IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

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No. 24-438

JOHN R. ORPHANOS, M.D.,
Defendant-Below, Petitioner

v.

MICHAEL RODGERS,
Plaintiff-Below, Respondent

BRIEF OF THE AMICI CURIAE OF WEST VIRGINIA UNIVERSITY BOARD OF GOVERNORS, WEST VIRGINIA HEALTH CARE ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, WEST VIRGINIA STATE MEDICAL ASSOCIATION, WEST VIRGINIA UNITED HEALTH SYSTEM, INC. DBA WEST VIRGINIA UNIVERSITY HEALTH SYSTEM, WEST VIRGINIA HOSPITAL ASSOCIATION, MARSHALL HEALTH NETWORK, INC., CHARLESTON AREA MEDICAL CENTER, INC., AND DEFENSE TRIAL COUNSEL OF WEST VIRGINIA

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I. INTRODUCTION[1]

The Medical Professional Liability Act ("MPLA") has governed medical malpractice litigation in West Virginia since 1986.[2] At that time, the Legislature declared "[t]hat our system of litigation is an essential component of this state's interest in providing adequate and reasonable compensation to those persons who suffer from injury or death as a result of professional negligence[.]"[3] The Legislature has also clarified that ensuring compensation to injured parties during medical care is inexorably tied to increases in medical professional liability insurance costs. The rising costs of medical malpractice insurance had grown so dire by 2003 that thirty-nine surgeons in and around Wheeling, West Virginia, walked off the job in protest of the rising malpractice insurance costs.[4] According to the MPLA's declaration of purpose, the statute seeks "to balance the rights of our individual citizens to adequate and reasonable compensation with the broad public interest in the provision of services by qualified health care providers who can themselves obtain the protection of reasonably priced and extensive liability coverable…"[5] Over the years, the MPLA has been a tremendous tool for striking the imperative balance between reining in the cost of medical professional liability insurance and providing injured parties with access to fair and reasonable compensation.

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[1] No counsel for a party authored the Amici Brief in whole or in part, no counsel or a party made a monetary contribution specifically intended to fund the preparation or submission of the Amici Brief, and no one other than the amici curiae, their members, or their counsel, made any monetary contribution to fund the preparation or submission of the Amici Brief.

[2] *See* W.Va. Code § 55-7B-1, *et seq.* originally enacted 1986.

[3] W.Va. Code § 55-7B-1.

[4] *W.Va. doctors strike over insurance costs*, CNN, (Jan. 1, 2003), http://www.cnn.com/2003/HEALTH/01/01/medical.malpractice/index.html.

[5] *Id.*

The MPLA initially set the maximum amount recoverable as damages for noneconomic loss at $1 million.[6] The Legislature revisited the MPLA and bifurcated the non-economic damages cap into two categories: one for $250,000 for medical professional liability resulting in injury, and the other for $500,000 for "(1)wrongful death; (2) permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities."[7] The 2003 amendment also included a mechanism for increasing the noneconomic cap annually in step with inflation.[8] With these amendments, the Legislature recognized that "[i]n recent years, the cost of insurance coverage has risen dramatically while the nature and extent of coverage has diminished, leaving the health care providers, the health care facilities and the injured without the full benefit of professional liability insurance coverage…"[9]

The Legislature also clearly understood this legislation's effect on the common law by deliberately limiting a jury's ability to award runaway verdicts in West Virginia. As this Court has stated, "the entire MPLA is an act designed to be in derogation of the common law."[10] The fact that the MPLA stands in derogation of the common law strikes at the heart of the MPLA's purpose of balancing access to compensation while improving the cost of, and access to, health care in West

[6] According to the CPI Inflation Calculator, this is the equivalent of $2,767,910.58 in 2023. U.S. Bureau of Labor Statistics CPI Inflation Calculator available at https://www.bls.gov/data/inflation_calculator.htm

[7] W. Va. Code § 55-7B-8.

[8] *Id.*

[9] *Id.*

[10] *Phillips v. Larry's Drive-In Pharmacy, Inc.*, 220 W. Va. 484, 491, 647 S.E.2d 920, 927 (2007).

Virginia. The limitations that the MPLA has placed on non-economic damage awards have undeniably helped stop the hemorrhaging of health care professionals from the state and have helped keep health care costs down for the citizens of West Virginia.[11]

Other states without health care tort reform laws have observed the harm that runaway verdicts can do to citizens' access to health care. For example, following a $98 million verdict in Iowa, which has no caps on non-economic damages in medical malpractice cases, Iowa's Obstetric and Gynecologic Associates of Iowa City and Coralville filed for bankruptcy under Chapter 11 of the United States Code.[12] In Kentucky, another state with no damage caps, Graves Gilbert Clinic cited a recent $21.3 million verdict against the facility as a driving force behind its filing for bankruptcy.[13] The verdict was "substantially higher than the maximum covered by our malpractice insurance, and the clinic simply does not have the resources to pay all of the very substantial difference."[14] The clinic "tried every way possible to reach a reasonable compromise, including the use of neutral intermediaries and an offer of installment payments, but nothing worked."[15] As such, the facility saw bankruptcy as its only option.[16] Shuttering an entire clinical practice is a prime example of the dangers associated with uncontrolled verdicts.

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[11] *See.* W.Va. Code §55-7B-1. "The cost of liability insurance coverage has continued to rise dramatically, resulting in the state's loss and threatened loss of physicians, which, together with other costs and taxation incurred by health care providers in this state, have created a competitive disadvantage in attracting and retaining qualified physicians and other health care providers."

[12] Sofia Mamakos, *Johnson County medical clinic files for bankruptcy after malpractice lawsuit*, The Daily Iowan, (Nov. 27, 2022), https://dailyiowan.com/2022/11/27/johnson-county-medical-clinic-files-for-bankruptcy-after-malpractice-lawsuit/ .

[13] Statement by The Physician-Directors of Graves Gilbert Clinic (Dec. 30, 2022), https://www.gravesgilbert.com/news/statement-by-the-physician-directors-of-graves-gilbert-clinic/

[14] *Id.*

[15] *Id.*

[16] *Id.*

"Shock verdicts" like this one also contribute to the spread of so-called "defensive medicine" by physicians to protect against litigation.[17] Defensive medicine may result in relatively benign treatment such as excess diagnostic treatment, hospitalization, or consultation. It also can manifest in unfavorable ways, such as when physicians curtail services to avoid high-risk patients or procedures. A powerful example of harmful defensive medicine can be found in neurosurgery, where many hospitals refuse to treat closed-head injuries given the high risk of medical liability involved. While prevalence varies in the literature, defensive medicine is commonplace.[18] In 2005, a survey was taken of physicians practicing in a range of specialties in the commonwealth of Pennsylvania (a state with no non-economic damage caps for medical malpractice actions), wherein more than 92% of physicians reported actively practicing defensive medicine.[19]

As medicine advances, critically ill patients who historically could not be treated become potentially treatable, and the risks of adverse outcomes (and catastrophic damage claims) rise. As the frequency and severity of medical malpractice verdicts rise, premiums for liability insurance will continue to increase. As this occurs in other jurisdictions, the MPLA's caps remain a bulwark from shock verdicts that could result in the decimation of clinical practices and help to reduce incidences of harmful defensive medicine.

Another issue for this Court's consideration is how a jury may find recklessness. Here, the Circuit Court refused to adjust the non-economic damage award to conform with the MPLA's

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[17] Jena A.B., Seabury S., Lakdawalla D., Chandra A., *Malpractice risk according to physician specialty* (N. Engl. J. Med. 2011 Aug 18).

[18] Kessler D, McClellan M., *Do doctors practice defensive medicine*? Quarterly J Econ May. 1996; 111:353-390.

[19] Studdert D.M., Mello M.M., Sage W.M., et al., *Defensive medicine among high-risk specialist physicians in a volatile malpractice environment*. JAMA. 2005; 293:2609-2617.

non-economic caps based on the jury's finding that Dr. Orphanos acted "recklessly." Importantly though (and as will be addressed in detail in this Amici Brief), no expert in this litigation testified that Dr. Orphanos was reckless in his treatment of the Respondent. The proposition that a jury should be allowed to find recklessness in the absence of any expert testimony to this effect, *particularly in a medical malpractice lawsuit,* is patently flawed.

When assessing a health care provider's conduct to evaluate negligence, it is well-settled that their conduct is judged by the standard of how a reasonable and prudent provider in the same practice area would conduct themselves in the same or similar circumstances.[20] This can only be accomplished through expert testimony.[21]

For example, in *Minnich v. MedExpress Urgent Care, Inc.-W. Virginia*, 238 W. Va. 533, 796 S.E.2d 642 (2017), a wrongful death suit was filed after a patient fell while attempting to access an examination table and died of his injuries. The plaintiff argued that the attending medical assistant was not a health care provider, and the fall did not involve health care services but could be judged under a standard of ordinary negligence. This Court rejected this argument, in part, because a jury would lack the ability to ascertain whether the appropriate standard of care had been violated under these circumstances in the absence of expert medical testimony:

> As an additional basis for deciding whether an action falls subject to a state's medical malpractice laws, many states look to "whether expert testimony is necessary to aid the jury's determination of fault, particularly with respect to the 'duty' and 'causation' elements of the claim." Dawkins, 758 S.E.2d at 504; see also Shirley, 587 S.E.2d at 874–75 (discussing existence of "medical question" and application of medical judgments as indicia of whether expert testimony is required to address allegations of ordinary versus professional negligence). The petitioner addresses the issue of whether expert testimony is required in this case in an overly narrow fashion. Omitting the impact of Ms. Hively's knowledge of Mr. Minnich's

[20] W. Va. Code § 55-7B-3.

[21] W. Va. Code § 55-7B-7.

> weakened condition, she suggests that the precautions required to ensure that a footstool is fully extended and "safe to use does not require specialized knowledge." But the issue of negligence, as pled in the complaint, links Ms. Hively's decision not to assist Mr. Minnich onto the examination table with her awareness of his condition and frailties.[22]

Similarly, this Court has often affirmed summary judgment in medical negligence cases due to the absence of competent expert testimony.[23]

W. Va. Code § 55-7B-7(a) plainly states, "The applicable standard of care and a defendant's failure to meet the standard of care, if at issue, *shall* be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court,"[24] and "It is well established that the word 'shall,' in the absence of language

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[22] *Minnich, supra* at 539, 796 S.E.2d at 648.

[23] *See, e.g., J.C. by & through Michelle C. v. Pfizer, Inc.*, 240 W. Va. 571, 584, 814 S.E.2d 234, 247 (2018) ("The development of the Zoloft label required the rendering of medical judgments as to whether essential information concerning risk is sufficiently conveyed; regulatory considerations; and how language in the label might be interpreted by physicians based upon how health services are provided in a given country. Accordingly, we readily reach the same conclusion articulated by the Panel: '[T]he subject matter of the documents relied on by Plaintiffs (animal studies, epidemiology, adverse event reports, core data sheets, FDA regulations) are not within the common knowledge and experience of the average juror" and that "such evidence cannot substitute for expert testimony on the adequacy of the Zoloft label.'"); *In re B.S.*, No. 17-0739, 2018 WL 317056, *3 (Jan. 8, 2018) (memorandum decision) (observing that petitioner had not offered expert to testify that stomach medication was causing her to have false-positive drug screens); *Pendleton v. Wexford Health Sources, Inc.*, No. 15-0014, 2015 WL 8232155, *3 (W.Va. Dec. 7, 2015) (memorandum decision) (agreeing with "the circuit court that expert testimony would be required to prove petitioner's theory of malpractice"); *Dellinger v. Pediatrix Med. Grp., P.C.,* 232 W. Va. 115, 124, 750 S.E.2d 668, 677 (2013) ("While petitioner urges that the jury may nonetheless infer proximate cause notwithstanding her lack of medical testimony on this issue, we find there is quite simply nothing upon which a jury may make such an inference beyond abject speculation."); *Moats v. Preston County Commission*, 206 W.Va. 8, 16, 521 S.E.2d 180, 188 (1999) (noting the case involved "complicated medical issues" and that while there "may be some circumstances where an expert is not needed, such as where a loaded gun is left in the presence of a mentally-ill person," the determination of "whether Valley deviated from the standard of care involves more complex issues that are not within the common knowledge of lay jurors"); *Farley v. Meadows*, 185 W.Va. 48, 404 S.E.2d 537 (1991) (affirming summary judgment where plaintiff lacked expert testimony to support her medical malpractice claim).

[24] (Emphasis supplied).

in the statute showing a contrary intent on the part of the Legislature, should be afforded a mandatory connotation."[25]

It would be incongruous to have a system where a plaintiff is required to have an expert to establish medical professional liability triggering certain damages cap because the "common knowledge of lay jurors" is inadequate to make those determinations in the absence of expert testimony but have those same jurors determine whether the health care provider was "reckless" so a plaintiff can avoid the damages cap based on their "common knowledge" of what constitutes recklessness. Were juries allowed to find recklessness without some evidentiary basis rooted in expert analysis, this would endanger the MPLA's non-economic damage caps by providing an end-around for juries to find reckless conduct with little-to-no evidentiary basis, threatening to upend the intent of the Legislature and stifle the MPLA's essential purpose.

II. AMICI CURIAE

The Amici Curiae, West Virginia University Board of Governors, West Virginia Health Care Association, American Medical Association, West Virginia State Medical Association, West Virginia United Health System, Inc. dba West Virginia University Health System, West Virginia Hospital Association, Mountain Health Network, Defense Trial Counsel of West Virginia, and West Virginia Chamber of Commerce, respectfully submit this Amici Brief in support of the appeal by the Petitioner, John R. Orphanos, M.D. The interests of the Amici, the reasons their Brief is desirable, and the matters addressed are set forth as follows:

A. WEST VIRGINIA UNITED HEALTH SYSTEM, INC. DBA WEST VIRGINIA UNIVERSITY HEALTH SYSTEM. The Amicus, West Virginia United Health System, Inc. dba West

[25] Syl. pt. 1, *Nelson v. W. Virginia Pub. Emps. Ins. Bd.*, 171 W. Va. 445, 300 S.E.2d 86 (1982).

Virginia University Health System "WVUHS," is a nonprofit health enterprise affiliated with West Virginia University. It is West Virginia's largest employer and healthcare provider. WVUHS provides health care services throughout West Virginia and in portions of the surrounding states of Maryland, Ohio, and Pennsylvania. WVUHS consists of more than twenty hospitals throughout its service territory, encompassing more than 1,800 beds, as well as five institutes, including the WVU Cancer Institute, the WVU Critical Care and Trauma Institute, the WVU Eye Institute, the WVU Health and Vascular Institute, and the WVU Rockefeller Neuroscience Institute. In keeping with the legislative findings and declaration of the purpose of the Medical Professional Liability Act "MPLA," WVUHS has an intense interest in ensuring that patients receive the best medical care and facilities available. WVUHS also recognizes that in every human endeavor the possibility of injury or death from negligent conduct commands that protection of the public served by health care providers is a vital state interest; that litigation is an essential component of the state's interest in providing reasonable and adequate compensation to those persons who suffer from injury or death as a result of professional negligence; that any limitation placed on the litigation system must be balanced with and considerate of the need to fairly compensate patients who have been injured as a result of negligent and incompetent acts by health care providers; that liability insurance is a crucial part of the litigation system, affording compensation to the injured while fulfilling the need and fairness of spreading the cost of the risks of injury; and that it is the duty and responsibility of the Legislature to balance the rights of individual citizens to adequate and reasonable compensation with the broad public interest in the provision of services by qualified health care providers and health care facilities who can themselves obtain the protection of reasonably priced and extensive liability coverage. Through

its hospitals and institutes, WVUHS provides the type of emergency medical services at issue in this appeal. WVUHS has a significant interest in seeing that emergency and trauma care services remain available to residents of West Virginia and that the statutory cap on damages is not compromised or eroded contrary to the purpose and language of the statute.

B. WEST VIRGINIA UNIVERSITY BOARD OF GOVERNORS. The Amicus, West Virginia University Board of Governors ("WVUBOG") is a West Virginia state agency, certified by the Legislature, pursuant to W. Va. Code § 18B-2A-1, et seq., as the governing body known as West Virginia University Board of Governors with the mission of general supervision and control over the academic and business affairs of West Virginia University. WVUBOG employs and supervises faculty, resident physicians, and other health care providers who provide medical professional services to patients throughout West Virginia, in in-patient and out-patient settings across various medical specialties. WVUBOG's physicians treat patients on both an acute and chronic basis. WVUBOG's physicians treat patients, such as Respondent Michael Rodgers, who present for trauma care. As health care providers defined by the MPLA, WVUBOG's physicians and other health care providers are vested in preserving and continuing the Trauma Cap codified at W. Va. Code § 55-7B-9c. This interest extends not only to the preservation of the current statutory scheme but also to the efficient and highest quality of health care services to the citizens of the State of West Virginia.

C. WEST VIRGINIA HEALTH CARE ASSOCIATION. The Amicus, West Virginia Health Care Association ("WVHCA") is a trade association representing over 120 nursing facility members, assisted living communities, and residential retirement centers providing health care services in West Virginia. Its members include privately-owned and nonprofit organizations.

WVHCA aims to advance extended-care providers' quality, value, and professionalism to benefit their residents and communities.

D. AMERICAN MEDICAL ASSOCIATION. The Amicus, American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and every state, including West Virginia. The AMA joins this brief on its behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

E. WEST VIRGINIA STATE MEDICAL ASSOCIATION. The Amicus, West Virginia State Medical Association ("WVSMA") is a 501(c)(6) organization comprised of active physicians, retirees, residents, and student members with the mission of advancing health and promoting quality and safety in the practice of medicine in West Virginia by representing the interests of patients, public health, and physicians. Its vision is to serve as the unified voice for the practice of medicine and the premier authority for evidenced-based health policy in West Virginia.

F. WEST VIRGINIA HOSPITAL ASSOCIATION. The Amicus, West Virginia Hospital Association ("WVHA") is a not-for-profit statewide organization representing hospitals and health systems across the continuum of care. The WVHA was founded in 1925 to serve as the

collective voice of the state's hospital community. Today, the mission of the WVHA is to support its members in achieving a strong, healthy West Virginia. WVHA members envision a robust health care system that supports optimizing the health status of West Virginians served by hospitals and improving the state's economic condition. The values of quality, transparency, integrity, collaboration, and innovation guide the actions of the Association so that member hospitals and health systems can provide high-quality, affordable, accessible health care for West Virginia families and communities. WVHA is an integral part of the state's hospital industry and aims to bring value to the health and wellness of West Virginians.

G. MOUNTAIN HEALTH NETWORK, INC. The Amicus, Marshall Health Network, Inc. ("MHN") f/k/a Mountain Health Network, Inc. is West Virginia's second academic health system and third largest health care employer. Marshall Health Network is comprised of Cabell Huntington Hospital ("CHH"), a 303-bed teaching hospital for Marshall University Joan C. Edwards School of Medicine ("JCESOM"), Pharmacy and Nursing; St. Mary's Medical Center ("SMMC"), a 393-bed teaching hospital which operates St. Mary's Schools of Nursing, Respiratory Care and Medical Imaging; Hoops Family Children's Hospital, a 72-bed pediatric specialty hospital within CHH; Huntington Internal Medicine Group ("HIMG"), an 80-member multi-specialty physician group; and Pleasant Valley Hospital ("PVH"), a 101 licensed acute bed hospital. Formally established in 2018, MHN is committed to improving the health and well-being of over one million children and adults in 38 counties in West Virginia, southern Ohio, and eastern Kentucky through understanding, respecting, and meeting their needs. Today, the regional hospital system features three acute care hospitals, one children's hospital, regional affiliates, and

Marshall University School of Medicine with $1.5B operating revenues, nearly 800 inpatient beds, and a significant physician and provider enterprise throughout the Tri-state area.

H. CHARLESTON AREA MEDICAL CENTER, INC. The Amicus, Charleston Area Medical Center, Inc. ("CAMC") is a not-for-profit health care services system comprised of Charleston Area Medical Center, CAMC Foundation, Inc., CAMC Health Education and Research Institute, Inc., CAMC Greenbrier Valley Medical Center, Inc., and CAMC Plateau Medical Center, Inc. CAMC is the second-largest health system in West Virginia, owning and operating a tertiary regional referral center and teaching hospital comprised of four hospital facilities currently licensed for a total of 956 beds, including CAMC General Hospital, CAMC Memorial Hospital, and CAMC Women and Children's Hospital, in Charleston, West Virginia, and CAMC Teays Valley Hospital in Hurricane, West Virginia. CAMC Greenbrier Valley Medical Center operates a 122-bed acute care hospital in Ronceverte, West Virginia. CAMC Plateau Medical Center operates a 25-bed acute care facility in Oak Hill, West Virginia. CAMC employs more than 10,000 people across its various health facilities, and more than 700 doctors have admitting privileges across this system. CAMC is the accredited sponsoring institution for 21 graduate medical education residency/fellowship programs, three pharmacy residency programs, a doctoral psychology internship program, and a School of Nurse Anesthesia. CAMC has one of the top heart programs in the United States; is a Robotic and Urology Center of Excellence; has the highest-level newborn intensive care unit and pediatric intensive care unit in West Virginia; and is one of the busiest Level I Trauma Centers in the state.

I. DEFENSE TRIAL COUNSEL OF WEST VIRGINIA. The Amicus Defense Trial Counsel of West Virginia ("DTCWV") is an organization of over 400 attorneys who engage

primarily in the defense of individuals and corporations in civil and administrative litigation in West Virginia. DTCWV is an affiliate of the Defense Research Institute, a nationwide organization of over 14,000 attorneys committed to research, innovation, and professionalism in the civil defense bar. DTCWV's goals include elevating the standards of legal practice within West Virginia, promoting the improvement of the administration of justice in West Virginia, and increasing the quality of legal services provided to our citizens. DTCWV is interested in the outcome of this matter because of this Court's interpretation of tort liability.

DTCWV is well-positioned to aid the Court's consideration of this appellate proceeding. At the threshold, DTCWV members routinely represent parties subject to the MPLA, and the statute's purpose, scope, and application have long been studied, understood, and employed by DTCWV's membership. As outlined in this Amici Brief, the Circuit Court's determination that the Respondent could present an argument to the jury that the Petitioner's actions were "reckless" without expert witness testimony establishing that level of violation of the standard of care is inconsistent with MPLA, its legislative purpose, and the civil rules. The evidentiary rulings are outliers that this Court should correct, and issuing a decision confirming the correct evidentiary standard for proving liability under the Trauma Cap will ensure the trial courts of this State correctly and uniformly apply the MPLA.

J. WEST VIRGINIA CHAMBER OF COMMERCE. The Amicus, West Virginia Chamber of Commerce ("Chamber") is dedicated to making West Virginia a better place to do business by giving private-sector employers a voice in state politics and protecting business interests before regulatory bodies, the Legislature, and the Courts.

The Amici have a vested interest in the continued efficient provision of health care services to the citizens of West Virginia. This interest is best promoted through the predictable litigation of health care claims under the statutory scheme of the MPLA consistent with the Legislature's purpose in balancing the safe and efficient provision of health care services with the affordability of the same. The Amici concur in the Legislative recognition of the fact that the unpredictable nature of traumatic injury health care services often results in a greater likelihood of unsatisfactory patient outcomes, a higher degree of patient and patient family dissatisfaction, and frequent malpractice claims, creating a financial strain on the trauma care system of West Virginia, increasing costs for all users of the trauma care system, and impacting the availability of these services.

The Amici agree with the Legislature's recognition that this fact requires appropriate and balanced limitations on the rights of persons asserting claims against trauma care health care providers, that this balance must guarantee the availability of trauma care services while mandating that these services meet all national standards of care, and to assure that our health care resources are being directed towards providing the best trauma care available, which culminated in the enactment of the Trauma Cap codified at W. Va. Code § 55-7B-9c.

The Amici agree with the Petitioner, John R. Orphanos, M.D. ("Petitioner"), that the Circuit Court committed a substantial legal error when it permitted the jury to consider the issue of "recklessness" under W. Va. Code § 55-7B-9c in the absence of competent evidence in the record to support such a finding and in contravention to the spirit and intent of the Trauma Cap.

This Court has previously granted motions for leave and considered amicus curiae briefs filed by non-parties with interest in the outcome of an appellate matter,[26] and this came Amici were granted leave in this case to file a brief in the Intermediate Court of Appeals.

III. STATEMENT OF THE CASE

The words "reckless," "recklessness," or "recklessly" appear 295 times in the appendix, but not a single witness, including an expert, ever uttered the word at trial. Without any witnesses

[26] *See, e.g., State ex rel. W. Virginia Acad., LTD v. W. Virginia Dep't of Educ.*, No. 21-0097, 2021 WL 2435876, at *1 (W. Va. June 15, 2021) ("We acknowledge and appreciate the amicus curiae brief filed by Katie Switzer, a parent who is interested in sending her children to a public charter school, in support of WV Academy's petition for mandamus.") (memorandum decision); *State ex rel. Maynard v. Just.*, 245 W. Va. 179, 181, 858 S.E.2d 229, 231 (2021) ("On February 5, 2021, Jason Stephens, an unsuccessful candidate for the Nineteenth Delegate District House of Delegates seat, filed a motion to intervene or, in the alternative, for leave to file an amicus curiae brief. The Court granted Mr. Stephens leave to file an amicus brief, which was filed on February 8, 2021. This Court appreciates the submission of the amicus curiae."); *Stacy J. v. Christopher H.*, No. 20-0074, 2021 WL 357776, at *1 (W. Va. Feb. 2, 2021) ("On June 30, 2020, petitioner's eighteen-year-old son, D.K., filed a motion to file an amicus brief with the amicus brief attached thereto. By order entered on August 27, 2020, this Court granted D.K.'s motion. The Court appreciates having D.K.'s views on this matter.") (memorandum decision); *Jefferson Cnty. Vision, Inc. v. Pub. Serv. Comm'n of W. Virginia*, No. 19-0774, 2020 WL 3172864, at *1 (W. Va. June 15, 2020) ("Christopher P. Stroech appeared on behalf of JCV, and John J. Meadows, Todd Swanson, Peter J. Raupp, and Ryan D. Ewing represented JUI. Jessica M. Lane and Natalie N. Terry responded for the Commission. Susan J. Riggs filed an amicus curiae brief on behalf of Roxul, USA, Inc., in support of the Commission's decision.") (memorandum decision); *W. Virginia Bd. of Educ. v. Bd. of Educ. of the Cnty. of Nicholas*, 239 W. Va. 705, 708, 806 S.E.2d 136, 139 (2017) ("The Court wishes to acknowledge and express its appreciation for the contributions of the amici curiae. Briefs were submitted on behalf of Richwood High School Alumni Association, American Federation of Teachers-West Virginia, Sharon Glasscock, Michael Fox, and Jocelyn Swearingen in support of the WVBOE's position. Briefs were likewise submitted on behalf of the West Virginia School Board Association in support of the Board's position."); *State ex rel. Perdue v. Nationwide Life Ins. Co.*, 236 W. Va. 1, 5, 777 S.E.2d 11, 15 (2015) ("We acknowledge the individual contributions of Xerox State & Local Solutions, Inc., d/b/a Xerox Unclaimed Property Clearinghouse, and of National Association of Unclaimed Property Administrators, each of which we thank for its assistance."); *Am. Bituminous Power Partners, L.P. v. Horizon Ventures of W. Virginia, Inc.*, No. 14-0446, 2015 WL 2261649, at *1 (W. Va. May 13, 2015) ("We wish to acknowledge the Amicus Curiae brief filed by the Bank Group Lenders in support of AMBIT.") (memorandum decision); *In re A.C.*, No. 12-0726, 2012 WL 5205707, at *1 (W. Va. Oct. 22, 2012) ("The child's adoptive parents, C.B. III and J.B., have also filed an amicus curiae brief, by counsel Clyde A. Smith Jr.") (memorandum decision); *State v. McLaughlin*, 226 W. Va. 229, 231, 700 S.E.2d 289, 291 (2010) ("The Court considered the amicus curiae briefs submitted on behalf of Shane Shelton and Jeffrey L. Finley, two defendants who, like the Defendant herein, are awaiting retrial of the penalty or mercy phase after having been convicted of first degree murder."); *In re Flood Litig. Coal River Watershed*, 222 W. Va. 574, 576, 668 S.E.2d 203, 205 (2008) ("Amicus Curiae for Alex Energy, et al."); *Phillips v. Larry's Drive-In Pharmacy, Inc.*, *supra* at 487, 647 S.E.2d at 923 ("We acknowledge the assistance of the National Association of Chain Drug Stores, Rite Aid of West Virginia, Inc., and the West Virginia Pharmacists Association, Inc., who submitted amicus curiae briefs in support of the defendant's position.").

testifying that the Petitioner was reckless and without any expert witness testifying as to the same, the jury was instructed that the Respondent "asserts … that it was reckless for the Defendant not to have performed a pre-operative MRI and not to have ordered IONM to monitor the spinal cord during surgery."[27] These two theories of recklessness were repeated in Respondent's opposition to Petitioner's post-trial motion to apply the statutory Trauma Cap: "Defendant recklessly failed to obtain the testing necessary to insure [sic] a safe and successful surgery. Before surgery, Defendant failed to order an MRI of the thoracic spine, relying instead on an earlier CT of the chest. … Defendant also failed to perform any intraoperative monitoring …."[28] Although the jury was never instructed on the same and, again, heard no expert testimony relative to any recklessness standard, the Respondent also argued post-trial that "Before surgery," the Petitioner "ordered a CT of the spine, but he did not order a postoperative CT myelogram," which the Respondent, again with absolutely no trial testimony, characterized as "recklessly failed to obtain the necessary testing."[29] The Court will notice that none of these three complaints – the failure to order a preoperative MRI, the failure to order intraoperative monitoring, and the failure to order a postoperative CT scan – are acts of commission commonly associated with recklessness, like performing surgery under the influence of alcohol or other substances, but are alleged acts of omission, i.e., falling below the standard of care regarding presurgical, surgical, and postsurgical testing and monitoring, which would be commonly present in every medical negligence case arising

[27] App. 1418.

[28] App. 1429.

[29] *Id.*

from surgery. This evidence of recklessness by omission is insufficient even under Comment (g) to Section 500 of the RESTATEMENT (SECOND) OF TORTS:

> Reckless misconduct differs from negligence in several important particulars. It differs from that form of negligence which consists in mere inadvertence, incompetence, unskillfulness, or a failure to take precautions to enable the actor adequately to cope with a possible or probable future emergency, in that reckless misconduct requires a *conscious choice of a course of action, either with knowledge of the serious danger to others involved in it or with knowledge of facts which would disclose this danger to any reasonable man*. It differs not only from the above-mentioned form of negligence but also from that negligence which consists in *intentionally doing an act with knowledge that it contains a risk of harm to others, in that the actor to be reckless must recognize that his conduct involves a risk substantially greater in amount than that which is necessary to make his conduct negligent*. The difference between reckless misconduct and conduct involving only such a quantum of risk as is necessary to make it negligent is a difference in the degree of the risk, but this difference of degree is so marked as to amount substantially to a difference in kind.[30]

Here, no evidence was presented to the jury to make this determination. Instead, it heard expert evidence of medical negligence and the argument of counsel that the alleged acts of omission – preoperative testing, surgical monitoring, and postoperative testing – were "reckless." Critically, the Petitioner offered expert testimony that the standard of care did not require a preoperative MRI because the CT was sufficient;[31] that the standard of care did not require the operative monitoring because it would have been unreliable and, if used, would not have prevented

[30] (Emphasis supplied).

[31] App. 3543-3545 ("In your opinion, was a preop MRI required? … No. … I would say in about 30 percent of the patients that come in with fractures that are neurologically normal, we don't get MRI scans. … I could see everything I needed to see on the CT scan. … if he was my patient, I wouldn't have ordered an MRI scan. … There is tons of patients at Vanderbilt that are just like Mr. Rodgers that we never get an MRI scan on.").

the Respondent's paraplegia;[32] and that the standard of care did not require a postoperative CT myelogram because it would have taken too long to administer to have been effective.[33]

The Respondent suffered a severe motorcycle accident and was transported to Charleston Area Medical Center, where he was diagnosed with a T5 fracture.[34] The Respondent was given a choice of treatment and elected a surgical fixation.[35] Unfortunately, the surgical repair was unsuccessful, rendering the Respondent a paraplegic.[36] The Respondent presented expert testimony regarding alleged breaches of the standard of care. The Petitioner presented expert testimony regarding compliance with the standard of care, with testimony that the Petitioner's expert would have made the same decisions based on the circumstances presented and that none of those decisions proximately caused the Respondent's paraplegia.

Under our justice system, it is one thing to leave to a jury the decision to resolve disputes over whether a health care provider violated the standard of care. It is quite another to have a jury find that a provider was reckless in the face of competent expert testimony that a comparable expert would have made the same decisions under the same circumstances.

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[32] App. 3555-3559 ("That's not what monitoring – the technology isn't that good. We wish it was much better. We wish it was reliable, but it's not. And to say that it is, is just incorrect. … 75 percent of the time it was a false alarm, and that's the problem. It's a false alarm. I stopped your surgery. I changed your operation for no reason at all. … And unfortunately the vast majority of times when you lose signals and it's real, you can't change anything. And that's what happened with Mr. Rodgers. … But the monitoring wouldn't have made any difference because the monitoring would have gone off … the stroke has occurred. You can't reverse it. … because it's so misleading, a lot of us don't like to use it. … it's not the standard of care.")

[33] App. 3561 ("it would take hours for us to get a stat emergency myelogram, and I know that. I mean, we've tried, but it takes hours. It's maybe three to four hours. And in this particular case, you don't have that kind of time. … A screw that's sticking into the spinal cord I could see on a plain CT. … I think he did exactly what – I know that he did exactly what I would have done.").

[34] App. 794-795.

[35] App. 795.

[36] App. 796.

Accordingly, the Amici Curiae, West Virginia University Board of Governors, West Virginia Health Care Association, American Medical Association, West Virginia State Medical Association, West Virginia United Health System, Inc. dba West Virginia University Health System, West Virginia Hospital Association, Mountain Health Network, Inc., Charleston Area Medical Center, Inc., Defense Trial Counsel of West Virginia, and West Virginia Chamber of Commerce, join in the request of the Petitioner, Michael R. Orphanos, M.D., that the judgment of the Circuit Court of Kanawha County is set aside, and the case remanded for application of the Trauma Cap to the jury's verdict.

IV. DISCUSSION OF LAW

A. W. VA. CODE § 55-7B-9C(H)(1)'S TRAUMA CAP REQUIRES EXPERT OR OTHER COMPETENT EVIDENCE OF A "RECKLESS DISREGARD OF A HARM TO THE PATIENT," WHICH DIFFERS FROM ORDINARY COMMON LAW RECKLESSNESS.

Notwithstanding Respondent's contrary arguments, the primary issue, in this case,[37] involves statutory construction. Specifically, the Legislature's intent by the following exception to the $500,000 trauma center damages cap: "reckless disregard of a risk of harm to the patient."[38] Amici respectfully submit that the Legislature did not intend to permit a trauma center patient to avoid the cap by substituting "reckless" for "negligent" in pleadings, instructions, and arguments to a jury without any supporting expert testimony or other competent evidence. The central fallacy

[37] For example, Respondent's repeated invocations of *Shamblin v. Nationwide Mut. Ins. Co.*, 185 W. Va. 585, 396 S.E.2d 766 (1990), App. 1473-1474, 2060-2061, 1968, and 3713, are irrelevant as this Court has rejected the use of a first-party insurance statute by a third-party medical negligence plaintiff to avoid the application of caps under the Medical Professional Liability Act. Similarly, this Court has consistently rejected Respondent's repeated arguments regarding equal protection, App. 1381-1383, 1941-1948, 1950, 3664-3666, *see MacDonald v. City Hosp., Inc.*, 227 W. Va. 707, 715 S.E.2d 405 (2011); *Verba v. Ghaphery*, 210 W. Va. 30, 552 S.E.2d 406 (2001); *Robinson v. Charleston Area Med. Ctr., Inc.*, 186 W. Va. 720, 414 S.E.2d 877 (1991).

[38] W. Va. Code § 55-7B-9c(h)(1).

in the Respondent's argument is that he focuses on the word "reckless" and ignores the accompanying "*disregard of a risk of harm to the patient*,"[39] rendering his repeated references to the common law standard of recklessness used in other contexts inconsequential.[40]

When determining a statute's meaning, this Court has held that "[t]he primary object in construing a statute is to ascertain and give effect to the intent of the Legislature."[41] As such, "[t]he basic and cardinal princip[le], governing the interpretation and application of a statute, is that the Court should ascertain the intent of the Legislature at the time the statute was enacted, and in the light of the circumstances prevailing at the time of the enactment."[42] "A statute should be so read and applied as to make it accord with the spirit, purposes and objects of the general system of law of which it is intended to form a part; it being presumed that the legislators who drafted and passed it were familiar with all existing law, applicable to the subject matter, whether constitutional, statutory or common, and intended the statute to harmonize completely with the same and aid in the effectuation of the general purpose and design thereof, if its terms are consistent therewith."[43]

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[39] For example, the Respondent's jury instructions used the terms "reckless in the care," "reckless for the Defendant," "recklessly in his care," and "recklessly injure or hurt a patient, App. 1365 and 1376, omitting the key statutory language "disregard of a risk of harm to the patient," which is qualitatively and quantitatively different.

[40] It is not inconsequential that, to establish venue arising from a third-party medical negligence claim, the Legislature intentionally selected a lower, common-law threshold. See Syl. pt. 3, *State ex rel. W. Virginia Univ. Hosps., Inc. v. Nelson*, 245 W. Va. 150, 857 S.E.2d 923 (2021) ("For purposes of determining venue, the cause of action for a third-party medical negligence claim pursued under West Virginia Code § 55-7B-9b (2003) arises in the county where the provider rendered or failed to render healthcare services with allegedly willful and wanton or reckless disregard of a foreseeable risk of harm to third persons.").

[41] Syl. pt. 1, *Smith v. State Workmen's Comp. Comm'r*, 159 W. Va. 108, 219 S.E.2d 361 (1975).

[42] Syl. pt. 1, *Pond Creek Pocahontas Co. v. Alexander*, 137 W. Va. 864, 74 S.E.2d 590 (1953).

[43] Syl. pt. 11, *Rice v. Underwood*, 205 W. Va. 274, 277, 517 S.E.2d 751, 754 (1998) (quotation marks and citations omitted).

Recently, in *State ex rel. W. Virginia Univ. Hosps., Inc. v. Scott*, this Court observed, "The 2015 amendment added the following sentence to the definition of 'medical professional liability': 'It also means 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.' … This addition to 'medical professional liability' combined with the broadened definition of 'health care,' expanded what services, and therefore what claims, are included in the definition of 'medical professional liability.'"[44]

The MPLA has defined the elements of every cause of action for medical negligence to include (1) failure "to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances" and (2) "Such failure was a proximate cause of the injury or death."[45] A screening certificate is required if a plaintiff intends to establish a cause of action based on medical negligence.[46] If the plaintiff relies upon a theory other than medical negligence, e.g., recklessness, "which does not require expert testimony supporting a breach of the applicable standard of care, the claimant or his or her counsel shall file a statement specifically setting forth the basis of the alleged liability of the health care provider in lieu of a screening certificate of merit."[47] In this case, *no statement was filed* by the Respondent or his counsel "*specifically setting forth the basis of the alleged liability of the health care provider in lieu of a screening*

[44] 246 W. Va. 184, 193, 866 S.E.2d 350, 359 (2021).

[45] W. Va. Code § 55-7B-3(a).

[46] W. Va. Code § 55-7B-6(b) ("The notice of claim shall include a statement of the theory or theories of liability upon which a cause of action may be based, and a list of all health care providers and health care facilities to whom notices of claim are being sent, together with a screening certificate of merit.").

[47] W. Va. Code § 55-7B-6(c).

certificate of merit" because his claim was not based on a theory independent of medical negligence. Rather, it was grounded in negligence, which triggered (1) the requirement of a screening certificate of merit as noted and (2) proof of a breach of the standard of care under W. Va. Code § 55-7B-7(a).[48] Only where competent expert evidence is presented that a health care provider displayed a "reckless disregard of harm to the patient" is the statutory exception satisfied because, as our Court recently noted, the core purpose of the statute is as follows: "The total amount of damages recoverable from an emergency medical provider was capped at $500,000.00."[49]

In *Mandeville v. Nathanson*,[50] for example, Judge Berger denied a motion for summary judgment in a case involving the Trauma Cap reasoning as follows:

> Reviewing these facts, the Plaintiff's expert witness, Dr. Galen, reported that "[d]ue to Dr. Nathanson's *reckless disregard* for the consequences of the lack of: diagnostic testing, initiation of appropriate antibiotics, appropriate consultation and admission to the hospital" on September 6, 2012, Mr. Dew "languished unnecessarily at home" and "developed progressive sepsis ..." (Report of Dr. Galen, att'd as Ex. J to Def's Mot. for Summ. J., at 3.) The Defendant attempts to mitigate this adverse fact by asserting that Dr. Galen "will say any magic words requested by counsel if the Court permits her." (Def.'s Reply, at 8.) However, the facts of record and the report of Dr. Galen create a genuine issue of material fact as to whether Dr. Nathanson's conduct was such that the Plaintiff could recover punitive damages.

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[48] "The applicable standard of care and a defendant's failure to meet the standard of care, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court."

[49] *Phillips v. Larry's Drive-In Pharmacy, Inc.*, 220 W. Va. 484, 490 n.8, 647 S.E.2d 920, 926 n.8 (2007).

[50] No. 5:14-CV-25013, 2016 WL 3566241, at *4 (S.D.W. Va. June 24, 2016) (emphasis supplied).

Similarly, Judge Berger's rejection of the Trauma Cap in *Lambert v. United States*[51] turned on competent expert testimony that the health care services provided were "reckless," applying the appropriate standards of care:

> Dr. Irvin testified that, had Dr. Wolfe employed the treatments required by the standard of care and/or transferred Ms. Smith to a facility with the ability to perform uterine artery embolization and with more expertise on the other treatment modalities, she would have been likely to retain her uterus and fertility. He gave the opinion that Dr. Wolfe's treatment was *reckless and fell egregiously below the standard of care*. … The Court credits Dr. Irvin's very thorough, well researched analysis, particularly in light of the Court's finding that there is little evidence to support a diagnosis of placenta accreta.

Respondent's argument to the trial court in this case that Judge Berger's "analysis of the recklessness issue did not cite the testimony of any experts"[52] in *Lambert* is at best misleading and at worst simply wrong as it turned on an expert's "opinion that Dr. Wolfe's treatment was *reckless and fell egregiously below the standard of care*." Likewise, Respondent's argument to the trial court that W. Va. Code § 55-7B-9c(h)(1) was not an issue in *Mandeville*[53] is incorrect: "Defendant argues that in light of this liability limitation, and the Plaintiff's failure to plead facts which support an exception to the liability cap that is '[i]n willful and wanton or reckless disregard of a risk of harm to the patient,' under Section 55-7B-9(f)(1) of the MPLA, the Plaintiff's claim cannot survive summary judgment."[54]

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[51] No. 14-CV-30075, 2016 WL 6782748, at *6 (S.D.W. Va. Nov. 15, 2016) (emphasis supplied).

[52] App. 2358.

[53] App. 2359 ("the issue in Mandeville was not whether Defendant was reckless for purposes of W. Va. Code §55-7B-9c(h)(1)").

[54] *Mandeville, supra* at *3.

Faced with the only two cases relying on expert testimony in applying the recklessness exception to the Trauma Cap,[55] Respondent referenced two non-West Virginia cases below.

In the first, *Szymanski v. Hartford Hosp.*,[56] the recklessness claim was based on allegations that a defendant nurse turned off a dialysis monitor and left the patient unattended, after which he bled to death, and her employer falsely advised his family that he died of natural causes, presenting circumstances which the court found together with expert testimony regarding the breach of the applicable standard of care was sufficient to survive a summary judgment motion. Nothing remotely like those facts is present in the instant case.

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[55] Although not a Trauma Cap case, in *Stephens v. Rakes*, 235 W. Va. 555, 566-567, 775 S.E.2d 107, 118-119 (2015) (emphasis supplied), the Court likewise relied on competent medical expert testimony to satisfy a recklessness requirement:

> In response to Dr. Stephens' motion for summary judgment, Mr. Rakes provided evidence that Dr. Stephens' care of the decedent was "dangerous and, at the very least, reckless." In addition to setting forth various criticisms of Dr. Stephens' actions, or inactions, regarding the decedent's medical care (which were discussed more thoroughly above), Dr. Schwartz's testimony sufficiently established Dr. Stephens' wanton negligence and reckless conduct:
>
> > So he got sedated when he shouldn't. He didn't get a bedside sitter to control his agitation if that was deemed necessary. He didn't get BiPAP when he needed it. He didn't get carbon dioxide levels measured and followed up. He didn't get a pulmonary consult. He didn't get any treatment for his COPD once he left the emergency room. He didn't get any of the care that he received on previous hospitalizations for respiratory failure. *So this was as bad a care as I've ever seen in my 30 years in a three-day hospitalization.*
>
> Furthermore, Dr. Scissors testified at trial that allowing a patient such as the decedent to remain sedated, placed in wrist restraints, and laid flat on his back with no ventilatory support was more than dangerous; this was "reckless."
>
> Upon review of all of the evidence presented at trial, we conclude that there was sufficient testimony presented for a jury to be convinced that willful, wanton and reckless conduct occurred warranting punitive damages …

See also TRIAL HANDBOOK FOR WEST VIRGINIA LAWYERS § 35:47 (*citing Rakes*).

[56] No. CV 89 03 63 831S, 1993 WL 89068 (Conn. Super. Ct. Mar. 12, 1993).

In the second, *Jamas v. Krpan*,[57] In a 1977 case, the court applied a common-law standard long ago abandoned in West Virginia: "[T]he negligence of the physician must be proved by expert medical testimony unless the negligence was so grossly apparent that a lay person could easily recognize it." It offers nothing in the context of this case.[58]

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[57] 116 Ariz. 216, 217, 568 P.2d 1114, 1115 (Ct. App. 1977).

[58] Respondent also cited the case of *Ballard v. Kerr*, 160 Idaho 674, 709, 378 P.3d 464, 499 (2016), but the statute was substantially different: "this cap on awards of non-economic damages shall not apply to '[c]auses of action arising out of willful or reckless misconduct.' I.C. § 6–1603(4)(a)" without the "disregard of a risk of harm to the patient" language of the West Virginia statute. This same common law "reckless misconduct" language, untethered to the accompanying "disregard of a risk of harm to the patient," was also involved in the recent case of *Mattson v. Idaho Dep't of Health & Welfare*, No. 49187, 2023 WL 3236922 (Idaho May 4, 2023), where the Idaho Tort Claims Act provided immunity except for "reckless, willful and wanton conduct." Indeed, the Idaho statute at issue in *Mattson*, Idaho Code Ann. § 6-904A, cross-references the following statutory definition of "Reckless, willful and wanton conduct": "when a person intentionally and knowingly does or fails to do an act creating unreasonable risk of harm to another, and which involves a high degree of probability that such harm will result. Idaho Code Ann. § 6-904C.2. In other West Virginia immunity or damages limitation statutes, the Legislature adopted similar common law "willful, wanton or reckless misconduct" standards, *see* W. Va. Code § 8-15-8c(a) ("no person, company or other organization who donates fire control or rescue equipment, including federal excess or surplus property, to a volunteer fire department is subject to civil liability for any personal injury, property damages or death resulting from any defect in the equipment unless the person, company or organization acted with malice, gross negligence, recklessness or intentional misconduct which proximately caused the personal injury, property damages or death"); W. Va. Code § 15-5-22 ("Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence or recklessness."); W. Va. Code § 16-5B-19(g)(2) ("A hospital police officer shall not be subject to civil or criminal liability unless one of the following applies … His or her acts or omissions were with malicious purpose, in bad faith, or in a wanton or reckless manner."); W. Va. Code § 16-47-6 ("Except in cases of willful, wanton or reckless misconduct, law-enforcement personnel are immune …."); W. Va. Code § 16-64-8(e) ("A business that has syringe litter on its property is immune from civil or criminal liability in any action relating to the needle on its property unless the business owner acted in reckless disregard for the safety of others."); W. Va. Code § 17C-2-5(d) ("The foregoing provisions shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons, nor shall such provisions protect the driver from the consequences of his reckless disregard for the safety of others."); W. Va. Code § 17F-1-2(f) ("No state institution of higher education, which operates, owns, trains or promotes an all-terrain vehicle rider safety awareness course approved by the commissioner, pursuant to this section, is liable for personal injuries to, or for the death of, a rider that may occur during an approved all-terrain vehicle rider safety awareness course, unless an employee or agent of the state institution of higher education's acts or omissions are with malicious purpose, in bad faith, or

undertaken in a wanton or reckless manner."); W. Va. Code § 17G-1-3 ("Any law-enforcement officer who, in good faith, records traffic stop information under the requirements of section two of this article may not be held civilly liable for the act of inaccurately recording the information unless the officer's conduct was unconstitutional, unreasonable, intentional or reckless."); W. Va. Code § 19-30-4 ("Any person who makes a good faith donation of prepared or perishable food which appears to be fit for human consumption at the time it is donated to a charitable or nonprofit organization is not liable for damages in any civil action or subject to criminal prosecution for any injury or death due to the condition of the food unless the injury or death is a direct result of the gross negligence, recklessness or intentional misconduct of the donor."); W. Va. Code § 20-3-4 ("The limitation of liability established by the preceding sentence shall not apply if the death, personal injury or property damage alleged was caused by such person's willful or criminal misconduct, gross negligence or reckless misconduct …."); W. Va. Code § 22-7-6(b)(1)(A) ("Nothing in this article shall limit in any way the liability of a project sponsor which liability results from the reclamation project or the water pollution abatement project and which would otherwise exist … For injury or damage resulting from the project sponsor's acts or omissions which are reckless or constitute gross negligence or willful misconduct."); W. Va. Code § 22-27-5(c)(1) ("Nothing in this article may limit an eligible landowner's liability which results from a reclamation project or water pollution abatement project and which would otherwise exist …For injury or damage resulting from the landowner's acts or omissions which are reckless or constitute gross negligence or willful misconduct."); W. Va. Code § 29-12A-5(b)(2) ("An employee of a political subdivision is immune from liability unless one of the following applies … His or her acts or omissions were with malicious purpose, in bad faith, or in a wanton or reckless manner."); W. Va. Code § 29-30-10(b) ("This section does not limit the liability of a volunteer health practitioner for … Willful misconduct or wanton, grossly negligent, reckless or criminal conduct."); W. Va. Code § 44D-10-1002(b) ("A trustee is not entitled to contribution if the trustee was substantially more at fault than another trustee or if the trustee committed the breach of trust in bad faith or with reckless indifference to the purposes of the trust or the interests of the beneficiaries."); W. Va. Code Ann. § 49-2-128(g) ("A caregiver is not liable for harm caused to a child in his or her care who participates in an activity approved by the caregiver, provided that the caregiver has acted as a reasonable and prudent foster parent, unless the foster parent commits an act or omission that is an intentional tort or conduct that is willful, wanton, grossly negligent, reckless, or criminal."); W. Va. Code § 55-7B-9b ("An action may not be maintained against a health care provider pursuant to this article by or on behalf of a third-party nonpatient for rendering or failing to render health care services to a patient whose subsequent act is a proximate cause of injury or death to the third party unless the health care provider rendered or failed to render health care services in willful and wanton or reckless disregard of a foreseeable risk of harm to third persons."); W. Va. Code § 55-19-5(c) ("The limitations on liability provided in this section shall not apply to any person, or any employee or agent thereof, that … Had actual knowledge of a defect in the product when put to the use for which the product was manufactured, sold, distributed, or donated; and acted with conscious, reckless, and outrageous indifference to a substantial and unnecessary risk that the product would cause serious injury to other."); W. Va. Code § 60A-10-5(g)(2) ("Absent negligence, wantonness, recklessness or deliberate misconduct, any retailer utilizing the Multi-State Real-Time Tracking System in accordance with this subdivision may not be civilly liable as a result of any act or omission in carrying out the duties required by this subdivision and is immune from liability to any third party unless the retailer has violated any provision of this subdivision in relation to a claim brought for the violation.").

Courts have relied on expert testimony in the context of a recklessness requirement in medical malpractice cases.[59] Indeed, as one court has observed:

> As noted above, plaintiff needed to have Dr. Weiss characterize how very bad the medical care given to plaintiff was so that recklessness could be proven. The jury would have no effective way of assessing defendant's conduct unless this type of testimony was elicited. The questions did not simply call for legal conclusions. A medical malpractice case is " * * * 'one of the classic examples of the *necessity* of expert opinion testimony as to the ultimate issue.' * * * " (Emphasis sic.) *Alexander v. Mt. Carmel Med. Ctr.* (1978), 56 Ohio St.2d 155, 162, 10 O.O.3d 332, 336, 383 N.E.2d 564, 568. Like necessary testimony from a physician about whether a defendant doctor deviated from the accepted standard of care, necessary testimony about the extent of the deviation should be allowed when recklessness or higher culpability is in issue.[60]

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[59] *See, e.g., Corrigan v. Methodist Hosp.*, 869 F. Supp. 1202, 1207 (E.D. Pa. 1994) ("Corrigan alleges that all defendants knowingly performed experimental surgery on her, without her consent, and with disastrous results. Corrigan's experts, including Carl A. Larson, Ph.D, P.E., Director, Division of Surgical and Rehabilitation Devices at the FDA during the time Acromed sought approval for use of the VSP Screws, have opined that the VSP Screws were an experimental device. Corrigan alleges that Davne knowingly used the VSP Screws in her surgery. A jury may well find that this is outrageous."); *McGee v. Bruce Hosp. Sys.,* 321 S.C. 340, 346, 468 S.E.2d 633, 637 (1996) ("[T]here was testimony Dr. Pearson should have re-positioned the catheter. Dr. Pearson argues he carefully weighed the risks of re-positioning the catheter and decided to leave it in its original position. Dr. Pearson may have made a conscious decision to leave the catheter in its original position. However, this conscious decision does not mean he acted without wilfulness or recklessness. There was evidence to establish recklessness because several experts testified moving the catheter posed no risks."); *Crystal v. Midatlantic Cardiovascular Assocs., P.A.,* 227 Md. App. 213, 133 A.3d 1198 (2016) (mere difference of opinion between expert witnesses concerning applicable standard of care was insufficient to establish fraud as there was no evidence the physician knew the falsity of his diagnosis or was recklessly indifferent to the truth of his assessment of plaintiff's medical condition); *Tatum v. Gigliotti*, 80 Md. App. 559, 569, 565 A.2d 354 (1989) (holding in context of Good Samaritan statute that emergency medical technician's failure to properly treat asthma patient did not constitute gross negligence, where even plaintiff's expert did not testify that defendant's actions constituted "reckless disregard for human life").

[60] *Lambert v. Shearer*, 84 Ohio App. 3d 266, 276, 616 N.E.2d 965, 971 (1992); *see also Birchfield v. Texarkana Mem'l Hosp.*, 747 S.W.2d 361, 365 (Tex. 1987) ("The Birchfields' expert witness testified on direct examination that Wadley's conduct constituted 'negligence,' 'gross negligence,' and 'heedless and reckless conduct,' and that certain acts were 'proximate causes"' of Kellie's blindness. Contrary to the holding of the court of appeals, such testimony is admissible. TEX. R. EVID. 704. Fairness and efficiency dictate that an expert may state an opinion on a mixed question of law and fact as long as the opinion is confined to the relevant issues and is based on proper legal concepts."); Opinion on Ultimate Issue., UNIF. RULES OF EVIDENCE 74 Rule 704 ("Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.") (*citing Lambert*).

Similarly, in *Christensen v. Cooper*,[61] where the patient needed to establish "reckless disregard" for purposes of a Good Samaritan Act[62] that otherwise immunized the defendants, the court reasoned as follows:

> Our de novo review of the propriety of the directed verdict is focused on the sufficiency of Appellant's expert's testimony that the medical care given by Dr. Cooper amounted to a "reckless disregard for the consequences," which, because of the statutory definition of that phrase, turns on whether sufficient evidence was admitted that Dr. Cooper "should have known" that his acts or omissions "would be likely to result in injury" to Mr. Christensen. The parties agree that the Act is intended to establish the standard of care that applies to emergency room doctors for unstable patients. They disagree, however, whether the standard of care established by the Act is ordinary negligence or something more stringent. We think this debate is largely academic because, regardless of which legal label is attached, the issue we must resolve is whether the proof was sufficient under the Act, based on the language of the Act.
>
> *The essence of Dr. Neimann's opinion was that Dr. Cooper should have recognized that Mr. Christensen was bleeding internally and needed immediate surgical intervention. Employing the Act's definition for reckless disregard, he concluded that Dr. Cooper should have known that these omissions would likely result in injury to Mr. Christensen*. During voir dire, counsel for Appellees asked Dr. Neimann questions regarding Dr. Neimann's interpretation of the meaning of "reckless disregard." In response to questions posited by defense counsel, Dr. Neimann opined that "reckless disregard," as defined by the statute, was, in his view, no different from the standard of care applicable in an ordinary medical negligence analysis. Seizing on this testimony, Appellees argued that Dr. Neimann had applied the wrong standard of care. The trial court agreed and granted the directed verdict.
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> *On appeal, Appellees concede that Dr. Neimann said the "magic words." In other words, they concede that Dr. Neimann stated his opinion using the language of the statute. Appellees also acknowledge that the evidence code permits this form of testimony by experts*. They argue, however, that the voir dire and cross examinations revealed that the

[61] 972 So. 2d 207, 210-211 (Fla. Dist. Ct. App. 2007) (emphasis supplied and footnote omitted).

[62] W. Va. Code § 55-7B-9c is akin to a Good Samaritan statute as it applies to "any action brought under this article for injury to or death of a patient as a result of health care services or assistance rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated by the Office of Emergency Medical Services as a trauma center, including health care services or assistance rendered in good faith by a licensed emergency medical services authority or agency, certified emergency medical service personnel or an employee of a licensed emergency medical services authority or agency."

> opinion was not supported by underlying facts or data and should be disregarded. We disagree because this testimony did not pertain to the facts or data upon which Dr. Neimann relied in reaching his conclusion. Rather, it focused on the doctor's opinion about the legal meaning of the Act, the inquiry about which was both irrelevant and outside the expertise of a medical expert. Whether the Act's standard is more similar to negligence or recklessness, as commonly defined, might be difficult to say, even for legal experts. But the application of the definition is not complicated. *The issue is whether Dr. Cooper should have known, based on all the relevant circumstances, that his failure to order immediate surgical intervention would likely result in injury to Mr. Christensen. While reasonable medical experts might disagree on the answer to this question, the application of this standard to a given set of facts is straight forward. Having read Dr. Neimann's testimony, it is clear that he understood and applied the correct standard, irrespective of whether he attached to it the correct legal label.*

In summary, the Amici respectfully submit that the judgment should be set aside where (1) the Respondent failed to provide statutory notice that he was seeking recovery under something other than medical negligence standard; (2) the Circuit Court's common law application of a recklessness standard ignored the statutory language "disregard of a risk of harm to the patient;" and (3) the Respondent presented no expert testimony satisfying the applicable "reckless disregard of a risk of harm to the patient."

V. CONCLUSION

WHEREFORE, the Amici Curiae, West Virginia University Board of Governors, West Virginia Health Care Association, American Medical Association, West Virginia State Medical Association, West Virginia United Health System, Inc. dba West Virginia University Health System, West Virginia Hospital Association, Marshall Health Network, Inc., Charleston Area Medical Center, Inc., Defense Trial Counsel of West Virginia, and West Virginia Chamber of Commerce, join in the request of the Petitioner, Michael R. Orphanos, M.D., that the judgment of the Circuit Court of Kanawha County is set aside, and the case remanded for application of the Trauma Cap to the jury's verdict.

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CERTIFICATE OF SERVICE

I hereby certify that on November 18, 2024, I served the foregoing "BRIEF OF THE AMICI CURIAE OF WEST VIRGINIA UNIVERSITY BOARD OF GOVERNORS, WEST VIRGINIA HEALTH CARE ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, WEST VIRGINIA STATE MEDICAL ASSOCIATION, WEST VIRGINIA UNITED HEALTH SYSTEM, INC. DBA WEST VIRGINIA UNIVERSITY HEALTH SYSTEM, WEST VIRGINIA HOSPITAL ASSOCIATION, MARSHALL HEALTH NETWORK, INC., CHARLESTON AREA MEDICAL CENTER, INC., AND DEFENSE TRIAL COUNSEL OF WEST VIRGINIA" on counsel of record using the Court's E-Filing System.

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