No. 331PA20 TWENTY-SIXTH DISTRICT

SUPREME COURT OF NORTH CAROLINA

****

EDWARD G. CONNETTE, as Guardian *ad litem* for AMAYA GULLATTE, a minor, and ANDREA HOPPER, individually and as parent of AMAYA GULLATTE, a minor, Plaintiffs-Appellants, v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, and/or THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS MEDICAL CENTER, and/or THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a LEVINE CHILDREN'S HOSPITAL, and GUS C. VANSOESTBERGEN, CRNA, Defendants-Appellees.	)	From Mecklenburg County

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DEFENDANTS-APPELLEES' NEW BRIEF

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INDEX

TABLE OF CASES AND AUTHORITIES

Statutes

Agency Rule

Rule of Professional Conduct

Bills

Attorney General Opinion

Secondary Sources

Other Authorities

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DEFENDANTS-APPELLEES' NEW BRIEF

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ISSUES PRESENTED

I. Should this Court reaffirm its decision in *Byrd v. Marion General Hospital* and decisions that follow *Byrd*?

II. Do *Byrd* and related decisions govern this case?

INTRODUCTION

For almost a century, it has been settled law in North Carolina that nurses are not liable for harm that results from physicians' medical decisions. This Court adopted that rule in *Byrd v. Marion General Hospital*, 202 N.C. 337, 162 S.E. 738 (1932). The North Carolina courts have applied it faithfully in the decades since.

That rule—the *Byrd* rule—is sound. It rests on a time-honored principle of tort law: Liability for a decision belongs to the decision-maker alone. The *Byrd* rule also aligns with the holdings of other courts across the country.

Despite these points, plaintiffs ask the Court to overturn the *Byrd* rule and create a broad new form of liability for nurses: liability for harm that results from physicians' medical decisions. Plaintiffs have not, however, offered any persuasive reason to disturb the law on this issue. They argue that nurses today have more training and work

more collaboratively with physicians than when this Court adopted the *Byrd* rule. But key medical decisions today are still reserved for physicians alone. No matter how much training nurses may have or how collaborative their work may be, when harm results from a physician's medical decision, the *Byrd* rule continues to assign responsibility where it belongs: to the physician.

Moreover, even if one preferred a different rule for policy reasons, changing North Carolina law to create a new form of liability for nurses would be a matter for the General Assembly. This case parallels *Parkes v. Hermann*, where, just six months ago, the Court held that deciding whether to create new medical-malpractice liability for "loss of chance" was a policy choice for the General Assembly. 376 N.C. 320, 324-26, 852 S.E.2d 322, 325-26 (2020). The same is true for the new medical-malpractice liability that plaintiffs want to impose on nurses.

Plaintiffs argue in the alternative that the *Byrd* rule does not apply in this case, but that argument fails as well. As the trial court concluded (and as plaintiffs agreed at trial), a physician made the medical decision at issue here. Under this Court's decision in *Byrd*, liability for that decision rests with the physician alone.

For these reasons, the Court should reaffirm its decision in *Byrd* and uphold the judgment below.

STATEMENT OF THE FACTS

The nurse whom plaintiffs seek to hold liable in this case is Mr. Gus VanSoestbergen, a certified registered nurse anesthetist (CRNA).

Mr. VanSoestbergen was on the medical team that performed a high-risk cardiac procedure to save the life of Amaya Gullatte, then a three-year-old girl. (T27 p 46:9-12)[1] The team also included an anesthesiologist, Dr. James Doyle. (T29 p 63:7-10)

Dr. Doyle prepared Amaya's anesthesia plan. (R p 366; T29 pp 150:7-157:14) As part of that plan, Dr. Doyle prescribed the use of a drug called sevoflurane to induce Amaya's anesthesia. (R p 366; T29 pp 154:8-157:14, 167:2-171:21) Mr. VanSoestbergen followed Dr. Doyle's plan and administered sevoflurane to Amaya. (R pp 366, 367-68; T29 pp 188:11-189:24, 241:10-243:19; T35 pp 74:19-78:23)

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[1] This brief refers to the trial transcript by volume number. For example, "T27" refers to volume 27 of the trial transcript.

During the procedure, Amaya's heart failed twice, causing injuries to her brain. (R pp 310-13, 321-24; T29 pp 164:7-19, 221:3-223:7) Plaintiffs then sued Dr. Doyle, Mr. VanSoestbergen, and others. (R p 60) Plaintiffs alleged, among other things, that the use of sevoflurane caused Amaya's injuries. (R pp 71-75)

Shortly before the trial at issue here, plaintiffs settled with Dr. Doyle and dismissed him with prejudice. (R pp 204-05; T1 pp 4:9-5:11, 7:11-11:1) Superior Court Judge Robert C. Ervin approved the settlement, finding that it was fair, reasonable, and in Amaya's best interest. (T1 pp 10:13-11:1)

Plaintiffs proceeded against Mr. VanSoestbergen. After a three-month trial, the jury entered a defense verdict. (R pp 556-57) The jury found that Mr. VanSoestbergen's administration of sevoflurane either met the standard of care or did not cause Amaya's injury. (R p 556)

Plaintiffs now challenge the exclusion of certain evidence at trial. They claim that Mr. VanSoestbergen, as a CRNA, had input into Dr. Doyle's anesthesia plan. They argue that Mr. VanSoestbergen should therefore bear the same responsibility as Dr. Doyle for Dr. Doyle's decision to prescribe sevoflurane. On that theory, plaintiffs

argue that the trial court should have allowed them to introduce evidence against Mr. VanSoestbergen that the use of sevoflurane breached the standard of care.

A. Factual background

1. Cardiologists diagnosed Amaya with serious heart conditions and ordered a high-risk procedure to save her life.

In October 2010, a pediatrician noticed that Amaya's heart rate was rapid and irregular. (R p 288) He referred Amaya to the Sanger Heart and Vascular Institute in Charlotte for evaluation. (R p 290)

Dr. Nicholas Sliz, a pediatric cardiologist at the Sanger Institute, diagnosed Amaya with three serious heart conditions. Those conditions caused Amaya to have a rapid, irregular heart rate, reduced her heart's ability to pump blood, and stopped her heart's valves from fully closing. (R pp 295-97; T25 pp 50:4-7, 74:2-75:8; T29 pp 130:18-131:18, 133:4-134:24; T32 pp 136:16-138:15) Had these conditions been left untreated, Amaya's heart eventually would have failed, and she could have died. (T25 pp 144:12-145:6; T29 pp 130:18-131:18)

Dr. Sliz consulted with Dr. Richard Smith, another Sanger Institute cardiologist. (R pp 295-97; T29 pp 124:5-20, 137:3-9) Dr.

Smith and Dr. Sliz decided to perform a complex procedure that involved inserting catheters through Amaya's vascular system and into her heart, identifying heart cells that were producing aberrant electrical signals, and removing those cells. (R pp 295-97; T25 pp 37:10-38:3; T29 p 137:5-23)

During this procedure, Amaya had to be in an anesthetic state with her breathing controlled. (T32 pp 116:6-117:18; T29 pp 94:22-97:1) The procedure thus required general anesthesia (meaning that Amaya would be unconscious) and the insertion of a tube into Amaya's windpipe. (R p 366; T29 pp 94:22-97:1; T32 pp 116:6-117:18; T35 pp 65:10-66:9)

Inducing anesthesia in patients with serious heart conditions like Amaya's creates a significant risk of heart failure. (T32 pp 114:20-117:20) These procedures are therefore done only when critically necessary. There is no dispute that the procedure here was critically necessary to save Amaya's life. (T25 pp 144:12-145:6)

2. Dr. Doyle chose the anesthesia plan for the procedure.

The anesthesia plan for Amaya's procedure was prepared by Dr. Doyle, a board-certified pediatric anesthesiologist. (R p 366;

T29 pp 62:11-63:10, 150:7-157:14) Dr. Doyle's medical training includes medical school, a four-year residency program in anesthesiology, and a one-year fellowship in pediatric anesthesiology. (T29 pp 63:16-67:6)

Dr. Doyle practiced at Levine Children's Hospital, where Amaya's procedure was performed. (R p 350) The hospital's rules for anesthesiologists required Dr. Doyle to prepare the anesthesia plans for his patients' procedures. (R p 366; T29 pp 82:7-12, 155:6-11, 157:8-14, 230:10-15, 237:16-238:6; T35 pp 57:9-59:14)

Before preparing the anesthesia plan for Amaya's procedure, Dr. Doyle met with Dr. Smith and reviewed Amaya's medical records. (T29 pp 123:7-124:20, 150:7-151:24) He then physically examined Amaya and asked her family questions about her health conditions and any previous reactions to anesthesia. (T29 pp 151:25-155:5) Dr. Doyle then prepared the anesthesia plan. (T29 pp 155:6-157:14)[2]

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[2] At Levine Children's Hospital, the anesthesia plan is part of a preoperative assessment form. (R p 366) That form calls for an anesthesiologist to prepare both a preliminary anesthesia plan and a final anesthesia plan. (R p 366) When the anesthesiologist assesses the patient shortly before a procedure, he or she prepares both plans at about the same time, as Dr. Doyle did here. (R p 366; T29 pp 156:1-157:14)

In that plan, Dr. Doyle decided to begin Amaya's anesthesia by having her inhale three gases: oxygen, then nitrous oxide, then sevoflurane. (R p 366; T29 pp 154:8-157:14, 168:5-169:13, 172:5-174:10) The sevoflurane would cause Amaya to fall asleep. (T29 pp 172:14-174:10; T35 pp 75:9-77:25) The medical team would then insert an IV in Amaya's arm and administer other anesthetics through the IV port. (R p 366; T29 pp 154:8-156:6, 168:5-169:13, 195:11-196:19, 247:6-248:4) The team would next insert an endotracheal tube into Amaya's windpipe to control her breathing. (T29 pp 247:6-249:20; T35 pp 74:19-80:12) At that point, Dr. Smith and his team would begin their work on Amaya's heart.

Dr. Doyle included the inhalation of sevoflurane in his anesthesia plan for Amaya because that was, as he explained, the "tried and true" method for inducing anesthesia in children with heart conditions. (T29 p 168:19; *see* T29 pp 168:9-170:3) Dr. Doyle estimated that he had used that method successfully for children with heart conditions as many as one thousand times. (T29 p 169:14-24)

Dr. Doyle decided not to use an IV-only induction method for Amaya. (T29 pp 168:5-171:21) He made that decision because, in his

judgment, starting an IV while Amaya was awake could have increased her stress, exacerbating her heart conditions. (T29 pp 168:5-171:21) An inhalation method of anesthesia, Dr. Doyle decided, would avoid that stress. (T29 pp 168:24-169:13, 170:8-18)

Dr. Doyle discussed his anesthesia plan with Amaya's mother, Ms. Hopper, and obtained her consent. (T29 pp 153:16-155:25) Dr. Doyle then completed and signed his anesthesia plan. (R p 366; T29 pp 156:1-157:14)

3. Mr. VanSoestbergen, a CRNA, learned about Dr. Doyle's anesthesia plan after Dr. Doyle had prepared it.

Amaya's medical team also included Mr. VanSoestbergen, a CRNA. A CRNA is a registered nurse with training in administering anesthesia. (T29 pp 77:12-78:14) Here, for example, after Mr. VanSoestbergen worked for several years as a registered nurse outside the anesthesia field, he completed a two-year program to become certified as a CRNA. (T34 pp 118:18-130:6)

In North Carolina, CRNAs must be supervised by physicians, dentists, podiatrists, or similar providers. 21 N.C. Admin. Code 36.0226(a) (2019); T35 pp 13:9-14:2. At Levine Children's Hospital,

CRNAs always work under the direction of anesthesiologists. (T29 pp 78:20-79:13; T35 pp 13:1-15:18) As noted above, the hospital also requires that anesthesiologists (as opposed to CRNAs) prepare anesthesia plans. *See supra* p 8 & n.2.

Here, as the hospital rules required, Mr. VanSoestbergen worked on Amaya's procedure under the direction of Dr. Doyle. (T29 pp 80:12-14, 230:10-15) When Mr. VanSoestbergen reviewed Amaya's chart as he prepared for her procedure, the chart already contained Dr. Doyle's anesthesia plan. (R pp 366, 367-68; T35 pp 57:9-59:14, 61:1-25, 62:20-25, 65:10-66:9)

After Mr. VanSoestbergen reviewed Amaya's chart, Dr. Doyle spoke with Mr. VanSoestbergen and verified that he understood Dr. Doyle's plan. (T29 pp 236:22-237:15) According to Dr. Doyle, Mr. VanSoestbergen was "planning the same thing I was planning," "agreed with my plan," and "didn't take exception to" it. (T29 p 238:6, 238:23-24; *see* T29 pp 237:16-238:25; T27 pp 206:16-207:15)

4. The medical team implemented Dr. Doyle's anesthesia plan.

When Amaya's procedure began, the medical team carried out Dr. Doyle's anesthesia plan. (R pp 366, 367-68) Dr. Doyle put a mask on Amaya's face, and Mr. VanSoestbergen controlled the gases flowing through the mask. (T29 pp 188:11-189:24; T35 pp 74:19-80:12) Mr. VanSoestbergen first gave Amaya oxygen, then nitrous oxide, then sevoflurane. (T29 pp 239:4-243:19; T35 pp 75:9-77:25)

After Amaya fell asleep, Dr. Doyle inserted an IV in her arm. (T29 pp 245:10-247:11; T35 p 77:12-25) As Dr. Doyle gave Amaya other anesthetic drugs through her IV port, Mr. VanSoestbergen turned off the sevoflurane. (T35 pp 76:25-77:25) Mr. VanSoestbergen then removed Amaya's mask and inserted an endotracheal tube in her windpipe to control her breathing. (T29 pp 248:5-249:20; T35 pp 79:4-80:12)

5. Amaya's heart failed twice, requiring chest compressions and lifesaving medicines to stabilize her.

Shortly after the tube was inserted, Amaya's heart rate began to drop. (T29 pp 164:1-19, 249:13-250:5) Using the IV port, Dr. Doyle injected atropine, a lifesaving drug commonly used when a patient's

heart slows. (T29 p 164:8-19; T35 pp 87:15-88:17) Dr. Doyle also began chest compressions. (T29 pp 164:8-166:23; T35 pp 87:15-88:17)

The medical team began emergency resuscitation of Amaya. (T29 pp 164:8-166:23) Dr. Doyle ordered the use of more lifesaving drugs, and the team continued chest compressions. (T29 pp 164:8-166:23; T33 pp 87:15-88:17) After about twelve minutes, Amaya's heart rate improved, so resuscitation was no longer needed. (T29 pp 165:23-166:2)

The team then moved forward with the heart procedure. About two hours later, Amaya's heart rate dropped again. (T29 pp 221:3-222:9) The team again started resuscitation. (T29 pp 221:3-222:9) Dr. Doyle ordered lifesaving drugs, and Dr. Smith performed chest compressions. (T29 pp 222:15-223:21) Amaya's heart rate improved, so the team stopped resuscitation. (T35 pp 101:12-103:21) The team then completed the procedure. (T35 pp 101:12-103:21)

Amaya's heart conditions required further procedures and investigation, including another procedure under general anesthesia the following day. (R pp 434-35) After these procedures, health care providers investigated Amaya's neurological functions. (R pp 310-13,

321-24) They diagnosed her with neurological injuries from a loss of oxygen to the brain. (R pp 310-13, 321-24)

B. Procedural background

1. Proceedings in the trial court

Plaintiffs (Amaya's mother and a separate guardian ad litem) sued Dr. Doyle and his medical practice. (R p 60) They also sued Dr. Sliz, Dr. Smith, Mr. VanSoestbergen, and their employer, the Charlotte-Mecklenburg Hospital Authority. (R p 60)

Plaintiffs alleged negligence against Drs. Sliz and Smith based on their advice that Amaya should undergo the heart procedure, as well as their actions during the procedure. (R pp 60, 71-78) Plaintiffs alleged negligence against Dr. Doyle and Mr. VanSoestbergen for their roles in Amaya's anesthesia. (R pp 3, 60, 71-78) On the anesthesia-related issues, plaintiffs' claims against the Hospital Authority derived entirely from their claims against Mr. VanSoestbergen. (R pp 3, 60, 73-75, 78-81)

After a three-month trial before Judge Robert C. Ervin, a jury returned a verdict in favor of Drs. Sliz and Smith. (R pp 97-98) The

jury, however, did not reach a verdict on the claims that were based on Dr. Doyle's and Mr. VanSoestbergen's actions. (R pp 97-98)

Plaintiffs then settled with Dr. Doyle. (R pp 204-05; T1 pp 4:9-5:11, 7:11-11:1) The case proceeded to a second trial, also before Judge Ervin, against Mr. VanSoestbergen and the Hospital Authority. This second trial also lasted for three months. (R pp 556-57)

Plaintiffs sought to introduce testimony that Amaya's anesthesia should have been induced through an IV-only method, using drugs other than sevoflurane. (T26 pp 155:1-156:23, 161:23-162:24) Plaintiffs would have used this testimony to support a theory that Mr. VanSoestbergen shared liability for Dr. Doyle's anesthesia plan because Mr. VanSoestbergen collaborated with Dr. Doyle and provided input on Dr. Doyle's plan.[3]

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[3] Although plaintiffs' brief (at 14) states that this proposed testimony came from a physician, Dr. Joseph Tobias, it actually came from a CRNA, Mr. Dean Cary. (T23 pp 74:20-75:11)

Plaintiffs also sought to introduce testimony from Mr. Cary that Mr. VanSoestbergen breached the standard of care by *failing* to collaborate with Dr. Doyle and by *neglecting* to provide input on Dr. Doyle's anesthesia plan. (T26 pp 157:22-158:6, 187:11-18) The trial court excluded this testimony because there was no evidence that additional collaboration or input would have prevented Amaya's injury.

The trial court granted defendants' motion in limine to exclude this testimony. (T23 pp 52:21-54:4, 61:2-8; T26 pp 188:25-189:24) The court recognized that under North Carolina law, only physicians may prescribe medications, so the anesthesia plan at issue was Dr. Doyle's plan. Plaintiffs agreed with these points:

> THE COURT: I think the law is that medication can only be prescribed by a physician.
>
> MR. EDWARDS: We agree with that.
>
> THE COURT: And so if that's the case, under the law, the decision to use sevoflurane has got to be Doyle's decision.
>
> MR. EDWARDS: Agreed. I agree with everything you just said.

(T23 p 23:8-15)[4]

(T26 pp 184:25-186:7, 189:17-24) Plaintiffs do not challenge that ruling here.

[4] *See also* T23 p 33:9-10 (plaintiffs' counsel: "[Mr. VanSoestbergen] can't order [medication]. We're not going to claim he can order [medication]."); T23 p 46:14-16 (plaintiffs' counsel: "So who can—who has the power to order the medicine? Dr. Doyle. Mr. Van Soestbergen did not have that power.").

Because Dr. Doyle made the decision to use sevoflurane, the court concluded that plaintiffs' proposed testimony that challenged the use of sevoflurane was inadmissible against Mr. VanSoestbergen. (T23 pp 58:18-22, 60:11-61:8; T26 pp 188:25-189:24) The court held that *Daniels v. Durham County Hospital Corp.*, 171 N.C. App. 535, 615 S.E.2d 60 (2005), which applied this Court's decision in *Byrd*, foreclosed plaintiffs' theory that Mr. VanSoestbergen was liable for Dr. Doyle's treatment decision. (T23 pp 60:11-61:8; T26 pp 188:25-189:24)

The trial court did not, however, exclude all theories of liability against Mr. VanSoestbergen. The court held that *Byrd* and *Daniels* allowed Mr. VanSoestbergen to be found liable for any errors in *how* he administered the sevoflurane. (T36 pp 63:25-64:22, 74:17-75:7)

Based on that ruling, plaintiffs introduced testimony that Mr. VanSoestbergen increased the dosage of sevoflurane too quickly and that the maximum dose of sevoflurane he gave Amaya was too high. (T23 pp 74:13-75:11; T25 pp 55:15-25, 65:21-69:18, 72:15-73:5, 103:16-106:16)

Defendants, in contrast, introduced evidence that the way Mr. VanSoestbergen administered the sevoflurane met the standard of

care. (*See* T32 pp 99:24-100:14; T33 pp 62:3-10, 83:21-85:8) Defendants also offered evidence that in any event, the sevoflurane did not cause Amaya's injuries. Defendants' evidence showed that Amaya's injuries instead resulted from a combination of other factors:

- Amaya's underlying heart disease,
- the pressurized breathing necessary for the heart procedure,
- Amaya's lack of consciousness during the procedure, and
- Amaya's response to intubation.

(T31 pp 80:10-81:20; T32 pp 41:13-21, 114:2-119:15; T33 pp 62:11-63:2)

The jury returned a verdict in favor of defendants. (R p 556) Plaintiffs appealed.

2. Proceedings in the Court of Appeals

A unanimous panel of the Court of Appeals affirmed. *Connette v. Charlotte-Mecklenburg Hosp. Auth.*, 272 N.C. App. 1, 13, 845 S.E.2d 168, 176 (2020), *disc. review allowed*, 854 S.E.2d 589 (N.C. 2021). The court held that *Byrd* foreclosed plaintiffs' theory that Mr. VanSoestbergen could be liable for "collaborating" with Dr. Doyle on the anesthesia plan in this case. *See id.* at 5-6, 845 S.E.2d at 171-72.

The court therefore upheld the trial court's exclusion of plaintiffs' proposed testimony. *See id.* at 5, 845 S.E.2d at 172.

SUMMARY OF ARGUMENT

Plaintiffs' arguments for reversing the decisions below fail.

Plaintiffs first argue that this Court should overrule its decision in *Byrd*. Pls.' Br. 17-27. They also argue that *Byrd* does not govern this case. *Id*. at 27-33.

When plaintiffs make these arguments, they describe Mr. VanSoestbergen's actions in a wide range of ways:

- "collaborat[ing]" with Dr. Doyle, *id.* at 2, 5, 28, 31;
- "develop[ing]" the anesthesia plan, *id.* at 4, 24, 26, 29, 31, 32, 33;
- "planning" and "selecting" the anesthesia, *id.* at 4, 6, 24, 28;
- "shar[ing] responsibility" for the anesthesia plan, *id.* at 10, 20, 21, 26;
- "independently c[oming] up with the same plan" that Dr. Doyle formulated, *id.* at 29;
- having a role in choosing the anesthesia, *id.* at 21, 32;
- "tak[ing] part" in the treatment decision, *id.* at 21, 28; and

- "act[ing] in concert" with Dr. Doyle, *id.* at 26.

Plaintiffs' shifting descriptions of Mr. VanSoestbergen's actions obscure a key fact: The anesthesia plan in this case was prepared *by Dr. Doyle*. The undisputed evidence at trial proved that fact. Indeed, as the trial court concluded, and as plaintiffs agreed at trial, North Carolina law *required* that Dr. Doyle prepare the anesthesia plan. Plaintiffs' descriptions of Mr. VanSoestbergen's role do not alter these points.

As these points confirm, plaintiffs here are suing Mr. VanSoestbergen over *Dr. Doyle's* anesthesia plan. They are doing so because, they say, Mr. VanSoestbergen had some form of input into that plan.

This Court's decision in *Byrd* forecloses that input-based theory of liability. Under *Byrd*, when a physician chooses a patient's treatment, a nurse who carries out that treatment is not liable for the physician's choice, unless the treatment was so obviously dangerous that any reasonable person would have recognized the danger. *Byrd*, 202 N.C. at 341-43, 162 S.E. at 740-41. Tort law instead makes the physician solely responsible for the treatment she chose. *Id.* at 342, 162 S.E. at 740.

The *Byrd* rule applies even when a nurse gives input into a physician's treatment decision. Indeed, that was the case in *Byrd*: A nurse told the responsible physician how long a patient had already been in the "sweat cabinet" at issue, and the physician used that information to decide how much longer the patient should stay in the cabinet. *See id.* at 340, 342, 162 S.E. at 739, 740. In that way, the nurse gave input into the physician's decision. Because the physician made the decision, however, this Court held that the nurse could not be liable for the patient's injuries. *See id.* at 343, 162 S.E. at 741.

Because *Byrd* rules out the sort of input-based liability that plaintiffs propose, plaintiffs argue that the Court should either overrule *Byrd* or hold that *Byrd* does not govern this case. Both of those arguments fail.

First, *Byrd* deserves reaffirmance, not overruling. This Court's holding in *Byrd*—that nurses are not liable for harm that results from physicians' treatment decisions—follows from settled tort principles. That rule also squares with the holdings of courts in other states. *See infra* pp 34-37.

Even though the Court in *Byrd* reviewed an old-fashioned medical treatment, the rule this Court adopted in *Byrd* remains sound in the modern medical context. As a result, this Court and the Court of Appeals have continued to follow the *Byrd* rule. *See Blanton v. Moses H. Cone Mem'l Hosp., Inc.*, 319 N.C. 372, 376, 354 S.E.2d 455, 458 (1987); *Daniels*, 171 N.C. App. at 538-40, 615 S.E.2d at 62-63; *Paris v. Michael Kreitz, Jr., P.A.*, 75 N.C. App. 365, 380-81, 331 S.E.2d 234, 245 (1985). Indeed, the Court of Appeals has explicitly held that *Byrd* aligns with modern statutes on nurses' scope of practice. *See Daniels*, 171 N.C. App. at 538, 540, 615 S.E.2d at 63 (citing N.C. Gen. Stat. § 90-171.20(7)). For these reasons, overruling *Byrd* would clash with stare decisis. *See infra* pp 41-43.

Even if these concerns did not exist, moreover, making nurses liable for offering input would be a matter for the General Assembly. This Court has held that new forms of liability are questions for the legislature if creating that liability would (1) depart from common-law principles, (2) require complex policy decisions, or (3) contravene the legislature's implicit rejection of that liability. As shown below, each of those circumstances applies here. *See infra* pp 43-59.

Second, *Byrd* controls this case. Dr. Doyle made the treatment decision at issue: to give Amaya inhaled sevoflurane. Mr. VanSoestbergen at most gave input into Dr. Doyle's decision. Those facts fall within *Byrd*'s holding that a nurse is not liable for giving input into a physician's treatment decision.

When plaintiffs argue otherwise, they misunderstand *Byrd* and portray the record inaccurately.

For example, plaintiffs argue that *Byrd* does not apply to CRNAs at all. By its terms, however, the *Byrd* rule applies to all nurses. CRNAs are nurses. Thus, holding that *Byrd* does not apply to CRNAs would overrule that decision, at least in part. For the reasons noted above, *Byrd* should not be overruled.

Plaintiffs' record-based arguments fare no better. Those arguments overstate the level of input that Mr. VanSoestbergen had into Dr. Doyle's anesthesia plan. Plaintiffs also overlook the evidence that Dr. Doyle's anesthesia plan did not cause Amaya's injury. Because of these record facts, plaintiffs' input-based-liability theory would not even change the outcome below.

In sum, plaintiffs' effort to undermine the *Byrd* rule fails doctrinally and factually. This Court should therefore follow *Byrd* and affirm the decisions below.

STANDARD OF REVIEW

This case involves the exclusion of plaintiffs' proposed expert testimony as irrelevant and doctrinally unsound. *See supra* pp 15-17.

This Court reviews the trial court's relevance ruling for abuse of discretion. *See, e.g.*, *State v. McGrady*, 368 N.C. 880, 893, 787 S.E.2d 1, 11 (2016).

Insofar as the trial court's evidentiary ruling involved embedded questions of law, this Court reviews those legal rulings de novo. *See, e.g.*, *Da Silva v. WakeMed*, 375 N.C. 1, 5, 846 S.E.2d 634, 638 (2020).

ARGUMENT

I. The Court Should Reaffirm *Byrd* and Related Cases.

Under this Court's decision in *Byrd*, as well as later decisions that follow *Byrd*, nurses are not liable for offering input into physicians' treatment choices. That rule remains sound. Even if there were

reasons to consider a change to the *Byrd* rule, moreover, that decision would be one for the General Assembly.

A. *Byrd* correctly rules out liability for nurses' input into physicians' treatment decisions.

Under principles of stare decisis, this Court overrules precedent only for compelling reasons. *See, e.g.*, *Stephenson v. Rowe*, 315 N.C. 330, 338-39, 338 S.E.2d 301, 306 (1986); *see also infra* pp 41-43. Here, plaintiffs have not identified any sound reason to overrule *Byrd*.

On the contrary, there are compelling reasons to reaffirm the *Byrd* rule. That rule follows established principles of tort law. It also aligns with decisions from courts across the country. And it fits with modern medical practice.

1. *Byrd*'s ban on input-based liability follows fundamental tort principles.

Byrd holds that nurses are not liable for offering input on treatment decisions made by physicians, absent extraordinary circumstances. That holding applies well-established principles of tort law.

a. *Byrd* follows the common-law principle that one person's responsibility for preventing harm forecloses another person's liability for that harm.

Under black-letter tort law, a defendant is not liable for negligence when another person is responsible for preventing the plaintiff's alleged injury. *See* Restatement (Second) of Torts § 452(2) & cmt. d (Am. Law Inst. 1965); 1 Dan B. Dobbs et al., *Dobbs' Law of Torts* § 213, at 745-47 (2d ed. 2011).

This principle stems from the absence of a duty: Person *B* has no duty to a plaintiff when the duty rests solely with Person *A*. *See* Restatement § 452(2) & cmt. d; Dobbs § 213, at 745-47. The principle also stems from an absence of proximate cause: *A*'s negligence is a superseding cause that precludes liability for *B*. *See* Restatement § 452(2) & cmt. f; Dobbs § 213, at 745-46 & nn.4-5. On these two bases, the common law holds that *A*'s responsibility for preventing a particular harm precludes liability against *B*.[5]

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[5] Many decisions applying this rule, including several of the decisions discussed below, phrase the rule in terms of superseding cause. But the concepts of duty and superseding cause are interchangeable in this area, so those decisions can be equally understood as resting on a lack of duty. *See* Dobbs § 213, at 745-46 & nn.3-7.

This common-law principle applies when, as here, the alleged negligence involves negligent decision-making. When *A* is responsible for a decision that harms the plaintiff, *B* (a non-decision-maker) is not liable for the harm caused by *A*'s decision.

Common-law cases illustrate this point.

For example, in *Kent v. Commonwealth*, the Massachusetts Supreme Judicial Court held that the Massachusetts parole board was not liable for harm that resulted from a federal agency's decision. 771 N.E.2d 770, 777-78 (Mass. 2002). The parole board transferred a prisoner to the custody of a federal immigration agency. *Id.* at 772. The federal agency deported the prisoner, but decided not to deport him again after he reentered the United States. *See id.* The prisoner then shot one of the plaintiffs. *Id.* at 772-73. The plaintiffs claimed that the Massachusetts parole board acted negligently by releasing the prisoner to the federal agency. *See id.* at 772, 776-77. The court concluded, however, that the plaintiffs' harm resulted from the federal agency's decision not to re-deport the prisoner. *Id.* at 778. Because the parole board did not make that decision, it was not liable for the decision's results. *See id.*

Similarly, in *Farwell v. Un*, the Fourth Circuit held that two physicians were not liable for their patient's suicide. 902 F.2d 282, 290 (4th Cir. 1990). The physicians advised the patient to commit himself to a hospital for mental-health treatment, but the patient chose to disregard that advice. *See id.* at 289-90. Because the patient, not the physicians, made that choice, the Fourth Circuit held that the physicians were not liable for the outcome of the choice. *See id.* at 290.[6]

As these cases illustrate, under the common law of torts, when *A* makes a decision and *B* does not, *B* is not liable for the results of *A*'s decision.

The same is true when, as here, *B* allegedly has input into *A*'s decision. Cases across the country illustrate this point as well.

For example, in *McCleaf v. State*, the Arizona Court of Appeals held that a probation officer was not liable for his allegedly negligent

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[6] The law on lawyers' professional responsibility, too, follows the principle that responsibility for the results of a decision lies with the decision-maker. When a supervising lawyer makes a reasonable decision on an arguable ethical question, the law of professional responsibility shields a junior lawyer from discipline for following that decision. *See* Restatement (Third) of the Law Governing Lawyers § 12(2) (Am. Law Inst. 2000); *see also* N.C. R. Prof'l Conduct 5.2(b).

input into a judge's decision. 945 P.2d 1298, 1302-03 (Ariz. Ct. App. 1997). The judge accepted the officer's recommendation not to issue an arrest warrant for a woman who had violated the terms of her probation. *Id.* at 1300. The woman then injured the plaintiff. *Id.* The plaintiff claimed that the officer's recommendation to the judge was negligent. *See id.* at 1300, 1302. Because it was the judge, however, who decided not to issue the arrest warrant, the court held that the officer was not responsible for the results of that decision. *See id.* at 1302-03.

Likewise, in *Connecticut Junior Republic v. Doherty*, the court held that a lawyer was not liable for his allegedly negligent input into a decision made by his client. 478 N.E.2d 735, 739 (Mass. 1985). That case involved the drafting of a will codicil. In the codicil, the lawyer mistakenly failed to list certain charities as beneficiaries. *See id.* at 737. But the testator reviewed the codicil and, with full knowledge of its contents, executed the codicil despite the lawyer's mistake. *See id.* at 737-38. The court held that the testator's decision to execute the codicil—like the judge's decision in *McCleaf*—absolved the lawyer from liability. *See id.* at 739.

In sum, under the common law, *B* is not liable for negligence when *A* is responsible for preventing the harm at issue. Even if *B* has input into *A*'s decision, *B* is not liable for harm caused by that decision.

The *Byrd* rule follows these principles. Under *Byrd*, a nurse is not liable for the results of a physician's treatment decision, even if the nurse has input into that decision. *See* 202 N.C. at 340, 342-43, 162 S.E. at 739-41. That is because, as the Court recognized, tort law makes physicians solely responsible for their treatment decisions. *Id.* at 342, 162 S.E. at 740. *Byrd* thus reflects the common-law principle that one person's responsibility for preventing harm forecloses holding another person liable for that harm.

b. *Byrd* also follows the common-law principle that others' negligence is unforeseeable.

Byrd's holding also reflects a second common-law principle: Absent notice to the contrary, people are entitled to assume that other people will act with due care. Under this principle, other people's negligence generally is not foreseeable. When the negligence of others causes an injury, that negligence is considered a superseding cause of the injury. *See, e.g.*, *Weavil v. Myers*, 243 N.C. 386, 391-92, 90 S.E.2d

733, 737-38 (1956); *Britt v. Sharpe*, 99 N.C. App. 555, 558, 393 S.E.2d 359, 361 (1990).

Medical-malpractice cases apply this principle by barring liability for defendants who rely on others who take responsibility for a patient.

For example, in *Monroe v. Rex Hospital*, the Court of Appeals held that a physician was not liable for the death of a patient because other health care providers negligently delayed providing the treatment ordered by the physician. 272 N.C. App. 75, 79-81, 844 S.E.2d 43, 47-48 (2020). The physician was entitled to assume that the other providers would act promptly; had they done so, the patient likely would have survived. *See id.* at 79-80, 844 S.E.2d at 47-48. *Monroe* illustrates how later providers' negligence is a superseding cause. *See id.* at 78-79, 81, 844 S.E.2d at 47-48.

Similarly, in *Siggers v. Barlow*, the Sixth Circuit held that an emergency-room physician was not liable for a misdiagnosis because hospital policies made a later physician responsible for telling the patient about the misdiagnosis. 906 F.2d 241, 245-47 (6th Cir. 1990). The later physician's negligent failure to fulfill that responsibility was a

superseding cause that barred liability for the first physician. *See id.* at 246-47.

Likewise, in *Spicer v. Osunkoya*, the Delaware Supreme Court held that a claim against a physician for a negligent misdiagnosis failed for lack of duty and for lack of proximate causation because the defendant physician had transferred responsibility for the patient's care to another physician. 32 A.3d 347, 351 (Del. 2011).

This Court's decision in *Byrd* accords with the principle that, absent notice to the contrary, other people's negligence is not foreseeable. Just as the physicians in the above cases were entitled to assume that other physicians would meet the standard of care, nurses are entitled to assume (except in cases of obvious negligence) that physicians will meet the standard of care. If a physician instead makes a negligent decision, that negligence is a superseding cause that bars liability against a nurse—including liability for any negligent input into the physician's decision.

Byrd's holding makes perfect sense, given the wide difference between physicians' training and nurses' training. In this case, for example, Mr. VanSoestbergen obtained his certification as a CRNA

after two years of anesthesia-specific training. In contrast, Dr. Doyle worked four years as an anesthesia resident, completed an additional one-year fellowship in pediatric anesthesia, and took exams to become a board-certified anesthesiologist. *See supra* p 8. Given this training difference, a nurse like Mr. VanSoestbergen is entitled to assume that a highly trained physician like Dr. Doyle will satisfy the standard of care.[7]

As these points confirm, *Byrd* follows common-law principles of foreseeability when it holds that, except in cases of obvious negligence, a nurse is not liable for a physician's breach of the standard of care.

c. *Byrd* is consistent with common-law principles of joint and several liability.

Plaintiffs do not address any of the common-law tort principles discussed above. Instead, they argue that *Byrd*'s holding conflicts with the tort concept of joint and several liability. Pls.' Br. 25-27. But joint

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[7] Drawing this contrast is not meant to denigrate the professionalism of nurses like Mr. VanSoestbergen, who make vital contributions to health care. Indeed, the importance of nurses' contributions, particularly in underserved communities, is a key reason not to overrule *Byrd*. *See infra* pp 53-55.

and several liability is a method of recovery, not an independent source of liability. It applies only *after* a court has decided that multiple defendants are liable to the plaintiff.[8] That liability question, of course, is the question to be decided here: whether nurses are liable for giving input into physicians' treatment decisions. The *Byrd* rule and the principles above show that nurses are not liable for those decisions. As a result, plaintiffs' arguments about joint and several liability assume a missing premise.

2. *Byrd* aligns with decisions in other states.

Byrd is also consistent with precedent from other states. Like this Court in *Byrd*, appellate courts in other states have held that nurses are not liable for harm that results from physicians' treatment decisions.

For example, in *Mesedahl v. St. Luke's Hospital Ass'n of Duluth*, the Minnesota Supreme Court directly followed *Byrd*. 259 N.W. 819, 822 (Minn. 1935). The court quoted and adopted *Byrd*'s holding that

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[8] *See, e.g.*, *Hairston v. Alexander Tank & Equip. Co.*, 310 N.C. 227, 234, 311 S.E.2d 559, 565-66 (1984); *Simpson v. Plyler*, 258 N.C. 390, 393, 128 S.E.2d 843, 845 (1963); Restatement (Second) of Torts § 875.

unless a physician's decision shows obvious negligence, a nurse is not liable for harm resulting from that decision. *See id.* Minnesota courts continue to apply *Mesedahl* and, by extension, *Byrd*. *See, e.g.*, *Burt v. Winona Health*, Civil No. 16-1085, 2018 WL 1094289, at *3 (D. Minn. Feb. 28, 2018) (unpublished).

The New York courts also apply a rule similar to the *Byrd* rule. In *Yakubov v. Jamil*, for example, the court held that a CRNA was not liable for alleged negligence because she was acting under the direct supervision of an anesthesiologist. 994 N.Y.S.2d 190, 191 (App. Div. 2014). The court explained that a nurse who works under physician supervision and does not exercise independent medical judgment typically cannot be liable for medical malpractice. *Id.* at 190-91. The only exceptions arise when "the directions from the supervising physician so greatly deviate from normal medical practice that the nurse should be held liable for failing to intervene, or the nurse commits an independent act that constitutes a departure from accepted medical practice." *Id.* at 191; *see also Toth v. Cmty. Hosp. at Glen Cove*, 239 N.E.2d 368, 374 n.3 (N.Y. 1968) (holding that hospitals are not

liable if their nurses follow physicians' orders unless those orders are "clearly contraindicated by normal practice").

The Florida courts, too, shield nurses from liability for physicians' treatment decisions. In *Siegel v. Husak*, for example, the court held that an advanced-practice nurse was not liable for an incorrect "nursing diagnosis" because she was acting under a physician's supervision. 943 So. 2d 209, 213-14 (Fla. Dist. Ct. App. 2006). The court applied the "long-settled legal principle that '[w]hen a nurse acts under the orders of a private physician in matters involving skill and decision, she is absolved from liability for her acts.'" *Id.* at 214 (quoting *Buzan v. Mercy Hosp.*, 203 So. 2d 11, 13 (Fla. Dist. Ct. App. 1967)).

The Washington Court of Appeals has likewise held that a nurse has no duty, absent a physician's clear error, to question a physician's decision to prescribe a drug. *See Silves v. King*, 970 P.2d 790, 796 (Wash. Ct. App. 1999).

The Supreme Court of Nebraska has also held that nurses working under physician supervision are not liable for negligence

unless they fail to follow physicians' orders. *See Jensen v. Archbishop Bergan Mercy Hosp.*, 459 N.W.2d 178, 182-83 (Neb. 1990).[9]

In sum, courts across the country apply the same rule that this Court adopted in *Byrd*. Plaintiffs have not argued otherwise.

3. *Byrd* remains sound in today's health care environment.

Plaintiffs argue that *Byrd* has become obsolete. Pls.' Br. 17. That argument, however, rests on a misreading of *Byrd*.

Plaintiffs describe the *Byrd* rule as an overbroad holding that nurses can never be liable for treatment-related decisions. *See id.* at 18. To the contrary, the *Byrd* Court recognized that nurses *can* be liable for treatment-related decisions in certain situations:

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[9] *See also Hunsaker v. Bozeman Deaconess Found.*, 588 P.2d 493, 508 (Mont. 1978) (agreeing with *Mesedahl* that, absent an emergency, nurses must follow a treating physician's orders); *Butler v. Caldwell Mem'l Hosp.*, 412 P.2d 593, 596 (Idaho 1966) (holding that nurses were not negligent because the decisions at issue "were within the ambit of the doctor's authority and responsibility"); *Minogue v. Rutland Hosp.*, 125 A.2d 796, 799 (Vt. 1956) (citing *Byrd* and adopting this Court's holding that, absent obvious negligence, nurses must follow physicians' orders); *Navarro v. George*, 615 A.2d 890, 892 (Pa. Commw. Ct. 1992) (holding that a nurse was not liable for dispensing medication prescribed by a physician).

- A nurse can be liable when a treatment chosen by a physician is so obviously dangerous that any reasonable person would have realized it. *See Byrd*, 202 N.C. at 341, 162 S.E. at 740.
- A nurse can also be liable when he chooses a treatment without instruction from or supervision by a physician. *See id.* at 343, 162 S.E. at 741.[10]

Plaintiffs' argument that *Byrd* is obsolete rests on another false premise as well: the premise that CRNAs and other advanced-practice nurses now "share responsibility" with physicians for treatment decisions. Pls.' Br. 20; *see also id.* at 27 (stating that Mr. VanSoestbergen and Dr. Doyle made a "joint decision").

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[10] *Byrd* also held that a nurse can be liable when he, with no physician present, negligently administers a treatment chosen by a physician. *See* 202 N.C. at 343, 162 S.E. at 741. Here, the trial court construed that holding as allowing plaintiffs to argue that Mr. VanSoestbergen negligently administered the anesthesia at issue, even though Dr. Doyle was present for the administration. *See supra* p 17. Even on that broad reading of the liability that *Byrd* allows, however, the jury found for Mr. VanSoestbergen. (R p 556)

Plaintiffs base their "shared responsibility" theory on a rule issued by the North Carolina Board of Nursing. That rule states that CRNAs' scope of practice includes "selecting" anesthesia. 21 N.C. Admin. Code 36.0226(c)(2)(b), *quoted in* Pls.' Br. 20. Plaintiffs argue that under this rule, CRNAs now have responsibility for planning anesthesia—responsibility that nurses did not have when this Court decided *Byrd*. Pls.' Br. 6-7, 20.

That "shared responsibility" theory clashes with North Carolina statutes. The CRNA rule cannot expand CRNAs' scope of practice beyond statutory limits. *See N.C. Med. Soc'y v. N.C. Bd. of Nursing*, 169 N.C. App. 1, 4-7, 13, 610 S.E.2d 722, 723-26, 729 (2005) (holding that the CRNA rule must be construed to conform it to statutes). Here, the operative statutes are the Medical Practice Act and the Nursing Practice Act. *See* N.C. Gen. Stat. §§ 90-18, 90-171.20 (2019).

The Medical Practice Act provides that only licensed physicians may engage in the "practice of medicine or surgery." *Id.* § 90-18(a). Under an express statutory definition, the practice of medicine or surgery includes treating an illness, diagnosing an illness, or prescribing a drug for another person. *Id.* § 90-1.1(5)(b), (c).

Likewise, the Nursing Practice Act provides that registered nurses (a group that includes CRNAs) may not prescribe treatment regimens or make medical diagnoses "except under supervision of a licensed physician." *Id.* § 90-171.20(7)(e).

Under these statutes, even if CRNAs and physicians share responsibility to some degree, CRNAs' share of the responsibility does not include prescribing treatment regimens or making medical diagnoses.

As both the Court of Appeals and the Attorney General have concluded, providing anesthesia involves the prescription of a treatment regimen and the making of a medical diagnosis.[11] By statute, then, CRNAs may not provide anesthesia without physician supervision. Thus, the CRNA rule's statement that CRNAs may "select" anesthesia does not, as plaintiffs contend, allow CRNAs to make anesthesia plans.[12]

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[11] *See N.C. Medical Society*, 169 N.C. App. at 4-7, 13, 610 S.E.2d at 723-26, 729; N.C. Att'y Gen., Advisory Opinion: Certified Registered Nurse Anesthetists; Nursing Practice Act, Article 9A, Chapter 90 (Dec. 31, 1998).

[12] North Carolina law is more restrictive of CRNA practice than is the law of some other states. *See, e.g.*, Ariz. Rev. Stat. Ann. § 32-

In sum, the statutory scopes of practice for physicians and nurses in North Carolina continue to treat physicians as the main decision-makers. *Byrd* rests on the principle that "the physician is solely responsible for the diagnosis and treatment of his patient." *See* 202 N.C. at 342, 162 S.E. at 740. That point is as correct in today's medical environment as it was nine decades ago.

4. Overruling *Byrd* would conflict with stare decisis.

Plaintiffs' arguments for overruling *Byrd* conflict not only with the reasoning of that decision, but with stare decisis.

Under stare decisis, this Court overturns its decisions only for compelling reasons. For example, overruling a precedent might be justified when that precedent conflicts with relevant legal principles, departs from decisions in other jurisdictions, or rests on premises that are no longer valid. *See, e.g.*, *Stephenson*, 315 N.C. at 339, 338 S.E.2d

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1634.04 (2017) (unlike North Carolina law, authorizing CRNAs to administer anesthesia without physician supervision); Cal. Bus. & Prof. Code § 2725(b)(2) (West 2021) (same); Ky. Rev. Stat. Ann. §§ 314.011(7)-(8), 314.042 (West 2018) (same). Plaintiffs appear to mistake the scope of CRNA practice in North Carolina for the scope of CRNA practice in states like these.

at 306; *Mims v. Mims*, 305 N.C. 41, 48-50, 286 S.E.2d 779, 784-86 (1982).

Plaintiffs have not shown that *Byrd* satisfies any of these criteria. To the contrary, as discussed above, the *Byrd* rule follows the relevant legal principles, aligns with decisions in other jurisdictions, and rests on ideas that remain valid today. *See supra* pp 25-41. Thus, there is no reason to overrule *Byrd*, much less the type of compelling reason that stare decisis demands.

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For eighty-nine years, this Court and the Court of Appeals have followed *Byrd* faithfully. *See Blanton*, 319 N.C. at 376, 354 S.E.2d at 458; *Daniels*, 171 N.C. App. at 538-40, 615 S.E.2d at 62-63; *Paris*, 75 N.C. App. at 380-81, 331 S.E.2d at 245. Indeed, in *Daniels*, the Court of Appeals not only followed *Byrd*, but also recognized that the decision fits with modern limits on nurses' scope of practice. *See Daniels*, 171 N.C. App. at 538, 540, 615 S.E.2d at 63. Specifically, the *Daniels* court held that *Byrd* and the Nursing Practice Act both prevent nurses from resolving medical disputes on diagnosis and treatment. *See id.*; *see also supra* p 22.

Thus, the question here is not, as plaintiffs contend, whether to overrule a single decision from 1932. The question is whether to overrule an entire line of decisions that extends into the modern medical era. For the reasons stated above, the Court should reaffirm the *Byrd* rule and leave this line of decisions intact.

B. Creating a new form of liability for nurses based on their input into physicians' treatment decisions is a matter for the legislature, not the courts.

Even if one favored a rule different from the *Byrd* rule, changing North Carolina law and creating a new form of liability for nurses still would not be a matter for the courts. It would be a policy decision for the General Assembly.

This Court's own decisions confirm this point. The Court has held that creating a new form of liability should be left to the legislature when creating that liability would:

1. Depart from common-law principles, *see, e.g.*, *Parkes*, 376 N.C. at 325-26, 852 S.E.2d at 325-26;
2. Require complex policy judgments, *see, e.g.*, *Azzolino v. Dingfelder*, 315 N.C. 103, 116, 337 S.E.2d 528, 537 (1985); or

3. Contravene existing views of the legislature, *see, e.g.*, *Bridges v. Parrish*, 366 N.C. 539, 543, 742 S.E.2d 794, 798 (2013).

As shown below, all three of these concerns apply here.

1. Establishing liability that departs from the common law is a task for the General Assembly.

This Court has held that creating a new form of liability should be left to the legislature when creating that liability would depart from common-law principles. Creating liability for nurses based on their input into physicians' treatment decisions would do just that.

This Court recently held in *Parkes* that departures from common-law principles should be left to the General Assembly. In that case, the Court declined to establish a new form of medical-malpractice liability for "loss of chance." *See* 376 N.C. at 321, 325, 852 S.E.2d at 322, 325. Imposing that new form of liability, the Court explained, "would require a departure from our common law on proximate causation and damages." *Id.* at 325, 852 S.E.2d at 325. The Court therefore concluded that deciding whether to allow liability for loss of chance was a task for the legislature. *See id.* at 325-26, 852 S.E.2d at 325-26.

Parkes is only the latest in a long line of this Court's decisions that hold that departures from the common law are matters for the General Assembly.[13]

These holdings reflect the distinct roles of the legislative and judicial branches. The legislative branch is "the policy-making agency of our government"; the judicial branch is not. *Rhyne v. K-Mart Corp.*, 358 N.C. 160, 169, 594 S.E.2d 1, 8 (2004) (quoting *McMichael v. Proctor*, 243 N.C. 479, 483, 91 S.E.2d 231, 234 (1956)). Departing from the common law is an act of policymaking. *See, e.g.*, *id.*; *Parkes*, 376 N.C. at 325-26, 852 S.E.2d at 325-26. Thus, the branch with the authority to

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[13] *See, e.g.*, *Bridges*, 366 N.C. at 542-43, 742 S.E.2d at 797-98 (leaving to the General Assembly the creation of liability for negligent storage of a firearm, because that liability would have departed from common-law tort principles on duty); *Jackson v. Bumgardner*, 318 N.C. 172, 183, 347 S.E.2d 743, 749-50 (1986) (leaving to the General Assembly the creation of medical-malpractice liability for the costs of rearing a child born after an unwanted pregnancy, because that liability would have departed from common-law tort principles on damages); *Gillikin v. Bell*, 254 N.C. 244, 246-47, 118 S.E.2d 609, 611 (1961) (leaving to the General Assembly the creation of liability for defamation of the deceased, because that liability would have departed from the common law); *Henson v. Thomas*, 231 N.C. 173, 174-76, 56 S.E.2d 432, 433-34 (1949) (leaving to the General Assembly the creation of liability for depriving children of their parents' affection, because that liability was unavailable at common law).

create new forms of liability that depart from the common law is the General Assembly. *See, e.g.*, *Gillikin*, 254 N.C. at 247, 118 S.E.2d at 611.

This principle defeats plaintiffs' request for the Court to replace *Byrd* with a new doctrine of input-based liability. As shown above, *Byrd*'s holding that nurses are not liable for offering input on physicians' treatment decisions applies common-law tort principles. *See supra* pp 25-34. The *Byrd* rule is also consistent with the common law in other jurisdictions. *See supra* pp 34-37. Changing North Carolina law to impose input-based liability on nurses would therefore depart from the common law. Unless and until the General Assembly adopts that new form of liability, the Court should adhere to *Byrd*.

2. Deciding whether to create input-based liability for nurses is a complex policy judgment for the General Assembly.

This Court has also held that creating a new form of liability should be left to the legislature when creating that liability would involve complex policy judgments. As shown below, that is the case here.

Multiple decisions of this Court show that complicated policy decisions are matters for the General Assembly.

For example, in *Azzolino*, the Court declined to recognize new forms of medical-malpractice liability for "wrongful life" or "wrongful birth" when a child is born with a genetic disorder. *See* 315 N.C. at 104, 337 S.E.2d at 530. Imposing this new liability would have raised a number of questions, including line-drawing questions about the scope of the new liability. *See id.* at 115-16, 337 S.E.2d at 536. The Court concluded that the legislature was better suited to address those questions than the courts were. *See id.* at 109-10, 115-16, 337 S.E.2d at 533, 537. The Court recognized that only the legislature could consider and address all of the issues related to a new form of liability at one time. *See id.* at 116, 337 S.E.2d at 537.

For similar reasons, in *Skinner v. Whitley*, the Court declined to narrow the common-law immunity that shields parents from liability for negligently injuring their minor children. 281 N.C. 476, 478, 483-84, 189 S.E.2d 230, 231, 234-35 (1972). The Court decided that the General Assembly was better suited to change the law because only it could enact comprehensive legislation that limited parental immunity while

still imposing safeguards for defendants. *See id.* at 484, 189 S.E.2d at 235.

These decisions act on the respective advantages of the legislative and judicial branches. The legislature, unlike the judiciary, can weigh all the factors on a given issue, balance competing interests, conduct an open debate, and address the issue comprehensively. *Rhyne*, 358 N.C. at 170, 594 S.E.2d at 8-9. Thus, when a decision on whether to create new liability involves complex policy judgments—judgments that require addressing several related issues at one time and balancing competing interests—that decision is one for the General Assembly.

That is the case here. As shown below, deciding whether to create input-based liability for nurses calls for complex policy judgments. Those judgments require policymakers to consider multiple related issues at the same time and to balance competing interests.

a. Creating input-based liability requires a decision-maker to draw difficult lines and to address the conflict between input-based liability and nurses' scope of practice.

Imposing liability on nurses who offer input would raise a number of related issues that need to be addressed together. Those issues

include line-drawing questions about how far the liability should extend. For example:

- Which nurses would face input-based liability: CRNAs? Other advanced-practice nurses? All nurses? And what would be the basis for any distinctions among different types of nurses?
- What would count as input that could trigger liability: Making an independent proposal about a treatment plan? Identifying multiple potential treatments and asking a physician which treatment she would like to use? Merely discussing, then following, a physician's chosen treatment?
- When would offering input (or withholding input) violate the standard of care? Would nurses have an obligation to challenge physicians' decisions in favor of alternatives, even when a decision reflects a medical judgment that is not obviously dangerous?

- Would the analysis of possible input-based liability differ based on a nurse's education level, years of experience, or familiarity with the patient or treatment at issue?[14]

As in *Azzolino* and *Skinner*, these questions should be addressed together—something that only the legislature can do. The courts, in contrast, could answer these questions only through the type of "piecemeal abrogation of established law" that is "ordinarily unwise and usually unsuccessful." *Skinner*, 281 N.C. at 484, 189 S.E.2d at 235.

Creating input-based liability for nurses would also raise another set of issues: conflicts with nurses' scopes of practice. Input-based liability would make nurses liable for harm caused by treatment plans. *See* Pls.' Br. 26-27. Under existing North Carolina statutes, however, nurses are not allowed to select patients' treatment plans at all. As shown above, the Medical Practice Act and the Nursing Practice Act

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[14] In its proposed amicus brief, the North Carolina Healthcare Association explains that plaintiffs' liability theory here is ill-defined. It also explains that health care professionals would have difficulty accounting for this potential liability when they provide health care. *See* North Carolina Healthcare Ass'n Br. § D(3).

reserve this authority for physicians and similar providers. *See supra* pp 39-41.

For these reasons, plaintiffs' theory would hold nurses liable for decisions that statutes bar nurses from making. Plaintiffs' theory would thus put nurses in an impossible situation—an outcome that conflicts with fairness.

Only the legislature could adopt plaintiffs' theory of input-based liability in a way that avoids this unfairness. That is because only the legislature could create input-based liability and, at the same time, amend the statutes that currently prevent nurses from making treatment decisions.

Considering whether to amend those statutes is a core legislative task. In fact, the scope of practice for CRNAs is a controversial issue that is debated often in the General Assembly.[15] During several recent

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[15] This issue is also debated often outside the General Assembly. *See, e.g.*, *N.C. Medical Society*, 169 N.C. App. at 4-10, 13, 610 S.E.2d at 723-27, 729 (describing and resolving conflict between the Medical Board and the Board of Nursing over CRNAs' scope of practice).

In its proposed amicus brief, the North Carolina Society of Anesthesiologists details the extensive history of legislation, rulemaking, and litigation over the scope of CRNA practice. *See* Society of Anesthesiologists Br. § I(C)-(H). Likewise, the North Carolina

legislative sessions, members and senators have proposed bills that would change CRNAs' scope of practice. Those proposals have not been enacted.[16] Even now, a bill to expand the scope of practice for CRNAs is before the General Assembly. *See* S.B. 249, § 1, 2021 Gen. Assemb., Reg. Sess. (N.C. 2021). The bill would allow CRNAs to select anesthesia and order procedures without physician supervision. *See id.* § 1, at 2:48-3:7. As of this writing, the bill has not become law, and its prospects for becoming law seem limited.[17]

Healthcare Association's proposed amicus brief describes the statutory and regulatory background of the scopes of practice for CRNAs and other nurses. *See* North Carolina Healthcare Ass'n Br. § A.

[16] *See, e.g.*, S.B. 143, 2019 Gen. Assemb., Reg. Sess. (N.C. 2019); H.B. 88, 2017 Gen. Assemb., Reg. Sess. (N.C. 2017); S.B. 240, 2015 Gen. Assemb., Reg. Sess. (N.C. 2015); H.B. 181, 2013 Gen. Assemb., Reg. Sess. (N.C. 2013).

The proposed amicus brief of the North Carolina Society of Anesthesiologists details the current statutory framework on CRNA practice, as well as recent legislative proposals on that issue. *See* Society of Anesthesiologists Br. § I(H).

[17] *See* Lucille Sherman, *100 NC lawmakers signed onto a health care bill. Then donors started calling.*, News & Observer (Apr. 4, 2021, 8:00 a.m.), https://www.newsobserver.com/news/politics-government/article250287935.html.

The need to harmonize any input-based liability with nurses' scope of practice calls for the General Assembly to address these issues together, not for the courts to address some issues and for the General Assembly to address others. Having two different branches of our state government address related issues, in varying and perhaps inconsistent ways, would turn a complex area of law into a morass.

b. Creating input-based liability would call for balancing competing interests, including the interests of patients who could be harmed by a new form of liability.

Creating liability for nurses would also call for balancing competing interests, a classic legislative responsibility.

Plaintiffs' proposed change in the law would call for the legislature to consider the interests of a wide range of patients, including patients who could be harmed by holding nurses liable for offering input to physicians. Nurses might recognize patient conditions that a physician would not; thus, a nurse's input might save a patient from injury. But making nurses liable for their input into physicians'

decisions could deter nurses from providing that input, leading to worse outcomes for patients.[18]

Creating input-based liability would also require the General Assembly to consider how the new liability would affect patients' access to care. Making nurses liable when physicians' treatment decisions lead to harm could discourage nurses from participating in high-risk cases like Amaya's—cases with a higher risk of adverse outcomes and expensive litigation. Imposing a new form of liability on CRNAs or other advanced-practice nurses could also discourage nurses from pursuing those credentials.[19]

Deciding the likelihood of these and other bad outcomes, and deciding what weight to give these risks, is a classic legislative

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[18] In its proposed brief, the North Carolina Healthcare Association explains how the *Byrd* rule aids the delivery of high-quality patient care. *See* North Carolina Healthcare Ass'n Br. § B.

[19] North Carolina already faces a shortage of nurses—a shortage that is projected to leave the state 12,900 nurses short by 2025. *See, e.g.*, *The Concern Is Real: Cone Health Residency Program Helps Retain Nurses, but Health Experts Say More Needs to be Done to Curb Shortage*, WFMYNEWS2 (June 10, 2021), https://www.wfmynews2.com/article/news/local/cone-health-nursing-shortage-concerns/83-d6d6f170-3ec6-4aff-a3ff-0f21f334f42f. Plaintiffs' proposed change in the law could worsen that shortage.

challenge. So is balancing these risks with the interests of plaintiffs who seek to recover against nurses. Those patients can already recover from a responsible physician, as Amaya and her family did here. (T1 pp 4:9-5:11, 7:11-11:1) The prospect of that recovery is one of many complicating factors that require legislative weighing.

Only the legislature is in a position to decide what weight to give these and other policy considerations. *See, e.g.*, *Rhyne*, 358 N.C. at 170, 594 S.E.2d at 8-9. As medical science and the health care economy change, moreover, the General Assembly is the branch best suited to adjust its chosen balance of competing interests.

3. The General Assembly has already implicitly rejected input-based liability for nurses.

Plaintiffs' proposal also clashes with another one of this Court's insights: Creating a new form of liability is a task for the General Assembly when that body has legislated in the same area without creating that liability.

For example, in *Bridges*, this Court declined to create liability for negligent storage of a firearm. *See* 366 N.C. at 543, 742 S.E.2d at 798. The Court relied on the fact that the General Assembly had enacted

statutes on the storage of firearms without creating the kind of liability the plaintiff proposed. *See id.*

Likewise, in *Gillikin*, this Court declined to create a claim for defamation of deceased persons because defamation claims had been the subject of legislative action by the General Assembly. 254 N.C. at 247, 118 S.E.2d at 611.

Most recently, in *Parkes*, the Court held that adopting loss-of-chance liability was a decision for the legislature, not for the courts. 376 N.C. at 325-26, 852 S.E.2d at 325-26. To reach that holding, the Court relied in part on the fact that the General Assembly had already enacted statutes to adjust common-law doctrines on medical malpractice. *See id.* at 326 n.2, 852 S.E.2d at 326 n.2.

The same concerns apply here. As the Court noted in *Parkes*, the General Assembly has legislated often in the area of medical malpractice. *See id.* Despite having done so, the General Assembly has never overruled *Byrd*. Indeed, it has never enacted any statute that would hold nurses liable for giving input into physicians' treatment decisions. By refraining from creating that liability, the General

Assembly has implicitly rejected plaintiffs' new type of malpractice claim.

To try to avoid this problem, plaintiffs argue that the General Assembly has already implicitly overturned *Byrd* and has created input-based liability. Plaintiffs base that argument on N.C. Gen. Stat. § 90-21.12. Pls.' Br. 22-24. They argue that section 90-21.12 requires nurses to be held to today's standard of care, whereas, in plaintiffs' view, *Byrd* requires nurses to be held to the standard of care that existed when *Byrd* was decided in 1932. *See id.* That argument fails for at least three reasons.

First, *Byrd* does not require nurses to follow a 1932 standard of care. *Byrd* held that a physician who decides on a patient's diagnosis or treatment is liable for that decision, but a nurse who merely provides input into that decision is not. *See supra* pp 20-21. That holding is not based on or limited by 1932 medical science. Instead, it rests on a timeless principle of tort law: Liability for a decision belongs to the decision-maker alone. *See supra* pp 26-30.

Second, section 90-21.12 does not conflict with *Byrd*. Under section 90-21.12, a medical-malpractice defendant is liable only if (1) he

provided "care," and (2) that care departed from the relevant standard of care. N.C. Gen. Stat. § 90-21.12(a). When a nurse just offers input into a treatment decision made by a physician, the nurse is not the person who provides the relevant care. The physician is. Section 90-21.12 therefore aligns with *Byrd*'s holding that a nurse is not liable for providing input into a physician's treatment decision.

Third, even if there were any tension between *Byrd* and section 90-21.12, the Court should reaffirm *Byrd* based on the doctrine of legislative acquiescence. Under that doctrine, when the legislature does not alter longstanding precedent from this Court or the Court of Appeals, this Court interprets statutes in the same area to make them consistent with those decisions. *See, e.g.*, *State v. Steen*, 376 N.C. 469, 480-81, 483, 852 S.E.2d 14, 22, 24 (2020); *Rowan Cnty. Bd. of Educ. v. U.S. Gypsum Co.*, 332 N.C. 1, 8-9, 418 S.E.2d 648, 653-54 (1992).

Here, this Court and the Court of Appeals have repeatedly followed *Byrd* over the 46 years since section 90-21.12 was enacted in 1975. *See supra* pp 22, 42. If the General Assembly viewed those decisions as inconsistent with section 90-21.12, it could have overturned them by statute. It has not. Most notably, in 2011, five years after

Daniels followed *Byrd*, the General Assembly amended section 90-21.12, but did not revise the statute in any way that would alter *Byrd*. *See Daniels*, 171 N.C. App. at 538-40, 615 S.E.2d at 62-63; *supra* pp 22, 42. These points show that the General Assembly has acquiesced in the *Byrd* line of decisions. Because of that acquiescence, the Court should construe section 90-21.12 in a way that leaves the *Byrd* line of decisions intact.

II. *Byrd* Governs This Case.

Plaintiffs also argue that, if the Court declines to overrule *Byrd*, the Court should still reverse the decisions below by limiting *Byrd* to its facts. Pls.' Br. 27, 33. Plaintiffs contend, in other words, that the lower courts erred by holding that *Byrd* controls this case. *See id.* at 27-29, 33.

Plaintiffs are mistaken. The lower courts were right to hold that *Byrd* bars plaintiffs' claim here against Mr. VanSoestbergen. *See Connette*, 272 N.C. App. at 6-7, 845 S.E.2d at 172; T26 pp 188:25-189:24. Plaintiffs' contrary arguments misconstrue *Byrd* and depart from the record.

A. *Byrd* forecloses plaintiffs' theory against Mr. VanSoestbergen.

Byrd holds that a nurse cannot be held liable on the theory that a treatment chosen by a physician was unsafe, unless the treatment was so obviously dangerous that any reasonable person would have objected to it. *See* 202 N.C. at 341, 343, 162 S.E. at 740-41; *supra* pp 20-21. That holding controls here.

Plaintiffs claim that the decision to induce Amaya's anesthesia with inhaled sevoflurane departed from the standard of care. Pls.' Br. 13-16. But that decision was made by Dr. Doyle. Dr. Doyle testified, without contradiction, that:

- he was "the one making the final calls about Amaya's anesthesia care,"
- the anesthesia plan was "[his] responsibility," and
- the anesthesia plan was "[his] plan."

(T29 pp 230:13-14, 237:23, 238:24; *see* T29 pp 79:2-13, 230:10-20, 237:23-238:25) Mr. VanSoestbergen corroborated these points, testifying that the anesthesia plan was "Dr. Doyle's plan." (T28 p 51:20)

In fact, North Carolina law *required* Dr. Doyle to make the decision about how to induce Amaya's anesthesia. *See supra* pp 39-41,

50-51. Choices of anesthesia methods, after all, involve prescribing medication and ordering treatment—decisions that the law allows only physicians to make. *See supra* pp 39-41. Plaintiffs conceded these points at trial. (*See* T23 pp 23:8-15, 33:9-10, 46:14-16); *supra* p 16.

The policies of Levine Children's Hospital, the hospital at issue here, likewise required Dr. Doyle to choose the anesthesia method for Amaya. Those policies provide that a CRNA may develop an anesthesia plan only under the direction of an anesthesiologist. (R p 493; T33 p 131:8-22)[20] To the same effect, the form that the hospital uses for anesthesia plans requires an anesthesiologist, not a CRNA, to sign off on the plan. Here, Dr. Doyle did exactly that, confirming that he made the decision at issue. (R p 366; T29 p 157:8-14)

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[20] The hospital's policies require "medical direction," the form of supervision under which a CRNA is most closely supervised. (R pp 492-93; T33 pp 131:17-132:6, 132:20-133:1, 179:18-180:2) Under medical direction, a CRNA is supervised by an anesthesiologist, a physician who specializes in anesthesia. (T33 pp 131:8-132:6, 179:18-180:2) The anesthesiologist must be in the procedure room or immediately available, and she must be present for induction and other critical aspects of the patient's anesthesia. (R pp 492-93; T33 pp 58:18-59:15, 179:5-180:2)

Because of those facts, plaintiffs cannot claim that Mr. VanSoestbergen made the decision at issue. Instead, they argue that Mr. VanSoestbergen is liable for providing input into Dr. Doyle's decision. *See* Pls.' Br. 21, 28-29.

As shown above, that argument clashes with *Byrd*. *Byrd* holds that a nurse cannot be liable for harm from a physician's treatment decision unless that decision was so obviously dangerous that any reasonable person would have objected to it. *See Byrd*, 202 N.C. at 341-43, 162 S.E. at 740-41.

Here, plaintiffs do not argue that Dr. Doyle's decision was obviously dangerous. They cannot, because they conceded at trial that Dr. Doyle's choice to use sevoflurane did not rise "to the level of gross negligence that required going up the chain." (T24 p 171:11-12) In fact, plaintiffs' only physician witness who testified about the standard of care, Dr. Tobias, agreed that the choice to use sevoflurane in Amaya's induction did not breach the standard of care. (*See* T25 pp 103:23-104:6, 146:5-23, 148:20-150:3)

Given the lack of obvious negligence on Dr. Doyle's part, this case falls within the core holding of *Byrd*. Thus, the courts below were right to follow *Byrd* and its progeny.

B. Plaintiffs' efforts to distinguish *Byrd* are unpersuasive.

Plaintiffs try to distinguish this case from *Byrd*, but their attempted distinctions stray from *Byrd* and from the record in this case.

1. Plaintiffs misconstrue *Byrd* when they argue that it does not apply to CRNAs.

To try to distinguish *Byrd*, plaintiffs argue that *Byrd*'s holding depends on the premise that nurses cannot provide input into treatment decisions. *See* Pls.' Br. 27. Plaintiffs then argue that this premise does not apply to CRNAs, because CRNAs' scope of practice allows them to offer input on treatment decisions. *See id.* at 27-28, 33.

Those arguments misconstrue *Byrd*. *Byrd*'s ban on input-based liability does not assume that nurses can never provide input into treatment decisions. Instead, the *Byrd* rule is based on the point that making treatment decisions is not a nurse's *responsibility*. As the *Byrd* Court explained, when a physician chooses a treatment, the treatment

is that "of the physician and not that of the nurse." 202 N.C. at 343, 162 S.E. at 741.

Other features of *Byrd* further contradict plaintiffs' argument that the decision rests on a "no input" premise. For example:

- *Byrd* held that nurses can be liable when physicians' chosen treatments are obviously dangerous. *See id.* at 341, 343, 162 S.E. at 740-41. Thus, the decision *requires* nurses to provide input into physicians' treatment decisions when those decisions are obviously dangerous.
- The nurse in *Byrd* provided input into the physician's decision: She and the physician discussed how long to leave the patient in the sweat cabinet. She also told the physician how long the patient had already been in the cabinet. *See id.* at 340, 342, 162 S.E. at 739, 740. Thus, *Byrd* involved actual input by a nurse, not any presumption that nurses can never provide input.

As these points show, *Byrd* does not rest on a presumption that nurses cannot provide input into physicians' treatment decisions.

Plaintiffs therefore err by relying on that supposed presumption to argue that *Byrd* does not apply to CRNAs.

Plaintiffs' argument that *Byrd* does not apply to CRNAs also fails for two further reasons.

First, plaintiffs are mistaken when they argue that CRNAs did not exist when *Byrd* was decided. *See* Pls.' Br. 5. Although the CRNA *credential* was first created in the 1950s, "[n]urse anesthetists have been providing anesthesia care to patients in the United States for more than 150 years."[21] By the time *Byrd* was decided, a national association of nurse anesthetists had been formed.[22] By then, in fact, a nurse anesthetist program already existed at Duke University.[23] Plaintiffs

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[21] Am. Ass'n of Nurse Anesthetists, *Certified Registered Nurse Anesthetists Fact Sheet* (Feb. 1, 2021), https://www.aana.com/membership/become-a-crna/crna-fact-sheet.

[22] *See* Am. Ass'n of Nurse Anesthetists, *AANA Timeline History*, https://www.aana.com/about-us/aana-archives-library/our-history (last visited June 16, 2021).

[23] N.C. Ass'n of Nurse Anesthetists, *NCANA History*, https://www.ncana.com/history (last visited June 16, 2021).

are therefore wrong to argue that applying *Byrd* to CRNAs is anachronistic.[24]

Second, plaintiffs fail in their efforts to draw a sharp distinction between CRNAs and other nurses. Plaintiffs state that CRNAs have "duties and capabilities far beyond those of a registered nurse." Pls.' Br. 10. Under North Carolina law, however, CRNAs *are* registered nurses. CRNAs thus have the same statutory scope of practice that other registered nurses have. *See* N.C. Gen. Stat. § 90-171.20(7), (8) (referring to only two types of nurses—registered nurses and licensed practical nurses—and defining the scopes of practice for each); *see also* 21 N.C. Admin. Code 36.0226(a) (stating that CRNAs are registered nurses).

For example, plaintiffs emphasize that CRNAs can collaborate with physicians. Pls.' Br. 10-11, 20, 28. But so can all registered nurses. *See* N.C. Gen. Stat. § 90-171.20(7)(e) (providing that registered

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[24] The proposed amicus brief of the North Carolina Society of Anesthesiologists details the history of physicians' and nurses' statutory scopes of practice. *See* Society of Anesthesiologists Br. § I(C). As the Society points out, the boundary between these scopes of practice is substantively the same now as it was when this Court decided *Byrd*. *Id.*

nurses can "[c]ollaborate with other health care providers in determining the appropriate health care for a patient").

In sum, plaintiffs have not offered any sound basis to distinguish CRNAs from registered nurses for liability purposes. Thus, if "collaborating" with a physician can create liability for CRNAs, it can create that liability for all registered nurses. As these points show, plaintiffs' arguments threaten a sweeping new form of liability for all registered nurses in North Carolina.

2. Plaintiffs' efforts to distinguish *Byrd* misunderstand the record.

Plaintiffs also try to distinguish *Byrd* by discussing the facts of this case. When they do so, however, they misconstrue the record.

First, plaintiffs overstate Mr. VanSoestbergen's level of input into Dr. Doyle's decision to use sevoflurane to induce Amaya's anesthesia. Plaintiffs say, for example, that Mr. VanSoestbergen and Dr. Doyle made a "joint decision." Pls.' Br. 27. To the contrary, the evidence shows that before Dr. Doyle and Mr. VanSoestbergen even discussed the anesthesia plan for Amaya, Dr. Doyle had already decided it. (R pp 366, 367-68; T35 pp 57:14-59:14, 61:16-25, 62:20-25, 65:10-66:9)

At most, then, Mr. VanSoestbergen's input consisted of accepting a decision that Dr. Doyle had already made. Thus, any holding that Mr. VanSoestbergen's role here supports input-based liability would create that liability *whenever* a nurse accepts a physician's decision that is not obviously dangerous.

Second, plaintiffs overstate the causal significance of Mr. VanSoestbergen's role here. Plaintiffs claim that Mr. VanSoestbergen caused Amaya's injury by giving Dr. Doyle negligent input. Pls.' Br. 27. There is no evidence, however, that any different input from Mr. VanSoestbergen would have caused Dr. Doyle to make a different treatment decision.

To the contrary, the record shows that Dr. Doyle would have made the same decision with or without Mr. VanSoestbergen's input. Dr. Doyle testified that it was his medical judgment that led him to induce Amaya's anesthesia with sevoflurane. (*See* T29 pp 168:18-172:20) Thus, even if input-based liability were a sound theory, the record shows that any negligence in Mr. VanSoestbergen's input had no causal effect.

Third, plaintiffs depart from the record when they state that "[t]here is no dispute that Amaya's injury resulted from the initial induction of anesthesia." Pls.' Br. 16-17; *see also id.* at 4 (similar). To the contrary, defendants showed at trial that Amaya's injury might well have resulted from other causes, including her serious preexisting medical condition and her physical reaction to intubation. *See supra* p 18. These dangers would have been present under any anesthesia plan.

Finally, plaintiffs err when they argue that the trial court prejudiced them by excluding their "input" evidence only after they had referred to that evidence in their opening statement. *See* Pls.' Br. 29-33. Any prejudice of that kind was self-inflicted. When plaintiffs made their opening statement, they knew that a motion to exclude this evidence was pending; the trial court had deferred a ruling on that motion. (*See* T2 pp 98:25-106:9; T23 p 58:2-14) Plaintiffs therefore gambled by referring to this evidence in their opening. They cannot blame the trial court because that gamble did not succeed.

For these reasons, plaintiffs' arguments depart not only from North Carolina law, but from the record in this case.

CONCLUSION

Defendants respectfully request that the Court affirm the judgment of the Court of Appeals.

Respectfully submitted, this 16th day of June, 2021.

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CONTENTS OF APPENDIX

Bills

Trial Transcript Excerpts

CONTENTS OF ADDENDUM