

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

MARISSA SHAFFER and TIMOTHY  
SHAFFER, individually and as parents  
and guardians of T.S., a minor,

2019 FEB 25 PM 2:47

CATHY S. CATSON, CLERK  
KANAWHA COUNTY CIRCUIT COURT

Plaintiffs,

v.

Civil Action No. 17-C-343  
Honorable Charles E. King

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

Defendants.

**ORDER GRANTING DEFENDANTS, WILLIAM BRAGG, M.D. AND GENERAL  
ANESTHESIA SERVICES, INC.'S MOTION FOR SUMMARY JUDGMENT**

On January 22, 2019, came Plaintiffs, Marissa Shaffer and Timothy Shaffer, and Defendants, William Bragg, M.D., General Anesthesia Services, Inc. ("GAS"), and Charleston Area Medical Center, Inc., by counsel, for a hearing on *Defendants, William Bragg, M.D. and General Anesthesia Services, Inc.'s Motion for Summary Judgment*. After hearing argument of counsel, reviewing Defendants' *Motion for Summary Judgment*, Plaintiffs' *Omnibus Response in Opposition to Defendants' Motions for Summary Judgment*, and after consulting other pertinent legal authorities, the Court hereby GRANTS Defendants' *Motion for Summary Judgment*.

The Court hereby makes the following findings of facts and conclusions of law:

**FINDINGS OF FACT**

1. On January 22, 2015, Plaintiff, Marissa Shaffer, was admitted to Charleston Area Medical Center ("CAMC") for the labor and delivery of her infant, T.S.
2. Prior to her admission, on October 7, 2014, she signed CAMC's Patient Agreement during the pre-registration process.

3. 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."

4. Ms. Shaffer testified that at the time she signed the Patient Agreement, she was aware that CAMC was a teaching hospital and that students may participate in her care while she was a patient at CAMC. *Deposition of Marissa Shaffer* at p. 43, l. 5-12 and p. 44, l. 4-11.

5. During the course of her labor, Ms. Shaffer requested that an epidural be placed for pain relief.

6. Defendant William Bragg, M.D., a Board Certified anesthesiologist, was called to place the epidural.

7. Garry Chapman, RN, a student nurse anesthetist ("SRNA") in the CAMC School of Nurse Anesthesia, was working with Dr. Bragg that day.

8. Ms. Shaffer testified that Dr. Bragg introduced the student to her and told her that the student would be "observing" during the epidural placement. *Id.* at p. 52, l. 9-22. Ms. Shaffer admitted during her deposition testimony that she knew the student was in the room at the time of her epidural. *Id.* at p. 44, l. 17-19 and p. 61, l. 14-24.

9. Prior to the administration of the epidural, Ms. Shaffer signed CAMC's Acknowledgement of Consent to Anesthesia.

10. Ms. Shaffer admitted that she consented to the epidural being placed. *Plaintiffs' Response to Defendants William Bragg, M.D. and General Anesthesia Services, Inc.'s First Set of Interrogatories, Requests for Production, and Requests for Admissions*, at Request for Admission No. 11.

11. According to the deposition testimony of Dr. Bragg, during the placement of the epidural, SRNA Chapman attempted to place the epidural needle in the epidural space. *Deposition of Dr. Bragg*, at p. 49, l. 20 to p. 50, l. 13. When SRNA Chapman could not find the epidural space, Dr. Bragg took over control of the epidural needle. *Id.*

12. It is undisputed that during the placement of the epidural, Ms. Shaffer suffered a wet tap.

13. There is disagreement among the parties as to whether Dr. Bragg or SRNA Chapman was in control of the epidural needle at the time of the wet tap. Dr. Bragg testified that he was in control of the epidural needle at the time the wet tap occurred. *Deposition of Dr. Bragg*, at p. 49, l. 20 to p. 50, l. 13. However, Ms. Shaffer believes that SRNA Chapman caused the wet tap. *Deposition of Marissa Shaffer*, at p. 75, l. 9 to p. 76, l. 4. It should be noted that the Plaintiff's expert, Dr. Bushman, testified that Dr. Bragg caused the wet tap. *Deposition of Dr. Bushman*, at p. 102, l. 2-6.

14. Plaintiffs claim that as a result of the wet tap, Ms. Shaffer suffered a headache for approximately one week, and currently suffers from post-traumatic stress disorder and depression.

15. On March 10, 2017, Plaintiffs filed their Complaint. In the Complaint, Plaintiffs assert claims of lack of informed consent (Count I) and medical negligence (Count II) against Dr. Bragg and GAS. Additionally, Plaintiffs' Complaint also asserted a claim for punitive damages for improper documentation, cover up and concealment against Dr. Bragg and GAS. However, Dr. Bragg and GAS filed a Motion for Partial Summary Judgement on punitive damages, which was already granted via this Court's

May 29, 2018 Order. Therefore, the only allegations that remain against Dr. Bragg and GAS are the informed consent and medical negligence claims.

16. Plaintiffs' disclosed two experts in this matter – Gerald Bushman, M.D., an anesthesiologist, and Frank Ochberg, M.D., a psychiatrist.

17. On July 30, 2018, Dr. Bushman was deposed in this matter. During his deposition, Dr. Bushman testified that a wet tap is a known complication of epidural placement and does not constitute medical negligence. *Deposition of Dr. Bushman*, p. 100, l. 13-21. 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.

*Id.*

18. Based upon the deposition testimony of Plaintiffs' expert, Dr. Bushman, this Court FINDS that the wet tap was not caused by a deviation from the standard of care, regardless of whether the wet tap was caused by Dr. Bragg or SNRA Chapman.

19. In regard to the teaching process between Dr. Bragg and SNRA Chapman, Dr. Bushman testified that he believes Dr. Bragg should have removed the epidural needle when SNRA Chapman could not feel loss of resistance to locate the epidural space. *Id.* at p. 6, l. 7-23, p. 164, 12-18, p. 183, l. 15 to p. 184, l. 9. However, Dr. Bushman testified that there is not a specific standard of care that required Dr. Bragg to remove and restart the needle when taking over the epidural needle from SNRA Chapman. *Id.* In other words, while Dr. Bushman would have removed the

epidural needle and restarted the procedure, there is not a standard of care within the field of anesthesiology that requires Dr. Bragg to remove the needle.

20. Based upon the testimony of Dr. Bushman, this Court FINDS that Dr. Bragg did not have a duty to remove and restart the epidural needle, and therefore, did not deviate from the standard of care when he took over the epidural placement from SRNA Chapman.

21. Dr. Bushman further testified that he does not have any criticisms of Dr. Bragg's medical care and treatment of the patient. *Id.* at p. 172, l. 24 to p. 173, l. 6.

22. Based upon Dr. Bushman's testimony and viewing the facts in the light most favorable to the Plaintiff, this Court FINDS that there is not any expert testimony that Dr. Bragg deviated from the standard of care in the actual performance and placement of Ms. Shaffer's epidural.

23. Dr. Bushman testified Dr. Bragg deviated from the standard of care during the informed consent process. *Id.* at p. 172, l. 24 to p. 173, l. 6. Specifically, Dr. Bushman testified that he believes that Dr. Bragg should have informed the patient that SRNA Chapman was going to perform part of the epidural. *Id.* at p. 123, l. 18 to p. 125, l. 5 and p. 135, l. 16-22.

24. Based upon the testimony of Dr. Bushman and viewing the facts in the light most favorable to the Plaintiffs, this Court FINDS that Plaintiffs have presented expert testimony that Dr. Bragg deviated from the standard of care during the informed consent process prior to the placement of Ms. Shaffer's epidural.

25. Dr. Bushman testified that nothing about the informed consent process caused the wet tap. *Id.* at p. 157, l. 25 to p. 158, l. 2. In other words, Dr. Bushman did



not link the deviation from the standard of care during the informed consent process to the cause of Ms. Shaffer's injury.

26. It should be noted for the record that Plaintiffs' psychiatry expert, Dr. Ochberg, was deposed on November 16, 2018. Dr. Ochberg did not offer any standard of care opinions against Dr. Bragg or GAS. *Deposition of Dr. Ochberg*, p. 52, l. 15-20 and p. 74, l. 7-10.

27. 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. *Id.* at p. 128, l. 1-4; p. 78, l. 4-13; p. 79, l. 5-19; p. 92, l. 21 to p. 93, l. 7; p. 97, l. 2-4; and p. 97, l. 17 to p. 99, l. 13.

28. Based upon the testimony of Dr. Bushman and Dr. Ochberg and viewing the facts in the light most favorable to the Plaintiffs, this Court FINDS that the alleged deviation from the standard of care during the informed consent process by Dr. Bragg did not cause or contribute to Ms. Shaffer's wet tap.

#### **CONCLUSIONS OF LAW**

29. Because this case involves health care services rendered to Ms. Shaffer, the Court FINDS that this medical negligence case is governed by the West Virginia Medical Professional Liability Act, West Virginia Code § 55-7B-1, *et seq.*

30. The West Virginia Medical Professional Liability Act provides:

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

- (1) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and

(2) Such failure was a proximate cause of the injury or death.

W. Va. Code § 55-7B-3(a).

31. Similarly, the Supreme Court of Appeals of West Virginia has held that "in a medical malpractice lawsuit . . . , the plaintiff must establish that the defendant doctor [health care provider] deviated from some standard of care, and that deviation was the proximate cause of the plaintiff's injury." *Mays v. Chang*, 579 S.E.2d 561, 565 (W. Va. 2003).

32. Furthermore, West Virginia Code § 55-7B-7(a) provides that "[t]he applicable standard of care and a defendant's failure to meet the standard of care, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court."

33. The Supreme Court of Appeals of West Virginia has explained "[i]t is the general rule that in medical malpractice cases negligence or want of professional skill can be proved only by expert witnesses." *Farley v. Shook*, 629 S.E.2d 739, 744 (W. Va. 2006) (internal citations omitted). Thus, the Supreme Court has concluded that, "expert testimony is required for the [plaintiffs] to meet their burden of proving negligence and lack of skill on the part of the physician and the causal connection of that negligence to their injuries." *Id.*

34. The Supreme Court of Appeals of West Virginia has set forth additional considerations for informed consent cases. In Syllabus Point 3 of *Cross v. Trapp*, 728 S.E.2d 87, 89 (W. Va. 2012), the Supreme Court of Appeals stated:

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 the 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.

Syl. Pt. 3, *Cline v. Kresa-Reahl*, 728 S.E.2d 87, 89 (W. Va. 2012) (citing Syl. Pt. 2, *Cross v. Trapp*, 170 W. Va. 459, 294 S.E.2d 446 (1982)).

35. In informed consent cases, a plaintiff must prove a causal relationship between the physician's failure to disclose information to his patient and the damage to the patient. *Adams v. El-Bash*, 338 S.E.2d 381, 385 (W. Va. 1985).

36. 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).

37. When considering a motion for summary judgment the Court "must draw any permissible inference from the underlying facts in the light most favorable to the party opposing the motion." *Painter v. Peavy*, 451 S.E.2d 755, 758 (W. Va. 1994).

38. In Syllabus Point 4 of *Painter v. Peavy*, 451 S.E.2d 755, (W. Va. 1994), the Supreme Court of Appeals 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.



39. Furthermore, the West Virginia Supreme Court of Appeals 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 v. Precision Coil*, 459 S.E.2d 329 (W. Va. 1995) (citing Syl. Pt. 3, *Aetna Casualty & Surety Co. v. Fed. Ins. Co. of New York*, 133 S.E.2d 770 (W. Va. 1963)) (additional citation omitted).

40. In this matter, Plaintiffs' anesthesiology expert, Dr. Bushman, testified that Dr. Bragg deviated from the standard of care during the informed consent process prior to the placement of Ms. Shaffer's epidural. However, Dr. Bushman testified that this deviation did not cause or contribute to Ms. Shaffer's wet tap. As stated above, Plaintiffs have not produced any expert testimony that Dr. Bragg's alleged deviation from the standard of care during the informed consent process caused or contributed to Ms. Shaffer's wet tap.

41. Based upon the testimony of Plaintiffs' expert witnesses, Dr. Bushman and Dr. Ochberg, and viewing the facts in the light most favorable to Plaintiffs, this Court FINDS that Plaintiffs have failed to prove an essential element of their medical negligence and informed consent claims because Plaintiffs have not linked Dr. Bragg's alleged deviation from the standard of care during the informed consent process to the proximate cause of Ms. Shaffer's injury – the wet tap.

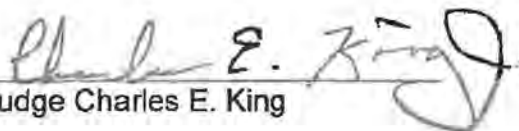
42. Because Plaintiffs' have not proven all of the elements of their medical negligence and informed consent claims, there is no genuine issue of fact to be tried by the jury, and Defendants, William Bragg, M.D. and General Anesthesia Services, Inc., are entitled to summary judgment as a matter of law.

43. For these reasons, the Court hereby GRANTS *Defendants, William Bragg, M.D. and General Anesthesia Services, Inc.'s Motion for Summary Judgment*, and DISMISSES Plaintiffs' Complaint against Defendants, William Bragg, M.D. and General Anesthesia Services, Inc., WITH PREJUDICE.

44. The exceptions and objections of the Plaintiffs are noted and preserved for the record.

45. The Circuit Clerk is hereby directed to send a certified copy of this Order to all counsel of record.

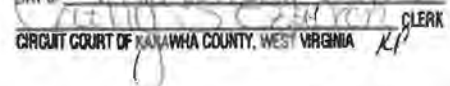
ENTERED this 25<sup>th</sup> day of February, 2019.

  
Judge Charles E. King

Prepared by:



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STATE OF WEST VIRGINIA  
COUNTY OF KANAWHA, SS  
I, CATHY S. GATSON, CLERK OF THE CIRCUIT COURT OF SAID COUNTY  
AND IN SAID STATE, DO HEREBY CERTIFY THAT THE FOREGOING  
IS A TRUE COPY FROM THE RECORDS OF SAID COURT  
GIVEN UNDER MY HAND AND SEAL OF SAID COURT THIS 27  
DAY OF February, 2019  
 CLERK  
CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

FILED *jd*

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

MARISSA SHAFFER AND TIMOTHY SHAFFER,  
individually and as parents and guardians of T.S.  
a minor,

2019 FEB 25 PM 2:47

CATHY S. GANSON, CLERK  
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Plaintiffs,

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Civil Action No. 17-C-343  
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WILLIAM BRAGG, M.D.; GENERAL  
ANESTHESIA SERVICES, INC.; and  
CHARLESTON AREA MEDICAL CENTER, INC.,

Defendants.

**ORDER GRANTING DEFENDANT, CHARLESTON AREA MEDICAL  
CENTER, INC.'S, MOTION FOR SUMMARY JUDGMENT**

On January 22, 2019, the Plaintiffs, Marissa Shaffer and Timothy Shaffer, the Defendants, William Bragg, M.D. and General Anesthesia Services, Inc., and the Defendant, Charleston, Area Medical Center, Inc., (CAMC), appeared by counsel before the Court for a hearing regarding the Defendants' respective motions for summary judgment. Prior to the hearing, the Court reviewed the motions and memoranda submitted by each party. At the hearing, the Court entertained oral argument from each party regarding their respective positions. After hearing argument, the Court determined that it was necessary to take the matter under advisement for further consideration. After considering Charleston Area Medical Center, Inc.'s motion, the Plaintiffs' response, and being otherwise sufficiently advised, the Court **GRANTS** Defendant, Charleston Area Medical Center, Inc.'s, Motion for Summary Judgment. In reaching this determination, the Court makes

the following findings of fact and conclusions of law:

**Findings of Fact**

1. Plaintiff, Marissa Shaffer, was admitted to CAMC Women's and Children's Hospital on January 22, 2015 for the delivery of her first child, T.S.

2. Prior to the admission, Ms. Shaffer admittedly read and signed a consent form acknowledging that CAMC was a teaching institution and that students in the healthcare profession may be involved in her care. Deposition of Marissa Shaffer at p. 43, l. 5-12 and p. 44, l. 4-11.

3. 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."

4. During her labor, Ms. Shaffer elected to have an epidural placed to help control her pain.

5. Garry Chapman, a student nurse anesthetist (SRNA) at CAMC's School of Nurse Anesthesia was assigned to the regional block rotation in the Labor & Delivery Unit that day and the medical records reflect that he entered Ms. Shaffer's room at 1:01 p.m. and performed a pre-anesthesia evaluation.

6. Per SRNA Chapman's deposition testimony, he would have taken Marissa Shaffer's medical history, explained the procedure in a very detailed manner, including the potential complications, and answered any questions that Ms. Shaffer had before setting up the sterile field for the anesthesiologist, Dr. Bragg, in accordance with his standard practice. Deposition of Garry Chapman at p. 109-111.

7. According to the medical records, Dr. Bragg entered Ms. Shaffer's room at 1:21 p.m. to perform the epidural.

8. Per Dr. Bragg's testimony, he started the epidural and then allowed SRNA Chapman to attempt to advance the epidural guide needle, which was unsuccessful, so he took over the procedure from the SRNA and advanced the guide needle and caused the wet tap. Deposition of William Bragg, M.D., at p. 51, l. 6-12.

9. Although SRNA Chapman does not specifically recall this incident, he testified that he has no reason to dispute that the events occurred as Dr. Bragg described. Deposition of Garry Chapman, at p. 88.

10. After properly positioning the epidural guide needle following the wet tap, Dr. Bragg threaded the epidural catheter himself and Ms. Shaffer experienced relief from her labor pain and subsequently delivered a healthy male infant.

11. The following day, Ms. Shaffer developed a post-dural puncture headache as a result of the wet tap that was treated with a blood patch.

12. Ms. Shaffer continued to have a headache following the initial blood patch, and required two additional blood patch treatments before her post-dural puncture headache completely resolved.

13. On March 10, 2017, the Plaintiffs filed the instant Complaint alleging that the Defendants deviated from the standard of care by causing a wet tap and that they failed to obtain informed consent for the SRNA's participation in the procedure. They further claim that CAMC willfully concealed the student's involvement in the procedure.



14. In terms of damages from the wet tap, Ms. Shaffer claims that she suffers from headaches and post-traumatic stress disorder and her husband, Timothy Shaffer, is making a claim for loss of consortium.

15. Pursuant to the Court's Scheduling Order, the Plaintiffs disclosed two expert witnesses, Gerald Bushman, M. D, an anesthesiologist, and Frank Ochberg, M.D., a psychiatrist.

16. The Plaintiffs' anesthesiology expert, Dr. Bushman, was deposed on July 30, 2018.

17. Dr. Bushman testified that a wet tap is a known complication of an epidural and he conceded that it is not a deviation in the standard of care for a wet tap to occur during the placement of an epidural. Deposition of Dr. Bushman, p. 100, l. 13-21.

18. Dr. Bushman further conceded that Dr. Bragg caused Ms. Shaffer's wet tap, not SRNA Chapman. *Id* at p. 102, l. 6-8.

19. Dr. Bushman further opined that SRNA Chapman deviated from the standard of care by not signing the anesthesia record, but he admitted that this failure caused the Plaintiffs any harm. *Id* at p. 125, l. 2-5.

20. Dr. Bushman testified Dr. Bragg deviated from the standard of care during the informed consent process. *Id.* at p. 172, l. 24 to p. 173, l. 6. Specifically, Dr. Bushman testified that he believes that Dr. Bragg should have informed the patient that SRNA Chapman was going to perform part of the epidural. *Id.* at p. 123, l. 18 to p. 125, l. 5 and p. 135, l. 16-22.

21. Dr. Bushman did not testify that CAMC or SRNA Chapman deviated from the standard of care regarding the informed consent process.

22. Dr. Bushman further testified that nothing about the informed consent process caused the wet tap. *Id.* at p. 157, l. 25 to p. 158, l. 2. In other words, Dr. Bushman did not link the deviation from the standard of care during the informed consent process to the cause of Ms. Shaffer's alleged injuries.

23. Dr. Ochberg testified only regarding causation and offered no opinions regarding the medical standard of care with regard to the administration of epidurals. Deposition of Dr. Ochberg at pp. 51-52 and p. 127.

24. Dr. Ochberg opined that Ms. Shaffer suffers from post-traumatic stress disorder (PTSD) and persistent depressive disorder. Deposition of Dr. Ochberg at pp. 50-51 and p. 91.

25. Dr. Ochberg testified that the wet tap was the cause of Ms. Shaffer's PTSD and persistent depressive disorder. Deposition of Dr. Ochberg at p. 127.

26. Dr. Ochberg further opined that Ms. Shaffer suffered a "moral injury" due to untruthfulness and concealment on the part of CAMC' concerning SRNA Chapman's involvement in the epidural procedure, but he admitted that a "moral injury" is not a recognized medical diagnosis. Deposition of Dr. Ochberg at p. 50.

27. Dr. Ochberg further admitted in his deposition that he has never personally diagnosed a patient to be suffering from a moral injury. Deposition of Dr. Ochberg at p. 112.

28. Based upon the testimony of Dr. Bushman and Dr. Ochberg and viewing

the facts in the light most favorable to the Plaintiffs, this Court **FINDS** that the alleged deviation from the standard of care during the informed consent process by CAMC did not cause or contribute to Ms. Shaffer to have a complication during her epidural procedure in the form of a wet tap, nor did it cause her alleged PTSD and depressive disorder.

29. The Court further **FINDS** that CAMC's alleged untruthfulness and "cover up" of SRNA Chapmans involvement in the placement of the epidural did not cause or contribute to any of Ms. Shaffer's alleged injuries.

### **Conclusions of Law**

1. Under Rule 56(c) of the West Virginia Rules of Civil Procedure, summary judgment "shall be rendered forthwith 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." *Powderidge Unit Owners Ass'n v. Highland Properties, Ltd.*, 196 W.Va. 489, 474 S.E.2d 872, 878 (1996). "Summary judgment is not a remedy to be exercised at the Circuit Court's option: it *must be granted when there is no genuine disputed issue of material fact.*" *Id.* at 878 (emphasis added).

2. In West Virginia, a party moving for summary judgment "must make a preliminary showing that no genuine issue of material fact exists." *Id.* at 878-79. "The movant does not need to negate the elements of the claims on which the non-moving party will bear the burden at trial." *Id.* at 879 (citation omitted). Rather the movant's burden is "only [to] point to the absence of evidence supporting the

non-moving party's apparent case." (citation omitted). *Id.* If the non-moving party meets this burden, "the non-movant must go beyond the pleadings and contradict the showing by pointing to *specific facts* demonstrating a jury worthy issue." *Id.* (emphasis added). "To meet the burden, the non-moving party must identify specific facts in the record and articulate the precise manner in which that evidence supports its claim." *Id.*

3. Because this case involves health care services rendered to Ms. Shaffer, the Court **FINDS** that this medical negligence case is governed by the West Virginia Medical Professional Liability Act, West Virginia Code § 55-7B-1, et seq.

4. The West Virginia Medical Professional Liability Act provides:

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and

(2) Such failure was a proximate cause of the injury or death.

W. Va. Code § 55-7B-3(a).

5. Similarly, the Supreme Court of Appeals of West Virginia has held that "in a medical malpractice lawsuit . . . , the plaintiff must establish that the defendant doctor [health care provider] deviated from some standard of care, and that deviation was the proximate cause of the plaintiff's injury." *Mays v. Chang*, 579 S.E.2d 561, 565 (W. Va. 2003).

6. Furthermore, West Virginia Code § 55-7B-7(a) provides that “[t]he applicable standard of care and a defendant’s failure to meet the standard of care, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court.”

7. The Supreme Court of Appeals of West Virginia has explained “[i]t is the general rule that in medical malpractice cases negligence, or want of professional skill, can be proved only by expert witnesses.” *Farley v. Shook*, 629 S.E.2d 739, 744 (W. Va. 2006) (internal citations omitted). Thus, the Supreme Court of Appeals has concluded that, “expert testimony is required for the [plaintiffs] to meet their burden of proving negligence and lack of skill on the part of the physician and the causal connection of that negligence to their injuries.” *Id.*

8. The Supreme Court of Appeals of West Virginia has set forth additional considerations for informed consent cases. In Syllabus Point 3 of *Cross v. Trapp*, 728 S.E.2d 87, 89 (W. Va. 2012), the Supreme Court of Appeals stated:

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 the 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.

Syl. Pt. 3, *Cline v. Kresa-Reahl*, 728 S.E.2d 87, 89 (W. Va. 2012) (citing Syl. Pt. 2, *Cross v. Trapp*, 170 W. Va. 459, 294 S.E.2d 446 (1982)).



9. In informed consent cases, a plaintiff must prove a causal relationship between the physician's failure to disclose information to his patient and the damage to the patient. *Adams v. El-Bash*, 338 S.E.2d 381, 385 (W. Va. 1985).

10. In this matter, Plaintiffs' anesthesiology expert, Dr. Bushman, did not testify that CAMC deviated from the standard of care during the informed consent process prior to the placement of Ms. Shaffer's epidural and Dr. Bushman conceded that the failure to obtain informed consent did not cause or contribute to Ms. Shaffer's wet tap.

11. Dr. Ochberg opined that the wet tap was the sole cause of Ms. Shaffer's PTSD and persistent depressive disorder. Since the Plaintiffs' only standard of care expert, Dr. Bushman, opined that the wet tap did not constitute negligence, the Plaintiffs' claimed damages have not been causally linked to any deviation in the standard of care or negligence.

12. Additionally, although Dr. Ochberg opined that Ms. Shaffer suffered a "moral injury" due to CAMC's alleged untruthfulness and attempt to cover up the student's involvement in the epidural procedure, Dr. Ochberg conceded that a "moral injury" is not a recognized medical diagnosis. Therefore, the Plaintiffs have failed to produce any expert testimony to establish that CAMC's alleged untruthfulness and/or alleged cover up of the student's involvement in the epidural placement caused the Plaintiffs' harm.

13. Based upon the testimony of Plaintiffs' expert witnesses, Dr. Bushman and Dr. Ochberg, and viewing the facts in the light most favorable to Plaintiffs, this

Court **FINDS** that Plaintiffs have failed to prove the essential elements of their medical negligence and informed consent claims against CAMC because Plaintiffs have not linked the alleged deviation from the standard of care during the informed consent process to the proximate cause of Ms. Shaffer's alleged injuries which Plaintiffs' expert causation witness has conceded was the wet tap.

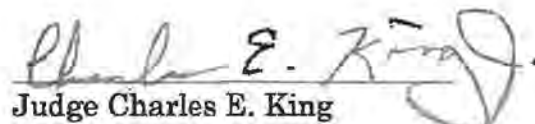
14. Because Plaintiffs' have not proven the requisite elements of their medical negligence and informed consent claims, there is no genuine issue of fact to be tried by the jury, and Defendant, Charleston Area Medical Center, Inc., is entitled to summary judgment as a matter of law.

15. For these reasons, the Court hereby **GRANTS** Defendant, Charleston Area Medical Center, Inc.,'s Motion for Summary Judgment, and **DISMISSES** Plaintiffs' Complaint against Charleston Area Medical Center, Inc., **WITH PREJUDICE**.

The exceptions and objections of the Plaintiffs are noted and preserved for the record.

The Circuit Clerk is hereby directed to send a certified copy of this Order to all counsel of record.

ENTERED this 25<sup>th</sup> day of February, 2019.

  
Judge Charles E. King

STATE OF WEST VIRGINIA  
COUNTY OF KANAWHA, SS  
I, CATHY S. GATSON, CLERK OF THE CIRCUIT COURT OF SAID COUNTY  
AND IN SAID STATE, DO HEREBY CERTIFY THAT THE FOREGOING  
IS A TRUE COPY FROM THE RECORDS OF SAID COURT  
GIVEN UNDER MY HAND AND SEAL OF SAID COURT THIS 26  
DAY OF FEBRUARY 2019.  
CATHY S. GATSON, CLERK  
CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA