and prosecuted by the local police. All charges were dropped when it was determined that the child had fabricated the accusations and was unable to distinguish fact from fantasy. The parents sued the psychiatrist, alleging negligence in diagnosing and treating the child and exacerbating the child's condition. After a jury returned a verdict in the plaintiff's favor, the Supreme Court considered whether the psychiatrist owed a duty of care to the parents as a threshold matter. Recognizing that the parents were third parties to the counseling relationship, the Court declined to

"impos[e] a duty of care to non-patients upon a therapist who treats sexually abused children."[37]

B. Breach

In addition to defining the duties owed to patients, the Court has rendered a number of important decisions addressing the circumstances in which a duty is breached. The earliest such cases involved the question of whether a physician who makes an error of judgment breaches the standard of care if the error itself does not constitute negligence. This "error of judgment" doctrine holds that medical practice is complicated and that an error that would have been made by a reasonable physician cannot be a basis for liability. Therefore, a plaintiff must show that the physician's decision breached the standard of care, not merely that it was erroneous. Applying the doctrine in a physician's favor, the Court's 1891 decision in *Williams v. Le Bar* explained that where "the most that a case discloses is an error of judgment on the surgeon's part, there is no liability."[38] In 1939, the Court again addressed the doctrine in *Hodgson v. Bigelow*, holding that liability does not attach for a physician's error of judgment "unless it is so gross as to be inconsistent with the degree of skill which it is the duty of every physician to possess."[39] Finally, in its 1935 decision in *Duckworth v. Bennett*, the Court again ratified the "error of judgment" doctrine.[40]

In 2014, the Court revisited the "error of judgment" doctrine and, in a sharply divided vote, ruled that its inclusion in a jury charge required a new trial because it unnecessarily confused the question of negligence before the jury. Specifically, in *Passarello v. Grumbine*, the Court concluded that the instruction was confusing because it asked the jury to not only determine whether a physician was negligent because of a failure to adhere to an objective standard of care but also consider whether the physician's "error" in the exercise of his or her "judgment" concerning an objective standard of care is not negligence.[41]

While *Duckworth*'s reliance on the "error of judgment" doctrine is no longer viable, the case remains notable for its articulation of the "two schools of thought" doctrine, which holds that a physician does not breach a duty of care by choosing, in the exercise of his or her professional judgment, one of two or more accepted courses of treatment.[42] The doctrine remains a viable defense under Pennsylvania law, though it was limited under certain circumstances by three cases decided within a year of each other in the early 1990s. In its 1992 decision in *Jones v. Chidester*, the Court noted that the doctrine operates as "a complete defense to malpractice" but stated that a "school of thought should be adopted not only by 'reputable and respected physicians' in order to insure quality but also by a 'considerable number' of medical practitioners."[43] In *Levine v. Rosen*, also in 1992, the Court held that the doctrine does not apply in cases claiming failure to diagnose.[44] Finally, in *Sinclair by*

Sinclair v. Block, decided in 1993, the Court held that the doctrine does not apply where a physician improperly performed a medical procedure.[45]

C. Causation

Although not as frequent as cases involving duty, the Court's causation cases have had a lasting impact on Pennsylvania medical malpractice law. First, in its 1966 decision in *Dornon v. Johnson*, the Court held that a physician's breach of duty must be a "substantial factual cause" of the injury for which damages are sought.[46] This concept, later referred to as "substantial factor," or "factual cause," continues to be the benchmark for proving causation in medical malpractice cases.

The Court's 1978 decision in *Hamil v. Bashline*, one of the most important medical malpractice rulings ever handed down in Pennsylvania, further refined the standard for causation.[47] That case involved whether and how a plaintiff can meet the traditional "substantial factor" standard of proving causation in a case where the harm might have occurred regardless of what the defendant did (or did not do) to prevent it.

The facts of *Hamil* were straightforward. The plaintiff and her husband presented to the emergency room at a hospital with her husband complaining of severe chest pains. As the hospital did not have working electrocardiogram equipment, the plaintiff was forced to transport her husband to a private physician's office for further evaluation. Her husband died at that office during the electrocardiogram. The plaintiff filed a wrongful death action.[48] At trial, her expert could not testify with the usual reasonable degree of medical certainty that the hospital's failure to have working electrocardiogram equipment caused the decedent's death because he might well have died of a heart attack even if the hospital had working equipment. Recognizing that any greater certainty was impossible, the plaintiff's expert testified that the negligence "probably" caused the decedent's death and that there was a 75 percent chance that the decedent would have survived had the hospital possessed working electrocardiogram equipment. The plaintiff lost the verdict, and on appeal, the Supreme Court discussed the burden of proving causation in a case where the harm might have occurred even if the defendant was not negligent.

The Court began its analysis by explaining that the plaintiff's negligence claim amounted to a claim for negligent performance of an undertaking to render services as described in the Restatement (Second) of Torts, Section 323. This provision encompasses situations where a defendant failed in a duty to protect the plaintiff against harm from another source, necessitating an inquiry into (1) what happened and (2) whether the harm might have been avoided had the defendant acted in a nonnegligent manner.[49] The Court went on to explain that "such cases by their very nature elude the degree of certainty one would prefer and upon which the law normally insists before a person may be held liable. Nevertheless, so that an actor is not completely insulated because of uncertainties as to the consequences of his negligent conduct, Section 323(a) tacitly

acknowledges this difficulty and permits the issue to go to the jury upon a less than normal threshold of proof."[50]

Applying this standard, the Court held that once a plaintiff has demonstrated that the defendant's acts or omissions "have increased the risk of harm to another, such evidence furnishes a basis for the fact-finder to go further and find that such increased risk was in turn a substantial factor in bringing about the resultant harm; the necessary proximate cause will have been made out if the jury sees fit to find cause in fact."[51] *Hamil* thus established the process for proving causation under the rubric of increased risk of harm in medical malpractice cases.

Although *Hamil* arose in the context of a claim for negligent treatment, the Court extended this precedent to cases involving a physician's misdiagnosis, such that evidence that the misdiagnosis increased the risk of harm is sufficient to create a jury question on causation.[52] The Court has also made clear that an evidentiary showing through expert medical testimony, made with a reasonable degree of medical certainty[53] that a defendant increased the risk of harm sustained by the plaintiff, suffices to make out a prima facie case of liability.[54] The Court has subsequently explained that *Hamil* and its progeny require a twofold analysis on causation: (1) whether the expert could testify to a reasonable degree of certainty that the defendant's action could cause the harm sustained by the plaintiff and then (2) whether the acts complained of caused the actual harm suffered by the plaintiff.[55]

In 1981, three years after *Hamil*, the Court rendered another landmark causation decision that considered whether expert testimony is required to establish causation in all medical malpractice cases or whether an inference of negligence might arise, without expert testimony, where direct proof of causation is absent but the circumstances indicate that the defendant must have been negligent. This inference of negligence is known as "*res ipsa loquitur*," which allows a jury to find negligence without expert testimony where the defendant's conduct is the only plausible explanation for a plaintiff's harm. In previous cases, the Court precluded *res ipsa loquitur* in the medical malpractice context,[56] but it considered the question anew in 1981 in *Jones v. Harrisburg Polyclinic Hospital*.[57]

In *Jones*, the plaintiff suffered nerve pain in her neck, back, and arms as a result of abdominal surgery. Because the plaintiff was unconscious during the surgery, she had no direct evidence of what caused the injury. As a result, she invoked *res ipsa loquitur* and argued that the only plausible explanation for her nerve pain was malpositioning during surgery. The jury returned a verdict in the plaintiff's favor. After the Superior Court reversed, the Supreme Court reinstated the verdict on grounds that the plaintiff was permitted to rely on *res ipsa loquitur* in a medical malpractice case. The Court acknowledged its prior reticence to recognize *res ipsa loquitur* in the medical malpractice setting[58] and explained that "[t]here is no longer a need to be reluctant to permit circumstantial proof in medical malpractice cases where the nature of the evidence provides the requisite reliability of the inference sought to be drawn."[59] It concluded that the inference of negligence should be permitted in those medical malpractice cases where the evidence is such that "it

can be established from expert medical testimony that such an event would not ordinarily occur absent negligence."[60]

In its 2003 *Toogood v. Owen* decision, the Court confirmed that *res ipsa loquitur* is a "procedural bypass to at least an inference, if not a direct proof, of negligence" for plaintiffs in medical malpractice suits.[61] At the same time, the Court cautioned that the doctrine "must be carefully limited" and "the realm of reasonable choice is best defined by those engaged in the practice."[62]

D. Damages

Although the Court's decisions regarding damages in medical malpractice cases have not been as prominent as rulings on duty, breach, and causation, a notable exception is the 1980 decision in *Kaczkowski v. Bolubasz*, which involved the calculation of a plaintiff's future lost earning capacity.[63] Prior to 1980, calculation of such lost earning capacity required a reduction to present value without accounting for inflation or increases in productivity. This resulted in insufficient awards for future lost earnings.[64] In *Kaczkowski*, the Court agreed that this approach "sacrifices accuracy to the prejudice of the victim by failing to compensate the victim to the full extent of the injury sustained."[65] The Court explained that it had a "responsibility to the citizenry to keep abreast of changes in our society"[66] and that the evolution of modern economics means that "the courts of this Commonwealth can no longer maintain their ostrich-like stance and deny the admissibility and relevancy of reliable economic data concerning the impact of productivity and inflation on lost future earnings."[67] To achieve a fairer approach, the Court adopted the "total offset method" for projecting an award of future lost earnings. This method specifically considers inflation and productivity increases and assumes that such factors will offset interest rates over time. Because these factors offset, there is no need to reduce an award of future wages to present value. As the Court explained, the total offset method "assumes that the effect of the future inflation rate will completely offset the interest rate, thereby eliminating any need to discount the award to its present value."[68]

III. THE COURT'S HANDLING OF STATUTES GOVERNING MEDICAL MALPRACTICE LITIGATION

In addition to applying common-law principles to the peculiarities of medical malpractice litigation, the Supreme Court has been frequently called on to interpret statutes governing aspects of that litigation. These statutes first surfaced in the 1960s and have presented important issues of statutory construction and constitutional law.

In the area of mental health law, the legislature enacted the Mental Health and Mental Retardation Act (MHMRA)[69] in 1966 and the Mental Health Procedures Act (MHPA)[70]

in 1976. The Court has been required to interpret both statutes in response to medical negligence claims. In *Rhines v. Herzel*, a patient in a mental hospital was killed by another patient with known homicidal tendencies who was allowed to associate with other patients without supervision.[71] The hospital argued that it was statutorily immune from suit under the MHMRA.[72] The Court rejected this argument, holding that the statutory immunity provision did not apply to claims of gross negligence and that gross negligence had been pled by allegations that the hospital allowed the patient to kill another and "conceal her body in the hospital grounds for several weeks thereafter."[73]

In 1989, the Court faced a similar question under the MHPA in *Farago v. Sacred Heart General Hospital*.[74] There, a patient in a co-ed inpatient psychiatric unit reported that she had been raped in a bathroom by a male patient.[75] After reviewing the circumstances and the statute, the Court found that the hospital had not been negligent in treating the patient in the "least restrictive environment" possible and that the hospital had not acted in a grossly negligent manner that would be required to withhold their statutory immunity.[76]

In 1974, the legislature enacted the Peer Review Protection Act (PRPA).[77] This important statute was intended to help hospitals self-regulate by evaluating physicians to determine if they should have privileges at a hospital and to provide immunity from liability for doing so.[78] However, in *Cooper v. Delaware Valley Med. Ctr.*, the plaintiff alleged that the hospital was using its review board maliciously to discriminate against physicians in receiving new patients in favor of the controlling member of the board. The Court found that although the act was intended to protect hospitals in many respects, it did not protect hospitals from a malicious abuse of the peer review process.[79]

The PRPA's confidentiality provision also has been subjected to judicial scrutiny. In *Hayes v. Mercy Health Corp.*, a physician sought discovery of an audiotape recording of the board's peer review session that addressed his performance.[80] In deciding that the physician was entitled to the tape, the Court held that the confidentiality provision was intended to protect the peer review process from litigation by patients but did not apply to participants or subjects seeking to determine if the peer review process had been misused.[81]

In 1975, the legislature enacted the Health Care Services Malpractice Act (HCSMA),[82] which sought to directly regulate medical malpractice claims by, inter alia, requiring such claims to be submitted to mandatory arbitration. The Court's initial review of the HCSMA occurred in its 1978 decision in *Parker v. Children's Hospital of Philadelphia*, which challenged the constitutionality of the mandatory arbitration requirement.[83] The Court allowed the legislature's experiment with mandatory arbitration for medical malpractice claims to continue, finding that "deference to [the] coequal branch" required an allowance of a "reasonable period of . . . time to test the effectiveness of the legislation."[84]

Revisiting the same challenge two years later in *Mattos v. Thompson*, the Court found that while a reasonable and short delay to allow for arbitration would be constitutional, the provision had left six cases unresolved for four years, and 73 percent of all cases filed had not been resolved since the statute was enacted.[85] Having provided time to test the

effectiveness of the act, the Court struck down the section enabling original jurisdiction to the arbitration panel, holding that it impermissibly interfered with the right to a jury trial guaranteed by Article I, Section 6 of the Pennsylvania Constitution.[86]

Lower courts initially read *Mattos* narrowly, requiring the Court to elaborate on the decision in a string of subsequent cases. First in *Chiesa v. Fetchko*, the Court held that all provisions of the arbitration process of the act had been declared unconstitutional; therefore, the courts did not have to consider collateral sources in their damage awards.[87] Then in *Heller v. Frankston*, the Court corrected the Commonwealth's mistaken belief that the decision in *Mattos* allowed concurrent jurisdiction between the courts and arbitration panels in a case regarding a dispute over the contingency fees allowed under the act.[88] There the Court again expressed that all provisions regarding the arbitration process were unconstitutional under the right-to-trial provision of the Pennsylvania Constitution and that the attorney's contingency fees were both "ancillary to and a component of that arbitration scheme."[89] The Court also reiterated that *Mattos* completely nullified Articles III, IV, V, and VI of the act.[90]

In the 1990s, the Court had occasion to address several issues related to the Catastrophic Loss (CAT) Fund, a state-affiliated entity that provided additional coverage to qualified healthcare providers beyond their primary insurance.[91] In *American Casualty v. Phico Ins. Co.*, the Court held that while hospitals are statutorily eligible to draw on the CAT Fund for the actions of their employees, a nurse was not eligible to participate in the fund on an individual basis.[92] In *King v. Boetther*, the Court held that the fund was required to pay postjudgment interest on a medical malpractice verdict.[93] It thereafter held in *Legal Capital, LLC v. Medical Prof'l Liab. Catastrophic Loss Fund* that a plaintiff could assign its right to payment from the CAT Fund to a third party.[94]

The Court also addressed the activities the fund was required to insure. First, in *Physicians Ins. Co. v. Pistone*, the Court decided that a physician's sexual acts toward his patient were not covered "professional act[s]."[95] Later, the Court also held that a daily bath administered in a nursing home by a nurse's aide that was prescribed by a physician was a "professional act," and therefore the home was entitled to draw on the CAT Fund in a claim against the aide for the patient's burns when placed into a scalding bath.[96]

Lastly, in *Dellenbaugh v. Commonwealth Med. Prof'l Liab. Catastrophic Loss Fund*, the Court addressed the state's liability for claims made against healthcare providers who had not made their required premium payment, even when the fund had not reported the provider's noncompliance to the board, which allowed them to continue practice.[97] The Court reviewed the purpose of the act, which was to "make available professional liability insurance at a reasonable cost," and held that it would be "inherently contrary" to this purpose to pay claims for providers who had not paid their annual surcharge.[98]

In *Lloyd v. Commonwealth Med. Prof'l Liab. Catastrophic Loss Fund*, the Court revisited the question of whether the CAT Fund properly denied a claim based on a hospital's failure to pay a surcharge fee.[99] There, a hospital failed to pay the fund's required premiums for a

physician as part of the hospital-physician employment agreement. On filing a claim with the fund, the hospital was notified that it would be denied, at which point it belatedly paid the surcharge.[100] After a large verdict for the plaintiff, the physician tendered the primary insurance along with "any and all rights" against the fund or hospital. The plaintiff then pursued the fund, challenging it on three separate grounds: (1) the plaintiff challenged the validity of the regulation that allowed the CAT Fund to exclude those who did not pay the surcharge, (2) the plaintiff argued that the fund did not suffer prejudice for the delayed payment of the surcharge, and (3) the plaintiff argued that the fund should be compelled to produce discovery on the times that it previously might have paid a claim for a provider who had not made timely payment.[101] The Court disregarded all three arguments, holding that the fund could not be compelled to pay claims for noncompliant providers and that, even if it had paid claims in the past, the Court could not compel it to violate the law again simply because it might have done so in the past.[102]

The Court also addressed a novel attempt to minimize self-insurance costs in *Milton S. Hershey Med. Ctr. v. Pa. Med. Prof'l Liab. Catastrophic Loss Fund*.[103] There, a hospital attempted to draw twice on the fund to pay a settlement: after tendering both the physician's and hospital's primary insurance along with the fund's million dollars in excess coverage for the physician, the hospital then attempted to claim a second million under a vicarious liability theory, primarily to avoid implicating the hospital's own self-funded excess insurance.[104] The Court rejected the hospital's claim. Although the justices agreed that the statute was ambiguous and could be read in that manner, the Court characterized the idea of paying twice for every claim as contrary to the fund's purpose, providing liability insurance "at reasonable cost."[105]

In 2002, the legislature enacted the Medical Care Availability and Reduction of Error (MCARE) Act[106] as a successor to the Health Care Services Malpractice Act. Among the MCARE Act's numerous salient provisions is a section defining the qualifications for expert testimony in medical malpractice actions.[107] The Court has rendered two significant decisions interpreting this aspect of the act. In its 2009 decision in *Freed v. Geisinger*, the Court held that an otherwise competent and properly qualified nurse was permitted to testify under the MCARE Act on medical causation about the cause of pressure sores, a subject well within a nurse's knowledge, and was not prohibited by the Professional Nursing Law from giving such expert opinion testimony.[108] In reaching its conclusion, the Court overturned its previous decision in *Flanagan v. Labe*, which had disallowed nurses from giving expert causation testimony.[109] In 2010, in *Vicari v. Spiegel*, the Court again addressed expert qualifications under the MCARE Act, making clear that a physician can give a standard-of-care opinion if, though he practiced in a different specialty than the defendant, he practiced in a specialty that had a substantially similar standard of care for the specific care at issue.[110]

IV. THE COURT'S PROMULGATION OF RULES RELATING TO MEDICAL MALPRACTICE AND EFFORTS TO TRACK MEDICAL MALPRACTICE FILINGS AND OUTCOMES

The HCSMA and the MCARE Act were promulgated partly in response to concerns about the volume and impact of medical malpractice litigation in Pennsylvania. In January 2003, the Supreme Court itself waded into the fray by promulgating two sets of rules specifically governing medical malpractice litigation. First, the Court promulgated Rules 1042.1 through 1042.12 governing professional liability actions (including actions arising out of alleged negligent medical care), which required any attorney filing a new professional liability action to file a "Certificate of Merit" warranting that an appropriate licensed professional had supplied to the attorney a written statement that there existed a reasonable probability that the defendant's actions were negligent and that such conduct was a cause in bringing about harm to the plaintiff.[111] Second, the Court promulgated Rule 1006(a.1), which created a new venue rule specific to medical malpractice actions.[112] This new rule made the venue for a medical malpractice action proper only where the cause of action arose, regardless of the location of the physician's office or any hospital affiliation.

In 2011, the Supreme Court amended Rule 1006(a.1) to fix a problem that arose from its original formulation. The original version of the rule provided that the venue was limited to the county where care was rendered. Several courts interpreted this provision as effectively precluding a plaintiff from bringing a medical malpractice action in Pennsylvania based on negligence that occurred in another state, even when jurisdiction existed in Pennsylvania, because there was no Pennsylvania county in which the negligence occurred.[113] The Court remedied this problem by further amending Rule 1006(a.1) to provide that the provision did not apply to causes of action that arose outside the Commonwealth; the general venue rules applied instead.[114]

The Court accompanied its promulgation of these rules with extensive follow-up research on medical malpractice litigation in Pennsylvania. Since 2003, the Court has maintained and published extensive statistics, broken down by county, case filings, jury verdicts, and nonjury verdicts in medical malpractice cases. These statistics are currently available on the "Research and Statistics" section of the Unified Judicial System's website (https://www.ujsportal.pacourts.us/). They show a dramatic reduction in medical malpractice filings since the Court promulgated these rules. From 2000 to 2003, an average of 2,733 new medical malpractice cases was filed per year in Pennsylvania. In 2010, that number had dropped to 1,490. In 2015, the most recent year for which statistics are available, the number had risen slightly to 1,530—still a reduction of more than 44 percent from the 2000–2003 average. The Supreme Court's diligence in collecting, maintaining, and publishing these statistics has helped demonstrate that the conditions that existed in the early 2000s no longer exist with respect to medical malpractice filings, and the Court continues to provide valuable information to Pennsylvanians about the operations of their judicial system.

V. CONCLUSION

Medical malpractice has become a major area of law and practice in Pennsylvania, fostered and managed by the Supreme Court over many decades through virtually every way that the Supreme Court acts—through its common-law decisions, its review of statutes under principles of statutory construction and under the Pennsylvania Constitution, its promulgation of procedural rules specific to medical malpractice litigation, and its research and publication of statistics on medical malpractice filings and results. This continues to be a dynamic area of law, and the Court will doubtless continue to play a vital role in defining and developing it.

NOTES

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1. Stratton v. Swanlond, Y. B. 48 Edw. 3, fol. 6, pl. 2 (1375) (Eng.) (decided in 1374 but published in 1375), reprinted in Carlton B. Chapman, "*Stratton vs. Swanlond*: The Fourteenth-Century Ancestor of the Law of Malpractice," *Pharos* 45 (1982): 20–22.
2. *See* Robert I. Field, "The Malpractice Crisis Turns 175: What Lessons Does History Hold for Reform?," *Drexel Law Review* 4 (2011): 7, 10–11, discussing Sir William Blackstone, *Commentaries on the Laws of England* (Oxford: Clarendon Press, 1765–69), 122 (additional citations omitted).
3. Field, "Malpractice Crisis," 14–16.
4. James C. Mohr, "American Medical Malpractice Litigation in Historical Perspective," *Journal of the American Medical Association* 283 (2000): 1731–32.
5. Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (New York: New York University Press, 1990), 2.
6. Field, "Malpractice Crisis," 12, citing De Ville, *Medical Malpractice*, 28–30 ("The proliferation of malpractice cases spread from state to state. It first appeared in western New York State. By 1850, it had reached Pennsylvania and Ohio and, by the mid-1850s, Vermont, New Hampshire, and Massachusetts.").
7. 22 Pa. 261 (1853).
8. Ibid., 267.
9. Ibid.
10. Ibid., emphasis in original.
11. Ibid.
12. Ibid.
13. *See* Small v. Howard, 128 Mass. 131, 132 (1880) (explaining that the locality rule protected rural and small-town practitioners by holding that that they were "not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in large cities").
14. 156 A.2d 835, 838 (Pa. 1959), emphasis added.
15. 282 A.2d 206 (Pa. 1971).
16. Ibid. (quoting Texas & Pacific Railway Co. v. Behymer, 189 U.S. 468, 470 [1935]).
17. Ibid., 283.
18. Ibid., 298–99 (citations omitted).
19. Pennsylvania Supreme Court, Committee for Proposed Standard Jury Instructions, Civil Instructions Subcommittee, *Pennsylvania*

Suggested Standard Civil Jury Instructions, 4th ed. (Mechanicsburg, Pa.: Pennsylvania Bar Institute, 2011), § 14.10.

20. 223 A.3d 663, 669 (Pa. 1966) (citing Dicenzo v. Berg, 340 Pa. 305, 307 [1940]); *see also* Valles v. Albert Einstein Med. Ctr., 805 A.2d 1232, 1237 (Pa. 2002) (holding that informed consent requires a physician to "advise the patient of those material facts, risks, complications and alternatives to surgery that a reasonable person in the patient's situation would consider significant in deciding whether to have the operation").
21. 223 A.3d at 166. *See also* Morgan v. MacPhail, 704 A.2d 617, 620 (Pa. 1997) (refusing to apply the doctrine of informed consent to non-surgical procedures, such as therapeutic or intravenous administration of drugs).
22. 961 A.2d 1229 (Pa. 2008). The Court analyzed the informed consent issues in Fitzpatrick under the rubric of the Medical Care Availability and Reduction of Error (MCARE) Act, 40 P.S. §§ 1303.101, *et seq.*, which was enacted in 2002. Section 504 of the MCARE Act replaced the common law of informed consent, adding the concept that a plaintiff need only show that the missing information would have been a substantial factor in the patient's decision. The concept of "substantial factor" had not been present in the common-law rubric.
23. 65 A.2d 243 (Pa. 1949). Prior to this, the duty was far more restricted. *See, e.g.*, Stewart v. Manasses, 90 A. 574, 575 (Pa. 1914) ("The injury was caused by the negligence of a hospital nurse, for whose service the plaintiff paid the hospital, and whose work the defendant was under no duty to supervise, and would not have been permitted to supervise, and for whose negligence he was not responsible.").
24. McConnell, 65 A.2d at 244.
25. Ibid., 246 (citations omitted).
26. Shull v. Schwartz, 73 A.2d 402, 403 (Pa. 1950) ("Even though the intern had been negligent in post-operative treatment, where the surgeon did not personally participate therein, the surgeon cannot be held liable."); Scacchi v. Montgomery, 75 A.2d 535, 537 (Pa. 1950) ("There was no evidence that the hospital intern or nurse were negligent in their post-operative care of the patient, but even if they had been, the defendant, under the facts in this case, would not have been liable.").
27. 208 A.2d 192 (Pa. 1965).
28. Ibid., 202.
29. Ibid., 202; *see also* ibid., 197 ("If a hospital functions as a business institution, by charging and receiving money for what it offers, it must be a business establishment also in meeting obligations. . . . One of those inescapable obligations is that it must exercise a proper degree of care for its patients, and, to the extent that it fails in that care, it should be liable in damages as any other commercial firm would be liable.").
30. 591 A.2d 703 (Pa. 1991).
31. Ibid., 707.
32. 57 A.3d 582 (Pa. 2012).
33. 575 A.2d 545, 549 (Pa. 1990).
34. 614 A.2d 226, 229 (Pa. 1992) (construing both the Sovereign Immunity Act and the Mental Health Procedures Act [MHPA] to reach this holding).
35. 733 A.2d 623 (Pa. 1999).
36. Ibid., 630.
37. 756 A.2d 1166, 1170 (Pa. 2000) (balancing the social utility of treatment for the child against the foreseeability of the harm).
38. 21 A. 525, 525 (Pa. 1891).
39. 7 A.2d 338, 342 (Pa. 1939); *see also* Ward v. Garvin, 195 A. 885 (Pa. 1938).
40. 181 A. 558, 559 (Pa. 1935) ("Where competent medical authority is divided, a physician will not be held responsible if, in the exercise of his judgment, he followed a course of treatment advocated by a considerable number of his professional brethren in good standing in his community.").
41. 87 A.3d 285, 305–6 (Pa. 2014).
42. Duckworth, 181 A. at 559 (quoted previously).
43. 610 A.2d 964, 969 (Pa. 1992); *see also* ibid., 967 ("Where competent medical authority is divided, a physician will not be held responsible if in the exercise of his judgment he followed a course of treatment advocated by a considerable number of recognized and respected professionals in his given area of expertise.").
44. 616 A.2d 623, 628 (Pa. 1992) ("The two schools of thought doctrine does not relieve a doctor from liability for failure to recognize symptoms of an illness.").
45. 633 A.2d 1137, 1141–42 (Pa. 1993) (holding the trial court erred by failing to instruct the jury that the two schools of thought doctrine was inapplicable to plaintiff's claim that the doctor failed to properly apply forceps during delivery).
46. 218 A.2d 808, 809 (Pa. 1966).
47. 392 A.2d 1280 (Pa. 1978).

48. Ibid., 1282–84.
49. Ibid., 1286–87.
50. Ibid., 1288.
51. Ibid.
52. Gradel v. Inouye, 421 A.2d 674 (Pa. 1980); Jones v. Montefiore Hosp., 431 A.2d 920 (Pa. 1981).
53. Hamil, 392 A.2d at 1285; *see also* Gradel, 421 A.2d at 679 (1980) ("Expert medical opinion on causation need not be unqualified and absolute, i.e., stated in 'categorical terms'; ordinarily, it must establish that the injury was, to a 'reasonable degree of medical certainty,' caused by the alleged negligence.").
54. Hamil, 392 A.2d at 1288; *see also* Gradel, 421 A.2d at 679 ("Medical opinion need only demonstrate, with a reasonable degree of medical certainty, that a defendant's conduct increased the risk that the harm sustained by plaintiff would occur. The jury, not the medical expert, then has the duty to balance probabilities and decide whether defendant's negligence was a substantial factor in bringing about the harm.").
55. Mitzelfelt v. Kamrin, 584 A.2d 888, 894 (1990).
56. *See, e.g.*, Donaldson v. Maffucci, 156 A.2d 835, 838 (Pa. 1959) ("No presumption or inference of negligence arises merely because the medical care or surgical operation terminated in an unfortunate result which might have occurred even though proper care and skill had been exercised, and where the common knowledge or experience of laymen is not sufficient to warrant their passing of judgment. In such cases the doctrine of res ipsa loquitur or of exclusive control may not be invoked, and *expert testimony in support of the plaintiff's claim is an indispensable requisite to establish a right of action.*") (internal citations omitted); *see also* Smith v. Yohe, 194 A.2d 167, 170 (Pa. 1963) (noting that generally *res ipsa loquitur* is not applicable in medical malpractice suits, and "the *only* exception to the requirement that expert testimony must be produced is 'where the matter under investigation is so simple, and the lack of skill or want of care so obvious, as to be within the range of the ordinary experience and comprehension of even non-professional persons'"), emphasis in original.
57. 437 A.2d 1134 (Pa. 1981).
58. Ibid., 1137.
59. Ibid., 1138.
60. Ibid.
61. Toogood v. Owen J. Rogal, D.D.S., P.C., 824 A.2d 1140, 1147 (Pa. 2003).
62. Ibid., 1149; *see also* Quinby v. Plumsteadville Family Practice, Inc., 907 A.2d 1061 (Pa. 2006) (applying a three part test to invoke the doctrine of *res ipsa loquitur*).
63. 421 A.2d 1027 (Pa. 1980).
64. Ibid.
65. Ibid., 1032.
66. Ibid., 1033.
67. Ibid.
68. Ibid., 1034. In the MCARE Act, the General Assembly enacted a provision that requires future damages for loss of future earning capacity in a medical malpractice action to be reduced to present value "based upon the return that the claimant can earn on a reasonably secure fixed income investment." 40 P.S. § 1303.510. Under this approach, such damages are presented to the jury with evidence of the effect of inflation and productivity increases over time. Based on this information, the jury determines the appropriate discount rate to be applied to the present value calculation. *See* ibid. This approach may produce a larger or smaller lump-sum award for loss of future earnings capacity depending on whether the jury decides the interest will outpace inflation and productivity increases or vice versa. The jury also may decide that these factors will offset, resulting in an award consistent with the rationale of Kaczkowski.
69. 50 P.S. § 4603.
70. Ibid., §§ 7101, *et seq.*
71. 392 A.2d 298, 299 (Pa. 1978).
72. Ibid., 300 (discussing the MHMRA).
73. Ibid.
74. 562 A.2d 300 (Pa. 1989).
75. The patient was discovered in the bathroom with the patient by a staff member but only reported the attack two weeks later. Ibid., 301.
76. Ibid., 302 (discussing the MHPA, 50 P.S. §§ 7102, 7144).
77. 63 Pa.C.S. § 425.
78. 654 A.2d 547 (Pa. 1995).
79. Ibid., 554.
80. 739 A.2d 114, 115 (Pa. 1999).
81. Ibid., 118.
82. 40 P.S. § 1303.701(d).
83. 394 A.2d 932 (Pa. 1978).
84. Ibid., 940.
85. 421 A.2d 190, 194–95 (Pa. 1980).
86. Ibid., 195.
87. 475 A.2d 740 (Pa. 1984).
88. 475 A.2d 1291, 1296 (Pa. 1984).
89. Ibid., 1294.

90. Ibid., 1295.
91. 40 P.S. §§ 1301.101, *et seq.*
92. 643 A.2d 91 (Pa. 1994).
93. 645 A.2d 219 (Pa. 1994).
94. 750 A.2d 299 (Pa. 2000).
95. 726 A.2d 339 (Pa. 1999).
96. Strine v. Commonwealth Med. Care Availability & Reduction of Error Fund, 894 A.2d 733, 742 (Pa. 2006).
97. 756 A.2d 1172, 1173 (Pa. 2000).
98. Ibid., 1174.
99. 821 A.2d 1230 (Pa. 2003).
100. Ibid., 1231–32.
101. Ibid., 1232.
102. Ibid., 1235–37.
103. 821 A.2d 1205 (Pa. 2003).
104. Ibid., 1206–7.
105. Ibid., 1207, 1211.
106. 40 P.S. §§ 1303.101, *et seq.*
107. 971 A.2d 1201, 1210 (Pa. 2009) (discussing the MCARE Act).
108. Ibid., 1211.
109. Ibid., 1205, 1210–11 (discussing Flanagan v. Labe, 690 A.2d 183 [Pa. 1997]).
110. Vicari v. Spiegel, 989 A.2d 1277, 1280–81 (Pa. 2010).
111. Pa.R.C.P. 1042.1.
112. Pa.R.C.P. 1006.
113. *See, e.g.*, Searles v. Estrada, 856 A.2d 85 (Pa. Super. 2004).
114. The Official Note to Pa.R.C.P. 1006(a.1) states, "This provision does not apply to a cause of action that arises outside of this Commonwealth." The amendment, dated June 15, 2011, became effective August 1, 2011.
115. 104 A.3d 338 (Pa., November 19, 2014).