IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

SCA EFiled: Jan 02 2025
03:05PM EST
Transaction ID 75361641

No. 24-438

JOHN R. ORPHANOS, M.D.,

Defendant-Below, Petitioner,

v.

MICHAEL RODGERS,

Plaintiff-Below, Respondent.

RESPONDENT MICHAEL RODGERS' BRIEF IN OPPOSITION TO PETITIONER JOHN R. ORPHANOS, M.D.'S OPENING BRIEF, WITH CROSS-ASSIGNMENT OF ERROR

John W. Barrett, Esq. (WVSB #7289)
P. Gregory Haddad, Esq. (WVSB #5834)
Kerrie L. Haddad, Esq. (WVSB #9439)
BAILEY GLASSER, LLP
209 Capitol Street
Charleston, West Virginia 25301
Tel. No. (304) 345-6555
Fax No. (304) 342-1110
jbarrett@baileyglasser.com
ghaddad@baileyglasser.com
khaddad@baileyglasser.com

Counsel for Plaintiff-Below, Respondent

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Rules

Other Authorities

CROSS-ASSIGNMENT OF ERROR

1. The ICA wrongly concluded the circuit court abused its discretion in denying Defendant Orphanos' motion to continue the trial and strike Plaintiff Michael Rodgers' supplemental life care plan, where (a) Orphanos had known of life expectancy issues for years, but disclosed no expert; (b) Orphanos finally disclosed a life expectancy expert, Dr. Jodi Gehring, *four business days* before trial, although Dr. Gehring had the relevant medical records for almost a year, and received the supplemental life care plan ten weeks before trial; and (c) in a balanced decision, the circuit court *allowed* Orphanos to use two late-disclosed experts whose opinions, if accepted by the jury, would preclude all new damages disclosed in Rodgers' supplemental life care plan, but *disallowed* the life expectancy expert, because Orphanos had long known of the issue, but failed to act until the eve of an already thrice-continued trial.

STATEMENT OF THE CASE

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

Plaintiff Michael Rodgers was a 49-year-old father, grandfather, small-business owner, mechanic, avid traveler, and "all around good guy." App. 2712-2719. He was admitted to Charleston Area Medical Center around 6:00 p.m. on June 4, 2017, with injuries sustained in a motorcycle accident. App. 2896, 2899-2900, 3009. He was transferred in stable condition the next morning to the ICU. App. 3010. Initial assessments showed that Mr. Rodgers had a broken "T5" (fifth thoracic) vertebra—a so-called "Chance fracture." App. 2604, 2796, 2822, 2825, 3014. There was no evidence of damage to his spinal cord. App. 2992.

Defendant Dr. John R. Orphanos, a CAMC neurosurgeon, received a request for consultation regarding Mr. Rodgers in the early morning of July 5. App. 3009. Consistent with his stable, non-emergent status, Dr. Orphanos' nurse practitioner saw Mr. Rodgers at 11:30 a.m. that day, almost 12 hours after his admission. App. 2902, 3010. She ordered a nonsurgical back brace. App. 2723, 2930-31.

When Dr. Orphanos saw Mr. Rodgers on the afternoon of July 5, he remained stable and presented no emergency—a fact Orphanos himself repeatedly confirmed. App. 2899-2900, 2906,

2909, 2949. Orphanos presented Mr. Rodgers and his family with two treatment options: the nonsurgical back brace prescribed by his nurse practitioner, or spinal surgery. App. 2949. Orphanos recommended surgery, App. 2949, 3011-12, which was scheduled for the following afternoon, June 6, nearly two full days after Mr. Rodgers' admission, App. 2819, 2930.

B. Defendant performs a perfunctory examination of Mr. Rodgers and fails to order a pre-operative MRI, choosing to go into surgery blind to the condition of the spinal cord.

Dr. Orphanos conceded it is crucial to gather as much information as possible before any kind of spinal surgery. App. 2898. As Plaintiff's spine-surgery expert Dr. Mark Weidenbaum said, "you want to cross every T and dot every I and give your patient the best chance for a good outcome." App. 2820. Nevertheless, Orphanos failed to perform some of the simplest information-gathering tasks, ignoring over 40 hourly nursing notes, App. 2925-26, and assessing Mr. Rodgers for just 19 minutes. App. 2911-12.

More importantly, Dr. Orphanos failed to obtain pre-operative testing necessary to ensure a safe and successful surgery. He did not order an MRI of the thoracic spine, where the fracture was located, instead relying on the earlier CT of the chest that did not provide an assessment of the spinal cord at all. App. 2804, 2812, 2817, 2916. Only an MRI could show the spinal cord and the soft tissue surrounding it. App. 2916-17.

From the time of his admission to the time of the first surgery performed by Defendant two days later, Mr. Rodgers was fully intact neurologically. App. 2808-09, 2908-09. "He had intact muscle strength, [and] … intact sensation," with "full strength in all of his leg and hip muscles." App. 2680-81. Mr. Rodgers' neurological functioning was "normal … Everything works," App. 2808-09, "five out of five … [with] completely normal strength," App. 2680-84.

C. Defendant performs non-emergency surgery on Plaintiff without intraoperative monitoring, rendering him an acute paraplegic for life.

Dr. Orphanos' June 6 surgery was performed to insert screws into Mr. Rodgers' vertebrae above and below the fractured T5 vertebra so that a rod could be inserted into the spine to immobilize the fracture. App. 2820-21. According to Plaintiff's expert Dr. Weidenbaum, a spine surgeon with 35 years of experience, this was "minimal surgery … You can get that person up and walking quickly. That's the goal of the surgery." App. 2823.

In his second devastating error, Dr. Orphanos chose to operate on Mr. Rodgers' spine without using a tool called intraoperative neurophysiologic monitoring ("IONM"). App. 2673. IONM involves placing electrodes on the hands, feet, legs, or arms, so a physician can track a patient's nerve functioning and identify any neural damage during surgery. App. 2688-89. IONM causes no pain—it's "all benefit[,] no risk." App. 2690-91. If the spinal cord is impacted during a surgery, IONM will trigger a real-time alert, "an early warning system so that you'll know if there is an issue right then and there and not find out about it later on, by which time it may be too late." App. 2827. Defendant had used IONM during his residency and in surgeries at CAMC, and nothing prevented him from using it during Mr. Rodgers' surgery. App. 2936-39. As Dr. Weidenbaum put it, Dr. Orphanos' failure to use IONM meant he was operating literally "blind to what's going on with the spinal cord[.]" App. 2831.

During the surgery, instead of inserting the surgical screws into the two vertebrae above and below the broken T5 vertebra, Defendant miscounted the vertebrae and placed the screw directly in the T5 vertebra, which increased the risk of "some movement of the bony structure across the fracture." App. 2825-2826. It was not until postoperative studies were done that Defendant learned the screws were protruding outside of the vertebral body at the T5 level. Dr. Weidenbaum testified that the misplaced screw was a contributing factor in causing Plaintiff's

paraplegia, App. 2847, and one that Orphanos would have detected if he used IONM, App. 2961.

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

When Mr. Rodgers woke up from surgery, he couldn't feel or move his legs. Medical records describe his post-surgical state as "flailing arms, confused, doesn't respond to tactile … or painful stimuli below the nipple, no movement obtained on command lower extremities[.]" App. 2953. His diagnosis was acute paraplegia—the complete loss of use of both legs. App. 2863, 2961.

Because of this, Defendant performed exploratory surgery. App. 2848-49. Even at this point, Orphanos had an opportunity to reverse the paralysis, but once again, he failed to obtain necessary testing—this time a CT myelogram—after discovering the paralysis. A CT myelogram allows the surgeon to visualize the spinal cord itself, App. 2916-17, so the surgeon can see where the spinal cord is compromised, App. 2846-47. But without the benefit of those test results, Defendant was unable to detect, let alone repair, the damage to Mr. Rodgers' spinal cord.

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

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

a. Failure to order MRI. Dr. Weidenbaum is a board-certified spine surgeon at Columbia University with more than 35 years of experience in spine surgery. App. 2777-81. He testified that Defendant deviated from the standard of care by failing to order a pre-surgical MRI that would have allowed him to see the spinal cord and surrounding soft tissue. App. 2803-04, 2812, 2817. As Dr. Weidenbaum put it, when it comes to the spinal cord, "you have to know before you go to surgery what you're dealing with." App. 2812-13, 2815-16.

Dr. Weidenbaum also testified that only a preoperative MRI would show the presence of

a significant amount of epidural fat surrounding Mr. Rodgers' spinal cord that could compress and damage the cord during surgery; Defendant learned of this epidural fat only *after* Mr. Rodgers was paralyzed by his first surgery, by which time it was too late. App. 2831, 2851-55.

b. Failure to utilize IONM. Two experts—neurologist and neurophysiologist Dr. Daniel Feinberg and spine surgeon Dr. Weidenbaum—testified that Defendant breached the standard of care by failing to use IONM during Mr. Rodgers' surgeries. App. 2673, 2688-2690.

Dr. Feinberg testified that IONM is used in every complex surgical spine case in his practice at Philadelphia's Penn Spine Center, which he founded. App. 2672. Had Orphanos used IONM, Dr. Feinberg said there was "no doubt that he would have been given an alert" to spinal cord compromise during surgery, enabling corrective action, App. 2689-2690—a point with which even Dr. Orphanos agreed. App. 2961. Dr. Feinberg explained that the lack of this warning system "took away the opportunity to change the surgery at the time that the signals would have been changed[,]" which could have led to a different surgical outcome. App. 2703. As he put it, "not using the monitoring took away any opportunity for the surgeon to change course and preserve the spinal cord." App. 2704.

Dr. Weidenbaum agreed that Orphanos' failure to use IONM breached the standard of care, because without it, he was "blind to what's going on with the spinal cord[.]" App. 2827-28, 2831-33, 2837. With real-time monitoring from IONM, Orphanos could have done "many things" to address the damage, including removing the surgical screw, or decompressing the spinal cord. App. 2860-61. IONM also would have alerted Defendant to spinal cord damage caused by inserting the screw directly into the fractured bone, which increased the risk of "movement of the bony structure across the fracture" and damage to the spinal cord. App. 2826.

c. Failure to perform a CT myelogram after the first surgery. Finally, Dr. Weidenbaum testified that Orphanos deviated from the standard of care by failing to perform a CT myelogram before the second surgery that would have allowed the spinal cord to be clearly seen so that remedial measures could be taken to relieve pressure on the spinal cord. App. App. 2804-05, 2864-65. A CT myelogram would have revealed exactly where the spinal cord was compressed, enabling Dr. Orphanos to decompress it, App. 2848-49, 2860-61, thereby providing "a much better chance of fixing it," App. 2865. But failing to perform a CT myelogram gave Mr. Rodgers "zero chance of recovery[.] [I]n a situation like this which is so catastrophic, we are obliged to pull out all the stops and do anything possible under our power to try to help. That means you got to try to find out exactly where the problem is and to the best of your ability to try to do something about it. What you do may not work, but at least you have to try." App. 2865-66.

F. The jury rejects Dr. Orphanos' testimony that Mr. Rodgers' accident caused his paralysis.

Defendant's causation theory was that Plaintiff suffered a vascular injury because of the forces necessary to cause the Chance fracture, and that the vascular injury, in turn, caused a spinal stroke, App. 3585, 3588, but Dr. Orphanos never mentioned this cause in his perioperative or post-operative records. App. 2935. He further testified, without explanation and contradicting spine surgeon Dr. Weidenbaum, that an MRI was unnecessary. App. 2920-21. He conceded that IONM would have alerted him to any spinal cord compromise that might cause a spinal stroke. App. 2939-2940. Even Dr. Orphanos' expert Dr. Berkman agreed. App. 3604-05.

Mr. Rodgers' experts rejected as anatomically infeasible the defense position that Mr. Rodgers' spinal cord blood supply was damaged in the accident, not during surgery. Dr. Feinberg testified that the segmental artery, which Defendant argued was damaged during the accident, does not supply blood to the spinal cord, "[s]o a dissection of the segmental artery at T5 would

not result in a spinal cord stroke." App. 2678. He further testified that because Mr. Rodgers' hip, leg and arm strength was "completely normal" before the surgery, it was "*impossible*" that Mr. Rodgers sustained damage to the spinal cord before the surgery. App. 2682-85. Like Dr. Weidenbaum, Dr. Feinberg attributed the spinal cord stroke to Orphanos' surgery. App. 2691-92.

A third Plaintiff's expert, Dr. Edward Greenberg, a board-certified radiologist, neuro-interventional surgeon, and diagnostic neuro-radiologist, also attributed the spinal-cord injury to the first surgery. He testified that Mr. Rodgers' spinal cord was injured in the fractured T5 area where Defendant mistakenly placed the surgical screw (App. 3236, 3275) and rejected alternative explanations offered by the defense.[1]

G. Dr. Orphanos' repeated surgical failures cost Mr. Rodgers the use of his legs and destroyed his quality of life.

Dr. Orphanos' repeated shortcomings permanently paralyzed Michael Rodgers. He battled infections, bed sores, and other serious health issues until July 2020, when he finally suffered a cerebral stroke. Uncontested evidence showed that, due to his paralysis, Mr. Rodgers developed an infected bed sore which caused bacterial sepsis, which caused bacterial vegetation to form on the heart valves that broke off and traveled to his brain, resulting in stroke. App. 3100-04. No witness testified as to any other cause of the cerebral stroke.

This stroke destroyed Mr. Rodgers' already-diminished quality of life. He is bed-bound, unable to perform the most basic activities of daily living. Registered nurse and certified life care

[1] One defense theory posited that damage to segmental arteries feeding the spinal cord at the T5 vertebra caused Mr. Rodgers' paraplegia. App. 3265, 3269. Dr. Greenberg, the only witness published in the "niche" field of vascular anatomy of the spinal cord, App. 3267-68, 3270, rejected that theory (App. 3269), pointing out that there is no segmental artery that feeds the spinal cord at that location. App. 3262-64. That, and the fact that Mr. Rodgers showed no signs of spinal cord injury before the first surgery (App. 3271-72), supported Dr. Greenberg's determination that Mr. Rodgers' spinal cord injury occurred in surgery. Dr. Greenberg also rejected a second defense explanation—that a clot in the collarbone or heart caused the injury during the surgery—as "completely false." App. 3273-74.

planner Nadene Taniguchi testified that Rodgers has lost almost all his independence and now relies on his girlfriend for everything from household chores to basic home nursing care, including diaper changes, bathing, and skin care to prevent bed sores. App. 3079, 3090-91. He will require around-the-clock care for the rest of his life, including regular diagnostic testing and medical surveillance by physiologists, urologists, orthopedics, and other health care specialists. App. 3084-85, 3111. The lifetime cost of providing these services is $8,305,630. App. 3112.

H. The jury finds that Defendant's recklessness caused Mr. Rodgers' paraplegia and stroke, and awards $17.6 million in damages.

A seven-day trial took place in March 2022. Through special interrogatories, the jury found that Defendant was not only negligent, but also reckless, thereby rendering the Trauma Cap inapplicable to this case. App. 46. The jury also found the surgery was non-emergent—a second ground that rendered the Trauma Cap inapplicable—and that Defendant's malpractice proximately caused Plaintiff's cerebral stroke in July 2020. *Id.* As a result, the jury awarded Plaintiff more than $17.6 million in damages. Thereafter, the parties briefed and argued a series of motions involving MPLA caps, offsets, and other prejudgment issues. On September 12, 2022, the Court entered final judgment of $9,862,384.58. App. 45-51.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Michael Rodgers does not request oral argument, as this appeal involves a straightforward application of settled law and a challenge to a jury verdict supported by substantial evidence. The circuit court's judgment should be affirmed in full.

ARGUMENT SUMMARY

In all its rulings save one, the ICA got this case right: (1) sufficient evidence supported the jury's verdict such that Orphanos' Rule 50 motion for judgment as a matter of law was properly denied; and (2) the Circuit Court did not abuse its discretion in denying Orphanos' Rule

59(a) motion for new trial. The single error identified by the ICA—a highly discretionary decision by the circuit court to refuse another continuance of an already thrice-continued trial for injuries sustained almost five years earlier—is precisely the sort of balanced ruling that trial courts must have discretion to make when managing their dockets. The circuit court did not abuse its discretion in that ruling, and this Court should affirm the judgment in full.

The only novel question presented was easily answered by the ICA, and this Court should allow that ruling to stand: the MPLA plainly exempts from trauma caps care provided to a patient "after the patient's condition is stabilized" and the patient "is capable of receiving medical treatment as a non-emergency patient[,]" W. Va. Code § 55-7B-9c(e), and Plaintiff presented sufficient evidence to support both findings. In fact, *Dr. Orphanos himself acknowledged both conditions were met. See infra* at App. 2801, 2899-2904, 2909, 2930-31. This issue is so clear that Dr. Orphanos did not even raise it as a basis for judgment as a matter of law, either before the trial court or the ICA. *See infra* at App. 1-44, 75-79.

But if the Court wishes to address a second, independent trauma cap exemption—which applies to care provided "in willful and wanton or reckless disregard of a risk of harm to the patient," W. Va. Code § 55-9c(h)—the jury's special interrogatory finding of recklessness was supported by sufficient evidence viewed in the light most favorable to Rodgers. Indeed, testimony from one neuroradiologist and two highly-credentialed spine experts showed that Dr. Orphanos failed to utilize basic precautions before, during, and after the surgery that would have alerted him to spinal cord compression, a failure that caused Mr. Rodgers—who pre-surgically showed completely normal, "five out of five" neurological functioning, and was even presented with a nonsurgical back brace as a treatment option—permanent paraplegia. As one of Plaintiff's experts testified, Dr. Orphanos breached the standard of care by operating "blind" to the

condition of Mr. Rodgers' spinal cord, App. 2831, and the experts combined showed that Dr. Orphanos ignored not one, not two, but three critical precautions that would have avoided exactly the tragic outcome that Mr. Rodgers suffered.

In short, the jury's verdict and the circuit court's posttrial rulings represent fairly routine decisions that occur in civil cases brought to judgment throughout the state, and they must be affirmed under the highly deferential standards accorded to jury verdicts and circuit court assessments of the evidence and management of its docket.

STANDARDS OF REVIEW

An order denying a Rule 50(b) motion for a judgment as a matter of law after trial is reviewed de novo. Syl. Pt. 3, *Alkire v. First Nat. Bank of Parsons*, 197 W. Va. 122, 128, 475 S.E.2d 122, 128 (1996). However, the Court's task is not "to review the facts to determine how it would have ruled on the evidence presented. Instead, its task is to determine whether the evidence," viewed most favorably to the nonmovant, "was such that a reasonable trier of fact might have reached the decision below." *Id.*

A trial court's denial of a Rule 59 motion for new trial "is entitled to great respect and weight, [and] … will be reversed on appeal [only] when it is clear that the trial court has acted under some misapprehension of the law or the evidence." Syl. Pt. 2, *Grimmett v. Smith*, 238 W. Va. 54, 55, 792 S.E.2d 65, 66-67 (2016). To determine whether sufficient evidence supports "a jury verdict the court should: (1) consider the evidence most favorable to the prevailing party; (2) assume that all conflicts in the evidence were resolved by the jury in favor of the prevailing party; (3) assume as proved all facts which the prevailing party's evidence tends to prove; and (4) give to the prevailing party the benefit of all favorable inferences which reasonably may be drawn from the facts proved." *Id.,* 238 W. Va. at 61, 792 S.E.2d at 71.

ARGUMENT

A. The Circuit Court and the ICA correctly concluded the MPLA's trauma cap was inapplicable, and correctly denied Orphanos' motion for judgment as a matter of law.

In his post-trial Rule 50(b) motion, and in his ICA appeal, Orphanos argued a single ground: "there was no evidence presented either during discovery or at trial to support a claim of recklessness as it related to Dr. Orphanos' care and treatment of the Plaintiff." App. 1980. Rather than address that argument, the ICA affirmed the circuit court's denial of the motion on a ground Orphanos failed to raise, finding that the MPLA's "nonemergency" exemption from the statutory trauma caps, W. Va. Code § 55-7B-9c(e), precluded the cap's application. *Orphanos v. Rodgers*, 903 S.E.2d 623, 634 (Int. Ct. App. 2024). This finding was correct.

1. By failing to raise the issue in its appeal of the Rule 50(b) ruling, Orphanos waived any argument that the surgery was not subject to the nonemergency exemption from the MPLA trauma caps.

"Nonjurisdictional questions … raised for the first time on appeal[] will not be considered." *Shaffer v. Acme Limestone Co., Inc.,* 206 W.Va. 333, 349 n. 20, 524 S.E.2d 688, 704 n. 20 (1999). Here, Orphanos never argued, either in his Rule 50(b) motion in the Circuit Court or in his two briefs at the ICA, that he was entitled to judgment as a matter of law because the non-emergency exception did not apply.[2]

Orphanos does not deny this, but vaguely claims that he addressed the argument "in his opening brief and reply." Br. at 19 n.9. But he only addressed the issue in support of his new trial motion—where he argued the court's instruction was error (which it wasn't, and he never even offered his own)—not in support of his Rule 50(b) motion. His argument for reversal of the denial of his Rule 50(b) motion *only* concerned the recklessness exception from the MPLA caps.

[2] Nor do the amici, which include hospitals providing emergency care, have anything to say on this issue. *See supra* at 15.

Orphanos has waived the nonemergency issue as a basis for his Rule 50(b) appeal.

2. Sufficient evidence supported the finding that the care at issue was not emergency care subject to the MPLA cap.

The MPLA's trauma caps (*see* W. Va. Code § 55-7-9c, reproduced in full at Exhibit A of this brief) apply to "any action brought under [the MPLA] 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 trauma center, and includes "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[.]" *Id.* § 55-7B-9c(a).

The statute's scope is narrowed by a key "non-emergency" exception: "The limitation on liability provided under subsection (a) of this section *does not apply* to any act or omission in rendering care or assistance which … [o]ccurs *after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a nonemergency patient*[.]" *Id*. § 55-7B-9(c)(e) (emphasis added). Put differently, the trauma cap applies to Mr. Rodgers' claim *unless* his surgery was performed (1) "after [Rodgers'] condition [was] stabilized," and (2) Rodgers "[was] capable of receiving treatment as a nonemergency patient." *Id.* As the ICA noted, the jury answered a special interrogatory finding that Mr. Rodgers' surgery was not an emergency surgery, and on this basis and viewing the evidence in the light most favorable to Rodgers, his damages were "outside of the trauma cap." 903 S.E.2d at 634-635.

The ICA was correct. At trial, Orphanos himself agreed that the surgery was not emergency surgery, and candidly explained why: "The definition of emergency surgery is when there is an acute threat to either life or limb. So at that time, he was clinically stable so it was not an emergency issue." App. 2899-2900. This unvarnished testimony supports the application of

both prongs of the non-emergency exception: (1) the surgery was undertaken "after [Rodgers'] condition [was] stabilized," and (2) Rodgers "[was] capable of receiving medical treatment as a non-emergency patient." W. Va. Code § 55-7B-9c(e).

Other evidence supports the application of the nonemergency exception. As outlined *infra* at App. 2816-2817, 2899-2902 (see also footnote 10 on App. 19-20), Mr. Rodgers was admitted on June 4; first evaluated by neurosurgery approximately 12 hours after admission and many hours after the order for neurosurgical consultation; and taken to surgery June 6, with normal neurological findings throughout the entire pre-operative period. App. 2817, 2900. Dr. Berkman, one of Orphanos' experts, readily agreed this was not emergency surgery. App. 3599. As he put it, "there was no emergency situation that required [him] to rush him to the operating room because of fear of deterioration that might prejudice or jeopardize his life or limb[.]" App. 2909. Even the surgical report itself stated the surgery was not an emergency. App. 475-486. The nonemergent nature of the procedure is also supported by the fact that Dr. Orphanos' nurse practitioner, who saw Mr. Rodgers approximately 18 hours after his admission, presented him with an option and prescription for a nonsurgical back brace. App. 2605-08, 2723.

Against this overwhelming evidence, Orphanos can only fall back on a nontextual interpretation of the trauma cap statute. As he would have it, once a patient is admitted to a trauma center with a condition, any care the patient received from that point forward is covered by the trauma cap. *See* Op. Br. at 18 ("[I]f the surgery is to treat an emergency condition for which the patient was admitted, the Trauma Cap applies based on the plain reading of the statute."). Orphanos so concludes by relying exclusively on Section 9c(d), which states the trauma cap applies to patients admitted to trauma centers with emergency condition "in the event that surgery is *required* as a result of the emergency condition within a reasonable time after the

patient's condition is stabilized[.]" W. Va. Code § 55-7B-9c(d) (emphasis added).[3] But as the evidence showed, surgery *was not* required; Orphanos and his nurse practitioner provided a treatment option of a nonsurgical back brace. App. 2723. And Orphanos cannot explain away the very next subsection, the Section 9c(e) nonemergency exclusion, which clearly applies here under the facts viewed in the light most favorable to Mr. Rodgers.

In a weak effort to claim Mr. Rodgers' condition was not "stable," Orphanos cites trial testimony that, at the time of the surgery, "Plaintiff was suffering from an unstable spine fracture that required surgical treatment." Br. at 18 (citing App. 2694-95). No one denies Rodgers' spine was "unstable," but the records and Orphanos' own testimony establish that at the time of the surgery, Rodgers condition "was clinically stable." And the 9c(e) exclusion applies not when the patient's *injury* is unstable, but when the patient's *condition* was stable. And it was.

Orphanos' baseless spin on the statute—that any patient admitted to a trauma care facility who receives surgery for the condition remains subject to the caps even after the patient is stable

[3] Orphanos claims (at 14) that Rule 20 argument is needed because this case presents an issue of first impression regarding the "'reasonable' amount of time between the original emergency care and follow-up surgery" under Section 9c(d)—odd, because Orphanos never offered a jury instruction that would allow a factual finding on that point. Nor did he even offer an instruction that would have allowed the jury to find that the challenged care was "necessitated by an emergency condition," W. Va. Code § 55-7B-9c(a) such that the trauma caps apply at all. An "emergency condition," as the ICA pointed out (903 S.E.2d at 634), is "any acute traumatic injury … which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities[.]" W. Va. Code § 55-7B-2(d). Yet again, Orphanos offered no testimony about standardized criteria for triage, despite ample evidence supporting the non-emergent nature of Mr. Rodgers' pre-surgical condition. *See infra* at 1-3, 12-15. Orphanos seems to think that he can forego having a jury make factual findings supporting his own defense, and then on appeal complain about the need to determine the very same factual issues that he failed to present for the jury's consideration. Perhaps better than most, this case shows the rationale for the Court's appellate waiver rule: "[W]hen an issue has not been raised below, the facts underlying that issue will not have been developed in such a way so that a disposition can be made.... Moreover, we consider the element of fairness. When a case has proceeded to its ultimate resolution below, it is manifestly unfair for a party to raise new issues [before this Court]. Finally, there is also a need to have the issue refined, developed, and adjudicated by the trial court, so that we may have the benefit of its wisdom." *In re E.B.,* 229 W. Va. 435, 468, 729 S.E.2d 270, 303 (2012) (cited authority omitted). Orphanos' failures, and Mr. Rodgers' long-unaddressed suffering and damages, make this case appropriate for summary disposition and affirmance of the trial court's judgment.

and is treated as a nonemergency patient—is irreconcilable with, and renders meaningless, the Section 9c(e) exclusion. Plaintiff's and the ICA's reading of the statute not only gives meaning to that exclusion, but it also makes sense: once a patient admitted to a trauma care facility is stabilized and can be treated as a nonemergency patient, as here, the cap no longer applies.

And if there is any doubt on the plain meaning of the statute, it has long been the rule that a statute in derogation of the common law, such as the MPLA's limitation on the common law right to damages for negligence, must "be interpreted in the manner that makes the least rather than the most change in the common law." Syl. Pt. 4, *Phillips v. Larry's Drive-In Pharmacy, Inc.,* 220 W. Va. 484, 486, 647 S.E.2d 920, 922 (2007). Orphanos' nontextual interpretation of the Act cannot stand in light of this interpretative canon.

Finally, on this point, the brief of the amici medical providers who operate trauma centers and emergency departments is more helpful for what it does not say than what it does say. Despite the emergency care focus of their operations, *nowhere in their brief do amici take issue with the clear application of the nonemergency exception to the statute*. Orphanos stands alone in his interpretative acrobatics. Amici only opine about the recklessness exception, but, as the ICA concluded, that issue need not be reached in order to affirm the judgment.

3. As the Circuit Court held in denying Orphanos Rule 50(b) motion, Rodgers presented sufficient evidence of recklessness to support the jury's finding that Orphanos' care was reckless, and therefore not subject to the trauma caps.

Should the Court nonetheless choose to address the issue, the trauma cap's second exemption applies when care is rendered "[i]n willful and wanton or reckless disregard of a risk of harm to the patient[.]" W. Va. Code § 55-7-9c(h). Orphanos challenges the circuit court's denial of his Rule 50(b) motion in two respects, first by arguing "the MPLA requires expert

testimony on the issue of 'recklessness,'" Br. at 21, and second by arguing there was insufficient evidence to support the jury's finding of recklessness.

These arguments fail. While the MPLA may require testimony that a physician breached the standard of care, W. Va. Code § 55-7B-7(a), the recklessness exception to the application of the trauma cap contains no such requirement,[4] and there is no basis to rewrite the statute to impose one. But perhaps more importantly, contrary to Orphanos' claims, Plaintiff provided sufficient evidence to support the jury's finding that Orphanos' care was reckless.

a. The trauma cap does not require an expert to testify the care was "reckless."

The MPLA does not require an expert to opine that a health care provider was "reckless" in order to avoid the trauma cap. There are several reasons why this is so.

(i) The statute says nothing about expert testimony—ergo no such testimony is required.

First, of course, the text of the recklessness exception says nothing about an expert testimony requirement. It simply states that the cap "does not apply where health care or assistance for the emergency condition is rendered … in willful and wanton or reckless disregard of a risk of harm to the patient." *Id*.

That, in and of itself, eviscerates Defendant's argument. Courts may not "arbitrarily … read into a statute that which it does not say." Syl. Pt. 11, in part, *Brooke B. v. Ray*, 230 W. Va. 355, 738 S.E.2d 21 (2013). "Just as courts are not to eliminate through judicial interpretation words that were purposely included, we are obliged not to add to statutes something the Legislature purposely omitted." *Id.*

[4] In fact, as the ICA pointed out, not only is there "no mandatory language requiring expert testimony" in the MPLA, "expert testimony is left to the discretion of the lower court as guided by the rules of evidence." 903 S.E.2d at n. 7 (citing W. Va. Code § 55-7B-7(a), which states that expert testimony shall be necessary "if required by the court.").

The ICA was correct that "under the MPLA there is no mandatory language requiring expert testimony on recklessness." 903 S.E.2d at 634 n.7. That omission is the end of the matter. Where, as here, "the language of a statute is free from ambiguity, its plain meaning is to be accepted and applied without resort to interpretation." Syl. Pt. 3, *Trulargo, LLC v. Pub. Serv. Comm'n,* 242 W. Va. 482, 836 S.E.2d 449 (2019).

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

Because the trauma cap provision contains no requirement of expert testimony, Defendant resorts to interpretive fiction in order to urge the Court to rewrite the statute, arguing that because the Legislature specifically referenced expert testimony in another part of the MPLA—Section 55-7B-7(a) (the "Standard-of-Care Provision")—the Court should read such a requirement into the trauma cap.

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

So held the Idaho Supreme Court in *Ballard v. Kerr*, 378 P.3d 464 (Id. 2016). There, a health care provider framed the issue as Defendant does here, arguing that because expert testimony is required to prove that a medical professional violated the standard of care, such testimony must be required to prove recklessness for purposes of determining whether the case falls within an exception to a damages cap. The Court rejected that argument, holding that "[w]here the legislature has not expressly provided that direct expert testimony is required to

prove recklessness in medical malpractice actions, *we decline to apply such a requirement*." *Id.* at 499-500 (emphasis added).

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

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

Even if expert testimony were required to establish recklessness, Orphanos' argument would still fail because it is based on the false premise that an expert must actually *label* the Defendant's actions as "negligent" or "reckless" within the meaning of the law. Here again, the law is the exact opposite of what Defendant claims it to be.

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

Thus, in *Jackson v. State Farm Mutual Auto Insurance Company*, 215 W. Va. 634, 644-45, 600 S.E.2d 346, 356-57 (2004), it was improper for an expert witness to testify as to whether

an insurance agent had acted with "actual malice" where such testimony "[did] not assist the trier of fact to understand the evidence or to determine a fact in issue." *Id*. The Court explained that "[a]fter the jurors are informed of industry practices of claims adjustment and settlement, the nature of State Farm's conduct in the instant case, and the applicable law concerning malice, they are as capable as [the expert] to determine whether State Farm's conduct indicates the existence of malice." *Id*. "Therefore," the Court concluded, the expert's opinion "does not assist the jury but rather is merely cumulative." *Id*. Further, "because [the testifying expert] has been recognized as an expert, there is a danger that jurors may consider him more qualified to determine the issue of malice than they are." *Id*.

Jackson is completely consistent with *Ballard,* where the Court held, "[o]nce an expert has opined as to the applicable standard of care and how a defendant's conduct breached that standard, in many cases a lay person could determine whether a defendant made a conscious choice to engage in such conduct and whether the risk and high probability of harm were objectively foreseeable." 160 Idaho at 710, 378 P.3d at 500.

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

correct standard of care. However, the Court will not make this determination simply because the expert witness did not use the 'magical' words. The jury sitting as the finder of fact makes that determination." *Id*.[5]

The upshot is that, under the MPLA, the expert's job is simply to testify whether the Defendant has violated the standard of care by "fail[ing] to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances." W. Va. Code § 55-7B-3. That Plaintiff's experts did not actually utter the magic words and label Defendant's conduct as "reckless" is irrelevant, because it is the jury's job to decide whether the facts supported such a finding—which it did.

(iv) The punitive damages statute has no bearing on the trauma cap.

Defendant's second argument—that the Trauma Cap must require expert testimony on "recklessness" because West Virginia's statute governing punitive damages, W. Va. Code § 55-7-29(a) (2015), requires "clear and convincing" evidence of reckless or malicious conduct (*see* Pet. Br. 15-16)—is perplexing, because the punitive-damages statute says nothing about expert testimony. So even if that statute had any bearing on how the Court should interpret the trauma

[5] Many decisions are in accord. *See Nowzaradan v. Ryans*, 347 S.W.3d 734, 741-42 (Tex. App. 2011) (to support a finding of gross negligence, Texas's Medical Practice Liability Act "requires that an expert opine regarding *the manner* in which the physician breach the applicable standard of care and the causal relationship between the breach and the plaintiff's injury, not the extent of the breach."); *Szymanski v. Hartford Hospital*, No. CV 89 03 63 831S, 1993 WL 89068 (Conn. Super. Mar. 12, 1993), at *3 ("The rationale for requiring expert testimony about standard of care in medical malpractice cases is that as laymen, jurors lack requisite knowledge as to medical standards. … However, once expert testimony provides jurors with such knowledge, they are able to make the factual determination as to whether the conduct in question was actionable at all, negligent, or reckless or wanton."); *Jamas v. Krpan*, 588 P.2d 1114, 1115 (Ariz. 1977) (noting that "[a]lthough a jury may not be competent to determine medical malpractice without the aid of expert testimony that the physician had deviated from the accepted standard of care, it does not necessarily follow that the jury, having been informed of community standards, is incompetent to judge the nature or gravity of the deviation; i.e., whether it was simple negligence or reckless disregard of the safety of the patient.").

cap, it is hard to understand how that would advance Defendant's cause here.

Stephens v. Rakes, 235 W. Va. 555, 775 S.E.2d 107 (W. Va. 2015), is not to the contrary. There, this Court affirmed a punitive damages award in a medical malpractice case because the plaintiff "provided evidence that Dr. Stephens' care of the decedent was 'dangerous, and at the very least, reckless.'" *Id*. at 118. The Court's ruling was based on its review of the evidence, and not the use of the word "reckless." *See id.*, 775 S.E.2d at 119. Even if the magic word "reckless" was somehow central to the Court's holding, it would be irrelevant here because there are compelling reasons why the standard for determining "recklessness" under a statute addressing the availability of *punitive* damages should not govern the applicability of the Trauma Cap, which sets a limit on the availability of certain *compensatory* damages in a medical malpractice case. Unlike compensatory damages, which are limited to the "concrete loss that the Plaintiff has suffered by reason of the Defendant's wrongful conduct," punitive damages raise special constitutional concerns due to their potential for imposing "grossly excessive or arbitrary punishments on a tortfeasor." *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 416 (2003) (cleaned up). For that reason, West Virginia, like many other states, has restricted the availability of punitive damages by requiring "clear and convincing" evidence of reckless or malicious conduct. W. Va. Code § 55-7-29(a) (2015).

The requirement of "recklessness" in the Trauma Cap, in contrast, serves a very different function: it is designed to allow the recovery of *compensatory* damages to which a patient would otherwise be entitled if their treatment had not occurred under emergency conditions. Because compensatory damages do not implicate the due process rights of a Defendant, there is no reason to assume that the Legislature would want the same burden of proof to govern recklessness determinations under the punitive damages statute and under the Trauma Cap.

(v) Sufficient evidence supported the jury's finding that Orphanos' care was reckless.

Defendant's argument that Plaintiff provided insufficient evidence of recklessness relies on a self-serving and highly selective characterization of the trial evidence, really more of closing argument than a proper appellate challenge to the sufficiency of the evidence. To read his recitation of the evidence on recklessness, one might think Orphanos *won* at trial.

Orphanos goes so far as to claim that "[b]ecause there was conflicting evidence regarding whether Dr. Orphanos even breached the standard of care, the circuit court erred in permitting the jury to consider the issue of 'recklessness.'" Br. at 27. But "a firmly-established principle of our jurisprudence is: 'Where, in the trial of an action at law before a jury, the evidence is conflicting, it is the province of the jury to resolve the conflict, and its verdict thereon will not be disturbed unless believed to be plainly wrong.'" Syl. Pt. 4, *Grimmett*, 238 W. Va. at 60, 792 S.E.2d at 71. Indeed, the Court must "consider the evidence most favorable to the prevailing party[,]" "give to the prevailing party the benefit of all favorable inferences which reasonably may be drawn from the facts proved[,]" and "assume that all conflicts in the evidence were resolved by the jury in favor of the prevailing party[.]" *Miller v. WesBanco Bank, Inc*., 245 W. Va. 363, 380, 859 S.E.2d 306, 323 (2021). So while Dr. Orphanos and his experts testified the standard of care was satisfied, that fact is neither surprising nor, at this appellate stage, relevant. The Court should disregard Orphanos' slanted characterization of the facts.

The jury was asked whether Orphanos' care was "reckless." "The usual meaning assigned to … 'reckless' … is that the actor has intentionally done an act of unreasonable character in disregard of a risk known to him or so obvious that he must be taken to have been aware of it, and so great as to make it highly probable that harm would follow." *Cline v. Joy Mfg. Co*., 172 W. Va. 769, 772 n.6, 310 S.E.2d 835, 838 n.6 (1983).

The evidence shows that the risk of harm was both grievous and obvious. *Before* surgery, Orphanos should have performed an MRI, which would have provided critical information about the condition of the spinal cord, such as the state of blood flow, or the presence of epidural fat that could put pressure on the cord. App. 2812, 2855. As Dr. Weidenbaum stated, "You don't know what you don't know. And so before proceeding to taking someone to surgery, you need to understand that everything is either fine, in which case I can proceed, or, oh, maybe there is a question and we should check that out before we proceed to surgery, but you have to know before you go to surgery on what you're dealing with." App. 2812-13.

During the surgery, Dr. Weidenbaum testified that Dr. Orphanos should have used IONM, and that without it, he was operating "blind to what is going on with the spinal cord." App. 2831. IONM would have alerted Orphanos to spinal cord damage during surgery, enabling him to take corrective action such as relieving pressure on the spinal cord. App. 2860-61. Because Orphanos did not use IONM, he only learned of the spinal cord damage two-and-a-half hours after surgery, by which time it was too late. *Id*.

And *after* surgery, Orphanos should have performed a CT myelogram, which would have provided a clear look at the spinal cord so he could identify where the compression had occurred, and that by not doing this simple test, Mr. Rodgers had "zero chance of recovery." App. 2865-66. Dr. Weidenbaum testified that Orphanos "definitely failed to meet the standard of care. In an acute paraplegic patient, you don't know why, you definitely need to look." App. 2865.

As Dr. Weidenbaum summed it up, "In a situation like this which is so catastrophic, we are obliged to pull out all the stops and do anything under your power to try to help. That means you got to try to find out exactly where the problem is and to the best of your ability to try to do something about it." App. 2865-66.

*****

Blowing through one stop sign can constitute negligence. But "blindly" blowing through three known stop signs in a row—(a) the failure to order the pre-surgical MRI in order to understand the condition of the spinal cord, (b) the failure to use IONM that would have alerted him to any damage so he could take corrective action, (c) and the failure to do post-surgical CT myelogram after Rodgers was rendered paraplegic—when the effect of an error is permanent and catastrophic, is reckless. Recklessness is the intentional doing of an act in disregard of known risk, "so great as to make it highly probable that harm would follow." *Cline,* 172 W. Va. at 772 n.6, 310 S.E.2d at 838 n.6. That standard was met here. The Court should affirm the circuit court's denial of Orphanos' Rule 50(b) motion.

B. The ICA correctly—on all grounds save one—concluded the circuit court did not abuse its discretion in denying Orphanos' new trial motion.

Orphanos' second challenge is to the circuit court's denial of his Rule 59(a) motion for a new trial. On all issues it addressed—save the one at issue in Plaintiff's cross-appeal—the ICA agreed with Plaintiff that the circuit court did not abuse its discretion in denying the motion. Here, Orphanos asks this Court to disregard the superior vantage points of the jury in resolving conflicting evidence, and the trial court in exercising its discretion to manage pretrial and evidentiary matters. The fair and efficient administration of justice warrants deference to these roles, and this in turn requires complete affirmance of the judgment below.

1. The Circuit Court's denial of Orphanos' motion for partial summary judgment and motion to exclude issues of recklessness provide no basis for a new trial.

Orphanos' first challenge—that "the ICA should have held that the circuit court erred in denying [his] Motion for Summary Judgment" on recklessness, Br. at 29—fails at the outset, for two reasons. First, Orphanos did not raise this issue in his ICA appeal papers, and it should not

be considered here. *Shaffer,* 206 W.Va. at 349 n. 20, 524 S.E.2d at 704 n. 20. Second, "[a]n order denying a motion for summary judgment is merely interlocutory, leaves the case pending for trial, and is not appealable except in special instances [such as claims of qualified immunity] in which an interlocutory order is appealable." Syl. Pt. 7, *State ex rel. Vanderra Res., LLC v. Hummel*, 242 W. Va. 35, 829 S.E.2d 35, 37 (2019) (additional cited authority omitted).

Nor is there merit to Orphanos' related challenge to the circuit court's denial of his motion in limine to exclude issues of recklessness at trial. His argument is based on a false premise: that there was insufficient expert testimony to support a recklessness finding. That argument is wrong for all the reasons discussed above—thus the denial of the motion was necessarily correct and did not amount to an abuse of discretion. *See* Syl. Pt. 3, *Jones v. Garnes*, 183 W. Va. 304, 306, 395 S.E.2d 548, 550 (1990) ("Rulings on the admissibility of evidence are largely within a trial court's sound discretion and should not be disturbed unless there has been an abuse of discretion.").

2. The jury instructions provide no basis to reverse denial of the new trial motion.

a. As the ICA held, the circuit court did not abuse its discretion in giving its "emergency" instruction.

The trauma cap is inapplicable if the care "[o]ccurs after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a *nonemergency patient."* W. Va. Code § 55-7B-9c(e)(1) (emphasis added). In keeping with that language, the court instructed the jury: "Michael Rodgers has asserted that the surgery carried out two days after his admission to the hospital was not an emergency surgery. If you find that the surgery carried out by the Defendant was not an emergency surgery, then you should answer the special interrogatory on the verdict form accordingly." App. 3636 (emphasis added). The verdict form in

turn posed this question: "Do you find that the first surgery performed on Michael Rodgers was an emergency surgery?" App. 1461. The jury answered "No."

That the instruction was framed in terms of an emergency "surgery" rather than an emergency "patient" is a distinction without a difference. *See State ex rel. Worley v. Lavender,* 147 W. Va. 803, 808, 131 S.E.2d 752, 755 (1963) ("the giving of an instruction substantially in the language of an applicable statute is not error."). While Orphanos now quibbles with the terminology, "it is the opposing party's burden to an instruction to propose one they believe is more in accordance with the law," and, as the ICA pointed out, *Orphanos proposed nothing*. *Orphanos*, 903 S.E.2d at n.14.

A defendant cannot fail to propose an instruction on a key element of an affirmative defense, and then appeal the instruction actually given. The circuit court's instruction sufficiently tracked the language of the nonemergency exception, and perhaps more to the point, there was not a shred of evidence to suggest the Rodgers surgery was in any way emergent. App. 1436-60.

b. The recklessness instruction provides no basis to reverse.

The trial court instructed that "Michael Rodgers has asserted that the Defendant was not only negligent, but that he was reckless in the care provided to Michael Rodgers. Recklessness means an act of unreasonable character in disregard for a risk known to him or so obvious that it must be taken that he was aware of it." App. 3636. This tracks *Cline*, which holds that recklessness requires that one "has intentionally done an act of an unreasonable character in disregard of a risk known to him or so obvious that he must be taken to have been aware of it, and so great as to make it highly probable that harm would follow." *Cline*, 310 S.E.2d at 838.

Orphanos' first challenge (at 31) is that the instruction should have tracked verbatim the language of the trauma cap's recklessness exception, which exempts from the caps conduct in "willful and wanton or reckless disregard of a risk of harm to the patient." W. Va. Code § 55-7B-

9c(h)(1). However, those terms are synonymous, and can be used "according to taste." *Cline*, 310 S.E.2d at 838 n. 6 ("[W]e wish to make clear that we are using the words 'willful,' 'wanton,' and 'reckless' misconduct synonymously"). The circuit court was free to choose any of them.

Orphanos' second argument is that the instruction's reference to an "unreasonable act" somehow reduces the standard to one of mere negligence—but this ignores that the instruction required a finding that the act be one "in disregard for a risk known to him or so obvious that it must be taken that he was aware of it." App. 3636. Once again, this tracks both *Cline* and the evidence at trial that Orphanos should have taken precautions *before* (through a presurgical MRI, which would have alerted him to the spinal cord's condition), *during* (by using IONM, without which Orphanos was operating "blind as to what is going on with the spinal cord"), and *after* (by performing a CT myelogram, a failure that gave Mr. Rodgers, already rendered paraplegic through the first surgery, "zero chance of recovery") the surgery, a series of failures that Dr. Weidenbaum testified led to "catastrophic" effect that required Orphanos to "pull out all the stops and do anything under [his] power to help," App. 2865-66, which he failed to do.

3. As the ICA held, the Circuit Court did not abuse its discretion by qualifying Plaintiff's experts.

Both the circuit court and the ICA rejected Orphanos' Rule 702 qualification challenges to expert testimony from three of Plaintiff's expert witnesses—Nurse Taniguchi, Dr. Feinberg, and Dr. Weidenbaum. But again, Defendant ignores the standard of review, which resolves these contentions of error. *See Mayhorn v. Logan Med. Found.*, 193 W. Va. 42, 44, 454 S.E.2d 87, 89 (1994) ("Whether a witness is qualified to state an opinion is a matter which rests within the discretion of the trial court and its ruling on that point will not ordinarily be disturbed unless it clearly appears that its discretion has been abused.").

Nurse Taniguchi. In his motion for new trial at the circuit court and his brief before the ICA, Defendant argued the circuit court should have precluded Nurse Taniguchi from "testifying regarding a causal link between Plaintiff's 2020 stroke and Dr. Orphanos' 2017 care." Pet. Br. 26. But as the ICA found, 903 S.E.2d at 640, not only did Nurse Taniguchi offer no such causation testimony, the circuit court ordered that she "*can't* give causation testimony." App. 2567 (emphasis added). Instead, the circuit court ruled it "permissible" for Ms. Taniguchi to read "from an infectious disease doctor's record at Carilion that says [Plaintiff] had an ulcer on his buttocks that seeded the valve that caused the stroke" and that it is "common knowledge" that "people that are paralyzed get bed sores." App. 2467-68.

Nurse Taniguchi did what life care planners do: she drew pertinent information from Rodgers' medical records—he was paralyzed, developed bed sores, and had a stroke—to calculate what would be necessary for his future care.[6] As the ICA found, 903 S.E.2d at 640, the circuit court did not abuse discretion in allowing Nurse Taniguchi to testify for these purposes.

To the extent Orphanos now claims Rodgers failed to present causation testimony linking his 2020 stroke to Orphanos' paralyzing surgery in 2017, the ICA was correct in finding that Orphanos had not properly made or preserved any such argument, either in the Circuit Court or the ICA. 903 S.E.2d at 640 n.20. And for good reason; defense experts agreed that his stroke was caused by bedsores that developed as a result of the paralysis.[7] And to the extent Orphanos claimed the paralysis was the result of Mr. Rodgers' own negligence, the jury concluded Mr. Rodgers was not contributorily negligent, and rejected conflicting evidence. App. 1463.

---

[6] *Frometa v. Diaz-Diaz*, No. 07 Civ. 6372(HB), 2008 WL 4192501, at *2-3 (S.D.N.Y. Sept. 11, 2008) (life care planner's experience and review of medical records was sufficient to qualify under *Daubert*); *North v. Ford Motor Co.*, 505 F. Supp. 2d 1113, 1119-20 (D. Utah 2007) (life care planner had sound methodology and met *Daubert*, and she could rely on other expert's reports or information).
[7] *See* App. 3311, 3317-20, 3323.

Dr. Feinberg. Orphanos' challenge to the trial court's qualification of Dr. Feinberg to testify is puzzling. He was offered as an expert in the fields of neurology, neurophysiology, neuromuscular medicine, and IONM—a ruling that Orphanos did not object to at trial. App. 2671-73. The issue is waived. Syl. Pt. 5, *Tennant*, 459 S.E.2d at 379 ("Failure to make timely and proper objection to remarks of counsel made in the presence of the jury, during the trial of a case, constitutes a forfeiture of the right to raise the question thereafter[.]").

Nonetheless, Orphanos now Monday-morning quarterbacks a challenge to his qualifications. Orphanos made the right call on game day. Dr. Feinberg, whose specialties include clinical neurophysiology, co-founded the Spine Center at the University of Pennsylvania, which performs more than 4,000 spine surgeries each year. App. 2669. He regularly treats patients in the hospital with injuries to the spinal cord, including spinal strokes, and "works very closely with the surgeons both neurosurgeons and orthopedic surgeons that take care of spinal patients." App. 2666-68. The "most common part of [his] practice" is working "with neurosurgeons and spine surgeons evaluating patients pre-operatively all the way through their postoperative" care, including "complicated patients" and "trauma patients." App. 2670-71. Dr. Feinberg uses IONM on all patients with thoracic spine injuries. App. 2671-73.

Regardless, Orphanos now claims that because Dr. Feinberg is not a neurosurgeon he cannot testify about the standard of care. But the MPLA does not require an exact correlation between the Defendant's specialty and the expert's specialty. Rather, it is sufficient if "the expert witness is engaged or qualified in a medical field in which the practitioner has experience and/or training in diagnosing or treating injuries or conditions similar to those of the patient." W. Va. Code § 55–7B–7. The Supreme Court in 1994 confirmed this approach in the seminal case on expert qualification, *Mayhorn,* 193 W. Va. at 49–50, 454 S.E.2d at 94–95, which held that an

expert "is not barred from testifying merely because he or she is not engaged in practice as a specialist in the field about which his or her testimony is offered." *Id.* The test for qualifying as an expert is more relaxed: "[T]o qualify a witness as an expert on the standard of care, the party offering the witness must establish that the witness has more than a casual familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty." *Id.* Moreover, "[d]isputes as to the strength of an expert's credentials … go to weight and not to the admissibility of their testimony." *Gentry v. Mangum*, 195 W. Va. 512, 527, 466 S.E.2d 171, 186 (1995). The opposing party is then free to present contrary evidence and, of course, to subject the expert to cross examination. *Gentry*, 466 S.E.2d at 186 (cited authority omitted). Orphanos did that, without success.

Dr. Feinberg's testimony that Mr. Rodgers' paralysis was caused by the surgery, and that the standard of care in performing a thoracic spine surgery requires use of IONM, App. 2673-75, fits comfortably within his expertise. There was no error in admitting his testimony, particularly considering Orphanos never objected to it.

Dr. Weidenbaum. After arguing that Dr. Feinberg would have to be a neurosurgeon or spine surgeon to testify as to the standard of care, Defendant says that Plaintiff's expert Dr. Weidenbaum, who *is* a board-certified spine surgeon, is also unqualified, because of what Defendant characterizes as his limited experience with Chance fractures. Br. at 35-36. Here again, Defendant ignores the liberal standard for expert qualifications under Rule 702 and confuses fodder for cross-examination with grounds for disqualification.

In fact, it is hard to fathom an expert more qualified than Dr. Weidenbaum to opine as to the standard of care for spinal surgeries. After medical school and a residency in general surgery, Dr. Weidenbaum completed a three-year residency in orthopedic surgery and a one-year

fellowship specializing in spine surgeries, almost forty years ago. App. 2776-79. Since that time, he has devoted his medical practice exclusively to spine surgery while working at Columbia-affiliated hospitals in New York. App. 2780-82. He is board-certified in that field. *Id.* He has written peer-reviewed articles and lectured internationally on subjects relating to spine surgery. App. 2785-87. He also has experience treating patients with Chance fractures, including surgeries like Mr. Rodgers' where the placement of rods and screws was required. App. 2787-88.

The court easily qualified Dr. Weidenbaum as an expert in spine surgery (App. 2789) under *Mayhorn*, which requires only a "casual familiarity with the standard of care and treatment commonly practiced by physicians engaged in the defendant's specialty." 454 S.E.2d at 95. Moreover, Defendant had ample opportunity to cross-examine Dr. Weidenbaum regarding his experience with Chance fractures. App. 2866-67. The circuit court did not abuse its discretion in allowing his testimony.

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

Before trial, *the Defendant* moved to exclude testimony from the Rodgers family concerning the standard of care and causation—hearsay testimony they were clearly unqualified to address. App. 1114-15. The circuit court agreed. App. 2561-62; App. 61-65 (precluding lay testimony "on causation, why something happened, if they are being told by a treating physician").

Then, in an about-face, *the Defendant* sought to examine Plaintiff's mother Bonnie Rodgers, a lay witness with no medical training (App. 2707-08), about the very thing he successfully sought to exclude: hearsay statements, recorded in her notes, about a conversation she had with one of her son's health care providers, a "Dr. Jodi Joseph." App. 2737-40.

The circuit court committed no error here, as the ICA found. First, it is not an error to refuse to admit evidence the proponent of the evidence himself has sought to exclude. Second, Mrs. Rodgers' notes about a conversation she had with one of her son's physicians is obvious hearsay under Rule 802, and the circuit court properly excluded it. Third, while Orphanos now tries to argue for the first time on appeal that Mrs. Rodgers' notes were admissible under Rule of Evidence 612(b), he does so based on a misreading of the rule. The rule gives "an adverse party certain options when a witness uses a writing or object to refresh memory … while testifying," including the right "to cross-examine the witness about it, and to introduce in evidence any portion *that relates to the witness's testimony*." *Id.* Mrs. Rodgers did not testify as to causation of her son's spinal cord injury—in fact the *in limine* ruling precluded her from so testifying—nor was she remotely qualified to do so, so her notes do not "relate to [her] testimony."

And finally, what possible admissible testimony could a lay witness provide about a nebulous note that "Dr. Joseph … thinks there was an infarction just above T3/T4—if a contusion, then paralysis would have happened at time of accident and there would have been no movement of the lower extremities when he got to trauma unit, possible spinal stroke"? Pet. Br. 32 n.16. Defendant could have had Dr. Joseph testify as to those opinions, if he could testify to them to a reasonable degree of certainty—and if he could somehow explain why Mr. Rodgers' preoperative lower extremity neurology was "completely normal" when he got to the trauma unit. App. 2680-83. He did not.

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

Nor did the circuit court abuse its discretion by denying Defendant's motion to exclude evidence that he miscounted Plaintiff's vertebrae during surgery. Defendant argues that this decision was improper because "whether Dr. Orphanos miscounted the vertebral bodies was of

no consequence to this case." Br. at 39.

Defendant's argument misses the point of Dr. Weidenbaum's testimony, which *showed why Defendant's failure to use IONM* violated the standard of care. As Orphanos concedes, Dr. Weidenbaum was careful to testify that the misplaced screw, alone, did not breach the standard of care. App. 2826 ("Q. [I]s miscounting the vertebra a failure or deviation from the standard of care? A. No."). But Dr. Weidenbaum went on to explain that if Dr. Orphanos had used IONM during the surgery, he would have received a real-time alert to the impact of the misplaced screw on the spinal cord, and could have taken corrective action to remove the screw or decompress the spinal cord right then and there. App. 2860-61. Because this testimony about the misplaced screw was directly relevant to the significance of the underlying deviation from the standard of care, the court was within its discretion in admitting that evidence.

Moreover, Plaintiff's counsel never stated or implied that the miscounting of the vertebrae was evidence of negligence; the transcript passages Defendant cites in his brief make that clear. *See* Br. at 38 nn. 21, 22. To the contrary, it was *Plaintiff's counsel* who elicited the testimony from Dr. Weidenbaum that miscounting the vertebrae did *not* breach the standard of care. App. 2826. Plaintiff's counsel also told the jury that "there are occasions on which miscounting can occur" and emphasized that Dr. Weidenbaum confirmed that miscounting the vertebrae "happens." *Id.* What Plaintiff's counsel emphasized to the jury in his closing of Dr. Weidenbaum's testimony was that Dr. Orphanos' failure to use IONM deprived him of real time monitoring and the chance to take immediate corrective action, and not that screw misplacement breached the standard of care.[8] Because this evidence went directly to the IONM issue, the circuit

[8] *See* App. 3671 (Plaintiff's counsel: "Why is IONM there? Common sense. It's going to tell you something is wrong. Dr. Orphanos told you if all of this was hooked up, he would have known something was going wrong when he could do something about it and would know, how is our blood pressure? Get it up. Is this — I'm putting in a screw and all of a sudden something is going wrong. Or I'm trying to drive

court did not abuse its discretion in allowing it, nor did Plaintiff's counsel overstep in his opening statement and closing argument.

And even if the circuit court committed error, any error would have been, as the ICA concluded, harmless, especially given Plaintiff's counsel's care in eliciting testimony that miscounting the vertebra was *not* a deviation of care. *Orphanos*, 903 S.E.2d at 643.

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

Defendant's argument that the court abused its discretion by allowing the use of a "pie chart" during closing that depicted a large "slice" of pie as non-economic damages is much ado about nothing, as the jury's award of $7.5 million in non-economic damages was subsequently cut down to $750,000 pursuant to West Virginia's non-economic damages cap. App. 50. For this reason, as the ICA found, the use of the pie chart did not influence the jury's verdict, *Orphanos*, 903 S.E.2d at 643, nor is the issue ripe given the ten-fold reduction in noneconomic damages.

That aside, Defendant's argument fails because (a) the pie chart did not suggest a "specific amount of money that should or should not be awarded relating to economic damages," as Defendant contends would violate the court's order or the case law he cites (*see* Pet. Br. 38–39); (b) defense counsel forfeited any objection by failing to object to the pie chart while it was before the jury, Syl. Pt. 5, *Tennant*, 459 S.E.2d at 379; and (c) most importantly, in Orphanos' counsel's own words at the time, the use of the pie chart is "a nonissue, Plaintiff's counsel is not going to use it anymore." App. 3691-92. This illustrates precisely why this Court defers to the judgment of trial judges in making these rulings: the circuit judge was there to see how the pie

---

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

chart was used, and so was Rodgers' trial counsel, who described the pie chart as a "nonissue" notwithstanding his newfound appellate strategy to try to make it one.

7. The cumulative error doctrine is inapplicable because there were no errors.

In invoking the cumulative error rule as enunciated in *Tennant,* 194 W. Va. at 118, 459 S.E.2d at 395, Defendant fails to heed the Supreme Court's admonition that the rule is to be used "sparingly."[9] To obtain a new trial, a party must not only show that there were errors, but that the errors were so pervasive and prejudicial in nature that "any resulting judgment [is] inherently unreliable." *Id.* Defendant has failed to identify even a single error by the trial court, let alone the type of errors that warrant application of the cumulative error doctrine.

CROSS-APPEAL

A. The Circuit Court did not abuse its discretion by denying a trial continuance and allowing Plaintiff to supplement his life care plan almost ten weeks before trial.

The ICA found that a *single* error in the voluminous record below required a new trial on damages: the circuit court's denial of a motion to continue the trial (which had already been continued three times, App. 4115, 263, 809) and related refusal to strike the supplemental life care plan that Rodgers produced almost ten weeks before trial. *Orphanos,* 903 S.E.2d at 637-39.

Although the ICA did not discuss it, the circuit court issued this decision amid a flurry of pretrial motions, capped off by a pretrial hearing at which the court disposed of *31* motions on subjects ranging from medical causation, to *Daubert* challenges, to summary judgment and trial bifurcation. App. 61-64 (order regarding motions); App. 2541-2584 (hearing transcript). In

[9] *Very* sparingly—the Supreme Court has invoked cumulative error just once to reverse a civil verdict. *Herbert J. Thomas Mem. Hosp. Ass'n v. Nutter,* 238 W. Va. 375, 795 S.E.2d 530 (2016) (applying cumulative error doctrine where the trial court propounded over 300 questions to witnesses; expressed "a jaundiced view" of the defendant's witnesses while being "friendly, courteous, and favorable to the plaintiff"; demonstrated "anger" toward defense counsel; and required defense counsel to file his own trial notes under seal after counsel sought a mistrial). Nothing of the sort happened here.

ordering a damages retrial, the ICA disregarded this context and wrongly substituted its judgment for that of the trial court, which had presided over the case through years of hard-fought litigation and trial. The ICA's overreach is irreconcilable with the bedrock principle that "the [trial] court … is in the best position to reweigh competing interests in deciding whether to grant a continuance or postponement. An appellate court looks primarily to the persuasiveness of the trial court's reasons for refusing the continuance and gives due regard … to its superior point of vantage." *State v. Snider,* 196 W. Va. 513, 519, 474 S.E.2d 180, 186 (1996).

For this reason, the timeline is critical in understanding the context in which the circuit court ultimately decided to allow Orphanos to use two new experts disclosed just days before trial, but to preclude him from using a third witness, Dr. Gehring, to testify about Mr. Rodgers' life expectancy:

- Life expectancy had been at issue since early 2020, when Plaintiff produced a life care plan showing projected life expectancy of 28 additional years. App. 206. Orphanos could have, but did not, contest this in his reports from a life-care planner (App. 236-249) and economist (App. 253-261), nor did he even seek to depose Ms. Taniguchi on her report during the discovery period. App. 4134.
- On July 9, 2020, Mr. Rodgers suffered a stroke (App. 3098-99) and disclosed relevant medical records on October 21, 2020. App. 1350.
- On January 5, 2022, almost ten weeks before trial, Rodgers produced a supplemental life care plan that accounted for additional stroke-related expenses, and that restated the same life expectancy. App. 823-837.
- Rather than submit reports disputing the new life care plan, Dr. Orphanos one month later moved to continue the trial or strike the plan, App. 838-844, citing several reasons, none of which was the need to obtain a life expectancy expert.
- At a February 18, 2022 hearing on the motion to continue (App. 4123-4144), the defense cited reasons included the COVID pandemic, a request for mediation, and the need to evaluate the cause of Rodgers' stroke for comparative fault purposes ("stroke causation"). App. 4125, 4130-4131. No mention was made of any need to disclose a life expectancy expert. The court denied the motion, stating "I try to accommodate both sides, but I am mindful of the fact that this case was filed in mid 2019 and I think it is time for this man to have his day in court, so I'm going to deny the Motion to Continue." App. 4139, App. 867-868.

- The Court held a second hearing, on February 22, on Orphanos' motion to strike the supplemental life care plan. App. 4150-52. Again, no mention was made of the need for a life expectancy expert. The court deferred a ruling.[10]
- Finally, on until March 7, 2022, just *four business days* before trial, Orphanos disclosed for the first time in the years of litigation life expectancy opinions from Dr. Gehring, whom he had already retained for other purposes, as well as two new opinions from infectious disease experts to testify regarding stroke causation. Plaintiff moved to strike these opinions on March 9. App. 1349-1353.

This culminated in the lengthy pretrial conference (resolving the 31 motions) on March 14, the day before trial. App. 2541-2584. The court opened discussion of the continuance and motion to strike by presenting three options: Rodgers could drop the supplemental life care plan and eliminate the stroke-related issues (including the three new expert opinions); keep the supplemental lifecare plan but allow all defense witnesses to testify; or continue the trial. App. 2549. After considerable back and forth, including an acknowledgment by defense counsel that he sent Dr. Gehring the updated life care plan and records in January (App. 2558), Plaintiff's counsel presented a compromise: allow the two new stroke causation experts, but disallow the new life expectancy opinion from Dr. Gehring, on the ground that "if [defense counsel] believed that there was going to be a life expectancy issue, then they would have had that information and knowledge at least by 2020," when Rodgers' stroke records were produced. App. 2557-59.[11] This led to the court's ruling: "I tend to agree with that, … to allow the infectious disease testimony to come in but not the life expectancy [from Dr. Gehring] … So then that's a fair compromise …. Let's move on." App. 2559. Defense counsel would be able to cross-examine Nurse Taniguchi on life expectancy figure, App. 2560, which he did at length at trial. App. 3061-63; 3114-3124.

[10] This was the hearing at which Plaintiff's counsel assured defense counsel he would provide "great latitude" (*Orphanos*, 903 S.E.2d at 638) in supplementing his expert disclosures—but disclosing four days before trial an entirely new opinion on an issue the Defendant had ignored for years, goes beyond any reasonable understanding of "great latitude."

[11] In fact, Dr. Gehring testified at her April 14, 2021 deposition, almost a year before the trial, that she had received, but not reviewed, the stroke medical records. App. 4186-4188. Dr. Orphanos says nothing about this, yet still seeks an excuse for disclosing Dr. Gehring's opinions just days before the March 2022 trial.

If this history shows anything, it shows a busy trial court exercising precisely the sort of "judicial balance" that this Court will respect absent "a firm conviction that an abuse of discretion has been committed." *Covington v. Smith*, 213 W.Va. 309, 322–23, 582 S.E.2d 756, 769–70 (2003). In the end, the circuit court excluded one *new* opinion from an already retained expert witness (Dr. Gehring) on a subject (life expectancy) that had been at issue for years, but that the Defendant ignored. Then, when Rodgers produced a new life care plan ten weeks before trial, Defendant sent it to his expert, but chose to file a slew of motions to exclude the plan rather than timely supplement his own disclosures. Only once those motions fell through did Orphanos finally produce three new expert disclosures, just four business days before trial. After hearing all of this, the circuit court issued what it accurately described as a "fair compromise": to *allow*, on the one hand, expert testimony from the two infectious disease experts who faulted Rodgers' for the stroke, thus completely eliminating stroke-related damages from the life care plan, but to *disallow*, on the other hand, the late-disclosed life-expectancy testimony from Dr. Gehring, because Orphanos had been on notice of that issue for years, Dr. Gehring had the stroke-related medical records for almost a year, and defense counsel acknowledged sending her the updated life care plan in January, with no disclosure until the eve of trial.

Who better to consider these issues and make these rulings than the circuit court? In short, this was the sort of balanced, case-specific judgment call that Justice Recht (perhaps writing from experience) likely had in mind when he wrote that circuit courts—as "sentinels of protecting the rights of all litigants"—must make "quickly, without unnecessary fear of reversal." *B.F. Specialty Co. v. Charles M. Sledd Co.,* 197 W. Va. 463, 465, 475 S.E.2d 555, 557 (1996) (finding no abuse of discretion in the trial court's decision to deny a trial continuance in a case that had been pending for more than seven years) (cited authority omitted). Reversing and

remanding for a new trial on damages sends the wrong message to circuit courts, needlessly delays justice, and disregards trial judges' superior vantage point in making difficult decisions to "secure the just, speedy, and inexpensive determination of every action." W. Va. R. Civ. P. 1. It is also manifestly unfair to a litigant who has suffered enormously, with no recompense (to this day) over the last six-and-a-half years as a result of Dr. Orphanos' negligent care.[12]

CONCLUSION

Plaintiff-Respondent urges the Court to affirm in full the circuit court's judgment.

Dated: January 2, 2025

[12]The ICA analyzed these issues under the rubric of the *Tallman* factors, consideration of which supports a finding that the circuit court acted within its discretion. Syl. Pt. 2, *State ex rel. Tallman v. Tucker*, 234 W. Va. 713, 714, 769 S.E.2d 502, 505 (2015) ("Factors that may assist a court in deciding whether to permit late supplemental expert witness disclosure include: (1) the explanation for making the supplemental disclosure at the time it was made; (2) the importance of the supplemental information to the proposed testimony of the expert, and the expert's importance to the litigation; (3) potential prejudice to an opposing party; and (4) the availability of a continuance to mitigate any prejudice."). *First*, Plaintiff's original life-care plan was disclosed *before* he suffered a stroke in July 2020, and required supplementation. App. 66-67. *Second*, the damages calculation in the supplemental report was essential to ensuring Plaintiff would be compensated for the catastrophic harm he suffered as a result of Orphanos' "blind" surgery. *Third*, the lower court correctly rejected Defendant's claim of prejudice because Defendant had been on notice of the life expectancy issue for years, and received the supplemental life care plan almost ten weeks before trial—but chose to pursue a series of unsuccessful motions rather than promptly supplement his expert disclosures. *See id.,* 234 W. Va. at 719, 769 S.E.2d at 508 ("There was no evidence showing … any prejudice as a result of the late disclosure … *six weeks from the trial date*.") (emphasis added). *Fourth*, the circuit court was within the bounds of discretion by refusing to continue a thrice-continued trial because of Defendant's delay in addressing the life expectancy issue until just days before trial.

Respectfully submitted,

RESPONDENT
By Counsel

John W. Barrett, Esq. (WVSB #7289)
P. Gregory Haddad, Esq. (WVSB #5834)
Kerrie L. Haddad, Esq. (WVSB #9439)
BAILEY GLASSER, LLP
209 Capitol Street
Charleston, West Virginia 25301
Tel. No. (304) 345-6555
Fax No. (304) 342-1110
jbarrett@baileyglasser.com
ghaddad@baileyglasser.com
khaddad@baileyglasser.com

EXHIBIT A

APPENDIX A
West Virginia Code § 55-7B-9c

§ 55-7B-9c. Limit on liability for treatment of emergency conditions for which patient is admitted to a designated trauma center; exceptions; emergency rules

(a) In 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, the total amount of civil damages recoverable may not exceed $500,000, for each occurrence, exclusive of interest computed from the date of judgment, and regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees.

(b) On January 1, 2016, and in each year thereafter, the limitation on the total amount of civil damages contained in subsection (a) of this section shall increase to account for inflation as determined by the Consumer Price Index published by the United States Department of Labor: *Provided,* That increases on the limitation of damages shall not exceed one hundred fifty percent of the amounts specified in said subsection.

(c) Beginning July 1, 2016, a plaintiff who, as a result of an injury suffered prior to or after said date, suffers or has suffered economic damages, as determined by the trier of fact or the agreement of the parties, in excess of the limitation of liability in section (a) of this section and for whom recovery from the Patient Injury Compensation Fund is precluded pursuant to section one, article twelve-d, chapter twenty-nine of this code may recover additional economic damages of up to $1 million. This amount is not subject to the adjustment for inflation set forth in subsection (b) of this section.

(d) The limitation of liability in subsection (a) of this section also applies to any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is required as a result of the emergency condition within a reasonable time after the patient's condition is stabilized.

(e) The limitation on liability provided under subsection (a) of this section does not apply to any act or omission in rendering care or assistance which:

(1) ***Occurs after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a nonemergency patient***; or

(2) Is unrelated to the original emergency condition.

(f) In the event that: (1) A physician provides follow-up care to a patient to whom the physician rendered care or assistance pursuant to subsection (a) of this section; and (2) a medical condition arises during the course of the follow-up care that is directly related to the original emergency

condition for which care or assistance was rendered pursuant to said subsection, there is rebuttable presumption that the medical condition was the result of the original emergency condition and that the limitation on liability provided by said subsection applies with respect to that medical condition.

(g) There is a rebuttable presumption that a medical condition which arises in the course of follow-up care provided by the designated trauma center health care provider who rendered good faith care or assistance for the original emergency condition is directly related to the original emergency condition where the follow-up care is provided within a reasonable time after the patient's admission to the designated trauma center.

(h) The limitation on liability provided under subsection (a) of this section does not apply where health care or assistance for the emergency condition is rendered:

(1) ***In willful and wanton or reckless disregard of a risk of harm to the patient; or***

(2) In clear violation of established written protocols for triage and emergency health care procedures developed by the Office of Emergency Medical Services in accordance with subsection (e) of this section. In the event that the Office of Emergency Medical Services has not developed a written triage or emergency medical protocol by the effective date of this section, the limitation on liability provided under subsection (a) of this section does not apply where health care or assistance is rendered under this section in violation of nationally recognized standards for triage and emergency health care procedures.

(i) The Office of Emergency Medical Services shall, prior to the effective date of this section, develop a written protocol specifying recognized and accepted standards for triage and emergency health care procedures for treatment of emergency conditions necessitating admission of the patient to a designated trauma center.

(j) In its discretion, the Office of Emergency Medical Services may grant provisional trauma center status for a period of up to one year to a health care facility applying for designated trauma center status. A facility given provisional trauma center status is eligible for the limitation on liability provided in subsection (i) of this section. If, at the end of the provisional period, the facility has not been approved by the Office of Emergency Medical Services as a designated trauma center, the facility is no longer eligible for the limitation on liability provided in subsection (a) of this section.

(k) The Commissioner of the Bureau for Public Health may grant an applicant for designated trauma center status a one-time only extension of provisional trauma center status, upon submission by the facility of a written request for extension, accompanied by a detailed explanation and plan of action to fulfill the requirements for a designated trauma center. If, at the end of the six-month period, the facility has not been approved by the Office of Emergency Medical Services as a designated trauma center, the facility no longer has the protection of the limitation on liability provided in subsection (a) of this section.

(l) If the Office of Emergency Medical Services determines that a health care facility no longer meets the requirements for a designated trauma center, it shall revoke the designation, at which

time the limitation on liability established by subsection (a) of this section ceases to apply to that health care facility for services or treatment rendered thereafter.

(m) The Legislature hereby finds that an emergency exists compelling promulgation of an emergency rule, consistent with the provisions of this section, governing the criteria for designation of a facility as a trauma center or provisional trauma center and implementation of a statewide trauma/emergency care system. The Legislature therefore directs the Secretary of the Department of Health to file, on or before July 1, 2003, emergency rules specifying the criteria for designation of a facility as a trauma center or provisional trauma center in accordance with nationally accepted and recognized standards and governing the implementation of a statewide trauma/emergency care system. The rules governing the statewide trauma/emergency care system shall include, but not be limited to:

(1) System design, organizational structure and operation, including integration with the existing emergency medical services system;

(2) Regulation of facility designation, categorization and credentialing, including the establishment and collection of reasonable fees for designation; and

(3) System accountability, including medical review and audit to assure system quality. Any medical review committees established to assure system quality shall include all levels of care, including emergency medical service providers, and both the review committees and the providers shall qualify for all the rights and protections established in article three-c, chapter thirty of this code.

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

No. 24-438

JOHN R. ORPHANOS, M.D.,

Defendant-Below, Petitioner,

v.

MICHAEL RODGERS,

Plaintiff-Below, Respondent.

CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of January 2025, a true copy of the foregoing **RESPONDENT MICHAEL RODGERS' BRIEF IN OPPOSITION TO PETITIONER JOHN R. ORPHANOS, M.D.'S OPENING BRIEF AND CROSS-ASSIGNMENT OF ERROR** was served upon counsel of record via the E-Filing system, which will provide notice of the same to the following:

Richard D. Jones, Esq.
J. Dustin Dillard, Esq.
Flaherty Sensabaugh Bonasso, PLLC
200 Capitol Street
Post Office Box 3843
Charleston, WV 25338-3843
rjones@flahertylegal.com
ddillard@flahertylegal.com

Thomas J. Hurney, Jr., Esq.
Blair E. Wessels, Esq.
Jackson Kelly PLLC
500 Lee Street East, Suite 1600
Charleston, WV 25301-3202
thurney@jacksonkelly.com
blair.wessels@jacksonkelly.com

Ancil G. Ramey, Esq.
Steptoe & Johnson, PLLC
P.O. Box 2195
Huntington, WV 25722-2195
ancil.ramey@steptoe-johnson.com

Christine S. Vaglienti, Esq.
West Virginia University Health System
Legal Services
1238 Suncrest Towne Centre
Morgantown, WV 26505
vaglientic@wvumedicine.org

Carol Ann Marunich, Esq.
WVU Legal Affairs
P.O. Box 6204
Morgantown, WV 26506-6204
carol.marunich@mail.wvu.edu

Robert M. Sellards, Esq.
John H. Zickefoose, Esq.
Ralph J. Hagy, Esq.
Bradley D. Dunkle, Esq.
Bailes Craig & Sellards, PLLC
401 10th Street, Suite 500
Huntington, WV 25701
rsellards@spilmanlaw.com
jzickefoose@spilmanlaw.com
rhagy@spilmanlaw.com
bdunkle@spilmanlaw.com

Caleb B. David, Esq.
Shuman McCuskey Slicer, PLLC
1411 Virginia Street, East, Suite 200
Charleston, WV 25301
cdavid@shumanlaw.com

Kaitlyn N. Pytlak-Morra, Esq.
West Virginia Chamber of Commerce
1624 Kanawha Blvd. East
Charleston, WV 25311
Kpytlak-morra@wvchamber.com

John W. Barrett, Esq. (WVSB #7289)