MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2199

2005 SENATE JUDICIARY

SB 2199

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2199

Senate Judiciary Committee

☐ Conference Committee

Hearing Date January 18, 2005

Tape Number	Side A	Side B	Meter #
1	X		3049 - End
1		X	0.0 - 1800
Committee Clerk Signature	Moira L Solberg		

Minutes: Relating to expert opinion required in certain civil cases.

Senator John (Jack) T. Traynor, Chairman called the Judiciary committee to order. All Senators were present. The hearing opened with the following testimony:

Testimony In Support of the Bill:

Sen Richard Brown, Dist #27, (meter 3049) Introduced the #1.

Bruce Levi - Representing ND Medical Assoc. (meter 3458) Gave his testimony, Att. #2 with a proposed amendment, Att #3.

Sen. Traynor asked how long this requirement has been in effect? **Mr. Levi** stated since 1981. It was revised in 1997, at that time it was a question of if an expert affidavit did not come in. The language was ambiguous as if a judge was required to dismiss the case or not. We came to an agreement in that session that the judge would dismiss the case, but without prejudice. There would still be provisions available for extended the time for filing the affidavit. This is a useful

tool for everyone in terms for getting basically the support of the claim out in from of everybody at the beginning of the litigation.

Shelly Peterson -President of ND Long Term Care Assoc. (meter 4376) gave testimony, Att. #4.

Lance Schreiner - Bismarck Attorney (meter 4613) I am hear on my own behalf to provide background to the reason for the amendment to remove the lack of informed consent exception from the bill itself. Personally I was involved in two cases in 2003, that were brought fourth to the ND Supreme Court with lack of conformed consent exceptions were used to return those cases. Even though there was not an expert on the negligence aspect of the case. (meter 4650). This was a negligence case that came back as a "lack of conformed consent". This became a long process.

The Supreme Court has said that (meter 5043) "It seeks to prevent pro-tractive litigation when a medical malpractice claimant can not substantiate the bases of a claim." Meaning if you do not have an expert witness, you will need one at trial, to prove that your case is not frivolous. The statute has also been interpreted as adopting case law that already existed in ND. It was always required that in a medical malpractice case you had to have an expert to support the allegations of negligence. The only exception is the an "obvious occurrence". (meter 5070).

Line 19, SB 2199 is also being an exception. This is counteractive to Supreme Courts opinion. (See attached Court cases & opinions) You can go on the Internet and pay a $500 fee and they will find you an expert opinion.

John Capsner, Vogal Law Firm in Bismarck (meter 630) What these amendments are trying to do is fix two in effect an acronymism to the statute. A plaintiff needs to have an expert in his work consent at the time of trial but they don't need to have an expert under the statute with in

three months. Who should be incorporated within the statute. Today a physician who has the clinic and was sued for negligence directly. The statute would apply an expert opinion would be required in 90 days. If the Clinic/employer was sued there would be no such 90 day requirement. It would only be required by the time of trial.

Joel Gilbertson - Bismarck Attorney (meter 909) Health Policy Consort ion and Merit Care. We are in support of this bill with these amendments.

Testimony Neutral to the Bill:

Paula J. Grossinger - ND Trial Lawyers (meter 1600) The amendment makes this bill more pallet able. If you adopt the amendment it would satisfy most of our concerns. Generally a person/claiment does not realize they are injured until another health care official has observed it, this could take months.

Testimony in Opposition of the Bill:

Richard McGee - Stated his objections. (meter 1643) and how the amendments help the bill.

Senator John (Jack) T. Traynor, Chairman closed the Hearing

Sen. Trenbeath stated that the concerns he had in this bill were addressed with the amendments and made the motion to Do Pass the Amendment on Att #3, seconded by **Senator Triplett.** All were in favor.

Sen. Trenbeath made the motion to do pass SB 2199 as amended. **Senator Hacker** seconded the amendment. All were in favor.

Carrier: **Sen. Trenbeath**

Senator John (Jack) T. Traynor, Chairman closed the Hearing

Date: 1/19/05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2199

Senate Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move to Amend Att #3

Motion Made By Sen Trenbeath Seconded By Sen. Triplett

Senators	Yes	No	SenatorsSen. Nelson	Yes	No
Sen. Traynor	✓		Sen. Nelson	✓	
Senator Syverson	✓		Senator Triplett	✓	
Senator Hacker	✓				
Sen. Trenbeath	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/19/95
Roll Call Vote #: (2)

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2199

Senate Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DO Pass as Amended

Motion Made By Sen Trenbeath Seconded By Sen. Hacker

Senators	Yes	No	SenatorsSen. Nelson	Yes	No
Sen. Traynor	✓		Sen. Nelson	✓	
Senator Syverson	✓		Senator Triplett	✓	
Senator Hacker	✓				
Sen. Trenbeath	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Trenbeath

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2199: Judiciary Committee (Sen. Traynor, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2199 was placed on the Sixth order on the calendar.

Page 1, line 13, remove "with the summons and complaint"

Page 1, line 14, remove the overstrike over "~~within three months of the~~"

Page 1, line 15, remove the overstrike over "~~commencement of the action~~"

Page 1, line 16, replace "filing" with "serving" and remove "by clear and convincing evidence"

Renumber accordingly

2005 HOUSE JUDICIARY

SB 2199

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2199

House Judiciary Committee

❑ Conference Committee

Hearing Date 3/1/05

Tape Number	Side A	Side B	Meter #
1	xx		38.3-end
1		xx	0-43.9
Committee Clerk Signature Dawn Penrose			

Minutes: 14 members present.

Chairman DeKrey: We will open the hearing on SB 2199.

Sen. Richard Brown: I am here to introduce you to SB 2199, having to do with expert opinion and an affidavit requirement. Support (see written testimony).

Representative Meyer: Is there any indication that if this passes, the insurance rates are going to come down.

Sen. Richard Brown: I'm not too sure if I understand your question. Medical liability insurance is a huge issue. It's priced over many states, and I'm not too sure what their pricing methodology is, our hope would be that this would hold the line on medical liability costs or bring it down.

Representative Onstad: It's asking that if a complaint has been made, the person has to bring in an expert opinion. What is considered an expert opinion, in the case of say a nursing home, on just negligent care or something, what is considered, who determines what is an expert.

Sen. Richard Brown: An attorney might need to answer that.

Chairman DeKrey: Thank you. Further testimony in support of SB 2199.

Bruce Levi, ND Medical Association: Support (see written testimony).

Representative Delmore: A couple of bills we heard this morning think they have more problems with the insurance companies than they do with other things, and I'm wondering if sometimes maybe we need to look at some statutes there, but is it your experience that in ND, we have an excessive of frivolous lawsuits.

Bruce Levi: I don't think we have an excess number of lawsuits period. I think, if you go back and we've asked the court for the statistics, the district court filings in professional negligence actions generally in ND for all professions. There aren't that many. I think that at the same time, though, the underwriting, the work the insurance market does, is based on that climate in those particular state. In our state, we have done a good measure of tort reform over the years, we've done a good measure of having a number of tools like this in place, that you can argue, one way or the other have provided an appropriate screen to create the kind of stability that we're looking for here. I think in ND, particularly, if you talk to a lot of the larger health systems, they've been doing some things to try and limit their exposure to premium increases and things like that. I know there's a lot of first dollar exposure now, trying to do different things to keep the premiums down in ND. I think if you look at one of the primary carriers in ND, Midwest Medical Insurance Company, the rate increases over the last two or three years, have been at about 5-6.8% was the last one. There's a measure of increase going on with respect to the premiums. At the same time, I think we compare favorably to a lot of other states in terms of

where we're at. I think our biggest fear is really the national trends, and whether national trends will impact the liability market in ND and start to bring things up to a greater degree as well.

Representative Delmore: Finding in the early stages of medical liability litigation, how easy is it to find an expert. I'm not so sure this is as much a medical problem as it is an insurance problem. I understand where you're coming from, but I think we also have an obligation in this committee, to look at our constituents and the consumers. How hard is it to find one of these experts and how expensive is it.

Bruce Levi: I don't practice, I work with the association. I think there may be some other testimony that can help with that. I don't know what it costs precisely. My understanding is that it's not always difficult to find an expert. I think you'll hear arguments on both sides of that, whether it's easy to get an in-state physician to act as an expert or not, but I think that generally it's not an overwhelming burden. I think generally these experts are provided. The experts are being provided in these cases now, in the early stages. What we're trying to do is expand the statute in those cases where the court has interpreted the statute to not apply in cases that obviously are medical liability cases and the different contexts in which health professionals find themselves in. It's not just a hospital. It's not just necessarily an individual physician or an individual hospital being sued. It's that they're in a nursing facility, acting as a medical director, providing care; they're in an ambulatory surgery center, they're in a clinic setting. Those entities are being name as defendants as well. So that's really what we're trying to accomplish.

Representative Delmore: Is admissible expert opinion explained anywhere, is it defined in the statute, as to what that would be.

Bruce Levi: Probably more explained in the court process, in terms of what foundation you need as a Rule of Evidence more than a statute.

Representative Zaiser: I guess my question is similar to Representative Delmore. What about the cost, if the claimant had a legitimate claim, could the cost of trying to find that expert witness be prohibited to the point where he simply could not bring forth the claim.

Bruce Levi: I don't think it's been a prohibitive cost in the past. I think that ultimately you are going to need an expert, and you're likely talking to an expert before you bring the claim. My answer would be, just in my experience, no, it's not going to be prohibitive.

Representative Zaiser: But wouldn't this process be up front of the contract one would sign with an attorney. So, for instance, if somebody was not affluent, or didn't have a whole lot of money, I assume like a cardiac expert or a neurologist expert, you're talking about a $5,000 bill or a $10,000 bill for just an opinion.

Bruce Levi: I don't know, again I'm not sure when the contracting process starts with the client, maybe someone else could explain that. Again, it's something, obviously that needs to be there, assessing the potential for litigation. Having the expert, wondering if it is a valid case, the issue with the statute primarily, is to ensure that there is expert opinion involved in deciding to bring the action by requiring that the expert be brought in and the affidavit done initially. I think that's part of that whole process in deciding whether or not you have an appropriate case to bring forward or not.

Representative Zaiser: Would this not then, my concern is that it might preclude those legitimate claimants from bringing forth the claim, just simply because of those upfront costs.

That is my concern. I agree with the concept of where you are going, but my concern would be a legitimate claim, which we all know are out there, would they be prohibited from pursuing that.

Bruce Levi: I guess based on the experience with the statutes in 1981, I never heard that they are prohibitive in the sense that they are being provided, the court's require them.

Representative Klemin: On this particular issue, right now the statute requires the plaintiff to have this expert opinion within three months. There's nothing being changed there, what is being changed is the procedure to require the plaintiff to serve this affidavit within those three months, rather than wait for the defense attorney to serve interrogatories, saying give me your expert's opinion. Basically it's not changing the requirement for the expert opinion, which has been there all the time. It's just shifting the burden to provide it upfront within that time, rather than having to wait until the defense attorney asks for it in discovery. Isn't that basically what we're talking about.

Bruce Levi: That's my understanding as well.

Representative Klemin: In doing this kind of thing, this is consistent with what is happening in the federal courts, in the discovery where you have to make certain initial disclosures and the court requires a scheduling order issued, where a discovery schedule is set out and typically requires the plaintiff, if they're going to have any expert, they've got to submit those opinions containing exactly what's here, so this is consistent with what is happening on the federal level, as I understand it.

Bruce Levi: Yes. I'm not that familiar with the federal side, but I think that's true as well.

Representative Onstad: This section does not occur to obvious occurrences. So the non-obvious must be, is that professional negligence then.

Bruce Levi: If you look at lines 18-21 of the bill, they talk about some of the obvious occurrences; unintentional failure to remove a foreign substance from within the body of a patient, performance of a medical procedure upon the wrong patient, organ, limb or other part of the patient's body. I think what they're really arguing there is that those are instances where expert opinion isn't necessary to prove essentially a prima facie case. Those are obvious things that are apparent to a lay person on the jury and you don't need medical testimony to support that.

Representative Onstad: It says, or other obvious, so I'm assuming that if everything is obvious, is not applied to this section and can be dealt with, without an expert.

Bruce Levi: I think as it applies here, any obvious occurrence doesn't require an expert.

Representative Onstad: To a normal person, I might think this is pretty obvious; and there the case goes and then, a professional becomes involved; who determines what is obvious. I might bring a case that is pretty obvious to me that there was something wrong.

Bruce Levi: The legislation as it's structured now, those obvious occurrences, there are some that are laid out in the statute, but I believe that there was a question about that, that would be something the plaintiff would talk to the court in terms of what is an obvious occurrence. If I don't provide my expert opinion, the question is should the court dismiss the case under the statute, and there's a discussion about whether or not this particular case involves an obvious occurrence or not. I think that is how it would be played out. But you're right, everything else is considered a non-obvious occurrence and requires expert opinion, and an affidavit submitted.

Representative Koppelman: One question is the non-inclusion of facilities such as nursing facilities, and so on. Was that intentional when the law was drafted, or was it originally thought they were included and only after the courts finding was it discovered they weren't.

Bruce Levi: I think perhaps from the standpoint from the health care community, it was unintended. From the standpoint of a more narrow construction of the statute, and the courts said we're not going to go beyond the obvious language, and we're going to construe this in a narrow way and that's what they did. So if a physician is the defendant, I think the idea probably, when the law was enacted in 1981, that would include any case involving a physician, it's not really under the way that the courts interpreted it, it's only in respect to the allegation against the physician as an individual, and not perhaps in the context of providing medical service in a nursing home, clinic or any other facilities that are out there.

Representative Koppelman: Why is alleged lack of informed consent being removed if it is an obvious occurrence, it seems to me that an expert witness would shed a lot of light on whether or not consent was given.

Bruce Levi: There are a number of Supreme Court cases, a couple that were decided just this last year. It was the circumcision case in Fargo and some others. There is obviously language in those cases involving and establishing the need for expert opinion, with respect to whether or not informed consent was appropriate or not. I think our view is that informed consent should not be lobbed into the same category as those cases that are obvious occurrences, based on the Supreme Court.

Representative Kretschmar: The affidavit that the statute talks about on line 13, do you envision that being made by the expert or by the lawyer saying I have an expert to give such and such opinion.

Bruce Levi: I believe that's how it's done now. I think that even though the word affidavit, I don't believe is in the existing language...

Representative Kretschmar: Yes, it is on line 16...

Bruce Levi: Yes, it is, the expert's affidavit on line 16, I believe that's how it's done now, that there is an affidavit provided by the plaintiff indicating the statement from the expert.

Chairman DeKrey: Thank you. Further testimony in support of SB 2199.

Leslie Oliver, ND Long Term Care Association: Support (see written testimony).

Representative Delmore: If there is a medical liability lawsuit right now, of negligence, can I currently sue both the hospital and the physician or nurse.

Leslie Oliver: Yes, you can. That happens all the time.

Representative Delmore: With this bill, that would still be a capability with a nursing home and the worker or physician, or the caretaker, does this exempt nursing homes from things that could happen to hospitals.

Leslie Oliver: No, I don't think so. I don't think it does anything more than acknowledge that a nursing home, a skilled nursing facility, basic care and assisted living facility is also a medical facility that provides medical care, nursing care, therapy care.

Representative Zaiser: This is not meant to be in any way negative, but are there any nursing care facilities in the state that, would there be a problem with having those skilled medical care individuals, in some cases, in a rural community where there is a situation where they are

referred to a more urban place where they have more people. In other words, do all facilities have those skilled professionals, that are capable, as you described it.

Leslie Oliver: That really is a question talking about the availability of competent nursing care, which is another question that was decided actually in the last session. The state facilities, skilled nursing facilities are all licensed, based on the same standards, and have to apply the same standards and follow those standards with respect to the levels of care, staffing, staff competency. They're the same whether you are in Hurdsfield or Fargo.

Representative Zaiser: But, for instance, you brought up what happened in the last session, in terms of having that 4 year degree versus that two year degree. Would that play a role in the determination of a skilled, people having individuals skilled or not.

Leslie Oliver: No, the level of care that's provided to an individual in a skilled nursing facility is based on, it's very complicated, but it's based on an analysis of that person's medical needs, and they get the care that is dictated by their physical condition, and their health care providers.

Representative Koppelman: In your opinion, if this law is not changed, could a defendant, as a strategic move, refuse to name individuals and name a facility, in order to avoid some provisions we have in law, that arguably are intended to apply across the board.

Leslie Oliver: Yes, and plaintiffs could certainly do that and are doing that right now. I'm dealing with a situation right now, that a skilled nursing facility, that's been served for medical negligence and the nurse that is involved, and the CNA, because both nurse assistants and registered licensed nurses come under the nurse practices act. They were not named, so there's no expert to date and the case has been around for... It drags the process out.

Representative Koppelman: In the case you cited, Van Klootwyk v. Baptist Home, was the failure of the court to apply this statute, did that have any effect on the disposition of the case, or was it just that it dragged it out because of the expert witness requirements and the three month window.

Leslie Oliver: I'm not sure what happened post Supreme Court or...

Representative Koppelman: I'm asking about the decision, was there any impact on the decision in the case, the outcome of the case, as a result that the court's decision not to apply this statute, or if your concern is strictly that it dragged the process out, because they weren't forced to bring those experts forth in that 3 month window.

Leslie Oliver: Yes, I think it dragged the process out. Because ultimately the Van Klootwyk group would have had to obtain an expert.

Representative Meyer: Is an expert defined anyway, like an expert for a nursing home or an expert opinion.

Leslie Oliver: Yes, it is defined. I'm not going to be able to cite you the NDCC sections.

Representative Klemin: It is with the Rules of Evidence.

Leslie Oliver: Thank you.

Representative Meyer: Concerning the lawsuit you quoted, when they ended up getting an expert opinion anyway, what difference would it have made, if the statute would have been in place. They ended up having to obtain an expert's opinion anyway, as far as the case went.

Leslie Oliver: The case that we have the Supreme Court decision in, is pre-expert. I can't tell you what happened because there was no expert at the time the Supreme Court decided the case. The Baptist Home made a motion to dismiss because there wasn't an expert, and the Court

refused to apply 28.01-46. So the case was sent back and I don't know what happened after that. I believe it settled.

Representative Klemin: Just to make sure that the scope of the statute provides, it applies to professional negligence, and I think it's particularly relevant in the case of a nursing home, that it doesn't apply to certain other kinds of things that might happen in that kind of facility, such as premises liability type of situations. If the nursing home, for some reason, for example, failed to get the ice off the sidewalk, and a resident slipped and was hurt. That would be a premises liability case, more than a professional negligence kind of case, is that correct.

Leslie Oliver: Yes, that's correct as I understand it.

Representative Klemin: So this does not apply to premises liability kinds of situations.

Leslie Oliver: No, that's not the intention of this bill.

Representative Klemin: Similarly, I guess another example would be, let's say we've got a kitchen, and the cook doesn't cook the hamburger good enough and so we've got e-coli bacteria, that's still in it, and somebody gets sick as a result, would that be an ordinary negligence type of situation, or professional negligence.

Leslie Oliver: That's a tough call. I don't know the answer to that, it may even be a chicken and an egg question that a plaintiff's attorney could respond to better than I.

Representative Klemin: Well, I guess a final question in this whole thing about experts here that is being discussed, this doesn't mean, even if the case gets dismissed on motions, it's without prejudice, which means that the plaintiff's lawyer can come back again and do it right the second time.

Leslie Oliver: That's correct. There was a question earlier about what happens if you can't find an expert, or they're too expensive. There's nothing in SB 2199 that would prevent a plaintiff's lawyer from asking for an extension because they feel they have a good case and they just haven't found the right expert. That is anticipated and certainly permissible. And there's nothing in the bill that would prevent, as you said, a plaintiff's lawyer from refiling the case.

Representative Kretschmar: Who would determine whether a suit is based on professional negligence or just ordinary negligence. Say, for example, a nurse, or a CNA forgets to put the side up on the bed, and the elderly patient rolls out and breaks their hip. Is that professional or ordinary, human negligence.

Leslie Oliver: That would be medical negligence, in my opinion.

Representative Boehning: How would this apply to ambulance services and volunteer services. Would these kinds of things actually apply, or is that a whole another realm of the issue, emergency medicine.

Leslie Oliver: I'm not sure. I don't know. There may be someone else who could answer that.

Chairman DeKrey: Thank you. Further testimony in support of SB 2199.

Paula Grosinger, ND Trial Lawyers Association: Support (see written testimony). First, I'll address the issue of whether it's professional negligence or just standard negligence. Based on my experiences as a registered nurse, the training I've received, the Nurse Practice Act and the other Acts that I know that are applicable to professionals, one of the determining factors would be to assess the scope of practice involved, whether something fell specifically within scope of practice and the applicable standards of care for that profession as it's regulated. Certainly, I

think in some instances, again I'm not an attorney, I'm a registered nurse, it would be up to the discretion of the court. We support this bill, primarily because it has been amended to a form that we can now support, which I think brings consistency to the law, and applies it equitably to all providers. I think, initially when the law was enacted back in 1981, which is in statute, 28.01-46, nursing homes didn't see a huge number of liability claims. I don't know if it were an intentional omission, I suspect that it was not, because I'm not privy to the discussion back in 1981, but as we are seeing more and more ND residents going into nursing care, and the number of nursing homes beds have increased significantly since 1981, I think you are going to see more instances where professional issues arise, you'll see more instances of problems involving employees. I recently actually assisted with a case involving a resident of a Morton county nursing home, who had been assaulted by a caregiver. In that case, there will be no professional negligence action or malpractice action filed, but it was a case where the parties were able to agree, the nursing home administration and other staff, took all of the appropriate action, to ensure that such an occurrence would not take place again, and that the offender was prosecuted criminally, rather than civilly, so there will be no civil claim. With regard to the rationale for this bill, that is where I really want to offer some clarification, because Sen. Brown said that one of the reasons that we wanted to enact this type of legislation, is to bring stability to the premium situation. This type of legislation, and I maintain almost all so-called tort reform legislation, will have absolutely no impact on malpractice premiums, either in this state, or in any state. It will not necessarily prevent litigation. Reform efforts generally only benefit insurance companies. I can cite instances in other states where they have enacted tort reform legislation, and it has done absolutely nothing to reduce or maintain a low level of malpractice premiums. In fact, Donald J.

Zook, a leading malpractice insurance company, Chief Executive, was quoted in the Wall Street Journal on June 24, 2002, saying, I don't like to hear insurance company executives say it's the tort system (this is in reference to rising malpractice premiums), he actually said, "it's self-inflicted" and it had to do with the underwriting practices and the investment practices of the insurance companies. California is often cited because they had enacted caps on payouts in malpractice awards, and actually malpractice premiums in CA continued to rise, are 8% higher than the average of all the states that have no caps, and what actually held the line on malpractice premiums in CA, was the fact that they enacted Proposition 103, which meant that they could not have increases in malpractice premiums without prior approval. Just to go back and answer a couple of questions that came up regarding what happens with regard to when a claim is filed and how difficult it is to get an expert opinion. It is not always easy to get an expert opinion, although it's much easier to get the expert opinion at the level where you are looking for an affidavit, than it is to find an expert to bring into court, if you have to litigate. Oftentimes, North Dakotans and their attorneys, have to find experts from out of state. I believe that, at one time, we may have had a requirement that you had to have your expert opinion from a practitioner within ND and because of the difficulty in finding ND practitioners, that was expanded to allow for expert opinion to come from out-of-state practitioners. As you're probably aware, the initial version of this bill, would have eliminated that three month period, in which the plaintiff could have gotten the expert opinion. In that form, we opposed this bill because that was a real critical window, with regard to discovery in these types of actions. What typically happens is that a patient or patient's family member, in the event that the patient is unable to pursue the claim themselves, who is the person of medical malpractice may not even be aware that an actual injury

occurred, until another health care practitioner makes such an observation. A patient who suspects that an injury, or a family member that suspects that an injury is due to malpractice, may have persistent pain, infection, some unexpected result or another adverse response to the medical treatment involved, and then contact an attorney, but at that point, they probably don't have any documentation. As you previously heard, there actually was a case involving a nursing home in which they did not name the nurse, or a nurse. One of the reasons for that, is that until you have that documentation, and it may take that three month window in order to get that documentation from the provider, you may not know the names of all the providers that were involved, or who actually committed the alleged malpractice; particularly with regard to nurses, you've got multiple shifts, some facilities run 12 hour shifts (2 shifts a day), some run 3 shifts per day, so you have multiple care givers across time. You may need to get those records in order to be able to name, and thoroughly go through those records before you can even name individuals in a case. The requirement for having an affidavit of expert is good from the standpoint of reducing litigation, but I would prefer to couch that, not just from the standpoint of preventing frivolous litigation, because again I think that many times we have instances of malpractice that are unrecognized, that never proceed to a claim on the part of injured individuals and their families. I know I've said this before, but when you have 98,000 preventable deaths, due to preventable medical errors in this country each year, the problem is not frivolous litigation. The problem is medical errors. What's going to reduce premiums, is reducing medical errors and that is what will bring stability to the system and to premiums. But again, going back to the scenario where you have an injured individual, who has now decided that they are going to pursue a claim, and have contacted an attorney, that injured individual goes to the attorney, presents their case as

they understand it. Basically, without documentation in most cases, the attorney is going to make a determination at that point, whether or not they feel that this is a valid claim that can be pursued, and they generally are not going to pursue a frivolous claim, because it is horrendously expensive to pursue these claims, when they are legitimate. The attorney then will put the defendant, or alleged defendant, that there is a potential claim. They have the period for discovery, in which they try to get records, and during that period of time, they usually will get the affidavit of an expert, so they can proceed with the claim if it is legitimate. Here's where the reduction in litigation is important. Not only do you not have frivolous claims going forward at this point, but if you have a legitimate claim, and you are able to secure the documentation, and you have that expert's affidavit, that may actually ensure that the defendant does settle. We need to recognize that there are legitimate claims that are settled at this point. I really loathe to make this about frivolous claims, because when someone is injured, in the medical setting, that is not frivolous; particularly when it causes permanent injury or pain. So in its amended form, SB 2199 does achieve the result of making fair application of the law across the professions involved, and allows those claims that are legitimate to progress and move forward.

Representative Koppelman: You're for the bill, right.

Paula Grosinger: But the rationale for the bill, I did disagree with.

Representative Meyer: What constitutes the commencement of the action. What is the three month deadline, what is the commencement of the action. What is that exactly.

Paula Grosinger: Actually I have the statute which is currently in the NDCC. My understanding, and actually we've had a couple of other pieces of legislation that have come up

this session, where this has been an issue. My understanding is that the commencement of the action, is...can I get back to you.

Representative Klemin: The service of the Summons.

Representative Zaiser: You had indicated that you supported the bill, but you had some question about the rationale for it. Given the number of legitimate claims that you think are out there, and deaths that have occurred due to medical reasons, do you have any ideas in regard to procedures, in which the medical institutions can involve themselves with other folks to minimize those kinds of mistakes so that they can be exposed to the world, and exposure actually usually minimizes a sort of repeat error.

Paula Grosinger: That's a really good question, and yes, I think that allowing these errors to come to the light of day is really important and currently most reports of physician error, do not see the light of day. We have a National Practitioner Databank in which all claims against physicians are actually reported and that depository of information is not accessible to the public. My understanding is that information is only accessible to other professionals like, if a hospital were planning to hire a physician, they could go to that databank and find out how many claims that this specific physician had had against him that were reported to that databank. But the American Medical Association, on its own web site, and I don't know if it's still up, but for a long period of time, actually had information for a physician which was instructional on how to avoid a report to the National Practitioner Databank, and so I think there's really a need for the AMA to move away from that kind of practitioner education and move toward bringing these things to the light of day and also opening that information up to the public and not have it just be restricted to practitioners and providers. Again, documentation is another important means of

ensuring that errors are reported and tracked and that hospitals, through their quality assurance programs or other improvement indices, make efforts to reduce errors. What happens all too often, in my own profession, is that reports basically are file 13, or the reporting person in many practice venues, is the one that becomes punished, rather than the person who committed the error, and so the emphasis becomes let's hide the errors rather than bring them to the light of day, but I think you are absolutely correct, Representative Zaiser, that bringing these things out into the light of day would reduce errors.

Representative Boehning: You keep talking about these 98,000 deaths that occurred with medical errors. Where were these deaths occurring, in emergency rooms or in the hospitals, in for two days or three days. Is there a breakdown we could have.

Paula Grosinger: That information comes from a Harvard study, and from a study entitled, To Err is Human. That's also been documented by the Veterans Administration, which by the way, this goes back to Representative Zaiser's question about preventing errors, the Veterans Administration, in its hospitals over the last several years, has taken a very proactive approach and kind of leapfrogged off the study that cited the 98,000 preventable medical errors and did a system wide change in their care delivery system. They have had a significant reduction in errors as a result. I will see if I can find an actual copy for the committee of that study and make copies and bring it in. They analyzed across all types, surgical, post-surgical, emergency, acute care, all types of patient situations for those statistics.

Chairman DeKrey: Thank you. Further testimony in support of SB 2199. Testimony in opposition. We will close the hearing.

(Reopened later in the same session)

Chairman DeKrey: What are the committee's wishes in regard to SB 2199.

Representative Koppelman: I think Representative Boehning had a good point, particularly because most of those are volunteer, and often times, a physician or nurse is not part of it, and they seemed to think that was a good idea.

Chairman DeKrey: The trouble with that is we didn't have any kind of a hearing on any of that.

Representative Koppelman: I understand, but I think the intent of the bill is to expand it to include entities that perhaps 24 years ago were assumed to be covered, and so I think in that spirit...

Representative Maragos: Yes, but aren't EMT's and everything licensed under a whole different set of rules. I don't know that it would pertain to this. Maybe we could find one of the EMT bills, or in the next session, extend that same protection to EMT's. They may already have it in their code that covers EMT's.

Representative Koppelman: That's why I asked Mr. Levi, at least I would say to hang onto it long enough to check that.

Chairman DeKrey: We can do that, but I guess from a standpoint of just never having had a hearing and it was never part of the bill, even if we did amend it to do that, I wouldn't support that amendment, because I think if they wanted to be in on this, two years from now they can come in and make their case, because if we amend it to that, then it's going to go to conference committee in the Senate, or they'll just concur. If they just concur, then we would have had no testimony or any public input whatsoever on that amendment if they just concurred.

Representative Meyer: Just for a point of reference for the committee, after having had to hire an expert opinion, a 4 hour testimony in court, costs us $10,000. It took us a little over 6.5 months to find him, and that did not include his airline ticket, his motel room or a lot of steak that he ate. So as a point of reference, that's how much money we're talking to get an expert opinion.

Representative Maragos: But I think you still need it under current law.

Representative Meyer: That's correct, and perhaps under this affidavit, but when you have a 3 month time limit, and if you're talking about expense.

Representative Koppelman: But Ms. Grosinger, testified that getting an expert for an affidavit would be less expensive.

Representative Meyer: Yes, that was my point.

Representative Zaiser: My only concern on that is that this process would be out front of the contract, the legal contract between the attorney and the individual and would there be that money available. I don't know.

Chairman DeKrey: I think most of those cases are taken on a contingency anyway, so the law firm pays the costs and then as the plaintiff, you're going to be eventually responsible for the costs of that case.

Representative Boehning: Would a second opinion from a doctor probably work as an affidavit as well, if you went to another physician because you thought something was wrong. Would that work as an expert witness. That would probably be covered under insurance.

Representative Meyer: The problem with getting an expert opinion, in the state of ND, and we ran into this for 6.5 months, you aren't going to get a doctor that comes in and says that.

They won't testify against each other. I mean, you have to go out of state and by the time you fly them in, and they decide it's the best money can buy. You're not going to have another doctor that steps up and gives you an expert opinion against his colleague.

Representative Boehning: I guess what I'm saying is that if you break your arm and he sets it wrong, you go back and he says there is nothing wrong with you, you go to another doctor, and he says that the first doctor screwed that up in there, he didn't set it properly. I would say that's an expert witness.

Representative Maragos: It's one thing for the doctor to give an opinion to the patient, but it's another thing for the doctor to get on the stand and say that other doctor screwed up. That's a whole different ball game.

Representative Koppelman: I think it's important to realize that this bill does nothing to change that, it's already required in the current law. All the bill does is says you have to have an affidavit and I think Ms. Grosinger indicated that might be a benefit, might make it easier and less costly to get an expert opinion.

Representative Delmore: I don't think this changes what we currently have, and I move a Do Pass on SB 2199.

Representative Maragos: Seconded.

Representative Onstad: How does this affect the mediation process we talked about here earlier.

Representative Kretschmar: It wouldn't. If that bill passes, you'd have to go into that first.

Representative Onstad: That would go first, and then you'd end up into something like this. Maybe you could eliminate that without a court case.

Representative Kretschmar: Regarding EMT service, we have in the statute, 23.27-04.1, gives immunity to civil liability to volunteers, and emergency medical personnel, and to doctors unless it can be proved that the damage resulted from intoxication, willful misconduct, or gross negligence, of the doctor or volunteer service.

Chairman DeKrey: The clerk will call the vote.

12 YES 0 NO 2 ABSENT **DO PASS** **CARRIER: Rep. Koppelman**

Date: 3/1/05
Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2199

HOUSE JUDICIARY COMMITTEE

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Rep. Delmore Seconded By Rep. Maragos

Representatives	Yes	No	Representatives	Yes	No
Chairman DeKrey	✓		Representative Delmore	✓	
Representative Maragos	✓		Representative Meyer	✓	
Representative Bernstein	✓		Representative Onstad	✓	
Representative Boehning	✓		Representative Zaiser	✓	
Representative Charging	A				
Representative Galvin	✓				
Representative Kingsbury	✓				
Representative Klemin	A				
Representative Koppelman	✓				
Representative Kretschmar	✓				

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep. Koppelman

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2199, as engrossed: Judiciary Committee (Rep. DeKrey, Chairman) recommends **DO PASS** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). Engrossed SB 2199 was placed on the Fourteenth order on the calendar.

2005 TESTIMONY

SB 2199

HH #1
9:30

SB 2199 – Expert Opinion Affidavit Requirement
Senate Judiciary Committee, January 19, 2005

Same to House

Section 28-01-46 incorporates a requirement put in place in 1981 that is designed to minimize frivolous medical liability claims by requiring that the plaintiff produce an expert opinion to support allegations of negligence in the early stages of litigation. It is designed to prevent protracted litigation when a plaintiff cannot substantiate a basis for the claim – in short, it acts as a preliminary screen of unsupported claims and prevents the necessity for an actual trial in those cases. It assures that claims have been evaluated and can be supported. If the plaintiff fails to provide the expert opinion, the trial court may, within its discretion, dismiss the action without prejudice or provide additional time for the plaintiff to provide the expert.

I understand that section 28-01-46 has been a useful tool in our state, and has fulfilled its purpose either directly or indirectly in discouraging meritless claims. I am concerned about the crisis in medical liability coverage market in more than twenty states in this country, and have introduced SB 2199 partly in response to several judicial opinions rendered by the North Dakota Supreme Court.

One of those Supreme Court opinions interpreted the scope of the statute and ruled that the expert opinion requirement did not apply to a plaintiff in a claim filed against a nursing home. In that case, the Supreme Court said it would not correct an alleged legislative oversight by rewriting the statute to apply to nursing homes. One of the justices in that case said: "The legislature will have to address expansion of the categories to whom NDCC 28-01-46 applies, if this result does not accord with legislative intent." SB 2199 expands these categories to other facilities or individuals who may be involved in a medical liability claim.

Other recent Supreme Court cases have interpreted section 28-01-46 to not apply in claims that allege a lack of informed consent. SB 2199 would remove the exception for allegations of lack of informed consent, and address other concerns with the statute.

I agreed to introduce SB 2199 at the request of the North Dakota Medical Association, North Dakota Long Term Care Association, North Dakota Healthcare Association, individual attorneys and others, who have representatives here today to discuss the bill.

I urge you to support the rationale for SB 2199 and recommend a "do pass" on the bill. Thank you.

AH #2

ND Medical Association

Testimony in Support of Senate Bill No. 2199
Senate Judiciary Committee
January 19, 2005

Mr. Chairman, Members of the Senate Judiciary Committee, I'm Bruce Levi. I represent the North Dakota Medical Association. The Association is the professional membership organization for physicians, residents and medical students in North Dakota.

The North Dakota Medical Association supports Senate Bill No. 2199. The bill would revise NDCC Section 28-01-46, North Dakota's statute requiring that the plaintiff produce an expert opinion to support allegations of negligence in the early stages of medical liability litigation. This is a mechanism used in at least 21 states to ensure that medical liability claims are supported by expert opinion at an early stage of the litigation. The affidavit required must identify the name and business address of the expert, indicate the expert's field of expertise, and contain a brief summary of the basis for the expert's opinion. If the plaintiff fails to provide the expert opinion, the trial court may, within its discretion, dismiss the action without prejudice or provide additional time for the plaintiff to provide the expert.

Since the 2003 Legislative Assembly, several North Dakota Supreme Court decisions have addressed issues relating to the statute, and it is the intent of this legislation to respond to those issues.

The Medical Association facilitated some discussion among our health care organizations in the state and several members of the defense bar. The bill you have as introduced reflects that discussion. In subsequent discussion, it was suggested that one element of the bill is not necessary at this time. We are offering an amendment to the bill that retains much of the current language relating to how the affidavit relating to the expert opinion is provided and the timeframe for submitting the affidavit, retaining the present requirement of submitting the affidavit within three months after the commencement of the action. We shared that amendment in advance with the State Bar Association.

The North Dakota Supreme Court has described the purpose of the expert affidavit statute:

> The statute attempts to minimize frivolous claims by requiring the plaintiff to produce an expert opinion to support the allegations of negligence in the early stages of litigation. The statute provides for preliminary screening of totally unsupported claims and seeks to prevent protracted litigation when a medical malpractice plaintiff cannot substantiate a basis for the claim. It was enacted to prevent the necessity of an actual trial in those cases. *Van Klootwyk v. Baptist Home, Inc.*, 665 N.W.2d 679 (2003) (citations omitted).

SB 2199 with the proposed amendments would:

1) Address the issues raised by the North Dakota Supreme Court in *Van Klootwyk v. Baptist Home, Inc.*, 665 N.W.2d 679 (2003) by further delineating defendants such as long term care facilities, ambulatory surgery centers and clinics to the list of defendants for which the expert opinion requirement is applicable. In *Van Klootwyk*, the Court construed the language in section 28-01-46 to only apply in an action for professional negligence against a physician, nurse, or hospital. SB 2199 would extend the expert opinion requirement to actions alleging professional negligence against a nursing, basic, or assisted living facility or by any other health organization, including an ambulatory surgery center or group of physicians operating a clinic or outpatient facility. These are additional categories in which a medical liability case may arise. A representative from the North Dakota Long Term Care Association will comment more fully on this aspect of the bill.

2) Remove a current exception that makes the expert opinion requirement inapplicable in cases alleging lack of informed consent, as is illustrated in the recent cases of Holman v. Berglund, 664 N.W.2d 516 (2003) and Haugenoe v. Bambrick, 663 N.W.2d 175 (2003). Bismarck attorney Lance Schreiner will comment more fully on this aspect of the bill.

From the standpoint of the North Dakota Medical Association, section 28-01-46 provides a measure of stability for physician practice in ensuring that claims of professional negligence have been evaluated and and can be supported to prevent unnecessary litigation and costs.

On behalf of North Dakota's physicians, I urge you to recommend a "do pass" on SB 2199 with the proposed amendments.

AH #3

PROPOSED AMENDMENTS TO SENATE BILL NO. 2199

Page 1, line 13, remove "with the summons and complaint"

Page 1, line 14, remove the overstrike over "~~within three months of the~~"

Page 1, line 15, remove the overstrike over "~~commencement of the action~~"

Page 1, line 16, replace "filing" with "serving", and remove "by clear and convincing evidence"

Renumber accordingly

AH #4

Testimony on SB 2199
Senate Judiciary Committee
January 19, 2005

Chairman Traynor and members of the Senate Judiciary Committee, thank you for the opportunity to testify on SB 2199. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. I am here to testify in support of SB 2199.

Section 28-01-46 minimizes frivolous claims alleging medical negligence against doctors, nurses and hospitals, by requiring an expert opinion supporting the allegations, within three months of commencing the action. SB 2199 appropriately expands the application of the statute to long term care facilities and other health care facilities providing professional medical care.

Nursing facilities are a prime target for medical malpractice actions. Without the amendments proposed in SB 2199, facilities are denied the statutory protections afforded other health care providers. A recent decision by the North Dakota Supreme Court, entitled Van Klootwyk v. Baptist Home, 2003 ND 112, offers the basis for the Association's support of SB 2199.

The Baptist Home was sued by a former resident's family members for personal injuries and wrongful death, alleging nursing malpractice. Because the plaintiffs' named the facility and not the nurses individually, the Court would not apply N.D.C.C. Section 28-01-46, the expert opinion time requirements, to the case. The protections of the statute were denied based upon a decision by the plaintiffs to sue the facility for the conduct of its nurse-employees.

Long term care facilities employ competent medical professionals providing nursing and therapy services, and must be afforded the protections contained in this bill. The North Dakota Long Term Care Association appreciates the Committee's consideration of SB 2199. Thank you for the opportunity to testify on SB 2199.

Shelly Peterson, President
North Dakota Long Term Care Association
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Bismarck, ND 58501
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Supreme Court of North Dakota.

Paula J. LARSEN, Plaintiff and Appellant,
v.
Robert W. ZARRETT, M.D., Fargo Clinic MeritCare, and St. Luke's Hospitals-MeritCare, Defendants and Appellees.

Civ. No. 920242.

March 29, 1993.

Patient sued doctor, clinic, and hospital for injuries allegedly received during surgery. The District Court, Cass County, East Central Judicial District, Lawrence A. Leclerc, J., dismissed the action, and plaintiff appealed. The Supreme Court, VandeWalle, C.J., held that plaintiff failed to comply with statutory requirement of expert testimony to support medical malpractice action.

Affirmed.

West Headnotes

[1] **Health** 804
198Hk804 Most Cited Cases
(Formerly 198Hk821(2), 299k18.80(6.1) Physicians and Surgeons)
Statute requiring expert testimony in action based on alleged medical negligence cases was designed to minimize frivolous **claims** against physicians, nurses, and hospitals by **avoiding** necessity of trial in an action based upon professional negligence unless plaintiff obtains expert opinion to **substantiate** allegations of negligence. NDCC **28-01-46**.

[2] **Health** 804
198Hk804 Most Cited Cases
(Formerly 198Hk821(4), 299k18.80(8) Physicians and Surgeons)
Prima facie case of medical malpractice consists of expert evidence establishing applicable standard of care, violation of that standard, and causal relationship between violation and harm complained of; however, expert testimony is not necessary to establish duty, breach of which is blunder so egregious that layman is capable of understanding its enormity. NDCC 28-01- 46.

[3] **Evidence** 571(3)
157k571(3) Most Cited Cases
Medical malpractice plaintiff's proffered expert testimony was not sufficient to support prima facie case, where neither of plaintiff's experts could definitely state that any deviation from usual medical malpractice had occurred. NDCC 28-01-46.

[4] **Health** 804
198Hk804 Most Cited Cases
(Formerly 198Hk821(5), 299k18.80(7) Physicians and Surgeons)
Doctrine of res ipsa loquitur did not excuse medical malpractice plaintiff from complying with statutory requirement that she support negligence allegation with expert testimony; statute specifically defined instances in which expert opinion was unnecessary and by implication excluded doctrine of res ipsa loquitur from those exceptions. NDCC 28-01-46.

***191** Gary Hazelton, Duranske & Hazelton, Bemidji, MN, for plaintiff and appellant. Submitted on brief.

Jane C. Voglewede (argued), and Wayne W. Carlson (on brief), of Vogel, Brantner, Kelly, Knutson, Weir & Bye, Ltd., Fargo, for defendants and appellees Robert W. Zarrett, M.D., and Fargo Clinic MeritCare.

Paul F. Richard (argued), and Jack G. Marcil (on brief), of Serkland, Lundberg, Erickson, Marcil & McLean, Ltd., Fargo, for defendant and appellee St. Luke's Hospitals-MeritCare.

VANDE WALLE, Chief Justice.

Paula J. Larsen appealed from a district court judgment dismissing with prejudice her medical malpractice action against Robert W. Zarrett, M.D., Fargo Clinic MeritCare, and St. Luke's Hospitals-MeritCare. We affirm.

On August 17, 1989, Dr. Zarrett performed surgery on Larsen for hemorrhoids and an inguinal hernia. After the surgery, Larsen complained of severe pain and ***192** numbness in her right leg. She was referred to a neurologist for further evaluation. A CT scan and an EMG study produced normal results.

In July 1991, Larsen commenced this action against Dr. Zarrett, Fargo Clinic, and St. Luke's Hospitals, seeking recovery for nerve damage suffered while she was under general anesthesia during the surgery. In January 1992, the defendants moved for summary judgment of dismissal, asserting that Larsen had not

obtained an admissible expert opinion to support her action, and that she therefore had failed to comply with the requirements of § 28-01-46, N.D.C.C. In February 1992, the trial court granted Larsen an additional 30 days to obtain a supporting expert opinion. In May 1992, the defendants renewed their motion for summary judgment of dismissal, asserting that Larsen still had not obtained an admissible supporting expert opinion. In June 1992, the trial court dismissed Larsen's action with prejudice. Larsen appealed.

Section **28-01-46**, N.D.C.C., provides:

> "***28-01-46**. Expert opinion required to maintain an action based upon alleged medical negligence except in obvious cases.* Any action for injury or death against a physician, nurse, or hospital licensed by this state based upon professional negligence is dismissible on motion unless the claimant has obtained an admissible expert opinion to support the allegation of professional negligence within three months of the commencement of the action or at such later date as set by the court. This section does not apply to alleged lack of informed consent, unintentional failure to remove a foreign substance from within the body of a patient, or performance of a medical procedure upon the wrong patient, organ, limb, or other part of the patient's body, or other obvious occurrence."

[1] Section **28-01-46** was designed to minimize frivolous **claims** against physicians, nurses, and hospitals [*Heimer v. Privratsky*, 434 N.W.2d 357 (N.D.1989)], by **avoiding** the necessity of a trial in an action based upon professional negligence unless the plaintiff obtains an expert opinion to **substantiate** the allegations of negligence. *Fortier v. Traynor*, 330 N.W.2d 513 (N.D.1983). The statute thus seeks to prevent **protracted litigation** when a medical malpractice plaintiff cannot **substantiate** a basis for a **claim**.

[2] Except for the three month limit for obtaining an admissible supporting expert opinion, § **28-01-46** has been viewed as essentially codifying the pre-existing case law in this jurisdiction requiring expert testimony to support a prima facie **claim** of medical malpractice. *Fortier v. Traynor, supra; Morlan v. Harrington*, 658 F.Supp. 24 (D.N.D.1986). A prima facie case of medical malpractice consists of expert evidence establishing the applicable standard of care, violation of that standard, and a causal relationship between the violation and the harm complained of. *Heimer v. Privratsky, supra; Peterson v. Kilzer*, 420 N.W.2d 754 (N.D.1988); *VanVleet v. Pfeifle*, 289 N.W.2d 781 (N.D.1980); *Winkjer v. Herr*, 277 N.W.2d 579 (N.D.1979). However, expert testimony is not necessary "to establish a duty, the breach of which is a blunder so egregious that a layman is capable of comprehending its enormity." *Arneson v. Olson*, 270 N.W.2d 125 (N.D.1978). *See also Heimer v. Privratsky, supra; Wasem v. Laskowski*, 274 N.W.2d 219 (N.D.1979); *Winkjer v. Herr, supra.*

[3] In this case, Larsen relied upon two experts to support her claim. Dr. John W. Tulloch, a neurologist, conducted an independent examination of Larsen, and reported that Larsen's recollection and supporting medical records "indicate that [her lumbar plexopathy] originated in relation to her operations August 17, 1989." Larsen's counsel then requested Dr. Tulloch to provide an expert opinion pursuant to the requirements of North Dakota law. Dr. Tulloch noted that Larsen's lumbar plexopathy was "an unusual outcome in relation to the type of surgeries" Larsen underwent, but said:

> "I am unable to say whether or not this is a deviation from the standard of care in such surgical cases. As a neurologist, I am simply not familiar enough with ***193** surgical standards of care to be able to attest that such standards were breached in this particular case. For this reason, I am sure that I would not be deemed a credible expert with respect to surgical standards of care. I believe that you would actually need a general surgeon's opinion on this matter."

Larsen contacted a second expert, Dr. Richard G. Strate, a surgeon who examined Larsen's medical records and suggested "further evaluation of this patient in hopes of determining precisely what is going on and possibly the causative factor."

Larsen was evaluated again by Dr. Tulloch who noted as a "potential etiology" that Larsen may have suffered "a stretch injury which is conceivable in a patient under general anesthesia who has to be managed in multiple positions on the operative table." Dr. Tulloch concluded that "I am quite certain that the only mechanism available for this proximal injury, provided that CT scan really did rule out hemorrhage, would be stretch."

After the defendants filed their initial motions for dismissal, Larsen's counsel wrote Dr. Strate and specifically asked him for his opinion whether there was a deviation from the surgical standard of care. [FN1] Dr. Strate concluded that Larsen "suffered either some stretching of the nerve or pressure upon

the nerve near the spinal column sometime immediately prior to, during, or immediately after her anesthetic and surgical procedure," but added:

> FN1. Larsen's counsel wrote to Dr. Strate: "Unfortunately defense counsel feels that neither your report nor Dr. Tulloch's report constitute an expert medical opinion that the surgical standard of care was not observed and thus caused Ms. Larsen's condition. They have filed a motion to dismiss Ms. Larsen's claim on this basis which is scheduled to be heard on February 4th in Fargo. North Dakota law requires that a plaintiff alleging negligence on the part of a physician obtain 'an admissible expert opinion to support the allegation of professional negligence within three months of the commencement of the action or at such later date as set by the court.' Thus, although I feel we have such an opinion I ask that you please drop me a note containing an opinion specifically addressing whether the condition [sic] suffers from has resulted from the surgeon's failure to meet the applicable surgical standard of care. Please keep in mind that what we are dealing with here is an issue of legal rather than medical causation. What is required is not certainty but rather an opinion that based on a review of the records and all other information it is more probable than not that the condition Ms. Larsen suffers from has resulted from failure to observe the applicable standard of care. Phrased another way, that the circumstances supporting a theory of negligence are of greater weight than the evidence supporting a theory of no negligence. Thus, it is not necessary to exclude all other possible theories. It is only necessary that the theory of negligence be the more probable theory than that or those of no negligence."

"I have ... re-examined the operative report and anesthetic record and find nothing that would indicate that there was any deviation from the usual practice in turning or positioning the patient for surgery. The operative procedures themselves were handled in a fairly straightforward manner and without complication.

"In summary, I feel that Ms. Larsen did indeed experience some event that led to a neurologic problem involving the lumbar plexus on the right side and this event most likely occurred sometime during the operative procedure. I cannot, however, identify any deviation from the standard practice as evidenced in her preoperative, operative, and postoperative records. This would appear to be a very unfortunate event which, however, could not have been predicted nor anticipated. I am also not sure what special precautions could possibly have been taken in view of the unknown etiology of this apparent nerve injury."

[4] Larsen's counsel again wrote to Dr. Strate, explained to him the doctrine of res ipsa loquitur, and asked: "is the injury suffered by Ms. Larsen one that ordinarily would not occur unless there had been a deviation from the standard of care or is the result rather one that is a recognized risk associated with surgery of this type which can occur even if the standard of care is observed?" Dr. Strate replied:

"I would consider that Ms. Larsen's problem would not be considered as a ***194** recognized risk associated with the surgery performed. The problem arises in that we have not been able to identify the cause of her injury. We can recognize that there has been an injury to the spinal cord roots based upon the patient's symptoms and upon the neurologic examination performed. We cannot, however, state that a particular action or lack of action on the part of the surgeon or anesthesiologist, or a particular position that the patient was placed in was the specific entity that led to the outcome seen.

"What can be said is that the patient was apparently neurologically normal prior to surgery. That she underwent anesthesia and two surgical procedures with an intra-operative change in position. That when she awoke from anesthesia symptoms of a neurologic deficit was [sic] present. I cannot, however, state that there was something done (or not done) that led to this condition."

Larsen does not assert that the expert opinions of Dr. Strate and Dr. Tulloch alone support a prima facie case of medical malpractice. Neither doctor could say that a violation of the applicable standard of care occurred or that there was a causal relationship between any such violation and the harm complained of. Rather, relying on authority from other jurisdictions, Larsen argues that the circumstantial evidentiary doctrine of res ipsa loquitur, when aided by the expert opinions of Dr. Strate and Dr. Tulloch, creates an inference of negligence. Larsen's authority from other jurisdictions applies res ipsa loquitur more expansively in medical malpractice cases than we have in our prior cases. *See, e.g.,*

Sagmiller v. Carlsen, 219 N.W.2d 885, 893 (N.D.1974) [res ipsa loquitur applies "only where the facts showing negligence are within the understanding of laymen, and the probability of the adverse result from the facts shown (are) within the common knowledge of laymen"]. According to Larsen, if we adopt the approach taken in other jurisdictions, dismissal under § 28-01-46 is improper because her nerve injury to the lower back during surgical procedures performed on other areas of her body is an "obvious occurrence" of negligence within the common knowledge of a layperson when that knowledge is aided by the testimony of her consulting expert witnesses. We reject this argument.

Section 28-01-46 specifically defines the instances in which an expert opinion is unnecessary as "lack of informed consent, unintentional failure to remove a foreign substance from within the body of a patient, or performance of a medical procedure upon the wrong patient, organ, limb, or other part of the patient's body, or other obvious occurrence." Under the rule of *ejusdem generis*, when general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects specifically enumerated. *Resolution Trust v. Dickinson Econo-Storage*, 474 N.W.2d 50 (N.D.1991). The word "obvious" means "easily understood; requiring no thought or consideration to understand or analyze; so simple and clear as to be unmistakable." Webster's Third New International Dictionary, at p. 1559 (1971). By enacting § 28-01-46, the Legislature has essentially defined the doctrine of res ipsa loquitur for purposes of medical malpractice cases in this jurisdiction and has given it a scope which is, perhaps, even more narrow and limited than our case law on the doctrine which preceded the statute's enactment. *See, e.g., Winkjer v. Herr, supra.*

Larsen's argument proposes a separate, unexpressed exception to the statute by combining the concept of an "obvious occurrence" with expert medical testimony to avoid dismissal of her malpractice claim. An "obvious occurrence" which must be explained by expert medical testimony is not only a contradiction in terms, but contravenes clear and unequivocal statutory language that requires "an admissible expert opinion to support the allegation of professional negligence." Larsen's proposal is better made to the Legislature than to this court.

Larsen alternatively contends that because her injury is to a different area of the body than the surgical situs and is of a ***195** type which is not an inherent risk of the operations she underwent, this case falls within the "other obvious occurrence" exception to § 28-01-46. We disagree.

The "obvious occurrence" exception applies only to cases that are plainly within the knowledge of a layperson. In an "obvious occurrence" case, expert testimony is unnecessary precisely because a layperson can find negligence without the benefit of an expert opinion. This case differs from the statutory examples of leaving a foreign substance within the body or operating on the wrong patient, limb, or organ. Rather, it involves technical surgical procedures and nerve damage, both of which have been recognized as generally being beyond the understanding of a layperson. *See Maguire v. Taylor*, 940 F.2d 375 (8th Cir.1991); *Lemke v. United States*, 557 F.Supp. 1205 (D.N.D.1983). Neither of Larsen's experts could say that her injury was the type that would occur only if there was negligence. It would be illogical to conclude that this case involved an "obvious occurrence" when Larsen's own medical experts could not find any deviation from the standard of care. There was no "obvious occurrence" of negligence in this case.

Larsen also asserts that, where knowledge of the mechanism of injury is within the exclusive control of the defendants, full discovery should be completed before a trial court considers motions for dismissal under § 28-01-46. We disagree. In very few medical malpractice cases is the mechanism of injury within the exclusive control of anyone other than the defending doctor, hospital, or nurse. As we have noted, the statute was designed to prevent protracted litigation when a medical malpractice plaintiff has no basis for a claim. Suspending the statute until the close of discovery, as Larsen suggests, would thwart this purpose and afford no protection against the frivolous claims the Legislature sought to diminish.

Moreover, the trial court granted Larsen additional time to find an admissible supporting expert medical opinion. Larsen had approximately 10 months to comply with the statute. The record does not show that any interrogatories were served on the defendants or that any depositions were taken.

Because Larsen failed to meet the requirements of § 28-01-46, we conclude that the trial court did not err in dismissing her medical malpractice action. [FN2]

FN2. We have not precisely defined the standard of review to be employed by this

court in reviewing a trial court's dismissal of a medical malpractice action under § 28-01-46, N.D.C.C., or the standard to be used by the trial court in making its initial determination on the motion. However, we have previously applied the abuse of discretion standard in reviewing a trial court's dismissal under § 28-01-46 in an unpublished summary affirmance. *See Johnson v. Kennedy*, 453 N.W.2d 830 (N.D.1990) (text in Westlaw).

The defendants in this case moved for dismissal under the statute through means of a Rule 56, N.D.R.Civ.P., motion for summary judgment, a method approved by at least one federal district court judge in this state. *See Morlan v. Harrington*, 658 F.Supp. 24 (D.N.D.1986). On appeal from a summary judgment, we determine whether the information available to the trial court, when viewed in the light most favorable to the opposing party, precludes the existence of a genuine issue of material fact and entitles the moving party to summary judgment as a matter of law. *See State Bank of Kenmare v. Lindberg*, 471 N.W.2d 470 (N.D.1991).

Because § 28-01-46 refers to an "admissible" expert opinion to support a medical malpractice claim, a trial court's role in reviewing an expert opinion under the statute may also be viewed as an evidentiary one. We have said that the decision to admit or not to admit expert testimony under Rule 702, N.D.R.Ev., rests within the sound discretion of the trial court, and its decision will not be reversed on appeal unless the court has abused its discretion. *See Nelson v. Trinity Medical Center*, 419 N.W.2d 886 (N.D.1988). A trial court abuses its discretion when it acts in an arbitrary, unreasonable, or unconscionable manner. *Fleck v. Fleck*, 337 N.W.2d 786 (N.D.1983). A trial court's decision is not arbitrary, unreasonable or unconscionable if the exercise of discretion is " 'the product of a rational mental process by which the facts of record and law relied upon are stated and are considered together for the purpose of achieving a reasoned and reasonable determination.' " *Kinney v. First National Bank*, 495 N.W.2d 69, 71 (N.D.1993), quoting *Matter of Altshuler*, 171 Wis.2d 1, 490 N.W.2d 1, 3 (1992).

A trial court's decision to dismiss a medical malpractice **claim** under the authority of § 28-01-46 does not fit neatly within the contours of either a typical summary judgment disposition or a typical evidentiary ruling made during the course of a trial. The statute, by requiring an admissible expert opinion within three months of the commencement of the action, accelerates the litigation process in a medical malpractice case. The summary judgment procedure under Rule 56 envisions completion of more discovery by all of the parties than can usually be accomplished under the time limitations of the statute. Likewise, the consequence of a dismissal under the statute is much more drastic than the consequence of a typical evidentiary ruling made by the court during the course of a trial. For these reasons, simply applying either a genuine-issue-of-material-fact analysis or an evidentiary-abuse-of-discretion analysis may not be appropriate. Rather, greater leniency for the plaintiff who is subject to a motion for dismissal under § 28-01-46 may be required than is typically given under either standard.

In any event, we need not resolve the question in this case. Applying either summary judgment principles or evidentiary-abuse-of-discretion principles, and even applying those principles liberally in favor of this plaintiff, we conclude that the trial court did not err in dismissing Larsen's medical malpractice claim because she failed to meet the requirements of the statute as a matter of law.

The judgment is affirmed.

***196** MESCHKE, J., VERNON R. PEDERSON and RALPH J. ERICKSTAD, Surrogate Judges and OLSON, District Judge, concur.

Surrogate Judge RALPH J. ERICKSTAD was Chief Justice at the time this case was heard and served as surrogate judge for this case pursuant to Section 27-17-03, N.D.C.C.

PEDERSON, Surrogate Judge, and OLSON, District Judge, sitting in place of LEVINE, J., and JOHNSON, J., disqualified, who was a member of the Court when this case was heard.

Justice NEUMANN and Justice SANDSTROM, not being members of the Court when this case was

heard, did not participate in this decision.

498 N.W.2d 191

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IN THE SUPREME COURT

STATE OF NORTH DAKOTA

2003 ND 92

Robert N. Haugenoe and Tracey Haugenoe, Plaintiffs and Appellants
v.
William S. Bambrick III, M.D., Mercy Medical Center, Defendants and Appellees

No. 20020252

Appeal from the District Court of Williams County, Northwest Judicial District, the Honorable William W. McLees, Judge.
AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.
Opinion of the Court by Maring, Justice.
Donald L. Peterson, Peterson Law Office, 900 20th Avenue SW, P.O. Box 96, Minot, N.D. 58702-0096, for plaintiffs and appellants.
John C. Kapsner, Vogel Law Firm, U.S. Bank Bldg., 200 North 3rd Street, Suite 201, P.O. Box 2097, Bismarck, N.D. 58502-2097, for defendant and appellee, Mercy Medical Center.
Lance D. Schreiner (appeared) and Tracy Vigness Kolb (argued), Zuger Kirmis & Smith, 316 North 5th Street, P.O. Box 1695, Bismarck, N.D. 58502-1695, for defendant and appellee, William S. Bambrick, III, M.D.

Haugenoe v. Bambrick

No. 20020252

Maring, Justice.

[¶1] Robert and Tracey Haugenoe appeal from the July 19, 2002, order[1] dismissing their complaint against Dr. William Bambrick and Mercy Medical Center without prejudice. We affirm in part, reverse in part, and remand for proceedings consistent with our opinion.

I

[¶2] A dismissal without prejudice is ordinarily not appealable because either party may commence another action. See Community Homes of Bismarck, Inc. v. Clooten, 508 N.W.2d 364, 365 (N.D. 1993). "However, a dismissal without prejudice may be final and appealable if the . . . dismissal has the practical effect of terminating the litigation in the plaintiff's chosen forum." Rodenburg v. Fargo-Moorhead YMCA, 2001 ND 139, ¶ 12, 632 N.W.2d 407. In this case, where the statute of limitations has run, a dismissal "effectively forecloses litigation in the courts of this state." Jaskoviak v. Gruver, 2002 ND 1, ¶ 8, 638 N.W.2d 1 (quoting Rodenburg, at ¶ 12). We conclude the December 2, 2002, judgment of dismissal is, therefore, appealable. See Jaskoviak, at ¶ 8.

II

[¶3] On May 19, 1999, Robert Haugenoe was treated at Mercy Medical Center for a severely comminuted[2] compound fracture of his right elbow and a fracture of his right wrist. Dr. William Bambrick performed a surgical open reduction and internal fixation of the elbow. The Haugenoes claim that after the surgery, Dr. Bambrick assured them the elbow was in proper alignment, when a second opinion from a doctor in Montana revealed the elbow was misaligned and missing bone fragments.

[¶4] The Haugenoes commenced an action on May 25, 2001. Their complaint contained three counts. The first count alleged "healthcare negligence" against both Dr. Bambrick and Mercy Medical Center. The Haugenoes alleged that Dr. Bambrick was negligent in his performance of the surgery and follow-up treatment of the right elbow and that Mercy Medical Center was negligent in giving Dr. Bambrick privileges at its facilities. The second count was an informed consent claim against Dr. Bambrick. The Haugenoes alleged that Dr. Bambrick failed to adequately inform Haugenoe of the risks of the surgery and follow-up treatment. In the third count, the Haugenoes alleged that due to Dr. Bambrick's "healthcare negligence," Tracey Haugenoe suffered a loss of her husband's consortium.

[¶5] Mercy Medical Center and Dr. Bambrick filed their answers to the complaint on June 13, 2001, and July 3, 2001, respectively, and served interrogatories on the Haugenoes on June 11, 2001, and July 2, 2001, respectively. Both Mercy Medical Center and Dr. Bambrick specifically inquired as to whether the Haugenoes had obtained an admissible expert opinion as required by N.D.C.C. § 28-01-46. Mercy Medical Center's interrogatories read as follows:

> INTERROGATORY NO. 10: Have you obtained an admissible expert opinion to support your allegations of professional negligence against Mercy Medical Center pursuant to N.D.Cent. Code § 28-01-46?

> INTERROGATORY NO. 11: If your answer to the immediately preceding interrogatory is in the affirmative, please attach a copy of the expert opinion affidavit referenced in § 28-01-46.

Dr. Bambrick's interrogatories read as follows:

> INTERROGATORY NO. 44: Have you obtained an admissible expert opinion to support your allegations of professional negligence against William S. Bambrick, III, M.D., as required by N.D.C.C. § 28-01-46?
>
> INTERROGATORY NO. 45: If your answer to the foregoing Interrogatory was in the affirmative, state:
>
> a. The expert's name and address;
>
> b. The expert's profession, business or occupation, and the field of expertise;
>
> c. The facts upon which you rely to support your contention that this expert's opinion is "admissible" as that term is used in N. D. C. C. § 28-01-46;
>
> d. Produce the expert's affidavit containing the information required by § 28-01-46.

Both Mercy Medical Center and Dr. Bambrick granted the Haugenoes extensions of time to answer the interrogatories and to provide an admissible expert opinion. The record reflects that Mercy Medical Center gave the Haugenoes until November 15, 2001, to respond and that Dr. Bambrick gave the Haugenoes until January 4, 2002, to respond. However, the Haugenoes never provided answers to either of the interrogatories and never provided any admissible expert opinion to either Mercy Medical Center or Dr. Bambrick.

[¶6] On February 4, 2002, Dr. Bambrick filed a motion to dismiss the Haugenoes' medical negligence claims because the Haugenoes had not provided an admissible expert opinion as required by N.D.C.C. § 28-01-46. Mercy Medical Center filed a similar motion to dismiss or for summary judgment on February 6, 2002. The Haugenoes filed an answer brief to Dr. Bambrick's motion to dismiss on February 20, 2002, claiming "N.D.C.C. § 28-01-46 does not apply to the present case where Bambrick misrepresented the condition of the elbow to Haugenoe." On March 21, 2002, the Haugenoes filed a brief in opposition to Mercy Medical Center's motion to dismiss or for summary judgment, arguing N.D.C.C. § 28-01-46 was not applicable to the case because Dr. Bambrick's misrepresentation of the condition of the elbow was an "obvious occurrence" under the statute.

[¶7] The trial court attempted to hold a hearing on Mercy Medical Center's and Dr. Bambrick's motions. However, a hearing was never held because of repeated cancellations by the Haugenoes. Instead, the parties submitted outlines of their oral arguments, and the court considered the matter based on the outlines. On July 19, 2002, the trial court entered its order dismissing the Haugenoes' entire complaint without prejudice. The court stated:

> It is undisputed that, to date, Haugenoes have not supplied Bambrick and Mercy with an admissible expert opinion in support of their professional negligence claims. It is also undisputed that: (a) the statutory time period for submitting an admissible expert opinion has long since expired; (b) Haugenoes obtained several extensions of time to answer interrogatories and submit an admissible expert opinion; and, (c) the expert opinion was not forthcoming even after several assurances from Haugenoes' counsel that the same would be provided.
>
> The Court further finds that the "obvious occurrence exception" provides no relief to Haugenoes in this situation-----as there can be little question that, "An open reduction and internal fixation are beyond the understanding of a layperson and require expert testimony to explain the complicated, technical surgical procedure."
>
> Accordingly, the Court is left with no alternative but to dismiss Haugenoes' complaint, without prejudice.

[¶8] The Haugenoes filed their notice of appeal on September 16, 2002. The judgment dismissing the complaint without prejudice was filed on December 2, 2002. On appeal, the Haugenoes first contend that the negligence claim against Dr. Bambrick should not have been dismissed because the alleged healthcare negligence falls within the "obvious occurrence" exception to N.D.C.C. § 28-01-46. They further contend that the informed consent claim should not have been dismissed because N.D.C.C. § 28-01-46 is not applicable to informed consent claims. We disagree with the Haugenoes' first contention but agree with their second contention.

III

[¶9] We need not address the appropriate standard of review under N.D.C.C. § 28-01-46, because the Haugenoes have not met the requirements of the statute as a matter of law. See Larson v. Hetland, 1999 ND 98, ¶ 13 n.2, 593 N.W.2d 785.

IV

[¶10] Section 28-01-46, N.D.C.C., requires a court to dismiss a malpractice action against a physician, nurse, or hospital, "unless the

claimant has obtained an admissible expert opinion to support the allegation of professional negligence within three months of the commencement of the action or at such later date as set by the court for good cause shown by the plaintiff." The statute attempts to minimize frivolous claims by requiring the plaintiff to produce an expert opinion to support the allegations of negligence in the early stages of litigation. See Larson, 1999 ND 98, ¶ 12, 593 N.W.2d 785. However, expert testimony is not required "to establish a duty, the breach of which is a blunder so egregious that a layman is capable of comprehending its enormity." Larsen v. Zarrett, 498 N.W.2d 191, 192 (N.D. 1993) (quoting Arneson v. Olson, 270 N.W.2d 125, 132 (N.D. 1978)). The statute, therefore, does not apply to claims involving "unintentional failure to remove a foreign substance from within the body of a patient, or performance of a medical procedure upon the wrong patient, organ, limb, or other part of the patient's body, or other obvious occurrence." N.D.C.C. § 28-01-46.

[¶11] The Haugenoes argue that their negligence claim against Dr. Bambrick falls within the obvious occurrence exception to N.D.C.C. § 28-01-46, and therefore, they were not required to produce an expert opinion within three months of the commencement of the action. The healthcare negligence alleged against Dr. Bambrick, however, is not the type of claim that falls within the obvious occurrence exception. We have previously explained that technical surgical procedures, like the one performed in this case, are recognized as being beyond the understanding of a layperson. See Larsen, 498 N.W.2d at 195. To establish a prima facie case of medical malpractice under N.D.C.C. § 28-01-46, the Haugenoes needed to produce "expert evidence establishing the applicable standard of care, violation of that standard, and a causal relationship between the violation and the harm complained of." Id. at 192 (citations omitted). Because no admissible expert opinion was ever provided by the Haugenoes, they failed to meet the requirements of N.D.C.C. § 28-01-46 as a matter of law. See Larson, 1999 ND 98, ¶ 13, 593 N.W.2d 785. Therefore, we affirm the trial court's dismissal of the Haugenoes' negligence claim against Dr. Bambrick.

Support for adding "prima facia" language

V

[¶12] The Haugenoes' complaint also contained a claim against Mercy Medical Center alleging:

> That Defendant Mercy Medical Center negligently gave Defendant William S. Bambrick III privileges in its facilities. That Defendant Mercy Medical Center failed to adequately investigate Defendant William S. Bambrick III's history, training and experience before granting him privileges. That despite a number of problems in the medical care provided by Defendant William S. Bambrick's [sic], Defendant Mercy Medical Center allowed Defendant William S. Bambrick to remain on staff

and retain privileges until May, 2001.

[¶13] In the Haugenoes' brief in opposition to Mercy Medical Center's motion to dismiss or for summary judgment, they argue: "Mercy obviously granted privileges to an incompetent physician to practice medicine in its facility." In their outline of oral argument, the Haugenoes assert, "it is obvious that [Mercy Medical Center] should not have been allowed to have a physician with a history such as Dr. Bambrick of prior claims and obvious inadequacies in both ability and veracity."

[¶14] On appeal, the Haugenoes state their issue broadly: "The District Court erred in dismissing this action pursuant to N.D.C.C. § 28-01-46." In their statement of facts, the Haugenoes merely state: "Mercy Hospital allowed Dr. Bambrick staff privileges despite four professional liability claims paid in the State of Florida. The State of North Dakota Board of Medical Examiners suspended Dr. Bambrick's license to practice medicine by stipulation in July, 2000." There is no argument presented, however, why it was error for the trial court to apply N.D.C.C. § 28-01-46 to the Haugenoes' claim against Mercy Medical Center. "Issues not briefed by an appellant are deemed abandoned." Anderson v. Heinze, 2002 ND 60, ¶ 12, 643 N.W.2d 24 (quoting Murchison v. State, 1998 ND 96, ¶ 13, 578 N.W.2d 514). Therefore, we affirm the trial court's dismissal of the Haugenoes' negligence claim against Mercy Medical Center.

VI

[¶15] The Haugenoes' final argument on appeal is that the trial court improperly dismissed their informed consent claim against Dr. Bambrick. On July 23, 2002, four days after the trial court had filed its order dismissing the Haugenoes' entire complaint without prejudice, Dr. Bambrick's counsel wrote a letter to the trial court, pointing out that although the court had dismissed the Haugenoes' entire complaint, "the motion we brought on behalf of Dr. Bambrick was for dismissal of the Haugenoes' medical negligence claim, not the entire complaint. The motion was brought pursuant to N.D.C.C. § 28-01-46 which by its language does not apply to alleged failure to obtain informed consent." Unsure as to whether the Haugenoes still intended to pursue the informed consent claim, Dr. Bambrick's counsel sent a copy of this letter to the Haugenoes' counsel, inviting him to "clarify this matter for the court before a final judgment is entered." Counsel for Dr. Bambrick also enclosed a proposed order for judgment for the trial court to sign if "the court finds it appropriate to dismiss the entire complaint."

[¶16] On September 16, 2002, the trial court sent another copy of the July 23, 2002, letter to the Haugenoes' counsel advising, "[i]f any clarification is needed please respond before judgment is entered."

That same day, the Haugenoes filed their notice of appeal. The Haugenoes never responded to the July 23, 2002, letter from Dr. Bambrick's counsel or the September 16, 2002, letter from the trial court. On November 22, 2002, the trial court signed the order for judgment that had been drafted by Dr. Bambrick's counsel. Judgment was entered on December 2, 2002.

[¶17] Dr. Bambrick filed a motion to dismiss the negligence claims against him based on the Haugenoes' failure to disclose an expert witness within three months of the commencement of the action. Dr. Bambrick never made a motion for summary judgment on the issue of informed consent and admitted his motion to dismiss did not apply to the Haugenoes' claim of failure to obtain informed consent. Therefore, whether the Haugenoes' informed consent claim against Dr. Bambrick should be dismissed was never before the trial court on its merits. We do not condone the Haugenoes' attorney's failure to respond to the requests for clarification made by the trial court and opposing counsel. A simple response by the Haugenoes' attorney may have prevented an appeal on this issue. Nevertheless, we decline to hold that the trial court's letter asking if there needs to be a clarification of its order raised this issue on the merits. We have previously cautioned against such informal letter practice. See Engh v. Engh, 2003 ND 5, ¶ 2 n.2, 655 N.W.2d 712.

[¶18] By its very language, N.D.C.C. § 28-01-46 "does not apply to alleged lack of informed consent, . . ." The trial court in this case clearly erred when it dismissed the Haugenoes' informed consent claim against Dr. Bambrick based on N.D.C.C. § 28-01-46. Therefore, we reverse the trial court's dismissal of the informed consent claim against Dr. Bambrick and remand for further proceedings consistent with our opinion.

[¶19] Mary Muehlen Maring
William A. Neumann
Dale V. Sandstrom
Lawrence A. Leclerc, D.J.
Gerald W. VandeWalle, C.J.

[¶20] The Honorable Lawrence A. Leclerc, D.J., sitting in place of Kapsner, J., disqualified.

Footnotes:

1. Although an order for judgment is not appealable, "an attempted appeal from an order for judgment will be treated as an appeal from a subsequently entered consistent judgment, if one exists." Koehler v. County of Grand Forks, 2003 ND 44, ¶ 6 n.1, 658 N.W.2d 741. Therefore, we will treat this as an appeal from the December 2, 2002, judgment dismissing the Haugenoes' claims without prejudice.

2. "[A] fracture in which the bone is splintered or crushed into numerous pieces." Merriam-Webster's Medical Desk Dictionary (2002).

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IN THE SUPREME COURT

STATE OF NORTH DAKOTA

2003 ND 103

Karen S. Holman and Michael A. Holman, Plaintiffs and Appellants
v.
Douglas D. Berglund, M.D., and the Q & R Clinic, Defendants and Appellees

No. 20020329

Appeal from the District Court of Burleigh County, South Central Judicial District, the Honorable Robert O. Wefald, Judge.
AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.
Per Curiam.
Donald L. Peterson (argued) of Peterson Law Office, P.O. Box 96, Minot, N.D. 58702-0096, for plaintiffs and appellants.
Lance D. Schreiner and Tracy Vigness Kolb (argued) of Zuger Kirmis & Smith, P.O. Box 1695, Bismarck, N.D. 58502-1695, for defendants and appellees.

Holman v. Berglund

No. 20020329

Per Curiam.

[¶1] Karen S. Holman and her spouse, Michael A. Holman, appeal the trial court's dismissal of their negligence claim and lack of informed consent claim against Douglas Berglund, M.D., and Q & R Clinic. We affirm in part, reverse in part, and remand for further proceedings.

[¶2] On November 2, 1999, Dr. Berglund surgically treated Karen Holman for ulcerative colitis by removing her large intestine and creating a stoma. On October 31, 2001, the Holmans sued Dr. Berglund and Q & R Clinic for malpractice, claiming Dr. Berglund negligently punctured Karen Holman's vaginal cuff and bladder, causing urine to drain through the opening. The Holmans also alleged lack of informed consent, among other claims. Dr. Berglund

and Q & R Clinic moved to dismiss the negligence claim because the Holmans failed to provide an expert opinion to support it within three months of the commencement of the action as required by N.D.C.C. § 28-01-46. After a hearing on the motion, the trial court dismissed all of the Holmans' claims against Dr. Berglund and Q & R Clinic. The Holmans appeal.

[¶3] The Holmans argue (1) the trial court erred in dismissing their negligence claim under N.D.C.C. § 28-01-46, and (2) the trial court erred in dismissing their lack of informed consent claim because the claim had not been heard by the trial court. We summarily affirm, summarily reverse, and remand for proceedings consistent with this opinion.

[¶4] The Holmans argue their negligence claim should not have been dismissed by the trial court under N.D.C.C. § 28-01-46 because the negligent act at issue was an obvious occurrence, and therefore, an expert opinion was not required. N.D.C.C. § 28-01-46 provides:

> Any action for injury or death against a physician, nurse, or hospital licensed by this state based upon professional negligence must be dismissed without prejudice on motion unless the claimant has obtained an admissible expert opinion to support the allegation of professional negligence within three months of the commencement of the action or at such later date as set by the court for good cause shown by the plaintiff. . . . This section does not apply to alleged lack of informed consent, unintentional failure to remove a foreign substance from within the body of a patient, or performance of a medical procedure upon the wrong patient, organ, limb, or other part of the patient's body, or other obvious occurrence.

Because the Holmans did not obtain an admissible expert's opinion as required by N.D.C.C. § 28-01-46 and the negligent act at issue does not fall within the statute's obvious occurrence exception, they failed to meet its requirements as a matter of law. We summarily affirm the trial court's dismissal of their negligence claim under N.D.R.App.P. 35.1(a)(7). Haugenoe v. Bambrick, 2003 ND 92, ¶ 11.

[¶5] The Holmans argue the trial court erred in dismissing their lack of informed consent claim because it had not been heard by the trial court. In their pre-trial motion to dismiss, Dr. Berglund and Q & R Clinic moved only for dismissal of the Holmans' negligence claim under N.D.C.C. § 28-01-46. The trial court dismissed all of the Holmans' claims, including the claim for lack of informed consent, which falls within the statutory exception under N.D.C.C. § 28-01-46. Because the trial court improperly dismissed the Holmans' lack of informed consent claim without a hearing, we summarily reverse and remand under N.D.R.App.P. 35.1(b). Haugenoe, 2003 ND 92, ¶ 18.

[¶6] Dale V. Sandstrom, Acting C.J.
William A. Neumann
William F. Hodny, S.J.
Mary Muehlen Maring
Carol Ronning Kapsner

[¶7] The Honorable William F. Hodny, S.J., sitting in place of VandeWalle, C.J., disqualified.

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Expert required to establish element of informed consent.

IN THE SUPREME COURT

STATE OF NORTH DAKOTA

2004 ND 173

Josiah Flatt, by and through his Natural Guardians Anita Flatt and James Flatt, Plaintiff and Appellant
v.
Sunita A. Kantak, M.D., MeritCare Hospital, and State of North Dakota, Defendants and Appellees

No. 20030285

Appeal from the District Court of Cass County, East Central Judicial District, the Honorable Cynthia Rothe-Seeger, Judge.
AFFIRMED.
Opinion of the Court by VandeWalle, Chief Justice.
Zenas Baer, Zenas Baer & Associates, P.O. Box 249, Hawley, MN 56549-0249, for plaintiff and appellant.
Angela Elsperger Lord (argued) and Jane C. Voglewede (on brief), Vogel Law Firm, P.O. Box 1389, Fargo, N.D. 58107-1389, for defendant and appellee, Sunita A. Kantak, M.D.
Douglas A. Bahr, Solicitor General, Attorney General's Office, 500 North 9th Street, Bismarck, N.D. 58501-4509, for defendant and appellee State of North Dakota.

Flatt v. Kantak

No. 20030285

VandeWalle, Chief Justice.

[¶1] Josiah Flatt, by and through his natural guardians Anita and James Flatt, appealed from an order denying his motion for a new trial and from an amended judgment entered upon a jury verdict finding Dr. Sunita Kantak was not negligent in obtaining Anita Flatt's informed consent for the circumcision of Josiah Flatt. We affirm.

I

[¶2] James and Anita Flatt are the parents of Josiah Flatt, who was born on March 6, 1997, at Meritcare Hospital in Fargo. On March 7, 1997, Dr. Kantak performed a circumcision on Josiah Flatt. Josiah Flatt's medical records, which were signed by Dr. Kantak and dated March 6, 1997, state, "RISKS OF LOCAL ANESTHESIA AND CIRCUMCISION DISCUSSED. PROCEDURE DESCRIBED. PARENT EXPRESSES UNDERSTANDING." According to Dr. Kantak, her discussion about circumcision with a parent typically includes a statement that circumcision is not medically recommended but is a choice, lidocaine is used for anesthesia with a risk of hemorrhage or seizure, circumcision is a minor surgery but is a surgery with risks such as bleeding, infection, trauma to the penis, and uretal meatus, and a benefit of circumcision includes less risk of urinary tract infection. Dr. Kantak testified it was not her standard practice to discuss with a parent every reported risk of circumcision. According to Meritcare's records, Anita Flatt was given written materials, including a booklet entitled "Infant Care," which discussed circumcision, and a booklet entitled "Should Your Infant Boy Be Circumcised?" Anita Flatt denied receiving any written materials or booklets while she was at the hospital. She recalled speaking with Dr. Kantak before the circumcision, but she denies being told by Dr. Kantak about any risks of circumcision, except for pain. On March 6, 1997, Anita Flatt signed a form documenting her consent for Josiah Flatt's circumcision. The form stated that her doctor had explained the nature and purpose of the surgery, other methods of treatment, risks involved, and the possibility of complications, and that she understood those risks and options.

[¶3] According to Anita and James Flatt, they later learned of other risks of circumcision and what the procedure entailed. They claimed Anita Flatt would not have consented to the procedure if there had been adequate disclosure. Josiah Flatt, by and through Anita and James Flatt, sued Dr. Kantak and Meritcare, alleging Dr. Kantak failed to obtain Anita Flatt's informed consent before performing the circumcision. Flatt also sued the State of North Dakota, alleging N.D.C.C. § 12.1-36-01, the female genital mutilation law, violated the equal protection provisions of the federal and state constitutions.

[¶4] The trial court dismissed Josiah Flatt's federal and state constitutional challenges, concluding he lacked standing to challenge N.D.C.C. § 12.1-36-01. The court dismissed Flatt's claims against Meritcare before submitting the case to a jury, and the jury returned a verdict finding Dr. Kantak was not negligent in obtaining Anita Flatt's consent for the circumcision. The court denied Flatt's motion for a new trial, and a judgment, with costs and disbursements, was entered dismissing the action.

II

[¶5] Flatt argues the trial court erred in preventing his experts, Dr.

Christopher Cold and Dr. Robert S. Van Howe, from testifying on the standard of care for obtaining informed consent for an elective medical procedure on an infant. He argues expert testimony is necessary to establish the degree of skill and care required of a physician and whether specified acts fall below that standard. He argues the trial court erred in excluding his experts' testimony, "ruling as a matter of law that the 'standard of care' is a legal issue."

[¶6] "The doctrine of informed consent is essentially the duty of a physician to disclose sufficient information to permit a patient to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgical procedure." Koapke v. Herfendal, 2003 ND 64, ¶ 14, 660 N.W.2d 206. If a physician fails to obtain a patient's informed consent, the physician may be found negligent. Jaskoviak v. Gruver, 2002 ND 1, ¶ 13, 638 N.W.2d 1. "A plaintiff in an informed-consent case must establish breach of a physician's duty of disclosure, causation, and injury." Id. An integral part of a physician's duty to a patient is the disclosure of available choices for treatment and the material and known risks involved with each treatment. Winkjer v. Herr, 277 N.W.2d 579, 587 (N.D. 1979).

[¶7] In Winkjer, 277 N.W.2d at 587, we recognized that a majority of courts have related a physician's duty of disclosure to a subjective standard of the custom of physicians practicing in the community, while a growing number of jurisdictions have adopted an objective standard for measuring the performance of a physician's duty of disclosure based on conduct that is reasonable under the circumstances. We said the jurisdictions adopting the objective standard have stated that a patient's right of self-determination in a particular treatment requires a standard set by law for physicians rather than a subjective standard that physicians may impose upon themselves, and expert testimony on the standard of disclosure is generally allowed as relevant evidence, but that testimony supplements and does not define a physician's legal duty to inform. Id. at 587-88. We acknowledged that expert medical testimony may not be required to establish the existence of a duty to disclose risks under the objective standard, but under either the objective or subjective standard, expert medical testimony is generally necessary to identify the risks of treatment, their gravity, likelihood of occurrence, and reasonable alternatives, especially when that information is outside the common knowledge of laypersons. Id. at 588. In Winkjer, at 588-89, we concluded the plaintiff had failed to produce expert testimony to refute the defendant's showing there was no genuine issue of fact regarding disclosure of a known risk. Although we recognized a growing number of jurisdictions had adopted the persuasive reasoning of the objective standard, we did not specifically decide whether the standard for disclosure is measured by "the custom of the physician practicing in the community," or by what is "reasonable under the circumstances."

Winkjer, at 587-89. See Lemke v. United States, 557 F. Supp. 1205, 1212 (D. N.D. 1983); Fortier v. Traynor, 330 N.W.2d 513, 517 (N.D. 1983). See also Laurel R. Hanson, Note, Informed Consent and the Scope of a Physician's Duty of Disclosure, 71 N.D. L. Rev. 71, 77-80 (2001).

[¶8] In Jaskoviak, 2002 ND 1, ¶¶ 17-19, 638 N.W.2d 1, without explicitly adopting either the subjective or objective standard of disclosure, we discussed common ground under both standards:

> In acquiring a patient's informed consent to a medical procedure, a physician should disclose a number of things:
>
> > It is sometimes said that the physician should disclose the diagnosis, the general nature of the contemplated procedure, the material risks involved in the procedure, the probability of success associated with the procedure, the prognosis if the procedure is not carried out, and the existence and risks of any alternatives to the procedure.
>
> 1 [Dan B.] Dobbs, [The Law of Torts], § 251 [2001]. See also Steven E. Pegalis, American Law of Medical Malpractice 2nd § 4:1, pp. 186-88 (1992), noting the American Hospital Association Risk Management Handbook advises disclosing the nature and purpose of the proposed test or treatment, the probable risks and benefits of the proposed intervention, alternative forms of care and their probable risks and benefits, remote or unusual risks involving severe injury, disability, or death, and the risks of refusing care or diagnostic tests.
>
> Assessing the materiality of a risk involves a two-pronged analysis: (1) "an examination of the existence and nature of the risk and the probability of its occurrence"; and (2) "a determination by the trier of fact of whether the risk is the type of harm which a reasonable patient would consider in deciding on medical treatment," Guidry [v. Neu], 708 So.2d [740,] 744 [(La. Ct. App. 1997)]. The materiality of information about the risk of a potential injury is a function of the severity of the potential injury and of the likelihood it will occur. 2 [J.D. Lee and Barry A. Lindahl,] Modern Tort Law, § 25:46 [(Rev. ed. 1989)]; 1 Dobbs, supra, at § 251. A physician is not required to inform a patient of risks that are so remote as to be negligible even where the consequences may be severe, and is not required to inform the patient of a very minor consequence even though the probability is high. 2 Modern Tort Law, supra, at § 25:46. Thus, as this Court recognized in Winkjer, 277 N.W.2d at 588:

> A duty to disclose can arise only if the physician knew or should have known of the risks to be disclosed. Cornfeldt v. Tongen, [262 N.W.2d 684 (Minn. 1977)]. Also, a physician is not required to disclose all possible risks and dangers of the proposed procedure but only those that are significant in terms of their seriousness and likelihood of occurrence. There is no need to disclose risks of little consequence, those that are extremely remote, or those that are common knowledge as inherent in the treatment. Cobbs v. Grant, 502 P.2d [1,] 11 [(Cal. 1972)].

Ultimately, a "trier of fact must determine whether a reasonable person in the plaintiff's position would attach significance to the specific risk." Guidry, 708 So.2d at 744. "The disclosure requirement is in essence a requirement of conduct prudent under the circumstances." 2 Modern Tort Law, supra, at § 25:47.

"[E]xpert medical testimony is generally necessary to identify the risks of treatment, their gravity, likelihood of occurrence, and reasonable alternatives." Winkjer, 277 N.W.2d at 588. "The necessity for expert testimony is particularly so when such information is outside the common knowledge of laymen." Id. "Expert testimony may be necessary under the lay standard, at least to establish the existence of a risk, its likelihood of occurrence, and the type of harm in question; after that, however, expert evidence may not be required." 2 Modern Tort Law, supra, at § 25:46. "However, experts may be required to show both that material information existed and that the defendant should reasonably have known about it." 1 Dobbs, at 656.

[¶9] Under both the subjective and objective standards, a physician must disclose material risks involved in a procedure, but the physician need not disclose all possible risks and dangers of a proposed procedure, and expert medical testimony is generally necessary to identify the material risks of treatment, their likelihood of occurrence, their gravity, that the physician reasonably should have known of the risk, and reasonable alternatives. Jaskoviak, 2002 ND 1, ¶ 18, 638 N.W.2d 1; Winkjer, 277 N.W.2d at 588. See also Koapke, 2003 ND 64, ¶ 15, 660 N.W.2d 206.

[¶10] To the extent Flatt claims the applicable legal standard for informed consent requires the disclosure of all risks for an elective procedure for a minor, he has not cited any caselaw to support that claim. His reliance on isolated language from Jaskoviak that "all risks potentially affecting the decision must be unmasked" is misplaced. In Jaskoviak, 2002 ND 1, ¶ 16, 638 N.W.2d 1 (quoting Canterbury v. Spence, 464 F.2d 772, 786-87 (D.C. Cir. 1972)), we

said a physician need not disclose all possible risks to the patient, rather the physician is required to disclose those risks that would be material to a reasonable patient's decision. See Canterbury, at 786 (declining to require "full" disclosure by a physician; stating it is unrealistic to expect a physician to discuss every risk of proposed treatment no matter how small or remote and "full" disclosure requires something less than "total" disclosure).

[¶11] In order to resolve and provide context to Flatt's argument about the trial court's decision on his experts' testimony, we quote extensively from Flatt's citations to the court's ruling. During Flatt's direct examination of Dr. Cold, the following questioning occurred:

> Q And you mentioned a term this morning, "proxy consent." Is the duty when you're obtaining proxy consent different than when you are obtaining express consent?
>
> MS. LORD: Your Honor, I object to that question as far as requesting an instruction on the law for a witness who's not qualified to do so.
>
> THE COURT: Sustained.
>
> Q (Mr. Baer continuing) Are you familiar with the duty of a physician when obtaining proxy consent?
>
> A Yes, I am.
>
> Q Could you describe that duty?
>
> A Proxy consent —
>
> MS. LORD: Same objection, Your Honor.
>
> THE COURT: Sustained. It's a matter of law. The Court will be instructing the jury on this. Please move on, Mr. Baer.
>
> . . . .
>
> Q Now, when performing elective surgeries, what is the obligation of a medical doctor in disclosing risks? What type of risks need to be disclosed?
>
> A Basically all the risks.
>
> MS. LORD: I request that that answer be stricken from the record. It is—I object to the form of the question. Mr. Baer has been instructed not to request instructions on the law from this witness, and that is a question that was inappropriate.

MR. BAER: May we approach the bench, Your Honor?

THE COURT: Yes.

(Discussion at the bench, out of the hearing of the jury and the court reporter.)

THE COURT: The objection is sustained.

. . . .

Q Okay. Then the next paragraph [of the "Infant Care" booklet] deals with consent.

A Right. "The written and verbal consent of one, or preferably both parents, is required." I think that's critical because both parents are involved in this decision. So I would agree with that.

MS. LORD: Your Honor, I request that the answer be stricken. This witness is again being asked questions about the state of the law, which he's not qualified to answer, and only the Court can give the jury the instruction on the law.

THE COURT: Sustained. The jury is admonished that the last response is stricken. You're not to consider it as evidence.

[¶12] After the court sustained those objections to Dr. Cold's testimony, the following colloquy occurred outside the presence of the jury:

MR. BAER: There are two issues I would like to address to the Court at this time, and the one is to put on the record the discussion we had at the bench during the testimony of Dr. Cold. And it dealt with the line of questioning of what the duty is of a doctor to disclose certain risks or benefits of a procedure.

And I believe that the context was that I was attempting to establish that the duty to disclose on an elective procedure is a different duty than is on a medically indicated procedure, and the Court did not allow inquiry into establishing that duty. I believe the Court indicated that the Court would give the duty. It seems to me that that misreads what the law is in North Dakota, that a plaintiff must establish through expert witnesses what the duty is of a medical doctor.

And in this case, I have been attempting to establish that duty of the elements and the extent of disclosure required

in an elective procedure. And the case that I would point to is the Jaskoviak case, which holds for the proposition that you need expert testimony to establish what the risks are and what risks must be disclosed for a particular procedure.

And I think it is extremely prejudicial to the plaintiff's case to disallow the expert witness to testify as to the duty associated with an elective procedure versus one of a medically indicated procedure. Thank you.

THE COURT: Defense.

MS. LORD: Your Honor, Mr. Baer was eliciting questions on the legal standard. We have no objection to questions being asked about the standard of care or whether the standard of care was met in this case, or what the material risks of the procedure are or if they're minor or significant, the benefits of the procedure. Those are all issues that go to informed consent. We had no objection to that line of questioning.

But when Mr. Baer is asking a witness on what the law requires for the duty of disclosure, that's something that the Court instructs the jury. And even though he needs expert testimony to state what the standard of care is, the expert cannot testify as to what the law will be at the close of the case.

THE COURT: It's my recollection that I did sustain their objection.

MR. BAER: Yes, you did.

THE COURT: That is on the record. So have you made your record?

MR. BAER: I made my record. I would like to know whether that is the ruling of the Court.

THE COURT: The ruling of the Court is that the objection is sustained.

MR. BAER: I want to make sure that I understand it. I don't recall me asking the expert witness any question about what the legal standard was. I only asked about what the duty was in a nonmedically indicated procedure. Not what the legal standard was. And I got to that question, their objection was raised that it invades the province of the Court. I don't see that as being the case. I want to be able to explore that with the expert witness.

THE COURT: I think the danger is that the jury could

assume that that is the legal standard, even though you didn't say legal standard or legal duty. And I believe I did say to the jury that I would be giving them instructions. Did I say that?

MR. BAER: I don't think so.

MS. VOGLEWEDE: You did.

THE COURT: If you want me to reiterate that again, I will do that, but the law has to come from the Court. You might have a difference of opinion with me, and I respect that, but I don't want the jury to be misled and think that any witness can tell them what the law is, because that's got to come from the Court.

MR. BAER: I certainly was not attempting to elicit from this expert what the law is.

THE COURT: You asked what is the duty. And that goes to what the law says they have to tell.

MR. BAER: Well, it is a standard.

THE COURT: I am not going to argue with you. That's what I understood you to ask. What is the duty, what must a physician—what's the duty of a physician. That goes to what is the duty that the law has to—the Court has to instruct on the law. You can ask about the risks, the benefits, those kinds of things, but the duty is something that is written in the law, and that's for the Court. And that's my decision in that regard.

[¶13] During Flatt's direct examination of Dr. Robert Van Howe, the following questioning occurred:

Q When a medical doctor talks about informed consent and obtaining informed consent, are there certain things, if that medical doctor is meeting the standard of care, that they must obtain and assess of a patient or a surrogate before they can get an informed consent?

A There are basically three elements. And this document lists it as four, although I think of the second and third as being one. First, there has to be disclosure.

MS. VOGLEWEDE: Your Honor, I am going to object to this again. It's attempting to have the witness state what the legal requirements are for the duties of informed consent.

THE COURT: Mr. Baer, we have discussed this before. I have ruled accordingly before. And this is a matter of the

law, the law comes from the Court.

THE WITNESS: Actually, I think this is ethical.

THE COURT: I'm sorry, don't argue with me.

THE WITNESS: I'm sorry.

THE COURT: So the objection is sustained.

Q (Mr. Baer continuing) Okay. Are you familiar, Dr. Van Howe, with the standard of practice of pediatricians to obtain informed consent?

A Yes, sir, I am.

Q And in order to meet that standard, what must a physician obtain?

A The physician needs to provide disclosure of information that the decision maker needs in order to make an informed decision. He needs to assess whether the receiver of the information understood the information and is competent to make the decision. And the third is that the decision is made voluntarily, without coercion.

Q Does the AAP statement on informed consent address the issue about the duty of a physician to a child patient?

A Yes, it does.

Q And does it say that the medical professional has a legal and ethical duty to their child patient to render competent medical care based on what that patient needs, not what somebody else expresses?

A That is correct.

MS. VOGLEWEDE: Objection.

THE COURT: When there's an objection, do not answer because I need to make a ruling.

MS. VOGLEWEDE: Objection, leading, and objection on the same grounds that it calls for an apparent explanation of what the legal duty is as opposed to accepted medical practice.

THE COURT: Sustained.

Q (Mr. Baer continuing) The AAP statement does address

the issue of problems with proxy consent; is that correct?

A That is correct.

Q What are the problems that the AAP statement addresses?

MS. VOGLEWEDE: Your Honor, I'm not sure where the examination is leading, but it seems to me all of these deal with legal issues, about the capacity of the parent to consent. I will object to the entire line of questioning.

THE COURT: Sustained.

Q (Mr. Baer continuing) As a pediatrician, is there a central guiding principle that you use in providing care to infants who cannot speak to you?

A Yes, you want to provide them the best care possible. You don't want to cause any unnecessary harm.

Q Are you familiar, Dr. Van Howe, with the standards of informed consent as it applies to medically indicated procedures or elective procedures or proxy consent procedures?

A Yes, I am.

Q Could you describe what the difference is between the standard for informed consent on a medically indicated versus a nonmedically indicated procedure?

MS. VOGLEWEDE: Your Honor, I will object to the form of the question. If he's asking about accepted medical practice as opposed to legal standard, I have no objection. If he's asking for the legal standard, I object on the grounds stated earlier.

THE COURT: What are you asking?

MR. BAER: I'm asking for the accepted medical practice between those.

THE COURT: Okay. Objection is overruled. You may answer.

[¶14] Later, Flatt called Dr. Robert Montgomery, a medical director at Meritcare, as an adverse witness for cross-examination. Dr. Montgomery was involved with reviewing complaints by Anita and James Flatt. The defense objected to Flatt's questions about the standard of care for pediatric physicians, arguing Dr. Montgomery

had not been disclosed as an expert witness and his involvement in the case had been in his capacity as a medical director to review treatment concerns raised by Anita Flatt. In the context of precluding Dr. Robert Montgomery from testifying about the standard of care for informed consent for a pediatric patient, the court explained:

> THE COURT: What I'm trying to convey — and perhaps I'm not very clear — that the elements of a claim for failure to obtain informed consent are legal elements, they're in the law, and those are the elements that the Court gives to the jury. That comes from me and not anybody else.
>
> If you want to have someone testify about those elements and what it means to give informed consent, what it means — what you should disclose in a case such as this, then you have to have expert testimony to do that. If you want to inquire of Dr. Montgomery how he reached those conclusions in the letter, then you can do that. But that's not what you were doing. You were asking him what is the — what is a pediatrician required to tell a patient to get informed consent, or something to that effect. You see, that's invading the province of the Court and the jury.
>
> MR. BAER: I would like to explore that and —
>
> THE COURT: I'm not going to change my ruling. I have ruled this — I have ruled this way many times.
>
> MR. BAER: Judge, I don't mean to even imply that you should change your ruling. I just want to understand where my limitations are. And as I understand the law under Jaskoviak and Winkjer v. Herr, in order for the plaintiff to even come into court to sustain a claim of lack of informed consent, I need to have expert witness testimony to establish what that standard of care is that's required. So I have the burden of proving what the standard of care is from the medical side of it.
>
> I'm not trying to invade the Court's province of giving the elements from a legal basis of an informed consent claim. All I'm trying to do is establish through my witnesses what that standard of conduct is for physicians in the pediatric practice. And we have had testimony that — and I think Dr. Kantak in her deposition even says that the AAP policy statements do provide essentially the standard of care.
>
> And so I just want to make sure that the record is clear that what I am trying to do is to meet my burden; and, that is, to prove what the standard of care is for physicians, AAP members, in the care and treatment of infants. And that may be something totally different than the legal requirement for an informed consent case, but that's the

Court's province.

But from a plaintiff's standpoint, I need to be able to prove what that standard of care is, because one of the instructions that the Court is going to have for the jury at the end is, Did the plaintiff prove the standard of care, No. 1, and, No. 2, was it breached? So that is my burden. And I'm not meaning to invade the province of the Court at all, nor get into the law aspect of it. I'm simply trying to establish what that standard of care is.

THE COURT: Ms. Voglewede.

MS. VOGLEWEDE: Your Honor, that is the role of expert testimony, and Mr. Baer had the opportunity to disclose experts to address those issues. Dr. Montgomery was not one of those people. Furthermore, there's no indication in this case that Dr. Montgomery was even asked to address that concern or that that was a concern that Anita Flatt had about informed consent. So it's clearly beyond his role in this case.

THE COURT: Well, what I will allow you to do, Mr. Baer, is to cross-examine Dr. Montgomery on those — is it one or two letters? Two letters?

MR. BAER: Two letters.

THE COURT: Okay. And to get into that because they are in evidence. But you have not disclosed him as an expert witness. So my objections to your asking him about the standard of care with informed consent with a pediatric patient are sustained. I am not going to change that ruling.

[¶15] We review a trial court's ruling on evidentiary issues pertaining to expert testimony under the abuse-of-discretion standard. Rittenour v. Gibson, 2003 ND 14, ¶ 29, 656 N.W.2d 691. A trial court abuses its discretion when it acts in an arbitrary, unreasonable, or unconscionable manner, or when its decision is not the product of a rational mental process. Anderson v. A.P.I. Co., 1997 ND 6, ¶ 18, 559 N.W.2d 204.

[¶16] Here, in response to Flatt's direct examination of Dr. Cold about a physician's "duty" or "obligation," the trial court stated it understood the questions to address "what the law says" physicians have to tell patients. Although perhaps inartfully stated, the court's decision did not preclude Flatt from introducing evidence about the accepted medical practice for a physician in obtaining informed consent. Rather, the court precluded Flatt from eliciting testimony about what the court perceived as the legal standard of informed consent. The court explained the jury could assume Flatt's questions

were asking about a legal standard even though he did not say legal standard or duty, which the court concluded would invade the province of the court to instruct the jury on the law. This record further reflects Flatt ultimately introduced expert testimony from Dr. Cold and Dr. Van Howe about their opinions on the medical standard of care for a physician's duty of disclosure of all known risks under these circumstances and on the risks and benefits of circumcision. Although some of the court's statements during an objection to Dr. Montgomery's testimony may suggest the court sustained objections to questions about the acceptable medical standard of care as opposed to the legal standard for informed consent, those statements were in the context of the court's ruling that Dr. Montgomery had not been disclosed as an expert and therefore was precluded from testifying about a physician's standard of care. The court's explanation of its ruling, as a whole, did not preclude Flatt from introducing expert testimony about the accepted medical practice for obtaining informed consent. Under these circumstances, we conclude the trial court did not abuse its discretion in ruling on the admission of Flatt's experts' testimony.

III

[¶17] Flatt argues the trial court erroneously excluded relevant, non-prejudicial evidence, including circumcision tools, a circumstraint, photos of an intact penis, minutes of hospital and clinic committee meetings, and videotapes showing different circumcision procedures. He also argues the trial court denied him the opportunity to cross examine expert witnesses.

[¶18] Under N.D.R.Ev. 103(a), error may not be predicated on a ruling that excludes evidence unless a substantial right of the party is affected. Generally, relevant evidence is admissible and irrelevant evidence is inadmissible. N.D.R.Ev. 402. Relevant evidence is evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. N.D.R.Ev. 401. Under N.D.R.Ev. 403, relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence. Rule 403, N.D.R.Ev., vests the trial court with discretion to control the introduction of evidence, and we review a trial court's decision on the admissibility of evidence to determine whether the court abused its discretion. Williston Farm Equip., Inc. v. Steiger Tractor, Inc., 504 N.W.2d 545, 548-49 (N.D. 1993). A court abuses its discretion when it acts in an arbitrary, unreasonable, or capricious manner, or misinterprets or misapplies the law. Anderson, 1997 ND 6, ¶ 18, 559 N.W.2d 204.

A

[¶19] The trial court excluded videotapes describing commonly used circumcision procedures, concluding their probative value was substantially outweighed by a danger of confusion of the issues or misleading the jury. The court also excluded a number of surgical instruments, surgical equipment, and photographs of an intact penis, concluding they were not relevant and would be a waste of time. Flatt argues the exhibits would have provided information that reasonable parents would want to know before deciding whether or not to circumcise their child. We agree with the trial court that those exhibits were not necessarily probative of the risks and benefits for circumcision in an informed consent case, and we conclude the court's exclusion of those exhibits was not arbitrary, capricious, or unreasonable, and was not a misapplication or misinterpretation of the law. We therefore conclude the court did not abuse its discretion in excluding those exhibits.

B

[¶20] The trial court excluded meeting minutes of hospital and clinic committees, which Flatt claims dealt directly with Meritcare's development of the booklet entitled "Should Your Infant Boy Be Circumcised?" Flatt claims those minutes do not reflect authorization to distribute the booklet and are relevant to whether Meritcare had a booklet on circumcision when Josiah Flatt was born in March 1997. He argues the court erred in excluding evidence about the development of the booklet to show a lack of informed consent. The booklet stated an initial publication date of December 1996, and a revised publication date of January 1997. The trial court concluded the minutes were cumulative evidence about when the booklet was published. Flatt has not cited any reference in the proffered minutes to dispute the publication date, or the availability of the booklet for distribution. We conclude the trial court's exclusion of those minutes was not arbitrary, capricious, or unreasonable, and was not an abuse of discretion.

C

[¶21] Flatt argues the trial court erred in permitting Dr. Theodore Sawchuk to testify about whether or not Josiah Flatt would need further surgery and whether or not he was injured as a result of the circumcision. Flatt claims the court erred in allowing Dr. Sawchuk to offer expert opinion testimony that was not previously disclosed. However, Dr. Sawchuk was a physician who saw Josiah Flatt as a result of Anita Flatt's post-surgery complaints to Meritcare, and Dr. Sawchuk testified as a treating physician. Under N.D.R.Ev. 701, witnesses are permitted to give testimony in the form of opinions or inferences that are rationally based on the perceptions of the witness and helpful to a clear understanding of the witness' testimony or the determination of a fact in issue. Dr. Sawchuk testified regarding his examination of Josiah Flatt and his findings and recommendations in

August 1997. Dr. Sawchuk's opinion that he did not consider Josiah Flatt to have an injury from the circumcision and would not need any surgery in the future was opinion testimony within the scope of his care as a treating physician. We conclude the trial court did not abuse its discretion in admitting Dr. Sawchuk's testimony.

D

[¶22] Flatt argues the trial court erred in limiting his examination of Dr. Robert Montgomery. When a motion for a new trial is made to the trial court, the movant is limited on appeal to a review of the grounds presented to the trial court. Andrews v. O'Hearn, 387 N.W.2d 716, 728 (N.D. 1986). Flatt did not raise this issue in his motion for a new trial, and he is precluded from raising this issue on appeal.

IV

[¶23] Flatt argues the jury instructions, as a whole, were misleading and prejudicial. Jury instructions must fairly and adequately inform the jury of the applicable law. Huber v. Oliver County, 1999 ND 220, ¶ 10, 602 N.W.2d 710. Although a party is entitled to instructions which present that party's theory of the case, a trial court is not required to instruct the jury in the exact language sought by that party if the court's instructions correctly and adequately inform the jury of the applicable law. Olson v. Griggs County, 491 N.W.2d 725, 729 (N.D. 1992); Wasem v. Laskowski, 274 N.W.2d 219, 226 (N.D. 1979). On appeal, we review jury instructions as a whole, and if they correctly advise the jury of the law, they are sufficient although parts of them, standing alone, may be erroneous and insufficient. Olson, at 729.

A

[¶24] Flatt argues the court's instruction about a physician's duty of disclosure erroneously blended the reasonable patient standard and the professional standard. Relying on language in Jaskoviak, 2002 ND 1, ¶ 16, 638 N.W.2d 1, he argues the court's instructions on the physician's duty to disclose were directly contrary to the reasonable patient standard, which he claims requires that "all risks potentially affecting the decision must be unmasked." However, as we have previously said, Flatt's reliance on isolated language in Jaskoviak is misplaced because that decision requires disclosure of material risks, not all risks. See also Koapke, 2003 ND 64, ¶ 15, 660 N.W.2d 206; Winkjer, 277 N.W.2d at 588.

[¶25] Flatt's requested instruction on a physician's duty of disclosure provided:

> A physician has a duty to disclose to the patient the

> available treatment alternatives, including no treatment, and the material and known risks potentially involved in each alternative. A patient's right of self-determination in a particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves. A physician has a duty to disclose to the patient the available treatment alternatives, including no treatment, and the material and known risks potentially involved in each alternative. The test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. A duty to disclose can arise only if the physician knew or should have known of the risks to be disclosed. A physician has no duty to disclose all possible risks and dangers of the proposed treatment but only those that are significant in terms of their seriousness and likelihood of occurrence. It is for you the jury to determine whether a risk is the type of harm which a reasonable patient would consider in deciding on consenting to medical treatment.

[¶26] The trial court instructed the jury on a physician's duty of disclosure:

> A physician has a duty to disclose to the patient, or in the case of a child, to his parent, the available alternatives and the material and known risks potentially involved in each alternative. A duty to disclose can arise only if the physician knew or should have known of the risk to be disclosed. A physician is not required to inform a patient of risks that are so remote as to be negligible even where the consequences may be severe, and is not required to inform the patient of a very minor consequence even though the probability is high. A physician has no duty to disclose all possible risks and dangers of the proposed procedure but only those that are significant in terms of their seriousness and likelihood of occurrence. A doctor should not be required to give a patient a detailed technical, medical explanation that in all probability the patient would not understand. There is no need to disclose risks of little consequence, those that are extremely remote, or those that are common knowledge as inherent in the treatment.

The trial court also instructed the jury:

> Disclosure to a patient which would be made by doctors of good standing, under the same or similar circumstances, is relevant and material to the determination of whether the doctor has fulfilled the duty to disclose.
>
> . . . .

> A risk is material if a reasonable patient would attach significance to the specific risk. Significance is based on the existence and nature of the risk and the probability of its occurrence.

[¶27] Flatt cannot complain about language in the court's instructions which tracked language in his requested instruction. Moreover, contrary to Flatt's claim, the court's instructions on the duty of disclosure did not relate a physician's duty of disclosure to the custom of physicians practicing in the community. Rather, the court's instructions effectively tracked language about materiality from our decisions in Koapke, 2003 ND 64, ¶¶ 14-15, 660 N.W.2d 206, Jaskoviak, 2002 ND 1, ¶¶ 17-18, 638 N.W.2d 1, and Winkjer, 277 N.W.2d at 587-89. See also Wasem, 274 N.W.2d at 226. Under Jaskoviak, and Winkjer, a physician is required to disclose material risks, not all risks. The court's instructions further defined materiality based on whether the risk was the type which a reasonable patient would consider in deciding on medical treatment. Under these circumstances, we reject Flatt's claim the instructions erroneously blended the subjective and objective standards for disclosure. Although we agree the reasonable patient standard is the appropriate standard, we conclude the trial court was not required to instruct the jury in the language sought by Flatt.

B

[¶28] Flatt argues the instructions erroneously told the jury "there is no claim for you to consider that the procedure was done wrong or that Dr. Kantak was negligent in performing the circumcision procedure." He argues the instruction is directly contrary to significant medical testimony indicating that undisclosed risks of adhesions and asymmetry were the cause of Flatt's complaints. However, Flatt's complaint did not allege the actual circumcision procedure was improperly or negligently performed, his proposed jury instructions did not include an allegation the procedure was improperly or negligently performed, and he has cited no expert testimony in this record to establish the medical standard of care for performing a circumcision.

C

[¶29] Flatt argues the trial court erred in not instructing the jury in language tracking N.D.C.C. § 23-12-13, which authorizes parents to consent to health care for their minor children. That statute requires the parent to determine, in good faith, that the minor would have consented to the proposed health care, and if such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining the proposed health care is in the minor's best interest. Flatt argues "[a] parent who, without adequate information, makes a decision to allow a medical doctor to

surgically amputate the most erogenous tissue of the male body for no therapeutic reason, could be viewed to be acting contrary to the best interests of the child."

[¶30] Flatt's proposed instruction provided:

> It is the law in the State of North Dakota that before a medical doctor may treat a minor patient, the medical doctor must obtain informed consent. Before a parent is authorized to provide informed consent, she must first determine in good faith that the patient, if not incapacitated, would consent to the proposed health care. If such a determination can be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

[¶31] We believe Flatt's proposed instruction addresses issues about Anita Flatt's fault, and the jury did not reach that issue because it determined Dr. Kantak was not negligent. We conclude any claimed error in the court's failure to give that instruction was harmless.

D

[¶32] Flatt argues the court erred in submitting a special verdict form with a question about Anita Flatt's comparative fault. The jury did not address Anita Flatt's fault because it determined Dr. Kantak was not negligent, and we conclude any claimed error in the special verdict form was harmless.

V

[¶33] Flatt argues the cumulative effect of the multiple errors deprived him of the substance of a fair trial. Flatt did not raise this issue in his motion for a new trial, and he is precluded from raising this issue on appeal. See Andrews, 387 N.W.2d at 728.

VI

[¶34] Flatt argues the trial court abused its discretion in taxing costs in favor of Dr. Kantak and Meritcare. Flatt argues the notice of entry of judgment in this case did not include the statement of costs and disbursements as an attachment as required by N.D.R.Civ.P. 54(e), which provides that "[a] copy of the [verified] statement [of costs and disbursements] must accompany the notice of entry of judgment." Dr. Kantak and Meritcare served Flatt with a verified statement of costs and disbursements of $64,580.57 almost a month before the notice of entry of judgment was served, and Flatt had notice of the costs claimed by Dr. Kantak and Meritcare. Although Dr. Kantak and Meritcare subsequently offered to serve both

documents together, the trial court did not require them to do so, and under these circumstances, we reject Flatt's claim that all costs should be denied for that reason.

[¶35] Flatt had notice of the statement of costs and disbursements and objected to costs and disbursements. After a hearing, the court reduced the award of costs and disbursements to $58,506.20. A trial court's decision on fees and costs under N.D.C.C. § 28-26-06 will not be reversed on appeal unless an abuse of discretion is shown. Patterson v. Hutchens, 529 N.W.2d 561, 567 (N.D. 1995). We conclude the trial court did not abuse its discretion in its award of costs and disbursements to Dr. Kantak and Meritcare.

VII

[¶36] Flatt argues the trial court erred in concluding he did not have standing to bring an equal protection challenge to N.D.C.C. § 12.1-36-01, the female genital mutilation law. The trial court concluded Flatt did not suffer an injury in fact and lacked standing to challenge the constitutionality of that statute. Flatt argues he has standing to challenge the statute under the equal protection provisions of the federal and state constitutions because he has suffered an injury. Flatt's argument is that his parents should have been prohibited from consenting to the circumcision. This is not an argument recognized under the equal protection clauses.

[¶37] Section 12.1-36-01, N.D.C.C., which criminalizes surgical alteration of female genitalia but not male genitalia, provides:

> 1. Except as provided in subsection 2, any person who knowingly separates or surgically alters normal, healthy, functioning genital tissue of a female minor is guilty of a class C felony.
>
> 2. A surgical operation is not a violation of this section if a licensed medical practitioner performs the operation to correct an anatomical abnormality or to remove diseased tissue that is an immediate threat to the health of the female minor. In applying this subsection, any belief that the operation is required as a matter of custom, ritual, or standard of practice may not be taken into consideration.

[¶38] The existence of standing is a question of law, which we review de novo. Nodak Mut. Ins. Co. v. Ward County Farm Bureau, 2004 ND 60, ¶ 12, 676 N.W.2d 752. In State v. Carpenter, 301 N.W.2d 106, 107 (N.D. 1980), we said:

> The question of standing focuses upon whether the litigant is entitled to have the court decide the merits of the dispute. It is founded in concern about the proper—and properly limited—role of the courts in a democratic

> society. See Schlesinger v. Reservists' Committee to Stop the War, 418 U.S. 208, 94 S.Ct. 2925, 41 L.Ed.2d 706 [1974]. Without the limitation of the standing requirements, the courts would be called upon to decide purely abstract questions. As an aspect of justiciability, the standing requirement focuses upon whether the plaintiff has alleged such a personal stake in the outcome of the controversy as to justify exercise of the court's remedial powers on his behalf. Baker v. Carr, 369 U.S. 186, 82 S.Ct. 691, 7 L.Ed.2d 663 (1962). The inquiry is two-fold. First, the plaintiff must have suffered some threatened or actual injury resulting from the putatively illegal action. Linda R.S. v. Richard D., 410 U.S. 614, 93 S.Ct. 1146, 36 L.Ed.2d 536 (1973). Secondly, the asserted harm must not be a generalized grievance shared by all or a large class of citizens; the plaintiff generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights and interests of third parties.

[¶39] Flatt's reliance on Arkansas Writers' Project, Inc. v. Ragland, 481 U.S. 221 (1987) and Orr v. Orr, 440 U.S. 268 (1979), to support his under-inclusive challenge to N.D.C.C. § 12.1-36-01 is misplaced. In Orr, at 270-71, a former husband objected to paying his ex-wife alimony and challenged Alabama statutes that required husbands, but not wives, to pay alimony upon divorce. The United States Supreme Court rejected the argument "that the only 'proper plaintiff' would be a husband who requested alimony for himself, and not one who merely objected to paying alimony." Id. at 272-73. The Court concluded the former husband bore a burden he would not bear if he were a female, because the state law imposed an alimony obligation on him and his alimony obligation was sufficient to establish standing. Id. at 273.

[¶40] In Ragland, 481 U.S. at 223-25, the publisher of a general interest magazine made a First Amendment challenge to an Arkansas sales tax that exempted proceeds derived from the sale of newspapers, and religious, professional, trade, and sports journals. The United States Supreme Court rejected the Tax Commissioner's argument that the publisher failed to assert an injury that could be addressed by a favorable court decision, concluding the publisher had standing to claim that others similarly situated were exempt from a state law that required the publisher to pay a tax. Id. at 227. The Court said the publisher's "'constitutional attack holds the only promise of escape from the burden that derives from the challenged statut[e].'" Id. (quoting Orr, 440 U.S. at 273).

[¶41] In both Orr and Ragland, the challenged statutes imposed obligations on the challengers either to pay alimony or a tax. In Linda R.S. v. Richard D., 410 U.S. 614, 615 (1973), the mother of an illegitimate child challenged the constitutionality of a Texas criminal statute that subjected any parents who failed to support their

children to prosecution. The Texas courts had construed the statute to apply solely to parents of legitimate children and not to parents of illegitimate children, and the Texas prosecuting attorney had refused to prosecute the alleged father of the mother's illegitimate child. Id. at 615-16. The United States Supreme Court said the mother had suffered an injury from the alleged father's failure to pay support. Id. at 618. The Court concluded, however, that abstract injury was not sufficient to establish standing, because parties who invoke judicial power must show they have sustained, or are in immediate danger of sustaining, some direct injury as a result of a statute's enforcement. Id. at 618. The Court concluded the mother did not have standing because she had not shown her failure to secure support resulted from the nonenforcement of the statute. Id.

[¶42] We conclude Flatt has not alleged an injury traceable to N.D.C.C. § 12.1-36-01. Although N.D.C.C. § 12.1-36-01 may benefit female minors, it does not impose an obligation on Flatt. The statute does not restrict Flatt's right to make medical decisions and has not imposed any burdens or obligations on him. A decision by a parent or guardian to have a minor boy circumcised is not controlled by that statute. Although the statute may prohibit minor females from having their genital tissue surgically altered, the statute has not burdened or injured Flatt in the sense that would confer standing on him. Flatt was circumcised because, through Anita Flatt, he consented to the procedure, and he has not demonstrated his circumcision resulted from the statute. We conclude Flatt lacks standing to challenge the constitutionality of N.D.C.C. § 12.1-36-01.

VIII

[¶43] Because we have concluded the trial court committed no reversible error in the proceedings leading up to the judgment, we also conclude the court did not abuse its discretion in denying Flatt's motion for a new trial. See Ali by Ali v. Dakota Clinic, Ltd., 1998 ND 145, ¶ 5, 582 N.W.2d 653.

IX

[¶44] We affirm the judgment and the order denying Flatt's motion for a new trial.

[¶45] Gerald W. VandeWalle, C.J.
William A. Neumann
Mary Muehlen Maring
Everett Nels Olson, S.J.

[¶46] The Honorable Everett Nels Olson, Surrogate Judge, sitting in place of Kapsner, J., disqualified.

Sandstrom, Justice, concurring specially.

[¶47] The patient or parents must be clearly informed of factual information about the medical procedure and its short-term and long-term consequences that might reasonably result in a patient's or parent's electing not to have the procedure performed. Koapke v. Herfendal, 2003 ND 64, ¶¶ 14, 15, 660 N.W.2d 206; Jaskoviak v. Gruver, 2002 ND 1, ¶¶ 13, 14, 638 N.W.2d 1; Bartal v. Brower, 993 P.2d 629, 634 (Kan. 1999); N.D.C.C. § 23-12-13(1)(e). I understand the majority to agree with this proposition, and I concur in it.

[¶48] Although the trial court is afforded wide discretion in deciding whether to admit or exclude evidence, Brandt v. Milbrath, 2002 ND 117, ¶ 13, 647 N.W.2d 674, I remain concerned that the cumulative effect of the trial court's decision limiting the plaintiffs' evidence may have denied them a fair trial, see Kingdon v. Sybrant, 158 N.W.2d 863, 869 (N.D. 1968), but I cannot say that my concern rises to a conviction that a new trial need be ordered.

[¶49] Dale V. Sandstrom

Berglund ads. Holman

		DATE REC'D/DATE
1.	Summons & Complaint	11/2/01 (R)
2.	Answer to Complaint	11/16/01 (S)
3.	Demand for Trial by Jury of Nine Persons	11/16/01 (S)
4.	Defendants' Interrogatories to Plaintiffs	11/16/01 (S)
5.	Demand for Filing of Complaint	3/6/02 (S)
6.	Notice of Motion (to dismiss)	3/19/02 (S)
7.	Defendants' Motion to Dismiss	3/19/02 (S)
8.	Brief Supporting Defendants' Motion to Dismiss	3/19/02 (S)
9.	Affidavit of Tracy Vigness Kolb	3/19/02 (S)
10.	Notification of Assignment and Case Number	3/22/02 (R)
11.	Answer Brief (plaintiff)	4/3/02 (R)
12.	Defendants' Reply Brief	4/10/02 (S)
13.	Order for Alternative Dispute Resolution	4/18/02 (R)
14.	Defendants' Alternative Dispute Resolution Statement	5/16/02 (S)
15.	Ruling from Judge Wefald - ADR is not appropriate	6/26/02 (R)
16.	Notice of Hearing	7/1/02 (R)
17.	Holman's answers to interrogatories & req. for prodc.	7/1/02 (R)
18.	Affidavit of Wayne Anderson (via fax)	7/1/02 (R)
19.	Register of Actions	7/15/02 (R)

Berglund ads. Holman		DATE REC'D/DATE
20.	Order on Motion to Dismiss	8/20/02 (R)
21.	Judgment of Dismissal without prejudice	8/23/02 (R)
22.	Notice of Entry of Judgment of Dismissal	9/25/02 (S)
23.	Notice of Appeal, Notice of Filing of Bond for Costs on Appeal, and Order for Transcript	11/26/02 (R)
24.	Notice of filing of the Notice of Appeal	12/2/02 (R)
25.	Motion and Brief to Extend Time for Filing Appellant's Brief	2/17/03 (R)
26.	Motion and Brief to Extend Time for Filing Appellant's Brief	3/3/03 (R)
27.	Brief of Appellants (bound separately)	3/10/03 (R)
28.	Register of Actions	3/19/03 (R)
29.	Supplemental Clerk's Certificate of Record	3/31/03 (R)
30.	Brief of Appellees (bound separately)	4/7/03 (S)
31.	Supreme Court Opinion	6/17/03 (R)
32.	Judgment in the Supreme Court	7/11/03 (R)
33.	Notice of Trial	8/1/03 (R)
34.	Defendants' Interrogatories to Plaintiffs, Set No. 2, and Rule 34 Request for Production of Documents	8/12/03 (S)
35.	Plaintiffs' Answers to Defendants' Int. Set 2 and Rule 34 Request for Production of Documents	9/15/03 (R)
36.	Plaintiffs' Supplemental Answers to Def. Int.	9/15/03 (R)
37.	Karen Holman Deposition Notice	9/29/03 (S)
38.	Michael Holman Deposition Notice	9/29/03 (S)

Berglund ads. Holman		DATE REC'D/DATE
39.	Karen Holman Amended Deposition Notice	11/12/03 (S)
40.	Michael Holman Amended Deposition Notice	11/12/03 (S)
41.	Request for Rule 16 Scheduling Conference	11/20/03 (S)
42.	Scheduling and Pretrial Order	12/4/03 (R)
43.	Amended Scheduling and Pretrial Order	12/11/03 (R)
44.	Identification of Expert Witness (Dr. Anderson)	1/12/04 (R)
45.	Notice of Motion, Motion, and Brief in Support of Motion for Summary Judgment	1/15/04 (S)

Berglund ads. Holman		DATE REC'D/DATE
46.	Deposition Notice Dr. Anderson	2/9/04 (S)
47.	Defendants' Identification of Expert Witness	2/10/04 (S)
48.	Admission of Service (Dr. Anderson)	2/12/04 (R)
49.	Notice of Hearing	2/18/04 (S)
50.	Plaintiffs' Brief Resisting Defendant's Motion for SJ	2/19/04 (R)
51.	Defendants' Supplemental Brief in Support of SJ	2/19/04 (S)
52.	Plaintiffs' Supplemental Brief Resisting Motion for SJ	2/24/04 (R)
53.	Order Granting Motion for Summary Judgment	2/26/04 (R)
54.	Affidavit of Identification	3/18/04
55.	Statement of Costs;	3/25/04 (S)
56.	Amended Judgment of Dismissal	3/25/04 (S)
57.	Notice of Entry of Amended Judgment of Dismissal	3/25/04 (S)
58.	Satisfaction of Judgment	9/30/04 (Filed)

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Bambrick ads. Haugenoe

		DATE REC'D/DATE
1.	Summons	6/1/01 (R)
2.	Notice of Appearance & Demand for Complaint	6/4/01 (S)
3.	Complaint (from Kapsner)	6/5/01 (R)
4.	Answer of Defendant Mercy Medical Center & Jury Demand	6/12/01 (R)
5.	Mercy's Interrogatories to Plaintiff	6/12/01 (R)
6.	Complaint (from Peterson)	6/19/01 (R)
7.	Bambrick's Answer to Complaint	7/2/01 (S)
8.	Bambrick's Demand for Trial by Jury of Nine Persons	7/2/01 (S)
9.	Bambrick's Interrogatories to Plaintiffs	7/2/01 (S)
10.	Bambrick's Motion and Notice of Motion to Dismiss	2/1/02 (S)
11.	Bambrick's Brief in Support of Motion to Dismiss	2/1/02 (S)
12.	Mercy Medical Center's Motion/Notice of Motion to Dismiss	2/6/02 (R)
13.	Mercy's Brief in Support of Motion to Dismiss	2/6/02 (R)
14.	Affidavit of John Kapsner	2/6/02 (R)
15.	Answer Brief (Plaintiff)	2/20/02 (R)
16.	Notice of Hearing (April 30, 2002)	2/20/02 (R)
17.	Bambrick's Reply Brief	2/25/02 (S)
18.	Affidavit of TVK	2/25/02 (S)

Bambrick ads. Haugenoe

		DATE REC'D/DATE
19.	Brief in Opposition to Defendant Mercy Medical Center's Motion to Dismiss or for Summary Judgment	3/2/02 (R)
20.	Affidavit of Donald L. Peterson	3/2/02 (R)
21.	Notice of Hearing	3/2/02 (R)
22.	Notice of Hearing	5/7/02 (S)
23.	Amended Notice of Hearing	5/14/02 (S)
24.	Nelson Recusal	5/10/02 (R)
25.	Order of Re-Assignment (Judge McLees)	5/13/02 (R)
26.	Outline of Oral Argument of Plaintiffs in Opposing Resisting Motion to Dismiss	6/13/02 (R)
27.	Outline of Oral Argument of Defendant Mercy Medical Center in Support of Motion to Dismiss	6/13/02 (R)
28.	Bambrick's Reply to Plaintiffs' Outline of Oral Argument	6/13/02 (S)
29.	Dismissal Order	7/17/02 (R)
30.	Notice of Appeal & Notice of Filing Notice of Appeal	9/16/02 (R)
31.	Notice of Filing of Notice of Appeal (from court)	9/18/02 (R)
32.	Clerks' Certificate of Record	10/15/02 (R)
33.	Supplemental Clerk's Certificate of Record	10/22/02 (R)
34.	Motion and Brief to Extend Time for Filing Appellants' Brief	10/24/02 (R)
35.	Supplemental #2 Clerk's Certificate of Record	11/23/02 (R)
36.	Motion and Brief to Extend Time for Filing Appellants' Brief	11/14/02 (R)

Bambrick ads. Haugenoe

		DATE REC'D/DATE
37.	Motion and Brief for Addl. Extension Filing Appellants' Brief	12/2/02 (R)
38.	Order for Judgment	12/3/02 (R)
39.	Judgment of Dismissal	12/3/02 (R)
40.	Supplemental #3 Clerk's Certificate of Record	12/3/02 (R)
41.	Notice of Entry of Judgment of Dismissal	12/9/02 (S)
42.	Supplemental #4 Clerk's Certificate of Record	12/11/02 (R)
43.	Affidavit of Donald Peterson (requesting extension to 1/10/03)	12/30/03 (R)
44.	Supreme Court Opinion	6/6/03 (R)
45.	Judgment in the Supreme Court	6/13/03 (R)
46.	Robert Haugenoe Deposition Notice	9/16/03 (S)
47.	Tracey Haugenoe Deposition Notice	9/16/03 (S)
48.	Scheduling Order	12/9/03 (R)
49.	Notice of Trial	12/9/03 (R)
50.	Notice of Motion, Motion, & Affidavit of Peterson re: extension to identify expert witness	1/14/04 (R)
51.	Identification of Expert Witness	
52.	Notice of Motion, Motion to Compel, and Brief in Support of Motion	2/16/04 (S)
53.	Letter to Judge McLees from Peterson Requesting Extension to Respond to Motion to Compel	2/26/04 (R)
54.	Judge McLees granting motion to extend response time	2/26/04 (R)

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		DATE REC'D/DATE
55.	Plaintiff's Answer Brief (motion to compel)	3/2/04 (R)
56.	Request for Hearing	3/2/04 (R)
57.	Notice of Hearing	3/2/04 (S)
58.	Order Granting Bambrick's Motion to Compel	3/9/04 (R)
59.	Supplemental Answer to Bambrick's Interrogatories	3/24/04 (R)
60.	Identification of Expert Witness	3/24/04 (R)
61.	Notice & Subpoena—deposition of Dr. Joshi	3/24/04 (S)
62.	Amended Notice & Subpoena—deposition of Dr. Joshi	4/6/04 (S)
63.	Second Amended Notice & Subpoena—deposition of Joshi	4/8/04 (S)
64.	Stipulation & Order Extending Dispositive Motion Deadline	4/15/04 (R)
65.	Admission of Service (Joshi)	4/15/04 (R)
66.	Defendant's identification of expert witness (Riemer)	5/3/04 (S)
67.	Notice, Motion and Brief Supporting Motion for SJ	5/13/04 (S)
68.	Stipulation	
69.	Motion to Open Discovery & Stay Proceedings	7/6/04 (R)
70.	Plaintiff's Motion for Summary Judgment	7/6/04 (R)
71.	Bambrick's Opposition to Motions	7/9/04 (S)
72.	Stipulation of Dismissal	
73.	Order for Dismissal and for Judgment	
74.	Judgment of Dismissal	
75.	Notice of Entry of Judgment of Dismissal	

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Senate Judiciary Hearing
Testimony presented by Paula J. Grosinger
Executive Director, North Dakota Trial Lawyers Association
Lobbyist #114

Senate Bill 2199
19 January 2005
701-202-1293

Currently:
North Dakota Century Code 28-01-46 mandates that any action for injury or death against a physician, nurse, or hospital based upon professional negligence must be dismissed without prejudice on motion unless the claimant has obtained an admissible expert opinion to support the allegation of professional negligence within three months of the commencement of the action or at such later date as set by the court for good cause shown by the plaintiff.

Chapter 32-42-03 further requires attorneys representing claimants to advise their clients about alternative dispute resolution options available to settle a claim prior to initiating any health care malpractice action. Defense attorneys are obligated to notify potential defendants about alternative dispute resolution options at the earliest opportunity after receiving notice of a potential malpractice claim or action. The statutes also require a good faith effort by both parties to resolve the claim through alternative dispute resolution prior (ADR) to initiation of a malpractice action.

An action is considered to have commenced with the service of a summons (not a complaint) upon a defendant. (Rule 3. North Dakota Supreme Court Rules N.D.R. Civ. P.)

How it works in practice:
A patient (or the patient's family member) who is the victim of malpractice may not be aware of the actual injury until another health care practitioner makes such an observation.

Or, a patient (or family member) suspects injury due to malpractice. Usually this is because of a persistent problem such as infection, pain, unexpected result, or some obvious adverse response to medical treatment.

Upon contacting an attorney, the patient (or family member) may have little or no available documentation. They may have anecdotal information from other health care providers. They may have only their personal observations of what transpired.

Contact is made with an attorney and the patient presents the problem. The attorney advises there may be cause for action and advises about the option of ADR to resolve the claim. A request to meet with the defendant may be made or a request for patient records. At this point the defense attorney would advise about ADR.

The potential plaintiff's attorney usually tries to speak with the health care provider. Potentially, the attorney may have enough information to decide not to proceed after such discussion. In practice, this does not generally occur because the provider usually refuses to discuss anything

until the action has actually commenced with the service of summons. There is usually a denial of any wrongdoing.

Once the summons has been served the plaintiff has three months to present the court with an admissible expert opinion to support the allegation of medical malpractice/negligence. This is the critical phase of discovery in which documents are requested and depositions taken. This is also a critical window for settlement.

The plaintiff (injured party) must waive privilege with regard to medical records and allow all defendants, their attorneys or authorized representatives to review such records and hold informal discussions amongst themselves with the plaintiff's attorney allowed to be present. This informal discussion is inadmissible in court.

Generally, a significant portion of the three-month window is devoted to gathering and reviewing all records and pertinent data on the part of the plaintiff's attorney. The appropriate expert must be found based on field of expertise, and the expert must conduct his/her own review of the records before formulating an affidavit supporting the allegations. North Dakota physicians and providers who are qualified and willing to render expert opinions in malpractice cases are scarce and such experts often must be sought out-of-state.

In some cases, the plaintiff's attorney must make an *ex parte* motion to the court requesting an extension.

Effect of Senate Bill 2199:

Senate Bill 2199 would limit or even eliminate the plaintiff's ability to conduct discovery. Discovery does not occur until an action has commenced.

Many medical malpractice plaintiffs would be unable to meet the requirement for serving an expert's affidavit at the time of commencing an action. Enough information may not be available to give an expert the basis for forming an opinion until after discovery has been conducted. Because *clear and convincing* evidence may not be forthcoming until discovery has been conducted, plaintiffs would have obstacles to getting the court to allow an extension.

The end result is that Senate Bill 2199 would diminish or eliminate the ability of injured patients to seek relief.

Conclusion

With over 98,000 deaths and many more injuries due to preventable medical errors each year, there should be emphasis on bringing medical errors to light and preventing them rather than limiting discovery.

SB 2199 will have no effect on malpractice premiums.

- 1,500 medical instruments are left inside patients each year[1]
- One in 50 hospitalized patients is injured due to negligence[2] (American Academy of Family Physicians)
- 98,000 Americans die due to hospital mistakes each year (National Academy of Sciences and National Institutes of Medicine)[3]

Enacting legislation like SB 2199 should not be done using the rationale that this will stabilize medical malpractice insurance premiums. The cure for rising malpractice premiums is reducing errors.

Medical malpractice insurers, who profited from double-digit returns on their stock market investments during the 1990s, let underwriting standards slide as they bid for more customers while keeping premiums artificially low. When the market dropped, or became what is called a "hard market," insurance companies increased premiums dramatically.

Rather than blame their Enron-like accounting practices (as in the case of St. Paul Companies which released $1.1 billion in reserves between 1992 and 1997 to boost its bottom line while trying to avoid paying taxes on those reserves)[4], and rather than admit they brought problems upon themselves with their underwriting and investment practices, insurance companies created a "crisis" complete with manufactured press events and headlines that played on the public's fears:

- "Doctors are leaving practice because of frivolous lawsuits and runaway jury verdicts."
- "Health care crisis caused by greedy plaintiffs and attorneys."
- "Doctors protest high malpractice premiums: Tort reform needed."

The National Center for State Courts confirms that overall claims rates continue to decline.[5] (North Dakota Insurance Department records indicate less than 2000 reported incidents of medical malpractice claims since they started keeping records in 1983)[6]. Second, juries and medical malpractice awards aren't a significant cause of premium increases. The national jury payout average is $125,000 with the average projected payout for all claims expected to settle between now and 2010 being less than $45,000. North Dakota is 49th in medmal payouts.[7] (Most tort cases result from automobile accident injuries and most civil case filings are contract disputes.[5])

There is no open reporting of medical mistakes or even medical malpractice.[11] Most peer review systems keep the public and injured patients in the dark about which doctors cause the most harm. Performance Improvement programs and Risk Management initiatives tend to stymie reporting of actual incidents. In fact, nursing staff who file incident reports related to errors may find they are now in a hostile and retaliatory work environment.[12]

There is a national databank which is supposed to contain reports of malpractice claims paid by insurers on behalf of named practitioners, but it's of no use to medical consumers. The public is denied access. In fact, the American Medical Association provides information on their website under the heading **"How to evade a report to the NPDB** (National Practitioners Data Bank)".[13]

Talking Points:

- Medical errors are the 8th leading cause of death in this country. November 1999 report of the Institute of Medicine (IOM), entitled *To Err Is Human: Building A Safer Health System* http://books.nap.edu/books/0309068371/html/index.html [14]

- More Americans die at the hands of incompetent or dangerous doctors than are killed by car crashes, homicides, suicides, illegal drug use and AIDS combined. Medicare patients are extremely vulnerable. A recent study of 16 types of patient safety incidents indicated such incidents may have contributed to the deaths of 263,864 medicare patients from 2000 to 2002.[15] *Health Grades Inc.*

- Patients are often harmed by inadequate care and outright medical mistakes in the days after they are sent home from the hospital. Nearly one in five patients have adverse events after they go home – new or worsening symptoms resulting from treatment they received, not from their underlying disease. [16]

- One out of four debtors in 1999 identified illness or injury as a reason for filing for bankruptcy. A significant number of these debtors identified tort injuries as the basis for their incapacity. As other research indicates that women receive a significantly larger proportion of their compensatory damages as noneconomic, it is notable that the study found that households headed by women, and single women, were nearly twice as likely to file for bankruptcy for medical reasons as households with a male present. For other especially affected categories, debtors over 65 years of age, 47.6% listed medical costs as a reason for filing, compared to 7.5% of debtors under 25.[17] *Elizabeth Warren, Harvard Economics Study*

- Talk about "greedy attorneys and clients." Attorneys have to bear the up front expense of hiring experts for the discovery phase of a malpractice lawsuit. This involves hiring medical doctors whose fees typically start at $400 - $500 per hour..

- Attorneys face legal sanctions for frivolous cases. If **Uniform Civil Code Rule 11** is violated, attorneys fees and costs are imposed on the plaintiff.

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Testimony in Support of Senate Bill No. 2199
House Judiciary Committee
March 1, 2005

Mr. Chairman, Members of the House Judiciary Committee, I'm Bruce Levi. I represent the North Dakota Medical Association. The Association is the professional membership organization for physicians, residents and medical students in North Dakota.

The North Dakota Medical Association supports Senate Bill No. 2199. The bill was passed in the Senate by a vote of 45-0. The bill would revise NDCC Section 28-01-46, North Dakota's statute requiring that the plaintiff produce an expert opinion to support allegations of negligence in the early stages of medical liability litigation. This is a mechanism used in at least 21 states to ensure that medical liability claims are supported by expert opinion at an early stage of the litigation. The affidavit required must identify the name and business address of the expert, indicate the expert's field of expertise, and contain a brief summary of the basis for the expert's opinion. If the plaintiff fails to provide the expert opinion, the trial court may, within its discretion, dismiss the action without prejudice or provide additional time for the plaintiff to provide the expert.

Since the 2003 Legislative Assembly, several North Dakota Supreme Court decisions have addressed issues relating to the statute, and it is the intent of this legislation to respond to those issues. The North Dakota Supreme Court has described the purpose of the expert affidavit statute:

> The statute attempts to minimize frivolous claims by requiring the plaintiff to produce an expert opinion to support the allegations of negligence in the early stages of litigation. The statute provides for preliminary screening of totally unsupported claims and seeks to prevent protracted litigation when a medical malpractice plaintiff cannot substantiate a basis for the claim. It was enacted to prevent the necessity of an actual trial in those cases. *Van Klootwyk v. Baptist Home, Inc.*, 665 N.W.2d 679 (2003) (citations omitted).

SB 2199 as engrossed would:

1) Address the issues raised by the North Dakota Supreme Court in *Van Klootwyk v. Baptist Home, Inc.*, 665 N.W.2d 679 (2003) by further delineating defendants such as long term care facilities, ambulatory surgery centers and clinics to the list of defendants for which the expert opinion requirement is applicable. In *Van Klootwyk*, the Court construed the language in section 28-01-46 to only apply in an action for professional negligence against a physician, nurse, or hospital. SB 2199 would extend the expert opinion requirement to actions alleging professional negligence against a nursing, basic, or assisted living facility or by any other health organization, including an ambulatory surgery center or group of physicians operating a clinic or outpatient facility. These are additional categories in which a medical liability case may arise. A representative from the North Dakota Long Term Care Association will comment more fully on this aspect of the bill.

2) Remove a current exception that makes the expert opinion requirement inapplicable in cases alleging lack of informed consent, as is illustrated in the recent cases of Holman v. Berglund, 664 N.W.2d 516 (2003) and Haugenoe v. Bambrick, 663 N.W.2d 175 (2003). In those cases, the Court interpreted section 28-01-46 to reverse a trial court's dismissal of claims alleging lack of informed consent. These are cases in which the defendant subsequently incurred additional time and expense to get a nonmeritorious case dismissed because it lacked the support of expert opinion.

From the standpoint of the North Dakota Medical Association, section 28-01-46 provides a measure of stability for physician practice in ensuring that claims of professional negligence have been evaluated and can be supported to prevent unnecessary litigation and costs. SB 2199 would strengthen the statute in light of the Supreme Court decisions.

On behalf of North Dakota's physicians, I urge you to recommend a "do pass" on Engrossed SB 2199.

Testimony on SB 2199
House Judiciary Committee
March 1, 2005

Chairman DeKrey and members of the House Judiciary Committee, thank you for the opportunity to testify on SB 2199. My name is Leslie Oliver, and I am counsel to the North Dakota Long Term Care Association. I am here to testify in support of SB 2199.

Section 28-01-46, North Dakota Century Code minimizes frivolous claims alleging medical negligence against doctors, nurses and hospitals, by requiring an expert opinion supporting the allegations, within three months of commencing the action. SB 2199 appropriately expands the application of the statute to long term care facilities and other health care facilities providing professional medical care.

Skilled nursing, basic care and assisted living facilities are prime targets for medical malpractice actions. Without the amendments proposed in SB 2199, facilities are denied the statutory protections afforded other health care providers. A recent decision by the North Dakota Supreme Court, entitled Van Klootwyk v. Baptist Home, 2003 ND 112, offers the basis for the Association's support of SB 2199.

The Baptist Home was sued by a former resident's family members for personal injuries and wrongful death, alleging nursing malpractice. Because the plaintiffs' named the facility and not the nurses individually, the Court would not apply N.D.C.C. Section 28-01-46, the expert opinion time requirements, to the case. The protections of the statute were denied based upon a decision by the plaintiffs to sue the facility for the conduct of its nurse-employees.

Long term care facilities employ competent medical professionals providing nursing and therapy services, and must be afforded the protections contained in this bill. The North Dakota Long Term Care Association appreciates the Committee's consideration of SB 2199.

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IN-HOSPITAL DEATHS FROM MEDICAL ERRORS AT 195,000 PER YEAR, HEALTHGRADES STUDY FINDS

Little Progress Seen Since 1999 IOM Report on Medical Errors

HealthGrades Honors 88 Hospitals Nationwide with Distinguished Hospital Award for Patient Safety™

Patient Safety Incidents In Hospitals Account for $6 Billion Per Year in Extra Costs

Lakewood, Colo. (July 27, 2004) – An average of 195,000 people in the U.S. died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002, according to a new study of 37 million patient records that was released today by HealthGrades, the healthcare quality company.

The HealthGrades Patient Safety in American Hospitals study is the first to look at the mortality and economic impact of medical errors and injuries that occurred during Medicare hospital admissions nationwide from 2000 to 2002. The HealthGrades study applied the mortality and economic impact models developed by Dr. Chunliu Zhan and Dr. Marlene R. Miller in a research study published in the Journal of the American Medical Association (JAMA) in October of 2003. The Zhan and Miller study supported the Institute of Medicine's (IOM) 1999 report conclusion, which found that medical errors caused up to 98,000 deaths annually and should be considered a national epidemic.

The HealthGrades study finds nearly double the number of deaths from medical errors found by the 1999 IOM report "To Err is Human," with an associated cost of more than $6 billion per year. Whereas the IOM study extrapolated national findings based on data from three states, and the Zhan and Miller study looked at 7.5 million patient records from 28 states over one year, HealthGrades looked at three years of Medicare data in all 50 states and D.C. This Medicare population represented approximately 45 percent of all hospital admissions (excluding obstetric patients) in the U.S. from 2000 to 2002.

"The HealthGrades study shows that the IOM report may have underestimated the number of deaths due to medical errors, and, moreover, that there is little evidence that patient safety has improved in the last five years," said Dr. Samantha Collier, HealthGrades' vice president of medical affairs. "The equivalent of 390 jumbo jets full of people are dying each year due to likely preventable, in-hospital medical errors, making this one of the leading killers in the U.S."

HealthGrades examined 16 of the 20 patient-safety indicators defined by the Agency for Healthcare Research and Quality (AHRQ) – from bedsores to post-operative sepsis – omitting four obstetrics-related incidents not represented in the Medicare data used in the study. Of these sixteen, the mortality associated with two, failure to rescue and death in low risk hospital admissions, accounted for the majority of deaths that were associated with these patient safety incidents. These two categories of patients were not evaluated in the IOM or JAMA analyses, accounting for the variation in the number of annual deaths attributable to medical errors. However, the magnitude of the problem is evident in all three studies.

"If we could focus our efforts on just four key areas – failure to rescue, bed sores, postoperative sepsis, and postoperative pulmonary embolism – and reduce these incidents by just 20 percent, we could save 39,000 people from dying every year," said Dr. Collier.

The HealthGrades study was released in conjunction with the company's first annual *Distinguished Hospital Award for Patient Safety*™, which honors hospitals with the best records of patient safety. Eighty-eight hospitals in 23 states were given the award for having the nation's lowest patient-safety incidence rates. A list of winners can be found at http://www.healthgrades.com.

Study Highlights

Among the findings in the HealthGrades Patient Safety in American Hospitals study are as follows:

- About 1.14 million patient-safety incidents occurred among the 37 million hospitalizations in the Medicare population over the years 2000-2002.
- Of the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incident(s).
- One in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died.
- The 16 patient-safety incidents accounted for $8.54 billion in excess in-patient costs to the Medicare system over the three years studied. Extrapolated to the entire U.S., an extra $19 billion was spent and more than 575,000 preventable deaths occurred from 2000 to 2002.
- Patient-safety incidents with the highest rates per 1,000 hospitalizations were failure to rescue, decubitus ulcer and postoperative sepsis, which accounted for almost 60 percent of all patient-safety incidents that occurred.
- Overall, the best performing hospitals (hospitals that had the lowest overall patient safety incident rates of all hospitals studied, defined as the top 7.5 percent of all hospitals studied) had five fewer deaths per 1000 hospitalizations compared to the bottom 10th

percentile of hospitals. This significant mortality difference is attributable to fewer patient-safety incidents at the best performing hospitals.

- Fewer patient safety incidents in the best performing hospitals resulted in a lower cost of $740,337 per 1,000 hospitalizations as compared to the bottom 10th percentile of hospitals.

The complete study, including the list of AHRQ patient-safety indicators, can be found at http://www.healthgrades.com.

"If the Center for Disease Control's annual list of leading causes of death included medical errors, it would show up as number six, ahead of diabetes, pneumonia, Alzheimer's disease and renal disease," continued Dr. Collier. "Hospitals need to act on this, and consumers need to arm themselves with enough information to make quality-oriented health care choices when selecting a hospital."

Distinguished Hospital Awards and Findings

In addition to its findings on patient safety, HealthGrades today honored 88 hospitals in 23 states with the *Distinguished Hospital Award for Patient Safety*, the first national hospital award to focus purely on hospital patient safety. The award was designed to highlight hospitals with the best records of patient safety in the nation and to encourage consumers to research their local hospitals before undergoing a procedure.

HealthGrades based the awards on a detailed study of patient safety events in hospitals nationwide from 2000 to 2002, using the list of patient-safety incidents developed by AHRQ. "Best" hospitals were identified as the top 7.5 percent of the hospitals studied and had significantly different patient-safety incident rates and costs compared to hospitals that were average or in the bottom 10th percentile. Among the "best" hospitals, the lower number of avoidable deaths and in-patient hospital costs were directly related to their lower overall patient-safety incident rates.

"If all the Medicare patients who were admitted to the bottom 10th percentile of hospitals from 2000 to 2002 were instead admitted to the "best" hospitals, approximately 4,000 lives and $580 million would have been saved," said Dr. Collier.

About HealthGrades

Health Grades, Inc. (OTCBB: HGRD) is the leading independent healthcare quality company, providing ratings, information and advisory services to healthcare providers, employers, health plans and insurance companies. HealthGrades works with healthcare providers to help assess, improve and promote their quality. HealthGrades provides consumers access to information about healthcare providers and practitioners through its Web site and provides liability insurers, employers and payers with critical information about healthcare quality.

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