NORTH CAROLINA LAW REVIEW

Volume 91 | Number 2 Article 7

1-1-2013

Senate Bill 33 Grants Protection to Emergency Room Providers - and Just about Everyone Else, Too

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INTRODUCTION

The North Carolina General Assembly recently passed a hotly debated bill that reformed medical malpractice liability in several ways.[1] Although this legislation received much attention because it placed a cap on noneconomic damages in medical malpractice suits,[2] another provision also drastically alters current medical malpractice law in North Carolina. The General Assembly gave emergency health care providers further protection from liability by raising the burden of persuasion from the normal "preponderance of the evidence" standard to the "clear and convincing" standard for plaintiffs with claims arising out of emergency treatment.[3] The General Assembly seemingly intended only to grant this heightened liability protection to health care providers working in hospital emergency rooms.[4] Drafters of the bill included limiting language tying the heightened protection directly to a patient's location in a hospital emergency room in all earlier drafts of the bill.[5] However, the final enacted version does not include language limiting the protection solely to emergency room providers.[6]

This Recent Development posits that by omitting the limitation based on a patient's location in a hospital emergency room,[7] the General Assembly inadvertently or unwisely extended the heightened protection intended solely for emergency room health care providers to providers in a myriad of other contexts.[8] In effect, the enacted language raises the evidentiary standard for plaintiffs bringing claims against any health care provider in *any* location, as long as the individual was treated for an "emergency medical condition" as that

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1. Act of July 25, 2011, ch. 400, § 6, 2011 N.C. Sess. Laws 1712 (codified at N.C. GEN. STAT. § 90-21.12 (2011)).

2. *See* Phillip Bantz, *Medical Malpractice Actions Continue to Fall*, N.C. LAW. WKLY., Sept. 12, 2011, at 3; *see also* Act of July 25, 2011, § 7 (capping noneconomic damages in medical malpractice suits).

3. *See* Act of July 25, 2011, § 6.

4. *See* discussion *infra* Part I.A.

5. *See* discussion *infra* Part I.A

6. *See* Act of July 25, 2011, § 6.

7. *See* discussion *infra* Part. I.A, B.

8. *See* discussion *infra* Part III.

term is defined under the Emergency Medical Treatment and Active Labor Act ("EMTALA").[9] Specifically, this protection may now extend to treatment of emergencies in local doctors' offices, in hospitals without emergency rooms, and even in situations occurring completely outside of a treatment facility where a health care provider intervenes to render emergency aid.[10] Further, because the new statute defers to EMTALA's definition of "emergency medical condition," which includes active labor cases where a pregnant woman is close to the time of her delivery, the General Assembly has changed the field of obstetrics malpractice by raising the burden of persuasion for many plaintiffs with claims arising out of normal childbirth.[11]

This Recent Development urges the General Assembly to amend the statute's language so it provides protection solely to emergency room health care providers treating emergency medical conditions. To do so, the General Assembly should reincorporate the explicit limitation, found in versions four and five of the bill, that the protection applies only to claims resulting from the "furnishing or the failure to furnish professional services *in a hospital emergency room*."[12] Without this limitation, the legislation places an unwarranted evidentiary burden on plaintiffs seeking recovery for injuries incurred through the negligence of heath care providers *outside* of emergency rooms.

This analysis will proceed in four parts. Part I sorts through the inner workings of the amended malpractice statute in North Carolina by explaining the transformation of the bill from the original filed version to the final enacted version, the apparent legislative intent behind the bill, and the overly broad wording of the newly amended malpractice statute. Next, Part II explains how the amended statute works when applied, and how Senate Bill 33 altered the plaintiff's burden of persuasion, but did not change the mental state that must be proven. Following the first two sections' discussion of the statute itself, Part III then explores the consequences of deferring to EMTALA's definition of "emergency medical condition" without also including a limitation that the patient was being treated in a hospital emergency room. Specifically, this Part explains how this

9. *See* Act of July 25, 2011, § 6; discussion *infra* Part III.

10. *See* discussion *infra* Part III.A, B.

11. *See* discussion *infra* Part III.C.

12. S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 20, 2011) (emphasis added); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 19, 2011) (emphasis added).

change may lead to heightened protection for providers working in non-hospital treatment facilities, in hospitals without emergency departments, in situations occurring outside of treatment facilities (such as in Good Samaritan and other emergency response situations), and in obstetrics suites and other child delivery cases. Lastly, Part IV recommends how the General Assembly should alter the statute's language in order for the heightened protection to only apply to treatment rendered (or failing to be rendered) in hospital emergency rooms.

I. BACKGROUND

A. *Legislative History and Intent of Senate Bill 33*

The legislative history of Senate Bill 33 strongly suggests that the General Assembly intended—at least up until the time of the final drafting stage of the bill—to only protect emergency health care providers when furnishing treatment in hospital emergency rooms, rather than protecting all health care providers in any situation they may find themselves providing emergency treatment.[13] In fact, all of the previous versions of Senate Bill 33 limited the protection to hospital emergency room treatment. Both the original filed version of

13. *See* N.C. S.B. 33 (Draft, Apr. 20, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish professional services in a hospital emergency room, the claimant must prove a violation of the standard of health care set forth in subsection (a) of this section by clear and convincing evidence."); N.C. S.B. 33 (Draft, Apr. 19, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish professional services in a hospital emergency room . . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Mar. 2, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish services pursuant to obligations imposed by 42 U.S.C. § 1395dd [EMTALA] for an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1) . . . ."); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Mar. 1, 2011) ("In any medical malpractice action arising out of the furnishing or the failure to furnish services pursuant to obligations imposed by 42 U.S.C. § 1395dd [EMTALA] for an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1) . . . ."); *N.C. Senate OKs Malpractice Reform*, WRAL (Mar. 2, 2011), http://www.wral.com/news/state/nccapitol/story/9205313/ ("Supporters say the change is needed because federal law doesn't let emergency room doctors choose their patients. They're required to treat anyone who needs help, no matter how difficult the case or how many other patients they're treating at the time. That makes emergency medicine a riskier specialty than other areas of practice."). Additionally, the Senate Judiciary Committee, in analyzing and summarizing an earlier version of the bill, labeled the section of this committee report that discussed the reforms to emergency health care as "Emergency Services *Required* to be Provided by Federal Law." S. JUDICIARY I COMM., SENATE PCS 33: MEDICAL LIABILITY REFORMS, S. 2011-33, Reg. Sess., at 1 (2011) [hereinafter LIABILITY REFORMS] (emphasis added). However, such services are only required under federal law in hospital emergency rooms, as discussed in the text accompanying *infra* note 19.

Senate Bill 33 and the first edited version stated that the heightened protection was to apply "[i]n any medical malpractice action arising out of the provision of emergency services as defined in G.S. 58-3-190(g)(2)."[14] Under the referenced North Carolina statute, "emergency services" includes the screening and treatment of emergency medical conditions in a hospital emergency department.[15] Thus, these two versions of the bill—the original filed version and first edited version—tied the protection directly to treatment in hospital emergency departments.[16]

Edited versions two and three of the bill continued to limit the protection only to hospital emergency room providers, but did so in a different way than the first two versions. The second and third edited versions provided that the protection applied "[i]n any medical malpractice action arising out of the furnishing or the failure to furnish services pursuant to obligations imposed by [EMTALA] for an emergency medical condition as defined in [EMTALA]."[17] EMTALA does not apply to all treatment facilities, but rather it applies only to "participating hospitals"—those hospitals that receive certain federal funding and have an "emergency department."[18] Therefore, these versions of the bill that limited the protection to those providers required to treat under EMTALA inherently included the limitation that the protection only extended to emergency department providers since they are the only providers with such an obligation.[19]

Lastly, versions four and five of the bill stated that the

14. S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Feb. 3, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Feb. 2, 2011).

15. *See* N.C. GEN. STAT. § 58-3-190(g)(2) (2011). This statute also includes "prehospital care and ancillary services routinely available to the emergency department," *id.*, but this Recent Development will not address the detailed nuances of when treatment services are considered to be "prehospital care" or ancillary to the emergency department.

16. *See id.*; N.C. S.B. 33 (Draft, Feb. 3, 2011); N.C. S.B. 33 (Draft, Feb. 2, 2011).

17. N.C. S.B. 33 (Draft, Mar. 2, 2011); N.C. S.B. 33 (Draft, Mar. 1, 2011).

18. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (2006) ("In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department . . . ."); Medero Diaz v. Grupo De Empresas De Salud, 112 F. Supp. 2d 222, 225 (D.P.R. 2000) ("A participating hospital is one that has executed a Medicare provider agreement with the federal government." (citations omitted)).

19. *See* 42 U.S.C. § 1395dd(a). There has been much controversy in the federal courts as to what it means that a patient has arrived at an emergency department, but what does and does not count as being in the emergency room is beyond the scope of this Recent Development. It is enough for this Recent Development's purposes to note that EMTALA duties only arise once a person arrives at the emergency department, *see id.*, without getting into the nuances of what counts as having arrived there.

heightened protection applied "[i]n any medical malpractice action arising out of the furnishing or the failure to furnish professional services in a hospital emergency room."[20] Thus, these two versions most clearly tied the protection to a patient's location in a hospital emergency room, but they left out the requirement that the patient must be suffering from an emergency medical condition, which was a limitation found in all of the other versions.[21] Notwithstanding other changes made between previous versions of the Senate Bill 33, one thing remained the same throughout: they all tied the protection to treatment in hospital emergency rooms.[22]

In addition to the previous versions of Senate Bill 33, other legislative history—including committee hearing minutes and committee bill summaries—suggests that the General Assembly intended for the protection to apply solely to hospital emergency providers. Committee meeting discussions were focused on balancing the concerns for emergency room health care providers with the concerns for the victims of emergency room medical malpractice.[23] One set of Senate committee meeting minutes captured Senator Nesbitt's concerns, noting, "Seems that this bill will take away the negligence standard in the emergency rooms. . . . We are trying to give people in emergency situations a little bit of slack, but not absolute immunity."[24] The record also summarized Senator Brown's position, stating that "the ER is a very special situation," and stating his belief "that those guys deserve some special protections."[25] The minutes from another committee meeting detailed Senator Stein's statement, noting that he "[could] only imagine how stressful it is to be an ER doc[tor] and want[ed] to recognize the unique challenges that they face."[26] In addition, a committee summary of one of the bill's earlier versions affirmed that the language had been

20. S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 20, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 19, 2011).

21. *See* N.C. S.B. 33 (Draft, Apr. 20, 2011); N.C. S.B. 33 (Draft, Apr. 19, 2011).

22. *See* N.C. S.B. 33 (Draft, Apr. 20, 2011); N.C. S.B. 33 (Draft, Apr. 19, 2011); N.C. S.B. 33 (Draft, Mar. 2, 2011); N.C. S.B. 33 (Draft, Mar. 1, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Feb. 3, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Feb. 2, 2011).

23. *See, e.g.*, *Senate Judiciary I Committee Feb. 24, 2011 Minutes*, 2011 Gen. Assemb., Reg. Sess. (N.C. 2011) [hereinafter *Feb. 24 Minutes*]; *Senate Judiciary I Committee Feb. 22, 2011 Minutes*, 2011 Gen. Assemb., Reg. Sess. (N.C. 2011) [hereinafter *Feb. 22 Minutes*]; *Senate Judiciary I Committee Feb. 17, 2011 Minutes*, 2011 Gen. Assemb., Reg. Sess. (N.C. 2011) [hereinafter *Feb. 17 Minutes*].

24. *Feb. 24 Minutes*, *supra* note 23, at 1 (statement of Sen. Nesbitt).

25. *Id.* (statement of Sen. Brown).

26. *Feb. 22 Minutes*, *supra* note 23, at 1 (statement of Sen. Stein).

intentionally altered to limit the application of the heightened protection "to malpractice actions arising out of emergency services required to be provided under EMTALA,"[27] which, as previously mentioned, are only required in hospital emergency departments.[28]

An examination of who the lobbying organizations were, as well as what the opponents of the bill were concerned about, further evidences that the focus all along was on emergency room care. For example, the North Carolina College of Emergency Physicians fought for Senate Bill 33 to be passed.[29] That organization is the North Carolina chapter of the American College of Emergency Physicians and is comprised of over 800 members practicing or studying emergency medicine in North Carolina.[30] On the other side of the debate, opponents of the bill included groups like North Carolina Advocates for Justice, who submitted a report to the General Assembly discussing the effects the bill would have on victims of malpractice in hospital emergency rooms and compiling letters from concerned citizens who were upset over the bill.[31] These constituent letters similarly focused on the effects this bill would have on emergency room malpractice victims, many telling personal stories of their own tragic experiences in a hospital emergency room.[32]

Overall, the record suggests that both the General Assembly and the public thought they were dealing with a provision that was going to give heightened protection to emergency room providers. Whether the General Assembly had a last minute change of heart and

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27. LIABILITY REFORMS, *supra* note 13, at 2.

28. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (2006).

29. *See Feb. 17 Minutes*, *supra* note 23, at 3 (statement of Greg Cannon, Secretary/Treasurer of North Carolina College of Emergency Physicians); Frank Smeeks, *Legislature Overrides SB33 Veto*, N.C. C. EMERGENCY PHYSICIANS (July 26, 2011), http://www.acepchapters.org/nc/News/LatestNews.aspx.

30. *About Us*, N.C. C. EMERGENCY PHYSICIANS, http://www.acepchapters.org/nc/AboutUs.aspx (last visited Sept. 14, 2012) ("The North Carolina College of Emergency Physicians ("NCCEP") is a chartered chapter of the American College of Emergency Physicians. NCCEP is a diverse group of practicing emergency physicians, including academicians, private practice physicians, large groups, small groups, individual physicians, board certified, non-board certified, rural, urban, residents, and medical students.").

31. For a report included in the submitted compilation of materials, see N.C. ADVOCATES FOR JUSTICE, SB 33: AN ATTACK ON VULNERABLE PATIENTS 1 (2011).

32. *See, e.g.*, Letter from Renee Hazelton to Bob Rucho, State Senator, N.C. Gen. Assembly (Feb. 10, 2011) (on file with the North Carolina Legislative Library and the author) ("Liam's pediatrician told me to take him to the emergency department, so I did. Despite my concerns, the ER doctor gave him only a very cursory exam . . . . As a result of the emergency doctor's negligence, my 16 month old son suffered a severe stroke . . . .").

purposefully extended the protection to other providers, or whether the change in the statute's scope was inadvertent, the newly amended malpractice statute has potentially far-reaching consequences outside of just hospital emergency rooms.

B. *The Language of North Carolina's Newly Amended Malpractice Statute*

The enacted version of Senate Bill 33 provides that,

> [i]n any medical malpractice action arising out of the furnishing or the failure to furnish professional services in the treatment of an emergency medical condition, as the term "emergency medical condition" is defined in 42 U.S.C. 1395dd(e)(1) [EMTALA], the claimant must prove a violation of the standards of practice set forth in subsection (a) of this section by clear and convincing evidence.[33]

Thus, the enacted version of the bill includes the limitation that the protection only applies for the treatment of an "emergency medical condition," but unlike *all* of the previous versions of the bill, the enacted version does not limit the heightened protection to a patient's location in a hospital emergency room.[34] It appears that in editing the final version, legislators intended to fix the language of versions four and five, which had left out the limitation that the protection only applied to treatment of an "emergency medical condition."[35] The General Assembly included the limitation based on the patient's physical condition in all other versions of the bill,[36] and the limitation was obviously thought important by the legislature, as they purposefully added it back into the final version after deleting it in versions four and five.[37] In making this final edit on the bill, the legislators were potentially trying to reincorporate the limitation based on the patient's medical condition ("emergency medical condition"), but, in doing so, inadvertently left out the second limitation based on the patient's location in a hospital emergency room. The emergency room location limitation, present in all previous drafts, had been the focus of the discussion all along.[38]

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33. Act of July 25, 2011, § 6, 2011 N.C. Sess. Laws 1712, 1715 (codified at N.C. GEN. STAT. § 90-21.12(b) (2011)).

34. *See id.*

35. *See* S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 20, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 19, 2011).

36. *See supra* notes 13–20 and accompanying text.

37. *See* Act of July 25, 2011, § 6.

38. *See* discussion *supra* Part I.A.

Regardless, whether the omission was intentional or inadvertent, removing the location limitation will cause serious and far-reaching consequences for medical malpractice litigation in North Carolina that were not discussed by the General Assembly in passing the bill.[39]

Although the statute fails to include the location limitation, it does place one limit on the outer bounds of the heightened protection—the patient's medical condition.[40] The heightened protection only applies to claims "arising out of . . . the treatment of an 'emergency medical condition,' " as defined under federal law in EMTALA.[41] EMTALA defines "emergency medical condition" as:

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
>
> (ii) serious impairment to bodily functions, or
>
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant woman who is having contractions—
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
>
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.[42]

Accordingly, under the new provision, anytime a health care provider treats or fails to treat a person in a condition that falls into one of these categories set out in EMTALA, she will have heightened protection from liability if the individual later sues for malpractice.[43]

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39. *See* discussion *infra* Part III.

40. *See* N.C. GEN. STAT. § 90-21.12(b) (2011).

41. *Id.* For a discussion of EMTALA and its history, see generally Lynn Healey Scaduto, *The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries*, 46 UCLA L. REV. 943 (1999).

42. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(e)(1) (2006).

43. *See* § 90-21.12(b).

II. THE NEW STATUTE IN ACTION

A. *Heightened Burden of Persuasion*

Although the muddied wording of the new medical malpractice statute makes it unclear as to *which* claims it will apply, it explicitly lays out what happens once a court determines that the statute does in fact apply to a particular malpractice claim—the plaintiff will face a heightened burden of persuasion.[44] A plaintiff's burden of persuasion defines the amount of evidentiary support required to convince a fact-finder to decide the case in her favor.[45] Rather than keeping with the typical "preponderance of the evidence" standard imposed in other medical malpractice actions,[46] the statute now provides that plaintiffs with claims resulting from the treatment of emergency medical conditions will have to prove their cases by "clear and convincing evidence."[47] This heightened protection from liability covers not just doctors, but all health care providers, including nurses and many other individuals rendering health care services in a number of medical fields.[48]

B. *Mental State Requirement*

Although plaintiffs treated for an emergency medical condition now face a heightened evidentiary standard, the mental state that the plaintiff must prove that the defendant provider possessed remains the same as for all medical malpractice claims—medical negligence.[49]

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44. *See id.*

45. *See* BLACK'S LAW DICTIONARY 223 (9th ed. 2009) (defining a party's burden of persuasion as "[a] party's duty to convince the fact-finder to view the facts in a way that favors that party").

46. *See* § 90-21.12(a).

47. *Id.* § 90-21.12(b); *see also In re* Smith, 146 N.C. App. 302, 304, 552 S.E.2d 184, 186 (2001) ("Clear and convincing evidence 'is greater than the preponderance of the evidence standard required in most civil cases.' " (quoting *In re* Montgomery, 311 N.C. 101, 109–10, 316 S.E.2d 246, 252 (1984)).

48. *See* § 90-21.11(1)(a) (defining "[h]ealth care provider" to include "[a] person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology"); *id.* § 90-21.11(2) (defining "[m]edical malpractice action," in part, as "[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"); *id.* § 90-21.12(b) (applying the heightened standard to medical malpractice actions arising from emergency treatment).

49. *See* § 90-21.12.

In proving a typical medical malpractice claim, plaintiffs must show that the defendant health care provider's mental state reached the level of medical negligence at the time of the alleged malpractice, and must do so by showing that the provider breached his statutory duty of care.[50] In North Carolina, the duty of care statute states that

> the care of such health care provider [must not have been] 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 under the same or similar circumstances at the time of the alleged act giving rise to the cause of action.[51]

The original draft of Senate Bill 33 protected emergency room providers by raising the mental state requirement so that doctors providing treatment of an emergency condition would only be found liable if their behavior deviated so far from the standard of care as to be considered grossly negligent.[52] To do so would mean that North Carolina emergency room providers would no longer be liable for carelessly and unintentionally providing inadequate care to patients.[53] Rather, to be liable for gross negligence, providers would have to "*conscious*[ly] disregard . . . the safety" of their patients, knowing that their actions were harmful, but purposefully performing them anyway.[54] As the Supreme Court of North Carolina has noted, "[T]he difference between ordinary negligence and gross negligence is substantial."[55] Thus, it follows that plaintiffs would have a much harder time proving that a health care provider's actions reached the level of gross negligence than if they only had to prove regular medical malpractice.[56] As one doctor explained the effect of a gross

50. *See id.* § 90-21.12(a).

51. *Id.*

52. *See* S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Feb. 2, 2011).

53. For a discussion of North Carolina's "same or similar community" standard for medical malpractice actions, which takes into account the provider's particular medical community in determining whether he is liable, see generally Casey Hyman, Comment, *Setting the "Bar" in North Carolina Medical Malpractice Litigation: Working with the Standard of Care that Everyone Loves to Hate*, 89 N.C. L. REV. 234, 244–46 (2010).

54. Yancey v. Lea, 354 N.C. 48, 53, 550 S.E.2d 155, 158 (2001) ("Thus, the difference between [regular negligence and gross negligence] is not in degree or magnitude of inadvertence or carelessness, but rather is intentional wrongdoing or deliberate misconduct affecting the safety of others. An act or conduct rises to the level of gross negligence when the *act* is done purposely and with knowledge that such act is a breach of duty to others, i.e., a *conscious* disregard of the safety of others. An act or conduct moves beyond the realm of negligence when the *injury or damage* itself is intentional.").

55. *Id.*

56. *See id.*

negligence standard, "It[ ] [would] be impossible for any patient to ever sue a physician in the emergency department.... The physician would literally have to show up for their shift drunk out of their mind."[57] Because of this extreme difficulty that injured plaintiffs would face in successfully bringing suits if emergency doctors were only held to a gross negligence standard, the original draft of Senate Bill 33 faced much opposition from North Carolina citizens,[58] as well as from advocacy groups, such as the North Carolina Advocates for Justice.[59]

After the original draft received this opposition for its gross negligence standard, the General Assembly chose to refrain from altering the mental state requirement.[60] Instead, as discussed above, legislators heightened the evidentiary standard, which means plaintiffs will still face a higher evidentiary standard if treated for an emergency medical condition,[61] but they will not have to prove the provider was grossly negligent. Under the enacted language now in place, emergency care providers will still be liable for acts constituting regular medical negligence, rather than only those constituting at least gross negligence, but plaintiffs will have to prove the commission of such medical negligence by clear and convincing evidence.[62]

III. CONSEQUENCES OF LEAVING OUT THE LIMITATION BASED ON A PATIENT'S LOCATION IN AN EMERGENCY ROOM

In North Carolina, plaintiffs who bring claims arising out of treatment for an emergency medical condition will now face the additional challenge of having to prove their case by clear and convincing evidence because North Carolina's new statute does not tie the heightened protection to a patient being in a hospital emergency room.[63] Thus, North Carolina's new tort reform has granted heightened protection not only to emergency room providers, but also to providers who are treating patients 1) in non-hospital

57. Travis Fain, *Negligence, Cap on Damages, Focus of Malpractice Reform Bill*, INDEP. WKLY. (Durham), Mar. 23, 2011, (News), at 9 (quoting Dr. John Faulkner) (internal quotation marks omitted).

58. *See, e.g.*, *supra* note 32.

59. *See, e.g.*, N.C. ADVOCATES FOR JUSTICE, *supra* note 31, at 2; *see also* N.C. ADVOCATES FOR JUSTICE, ANALYSIS OF SENATE BILL 33 – MEDICAL LIABILITY REFORMS (2011) (critiquing S.B. 33 section by section).

60. *See* N.C. GEN. STAT. § 90-21.12(b) (2011).

61. *See* discussion *supra* Part II.A.

62. *See* § 90-21.12.

63. *See id.* § 90-21.12(b).

treatment facilities, as well as in hospitals that do not have an emergency department; 2) outside of treatment facilities—such as in Good Samaritan or Emergency Medical Services ("EMS") response situations; and 3) in many childbirth situations occurring outside of the emergency room.

A. Treatment Facilities Outside of Hospital Emergency Rooms

A potential consequence of the new statute is that patients who are treated in non-emergency treatment facilities with no emergency health care providers on staff may also face this heightened burden, as long as the treatment was for an "emergency medical condition."[64] Previous versions of the bill excluded from their protection those providers working in hospitals without emergency departments, as well as those working in non-hospital treatment facilities, by either explicitly linking the protection to hospital emergency rooms or by linking it to treatment obligations imposed by EMTALA.[65] EMTALA does not impose any treatment obligations on hospitals without emergency departments nor on non-hospital treatment facilities, such as local doctors' offices.[66] However, since the amended statute lacks a location limitation,[67] whenever a patient is treated in a non-emergency treatment facility for symptoms "that could reasonably be expected" to lead to serious impairment notwithstanding medical treatment,[68] the patient will now face a heightened evidentiary standard under the plain meaning of the statute.[69]

The following example best illustrates the negative consequences of failing to tie the heightened evidentiary standard to a patient's location in a hospital emergency room: Suppose a patient goes into his local family doctor's office for a common cold and while there suffers a heart attack. Under the definition of "emergency medical condition" found in EMTALA, a heart attack would certainly qualify as a condition that "could reasonably be expected" to result in serious health impairments for the patient.[70] Under the plain language of the new statute, if the local family doctor then attempts to provide

64. *See id.*
65. *See* discussion *supra* Part I.A.
66. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (2006).
67. *See* § 90-21.12(b).
68. *See* 42 U.S.C. § 1395dd(e)(1).
69. *See* § 90-21.12(b).
70. *See* 42 U.S.C. § 1395dd(e)(1).

treatment to the patient for the heart attack, she will fall within the heightened protection because she would be "furnish[ing] professional services in the treatment of an emergency medical condition."[71] Therefore, if the patient later brings a medical malpractice claim against the local doctor for treatment of the heart attack, he will have to prove his case by clear and convincing evidence.[72] The doctor will already have one level of protection against the claim because, as mentioned above, North Carolina's statutory standard of care already takes into account the doctor's level of training and specific circumstances of the incident.[73] Even without the new protection, this doctor would only be held to the standard of other local family doctors lacking emergency room expertise and treating a heart attack patient in a regular doctor's office with limited emergency resources at hand.[74] If the doctor fails to meet this fairly subjective standard, then she would have been by definition medically negligent, and malpractice would have occurred.[75]

The new heightened evidentiary standard, with no limitation based on patient location, adds an additional burden for this plaintiff: the plaintiff must still establish that the doctor failed to meet the standard for treating a heart attack in the same way other local family doctors with little emergency training and few resources would treat it,[76] but he will now have to prove this already difficult claim by clear and convincing evidence.[77] The fact that the legislators did not discuss this result when debating Senate Bill 33 suggests that the General Assembly did not fully contemplate the wide reaching effects of leaving out the patient-limiting language.[78]

B. Good Samaritan and Other Volunteer Emergency Response Situations

The language of North Carolina's new medical malpractice statute also encompasses many "Good Samaritan" situations where doctors, nurses, or other health care providers simply happen upon an emergency—stopping on the side of the road to aid in an accident or

71. *See* § 90-21.12(b).
72. *See id.*
73. *See id.* § 90-21.12(a).
74. *See id.*
75. *See id.*
76. *See id.*
77. *See id.* § 90-21.12(b).
78. *See* discussion *supra* Part I.A.

rushing to the aid of a fellow passenger on a plane or patron in a movie theater—as well as more coordinated response efforts, such as those of EMS providers.[79] Because the statute as currently worded applies to the treatment of an "emergency medical condition" without any requirement that the treatment be in a hospital emergency room, it follows that the heightened protection would apply to treatment of emergency conditions by Good Samaritans or EMS providers, even though such treatment occurs outside of the emergency room.[80] However, whether or not the new heightened protection will in fact extend to such situations will depend on whether or not the services rendered by these providers are considered "professional services."[81]

As previously discussed, the heightened protection only applies in medical malpractice actions, and medical malpractice actions may only be brought if the treatment arose out of "professional services."[82] In addition, the new provision specifically providing protection for emergency treatment also limits the protection to claims "arising out of the furnishing or the failure to furnish professional services."[83] Accordingly, the new heightened protection will only apply to emergency services rendered outside of a treatment facility if the following two criteria are met: 1) the services rendered are considered "professional services" by the court; and 2) they were rendered for an "emergency medical condition."[84]

Under North Carolina law, "[a] 'professional' act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual."[85] For example, the North Carolina Court of Appeals considered the decision to put restraints on a patient to be "a medical decision requiring clinical judgment and intellectual skill [and was thus] a professional service,"[86] while "the removal of [a patient] from

79. *See* § 90-21.12(b).

80. *See id.*

81. *See id.*

82. *See id.* § 90-21.11(2) (defining "medical malpractice" as "[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").

83. *See id.* § 90-21.12(b).

84. *See id.*

85. Smith v. Keator, 21 N.C. App. 102, 105–06, 203 S.E.2d 411, 415 (citation omitted), *aff'd*, 285 N.C. 530, 206 S.E.2d 203 (1974).

86. Sturgill v. Ashe Mem'l Hosp., Inc., 186 N.C. App. 624, 630, 652 S.E.2d 302, 306 (2007) (citing *Smith*, 21 N.C. App. at 105–06, 203 S.E.2d at 415).

[an] examination table to [a] wheelchair did not involve an occupation involving specialized knowledge or skill, as it was predominately a physical or manual activity" and thus did "not fall into the realm of professional medical services."[87] In deciding whether or not a particular act constitutes the rendering of professional services, North Carolina courts focus on whether it was a physical act that could be done just as well by a layperson.[88]

The fact-based determination as to whether a Good Samaritan or other emergency service provider rendered "professional services" can be illustrated by the following examples. A Good Samaritan who happens upon a car accident or an EMS provider who responds to a 911 call would arguably avoid medical malpractice liability for injuries caused by removing a person from a burning car simply because it was merely a physical act that could be done just as well by a layperson and requires no advanced medical knowledge.[89] However, that same health care provider most likely could be subject to medical malpractice liability for administering prescription drugs at the scene of the accident since that requires "specialized instruction and study."[90]

Accordingly, the fact that the new heightened protection will apply to at least some Good Samaritan and emergency response situations (dependent on whether professional services were rendered) further bolsters this Recent Development's argument that the new protection extends too broadly and should be explicitly limited to hospital emergency rooms. The General Assembly already granted Good Samaritan and other volunteer emergency service providers immunity from *all* regular negligence claims through two previous enactments. First, in North Carolina, individuals who act as Good Samaritans and aid at the scene of a car accident are already protected from liability by a heightened mental state requirement: Good Samaritans aiding at the scene of a car accident may not be held liable for mere negligence, but rather, must be found at least

87. Lewis v. Setty, 130 N.C. App. 606, 608, 503 S.E.2d 673, 674 (1998).

88. *Compare Smith*, 21 N.C. App. at 106, 203 S.E.2d at 415 ("Administering a massage requires manual skill and dexterity, but it does not require mental or intellectual skill, advanced knowledge, or specialized instruction and study. An uneducated person can give a massage as well as an educated person."), *and Lewis*, 130 N.C. App. at 608, 503 S.E.2d at 674 (holding that placing a patient in a wheelchair was a physical activity requiring no advanced skills and thus not a professional service), *with Stugill*, 186 N.C. App. at 630, 653 S.E.2d at 306 (finding the decision to restrain a patient to be a professional service because it required specialized knowledge or skill).

89. *See Lewis*, 130 N.C. App. at 608, 503 S.E.2d at 674.

90. *See Smith*, 21 N.C. App. at 106, 203 S.E.2d at 415.

grossly negligent.[91] Therefore, under the new medical malpractice statute, if a doctor or a nurse happens to be the first on the scene of an accident and renders emergency care as a Good Samaritan, they may be shielded by two layers of protection: they will only be liable if they are at least grossly negligent, rather than merely negligent,[92] and plaintiffs may have to prove the provider's gross negligence by clear and convincing evidence.[93] Second, the General Assembly also extended immunity from regular negligence claims in two other ways through a separate enactment: 1) the statute granted such protection to all volunteer medical providers, including EMS personnel who do not just happen upon the scene of an emergency, as is the case in the more typical Good Samaritan situations; and 2) the statute extended the immunity to volunteer treatment of any emergency situation falling within the statute's definition, rather than solely treatment at car accident scenes to which the first Good Samaritan statute discussed is limited.[94]

The amended statute's double-layered protection for volunteer emergency providers appears unintentional. The General Assembly already carefully considered how best to provide protection to Good Samaritans and other volunteer emergency service providers, and chose to do so explicitly through an elevated mental state requirement rather than a heightened burden of persuasion.[95] In fact,

91. *See* N.C. GEN. STAT. § 20-166(d) (2011) ("Any person who renders first aid or emergency assistance at the scene of a motor vehicle crash on any street or highway to any person injured as a result of the accident, shall not be liable in civil damages for any acts or omissions relating to the services rendered, unless the acts or omissions amount to wanton conduct or intentional wrongdoing.").

92. *See id.*

93. *See id.* § 90-21.12(b).

94. *See id.* § 90-21.14(a) ("Any person, including a volunteer medical or health care provider at a facility of a local health department as defined in G.S. 130A-2 or at a nonprofit community health center or a volunteer member of a rescue squad, who receives no compensation for his services as an emergency medical care provider, who renders first aid or emergency health care treatment to a person who is unconscious, ill or injured, (1) [w]hen the reasonably apparent circumstances require prompt decisions and actions in medical or other health care, and (2) [w]hen the necessity of immediate health care treatment is so reasonably apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the person, shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the person rendering the treatment. The immunity conferred in this section also applies to any person who uses an automated external defibrillator (AED) and otherwise meets the requirements of this section.").

95. *See id.* §§ 20-166, 90-21.14(a).

one Senate committee report summarizing an earlier draft of Senate Bill 33 explicitly discussed this issue, stating that, "under current law, providers of emergency medical care who are *compensated* for their services are subject to liability in malpractice actions under the general standard of care," while noting that, in contrast, voluntary providers must be at least grossly negligent to be liable.[96] After noting this distinction, the report went on to provide that Senate Bill 33 had been altered so that heightened protection would also extend to compensated providers who have a duty to treat under EMTALA[97] (which only arises in emergency departments).[98] This report supports the conclusion that the General Assembly did not intend for the new heightened evidentiary standard to apply to claims arising out of treatment by voluntary health care providers, as legislators explicitly recognized that those providers were already protected under North Carolina law.[99]

C. Active Labor During Childbirth

Yet another consequence, and arguably the most serious, is the amended statute's effect on obstetrics malpractice claims. The plain language of the statute now encompasses many claims arising out of normal childbirth. This unfortunate result is due to the provision's deferral to EMTALA's definition of "emergency medical condition," which includes certain active labor cases,[100] without also including a limitation based on the patient's location in an emergency department.[101] Under EMTALA, a woman is considered to be in an "emergency medical condition" if she is having contractions and "there is inadequate time to effect a safe transfer to another hospital before delivery, or [if] transfer may pose a threat to the health or safety of the woman or the unborn child."[102] Thus, because North Carolina's new statute defers to this same definition, a woman will now be considered to be in an "emergency medical condition" once she is in active labor and there would not be enough time to get her to a different hospital before delivery, or such transfer would be

96. *See* LIABILITY REFORMS, *supra* note 13, at 2.
97. *See id.*
98. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (2006).
99. *See* LIABILITY REFORMS, *supra* note 13, at 2.
100. *See* 42 U.S.C. § 1395dd(e)(1)(B).
101. *See* N.C. GEN. STAT. § 90-21.12(b) (2011).
102. 42 U.S.C. § 1395dd(e)(1)(B).

unsafe.[103]

Courts may face difficulty in deciding whether the new heightened protection applies to obstetrics malpractice claims because, if they attempt to apply the literal language of the statute, they will have to determine, hypothetically, whether a patient could have been safely transferred, even though the doctor may have never contemplated transferring the patient.[104] This absurdity in the new provision's application results from the fact that EMTALA's purpose is to prevent emergency room facilities from turning away patients in true emergency situations and to thwart health care providers' efforts to dump patients on other nearby facilities.[105] Thus, EMTALA's definition of "emergency medical condition," which was enacted to delineate the situations in which providers may legally turn away or transfer patients, makes little sense when applied to situations where providers are trying to *treat* the active labor patients rather than get rid of them.[106] Due to the unnecessary inquiry resulting from courts

103. *See* § 90-21.12(b); *see also* 42 U.S.C. § 1395dd(e)(1)(B) (defining "emergency medical condition").

104. *See* § 90-21.12(b); *see also* 42 U.S.C. § 1395dd(e)(1)(B) (defining "emergency medical condition"). For a case engaging in this hypothetical inquiry when applying EMTALA, see Burditt v. U.S. Dep't of Health and Human Servs., 934 F.2d 1362, 1369–70 (5th Cir. 1991) ("Burditt challenges the ALJ's finding that, at approximately 5:00, there was inadequate time to safely transfer Rivera to John Sealy before she delivered her baby. Dr. Warren Crosby testified that, based on Burditt's own examination results, Rivera would, more likely than not, deliver within three hours after Burditt spoke with Downing at John Sealy. This expert testimony constitutes substantial record evidence to sustain the ALJ's finding. Burditt does not challenge DAB's conclusion that the ambulance trip from DeTar to John Sealy takes approximately three hours. We therefore hold that DAB properly concluded that Rivera was in active labor under 42 U.S.C. § 1395dd(e)(2)(B).").

105. *See* Trivette v. N.C. Baptist Hosp., Inc., 131 N.C. App. 73, 75, 507 S.E.2d 48, 50 (1998) ("EMTALA imposes these limited duties upon hospitals with emergency rooms because EMTALA was primarily, if not solely, enacted to deal with the problem of patients being turned away from emergency rooms for non-medical reasons."), *aff'd in part*, 350 N.C. 299, 512 S.E.2d 425 (1999).

106. As a result of the statute's deferral to EMTALA's definition of emergency medical condition, the heightened evidentiary burden will oscillate in child delivery cases depending solely on the geographic location of other hospitals. For example, a woman being treated in a rural North Carolina community hospital far from other hospitals may be penalized with a heightened evidentiary standard much sooner in the childbirth process than a woman being treated in an urban area. *See* 42 U.S.C. § 1395dd(e)(1)(B). Hypothetically, assume a woman is at a local community hospital in rural North Carolina located two hours from the next hospital, and she is progressing through a normal delivery on the obstetrics floor. Under the definition of "emergency medical condition" in EMTALA, which North Carolina's new provision defers to, that woman will be considered to be in an "emergency medical condition" once she could not be transferred to another hospital before giving birth. *See id*; *see also Burditt*, 934 F.2d at 1369–70 (engaging in the hypothetical inquiry when applying EMTALA of whether a patient in labor could be safely transferred to a different hospital). Thus, because she is two hours

attempting to apply the literal language of the statute, perhaps they will instead forgo the hypothetical inquiry and merely hold that a woman near the time of her delivery is in an emergency medical condition regardless of the proximity of other hospitals. There is no telling how courts will choose to analyze the new language until it is grappled with in an actual active labor case. However, even if courts choose not to extend the heightened burden to childbirth cases at all, altering the statute to explicitly limit it to hospital emergency rooms would make clear a currently muddled framework.[107]

As the statute is currently worded, every single woman giving birth in North Carolina could be considered to be in an "emergency medical condition" at some point in her delivery progression.[108] Without a link to emergency room treatment, the heightened burden of persuasion now no longer extends only to true emergency child delivery cases presenting in a hospital emergency room, but to delivery claims arising in many other contexts, as well.[109] For example, all women giving birth on an obstetrics floor of a hospital could face

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away from the next hospital, she will be considered to be in an "emergency medical condition" for the entire two hours preceding her child's delivery. *See* 42 U.S.C. § 1395dd(e)(1)(B). If any alleged malpractice occurs during that two-hour time frame preceding the birth, she will face the heightened burden of persuasion under the new statute because during that time she will be receiving treatment for an "emergency medical condition." *See* § 90-21.12(b); *see also* 42 U.S.C. § 1395dd(e)(1)(B) (defining "emergency medical condition"). In contrast, assume a woman is going through labor at a hospital in an urban area, which is located only five minutes from the next hospital. She will not be considered to be in an "emergency medical condition" until she passes the point in time where she could not get to that next hospital before delivering the baby. *See* § 395dd(e)(1)(B). Thus, she will only be considered to be in an emergency medical condition for the five minutes preceding her child's birth. *See id.* Accordingly, she will only face a heightened burden of persuasion for any claims arising out of those five minutes prior to delivery. To summarize, the woman in rural North Carolina will face a heightened burden for any malpractice that occurs the entire two hours before her baby's delivery, but the woman in urban North Carolina will only face the heightened burden for malpractice that occurs in those last five minutes before the birth. Thus, the further from other hospitals the patient is located, the sooner in the birthing process that patient falls under the new heightened evidentiary standard. This example illustrates the difficulty of applying EMTALA's definition of "emergency medical condition" to situations where a doctor is treating, rather than trying to transfer, an active labor patient.

107. One federal district court dealing with an emergency birth situation after the statute was amended did not discuss the plaintiffs' burden of persuasion, but rather, merely stated they had met it. *See* Burk v. United States, No. 5:10-CV-470-H, 2012 WL 1185011, at *2 (E.D.N.C. Apr. 9, 2012) (applying North Carolina's medical malpractice statute in an emergency birth situation). Thus, this case sheds no light on how courts may apply the new statute to child delivery cases. Perhaps this conclusion was due in part to the court's confusion regarding which evidentiary standard to apply.

108. *See* § 90-21.12(b); *see also* 42 U.S.C. § 1395dd(e)(1)(B) (defining "emergency medical condition").

109. *See* § 90-21.12(b).

this heightened burden if malpractice occurs during that window of time where they are considered to be in an "emergency medical condition" because they could not hypothetically make it to another hospital before giving birth.[110] Further, the new provision arguably encompasses most, if not all, claims arising out of emergency Cesarean sections since such procedures are performed under very serious conditions, such as severe fetal distress or a prolapsed cord.[111] Under these types of dire circumstances, delay in the delivery would be almost certain to cause injury to the mother or child, and thus, transfer could not be safely executed before birth.[112]

It seems unlikely that the General Assembly intended to change the entire field of obstetrics malpractice in such a covert manner, particularly considering the tragedy associated with many claims arising out of childbirth.[113] As the United States Supreme Court has said, Congress "does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes."[114] Similarly, it seems hard to imagine that the North Carolina General Assembly would hide such a profound change to obstetrics malpractice in a "mousehole" like this one.

At no point does the legislative history suggest that the General Assembly intended the new protection to affect claims arising in normal childbirth cases occurring in obstetrics suites or operating

110. *See id.*; *see also* 42 U.S.C. § 1395dd(e)(1)(B) (defining "emergency medical condition"). For an example of a court finding under EMTALA that once a woman reaches the point where she could not be safely transferred to another hospital she is considered to be in an "emergency medical condition," see *Burditt*, 934 F.2d at 1369–70.

111. *See* JOEL M. EVANS & ROBIN ARONSON, THE WHOLE PREGNANCY HANDBOOK: AN OBSTETRICIAN'S GUIDE TO INTEGRATING CONVENTIONAL AND ALTERNATIVE MEDICINE BEFORE, DURING, AND AFTER PREGNANCY 479 (2005).

112. *See generally id.* (describing complications giving rise to emergency Cesarean sections and their corresponding dangers).

113. *See, e.g.*, Estate of McCall v. United States, 663 F. Supp. 2d 1276, 1294 (N.D. Fla. 2009) ("There is no question, as shown by the evidence, that Mr. and Mrs. McCall were both very close to their daughter and that this tragedy has greatly impacted the quality of their lives, emotionally as well as physically. They were otherwise healthy, active, and excited about helping their daughter and new grandson. They went to the hospital with the happy and hopeful expectation of bringing their daughter home with a healthy baby but instead found themselves faced with the agonizing decision of whether to remove life support from her. Mr. McCall struggled as he recounted their hope of Michelle possibly regaining consciousness as they laid W.W. across her before she died, and also so they could have one photograph of her 'holding' her baby before she died. The pain from the loss of their only daughter and the mental agony of having to make the decision to remove her from life support will not soon abate, if ever in their lifetimes.").

114. Whitman v. Am. Trucking Ass'ns, 531 U.S. 457, 468 (2001).

rooms, rather than emergency rooms.[115] Arguably, active labor patients arriving in the emergency room just moments before birth would constitute what the average person would consider an "emergency." However, a delivery proceeding as normal in an obstetrics suite may now also be an "emergency medical condition" in North Carolina.[116] As mentioned above, there is no telling how courts will choose to apply the statute's new language in the future, but the mere fact that the language allows an extension to regular childbirth cases could lead to confusion for courts and potentially disparate treatment of child delivery malpractice claims depending on different courts' analyses under this unclear framework.

IV. RECOMMENDATIONS FOR AMENDING THE STATUTE

The General Assembly should amend the statute to reincorporate its limitation from previous versions of the bill that the heightened protection only applies to hospital emergency room providers.[117] To do this, the statute should take its beginning language from versions four and five of the bill to impose the location limitation,[118] and it should take from the currently enacted statute the language imposing the limitation based on the patient's emergency medical condition, as well as the language providing for the heightened evidentiary standard.[119] Thus, this Recent Development

115. *See, e.g.*, *Feb. 24 Minutes*, *supra* note 23; *Feb. 22 Minutes*, *supra* note 23; *Feb. 17 Minutes*, *supra* note 23; discussion *supra* Part I.A. Furthermore, there are examples of state legislatures explicitly extending such protection in the context of obstetrics. Texas, for example, intended to include certain claims arising out of emergency situations in obstetrics suites, rather than only in emergency rooms, and thus explicitly provided for this in its emergency care statute. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.153 (West 2011) ("In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with willful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.").

116. *See* N.C. GEN. STAT. § 90-21.12(b) (2011); *see also* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(e)(1)(B) (2006) (defining "emergency medical condition").

117. *See* discussion *supra* Part I.A.

118. S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 20, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Apr. 19, 2011).

119. *See* § 90-21.12(b). One issue that remains unclear is whether the General Assembly intended to have the protection apply only to emergency room doctors who are

suggests the statute should be amended to read:

> In any medical malpractice action arising out of the furnishing or the failure to furnish professional services in a hospital emergency room[120] [for] an emergency medical condition, as the term "emergency medical condition" is defined in 42 U.S.C. 1395dd(e)(1) [EMTALA], the claimant must prove a violation of the standards of practice set forth in subsection (a) of this section by clear and convincing evidence.[121]

Altering the language as suggested here will address the concerns posed above by this Recent Development. First, by tying the protection to treatment "in a hospital emergency room," patients being treated for emergencies in non-hospital treatment facilities (or hospitals without emergency rooms) will no longer face the burden of proving their claims by clear and convincing evidence. Since health care providers in North Carolina are already protected by the "same or similar community" standard encompassed in its medical

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forced to treat under federal law because their hospital is covered by EMTALA's obligations, or whether it intended for the protection to apply to all hospital emergency room providers, regardless of whether or not the hospital was under EMTALA's regulations. However, this distinction is statistically insignificant, as approximately ninety-eight percent of hospitals in the United States participate in Medicare federal funding programs, and thus are participating hospitals governed by EMTALA. *See* JACK JALLO & CHRISTOPHER M. LOFTUS, NEUROTRAUMA AND CRITICAL CARE OF THE BRAIN 437 (2009); *see also* Medero Diaz v. Grupo De Empresas De Salud, 112 F. Supp. 2d 222, 225 (D.P.R. 2000) ("A participating hospital is one that has executed a Medicare provider agreement with the federal government." (citations omitted)). Therefore, in practical terms, whether the statute extends protection only to providers working in emergency departments who have a duty to treat under EMTALA, or whether it extends the protection to all hospital emergency room providers treating emergency conditions, will not have a large effect on the number of plaintiffs subject to the heightened evidentiary standard. However, a conscious choice between the two would speak to the policy rationale behind this piece of the reform. It would testify as to whether the purpose is to protect emergency care providers due to the high-stress environment of hospital emergency rooms, or whether it is to protect doctors when federal law strips them of their ability to choose whether to treat a patient or not. Thus, legislators should consider this distinction if and when they decide to amend the statute's language. If they choose to only extend the protection to treatment required by EMTALA, then they should draw the beginning part of the provision from versions two and three rather than versions four and five. In this case, the statute should read, "In any medical malpractice action arising out of the furnishing or the failure to furnish services pursuant to obligations imposed by 42 U.S.C. § 395dd, for an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1)," S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Mar. 2, 2011); S.B. 33, 2011 Gen. Assemb., Reg. Sess. (Draft, N.C. Mar. 1, 2011), "the claimant must prove a violation of the standards of practice set forth in subsection (a) of this section by clear and convincing evidence." § 90-21.12(b).

120. N.C. S.B. 33 (Draft, Apr. 20, 2011); N.C. S.B. 33 (Draft, Apr. 19, 2011).

121. § 90-21.12(b).

malpractice statute,[122] non-emergency health care providers—who do not have to work in the stressful emergency room work environment day in and day out—need no further protection from liability through a heightened evidentiary standard. Such non-emergency providers are already only held to the standard of other providers in their similar community with similar training if and when they treat emergencies, not to the standard of a trained emergency room provider.[123] Thus, reincorporating the location limitation will do away with this unnecessary extra burden for injured plaintiffs.

Second, reincorporating the location limitation will provide clarity in the area of Good Samaritan and volunteer EMS treatment of emergency conditions. North Carolina has already granted Good Samaritans and volunteer emergency providers protection from liability by raising the mens rea requirement from negligence to gross negligence for these individuals.[124] Thus, imposing upon injured plaintiffs the additional burden of proving gross negligence by clear and convincing evidence, rather than the typical preponderance of the evidence standard, would render recovery an even more difficult task. Those providing voluntary treatment to injured persons certainly deserve some level of protection from liability, but granting both a heightened mens rea, as well as a heightened evidentiary standard—as the current language of the statute does—would seem to push the balance too far in favor of health care providers at the expense of injured plaintiffs. Reincorporating the location limitation strikes an appropriate balance by allowing volunteer emergency providers and Good Samaritans to keep their already granted statutory protection, while not placing an additional hardship on injured plaintiffs through a heightened evidentiary standard.

Lastly, reincorporating the location limitation will ensure that the heightened protection does not extend to claims arising out of normal childbirth. Rather, the protection will only extend to claims arising out of emergency childbirth cases treated in hospital emergency rooms, not obstetrics suites. Some may argue that the extension of the heightened protection to normal childbirth claims outside of the emergency room is actually desirable because it would protect obstetricians who also work in high-stress environments like

122. *See id.* § 90-21.12(a).
123. *See id.*
124. *See id.* §§ 20-166, 90-21.14(a).

emergency room providers.[125] However, this Recent Development does not attempt to address the policy concerns as to whether such an extension would be a valuable addition to North Carolina malpractice law. Rather, this Recent Development sets forth the proposition that the current statute is unclear, could lead to disparate treatment of childbirth claims, and needs to be clarified. By reincorporating the location limitation, the current statute will clearly only apply to treatment in hospital emergency rooms. If the General Assembly decides such protection should be extended to health care providers rendering treatment in normal childbirth situations occurring in obstetrics suites, this would be best addressed in a separate statute dealing solely with heightened protection for obstetric providers and should be done explicitly rather than in such a round-about fashion as in the current statute.

CONCLUSION

This Recent Development argues that the General Assembly inadvertently or unwisely extended the heightened burden of persuasion to a much larger number of plaintiffs than solely those treated in hospital emergency rooms. Currently in North Carolina, *any* plaintiff who is unfortunate enough to suffer from an "emergency medical condition" and then faces the further misfortune of falling victim to medical malpractice during the treatment of that condition will face added difficulty in proving his claim, regardless of whether the treatment was in a hospital emergency room or not. First, the new statute extends the heightened protection to providers working in non-hospital treatment facilities, such as local doctors' offices, as well as to hospitals that have no emergency department. Second, it bestows a double layer of protection upon Good Samaritan health care providers who happen onto the scene of a car accident, as well as to all other volunteer emergency service providers, since these providers already have total immunity from regular negligence claims under North Carolina law. Last, but not least, the statute may have serious unintended consequences for the field of obstetrics malpractice. Now, anytime a woman in active labor is close to delivery, she may be subject to the heightened evidentiary standard by virtue of the legislators' deferral to EMTALA's definition of "emergency medical condition" without the limitation that the

125. For example, the Texas legislature made the decision to extend heightened protection from liability to at least some providers faced with malpractice claims arising in obstetrics suites. *See supra* note 115.

treatment was furnished in a hospital emergency room. These potential consequences of the new statute not only go against policy concerns for the victims of medical malpractice and their ability to recover, but they also arguably lay outside the scope of the General Assembly's intent (at least as it was depicted to the public)—to protect hospital emergency room providers from unwarranted liability.

This Recent Development urges the General Assembly to make the necessary and simple revision to reincorporate the limitation on the heightened protection based on a patient's location in a hospital emergency room. Although it is unclear how courts may interpret this statute in the future, it is clear that the statute's plain language currently applies to many plaintiffs outside of those being treated in hospital emergency rooms. Furthermore, although this Recent Development suggests that the General Assembly may have intended only to protect emergency room providers, the legislative history is not *so* crystal clear as to definitively ensure that a court interpreting the statute in light of its history would not also apply the protection to all of these other providers. Therefore, the General Assembly needs to take action to explicitly narrow the terms of the protection to emergency room providers to avoid the serious unintended consequences that may otherwise result.

ELIZABETH HILL**

** The author would like to extend her gratitude to several individuals who assisted in the development of this piece. First and foremost, the author would like to thank her parents, Timothy and Cynthia Hill, for their endless support throughout the writing process. Thank you also to Professor Joan Krause at the University of North Carolina School of Law for her guidance and advice on this topic, as well as her patience in answering the author's many questions along this journey. Last, but certainly not least, the author would like to thank Alex Bowling, this Recent Development's Primary Editor, for his incredible dedication to improving this piece, as well as all of her other friends serving on the *North Carolina Law Review* staff and board for their diligent efforts in guiding this piece through the publication process.

North Carolina Law Review

VOLUME 91 MARCH 2013 NUMBER 3

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The *North Carolina Law Review* (ISSN 0029-2524) is published six times a year, in December, January, March, May, June, and September, by the North Carolina Law Review Association.

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Single and Back Issues: Single copies of current and back issues from the previous five volumes are available from the North Carolina Law Review Association for $12.00 per copy for Issues 1–4 and $15.00 for Issues 5–6 (add $5.00 for international deliveries). Back issues and complete sets of the *Review* are available from William S. Hein & Co., 1285 Main Street, Buffalo, NY 14209, at prices that may vary. Back issues are also available in PDF format on HeinOnline at http://heinonline.org.

Publication Information: The text and citations of the *Review* conform to the nineteenth edition of *The Bluebook: A Uniform System of Citation.* The *Review* is printed by Joe Christensen, Inc., in Lincoln, Nebraska. ISSN 0029-2524.

Materials cited "on file with the North Carolina Law Review" will be retained for a maximum of five years from date of publication.

Periodicals postage paid at Chapel Hill, North Carolina and additional mailing offices.

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