Sanity restored? N.C. Supreme Court to revisit 'same or similar communities' standard

By MARK McGRATH

Since the North Carolina Court of Appeals issued its decision in Henry v. Southeastern Ob-Gyn Associates, P.A in 2005, trial courts have been bouncing medical experts from North Carolina courtrooms like drunken rugby clubbers. Because any medical expert, however qualified, can fail to recall the population and per capita income of Ahoskie in the heat of deposition battle, even "slam dunk" malpractice cases, staffed with the finest physician experts in the land, confront the prospect of dismissal. Fueled by unintelligible opinions from a badly flummoxed Court of Appeals, an appalling dearth of appellate case law guidance, and a healthy measure of anti-plaintiff bias at the trial judge level, courts have grown accustomed to tossing expert witnesses who demonstrate anything less than an encyclopedic familiarity with local demographic trivia.

Like a midnight call from the governor's office, the Supreme Court has signaled in two recent cases that it may be willing to end the madness. In agreeing to review the cases of Crocker v. Roethling and O'Mara v. Wake Forest University Health Sciences, the high court has presented itself with a golden opportunity to restore sanity to an area of law that has suffered for too long beneath a shroud of confusion.

THE OPINIONS

In Crocker, parents sued a physician for negligently delivering their daughter. Following the discovery deposition of the plaintiffs' sole standard of care witness, defendant moved for summary judgment on the grounds that the expert failed to demonstrate sufficient familiarity with the standards of practice in Goldsboro or similar communities to testify in the case. Judge "Rusty" Duke granted the motion for summary judgment, and plaintiffs appealed.

In opposition to the motion, plaintiff submitted an affidavit from its expert. The affidavit indicated, among other things, that the expert was familiar with the training, education and experience of the defendant, that he had reviewed the deposition of the defendant in which he described his training, education and experience, that he had reviewed data and information regarding the community of Goldsboro, Wayne County and the hospital where the alleged malpractice took place, that he was familiar with the population of Goldsboro, that he had familiarized himself with the level of care available at the hospital, and that he was aware how many physicians practiced obstetrics in Goldsboro. In conclusion, the expert stated in his affidavit that he was "familiar with the prevailing standard of care for handling shoulder dystocia in the same or similar communities to Goldsboro in 2001 by a physician with the same or similar training, education and experience" as the defendant.

Writing for the court, Justice Bryan affirmed the summary judgment order, finding that the affidavit lacked sufficient facts to support the expert's claim that he had familiarized himself with the prevailing standards of practice in Goldsboro for handling shoulder dystocia cases.

In support of its decision, and consistent with Henry and its progeny, the court cited testimony given by the expert during his discovery deposition. In particular, the court held that the expert had failed to establish that Goldsboro was similar to Phoenix, the community in which the expert practiced medicine, and that he practiced in "much larger" hospitals than those found in Goldsboro. The court held that the expert's failure to articulate specific points of similarity between Goldsboro and Phoenix was fatal to his candidacy as an expert in the case. Similarly, O'Mara involved allegations of negligent delivery. Unlike

Crocker, the O'Mara case involved an appeal from a defense verdict. But like Crocker, one of the assignments of error arose from the trial court's exclusion of a critical standard of care expert. The trial court based its exclusion of the witness primarily upon the expert's insistence that the treatment and care at issue were governed by a national standard of care. In affirming the trial court's exclusion of the expert, the Court of Appeals agreed that by invoking a national standard of care, the witness had ipso facto disqualified himself from testifying.

HERE WE GO AGAIN

These opinions illustrate beautifully the gross distortion of the "same or similar communities" standard that has been engineered by the Court of Appeals since Henry. Crocker in particular highlights the outlandish extremes to which this line of cases has taken us. When elected judges with no medical background whatsoever begin to substitute their judgment for the professional opinions of doctors who familiarized themselves with local standards of medical practice, we are at a sorry pass indeed.

The Court of Appeals' obsession with locality be it a manifestation of bona fide bemusement or a calculated agenda of tort reform activism has not only steered a course straight toward the "locality rule," an antiquity specifically rejected by the General Assembly in enacting G.S. Sect. 90-21.12, but is also thumbing its nose at the medical establishment, which has long recognized that medical standards in this country have undergone an unprecedented degree of standardization since the enactment of Sect. 90-21.12 in 1976.

The notion that each community in North Carolina possesses an articulable and distinct standard of practice for a given medical procedure is beyond preposterous. Is there really a Charlotte standard of practice for delivering babies? Is there truly a standard of practice unique to Burgaw for ensuring that prescriptions are filled accurately? Are procedures for preventing the development of bed sores different in Lumberton than they are in Los Angeles? Of course not. It's time to wake up, folks: The concept of community-specific medical standards exists only in the surreal netherworld of North Carolina appellate case law.

STANDARDIZATION OF MEDICAL STANDARDS AND COMPETENCE

While the North Carolina courts are clearly a little slow on the uptake, the standardization of medical expertise in modern America has been well-accepted among medical professionals for quite some time. In short, and to parallel the language of the operative statute, all communities in this country, except with respect to the most exotic of medical techniques and technology, are now "similar" in terms of medical standards and expectations.

In a recent article appearing in the Journal of the American Medical Association, a team of physicians assessed this trend and the disturbing tendency in some jurisdictions (North Carolina among them) to adhere stubbornly to the fiction of localized standards.

The authors conclude that the continuing existence of locality rules flies in the face of medical standardization. "The locality rule originated," they write, "in a time when rural and urban physicians may have had vastly different experience with respect to their education, training, and ability to obtain the latest information relating to diagnosis." Things have changed radically, they observe. "Today," they reason, "rural and urban physicians have access to the same information and have the same opportunities to stay current in their specialty. Thus, the locality rule has become an anachronism, but

one that persists in some jurisdictions." This is especially absurd, they add, when "medical licensing requirements and board certification requirements are based on national standards."

The authors go on to point out that archaic locality rules not only harm litigants, but also negatively impact the quality of care rendered in the jurisdictions that perpetuate them. First, localized standards excuse substandard care. For example, assume that no doctor in Asheville tests expectant mothers for gestational diabetes. If one were to accept the "same community" standard on its face, this is the local standard. Accordingly, physicians neglecting to perform such tests, however negligent and ill-advised such a practice might be, would be acting in accordance with the local standard. It is a rather frightening prospect to consider that an out-of-state medical expert may not be qualified to render an opinion that this is a negligent and dangerous practice.

The authors of the JAMA piece also point out that, while it was originally designed to protect doctors, the locality rule actually "imposes additional duties and legal risk on physicians. Not only must they remain aware of advances in their specialty, physicians must also be aware of the standard of care in their locality, whether or not that standard is considered substandard at the national level." The article goes on to point out that:

The locality rule may cause additional difficulties for a physician who practices in multiple states. If the standards of care are different in the various jurisdictions, the physician may be at legal risk for exercising his or her own best judgment rather than conforming to local practice standards. Furthermore, the practice of evidence-based medicine may not be acceptable if this practice is inconsistent with the local standard of care. Adherence to the local rule thus could delay the incorporation of new scientific knowledge into the practice of medicine in some communities.

The authors conclude that:

The persistence of [the locality rule] may serve to promote the practice of substandard medicine. Patients seeking medical care should be able to expect a certain level of competency and skill from their physicians, no matter where the patient lives or where the physician practices. The standards by which physicians are measured should be the same throughout the country and should not depend on the location of the physician's practice. Location should only be considered in relation to the availability of diagnostic facilities or service, or access to subspecialist physicians, not with respect to the knowledge or skill of the treating physician.

WILL THE HIGH COURT RISE TO THE OCCASION?

The question remains: Will the Supreme Court rescue our jurisprudence from its backward course, and will it once and for all eradicate the absurd notion that communities have distinct standards of practice that are a function of their demographics?

In predicting the future, observers would be well-advised to remember our history. In the not-too-distant past, the North Carolina appellate courts accepted the idea that national standards of care governed most practitioners and most healthcare facilities. Specifically, our courts routinely allowed medical experts to apply a national or uniform standard of care in three situations which would cover virtually all medical malpractice cases: (1) when the care at issue was rendered in an accredited institution; (2) when the treatment was not characterized by a nuance or idiosyncrasy that was unique to the community at issue; and (3) when the defendant was a medical specialist, not a "country doctor."

Prior to Henry, our courts had accepted the idea that national standards of practice would apply when the defendant committed malpractice in an accredited facility. In Rucker v. High Point Memorial Hospital, Inc.,6 plaintiff sued the defendant surgeon for failing to properly treat a shotgun wound to his leg. The defendant rendered the medical treatment in an accredited hospital located in High Point. At trial, plaintiff called as an expert Dr. Julius Levy, a surgeon trained and educated in Louisiana with practice experience in the states of Virginia, Louisiana and Virginia.

At trial, Dr. Levy "admitted that he was not familiar with the facilities of the defendant hospital and was not familiar with the members of its staff or with their qualifications." The court excluded his testimony on the basis that he "was not acquainted with the medical staff" at the High Point hospital where the defendant treated the plaintiff and that he possessed no knowledge or information regarding its facilities.

The Court of Appeals agreed with the trial court on this issue. The Supreme Court reversed and ordered a new trial. In finding that Dr. Levy was qualified to render opinions regarding the standard of care in High Point, the court noted that "Dr. Levy testified that he is familiar with fully accredited hospitals and the standards and practices of such hospitals are essentially the same throughout the United States in the treatment of gunshot wounds [and] that the treatment of such wounds is standard." The court held that Dr. Levy had laid an appropriate foundation for testifying to a national or uniform standard based on testimony indicating that he "kept up with the surgical practices and procedures in hospitals, other than those on whose staffs he served, by attending seminars, professional society meetings, by reading reports and medical journals, and by consulting with other doctors." 10 As a result, the court held that Dr. Levy should have been allowed to testify that "the treatment of gunshot wounds of the extremities is standard throughout the United States among qualified surgeons" and that he did "not know of any variations of standards of the management of gunshot wounds of the lower extremities from any one community to another within the United States."

Applying this reasoning, the court observed that:

The testimony that the treatment is essentially the same is by no means surprising. All shotguns are smooth bore. They perform uniformly as to range and penetration. The ammunition provided for shotguns is practically uniform throughout the United States. To his knowledge, acquired through service, seminars, personal consultations, journals and periodicals, gunshot wounds and their treatment are not essentially different in any section of the United States.

The court held that when the care is rendered in an accredited facility, expert witnesses are not required to demonstrate an intimate familiarity with the community where the negligent treatment occurred. In so holding, the court observed that "[i]n 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."

The court also held that, because the treatment of gunshot wounds is not subject to geographical variation or nuance, it made little sense to require an expert witness to demonstrate personal familiarity with the community where the malpractice occurred. The following passage is telling:

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 snakebites, but not about frozen feet. A gunshot would require the same treatment whether in Florida or Alaska.

A similar result was reached in Haney v. Alexander. In Haney, plaintiff offered the testimony of two physicians to support the contention that the nurses who treated the decedent negligently failed to monitor his vital signs. On appeal the defendant argued that the court should have excluded the testimony of the experts because they were unfamiliar with the standards of nursing care in Lumberton, the community where the alleged malpractice occurred.

Citing Rucker, the Court of Appeals rejected this argument. The court noted that the experts were familiar with "the basic duty of all nurses in accredited hospitals across the nation to take vital signs when a patient exhibits unusual or new symptoms." Further, the experts testified that "there was no variation in the nursing standard of care for all nurses in accredited hospitals across the country ... with respect to the basic duties at issue in this case." The court held that, because the experts testified that "the standard of care for taking and reporting vital signs of a deteriorating patient was the same for nurses in accredited hospitals across the country," their testimony should have been allowed.18 The court concluded that, "[w]here the standard of care is the same across the country, an expert witness familiar with that standard may testify despite his lack of familiarity with the defendant's community." See also Cox v. Steffes, 161 N.C. App. 237, 587 S.E.2d 908 (2003) (expert permitted to testify to national and universal standard of care where treatment was rendered in accredited Level 2 hospital).

MEDICAL SPECIALISTS

Prior to Henry, national standards of care had long been recognized when the defendant physician was a medical specialist, not a snuff-dipping country bumpkin.

In Harris v. Miller, the plaintiff alleged negligent surgical treatment against the defendant orthopedic surgeon. Plaintiff offered at trial the testimony of an orthopedic surgeon who testified that there was a "generally recognized national standard of care for orthopedic surgeons." The evidence revealed that the expert had no familiarity with the standards of practice in Beaufort County, where the surgery occurred. The Court of Appeals held that the expert was "no less competent to testify as to the applicable standard of practice because of his foundation testimony that in his opinion there is a national standard of care for orthopedic surgeons and that he was familiar with the national standard."

Consistent with Harris, the North Carolina courts have repeatedly held that expert witnesses should be allowed to testify to a national or uniform standard of care when the defendant practitioner is not a "country doctor" but a trained medical specialist. See Rucker v. High Point Memorial Hospital, Inc., 285 N.C. 519, 206 S.E.2d 196 (1974) (expert witness should have been allowed to testify that care was subject to a national standard of care where defendant was a surgeon and on the medical staff of an accredited hospital); Baynor v. Cook, 125 N.C. App. 274, 480 S.E.2d 419 (1997) (expert familiar with national standard of care applicable to emergency room physicians could testify where the standard would apply to emergency room physicians everywhere, regardless of the community); Brooks v. Wal-

Mart Stores, Inc., 139 N.C. App. 637, 535 S.E.2d 55 (2000), rev. denied, 353 N.C. 370, 547 S.E.2d 2 (2001) (pharmacist expert could testify to national standard of care applicable to pharmacists); Cox v. Steffes, 161 N.C. App. 237, 587 S.E.2d 908 (2003) (expert permitted to testify to national and universal standard of care where defendant was a board-certified surgeon); Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596, petition denied, 305 N.C. 587, 292 S.E.2d 571 (1982) (expert witness permitted to testify that the standards of board certified surgeons were the same throughout the country).

In failing to abide by these decisions the Court of Appeals seems to be suffering from a convenient case of judicial amnesia. This line of cases could have been invoked to allow the testimony of every expert who has been excluded in the line of cases decided since Henry. That these cases were not cited speaks volumes about the court's ideological bent since 2005.

SHOULD LOCALITY PLAY A CONTINUING ROLE?

Because community-specific medical standards are so clearly a legal fantasy, a misguided judicial concoction, is there room for local nuance and variation at all?

Clearly, there should be. If a given medical procedure or treatment is indeed governed by an idiosyncratic standard that is unique to the community at issue, it would clearly be improper to judge practitioners in that community by a different standard. In that highly unusual situation, and especially because experts for the plaintiff will always need to be recruited from outside the defendant's community, the burden to define and enunciate the local standard should be borne by the defendant. In other words, the defendant should be required to come forward with evidence of specific demographic features of the subject community that engender and warrant the application of a local standard.

If a defendant meets his burden, the plaintiff should be provided with an opportunity to demonstrate either that his expert has familiarized herself with the local standard, or is familiar with the standards of practice in communities possessing similar demographic characteristics, or should be provided with an opportunity to rebut the contention that the care at issue is subject to a local standard of practice. Any disagreements or discrepancies raised by conflicting testimony or evidence should be resolved by the jury, not by a judge on a motion to exclude expert witness testimony.

CONCLUSION

Since the Henry case, qualified experts have been excluded from trials and injured patients have lost their day in court with disturbing frequency, all attributable to a systematic mutilation of the same or similar communities standard by our courts. The General Assembly enacted this standard not to prevent experts from testifying or to confine the pool of potential experts to doctors who practice in the community at issue, but to prevent the imposition of "big city" standards on small town practitioners. In the modern era of standardized medical education, board certification and national accreditation, the locality rule has lost all vestiges of currency.

It is telling that, of all the cases in which experts have been excluded for lack of familiarity with the community at issue, not one has involved the non-presence of a sophisticated diagnostic device, a failure to purchase advanced technology and have it readily available, the unavailability of a rare subspecialist or an inability to perform an exotic medical technique the very kinds of criticisms that the locality rule was designed to prevent. All of these have involved routine medical care that is practiced the same in communities, large and small, across the country.

If out-of-state experts were routinely coming into court to criticize community hospitals for not possessing advanced medical technology or were testifying against small-town surgeons for not being able to perform exotic and experimental surgeries, one might sense the justice in excluding experts hailing from Beth Israel or Johns Hopkins. But this is clearly not the case. Blind imposition of local standards and the exclusion of experts who are unable to articulate why setting a broken arm in Greensboro is different than it is in Chicago does nothing to protect small-town practitioners from big city standards. It serves only to deprive litigants of an opportunity to litigate meritorious claims and to preserve the fiction that North Carolina communities are being served by unsophisticated "aw, shucks" practitioners who provide substandard care.

A reality check is long overdue. Malpractice lawyers and the voters of this state will be watching closely.