No. 331PA20 TWENTY-SIXTH DISTRICT

SUPREME COURT OF NORTH CAROLINA

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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 COA 19-354 11 CVS 18175

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MOTION OF THE NORTH CAROLINA HEALTHCARE ASSOCIATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

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TO THE HONORABLE SUPREME COURT OF NORTH CAROLINA:

NOW COMES the North Carolina Healthcare Association ("NCHA") and, under Rule 28 of the North Carolina Rules of Appellate Procedure, seeks leave to file a brief *amicus curiae* in support of Defendants-Appellees.

NCHA attaches its *amicus curiae* brief for consideration should the Court grant this request. As the association representing North Carolina's individual and multi-hospital health systems, NCHA has a strong interest in this case and offers its unique perspective to the Court about the issues raised by Appellants.

NCHA's Interest in this Case

NCHA represents hospitals and healthcare services in nearly every North Carolina county. Its members employ thousands of advanced-practice registered nurses ("APRNs"), including hundreds of Certified Registered Nurse Anesthetists ("CRNAs"). Overruling or destabilizing this Court's decision in *Byrd v. Marion General Hospital*, 202 N.C. 337, 162 S.E. 738 (1932), which defines the scope of liability for these nurses, would have a number of profound effects.

NCHA's view is that expanding a CRNA's role to require the CRNA to challenge the direction of a supervising physician or face liability for that physician's decisions threatens to jeopardize patient care. The current approach encourages *input* from CRNAs and other APRNs into a physician's ultimate decision, but recognizes that in making life-or-death decisions there must be a chain of command, with only one practitioner in charge. APRNs are educated and trained professionals vital to our healthcare system and patients—especially critical-care patients—benefit from their collaboration with physicians. Many of NCHA's members have crafted policies to promote this patient-centric approach to care. The *Byrd* doctrine promotes this robust exchange of information while still placing the final treatment decision appropriately in the physician's hands.

Amicus Participation NCHA is Desirable

Amicus curiae participation by NCHA will permit this Court to better understand the position of hospitals and health systems across North Carolina about the potential recognition of a new cause of action in medical malpractice cases and how it will impact hospitals, physicians employed by or under contract with hospitals, other physicians, and CRNAs.

NCHA regularly monitors and advocates on issues involving hospitals. NCHA has often filed *amicus curiae* briefs on behalf of hospital interests before this Court and the Court of Appeals. *See, e.g.*, Parkes v. Hermann, 376 N.C. 320, 852 S.E.2d 322 (2020) (creation of cause of action for loss of chance); *Anderson v. Assimos*, 365 N.C. 415, 572 S.E.2d 101 (2002) (constitutionality of Rule 9(j)); *Virmani v. Presbyterian Health Services Corporation,* 493 S.E.2d 310 (1997) (release of peer review protected materials); *Knight Publishing Company v. Charlotte Mecklenburg Hospital Authority*, 172 N.C.App. 486, 616 S.E.2d 602 (2005), rev. den. 360 N.C. 176, 626 S.E.2d 299(2005) (compensation disclosure by public hospitals under the public records law); *Estate of Ray v. Forgy,* 227 N.C. App. 24, 744 S.E.2d 468 (2013) (applicability of apparent agency to medical malpractice claim against hospital for physician negligence); and *Hammond v. Saini,* 367 N.C. 607, 766 S.E.2d 590 (2016) (medical peer review privilege relating to root cause analysis).

NCHA's Brief Will Aid the Court

Appellants contend that public policy favors overruling *Byrd*. NCHA's stated mission is to improve the health of North Carolina's communities by advocating for sound public policy. NCHA regularly engages with its members to consider their

needs and to make policy recommendations as appropriate. NCHA can offer a unique perspective as to the reasons why destabilizing *Byrd* would cause significant problems for both healthcare systems and patients across North Carolina.

If any citizens of North Carolina believe that APRNs should be authorized to make treatment decisions—and bear the attendant liability therefor—such a policy proposal must be addressed to the General Assembly, and not the courts. In fact, the scope of CRNA practice, and the relationship between a CRNA's duties and those of an anesthesiologist, have long been matters of legislative decision-making, and the General Assembly has repeatedly declined to expand the scope of practice for CRNAs to include practicing outside the supervision of a licensed anesthesiologist. The same is true for the scopes of practice for other APRNs. Overruling or destabilizing *Byrd* would directly contradict repeated and decisive legislative determinations on this very issue.

Overruling *Byrd* also would effectively establish a new tort for "negligent input" without any guidance about the contours of that tort. There is no indication that any health care provider would benefit from uncertainty about what conduct might impose medical malpractice liability on an APRN. The current regime promotes certainty in roles and facilitates NCHA's policy objectives of helping its members provide efficient and effective patient care to the citizens of North Carolina.

For these reasons, NCHA respectfully requests leave to participate as *amicus curiae* in this appeal.

Respectfully submitted, this 16th day of June 2021.

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No. 331PA20 TWENTY-SIXTH DISTRICT

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BRIEF OF *AMICUS CURIAE* NORTH CAROLINA HEALTHCARE ASSOCIATION

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Acts

Other Authorities

STATEMENT OF INTEREST

Amicus Curiae North Carolina Healthcare Association ("NCHA") represents hospitals and healthcare services in nearly every county in North Carolina. Its members employ thousands of advanced-practice registered nurses, including hundreds of Certified Registered Nurse Anesthetists ("CRNA"s). NCHA is a united voice for hospitals, health systems, and care providers to ensure they can offer premium, cost-effective care to all North Carolinians. NCHA also serves as a resource for members, lawmakers, the business community, and the public on health care issues and policies.

NCHA's vision is clear: A North Carolina where high-quality healthcare is equitable and accessible for all. Given its mission, history, and expertise in matters of health care policy and delivery of quality care to North Carolina's citizens, NCHA has a substantial interest in the issues raised in this case.[1]

INTRODUCTION

Hospitals and health care providers are among the most heavily regulated entities in the country. Laws and regulations dictate virtually every aspect of the delivery of health care. As the practice of nursing has become more specialized—including the introduction of advanced-practice nurses—statutes and administrative regulations have been developed to define the scope of those practices. In North Carolina, unlike other states, the evolution of the CRNA's role has *not* included

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[1] No person or entity—other than amicus curiae, its members, or its counsel—directly or indirectly wrote this brief of contributed money for its preparation. N.C. R. App. P. 28(i)(2).

authority to make prescribing decisions, which the North Carolina General Assembly has limited to licensed physicians. Now, Appellants urge this Court to overrule or limit its decision in *Byrd v. Marion General Hospital*, 202 N.C. 337, 162 S.E. 738 (1932). This amounts to a demand that this Court legislate to extend anesthesia-prescribing rights and duties to CRNAs.

There is no debate that all advanced-practice nurses are educated and trained professionals vital to our healthcare system and that patients—especially critical-care patients—benefit from their collaboration with treating physicians. Indeed, many of NCHA's members have crafted policies to promote this patient-centric approach to care that adhere to legislative enactments defining the relationship between a CRNA's duties and those of an anesthesiologist.

The General Assembly has, time and time again upon examining the issue, declined to expand the scope of practice for CRNAs to include practicing outside the supervision of a licensed anesthesiologist. Yet Appellants ask this Court to contradict the General Assembly's considered decision and to impose potential malpractice liability on a CRNA for an allegedly negligent anesthesia plan developed by a medical doctor who is a board-certified anesthesiologist. If the citizens of North Carolina believe that CRNAs should be authorized to make prescribing decisions—and bear the attendant risk and liability—that proposed change in policy must be addressed to the General Assembly. Only the General Assembly is positioned to gather input and data from myriad perspectives and consider broader implications of such a policy shift on the delivery of health care to North Carolinians. And the General Assembly

can do so through the appropriate legislative process, without the constraints and limits necessarily imposed by the adversary system.

Based on its members' experience and expertise, NCHA believes that expanding a CRNA's responsibilities to include the duty to challenge the direction of a supervising physician or face liability for that physician's decisions threatens to undermine patient care. The current regime encourages *input* from CRNAs and other Advanced Practice Registered Nurses ("APRN"s) into a physician's ultimate decision, but recognizes that when life-or-death decisions must be made, there must be a singular ultimate decisionmaker, and that providing *input* into another's medical decision cannot impute malpractice liability for the final decision itself. The *Byrd* doctrine promotes this robust exchange of information while still placing the final treatment decision appropriately in the physician's hands. At the same time, it affords injured patients recourse through claims against the prescribing physician for an allegedly improper anesthesia care plan, and/or against a CRNA for failing to administer the prescribed anesthesia within the standard of care applicable to the CRNA's defined scope of practice.

ARGUMENT

A. The Scope Of Practice And Resulting Civil Liability Of CRNAs And Other APRNs Is A Determination For The General Assembly.

North Carolina's General Assembly has closely regulated the practice of nursing since 1903, when North Carolina became the first state to pass legislation on nurse licensure. Phoebe Pollitt & Wendy Miller, "North Carolina, Pioneer in American Nursing," 110 AM. J. OF NURSING 70, 70 (Feb. 2010). Thus, for over 115

years, the General Assembly has adopted and modified the state's Nursing Practice Act, codified at N.C. Gen. Stat. § 90-171.19 *et seq.*, to govern the field of nursing. More importantly, the term "nursing" has been defined by statute since 1953, and the North Carolina General Assembly has repeatedly refused to make certain changes to that definition, including those suggested by Appellants. *See North Carolina Nursing History*, APP. ST. UNIV., https://nursinghistory.appstate.edu/major-highlights-nc-laws-related-nursing-practice (last visited Jun. 9, 2021). It is well within the purview of the legislature—not the judiciary—to determine the scope of practice and liability for nurses in the state, and the General Assembly has already spoken to Appellants' position or is in the process of so doing through recent legislation.

1. The Allowable Scope Of Practice For APRNs, Including CRNAs, Is Defined By Statute And Mandates Supervision By And Deference To A Supervising Physician.

The North Carolina General Assembly defines "nursing," codified in the Nursing Practice Act at § 90-171.20 (4), as

> a dynamic discipline which includes the assessing, caring, counseling, teaching, referring and implementing of prescribed treatment in the maintenance of health, prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to; assisting; and sustained, vigilant, and continuous care of those acutely or chronically ill; supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of individuals, groups, and communities; the supervision, teaching, and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services.

Importantly, the Nursing Practice Act goes on to define the "practice of nursing by a registered nurse" as "[c]ollaborating with other health care providers in

determining the appropriate health care for a patient but, subject to the provisions of G.S. 90-18.2, *not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of a licensed physician*." § 90-171.20 (7)(e) (emphasis added). Thus, far from staying silent on the issue, the relevant state statute explicitly denies nurses the ability to *prescribe* medical treatment, unless a doctor supervises.

This unequivocal position limiting the scope of a registered nurse's practice aligns with the North Carolina Medical Board's. In 1992, North Carolina's Board of Nursing ("BON") proposed an administrative rule expanding the scope of practice for CRNAs to include the administration of anesthesia without a doctor's supervision. *See N. Carolina Med. Soc. v. N. Carolina Bd. of Nursing*, 169 N.C. App. 1, 4, 610 S.E.2d 722, 724 (2005) (discussing the history of administrative rule 21 N.C.A.C. 36.0226). Both the Medical Board and North Carolina's Attorney General rejected the BON's proposed rule in favor of continued physician supervision, and a later amendment to the rule prohibited a CRNA from "prescrib[ing] a medical treatment regimen or mak[ing] a medical diagnosis except under the supervision of a licensed physician." *Id.* at 5–9, 610 S.E.2d at 724–26. Indeed, the North Carolina Court of Appeals emphasized that "[p]hysician supervision of nurse anesthetists providing anesthesia care, when that care includes prescribing medical treatment regimens and making medical diagnoses, is a *fundamental patient safety standard* required by North Carolina law." *Id.* at 14, S.E.2d at 729 (emphasis added). The Medical Board's updated 2017 position statement maintains its position that "[a]nesthesia should be

administered by an anesthesiologist or a CRNA *supervised by a physician*." *Position Statements*, N.C. MED. BD. 29 (Jan. 2017), https://www.ncmedboard.org/images/uploads/other_pdfs/PS_Jan2017.pdf (emphasis added).

2. The General Assembly Has Repeatedly Rejected Proposals To Expand The Allowable Practice Of CRNAs And Other APRNs.

The General Assembly, with this explicit definition of "practice of nursing by a registered nurse," has declined to expand or alter this definition for CRNAs. First, it is important to note that a state agency "may not adopt a rule that … enlarges the scope of a profession, occupation, or field of endeavor for which an occupational license is required." N.C. Gen. Stat. § 150B–19(2); *see also In re Trulove,* 54 N.C. App. 218, 221, 282 S.E.2d 544, 546 (1981) ("Administrative regulations must be drafted to comply with statutory grants of power and not vice versa."). Thus, any change to a registered nurse's, or CRNA's, scope of practice should come from the legislature itself. *See also* Appellees' Br. at 50–53.

In 2019, legislators introduced the SAVE Act[2] in an attempt to expand the scope of advanced nursing practice. H.R. 195, Reg. Sess. (N.C. 2019). The North Carolina Nursing Association ("NCNA") describes the bill as one to "grant full-practice authority for Advanced Practice Registered Nurses," which has been the "centerpiece" and one of the "highest priorities" for the NCNA for many years. *SAVE Act*, N.C. NURSES ASSOC., https://ncnurses.org/advocacy/legislative/save-act/ (last

[2] The bill's full title is: An Act to Deliver Safe, Accessible, Value-Directed, and Excellent (SAVE) Health Care Throughout North Carolina by Modernizing Nursing Regulations.

visited Jun. 4, 2021). Yet the General Assembly did not advance the bill out of the committee to which it was assigned for a full vote.

Legislators reintroduced an amended SAVE Act in March 2021. Unlike the current law, the new proposed Act adds a definition of the scope of a CRNA's practice to include "(a) [s]electing, ordering, procuring, *prescribing*, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures. (b) Ordering, *prescribing*, performing, supervising, and interpreting diagnostic studies, procedures, and interventions. [and] (c) Consulting with or referring to other health care providers as warranted by the needs of the patient." S.B. 249, Reg. Sess. (N.C. 2021) (emphasis added). This bill would substantially increase the scope of practice for advanced practice registered nurses, including CRNAs.

This newly reintroduced SAVE Act is currently in committee. Given the General Assembly's historical reluctance to expand the scope of practice of advanced practice registered nurses, consistent with the positions of the Medical Board and Attorney General, the proposed amendment's fate is unsure. In light of the ongoing attention of the General Assembly to this issue, and this Court's longstanding practice of deferring similar policy decisions to the legislative branch, deference to the General Assembly's deliberative process is appropriate here.

B. Delivering The Best Patient Care Requires That There Be A Singular Ultimate Decisionmaker, And That Subordinate Practitioners Defer To The Physician's Judgment Without Fear Of Their Own Liability.

The practice of medicine, particularly in surgical and critical care situations, often requires practitioners to make rapid decisions under high-risk and evolving circumstances. In these situations, it is imperative that roles and responsibilities

among practitioners and staff be clearly delineated, and that there be one provider—usually a licensed physician—responsible for making final decisions about patient care.

The Court of Appeals examined just such a situation in *Clark v. Perry*. There, a pulmonary medicine specialist ordered an emergency blood transfusion for an ICU patient whose hemoglobin level had dropped precipitously. 114 N.C. App. 297, 302, 442 S.E.2d 57, 60 (1994). The specialist was, at the time, unaware that the patient recently had been baptized as a Jehovah's Witness and had signed paperwork upon his hospital admission refusing blood products. *Id.* The patient died of underlying disease just days later, and his widow sued the specialist and the hospital, with the claim against the hospital premised on the allegation that the nurses were negligent in following the transfusion orders from the specialist.

The Court of Appeals rejected the negligence claim against the hospital, noting that the evidence suggested "that had Clark not received a transfusion, his life could have been endangered" and thus it arguably may have constituted malpractice for the hospital's nurses *not* to have followed [the specialist's] order to administer the transfusion to Clark. *Id.* at 313, 442 S.E.2d at 66. Instead, the Court of Appeals reasoned, it the appellant's burden to show that the standard of care for a nurse faced with an emergency situation *required* defiance of the supervising physician's order.

This holding is consistent with *Byrd* and with a model providing the best patient care. As recognized by the North Carolina Medical Board, when a physician is charged with supervising another licensed healthcare practitioner, "[t]he *physician*

must always maintain the *ultimate responsibility* to assure that high quality care is provided to every patient." *Position Statement: Physician supervision of other licensed health care practitioners*, N.C. MED. BD (Jul. 2007; am. Nov. 2015), https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/physician_supervision_of_other_licensed_health_care_practitioners (last visited Jun. 14, 2021) (emphasis added). As Appellants note, quality health care often is provided in teams, but when critical decisions need to be made, there must be *one* individual with ultimate authority: the pilot in command. *See, e.g.*, Roy F. Baumeister et al., "Who's in Charge Here?: Group Leaders Do Lend Help in Emergencies," PERSONALITY & SOC. PSYCH. BULL., Mar. 1988 at 17 (finding that a designated leader is more likely to respond to an emergency than individuals in a group without a designated leader). The General Assembly has vested that responsibility in licensed physicians.

C. North Carolina Jurisprudence Supports The Lower Courts' Decisions In This Case, Which Strike The Right Balance.

Appellants insist that adherence to *Byrd* is inconsistent with current standards of care applicable to APRNs. Not so. *Byrd* simply recognizes the supervisory authority of physicians while still allowing an injured plaintiff to sue an APRN based on decisions made within his or her statutory authority.

A patient who claims he was harmed by an anesthesiologist's prescribing decision certainly may have a cause of action against that physician for medical negligence—just like the negligence claim Appellants pursued in this case years ago.

If the plaintiff can prove that a CRNA breached the standard of care by improperly administering drugs prescribed by the physician that were obviously negligent, the plaintiff can seek recovery against the physician for his instructions and from the subordinate staff for adhering to them. *See Blanton v. Moses H. Cone Mem. Hosp.*, 319 N.C. 372, 376, 354 S.E.2d 455, 458 (1987). What a litigant cannot do, however, is seek recovery for a prescribing decision from both the anesthesiologist (who has prescribing authority) and the CRNA (who does not) based on the allegation that the prescribing decisions were merely negligent. *See Daniels v. Durham Hosp. Corp.*, 171 N.C. App. 535, 540, 615 S.E.2d 60, 63 (2005) (such situations involve "a medical dispute regarding diagnosis and treatment that nurses are not qualified to resolve"); *Paris v. Krietz*, 75 N.C. App. 365, 380, 331 S.E.2d 234, 245 (1985) (a nurse's "duty to disobey [the supervising physician] does not extend to situations where there is a difference of medical opinion").

Moreover, North Carolina law already provides a mechanism for holding nurses accountable when they fail to recognize a doctor's potentially dangerous order. The standard is one of a reasonable person—a nurse is subject to liability if he fails to recognize that the "order was so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result to the patient from the execution of such order or performance of such direction." *Byrd*, 202 N.C. 337, 162 S.E. at 740. The North Carolina Court of Appeals has time and again reaffirmed this standard, acknowledging that "[w]hile medical practices, standards, and expectations have certainly changed since 1932 and even since 1987, this Court is not free to alter

the standard set forth in *Byrd* and *Blanton*." *Daniels*, 171 N.C. App. at 539, 615 S.E.2d at 63.

Appellants correctly note that in some states, CRNAs are authorized by law to prescribe anesthesia drugs and work independently of a supervising anesthesiologist. But other states, like North Carolina, allow only a licensed physician to make prescribing decisions, and their courts readily adhere to the same rule *Byrd* adopted. This includes many cases that have arisen since the "expansion" of duties of advanced-practice nurses that Appellants contend justify legislating from the bench a new standard of care. *See* Appellees' Br. at 34–37.

D. Appellants Would Effectively Create An Entirely New Tort For "Negligent Input" Specific To Certain Nursing Professionals Without Clear Guidance About What Acts Or Omissions Would Subject A Practitioner To Liability.

Because CRNAs are not the ultimate decisionmakers in selecting and prescribing anesthetics and are not permitted by law to prescribe anesthesia themselves, the expansion of medical malpractice liability that Appellants advocate must be grounded in an allegation that the CRNA breached some undefined standard of care by failing to provide "reasonable input" into the anesthesiologist's choice of drugs. In so doing, Appellants invite this Court to create a new cause of action entirely specific to a subset of nurses, without the ability to define what conduct would satisfy a CRNA's "duty" to provide input into a prescribing decision or how to determine whether a CRNA provided such input forcefully enough if a physician elects a treatment course other than the one the CRNA suggested. The Court should decline that invitation.

1. The Judicial Creation Of A New Tort For "Negligent Input" Would Infringe Upon The Role And Duties Of The Legislative Branch

As this Court has held, it is for the General Assembly, not the judicial branch, to create new causes of action:

> Our province is to enforce the law as we find it and to determine the existence or nonexistence of such a cause of action by the state of the law as it now exists. In doing so, we are not permitted to find a way out for plaintiffs by engaging in judicial empiricism.

Henson v. Thomas, 231 N.C. 173, 176, 56 S.E.2d 432, 434 (1949); *see also Elliott v. Elliott*, 235 N.C. 153, 158, 69 S.E.2d 224, 227 (1952) ("[T]his Court does not make the law. This is the province of the General Assembly."). This is particularly true when faced with what Appellants acknowledge is primarily an issue of public policy.

> The General Assembly is the "policy-making agency" because it is a far more appropriate forum than the courts for implementing policy-based changes to our laws. This Court has continually acknowledged that, unlike the judiciary, the General Assembly is well equipped to weigh all the factors surrounding a particular problem, balance competing interests, provide an appropriate forum for a full and open debate, and address all of the issues at one time.

Rhyne v. K-Mart Corp., 358 N.C. 160, 169-70, 594 S.E.2d 1, 8-9 (2004) (citations omitted); *see also Gardner v. North Carolina State Bar*, 316 N.C. 285, 293, 341 S.E.2d 517, 522 (1986) (the Court's duty is to interpret the law as it exists, because "questions as to public policy are for legislative determination").

When considering such policy questions, the General Assembly is uniquely positioned to hold hearings, collect data, form opinions, and debate the effect of the proposed change on *all* North Carolina citizens and stakeholders. *See Black v.*

Littlejohn, 312 N.C. 626, 635, 325 S.E.2d 469, 476 (1985) (recognizing the legislature's ability to use outside information to "strike a delicate balance" among competing policy rationales when considering medical malpractice statutes). The General Assembly's ability to gather professional and academic recommendations, consider public sentiment, and weigh the effects of the proposed change in the law is precisely why decisions about the scope of medical malpractice liability are vested in the legislative branch.

2. The General Assembly Has Repeatedly Expressed Its Intent To Legislatively Define The Scope Of Medical Malpractice Actions.

As this Court has recognized, for at least 45 years, the General Assembly has repeatedly and decisively acted to define the scope of medical malpractice liability, belying any indication that it would support expanding liability in this context.

In 1976, the North Carolina General Assembly enacted several laws governing professional malpractice claims in a sweeping reform of the medical malpractice landscape. *See* An Act to Revise and Provide for Procedural and Substantive Laws Governing Claims for Professional Malpractice: To Revise the Statute of Limitations for Adults and Minors; To Provide for a Standard of Care, a Doctrine of Informed Consent, an Extension of the Good Samaritan Law, and the Elimination of the Ad Damnum Clause, 1975-76 N.C. Sess. L., ch. 977 §§ 1-2. Among other provisions, these laws created a statute of repose for medical negligence claims, codified the community standard of care requirement applicable to physicians, and limited lawsuits based on alleged lack of informed consent. *See* N.C. Gen. Stat. §§ 1-15(c), 90-21.12(a), 90-21.13. Several years after these reforms, this Court recognized the new laws as

representative of the General Assembly's policy goal of "decreas[ing] the number and severity of medical malpractice claims in an effort to decrease the cost of medical malpractice insurance." *Black*, 312 N.C. at 633, 325 S.E.2d at 475. The reforms were crafted through months of study, including consideration of a report by the legislative-created North Carolina Professional Liability Insurance Study Commission. *Id.* In *Black*, this Court carefully reviewed the General Assembly's adoption or rejection of each of the Commission's recommendations in discerning legislative intent. *Id.* at 631–36, 325 S.E.2d at 473–477. The General Assembly's repeated rejections of proposals to enact the change advocated by Appellants merit the same deference.

Then, in 1995, the General Assembly codified new requirements for expert testimony in medical malpractice actions. Rule 9(j) of the Rules of Civil Procedure now requires that a medical malpractice complaint must specifically allege that the patient's care had been reviewed by a qualified expert before filing, and further requires that standard-of-care expert testimony be excluded unless the proffered expert spends the majority of his or her professional time working within the medical specialty at issue. *See* An Act to Prevent Frivolous Medical Malpractice Actions by Requiring that Expert Witnesses in Medical Malpractice Cases Have Appropriate Qualifications to Testify on the Standard of Care at Issue and to Require Expert Witness Review as a Condition of Filing a Medical Malpractice Action, 1995-96 N.C. Sess. L., ch. 30 §§ 1-2 (codified at N.C. Gen. Stat. §§ 1A-1, Rule 9(j) and 8C-1, Rule 702). This Court recognized that the General Assembly's intent was to subject

medical malpractice plaintiffs to more "stringent" standards for filing and proving their claims. *See Thigpen v. Ngo*, 355 N.C. 198, 203–04, 558 S.E.2d 162, 166 (2002). In 2011, the General Assembly amended the Rule 9(j) requirements and enacted a number of other reforms specific to medical malpractice cases, including shortening the limitations period for minors, imposing a clear-and-convincing evidentiary burden of proof on actions challenging emergency care, and establishing a cap on non-economic damages. *See* An Act to Reform the Laws Relating to Money Judgment Appeal Bonds, Bifurcation of Trials in Civil Cases, 2011-12 N.C. Sess. L., ch. 400 (cited provisions codified at N.C. Gen. Stat. §§ 1-17, 90-21.12(b), and 90-21.19).

The General Assembly's repeated enactment of medical malpractice reform statutes show that it is not only ready and willing to act when it sees the need to legislate, but it also demonstrates the General Assemby's command of the boundaries of medical malpractice liability. That expression of legislative intent should be afforded deference.

3. A New Cause Of Action For "Negligent Input" Would Be Impossibly Speculative.

Even if this Court were to accept Appellants' position, and impose upon North Carolina's CRNAs potential malpractice liability for alleged negligence in the selection of anesthesia, that would not change the fact that CRNAs are not legally permitted to prescribe anesthesia drugs. In other words, Appellants urge CRNA liability for providing inadequate, incorrect, or even inarticulate input into a decision that the CRNA cannot make, and which ultimately must be made by a supervising licensed physician.

Appellants advocate for this new standard of care, but provide no guideposts by which this Court may define the contours of a CRNA's duty to provide input to the anesthesiologist's prescribing decision. Could the CRNA subject himself to potential liability only if he actively participated in a discussion with the anesthesiologist, or would staying silent also breach this new standard of care? What if the anesthesiologist did not solicit the CRNA's opinion—would the CRNA be duty-bound to speak up? How vociferously must the CRNA advocate for a particular drug to meet the standard of care? These are all questions for which there is no easy answer in the law, in hospital regulations, in textbooks, or in practice, because it would be an entirely novel imposition of a legal duty upon a nursing professional who must be supervised by a licensed physician.

Appellants also fail to address the obvious issues with pleading and proving proximate cause in a critical-care situation in which a physician would be free to accept or reject the input of a CRNA. How would the plaintiff or defendant establish what an anesthesiologist would have done if the CRNA suggested different drugs, or advocated more forcefully for an alternate anesthesia plan? Would plaintiffs bear the burden of obtaining a Rule 9(j) expert to opine not only that the CRNA breached the standard of care to provide anesthesia input but also that the anesthesiologist would have acted differently but for that breach? How would the expert possibly know?

These unanswered questions illustrate how the adoption of an entirely new cause of action applicable to APRNs would not only expand medical malpractice liability beyond the clear bounds drawn by the General Assembly but also would

create substantial uncertainty in defining the new duty of care owed by an APRN. In practice, an APRN must defer to the judgment of the supervising physician, and failure to do so could put patients' lives at stake. Must an APRN interrupt a critical care situation to challenge a physician's directive, under the threat of tort liability if he does not do so? This Court should avoid the invitation to disrupt the legally mandated roles of supervising physician and nursing staff and decline to expand medical malpractice liability to impose duties on nurses that are at odds with the statutory limits on their practices.

NCHA advocates for quality and affordable healthcare for the residents of our State, including an environment that responsibly balances our liability system with the demands on our State's health care providers and hospitals to provide quality healthcare. Creating a cause of action for "negligent input" applicable to a subset of nurses would increase defensive medicine costs, create uncertainty for hospitals and providers as to liability, particularly in critical care and emergency medicine situations, and will likely lead to higher insurance premiums and healthcare costs.

CONCLUSION

The decisions of the trial court and the Court of Appeals in this case are consistent with the law, appropriately deferential to the General Assembly's policy-making authority, and, most importantly, protective of the most critically ill patients in this State. For the reasons set forth above, *amicus* North Carolina Healthcare Association, on behalf of its member providers, respectfully urges this Court to affirm the decisions below.

Respectfully submitted, this 16th day of June 2021.

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that they served a copy of the foregoing *Motion of The North Carolina Healthcare Association for Leave to File Amicus*

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