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WEST VIRGINIA SUPREME COURT OF APPEALS

NICHOLAS A. GHAPHERY, D.O.,	:	
As Personal Representative of	:	
the Estate of Austin Ghaphery,	:	
Plaintiff Below, Petitioner,	:	
	:	
v.	:	**No. 24-52**
	:	
WHEELING TREATMENT CENTER,	:	
LLC and JOHN SCHULTZ, M.D.,	:	
Defendants Below, Respondents	:	

PETITIONER'S REPLY BRIEF

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I. Respondents' attempt to have the Court engage in Fact Finding reserved for the jury.

Respondents continue to assert as "undisputed" a number of factual assertions that, in fact, constitute genuine issues of material fact for resolution by the jury, none of which were relied upon by the Trial Court in its dismissal of Petitioner's case by Summary Judgment after three years in litigation, and several days before trial. (Vol. 3 JA 886-888). In fact, most of those assertions of fact reiterated by Respondents as "undisputed" in their response lack all *indicia* of trustworthiness.

In point, and as to Petitioner's first theory of recovery (assessment for admission to the Respondents' MAT treatment facility), Respondents' claim certain "disputed facts" as "undisputed",(i.e., "that Austin told Respondents that he did not use illicit drugs and was there at the insistence of his father," (Respondents' Br. pg. 1); that "Decedent did not disclose an addiction to opioids, a history of abuse of opioids, nor an imminent intent to use opiates in the future" (Respondents' Br. pg. 2); and that "it is undisputed that the Decedent never advised anyone at WTC that he had a history of opioid abuse for a period of one (1) year prior to his presentation, nor did he express to WTC personnel an intent to use opioids in the future." (Respondents' Br. pg. 4). These facts are all disputed.

Dr. Ghaphery testified in his deposition that after Austin's first apparent overdose on illicit drugs, Austin came to him and indicated that he was in over his head and needed help regarding drugs and asked his father to help him. (Vol. 1, JA 210-211). After a search of drug treatment facilities available in the Wheeling area, Dr. Ghaphery testified that when he read "Wheeling Comprehensive Treatment Center" he interpreted that as it was a all encompassing drug facility. Not specific to opiate." (Vol. 1, JA 214). He then made an appointment for his son at Respondents' facility. (Vol. 2, JA 406).

WTC's own internal policies require that a "history" of illicit drug use be collected from the patient by use of a Patient Screening Form, which is designed to elicit just those facts Respondents claim to be "undisputed" (i.e., the nature, history, duration of drug use or dependency; the level of care patient is seeking at this time; the ambulatory detox level of care; level of medical monitoring if necessary; and level of outpatient care is patient seeking, intensive outpatient services or outpatient services (Counseling services only, no medical service is needed)) (Vol. 2, JA 438-439 and JA 580-582).

Yet, Petitioner's evidence tends to prove that Respondents' did not utilize the Patient Screening form as required by their own internal policies to either obtain or document any statement of Austin touching on his history of drug abuse, or the nature or extent of his drug problem, which was the whole purpose of his visit, yet claim to remember years later that he came in and denied having any drug problem. (Vol. 2, JA 413-416 and Vol. 2 JA 506).

Said testimony is also completely at odds with the testimony of Dr. Ghaphery that despite his son keeping his drug problem secret for years, his son finally admitted to his father that he was over his head with drugs, pled for his father to get him help, and in agreement with Austin, made an appointment at Respondents' facility for help with his "drug problem." Respondents have not disputed that the whole reason for his "appointment" was to seek help with his drug problem. A jury may reasonably fail to credit Respondents' "memory" of Austin's comments inconsistent with the whole reason he made an appointment at Respondents' facility on September 28, 2017, as not credible.

In addition, State regulations define "assessments" for an individual seeking admittance to a MAT Program as follows:

> Any individual seeking admittance to the MAT program shall undergo a pre-admission initial assessment in order to determine whether the person meets the

> criteria for admission to a MAT program. The initial assessment, consisting of a physical assessment and an intake screening, shall be conducted by the medical director, an approved program physician or a supervised physician extender. The initial assessment shall focus on the individual's eligibility and need for treatment and shall provide indicators for initial dosage level, if required and if admission is determined appropriate. The determination of admission eligibility shall be made using accepted medical criteria such as those listed in the latest approved version of the Diagnostic and Statistical Manual for Mental Disorders. (my emphasis) (Vol. 2 JA 441),

Yet, Petitioner's evidence tends to prove that NO medical criteria as required by the State regulations were utilized by Respondents in their assessment of Austin's eligibility for admission to the MAT Program.

It is important to note at the outset that the Intermediate Court of Appeals found Austin's assessment to be included in the definition under the MPLA of health care services, as "any act, service, or treatment provided under, pursuant to, or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis, or treatment..." under W.Va. Code 55-7B-2(e)(1). (69 C.S.R. 11, Vol. 3, JA 994), before thereafter inconsistently finding that he received no "treatment or diagnosis" under the Act. (Vol. 3 JA 995).

As to Petitioner second theory of recovery, (the suicide risk assessment conducted on Austin), Respondents' again claim certain "disputed facts" as "undisputed," i.e. that "he [Austin] did not disclose any active suicidal ideations and was not otherwise in crisis (Respondents' Br. pg. 1), and that he told Respondents' staff "that he previously had suicidal ideations, but was not actively suicidal" (Respondents' Br. pg. 2).

Nor does the only record of Austin's visit to Respondents' facility on September 28, 2017, corroborate what Respondents now claim was told to them by Austin. It states as follows:

Case Notes

Date: 6/2812019
Time: 16:30:24

Wheeling Treatment Center
40 Orrs Lane
Triadelphia. WV 26059- 304-547-9197

Patient: 2797- Ghaphery, Austin CID:

9/28/2017 1 Units Assessment/Admission Individual Note 07:30 AM-11:15 AM(225 min.)

Assessment/Admission- Austin came in today for his initial screening. Pt was assessed by counselor and determined not to be in withdraw and meet for criteria for treatment. Concerned was noted that Pt was having suicidal ideations and had a plan to follow through with utilizing a gun. Pt reported being depressed and had a recent break-up of a long term relationship. Discussion was had with Clinical director. Medical director, and director that Pt was in need of a further assessment elsewhere. Attempts were made to contact Pt's emergency contact to inform the clinic was requesting further evaluation. Multiple attempts were made but no-one was able to be contacted.

Pt was spoken to again by counselor regarding the concerns and attempted to contact his mother but was unsuccessful. Pt met with Cslr. and medical director and Pt. disclosed that he was prescribed Lexapro which he had not inform Cslr,.of him taking and agreed with the doctor to follow through with going to see the doctor next week. Cslr gave Pt referral phone numbers for individual counseling. Pt agreed be would seek out treatment. Under this agreement with staff Pt. was allowed to leave the facility.

Counselor: Jamie Coen-Pickens

9/28/2017
2:36:38PM
Date

(under-linings are my emphasis) (Vol. 2, JA 502).

The Case Notes above use the words "was having'. "Was having" indicates "active suicidal ideations," consistent with the "concerned" (sic) noted that Respondent's patient (Pt) was "in need of a further assessment elsewhere," and prompting an attempt for "emergency contact" with his family. In fact, Coen-Pickens subsequent testimony years later that Austin was only speaking of "prior suicidal ideations," is at odds with the testimony of Austin's father that Austin called him (before he had his "suicidal assessment" with Dr. Shultz), and told him he was being transferred to Northwood for evaluation and/or treatment:

> "The first phone call, he said – I answered the phone. He said, "Dad, they want to admit me to Northwood. I saw the counselor, but I have to go see the doctor next." I said "Okay." I said, "Okay. Call me you know, when we know what direction wer're going." (Vol. 1, JA 234-235).

When he finally did see Austin on the day of his assessment, while still " technically a patient" as found by the lower court, and receiving Health Care Services under the MPLA as

agreed by the Intermediate Court, Dr. Shultz admits to having conducted a "suicidal assessment" on Austin, which Petitioner's expert has indicated did not meet the standard of care, and is the source of the second theory of liability advanced by Petitioner in the above case (see *infra*, at pg. 10).

The underlying Circuit Court opinion, affirmed by the Intermediate Court of Appeals, did not rely on resolution of any of the factual assertions raised herein by Respondents, but only on one fact undisputed by both parties—that Ausin was assessed but not accepted for treatment at Respondent's facility (Vol. 3, JA 886-888).

Nevertheless, in affirming Judge Wilson's opinion, the Intermediate Court did engage in a "fact finding" by accepting Respondent's assertions in certain respects as true:

With respect to the failure to admit to the MAT Program:

> "...Austin was also showing no signs that he needed opioid treatment. Austin did not appear intoxicated, was not suffering from withdrawal symptoms, denied illicit drug use, was not in addiction recovery and told WTC staff he was only there at the behest of his parents. Dissimilar to Gooch, but in support of WTC and its Medical Director, Austin was told that he did not meet the criteria for admission, and that was he was not a patient." (my emphasis). (Vol. 3 JA 996).

With respect to the issue of the suicidal assessment:

> "...First, the record indicates the Medical Director did not provide medical or psychiatric advice to Austin, other than emphasizing that he should keep his appointment with Dr. Schmitt or contact a crisis center if his mental status deteriorates. This is not medical advice which causes a duty to provide care. (my emphasis) (Vol. 3 JA 997).

With respect to the ultimate finding of fact of the Intermediate Court of Appeals:

> "We agree with the circuit court that this is a tragic case. However, there is no genuine issue of material fact that Austin was not a "patient" of WTC or its Medical Director on September 28, 2017. Therefore, WTC and its Medical Director owed no duty to provide care to Austin on that date." (Vol. 3 JA 997-998).

Seizing on the fact that the Intermediate Court of Appeals wrongly engaged in "fact finding" of certain disputed facts, Respondents hope that this Honorable Court will do the same and take this case away from a jury who under our system is the finder of the facts.

II. Respondents' continuing misstatement of Plaintiff's claims.

Respondent's continue to argue that Petitioner's claim attempts to impose a "duty" on Respondents to have accepted Austin as a "patient" for MAT "treatment," when in fact his claim implicates the duty under the MPLA to adhere to the standard of care while he was a "patient" otherwise receiving "health care" services at the time of his assessment on September 28, 2017, i.e., **(1)** Respondents' assessment as to whether or not Austin met the eligibility criteria for admission to the MAT program; and **(2)** Respondents' suicide risk assessment admittedly conducted by Dr. Shultz; both of which assessments were made while Petitioner was a patient and receiving "health care" services apart from being accepted as a patient for "treatment" under Respondents' MAT Program.

(1) The pre-admission initial assessment

The Intermediate Court agreed that for the purpose of Austin's pre-admission initial assessment of September 28, 2017, he was being provided "health care" as defined under the MPLA:

> There is no dispute that WTC and its Medical Director are health care providers. For purpose of this decision we find Austin presumably received extremely limited "health care" during his pre-admission initial assessment to determine whether he was an appropriate candidate for the medication assisted treatment program. West Virginia Code §55-7B-2(e) lists various definitions of "health care." The definition most relevant to this case is West Virginia Code §55-7B-2(e)(1) which defines health care as "[a]ny act, service, or treatment provided under, pursuant to, or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis, or treatment . . . ." (Vol. 3, JA 994).

The MPLA also provides that "patient" means "a person who receives or should have received healthcare from a licensed health care provider under a contract, express or implied." W.Va. Code §55-7B-2(m).

Yet, after agreeing Austin received "healthcare" during his initial assessment for admission to Respondents' MAT Program, the Intermediate Court, relying on *Gooch v. WV Dept. of Public Safety*, 195 W.Va. 357, 465 S.E.2d 326 (2005), incorrectly found, that he was not a patient for purposes of his initial assessment:

> "The Circuit court below ruled that Austin was "technically a 'patient' [solely] while he was there for the pre-admission assessment..." However, Austin was not a patient of WTC or it Medical Director for purposes of diagnosis and treatment." (Vol. 3, JA 995).

Worse, it determined as a matter of undisputed fact, that Austin was not a "patient" at the time said health care services were provided, despite the many references by Respondents that Austin was its patient during his initial assessment discussed at page 4, *supra*.

One fact that has not been disputed by Respondents in this case at any level is that State Regulations governing "Assessments" of eligibility for admission to Respondents' MAT Program requires the use of accepted medical criteria such as those listed in the latest approved version of the Diagnostic and Statistical Manual for Mental Disorders." (Vol. 2 JA 441).

The applicable regulation, 69 C.S.R. 11, provides as follows:

> **21.2.** Any individual seeking admittance to the MAT program shall undergo a pre-admission initial assessment in order to determine whether the person meets the criteria for admission to a MAT program. The initial assessment, consisting of a physical assessment and an intake screening, shall be conducted by the medical director, an approved program physician or a supervised physician extender. The initial assessment shall focus on the individual's eligibility and need for treatment and shall provide indicators for initial dosage level, if required and if admission is determined appropriate. The determination of admission eligibility shall be made using accepted medical criteria such as those listed in the latest approved version of the Diagnostic and Statistical Manual for Mental Disorders. (my emphasis) (Vol. 2 JA 441).

As the Court will plainly see, the applicable State Regulation does not "qualify" adherence to said standards on whether or not a person such as Austin was ultimately admitted for Medication Assisted Treatment (MAT), but as a required standard for the assessment itself, a "diagnostic" requirement for Respondents to have a license to dispense otherwise controlled substances to patients found to have opioid drug addiction. As such, and consistent with the findings of the Intermediate Court of Appeals, such as assessment constituted healthcare under the MPLA. While the Circuit Court found that Austin was "technically a patient" while he was there for the pre-admission assessment..." (Vol. 3 JA 887), the Intermediate Court found as a matter of "fact", that Austin was not a patient during the pre-admission assessment, presumably because of no express or implied contract between him and Respondents to be so assessed and/or based solely on the fact that he was not thereafter admitted for treatment at the MAT facility. Thus, WTC argues, and the Intermediate Court agrees, that even if Austin had the status of "patient" for his initial assessment, Respondents are somehow absolved from complying with the required standard of care solely by refusing to accept him for further treatment, and that because Austin was not ultimately admitted to the MAT Program, he never became a patient of WTC or Dr. Schultz in the first place such as to create a patient/healthcare provider relationship; and that they accordingly had no duty to comply with the standard of care. This, of course, is a logical fallacy, as a matter of fact, and prevailing law. The test under the MPLA for whether a person is a "patient" of a healthcare provider is whether the person received "healthcare" under an express or implied contract (W.Va. Code §55-7B-2m), NOT whether the person was "admitted" for further care. The very making of an appointment for assessment of Austin for its MAT Program, which by Respondent's own policy and State regulations requires that such an assessment be based on medical criteria, constitutes an "implied contract" for said services. Dr. Ghaphery, as a

long-time physician himself, understood he or Austin could be billed for any services rendered by Respondents' health care facility, whether in the nature of, or related to, any diagnostic or treatment services. As the Intermediate Court of Appeals noted, the definition of healthcare under the MPLA is broad:

> The definition most relevant to this case is West Virginia Code §55-7B-2(e)(1) which defines health care as "[a]ny act, service, or treatment provided under, pursuant to, or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis, or treatment . . . ." (Vol. 3, JA 994).

Thus, the Intermediate Court of Appeals has already agreed that when WTC and Dr. Schultz conducted an initial assessment of Austin's condition to determine whether he met the criteria for admission to the MAT Program such assessment constituted a medical diagnosis or other act or service which should have been performed such as to meet the definition of healthcare under W.Va. Code §55-7B-2(e)(1). Whether that diagnosis, act, or service resulted in the decision to ultimately admit Austin to the MAT Program or the decision not to admit him for that purpose is wholly irrelevant to the question of whether Respondents were under a duty to provide that healthcare in a manner consistent with the standard of care, which theory Petitioner's expert testimony fully supports. (Vol. 3, JA 994).

Respondents' attempt to refocus Plaintiffs case from claiming a duty to abide by the standard of care in doing its initial assessment as implicating Respondents' constitutional right to refuse to treat any patients is disingenuous. This case is not about infringing Respondents' constitutional right to accept patients for treatment. Having accepted Austin as a patient at least for the assessment required by its own policies and State law, by setting him up for an appointment and actually doing an assessment governed by State Law, Respondents' own actions defeat their Constitutional Law argument, notwithstanding Respondents desperate attempt to make a "federal case" out of Petitioner's action under the MPLA. While healthcare providers are certainly free to

decide who may or may not become their patients for any reason not inconsistent anti-discrimination or other laws, if they provide healthcare in reaching that decision under the MPLA, they are required to provide such healthcare in accordance with the applicable standard of care. The idea that a healthcare provider can provide diagnostic, or other acts or services to a person to determine whether to admit a person to a facility and escape responsibility for complying with the MPLA in conducting those diagnostic, or other acts or services in cases where they decide against admission, turns the MPLA on its head. Healthcare providers should not be permitted to avoid doing their assessments for admission for treatment in accordance with the standard of care by simply deciding against admitting the person for further care.

Finally, as to the Intermediate Court's finding as a matter of undisputed fact (as opposed to law) that Austin was not a "patient' at the time of his initial assessment, this Court is referred back to the only record of Austin's visit of September 28, 2017, 2017, (pg. 4, *infra*), which refers to his being a "patient," or "Pt" no less than 10 times. See also Petitioner's analysis of *Gooch*, and its progeny, appearing on pgs. 14-16 of its Petitioner's Brief.

(2) The MPLA required Dr. Shultz to adhere to the Standard of care when he admittedly undertook to do a suicide risk assessment on Austin, whether or not Austin was deemed eligible for admission to the MAT Treatment program.

The rule under the MPLA is straightforward: if a healthcare provider furnishes "healthcare", including diagnostic services to a person under an express or implied contract (which the ICA found to be the case in this Appeal), such healthcare provider is required to meet the standard of care with respect to the healthcare provided. A suicide risk assessment is a medical term of art. Plaintiff's expert, Dr. Santoro, opined that when conducting a suicidal assessment, a doctor has to comply with the applicable standard of care. (Vol. 2, JA 431) Dr. Shultz admittedly undertook to conduct a suicidal assessment on Austin on September 28, 2017, during such time as

he was being otherwise being provided Health Care Services as found by the Intermediate Court of Appeals at the time of his visit of September 28, 2017.

As Petitioner has repeatedly reminded the Trial Court and Intermediate Court of Appeals, Plaintiff's experts did not testify, and Petitioner does not contend, that Respondents had a duty to accept him as a patient or "commit" him to a psychiatric facility, only that they had to exercise the standard of care required by their own internal policies and State Law in determining whether he was eligible for treatment in the MAT Program; and in conducting the suicide assessment that Dr. Shultz undertook while Austin was otherwise receiving healthcare services as ultimately found by the Intermediate Court of Appeals.

III. The Issue of Causation is not on appeal and raises genuine issues of material fact for resolution by the jury.

Recognizing genuine issues of material fact as to causation for determination by a jury, neither the Trial Court nor the Intermediate Court based its decision on a finding that Petitioner could not prove causation as a matter of law, either as to his allegation of failure to meet the standard of care in assessing Austin for admission to its facility for MAT treatment, or Dr. Schultz's failure to meet the standard of care in doing the suicidal assessment on Austin. Nor have Respondents raised any counter- assignments of error. Nevertheless, Respondents continue to seek a ruling form this court on "causation" as a matter of law, reiterating over and over that there is no evidence that Austin committed suicide, and unfairly characterizing this as part of Petitioner's causation argument. In the same vein, they argue that even Petitioner's expert agrees that it was not a violation of the standard of care that Respondents utilized blood screening did not test for fentanyl, where Petitioner has never argued that such constituted a breach of Respondents' duty of care, but was nevertheless material evidence as to causation —why the simple blood test offered to Austin without Respondents otherwise adhering to required "medical criteria" in their

assessment of him, led to Respondents' incorrect assessment of his eligibility for the MAT program, and/or drug problem.

That has not prevented Respondents from mischaracterizing Petitioner's position in this appeal. In any event, sufficient evidence exists from which a reasonable finder of fact may determine that Respondents' failure to meet the applicable standard of care was a proximate cause of Austin's death as to both theories advanced by Petitioner herein.

Petitioner's evidence is that Respondents' failure to meet the standard of care in conducting Austin's pre-admission initial assessment resulted in the erroneous conclusion that he did not meet the criteria for treatment, and was a proximate cause of his death (Vol. 2 JA 432-433). Petitioner will also show that but for the failure to properly conduct Austin's pre-admission initial assessment it was more probable than not that he would have been admitted to the MAT Program, and that upon admission, state and federal regulations would have required WTC to provide medical, counseling, vocational, educational, recovery, random drug testing, and substance use disorder counseling/monitoring in addition to referral to off-site facilities (C.S.R. 69-11-26). Expert testimony will further establish that the very reason why the standard of care requires MAT Programs to properly conduct pre-admission initial assessments is because the failure to do so carries with it the likelihood of the exact type of harm suffered in this case (i.e. death by drug overdose) (Vol. 2 JA 434).

Likewise, Petitioner is able to offer proof that Respondents' failure to appropriately assess Austin's suicidality was a proximate cause of his death. Here the Petitioner has presented expert testimony that given the risk factors present at the time of Austin's visit to WTC, the standard of care required Austin to be referred to a psychiatric facility where he could have been properly evaluated and treated (Vol. 2 JA 468-69). Petitioner's expert has also opined that it is the fact that

patients like Austin are known to be at an elevated risk for injury or death by drug overdose if they are not placed in a supervised psychiatric setting which gives rise to the standard of care requiring healthcare providers to arrange for their admission to a psychiatric facility where they may obtain evaluation and treatment (Vol. 2 JA 470).

Petitioner's expert testified below that "the foreseeability of a patient being injured or dying from a drug overdose by not adhering to the standard of care is the reason why there exists a duty for physicians to follow the standard of care when conducting a suicide risk assessment of a person with as many risk factors as those present in Austin's case" (Vol. 2 JA 470-471). Thus, rather than being the result of some intervening, superseding, or remote cause, Austin's death can be found to be the direct and entirely foreseeable result of the Respondents' failure to adhere to the applicable standard of care.

Further evidence of proximate causation (i.e. tying Respondents' failure to meet the standard of care to Austin's death) is the expert opinion showing that in the event Austin's suicidality had been appropriately assessed, and arrangements made for his admission to a psychiatric facility it is more probable than not that his drug problem would have been properly evaluated, including information about the type of drugs used, the routes that drugs were used, and the time that drugs were used (Vol. 2 JA 472). The record below also contains proof that but for the Respondents' failure to appropriately assess Austin's suicidality and arrange for his admission to a psychiatric facility, Austin would have been evaluated as an inpatient for a period of time during which he would have received intense counseling for drug abuse, depression and other issues (Vol. 2 JA 472); he also would have undergone a thorough treatment regimen which would have included programs designed to prevent him from continuing his drug use, and intervention to assist his depressive illness for purposes of decreasing the risk of injury or death resulting from

drug use (Vol. 2 JA 474). Thus, if an appropriate suicide risk assessment had been conducted and arrangements made for Austin to be admitted to a psychiatric facility, there is evidence from which a reasonable finder of fact may conclude that Austin would have received inpatient and outpatient treatment "such that he would not have died by drug overdose some 36 days after seeking entry to Wheeling Treatment Center for help with his drug problem" (Vol. 2 JA 474-75). It is clear that evidence of proximate cause as adduced via expert testimony is sufficient to carry a case to the jury. *Sexton v. Greico*, 216 W.Va. 714, 613 S.E.2d 81 (2005).

Respondents spend pages of their brief arguing that under the State's involuntary commitment laws, they had no duty to have Austin "committed" to a psychiatric facility. Again, this mischaracterizes Petitioner's proof. Apparently, Respondents' exercise in this regard results from the Trial Court's incorrect ruling below that:

> "the critical fact is that Austin Ghaphery was denied admission to the Wheeling Treatment Program. Therefore, absent a healthcare provider relationship, there was no duty or law requiring that Wheeling Treatment Center had to accept Austin, either voluntarily or involuntarily, to its inpatient psychiatric treatment facility. When the Wheeling Treatment Center denied the admission to the facility, it had no reason or legal duty to attempt to commit Austin voluntarily or involuntarily. Thus the Defendants in this case had no duty to attempt to prevent Austin's death by opioid overdose 21 days after he was denied admission to the program." (Vol. 3 JA 887).

The lower court was incorrect in its assessment of Petitioner's causation argument. Respondents' facility does not have an inpatient or outpatient psychiatric unit. Petitioner's expert witness rather testified that but for the breach of the standard of care by Dr. Schultz's suicide assessment, he would have to a reasonable degree of probability been referred for appropriate psychiatric care elsewhere, which was exactly what WTC was considering doing until Dr. Schultz did "his" suicidal evaluation and nixed the idea (Vol. 2, JA 479 and JA 505-506).

Petitioner's causation argument was never that he should have been "committed" involuntarily (to any psychiatric facility) if Dr. Schultz had complied with the standard of care, but that he would have been referred for an appropriate psychiatric evaluation and/or treated elsewhere; and that according to Petitioner's expert, Dr. Goldberg, that would more probably than not have lead to a course of treatment, including for his drug problem, that would have prevented his accidental death by opioids (Vol. 2, JA 468-469) at that the time it occurred.

IV. Remand to Amend Plaintiff's Complaint

Respondents concede that Austin received health care services by Respondents under the MPLA.

> "The definition of "health care" is likewise sufficiently broad to encompass the instant case as it includes:
>
> (2) ***Any act, service*** or treatment performed or furnished, or ***which should have been performed or furnished***, by any health care provider or person supervised by or acting under the direction of a health care provider or licensed professional for, to or on behalf of a patient during the patient's medical care, treatment or confinement, including, but not limited to, staffing, medical transport, ***custodial care or basic care***, infection control, positioning, hydration, nutrition and similar patient services; and
>
> (3) ***The process employed by*** health care providers and ***health care facilities for the*** appointment, employment, contracting, credentialing, privileging and ***supervision of health care providers***.
>
> W. VA. CODE §55-7B-2(e) (2017) (emphasis added). The MPLA further defines a "patient" as "a natural person who receives or should have received health care from a licensed health care provider under a contract, expressed or implied." W.VA. CODE § 55-7B-2(m)." (Respondents' Br. p. 26).

Accordingly, Respondents claim that the MPLA applies to this action and that it would be futile to allow Petitioner to amend the Complaint under a common law test of foreseeability.

Petitioner welcomes this seeming admission by Respondents. Petitioner has always believed this case is governed by the MPLA.

Yet if this Honorable Court affirms the Intermediate Court of Appeals' finding of fact that Austin did not constitute a "patient" under the Act, Petitioner interprets that as a finding that the MPLA does not apply, and that Petitioner's only relief is to be able to amend his Complaint to alleged a common law duty based on "foreseeability" of harm – where Respondents hold forth as a "comprehensive" drug treatment center, and offer initial assessments as part of the services, and yet limit their treatment to persons with such severe addictions, that they need not even follow the standard of care in assessing them.

V. ORAL ARGUMENT

In their respective submissions to this Honorable Court, both parties agree that oral argument would be of benefit, and Petitioner reiterates his request for same, by incorporating by reference that section in Petitioner's Brief, pgs. 11-12.

VI. CONCLUSION

Respondents in their response seize upon the inconsistency of the Intermediate Court of Appeals' determination below that the definition of healthcare services under the MPLA is broad enough to include Austin's assessment (as fully cited on pg. 9, *supra*), and its determination as a matter of "fact" notwithstanding that "....Austin was not a patient of WTC or its Medical Director for purposes of diagnosis or treatment," (Vol. 3 JA 995), presumably because he had no express or implied contract for the health care services he received that day (his assessment), (Vol. 3, JA 995) and/or that he didn't receive "treatment or a diagnosis" as part of the assessment, (Vol. 3, JA 995) -- as if he walked in unannounced and was turned down even for assessment. But Respondents voluntarily set up an appointment with Austin's father for the purpose of conducting

an "assessment" for his drug problem, which is what the only record of Austin's visit clearly shows: "Pt comes in today for his assessment…", along with referring to him as a Patient at least 10 times. (pg. 4, *supra*)

Similar medical assessments, whether or not they lead to treatment, are conducted in countless healthcare facilities in West Virginia and the country at large, usually prefatory to a determination as to whether or not that healthcare facility, or any other, should offer treatment to the patient.

In asking this Court to uphold the Intermediate Court's finding of no patient status for Austin when he received his assessment, either because he had no express or implied contract for "treatment," or because Respondents did not provide "treatment" or "diagnosis," Respondents ask this Court not only to deprive Austin's estate of its constitutional right to a jury trial, but to create confusion over the clear language of the MPLA as to what acts or services of a health care facility constitute health care, and what "type" of healthcare must conform to the standard of care – inviting "immunity type" arguments such as being made by Respondents here, that certain acts and services in the provision in health care, prefatory to actual treatment, need not be performed in adherence to the standard of care.

Respectfully submitted,

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CERTIFICATE OF SERVICE

Service of the foregoing REPLY BRIEF OF PETITIONER, was had upon the following by e-mailing a true and complete copy thereto to the e-mail addresses listed below, this 24th day of June, 2024, as follows:

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