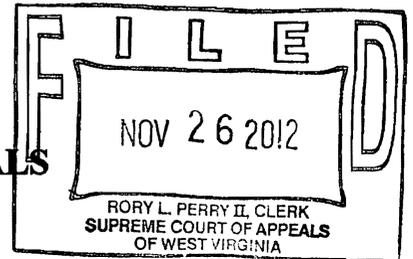


**IN THE SUPREME COURT OF APPEALS
OF WEST VIRGINIA
AT CHARLESTON**



**TERESA DELLINGER, Individually and
in Her capacity as Executrix of the Estate of
AMBER DELLINGER, Deceased,**

PLAINTIFF/PETITIONER

vs:

**Civil Action No. 09-C-681
Hon. Paul Zakaib, Jr.**

12-1069

**CHARLESTON AREA MEDICAL CENTER, INC.
and PEDIATRIX MEDICAL GROUP, INC.**

DEFENDANTS/RESPONDENTS

PETITIONER'S BRIEF

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**CHARLESTON AREA MEDICAL CENTER, INC.
and PEDIATRIX MEDICAL GROUP, INC.
DEFENDANTS/RESPONDENTS**

PETITIONER'S BRIEF

I.

ASSIGNMENT OF ERROR

The trial court erred in entering a summary judgment in favor of defendant Pediatrix Medical Group, Inc. The award of summary judgment constituted error because the case involved disputed issues of material fact that should have been submitted to the trier of fact for resolution rather than being decided by the trial court upon summary motion.

II.

STATEMENT OF THE CASE

A. *Proceedings in the Court below*

Teresa Dellinger ("Ms. Dellinger"), Individually and in her capacity as Executrix of the Estate of Amber Dellinger ("Amber"), her late daughter, filed the present action on April 14, 2009

in Kanawha County Circuit Court pursuant to the West Virginia Medical Professional Liability Act (“the MPLA”), W.Va. Code §§ 55-7B-1 *et seq* (2003). See Amended Complaint ¶ 1. Charleston Area Medical Center, Inc. (“CAMC”), was initially the sole named defendant. Ms. Dellinger filed an Amended Complaint on May 14, 2009, however; in that pleading she added Pediatrix Medical Group, P.C. (“Pediatrix”), as a second defendant. A period of pretrial discovery ensued. On January 14, 2011, Ms. Dellinger named Marc E. Weber, M.D., J.D., as her liability expert, and Robert Rufus as her economist.

Pediatrix filed a motion for summary judgment on May 20, 2011, to which Ms. Dellinger responded. The parties appeared at a pre-trial conference on July 15, 2011, at which (a) Ms. Dellinger moved for a continuance; and (b) the parties engaged in oral argument with respect to the pending summary judgment motion. The Court granted the continuance but overruled Pediatrix’s summary judgment motion at that proceeding. Also at that July 15, 2011 pre-trial conference, trial was rescheduled for March 12, 2012.

Pediatrix renewed its motion for summary judgment on February 12, 2012. Mrs. Dellinger responded to the motion on February 29, 2012. The parties then appeared on March 5, 2012 for a pre-trial conference in preparation for the scheduled March 12, 2012 trial. Counsel for Mrs. Dellinger informed the court that the plaintiff and CAMC had reached a settlement. As a result, the summary judgment proceedings after that point involved Pediatrix only; CAMC was out of the case.

The court then took the renewal of Pediatrix’s summary judgment motion under advisement pending the parties’ settlement negotiations. The parties were unable to resolve the matter; however. The court then reversed itself on the issue of summary judgment and granted Pediatrix’s motion, which was the very same motion it had earlier overruled on July 15, 2011. Thus, the court granted

summary judgment to Pediatrix on March 7, 2012, although it did not actually enter an Order Granting Pediatrix Medical Group P.C.'s Motion for Summary Judgment ("the Order"), until July 25, 2012, *i.e.*, after it had considered (but then overruled) Mrs. Dellinger's post-decision motion.

Mrs. Dellinger then timely filed a Motion for Reconsideration, to which Pediatrix responded on July 18, 2012 with its Pediatrix Medical Group, P.C.'s Response to Plaintiff's Motion for Reconsideration. The court overruled the Motion for Reconsideration and thus entered the summary judgment Order on July 26, 2012

Mrs. Dellinger then filed her Notice of Appeal on August 24, 2012, with attachments. Mrs. Dellinger now files the within Petitioner's Brief, in which she asks the Court to reverse the grant in the trial court of summary judgment to Pediatrix.

B. Statement of Facts

Mrs. Dellinger is a resident of Fayette County, West Virginia; she was named the executrix of her daughter Amber's estate on October 12, 2007 (Amended Complaint ¶ 2). The remaining defendant, Pediatrix, is a West Virginia Corporation that provides medical services in Kanawha County, West Virginia (Amended Complaint ¶ 4).¹ Specifically, "Pediatrix provides the doctors to cover the [CAMC] intensive care unit ["ICU"] (Deposition taken on December 21, 2010 of Manuel Jose Caceres, M.D. ["Caceres Dep.,"] p. 103, l. 2-3).

Amber, who was six years old at the time of her death (Amended Complaint ¶ 11), was brought to the Raleigh General Hospital in Beckley, West Virginia on September 18, 2007 by her parents, Mrs. Dellinger and her husband, on account of symptoms of headache and fever. She was

¹ Defendant CAMC, with whom Mrs. Dellinger settled its lawsuit, is also a West Virginia corporation providing medical services in Kanawha County, West Virginia (Amended Complaint ¶ 3).

treated and released (Order, Findings of Fact ¶ 20). The Dellingers returned Amber to the hospital the next day because her symptoms had returned; in addition, Amber was now suffering from nosebleed, vomiting, abdominal pain and backache. A diagnosis indicated an elevated white blood count and so she was admitted to the hospital's pediatrics floor (Order, Findings of Fact ¶ 21).

Amber's condition became more worrisome still; hence, she was transferred by ambulance to CAMC's Women's and Children's Division on September 21, 2007. There, Amber was diagnosed with La Crosse Virus and La Cross Encephalitis, conditions in which the virus invades and attacks the brain (Order, Findings of Fact ¶ 22). At the same time, however, Amber's treatment seemed to work; she appeared to make remarkable progress and was overall adjudged to be doing very well (Amended Complaint ¶ 7). Indeed, Manuel Jose Caceres, M.D. ("Dr. Caceres"), the pediatric intensive care physician and a Pediatrix employee, testified that Amber was doing "better," and was "awake and alert" and active (Caceres Dep. p. 83, l. 24 to p. 84, l 2) .She had, for example, a good Glasgow coma scale score of 15 (Caceres Dep. p. 83, l.22-24) Still, the Dellingers and others were advised (and were advising) that Amber should not become excited or agitated, for such a state could interfere with her recovery (Amended Complaint ¶ 8).

In the early morning of September 23, 2007, however, Amber complained of pain at the site of the IV in her left arm. In response, a CAMC employee, Melissa Childers, R.N., undertook to start a new IV (Amended Complaint ¶ 9); indeed, she apparently made eleven attempts to insert the IV (Amended Complaint ¶ 10). During this process, Amber began having a focal seizure activity, lost consciousness and required emergency intervention (Order, Findings of Fact ¶ 23). Amber was bubbling and gurgling (Caceres Dep. p. 36, l. 14 to p. 37, l 13), and even foaming from the mouth at this time (Amended Complaint ¶ 12). Mr. and Mrs. Dellinger were in the room at the time and

strenuously objected to this ongoing IV procedure (Amended Complaint ¶ 13). Then, Amber went limp and/or became unconscious at around 2:15 (Caceres Dep. p. 58, l. 4-23).

At around 2:30 or 2:35 a.m., Dr. Caceres was called by a pediatric medical resident named Anita Hawks, D.O, a CAMC employee (Order, Findings of Fact ¶ 23). Dr. Caceres, a pediatric intensive care physician (Order, Findings of Fact ¶ 24), was an employee of defendant Pediatrix (Caceres Dep. p. 10, l. 13-16), Dr. Hawks related the emergency that had arisen regarding Amber and told Dr. Caceres that Amber was being transferred from a so-called treatment room to the ICU (Caceres Dep. P. 23, l. 1-22). Dr. Caceres was so informed because he was on call as the attending physician in the CAMC pediatric ICU unit (Caceres Dep. p. 16, l. 13-17; Order, Findings of Fact ¶ 24). Because the nurses involved in Amber's care, along with Dr. Hawk, were all CAMC employees, Dr. Caceres is the only Pediatrix employee involved in this case.

In actuality, Dr. Caceres had three conversations with people at CAMC regarding Amber's condition during those early morning hours. The first conversation took place "[r]ight around 2:30 a.m." (Caceres Dep. p. 23, l. 3), when Dr. Caceres was called at home by Dr. Hawk (Caceres Dep. p. 23, l. 4-6). Dr. Hawk called Dr. Caceres a second time between 2:30 a.m. and 2:45 a.m. to discuss a "careful plan" to order various tests, including a blood gas test and a chest x-ray (Caceres Dep. p. 39, l. 7-8, 16 to p. 40, l. 7 to p. 44, l. 24). The stated reason for the x-ray was "'verified respiratory distress" (Caceres Dep. p. 44, l. 21-24). The third conversation, which took place around 3:35 a.m., was again with Dr. Hawk. She advised Dr. Caceres that the anti-seizure medication was not stopping the seizures; hence the administration of a stronger medication, Phenobarbital, was indicated (Caceres Dep. p. 40, l. 8-14; p. 51, l. 1-15), It was as a result of this conversation that Dr. Caceres decided to come to the hospital to deal with matters first-hand (Caceres Dep. p. 40, l. 9-14),

Of course, a central inquiry in this case focuses on Dr. Caceres' responses to these three conversations, particularly in regard to the time span between 2:30 a.m.—when Dr. Caceres was first notified of Amber's distress—and approximately 4:00 a.m.—when he began to perform an intubation to deal with these questions. Whether Dr. Caceres acted appropriately during those ninety minutes—not whether he acted appropriately once he actually got to the hospital at between 3:50 a.m. and 4:00 a.m., involve genuine issues of material fact, which need to be resolved by the trier of fact. Amber was transferred to the ICU at between 2:30 and 2:45 a.m. (Order, Findings of Fact ¶ 24; Caceres Dep. p. 22, l. 10-15).² She was admitted under Dr. Caceres's authority (Caceres Dep. P. 27, l. 13-16). At the same time, Dr. Caceres testified that the first time he had any direct contact with Amber was on September 23, 2007 at 3:40 a.m. (Caceres Dep. p. 83, l. 4-10). Although that 3:40 a.m. time is subject to a few minutes' revision depending upon when Dr. Caceres actually got to the hospital, *see* Caceres Dep. p. 51, l. 5 to p. 52, l. 20, it does seem established that Dr. Caceres had never seen Amber before his arrival at CAMC in the early hours of September 23, 2007—whenever that took place in fact.

Once in the ICU, Amber was treated by both Dr. Hawks and Dr. Caceres. Dr. Hawks conducted a physical examination of Amber (Caceres Dep. p. 28, l.7-18). A blood gas sample was to be collected around 3:15 a.m. and tested. Other medications were prescribed as well (Order, Findings of Fact ¶ 25). Dr. Caceres testified that Amber's blood gases “did indicate that she might have a respiratory acidosis (Caceres Dep. P. 32, l. 24 to p. 33, l. 1).³ Moreover, the X-rays she had

² On the other hand, Dr. Caceres did not take any notes of the case until 4:10 a.m. (Caceres Dep. P. 22, l. 16-24), so some of these time estimates are potentially speculative.

³Respiratory acidosis is a condition in which decreased ventilation or hypoventilation causes increased blood carbon dioxide concentration and decreased pH.

been given after the seizures had started, indicated Amber was suffering from respiratory distress (Caceres Dep. p. 43, l. 15-17), or respiratory distress/seizure (Caceres Dep. p. 55, l. 10-14).

Dr. Caceres testified that Amber's breathing had become labored (Caceres Dep. p. 35, l. 18 to p. 36, l. 3). He testified that he decided to intubate⁴ for several medical reasons:

[E]ven though I was planning to intubate prophylactically to continue the treatment of seizures, we at that point realized that now we need to intubate also because of the respiratory acidosis.

(Caceres Dep. P. 43, l. 10-14).⁵ Dr. Caceres testified that he intubated Amber at around 3:40 a.m. (Caceres Dep. p. 48, l. 13-17); however, based on his time schedule in getting from home to the hospital (Caceres p. 53, l. 1 to p. 54, l. 12), it could have been a few minutes later, perhaps as late as 4:00 p.m.

With respect to this time line, the trial judge found that "Dr. Caceres arrived at CAMC to evaluate the patient no later than 3:50 a.m." (Order, Findings of Fact ¶ 26). Dr. Caceres testified that it takes him fifteen to twenty minutes to intubate a patient (Caceres p. 47, l. 21 to p. 48, l. 2). Given the necessary time to prepare for the procedure, the intubation could not have occurred before 4:00 a.m. and could well, subject to the findings of the trier of fact, have occurred somewhat later.

The overall point is that there was allegedly a significant delay in Amber's treatment from the moment she began to show signs of distress. Amber began gagging and went limp around 2:15

⁴ Tracheal intubation is the placement of a flexible plastic tube into the trachea, or windpipe, to maintain an open airway to prevent the possibility of asphyxiation or airway obstruction.

⁵ Dr. Caceres, although on call, was at home and not actually not at the hospital when Amber's emergency began. He came in specifically to intubate the young girl (Caceres Dep. p.33, l. 8-14)

a.m. She was admitted to the ICU at 2:35 a.m. An anti-seizure order was placed at 2:45 a.m. Blood gases were collected at 3:15. An x-ray was taken around 3:30 a.m., or before the time the intubation was performed. This time line entails that there is a time period of from between 1½ and 1¾ hours during which time Amber was unresponsive and the point in time at which the intubation was performed by Dr. Caceres. See Caceres Dep. p. 60, l. 4-24. The question of what happened—or, more to the point, did not happen—during that period is central to the resolution of this case.

In addition, the evidence shows that Dr. Caceres was not informed at home before he left for the hospital that true state of Amber’s condition. For example, the blood gas studies entailed an immediate need to intubate because Amber was clearly in respiratory acidosis (Caceres Dep. p. 61. l. 20 to p. 62, l. 6). It is the timing of Dr. Caceres’s learning of these details that is troublesome:

Q. Did you first learn of the blood gas when you arrived at the hospital or did you learn it at home?

A. No, I learned when I arrived at the hospital.

(Caceres Dep. p. 62, l. 9-13). See also Caceres Dep. p. 43, l. 5)(Dr. Caceres first learned the results of the blood gas test “[w]hen I came in”).

The trial judge found as a fact that “[i]t is uncontested that the blood gas results were first available to Dr. Caceres at approximately 3:50 a.m.” (Order, Findings of Fact ¶ 27). As will be discussed in greater detail below, Mrs. Dellinger finds this statement to be unsupported by the record. What is uncontested is the fact that it was 3:50 a.m. before Dr. Caceres first learned of the blood gas results. The blood gas test was taken at 3:15 a.m. (Caceres Dep. p. 66, l. 7-9; p. 76, l. 2-5). Dr. Caceres was called to come in to treat Amber at 3:30 or 3:35 a.m. (Caceres Dep. p. 51, l. 1-5). It is clear that Dr. Caceres was not told about the blood gas results in any of the phone calls he

received at home. Whether they were available and whether he could have been given those results at those times (or perhaps even sometime via a cell phone during the drive to CAMC), is a genuine issue of material fact that a jury must resolve.

In any event, Amber got no better. She became completely unresponsive later that same day, or at approximately 11:00 a.m. on September 23, 2007 (Caceres Dep. p. 72, l. 2-12). Amber then died the next day, or on September 24, 2007 (Order, Findings of Fact ¶ 28). Dr. Caceres testified that Amber died because of “[i]nflammation of the brain due to the La Crosse virus” (Caceres Dep. p. 81, l. 14-15). For his part, the trial court did not fix a cause of death as a finding of fact. Instead, the court simply noted that “[s]he had La Crosse Encephalitis” (Order, Findings of Fact ¶ 28).

It should be noted that Mrs. Dellinger’s expert medical witness, Marc E. Weber, M.D., disagreed with Dr. Caceres. Dr. Weber testified that Amber died on account of “an acute hypoxic ischemic event, probably on the basis of acute laryngospasm when she was in the treatment room as opposed to [Dr. Caceres’s theory of] acute decompensation of her La Crosse encephalitis and cerebral herniation” (Deposition taken on October 18, 2011 of Marc E. Weber, M.D. [“Weber Dep.”] p. 37, l. 6-11; p. 38, l. 1-15).⁶ As the Court will see, however, the mere fact that the effective ultimate cause of death allegedly took place in the treatment room instead of the ICU by no means lets Pediatrix off the hook. Genuine issues of material fact remain unsettled regarding Pediatrix’s responsibility for its alleged failure to recognize Amber’s respiratory distress and the resulting failure

⁶ A laryngospasm is an uncontrolled, involuntary muscular contraction, or spasm, of the laryngeal cords, which causes a partial blocking of the act of inhaling, or breathing in.

to take proper steps to treat and correct her medication, thereby to prevent the catastrophic results which led to the young girl's death. These issues will be discussed in detail below.⁷

III.

SUMMARY OF ARGUMENT

The trial court erred in entering summary judgment in favor of defendant Pediatrix. As required by law, plaintiff Dellinger presented a qualified expert to support her case. Marc E. Weber, M.D., J.D. the plaintiff's expert witness, presented a clear and cogent basis for his opinions on causation, standard of care and the deviation therefrom by Dr. Caceres, an employee of Pediatrix, and a physician who cared Amber, the deceased patient. Dr. Weber's opinions satisfied Mrs. Dellinger's evidentiary burden; hence, she has presented a prima facie case for recovery. On account of Dr. Weber's testimony, therefore, the trial court should have found the existence of genuine issues of material fact sufficient to overcome Pediatrix's summary judgment motion. It follows that Pediatrix's summary judgment motion should have been overruled.

IV.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Mrs. Dellinger urges that the error committed by court below in granting judgment to Pediatrix is so clear that oral argument is unnecessary. If the Court finds oral argument necessary, however, argument should focus, Mrs. Dellinger believes, on W.Va.R.App.P. 19(a)(1), (2),(4).

⁷ The trial court discussed Dr. Weber's testimony first in its Order, Findings of Fact ¶¶ 29-33, and then second in its Order, Conclusions of Law ¶¶ 10-15. Because Dr. Weber's testimony applies most directly to Mrs. Dellinger's legal arguments and the trial courts conclusions of law alike, her discussion of Dr. Weber's deposition will be undertaken in the Argument portion of this brief.

V.

ARGUMENT

**THE TRIAL COURT IMPROPERLY AWARDED
DEFENDANT PEDIATRIX A SUMMARY JUDGMENT**

A. Introduction.

Mrs. Dellinger acknowledges that this case is governed by the following principle:

"It is the general rule that in medical malpractice cases negligence or want of professional skill can be proved only by expert witnesses." Syllabus Point 2, *Roberts v. Gale*, 149 W.Va. 166, 139 S.E.2d 272 (1964).

Syl. Pt. 4, *Estate of Fout-Iser ex rel. Fout-Iser v. Hahn*, 220 W.Va. 673, 649 S.E.2d 246 (2007). Mrs.

Dellinger acknowledges as well that this case, a medical malpractice dispute, is also governed by statutory law requirements:

When a particular defendant's failure to meet the standard of care is at issue in medical malpractice cases, the sufficiency and nature of proof required is governed by West Virginia Code § 55-7B-7(a) (2003), which specifically provides that: "The applicable standard of care and a defendant's failure to meet the standard of care, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court."

Syl. Pt. 5, *id.* Finally, Mrs. Dellinger agrees that the trial court cited both *Roberts v. Gale*, 149 W.Va. 166, 139 S.E.2d 272 (1964) and *Fout-Iser* for the proper standard. Thus, she has no quarrel whatever with the trial court on that score. The problem is that trial court accurately announced those principles but then did not apply those principles properly to the facts of this case.

A recent federal court sketched these standards in a useful way by combining the complementary, statutory and common law requirements, as follows:

Under West Virginia law, a plaintiff must comply with the Medical Professional Liability Act [MPLA]. To establish medical malpractice, the MPLA provides that the Plaintiff must prove the following: "(1) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and (2) Such failure was a proximate cause of the injury or death . . ." W. Va. Code § 55-7B-3(a). Under West Virginia law, "[i]t is the general rule that in medical malpractice cases, negligence or want of professional skill can be proved only by expert witnesses." Syllabus Point 2, *Roberts v. Gale*, 149 W. Va. 166, 139 S.E.2d 272 (1964). Expert testimony, however, is not required "where the lack of care or want of skill is so gross as to be apparent, or the alleged breach relates to noncomplex matters of diagnosis and treatment within the understanding of lay jurors by resort to common knowledge and experience." *Farley v. Shook*, 218 W. Va. 680, 629 S.E.2d 739 (2006).

Massie v. United States, 2012 U.S. Dist. Lexis 106401 at *10 to *11 (S.D.W. Va., filed July 20, 2012)(applying West Virginia law).

Mrs. Dellinger has successfully presented the expert testimony required in this case. She has presented her case in full fidelity to the principles announced in *Roberts* and *Fout-Iser* and then recapitulated in *Massie*. When those principles are properly applied here, it will become clear that the trial court incorrectly sustained Pediatrix's summary judgment motion. Accordingly, Mrs. Dellinger urges the Court to reverse the judgment below.

B. The Present Case Involves Genuine Issues of Material Fact That Preclude Summary Judgment.

As the Court will see upon examination of the arguments below, this case presents important issues involving the application of summary judgment principles to medical malpractice law. The trial court's decision was plainly wrong. For that reason, petitioner Teresa Dellinger respectfully urges the Court to resolve the issues raised in this submission so as to reverse the judgment below and to remand the matter to the trial court for a trial before the trier of fact.

C. Summary Judgment Standard of Review.

The Court recently summarized the principles governing the award of a summary judgment in the trial court, as follows:

This Court has previously held that

"[a] motion for summary judgment should be granted only when it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law.' Syllabus Point 3, *Aetna Casualty & Surety Co. v. Federal Insurance Co. of New York*, 148 W. Va. 160, 133 S.E.2d 770 (1963).

Syl. Pt. 1, *Andrick v. Town of Buckhannon*, 187 W. Va. 706, 421 S.E.2d 247 (1992). Further, this Court held in syllabus point two of *Williams v. Precision Coil, Inc.*, 194 W. Va. 52, 459 S.E.2d 329 (1995), that

[s]ummary judgment is appropriate if, from the totality of the evidence presented, the record could not lead a rational trier of fact to find for the nonmoving party, such as where the nonmoving party has failed to make a sufficient showing on an essential element of the case that it has the burden to prove.

Id. at 56, 459 S.E.2d at 333.

Dean v. State, ___ W. Va. ___, ___ S.E.2d ___. 2012 W. Va. Lexis 782 at *12 to *13 (W.Va., filed November 9, 2012)(trial court entry of summary judgment reversed). In adjudicating the appeal of a lower court grant of summary judgment, the standard of review is de novo. *Feroletto Steel Co., Inc. v. Oughton*, ___ W. Va. ___, ___ S.E.2d ___. 2012 W. Va. Lexis 690 at *4 to *5 (W.Va., filed September 25, 2012)(trial court entry of summary judgment reversed). In light of these principles, it follows that:

Our precedent makes clear that "[a] party who moves for summary judgment has the burden of showing that there is no genuine issue of fact and any doubt as to the existence of such issue is resolved against the movant for such judgment." Syllabus Point 6, *Aetna Casualty and Surety Company [v. Federal Insurance Co. of New York]*, 148 W. Va. 160, 133 S.E.2d 770 (1963)], *supra*.

Meadows v. Massey Coal Services, Inc., ___ W. Va. ___, ___ S.E.2d ___. 2012 W. Va. Lexis 665 at *8 (W. Va., filed September 24, 2012)(trial court entry of summary judgment reversed). Above all, “[t]he trial judge should resist the temptation to try cases in advance on motions for summary judgment[.]” *Marcus v. Staubs*, ___ W. Va. ___, ___ S.E.2d ___, 2012 W. Va. Lexis 827 at *42 (W. Va., filed November 15, 2012), quoting *Warner v. Haught, Inc.*, 174 W. Va. 722, 731, 329 S.E.2d 88, 97 (1985)(trial court entry of summary judgment reversed).

Needless to say, these same principles apply in a review of medical malpractice summary judgment cases. *Cartwright v. McComas*, 223 W. Va. 161, 672 S.E.2d 297, 300 (2008)(trial court entry of summary judgment reversed).

D. The Trial Court’s Entry of Summary Judgment for Pediatrix was Error.

The trial court concluded that “[t]here is no material dispute that Pediatrix/Dr. Caceres did not proximately cause or contribute to the patient’s death” (Order, Conclusions of Law ¶ 14). This finding was based, needless to say, on the trial court’s finding that “[d]uring his deposition, Dr. Weber admitted that Dr. Caceres met the applicable standard of care in his evaluation, care and treatment of the patient” (Order, Conclusions of Law ¶ 11). On that basis, the trial court found that Mrs. Dellinger “has not and cannot establish a prima facie case of medical professional liability as to Pediatrix Medical Group, P.C. and summary judgment is proper” (Order, Conclusions of Law ¶ 16).

As Mrs. Dellinger will demonstrate, these conclusions are the product of an unduly blinkered and selective reading of Dr. Weber’s testimony. A review of that testimony will reveal that when the deposition is evaluated in its entirety, the required prima facie case as to Pediatrix’s liability has

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been made out. It follows that the summary judgment entered below is flawed and thus subject to reversal in this tribunal.

As noted above, Dr. Weber testified that Amber died on account of “an acute hypoxic ischemic event” (Weber Dep. p. 37, l. 7). He expanded upon that conclusion in the following way:

Well, I think that [Amber] was upset with the i.v. stick or sticks, depending on whose testimony is accurate, as any child would be, and more likely than not just got agitated, threw up, and an acute laryngospasm from the vomit from the acid.

I don't think she had an aspiration, pneumonia per se. That would seem to be supported by subsequent chest x-ray where the initial radiographic findings that might have been consistent with aspiration appeared to be cleared up with positive pressure ventilation. So that would be, in fact, more consistent with an atelectasis that had resolved from the resuscitation attempts.

(Weber Dep. p. 45, l. 10-24). In somewhat more lay-friendly language, Dr. Weber continued:

What happened was she got agitated and basically threw up or vomited and some of that got into the upper airway.

Acid is very irritating to the vocal cords and it certainly is a known trigger for laryngospasm, where your vocal chords kind of clamp shut.

And she subsequently – the evidence for that is that she subsequently had seizure activity where she had not any seizure activity prior

””

At some point, for some finite period of time she would not be moving air ... usually it has to be for several minutes.

(Weber Dep. p. 44, l. 5-15, 19-20, 23-24).

Dr. Weber then fixed the point in time at which Amber suffered an irreversible injury, as follows:

I think that the irreversible injury occurred at the time whatever happened in the treatment room, and *that subsequently the management contributed to it somewhat* only because, again, although there was no documentation in the record of hypokinesia other than that blood gas result, which is consistent with a significant respiratory acidosis, is certainly concerning as respiratory failure, I should say.

(Weber Dep. p. 52, l. 7-16)(emphasis supplied). In short, “the *majority* of the damage was done in the treatment room” (Weber Dep. p. 54, l. 14-15). The majority, that is, but perhaps not all of that damage. With respect to that damage, however, Dr. Weber testified that “based on the medical records,” he had no criticism of the treatment that occurred in the treatment room (Weber Dep. p. 61, l. 20-23). At the same time, his opinion might, he allowed, be different if he went beyond those records:

If, in fact, what was happening was not being interpreted correctly by the nursing personnel and Amber was, indeed, having more airway compromise than is indicated in the medical record, then intervention in terms of airway management was indicated more emergent.

(Weber Dep. p. 62, l. 3-9).

To this point, Dr. Weber’s expert testimony focused on the activity in the treatment room. He was then asked about his views on what went on in the ICU. His views were critical of Pediatrix:

Q. ... do you have any criticisms of the care that the patient received in the PICU?

A. I believe there should have been a more emergent intubation and airway management.

(Weber Dep. p. 65, l. 6-11). Dr. Weber explained his reasons for that criticism in the following terms:

The basis is twofold. It goes back to the original crux of the case, I guess, either this is related to acute deterioration based on the La Crosse encephalitis and herniation syndrome, in which more emergent airway management may, indeed, have been indicated if those modalities would make a difference in the outcome versus the fact that some event, aspiration, acute laryngospasm caused hypoxia and ischemic in the treatment room, and the only thing in the medical record, like I have alluded to, that’s concerning is the blood gas result at 03:25.

(Weber Dep. p. 65, l. 13 to p. 66, l. 1). Dr. Weber’s expert opinion was that “the [blood] gas results were available some time before they decided to intubate” (Weber Dep. p. 71, l. 11-1). As a result,

Dr. Weber opined that the intubation should have been undertaken earlier, that is, around the time the blood gas results were returned to the unit (Weber Dep. p. 73, l. 2-7).

It was Dr. Caceres who made the decision to intubate. As noted, Dr. Caceres had been in contact with the treatment room on three occasions during this period. It was, therefore, Dr. Caceres who made the decision not to intubate earlier, as Dr. Weber suggested was indicated. In Dr. Weber's view, the decision to delay was made based on the patient being loaded up with anti-seizure medications (Weber Dep. p. 73, l. 14-22). Hence, any delay—and the results of that delay—are entirely the result of Dr. Caceres's decision and thus became Dr. Caceres's responsibility.

Thus, Dr. Weber's sole criticism of the care given to Amber in the treatment room was the possibility that different and/or more forceful resuscitation efforts should have been taken (Weber Dep. p. 74, l. 12 to p. 75, l. 7). Given Dr. Caceres's role in Amber's treatment and his three contacts with the care givers in the treatment room before he got to the hospital, however, that criticism is justly laid at Dr. Caceres's feet. The point was then clarified later in his deposition:

Q. ... You don't have any criticism of Dr. Caceres while the patient was up in the pediatrics unit. Right?

A. Well, I think we've talked that I think the airway should have been managed more aggressively at or around the time the blood gas results were returned. I understand that he wasn't in the unit [but] he was in phone contact ... (Weber Dep. p. 106, l. 5-13). Indeed, Dr. Weber repeated time after time his insistence that the intubation should have been undertaken sooner and more emergently. See Weber Dep. p. 106, l. 8-24, p. 107, l. 23-25, p. 108, l. 1 to p. 109, l. 1, That is, as Dr. Weber testified, "I think ... it needed to have been done more emergently based on the blood gas results" (Weber Dep. , p. 111, l. 3-5).

In spite of this testimony, the trial court somehow concluded that "[d]uring his deposition, Dr. Weber *admitted* that Dr. Caceres met the applicable standard of care in his evaluation, care and

treatment of the patient” (Order, Conclusions of Law ¶ 11)(emphasis supplied). The trial court likewise opined that “Dr. Marc Weber, *admitted* that Pediatrix/Dr. Caceres met the applicable standard of care with respect to the patient” Order, Conclusions of Law ¶ 10)(emphasis supplied). The truth, however, is that these statements rest upon a total misreading of the evidence in general and of Mr. Weber’s deposition in particular.

Evidence that the summary judgment Order ran off the rails can be seen in the trial judge’s announcement that “[t]here is no material dispute of fact that Pediatrix/Dr. Caceres was not provided with the information that Dr. Weber defines as triggering the duty to intubate the patient—the blood gas result—prior to 3:50 a.m.(Order, Conclusions of Law ¶ 13). In fact, there is not only a “material dispute of fact” over the time of that “triggering” event but in actuality the record leaves the matter entirely undetermined and thus a matter for the jury to decide for itself.

Contrary to the trial court’s finding, Dr. Weber was absolutely clear in his conviction that the time when the blood gas results were returned was undetermined:

Q. Do you know what time the result of the blood gas study was recorded:

A. I think there was some questioning about that. I don’t recall seeing on the lab slip anything. There were some notes that referenced the results, but unless I missed it, I don’t recall a time that that was – that the actual result was returned.

(Weber Dep. p. 66. l. 6-13). Dr. Weber’s sole statement in this regard was that the blood gas was collected at 3:15 a.m. (Weber Dep. p. 65. l. 23 to p. 66, l. 6). And, if that statement was not clear enough, Dr. Weber made it even clearer:

Q. So based on the medical record, do you know or do you have an opinion as to when those blood gas studies were available?

A. I don’t think it was clear in the medical record.

(Weber Dep. p. 68. l. 17-21).

Accordingly, the trial court based its summary judgment on its supposed reading of Dr. Weber's deposition to the effect that "[i]t is undisputed that once the 3:50 a.m. blood gas results were available to Pediatrix/Dr. Caceres, he met the appropriate standard of care by properly and timely intubating the patient" (Order, Conclusions of Law ¶ 13)(emphasis supplied). As we can see, this conclusion is faulty in a number of respects.

First, it is not at all clear that the blood gas study results were not available until 3:50 a.m.; as noted, what Dr. Weber said—and *all* Dr. Weber said—was that the blood was collected at 3:15 a.m. (Weber Dep. p. 65. l. 23 to p. 66, l. 6), and that in the normal course, the results would be available "in a few minutes" (Weber Dep. p. 113. l. 20). Dr. Weber *never* said the results were not available until 3:50 a.m. Because that supposed 3:50 a.m. test result time is a mere guesstimate or gratuitous assumption by the trial court rather than a fact both found and supported by the medical records, the trial court's conclusion is revealed to be an unsupported, fact-free hypothesis and thus a poor basis indeed for the entry of a summary judgment.

Second, the trial court wrongly concludes that "[a]s Dr. Weber admits, Pediatrix/Dr. Caceres met this applicable standard of care in this matter" (Order, Conclusions of Law ¶ 15)(emphasis supplied). This statement is based on Dr. Weber's supposed admission that Dr. Caceres did nothing wrong—at least past 3:50 a.m. This conclusion, however, misreads Dr. Weber's testimony, for Dr. Weber made no such admission. In fact, the following exchange illustrates to the contrary what Dr. Weber said in fact:

Q. Okay. So I want to make sure. You have no criticism of Dr. Caceres before 3:45 a.m.; correct?

- A. I don't have any criticism prior to the time he was aware or should have been aware of the blood gas result. That's correct.

(Weber Dep. p. 108. l. 8-14).

Accordingly, Dr. Weber does not absolve Dr. Caceres's efforts as of 3:45 a.m. Rather, he absolves him as of the time he either knew or should have known the results of the blood gas study. That time, however, is unknown; neither the deposition testimony nor the medical records reveal it. Thus, Dr. Weber would fault or not fault Dr. Caceres depending upon the time the blood gas study was available. But that fact of that availability is the very question in this case; it is one that the trial court clearly begged. Until that fact is determined—and clearly it is a matter for the finder of fact to determine—the issue of whether “Pediatrix/Dr. Caceres met this applicable standard of care in this matter” (Order, Conclusions of Law ¶ 15), cannot be answered. Certainly, it could not—and should not—have been answered by the trial court in the course of its adjudication of the summary judgment motion. That it did so renders the Order below reversible error.

Third, the trial court flatly sidestepped the crucial issue in this case. That issue, of course, concerns Dr. Weber's criticism that “I think the airway should have been managed more aggressively at or around the time the blood gas results were returned” (Weber Dep. p. 106, l. 9-12). One can see of good illustration of the trial court's inadequate treatment of this issue in its Order, Conclusions of Law ¶ 11. There, the trial court cites various bits and pieces of Dr. Weber's deposition testimony to support the court's conclusion that Dr. Weber had admitted that Dr. Caceres had fully “met the applicable standard of care in his evaluation, care, and treatment of the patient” (Order, Conclusions of Law ¶ 11). One can see from these selected quotations that Dr. Weber is careful to qualify his exculpation of Dr. Caceres by premising his statement on the assumption that his airway management of Amber was sufficiently emergent. But that statement had to be an assumption only

because, once again, the date of the triggering event—the arrival of the blood gas study result—was and is unknown.

Dr. Weber was careful to testify only in accordance with the facts as they were known. As such, he dealt with the data with scalpel-like care. The result is that his testimony was subtle, nuanced and properly qualified. Nevertheless, his testimony was clear and unambiguous enough so that under applicable law a jury question as to proximate cause and hence liability was presented:

It was reversible error for the trial court to grant judgment as a matter of law to the defendants on the grounds that proximate cause could not be established through inferences.

Sexton v. Grieco, 216 W.Va. 714, 613 S.E.2d 81, 87 (2005). This standard entails in turn that allegations of a departure from the standard of care do not require that an expert like Dr. Weber identify the precise acts that constitute that departure but instead permits the trier of fact to infer those actions from the condition of the patient herself. *Estate of Fout-Iser ex rel. Fout-Iser v. Hahn, supra*, 649 S.E.2d at 251-52.

The care with which Dr. Weber approached the case is underscored by the fact he relied on the medical record only; he avoided attempting to resolve factual conflicts (Weber Dep. p. 78, l. 10-15). That is because “the medical record is medical record and that’s what I rely on” (Weber Dep. p. 62, l. 23-24). Do factual conflicts exist in this case? Of course they do. But they are matters for the jury to resolve. Certainly, an expert like Dr. Weber is not required to resolve factual conflicts in his deposition testimony. *Estate of Fout-Iser ex rel. Fout-Iser v. Hahn, supra*, 649 S.E.2d at 251-52. Clearly, then, when the inferences of Dr. Weber’s testimony are given their due weight, the inappropriateness of deciding this case on the basis of a summary disposition is manifest.

The trial court, in contrast to the expert witness, considered Dr. Weber's testimony with all the finesse of a sledgehammer. Its conditions and qualifications were overlooked. The trial court ignored Dr. Weber's repeated statements that the airway management practices undertaken or not undertaken in light of Amber's changing condition troubled him and suggested Dr. Caceres's fault in the matter. In short, the trial court picked and chose among the pages of the deposition. It brutally ripped statements out of context. In all, it failed to give due credit to the actual tenor of Dr. Weber's testimony. This was so even though a fair reading of Dr. Weber's testimony reveals the presence of genuine issues of material fact as to whether Dr. Caceres's treatment of Amber met the applicable standard of care and thus proximately cause or contribute to the young girl's death.

The trial court also based its decision on its finding that Dr. Weber supposedly "admitted he could not opine that Dr. Caceres proximately caused any injury to the patient" (Order, Conclusions of Law ¶ 12). As we have seen above, Dr. Weber made no such admission. What Dr. Weber did was to admit that he could not "quantify" the injury caused by the alleged delay in intubation (Weber Dep. p. 112, l. 14-15). Nor could Dr. Weber state that it was "more likely than not that [Amber] would have lived if the blood gas value would have been given to Dr. Caceres earlier" (Weber Dep. p. 112, l. 14-19).

Dr. Weber's inability to quantify Amber's injuries or to opine as to whether or she not would have survived the alleged delay in treatment by no means entitles Pediatrix to summary judgment. That Amber would have suffered injury if the airway management efforts were wrongly delayed is a certainty. The job of quantifying those injuries is for the jury. As this Court noted:

We further find that the circuit court erred by concluding that the Isers failed to present evidence of causation. In that regard, the deposition testimony before the circuit court demonstrated that the delay in treatment of Maranda was significant.

Estate of Fout-Iser ex rel. Fout-Iser v. Hahn, supra, 649 S.E.2d at 251. The same is true here.

Dr. Weber found there were two possibilities as to what had gone wrong with Amber's treatment (Weber Dep. p. 48, l. 23 to p. 49, l. 14.). One was an inability to breathe for a period of time, which, if airway management was delayed, could have caused Amber's injuries and ultimately her death. The second possibility was that her injuries and death were caused by the La Crosse encephalitis that brought her to CAMC in the first place. As to these two possibilities, Dr. Weber testified that in his opinion the La Crosse encephalitis explanation was the less likely (Weber Dep. p. 49, l. 23 to p. 49, l. 19-24).⁸ Those findings are entirely sufficient to support a prima facie case of medical professional liability. As the Court has noted:

This Court has also consistently recognized that questions of proximate cause are often fact-based issues best resolved by a jury. The uncertainties implicit in this medical record are prime territories for jury determination

Stewart v. George, 216 W.Va. 288, 607 S.E.2d 394, 399 (2004).

Dr. Weber testified that Amber's death was the result of "an acute hypoxic ischemic event, probably on the basis of acute laryngospasm when she was in the treatment room as opposed to [Dr. Caceres's theory of] acute decompensation of her La Crosse encephalitis and cerebral herniation" (Weber Dep. p. 37, l. 6-11; p. 38, l. 1-15). *See also* Weber Dep. p. 44, l. 5-15, 19-20, 23-24. Dr. Weber then criticized the apparent delay in dealing with airway management in response to that event. (Weber Dep. p. 65, l. 9-11) ("I believe there should have been a more emergent intubation and airway management"). Dr. Weber relied on the medical record only and avoided any attempt to resolve factual conflicts (Weber Dep. p. 78,

⁸ After all, the blood gas study undertaken at 3:15 a.m. on September 23, 2007 revealed a Co2 level that had been elevated to 84 or 87, a fact indicating that a acute hypoxic ischemic injury had taken place (Weber Dep. p. 44, l. 12-15, p. 52, l. 7-16, p. 54, l. 7-15, p. 55, l. 5-10).

l. 10-15). In short, Dr. Weber, the plaintiff's expert, presented a clear and cogent basis for his opinions on causation, standard of care and the deviation therefrom by Dr. Caceres. These opinions entail that Mrs. Dellinger has made out a prima facie case of medical professional liability under the MPLA. It follows that Pediatrix's summary judgment motion should have been overruled and the matter set for trial before the trier of fact—the body whose proper role, after all, is to resolve those factual conflicts.

The trial court had earlier heard but overruled defendants' motion for summary judgment on July 15, 2011. Without hearing any new evidence, the trial court reversed itself and sustained the renewed Motion on March 7, 2012. Mrs. Dellinger submits that the trial court ruled correctly the first time around; summary judgment is simply improper in this case. As this Court counseled only days ago, "[t]he trial judge should resist the temptation to try cases in advance on motions for summary judgment[.]" *Marcus v. Staubs, supra*, 2012 W.Va. Lexis 827 at *42. The trial court in this case did not resist that temptation; a fortiori, the trial court erred in awarding Pediatrix a summary judgment. Mrs. Dellinger respectfully submits that the Court should disapprove and reverse that summary judgment order and remand the case to the Circuit Court of Kanawha County for a trial before the trier of fact.

VI.

CONCLUSION

For the reasons set out above, petitioner/plaintiff Teresa Dellinger, individually and in her capacity as Executrix of the Estate of Amber Dellinger, Deceased, respectfully asks the Court to disapprove and vacate the orders entered below and to remand the matter to the trial court for a trial before the trier of fact.

Dated: November 26, 2012

Respectfully submitted,

TERESA DELLINGER, individually and in
her capacity as Executrix of the Estate of
AMBER DELLINGER, Deceased

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**IN THE SUPREME COURT OF APPEALS
OF WEST VIRGINIA
AT CHARLESTON**

**TERESA DELLINGER, Individually and
in Her capacity as Executrix of the Estate of
AMBER DELLINGER, Deceased,**

PLAINTIFF/PETITIONER

vs:

**Civil Action No. 09-C-681
Hon. Paul Zakaib, Jr.**

**CHARLESTON AREA MEDICAL CENTER, INC.
and PEDIATRIX MEDICAL GROUP, INC.**

DEFENDANTS/RESPONDENTS

CERTIFICATE OF SERVICE

I, John D. Wooton, counsel for petitioner/plaintiff Teresa Dellinger, individually and in her capacity as Executrix of the Estate of Amber Dellinger, Deceased, do hereby certify that a true and exact copy of the foregoing Petitioner's Brief was this day mailed to the following address by first class mail, postage prepaid:

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Dated: November 26, 2012



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