No. 414PA07 TWENTY-THIRD DISTRICT

SUPREME COURT OF NORTH CAROLINA

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JOSEPH O'MARA, a minor, by and through his Guardian Ad Litem, Larry Reavis; and JANELLA O'MARA, Plaintiffs,	)	
	)	FROM YADKIN COUNTY
v.	)	[No. 04 CVS 298]
	)	[No. COA 06-1067]
WAKE FOREST UNIVERSITY HEALTH SERVICES; NORTH CAROLINA BAPTIST HOSPITAL; FORSYTH MEMORIAL HOSPITAL, INC.; and NOVANT HEALTH, INC., Defendants.	)	

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BRIEF OF AMICUS CURIAE
NORTH CAROLINA ACADEMY OF TRIAL LAWYERS

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BRIEF OF AMICUS CURIAE
NORTH CAROLINA ACADEMY OF TRIAL LAWYERS

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QUESTION PRESENTED

DOES AN EXPERT'S OPINION THAT A NATIONAL STANDARD OF CARE APPLIES TO THE MEDICAL CARE AT ISSUE PRECLUDE THE EXPERT FROM TESTIFYING IN A MEDICAL MALPRACTICE TRIAL?

STATEMENT OF FACTS

This amicus adopts the statement of facts in Plaintiffs-Appellants' New Brief.

SUMMARY OF ARGUMENT

The Court of Appeals affirmed the exclusion of an expert in a medical malpractice case because he testified in his deposition that he had applied a national standard of care. In

doing so, the Court of Appeals replicated an error it has made with increasing frequency. Automatically disqualifying an expert who recognizes a national standard of care would resurrect the "locality rule" that this Court and the legislature repudiated more than thirty years ago.

Application of a national standard of care in a particular case, based on testimony by a qualified medical expert, is perfectly compatible with the "similar communities" requirement of G.S. 90-21.12. With medicine moving inexorably toward national standards, almost all communities in the United States are now "similar" with respect to the prevailing standards of practice. Once the plaintiff offers evidence that a national standard applies to the care at issue, the defendant should then have the burden of producing evidence of relevant features of the defendant's community that would justify applying a standard of care that deviates from the national norm.

ARGUMENT

I. IN ENACTING G.S. 90-21.12, THE GENERAL ASSEMBLY REJECTED THE LOCALITY RULE, AND PERMITTED PLAINTIFFS IN MEDICAL MALPRACTICE ACTIONS TO ESTABLISH LIABILITY BY PROVING THAT THE DEFENDANT VIOLATED THE STANDARDS OF PRACTICE IN "SIMILAR COMMUNITIES."

Like Crocker v. Roethling, 2007 N.C. App. LEXIS 1403, disc. rev. granted, No. 374P07 (Nov. 8, 2007),[1] this case requires the

[1] This amicus, the North Carolina Academy of Trial Lawyers, filed an amicus brief in Crocker v. Roethling on December 10,

Court to interpret the "similar communities" language in North Carolina's medical malpractice statute, G.S. § 90-21.12, enacted in 1976. That statute 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.

G.S. § 90-21.12 (emphasis added).

The "same or similar communities" language in the malpractice statute simply codified existing case law. In Wall v. Stout, 310 N.C. 184, 191, 311 S.E.2d 571, 576 (1984), the defendant physician argued that "the passage of G.S. 90-21.12 was merely intended to codify the 'same or similar communities' standard of care previously adopted by this Court in Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970)." Justice Branch, writing for a unanimous Court, agreed: "the intended purpose of G.S. 90-21.12 was merely to conform the statute more closely to the existing case law applying a 'same or similar community' standard of care." Id. at 192, 311 S.E.2d at 576. Thus, to

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2007. Because the principal legal issue in both cases is the same, the Academy makes essentially the same argument here that it made in Crocker.

discern the meaning of “similar communities” in the statute, we must start with this Court’s decisions in the years immediately preceding its enactment.

Thirty seven years ago, in Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970) (Higgins, J.), this Court buried the “locality rule” in medical malpractice cases. The defendant, a surgeon in Jacksonville, North Carolina, performed biopsies on the plaintiff’s legs. The incisions became infected, causing pain and scarring. The plaintiff filed suit, alleging that the defendant negligently performed the procedure. At trial, the plaintiff sought to prove a violation of the standard of care through the testimony of a surgeon on the teaching staff of Bowman Gray School of Medicine in Winston-Salem. The witness was not familiar with the actual practice in Jacksonville, but was familiar with the practice in similar communities around Winston-Salem. Because the expert was “not familiar with Jacksonville,” id. at 138, 171 S.E.2d at 396, the trial judge excluded the expert’s testimony, and directed a verdict for the defendant.

On appeal, Justice Higgins explained why the locality rule must be abandoned:

> The "locality rule" (never recognized in England) had its origin in the very old and far away days when there were many little institutions which called themselves medical schools. Students were admitted who could show a high school diploma or furnish a certificate from a school

> principal that the bearer had completed the "equivalent" of a high school course of study. At the end of the course, he was given an M.D. degree. Passing the licensing board was in the nature of a formality. In many rural communities, ever thereafter the doctor was on his own. Frequent refresher courses, now generally attended, were unknown.
>
> Now medical schools admit only college graduates. They are equipped to the highest point of efficiency and turn out doctors who must continue their studies by internships and by actual experience under expert supervision. They continue to study, continue to attend refresher courses, and have access to journals which afford them opportunity to keep them current in the latest treatments and procedures.
>
> In the old days, there was some reason for the "locality rule" as the standard by which to judge a doctor's procedures. Then, except for a few stops on the railroads, the quickest mode of travel was by "coach and four". Forty miles between sun up and sun down was a full day's travel -- less than 50 minutes will suffice today. A doctor's practice was limited to a small area. Because of the vast changes, some of which are touched on here, the reason for the "locality rule" has ceased to exist.

Id. at 139-40, 171 S.E.2d at 396-97. Applying a “same or similar locality” standard, id. at 397, 171 S.E.2d at 140-41, the Court held that the expert should have been allowed to testify.

Three years later, in Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973) (Lake, J.), this Court again considered the exclusion of the plaintiff’s expert, based on his lack of familiarity with the defendant’s community (Mount Airy). The Court reaffirmed its decision in Wiggins:

> [I]n Wiggins v. Piver, we held that an expert witness, otherwise qualified, may state his opinion as to whether the treatment and care given by the defendant to the

> particular patient came up to the standard prevailing in similar communities, with which the witness is familiar, even though the witness be not actually acquainted with actual medical practices in the particular community in which the service was rendered at the time it was performed.

Id. at 101, 199 S.E.2d at 443. As in Wiggins, the Court found that the trial court erred in excluding the plaintiff's expert.

In Rucker v. High Point Memorial Hospital, 285 N.C. 519, 206 S.E.2d 196 (1974) (Higgins, J.), the plaintiff claimed that he received substandard medical care for a shotgun wound in his leg. At trial, the plaintiff's expert testified that a national standard of care applied:

> There is no difference in the standards of treatment of gunshot wounds to the lower extremities in the hospitals where I have practiced in Clarksdale, Mississippi, in Norfolk, Virginia Naval Hospital, in Alexandria, Louisiana, in Biloxi, Mississippi, in Touro Infirmary in New Orleans, in Sara Mayo Hospital in New Orleans, East Jefferson Hospital in Metairie, Louisiana, or Lakeside Hospital in Metairie, Louisiana. From my attendance in seminars, reading of publications, my academic affiliations, my travels and speaking with other doctors, keeping up with the literature, to the best of my knowledge, *the standards are the same around the United States; there is no difference in the standards*.

Id. (emphasis added). The trial court excluded the testimony because "Dr. Levy stated he was not acquainted with the medical staff at High Point Memorial Hospital and did not know about its facilities." Id. Because the trial court's ruling left the plaintiff without a standard of care expert, the case was dismissed.

As in Wiggins and Dickens, this Court in Rucker held that the trial judge erred in excluding the expert's testimony. Even though he was not familiar with "the facilities of defendant hospital and . . . the members of its staff or . . . their qualifications," id. at 526, 206 S.E.2d at 201, the expert's familiarity with national standards in the treatment of gunshot wounds was sufficient to permit him to testify about the standard of care that applied in High Point, North Carolina. Id. at 527, 206 S.E.2d at 201.

When it codified "existing case law applying a 'same or similar community' standard of care" in G.S. § 90-21.12, Wall v. Stout, 310 N.C at 192, 311 S.E.2d at 576, the legislature approved this Court's broad understanding of "similar" communities in Wiggins, Dickens and Rucker. Since its decision in Rucker in 1974, this Court has not spoken on the issue.

II. THE COURT OF APPEALS HAS RESURRECTED THE LOCALITY RULE BY IMPOSING AN INCREASINGLY STRINGENT AND UNREALISTIC STANDARD TO DETERMINE WHETHER AN EXPERT IS FAMILIAR WITH THE STANDARDS OF PRACTICE IN "SIMILAR COMMUNITIES."

A. The First 25 Years

While this Court has remained silent, the Court of Appeals has issued dozens of opinions attempting to apply G.S. § 90-21.12's "same or similar communities" requirement. For the first 25 years after the statute was enacted, the Court of Appeals generally followed the wide path laid out by this Court

in Wiggins, Dickens and Rucker. Time after time, the Court of Appeals overturned rulings by trial judges who had excluded an expert witness on the ground that he lacked sufficient familiarity with the defendant's community. Page v. Wilson Memorial Hospital, 49 N.C. App. 533, 272 S.E.2d 8 (1980); Howard v. Piver, 53 N.C. App. 46, 50, 279 S.E.2d 876, 879 (1981) ((“The horse-and-buggy days are gone.”); Simons v. Georgiade, 55 N.C. App. 483, 494, 286 S.E.2d 483, 494 (1982) (expert testified that the standards of board certified surgeons are the same throughout the country); Warren v. Canal Industries, Inc., 61 N.C. App. 211, 300 S.E.2d 557 (1983); Haney v. Alexander, 71 N.C. App. 731, 736, 323 S.E.2d 430, 434 (1984) (“Where the standard of care is the same across the country, an expert witness familiar with that standard may testify despite his lack of familiarity with defendant's community.”); White v. Hunsinger, 88 N.C. App. 382, 385-86, 363 S.E.2d 203, 205 (1988); Harris v. Miller, 103 N.C. App. 312, 329, 407 S.E.2d 556, 565 (1991) (expert testified that a national standard of practice applied to orthopedic surgeons; “Plaintiff's witness was, in effect, familiar with the standard of practice in Beaufort County and similar counties because he was familiar with the national standard of practice”); Marley v. Graper, 135 N.C. App. 423, 428, 521 S.E.2d 129, 134 (1999) (Edmunds, J.) (“if the standard of care for a given procedure is ‘the same across the

country, an expert witness familiar with that standard may testify despite his lack of familiarity with the defendant's community'"); cf. Baynor v. Cook, 125 N.C. App. 274, 278, 480 S.E.2d 419, 421 (1997) (trial court properly allowed plaintiff's experts to testify based on their familiarity with the national standard of care). Only in a small minority of cases did the Court of Appeals affirm the exclusion of the expert's testimony because of a failure to meet the "similar community" requirement. Thompson v. Lockert, 34 N.C. App. 1, 5, 237 S.E.2d 259, 261 (1977) (pre-statute); Tucker v. Meis, 127 N.C. App. 197, 487 S.E.2d 827 (1997); cf. Dailey v. North Carolina State Board of Dental Examiners, 60 N.C. App. 441, 299 S.E.2d 473 (1983) (disciplinary proceeding before state regulatory agency).

B. Henry v. Southeastern Ob-Gyn Associates

The landscape changed in 2001 when the Court of Appeals issued its divided opinion in Henry v. Southeastern Ob-Gyn Associates, P.A., 145 N.C. App. 208, 550 S.E.2d 245, aff'd, 354 N.C. 570 (2001) (per curiam). The plaintiffs in Henry alleged that the defendants had provided negligent prenatal and obstetrical care in Wilmington, North Carolina. At trial, they tendered one expert witness: Dr. Chauhan, a board-certified obstetrician practicing in Spartanburg, South Carolina, and licensed in South Carolina and Georgia. The trial court found that the plaintiffs failed to present competent medical

testimony establishing the relevant standard of care, and directed a verdict for the defendants.

On appeal, Judge McCullough found that Dr. Chauhan failed to testify that he was familiar with the standard of care in Wilmington or similar communities. Id. at 210, 557 S.E.2d at 246. "Although Dr. Chauhan testified that he was familiar with the national standard of care, there is no evidence that the national standard of care is the standard practiced in Wilmington." Id., 557 S.E.2d at 246-47. Because Dr. Chauhan "was unfamiliar with the relevant standard of care," his opinion as to whether the defendants breached the standard was "unfounded and irrelevant." Id. Accordingly, the defendants were entitled to a directed verdict as a matter of law.

In a separate opinion, Judge Greene concurred in the result. He agreed with Judge McCullough that "our General Assembly has rejected the use of a regional or national standard of care." Id. at 213, 550 S.E.2d at 248 (citing G.S. § 90-21.12). "The rationale for focusing on the standard of practice in the same or a similar community, as opposed to a national standard, is that available medical resources, i.e., the conditions, facilities, and equipment available to a healthcare professional, may differ from community to community." Id. (citing David W. Louisell & Harold Williams, 1 Medical Malpractice § 8.04 at 8-36.4 (2001)). Judge Greene continued:

> Thus, section 90-21.12 permits a physician, otherwise qualified under Rule 702 of the North Carolina Rules of Evidence, to testify regarding the applicable standard of care in a medical malpractice case when that physician is familiar with the experience and training of the defendant and either (1) the physician is familiar with the standard of care in the defendant's community, or (2) the physician is familiar with the medical resources available in the defendant's community and is familiar with the standard of care in other communities having access to similar resources.
>
> In this case, Dr. Chauhan did not testify that he was familiar with defendants' training, experience, or the standard of care practiced in defendants' community. Additionally, Dr. Chauhan did not testify he was familiar with the resources available in defendants' community as well as the standard of care practiced in communities with similar resources. Thus, Dr. Chauhan's testimony was not sufficient to establish the applicable standard of care in this case.

Id. at 213-14, 550 S.E.2d at 248-49.

Judge Hudson dissented. In her view, "the statute is satisfied where an expert witness testifies that he is familiar with the standard of care in the community in question as a result of the existence of, and his familiarity with, a standard of care for the treatment in question that is uniform across the country, and which does not vary depending upon the community." Id. at 215, 550 S.E.2d at 249.

> This . . . approach may, at first blush, appear to be the equivalent of applying a national standard of care. And, as the majority aptly notes, it is clear that the legislature, in codifying the same or similar community approach in G.S. § 90-21.12, specifically intended not to adopt a national standard of care. However, I believe there is a crucial, albeit subtle, distinction between adopting a national standard of care as a matter of law, and allowing a party to present evidence of a national standard of care as a

> matter of fact. *Without adopting a national standard of care as a matter of law, I believe G.S. § 90-21.12 permits the jury to consider factual evidence of the existence of a national standard of care in the process of determining the standard of care in the community in question.*

Id. at 215, 550 S.E.2d at 249-50 (emphasis added). Finding that Dr. Chauhan's testimony met the statutory requirement, Judge Hudson would have remanded for a new trial.

Judge Hudson got it right. The malpractice statute, while precluding the adoption of a national standard of care as a matter of law, does not prevent parties from offering evidence that a national standard applies to the care at issue.[2] Other state appellate courts, applying a "similar communities" rule, have reached the same conclusion. For example, in Purtill v. Hess, 489 N.E.2d 867 (1986), an Illinois trial judge, relying on the state's "similar locality" rule, had rejected the affidavit of the plaintiff's expert attesting to a national standard of care. The Illinois Supreme Court reversed. After citing cases from other states, including this Court's decision in Rucker, the Illinois court concluded: "when [plaintiff's expert] stated in his affidavit that he was familiar with the *minimum* standards of medical practice in relation to the diagnosis and treatment

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[2] The latest edition of a leading treatise on medical malpractice, David W. Louisell & Harold Williams, 5-29 Medical Malpractice § 29.02[2][b] (2007), includes an extensive discussion of Henry. The author commends Judge Hudson's "vigorous dissent," which "comports more closely with the majority view of the requirements for medical testimony than does the majority opinion in this case."

of rectovaginal fistulae and that those *minimum standards* were *uniform* throughout the country, localities similar to [defendant's community] were included within his scope of knowledge." Id. at 876 (emphasis in original).

Based on Judge Hudson's dissent, the plaintiffs in Henry appealed to this Court. Without explanation, the Court simply affirmed, per curiam. With three separate opinions in the Court of Appeals, each enunciating a different interpretation of the statute, the meaning of this Court's affirmance was difficult to discern. See Cox v. Steffes, 161 N.C. App. 237, 246 n.1, 587 S.E.2d 908, 914 n.1 (2003) (Geer, J.) ("It is unclear whether Henry is controlling authority.").

C. Post-Henry

While this Court's intent in Henry remained obscure, the effect on litigants and the lower courts was immediate and profound. Defendants redoubled their challenges to plaintiffs' experts before and during trial, with capricious and unpredictable results. The Court of Appeals, which had previously followed this Court's wise guidance in Wiggins, Dickens and Rucker, now wandered erratically from case to case, with irreconcilable results.

In the first wave of post-Henry appeals arising from the exclusion of experts based on their alleged unfamiliarity with "similar communities," the Court of Appeals reversed and

affirmed with approximately equal frequency. In five cases from 2002 through 2005, the Court of Appeals held that the trial court erred in excluding the expert. Leatherwood v. Ehlinger, 151 N.C. App. 15, 564 S.E.2d 883 (2002); Coffman v. Roberson, 153 N.C. App. 618, 571 S.E.2d 255 (2002); Cox v. Steffes, 161 N.C. App. 237, 587 S.E.2d 908 (2003); Pitts v. Nash Day Hospital, 167 N.C. App. 194, 605 S.E.2d 154 (2004), aff'd, 359 N.C. 626 (2005) (per curiam); Billings v. Rosenstein, 174 N.C. App. 191, 619 S.E.2d 922 (2005). In four cases during the same period, other panels of the court reached the opposite conclusion. Smith v. Whitmer, 159 N.C. App. 192, 582 S.E.2d 669 (2003); Barham v. Hawk, 165 N.C. App. 708, 600 S.E.2d 1 (2004), aff'd, 360 N.C. 358, 625 S.E.2d 778 (2006) (per curiam) (equally divided court); Bak v. Cumberland County Hospital System, 2004 N.C. App. LEXIS 1522 (2004) (unpublished); Ramirez v. Little, 2005 N.C. App. LEXIS 421 (2005) (unpublished).

While the judges on the Court of Appeals labored dutifully to harmonize their decisions, those efforts were bound to fail, in the absence of renewed direction from this Court. In Pitts v. Nash Day Hospital, 167 N.C. App. at 197 n.2, 605 S.E.2d at 156 n.2, Judge Calabria, with dry understatement, aptly observed: "There appears to be some conflict concerning what testimony sufficiently obviates the need to show an expert's familiarity with a defendant's community under N.C. Gen. Stat. §

90-21.12." In Pitts, the majority concluded that plaintiff's expert had the requisite familiarity, and should have been permitted to testify. Judge Steelman dissented, contending that the majority had in effect adopted a national standard of care. Id. at 203, 605 S.E.2d at 160. This Court affirmed, per curiam, without issuing an opinion.

Perhaps exhausted by trying to reconcile the irreconcilable, the Court of Appeals embarked on a new approach in 2006: affirm every trial court decision. The court has issued five opinions since January 2006 regarding the "similar communities" requirement. Each time the Court of Appeals ruled that the plaintiff's expert was properly excluded from testifying. Purvis v. Moses H. Cone Memorial Hospital, 175 N.C. App. 474, 624 S.E.2d 380 (2006); Treat v. Roane, 179 N.C. App. 436, 634 S.E.2d 273 (unpublished), disc. rev. denied, 360 N.C. 655, 639 S.E.2d 61 (2006); O'Mara v. Wake Forest University Health Sciences, __ N.C. App. __, 646 S.E.2d 400, disc. rev. granted, No. 414PA07 (Dec. 6, 2007); Crocker v. Roethling, 2007 N.C. App. LEXIS 1403 (2007) (unpublished), disc. rev. granted, No. 374PA07 (Nov. 8, 2007); Webb v. Alamance Regional Medical Clinic, 2007 N.C. App. LEXIS 1710 (2007) (unpublished).

III. AN EXPERT'S OPINION THAT A NATIONAL STANDARD OF CARE APPLIES TO THE MEDICAL CARE AT ISSUE DOES NOT PRECLUDE THE EXPERT FROM TESTIFYING IN A MEDICAL MALPRACTICE TRIAL.

We have come full circle back to the "very old and far away days" that this Court evoked so vividly in 1970. Wiggins, 276 N.C. at 139, 171 S.E.2d at 396. Justices Higgins and Lake would surely be amazed to see qualified experts barred from testifying simply because they recognized that a particular procedure was governed by national standards. They would find it astonishing that that the locality rule, which they thought they had buried in Wiggins, Dickens and Rucker, has been resurrected in the guise of requiring experts to prove their familiarity with similar communities. They would be even more astonished that this revival has occurred in an era when medicine has moved inexorably toward a uniform national standard of care.

The notion that a different standard of care applies to board-certified obstetricians practicing in Winston-Salem, North Carolina and those practicing in Wilkes-Barre, Pennsylvania is utterly antithetical to modern medical education and training. Obstetricians in both communities took the same national examinations during medical school and the same board certification examinations upon completion of their residencies. In both communities, they rely on the same medical journals, take the same continuing medical education courses, use the same medical devices, and have instant access to the same information

through the internet. See Lewis, "The Locality Rule and the Physician's Dilemma: Local Medical Practice vs the National Standard of Care," JAMA (June 20, 2007 - Vol 297, No. 23, 2633) at 2634 ("[M]edical education has become standardized under national accreditation and continuing education programs. [W]ith the availability of modern technology, rural and urban physicians generally have the same access to information for patient care."). No physician relocating from one city to another has ever attended a seminar on "the local standard of care." Indeed, any board-certified physician who dared to propagate standards of practice that depart significantly from the national standard of care would be subject to discipline by the North Carolina Medical Board. The "Winston-Salem standard of care" exists only in the fantasy world of lawyers seeking to disqualify opposing experts, and judges who are willing to indulge them.

In enacting G.S. § 90-21.12, the legislature obviously did not intend to require the communities with which the expert is familiar to be "similar" in every respect to defendant's community. The communities need be similar only with regard to features that are ***relevant*** to the care at issue. For example, in the case now before the Court, the plaintiffs allege that the defendant obstetrician was negligent in failing to promptly perform a C-section when the baby exhibited signs of fetal

distress. Forsyth Memorial Hospital, a large teaching hospital, is fully equipped for cesarean deliveries. Defendant Mertz testified that there was no lack of necessary equipment, personnel or facilities at the hospital. P.A. 20 (Appendix to Plaintiffs-Appellants' New Brief). Nothing else about Winston-Salem is relevant to the alleged negligence.

In most of the cases previously considered by our appellate courts, no relevant features distinguished the defendant's community from other communities. As in this case, the defendant could have made no credible claim that the alleged deficiency in care was related in any way to a lack of local resources or facilities. See, e.g., Wiggins, 276 N.C. at 138, 171 S.E.2d at 395-96 ("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."); Rucker, 285 N.C. at 519, 206 S.E.2d at 196 (treatment of gunshot wounds); Thompson, 34 N.C. App. at 1, 237 S.E.2d at 259 (orthopedist's performance of laminectomy diskectomy); Page, 49 N.C. App. at 536, 272 S.E.2d at 11 (nurse's use of bedpan); Howard, 53 N.C. App. at 51, 279 S.E. 2d at 879-80 (discontinuation of anti-seizure medication). With medical standards approaching national uniformity, the occasions in

which the expert's community differs from the defendant's community in a way that is relevant to the alleged negligence will be increasingly rare.

Consistent with the reality of modern medicine, our courts should presume that every community in North Carolina is similar to every other community in the United States with respect to the standards of medical practice. That presumption is rebuttable: if the defendant health care provider can show that the care at issue was constrained by limited local facilities, the trial court could require the plaintiff's expert to demonstrate familiarity with the standards of practice in communities with similar limitations. For example, if the national standard of care is to order a CT scan for a suspected subdural hematoma, and the defendant emergency physician practices in a small rural hospital that does not have a CT scanner, the plaintiff's expert should be familiar with the standard of care in a hospital that lacks a CT scanner.

If this Court is unwilling to establish a legal presumption that communities in the United States are similar with respect to the applicable standard of care, it should at least require the defendant to produce specific facts that a local standard applies. If, as in Wiggins and Rucker, the plaintiff (like the plaintiff here) presents expert testimony that the defendant's care is subject to a national standard, the defendant should

then have the burden of producing evidence of specific, relevant features of the defendant's community that would justify applying a standard of care that deviates from the national norm. If the defendant meets that burden of production, the plaintiff should have the opportunity to present evidence that her expert is familiar with the standards of practice in communities with similar features, or to rebut the defendant's contention that a different local standard applies. In either case, the task of resolving conflicting expert testimony should be left to the jury.

CONCLUSION

For the foregoing reasons, and for the reasons set forth in Plaintiffs-Appellants' New Brief, this Court should reverse the decision of the Court of Appeals.

This the 7th day of January, 2008.

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CERTIFICATE OF SERVICE

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