UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

In the matter of **Evanston Northwestern Healthcare Corporation,** a corporation, and **ENH Medical Group, Inc.,** a corporation.	Docket No. 9315 **Public Record**

RESPONDENTS' OPPOSITION TO COMPLAINT COUNSEL'S MOTION *IN LIMINE* TO EXCLUDE CERTAIN TESTIMONY OF DR. MARK CHASSIN

Pursuant to the Third Revised Scheduling Order entered in this proceeding, Respondent Evanston Northwestern Healthcare Corporation ("ENH") and ENH Medical Group, Inc., by counsel, hereby oppose Complaint Counsel's Motion *In Limine* to Exclude Certain Testimony of Dr. Mark Chassin ("Motion").

INTRODUCTION

Dr. Chassin conducted the most comprehensive, multi-method quality of care investigation to date in any hospital merger case. In particular, he evaluated reliable data sources, reviewed contemporaneous documents, considered deposition testimony and personally interviewed witnesses with relevant knowledge – an approach that is consistent with the type of methods reasonably relied on by experts in his field. Dr. Chassin relied on his significant experience with healthcare quality assessment and thorough investigation to demonstrate that the merger of ENH and Highland Park Hospital ("HPH") (the "Merger") resulted in material quality of care improvements.

In contrast, Complaint Counsel's primary quality of care expert, Dr. Patrick Romano, places disproportionate reliance on administrative data, thus overlooking critical information relevant to his opinions. In a misguided effort to obscure this reality and assert a "tails we win, heads you loose" argument, Complaint Counsel have moved *in limine* to prevent Dr. Chassin from relying on any witness statements – regardless of whether those statements come in the form of trial testimony or witness interviews. Complaint Counsel's efforts to attack Dr. Chassin's "multi-method approach" directly conflict with the Federal Rules of Evidence ("FRE").

First, Dr. Chassin, like virtually every other expert in the history of litigation, intends to base his opinions, in part, on trial witness testimony. According to Complaint Counsel, however, allowing Dr. Chassin to explain how he relied on trial witness testimony would result in improperly redundant testimony. This argument is frivolous. Dr. Chassin is entitled – in fact, he is required under FRE 702 – to apply his analysis to the "facts of the case." Experts routinely rely on trial testimony by fact witnesses and, when appropriate, recap the pertinent testimony. This situation is no different.

Second, Dr. Chassin also intends to rely, in part, on witness interviews he personally conducted to corroborate information he learned from other sources. According to Complaint Counsel, however, Dr. Chassin also should be precluded from basing his analysis on hearsay. This argument fares no better. FRE 703 expressly permits experts like Dr. Chassin to base their opinions on inadmissible evidence such as hearsay, especially in the bench trial context.

Finally, Complaint Counsel make an unprecedented and unwarranted request for "an order requiring the Parties to meet and confer to narrowly tailor any testimony from Dr.

Chassin to F.R.E. 702 and 703 principles." This requested relief is unwarranted because Complaint Counsel have identified no legal basis to exclude any of Dr. Chassin's proffered testimony. Moreover, the purported rationale for such a meeting is suspect. This is not a jury trial and, therefore, Complaint Counsel's concerns of unduly prejudicial testimony are facially unfounded. Any specific objections to Dr. Chassin's testimony can be raised, and decided, at trial.

BACKGROUND

I. Background Regarding Quality of Care Allegations

Counts I and II of the Complaint allege that the Merger violated the Clayton Act § 7. 15 U.S.C. § 18. In these Counts, Complaint Counsel specifically allege that the merged entity raised the rates it charges to private payors for general acute care inpatient hospital services "without a corresponding improvement in quality of care." Compl. ¶¶ 24, 28.[1] Complaint Counsel thus carry the burden of showing that ENH's post-Merger rate increases cannot be explained by corresponding quality of care improvements.[2]

II. Complaint Counsel Primarily Rely On Proffered Testimony From Dr. Romano To Meet Their Quality Of Care Burden Of Proof

In an effort to satisfy their burden concerning quality of care issues, Complaint Counsel have provided an expert report by Dr. Patrick Romano. According to his proffered testimony, Dr. Romano will opine at trial that his evaluation of certain data purportedly shows that: (1) quality of care did not improve as a result of the merger; and (2) to the extent quality

[1] Complaint Counsel's Motion contains gratuitous, unsupported assertions concerning the magnitude of the post-merger rate increases. Respondents dispute these assertions and will address them at trial.

[2] *See, e.g.*, "Everything Old is New Again: Health Care and Competition in the 21st Century," Prepared Remarks of Timothy J. Muris, Chairman, Federal Trade Commission at 18 ("The Commission is always willing to consider arguments about how a particular transaction or conduct will improve quality, and it will pay close attention to such arguments in weighing the competitive implications.") (pertinent pages attached as Ex. 1).

of care did improve, such improvements could have been achieved absent the merger. Dr. Romano's consideration of relevant information, however, was incomplete. He did not interview any witness to support his conclusions but, instead, relied almost entirely on administrative data (much of which is unreliable and have inherent limitations).[3]

III. Respondents Rely On Dr. Chassin To Show That The Merger Resulted In Significant Quality Of Care Improvements

A. Dr. Chassin's Expertise

Respondents have proffered testimony by Dr. Mark Chassin, M.D., M.P.P., M.P.H.[4] Dr. Chassin – the Edmond A. Guggenheim Professor of Health Policy and Chairman of the Department of Health Policy at the Mount Sinai School of Medicine in New York City and the Executive Vice President for Excellence in Patient Care of the Mount Sinai Medical Center – is a leading expert on quality of care measurement and evaluation.

In addition to his private-sector experiences and academic publications, Dr. Chassin has "real world" experience in the public-sector on both the state and federal levels. On the state level, Dr. Chassin served as Commissioner of the New York State Department of Health ("Health Department") from 1992-1994. In that capacity, Dr. Chassin led a department responsible for licensing and regulating all hospitals, freestanding diagnostic and treatment centers and nursing homes in New York. On the federal level, Dr. Chassin served as Deputy Director and Medical Director of the Office of Professional Standards Review Organizations ("PSRO") in the U.S. Department of Health and Human Services from 1979-1981. The PSRO

[3] Ironically, Dr. Romano also purports to rely on inadmissible witness testimony from an investigational hearing – a practice that, according to Complaint Counsel, is improper.

[4] Copies of Dr. Chassin's and Dr. Romano's respective reports, without exhibits, were attached to Complaint Counsel's Motion.

program was the first nationwide effort to improve quality and control utilization in the Medicare program.[5]

B. Dr. Chassin's Analytical Framework

Dr. Chassin devotes 31 paragraphs of his report to describing a conceptual and analytic framework for defining, measuring and improving the quality of health care. As an initial matter, Drs. Chassin and Romano both agree that:

[REDACTED]

Chassin Report ¶ 20; Romano Report at 5.[6] Dr. Chassin will testify that, to properly assess quality under this definition, one must consider information from a variety of sources. Again, Dr. Romano agrees with this general approach when he says that

[REDACTED]

Romano Report at 8.

Dr. Chassin will then testify how he specifically assessed quality of care in this case – in particular, the important role of conducting witness interviews – consistent with his experiences as New York State Health Commissioner:

[REDACTED]

[5] This summary of Dr. Chassin's relevant experience is far from comprehensive. *See* Chassin Report ¶¶ 1-6.

[REDACTED]

Chassin Report ¶ 49 (emphasis added).

Dr. Chassin further explains in his report that his personal investigation of how the Merger affected quality of care included, among other things:

[REDACTED]

Chassin Report ¶¶ 51-52. Dr. Chassin's notes of his substantive interviews have been produced to Complaint Counsel. (In contrast, Dr. Romano did not produce any notes.)

[6] Dr. Chassin is an elected member of the Institute of Medicine ("IOM") of the National Academy of Sciences. Chassin Report ¶ 5. Dr. Chassin participated on the IOM committee that developed this widely-accepted definition of quality. Chassin Report ¶ 20.

IV. Complaint Counsel Submitted Two Rebuttal Reports On Quality Of Care Issues

Complaint Counsel submitted two rebuttal reports on quality of care issues – one by Dr. Romano and one by a newly-disclosed expert, Dr. Epstein.[7] Neither rebuttal expert relies on a "multi-method approach" like the one conducted by Dr. Chassin (in fact, Dr. Epstein does not cite any specific evidence, documentary or testimonial, in his rebuttal report). Instead, both rebuttal experts offer identical, unsupported criticism of Dr. Chassin's comprehensive methods – in particular, his reliance on witness interviews – to assess quality of care. Respondents and Dr. Chassin will establish at trial that Complaint Counsel's naked criticisms reflect nothing more than an effort to disguise the incomplete and erroneous analyses offered by Complaint Counsel's experts.

ARGUMENT

Complaint Counsel badly misconstrue the pertinent legal principles governing expert testimony. They challenge portions of Dr. Chassin's proffered testimony under Rule 702 of the Federal Rules of Evidence ("FRE"), which requires that expert testimony: (1) be based "upon sufficient facts or data," (2) be "the product of reliable principles and methods," and (3) result from a reliable application of those principles and methods "to the facts of the case." Fed. R. Evid. 703; *see also Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 150 (1999) ("[T]here are many different kinds of experts, and many different kinds of expertise.... The gatekeeper inquiry must be tied to the facts of a particular case."). In general, Complaint

[7] Complaint Counsel resort to claiming that Dr. Chassin offers "little to no bona fide expert opinion to begin with." Mot. at 2. This cheap shot is surprising given that Complaint Counsel submitted not one, but two, rebuttal experts in response to Dr. Chassin's report. Complaint Counsel fail to explain why they purportedly need two experts to rebut an expert opinion that is not "bona fide." The reason for this omission is obvious – Complaint Counsel are concerned that Dr. Chassin is a more credible expert than Dr. Romano. This is precisely why Complaint Counsel have proffered testimony by Dr. Epstein, who merely seconds Dr. Romano's opinions. As the Court is aware, Dr. Epstein's rebuttal report is the subject of a pending motion to strike because it is redundant and improperly usurps the role of the fact-finder. In the alternative, Respondents requested leave to submit a sur-rebuttal report.

Counsel assert that Dr. Chassin somehow acted inconsistently with FRE 702 when he relied, in part, on interviews of ENH employees to ascertain "the facts of the case" for the purpose of preparing his report and then applied these facts to established principles and methods.

Although Complaint Counsel's precise arguments are not clearly articulated, it appears as if they make two distinct claims to support their unprecedented request for an order requiring the parties "to meet and confer to narrowly tailor any testimony from Dr. Chassin to Rule 702 and 703 principles."[8] First, Complaint Counsel argue, without any support, that Dr. Chassin should not be permitted to rely on the trial testimony of fact witnesses because such testimony would "add[] nothing to the firsthand fact testimony and marshalling of the facts by counsel in briefs and argument." Mot. at 4. Second, they argue, contrary to express FRE language, that Dr. Chassin should be precluded from relying on hearsay statements from interviews with ENH employees who will not testify at trial. *Id.* Neither argument withstands scrutiny.

I. Dr. Chassin May Rely On The Testimony Of Trial Witnesses To Support His Opinions.

As Complaint Counsel acknowledge, experts must apply reliable principles and methods to the facts of the case. Dr. Chassin intends to do precisely that when he relies, in part, on the trial testimony of a number of fact witnesses who will testify at trial about quality of care issues. According to Complaint Counsel, Dr. Chassin should be precluded from explaining how this fact testimony supports his analysis because such an explanation purportedly would result in redundant trial testimony. This argument has absolutely no merit.

[8] Any such meeting would be unproductive because each and every opinion in Dr. Chassin's report easily satisfies these principles.

First, ample authority confirms that experts are expected to assist the trier of fact by applying the "facts of the case" to reliable principles and methods of a particular expertise. Indeed, expert opinions that offer only "subjective belief or unsupported speculation" are generally not admissible. *O'Conner v. Commonwealth Edison Co.,* 13 F.3d 1090, 1106 (7th Cir. 1994). Expert testimony must be founded on the record evidence. *Bourelle v. Crown Equip. Corp.* 220 F.3d 532, 539 (7th Cir. 2000). "[A]n expert's report that does nothing to substantiate [an] opinion is worthless, and therefore inadmissible." *Minasian v. Standard Chartered Bank, PLC*, 109 F.3d 1212, 1216 (7th Cir. 1997). While FRE 705 permits an expert to "testify in terms of opinion or inference and give reasons therefore without first testifying to the underlying facts or data," it certainly does not limit the ability of the expert to testify as to the facts underlying his opinion. FRE 705, Advisory Committee Notes, 1972 Proposed Rules (stating that "the rule allows counsel to make disclosure of the underlying facts or data as a preliminary to the giving of an expert opinion, if he chooses").

Second, the Federal Rules of Civil Procedure require that expert reports disclosed to opposing parties prior to trial contain "a complete statement of all opinions to be expressed and the basis and reasons therefor [and] the data or other information considered by the witness in forming the opinions." Fed. R. Civ. P. 26(a)(2)(B). Complaint Counsel assert that Dr. Chassin's discussion of "the basis and reasons" for his opinions is too complete to the point of being redundant of fact witness trial testimony. Of course, they cite no authority to support their position that portions of an expert report can be stricken on this ground.

II. Dr. Chassin May Rely On Hearsay Interview Statements To Support His Opinions.

A. The FRE Expressly Allow Experts To Rely On Hearsay.

Complaint Counsel erroneously assert that the FRE preclude Dr. Chassin from basing his opinions on witness interviews. Instead of quoting the pertinent portion of FRE 703 (which is only three sentences), Complaint Counsel elected to offer their own summary of that rule: "That rule provides that, regardless of the expert's methodology, admissibility of hearsay evidence purporting to support expert testimony is limited." Mot. 2. This is a gross mischaracterization of FRE 703, which states in full:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at *or before* the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, *the facts or data need not be admissible in evidence*. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their prejudicial effect.

Fed. R. Evid. 703 (emphases added). Complaint Counsel avoid quoting the first two sentences of this rule because they directly conflict with Complaint Counsel's argument that Dr. Chassin cannot rely on hearsay in forming his opinions. Instead, Complaint Counsel rely heavily on the last sentence of this rule. But that sentence discusses only what facts or data can be "disclosed to the jury" – an issue irrelevant here given that this case will not be tried before a jury. Weinstein's Federal Evidence § 703.05[2] at 703-27 ("A district court sitting as the trier of fact is presumed to be able to ignore inadmissible evidence.").

Federal Courts have consistently read FRE 703 to allow experts to rely on hearsay or otherwise inadmissible information in forming their opinions (thus avoiding a prolonged trial in which each and every witness relied on by the expert testifies). *See, e.g.*,

Baumholser v. Amax Coal Co., 630 F.2d 550, 553 (7th Cir. 1980) ("Barnes was testifying as an expert and as such was entitled to rely on hearsay evidence to support his opinion, so long as that evidence was of a type reasonably relied upon by other experts in the field. That evidence need not be independently admissible."). In particular, interviews by experts repeatedly have been admitted into evidence to show the basis for expert opinions. *United States v. Mulder*, 273 F.3d 91, 102 (2d Cir. 2001) (allowing testimony from expert who relied largely on the statements of detectives he supervised, victim contractors, and informants to form his opinions); *United States v. Lundy*, 809 F.2d 392 (7th Cir. 1987) (holding that arson expert could rely on interviews to form his opinions). Even in fields of expertise that may otherwise rely heavily on empirical data, interviews have been recognized, and admitted, as an appropriate basis for an expert's opinion. *United States v. Affleck*, 776 F.2d 1451, 1457 (10th Cir. 1985) (allowing accounting expert to relate to the jury the interviews that formed the basis of his opinion when empirical data was incomplete or unreliable); *see also, Local 159 v. Nor-Cal Plumbing, Inc.*, 1999 U.S. App. LEXIS 17968 (9th Cir. 1999) ("Because the district court determined that the data was of a type upon which accountants reasonably rely in forming their opinions, it did not err in permitting the experts to rely on this data in the course of their testimony or in admitting the data for the limited purpose of explaining the basis of their opinions."). Ex. 2.

FTC Administrative Law Judges ("ALJ") have set identical precedent. In *In the Matter of Champion Spark Plug Co.*, 1982 FTC LEXIS 81 (Aug. 20, 1982), Judge Timony allowed an expert to cite his telephone conversation with a K-Mart employee as the basis for his opinion that K-Mart does not install windshield wipers. Ex. 3. Similarly, in *In the Matter of R.R. Donnelley & Sons Co.*, 1993 FTC LEXIS 181 (July 28, 1993), the ALJ held that

"[e]xperts commonly rely on hearsay evidence to form their opinions." Ex. 4; *see also* Weinstein's Federal Evidence § 703.05[1] ("If underlying facts or data are of a type that the judge considers are reasonably relied on by experts in the field, they need not be admissible in evidence.").

Under this authority, Dr. Chassin may testify about his "multi-method approach" – even if the basis for his opinion relies, in part, on hearsay – because Dr. Chassin's approach is the type of method reasonably relied on by experts in his field. Chassin Report ¶ 50; s*ee also* American College of Obstetricians and Gynecologists, Voluntary Review of Quality of Care (ACOG Report, ENHLPK 029688-029787) (explaining that the evaluation of quality of care was based on "the hospital's preliminary data; a tour of the facility; interviews with members of the medical and nursing staff and hospital administration; and chart reviews.") (Ex. 5); Charles Vincent, *Understanding and Responding to Adverse Events*, 348 NEW ENG. J. MED., 1051, 1053 (2003) ("Although a considerable amount can be gleaned from written records, interviews with the people involved are the most important method of identifying contributory factors") (Ex. 6). In fact, the Joint Commission on the Accreditation of Healthcare Organizations ("Joint Commission" or "JCAHO") employs many of the same methods – including staff interviews – carried out by Dr. Chassin. *See, e.g.*, Joint Commission Accreditation Process ("The on-site survey process is a key activity in the accreditation process. The survey will consist of staff, resident and family interviews, tours, observations, and review of selected documentation in an effort to understand how your systems are compliant with the Joint Commission standards.").[9] Further, Dr. Romano states that

[REDACTED]

[9] *Available at* http://www.jcaho.org/accredited+organizations/health+care+network/survey+process/index.htm (last visited Dec. 29, 2004) (emphasis added) (Ex. 7).

[REDACTED]

Romano

Report at 7 (emphasis added). Even Complaint Counsel concede, as they must, that Dr. Chassin's approach, which "relies primarily on descriptions of purported improvements in the quality of care at HPH, . . . has gained wide acceptance." Mot. at 6. Accordingly, there can be no dispute that his reliance on hearsay evidence is permissible under FRE 703.

Nevertheless, Complaint Counsel ask the Court to ignore FRE 703, pertinent authority and Dr. Chassin's extensive background in assessing quality of care. According to Complaint Counsel, Dr. Chassin's reliance on witness interviews is necessarily unreliable because such method purportedly does not follow certain "parameters" deemed warranted by Dr. Romano "to ensure the reliability and validity of such work." *Id.* at 6-7. Complaint Counsel's argument can thus be summarized as follows: "Preclude Dr. Chassin from testifying because our expert says that his method is unreliable." Although we can understand why Complaint Counsel and Dr. Romano do not want the Court to hear from Dr. Chassin, this desire, of course, is no basis to strike any of Dr. Chassin's testimony.

B. Dr. Chassin Will Not Be A Mere "Mouthpiece" To Admit Hearsay Into Evidence But, Instead, Will Testify As To His Extensive Investigation That Forms The Basis Of His Opinion.

Complaint Counsel rely on select quotes from Dr. Chassin's report, taken out of context, in a misguided effort to portray Dr. Chassin as a mere "mouthpiece" through which Respondents intend "to funnel" fact witness testimony. Mot. at 6. And they badly mischaracterize Dr. Chassin's report when they assert that "Dr. Chassin virtually repeats the information he learned during interviews with ENH employees and associated physicians and

offers limited expert analysis." Mot. at 6. Dr. Chassin's employee interviews were part of a "multi-method approach" to reliably measure and evaluate quality of care improvements due to the Merger. Chassin Report ¶ 50. To claim, as do Complaint Counsel, that Dr. Chassin's report provides only a "factual narrative of hearsay information" overlooks pages of opinions that analyze the facts of this case – as reflected in data, documents and interviews – in the context of reliable principles and methods used in assessing quality of care. Mot. at 1.

Accordingly, it should hardly be surprising that Complaint Counsel have mischaracterized applicable precedent. In particular, Complaint Counsel confuse the distinction between evidence proffered in Dr. Chassin's report to show the basis for his expert opinion and evidence offered for the truth of the matter asserted.

This confusion is perhaps best highlighted in Complaint Counsel's reliance on the Ninth Circuit's holding in *Paddack v. Christensen*:

> In *Paddack*, 745 F.2d 1254, 1262 (9th Cir. 1984), for example, the court found that audit reports were hearsay and that the expert could not rely on such evidence to establish the truth of what they assert.

Mot. at 8. This holding is inapposite because Respondents have not offered Dr. Chassin's interview memoranda into evidence for the truth of the matters asserted. Indeed, these memoranda are not even on Respondents' exhibit list. To the extent Dr. Chassin refers to the interviews during his testimony at the hearing, the discussion will be admissible for the purpose of showing Dr. Chassin's basis for his opinion. The court in *Paddack* held that the hearsay audit reports at issue in that case were admissible for this purpose:

> Rule 703 merely permits such hearsay, or other inadmissible evidence, upon which an expert properly relies, to be admitted to explain the basis of the expert's opinion. *See Fox v. Taylor Diving & Salvage Co.*, 694 F.2d 1349, 1356 (5th Cir.1983) ("An expert is permitted to disclose hearsay for the limited purpose of explaining the basis for his expert opinion, Fed.R.Evid. 703, but not as

> general proof of the truth of the underlying matter, Fed.R.Evid. 802."). *See generally* S. Saltzburg & K. Redden, *Federal Rules of Evidence Manual* 467 (3d ed. 1982). It does not allow the admission of the [audit] reports to establish the truth of what they assert.

Paddack, 745 F.2d at 1261-62 (emphasis added). Thus, while the audit reports could not become admissible for the truth of the information they contained, they were clearly admissible for the limited purpose of showing the basis for the expert's opinion. *Id.* *Paddack* thus supports Respondents' position that Dr. Chassin can testify at trial about his interviews to explain the basis for his opinions.

Complaint Counsel similarly place undue reliance on the holding in *United States v. Lundy*, 809 F.2d 392 (7th Cir. 1987). In *Lundy*, an arson expert based his opinion, in part, on interviews regarding the defendant's motives, plan and opportunities to start the fire. The Seventh Circuit held that the expert's use of such interviews constituted admissible opinion testimony because arson investigators rely on interviews as part of their inquiries into the cause of a fire. *Id.* at 395 (holding "hearsay and third-party observations that are of a type normally relied upon by an expert in the field are properly utilized by such an expert in developing an expert opinion"). This holding is consistent with Dr. Chassin's proffered testimony – which, as discussed above, is of a type reasonably relied on by experts in his field.

Finally, the decision in *Wantanabe Realty Corp. v. City of New York*, 2004 WL 188088 (S.D.N.Y. Feb. 2, 2004), is easily distinguished. In *Wantanabe*, the court ruled inadmissible the testimony of a damages expert who was merely passing along to the jury a single price quote from a single company.[10] *Id.* at *2. Literally, the entirety of the information

[10] The court held that the expert testimony was inadmissible on the alternative ground that no expert would base an opinion on "a single quotation provided by a foreign manufacturer" and that it was unclear how the expert would have assisted the trier of fact in understanding the evidence, as a jury certainly would have been capable of reading the Intamin estimate." Wantanabe, 2004 WL 188088 at *2 n.25 (S.D.N.Y. Feb. 2, 2004). Ex. 8.

being passed off as expert analysis was the single company's price quote. *Id.* The testimony lacked any expert compilation and analysis of a competitive bid for the particular job. *Id.* Dr. Chassin's expert opinion, on the other hand, is based on multiple interviews and empirical data when available and reliable. Most importantly, Dr. Chassin's 124-page report analyzes the facts of this case – as determined by, among other sources, witness interviews – in light of his quality of care expertise. His proffered testimony thus goes far beyond the scant analysis at issue in *Wantanabe*.

C. The Specific Examples Cited By Complaint Counsel, When Viewed In Context, Demonstrate The Comprehensive Nature And Reliability Of Dr. Chassin's "Multi-Method Approach."

Complaint Counsel address three opinions by Dr. Chassin that purportedly support their view that the parties should meet-and-confer to limit his testimony. But all three of these topics addressed by Dr. Chassin demonstrate that he properly applies the facts of this case to his "multi-method approach." Indeed, most of the underlying facts relied on by Dr. Chassin in the three examples will be discussed by trial witnesses – thus rendering Complaint Counsel's argument that they are deprived a cross-examination right even more meritless.

1. Dr. Chassin Properly Assesses Problems In HPH's Obstetrics And Gynecology Department.

Dr. Chassin's assessment of the pre-merger obstetrical and gynecological ("OB/GYN") services at HPH was specific and supported by data from a variety of sources. Complaint Counsel's assertion that these "sweeping statements and others like them are highly prejudicial and useless" ignores the type of information Dr. Chassin relied upon. In completing his review of OB/GYN services at HPH, Dr. Chassin included an analysis of external audits performed by third parties:

[REDACTED]

[REDACTED]

Chassin Report ¶¶ 59-60.

[REDACTED]

Chassin Report ¶¶ 61, 64.

Dr. Chassin relied on two separate reviews by outside organizations (ACOG and CHRPP), in addition to qualitative interviews, to complete his analysis of this service at HPH. The fact that these particular examples were also identified as problem areas by contemporaneous pre-merger audits of HPH, and corroborated by ENH personnel, further illustrates that Dr. Chassin's analysis was objective and comprehensive in scope.

2. <u>Dr. Chassin Properly Assesses Problems In HPH's Nursing Culture.</u>

Dr. Chassin considered several sources of information in the scope of his review of pre-merger nursing services at HPH. For example, his analysis of nursing services is predicated, in part, on contemporaneous documentation of HPH's pre-merger problems with nursing services, external audits of the same issue, as well as interviews of ENH personnel with first-hand knowledge. The following excerpt from Dr. Chassin's report illustrates this multi-source approach:

[REDACTED] [11]

11 Citing Krasner Interview.

[12]

[REDACTED]

[13]

[REDACTED]

[14, 15]

Chassin Report ¶ 69.

Dr. Chassin did not merely rely on ENH employees' accounts of the dysfunctional nursing culture at HPH pre-merger but, rather, he sought and obtained other, objective documentation of the issue that corroborated information obtained from interviews. The documentary evidence, coupled with qualitative interviews, formed the basis of Dr. Chassin's analysis of this issue. Dr. Chassin purposefully included different types and sources

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12 Citing Mayer Interview, Krasner Interview, and Hansfield Interview.

13 Citing *Bolduan v. Highland Park Hospital.*

14 Citing ANCC Magnet Recognition Program website, *available at* http://www.nursingworld.org/ancc/magnet/benes.html (last visited, Nov. 1, 2004).

15 Citing Havens, D. and Aiken, L., Shaping Systems to Promote Desire Outcomes, the Magnet Hospital Model. *Journal of Nursing Administration*; Vol. 29:2 (February 1999).

of information in his analysis in an effort to be as comprehensive as possible. Had Dr. Chassin omitted interviews of pertinent fact witnesses, Complaint Counsel likely would have criticized him for potentially excluding relevant sources of information from his analysis. The fact that the qualitative interviews and documentary evidence reveal congruent information is a testament to the reliability and validity of Dr. Chassin's approach.

Complaint Counsel argue that certain of Dr. Chassin's specific assessments of problems in HPH's nursing culture are too "vague" and thus "misleading." Mot. at 10-11. These arguments are addressed, and discredited, below.

a. Dr. Chassin's Analysis Of The Underreporting Of Medical Errors At HPH Is Neither Vague Nor Misleading.

[REDACTED]

The following report excerpt discusses the process that HPH employed pre-Merger for the reporting of medication errors, one type of medical error:

[REDACTED] [16]

17

16 Citing James B. Every Defect a Treasure: Learning From Adverse Events in Hospitals. *Medical Journal of Australia* 1997;166:484-87; *see also* Jha AK, et al. Identifying Adverse Drug Events: Development of a Computer-Based Monitor and Comparison With Chart Review and Stimulated Voluntary Report. *JAMIA* 1998;5:305-14.

17 Citing Mayer Interview.

Chassin Report ¶ 114.

Dr. Chassin further applied the facts garnered from several sources to the appropriate standards and benchmarks established by several authoritative sources, including external accrediting bodies, such as the Joint Commission:

[REDACTED]

[18]

Chassin Report ¶ 98 (emphasis added). Dr. Chassin's conclusions regarding the effect of HPH's pre-merger nursing culture on the underreporting of medical errors, including medication errors, is based on well-established principles in the field of healthcare quality assessment. To the extent Complaint Counsel disagree with this line of reasoning, they will have an opportunity to cross-examine both Dr. Chassin and the appropriate fact witnesses on this issue (as well as other quality of care issues) at trial.

b. Dr. Chassin's Analysis of HPH Pre-Merger Nursing Culture Is Neither Vague Nor Misleading.

Dr. Chassin employed a multi-faceted approach to assess a particular clinical service area with a variety of available information. As with other areas, Dr. Chassin's analysis of the nursing culture at pre-merger HPH is based on a review of the documentary record, as well as qualitative interviews:

[REDACTED]

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18 Citing Chassin and Becher, The Wrong Patient and Sentinel Event Alert Issue No. 30.

19

[REDACTED]

20

Chassin Report ¶ 95.

In addition, Complaint Counsel's contention that whether a nursing culture is punitive is an issue of fact, not expert opinion, is misguided. Dr. Chassin clearly enumerates several well-established criterion used to assess the quality of nursing services. For example, Dr. Chassin's consideration of and reliance upon the organizational elements of nursing culture

[REDACTED]

as used by the American Nursing Credentialing Center, provides a clear delineation of the factors – or the absence of which – that Dr. Chassin considered in concluding that pre-merger HPH had a punitive nursing culture. Chassin Report ¶ 96. Against those standards, Dr. Chassin concluded:

[REDACTED]

Chassin Report ¶ 98.

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19 Citing Mayer Interview and O'Brien Interview.

20 *Id.*

Applying the facts regarding HPH's pre-merger nursing services to the organizational elements of nursing culture falls well within the province of expert opinion.

3. Dr. Chassin Properly Assesses Problems in HPH's Quality Assurance Program.

Complaint Counsel also criticize Dr. Chassin's analysis of HPH's pre-merger Quality Assurance ("QA") program, including: adverse event case reviews; medication error reporting; and physician discipline. Chassin Report ¶¶ 106-117. Regarding Dr. Chassin's analysis of physician discipline, Complaint Counsel assert that "Dr. Chassin should be precluded from testifying to this statement because it is very misleading." Mot. at 12.

[REDACTED]

Chassin Report ¶ 117. These are facts and, therefore, Complaint Counsel offer no explanation as to how this analysis is misleading. In any event, Complaint Counsel may choose to exercise their right of cross-examination if they disagree with Dr. Chassin's testimony.

Complaint Counsel also request that paragraph 114 of Dr. Chassin's report concerning medication errors be excluded. Mot. at 12. It is unclear, however, what Complaint Counsel find inappropriate about Dr. Chassin's analysis concerning medication errors given that he reviewed contemporaneous documentation and can be cross-examined on his analysis and attendant conclusions:

[REDACTED]

[REDACTED]

Chassin Report ¶ 114. The same reports cited in the foregoing excerpt were, of course, also available to Complaint Counsel for analysis by their quality of care experts. Complaint Counsel fail to identify any principled reason for excluding this analysis as the information is the type relied upon by experts in the field of healthcare quality evaluation.

Finally, Complaint Counsel allege that they are prejudiced because Respondents have omitted various witnesses from their witness list with knowledge concerning pre-merger QA at HPH. But Respondents, through their initial disclosures and supplements thereto, have informed Complaint Counsel of the existence of persons knowledgeable about quality of care at HPH. Further, pre-merger HPH quality of care personnel have been identified during the discovery depositions of Respondents' employees. Complaint Counsel thus had ample opportunity to depose all pertinent witnesses. Indeed, Complaint Counsel have included two such witnesses on their witness list (Peggy King and Lois Huminiak).

D. Complaint Counsel's Cries Of "Prejudice" Are Unfounded.

Complaint Counsel repeatedly argue that allowing Dr. Chassin to testify about his thorough investigation of quality of care issues would be unduly prejudicial because such testimony would deprive Complaint Counsel of their right to cross-examine witnesses. As

demonstrated above, however, Complaint Counsel misconstrue the pertinent legal standard, which expressly allows experts to base their opinions on hearsay and limits that right only in the context of a jury trial. Regardless, Complaint Counsel neglect to mention that the employees interviewed by Dr. Chassin were disclosed to Complaint Counsel during discovery – through Respondents' initial disclosures, witness lists as well as the reams of documents (both hard copy and electronic) produced concerning quality of care issues.

Indeed, Complaint Counsel have deposed eleven of the witnesses interviewed by Dr. Chassin, eight of these witnesses appear on Respondents' final proposed witness list, and (as indicated above) an additional two of these witnesses appear on Complaint Counsel's final proposed witness list. Complaint Counsel have had, and will have at trial, ample opportunity to cross-examine witnesses interviewed and relied on by Dr. Chassin. Finally, Complaint Counsel will have their opportunity to depose Dr. Chassin on his witness interviews and argue to the Court that Dr. Romano's more limited approach in assessing quality of care somehow is more reliable.

III. Complaint Counsel's Requested "Meet and Confer" Remedy Is Peculiar And Inappropriate.

Complaint Counsel attempt to dodge their burden of identifying proffered expert testimony that should be stricken as a matter of law when they request "an order requiring the Parties to meet and confer to narrowly tailor any testimony from Dr. Chassin to F.R.E. 702 and 703 principles." Their proposal of such a meet-and-confer is unprecedented and highlights that this issue is not appropriate for the *in limine* context. Again, to the extent Complaint Counsel believe that Dr. Chassin's comprehensive "multi-method approach" somehow is less reliable than the limited method used by Dr. Romano, Complaint Counsel can depose and cross-examine Dr. Chassin on this issue and have Dr. Romano defend his method

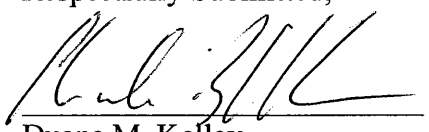
at trial. Moreover, Complaint Counsel's proposed meet-and-confer process is unworkable given the tight pre-trial expert deposition schedule (at least seven, and as many as eleven, expert depositions need to be taken in the few weeks left before trial).

CONCLUSION

For the foregoing reasons, Respondent request that the Court deny Complaint Counsel's Motion In Limine To Exclude Certain Testimony Of Dr. Mark Chassin.

Dated: January 12, 2005

Respectfully Submitted,



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Counsel for Respondent

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

In the matter of	)	
Evanston Northwestern Healthcare Corporation, a corporation, and	)	Docket No. 9315
ENH Medical Group, Inc., a corporation.	)	

ORDER

Upon consideration of Complaint Counsel's Motion *In Limine* to Exclude Certain Testimony of Dr. Mark Chassin, Respondents' opposition thereto, any hearing thereon, and the entire record in this action, it is hereby

ORDERED, that the Motion is DENIED.

The Honorable Stephen J. McGuire
Chief Administrative Law Judge

Date: _____, 2005

CERTIFICATE OF SERVICE

I hereby certify that on January 12, 2005, copies of the foregoing Respondents' Opposition to Complaint Counsel's Motion *In Limine* to Exclude Certain Testimony of Dr. Mark Chassin and a proposed order **(Public Record Version)** were served (unless otherwise indicated) by email and first class mail, postage prepaid, on:

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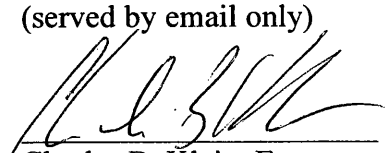

Charles B. Klein, Esq.

Exhibits

Everything Old is New Again: Health Care and Competition in the 21st Century

Prepared Remarks of

Timothy J. Muris*
Chairman

Federal Trade Commission

Before

7th Annual Competition in Health Care Forum

Chicago, Illinois

November 7, 2002

*This speech does not necessarily reflect the views of the Commission or any other individual Commissioner.

Exhibit 1

Thank you for inviting me to address the 7th Annual Competition in Health Care Forum. Chicago is a singularly appropriate location for this forum – particularly the 7th such forum. The 7th Circuit Court of Appeals, which has issued a series of seminal opinions in health care antitrust, is located just a few miles from here. One can track many of the major developments in health care antitrust in the last few decades simply by listing the names of 7th Circuit cases, including *Indiana Federation of Dentists*,[1] *Ball Memorial Hospital*,[2] *Hospital Corporation of America*,[3] *Schachar*,[4] *Wilk*,[5] *Rockford Memorial Corporation*,[6] *Marrese*,[7] *Sanjuan*,[8] *Marshfield Clinic*,[9] and *In re Brand Name Prescription Drugs Antitrust Litigation*.[10]

Chicago is also an appropriate place to discuss antitrust and the professions because it is the home to professional organizations representing physicians, surgeons, dentists, hospitals, and lawyers. Each of these professions and professional organizations has been involved in important antitrust cases – some initiated by the Commission and others by private plaintiffs.[11] The antitrust cases brought against these organizations transformed the market for professional services and played important roles in the

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1 *Indiana Fed'n of Dentists v. FTC*, 745 F.2d 1124 (7th Cir. 1984), *rev'd*, 476 U.S. 447 (1986).

2 *Ball Mem'l Hosp. Inc., v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

3 *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381 (7th Cir. 1986).

4 *Schachar v. American Academy of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989).

5 *Wilk v. American Med. Ass'n*, 895 F.2d 982 (7th Cir. 1990); *Wilk v. American Med. Ass'n*, 719 F.2d 207 (7th Cir. 1983).

6 *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990).

7 *Marresse v. American Academy of Orthopedic Surgeons*, 977 F.2d 585 (7th Cir. 1992).

8 *Sanjuan v. American Bd. of Psychiatry and Neurology, Inc.*, 40 F.3d 247 (7th Cir. 1994).

9 *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995).

10 *In re Brand Name Prescription Drugs Antitrust Litigation*, 288 F.3d 1028 (7th Cir. 2002); *In re Brand Name Prescription Drugs Antitrust Litigation*, 186 F.3d 781 (7th Cir. 1999); *In re Brand Name Prescription Drugs Antitrust Litigation*, 123 F.3d 599 (7th Cir. 1997).

11 *See, e.g., American Med. Ass'n*, 94 F.T.C. 701 (1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982) (physicians); *Wilk v. American Med. Ass'n*, 719 F.2d 207 (7th Cir. 1983) (physicians, surgeons, hospitals); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (lawyers); *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir. 1977) (dentists). For a comprehensive review of antitrust health care cases brought by the FTC, see Health Care Services and Products Division, *FTC Antitrust Actions in Health Care Services and Products*, available at <http://www.ftc.gov/bc/hcindex/hcupdate020118.pdf>.

development of antitrust law. These cases also had a powerful impact on public attitudes toward competition and the professions.

I will talk this afternoon about several subjects, including the nature of the current health care marketplace, the importance of competition in health care, the kinds of anticompetitive behavior the Commission is seeing, the agency's enforcement and research agenda, its efforts to protect and promote quality and efficiencies, and the Commission's various initiatives in health care since I became Chairman 17 months ago. First, though, I wanted to spend a few minutes on the title of my talk.

My speech this afternoon is titled "Everything Old is New Again: Health Care and Competition in the 21st Century." As most of you know, I'm a recovering law professor. Law professors typically use colons in the titles of their articles and speeches. Law professors also routinely explain the significance of their titles, especially why they unify, synthesize, clarify, and otherwise illuminate the subject. My aim is more modest; my title simply reflects several points I want to emphasize about the health care marketplace and the Commission.

First, as a nation we are seeing dramatic premium increases for health care coverage of a sort not experienced for almost a decade.[12] During the mid-1990s, many believed that managed care had solved the problem of ever-increasing health care costs. That assessment was unduly optimistic. The recent cost increases helped make health care a live issue on the legislative and policy agenda. The Commission will confront

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[12] Jon R. Gabel et al., *Job Based Health Benefits in 2002: Some Important Trends*, 21 HEALTH AFF., Sept.-Oct. 2002, at 143; Bradley C. Strunk et al., *Tracking Health Care Costs*, Health Affairs Web Exclusive (Sept. 26, 2001), available at http://www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_92601.htm.

novel fact patterns and legal issues as the private sector develops new strategies to address these cost increases, while simultaneously ensuring access and high quality.

Second, the Commission continues to see a wide variety of overt anticompetitive behavior in health care, along with some new variants. The Commission continues to bring cases against physicians alleging price fixing – much like those brought by the agency during the last 20 years – although several of the new cases involve an unprecedented number of doctors and consultants, who coordinated the conduct under the guise of assisting in negotiations with payors.

Conversely, the Commission's pharmaceutical docket reflects a new variation on an old theme. The Commission has brought cases against branded and generic pharmaceutical companies that have engaged in a variety of forms of alleged anticompetitive conduct. Pharmaceutical cases account for the majority of the Commission's antitrust resources devoted to health care and a sizeable percentage of the Bureau of Competition's budget.[13] The agency also spent a great deal of time this year preparing an empirical study of the performance of the Hatch-Waxman Amendments.[14] The report of this study included concrete recommendations to address the possibility of future abuse of the Hatch-Waxman framework. These efforts have had far-reaching consequences; about two weeks ago, the President announced that the Food and Drug Administration would take regulatory action to curb the most important problem the Commission's study identified.[15]

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[13] In 1996, less than 5% of new competition investigations involved pharmaceuticals, while in 2001, the percentage of new investigations involving pharmaceutical products was almost 25%.

[14] *See Generic Drug Entry Prior to Patent Expiration: An FTC Study* (July 2002), available at <http://www.ftc.gov/os/2002/07/genericdrugstudy.pdf>.

[15] *See* Food and Drug Administration, *Applications for FDA Approval to Market a New Drug: Patent Listing Requirements and Application of 30-Month Stays on Approval of Abbreviated New Drug Applications Certifying That a Patent Claiming a Drug is Invalid or Will Not be Infringed*, 67 Fed. Reg.

Third, from a more personal perspective, the Commission has been pounding the health care antitrust beat since the Supreme Court established in *Goldfarb* that there was no "learned professions exception" to the antitrust laws.[16] Indeed, even before the Supreme Court's 1975 decision in *Goldfarb,* the agency established a task force to investigate occupational regulations in several industries, including health care. I was proud to play a role in launching that effort as an assistant to the Director of the FTC's Policy Planning Office, my first job at the Commission. As Chairman, I can assure you that the FTC will continue to address anticompetitive conduct in health care. In this task, the FTC is aided by its partners at the Department of Justice and the state attorneys general.

Fourth, in addition to antitrust, the Commission also has an important consumer protection role in the market for healthcare goods and services. Miracle cures and snake-oil are far older than the Commission, but the rise of the Internet and cross-border marketing has simultaneously increased the rewards and decreased the costs and risks of defrauding people. Deceptive and unfair marketing practices are far too common in health care. The Commission has undertaken several important initiatives in this area, including Operation Cure.All, which challenged deceptive and unsubstantiated health claims for serious illness.[17] The FTC has also focused its attention on purveyors of

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65448 (Oct. 24, 2002), available at <http://www.fda.gov/OHRMS/DOCKETS/98fr/102402b.htm>. *See also Statement of Federal Trade Commission Chairman Timothy Muris on the FDA's Proposals to Improve Consumer Access to Lower-Cost Generic Drugs* (Oct. 21, 2002), available at <http://www.ftc.gov/opa/2002/10/murisfda.htm>.

16 *See Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). For a historical perspective on the Commission's involvement in health care, *see* Carl F. Ameringer, *Federal Antitrust Policy and Physician Discontent: Defining Moments in the Struggle for Congressional Relief*, 27 J. HEALTH, POLITICS, POL'Y & L. 543 (2002).

17 *See Operation Cure.All: Introduction*, available at <http://www.ftc.gov/bcp/conline/edcams/cureall/index.html>; *Bogus Cancer Care Guru Settles FTC Charges*, (Oct. 28, 2002), available at <http://www.ftc.gov/opa/2002/10/walker.htm>.

anthrax tests and weight loss products when those products do not perform as advertised.[18]

A more general consumer protection problem in health care is the relative scarcity of information about cost and quality. Without good information, transaction costs and uncertainty increase dramatically. Consumers have great difficulty obtaining the goods and services they desire. The Commission has been a strong voice for allowing competition to deliver truthful and accurate information to consumers, and has long supported the voluntary disclosure of truthful non-deceptive information by market participants. Nobel Laureate George Stigler once observed that advertising is "an immensely powerful instrument for the elimination of ignorance."[19] Studies by the Bureau of Economics have confirmed that advertising provides a powerful tool to communicate information about health and wellness to consumers – and the information can change people's behavior.[20] Two months ago, the FTC staff responded to a request by the FDA for comments addressing whether its regulations, guidelines, policies, and practices comply with the First Amendment. These staff comments outlined the empirical evidence on the benefits to consumers from the free flow of truthful and non-deceptive commercial information.[21] These actions exemplify the Commission's commitment to consumer empowerment through information.

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[18] *See Tipping the Scales? Weight Loss Ads Found Heavy on Deception* (Sept. 2002), available at <http://www.ftc.gov/bcp/conline/features/wgtloss.htm>; *FTC Announces First Two Enforcement Actions Against Purveyors of Bioterrorism Defense Products* (Feb. 27, 2002), available at <http://www.ftc.gov/opa/2002/02/vitalraw.htm>.

[19] George J. Stigler, *The Economics of Information*, 69 J. POLIT. ECON. 213 (1961).

[20] *See* Pauline Ippolito & Jan Pappalardo, *Advertising, Nutrition & Health: Evidence from Food Advertising 1977-1997, FTC Bureau of Economics Staff Report* (Sept. 2002), available at <http://www.ftc.gov/opa/2002/10/foodads.htm>.

[21] *FTC Staff Provides FDA With Comments on First Amendment Commercial Speech Doctrine* (Sept. 22, 2002), available at <http://www.ftc.gov/opa/2002/09/fdacomment.htm>.

Much remains to be accomplished in this area of the law to ensure that the market for health care goods and services operates efficiently. If I surveyed the public about whether they had better information about their last purchase of health care services or their last car, we all know what the answer would be. Information about the cost and quality of a wide array of cars is readily available from car manufacturers, dealers, car and consumer magazines, and friends and neighbors. The Internet provides a powerful tool to tap such information and reduce the costs of buying a vehicle.[22] Trying to get similar information about health care goods and services is far more difficult, although there have been some promising recent developments.[23]

Finally, and most important, although there is plenty of misinformation and misapprehension about the role of the Commission and the application of the antitrust laws to the health care marketplace, the FTC's basic task remains the same as it has always been. The Commission works to ensure that the approximately 15% of our nation's GDP devoted to health care, amounting to about $1.3 trillion per year, is spent in robustly competitive markets. Aggressive competition promotes lower prices, higher quality, greater innovation, and enhanced access. More concretely, in health care, competition results in new and improved drugs, cheaper generic drugs, treatments with

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[22] Of course, the quality and reliability of the information that is obtained is a separate matter. *See* Jane E. Brody, *The Hazards of Point-and-Click Medicine,* N.Y. TIMES, Aug 31, 1999, at F1.

[23] *See* Arnold M. Epstein, *Public Release of Performance Data: A Progress Report From the Front,* 283 JAMA 1884 (2000); Stephen F. Jencks, *Clinical Performance Measurement – A Hard Sell,* 283 JAMA 2015 (2000); Daniel R. Longo, et al., *Consumer Reports in Health Care: Do They Make a Difference in Patient Care?,* 278 JAMA 1579 (1997); Eric C. Schneider & Arnold M. Epstein, *Influence of Cardiac-Surgery Performance Reports on Referral Patterns and Access to Care: A Survey of Cardiovascular Specialists,* 335 NEW ENGL. J. MED. 251 (1996).

These informational difficulties are not unique to health care. Similar informational impediments affect the markets for most professional services, including lawyers.

less pain and fewer side effects, and treatments offered in a manner and location consumers desire.[24]

The Commission does not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the marketplace. What the Commission does have is a commitment to vigorous competition in both price and non-price parameters. The FTC supports initiatives to enhance quality of care and ensure the free-flow of information because such initiatives benefit patients. The staff issued a favorable opinion to one such initiative, MedSouth in Denver, involving clinical integration,[25] and the staff is currently considering other requests for guidance. The FTC recently closed an investigation in which physician collaboration resulted in a substantial degree of market concentration because the parties demonstrated that considerable efficiencies resulted, notably dramatic improvements in the quality of care. There is great flexibility for health care providers to develop and implement novel financing and delivery arrangements without running afoul of the antitrust laws, although, not surprisingly, the FTC draws the line at anticompetitive conduct.

Simply stated, there is no inherent inconsistency between vigorous competition and the delivery of high quality health care. Theory and practice confirm that quite the opposite is true – when vigorous competition prevails, consumer welfare is maximized in health care and elsewhere in the economy. Interference with competition is far more likely to decrease consumer welfare than increase it. As the Supreme Court observed in *Indiana Federation of Dentists*, such interference necessarily and improperly preempts

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[24] *See, e.g.*, Frank R. Lichtenberg, *Are the Benefits of Newer Drugs Worth Their Cost? Evidence From the 1996 MEPS*, 20 HEALTH AFF., Sept.-Oct. 2001, at 241.

[25] Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002) (staff advisory opinion re: MedSouth, Inc.), available at <http://www.ftc.gov/bc/adops/medsouth.htm>.

"the working of the market by deciding . . . that customers do not need that which they demand."[26]

So much for my title. Let me now address in greater detail the issues that bring us here today. As Bob Pitofsky, my good friend and immediate predecessor as Chairman, noted in a speech he gave five years ago, "in health care as in no other area, there appears to be a recurring need to return to first principles, and to talk about why competition and antitrust enforcement make sense."[27] As Bob correctly observed in the very next sentence of his speech, it is one of the singular ironies of work at the Commission that even "as markets have become more competitive and our antitrust analysis more sophisticated, and even as policy makers rely more and more on competition as a useful tool for improving the delivery of health care, the question continues to be raised: is competition a good idea in this context?"[28]

My perspective, both as Chairman of the FTC and as an academic, is that competitive markets systematically outperform all alternative forms of distribution. Problems in the market are always a matter of concern, and the Commission exists to address a variety of such problems. A comparative institutional perspective makes clear, however, that every arrangement for delivering goods and services is imperfect.[29] It is a classic nirvana fallacy to assume that because markets are not perfect, a market-replacing

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[26] *Indiana Fed'n of Dentists v. FTC*, 476 U.S. 447, 459 (1986). *See also* Robert Pitofsky, *Prepared Statement of Federal Trade Commission Concerning H.R. 1304* (June 22, 1999), available at <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm> ("The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace."). Of course, the presence of insurance complicates the picture, because the availability of coverage creates moral hazard problems by lowering the marginal cost of consuming particular health care services.

[27] Robert Pitofsky, *Thoughts on Leveling the Playing Field in Health Care Markets*, National Health Lawyers Association Twentieth Annual Program on Antitrust in the Health Care Field, Washington, D.C., (Feb. 13, 1997), available at <http://www.ftc.gov/speeches/pitofsky/nhla.htm>.

[28] *Id.*

[29] *See* Neil K. Komesar, *Imperfect Alternatives: Choosing Institutions in Law*, 1994 ECONOMICS AND PUBLIC POLICY 204 ("Bad is often best because it is better than the available alternatives.").

alternative necessarily will be better.[30] Unfortunately, such reasoning prevails far too often in discussions of health policy – a fact that helps explain the continuing need to return to first principles.

Whenever one encounters a market problem, the correct response is to correct the market imperfection, and then allow the market to work. The wrong response is to assume the market cannot work and regulate it out of existence. Consider for a moment your reaction if someone told you that cars were too important a product to be left to the vagaries of the market. There are many reasons there might be failures in the markets for new and used cars. Cars are an infrequent purchase. Pricing is far from transparent, particularly if you are leasing or have a trade-in. Quality is difficult to discern, particularly in used cars. There are so many options and models, it is hard to make meaningful comparisons among different manufacturers. Yet, despite these potential problems, we rely on the market – backstopped by some modest safety and disclosure regulations and a limited products liability regime – to deal with millions of discrete purchase and sale transactions every year.

The Performance of the Health Care Market

Of course, health care and cars are not identical, but the differences are not as large as some people assume. What is known about the performance of the health care market along the relevant dimensions of cost, quality, and access?

Cost is obviously the most easily noticeable factor for many people. The total amount spent on health care in the United States is about $1.3 trillion per year.[31] Federal,

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[30] *See* Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969) ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This nirvana approach differs considerably from a comparative institution approach in which the relevant choice is between alternative real institutional arrangements.")

state, and local spending accounts for 45% of the total; private insurance and other private spending accounts for 40%; and consumer out-of pocket spending accounts for 15%. The amount spent on health care rose substantially during the 1970s and 1980s but stabilized during most of the 1990s at around 13.5% of GDP.[32] The last few years have seen the return of dramatic cost increases, some attributable to increased utilization and some attributable to increased prices.[33] Hospital care just surpassed pharmaceuticals as the key driver of increased health care costs.[34]

The $1.3 trillion spent by Americans on health care every year purchases a wide array of medical goods and services. Approximately 32% goes to in-patient hospital care. That figure has declined substantially over the past twenty years, as outpatient care has increased and hospitalization rates and lengths of stay have declined. Only 22% is spent on physician and clinical services, although physicians affect a far larger percentage of total expenditures on health care. Prescription drugs account for about 9%, a figure that has increased substantially over the past decade. The remaining 37% is split between long-term care, administrative, and other expenditures.

Quality presents a more variable picture. At its best, American health care is *the* best in the world. Our markets for innovation in pharmaceuticals and medical devices are second to none. People from all over the world come to the United States to receive cutting-edge treatments from physicians using the most sophisticated technology available. American know-how has made it possible for millions of people with health problems to live productive, pain-free lives.

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31 *See* Centers for Medicare & Medicaid Servs., *U.S. Health Care System,* available at <http://www.cms.gov/charts/series/sec1.pdf>, page 6.

32 *Id.* at 3.

33 *Id.* at 5. *See also* Strunk, *supra* note 12.

34 *Id.*

Nevertheless, health care quality varies tremendously without regard to cost, source of financing, and patient preferences. Local practice norms play a significant role; in health services research circles, experts believe that "geography is destiny" in determining the care one receives.[35] The Institute of Medicine reports on medical error and patient safety attracted wide attention, but several decades of health services research literature documents pervasive quality shortcomings, whether one considers acute care, chronic care, or preventative care.[36]

On the access side, approximately 65% of the under-65 population, or roughly 177 million Americans, obtain health insurance through their employers.[37] Most employees of large and medium-sized corporations are offered employment-based coverage, although not all choose to purchase it. Dependents of employees can usually obtain coverage through the working member of the family.[38] Employment-based coverage is much less available to those who work in certain industries (e.g., agriculture, retail, and food service), temporary and part-time employees, and those who work for

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[35] Dartmouth Atlas of Health Care in the United States, Chapter 7, available at <http://www.dartmouthatlas.org/98US/chap_7_sec_1.php> ("The reality of health care in the United States is that geography is destiny. The amount of care consumed by Americans depends more on where they live – the local supply of resources and the prevailing practice style - than on their needs or preferences")

[36] *See, e.g.* Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001); Institute of Medicine, *To Err Is Human* 16 (1999); Mark A. Schuster, Elizabeth A. McGlynn, and Robert H. Brook, *How Good Is the Quality of Health Care in the United States?* 76 Milbank Quarterly 517 (1998); Mark R. Chassin, Robert Galvin & The National Roundtable on Health Care Quality, *The Urgent Need to Improve Health Quality,* 280 JAMA 1000 (1998); Paul D. Cleary & Susan Edman-Levitan *Health Care Quality: Incorporating Consumer Perspectives,* 278 JAMA 1608 (1997); Robert H. Brook, *Managed Care is Not the Problem, Quality Is,* 278 JAMA 1612 (1997).

[37] *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH, POL'Y, L. & ETHICS 23, 26 (2001). It is an oversimplification to equate access with whether one has insurance. The absence of coverage, however, has a substantial impact on how many medical services one receives, how timely the services are provided, and the dollar value of those services. *See* Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured* (May 10, 2002) http://www.kff.org/content/2002/20020510/may10pres.pdf. *But see* Helen Levy and David Meltzer, *What Do We Really Know about whether Health Insurance Affects Health?*, JCPR WORKING PAPER 275 (Jan. 24, 2002) http://www.jcpr.org/wpfiles/levy_meltzer.pdf.

[38] *See* Hyman & Hall, *supra* note 37, at 26. As employment-based health insurance coverage has evolved toward increased cost sharing in recent years, fewer employees have elected to cover family members through such insurance.

small businesses.[39] Medicare, Medicaid, and other governmental programs cover approximately 75 million Americans. Approximately 40 million Americans are uninsured in any given year. Relatively few Americans are chronically uninsured, however, and the uninsured do have some access to medical care, including emergency care.[40]

For access, the most significant development of the last decade was the rise and decline of managed care – particularly of the more restrictive forms of managed care.[41] In 1988, almost 80% of people with health insurance had traditional indemnity coverage.[42] The most recent figures indicate that only about 5% of people with health insurance still have indemnity coverage.[43] Preferred provider organizations, which accounted for 11% of the coverage market in 1988 now have 52% of the coverage market.[44] Point-of-service plans, which did not even exist in 1988, have 18% of the coverage market.[45]

Antitrust Enforcement Initiatives

Let me now take a few minutes, and describe recent enforcement initiatives by the Commission and the Department of Justice.

Pharmaceuticals

As I noted previously, pharmaceuticals represent a significant (and rapidly growing) percentage of the money spent on health care and on health care competition

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[39] *Id.*; James Maxwell, Peter Temin & Saminaz Zaman, *The Benefits Divide: Health Care Purchasing in Retail Versus Other Sectors*, 21 HEALTH AFF., Sept.-Oct. 2002, at 224.

[40] Access to emergency care is ensured by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

[41] *See* James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001); Debra A. Draper et al., *The Changing Face of Managed Care*, 21 HEALTH AFF., Jan.-Feb. 2002, at 11.

[42] *See* Gabel, *supra* note 12, at 148.

[43] *Id.*

[44] *Id.*

[45] *Id.*

policy enforcement. Because of innovation, a growing number of medical conditions can now be treated more effectively with drugs and drug therapy than with hospital stays and surgery. The development of new drugs is risky and costly, which obviously raises the prices of branded prescription drugs. The availability of generic versions of branded drugs has had a substantial impact on prices.[46]

In the Hatch-Waxman Amendments to the Food, Drug and Cosmetic Act, Congress sought to balance innovation and greater market access – the former protected by patent rights, and the latter protected by competition from generic drug products.[47] Although Hatch-Waxman has numerous technical provisions, the basic framework is fairly straightforward. Branded drug manufacturers must file information with the FDA, specifying the patents that claim the drug products they intend to market.[48] Once the drug product is approved, the FDA lists the patents in an agency publication widely known as the Orange Book.[49]

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[46] Studies of the pharmaceutical industry indicate that the first generic competitor typically enters the market at a significantly lower price than its branded counterpart and gains substantial market share from the branded product. *See* David Reiffen & Michael Ward, *Generic Drug Industry Dynamics* (Feb. 2002), available at <http://www.ftc.gov/be/workpapers/industrydynamicsreiffenwp.pdf>. Subsequent generic entry typically brings prices down even further. *Id.* The policies of many health plans, both public and private, which require generic substitution whenever possible, accelerate this trend.

[47] Drug Price Competition and Patent Restoration Act of 1984, Pub. L. No. 98-417, 98 Stat. 1585 (1984) (codified as amended at 21 U.S.C. § 355 (2000)). Prior to Hatch-Waxman, a generic drug manufacturer could not commence the process of obtaining FDA approval until all patents on the relevant branded product had expired because doing so would have constituted patent infringement. In practice, this meant that the FDA approval process extended the term of the branded manufacturer's patent. The Hatch-Waxman Amendments represented a compromise solution to this problem, balancing an expedited FDA approval process (speeding generic entry) against additional intellectual property protections (to ensure continuing innovation). On the balance struck in Hatch-Waxman between innovation and greater market access, s*ee, e.g., Abbott Labs. v. Young*, 920 F.2d 984, 991 (D.C. Cir. 1990) (Edwards, J., dissenting) (citations omitted) (Hatch-Waxman "emerged from Congress's efforts to balance two conflicting policy objectives: to induce brand-name pharmaceutical firms to make the investments necessary to research and develop new drug products, while simultaneously enabling competitors to bring cheaper, generic copies of those drugs to market.")

Of course, branded pharmaceuticals for the treatment of the same disease or condition compete with one another as well, and generic and branded pharmaceuticals compete with other forms of treatment.

[48] The filing is technically called a "New Drug Application" or NDA.

[49] The official title of the book is "Approved Drug Products with Therapeutic Equivalence."

A generic drug manufacturer wishing to enter the market with a generic version of a branded drug must provide the FDA with certain information, including certifications regarding each patent listed in the Orange Book.[50] A "Paragraph IV certification" asserts that the patent in question is invalid or not infringed and that the generic applicant seeks entry prior to the patent's expiration. If a patent holder brings an infringement suit against the generic applicant, the filing of that suit triggers an automatic 30-month stay of FDA approval of the generic drug.[51] Unless the patent litigation is resolved in favor of the generic drug manufacturer, it cannot enter the market during this period.

Hatch-Waxman also provides 180 days of marketing exclusivity to the first generic drug manufacturer that files its application with the FDA and receives approval to market a particular generic drug prior to the expiration of the branded drug's products.[52] After the 180 days, the FDA is free to approve subsequent generic applicants, assuming other regulatory requirements are met.

Although many branded and generic manufacturers have acted in good faith, others have allegedly attempted to "game" this system, securing greater profits for themselves without providing a corresponding benefit to consumers. The Commission has attacked such alleged conduct with cases brought against both branded and generic drug manufacturers. The Commission's first generation of pharmaceutical litigation focused on agreements between branded and generic drug manufacturers that allegedly delayed the entry of generic drugs. These agreements settled patent infringement

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[50] The filing is technically called an "Abbreviated New Drug Application" or ANDA. The purpose of the ANDA is to establish the bioequivalency of the generic drug with the branded drug.

[51] If the patent holder does not bring suit within 45 days, the FDA must approve the ANDA immediately, if other regulatory conditions are fulfilled.

[52] The 180-day period is calculated from the date of the first commercial marketing of the generic drug product or the date of a court decision declaring the patent invalid or not infringed, whichever is sooner.

litigation brought by the branded drug manufacturer against the generic drug manufacturer. Although settlement of patent infringement litigation can be efficient and pro-competitive, certain agreements can delay generic entry by "parking" the 180-day marketing exclusivity provided by the Hatch-Waxman Amendments. The Commission has aggressively targeted such alleged agreements and obtained consent judgments in two such cases.[53] In a third case, the Commission entered a consent judgment against one firm[54] and the case against the other two respondents is currently pending before the Commission.[55]

The Commission's second-generation pharmaceutical cases involved unilateral action by branded drug manufacturers. The Commission alleged that improper Orange Book listing constituted anticompetitive abuse of the Hatch-Waxman process by creating the possibility of obtaining unwarranted 30-month stays of FDA approval of generic drug products.[56] Such conduct raises *Noerr-Pennington* issues, which the Commission has also addressed through an amicus filing in the BuSpar case.[57]

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[53] *See Abbott Lab.*, Dkt. No. C-3945 (May 22, 2000) (consent order), available at <http://www.ftc.gov/os/2000/03/abbot.do.htm>; *Geneva Pharm., Inc.*, Dkt. No. C-3946 (May 22, 2000) (consent order), available at <http://www.ftc.gov/os/2000/03/genevad&o.htm>; *Hoechst Marion Roussel, Inc.*, Dkt. No. D-9293 (May 8, 2001) (consent order), available at <http://www.ftc.gov/os/2001/05/hoechstdo.pdf>.

[54] *See Schering Plough Corp.*, Dkt. No. D-9297 (Apr. 2, 2002) (consent order as to American Home Products).

[55] *See Schering Plough Corp.*, Dkt. No. D-9297 (June 27, 2002) (initial decision), available at <http://www.ftc.gov/os/caselist/d9297.htm>.

[56] *See Biovail Corp.* Dkt. No. C-4060 (Oct. 2, 2002) (consent order).

[57] The Commission filed an amicus brief in *In re Buspirone*, 185 F. Supp. 2d 363 (S.D.N.Y. 2002), a pivotal case involving allegations of fraudulent Orange Book listing practices. In opposing Noerr immunity, the Commission successfully argued that submitting patent information for listing in the Orange Book did not constitute "petitioning" the FDA and that, even if it did, various exceptions to Noerr immunity applied. The district court subsequently issued an order denying Noerr immunity and adopting much of the Commission's reasoning.

The Commission has also scrutinized agreements among manufacturers of generic drugs not to compete against one another. The Commission has brought one such case and will pursue others as the facts warrant.[58]

Physicians

In the past year, the Commission has reached settlements with five groups of physicians for allegedly colluding to raise consumers' costs.[59] Three of the cases are in Denver; one is in Napa; and one is in Dallas-Fort Worth. The number of physicians involved ranged from eight in Napa to more than twelve hundred in Dallas-Fort Worth. To resolve these matters, the physicians agreed to refrain from engaging in similar conduct in the future, to take certain measures to ensure compliance with the consent judgment, and, in one instance, to dissolve the organization through which the physicians conducted their alleged anticompetitive activity. In three of the cases, the FTC also obtained relief against the consultants who were involved in coordinating the alleged collusive conduct.[60]

Those who would justify such conduct suggest that it is necessary to counter the monopsony power of insurers. A recent *American Medical News* editorial referred to the

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[58] *See Consent Order Resolves Charges That Biovail and Elan Agreement Unreasonably Restrained Competition In Market for Generic Anti-hypertension Drug* (June 27, 2002), available at <http://www.ftc.gov/opa/2002/06/biovailelan.htm>.

[59] *See, e.g., System Health Providers*, Dkt. No. C-4064 (Oct. 24, 2002) (consent order); *R. T. Welter & Assocs., Inc. (Professionals in Women's Care)*, Dkt. No. C-4063 (Oct. 8, 2002) (consent order); *Physician Integrated Servs. of Denver, Inc.*, Dkt. No. 4054 (July 16, 2002) (consent order); *Aurora Associated Primary Care Physicians, L.L.C.*, Dkt. No. 4055 (July 16, 2002) (consent order); *Obstetrics and Gynecology Medical Corporation of Napa Valley*, No. C-4048 (May 14, 2002) (consent order).

[60] In addition to these enforcement efforts, this year, the FTC staff also has filed comments with three state legislatures opposing legislation that would allow physician collective bargaining. *FTC Staff Opposes Ohio Bill To Allow Physician Collective Bargaining* (Oct. 21, 2002), available at <http://www.ftc.gov/opa/2002/10/physicians.htm>; *FTC Staff Opposes Washington State Proposal to Allow Physician Collective Bargaining* (Feb. 14, 2002), available at <http://www.ftc.gov/opa/2002/02/washphys.htm>; *FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining* (Jan. 31, 2002), available at <http://www.ftc.gov/opa/2002/01/alaskaphysicians.htm>.

"competition of physician Davids against health plan Goliaths," and suggested that federal antitrust enforcement has "unfortunately favored the big guys."[61] Yet the AMA's own data indicates that insurer market concentration is not a problem in either Denver or Dallas-Fort Worth – the markets which accounted for four of the five physician price-fixing cases brought by the Commission in the past year.[62] In the Denver market, the AMA has calculated that the combined HHI for HMOs and PPOs is 1,336. In the Dallas-Fort Worth market, the AMA has calculated that the combined HHI for HMOs and PPOs is 1,377. Thus, even the AMA's data does not suggest excessive payor concentration in the markets where the Commission has identified collusive physician conduct. Bluntly stated, this conduct had everything to do with physician self-interest and little or nothing to do with insurer monopsony power.

The alleged conduct I have described is naked price fixing, plain and simple. Such conduct is summarily condemned under the antitrust laws, because it has no pro-competitive justifications. Of course, it does not follow that all collective conduct is problematic, even though some physicians suggest that the antitrust laws prevent them from delivering high quality care. The antitrust laws actually provide a considerable degree of flexibility in dealing with efficiencies and quality, as long as the conduct in question is, on balance, pro-competitive and the efficiencies derive from the challenged conduct. If anything, competition law has played a major role in ensuring the delivery of

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61 Editorial, *It's about time: Insurers facing antitrust scrutiny,* AMERICAN MED. NEWS, Oct. 14, 2002, available at <http://www.ama-assn.org/sci-pubs/amnews/amn_02/edsa1014.htm>.

62 American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, at 13 (Nov. 2001). The AMA did not calculate an HHI for Napa Valley. The Horizontal Merger Guidelines treat an HHI of 1300 as at the low end of a moderately concentrated market. United States Department of Justice and Federal Trade Commission, *1992 Horizontal Merger Guidelines,* available at <http://www.ftc.gov/bc/docs/horizmer.htm> ("the spectrum of market concentration as measured by the HHI into three regions that can be broadly characterized as unconcentrated (HHI below 1000), moderately concentrated (HHI between 1000 and 1800), and highly concentrated (HHI above 1800)").

high quality care, by assuring consumers a range of different health care products and services, empowering purchasers to define quality for themselves, and improving access through price competition.

Quality is obviously an important part of the competitive mix when purchasing health care, and competition law does not hinder the delivery of high quality care. The Commission is always willing to consider arguments about how a particular transaction or conduct will improve quality, and it will pay close attention to such arguments in weighing the competitive implications. Moreover, because quality is so important in health care, we should err on the side of conduct that promises to improve patient care.

Clinical integration that increases quality of care is one example of permissible pro-competitive collective conduct. As I mentioned earlier, the staff recently issued an advisory opinion to MedSouth on this issue. The physicians proposed an innovative form of clinical integration that would allow them to treat patients more effectively. The staff concluded that the collective negotiation of fees was reasonably related to the physicians' clinical integration and quality objectives, even though there was no financial integration. As I also mentioned previously, the Commission recently closed an investigation in which physician collaboration resulted in a substantial degree of market concentration because the group demonstrated that considerable efficiencies resulted, including dramatically improved quality of care.

Collaborative conduct of this sort does not violate the antitrust laws, because there are substantial pro-competitive benefits. However, if a group has no justifications for its price fixing, the inquiry ends and the conduct is summarily (and appropriately) condemned by the antitrust laws.

Hospitals

As you already know, in the last eight years the Commission and Department of Justice are 0 for 7 in hospital merger cases.[63] Obviously, the template for trying hospital merger cases that was used with such great success in the 1980s and early 1990s no longer works. Although some have suggested the Commission should just fold its tent and ignore hospital mergers, I do not believe that response is acceptable.

Accordingly, last summer, the Commission established a new merger litigation task force.[64] The task force will screen targets, select the best cases, and develop new strategies for trying them. The merger task force will also take a hard look at which strategies worked and which did not in the prior hospital merger cases.

In addition, the Commission is in the midst of a retrospective study of consummated hospital mergers. The Bureaus of Economics and Competition are evaluating the effects of hospital mergers in several cities. The agency will announce the results of these studies regardless of the outcome. If the studies find efficiencies associated with some or all of the mergers, the staff will say so. If, on the other hand, the studies indicate that the mergers were anticompetitive, then Commission will carefully consider whether administrative litigation is appropriate. Whether or not there is an appropriate remedy will obviously influence the Commission's analysis of whether to pursue such a proceeding.

In either event, the agency will obtain useful real-world information, allowing the Commission to update its prior assumptions about the consequences of particular

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[63] *See* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF., Apr.-Mar. 2002, at 185, 186.

[64] *See Federal Trade Commission Announces Formation of Merger Litigation Task Force* (Aug. 28, 2002), available at <http://www.ftc.gov/opa/2002/08/mergerlitigation.htm>.

transactions and the nature of competitive forces in health care. In *California Dental*, the Supreme Court emphasized the importance of relying on real-world empirical evidence, instead of hunches, guesswork, and theoretical predictions.[65] The retrospective study represents an effort to meet this challenge. To the extent ex post data reveal a real problem in some of these mergers, that data may bolster the Commission's position the next time it seeks a preliminary injunction against a proposed merger in federal district court.

Insurers

Competition must be maintained at all levels of health care if consumers are to receive the full benefit of the nation's antitrust laws. Historically, purchasers have been subject to less searching scrutiny under the antitrust laws than sellers.[66] As then-Judge and now-Justice Stephen Breyer once observed, when Congress enacted the Sherman Act, its focus was on prices that were too high, not too low. As such, Judge Breyer asserted that "courts should be cautious – reluctant to condemn too speedily – an arrangement that, on its face, appears to bring low price benefits to the consumer."[67]

Of course, there are concrete dangers associated with monopsony power – although structural features beyond purchaser concentration are necessary for the exercise

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[65] *California Dental Ass'n v. FTC*, 526 U.S. 756, 776-781 (1999). Although the professional context of the dispute in California Dental was an important factor for the majority, a fuller evidentiary record would have revealed that the restraints in question were likely anticompetitive. *See* Timothy J. Muris, *California Dental Association v. FTC: The Revenge of Footnote 17*, 8 SUP. CT. ECON. REV. 265 (2000). Unfortunately, the 9th Circuit Court of Appeals dismissed the case without allowing the Commission to submit additional evidence. *See FTC Dismissed California Dental Case* (Feb. 15, 2001), available at <http://www.ftc.gov/opa/2001/02/cdadismisspr.htm>.

[66] To be sure, the relevant statutes do not differentiate in any way between buyers and sellers, and there are sound economic reasons for applying similar scrutiny to monopoly and monopsony practices.

[67] *Kartell v. Blue Shield*, 749 F.2d 922, 931 (1st Cir. 1984).

of monopsony power.[68] When monopsony power exists, the correct response is to address it directly, rather than to rely on physician collusion to create countervailing power. Indeed, relying on seller collusion to address buyer monopsony risks the worst of all worlds, as monopolistic sellers and monopsonistic buyers both act in their own interest to the detriment of patients.

The increasing consolidation of the health insurance market and the possible development of monopsony power have not escaped the attention of the antitrust agencies. Of course, the McCarran-Ferguson Act complicates enforcement in this area because it largely exempts the "business of insurance" from federal antitrust scrutiny.[69] The Commission also labors under several distinct disadvantages in addressing anticompetitive conduct by purchasers. In many geographic markets, non-profit firms have a major position in the purchasing side of the health care market. The Commission has limited jurisdiction over nonprofit firms, unless they are merging or operating for the benefit of for-profit members. The Commission is also prohibited by statute from studying the business of insurance without prior approval from two key Congressional committees.[70]

The Department of Justice primarily has dealt with the financing side of the health care market. The Antitrust Division has made it a priority to scrutinize mergers through which the merged insurer would have sufficient market power to increase prices or reduce quality in the sale of managed care plans in specific geographic areas or to acquire

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68 In addition to a substantial market share, market elasticity of supply and elasticity of demand among non-monopsonist firms must be low. R.D. Blair & J.L. Harrison, MONOPSONY: ANTITRUST LAW AND ECONOMICS (1993).

69 15 U.S.C. § 1012(b).

70 15 U.S.C. § 46.

monopsony power over providers.[71] The DOJ also plans to focus on collective or unilateral activity by health insurers that may raise competitive concerns, depending on the insurer's market power and other relevant market conditions. For example, the Department of Justice recently scrutinized the health insurance market in a major metropolitan area for possible evidence of coordination or collusion among managed care plans operating there.[72] The Department of Justice has also investigated "all products" and "most favored nations" clauses in insurance contracts – in some instances forcing insurers to remove them from their contracts when they have a dominant market position and their use raises anticompetitive concerns.[73]

The Commission's Research Agenda

As my earlier remarks reflect, the Commission has brought and will continue to bring cases against anticompetitive practices affecting the health care industry. Besides bringing cases, the Commission also conducts studies, holds hearings, and issues reports to Congress and the public. The Commission's deliberative and research capacities are particularly helpful in health care because the agency can study and evaluate the evolving marketplace and selectively intervene when it discovers anticompetitive conduct. The agency also uses its deliberative and research capacities to obtain a broader and deeper understanding of the facts that emerge in enforcement matters. The Commission then uses this understanding to inform its enforcement decisions.

The generic drug study, which I mentioned earlier, exemplifies the latter approach. After initiating several pharmaceutical cases, the Commission conducted a

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71 Address by Deborah Platt Majoras, available at <http://www.usdoj.gov/atr/public/speeches/200195.htm>. My remarks concerning the Department of Justice's priorities and activities are based on this speech.

72 *Id.*

73 *Id.*

study to examine whether such anticompetitive conduct was limited to the cases already identified. The study also examined the performance of the Hatch-Waxman Amendments more broadly to determine the nature and extent of anticompetitive impediments to generic entry. The study involved gathering information from more than 90 companies and took more than a year to complete. The report was issued in July 2002, and it immediately became the gold standard for what is known about the actual performance of the Hatch-Waxman Amendments. As I noted previously, last month, the President proposed regulations to curb the most important problem the Commission's study identified.

The Bureau of Economics is also working closely with several outside academics to study quality of care, so the Commission can factor non-price competition into its analysis of future cases. With the assistance of these academics, the Commission is studying the impact of regulation and competition on quality. This research will help provide a sound empirical basis to assess the interaction of competition and health care quality.

The health care workshop held by the FTC on September 9-10, 2002, was also an important part of the Commission's research agenda. The workshop featured presentations by academics, providers, insurers, employers, patient groups, and representatives of the Commission, Department of Justice, and state attorneys general. The workshop had more than a dozen speakers and five panel discussions. The panels focused on clinical integration, payor/provider issues, group purchasing organizations, generics and branded pharmaceuticals, and direct-to-consumer advertising of pharmaceuticals. Each panel presented a broad range of views on each of these subjects

from knowledgeable panelists. Several hundred people attended the workshop. The staff is already using some of the information obtained at the workshop in pending investigations. The workshop also made clear that there is a considerable diversity of views on the appropriate role and priorities for the Commission and other enforcement agencies.

The Commission's research agenda remains a work in progress. I am pleased to announce that the Commission has authorized an extended set of hearings on health care and competition policy, commencing in February 2003 and continuing through the year. The hearings broadly will examine the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of the citizenry for high-quality, cost-effective health care. The hearings will examine some of the subjects covered in the September 9-10, 2002, workshop at greater depth, and will also address a broader range of issues. The Department of Justice will co-host the hearings.

Our goals are two-fold. First, we hope to gain a better understanding of the marketplace to inform our enforcement agenda. Second, we will report to Congress and the public on our findings. We are still developing a list of specific topics, but I expect that the hearings will examine hospital mergers, pharmaceuticals, the significance of non-profit status, vertical integration, the boundaries of the state-action and Noerr-Pennington doctrines, monopsony power, and the adequacy of existing remedies for anticompetitive conduct.

The hearings will also consider the implications of the Commission's consumer protection mandate with regard to the performance of the health care financing and

delivery markets. Although the Commission has considerable expertise in dealing with snake-oil, the agency is interested in evaluating whether there is a broader consumer protection role for the Commission, similar to its role in other areas of the economy. Thus, the hearings will consider the disclosure of costs, risks, and benefits by manufacturers of medical devices and pharmaceuticals (both prescription and over-the-counter), and by providers of professional services in connection with advertising and other forms of information dissemination.

Quality will be a major item on the hearing agenda. The hearings probably will devote several days to considering how quality should be factored into an antitrust analysis. Measuring and disseminating information about health care quality raises complex questions. These are obviously subjects on which agencies other than the Commission have considerable expertise. The Commission will be working closely with these agencies during the hearings, and as the agency develops cases, to ensure that the Commission's antitrust analysis fully incorporates these considerations. For example, our recent alleged price-fixing cases did not involve quality issues. There are many more complex issues in the health care market, however, and we need to educate ourselves about them.

Quality also can figure in markets in new ways. Last week, the Institute of Medicine recommended that the federal government should start paying more to providers who deliver high quality services.[74] To date, such arrangements are uncommon in the private sector and almost unheard of in the public sector.[75] The hearings

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74 Robert Pear, *Study Tells U.S. To Pay More For the Best Medical Care*, N.Y. TIMES, Oct. 31, 2002, at 21.

75 David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASHINGTON & LEE L. REV. 1427 (2001).

accordingly will include some consideration of the comparative competitive effects of explicit and implicit contracts for quality.

As with the workshop held in September, the agency will invite representatives of industry, academia, other branches of government, antitrust practitioners, and patient groups to participate. There will be at least twenty days of hearings, primarily at the Commission's headquarters in D.C. The Commission will prepare an extensive report, which will help ensure that everyone recognizes the significance of the "first principles" alluded to by Bob Pitofsky. The report will also lay out the costs and benefits of various policy options we face as a nation in dealing with health care – a sector of our economy that accounts for 1 in every 7 dollars in the GDP.

Conclusion

From my perspective as Chairman of the FTC, it is somewhat surprising to hear so much skepticism about the application of competition law and policy to health care. Clearly, much remains to be done to explain the benefits of markets, both in theory and in practice, for the financing and delivery of health care and the role of the Commission in ensuring that outcome.

Happily, health care is the area of the economy in which the promise implicit in the creation of the Commission has been most fully met. There are substantial consumer welfare benefits and synergies from creating an agency combining administrative expertise and enforcement authority, addressing antitrust, consumer protection, and competition advocacy. Since 1975, when the Commission sharpened its focus on this area, through six presidents and eight Chairmen, the Commission has maintained a leadership role in implementing competition law and policy in health care.

I was proud to participate in this endeavor at the outset in the Commission's Policy Planning Office. As Director of the Bureau of Competition in the early 1980s, I was proud to play a role in consolidating the Commission's leadership in this area, with cases like *Indiana Federation of Dentists.* As Chairman, I am proud to maintain and extend the Commission's important work.

Vigorous competition can be quite unpleasant for competitors. Indeed, as Judge Easterbrook noted in *Ball Memorial*, "competition is a ruthless process."[76] Yet ruthless competition is exactly what the drafters of the Sherman, Clayton, and FTC Acts mandated when they wrote these three statutory charters of economic freedom.[77]

The job of the FTC is to protect competition from those who would interfere with its efficient operation to the detriment of consumers. The Commission's enforcement and research agenda makes me quite confident the agency will successfully meet the challenges of applying competition law and policy to health care. Everything old may be new again, but some things never go out of style.

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76 *Ball Mem'l Hosp.*, 784 F.2d at 1338.

77 *See, e.g., Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 4 (1958) ("The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade.")

LEXSEE

LOCAL 159, 342, 343 & 444; LOCAL 343 UNITED ASSOC. JOURNEYMEN & APPRENTICE TRAINING TRUST FD; LOCAL 343 UNITED ASSOC. OF PLUMBING, Plaintiffs-Appellees and Cross-Appellants, v. NOR-CAL PLUMBING, INC.; NORTH BAY PLUMBING, INC.; ELMAR LEE PETTIT, a.k.a. ELMER LEE PETTIT; AUDREY JEAN PETTIT, Defendants-Appellants and Cross-Appellees.

Nos. 96-16172 & 96-16284

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

1999 U.S. App. LEXIS 17968

January 11, 1999, Argued and Submitted, San Francisco, California; January 12, 1999, Submission Deferred; February 10, 1999, Re-Submitted
July 27, 1999, Filed

NOTICE: [*1] RULES OF THE NINTH CIRCUIT COURT OF APPEALS MAY LIMIT CITATION TO UNPUBLISHED OPINIONS. PLEASE REFER TO THE RULES OF THE UNITED STATES COURT OF APPEALS FOR THIS CIRCUIT.

SUBSEQUENT HISTORY:

Reported in Table Case Format at: *1999 U.S. App. LEXIS 29067.*

Certiorari Denied February 22, 2000, Reported at: *2000 U.S. LEXIS 1058.*

PRIOR HISTORY: Appeal from the United States District Court for the Northern District of California. D.C. No. CV-87-2365-SYI. Susan Y. Illston, District Judge, Presiding.

DISPOSITION: AFFIRMED.

CASE SUMMARY:

PROCEDURAL POSTURE: Defendant employers appealed the judgment from the United States District Court for the Northern District of California finding that defendant's corporations were alter egos and that defendant created the corporations in order to avoid responsibilities under the collective bargaining agreement. Plaintiff cross-appealed the dismissal of plaintiff's fraud claim.

OVERVIEW: The court affirmed the judgment finding that plaintiff was permitted to pierce defendant's corporate veil. The court held the trial court applied the proper alter ego test and any argument that defendant had against the use of the test was abandoned because defendant failed to object to the test before a previous appeal. Furthermore, the court held that the law of the case doctrine was properly applied because the only issue remaining was whether defendant intentionally used the corporation in order to avoid collective bargaining requirements, the evidence of intent was not contradicted, and the evidence of intent was properly admitted. Additionally, the court held that any error committed when the trial judge submitted the veil-piercing issue to the jury was harmless, that the jury instructions were proper, and that the expert testimony was properly admitted because defendant failed to object that certain testimony called for a legal conclusion. Finally, the court held that plaintiff's fraud action was properly dismissed, that any error in the admission of evidence was harmless, and that damages were properly determined. Therefore, the court affirmed the trial court's judgment.

OUTCOME: The judgment finding that defendant's corporations were alter egos and that defendant created the corporations in order to avoid responsibilities under

Exhibit 2

the collective bargaining agreement was affirmed, because the alter ego test was properly applied and the trial court properly admitted evidence. Additionally, the judgment dismissing plaintiff's fraud claim was affirmed.

LexisNexis(R) Headnotes

Business & Corporate Entities > Corporations > Shareholders & Other Constituents > Disregard of Corporate Entity

[HN1] For determining whether a company was the alter ego of another company the first step is to determine whether the two firms alleged to be alter egos meet the following criteria for finding that they are a single employer: (1) common ownership; (2) common management; (3) interrelation of operations; and (4) centralized control of labor relations. If this threshold showing is met, it must be shown that one of the two firms was created or being used in an attempt to avoid collective bargaining obligations through a sham transaction or a technical change in operations.

Civil Procedure > Preclusion & Effect of Judgments > Law of the Case Doctrine

[HN2] Under the law of the case doctrine, a court is generally precluded from reconsidering an issue that has already been decided by the same court, or a higher court in the identical case. A court may have discretion to depart from the law of the case where: 1) the first decision is clearly erroneous; 2) an intervening change in the law has occurred; 3) the evidence on remand is substantially different; 4) other changed circumstances exist; or 5) a manifest injustice would otherwise result. A district court's decision whether to apply the law of the case doctrine is reviewed for an abuse of discretion.

Civil Procedure > Appeals > Standards of Review > Abuse of Discretion

[HN3] A district court's formulation of civil jury instructions is generally reviewed for an abuse of discretion, although where one party claims that the trial court misstated the law, we must review the instructions de novo. The instruction must be viewed as a whole and evaluated in the context of the whole trial. An error instructing the jury in a civil case does not require reversal if it more probably than not was harmless.

Civil Procedure > Jury Trials > Right to Jury Trial

[HN4] Entitlement to a jury trial in federal court is a question of law reviewed de novo.

Civil Procedure > Jury Trials > Right to Jury Trial

[HN5] There is no constitutional right to have one's case tried by a judge rather than a jury. The Federal Rules of Civil Procedure do provide that both parties' consent is necessary to hold a jury trial when there is no right to have a jury decide the claim.

Business & Corporate Entities > Corporations > Shareholders & Other Constituents > Disregard of Corporate Entity

[HN6] Whether to pierce the corporate veil and hold a shareholder personally liable depends on a three-part test: [1] the amount of respect given to the separate identity of the corporation by its shareholders, [2] the degree of injustice visited on the litigants by recognition of the corporate entity, and [3] the fraudulent intent of the incorporators. Once the first threshold factor is met, only one of the latter two must be satisfied.

Business & Corporate Entities > Corporations > Shareholders & Other Constituents > Disregard of Corporate Entity

[HN7] The intent to avoid collective bargaining obligations sufficient to satisfy the alter ego theory of liability does not necessarily satisfy the fraud factor in the veil-piercing test.

Business & Corporate Entities > Corporations > Shareholders & Other Constituents > Disregard of Corporate Entity

[HN8] To pierce the corporate shell, the plaintiff must prove some fraudulent conduct directed at them specifically or at a group of creditors to which they belong.

Civil Procedure > Appeals > Standards of Review > Abuse of Discretion

[HN9] The district court's rulings on the admissibility of expert testimony are reviewed for an abuse of discretion. Such rulings will be reversed only if manifestly erroneous.

Evidence > Witnesses > Expert Testimony

[HN10] The Federal Rules of Evidence permits an expert to testify to his opinion if the expert's scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue. Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

Civil Procedure > Appeals > Standards of Review > De Novo Review

[HN11] The denial of a motion for judgment as a matter of law is reviewed de novo.

Civil Procedure > Trials > Judgment as Matter of Law

[HN12] Judgment as a matter of law should be granted where the evidence permits only one reasonable conclusion, and that conclusion is contrary to the jury's.

Evidence > Witnesses > Expert Testimony
[HN13] Every expert will make decisions as to which pieces of evidence to rely on; on cross-examination the opposing party is entitled to challenge why the expert seemingly ignored certain evidence.

Evidence > Witnesses > Expert Testimony
[HN14] The scope and extent of cross-examination of expert witnesses rests in the sound discretion of the trial court and is not subject to exception unless wholly arbitrary, unreasonable and abusive, and the examination need not be extended to permit interrogation about collateral, immaterial or irrelevant matters.

Evidence > Witnesses > Expert Testimony
[HN15] The Federal Rules of Evidence provide that experts may be required to disclose the sources upon which they have relied, but they do not make these sources automatically admissible. Moreover, cumulative and non-relevant evidence may be excluded.

Civil Procedure > Appeals > Standards of Review > Abuse of Discretion
[HN16] Hearsay rulings are reviewed for abuse of discretion.

Evidence > Writings & Real Evidence > Summaries
[HN17] A summary is admissible if it helps boil down the contents of voluminous writings, recordings, or photographs which cannot conveniently be examined in court. The proponent of a summary must establish a foundation that: (1) the underlying materials upon which the summary is based are admissible in evidence; and (2) the underlying documents were made available to the opposing party for inspection. It is clear that a summary of both inadmissible and admissible hearsay should not be admitted under *Fed. R. Evid. 1006*. Where it is uncertain precisely which portions of the summary rest on inadmissible hearsay, the whole summary is inadmissible.

Civil Procedure > Trials > Special Verdicts & Interrogatories
[HN18] The district court has broad discretion in deciding whether to employ a special or general verdict. This discretion extends to determining the content and layout of the verdict form, and any interrogatories submitted to the jury, provided the questions asked are reasonably capable of an interpretation that would allow the jury to address all factual issues essential to judgment.

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JUDGES: Before: WIGGINS, TASHIMA, and SILVERMAN, Circuit Judges.

OPINION:

MEMORANDUM *

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Cir. R. 36-3.

In our published Opinion filed concurrently herewith, we hold that the district court had subject matter jurisdiction of this case. Here, we dispose of the laundry list of substantive as well as procedural issues raised by both the Employers and the Trust Funds. n1 We affirm the district court in all respects.

n1 In this Memorandum, we use the same shorthand references we adopted in our published Opinion.

[*4]

I. Alter Ego Claim

The heart of the suit against the Employers is the Trust Funds' allegation that North Bay was the alter ego of Nor-Cal. At trial, the district court followed the two-part test laid out in *UA Local 343 of the United Ass'n of Journeymen v. Nor-Cal Plumbing, Inc., 48 F.3d 1465* (9th Cir.), cert. denied, *516 U.S. 912, 133 L. Ed. 2d 203, 116 S. Ct. 297 (1995)* ("UA Local 343 I"). [HN1] Under UA Local 343 I, for determining whether North Bay was the alter ego of Nor-Cal the first step is to determine whether the two firms alleged to be alter egos meet the following criteria for finding that they are a single employer: (1) common ownership; (2) common management; (3) interrelation of operations; and (4) centralized control of labor relations. See *48 F.3d at 1471.* If this threshold showing is met, it must be shown that one of the two firms was created or being used in an attempt to avoid collective bargaining obligations "through a sham transaction or a technical change in operations." *Id. at 1472* (quoting *A. Dariano & Sons, Inc. v. District Council of Painters No. 33, 869 F.2d 514, 518 (9th Cir. 1989)).* [*5]

In UA Local 343 I, we found that there was ample evidence that Nor-Cal and North Bay constituted a single employer but remanded the case for a determination of the second part of the alter ego test: whether Pettit created and operated North Bay with the intent to avoid the obligations under Nor-Cal's CBA. See *48 F.3d at 1471-74.* Our finding that Nor-Cal and North Bay were a single employer was treated as the "law of the case" by the trial court. It read to the jury a Statement of Established Facts ("Statement") which summarized the decision in UA Local 343 I that Nor-Cal and North Bay constituted a single employer. The Statement properly explained to the jury that the "single employer" factors had been met and put into context the issue that remained for the jury -- whether Pettit had the intent to avoid the collective bargaining obligations through a sham operation. See *Robertson Oil Co. v. Phillips Petroleum Co., 930 F.2d 1342, 1344-45 (8th Cir. 1991)* (in retrial limited to punitive damages issue, trial judge did not err in summarizing for the jury the issues established at the prior jury trial). n2

n2 The Employers complain that some of the facts included in the Statement were controverted by evidence at trial. For instance, the Statement mentioned that the fourth single employer factor -- centralized control of labor relations -- was supported by the fact that "Elmar Lee Pettit told associates that a non-union shop was the only way he could make any money." *UA Local 343 I, 48 F.3d at 1472.* At trial, Pettit testified that he never made any such statement. The Employers contend that they were prejudiced when the testimony of Pettit and their other witnesses at trial contradicted the "Established Facts" because the jury was instructed to accept as true the facts included in that instruction and necessarily would assume that the Employers' witnesses were lying. We conclude that any prejudice that resulted was not due to an error by the district court, which

properly summarized the evidence supporting the single employer finding.

[*6]

The Employers argue that the test in this Circuit for "alter ego" status is at odds with the test set forth in 1976 in *Crawford Door Sales Co., 226 N.L.R.B. 1144 (1976).* n3 The district court used the same Ninth Circuit test in ruling on summary judgment that North Bay was the alter ego of Nor-Cal, see *UA Local No. 343 of the United Ass'n of Journeymen v. Nor-Cal Plumbing, Inc., 797 F. Supp. 767, 771-72 (N.D. Cal. 1992),* and the Employers did not challenge the test on the first appeal. As such, the Employers waived their right to review of the issue on this subsequent appeal. See *Kesselring v. F/T Arctic Hero, 95 F.3d 23, 24-25 (9th Cir. 1996).* n4

n3 The NLRB enunciated seven factors to consider in determining whether two enterprises are alter egos: "'substantially identical' management, business purpose, operation, equipment, customers, and supervision, as well as ownership." *Crawford Door Sales Co., 226 N.L.R.B. 1144.*

n4 Even if the issue could be raised on this appeal, the Employers' argument would fail. Long ago, we found that the "alter ego" factors set forth in Crawford Door Sales Co. were "essentially the same factors" examined under our test to determine whether two firms constitute a single employer. See *NLRB v. Big Bear Supermarkets No. 3, 640 F.2d 924, 928 n.5 (9th Cir. 1980).* Therefore, this Court has already held that there is no substantive difference between the sets of factors.

[*7]

The Employers also contend that, in the circumstances of this case, the court erred in not departing from the "law of the case" when it applied the alter ego test set forth in UA Local 343 I. [HN2] "Under the 'law of the case' doctrine, 'a court is generally precluded from reconsidering an issue that has already been decided by the same court, or a higher court in the identical case.'" *United States v. Alexander, 106 F.3d 874, 876 (9th Cir. 1997)* (quoting *Thomas v. Bible, 983 F.2d 152, 154 (9th Cir. 1993)).* "A court may have discretion to depart from the law of the case where: 1) the first decision is clearly erroneous; 2) an intervening change in the law has occurred; 3) the evidence on remand is substantially different; 4) other changed circumstances exist; or 5) a manifest injustice would otherwise result." Id. A district court's decision whether to apply the law of the case doctrine is reviewed for an abuse of discretion. See *Rebel Oil Co. v. Atlantic Richfield Co., 146 F.3d 1088, 1093* (9th Cir.), cert. denied, *142 L. Ed. 2d 450, 119 S. Ct. 541 (1998).*

First, the Employers point to *Johnstown Corp., 322 N.L.R.B. 818 (1997),* [*8] decided after UA Local 343 I, contending that it constituted intervening authority because it changed the test for determining whether one employer is the alter ego of another. Johnstown Corp., however, did not set forth a new alter ego test; it held only that the alter ego and single employer doctrines are related, but separate, concepts, and that the alter ego doctrine is not a mere subset of the single employer doctrine. n5 See *322 N.L.R.B. 818.* The gist of Johnstown Corp. is that a court may find an entity to be an "alter ego" without first finding it to be a "single employer," making it easier to find that one entity is another's alter ego. See id. Nothing in Johnstown Corp. contradicts the substance of this Circuit's test or casts doubt on the district court's determination that the only remaining alter ego element to be decided at trial was the intent to use North Bay as a sham to avoid Nor-Cal's collective bargaining obligations.

n5 UA Local 343 I similarly recognized that the "single employer" and the "alter ego" theories are "conceptually related, but distinct theories." *48 F.3d at 1470.*

[*9]

Second, the Employers contend that the "law of the case" was contradicted by substantially different evidence put on at trial. At trial, Nor-Cal's purchasing agent was shown to have no personal knowledge of facts included in his affidavit and relied upon by UA Local 343 I in finding that the third "single employer" factor -- interrelation of operations between Nor-Cal and North Bay -- had been established. See *48 F.3d at 1472.* Even without the affidavit, however, there was sufficient evidence of the interrelation of operations to sustain summary judgment. See id. The Employers provide no other meaningful support for their claim that substantially different evidence was brought out a trial. We conclude, therefore, that the district court correctly applied the law of the case regarding the alter ego test.

The Employers also argue that the Trust Funds relitigated the single employer factors under the guise of proving the intent prong of the alter ego test. They contend that the Trust Funds should only have been able to put on "new" evidence of Pettit's intent, and that the jury could not have made an objective finding on the issue of alter ego intent when faced [*10] with the same evidence used for the single-employer showing and

instructed by the trial judge that these facts had been established in a prior proceeding. We reject this argument. Some of the evidence that established the single-employer factors was also relevant to the issues of alter ego intent, veil-piercing and § 301 fraud. The district court was not required to exclude it just because the finding that Nor-Cal and North Bay were single employers was not before the jury.

The Employers challenge several aspects of the instructions on the alter ego claim. [HN3] A district court's formulation of civil jury instructions is generally reviewed for an abuse of discretion, although where one party claims that the trial court misstated the law, we must review the instructions de novo. See *Mockler v. Multnomah County, 140 F.3d 808, 812 (9th Cir. 1998).* The instruction must be viewed as a whole and evaluated in the context of the whole trial. See *United States v. Marabelles, 724 F.2d 1374, 1382 (9th Cir. 1984).* An error instructing the jury in a civil case does not require reversal if it more probably than not was harmless. See *Snyder v. Freight, Construction, Gen. Drivers, Warehousemen & Helpers, Local No. 287, 175 F.3d 680, 689 n.12 (1999).* **[*11]**

The Employers contend that the judge's instructions on alter ego liability effectively reversed the burden of proof in stating that a double-breasted operations "may be legal," when in fact they are legal unless shown to be alter egos. See *A. Dariano & Sons, Inc., 869 F.2d at 517* (finding that double-breasting "is not inherently illegal"). We find this argument unconvincing because the jury was explicitly instructed that the Trust Funds had the burden of proof on the alter ego claim.

Nor did the district court err in not including certain specific facts helpful to the Employers' case when it instructed the jury that it should consider certain factors in determining whether North Bay was Nor-Cal's alter ego. The judge instructed the jury to consider only general factors, such as "whether North Bay Plumbing was in reality a disguised continuance of the business operations of Nor-Cal Plumbing." Likewise, the trial judge adequately explained the nature of a double-breasted operation in stating that "a double-breasted operation occurs when the owners of one company that is a party to a labor agreement own a second company that is non-union," and in explaining when such **[*12]** an operation is not legal.

II. Piercing the Corporate Veil

A. The Use of a Jury Trial

Nor-Cal and Pettit contend that the district court erroneously found that a jury trial was required on the veil-piercing issue. n6 [HN4] "Entitlement to a jury trial in federal court is a question of law reviewed de novo." *United States v. California Mobile Home Park Management. Co., 107 F.3d 1374, 1377 (9th Cir. 1997).*

n6 North Bay and Audrey Pettit contend that they had the right to a jury trial on the issue.

We need not decide whether submission of the claim to a jury was an error, because, even if it were, it was harmless. [HN5] There is no constitutional right to have one's case tried by a judge rather than a jury. See *Beacon Theatres, Inc. v. Westover, 359 U.S. 500, 510, 3 L. Ed. 2d 988, 79 S. Ct. 948 (1959)* (holding that "the right to jury trial is a constitutional one . . . while no similar requirement protects trial by the court"); *United Press Ass'ns v. Charles, 17 Alaska 46, 245 F.2d 21, 23 (9th Cir. 1957)* **[*13]** (finding that "there is no express prohibition of jury trial in the Constitution, treaties or laws of the United States"). The Federal Rules of Civil Procedure do provide that both parties' consent is necessary to hold a jury trial when there is no right to have a jury decide the claim. See *Fed. R. Civ. P. 39(c)* ("In all actions not triable of right by a jury . . . the court, with the consent of both parties, may order a trial with a jury whose verdict has the same effect as if trial by jury had been a matter of right."). While Nor-Cal and Pettit did not consent to a jury trial, reversal is not warranted because, as discussed below, the jury's verdict piercing the veil with respect to Pettit was supported by ample evidence and any error was more likely than not harmless. See *United Press Ass'ns, 245 F.2d at 26* (finding that any error in submitting case to jury was only procedural and should be reviewed for harmless error).

B. Jury Instructions

[HN6] Whether to pierce the corporate veil and hold a shareholder personally liable depends on a three-part test: "[1] the amount of respect given to the separate identity of the corporation by its shareholders, [2] **[*14]** the degree of injustice visited on the litigants by recognition of the corporate entity, and [3] the fraudulent intent of the incorporators." *UA Local 343 I, 48 F.3d at 1475.* Once the first threshold factor is met, only one of the latter two must be satisfied. See id. In UA Local 343 I, we held that summary judgment was inappropriate because there were disputed facts regarding both the fraud and injustice factors. See id. Specifically, we held that, on the issue of fraud, the facts were in dispute as to whether the Pettits had misused the corporate form fraudulently to evade the obligations of the Trust Agreement. See *id. at 1476.* As for the injustice factor, we noted that the inability to collect, on its own, is not sufficient, and that genuine issues of fact remained. See id.

The Employers contend that the district court's jury instructions on veil-piercing strayed from the elements of the veil-piercing test. The district court instructed the jury that the fraud factor was satisfied if the jury found that "the Pettits had fraudulent or deceitful intent in forming or using their corporations." The court further told the jury that **[*15]** in deciding whether the Pettits had this intent, it should "consider undercapitalization of the corporation and the use of the corporate form to perpetrate a fraud, such as tax fraud, or to evade collective bargaining obligations." The court also instructed the jury to "consider whether the Pettits' use of corporate assets for personal gain diminished the ability of the corporations to satisfy their obligations."

The Employers allege that this charge to the jury misstated the law because in essence the jury was instructed that "garden-variety" fraud was sufficient to satisfy the fraud factor of the veil-piercing test.

[HN7] The intent to avoid collective bargaining obligations sufficient to satisfy the alter ego theory of liability does not necessarily satisfy the fraud factor in the veil-piercing test. See *id. at 1475.* "Garden-variety fraud" -- in this case, the Pettits' concealment of the relationship between North Bay and Nor-Cal-- is, by itself, insufficient to pierce the corporate veil. See *id. at 1476.* Rather, the Trust Funds must show that the Pettits misused the corporate form to perpetrate their fraudulent scheme to evade Nor-Cal's obligations **[*16]** to make contributions to the Trust Funds. See id.; *NLRB v. O'Neill, 965 F.2d 1522, 1531 (9th Cir. 1992)* (because individual had created corporation with intent to avoid collective bargaining obligations, fraud factor of veil-piercing test was satisfied).

The district court advised the jury to "consider the use of the corporate form . . . to evade legal obligations." The instruction tracked the language in UA Local 343 I that "whether the Pettits misused the corporate form to fraudulently evade the obligations of the collective bargaining agreement is in dispute." *48 F.3d at 1476.* The district court did not instruct the jury that "garden variety" fraud was sufficient to pierce the veil.

The Employers also contend that the trial judge's instruction was erroneous in including tax fraud as a proper basis for finding the Pettits liable on a veil-piercing theory.

[HN8] To pierce the corporate shell, the Trust Funds must prove some fraudulent conduct directed at them specifically or at a group of creditors to which they belong. See *Board of Trustees of the Mill Cabinet Pension Trust Fund v. Valley Cabinet & Mfg. Co., 877 F.2d 769, 774 (9th Cir. 1989)* **[*17]** (finding fraud factor not satisfied because there was no intent to defraud the trust fund); *Plumbers & Fitters, Local 761 v. Matt J. Zaich Constr. Co., 418 F.2d 1054, 1058 (9th Cir. 1969)* ("The disregarding of the corporate form of business should not rest on the manner of doing business in general but should rest on the effect that the manner of doing business has on the particular transaction involved."). The Employers' tax fraud was not designed to help them avoid their obligations under the CBA. Therefore, evidence of tax fraud does not tend to prove the fraud factor of the veil-piercing test.

The district court's error, however, was more probably than not harmless, and therefore reversal is not warranted. As we discuss below, ample evidence supported the jury's conclusion that the fraud prong of the veil-piercing test was satisfied by Pettit's misuse of the corporate form fraudulently to evade the obligations of his corporations to make contributions to the Trust Funds. See *Benigni v. City of Hemet, 879 F.2d 473, 480 (9th Cir. 1988)* (holding that "the failure to give a proper instruction did not prejudice the defendants because the evidence would **[*18]** have supported a verdict for the plaintiff even with that instruction").

The Employers also claim that the district court erred in instructing the jury that the "injustice" factor would be satisfied if the jury found "that it would be unjust to allow the Pettits to retain the rewards of their conduct." The Employers assert that the correct inquiry is "the degree of injustice visited on the litigants by recognition of the corporate entity," *UA Local 343 I, 48 F.3d at 1475* (quoting *Seymour, 605 F.2d 1105 at 1111)* (emphasis added), not the injustice of not holding the Pettits personally liable. The court, however, cured any error by subsequently instructing the jury that it had to determine "whether injustice will result to the plaintiffs." n7

n7 We reject the Employers' additional arguments that the district court's instructions did not provide adequate guidance to the jury on several issues. The district court adequately conveyed to the jury that the corporate veil should only be lifted in certain limited circumstances. It did not abuse its discretion in not specifically instructing the jury that it could only pierce the veil if it found that the Pettits had "controlled and dominated the corporation such that the individuality of the corporation ceased" but instead in instructing the jury to consider a sum of factors regarding the Pettits' control and lack of separateness. Further, the court did not abuse its discretion in tailoring the instructions to include only those veil-piercing factors relevant to this case. Finally, the court's failure to explain the terms "undercapitalization" and

"commingling" did not constitute an abuse of discretion, particularly when the instructions are evaluated in light of the long trial in which the jury became familiar with these terms through expert testimony. See *Marabelles, 724 F.2d at 1382-83.*

[*19]

C. Expert Testimony

The Employers argue that the Trust Funds' expert Paul Meyer was improperly permitted to testify to the legal conclusion that the Pettits should be found personally liable under the veil-piercing doctrine. On direct examination, the Trust Funds' counsel asked if Meyer had an opinion on "whether the corporate veil of Nor-Cal and North Bay has been pierced and the Pettits should be held personally responsible." The Employers' counsel objected on the ground that the testimony "goes to the ultimate issue." The judge overruled the objection. Meyer then responded, "Yes, that is my opinion," and that he believed "the corporations and the Pettits should be one in the same as it relates to the functioning of the expenses."

[HN9] The district court's rulings on the admissibility of expert testimony are reviewed for an abuse of discretion. See *Kumho Tire Co. v. Carmichael, 526 U.S. 137, 143 L. Ed. 2d 238, 119 S. Ct. 1167, 1176 (1999); Desrosiers v. Flight Int'l, 156 F.3d 952, 960* (9th Cir.), cert. dismissed, *119 S. Ct. 634 (1998).* Such rulings will be reversed only if "manifestly erroneous." Id. (quoting *General Elec. Co. v. Joiner, 522 U.S. 136, 118 S. Ct. 512, 517, 139 L. Ed. 2d 508 (1997)).* **[*20]**

[HN10] The Federal Rules of Evidence permit an expert to testify to his opinion if the expert's "scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue." *Fed. R. Evid. 702.* "Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." *Fed. R. Evid. 704(a).*

Expert testimony regarding a legal conclusion can be problematic. See *Aguilar v. International Longshoremen's Union Local No. 10, 966 F.2d 443, 447 (9th Cir. 1992)* (finding that reasonableness and foreseeability of plaintiff's reliance were matters of law for court's determination and therefore were inappropriate subjects for expert testimony); *United States v. Scop, 846 F.2d 135, 139 (2d Cir. 1988)* (holding that "Rule 704 was not intended to allow experts to offer opinions embodying legal conclusions."); *Marx & Co. v. Diners' Club, Inc., 550 F.2d 505, 509-10 (2d Cir. 1977)* (expert's testimony consisting of legal conclusions construing contract was inadmissible).

During the trial, however, the **[*21]** Employers did not specifically object that the testimony called for a "legal conclusion," but instead objected on the grounds that the testimony "goes to an ultimate issue." Given that testimony going to an "ultimate issue" is not inadmissible in a civil case solely on that ground, the Employers' objection on this ground was properly overruled and they failed to preserve for appeal their current objection that the testimony concerned a legal conclusion. See *United States v. Gomez-Norena, 908 F.2d 497, 500 (9th Cir. 1990).*

The Employers further contend that, while the court allowed Meyer to testify to the legal conclusion on the veil-piercing issue, it did not permit the Employers' expert Samuel Gallina to reach the issue. At trial, the Employers asked Gallina, "And have you formed an opinion as to whether or not the corporate form should be respected or whether the Pettits' personal assets should be reached?" The Trust Funds objected on the grounds that the question called for a legal conclusion, and the judge sustained the objection. The Employers' argument that this ruling was in error in light of the court's admission of Meyer's testimony fails because, unlike **[*22]** the Employers, the Trust Funds made the relevant objection that the question called for a legal conclusion. Moreover, the Employers were not actually prevented from receiving an answer to the question to which the Trust Funds had objected; counsel merely broke up the question into two separate ones and received answers to each part.

The Employers also argue that the judgment should be reversed because the Trust Funds' expert James Miller was permitted to testify repeatedly that the Employers had committed tax fraud. As discussed above, the evidence of tax fraud was not relevant to the fraud prong of the veil-piercing inquiry. Much of the evidence of the conduct that constituted tax fraud, however, was relevant to the "commingling" factor of the veil-piercing test, and thus the majority of the evidence was not erroneously admitted. Any error was harmless. n8

n8 We find the Employers' other objections to Miller's testimony to be without merit.

D. Substantial Evidence

The Employers appeal the district court's **[*23]** denial of their motion for judgment as a matter of law on the veil-piercing claim, arguing that the jury's verdict on this issue was not supported by substantial evidence. Specifically, they dispute whether substantial evidence supports the fraud and injustice prongs of the veil-piercing inquiry. [HN11] The denial of a motion for

judgment as a matter of law is reviewed de novo. See *Scott v. Ross, 140 F.3d 1275, 1281 (9th Cir. 1998)*, cert. denied, *119 S. Ct. 1285 (1999)*. [HN12] Judgment as a matter of law should be granted where the evidence permits only one reasonable conclusion, and that conclusion is contrary to the jury's. See id.

We agree that evidence of Pettit's tax fraud should not be considered in determining whether there is substantial evidence supporting the fraud prong. We find, however, that substantial evidence buttresses the conclusion that Pettit abused the corporate form fraudulently to evade his contractual obligations to make contributions to the Trust Funds. Contrary to the Employers' contention, much of the same evidence relevant to prove under the alter ego theory that North Bay was created and operated "in an attempt to avoid the obligations **[*24]** of Nor-Cal's collective bargaining agreement," *UA Local 343 I, 48 F.3d at 1473,* will also be relevant to show the Employers' abuse of the corporate form to avoid its contractual obligations under the veil-piercing test. UA Local 343 I held only that proving labor law alter ego liability is not necessarily sufficient on its own to satisfy the fraudulent intent element of the veil-piercing test. See *id. at 1475.* We previously found that there was substantial evidence offered at the summary judgment stage that Pettit's purpose in establishing North Bay was to avoid his contractual obligations to make contributions to the Trust Funds. See *id. at 1473.* When added to the evidence of the abuse of the corporate form elicited through the Trust Funds' experts' testimony, along with all the other evidence adduced at trial, we find that substantial evidence supported the jury's determination that Pettit misused the corporate forms of North Bay and Nor-Cal to perpetrate his fraud on the Trust Funds. Pettit's conduct appears to be a paradigmatic example of abusing the corporate form to defraud creditors. n9 Accordingly, we affirm the district **[*25]** court's denial of the Employers' motion for a judgment as a matter of law.

n9 Because of the substantial evidence of Pettit's fraudulent intent sufficient to uphold the verdict imposing individual liability on Pettit, we need not consider whether the Trust Funds presented substantial evidence to satisfy the injustice factor of the veil-piercing inquiry.

III. Section 301 Fraud Claim

The district court allowed the jury to consider whether North Bay and Nor-Cal were guilty of fraud under § 301 of LMRA in deliberately concealing through affirmative misrepresentations that they were alter egos, thereby inducing the Trust Funds not to exercise their rights based on the Nor-Cal CBA. The jury held Nor-Cal and North Bay liable on the claim, and the Employers now appeal this basis of liability. We need not consider the propriety of this claim, however, because the jury returned a special verdict specifically finding Nor-Cal and North Bay liable on the alter ego theory. The jury's express adoption of this theory **[*26]** is sufficient alone to support the judgment against Nor-Cal and North Bay. See *Taylor v. Burlington N. R.R. Co., 787 F.2d 1309, 1315 (9th Cir. 1986).*

The district court dismissed a similar fraud claim against the individual Pettits. The Trust Funds appeal this determination. n10

n10 Although Pettit was found personally liable on a veil-piercing theory, and thus it is inconsequential whether the § 301 fraud claim against him should have been allowed to proceed, the jury did not pierce the veil with respect to his wife, and so we must determine whether the district court should have allowed the jury to consider the § 301 claim against her.

In suits under § 301, we have refused to impose personal liability on the sole shareholder of a corporate employer that has breached its obligations under LMRA, except when the veil-piercing test has been satisfied. See *Audit Servs., Inc. v. Rolfson, 641 F.2d 757, 764 (9th Cir. 1981).* See also *Antol v. Esposto, 100 F.3d 1111, 1118 (3rd Cir. 1997)* **[*27]** (noting that individual corporate officers are not liable under § 301 when there is no basis for piercing the corporate veil). n11 Therefore, the district court did not err in striking the cause of action under § 301 against the Pettits.

n11 Of course, where a collective bargaining agreement specifically provides for personal liability of a corporate officer, such a provision will be upheld. See *Employee Painters' Trust v. J & B Finishes, 77 F.3d 1188, 1192 (9th Cir. 1996)*

IV. Evidentiary Objections

The Employers contend that the Trust Funds' expert witnesses, accountants Meyer, Miller, and Steve Grannis, all relied on hearsay and information from lay witnesses in their testimony, and thus they argue that neither the experts' opinions nor the underlying data should have been admitted at trial. They correctly assert that much of the data underlying the experts' testimony could not be

independently admitted into evidence because it was hearsay.

Meyer testified that it was common for [*28] experts testifying to similar issues to rely on sworn and unsworn statements of witnesses. Further, there is authority for accountants relying on lay witnesses in forming their opinions and relaying them at trial. See *United States v. Affleck, 776 F.2d 1451, 1457 (10th Cir. 1985)* (finding that accountant testifying as expert witness relied on reasonable data including **hearsay from interviews** with previous accountant of defendant, other former employees, and bankruptcy trustee); *International Adhesive Coating Co. v. Bolton Emerson Int'l, Inc., 851 F.2d 540, 545 (1st Cir. 1988)* (holding that accountant expert witness had reasonably relied on interviews with company personnel). Because the district court determined that the data was of a type upon which accountants reasonably rely in forming their opinions, it did not err in permitting the experts to rely on this data in the course of their testimony or in admitting the data for the limited purpose of explaining the basis of their opinions. See *Fed. R. Evid. 703*; *Paddack v. Dave Christensen, Inc., 745 F.2d 1254, 1261-62 (9th Cir. 1984)* (holding that if information relied on by an [*29] expert is not independently admissible, it may be admitted to help explain expert's opinion but not to establish the truth of what it asserts). The district court properly instructed the jury that the hearsay evidence was to be considered only as a basis for the expert opinion and not as substantive evidence. See *Paddack, 745 F.2d at 1262.* Accordingly, the district judge did not abuse her discretion in admitting this evidence.

The Employers also contend that several of the Trust Funds' experts improperly gave their opinions on witness credibility in the course of testifying by relying on certain statements of witnesses while not relying on other evidence. In Scop, the Second Circuit found that it was improper for expert witnesses to offer opinions based on their assessment of the credibility of another witness's testimony at trial. See *846 F.2d at 142.* See also *United States v. Barnard, 490 F.2d 907, 912-13 (9th Cir. 1976)* (holding that expert psychiatric testimony that defendant-witness was a sociopath who would lie to his advantage was improper opinion about defendant's credibility). The Trust Funds' experts did not directly [*30] or indirectly comment on the credibility of other witnesses, and thus Scop and Barnard are not on point. The experts merely chose to rely on certain evidence they deemed to be consistent with other evidence. n12 [HN13] Every expert will make decisions as to which pieces of evidence to rely on; on cross-examination the opposing party is entitled to challenge why the expert seemingly ignored certain evidence.

n12 The one occasion on which Meyer stated that he believed Nor-Cal's business records supported the testimony of a particular witness did not amount to a judgment on the credibility of the witness.

The Employers contend, however, that they were not permitted to cross-examine the Trust Funds' experts to bring attention to the experts' decisions to ignore some evidence. [HN14] "The scope and extent of cross-examination of expert witnesses rests in the sound discretion of the trial court and "is not subject to exception unless wholly arbitrary, unreasonable and abusive, and the examination need not be extended to [*31] permit interrogation about collateral, immaterial or irrelevant matters.'" *United States v. 10.48 Acres of Land, 621 F.2d 338, 340 (9th Cir. 1980)* (quoting *United States v. 25.02 Acres of Land, 495 F.2d 1398, 1402 (10th Cir. 1974)).* We find that the trial judge did permit cross-examination testing the foundation of the expert's opinion, and only excluded questions that were not relevant to the expert's testimony or were overly prejudicial. In cross-examining both Meyer and Miller, the Employers sought to bring to light allegations that the Trust Funds' investigator had gotten a witness drunk before taking his declaration. During their direct examinations, Meyer had not relied on that witness's testimony at all, and Miller had relied on only one piece of testimony from the declaration that was corroborated by the witness's later deposition testimony. The trial judge permitted the Employers to cross-examine Miller on his reliance of the witness's declaration for the one point from the declaration, but sustained the Trust Funds' objections to the Employers' attempt to further delve into the evidence of impropriety on the Trust Funds' part during the taking [*32] of the witness's declaration. Because Meyer or Miller did not rely extensively on the witness's declaration, the district court did not abuse its discretion in concluding that cross-examining them about the reliability of the declaration would not have been probative. Similarly, the district court did not abuse its discretion in excluding a question on the cross-examination of Meyer regarding prejudicial deposition testimony by Nor-Cal's bookkeeper when her testimony did not relate to any matter to which Meyer had testified.

The Employers also complain that the district court erred in refusing their request to admit the Lindquist files -- 19 boxes of documents that the experts had perused before testifying -- to show the jury the items that the Trust Funds' experts had chosen to ignore in forming their opinions. [HN15] The Federal Rules of Evidence provide that experts may be required to disclose the sources upon which they have relied, but they do not make these sources automatically admissible. See *Fed.*

R. Evid. 705. Moreover, cumulative and non-relevant evidence may be excluded, see *Fed. R. Evid. 402, 403,* and much of the evidence in the Lindquist files had already been admitted **[*33]** or was not probative. The Employers had access to all the contents and were free to introduce particular pieces of evidence. It was not an abuse of discretion to refuse to admit the Lindquist files into evidence wholesale.

The Employers also appeal the admission of certain evidence they deem was inadmissible hearsay. [HN16] Hearsay rulings are reviewed for abuse of discretion. See *Hagood v. Sonoma County Water Agency, 81 F.3d 1465, 1479 n.24 (9th Cir. 1996).*

The Employers contend that Trial Exhibits 48 and 53A, summaries based on a variety of records and testimony taken over the course of the litigation, were erroneously admitted. [HN17] A summary is admissible if it helps boil down "the contents of voluminous writings, recordings, or photographs which cannot conveniently be examined in court ...." *Fed. R. Evid. 1006.* "The proponent of a summary must establish a foundation that: (1) the underlying materials upon which the summary is based are admissible in evidence; and (2) the underlying documents were made available to the opposing party for inspection." *Paddack, 745 F.2d at 1259.* "It is clear that a summary of both inadmissible and admissible hearsay should **[*34]** not be admitted under Rule 1006." *Id. at 1260.* Where it is uncertain precisely which portions of the summary rest on inadmissible hearsay, the whole summary is inadmissible. See *id. at 1261.*

Exhibit 48, mainly comprised of Nor-Cal and North Bay records that constitute party admissions, was partly based on the deposition testimony of two customers of Nor-Cal and North Bay. Similarly, the data underlying Exhibit 53A primarily consisted of Nor-Cal and North Bay records, but did include summaries produced by one of Nor-Cal and North Bay's customers. Therefore, both exhibits contained hearsay. They were admitted over the Employers' objection that they contained hearsay and assumed facts not in evidence.

While a summary of hearsay properly admitted as a business record is admissible, see *Papadakis v. United States, 208 F.2d 945, 951-52 (9th Cir. 1953),* the Trust Funds did not lay a foundation for the underlying data to be admitted as business records. See *Fed. R. Evid. 803(6).* Because the summaries contained hearsay to which no exception applies, it was error to admit them into evidence.

Reversal is only warranted, however, if prejudice **[*35]** is shown. *City of Long Beach v. Standard Oil Co., 46 F.3d 929, 936 (9th Cir. 1995).* The exhibits in question were mainly based on the non-hearsay records of North Bay and Nor-Cal. The fact that the jury considered some hearsay statements of Nor-Cal and North Bay's customers did not prejudice the verdict. Therefore, reversal is not warranted on these grounds.

The Employers also challenge the admission of the testimony of two former North Bay employees regarding out-of-court statements made by John Adams, the deceased former supervisor of North Bay, about statements Pettit made to Adams. We found in UA Local 343 I that North Bay and Nor-Cal were a single employer, owned and operated by Pettit. See *48 F.3d at 1473.* Therefore, Adams, as a North Bay employee, was Pettit's agent, and the statements Adams made within the scope of his employment were clearly admissible as agent admissions. See *Fed. R. Evid. 801(d)(2)(D).*

V. Special Verdict

[HN18] The district court has broad discretion in deciding whether to employ a special or general verdict. See *United States v. Real Property Located at 20832 Big Rock Drive, 51 F.3d 1402, 1408 (9th Cir. 1995).* **[*36]** "This discretion extends to determining the content and layout of the verdict form, and any interrogatories submitted to the jury, provided the questions asked are reasonably capable of an interpretation that would allow the jury to address all factual issues essential to judgment." Id.

The special verdict form in this case asked the jury to answer the ultimate question with respect to each claim -- alter ego liability, § 301 fraud, and veil-piercing -- and then asked the jury to ascertain the amount of damages. The Employers contend that the verdict form should have asked for an answer on each element of each claim, thus ensuring that the jury understood the instructions given them. Given the deference accorded to the trial judge's choice of verdict forms and the great length and confusing nature of the verdict form the Employers proposed, we reject the Employers' argument. There was no abuse of discretion.

VI. Relitigation of Damages

The Trust Funds appeal the amount of damages awarded them at trial, claiming that the district court's calculation of compensatory damages at the summary judgment stage was the "law of the case" and that the amount should not have been **[*37]** relitigated at trial. We find that the doctrine of the "law of the case" is inapplicable to the amount of damages because UA Local 343 I did not decide the issue explicitly or by necessary implication. See *Rebel Oil Co., 146 F.3d at 1093.* Our reversal of the grant of summary judgment necessarily nullified the award of compensatory damages and the Employers did not concede the validity of the

amount awarded on summary judgment by not appealing the amount of damages in UA Local 343 I. See *Wheeler v. John Deere Co., 935 F.2d 1090, 1096 (10th Cir. 1991)* (where first judgment was reversed, jury's award of damages was reversed and could not be reinstated at second trial, even though defendant failed to appeal amount of damages awarded by the first jury). The amount of consequential damages awarded by the jury stands.

VII. Conclusion

For the aforementioned reasons, the judgment of the district court is

AFFIRMED.

FOCUS - 8 of 23 DOCUMENTS

In the Matter of CHAMPION SPARK PLUG COMPANY, a corporation

DOCKET NO. 9141

Federal Trade Commission

1982 FTC LEXIS 81

ORDER DENYING MOTION TO STRIKE

August 20, 1982

ALJ: [*1]

James P. Timony, Administrative Law Judge

ORDER:

ORDER DENYING MOTION TO STRIKE

Complaint counsel move to strike RX 4008 and RX 4009 and testimony related thereto. The exhibits are depositions of two executives of Fram Corporation.

Dr. Nelson, complaint counsel's expert, testified as to why Fram was unsuccessful in producing windshield wipers. On cross-examination, he said he read, but did not rely on, the depositions in question. n1 The depositions apparently contradict Dr. Nelson as to the reason for Fram's lack of success, and they were admitted for impeachment purposes only. n2

n1 Complaint counsel apparently later expanded the basis for Dr. Nelson's opinions concerning Fram's experience to include the depositions. (Tr. 6402)

n2 Respondent cannot, of course, base a finding on the depositions as to the reason for Fram's failure; the depositions can be used solely to dispute Dr. Nelson's testimony.

Dr. Nelson has previously cited his telephone call to a buyer for K-Mart as the basis for his opinion that K-Mart does not install windshield wipers. n3 I believe that the depositions, where opposing counsel had the opportunity to cross-examine, n4 are at least as trustworthy as **[*2]** such a telephone call.

n3 This was admitted under **Rule 703,** allowing **hearsay** as the basis for an opinion if of a type reasonably relied on by **experts** in the field.

n4 In Bobb v. Modern Products, Inc., 648 F. 2d 1051 (5th Cir. 1981), defendant's counsel successfully argued to exclude the deposition of plaintiff's medical expert on the grounds that he did not receive timely notice and did not attend the deposition; that it was taken after the cut-off date for discovery; and that it was cumulative. The circuit court found reversible error when defendant's counsel was then allowed to use the defective deposition to cross-examine another medical expert who testified for plaintiff.

Here, by contrast, the depositions were not defective and respondent's counsel has consistently supported the accuracy of the testimony in the depositions.

Exhibit 3

The motion to strike is denied. In summary, the ruling here is that where an expert reviews depositions of a third party, taken in the same case, and parts of the depositions serve as the basis for his opinion, those depositions n5 will be admitted in evidence for purposes of impeachment.

n5 See Rule 3.33(g)(iv).

FOCUS - 5 of 23 DOCUMENTS

In the Matter of R.R. DONNELLEY & SONS CO., a corporation, and PAN ASSOCIATES, L.P., a limited partnership.

DOCKET NO. 9243

Federal Trade Commission

1993 FTC LEXIS 181

July 28, 1993

ORDER:
[*1]

ORDER RULING ON COMPLAINT COUNSEL'S MOTION TO ADD ADDITIONAL EXHIBITS

On June 24, 1993, I stated that complaint counsel could respond to exhibits prepared by Dr. Hausman which I received in evidence even though complaint counsel had not received prior notice with respect to these exhibits.

Complaint counsel now offer CX's 1442-1459 in response to these exhibits. Donnelley objects to most of them, arguing that they are not responses to the few exhibits which I received but are an attempt to introduce new evidence. The exhibits are:

CX's 1451 and 1459: These exhibits relate to RX-691, which was given to complaint counsel on June 8, 1993, the date that Donnelley was to reveal its surrebuttal exhibits. They do not relate to a new exhibit and are therefore rejected.

CX's 1445, 1449 and 1450: These proposed exhibits relate to documents that were not received in evidence and they are rejected.

CX 1442: The documents to which this proposed exhibit relate were new exhibits since complaint counsel were not fully apprised of their intended use until the morning of June 17. This document will be received in evidence.

CX's 1443 and 1444: These documents relate to **[*2]** late-submitted RX-708 and will be received in evidence.

CX's 1452, 1453, 1454, 1456, 1457 and 1458: **Experts** commonly rely on **hearsay** evidence to form their opinions. Since Dr. Hilke's notes are reliable **hearsay,** they will be received in evidence.

CX's 1446, 1447, 1448, 1455: Donnelley does not object to these exhibits. Therefore,

IT IS ORDERED that the following exhibits be, and they hereby are, received in evidence: CX's 1442-A-D (in camera), 1443-A-D (in camera), 1444 (in camera), 1446-A-E (in camera), 1447-A-E (in camera), 1448-A-F (in camera), 1452-A-E (in camera), 1453-A-B (in camera), 1454-A-E, 1455-A-Z-26, 1456 (in camera), 1457 (in camera), and 1458-A-B (in camera).

Dated: July 28, 1993

REDACTED

Exhibit 5

HEALTH POLICY REPORT

PATIENT SAFETY

Understanding and Responding to Adverse Events

Charles Vincent, Ph.D.

An adverse outcome for a patient is difficult, sometimes traumatic, for all concerned. Such incidents pose considerable challenges to an organization, both in terms of the need to respond intelligently to their occurrence and in terms of the need to deal with their aftermath. The challenge is to find a way forward that provides the necessary support for the people involved while ensuring that the lessons of the incident are learned both by individual staff members and by the overall organization. In this article, I address two broad themes: first, how to investigate clinical incidents and learn useful lessons from them, and second, how to support the patients, families, and staff members who are involved.

HUMAN ERROR AND SYSTEMS APPROACHES IN MEDICINE

In most high-risk industries, learning from accidents and near-misses is a long-established practice and a cornerstone of safety analysis and improvement. Aviation accidents, for instance, are exhaustively investigated, and the lessons learned are disseminated widely, with important changes made mandatory by regulatory authorities. In contrast, learning within the health care sector, with some notable exceptions, has generally been fragmentary and uncertain.[1,2] There are a number of methods of investigation and analysis available in health care, but they tend to be underdeveloped in comparison with the methods available in industry. In the United States, the most familiar is the approach of root-cause analysis, developed by the Joint Commission on Accreditation of Healthcare Organizations, an intensive process with origins in "total quality management" approaches to health care improvement.[3] The Veterans Health Administration has developed a highly structured system of triage questions that is being disseminated throughout the system.[4] In Britain, my colleagues and I have developed a method based on James Reason's model of organizational accidents and a framework of contributory factors.[5,6] The protocol describing this method provides a step-by-step guide to the systematic investigation and analysis of any clinical incident.

The purpose of such analyses is often framed as the need to find the root cause of an adverse incident, tracing it back over a series of events to some fundamental problem. However, this perspective is misleading in two important respects. First, it implies that the incident has a single root cause, or at least a small number of causes, but this is an oversimplification. Usually, a chain of events and a wide variety of contributory factors lead up to the event. Second, it implies that the purpose of the investigation is simply to find out what caused the incident. However, while determining a cause is important, it is not the final goal. The real purpose is to use the incident to reveal gaps and inadequacies in the health care system. From this perspective, the investigation is proactive and forward-looking. For these reasons, we prefer the approach called "systems analysis" over "root-cause analysis."

ANALYSIS OF CLINICAL INCIDENTS

Studies of accidents in industry, transportation, and the military have broadened the understanding of accident causation, reducing the focus on the individual persons who may have made an error and aiming it instead on preexisting organizational factors. The theory underlying the approach described here is based on Reason's organizational-accident model.[7] Reason's essential insights are as follows. Incidents and accidents are usually preceded by some kind of "unsafe act," in which a person makes an error or mistake. However, to understand how this mistake occurred, it is necessary to look further, back to the "error-producing conditions" that led to the unsafe act and to "latent failures," or the decisions made by management and others that may have had a bearing on the outcome. We have extended and adapted Reason's model for use in health

Exhibit 6

care by developing a broad framework of contributory factors that can affect clinical practice and that includes both error-producing conditions and latent failures[8] (Table 1). The framework essentially summarizes the major influences on clinicians in their daily work and the systemic contributions to adverse outcomes, or indeed to good outcomes.

CARE-MANAGEMENT PROBLEMS

IDENTIFICATION

Once the sequence of events is clear, there are three main considerations: the care-management problems identified among the events, the clinical context of each of these problems, and the factors contributing to their occurrence.

The first step in any analysis is to identify "care-management problems," which broadly speaking are the health care equivalent of Reason's unsafe acts. Care-management problems are actions or omissions by staff members in the process of care. They may be simple mistakes, such as picking up the wrong syringe; lapses of judgment; omission of a procedure because of forgetfulness; or, in rare cases, deliberate departures from safe operating practices, procedures, or standards (Table 2). Care-management problems have two essential features: first, they involve care that deviates from safe limits of practice, and second, the deviation leads, directly or indirectly, to an adverse outcome for the patient.

CLINICAL CONTEXT AND PATIENT-RELATED FACTORS

For each care-management problem identified, the investigator should record the salient clinical events or the condition of the patient at the time (e.g., heavy bleeding or decreasing blood pressure). The investigator also needs to record other patient-related factors that may have affected the process of care (e.g., great distress on the part of the patient or an inability to understand clinicians' instructions).

CONTRIBUTORY FACTORS

Having identified the care-management problem, the investigator should then consider the conditions in which errors may occur within the overall organ-

Table 1. Framework of Factors Influencing Clinical Practice and Contributing to Adverse Events.*

Framework	Contributory Factors	Examples of Problems That Contribute to Errors
Institutional	Regulatory context Medicolegal environment	Insufficient priority given by regulators to safety issues; legal pressures against open discussion, preventing the opportunity to learn from adverse events
Organization and management	Financial resources and constraints Policy standards and goals Safety culture and priorities	Lack of awareness of safety issues on the part of senior management; policies leading to inadequate staffing levels
Work environment	Staffing levels and mix of skills Patterns in workload and shift Design, availability, and maintenance of equipment Administrative and managerial support	Heavy workloads, leading to fatigue; limited access to essential equipment; inadequate administrative support, leading to reduced time with patients
Team	Verbal communication Written communication Supervision and willingness to seek help Team leadership	Poor supervision of junior staff; poor communication among different professions; unwillingness of junior staff to seek assistance
Individual staff member	Knowledge and skills Motivation and attitude Physical and mental health	Lack of knowledge or experience; long-term fatigue and stress
Task	Availability and use of protocols Availability and accuracy of test results	Unavailability of test results or delay in obtaining them; lack of clear protocols and guidelines
Patient	Complexity and seriousness of condition Language and communication Personality and social factors	Distress; language barriers between patients and caregivers

* The framework is based on Vincent et al.[8]

Table 2. Examples of Care-Management Problems.
Failure to monitor, observe, or act
Delay in diagnosis
Incorrect assessment of risk (e.g., risk of suicide or self-harm)
Loss of information during transfer to other health care staff
Failure to note faulty equipment
Failure to carry out preoperative checks
Deviation from an agreed protocol (without clinical justification)
Failure to seek help when necessary
Use of incorrect protocol
Treatment given to wrong body site
Wrong treatment given

izational context. These are the contributory factors. For each care-management problem, the investigator uses the proposed framework based on Reason's model (Table 1), both during interviews and afterward, to identify the factors that led to the care-management problem. A variety of factors may be relevant. Individual factors may include lack of knowledge or experience on the part of particular staff members. Task factors may include the unavailability of test results or protocols. Team factors may include inadequate supervision or poor communication among staff members. Factors related to the work environment may include heavy workloads, inadequate staffing, or limited access to vital equipment.

Any combination of these factors can contribute to the occurrence of a single care-management problem. The investigator should differentiate between contributory factors that were relevant only on the particular occasion in question and those that are long-standing features of the organization. For instance, a failure of communication between two midwives may have contributed to a care-management problem. If such a failure of communication seldom occurs, then it may not have any implications beyond the specific care-management problem in question and may not need to be considered further. If, on the other hand, such a failure is common, then the incident clearly reflects a wider, systemic problem that needs to be addressed.

THE INVESTIGATION PROCESS

Information can be gleaned from a variety of sources. Case records, statements from witnesses, and any other relevant documents should be reviewed. Structured interviews with involved members of the staff are then undertaken to establish the sequence of events, the main care-management problem, and the contributory factors, as perceived by each staff member. Interviews should include the following key questions: "What happened?" (which provides information on the outcome and chronology), "How did it happen?" (which helps identify the care-management problem), and "Why did it happen?" (which helps identify contributory factors).

Although a considerable amount of information can be gleaned from written records, interviews with the people involved are the most important method of identifying contributory factors. This is especially true if the interview explores these factors systematically and thus allows each interviewed staff member to collaborate in the investigation. In the interview, the story and "the facts" are just the first stage of information gathering. The investigator should also encourage the staff member to identify both the care-management problems and the contributory factors, an approach that greatly enriches both the interview and investigation. Of course, the incident should also be discussed with the involved patient and his or her family, and they should be informed of the results of the inquiry. The potential contribution of patients to such investigations has yet to be properly explored.

Investigations based on this method have been conducted in hospitals, primary care settings, and mental health units. The protocol may be used in a variety of formats and may be used by individual clinicians, researchers, or risk managers or by clinical teams. In cases of serious incidents, a team of investigators with different skills and backgrounds may be assembled; otherwise, often only a risk manager or an individual clinician is needed. A clinical team may use the method to guide and structure reflection on an incident and to ensure that the analysis is full and comprehensive. The team approach is also useful for promoting understanding of the protocol itself and for introducing systems-oriented analysis. Although reading about systems analysis is helpful, actually analyzing an adverse incident brings the method to life.

The contributory factors that reflect general

problems in a unit should be the targets for change and systems improvement. When obvious problems are identified after a single adverse incident, action may be taken immediately; when more substantial changes are being considered, other sources of data (e.g., routine audits and outcome data) and the results of other incident analyses should also be taken into account. Recommendations may be made in a formal report, but it is essential that the people responsible for implementation are specified and that the recommendations are followed up with monitoring of the actions taken and of the outcomes.

THE EFFECT OF ADVERSE INCIDENTS ON PATIENTS AND FAMILIES

Patients are often in a vulnerable psychological state, even when the diagnosis is clear and the treatment goes according to plan. Even routine procedures and normal childbirth may produce posttraumatic symptoms.[9,10] Therefore, when patients experience harm or an unexpected event, their reaction is likely to be particularly severe. Patients and relatives may suffer in two distinct ways after an adverse outcome: they may suffer first from the incident itself and second from the manner in which the incident is subsequently handled. Many people harmed by treatment suffer further trauma if the incident is handled insensitively or inadequately. Conversely, when staff members come forward, acknowledge the damage, and take the necessary corrective actions, the overall effect on patients can be greatly reduced.

Medical injuries differ from most other injuries in two important respects. First, patients are unintentionally harmed by the people in whom they have placed considerable trust, so their reaction may be especially powerful and complex. Second, they are cared for by members of the same profession, and in some cases the same clinicians, as those who were involved in the injury itself. They may be very frightened by what has happened and have a range of conflicting feelings about those involved, even when staff members are sympathetic and supportive.[11,12]

A patient's initial reactions to a medical injury are most likely to be fear, loss of trust, and a feeling of isolation. Traumatic and life-threatening events produce a variety of symptoms in addition to any physical injury. Anxiety, intrusive memories, emotional numbness, and flashbacks are all common sequelae and are important components of posttraumatic stress disorder.[13] The full effect of most incidents becomes apparent only in the long term. A perforated bowel, for example, may require a series of additional operations and additional time in the hospital. The long-term consequences may include chronic pain, disability, and depression, with deleterious effects on family relationships and the ability to work. Whether a patient who has been harmed actually becomes depressed and to what degree depends on the severity of the injury; the support he or she has from family, friends, and health professionals; and a variety of other factors.[14]

When a patient dies, the trauma to his or her family members may be very severe, particularly if the death was potentially avoidable.[15] By analogy, many people who have lost a spouse or child in a road accident continue, for years afterward, to ruminate about the accident and about what could have been done to prevent it. They are often unable to accept, resolve, or find any meaning in the loss.[16] Likewise, relatives of a patient whose death is sudden or unexpected may find the loss very difficult to bear. If the death was avoidable, in the sense that poor treatment played a part in it, relatives may face an unusually traumatic and prolonged bereavement.

CARING FOR PATIENTS HARMED BY TREATMENT

The trauma to patients harmed by treatment can be greatly reduced if certain basic principles[12] are borne in mind. Clinicians should believe people who say their treatment has harmed them, at least in the first instance. Given the scale of potential harm from medical treatment, such a claim should at least be considered seriously. The patient may have information the caregivers lack. If the patient's concern is groundless, a complete and sympathetic explanation is essential therapy. Being ignored can be distressing to a patient and may delay remedial treatment. Caregivers should also be honest and open about the incident and about what is being done to prevent a recurrence. The lack of an explanation, and of an apology if appropriate, may be experienced by the patient as extremely punitive and distressing and may be a powerful stimulus to complaint or litigation.[17] Clinicians should ensure continuity of care and maintain the therapeutic relationship. After an injury, patients and families need more support, not less, although both patients and clinicians may feel a natural wish to distance themselves from one another after an adverse event.

Patients should be asked specific questions about emotional trauma, especially with regard to any anxieties they may have about future treatment. Psychological treatment may be needed when reactions are severe. In addition, the institution should provide practical and financial help quickly. A relatively small sum of money can make a substantial difference after an injury when it is spent wisely on child care or disability aids or when it is used to alleviate temporary financial hardship.

The initiatives of individual clinicians and risk managers must be strongly supported by policies and directives at the institutional level. It is unreasonable to expect a clinician to be honest and open about problems that have occurred if he or she anticipates later facing sanctions from senior management. All health care organizations need a strong, proactive policy of active intervention and monitoring of patients who have been harmed by treatment. Clearly, there is an ethical imperative to inform patients of adverse outcomes, but the fear of legal action and media attention can act as a major disincentive to do so. Nevertheless, organizations that have followed the path of open disclosure have not been overwhelmed by lawsuits and have argued strongly for others to follow their example.[12,18]

THE EFFECT OF ADVERSE INCIDENTS ON STAFF

The aftermath of an adverse event can also have profound consequences on the staff members involved, particularly if an individual member is seen, rightly or wrongly, as primarily responsible for the outcome. After making a mistake, caregivers may experience shame, guilt, and depression; litigation and complaints impose an additional burden. In some cases, doctors or nurses may become very anxious about practicing clinical medicine, seek out a specialty with less direct patient contact, or abandon medicine entirely.[19,20] Wu expresses the typical reaction of the clinician in such a situation, whom he aptly describes as "the second victim," thus:

> Virtually every practitioner knows the sickening feeling of making a bad mistake. You feel singled out and exposed — seized by the instinct to see if anyone has noticed. You agonize about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger.[21]

The reaction of the patient and his or her family may be hard to bear, especially if the outcome is severe and if there has been close involvement between the patient and the clinician over a long period. The reaction of colleagues, whether supportive or defensive and critical, may be equally powerful. Clinicians, like everyone else, vary in temperament, resilience, and attitude with respect to their own errors. To a highly self-critical person, errors and mistakes may be particularly disturbing. The high personal standards of excellent clinicians may in fact make them particularly vulnerable to the consequences of mistakes. This tendency is generally reinforced during medical training; the culture of medical school and residency implies that mistakes are unacceptable and, when serious, that they point to a failure of effort or character.[22]

SUPPORTING STAFF AFTER ADVERSE INCIDENTS

News of a major adverse incident spreads rapidly. Caregivers who are directly involved, in addition to feeling anxious and ashamed, may also feel isolated. With other staff members, too, a number of things can be done to limit the damage and support those involved.

Clinicians should be open about error and its frequency. Senior staff members' talking openly about past mistakes and problems is particularly effective. The need for support is not a sign of weakness. Clinicians are trained to be resilient, but almost all are grateful for the support of colleagues when a problem occurs. For a particularly profound reaction, perhaps, for example, to the death of a child, formal psychological intervention may be valuable.[23,24]

Clear guidelines for discussing errors with patients should be backed up by an institutional policy on open disclosure. In addition, the institution should offer training in the difficult task of communicating with patients and families in the aftermath of an adverse event.[25] Basic education in the law and the legal process surrounding medical incidents should also be offered and may reduce some of the anxiety about possible legal action.

CONCLUSIONS

The learning and organizational change that can follow the systematic and thoughtful investigation of an incident have not been given sufficient attention in health care. Such investigations are only one component of general quality and safety strategies, but they are a vitally important one. The patient's perspective has been neglected in patient-safety strategies,[26] and yet few things are more destructive to public trust and staff morale than the failure to respond positively to the patients and staff involved in adverse events. Systems analyses and support for patients and staff should be absolute priorities in any risk-management and safety strategy.

I am indebted to Donald Berwick, M.D., and Lucian Leape, M.D., for their helpful comments on an initial draft of this article and to Sally Taylor-Adams, principal coauthor of the original protocol of analysis and investigation.

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Survey Process

The on-site survey process is a key activity in the accreditation process. The survey will consist of staff, resident and family interviews, tours, observations, and review of selected documentation in an effort to understand how your systems are compliant with the Joint Commission standards.

The Joint Commission health care network standards address your organization's level of performance in specific areas - not simply what the organization is capable of performing, but what it actually does. Standards are based on maximum achievable expectations, and set forth performance expectations for activities that affect the quality of care. The method of how to meet the performance objectives articulated in the standards is up to your organization.

The Accreditation Process

In 2004, the Joint Commission introduced significant changes into the accreditation process. To understand the changes in the process, there are several significant new terms to learn which explain the changes: Periodic Performance Review, Plan of Action, Measure of Success Priority Focus Process, Tracer Methodology, and Evidence of Standards Compliance.

The new accreditation process shifts accreditation away from survey preparation to continuous standards compliance. The survey becomes just the on-site evaluation piece of a continuous process.

Periodic Performance Review (PPR)

Beginning with resurveys scheduled in July 2005, organizations will be required to participate in a mid-cycle evaluation of standards compliance called the Periodic Performance Review (PPR). Fifteen months after the completion of its last on-site survey an organization will receive an electronic tool to assist in the Periodic Performance Review. The organization will have three months in which to complete the assessment

The PPR will be required for organizations scheduled for resurvey beginning in July 2005. While it is not required that long term care facilities new to accreditation complete the PPR prior to their initial accreditation survey, we've taken steps to familiarize you with the methodology as well. The *Comprehensive Accreditation Manual for Health Care Networks (CAMHCN)* has been

Other Programs' Standards

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- Standards Online Question Submission Form
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- Infection Control
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- Sign Up for Newsletters
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- Eisenberg Award
- Infomart
- Education
- Publications

Exhibit 7

formatted to include a self-assessment grid next to each element of performance. You can use the grid for your own "paper self-assessment." Also included in the *CAMHCN* is a disc with a chapter of the PPR tool so that organizations can familiarize themselves with the tool.

The Full PPR process requires organizations to review all applicable standards and Accreditation Participation Requirements from the *CAMHCN*, and the National Patient Safety Goals. Physician involvement will be a very important part of the self-assessment process with the PPR. If you have made a habit of conducting mock surveys in your organization, the PPR should be a familiar process.

Completion of the assessment portion of the PPR will allow an organization to identify areas where it may not be in compliance with standards. The goal of a Periodic Performance Review is to help organizations identify performance areas out of compliance, and to guide them along the road to correcting these non-compliant areas before the next on-site survey.

For those areas self-identified as out of compliance with Joint Commission standards, the organization will submit a Plan of Action to the Joint Commission along with Measures of Success that will substantiate that the standard has been brought into compliance. Within the Joint Commission, there is a Standards Interpretation Group (SIG) whose responsibilities include answering organizations' questions about interpreting and applying the standards. The SIG will review each organization's Plan of Action and Measure of Success in a telephone interview and indicate whether the action plans, Measures of Success and timetables are acceptable to bring the standard into compliance.

During the next on-site visit following submission of a PPR, the surveyor will look for the measures of success that the organization provided as part of the Plan of Action. If at the time of on-site survey the surveyor finds less than 12 months of standards compliance, a requirement could result that would require resolution within 90 days after completion of the on-site review.

In response to concerns about legal disclosure of PPR information shared with the Joint Commission, two options to the full PPR are available to organizations. The first option allows the organization to perform the mid-cycle self-assessment, develop the plan of action and Measure of Success and discuss standards-related issues with the Joint Commission staff without submitting the PPR or plan of action. The second option provides for the organization to undergo a mid-cycle survey (a fee will be charged to cover costs) and to submit a plan of action with Measures of Success for areas of non-compliance.

Priority Focus Process

Priority Focus is a new process that takes organization-specific presurvey information and converts it into useful information that includes priority focus areas and clinical service groups to help the surveyor focus the on-site activity. This will allow

surveys to be more customized to each organization. The on-site survey agendas will be developed based on information gathered about the organization from several sources, and will be structured to spend more time on areas that have been challenges for the organization in the past. Organizations should find the Priority Focus Process information driven and focused on their specific performance.

Data sources that will contribute to the Priority Focus Process will include:

- Previous requirements for improvement from past surveys
- Data from the completed Application for Accreditation
- Performance Measurement data such as ORYX measures or MDS Quality Indicator profiles or Quality Measures
- Complaints about the organization (if any) received by the Joint Commission's Office of Quality Monitoring

(Priority focus process for initial organizations will be done, although the data set from which to pull information will be limited.)

Tracer Methodology
Tracer Methodology is a revision to the on-site survey that makes the resident care experience the 'table of contents' to assess standards compliance. Using the information from the Priority Focus Process, the surveyor(s) will select patients from an active patient list to 'trace' their experience throughout the organization. Patients typically selected are those who have received multiple or complex services or have been triggered by the MDS quality indicators or quality measures.

The surveyor(s) will follow the patient's experience, looking at services provided by various individuals and departments within the organization, as well as 'hand-offs' between them. This type of review is designed to uncover systems issues, looking at both the individual components of an organization, and how the components interact to provide safe and quality resident care.

The number of patients followed under the Tracer Methodology will depend on the size and complexity of the organization, and the length of the on-site survey.

Evidence of Standards Compliance
The report left with the organization at the end of the on-site survey will be the final report, and will identify any standards that were scored as partial or non-compliant. For those standards scored as non-compliant, the organization will have to submit Evidence of Standards Compliance (ESC) to the Joint Commission within ninety days of the completion of the survey (45 days after July 1, 2005). ESC includes evidence that the organization is now in full compliance with the standard and quantifiable Measures of Success (MOS) for all partial or non-compliant Elements of Performance. These Measures of Success will show

that compliance has been sustained over time. Once the ESC and MOS are approved by the Joint Commission, the organization moves into the accredited decision status. The organization submits MOS data at the end of four months to show that it has maintained compliance over time with the standards.	

H
Motions, Pleadings and Filings

Only the Westlaw citation is currently available.

United States District Court,
S.D. New York.

WANTANABE REALTY CORP., et al., Plaintiffs,
v.
THE CITY OF NEW YORK, et al., Defendants.

No. 01 Civ.10137(LAK).

Feb. 2, 2004.

Background: Owner of demolished roller coaster brought action for damages against city, alleging that demolition was unjustified. In bifurcated trial, first jury found city liable for common law trespass.

Holdings: On second jury's finding that there were no damages, the District Court, Kaplan, J., held that:
(1) testimony of owner's expert as to his opinion of roller coaster's replication cost was unreliable, and therefore inadmissible;
(2) testimony of owner's expert as to his opinion of roller coaster's pre-demolition value was not admissible; and
(3) testimony of owner's expert as to his opinion of roller coaster's "historic value" was not admissible.
Ordered accordingly.

West Headnotes

[1] Evidence 555.9
157k555.9 Most Cited Cases
In action for damages brought against city by owner of demolished roller coaster, testimony of owner's expert as to his opinion of roller coaster's replication cost was not admissible, where expert's opinion lacked reliable basis, given that it was based on cost estimate prepared for litigation by third-party. Fed.Rules Evid.Rule 702, 28 U.S.C.A.

[2] Evidence 555.9
157k555.9 Most Cited Cases
In action for damages brought against city by owner of demolished roller coaster, testimony of owner's expert as to his opinion of roller coaster's pre-demolition value was not admissible, where opinion was based entirely on inadmissable replication cost estimate, and expert failed to explain how he reached his conclusions. Fed.Rules Evid.Rule 702, 28 U.S.C.A.

[3] Evidence 555.9
157k555.9 Most Cited Cases
In action for damages brought against city by owner of demolished roller coaster, testimony of owner's expert as to his opinion of roller coaster's "historic value" was not admissible, where expert never expressed reliable basis for his estimate that roller coaster would have drawn 100,000 people more than would a replica or a newly built roller coaster, and that revenue would have been $50 per person, and he did not provide connection between either of incremental revenue figures he gave and either net profit or value attributable to historic nature of roller coaster. Fed.Rules Evid.Rule 702, 28 U.S.C.A.
Barry S. Gedan, for Plaintiffs.

Dana Biberman, Kerri A. Devine, Assistant Corporation Counsel, Michael A. Cardozo, Corporation Counsel of the City of New York, for Municipal Defendants.

MEMORANDUM OPINION

KAPLAN, J.

*1 In November 2000, the City of New York demolished the Thunderbolt, a roller coaster at Coney Island that had not been used since 1982 or 1983, allegedly on the ground that the structure had become hazardous. Plaintiff, the owner, brought this action for damages, claiming that the demolition was unjustified. The trial was bifurcated. The first jury found the City liable for common law trespass. The second jury rendered a special verdict that, in substance, found no damages, so plaintiff recovered nominal damages alone.

Shortly before the damages trial, the Court granted defendants' motion *in limine* to exclude the testimony of one of plaintiff's proposed expert witnesses, Richard Battaglia, and indicated that an opinion would follow in the event the matter was not resolved in a manner that obviated any need for it. As no such resolution has been reached, this opinion follows. [FN1] The Court assumes familiarity with its previous opinions. [FN2]

FN1. Mr. Battaglia's deposition was taken *de bene esse* on December 12, 2003, as he could not be in New York City at the time of the trial. The Court therefore had before it his trial testimony (i.e., the December 12 deposition), as well as his deposition of September 9, 2002, and his report, dated July 19, 2002. It might be noted also that Mr. Battaglia was deposed *de bene esse* in January 2004 for purposes of plaintiff's rebuttal case and that part of that deposition was received in evidence at the damages trial.

FN2. *Wantanabe Realty Corp. v. City of New York,* --- F. Supp . 2d ----, No. 01 Civ. 10137(LAK), 2003 WL 22862646 (S.D.N.Y. Dec. 3, 2003); *Wantanabe Realty Corp. v. City of New York,* --- F.Supp.2d ----, No.01 Civ. 10137(LAK), 2003 WL 21543841 (S.D.N.Y. July 10, 2003, as corrected July 14, 2003).

The Proposed Testimony

Plaintiff proposed to call Mr. Battaglia to testify that replicating the Thunderbolt anew would cost $15.8 million, [FN3] that it had an historic value of $ 4 to $5 million, [FN4] and that the value of the Thunderbolt just prior to its destruction was $10.7 million, of which he attributed $5 million to "historic value." [FN5] According to Mr. Battaglia's report, the $15.8 million replication cost [FN6] included, among other things, $8.1 million for a ride system, which was simply a price quote obtained from a Swiss manufacturer, plus $700,000 for shipping the ride from Switzerland and $1.4 million for installing it in Coney Island, and an additional $928,800 to rebuild the so-called Kensington Hotel.

FN3. Battaglia Dep. at 68-82. Unless otherwise indicated, references are to the December 12, 2003, deposition transcript.

FN4. *Id.* at 86-92.

FN5. *Id.* at 93-94.

FN6. The report placed the figure at $17.1 million. Mr. Battaglia subsequently reduced the amount in light of facts that came to his attention following its preparation.

Qualifications

The threshold question tendered by defendants was whether Mr. Battaglia was qualified to offer opinions as to the replication cost of the Thunderbolt, its pre-demolition value, and its "historic value."

Mr. Battaglia has a B.S. in business with a marketing emphasis. For a number of years, he worked for The Disney Company, first as a ride operator and then in supervisory capacities and in the marketing department at Disneyland. [FN7] Later, he joined a three-person project development team that assessed the relative success of different rides at Disneyland in preparation for the development of Disney World in Florida. [FN8] After leaving Disney, Mr. Battaglia joined Ringling Bros. Barnum & Bailey Circus as a vice president of planning where he did similar work. [FN9]

FN7. Battaglia Dep. at 6-7.

FN8. *Id.* at 8-9, 11-12.

FN9. *Id.* at 13-18.

Eventually, Mr. Battaglia and another started the firm with which he now is associated, Battaglia Incorporated, [FN10] which develops theme parks and entertainment complexes and resorts for clients on a turnkey basis, developing a concept, participating in design, doing feasibility analyses and preparing architectural and engineering drawings. [FN11] While it does not actually build, it sometimes oversees general contractors on behalf of owners. [FN12] It is involved also in developing revenue estimates in order to evaluate proposed capital investments and in making initial estimates of the costs of constructing proposed amusement rides. [FN13]

FN10. *Id.* at 5-6.

FN11. *Id.* at 18-20.

FN12. *Id.* at 19.

FN13. *Id.* at 20-24.

***2** It is far from clear that Mr. Battaglia's background, even given the liberality of the standards for qualification, qualified him to testify concerning these matters. It was unnecessary to make such a determination, however, in light of the discussion that follows.

Replication Cost

[1] The measure of damages in this case was the lesser of the value of the structure, in its then depreciated condition, immediately prior to demolition, and the amount, if any, by which the demolition reduced the fair market value of the real estate. [FN14] Plaintiff contended that the difference between building a new replica of the Thunderbolt and the cost to repair the deteriorated structure was a fair estimate of the roller coaster's depreciated value prior to demolition. [FN15] Testimony regarding the replication cost of the Thunderbolt therefore was relevant, contrary to defendants' contention. There remains, however, defendants' assertion that Mr. Battaglia's opinion as to replication cost was insufficiently reliable and grounded.

FN14. *Hartshorn v. Chaddock*, 135 N.Y. 116, 121-22, 31 N.E. 997 (1892); *Property Owners Ass'n of Harbor Acres v. Ying*, 137 A.D.2d 509, 510, 524 N.Y.S.2d 252, 252 (2d Dept.1988); *see also Jenkins v. Etlinger*, 55 N.Y.2d 35, 39, 447 N.Y.S.2d 696, 698, 432 N.E.2d 589 (1982). *See* Jury Charge at 3.

FN15. *See* Order, Jan. 5, 2004; Trial Tr. 30-31, 180, 954, 962, 995- 96.

In assessing reliability under Rule 702, *Daubert v. Merrell Dow Pharmaceuticals*, [FN16] and its progeny, a district court should consider indicia of reliability, including, but not limited to, (1) whether the testimony is grounded on sufficient facts, (2) whether the underlying methodology is reliable, and (3) whether the witness has applied the method reliably to the facts. [FN17] Admissibility, when challenged, must be established by the proponent by a preponderance of the evidence. [FN18] "The burden of demonstrating that the testimony is competent, relevant, and reliable rests with the proponent of the testimony." [FN19]

FN16. 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993).

FN17. *Amorgianos v. Nat'l R.R. Passenger Corp.*, 303 F.3d 256, 265 (2d Cir.2002).

FN18. *Daubert* 509 U.S. at 592 n. 10.

FN19. *Travelers Property & Casualty Corp. v. General Electric Co.*, 150 F.Supp.2d 360, 363 (D.Conn.2001). *Accord, Astra Aktiebolag v. Andrx Pharmaceuticals, Inc.*, 222 F.Supp.2d 423, 486 (S.D.N.Y.2002); *Cayuga Indian Nation of New York v. Pataki*, 83 F.Supp.2d 318, 321 (N.D.N.Y.2000).

The principal figure in Mr. Battaglia's replication cost estimate was the $10.2 million quote for the ride system ($8.1 million), the cost of shipping it from Switzerland ($700,000) and the installation cost ($1.4 million). [FN20] It is clear from his report that the $8.1 million bid was that of Intamin, [FN21] a Swiss roller coaster manufacturer and the only supplier from whom Mr. Battaglia sought a quotation. [FN22] To be sure, Mr. Battaglia asserted that his firm "actually did a cost estimate in-house to determine what we felt it was going to cost to fabricate the roller coaster" and that Intamin's bid "corroborated" that estimate. [FN23] But he never offered his firm's in-house estimate, and he certainly never demonstrated the basis for it. In consequence, even if the Court had accepted the assertion that Mr. Battaglia's firm did develop its own estimate, a matter as to which it has reservations, there would have been no basis upon which it reasonably could have concluded that it was reliable and soundly based.

FN20. Battaglia Dep. at 69-70, 72-73.

FN21. *See* Battaglia Report, prepared July 19, 2002, at 8-10.

FN22. Battaglia Dep. at 122.

FN23. *Id.* at 69.

To the extent that the $10.2 million estimate was simply a relation of Intamin's bid, it was not Mr. Battaglia's opinion at all and may not be received as expert testimony. The Court is mindful that Rule 703 allows an expert to rely upon information supplied by another in forming an opinion where the material relied upon is of a type reasonably relied upon by experts in the field. [FN24] But this was not such a situation. Mr. Battaglia was not proposing to offer an opinion based on the Intamin estimate. [FN25] He was proposing to offer the Intamin estimate itself, which of course was hearsay, as it was Mr. Battaglia's account of Intamin's out of court statement that it would have built, shipped and installed the ride system for the quoted price and it was offered for the truth of the matters asserted. But an expert may not act as a "mere conduit" for the hearsay of another. [FN26] Nor did the Intamin estimate come under an exception to the hearsay rule. Rule 803(17), the exception for market reports and commercial

publications, was not applicable, as it covers only those market quotations prepared for general use by an industry or the general public. [FN27] Unpublished price quotations or estimates done for litigation, as was this one, do not contain similar guarantees of reliability. The exception under Rule 807 is equally unavailable, as there is nothing particularly trustworthy about the Intamin estimate, and plaintiff in any case did not rely upon this rule. [FN28]

FN24. *See Gussack Realty Co. v. Xerox Corporation*, 224 F.3d 85 (2d Cir.2000) (expert testimony properly admitted even though expert relied on data provided by another); *In re Agent Orange Product Liability Litigation*, 611 F.Supp. 1223, 1245 (E.D.N.Y.1985), *aff'd*, 818 F.2d 187 (2d Cir.1987), *cert. denied*, 487 U.S. 1234, 108 S.Ct. 2898, 101 L.Ed.2d 932 (1988) (expert may rely on hearsay, provided that data is reasonably relied upon by experts in the field).

FN25. In any case, there was no foundation that would have justified a finding that an expert would offer an opinion based on a single quotation provided by a foreign manufacturer, and the Court declines so to find. Even if there had been such a foundation, it is unclear how Mr. Battaglia could have assisted the trier of fact in understanding the evidence, as required under Rule 702, as a jury certainly would have been capable of reading the Intamin estimate, were it independently admissible, itself.

FN26. *Valentin v. New York City*, No. 94 Civ. 3911(CLP), 1997 WL 33323099, at *27 (E.D.N.Y. Sept.9, 1997) (expert cannot testify on current state of sexual harassment training when only knowledge comes from statements by others that the training is superficial); *see also Hutchinson v. Groskin*, 927 F.2d 722 (2d Cir.1991) (district court erred in allowing physician to testify that three other doctors had reached the same conclusion, as testimony of others would be hearsay not subject to cross-examination).

FN27. 5 Weinstein's Federal Evidence § 803.19[1], at 803-118.

FN28. It is established in this circuit that Rule 807 permits the admission of hearsay where (a) it is particularly trustworthy, (b) it bears on a material fact, (c) it is the most probative evidence available, (d) admitting it would promote justice, and (e) there is adequate notice to the opposing party. *United States v. Bryce*, 208 F.3d 346, 350 (2d Cir.1999) (as amended Mar. 7, 2000).

***3** The remainder of Mr. Battaglia's replication figure includes an estimate for cost of replicating the so-called Kensington Hotel and a number of other elements, such as signage and lighting. Mr. Battaglia's opinion as to a replication cost of $928,800 for the replacement of the Kensington Hotel clearly lacked any reliable basis. This was derived by applying a $135 per square foot construction cost figure for which no basis was given, to an unreliable 6,880 square foot estimate of the size of the building, all without any real knowledge of the characteristics of the structure. The other elements in Mr. Battaglia's replication cost estimate together account for something in the neighborhood of $4 to $6 million and may be dealt with summarily. The Court was not persuaded that there was a reliable and sound basis for any of it. [FN29]

FN29. For example, the estimate included $500,000 for site preparation. Battaglia Dep. at 70. Mr. Battaglia did not explain what site preparation was necessary, much less the basis for estimating its cost at $500,000. He offered similar *ipse dixits* with respect to many other items, including $2.25 million for drawings and engineering, $250,000 to replace a maintenance area, $175,000 for a public address system, $250,000 for lighting, $327,500 for signage and so on. *Id.* at 76.

Pre-demolition Value

A. The Roller Coaster

[2] Mr. Battaglia assigned a $5.7 million value (exclusive of "historic value") to the roller coaster prior to demolition of which he attributed $660,000 to the hotel building. Put another way, he valued the roller coaster itself, including the ride system, the cars, and various other elements, at $5.1 million. In arriving at a figure for the value of the ride system, he started with the Intamin quotation of $8.1 million, estimated how much of that quotation represented the cost of the track, estimated that 50 percent of the track of the roller coaster was reusable, and valued

that at half of the Intamin quotation that he attributed to the track. [FN30] This portion of the proposed testimony was unreliable for the reasons described above, as it is based entirely on the inadmissable replication cost estimate.

FN30. Battaglia Dep., Sept. 9, 2002, at 46.

The second component of the $5.1 million pre-demolition value of the Thunderbolt encompassed the value of the queue structure, storage, locker room, signage, lighting and other elements. [FN31] Mr. Battaglia purportedly determined the value of these structures as they existed immediately prior to demolition by multiplying the dimensions of each unit, which were supplied by plaintiff, by a unit cost, to arrive at value per square foot. [FN32] Mr. Battaglia gave little explanation of how he determined the unit cost save to say that he took the unit cost to build each structure in today's market and decreased it to reflect what the structure would have been "worth" per square foot. [FN33] Nor did Mr. Battaglia explain how he reached a value of $150,000 for the two roller coaster trains, a third component of the pre-demolition value. [FN34] In reaching this estimate, he relied on a faint picture from a magazine article, and he had no knowledge of the size of the trains or whether they had been covered. [FN35]

FN31. *See* Battaglia Report at 5.

FN32. Battaglia Dep. at 94.

FN33. Battaglia Dep., Sept. 9, 2002, at 77-81.

FN34. *Id.* at 82-86.

FN35. *Id.*

As the December 12, 2003 was a *de bene esse* deposition, it was Mr. Battaglia's trial testimony. In view of the fact that it was plaintiff's burden to develop a record demonstrating admissibility, and its failure to do so, the defendants' motion was granted with respect to Mr. Battaglia's opinion concerning the pre-demolition value of the roller coaster.

2. Kensington Hotel

*4 Mr. Battaglia testified that the Kensington Hotel building was worth $660,000 before demolition. His first step in determining the value of the building was to accept as correct the owner's estimate of the square footage of the building (6,880 square feet) without even ascertaining whether the owner had measured it. [FN36] Then--without looking at architectural drawings [FN37] or knowing the condition of its structural members [FN38] or whether it had electricity or plumbing [FN39]--he multiplied the building area by an assumed $125 per square foot value and then subtracted $200,000 for fire damage. [FN40]

FN36. Battaglia Dep. at 104-05, 122-23.

FN37. *Id.* at 105.

FN38. *Id.* at 107.

FN39. *Id.* at 107-08.

FN40. *Id.* at 61, 64-66.

There was nothing in the record to support a view that the $660,000 figure had any reliable basis, even assuming that Mr. Battaglia were qualified to offer an opinion on that point, which is highly debatable but need not be determined.

3. Historic Value

[3] Mr. Battaglia opined that the Thunderbolt had a pre-demolition "historic value" of $5 million, above and beyond the $5.1 million value of the structure. [FN41] In reaching this figure, he asserted that he felt that the ridership of the roller coaster would be increased by "at least another hundred thousand ... and at $50 per person we would generate $5 million, and so that would be the value." [FN42] Presumably, this means that the Thunderbolt--as it stood prior to demolition and assuming that it were restored to operating condition--would have drawn 100,000 people more than would a replica or a newly built roller coaster. There were a great many problems with this proposed testimony.

FN41. *Id.* at 85-87.

FN42. *Id.* at 88.

To begin with, Mr. Battaglia never articulated any reliable basis for this 100,000 estimate. [FN43] While he doubtless has experience in the theme park field, he has had no experience in marketing historic roller coasters. [FN44] There is nothing in his background, at least so far as it was developed, to suggest that he has any reliable basis for coming to such a figure. And surely there is no evidence of any empirical market research such as consumer surveys, polling,

focus groups or the like.

FN43. He said that "you can range between 3 and 10 percent increase in attendance based on a known entity, say if you had built a ride that was based on, oh, say, Indiana Jones ..." *Id.* at 96-97. The Thunderbolt, however, has not operated since 1982 or 1983. There was no evidence that it then had the sort of awareness among potential consumers that has been achieved in recent times for hit motion pictures, let alone evidence that it does so now, after having been a disused relic for the better part of two decades. So there was no reason to suppose that Mr. Battaglia's 3 to 10 percent rule of thumb would have been applicable. Even if there were, an increase in ridership of 100,000 to 200,000 people, would have presupposed a ridership of a generic roller coaster of 1 million to 2 million persons at the low end to 3.3 million to 6.6 million at the high. It appeared, however, that the total capacity of the Thunderbolt, using plaintiff's assumption of 134 operating days per season and assuming operation for 12 hours per day rain or shine, was not more than approximately 1.6 million. *Daubert* Hearing, DX W1.

FN44. Battaglia Dep. at 56.

Second, there is no basis for supposing that the $50 per person revenue figure Mr. Battaglia used would have been appropriate in this case. His testimony suggests that this was a per capita revenue figure derived from "a theme park setting," [FN45] which is unlike that in which the Thunderbolt was situated. When pressed on this point, he conceded that a more appropriate revenue figure would have been $20 per capita, but then revised his incremental ridership estimate upward to 200,000 in light of the decreased cost. [FN46] But there was no basis for concluding that either the $20 per capita revenue figure or the revised incremental ridership estimate was reliable or predicated on any appropriate basis.

FN45. *Id.* at 88.

FN46. *Id.* at 90-91.

Third, Mr. Battaglia's testimony provides no connection between either of the incremental revenue figures he gave and either net profit or value attributable to the historic nature of the roller coaster other than the *ipse dixit* that $4 million or $5 million in incremental revenue equated to a $4 million to $5 million incremental value. [FN47]

FN47. *Id.* at 88, 91.

***5** Accordingly, the defendants' motion was granted as to Mr. Battaglia's proposed testimony regarding historic value.

Conclusion

This Court is obliged to serve as a gatekeeper to ensure that expert testimony is competent, relevant, and reliable. Bearing in mind that qualified experts may reach different conclusions, each of which is sufficiently competent and reliable to place before the trier of fact, the proponent of Mr. Battaglia's testimony did not persuade the Court that Mr. Battaglia surmounted the relatively low hurdle required by *Daubert* and its progeny. Nor, in light of the fact that Mr. Battaglia's trial testimony already was before the Court in deposition form, could any of these difficulties have been cured. Accordingly, defendants' motion *in limine,* with respect to plaintiff's direct case was granted. [FN48]

FN48. The Court dealt with the use of Mr. Battaglia's testimony on plaintiff's rebuttal case in a separate order. *See* Order, Jan. 27, 2004.

SO ORDERED.

2004 WL 188088 (S.D.N.Y.)

Motions, Pleadings and Filings (Back to top)

- 1:01CV10137 (Docket) (Nov. 16, 2001)

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