MEDICAL MALPRACTICE
RECENT DEVELOPMENTS: MAY 2014 – MAY 2015

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DISCLAIMER: The majority of the cases reported in this manuscript represent North Carolina medical malpractice law as interpreted and applied by the courts ***before*** the effects of the 2011 radical tort reforms bills, Senate Bill 33 and House Bill 542. The sweeping changes brought on by these two bills may strip portions of these cases of their precedential value. The author has not undertaken any analysis on whether these decisions will survive after SB33 or HB542, and makes no representations to that effect in this manuscript.

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INTRODUCTION

This manuscript provides an analysis of all **published** medical malpractice opinions reported from the North Carolina Court of Appeals and the North Carolina Supreme Court from May 2014 to May 2015. For each case, I have provided a grey box snapshot of all the background data on the case in (e.g. county of origin, plaintiff/defense attorneys involved, and author of opinion), as well as a analysis of the case according to a classic law school style framework (e.g. procedural history, factual background, rules/controlling authority, analysis and arguments, and impact of the case on our practice.) No unpublished medical malpractice opinions have been analyzed in this manuscript.

Many of these cases were litigated by fellow members of the NCAJ, and most received discussion on the NCAJ listservs. Please note that I have only analyzed the facts and law contained in each written opinion. Out of fairness, I have refrained from including any facts/arguments learned about the case through listserv discussion that do not already appear in the text of each opinion (although to learn the "whole story" behind several of these cases the reader will be well-served to examine the appellate record/briefs, and any listserv discussions.)

Brewer v. Hunter,
___ N.C. App. ___, 762 S.E.2d 654, 2014 N.C. App. LEXIS 974 (2014)

Prior History: Gaston County, 11 CVS 1437	**NCCOA Filed Date:** September 2, 2014
Plaintiff Attorney(s): Thomas D. Bumgardner Brian N. Eisen	**Defense Attorney(s):** Sara Lincoln (Lincoln Derr) Scott Addison (Lincoln Derr)
Judge (Author of opinion): Davis, Mark	**Judges (Concurring / Dissenting):** Hunter, Jr., Robert N. (concur) Ervin, Sam IV (concur)
Type of Medical Care Involved: Procedural, discovery issues	**Decision for Plaintiff or Defense Bar?** Plaintiff

Procedural History:
Appeal by Defendants from Judge F. Donald Bridges' order granting Plaintiff's motion to compel medical records of defendant-surgeon's prior patients.

Background Facts:
The plaintiff had been suffering from chronic back pain for several years and was referred to defendant, a neurosurgeon, for evaluation. The defendant performed a thoracic laminectomy on plaintiff, and upon awakening from the surgery the plaintiff was paralyzed from the waist down. Plaintiff filed a medical malpractice action against the Defendant.

Key Case Facts:
After suit was filed, plaintiffs requested the defendant to produce in discovery all documents "showing Dr. Hunter's complications and complications rate for thoracic laminectomies" during the five years prior to the plaintiff's surgery. In response, defendant produced a letter from Gaston Memorial Hospital identifying only 14 laminectomies with a statement saying all of them were performed "with no issues noted." Plaintiff then took the defendant's deposition during which the defendant revealed he had personally created a list of 44 prior laminectomy patients. A copy of this list, with patient names redacted, was given to the plaintiff. Following the deposition, the plaintiff moved to compel full production of the surgery records related to these 44 patients and defendants refused to produce, arguing the same were protected by the physician-patient privilege and not subject to discovery.

The trial court granted Plaintiffs' motion to compel in part and required production of prior surgery records. Specifically, the trial court ordered that the defendant was required to (1) produce only 25 of the 44 patient records requested; (2) provide for the redaction of information that could reveal the identity of the patients whose records were being produced; and (3) recognize the potential need of the parties to obtain an *in camera* inspection of any portions of the records to be produced containing other personal or sensitive information that could potentially require redaction. Defendant appealed[1].

[1] The defendant was allowed to immediately appeal this ruling as it affected a privilege issue and therefore a substantial right. As the COA reasoned, "In the present case, Defendants argue that the documents at issue are immune from discovery based on the privilege set out in N.C. Gen. Stat. § 8-53, which governs

Issue(s):
Was it an abuse of discretion for the trial court to conclude that production of non-party, prior medical records here was "necessary to a proper administration of justice?"

Holding:
No. Under these circumstances, the trial court was well within its discretion to order to the type and scope of production it did for the defendant's prior medical records.

Rules / Controlling Authority:
N.C. Gen. Stat. § 8-53 states that a trial court has the authority to order the disclosure of medical records despite the assertion of physician-patient privilege where doing so is "***in his opinion disclosure is necessary to a proper administration of justice***." N.C. Gen. Stat. § 8-53 (2013) (emphasis added).

"While the General Assembly could have drafted N.C. Gen. Stat. § 8-53 so as to impose greater restrictions on the disclosure of non-party medical records than those applicable to the disclosure of the medical records of parties to the litigation before the court, no such distinction has been drawn in this statute. Instead, HN4 N.C. Gen. Stat. § 8-53 leaves the discoverability of *all* patient records subject to the discretion of the trial courts of this State based upon whether the court believes the disclosure of records is "necessary to a proper administration of justice." N.C. Gen. Stat. § 8-53." (emphasis in original)

"'The physician-patient privilege is not an absolute privilege, and it is in the trial court's discretion to compel the production of evidence that may be protected by the privilege if the evidence is needed for a proper administration of justice.' *Id*. at 170, 631 S.E.2d at 45. We further emphasized that '[t]he decision that disclosure is necessary to a proper administration of justice is one made in the discretion of the trial judge, and the defendant must show an abuse of discretion in order to successfully challenge the ruling.'" *Id*. at 171, 631 S.E.2d at 46 (citations and quotations omitted).

Analysis & Arguments:
Defendants argued that the production of **non-party** medical records should be compelled only in exceptional circumstances. However, relying on the authority above, the COA found that no such limitation existed in the plain language of G.S. § 8-53. The General Assembly could have inserted this policy limitation into the statute if it had so desired, but it clearly had not done so. Therefore, the privilege does not require any greater finding by the trial court when the medical records being sought are those of non-parties to the litigation.

The COA further reasoned that the trial court did not abuse its discretion by ordering the type and scope of production it did for prior patient medical records. Relying heavily on the ordered entered by the trial court as evidence of its proper deliberation on the issue, the COA found the trial court was within his discretion when it concluded the following:

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the discoverability of a patient's medical records. Our Supreme Court has held that 'when . . . a party asserts a statutory privilege which directly relates to the matter to be disclosed under an interlocutory discovery order, and the assertion of such privilege is not otherwise frivolous or insubstantial, the challenged order affects a substantial right[.]' Sharpe, 351 N.C. at 166, 522 S.E.2d at 581. Accordingly, we possess jurisdiction over this appeal." *Brewer*, 762 S.E.2d at 656-657.

> "The request of records are [sic] relevant from the standpoint of credibility, experience, and technique used. That the records that I'm going to encompass by this order are necessary for the administration of justice.
>
> The Court has considered the interests of the parties and the issues at stake in this litigation and carefully weighed these interests against the concern to protect the private health information of non-party patients. A balance between these competing interests is best obtained by compelling production of some of the requested documents, with appropriate redactions that would allow for the protection of the identity of the patients."

Lastly, the COA found that the trial court's decision to grant plaintiffs' motion in a limited fashion, keeping open the possible need for *in camera* inspection of certain records, was further evidence of its proper exercise of discretion.

Impact of Decision on Plaintiff's Practice:
This case is a great case for plaintiffs on an important discovery issue that should be pursued against defendant healthcare providers in many medical negligence cases. It also highlights the importance of drafting quality orders at the trial court level to help protect favorable rulings on appeal.

Goodman v. Living Centers-Southeast, Inc.,
___ N.C. App. ___, 759 S.E.2d 676, 2014 N.C. App. LEXIS 608 (2014)

Prior History: Rowan County, 13 CVS 172	**NCCOA Filed Date:** June 17, 2014
Plaintiff Attorney(s): Michael Doran (Doran, Shelby)	**Defense Attorney(s):** Amy E. Oleska (Hagwood Adelman)
Judge (Author of opinion): Elmore, Rick	**Judges (Concurring / Dissenting):** McCullough, J. Douglas (concur) Davis, Mark (concur)
Type of Medical Care Involved: Nursing home, ordinary negligence	**Decision for Plaintiff or Defense Bar?** Plaintiff

Procedural History:
Appeal by plaintiff from trial court's order dismissing the complaint for failure to comply with the medical malpractice statute of repose.

Background Facts:
On April 22, 2008, plaintiff was admitted as a resident at the Brian Center, a long-term care nursing and rehab facility. On September 13, 2008, employees of the Brian Center improperly positioned an IV fluid pole and delivery system too close to the plaintiff's bed and failed to warn

him of its unstable placement. The IV system fell on top of plaintiff's upper body and head, causing traumatic injuries. The plaintiff received treatment but later died.

Key Case Facts:
On October 5, 2010, plaintiff's estate filed a complaint stating causes of action for negligence, wrongful death, and breach of contract. Specifically, the plaintiff alleged that defendant breached its duties "(1) to exercise due care with respect to providing reasonably safe living quarters for its residents, (2) to warn residents of unsafe conditions, and (3) to supervise patients when:

> a) Defendant placed the aforesaid instrumentality in such a position as to be unreasonably unstable so as to constitute a hazard to those in close proximity hereto, such as plaintiff's decedent;
>
> b) Defendant failed to properly supervise the plaintiff's decedent's activities once defendant installed use of the instrumentality to provide intravenous fluids to plaintiff's decedent; AND
>
> c) Defendant failed to warn plaintiff's decedent of the presence of the instrumentality and to warn plaintiff's decedent of the instability of the equipment."

On January 18, 2012, plaintiff voluntarily dismissed the action pursuant to Rule 41, and then refiled the case one year later on January 18, 2013 with the same allegations as described above. Defendant moved for dismissal arguing that plaintiff's complaint was for medical malpractice and therefore it was filed outside the four year statute of repose for MM actions. The trial court agreed and granted the motion to dismiss. Plaintiff appealed.

Issue:
1) Did the plaintiff allege a case of medical malpractice such that the four year statute of repose applies to bar this complaint?

Holding:
1) No. Plaintiff's complaint alleges ordinary negligence and thus the four year SOR is inapplicable.

Rules / Controlling Authority:
A medical malpractice action is defined as a "civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional [health care] services." N.C. Gen. Stat. § 90-21.11(2)(a) (2013).

"The North Carolina Court of Appeals has defined 'professional services' as an act or service 'arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor [or] skill involved is predominantly mental or intellectual, rather than physical or manual.'" *Lewis v. Setty*, 130 N.C. App. 606, 608, 503 S.E.2d 673, 674 (1998) (quotation omitted).

> The COA here looked to three cases for particular guidance on the dividing line between ordinary negligence and medical malpractice:
>
> ***1) Lewis v. Setty***: "In *Setty*, the quadriplegic plaintiff was injured when he was moved from an examination table to a wheelchair. This Court held that the alleged negligent

conduct was 'predominately a physical or manual activity' which did not implicate the defendant's professional services but fell 'squarely within the parameters of ordinary negligence.'"

2) Norris v. Rowan Memorial Hospital: "In *Norris v. Rowan Memorial Hospital*, this Court concluded that the hospital employees' failure to raise the rails of a bed or instruct the patient to ask for assistance in getting out of bed (which resulted in the patient falling and breaking her hip) stemmed from ordinary negligence because the 'alleged breach of duty did not involve the rendering or failure to render professional nursing or medical services requiring special skills.'"

3) Taylor v. Vencor: "In *Taylor v. Vencor, Inc.*, the administrator [alleged] that the nursing home failed 'through inadequate staffing and other negligent behavior, to provide adequate observation and supervision' of a patient who died after lighting her nightgown on fire when attempting to light a cigarette. 136 N.C. App. 528, 529, 525 S.E.2d 201, 202 (2000). This Court held that 'the observance and supervision of the plaintiff, when she smoked in the designated smoking area, did not constitute an occupation involving specialized knowledge or skill.' *Id.* at 530, 525 S.E.2d at 203. We additionally remarked: 'Preventing a patient from dropping a match or a lighted cigarette upon themselves, while in a designated smoking room, does not involve matters of medical science.'"

"The distinction between medical malpractice actions and ordinary negligence actions is significant for two primary reasons. First, medical malpractice actions are subject to the statute of repose, which mandates: '[I]n no event shall an action be commenced more than four years from the last act of the defendant giving rise to the cause of action[.]' N.C. Gen. Stat. § 1-15(c). Second, plaintiffs filing a medical malpractice action are required to comply with the certification requirements of Rule 9(j) of the North Carolina Rules of Civil Procedure. See N.C. R. Civ. P. § 1A-1, Rule 9(j)."

Analysis & Arguments:
This opinion does not discuss the specific arguments made by defendant in support of its position that plaintiff's allegations involved the "failure to furnish professional services." Instead, the COA relied on the above case law to conclude the following:

"In essence, plaintiff alleges that defendant, through its agents, failed to safely position the I.V. apparatus in the decedent's room and failed to warn the decedent accordingly. Based on prevailing case law, we hold that defendant's acts or failure to act clearly involved the exercise of manual dexterity as opposed to the rendering of any specialized knowledge or skill. See, e.g., *Norris*, 21 N.C. App. at 626, 205 S.E.2d at 348. Accordingly, we hold that the claims asserted in plaintiff's complaint sound in ordinary negligence rather than medical malpractice."

Impact of Decision on Plaintiff's Practice:
This is another case continuing the recent trend of our appellate courts making clear that many different types of nursing home and assisted living cases will sound in ordinary negligence, and not be subject to any of the procedural or evidentiary requirements of medical malpractice actions.

Hammond v. Saini, et. al.,
367 N.C. 607, 766 S.E.2d 590 (2014)

Prior History: Cumberland County, 11 CVS 8281	**NCCOA Filed Date:** December 19, 2014
Plaintiff Attorney(s): Mark Sternlicht (Beaver, Holt, Sternlicht) Burton Craige (Patterson Harkavy) Narendra Ghosh (Patterson Harkavy)	**Defense Attorney(s):** Mark Anderson (McGuireWoods) Patrick Meacham (McGuireWoods) Monica Webb (McGuireWoods)
Judge (Author of opinion): Jackson, Barbara	**Judges (Concurring / Dissenting):** Unanimous
Type of Medical Care Involved: N/A, procedural, discovery issues	**Decision for Plaintiff or Defense Bar?** Plaintiff

Procedural History:
On grant of defendant's petition for discretionary review of Court of Appeals' order affirming trial court's grant of plaintiff's motion to compel.

Background Facts:
Plaintiff suffered serious injuries from an operating room fire due to alleged anesthesia-related negligence. Plaintiff filed suit and sought discovery of documents and information in defendants' possession related to the fire incident. Among other things, Plaintiff specifically moved to compel (1) documents titled "Quality Care Control Reports" ("QCC Reports") prepared by hospital employees; (2) notes taken by CCHS Risk Manager Harold Maynard; and (3) a document titled "Root Cause Analysis Report" ("RCA Report"). Defendants objected and refused to produce any of the requested discovery based upon assertions of the medical review privilege under G.S. § 131E-95(b), work-product doctrine, and attorney-client privilege[2]. After an *in camera* inspection, the trial court entered orders granting plaintiff's motions to compel. The Court of Appeals later affirmed the trial court's order in a unanimous opinion. Defendant filed a PDR on the sole issue of the § 131E-95(b) medical review privilege which was granted.

Key Case Facts:
Defendants argued that after the operating room fire that injured plaintiff, CCHS established a Root Cause Analysis Team ("RCA Team"), which constitutes a medical review committee pursuant to N.C.G.S. § 131E-76(5)(c). Defendants contended that as a result, the QCC Reports, Maynard's notes, and the RCA Report, all of which were allegedly considered or produced by the RCA Team, were protected by N.C.G.S. § 131E-95.

Specifically, Defendant relied upon an affidavit from Risk Manager Maynard, stating:

> *3. The attached CCHS Administrative Policy titled "Sentinel Events and Root Cause Analysis" was in place on September 17, 2010.*

[2] Because defendant failed to advance any specific arguments regarding the attorney-client privilege in their brief, the COA held that defendant's waived this issue entirely.

4. Pursuant to this policy, the events related to Ms. Hammond's surgery on September 17, 2010, were considered to be a sentinel event and a root cause analysis was performed that resulted in the production of a root cause analysis report. The sentinel event and root cause analysis processes are peer review processes designed to evaluate the quality, cost of, and/or necessity for hospitalization and/or the providing of health care.

5. In general, the peer review committees established to deal with sentinel events and prepare a root cause analysis are created by the medical staff and governing board of CCHS and operate under the attached written procedures, which have been adopted by the medical staff and governing board of the healthcare system. This was true on September 17, 2010.

6. Pursuant to the attached CCHS policy, the sentinel event and root cause analysis activities are considered Medical Review Committees as defined by N.C.G.S. §[ ]131E-76(5). The proceedings related to the sentinel event and root cause analysis peer review activities, the records and materials they produce, and the materials they consider are confidential pursuant to N.C.G.S. §[ ]131E-95.

Issue(s):
1) Did defendant meet its burden of proving the RCA Team was a hospital committee "created by the governing board or medical staff of the hospital or system" under § 131E-76(5)(c)?

2) Did defendant meet its burden of proving the RCA Team was "operating under written procedures adopted by the governing board or medical staff of the hospital or system" under § 131E-76(5)(c)?

Holding:
1) No.
2) No.

Rules / Controlling Authority:
"The party asserting the privilege has the burden to demonstrate each of its essential elements and cannot meet this burden by mere conclusory assertions. *In re Miller*, 357 N.C. 316, 336, 584 S.E.2d 772, 787 (2003)."

Pursuant to subsection 131E-95(b), "[t]he proceedings of a medical review committee, the records and materials it produces and the materials it considers" are shielded from discovery and introduction into evidence in certain civil cases."

Under 131E-76(5), a "medical review committee" is "any of the following committees formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing:

a. A committee of a state or local professional society.
b. A committee of a medical staff of a hospital.
c. A committee of a hospital or hospital system, if created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital or system.
d. A committee of a peer review corporation or organization.

§ 131E-76(5) (2013)

"Necessarily, to establish the applicability of the definition in subdivision (c), the evidence must set forth either how the committee was 'created' or how the 'written procedures' it 'operat[es] under' were 'adopted.'" N.C.G.S. § 131E-76(5)(c); *see also Shelton v. Morehead Mem'l Hosp.*, 318 N.C. 76, 84, 347 S.E.2d 824, 829-30 (1986).

Analysis & Arguments:
Similar to what the COA concluded below, the NCSC here reasoned that Maynard's affidavit did not sufficiently demonstrate that the RCA Team met the necessary criteria under 131E-76(5)(c), explaining that "the affidavit merely recites the language of the statute and offers the conclusory assurance that each requirement has been satisfied. The affidavit does not provide specific evidence that could serve as the basis of findings of fact or conclusions of law. In addition, it explains none of the formal organizational processes that led to the adoption of the RCA Policy and the creation of the RCA Team and identifies none of the departments or personnel involved."

Moreover, with regards to the RCA Policy, the NCSC explained that "[n]othing about the policy itself indicates that the RCA Team 'operat[ed] under' the policy in this investigation," nor does it appear "that the RCA Policy was 'adopted by the governing board or medical staff of' CCHS. The policy states only that it was 'approved by MN' and that it originated in the 'Performance Improvement/Patient Safety' department. No evidence has identified these entities as the governing board or medical staff of CCHS." (internal citations omitted).

Thus, the NCSC could not conclude that the RCA Team constituted a "medical review committee" and therefore affirmed the trial court's decision that none of the subject materials it allegedly created were protected by the 131E-95(b) privilege.

Impact of Decision on Plaintiff's Practice:
This is an excellent opinion from the NCSC as it (i) provides an excellent analysis and breakdown of the medical review privilege, and (ii) serves as a clear message that defendants must actually meet their burden of proving every element of the privilege exists before it will be applied.

Hawkins v. Emergency Med. Physicians of Craven Cnty., PLLC,
770 S.E.2d 159, 2015 N.C. App. LEXIS 372 (2014)

Prior History: Craven County, 11 CVS 1403	**NCCOA Filed Date:** April 7, 2015
Plaintiff Attorney(s): Butler Daniel (Butler Daniel & Assoc.) Erin K. Pleasant (Butler Daniel & Assoc.)	**Defense Attorney(s):** Jaye E. Bingham (Cranfil Sumner) Christopher M. Hinnant (Cranfil Sumner)
Judge (Author of opinion): Elmore, Rick	**Judges (Concurring / Dissenting):** Davis, Mark (concur) Tyson, John M. (concur)
Type of Medical Care Involved: Anticoagulation after head injury	**Decision for Plaintiff or Defense Bar?** Defense

Procedural History:
Appeal by plaintiff of trial judge W. Allen Cobb's order granting summary judgment for Defendant.

Background Facts:
Plaintiff fell at home and hit his head causing loss of consciousness and a laceration. He was taken the Craven County emergency department where he was treated by Defendant Dr. Lavine. Dr. Lavine ordered an EKG which revealed the plaintiff was suffering from atrial fibrillation. He also ordered a cranial CT which came back normal. Dr. Lavine ordered the plaintiff be admitted to the hospital for treatment of his a-fib, and out of concern for his atrial flutter and stroke risk, Dr. Lavine prescribed the plaintiff a dose of Lovenox to prevent blood clotting before he left the ED. After plaintiff was admitted to the hospital, Dr. Lavine's care ended and the treatment was managed by other defendant physicians who also prescribed the plaintiff several additional doses of Lovenox for the same precautionary reasons. To try and resolve this atrial flutter, the plaintiff underwent a cardioversion procedure, however they had difficulty waking him after the procedure. An MRI revealed he had suffered a brain hemorrhage while in surgery. He later died from hemorrhage complications. His estate filed suit against Dr. Lavine and the subsequent hospital physicians, alleging that the administration of a blood thinner in a patient with a closed head injury was negligent and lead to his hemorrhage and death.

After taking depositions of plaintiff's experts, Dr. Lavine moved for summary judgment arguing that plaintiff had failed to present sufficient evidence that any of his actions were a proximate cause of the decedent's death.

Key Facts: Deposition Testimony of Plaintiff's Experts Regarding Causation:
Plaintiff had four experts on the issue of causation. The COA identified the following testimony from each expert on the issue of causation for Dr. Lavine's conduct:

> **Dr. Meredith:**
> When asked if the Lovenox ordered by Dr. Lavine actually caused Mr. Hawkins' death, Dr. Meredith responded, "Lovenox contributed significantly."
>
> However, he later gave the following testimony:

Q. Let me ask you this. Will you have any opinions on the issue of causation? Are you familiar with that term?
A. I am familiar with that term, and my response to that is no.

In addition, when asked whether the dose of Lovenox ordered by Dr. Lavine in the ED caused Mr. Hawkins' bleed which led to his death, Dr. Meredith stated, "I can't answer that."

Dr. Strothers:
[Q. Was there a violation in the standard of care?]
A. [M]y understanding is that Dr. Bobbitt wrote the admission orders. So Dr. Lavine wouldn't have been responsible for the care afterwards, except that he placed him on the Lovenox . . . I think since there had only been one dose of Lovenox, that [Mr. Hawkins'] odds would have improved, because he would have had what's thought to be a lesssant [sic] for anticoagulative dose of Lovenox. But I can't say what the change in those odds would have been.

Dr. Stark:
Q. [I]f I understand what you're saying, is that your opinions will focus on how the care that was rendered by Dr. Williams caused or contributed to the death of [Mr. Hawkins]?
A. Yes.

Dr. Fischer:
This expert's causation testimony was focused only on the doses of Lovenox the decedent received after Dr. Lavine's care ended. Dr. Fischer testified that "certainly most importantly the four doses of Lovenox would have had a substantial effect on [Mr. Hawkins'] bleeding times and the progression of the bleeding in the interval," and that "the Lovenox was the principal causative agent for the bleeding."

Key Facts: Subsequent Affidavits of Plaintiff's Experts Regarding Causation
One week before the summary judgment hearing occurred, Plaintiff presented Affidavits from Drs. Meredith, Strothers, and Stark, all three of whom averred: "[I]n my opinion, starting this patient (Mr. Hawkins) on a course of Lovenox by Dr. Lavine was unquestionably a direct cause of his ultimate demise." (emphasis in original).

Issues:
1) Was the deposition testimony of plaintiff's experts taken together enough to survive summary judgment on the causation issue against Dr. Lavine?

2) Were plaintiff's expert affidavits sufficient to survive summary judgment on the causation issue against Dr. Lavine?

Holdings:
1) No.
2) No.

Rules & Controlling Authority – Issue 1

- Causation Proof in General:
"Proximate causation is a cause 'which produces the result in continuous sequence and without which it would not have occurred, and one from which any man of ordinary prudence could have

foreseen that such a result was probable under all of the facts then existing.'" *Kanoy v. Hinshaw*, 273 N.C. 418, 426, 160 S.E.2d 296, 302 (1968).

"There is a two-pronged formula for proximate cause, which consists of a cause-in-fact and reasonable foreseeability. If a plaintiff is unable to show a cause-in-fact nexus between the defendant's conduct and any harm." *Hawkins*, 2015 N.C. App. LEXIS 372, *15.

- Causation Proof in Medial Negligence Cases:

At summary judgment in a medical negligence case, if a defendant proves that the plaintiff cannot establish the element of proximate cause then the burden shifts to the plaintiff, who is then required "to prove, in part, that the treatment caused the injury. Not only must it meet our courts' definition of proximate cause, but evidence connecting medical negligence to injury also must be probable, not merely a remote possibility." *Cousart v. Charlotte-Mecklenburg Hosp. Auth.*, 209 N.C. App. 299, 302, 704 S.E.2d 540, 543 (2011) (quotation and citation omitted).

"Plaintiffs are required to make a *prima facie* case of medical negligence during a summary judgment hearing, 'which includes articulating proximate cause ***with specific facts couched in terms of probabilities***.' *Cousart*, 209 N.C. App. at 303-04, 704 S.E.2d at 543 (emphasis added).

"A medical negligence plaintiff must rely on expert opinion testimony to establish proximate causation of the injury in a medical malpractice action." *Cousart*, 209 N.C. App. at 303, 704 S.E.2d at 543; see also Smithers v. Collins, 52 N.C. App. 255, 260, 278 S.E.2d 286, 289 (1981) (noting that expert testimony is generally necessary "when the standard of care and proximate cause are matters involving highly specialized knowledge beyond the ken of laymen").

"[A]n expert "s not competent to testify as to a causal relation which rests upon mere speculation or possibility." *Young v. Hickory Bus. Furn.*, 353 N.C. 227, 230, 538 S.E.2d 912, 915 (2000).

A medical negligence plaintiff can survive summary judgment on causation if he/she can show that one defendant's breach in the standard of care actually caused subsequent treating physicians to rely on the defendant's bad decision-making in proceeding with a course of treatment that later injures the plaintiff. *See Burgess v. Campbell*, 182 N.C. App. 480, 642 S.E.2d 478 (2007).

Analysis and Arguments – Issue 1:

The COA analyzed the deposition testimony of each expert in light of the above law that medical causation opinions must be stated "with specific facts couched in terms of probabilities." The COA concluded that none of the experts opined that Dr. Lavine's Lovenox order was a "reasonably probable" cause of Mr. Hawkins' death. The Court pointed out that either the experts refused to provide an opinion on that specific issue (Dr. Meredith, Dr. Stark); the experts could not say to what degree the Dr. Lavine's dose of Lovenox actually contributed to the death (Dr. Strothers); or that the experts' causation opinions were limited to breaches committed by defendants other than Dr. Lavine (Dr. Stark, Dr. Fischer). The COA concluded the deposition testimony was insufficient for plaintiff to survive summary judgment because "none of the experts testified that Mr. Hawkins would not have or probably would not have died had Dr. Levine not administered the dose of Lovenox to Mr. Hawkins in the ED."

Moreover, the Court reasoned that the plaintiff had failed to present sufficient evidence similar to the *Burgess* case that Dr. Lavine's treatment decisions either "misled the subsequent treating physicians or caused them to engage in a plan of treatment that caused Mr. Hawkins' death," as the record showed that "the subsequent treating physicians were at liberty to continue or cancel Dr. Lavine's order of Lovenox" at any time after doing their own independent evaluations of Mr. Hawkins. Thus, the plaintiff failed to present sufficient evidence that Dr. Lavine's order amounted to a "plan of care" that subsequent treating doctors "were likely to follow."

In sum, the COA concluded that plaintiff "failed to establish the first prong of the proximate cause analysis – that Dr. Lavine's conduct directly caused Mr. Hawkins' death."

Rules & Controlling Authority – Issue 2 (Affidavits):
"A party opposing a motion for summary judgment cannot create a genuine issue of material fact by filing an affidavit contradicting his prior sworn testimony." *Pinczkowski v. Norfolk S. Ry. Co.*, 153 N.C. App. 435, 440, 571 S.E.2d 4, 7 (2002).

Where an expert's affidavit is in enough conflict with prior deposition testimony, "the affidavit should be disregarded as a sham issue of fact . . . [a] genuine issue of material fact is not created where the only issue of fact is to determine which of the two conflicting versions of the [expert's] testimony is correct." *Rohrbough v. Wyeth Labs., Inc.*, 916 F.2d 970, 974 (4th Cir. 1990).

Analysis and Arguments – Issue 2:
The COA compared the deposition testimony against the affidavit testimony of the three experts at issue to see if the testimony on causation was in direct conflict. On the one hand, the COA pointed out that none of the three experts testified in deposition that Dr. Lavine's conduct "did cause or *probably* caused Mr. Hawkins' death." Yet, in their affidavits each expert stated that "Dr. Lavine's conduct was unquestionably a direct cause of Mr. Hawkins' ultimate demise." Accordingly, the COA concluded that this level of conflict "created a credibility issue, not a genuine issue of material fact" sufficient to survive summary judgment.

Impact of Decision on Plaintiff's Practice:
This is a tough case for plaintiffs on causation. That said, it does highlight the analysis courts are required to go through on the ***actual cause*** prong of the single element North Carolina collectively refers to as "proximate cause." Proximate cause is not just about foreseeable injury. It's also about a direct, but-for link that, more likely than not, existed between defendant's breach and plaintiff's ultimate injury.

Lassiter v. N.C. Baptist Hosps, Inc.,
761 S.E.2d 720, 2014 N.C. App. LEXIS 833 (2014)

Prior History: Johnston County, 11 CVS 3982	**NCCOA Filed Date:** August 5, 2014
Plaintiff Attorney(s): Charles Carpenter (Pulley Watson) Tracy Lischer (Pulley Watson) Joseph Edwards (Edwards & Edwards) Sharron Edwards (Edwards & Edwards)	**Defense Attorney(s):** Gray Wilson (Wilson, Helms) Linda Helms (Wilson, Helms) Richard Vanore (Carruthers & Roth) Norman Klick (Carruthers & Roth)
Judge (Author of opinion): McCullough, J. Douglas	**Judges (Concurring / Dissenting):** Stephens, Linda (concur) Stroud, Donna S. (concur)
Type of Medical Care Involved: n/a, procedural	**Decision for Plaintiff or Defense Bar?** Plaintiff

Procedural History:
Appeal by plaintiff from orders entered by The Hon. Thomas H. Locke taxing expert witness costs to plaintiff.

Key Facts:
The parties had a Discovery Scheduling Order ("DSO") in place governing the timing of expert designations and depositions. The DSO required Plaintiff to make his expert witnesses available for deposition no later than November 15, 2012. Importantly, the DSO was silent on any issues surrounding expert witness subpoenas and whether the parties waived the subpoena requirements for purposes of taxing costs.

Four of plaintiff's eight experts were deposed before the November 15 deadline; however plaintiffs failed to offer dates for four other experts before the deadline. None of plaintiff's experts were ever placed under subpoena for their depositions.

Defendants filed a motion to exclude those experts from later testifying at trial. The trial court granted defendants' motion and thereafter plaintiff filed a Voluntary Dismissal Without Prejudice pursuant to Rule 41(a). Following the dismissal, defendants filed motions seeking reimbursement of their costs associated with taking the depositions of plaintiff's first four experts. The trial court granted defendants' costs motions, finding that the fact that the DSO was silent on the issue meant that the parties had waived the subpoena requirement for taxing costs.

Issue: Did the trial court err by taxing costs for expert depositions when none of the experts at issue were ever placed under subpoena?

Holding: Yes.

Rules & Controlling Authority:

Rule 41(d) provides the following: "Costs. - A plaintiff who dismisses an action or claim under section (a) of this rule shall be taxed with the costs of the action unless the action was brought in forma pauperis."

G.S. § 6-20 provides: "[i]n actions where allowance of costs is not otherwise provided by the General Statutes, costs may be allowed in the discretion of the court. Costs awarded by the court are subject to the limitations on assessable or recoverable costs set forth in G.S. 7A-305(d), unless specifically provided for otherwise in the General Statutes."

G.S. § 7A-305(d)(11) grants the trial court authority to award as discretionary costs "[r]easonable and necessary fees of expert witnesses solely for actual time spent providing testimony at trial, deposition, or other proceedings."

G.S. § 7A-314(a), (b), and (d) provide:

> "(a) A witness under subpoena, bound over, or recognized shall be entitled to receive five dollars ($ 5.00) per day, or fraction thereof, during his attendance[.]
>
> (b) A witness entitled to the fee set forth in subsection (a) of this section . . . shall be entitled to receive reimbursement for travel expenses . . .
> . . .
> (d) An expert witness . . . shall receive such compensation and allowances as the court, or the Judicial Standards Commission, in its discretion, may authorize. . . ."

"In sum, before a trial court may assess expert witness testimony fees as costs, the testimony must be (1) reasonable, (2) necessary, and (3) given while under subpoena." *Peters*, 210 N.C. App. at 26, 707 S.E.2d at 741.

"Where § 7A-314 specifically authorizes the court to tax expert witness fees as costs, only 'witness[es] under subpoena, bound over, or recognized' are included. Read *in pari materia*, with specific statutes prevailing over general ones, § 7A-314 limits the trial court's broader discretionary power under § 7A-305(d)(11) to award expert fees as costs only when the expert is under subpoena." *Jarrell v. The Charlotte-Mecklenburg Hospital Authority*, 206 N.C. App. at 563, 698 S.E.2d at 193 (2010).

Analysis and Arguments:
The COA distinguished this case from the facts in *Jarreell* by pointing out that in *Jarrell* the DSO had explicit language stating "all parties agree that experts need not be issued a subpoena either for deposition or trial and waive that requirement of the statute as it may affect the recovery of costs;" whereas the DSO in this case had no such language. It was, instead, silent on that issue. Accordingly, the COA concluded: "Based on the foregoing, we hold that the trial court erred by awarding costs for expert witnesses when the witnesses were not under subpoena. *See Stark v. Ford Motor Co.*, N.C. App. , , 739 S.E.2d 172, 176 (2013) (citing *Jarrell*, Ford Motor Company conceded and our Court agreed that the trial court erred in awarding fees for expert witnesses incurred while the expert witnesses were not under subpoena)."

Impact of Decision on Plaintiff's Practice:
This case reinforces the very clear rule that, unless there is a specific provision to the contrary in a DSO, a party cannot collect expert costs unless that expert was placed under subpoena.

Peter v. Vullo,
758 S.E.2d 431, 2014 N.C. App. LEXIS 557 (2014)

Prior History: Mecklenburg County, 11 CVS 18251	**NCCOA Filed Date:** June 3, 2014
Plaintiff Attorney(s): Stephen M. Russell, Jr. (Van Laningham Duncan)	**Defense Attorney(s):** John H. Beyer (Parker Poe) Jami J. Farris (Parker Poe) John D. Branson (Parker Poe) Tricia Derr (Lincoln Derr)
Judge (Author of opinion): McCullough, J. Douglas	**Judges (Concurring / Dissenting):** Hunter, Robert C. (concur) Geer, Martha A. (concur)
Type of Medical Care Involved: Anesthesiology, nerve damage	**Decision for Plaintiff or Defense Bar?** Partial Plaintiff, Partial Defense

Procedural History:
Appeal from order of Judge Richard D. Boner granted defendants' motion for summary judgment.

Background Facts:
Plaintiff was referred to a foot and ankle specialist for ankle surgery. The surgery was performed at Carolinas Medical Center hospital in Charlotte ("CMC"). The surgery involved placing the plaintiff under conscious sedation by an anesthesiology team, led by defendant Dr. Vullo. In attempting to administer a nerve block to plaintiff's leg before surgery, the anesthesiology team permanently injured a nerve in plaintiff's leg. Plaintiff filed a medical malpractice action against Dr. Vullo and CMC hospital system, alleging CMC was liable via agency for Dr. Vullo's actions. After depositions of Plaintiff's experts, defendants moved for summary judgment, arguing plaintiff had failed to forecast sufficient evidence of (i) an expert qualified in the necessary standard of care to opine that Dr. Vullo breached the standard of care, and (ii) actual or apparent agency claims against CMC.[3]

Key Facts: Deposition and Affidavit Testimony of Plaintiff's Experts
During deposition, one of plaintiff's experts, Dr. Fiamengo, testified that Dr. Vullo had breached the standard of care and caused the permanent never injury. However, when pressed about which standard of care he was applying, Dr. Fiamengo admitted: (i) he had no taken "anything" about the Charlotte medical community into consideration in forming his opinion; and (ii) the standard he was applying to Dr. Vullo was a "national standard of care."

Following his deposition and after defendant Vullo moved for summary judgment, plaintiff submitted an affidavit from Dr. Famiengo that stated the following: (i) he had now reviewed information regarding the Charlotte medical community and its population; (ii) he is familiar with the level of care and resources available for anesthesiologist practicing in this type of setting; (iii) he has worked before in communities similar to Charlotte and the standard of care

[3] Additionally, defendants argued that plaintiff's loss of consortium claim was derivative and therefore should be dismissed along with the aforementioned claims.

for nerve block procedures would be the same between the two areas; (iv) he is familiar with the standard of care for nerve blocks in the same or similar community as Charlotte for a physician with the same or similar training, education, and experience as Dr. Vullow; and (v) Dr. Vullo breached this standard in the way he performed this nerve block procedure on plaintiff.

Key Facts: Agency Issues Surrounding Dr. Vullo and CMC
Dr. Vullo was not an employee of Defendant CMC. Instead, he was an employee of American Anesthesiology of the Southeast, PLLC, which had previously acquired Southeast Anesthesiology Consultants in 2010. Dr. Vullo had privileges at CMC and provided anesthesia services there.

Before surgery, plaintiff signed several consent forms that explicitly stated: (1) that "anesthesiologists . . . may not be employed by or be agents of the hosptail;" (ii) that "Southeast Anesthesiology Consultants" acted as "independent contractors, [and] are not employees or agents" of CMC; and (iii) that Dr. Anderson of OrthoCarolina would be the actual physician performing her surgery at CMC.

Issues:
1) After considering the deposition and affidavit testimony of plaintiff's expert, did the plaintiff forecast sufficient evidence to survive summary judgment against Dr. Vullo?

2) Did plaintiff forecast sufficient evidence of either actual or apparent agency to survive summary judgment against CMC hospital?

Holdings:
1) Yes.
2) No.

Rules & Controlling Authority – Issue 1 (Deposition and Affidavit Testimony):
"In order to maintain an action for medical malpractice, a plaintiff must offer evidence to establish (1) the applicable standard of care; (2) breach of that standard; (3) proximate causation; and (4) damages." *Robinson v. Duke Univ. Health Systems,* N.C. App. , , 747 S.E.2d 321, 334 (2013) (citation omitted).

"When plaintiffs have introduced evidence from an expert stating that the defendant doctor did not meet the accepted medical standard, [t]he evidence forecast by the plaintiffs establishes a genuine issue of material fact as to whether the defendant doctor breached the applicable standard of care and thereby proximately caused the plaintiff's injuries. This issue is ordinarily a question for the jury, and in such case, it is error for the trial court to enter summary judgment for the defendant." *Robinson*, N.C. App. at , 747 S.E.2d at 335 (citation omitted).

"[T]he standard of care must be established by other practitioners in the particular field of practice of the defendant health care provider or by other expert witnesses equally familiar and competent to testify as to that limited field of practice. Although 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 of similar communities."
Smith v. Whitmer, 159 N.C. App. 192, 195-96, 582 S.E.2d 669, 671-72 (2003) (internal citations and quotation marks omitted).

Analysis and Arguments – Issue 1:

The COA concluded that, after considering Dr. Famiengo's affidavit, the plaintiff had presented sufficient evidence that "[t]he applicable standard in Charlotte in 2010 for an anesthesiologist such as Dr. Vullo" had been violated in the way that Dr. Vullo had performed this nerve block, and this violation "directly caused Ms. Peter's injuries." Thus, the COA reasoned that this evidence was enough to survive summary judgment.

The COA disagreed with defendants' argument that Dr. Famiengo's affidavit should be stricken under "the law as set forth in *Wachovia Mortgage Co. v. Autry-Barker-Spurrier Real Estates, Inc.*, 39 N.C. App. 1, 249 SE2d 727 (1978) (holding that a party opposing a motion for summary judgment cannot create an issue of fact by filing an affidavit contradicting the prior sworn testimony of a witness)." In so doing, the COA relied on the facts and holding in in *Roush v. Kennon*, 188 N.C. App. 570, 656 S.E.2d 603 (2008), where the expert at issue similarly testified that he had applied a national standard of care during his deposition, and then subsequently filed an affidavit showing that he had later familiarized himself on the standard of care applicable to the defendant's medical community and those standards were the same the expert had previously applied during his deposition. Following the holding in *Roush*, the COA concluded that it was error for the trial court to have "characterized Dr. Fiamengo's affidavit testimony as a tactic to contradict his own prior deposition testimony, in an attempt to create an issue of fact to defeat defendants' summary judgment motions."

Rules & Controlling Authority – Issue 2 (Actual and Apparent Agency):
"Under the doctrine of *respondeat superior*, a hospital is liable for the negligence of a physician or surgeon acting as its agent. There will generally be no vicarious liability on an employer for the negligent acts of an independent contractor. Unless there is but one inference that can be drawn from the facts, whether an agency relationship exists is a question of fact for the jury. If only one inference can be drawn from the facts then it is a question of law for the trial court." *Hylton v. Koontz*, 138 N.C. App. 629, 635, 532 S.E.2d 252, 257 (2000) (citations omitted).

"[A]pparent agency would be applicable to hold the hospital liable for the acts of an independent contractor if the hospital held itself out as providing services and care." *Diggs v. Novant Health, Inc.*, 177 N.C. App. 290, 305, 628 S.E.2d 851, 861 (2006) (citation omitted).

"Under this approach, a plaintiff must prove that (1) the hospital has held itself out as providing medical services, (2) the plaintiff looked to the hospital rather than the individual medical provider to perform those services, and (3) the patient accepted those services in the reasonable belief that the services were being rendered by the hospital or by its employees. A hospital may avoid liability by providing meaningful notice to a patient that care is being provided by an independent contractor." *Id.* at 307, 628 S.E.2d at 862 (citation omitted).

"[O]ur Court has established that 'evidence that a physician has privileges at a hospital is not sufficient, standing alone, to make the physician an agent of the hospital[.]'" *Id.* at 301, 628 S.E.2d at 859.

Analysis and Arguments – Issue 2:
Plaintiffs argued that "'an inference can be drawn that an agency relationship existed between Dr. Vullo and the Hospital Defendants' since CMC and CMC Mercy held themselves out as providing medical services to Ms. Peter under the doctrine of apparent agency." Plaintiffs attempted to similarities to the facts and holding in *Diggs v. Novant Health, Inc.*, 177 N.C. App. 290, 628 S.E.2d 851 (2006), where the court upheld a finding of apparent agency, to those present in this case, arguing that "a jury could decide that Ms. Peter accepted medical services in

the reasonable belief that the services were being provided by the hospital defendants. After thoughtful review, we find the facts of the present case distinguishable."

The COA disagreed with the plaintiff, saying: "[d]istinguishable from the facts found in *Diggs*, Ms. Peter was provided meaningful notice from the hospital defendants that the anesthesiologists may be independent contractors. In fact, the hospital defendants expressly disclaimed that independent contractors providing certain services at the hospital defendants' facilities were not agents of the hospital defendants."

Plaintiff also cited in contrast the facts found in *Ray v. Forgy*, N.C. App. , 744 S.E.2d 468 (2013) to argue that the consent forms here were insufficient to defeat the apparent agency claims because, unlike in *Ray* where the forms identified the physician who allegedly violated the standard of care as being an independent contractor, here the forms provided "no identification of the treating physician on the [h]ospital [d]efendants' release form, or a quantification of the likelihood of Mrs. Peter being treated by an unidentified non-employee physician." The COA found this argument unpersuasive, explaining:

> [T]he consent form identified that "anesthesiologists . . . may not be employed by or be agents of the hospital." The authorization form also provided that "certain independent professional groups" were independent contractors and identified a non-comprehensive list of the independent professional groups that included Southeast Anesthesiology Consultants, P.A., a predecessor to Dr. Vullo's employer American Anesthesiology of the Southeast, PLLC. Therefore, comparing the facts of Ray and the facts in the case before us, we find them to be more analogous than dissimilar as plaintiffs argue.

Impact of Decision on Plaintiff's Practice:.
In contrast to the *Hawkins* case reported earlier in this manuscript, this case stands as a helpful example of when a subsequent affidavit by an expert following his/her deposition can be considered admissible for purposes of defeating summary judgment. However, this case also serves as a reminder of the difficulties plaintiffs face in proving the elements of apparent agency claims against hospitals when multiple consent forms were signed by the patient discussing the independent contractor status of certain physicians – even if those physicians are never specifically identified.

Ratledge v. Perdue,
2015 N.C. App. LEXIS 91 (2015)

Prior History: Pitt County, 13 CVS 2330	**NCCOA Filed Date:** February 17, 2015
Plaintiff Attorney(s): Graham Stiles (Asbill Stiles)	**Defense Attorney(s):** Robert D. Walker (Walker, Allen) Ashley H. Rodriguez (Walker, Allen)
Judge (Author of opinion): Calabria, Ann Marie	**Judges (Concurring / Dissenting):** McCullough, J. Douglas (concur) Steelman, Sanford (concur)
Type of Medical Care Involved: Hand surgery, severed ulnar nerve	**Decision for Plaintiff or Defense Bar?** Defense

Procedural History:
Plaintiff's appeal from Judge W. Russell Duke's order dismissing the complaint for failure to comply with Rule 9(j).

Background Medical Facts:
Plaintiff was a baseball player at ECU. He went to see defendant Dr. Perdue who determined he had fractured a bone in his hand and recommended surgery. Dr. Perdue performed the surgery and plaintiff thereafter experienced hand and arm pain. Plaintiff went for a second opinion and on May 29, 2009, he was informed by his new physician that Dr. Perdue had severed his ulnar never during the surgery and this was the cause of the pain.

Key Facts – Facts Relevant to Rule 9(j) Issues:
Plaintiff's attorney sent medical records to an expert witness service called CorVel Corporation, a company which offered expert reviews of potential medical malpractice cases and referrals to experts. The claim was reviewed by Dr. Robert Pennington and CorVel provided plaintiff's lawyer with a "Peer Review" report purporting to represent Dr. Pennington's views on the case. However, the report was signed or otherwise formally verified by Dr. Pennington. Importantly, the form never actually stated that the care of Dr. Perdue fell below the applicable standard of care or that Dr. Pennington would testify to that effect. The plaintiff's lawyer also never received any correspondence from CorVel confirming that Dr. Pennington was willing to testify.

The statute of limitations was set to expire on May 29, 2012. On March 16, 2012, plaintiff filed a complaint containing a Rule 9(j) certification and defendant thereafter served 9(j) interrogatories. Plaintiff provided unverified responses and defendant moved to compel verified responses. The trial court granted the motion and required verified responses produced in 15 days. Plaintiff failed to meet this deadline and defendant filed a motion to dismiss. Plaintiff then filed a Voluntary Dismissal Without Prejudice on March 14, 2013, and the refiled a new action with the same malpractice allegations and 9(j) certification on September 30, 2013. Defendants moved to dismiss the new action for failure to comply with Rule 9(j) and the trial court granted the motion.

Issue:
1) Did the trial court err in dismissing the complaint for failure to comply with Rule 9(j)?

Holdings:
1) No.

Rules / Controlling Authority:
"It is also now well established that even when a complaint facially complies with Rule 9(j) by including a statement pursuant to Rule 9(j), if discovery subsequently establishes that the statement is not supported by the facts, then dismissal is likewise appropriate." *Ford v. McCain*, 192 N.C. App. 667, 672, 666 S.E.2d 153, 157 (2008).

"Because Rule 9(j) requires certification at the time of filing that the necessary expert review has occurred, compliance or noncompliance with the Rule is determined at the time of filing. The Court of Appeals has held that when conducting this analysis, a court should look at 'the facts and circumstances known or those which should have been known to the pleader' at the time of filing. We find this rule persuasive, as any reasonable belief must necessarily be based on the exercise of reasonable diligence under the circumstances. As a result, the Court of Appeals has correctly asserted that a complaint facially valid under Rule 9(j) may be dismissed if subsequent discovery establishes that the certification is not supported by the facts, at least to the extent that the exercise of reasonable diligence would have led the party to the understanding that its expectation was unreasonable." *Moore v. Proper*, 366 N.C. at 31-32, 726 S.E.2d at 817 (2012) (internal quotations and citations omitted).

"Our appellate courts have also addressed the situation in which a Rule 41(a)(1) voluntary dismissal was taken after the filing of a complaint lacking any Rule 9(j) certification. The courts have held that if (1) the initial complaint does not contain a Rule 9(j) certification; (2) the required certification is not filed prior to the expiration of the statute of limitations and the 120-day extension permitted by Rule 9(j); and (3) the plaintiff takes a voluntary dismissal under Rule 41, then a re-filed complaint -- even though containing a Rule 9(j) certification -- must be dismissed . . . ." *Ford*, 192 N.C. App. at 671, 666 S.E.2d at 156-57.

A "defective original complaint cannot be rectified by a dismissal followed by a new complaint complying with Rule 9(j), where the second complaint is filed outside of the applicable statute of limitations." *McKoy v. Beasley*, 213 N.C. App. 258, 263, 712 S.E.2d 712, 716 (2011)

Analysis & Argument:
The analysis in this case was fairly straightforward. Citing *McKoy v. Beasley*, the COA first concluded that because the second complaint was filed after the expiration of the statute of limitations, then "in order to survive defendants' motion to dismiss, plaintiff's 16 March 2012 complaint must have included a valid Rule 9(j) certification." Based on the facts cited by the trial court, the plaintiff could not make this showing.

The COA concluded that the facts below "establish that plaintiff never received any definitive confirmation that Dr. Pennington either believed that plaintiff's treatment by Dr. Perdue fell below the applicable standard of care or that Dr. Pennington would testify to that effect. Thus, the court's findings support its conclusion of law that plaintiff failed to comply with Rule 9(j) prior to the expiration of the statute of limitations, because, at the time of the filing of the original complaint, 'the exercise of reasonable diligence would have led [plaintiff] to the understanding that [his] expectation [that Dr. Pennington would testify] was unreasonable.'"

Impact of Decision on Plaintiff's Practice:

This decision is a good reminder of the interplay between Rule 41(a) dismissals and Rule 9(j). But, perhaps more than anything, this case should serve as a warning about relying on expert witness services to handle any aspects of Rule 9(j) compliance in your cases. The better course of action would be to vet the entire process yourself to determine adequate compliance with Rule 9(j).

Wheeless v. Maria Parham Med. Ctr., Inc.,
768 S.E.2d 119, 2014 N.C. App. LEXIS 1247 (2014)

Prior History: Vance County, 13 CVS 335	**NCCOA Filed Date:** December 2, 2014
Plaintiff Attorney(s): Arlene L. Velasquez-Colon (Colon & Assoc) Jeannette Griffith Congdon (Congdon Law)	**Defense Attorney(s):** James W. Powell (Womble Carlyle) Theresa M. Sprain (Womble Carlyle) Dan McLamb (Yates McLamb) Samuel G. Thompson, Jr. (Yates McLamb) John B. Ward (Yates McLamb)
Judge (Author of opinion): Bryant, Wanda	**Judges (Concurring / Dissenting):** Elmore, Rick (concur) Ervin, Sam IV (concur)
Type of Medical Care Involved: Medical Executive Committee	**Decision for Plaintiff or Defense?** Defense

ABBREVIATED CASE REPORT

Please note: this is an abbreviated case report as the vast majority of the decision does not involved medical negligence facts or issues. Instead, the case largely centers on a physician dispute with a hospital medical executive committee. Only those small portions relevant to medical malpractice case law have been reported below.

Learned Profession Exception to Ch. 75 Unfair or Deceptive Trade Practices:
Plaintiff attempted to assert a Ch. 75 UDTP claim against the defendant hospital and MEC members for violating the terms of a confidential settlement agreement by making an anonymous complaint to the N.C. Medical Board about matters covered under the settlement agreement. The COA held here that "defendants' alleged conduct in making a complaint to the Medical Board is integral to their role in ensuring the provision of adequate medical care," and therefore the learned profession exception applied to bar plaintiff's Ch. 75 claim.

Medical Malpractice Claims When No Physician-Patient Relationship Exists:
Plaintiff also attempted to assert a medical malpractice claim under G.S. § 90-21.11 against the same defendants for the same conduct. However, no physician-patient relationship existed between the plaintiff and the hospital defendants he sued. The COA cited several cases holding "It is well settled that the relationship of physician to patient must be established as a prerequisite to an actionable claim for medical malpractice." *Easter v. Lexington Mem'l Hosp., Inc.*, 303 N.C. 303, 305-06, 278 S.E.2d 253, 255 (1981). Accordingly, the plaintiff's medical malpractice claim here was dismissed.

Wiggins v. East Carolina Health-Chowan, Inc.,
760 S.E.2d 323, 2014 N.C. App. LEXIS 676 (2014)

Prior History: Chowan County, 08 CVS 186	**NCCOA Filed Date:** July 1, 2014
Plaintiff Attorney(s): Charles G. Monnett III (Monnett & Assoc)	**Defense Attorney(s):** Charles E. Simpson, Jr. (Harris, Creech) Thomas E. Harris (Harris, Creech)
Judge (Author of opinion): Hunter, Robert C.	**Judges (Concurring / Dissenting):** Bryant, Wanda (concur) Steelman, Sanford (concur)
Type of Medical Care Involved: Labor and delivery	**Decision for Plaintiff or Defense?** Plaintiff

Procedural History:
Appeal by plaintiffs from judgment entered by Judge Gary E. Trawick following defense verdict at trial.

Background Facts:
Plaintiff-mother was going through a long labor at defendant hospital. After pausing briefly during the night, defendants decided to induce plaintiff with Pitocin in the morning to speed the labor along. Up to this point there had been no sign of any injury to the baby or mother. Defendants administered Pitocin at 8:08am without performing a vaginal exam first, in direct violation of hospital protocols. It was not until 12:54pm that a vaginal exam was performed revealing a cord prolapse. An emergency code was called and a C-section was performed. The plaintiffs alleged that the baby suffered permanent brain injury as a proximate result of defendants' failure to perform a C-section in a timely fashion.

Several experts testified during trial that cord prolapse is uncommon and qualifies as a medical emergency. All experts testified that plaintiff-mother had no prior risk factors of developing a cord prolapse.

During the charge conference, defendants requested the trial judge give the jury the Sudden Emergency Doctrine instruction in light of the cord prolapse facts of the case. Plaintiff preserved his objection properly and argued the instruction was inapplicable in medical negligence cases. The trial judge granted the defendants' motion, gave the instruction, and the jury rendered a defense verdict from which plaintiff appealed.[4]

Issue:
Did the trial court err in giving the sudden emergency instruction here because the doctrine is inapplicable in medical negligence cases in North Carolina?

Holding:

[4] Plaintiff also appealed the trial judge's decision not to instruct the jury on defendant's liability for unsuccessful or harmful subsequent medical treatment necessitated by defendant's negligence. The COA, however, did not have to reach this issue in the opinion below.

Yes.

Rules / Controlling Authority:

- Jury Instruction Rules in General:

"The trial court is responsible for ensuring that the jury is properly instructed [*326] before deliberations begin." (citing *Mosley & Mosley Builders, Inc. v. Landin Ltd.*, 87 N.C. App. 438, 445, 361 S.E.2d 608, 612 (1987)).

"It [is] the duty of the [trial] court to instruct the jury upon the law with respect to every substantial feature of the case." *Mosley*, 87 N.C. App. 438, 445, 361 S.E.2d 608, 612 (1987)

A trial court's primary purpose in instructing the jury is "the clarification of issues, the elimination of extraneous matters, and a declaration and an application of the law arising on the evidence." *Littleton v. Willis*, 205 N.C. App. 224, 228, 695 S.E.2d 468, 471.

"In considering whether to give a requested jury instruction, the evidence must be viewed in the light most favorable to the party requesting the instruction." (citing *Carrington v. Emory*, 179 N.C. App. 827, 829, 635 S.E.2d 532, 534 (2006)).

"On appeal, this Court should consider the jury charge contextually and in its entirety." (citing *Hammel v. USF Dugan, Inc.*, 178 N.C. App. 344, 347, 631 S.E.2d 174, 178 (2006)).

"The charge will be held to be sufficient if it presents the law of the case in such manner as to leave no reasonable cause to believe the jury was misled or misinformed. The party asserting error bears the burden of showing that the jury was misled or that the verdict was affected by an omitted instruction. Under such a standard of review, it is not enough for the appealing party to show that error occurred in the jury instructions; rather, it must be demonstrated that such error was likely, in light of the entire charge, to mislead the jury." *Hammel v. USF Dugan, Inc.*, 178 N.C. App. 344, 347, 631 S.E.2d 174, 178 (2006).

- Sudden Emergency Doctrine:

N.C.P.I.-Civ. 809.00A: "A person who, through no negligence of his own, is suddenly and unexpectedly confronted with imminent danger to himself and others, whether actual or apparent, is not required to use the same judgment that would be required if there were more time to make a decision. The person's duty is to use that degree of care which a reasonable and prudent person would use under the same or similar circumstances. If, in a moment of such emergency, a person makes a decision that a reasonable and prudent person would make under the same or similar conditions, he does all that the law requires, even if in hindsight some different decision would have been better or safer."

"In a general negligence action in North Carolina, the sudden emergency instruction can be requested when a party presents substantial evidence showing that a party (1) perceived an emergency situation and reacted to it, and (2) the emergency was not created by that party's own negligence." (citing *Carrington*, 179 N.C. App. at 829-30, 635 S.E.2d at 534).

"The doctrine of sudden emergency creates a less stringent standard of care for one who, through no fault of his own, is suddenly and unexpectedly confronted with imminent danger to himself or others." *Marshall v. Williams*, 153 N.C. App. 128, 131, 574 S.E.2d 1, 3 (2002) (citation and quotation marks omitted).

"One who is required to act in an emergency is not held by the law to the wisest choice of conduct, but only to such choice as a person of ordinary care and prudence, similarly situated would have been." *Masciulli v. Tucker*, 82 N.C. App. 200, 205-06, 346 S.E.2d 305, 308 (1986) (citation and quotation marks omitted).

Analysis & Arguments:
Defendants cited multiple cases from other jurisdictions holding that the sudden emergency doctrine may apply in certain situations against healthcare providers. Plaintiff argued that the doctrine is inapplicable to medical negligence cases in North Carolina because the standards of practice already take into account what a reasonable provider would do under the same or similar circumstances facing the defendant. The COA agreed with Plaintiff for three reasons:

> 1) Citing a clear line of precedent, the COA pointed out that the sudden emergency doctrine in North Carolina appellate history had only ever been applied to ordinary negligence cases and was primarily focused in motor vehicle collision cases.
>
> 2) The N.C. Supreme Court has made clear that applying one standard of care to a wide range of medical scenarios is intentional in this state, saying: "Our Supreme Court has described the standard for medical professionals as 'completely unitary in nature, combining in one test the exercise of 'best judgment,' 'reasonable care and diligence' and compliance 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.'" (quoting *Wall v. Stout*, 310 N.C. 184, 193, 311 S.E.2d 571, 577 (1984)).
>
> 3) "[T]he standard of care for healthcare professionals, both at common law and as enunciated in section 90-21.12, is designed to accommodate the factual exigencies of any given case, including those that may be characterized as medical emergencies." (citing *Brawley v. Heymann*, 16 N.C. App 125, 128, 191 S.E.2d 366, 367-368 (1972), which held that "[a] jury could reasonably conclude from such findings that defendant failed to give, or see that plaintiff was given, such care as a reasonably prudent physician *in the same or similar circumstances* would have provided[.]") (emphasis in opinion).

In dicta, the COA also pointed out that even if the doctrine were applicable to medical negligence cases that the trial court still committed error in reading the pattern instruction to the jury here because the pattern instruction focus on the conduct of a "prudent person" in an emergency situation: "The charge instructs the jury to simultaneously apply the 'standards of practice among *members of the same healthcare profession* with similar training and experience situated in the same or similar communities at the time the health care is rendered' in addition to the duty to 'use that degree of care which a *reasonable and prudent person* would use under the same or similar circumstances.' These duties are incompatible. Healthcare professionals are held to a higher standard of care than laypersons."

Interesting Point of Note:
In FN 2 of the opinion, the COA here discussed the recent tort reform changes to G.S. 90-21.12 for "emergency medical conditions" now requiring a claimant to "prove a violation of the standards of practice . . . of this subsection by clear and convincing evidence." Encouragingly, the COA correctly pointed out that this new provision did ***not*** lower the applicable standard of care for healthcare providers facing emergency medical conditions; instead, it simply raised the burden of proof for establishing the same type of breach in the standards occurred. This is potentially a very important footnote as plaintiffs in emergency cases may very well face the

erroneous argument that the new statute makes any actions acceptable that would previously been considered breaches in the standard of care. If the actions were violations of the standards under the old law, they are still violations under the new law. The only difference is that the plaintiff must now prove those same violations occurred by clear and convincing evidence (as opposed to by a preponderance of the evidence.)

Impact of Decision on Plaintiff's Practice:
This is an excellent and well-reasoned opinion that rightly concludes the sudden emergency instruction has no place in medical negligence cases. This represents a significant victory for the plaintiff's bar.

Wright v. WakeMed,
767 S.E.2d 408, 2014 N.C. App. LEXIS 1399 (2014)

Prior History: Vance County, 13 CVS 1399	**NCCOA Filed Date:** December 31, 2014
Plaintiff Attorney(s): Michael F. Rogers (Rogers and Rogers)	**Defense Attorney(s):** Dan McLamb (Yates McLamb) Crystal B. Mezzullo (Yates McLamb) Andrew C. Buckner (Yates McLamb)
Judge (Author of opinion): Ervin, Sam IV	**Judges (Concurring / Dissenting):** Elmore, Rick (concur) Davis, Mark (concur)
Type of Medical Care Involved: Medication administration and lists	**Decision for Plaintiff or Defense?** Defense

Procedural History:
Appeal by plaintiffs from judge Beecher R. Gray's order granting defendant's motion to dismiss for failure to include a Rule 9(j) certification.

Background Facts:
Plaintiff was admitted to defendant WakeMed for spinal surgery. Plaintiff was discharged from the WakeMed surgical recovery unit to the WakeMed Rehab facility. At the time of transfer, the WakeMed Rehab admission orders contained a list of medications for plaintiff that included over a dozen medications. However, three of those meds were erroneously included and not actually prescribed to plaintiff: Xanax, Geodon, and Lithium. Plaintiff was administered all of these medications and suffered from lethargy and somnolence. Plaintiff filed a medical malpractice complaint against WakeMed without a Rule 9(j) certification, instead relying on the doctrine of *res ipsa loquitur*. Defendants answered and moved to dismiss for failure to include a 9(j) certification, arguing that *res ipsa* was unavailable based on the plaintiff's allegations.

Issue:
Did the trial court correctly conclude that *res ipsa loquitur* was not available based on plaintiff's allegations, and therefore the complaint should be dismissed for failing to include a Rule 9(j) certification?

Holding:
Yes.

Rules / Controlling Authority:

- Res Ipsa Loquitur in General:
"*Res ipsa loquitur* (the thing speaks for itself) simply means that the facts of the occurrence itself warrant an inference of defendant's negligence, i.e., that they furnish circumstantial evidence of negligence where direct evidence of it may be lacking." *Sharp v. Wyse*, 317 N.C. 694, 697, 346 S.E.2d 485, 487 (1986) (quotation marks, citation, and emphasis omitted).

"The doctrine of *res ipsa loquitur* applies when (1) direct proof of the cause of an injury is not available, (2) the instrumentality involved in the accident is under the defendant's control, and (3) the injury is of a type that does not ordinarily occur in the absence of some negligent act or omission." *Alston v. Granville Health System*, N.C. App. , , 727 S.E.2d 877, 879 (internal quotation marks and citation omitted), disc. review dismissed, 366 N.C. 247, 731 S.E.2d 421 (2012).

"Thus, in order to successfully assert a claim based on the doctrine of *res ipsa loquitur*, a 'plaintiff must [be] able to show - without the assistance of expert testimony - that the injury was of a type not typically occurring in the absence of some negligence by defendant.'" *Diehl v. Koffer*, 140 N.C. App. 375, 378, 536 S.E.2d 359, 362 (2000) (emphasis omitted).

"As a result of the fact that the doctrine of *res ipsa loquitur* only applies in the absence of direct proof of the cause of the plaintiff's injury, a plaintiff is not entitled to rely on it in the event that there is direct evidence of the reason that the plaintiff sustained the injury for which he or she seeks relief.'" *Robinson v. Duke University Health Systems, Inc.*, N.C. App. , , 747 S.E.2d 321, 330 (2013), disc. review denied, 367 N.C. 328, 755 S.E.2d 618 (2014).

- Res Ipsa Loquitur in Medical Negligence Cases:
"In order for the doctrine of *res ipsa loquitur* 'to apply in a medical malpractice claim, a plaintiff must allege facts from which a layperson could infer negligence by the defendant based on common knowledge and ordinary human experience.'" *Smith v. Axelbank*, N.C. App. , , 730 S.E.2d 840, 843 (2012).

"Our Courts have consistently found that *res ipsa loquitur* is inappropriate in the usual medical malpractice case, where the question of injury and the facts in evidence are peculiarly in the province of expert opinion." *Robinson*, N.C. App. at , 747 S.E.2d at 329 (internal quotation marks and citation omitted).

"Nevertheless, where proper inferences may be drawn by ordinary men from approved facts which give rise to *res ipsa loquitur* without infringing this principle, there should be no reasonable argument against the availability of the doctrine in medical and surgical cases involving negligence, just as in other negligence cases, where the thing which caused the injury does not happen in the ordinary course of things, where proper care is exercised." *Mitchell v. Saunders*, 219 N.C. 178, 182, 13 S.E.2d 242, 245 (1941)..

Analysis & Arguments:
The COA concluded that plaintiff's allegations made *res ipsa* unavailable as a cause of action for two main reasons:

1) "In her complaint, Plaintiff has alleged that the ***injuries for which she seeks redress were sustained as the result of an explicitly delineated series of events***. More specifically, Plaintiff has alleged that her injuries resulted from the ingestion of specific medications that she should not have received and that her ingestion of these medications resulted from the fact that medications that she had not been prescribed were included on the materials that accompanied her transfer from WakeMed ACUTE to WakedMed REHAB. In support of this assertion, Plaintiff produced a list of the medications that were originally prescribed for her and "Admission Medications Orders" signed by Dr. Deol showing that Xanax, Geodon, and Lithium had been added to the list of medications that she had originally been instructed to take at or about the time of her transfer. As a result, ***Plaintiff has explicitly alleged that she was injured in a specific manner by a specific act of negligence, a fact that bars her from any attempt to rely on the doctrine of res ipsa loquitur***." (emphasis added).

2) The COA concluded that expert testimony would be required here to establish what actually cause the injuries she alleged (lethargy and somnolence). The Court likened the facts here to those of *Smith v. Axelbank*, N.C. App. , , 730 S.E.2d 840, 843 (2012) to reason that "a jury would not be able to determine whether Plaintiff's injury resulted from the ingestion of Xanax, Geodon, and Lithium without having the benefit of expert witness testimony, since a lay juror would not necessarily know what these medications are, how they affect the human body, and how they might be expected to affect Plaintiff specifically." The Court pointed out in FN 2 that this problem is exacerbated by the fact that the plaintiff's regular list of medications included "over a dozen" other drugs that she took along with the three erroneous medications; accordingly, "expert medical testimony would be necessary to explain the interactions among this collection of medications and whether the injuries that Plaintiff claims to have sustained could have resulted from the ingestion of one or more of these other medications." In sum, "[s]imply put, since 'the average juror [is] unfit to determine whether [P]laintiff's [somnolence and lethargy] would rarely occur in the absence of' the ingestion of Xanax, Geodon, and Lithium."

Impact of Decision on Plaintiff's Practice:
This case highlights again the inherent difficulties in basing a medical negligence claim on *res ipsa loquitur*. It seems, when possible, that plaintiffs would be better served to **carefully** plead *res ipsa* in the alternative as discussed in *Robinson v. Duke Univ. Health Sys., et. al.*, ___ N.C. App. ___, 747 S.E.2d 321, 2013 N.C. App. LEXIS 885 (2014), review denied by, *Robinson v. Duke Univ. Health Sys.*, 2014 N.C. LEXIS 215 (N.C. Mar. 6, 2014)