

**MEDICAL MALPRACTICE
RECENT DEVELOPMENTS: MAY 2012 – MAY 2013**

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DISCLAIMER: All 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 2012 to May 2013. The cases are arranged in alphabetical order according to Plaintiff last name. 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 No unpublished medical malpractice opinions have been analyzed in this manuscript.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.)

PUBLISHED OPINIONS

Alston v. Granville Health Sys.

____ N.C. App.____, 727 S.E.2d 877, 2012 N.C. App. LEXIS 762 (2012),
disc. rev. denied, 731 S.E.2d 421, 2012 N.C. LEXIS 758 (N.C., Aug. 23, 2012)

Prior History:

Granville County, 09 CVS 306; and
Alston v. Granville Health Sys., 207 N.C.
App. 264, 699 S.E.2d 478 (2010)
(unpublished)

NCCOA Filed Date:

June 19, 2012

Plaintiff Attorney(s):

D. Lynn Whitted

Defense Attorney(s):

Timothy P. Lehan (Smith Anderson)
Brian A. McGann (Smith Anderson)
William P. Daniel (Young Moore)
Elizabeth P. McCullough (Young Moore)
Kelly E. Street (Young Moore)
Michelle A. Greene (Young Moore)

Judge (Author of opinion):

Stephens, Linda

Judges (Concurring / Dissenting):

McGee, Linda M. (concur)
Hunter, Robert N., Jr. (concur)

Type of Medical Care Involved:

Lack of bed restraints following surgery

Decision for Plaintiff or Defense Bar?

Defense

Procedural History:

This case was filed in 2009, and in 2010 the Plaintiff appealed the trial court's grant of Defendants' 12(b)(6) motion to dismiss. That appeal resulted in an unpublished NCCOA decision reversing the 12(b)(6) dismissal, and remanding the case back to the trial court. See Appendix, *Alston v. Granville Health Sys.*, 207 N.C. App. 264, 699 S.E.2d 478 (2010) (unpublished). Following discovery, Defendants motions for summary judgment were granted by Judge Henry W. Hight, Jr., and Plaintiff appealed from said orders.

Background Facts:

Defendants' originally filed 12(b)(6) motions because Plaintiff's complaint contained no Rule 9(j) certification. Plaintiff's complaint alleged injuries sustained after surgery as a result of a fall from the operating table. In the 2010 appeal of the 12(b)(6) dismissal, the NCCOA found that "[d]espite its confusing nature, we nevertheless conclude that Plaintiff's complaint sufficiently alleges the requisite elements to support a cause of action under a theory of *res ipsa loquitur*," as Plaintiff's complaint stated the following: "while Decedent was unconscious and under Defendants' care, she fell off a gurney and was injured," and "[d]irect proof of the cause of the injuries herein before complained of is not available to Plaintiff's intestate." *Alston v. Granville Health Sys.*, 2010 N.C. App. LEXIS 1838, 6 (unpublished).

The 2010 NCCOA opinion went on to explain that the certification requirements of Rule 9(j) do not apply to *res ipsa claims*, as these claims sound in ordinary negligence and not medical malpractice. Thus, the Plaintiff's complaint allegations taken as true are sufficient to survive 12(b)(6). The court took care to note, however, that Plaintiff's allegations – taken as true – made them distinguishable from *Sturgill v. Ashe Mem'l. Hosp., Inc.*, 186 N.C. App. 624, 652 S.E.2d 302 (2007), which held where plaintiff alleges a failure to provide proper bed restraints caused injury, the claim is for medical malpractice claim requiring compliance with Rule 9(j). The court further commented that Plaintiff is "bound by" the allegation of no direct proof of causation going forward under her *res ipsa* theory.

Key Case Facts:

Through discovery, Defendants presented evidence in support of their summary judgment motions showing that a failure to restrain plaintiff by operating room staff was the actual cause of her injuries. This included evidence that:

- Plaintiff was restrained and under anesthesia during surgery;
- Defendant surgeon (Dr. Hall) did not remove the restraints before he stepped away from the operating table to write his op note;
- Either the anesthesiologist or the CRNA's then became responsible for plaintiff's care and made the decision at that time that the restraints could be safely removed;
- The restraints were then removed;
- Thereafter, according to a defense expert, the plaintiff began to wake and feel the presence of an intubation tube in her throat, and this cause her to suddenly move; and
- Plaintiff's sudden movement, combined with the lack of bed restraints, caused her to fall off the table and sustain injury as a result.

Importantly, the Plaintiff did not present **any** evidence in response to the summary judgment motions to refute Defendants' contention that direct proof of injury was available. Instead, she apparently relied solely on her complaint allegations of *res ipsa*, and the NCCOA's 2010 opinion, to survive summary judgment.

Issue(s):

- 1) Did the 2010 NCCOA opinion reversing 12(b)(6) dismissal establish the law of the case on plaintiff's ability to move forward to trial under a *res ipsa* theory?
- 2) Was the trial court's decision to grant summary judgment in error?

Holding:

- 1) No. The trial court's resolution of Rule 12(b)(6) and summary judgment motions present different inquiries.
- 2) No. Plaintiff's complaint rested solely on *res ipsa*. Given that uncontroverted evidence existed that the lack of bed restraints caused plaintiff's injury, a *res ipsa* theory of recovery is foreclosed and plaintiff's action must be dismissed.

Rules / Controlling Authority on Issue 1:

The questions settled in a prior appellate decision "become the law of the case, both in subsequent proceedings in the trial court and on subsequent appeal, *provided the same facts and the same questions which were determined in the previous appeal are involved in the second appeal.*" *Hayes v. Wilmington*, 243 N.C. 525, 536, 91 S.E.2d 673, 681-82 (1956) [**4] (emphasis added).

"[T]he denial of a motion to dismiss made under Rule 12(b)(6) does not prevent the court . . . from thereafter allowing a subsequent motion for summary judgment made and supported as provided in Rule 56." *Barbour v. Little*, 37 N.C. App. 686, 692, 247 S.E.2d 252, 255-56 (1978).

Rules / Controlling Authority on Issue 2:

"*Res ipsa loquitur* claims are normally based on **facts that permit an inference** of defendant's negligence. The certification requirements of Rule 9(j) apply only to medical malpractice cases where the plaintiff seeks to prove that the **defendant's conduct** breached the requisite standard of care -- not to *res ipsa loquitur* claims." *Anderson v. Assimos*, 356 N.C. 415, 417, 572 S.E.2d 101, 103 (2002) (emphasis added)¹

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." *Grigg v. Lester*, 102 N.C. App. 332, 333, 401 S.E.2d 657, 657-58 (1991).

"Our Court has held that the *res ipsa loquitur* doctrine is only applicable where there is no direct proof of the cause of the injury available to the plaintiff." As such, where evidence constituting direct proof of the cause of injury is presented, "the doctrine of *res ipsa loquitur* [is] not applicable." *Yorke v. Novant Health, Inc.*, 192 N.C. App. 340, 352-53, 666 S.E.2d 127, 136 (2008).

"[W]here the [*res ipsa loquitur*] rule does not apply, the plaintiff must prove circumstances tending to show some fault of omission or commission on the part of the defendant *in addition* to those which indicate the physical cause of the accident." *Kekelis v. Whitin Machine Works*, 273 N.C. 439, 444, 160 S.E.2d 320, 323 (1968) (emphasis in original).

¹ This case was cited and relied upon in the underlying NCCOA unpublished opinion *Alston v. Granville Health Sys.*, 2010 N.C. App. LEXIS 1838 (unpublished). Although the court does note re-cite the *Anderson* case here, the court stated that the *res ipsa* analysis it employed in 2010 was correct.

“Because the decision to apply restraints is a medical decision requiring clinical judgment and intellectual skill, it is a professional service” under N.C. Gen. Stat. § 90-21.11. *Sturgill v. Ashe Mem'l Hosp., Inc.*, 186 N.C. App. 624, 630, 652 S.E.2d 302, 306 (2007).

Analysis & Arguments:

Plaintiff made two basic arguments on appeal: (1) the 2010 NCCOA opinion reversing 12(b)(6) dismissal established the “law of the case” on the *res ipsa* issue, and Defendants could not “re-litigate” it; and (2) even so, summary judgment was improper here because the complaint appropriately alleges *res ipsa*.

The court quickly dispensed with the first argument, finding that “although in the first appeal we held that Plaintiff’s complaint, considered on its own and taking its allegations as true, sufficiently set forth a claim of negligence under the theory of *res ipsa loquitur*, the trial court was not precluded from thereafter determining that “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law” under Rule 56. *Alston*, 727 S.E.2d at 879.

The court went on to conclude that summary judgment was proper here because through discovery “Defendants presented evidence showing that *res ipsa loquitur* is not applicable because there is evidence that direct proof of the cause of Decedent’s injury is available.” Defendants presented various forms of evidence showing “that the cause of Decedent’s fall from the table was the failure of the medical personnel to restrain Decedent,” and “Plaintiff offered nothing to refute Defendants’ forecast of evidence on why Decedent fell off the table.” *Id.* at 880.

The court found that Plaintiff’s complaint alleging no direct proof of the cause of injury had been refuted by Defendants, “and, rather than presenting his own evidence to rebut or supplement Defendants’ evidence, Plaintiff instead unwisely chose to rest on his pleadings.” *Id.*, FN 2. Thus, the uncontroverted evidence “presented by Defendants establish that the cause of Decedent’s injury was the absence of restraints on Decedent as she awoke from anesthesia. This proof of the cause of Decedent’s injury precludes application of the *res ipsa loquitur* doctrine.” *Id.* at 880.

Given that *res ipsa* was rendered inapplicable, in order to survive summary judgment, “Plaintiff must have presented some evidence tending to show that medical personnel negligently failed to restrain Decedent on the operating table.” *Id.* However, under *Sturgill*, such a claim is for medical malpractice, and because Plaintiff never included a Rule 9(j) certification in her complaint her case must be dismissed.

Impact of Decision on Plaintiff’s Practice:

If relying on the *res ipsa loquitur* doctrine, this case highlights the importance of being prepared to rebut any evidence that may come out during discovery that some act or omission of the healthcare providers was the actual cause of the plaintiff’s injury. If such evidence emerges, then in order to survive under *res ipsa* the plaintiff must present sufficient evidence in rebuttal from which a jury could still find that “no direct proof of the cause of injury” is available.

Braden v. Lowe

____ N.C. App.____, 734 S.E.2d 591; 2012 N.C. App. LEXIS 1247 (2012),
disc. rev. denied, N.C. LEXIS 263 (N.C., Mar. 7, 2013)

Prior History:

Forsyth County, 09 CVS 6174

NCCOA Filed Date:

November 6, 2012

Plaintiff Attorney(s):

Kimberly Sullivan (Horack Talley)
Christopher C. Fallon (Cozen O'Connor)

Defense Attorney(s):

Norman F. Klick, Jr. (Carruthers & Roth)
Robert N. Young (Carruthers & Roth)

Judge (Author of opinion):

McGee, Linda M.

Judges (Concurring / Dissenting):

Beasley, Cheri (concur)
Thigpen, Cressie (concur)

Type of Medical Care Involved:

Post-op infection management

Decision for Plaintiff or Defense Bar?

Plaintiff

Procedural History:

Appeal by Plaintiff Judge John O. Craig's grant of Defendants motions to dismiss pursuant to Rules 9(j) and 12(b)(6).

Background Facts:

Plaintiff-decedent in this case was Gregory Alan Braden, M.D., a distinguished interventional cardiologist from Winston-Salem. He suffered from diabetes, gout, and cellulitis, which affected his extremities. As a result, he sought treatment for an infected big toe from the Defendant, Dr. Lowe, an orthopedic surgeon. After performing a drainage procedure, the Plaintiff's toe became badly infected with MRSA, and the Defendant later surgically amputated Plaintiff's toe. At the time of surgery, the hospital's "auto stop" policy cancelled any pending antibiotic treatment orders. Following surgery, the Defendant failed to write a new order for IV antibiotics, and Plaintiff alleged that as a result he went without necessary antibiotic treatment for nine days. Plaintiff alleged that this negligent delay in treatment allowed the infection to "ravage" his body and eventually cause his wrongful death.

Key Case Facts:

Plaintiff's Rule 9(j) expert was Dr. William F. Alleyne, an internal medicine, pulmonary diseases, and critical care medicine specialist. At his deposition, Dr. Alleyne testified to the following:

- The specialties of internal medicine, pulmonary diseases, and critical care are not the same or similar specialty as orthopedic surgery;
- He has never specialized in orthopedics or a similar specialty;
- Since 2000, he **did** regularly take patients in for invasive procedures (e.g. bronchoscopy), after which he had to rewrite antibiotics due to hospital auto-stops;
- Since 2000, he **did not** take patients to the operating room who were on antibiotics, operate on them, and then have to re-start their antibiotics orders.

Following Dr. Alleyne's deposition, the Defendants filed motions to dismiss pursuant to Rule 9(j) and 12(b)(6) arguing that the Plaintiff could not have reasonably expected this expert to qualify as an expert under Rule 702's "same or similar specialty" requirement. In defense of summary judgment, Dr. Alleyne submitted a supplementary affidavit² in which he explained further that on a daily basis since 2004 he had to restart IV antibiotics orders as a result of hospital auto-stops due to invasive procedures or other operative procedures, and during 2004 he regularly ordered antibiotics for the treatment of MRSA infections.

Interesting Procedural Fact:

The trial court initially granted Defendants' motions to dismiss. Subsequently, Plaintiff filed a motion for reconsideration, and included Dr. Alleyne's supplementary affidavit as evidence. The court found upon reconsideration that Dr. Alleyne did, in fact, practice in a similar specialty "insofar as the procedure for restarting antibiotics following an auto-stop," but still dismissed Plaintiff's case based on the finding that there was no evidence that Dr. Alleyne actually "participated in such activity during the twelve months preceding January 15, 2005."

Issue(s):

The court narrowly defined the issue as follows: Was the trial court correct in finding that Plaintiff could not have reasonably expected Dr. Alleyne to comply with Rule 702's requirement that an expert must have performed the procedure at issue within the year preceding the alleged negligence?

Holding:

No. The trial court erred in finding no reasonable expectation here.

Rules / Controlling Authority

"Whether the pleader could reasonably expect the witness to qualify as an expert under Rule 702 presents a question of law and is therefore reviewable *de novo* by this Court." *Trapp v. Maccioli*, 129 N.C. App. 237, 241 n. 2, 497 S.E.2d 708, 711 n. 2 (1998).

Pursuant to Rule 9(j), "[t]his Court inquires as to whether [the] plaintiff reasonably expected [the experts] to qualify as expert witnesses pursuant to Rule 702, *not* whether they ultimately will qualify . . . In other words, were the facts and circumstances known or those which should have been known to the pleader such as to cause a reasonable person to believe that the witness would qualify as an expert under Rule 702." *Grantham v. Crawford*, 204 N.C. App. 115, 118-19, 693 S.E.2d 245, 245 and 248 (2010) (emphasis added).

"What must be established in discovery is not whether the witness is 'in fact not an expert[,] but whether 'there is ample evidence in th[e] record that a reasonable person armed with the knowledge of the plaintiff at the time the pleading was filed would have believed that [the witness] would have qualified as an expert under Rule 702.'" *Morris v. Southeastern Orthopedics Sports Med. & Shoulder Ctr.*, 199 N.C. App. 425, 437-38, 681 S.E.2d 840, 849 (2009).

The key admissibility criteria under Rule 702(b) cited and relied upon by the court were as follows:

² Although the issue was briefed by both sides, the court never addressed the admissibility of Dr. Alleyne's supplemental affidavit, and instead apparently considered it proper in its entirety.

- **Rule 702(b)(1)(b):** an expert is allowed to “specialize in a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients.”
- **Rule 702(b)(2)(a):** During the year immediately preceding the date of the occurrence that is the basis for the action, an expert is allowed to have devoted a majority of his or her professional time to “the active clinical practice of the same specialty or a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients.”

Analysis & Arguments:

The parties attempted to characterize “the procedure that is the subject of the complaint” in very different ways. Predictably, Defendants argued that the procedure at issue was the surgical amputation of decedent’s toe; whereas Plaintiff argued the procedure was, instead, the restarting of antibiotics following an auto-stop. Without offering any analysis on the issue, the court agreed with the trial court’s determination that “Dr. Alleyne “practiced in a similar specialty to that of . . . [D]efendant Dr. Lowe, insofar as the procedure for restarting antibiotics following an auto-stop,” and the such a decision was “without error.”

Pursuant to the *de novo* standard of review here, the court simply disagreed with the trial court’s conclusion regarding the expert’s apparent failure to meet the Rule 702 requirement of performing the procedure at issue within the year preceding the alleged negligence. The court found that it was “clear” from Dr. Alleyne’s affidavit that he stated he performed auto-stop antibiotic procedures “on a daily basis since 2004,” and this testimony was “sufficient to give Plaintiff a reasonable expectation that Dr. Alleyne **performed the procedure during the twelve months preceding 15 January 2005** and thus would qualify as an expert pursuant to Rule 702.” *Braden*, 734 S.E.2d at 597-598 (emphasis added).

Impact of Decision on Plaintiff’s Practice:

This appears to be a simple and strong opinion for the plaintiffs’ medical malpractice bar. The two big takeaways from this case are: (1) when considering the “similar specialty” prongs of Rule 702(b), it is appropriate to apply a narrow focus on the procedure at issue, and even providers from starkly different practice fields can be found to practice in a sufficiently “similar specialty;” and (2) although the court did not explicitly state it here, this opinion appears to stand for the proposition that an expert is **not** required to devote a majority of his/her professional time during the preceding year to actually performing the procedure at issue, but rather devote a majority of time to the practice of a “similar specialty” during the year preceding that included, **at some point during that year**, the performance of the subject procedure.

Crossman v. Life Care Ctrs. of Am., Inc.,
____ N.C. App.____, 727 S.E.2d 866, 2012 N.C. LEXIS 408 (2012)

Prior History:

Henderson County, 11 CVS 52

NCCOA Filed Date:

January 15, 2013

Plaintiff Attorney(s):

Kenneth L. Connor (Connor & Connor)

Defense Attorney(s):

Terrill Johnson Harris (Smith Moore)
Elizabeth Brooks Scherer (Smith Moore)

Judge (Author of opinion):

Stephens, Linda

Judges (Concurring / Dissenting):

Geer, Martha A. (concur)
McCullogh, J. Douglas (concur)

Type of Medical Care Involved:

Nursing home/Long-term care neglect

Decision for Plaintiff or Defense Bar?

Plaintiff

Procedural History:

Appeal by Defendants from trial court's (Judge Eric Levinson) denial of motion to dismiss.

Background Facts:

Decedent suffered a stroke in 2000 and became physically disabled, although he maintained his mental faculties. By 2004, he had to be placed in Defendant's extended care facility. Plaintiff alleged that from 2007 to 2009 was the victim of ordinary and medical negligence, fraud, willful and wanton conduct, and unfair and deceptive trade practices by Defendants. Plaintiff's alleged injuries included malnutrition, dehydration, encephalopathy, pain, suffering, mental anguish, disfigurement, and wrongful death.

Key Case Facts:

At the time decedent entered Defendant's care facility in 2004, he was of sound mind. At that time, he voluntarily signed an Arbitration Agreement that committed all care disputes to binding arbitration under the AAA. However, in 2003, the AAA issued a Policy Statement to all potential arbitration parties that it would "no longer accept administration of cases involving individual patients without a *post-dispute* agreement to arbitrate." (emphasis added). Here, decedent signed the Agreement after the issuance of this Policy Statement, but *before* any dispute arose over his care. No agreement was signed after this care dispute arose.

Importantly, the Agreement executed by the parties here required that any hearing "shall be held before a board of three arbitrators selected from the American Arbitration Association," and that these arbitrators would apply all the rules of AAA.

Defendants filed a motion to dismiss and compel arbitration. After conducting discovery solely on the arbitration issue, the trial court denied the motions finding the contract was unenforceable due to impossibility of material terms, namely the employment of the AAA, which was made unavailable pursuant to the 2003 Policy Statement.

Issue(s):

Did the trial court correctly conclude the Arbitration Agreement here was unenforceable due to impossibility?

Holding:

Yes.

Rules / Controlling Authority

North Carolina “require[s] the application of contract law to determine whether a particular arbitration agreement is enforceable[,] thereby placing arbitration agreements upon the same footing as other contracts.” *Raper v. Oliver House, LLC*, 180 N.C. App. 414, 419, 637 S.E.2d 551, 554 (2006).

“An [arbitration agreement] is valid, enforceable, and irrevocable except upon a ground that exists at law or in equity for revoking a contract.” N.C. Gen. Stat. § 1-569.6 (2011).

A contract is unenforceable due to impossibility “if the subject matter of the contract is destroyed without fault of the party seeking to be excused from performance.” *Brenner v. Sch. House, Ltd.*, 302 N.C. 207, 210, 274 S.E.2d 206, 209 (1981).

Analysis & Arguments:

Defendant’s argued that the contract was not impossible, and that the only effect of the 2003 Policy Statement was that the arbitrators would not be chosen “from an *official panel* of AAA arbitrators,” but could be chosen from elsewhere. Defendant’s relied primarily upon *Westmoreland v. High Point Healthcare Inc.*, ___ N.C. App. ___, 721 S.E.2d 712 (2012) for this argument. The court easily distinguished *Westmoreland* on the basis of key a difference in the Arbitration Agreement in that case versus the agreement between the parties here.

In *Westmoreland*, the NCCOA held that a pre-dispute arbitration agreement was enforceable – even after the 2003 Policy Statement – where it stated “the arbitration proceeding shall be conducted before one neutral arbitrator selected in accordance with the rules of the AAA.” *Westmoreland*, 721 S.E.2d at 719. The court there concluded that the contract did not fail because it did **not** provide that an AAA arbitrator must be used to conduct arbitration. In the case *sub judice*, however, the agreement language “specifically require[s] the use of ‘arbitrators selected from the American Arbitration Association,’ and “[t]his language indicates the parties’ intention to arbitrate under the auspices of the AAA, unlike the procedure contemplated in *Westmoreland*.” *Crossman*, 738 S.E.2d at 740. “By requiring the selection of AAA arbitrators, the Agreement sought to employ an organization that refuses to be so employed. This requirement constitutes an integral and material provision of the Agreement. Accordingly, we hold that the Agreement is unenforceable as impossible to perform.” *Id.*

The Court further concluded that N.C. Gen. Stat. § 1-569.11 did not save this contract as the impossible material term here did not involve the mere “process of selecting a particular arbitrator, but rather the unavailability of a pool of arbitrators who have been mandated by the agreement.” *Id.* Thus, even a severability clause in this agreement could not save the complete lack of this material term.

Impact of Decision on Plaintiff’s Practice:

Although not a typical medical malpractice case, this opinion helps identify ways certain arbitration agreements can be defeated.

Estate of Ray v. Forgy,

___ N.C. App. ___, 2013 N.C. App. LEXIS 478 (2013)

Prior History:

Burke County, 04 CVS 1291

NCCOA Filed Date:

May 7, 2013

Plaintiff Attorney(s):

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E. Fitzgerald Parnell, III (Poyner Spruill)
Cynthia L. Van Horne (Poyner Spruill)
C. Michael Bee (Hill, Peterson, Carper,
Bee...)
C. Sue Holvy (C. Sue Holvy, PLLC)

Defense Attorney(s):

Phillip T. Jackson (Roberts & Stevens)
Ann-Patton Hornthal (Roberts & Stevens)

Richard V. Bennett, *amicus curiae* (NCADA)
Joshua H. Bennett, *amicus curiae* (NCADA)
Linwood L. Jones, *amicus curiae* (NC Hosp.
Assc.)

Burton Craige, *amicus curiae* (NCAJ)

Judge (Author of opinion):

Martin, John C.

Judges (Concurring / Dissenting):

Stephens, Linda (concur)
Hunter, Robert C. (concur)

Type of Medical Care Involved:

Lap Choley Surgery; Post-Op Biliary Leak

Decision for Plaintiff or Defense Bar?

50% for Plaintiff; 50% for Defense

Procedural History:

Plaintiff's appeal from trial court's (Judge Robert C. Ervin) grant of Defendant hospital's summary judgment motion.

Background Facts:

Decedent visited her primary care doctor's office complaining of abdominal pain, nausea, and vomiting. Decedent was admitted to Defendant hospital for five days, during which another primary care physician requested Defendant Dr. Forgy provide a surgical consult. Dr. Forgy thereafter recommended she undergo gastroscopy and colonoscopy studies, and then also a laparoscopic cholecystectomy to remove the gall bladder. Following discharge after the surgery, decedent visited Dr. Forgy's private office three different times for follow-up. Days later, decedent was taken emergently back to Defendant hospital for complications, and Dr. Forgy was called in again to consult. Dr. Forgy suspected a biliary leak, and performed an exploratory laparotomy on decedent, but believed he found no leak. Decedent's condition quickly worsened post-op and she was transferred to the ICU at Frye Regional Hospital where it was discovered she did, in fact, have a biliary leak that Dr. Forgy missed. She later died from related complications.

Three issues emerged in Defendant hospital's summary judgment motion: (1) apparent agency of Dr. Forgy; (2) corporate negligence; and (3) requirement of Rule 9(j) certification.

Key Case Facts – Apparent Agency:

The key facts bearing on the apparent agency issue are as follows:

- Before the gastroscopy, colonoscopy, and lap choley procedures, decedent signed request for treatment forms where she wrote Dr. Forgy in under the box labeled "Physician," and checked a separate box labeled "Grace Hospital Personnel";

- Decedent’s husband signed a nearly identical form before a procedure was performed on his wife by Dr. Forgy;
- Decedent visited Dr. Forgy at his private clinic on three, separate occasions;
- At each clinic visit, Decedent signed forms specifically for Dr. Forgy’s practice and provided insurance information;
- Decedent signed a hospital release saying she understood that certain physicians at Defendant hospital were independent contractors with privileges, and not hospital employees;
- Plaintiff presented evidence that Dr. Forgy’s picture, name, and telephone number were advertised in Defendant hospital’s brochure;
- Plaintiff presented evidence that Dr. Forgy never told decedent or her husband that he was not an employee of Defendant hospital.

Key Case Facts – Corporate Negligence:

- In 2001, Dr. Forgy filled out “Application for Reappointment Form” to renew his privileges at Defendant hospital;
- The form asked if any Forgy had any liability suits filed against him since his last application, and if so to explain the circumstances surrounding each one. Dr. Forgy answered YES, indicated two suits had been filed, but did not include any explanation as the form required;
- Dr. Forgy acknowledged in his deposition that several suits had been filed against him, but that he did not recall ever discussing them with anyone at Defendant hospital.

Issue(s):

- 1) Did the trial court err in granting summary judgment for Defendant hospital on the apparent agency claim?
- 2) Did the trial court err in granting summary judgment for Defendant hospital on the corporate negligence claim?
- 3) Did the trial court err in denying summary judgment for Defendant hospital based on Rule 9(j)?

Holding(s):

- 1) No.
- 2) Yes.
- 3) No.

Rules / Controlling Authority – Issue 1 (Apparent Agency):

“To hold a hospital liable for the negligence of a doctor under the theory of apparent agency, 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.” *Diggs v. Novant Health, Inc.*, 177 N.C. App. 290, 307, 628 S.E.2d 851, 862 (2006), *disc. review and supersedeas denied*, 361 N.C. 426, 648 S.E.2d 209 (2007).

Analysis & Arguments – Issue 1 (Apparent Agency):

The court concluded that despite Plaintiff's forecast of evidence to the contrary, the totality of the evidence "suggests there is no issue of material fact whether Ray looked to the hospital rather than to the individual medical provider, Dr. Forgy, to perform her surgeries." The court cited the facts above (see first five bullet points under key apparent agency facts) to conclude that, like the Plaintiff in *Diggs*, the decedent and her husband here "looked to Dr. Forgy separate and distinct from Grace Hospital and its personnel to receive medical treatment." *Estate of Ray*, 2013 N.C. App. LEXIS 478 at 7.

These facts, combined with the hospital release that decedent signed putting her on notice of independent contractors, lead the court to conclude "it would not be reasonable for a patient presented with this form to assume that Dr. Forgy was a hospital employee." *Id.*

The court here never addressed or distinguished Plaintiff's facts supporting apparent agency (see last two apparent agency fact bullet points above). The court apparently disregarded this evidence in its entirety, with no explanation as to why, and concluded that the trial court did not err in finding no genuine issue of material fact existed on this issue.

Rules / Controlling Authority – Issue 2 (Corporate Negligence):

"[T]here are fundamentally two kinds of [corporate negligence] claims: (1) those relating to negligence in clinical care provided by the hospital directly to the patient, and (2) those relating to negligence in the administration or management of the hospital." *Estate of Waters v. Jarman*, 144 N.C. App. 98, 101, 547 S.E.2d 142, 144, *disc. review denied*, 354 N.C. 68, 553 S.E.2d 213 (2001).

"A failure to inquire further into a matter listed on an application for renewal of surgical privileges has been deemed sufficient to raise a genuine issue of material fact as to whether a hospital was negligent in re-credentialing a doctor." *Estate of Ray* at 10 (citing *Carter v. Hucks-Folliss*, 131 N.C. App. 145, 147-48, 505 S.E.2d 177, 178-79).

Analysis & Arguments – Issue 2 (Corporate Negligence):

The court cited the facts above (see key facts bullet points on corporate negligence), as well as the *Carter* case above, and concluded the following: "Considered in the light most favorable to plaintiffs, this evidence permits at least an inference that the hospital defendants were not reasonably diligent in reviewing Dr. Forgy's qualifications, raising a genuine issue of material fact with respect to their negligence in renewing Dr. Forgy's surgical privileges. Accordingly, we hold the court erred in granting defendants' motion for summary judgment." *Estate of Ray* at 11.

Rules / Controlling Authority – Issue 3 (Rule 9(j) Certification):

"Cases alleging a failure by the hospital to adequately monitor and oversee a physician or which contend the hospital was negligent in granting privileges to unqualified physicians are examples of the latter, and require the court to apply the reasonably prudent person standard of care in assessing negligence." *Estate of Ray* at 9 (citing *Estate of Waters* at 102-03, 547 S.E.2d at 145).

"Where corporate negligence claims 'arise out of policy, management or administrative decisions, such as granting or continuing hospital privileges, failing to monitor or oversee performance of the physicians, credentialing, and failing to follow hospital policies,' the claim is rooted in ordinary negligence principles and the 'reasonably prudent person' standard should be applied." *Estate of Ray* at 12-13 (citing *Estate of Waters*, 144 N.C. App. at 102-03, 547 S.E.2d at 145).

Analysis & Arguments – Issue 3 (Rule 9(j) Certification):

Without any analysis, the court cited the above law from *Estate of Waters v. Jarman*, and concluded that this corporate negligence claim sounded in ordinary negligence and no Rule 9(j) certification was required.

Impact of Decision on Plaintiff's Practice:

This is a very important case on apparent agency, and highlights how easily such a claim can be defeated if the evidence suggests the patient looked to the individual doctor separately from the hospital to provide care.

Important Note:

The precedential value of this case regarding corporate negligence and Rule 9(j) is in serious jeopardy given the new provisions of Senate Bill 33. This tort reform bill expanded the definition of a medical malpractice action under N.C. Gen. Stat. 90-21.11(2) specifically to include any civil actions against a hospital or facility alleged a "breach of administrative or corporate duties to the patient, including, but not limited to, allegations of negligent credentialing or negligent monitoring and supervision." N.C. Gen. Stat. § 90-21.11(2)(b) (2013). However, before such a claim will be found to be a "medical malpractice action," the new statute also requires that the claim "arises from the same facts or circumstances as a claim under subdivision (a) of this subdivision." Subdivision (a) describes only those claims "arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider." N.C. Gen. Stat. § 90-21.11(2)(a) (2013). Thus, it would appear that there are still a narrow window of potential cases where the precedents in *Estate of Waters* and *Estate of Ray* will continue to hold value.

Estate of Wooden v. Hillcrest Convalescent Ctr., Inc.,

___ N.C. App. ___, 731 S.E.2d 500, 2012 N.C. App. LEXIS 1019 (2012)

Prior History:

Durham County, 10 CVS 5560

NCCOA Filed Date:

August 21, 2012

Plaintiff Attorney(s):

John Wait (Wait Law, PLLC)

Defense Attorney(s):

Mark E. Anderson (McGuireWoods)
Heather R. Wilson (McGuireWoods)
Monica E. Webb (McGuireWoods)
Andrew A. Vanore. III (Brown, Crump, Vanore...)
W. John Cathcart, Jr. (Brown, Crump, Vanore...)

Judge (Author of opinion):

Hunter, Jr., Robert N.

Judges (Concurring / Dissenting):

Martin, John C. (concur)
Elmore, Rick (concur)

Type of Medical Care Involved:

N/A (issues here are procedural)

Decision for Plaintiff or Defense Bar?

Plaintiff

Procedural History:

Appeal by Plaintiff from trial court's (Judge Orlando Hudson) grant of Defendants' motions to dismiss and to amend to add statute limitations as a defense.

Background Facts:

The background medical facts here are largely irrelevant, as the issues reported in this opinion are primarily procedural in nature.

Key Procedural Case Facts (chronology important here):

- **9/30/08:** Date of decedent's death. Thus, the statute of limitations on any wrongful death claim was set to expire on **9/30/10**.
- **9/17/10:** Plaintiff moved for a 120-day extension under Rule 9(j). In support of this motion, Plaintiff represented additional time was needed to locate experts willing to testify, and to gather medical records to show to experts. This same day, Judge James E. Hardin granted Plaintiff's request for a 120-day extension, and effectively extended the statute of limitations to **01/28/11**.
- **01/25/11:** Plaintiff timely filed the complaint.
- **04/18/11:** Defendants served their Answers, and Defendant Duke served Plaintiff with standard Rule 9(j) interrogatories. Plaintiff responded to the interrogatories, stating that Dr. Frances Eason was its sole Rule 9(j) expert, and that she first rendered her opinion back in **August 2010**, before Plaintiff moved for a Rule 9(j) extension. Dr. Eason was a professor of adult health nursing at ECU, and licensed registered nurse in North Carolina.

Based on the above, Defendants filed motions to dismiss and to amend their Answers to include statute of limitations as a defense. The bases for the motions to dismiss included allegations that Plaintiff sought the extension in bad faith, and that Plaintiff could not have reasonably expected Dr. Eason to qualify as an expert witness on the standard of care of physicians.

- **07/11/11:** Judge Orlando Hudson heard Defendants' motions and granted them in open court, thereby dismissing Plaintiff's entire complaint in the process.
- **07/27/11:** Before Judge Hudson had entered the court's judgment, Plaintiff's counsel filed a motion requested findings of fact and conclusions of law be included in the court's order.
- **07/28/11:** Judge Hudson entered an order granting Defendants' motions without including findings of fact or conclusions of law.
- **08/24/11:** Judge Hudson entered an order denying Plaintiff's motion requesting findings of fact and conclusions of law.

Issue(s):

- 1) Did the trial court properly grant Rule 9(j) dismissal on the basis that Plaintiff's complaint allegedly included claims against physicians and other non-nursing healthcare professionals outside the expertise of Dr. Eason?
- 2) Assuming *arguendo* the answer to Issue 1 above is "Yes," did the trial court properly dismiss Plaintiff's entire complaint for failure to comply with Rule 9(j) only on certain claims but not others?

- 3) Did the trial court properly grant Rule 9(j) dismissal on the basis that Plaintiff moved for a Rule 9(j) extension when it was unnecessary, and therefore for an improper purpose?
- 4) Did the trial court properly grant Defendants' motion to amend to add statute of limitations as a defense?

Holding(s):

- 1) No.
- 2) No.
- 3) No.
- 4) Yes.

Overarching Rule / Controlling Authority:

"This result is dictated by our Supreme Court's recent opinion in *Moore v. Proper*, ___ N.C. ___, 726 S.E.2d 812 (2012), which requires trial courts in dismissing complaints under Rule 9(j) to make findings of fact and conclusions of law. We realize that at the time the trial court's decision was reached and this appeal was argued, neither the parties nor the trial judge had the benefit of this decision." *Estate of Wooden*, 731 S.E.2d at 502.

Rules / Controlling Authority – Issue 1 (9(j) certification):

When a trial court determines a Rule 9(j) certification is not supported by the facts, "the court must make written findings of fact to allow a reviewing appellate court to determine whether those findings are supported by competent evidence, whether the conclusions of law are supported by those findings, and, in turn, whether those conclusions support the trial court's ultimate determination." *Moore*, 726 S.E.2d at 818.

Analysis & Arguments – Issue 1:

There was no dispute among the parties that Dr. Eason was properly qualified under Rules 9(j) and 702(b) to opine on the care of nursing providers. The parties dispute centered around Defendants' allegation that Plaintiff's complaint alleged the negligence of physician and other non-nursing providers, and as such Plaintiff could not have reasonably expected Dr. Eason to qualify on those defendants. However, the court stated that in the absence of the findings of fact and conclusions of law required in *Moore*, it was not even able to determine whether Plaintiff's complaint contained the allegations Defendants suggested, or whether the law applied to those allegations entitled the Defendants to the relief they had requested. Therefore, the court found that this could not have been a proper basis for the trial court's dismissal below, vacated this order, and remanded the case for further evidence and findings.

Rules / Controlling Authority – Issue 2 (dismissal of entire complaint):

"The question whether a medical malpractice complaint partially in compliance with Rule 9(j) should be dismissed in its entirety is one of first impression in North Carolina, and we therefore consider Rule 9(j) *in pari materi* with other Rules of Civil Procedure in an effort to harmonize Rule 9(j) with those Rules." *Estate of Wooden*, 731 S.E.2d at 506 (citing *Brisson v. Kathy A. Santoriello, M.D., P.A.*, 351 N.C. 589, 595, 528 S.E.2d 568, 571 (2000)).

"A motion to dismiss under Rule 12(b)(6) allows for dismissal of less than all of a party's claims. *Morrow v. Kings Dep't Stores, Inc.*, 57 N.C. App. 13, 16, 290 S.E.2d 732, 734 (1982). Likewise, Rule 41 allows for partial dismissals, see N.C. Gen. Stat. § 1A-1, Rule 41 (allowing voluntary or involuntary dismissal of "an action or any claim therein"), and Rule 56 allows for partial summary judgments, see N.C. Gen. Stat. § 1A-1, Rule 56(a)-(b) (allowing the claimant or

defending party to “move . . . for a summary judgment in his favor upon all or any part” of a claim).” *Estate of Wooden*, 731 S.E.2d at 506-507.

Analysis & Arguments – Issue 2:

The court cited the procedural rules above and concluded: “Thus, each of the procedural mechanisms through which Rule 9(j) is raised permits judgment on less than the entire complaint, and we accordingly conclude that Rule 9(j) allows for partial dismissal of a complaint alleging medical malpractice.” *Estate of Wooden*, 731 S.E.2d at 506-507.

Therefore, assuming Plaintiff’s complaint was only partially defective under Rule 9(j), the trial court improperly dismissed the entire complaint and not just those defective claims.

Rules / Controlling Authority – Issue 3 (9(j) extension):

“In order for a trial court to void an extension of time, the court must indicate its basis – such as a Rule 11’s ‘improper purpose’ provision.” *Estate of Wooden*, 731 S.E.2d at 507.

Analysis & Arguments – Issue 3:

“In making this contention, Defendants rely on a footnote in a decision from this Court, which stated: ‘Although not raised as an issue by either party, we note this Court holds that Rule 9(j)’s ‘willingness to testify’ requirement is met when a medical expert opines during a telephone conversation that the applicable standard of care was breached.” *Estate of Wooden*, 731 S.E.2d at 507 (quoting *Phillips*, 155 N.C. App. at 376 n.2, 573 S.E.2d at 603 n.2.)

“Their reliance on this case is misplaced because under the facts of that case, the physician-witness tendered an affidavit to the court stating that he was ‘willing’ to testify before the complaint was filed.” *Id.* No such affidavit or facts were presented about Dr. Eason’s willingness to testify before the complaint was filed here.

Furthermore, the trial court made no findings or conclusions as to why Judge Hardin’s Rule 9(j) extension should be voided. As such, the court here held: “we decline to presume that the trial court intended to void an order entered by another superior court judge to afford Plaintiff sufficient time to comply with Rule 9(j)’s requirements.” Again, the court remanded the case for further findings and evidence.

Rules / Controlling Authority – Issue 4 (motion to amend):

A trial court’s decision to allow a motion to amend “will not be reversed on appeal absent a showing of abuse of discretion.” *Mauney v. Morris*, 316 N.C. 67, 72, 340 S.E.2d 397, 400 (1986).

The party opposing a motion to amend has the burden to demonstrate that allowing the amendment would be prejudicial. *Id.*

Analysis & Arguments – Issue 4:

The court easily concluded that Defendants learning the new information regarding the timing of Dr. Eason’s initial opinions was good cause to amend, and further concluded that Plaintiff had made no showing as to how granting the motion to amend would cause it any prejudice. Thus, the trial court properly granted the motion to amend.

Impact of Decision on Plaintiff’s Practice:

This is a very important case, as it established for the first time in North Carolina that an entire complaint cannot be dismissed if only a portion of it fails to comply with Rule 9(j). Moreover, it

highlights the importance of the trial court making findings of fact and conclusions of law pursuant to the *Moore v. Proper* mandate.

Higginbotham v. D'Amico,

___ N.C. App. ___, 2013 N.C. App. LEXIS 382 (2013)

Prior History:

Durham County, 10 CVS 3136

NCCOA Filed Date:

April 16, 2013

Plaintiff Attorney(s):

Paul I. Klein (Cranford, Buckley, Shultze...)

Defense Attorney(s):

Dan J. McLamb (Yates McLamb)
Lori Meyerhoffer (Yates McLamb)

Judge (Author of opinion):

Stephens, Linda

Judges (Concurring / Dissenting):

Geer, Martha A. (concur)
Dillon, R. Christopher (concur)

Type of Medical Care Involved:

Abdominal Surgery; Informed Consent

Decision for Plaintiff or Defense Bar?

75% for Plaintiff; 25% for Defense

Procedural History:

Appeal by Plaintiff from Judge Carl Fox's grant of summary judgment on Plaintiff's battery claim, and by Plaintiff from Judge Wayne Abernathy's grant of directed verdict to Defendant's on Plaintiff's medical malpractice claim.

Background Facts:

Plaintiff was experiencing pain and numbness in his left arm. He was eventually referred to a major medical center for diagnosis, and chose Defendant Duke University. While at Duke, he was diagnosed with thoracic outlet syndrome ("TOS"), and was referred to Defendant D'Amico, a thoracic surgeon. Dr. D'Amico recommended a surgical procedure to remove Plaintiff's first rib on his left side, and Plaintiff signed a consent form agreeing to this procedure. After the operation, Plaintiff discovered that D'Amico had accidentally excised his second rib, and not the first. This caused Plaintiff to suffer major complications.

The Plaintiff filed a complaint alleging medical malpractice, lack of informed consent, and battery. On appeal, only the issues of medical malpractice (national standard of care) and battery were taken up.

Key Case Facts – Issue 1 (Medical Malpractice / National Standard of Care):

Plaintiff's expert, Dr. Robert Steisand (vascular surgeon), repeatedly used the phrase "national standard of care" (hereinafter "SOC") during his deposition. However, he went on to clarify his testimony by explaining the following:

- Duke had a "fine reputation as a medical institution," and that the SOC at Duke would be the "national SOC that's applied to all finder institutions";
- The SOC for Duke would be that of any "top level teaching hospital in urban settings," such as UCLA or Johns Hopkins;

- Duke, like “other major university hospitals,” would have the “highest standard of care of the best hospitals in the nation.”

Key Case Facts – Issue 2 (Battery):

The pertinent facts included:

- Plaintiff verbally agreed to, and signed a consent form agreeing to an operation to remove his first rib;
- Defendant D’Amico and a defense expert on informed consent both acknowledged that Plaintiff never gave his consent for an operation to remove his second rib;
- Plaintiff admitted he **did** consent to a procedure which included the removal of his first rib;
- Plaintiff’s expert (Streisand) admitted that removal of the second rib was a “recognized complication” of the procedure to remove the first rib, and if it had been noticed in the recovery room immediately after surgery it would not even have been a breach in the standard of care;
- Defense experts also testified that removal of the second rib was a known risk of this first rib procedure

Issue(s):

- 1) Did the trial court err in granting a directed verdict for the defense on Plaintiff’s medical malpractice claim as a result of the “national standard of care” issue?
- 2) Did the trial court err in granting summary judgment for the defense on Plaintiff’s battery claim

Holding(s):

- 1) Yes.
- 2) No.

Rules / Controlling Authority – Issue 1 (National Standard of Care):

Where an issue exists as to whether an expert improperly applied a national standard of care, “the critical inquiry is whether the doctor’s testimony, **taken as a whole**, meets the requirements of N.C. Gen. Stat. § 90-21.12. In making such a determination, a court should consider whether an expert is familiar with a community that is similar to a defendant’s community in regard to physician skill and training, facilities, equipment, funding, and also the physical and financial environment of a particular medical community.” *Pitts v. Nash Day Hosp., Inc.*, 167 N.C. App. 194, 197, 605 S.E.2d 154, 156 (2004) (emphasis added), *affirmed per curiam*, 359 N.C. 626, 614 S.E.2d 267 (2005).

“The mere use of the phrase ‘national standard of care’ is not fatal to an expert’s testimony if the expert’s testimony otherwise meets the demands of section 90-21.12.” *Id.*

“Where 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.” *Haney v. Alexander*, 71 N.C. App. 731, 736, 323 S.E.2d 430, 434 (1984), *cert. denied*, 313 N.C. 329, 327 S.E.2d 889 (1985).

Note: In support of its citation to have above statement of law from the *Haney* case, this court also cited *Cox v. Steffes* as standing for the following example of acceptable expert

testimony: “the expert testified that the standard of care at issue in th[at] case was in fact the same across the nation. As to post-operative care, [the expert] first testified, ‘I think it is universally accepted the standard of care.’ He then agreed more specifically that with respect to post-operative care ‘the standard of care applicable for that would be the same across the US in 1994 for any board-certified surgeon[.]’” *Cox v. Steffes*, 161 N.C. App. 237, 244, 587 S.E.2d 908, 913 (2003), *disc. review denied*, 358 N.C. 233, 595 S.E.2d 148 (2004).

However, this author believes this type of citation and reliance on *Haney* and *Cox* may be in conflict with other recent appellate opinions.³

Analysis & Arguments – Issue 1:

The court found that the expert’s testimony as a whole “does not suggest that Streisand was asserting a national standard of care which would be the same at hospitals in every community across the country. On the contrary, Streisand testified that the standard of care at Duke was the same as found at other ‘top level . . . teaching hospitals in urban settings’ and ‘other major university hospitals[,]’ such as UCLA and Johns Hopkins, to wit, the ‘highest standard of care of the best hospitals in the nation[.]’”

The court found this type of testimony was persuasively analogous to the testimony that was deemed acceptable by the NCSC in *Rucker v. High Point Mem’l Hosp.*, 285 N.C. 519, 206 S.E.2d 196 (1974). There, the expert ‘testified he was familiar with the standards of practice and procedures in duly accredited hospitals and that they were essentially the same throughout the United States. However, the plaintiff alleged and both defendants admitted that the defendant High Point Memorial Hospital was engaged, at all times herein mentioned, in operating and maintaining ‘a fully accredited hospital’ in the City of High Point.” *Id.* at 526, 206 S.E.2d at 201 (emphasis omitted).

“Thus, in *Rucker*, our Supreme Court specifically held that expert standard of care testimony met the requirements of section 90-21.12 where the ‘same or similar communit[y]’ was a group of the defendant’s *peer* institutions in the sense of “physician skill and training, facilities, equipment, funding, and also the physical and financial environment of a particular medical community. Here, instead of testifying to the standard of care at fully accredited hospitals, Streisand testified to the standard of care at top teaching hospitals associated with a major university.”

Note: Notably, the court offered this encouraging remark in response to the defense’s “community” arguments here: “We observe particularly that Defendants’ contention that Streisand should have been familiar with the community of Durham is entirely unconvincing. It cannot be reasonably maintained that the standard of care at Duke is better approximated by comparison to community hospitals in Durham or similarly sized cities than to other renowned, ‘top level teaching hospitals’ attached to major universities, such as UCLA and Johns Hopkins.”

Rules / Controlling Authority – Issue 2 (Battery):

³ Namely, see *Crocker v. Roethling*, 719 S.E.2d 83 (2011), where the NCCOA made clear that “[t]his Court, however, has recognized very few ‘uniform procedures’ to which a national standard may apply, and to which an expert may testify . . . This Court has been particularly reluctant to find a national standard for especially complex procedures.” *Id.* at 86-87 (citing *Henry v. Southeastern Ob-Gyn Assocs.*, P.A., 145 N.C. App. 208, 211, 550 S.E.2d 245, 247 (2001)). In *Crocker*, the court declined to find national standard of care testimony acceptable for aspects of labor and delivery care.

“Where a medical procedure is completely unauthorized, it constitutes an assault and battery, i.e., trespass to the person. . . . If, however, the procedure is authorized, but the patient claims a failure to disclose the risks involved, the cause of action is bottomed on negligence. Defendants' failure to make a proper disclosure is in the nature of malpractice (negligence). . . .” *Nelson v. Patrick*, 58 N.C. App. 546, 550, 293 S.E.2d 829, 832 (1982).

Analysis & Arguments – Issue 2:

The court recognized that Plaintiff never consented to an operation to remove his second rib. Yet, it was undisputed that that he *did* consent to a procedure to remove his first rib, and that procedure carried with it certain risks, one of which was accidental removal of the wrong rib. After analyzing the key facts (see bullet points above), the court found that “*all* of the standard of care evidence was that the resulting event was a recognized complication of the consented-to surgical procedure.” Thus, summary judgment was appropriate for defendant on the battery issue.

Impact of Decision on Plaintiff’s Practice:

This is a very promising opinion on the “national standard of care” issue, as it further reinforces that an expert will not be excluded simply for using this oft-feared phrase. The case does, however, appear to be slightly in conflict with some of the other recent national standard of care decisions from the NCCOA (see footnote 3, *supra*). The other important aspect of this case is that (in this author’s opinion) accurately states and applies the law of medical battery in North Carolina. It highlights the, perhaps unwelcome, truth that as long as the defendant can show the plaintiff’s injury was a known risk of the procedure that was consented to, then the intentional tort of battery is no longer applicable.

<u>Katy v. Capriola,</u> ____ N.C. App. ____, 2013 N.C. App. LEXIS 393 (2013)	
Prior History: McDowell County, 09 CVS 434	NCCOA Filed Date: April 16, 2013
Plaintiff Attorney(s): William R. Elam (Elam & Rousseaux) William H. Elam (Elam & Rousseaux)	Defense Attorney(s): Joseph T. Carruthers (Carruthers & Bailey)
Judge (Author of opinion): Calabria, Ann Marie	Judges (Concurring / Dissenting): Bryant, Wanda G. (concur) Geer, Martha A. (concur)
Type of Medical Care Involved: Congestive Heart Failure; Stroke Prevention	Decision for Plaintiff or Defense Bar? 75% for Defense; 25% for Plaintiff

Procedural History:

Appeal by Defendants Riser (physician assistant) and McDowell Emergency Physicians, PLLC from jury verdict, judgment, and denial of motion for new trial by Judge Joseph Crosswhite.

Background Facts:

Decedent gave birth to twins on 2/9/08, and two days later a chest x-ray revealed possible pneumonia. She was treated with antibiotics and discharged on 2/13/08. Two days later, she was experience shortness of breath and was referred to Defendant McDowell County ER where she was again treated for pneumonia and discharged. On 2/22/08, she returned to the ER complaining of SOB. This time, she was seen by Defendant Riser, a physician assistant, as well as Defendant Dr. Michael Capriola. A chest x-ray was done, but the results could not be read as all radiologists were out over the weekend. Both Riser and Capriola believed she had pneumonia, so they changed her antibiotics and discharged her with instructions to return if her symptoms continued or worsened. The chest x-ray was finally read on 2/25/08 and it revealed congestive heart failure.

On 2/27/08, an ER doctor called decedent's husband and instructed the decedent to follow up with a physician ASAP, or return to the ER if an appointment could not be scheduled. The opinion states "although [decedent] was feeling badly and wanted to go the ER, [her husband] convinced her to wait." On 3/1/08, decedent returned to the ER and she was transferred to Mission Hospital the next day where she began to receive extensive treatment. Despite treatment at Mission, decedent suffered a stroke on 3/7/08 and thereafter declined until her death from stroke complications on 3/23/08.

Plaintiff filed a wrongful death complaint alleging, *inter alia*, that Defendants Riser and McDowell ER negligently delayed the diagnosis of congestive heart failure which cause the stroke and death of decedent. The case was tried with the jury returning a verdict for the Plaintiff. In motions for JNOV and for a new trial, Defendants raised several issues on appeal here, each of which are listed below.

Key Facts on Issue 1 (Standard of care opinions re non-physicians)

Before offering opinions in his own defense, the trial court granted Plaintiff's motion pursuant to *Sherrod v. Nash General Hosp., Inc.*, 348 N.C. 526, 500 S.E.2d 708 (1998) to not formally recognize Dr. Capriola as an expert witness. Defendant Capriola proceeded to offer, without objection, standard of care opinions in defense of his own care. He testified he was a licensed and board certified family practice physician, a specialty that included within it emergency medicine. He also testified on *voir dire* that he worked directly with Defendant Riser as his supervising physician, that he worked with him in caring for decedent, and that he was familiar with the standard of care for physician assistants.

Upon motion of Plaintiff, the trial court prevented Capriola from offering any opinions regarding Defendant Riser's compliance with the standard of care for a PA. The trial court articulated no basis for granted Plaintiff's motion to exclude this testimony.

Key Facts on Issue 2 (Prejudice as a result of exclusion of expert testimony):

During closing argument, Plaintiff's counsel specifically emphasized to the jury that Defendants had presented "only one expert" who testified that Riser had not breached the standard of care. Plaintiff argued that the exclusion of Capriola's testimony regarding Riser was not prejudicial because such testimony, had it been offered, would have been merely cumulative.

Key Facts on Issue 3 (Contributory negligence):

See "Background Facts" above

Key Facts on Issue 4 (Special jury instruction on proximate cause)

Based on the law as stated in *White v. Hunsinger*, 88 N.C. App. 382, 363 S.E.2d 203 (1988), the Defendant's requested the following special jury instruction be given on proximate cause:

It is not enough for plaintiff to show that earlier hospitalization of Aziza Katy would have improved her chances of survival and recovery. Rather, plaintiff must prove that it is probable that a different outcome would have occurred with earlier hospitalization. Plaintiff must prove by the greater weight of the evidence that the alleged delay in hospitalization more likely than not caused the stroke and death.

The trial court denied this request, and instead read only the pattern instruction on proximate cause, which reads, in pertinent part:

The plaintiff not only has the burden of proving negligence, but also that such negligence was a proximate cause of Aziza Katy's death. Proximate cause is a cause which in a natural and continuous sequence produces a person's injury and is a cause which a reasonable and prudent health care provider would have foreseen would probably produce such injury or similar injurious result.

Key Facts on Issue 5 (Evidence of remarriage):

At some point after his decedent-wife's death, Plaintiff-husband remarried. Defendant's argued that evidence of this remarriage should be admissible on the issue mitigation of Plaintiff's wrongful death damages. The trial court disagreed and excluded this evidence altogether.

Issue(s):

- 1) Did the trial court err in preventing Dr. Capriola from offering standard of care testimony regarding Defendant Riser, a PA?
- 2) Did the trial court's exclusion of the testimony in Issue 1 actually prejudice the Defendants?
- 3) Did the trial court err in granting directed verdict for the Plaintiff on the issue of contributory negligence?
- 4) Did the trial court err in not giving the special jury instruction on proximate cause?
- 5) Did the trial court err in excluding evidence of Plaintiff-husband's remarriage?

Holding:

- 1) Yes.
- 2) Yes.
- 3) Yes.
- 4) Yes.
- 5) No.

Rules/Controlling Authority – Issue 1 (Standard of care opinions re non-physicians):

Pursuant to Rule 702(d), "a physician who qualifies as an expert under subsection (a) of this Rule and who by reason of active clinical practice or instruction of students has knowledge of the applicable standard of care for . . . physician assistants . . . may give expert testimony in a medical malpractice action with respect to the standard of care of which he is knowledgeable of . . . physician assistants licensed under Chapter 90 of the General Statutes. . . ."

Under Rule 702(d), a physician may testify regarding the applicable standard of care for a physician assistant if the physician “is familiar with the experience and training of the defendant and either (1) the physician is familiar with the standard of care in the defendant's community, or (2) the physician is familiar with the medical resources available in the defendant's community and is familiar with the standard of care in other communities having access to similar resources.” *Purvis v. Moses H. Cone Mem'l Hosp. Serv. Corp.*, 175 N.C. App. 474, 478, 624 S.E.2d 380, 384 (2006).

“[A] formal tender [of a witness as an expert] is not an essential prerequisite to eliciting an opinion.” *Waynick Constr. v. York*, 70 N.C. App. 287, 292, 319 S.E.2d 304, 307 (1984).

Analysis & Arguments – Issue 1:

Plaintiffs argued in their NCCOA brief that since Dr. Capriola could not be formally recognized as an expert pursuant to *Sherrod*, that this also precluded him from offering expert opinions in defense of Defendant Riser's care. The court disagreed, and stated that this was a misinterpretation of *Sherrod*, as that case only stands for the proposition that the court cannot formally recognize before the jury a defendant as an expert *in his/her own field of practice*. The court concluded that *Sherrod* in no way prevented a defendant from being allowed to testify as an expert regarding the care of a non-physician co-defendant.

Rules/Controlling Authority – Issue 2 (Prejudice as a result of exclusion of expert testimony):

The court cited *Barham v. Hawk*, 165 N.C. App. 708, 712, 600 S.E.2d 1, 4 (2004), *aff'd per curiam by an equally divided court*, 360 N.C. 358, 625 S.E.2d 778 (2006) as authority saying, “In *Barham v. Hawk*, this Court found that the defense counsel's emphasis on improperly admitted expert testimony during his closing argument was prejudicial error, because the defendant's emphasis indicated the importance of the testimony to the outcome of the case.”

However, in Footnote 1, the court noted: “While the opinion in *Barham* has no precedential value, we find its prejudicial error reasoning persuasive.”

Analysis & Arguments – Issue 2:

The court reasoned that here “plaintiff's emphasis on defendants' presentation of ‘only one expert’ demonstrates the importance of Capriola's testimony to the determination of whether Riser's treatment met the standard of care for physician assistants.” The court also stated that “Capriola was Riser's supervising physician and worked directly with him in evaluating and diagnosing Mrs. Katy,” and as such “his opinion as to Riser's performance would potentially carry great weight with a jury tasked with determining whether Riser was negligent.” This was enough for the court to conclude that “a different result would have likely ensued had the [trial court's exclusion] not occurred.”

Rules/Controlling Authority – Issue 3 (Contributory negligence):

“A directed verdict for the plaintiff on the issue of his contributory negligence must be sustained by the appellate court unless there is substantial evidence the plaintiff's negligence was a proximate cause of his injuries.” *Andrews v. Carr*, 135 N.C. App. 463, 467, 521 S.E.2d 269, 272 (1999).

“If there is more than a scintilla of evidence that plaintiff is contributorily negligent, the issue is a matter for the jury, not for the trial court.” *Cobo v. Raba*, 347 N.C. 541, 545, 495 S.E.2d 362, 365 (1998).

In *McGill v. French*, 333 N.C. 209, 215, 424 S.E.2d 108, 112 (1993), “the plaintiff alleged that the defendant had committed medical malpractice by failing to inform him that he had prostate cancer, which eventually resulted in his death. Our Supreme Court held that the trial court properly submitted the issue of the plaintiff’s contributory negligence to the jury based upon evidence that the plaintiff had failed to keep appointments and report his worsening symptoms to the defendant “during a crucial time of his illness.”

In *Andrews v. Carr*, *supra*, “the plaintiff engaged in activities contrary to the defendant-physician’s post-operation instructions after undergoing a negligent hernia operation. The Andrews Court upheld the entry of a directed verdict in favor of the plaintiff on the issue of contributory negligence, reasoning that because the plaintiff’s activities occurred subsequent to the completion of the defendant’s negligent treatment, they did not constitute contributory negligence.”

Analysis & Arguments – Issue 3:

Plaintiff argued that this case was controlled by *Andrews* because any alleged contributory negligence of plaintiffs in not returning to the ER quickly enough occurred multiple days after Defendants Riser and Capriola’s negligent failure to diagnosis had occurred. The court disagreed and concluded that the reasoning in *McGill* controlled here.

The court found that the Defendants’ “instructions demonstrate that, unlike the plaintiff in *Andrews*, Mrs. Katy’s treatment for her condition was not completed and that she potentially required further treatment if her condition either did not improve or worsened. However, when Mrs. Katy’s condition continued to deteriorate, she failed to immediately seek medical attention. Instead, despite the explicit instructions from the ER physicians, Mrs. Katy delayed reporting her symptoms until 1 March 2008 when she returned to the ER. Mrs. Katy’s actions provide more than a scintilla of evidence that she, like the plaintiff in *McGill*, failed to take ‘an active responsibility for h[er] own care and well-being[.]’ (citing *Cobo*) ‘during a crucial time of h[er] illness.’” (citing *McGill*).

Rules/Controlling Authority – Issue 4 (Special instruction on proximate cause):

“When reviewing the refusal of a trial court to give certain instructions requested by a party to the jury, this Court must decide whether the evidence presented at trial was sufficient to support a reasonable inference by the jury of the elements of the claim. If the instruction is supported by such evidence, the trial court’s failure to give the instruction is reversible error.” *Ellison v. Gambill Oil Co.*, 186 N.C. App. 167, 169, 650 S.E.2d 819, 821 (2007) (citations omitted), *aff’d per curiam and disc. rev. improvidently allowed*, 363 N.C. 364, 677 S.E.2d 452 (2009).

A specific jury instruction should be given when “(1) the requested instruction was a correct statement of law and (2) was supported by the evidence, and that (3) the instruction given, considered in its entirety, failed to encompass the substance of the law requested and (4) such failure likely misled the jury.” *Outlaw v. Johnson*, 190 N.C. App. 233, 243, 660 S.E.2d 550, 559 (2008).

“Proof of proximate cause in a malpractice case requires more than a showing that a different treatment would have improved the patient’s chances of recovery.” *White v. Hunsinger*, 88 N.C. App. 382, 363 S.E.2d 203 (1988).

In a wrongful death medical malpractice case, “[the] plaintiff could not prevail at trial by merely showing that a different course of action would have improved [the decedent]’s chances of survival.” Instead, the plaintiff must forecast evidence showing that had the defendant acted

sooner, “[the decedent] would not have died. ***The connection or causation between the negligence and death must be probable, not merely a remote possibility.***” *Id.* (emphasis added).

Analysis & Arguments – Issue 4:

The court found that all four elements from *Outlaw* were met here and the special instruction should have been given. Plaintiff did present evidence that earlier diagnosis and hospitalization would have prevented decedent’s death. However, the court pointed out that that other evidence existed from which the jury could find that earlier hospitalization would have only given decedent the possibility of “an improved chance of survival.” The record showed there was a “significant amount of conflicting testimony as to whether the eight-day delay in Mrs. Katy’s treatment proximately caused her injuries,” and it was disputed whether “it was probable that Mrs. Katy’s risk of stroke increased due to the delay in her treatment.” Thus, the court concluded that the trial court’s failure to give the special instruction here was “likely to mislead the jury” on the actual law of proximate cause in these types of cases.

Rules/Controlling Authority – Issue 5 (Evidence of remarriage):

Pursuant to N.C. Gen. Stat. § 28A-18-2(b), damages for wrongful death include “[t]he present monetary value of the decedent to the persons entitled to receive the damages recovered.”

The statute further provides that “[a]ll evidence which reasonably tends to establish any of the elements of damages included in subsection (b), or otherwise reasonably tends to establish the present monetary value of the decedent to the persons entitled to receive the damages recovered, is admissible in an action for damages for death by wrongful act.” N.C. Gen. Stat. § 28A-18-2(c)(2011).

“North Carolina has long adhered to the collateral source rule, which ‘provides '[a] tort-feasor [sic] should not be permitted to reduce his own liability for damages by the amount of compensation the injured party receives from an independent source.’” *Muscatell v. Muscatell*, 145 N.C. App. 198, 201, 550 S.E.2d 836, 837-38 (2001) (quoting *Fisher v. Thompson*, 50 N.C. App. 724, 731, 275 S.E.2d 507, 513 (1981)).

“Indeed, many jurisdictions have used the collateral source rule as a justification to exclude evidence of remarriage by the decedent's spouse in a wrongful death action. *See, e.g., Seaboard Coast Line R.R. Co. v. Hill*, 270 So.2d 359, 360-61 (Fla. 1972); *Westfall v. Caterpillar, Inc.*, 120 Idaho 918, 821 P.2d 973, 979 (Idaho 1991); *Pape v. Kansas Power and Light Co.*, 231 Kan. 441, 647 P.2d 320, 324-25 (Kan. 1982); *Addair v. Bryant*, 168 W. Va. 306, 284 S.E.2d 374, 380 (W.Va. 1981).”

Analysis & Arguments – Issue 5:

The court recognized that there was no North Carolina case on point for this issue. Without really any analysis, the court cited the above law and concluded that the collateral source rule “requires the exclusion of evidence of plaintiff’s remarriage in the instant case” and “Defendants should not be permitted to reduce their liability for the damages caused by Mrs. Katy’s death simply because plaintiff has remarried.”

Impact of Decision on Plaintiff’s Practice:

This case provides a very helpful analysis of two crucial areas: contributory negligence in medical malpractice cases, and proximate cause in delayed diagnosis/treatment cases. Also, for the first time in North Carolina, our appellate courts have ruled that evidence of remarriage in wrongful death cases is barred by the collateral source rule.

Manning v. Anagnost.

___ N.C. App. ___, 739 S.E.2d 859, 2011 N.C. App. LEXIS 181 (2013)

Prior History:

New Hanover County, 09 CVS 4866

NCCOA Filed Date:

February 19, 2013

Plaintiff Attorney(s):

Brent Adams (Brent Adams & Associates)

Defense Attorney(s):

Jerry A. Allen (Walker Allen)

Judge (Author of opinion):

Steelman, Jr., Sanford L

Judges (Concurring / Dissenting):

Stephens, Linda (concur)

McCullough, J. Douglas (concur)

Type of Medical Care Involved:

Unclear from opinion

Decision for Plaintiff or Defense Bar?

Defense

Procedural History:

Appeal by Plaintiff from jury verdict and trial judgment

Background Facts:

The background medical facts are largely irrelevant to the issues in this case, and as a result they are scant in this opinion. The medical care at issue appeared to revolve around a hospitalized decedent on Coumadin that fell in her hospital room, hitting her head. Defendant Dr. Anagnost claimed to have examined the patient after she fell. The decedent complained of headaches after she fell, and within a few days she was diagnosed with permanent brain damage from a subdural hematoma. She passed away a week later.

Plaintiff filed suit against multiple physicians, but filed voluntary dismissals against all but Dr. Anagnost after jury selection. After the verdict was returned for the Defendant, Plaintiff appealed and raised several issues, each of which are discussed below

Key Case Facts – Issue 1 (character evidence):

During trial, Plaintiff's counsel accused the Defendant of not personally performing an examination of the decedent, despite his claim to the contrary. The trial court found this amounted to an attack on credibility, and allowed the Defendant to put on three witnesses who testified to the Defendant's good reputation for truthfulness.

Key Case Facts – Issue 2 (deposition transcript in lieu of live testimony):

Dr. Alsina was a treating physician that was deposed during discovery. The trial court allowed Dr. Alsina's deposition testimony to be admitted in lieu of his live testimony. Dr. Alsina's office was located less than 100 miles away from the county of trial, however, he was out of town during the time the defense attempted to call him as a witness. Before trial, both sides had subpoenaed Dr. Alsina to appear during the first week of trial, but he informed them that he would be away at a conference during that time. Each party agreed to release Dr. Alsina's from subpoena given that his testimony would likely not be needed until later during the trial. When Plaintiff unexpectedly dismissed all but of the defendants after jury selection, this resulted in the remaining Defendant needing to call Dr. Alsina to the stand while he was out of state in his conference. As a result, the trial court allowed his deposition into evidence pursuant to Rule 32.

Key Case Facts – Issue 3 (failure to tender treating physician as an expert):

Dr. Alsina was a treating physician, and no party formally tendered him as an expert witness during his deposition (which was admitted in lieu of his live testimony, see above).

Key Case Facts – Issue 4 (use of denials in defendant’s Answer at trial):

In his Answer, Defendant denied several allegations based on “lack of knowledge and information.” These denials were expressly based on the fact that Defendant did not have access to the complete medical records at the time his Answer was filed. Plaintiff argued that these denials were made in bad faith and that Defendant should be estopped from denying the same allegations at trial.

Issue(s):

- 1) Did the trial court err in allowing the Defendant to introduce character evidence?
- 2) Did the trial court err in allowing the Defendant to introduce Dr. Alsina’s deposition in lieu of his live testimony?
- 3) Did the trial court err in allowing Dr. Alsina opinion testimony where he was not tendered as an expert witness?
- 4) Did the trial court err in allowing the Defendant to respond at trial to the allegations he previously denied in his Answer based upon lack of knowledge or information?

Holding:

- 1) No.
- 2) No.
- 3) No.
- 4) No.

Rules / Controlling Authority – Issue 1 (character evidence):

“Where a party testifies and the credibility of his testimony is challenged, testimony that his general character is good is competent and proper evidence for consideration upon the truthfulness of his testimony.” *Holiday v. Cutchin*, 311 N.C. 277, 280, 316 S.E.2d 55, 57-58 (1984).

A witness' credibility may be attacked or supported by evidence of reputation or opinion, and evidence of truthful character is admissible once a witness' character for truthfulness has been attacked by opinion or reputation. N.C. R. Evid. 608(a).

Analysis & Arguments – Issue 1:

“At trial, plaintiff repeatedly attacked defendant's testimony that he had personally examined decedent on 20 September 2007, following her fall . . . By calling into question the credibility of defendant, plaintiff opened the door for defendant to present the three witnesses who testified as to his character for truthfulness.”

Rules / Controlling Authority – Issue 2 (deposition transcript in lieu of live testimony):

Rule 32 provides, in part that “The deposition of a witness, whether or not a party, may be used by any party for any purpose if the court finds: . . . that the witness is at a greater distance than 100 miles from the place of trial or hearing, . . . **or** that the party offering the deposition has been unable to procure the attendance of the witness by subpoena; **or** upon application and notice, that such exceptional circumstances exist as to make it desirable, in the interest of justice

and with due regard to the importance of presenting testimony of witnesses orally in open court, to allow the deposition to be used. . . N.C.R. Civ. P. 32 (a) (4) (emphasis added).

A deposition is admissible so long as one of the foundational requirements of Rule 32 has been satisfied. *Suarez v. Wotring*, 155 N.C. App. 20, 28, 573 S.E.2d 746, 751 (2002).

Analysis & Arguments – Issue 2:

Based on the facts above, the court agreed with the trial judge’s finding that “Dr. Alsina's absence was ‘acquiesced by both parties[,]’ and that ‘in the interests of justice’ the deposition could be presented to the jury, ‘subject to the usual completeness requirements of the rules.’”

Rules / Controlling Authority – Issue 3 (failure to tender treating physician as an expert):

A treating physician in a medical malpractice action who testifies regarding the care rendered to a patient does not testify as an expert, but as a lay witness. *Turner v. Duke Univ.*, 325 N.C. 152, 167-68, 381 S.E.2d 706, 715-16 (1989).

Analysis & Arguments – Issue 3:

Without analysis, the court stated that here, “Dr. Alsina was a treating physician for decedent. His testimony was lay testimony, and defendant was not required to tender him as an expert witness.”

Rules / Controlling Authority – Issue 3 (use of denials in defendant’s Answer at trial):

If a party is “without knowledge or information sufficient to form a belief as to the truth of an averment, he shall so state and this has the effect of a denial.” N.C. R. Civ. P. 8(b).

A denial or qualification of an averment must be made in good faith. One not made in good faith may be stricken. *WXQR Marine Broadcasting Corp. v. Jai, Inc.*, 83 N.C. App. 520, 521, 350 S.E.2d 912, 913 (1986).

Analysis & Arguments – Issue 4:

Again, without analysis, the court agreed with the trial judge’s finding that the unavailability of complete medical records at the time of the Answer was a sufficient good faith basis to deny these allegations.

Moore v. Proper,

___ N.C. ___, 726 S.E.2d 812, 2012 N.C. LEXIS 411 (2012)

Prior History:

Madison County, 09 CVS 93

NCSC Filed Date:

June 14, 2012

Plaintiff Attorney(s):

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Robert N. Young, amicus curiae (NCADA)

Judge (Author of opinion):

Martin, Mark

Judges (Concurring / Dissenting):

Newby, Paul (concurring in part and concurring in result)

Type of Medical Care Involved:

General Dentistry

Decision for Plaintiff or Defense?

Plaintiff

Procedural History:

Appeal by Defendants from NCCOA's reversal of trial court's order of summary judgment in favor of defendants pursuant to Rule 9(j).

Background Facts:

In January 2006, Plaintiff sought treatment for a toothache and was treated by as defendant, a general dentist in Asheville, N.C. Plaintiff alleged that defendant fractured her jaw while extracting a tooth, and thereafter discharged her without notifying her of the fracture and providing the proper follow up care.

Key Case Facts:

Plaintiff timely filed a medical malpractice complaint containing a proper Rule 9(j)(1) certification. Plaintiff subsequently designated Dr. Joe Dunn, a retired general dentist, as her expert. The following are the pertinent facts regarding Dr. Dunn's expert qualifications under Rule 702 and his "active clinical practice":

- **From Plaintiff's Expert Designation:** Graduated from Louisville School of Dentistry in 1970, and practiced general dentistry specifically in Asheville, N.C. for nearly 25 years.
- **From 9(j) Interrogatory Responses:** Dunn practiced general dentistry for over 35 years before retiring in 1997. He maintained a valid license since his retirement. He did not engaged in any teaching activities.
- **From Dr. Dunn's Deposition:** During relevant time period from January 2005 to January 2006, Dunn worked approximately 30 days doing "fill-in work" for fellow dentists in the Asheville area. When asked what percentage of his time during this year was spent in the active clinical practice of dentistry, Dunn testified that

“whenever you are looking at a patient you are practicing clinical dentistry . . . **So I would say when I am there it is 100 percent.**” Dunn was retired during this year, spent time running for Asheville mayor, serving on city council, playing with his grandchildren, and golfing. When asked what percentage of the entire year he spent working in the active clinical practice of dentistry, Dunn testified that “**it’s got be less than five percent, I guess.**”

- **From Dr. Dunn’s Summary Judgment Affidavit:** Dunn clarified that during the year in question when he worked as a dentist he only treated patients in a clinical setting and engaged in no administrative duties. He reiterated that he spent “**100 percent of his professional time in the active clinical practice of dentistry and other activities were personal, not professional.**”

Based on this testimony, defendants filed a motion to dismiss for failure to comply with Rule 9(j) on the basis that no reasonable person could have expected Dr. Dunn to qualify as an expert under Rule 702. The NCCOA reversed the trial court’s summary judgment order, and Defendants appealed that ruling.

Issue:

Based on the above did plaintiff comply with 9(j)?

Holding:

Yes. Based on Dunn’s total testimony and the controlling case law at the time the complaint was filed, a reasonable plaintiff could have expected Dr. Dunn to qualify under Rule 702.

Rules / Controlling Authority:

I. Statutory Interpretation of Rules 9(j) and 702(b):

Rule 9(j): A medical malpractice complaint shall be dismissed unless “[t]he pleading specifically asserts that the medical care has been reviewed by a person who is **reasonably expected to qualify** as an expert witness under Rule 702 of the Rules of Evidence.” Rule 9(j)(1) (emphasis added).

Rule 702(b)(2)(a): An expert is not qualified to opine on the standard of care unless: “During the year immediately preceding the date of the occurrence that is the basis for the action, the expert witness must have devoted a **majority of his or her professional time** to either or both of the following:

- a. The **active clinical practice** of the same health profession in which the party against whom or on whose behalf the testimony is offered, and if that party is a specialist, the active clinical practice of the same specialty or a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients; or . . .” Rule 702(b)(2)(a) (emphasis added)

Three Elements: When an expert is proffered under Rule 702(b)(2)(a), the inquiry can be broken down into the three elements: “(1) whether, during the year immediately preceding the incident, the proffered expert was in the same health profession as the party against whom or on whose behalf the testimony is offered; 2 (2) whether the expert was engaged in active clinical practice during that time period; and (3) whether the majority of the expert’s professional time was devoted to that active clinical practice.” *Id.*

“Clinical”: The term “clinical” means “actual experience in the observation and treatment of patients—not activities simply relating to the health profession, such as administration or continuing education.” *Id.*

“Active”: “A continuum exists between active and inactive clinical practice. On the one hand, there is inactive practice, an extreme example of which would be a professional performing one hour of clinical practice per year. On the other hand, there is active practice, an extreme example of which would be a full-time practitioner devoting eighty hours to clinical practice each week. Whether a professional's clinical practice is considered active during the relevant time period will necessarily be decided on a case-by-case basis considering, among other things, the total number of hours engaged in clinical practice, the type of work the professional is performing, and the regularity or intermittent nature of that practice. No one factor is likely to be determinative. Instead, the court must look to the totality of the circumstances when making this determination.” *Id.* (internal citations omitted).

“Majority of His/Her Professional Time”: “When referring to the expert witness, Rule 702 states that the court should look to ‘*his or her* professional time.’ Therefore, professional time is the professional's actual time spent engaged in the profession of which he or she is being proffered as an expert. This time may include time spent in clinical practice, administration, continuing education, or any other capacity related to the field—necessarily excluding time spent outside the profession. Using the aggregate time spent in the profession, the trial court must determine the proportion of that time during which the proffered expert was engaged in active clinical practice, as defined above, and whether this time constituted at least a majority of his or her total professional time. Whereas the second inquiry is concerned with quantity and quality, this third inquiry is concerned with proportionality.” *Moore*, 726 S.E.2d at 819 (internal citations omitted).

Important Point of Clarification on Elements 2 and 3: “The interaction between the second and third inquiries prevents absurd results. For instance, a professional likely would not qualify under Rule 702(b) if he or she spent one hundred percent of his or her professional time in clinical practice but practiced only ten hours during the relevant year. Similarly, a professional who spent eighty hours per week in the profession as an administrator but very little time performing clinical work likely would not qualify under Rule 702(b). In both cases, the professional would fail the second prong by not having engaged in an active clinical practice. *At the same time, the interaction between these inquiries is meant to prevent absurd outcomes in which practitioners who are familiar with the local standard of care are unable to qualify.*” *Moore*, 726 S.E.2d at 819 (emphasis added).

II. How to Assess “Reasonable Expectation”

“We ‘presum[e] that the legislature carefully chose each word used.’ Therefore, to “give every word of the statute effect,” we must ensure that the two questions are not collapsed into one. Ignoring the term reasonably expected would thus contravene the manifest intent of the legislature. Accordingly, a trial court must analyze whether a plaintiff complied with Rule 9(j) by including a certification complying with the Rule before the court reaches the ultimate determination of whether the proffered expert witness actually qualifies under Rule 702.” *Moore*, 726 S.E.2d at 817 (internal citations omitted).

“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.” *Id.* (citing *Thigpen*, 355 N.C. at 203-04, 558 S.E.2d at 166).

“Any reasonable belief must necessarily be based on the exercise of *reasonable diligence under the circumstances* . . . [thus, a complaint] may be dismissed if subsequent discovery establishes that the [Rule 9(j)] 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*. Therefore, to evaluate whether a party reasonably expected its proffered expert witness to qualify under Rule 702, the trial court must look to all the facts and circumstances that were known or should have been known by the party at the time of filing.” *Moore*, 726 S.E.2d at 817 (emphasis added) (internal citations omitted).

“Though the party is not necessarily required to know all the information produced during discovery at the time of filing, the trial court will be able to glean much of what the party knew or should have known from subsequent discovery materials. But to the extent there are reasonable disputes or ambiguities in the forecasted evidence, the trial court should draw all reasonable inferences in favor of the nonmoving party at this preliminary stage of determining whether the party *reasonably expected* the expert witness to qualify under Rule 702.” *Moore*, 726 S.E.2d at 817-818 (internal citations omitted) (emphasis in original).

New Requirement for Trial Court’s that Dismiss under Rule 9(j):

“When the trial court determines that reliance on disputed or ambiguous forecasted evidence was not reasonable, the court must make written findings of fact to allow a reviewing appellate court to determine whether those findings are supported by competent evidence, whether the conclusions of law are supported by those findings, and, in turn, whether those conclusions support the trial court's ultimate determination.” *Moore*, 726 S.E.2d at 818 (emphasis added).

Analysis & Arguments:

The good facts identified by the Court as suggesting reasonable expectation included:

- “At the time of filing, plaintiff knew or should have known that Dr. Dunn was a licensed dentist with over thirty-five years of full-time experience
- During that period, he served as a dentist in the United States Navy and then spent the remainder of his career practicing general dentistry in Asheville.
- Following his retirement from full-time practice, he continued to perform clinical dentistry as director of a local clinic.
- To maintain his license to practice dentistry, Dr. Dunn participated in required continuing education courses each year, which would give him at least some degree of insight into the current standard of care for his profession.
- Plaintiff also knew that since Dr. Dunn's retirement, he had continued to practice general clinical dentistry on a fill-in basis.”

The Court made an important finding regarding how “active” Dr. Dunn’s fill-in practice was:

- “The extent of Dr. Dunn's fill-in work from January 2005 to January 2006 was somewhat unclear. Dr. Dunn's deposition testimony revealed that during that one-year period he could have practiced as few as thirty days, or even more than two and one-half months when he filled in full time for a friend. ***Based on that conflicting information, it was at least reasonable to infer that Dr. Dunn engaged in fairly regular clinical dental practice for a substantial number of hours, the totality of which was reasonably likely to amount to active clinical practice.***” (emphasis added).

The Court also made an important finding regarding Dr. Dunn's "professional time":

- "Additionally, all of Dr. Dunn's time in the dental profession was spent engaged in clinical practice. Because **activities completely unrelated to dentistry, such as running for mayor, are not included as part of Dr. Dunn's professional time**, it was thus reasonable for plaintiff to infer that Dr. Dunn had devoted a majority of his professional time to the active clinical practice of dentistry." (emphasis added).

Justice Newby's Dissent:

The thrust of Justice Newby's detailed dissent can be summed up with the following to excerpts:

- "[A]scertaining whether a proffered expert's clinical practice is 'active' depends on a number of factors, none of which is likely to be dispositive. These factors include the amount of time that individual spends observing and treating patients and the frequency and regularity with which the proffered expert engages in those activities. The more infrequently or intermittently the proffered expert observes and treats patients, the more likely that individual does not qualify as an expert under Rule 702(b)(2)(a). **The most important factor in this inquiry is the type of work the individual is performing.** An individual who is not performing the activities of other clinical practitioners of the same health profession likely will not qualify as an expert. For example, an individual who observes or diagnoses patients but who does not regularly perform the various treatments done by other members of that health profession likely would not qualify as an expert under this rule. Allowing an individual who does not function as do the vast majority of the other members of the same health profession to qualify as an expert under this rule would contravene the General Assembly's intention to ensure that experts in medical malpractice cases would be 'qualified practitioners of a competence similar to those of the practitioners who are the object of the suit.'" (internal citations omitted). *Moore*, 726 S.E.2d at 822 (Newby, J., dissenting) (emphasis added).
- "Dr. Dunn did not engage in 'active clinical practice' during the period from January 2005 to January 2006. Resolving factual ambiguities in favor of plaintiff, Dr. Dunn spent approximately twenty-five percent of the work days in the year engaged in the clinical practice of dentistry. Moreover, because when he worked largely depended on the illness or vacation of others, Dr. Dunn did not practice with much consistency or frequency. Finally, Dr. Dunn acknowledged that he spent most of his time in clinical practice checking hygiene patients and did not undertake most of the treatments and procedures normally performed by dental clinicians. Considering these factors together, it is unreasonable to expect Dr. Dunn to be deemed to have engaged in the active clinical practice of dentistry during the relevant time period. And, as a result, he is not 'reasonably expected' to qualify as an expert witness under Rule 702." *Moore*, 726 S.E.2d at 824 (Newby, J., dissenting).

Impact of Decision on Plaintiff's Practice:

This is an extremely important case that speaks for itself. It will likely be the controlling authority on Rule 9(j) issues of "reasonable expectation," "active clinical practice," and "majority of his or her professional time" for years to come.