No. 24-52

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

NICHOLAS A. GHAPHERY, D.O.,
As Personal Representative of the
Estate of Austin Ghaphery,

Petitioner,

v.

ON APPEAL FROM
INTERMEDIATE COURT OF APPEALS OF W.VA.,
NO. 22-ICA-150; AND
CIRCUIT COURT OF OHIO COUNTY, W.VA.
CIVIL ACTION NO. 19-C-182

WHEELING TREATMENT CENTER, LLC,
And JOHN SCHULTZ, M.D.,

Respondents.

RESPONDENTS' BRIEF

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III. REBUTTAL STATEMENT OF THE CASE

On November 3, 2017, the Petitioner's Decedent was found dead at the Petitioner's home from an accidental drug overdose. The REPORT OF DEATH INVESTIGATION AND POST-MORTEM EXAMINATION FINDINGS of the West Virginia Office of the Chief Medical Examiner lists the cause of death as being due to fentanyl, nor-fentanyl, heroin, amphetamine and cocaine intoxication, with the manner of death identified as an ***accident***. (JA Vol. 1: 284). Despite the Petitioner's continued critique of the Respondents' suicide assessment of the decedent, there is no allegation, let alone actual evidence, that the decedent committed suicide.

On or about July 29, 2019, Petitioner filed the underlying civil action asserting claims for medical professional liability and wrongful death, alleging that the Decedent had presented to the Wheeling Treatment Center on September 28, 2017, and "requested treatment for his substance use disorder" and advised the Respondents' staff that "he was having suicidal ideation and had a plan to follow through by the use of a gun." (JA Vol. 1: 2). While the Petitioner asserts that the Decedent presented to the Respondents "for help with his drug problem" the decedent reported to the Respondents that he did not use illicit drugs and was there at the insistence of his father. (JA Vol.: 304, 308-09). Likewise, evidence adduced during discovery further established that at the time the Decedent presented to the Wheeling Treatment Center, he did not disclose any *active* suicidal ideations and was not otherwise in crisis. (JA Vol. 1: 296, 303, 308-09, 316).

The Wheeling Treatment Center ("WTC") is a medication-assisted treatment (MAT) facility utilizing methadone and/or suboxone, in conjunction with counseling / behavior therapy, for the treatment of long-term opioid addiction, i.e. opioid use disorder. (JA Vol. 1: 304; Vol 2: 359). The Respondents are not a full-service hospital; are not a behavioral medicine crisis center;

are not an in-patient psychiatric facility; and Respondents treat *only* opioid *addiction*[1], the process for which is heavily regulated by both state and federal agencies, statutes and regulations. *See e.g.*, 42 U.S.C.A. § 8.1, *et. seq*.; 69 W.V.C.S.R. 11, *et. seq*.

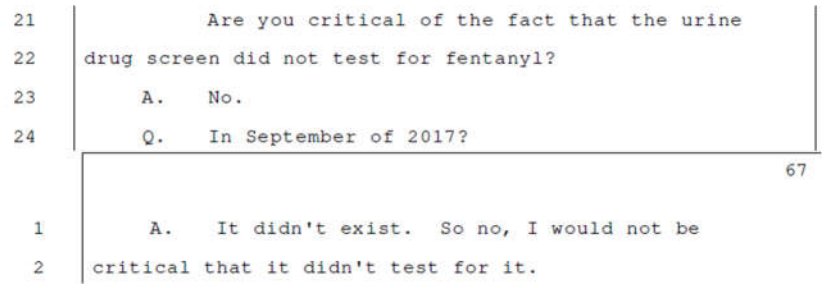
Upon presentation to the WTC on September 28, 2017: the Decedent's urine drug screen came back negative for opioids (JA Vol. 1: 292); the Decedent did not disclose an addiction to opioids, a history of abuse of opioids, nor an imminent intent to use opiates in the future (JA Vol. 1: 293, 295, 304, 308-09); and he was not exhibiting any clinical signs of opioid withdrawal. (JA Vol. 1: 293, 302, 310, 319-20). Thus, he did not meet the criteria for MAT program admission and was not accepted as a patient. (JA Vol. 1: 293, 306, 327-328).

During his pre-admission assessment by Respondents, the Decedent did disclose ongoing medical treatment by his primary care physician, Brad Schmitt, M.D., for depression with a *past history* of suicidal thoughts. (JA Vol. 1: 293, 308-09). Based upon the Decedent's statements to staff that he previously had suicidal ideations, but was not actively suicidal, and that he was undergoing medical management of his depression, the Respondents obtained the Decedent's agreement to follow up with his treating family physician to further discuss treatment of his depression. (Id.). The Decedent was given a referral sheet containing contact information for alternative behavioral health providers and was encouraged to seek follow up treatment with his primary care physician with whom he was already treating for his symptoms of depression. (JA

[1] Opioid addiction or "opioid use disorder" is defined by the DSM as "[a] problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two" of various conditions and circumstances occurring within a 12-month period. These circumstances include things like opioids being taken in larger amounts or over a longer period than was intended; a persistent desire or unsuccessful efforts to cut down or control opioid use; craving, or a strong desire or urge to use opioids; recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home; continued use despite persistent or recurrent social or interpersonal problems cause or exacerbated by the effects of opioids; giving up important social, occupational, or recreational activities because of opioid use; recurrent opioid use in situations in which it is physically hazardous; tolerance; and/or withdraw.

Vol. 1: 304). At that time, the Decedent was advised that he was not being admitted to and/or accepted as a patient of WTC. (JA Vol. 1: 306). The Decedent then left the facility and was picked up from WTC on September 28, 2017, by his father, the Petitioner, Nicholas Ghaphery, M.D. (JA Vol. 1: 321). Importantly, the Petitioner (who is also a board-certified physician) testified that at no time on September 28th did Austin Ghaphery appear to be under the influence of drugs or suicidal – not before he was dropped off at WTC by the Petitioner, nor when he was picked up from WTC by the Petitioner. (JA Vol. 1: 320, 322-23). Moreover, there is no dispute in this case that the Decedent and the Petitioner understood that Austin Ghaphery was not accepted into the program and would not be receiving any treatment whatsoever from the Respondents.

In his efforts to obviate the facts adduced in this case, the Petitioner presents a wholly speculative argument that because the urine toxicology screen utilized by the Respondents did not test for fentanyl (no test for fentanyl was available at that time) that the Decedent "could have used fentanyl prior to his visit to WTC" such that he would not have tested positive for opiates but still should have qualified for acceptance into WTC's MAT program. Unfortunately for Petitioner, there is absolutely no evidentiary support for this speculation, and it is wholly immaterial. Despite having arrived at the eve of trial, on three separate occasions, in a litigation that spanned many years, Petitioner failed to produce any *evidence* that the Decedent had consumed opiates, was under the influence of opiates, or otherwise should have tested positive for opiates upon his presentation to WTC on September 27, 2017. (JA Vol. 2: 428). Furthermore, such speculation by the Petitioner is immaterial because, as was admitted by Petitioner's retained expert, the use of a urine test for fentanyl was simply not the standard of care in 2017, because no such test existed.



Are you critical of the fact that the urine drug screen did not test for fentanyl?
A. No.
Q. In September of 2017?

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A. It didn't exist. So no, I would not be critical that it didn't test for it.

(Depo. Tr. William Santoro, M.D., pg. 66, lines 21-24, pg. 67, lines 1-1).

While the opiate-negative urine drug screen is concerning for a person seeking MAT treatment, the Decedent could have still qualified for the Respondents' MAT program (even with a negative drug screen) *if* he had disclosed a one (1) year history of opioid use and/or an intention of future opioid use. *See e.g.*, 69 CSR § 11-21.7; 69 CSR § 11.21.9(d). Yet, 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. As such, the record before this Court is devoid of any evidence (presented to WTC or otherwise) which would have qualified the Decedent for admission into Respondents' MAT program. What the record in this matter *does* establish is that the Decedent, at the request of his father, the Petitioner, began seeing board certified family medicine practitioner Brad Schmitt, M.D., for issues related to depression, suspected drug use, and other medical ailments beginning on July 18, 2017. (JA Vol. 2: 342-43). As part of his treatment with Dr. Schmitt, the Decedent emphatically denied illicit drug use. (JA Vol. 1: 329-33; Vol. 2: 334-41). Dr. Schmitt ultimately prescribed medication as an initial plan of treatment for the Decedent's depression, as well as his attention deficit disorder ("ADD"). (Id.).

Discovery likewise revealed that the Decedent saw his primary care physician, Dr. Schmitt, for a follow-up visit/discussion on September 21, 2017, seven (7) days *before* presenting to the WTC. (Id.). During this office visit, the Decedent reported to Dr. Schmitt that "he has had suicidal

thoughts but no plan" and that he had previously discussed these suicidal thoughts with his parents which resulted in all guns being removed from the Petitioner's home. (JA Vol. 1: 333). As a result of this disclosure, Dr. Schmitt and the Decedent "made an agreement" that the Decedent would tell his parents or go to a crisis unit if his depressive symptoms became worse or if he developed a plan. (Id). Dr. Schmitt prescribed a trial of Lexapro with "close follow up" and indicated that he would consider referral to a "psych" if the Decedent's symptoms did not improve. (Id).

Thereafter on October 5, 2017, seven (7) days *after* the Decedent had been declined admission to WTC, the Decedent again went to see his primary care physician, Brad Schmitt, M.D., at which time Dr. Schmitt noted that Austin was "much improved over [the] last few weeks" indicating that Austin believed that "time" and the "medication has help[ed] substantially" and that his depression was much improved. (JA Vol. 2: 338). Dr. Schmitt specifically noted at that time that the Decedent was "smiling" and had improved affect, good insight, and good judgment with no suicidal or homicidal ideations. (JA Vol. 2: 339). Dr. Schmitt made no changes in the Decedent's Lexapro prescription but reiterated that he was to call immediately or get to a crisis unit if he got any worse or developed suicidal ideations. (JA Vol. 2: 340). The Decedent was to follow up with Dr. Schmitt again in four (4) weeks. (Id.).

Eight (8) days later, on October 13, 2017, the Petitioner, a board-certified family practice doctor in his own right, called Dr. Schmitt with the Decedent to advise that the Decedent was "doing better on Lexapro" and tolerating the medication well, but felt he could be "doing a little better." (JA Vol. 2: 336). As a result, Dr. Schmitt increased the Decedent's Lexapro dose from 10 mg. to 20 mg., indicating that he had a follow up appointment "next week" [the week of October 16th -20th]. (Id.). There are no records of the Decedent attending or otherwise cancelling or rescheduling an appointment with Dr. Schmitt. (JA Vol. 2: 345-46).

Another t*wenty-one* (21) days after that, and while the Petitioner was away at the Greenbrier Resort for a medical conference, the Decedent was found dead in their home from an accidental drug overdose which included fentanyl, heroin and cocaine. (JA Vol. 1: 284). The Medical Examiner's Report noted no evidence of injuries on the Decedent and no indication that this was anything other than the voluntary, though accidental, ingestion of a fatal combination of illegal drugs by the Decedent that caused his death. (JA Vol 1: 283-84).

IV. SUMMARY OF ARGUMENT

Petitioner's Decedent presented to the Wheeling Treatment Center on September 28, 2017, to be *considered* for admission to the medication assisted opioid treatment program. Despite Petitioner's arguments to the contrary, there is no law and no duty which mandated that the Respondents accept Austin Ghaphery as a patient; they have the constitutional right to refuse treatment of any individual, at their discretion – so long as there is no discriminatory intent. Right or wrong, the Decedent was not accepted as a patient and the Respondents were under no legal duty to do so. Accordingly, no physician-patient relationship was formed and at no time did the Respondents, either individually or collectively, agree to provide *any* medical service to the Decedent. Rather, he was immediately rejected from the program, was never a patient of the Respondents, and was free to obtain treatment from whatever source he and his family chose.

Moreover, these Respondents engaged in no act or failure to act which proximately caused any injury or damage to the Petitioner and/or his Decedent. When the Decedent presented to the Respondents' MAT program on September 28, 2017: his urine drug screen came back negative for opioids (JA Vol. 1:292); he did not disclose an addiction to opioids, a history of abuse of opioids, nor an imminent intent to use opiates in the future (JA Vol. 1: 293, 304, 308-09); and he was not exhibiting any clinical signs of opioid withdrawal. (JA Vol. 1: 293, 302, 310, 319-20).

Likewise, despite the Petitioner's claims that the Respondents should have sought voluntary and/or involuntary commitment of the Decedent, the factual certainty in this case is that the Decedent was not in psychiatric crisis and was not a danger to himself or others on the day he presented to WTC. (JA Vol. 3: 862). While the Petitioner's experts arrive at their opinions of an inadequate assessment by discounting and refusing to believe the testimony of the Respondents, perhaps most devastating to the Petitioner's claim is the lack of ***any evidence*** that the Decedent ever attempted or committed suicide.

Despite these facts and operable law, the Petitioner seeks to have this Court create a legal duty upon a healthcare professionals to accept as patients, diagnose, and then render treat to all persons who present to them without consideration of whether that person is appropriate for treatment by that particular healthcare professional, whether that healthcare professional's scope of practice permits treatment of that individual's condition(s), and/or whether that healthcare professional wants to accept the person as a patient. Such a ruling would then extend the liability of healthcare providers for the subsequent illness and/or death of every person whom they declined to treat, provided no treatment to, and never saw again.

A ruling in favor of the Petitioner would require all healthcare providers, regardless of specialty or permissible scope of practice, to diagnose – with or without the consent and cooperation of the patient, any and all potential medical and/or mental health conditions of the person, accept them as a patient for treatment of all nature of medical problems, make direct referral(s) to any number of additional healthcare providers, and then somehow force the patient to follow up. While infringing greatly upon the constitutional autonomy of all healthcare providers to voluntarily enter into (or not enter into) physician-patient relationships, a ruling in favor of the Petitioner would be a violation of the Respondents' Constitutional right against involuntary

servitude, deprive them of the opportunity to exercise their medical judgment, and strip them of the right to choose which patients to accept and treat.

Finally, Petitioner's claims herein are governed by the West Virginia Medical Professional Liability Act ("MPLA"), as a function of the operative facts and *allegations* at issue, i.e., "medical professional liability" against a "health care provider." See W.VA. CODE § 55-7B-1, *et. seq.* Consequently, amendment of the Petitioner's Complaint is not warranted as the same would be futile under longstanding West Virginia law. *See, e.g.,* Blankenship v. Ethicon, 221 W.Va. 700, 656 S.E.2d 451, 458 (2007).

V. STATEMENT REGARDING ORAL ARGUMENT

Pursuant to Rule 18 of the West Virginia Rules of Appellate Procedure, Petitioner submits that oral argument is necessary as there are extensive legal arguments on behalf of the Respondents in support of affirming the Circuit Court and Intermediate Court of Appeal's rulings. While adequately presented in Respondents' Brief and the record below, Respondents submit that this Honorable Court will be significantly aided by oral argument. Oral argument is appropriate pursuant to Rule 20 of the West Virginia Rules of Appellate Procedure argument, as a case involving "issues of fundamental public importance" as well as implication of the Respondents' constitutional liberties not to be required to accept patients through the erroneous application of an alleged "standard of care" for the performance of an admission assessment for which there can be no duty to accept the patient for admission. W.VA. R. APP. P. 20(a)(2).

VI. ARGUMENT

In this case, the Petitioner seeks an unprecedented ruling from this Court which would be tantamount to the unconstitutional curtailment of West Virginia healthcare professionals' right to choose whether or not to enter into a voluntary physician-patient relationship. More dangerous,

however, is that any ruling which creates a legal duty upon a healthcare provider to treat any and all persons under any and all circumstances, outside of EMTALA, correspondingly extends the liability of healthcare providers for the subsequent illness and/or death of every person whom they declined to treat, provided no treatment to, and never saw again.

Concerningly, a ruling in favor of the Petitioner, and thus the expansive finding of "duty" that would require, would necessarily deny not only healthcare providers, but really all service providers, i.e. lawyers, accountants, contractors, etc., the right to decline to accept patients, clients, and customers whom they do not and/or cannot treat, represent, or provide services to following preliminary discussions with a putative patient/client/customer. In short, a ruling in favor of the Petitioner would necessarily find that if a service provider is approached about a service and declines to provide it, that he or she could still be indefinitely liable for any damage which one might argue arises, however tenuously, from the failure to perform the service ~ even when the person seeking, and allegedly qualified to receive the service, was fully aware that the service was not going to be provided and takes no action to find any other professional willing to perform said service. Such an extension of the doctrine of "legal duty" and *ad infinitum* liability is untenable under the law.

A. DEFENDANTS' MOTION FOR SUMMARY JUDGMENT WAS PROPERLY GRANTED BY THE CIRCUIT COURT AND UPHELD BY THE INTERMEDIATE COURT OF APPEALS AS THE RESPONDENTS HAD NO LEGAL DUTY TO ACCEPT PETITIONER'S DECEDENT AS A PATIENT OR TO PROVIDE HIM WITH MEDICAL TREATMENT.

The ruling from the Circuit Court, as set forth in its September 21, 2022, REVISED ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND FINDING THAT DEFENDANTS HAD NO DUTY TO ACCEPT OR TREAT THE DECEDENT, AUSTIN GHAPHERY was that these Respondents "had no duty, as a matter of law, to accept as patient or otherwise treat the decedent[.]" (JA Vol. 3: 888). In harmony with the precedent of this Court and the national

majority, the Circuit Court found "that there is no duty of care owed to every person who is screened but not accepted for treatment as a patient, and, in this case, is never treated as a patient and who is never seen again." (JA Vol. 2: 888). Contrary to the Petitioner's assignments of error and arguments regarding the Decedent's status as a patient, the Circuit Court found that "[a]lthough [the Decedent] was technically identified as a "patient" while he was there for pre-admission assessment, he was not accepted as a patient thereafter because he was refused admission to the program." (JA Vol. 3: 887).

No liability can arise from the Respondents' failure to accept the Decedent as a patient regardless of whether he objectively qualified for the Respondents' MAT program or not. The Respondents' refusal to admit the Decedent as a patient to the WTC MAT program is simply not actionable. Despite the Petitioner's attempt to create such a tort, and thereafter a genuine issue of fact with allegations, as opposed to material facts, his efforts are in vain as this case presents purely a question of law. As acknowledged by the Intermediate Court of Appeals, the Petitioner "cites no federal or state statute or rule which imposes a legal requirement on WTC or its Medical Director to admit or treat individuals for opioid addiction or any other diagnosis." (JA Vol. 3: 997). "West Virginia's medication assisted treatment legislative rule does not impose a requirement on facilities to provide healthcare even if an individual meets the criteria for admission." Id. Rather, "medication assisted treatment facilities are free to decline patients regardless of whether they qualify for opioid treatment and regardless of their mental status." Id. And yet, as it so happens, the Petitioner's Decedent *did not qualify* for the Respondents' medication assisted treatment program on September 27, 2017, when he presented for his pre-admission assessment. Nevertheless, and even if the Decedent had somehow objectively qualified

for the Respondents' MAT program and was declined, the Respondents' failure to accept the Petitioner's Decedent as a patient is not actionable. Id.

The Petitioner's arguments before this Court boil down to a flawed and speculative theory, unfairly reasoning that since the Decedent died of an accidental opioid drug overdose thirty-six (36) days *after* he presented to the Respondents for assessment, then it should be retrospectively presumed that the Decedent qualified for admission into the Respondents' MAT program a month earlier, and thus it was a breach of the standard of care for the Respondents not to accept him or otherwise transfer the Decedent for commitment to an in-patient psychiatric facility. As a factual matter, the Petitioner's strained theory completely ignores not only the very real passage of time, over a month between the Decedent's presentation and his death, but also the objective medical findings of another, independent physician, Dr. Bradley Schmitt, who assessed the Decedent *after* the Respondents (JA Vol. 2: 337-38), as well as the testimony of the Petitioner, also a medical doctor, regarding his observation of his son during that intervening time period. (JA Vol. 1: 318). The Petitioner conveniently ignores the total absence of any statutory or common law duty on the part of the Respondents to provide treatment to the Decedent while simultaneously seeking to infringe upon the Respondents' constitutional right not to be forced into a physician-patient relationship against their will by asserting a nonexistent standard of care which would require all healthcare providers to involuntarily accept all persons as patients for treatment.

Under the law, there simply is no "standard of care" governing how or when a healthcare provider may decline to accept a patient, and no mandate to treat a person outside of the limited scope dictated by EMTALA, which is not applicable here. "Standard of care" is the level at which one performs a duty owed. "Duty" is a legal obligation that is deemed to arise under the law in designated circumstances. Once such a duty is established, then the standard of care dictates the

manner in which those obligations must be carried out. Presently, however, the Petitioner's arguments herein confuse the legal question of whether a duty exists, with the factual question of whether, once established, that duty was breached by the failure of the practitioner to comply with the applicable standard of care. "In order to establish a prima facie case of negligence in West Virginia, it must be shown that the defendant has been guilty of some act or omission in violation of a duty to the plaintiff. No action will lie without a duty broken." Syl. Pt. 1, Parsley v. General Motors Acceptance Corp., 167 W.Va. 866, 280 S.E.2d 703 (1981); Syl. Pt. 4, Wal-Mart Stores East, L.P. v. Ankrom, 244 W.Va.437, 854 S.E.2d 257 (2020); Salas v. Gamboa, 760 S.W.2d 838 (Tex. App. 1988) ("[i]t is clear that before the question of standard of care is reached, the court must first determine as a question of law whether there is a legal duty on the defendant's part."). West Virginia law provides that whether a particular party owes a duty of care is an issue of law which may be properly decided by a trial court a motion for summary judgment. Syl. Pt. 5, Aikens v. Debow, 208 W.Va. 486, 541 S.E.2d 576 (2000).

In a medical malpractice action, a plaintiff must prove that the physician owed a duty of care to the patient to act according to an applicable standard of care. Stated another way, "[t]he essence of a medical malpractice action is a physician-patient relationship. . . . unless such a relationship is established, a legal duty cannot exist between the parties." Gooch v. West Virginia Dept. of Public Safety, 195 W. 357, 366, 465 S.E.2d 628, 637 (1995). The formation of the physician-patient relationship is a prerequisite to the imposition of a legal duty on a physician and/or healthcare facility to provide medical services to a patient. Id. Consequently, a health care provider's duty to act arises because of a physician-patient relationship and does not exist absent that relationship. Id. Without sufficient evidence to establish the creation of a physician-patient relationship, no finding can be made as to whether these Respondents breached, violated, or

appropriately discharged any such duty related to the Decedent. *See e.g.*, State ex rel. West Virginia Board of Examiners for Speech-Language Pathology and Audiology v. Lindsay, 2018 WL 3005950 *5 (W.Va. Sup. Ct. App., June 15, 2018), unreported. "The essence of a medical malpractice action is a physician-patient relationship. . . . unless such a relationship is established a legal duty cannot exist between the parties." Gooch, 195 W.Va. 357, 366, 465 S.E.2d 628, 637 (1995).

Petitioner's medical negligence action alleges that the Respondents breached the standard of care in their pre-patient assessment of the Decedent and therefore failed to either accept him as a patient of the WTC's opioid MAT program and/or failed to seek his involuntary commitment to an inpatient psychiatric facility for psychiatric treatment. During recitation of his case to the Circuit Court, the Intermediate Court of Appeals and now this Court, the Petitioner wholly ignores the absence of any legally recognized *duty* on the part of the Respondents to accept the Decedent as a patient and skips directly to arguing that the Respondents failed to meet the standard of care. The Petitioner seeks to muddle this record with baseless allegations and allegedly disputed facts without mention or reference to *any* judicial precedent which might provide the legal predicate for his claim, i.e. any legal support establishing that the Respondents *had a duty* to accept the Petitioner's Decedent as a patient and/or a duty to provide him with any care or treatment of any kind. While the Respondents vehemently deny that they were negligent, in the absence of a duty to accept the Decedent into the MAT program, the manner in which the Respondents went about determining whether or not they would accept the Decedent as a patient is wholly immaterial. In the absence of a legally recognized duty on the part of the Respondents to accept the Decedent into their MAT program, there can be no claim that the Respondent's negligently failed to do so.

Moreover, there is no and there can be no dispute that the Petitioner's Decedent "was told that he did not meet the criteria for admission and that he was not a patient." (JA Vol. 3: 996). Respondent's declination to treat the Decedent, for any reason or no reason – so long as it was not a discriminatory reason, sound or not, is not actionable and cannot form the basis of a successful medical professional liability claim. To be clear, there are no claims of discrimination in the failure to accept Austin Ghaphery as a patient. Rather, the Petitioner repeats *ad nauseum* his allegations that the Decedent was not properly assessed for admission and that the Respondents had a duty to properly assess him for admission to their MAT program, but, alas, that is simply not the law. In this, and nearly every other instance involving any service provider, only the manner in which the services are actually provided and not the fact that the service provider declined to provide services (save in cases of alleged discrimination) is subject to retrospective scrutiny set against a standard of care. In short, if the health care provider – or the lawyer, the accountant, the contractor, is not legally required to accept the individual as a patient, client or customer, then the method used by the service provider in deciding whether or not to voluntarily undertake to provide his/her services cannot be subject to outside evaluations about whether the service provider was "negligent" in refusing to provide the service.

The Respondents have a virtually unqualified right, short of discrimination, to refuse to treat or otherwise accept as a patient any person, including the Decedent. At no time were the Respondents legally obligated to accept and treat the Decedent as a patient, regardless of whether the Petitioner can cobble together enough speculation and conjecture to prove that he should have qualified for treatment there or not. Without a legally imposed duty to accept the Petitioner's Decedent, or any putative patient, following the satisfaction of designated criteria, there simply is no recognized "standard of care" for how a pre-admission assessment or evaluation must be

conducted, when the person must be accepted as a patient, and when that patient must be treated by a provider. Admittedly, had the Respondents accepted the Petitioner's Decedent into the MAT program, his admission to and treatment in the program would have been governed by specific state regulations. However, the reverse is simply not true: "[B]ecause a physician has the right to reject employment, the reason a physician declines to treat a patient is immaterial to the issue of medical malpractice." St. John v. Pope, 901 S.W.2d 420, 434 (Tex. Sup. Ct. 1995), *citing* Salas v. Gamboa, 760 S.W.2d 838, 841 (Tex. App. – San Antonio 1988). "[A] physician may decline treatment and thereby decline to create a physician-patient relationship, even on the basis of an erroneous conclusion that the patient's condition is beyond his or her ability to treat." St. John, 901 S.W.2d 423.

The implicit understanding when the Petitioner's Decedent presented to the WTC on September 28, 2017, was that he would be *considered* for admission to the MAT treatment program for opioid use disorder. Right or wrong, fully and appropriately assessed for admission as testified to by the Respondents, or negligently assessed as alleged by Petitioner, the Decedent was not accepted as a patient and the Respondents were under no legal duty to do so. Accordingly, no physician-patient relationship was formed and at no time did the Respondents, either individually or collectively, agree to provide *any* medical service to the Decedent. Consequently, the Decedent left the facility that day with the Petitioner, fully aware that no treatment had been rendered or would be rendered in the future by these Respondents; the Decedent was not accepted as a patient at the Wheeling Treatment Center.

There is no statutory or common law duty which mandates that the Respondents accept anyone as a patient; they have the right to refuse treatment of any individual, at their discretion – so long as there is no discriminatory intent. This is particularly so when, as here, a determination

was made that the individual was not a qualifying candidate for the type of treatment which they offer. Consequently, for this Court to impose such a duty herein would be an unprecedented expansion of liability for healthcare providers throughout the State of West Virginia. Distinguishable from a physician's duty to *continue* to treat a patient with whom a physician-patient relationship has been established, the legal limitations on a physician or medical facility's refusal to accept a person for treatment are incredibly narrow and encompass only the Emergency Medical Treatment & Labor Act (EMTALA) and certain refusals based upon a discriminatory reason. In fact, the very existence of the EMTALA, which incidentally applies only to hospitals and not to individual physicians, is evidence that there is no common law duty on healthcare facilities, and particularly individual physicians, to accept patients for treatment.[2] *See e.g.*, Ramonas v. West Virginia University Hospitals-East, 2009 WL 3295024 (N.D.W.Va. Oct. 13, 2009) (unreported) (recognizing that EMTALA arose out of necessity as under traditional state tort law, hospitals are under no legal duty to provide even emergency medical care to all persons regardless of their ability to pay for services); Schubert v. Freed, 682 F.Supp.2d 657 (N.D.W.Va. 2010) (Acknowledging EMTALA allows a civil suit against a participating hospital, but not a treating physician). The legal justification by which hospitals, with emergency departments, are

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[2] Congress enacted the Emergency Treatment and Active Labor Act ("EMTALA") "to address a growing concern with preventing 'patient dumping,' the practice of refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized." *Power v. Arlington Hosp. Ass'n,* 42 F.3d 851, 856 (4th Cir.1994). "The Act accordingly imposes two principal obligations on hospitals. … when an individual seeks treatment at a hospital's emergency room, 'the hospital must provide for an appropriate medical screening examination ... to determine whether or not an emergency medical condition' exists. § 42 U.S.C. 1395dd(a). Second, if the screening examination reveals the presence of an emergency medical condition, the hospital ordinarily must 'stabilize the medical condition' before transferring or discharging the patient. § 42 U.S.C. 1395dd(b)(1)." *Vickers v. Nash Gen. Hosp., Inc.,* 78 F.3d 139, 142 (4th Cir.1996).

Ramonas v. W. Virginia Univ. Hosps.-E., 2009 WL 3295024, at *3 (N.D.W. Va. Oct. 13, 2009).

subjected to EMTALA is based upon their voluntary participation and prior decision to receive compensation from the Medicare program. In the absence of this election by the Medicare participating hospital, not even EMTALA can force a hospital to treat a patient, even one in an emergency medical crisis. 42 U.S.C. § 1395dd(e)(2).

The right of a healthcare provider to refuse to accept a patient is a constitutional one protected by the Thirteenth Amendment to the Constitution which provides that "involuntary servitude . . shall not exist within the United States, or any place subject to their jurisdiction." U.S.C.A. CONST. AMEND. 13. In fact, the Constitutional protection against "involuntary servitude" is wholly invoked by *any* law which seeks to compel service of labor by putting in place penalties for failing or refusing to perform such service. "[A]lthough the court might not impute to a state an actual motive to oppress by a statute, yet it should consider the material operation of such a statute and strike it down if it becomes an instrument of coercion forbidden by the federal Constitution." Bolyard v. Bd. of Educ. of Grant County, 214 W.Va. 381, 385, 589 S.E.2d 523, 527 (2003) (dissent of Justice McGraw) (quoting Ex parte Hudgins, 86 W.Va. 526, 533, 103 S.E.327, 330 (1920), quoting Bailey v. Alabama, 219 U.S. 219, 31 S.Ct. 145, 55 L.Ed. 191 (1911).

"As is true of all callings, physicians are not obliged to practice their profession or render services to everyone who asks. It is only with a physician's consent, whether express or implied, that the doctor-patient relationship comes into being." St. John, 901 S.W.2d 420, 423 (Tex. Sup. Ct. 1995). "Medical malpractice also differs from ordinary negligence in the circumstances under which a duty arises. Generally the duty to refrain from negligently injuring others requires no prior relationship." Id. By contrast, professionals do not owe a duty to exercise their particular talents, knowledge, and skill on behalf of every person they encounter in the course of the day. Id.; *accord*, Gooch v. West Virginia Dept. of Public Safety, 195 W.Va. 357, 366, 465 S.E.2d 628, 637

(1995). Consistent therewith, there is simply no existing legal precedent by any court, state or federal statute, which imposes upon these Respondents a legal duty to have accepted the Decedent as a patient, whether he was properly assessed by them or not. To do so would expose these Respondents, and healthcare providers in general, "to liability to the public at large with no manageable limits. *Aikens* noted that '[e]ach segment of society will suffer injustice, whether situated as plaintiff or defendant, if there are no finite boundaries to liability.'" City of Charleston, West Virginia v. Joint Commission, 473 F.Supp.3d 596, 623 (S.D.W.Va. 2020) (referencing Aikens v. Debow, 208 W.Va 486, 502, 541 S.E.2d 576, 592 (2000)). A duty upon a healthcare providers, as a matter of law, to accept every person as a patient simply does not exist and should not be created by this Court.

The ruling sought by the Petitioner is unprecedented; there is genuinely no difference between the holding Petitioner asks this Court to make for the Respondent healthcare providers and a holding which provides that every lawyer who agrees to meet with and listen to the plight of a potential client is subject to liability for all damages allegedly arising from the failure of the client to receive legal services, *even when that client knew and acknowledges the lawyer had refused to take the case*. Likewise, there is no difference between what the Petitioner is asking this Court to hold than a holding which subjects a contractor who comes out to look at a leaky basement to liability for all damages allegedly arising from the failure of a homeowner to have the leak repair performed *when the homeowner knew the contractor did not agree to perform the repair*. Under the Petitioner's theory, in both of these instances just like in this case, the lawyer and the contractor would be subject to civil litigation seeking damages for their failure to take the case or perform the repair job, subject to some artificial "standard of care" where paid experts opine about why they *should have* taken the case or performed the job. A potential client can have

the very best case or be offering the easiest, most lucrative repair project and if that service provider makes clear that no such legal or repair services will be provided, no liability will or should attach. No lawyer is required to take even the best case from a potential client, no contractor is required to fix every leak for which he goes out and provides an estimate, and no physician is required to accept for treatment every person presenting as a putative patient. *See e.g.*, Jackson v. Isaac, 76 S.W.3d 177, 180 (Tex. App. – Eastland 2002) (*citing* St. John v. Pope, supra at p.424 ~ holding that although a physician may listen to a potential patient's symptoms and come to a conclusion about the basis of the condition, he may do so for the purpose of evaluating whether he should take the case, *not as a diagnosis for a court of treatment*, without establishing a physician-patient relationship) (emphasis in original). As such the Respondents were properly entitled to the summary judgment granted by the Circuit Court and upheld by the Intermediate Court of Appeals.

B. DEFENDANTS' MOTION FOR SUMMARY JUDGMENT WAS PROPERLY GRANTED BY THE CIRCUIT COURT AND UPHELD BY THE INTERMEDIATE COURT OF APPEALS AS THERE WAS NO DUTY TO SEEK INVOLUNTARY COMMITMENT OF OR PROVIDE PSYCHOLOGICAL SERVICES TO THE PETITIONER'S DECEDENT

Despite definitive testimony from the Petitioner, himself a medical doctor, that the Decedent was not having a mental health crisis – either at the time he dropped the Decedent off at WTC or when he picked the Decedent up from WTC, nor at any time during the intervening thirty-six (36) days before his death, the Petitioner seeks compensation from these Respondents for a purported breach in the standard of care as to the Respondents' suicide assessment of the Decedent. (JA Vol.1: 316, 322). Importantly, it must also be recalled that Austin Ghaphery did not die as a result of suicide. Rather, his cause of death was determined by the West Virginia Medical Examiner's office to be accidental and not suicide. Yet, the Petitioner vigorously argues to this Court that the Respondents should have sought to commit the Decedent to an in-patient psychiatric

treatment facility, on the basis of their interactions on September 28, 2017. And again, the Petitioner cannot cite to any authority imposing upon the Respondents a legal duty to seek such a commitment. On the contrary, while "[a]ny adult person *may* make an application for involuntary hospitalization for examination of an individual" the statute requires that the applicant have:

> reason to believe that the individual to be examined has a substance use disorder as defined by the most recent edition of the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, inclusive of substance use withdrawal, is mentally ill and, because of his or her substance use disorder or mental illness, the individual is likely to cause serious harm to himself, herself, or to others if allowed to remain at liberty while awaiting and examination [.]

W.VA. CODE § 27-5-2(a). As an initial matter, the statutory language is permissive ~ using the word "may". Thereafter, there is no mandate that a physician seek examination under this statute. Furthermore, "[t]he person making the application shall make the application under oath" and "shall give information and state facts in the application required by the form provided for this purpose by the Supreme Court of Appeals." W.VA. CODE § 27-5-2(b) and (d).

As stated in the West Virginia Code and on the face of the Supreme Court of Appeals of West Virginia's APPLICATION FOR INVOLUNTARY CUSTODY FOR MENTAL HEALTH EXAMINATION form itself, completion of the application would *not* have resulted in commitment of the Decedent to an in-patient psychiatric facility, but only in an examination to determine whether or not he was having a "psychiatric emergency" which the statute defines as "an incident during which an individual loses control and behaves in a manner that poses substantial likelihood of physical harm to himself, herself or others." W.VA. CODE § 27-5-2(e). Thereafter, "[i]f the examination reveals that the individual is not mentally ill or has no substance use disorder, or is determined to be mentally ill or has a substance use disorder *but not likely to cause harm to himself*, herself, or others, the individual *shall be immediately released* without the need for a probable cause hearing[.]" W.VA. CODE § 27-5-2(e)(emphasis added). In other words, even if the examiner would

have determined that the Decedent had a substance use disorder or was mentally ill, unless that substance use disorder or mental illness was "likely to cause harm" to him or someone else, the Decedent would have been required to have been "immediately released." Id.

Despite the Petitioner's tenuous and convoluted theory of causation, the Decedent was simply not in psychiatric crisis, was not a patient of the Respondents, and was under the care of another physician for treatment of depression. Additionally, the overwhelming evidence in this case is that the Decedent was not actively suicidal on September 28, 2017, and therefore was not "likely to cause harm to himself" on that date. In fact, it is also undisputed that the Decedent did not intentionally harm himself on September 28, 2017, and did not attempt suicide on that date or any date thereafter. (JA Vol 1: 284, 316, 318, 325). Rather, the Decedent's established cause of death as an accident is consistent with the fact that the Petitioner, a board-certified physician, drove his son to WTC on the morning of September 28, 2017, and noted absolutely no issues with him at that time ~ and certainly no indications toward self-harm. (JA Vol 1: 316).

Q: Okay. So when he went to the treatment center a week later, do you have any reason to believe that he was suicidal then when he wasn't suicidal on the 21st?
A: I took him to the treatment center, not from a suicidal standpoint, specifically. I took him to the treatment center because of the drugs.
Q: I understand, but I'm asking you, did you consider him to be suicidal when you took him to the treatment center?
A: Oh, no.
Q: Do you have any reason to believe that he was suicidal at the time that you took him to the treatment center?
A: Not -- no.
Q: Was he exhibiting any symptoms that you associated with his depression or --
A: No.

(JA Vol 1: 316). Thereafter, the Petitioner picked up the Decedent from WTC just a few hours later, and immediately after he was seen by WTC staff, and again noted no issues with the Decedent:

Q: And then you didn't ask Austin why he didn't qualify?
A: No.
Q: And from that day to the day of his death, you didn't have anymore discussions with him about his drug use?
A: I - - no, ma'am. I don't believe so.
Q: During that time period, did you see Austin where you believed him to be under the influence of drugs?
A: I don't believe.
Q: Did you continue to do any kind of monitoring of your son who has had depression and told you he's abusing drugs?
A: Other than, you know, observation, just watching his demeanor, and he - - I thought he was improving. No.

(JA Vol 1: 322-23). Such testimony clearly does not establish that on September 28, 2017, the Decedent was in crisis, was displaying signs of mental illness, or was exhibiting any signs, symptoms or behavior justifying the completion of an APPLICATION FOR INVOLUNTARY CUSTODY FOR MENTAL HEALTH EXAMINATION.

Although he was not present for the examination at WTC and has offered no testimony to support such an allegation, Petitioner maintains that during the Decedent's evaluation at WTC the Decedent disclosed to Jamie Coen-Pickens that he was actively (currently) having suicidal ideations with a plan to follow through with a gun. These allegations are based solely upon an inaccurate, self-serving misinterpretation of a Case Note written by Mrs. Coen-Pickens. (JA Vol 1:293). Ms. Coen-Pickens clearly testified, under oath, that the suicidal thoughts relayed to her by the Decedent were "past thoughts of suicide" and that he was "not actively suicidal that day." (JA Vol 1: 307-09).

Moreover, the Respondent Medical Director likewise testified, under oath, that the Decedent told him that he was not suicidal at that time. (JA Vol 3: 862) The testimony of the Respondents, that the Decedent's suicidal ideations were a thing of the past, is wholly consistent both with the sworn testimony of his father, the Petitioner who observed the Decedent that very

same day, both before and after he was at the WTC, as well as with the medical records of the Decedent's primary care physician, Dr. Schmitt, who treated the Decedent afterward:

> Q: And he was continuing to go out and socialize, or what was he doing during those days? [between his visit to the Wheeling Treatment Center and his death]
> A: As far as I know, you know, things were going on as normal, whatever normal is.
> Q: Did he indicate to you during that conversation that he was having any suicidal ideations?
> A: We talked about - - I did ask him, "Would you do anything" - - I mean, the depression for me was probably the driving force. And I did ask him, "Are you concerned - - do I have to be" - - I said, "Do I have to be concerned about you hurting yourself?" And he said, "No." He said, "you know, I have thought about it." I said, "Well, okay, You've thought about it. What were you going to do?"
> He said, "Well, you know, I would probably use a gun." And I said "Oh."
> He said, "But I - - don't worry, Dad. I would never do anything to hurt myself," and I took the man, young boy at his word - - young man at his word.

(JA Vol 1:313-14).

The Decedent was treated by his primary care physician, Brad Schmitt, M.D., during a follow-up visit on September 21, 2017, seven (7) days before presenting to the Wheeling Treatment Center. (JA Vol 1:331). At that time, the Decedent reported to Dr. Schmitt that "he has had suicidal thoughts but no plan" and that he had discussed these suicidal thoughts with his parents which resulted in all guns being removed from the Petitioner's home. (Id). It is important to note that although the Petitioner's expert completely discounts the testimony of the Respondents as to the sufficiency of their suicide assessment, this is virtually the same conversation as was subsequently documented by Ms. Coen-Pickens when the Decedent was at WTC. Despite his agreement with his parents, and with Dr. Schmit that he would tell his parents, tell Dr. Schmitt and/or go to a crisis unit if his symptoms became worse, the Decedent never did any of these things. Instead, the evidence clearly demonstrates that the Decedent's mental health improved as

is documented in the medical records and the Petitioner's own deposition testimony. (JA Vol. 2: 338). The Petitioner testified that he, the parent with whom the Decedent lived, never felt like the Decedent was a danger to himself. (JA Vol. 1:315).

Furthermore, Petitioner's counsel's interpretation of the WTC's Case Note is self-serving, disingenuous, and contrary not only to the testimony of its author, but also to that of the Petitioner. The overwhelming evidence in this case is that the Decedent had previously discussed with his parents and his family physician *prior* thoughts of suicide, but never that he was actively suicidal, and that he made no expression of active suicidal ideations on the day he presented to the WTC. Additionally, the mischaracterization of the Respondent Medical Director's testimony as an "admission of a standard of care" in this case, adds no validity to the Petitioner's arguments as the hypothetical questions required that the witness assume as true Petitioner's *allegations* regarding the Decedent's mental status on the day of the presentation, rather than being an analysis of the facts and evidence as to Austin Ghaphery's actual presentation as discussed above.

Based on the foregoing, there is no evidence in the record which would support the finding of a duty on the part of these Respondents to seek the Decedent's commitment to a psychiatric facility at that time and certainly no showing that the failure to do so was a proximate cause of Austin Ghaphery's death more than a month later by accidental overdose. (JA Vol. 1: 284; Vol. 2: 557). If the Petitioner had wanted to argue that his son's death was a suicide, he was obligated to have the Death Certificate amended accordingly. *See e.g.*, Goldizen v. Grant County Nursing Home, 225 W.Va. 371, 693 S.E.2d 346 (2010) (holding that the Death Certificate is prima facie evidence as to the cause of death). In reality, and consistent with the Petitioner's own observations and testimony, the Decedent was not exhibiting or expressing any active suicidal ideations on the day he presented to the WTC. Accordingly, these Respondents were and remain entitled to

summary judgment on Petitioner's claims that the Respondents negligently failed to seek commitment of the Decedent to a psychiatric treatment center, Northwood, or otherwise.

C. PETITIONER IS NOT ENTITLED TO AMEND HIS COMPLAINT AS HIS CAUSE OF ACTION IS GOVERNED BY THE MPLA

The Petitioner's brief seems to suggest that if the Respondents owed the Decedent no duty to accept him as a patient, then the Complaint could have been amended to avoid the MPLA and save his cause of action. His presumption is based on a continued misunderstanding of the application of the West Virginia Medical Professional Liability Act, W.VA. CODE § 55-7B-1, *et seq.* (2016). and the relationship of the parties herein. The MPLA is deemed to apply where, as here, two conditions are satisfied: (1) a plaintiff "sues a 'health care provider' or 'health care facility' for (2) 'medical professional liability' as those terms are defined under the Act." State ex rel. W.Va. Div. of Correction & Rehabilitation v. Ferguson, 248 W.Va. 471, 480, 889 S.E.2d 44, 53 (2023). "When those conditions are present, the action must be brought under the Medical Professional Liability Act, even if another cause of action would otherwise apply." Neidig v. Valley Health System, 90 F.4th 300, 304 (4th Cir. 2024), citing Minnich v. MedExpress Urgent Care, Inc.-W.Va., 238 W.Va. 533, 537, 796 S.E.2d 642, 646 (2017). "The Act's legislative history makes clear 'the Legislature's intent for the [MPLA] to broadly apply to services encompassing patient care – not just the care itself." Neidig at 305, quoting State ex rel. West Virginia University Hospital, Inc. v. Scott, 246 W.Va. 184, 193, 866 S.E.2d 350, 359 (2021).

The clear and unambiguous language of the Act provides that the definition of "medical professional liability" includes "any liability for damages resulting from the death or injury of a person for any tort or breach of contract based on health care services rendered, *or which should have been rendered*, by a health care provider or health care facility to a patient" as well as "other claims that may be contemporaneous to or related to the alleged tort or breach of contract or

otherwise provided, all in the context of rendering health care services." W.VA. CODE § 55-7B-2(i). 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).

As aptly recognized by the Circuit Court and Intermediate Court of Appeals, the Decedent was " 'technically a "patient" [solely] while he was there for pre-admission assessment . . .' However, [the Decedent] was not a patient of WTC or its Medical Director ***for purposes of diagnosis or treatment***." (JA Vol. 3: 995) (emphasis added). Allowing the Petitioner to amend his pleading to remove reference to the MPLA would be utterly futile. As this Court held nearly two (2) decades ago in *Blankenship v. Ethicon*, a plaintiff cannot avoid the MPLA by virtue of failing to expressly allege a malpractice claim. 221 W.Va. 700, 707, 656 S.E.2d 451, 458 (2007). If a claim falls squarely under the MPLA, the manner in which a complaint is drafted will not prevent the invocation of the MPLA. Id. (approving circuit court's analysis that plaintiffs' labeling "as 'products' claims does not change the fundamental [MPLA] basis of this tort action"); *see also*, Gray v. Mena, 218 W.Va. 564, 570, 625 S.E.2d 326, 332 (2005) (permitting plaintiff who opted

not to bring MPLA action opportunity to amend complaint and comply with MPLA requirements rather than upholding dismissal for non-compliance with MPLA filing requirements). It has been the law in West Virginia for many years that "the determination of whether a cause of action falls within the MPLA is based upon the factual circumstances giving rise to the cause of action, *not the type of claim asserted.*" Blankenship, 221 W.Va. at 702-03, 656 S.E.2d at 453–54 (emphasis supplied); Minnich v. MedExpress Urgent Care, Inc.-W. Va., 796 S.E.2d 642, 646 (W. Va. 2017); Scott, 866 S.E.2d at 359 ("It goes without saying that [a plaintiff] cannot avoid the MPLA with creative pleading.").

While it is impossible for the Petitioner to avoid the application of the MPLA in this matter, satisfying the definition of 'patient' under the MPLA for the purposes of the cause(s) of action alleged in the Complaint, or even for the limited purpose of *considering* the Decedent for admission into the Respondents' MAT program, does not then create an indelegable legal duty upon the Respondents to ensure the healthcare and safety of the Decedent for all time. There is no evidence that the Respondents ever made an actual diagnosis of the Decedent as having or not having a drug addiction. (JA Vol. 1: 300). Rather, the only determination made regarding the Decedent by these Respondents was that he was not being accepted into the Respondents' MAT program for opioid addiction, thereby failing to form the physician-patient relationship necessary for the creation of a legal duty between the parties. Gooch v. West Virginia Dept. of Public Safety, 195 W.Va. 357, 366, 465 S.E.2d 628, 637 (1995). The Respondents agreement to meet with and consider the Decedent for admission does not and cannot translate into consent to provide the Decedent with a diagnosis, treatment, or to accept him into the MAT program as a patient. Gooch at 637 (Holding casual contact with a person, whether or not the contact is associated with a medical context, is not sufficient to imply or establish a professional relationship. Rather, the

creation of that relationship requires that the parties reach an agreement, expressed or implied, that care will be provided).

The Petitioner argues that application of the MPLA is mutually exclusive with the refusal of the Respondents to accept the Decedent as a patient for purposes of diagnosis and treatment; however, he presents no legal authority for such a theory and long-standing precedent of this Court as to the application of the MPLA suggests otherwise. While the Petitioner has alleged what can only be interpreted as a claim for medical professional liability against these healthcare providers, and such allegations are governed by the MPLA, the fact that the MPLA governs the claims in no way serves to *prove* the validity of allegations; the allegations must rise and fall by application of the law to the facts of the case.

Under West Virginia law, a successful medical malpractice action must be predicated on the existence of a physician/patient relationship and not simply whether an individual makes allegations in the Complaint which are sufficient to meet the definition of a "patient" so as to pursue a civil action under the guise of the West Virginia Medical Professional Liability Act ("MPLA"). *See e.g.*, W.VA. CODE § 55-7B-1 (2016). Making allegations in the Complaint sufficient to satisfy application of the MPLA is not the same thing as, nor the criteria for, establishing the existence of a continuing physician-patient relationship. In this case, it is *alleged* that the Decedent, a natural person, should have received healthcare from the Respondents as healthcare providers, thereby meeting the definitional requirement of the MPLA. However, at all times relevant hereto, Austin Ghaphery was advised that he was not a patient of the WTC, was not accepted into the MAT program, and would not be receiving any healthcare services from the Respondents. (JA Vol 1:295, 297, 300).

The only agreement present in this case was that the Respondents would meet with the Decedent to consider him for admission to the treatment program; right, wrong or indifferent, both the Decedent and his father, the physician Petitioner, understood on the very day of the presentation that no further services were being offered or provided to the Decedent. To state it plainly: The Decedent left the WTC with full knowledge that he was not a patient there and that he would not be returning for treatment. In the parking lot, the Decedent immediately got into the car with the Petitioner, a board-certified family practice physician, and conveyed to him that he had not been accepted as a patient at WTC, he had received no treatment, and would not be returning there for treatment.

VII. CONCLUSION

The ruling from the Circuit Court as set forth in its September 21, 2022, REVISED ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND FINDING THAT DEFENDANTS HAD NO DUTY TO ACCEPT OR TREAT THE DECEDENT, AUSTIN GHAPHERY, as well as the Memorandum Decision of the Intermediate Court of Appeals, should be affirmed as both correctly held that these Respondents had no duty, as a matter of law, to accept as a patient or otherwise treat the Decedent. After review of all the evidence submitted in this matter, the Circuit Court correctly concluded that "that there is no duty of care owed to every person who is screened but not accepted for treatment as a patient, and, in this case, is never treated as a patient and who is never seen again." (JA Vol. 2: 888). The Intermediate Court of Appeals then performed a *de novo* review of all of the evidence in this case and found that "there is no question that WTC declined to treat [the Decedent] after he was initially screened for admission into a special purpose program" and "no evidence was presented that WTC and its Medical Director, provided specific medical advice, or gave a specific diagnosis to [the Decedent]. Therefore, no express or implied contract

to provide and receive care was agreed to, and WTC and its Medical Director owed no duty to admit [the Decedent] to its medication assisted treatment program." (JA Vol. 3: 995-96). Summary judgment in favor of the Respondents was and continues to be appropriate in this matter because "medication assisted treatment facilities are free to decline patients regardless of whether they qualify for opioid treatment and regardless of their mental status." (JA Vol. 3: 997).

WHEREFORE, the Respondents, Wheeling Treatment Center and John Schultz, M.D., by counsel, respectfully request this Court enter an Order affirming the Circuit Court's grant of summary judgment to the Respondents, and granting such other and further relief in favor of the Respondents as the Court deems just and appropriate under the circumstances.

Respectfully submitted,
WHEELING TREATMENT CENTER, LLC AND JOHN SCHULTZ, M.D.
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No. 24-52

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

NICHOLAS A. GHAPHERY, D.O.,
As Personal Representative of the
Estate of Austin Ghaphery,

Petitioner,

v.

ON APPEAL FROM
INTERMEDIATE COURT OF APPEALS OF W.VA., NO. 22-ICA-150; AND
CIRCUIT COURT OF OHIO COUNTY, W.VA. CIVIL ACTION NO. 19-C-182

WHEELING TREATMENT CENTER, LLC,
And JOHN SCHULTZ, M.D.,

Respondents.

CERIFICATE OF SERVICE

I, the undersigned counsel, hereby certify that on this 3rd day of June 2024, the foregoing **RESPONDENTS' BRIEF** has been filed electronically using the WV E-Filing System which will provide service upon all counsel of record.

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