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Setting the Bar in North Carolina Medical Malpractice Litigation: Working with the Standard of Care That Everyone Loves to Hate

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INTRODUCTION

In January 2008, the Supreme Court of North Carolina was poised to review two medical malpractice cases,[1] *O'Mara v. Wake*

1."[T]he term 'medical malpractice action' means a civil action for damages for personal injury or death 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 (2009).

Forest University Health Sciences[2] and *Crocker v. Roethling*.[3] The court was reviewing each case on the issue of whether an expert witness was appropriately qualified to testify on the relevant standard of care required of the defendant-physician.[4] These cases epitomized the confusion surrounding the North Carolina requirement that expert witness testimony in medical malpractice cases speak to whether the defendant breached the standard of care for a doctor in the "same or similar communit[y]."[5] This confusion stemmed from decisions of the North Carolina Court of Appeals in *Henry v. Southeastern OB-GYN Associates*[6] and *Pitts v. Nash Day Hospital, Inc.*[7] These cases reinforced the requirement of section 90-21.12 of the General Statutes of North Carolina that an expert must be familiar with the standard of care in the defendant-physician's medical community, or a community similar to the defendant-physician's medical community.[8] Likewise, the cases emphasized that knowledge of a national or statewide standard of care, by itself, is not adequate to qualify an expert to testify in a North Carolina medical malpractice trial.[9] As a result of these decisions, North Carolina courts have since stringently applied section 90-21.12 in establishing that an expert witness is qualified to testify on the appropriate standard of care.[10]

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2. 184 N.C. App. 428, 646 S.E.2d 400, *disc. review granted in part*, 362 N.C. 85, 659 S.E.2d 1 (2007), *and disc. review improvidently allowed by* 363 N.C. 117, 678 S.E.2d 658 (2009).

3. 184 N.C. App. 377, 646 S.E.2d 442, 2007 N.C. App. LEXIS 644 (2007) (unpublished table decision), *rev'd*, 363 N.C. 140, 675 S.E.2d 625 (2009).

4. Specifically, *O'Mara* was reviewed, in part, on the issue of whether expert testimony was correctly excluded when the expert answered affirmatively when asked by defense counsel during the discovery deposition if he was applying a national standard of care. *O'Mara*, 184 N.C. App. at 435, 646 S.E.2d at 404. Similarly, *Crocker* was reviewed on whether summary judgment for the defendants was proper due to the expert failing to sufficiently establish knowledge of the standard of care in Goldsboro, North Carolina. *Crocker*, 2007 N.C. App. LEXIS 644, at *7–8.

5. N.C. GEN. STAT. § 90-21.12 (2009). This Comment refers to the standard of care imposed on physicians in North Carolina by section 90-21.12 as the "same or similar community" standard of care.

6. 145 N.C. App. 208, 550 S.E.2d 245, *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

7. 167 N.C. App. 194, 605 S.E.2d 154 (2004), *aff'd per curiam*, 359 N.C. 626, 614 S.E.2d 267 (2005).

8. *See Henry*, 145 N.C. App. at 212, 550 S.E.2d at 248; *Pitts*, 167 N.C. App. at 197, 605 S.E.2d at 156.

9. *See Henry*, 145 N.C. App. at 212, 550 S.E.2d at 248; *Pitts*, 167 N.C. App. at 197, 605 S.E.2d at 156.

10. *See, e.g.*, Purvis v. Moses H. Cone Mem'l Hosp. Serv. Corp., 175 N.C. App. 474, 480–81, 624 S.E.2d 380, 385 (2006) (upholding summary judgment for the defendants for failure of plaintiff's expert witness to qualify to testify on the standard of care required by § 90-21.12); *see also* Mark McGrath, *Back to the Horse and Buggy Days: North Carolina*

After *Henry* and *Pitts*, however, confusion remained over how to establish the expert's familiarity with the standard of care of a "same or similar community," as required under section 90-21.12.[11] This ongoing confusion came from the fact that no clear guidelines had been established to enable lawyers to know with certainty whether a medical community was the same as or similar to the medical community in which a defendant-physician practiced, and thus that an expert witness was qualified to testify on the relevant standard of care in a North Carolina medical malpractice case.[12] As was evident from the multitude of cases progressing from the trial courts to the court of appeals on the issue of whether the expert witness was qualified to testify on the standard of care, the meaning of same or similar community and the prerequisites for establishing that an expert actually knew the standard of care in a community were far from clear.[13] Thus, when the Supreme Court of North Carolina granted discretionary review for *O'Mara*[14] and *Crocker*,[15] there appeared to be

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Courts Harken a Return to the 'Locality Rule' in Medical Malpractice Cases, N.C. LAW. WKLY., Jan. 31, 2005, at 12, 12 (describing how a "narrowing" of North Carolina courts' application of the "same or similar community" standard began after the North Carolina Court of Appeals decision in *Henry*). This will be discussed more in depth in Part I.

11. *See* Mark Canepa, *Making Your Way Through the Minefield of Expert Witness Selection in Malpractice Cases in North Carolina*, N.C. ST. B.J., Winter 2005, at 6, 6–8 (describing the lack of a "working definition" of the standard of care for medical malpractice cases in North Carolina).

12. *See id.* at 6–7.

13. *See id.* at 7 (portraying § 90-21.12 as "a minefield for lawyers on both sides of the bar, leaving a trail of summary judgments, directed verdicts, and reversed decisions in its wake"); *see also* Barringer v. Wake Forest Univ. Baptist Med. Ctr., 197 N.C. App. 238, 251, 677 S.E.2d 465, 474 (2009) (reversing the trial court's grant of summary judgment for "all claims which depended on the testimony" of an expert witness found unqualified to testify on the relevant standard of care); Crocker v. Roethling, 184 N.C. App. 377, 646 S.E.2d 442, 2007 N.C. App. LEXIS 644, at *1 (2007) (unpublished table decision) (affirming the trial court's grant of summary judgment for the defendants), *rev'd*, 363 N.C. 140, 675 S.E.2d 625 (2009); *Purvis*, 175 N.C. App. at 480, 624 S.E.2d at 385 (affirming the trial court's exclusion of an expert witness when the expert became familiar with the community in question based on Internet materials dated four years after the incident giving rise to the litigation); Treat v. Roane, 179 N.C. App. 436, 634 S.E.2d 273, 2006 N.C. App. LEXIS 1875, at *18 (2006) (unpublished table decision) (finding no error in the trial court's exclusion of plaintiff's medical expert testimony for the expert's failure to meet the requirements of § 90-21.12 "to establish the applicable standard of care"); Leatherwood v. Ehlinger, 151 N.C. App. 15, 22–23, 564 S.E.2d 883, 888 (2002) (reversing the trial court's grant of summary judgment for the defendants after finding that the expert witness was sufficiently familiar with the standard of care in Asheville, North Carolina).

14. O'Mara v. Wake Forest Univ. Health Scis., 362 N.C. 85, 659 S.E.2d 1 (2007) (granting discretionary review), *disc. review improvidently allowed by* 363 N.C. 117, 678 S.E.2d 658 (2009).

15. Crocker v. Roethling, 361 N.C. 691, 654 S.E.2d 250 (2007) (granting discretionary review).

a "golden opportunity" for the court to clarify section 90-21.12's requirements and application, and to "restore sanity to an area of law that has suffered for too long beneath a shroud of confusion."[16]

However, the Supreme Court of North Carolina fell short of establishing a clear guide for qualifying an expert to testify under section 90-21.12. In *O'Mara*, the Supreme Court ultimately determined that discretionary review was improvidently allowed and did not decide the matter.[17] In *Crocker*, the court reversed the trial court's grant of summary judgment for the defendants and remanded the case to the trial court.[18] The opinion did not clarify the pervasive question of how to satisfy section 90-21.12's requirement that an expert witness in a medical malpractice case testify on the standard of care of the "same or similar community."[19] *Crocker* ultimately returned to the Supreme Court of North Carolina with a petition for writ of mandamus, which the high court denied.[20] Thus, the court, in effect, "punted" on this issue. As a result, the question of how to establish that an expert is qualified to testify about the standard of care in the defendant doctor's community was left open.[21]

The "same or similar community" approach under section 90-21.12, with clarification, can be effectively and efficiently implemented by requiring an expert witness to demonstrate his familiarity with the defendant's medical community, or a community established as being similar, and showing how that familiarity enables the expert to ascertain the relevant standard of care. Showing that the expert witness is actually familiar with the medical community at issue will ensure that the expert is truly qualified to testify on the applicable standard of care.[22] In addition, doing so will guarantee that physicians are held to a standard that takes into account the realities of their medical communities.[23]

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16. Mark McGrath, *Sanity Restored? N.C. Supreme Court to Revisit 'Same or Similar Communities' Standard*, N.C. LAW. WKLY., Jan. 14, 2008, at 3, 3.

17. O'Mara v. Wake Forest Univ. Health Scis. 363 N.C. 117, 117, 678 S.E.2d 658, 658 (2009).

18. Crocker v. Roethling, 363 N.C. 140, 149, 675 S.E.2d 625, 632 (2009).

19. *See Crocker*, 363 N.C. at 147, 675 S.E.2d at 631 ("[There is no] particular method by which a medical doctor must become 'familiar' with a given community. Many methods are possible, and our jurisprudence indicates our desire to preserve flexibility in such proceedings.").

20. Crocker v. Roethling, No. 374PA07-3, 2009 N.C. LEXIS 891, at *1 (N.C. 2009) (dismissing petition for mandamus).

21. *See Crocker*, 363 N.C. at 147, 675 S.E.2d at 631.

22. *See infra* Part III.B.

23. *See infra* Part III.C.3.

In contrast to section 90-21.12, which takes the defendant's medical community into consideration when determining the relevant standard of care, a national standard of care looks at whether a physician's actions failed to meet the "level of care, knowledge, and skill that reasonably competent physicians in the national medical community would ordinarily exercise when acting in the same or similar circumstances."[24] Though some argue that a national standard of care should be imposed in North Carolina,[25] a national standard of care is not necessary to appropriately resolve medical malpractice claims or to resolve the confusion surrounding qualifications for expert witnesses to testify on the relevant standard of care in North Carolina.

Part I of this Comment provides background information on section 90-21.12 and the current state of the law in North Carolina regarding qualifying expert witnesses in a medical malpractice claim.[26] Part II discusses and responds to arguments for imposing a national standard of care, which would disregard the North Carolina "same or similar community" standard of care.[27] Part III explores why a national standard of care and alternative methods are not the appropriate remedy for North Carolina medical malpractice law and

24. 61 AM. JUR. 2D *Physicians, Surgeons, & Other Healers* § 202 (2010).

25. *See* McGrath, *supra* note 10, at 13 (arguing that "the time has come to scrap the same or similar communities standard altogether").

26. A plaintiff must show four distinct elements in order to successfully litigate a medical malpractice claim. *See* THOMAS W.H. ALEXANDER ET AL., NORTH CAROLINA TORT LAW, 2000, at 555 (2000). First, she must establish the standard of care. *See id.* Second, she must demonstrate a breach of that established standard by the defendant. *See id.* Third, she must establish that the defendant's breach of the standard of care was the proximate cause of her injuries. *See id.* Finally, she must show "damages," or that the plaintiff was indeed injured by the defendant's breach. *See id.*

27. Throughout this Comment, the term "standard of care" refers to the measurement to which a medical professional is held when determining whether she is liable for professional malpractice. *See id.* at 555–57. In an ordinary, non-professional negligence case, a standard of care is not typically set out for the jury because the activities that the defendant was involved in are those that the jury is most likely familiar with. *See* Page Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH. L. REV. 351, 351–52 (1978). Thus, the jury can effectively evaluate whether the defendant "fail[ed] to exercise ordinary care under the circumstances" in carrying out that activity because they are only required to "evaluate the conduct of a normal person while in the performance of an activity commonly engaged in by the public." *Id.* (emphasis omitted). In contrast, "the risks and hazards related to the delivery of health care services are not commonly known," so a jury will be unable to determine whether the defendant fell short of exercising reasonable care without first being told what that reasonable care is. *Id.* at 353. Furthermore, what a non-medical professional would do in a medical situation is different from the standard applied to a defendant-physician due to the differences in medical training and knowledge between a medical professional and a non-medical professional. *See id.*

why, with clarification, the current "same or similar community" standard used in North Carolina is fitting. Part III then discusses how the current "same or similar community" standard can be applied in practice to ensure that experts have sufficient familiarity with the defendant-physician's medical community to testify on the relevant standard of care, while still maintaining efficiency and effectiveness in implementation. This Comment concludes that the Supreme Court of North Carolina was correct in upholding section 90-21.12's requirement that an expert witness ground his testimony in the defendant-doctor's same or similar community, but maintains that there must be further clarification on the practical application of the rule.

I. THE ROAD TO SECTION 90-21.12

A. *The Use of Experts in Medical Malpractice*

In North Carolina, any plaintiff claiming that a health care provider[28] committed medical malpractice by not meeting the standard of care required of health care providers under section 90-21.12 must show that an expert witness examined the defendant-physician's work.[29] The expert witness must be "reasonably expected" to meet the qualification requirements under Rule 702 of the North Carolina Rules of Evidence[30] and must testify that the medical care provided by the defendant-physician did not meet the relevant

28. A health care provider is

> any person who . . . 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 or a nursing home; 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 or under the supervision of any of the foregoing persons, hospital, or nursing home.

N.C. GEN. STAT. § 90-21.11 (2009).

29. N.C. R. CIV. P. 9(j)(1); *see also* Mozingo v. Pitt Cnty. Mem'l Hosp., Inc., 101 N.C. App. 578, 584, 400 S.E.2d 747, 750 (1991) (stating that a plaintiff in a medical malpractice case "must prove 'that defendant was negligent in his care of plaintiff and that such negligence was the proximate cause of plaintiff's injuries and damage' " (quoting Beaver v. Hancock, 72 N.C. App. 306, 311, 324 S.E.2d 294, 298 (1985))), *aff'd*, 331 N.C. 182, 415 S.E.2d 341 (1992).

30. N.C. R. CIV. P. 9(j)(1).

standard of care.[31] While ordinary negligence claims allow a jury to determine whether a defendant exhibited the care of a reasonable person, medical malpractice claims compare the defendant-physician's actions to those of other physicians due to the nature of health care work.[32] Likewise, the average layperson does not have the "specialized knowledge" needed to make this comparison, so the testimony of an expert witness is used to determine the relevant standard of care and decide whether the defendant-physician's work met that standard.[33]

The testimony of an expert witness is required to establish two essential elements of the plaintiff's claim.[34] First, testimony of an expert witness is used to establish the duty element of a professional malpractice case; an expert witness must testify on the standard of care that the defendant-physician is held to and whether the defendant-physician violated that standard.[35] Second, the use of expert testimony is used to show whether the "defendant's treatment proximately caused [the] plaintiff's injury," which satisfies the

31. *Id.* Rule 9 further provides that a medical malpractice action will not be dismissed if the plaintiff shows 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," or that "the pleading alleges facts establishing negligence under the existing common-law doctrine of res ipsa loquitur." *Id.* at 9(j)(2)–(3). Rule 702(e) allows a witness to qualify as an expert without meeting certain requirements if he is "otherwise qualified as an expert witness," and there are "extraordinary circumstances" such that the court determines that allowing the motion will "serve the ends of justice." N.C. R. EVID. 702(e). "Res ipsa loquitur" refers to conduct so blatantly negligent that a jury would be able to ascertain that the defendant doctor breached the standard of care even without an expert witness to establish what the standard of care is. *See* ALEXANDER ET AL., *supra* note 26, at 575; *see also* Tice v. Hall, 310 N.C. 589, 593, 313 S.E.2d 565, 567 (1984) (stating that if res ipsa loquitur is applied, "the nature of the occurrence and the inference to be drawn supply the requisite degree of proof to carry the case to the jury without direct proof of negligence"); *id.* at 592, 313 S.E.2d at 567 (explaining that res ipsa loquitur is typically seen in " 'instances where foreign bodies, such as sponges, towels, needles, glass, etc., are introduced into the patient's body during surgical operations and left there' " (quoting Mitchell v. Saunders, 219 N.C. 178, 182, 13 S.E.2d 242, 245 (1941))).

32. *See* Michael D. Greenberg, *Medical Malpractice and New Devices: Defining an Elusive Standard of Care*, 19 HEALTH MATRIX 423, 428 (2009).

33. Leatherwood v. Ehlinger, 151 N.C. App. 15, 20, 564 S.E.2d 883, 886 (2002) (citing Mazza v. Huffaker, 61 N.C. App. 170, 175, 300 S.E.2d 833, 837 (1983)).

34. *See* ALEXANDER ET AL., *supra* note 26, at 555.

35. *See* Mozingo v. Pitt Cnty. Mem'l Hosp., Inc., 101 N.C. App. 578, 585, 400 S.E.2d 747, 750–51 (1991) (stating that a physician has "a duty . . . to conform to the statutory standard of care" that arises "[w]hen a physician and a patient enter into a consensual physician-patient relationship for the provision of medical services"); *see also id.* at 588, 400 S.E.2d at 753 (explaining that "the issue of whether a duty exists is a question of law for the court").

causation element of a professional malpractice case.[36] As a medical malpractice claim will be dismissed if a plaintiff fails to establish any essential element of the claim,[37] establishing the relevant standard of care through expert testimony is essential to the plaintiff's case.[38]

North Carolina imposes two separate qualification analyses on proposed expert witnesses in medical malpractice cases. The first qualification requires the expert witness to be a qualified medical expert under Rule 702 of the North Carolina Rules of Evidence.[39] The rule enables qualified witnesses to use opinion testimony in all situations where the witness's proficiency in the subject matter will help the jury "understand the evidence or ... determine a fact in issue."[40] However, if the expert witness is being used in a medical malpractice case, Rule 702 imposes stricter requirements on the qualification of that witness.[41] First, the expert must be licensed to provide health care services in the United States.[42] Second, if the defendant-physician specializes in a particular field of medicine, the expert's specialty must be the same as or similar to the defendant's specialty.[43] Likewise, the expert must perform similar procedures and "treat[] similar patients" as the defendant-physician.[44] Third, the expert must have spent the majority of her time in "active clinical practice" in the defendant-physician's specific line of work or teaching students in a classroom or clinical setting in the defendant's same line of work.[45] Fourth, a doctor must have appropriate

36. Tripp v. Pate, 49 N.C. App. 329, 332, 271 S.E.2d 407, 409 (1980) (citing Ballenger v. Crowell, 38 N.C. App. 50, 54, 247 S.E.2d 287, 291 (1978)).

37. *See* Lowery v. Newton, 52 N.C. App. 234, 237, 278 S.E.2d 566, 570 (1981) (stating that the essential elements of a medical malpractice case are "(1) the standard of care; (2) breach of the standard of care; (3) proximate causation; and (4) damages"); *see also* Treat v. Roane, 179 N.C. App. 436, 634 S.E.2d 273, 2006 N.C. App. LEXIS 1875, at *7 (2006) (unpublished table decision) ("The burden is on the plaintiff to establish the standard of care through expert testimony."). A party moving for summary judgment must establish either that the plaintiff failed to demonstrate " 'an essential element of [his] claim' "; that " 'an essential element of [the] claim' " cannot be supported by sufficient evidence; or that a " 'plaintiff cannot surmount an affirmative defense which would bar the claim.' " *Mozingo*, 101 N.C. App. at 583, 400 S.E.2d at 750 (quoting Raritan River Steel Co. v. Cherry, Bekaert & Holland, 101 N.C. App. 1, 4, 398 S.E.2d 889, 890 (1990), *rev'd*, 329 N.C. 646, 407 S.E.2d 178 (1991)).

38. *See* ALEXANDER ET AL., *supra* note 26, at 558.

39. N.C. R. EVID. 702(a)–(h).

40. *Id.* at 702(a). The expert witness must be "qualified as an expert by knowledge, skill, experience, training, or education." *Id.*

41. *Id.* at 702(b).

42. *Id.*

43. *Id.* at 702(b)(1).

44. *Id.*

45. *See id.* at 702(b)(2)–(c).

"knowledge of the applicable standard of care" required of health care professionals.[46] However, Rule 702 provides that even if all of these requirements are met, the trial judge may still "disqualify an expert witness on [other] grounds."[47]

The second qualification for expert witnesses requires the expert witness to be sufficiently familiar with the relevant standard of care in "same or similar communities" under section 90-21.12.[48] The trial judge makes the preliminary determination of whether the expert witness has met these requirements and is thus qualified to testify.[49] In doing so, the trial court has broad discretion to decide whether to admit the testimony of a proposed expert witness.[50] As a result, only a finding of an "abuse of discretion" will cause the trial court's decision regarding the two qualification requirements to be reversed.[51] However, these preliminary determinations by the trial court only go so far as to determine whether the witness's testimony is admissible based on the expert's qualifications and the reliability of his opinion;[52] all questions regarding the weight and credibility of the expert's testimony are left for the jury.[53]

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46. *Id.* at 702(d).

47. *Id.* at 702(g); *see, e.g.*, Hunt v. Bradshaw, 251 F.2d 103, 107 (4th Cir. 1958) (stating that whether an expert witness is qualified to testify is within the trial judge's "sound discretion").

48. N.C. GEN. STAT. § 90-21.12 (2009). This qualification requirement is discussed in depth *infra* Parts II and III.

49. Howerton v. Arai Helmet, Ltd., 358 N.C. 440, 458, 597 S.E.2d 674, 686 (2004) (citing N.C. R. EVID. 104(a)).

50. *Id.* (citing State v. Bullard, 312 N.C. 129, 140, 322 S.E.2d 370, 376 (1984)).

51. *Id.*

52. *See* Crocker v. Roethling, 363 N.C. 140, 144, 675 S.E.2d 625, 629 (2009). It is worth noting that the "reliability" of an expert's testimony is a determination of whether the "scientific or technical area underlying a qualified expert's opinion is sufficiently reliable" to form the basis of the expert witness's opinion. *Howerton*, 358 N.C. at 460–61, 597 S.E.2d at 687–88. For a medical malpractice case, the expert's testimony must establish the applicable standard of care to which the defendant-physician must be held. *See* § 90-21.12. Thus, in a medical malpractice case, the expert's knowledge of the defendant's community which enables the expert to ascertain the standard of care in the same or similar community is the information "underlying" the expert's opinion. *See id.* As a result, the question of whether an expert is sufficiently familiar with the defendant's community to know what the relevant standard of care is can be thought of as determining whether the expert's testimony is reliable.

53. *Howerton*, 358 N.C. at 460–61, 597 S.E.2d at 687–88 (citing Queen City Coach Co. v. Lee, 218 N.C. 320, 323, 11 S.E.2d 341, 343 (1940)); *see also Crocker*, 363 N.C. at 147, 675 S.E.2d at 631 ("[M]atters of credibility are for the jury, not for the trial court.").

B. *The Demise of the Locality Rule*

In the early 1900s, North Carolina had an even narrower standard to qualify witnesses as medical experts.[54] This standard, sometimes known as the "locality rule," required an expert witness to testify that the defendant-physician breached the standard of care of a physician in the " 'same' locality."[55] This rule was established during a time when the education and training of doctors was less formal and less standardized.[56] Furthermore, during this time, doctors often practiced in remote communities with little access to continuing education or communication with one another.[57] As a result of limited access to other medical communities, doctors were not held to a standard of care beyond their own community.[58] As North Carolina became less rural and the education of physicians and the practice of medicine became more formalized and regulated,[59] the locality rule became " 'too narrow' "[60] and outdated.[61] Furthermore, it was

54. *See* Wiggins v. Piver, 276 N.C. 134, 140, 171 S.E.2d 393, 397 (1970).

55. *Id.* (quoting Harold N. Bynum, Note, *Torts—Medical Malpractice—Rejection of "Locality Rule,"* 46 N.C. L. REV. 680, 682 (1968)); *see also* Baynor v. Cook, 125 N.C. App. 274, 278, 480 S.E.2d 419, 421 (1997) (describing the "strict 'locality' rule that had previously existed in this State"); Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 705 (2002) (explaining how the locality rule only held "physicians . . . to the standard of care practiced by other physicians in the same community as the defendant").

56. *See Wiggins*, 276 N.C. at 139, 171 S.E.2d at 396.

57. *See id.* at 139–40, 171 S.E.2d at 396–97; *see also* Sims v. Charlotte Liberty Mut. Ins. Co., 257 N.C. 32, 40–41, 125 S.E.2d 326, 332–33 (1962) (Higgins, J., concurring) (describing doctors' rudimentary practices at the turn of the 20th century); James O. Pearson, Jr., Annotation, *Modern Status of "Locality Rule" in Malpractice Action Against Physician Who Is Not a Specialist*, 99 A.L.R. 3d 1133, 1138 (1980) (explaining that the purpose of the locality rule is to take into account the varying opportunities, experiences, and resources available to doctors in rural and urban areas); Amy Lynn Sorrel, *Liability by Locality: Practical Standard or Outdated Notion?*, AM. MED. NEWS (Jan. 18, 2010), http://www.ama-assn.org/amednews/2010/01/18/prsa0118.htm (describing the locality rule's original intention of preventing doctors in rural locations from being held to the same standard of care as doctors in urban locations).

58. *See Wiggins*, 276 N.C. at 139–40, 171 S.E.2d at 396–97.

59. *See id.*

60. *See id.* at 140, 171 S.E.2d at 397 (quoting WILLIAM LLOYD PROSSER, HANDBOOK OF THE LAW OF TORTS 166–67 (3d ed. 1964)); *see also* Rucker v. High Point Mem'l Hosp., 285 N.C. 519, 527, 206 S.E.2d 196, 201 (1974) (explaining that a doctor may be held to a broader standard of care if he or she is a staff member at a "duly accredited hospital").

61. *See Wiggins*, 276 N.C. at 139–40, 171 S.E.2d at 397; *see also* Michael Frakes, *Malpractice Standards of Care and Regional Variations in Physician Practice Styles* 10 (Oct. 2009) (unpublished working paper), *available at* http://www.law.harvard.edu/programs/petrie-flom/fellowship_program/MalpracticeStandards_Frakes.pdf (describing how geographic restrictions on standard of care laws were relaxed as disparities in doctor education, training, and resource availability became less pronounced); Sorrel, *supra* note 57 (describing the standard of care as a "totally fluid concept" that can adapt to

understandably difficult to find an expert witness "from the same community to testify against a colleague."[62] To account for these difficulties and changes, the locality rule's requirement that an expert witness testify on the standard of care in the defendant's community was relaxed to allow testimony on the standard of care in similar communities.[63] As a result, the "same or similar community" view emerged as the common law standard of care in North Carolina.[64]

C. *North Carolina's "Same or Similar Community" Rule*

Prior to the enactment of section 90-21.12,[65] North Carolina adhered to a common law "same or similar community" rule.[66] This common law rule expanded the relevant criteria on which to base a defendant-physician's standard of care by enabling plaintiffs to establish a defendant-physician's breach of that standard through the testimony of an expert from a same or similar community.[67] However, there were still vast differences in resources, education, training, and facilities among different communities.[68] As a result, the common law "same or similar community" rule still considered the defendant-physician's medical community.[69] Therefore, by accounting for " 'the changing conditions of social, commercial, and industrial life' " in North Carolina while still acknowledging the realities of North Carolina medical communities, the common law rule remained true to " 'well-settled principles' " of North Carolina law.[70]

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accommodate the reality that while the strict locality rule may no longer be necessary, discrepancies between health care in different communities still exist).

62. Peter P. Budetti et al., *Medical Malpractice Law in the United States*, KAISER FAMILY FOUND., 6 (May 2005), http://kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf (describing the difficulty in finding expert witnesses willing to "point fingers at their fellow physicians"); Frakes, *supra* note 61, at 9–10 (describing the " 'conspiracy of silence' " that made it difficult to find expert witnesses to testify under the strict locality rule); Keeton, *supra* note 27, at 359; *see also Wiggins*, 276 N.C. at 140, 171 S.E.2d at 397 (stating that there was an "insurmountable handicap" whenever a plaintiff came from "a community with only one doctor"); Pearson, *supra* note 57, at 1139 (describing doctors' reluctance to testify against other doctors in the same community as a reason for expanding the strict locality rule to allow testimony on the standard of care of a similar community).

63. *See Wiggins*, 276 N.C. at 140–41, 171 S.E.2d at 397–98.

64. *See id.*

65. N.C. GEN. STAT. § 90-21.12 (2009).

66. *See Wiggins*, 276 N.C. at 139–41, 171 S.E.2d at 396–98 (reversing and remanding the trial court's exclusion of expert testimony based on adherence to the locality rule).

67. *See id.* at 140, 171 S.E.2d at 397.

68. *See id.*

69. *See id.*

70. *See id.* at 141, 171 S.E.2d at 397 (quoting Firemen's Ins. Co. v. Seaboard Air Line R.R., 138 N.C. 42, 42, 50 S.E. 452, 452 (1905)). The common law requirements for

In 1975, the North Carolina General Assembly codified this common law rule by passing section 90-21.12.[71] Section 90-21.12 establishes the relevant standard of care for medical malpractice actions as follows:

> 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.[72]

The statute was meant to codify North Carolina's common law "same or similar community" rule.[73] As a result, physicians were still

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standard of care were clearly set forth in *Hunt v. Bradshaw*, and included requiring a physician to (1) "possess the . . . learning, skill and ability" that would ordinarily be held by other physicians "similarly situated"; (2) apply that "knowledge and skill" to the "patient's case" with "reasonable care and diligence"; and (3) use her "best judgment" in treating and caring for the patient. 242 N.C. 517, 521, 88 S.E.2d 762, 765 (1955). Furthermore,

> an expert witness, otherwise qualified, may state his opinion as to whether the treatment and care given by the defendant to the particular patient came up to the standard prevailing in similar communities, with which the witness is familiar, even though the witness be not actually acquainted with actual medical practices in the particular community in which the service was rendered at the time it was performed.

Dickens v. Everhart, 284 N.C. 95, 101, 199 S.E.2d 440, 443 (1973). This common law rule, which balanced the need to take into account both the changes and remaining differences in North Carolina's population and medical communities, represented the standard of care that medical professionals were held to in North Carolina.

71. *See* Act of May 12, 1976, ch. 977, § 4, 1975 N.C. Sess. Laws 1, 4–6 (codified at N.C. GEN. STAT. § 90-21.12 (2009)).

72. N.C. GEN. STAT. § 90-21.12 (2009); *see also* Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 213, 550 S.E.2d 245, 248 (Greene, J., concurring) (establishing the elements of the North Carolina statute as holding physicians to "a standard of care practiced among other members of their profession (1) in the same or a similar community, (2) with similar training, and (3) with similar experience" (citing § 90-21.12)), *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

73. *See* Wall v. Stout, 310 N.C. 184, 192, 311 S.E.2d 571, 576 (1984) (stating that the statute was written "to conform . . . to the existing case law applying a 'same or similar community' standard of care"); Howard v. Piver, 53 N.C. App. 46, 51, 279 S.E.2d 876, 879 (1981) (stating that the statute was intended to codify the common law rule of *Wiggins* and *Dickens*).

required to use the same care with patients as before enactment of the statute,[74] with no departure from "established principles of malpractice law" and no "new standard of care."[75]

There were several reasons for codifying the common law rule in North Carolina. Codification led to clarification of the geographic area to which a physician's standard of care applied[76] and provided guidance to health care professionals about the quality of care they were expected to provide.[77] In addition, section 90-21.12 ensured that doctors were not held to a strict locality standard.[78] As a result, the statute accounted for the increasing standardization between communities and the difficulties that arose from applying the locality rule.[79] However, the statute was also intended to prevent the application "of a national or regional standard of care."[80] Thus, codification ensured that the standard of care took into account variations between communities.[81]

D. Lingering Uncertainty

Even after section 90-21.12 codified the "same or similar community" standard, confusion remained over how to ensure that an expert was sufficiently familiar with a same or similar community in

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74. *See Wall*, 310 N.C. at 192, 311 S.E.2d at 576.

75. Makas v. Hillhaven, Inc., 589 F. Supp. 736, 740 (M.D.N.C. 1984) (citing Simons v. Georgiade, 55 N.C. App. 483, 493, 286 S.E.2d 596, 603 (1982)).

76. *See id.*

77. *See* Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1255 (1975).

78. *See* Baynor v. Cook, 125 N.C. App. 274, 278, 480 S.E.2d 419, 421 (1997).

79. *See supra* notes 59–61 and accompanying text; *see also* Cramm et al., *supra* note 55, at 706 (stating that one problem with the strict locality standard of care was the concern that experts were often reluctant "to testify against another physician in the same community").

80. Page v. Wilson Mem'l Hosp., Inc., 49 N.C. App. 533, 535, 272 S.E.2d 8, 10 (1980) (noting the intent of the General Assembly in adopting § 90-21.12). The General Assembly's report states that

> [t]he North Carolina Supreme Court has gone only as far as a 'same or similar communities' standard of care, and the Commission recommends that this concept be enacted into the General Statutes to avoid further interpretation by the Supreme Court which might lead to regional or national standards for all health care providers.

Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 209–10, 550 S.E.2d 245, 246 (quoting N.C. PROF'L LIAB. INS. STUDY COMM'N, REPORT TO THE GENERAL ASSEMBLY OF 1976, at 32 (1976)), *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

81. *See Henry*, 145 N.C. App. at 213, 550 S.E.2d at 248 (Green, J., concurring); *see also* Tucker v. Meis, 127 N.C. App. 197, 199, 487 S.E.2d 827, 829 (1997) (finding expert's testimony to be "irrelevant" because the expert only knew the statewide standard of care).

order to be qualified to testify on the appropriate standard of care. Though the stricter rules in North Carolina's history were outdated and a solid shift to the "same or similar community" standard was a welcome change, the diminished clarity of how to obtain an expert witness was a casualty of the shift away from the locality rule.[82] The multitude of cases reaching the North Carolina Court of Appeals in the years following the statute's adoption indicates the confusion over the "same or similar community" standard.[83] These cases examined a variety of questions but had two recurring issues. One line of cases examined whether a proposed expert witness was sufficiently familiar with the defendant-physician's medical community to be qualified to testify to the relevant standard of care.[84] A second line of cases examined whether a proposed expert witness's medical community was sufficiently "similar" to the medical community of the defendant-physician such that the expert witness could testify to the standard of care in the community at issue.[85] The following riddle summarized the

82. *See* Cramm et al., *supra* note 55, at 707.

83. *See, e.g.*, Tice v. Hall, 63 N.C. App. 27, 36–37, 303 S.E.2d 832, 837–38 (1983) (reversing a directed verdict for defendant after finding that the expert witness sufficiently established the standard of care for surgeons in Fayetteville, North Carolina), *aff'd*, 310 N.C. 589, 313 S.E.2d 565 (1984); Simons v. Georgiade, 55 N.C. App. 483, 492–94, 286 S.E.2d 596, 602–03 (1982) (finding that the standard of care for Durham, North Carolina, was properly established under § 90-21.12 even though the plaintiff did not specifically ask whether the defendant "deviat[ed] from standard medical practice *in Durham, North Carolina, or in similar communities in 1975 and 1976*" and that the expert witness stated that board-certified surgeons adhere to the same standards across the country); Thompson v. Lockert, 34 N.C. App. 1, 4–6, 237 S.E.2d 259, 261–62 (1977) (holding that the trial court properly excluded the testimony of plaintiff's expert witness due to a failure to show that the medical community of Smithtown, New York, was similar to the medical community of Salisbury, North Carolina).

84. *See, e.g.*, Marley v. Graper, 135 N.C. App. 423, 430, 521 S.E.2d 129, 134 (1999) (stating that the expert witness's failure to "testify that he was familiar with the standard of care for Greensboro" was satisfactory in light of his testimony that the defendant-physician "met the highest standard of care found anywhere in the United States"); *Tucker*, 127 N.C. App. at 198–99, 487 S.E.2d at 829 (holding that the trial court correctly granted defendant's motion for a directed verdict when plaintiff's expert witness "fail[ed] to testify that he was familiar with the standard of care in Winston-Salem or similar communities"); Mozingo v. Pitt Cnty. Mem'l Hosp., Inc., 101 N.C. App. 578, 590–91, 400 S.E.2d 747, 754 (1991) (finding that the physicians setting forth the standard of care in affidavits supporting defendant's motion for summary judgment were not shown to be familiar with the standard of care in Pitt County, North Carolina), *aff'd*, 331 N.C. 182, 415 S.E.2d 341 (1992).

85. *See, e.g.*, *Henry*, 145 N.C. App. at 213, 550 S.E.2d at 248 (holding that testimony of plaintiff's expert witness was properly excluded and thus defendant's motion for a directed verdict was properly granted based on the expert's failure to show that either a national standard of care or the standard of care in Spartanburg, South Carolina, was the relevant standard of care for Wilmington, North Carolina); White v. Hunsinger, 88 N.C. App. 382, 385–86, 363 S.E.2d 203, 205 (1988) (finding that the testimony of the plaintiff's expert

confusion over these issues: "When is a board certified medical doctor with 20 years of directly related surgical experience not qualified to testify as a surgical expert on the standard of care in a medical malpractice case? When he or she is asked to testify in a North Carolina courtroom."[86]

As demonstrated in *Crocker v. Roethling* and *O'Mara v. Wake Forest University Health Sciences*, confusion over interpreting section 90-21.12 is far from over.[87] While the *Crocker* court reversed and remanded the exclusion of the plaintiff's expert testimony, it explained that

> [n]othing in our statutes or case law suggests that a prospective medical expert must produce documentation of his research or attempt to explain to the trial judge how his knowledge about the community enabled him to ascertain the relevant standard of care. Nor do they prescribe any particular method by which a medical doctor must become "familiar" with a given community. Many methods are possible, and our jurisprudence indicates our desire to preserve flexibility in such proceedings. The witness must show only that "other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue."[88]

No development in this area of jurisprudence has clearly explained how to ensure that an expert has sufficient knowledge to testify on the standard of care used in a "same or similar community" and thus to testify on the relevant standard of care.[89] In contrast to current North Carolina law, implementing a procedure that requires an expert witness to demonstrate his familiarity with the defendant-physician's medical community and make the link between this knowledge and his testimony on the applicable standard of care will ensure that this confusion is alleviated, and that section 90-21.12 is

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witness was not "incompetent" based on the expert "not practicing in a community similar to New Bern at the time of defendant's alleged negligence").

86. Canepa, *supra* note 11, at 6.

87. *See* Crocker v. Roethling, 184 N.C. App. 377, 646 S.E.2d 442, 2007 N.C. App. LEXIS 644 (2007) (unpublished table decision), *rev'd*, 363 N.C. 140, 675 S.E.2d 625 (2009); O'Mara v. Wake Forest Univ. Health Scis., 184 N.C. App. 428, 646 S.E.2d 400, *disc. review granted in part*, 362 N.C. 85, 659 S.E.2d 1 (2007), *and disc. review improvidently allowed by* 363 N.C. 117, 678 S.E.2d 658 (2009); *see also* McGrath, *supra* note 10, at 1 (describing the Supreme Court of North Carolina's "agreeing to review the cases of Crocker v. Roethling and O'Mara v. Wake Forest University Health Sciences").

88. Crocker v. Roethling, 363 N.C. 140, 147, 675 S.E.2d 625, 631 (2009) (quoting N.C. R. EVID. 702(a)).

89. *See id.*

effectively implemented in North Carolina medical malpractice litigation. However, there are opponents of the "same or similar community" standard of care who think that it is no longer relevant as health care becomes more standardized. The next Part will explore these arguments, and illustrate how the "same or similar community" standard of care remains necessary and effective.

II. A WEALTH OF OPPOSITION: A DISCUSSION OF ARGUMENTS AGAINST THE "SAME OR SIMILAR COMMUNITY" STANDARD OF CARE

Although the "same or similar community" standard of section 90-21.12 can be appropriate and effective, there is opposition to this proposition. Some argue that all forms of geographic narrowing in determining the relevant standard of care are no longer necessary and that a nationwide standard of care is now appropriate for all medical communities.[90] This idea is based on two premises. First, proponents of this argument say that there are no longer variations in medical communities, so forms of non-national standards of care are an "anachronism."[91] Second, proponents claim that a national standard provides a "floor" to ensure that all patients receive adequate medical treatment.[92] However, geographic variations in population and medical practices still exist, making it impractical and unfair to require all physicians to meet the same standard of care.[93] Furthermore, the "same or similar community" standard was created with the specific intention of acknowledging the improvements and standardization that have been made in medicine by moving away from North Carolina's historic strict locality rule.[94]

Additionally, critics of the "same or similar community" standard argue that jurisdictions applying a standard of care other

90. *See generally* Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs. the National Standard of Care*, 297 J. AM. MED. ASS'N 2633 (2007) (arguing for a national standard of care); Andrea Hughes, *States' "Locality Rule" Hurts Patients*, GEN. HEALTH CHANNEL (June 20, 2007), http://www.ivanhoe.com/channels/p_channelstory.cfm?storyid=16428 (arguing against the use of a locality rule); Sorrel, *supra* note 57 (comparing the benefits and risks of both a national standard and a locality standard).

91. *See* Lewis et al., *supra* note 90, at 2636.

92. *See* Hughes, *supra* note 90.

93. *See infra* Part III.

94. *See* Wiggins v. Piver, 276 N.C. 134, 139–40, 171 S.E.2d 393, 396–97 (1970).

than a national standard of care have diminished medical care.[95] This argument is based on three premises. First, these critics claim that requiring physicians to know the standard of care for the specific community they practice in "imposes additional duties and legal risk on physicians," and thus makes the job of physicians and other health care providers more difficult.[96] Therefore, proponents of this view conclude that community standards of care distract the health care provider; rather than focusing on her true job—taking care of patients—she instead must expend time and energy to remain abreast of the accepted practice of other providers in her community.[97] Second, proponents of this view claim that such standards diminish medical care by hindering the integration of medical and scientific advances into the standard of care.[98] Furthermore, these proponents claim that these standards cause concern and indecision for doctors when there is divergence between local and national practice standards.[99] However, under the "same or similar community" standard of care, an expert witness can still testify on any national uniformity of the procedure or treatment at issue.[100] As a result, applying the "same or similar community" standard of care will not diminish medical care.[101] Instead, applying this standard will enable health care providers to work with confidence within the reality of

95. *See* Lewis et al., *supra* note 90, at 2636; Sorrel, *supra* note 57 (stating that physicians in states without a national standard of care must adhere to the standard of care of their community, even when this standard is lower than that of other locations).

96. *See* Lewis et al., *supra* note 90, at 2634.

97. *See id.*; *see also* Peggy Peck, *Standard of Care Remains a Moving Target in Medical Malpractice Cases*, MEDPAGE TODAY (June 20, 2007), http://www.medpagetoday.com/PublicHealthPolicy/HealthPolicy/5971 (stating that physicians practicing in more than one jurisdiction are required to know the standard of care for each location, which can detract from the physician's focus on the patient).

98. Lewis et al., *supra* note 90, at 2633.

99. *Id.*

100. *See infra* Part III.B.

101. *See* C. Jerry Willis, *Establishing Standards of Care: Locality Rules or National Standards*, AAOS NOW (Feb. 2009), http://www.aaos.org/news/aaosnow/feb09/managing9.asp (stating that physicians typically make medical decisions with the goal of giving patients the best care possible under the circumstances, regardless of the standard of care applicable in their jurisdiction). Furthermore, the notion that implementing a national standard of care positively impacts the quality of medical care provided is not supported by evidence; tort reform efforts, which are sometimes viewed as an indicator of declining medical care, are disproportionately found in states that have adopted a national standard of care for medical malpractice lawsuits. *Id.*; *see also* Frakes, *supra* note 61, at 46–47 (describing how applying a national standard of care still relies on the use of opposing experts, thus minimizing the potential benefit of this approach).

their own medical community.[102] Therefore, adhering firmly to the requirements of the statute will allow physicians to practice medicine without the additional concern of being held to national standards that may not apply to their medical community,[103] and thus enable them to focus their efforts and attention on caring for their patients.[104]

Furthermore, opponents of community-based standards of care claim that requiring experts to know the standard of care in the same or similar community is wholly unrealistic.[105] These opponents argue that physicians do not know how other physicians practice—whether in their own community or elsewhere—and, as a result, expert witness testimony is often based on how the witness personally would have acted (or thinks he would have acted) if in the same situation as the defendant.[106] However, this concern that expert witnesses are not actually familiar with the appropriate standard of care can be abated by requiring an expert witness to demonstrate his familiarity with the defendant's community or one similar to it and how this familiarity enables him to ascertain the relevant standard of care.[107]

Finally, opponents of community standards of care claim that such standards give too much power to health care professionals.[108] This claim is based on the assertion that allowing the standard of care to be determined from the actions of health care providers in the community "place[s] the profession above the law."[109] Additionally,

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102. *See* John C. Drapp III, *The National Standard of Care in Medical Malpractice Actions: Does Small Area Analysis Make It Another Legal Fiction?*, 6 QUINNIPIAC HEALTH L.J. 95, 128–29 (2003) (describing how applying a national standard of care causes physicians to "be preoccupied with thoughts about whether the actions they take will lead to medical malpractice suits in which the plaintiff patient will bring in an out-of-town doctor to testify to a standard of care that really is not applicable in the first place, but is in fact legally applicable because of a supposed national standard of care"); *see also* Sorrel, *supra* note 57 (describing how medical malpractice standards of care that address the actual medical community that a physician practices in helps "keep[] the legal and medical standards in sync").

103. *See* Sorrel, *supra* note 57 (stating that failing to consider the realities of a medical community can "undermine the overall medical infrastructure" of rural localities).

104. Willis, *supra* note 101 (stating that most physicians understand their job is to provide patients with the best care possible under the circumstances, not to minimize medical malpractice liability).

105. *See* Cramm et al., *supra* note 55, at 710.

106. *See id.* (noting that an expert witness's determination of the community standard of care usually relies on whether the expert "would not have treated the patient that way," or what "the expert personally believes *should be* the standard of care").

107. *See infra* Part III.C.1–2.

108. *See* Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 958–59 (2002).

109. *Id.*; *see also* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 191 (2000) (explaining

these opponents argue that allowing physicians to set the standard of care diminishes the role of the jury in medical malpractice cases by requiring the expert, not the jury, to establish whether the defendant breached the appropriate standard of care and is therefore liable for medical malpractice.[110] However, the North Carolina "same or similar community" standard of care does not require an expert witness to have actually practiced in the same community or state as the defendant-physician.[111] The statute only requires that the expert demonstrate familiarity with the medical community at issue and illustrate how that familiarity enables him to know the relevant standard of care.[112] As a result, in contrast to the opponents' claims, the physicians in the community at issue are not required to testify at trial, and thus do not "set [their] own standard of care."[113]

In sum, some proponents of a national standard of care for medical malpractice cases argue that non-national standards of care are no longer necessary, diminish medical care, are unrealistic, and give too much power to health care professionals. However, the requirement of section 90-21.12 that an expert witness testify regarding the standard of care of a "same or similar communit[y]"[114] is better suited to determine whether a physician is liable for medical malpractice because it takes into account the real conditions of a defendant physician's medical community.[115]

III. A WORKABLE SYSTEM

A. *Abandoning the "Same or Similar Community" Standard of Care Is Not the Answer*

This section will discuss why implementing a national standard of care in North Carolina is unnecessary and unwise, as a national standard of care is against the intent of the North Carolina General Assembly and is imprudent in light of the remaining disparities between North Carolina medical communities. This section will then briefly explore some alternative ways of determining the standard of

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that jurisdictions that have discarded standards of care relying on custom "have reiterated the basic tort notion that an industry is not permitted to set its own standard of care").

110. *See* Peters, *supra* note 108, at 958–59.

111. *See infra* Part III.C.1.

112. *See* N.C. GEN. STAT. § 90-21.12 (2009); *infra* Part III.C.

113. Peters, *supra* note 109, at 191.

114. § 90-21.12.

115. *See infra* Part III.

care in medical malpractice cases and will discuss why the "same or similar community" standard of care remains the best option.

1. A National Standard of Care Is Not the Answer

The criticisms of the "same or similar community" standard of care are also unconvincing because adopting a national standard of care expressly contradicts the intent of the North Carolina General Assembly.[116] Legislators viewed variations in medical communities as important factors to consider in medical malpractice cases.[117] While the notion that all communities and physicians should be held to the highest standards in treating patients is certainly ideal, the truth is that all North Carolina medical communities are simply not equally equipped. As section 90-21.12 evaluates physicians' conduct by considering all factors that "are relevant and central to the legal analysis,"[118] it effectively takes this reality into account. Therefore, the statute allows physicians to focus on treating patients in the best way that they actually can, instead of in a way that is beyond the resources and capabilities of their medical environment.

Further, maintaining the "same or similar community" standard of care is important because a national standard of care does not accurately account for the realities of medical communities in the state or in the nation. This is due in large part to the fact that national, state, and even regional variations still exist between medical communities, as general disparities between communities and the medical services available to residents of those communities are still present.[119] These disparities are evident in a number of ways; for example, disparities between medical communities are illustrated through differences in the "available medical resources . . . conditions, facilities, and equipment available to a health care professional,"[120]

116. *See* § 90-21.12; Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 210, 550 S.E.2d 245, 246, *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

117. *See Henry*, 145 N.C. App. at 210, 550 S.E.2d at 246.

118. *Id.* at 217, 550 S.E.2d at 250 (Hudson, J., dissenting).

119. *See* Drapp, *supra* note 102, at 118–20 (discussing how "significant geographic variation" exists in the availability of medical resources); *see also Henry*, 145 N.C. App. at 211, 550 S.E.2d at 247 ("This Court, however, has recognized very few 'uniform procedures' to which a national standard may apply, and to which an expert may testify."); *Find Shortage Areas: HPSA & MUA/P by Address*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx (last visited Nov. 17, 2010) (allowing a search for health-professional shortage areas and medically underserved areas by address).

120. *Henry*, 145 N.C. App. at 213, 550 S.E.2d at 248 (Greene, J., concurring).

diagnostic testing decisions,[121] "medically necessary" interventions, "discretionary surgery," and disease management.[122] These disparities illustrate the necessity of a standard of care that considers the defendant's medical community, because physicians must work with the resources and facilities available to them. Therefore, physicians in communities with minimal resources should not be expected to use the same procedures, techniques, and treatments as physicians with a plethora of resources. Disparities between medical communities are evident in the classification of areas as "Medically Underserved Areas," classification of areas as "Health Professional Shortage Areas," racial make-up of communities, and rural versus non-rural areas.

First, disparity in medical communities is evident from the fact that 4,167,774 North Carolinians lived in "Medically Underserved Areas" ("MUAs") as of 2006.[123] A medical community is designated as an MUA after a consideration of four variables: "ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over."[124] These variables demonstrate that a community designated as an MUA has some combination of a shortage of health care professionals, poor health outcomes, and a population that is likely without the means to seek secondary medical care.[125] Therefore, for a North Carolina

121. *See* Kathleen N. Gillespie et al., *Practice Pattern Variation Between Two Medical Schools*, 27 MED. CARE 537, 537–38 (1989).

122. *At Eisenberg Lecture, Wennberg Discusses Practice Variation, Urges Healthcare Finance Reform*, STAN. UNIV. CTR. FOR HEALTH POL'Y/CTR. FOR PRIMARY CARE & OUTCOMES RESEARCH (Jan. 1, 2006), http://healthpolicy.stanford.edu/news/at_eisenberg_lecture_wennberg_discusses_practice_variation_urges_healthcare_finance_reform_20060101/.

123. Sara Rosenbaum et al., *National Health Reform: How Will Medically Underserved Communities Fare?*, GEIGER GIBSON/RCHN COMTY. HEALTH FOUND. RESEARCH COLLABORATIVE, 7 (July 9, 2009), http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf.

124. *Shortage Designation: Medically Underserved Areas and Populations*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://bhpr.hrsa.gov/shortage/muaguide.htm (last visited Nov. 17, 2010).

125. *See id.* "Secondary medical care" is specialized care and continuing, long-term treatment for medical issues that are "common and less frequently encountered." JAMES F. MCKENZIE ET AL., AN INTRODUCTION TO COMMUNITY HEALTH 387 (6th ed. 2008). This type of care is often necessary for patients with "chronic or long-term conditions" and is usually given after a referral from a patient's primary care provider. *Id.*

community to be labeled an MUA, variations in the medical services available must exist.[126]

These variables illustrate discrepancies in the medical care available in different communities, as well as the unique concerns that health care providers in these communities deal with daily. The available resources and funding in a medical community form the foundation for the care that local health care professionals have the opportunity to provide; these resources essentially lay the foundation for the appropriate standard of care to which health care providers in each community should be held.[127] These differences in "facilities, equipment, [and] funding" even occur throughout the state, making the variations even more directly linked to the need for a differentiated standard of care.[128] The "same or similar communities" standard of section 90-21.12 takes into account these variations in medical communities.[129] As a result, section 90-21.12 holds health care professionals accountable for the standard of care that is actually available and possible in a medical community,[130] instead of exhausting doctors' efforts in trying to adhere to standards that are not practical for the circumstances.[131]

Second, these disparities between medical communities can be seen in the number of health care professionals available to serve a given community. The differences in available health care providers between communities is evidenced by communities' designations as Health Professional Shortage Areas ("HPSAs"). While the MUA designation takes into account a variety of factors to determine whether an area has "a shortage of personal health services,"[132] the

126. *See* Rosenbaum et al., *supra* note 123, at 8.

127. *See* Tucker v. Meis, 127 N.C. App. 197, 198, 487 S.E.2d 827, 829 (1997); *see also* Press Release, Univ. of Cal. at S.F. News Office, High Volume Hospitals Have Lower Death Rates for Many Surgeries and HIV/AIDS (Feb. 29, 2000), http://news.ucsf.edu/releases/high-volume-hospitals-have-lower-death-rates-for-many-surgeries-and-hiv-aid/ (stating that high-volume hospitals have better health outcomes than low-volume hospitals).

128. *See Tucker*, 127 N.C. App. at 199, 487 S.E.2d at 829; *see also* Sorrel, *supra* note 57 (discussing the need to keep "legal and medical standards in sync" with reality).

129. *See* N.C. GEN. STAT. § 90-21.12 (2009).

130. *See* Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 217, 550 S.E.2d 245, 250 (Hudson, J., dissenting), *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

131. *See* Drapp, *supra* note 102, at 129 (describing how a national standard of care can cause doctors to devote more time to considering the potential legal ramifications of their actions than using their own knowledge, training, and experience to provide the best medical care for patients).

132. *See Shortage Designation: HPSAs, MUAs & MUPs*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://bhpr.hrsa.gov/shortage/index.htm (last visited Nov. 17, 2010); *see*

HPSA classification looks only at whether a given area has enough health care providers to serve the community.[133] Throughout the United States, there are 6,204 HPSAs for primary care physicians, meaning these areas do not have enough doctors to provide the care necessary to adequately serve the population or area.[134] As sixty-five million people live in these areas, 16,643 primary care physicians would be needed to meet the basic requirements for adequate primary care in these locations, which is only a ratio of 2,000 residents to one primary care provider.[135] Therefore, in areas with a severe shortage of physicians, holding the available physicians to the same standard of care as a physician in a location with a multitude of doctors that can focus more attention on each patient seems not only unfair, but impracticable.

North Carolina is no different, as disparities in the availability of health care professionals exist throughout the state.[136] Thirty-eight counties were designated as "Persistent HPSAs" in 2005, meaning they had been "designated as HPSA by the Health Resources and Services Administration (HRSA) from 1999 to 2005, or in 6 of the last 7 releases of [the] HPSA definition."[137] As North Carolina has 100 counties, this means that thirty-eight percent of North Carolina counties have a shortage of health care providers.[138] These classifications are not insignificant, as far fewer medical school graduates choose to practice in North Carolina's rural counties or HPSAs as compared to metropolitan counties.[139] Furthermore,

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also supra note 124 and accompanying text (stating the variables considered in designating an area as an MUA).

133. *See Shortage Designation: HPSA Designation Criteria*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://bhpr.hrsa.gov/shortage/hpsacrit.htm (last visited Nov. 17, 2010).

134. *See Shortage Designation: HPSAs, MUAs & MUPS*, *supra* note 132 (stating that there are also 4,230 Dental HPSAs and 3,291 Mental Health HPSAs in the United States).

135. *See id.*

136. CECIL G. SHEPS CTR. FOR HEALTH SERVS. RESEARCH, UNIV. OF N.C. AT CHAPEL HILL, TRENDS IN LICENSED HEALTH PROFESSIONS IN NORTH CAROLINA: 1979–2005, at 12 (2007) [hereinafter TRENDS IN LICENSED HEALTH PROFESSIONS].

137. N.C. RURAL HEALTH RESEARCH & POL'Y ANALYSIS CTR., UNIV. OF N.C. AT CHAPEL HILL, PERSISTENT HEALTH PROFESSIONAL SHORTAGE AREAS (PHPSAS) NORTH CAROLINA, 2005, http://www.shepscenter.unc.edu/rural/maps/PHPSA05_NC.pdf (last visited Nov. 17, 2010).

138. *See Shortage Designation: Medically Underserved Areas and Populations*, *supra* note 124.

139. *See* CECIL G. SHEPS CTR. FOR HEALTH SERVS. RESEARCH, UNIV. OF N.C. AT CHAPEL HILL, 2005 NORTH CAROLINA PHYSICIANS: MEDICAL SCHOOL TRAINING (2005), http://www.shepscenter.unc.edu/hp/publications/MDTrainFS05.pdf (stating that only 24.3% of International Medical Graduates ("IMGs"), 18.6% of medical graduates from U.S. or Canadian schools, and 19.7% of medical graduates from North Carolina medical schools "list a primary practice location in a nonmetropolitan county," and only

although the number of physicians available to serve each 10,000 North Carolina residents is increasing,[140] as of 2008 there was still one North Carolina county with no doctor actively practicing and twenty-five North Carolina counties with fewer than seven physicians for every 10,000 persons.[141] While health care providers should always provide the best care possible, as a practical matter, doctors in communities with scarce resources should be held to a different standard of care than those in metropolitan areas or large, well-staffed, and resource-rich hospitals. It is unreasonable to apply a national standard of care that does not take into account the realities of the medical community.

Third, twenty-nine North Carolina counties were classified as rural in 2005.[142] There exist differences in racial demographics between rural and metropolitan areas.[143] Therefore, some areas are likely to have disproportionate populations of certain racial groups. This demographic difference can have an impact on treatment outcomes, as evidence shows that different demographic groups react differently to certain medical treatments and strategies.[144] This shows

about 36.5% of IMGs, 30.1% of medical graduates from U.S. and Canadian Schools, and 27% of medical graduates from North Carolina schools choose to practice in counties that are either "whole or part-county Persistent Health Professional Shortage Areas").

140. *See* TRENDS IN LICENSED HEALTH PROFESSIONS, *supra* note 136, at 12.

141. *See Physicians per 10,000 Population North Carolina, 2008*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RESEARCH, UNIV. OF N.C. AT CHAPEL HILL, http://www.shepscenter.unc.edu/hp/2008/maps/mdpop2008.pdf (last visited Nov. 17, 2010).

142. *See Core Based Statistical Areas (CBSAs) North Carolina, 2005*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RESEARCH, UNIV. OF N.C. AT CHAPEL HILL, http://www.shepscenter.unc.edu/rural/maps/NC _CBSA_Nov05.pdf (last visited Nov. 17, 2010).

143. *RUPRI State Demographic and Economic Profile Series: North Carolina*, RURAL POLICY RESEARCH INST., 4, http://www.rupri.org/Profiles/NorthCarolina2.pdf (last visited Nov. 17, 2010).

144. *See, e.g.*, NAT'L CANCER INST., CANCER HEALTH DISPARITIES (Mar. 11, 2008), *available at* http://www.cancer.gov/cancertopics/factsheet/disparities/cancer-health-disparities; Juan Carlos Arango-Lasprilla et al., *Traumatic Brain Injury and Functional Outcomes: Does Minority Status Matter?*, 21 BRAIN INJ. 701, 707 (2007) (discussing that minorities often have worse outcomes than Caucasians one year after suffering a traumatic brain injury); Paul S. Chan et al., *Racial Differences in Survival After In-Hospital Cardiac Arrest*, 302 J. AM. MED. ASS'N 1195, 1199–1200 (2009) (finding that black patients were less likely to survive to hospital discharge); Jana Kaida Silva et al., *Ethnic Differences in Perinatal Outcome of Gestational Diabetes Mellitus*, 29 DIABETES CARE 2058, 2060–62 (2006) (describing differences in perinatal outcomes for babies born to certain ethnic groups); Jeff Whittle et al., *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 NEW ENG. J. MED. 621, 623–24 (1993) (finding that, even after accounting for financial and situational disparities, black patients were less likely to use invasive cardiac procedures than white patients); *Black Women More Likely to Have More Aggressive, Less Treatable Form of Breast Cancer*, SCIENCEDAILY (Sept. 13, 2007), http://www.sciencedaily.com/releases/

that different patients might have a negative or positive reaction to a proposed medical treatment for a reason wholly separate from their physician's ability to meet the applicable standard of care.[145] A national standard of care may not require the expert witness to be familiar with the defendant-physician's medical community and with the demographics of that community. As a result, a national standard of care may hold a physician to an improper standard if factors outside of the physician's control lead to a negative outcome. Since a "same or similar community" standard of care requires an expert witness to be familiar with the defendant-physician's medical community, the expert witness must know whether the defendant-physician was dealing with factors, such as demographics, that might have impacted the medical outcome.[146]

Fourth, variations in medical strategies for treating patients exist between different geographic regions. While there are ample examples of this regional differentiation, a few are listed to illustrate this point.[147] Clear "geographic variation" exists for the "treatment of . . . [heart attacks] in the United States."[148] These differences are evident in the use of "aspirin therapy" and other pharmaceuticals, surgical solutions, and even counseling to patients upon discharge.[149] Also, the regularity with which different pediatric hospitals use "[a]ntireflux procedures"[150] for children with gastroesophageal reflux

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2007/09/070911214659.htm; *Hispanic Women at Higher Risk for Breast Cancer—May be Biological*, SCIENCEDAILY (Apr. 10, 2007), http://www.sciencedaily.com/releases/2007/04/070409082423.htm; *Racial Disparities Seen in Male Breast Cancer Survival*, SCIENCEDAILY (Mar. 18, 2007), http://www.sciencedaily.com/releases/2007/03/070317125448.htm; *Studies Shed Light on Racial Disparities in Cancer Survival*, SCIENCEDAILY (July 13, 2009), http://www.sciencedaily.com/releases/2009/07/090707161413.htm; *Study of Neighborhoods Points to Modifiable Factors, Not Race, in Cancer Disparities*, SCIENCEDAILY (Apr. 13, 2009), http://www.sciencedaily.com/releases/2009/04/090413083320.htm; *Worse Breast Cancer Outcomes for Women from Poorer Backgrounds Are Not Due to Late Diagnosis Alone*, SCIENCEDAILY (Mar. 24, 2010), http://www.sciencedaily.com/releases/2010/03/100324085300.htm.

145. *See, e.g.*, *Findings Reveal Racial Disparities in Pain Treatment Outcomes*, THE MED. NEWS (Feb. 5, 2010), http://www.news-medical.net/news/20100205/Findings-reveal-racial-disparities-in-pain-treatment-outcomes.aspx (describing how different races react differently to certain treatments).

146. *See supra* Part III.A.1.

147. *See* Peters, *supra* note 108, at 946 (describing how "physician practices vary widely, even within narrow geographic areas").

148. Gerald T. O'Connor et al., *Geographic Variation in the Treatment of Acute Myocardial Infarction: The Cooperative Cardiovascular Project*, 281 J. AM. MED. ASS'N 627, 628 (1999).

149. *Id.* at 629–31.

150. Adam B. Goldin et al., *Variations Between Hospitals in Antireflux Procedures in Children*, 163 ARCHIVES PEDIATRICS & ADOLESCENT MED. 658, 658 (2009).

disease ("GERD") has "tremendous variation" relative to other treatments such as "appendectomies, pyloromyotomies, and gastrostomy tube placements."[151] As this variation exists despite the lack of regional "clustering" of GERD,[152] and despite the improbability that the variations are attributable to "significant differences in each hospital's population," the variation appears to be due to differing treatment strategies between hospitals.[153] In addition, "pediatric hospital admission rates" for "pneumonia and bronchitis/asthma" vary between communities within the same state.[154] These variations in medical treatment strategies come from the fact that medical problems are extremely multifaceted and complex.[155] This complexity means that there is great "variety in possible therapeutic responses" to each medical problem, and each physician likely possesses different "preferences and . . . knowledge of medical literature and practices."[156] Therefore, preferred treatment strategies are likely to vary from place to place depending on the training and custom of that location; the customary treatment in one location might not be the accepted practice in another location.[157] The "one-size-fits-all" approach of a national standard of care will not always be appropriate.[158]

2. A Discussion of Alternative Approaches

The proposed implementation of section 90-21.12 will ensure that the "same or similar communities" standard of care is workable and appropriate in North Carolina medical malpractice cases. This

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151. *Id.* at 660–61.

152. *Id.* at 661.

153. *Id.*

154. Susan M. C. Payne et al., *Variations in Pediatric Pneumonia and Bronchitis/Asthma Admission Rates*, 149 ARCHIVES PEDIATRICS & ADOLESCENT MED. 162, 162–64 (1995).

155. *See* Peters, *supra* note 108, at 947 (noting the "highly differentiated nature" of medicine).

156. *Id.*

157. *See Advice for New EM Grads*, MOVIN' MEAT (June 11, 2008, 6:30 AM), http://allbleedingstops.blogspot.com (advising newly-hired physicians to "[f]igure out the local standard of care," as "[e]very hospital handles stuff differently"). The blog gives examples of possible variations in hospitals, asking: "Do they admit syncope? Is there a rapid chest pain protocal [sic]? Does your group write admitting orders? Who admits GI bleeds? How sick do you need to be to get into the ICU? Conscious sedation?" *Id.* The blog then advises the young physicians to adhere to the local methods, treatments, and protocol, by saying "[d]on't rock the boat (yet)." *Id.*; *see also* Peters, *supra* note 108, at 958 (stating that "medical customs differ widely and inexplicably from one location to another").

158. *See* Sorrel, *supra* note 57.

section will briefly explore other proposed methods for establishing the standard of care. This section will then confirm the value of this proposed procedure under section 90-21.12 as a simpler, more efficient way to determine the applicable standard of care.

a. Objective Geographic Survey Approach[159]

One proposed method of establishing the standard of care for medical malpractice cases uses "surveys of a relevant population of physicians to determine [the standard of] care."[160] This method relies on surveys of other physicians' responses to a medical case to determine whether the treatment and care provided by a defendant-physician in a certain circumstance was appropriate or reasonable.[161] Likewise, this method may rely on "statistical data about doctors' performance[s]" to ascertain the standard of care and the appropriate responses to given medical situations.[162] While this approach claims to provide a more reliable representation of the standard of care in a given community and to minimize the jury's need to rely on the "credibility or . . . sympathy" of a witness,[163] there are several likely problems. First, requiring the standard of care to be derived from objective studies that survey a certain geographic region's approach to medical care would likely be costly. Second, there is a desire to avoid using a " 'mechanistic and rigorous' " method of qualifying expert witnesses to testify in medical malpractice cases.[164] Surveys may also be more impractical in "cases in which the relevant facts are . . . lengthy [or] in dispute and can [not] be readily extracted from the medical records."[165] Finally, there is the persistent truth that "statistical analysis is itself subject to error,"[166] which would discredit any claim to this method's greater accuracy. Therefore, the thorough

159. This Comment refers to the variety of proposals that deal with using broad, objective studies to determine the standard of care in a given area as "Objective Geographic Survey Approaches."

160. Cramm et al., *supra* note 55, at 726.

161. *Id.* at 726–29.

162. William Meadow & Cass R. Sunstein, *Statistics, Not Experts*, 51 DUKE L.J. 629, 631 (2001) (emphasis omitted); *see also* Michelle M. Mello, *Using Statistical Evidence to Prove the Malpractice Standard of Care: Bridging Legal, Clinical, and Statistical Thinking*, 37 WAKE FOREST L. REV. 821, 821 (2002) (discussing the pros and cons of "supplement[ing] expert opinion testimony in medical malpractice cases with more objective empirical evidence").

163. Meadow & Sunstein, *supra* note 162, at 641.

164. Crocker v. Roethling, 363 N.C. 140, 150, 675 S.E.2d 625, 633 (2009) (quoting Howerton v. Arai Helmet, Ltd., 358 N.C. 440, 464, 597 S.E.2d 674, 690 (2004)).

165. Cramm et al., *supra* note 55, at 734.

166. Meadow & Sunstein, *supra* note 162, at 642.

application of section 90-21.12 in North Carolina is likely less costly and more practical than (and as accurate as) the proposed objective survey approaches.

b. Reasonableness Approach

Another proposed approach requires determining whether a physician acted reasonably in a given situation, instead of determining if she breached an established standard of care.[167] This approach treats medical malpractice cases more like ordinary negligence cases because it relies on whether the defendant acted as a reasonable, prudent person would act.[168] Under this method, the jury has a greater role in determining the liability of a defendant since it ultimately sets the standard for the defendant and tailors that standard to the "values of the community."[169]

However, the practice of medicine involves specialized knowledge, training, and experience not likely shared by the jury.[170] Therefore, asking a jury to apply a "reasonable person" analysis to medical professionals is problematic.[171] Furthermore, "articulat[ing] the standard in terms of the reasonable, prudent physician" typically does not eliminate the need for "expert testimony," so this proposed approach does not appear to effectuate a "change in the way that most malpractice cases are tried."[172] In addition, it is difficult to reconcile North Carolina's system, in which the standard of care is developed from testimony of qualified experts, with the "reasonable person standard."[173]

167. Cramm et al., *supra* note 55, at 707–08.

168. *See* ALEXANDER ET AL., *supra* note 26, at 16 (introducing the elements required to show negligence).

169. Peters, *supra* note 108, at 959.

170. *Id.* at 921 (noting the concern that "lay jurors lack the training needed to evaluate complex medical treatment decisions").

171. Leonard J. Nelson III, Helling v. Cary *Revisited: Physician Liability in the Age of Managed Care*, 25 SEATTLE U. L. REV. 775, 776 (2002).

172. *Id.* at 776–77.

173. King, *supra* note 77, at 1245–46.

c. Daubert *Approach*[174]

Finally, others propose that the approach developed in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[175] which guides judges to determine whether the basis for an expert's testimony is valid,[176] can be applied to expert testimony in medical malpractice cases.[177] This approach is useful in "exclud[ing] expert opinion grounded on incorrect factual assumptions . . . [and] ensur[ing] that the expert's opinion regarding the standard of care is based on valid science."[178] However, expert testimony on the standard of care in medical malpractice cases involves the expert "merely stating an empirical fact she has perceived."[179] This is inherently different from "expert testimony in most other tort cases," which requires the expert to give "an opinion derived from data or other scientific inquiry by employing a recognized methodology."[180] As a *Daubert* analysis is "inapplicable to a percipient witness,"[181] it is not likely the best approach to establishing whether a stated standard of care is appropriate. Furthermore, this approach conflicts with North Carolina's reluctance for trial courts to take on a "gatekeeping" role.[182]

Despite arguments that a national standard of care or an alternate approach should be implemented, the "same or similar community" standard of care remains the best way to determine whether a North Carolina physician is liable for medical malpractice.

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174. The determination of whether a medical expert is qualified to testify in a medical malpractice case has been distinguished from the role of the court in deciding whether a scientific or technical expert's testimony is "valid" under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). While courts have a "gatekeeping" role in the *Daubert* analysis, *id.* at 579, "courts have not been rigorous about screening experts based on their qualifications or knowledge" and "have been more inclined to employ [a] laissez-faire approach." Cramm et al., *supra* note 55, at 707. Whether an expert's opinion is based on "valid" or "reliable" data or methodology is more pertinent to the determination of whether a defendant-physician's breach of the standard of care caused the plaintiff's injury, which is another essential element of a professional malpractice claim. *See* Leatherwood v. Ehlinger, 151 N.C. App. 15, 23–24, 564 S.E.2d 883, 888–89 (2002).

175. 509 U.S. 579 (1993).

176. *See id.* at 594–95.

177. *See* Nichole Hines, iBrief, *Why Technology Provides Compelling Reasons to Apply a* Daubert *Analysis to the Legal Standard of Care in Medical Malpractice Cases*, 2006 DUKE L. & TECH. REV. 0018, 2 (2006), http://www.law.duke.edu/journals/dltr/articles/2006dltr0018.html.

178. *Id.* at 7.

179. Cramm et al., *supra* note 55, at 725.

180. *Id.*

181. *Id.*

182. *See* Crocker v. Roethling, 363 N.C. 140, 150, 675 S.E.2d 625, 633 (2009).

The next section will discuss how implementation of the "same or similar community" standard of care can occur in a way that allows the existence of a nationally uniform standard to be considered when appropriate.

B. *Living in Harmony: Reconciling the "Same or Similar Community" Standard with National Standardization of Health Care*

While the North Carolina statute plainly requires expert witnesses in medical malpractice cases to testify to the standard of care in a "same or similar community,"[183] the manner in which expert witnesses can establish their familiarity with the relevant standard of care and thus their qualification to testify under section 90-21.12 is unclear. This section will propose a manner in which expert witnesses can establish their familiarity with the defendant-physician's medical community, and explain how section 90-21.12 can be effective as health care continues to become more standardized across the nation.

In order to know the relevant standard of care, it seems unavoidable that the witness must have actual knowledge of the defendant's medical community, regardless of whether the witness is testifying to the standard of care in the "same" community (i.e. defendant's own medical community) or a "similar" community. However, mere knowledge or familiarity with the defendant-physician's medical community provides no inherent insight as to the standard of care that applies to that community. Therefore, the witness should be required to elucidate the link between the knowledge of the community and the relevant standard of care. This requirement will not infringe upon the court's decision in *Crocker v. Roethling*, which stated that an expert witness is not required to describe "how his knowledge about the community enabled him to ascertain the relevant standard of care."[184] Instead, the link would merely connect the witness's professed knowledge to his testimony on the standard of care. This would serve to simplify the process for the jury, similar to authentication of real evidence in a trial.[185] Thus, the entire "link" could be made in a simple three step process: (1) "I am familiar with defendant's community due to A, B, and C"; (2) "My

183. N.C. GEN. STAT. § 90-21.12 (2009).

184. *Crocker*, 363 N.C. at 147, 675 S.E.2d at 631.

185. *See* State v. Williams, 191 N.C. App. 254, 662 S.E.2d 577, 2008 N.C. App. LEXIS 1207, at *23 (2008) (unpublished table decision) (explaining that authentication is "a condition precedent to admissibility" of evidence in a trial, and can be satisfied by a witness's "[t]estimony that a matter is what it is claimed to be").

familiarity with the community enables me to testify to the standard of care used there"; and (3) "This is the standard of care . . . ." If the expert happens to be testifying about the standard of care in a similar community, only the first step must be changed: "I am familiar with this community due to D, E, and F, and I know that this community is similar to the defendant's community due to G, H, and I." This does not need to be a rigorous process in every case.[186] However, a step must be made between an expert's "superficial statements of fact about the community in question" and the "expert's bald assertion of familiarity with the applicable standard of care."[187] Without this link, there is no way for the judge to ascertain whether the expert is actually helping the jury "determine a fact in issue," as is required by Rule 702.[188] Thus, the link goes to a preliminary matter of whether the expert is qualified to testify, rather than to a matter of credibility that should be left for the jury.[189]

Even with the "same or similar community" standard in place, a national standard of care can still have a role in expert testimony. If a national standard of care truly applies to the community at issue, it will be one component of the standard of care to which the witness must testify.[190] Therefore, the expert witness should present adherence to a national standard of care as part of the expert's demonstration of familiarity with the defendant's medical community.[191] However, this does not eliminate the need for the

186. *Crocker*, 363 N.C. at 152, 675 S.E.2d at 634 (Martin, J., concurring).

187. *Id.* at 160, 675 S.E.2d at 638 (Newby, J., dissenting).

188. N.C. R. EVID. 702(a).

189. *See* Howerton v. Arai Helmet, Ltd., 358 N.C. 440, 458, 460–61, 597 S.E.2d 674, 686–88 (2004) (stating that "trial courts must decide preliminary questions concerning the qualifications of experts to testify or the admissibility of expert testimony" but that questions regarding "the weight to be afforded to" an expert's testimony should be left to the jury).

190. Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 215, 550 S.E.2d 245, 249–50 (Hudson, J., dissenting), *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001); *see also id.* at 212, 550 S.E.2d at 248 (majority opinion) (" '[I]f the standard of care for Greensboro matched the highest standard in the country, [defendant's] treatment of [plaintiff] exceeded that standard.' " (quoting Marley v. Graper, 135 N.C. App. 423, 430, 521 S.E.2d 129, 134 (1999))).

191. *Id.* at 217, 550 S.E.2d at 250–51 (Hudson, J., dissenting) (stating that "there is no reason why a jury should not be allowed to consider factual evidence of a national standard of care" when "determin[ing] the applicable standard of care in each particular case"). Thus, just as the expert's knowledge of the community's population, resources, facilities, medical professionals available, among other things, will each be factors that the expert will consider when determining the standard of care used in that community, the existence of a national standard of care that applies to that community will also be taken into account when ascertaining the standard of care used in that community. The jury's determination will include the consideration of whether a reasonable physician in that

expert to demonstrate actual knowledge of the community and the means through which this familiarity enabled the witness to testify to the standard of care. If experts do not demonstrate their familiarity with the community, they fail to show that they have any real way of knowing that the national standard applies to that community, and thus, that the national standard of care is relevant.[192] Furthermore, testifying about a national standard without showing why it is relevant to the community at issue ignores the requirements of section 90-21.12.[193] However, the national standard of care can be applied to a North Carolina medical malpractice case after the expert witness first establishes his familiarity with the community at issue, links that familiarity to the standard of care, and compares that community standard to a national standard.[194] Thus, the court would not disqualify an expert's testimony because of the mere mention of a national standard of care.[195]

Ultimately, the jury should not be instructed on the national standard of care, but should only be allowed to consider the expert's testimony regarding the existence of a national standard in the community at issue when considering "the greater weight of the evidence."[196] This is because the statute clearly requires that the final standard of care that the jury considers when determining whether a defendant-physician is liable must be the standard of care of a "same or similar communit[y]," not the nation.[197] By implementing this process for qualifying an expert witness to testify on the relevant standard of care in a North Carolina medical malpractice case, the

community with the resources, facilities, personnel, population, and funding available in that community would have (a) known that a national standard of care applied, and (b) acted as she did.

192. *See id.* at 212–13, 550 S.E.2d at 248 (majority opinion) (holding that the expert witness's testimony was "unfounded and irrelevant" because of the witness's failure to show how familiarity with the national standard of care had any application to the standard of care at issue); *id.* at 219, 550 S.E.2d at 252 (Hudson, J., dissenting) ("[H]ow can you compare an apple if the only thing you've looked at is oranges?").

193. *Id.* at 215, 550 S.E.2d at 249 (describing the "crucial, albeit subtle, distinction between adopting a national standard of care as a matter of law, and allowing a party to present evidence of a national standard of care as a matter of fact").

194. *Id.* at 221, 550 S.E.2d at 253 (explaining that an expert witness can testify about a national standard of care only if "he also specifically testif[ies] that he is familiar with the standard of care in the community in question or similar communities based on his assertion that the uniform standard is, in fact, the standard practiced in the community in question").

195. Crocker v. Roethling, 363 N.C. 140, 146, 675 S.E.2d 625, 631 (2009).

196. N.C. GEN. STAT. § 90-21.12 (2009).

197. *Id.*

existence of a national standard of care can be a component of the expert's testimony under section 90-21.12.

C. *How Section 90-21.12 Can Be Efficiently Implemented into North Carolina Medical Malpractice Law*

As is evident from the *North Carolina State Bar Journal* article advising attorneys on how to navigate the "minefield" of requirements for expert witnesses in medical malpractice cases, section 90-21.12 is not an easy statute to adhere to in practice.[198] However, this section briefly sets forth some suggestions for a workable approach to expert witness qualification that will enable the "same or similar community" standard of care to be implemented in an effective and efficient manner.[199] Courts should require expert witnesses to demonstrate their familiarity with the defendant-physician's medical community and show how this familiarity enables them to ascertain the relevant standard of care.

1. Establishing Familiarity

The first step in determining whether a proposed expert witness is qualified to testify under section 90-21.12 is to establish that the expert is sufficiently familiar with the defendant's medical community to know the standard of care.[200] North Carolina's statute does not prescribe a specific way that an expert witness must demonstrate his qualifications.[201] However, "*some* acceptable method" of ascertaining

198. Canepa, *supra* note 11, at 6.

199. Although section 90-21.12, Rule 702, and Rule 9(j) set forth other requirements on obtaining a qualified expert witness for a medical malpractice case, this Comment only focuses on the requirement of section 90-21.12 that an expert testify about the standard of care in a "same or similar community."

200. *See* Smith v. Whitmer, 159 N.C. App. 192, 196, 582 S.E.2d 669, 672 (2003) (stating that a proposed "witness must demonstrate that he is familiar with the standard of care in the community where the injury occurred, or the standard of care of similar communities"). This Comment maintains that the expert establishes knowledge of the relevant standard of care by demonstrating familiarity with the defendant's community and then uses the established familiarity to show that the expert knows the appropriate standard of care.

201. *See* Crocker v. Roethling, 363 N.C. 140, 147, 675 S.E.2d 625, 631 (2009).

> Nothing in our statutes or case law . . . prescribe[s] any particular method by which a medical doctor must become "familiar" with a given community. Many methods are possible, and our jurisprudence indicates our desire to preserve flexibility in such proceedings. The witness must show only that "other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue."

the relevant standard of care is necessary.[202] There are a number of factors to consider.

First, the expert should have some knowledge of the medical resources that are available in the defendant's community.[203] This includes knowledge of the community's "conditions, facilities, and [the] equipment available to a health care professional."[204] Second, the expert should be familiar with the demographics of the community[205] and any specific medical problems that may occur in that community more or less frequently than in other communities.[206] Third, the number of health care professionals in the community is also relevant to being familiar with the medical community at issue, as this will undoubtedly reflect the resources to which a community has access, the extent of care that the community is capable of providing, and the time and focus that health care professionals in that community are able to provide to each individual patient.[207] Finally, the expert witness should know whether a national or statewide standard of care applies to the community at issue. The presence or lack of a broader standard of care is an important component of every medical community, and an expert witness who is sufficiently familiar with a community so as to be able to testify on its standard of care should certainly have that knowledge.[208]

While the *Crocker* court states that "a prospective medical expert . . . [need not be required to] produce documentation of his

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Id. (quoting N.C. R. EVID. 702(a)); *see also id.* at 150, 675 S.E.2d at 633 (Martin, J., concurring) (stating that "the North Carolina approach is decidedly less mechanistic and rigorous than . . . the federal approach").

202. *Id.* at 158, 675 S.E.2d at 638 (Newby, J., dissenting).

203. *See Smith*, 159 N.C. App. at 196–97, 582 S.E.2d at 672–73 (affirming the trial court's exclusion of the expert's testimony after the expert "offered no testimony regarding . . . the resources available in the defendants' medical community").

204. Henry v. Se. OB-GYN Assocs., 145 N.C. App. 208, 213, 550 S.E.2d 245, 248 (Greene, J., concurring) (explaining that medical communities tend to differ based on the above mentioned characteristics), *aff'd per curiam*, 354 N.C. 570, 557 S.E.2d 530 (2001).

205. *See* Purvis v. Moses H. Cone Mem'l Hosp. Serv. Corp., 175 N.C. App. 474, 480–81, 624 S.E.2d 380, 385 (2006) (affirming summary judgment where expert failed to qualify for lack of demographic knowledge).

206. *See Henry*, 145 N.C. App. at 217, 550 S.E.2d at 250 (Hudson, J., dissenting).

207. *See supra* Part III.A.

208. *See Smith*, 159 N.C. App. at 197, 582 S.E.2d at 673 (affirming exclusion of expert testimony where expert failed to connect a national standard of care to the community in question); *see also* Treat v. Roane, 179 N.C. App. 436, 634 S.E.2d 273, 2006 N.C. App. LEXIS 1875, at *10–11 (2006) (unpublished table decision) (explaining that the expert cannot merely state that a national standard of care applies to a certain community without establishing that his knowledge of the community is the basis for his opinion).

research,"[209] having a witness to testify about a "same or similar community" is an essential requirement of the North Carolina statute.[210] Although the ultimate determination should be *whether* the proposed witness is sufficiently familiar with the community at issue to determine the relevant standard of care, *how* the expert gained the familiarity with the community is an essential part of determining whether the expert actually has the requisite familiarity.[211] If the witness only claims to know the relevant standard of care, but in reality lacks the familiarity with the defendant's community to either know the community's standard of care or know that the community is similar to another community for which the expert does know the standard of care, an essential element of the plaintiff's case has not been shown.[212]

However, if the expert shows her familiarity is grounded in actual evidence, "the weight to be afforded to the evidence" is left to the trier of fact.[213] Thus, "[b]ook or Internet research may be a perfectly acceptable method of educating oneself regarding the standard of medical care applicable in a particular community."[214] Likewise, a proposed expert witness need not "have actually practiced in the community in which the alleged malpractice occurred, or even to have practiced in a similar community."[215] The definitive determination is whether the expert is familiar with the community at issue or a similar community, for which the requisite confirmation is flexible.[216] However, if the witness's sole knowledge of the community at issue comes from a party's lawyer, an inherently biased source, a jury will likely have reason to afford the expert's testimony less weight even if the expert demonstrates familiarity with the community.[217]

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209. Crocker v. Roethling, 363 N.C. 140, 147, 675 S.E.2d 625, 631 (2009).

210. N.C. GEN. STAT. § 90-21.12 (2009).

211. *See Treat*, 2006 N.C. App. LEXIS 1875, at *10–11 (disqualifying an expert who failed to state why he believed a national standard of care applied to the community in question).

212. *See supra* Part I.C.

213. *See Crocker*, 363 N.C. at 150, 675 S.E.2d at 632.

214. *Id.* at 151, 675 S.E.2d at 633 (Martin, J., concurring).

215. *Id.*

216. *See id.* at 146–47, 675 S.E.2d at 630–31 (majority opinion) (noting that the expert stated that he was familiar with the community in question, which distinguished the case from previous cases where the expert had not demonstrated that familiarity).

217. *See* Smith v. Whitmer, 159 N.C. App. 192, 196–97, 582 S.E.2d 669, 672–73 (2003) (excluding expert's testimony where his professed familiarity with the community in question was from a conversation with plaintiff's counsel).

Furthermore, if the expert is testifying about the standard of care in a community "similar" to the defendant's medical community, the expert should still be required to demonstrate familiarity with the defendant's community. Without establishing this familiarity, the expert's assertion that the defendant's medical community is similar to the allegedly "similar" medical community is baseless. However, once the expert illustrates his familiarity with each community and his reasons for calling the two communities "similar," the expert should not be required to demonstrate why the standard of care in the defendant's community is the same as the standard of care in the "similar" community. If the two medical communities are accepted as "similar," the standard of care in each community can be expected to be the same; if there is a reason that the standard of care in one community differs from that in the other, the communities are likely not "similar" in the first place. Requiring the expert witness to demonstrate familiarity with the defendant's medical community, or likewise, to demonstrate familiarity with the defendant's medical community and an allegedly similar community for which the expert claims to know the standard of care, will limit disputes over whether an expert is qualified to testify on the relevant standard of care under section 90-21.12.

2. The Essential Link

After establishing sufficient familiarity with the pertinent community, the expert witness must then make the connection between the familiarity and his testimony on the relevant standard of care. [218] This can be in the form of authenticating that the familiarity with the community allows the expert witness to know the standard of care of the community. This was seen in *Leatherwood v. Ehlinger*,[219] where an expert established familiarity with the community and stated, " 'Asheville and other [similar] communities . . . practice in the same national standards.' "[220] Thus, the medical expert need not "attempt to explain to the trial judge how his knowledge about the community enabled him to ascertain the relevant standard of care";[221] he must only state that there is indeed a basis for his testimony regarding the standard of care, i.e., the familiarity with the

218. *See Crocker*, 363 N.C. at 160, 675 S.E.2d at 638 (Newby, J., dissenting).

219. 151 N.C. App. 15, 564 S.E.2d 883 (2002).

220. *Id.* at 22, 564 S.E.2d at 888.

221. *Crocker*, 363 N.C. at 147, 675 S.E.2d at 631; *see also id.* at 153, 675 S.E.2d at 634 (Martin, J., concurring) (opining that a voir dire examination of an expert need only be utilized in "close cases").

community.[222] Requiring the expert witness to clarify how his demonstrated familiarity with the community enables him to ascertain the relevant standard of care and helps eliminate controversy that may arise regarding whether the expert is actually familiar with the appropriate standard of care and thus eligible to testify in a medical malpractice case.

3. Why Do It This Way?

This proposed procedure requires expert witnesses to demonstrate the evidence upon which their testimony regarding a community's standard of care is based, in contrast to current North Carolina law, which does not require an expert witness to express this underlying knowledge.[223] Although seemingly complex, this implementation of section 90-21.12 is necessary for medical malpractice cases for a number of reasons. First, in order for medical malpractice outcomes to be accurate and just, there must be an expert witness that can attest to truly being familiar with the applicable standard of care such that the expert witness can confidently give an opinion on whether the defendant-physician breached that standard. Medical treatment often involves making complex decisions based on a multitude of factors,[224] many of which are inherently risky.[225] As physicians are specifically trained to make these choices and undertake these responsibilities, they must be able to do so with the confidence that can only come from knowing the legal ramifications of their actions.[226] Thus, the efficient functioning of medical practice depends on a physician's ability to rely on a clearly stated and adequately supported standard of care that takes into account the realities of the specific medical community at issue. Likewise, the complexity of medical malpractice cases results in the need for an expert witness.[227] Requiring an expert witness to demonstrate his familiarity with the community at issue, and thus with the relevant standard of care, will "protect[] the jury from unreliable expert testimony yet preserv[e] the jury's role in weighing the credibility of expert testimony when appropriate."[228] In addition, the more

222. *See Smith*, 159 N.C. App. at 196, 582 S.E.2d at 672.

223. *See Crocker*, 363 N.C. at 147, 675 S.E.2d at 631.

224. *See supra* Part III.A.1.

225. *See* Keeton, *supra* note 27, at 359.

226. *See* King, *supra* note 77, at 1255 (arguing that a cognizable legal standard would allow physicians to predict the consequences of their actions and eliminate the tendency for physicians to practice defensive medicine).

227. *See Crocker*, 363 N.C. at 157, 675 S.E.2d at 637 (Newby, J., dissenting).

228. *Id.* at 153, 675 S.E.2d at 635 (majority opinion).

evidentiary basis there is for an expert's testimony, the more credibility a jury will likely give to the testimony.[229]

Second, this suggested implementation of qualifying expert witnesses under section 90-21.12 is necessary because it will help ensure that the medical malpractice system is functioning effectively by fulfilling its main objectives.[230] Medical malpractice claims purportedly deter physicians from acting negligently.[231] Although negative outcomes in medical care often come with a tremendous amount of emotion, the fault does not always lie in the hands of the health care provider; however, the "current malpractice system does an extraordinarily poor job in identifying cases of true malpractice and screening out iatrogenic injury occurring without physician fault."[232] Applying section 90-21.12 in the proposed manner will ensure deterrence, as physicians will know that there is a clear process for finding a credible expert witness to testify against them in a medical malpractice action if they fail to exercise care. Furthermore, requiring potential medical experts to establish their familiarity with the defendant's medical community and to link that familiarity with their ability to ascertain the relevant standard of care in a same or similar community will be a strong step towards correctly determining whether a defendant-physician was actually negligent, because the expert's testimony will be clearly based on the expert's factual knowledge. If a physician believes that there is a medical malpractice system in place that will punish physicians that are truly acting negligently, she will likely attempt to perform her job with the utmost care in order to avoid liability.

Third, applying section 90-21.12 in this manner will ensure that victims who are truly injured by a physician's negligent acts will prevail in medical malpractice actions and thus be "made whole."[233] Expert witnesses who are qualified under this proposed implementation of section 90-21.12 will have already demonstrated their familiarity with the applicable standard of care and their knowledge that the defendant-physician breached this standard.[234]

229. *See id.* at 157, 675 S.E.2d at 637 (Newby, J., dissenting) (explaining that "lay jurors will naturally accord great weight to expert testimony").

230. Andrew Brine, Note, *Medical Malpractice and the Goals of Tort Law*, 11 HEALTH L.J. 241, 243–44 (2003).

231. *Id.* at 247.

232. Cramm et al., *supra* note 55, at 713, 715–16 (describing a study finding 83% of medical malpractice claims "were filed against providers who had not been negligent").

233. *See* Brine, *supra* note 230, at 244.

234. *See supra* Parts III.B, III.C.1–2.

Therefore, a jury will likely find this testimony credible, which will be a major step towards reaching a fair outcome in a medical malpractice trial.

Fourth, applying section 90-21.12 in this manner will serve to educate physicians on the acceptable way to practice medicine in their community. Negligence often arises among professionals due to ignorance of the acceptable way to perform one's job.[235] Requiring an expert witness to demonstrate how he became familiar with the defendant-physician's medical community and to describe how this familiarity allowed him to know the relevant standard of care could help inform other physicians in the local medical community. Not only would doctors be on notice of the existence of their unique community, but, more importantly, they could be better aware of the standards to which they must adhere.[236]

Finally, requiring the expert witness to demonstrate his knowledge of the defendant's community and how this knowledge enables him to testify on the relevant standard of care will serve to maintain the roles of judge and jury in the courtroom, thus maintaining the nature of North Carolina's legal system.[237] If an expert clearly demonstrates his familiarity with a medical community, the witness's subsequent testimony is less likely to be challenged. Whether the expert testifies that another community is similar to the one in question, that a national or statewide standard applies, or generally as to the standard of care, this link underlines how the expert actually knows the relevant standard of care. As a result, the link between the expert's familiarity with the medical community and the standard of care does nothing but strengthen his testimony. Furthermore, finding an expert witness who either has or is willing to obtain the requisite familiarity with the pertinent medical community is not a herculean task, as it often was under the locality rule,[238] since there is "ample opportunity to obtain supportive expert testimony in malpractice cases."[239]

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235. Brine, *supra* note 230, at 253.

236. *Cf.* Drapp, *supra* note 102, at 128 (discussing the uncertainty a national standard of care imposes on health care providers).

237. Crocker v. Roethling, 363. N.C. 140, 147–48, 675 S.E.2d 625, 631 (2009).

238. *See supra* note 62 and accompanying text; *see also* Drapp, *supra* note 102, at 124 (describing the unwillingness of physicians to testify as witnesses against colleagues, referred to as the "conspiracy of silence").

239. Cramm et al., *supra* note 55, at 700; *see also* Drapp, *supra* note 102, at 125–27 (discussing how a national standard of care allows a party to "search for the witness who will best support his medical and legal theories"); Peters, *supra* note 108, at 922 (describing the availability of "plaintiffs' attorneys and their hired-gun experts"). *See*

CONCLUSION

Section 90-21.12 is appropriate to effectively and efficiently meet the realities of North Carolina's medical landscape, while still ensuring a just resolution to medical malpractice claims. Therefore, changing section 90-21.12 to a national standard of care is not necessary. Expert witnesses should be required to demonstrate their knowledge of the defendant's medical community, and, if applicable, a similar community, and to show the link between their familiarity with that community and their testimony on the relevant standard of care. Statements on the presence of a national standard of care should not be barred, but should be taken in context as one element of the expert's knowledge of the community at issue. Remaining true to North Carolina's statute will bring predictability to both medical providers and medical patients in North Carolina, as physicians will be able to act with confidence, patients will know what to expect from treatment, and patients will be aware of their rights within the medical malpractice system.

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generally Medical Experts for Malpractice & Personal Injury Cases, AMFS: AMERICA'S PREMIER EXPERT WITNESSES, http://www.amfs.com/ (last visited Nov. 17, 2010) (boasting "8,500+ Experts in 250+ Specialties"); *Medical Malpractice Expert Witnesses and Consultants*, EXPERTPAGES, http://expertpages.com /experts/medicalmalpractice.htm (last visited Nov. 17, 2010) (allowing users to choose an expert witness by state).