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

BRIEF OF RESPONDENT, CHARLESTON AREA MEDICAL CENTER, INC., IN RESPONSE TO PETITION FOR APPEAL OF MARISSA SHAFFER AND TIMOTHY SHAFFER

Respectfully Submitted,

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II. STATEMENT OF THE CASE

A. Factual Background

On January 22, 2015, Marissa Shaffer was admitted to CAMC Women's and Children's Hospital for the delivery of her first child. Prior to her admission, Mrs. Shaffer read and signed a consent form acknowledging that CAMC is a teaching institution and that students in the healthcare profession may be involved in her care. (JA 242, Paragraph 7). During labor, she elected to have an epidural placed to help control her pain. Garry Chapman, a student nurse anesthetist ("SRNA") from CAMC's School of Nurse Anesthesia was assigned to the regional block rotation in the Labor & Delivery Unit that day. Although SRNA Chapman does not recall being involved in Mrs. Shaffer's care, the medical records reflect that an SRNA entered Mrs. Shaffer's room at 1:01 p.m. (SJA 70). SRNA Chapman also testified during his deposition that the handwriting on the pre-anesthesia history record appeared to be his; therefore, it is likely that he performed the pre-anesthesia evaluation. (SJA 73; lns. 1-7). SRNA Chapman further testified that his standard practice at the time would have been to first introduce himself to the patient followed by at least 15 to 20 minutes of talking to the patient. (SJA 73, lns. 13-25; SJA 74; lns. 20-25). He explained that during this time, he would have taken the patient's history and then explained the procedure in a very detailed manner, the potential complications, and answered any questions. (SJA 75, lns. 1-25; SJA 76, lns. 1-12). SRNA Chapman testified that after answering all of the patient's questions, he would set up a sterile field for the anesthesiologist. *Id.*

According to the medical records, Dr. Bragg entered Mrs. Shaffer's room at 1:21 p.m. (SJA 77). Dr. Bragg testified that he specifically recalls Mrs. Shaffer due to complications which occurred during her epidural procedure. (SJA 79, lns. 4-16). Dr. Bragg testified that he started the epidural and then allowed SRNA Chapman to attempt to advance the epidural needle, which was unsuccessful. (SJA 80, lns. 6-10). Dr. Bragg testified that he then took over and advanced the needle, causing a wet tap.[1] (SJA 80, lns. 11-13). Although SRNA Chapman does not have any independent recollection of Mrs. Shaffer or the wet tap, he testified that he does not have any reason to disagree with Dr. Bragg's version of the events.

After properly positioning the needle following the wet tap, Dr. Bragg threaded the epidural catheter himself and Mrs. Shaffer experienced relief from her labor pain. She subsequently delivered a healthy male child via cesarean section, but she developed a post-dural puncture headache the following day as a result of the wet tap. Dr. Bragg performed a blood patch to treat the post-dural headache, but Mrs. Shaffer continued to suffer from the headache. Therefore, two more blood patches were required to successfully treat her post-dural puncture headache.

Sometime in late February or early March, 2015, Mrs. Shaffer contacted Dawn Schoolcraft, who was the Associate Administrator at CAMC Women's and

[1] Wet taps are known complications of epidurals which can occur even in the hands of the most experienced providers. A wet tap occurs when the epidural needle enters into the dura matter (the protective covering over the spinal cord) and causes spinal fluid to leak through the dural puncture. Fortunately, most patients do not experience any complications related to a wet tap, but some do suffer from a severe headache. The treatment for a post-dural puncture headache is a blood patch, which is a procedure where a small amount of blood is taken from the patient and inserted into the epidural space to seal the hole created by the wet tap.

Children's Hospital. Ms. Schoolcraft testified that Mrs. Shaffer informed her that she had experienced a complication related to her epidural and that she had mistakenly gone to the Women's and Children's Emergency Department for treatment rather than the anesthesia holding area.[2] (SJA 258, pg. 12; lns. 6-15). During that conversation, Mrs. Shaffer stated that she did not feel that she should be responsible for the charges related to the emergency room visits, and she requested that the charges be removed from her account. (SJA 258, pg. 13; lns. 1-24). As a result of the complaint, Ms. Schoolcraft initiated a grievance procedure to determine if the charges needed to be waived. (SJA 259, pg. 14, lns. 21-24; pg. 15, lns. 1-7). Ms. Schoolcraft testified that her primary focus in response to Mrs. Shaffer's complaint was to determine whether or not to waive the emergency department charges. (SJA 259, pg. 15, lns. 23-24). Specifically, she wanted to determine if Mrs. Shaffer was sufficiently advised where to get follow up care related to the wet tap so that a charge would not be incurred. (SJA 259, pg. 16, lns. 1-11).; SJA 261, pg. 22, lns. 1-21). However, Mrs. Schoolcraft also reached out to Marion Jones, the lead CRNA at Women's and Children's Hospital, as well as Marty Henley, the chief CRNA at CAMC, and asked them to review the clinical side of Mrs. Shaffer's complaint regarding the student's involvement in causing the wet tap. (SJA 259, pg. 15, lns. 9-16). After conducting her investigation into the communication side of the complaint, she was not convinced that the message was conveyed to Mrs. Shaffer to go to the anesthesia holding area instead of the

[2] Dawn Schoolcraft has married since authoring the March 20, 2015 letter, and she now goes by Dawn Duffield.

Emergency Department if she needed further care related to the wet tap. (SJA 259, pg. 16, lns. 3-11). Accordingly, she agreed to write off all of her charges related to Mrs. Shaffer's Emergency Department visits. *Id.*

On March 20, 2015, Ms. Schoolcraft sent Mrs. Shaffer a letter informing her that the Emergency Department charges would be waived. (JA 244-245). In the letter, she mistakenly stated that "no student was involved in the epidural placement." Of note, Ms. Schoolcraft does not have any medical training, and she would not have understood that placing an epidural needle is a process that involves multiple steps. (SJA 257, pg. 7, lns. 15-16). During her deposition, Ms. Schoolcraft explained that she was told that a student was not involved in the epidural placement, which was why she included it in her letter. (SJA 259, pg. 17, lns. 12-17). However, testified that she subsequently learned that it would have been more accurate if she stated that a student did not cause the wet tap. (SJA 262, pg. 27, lns. 5-16).

CRNA Marion Jones was also questioned about her involvement in the grievance process. She testified that Ms. Schoolcraft contacted her and asked her to investigate Mrs. Shaffer's complaint regarding the student's involvement in causing the wet tap. (SJA 269, pg. 51, lns. 2-17). In response, she contacted Dr. Panger, who is the director of anesthesiology at Women's and Children's Hospital, because CRNAs do not have any involvement in placing epidurals in laboring patients. (SJA 269, pg. 52, lns. 13-20). Dr. Panger agreed to look into the incident, and he later informed her he spoke to Dr. Bragg who stated that a student was initially involved

in placing the epidural, but that Dr. Bragg personally caused the wet tap. (SJA 269, pg 53, lns. 10-16; SJA 270, pg. 54, lns. 4-12). In response, CRNA Jones notified Ms. Schoolcraft of the same. (SJA 270, pg. 54, lns. 13-18). CRNA Jones was asked about the language used in Ms. Schoolcraft's letter, and she explained that it was just semantics because the issue that Mrs. Shaffer was complaining about was the wet tap caused by Dr. Bragg. (SJA 270, pg. 56, lns. 23-24; pg 57; lns. 1-9). CRNA Jones further testified that the majority of Mrs. Shaffer's complaint was related to being charged for multiple Emergency Department visits to deal with her post-dural puncture headache; therefore, that was the primary focus of the investigation. (SJA 271, pg. 60, lns. 12-21).

Additionally, CRNA Marty Henley was deposed in this matter. She also testified that she was contacted by Ms. Schoolcraft to determine whether a student was involved in causing Mrs. Shaffer's wet tap. (SJA 274, pg. 12, lns. 16-21). Therefore, she reached out to CRNA Marion Jones and Dr. Persily, who is the President of GAS, to investigate the complaint. (SJA 274, pg. 12, lns. 23-24; pg. 13, lns. 1-12). Dr. Persily informed CRNA Henley that he spoke to Dr. Bragg and Dr. Bragg stated that he personally caused the wet tap. (SJA 275, pg. 14, lns. 10-16). CRNA Henley testified that she did not ask if the student had any involvement in the epidural placement, because the issue at hand was whether the student caused the wet tap. (SJA 275, pg. 15, lns. 3-12).

There was no further investigation into the incident because it was factually determined that Dr. Bragg caused the wet tap, which is a known complication of

epidurals which occurs in the absence of negligence. Additionally, Mrs. Shaffer's primary complaint was related to charges that she incurred for treatment related to the post-dural puncture headaches which was addressed, and all of her fees in this regard were waived.

B. Procedural History

On July 17, 2017, the Petitioners filed a Complaint in the Circuit Court of Kanawha County, West Virginia, alleging that the Respondents deviated from the standard of care by failing to obtain informed consent for the SRNA's participation in the placement of a labor epidural. They further alleged that the Respondents willfully concealed the SRNA's involvement in the procedure, entitling them to punitive damages.[3] As a result of the alleged deviation in the standard of care, Mrs. Shaffer claimed that she suffers from post-traumatic stress disorder and emotional distress. Her husband, Timothy Shaffer, also asserted a claim for loss of consortium.

At the close of discovery, this Respondent filed a motion for summary judgment asserting that the Petitioners failed to make a sufficient showing of the essential elements of their medical malpractice case, entitling the Respondent to summary judgment. Specifically, Petitioners failed to present any expert testimony that CAMC deviated from the standard of care by failing to obtain informed consent, or that any deviations in the standard of care caused the Petitioners any

[3] Of note, the Petitioners did not assert a cause of action for the tort of outrage or intentional or reckless infliction of emotional distress, as the Petitioners now assert in their Petition for Appeal. Instead, they specifically alleged that Mrs. Shaffer's emotional distress and PTSD was related to the wet tap.

harm. The Petitioners filed an omnibus response in opposition to the Respondents' respective motions for summary judgment. On January 22, 2019, a hearing was held regarding the parties' respective positions, and the Circuit Court took the matter under advisement. On February 25, 2019, the Circuit Court entered an order granting the Respondent's motion for summary judgment. (JA 14).

I. SUMMARY OF ARGUMENT

This Court should deny the Petitioners' Petition for Appeal, because the Circuit Court did not err in granting Charleston Area Medical Center, Inc.'s, motion for summary judgment. The record is very clear that there is absolutely no genuine issue of material fact as the Petitioners failed to make a sufficient showing of the essential elements of their claim. Simply put, the Petitioners failed to met their burden of proof by failing to show that the Respondent deviated from the standard of care, by failing to obtain informed consent for the SRNA's participation in the placement of a labor epidural, or that any alleged deviations from the applicable standard of care proximately caused the Petitioners' alleged damages. Accordingly, the Circuit Court appropriately concluded that a rationale trier of fact could not find for the Petitioners at trial.

Furthermore, this Court should completely disregard the Petitioners' third assignment of error because the Petitioners never asserted a claim for the tort of outrage or intentional or reckless infliction of emotional distress at the trial court level. Instead, they claimed that CAMC deviated from the standard of care by failing to obtain informed consent for the SRNA's participation in the placement of

a labor epidural, causing Mrs. Shaffer to suffer a wet tap that resulted in headaches, PTSD, and emotional distress. Therefore, they cannot now change their theory of liability in an attempt to convince this Court to reverse the Circuit Court's determination that summary judgment was appropriate.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

The Respondent requests oral argument pursuant to Rule 20 of the West Virginia Rules of Appellate Procedure.

V. ARGUMENT

A. Standard of Review

"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). In conducting the review, the Court is to apply the same standard for granting summary judgment that is applied by the circuit court. Summary judgment is appropriate where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, such as where the non-moving party has failed to make a sufficient showing of an essential element of the case that it has the burden to prove. *Id.* at Syl. Pt. 4. The circuit court's function at the summary judgment stage is not to weigh the evidence and determine the truth of the matter, but to determine whether there is a genuine issue for trial. *Id.* at Syl. Pt. 3.

B. The Circuit Court Appropriately Granted Charleston Area Medical Center, Inc.'s, Motion for Summary Judgment Because Petitioners Failed to Meet The Requisite Elements of Their Claim

1. Petitioners Failed to Provide Sufficient Evidence That Charleston Area Medical Center, Inc. Deviated From The Standard of Care With Respect To Informed Consent

Under West Virginia law, the plaintiffs must prove that a health care provider deviated from the applicable standard of care and that this deviation was the proximate cause of the injury to the plaintiff. W. Va. § 55-7B-11. Specifically, the statute provides that 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:

> (a) the health care provider failed to exercise that degree of care, skill, and learning 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
>
> (b) such injury was the proximate cause of injury or death.

West Virginia case law further provides that in a medical malpractice action, proof that negligence or want of professional skill was the proximate cause of injury of which a patient complains must ordinarily be through the scientific testimony of an expert witness. *Hicks v. Chevy*, 178 W. Va. 118, 358 S.E.2d 202 (1987). *See also, Cunningham v. West Virginia-Am. Water Co.*, 193 W. Va. 450, 457 S.E.2d 127 (1995).

This Court has set forth additional considerations for informed consent cases. In *Cross v. Trapp*, 170 W.Va. 459, 294 S.E.2d 446 (1982), the Court held the

following:

> 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 the 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.

Additionally, the 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).

In the case at hand, the Petitioners assert that CAMC deviated from the standard of care by failing to obtain informed consent for the SRNA's participation in the placement of Mrs. Shaffer's labor epidural. They, however, have failed to provide the necessary expert testimony that CAMC deviated from the standard of care with respect to informed consent. The plaintiffs' anesthesiology expert, Dr. Bushman, was deposed for more than six hours. During that deposition, all of his opinions were explored in great detail. He specifically testified that it was his opinion that Dr. Bragg deviated from the standard of care by failing to obtain informed consent regarding the student's participation in the placement of the epidural. (JA 146, pg. 150, lns. 4-9).

The Petitioners failed to cite to any testimony rendered by any expert that CAMC deviated from the standard of care by failing to obtain informed consent for the student's participation in Mrs. Shaffer's car, because no such testimony was elicited during discovery. Instead, the Petitioners argue that their informed consent

claim against CAMC should have survived summary judgment because Dr. Bushman's Screening Certificate of Merit is sufficient evidence to support their claim that CAMC deviated from the standard of care by failing to obtain informed consent for the SRNA's involvement in the epidural placement. Pursuant to W. Va. Code 55-7B-6(j), a Screening Certificate of Merit is confidential and it is 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. In this case, there was no such finding. Additionally, Dr. Bushman's opinions with respect to informed consent were fully explored during his deposition, and he did not render the opinion that CAMC deviated from the standard of care with respect to informed consent. Even if the Petitioners were permitted to rely on Dr. Bushman's Screening Certificate of Merit as evidence, he specifically stated in the Screening Certificate of Merit that CAMC is responsible for the trainee's activity, including complications, but he does not opine that CAMC breached the standard of care by failing to obtain informed consent as the Petitioners suggest. (JA 80-82)

In further support of their argument, the Petitioners contend that because Dr. Bushman was not asked about the assignment of responsibility for the different aspects of the informed consent process between the Hospital and the anesthesiologist during his deposition, the Circuit Court erred in granting the Respondent's motion for summary judgment. Counsel for the Petitioners certainly had the opportunity to further question Dr. Bushman at his deposition with respect to his criticisms of CAMC if he felt that his testimony was unclear, or that his

opinions were not fully explored, which was not done. Dr. Bushman was clear and unambiguous during his deposition that he believed that Dr. Bragg deviated from the standard of care with respect to obtaining informed consent for the student's involvement in the procedure. (JA 146, pg. 150, lns. 4-9). He was also specifically asked "[a]s far as the informed consent process goes, have we explored all of the ways in which you believe that the standard of care was not met." (JA 147, pg. 154, lns. 17-19). In response, he stated "I believe that we have exhaustively covered my problems with the consent process. . . ." (JA 147, pg. 155, lns. 4-18). Accordingly, Dr. Bushman's opinions with respect to informed consent were completely expressed during his deposition.

Finally, the Petitioners seemingly argue that CAMC deviated from the standard of care with respect to the content of its written consent forms. There is absolutely no testimony that supports any such deviation in the standard of care. Instead, Dr. Bushman, conceded during his deposition that the consent process is the communication between the provider and the patient - not what is contained in the consent form. (JA 140, pg. 126, lns. 7-10). Dr. Bushman further testified that he does not believe that the standard of care requires an anesthesia consent form to specifically state that a trainee could potentially be involved in the placement of an epidural. (JA 142, pg. 135, lns. 16-22). Furthermore, the Petitioners' contention that Dr. Sullivan, a defense expert, testified that the standard of care required disclosure of a trainee's participation is completely false. Dr. Sullivan specifically testified that "there are no specific guidelines of what degree of detail needs to be

disclosed in terms of [a trainee's] specific participation in a procedure. . . ." (JA 172, lns. 9-14). Therefore, the Petitioners failed to satisfy their burden of proof on this issue.

The Petitioners failed to produce the required expert testimony that CAMC deviated from the standard of care with respect to the informed consent process. Accordingly, the Circuit court appropriately granted Respondent's motion for summary judgment.

2. The Petitioners Failed to Provide Sufficient Evidence That Charleston Area Medical Center, Inc.'s Alleged Deviation In The Standard of Care Caused The Petitioners' Alleged Injuries

Even if the Petitioners could somehow prove that CAMC deviated from the standard of care with respect to informed consent, they offered no proof during discovery regarding causation. In this case, the Petitioners clailm that the Respondent deviated from the standard of care **solely** with respect to informed consent. Therefore, they must prove that the alleged failure to obtain informed consent resulted in their alleged injuries. Dr. Bushman unequivocally testified that nothing about the informed consent process caused the wet tap. (JA 147, pg. 157, ln. 25; JA 148, pg. 158, lns. 1-2). Further, the Petitioners' psychiatric expert, Dr. Ochberg, testified that the cause of Mrs. Shaffer's PTSD and persistent depressive disorder is the wet tap - not the lack of informed consent or CAMC's "lying" regarding the SRNA's involvement. (JA 203, pg. 99, lns. 10-13; JA 210, pg. 128, lns. 1-4). While Dr. Ochberg opined that Mrs. Shaffer suffered a "moral injury" due to CAMC informing her that no student was involved in her epidural, he conceded that

a "moral injury" is not even a medical diagnosis. (JA 204, pg. 101, lns. 13-20); JA 205, pg. 107, lns. 19-24). In fact, Dr. Ochberg has never diagnosed a patient with a moral injury, including Mrs. Shaffer, because he has never considered it a medical diagnosis. (JA 206, pg. 112, lns. 14-20). Although Dr. Bushman testified that he believes that Mrs. Shaffer suffered psychological harm due to CAMC's "lying," he conceded that he will not testify at trial that Mrs. Shaffer suffers from PTSD. (JA 147, pg. 156, lns. 7-11). He further conceded that he has not reviewed any of her medical records or interviewed her. (JA 147, pg. 156, lns. 12-13). Dr. Bushman also admitted that he is not a psychiatrist or psychologist and that the defense's psychiatric expert would have more expertise by virtue and training to determine whether Mrs. Shaffer suffered any emotional harm and that his opinions should be given weight in this situation. (JA 157, pg. 194, lns. 8-17). Accordingly, the Petitioners are barred from now claiming that Mrs. Shaffer's alleged psychological injuries were caused by anything other than the wet tap.

The Petitioners argue that the question posed to Dr. Bushman "[d]o you agree that nothing about the informed consent process caused the wet tap?" is ambiguous. To the contrary, the question is very clear and concise. They further argue that there is nothing in Dr. Bushman's affirmative response to the question that suggests that he was applying the legal definition of proximate cause for informed consent cases in West Virginia rather than the ordinary meaning of the word "caused" when he gave his answer. This argument is severely flawed because Dr. Bushman clearly understands the definition of the word "caused," and its

meaning is no different in the legal setting. If Petitioners' counsel believed that Dr. Bushman did not understand the question or the definition of the word "cause", he certainly had the opportunity to object to the question and to ask Dr. Bushman his own questions setting forth the "legal" definition of "cause" to clarify his opinion, which he failed to do. Because there was no expert testimony linking causation to any deviations in the standard of care, the circuit court appropriately granted summary judgment.

The Petitioners further argue that there is a genuine issue of fact as to whether the SRNA's participation caused the wet tap, which is completely without merit. There is no factual dispute that Dr. Bragg caused the wet tap or that the wet tap was not the result of any negligence. While the Petitioners contend that the student's participation in the procedure made it more likely for a wet tap to occur when Dr. Bragg took over the procedure, there is no expert testimony that supports that the standard of care required Dr. Bragg to remove the needle and start over. In fact, Dr. Bushman conceded that while he personally would have started the procedure over, the standard of care did not require Dr. Bragg to do so. (JA 110, pg. 6, lns. 7-24; pg. 7, lns. 1-7). There can be no causation when there is no deviation in the standard of care. Accordingly, the SRNA's involvement in this case makes absolutely no difference with respect to causation, because there is no expert testimony to support any causal links between the alleged lack of informed consent and damages.

C. The Petitioners Failed To Pled A Cause of Action for a Tort of Outrage Claim

The Petitioners further assert that the Circuit court erred in finding a lack of evidence to support their tort of outrage claim against CAMC for lying to Mrs. Shaffer about the SRNA's involvement in her epidural placement. Significantly, this cause of action has never been pled, and this assignment of error should be entirely disregarded. The Petitioners' Complaint contained a "Prayer for Exemplary Damages for Improper Documentation, Cover Up, and Concealment" in which they alleged the failure of the records and of CAMC to admit and record the presence or identify of the SRNA, speaks to a deliberate cover up by one or more of the defendants of the student's participation, most likely because Dr. Bragg and the SRNA knew that informed consent to the student's participation had not been obtained. (SJA 253, Paragraph 35). They further alleged that the improper documentation of the student's participation clearly speaks to negligence, as the cost of the student's participation clearly outweighs the zero benefit to society and the student in training of future skilled practitioners, and that Mrs. Shaffer was forced to suffer the cost of having a trainee inflict injury upon her, while society was deprived of the benefit of the trainee receiving documented training. (SJA 253, Paragraph 36). Additionally, the Petitioners allege that the willful concealment of a negligent act may be sufficient grounds for an award of punitive or exemplary damages even when the underlying act is merely negligent. (SJA 253, Paragraph 38). Finally, the Petitioners alleged that Dr. Bragg and CAMC's SRNA willfully concealed the SRNA's placement of the epidural from the medical records to cover

up the failure to obtain informed consent for the student's participation in the epidural procedure. (SJA 253, Paragraph 39; SJA 254, Parapgraph 40). These allegations were pled with regard to a claim for punitive damages - not to assert a separate cause of action for the tort of outrage.

In order for a plaintiff to prevail on a tort of outrage claim and/or a claim for intentional or reckless infliction of emotional distress, four elements must be established. It must be shown that (1) the defendant's conduct was atrocious, intolerable, and so extreme and outrageous as to exceed the bounds of decency; (2) that the defendant acted with the intent to inflict emotional distress, or acted recklessly when it was certain or substantially certain emotional distress would result from its conduct; (3) that the actions of the defendant caused the plaintiff to suffer emotional distress; and (4) that the emotional distress suffered by the plaintiff was so severe that no reasonable person could be expected to endure it. Syl Pt. 3, *Travis v. Alcon Labs, Inc.*, 202 W. Va. 369, 504 S.E.2d 419 (1998). This Court has held that liability for such a cause of action is only found where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community. *Id.* at 375, 504 S.E.2d at 425. Generally, the case is one in which the recitation of the facts to an average member of the community would arouse his resentment against the actor, and lead him to exclaim, "Outrageous!" *Id.* Additionally, this Court has held that "[t]here is no occasion for the law to intervene in every case where someone's feelings are hurt." *Tanner v. Rite Aid of W.Va., Inc.*,

194 W.Va. 643, 651, 461 S.E.2d 149, 157 (1995).

In the instant case, the Petitioners failed to assert in the Complaint that CAMC's "lying" was atrocious, intolerable, and so extreme and outrageous as to exceed the bounds of decency or that it acted with the intent to inflict emotional distress, or acted recklessly when it was certain or substantially certain emotional distress would result from its conduct. The Petitioners also failed to allege that the actions of CAMC caused Mrs. Shaffer to suffer emotional distress or that the emotional distress suffered by her as a result of CAMC's conduct was so severe that no reasonable person could be expected to endure it. Accordingly, the Petitioners claim that the circuit court erred in granting summary judgment on this ground must be rejected. Furthermore, assuming that the Petitioners' prayer for relief can somehow be interpreted as a suffiently pled claim for the tort of outrage, it can hardly be argued that CAMC's response to Mrs. Shaffer's complaint would make a reasonable person exclaim "outrageous!" Instead, her complaint was timely and thoroughly investigated by CAMC, and her medical bills at issue were completely waived as a result of the investigation.

VI. CONCLUSION

WHEREFORE, for the reasons set forth above, the Respondent, Charleston Area Medical Center, Inc., respectfully requests that this Honorable Court affirm the rulings of the Circuit Court in granting the Respondent's Motion for Summary Judgment.

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Respondents/Defendants

CERTIFICATE OF SERVICE

I, D.C. Offutt, Jr., counsel for Charleston Area Medical Center, Inc., do hereby certify that I served a true and correct copy of the foregoing ***"Brief of Respondent, Charleston Area Medical Center, Inc., In Response to Petition for Appeal of Marissa Shaffer and Timothy Shaffer,"*** upon the following by U.S. Mail, postage pre-paid this 8th day of August, 2019:

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