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Statutory Standard of Care for North Carolina Health Care Providers

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COMMENT

STATUTORY STANDARD OF CARE FOR NORTH CAROLINA HEALTH CARE PROVIDERS

INTRODUCTION

Malpractice claims against health care providers are occurring with increasing frequency. Every attorney engaged in the general practice of law is very likely to be confronted with the unique problems associated with litigating such claims. Although a malpractice case is essentially a negligence claim involving the elements of duty, breach of duty, causation, and damages, there are additional common law and statutory elements which must be established.

This comment will examine the North Carolina statutory standard of care applicable to health care providers. Emphasis is directed to practical aspects. The topics selected for discussion are: review of relevant statutes, case law requirements to establish the standard of care, statutory effect of "same or similar community", obtaining competent expert testimony, viability of national standards and uniform treatment, and the potential of an absolute defense as a statutory flaw. Finally, an equitable interpretation is proposed to eliminate this flaw.

RELEVANT STATUTES

The North Carolina General Assembly enacted new legislation concerning health care providers during the 1976 second session. Under North Carolina General Statute § 90-21.11, a definitional section, the umbrella of "health care provider" is spread to cover without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or

a hospital as defined by G.S. 131-126.1(3); or a nursing home as defined by G.S. 130-9(e)(2); or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home.3

Simultaneously, the General Assembly established a statutory standard of care applicable to all health care providers. This statute provides:

In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.4

These statutes are derived from recommendations of the Professional Liability Insurance Study Commission. The Commission was created by the 1975 General Assembly to study malpractice insurance rates and to submit a written report with recommended legislation to the General Assembly.5 The General Assembly added the requirement of “similar training and experience” and made minor changes in the phrasing of the Commission’s proposals.6 The changes apparently were intended to conform the statute more

5. 1975 N.C. Sess. Laws ch. 623. Two insurance company representatives, two health professionals, and eight members of the General Assembly, drawn equally from the House and Senate, composed the committee.
6. The commission’s proposed standard of care read: “In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the practice and procedures for services which were provided in the same or similar communities by similar health care providers at the time of the alleged act giving rise to the cause of action.” NORTH CAROLINA PROFESSIONAL INSURANCE STUDY COMMISSION REPORT note 2, appendix VI, at 3 (March 12, 1976). For a discussion of the Commission’s report and recommendations, see Comment, Medical Malpractice in North Carolina, 54 N.C.L. REV. 1214 (1976).
closely with the existing case law standard. In Hunt v. Bradshaw,\(^7\) the North Carolina Supreme Court stated: "A physician or surgeon who undertakes to render professional services must meet these requirements: (1) He must possess the degree of professional learning, skill and ability which others similarly situated ordinarily possess; (2) he must exercise reasonable care and diligence in the application of his knowledge and skill to the patient's case; and (3) he must use his best judgment in the treatment and care of his patient."\(^8\) The court further provided that if the health care provider meets these standards, he cannot be held civilly liable; but if he fails to meet any one of these standards, and his failure proximately causes injury and damages, he is liable.\(^9\)

While the new statute does substantially enlarge the number of professions covered,\(^10\) it does not appear to materially alter the existing common law standard, which has existed for approximately seventy years.\(^11\) The North Carolina Court of Appeals recently stated that the statute "clearly shows that the standard of care applicable to health providers in North Carolina as developed by case law is now adopted by the legislature."\(^12\)

**CASE LAW REQUIREMENTS**

Initially a plaintiff must establish that the physician-patient relationship existed at the time of the alleged acts before a health care provider can be held to the applicable standard of care and treatment.\(^13\) In order to establish liability, there also must be proof of actionable negligence by the provider which was the proximate cause of plaintiff's injury.\(^14\)

In rare cases, "there is manifest such obvious gross want of care and skill as to afford, of itself, an almost conclusive inference

\(^7\) 242 N.C. 517, 88 S.E.2d 762 (1955).
\(^8\) Id. at 521, 88 S.E.2d at 765.
\(^9\) Id. at 522, 88 S.E.2d at 765.
\(^10\) As Chapter 90 licensees, veterinarians, embalmers, and funeral directors are now deemed to be health care providers by N.C. GEN. STAT. § 90-21.11 (Supp. 1977); see N.C. GEN. STAT. §§ 90-187.10 (1975), 90-210.25 (Supp. 1977), respectively.
\(^13\) Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931).
of negligence . . . [that] neither affirmative proof of negligence, nor expert testimony . . . need be given by the plaintiff.' "15 In the case quoted above, a physician broke a large bone in the plaintiff’s leg while reducing the fracture of a smaller bone. Plaintiff’s leg became infected, swollen, and eventually burst. After being informed by the plaintiff of the complications, the physician promised to return to the room in a few minutes. He returned seven days later.16

In a more extreme case, the plaintiff, a healthy, middle-aged man, was admitted to Duke Hospital for surgery to correct fallen arches and the resulting pain in his left foot.17 He was informed that the surgery would require no more than forty to forty-five minutes and would involve making a small incision in his back and clipping a nerve. When the plaintiff was taken into surgery, an eight-inch anterior incision was made and all of his lower internal organs were lifted out. While clipping the nerve, the resident performing the surgery punctured two large veins. Massive bleeding ensued and the resident punctured other arteries and veins while attempting to control the blood flow. A chief surgeon, summoned from his home, examined the plaintiff and determined that the damage was beyond repair. In an effort to save the plaintiff’s life, the surgeon tied the torn arteries, veins, and fibrous tissue and clipped them en mass. With the blood supply lost, the left leg developed gangrene and was amputated below the knee. Gangrene again developed and the knee joint was amputated. Plaintiff suffered a myocardial infarction. Later, gangrene developed in his right leg and it too was amputated. During his stay in the hospital, the plaintiff was administered between fourteen and seventeen pints of blood. He also became addicted to drugs. When the plaintiff asked for an explanation of the operations, the resident’s only comment was, “‘I played hell; that is what happened.’” The court held that the plaintiff’s evidence was sufficient to take the case to the jury.18

In the cases discussed above, “[t]he absence of expert medical testimony, disapproving the treatment or lack of it, is not perforce fatal to the case. There are many known and obvious facts in the realm of common knowledge which speak for themselves, sometimes louder than witnesses, expert or otherwise.”19

16. Id. at 73, 197 S.E. at 702.
18. Id. at 119, 121, 72 S.E.2d at 6, 8.
Cases which show such gross dereliction and abuse of the patient are rare. Generally, to establish a prima facie case plaintiff must demonstrate by the testimony of a qualified expert that the treatment administered by defendant was in negligent violation of the accepted standard of medical care in the community and that defendant's treatment proximately caused the injury. Proof of what is approved practice and what constitutes the standard of care for a health care provider may be established only by the testimony of a qualified expert. Whether an operation should have been performed on a given patient is also a matter within the realm of expert testimony. Additionally, only an expert can testify to the propriety of treatment for a disease which is unfamiliar to the general public.

When the type of treatment or care provided is not materially or exclusively within the province of a particular specialty, a properly qualified general practitioner is a competent expert witness to testify against a specialist. Here the test is the same as for any other expert: whether the general practitioner's qualifications exhibit sufficient knowledge of the subject to permit the jury to consider his opinion. If an expert witness establishes the standard of care required of the defendant, lay witnesses have been permitted to testify to the defendant's departure therefrom.

SAME OR SIMILAR COMMUNITY

"Formerly it was generally held that allowance must be made for the type of community in which the physician carries on his practice, and for the fact, for example, that a country doctor could not be expected to have the equipment, facilities, libraries, contacts, opportunities for learning, or experience afforded by large cities." The allowance some courts initially made was to compel the plaintiff's expert witness to reside or practice in the same community as the defendant in order to testify on the standard to which the defendant had to conform. This "same locality" rule persisted in North Carolina until 1970 even though the courts had been urged to abandon it earlier.

22. Id.
28. See Note, Medical Malpractice: Rejection of the "Locality Rule," 46
In *Wiggins v. Piver*, the plaintiff alleged that the defendant had failed to use due diligence and skill in post-surgical treatment by allowing incisions in her leg to become infected. She also alleged that the defendant had not properly aligned the incisions when he sutured them, causing excessive scarring. At trial, the plaintiff attempted to introduce testimony from a highly qualified surgeon who resided in Winston-Salem, North Carolina. When asked whether the defendant had conformed to good medical practice in Jacksonville, North Carolina, or similar communities, the surgeon testified that he was not familiar with the actual practice in Jacksonville but that he was familiar with standard practice in similar communities. Defendant’s objection was sustained by the trial court who “acted upon the assumption that the law required the expert to be familiar with the locality where the alleged improper practices occurred; and that one who testifies as to his knowledge of similar localities would not qualify him to give an expert opinion.”

After reviewing the reasons for the “strict locality” rule, the court held that the Winston-Salem witness was competent to express his expert opinion and stated: “Reason does not appear to the non-medically oriented mind why there should be any essential difference in the manner of closing an incision, whether performed in Jacksonville, Kinston, Goldsboro, Sanford, Lexington, Reidsville, Elkin, Mount Airy, or any other similar community in North Carolina.”

Three years later, the court reiterated its position that an expert’s knowledge of practices in similar communities was sufficient for him to testify on the standard of care in the defendant’s community. In *Dickens v. Everhart*, the plaintiff sought to recover damages for the wrongful death of his seventeen-year-old daughter who had succumbed to blood poisoning after having a tooth extracted. The plaintiff sought to introduce into evidence expert testimony from a pathologist who had practiced in North Carolina, had treated patients from the defendant’s locality, and had familiarized himself with the general practice of medicine in the defendant’s community. The witness was allowed to testify in detail about his education, training, and experience. The trial court asked the witness whether he came to North Carolina after defendant’s treatment

30. *Id.* at 137, 171 S.E.2d at 395.
31. *See* text accompanying note 26 *supra*.
32. 276 N.C. at 138, 171 S.E.2d at 395-96.
of the deceased. When the witness answered affirmatively, the defendant objected to further testimony. In sustaining the objection, the trial court stated, "that this man was either a medical student or an intern in Ohio or somewhere else in 1964. In my view it is impossible for him to know what is the customary practice in this case at that time." 

In reversing the trial court for error in excluding the testimony, Justice Lake read *Wiggins v. Piver* to hold: "an expert witness, otherwise qualified, may state his opinion as to whether the treatment and care given by the defendant to the particular patient came up to the standard prevailing in similar communities, with which the witness is familiar, even though the witness be not actually acquainted with actual medical practices in the particular community in which the service was rendered at the time it was performed." The court also stated that "the character of the community in which the defendant practices is a circumstance to be considered in determining the degree of skill and ability to be required of him." A defendant cannot avoid liability, however, by merely showing "that he possesses the required professional knowledge and skill. He must [also] exercise reasonable diligence in the application of that knowledge and skill to the particular patient's case . . . ." 

The treatment a defendant provides is judged by, and the expert's knowledge and opinion must be based on, the prevailing standards among members of the defendant's profession "with similar training and experience situated in the same or similar communities" at the time of a defendant's actions. In selecting a medical expert, a plaintiff must carefully examine the provisions of the statutory standard. The statute not only states the rule by which a defendant will be judged, it also sets certain limits which determine whether the expert's opinion can be considered by the jury. In many instances, the statutory prerequisites will determine whether the plaintiff's expert will be allowed to testify at all.

**Obtaining Competent Expert Testimony**

Rarely will a plaintiff find a qualified expert from the defen-
dent's community who is willing to testify against the defendant. This refusal to testify and the tendency to close ranks around a negligent professional brother has been termed the "conspiracy of silence." Assuming this conspiracy still exists to some extent today, a plaintiff must look elsewhere for his expert.

Since the plaintiff will not usually obtain an expert from the defendant's community, the statute dictates that the expert's testimony will be excluded unless the plaintiff additionally shows that the expert is familiar with standards of the same profession in "similar communities." The end result is that plaintiff's witness, properly qualified as an expert in his own right, must be further qualified by showing that he has practiced or has knowledge of practices in communities that are similar to the defendant's community.

Relevant characteristics of similarity include the number, size, and accreditation of hospitals and the number of health care providers engaged in the defendant's field of practice. Facts indicating the geographic size, population, general economy of the defendant's community, as well as its proximity to medical centers or schools, should also be gathered. These facts and characteristics, compared with the same characteristics of one or more communities in which


41. There are several sources to pursue. The physician who treated the plaintiff subsequent to his ordeal with the defendant is a source, if he is willing to testify. His treatment would be close in time to the defendant's treatment, and his first-hand observations would be pertinent to plaintiff's present condition. A medical school or center in the area may also be a source of experts willing to testify. Further, other attorneys in the area who have handled malpractice claims may be willing to furnish names of experts they have utilized.

Several commercial and non-profit organizations provide physicians who will review a plaintiff's medical records and who will express their opinion of whether the plaintiff possesses a credible malpractice claim. Medical-Legal Consulting Service, Inc., 8401 Connecticut Avenue, Chevy Chase, Maryland 20012, advertises this service for a fee. The writer is informed that the American College of Legal Medicine, 1340 North Astor Street, Suite 2608, Chicago, Illinois 60610, provides this service free of charge.

42. N.C. GEN. STAT. § 90-21.12 (Supp. 1977); see text accompanying note 4 supra.


the plaintiff's expert has trained or practiced, should lay a sufficient foundation to establish the witness's familiarity with standards of practice and thus enable him to testify. One writer has stated "that the fundamental comparison . . . is the similarity of the expert witness's knowledge of medical practices and procedures compared to the defendant's knowledge of these same aspects of the medical profession."\textsuperscript{45} However, no one characteristic appears to be determinative.

An alternative to obtaining an outside expert to testify on the required standard is to use the defendant as a plaintiff's witness. In a recent case the plaintiff's adverse examination of the defendant was sufficient to justify a jury finding that the defendant did not exercise reasonable diligence in the application of his knowledge and skill.\textsuperscript{46} The deposition of plaintiff's out-of-state expert was excluded from evidence when it was not shown that the community he practiced in was similar to that of the defendant. During the adverse examination, the defendant testified at great length about the methods and procedures he had followed during surgery. He also testified that he did " 'not know definitely what happened to the vessels, but they were probably cut with the pituitary rongeur.' "\textsuperscript{47} The court stated that the plaintiff had established "the standard of professional competence and care customary for Diplomates of the American Board of Orthopedic Surgeons practicing in communities similar to Salisbury, North Carolina" by calling the defendant as her witness.\textsuperscript{48} Few plaintiffs will be fortunate enough to have a defendant tie his own noose.

For example, in \textit{Koury v. Follo},\textsuperscript{49} the plaintiff sought to recover damages from a specialist in pediatrics who had prescribed a drug for a nine-month-old child. The drug manufacturer's label warned

\textsuperscript{45} 6 W.F.L. Rev. 553, 558 (1970).
\textsuperscript{47} Id. A pituitary rongeur is a hand-operated, spoon-shaped surgical instrument. In this case the defendant used it to remove material from a ruptured disc in the plaintiff's spine.
\textsuperscript{48} Id. at 20, 237 S.E.2d at 270. See also Belk v. Schweizer, 268 N.C. 50, 149 S.E.2d 565 (1966). The plaintiff's expert testimony consisted of a thirty-six page deposition by a physician and an adverse examination by deposition of the defendant. Both were read to the jury. Defendant's evidence included 211 record pages of testimony by six physicians. After examining the evidence in the light most favorable to the plaintiff, the court held that the plaintiff's evidence was sufficient to have the jury determine whether the treatment was in accordance with the required standard of care.
\textsuperscript{49} 272 N.C. 366, 158 S.E.2d 548 (1968).
in red letters, "Not for Pediatric Use." The child became deaf. The plaintiff's witnesses included an expert in the use of antibiotics in the treatment of diseases. He testified that the defendant had prescribed almost twice the appropriate amount of the drug in relation to the baby's body weight. The plaintiff also called an expert in eye, ear, nose, and throat practice. He testified that the baby was totally deaf and that anything toxic to a nerve could affect the hearing nerve. The plaintiff then called the defendant as an adverse witness. Defendant's opinion was that he had prescribed the standard dosage used by pediatricians in his community. A nonsuit was entered at the close of the plaintiff's evidence. In reversing the judgment of nonsuit, the court held that plaintiff's evidence, if true, would be sufficient to support a finding that the defendant disregarded express warnings and prescribed a dosage far in excess of what was recommended.

There are at least two disadvantages in using an adverse examination of the defendant to establish the standard of care or departure therefrom. When a plaintiff introduces testimony during an adverse examination, the defendant is represented as "worthy of belief." Also, if the plaintiff in *Koury* had attempted to establish the standard of care solely by using defendant's testimony, the defendant would have established that he acted in conformity therewith.

Use of medical treatises or periodicals is another method to establish the standard of care. The 1977 General Assembly enacted legislation authorizing admissibility of statements in published treatises, periodicals, or pamphlets. North Carolina General Statute § 8-40.1 provides:

> In all actions in the superior court to the extent called to the attention of an expert witness upon cross-examination or relied upon by him in direct examination, the hearsay rule shall not exclude statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice, even though the declarant is available as a witness. If ad-

50. *Id.* at 368, 158 S.E.2d at 551.
51. *Id.* at 372, 158 S.E. at 554.
53. See text accompanying notes 49-51 *supra*.
54. 1977 N.C. Sess. Laws ch. 1116 § 2. The legislation was enacted and effective on July 1, 1977.
mitted, the statements may be read into evidence but may not be received as exhibits unless agreed to by counsel for the parties.55

This statute places North Carolina in accordance with the text of the Federal Rules of Evidence regarding use of published material.56 Although a pre-statute decision, Stone v. Proctor57 illustrates practical techniques in the use of published material. Plaintiff established the standard of care with a professional journal. The plaintiff in Stone was treated for a mental disorder by a surgeon who was also a specialist in the field of psychiatry.58 Part of the defendant’s treatment involved administering electroshock therapy. After the initial treatment, the plaintiff complained of severe pains in his lower back. The defendant administered drugs and heat for the pain; he did not attempt to determine its cause. The defendant continued the electroshock treatments, increasing their duration and intensity. The plaintiff was discharged from the hospital still suffering the back pains. After consulting a radiologist, who x-rayed the plaintiff, it was determined that his ninth vertebra suffered a compressed fracture.

On adverse examination, the defendant stated that he was a Fellow of the American Psychiatric Association and that he subscribed to the American Journal of Psychiatry. Plaintiff identified as an exhibit a publication which contained Standards for Electroshock Treatment. The American Psychiatric Association had approved these standards a year before the plaintiff was treated. The defendant testified that he was familiar with these standards. The court sustained an objection to further answers. In an offer of proof, the plaintiff asked the defendant whether these standards were the same he observed in his practice in the community. The defendant would have answered, "‘yes, generally.’"59 One of the standards

55. N.C. GEN. STAT. § 8-40.1 (Supp. 1977). 1979 N.C. Sess. Laws ch. 8 amends this statute by deleting the words “superior court” from the first sentence and substituting in lieu thereof the words “district and superior courts.” The amendment was ratified and effective on February 5, 1979.

56. Fed. R. Evid. 803. “The following are not excluded by the hearsay rule... (18) Learned treatises. To the extent called to the attention of an expert witness upon cross-examination or relied upon him in direct examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science or art, established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence but may not be received as exhibits.” The Federal Rules of Evidence became effective July 1, 1975.


58. Psychiatrists and psychologists are health care providers. See text accompanying note 3 supra.

59. 259 N.C. at 635, 131 S.E.2d at 298.
included in the publication was: "'If the patient should complain of pain or impairment of function, he should receive a physical examination, including x-ray, to ascertain whether he has suffered accidental damage.'"60 The trial court excluded the question, the answer, and the standard. At the close of plaintiff's evidence, a judgment of nonsuit was entered.

On appeal the defendant contended that the trial court was correct since medical evidence by a specialist in psychiatry was necessary to establish the standard required and that no specialist was called to testify. In reversing the judgment of nonsuit, the court stated:

The defendant was familiar with the standards above referred to. They were fixed by the Association to which he belonged and in which he was a Fellow. They applied directly to his specialty and to the safety of patients undergoing shock treatment. His acknowledgment of their authenticity and their applicability to the Winston-Salem area were sufficient to warrant their admission in evidence.61

The new statute regarding the use of published material has not been interpreted by the supreme court. It is clear that the statute changes the general common law rule on admissibility of textbooks or periodicals.62 The texts of the Federal Rules of Evidence and the North Carolina statute are virtually identical. The various interpretations accorded the federal rule should disclose potential applications of the North Carolina statutes.

VIABILITY OF NATIONAL STANDARDS AND UNIFORM TREATMENT

Apart from "similar community," the nature of the particular treatment administered also can have a material bearing on an outside witness' competency to testify to the standard of care required of the defendant. In Rucker v. High Point Memorial Hospital, Inc.,63 the plaintiff, shot in the leg while hunting, was taken to a general practitioner in the area who "administered first aid and advised

60. Id.
61. Id. at 636-37, 131 S.E.2d at 299.
62. See Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548 (1968) wherein Justice Lake stated: "It is well settled in this State . . . that excerpts from medical textbooks, and similar publications, are incompetent as evidence to prove the correctness of a statement of fact or theory therein. . . . [T]he publication is objectionable both under the Hearsay Rule and under the rules applicable to opinion testimony by expert witnesses."
immediate hospitalization. Room was carried to the emergency room at High Point Memorial and examined by the surgeon in charge. After examining the plaintiff and ordering a nurse to "['just give him a shot',"] the surgeon told the plaintiff to return home and apply heat. Over the weekend the pain became unbearable and the plaintiff returned to the hospital. A different surgeon examined and x-rayed his leg. When these x-rays disclosed the presence of gas gangrene, the plaintiff was transferred to Duke Medical Center where he underwent numerous operations over several weeks. The plaintiff permanently lost seventy-five percent of the functional use of his leg. He sued the High Point hospital and the emergency room surgeon alleging that the surgeon was employed by the hospital and that he "held himself out to possess that degree of skill, ability and learning common to medical practitioners in said community and similar communities." At trial, plaintiff sought to introduce expert testimony from a surgeon who had practiced in hospitals in Portsmouth, Virginia, and who was then practicing in Louisiana and Mississippi and teaching surgery at Tulane University Medical School. The witness would have testified that treatment of shotgun wounds is essentially the same throughout the United States and "that x-ray examination is required to determine the extent of the injury and to determine what, if any, operative procedures should be followed." This testimony was excluded because the witness "was not acquainted with the medical staff at High Point Memorial Hospital and did not know about its facilities." The defendant's motion to dismiss at the close of plaintiff's evidence was allowed. In awarding a new trial, the court held that the trial court had committed error in refusing to permit the witness to testify as an expert for the plaintiff. The court reasoned "that gunshot wounds of the lower leg lend themselves most readily to uniform medical and surgical treatment without regard to locality. Not all injuries are so uniform and the treatment so generally well known and followed." Other courts agree, stating that treatment of fractures, administration of x-rays, and cataract operations

64. Id. at 523, 206 S.E.2d at 198.
65. Id.
66. Id. at 521, 206 S.E.2d at 197.
67. Id. at 527, 206 S.E.2d at 201.
68. Id. at 525, 206 S.E.2d at 200.
69. Id. at 526, 206 S.E.2d at 200.
70. Id. at 528-529, 206 S.E.2d at 201.
71. Id. at 527, 206 S.E.2d at 201 (emphasis supplied). Cited as examples were rattlesnake bites in Alaska and frost bite in Florida.
are uniform throughout the United States.

After Stone and Rucker expert testimony seemingly should have been admitted without regard to locality if the defendant were nationally certified or licensed or if the treatment for a given injury or illness were uniform in any accredited hospital or by any competent professional. However, the first North Carolina appellate court to apply these standards since the enactment of the statute balked when confronted with the issue. In Thompson v. Lockert, the plaintiff sought damages from an orthopedic surgeon alleging that he had lacerated her left iliac artery and inferior vena cava while performing a laminectomy discectomy. The defendant was certified by and a Diplomate of the American Board of Orthopedic Surgeons and practiced in Salisbury, North Carolina. The plaintiff forwarded her medical records to an orthopedic surgeon practicing in Smithtown, New York. He was also certified by and a Diplomate of the American Board of Orthopedic Surgeons. The New York surgeon reviewed these records and testified by deposition. He stated in the deposition that "I have never practiced medicine in North Carolina and I have never seen the plaintiff, Mrs. Thompson, as a patient personally." During trial the plaintiff introduced into evidence the deposition of the defendant, the medical records from the hospital where the surgery was performed, the deposition of the New York surgeon, and other documents.

This evidence did not disclose whether Smithtown, New York, is "similar" to Salisbury, North Carolina, or whether the New York surgeon was familiar with the standard of care for board certified orthopedic surgeons practicing in communities similar to Salisbury. The trial court excluded the New York surgeon's testimony and granted the defendant's motion for a directed verdict.

Before the court of appeals, the plaintiff argued that the standard of care applicable to a board certified orthopedic surgeon had no relation to any geographic community and that Rucker had extended the care required of a specialist to a national standard.

75. See text accompanying notes 57-61 supra.
76. See text accompanying notes 63-71 supra.
77. 34 N.C. App. 1, 237 S.E.2d 259, cert. denied, 293 N.C. 593, 239 S.E.2d 264 (1977); see text accompanying notes 46-48 supra.
78. For a detailed description of the operation by the surgeon who performed it, see 34 N.C. App. 7-20, 237 S.E.2d 263-270.
79. Id. at 6, 237 S.E.2d at 262.
80. Id. at 3, 237 S.E.2d at 260.
81. See text accompanying notes 63-71 supra.
The court disagreed and stated that *Rucker* "was applicable only to the standard of care of 'accredited hospitals' . . . throughout the United States."82 In regard to the statutory standard of care the court stated: "The case law and the legislation reflect the general policy of both the judicial and legislative branches of the government in North Carolina with respect to the standard of care to be imposed upon defendant in this case *i.e.*, the 'same or similar community' rule."83 Because the statute specifically includes "hospital as defined by G.S. 131-126.1(3) . . . or any . . . person acting at the direction or under the supervision of any . . . hospital,"84 the viability of *Rucker* or any application of uniform standards will have to be determined by the North Carolina Supreme Court.

**A FLAW: POTENTIAL ABSOLUTE DEFENSE**

One commentator has suggested that the statutory standard of care is unfair by providing an absolute defense for health care providers who act in conformity with professional standards.85 The comment reasons that until the enactment of the statute, the courts were free to modify their common law standard on a case-by-case basis. "Under the . . . legislation, however, a physician who acts in accordance with standard procedure in the same or similar community seems to have an absolute defense."86 Other jurisdictions have considered whether conformity with standard practice would provide an absolute defense to a health care provider.

In *Favalora v. Aetna Casualty & Surety Co.*,87 the plaintiff, a seventy-one-year-old female, fainted and fell to the floor while being

82. 34 N.C. App. at 4, 237 S.E.2d at 261.

83. *Id.* The plaintiff filed her action on September 16, 1974. The statute became effective on July 1, 1976, and does not apply to litigation pending on that date. *See* text accompanying note 4 *supra*. The court admitted knowledge of the effective date in its opinion. 34 N.C. App. at 5, 237 S.E.2d at 261.

The plaintiff also did not introduce into evidence all of the medical records and x-rays that were before the New York surgeon when he rendered his opinion. Alternatively, the court ruled that the trial court properly sustained the defendant's objections to the plaintiff's hypothetical questions, and stated: "'Since it is the jury's province to find the facts, the data upon which an expert witness bases his opinion must be presented to the jury in accordance with established rules of evidence.' *Todd v. Watts*, 269 N.C. 417, 420, 152 S.E.2d 448, 451 (1967). . . ." 34 N.C. App. at 6, 237 S.E.2d at 262.

84. N.C. GEN. STAT. § 90-21.11 (Supp. 1977); *see* text accompanying note 3 *supra*.


86. *Id.*

x-rayed. She suffered a severe fracture of her right femur. The plaintiff had a history of fainting and had fasted the previous day as a necessity for the tests she was to undergo. Standard practice in the community did not require the plaintiff’s history to be included on the x-ray request, even though space had been provided. In affirming the judgment for the plaintiff, the court stated: “We believe that conformity with the standard of care observed by other medical authorities in good standing in the same community cannot be availed of as a defense when the criterion relied upon is shown to constitute negligence . . . .”

The court reasoned further:

To relieve a member of the medical profession from liability for injury to a patient on the ground that he followed a degree or standard of care practiced by others . . . is, in our opinion, unthinkable when the degree or standard of care in question is shown to constitute negligence because it fails to meet the test of reasonable care and diligence required of the medical profession. To hold otherwise is to exempt one from even willful negligence on the patently unsound ground that others in the same profession do likewise. Such instances, in our judgment, do not involve errors of judgment or diagnosis occasioned by a disparity of innate skill and ability against which the law affords the physician protection, but rather constitutes failure of the physician to exercise reasonable care and diligence along with his best judgment in his application to the patient of the degree of skill of which he is possessed.

The court wanted no misinterpretation of its opinion: “We are firm in the opinion that it is patently absurd, unreasonable and arbitrary to hold that immunity from tort liability may be predicated upon a degree of care or procedure amounting to negligence notwithstanding such procedure is generally followed by other members of the profession in good standing . . . .”

In Helling v. Carey, the Washington Supreme Court held as a matter of law that health care providers were negligent in conforming with standard practice. The plaintiff, a thirty-two-year-old female, initially consulted the defendants for nearsightedness and was fitted with contact lenses. The defendants were specialists in ophthalmology. Over the next nine years she consulted the defendants for eye irritation. Until her last visit, the defendants assumed the plaintiff’s irritation related solely to her use of the contacts. During the last visit, a pressure test disclosed the presence of glau-

88. Id. at 550.
89. Id. at 551.
90. Id.
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Coma, a progressive disease with few symptoms. Without a pressure test, glaucoma is generally undetected until extensive and irreversible loss of vision has occurred. During the trial, it was established by unanimous expert testimony for the plaintiff and the defendants "that the standards of the profession for that specialty in the same or similar circumstances do not require routine pressure tests for glaucoma upon patients under 40 years of age . . . [since] the disease rarely occurs in this age group." From a verdict for the defense the plaintiff appealed, contending that the standard of care for ophthalmologists was inadequate to protect her from the incidence of glaucoma. The defendants contended the standard was adequate because of the rarity of the disease in patients under forty.

In awarding a new trial on the issue of damages only, the court held:

Under the facts of this case reasonable prudence required the timely giving of the pressure test to this plaintiff. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so, the defendants were negligent, which proximately resulted in the blindness sustained by the plaintiff for which the defendants are liable.

These courts reserved the right to judge the reasonableness of the defendant's conduct, and did not blindly follow the professional standards down the road to absolute defense.

92. Id. at ___, 519 P.2d at 982.
93. Id. It was stated that glaucoma occurs in about 1 out of 25,000 people under forty years of age.
94. Id. at ___, 519 P.2d at 983 (emphasis supplied).
95. In Gates v. Jensen, 20 Wash. App. 81, 579 P.2d 374 (1978), the Washington Court of Appeals held that WASH. REV. CODE § 4.24.290 abolished the Helling rule. This statute provides in part: "In any civil action for damages based on professional negligence . . . the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care and learning possessed by other persons in the same profession and that as a proximate result of such failure the plaintiff suffered damages . . . " The court stated: "The statute by its express terms clearly requires a departure from the standard of the profession to sustain recovery in a medical malpractice case." Id. at ___, 579 P.2d at 376. However, the attorney for the
Over 75 years ago, the North Carolina Supreme Court ruled that it was not bound by standards set by the local profession. Locally established standards were not conclusive evidence of proper care and treatment. In *McCracken v. Smathers,* the plaintiff brought a malpractice action against a dentist, alleging negligence both in filling a tooth with a live nerve without proper packing and in boring unnecessarily through the jawbone. The jury awarded $500 to the plaintiff. The defendant appealed, contending that he could not be held liable if he exercised the degree of skill and care that was exercised by other dentists in the neighborhood. The supreme court disagreed and affirmed the judgment, stating that members of a profession in a given area "might be men of very inferior qualifications, and to say that they might set themselves up as the standard of learned profession, and prove the standing of each by the ability of the other, would be equally unjust to the profession and to its patients."

While the North Carolina courts recognize that a health care provider will not be held liable for an honest error in judgment, *Hunt v. Bradshaw* requires the provider to "exercise reasonable care," and to "use his best judgment. in the treatment and care of his patient."

These requirements may place the provider in a dilemma. If the provider's best judgment is that adherence to standard treatment would further complicate an ailment, liability may result if he fails to deviate from standard practice and further injury occurs. The plaintiff could assert that the provider failed to exercise reasonable care according to his best judgment. If the provider does deviate and further injury occurs, the plaintiff could assert that the statute required the provider to act in conformity with standard practice.

**CONCLUSION**

While the court should not hastily impose its own determination of standard practice over those schooled in a profession,
Hunt's\textsuperscript{101} requirements of reasonable care and best judgment, and the disregard of local professional standards from \textit{McCracken},\textsuperscript{102} support preservation of the court's right to judge whether professional standards constitute negligence. By according conclusive weight to professional standards and providing an absolute defense to a defendant, the court abrogates its duty to determine negligent conduct and freezes the standard to a level lower than that which should be available to patients.

The following interpretation of the statute would enhance the maintenance of sound health care standards and would be equitable to both plaintiffs and defendants: a \textit{presumptive} defense is granted if the health care provider acts in conformity with the professional standard of care in similar communities. Nothing else appearing, the provider is absolved of liability. However, if the professional standard is unreasonable under the circumstances, the court may determine that the standard constitutes negligence as a matter of law.

\textbf{JOHN MARSH TYSON}

\footnotesize{\textsuperscript{101} See text accompanying notes 7-9, 21-22, 99 \textit{supra}. \textsuperscript{102} See text accompanying notes 95-97 \textit{supra}.}