N.C. Medical Malpractice – Theories of Liability

1. Medical Malpractice – "traditional" malpractice v administrative negligence
    a. G.S. 90-21.11(2) defines a "medical malpractice action" as either:
        i. G.S. 90-21.11(2)a - A civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider.
        ii. G.S. 90-21.11(2)b - A civil action against a hospital, a nursing home licensed under Chapter 131E of the General Statutes, or an adult care home licensed under Chapter 131D of the General Statutes for damages for personal injury or death, when the civil action (i) alleges a breach of administrative or corporate duties to the patient, including, but not limited to, allegations of negligent credentialing or negligent monitoring and supervision and (ii) arises from the same facts or circumstances as a claim under sub-subdivision a. of this subdivision.
        iii. Practitioners and the courts may refer to claims under G.S. 90-21.11(2)a (i.e. i. above) as traditional medical malpractice and claims under G.S. 90-21.11(2)b (i.e. ii. above) as administrative negligence or malpractice.
2. Health Care Provider Defined.
    a. G.S. 90-21.11(1) defines "health care provider" to include, "without limitation," any of the following:
        i. A person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.
        ii. A hospital, a nursing home licensed under Chapter 131E of the General Statutes, or an adult care home licensed under Chapter 131D of the General Statutes.
        iii. Any other person who is legally responsible for the negligence of a person described by sub-subdivision a. of this subdivision, a hospital, a nursing home licensed under Chapter 131E of the General Statutes, or an adult care home licensed under Chapter 131D of the General Statutes.
        iv. Any other person acting at the direction or under the supervision of a person described by sub-subdivision a. of this subdivision, a hospital, a nursing home

licensed under Chapter 131E of the General Statutes, or an adult care home licensed under Chapter 131D of the General Statutes.

3. Standard of Care.
    a. Depends on circumstances of case.
    b. G.S. 90-21.12 defines the standard of care
        i. In non-emergency cases
            1. in any medical malpractice action as defined in G.S. 90-21.11(2)(a), the defendant health care provider shall not be liable for the payment of damages unless the trier of fact finds 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 under the same or similar circumstances at the time of the alleged act giving rise to the cause of action;
            2. or in the case of a medical malpractice action as defined in G.S. 90-21.11(2)(b), the defendant health care provider shall not be liable for the payment of damages unless the trier of fact finds by the greater weight of the evidence that the action or inaction of such health care provider was not in accordance with the standards of practice among similar health care providers situated in the same or similar communities under the same or similar circumstances at the time of the alleged act giving rise to the cause of action.
        ii. Heightened Burden of Proof in Emergency Cases (G.S. 90-21.12(b)) –
            1. jury must find breach by clear and convincing evidence rather than a mere preponderance of the evidence.
        iii. Same or Similar Community Standard – *not* a national or regional standard
            1. allows for consideration of the effect that variations in facilities, equipment, funding, etc., throughout the state might have on the standard of care
            2. more than mere physician skill and training; rather, it also involves the physical and financial environment of a particular medical community
            3. However, some cases have held that some large, university hospitals (i.e. Duke Univ.) may be held to a "national standard." *Higginbotham v. D'Amico*, 226 N.C. App. 441, 741 S.E.2d 668 (2013).
4. Informed Consent.
    a. G.S. 90-21.13 – defines what informed consent is and who may give it:

i. No recovery for health care treatment that treatment was rendered without the informed consent where:
    1. consent of the patient or other person authorized to give consent for 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; OR
    3. A reasonable person … would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2)….
ii. Requires expert testimony to establish standard of care.
iii. A written consent that meets the requirements is presumed to be valid. (G.S 90-21.13(b))
    1. Once a health care provider shows these elements, then the burden shifts to the plaintiff to produce any evidence to rebut the validity of the consent.
    2. Presumption may be rebutted only upon evidence of fraud, deception or misrepresentation of a material fact.
iv. To obtain summary judgment on the issue of a signed written consent, a health care provider must show (1) the circumstances surrounding the consent, (2) the risks inherent in the procedures offered, (3) the standard in the community for obtaining consent and (4) that the standard was met under the circumstances. *Estrada v. Jaques*, 70 N.C. App. 627, 321 S.E.2d 240 (1984)
v. Statute defines who may give informed consent. (G.S. 90-21.13(c)).

5. Breach of Warranty or Guaranty.
    a. A health care provider may be liable for breach of warranty if promised a particular result or that the injury suffered would not occur.
    b. A claim arising from a health care provider's guarantee, warranty, or assurance must satisfy the "statute of frauds" requirement imposed by G.S. § 90-21.13(d), which reads:

> No action may be maintained against any health care provider upon any guarantee, warranty or assurance as to the result of any medical, surgical or

> diagnostic procedure or treatment unless the guarantee, warranty or assurance, or some note or memorandum thereof, shall be in writing and signed by the provider or by some other person authorized to act for or on behalf of such provider.

c. Breach of contract cases in the medical malpractice context are rare and would be unusual to see.

6. Res Ipsa Loquitor.
    a. Res ipsa loquitur applies when "(1) direct proof of the cause of an injury is not available, (2) the instrumentality involved in the accident [was] under the defendant's control, and (3) the injury is of a type that does not ordinarily occur in the absence of some negligent act or omission." *Grigg v. Lester*, 102 N.C. App. 332, 333 (1991).
    b. For the doctrine to apply, "an average juror must be able to infer, through his common knowledge and experience and without the assistance of expert testimony, whether negligence occurred." *Hayes v. Peters*, 184 N.C. App 285, 287–88 (2007).
    c. Has limited applicability and has been confined to limited circumstances (e.g. retained foreign bodies and injuries to patient to body parts outside the surgical field).
7. Medical Malpractice Does Not Include Loss of Chance
    a. Loss of Change Doctrine (i.e. claim that defendant's negligence diminished patient's likelihood of full recovery, thus proximately causing injury) has been rejected in North Carolina. *Parkes v. Hermann*, 376 N.C. 320, 852 S.E.2d 322 (2020).
    b. Mere loss of chance is not sufficient - plaintiff must present expert testimony that defendant's negligence was more likely than not to have caused plaintiff's injury.
8. Medical Malpractice vs. Ordinary Negligence.
    a. A claim against a "health care provider," for ordinary negligence (e.g. slip and fall) is not a medical malpractice matter.
    b. "Professional services" are an act or service "arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor [or] skill involved is predominantly mental or intellectual, rather than physical or manual." *Lewis v. Setty*, 130 N.C. App. 606, 608, 503 S.E.2d 673, 674 (1998).
    c. However, the definition of "medical malpractice action" includes breaches of "administrative or corporate duties to the patient" (such as negligent credentialing and negligent monitoring or supervision) that arise from the same set of facts as a traditional ("professional services") medical malpractice claim. G.S. 90-21.11(2)b.
    d. Beyond the scope of this presentation, but the distinction will have significant implications for Rule 9(j) certification issues, statute of limitations, and statute of repose.