

ASSESSING AND EVALUATING THE MALPRACTICE CASE: PLAINTIFF'S VIEW

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A. What Malpractice Is, or Isn't

The term “malpractice” is nothing more, or less, than negligence on the part of a professional. Negligence is always the failure of one owing a duty to another to follow a course of conduct imposed by law. A “medical malpractice” claim arises when a health care professional, defined in N.C.G.S. §90- 21.11,¹ is negligent and, as a proximate result, the patient suffered injury.

Every health care provider is under a duty:

- to use his/her best judgment in the treatment and care of the patient;²
- to use reasonable care and diligence in the application of his/her knowledge and skill to the patient's care;³
- to provide health care in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time the

¹ “Definition - As used in this Article, the term “health care provider” means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital as defined by G.S. §131-126.1(3); or a nursing home as defined by G.S. §130-9(e)(2); or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction of or under the supervision of any of the foregoing persons, hospital, or nursing home.”

² *Wall v. Stout*, 310 N.C. 184, 311 S.E.2d 571 (1984).

³ *Id.*

health care is rendered.⁴

⁴ N.C.G.S. §90-21.12 provides: “Standard of health care - In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.”

The term “standard of care” is not well defined. The North Carolina Pattern Jury Instructions advises the jury: “In determining the standards of practice . . . you must weigh and consider the testimony of the witnesses who purport to have knowledge of those standards of practice rather than your own ideas and standards.”⁵ In other words, the standard of care will be defined, in each case, by the expert witnesses tendered by the parties.

Not every unfortunate result of medical treatment is malpractice. Sometimes it’s just bad luck, not bad medicine. Likewise, not every negligent act or omission on the part of a health care provider should result in a malpractice claim.

B. “Screening” the Case and the Potential Client – The Initial Evaluation

Always keep in mind that “case selection” is not our decision alone. More case selection is done by the clients than by us, as lawyers. The 1990 Harvard Medical Practice Study⁶ tells us that less than 10% of medical malpractice victims become involved in the legal process. We choose, then, from a very small percentage of potential plaintiffs who, in order to decide to hire a lawyer, must overcome a natural fear of the unknown, their distaste for the legal system, and their emotional blocks.

In this age of “tort reform” it is increasingly necessary for lawyers to aggressively screen cases

Never forget that there are two crucial aspects to every malpractice case: negligence (whether in the form of bad judgment, a deviation from the standard of care, or the failure to properly apply skill and knowledge), and injuries that result in damages. Without the presence of both there is no basis for a malpractice claim.

The **initial consultation** with the prospective client is crucial. Be sure to set aside plenty of time. There will be questions you will need to ask, but your primary activity at

⁵ N.C.P.I. - Civil 809.05

⁶ The Report of the Harvard Medical Practice Study, *Patients, Doctors and Lawyers. Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990) President and Fellows of Harvard College.

the initial meeting will be to listen. Your first impressions of the case, and of the client, are very important.

Because of the time and expense involved in preparing and presenting a malpractice claim, early evaluation of the client and the claim is crucial in order to avoid unpleasantness later. Bearing this in mind, there are certain basic questions to be addressed before a case should be accepted:

1. Did the potential defendant's actions constitute malpractice, or were the patient's injuries an unavoidable and unfortunate outcome? As a corollary, what kind of liability is involved?
2. If there is evidence of malpractice, was the patient's injury the proximate result of the malpractice, or is there another medical explanation?
3. What is the applicable statute of limitations?
4. Will a reputable expert be willing to testify to the fact that there was malpractice?
5. Are the damages resulting from the malpractice sufficiently large to warrant the time and expense involved in the proper preparation and handling of the case?
6. Are there any "red flags" indicating problems with the case, or with the client?

What is the applicable Statute of Limitations? Even the best case is worthless if it is time barred. Either the statute of limitations and the statute of repose can bar a case.

For any personal injury claim (including malpractice) the general three year limitations period set in N.C.G.S. §1-52(16). However, in malpractice actions there are other limitations which must be met.

In the case of a foreign object left in the body following surgery, the limitations period is one year from the date of discovery, but in no event may an action be commenced more than 10 years from the date of the last negligent act or omission of the defendant.

N.C.G.S. §1-15(c)

If discovery of the malpractice is two or more years after the occurrence, suit must

be brought within one year of discovery. In no event shall an action be commenced more than four years from the date of the last negligent act or omission of the defendant.

N.C.G.S. §1-15(c)

If the injured party is a minor, and the above limitations periods expire before the minor reaches the full age of 19 years, the action may be brought at any time before the minor reaches the full age of 19 years. N.C.G.S. §1-17(b).

If the patient has died, the wrongful death limitations periods will apply, as well. Generally, wrongful death claims are barred two years from the date of death, provided that whenever the decedent would have been barred from bringing a personal injury action, had he/she lived, by the three year statutes, above, no action for wrongful death may be brought. N.C.G.S. §1-53(4).

In the unusual case that the claim is based on a battery, subject to the above exceptions applicable to malpractice actions, the applicable limitation period is three years. N.C.G.S. §1-52(19).⁷

It is not always easy to determine exactly when the limitations period will begin to run. Where a health care provider continues to provide treatment, continuously, for the injuries giving rise to the claim, even after the original negligent act or omission, the statute of limitations begins to run at the conclusion of the course of treatment by the health care provider. This is the **continued course of treatment doctrine**. See, *Horton v. Carolina Medicorp, Inc., et al.*, 119 N.C. App. 777, 460 S.E.2d 567 (1995).

Was there malpractice? This is truly the threshold question to be addressed before accepting a potential medical negligence case. It goes without saying that, absent evidence of legal liability, there is no case, regardless of the medical outcome of the treatment involved.

Because of the cost, in time and money, of preparing and prosecuting a medical malpractice claim, it is seldom worth a “roll of the dice” on a case in which, although the severity of injury and potential for damages are great, there is a lack of clarity of liability.

⁷ Former N.C.G.S. §1-54(3) provided for a one-year limitation period. This has been recently changed and the applicable limitation is now three years.

Most cases in which there is genuine doubt about the liability of the defendant, even when there is an expert willing to testify that there was a breach of the standard of care, should be declined. Consider, for example, an obstetrical case in which there is neonatal brain damage and the reviewing expert says he/she would be willing to testify that there was a breach of the standard of care. The lawyer must think long and hard about the likely difficulty of presenting the case to the jury. Is the reviewing expert being too much of an advocate and placing the lawyer in the position of accepting a case with borderline liability? While the expert may believe the case to be justified, there may be a lack of important records which complicate presentation of the case. Are there fetal monitoring strips that show continuous periods of fetal distress? Does the hospital record contain notes that indicate fetal distress or the presence of meconium? If there is no documented evidence of fetal distress which required a response, it may not be possible to convince an already dubious jury that the doctor was negligent unless the record itself is so incomplete that it indicates negligence in monitoring.

Nevertheless, if the lawyer is so enamored of the potential damages in the case that he/she is willing to accept it and move forward, he/she must do so with the realistic expectation of spending a lot of time and money on the case for an uncertain return.

How does one go about deciding that there is enough clear evidence of malpractice to accept the case?

Investigation begins with detailed fact gathering from the client and the client's family. Be sure and establish a cogent sequence of events. When did the first signs or symptoms arise? When was the patient first seen by a health care provider for the condition? Get a complete medical history and **do not always trust what the potential client tells you** about his/her medical history. The history should be as detailed as possible and then corroborated by medical records, if possible.

Do not be misled by the potential client telling you that a subsequent treating physician told him/her that malpractice had occurred and urged him/her to get a lawyer. There may be cases where that has happened, but the cases in which the subsequent treater is willing to say so, on the record, are rare. Statements such as "If I had seen you before

this stage of your disease, the outcome would be different” or “There is no way this condition should have been treated this way” or “I have never seen a scar as bad as that one, how could he ever have done that” rarely show up in the records or in the memory of the doctor who supposedly uttered them.

The initial interview should leave you with some feeling about whether the case should be taken to the next step, which is obtaining the medical records for a review.

The initial interview with the client should sufficiently guide you in identifying the records needed. This included both hospital and physician records. Remember that the client must sign a HIPAA-friendly authorization to allow you to obtain the records. When obtaining hospital records, do not be tempted to be selective in what records you want. Get the entire chart. Even though much of what you get will likely be ultimately irrelevant, there is no way of knowing this before you get, and read, the records. You should also be aware that even if you request an entire chart from a treating physician, or the potential defendant, you are not likely to get anything but office notes, lab and radiology reports, and perhaps a medication record. If you don't ask specifically for the doctor's intake or patient questionnaire, you are unlikely to get it. You are also unlikely to get copies of any other health care provider's records that have been sent to the doctor, and kept in the patient's chart. Many doctors do not consider these documents to part of “their” chart and are reluctant to send them.

Once the records are in hand, they must be reviewed, not only for evidence of liability, but also for evidence of causation.

The type of liability will also have an impact on whether the case is one which should be undertaken. Some cases are easier to prove than others. A claim arising out of a failure to follow up on a post-operative complication could be tried with only one expert. By contrast, a birth trauma case will involve the use of many experts, such as an obstetrician, a pediatric neurologist, an obstetrical nurse, a placental pathologist, a life care planner, an economist, a geneticist, a neuroradiologist, and maybe more than one of each.

Finally, in looking at the liability, what was the “horror factor,” if any. If the negligence was particularly egregious, or if the injuries are viscerally appalling, that, too,

must be taken into account.

If there was negligence, did it cause the problem? An experienced malpractice lawyer can often review records for the purpose of ruling out either liability or causation. The first step in a records review is to determine what the records reveal about the cause of the injury. First, look at the Admission History and Physical and the Discharge Summary. These documents will itemize the patient's condition at the time of admission and at the time of discharge. If there is a medical condition which arose during the hospitalization, that should be reflected on the Discharge Summary. If it is not, look carefully at the Nurses Notes and Physician's Orders to see if there is a condition described, but not documented subsequently. The onset of the complaint should be correlated with the Progress Notes and the Nurses Notes. There may be notes within the record indicating a course of treatment or therapy which was related to the patient's condition, and notes following the treatment indicating the patient's complaints. This may establish the necessary nexus between the treatment and the patient's complaint, although it may not necessarily establish negligence.

Many law offices employ one or more medical professionals, such as a nurse, to help in the review of the case. You can also contract with such professionals on a case by case basis. These professionals can prepare a chronology of treatment and complaint, as well as offer suggestions concerning both liability and causation. There are also services available for this purpose and many of them are quite good. They tend to be more expensive, however, and, in my experience, may be more biased toward finding liability or causation if they perceive that's what they're being paid to do. If you want to use such a service, get a recommendation from an experienced malpractice lawyer before spending the money.

If it is not clear that the condition was caused by the negligence of the provider, then the case must be treated in the same manner as the case in which there is lack of clarity of liability. If the client's condition could have been caused by something other than the alleged negligent act or omission, and the other cause is as likely to be culprit as the negligence, the case should probably be avoided. Bear in mind, however, that even in

cases in which causation is manifest, there is likely to be a defense of lack of causation.

A medical malpractice lawyer must be willing to educate him/herself about the relevant medicine of the case. If you don't have a library of medical texts in your office, go to the nearest medical school or AHEC library to read about it. Learn to do internet research. Attached to this paper is an Appendix of internet sites that may be helpful in your "medical education."⁸

Will an expert testify? Once the lawyer is sufficiently familiar with the relevant medicine, and has a working knowledge of the facts of the case, the decision can be made to send (or not) the records to one or more experts for review. Expert consultation and review is discussed below in more detail. Suffice it to say that, for the plaintiff, one of the most difficult problems in the case may be obtaining a qualified and respected expert to review the case and give an appropriate opinion.

Without an expert opinion that there has been a breach of the standard of care, or that the potential defendant did not use reasonable care and diligence in the application of his/her knowledge and skill to the patient's care, there is no case. Further, an expert opinion to the effect that there was no negligence in the patient's care can save the lawyer untold hours of work and thousands of dollars spent in an uncertain cause.

If the reviewing expert is to testify at trial, he/she should not only meet the qualifications test imposed by NCRE 702 and NCRCP 9(j), the expert should also be well respected in his/her specialty. Be very cautious about using a service to locate an expert and about using a "well traveled" expert. If the defense does not respect your experts, it will be very difficult to get the case settled.

Rule 702, N.C. Rules of Evidence, imposes limitations on the type of experts who can give standard of care testimony against a defendant health care provider. A standard of care expert must:

- specialize in the same specialty as the defendant or specialize in a similar specialty which includes the performance of the procedure at issue and have

⁸ See "Appendix A", attached

prior experience treating similar patient;

- during the year preceding the date of the occurrence, devoted a majority of his/her professional time to either:
 - the active clinical practice of the same profession or specialty, or
 - the instruction of students in the same profession or specialty.

I suspect this rule was enacted to prevent doctors who had retired from supplementing their retirement income with expert witness fees, although a *recently* retired doctor should be able to do so, at least for a little while. Another likely purpose of the rule was to prevent, for example, a family practice doctor from testifying against a neurosurgeon. Overall, it's not a bad rule, but the devil is certainly in some of the details.

In *FormyDuval v. Bunn*, 138 N.C. App. 381, 530 S.E.2d 96, disc. rev. denied, 353 N.C. 262, 546 S.E.2d 93 (2000), the defendant was a "general practitioner," who had completed medical school and one year of residency. He was not certified by any specialty board. Plaintiff offered three experts. One of these experts, also not board certified, had worked for several years in the emergency department of a hospital, not in a general practice. The other two experts were board certified, one in oncology and the other in emergency medicine and family practice. The emergency physician was not allowed to testify because he failed to meet the requirement of being in a similar clinical practice or teaching. The other two were disqualified as being "specialists" and therefore lacking the requirement of having the same level of training and experience as the defendant.

The next year, the Court of Appeals decided *Edwards v. Wall*, 142 N.C. App. 111, 542 S.E.2d 248 (2001). In *Edwards* the defendant doctor was a pediatrician. Plaintiff's expert was board certified in pediatrics and also in the subspecialty of pediatric gastroenterology. The trial court, relying on *FormyDuval*, disqualified plaintiff's expert. On appeal, the court found that, since the plaintiff's expert was board certified in pediatrics, just like defendant, and had prior experience treating similar patients (i.e., children suffering from appendicitis), he was qualified to testify as an expert and reversed the trial court. The court also noted that it found no case law holding that Rule 702 requires that an expert and the physician defendant work in exactly the same practice

setting. See also, *Sweatt v. Wong*, 145 N.C. App. 33, 549 S.E.2d 222 (2001), in which the trial court, over defense objections, allowed the testimony of a general surgeon, who also had certification in laparoscopic surgery. The witness was also the director of the emergency department at Duke University and had experience diagnosing patients who, after surgery, had signs and symptoms similar to those of the deceased. Defendants argued on appeal that, since the witness was an emergency physician, he was not qualified to testify against the defendant general surgeons. The court found that there was evidence the witness engaged in the same diagnostic procedures as did defendants and had an active clinical practice including diagnosing patients with post-abdominal surgery complications. Thus, he was properly qualified.

These are only some of the problems confronted in trying to get the right fit for expert testimony. If an expert is to testify on the applicable standard of care, he/she must be able to demonstrate some familiarity either with the specific community in which the malpractice occurred, or one similar to it.

The poster child for the pitfalls of the “locality rule” is *Henry v. Southeastern OB-Gyn Associates*, 142 N.C. 561, 550 S.E.2d 245 (2001). In this New Hanover County case, plaintiffs tendered a single expert witness who was from Spartanburg, South Carolina. The witness was excluded, after which the trial court directed a verdict for the defense. Plaintiffs argued that, while the witness was unfamiliar with the medical community in Wilmington, N.C., he could still testify to the prevailing standard of care there because he was familiar with the “national” standard of care. Further, he had testified that he was familiar with the standard of care in Spartanburg, which would be the same standard applied at Duke or UNC Hospitals. This testimony was elicited at the witness’ pretrial deposition. Plaintiffs did not submit any affidavits or supplemental discovery between the time the doctor was deposed and when his testimony was offered at trial. The court held that the expert failed to make the necessary connection to the community in which the alleged negligence took place.

Just as the courts do not recognize a “national” standard of care, they do not recognize a “statewide” standard of care. In *Tucker v. Meis*, 127 N.C. 197, 487 S.E.2d 827

(1997), plaintiff's expert testified that he was familiar with the standard of care in North Carolina. However, he failed to make the required connection to the community in which the alleged negligence occurred or a similar community. The testimony was excluded.

In *Leatherwood v. Ehlinger*, 151 N.C. App. 15, 564 S.E.2d 883 (2002), a shoulder dystocia case, plaintiff's expert, licensed in South Carolina and Alabama, practiced in Greenville, South Carolina and had practiced in communities in Alabama and Mississippi which were similar in size to Asheville, North Carolina (where the case was tried). He specifically testified that "Asheville and other communities that size practice in the same national standards" with respect to the management of shoulder dystocia. The court found that he made the statutorily required connection to the community where the malpractice occurred or to a similarly situated community and could therefore testify. Thus, the fact that the expert believes a national standard exists does not necessarily exclude his/her testimony. It will be received as long as the expert can make the required connection to the community in question, or similar communities.

In a later section of this manuscript we will discuss how to prepare the expert to meet the "same or similar community" test.

How do you find a good witness? Given the importance of the expert in medical negligence cases, the lawyer should find the most capable individual with regard to reputation, clinical and academic accomplishment, knowledge, communication skills, reliability, availability and affability. This can be a real challenge, but it is an absolute necessity. There are a number of places to look.

If you follow case reports in *North Carolina Lawyers' Weekly* expert witnesses are often identified. You can ask around for suggestions from fellow lawyers. If you have done medical research, you will have seen journal articles or other literature on the relevant subject matter. These authors, who have expressed opinions in writing or who have clear relevant experience may be willing to review and testify. If not, they may be willing to give you other names to contact.

The internet is another source for potential experts. In doing your medical research, note the names and locations of the authors of the articles you read. Of course,

locating experts this way means you will be contacting them “cold,” which is harder than calling the last person you used, or using a service. However, if you are successful you are more likely to find someone the defense will respect. You can also check the web sites of medical schools and large hospitals.

Obviously, the prime candidate is one who has written on the medical issues involved in your case. Sometimes, particularly in today’s environment, you might get the cold shoulder, but the interest of an academic may be piqued if, when you call or write, you mention his/her article. Having read, and referred to, the doctor’s article makes him/her more likely to respond. I suggest that, when you contact the doctor’s office, you establish a relationship with the doctor’s assistant or secretary. He or she will know whether the doctor might be interested in helping and will know the doctor’s history with regard to reviewing cases.

There are also many services available to lawyers. These services will, for a fee, locate one or more witnesses which may (or may not) fit our specific criteria. This will add to the expense of the case and if the witness is associated with a service, he/she will probably face some cross examination on that point.

I suggest you avoid witnesses who advertise their services.

Medical school faculty make pretty good witnesses. They always come equipped with impressive credentials and they are teachers by profession. A witness who can “teach” the jury, by explaining medical concepts in lay terms, is an invaluable asset at trial.

Don’t assume, simply because the potential expert has an impressive CV, that he/she is the best expert for your case. Jurors are not, in my experience, overly impressed or influenced by the mere fact that a doctor has written or lectured extensively. They really want someone who sounds like he/she has a good degree of common sense and can teach them what they need to know to make their decision.

A witness “from the trenches” can be extremely effective, as long as he/she can stand up during cross examination, understand the nature of plaintiff’s burden of proof, and remain firm in their opinions. Don’t shy away from a possible witness simply because

he/she has not testified before. As long as the witness can communicate effectively, this lack of experience can lend credibility to the case.

Is the case worth taking? Just like resolving issues of liability and causation, an objective assessment of the potential value of the case is an important element in the screening process. A melancholy situation can arise after a recovery in which, after payment of expenses and legal fees, there is little left for the client.

No case should be accepted unless the injury incurred is serious enough to warrant a recovery large enough to cover expenses, adequately compensate the lawyer, and satisfy the client. Handling cases on a contingency fee mandates careful assessment of liability and damages at the earliest moment.

Expenses can be estimated with some degree of accuracy. It is difficult to imagine a malpractice case that would not involve a minimum of \$20,000 to \$30,000 in out of pocket expenses and in some cases the expenses can exceed \$100,000. Unless you are in a very unusual situation, you will not see many clients who can finance their case. A lawyer handling malpractice cases should set a minimum value threshold, below which he/she will not accept employment. Of course, this doesn't mean every case with potential recovery over the minimum should be accepted, or that it would be a mistake to take on a case where the anticipated recovery is less than the threshold. Given the current trend, you must assume from the outset that the case will go to trial. At the very least, it will require filing suit, disclosing witnesses, attending and taking numerous depositions, and getting to mediation before the case will be resolved.

Unfortunately, this means that there are many otherwise meritorious cases which must be declined, simply because the possible recovery will not justify the cost involved.

What are the "red flags?" The presence of a "red flag" does not mean that you should not take a case. It does mean that you should proceed with caution.

The client with unreasonable expectations: Disappointment is almost always a function of expectation. If a client insists that the case has value well beyond what is reasonable, you are unlikely to dissuade him/her from that opinion. Any recovery less than what this client wants or expects will be disappointing and, no matter how well you

represented him/her, it will be your fault. Avoid the client whose focus is more on the money than the facts of his/her case.

The client with “outside” advisors: This is the client who will follow the advice of some trusted family friend or business associate, not that of his/her lawyer. This client is also typically one with unreasonable expectations.

The angry client: A certain degree of anger at his/her situation is understandable, but when a client’s level of anger against the defendant strikes you as extreme, it probably is and this client will not want to follow your advice if he/she perceives the alternative as inflicting injury on or punishing the defendant. The client must accept that a medical malpractice case is a poor vehicle for vengeance. It is unlikely to produce a public apology, or even a recognition of wrongdoing. It may actually have the salutary effect of bringing some change in some courses of conduct, but there is no guarantee that will happen.

The client whose case has already been declined: This is the client who brings in all the medical records and a letter from another lawyer declining the case. We sometimes see clients who have been turned down by several lawyers. As a rule, if a client has been turned down once, we don’t worry too much about it, but we will call the lawyer who declined the case to see if he/she really was “too busy” or had a conflict. If the client has already consulted several lawyers, he/she probably has no case.

Be very cautious when a client tells you “Lawyer X told me I had a great case, but he’s too busy to take it on right now.” If it truly is a great case, Lawyer X will find the time for it.

The client who “knows it all:” This is the client who will argue with you every time you try to discuss a potential weakness in the case. This client is convinced that, if only the jury can hear the case, success is assured. He/She knows of many cases, “just like this,” or where there was a huge recovery for minimal injury and will not accept an evaluation of his/her case that is not mind-boggling.

The unlikeable client: If you don’t like the client, neither will the jury.

The noncompliant client: There are actually two clients in this category. The

client who fails to cooperate with the lawyer in the preparation of the case, and the client whose medical records indicate significant noncompliance with medical advice and treatment. In the first instance, the client will make it more difficult to properly prepare the case. In the second instance, the case will be open to attack from the defense.

Of course, there are other red flags, but these are the most representative.

C. The Need/Benefits of Expert Consultation and Review

It is the rare medical negligence case in North Carolina that will not require the services of one or more expert witnesses. N.C.G.S. §1A-1, Rule 9(j) states, in pertinent part:

(j) *Medical malpractice.* – Any complaint alleging medical malpractice by a health care provider as defined in G.S. 90-21.11 in failing to comply with the applicable standard of care under G.S. 90-21.12 shall be dismissed unless:

(1) The 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 and who is willing to testify that the medical care did not comply with the applicable standard of care;

(2) The pleading specifically asserts that the medical care has been reviewed by a person that the complainant will seek to have qualified as an expert witness by motion under Rule 702(e) of the Rules of Evidence and who is willing to testify that the medical care did not comply with the applicable standard of care, and the motion is filed with the complaint; or

(3) The pleading alleges facts establishing negligence under the existing common-law doctrine of *res ipsa loquitur*.

The constitutionality of this rule has been challenged in *Anderson v. Assimos*, 146 N.C. App. 339, 553 S.E.2d 63 (2001) the Court of Appeals found the rule violated Article I, Section 18 of the North Carolina Constitution and the Equal Protection Clauses of the North Carolina and United States Constitutions. On appeal, the Supreme Court, in a Per Curiam opinion, dismissed that portion of the appeal, finding that the underlying complaint alleged *res ipsa loquitur* as the sole basis for the negligence claim and that the

constitutional challenge had not been properly raised below. The Court thus declined to address the constitutionality of the rule. *Anderson v. Assimios*, 356 N.C. 415, 572 S.E.2d 101 (2002). For the time being, lawyers bringing lawsuits alleging a breach of the standard of care must comply with the rule.

As a practice note, in making the required certification it is recommended that a constitutional challenge be included, thus preserving the constitutional issue for appeal, if necessary.

It should be noted that Rule 9(j) is worded so that it would seem to apply *only* to those claims in which the negligence is alleged to consist of a breach of the standard of care. There are, of course, other bases for malpractice claims, including the failure of defendant to use his/her best judgment in the treatment and care of patients and the failure to use reasonable care and diligence in the application of his/her knowledge and skill to the patient's care.⁹

Notwithstanding whether the rules require pre-filing certification, unless there is a pretty clear case of *res ipsa loquitur* (and those are rare), experts will be needed simply because there is no other way to determine not only the applicable standard of care, but also whether or not the defendant used good judgment or exercised reasonable care and diligence in the treatment of the patient.

⁹ See footnotes 2 and 3, *supra*

A distinction should be made between experts retained to be used as witnesses, and those retained for consultation only. This is an important distinction because opinions, suggestions, advice or other work done by those who are consultants only are unlikely to be discoverable.¹⁰ *Mack v. Moore*, 91 N.C. App. 478, 372 S.E.2d 314 (1988), appeal dismissed and cert. denied 323 N.C. 704, 377 S.e.2d 225 (1989).

A consulting expert is just that. He/She will not be expected to testify, but will act only as an “advisor” to the lawyer. Preferably, this consultant is near at hand, or easily contacted by telephone. He/She can explain medical issues and help the lawyer prepare for deposing defense experts.

Of course, a single expert can fulfill both functions, and usually does. Great care should be taken to make sure the expert understands the duality of his/her role and that any matter constituting work product or preparation for litigation is removed from the witness’ file before he/she testifies. Understand that the defense may make an issue of the removal of any material from the file. The expert should be prepared to testify that he/she did not rely on any of this material in forming his/her opinions in the case.

The question sometimes arises whether or not to get a written report from an expert retained to testify. Keep in mind that such a report is properly discoverable. If your expert subsequently changes his/her opinion based on evidence developed later, he/she may be subjected to some cross-examination on the changes, with the suggestion that the witness has changed his/her mind, or wasn’t confident of the original report. In cases where a change of opinion might be a good idea, the expert may be reluctant to do so, having already staked him/herself out.

Some lawyers will get a written report from the Rule 9(j) witness, so they will have something “in the file” to support having filed suit, even if that expert isn’t used later, or for some reason becomes unavailable or unwilling to testify.

If the basis of the claim is ordinary negligence, rather than malpractice, no Rule

¹⁰ Rule 26(b) (1) allows parties to discover only matters which are “not privileged.” Rule 26(b)(4) allows discovery of “facts known and opinions held by experts, *otherwise discoverable under the provisions of subsection (b)(1)*” of the rule.

9(j) certification is required. In *Lewis v. Setty*, 130 N.C. App. 606, 503 S.E.2d 673 (1998), a physician and plaintiff's personal assistant attempted to move plaintiff from an examination table back to a wheel chair. In the course of moving plaintiff, his hip was fractured. The court held that the doctor's actions in moving the patient did not constitute the rendering of professional medical services as it did not require specialized knowledge or skill and was predominantly a physical or manual activity. For that reason, Rule 9(j) did not apply to the claim because it sounded in ordinary negligence and not medical malpractice.

D. Pre-Litigation Checklist

Once the case is accepted and favorably reviewed, the case is ready to proceed to suit. Most of what happens next, at least procedurally, can be anticipated, so there are a few things to keep in mind:

- Make sure ALL of the client's medical records are on hand. The records should be kept together. It is a good idea to number pages for easy reference. There are software programs available to do this without the manual labor of Bates stamping every page. Just load the program and run the records through your printer (if you have a laser printer) and the pages will be numbered.
- Make sure you have a good, usable, chronology of the facts of the case. Again, software programs such as CaseMap make this much easier, linking facts to specific witnesses and exhibits.
- Make sure your experts are still on board. If you need additional experts, either on standard of care, causation, or damages, make sure you have them and that their work is completed. It won't be long after suit is filed before expert witness designation takes place and if a life care planner hasn't had sufficient time to complete his/her work, the whole case can be in trouble.
- Prepare the complaint. Make sure the complaint complies with the requirements of Rule 9(j).
- Prepare any discovery to be served with the complaint.

- You may assume the defense will automatically obtain an enlargement of time in which to answer.
- Once the answer is served, make plans to begin taking depositions of fact witnesses. You should depose any defendants as soon as practicable so that transcripts will be available to your experts before their depositions.
- Prepare YOUR proposed Discovery Scheduling Order. You will have to make changes, but it is usually better for your document to be the working document. Be aware the defense will want to stretch things out as much as possible, while, if your case is prepared, you should want to move things along quickly.
- Think about possible mediators for the case.
- Make arrangements for the preparation of exhibits for trial and/or mediation. Of course, this is not an exhaustive checklist.

E. Potential Areas of Liability – Theories and Causes of Action

The typical medical negligence case may involve issues of failure to diagnose, improper or negligent surgery, improper medication, and the like. There are, however, other theories that should be considered.

Corporate liability is discussed elsewhere in your materials. It would include hospital liability on grounds other than *respondeat superior*, corporate liability, and ostensible or apparent agency.

In thinking about the issues in the case, consider claims for **negligent or intentional infliction of emotional distress**. If your client is not the patient, there are several factors necessary for recovery. In North Carolina, a person who suffers severe emotional distress arising from concern for another person may recover damages if they can prove they ‘suffered such severe emotional distress as a proximate and foreseeable result of defendant’s negligence. *Hickman v. McKoin*, 337 N.C. 460, 462, 446 S.E.2d 80, 82 (1994). “Neither a physical impact, a physical injury, nor a subsequent physical manifestation of emotional distress is an element of the tort [known as] negligent infliction of emotional distress.” *Johnson v. Ruark Obstetrics*, 327 N.C. 283, 304, 395 S.E.2d 85, 97,

reh'g denied, 327 N.C. 644, 399 S.E.2d 133 (1990). The emotional distress must be severe, and it must be foreseeable that plaintiff would suffer emotional distress. In *Wrenn v. Byrd, 120 N.C. App. 761, 464 S.E.2d 89 (1995)* plaintiff's husband was released from the local emergency room after defendant diagnosed gastroenteritis. Fourteen hours later he was returned to the emergency room by another doctor, who diagnosed septic shock. He ultimately had both feet and one finger amputated due to the infection. Suit was brought by the plaintiff and her husband, but by the time defendants filed a summary judgment motion all claims had been voluntarily dismissed except plaintiff's claim for emotional distress. The trial court granted summary judgment, finding that plaintiff's psychologist had described her depression as "moderate" and therefore not "severe." Defendants also contended that her emotional distress was not foreseeable. On appeal, the court found that chronic depression, even though described as "moderate," constituted severe emotional distress. Since the plaintiff-wife was present for most of the time her husband was treated, and visited him daily in the hospital, seeing firsthand the disabling effects of defendants' negligence, it was foreseeable that she would suffer emotional distress at her husband's condition.

A species of emotional distress claim may arise when the defendant's negligent conduct creates a fear or anxiety about future disease. In *Bullock v. Newman, 93 N.C. App. 545, 378 S.E.2d 562 (1989)*, plaintiff alleged that defendant negligently failed to advise plaintiff of the results of a biopsy for nearly three months. Although a subsequent mastectomy was successful, and the delay apparently did not significantly alter plaintiff's medical condition or change her treatment, she nevertheless suffered from "cancerphobia," a fear that the cancer had spread or would recur.. The trial court granted defendant's motions for summary judgment but the Court of Appeals held that the complaint alleged a compensable injury.

Remember that a defendant must use the statutorily recognized methods of discovery set out in Rule 26 of the Rules of Civil Procedure. **Unauthorized releases** of a patient's medical records by a health care provider can give rise to a cause of action. *Jones v. Asheville Radiological Group, P.A., et al., 134 N.C. App. 520, 518 S.E.2d 528*

(1999).

North Carolina does not recognize a claim for “**wrongful birth.**” *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E.2d 528 (1985), but it does recognize a claim for “**wrongful conception**” in certain circumstances. For example, in *McAllister v. Ha*, 126 N.C. App. 326, 485 S.E.2d 84 (1997), plaintiffs consulted defendant for bloodwork to be tested for sickle cell disease. Defendant allegedly told them that if he did not call them, “there was nothing to be concerned about.” He didn’t call to inform them of the test results, which showed them both to be sickle cell carriers. Unaware of the substantial risk that any child born to them would be afflicted with the disease, they conceived and the child had sickle cell disease. The trial court, relying on *Azzolino*, dismissed the case for failure to state a claim for relief. On appeal, the Court reversed, drawing a distinction between “wrongful birth” on the one hand, and “wrongful conception” on the other. Whereas in *Azzolino* the child had already been conceived, and the plaintiff-parents contended that the doctors failed to advise them concerning amniocentesis and genetic counseling so they could decide whether to abort the baby, in *McAllister* the contention was that the failure to inform the parents of the positive test results prevented them from deciding whether or not to conceive in the first place.

As a partial response to hospitals’ practice of **patient dumping**, in which hospitals either sent a patient in need of care to another facility or simply turned the patient away due to his/her inability to pay for services, Congress enacted the Emergency Medical Treatment and Active Labor Act (**EMTALA**) in 1986. 42 U.S.C. §1395dd. The purpose of EMTALA was to insure that all patients, regardless of ability to pay, could receive medical treatment in emergency situations. EMTALA provides a cause of action for private plaintiffs. The statute imposes two obligations on hospital emergency departments: 1) when a patient seeks treatment at a hospital emergency room, the hospital must provide for an appropriate screening examination, and 2) if the screening examination reveals “an emergency medical condition,” the hospital must stabilize that condition before transferring or discharging the patient. *Trivette v. N. C. Baptist Hospital, Inc.*, 131 N.C. App. 73, 507 S.E.2d 48 (1998). There is a two year statute of limitations applicable to

EMTALA claims.

Since health care providers do not ordinarily insure the success of their treatment, actions for **breach of contract** or **breach of warranty** are rare. N.C.G.S. §90-21.13(d) requires a plaintiff to show a writing to prove a warranty, guarantee, or assurance as to the result of medical treatment or services. In *Jackson v. Bumgardner*, 318 N.C. 172, 347 S.E.2d 743 (1986), a case arising before the statutory requirement of a writing was enacted by the General Assembly, plaintiff-wife had an intrauterine device placed for birth control. She began to suffer abnormal uterine bleeding and consulted defendant for treatment. Plaintiffs testified that they discussed their financial situation with defendant and at their request he promised to replace the IUD if it became necessary to remove it during her D and C. He didn't. She got pregnant. She had a healthy baby. Plaintiffs sued, alleging not only malpractice but also breach of contract (the promise to replace the IUD). The Court ruled that plaintiffs could not recover damages for breach of contract, since her intent in consulting defendant was to seek treatment for her uterine bleeding and later for abdominal pain and it was for these conditions that defendant treated her. Any promise by defendant to replace the IUD was merely incidental to the "contract" by which he agreed to treat her medical condition.

Claims based exclusively on **lack of informed consent** are very difficult to win. N.C.G.S. §90-21.13(a) defines the parameters of a claim based on lack of informed consent. There are three enumerated instances when such a claim will not be allowed:

1. The informed consent obtained was in accordance with the applicable standards of practice;
2. A reasonable person would have a general understanding of the *usual and most frequent* risks and hazards inherent in the procedure; and
3. A reasonable person, under the circumstances would have undergone the procedure or treatment if the above two provisions were met.

Furthermore, the statute provides that a written consent, meeting the above provisions, signed by the patient is presumed to be valid, unless there is evidence of fraud, deception or misrepresentation of a material fact. N.C.G.S. §90-21.13(b). The patient or person

authorized to give the consent must be physically and mentally competent to give the consent. N.C.G.S. §90-21.13 (c).

In *Foard v. Jarman*, 93 N.C. App. 515, 378 S.E.2d 571 (1989) the patient suffered complications following gastric reduction surgery. The evidence showed that prior to the surgery defendant gave plaintiff a booklet that described the procedure and listed risks involved in the surgery. After reading the booklet, plaintiff elected to proceed with the operation. The claim alleged that defendant “failed to warn plaintiff of the seriousness of the surgical procedure” and the “failure . . . to reasonably disclose to her the various choices with respect to the proposed treatment and the dangers inherently and potentially involved in the treatment.” Defendant’s motion for summary judgment was granted.

On appeal, the court noted that the burden of proof was on the plaintiff to show that the consent was obtained in violation of subsection (a) of the statute, citing *Nelson v. Patrick*, 73 N.C. App. 1, 326 S.E.2d 45 (1985). In passing on the grant of summary judgment, the Court of Appeals noted a lack of evidence from defendant that he obtained the consent in accordance with the standard of care, or that a reasonable person would have had the surgery if adequately advised. For that reason, the trial court was reversed. Note that, at trial, the plaintiff still must carry the burden of proof imposed by the statute.

In *Osburn v. Sofamor-Danek, Inc., et al.*, 135 N.C. App. 234, 520 S.E.2d 88 (1999) where the use of a medical device had not been approved by the FDA, and was in fact experimental, the physician was not necessary under any obligation to disclose that fact in obtaining informed consent, since the statute requires disclosure only of the most frequent risks inherent in the use of the device. However, evidence that a device is experimental or investigative may give rise to a jury instruction that plaintiff’s are required to prove that such disclosure is demanded by the applicable standard of care. The court was apparently unimpressed with a requirement of the Food, Drug and Cosmetic Act that informed consent include disclosure of the investigational nature of the device. See also, *Estrada v. Jacques*, 70 N.C. App. 627, 321 S.E.2d 240 (1984).

In *Bowlin v. Duke University, et al.*, 108 N.C. App. 145, 423 S.E.2d 320 (1992) the court held that it was not a breach of the informed consent statute for the surgeon to fail to

advise the patient that a fourth-year medical student would participate in her surgery. Where plaintiff herself testified that, even if she had been told of the possibility of post-surgical infection, she would have proceeded with the surgery, anyway. This testimony established that any failure of disclosure of possible infection, even if negligent, was not a proximate cause of the patient's condition.

Any misrepresentation of fact in obtaining a patient's consent must be intentional, not merely negligent, in order to give rise to a claim under subsection (b) of the statute. *Liborio v. King*, 150 N.C. App. 531, 564 S.E.2d 272, cert. denied, 356 N.C. 304, 570 S.E.2d 726 (2002).

A health care provider is under no obligation to discuss or disclose his/her level of experience in performing the procedure in question as part of the duty to obtain informed consent. *Foard, supra*. However, if the surgeon intentionally misrepresents his/her level of training and experience, such misrepresentation might give rise to a claim under subsection (b) if a reasonable person would have declined the surgery but for the misrepresentation. If the patient asks, the physician must give an honest response. See *Jackson v. Kokemoor*, 199 Wis.2d 615, 545 N.W.2d 495 (1995) where a surgeon's lack of experience in clipping an aneurysm was admissible to prove lack of informed consent. However, where a physician was not a plastic surgeon and had no hospital privileges, he was not required to disclose that information to a patient. *Ditto v. McCurdy*, 947 P.2d 952 (Haw. 1997).

Ordinarily, disclosure of material risks inherent in a procedure is not dependent on the percentage of risk occurrence only, but must also consider the severity of a risk outcome should an alleged small risk materialize. See, *Ashe v. Radiation Oncology Associates*, *** (Tenn. App. 1998), holding that a risk of 1 to 2%, according to plaintiff's expert, of radiation injury to the spinal cord, resulting in paralysis, presented a jury question negating a directed verdict for the physician.

Res ipsa loquitur or, "the thing speaks for itself" can also give rise to a malpractice claim. This doctrine is addressed to those situations where the facts or circumstances accompanying an injury by their very nature raise a presumption of negligence on the part

of defendant. It is applicable when no proof of the cause of an injury is available, the instrument involved in the injury is in the exclusive control of defendant, and the injury is of a type that would not normally occur in the absence of negligence. *Grigg v. Lester*, 102 N.C. App. 332, 401 S.E.2d 657, cert. denied, 329 N.C. 788, 408 S.E.2d 520 (1991).

Our courts have frequently stated that the doctrine of *res ipsa loquitur* is inappropriate in the typical medical malpractice case, since the question of injury and facts in evidence are “peculiarly the province of the expert.” *Bowlin v. Duke University, et al.*, 108 N.C. App. 145, 423 S.E.2d 320 (1992).

Notwithstanding that, there are cases in which our courts have consistently applied the doctrine, most notably cases in which surgical devices are left within the surgical site. *Tice v. Hall*, 310 N.C. 589, 313 S.E.2d 565 (1984) [surgical sponge left in abdomen following hernia surgery]; *Hyder v. Weilbaecher*, 54 N.C. App. 287, 283 S.E.2d 426 (1981) [8½ -inch stainless steel wire imbedded in patient’s liver].

Applicability of the doctrine requires a showing that 1) the injurious result must rarely occur standing alone, and 2) the result must not be an inherent risk of the operation. *Parks v. Perry*, 68 N.C. App. 202, 314 S.E.2d 287 (1984).

A physician undertaking treatment of a patient, in the absence of an agreement limiting his/her services, is under a duty of continuing to treat the patient as long as the case requires his/her medical attention. A failure to meet this duty may give rise to a claim based on **abandonment**. Once initiated, the doctor-patient relationship continues until the patient no longer needs treatment, or until it is terminated by mutual consent of the parties, or by the patient’s discharge. A physician has a right to withdraw from treating a patient, so long as he/she gives the patient reasonable notice in order for the patient to obtain other medical care. *Tierney v. Univ. of Michigan Regents*, 257 Mich. App. 681, 669 N.W.2d 575 (2003). The essence of abandonment is unilateral, nonconsensual, termination by the health care provider. *Dicke v. Graves*, 9 Kan. App.2d 1, 668 P.2d 189 (1983). A physician who is employed only for a specific occasion or service is under no obligation to continue treatment thereafter. *Brandt v. Grubin*, 131 N.J. Super. 182, 329 A.2d 82 (1974).

APPENDIX A
USEFUL INTERNET SITES

American Medical Association	www.ama-assn.org	Location, specialties, education, address, and phone numbers for doctors nationwide
N.C. Medical Board	www.docboard.com	State medical licensure of doctors
Medscape	www.medscape.com	Medical news, literature and info
U.S. Food & Drug Adm.	www.fda.gov	Info on drug testing & approval
Medline	www.medline.com	Links to medical info and literature

Medical Matrix	www.medmatrix.org/ reg/login.asp	Ranked, peer reviewed annotated updated clinical medical resources
Health Hippo	www.hipp.finldaw.com	Comprehensive links relating to health & law topics
The Doctor's Page	www.doctorspage.net	Practicing doctors' webpage with wide range of resources for doctors & patients
The Medical Literature Guide	www.amedeo.com	Medical literature & updates on new articles published on topics you select
Cancer Web	www.graylab.ac.uk/ cancerweb/html	Information on many aspects of cancer investigation, treatment
Doctors' Guide to the Internet	www.doctorsguide.com	Source for peer reviewed literature, case studies, webcasts, & links to journals
Medical World Search	www.mwsearch.com	Links users to text from thousands of medical sites, with a thesaurus allowing search using phrases
Web/MedLit	www.webmedlit.com	Tracks 22 medical journals, which are updated regularly, allowing users to create queries that can be bookmarked
Centers for Disease Control	www.cdc.gov	Fact sheets, disease prevention & other

		health info; links to state, local health dept's
National Cancer Institute	www.nci.nih.gov	Info on gov't cancer initiatives & studies
National Center for Health Statistics	www.cdc.gov/nchs	Comprehensive source for nat'l statistics & trends
National Institutes of Health	www.nih.gov	NIH news; links to scientific resources & other health info, such as consumer health publications, clinical trials, hotlines, Medline, NIH Info Index
American Academy of Family Physicians	www.aafp.org	Family practice info, including consumer health database
American Academy of Pediatrics	www.aap.org	Info on pediatrics, including child safety
American Cancer Society	www.cancer.org	Types of cancer, prevention, treatment
American Dental Association	www.ada.org	Dental news, including research & clinical issues
American Heart Association	www.americanheart.org	Heart disease & its prevention, treatment, risk factors
American Hospital Association	www.aha.org	News, advocacy on issues affecting hospitals, including gov't regulation
MEDLINE	www.ncbi.nlm.nih.gov/PubMed	Search for articles by topic

MEDLINEPlus

www.nlm.nih.gov/medlineplus

Info on doctors,
hospitals,
organizations; medical
dictionary; searches by
topic

OncoLink

www.oncolink.org

Cancer types,
specialists, clinical
trials

For a more comprehensive list, feel free to visit my website, www.horsleylawfirm.com, and go to “Resource Links.”