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No. 19-0305

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

FILED
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SUPREME COURT OF APPEALS
OF WEST VIRGINIA

MARISSA SHAFFER and
TIMOTHY SHAFFER,

Plaintiffs Below, Petitioners

vs.

WILLIAM BRAGG, M.D.,
GENERAL ANESTHESIA SERVICES, INC., and
CHARLESTON AREA MEDICAL CENTER, INC.,

Defendants Below, Respondents.

****

From the Circuit Court of
Kanawha County, West Virginia
Civil Action No. 17-C-343
Honorable Charles E. King

****

RESPONDENTS, WILLIAM BRAGG, M.D. AND GENERAL ANESTHESIA SERVICES, INC.'S RESPONSE TO PETITION FOR APPEAL OF MARISSA SHAFFER AND TIMOTHY SHAFFER

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ASSIGNMENTS OF ERROR

Petitioners have asserted three assignments of error. Only the first assignment of error applies to Respondents, William Bragg, M.D. ("Dr. Bragg") and General Anesthesia Services, Inc. ("GAS") (collectively referred to herein as "Respondents"), as the other two assignments of error deal with specific allegations against Respondent, Charleston Area Medical Center, Inc. ("CAMC"). Thus, the only assignment of error addressed in Respondents, Dr. Bragg and GAS's response brief is whether "the Circuit Court erred in finding that Plaintiffs did not submit expert testimony of a causal connection between the alleged failure of informed consent and the injuries suffered by Marissa Shaffer[?]"

However, it should be noted that by not responding to the second and third assignment of error, Respondents do not agree with the Petitioners on these issues. Because the second and third assignment of error deal with allegations raised only against Respondent CAMC, Respondents are not addressing those assignments in their response brief, but will allow Respondent CAMC to address those allegations.

STATEMENT OF THE CASE

Pursuant to Rule 10(d) of the West Virginia Rules of Appellate Procedure, a brief statement of the case is being provided by Respondents to correct the inaccuracies and omissions in the Petitioners' statement of the case and provide this Court with additional facts that were relevant to the Circuit Court when granting summary judgment in favor of Respondents.

A. FACTUAL BACKGROUND

On January 22, 2015, Petitioner, Marissa Shaffer ("Ms. Shaffer"), was admitted to CAMC for the labor and delivery of her infant. Prior to her admission, she signed CAMC's Patient Agreement, agreeing to various terms of treatment.[1] JA 88. Ms. Shaffer testified that at the time she signed the Patient Agreement, she was aware that CAMC was a teaching hospital. JA 88. Specifically, paragraph 7 of the Patient Agreement states "I understand that CAMC is a teaching hospital, and that students in the health care sciences and resident physicians may observe and participate in my treatment under supervision." JA 242. Ms. Shaffer admitted during her deposition that she was aware that students may participate in her care while she was a patient at CAMC. JA 88.

During the course of her labor, Ms. Shaffer requested that an epidural be placed for pain relief. Dr. Bragg, a Board-Certified anesthesiologist, was called to place the epidural. A student registered nurse anesthetist ("SRNA"), Garry Chapman ("SNRA Chapman"), was working with Dr. Bragg that day. From the medical records, it appears that SNRA Chapman entered the room at 1:01 p.m. ahead of Dr. Bragg. SJA 34. Although SRNA Chapman does not recall participating in Ms. Shaffer's care, he testified that his handwriting appears on the anesthesia history. SJA 36. SRNA Chapman testified that he would have introduced himself to the patient and taken the patient's history. SJA 36. It should be noted that Ms. Shaffer's recollection is that Dr. Bragg came into her room first, although this fact is not supported by the medical record. JA 90.

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[1] Ms. Shaffer signed the CAMC Patient Agreement on October 7, 2014. She testified that as part of her birthing class at CAMC, she was given the option to pre-register for her delivery, which she did. JA 88.

Ms. Shaffer recalls that the student was introduced to her. JA 90. In fact, Ms. Shaffer testified that Dr. Bragg introduced the student to her and told her that the student would be "observing" during the epidural placement. JA 90. Further, Ms. Shaffer admitted during her deposition testimony that she knew the student was in the room at the time of her epidural. JA 88, 92.

According to the medical record, Dr. Bragg entered the patient's room at 1:21 p.m. SJA 37-38. Dr. Bragg spoke to the patient regarding the epidural procedure and its' risks. JA 91, SJA 40. After speaking to Dr. Bragg, Ms. Shaffer signed the CAMC' Acknowledgement of Consent to Anesthesia. JA 91, 243, SJA 29-30 at ¶ 7. Ms. Shaffer admitted that she consented to the epidural being placed.[2] SJA 30 at ¶ 11. Ms. Shaffer also testified that she never expressed concerns about students having any involvement in her care at CAMC. SJA 12.

At 1:26 p.m., Dr. Bragg started the epidural procedure by numbing the patient's back and starting the epidural needle on the correct trajectory. SJA 42. Dr. Bragg then allowed SRNA Chapman to feel for loss of resistance. SJA 42. Loss of resistance is the sensation that the anesthesia provider feels when the tip of the epidural needle enters the epidural space. However, SRNA Chapman did not feel any loss of resistance, meaning he could not find the epidural space. SJA 42. At that point, Dr. Bragg took over control of the needle and advanced the needle. SJA 42. Immediately upon advancing the needle, Ms. Shaffer suffered a wet tap. SJA 43. A wet tap is when the epidural needle punctures the dura mater (the protective covering over the spinal cord) and causes spinal fluid to leak through the dural puncture.

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[2] Per Ms. Shaffer's responses to Dr. Bragg and GAS's Requests for Admissions, she "consented to having an epidural placed, but not to having an epidural misplaced." SJA 30, at ¶ 11.

It is undisputed that the injury suffered by Ms. Shaffer in this case is the wet tap. As a result of the wet tap, Ms. Shaffer suffered a headache for approximately one week following the birth of her infant.

B. EXPERT DEPOSITION TESTIMONY

On July 30, 2018, Petitioners' anesthesiology expert, Gerald Bushman, M.D. ("Dr. Bushman"), was deposed in this matter. During his deposition, Dr. Bushman testified that he believes Dr. Bragg caused the wet tap and believes that the epidural needle was in Dr. Bragg's hands at the time the wet tap occurred. JA 134. It should be noted that in Petitioners' Petition for Appeal, Petitioners assert that Ms. Shaffer testified that it was her belief that SRNA Chapman caused the wet tap. *Petition for Appeal* at p. 5. According to Dr. Bushman, Ms. Shaffer's own expert, Ms. Shaffer could not know who caused the wet tap. JA 134. Specifically, Dr. Bushman testified:

> Q. Okay. Now the plaintiff Marissa Shaffer believes and testified that it was her recollection that Garry Chapman caused the wet tap. Do you believe Ms. Shaffer is lying?
> A. I believe that she believes that but I also believe that she cannot know that.
> Q. Okay. And you would agree with me that as the patient who is receiving the epidural you actually cannot see what is going on behind you, correct?
> A. No. She's inferring a result based on things that she observed being said and done. And she can't know at what point Dr. Bragg took the needle over from Mr. Chapman, but she knows what she heard. And so she's making a very subtle leak in assuming something that actually she couldn't possibly know.

JA 134.

Importantly, Dr. Bushman testified that a wet tap **is not** medical negligence, but is a known complication of epidural placement – a fact that was completely omitted from Petitioners' Petition for Appeal. JA 133. Specifically, Dr. Bushman testified as follows:

Q. ... And a wet tap is a known complication?
A. It is.
Q. And I think you say this within your initial letter but **it's not a deviation from the standard of care to have a wet tap?**
A. **Correct.**
Q. In other words, to put it in simpler terms, **it's not medical negligence to cause a wet tap, correct**?
A. **Correct**.

JA 133 (emphasis added).

In Petitioners' Petition for Appeal, Petitioners argue that the causal connection between the student's involvement and the wet tap was the fact that Dr. Bragg was "lost" in the patient's anatomy when he took control of the needle. *Petition for Appeal* at p. 19. Petitioners argue that Dr. Bragg "didn't or couldn't know where [the needle] was" when he took over control of the needle. *Id.* Importantly, Dr. Bragg testified that while he does not specifically recall what he felt when he took over the needle from SNRA Chapman, he must have felt resistance when he took over the epidural needle because he would not have advanced the needle if he did not feel resistance. SJA 43.

Dr. Bushman testified that he believes Dr. Bragg should have removed the epidural needle when SRNA Chapman could not locate the epidural space. JA 110, 149. However, Dr. Bushman testified that there is not a specific standard of care that would require Dr. Bragg to remove the needle and restart the procedure when taking over the epidural needle from SNRA Chapman. JA 110, 134, 149. In other words, while Dr. Bushman would have chosen to remove the epidural needle and restart the procedure, there is not a standard of care within the field of anesthesiology that required Dr. Bragg to remove the needle and restart the procedure. Therefore, Dr. Bushman

testified that he does not have any criticisms of Dr. Bragg's medical care and treatment of the patient. JA 151.

Petitioners argue that "Dr. Bushman also testified that but for the student's participation in the epidural placement, the wet tap would not have occurred." *Petition for Appeal* at p. 9. Petitioners misstate Dr. Bushman's testimony. Dr. Bushman testified that an experienced practitioner, such as Dr. Bragg, has between a 1 and 3% chance of causing a wet tap during an epidural placement. JA 133. Dr. Bushman further testified that wet taps occur regardless of whether a student is involved in the procedure. JA 133.

Dr. Bushman's criticism of Dr. Bragg is regarding the informed consent process. Dr. Bushman believes Dr. Bragg deviated from the standard of care in the informed consent of the patient. JA 151. Specifically, Dr. Bushman believes that Dr. Bragg should have informed the patient that SRNA Chapman was going to perform part of the epidural. JA 139, 142. Dr. Bushman testified that Dr. Bragg's failure to perform a proper informed consent removed Petitioner's "option of declining the trainee's participation in her care." JA 146.

However, Dr. Bushman testified that nothing about the consent process caused the wet tap. JA 147-148. In fact, Dr. Bushman testified that Dr. Bragg did not cause any harm to the patient:

> Q. Did anything Dr. Bragg did or did not do cause any psychological harm to the patient?
>
> A. I think to the extent that I've described the short-comings and the technical performance, the epidural and the failure to truly inform – to obtain a truly informed consent process detailing participation of a trainee, I think Dr. Bragg – **I don't know of any evidence that Dr. Bragg had any impact on her emotional response to the**

> **complication** in the days and weeks and perhaps months of disability that it seemed to cause.

JA 147 (emphasis added).

In addition to Dr. Bushman, Plaintiffs also disclosed a psychiatry expert, Frank Ochberg, M.D. Dr. Ochberg was deposed on November 16, 2018. Of note, Dr. Ochberg testified that he would not offer standard of care opinions against Dr. Bragg. JA 191, 197. In regard to causation and damages, Dr. Ochberg testified that as a result of the wet tap, Ms. Shaffer suffers from post-traumatic stress disorder (PTSD) and persistent-depressive disorder. JA 198, 201-203. In addition, Dr. Ochberg believes Ms. Shaffer suffers from a moral injury, as a result of a perceived lie. JA 204-205. Importantly, Dr. Ochberg testified that the "perceived lie" was not attributable to Dr. Bragg. JA 196-197, 209. Therefore, it is Dr. Ochberg's opinion that the wet tap was the injury that caused Ms. Shaffer's PTSD and depression. JA 210.

Petitioners argue that Dr. Sullivan, Respondents' anesthesiology expert, testified that "Chapman's involvement made it <u>more likely</u> that the procedure would result in a [unintentional dural puncture] than if Bragg had performed the procedure from start to finish." *Petition for Appeal* at p. 20 (emphasis added). This was not Dr. Sullivan's testimony. Dr. Sullivan testified as follows:

> Q. So let's assume the guide needle was in Dr. Bragg's hands when Ms. Shaffer's dural [sic] was accidentally punctured, okay. Do you agree, based upon your review of Dr. Bragg's testimony, that Dr. Bragg's uncertainty as to the location of the tip of the guide needle, when he took it over from the student nurse anesthetist, made the puncture of Ms. Shaffer's dural [sic] more likely than it would have been had Dr. Bragg had full control of the guide needle from the moment of insertion to completion?
>
> Ms. Malone: Object to the form. You can answer.

A. It's possible. I certainly didn't feel as strongly as your expert witness did about that. He seemed to feel that that specific phenomena was directly linked to causation.
Q. And you think it's possible, but you're not as certain?
A. It is possible that it might increase it slightly, but not to the degree that I would feel confident in stating that it was linked directly to causation.

SJA 278. Thus, Dr. Sullivan testified that the risk of a dural puncture possibly increases slightly with the involvement of an SRNA, but unlike Petitioners asserted, he did not testify that the involvement of an SRNA made it "more likely" to have a dural puncture. Furthermore, he did not testify that to a reasonable degree of medical probability that the involvement of the SRNA increased the risk to Ms. Shaffer of suffering a dural puncture. Petitioners misstated Dr. Sullivan's testimony.

C. PROCEDURAL HISTORY

On March 10, 2017, Plaintiffs filed their Complaint. In the Complaint, Plaintiffs asserted claims of lack of informed consent (Count I) and medical negligence (Count II) against Dr. Bragg and GAS. SJA 247-254. Additionally, Plaintiffs' Complaint also asserted a claim for punitive damages for improper documentation, cover up and concealment against Dr. Bragg and GAS. SJA 247-254.

On May 29, 2018, the Circuit Court granted Dr. Bragg and GAS filed a Motion for Partial Summary Judgement on punitive damages. SJA 1-3. On February 25, 2019, the Circuit Court granted Dr. Bragg and GAS's Motion for Summary Judgment on the informed consent and medical negligence claims. JA 4-13.

On June 21, 2019, Petitioners filed their Petition for Appeal regarding the Court's granting of summary judgment on the informed consent claim. Petitioners are not

appealing the Court's granting of summary judgment to Dr. Bragg and GAS on the medical negligence claim. *See e.g. Petition for Appeal* at p. 1.

SUMMARY OF ARGUMENT

The Circuit Court did not err in granting summary judgment on Petitioners' informed consent claim. First, the Circuit Court properly considered Dr. Bushman's testimony regarding informed consent and causation. Specifically, Dr. Bushman testified that nothing about the informed consent process caused Petitioner's wet tap. JA 147-148. Petitioners argue that the question was ambiguous and that Dr. Bushman did not understand the legal definition of "cause," however, Petitioners' counsel did not object to this question or rehabilitate Dr. Bushman at the end of Respondents' counsel's questioning. Furthermore, Dr. Bushman did not change his testimony following his deposition on his errata sheet. SJA 279-280.

Second, the Circuit Court properly disregarded the causation opinions set forth in Dr. Bushman's Screening Certificate of Merit and the Addendum thereto. Per West Virginia Code § 55-7B-6(j) 2017, a Screening Certificate of Merit is not admissible as evidence in any court proceeding. Therefore, the Circuit Court properly disregarded Dr. Bushman's causation opinions as set forth in his Certificate of Merit.

Third, Dr. Bushman testified that the student's involvement in the epidural placement was the "most important part of causation." JA 146. However, Petitioners and their expert conceded that there was no medical negligence in this case. *Petition for Appeal* at p. 1, JA 151. Whether Dr. Bragg caused the wet tap himself or the student's involvement played a role is of no consequence to this case because the

standard of care in performance of the epidural was not breached. *See e.g. Hamilton v. Ryu,* No. 16-0856 (W. Va. Supreme Court, October 20, 2017) (memorandum decision).

Finally, this case does not fit the traditional paradigm of an informed consent case because Dr. Bragg met his duty of disclosure per the factors set forth in Syllabus Point 3 of *Cline v. Kresa-Reahl*, 229 W. Va. 203, 728 S.E.2d 87 (2012). Additionally, there is no allegation that Dr. Bragg did not tell Ms. Shaffer of the material risks of the procedure. *See e.g. Adams v. El-Bash*, 175 W. Va. 781, 785, 338 S.E.2d 381, 386 (1985).

In informed consent cases, there must be "proof of a causal relationship between the physician's failure to disclose information to his patient and damages to the patient." *Adams*, *supra*, 175 W. Va. at 785, 338 S.E.2d at 385 (citation omitted). Dr. Bushman testified that nothing about the informed consent process caused the wet tap. JA 147-148. Petitioners have failed to show that Dr. Bragg's deviation from the standard of care during the informed consent process caused any harm to Ms. Shaffer. Therefore, this Court should uphold the Circuit Court's February 25, 2019 Order granting summary judgment to the Respondents.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Oral argument is necessary pursuant to Rule 18(a) of the West Virginia Rules of Appellate Procedure because the parties have not waived oral argument and oral argument will aid in this Court's consideration of this case. W. Va. R. App. P. 18(a)(1), (4).

Oral argument should be set pursuant to Rule 19(a) of the West Virginia Rules of Appellate Procedure. Argument is proper pursuant to Rule 19 because this case

involves assignments of error in the application of settled law and a narrow issue of law. See W. Va. R. App. P. 19(a)(1), (4). Because Petitioners are alleging errors in the application of settled law, the case is appropriate for a memorandum decision. W. Va. R. App. P. 10(c)(6), 19(g).

ARGUMENT

A. STANDARD OF REVIEW

Petitioners appeal two orders from the Circuit Court of Kanawha County, both dated February 25, 2019, granting summary judgment to Respondents. JA 4-13 and 14-23. This Court has long held that "[a] circuit court's entry of summary judgment is reviewed *de novo*." Syl. Pt. 1, *Painter v. Peavy*, 192 W. Va. 189, 451 S.E.2d 755 (1994).

When reviewing a Circuit Court's decision regarding summary judgment, this Court applies the same standard required of the Circuit Court. *Carr v. Michael Motors*, 210 W. Va. 240, 244, 557 S.E.2d 294, 298 (2001) (citation omitted). *See also Williams v. Precision Coil*, 194 W. Va. 52, 58, 459 S.E.2d 329, 335 (1995). This Court has 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." Syl. Pt. 1, *Williams, supra*, (citing Syl. Pt. 3, *Aetna Cas. & Sur. Co. v. Fed. Ins. Co. of New York*, 148 W. Va. 160, 133 S.E.2d 770 (1963)). A motion for summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to

judgment as a matter of law." W. Va. R. Civ. P. 56(c). In Syllabus Point 4 of *Painter*, *supra*, the Supreme Court of Appeals of West Virginia stated that:

> Summary judgment is appropriate where the record taken as a whole 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 Syl. Pt. 4 (emphasis added).

B. THE CIRCUIT COURT PROPERLY GRANTED SUMMARY JUDGMENT.

Per the Circuit Court of Kanawha County's February 25, 2019 Order granting Respondents' Motion for Summary Judgment, the Circuit Court found that Petitioners presented testimony from Dr. Bushman that Dr. Bragg deviated from the standard of care during the informed consent process prior to the placement of Petitioner's epidural. JA 8 at ¶ 24. The Circuit Court further found that Petitioners did not present expert testimony that the alleged deviation from the standard of care during the informed consent process caused or contributed to Petitioner's injury, the wet tap. JA 9 at ¶ 28. As a result of these findings, the Circuit Court granted summary judgment on Petitioners' informed consent claim. For the reasons set forth herein, the Circuit Court of Kanawha County appropriately granted summary judgment to the Respondents on the informed consent claim because Dr. Bragg's alleged failure to disclose the SRNA's involvement did not cause any damage to the Petitioner.

1. DR. BUSHMAN'S TESTIMONY REGARDING CAUSATION WAS NOT AMBIGUOUS.

Petitioners argue that the Circuit Court relied on a "single, ambiguous question and answer" in Dr. Bushman's testimony when finding that no causation existed on the

informed consent claim. *Petition for Appeal* at p. 16. Specifically, Dr. Bushman testified as follows:

> Q. Do you agree that nothing about the informed consent process caused the wet tap?
> A. Correct.

JA 147-148. Petitioners argue that Dr. Bushman was not applying the legal definition of proximate cause for informed consent cases at the time he rendered his answer. *Petition for Appeal* at p. 16.

Dr. Bushman is Petitioners' retained anesthesia expert. As a retained medical expert, Petitioners' counsel would have had the opportunity to discuss and explore his opinions with him prior to his deposition. Petitioners' counsel would have had the opportunity to explain and prepare Dr. Bushman for the nuances of West Virginia malpractice law prior to his deposition. As a retained expert, Dr. Bushman should have been prepared for questions regarding his opinions and the cause of the Petitioner's injuries.

At the time the question was asked of Dr. Bushman in his deposition, Petitioners' counsel did not object to the question. Moreover, at the end of Respondents' six-hour examination of Dr. Bushman, Petitioners' counsel did not ask any questions to clarify or rehabilitate Dr. Bushman's opinion regarding informed consent and causation. JA 159. In fact, the only questions asked by Petitioners' counsel of Dr. Bushman were to clarify his personal notes. JA 159. Moreover, Dr. Bushman opted to read his deposition transcript, and did not change or correct his testimony regarding informed consent and the cause of the wet tap. JA 279-280. Therefore, Dr. Bushman's testimony on informed

consent and the cause of the Petitioner's injury is not ambiguous and was properly considered by the Circuit Court.

2. Dr. Bushman's Screening Certificates of Merit are not admissible as evidence to defeat summary judgment.

Petitioners argue that Dr. Bushman "explained the causal issues in greater detail in his Addendum to his screening certificate of merit (JA 100-01) – which, like his original certificate of merit, was also prepared as a sworn statement and submitted to the circuit court in opposition to the motions for summary judgment[.]"[3] *Petition for Appeal* at p. 19. The Circuit Court properly disregarded the Screening Certificates of Merit and solely relied on Dr. Bushman's deposition testimony.

Per the West Virginia Medical Professional Liability Act ("MPLA"), West Virginia Code § 55-7B-6(j):

> [A] notice of claim, a health care provider's response to any notice of claim, a **screening certificate of merit** and the results of any mediation conducted pursuant to the provisions of this section are **confidential and are not admissible as evidence in any court proceeding**, unless the court, upon hearing, determines that failure to disclose the contents would cause a miscarriage of justice.

W. Va. Code § 55-7B-6(j) (2017) (emphasis added). The MPLA is clear that Dr. Bushman's Screening Certificate of Merit and the Addendum to his Screening Certificate of Merit are not admissible as evidence in <u>any</u> court proceeding, including hearings on motions for summary judgment.

The MPLA provides that Screening Certificates of Merit may be admissible as evidence where failure to disclose its contents would be a miscarriage of justice. *Id.* In this case, Petitioners did not move the Circuit Court to admit the Certificate of Merit and

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3 Dr. Bushman's Screening Certificate of Merit appears at JA 80-84 and the Addendum to his Screening Certificate of Merit appears at JA 100-101.

its Addendum into evidence, and as a result the Circuit Court did not conduct such a hearing and did not find that the Screening Certificate of Merit or the Addendum was admissible as evidence. Therefore, the Circuit Court properly disregarded and omitted Dr. Bushman's Screening Certificate of Merit and the Addendum to his Screening Certificate of Merit as evidence when considering Respondents' summary judgment motions in this matter.

3. SRNA CHAPMAN'S INVOLVEMENT IN THE EPIDURAL IS OF NO CONSEQUENCE BECAUSE THE STANDARD OF CARE WAS NOT BREACHED DURING THE PLACEMENT OF THE EPIDURAL.

Petitioners argue that SRNA Chapman's involvement in the placement of the epidural made it more likely that the wet tap would occur. *Petition for Appeal* at p. 18. First, while Petitioners' expert, Dr. Bushman, believes that SRNA Chapman's involvement in the Petitioner's epidural placement was "the most important part of causation," Dr. Bushman conceded that even without the student's involvement, there was a "between 1 and 3 percent" chance of a wet tap occurring because a wet tap is a known complication of an epidural placement. JA 133, 146. Dr. Bushman also conceded that he believes that the needle was in Dr. Bragg's hands when the wet tap occurred. JA 134, 154.

Regardless of whether Dr. Bragg caused the wet tap himself or whether the student's involvement in the procedure led to the wet tap, the wet tap does not constitute medical negligence. Petitioners have conceded that there was no medical negligence in this case, as they are not appealing the Circuit Court's granting of summary judgment on the medical negligence claim. *Petition for Appeal* at p. 1. Furthermore, Dr. Bushman conceded in his deposition that Dr. Bragg did not deviate

from the standard of care in his medical care and treatment of the patient. JA 151. Dr. Bushman testified that a wet tap is a known complication of an epidural, and the fact that it occurred in this case is not a deviation from the standard of care on behalf of either Dr. Bragg or SRNA Chapman. JA 133. Dr. Bushman also testified that there is no standard of care that required Dr. Bragg to remove the epidural needle and restart the epidural procedure when the student could not find the epidural space. JA 110, 149. Therefore, as Petitioners concede, there is no evidence that the standard of care was breached by either Dr. Bragg or SRNA Chapman, regardless of whom caused the wet tap.

It does not matter whether Dr. Bragg caused the wet tap himself or whether the student's involvement played a role in causation because the standard of care during the epidural procedure is not at issue in this case. In *Hamilton v. Ryu*, this Court issued a memorandum decision on a similar set of facts. *Hamilton v. Ryu*, No. 16-0856 (W. Va. Supreme Court, October 20, 2017) (memorandum decision). The *Hamilton* plaintiff underwent elbow surgery by defendant, Dr. Ryu. The informed consent form contained the risks of surgery and also indicated that a resident may perform portions of the procedure. Following surgery, plaintiff argued that she experienced an ulnar nerve injury as a result of the surgery. Plaintiff asserted claims of informed consent, arguing that she would not have had the surgery if she knew a resident would be performing part of the procedure, and medical negligence alleging that Dr. Ryu deviated from the standard of care during the surgery. The case proceeded to verdict, and the jury found in favor of the defendant. *Id.*

On appeal, the plaintiff argued that the trial court improperly excluded Dr. Ryu's surgery schedule, which would have shown that the resident performed the portion of the surgery that would have injured her ulnar nerve. This Court found that the plaintiff did not present expert testimony that the standard of care was breached during surgery. *Id.* Therefore, this Court noted that it was of no consequence whether Dr. Ryu or a medical resident performed the part of the surgery that caused the injury because the standard of care was not at issue in the case. *Id.*

Similar to the *Hamilton* case, the Petitioners in this case have argued that it was the student's involvement in placing the epidural that led to the wet tap. Since the Petitioners have conceded that the wet tap is a known complication and does not amount to medical negligence, it is of no consequence whether SRNA Chapman or Dr. Bragg caused the wet tap. Regardless of which medical provider caused the wet tap, the wet tap is not medical negligence and any reference to who caused the wet tap is of no consequence to this matter.

4. SUMMARY JUDGMENT WAS APPROPRIATE ON PETITIONERS' INFORMED CONSENT CLAIM BECAUSE THERE IS NO CAUSAL LINK TO THE PETITIONER'S INJURY.

In regard to informed consent cases, this Court has previously found:

> The doctrine of informed consent is a nebulous one complicated by semantics. However, quality physician-patient communication and the duty of disclosure occasioned by the doctrine of informed consent are not necessarily coextensive. Informed consent is implicated in situations which run the gamut from procedures to which a patient never agreed at all, to treatments, the medical implications of which were not fully communicated. ... Informed consent is required for a particularized, selected procedure or treatment modality which is affirmatively elected by the patient. A breach of the standard of care by a physician in an area outside of the narrow construct of a physician's duty of disclosure as to a recommended medical treatment or procedure may well be equally actionable, but sounds in traditional medical negligence.

Cline v. Kresa-Reahl, 229 W. Va. 203, 209-210, 728 S.E.2d 87, 93-94 (2012).

In regard to a physician's duty of disclosure during the informed consent process, this Court has held:

> A physician has a duty to disclose information to his or her patient in order that the patient may give to the physician an informed consent to a particular medical procedure such as surgery. In the case of surgery, the physician ordinarily should disclose to the patient various considerations including (1) the possibility of surgery, (2) the risks involved concerning the surgery, (3) alternative methods of treatment, (4) the risks relating to such alternative methods of treatment and (5) the results likely to occur if the patient remains untreated.

Id. at Syl. Pt. 3 (citing Syl. Pt. 3, *Cross v. Trapp,* 170 W. Va. 459, 294 S.E.2d 446 (1982)).

It should be noted that in this case, Petitioners admit that Ms. Shaffer agreed and consented to the epidural placement. SJA 30. There is no allegation in this case that Ms. Shaffer was not adequately informed of the risks or medical implications of the epidural placement. JA 93, 140-141, 243. She was aware of the alternative methods of treatment – i.e. giving birth without an epidural – but requested that she have an epidural for pain relief. JA 34, 93. Therefore, Dr. Bragg met his duty of disclosure as described by the factors set forth in Syllabus Point 3 of the *Cline v. Kresa-Reahl* case.

Because Dr. Bragg met his duty of disclosure as outlined by this Court, this informed consent case is nebulous and does not fit the mold of a traditional informed consent matter. Petitioners have argued, and their expert Dr. Bushman has testified, that Dr. Bragg deviated from the standard of care in the informed consent process because Ms. Shaffer did not understand that SRNA Chapman would be participating in the epidural placement. JA 139, 142, 151. However, Ms. Shaffer admits that she was aware that SRNA Chapman was in the room at the time of the epidural placement and

that she was aware that SRNA Chapman would be "observing" during the procedure. JA 88, 90.

Petitioners have argued that it was important for Ms. Shaffer to know that the student would be participating in the epidural placement because the student's involvement increased the risk of a wet tap occurring. *Petition for Appeal* at p. 19. However, Dr. Bushman testified that Dr. Bragg did not have a duty to tell Ms. Shaffer that there was an increased risk of a wet tap occurring with the student's involvement. JA 144. Therefore, Dr. Bragg did not have to tell Ms. Shaffer that SRNA Chapman's involvement increased the risk of a wet tap.

In informed consent cases, there must be proof of "a causal relationship between the physician's failure to disclose information to his patient and damage to the patient." *Adams v. El-Bash*, 175 W. Va. 781, 785, 338 S.E.2d 381, 385 (1985) (citing *Cross*, *supra*, 170 W. Va. at 465, 294 S.E.2d at 452). This Court has further held that:

> [T]he causality requirement in cases applying the doctrine of informed consent is to be resolved by an objective test: whether a reasonable person in the patient's position would have withheld consent to surgery or therapy had <u>all material risks</u> been disclosed. If disclosure of <u>all material risks</u> would not have changed the decision of a reasonable person in the position of the patient, there is no causal connection between nondisclosure and his damage. If, however, disclosure of <u>all material risks</u> would have caused a reasonable person in the position of the patient to refuse the surgery or therapy, a causal connection is shown.

Adams, *supra*, 175 W. Va. at 785, 338 S.E.2d at 386 (citing *Cross*, *supra*, 170 W. Va. at 467, 294 S.E.2d at 454-455) (emphasis added). Stated succinctly:

> In cases applying the doctrine of informed consent, where a physician fails to disclose the <u>risks of surgery</u> in accordance with the patient need standard of disclosure and the patient suffers an injury as a result of the surgery, a causal relationship, between such failure to disclose information and damage to the patient, may be shown if a reasonable person in the

> patient's circumstances would have refused to consent to the surgery had the risks been properly disclosed.

Adams, *supra*, 175 W. Va. at 786, 338 S.E.2d at 386 (emphasis added).

This Court's findings in *Adams* clearly state that a causal relationship between informed consent and the damage to the patient occurs when a physician fails to disclose the risks of the procedure, and a reasonable person would have refused the procedure had the risks been disclosed. As discussed above, this case does not involve Dr. Bragg's failure to disclose the risks of the epidural procedure. In fact, Petitioners' expert, Dr. Bushman, testified that Dr. Bragg was not required to tell the Petitioner that SRNA Chapman's involvement increased the risk of a wet tap. JA 144. This case is about Dr. Bragg's alleged failure to disclose the extent of SRNA Chapman's involvement in the procedure. Because the case does not involve the disclosure of the risks of the procedure, the determination of a causal connection as described in *Adams* does not fit this case.

What is clear from the *Adams* case is that there must be a causal relationship between Dr. Bragg's failure to disclose information to Ms. Shaffer and Ms. Shaffer's wet tap. Dr. Bushman was clear in his deposition that nothing about the informed consent process caused the wet tap. JA 147-148. Dr. Bushman testified that the wet tap was caused by Dr. Bragg failing to remove the epidural needle and restart the procedure when SNRA Chapman could not locate the epidural space. However, Dr. Bushman conceded that there was no standard of care that required Dr. Bragg to restart the procedure. JA 110, 134, 149. Thus, while the Petitioner suffered a known complication of an epidural, the epidural procedure was performed within the standard of care.

Petitioners have failed to show that Dr. Bragg's alleged failure to properly advise Ms. Shaffer of the student's participation in the epidural placement caused any injury to Ms. Shaffer. Ms. Shaffer's injury – the wet tap – was a known complication of a properly performed procedure. As Dr. Bushman testified, the informed consent process did not cause the wet tap. Therefore, the Circuit Court of Kanawha County properly found that Petitioners did not show a causal relationship between the informed consent process and the Petitioner's injury and dismissed Petitioners' claim for failing to prove an essential element of their informed consent claim.

C. PETITIONERS' SECOND AND THIRD ASSIGNMENTS OF ERROR DO NOT APPLY TO DR. BRAGG AND GAS.

Petitioners raise two additional assignments of error in their *Petition for Appeal*. Both the second and third assignment of error deal with claims against Respondent CAMC and do not involve claims against Respondents, Dr. Bragg and GAS. Therefore, these Respondents are not responding to these assignments of error.

CONCLUSION

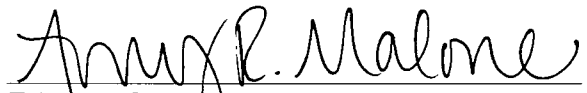
As stated herein, Petitioners' anesthesia expert, Dr. Bushman, was clear that Dr. Bragg did not deviate from the standard of care in his performance of Petitioner's epidural. Petitioners' allegation that Dr. Bragg deviated from the standard of care during the informed consent process is not causally related to the Petitioner's injury – the wet tap. Therefore, the Circuit Court of Kanawha County appropriately granted summary judgment to Respondents, Dr. Bragg and GAS, and the February 25, 2019 Order granting Dr. Bragg and GAS's motion for summary judgment should be affirmed.

WHEREFORE, for the foregoing reasons, Respondents, William Bragg, M.D. and General Anesthesia Services, Inc., respectfully request that this Court deny Petitioners'

Petition for Appeal and affirm the summary judgment order from the Circuit Court of Kanawha County.

WILLIAM BRAGG, M.D. and GENERAL ANETHESIA SERVICES, INC.

By Counsel.



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IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Marissa Shaffer and Timothy Shaffer,

Petitioners/Plaintiffs

vs. **Docket No.: 19-0305**

William Bragg, M.D.;
General Anesthesia Services, Inc., and
Charleston Area Medical Center, Inc.

Respondents/Defendants.

CERTIFICATE OF SERVICE

I, Amy Rothman Malone, counsel for Respondents/Defendants, William Bragg, M.D. and General Anesthesia Services, Inc., do hereby certify that on the 5th day of August, 2019, the foregoing **"Respondents, William Bragg, M.D. and General Anesthesia Services, Inc.'s Response to Petition for Appeal of Marissa Shaffer and Timothy Shaffer"** was served upon the following counsel of record via hand delivery or U.S. Mail, postage prepaid, as follows:

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