Back to the Horse and Buggy Days: North Carolina Courts Harken A Return To The 'Locality Rule' In Medical Malpractice Cases

By Mark McGrath

In the seminal case of Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970), the North Carolina supreme court rejected the so-called "locality rule" in favor of the more liberal "same or similar communities" standard presently used to measure the performance of health care providers in medical malpractice cases. In a remarkable turn of events, recent decisions of the North Carolina courts augur a return to the locality rule, or some variant of it, and reveal that, like the reports of Twain's death, the demise of the locality rule pronounced in Wiggins was greatly exaggerated.

The Locality Rule

Under the locality rule the performance of physicians and other providers was judged by the standards existing in the community where the malpractice occurred.

As a corollary to the rule, only physicians who had personal familiarity with that community were permitted to testify as experts in the case. The shortcomings of the rule, and the predicament in which it placed lawyers who represented injured patients are obvious: in 1950 North Carolina, how likely was the prospect that a physician in Pittsboro would testify against his colleague? Not very. As a result, it was very difficult, and frequently impossible, to find experts who were willing or able to testify in malpractice cases.

Rejection Of The Locality Rule

By 1970, the cultural milieu that spawned the locality rule had become a thing of the past. As the Wiggins court observed, the locality rule "had its origin in the very old and far away days when there were many little institutions which called themselves medical schools," a time when "students were admitted who could show a high school diploma or furnish a certificate from a school principal that the bearer had completed the 'equivalent' of a high school course of study." Moreover, the court observed, in "many rural communities... the doctor was on his own. Frequent refresher courses, now generally attended, were unknown." Sensitive to the professional limitations of the proverbial "country doctor" many jurisdictions, including North Carolina, deemed it unjust to subject the care rendered in rural areas to the standards of practice prevailing in urban communities.

Among the factors cited by Wiggins as grounds for rejecting the archaic rule were "changes in the rural-urban population pattern of the country and changes in medical education, training, and communication," factors that had led to an increase in the "standardization of medical practices." The Wiggins court concluded that, given the increasing uniformity of education, experience and training among health care professionals, the locality rule had "lost all potency."

In rejecting the locality rule, Wiggins held that experts were competent to testify on standard of care issues as long as they were familiar with the standard of practice in similar localities. Following Wiggins, the North Carolina General Assembly enacted N.C. Gen. Stat. Sect. 90- 21.12 in 1975, thus codifying the "same or similar communities" standard that presently governs North Carolina malpractice cases.

Application Of The Same Or Similar Communities Standard Following Wiggins

The Wiggins decision, and the rulings of the North Carolina appellate courts that appeared in its wake, marked a clear and steady course away from the precedential baggage of the locality rule. Taken together, these decisions reveal a charitable jurisprudence that tended to err on the side of inclusion when issues of "familiarity" and "similarity" were in doubt; a jurisprudence that exalted substance over form, and one that seems lavishly liberal in light of recent opinions addressing these same issues.

In Wiggins itself, the issue was whether the defendant physician, who practiced in Jacksonville, properly performed a series of biopsies on the patient. The trial court excluded the testimony of the plaintiff's expert on the basis that he was not familiar with the standards of practice in Jacksonville. In ruling that the expert should have been permitted to testify, the court observed that the surgical procedure at issue "would seem to be as simple and uncomplicated as any cutting operation one may imagine. 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, Mt. Airy, or any other similar community in North Carolina."

In the years following Wiggins, the North Carolina courts continued to distance themselves from the locality rule. In Dickens v. Everharl, 284 N.C. 95,199 S.E.2d 440 (1973), the court held that the plaintiff's expert witness should have been permitted to testify based on his familiarity with communities in California that were similar to Mt. Airy, notwithstanding his total lack of familiarity with the standards of practice in Mt. Airy. Similarly, in Page v. Wilson Memorial Hospital, 49 N.C. App. 533,272 S.E.2d 8 (1980), the court allowed a nurse who had taught and worked at hospitals in Greenville, Rocky Mount, Williamston and Washington to testify regarding the standards of practice in Wilson County because the witness had worked in "adjoining and nearby communities."

In Howard v. Piver, 53 N.C. App. 46, 279 S.E.2d 876 (1981), the plaintiff's expert testified at trial that he was familiar with the standard of care for physicians and surgeons in Jacksonville and similar communties. On cross examination, however, the expert conceded that he had never been inside the hospital where the negligent care occurred, did not know any doctors in Jacksonville, and had never practiced outside of Chapel Hill. The court held that, notwithstanding this evidence, the expert's education, training and experience qualified him to render opinions regarding the standards of practice in Jacksonville. In so holding, the court noted that "the horse and buggy days are gone," and with it the geographical focus of the locality rule. Given the relative simplicity of the medical issues (discontinuance of anti-seizure medication), the trial court's emphasis on locality made little sense:

"The treatment of epilepsy with anti-seizure medication is a long-established practice. Plaintiffs underlying thesis in this case is that [the defendant] should not have discontinued her medication which she had taken for thirty years to control her seizures and that discontinuation of her seizure medication would predictably precipitate seizures. Reason does not appear in this case, considering the nature of the medical question involved, why a different standard should apply to the discontinuation of anti-seizure medication in Jacksonville, in Kinston, in Goldsboro, or even in Chapel Hill."

The court concluded that, "when there are no variations in the standards for handling of a particular medical problem from one community to another, a medical expert familiar with the standard and with the defendant's deviation from the standard" should be permitted to testify.

Similarly, in Rucker v. High Point Memorial Hospital, 285 N.C. 519, 206 S.E.2d 196 (1974), the plaintiff alleged that he received negligent treatment for a shotgun wound while he was a patient at High Point

Memorial Hospital. Plaintiffs expert witness testified that the standards of practice for treating gunshot wounds at accredited hospitals were uniform and standardized across the country. In allowing the testimony the court held that "in this case." we are not dealing with a local country doctor. We are dealing with a duly accredited hospital and a member of its staff who was in charge of its emergency department" In support of its decision the court cited testimony from the expert indicating that there was "no difference in the standards of treatment of gunshot wounds to the lower extremities in the hospitals" where he had practiced, and that based on his "attendance in seminars, reading of publications…academic affiliations… travels… speaking with other doctors [and] keeping up with the literature," he could comfortably testify that the standards for treating gunshot wounds "were the same around the United States" and that "there [was] no difference in the standards." The court observed that the treatment of gunshot wounds was not the kind of medical procedure that invited geographical nuance or variation:

"Sound reason supports the view 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. The medical profession in Alaska, for example, would be informed and knowledgeable on the treatment of snow blindness, frozen feet and frostbitten lungs, but they would be without experience in the treatment of rattlesnake bites. A Florida doctor would know about the snake bites, but not about frozen feet A gunshot would would require the same treatment in Florida or Alaska."

Narrowing The Standard

A conspicuous narrowing of the same or similar communities standard began with the decision of Henry v. Southeastern OB-GYN, 145 N.C. App. 208,550 S.E.2d 245, disc. rev. denied, 354 N.C. 570, 557 S.E.2d 530 (2001). In Henry, the witness, a physician in Spartanburg, South Carolina, testified that he was familiar with the standards of practice in Spartanburg, and also testified that he believed that standard would be the same as the standards prevailing in Durham and Chapel Hill.The witness did not profess, however, to any specific familiarity with the standards of practice in Wilmington, where the malpractice occurred. In rejecting the testimony of the expert, the court held that "the concept of an applicable standard of care encompasses more than mere physician skill and training; rather, it also involves the physical and financial environment of a particular medical community."

In addition to its focus on the physical characteristics of the communities being compared, the Henry decision is remarkable for the resounding fashion in which it rejected application of a national standard of care to the treatment at issue. Sidestepping the holdings in cases such as Howard and Rucker, and citing a 20-year-old law review article, the court held that application of a uniform standard of care would be reserved for the simplest and most pedestrian procedures, citing as examples the changing of bedpans and the monitoring of vital signs.

The Court of Appeals moved even closer to the locality rule in Smith v. Whitmer, 159 N.C. App. 192, 582 S.E.2d 669 (2003). In Smith the expert, who practiced in Abingdon, Virginia, testified that he was familiar with the standard of care for orthopedic surgeons practicing in Tarboro and Rocky Mount, where the defendants practiced, that he had taken steps to familiarize himself with Rocky Mount and Tarboro, that those communities seemed similar to Abingdon, and that given the relative simplicity of the orthopedic procedure at issue, there was no significant degree of variation between the way the procedure was performed across the country. Upon questioning by the defense, the expert conceded during his

deposition that he was not licensed to practice in North Carolina, had never visited Tarboro or Rocky Mount, and had no "affiliation" with any physicians practicing in those communities. Following the deposition, the defendants filed a motion to exclude the expert's testimony on the grounds that the expert was not familiar with the standards of care and practice in Rocky Mount and Tarboro. The trial court granted the motion.

The court of appeals affirmed. The court held that, while "it is not necessary for the witness testifying as to the standard of care to have actually practiced in the same community as the defendant... the witness must demonstrate that he is familiar with the standard of care in the community where the injury occurred, or the standard of care in similar communities." Breaking new legal ground, the Smith court did not accept the expert's claims of familiarity with Rocky Mount and Tarboro, and scrutinized the basis of the claim in excruciating detail. The court held that although the expert "asserted that he was familiar with the applicable standard of care, his testimony is devoid of support for this assertion." In support of its decision, the court cited as relevant the expert's inability to recall during his deposition the specific points of similarity between Abingdon and the communities in question, his failure to speak to health care practitioners in those communities prior to testifying, and the fact that he had never personally visited Tarboro or Rocky Mount.

Most recently, in Pitts v. Nash Day Hospital, 2004 N.C. App. LEXIS (December 7,2004), the Court of Appeals inched even closer to the locality rule. Although the Pitts court reversed the trial court's exclusion of the plaintiffs witness, the court emphasized as never before the degree to which specific community traits will be analyzed to determine whether given communities are, as a matter of law, similar. For example, the court held that factors to be considered include the communities' facilities, equipment, and physical and financial environment. In an extraordinary dissent, Judge Steelman suggested that the inquiry should go even further. Judge Steelman wrote that factors such as population, industrial base and funding should be considered in determining whether an expert's claims of similarity should be accepted at face value, as well as the degree to which such factors impact the resources available to caregivers in the communities being compared. While most of these factors had been cited in prior cases in various contexts, never before Pitts had they been presented as a laundry list of demographic traits that could be invoked to challenge an expert's claims of familiarity and similarity.

What Does The Future Hold?

The North Carolina courts have done a full about-face in the 34 years since Wiggins. Wiggins and its immediate progeny recognized that improvements in medical training, equipment and resources had obviated the locality rule. These rulings reflected an appreciation that, with the exception of novel and experimental procedures, it made little sense to confine the pool of experts to physicians having personal knowledge of the community at issue. Among other things, these decisions reflected a willingness to expand the types of procedures for which a national standard would be recognized, reserving the preoccupation with locality for those techniques whose standards of practice truly varied from community to community.

In the cases since Henry our courts have exhibited a revived obsession with locality. Among other things, these "hard look" decisions cast a suspicious eye at outlanders who claim familiarity with the communities of North Carolina, and make clear that any expert who applies a national standard of care in reaching his conclusions will be excluded unless the procedure at issue is something on the order of a diaper change. Given the increasingly draconian decisions coming out of Raleigh, and the heightened

focus on community features such as physical environment, industrial base and financial capacity, the time may soon come when plaintiffs will be forced to designate urban planners, demographers, sociologists and public health experts to opine that the community where the malpractice occurred is in all material regards similar to the communities where their experts practice.

So what is to be done? The answer is simple, but controversial: the time has come to scrap the same or similar communities standard altogether. Indeed, it is long overdue.

Talk to the experts. Doctors marvel at the absurdity of the standard. The reason? The standard distorts reality and does nothing to advance the quest for medical truth. As any candid physician will concede, except for the most exotic procedures and techniques, the standards of practice in Wilmington are no different than the standards of practice in Milwaukee, Hartford, Baltimore or a thousand other communities across the country. Standardized medical education, geographical mobility within the medical profession, a nationwide hospital accreditation program, national boards of certification for medical specialties, and revolutionary improvements in communication and information exchange have rendered the same or similar communities standard obsolete. Stripped of its historical rationale, the same or similar communities is simply an artifact of a by gone era, an anachronism that is useful today only as a pretext for excluding qualified experts.

Make that qualified plaintiff's experts. While the reasons underlying the recent trend of judicial recidivism might be debatable, one thing is beyond dispute: injured patients are bearing a disproportionate share of its wrath. It is telling that, of the dozens of appellate cases that have interpreted the same or similar communities standard over the past 34 years, not one has affirmed or resulted in the exclusion of a witness for the defense.

The reason for this disparity? The conspiracy of silence among physicians has never been stronger. Finding a physician in New Bern who is willing to testify against his cross-town colleague is about as likely as succeeding on a Woodson claim. In most cases, defendant physicians can rely upon their colleagues to testify on their behalf or, if not, a physician from a similar community within the state. Plaintiffs, on the other hand, always have to look for experts beyond the community where the malpractice occurred, and almost always have to recruit outside the state. As a result, plaintiffs are usually the only parties in a malpractice case who are forced to shepherd experts through the same or similar communities minefield.

And that is no easy task. Getting an expert to trial can be difficult when the expert lives in Pittsburgh, has never visited Kinston, and cannot understand why botching an appendectomy in Kinston has to be different than botching the same procedure in Pennsylvania. Making things even more perilous, any misstep along the way can spell disaster. Recent cases instruct that the merest lapse in syntax or failure of recall during a deposition can be invoked as a basis for excluding your witness. And there seems to be no relief in sight.

Given the trend of recent decisions, the best hope for resolving this scandal lies with the legislature. In the meantime, qualified and competent experts will continue to be excluded when they trip over questions regarding the industrial base of Burlington, or forget how many accredited hospitals lie within forty miles of Hillsborough, or cannot recall the per capita income of Wadesboro, or have trouble articulating why the standard for transfusing a patient is the same in San Diego as it is in Charlotte without suggesting that the standard of care for the procedure is uniform across the country.

Of course, the ultimate consequence of this trend is that, although 34 years have passed since Wiggins, it is now more difficult than ever to escort a meritorious medical malpractice case to trial in North Carolina.

And, perhaps, in that ineluctable truth lies the method beneath the madness.