Volume 62 | Number 4 Article 4

4-1-1984

The North Carolina Medical Malpractice Statute

Robert G. Byrd

THE NORTH CAROLINA MEDICAL MALPRACTICE STATUTE

ROBERT G. BYRD†

North Carolina's Medical Malpractice Act sought to codify the customary practice standard of care and the same or similar community rule in malpractice actions. It further provides for a customary practice standard and an objective standard of causation in informed consent cases. The provisions governing the requirement for expert testimony, the qualifications of expert witnesses, and the scope of the customary practice standard are susceptible to several interpretations, and the caselaw reflects the statute's ambiguity. Professor Byrd examines some of the statute's ambiguous provisions and argues that the statute must be interpreted in light of the common law previously governing malpractice actions. He cautions that interpretation of the statute without regard to the common law and without sufficient sensitivity to the policies underlying the statute and malpractice law may yield results contrary to the legislative purpose.

The North Carolina Medical Malpractice Actions law,[1] adopted in the aftermath of the malpractice liability insurance crisis of the mid 1970s,[2] establishes the standard of care for determining liability in both orthodox malpractice actions and informed consent cases. The law applies to all malpractice cases based upon incidents occurring before or after July 1, 1976, its effective date,[3] except those cases in which litigation was pending on that date.

The statute incorporates many aspects of traditional malpractice law, introduces some new concepts, and contains provisions that may be interpreted to fall into either of these categories. Because of this mixture of the old, the new, and the uncertain, the overall impact of the statute is unclear. It may be interpreted as doing little more than codifying existing law, or it may be construed as effecting sweeping changes. Although the statute has been in effect for seven years, no case presenting the major questions arising under it has been decided. The absence of such a decision is not in itself reason for concern, but the possibility that these questions could be resolved in a less deliberate way is not entirely remote. A major interpretation could unwittingly evolve from the cumulative effect of isolated cases, none of which seems to be

† Burton Craige Professor of Law, University of North Carolina School of Law. B.S. 1953, J.D. 1956, North Carolina (Chapel Hill). The author wishes to express his appreciation to David Mayberry and Cathy Rudisill for their valuable research assistance in the preparation of this Article.

1. N.C. GEN. STAT. §§ 90-21.11 to -21.14 (1981).

2. *See* NORTH CAROLINA PROFESSIONAL LIABILITY INSURANCE STUDY COMMISSION, REPORT TO THE GEN. ASSEMBLY OF 1976, at 6-15 (1976) [hereinafter cited as LIABILITY INSURANCE STUDY].

3. Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596, *cert. denied*, 305 N.C. 587, 292 S.E.2d 571 (1982).

of particular significance individually.[4] An important interpretation included in a pattern jury instruction could gain general acceptance from continued use.[5]

The enactment and earlier judicial adoption of the same or similar communities rule, as well as other aspects of the customary practice standard, raise important questions concerning the qualification of experts who will be permitted to testify about customary practices. In the past, the judiciary has virtually ignored this issue. It is now being presented with increasing frequency and a body of law on the subject is evolving.[6]

The need exists for a careful examination of the statute in the context of the fundamental principles underlying the recognition and application of the customary practice standard. Unless a different result clearly is mandated by the statute, any resolution of questions implicating major changes in, or practical application of, the customary practice standard should be consistent with these basic principles.

I. THE CUSTOMARY PRACTICE STANDARD

The objective standard in negligence law holds every person to a minimum level of knowledge and discretion. An individual cannot escape liability by showing his capabilities were less than the minimum level.[7] This principle applies to professionals as well as to others.[8] In the ordinary case the jury needs no special guidance to apply the objective standard. On the other hand, the minimum level of knowledge and discretion to which the professional is to be held is not within the jury's competence and, for that reason, the need to inform the jury on these matters arises.

The professional standard of care is in effect a statement of the reasonable

---

4. *See infra* text accompanying notes 94-99, 144-56.

5. *See infra* text accompanying notes 86-87.

6. *See, e.g.*, Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970).

7. Heath v. Swift Wings, Inc., 40 N.C. App. 158, 252 S.E.2d 526, *cert. denied*, 297 N.C. 453, 256 S.E.2d 806 (1979).

8. In Hardy v. Dahl, 210 N.C. 530, 534, 187 S.E. 788, 790 (1936), the court held:

> One who undertakes to treat the sick, and holds himself out as competent to administer a certain kind or character of treatment, undertakes to bring to his employment . . . a fair, reasonable, and competent degree of skill and reasonable care and diligence in the use of his skill . . . and is answerable in damages for injuries proximately resulting from want of that degree or [*sic*] knowledge and skill ordinarily possessed by those of his system or method of practice . . . .

In an earlier case, Nash v. Royster, 189 N.C. 408, 127 S.E. 356 (1925), the supreme court found that:

> "The law holds [the physician] liable for an injury to his patient resulting from want of the requisite knowledge and skill . . . . The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belongs only to a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing. Still he is bound to keep abreast of the times, and a departure from approved methods in general use . . . will render him liable, however good his intentions may have been. . . ."

Id. at 415, 127 S.E. at 360 (quoting Pike v. Honsinger, 155 N.Y. 201, 209-10, 49 N.E. 760, 762 (1898)).

care standard specifically tailored to the professional. The statement of the standard in *Hunt v. Bradshaw*[9] is typical:

> A physician or surgeon who undertakes to render professional services must meet these requirements: (1) He must possess the degree of professional learning, skill and ability which others similarly situated ordinarily possess; (2) he must exercise reasonable care and diligence in the application of his knowledge and skill to the patient's case; and (3) he must use his best judgment in the treatment and care of his patient.[10]

This articulation of the standard recognizes the superior knowledge, skill, and training of the professional and also recognizes that they are to be taken into account in determining if he has acted reasonably. Its application is not limited to the professional but is appropriate in any case in which an individual holds himself out as belonging to a group whose members possess special knowledge or ability.[11]

Although identification of a minimum standard related to the special qualifications possessed by physicians is helpful, the jury still may lack the expertise to apply it. Expert testimony usually will be necessary to enable the jury to know the level of knowledge, skill, and training the professional should possess and to evaluate the reasonableness of his application of them in a given case.

The customary practice standard not only incorporates the minimum standard of care but also provides a mechanism for admission of expert opinion testimony to provide the jury a basis for determining negligence. In many cases the expert's opinion that conduct deviated from customary practice is the only practical way of getting before the jury the minimum level of qualifications and discretion required. From this perspective, the customary practice standard is simply an application of reasonable care to the higher qualifications possessed by the health care provider. Refinements in the concept of customary practice,[12] at least as long as they are reasonably related to defining the appropriate minimum standard, do not conflict with this view. For example, adoption of the same or similar community rule[13] presumably reflects the belief, based in large part on the well-worn distinction between the country doctor and the big city doctor, that the quality of medical practice differs with the character of communities and that the standard of care, to be fair, must reflect this difference.

North Carolina courts have adopted this concept of customary practice. In an early case, the court said: "It is really the application of the ordinary principles in the law of negligence to a case requiring professional knowledge

9. 242 N.C. 517, 88 S.E.2d 762 (1955).

10. *Id.* at 521, 88 S.E.2d at 765.

11. Plyler v. Moss & Moore, Inc., 40 N.C. App. 720, 254 S.E.2d 534 (1979); Heath v. Swift Wings, Inc., 40 N.C. App. 158, 252 S.E.2d 526, *cert. denied*, 297 N.C. 453, 256 S.E.2d 806 (1979).

12. For fuller discussion, see *infra* text accompanying notes 14-52.

13. For fuller discussion, see *infra* text accompanying notes 68-76.

and skill in the performance of the duty which one person owes to another."[14] The North Carolina Supreme Court has recognized that customary practice, as a standard of care, encompasses a consideration of the state of medical knowledge rather than simply doctors' normal practices. In *Groce v. Myers*[15] the court observed:

> One of the incidental obligations of science imposed on professional men is that they shall be judged by the standards of the science they profess, and not wholly by empirical standards, vague and indefinite, and incapable of scientific expression, behind which may lurk charlatanry and quackery.[16]

Accordingly, the court has rejected any absolute requirement of expert testimony and has upheld malpractice actions when the evidence reasonably permitted the jury to infer negligence.[17]

Results in North Carolina cases are consistent with these principles. A jury, without the aid of an expert, usually will have no basis for deciding whether a diagnosis was reasonable,[18] the decision to operate was warranted,[19] the drug prescribed for an ailment was suitable,[20] or the technical procedures followed in an operation were consistent with accepted practice;[21] in all these cases, expert testimony will be required. Except in unusual cases,[22] the jury cannot infer negligence from proof of injury or other adverse consequences of treatment or medication because such results can occur when reasonable care is present.[23] In other situations, however, the judgment of the reasonableness of the doctor's actions is clearly within the jury's competence and expert evidence is not needed. Such is the case when a surgeon sews up in

14. Mullinax v. Hord, 174 N.C. 607, 612, 94 S.E. 426, 429 (1917).

15. 224 N.C. 165, 29 S.E.2d 553 (1944).

16. *Id.* at 170, 29 S.E.2d at 556.

17. Jackson v. Mountain Sanitarium & Asheville Agriculture School, 234 N.C. 222, 67 S.E.2d 57 (1951); Gray v. Weinstein, 227 N.C. 463, 42 S.E.2d 616 (1947); Covington v. James, 214 N.C. 71, 197 S.E. 701 (1938).

18. Thornburg v. Long, 178 N.C. 589, 101 S.E. 99 (1919).

19. Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

20. Sharpe v. Pugh, 21 N.C. App. 110, 203 S.E.2d 330, *aff'd*, 286 N.C. 209, 209 S.E.2d 456 (1974) (equal division of six-member court required that court of appeals decision be affirmed without becoming precedent).

21. Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

22. Waynick v. Reardon, 236 N.C. 116, 72 S.E.2d 4 (1952) (during minor surgery major veins and arteries were perforated, resulting in the amputation of both legs, a heart attack, and drug addiction; evidence held sufficient seemingly without expert testimony); *but cf.* Connor v. Haywarth, 206 N.C. 721, 175 S.E. 140 (1934) (plaintiff's evidence showed that his leg was broken above and below knee, that defendant set lower break but, despite plaintiff's repeated complaints, did not set or otherwise treat upper break, that weights attached to leg with tape pulled off and were not reattached for long periods of time, and that tape's pulling off tore away skin to the bone; absence of expert testimony held fatal to claim).

23. Boyd v. Kistler, 270 N.C. 744, 155 S.E.2d 208 (1967) (red streak on patient's cheek and lip when she awoke after surgical extraction of teeth); Lentz v. Thompson, 269 N.C. 188, 152 S.E.2d 107 (1967) (severance of spinal accessory nerve an inherent risk of carefully performed biopsy); Boger v. Ader, 222 N.C. 758, 23 S.E.2d 852 (1943) (adverse reaction to medicine); Lippard v. Johnson, 215 N.C. 384, 1 S.E.2d 889 (1939) (stinging sensation from novocaine injection and painful skin condition at injection site).

his patient a lap pack,[24] a sponge,[25] or a jagged piece of glass from a broken test tube.[26] Expert evidence is not required in cases of clear neglect of or inattention to the patient by the doctor, because resolving such cases does not require any understanding of technical medical knowledge and skill or their application.[27] In some cases, although expert testimony is required to establish the standard of care, lay testimony will suffice to permit the jury to find noncompliance with it.[28] Finally, when the experts disagree concerning the appropriateness of particular treatment or procedures employed, the question of the doctor's negligence is left to the jury even though its determination falls outside the realm of common knowledge and experience.[29]

This view of customary practice and the authority of the cases applying it should not be affected by the codification of the customary practice standard. Although, under the statute,[30] liability can be imposed only when the care provided is inconsistent with customary practice, nothing in the statute suggests that the legislature intended to introduce a concept of customary practice different from that developed by judicial decision. The report of the study commission recommending statutory adoption of the customary practice standard furnishes additional evidence in support of this view. It provides as follows:

> The 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.[31]

Thie quote makes clear that the study commission's concern was directed to the choice between a national or regional standard and the same or similar communities standard rather than to the general concept of customary practice. In fact, the same or similar communities recommendation is expressly related to the earlier judicially developed standard. Finally, the study commission's rejection of proposals to limit or preclude the use of *res ipsa loquitur*

24. Shearin v. Lloyd, 246 N.C. 363, 98 S.E.2d 508 (1957).

25. Mitchell v. Saunders, 219 N.C. 178, 13 S.E.2d 242 (1941).

26. Pendergraft v. Royster, 203 N.C. 384, 166 S.E. 285 (1932). Other cases upholding a cause of action under similar circumstances are Blaine v. Lyle, 213 N.C. 529, 196 S.E. 833 (1938) (dropping metal probe into plural cavity) (dictum); Hyder v. Weilbaecher, 54 N.C. App. 287, 283 S.E.2d 426 (eight inch wire left in patient's body), *cert. denied*, 304 N.C. 727, 288 S.E.2d 804 (1981).

27. Wilson v. Martin Memorial Hosp., 232 N.C. 362, 61 S.E.2d 102 (1950) (failure to treat lacerations caused by child delivery and failure to discover torn stitches and decomposed tissue before discharging patient); Gray v. Weinstein, 227 N.C. 463, 42 S.E.2d 616 (1947) (11 hour delay in attending infant who had eaten 12 aspirin tablets); Groce v. Myers, 224 N.C. 165, 166, 29 S.E.2d 553, 554 (1944) (doctor told father of patient with broken arm to "just . . . tie something around it and let it hang down"); Gower v. Davidian, 212 N.C. 172, 193 S.E. 28 (1937) (fracture and dislocated vertebrae; failure to make X-ray or clinical examination before releasing patient).

28. Jackson v. Mountain Sanitarium & Asheville Agriculture School, 234 N.C. 222, 67 S.E.2d 57 (1951); Smithers v. Collins, 52 N.C. App. 255, 278 S.E.2d 286, *cert. denied*, 303 N.C. 546, 281 S.E.2d 394 (1981).

29. *Groce*, 224 N.C. at 171, 29 S.E.2d at 557-58.

30. N.C. GEN. STAT. § 90-21.12 (1981).

31. LIABILITY INSURANCE STUDY, *supra* note 2, at 32.

in malpractice cases is clear evidence that it did not intend its recommendation to make expert evidence of customary practice the exclusive method of proof in such cases.[32]

A narrower view of the customary practice standard is sometimes urged, and the contention is made that, even when the issues involved are within the realm of common knowledge and experience, malpractice cannot be established without expert testimony that the defendant's conduct deviated from customary practice. Although this view was rejected by the court under the common-law standard,[33] two law review comments apparently interpret the statute to give added significance to customary practice in the determination of malpractice liability.[34] In addition, the interpretation of the statute in certain court of appeals cases, decided after adoption of the statute, seems somewhat ambiguous.

The decision in *Pate v. Tripp*[35] suggests that expert evidence of customary practice is required by the statute in all malpractice cases. The following quotation reflects this attitude:

> First, plaintiff argues she presented evidence the hospital was negligent in not reporting promptly the results of certain tests ordered by plaintiff's doctors after her surgery, thereby causing a delay in the diagnosis of plaintiff's condition. In order to withstand a motion for directed verdict on this issue, however, plaintiff was required by N.C. Gen. Stat. § 90-21.12 . . . to offer some evidence that the care of the defendant hospital was not in accordance with the standards of practice among *other hospitals* in the same or similar communities. Plaintiff failed to present any evidence of the standard of care for a *hospital* in Kinston or similar communities regarding time necessary to report test results.[36]

Although the court held the absence of expert evidence of customary practice to be fatal, it is not clear whether the court believed that such evidence was mandated by the customary practice standard, by the legislature's codification of the standard, or by the view that the issues involved fell outside the jury's competence.[37] Disagreement with the opinion can be expressed on any of

---

32. *Id.* at 26.

33. Jackson v. Mountain Sanitarium & Asheville Agriculture School, 234 N.C. 222, 67 S.E.2d 57 (1951); Gray v. Weinstein, 227 N.C. 463, 42 S.E.2d 616 (1947); Covington v. James, 214 N.C. 71, 197 S.E. 701 (1938).

34. Comment, *Statutory Standard of Care for North Carolina Health Care Providers*, 1 CAMPBELL L. REV. 111, 125-29 (1979); Comment, *Medical Malpractice in North Carolina*, 54 N.C.L. REV. 1214, 1222-23 (1976). These comments suggest, respectively, that the statute makes compliance with customary practice a "presumptive" or "absolute" defense. These defense characterizations leave unclear their view of the effect of the statute in determining the sufficiency of plaintiff's evidence when proof of customary practice has not been introduced.

35. 49 N.C. App. 329, 271 S.E.2d 407 (1980).

36. *Id.* at 333, 271 S.E.2d at 409-10.

37. The determination whether a hospital has unreasonably delayed in reporting the results of laboratory tests seems to be clearly within the competence of the jury. Proof of the time required to conduct such tests and to prepare reports, along with evidence of the work load of the laboratory, may be necessary. When these facts are shown, however, the jury can determine whether the delay was unreasonable. Depending upon the circumstances, proof of these facts may be given by a lay witness or may require expert testimony. The need for expert evidence to estab-

these grounds, but the importance of the case decreases substantially if it is based solely on the view that the evidence presented complex medical issues. The effect of the decision, if interpreted to be based on either of the other two grounds, would be to impose an absolute requirement of expert evidence of customary practice in any malpractice case.[38]

Similar uncertainties are inherent in the decision in *Tice v. Hall*.[39] *Tice* involved a classic *res ipsa loquitur* situation—a surgeon left a sponge in the patient—in which proof of customary practice has not been required. Nevertheless, the court strained to find evidence that customary practice entailed a search for sponges by the surgeon before the incision was closed. Finding such evidence in the testimony of plaintiff's expert witness that "it is in accordance with my standard practice to make a systematic search"[40] and defendant's testimony that he "looked at all the organs to make sure there [was] no foreign body within the patient,"[41] the court held that plaintiff could rely on *res ipsa loquitur* to show breach of the standard.

The court's analysis in *Tice* may have been prompted by the testimony of plaintiff's expert witness that customary practice permitted a surgeon to rely on the nurse's sponge count.[42] The court, in light of this testimony, apparently believed that a finding of malpractice was permissible only if an independent duty of inspection by the surgeon was also imposed by customary practice. The logic of the court's position, although initially appealing, does not withstand careful scrutiny. Common sense dictates that a surgeon search for sponges before closing an incision and jurors need no expert to inform them of this. If, as the court held, the presence of the sponge will permit an inference

---

lish basic facts and the necessity for proof of customary practice should not be confused, and the latter should be required only in cases in which it is essential to the jury's understanding and resolution of the case.

38. In Page v. Wilson Memorial Hosp., 49 N.C. App. 533, 272 S.E.2d 8 (1980), plaintiff, a 69 year old patient who was physically impaired and who had "experienced periods of confusion and mental dullness," *id.* at 533, 272 S.E.2d at 9, was injured when she fell from a bedpan which had been placed in a chair. Plaintiff alleged that the attending nurse was negligent in leaving the room on several occasions while plaintiff was in this position. The trial judge's exclusion of expert testimony that defendant's conduct was inconsistent with customary nursing practice was reversed. This disposition of the case made it unnecessary for the court to address the question whether expert testimony was required to establish negligence under these circumstances. Nonetheless, the case is of interest because, as far as can be determined, neither plaintiff's attorney, the trial judge, nor the court of appeals considered the possibility that the facts of the case, without expert evidence of customary practice, would be sufficient to permit the jury to infer the nurse's negligence. Yet, common sense suggests that the jury, under the circumstances shown, could reasonably infer the nurse's negligence without being assisted by evidence of customary practice.

39. 63 N.C. App. 27, 303 S.E.2d 832 (1983).

40. *Id.* at 30, 303 S.E.2d at 834.

41. *Id.* at 35, 303 S.E.2d at 837.

42. The importance of this testimony is suggested by the differing views of Judge Becton in *Tice* and in Hyder v. Weilbaecher, 54 N.C. App. 287, 283 S.E.2d 426 (1981), *cert. denied*, 304 N.C. 727, 288 S.E.2d 804 (1982). In *Hyder* he concurred in an opinion that applied *res ipsa loquitur* to proof that a wire was left in a patient after an operation and that held erroneous a jury instruction requiring expert testimony of customary practice. In *Tice* Judge Becton dissented: "Because the evidence shows that the standard of practice is for the surgeon to rely on the sponge counts provided by operating room nurses and that [defendant] did that in the case *sub judice*, I believe the trial court correctly granted the defendant's motion for a directed verdict." 63 N.C. App. at 38, 303 S.E.2d at 838.

that it could have been discovered by reasonable inspection, the law surely will impose upon surgeons the duty to conduct a reasonable search. The idea that surgeons rely exclusively on the nurses' sponge counts without conducting their own inspections seems hardly credible. The need for and conduct of such a search does not involve weighty matters of medical sense, exercise of the surgeon's expert discretion, or imposition of a substantial obligation on the surgeon's time.

The implications of *Tice* are disturbing. It may be interpreted to require proof of customary practice even when the jury, unaided by experts, is competent to judge the reasonableness of a physician's conduct. Further, this interpretation seems to require the conclusion that compliance with customary practice, no matter how unreasonable that practice may be, cannot constitute malpractice.

Other court of appeals decisions recognize that in appropriate cases malpractice can be established without expert evidence of customary practice. In *Hyder v. Weitbaecher*,[43] in which a surgeon left an eight and one-half inch wire in a patient, the court held that *res ipsa loquitur* applied to permit an inference of the surgeon's negligence. It also held erroneous an instruction[44] by the trial judge that the jury could find the standard of care only "through evidence presented by practitioners who were called as expert witnesses": "The facts of this case gave rise to the inference that the defendant doctor did not exercise due care. By imposing an external standard established by expert testimony, the trial court essentially negated this inference to plaintiff's prejudice."[45] In another case, *Smithers v. Collins*,[46] the court held that lay testimony was adequate to show a doctor's failure to follow certain procedures that experts had testified were performed customarily. Further, extensive dictum[47] in the case indicates that expert testimony of customary practice would be unnecessary in any case in which the jury, based upon common knowledge and experience, could understand and evaluate the doctor's conduct.

---

43. 54 N.C. App. 287, 283 S.E.2d 426 (1981), *cert. denied*, 304 N.C. 727, 288 S.E.2d 804 (1982).

44. Unfortunately, the North Carolina Pattern Jury Instructions uses a *res ipsa loquitor* fact situation in a model instruction illustrating the appropriate charge on the standard of care in medical malpractice cases. NORTH CAROLINA CONFERENCE OF SUPERIOR COURT JUDGES, NORTH CAROLINA PATTERN JURY INSTRUCTIONS FOR CIVIL CASES 809.00 (1975) [hereinafter cited as N.C.P.I.].

45. *Hyder*, 54 N.C. App. at 292, 283 S.E.2d at 429.

46. 52 N.C. App. 255, 278 S.E.2d 286, *cert. denied*, 303 N.C. 546, 281 S.E.2d 394 (1981) (standard of care established by expert testimony that pelvic and stethoscopic examinations required when intestinal obstruction suspected; breach could be established by lay testimony that neither examination was performed).

47. The court stated:

> [E]xpert testimony is generally required when the standard of care and proximate cause are matters involving highly specialized knowledge beyond the ken of laymen. It has never been the rule in this State, however, that expert testimony is needed in *all* medical malpractice cases to establish either the standard of care or proximate cause. Indeed, when the jury, based on its common knowledge and experience, is able to understand and judge the action of a physician or surgeon, expert testimony is not needed.

Id. at 260, 278 S.E.2d at 289.

One other case, although decided prior to enactment of the statute, merits consideration. In *Norris v. Rowan Memorial Hospital*[48] an elderly and sedated hospital patient was injured after falling while attempting to use the bathroom at night. Plaintiff alleged that a nurse employed by the hospital was negligent in failing to raise the rails on her bed and to instruct her to use the call button to obtain assistance in going to the bathroom. Expert evidence of customary practice was not introduced by plaintiff. The court, in reversing a directed verdict for defendant, said:

> Where, as here, the alleged breach of duty did not involve the rendering or failure to render professional nursing or medical services requiring special skills, expert testimony on behalf of the plaintiff as to the standards of due care prevailing among hospitals in like situations is not necessary to develop a case of negligence for the jury. Under the factual situations here presented the jury was fully capable without aid of expert opinion to apply the standard of the reasonably prudent man.[49]

The *Norris* case is important because it carefully relates the need for expert testimony to the particular facts and the jury's ability to understand them. Such a careful factual analysis is not present in some of the other cases and, as a result, the court's reliance on the general rule that expert testimony is needed creates uncertainty. Because the other cases involve facts that the jury seemed capable of assessing, the danger exists that they could be regarded as precedent requiring expert testimony in all malpractice actions.[50]

A failure of the court, in applying the statute, to recognize the true basis for the customary practice standard would be unfortunate. To equate customary practice with doctors' usual practices fails to relate their conduct to the superior knowledge they hold themselves out to possess and confers a special privilege on the profession to establish its own standard of care. To permit doctors or other professionals to escape liability by following a customary practice that is obviously unreasonable conflicts with both policy and precedent.[51] Furthermore, the reasonableness of a practice customarily followed in the profession is seldom an issue in a case. The issue usually presented is whether the absence of expert testimony of customary practice is fatal to a malpractice claim even when the jury has sufficient understanding and knowl-

---

48. 21 N.C. App. 623, 205 S.E.2d 345 (1974).

49. *Id.* at 626, 205 S.E.2d at 348. In Ballance v. Wentz, 22 N.C. App. 363, 206 S.E.2d 734, *aff'd*, 286 N.C. 294, 210 S.E.2d 390 (1974), another prestatutory case, the majority and dissent adopted different views of the jury's capability to determine the reasonableness of a physicians' conduct when a traction rig suspending plaintiff's broken arm collapsed.

50. *See, e.g.*, *Tice*, 63 N.C. App. 27, 303 S.E.2d 832 (sponge left in patient; proof that customary practice required surgeon to search for sponges vital under particular facts); Page v. Wilson Memorial Hosp., 49 N.C. App. 533, 272 S.E.2d 8 (1980) (disoriented patient fell from bedpan in chair; remanded for improper exclusion of testimony that absence of attendant inconsistent with customary practice); Tripp v. Pate, 49 N.C. App. 329, 271 S.E.2d 407 (1980) (whether delay in reporting laboratory results unreasonable; absence of evidence of customary practice held fatal under N.C. GEN. STAT. § 90-21.12 (1981) (requiring such proof in medical malpractice cases)).

51. Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) (ophthalmologist negligent as matter of law for failing to give glaucoma test to low risk patient despite uncontradicted testimony that such failure was in accord with universal practice).

edge to judge the reasonableness of the conduct involved. Undoubtedly, the issues involved in many malpractice cases are beyond the competence of the jury so that expert testimony is essential. When common sense permits the jury to understand and evaluate the conduct, however, insistence upon expert proof of customary practice serves only to create an unreasonable and artificial barrier to recovery.

Recognition that the customary practice standard does not require introduction of expert evidence when the jury is competent to understand and judge the reasonableness of defendant's conduct assumes even greater importance in light of the statute's broad definition of health care providers to whom the standard will apply.[52] Because the level of skill and expertise of many of these health care providers is less than that possessed by physicians, common knowledge and experience may permit, at least in some cases, the jury to judge the reasonableness of their conduct. In addition, they are likely to perform many activities that, although related to the provision of medical services, involve no application of technical skills and are therefore as readily understood by lay persons as by experts.

II. EXPANDED APPLICATION OF CUSTOMARY PRACTICE STANDARD

North Carolina General Statutes section 90-21.11 defines health care provider to include:

> [A]ny person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital . . . ; 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.[53]

Although the breadth of this definition is apparent, a few observations about its coverage may be appropriate. First, members of a variety of occupational groups are declared to be health care providers. Among these groups exist vast differences in the levels of skill, knowledge, training, education, and expertise possessed and the nature of activities performed. The qualifications and activities of some, such as the physician, surgeon, and dentist, are encompassed by the traditional view of the medical professional. Others, such as chiropractors and podiatrists, although generally regarded as less well qualified by education and training, have customarily been accorded a status similar to that of the physician. Nurses and other physicians' assistants engage in a

52. *See infra* text accompanying note 53.
53. N.C. GEN. STAT. § 90-21.11 (1981).

variety of activities that may or may not involve professional medical skills. A variety of persons working in hospitals, nursing homes, and laboratories may be unskilled or semi-skilled or may be involved in administrative rather than medical activities. The same may be true for members of other groups who are health care providers because they "perform duties associated with" any of the occupational activities listed, are "legally responsible for" the negligence of another health care provider, or act "at the direction or under the supervision of" a health care provider.

The purpose of the statute is to fix the standard of care in tort actions arising out of the provision of health care. The two substantive provisions[54] establish the customary practice standard of care for treatment and informed consent cases. Because the definition of health care provider is important only in relation to these substantive provisions, the apparent effect of the statute is to apply the customary practice standard to all health care providers.

An amendment[55] to the Medical Malpractice Actions bill while it was under consideration by the General Assembly, however, indicates a legislative intent to restrict application of the customary practice standard more narrowly than the definition of health care provider suggests. The original bill applied the customary practice standard "in any action . . . arising out of the furnishing of or failure to furnish medical, dental or other health care . . . ."[56] The amendment restricted the provision's application to "the furnishing or failure to furnish *professional services in the performance* of medical, dental, or other health care . . . ."[57] At the very least, this additional phrase would seem to exclude administrative, housekeeping, and related support activities. This interpretation leaves intact the definition of health care provider in the preceding section. At the other extreme, an interpretation of the new language to restrict the statute's coverage to the traditional professions would conflict directly with the statute's own definition of health care provider. If the legislature intended this result, presumably a more limited definition of health care provider would have been used for this purpose. Unfortunately, little middle ground exists between these interpretations. If the definition section is to remain intact, activities related to "laboratory analysis, rendering assistance to a physician, dental hygiene," and those of a nursing home attendant, for example, must be regarded as "professional services."

Theoretical and practical considerations argue against broadly applying the customary practice standard the legislature apparently has adopted. Adoption of the customary practice standard for physicians and related professionals is an exception to the general unwillingness of courts to permit the customs and practices of a group to establish the standard of care for determining tort liability of its members. The North Carolina decisions have iden-

54. *Id.* §§ 90-21.12 to .13.

55. H.B. 1293, Gen. Assembly of 1975, 2d Sess. § 4 (1976) (incorporating amendment 2 of May 6, 1976) (codified at N.C. GEN. STAT. § 90-21.12 (1981)).

56. *Id.* (original version before amendments).

57. *Id.* (emphasis added).

tified two primary reasons for this exception. One justification, particularly relied upon in early cases but less important today, was effectively set forth by Justice Seawell in *Groce v. Myers*:[58]

> The usual argument which has relegated the decision of malpractice cases to the opinion of professional men . . . as distinguished from the jury, is that the practice of medicine and surgery is empiric—which means that it has not yet become a matter of scientific knowledge or proceeding. The implication is that only a doctor can know from his own actuarial or statistical experience, or that of others handed down to him, what is good or bad practice in any case. On this theory the doctor, instead of being an expert in scientific learning and methods, is an expert in the trial and error results which are nowhere available except in the arena of the profession.[59]

The second justification is based upon an entirely different view of medical practice. It was stated succinctly by Justice Barnhill in *Jackson v. Mountain Sanitarium & Asheville Agriculture School*:[60]

> Usually, what is the standard of care required of a physician or surgeon is one concerning highly specialized knowledge with respect to which a layman can have no reliable information. As to this, both the court and jury must be dependent on expert testimony. Ordinarily there can be no other guide.[61]

Obviously, these reasons for the customary practice exception do not apply to many of the groups included within the definition of health care provider. As pointed out earlier,[62] not only highly skilled experts, but also unskilled individuals and a variety of other persons who in terms of skill and qualification range between the two, come within the definition. For many of these, expert evidence is not required to inform the jury of the qualifications such individuals must possess or to enable it to judge the reasonableness of their conduct. Reason to exclude them from the reasonable and prudent person standard simply does not exist.

Serious practical problems arise if the customary practice standard is applied indiscriminately to any individual who "performs duties associated with" health care. The concept of customary practice entails some type of professional group for which a common body of knowledge exists, certain practices and procedures are generally accepted, and among whose members general dissemination of the knowledge, practices, and procedures occurs. Customary practice involves more than merely the usual way of doing something. Grave doubts exist that a customary practice in this sense can be identified for many of the groups included in the definition of health care provider.

Under the customary practice standard, plaintiff, to establish a cause of action in most cases, must introduce expert testimony that defendant's conduct

58. 224 N.C. 165, 29 S.E.2d 553 (1944).
59. *Id.* at 169, 29 S.E.2d at 556.
60. 234 N.C. 222, 67 S.E.2d 57 (1951).
61. *Id.* at 226-27, 67 S.E.2d at 61.
62. *See supra* text accompanying notes 55-57.

deviated from customary practice.[63] Insistence on such testimony when the group lacks the characteristics set out in the preceding paragraph will likely result in presentation of the witness' own practice in the guise of customary practice. Even in this context, finding an expert witness may be difficult. Because the experience of many individuals in these groups will be limited—often restricted to a single institution or setting—they may well question their own competence to testify about customary practice. Further, members of these groups may be even more reluctant than doctors to testify against their colleagues.

Interpreting the statute to limit proof of negligence exclusively to expert evidence of customary practice in actions against health care providers is likely to create uncertainty, promote litigation, and result in unfair decisions on the liability issue. Even if the traditional, less restrictive view of customary practice advocated earlier is adopted, substantial difficulties will be encountered under this provision of the statute. Contrary to the apparent purpose of the statute, resolution of claims against some health care providers will probably be more burdensome and expensive than under prior law.

III. CUSTOMARY PRACTICE IN TREATMENT CASES

North Carolina General Statutes section 90-21.12 provides:

> 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.[64]

The customary practice standard is not a monolithic standard uniformly applied to all malpractice actions. A practitioner is held to the customary practice in his area of medicine.[65] A physician engaged in family practice is judged by customary practice in family medicine. The higher level of training and education of various specialists is taken into account and each is judged by the customary practice in his speciality.[66] To the extent that society permits practice of the healing arts by individuals who lack the full credentials of a regular physician, the conduct of each is measured by the customary practice

63. Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); Ballenger v. Crowell, 38 N.C. App. 50, 247 S.E.2d 287 (1978).

64. N.C. GEN. STAT. § 90-21.12 (1981).

65. Whitehurst v. Boehm, 41 N.C. App. 670, 673-74, 255 S.E.2d 761, 765 (1979) (customary practice of orthopedic surgeon inappropriate standard in determining podiatrist's negligence).

66. Koury v. Follo, 272 N.C. 366, 372-73, 158 S.E.2d 548, 554 (1968); Belk v. Schweizer, 268 N.C. 50, 56, 149 S.E.2d 565, 569-70 (1966).

of the particular school to which he belongs.[67]

Another variable in the customary practice standard reflects the perception that the level of sophistication of practice in a particular field of medicine varies with the surrounding environment. The principle involved is illustrated by the often repeated statement that a country doctor should not be held to the standard of a big city practitioner. The differences that justified this distinction were based upon general observation rather than proof in any specific case. The assumptions that supported this distinction became the basis for the locality rule under which conduct was assessed on the basis of customary practice in the locality in which a defendant practiced.

The number of adherents to the locality rule declined as advances in medical science, stricter regulation of the medical profession, and improvements in medical education and practice removed many of the factors that earlier contributed to different levels of quality in practice. The prevailing standard became customary practice in the "same or similar community" and a trend toward a national standard developed.[68] This trend was arrested, if not reversed, by medical malpractice legislation adopted by many states in the mid-1970s in response to the malpractice insurance crisis. Today, a majority of jurisdictions follow the same or similar community rule. Its adoption, however, may reflect as much the perception that malpractice liability can be curtailed by excluding the testimony of outside experts as the belief that real differences in the quality of practice exist.

In 1970 North Carolina judicially adopted the same or similar community rule.[69] The court, in doing so, assumed that the locality rule had been in effect prior to that time. Whether this assumption was consistent with prior practice is unknown; little evidence in appellate decisions supports it, however. Discussion in earlier cases, although not directed to the specific issue under consideration, described the customary practice standard in very broad terms. Descriptions used to characterize the standard have included the care and skill such as is " 'ordinarily possessed by the average member of the profession' "[70] and such "reasonable skill and diligence as is ordinarily exercised in his profession."[71] There is only one case[72] in which the locality rule was even mentioned, and in that case the court was addressing the form of the hypothetical question asked a witness rather than the locality rule per se. The closest the court came to dealing with the issue was in *McCracken v. Smathers*,[73] in which the court upheld the refusal of the trial court to give defendant's requested instruction that "the care and skill required . . . is . . . such as is possessed by

67. Hardy v. Dahl, 210 N.C. 530, 534, 187 S.E. 788, 790 (1936).

68. 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 8.06, at 211 (1983).

69. Wiggins v. Piver, 276 N.C. 134, 139-41, 171 S.E.2d 393, 396-98 (1970).

70. Long v. Austin, 153 N.C. 508, 511, 69 S.E. 500, 501 (1910) (quoting McCracken v. Smathers, 122 N.C. 799, 803, 29 S.E. 354, 355 (1898)).

71. Brewer v. Ring, 177 N.C. 476, 488, 99 S.E. 358, 364 (1919).

72. Jackson v. Joyner, 236 N.C. 259, 264, 72 S.E.2d 589, 593 (1952).

73. 122 N.C. 799, 29 S.E. 354 (1898).

men of his profession *in the neighborhood*."[74] The court said:

> The degree of care and skill required is that possessed and exercised by the ordinary members of his profession. . . . It cannot be measured simply by the profession in the *neighborhood*, as this standard of measurement would be entirely too variable and uncertain. "Neighborhood" might be construed into a very limited area, and is generally so understood among our people. It might contain but few dentists, in sparsely settled sections perhaps only one or two. Both might be men of very inferior qualifications, and to say that they might set themselves up as the standard of a learned profession, and prove the standing of each by the ability of the other, would be equally unjust to the profession and to its patients. . . . In the well-considered case of *Gramm v. Booner*, 56 Ind. 497, 501, the Court says: "It seems to us that physicians or surgeons practicing in small towns, or rural or sparsely populated districts, are bound to possess and exercise at least the average degree of skill possessed and exercised by the profession in such localities generally. It will *not* do, as we think, to say that if a surgeon or physician has exercised such a degree of skill as is ordinarily exercised in the *particular* locality in which he practices, it will be sufficient."[75]

This historical excursion is beside the point because, whatever the law may have been, the same or similar community rule has since been adopted by first the court and then the legislature.[76]

The North Carolina statute seems to incorporate a third variable in the customary practice standard. It provides that negligence is to be determined by "standards of practice among members of the same health care profession *with similar training and experience* situated in the same or similar communities . . . ."[77] The emphasized language suggests that the standard for determining liability of a general practitioner in practice for ten years would differ from that for one in practice for only two years. Such an interpretation of the statute would result at best in continuous litigation concerning the similarity of a witness' experience to defendant's or at worst in a subjective standard that practically would preclude finding liability.

In *Lowery v. Newton*[78] the "similar training and experience" language was omitted from the hypothetical question relating to customary practice put to plaintiff's witness and from the trial judge's instruction to the jury. The court of appeals held that neither omission was prejudicial error. In regard to its omission from the hypothetical question, the court said: "To contend that the substitution of 'under the same or similar circumstances' in lieu of 'with similar training and experience' is significant, places form over substance. Such technical error is harmless."[79] The alleged error in the jury instruction

74. *Id.* at 802, 29 S.E. at 355.
75. *Id.* at 803-04, 29 S.E. at 355-56.
76. N.C. GEN. STAT. § 90-21.12 (1981).
77. *Id.* (emphasis added).
78. 52 N.C. App. 234, 278 S.E.2d 566, *cert. denied*, 304 N.C. 195, 291 S.E.2d 148 (1981).
79. *Id.* at 238, 278 S.E.2d at 570.

was dealt with in a similar manner:

> Defendants argue that since the enactment of this statute in 1975 only a literal interpretation of the wording will suffice. We do not agree. It is the concept expressed by the words of the statute which controls. The words "similarly situated" can easily encompass not only geographic location, but also standing within a profession.[80]

Although the court disposed of the issues in *Lowery* in a sensible way, problems remain. The decision leaves largely unresolved whether the customary practice standard against which a defendant's conduct is measured must reflect his level of training and experience and how this factor will be reflected in the qualification of expert witnesses. The decision does not reject "training and experience" as an element of customary practice but only finds the "similarly situated" instruction sufficient to "encompass . . . standing within a profession."[81]

The court of appeals, in a case not involving medical malpractice, has recognized the inappropriateness of such a limit on the standard of care.[82]

> The trial court improperly introduced a subjective standard of care into the definition of negligence by referring to the "ordinary care and caution, which an ordinary prudent pilot *having the same training and experience as Fred Heath*, would have used in the same or similar circumstances."
>
> [O]bjective standards avoid the evil of imposing a different standard of care upon each individual. The instructions in this case . . . are misleading at best, and a misapplication of the law. They permit the jury to consider Fred Heath's own particular experience and training, whether outstanding or inferior, in determining the requisite standard of conduct, rather than applying a minimum standard generally applicable to all pilots. The plaintiff is entitled to an instruction holding Fred Heath to the objective minimum standard of care applicable to all pilots.[83]

The court's analysis applies equally to the malpractice standard of care. Incorporation of "similar training and experience" into the customary practice standard would effectively eliminate any minimum standard of care to which health care providers will be held. The unfortunate consequences of this result would be compounded by the greatly expanded application of the customary practice standard dictated by the statute. Apart from the question of fairness it would present, such a limited standard of care would pose significant problems in qualifying an expert witness to testify on customary practice. What factors would be relevant to determining if experience is similar? Could a family practitioner in practice for ten years establish the standard of care applicable to one in practice for two years? What would constitute similar

80. *Id.* at 242, 278 S.E.2d at 573.

81. *Id.*

82. Heath v. Swift Wings, Inc., 40 N.C. App. 158, 252 S.E.2d 526, *cert. denied*, 297 N.C. 453, 256 S.E.2d 806 (1979).

83. *Id.* at 163, 252 S.E.2d at 529.

training? Would the quality of medical schools and hospitals in which education and residency training were acquired be relevant?

Serious grounds exist, therefore, to question whether the legislature intended the "similar training and experience" language to introduce another variable in the customary practice standard. Because this interpretation eliminates, for practical purposes, the idea of a minimum standard of care—an idea that is basic to all negligence law—and poses extreme practical difficulties in the application of the customary practice standard, it should be adopted only if no other reasonable interpretation is possible. That the statute, if interpreted in this way, conflicts with prior law also supports this conclusion.

A reasonable interpretation that avoids all of these consequences is possible. The statute can be read to include two, rather than three, elements in the customary practice standard: (1) "members of the same health care profession with similar training and experience" and (2) "situated in the same or similar communities." Under this reading, the phrase "similar training and experience" modifies "same health care profession" and serves the legitimate purpose of distinguishing between the general practitioner and the specialist, and among various specialists—distinctions that were recognized in prior law. This interpretation also is supported by the substitution of the phrase "similar training and experience" for the phrase "in his field of practice" incident to a broader amendment to the bill while it was being considered by the legislature.[84] In this context, the phrase has a clear meaning, serves a useful purpose, and is consistent with prior law. On the other hand, if it is interpreted to introduce a separate variable in customary practice, its meaning is unclear, it undermines a basic principle of negligence law, and it introduces a novel concept to medical malpractice. The choice of interpretations seems obvious.

Against this background, it is unfortunate that the North Carolina Pattern Jury Instructions[85] include the "similar training and experience" language as a separate element of the standard of care. For example, in defining negligence for a general practitioner, the instructions state: "[T]hat care must only be in accordance with the standards of practice among general practitioners with similar training and experience. . . ."[86] The applicable standard under this instruction is not that standard prevailing among general practitioners but a more limited one that considers only "general practitioners with similar training and experience." Under the better interpretation, general practice is the health care profession, all of whose members must have "similar training and experience," to which this individual belongs; once this determination is made, the importance of similar training and experience is spent. An instruction on similar training and experience, such as that in the pattern instruction, would be unnecessary and if given would likely constitute reversible error.[87]

84. H.B. 1293, Gen. Assembly of 1975, 2d Sess. § 4 (1976) (incorporating amendment 7 of May 7, 1976) (codified at N.C. GEN. STAT. § 90-21.12 (1981)).

85. N.C.P.I., *supra* note 44, at 809.00 (1981).

86. N.C.P.I., *supra* note 44, at 809.05 (1980).

87. *See* Heath v. Swift Wings, Inc., 40 N.C. App. 158, 252 S.E.2d 526, *cert. denied*, 297 N.C. 453, 256 S.E.2d 806 (1979).

The primary reason given by the study commission for recommending codification of the same or similar community standard was "to avoid further interpretation by the Supreme Court which might lead to regional or national standards for all health care providers."[88] It would be ironic if the most far reaching change effected by the Medical Malpractice Actions legislation resulted from judicial misinterpretation of the legislation.

IV. QUALIFYING THE EXPERT UNDER THE CUSTOMARY PRACTICE STANDARD

Medical skills and practice are generally beyond the understanding of lay persons, so expert testimony is usually required to establish malpractice.[89] Because customary practice is the standard of care in malpractice cases, to establish negligence the expert's testimony must show that the defendant's conduct deviated from customary practice.[90] Generally, familiarity with the customary practice that is the standard of care in the particular case is the essential qualification the expert must possess in order to testify.[91]

The North Carolina statute relates the customary practice standard to (1) members of the same health care profession (2) situated in the same or similar communities (3) at the time of the alleged act giving rise to the cause of action.[92] This enumeration assumes that the "similar training and experience" language in the statute simply identifies the relevant health care profession.[93] If this interpretation is wrong, similar training and experience would be a fourth factor to be considered. As a witness' familiarity with the relevant customary practice is necessary to qualify him as an expert who can testify that defendant's conduct was negligent, it may be helpful to inquire how each of these factors relate to the witness' qualification.

A. Same Health Care Profession

The usual and safest practice is to call as witnesses members of the same health care profession. Departure from this practice may result in exclusion of the witness' testimony or, if it is admitted, a low estimation of its value by the jury. It is entirely conceivable, however, that a physician could be familiar with customary nursing practice or a specialist with customary practice for family practitioners, particularly in relation to treatments or disorders that overlap his area of specialty. When such familiarity exists, admission of the testimony would seem to be permissible. The witness' testimony, of course, must concern customary practice in defendant's area of medicine and not his

88. LIABILITY INSURANCE STUDY, *supra* note 2, at 32.

89. Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); Connor v. Hayworth, 206 N.C. 721, 175 S.E. 140 (1934); Ballenger v. Crowell, 38 N.C. App. 50, 247 S.E.2d 287 (1978).

90. Tripp v. Pate, 49 N.C. App. 329, 271 S.E.2d 407 (1980); Ballenger v. Crowell, 38 N.C. App. 50, 247 S.E.2d 287 (1978).

91. Lowery v. Newton, 52 N.C. App. 234, 278 S.E.2d 566, *cert. denied*, 304 N.C. 195, 291 S.E.2d 148 (1981); Whitehurst v. Boehm, 41 N.C. App. 670, 255 S.E.2d 761 (1979).

92. N.C. GEN. STAT. § 90-21.12 (1981).

93. *See supra* text accompanying notes 77-87.

own. Testimony directed to the witness' area of medicine should be excluded as irrelevant to the standard of care applicable to the defendant.

The North Carolina cases give no clear answer on this issue. In *Whitehurst v. Boehm*[94] exclusion by the trial court of testimony by an orthopedic surgeon in a suit against a podiatrist was upheld. The court concluded:

> We hold that, in malpractice cases, the applicable standard of care for podiatrists and other "allied occupations" to medicine must be established by other practitioners in the particular field of practice or by other expert witnesses *equally* familiar and competent to testify with respect to that limited field of practice.[95]

The proffered testimony in *Whitehurst* concerned customary practice of orthopedic surgeons and not that of podiatrists. Examination of the opinion clearly shows that the basis for the decision was the inappropriateness of the standard of care to which the testimony related rather than the witness' being an orthopedic surgeon. Despite the court's characterization of the quoted statement, it probably should be considered dictum in view of the issue decided. In any event, the statement indicates that testimony of persons outside of defendant's area of practice may come in; it also suggests, however, by its emphasis on "equally," that the test of the witness' familiarity with the relevant customary practice will be stringent.

The court in *Vassey v. Burch*,[96] a malpractice action against a nurse, held that a physician's affidavit, which stated that accepted medical practice required that the patient be checked for appendicitis, was insufficient to preclude summary judgment for the defendant. The basis for the decision was again that the evidence related to an improper standard of care. The court concluded: "Although the affidavit of Dr. Stewart Todd may be sufficient to establish the accepted standard of medical care for a doctor in his office, it does not establish the standard of care for a nurse in a hospital."[97]

In *Lowery v. Newton*[98] the admission of a neurosurgeon's testimony in a malpractice action against a plastic surgeon was upheld. It is unclear whether this testimony related to customary practice of neurosurgeons or plastic surgeons. The court reasoned:

> There is some overlapping in the various areas of health care.
>
> . . . .
>
> The overriding area of medical care before us is surgery—not plastic surgery alone or neurological surgery alone. The operation involved some expertise by the surgeon in both areas. The prior experience and training of [the witness] as a general surgeon *and plastic surgeon* is sufficient to qualify him to testify as an expert for the purpose of establishing the standard of care and breach thereof required

94. 41 N.C. App. 670, 255 S.E.2d 761 (1979).

95. *Id.* at 677, 255 S.E.2d at 767.

96. 45 N.C. App. 222, 262 S.E.2d 865, *rev'd on other grounds*, 301 N.C. 68, 269 S.E.2d 137 (1980).

97. *Id.* at 226, 262 S.E.2d at 867.

98. 52 N.C. App. 234, 278 S.E.2d 566, *cert. denied*, 304 N.C. 195, 291 S.E.2d 148 (1981).

in the case before us.[99]

This brief statement of the court suggests two different ideas relating to the qualification of the expert witness. First, it suggests that each area of specialization in a broad field of medical practice, such as surgery, will not necessarily be regarded as sui generis in determining the qualification of an expert to testify about customary practice. Second, it indicates that when areas of medical practice overlap, an expert in either area may be permitted to testify if the treatment involves matters common to the two areas. In these situations, admission of the witness' testimony, even if it is related to customary practice in his own area of practice, seems proper because little likelihood exists that its admission will subject the defendant to an inappropriate, higher standard of care.

B. Time and Underlying Basis of Knowledge

Customary practice prevailing at the time of the defendant's alleged malpractice is the standard of care to which a witness' testimony must be directed.[100] This time factor and the underlying basis for the expert's knowledge are so closely related that they need to be examined together. The test of the witness' qualification in these respects should be whether he has adequate knowledge of customary practice to be of help to the jury. If he does, his testimony should be admitted. His testimony should not be excluded because there are witnesses who are better qualified or more knowledgable. Although these factors may affect the jury's assessment of the evidence, they are not proper grounds for its exclusion. That a witness' knowledge of customary practice is based upon earlier training and experience should not necessarily render him incompetent. While training and experience twenty years earlier may provide an inadequate basis of knowledge of current practice, a similar conclusion is not justified when the witness' training and experience occurred only a few years earlier. Similar reasoning should apply in judging the adequacy of the source of the witness' knowledge. Actual practice is the obvious way to acquire knowledge of current practice, but it is not the only way. In reality, the practitioner's knowledge of the customary practice in the profession must, for the most part, come from sources other than his own practice. That he is engaged in practice simply ensures the expertise, incentive, and opportunity to keep abreast of professional developments.

The North Carolina cases seem consistent with this analysis. Although the witness' knowledge of the customary practice existing at the time of the defendant's alleged malpractice must be shown, proof that he was engaged in practice at that time is not required.[101] "It would be unduly restrictive . . . to require an expert to have knowledge of the standard of care . . . at the time of

99. *Id.* at 239-40, 278 S.E.2d at 571.

100. N.C. GEN. STAT. § 90-21.12 (1981).

101. *See* Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973); Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596, *cert. denied*, 305 N.C. 587, 292 S.E.2d 571 (1982).

the alleged act only by having practiced in the particular field *at that time*."[102] Witnesses have been found qualified to testify if at the time of the alleged malpractice they were medical students, interns, or residents[103] still in training for the area of medical practice to which their testimony related. In *Williams v. Reynolds*,[104] a case involving veterinary malpractice, the trial court rejected efforts to qualify the witness based on his knowledge of customary practice in both similar communities and the particular community in which the defendant practiced. The court of appeals, in finding error, said:

> Furthermore, to say that this veterinarian . . . cannot testify as to the accepted medical standards prevailing in Wake County during October and November 1975, simply because he did not begin practicing here until two months later, is fatuous. The fact that he was not actually practicing in Wake County at the actual time of treatment is merely a factor for the jury to consider in deciding what weight it will give to his testimony.[105]

The court has recognized that knowledge of customary practice may be acquired through means other than formal practice. Personnel at teaching hospitals may obtain sufficient knowledge of customary practice in other communities through the various activities in which they engage. *Howard v. Piver*[106] indicates, although other grounds for the decision also exist, that a doctor who practiced and taught at Memorial Hospital in Chapel Hill, but to whom patients were referred and hospital records sent from throughout North Carolina, was competent to testify regarding customary practice in communities similar to Jacksonville. In *Page v. Wilson Memorial Hospital*[107] the court of appeals, in sustaining the admission of testimony of a nurse in a malpractice action against the hospital, cataloged the nurse's credentials. The one most relevant to her familiarity with practice in similar communities was that "she supervised student nurses in caring for patients" in several other county hospitals in eastern North Carolina.[108] Knowledge acquired through residency or other training[109] or through service as clinical director of a statewide medical organization[110] may provide sufficient familiarity with the relevant customary practice. In *Rucker v. High Point Memorial Hospital*[111] a witness who had obtained knowledge of a relevant standard of care through service, seminars,

102. Simons v. Georgiade, 55 N.C. App. 483, 494-95, 286 S.E.2d 596, 603, *cert. denied*, 305 N.C. 587, 292 S.E.2d 571 (1982).

103. *See, e.g.*, Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973); Spillman v. Forsyth Memorial Hosp., 30 N.C. App. 406, 227 S.E.2d 292 (1976).

104. 45 N.C. App. 655, 263 S.E.2d 853 (1980).

105. *Id.* at 660, 263 S.E.2d at 856.

106. 53 N.C. App. 46, 279 S.E.2d 876 (1981).

107. 49 N.C. App. 533, 272 S.E.2d 8 (1980).

108. *Id.* at 535, 272 S.E.2d at 10.

109. Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973) (internship, residency, and subsequent practice); Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596 (residency, training, and subsequent practice), *cert. denied*, 305 N.C. 587, 292 S.E.2d 571 (1982).

110. Hart v. Warren, 46 N.C. App. 672, 266 S.E.2d 53, *cert. denied*, 301 N.C. 89 (1980).

111. 285 N.C. 519, 206 S.E.2d 196 (1974).

personal consultations, journals, and periodicals was held competent to testify concerning it.

C. *Same or Similar Community Rule*

Since adoption of the same or similar community rule in 1970 and its subsequent codification in 1976, efforts to exclude expert testimony seeking to establish malpractice, on grounds of the witness' lack of familiarity with customary practice in the same or similar community, have become almost routine and the issue now has been litigated in a number of cases. Despite these developments, the courts have not attempted to define or establish general guidelines for determining what constitutes similar communities. A general statement in *Williams v. Reynolds*[112] identified the nature of the treatment involved, the character of the community concerned, and the comparability of medical facilities available as relevant considerations.[113] Geographical proximity of the communities apparently is not necessary,[114] and no requirement that the practitioner was trained or had practiced in North Carolina seems to exist.[115]

The circumstance most emphasized in the cases is the nature of the treatment involved. This consideration was initially relied on in *Wiggins v. Piver*,[116] the first case to adopt the same or similar community standard, in which the court said:

> The operative procedures here involved would seem to be as simple and uncomplicated as any cutting operation one may imagine. Reason does not appear to the non-medically oriented mind why there should be any essential differences in the manner of closing an incision, whether performed in Jacksonville, Kinston, Goldsboro, Sanford, Lexington, Reidsville, Elkin, Mt. Airy, or any other similar community in North Carolina.[117]

Courts have relied on similar reasoning in subsequent cases to find experts qualified to testify about customary practice.[118] These cases imply that when treatment is uncomplicated or involves procedures that are generally followed in the profession, other differences between the communities involved may not be important. In many of these cases, however, the identity of the communi-

112. 45 N.C. App. 655, 263 S.E.2d 853 (1980).

113. *Id.* at 658, 263 S.E.2d at 855.

114. Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973) (Mt. Airy, N.C. compared to Youngstown, Ohio and Los Angeles, Ca.); Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596 (Durham, N.C. compared to Winston-Salem, N.C. and Charlottesville, Va.), *cert. denied*, 305 N.C. 587, 292 S.E.2d 571 (1982); Williams v. Reynolds, 45 N.C. App. 655, 263 S.E.2d 853 (1980) (Wake County, N.C. compared to Evansville, Ind. and Chicago, Ill.).

115. *See* cases cited *supra* note 114.

116. 276 N.C. 134, 171 S.E.2d 393 (1970).

117. *Id.* at 138, 171 S.E.2d at 395-96.

118. *See* Rucker v. High Point Memorial Hosp., 285 N.C. 519, 206 S.E.2d 196 (1974); Howard v. Piver, 53 N.C. App. 46, 279 S.E.2d 876 (1981); Page v. Wilson Memorial Hosp., 49 N.C. App. 533, 272 S.E.2d 8 (1980); Williams v. Reynolds, 45 N.C. App. 655, 263 S.E.2d 853 (1980).

ties coupled with general knowledge about them, without additional proof, may well have justified a conclusion that they were similar.

In *Rucker v. High Point Memorial Hospital*,[119] in which no basis existed for finding similarity in the communities, the reason for finding the expert's testimony admissible was that "gunshot wounds of the lower leg lend themselves most readily to uniform medical and surgical treatment without regard to locality."[120] There is evidence in the decision that the court was not yet ready to state a generally applicable rule on this issue. The court observed that the case involved a "*duly accredited hospital*" rather than a "local country doctor" and that "[n]ot all injuries [are] so uniform and the treatment so generally well known and followed."[121] Language in a later court of appeals case, *Thompson v. Lockert*,[122] suggests that the *Rucker* rule may be limited to duly accredited hospitals; neither the issue nor the facts involved, however, paralleled those in *Rucker*. In *Thompson* there was no evidence that uniform medical procedures applied to the treatment involved,[123] and the court held only that the reasoning in *Rucker* did not support adoption of a national standard for diplomates of the American Board of Orthopedic Surgeons.

The court has not yet expressly considered other factors, such as those identified in the *Williams* case, that may be relevant to determining whether communities are similar. When obvious similarity of communities exists, the court apparently has not insisted upon specific proof that the communities are comparable in size, available medical facilities, or other characteristics. In a suit against Wilson County Hospital, a witness familiar with practice in several other eastern North Carolina county hospitals was permitted to testify, despite defendant's objection that no proof existed to show that the communities were similar.[124] Similarity of medical practice at three university medical centers located in Winston Salem, Charlottesville, and Durham was found when only minimal proof apparently had been offered to show that the communities were similar.[125] Common knowledge, without special proof, makes apparent numerous elements that show the communities involved in these two cases were similar.

A reasonable argument can be made that detailed proof that communities within North Carolina are similar should be required only in exceptional cases.[126] Undoubtedly, there are other situations, less capable of general char-

119. 285 N.C. 519, 206 S.E.2d 196 (1974).

120. *Id.* at 527, 206 S.E.2d at 201.

121. *Id.*

122. 34 N.C. App. 1, 237 S.E.2d 259, *cert. denied*, 293 N.C. 593, 239 S.E.2d 264 (1977).

123. Another case that is factually distinguishable is Bullard v. North Carolina Nat'l Bank, 31 N.C. App. 312, 229 S.E.2d 245 (1976), in which the court dispensed with the unusual argument that *Rucker* prohibits testimony by experts familiar with practice in similar communities and requires familiarity with national standards.

124. Page v. Wilson Memorial Hosp., 49 N.C. App. 533, 272 S.E.2d 8 (1980).

125. Simons v. Georgiade, 55 N.C. App. 483, 286 S.E.2d 596, *cert. denied*, 305 N.C. 587, 291 S.E.2d 571 (1982).

126. In Dailey v. North Carolina State Bd. of Dental Examiners, 60 N.C. App. 441, 443, 299 S.E.2d 473, 475, *cert. denied*, 308 N.C. 386, 302 S.E.2d 249 (1983), involving disciplinary proceedings against a New Bern dentist for rendering negligent treatment, the court held that findings and

acterization, for which a similar view would be equally reasonable. A requirement of detailed proof in such cases may simply add to the time and expense of litigation, constitute a technical obstacle to admission of relevant evidence, and promote an artifically narrow view of medical practice.

In other situations, serious question may exist about the similarity of the communities and proof of this fact will be required. Thus, when there was no evidence to establish the similarity of the communities involved, the testimony of a Chicago dentist offered to establish dental malpractice in New Bern[127] and that of a New York neurosurgeon offered to show negligent surgery in a hospital in Rowan County have been held inadmissible.[128] The difficult question in these situations is what proof should be offered to show that the communities are similar. The only possible answer to this question, although it may appear simplistic, is to offer evidence to establish as many common or similar characteristics of the communities, such as size, medical facilities, type of community, and quality of medical practice, as possible. When the treatment is uncomplicated or involves uniform or generally accepted procedures, evidence of this fact should certainly be offered. The witness' own opinion of the similarity of the communities also should be solicited.

A great deal of discretion necessarily will be involved in determining whether communities are similar. The importance of any characteristic may depend on the facts of a particular case or on the presence or absence of other similarities. No rule of thumb exists to determine what differences in size, population, or medical facilities may be present while still permitting the communities to be regarded as similar. Even the relationship between customary practice in a particular community and the factors commonly relied on to show the similarity of communities is a tenuous one at best.

A number of states that have adopted the same or similar community rule apply a general or national standard to specialists.[129] Although the court of appeals in one case found the reasons for this distinction "appealing and persuasive," it rejected the idea as inconsistent with North Carolina case law and statutes.[130] Its assessment is accurate on both points.

V. INFORMED CONSENT

Medical treatment performed without a patient's consent, such as an unauthorized operation, may constitute a battery.[131] Difficult problems arise

conclusions of law couched in terms of a "standard of practice observed in North Carolina" were erroneous. Because this case involved application of an improper standard of care, it does not seem inconsistent with the statement made in the text.

127. Dailey v. North Carolina State Bd. of Dental Examiners, 60 N.C. App. 441, 299 S.E.2d 473, *cert. denied*, 308 N.C. 386, 302 S.E.2d 249 (1983).

128. *Thompson*, 34 N.C. App. 1, 237 S.E.2d 259.

129. Cases applying the national standard to specialists are collected at Annot., 18 A.L.R.4th 603, 614-16 (1982).

130. *Thompson*, 34 N.C. App. at 4, 237 S.E.2d at 261.

131. Lewis v. Shaver, 236 N.C. 510, 73 S.E.2d 320 (1952); Nelson v. Patrick, 58 N.C. App. 546, 293 S.E.2d 829 (1982).

when interpreting the scope of a patient's consent to determine if treatment is authorized. The older cases tended to interpret the scope of consent narrowly so that any different operation or extension of one for which consent had been given was held to be a battery.[132] Recent cases tend to give a broader interpretation to the scope of a patient's consent. In *Kennedy v. Parrott*[133] defendant surgeon diagnosed plaintiff's ailment as appendicitis and recommended an operation to which plaintiff consented. During the operation defendant discovered enlarged cysts on plaintiff's ovary and punctured them. Although this act was done skillfully, severe complications resulted. The court, in rejecting plaintiff's battery claim, said:

> In major internal operations, both the patient and the surgeon know the exact condition of the patient cannot be finally and definitely diagnosed until after the patient is completely anesthesized and the incision has been made. In such a case the consent—in the absence of proof to the contrary—will be construed as general in nature and the surgeon may extend the operation to remedy any abnormal or diseased condition in the area of the original incision whenever he, in the exercise of his sound professional judgment, determines that correct surgical procedure dictates and requires such an extension of the operation originally contemplated. This rule applies when the patient is at the time incapable of giving consent, and no one with authority to consent for the patient is immediately available.[134]

A related but distinguishable problem arises when a patient consents to the operation performed but has not been properly advised of the risks of, and options to, the operation so that his consent is not an informed one. Today, a majority of jurisdictions hold that no battery exists under these circumstances and that the patient's cause of action, if any, must be in negligence.[135] Although most North Carolina informed consent cases have been tried on a negligence theory, a failure to distinguish the two situations sometimes occurs. For example, in *Brigham v. Hicks*[136] the court, in considering an informed consent claim, said: "The courts in this state had recognized that there may be an action for assault if a physician performs a surgical procedure on a person without properly informing that person of the risks involved so that an informed consent may be given."[137]

The distinction between battery and informed consent cases is recognized and clearly stated in a recent court of appeals decision:[138]

---

132. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18, at 104-05 (4th ed. 1971).

133. 243 N.C. 355, 90 S.E.2d 754 (1956).

134. *Id.* at 362-63, 90 S.E.2d at 759.

135. W. PROSSER, *supra* note 132, § 32, at 165.

136. 44 N.C. App. 152, 260 S.E.2d 435 (1979).

137. *Id.* at 156, 260 S.E.2d at 437.

In Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571 (1975), in which a patient claimed her consent to an operation had been induced by the doctor's representation that the operation was simple and involved no danger, the court, although it found no cause of action, gave extensive consideration to the battery theory alleged by the plaintiff.

138. Nelson v. Patrick, 58 N.C. App. 546, 293 S.E.2d 829 (1982).

> Where a medical procedure is completely unauthorized, it constitutes an assault and battery . . . . If, however, the procedure is authorized, but the patient claims a failure to disclose the risks involved, the cause of action is bottomed on negligence.[139]

North Carolina cases suggest that a battery action can be maintained when the patient's consent is obtained by the doctor's fraudulent misrepresentations about the treatment or operation.[140] This result can be justified on the grounds that, under these circumstances, the issue of the reasonableness of the doctor's disclosure does not arise.

Courts are substantially divided on the question whether a reasonable care or customary practice standard should be applied in informed consent cases. A brief description of the two views may be helpful. Jurisdictions[141] adopting the reasonable care standard require disclosure of all risks that would be important to a reasonable person when deciding whether to consent to medical treatment. They recognize that expert evidence usually will be required to identify the risks involved in medical treatment, the alternatives to the treatment, and the risk associated with such alternatives; once these facts have been established, however, the courts consider the judgment about the reasonableness of the doctor's disclosure to be within the jury's competence. Initially, at least, doubts existed concerning the presence of any generally accepted medical practice in the profession relating to disclosure. Exercise of discretion by the doctor in determining disclosures to be made is recognized, but the burden to justify limited disclosure for this reason is placed on the doctor.[142]

Jurisdictions[143] following the customary practice standard regard the disclosure issue to be an amalgam of risks, alternatives, discretion, and judgment in which these factors are interrelated and, therefore, not practically separable into distinct departments. Assessing and balancing these factors requires professional skill and knowledge, and the judgment regarding the extent of disclosure is a professional one. For these reasons, the determination of negligence in informed consent cases as well as in treatment cases must be based upon the customary practice standard.

Although the North Carolina Supreme Court recognized the informed consent doctrine in 1964,[144] no clear choice between the reasonable care and customary practice standards had been made by the court when a legislative

---

139. *Id.* at 550, 293 S.E.2d at 832.

140. *See* Hunt v. Bradshaw, 242 N.C. 517, 524, 88 S.E.2d 762, 767 (1955) (Bobbitt, J., concurring); Brigham v. Hicks, 44 N.C. App. 152, 260 S.E.2d 435 (1979).

141. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

142. Canterbury v. Spence, 464 F.2d 772, 791 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Miller v. Kennedy, 11 Wash. App. 272, ___, 522 P.2d 852, 863-64 (1974).

143. *See, e.g.*, Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976).

144. Watson v. Clutts, 262 N.C. 153, 136 S.E.2d 617 (1964).

standard was adopted in 1976.[145] In *McPherson v. Ellis*,[146] a case decided in 1982 to which the new statute was inapplicable, the court addressed the issue but left it open:

> A major issue in informed consent cases is whether a plaintiff must present expert medical testimony to establish the existence and scope of a physician's duty to disclose risks of a proposed treatment . . . . The Court of Appeals apparently proceeded under the theory that such testimony is not required. . . . The determination of this issue is not essential to the resolution of this case; therefore we express no opinion. . . .[147]

The statutory standard of care for informed consent cases is set out in North Carolina General Statute section 90-21.13:

> (a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient . . . where:
>
> (1) The action of the health care provider in obtaining the consent of the patient . . . was 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; and
>
> (2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities . . . .[148]

---

145. Court of appeals decisions on the question are in conflict. *See* Nelson v. Patrick, 58 N.C. App. 546, 293 S.E.2d 829 (1982) (statute adopting customary practice standard codified preexisting law); McPherson v. Ellis, 53 N.C. App. 476, 281 S.E.2d 94 (1981), *rev'd*, 305 N.C. 266, 287 S.E.2d 892 (1982) (reasonable care standard); Brigham v. Hicks, 44 N.C. App. 152, 260 S.E.2d 435 (1979) (unnecessary to decide); Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571 (1975) (dictum expressing preference for customary practice standard).

146. 305 N.C. 266, 287 S.E.2d 892 (1982).

Although earlier supreme court cases contain general discussions that appear consistent with the reasonable care standard, they are inconclusive. Three cases involved the sufficiency of plaintiff's evidence for submission to the jury; no indication exists that evidence of customary practice was presented in any of the cases. The court in Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548 (1968), found the evidence sufficient, but the holding is extremely narrow and, despite the absence of expert testimony, might have been reached even under the customary practice standard.

The other two cases found the evidence insufficient but neither decision appears to be based on the absence of proof of customary practice. The court in Watson v. Clutts, 262 N.C. 153, 159, 136 S.E.2d 617, 620-21 (1964), held that plaintiff's cause of action was defeated by her admission that she was advised that "she would have to remain in the hospital approximately a week prior to surgery as this was a serious operation" and that the operation was not without risk. The court in Starnes v. Taylor, 272 N.C. 386, 393, 158 S.E.2d 339, 344 (1968), in finding the evidence insufficient, noted that the risk involved was commonly known, the likelihood of its occurrence was slight, and the need existed to vest discretion in the doctor to avoid creating patient anxiety. The court also noted that "the defendant [physician] gave the plaintiff the customary warning that any surgical procedure is accompanied by some risk of unfortunate consequences." *Id.*

147. *McPherson*, 305 N.C. at 270, 287 S.E.2d at 895.

148. N.C. GEN. STAT. § 90-21.13 (1981).

Although it generally is assumed that this legislation adopted the customary practice standard for North Carolina,[149] an examination of the statutory language reveals that the standard is more complex. Two distinct requirements are set out in the statute and the construction of the statute clearly indicates that both must be met before the limitation on the health care provider's liability contained in it applies. The first requirement is that the health care provider's action in obtaining consent be in accordance with customary practice.[150] This provision, if it stood alone, would effect an adoption of the customary practice standard. A second and additional requirement, however, must be met for the limitation on liability to apply. The information provided by the health care provider must permit a reasonable person to "have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments."[151]

The statute does not provide that the defendant can escape liability either by complying with customary practice or by providing information that will enable a reasonable person to understand the treatment and risks. Instead, it imposes a minimum level of disclosure that must always be made and, when it is not, the fact that less disclosure is consistent with prevailing customary practice will not prevent imposition of liability. If the information customarily provided in the profession meets or exceeds the minimum disclosure fixed by the statute, liability cannot be imposed. On the other hand, if disclosures customarily made fall below the level required by the statute, a basis for liability exists.

Under this interpretation, the plaintiff in an informed consent case may establish the health care provider's negligence in either of two ways. First, he may show that the information provided did not comply with customary practice relating to disclosure. This approach usually will require testimony of experts who are familiar with the relevant customary practice standard. Second, he may show that the disclosures made did not meet the minimum standard of disclosure required by the statute. Expert testimony to show that defendant's conduct deviated from customary practice would not be necessary under this approach. Because the minimum disclosure required by the statute is tied to risks and hazards "recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities,"[152] expert evidence to identify these risks would likely be required. Presumably, however, as the latter testimony involves facts rather than judgment and is not a direct condemnation of a colleague, less difficulty will be encountered in finding experts who are willing to appear.

The definition of customary practice in relation to the duty of disclosure is the same as that which applies to orthodox medical treatment. The relevant

149. *E.g.*, Nelson v. Patrick, 58 N.C. App. 546, 293 S.E.2d 829 (1982).
150. N.C. GEN. STAT. § 90-21.13(a)(1) (1981).
151. *Id.* § 90-21.13(a)(2).
152. *Id.*

standard of practice is limited to defendant's area of medicine in the same or similar communities. Earlier discussion of these constituent elements of the customary practice standard apply here as well.

Interpretation of the minimum standard of disclosure provisions may prove difficult. What is meant by the phrase "usual and most frequent risks and hazards" of treatment and procedures? As the statute limits disclosure to those that are recognized by practitioners in the same medical field in the same or similar communities, it apparently assumes that the phrase has some generally accepted meaning in the profession. The validity of this assumption is subject to doubt.

Because of the conservative stance of the court in handling informed consent claims under the common law, the statute may enhance the possibility for recovery in these cases. The relative lack of success of informed consent claims[153] and the fact that they could be decided without determining whether customary practice or reasonable care was the standard to be applied to them reflect the court's conservatism. Great importance was attached to the doctor's discretion not to make disclosures that might produce anxiety in the patient and adversely affect the patient or the success of the treatment, and, in this context, very limited disclosures were held adequate as a matter of law.[154] For example, in *Watson v. Clutts*[155] disclosure was held adequate when the patient was informed that a thyroidectomy was a serious operation, but was not informed of specific risks involved, including the possibility of complete loss of speech, or of available alternative methods of treatment. The court stated that any conflict between the duty of informing the patient and the possibility of frightening him should be resolved in favor of the primary duty to do what is best for the patient.[156]

The continued authority of these cases under the statute is doubtful. Although discretion undoubtedly will be a consideration in determining the extent of disclosure customarily made in practice, both its presence and significance in a case will depend upon expert evidence. It should no longer be a generalized element for the court to weigh as it sees fit. To consider discretion as a limitation upon the duty to inform under the minimum disclosure standard seems inconsistent with both the language and purpose of the statute. Under this standard legitimate exercise of discretion in withholding information probably should be considered a defense that the doctor may prove to justify his failure to make the minimum disclosures required.

The test of actual causation in informed consent cases also is changed by

153. In eleven cases reviewed, plaintiff's evidence was held sufficient in only three, two of which were probably orthodox treatment cases rather than informed consent cases. In the other eight cases, plaintiff's proof of negligence or causation was held insufficient in six and the cause of action failed at the pretrial stage in two. No case affirming an award of damages could be found.

154. Starnes v. Taylor, 272 N.C. 386, 158 S.E.2d 339 (1968); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

155. 262 N.C. 153, 136 S.E.2d 617 (1964).

156. *Id.* at 159, 136 S.E.2d at 621.

the statute.[157] If consent to treatment would have been given, had adequate disclosure been made, no cause of action for negligent failure to inform is recognized. Conflict generally exists concerning whether this determination should be based on what the particular patient would have decided or on the decision a reasonable person would have made under the circumstances.[158] In a case[159] arising before the effective date of the statute, the North Carolina Supreme Court adopted the subjective standard, observing that an individual's "right to decide for himself what is to be done with his body [should not be] made subject to a standard set by others."[160] The statute, however, adopts the objective standard and denies recovery if "a reasonable person, under all the surrounding circumstances, would have undergone such treatment" had proper disclosure been made.[161] Even under the objective standard, no right of recovery exists when the plaintiff would have consented to the treatment.[162]

VI. CONCLUSION

The North Carolina General Assembly's apparent purpose in codifying the same or similar community standard for health care providers was to foreclose judicial adoption of a regional or national standard.[163] The potential for serious consequences beyond this purpose arises both from ambiguities in its wording and from cases that seem to interpret it to require expert testimony of customary practice in every case before malpractice liability can be established. A literal or narrow interpretation of the statute could undermine the objective standard in malpractice cases. The objective standard is a basic principle of all negligence law, which traditionally has been applied to hold the health care provider to the level of skill, training, and learning possessed by other practitioners in his field. Such an interpretation would diminish the role

157. N.C. GEN. STAT. § 90-21.13(a)(3) (1981).

158. The choice between the objective and subjective tests is not easy. The objective test may preclude consideration of the plaintiff's "fears, apprehensions, religious beliefs, or superstitions." McPherson v. Ellis, 305 N.C. 266, 273, 287 S.E.2d 892, 897 (1982). Under the subjective test, whether plaintiff's testimony after the injury, even if given in good faith, actually reflects what his decision would have been prior to undergoing treatment is questionable.

159. McPherson v. Ellis, 305 N.C. 266, 287 S.E.2d 892 (1982).

160. *Id.* at 273, 287 S.E.2d at 897.

161. N.C. GEN. STAT. § 90-21.13(a)(3) (1981).

162. Tripp v. Pate, 49 N.C. App. 329, 271 S.E.2d 407 (1980).

163. In Wall v. Stout, __ N.C. __, 311 S.E.2d 571 (1984), decided after this Article was written, the North Carolina Supreme Court held that the legislature's purpose in enacting the malpractice statute was not to "eliminate the previously existing common law" but "merely to conform the statute" . . . to existing case law applying a 'same or similar community standard.'" *Id.* at __, 311 S.E.2d at 576. In finding inappropriate a jury instruction that enumerated three separate elements plaintiff must prove to establish malpractice, each of which essentially encompassed breach of customary practice, the court, in a footnote, seems to equate the statutory standard to the professional's skill, knowledge, training, and experience and to view the issue of reasonable care in application of these qualifications as unrelated to the statutory standard. *Id.* at __, 311 S.E.2d at 580 n.2. This view, although acceptable in cases in which the issues are within the jury's competence, creates serious problems in cases in which the jury needs the assistance of expert testimony. Because the court's purpose was to indicate that proof of either lack of qualifications, reasonable care, or good judgment sufficed to establish malpractice and that it would be improper to require a finding of all three, the limitation on the statute suggested by the court's language may have been inadvertent.

of malpractice litigation in achieving competent medical services for the public, deprive some incompetently treated victims of all recovery, and increase the burden of establishing malpractice claims for others. Concern about these effects is heightened because the statutory standard is made applicable to essentially all persons connected with the provision of health care services.

This Article has examined the purpose of the statute in its overall context to show that such an interpretation is neither desirable nor reasonable. The statute cannot be divorced from the common law it codifies and viewed as an exclusive statement of malpractice liability law. Even the concepts of customary practice and same or similar community are meaningful only in terms of their common-law development. Unless thoughtful and careful consideration is given to the statute in this broader context, fundamental and undesirable changes in malpractice liability law may result from isolated cases that focus narrowly upon particular language of the statute.

Sensible application of the "same or similar community" standard also challenges the courts. Except in extreme cases, little difference in the quality of medical services between communities may exist in an era in which substantially equal education, training, opportunity, and medical facilities are available to practitioners. Under these circumstances, undue emphasis on geography, size, and similar factors, rather than ensuring fairness to the practitioner, may erect unfair barriers to the victim's recovery.