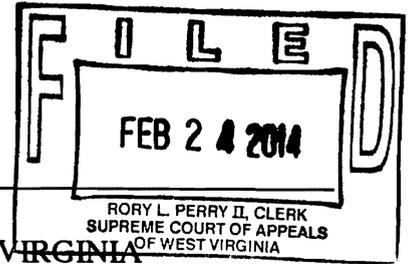


No. 13-1079



IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DELILAH STEPHENS, M.D.,
Defendant Below,
Petitioner

vs.)

No. 13-1079

CHARLES RAKES, personal representative
of the Estate of GARY RAKES,
Plaintiff Below,
Respondent

RESPONDENT'S BRIEF

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III. STATEMENT OF THE CASE

This medical malpractice action stems from the medical treatment received by the decedent, Gary Rakes, while in the care of his attending physician, Dr. Delilah Stephens, the Petitioner and Defendant below, at the Bluefield Regional Medical Center (hereinafter “BRMC”). Gary Rakes suffered from several chronic health problems, including obstructive sleep apnea, COPD, and chronic hypercapnia, which caused him to retain excess carbon dioxide (CO₂) in his blood and to become confused and agitated. (*See* Death Summary authored by Delilah Stephens, **Exhibit 24** : SCT0936 – SCT0937 and Death Certificate authored by Delilah Stephens, **Exhibit 23** : SCT0933 – SCT0934). While at home, Mr. Rakes used a bilevel positive airway pressure (hereinafter “BiPAP”) portable ventilator to treat the condition, and to help expel the CO₂ from his blood. *Id.*

Additionally, Mr. Rakes had a documented allergy/drug sensitivity to a drug called Seroquel which caused him to become excessively sedated. *Id.* Sedatives are contraindicated for persons with obstructive sleep apnea, particularly when given without proper ventilatory support. The “black box” warnings for Seroquel indicate “somnolence” as a potential side affect, and it is contraindicated in elderly patients with dementia-related psychosis. *Id.*

On prior occasions, Mr. Rakes was hospitalized at BRMC with acute respiratory distress caused by excess CO₂ retention that caused decreased mental and respiratory function. (*See* BRMC records from Oct. 2008, March 2010, and June 2010, **Exhibit 24** : SCT1010 – SCT1051). During these visits, multiple arterial blood gas levels (hereinafter “ABG’s”) were obtained in order to monitor the amount of CO₂ in his blood. *Id.* Additionally, a pulmonologist was always consulted to properly manage Mr. Rakes’ lung problems. *Id.* Likewise, in prior visits to BRMC,

Mr. Rakes was given ventilatory support with BiPAP to help him expel the excess CO₂ from his lungs. *Id.*

Prior to his final visit, Mr. Rakes had presented to BRMC in late June 2010 where the Defendant, Delilah Stephens, was listed as his attending physician. (*See* BRMC records from Oct. 2008, March 2010, and June 2010, **Exhibit 24** : SCT1010 – SCT1051). During that visit, a pulmonologist was consulted to manage Mr. Rakes lung issues, multiple ABG's were taken to monitor his CO₂ levels, and Mr. Rakes' received a BiPAP and breathing treatments such as bronchodilators to help him expel excess CO₂ from his lungs. *Id.* He was successfully treated and went home.

In contrast, Mr. Rakes received none of this treatment while under the care of Dr. Stephens during his final hospital admission in September 2010. During the early morning hours of September 3, 2010, Mr. Rakes presented to BRMC with an exacerbation of the same chronic lung problems for which he had presented on his June 2010 visit. (*See* BRMC records from Sept. 2010, **Exhibit 24** : SCT0935 – SCT1009). His initial ABG's revealed that he had "panic high" CO₂ levels in his blood. (*Id.* at SCT0998). In a complete contradiction to the care Dr. Stephens managed just over two month earlier, on this occasion she chose not to order any follow up ABG studies, which is the standard for measuring CO₂ levels in the blood. (*See* BRMC records from Sept. 2010, **Exhibit 24** : SCT0935 – SCT1009).

Dr. Stephens chose not to consult a pulmonologist to treat Mr. Rakes at any time during the September 2010 admission. *Id.* She chose not to give him any breathing treatments. *Id.* Mr. Rakes needed BiPAP when he was asleep, and he did not receive it even though he was heavily sedated. (**Exhibit 24** : SCT0935 – SCT1009). Dr. Stephens was aware that Mr. Rakes had been

given a large dose of an anti-psychotic sedative called Seroquel to which Mr. Rakes had a known and documented adverse reaction. *Id.* She was aware that he had also been given another anti-psychotic sedative called Haldol. *Id.* She chose not to take any counter-measures to address his heavy sedation. (**Exhibit 24** : SCT0935 – SCT1009). She chose not to order BiPAP until 10:00 p.m. on September 4, 2010, even though Mr. Rakes was in an obtunded state. *Id.* Gary Rakes was heavily sedated, and placed flat on his back while in wrist restraints on the night of September 3, 2010, until the time he died on the morning of September 5, 2010. *Id.*

Prior to trial in this medical malpractice action, the Petitioner moved the Circuit Court for Summary Judgment on the issues of liability and punitive damages. A pre-trial conference was held on April 29, 2013, where those motions, along with other motions *in Limine* were argued before the Honorable Judge Omar Aboulhosn. (*See Exhibit 15, 16, 17, and Plaintiffs motion in Limine at Exhibit 28* : SCT1345 – SCT1365). The Respondent's response to the Petitioner's motions for Summary Judgment cited to the BRMC medical records, the death certificate and death summary (both authored by Dr. Stephens), and deposition testimony by the Respondent's two expert witnesses, Dr. Schwartz and Dr. Scissors. (*Id. at Exhibit 17* : SCT 0777 – SCT0900). Importantly, the Respondent's response pointed out that the Petitioner had changed her opinion on Gary Rakes' cause of death after she was sued, that both of the Plaintiff's experts were critical of the lack of care that she provided Gary Rakes as his attending physician, and that these failures on her part were a proximate cause of Gary Rakes' death. *Id.* Dr. Schwartz testified that it was the worst three days of care he had ever seen. *Id.* The Court denied both of the Petitioner's motions for Summary Judgment and entered an Order regarding its rulings on May 14, 2013. (*See Exhibit 20* : SCT0924 – SCT0928).

Significantly, the Plaintiff moved the Court *in Limine* to preclude the Petitioner from mentioning to the jury that Gary Rakes was non-compliant with the use of his BiPAP machine prior to his last hospital admission, or that he was somehow responsible for his acute respiratory problems. (See **Exhibit 28** : SCT1345 – SCT1365). The rationale for the motion was that a jury is not permitted to consider any negligent conduct on the part of the plaintiff that led him to seek medical attention. *Rowe v. Sisters of the Pallottine Missionary Society*, 211 W. Va. 16, 22; 560 S.E.2d 491 (2001). In a medical malpractice lawsuit, a health care provider cannot claim that a plaintiff is comparatively negligent even if his conduct triggers the need for the medical treatment. *Id.* The Court granted the Respondent’s motion prohibiting any statements, arguments or references that the decedent Gary Rakes was comparatively negligent in requiring medical treatment. (See **Exhibit 20** : SCT0924 – SCT0928).

Along those same lines, during *voir dire*, Respondent’s counsel inquired of the entire jury panel whether any of them had heard of the medical condition COPD, one of the serious respiratory issues from which the decedent Gary Rakes suffered. (See pages 48 - 53 of **Exhibit 30** : SCT1546 – 1548). As expected, a number of people on the panel raised their hands. *Id.* Plaintiff’s counsel continued to ask the panel about their knowledge of COPD. *Id.* One potential juror, Tracy Boyer, raised her hand to indicate that she had heard of COPD. *Id.* When asked what she knew, Ms. Boyer stated, “I know that COPD can come from smoking so many years.” (See pages 52 - 53 of **Exhibit 30** : SCT1547 – 1548). Ms. Boyer went on to state that she didn’t know anyone with COPD, but she had seen commercials on TV, and that “you could catch emphysema with it.” *Id.*

Although other members of the panel stated they had knowledge of COPD, this was the

first and only time during *voir dire* that any panel member displayed a direct connection between smoking and COPD.¹ This concerned Respondent's counsel because there is mention throughout Gary Rakes' medical records that Mr. Rakes was a life long smoker and had recently quit in the last few years before his death (*See Exhibit 24* : SCT0935– SCT1051). Although, Mr. Rakes' family denies that he ever smoked, Respondent's counsel preferred that it not be mentioned at all during trial to prevent bias against Mr. Rakes for causing or contributing to his own lung problems by smoking. This is the same reasoning argued in the Plaintiff's above-referenced Motion *in Limine*. Because Ms. Boyer linked smoking as the only cause of COPD, and that was her only knowledge of the condition, Respondent's counsel used his second peremptory strike to remove her from the jury panel. Counsel for the Petitioner objected to Ms. Boyer being removed from the panel because she is an African-American, as is the Petitioner. (*See Exhibit 30* : SCT1563 – SCT1564). During the bench conference, when asked for a non-discriminatory reason for the strike, Respondent's counsel stated that “[s]he made references to smoking and causing lung problems, other issues that I think would make her a bad juror for my client.” *Id.* After the Court took a brief recess, a hearing on the issue took place outside of the presence of the jury where counsel again placed their objection and response on the record. The Court overruled the Petitioner's objection to striking Ms. Boyer as a juror. *Id.*

Throughout the course of the trial, the Court also denied the Defense team's motions for Judgment as a Matter of Law. Their argument claimed that the Respondent had failed to establish a *prima facie* case of negligence and right to recovery. During Respondent's case-in-chief,

¹ Juror Darago said her husband had COPD and black lung as a result of being a coal miner, and Juror Vance stated that he has emphysema because his lungs were burnt while he was a firefighter, and he smoked. (*See* pages 49 - 53 of *Exhibit 30* : SCT1547 – 1548)

however, the evidence which clearly established the Respondent's *prima facie* case of medical malpractice.

In addition to the aforementioned evidence contained in Gary Rakes' medical records, the Respondent presented additional evidence, including the death certificate and death summary, and expert witness testimony from a hospitalist and pulmonologist. The main highlights from this evidence is listed below:

Death Certificate and Death Summary authored by Dr. Delilah Stephens
(See Exhibit 23 : SCT0933 – 0934 and Death Summary at Exhibit 24 : SCT 0936 – 0937)

- a. Dr. Stephens wrote on the Death Certificate that Gary Rakes died as a result of *Acute on Chronic Hypercapnic Respiratory Failure* due to or as a consequence of *Adverse Drug Reaction to Seroquel*.
- b. Dr. Stephens wrote in the Death Summary that Mr. Rakes' increased agitation may have been related to his increased hypercapnia. She wrote that Mr. Rakes was not on his BiPAP because the settings were unknown. She also wrote that Mr. Rakes was so sedated on September 4, 2010 that they couldn't wake him up. She still chose not order any ventilatory support with BiPAP until approximately 12 hours later.

Testimony of Respondent's Expert Witness Dr. Scissors – Hospitalist

- a. Mr. Rakes's CO2 level was dangerously high when he presented to BRMC on September 3, 2010. (See Exhibit 30 : SCT1584).
- b. Dr. Stephens took over his care and was the attending physician after he was initially treated in the Emergency Department. *Id.* She was also his attending physician two months before the September 3, 2010 admission. *Id.* Those records were available to Dr. Stephens.
- c. During the previous visit when she was Mr. Rakes' attending physician, Dr. Stephens provided appropriate care when she consulted a pulmonologist, put him on BiPAP, and gave him breathing treatments, and Mr. Rakes walked out of the hospital. (*Id.* at 1585).
- d. During his final hospital admission, Dr. Stephens deviated from the standard of care by choosing not to consult a pulmonologist or provide any

treatment for Mr. Rakes' lung problems after he came under her care. (*See Exhibit 30 : SCT1585 – SCT1586*).

- e. Dr. Stephens deviated from the standard of care by choosing not to repeat the ABG test to monitor his CO₂ level, even though the tests upon his arrival showed a dangerously high level of CO₂. *Id.*
- f. Dr. Stephens did not initially order a BiPAP because she didn't know the proper settings. Even though Mr. Rakes was given medications (sedatives) that worsened his CO₂ problem, Dr. Stephens chose not to give him the BiPAP when she realized he was heavily sedated and unconscious on the morning of September 4, 2010. (*Id.* at 1586 – SCT1587, SCT1588 – SCT1591).
- g. Mr. Rakes did not receive any treatment for his lungs from the time Dr. Stephens took over his care until he died. He was sedated, placed in wrist restraints, and laid flat on his back with no ventilatory support. This was more than dangerous; this was "reckless". (*Id.* at SCT1591). All of these deviations were a proximate cause of his death. (*Id.* at 1594).

Testimony of Respondent's Expert Witness Dr. Schwartz – Pulmonologist

- a. Dr. Schwartz testified that Gary Rakes received appropriate care in the emergency department at BRMC prior to being placed in Dr. Stephens' care. (*Exhibit 30 : SCT1655*).
- b. Mr. Rakes' ABG test in the emergency department revealed that he had an extremely elevated CO₂ level. *Id.*
- c. Mr. Rakes was transferred into Delilah Stephens' care on September 3, 2010. She did not understand that Mr. Rakes' elevated CO₂ levels were causing him to be confused. (*Id.* at SCT1656).
- d. Dr. Stephens never ordered any treatment, including BiPAP, for Mr. Rakes' respiratory problems on September 3, 2010. Apparently, they didn't know his BiPAP settings. (*Id.* at SCT1656 – SCT1657).
- e. Mr. Rakes was physically and chemically restrained by wrist restraints and anti-psychotic sedatives. (*Exhibit 30 : SCT1657*).
- f. Mr. Rakes was so heavily sedated on September 4, 2010, that he was in an obtunded state, which means that he did not respond to voice; rather, he only responded to physical stimuli which caused him pain. *Id.*

- g. Dr. Stephens deviated from the standard of care by failing to order follow up ABG testing after the initial ABG revealed a panic high level. (*Id.* at 1659).
- h. When Dr. Stephens finally ordered the BiPAP for Mr. Rakes to be received on the night of September 4, 2010, the settings were incorrect and Mr. Rakes was not likely to survive. *Id.*
- i. Gary Rakes died as a result of Dr. Stephens' deviations from proper medical care, including her failure to provide any treatment for his respiratory issues outside of the initial breathing treatment in the emergency department. (**Exhibit 30** : SCT1659 – SCT1660).

The Circuit Court denied the Petitioner's Motion for Judgment as a Matter of Law. At the conclusion of the trial, the jury returned a verdict in favor of the Respondent, and awarded \$500,000.00 in compensatory damages, and \$500,000.00 in punitive damages. (*See* Judgment Order at **Exhibit 26** : SCT1056 – 1061). Likewise, the Circuit Court denied the Petitioner's Motion for Renewed Motion for Judgment as a Matter of Law, or in the Alternative, Motion for a New Trial. (*See* September 9, 2013 Order Denying Petitioner's Renewed Motion for Judgment as a Matter of Law, or Motion for a New Trial **Exhibit 31** : SCT1927 – 1947).

IV. SUMMARY OF ARGUMENT

The Circuit Court's denial of the Petitioner's Motions for Summary Judgment regarding liability and punitive damages was correct. Both of the Respondent's experts testified in their depositions that Dr. Stephens should have ordered the BiPAP from the very beginning of the hospital admission on September 3, 2010. She should have ordered follow up ABG testing. She should have made sure that the BiPAP settings were correct, and that Mr. Rakes actually receive the BiPAP, which he did not. She should have consulted his pulmonologist. She should have taken appropriate action once she realized that Mr. Rakes had received Seroquel and Haldol, instead of allowing him to lie flat on his back in an obtunded state for the majority of his hospital

admission while his CO2 levels continued to rise to the point that he succumbed to respiratory arrest. The Respondent's experts testified in their depositions that these failures by Dr. Stephens were all proximate causes of Mr. Rakes' death.

Likewise, the Circuit Court correctly denied the Petitioner's motion for Summary Judgment with regard to punitive damages because, in addition to the above failures by Dr. Stephens that led to Gary Rakes' death, a jury could find that her actions were reckless. There was direct testimony from Dr. Kenneth Scissors that the Petitioner's care was "reckless". This, combined with the undisputed fact that Dr. Stephens rescinded her initial findings on the Death Certificate once she became involved in the lawsuit and that she otherwise attempted to cover up her involvement by blaming hospital staff, was enough to create genuine issues of fact that leave the question for a jury to decide.

With regard to the Petitioner's *Batson* challenge, the Respondent's attorney gave a valid, non-discriminatory reason for striking Juror Bolyard after the challenge was raised. The Respondent's attorney had previously filed a Motion *in Limine* to preclude evidence that the decedent contributed to his own demise, and the medical records incorrectly stated that the decedent was a life-long smoker. Juror Bolyard's responses during *voir dire* established that her only knowledge of COPD, one of the conditions suffered by Gary Rakes, was that it was caused solely by smoking. The Court overruled the challenge correctly, as the non-discriminatory reason was sufficient for striking Juror Bolyard from the panel.

Furthermore, the Court's rulings related to whether prejudicial error crept into the record during trial were correct, because, at the very most, any remarks made were harmless error. Finally, the Circuit Court's denial of the Petitioner's DNR instructions was correct because the

proposed jury instruction was a misstatement of the law, was irrelevant to the case, and did not affect the Petitioner's ability to present her theory of the case.

V. STATEMENT REGARDING ORAL ARGUMENT AND DECISION

The Petitioner has requested oral argument pursuant to Rule 18(a). The Respondent and Plaintiff below respectfully submit that oral argument is not necessary because the dispositive issues have been decided in a thorough Final Order setting forth detailed findings of fact and conclusions of law. Both Petitioner and Respondent are represented by competent counsel, and the facts and legal arguments are adequately presented in the briefs and record on appeal. To the extent this Court deems oral argument would significantly aid the decisional process, the Respondent would be honored to appear and defend the issuance of the Final Order by the Circuit Court.

VI. ARGUMENT

A. Applicable Standard of Review

1. Motions for Summary Judgment

The Circuit Court correctly denied the Petitioner's Motions for Summary Judgment with regard to liability and punitive damages in the case below. A Circuit Court's entry of Summary Judgment is reviewed *de novo*. Syl. Pt. 1, *Davis v. Foley*, 193 W. Va. 595, 457 S.E.2d 532 (1995). Additionally, "[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." Syl. Pt. 3, *Aetna Casualty & Surety Co. v. Federal Ins. Co. Of N.Y.*, 148 W. Va. 160, 133 S.E.2d 770 (1963). Furthermore, "[a] party who moves for summary judgment has the burden of showing that there is not genuine issue of fact and any doubt as to the existence

of such issue is resolved against the movant for such judgment.” (*Id.* at Syl. Pt. 6) Petitioner did not meet this burden; thus, the ruling was proper.

2. Renewed Motion for Judgment as a Matter of Law and Motion for New Trial

The Circuit Court correctly denied the Petitioner’s Renewed Motion for Judgment as a Matter of Law and Motion for New Trial. “The appellate standard of review for an order granting or denying a renewed motion for a judgment as a matter of law after trial pursuant to Rule 50(b) of the *West Virginia Rules of Civil Procedure* is *de novo*.” Syl. Pt. 1, *Fredeking v. Tyler*, 224 W. Va. 1, 680 S.E.2d 16 (2009). This Court has also stated that when it “reviews a trial court’s order granting or denying a renewed motion for judgment as a matter of law under Rule 50(b). . .it is not the task of this Court to review the facts to determine how it would have ruled on the evidence presented. Instead, its task is to determine whether the evidence was such that a reasonable trier of fact might have reached the decision below. Thus, when considering a ruling on a renewed motion for judgment as a matter of law after trial, the evidence must be viewed in the light most favorable to the nonmoving party.” *Id.* at Syl. Pt. 2.

Finally, this Court has stated “[w]e review the rulings of the circuit court concerning a new trial and its conclusions as to the existence of reversible error under an abuse of discretion standard, and we review the circuit court’s underlying factual findings under a clearly erroneous standard. Questions of law are subject to a *de novo* review.” *Tennant v. Marion Health Care Foundation*, 194 W. Va. 97, 104, 459 S.E.2d 374, 381 (1995).

B. The Circuit Court of Mercer County Properly Denied Petitioner’s Motion for Summary Judgment on Respondent’s Amended Complaint as There Were Genuine Issues of Material Fact that Petitioner Proximately Caused the Death of Gary Rakes.

The Circuit Court correctly denied the Petitioner's motion for Summary Judgment regarding liability prior to the trial in this matter. The Respondent's expert witnesses submitted reports, testified at depositions, and a jury returned a verdict to support the Respondent's allegations that Dr. Stephens was responsible for causing Mr. Rakes' death. Dr. Stephens deviated from the standard of care when providing medical treatment to Mr. Rakes, and those deviations from the standard of care were all proximate causes of his death. The West Virginia Supreme Court of Appeals has been clear in stating that "a plaintiff's burden of proof is to show that a Petitioner's breach of a particular duty of care was *a proximate cause* of the plaintiff's injury, not the *sole proximate cause*." *Mays v. Chang*, 213 W. Va. 220, 224; 579 S.E.2d 561, 565 (2003). Additionally, "[a] party in a tort action is not required to prove that the negligence of one sought to be charged with an injury was the sole proximate cause of an injury." *Id.*

In her motion for summary judgment, Dr. Stephens stated that her actions were not the *sole proximate cause* of Mr. Rakes' death because *she* did not personally order Seroquel for Mr. Rakes on September 3, 2010; *she* did not order Seroquel for Mr. Rakes on September 4, 2010; and *she* was not the one that failed to administer BiPAP on the night of September 4, 2010. However, Dr. Stephens' argument failed for many reasons, the most important of which is that she was the attending physician/hospitalist that was in charge of Mr. Rakes' medical treatment.

As this Court stated in *Mays*, and as the Respondent stated in his Response to Petitioner's Motion for Summary Judgment, the Plaintiff must only prove that a particular defendant's actions be *a proximate cause* of injury, not the *sole proximate cause*. (*Id.* and **Exhibit 17** – Plaintiff's

Response to Petitioner's Motions for Summary Judgment).² In *Mays*, a patient received treatment for diabetes and high blood pressure from a particular doctor for three and one-half years before the patient was ultimately diagnosed with colorectal cancer and subsequently died. 213 W. Va. 220 at 222; 579 S.E.2d 561 at 564. The trial court excluded the plaintiff's evidence concerning whether the doctor had performed a particular blood test because the court believed that it was not foreseeable that this test would lead to the discovery of the patient's cancer, and therefore the failure to do so was not a proximate cause of the failure to diagnose the cancer. *Id.* In overturning the trial court, the *Mays* Court stated that "because we believe reasonable jurors could draw different conclusions from the evidence proffered by the appellant, we find that the circuit court erred in excluding the appellant's blood test evidence". *Id.* Therefore, it is clear from *Mays* that a defendant is not entitled to summary judgment where a question of fact regarding proximate cause exists.

The Petitioner has stated all of the reasons why her actions were not the *sole* proximate cause of Mr. Rakes' death, but has failed to mention the following deviations from the standard of care that were *a* proximate cause of Mr. Rakes' death:

1. After Mr. Rakes was admitted to BRMC on September 3, 2010, and placed under Dr. Stephens' care, Dr. Stephens failed to order another ABG test to check the critical CO2 levels in his blood. (Pages 26 –34 of **Exhibit 12** : SCT0487 – SCT0495, Dr. Schwartz deposition) .

² Respondent's Response to Petitioner's Motion for Summary Judgment regarding liability included both of its Expert Witness disclosures (**Exhibits 13 & 14**), the records related to Mr. Rakes' medical care at BRMC in September 2010 (**Exhibit 24** : SCT0935 – SCT1009), and deposition testimony from its expert witness, Dr. Schwartz (**Exhibit 12**).

2. After Mr. Rakes was admitted to BRMC on September 3, 2010, Dr. Stephens failed to order BiPAP to help provide ventilatory assistance so that he could expel CO₂ from his lungs. She finally ordered BiPAP on September 4, 2010, for 10:00 p.m. that evening, but even then, the settings were not appropriate. She never followed up to see if the BiPaP order was carried out, which it wasn't. *Id.*
3. Dr. Stephens failed to take any countermeasures after noting in the record on September 4, 2010, that Mr. Rakes had received Seroquel, a drug to which he had a known adverse reaction. *Id.*
4. Dr. Stephens failed to consult Mr. Rakes' pulmonologist, who had helped to provide him with proper ventilatory assistance during previous hospital admissions when he received a sedative. She consulted a neurologist instead. *Id.*
5. Dr. Stephens failed to consult Mr. Rakes' pulmonologist when she did not know Mr. Rakes' BiPAP settings. Instead, Dr. Stephens waited while Mr. Rakes' languished in the hospital until she ordered BiPAP with her own arbitrary and incorrect settings. (Pages 26 – 34 of **Exhibit 12** : SCT0487 – SCT0495, **Exhibit 24** : SCT0935 – SCT1009) .
6. After Dr. Stephens finally ordered the BiPAP for September 4, 2010, with inadequate settings, she did not make sure that the critical order was followed, even though she was in charge of Mr. Rakes' care. Moreover, she ordered the BiPaP to be administered at night, while Mr. Rakes needed

it for sleep and was heavily sedated. *Id.*

7. Dr. Stephens never treated Mr. Rakes for his chronic pulmonary disease, which was the reason for his final hospital admission, as well as previous hospital admissions. *Id.*

To provide an appropriate analogy of Dr. Stephens' care of Mr. Rakes, it was similar to treating a patient who was slowly bleeding to death from a leg wound by consulting a cardiologist who prescribes aspirin and other blood thinners, to which the patient has a known allergy, and then leaving the hospital without ever treating the leg wound.

The Petitioner Stephens' main focus of her motion for Summary Judgment was that the Plaintiff's expert Dr. Schwartz stated in his deposition that if Mr. Rakes received the BiPAP that Dr. Stephens ordered, then he would have survived. In other words, Dr. Stephens argues that she ordered a BiPAP, and it is not her fault that the staff at the hospital failed to carry out the order. This argument is inaccurate and also fails to account for her role as attending physician in charge of Mr. Rakes' care.

First, that is **not** what Dr. Schwartz said at his deposition. In response to Petitioner's counsel asking at what point in time BiPAP therapy would have been too late to save Mr. Rakes, Dr. Schwartz stated:

Well, bizarrely, it was ordered for the night of the 4th. It was ordered QHS, which is evening. But he did not die until the following morning. And I do believe that 9:00 or 10:00 p.m., if he would have gotten *appropriate* BiPAP therapy, he may well have survived.

(Page 30 of **Exhibit 12** – SCT0491) (emphasis added).

...

Q: I don't think you said that it was too late, I think you testified that if the BiPAP

order would have been followed, that – to a reasonable degree of medical certainty, that in likelihood he would have survived.

A: *If it was ordered differently.* I don't like the way it was set up in terms of the orders. I'm critical of that, as I've said. And of course he would need continued monitoring. So in the gentleman with severe respiratory acidosis, he needed measurements of his carbon dioxide level as time went on. So there was a BiPAP order to start that night. There was no measures or orders for arterial blood gases to monitor his carbon dioxide. All the time he's sedated and sleepy and hard to [*sic*] arose and has worsened mental status, they don't check his carbon dioxide level. So had BiPAP been used *correctly*, even on the evening of the 4th, he likely would have survived, ***but that order – and in the context of all the other orders that were not there, was too little too late.***

(Pages 32 – 33 of **Exhibit 12** – SCT 0493 – 0494) (emphasis added).

Furthermore, Dr. Schwartz also stated in his deposition that:

Well, if I was the admitting doctor and got him from the emergency room, he would have had an order for BiPAP as part of his admitting orders. I also would have used different settings than what he was set on, which I think were incorrect. (Page 25 of **Exhibit 12** – SCT0486).

So his pressure settings I was in disagreement with, and obviously the timing, as I already addressed. (Page 26 of **Exhibit 12** – SCT0487).

He should have had the therapy when he got admitted 24 hours a day, with monitoring of his carbon dioxide level. His carbon dioxide level was extremely elevated. That was the likely cause of his abnormal mental status when he came in. And the treatment of that was straightforward, which is to use BiPAP at the time of his hospitalization for acute decompensation. (Page 26 of **Exhibit 12** – SCT0487).

When asked specifically about additional criticisms of Dr. Stephens, Dr. Schwartz said:

So he got sedated when he shouldn't. He didn't get a bedside sitter to control his agitation if that was deemed necessary. He didn't get BiPAP when he needed it. He didn't get carbon dioxide levels measured and followed up. He didn't get a pulmonary consult. He didn't get any treatment for his COPD once he left the emergency room. He didn't get any of the care that he received on previous hospitalizations for respiratory failure. So this was as bad a care as I've ever seen in my 30 years in a three-day hospitalization. If I can summarize it that way. (Pages 33 –34 of **Exhibit 12** : SCT0494 – SCT0495).

In addition to criticizing the BiPAP settings ordered by Dr. Stephens, Dr. Schwartz testified that Dr. Stephens should have ordered the BiPAP from the very beginning of the hospital admission on September 3, 2010. *Id.* Likewise, she should have made sure that the BiPAP settings were correct, and that Mr. Rakes actually received the BiPAP. She should have consulted his pulmonologist. She should have taken appropriate action once she realized that Mr. Rakes had received Seroquel. She should have done a number of things that she failed to do that were all proximate causes of Mr. Rakes' death.

Therefore, because there were genuine issues of fact that were properly tried before a jury; because the Petitioner failed to meet its burden in proving that no genuine issues of fact existed, which is evidenced by the by the jury's verdict; and because these issues were resolved properly against the moving party, the Circuit Court was correct to deny the Petitioner's Motion Summary Judgment.

C. The Circuit Court of Mercer County Properly Denied Petitioner's Motion for Summary Judgment on Respondent's Claim for Punitive Damages as There Were Genuine Issues of Fact that Petitioner Acted Recklessly in Her Care of Gary Rakes

The Petitioner's Motion for Summary Judgment with regard to punitive damages was properly denied by the Circuit Court because the Respondent demonstrated that a genuine issue of fact existed as to whether the Petitioner's medical care of the decedent Gary Rakes was reckless. The Petitioner is incorrect in her argument that the Respondent must prove that Dr. Stephens' actions were intentional in order to receive an award for punitive damages; it is clear in West Virginia that proving that a defendant's actions were reckless is also sufficient for an award of punitive damages. Syllabus Point 4 of *Mayer v. Frobe*, 40 W. Va. 246 (1895); *Stone v. Rudolph*, 127 W. Va. 335, 345 (1945); *see also Addair v. Huffman*, 156 W. Va. 592, 603 (1973). In his

response to the Petitioner's Motion for Summary Judgment regarding punitive damages, the Respondent presented evidence that the care Dr. Stephens provided was dangerous and, at the very least, reckless.

This Court first developed the standard for awarding punitive damages in Syllabus Point 4 of *Mayer v. Frobe*, 40 W. Va. 246 (1895) that stated:

In actions of tort, where gross fraud, malice, oppression, or wanton, willful, or **reckless** conduct or criminal indifference to civil obligations affecting the rights of others appear, or where legislative enactment authorizes it, the jury may assess exemplary, punitive, or vindictive damages; these terms being synonymous. (emphasis added)

Likewise, this Court has expounded on *Mayer*, adding that "the punitive damages definition of malice has grown to include not only meanspirited conduct, but also extremely negligent conduct that is likely to cause serious harm." *TXO Prod. Corp. v. Alliance Res. Corp.*, 187 W. Va. 457, 474, 419 S.E.2d 870, 887 (1992). The Petitioner is adamant that there must be some willful or wanton intent involved before punitive damages are awarded; however, this Court has further clarified that "wanton negligence" means "reckless":

Reckless indifference to the consequences of an act or omission, where the party acting or failing to act is conscious of his conduct and, without any actual intent to injure, is aware, from his knowledge of existing circumstances and conditions, that his conduct will inevitably or probably result in injury to another.

Stone v. Rudolph, 127 W. Va. 335, 345 (1945); *see also Addair v. Huffman*, 156 W. Va. 592, 603 (1973) (holding that "[t]he foundation of an inference of malice is the general disregard or the rights of others, rather than an intent to injure a particular individual.").

Therefore, it is clear that an appellate court need only be satisfied that a jury could reasonably conclude that Dr. Stephens' actions were fraudulent, malicious, oppressive, wanton willful **or reckless** in deciding whether to uphold an award of punitive damages, and not solely

malicious or with intent.

As evidence of Delilah Stephens' dangerous and reckless care of Mr. Rakes, the Respondent submitted the following in its Response to Petitioner's motion for Summary Judgment regarding punitive damages, along with supporting exhibits:

1. Dr. Stephens was aware the Mr. Rakes received an order of 100 mg of Seroquel for Mr. Rakes, a drug to which he had a documented drug sensitivity, on top of 5 milligrams of Haldol. Both drugs are heavy sedatives, which are contraindicated for patients such as Mr. Rakes. There was no justification for administering these drugs to Mr. Rakes. Further, she failed to take any sort of counter-measures to address the mistake.
2. Dr. Stephens failed to order ABG's after Mr. Rakes' hospital admission, which resulted in no one at the hospital having any sort of measurement of the CO2 levels in Mr. Rakes' blood, the critical issue that caused him to be admitted.
3. Dr. Stephens failed to treat Mr. Rakes' chronic lung disease in any fashion, except for ordering a BiPAP to be administered the night of September 4, 2010, which was too late, and with inappropriate settings. *Id.* The reason Dr. Stephens stated that she did not order BiPAP sooner is because she didn't know the settings – however, she never consulted any pulmonologist, not to mention Mr. Rakes' treating pulmonologist that works at BRMC. *Id.* Dr. Stephens never followed up to ensure that the BiPap was administered. It never was.
4. During previous hospital admissions, a pulmonologist was consulted so that Mr. Rakes' would receive appropriate treatment for his chronic lung disease. Dr.

Stephens failed to consult a pulmonologist during the September 3-5, 2010 admission, and Mr. Rakes died.

5. Dr. Stephens noticed that Mr. Rakes' was so sedated that he could not be roused without aggressive physical stimulation, however, she still did not attempt to treat Mr. Rakes' critical CO2 level with immediate and appropriate BiPAP, or ensure that he not receive further doses of Seroquel.
6. Dr. Stephens even authored the Death Summary blaming Mr. Rakes' death on the administration of Seroquel, but rescinded this opinion during her deposition. She was reckless with her medical care and continues to act recklessly with her frivolous opinions.

(*See Exhibit 17* – Respondent's Response to motion for Summary Judgment with exhibits : SCT0777 – SCT0900).

The Respondent presented evidence in the form of the death certificate, medical records, expert testimony, and Dr. Stephen's own testimony. *Id.* That evidence made it clear that Dr. Stephens knew Mr. Rakes was in the hospital because of his elevated CO2 (hypercapnia), that she knew elevated CO2 could be deadly, and that she chose not to treat it. *Id.* Dr. Stephens chose not to provide any ventilatory support to Mr. Rakes; she chose not to provide any treatment for his respiratory issues; she chose not to order follow up ABG tests; she chose not to consult a pulmonologist; and she chose not to do anything to counter the effects of the sedatives that placed him in an unconscious state while he lay flat on his back in wrist restraints. (*See Exhibit 17* – Respondent's Response with exhibits : SCT0777 – SCT0900).

The Respondent's expert Dr. Schwartz provided an accurate summary of Dr. Stephens'

pattern of utter incompetence and blatant neglect regarding Mr. Rakes' care:

So he got sedated when he shouldn't. He didn't get a bedside sitter to control his agitation if that was deemed necessary. He didn't get BiPAP when he needed it. He didn't get carbon dioxide levels measured and followed up. He didn't get a pulmonary consult. He didn't get any treatment for his COPD once he left the emergency room. He didn't get any of the care that he received on previous hospitalizations for respiratory failure. So this was as bad a care as I've ever seen in my 30 years in a three-day hospitalization. If I can summarize it that way.

(Pages 33 –34 of **Exhibit 12** : SCT0494 – SCT0495) Dr. Scissors testified at trial that allowing a patient such as Mr. Rakes to remain sedated, placed in wrist restraints, and laid flat on his back with no ventilatory support was more than dangerous; this was “reckless”. (*Id.* at SCT1591).

Therefore, because the Respondent presented sufficient evidence in its response to the motion for Summary Judgment highlighting the reckless actions of Dr. Stephens; because a jury could have found that the Petitioner's care of the decedent was reckless; and because this Honorable Court recognizes that a tortfeasor's conduct does not have to be intentional before a jury may award punitive damages, the Circuit Court properly denied the Petitioner's motion for Summary Judgment regarding punitive damages.

D. The Petitioner's Renewed Motion for Judgment as a Matter of Law was properly denied because the Respondent presented sufficient evidence that established a *prima facie* case of negligence that was a proximate cause of Gary Rakes' death.

The Petitioner's motion was properly denied because the Respondent presented sufficient evidence to establish a *prima facie* case of negligence pursuant to the West Virginia Medical Professional Liability Act (MPLA). “Upon a motion for directed verdict, all reasonable doubts and inferences should be resolved in favor of the party against whom the verdict is asked to be directed.” Syl. Pt. 5, *Wager v. Sine*, 157 W. Va. 391, 201 S.E.2d 260 (1973). Likewise, “every reasonable and legitimate inference fairly arising from the testimony, when considered in its

entirety, must be indulged in favorably to plaintiff; and the court must assume as true those facts which the jury may properly find under the evidence.” Syl. Pt. 1, *Jividen v. Legg* 161 W. Va. 769, 245 S.E.2d 835 (1978).³

Pursuant to the MPLA, the Respondent provided the necessary elements required in proving that Gary Rakes’ death resulted from the failure of Dr. Delilah Stephens to follow the accepted standard of care. Specifically, that Dr. Stephens 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 she belonged acting in the same or similar circumstances, and that such failure was *a proximate cause of the injury or death*. See W. Va. Code § 55-7B-3(a). (See page 330 – 331 of **Exhibit 30** : SCT1660; See pages 236 – 240 of **Exhibit 30** : SCT1593 – 1594).

As stated above, the Respondent presented evidence through medical records and qualified expert witness testimony that Dr. Stephens deviated from the acceptable standard of care by (1) failing to order followup ABG tests after Mr. Rakes came under her care (**Exhibit 30** : SCT1585 – 1586, SCT 1659); (2) failing to provide any bronchodialators or breathing treatments (*Id.*); (3) failing to order BiPAP on September 3, 2010 and during the day of September 4, 2010 (*Id.*); (4) failing to provide *appropriate* BiPAP settings for when the order was actually to be carried out on the night of September 4, 2010 (**Exhibit 30** : 1659); (5) allowing Mr. Rakes to remain heavily

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See also; Syllabus Point 4, *Laslo v. Griffith*, 143 W. Va. 469, 102 S.E.2d 894 (1958) (When a case involving conflicting testimony and circumstances has been fairly tried, under proper instructions, the verdict of the jury will not be set aside unless plainly contrary to the weight of the evidence or without sufficient evidence to support it.); Syllabus Point 3, *Walker v. Monongahela Power Co.*, 147 W. Va. 825, 131 S.E.2d 736 (1963) (In determining whether the verdict of a jury is supported by the evidence, every reasonable and legitimate inference, fairly arising from the evidence in favor of the party for whom the verdict was returned, must be considered, and those facts, which the jury might properly find under the evidence, must be assumed as true.); *Sargent v. Malcomb*, 150 W. Va. 393, 146 S.E.2d 561 (1966) (An award of a new trial should be reversed if a consideration of the evidence shows that the case is a proper one for jury determination.)

sedated in an obtunded state even after she examined him on September 4, 2010 (**Exhibit 30** : 1657); and (6) by failing to consult a pulmonologist like had been done during past admissions. (**Exhibit 30** : SCT1585 – SCT1586).

Likewise, the Respondent presented sufficient evidence through expert witness testimony that Dr. Stephens' deviations from the acceptable standard of care were a proximate cause of Gary Rakes' death. (*See* page 330 – 331 of **Exhibit 30** : SCT1660; *See* pages 236 – 240 of **Exhibit 30** : SCT1593 – 1594). The Defense team has misstated the actual testimony by stating that “Dr. Schwartz testified that had Dr. Stephens' order for BiPAP therapy been carried out, Mr. Rakes would have survived.” The Petitioner argues that this was Dr. Schwartz's testimony, and that because the nurses failed to carry out Dr. Stephens' BiPAP order on the night before he died, she is absolved of any causation due to the “intervening cause.” The transcript says otherwise. Dr. Schwartz specifically testified that had Dr. Stephens' orders been carried out, they would not have saved Mr. Rakes because Dr. Stephens did not order appropriate BiPAP therapy settings considering Mr. Rakes' critical condition on the night of September 4, 2010:

Q. Had the BiPAP been applied to Mr. Rakes at 10 p.m. on that night, with the settings ordered by the doctor, would he have survived there [*sic*] hospital visit?

A. Well, the settings were set very low. I mean the numbers wouldn't mean much to the lay individual, but they set them at a very low level, which was sort of too little too late. So had he gotten more serious levels of BiPAP in these assessments – again, it's not just ordering the BiPAP, as I said, he needed a BiPAP pressure set and he needed follow-up checks to say, is he getting better? So he didn't have the BiPAP or the orders very well – not being ordered until late in the evening of the 4th, certainly there were no orders for any checks of his carbon dioxide level during the day or after the BiPAP was started.

So the way they had ordered it I think would not likely have saved his life, given his heavy sedation.

(Page 329 of **Exhibit 30** : SCT1659). Both of the Respondent's expert witnesses testified that Dr.

Stephens provided such poor care of Mr. Rakes by the course of treatment that she chose, that Mr. Rakes would have died regardless of whether the BiPAP at the settings Dr. Stephens ordered would have been applied a few short hours before his death. She allowed his condition to become so dire because of her choices, that included no care for his elevated CO2 levels, that BiPAP set to her specifications was not enough at that point. In addition, contrary to her trial testimony, Dr. Stephens noted in the *Death Summary* that the BiPAP was never applied because they couldn't get Mr. Rakes' settings—there was no mention of any nurse's failure to apply the BiPAP (**See Exhibit 23 : SCT0933 – 0934**).

The West Virginia Supreme Court of Appeals has been clear in stating that “a plaintiff's burden of proof is to show that a defendant's breach of a particular duty of care was a proximate cause of the plaintiff's injury, not the *sole* proximate cause.” *Mays v. Chang*, 213 W. Va. 220, 224; 579 S.E.2d 561, 565 (2003). Additionally, “[a] party in a tort action is not required to prove that the negligence of one sought to be charged with an injury was the sole proximate cause of an injury.” *Id.* The Respondent's qualified experts testified specifically that Dr. Stephens deviated from the acceptable standard of care in her treatment of Gary Rakes as outlined above, and that these deviations were proximate causes of his death. (**See page 330 – 331 of Exhibit 30 : SCT1660; See pages 236 – 240 of Exhibit 30 : SCT1593 – 1594**). Furthermore, they specifically rebutted the Petitioner's claim that the nurses' failure to administer BiPAP therapy was an intervening/superseding cause because they believe Mr. Rakes would have died regardless at that point. (Page 329 of **Exhibit 30 : SCT1659**).

Therefore, because the Respondent's presented evidence in the form of expert testimony stating that Dr. Stephens' deviations from the appropriate standard of care were a proximate cause

of Mr. Rakes' death, and because all doubts and inferences should be decided in favor of the non-moving party, this Court should uphold the Circuit Court's denial of Petitioner's Renewed Motion for Judgment as a Matter of Law.

E. The Petitioner's Renewed Motion for Judgment as a Matter of Law with regard to punitive damages was properly denied because the Respondent presented evidence that the Petitioner acted with recklessness in her care and treatment of the decedent.

The Circuit Court's denial of the Petitioner's renewed Motion as a Matter of Law with regard to punitive damages should be denied because the jury was properly instructed, and the Respondent presented sufficient evidence that Petitioner Dr. Stephens' care of the decedent Gary Rakes was dangerous, and at the very least reckless. Again, "[u]pon a motion for directed verdict, all reasonable doubts and inferences should be resolved in favor of the party against whom the verdict is asked to be directed." Syllabus Point 5, *Wager v. Sine*, 157 W. Va. 391, 201 S.E.2d 260 (1973). Likewise, "every reasonable and legitimate inference fairly arising from the testimony, when considered in its entirety, must be indulged in favorably to plaintiff; and the court must assume as true those facts which the jury may properly find under the evidence." Syl. Pt. 1, *Jividen v. Legg* 161 W. Va. 769, 245 S.E.2d 835 (1978).

The Respondent presented evidence in the form of the death certificate, medical records, expert testimony, and Dr. Stephen's own testimony. That evidence made clear that Dr. Stephens knew Mr. Rakes was in the hospital because of his elevated CO₂ (hypercapnia), that she knew elevated CO₂ could be deadly, and that she chose not to treat it. Dr. Stephens chose not to provide any ventilatory support to Mr. Rakes, she chose not to provide any treatment for his respiratory issues, she chose not to order follow up ABG tests, she chose not to consult a pulmonologist; and she chose not to do anything to counter the effects of the sedatives that placed him in an

unconscious state while he lay flat on his back in wrist restraints.. Furthermore, both of the Respondent's experts testified that Dr. Stephens' lack of treatment was dangerous, and Dr. Scissors testified that it was "reckless." (Page 227 of **Exhibit 30** : SCT1591,Page 332 of **Exhibit 30** : SCT1660).

As outlined above, the Respondent presented evidence that Dr. Stephens' treatment and lack of treatment of Gary Rakes was dangerous and reckless, and therefore sufficient for this Court to determine pursuant to *Mayer v. Frobe* and its progeny that the Respondent was entitled to receive a punitive damage award. At trial, Dr. Stephens admitted that Mr. Rakes was supposed to receive BiPAP when he was asleep to help with his ventilation. (Page 913 of **Exhibit 30** : 1856). She observed him in an obtunded state on the morning of September 4th, aware that he needed BiPAP while he was asleep, yet ordered it to be administered twelve (12) hours later. (Page 913 – 914 of **Exhibit 30** : 1856 – 1857). Dr. Stephens stated in the Death Summary that Mr. Rakes never received a BiPAP because the settings were unknown, and changed her story at trial, stating that there were other reasons. (Death Summary at **Exhibit 24** : SCT0936 – SCT 0937; Page 910 of **Exhibit 30** : 1853). Later at trial, she blamed the nursing staff as the reason Mr. Rakes never received BiPAP. (Page 914 of **Exhibit 30** : 1857). She never consulted a pulmonologist. (Page 901 – 903 of **Exhibit 30** : 1853 – 1854). Dr. Stephens apparently examined Mr. Rakes again during the afternoon of September 4th, and failed to abort Dr. Razzaq's order for additional Seroquel. (Pages 916 -917 **Exhibit 30** : 1857).

The Circuit Court's ruling that the Respondent had presented sufficient evidence to justify an award of punitive damages was correct. The requirement of the Circuit Court to review the punitive damage award within the guidelines of Syllabus Points 3 and 4 of *Garnes v. Fleming*

Landfill, Inc., 186 W. Va. 656, 413 S.E.2d 897 (1991) and Syllabus Point 15 of *TXO Prod. Corp. v. Alliance Res. Corp.*, 187 W. Va. 457, 419 S.E.2d 870 (1992) is satisfied. *Garnes* also requires the Court to determine whether the punitive award was excessive. In making this determination, the Court must consider the following:

(1) Punitive damages should bear a reasonable relationship to the harm that is likely to occur from the defendant's conduct as well as to the harm that actually has occurred. If the defendant's actions caused or would likely cause in a similar situation only slight harm, the damages should be relatively small. If the harm is grievous, the damages should be greater.

Garnes at Syllabus Point 3. With regard to the first factor for consideration, an award of \$500,000.00 is reasonable considering that the harm involved the loss of human life.

(2) The jury may consider (although the court need not specifically instruct on each element if doing so would be unfairly prejudicial to the defendant), the reprehensibility of the defendant's conduct. The jury should take into account how long the defendant continued in his actions, whether he was aware his actions were causing or were likely to cause harm, whether he attempted to conceal or cover up his actions or the harm caused by them, whether/how often the defendant engaged in similar conduct in the past, and whether the defendant made reasonable efforts to make amends by offering a fair and prompt settlement for the actual harm caused once his liability became clear to him.

Id. The second factor also militates in favor of upholding the punitive damages award; the Petitioner attempted to conceal her actions by changing her opinion as to cause of death once she became involved in the lawsuit. The Petitioner stated in the Death Summary that the BiPAP was not applied because the settings were unknown, but testified at trial that it was not applied because the nurse did not carry out her order. The Petitioner stated in the Death Summary and Death Certificate that Seroquel played a role in Mr. Rakes death, and then changed her story after the lawsuit was filed. The Petitioner refused to pick up multiple certified mail attempts with a Notice of Claim, then filed a Motion to Dismiss at the outset of the case because she didn't have the

opportunity to mediate. Upon information and belief, the Petitioner's representatives walked out of court-ordered mediation in less than an hour, and offered zero to settle the lawsuit. (*See* Circuit Court's Order Denying Petitioner's Motion, Findings of Fact, **Exhibit 31** : SCT 1927 – 1947).

(3) If the defendant profited from his wrongful conduct, the punitive damages should remove the profit and should be in excess of the profit, so that the award discourages future bad acts by the defendant.

(4) As a matter of fundamental fairness, punitive damages should bear a reasonable relationship to compensatory damages.

(5) The financial position of the defendant is relevant. Id.

Factors three through five also favor upholding the award. The Petitioner's financial position is inconsequential in reality because she was covered by insurance and could have settled. Likewise, she is a doctor who likely is among the nations top earners, and she was being paid for the treatment she provided to Mr. Rakes as an employee of BRMC. Lastly, the punitive award was the same amount as the compensatory damages awarded by the jury, and a 1:1 ratio is certainly reasonable.

The Court also considered the factors from Syllabus Point 4 of *Garnes v. Fleming Landfill, Inc.*, that states:

When the trial court reviews an award of punitive damages, the court should, at a minimum, consider the factors given to the jury as well as the following additional factors:

(1) The costs of the litigation;

(2) Any criminal sanctions imposed on the defendant for his conduct;

(3) Any other civil actions against the same defendant, based on the same conduct; and

(4) The appropriateness of punitive damages to encourage fair and reasonable settlements when a clear wrong has been committed. A factor that may justify

punitive damages is the cost of litigation to the plaintiff.

Because not all relevant information is available to the jury, it is likely that in some cases the jury will make an award that is reasonable on the facts as the jury know them, but that will require downward adjustment by the trial court through remittitur because of factors that would be prejudicial to the defendant if admitted at trial, such as criminal sanctions imposed or similar lawsuits pending elsewhere against the defendant. However, at the option of the defendant, or in the sound discretion of the trial court, any of the above factors may also be presented to the jury.

186 W. Va. 656, 413 S.E.2d 897. There are no mitigating factors that exist in this case which require altering the verdict contemplated and awarded by the jury. No criminal sanctions were imposed and no other lawsuits exist. After the Respondent spent more than \$50,000 litigating the case, the jury returned with a verdict that has a 1:1 ratio of compensatory to punitive damages. The Respondent offered to settle with the Petitioner for \$100,000 pre-trial. Again, there are no mitigating factors in this case that require altering the punitive damage award. *Id.*

Therefore, because the Respondent provided sufficient evidence, and because the punitive damage award was reasonable, this Court should uphold the Circuit Court's denial of Petitioner's renewed Motion for Judgment as a Matter of Law with regard to punitive damages.

F. The Circuit Court Properly Denied Petitioner's Motion for a New Trial

1. Respondent's Peremptory Strike of Tracey Boyer was Proper Pursuant to *Batson v. Kentucky*, West Virginia Law, and is Not Grounds for a New Trial.

The Circuit Court properly overruled the Petitioner's *Batson* challenge at the trial because Respondent's counsel explained his non-discriminatory reason for making the strike. As stated above, Respondent's counsel used his second peremptory strike to remove Ms. Tracey Boyer, a jury panel member who happens to be African American. The reason for this strike, and which Respondent's counsel offered on the record at the bench conference and later at a hearing outside

of the presence of the jury, was that Ms. Boyer clearly made a strong connection that smoking caused COPD, one of the conditions for which the decedent presented to BRMC on September 3, 2010. (Pages 114 – 119 of **Exhibit 30** : SCT1563 – SCT1564).

Under *Batson v. Kentucky*, after the objecting party raises its case of discrimination, the striking party must offer a neutral explanation for making the strike. 476 U.S. 79 (1986). Finally, the trial court must determine whether the opponent of the strike has carried his burden of proving purposeful discrimination. *Id.* This Court gives substantial deference the Trial Court's ruling. *Parham v. Horace Mann Ins. Co.*, 200 W. Va. 609, 615 490 S.E. 696, 702 (1997).

Certainly, on its face, the explanation provided by counsel is sufficient under *Batson*. There are many medical records that were used at trial that state that Mr. Rakes was a life-long smoker who had recently quit. (BRMC records, **Exhibit 24** : SCT 0935 – 1051). Respondent's counsel did not want the issue raised at anytime during trial because of juror bias against smokers who may cause their own poor health conditions. Although the Petitioner claims that both Respondent's counsel and his rationale for striking Ms. Boyer are not credible, this Court need only look to the record and the Respondent's previously filed Motion *in Limine* to preclude the Petitioner from eliciting testimony regarding the Respondent contributing to his health conditions. (Exhibit H of **Exhibit 28** : SCT1345 – SCT1365).

The rationale for the Respondent's strike is quite clear, and the Circuit Court agreed. Respondent's counsel sought to keep out any evidence that Mr. Rakes contributed to his own poor health prior to trial, and certainly prior to striking Ms. Boyer for her comments. This Court has stated that “[t]here will seldom be much evidence bearing on that issue, and the best evidence often will be the demeanor of the attorney who exercises the challenge.” *Pleasants v. Alliance Corp.*,

209 W. Va. 39, 45 , 543 S.E.2d 320, 326 (2000). Not only did Respondent's counsel state a valid, neutral explanation for striking Ms. Boyer, but the Circuit Court was in the unique position where it had evidence to confirm the rationale behind the explanation by looking to counsel's past actions.

As a last resort, the Petitioner has basically claimed that Respondent's counsel had an abundance of time in which to fabricate a non-discriminatory reason for striking Ms. Boyer. However, as the transcript reflects, Respondent's counsel immediately stated his non-discriminatory rationale for striking Ms. Boyer while at the bench immediately after the challenge, and later at a hearing held shortly after the challenge. Admittedly, as the transcript reflects, counsel for the Respondent was taken aback and shocked at the objection and its racist implications; however, he also gave his reason for the strike immediately while standing at the bench, within seconds of the objection. (Pages 114 – 119 of **Exhibit 30** : SCT1563 – SCT1564). Regardless, the this Court's decision in *Parham* tells us that we are not "on the clock," as even substantial delays in responding to a *Batson* challenge have only been deemed harmless error. *See Parham v. Horace Mann Ins. Co.*, 200 W. Va. 609, 617 490 S.E. 696, 704 (1997).

Therefore, because the Circuit Court's ruling is given substantial deference, and because the Respondent gave a credible, non-discriminatory reason for striking Ms. Boyer as a juror, the Circuit Court properly denied the Petitioner's Motion for a New Trial.

2. **Respondent's Counsel did not violate the Court's *in Limine* ruling during his opening statement, and further, the Circuit Court did not commit reversible error in refusing to grant a mistrial.**

Respondent's counsel did not violate the *in Limine* order of the Court during his opening statement. Prior to trial, and without objection, the Petitioner moved to preclude Respondent's

counsel from saying that Dr. Stephens ordered Seroquel. Respondent's counsel never said at anytime during the trial that Dr. Stephens ordered Seroquel. However, both Seroquel and Haldol were a big part of this case. The *Petitioner* proffered two experts to opine that Haldol and Seroquel did not play a role in Gary Rakes' death. Gary Rakes received a large dose of Haldol and Seroquel on the night of September 3, 2010, without any ventilatory support. Dr. Stephens discussed the Haldol order with Dr. Jose before it was administered and approved of the order. (See page 827 of **Exhibit 30** : SCT1835). Respondent's expert, Dr. Kenneth Scissors, opined that Haldol was "very dangerous" for a patient like Mr. Rakes. (See page 211 of **Exhibit 30** : SCT1587). Dr. Stephens knew that Mr. Rakes had received Seroquel on September 3, 2010, although she states she did not find out until the morning September 4, 2010. The two drugs caused Mr. Rakes to be unconscious and unresponsive. The problem with this is that he retained CO₂, had sleep apnea and obesity hypoventilation syndrome. Therefore, when he was unconscious, he needed ventilatory support and testing of his CO₂ levels.

Every single doctor or nurse involved in the case denies that they ordered Seroquel on the night of September 3, 2010.⁴ Moreover, none of the doctors or nurses admit to even administering Seroquel to Mr. Rakes on that night. Respondent's counsel made it clear in opening statements, closing argument, and throughout the examination of witnesses that Dr. Stephens denied giving him the Seroquel. (See page 152 of **Exhibit 30** : SCT1572; See page 211 of **Exhibit 30** : SCT1587). Petitioner's counsel also made it clear in his opening that Dr. Stephens did not give him the

⁴ Nurses Laura Potter, Larry Rose, Matthew Grose, and Dr. Toni Muncy all deny ordering or administering Seroquel to Gary Rakes on September 3, 2010. No one has admitted to ordering or administering the medication. This is evident from their depositions which were also read at trial. (See **Exhibits 5, 6, 7, & 8**).

Seroquel. (*See* page 175 of **Exhibit 30** : SCT1578). No one during the trial at any time said that Dr. Stephens ordered the Seroquel. However, she did approve of the Haldol Order and knew that Mr. Rakes had been given Seroquel, and chose not to do anything.

The Respondent's theory of negligence, supported by the medical records and expert testimony, was that Dr. Stephens knew Gary Rakes was in the hospital for his respiratory problems, yet she chose not to consult a pulmonologist, chose not to get him ventilatory support, chose not to order bronchodialators, and most importantly, chose not to do anything to support his breathing, even after she saw him in an obtunded state, heavily sedated with Haldol and Seroquel.

Respondent's counsel made it clear throughout the trial that, although Dr. Stephens knew about the sensitivity to Seroquel, she did not order the drug to be given to Gary Rakes:

She found out about it on September 4th, 2010,. He was unconscious. She didn't do anything to give this patient ventilatory support. . .

(*See* page 152 of **Exhibit 30** : SCT1572)

Q. *A little bit later that evening a doctor other than Dr. Stephens apparently ordered a drug called Seroquel for Mr. Rakes.*

A. *Correct.*

(*See* page 211 of **Exhibit 30** : SCT1587)

Doctors ordering medications? Dr. Stephens didn't order the Seroquel. I'm not trying to say that.

(*See* page 972 of **Exhibit 30** : SCT1871)(emphasis added).

Dr. Stephens was aware that Mr. Rakes had been given Seroquel by someone; she was aware that he had a sensitivity to Seroquel, and, most importantly, she saw the effect the drug had on him. However, even after knowing all of these things, she allowed him to remain sedated with no followup ABG's or ventilatory support. Although the Petitioner states in her brief that

Respondent's counsel said she ordered Seroquel, the transcript proves otherwise. Regardless of whether the Petitioner believes that the message was "implied" in Respondent's opening statement, there was ample time for Petitioner's counsel to make it clear after opening statements. In fact, counsel for the Respondent went out of his way to make it perfectly clear to the jury throughout the trial and in closing argument that Dr. Stephens did not Order Seroquel.

Regardless, Rule 61 (Harmless Error) of the West Virginia Rules of Civil Procedure states:

No error in either the admission or the exclusion of evidence and no error or defect in any ruling or order or in anything done or omitted by the court or by any of the parties is ground for granting a new trial or for setting aside a verdict or for vacating, modifying or otherwise disturbing a judgment or order, unless refusal to take such action appears to the court inconsistent with substantial justice. The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties.

(*W.V.R.C.P. 61*) The appropriate test for harmlessness is whether a court can say with fair assurance, after stripping the erroneous evidence from the whole, that the remaining evidence was independently sufficient to support the verdict and that the judgment was not substantially swayed by the error. *McDougal v. McCammon*, 193 W. Va. 229, 236, 455 S.E.2d 788, 795 (1995).

Therefore, because Respondent's counsel never stated that Dr. Stephens ordered Seroquel and because any implications that Defense counsel believes are present would only be harmless error, the Circuit Court properly denied the Petitioner's Motion for New Trial.

3. **No Comments made by Respondent's counsel inflamed, prejudiced or misled the jury, and the Circuit Court properly denied Petitioner's Motion for New Trial**

In their Motion for a new trial, the Petitioner claimed that Respondent's counsel used phrases throughout the trial that were calculated to inflame, prejudice or mislead the jury. One such phrase Respondent's counsel used during opening statement was "captain of the ship." (*See Page*

150 of **Exhibit 30** : SCT1572). The context behind using the phrase was that Dr. Stephens was the attending physician, and responsible for the course of treatment she chose for Gary Rakes. *Id.* The Defense team claims that Respondent’s counsel used this phrase at multiple times throughout his opening statement and during his case in chief; however, the transcript proves otherwise. He only used the phrase during opening statement in an accurate description of the relationship between Dr. Stephens and the hospital staff.

Respondent’s counsel made limited use of this phrase solely for the purpose of describing Dr. Stephens’ role as attending physician during opening statements. The next morning, counsel for the Petitioner offered a West Virginia case that they believed barred the Respondent from using the “captain of the ship” as a theory of liability. However, the Respondent was merely using the phrase as description of the facts, not as its theory of liability in the case. The Respondent never stated that Dr. Stephens was vicariously liable for the actions of nursing staff or other doctors, but rather that she was responsible for the course of treatment she recklessly set into action; in other words, what was in her control. Regardless, a curative instruction was given by the Court that explained to the jury very clearly that Dr. Stephens could not be held liable for the actions of any of the other doctors or staff, and to disregard the use of that terminology. (*See Page 482 of Exhibit 30* : 1697).

Additionally, the Petitioner argues that Respondent’s Counsel’s use of the phrase “their money” during closing argument was so prejudicial that it warrants a new trial. After the Respondent’s closing argument, the Petitioner objected to the use of the phrase because it implied that there was insurance money available. Likewise, Petitioner’s counsel argued that it was improper for Respondent’s counsel to request the jury to send a message to the community so that

this type of case would not happen again. However, as the Court stated before overruling the objection, any potentially improper remarks were certainly not as clear as Defense counsel believed them to be. (*See* pages 978 - 979 **Exhibit 30** : SCT1873).

Assuming *arguendo* that the comments were improper, the comments did not amount to reversible error pursuant Rule 61 of the West Virginia Rules of Civil Procedure. Again, the appropriate test for harmlessness is whether a court can say with fair assurance, after stripping the erroneous evidence from the whole, that the remaining evidence was independently sufficient to support the verdict and that the judgment was not substantially swayed by the error. *McDougal v. McCammon*, 193 W. Va. 229, 236, 455 S.E.2d 788, 795 (1995). Furthermore, a reviewing court should not second-guess a jury verdict where there is clear evidence to sustain its verdict, “even with the presence of some prejudicial evidence.” *McDougal*, 193 W. Va. at 239, 455 S.E.2d at 798. In making the determination of whether the verdict was influenced by trial error, the trial court must ascertain whether it has grave doubt about the likely effect of an error on the jury’s verdict. The error is deemed harmful only if the reviewing court has grave doubt. *Lacy v. CSX Transp. Inc.*, 205 W. Va 630, 644, 520 S.E.2d 418, 432 (1999). Although comments made during a closing argument may be prejudicial, they will be treated as harmless error when the jury has been adequately instructed. *Foster v. Sakhai*, 210 W. Va. 716, 729, 559 S.E.2d 53, 66 (2001).

Finally, the Petitioner argues that the cumulative error doctrine should apply because all of these statements made the jury’s decision unreliable, however, as this Court stated in *Tenant v. Marion Health Care Found., Inc.*, that doctrine only applies where it is apparent that a reversal of the judgment is necessary. As the Honorable Judge Aboulhosn implied after the Respondent’s closing argument, those remarks were misinterpreted by Petitioner’s counsel. (*See* pages 978 - 979

Exhibit 30 : SCT1873).

Therefore, considering the evidence in light most favorable to the Respondent, and because the Respondent's comments did not constitute error, the Circuit Court properly denied the Petitioner's Motion for a New Trial.

4. The Circuit Court correctly refused to give the Petitioner's Do Not Resuscitate instruction because it was a misstatement of the law.

The Petitioner requested that the following jury instruction be given:

Ladies and gentlemen, in West Virginia, every person shall be presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest unless a do-not-resuscitate order has been issued for that individual. It is well established under the law in West Virginia that all health care providers shall comply and respect a do-not-resuscitate order when completed by a physician. Under the law in West Virginia, a health care provider can be subject to criminal prosecution or civil liability for providing cardiopulmonary resuscitation to a person when a do not resuscitate order has been issued for that person. W.Va. Code § 16-30C-1 et seq.

(*See Exhibit 22*). As the Court properly pointed out during the trial, the proposed instruction is a misstatement of the applicable law. (*See pages 684 - 688 Exhibit 30 : SCT1799 – SCT1800*). The Petitioner's instruction included a provision, which does not exist anywhere in W.Va. Code § 16-30C-1 et seq., that imposes criminal penalties on a health care provider if they provide CPR on someone who has executed a Do Not Resuscitate (DNR) Order. However, there is no such code section that subjects a health care professional to criminal penalties for performing CPR.

Regardless, the Petitioner's proposed instruction was not relevant to the facts of the case. The Respondents agreed that Mr. Rakes had a DNR order in place, and that he did not want to be intubated if he went in to cardiac or respiratory arrest. The Respondent has always asserted that Dr. Stephens' deviations from the acceptable standard of care unnecessarily put Mr. Rakes into

respiratory arrest. Dr. Stephens agreed, her experts agreed, and the Respondent's experts all agreed that Mr. Rakes did not need to be intubated on September 3rd or 4th, and therefore the DNR was inapplicable.

This Court has held that “[a]n instruction which does not correctly state the law is erroneous and should be refused.” Syllabus Point 2, *State v. Collins*, 154 W. Va. 771, 180 S.E.2d 54 (1971). Likewise, “[e]ven if a requested instruction is a correct statement of the law, refusal to grant such instruction is not error when the jury was fully instructed on all principles that applied to the case and the refusal of the instruction in no way impeded the offering side's closing argument or foreclosed the jury's passing on the offering side's basic theory of the case as developed through the evidence.” Syllabus Point 2, *Shia v. Chvasta*, 180 W. Va. 510, 377 S.E.2d 644 (1988).

Notwithstanding the proffered instruction being contrary to the law, it was irrelevant to the facts of the case. Furthermore, refusing to give the instruction did not impede Petitioner's counsel from arguing anything related to the DNR order. The instruction was simply not relevant to the case because the Respondent's entire case had to do with the reckless actions of Dr. Stephens that caused Mr. Rakes' health to decline to the point where he went into respiratory arrest.

Therefore, because the proffered instruction was contrary to the law, and because the Court's refusal to give the instruction did not impede upon or prejudice the Petitioner's theory of the case, the Circuit Court properly denied the Petitioner's Motion for a New Trial.

VII. CONCLUSION

For each of the foregoing reasons, it is clear that, under the respective standards applicable to each of the Petitioner's assignments of error, the Circuit Court properly denied the Petitioner's

Motions for Summary Judgment regarding liability and punitive damages, and properly denied Petitioner's Renewed Motion for Judgment as a Matter of Law, or in the alternative, Motion for a New Trial. Therefore, Respondent, Charles Rakes as the Administrator of the Estate of Gary Rakes, respectfully requests that the "Order Denying Defendant's Renewed Motion for Judgment as a Matter of Law or in the Alternative Motion for a New Trial" of the Circuit Court of Mercer County, West Virginia, entered on September 9, 2013, and the Court's Order denying the Petitioner's Motions for Summary Judgment regarding liability and punitive damages entered on May 14, 2013, be affirmed in their entirety, that all relief requested by Petitioner, Delilah Stephens, be denied and all such other and further relief which this Honorable Court deems appropriate.

**RESPONDENT/PLAINTIFF BELOW
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No. 13-1079

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

DELILAH STEPHENS, M.D.,
Defendant Below,
Petitioner

vs.)

No. 13-1079

CHARLES RAKES, personal representative
of the Estate of GARY RAKES,
Plaintiff Below,
Respondent

CERTIFICATE OF SERVICE

I, Alex J. Shook, counsel for respondent, hereby certify that on the 21st day of February, 2014, I have served a true copy of the foregoing "**Respondent's Brief**," upon the following person by depositing a true copy thereof in the United States Mail, postage pre-paid and addressed as follows:

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