INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

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No. 23-ICA-58

JOHN R. ORPHANOS, M.D.,

Defendant-Below, Petitioner,

v.

DOCKET NO. 23-ICA-58

(On Appeal from Circuit Court of Kanawha County, Civil Action No. 19-C-561)

MICHAEL RODGERS,

Plaintiff-Below, Respondent.

RESPONDENT MICHAEL RODGERS' BRIEF IN OPPOSITION TO PETITION FOR APPEAL OF JOHN R. ORPHANOS, M.D.

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INTRODUCTION

A Kanawha County jury concluded that Petitioner-Defendant neurosurgeon John R. Orphanos provided reckless medical care to 49-year-old Respondent-Plaintiff Michael Rodgers, which left Mr. Rodgers — a small-business owner, mechanic, and devoted father and grandfather who "never met a stranger" (JA 2970-2977[1]) — with permanent paraplegia. As a result of the Defendant's malpractice, Mr. Rodgers is now confined to a wheelchair and unable to perform without assistance even the simplest tasks of eating, dressing, bathing, personal hygiene, and basic self-care.

After a seven-day trial, the jury in this case credited the testimony from Plaintiff's highly qualified, board-certified experts that Defendant recklessly deviated from the standard of care by operating on Mr. Rodgers' spine without the benefit of basic diagnostic and monitoring tools to detect spinal cord abnormalities and damage before and during surgery. Because Defendant was operating "blind to what's going on with the spinal cord," JA 3090, a patient whose neurological functioning was "five out of five" and "completely normal" before surgery emerged with immediate, permanent paraplegia – exactly the result that the tools Defendant cavalierly elected not to use are intended to avoid.

It was only after the surgery that Defendant realized his life-altering error and undertook a second surgery to try and correct it. But, for the second time, he did so without the requisite tools and technology that would have allowed him to find and reverse some of the damage he caused. Instead, he cemented the tragic outcome for Plaintiff. The multiple surgeries and mistakes also left Mr. Rodgers with a host of other life-threatening medical problems arising from his paraplegia that resulted in a stroke that he barely survived. Mr. Rodgers is now bedridden and has a life of

[1] References to "JA" are to the Appendix filed by Plaintiff in his appeal of certain rulings below, Docket No. 23-ICA-64.

complicated and expensive medical care ahead of him.

For these and other reasons, the jury returned a unanimous verdict awarding Mr. Rodgers $17.6 million, a figure that the trial court later reduced to $9.86 million in large part by application of statutory damages caps that Plaintiff does not challenge in this appeal. JA 1797-98, 1865. As part of that verdict, the jury concluded that Defendant was not only negligent in his treatment of Mr. Rodgers, but that he also behaved recklessly, thus precluding application of West Virginia's Medical Professional Liability Act's "Trauma Cap," W. Va. Code § 55-7B-9c.[2]

Here, Defendant raises 16 assignments of error in his effort to overturn the jury verdict against him or, at a minimum, obtain a ruling that the Trauma Cap applies here and thus limits all damages to $500,000, far less than Plaintiff's $1.3 million in medical bills alone. JA 1336.

Most of Defendant's purported errors concern the jury's finding that he acted recklessly, which Defendant contends is not properly supported by Plaintiff's experts' testimony because they did not specifically opine that he was reckless. Defendant is wrong: on its face, the Trauma Cap does not require expert testimony on "recklessness," but even if it did, there was ample evidence in this case to support the jury's finding that Defendant behaved recklessly.

Defendant also challenges a hodge-podge of the court's discretionary rulings on grounds that do not withstand even the mildest form of scrutiny. His contention that this appeal is about "ensuring a level playing field" is mere bluster; this was a fair trial in which Plaintiff amply demonstrated, via impeccably credentialed expert testimony, that Defendant's treatment of Mr.

[2] The Trauma Cap places a $500,000 limit on compensatory damages recoverable in cases where a patient receives treatment for an emergency condition in a designated trauma center. *See* W. Va. Code § 55-7B-9c(a). This cap does not apply, however, where the malpractice "[o]ccurs after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a nonemergency patient." *Id.* § 55-7B-9c(e)(1). There is a further exception where the medical care is "rendered … [i]n willful and wanton or reckless disregard for the care of the patient." *Id*. §55-7B-9c(h)(1). Here, the jury made two findings that, if affirmed, independently render the Trauma Cap inapplicable: (1) Mr. Rodgers' surgery was not an emergency; and (2) Defendant's treatment of Plaintiff was reckless. JA 1336-39.

Rodgers violated the standard of care at every turn. That Defendant disagrees with the jury's verdict is not a reason to overturn the well-considered deliberations of this jury and the well-reasoned conclusions of the court below.

STATEMENT OF THE CASE

1. Mr. Rodgers is admitted to CAMC neurologically intact and medically stable and does not require emergency surgery.

Michael Rodgers was a 49-year-old father, grandfather, small-business owner, mechanic, avid traveler, and "all around good guy," as his mother testified. JA 2971-78. He was admitted to Charleston Area Medical Center around 6:00 p.m. the evening of June 4, 2017, after suffering injuries in a motorcycle accident. JA 3155, 3158-59, 3268. His condition was stable, and he was transferred the morning of June 5 to the intensive care unit. JA 3269. Initial assessments showed that Mr. Rodgers had sustained a broken "T5" (fifth thoracic) vertebra — a so-called "Chance fracture" of the vertebra. JA 2863, 3055, 3081, 3084, 3273. There was no evidence of damage to the spinal cord. JA 3251. To the contrary, he was neurologically intact until surgery was carried out two days after his admission. *See* infra at 4-5.

Defendant received a notice of consultation regarding Mr. Rodgers in the early morning hours of July 5. JA 3268. Consistent with Plaintiff's stable, non-emergent status, Defendant's nurse practitioner saw Mr. Rodgers at 11:30 a.m. the next day, almost 12 hours after his admission to CAMC. JA 3161, 3269. She assessed Mr. Rodgers and ordered a nonsurgical back brace as a treatment option. JA 3189-90.

When Defendant saw Mr. Rodgers the afternoon of July 5, he remained stable and presented no emergency — a fact confirmed repeatedly by Defendant himself. JA 3158-59, 3165, 3168, 3208. Defendant presented Mr. Rodgers and his family with two treatment options: a nonsurgical back brace as recommended by his nurse practitioner or spinal surgery. JA 3208. In

the end, Defendant recommended surgery. JA 3208, 3270-71. The surgery was scheduled for the following afternoon, June 6, nearly two full days after Mr. Rodgers' admission. JA 3078, 3189.

2. Defendant performs a perfunctory examination of Mr. Rodgers and fails to order a pre-operative MRI, choosing to go into surgery blind.

Defendant conceded it is critically important to gather as much information as possible before any kind of spinal surgery. JA 3153. As Plaintiff's spine-surgery expert Dr. Mark Weidenbaum said, "you want to cross every T and dot every I and give your patient the best chance for a good outcome." JA 3077. Nevertheless, Defendant failed to perform some of the simplest information-gathering tasks. He did not even read Plaintiff's entire chart; instead, he chose to ignore over 40 hourly nursing notes. JA 3184-85. Further, even though Defendant claimed that his in-person assessment of Mr. Rodgers was his "gold standard," his assessment took barely 19 minutes. JA 3166-67. And Defendant's finding that Plaintiff was mentally competent to participate in his assessment directly contradicts every nursing note and the notes written by ER staff — all of which documented the fact that Plaintiff was confused, disoriented, or both. JA 3172, 3181-82.

Defendant also failed to obtain the pre-operative testing necessary to insure a safe and successful surgery. Before surgery, Defendant did not order an MRI of the thoracic spine, where the fracture was, instead relying on the earlier CT of the chest. JA 3071, 3076. Because it was a chest CT, it did not provide a full assessment of the spinal cord at all, but instead only displayed the bony structures of the spine. JA 3063, 3175. Only an MRI could show the spinal cord and the soft tissue surrounding it. JA 3175-76.

From the time of his admission to the time of the first surgery performed by Defendant two days later, Mr. Rodgers was fully intact neurologically. JA 3067-68, 3167-68. This meant that muscle resistance tests showed that "he had intact muscle strength, [and] he had intact sensation," with "full strength in all of his leg and hip muscles." JA 2939-40. Mr. Rodgers' neurological

functioning was "normal . . . Everything works." JA 3067-68. *See also* JA 2940-43 (Mr. Rodgers' preoperative neurological functioning was "five out of five . . . [with] completely normal strength").

3. Two days after Mr. Rodgers' admission, Defendant performs non-emergency surgery on Plaintiff without intraoperative monitoring, rendering Mr. Rodgers an acute paraplegic for life.

The purpose of the Defendant's first surgery on June 6 was to insert screws into Plaintiff's vertebrae above and below the fractured T5 vertebra so that a rod could be inserted into the spine to stabilize the fracture. JA 3079-80. As Dr. Weidenbaum testified based on his expertise as a spine surgeon, "this was "minimal surgery … You can get that person up and walking quickly. That's the goal of the surgery." JA 3082; *see also* JA 3080 ("the goal is to immediately be able to get . . . up and out of bed walking around . . . to avoid all the problems of being in prolonged bed rest.").

Even though it was available, Defendant elected to operate on Mr. Rodgers' spine without using a half-century old tool called intraoperative neurophysiologic monitoring ("IONM," or "intraoperative monitoring"). JA 2932**.** IONM involves placing electrodes on the hands, feet, legs, or arms so a physician can track the nerve functioning of an anesthetized patient so the physician can identify any damage to the patient's nerves during surgery. JA 2947-48. IONM causes no pain, and is "all benefit[,] no risk." JA 2949-50. If the spinal cord is impacted during a surgery, IONM will trigger a real-time alert, "an early warning system so that you'll know if there is an issue right then and there and not find out about it later on[,] by which time it may be too late." JA 3086. Defendant admitted that he had used IONM during his residency and his years of practice performing surgeries at CAMC, and that there was nothing preventing him from using it during Rodgers' surgery. JA 3195-98. As Dr. Weidenbaum testified, Defendant's failure to use IONM meant that he was operating literally "blind to what's going on with the spinal cord[.]" JA 3090.

During the surgery, instead of inserting the screws into the two vertebrae above and below the broken T5 vertebra, Defendant miscounted the vertebrae, and placed the surgical screw directly in the fractured T5 vertebra. JA 3084-85. That increased the risk there might be "some movement of the bony structure across the fracture." JA 3085. It was not until postoperative studies were done that Defendant learned the screws were protruding outside of the vertebral body at the T5 level. Dr. Weidenbaum specifically testified that one of the screws protruded medially — i.e., toward the spinal cord — and that the misplaced screw was a contributing factor in causing Plaintiff's paraplegia. JA 3106. Defendant agreed that if IONM had been used during the surgery, he would have been alerted to the changed condition of the spinal cord. JA 3220.

4. Mr. Rodgers wakes up from surgery without the use of his legs, and Defendant decides to operate blind — again.

Michael Rodgers had been neurologically intact prior to the surgery on June 6. But when he woke up from surgery, he couldn't feel or move his legs. Medical records describe Mr. Rodgers' state after the surgery as "flailing arms, confused, doesn't respond to tactile . . . or painful stimuli below the nipple, no movement obtained on command lower extremities[.]" JA 3212. He was diagnosed with acute paraplegia — the complete loss of use of both legs. JA 3122, 3220.

Because of the new onset paraplegia, Defendant performed an exploratory surgery. JA 3107-08. Even at this point, there was still an opportunity to reverse Plaintiff's paralysis. But once again, Defendant failed to obtain necessary testing — this time a CT myelogram after discovering Plaintiff's paralysis. Unlike a CT, a CT myelogram allows the surgeon to visualize the spinal cord itself, JA 3175-76, so the surgeon can see exactly where the spinal cord is compromised. JA 3105-06. But without the benefit of those test results, Defendant was unable to detect, let alone repair, the damage to Mr. Rodgers' spinal cord.

During this exploratory surgery, Defendant attempted to relieve pressure on the spinal cord by removing fat and bone. JA 3112-13. To no avail: Mr. Rodgers remained paralyzed after this second surgery. JA 3220.

5. Expert testimony establishes that Defendant deviated from the standard of care in three critical respects.

The jury heard expert testimony from two expert physicians, Dr. Mark Weidenbaum and Dr. Daniel Feinberg, that Defendant deviated from the standard of care in three respects.

a. Failure to order MRI.

Dr. Weidenbaum is a board-certified spine surgeon at Columbia University with more than 35 years of experience in spine surgery, including a fellowship in the subject. JA 3036-40. He testified that Defendant deviated from the standard of care by failing to order an MRI before the first surgery. JA 3071, 3076. Because Mr. Rodgers' condition was not acute, Defendant had ample time to order the MRI, and should have done so, because, unlike the chest CT scan that Defendant viewed before the surgery, an MRI would have allowed Defendant to see the spinal cord and surrounding soft tissue to assess its condition before surgery. JA 3062-63, 3065. As Dr. Weidenbaum put it, when it comes to the spinal cord, "you have to know before you go to surgery on what you're dealing with." JA 3071-72; 3074-75.

Dr. Weidenbaum also testified that only a preoperative MRI would show the presence of a significant amount of epidural fat surrounding Mr. Rodgers' spinal cord — a fact that Defendant, operating blind as to the condition of the spinal cord because of the lack of a preoperative MRI, learned of only *after* Mr. Rodgers was paralyzed during his first surgery. JA 3110-14.[3]

[3] While an MRI was ordered after the first surgery, because of the rods and screws placed, the metallic distortion was such that the MRI was useless in viewing the area where the surgery had been performed. JA 3505-06.

b. Failure to utilize IONM.

Two experts — neurologist and neurophysiologist Dr. Daniel Feinberg and spine surgeon Dr. Weidenbaum — testified that Defendant breached the standard of care by failing to use IONM during Mr. Rodgers' surgeries. JA 2932, 2947-49.

A neurophysiologist and expert in neurophysiological operative monitoring, Dr. Feinberg testified that IONM is used in every complex surgical spine case in his practice at the Penn Spine Center, which he founded. JA 2931. Dr. Feinberg testified that, had Defendant used IONM, there was "no doubt that he would have been given an alert" to any damage to the spinal cord during surgery, enabling corrective action, JA 2948-49 — a point with which even Defendant agreed. JA 3220. Dr. Feinberg further explained that the lack of this warning system "took away the opportunity to change the surgery at the time that the signals would have been changed[,]" which could have led to a different surgical outcome for Mr. Rodgers. JA 2962; *see also* JA 2963 ("not using the monitoring took away any opportunity for the surgeon to change course and preserve the spinal cord.").

Dr. Weidenbaum agreed that Defendant's failure to use IONM during the surgery breached the standard of care, because without the use of IONM, Defendant would be "blind to what's going on with the spinal cord[.]" JA 3086-87, 3090-92, 3096. With the real-time monitoring provided by IONM, Defendant could have done "many things" to address the damage, including removing the surgical screw, or decompressing the spinal cord. JA 3119-20. IONM also would have alerted Defendant to spinal cord damage caused by his insertion of the screw directly into the fractured bone, an error that increased the risk there might be "some movement of the bony structure across the fracture." JA 3085. Dr. Weidenbaum testified that one of the screws protruded medially — i.e.,

impacting the spinal cord — and that the misplaced screw, which Defendant only learned of after the first surgery, was a contributing factor in causing Mr. Rodgers' paraplegia. JA 3106.

c. Failure to perform a CT myelogram after the first surgery.

Finally, Dr. Weidenbaum testified that Defendant deviated from the standard of care by failing to perform a CT myelogram before the second surgery, where the purpose was to explore the cause of the paralysis and take remedial measures to relieve pressure on the spinal cord. JA 3123-24. A CT myelogram is an injection of dye around the spine so that the spinal cord can be located and seen more clearly. JA 3063-64. Here, a CT myelogram would have revealed exactly where the spinal cord was compressed, enabling Defendant to decompress it, JA 3107-08, 3119-20, thereby giving Defendant "a much better chance of fixing it." JA 3124. Defendant's failure to perform a CT myelogram gave Mr. Rodgers "zero chance of recovery. . . . [I]n a situation like this which is so catastrophic, we are obliged to pull out all the stops and do anything possible under our power to try to help. That means you got to try to find out exactly where the problem is and to the best of your ability to try to do something about it. What you do may not work, but at least you have to try." JA 3124-25.

6. The jury hears testimony from Defendant about the cause of the injury and rejects his contention that Mr. Rodgers' accident caused his stroke.

Defendant's causation theory was that Plaintiff suffered a vascular injury because of the force that caused the Chance fracture, and that the vascular injury, in turn, caused a spinal stroke. JA 3844, 3847. Significantly, Defendant never mentioned vascular injury and stroke in any of his records — not in his perioperative report and not in the records of any of his subsequent visits. JA 3194. Nevertheless, Defendant testified that's what happened at the time of Plaintiff's surgery. JA 3193-94, 3215. Defendant further testified, without any explanation, that an MRI was simply unnecessary. JA 3179-80. He conceded that IONM would have detected any spinal cord

compromise during any drops in Plaintiff's blood pressure that might result in a spinal stroke, and it would have sounded an alert. JA 3198-99. Defense expert Dr. Berkman agreed with this concession. JA 3863-64.

Mr. Rodgers' experts rejected as anatomically infeasible the defense position that Mr. Rodgers' spinal cord was damaged in the accident, not during surgery. Dr. Feinberg testified that the segmental artery does not supply blood to the spinal cord, "[s]o a dissection of the segmental artery at T5 would not result in a spinal cord stroke." JA 2937. He further testified that because Mr. Rodgers' hip, leg and arm strength was "completely normal" the day before the surgery, it was "impossible" that Mr. Rodgers sustained damage to the spinal cord before the surgery. JA 2941-42. Dr. Feinberg explained that, based on that fact alone, there was "no possibility" that Mr. Rodgers sustained the damage in the accident. JA 2943-44. Like Dr. Weidenbaum, Dr. Feinberg attributed the cause of the spinal cord stroke to Orphanos' surgery. JA 2950-51.

Dr. Edward Greenberg, a board-certified radiologist, neuro-interventional surgeon, and diagnostic neuro-radiologist, also pinpointed the cause of the spinal-cord injury to damage inflicted by Defendant during his first surgery on Mr. Rodgers. Dr. Greenberg testified that Mr. Rodgers' spinal cord was injured in the fractured T5 area where Defendant mistakenly placed the surgical screw (JA 3495, 3534) and rejected alternative explanations offered by the defense.[4]

[4] One defense theory posited that damage to segmental arteries feeding the spinal cord at the T5 vertebra caused Mr. Rodgers' paraplegia. JA 3524, 3528. Dr. Greenberg, the only testifying physician who is published in the "niche" field of vascular anatomy of the spinal cord, JA 3526-27, 3529, rejected that theory (JA 3528), pointing out that there is no segmental artery that feeds the spinal cord at that location. JA 3521-23. That fact, coupled with the fact that Mr. Rodgers showed no signs of spinal cord injury before the first surgery (JA 3530-31), supported Dr. Greenberg's determination that Mr. Rodgers' spinal cord injury occurred in surgery. Dr. Greenberg also rejected a second defense explanation — a theory that a clot in the collarbone or heart caused the injury during the surgery — as "completely false," and noted that another of the Defendant's own experts could not support this theory. JA 3532-33.

7. Defendant's malpractice cost Mr. Rodgers the use of his legs and destroyed his quality of life.

Michael Rodgers is paralyzed for life. He battled infections, bed sores, and other serious health issues until July 2020, when he finally suffered a stroke caused by an infected bed sore. The evidence specifically showed that, due to his paralysis, Plaintiff developed an infected bed sore which, in turn, caused bacterial sepsis. The bacteria caused bacterial vegetation to form on the heart valves, which subsequently broke off and traveled to his brain, resulting in Mr. Rodgers' stroke. JA 3359-63.

Tragically, Plaintiff's stroke caused even more physical impairments and limitations. Instead of being wheelchair-bound, with use of both arms, Plaintiff is now bedfast, unable to perform the most basic activities of daily living. The nature of his limitations was described by Nadene Taniguchi, a registered nurse and certified life care planner. JA 3318. She testified that Plaintiff has lost almost all his independence and relies on his girlfriend for everything from household chores to basic home nursing care, including diaper changes, bathing, and skin care to prevent bed sores. JA 3338, 3349-50. Nurse Taniguchi further testified that Plaintiff will require around-the-clock care for the rest of his life. JA 3370. Because of his paralysis, Plaintiff will also require regular diagnostic testing and medical surveillance by physiologists, urologists, orthopedics, and other health care specialists. JA 3343-44. To accommodate Plaintiff's limitations, it will also be necessary to build ramps, widen doorways, and make modifications to the floor plan of Plaintiff's home. JA 3353-54. According to Nurse Taniguchi's life care plan, the cost of providing these and other medical services over Plaintiff's 27.3-year life expectancy comes to $8,305,630. JA 3371.

8. The jury finds that Defendant's reckless misconduct caused Mr. Rodgers' paraplegia and stroke and awards $17.6 million in damages.

This case was tried in March 2022. Responding to special interrogatories, the jury found that Defendant was not only negligent, but was also reckless, thereby rendering the Trauma Cap inapplicable to this case. JA 1861. The jury likewise found the surgery performed by Defendant was non-emergent (which also rendered the Trauma Cap inapplicable) and that Defendant's malpractice proximately caused Plaintiff's stroke in July 2020. JA 1861. As a result, the jury awarded Plaintiff more than $17.6 million in damages. Thereafter, the parties briefed and argued a series of motions involving MPLA caps, offsets, and other prejudgment issues. On September 12, 2022, the Court entered final judgment in the amount of $9,862,384.58. JA 1860-1866.

SUMMARY OF ARGUMENT

Defendant's appeal is not about "ensuring a level playing field." Pet. Br. 10. It is about a defendant's disagreement with a verdict that he feels should have gone his way — a verdict reached after a fair trial by a properly-instructed jury that considered expert testimony from both Plaintiff and Defendant, sided with Mr. Rodgers, and found that Defendant acted recklessly in performing spine surgery "blind" to the condition of Mr. Rodgers' spinal cord, JA 3090, rendering a patient who entered surgery with full neurological strength to one who woke up with permanent paraplegia. The jury's $17.6 million verdict, which was reduced post-trial to less than $10 million, represents the bare minimum that Mr. Rodgers requires to take care of his basic medical needs for the rest of his life — needs that are a direct result of Defendant's indefensible recklessness, as the jury found.

Defendant's main argument is that, because none of Mr. Rodgers' experts specifically labeled his conduct as "reckless," the jury's conclusion on this point cannot stand. In so arguing, Defendant seeks to shoehorn this case into the MPLA's Trauma Cap, W. Va. Code § 55-7B-9c(h)(l)

— which, if applicable, would limit the total damages here to $500,000. This argument fails for a host of reasons, including (1) the Trauma Cap itself contains no reference to expert testimony (*see* W. Va. Code § 55-7B-9c(h)(l)); and (2) another provision of the MPLA that governs the standard of care for medical professionals, *see id.* § 55-7B-7(a), *does* contain a reference to expert testimony (which means that the Legislature knows how to require such testimony when it wants to). The fact that expert testimony is referenced in the MPLA's standard-of-care provision but *omitted* from the Trauma Cap necessarily means that no such testimony is required to demonstrate recklessness under the latter. Syl. Pt. 3, *Manchin v. Dun*fee, 174 W. Va. 532, 535, 327 S.E.2d 710, 714 (1984).

Even if expert testimony were required to establish recklessness under the Trauma Cap (it is not), Defendant's argument would still fail because an expert's job is to opine on whether the Defendant deviated from the applicable standard of care; it is the *jury's* job to apply the law to the facts. That Plaintiff's experts here did not actually label Defendant's conduct as "reckless" is legally irrelevant, because it is up to the jury to decide whether the facts supported such a finding — and here, the facts certainly did. Defendant's argument that the presence of conflicting expert testimony as to whether he violated the standard of care precluded a finding of recklessness is simply wrong as a matter of law; it does not.

Finally, even if there were insufficient evidence to support the jury's finding of recklessness the verdict should still stand because the jury *also* found that this was not an emergency surgery — and that fact alone, which was amply supported by all the expert testimony, is more than sufficient to render the Trauma Cap inapplicable here.

Defendant offers a hodge-podge of other arguments challenging discretionary rulings of the court that would withstand scrutiny even under a de novo standard of review. For example, he challenges the court's decision to allow Plaintiff to update his life care plan to reflect recently

incurred medical damages (while allowing Defendant time to submit new rebuttal reports), an even-handed ruling well within the court's ample discretion. He challenges the court's equally correct decision not to allow Plaintiffs' mother to be questioned about what a non-testifying physician apparently told her about the cause of Mr. Rodgers' spinal injury (testimony that would have constituted rank hearsay, among other things). He then mischaracterizes statements of counsel in order to claim they were improper; challenges jury instructions that were accurate and fair to both parties and did not mislead the jury; and even challenges the court's decision to allow a board-certified spine surgeon with 35 years of experience to offer expert testimony on spine surgery.

None of these challenged decisions comes even close to an abuse of discretion, much less the sort of fundamental error that could invoke the "sparingly" used cumulative error rule that Defendant invokes at the end of his brief. *See Tennant v. Marion Health Care Fdn., Inc.*, 194 W. Va. 97, 118, 459 S.E.2d 374, 395 (1995). At most, the purported errors reflect the Defendant's disagreement with the verdict, which provides no basis for appeal at all.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Pursuant to West Virginia Rules of Appellate Procedure 18(a), Mr. Rodgers respectfully requests Rule 19 oral argument because it involves narrow issues of law. Contrary to Defendant's contention, this appeal is not appropriate for Rule 20 argument because it involves a straightforward application of settled law and a challenge to a jury verdict supported by substantial evidence.

STANDARD OF REVIEW

"The appellate standard of review for an order granting or denying a renewed motion for a judgment as a matter of law after trial pursuant to Rule 50(b) of the West Virginia Rules of Civil Procedure [1998] is de novo." Syl. Pt. 1, *Fredeking v. Tyler*, 224 W.Va. 1, 680 S.E.2d 16 (2009).

A circuit court's decision to grant a new trial is reviewed for an abuse of discretion. *Contemporary Galleries of West Virginia, Inc. v. Riggs Commercial Realty, LLC*, 246 W. Va. 431, 435, 874 S.E.2d 34, 38 (2022); *Tennant*, 459 S.E.2d at 381.[5]

ARGUMENT

I. THE CIRCUIT COURT DID NOT ERR IN DENYING DEFENDANT'S VARIOUS MOTIONS ON THE ISSUE OF "RECKLESSNESS."

As noted above, the Trauma Cap places a $500,000 limit on compensatory damages recoverable in cases where a patient receives treatment for an emergency condition in a designated trauma center. *See* W. Va. Code § 55-7B-9c(a). It contains an exception, however, in cases where the medical care is "rendered … [i]n willful and wanton or reckless disregard for the care of the patient." *Id*. § 55-7B-9c(h)(1). The circuit court found that the Trauma Cap is inapplicable to this case based on the jury's finding that the surgery was non-emergent and that Defendant was reckless. JA 1861.

Here, Defendant argues that the Trauma Cap should apply because even though, on its face, it does not require expert testimony to prove recklessness, *see* W. Va. Code § 55-7B-9c(h)(l), the Court should read such a requirement into the Trauma Cap because (1) a different section of the MPLA, W. Va. Code § 55-7B-7(a), requires expert testimony on the standard of care; and (2) an entirely different statute, W. Va. Code § 55-7-29(a), requires "clear and convincing" evidence

[5] Additional standards of review pertaining to other issues raised by Defendant are set forth below.

of actual malice or recklessness to support an award of punitive damages. Both arguments are wrong as a matter of law.[6]

A. The Trauma Cap does not require expert testimony on the issue of recklessness.

Contrary to Defendant's argument, W. Va. Code § 55-7B-9c(h)(1) does not require expert testimony specifically opining that a health care provider was "reckless" to avoid application of the Trauma Cap. There are several reasons why this is so.

1. The text of the Trauma Cap says nothing about expert testimony — ergo no such testimony is required.

First, of course, the text of the Trauma Cap says nothing about expert testimony. It simply states that the cap on damages "does not apply where health care or assistance for the emergency condition is rendered . . . in willful and wanton or reckless disregard of a risk of harm to the patient." *Id*. That, in and of itself, disproves Defendant's argument right out of the starting gate, because West Virginia law is clear: Courts may not "arbitrarily . . . read into a statute that which it does not say." Syl. Pt. 11, in part, *Brooke B. v. Ray*, 230 W. Va. 355, 738 S.E.2d 21 (2013). "Just as courts are not to eliminate through judicial interpretation words that were purposely included, we are obliged not to add to statutes something the Legislature purposely omitted." *Id.*; *see also* Syl. Pt. 1, *Consumer Advoc. Div. v. Pub. Serv. Comm'n*, 182 W. Va. 152, 386 S.E.2d 650 (1989) ("A statute, or an administrative rule, may not, under the guise of 'interpretation,' be modified, revised, amended or rewritten.").

[6] Defendant also argues that this was not an emergency surgery, and challenges the jury instructions on this point. The flaws in this argument are addressed *infra* at Point II(F)(2). But even if this was an emergency surgery, the Trauma Cap would still not apply because Defendant was reckless. *See* W. Va. Code § 55-7B-9c(h)(1).

2. Under the doctrine *expressio unius est exclusio alterius*, the reference to expert testimony in the MPLA's Standard-of-Care Provision may not be imported into the Trauma Cap.

Defendant nonetheless insists that, because the Legislature specifically referenced expert testimony in another part of the MPLA — Section § 55-7B-7(a) (the "Standard-of-Care Provision") — this Court should read such a requirement into the Trauma Cap.

This argument gets things exactly backwards: the fact that expert testimony is referenced elsewhere in the MPLA but *omitted* from the Trauma Cap "necessarily" means that no such testimony is required to demonstrate recklessness under the latter. *See* Syl. Pt. 3, *Manchin,* 327 S.E.2d at 713 (under "the familiar maxim '*expressio unius est exclusio alterius*,' the express mention of one thing *necessarily* implies the exclusion of another") (emphasis added).

So held the Idaho Supreme Court in *Ballard v. Kerr*, 378 P.3d 464 (Idaho 2016), where a health care provider framed the issue in much the same way Defendant does here, arguing that because, in a medical malpractice case, expert testimony is required to prove that a medical professional violated the standard of care, such testimony must be required to prove recklessness for purposes of determining whether the case falls within an exception to a damages cap.[7]

The Idaho Supreme Court rejected that argument, holding that "[w]here the legislature has not expressly provided that direct expert testimony is required to prove recklessness in medical malpractice actions, *we decline to apply such a requirement*." *Id.* at 499-500 (emphasis added) (holding that "[a]lthough section 6–1012 requires that the applicable standard of care and the

[7] In Idaho, as in West Virginia, a plaintiff in a medical malpractice case must "affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence" that the Defendant failed to meet the applicable standard of care for medical professionals. *See* Idaho Code § 6-1012. And in Idaho, as here, there is a cap on damages that applies *except* where a plaintiff can prove that the medical professional acted recklessly. *Id.* § 6–1603(4)(a).

Defendant's breach thereof be proven by direct expert testimony, there is no requirement that a plaintiff provide expert testimony to prove recklessness.").

Ballard is squarely applicable here. Just as in Idaho, the Trauma Cap is "silent on [a need for expert testimony on] the issue of recklessness." *Id.* Just as in Idaho, other provisions of West Virginia law expressly require expert testimony and heightened standards of proof. *See id.* (citing Idaho's MPLA and punitive damages statute). Just as in Idaho, that necessarily means that no such testimony is required to demonstrate recklessness under the Trauma Cap. *See State ex rel. Riffle v. Ranson*, 195 W. Va. 121, 128, 464 S.E.2d 763, 770 (1995) ("If the Legislature explicitly limits application of a doctrine or rule to one specific factual situation and omits to apply the doctrine to any other situation, courts should assume the omission was intentional.").

3. The MPLA's Standard-of-Care Provision merely requires expert testimony on whether the Defendant deviated from the Standard of Care, not a legal conclusion on "negligence" or "recklessness."

Even if expert testimony were required to establish recklessness under the Trauma Cap, Defendant's argument would still fail because it is based on a false premise: that, in testifying whether a Defendant has met the applicable standard of care under § 55-7B-7(a), an expert must actually *label* the Defendant's actions as "negligent" or "reckless" within the meaning of the law. Here again, the law is the exact opposite of what Defendant claims it to be.

As West Virginia's Supreme Court of Appeals has explained, "[a]s a general rule, an expert witness may *not* testify as to questions of law such as the principles of law applicable to a case, the interpretation of a statute, the meaning of terms in a statute, the interpretation of case law, or the legality of conduct. It is the role of the trial judge to determine, interpret and apply the law applicable to a case." Syl. Pt. 10*, France v. Southern Equipment Co*., 225 W. Va. 1, 689 S.E.2d 1 (2010) (emphasis added).

Thus, in *Jackson v. State Farm Mutual Auto Insurance Company*, 215 W. Va. 634, 644–45, 600 S.E.2d 346, 356-57 (2004), the Court held that it was improper for an expert witness to testify as to whether an insurance agent had acted with "actual malice" where such testimony "[did] not assist the trier of fact to understand the evidence or to determine a fact in issue." *Id*. The Court explained that "[a]fter the jurors are informed of industry practices of claims adjustment and settlement, the nature of State Farm's conduct in the instant case, and the applicable law concerning malice, they are as capable as Mr. Diaz to determine whether State Farm's conduct indicates the existence of malice." *Id*. "Therefore," the Court concluded, the expert's opinion "does not assist the jury but rather is merely cumulative." *Id*. Further, "because Mr. Diaz has been recognized as an expert, there is a danger that jurors may consider him more qualified to determine the issue of malice than they are." *Id*.

This is not to say that an expert is prohibited from labeling a Defendant's behavior as "negligent" or "reckless." To the contrary, Evidence Rule 704 provides that "[a]n opinion is not objectionable just because it embraces an ultimate issue." But such testimony is most certainly not required, because an expert's job is simply to opine on whether the Defendant deviated from the applicable standard of care; it is the jury's job to apply the law to the facts.

So held the court in *Estate of Burns by and through Vance v. Cohen*, No. 5:18-cv-00888, 2019 WL 2553629, at *4 (S.D.W. Va. June 19, 2019), where a doctor sued for medical malpractice argued that, "because the Plaintiff's expert witness did not expressly state that the Defendant's conduct was 'extreme and egregious bad conduct' or use the legal terms wanton, willful, reckless conduct, or criminal indifference, the Court should deprive the jury of the opportunity to hear the evidence and make that determination." *Id*. The court rejected that argument, stating that "[v]iewing the evidence in the light most favorable to the non-moving party, a jury could make a

reasonable inference that the Defendant was grossly negligent. The jury could also review the evidence in this case and find that the Defendant fully met the correct standard of care. However, the Court will not make this determination simply because the expert witness did not use the 'magical' words. The jury sitting as the finder of fact makes that determination." *Id*.

Likewise, in *United States v. Jacques Dessange, Inc.,* No. S2 99 Cr. 1182 (DLC), 2000 WL 294849, at *2 (S.D.N.Y. Mar. 21, 2000), an accounting firm argued that it was entitled to summary judgment because the Plaintiff's expert "[did] not actually say that Andersen's audit was 'reckless' or an 'extreme departure' from [general accounting standards]." As in *Estate of Burns,* the *Dessange* court rejected that argument, stating that "[t]he absence of a talismanic phrase in an expert's testimony will not prevent a fact finder from concluding that Andersen's conduct was reckless. Indeed, while experts may opine on ultimate issues, *they should avoid using in their testimony the very words and phrases that constitute the elements of a claim that a jury must find*." *Id.* (emphasis added).

Finally, in *Nowzaradan v. Ryans*, 347 S.W.3d 734, 741-42 (Tex. App. 2011), a patient added a claim of gross negligence to her medical-malpractice action against her doctor relating to her prosthetic-hip dislocation. The doctor moved to dismiss the claim on the ground that the patient's expert report did not support the contention of gross negligence. The Texas court denied the motion, holding that Texas's Medical Practice Liability Act "requires that an expert opine regarding *the manner* in which the physician breach the applicable standard of care and the causal relationship between the breach and the plaintiff's injury, *not the extent of the breach.*" *Id.* (emphasis added).[8]

[8] *See also Szymanski v. Hartford Hospital*, No. CV 89 03 63 831S, 1993 WL 89068 (Conn. Super. Mar. 12, 1993), at *3 ("The rationale for requiring expert testimony about standard of care in medical malpractice cases is that as laymen, jurors lack requisite knowledge as to medical standards…. However, once expert testimony provides jurors with such knowledge, they are able to make the factual determination as to

* * *

The upshot of the foregoing is that, even if expert testimony were required on the issue of recklessness for purposes of establishing an exception to the Trauma Cap, that would *not* mean that an expert must expressly state, using the magic words, that a medical professional was "reckless" in order for a jury to make such a finding. Rather, under the MPLA, the expert's job is simply to testify whether the Defendant has violated the standard of care by "fail[ing] 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." W. Va. Code § 55-7B-3. That Plaintiff's experts here did not actually label Defendant's conduct as "reckless" is legally irrelevant, because it is up to the jury to decide whether the facts supported such a finding.

4. The punitive damages statute has no bearing on the Trauma Cap.

Defendant's second argument — that the Trauma Cap must require expert testimony on "recklessness" because West Virginia's statute governing punitive damages, W. Va. Code § 55-7-29(a) (2015), requires "clear and convincing" evidence of reckless or malicious conduct (*see* Pet. Br. 15-16) — is perplexing, because the punitive-damages statute does not say anything about expert testimony. So even if that statute had any bearing on how the Court should interpret the Trauma Cap, and there is no reason that it should, it is hard to understand how that would advance Defendant's cause here.

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whether the conduct in question was actionable at all, negligent, or reckless or wanton."); *Jamas v. Krpan*, 588 P.2d 1114, 1115 (Ariz. 1977) (noting that "[a]lthough a jury may not be competent to determine medical malpractice without the aid of expert testimony that the physician had deviated from the accepted standard of care, it does not necessarily follow that the jury, having been informed of community standards, is incompetent to judge the nature or gravity of the deviation; i.e., whether it was simple negligence or reckless disregard of the safety of the patient.").

Stephens v. Rakes, 235 W. Va. 555, 775 S.E.2d 107 (W. Va. 2015), is not to the contrary. There, the Supreme Court of Appeals affirmed an award of punitive damages in a medical malpractice case because the plaintiff "provided evidence that Dr. Stephens' care of the decedent was 'dangerous, and at the very least, reckless.'" *Id*. at 118. The Court's ruling was based on its review of the evidence, and not the use of the word "reckless." *See id.*,775 S.E.2d at 119.

Even if use of the magic word "reckless" was somehow central to the Court's holding in *Stephens*, that would not matter because there are compelling reasons why the standard for determining "recklessness" under a statute addressing the availability of *punitive* damages should not govern the applicability of the Trauma Cap, which sets a limit on the availability of certain *compensatory* damages in a medical malpractice case. Unlike compensatory damages, which are limited to the "concrete loss that the Plaintiff has suffered by reason of the Defendant's wrongful conduct," punitive damages raise special constitutional concerns due to their potential for imposing "grossly excessive or arbitrary punishments on a tortfeasor." *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 416 (2003) (cleaned up). For that reason, West Virginia, like many other states, has restricted the availability of punitive damages by requiring "clear and convincing" evidence of reckless or malicious conduct before punitive damages may be imposed. W. Va. Code § 55-7-29(a) (2015). The requirement of "recklessness" in the Trauma Cap, in contrast, serves a very different function; it is designed to allow the recovery of *compensatory* damages to which a patient would otherwise be entitled if their treatment had not occurred under emergency conditions. Because compensatory damages do not implicate the due process rights of a Defendant, there is no reason to assume that the Legislature would want the same burden of proof to govern recklessness determinations under the punitive damages statute and under the Trauma Cap.

B. There was ample expert testimony supporting the jury's conclusion that Defendant behaved recklessly.

Defendant is equally wrong then he argues that "Plaintiff did not produce any evidence or expert opinion during discovery or at trial to support the jury's finding that Dr. Orphanos was reckless." Pet. Br. at 13; *see also id*. at 15. "The usual meaning assigned to 'wilful,' 'wanton' or 'reckless . . . is that the actor as intentionally done an act of unreasonable character in disregard of a risk known to him or so obvious that he must be taken to have been aware of it, and so great as to make it highly probable that harm would follow." *Cline v. Joy Mfg. Co*., 172 W. Va. 769, 772 n.6, 310 S.E.2d 835, 838 n.6 (1983). In this case, there was ample expert testimony from which the jury could reasonably conclude that Defendant "intentionally … disregard[ed] … a risk known to him," particularly given that, "[i]n determining whether there is sufficient evidence to support a jury verdict the court must, inter alia, "assume that all conflicts in the evidence were resolved by the jury in favor of the prevailing party" and "give to the prevailing party the benefit of all favorable inferences which reasonably may be drawn from the facts proved." Syl. Pt. 5, *Orr v. Crowder*, 173 W. Va. 335, 315 S.E.2d 593 (1983).

Defendant's only legal argument on this point is that "[b]ecause there was conflicting evidence regarding whether Dr. Orphanos even breached the standard of care, the circuit court erred in permitting the jury to consider the issue of "recklessness." Pet. Br. at 19. It is well established, however, that conflicted expert testimony does not prevent a jury from concluding that defendant committed error. *See, e.g., Estate of Burns*, 2019 WL 2553629, at *4 (allowing case to go to the jury on issue of punitive damages despite conflicting expert evidence as to "whether the Defendant provided the appropriate standard of care, whether he was negligent, or whether he was grossly negligent"); *Wolf v Persaud, No. 473*, 14 N.Y.S.3d 601, 602 (N.Y. App.

2015) (holding that conflicting expert testimony on whether a doctor committed malpractice by failing to order an MRI "merely presented a question of fact for the jury to resolve"); *Mitrovic v Silverman*, 961 N.Y.S.2d 75, 76 (N.Y. App. 2013) (holding that "contradictory affidavits, each based upon the expert's relevant experience in the field of chiropractics, were sufficient to raise a disputed issue regarding whether defendants deviated from accepted practice by failing to order an MRI").[9]

II. THE CIRCUIT COURT DID NOT ABUSE ITS DISCRETION IN DENYING DEFENDANT'S MOTION FOR NEW TRIAL.

A. The Circuit Court did not abuse its discretion by failing to grant Dr. Orphanos' motion in limine on "recklessness."

Defendant's argument that the circuit court abused its discretion by not granting his motion in limine on "recklessness" (Pet. Br. 20-21) is based on an erroneous premise: that there was insufficient expert testimony to support a finding of recklessness in this case. That argument is wrong for all the reasons discussed above — thus the denial of the motion was necessarily correct and did not amount to an abuse of discretion. *See* Syl. Pt. 3, *Jones v. Garnes*, 183 W. Va. 304, 306, 395 S.E.2d 548, 550 (1990) ("Rulings on the admissibility of evidence are largely within a trial court's sound discretion and should not be disturbed unless there has been an abuse of discretion.").

[9] *Karpacs-Brown v. Murthy*, 224 W. Va. 516, 686 S.E.2d 746 (W. Va. 2009), is not to the contrary. Defendant cites *Karpacs-Brown* for the proposition that the presence of conflicting testimony necessarily prevents a court from finding that a doctor was sufficiently reckless to warrant an award of punitive damages. But that's not what *Karpaks* holds. There, the Supreme Court affirmed the trial court's decision not to allow jury to consider punitive damages, *not* because there was conflicting evidence on culpability, but rather because the Court "simply [did] not find sufficient evidence in the record to support a punitive damage instruction." *Id*. at 757. *Karpacs-Brown* is also inapposite because, as explained above, there are good reasons why punitive damages require heightened evidence of reckless that do not apply to the Trauma Cap.

B. The Circuit Court did not abuse its discretion by allowing Plaintiff's expert witnesses to supplement their life care plan and economic reports or by limiting Dr. Orphanos' rebuttal expert testimony.

On January 5, 2022 — more than two months before trial — Plaintiff served supplemental expert witness disclosures to update his life care plan and economic report and account for the additional economic damages resulting from the stroke Plaintiff suffered after the initial due date for expert reports. JA 712–35; JA 2440–41 (court noting that the updated reports remained materially the same but "included additional claimed medical care needs resulting from the stroke"). The supplemental reports contained no causation opinions, and did not change the experts' opinions in any other material way. *Id.*

A month later, Defendant moved to exclude those reports as untimely. JA 736–41. That same day, Defendant also moved to continue the trial based on those concerns about Plaintiff's supplemental reports and COVID-19. JA 860–66. Exercising its broad discretion, the lower court denied both motions. JA 2440-41; JA 889–90. But to strike a "fair compromise," the court permitted Defendant to supplement his expert disclosures to address the substance of Plaintiff's updated life care plan and economic report. JA 2439–47; JA 2703-05. In doing so, the court excluded one of Defendant's supplemental expert disclosures because it included an entirely new opinion about Plaintiff's life expectancy, and was served just one week before trial. JA 2439–47.

Defendant asserts two interrelated contentions of error: First, he says consideration of the factors a court may assess when considering supplemental expert disclosures "tips the scales in favor of Dr. Orphanos." Pet. Br. 21–23 (citing Syl. Pt. 2, *State ex rel. Tallman v. Tucker*, 234 W. Va. 713, 714, 769 S.E.2d 502, 505 (2015)). Second, Defendant claims the court erred by excluding his expert's new opinion on Plaintiff's life expectancy and by denying Defendant's request for a continuance. *See id.* at 23–24. Neither argument has merit; in truth, the lower court properly and

fairly exercised its discretion on these issues and should be affirmed. *See Jones,* 395 S.E.2d at 550; *Tallman*, 769 S.E.2d at 504.[10]

Defendant all but admits he cannot satisfy the high burden on appeal of showing the court abused its discretion as to these rulings, when he merely claims that factors set forth in *Tallman*, 769 S.E.2d at 504,"tip[ ] the scales in favor of Dr. Orphanos." Pet. Br. 22. Tipped scales does not amount to abuse of discretion, and in any event, Defendant is wrong for myriad reasons.

Applying the *Tallman* factors: *First*, Plaintiff's supplemental expert disclosures were warranted because his original life care plan and economic report were submitted *before* he suffered a stroke in July 2020. JA 2439–40. *Second*, those updated damages calculations were essential to ensuring Plaintiff would be justly compensated should the jury find Defendant liable for the life-altering surgeries that left Mr. Rodgers a permanent paraplegic — indeed, these calculations were adopted in the jury's verdict. *Third*, the lower court rightly rejected Defendant's claim of prejudice because it allowed Defendant more than two months to *also* supplement his expert reports. *See Tallman* 234 W. Va. at 719, 769 S.E.2d at 508 ("There was no evidence showing . . . any prejudice as a result of the late disclosure . . . *six weeks from the trial date*.") (emphasis added)). Moreover, the supplemental reports were changed only to account for the economic impact of Plaintiff's stroke. *Fourth*, the court properly exercised its discretion by denying Defendant's motion to continue the trial because it allowed Defendant to make significant supplemental expert disclosures and there was no prejudice. JA 889–90.

[10] Under *Tallman*, "[c]ourts consider the following factors in determining whether to permit late supplemental expert disclosures: "(1) the explanation for making the supplemental disclosure at the time it was made; (2) the importance of the supplemental information to the proposed testimony of the expert, and the expert's importance to the litigation; (3) potential prejudice to an opposing party; and (4) the availability of a continuance to mitigate any prejudice." Syl. Pt. 2, *Tallman*, 769 S.E.2d at 504.

Defendant's claim that the court abused its discretion by excluding Dr. Jodi Gehring's new opinion about Plaintiff's life expectancy (Pet. Br. 23) — one that was disclosed a week before trial — is likewise meritless. JA 1154, 1283–87. Despite allowing all his other supplemental disclosures, Defendant contends the court "denied [him] a fair opportunity to rebut Plaintiff's new opinions." Pet. Br. 23. But that is simply untrue. As explained above, the court allowed Defendant to supplement numerous expert disclosures to rebut the updated medical costs in Plaintiff's supplemental expert disclosures. JA 1150–1288. The court even allowed an entirely new opinion from Dr. William A. Petri regarding causation of Plaintiff's July 2020 stroke. *Id.* Considering Defendant's substantial supplemental expert disclosures, the court explained it struck a "fair compromise" and excluded only the new opinion from Dr. Gehring regarding Plaintiff's life expectancy because it had not been previously disclosed and was "unrelated to [Plaintiff's] late disclosure." JA 2703-05.

Reaching fair compromise is exactly the type of discretionary work trial courts must do to conduct trials, and their decisions "should not be disturbed unless there has been an abuse of discretion." Syl Pt. 3, *Garnes*, 395 S.E.2d at 350. The court acted well within its discretion in issuing these rulings.

C. The Circuit Court did not abuse its discretion by denying Dr. Orphanos' motion in limine regarding the miscounting of vertebrae during surgery.

Nor did the circuit court abuse its discretion by denying Defendant's motion to exclude evidence that he miscounted Plaintiff's vertebrae during surgery. Defendant argues that this decision was improper because Plaintiff's expert Dr. Weidenbaum testified that miscounting the vertebrae did not alone violate the standard of care — and thus, he contends, Plaintiff's counsel should not have been allowed to argue during opening and closing that "miscounting the vertebrae was indicative of Dr. Orphanos' negligence and recklessness." Pet. Br. 25.

Defendant's argument misses the point of Dr. Weidenbaum's testimony, which showed why Defendant's failure to use IONM violated the standard of care. As Defendant concedes, Dr. Weidenbaum was careful to testify that the misplaced screw, alone, did not breach the standard of care. JA 3085 ("Q. [I]s miscounting the vertebra a failure or deviation from the standard of care? A. No."). But Dr. Weidenbaum went on to explain that if Dr. Orphanos had used IONM during the surgery, he would have received a real-time alert to the impact of the misplaced screw on the spinal cord, and could have taken corrective action to remove the screw or decompress the spinal cord right then and there. JA 3119-20. Because this testimony about the misplaced screw was directly relevant to the significance of the underlying deviation from the standard of care, the court acted well within its discretion in admitting that evidence. *See Jones*, 395 S.E.2d at 550 ("Rulings on the admissibility of evidence are largely within a trial court's sound discretion and should not be disturbed unless there has been an abuse of discretion.").

Moreover, Plaintiff's counsel never stated or implied in opening or closing that the miscounting of the vertebrae was itself evidence of recklessness or negligence; the transcript passages Defendant cites in his brief make that clear. *See* Pet. Br. at 25 nn.14 & 15. Indeed, it was Plaintiff's counsel who elicited the testimony from Dr. Weidenbaum that miscounting the vertebrae did *not* breach the standard of care. JA 3085. He also told the jury that "there are occasions on which miscounting can occur" and emphasized that Dr. Weidenbaum confirmed that miscounting the vertebrae "happens." *Id.* What Plaintiff's counsel emphasized to jury in his closing of Dr. Weidenbaum's testimony was that Dr. Orphanos' failure to use IONM deprived him of real time monitoring and the chance to take immediate corrective action.[11] Because this evidence went

[11] *See* JA 3929 ("Why is IONM there? Common sense. It's going to tell you something is wrong. Dr. Orphanos told you if all of this was hooked up, he would have known something was going wrong when he could do something about it and would know, how is our blood pressure? Get it up. Is this — I'm putting in a screw and all of a sudden something is going wrong. Or I'm trying to drive a pilot hole into that

directly to the IONM issue, the circuit court did not abuse its discretion in allowing it, nor did Plaintiff's counsel overstep in his opening statement and closing argument.

D. The Circuit Court did not abuse its discretion by qualifying Plaintiff's experts.

Defendant also argues for a new trial based on his assertion that three of Plaintiff's expert witnesses — Nurse Taniguchi, Dr. Feinberg, and Dr. Weidenbaum — were not qualified to testify as experts. Pet. Br. 26-32. But again, Defendant ignores the standard of review, which easily resolves these contentions of error. *See Mayhorn v. Logan Med. Found.*, 193 W. Va. 42, 44, 454 S.E.2d 87, 89 (1994) ("Whether a witness is qualified to state an opinion is a matter which rests within the discretion of the trial court and its ruling on that point will not ordinarily be disturbed unless it clearly appears that its discretion has been abused.").

1. Nurse Taniguchi. Defendant argues the lower court should have precluded Nurse Taniguchi from "testifying regarding a causal link between Plaintiff's 2020 stroke and Dr. Orphanos' 2017 care." Pet. Br. 26. To make this argument, Defendant begins by misrepresenting the court's ruling and suggesting that it "permitted Nurse Taniguchi to testify as to a causation" generally. Pet. Br. 26. That is simply false. Rather, the court ordered that Nurse Taniguchi "*can't* give causation testimony." JA 2713 (emphasis added). Instead, the court ruled that it is "permissible" for Ms. Taniguchi to read "from an infectious disease doctor's record at Carilion that says [Plaintiff] had an ulcer on his buttocks that seeded the valve that caused the stroke" and that "people that are paralyzed get bed sores," which is "common knowledge." JA 2713–14. That is a far cry from "permit[ing] Nurse Taniguchi to testify as to a causation," linking Dr. Orphanos' botched surgeries to Plaintiff's stroke as Defendant claims on appeal. Pet. Br. 26.

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fractured vertebra, something is going wrong. You stop. You look. You listen. You correct. He didn't have that information and so he kept going, kept going, kept going for three hours before he had a problem.").

Not only does the Defendant misrepresent what the court ruled, but he misrepresents Ms. Taniguchi's testimony to advance this argument. Defendant says that "Nurse Taniguchi was permitted to . . . testify that the medical records established a link between the 2020 stroke and Dr. Orphanos' 2017 care." Pet. Br. 27. But Nurse Taniguchi never said any such thing. Nor did she testify about breaches of the standard of care — at all.

It is well established that a life care planner may rely on a patient's medical records when compiling an appropriate life care plan for that patient.[12] It is hard to fathom an expert creating a life care plan any other way. Here, Nurse Taniguchi did exactly what life care planners do — she reviewed Plaintiff's medical records to determine the nature and scope of his injuries. Far from rendering a medical causation opinion, Nurse Taniguchi simply drew pertinent information from Plaintiff's medical records — he was paralyzed, developed bed sores, and had a stroke — which she then used to determine what would be necessary for Plaintiff's future care. The circuit court clearly did not abuse discretion in allowing Nurse Taniguchi to testify for these purposes.

2. Dr. Feinberg. Next, Defendant argues that Dr. Feinberg was not qualified to testify that the standard of care required Defendant to use IONM during the surgery. This is plainly wrong. Dr. Feinberg, whose specialties include clinical neurophysiology, co-founded the Spine Center at the University of Pennsylvania, which performs more than 4,000 spine surgeries each year. JA 2928. He regularly treats patients in the hospital with injuries to the spinal cord, including spinal strokes, and "works very closely with the surgeons both neurosurgeons and orthopedic surgeons that take care of spinal patients." JA 2924–26. The "most common part of [his] practice" is working

[12] *Frometa v. Diaz-Diaz*, No. 07 Civ. 6372(HB), 2008 WL 4192501, at *2-3 (S.D.N.Y. Sept. 11, 2008) (holding that a life care planner's experience and review of medical records was sufficient to qualify under Daubert); *North v. Ford Motor Co.*, 505 F. Supp. 2d 1113, 1119-20 (D. Utah 2007) (holding that life care planner had sound methodology and met Daubert, and she could rely on other expert's reports or information).

"with neurosurgeons and spine surgeons evaluating patients pre-operatively all the way through their postoperative" care, including "complicated patients" and "trauma patients." JA 2929–30. As part of Dr. Feinberg's work with those surgeons and patients, he uses intraoperative neurophysiological monitoring or "IONM" on all patients with thoracic spine injuries. JA 2930–32. With no objection from Defendant, the court qualified Dr. Feinberg as an expert in neurology, neurophysiology, neuromuscular medicine and IONM. *Id.*

At trial, Dr. Feinberg's testimony addressed two categories: (1) whether Mr. Rodgers' paralysis was caused by the motorcycle accident or by the surgery, and (2) whether the appropriate standard of care requires use of IONM during a thoracic spine surgery. JA 2932–35 ("My opinion is that the spinal cord injury was sustained during the surgery."); JA 2949 ("the failure to use IONM in treating a thoracic fracture with surgery is a deviation from the standard of care."). Dr. Feinberg was not asked whether "any specific action taken by Dr. Orphanos . . . caused the paralysis" or to opine about the nuanced mechanics of an orthopedic spinal surgery. Pet. Br. 29. That's a different question — one that Plaintiff had a spine surgeon, Dr. Weidenbaum, address.

Like so many of Defendant's contentions of error, to make this argument he grafts additional requirements onto clearly established legal standards and misstates trial testimony. Contrary to Defendant's argument, the MPLA does not require a one-to-one correlation between the Defendant's specialty and the expert's specialty. W. Va. Code § 55–7B–7. Rather, it is sufficient if "the expert witness is engaged or qualified in a medical field in which the practitioner has experience and/or training in diagnosing or treating injuries or conditions similar to those of the patient." *Id.*

The Supreme Court in 1994 confirmed this approach in the seminal case on expert qualification, *Mayhorn,* 193 W. Va. at 49–50, 454 S.E.2d at 94–95, which held that an expert "is

not barred from testifying merely because he or she is not engaged in practice as a specialist in the field about which his or her testimony is offered." *Id.* The test for qualifying as an expert is much more relaxed: "[T]o qualify a witness as an expert on the standard of care, the party offering the witness must establish that the witness has more than a casual familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty." *Id.*

Moreover, "[d]isputes as to the strength of an expert's credentials . . . go to weight and not to the admissibility of their testimony." *Gentry v. Mangum*, 195 W. Va. 512, 527, 466 S.E.2d 171, 186 (1995); *see also* Syl. Pt. 3, *Walker v. Sharma*, 221 W. Va. 559, 561, 655 S.E.2d 775, 777 (2007) ("[I]ssues that arise as to the physician's personal use of a specific technique or procedure to which he or she seeks to offer expert testimony go only to the weight to be attached to that testimony and not to its admissibility"). And under Rule 702, courts are admonished to err on the side of admissibility and let the jury hear relevant expert opinions. Cleckley, *Handbook on Evidence for West Virginia Lawyers* §7–2(A) at 24 ("[t]his standard is very generous and follows the general framework of the federal rules which favors the admissibility of all relevant evidence"). The opposing party is then free to present contrary evidence and, of course, to subject the expert to cross examination. *Gentry*, 466 S.E.2d at 186 (citing *Daubert v. Merrell Dow Pharmaceuticals, Inc*., 509 U.S. 579, 594 (1993)).

Under the foregoing standards, the circuit court clearly did not abuse its discretion in allowing Dr. Feinberg to testify as an expert on IONM. Defendant had ample opportunity, moreover, to cross-examine him on his qualifications and opinions.

3. Dr. Weidenbaum. After repeatedly arguing that Dr. Feinberg would have to be a neurosurgeon or spine surgeon to testify as to the standard of care, Defendant says that Plaintiff's expert Dr. Weidenbaum, who *is* a board-certified spine surgeon, is also unqualified, because "his

familiarity and knowledge of Chance fractures was very limited." Pet. Br. 30–31. Here again, Defendant ignores the liberal standard for expert qualifications under Rule 702 and confuses fodder for cross-examination with grounds for disqualification. *See Mayhorn*, 454 S.E.2d at 94–95 (an expert "is not barred from testifying merely because he or she is not engaged in practice as a specialist in the field about which his or her testimony is offered." *Id*.

In fact, it is hard to fathom an expert more qualified than Dr. Weidenbaum to opine as to the standard of care for spinal surgeries such as the one at issue. After medical school, Dr. Weidenbaum completed a two-year residency in general surgery, followed by a three-year residency in orthopedic surgery and a one-year fellowship specializing in spine surgeries. JA 3035–38. Since completing his spine surgery fellowship in 1987, he has devoted his medical practice exclusively to spine surgery while working at Columbia-affiliated hospitals in New York. JA 3039–41. He is also board-certified in that field. *Id.* Throughout his career, Dr. Weidenbaum has written for peer-reviewed journals and lectured internationally on subjects relating to spine surgery. JA3044–46. Dr Weidenbaum also has experience treating patients with Chance fractures, including surgeries where the placement of rods and screws was required. JA 3046–47. The court thus easily qualified Dr. Weidenbaum as an expert in spine surgery (JA3048) under *Mayhorn*, which only requires a "casual familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty." 454 S.E.2d at 95. Moreover, Defendant had ample opportunity to cross-examine Dr. Weidenbaum regarding his experience with Chance fractures. JA3125–26. The circuit court did not abuse its discretion in allowing Dr. Weidenbaum to testify on spine surgery.

E. The Circuit Court did not abuse its discretion in precluding Defendant from cross-examining Plaintiff's mother regarding notes of her conversation with one of Plaintiff's treating physicians.

Before trial, the Defendant moved to exclude testimony regarding statements made by Plaintiff's health care providers on the basis that such statements are hearsay. JA981–85. The circuit court agreed. JA2707–08; JA1806–07 (lay witnesses "can't testify" "on causation, why something happened, if they are being told by a treating physician"). Then, at trial, Defendant sought to examine Plaintiff's mother Bonnie Rodgers, a retired office worker with an 11th grade education (JA 2966-67), about the very thing Defendant successfully sought to exclude: hearsay statements, recorded in her own notes, about a conversation she had with one of her son's health care providers, a "Dr. Jodi Joseph." JA 2996–2999.

This claimed "error" speaks volumes about Defendant's appeal, and is flat wrong for numerous reasons. *First*, Mrs. Rodgers' notes about a conversation she had with one of her son's physicians is hearsay, inadmissible under Rule 802, and the circuit court properly excluded it. *Second*, while Orphanos now tries to argue for the first time on appeal that Mrs. Rodgers' notes were admissible under Rule 612(b), he does so based on a wild misreading of the rule. The rule gives "an adverse party certain options when a witness uses a writing or object to refresh memory . . . while testifying," including the right "to cross-examine the witness about it, and to introduce in evidence any portion *that relates to the witness's testimony*." *Id.* Rule 612(a), (b). Mrs. Rodgers did not testify as to causation of her son's spinal cord injury, nor was she remotely qualified to do so, so her notes do not "relate to [her] testimony." Reference to notes used to refresh recollection does not somehow magically convert everything in those notes into admissible evidence.

And finally, what possible admissible testimony could a non-medical witness provide about a note that says, "Dr. Joseph . . . thinks there was an infarction just above T3/T4 — if a

contusion, then paralysis would have happened at time of accident and there would have been no movement of the lower extremities when he got to trauma unit, possible spinal stroke"? Pet. Br. 32 n.16. Defendant could have had Dr. Joseph testify as to those opinions, if he could testify to them to a reasonable degree of certainty — and if he could somehow explain why Mr. Rodgers' preoperative lower extremity neurology was "completely normal" when he got to the trauma unit. JA 2940-43. He did not. The trial court committed no error in refusing to allow Defendant to question Bonnie Rodgers about a non-testifying physician's musings about stroke causation. To the contrary, allowing such testimony would have been an error.

F. The jury instructions on "recklessness" and "emergency surgery" did not misstate the law.

The circuit's court's instructions on recklessness and the "emergency surgery" provision of the Trauma Cap were "accurate and fair to both parties" and did not mislead the jury. *Tennant*, 194 W. Va. at 116, 459 S.E.2d at 393. Thus, there was no error.

1. The recklessness instruction was proper.

Regarding recklessness, the court instructed the jury "that Michael Rodgers has asserted that the Defendant was not only negligent, but that he was reckless in the care provided to Michael Rodgers. Recklessness means an act of unreasonable character in disregard for a risk known to him or so obvious that it must be taken that he was aware of it." JA 3895.

Defendant first argues that the instruction should have tracked verbatim the language of W. Va. Code § 55-7B-9c(h)(1), which refers to "willful and wanton or reckless disregard of a risk of harm to the patient." *See* Pet. Br. 35-36. This argument fails because, in West Virginia, the terms willful, wanton, and reckless are used "synonymously." *Cline*, 310 S.E.2d at 838 ("we wish to make clear that we are using the words 'willful,' 'wanton,' and 'reckless' misconduct

synonymously"). The circuit court was at liberty to choose any one of these three synonymous legal terms.

Defendant also argues that the circuit court erred by failing to give a definition of recklessness consistent with footnote 6 of *Cline*. Pet. Br. 36 (citing *Cline,* 310 S.E.2d at 838 n.6). The *Cline* footnote provides as follows:

> The usual meaning assigned to "willful," "wanton," and "reckless," according to taste as to the word used, is that the actor has intentionally done *an act of an unreasonable character in disregard of a risk known to him or so obvious that he must be taken to have been aware of it,* and so great as to make it highly probable that harm would follow. It usually is accompanied by a conscious indifference to the consequences, amounting almost to willingness that they shall follow; and it has been said that this is indispensable.

Id. (emphasis added; citation omitted). Defendant argues that the court's instruction is inconsistent with *Cline* because it "leaves out the requirement that the act must be 'intentionally done.'" Pet. Br. at 36. That argument fails because there is no dispute that Defendant "intentionally" chose to operate on Plaintiff "blind" — i.e., without a pre-operative MRI or the use of IONM during the operation. So the omission of that part of the *Cline* footnote is irrelevant. What *is* relevant here is whether Defendant's decision to operate "blind" was "an act of unreasonable character in disregard of a risk known to him or so obvious that it must be taken that he was aware of it." JA 3895. The court's recklessness instruction tracked that part of the *Cline* footnote verbatim, and there was accordingly no error.

2. The instruction on the Trauma Cap's "emergency" exception was proper.

The circuit court's "emergency" instruction was unquestionably proper as well. The Trauma Cap is inapplicable if the care provided "[o]ccurs after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a *nonemergency patient*." W. Va. Code § 55-7B-9c(e)(l) (emphasis added). In keeping with that language, the court instructed the jury as

follows: "If you find that the surgery carried out by the Defendant was *not an emergency surgery*, then you should answer the special interrogatory on the verdict form accordingly." JA 3895 (emphasis added). That the instruction was framed in terms of an emergency "surgery" rather than an emergency "patient" is a distinction without a difference. *See State ex rel. Worley v. Lavender*, 147 W. Va. 803, 808, 131 S.E.2d 752, 755 (1963) ("the giving of an instruction substantially in the language of an applicable statute is not error.") (cleaned up).

Nor is there any basis for Defendant's argument that the court erred by not instructing the jury that the Trauma Cap applies in certain cases where "surgery is required as a result of the emergency condition within a reasonable time after the patient's condition is stabilized." *See* Pet. Br. 37-38 (citing W. Va. Code § 55-7B-9c(d)). This argument fails because it is undisputed that Defendant recommended two *alternative* treatments for Plaintiff's fracture — a conservative, nonsurgical back brace *or* the rods-and-screws surgery he eventually performed. JA 3208. Because Plaintiff's surgery was not, in fact, "required" as a result of the fracture, subsection 9c(d) simply does not apply to this case — and thus there was no need to instruct this jury on this point. *See State v. Gum*, 172 W. Va. 534, 546, 309 S.E.2d 32, 44 (1983) (it is not error to refuse a proposed instruction not supported by the evidence).[13]

[13] Dr. Orphanos and each physician who testified about the matter agreed that the surgery was not emergency surgery, as evidenced by the facts that Mr. Rodgers was admitted on June 4, wasn't evaluated by neurology for approximately 12 hours after admission and many hours after the order for neurological consultation, and wasn't taken to surgery until June 6, with normal neurological findings throughout the entire pre-operative period. JA 3075, 3159 (Dr. Weidenbaum) ("[T]he definition of emergency surgery is when there is an acute threat to either life or limb. So at that time, he was clinically stable so it was not an emergent issue."); JA 3208 (Dr. Orphanos) (agreeing that "this was not an emergency surgery based upon the records that you see from the operating room[.]"; JA 3162, 64 (Dr. Orphanos) (agreeing that when he first evaluated Mr. Rodgers more than 24 hours before the surgery "he was not a patient that was an emergency that required you to rush him to the emergency department to save his life and limb[.]"); JA 3168 (Dr. Orphanos) (agreeing that "there was no emergency situation that required [him] to rush him to the operating room because of fear of deterioration that might prejudice or jeopardize his life or limb[.]"); JA 3858 (defense expert Dr. Berkman) ("Q. You agree this was not an emergency surgery. A. Yeah, I agree."). Even the surgical report itself stated that Plaintiff's surgery was not an emergency. JA 324-35.

G. Plaintiff's use of the demonstrative "pie chart" during closing argument was proper under West Virginia law.

Defendant's argument that the court abused its discretion by allowing the use of a "pie chart" during closing that depicted a large "slice" of pie as non-economic damages is much ado about nothing, because the jury's award of $7.5 million in non-economic damages was subsequently cut down to $750,000 pursuant to West Virginia's non-economic damages cap. JA 1865. Defendant does not even attempt to argue that this amount is excessive — no surprise, given the immense pain and suffering that Plaintiff has experienced, and will continue to experience throughout his life, as a direct result of Defendant's recklessness.

That aside, Defendant's argument fails because (1) the pie chart did not suggest a "specific amount of money that should or should not be awarded relating to economic damages," as Defendant contends would violate the court's order or the case law he cites (*see* Pet. Br. 38–39); and (2) Defendant forfeited this argument in any event by lodging his objection *after* the pie chart had already been used and taken down. *See* JA 3948-51 (noting that the chart was already "gone" and would not be shown to the jury again and that the court had already instructed the jury on damages); Syl. Pt. 5, *Tennant*, 459 S.E.2d at 379 ("Failure to make timely and proper objection to remarks of counsel made in the presence of the jury, during the trial of a case, constitutes a forfeiture of the right to raise the question thereafter in the trial court or in the appellate court."). For these reasons, too, the pie-chart argument should be rejected.

H. The cumulative error doctrine has no application here because there were no errors.

In invoking the cumulative error rule as enunciated in *Tennant,* 194 W. Va. at 118, 459 S.E.2d at 395, Defendant fails to heed the Supreme Court's admonition that the rule is to be used

"sparingly."[14] To obtain a new trial, a party must not only show that there were errors, but that the errors were so pervasive and prejudicial in nature that "any resulting judgment [is] inherently unreliable." *Id.*

Suffice it to say that Defendant has failed to identify even a single error by the trial court, let alone the type of errors that warrant application of the cumulative error doctrine.

[14] *Very* sparingly – in fact, the Supreme Court has invoked cumulative error just once to reverse a civil verdict. *Herbert J. Thomas Mem. Hosp. Ass'n v. Nutter,* 238 W. Va. 375, 795 S.E.2d 530 (2016) (applying cumulative error doctrine where, among other things, the trial court propounded over 300 questions to witnesses; expressed "a jaundiced view" of the defendant's witnesses while being "friendly, courteous, and favorable to the plaintiff"; demonstrated "anger" toward defense counsel; and required defense counsel to file his own trial notes under seal after counsel sought a mistrial). Nothing of the sort happened here, and Defendant doesn't claim it did.

CONCLUSION

Plaintiff-Respondent urges the Court to affirm the jury's amply-supported verdict and reject Defendant-Petitioner's challenges to the circuit court's proper rulings and judgment order, and affirm the judgment order in all respects, subject to modification on grounds of the assignments of error lodged by Plaintiff-Respondent in his opening brief in Appeal No. 23-ICA-64.

Respectfully submitted,

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INTERMEDIATE COURT OF APPEALS OF WEST VIRGINIA

No. 23-ICA-58

JOHN R. ORPHANOS, M.D.,

Defendant-Below, Petitioner,

v. **DOCKET NO. 23-ICA-58**

(On Appeal from Circuit Court of Kanawha County, Civil Action No. 19-C-561)

MICHAEL RODGERS,

Plaintiff-Below, Respondent.

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of July, 2023, a true copy of the foregoing **RESPONDENT MICHAEL RODGERS' BRIEF IN OPPOSITION TO PETITION FOR APPEAL OF JOHN R. ORPHANOS, M.D.** was served upon counsel of record via the E-Filing system, which will provide notice of the same to the following:

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