

Examples of Medical Malpractice

- Misdiagnosis of, or failure to diagnose, a disease or medical condition
- Failure to provide appropriate treatment for a medical condition
- Unreasonable delay in treating a diagnosed medical condition

Danger Zones

- Patient doesn't like you
- Records not complete, factual, legible, detailed, etc.
- Informed consents not given the time and consideration they deserve
- Improperly altering a record
- Not tracking lab or referrals
- Not being careful what you say, patients remember
- Language access

Theories of Liability for Patient Care

- Negligence – a legal theory in which a patient can file a civil lawsuit and recover damages. To win such a case, the plaintiff (patient) must prove the physician did not exercise reasonable care. The defendant (the physician) will owe monetary damages to compensate the plaintiff for the injury. There are three elements of the case:
 - The physician owed the patient a duty of care
 - The physician breached that duty
 - The patient was harmed as a result of the physician's actions or failure to act
- Duty of care – this is established from the existence of a physician-patient relationship
 - Hypothetical: Does a physician who is performing a fitness for duty exam for an employer have to reveal any dangerous conditions he or she may find?
 - Answer: Courts are divided, so take a look at the contract. Is the duty to the employer or the employee?

- Hypothetical: Is there a duty of care in the case of a telephone screening?
 - Answer: Again, courts are divided. Evaluate practice protocols very carefully.
- Standard of care – this is the scope of the physician’s duties to the patient. Standard of care is defined by the level of care that would be provided by a reasonable physician (or other health care provider) under similar circumstances in similar geographic regions.
 - The standard of care is carefully evaluated on the specific circumstances of the case.
 - Other contributing factors may include
 - Managed care contracts - they may raise the standard of care
 - Whether a law or regulation was violated
 - Whether there were clinical practice guidelines in place and whether they were followed.
 - Whether the treatment was consistent with medical literature
 - Do marketing materials imply a guarantee of a good result?
- Causation – A patient must prove that the physician was the proximate cause of the injury. This means that but for the physician’s actions or inaction, the same result would not have occurred. This can sometimes be hard to prove.
 - Ex. Failure to diagnose: A patient must prove that had the physician diagnosed cancer earlier, he or she would have had a different outcome.
- Sources of Liability for the Practice
 - Informed consent – physicians are required to explain the risks, benefits, and alternatives connected with a procedure
 - Patient’s diagnosis
 - Nature and purpose of procedure
 - Risks and consequences
 - Potential benefits and probability of success if known
 - Feasible alternatives
 - Prognosis if procedure is not undertaken
 - Prescribing practices
 - Possible drug interactions
 - Drug allergies
 - Legibility of prescription
 - Patient education on side effects
 - Compliance with scope of practice laws (PAs and NPs)
 - Policies addressing refills

Monthly Medical-Legal Roundtable – Medical Malpractice Danger Zones, October 2007
Presented by Heather Skelton, Attorney at Law

- Scope of practice laws – acting within licensure and proper oversight
- Failure to follow-up – implement administrative procedures to prevent gaps in patient care
 - Missed appointments
 - Referrals
 - Abnormal test results
 - Compliance with prescribed treatment
- Utilization Review – physicians need to exercise independent judgment with respect to denied procedures. Inform the patient, use the appeals process.
- Referral liability – refer things out if the practice is not equipped to treat the patient
- Abandonment – 30 days of emergency care after notification of dismissal

Statutes

- Medical Malpractice Actions
- Statute of Limitations
 - 3 years from the date of the last act or within one year of the date when the injury was or should have been discovered, but not more than 4 years from the date of the last act of defendant
 - Foreign objects – 1 year from date of discovery, but no more than 10 years total
 - Wrongful death – two years
 - Minor – child may bring suit anytime before 19th birthday
- Contributory negligence bars recovery
- Punitive damages are limited to 3 times compensatory or \$250,000, whichever is greater
- New Voluntary Arbitration of Health Care Claims Act \$1m cap, 10 months, 2 weeks

Article 1B.

Medical Malpractice Actions.

§ 90–21.11. Definitions.

As used in this Article, the term "health care provider" means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital or a nursing home; or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home.

As used in this Article, the term "medical malpractice action" means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider. (1975, 2nd Sess., c. 977, s. 4; 1987, c. 859, s. 1; 1995, c. 509, s. 135.2(o).)

§ 90–21.12. Standard of health care.

In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action. (1975, 2nd Sess., c. 977, s. 4.)

§ 90–21.12A. Nonresident physicians.

A patient may bring a medical malpractice claim in the courts of this State against a nonresident physician who practices medicine or surgery by use of any electronic or other media in this State. (1997–514, s. 2.)

§ 90–21.13. Informed consent to health care treatment or procedure.

(a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient where:

- (1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and
- (2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards

inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; or

(3) A reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this subsection.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact.

(c) A valid consent is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

(d) No action may be maintained against any health care provider upon any guarantee, warranty or assurance as to the result of any medical, surgical or diagnostic procedure or treatment unless the guarantee, warranty or assurance, or some note or memorandum thereof, shall be in writing and signed by the provider or by some other person authorized to act for or on behalf of such provider.

(e) In the event of any conflict between the provisions of this section and those of G.S. 35A-1245 and Articles 1A and 19 of Chapter 90, the provisions of those Articles shall control and continue in full force and effect. (1975, 2nd Sess., c. 977, s. 4; 2003-13, s. 5.)

§ 90-21.14. First aid or emergency treatment; liability limitation.

(a) Any person, including a volunteer medical or health care provider at a facility of a local health department as defined in G.S. 130A-2 or at a nonprofit community health center or a volunteer member of a rescue squad, who receives no compensation for his services as an emergency medical care provider, who renders first aid or emergency health care treatment to a person who is unconscious, ill or injured,

(1) When the reasonably apparent circumstances require prompt decisions and actions in medical or other health care, and

(2) When the necessity of immediate health care treatment is so reasonably apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the person,

shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the person rendering the treatment.

(a1) Recodified as § 90-21.16 by Session Laws 2001-230, s. 1(a).

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his business or profession. Services provided by a volunteer health care provider who receives no compensation for his services and who renders first aid or emergency treatment to members of athletic teams are deemed not to be in the normal and ordinary course of the volunteer health care provider's

business or profession.

(c) In the event of any conflict between the provisions of this section and those of G.S. 20-166(d), the provisions of G.S. 20-166(d) shall control and continue in full force and effect. (1975, 2nd Sess., c. 977, s. 4; 1985, c. 611, s. 2; 1989, cc. 498, 655; 1991, c. 655, s. 1; 1993, c. 439, s. 1; 1995, c. 85, s. 1; 2000-5, s. 4; 2001-230, ss. 1(a), 2.)

§ 90-21.15. Emergency treatment using automated external defibrillator; immunity.

(a) It is the intent of the General Assembly that, when used in accordance with this section, an automated external defibrillator may be used during an emergency for the purpose of attempting to save the life of another person who is in or who appears to be in cardiac arrest.

(b) For purposes of this section:

- (1) "Automated external defibrillator" means a device, heart monitor, and defibrillator that meets all of the following requirements:
 - a. The device has received approval from the United States Food and Drug Administration of its premarket notification filed pursuant to 21 U.S.C. § 360(k), as amended.
 - b. The device is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia and is capable of determining, without intervention by an operator, whether defibrillation should be performed.
 - c. Upon determining that defibrillation should be performed, the device automatically charges and requests delivery of, or delivers, an electrical impulse to an individual's heart.
- (2) "Person" means an individual, corporation, limited liability company, partnership, association, unit of government, or other legal entity.
- (3) "Training" means a nationally recognized course or training program in cardiopulmonary resuscitation (CPR) and automated external defibrillator use including the programs approved and provided by the:
 - a. American Heart Association.
 - b. American Red Cross.

(c) The use of an automated external defibrillator when used to attempt to save or to save a life shall constitute "first-aid or emergency health care treatment" under G.S. 90-21.14(a).

(d) The person who provides the cardiopulmonary resuscitation and automated external defibrillator training to a person using an automated external defibrillator, the person responsible for the site where the automated external defibrillator is located when the person has provided for a program of training, and a North Carolina licensed physician writing a prescription without compensation for an automated external defibrillator whether or not required by any federal or state law, shall be immune from civil liability arising from the use of an automated external defibrillator used in accordance with subsection (c) of this section.

(e) The immunity from civil liability otherwise existing under law shall not be diminished by the provisions of this section.

(f) Nothing in this section requires the purchase, placement, or use of automated external defibrillators by any person, entity, or agency of State, county, or local government. Nothing in this section applies to a product's liability claim against a manufacturer or seller as defined in G.S. 99B-1.

(g) In order to enhance public health and safety, a seller of an automated external defibrillator shall notify the North Carolina Department of Health and Human Services, Division of Facilities Services, Office of Emergency Medical Services of the existence, location, and type of automated external defibrillator. (2000-113, s. 1.)

§ 90-21.16. Volunteer health care professionals; liability limitation.

(a) This section applies as follows:

- (1) Any volunteer medical or health care provider at a facility of a local health department or at a nonprofit community health center,
- (2) Any volunteer medical or health care provider rendering services to a patient referred by a local health department as defined in G.S. 130A-2(5) or nonprofit community health center at the provider's place of employment,
- (3) Any volunteer medical or health care provider serving as medical director of an emergency medical services (EMS) agency,
- (4) Any retired physician holding a "Limited Volunteer License" under G.S. 90-12(d), or
- (5) Any volunteer medical or health care provider licensed or certified in this State who provides services within the scope of the provider's license or certification at a free clinic facility,

who receives no compensation for medical services or other related services rendered at the facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services rendered to the patient referred by a local health department or nonprofit community health center at the provider's place of employment shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the rendering of the services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services. The free clinic, local health department facility, nonprofit community health center, or agency shall use due care in the selection of volunteer medical or health care providers, and this subsection shall not excuse the free clinic, health department facility, community health center, or agency for the failure of the volunteer medical or health care provider to use ordinary care in the provision of medical services to its patients.

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his or her business or profession. Services provided by a medical or health care provider who receives no compensation for his or her services and who voluntarily renders such services at facilities of free clinics, local health departments as defined in G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or health care provider's business or profession.

(c) As used in this section, a "free clinic" is a nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative costs and that maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section.

(1991, c. 655, s. 1.; 1993, c. 439, s. 1; 1995, c. 85, s. 1; 2000–5, s. 4; 2001–230, ss. 1(a), 1 (b).)

§ 90–21.17. Portable do not resuscitate order.

(a) It is the intent of this section to recognize a patient's desire and right to withhold cardiopulmonary resuscitation to avoid loss of dignity and unnecessary pain and suffering through the use of a portable do not resuscitate ("DNR") order. This section establishes an optional and nonexclusive procedure by which a patient or the patient's representative may exercise this right.

(b) A physician may issue a portable DNR order for a patient:

- (1) With the consent of the patient;
- (2) If the patient is a minor, with the consent of the patient's parent or guardian; or
- (3) If the patient is not a minor but is incapable of making an informed decision regarding consent for the order, with the consent of the patient's representative.

The physician shall document the basis for the order in the patient's medical record.

(c) The Department of Health and Human Services shall develop a portable DNR order form. The official form shall include fields for the name of the patient; the name, address, and telephone number of the physician; the signature of the physician; and other relevant information. The form may be approved by reference to a standard form that meets the requirements of this subsection. For purposes of this section, the "patient's representative" means an individual from the list of persons authorized to consent to the withholding of extraordinary care pursuant to G.S. 90–322 or an individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

(d) No physician, emergency medical professional, hospice provider, or other health care provider shall be subject to criminal prosecution, civil liability, or disciplinary action by any professional licensing or certification agency for withholding cardiopulmonary resuscitation from a patient in good faith reliance on an original DNR form adopted pursuant to subsection (c) of this section, provided that (i) there are no reasonable grounds for doubting the validity of the order or the identity of the patient, and (ii) the provider does not have actual knowledge of the revocation of the portable DNR order. No physician, emergency medical professional, hospice provider, or other health care provider shall be subject to criminal prosecution, civil liability, or disciplinary action by any professional licensing or certification agency for failure to follow a DNR form adopted pursuant to subsection (c) of this section if the provider had no actual knowledge of the existence of the DNR order.

(e) A health care facility may develop policies and procedures that authorize the facility's provider to accept a portable DNR order as if it were an order of the medical staff of that facility. This section does not prohibit a physician in a health care facility from issuing a written order, other than a portable DNR order, not to resuscitate a patient in the event of cardiac or respiratory arrest, in accordance with acceptable medical practice and the facility's policies.

(f) Nothing in this section shall affect the validity of portable DNR forms in existence prior to the effective date of this section. (2001–445, s. 1.)

§ 90–21.18. Medical directors; liability limitation.

A medical director of a licensed nursing home shall not be named a defendant in an action

pursuant to this Article except under any of the following circumstances:

- (1) Where allegations involve a patient under the direct care of the medical director.
- (2) Where allegations involve willful or intentional misconduct, recklessness, or gross negligence in connection with the failure to supervise, or other acts performed or failed to be performed, by the medical director in a supervisory or consulting role. (2004-149, s. 2.9.)

§ 90-21.19. Reserved for future codification purposes.

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Breaking News--Average or Poor Hospitals Linked to Excess Medicare Mortality

October 16, 2006

Breaking News--In a new report by Healthgrades, a for-profit health care quality rating service, more than 300,000 Medicare patients died from 2003 to 2005 because they were hospitalized in institutions that were rated average or poor, according to MedPage.com.

Finding from the report include that a typical Medicare patient had about a 49 percent lower risk of dying in a top-rated hospital last year than in a hospital that was rated average by HealthGrades.

The report estimates that if all hospitals that treat Medicare patients performed as well as the five-star rated best hospitals, "302,403 Medicare lives could have been saved from 2003 to 2005."

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\$53 million verdict — brake mechanic suffering from mesothelioma

\$13.5 million verdict — one of the very first Vioxx trial cases

\$15 million settlement — man wound up a paraplegic due to negligent hospital care

\$37 million verdict — 2 asbestos lung cancer plaintiffs

\$47 million verdict — boilermaker who died from mesothelioma

\$75 million verdict — historic consolidated trial involving men who had worked at the Brooklyn Navy Yard in the 1940s and 1950s

\$12.7 million verdict — iron worker who was injured due to unsafe working conditions

\$64.65 million award — 4 asbestos plaintiffs

\$17.5 million — consolidated trial of 5 mesothelioma victims

\$25 million jury verdict — brake reliner

\$5.8 million settlement — failure to perform timely C-Section

\$30 million verdict — 7 former power-plant workers suffering from asbestos-related illnesses

\$6 million settlement — pediatric malpractice case

\$14 million consolidated verdict — 5 asbestos-related cancer suits: shipyards/powerhouses/construction

\$8 million settlement — obstetrical

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What medical procedure were you

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malpractice resulted in neurological deficits

\$3.5 million — 2 asbestos exposure cases

\$600,000 settlement — motor vehicle negligence resulting in serious injury

\$44 million verdict — 5 asbestos cases, including \$11.6 million awarded to widow of sheet metal worker who died of mesothelioma

\$1.6 million settlement — suicide after premature hospital discharge

\$2.6 million settlement — ill-fitting prosthesis caused decubitus ulcers

\$1.5 million settlement — construction worker fell off elevated train tracks

\$750,000 settlement — defective construction equipment resulted in serious injury to worker

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**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2007**

**SESSION LAW 2007-541
HOUSE BILL 1671**

AN ACT TO PROVIDE FOR THE ARBITRATION OF CLAIMS FOR PERSONAL INJURY OR WRONGFUL DEATH BASED ON ALLEGED NEGLIGENCE IN THE PROVISION OF HEALTH CARE, UPON THE AGREEMENT OF ALL PARTIES.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1H.

"Voluntary Arbitration of Negligent Health Care Claims.

"§ 90-21.60. Voluntary arbitration; prior agreements to arbitration void.

(a) Application of Article. – This Article applies to all claims for damages for personal injury or wrongful death based on alleged negligence in the provision of health care by a health care provider as defined in G.S. 90-21.11 where all parties have agreed to submit the dispute to arbitration under this Article in accordance with the requirements of G.S. 90-21.61.

(b) When Agreement Is Void. – Except as provided in G.S. 90-21.61(a), any contract provision or other agreement entered into prior to the commencement of an action that purports to require a party to elect arbitration under this Article is void and unenforceable. This Article does not impair the enforceability of any arbitration provision that does not specifically require arbitration under this Article.

"§ 90-21.61. Requirements for submitting to arbitration.

(a) Before Action Is Filed. – Before an action is filed, a person who claims damages for personal injury or wrongful death based on alleged negligence in the provision of health care by a health care provider as defined in G.S. 90-21.11 and the allegedly negligent health care provider may jointly submit their dispute to arbitration under this Article by, acting through their attorneys, filing a stipulation to arbitrate with the clerk of superior court in the county where the negligence allegedly occurred. The filing of such a stipulation provides jurisdiction to the superior court to enforce the provisions of this Article and tolls the statute of limitations.

(b) Once Action Is Filed. – The parties to an action for damages for personal injury or wrongful death based on alleged negligence in the provision of health care by a health care provider as defined in G.S. 90-21.11 may elect at any time during the pendency of the action to file a stipulation with the court in which all parties to the action agree to submit the dispute to arbitration under this Article.

(c) Declaration Not to Arbitrate. – In the event that the parties do not unanimously agree to submit a dispute to arbitration under subsection (b) of this section, the parties shall file a declaration with the court prior to the discovery scheduling conference required by G.S. 1A-1, Rule 26(f1).

The declaration shall state that the attorney representing the party has presented the party with a copy of the provisions of this Article, that the attorneys representing the parties have discussed the provisions of this Article with the parties and with each other, and that the parties do not unanimously agree to submit the dispute to arbitration under this Article. The declaration is without prejudice to the parties' subsequent agreement to submit the dispute to arbitration.

"§ 90-21.62. Selection of arbitrator.

(a) Selection by Agreement. – An arbitrator shall be selected by agreement of all the parties no later than 45 days after the date of the filing of the stipulation where the parties agreed

to submit the dispute to arbitration under this Article. The parties may agree to select more than one arbitrator to conduct the arbitration. The parties may agree in writing to the selection of a particular arbitrator or particular arbitrators as a precondition for a stipulation to arbitrate.

(b) Selection From List. – If all the parties are unable to agree to an arbitrator by the time specified in subsection (a) of this section, the arbitrator shall be selected from emergency superior court judges who agree to be on a list maintained by the Administrative Office of the Courts. Each party shall alternately strike one name on the list, and the last remaining name on the list shall be the arbitrator. The emergency superior court judge serving as an arbitrator would be compensated at the same rate as an emergency judge serving in superior court.

"§ 90–21.63. Witnesses; discovery; depositions; subpoenas.

(a) General Conduct of Arbitration; Experts. – The arbitrator may conduct the arbitration in such manner as the arbitrator considers appropriate so as to aid in the fair and expeditious disposition of the proceeding subject to the requirements of this section and G.S. 90–21.64. Except as provided in subsection (b) of this section, each side shall be entitled to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert.

(b) Experts in Case of Multiple Parties. – Where there are multiple parties on one side, the arbitrator shall determine the number of experts that are allowed based on the minimum number of experts necessary to ensure a fair and economic resolution of the action.

(c) Discovery. – Notwithstanding G.S. 90–21.64(a)(1), unless the arbitrator determines that exceptional circumstances require additional discovery, each party shall be entitled to all of the following discovery from any other party:

(1) Twenty-five interrogatories, including subparts.

(2) Ten requests for admission.

(3) Whatever is allowed under applicable court rules for:

a. Requests for production of documents and things and for entry upon land for inspection and other purposes; and

b. Requests for physical and mental examinations of persons.

(d) Depositions. – Each party shall be entitled to all of the following depositions:

(1) Depositions of any party and any expert that a party expects to call as a witness. – Except by order of the arbitrator for good cause shown, the length of the deposition of a party or an expert witness under this subdivision shall be limited to four hours.

(2) Depositions of other witnesses. – Unless the arbitrator determines that exceptional circumstances require additional depositions, the total number of depositions of persons under this subdivision shall be limited to five depositions per side, each of which shall last no longer than two hours and for which each side shall be entitled to examine for one hour.

(e) Subpoenas. – An arbitrator may issue a subpoena for the attendance of a witness and for the production of records and other evidence at any hearing and may administer oaths. A subpoena shall be served in the manner for service of subpoenas in a civil action and, upon the motion to the court by a party to the arbitration proceeding or by the arbitrator, enforced in the manner for enforcement of subpoenas in a civil action.

"§ 90–21.64. Time limitations for arbitration.

(a) Time Frames. – The time frames provided in this section shall run from the date of the filing of the stipulation where the parties agreed to submit the dispute to arbitration under the Article. Any arbitration under this Article shall be conducted according to the time frames as follows:

(1) Within 45 days, the claimant shall provide a copy to the defendants of all relevant medical records. Alternatively, the claimant may provide to the defendants a release, in compliance with the federal Health Insurance Portability and Accountability Act, for all relevant medical records, along with the names and addresses of all health care providers who may have possession, custody, or control of the relevant medical records. The provisions of this subdivision shall not limit discovery conducted pursuant to G.S. 90–21.63(c).

(2) Within 120 days, the claimant shall disclose to each defendant the name and curriculum vitae or other documentation of qualifications of any expert the

claimant expects to call as a witness.

(3) Within 140 days, each defendant shall disclose to the claimant the name and curriculum vitae or other documentation of qualifications of any expert the defendant expects to call as a witness.

(4) Within 160 days, each party shall disclose to each other party the name and curriculum vitae or other documentation of qualifications of any rebuttal expert the party expects to call as a witness.

(5) Within 240 days, all discovery shall be completed.

(6) Within 270 days, the arbitration hearing shall commence.

(b) Scheduling Order. – The arbitrator shall issue a case scheduling order in every proceeding specifying the dates by which the requirements of subdivisions (2) through (6) of subsection (a) of this section shall be completed. The scheduling order also shall specify a deadline for the service of dispositive motions and briefs.

(c) Public Policy as to When Hearings Begin. – It is the express public policy of the General Assembly that arbitration hearings under this Article be commenced no later than 10 months after the parties file the stipulation where the parties agreed to submit the dispute to arbitration under this Article. The arbitrator may grant a continuance of the commencement of the arbitration hearing only where a party shows that exceptional circumstances create an undue and unavoidable hardship on the party or where all parties consent to the continuance.

"§ 90–21.65. Written decision by arbitration.

(a) Issuing the Decision. – The arbitrator shall issue a decision in writing and signed by the arbitrator within 14 days after the completion of the arbitration hearing and shall promptly deliver a copy of the decision to each party or the party's attorneys.

(b) Limit on Damages. – The arbitrator shall not make an award of damages that exceeds a total of one million dollars (\$1,000,000) for any dispute submitted to arbitration under this Article, regardless of the number of claimants or defendants that are parties to the dispute.

(c) Finding if Damages Awarded. – If the arbitrator makes an award of damages to the claimant, the arbitrator shall make a finding as to whether the injury or death was caused by the negligence of the defendant.

(d) Paying the Arbitrator. – The fees and expenses of the arbitrator shall be paid equally by the parties.

(e) Attorneys' Fees and Costs. – Each party shall bear its own attorneys' fees and costs.

"§ 90–21.66. Judgment by court.

After a party to the arbitration proceeding receives notice of a decision, the party may file a motion with the court for a judgment in accordance with the decision at which time the court shall issue such a judgment unless the decision is modified, corrected, or vacated as provided in G.S. 90–21.68.

"§ 90–21.67. Retention of jurisdiction by court.

The court shall retain jurisdiction over the action during the pendency of the arbitration proceeding. The court may, at the request of the arbitrator, enter orders necessary to enforce the provisions of this Article.

"§ 90–21.68. Appeal of arbitrator's decision.

There is no right to a trial de novo on an appeal of the arbitrator's decision under this Article. An appeal of the arbitrator's decision is limited to the bases for appeal provided under G.S. 1–569.23 or G.S. 1–569.24.

"§ 90–21.69. Revised Uniform Arbitration Act not applicable.

The provisions of Article 45C of Chapter 1 of the General Statutes do not apply to arbitrations conducted under this Article except to the extent specifically provided in this Article."

SECTION 2. G.S. 1–569.3 is amended by adding a new subsection to read:

"(c) This Article does not govern arbitrations under Article 1H of Chapter 90 of the General Statutes."

SECTION 3. This act becomes effective January 1, 2008, and applies to agreements to arbitrate entered into on or after that date.

In the General Assembly read three times and ratified this the 23rd day of July, 2007.

s/ Marc Basnight
President Pro Tempore of the Senate

s/ Joe Hackney
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 10:07 p.m. this 31st day of August 2007