STATE OF SOUTH DAKOTA	IN CIRCUIT COURT
COUNTY OF YANKTON	FIRST JUDICIAL CIRCUIT

MARY CLINE, Individually and as Personal Representative of the Estate of MAX CLINE, Plaintiff, v. YANKTON MEDICAL CLINIC, P.C., JOHN FRANK, M.D., and MICHAEL PIETILA, M.D., Defendants.	Civ. No. 14-355 **PLAINTIFF'S BRIEF OPPOSING DEFENDANTS' MOTION TO AMEND SCHEDULING ORDER**

COMES NOW Plaintiff, by and through her attorneys of record and respectfully submits this Brief Opposing Defendants' Motion to Amend Scheduling Order, and states as follows:

INTRODUCTION

Plaintiff opposes Defendants' request for a 30-day extension of time to disclose experts. Defendants failed to disclose the identity of any expert or request an extension until after work hours at 5:25 p.m. on Friday, January 15, 2016, the day the same were due. Defendants have failed to state any good cause for their failures.

FACTS

On November 2, 2012, Defendant, John Frank (hereinafter "Frank"), ordered a chest CT for decedent, Max Cline (hereinafter "Max"), after finding pulmonary nodules on chest x-ray. *Amended Complaint* ¶6. On November 14, 2012, Max was seen by Defendant, Michael Pietila, (hereinafter "Pietila"), who holds himself out as an expert in lung cancer treatment at Defendant,

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Yankton Medical Clinic, P.C. (hereinafter "Clinic"). *James Aff*. Ex. A.[1] Max's CT findings included possible metastasis and the radiologist recommended a follow up CT in three months. *Amended Complaint* ¶7. Despite the potential for malignancy, Pietila minimized the threat of cancer calling it "unlikely" and misdiagnosed Max's lung malignancy as "pneumonia." *James Aff*. Ex. C.

From November 2, 2012, when the nodules were discovered, until August 18, 2014, when Max learned he had Stage IV lung and brain cancer, neither Frank, Pietila nor anyone at Clinic advised Max that the nodules could be cancer. *James Aff*. Ex. D. During the same period, neither Frank, Pietila nor anyone at Clinic advised Max that a follow up CT had been recommendedby the radiologist. *Id*. From the period November of 2012 to August 14, 2014, Max had contact with Clinic 21 times without anyone mentioning the lung nodules or scheduling Max for a CT scan. *Id*. Max died from the cancer on October 31, 2014. *Amended Complaint* ¶19.

Defendants pushed scheduling and on April 15, 2015, filed a Motion for Scheduling Order pursuant SDCL §15-6-16. *James Aff*. Ex. E. Counsel for Defendants identified the expert disclosure date as the primary date that would trigger the remaining schedule. *James Aff*. Ex. F. On September 15, 2015, the Court entered its oral Scheduling Order and signed its written order on October 2, 2015, providing Plaintiff's just under two months to disclose experts on November 13, 2015. *James Aff*. Ex. G. Defendants were given until January 15, 2016, four months to disclose experts pursuant to Defendants' own motion. *Id*.

On Friday evening, January 15, 2016, at 5:25 p.m., counsel for Defendants sent counsel for Plaintiff an email stating that Defendants wanted an additional 30 days to "finalize" expert

[1] Pietila also identifies himself as Chairman of the Board of Directors at Avera Sacred Heart Hospital. *James Aff*. Ex. B.

disclosures. *James Aff*. Ex. H.[2] Defendants did not otherwise contact Plaintiff's counsel or the Court. On January 16, 2016, at 5:03 a.m., counsel for Plaintiff advised counsel for Defendants that Plaintiff did not agree to an extension of the expert disclosures. *James Aff*. Ex. I.

On January 25, 2016, ten days after Defendants were delinquent with their expert disclosures, Defendants filed a Notice of Hearing on Defendants' Motion to Amend Scheduling Order. *James Aff*. Ex. J. Defendants, however, filed no motion, brief or affidavit identifying the basis for their motion. On February 11, 2016, twenty seven days after failing to comply with the scheduling order, Defendants for the first time filed a motion, brief and affidavit outlining the basis and rationale for its motion and provided the Court with copies of the same on February 12, 2016. *James Aff*. Ex. K. Defendants failed to cite any facts or evidence of "good cause" for their failure to timely disclose expert witnesses or make any timely request for extension with Plaintiff's counsel or motion with the Court.

ARGUMENT

I. GOOD CAUSE IS A THRESHOLD REQUIRMENT.

SDCL § 15-6-16 provides, "a schedule ***shall not*** be modified except by leave of the judge ***upon a showing of good cause***." (Emphasis added). Every relevant decision contemplating amendment of a scheduling order acknowledges the threshold prerequisite of good cause. Defendants cite *Tosh v. Schwab*, 743 N.W.2d 422 (SD 2007), in support of their position that this Court's Scheduling Order can be disregarded. *Defendants' Brief*, pg. 3. In *Tosh*, the Court confirmed the requirement of good cause pursuant to SDCL § 15-6-16. *Id*. at 429. In *Tosh*, unlike the present case, Plaintiff timely disclosed his expert witness and made a timely motion to amend the scheduling order after his expert was excluded by defendant's *Daubert* motion. *Id*. at 430. Consistent with the good cause requirement, the *Tosh* Court analyzed the elements that

[2] Defendant did not state any reasons for the delay and did not provide the name or specialty of any experts.

factor into a good cause determination as found in *State v. Moeller*, 616 N.W.2d 424. There, the Court noted, "[a] continuance may properly be denied when the party had ample time for preparation or the request for a continuance was not made until the last minute." *Id*. at 431. *Moeller* referred to the threshold determination as "due diligence". *Id*. Other factors trial courts must consider in deciding whether or not to grant a continuance include whether the continuance motion was motivated by procrastination or bad planning. *Tosh supra* at 430. Defendants have failed to provide any necessary evidence on which the Court can properly determine whether to excuse Defendants' disregard of the Court's Scheduling Order.

Defendants' attempt to by-pass South Dakota's threshold good cause requirement by citing the Connecticut Federal District Court decision in *Equant Integration Services, Inc. v. United Rentals*, 217 F.R.D. 113 (D. Conn. 2003). Unlike Defendants' violation of this Court's Scheduling Order, the trial court in *Equant* had not entered a scheduling order for defendants to violate. *Id*. at 115-16. Had the court in *Equant* entered an expert disclosure order pursuant to Fed. R. Civ. P. 16(b), a preliminary good cause showing would have been required under the federal rule just as it is required by SDCL § 15-6-16. Pursuant to Rule 16(b), a schedule "may be modified only for good cause and with the judge's consent." Fed. R. Civ. P. 16(b)(4). "The primary measure of good cause is the movant's diligence in attempting to meet the order's requirements." *Sherman v. Winco Fireworks, Inc*., 532 F.3d 709, 717 (8th Cir. 2008) (quoting *Rahn v. Hawkins*, 464 F.3d 813, 822 (8th Cir. 2006). "The 'exacting' standard set by Rule 16(b) requires that a moving party first make the requisite good cause showing." *Shukh v. Seagate Tech., LLC*, Civ. No. 10-404 (JRT/JJK), 2013 U.S. Dist. LEXIS 833, 2013 WL 53835 at *3 (D. Minn. Jan. 3, 2013) (citing *E.E.O.C. v. Hibbing Taconite*, 266 F.R.D. 260, 265 (D. Minn. 2009)). While the prejudice to the nonmovant resulting from modification of the scheduling

order may also be a relevant factor, generally, a court will not consider prejudice if the movant has not been diligent in meeting the scheduling order's deadlines. See *Morrison Enters., LLC v. Dravo Corp.*, 638 F3d 594, 610 (8th Cir. 2011); See also *Bradford v. DANA Corp.*, 249 F.3d 807, 809 (8th Cir. 2001) (concluding that there was "no need to explore beyond the first criterion, [diligence] because the record clearly demonstrate[d] that Bradford made only minimal efforts to satisfy the [scheduling] order.").

In *Thompson v. Mehlhaff*, 698 N.W. 2d 512 (SD 2005), the court, in excluding expert testimony, considered "the party's explanation for failure to comply with the scheduling order." *Id*. at 521. Even where no scheduling order exists and the good cause requirement of SDCL § 15-6-16 is not expressly stated, our courts impose a good cause or diligence standard in determining whether to allow untimely expert testimony pursuant to SDCL § 15-6-37. In *Schrader v. Tjarks*, 522 N.W.2d 205 (SD 1994), the court determined that plaintiff was not motivated by "procrastination" or "bad planning" and, in fact, timely disclosed experts. *Id*. at 210. "Imposing a sanction such as the exclusion of testimony **should result** when 'failure to comply has been due to … **willfulness**, bad faith, or **any fault of petitioner**.' Chittenden, 286 N.W. 2d at 316 (citation omitted)." *Id*. (Emphasis added).

II. DEFENDANTS HAVE FAILED TO IDENTIFY ANY GOOD CAUSE.

Defendants have failed to provide any good cause basis or describe any diligent efforts upon which this Court can excuse Defendants' failure to comply with this Court's Scheduling Order or the failure to timely request a continuance. The entirety of Defendants' justification consists of the following:

> We were unable to finalize and complete Defendants' expert disclosures on or before the expert disclosure deadline. Among the reasons was difficulty communicating with our original consultant.

Evans Aff. at ¶ 2. Defendants' failure to describe any meaningful good cause justification for disregarding the Scheduling Order necessarily prevents the Court from providing Defendants the relief they request. For example, who is the original consultant? Why was this consultant necessary for compliance with the Scheduling Order? When was the consultant contacted? What was the communication difficulty? How did the communications difficulty prevent these Defendants from disclosing even the identity of any expert witnesses or timely requesting a continuance?

Defendants' vague assertion is not credible. All of these Defendants are insured by MMIC. *James Aff*. Exhibits L, M and N, MMIC Declarations Sheets. As insureds of MMIC, these Defendants had the benefit of expert witness reviews the moment Pietila's misdiagnosis was discovered on August 14, 2014, 17 months before Defendant's expert disclosure deadline. MMIC insureds, like Defendants, are required to report claim events in a timely manner. *James Aff*. Ex. O, MMIC Claims Policy; Ex. P, MMIC Liability Policy. If a claim is not reported, MMIC provides no coverage. *James Aff*. Ex. Q, Dee Ledford Depo pg. 63. Reportable events include unfavorable outcomes. *James Aff*. Ex. O. Even if Defendants failed to report Pietila's mistake, Defendants' MMIC malpractice policy required that Defendants "shall notify MMIC" if medical records are requested such as from a patient's attorney. *Id*.; see also *James Aff*. Ex. P. So, if Pietila's misdiagnosis didn't trigger reporting to MMIC, the September 30, 2014 request for medical records from Johnson, Miner, Marlow, Woodward & Huff, Prof. LLC, did. *James Aff*. Ex. R.

Once Defendants give notice of their malpractice claims, MMIC's "team of highly trained professionals performs a prompt, thorough investigation and evaluation, backed by ***medical experts*** who assist [MMIC] in reviewing, analyzing, and evaluating the care and

treatment provided." *James Aff*. Ex. S; MMIC Claim Services. (Emphasis added). Consistent with MMIC's Physician Litigation Support Program, "[t]he process begins the moment we know you are involved in a lawsuit or claim" and within a few days, a qualified professional calls each insured personally. *Id*. MMIC's litigation program provides the insured doctor the benefit of a colleague "skilled in litigation coaching." *James Aff*. Ex. S, MMIC 2014 Annual Report. Defendant doctors also "receive coaching on how to be a credible and persuasive witness." *Id*.

In South Dakota, both the MMIC claims consultant and defense counsel work to secure medical experts. *James Aff*. Ex. Q, Dee Ledford Depo pg. 41-42. In addition, claim consultants "work closely with MMIC's physican advisory council (PAC) to review, analyze and evaluate the majority of cases." *James Aff*. Ex. T, MMIC Claim Services. The PAC members include legal advisors and physicians from multiple specialties who "[h]elp MMIC claim consultants and defense counsel understand the medicine and potential problems with care, treatment and patient outcomes" and "[i]dentify medical experts to assist the insured physician involved in the case." *Id*.

It is difficult to comprehend how Defendants' counsel had difficulty communicating with the original consultant when the PAC of the largest medical malpractice insurer in the Midwest meets quarterly and "anybody" within MMIC has access to the claim files. *James Aff*. Ex. Q, Dee Ledford Depo pg. 33, 40, 57. At a minimum, Plaintiff is entitled to more than Defendants' bald assertions before the Court considers excusing Defendants' blatant disregard of the very Scheduling Order Defendants motioned up.

MMIC is just one of the medical malpractice insurance companies governed by its parent company, Constellation. *James Aff*. Ex. U. Thus, these Defendants have nationwide access to expert witnesses insured by a Constellation entity. *Id*. In South Dakota, MMIC touts a 70%

market share of our healthcare industry. *James Aff*. Ex. V., MMIC 2012 Annual Report. MMIC has expanded its influence over potential experts and encouraged physicians and hospitals to join a broader effort to deny any reimbursement to any injured patient by distributing dividends when medical malpractice payouts are low. *James Aff*. Ex. W., MMIC 2013 Annual Report. In 2013, MMIC paid $6,000,000 back to policyholders, bringing the total of distributed dividends since 1994 to more than $114,000,000. *Id.* This payout to a majority of the treating and testifying physicians in South Dakota may explain, in part, MMIC phenomenal trial success rate of 97%. *Id*.

MMIC's connections to the policyholder/investor pool of expert witnesses is not limited to the Constellation family of companies. MMIC is also a member of PIAA, the medical professional insurers' trade association. *James Aff*. Ex. X and Ex. Y. PIAA members insure more than two-thirds of America's private practicing physicians and 2,000 hospitals. *Id*. The significance of MMIC's membership is that PIAA provides its members, and their designated defense law firms, access to the PIAA Expert Witness Database "anytime, anywhere." *James Aff*. Ex. Z. PIAA describes the service as "invaluable for identifying and evaluating experts … such as demeanor, truthfulness, and how the expert will be perceived by a jury." *Id*. This leads to better results at trial. *Id*.

With such vast resources and overwhelming advantages in the evaluation and selection of expert witnesses, Defendants' suggestion of good cause for ignoring the Court's Scheduling Order is not credible.

III. "PREJUDICE" IS NOT A CONSIDERATION WHERE DEFENDANTS' VIOLATION IS WITHOUT GOOD CAUSE.

Defendants essentially ignore the threshold requirement of demonstrating good cause for failing to comply with this Court's Scheduling Order and attempt to equate good cause with

prejudice to the Plaintiff. The issue of prejudice is not reached, however, until Defendants make a fundamental showing of good cause. Yet, prejudice exists by virtue of any delay in expert disclosure. For example, each Defendant conditioned responses to Plaintiff's written discovery on "additional facts and documents as are uncovered, developed, or relied upon by Defendant, his experts, and Defendants' counsel in the continuing discovery and investigation of the issues in this action." *James Aff*. Exhibits AA, BB and, CC, Defendants' written discovery objections. Late disclosure creates a delay in conducting a complete deposition of Defendants which in turn causes last minute amendments and expense with Plaintiff's expert witness and shortens Plaintiff's counsel's preparation time. Defendants should not be allowed to have it both ways – first, qualifying their discovery responses on expert disclosures and then delaying their expert disclosures.

IV. "BAD FAITH" IS NOT THE TEST PURSUANT TO SDCL § 15-6-16.

Just as Defendants cite no facts in support of their incredible claim of excuse, Defendants cite no authority that allows the Court to abandon the requirement of good cause found in SDCL § 15-6-16. *Schrader v. Tjarks*, 522 N.W.2d 205 (SD 1994), merely requires "procrastination" or "bad planning" or "any fault of petitioner" to deny the request for continuance. *Id*. at 210. "Imposing a sanction such as the exclusion of testimony **should result** when 'failure to comply has been due to … **willfulness**, bad faith, or **any fault of petitioner**.' Chittenden, 286 N.W. 2d at 316 (citation omitted)." *Id*. (Emphasis added). Defendants simply failed to disclose even the name and specialty of any experts and failed to take any steps to seek or secure a continuance until after they already violated the Court's Scheduling Order. To compound the matter, Defendants have refused to provide any evidence of good cause for their failures or diligence in attempting to comply with the Court's Order.

V. "MANIFEST INJUSTICE" AND "EXTREME REMEDY" ARE NOT THE TESTS PURSUANT TO SDCL § 15-6-16.

Defendants cite *Schrader* to suggest a shifting of the burden of proof for purposes of creating a "manifest injustice" theory. While negligence "must be established by the testimony of medical experts," it is a rule for plaintiffs in medical malpractice cases as "plaintiff has the burden to show whether the 'doctor deviated from the required standard of care.'" *Schrader* at 210. Defendants have no burden and require no experts – particularly, since Defendants are themselves experts. Pietila holds himself out as a lung cancer specialist and Frank as board certified in internal medicine. *James Aff.* Exhibits A and DD. There is no requirement that the Defendants have additional expert witnesses. Any defense argument of "manifest injustice" and "prejudice" to defendants in the medical malpractice setting is fundamentally distorted and disingenuous.

1. *"Manifest Injustice" - Buying verdicts through cumulative experts.*

Defendants' assertion of "manifest injustice" necessarily invokes consideration of the injustices, inherent in the medical malpractice system, that punish victims of medical harm. In virtually every malpractice case, plaintiffs face cumulative expert witnesses because the defendants are themselves experts. Defendants' malpractice insurers have unlimited access to experts and financially incentivize both treating and expert medical witnesses. These insurance corporations have enormous resources to buy verdicts and manipulate the trial process through cumulative expert witness. The defense is allowed to duplicate and bolster the defendant physician's testimony by repeating it through additional expert testimony.

This case presents an excellent example of the intended abuse. Here, Defendants, after ignoring the expert disclosure deadline, unloaded 6 late expert witnesses in addition to Pietila

and Frank. On February 5, 2016, Defendants' counsel sent correspondence identifying 3 new expert witnesses. James Aff. Ex. EE. The first expert, was Kamran Darabi, M.D., a cancer doctor to duplicate and bolster Pietila's testimony. *James Aff*. Ex. FF. Second, was Thomas Huber, M.D., a family physician to duplicate and bolster Frank's testimony. *James Aff*. Ex. GG. The third, Clinton Merrill, M.D., a cancer and internal medicine doctor was both the third cancer doctor and third internal medicine witness. *James Aff*. Ex. HH.

In their correspondence of February 5, 2016, 21 days after already missing their deadline, Defendants' exhibited their arrogance and entitlement by adding, "I anticipate that we will disclose one, and perhaps two, additional experts next week." *James Aff*. Ex. EE. On February 11, 2016, 27 days after missing their deadline, Defendants' counsel sent correspondence disclosing a fourth cancer expert, James Michaelson, Ph.D. *James Aff*. Exhibits II and JJ. On February 12, 2016, 28 days after missing their deadline, Defendants' counsel sent correspondence disclosing a fifth cancer expert, Peter Julian, M.D. *James Aff*. Exhibits KK and LL. On February 18, 2016, 34 days after missing their deadline, Defendants' counsel sent correspondence disclosing the sixth cancer expert, Lee M. Kamman, M.D. (without CV). *James Aff*. Exhibits MM and NN. On February 23, 2016, 39 days after missing their deadline, Defendants' counsel sent correspondence disclosing the CV of Dr. Kamman - no doubt delayed due to difficulty communicating with the original consultant. *James Aff*. Ex. NN-1, NN-2.

Contrary to Defendants' assertion, that their barrage of experts is necessary for a "fair, just and equitable verdict," Defendants are asking the Court to protect their grossly unlevel playing field that perpetuates a ridiculous MMIC trial win rate of 97%. Defendants seek an improper advantage through numerical superiority and by reinforcing the same testimony multiple times. Interestingly, courts allow cumulative testimony to bolster defendant doctors in

front of the jury but prevent the jury from hearing about the defendant doctors' prior instances of similar malpractice. Defendants' battery of cumulative and well coached experts are allowed to entertain juries with a professionally staged production with preordained victors and losers reminiscent of the Coliseums.

Defendants' strategy further contemplates creating unreasonable expense for Max's widow in deposing and preparing for this battalion of cumulative experts. Based upon their expert disclosures, Defendants don't even attempt to hide their attack on the widow of their victim by taking multiple bites at the apple. Attacking the victims, families and witness to Defendants' wrongful acts is nothing new to these Defendants as reflected in the pending litigation, *Howes v. Yankton Medical Clinic, P.C.*, U.S. Dist. Ct., Southern Div. S.D., Civ. #154177. *James Aff*. Ex. OO, Complaint.[3]

Cumulative expert witnesses should be prevented in accordance with multiple rules, including, SDCL §§19-19-2 (Rule 102), 19-15-18 (Rule 707(a)), 19-12-3 (Rule 403) and 15-6-26(b) - (c). SDCL §19-9-2 provides:

> Purpose and construction of chapters. Chapters 19-9 to 19-18, inclusive, shall be construed to secure fairness in administration, elimination of unjustifiable expense and delay, and promotion of growth and development of the law of evidence to the end that the truth may be ascertained and proceedings justly determined.

The Court is specifically empowered to impose reasonable limitations upon the number of expert witnesses called. SDCL §19-15-18. In addition, the Court can prevent needless presentation of cumulative evidence pursuant to SDCL §19-12-3. SDCL §15-6-26(b), gives the Court authority to regulate discovery methods and prevent cumulative, duplicative, burdensome and expensive

[3] The case was originally filed in South Dakota State Court but removed to Federal Court by Defendants. Plaintiffs' allegations in *Howes* include using monopoly power by refusing to provide medical treatment to patients in their home market who seek redress for negligent harm.

discovery.

In, *Hayes v. Northern Hills General Hospital*, 628 N.W.2d 739, 2001 SD 69 (S.D. 2001), Defendant, a medical doctor, represented at trial that an expert witness was to testify as an expert on emergency room procedures. The trial court ruled that such testimony would be cumulative, a decision with which the Supreme Court agreed and held:

> Michael Myers, the chair of the University of the South Dakota Department of Health Services Administration and a professor at the School of Law, testified about emergency room procedure, operations, and medical conduct. Cumulative evidence is evidence of the same character as evidence previously produced and which supports the same point. *Stormo v. Strong*, 469 N.W.2d 816 (S.D.1991).

See also, *State v. DeMarias,* 27 S.D. 303, 308, 130 N.W. 782, 784 (1911); *State v. Gerdes,* 258 N.W.2d 839 (S.D.1977).

Other Courts have also addressed limiting the number of expert witnesses for each side. *Gotwald v. Gotwald*, 768 S.W.2d 689, 700 (Tenn. Ct. App. 1988) (Franks, J. concurring). A trial judge has discretion to limit the number of expert witnesses on each side as to a particular issue, *Conlee v. Taylor,* 153 Tenn. 507, 285 S.W. 35 (1926); *Powers v. McKenzie*, 90 Tenn. 167, 16 S.W. 559 (1891). In *Grab ex rel. Grab v. Dillon*, 103 S.W.3d 228, (Mo.App. E.D. 2003), the plaintiff in a medical malpractice action sought to introduce a conclusion from a pathologist, which "came to the same conclusion as five other pathologists who reviewed the slides." The trial court excluded the pathologist's opinion because "[i]t is typically considered proper to exclude cumulative evidence. *Destin,* 803 S.W.2d at 116. Given that the pediatric pathologist's opinion that the slides contained epididymis was merely cumulative to the opinion of numerous other pathologists, Parents have failed to show how they were prejudiced by the exclusion … ."

Parties have no more right to present cumulative expert testimony than any other sort of cumulative evidence. The Maryland Court of Special Appeals upheld a trial court's decision, in a medical malpractice case, to exclude the testimony of an expert that would have been merely cumulative of other testimony given in the case. *Mahler v. Johns Hopkins Hosp., Inc.*, 170 Md. App. 293, 322-23 (2006). The court found after examining the record that there was evidence presented at trial by both sides on the issues that the excluded expert would have addressed. The court gave an example:

> [A]ppellant proffered that Dr. Zide's testimony was that "the material risks of the genioplasty [were] wound dehiscence, nerve injury, soft tissue changes, ptosis, [and] chin deformity." But such testimony had already been elicited from Doctors Tufaro and Manson. Dr. Tufaro testified that the risks included lip ptosis, dimpling of the soft tissues around the chin, and a change in position of the lower lip. And Dr. Manson testified that the risks included ptosis of the chin, dimpling, damage to sensory nerves, and a lowering of the position of the lip. Id. at 323. The court ultimately ruled, "Dr. Zide's testimony would have been, as the circuit court ruled, cumulative. Therefore, the circuit court did not abuse its discretion in excluding Dr. Zide's testimony."

Id.

Similarly, in *Rotwein v. Bogart*, 227 Md. 434 (1962), the Maryland Court of Appeals held that cumulative expert testimony had properly been excluded. In that breach of warranty action, with regard to, *inter alia*, the installation of a floor, the plaintiff sought to introduce a flooring expert. The trial court refused to admit it and the Court of Appeals upheld this ruling, stating, "this was rebuttal and cumulative testimony… As the jury had this testimony [regarding the flooring], we do not believe that further testimony would have been of appreciable help, which is the true criterion herein." Id. at 437.

The District of Columbia has also considered this issue. In *In re Moses*, 659 A.2d 829 (D.C. 1995), the guardian ad litem presented three witnesses: two social workers who testified as lay

witnesses and a psychiatrist who testified as an expert witness as to competency and care. On appeal the D.C. Court of Appeals found that, "the trial judge…properly exercised his discretion to exclude a third social worker's testimony as well as testimony of an independent psychologist and his written report as cumulative evidence." Id. at 831 (citing *Washington Times Co. v. Bonner*, 86 F.2d 836, 846 (D.C. Cir. 1936)).

There are also federal cases limiting expert testimony where it was found to be cumulative. In *Washington v. Greenfield*, 1986 WL 15758 (D.D.C. 1986), the Court limited the testimony of multiple gynecologists as cumulative and unnecessary evidence at trial. Likewise, in *Geico Cas. Co. v. Beauford*, 2007 WL 2412974 (M.D. Fla. 2007), the district court found that insurance industry experts had basically the same opinions and excluded an expert as cumulative. Similarly, in *Leefe v. Air Logistics, Inc.*, 876 F.2d 409, 411 (5th Cir. 1989), a personal injury case from the U.S. Court of Appeals for the Fifth Circuit, the trial court disallowed the testimony of the plaintiff's second medical expert on grounds that it would be repetitious and cumulative – although not identical – to testimony already provided by plaintiff's first medical expert. Despite that plaintiff's counsel had proffered that the second medical expert would provide more exact testimony than the first as to the odds of the plaintiff developing arthritis and a precise disability rating, the court ruled that the more general testimony of the first expert had been sufficient. Id.

The Court of Appeals for the Fifth Circuit agreed with the trial court under Rule 403 and deferred to the trial court's discretion. Id. The court further added: "We do want to discourage attorneys from parading additional experts before the court in the hope that the added testimony will improve on some element of the testimony by the principal expert." Id. The court in *Bowman v. General Motors Corp.*, 427 F. Supp. 234, 239 (E.D. P.A. 1977), likewise excluded the testimony of an expert, in part, under Rule 403 and noted that allowing the additional expert

would only have served the plaintiff's "tactical advantage" in allowing a "rerun of testimony already provided by another expert…."

Rule 403 states: "Although 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." A medical malpractice trial should not be a contest to see which party can line up the most experts to say the same thing over and over. A jury should not base its decision on the number of witnesses presented by each side. The practice of having multiple experts to give the same opinions unnecessarily increases the cost of litigation for all sides, and is otherwise a waste of the Court's and the parties' time and resources. Limiting the number of experts who have nothing to add beyond what the last expert said will in no way prejudice a party from presenting its case. However, placing no limit on such cumulative expert testimony poses a risk of confusing the issues and presents a substantial risk of unfair prejudice to the party who presents their case efficiently and succinctly. The Reference Manual on Scientific Evidence, contains the following comment:

> Some local rules and standing orders limit parties to one expert per scientific discipline. Ordinarily, it should be sufficient for each side to present, say a single orthopedist, oncologist, or rehabilitation specialist. However, as science increases in sophistication, subspecialties develop. In addition, experts in a single subspecialty may be able to bring to bear a variety of experiences or perspectives relevant to the case. If a party offers testimony from more than one expert in what appears to be a distinct discipline, the party should justify the need for it and explain why a single expert will not suffice. Attorneys may try to bolster the weight of their case before a jury by cumulative expert testimony, thereby adding cost and delay. The court should not permit such cumulative evidence, even where multiple parties are represented on one or both sides.

W.W. Schwarzer & J.S. Cecil, "Management of Expert Evidence," p. 48, Reference Manual on Scientific Evidence, 2d ed. (Federal Judicial Center, 2000). *See also, In Re Factor VIII or IX*

The North Carolina Court of Appeals upheld the trial court's limitation of the number of expert witnesses in a condemnation case. *Board of Transportation v. Easton Developers and Rentals, Inc.*, 28 N.C. App. 114, 118, 220 S.E.2d 198, 200 (1975). *See also, State v. Wright*, 274 N.C. 380, 397, 163 S.E.2d 897, 909 (1968) (Reasonable limitation on the number of witnesses is within the discretion of the trial court.).

In the case of *Carpenter v. Alonso*, 587 So.2d 572, 573 (Florida Ct. App., 3rd Dist. 1991), the Florida Court of Appeals held that a trial Court may properly limit expert witnesses in a medical malpractice case to one expert per side. The *Carpenter* case illustrates the built-in advantage afforded to defendants in medical malpractice cases, since the defendant physicians were allowed to testify as experts in addition to their designated experts in the case.

In the case of *Night v. Haydary*, 233 Ill. App. 3d 564, 576, 585 N.E. 2d 243, 252, 165 Ill. Dec. 847, 856 (Ill. App., 2nd Dist. 1992), the Illinois Court of Appeals noted that Illinois Supreme Court Rule 218 gives the Trial Court inherent authority to limit and regulate the number of expert witnesses to expedite the efficient administration of justice. Based on this authority, the Trial Court did not abuse its discretion in this medical malpractice case by limiting the number of expert witnesses allowed to testify at trial.

In the case of *Patterson v. Hucheons*, 529 N.W.2d 561, 565 (N.D. 1995), the North Dakota Supreme Court upheld the trial court's limitation of expert witnesses in a medical malpractice case. The Court cited *Johnson v. Ashby*, 808 F.2d 676, 678 (8th Cir. 1987), for the proposition that "Trial Court's have discretion to place reasonable limits on the presentation of

evidence to prevent undue delay, waste of time, or needless presentation of cumulative evidence."

The concept of "manifest injustice" does not support Defendants' request to extend the expert disclosure deadline.

2. *"Manifest Injustice" - A broken system.*

To consider Defendants' reliance on "manifest injustice," in the vacuum of an isolated motion in this individual diagnostic error case, ignores the reality of our systemically corrupt health industry that fails to protect patients but instead insulates inept medical providers from any accountability. MMIC acknowledges that diagnostic error is the third leading cause of death in the United States. *James Aff*. Ex. S. Only heart disease and cancer kill more people in this country. *Id*.

These preventable medical deaths, the conflicted relationships that allow them, and the money that covers them up, are unacceptable as recently disclosed by Harald "Lars" Aanning, M.D. *James Aff*. Ex. PP.[4] Dr. Aanning is a retired surgeon who practiced at Defendant, Yankton Medical Clinic, P.C. *Id*. Dr. Aanning references the *Journal of Patient Safety* that determined that as many as 440,000 people die from preventable medical errors every year. *Id*. at ¶53. In discussing the failure of peer review, a practice heralded for promoting patient safety, Dr. Aanning noted that with 1,200 preventable medical deaths per day, protected peer review fails to provide even minimal patient safety protection. *Id*. at ¶79.

[4] Dr. Aanning filed his Affidavit in Opposition to the South Dakota State Medical Association's Motion to File a Brief as Amicus Curiae in the consolidated case, Novotny v. Sacred Heart Health Services, et. al., S.D. S. Ct. #27615.

Dr. Aanning identified, what would be considered "manifest injustice" when comparing the plight of medical malpractice victims to that of the offending providers and their allies, as follows:

> Plaintiffs in these lawsuits have been maimed and disabled which translates into human suffering in the form of emotional, physical and economic agony resulting in the destruction of families. While their cases grind through the court system, these injured patients struggle every minute with broken bodies, broken spirits and broken finances. Some involved have already died and others likely will die without any resolution.
>
> The stakes are high for patients when peer review is protected. Healthcare is the number one cause of bankruptcy filings in the United States. *Medical Bills are the Biggest Cause for US Bankruptcies*, www.cnbc.com/id/100840. Most medical bankruptcy filers were middle-class, well-educated homeowners and three-quarters of filers had health insurance that didn't cover the medical costs. "'Unless you're Warren Buffett or Bill Gates, you're one illness away from financial ruin in this country,'" says lead author Steffie Woolhandler M.D., of the Harvard Medical School, in Cambridge, Mass. 'If an illness is long enough and expensive enough, private insurance offers very little protection against medical bankruptcy, and that's the major finding in our study." www.cnn.com/2009/HEALTH/06/05/bankruptcy.medical.bills/index.html?_s=PM:HEALTH.
>
> The perspective from the physician, hospital and malpractice insurance company is an altogether different story. While patients are saddled with skyrocketing healthcare costs, profits have never been higher for the healthcare industry. As a general surgeon having been a member of Yankton Medical Clinic, P.C., I can attest that individual South Dakota doctors enjoy extraordinary incomes. Public court documents revealed that a general surgeon employed in the Avera system has annual earnings in excess of $1,000,000. *Krouse v. Krouse*, 2nd Jud. Cir., Lincoln Co., SD #12-545, findings of the Honorable Susan Sabers, Circuit Court Judge.
>
> Defendant Avera Health and Avera Sacred Heart Hospital had combined total revenues in 2013 of more than $250,000,000 and net assets of nearly $500,000,000. 2013 IRS Form 990, http://foundationcenter.org/findfunders/990finder/. In the same year Avera Health's CEO received individual compensation of $1,371,237 and the CEO of Avera Sacred Heart Hospital received individual compensation of $506,498. *Id*.
>
> MMIC, the medical malpractice insurance company that insures some of the Defendants in this case and nearly 3 out of every 4 physicians in South Dakota, in

> 2014 had a net income of $35,000,000 and total assets in excess of a billion dollars. *MMIC 2014 Annual Report*, http://www.mmicgroup.com/pdf/annualreports/MMIC_2014_AnnualReport.pdf. MMIC had a policyholder's surplus of $310,203,000. *Id*.
>
> MMIC has created an additional income stream for its policyholders and incentivized physicians to join in a global effort to deny any reimbursement to any injured patient by distributing dividends when medical malpractice payouts are low. In 2013, MMIC paid $6,000,000 back to policyholders, bringing the total of
>
> distributed dividends since 1994 to more than $114,000,000. *MMIC 2013 Annual Report*, http://www.mmicgroup.com/annualreports/2013AnnualReport/.

Id. at ¶¶ 65-70.[5]

Dr. Aanning also identified a "manifest injustice" in the conflicts of, what Dr. Aanning termed, "South Dakota's medical complex," as follows:

> MMIC has developed powerful influence at the highest levels of South Dakota's medical complex with the successful placement of Mary Carpenter, M.D., one of its controlling board members, 1) on the executive committee of the SDSMA, 2) as recent president of the South Dakota Board of Medical and Osteopathic Examiners, 3) as medical director for South Dakota Medicaid and Corrections Health, 4) as medical consultant for the South Dakota Department of Health, and 5) as SDSMA delegate to the AMA. Dr. Carpenter is necessarily conflicted in her obligation to protect the public by rooting out bad doctors when doing so will result in financial liability for her insurance company and its shareholders. "No man can serve two masters: for either he will hate the one, and love the other; or else he will hold to the one, and despise the other." Matthew 6:24.
>
> The political disparity between patients and medical related corporations is highlighted by the fact some of Dr. Carpenter's appointments to South Dakota positions are made by South Dakota's Governor. While, the Governor is not a Defendant or employed by a Defendant, his Lieutenant Governor, Matt Michels, is. Defendant Michels not only serves as Lt. Governor but he is also paid by Defendant Avera Health as legal counsel. According to Dr. Neumayr, of Defendant Avera Sacred Heart's MEC, Defendant Michels was instrumental in

[5] In 2015, Avera's regional "health ministry rooted in the Gospel" reported gross patient and resident revenue of $3,725,320,981 and net profit margin of $44,849,412. Avera 2015 Annual Report, http://www.averaannualreports.org/.

> convincing the medical staff to approve Soosan despite the medical staff's original disapproval. See, Exhibit A.
>
> MMIC's lobbying efforts, financial incentives and infiltration of medical and political organizations has paid off. In 2013, in addition to record profits, MMIC physicians won 39 of 40 trials against patients for a 97% success rate. *MMIC 2013 Annual Report, supra.*

Id. at ¶¶ 71-73.

According to National Institute on Money in State Politics, South Dakota's Governor, who appointed a board member from MMIC's parent company to the medical board, and Lt. Governor received $306,361 in campaign contributions from health related industries. *James Aff*. Ex. QQ and RR, www.followthemoney.org reports. The Center for Public Integrity reports that "the state's top officeholders are able to legally skirt existing fundraising limits and get relatively large sums into campaign coffers with little effort." *James Aff*. Ex. SS, www.publicintegrity.org, 2012. "Lack of oversight was, in part, responsible for the Rushmore State's "F" grade for regulation of political finances from the State Integrity Investigation." *Id*.

Nationally, the PIAA, that represents the malpractice insurers of 2/3 of America's practicing doctors, and of which MMIC is a member, has a political action committee (PAC) of its own. *James Aff*. Ex. TT; see also *James Aff*. Exhibits X and Y. The primary purpose of PIAA's PAC, "is to support candidates for the U.S. House and Senate who share our views on tort reform and other issues of importance to medical/dental liability insurers. *Id*. Ex TT.

> We are at a tipping point in American medicine today. Business interests have taken over and are routinely over-riding medical ethics - on a daily basis. And if patients cry "harm", why they are either crazy or they get shut down by a mafia-like system that is in full control - all the way up to the FDA and the United States Congress. Harmed patients have no real rights in America.
>
> ***
>
> When people get harmed in America, they go home, they go bankrupt or they die. They very certainly do not lobby congress. They are excluded from the democratic process.

Hooman Noorchashm, M.D., Ph.D., cardiothoracic surgeon at Jefferson University. *James Aff.* Ex. PP at ¶ 18.

The reality of medical malpractice in our courts was described by someone who has seen both sides, Lawrence Schlachter, M.D., a former neurosurgeon and current attorney. *James Aff.* Ex. UU, *When a Brain Surgeon Becomes a Malpractice Lawyer*, *ProPublica*, Feb. 16, 2016. In a recently published question and answer session, Dr. Schlachter revealed the following:

> **Q. What did you see as a medical malpractice attorney that you did not see when you were practicing medicine?**
> **A.** I saw doctors and hospital officials cover up records, lie, not tell the patient and family what happened. I've seen fractures in the health care system, a lack of patient safety, and human nature and arrogance causing people to circle the wagons. I saw doctors come to court and say things that weren't true. I saw patients come to court and not get justice. After 12 years of this I've reached the point where I've almost become the investigative reporter instead of the lawyer. There has to be something done about this. It's not sustainable, and it's not right.
>
> **Q. Did you see these problems when you were practicing medicine?**
> **A.** To a limited extent. When you're practicing medicine you don't see any of the legal cases unless you're in them or testifying in them. In terms of actual cover-ups or denials, you do see it to some extent between yourself and your partners. You tend to not do much about it. For example, when one of my partners got sued, I thought he did something wrong but I didn't step up and say it. I just stayed out of the way and stayed quiet.
>
> **Q. So when you were a doctor were you part of the problem?**
> **A.** Not to the extent that I'm seeing as a lawyer. I never went to a courtroom and lied about anything. I never gave expert testimony that was dishonest to protect someone else at the expense of an injured patient. I certainly was part of the doctors that tried to stay out of it. I didn't throw myself into the fray.
>
> **Q. Do you think lots of doctors are in a similar position to the one you were in?**
> **A.** Yes. The real issue is that medicine is incapable of regulating itself. Doctors, like any other profession or business, will act in their own self-interest and protect their own self-interest. How far they go is an individual choice, depending on the stresses that are on the institution or the doctor. But everyone tries to not discuss what went wrong, to not expose themselves to a medical-legal situation or litigation. I think the self-interest of all the different groups has such control over who is supposed to do the regulation that there is just enough regulation for the public not to create a riot.

Q. What are the biggest patient safety problems you see?
A. I see a lot of non-physicians being deeply involved in the patient's care. I see doctors now who have physician assistants, nurse practitioners, scribes, all different types of things. As a matter of efficiency, for economic benefit, the physician does less. That can be an advantage if the helpers really care about the patient. They may see things the physician doesn't see. But the extension of that to the extreme can be very dangerous.
I was just on the phone an hour ago where a spine surgeon here in Atlanta did an operation on a patient in the hospital and then never saw the patient again. Within hours of the surgery the patient was complaining to everybody. All that was necessary was for someone to listen to him and for the doctor to help him. They could have done a CT scan immediately, taken him to the operating room and he would have been OK. But now this guy has a chronic pain problem for the rest of his life. He's on chronic medication. He can't work. His life is ruined. This is unacceptable. Why does this physician practice in such a way he doesn't see his patients after the operation?

Q. What do your friends from the medical field say about your work as a medical malpractice attorney?
A. My friends know me as a person who has integrity, and they know me as a good doctor. So they think I'm doing the right thing. Mine is an unusual combination of talents and circumstances. I have a doctor's heart and compassion and a lawyer's awareness that great harm is sometimes done to patients through narcissism, carelessness or ineptitude.

Q. Lots of doctors care about improving patient safety. So why is it so hard to keep patients safe?
A. They're afraid to come out. They're in the closet. They're afraid of retribution, isolation. Why aren't all the doctors knocking my door down to be expert witnesses? They're not. I struggle to find people who will help me. The flip side is why are so many willing to testify the other way and stretch the truth and not tell it like it is? I think most of my colleagues don't hate me, but they don't want to help me.

Q. What's the way forward?
A. That's the question everybody asks to which I don't have a simple answer. Things in this world don't change quickly. We have a complicated political and legislative process. Medicine as practiced today is an evolution of 100 years of different economic stresses, different political stresses. Nothing is going to change quickly from anything I do or you do. It all is an evolution. I don't think I have the power to fix anything in and of myself. Other than raise the awareness of people. Just like your investigative reporting does: You almost shame people into making things better.
There has to be a way for people to be told the truth and for there to be accountability. Accountability doesn't necessarily mean punishment. It could be rehabilitation, supervision, a lot of different things. But there has to be a just and

> fair way for people to get good care and for doctors to know what they're doing and be held accountable when they make mistakes.
>
> **Q. How do you mandate doing the right thing?**
> **A.** There have to be punishments or sanctions involved in accountability. The only way to make people accountable if they don't want to be is to take away their license or take away their income. What other ways can there be? It's pretty draconian, but if people are fearful they are more likely to do the right thing. Everyone's going to act in their own self interests. That's the way the world works.

Id.

Sometimes the manipulation of the medical system takes more subtle forms than graft and cover-ups. Skewing the reportable statistics to mask poor outcomes in medical institutions gives the public a false sense of safety and integrity. For example, the Avera system is facing implementation of the upcoming federally mandated satisfaction tool called NH-CAHPS, which stands for Nursing Home Consumer Assessment of Healthcare Providers Systems. *James Aff*. Ex. VV. The intended purpose of the survey is to assess patient satisfaction and determine future reimbursement from uninfluenced and anonymous responses. *Id*. See also *James Aff*. Ex. WW.

Independence and anonymity are so important, My Inner View, the independent survey company, advises the resident or family member that their responses "will remain completely confidential," the "completed survey will be received by My Inner View in the envelope provided," "individual responses will never be disclosed" and even "your handwriting is not seen by facility staff." *Id*. Ex. WW. Of course, anonymity is critical due to the dependency of nursing home patients on care givers and the fear of retribution or neglect in the event of a wrong answer.

To improve its satisfaction rating and guarantee maximum reimbursement, Avera preemptively circumvented the intent of the survey in both its "independent" and "confidential"

components. Couched in terms of a helpful "update" and "preview," Avera exerted its pre-survey pressure by initially massaging the survey taker and then suggesting the necessary answers for maximum profits. *Id*. Avera wrote, "we will be measured based ***only*** on our 'top box' performance, which simply means how many 'always' responses we receive along with how many '9' or '10's we receive." *Id*. To seal the deal, Avera wrote, "[o]ne of our leaders will be following-up with you to see if you have any questions and assist you in better understanding this new survey tool" - independence, confidentiality and patient safety be damned. *Id*. Once the phony results are tallied, the public (jury pool) can expect multiple press releases and a banner flung from its rooftop celebrating Avera's ill-gotten accomplishments.

Medical error has reached epidemic proportion. Its impact on American society and culture in sheer numbers of deaths, dwarfs other causes that have defined several generations. Every year bad medicine kills as many Americans as died in WWII; every 50 days bad medicine kills as many Americans as died in Vietnam; and every 3 days bad medicine kills as many people as died in the World Trade Centers on 9/11.

A system where patients can lose 97% of their lawsuits despite medical error being the third leading cause of death – constitutes "manifest injustice." The statistics suggest that manipulation by the "medical complex" and its persuasive massaging has had an impact in the courts. The negligence standard has been bastardized into a near absolute immunity under a preferential standard of care analysis. Damage caps and favorable statute of limitations of actions exist by virtue of an imaginary medical malpractice crisis. Relevant evidence supporting victims' claims is lost in the black hole of a failed peer review system that protects bad doctors and profits.

There is no longer any doubt that special rules exist for medical malpractice defendants – rules that have statistically guaranteed verdicts in their favor while preventing victims from sharing any evidence of the reality of the failed system with the fact finder. Here, Defendants blatantly violated a rule. Since the courts enforce rules against plaintiffs that have produced staggering outcomes favoring doctors, Plaintiff simply requests that this Court enforce the unambiguous rule of SDCL § 15-6-16. In the alternative, Plaintiff requests the same leeway to disregard the rules the Court grants to Defendants.

CONCLUSION

Defendants disregarded this Court's Scheduling Order without even bothering to make a timely request for an extension. Defendants have failed to state any fact that would support a threshold finding of good cause or show any diligent effort of compliance. Defendants couldn't identify a single expert within 17 months after learning of Pietila's misdiagnosis. Yet, in just a month after missing the deadline, Defendants identified 6 cumulative experts to say the same thing. The law and every conceivable equity favors denial of Defendants' Motion to Amend the Scheduling Order.

WHEREFORE, Plaintiff respectfully requests the Court deny Defendants' request to amend the Scheduling Order.

Dated this 4th day of March, 2016.

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CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the foregoing Brief in Opposition to Defendants' Motion to Amend Scheduling Order was served by Odyssey on March 4th, 2016, to the following attorneys of record:

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