Click to return to Table of Contents

West Virginia Medical Professional Liability & Health Care Litigation Review 2017-19[1]

Thomas J. Hurney, Jr.
Laurie K. Miller
Candice M. Harlow
Jackson Kelly PLLC
Charleston, West Virginia

INTRODUCTION

In 2017, the West Virginia Legislature amended several provisions of the Medical Professional Liability Act, W.Va. Code 55-7B-1 *et seq.* ("MPLA"), primarily regarding its application to long-term health care facilities. Senate Bill 338 builds upon the 2015 amendments, which expanded the definition of "health care" and "medical professional liability" to ensure the MPLA's application to claims against nursing homes and assisted living facilities.

The Supreme Court of Appeals of West Virginia has not yet had an opportunity interpret the 2017 amendments (or the 2015 amendments, for that matter); in fact, there have not been many MPLA cases presented to the Court in the last several terms.[2]

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[1] This paper continues a series of prior papers which track updates in the law of Medical Professional Liability which Thomas J. Hurney, Jr. and others have written for WVU CLE, Defense Trial Counsel of West Virginia and other organizations. The "MPLA at a Glance" section is more or less the same in each paper, followed by cases and statutes passed in the year prior to the date of the paper. For West Virginia law prior to the enactment of the original MPLA in 1986, read Mike Farrell's seminal article, The Law of Medical Malpractice in West Virginia, 82 W.VA. L. REV. 251 (1979). For more about the MPLA, see Thomas J. Hurney, Jr. & Robby J. Aliff, Medical Professional Liability in West Virginia, 105 W.Va. L. REV. 369 (Winter 2003), and Thomas J. Hurney, Jr. and Jennifer Mankins, Medical Professional Liability in West Virginia, Part II, 114 W.Va. L. REV 573 (2012). See also, Thomas J. Hurney, Jr., Hospital Liability in West Virginia, 95 West Virginia Law Review 943 (1993).

[2] Pending before the Supreme Court of Appeals of West Virginia is the matter of *Robert Smith, as Administrator and Personal Representative of the Estate of Aspen Smith, deceased v. Carolyn Clark, M.D. and Cabell Huntington Hospital, Inc., a West Virginia corporation* (No. 17-1086), which was orally argued on April 9, 2019. Petitioner brought a wrongful death claim against Respondents, Dr. Clark and Cabell Huntington Hospital, when an infant died during an attempt to deliver her from her mother's womb during an obstetrical emergency. A jury found in favor of the Respondents, finding no violations in the standard of care. Petitioner is appealing the circuit court's order denying a new trial on several bases. Petitioner claims the circuit court erred by (1) giving a multiple methods of treatment jury instruction; (2) failing to exclude Respondent's placental pathology expert; (3) striking Petitioner's nursing expert; (4) failing to give an "eggshell plaintiff" jury instruction; (5) precluding the cross-examination of Respondent Dr. Clark with prior testimony; (6) admitting undisclosed opinions by Respondents' expert; (7) precluding the testimony of Petitioner's (third) expert regarding standard of care; and (8) failing to strike a juror for cause based upon personal and business relationships with Respondents.

A few cases bear mention. In *Minnich v. MedExpress,* where a patient fell in an examining room, the Court found the action was governed by the MPLA. Notably, in doing so, the Court in *Minnich* applied the pre-2015 amendment definition of "health care."

In a case of first impression, the Court significantly diminished a hospital's discretion and immunity for decisions relating to privileges of health care providers. In *Camden-Clark Memorial Hospital Corporation v. Nguyen*, the Court limited long-standing jurisprudence, finding that a hospital lacked qualified immunity where a physician alleged the decision to terminate his privileges was made in retaliation to complaints he made about quality of care/patient safety.

Barber v. Camden Clark, while not an MPLA case, held that a patient could bring suit for wrongful disclosure of medical records where a hospital, with notice to the patient's counsel, produced records in response to a subpoena.

This paper will review the MPLA, including recent amendments and case law, as well as other court opinions affecting health care providers.

I.
MPLA AT A GLANCE

The Medical Professional Liability Act (MPLA), West Virginia Code §§ 55-7B-1 *et seq*., was first passed in 1986 and amended in 2001, 2003, 2015, and 2017. The MPLA governs all "medical professional liability actions," which the statute defines to include any actions in tort or contract against health care providers by patients arising from health care.[3]

1986 MPLA (MPLA I)

MPLA I applied to injuries occurring after June 6, 1986.[4] The statute codified the elements of a medical professional liability action, established a one million dollar cap on non-economic damages,[5] and limited joint and several liability.[6] MPLA I also restricted the statement of damages in *ad damnum* clauses,[7] required expert testimony and set forth

3 W.Va. Code § 55-7B-2(d) (1986).

4 W.Va. Code § 55-7B-9 (1986). Under the original version of § 55-7B-9, only defendants present at verdict are considered by the jury in its apportionment. See, *Rowe v. Sisters of the Pallottine Missionary Society,* 211 W.Va. 16, 560 S.E.2d 491 (2001). See also, *Landis v. Hearthmark,* Slip Op. No. 13-0159 (W.Va. Oct. 17, 2013)(allowing third party action by child against parents despite parental immunity; jury allowed to consider parents' fault in allocation and for intervening cause).

5 W.Va. Code § 55-7B-8 (1986).

6 W.Va. Code § 55-7B-9 (1986).

7 W.Va. Code § 55-7B-5 (1986).

qualifications thereof,[8] established a shortened statute of limitations for claims by minors[9] and a ten year statute of repose,[10] and specified various pretrial procedures.[11]

2001 Amendments (MPLA II)

MPLA II (H.B. 601), passed in 2001, applies to actions filed after March 1, 2002.[12] MPLA II required service of Notice of Claim and Certificate of Merit as a mandatory prerequisite to filing suit;[13] mandatory mediation;[14] exchange of medical records;[15] various management and scheduling directives designed to expedite actions;[16] voluntary summary jury trials;[17] an increase in the number of jurors from six to twelve with nine required to prevail;[18] and elimination of third party claims under the Unfair Trade Practices Act.[19]

2003 Amendments (MPLA III)

MPLA III (H.B. 2122) applies to actions filed after July 1, 2003.[20] The amendments added provisions for expedited resolution of cases;[21] limited the use of "loss of chance";[22] eliminated joint and several liability;[23] provided for collateral source adjustment of damages for medical bills;[24] strengthened expert witness qualifications;[25] restricted ostensible agency;[26] limited actions against health care providers by third parties;[27] lowered the non-economic caps to $250,000, and $500,000 for more serious cases;[28] and provided an overall $500,000 cap on

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8 W.Va. Code § 55-7B-7 (1986).
9 W.Va. Code § 55-7B-4(b) (1986).
10 W.Va. Code § 55-7B-4(a) (1986).
11 W.Va. Code § 55-7B-6 (1986) (This section, as amended, is now § 55-7B-6b).
12 W.Va. Code § 55-7B-10(a) (2001).
13 W.Va. Code § 55-7B-6 (2001).
14 W.Va. Code § 55-7B-6b(b) (2001).
15 W.Va. Code § 55-7B-6a (2001).
16 W.Va. Code § 55-7B-6b (2001).
17 W.Va. Code § 55-7B-6c (2001).
18 The twelve-person jury was struck down as unconstitutional in *Louk v. Cormier,* 218 W.Va. 81, 622 S.E.2d 788 (2005). See also, *Richmond v. Levin,* 219 W.Va. 512, 637 S.E.2d 610 (2006).
19 W.Va. Code § 55-7B-5(b) (2001). A health care provider can still file a first party action against a carrier but not until after the underlying matter is resolved. *Id, §* 55-7B-5(c).
20 W.Va. Code § 55-7B-10(b) (2003).
21 W.Va. Code § 55-7B-6d (2003).
22 W.Va. Code § 55-7B-3(b) (2003).
23 W.Va. Code § 55-7B-9 (2003).
24 W.Va. Code § 55-7B-9a (2003).
25 W.Va. Code § 55-7B-7 (2003).
26 W.Va. Code § 55-7B-9a(g) (2003).
27 W.Va. Code § 55-7B-9b (2003).
28 W.Va. Code § 55-7B-9c (2003).

all damages (both economic and non-economic) in "trauma" cases.[29] H.B. 2122 also created a patient compensation fund.[30]

2015 Amendments (MPLA IV)

The legislature significantly amended the MPLA in 2015 (MPLA IV) in Senate Bill 6 in response to a series of decisions by the Supreme Court of West Virginia which narrowly interpreted the applicability of the Act, thereby exposing health care providers, particularly hospitals, nursing homes, and other related long-term care facilities, to increased risk of liability not subject to the MPLA's protections.

MPLA IV amended, by adding and removing, several categories within the definition of "health care facility" and "health care provider" in W.Va. Code § 55-7B-2:

> (f) "Health care facility" means any clinic, hospital, *pharmacy*, nursing home, ~~or~~ assisted living facility, ~~including personal care home~~, residential care community, ~~and residential board and care home, or~~ *end-stage renal disease facility, home health agency, child welfare agency, group residential facility*, behavioral health facility or comprehensive community mental ~~health/mental retardation center, in and licensed~~ *health center intellectual/developmental disability center or program, or other ambulatory health care facility, in and licensed, regulated or certified* by the State of West Virginia *under state or federal law* and any state-operated institution or clinic providing health care *and any related entity to the health care facility*.
>
> (g) "Health care provider" means a person, partnership, corporation, professional limited liability company, health care facility, *entity* or institution licensed by, or certified in, this state or another state, to provide health care or professional health care services, including, but not limited to, a physician, osteopathic physician, *physician assistant, advanced practice registered nurse,* hospital*, health care facility*, dentist, registered or licensed practice nurse, optometrist, podiatrist, chiropractor, physical therapist, ~~psychologist~~, *speech therapist, occupational therapist, psychologist, pharmacist, technician, certified nursing assistant, emergency medical service personnel*, emergency medical services authority or agency*, any person supervised by or acting under the direction of a licensed professional, any person taking actions or providing service or treatment pursuant to or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis or treatment;* or an officer,

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[29] W.Va. Code § 55-7B-9c (2003).

[30] W.Va. Code § 29-12C-1 (2003). Other statutes offer liability protection in specific circumstances to health care providers (and others), advancing a policy to encourage the provision and improvement of medical care. See, W.Va. Code § 30-3C-2(a)(1)(peer review protection); W.Va. Code § 30-3-10A(a)(Good Samaritans); W.Va. Code § 55-7-15, 19 (retired physicians with special volunteer medical license who provide care without pay for the indigent, absent gross negligence or willful misconduct); W.Va. Code § 55-7-23(a)(Innocent Prescribers Act); W.Va. Code § 30-5-12 (protection for pharmacists and pharmacies who dispense medications unchanged); West Virginia Code § 55-7-11(b)(1)(Expressions of sympathy or apology by a healthcare provider).

> employee or agent ~~thereof~~ *of a health care provider* acting in the course and scope of ~~such~~ *the* officer's, employee's or agent's employment.

MPLA IV also amended the definition of "health care." West Virginia Code 55-7B-2(e) previously stated that "health care" meant "any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to or on behalf of a patient during the patient's medical care, treatment or confinement." MPLA IV broadened the definition to include "any act, *service or* treatment," including those "pursuant to or in furtherance of" a physician's or health care facility's plan of care, medical diagnosis, or treatment. The definition now also includes such acts, services, or treatments performed by persons "*supervised or acting under the direction of a health care provider or licensed professional* for, to or on behalf of a patient" during their medical care, "*including, but not limited to, staffing, medical transport, custodial care or basic care, infection control, positioning, hydration, nutrition and similar patient services*. . . ." Finally, the definition adds "[t]he process employed by health care providers and health care facilities for the appointment, employment, contracting, credentialing, privileging and supervision of health care providers."

In its entirety, the amended W.Va. Code 55-7B-2(e) states:

(e) "Health care" means:

> (1) Any act, service or treatment provided under, pursuant to or in the furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis or treatment;
>
> (2) Any act, service or treatment performed or furnished, or which should have been performed or furnished, by any health care provider or person supervised by or acting under the direction of a health care provider or licensed professional for, to or on behalf of a patient during the patient's medical care, treatment or confinement, including, but not limited to, staffing, medical transport, custodial care or basic care, infection control, positioning, hydration, nutrition and similar patient services; and
>
> (3) The process employed by health care providers and health care facilities for the appointment, employment, contracting, credentialing, privileging and supervision of health care providers.

A consistent change was made to West Virginia Code § 55-7B-2(i), which expanded the definition of "medical professional liability" to include "other claims that may be contemporaneous to or related to the alleged tort or breach of contract . . . all in the context of rendering health care services." That section now states:

> (i) "Medical professional liability" means any liability for damages resulting from the death or injury of a person for any tort or breach of contract based on health care services rendered, or which should have been rendered, by a health care provider or health care facility to a patient. *It also means other claims that may be contemporaneous to or related to the alleged tort or breach of contract or otherwise provided, all in the context of rendering health care services.*"

These changes expanded (and were intended to expand) the definition of health care and medical professional liability to ensure that the MPLA is applied to services typically provided to patients in hospitals and nursing homes as part of the overall plan of care. The amendment can be fairly seen as a response to *Manor Care v. Douglas,* 234 W.Va. 57, 763 S.E.2d 73 (2014), where the Court upheld a jury's verdict finding a percentage of the nursing homes' negligence was "ordinary."

In *Manor Care,* the plaintiffs' lawyers argued that understaffing and failure to provide adequate nutrition and hydration were not "health care" but instead "ordinary negligence." They argued "there was ample evidence presented at trial, and specific findings made by the trial court, as to how non-healthcare decisions, such as budgetary constraints, lack of staff, and poor management of the facility, affected all of the residents, including Ms. Douglas." [31] The circuit court permitted the jury to apportion by percentage between "medical" and "ordinary" negligence, with the MPLA applying only to the percentage of the award of noneconomic loss that was "medical" negligence. The Supreme Court affirmed this part of the verdict.

By expanding the MPLA's definition of "health care," more services provided as part of, and important to, the overall care and treatment of patients are included in the definition

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[31] The *Manor Care* opinion states:

> Evidence presented at trial demonstrated that Heartland Nursing Home had been chronically understaffed. There had been numerous complaints from residents and their families, as well as by Heartland Nursing Home employees. At least one employee who complained of understaffing was reprimanded for her complaint, and the complaint was apparently removed from Heartland Nursing Home records. Additionally, and notwithstanding attempts to conceal the understaffing, surveys by the West Virginia Department of Health and Human Services documented Heartland Nursing Home's understaffing and improper records pertaining to staff that occurred prior to Ms. Douglas' admission to that facility. Nevertheless, Heartland Nursing Home remained understaffed and, as a result, Ms. Douglas did not survive the adverse effects of her stay there. *Daniel v. Charleston Area Med Ctr., Inc.,* 209 W.Va. 203, 204, 544 S.E.2d 905, 906 (2001)("Upon a trial court's determination that an expert witness is required to prove standard of care or proximate cause in an action brought under the West Virginia Medical Professional Liability Act, West Virginia Code 5§ 55-7B-1 to -11 (1986) (Repl.Vo1.2000), a reasonable period of time must be provided for retention of an expert witness."); *State ex rel. Weirton Med. Or. v. Mazyne,* 214 W.Va. 146, 148, 587 S.E.2d 122, 124 (2002)("The necessity of expert witnesses in medical malpractice cases must be resolved during the mandatory status conference required by W.Va.Code § 55-7B-6 (1986). Accordingly, dates set forth in an initial scheduling order entered by the court pursuant to W.Va. R. Civ. P. 16 for the identification of expert witnesses are not controlling.").

of medical professional liability. W.Va. Code § 55-7B-2(i). Although the Court has yet to address this new definition, these changes should counter the effect of *Manor Care* and eliminate or at least significantly narrow expansive arguments about "ordinary" negligence.

The amended definition also extends the applicability of the MPLA to claims against hospitals for negligence in granting credentials and privileges and in monitoring health care providers. Like the other amendments to this subsection, the amendment was driven by concerns that hospitals could be exposed to claims related to health care that avoided the protection of the MPLA.

The MPLA definitions were similarly expanded to provide protection to pharmacies as "health care facilities" under W.Va. Code § 55-7B-2(f) and pharmacists as "health care providers," *Id.* 2(g), likely in late response to *Phillips v. Larry's Drive-In Pharmacy, Inc.*, 220 W. Va. 484, 647 S.E.2d 920 (2007)(holding a pharmacy was not a "health care provider" under the applicable provisions of the MPLA).[32]

MPLA IV also extended the application of the MPLA to other entities related to the health care provider or facility which treats the patients, including parent and sister corporations. In *Manor Care,* plaintiffs argued their claims against "non-health care provider" corporations, such as a related management company, were not protected by the MPLA. The Court did not directly address the issue, finding it had been waived by the defendant below.

The concept of "related entity" is found in amendments to two sections of the MPLA. Section 55-7B-2(f), quoted above, now includes "related entities" in the definition of health care facilities. *Id.* 2(f) ("'Health care facility'" means any clinic, hospital, pharmacy, [etc.], . . . *and any related entity to the health care facility.*"). MPLA IV specifically added "related entity" as a new definition in § 55-7B-2(n):

> (n) "Related Entity" means any corporation, foundation, partnership, joint venture, professional limited liability company, limited liability company, trust, affiliate or other entity under common control or ownership, whether directly or indirectly, partially or completely, legally, beneficially or constructively, with a health care provider or health care facility; or which owns directly, indirectly, beneficially or constructively any part of a health care provider or health care facility.

Other definitional changes are important to nursing homes, which have individual buildings or facilities generally owned by parent entities, and have certain services provided by separate corporations, such as budgeting and management services. These changes can also be important to hospitals as they will ensure the MPLA applies to related entities in a

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[32] *See* The Honorable Judge Joseph K. Reeder and Matthew G. Chapman, 2015 West Virginia Legislation Update: Part I, 118 W. Va. L. Rev. Online 23 (Sept. 29, 2015)(online at https://wvlawreview.wvu.edu/west-virginia-law-review-online/2015/09/29/2015-west-virginia-legislation-update-part-i).

hospital system, or which are designed to provide services to several hospitals, and more particularly to entities set up to employ physicians. The changes reflect the evolving way of providing health care services and guarantee the applicability of the MPLA.

A new section, W.Va. Code § 55-7B-7a, limits the admissibility of state and federal investigative reports, disciplinary actions, accreditation reports or assessment of penalties, unless they apply to the injured person or substantially similar conduct within one year of the incident involved. It prohibits the introduction of evidence about staffing levels if state staffing requirements are met. Finally, even if the evidence satisfies these provisions, it may only be admitted if there is a final order which is otherwise admissible under the West Virginia Rules of Evidence. Section 55-7B-7a, "Admissibility of certain information," states:

> (a) In an action brought, there is a rebuttable presumption that the following information may not be introduced unless it applies specifically to the injured person or it involves substantially similar conduct that occurred within one year of the particular incident involved:
>
> (1) A state or federal survey, audit, review or other report of a health care provider or health care facility;
>
> (2) Disciplinary actions against a health care provider's license, registration or certification;
>
> (3) An accreditation report of a health care provider or health care facility; and
>
> (4) An assessment of a civil or criminal penalty.
>
> (b) In any action brought, if the health care facility or health care provider demonstrates compliance with the minimum staffing requirements under state law, the health care facility or health care provider is entitled to a rebuttable presumption that appropriate staffing was provided.
>
> (c) Information under this section may only be introduced in a proceeding if it is otherwise admissible under the West Virginia Rules of Evidence.

MPLA IV also amended § 55-7B-7, dealing with expert witnesses, to include a new requirement that "the expert witness's opinion is grounded on scientifically valid peer reviewed studies if available; . . . ."[33]

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[33] W.Va. Code § 55-7B-7(4). There will likely be a challenge to constitutionality of the evidentiary provisions in S.B. 6. Statutory provisions in the MPLA related to expert witness qualifications in the original MPLA were struck down as unconstitutional. *Mayhorn* v. *Logan Medical Foundation,* 193 W.Va. 42, 454 S.E.3d 87 (1994)(MPLA expert requirements violated separation of powers and was an unconstitutional legislative intrusion into the Court's rule-making power). A provision in the 2001 amendments expanding the number of

The definition of "collateral source" was amended to exclude benefits payable under Medicare directly attributable to the medical injury in question. The amended provision of Section 55-7B-2(b) states:

> (b) "Collateral source" means a source of benefits or advantages for economic loss that the claimant has received from:
>
> (1) Any federal or state act, public program or insurance which provides payments for medical expenses, disability benefits, including workers' compensation benefits, or other similar benefits. *Benefits payable under the Social Security Act and Medicare are not considered payments from collateral sources except for Social Security disability benefits directly attributable to the medical injury in question*; . . . .

Section 55-7B-9c also includes new provisions that provide for an inflationary increase of the limitation on damages related to trauma care but states that any amount awarded in excess of the limitation of liability under the so-called "trauma cap" is not subject to inflation:

> (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[34] 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.

Section 55-7B-9c(a) was also amended to be consistent with Sections 55-7B-8(a) (which was amended to state the maximum amount recoverable as compensatory damages for noneconomic loss "~~shall~~ *may* not exceed $25,000 ~~per~~ *for each* occurrence, ...") and 8(b).

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jurors was struck down for the same reason. *Louk v. Cormier,* 218 W.Va. 81, 622 S.E.2d 788 (2005)(striking down twelve member jury). However, the Court has upheld and applied other provisions related to the requirements for expert testimony. *Daniel,* 209 W.Va. 203, 544 S.E.2d 905; *State ex rel. Weirton,* 214 W.Va. 146, 587 S.E.2d 122.

[34] In addition to the requirements set forth in W.Va. Code § 29-12d-3, Section 1(f) of the West Virginia Patient Injury Compensation Fund provides that "[t]he fund shall not provide compensation to claimants who file a claim with the Patient Injury Compensation Fund on or after July 1, 2016."

Section 9c(a) now states "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."*

Section 55-7B-9d, entitled "Adjustment of verdict for past medical expenses" is a new provision stating:

> A verdict for past medical expenses is limited to:
>
> (1) The total amount of past medical expenses paid by or on behalf of the plaintiff; and
>
> (2) The total amount of past medical expenses incurred but not paid by or on behalf of the plaintiff for which the plaintiff or another person on behalf of the plaintiff is obligated to pay.

As with the prior MPLA amendments, S.B. 6 applies "to all causes of action alleging medical professional liability which are filed on or after July 1, 2015." W.Va. Code § 55-7B-10(b) (2015).

2017 Amendments (MPLA V)

Senate Bill 338 (MPLA V) modified the MPLA with additional protections for long-term health care facilities. The MPLA V amendments apply to causes of action "arising or accruing" on or after July 1, 2017 – this is a change from previous amendments that applied to causes of action "filed" on or after the effective dates but is consistent with the original MPLA.

First, the definition of "occurrence" was added to Section 2:

> (l) "Occurrence" means any and all injuries to a patient arising from health care rendered by a health care facility or a health care provider and includes any continuing, additional or follow-up care provided to that patient for reasons relating to the original health care provided, regardless if the injuries arise during a single date or multiple dates of treatment, single or multiple patient encounters, or a single admission or a series of admissions.

As with the expansion of the definition of "health care" in MPLA IV, this amended definition provides yet another layer of protection to health care providers, including but certainly not limited to long-term care facilities, that render ongoing or extended health care services by clarifying that all services related to the original health care provided will be considered as a single occurrence. This definition is particularly important because the

limitations on liability for noneconomic losses and treatment of emergency conditions are based on "each occurrence."[35]

Section 4 of the MPLA was amended to reduce the statute of limitations for causes of action alleging medical professional liability against a nursing home, assisted living facility, and/or any of their related entities or employees from two (2) years to one (1) year from the date of the injury or from the date when the person, with the exercise of reasonable diligence, should have discovered such injury:

> (a) A cause of action for injury to a person alleging medical professional liability against a health care provider, *except a nursing home, assisted living facility, their related entities or employees or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees*, arises as of the date of injury, except as provided in subsection (c) of this section, and must be commenced within two-years of the date of such injury, or within two-years of the date when such person discovers, or with the exercise of reasonable diligence, should have discovered such injury, whichever last occurs: Provided, That in no event shall any such action be commenced more than ten years after the date of injury.
>
> (b) *A cause of action for injury to a person alleging medical professional liability against a nursing home, assisted living facility, their related entities or employees or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees arises as of the date of injury, except as provided in subsection (c) of this section, and must be commenced within one year of the date of such injury, or within one year of the date when such person discovers, or with the exercise of reasonable diligence, should have discovered such injury, whichever last occurs: Provided, That in no event shall any such action be commenced more than ten years after the date of injury.*

However, and likely given the significant reduction in the time to file a claim, MPLA V also tolls an action against a nursing home, assisted living facility, or related entity one-hundred eighty (180) days from the date the notice of claim was mailed to thirty (30) days following receipt of a response to the notice of claim (or from when such a response would be due) and further provides a claimant or his/her counsel with an additional one-hundred eighty (180) days to serve a screening certificate of merit in instances where, and upon providing a statement of intent, there is insufficient time to obtain one prior to the expiration of the statute of limitations.

With respect to the notice of claim prerequisites, W.Va. Code 55-7B-6(i)(2) now states, in full:

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[35] W.Va. Code §§ 55-7B-8(a), 8(b), and 9c(a). The MPLA further provides that each health care provider must maintain medical professional liability insurance in the aggregate amount of at least $1 million "for each occurrence" to be afforded the protections set forth in the MPLA. See W.Va. Code §§ 55-7B-8(c) and 9(g).

> In medical professional liability actions against a nursing home, assisted living facility, their related entities or employees or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, except as otherwise provided in this subsection, any statute of limitations applicable to a cause of action against a health care provider upon whom notice was served for alleged medical professional liability shall be tolled one hundred eighty days from the date of mail of a notice of claim to thirty days following receipt of a response to the notice of claim, thirty days from the date a response to the notice of claim would be due, or thirty days from the receipt by the claimant of written notice from the mediator that the mediation has not resulted in a settlement of the alleged claim and that mediation is concluded, whichever last occurs.

And, with respect to the screening certificate of merit prerequisites, W.Va. Code 55-7B-6(e) now states:

> In medical professional liability actions against a nursing home, assisted living facility, their related entities or employees or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, if a claimant or his or her counsel has insufficient time to obtain a screening certificate of merit prior to the expiration of the applicable statute of limitations, the claimant shall comply with the provisions of subsection (b) of this section except that the claimant or his or her counsel shall furnish the health care provider with a statement of intent to provide a screening certificate of merit within one hundred eighty days of the date the health care provider receives the notice of claim.

These amendments are compared with a "traditional" medical professional liability action, where the statute of limitations is tolled from the date of mail of a notice of claim to only thirty (30) days following receipt of a response to the notice of claim (or from when such a response would be due), and where a claimant may have, upon providing defendant(s) with a statement of intent, an additional sixty (60) days to provide a screening certificate of merit if there is insufficient time to obtain one.

MPLA V also established venue for all claims against long-term care facilities. Added section 55-7B-4(e) now requires that all liability actions against nursing homes, assisted living facilities, or their related entities or employees "*shall* be brought in the circuit court of the county . . . *at which the alleged act of medical professional liability occurred is located*, unless otherwise agreed upon by the nursing home, assisted living facility, related entity or a distinct part of an acute care hospital providing intermediate care or skilled nursing care and the plaintiff."[36] This new requirement serves to limit venue shopping, preventing parties from filing cases in "more

[36] The Statute very clearly provides that "[n]othing in this subsection shall prohibit a party from removing the action to federal court." *Id.*

favorable" counties where a parent or lateral facility may be incorporated rather than where the alleged injury occurred.

Finally, while not reflected in the 2017 MPLA Amendments, in January 2017, the West Virginia Board of Risk and Insurance Management (BRIM) published an Amended Advisory Bulletin regarding the interpretation of West Virginia Code § 29-12D-1a that applies to all settlements and judgments rendered in medical professional liability claims. BRIM is responsible for administration of the Patient Injury Compensation Fund (PICF), which was originally created in 2004 as a fund to compensate claimants who were unable to collect all civil damages awarded to them under the MPLA actions. A new section, effective July 1, 2016, provided that a one percent (1%) assessment was to be levied on the gross amount of any settlement or judgment. The language of the new section was unclear as to whether the 1% assessment should come from out of the gross amount of the settlement/judgment, or in addition to it. The Amended Advisory Bulletin stated that, although the defendant is charged with "remitting" payment to the clerk, "the 1% assessment is not a payment in addition to the amount of the settlement or judgment; rather, it is part of the gross amount of the settlement or judgment."

II.
MEDICAL PROFESSIONAL LIABILITY IN COURTS

Defining "Health Care"

In *Minnich v. MedExpress Urgent Care,* 238 W. Va. 533, 796 S.E.2d 642 (2017), the Court addressed the applicability of the MPLA. Mr. Minnich presented to MedExpress with complaints of shortness of breath, weakness, and possible pneumonia. According to his wife, a "medical assistant" escorted Mr. and Mrs. Minnich into an examination room. When Mr. Minnich tried to climb up on the bed, he fell (apparently on his wife), they both sustained injuries, and Mr. Minnich died 90 days later. Mrs. Minnich sued, individually and on behalf of her husband's Estate, claiming negligence based on "premises liability" and argued the MPLA did not apply to her claims. The circuit court disagreed, granting summary judgment and finding the action was governed by the MPLA. The circuit court directed Plaintiff to amend the complaint. Plaintiff unsuccessfully sought a Writ of Prohibition and then reconsideration of the court's ruling.

On appeal, the Court rejected Plaintiff's argument that the medical assistant was not a "health care provider" as defined in the MPLA because she was not licensed as such. Finding she was an "employee" of a qualified health care facility, the Court explained: "Because the status of MedExpress as a health care facility is not disputed, Ms. Hively, as respondent's employee, qualifies as a 'health care provider' for purposes of the MPLA." The Court "quickly dispense[d] with the petitioner's attempt to rely on her decision to file what she characterized as a 'premises liability' claim and not a medical malpractice claim," finding that

> [w]hile the petitioner would have us believe that the fact that a licensed health professional, such as a nurse or doctor, had not yet undertaken a physical examination of Mr. Minnich controls whether this case falls under the MPLA, we are not persuaded. Integral to the diagnosis and examination of a patient by a medical professional is the component of the health care visit that customarily precedes the actual physical examination. Absent the intake aspect of a patient's visit to a health care provider, the examination would not be as properly focused or as likely to result in a correct diagnosis. Consequently, we have little difficulty viewing the questioning by Ms. Hively of the Minnichs and the taking of vital signs that occurred prior to the fall as transpiring during the course of or "within the context of the rendering of medical services." *Gray,* 218 W.Va. at 570, 625 S.E.2d at 332. The petitioner's attempt to exclude any injuries sustained by a patient before a doctor or nurse enters the examination room, but after a medical history and intake have been taken, from the reach of the MPLA is unavailing.
>
> The critical inquiry is whether the subject conduct that forms the basis of the lawsuit is conduct related to the provision of medical care. . . . We simply cannot accept the petitioner's attempt to frame the injuries Mr. Minnich sustained in this case as being unrelated to the provision of health care services.

Examining the facts, the Court found "the injuries sustained by Mr. Minnich as a result of the fall were sustained in the course of his evaluation at MedExpress. That evaluation, an essential aspect of Mr. Minnich's medical diagnosis and/or treatment which involved usage of the examination table as medical equipment, was necessarily part of the health care services MedExpress undertook to provide Mr. Minnich." The Court also found Plaintiff pled the case in such a manner as to attack the clinical judgment of the Medical Assistant. "We agree with the trial court's assessment that the petitioner has raised the issue of whether proper clinical judgment was exercised in the course of Mr. Minnich's health care evaluation. Absent expert witness' testimony, the jury will be unable to determine whether Ms. Hively breached the duty of care she owed as a 'health care provider' to Mr. Minnich in connection with his receipt of health care at MedExpress."

The Court remanded the case, but allowed Plaintiff to amend, stating the remand "expressly incorporates the specific directive set forth in the December 1, 2014, summary judgment ruling that the petitioner shall be granted a reasonable period of time to amend her complaint to assert a claim under the Medical Professional Liability Act."

The Court expressly stated the 2015 definition of "health care" did not apply to the case (see *Minnich*, supra at n.4, n.12); accordingly, the Court's decision in *Minnich* is based upon the prior, more narrow definition of the term.

Liability based on "Actual Control" of a Health Care Facility

The Court's decision in *Hooper v. 1543 Country Club Rd. Manor Operations LLC*, No. 16-1226, 2018 WL 472952 (W. Va. Jan. 19, 2018) affirms the denial of a motion for new trial after a defense verdict in a nursing home case. The Court tacitly approved a jury instruction on "corporate negligence," stating that a company is not liable for another company's acts unless it controls the day-to-day operations and, therefore, the jury must find "actual control" to hold the defendant responsible for plaintiff's claims. The court rejected plaintiffs' argument that "they were not required, under [*Manor Care, Inc., v. Douglas*, 234 W. Va. 57, 763 S.E.2d 73 (2014)], to present evidence that [Defendant] exercised actual control over the operations of the Center, but that [Defendant] committed its own wrongs and that the jury could find [Defendant] directly liable for [Defendant]'s conduct." The Court distinguished *Manor Care* because the plaintiffs did not demonstrate Defendant's conditions were "reprehensible," "horrible," or "unbearable,' or that they engaged in any fraudulent tor intentionally misleading behavior. Simply put, the Court held that "Petitioner did not present evidence that [Defendant] was directly involved in the day-to-day operations of the facility."

Reptile Tactics, Trial and Evidentiary Issues

The Supreme Court of Appeals of West Virginia affirmed, in a memorandum opinion, a circuit court's pretrial and trial evidence rulings limiting questions using "Reptile" tactics in *Brown v. Berkeley Family Med. Assocs., Inc.*, No. 16-0572, 2017 WL 3821807 (W. Va. Sept. 1, 2017). Reptile tactics are arguments and questions designed to cast medical decisions as "safety" decisions and convince juries they must protect the safety of the community.[37]

In *Brown,* the patient was evaluated at Berkeley Family Medicine by Jewell, a Physician's Assistant. After a CT scan was read consistent with pneumonitis, Jewell prescribed antibiotics and scheduled a follow-up appointment. The patient's condition deteriorated, and he died. The case went to trial and the jury found "Jewell deviated from the accepted standard of care in her treatment of petitioner's decedent, but that such deviation did not proximately cause or contribute to the decedent's death." Plaintiffs' post-trial motions were denied, and they appealed.

On appeal, Plaintiffs raised a variety of errors. They challenged the trial court's ruling which prohibited "petitioner from arguing that jurors had the power to improve the personal and community safety of jury members by reaching a verdict that would reduce or eliminate allegedly dangerous or unsafe conduct. Respondents contend that such an argument encourages jurors to depart from impartiality." The circuit court denied the pretrial motion but allowed the defense to raise the issue on timely objection at trial. From opening on, Plaintiff launched a Reptile attack and the defense objected:

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[37] This technique is derived from David Hall and Don Keenan, "Reptile: The 2009 Manual of the Plaintiff's Revolution." The "reptile strategy" is based on specifically asking questions about risk, safety and the community to prejudice juries against defendants.

> During his opening statement, petitioner's counsel likened the standard of care to be adhered by medical professionals as a "rule". In response to an objection made by respondents' counsel, the circuit court ruled that the standard of care must be described to the jury, by both parties, simply as a standard of care, not a rule. Additionally, in response to another objection made by respondents, petitioner's counsel was cautioned by the court to refrain from using the term "danger" or "dangerous" to describe the decedent's medical condition.

The Supreme Court found the circuit court did not abuse its discretion when it placed "limits on petitioner's ability to present her case by arbitrarily selecting words and phrases petitioner's counsel could not use, such as 'rule,' danger,' and 'dangerous,'" stating

> [W]e find that the circuit court did not err in prohibiting petitioner from using certain terms that were potentially confusing and misleading to jurors. Petitioner was not prejudiced and manifest injustice did not result from the circuit court's ruling. Petitioner was afforded the opportunity to present her arguments and her case in a fair and impartial manner, free from arguably confusing or misleading inferences.

While the Supreme Court did not use the term "Reptile" anywhere in its opinion, it expressly recognized the impropriety of referring to the standard of care as a "safety rule" and the risk of confusing and misleading jurors. The Memorandum Opinion shows that a focus on the language used, rather than arguing generally about the "Reptile" approach, is an effective way to demonstrate to the Court the impropriety of the type of questions used.[38]

The Court also affirmed a number of other evidentiary rulings of interest, including the circuit court's ruling "excluding [introduction of] a copy of West Virginia Code §30-3-16, repealed in 2014, governing physician assistants," which the plaintiff wanted to publish to the jury. The Court agreed with the circuit court's finding that, "given the possibility of confusion that may arise for the jury if a copy of the statute was admitted into evidence, it was properly excluded. Petitioner read the relevant portions of the statute into the record and was provided the opportunity to question her expert regarding the statute."

The Court also affirmed the exclusion of the medical practice's job description for Physician Assistants because it was not in effect at the time of the care and, nonetheless, Plaintiffs' counsel was allowed to read portions into the record while examining his expert.

The Court rejected Plaintiffs' argument that the circuit court improperly allowed the defense expert, a family practitioner, to "offer testimony as to the radiologist's impressions."

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[38] "Memorandum decisions may be cited in any court or administrative tribunal in this State; provided, however, that the citation must clearly denote that a memorandum decision is being cited, e.g. *Smith v. Jones,* No. 11-098 (W.Va. Supreme Court, January 15, 2011)(memorandum decision). Memorandum decisions are not published in the West Virginia Reports, but will be posted to the Court's website."

The Court explained "[a]fter hearing the arguments of counsel and context of the testimony at issue, the circuit court found that respondents' expert testified not to what the radiologist was thinking, but rather to the expert's own interpretation of the report issued by the radiologist. Accordingly, there was no error."

The Court also rejected the plaintiffs' argument that it was error to allow the treating physician, who was not a defendant but was a named expert, to testify about his belief that the Physician's Assistant was "a careful individual and an outstanding physician assistant" and as to the treatment plan he would have recommended. However, he "was permitted to testify, not to [the Physician's Assistant's] character, but to her clinical skills and his direct observations of her work." The Court further explained that, "[i]n his position as the supervising physician of [the Physician's Assistant] at BFMA, [the treating physician's] testimony as to the proposed treatment plan for decedent was relevant to the issue of whether [the Physician's Assistant] was properly supervised by [the practice]."

Additionally, the Court rejected Petitioner's argument that the circuit court erred in submitting the issue of comparative fault to the jury because there was no evidence of fault on the part of the plaintiff. Because this error was not raised below, the Court declined to address it but also found "this issue to be moot as the jury found no liability against respondents. As such, it was not necessary for the jury to consider the decedent's comparative negligence."

Last, the Court rejected Petitioner's claim there was an improper *"Batson"* exclusion of a juror and that the cumulative error doctrine required reversal.

Evans v. Bluefield Hospital Co., LLC, was a wrongful death action where the plaintiff claimed, "the care provided to the decedent during his hospitalization deviated from the standard of care and that such deviation proximately caused the decedent's death." The case went to trial and after a defense verdict, plaintiff sought a new trial, arguing that jurors were acquainted with one of the defense witnesses. During trial, one of the jurors came forward after a defense witness testified to state she was acquainted with the witness and had not recognized her because she only knew her by her maiden name. Another juror was "friends" with the witness on Facebook. The Supreme Court affirmed denial of the motion for new trial, finding the relationships were slight and that plaintiff's counsel could have raised them pre-trial. The court also rejected plaintiff's argument that the verdict was contrary to the weight of the evidence that the defendants violated the standard of care. Finding there was expert testimony on both sides of the issue, the Court affirmed the discretionary ruling of the circuit court. Citing *Tri-State Petroleum Corp. v. Coyne*, 240 W. Va. 542, 814 S.E.2d 205 (2018), the Court concluded "[t]his is a classic 'battle of the experts,' and we decline [petitioner's] invitation to substitute our own determination as to these experts' credibility and persuasiveness for the jury's. For these reasons, we cannot find that the circuit court abused its discretion in denying petitioner's motion for a new trial on this ground."

Standing and Statute of Limitations in MPLA Actions

Williams v. CMO Mgmt., LLC, 239 W.Va. 530, 803 S.E.2d 500, 501 (W. Va. 2016) was a nursing home action where plaintiffs claimed wrongful death claim due to "systemic problems at the nursing facility concerning staffing, budgeting and allocation of resources, and inappropriate policies and procedures." This case is important because the Court applied the statute of limitations to prohibit evidence and claims that were more than two years from the date the action was filed.

CMO moved for summary judgment, arguing that the MPLA applied to all of Plaintiff's claims and, therefore, the two-year limitations period barred any claims accruing prior to April 19, 2011. Relying on *Manor Care*, supra, Plaintiff asserted that not all of her claims fell under the MPLA.[39] However, the trial court applied the two-year statute of limitations and held that "any claims arising from the care and treatment provided by the nursing facility prior to April 19, 2011, were time barred." As explained by the Supreme Court of Appeals, "[b]ecause Mr. Thompson died on July 2, 2011, the effect of this ruling was to limit the petitioner to introducing evidence of the injuries that occurred during a two-and-a-half-month period (April 19, 2011, to July 2, 2011)."

Trial commenced on October 21, 2014 and the jury found in favor of the Plaintiff, finding that CMO deviated from the standard of care in its treatment of Mr. Thompson. "[T]he jury decided that 75% of the negligence was medical in nature and 25% was non-medical, as it pertained to inadequate staff and/or training. In awarding compensatory damages, the jury determined that $10,000 was attributable to damages suffered by Mr. Thompson and $90,000 was suffered by the estate for his wrongful death."

For reasons not entirely clear, Plaintiff sought a new trial on the basis that the trial court, by applying the two-year limitations period (rather than the tolling provision found in the savings statute), prevented the introduction of pertinent evidence of the decedent's injuries. Plaintiff also argued that the court erred in failing to apply the discovery rule to toll the statute of limitations until the date of death, given "his incompetency and the absence of a legal representative charged to act on his behalf."

The Supreme Court succinctly stated the issue: "the statute of limitations issue at the center of this appeal concerns the time period for which the trial court permitted evidence to be introduced related to personal injuries the petitioner alleges [the decedent] sustained while living at the nursing facility." Distinguishing the case from prior decision in *Martin v. CAMC, Inc.*, No. 12-0710, 2013 WL 2157698 (W.Va. May 17, 2013), the Court stated:

> In contrast to *Martin,* the case before us presents a question of when Mr. Thompson's injuries could have been legally discovered which is linked to yet

[39] In footnote 8, the Court expressly stated that the 2015 MPLA amendments had "no impact on the outcome of this case."

> another distinction — the absence of a legal representative appointed prior to Mr. Thompson's death. While Mr. Martin was still living when his medical malpractice suit was instituted on his behalf, Mr. Thompson's cause of action was only asserted after his death. The trial court overlooked these significant differences, limiting its analysis to our brief recognition in *Martin* of the rule of statutory construction which "requires that a specific statute be given precedence over a general statute relating to the same subject matter where the two cannot be reconciled.'… Though the legal analysis we employed in *Martin* was admittedly scant, the trial court mistakenly concluded that the limitations period issue presented in this case — one that clearly does not require quantitative determination of two versus twenty years for purposes of instituting MPLA lawsuit — was resolved by the ruling we issued in *Martin.*

The Court then found that the discovery of the decedent's injuries, during the time period he was incapacitated, began to run when a representative was appointed because "[u]ntil she was appointed as his legal representative following his death, the petitioner had no power to stand in Mr. Thompson's legal shoes." Further, "[b]ecause a medical power of attorney is not the equivalent of a general power of attorney, she cannot be charged with knowledge of his injuries for purposes of the statute of limitations."

Accordingly, the Court found Plaintiff's cause of action was timely filed within two years of Mr. Thompson's death.

> However, the trial court constrictively applied the limitations period to prevent the petitioner from introducing evidence related to a two-year period of time when Mr. Thompson was actually alive and susceptible to injury. By its ruling, the trial court effectively shortened the legislative grant of a two-year period in which to seek recovery for injuries that were sustained. Obviously, no personal injuries were sustainable beyond the point of death. As a result, the trial court erred in limiting the petitioner to introducing evidence for the two-year-period directly preceding the filing of her suit. Accordingly, this matter is reversed and remanded solely on the issue of the personal injury claim and the trial court is directed to permit the introduction of admissible evidence for the two-year period that preceded Mr. Thompson's death.

Therefore, while the Court affirmed denial of a new trial on the wrongful death claim, it reversed and remanded the action as to the personal injury claim. Consistent with its analysis of the appointment of the representative for the state, the Court issued two new syllabus points:

> 2. An individual with a medical power of attorney does not have the power to make binding legal decisions for the subject incapacitated person.
>
> . . . .

> 4. The authority of a personal representative to bring a personal injury action on behalf of a deceased individual pursuant to West Virginia Code § 55-7-8a(c) (2008) includes the authority to bring a medical malpractice action under the Medical Professional Liability Act, West Virginia Code §§ 55-7B-1 to-12 (2008 & Supp.2015), for injuries sustained prior to death that did not result in death. Because West Virginia Code § 55-7-8a(c) incorporates the general disability savings statute, West Virginia Code § 55-2-15 (2008), the tolling provisions of the general disability savings statute apply to a medical malpractice cause of action brought by a personal representative under authority of West Virginia Code § 55-78a.

In *Parsons v. Herbert J. Thomas Mem'l Hosp. Ass'n*, No. 16-1178, 2017 WL 5513620 (W. Va. Nov. 17, 2017), the Supreme Court of Appeals of West Virginia affirmed, in a memorandum opinion, the dismissal of a complaint as barred by the statute of limitations.

In *Parsons*, Plaintiff attempted to argue that the statute of limitations on her medical negligence claim did not begin to run until after she retained a medical expert to review the records in question. Plaintiff underwent a hysterectomy by defendant physician Dr. Goad at Thomas Hospital on June 26, 2013. On July 11, 2013, she was diagnosed with a postoperative wound infection and enterocutaneous fistula. According to Plaintiff, she was led to believe her issues resulted from mesh implanted during a prior surgery. Therefore, she sought legal counsel in late July 2013 and was ultimately referred to counsel who filed the case on November 27, 2013.

In 2015, Plaintiff's counsel had the records reviewed by a medical expert (Dr. Awtrey) who determined that Plaintiff's injuries were the result of Dr. Goad's medical negligence, and not the mesh implants. Plaintiff filed her Complaint against Dr. Goad and Thomas Hospital on November 24, 2015. Defendants filed separate Motions to Dismiss/Motions for Summary Judgment, which were both granted by the circuit court, arguing that Plaintiff's Complaint was untimely and that her claims were barred by the statute of limitations.[40]

Plaintiff appealed, arguing that her two-year statute of limitations did not begin to run until July 29, 2015, when Dr. Awtrey first notified Plaintiff's counsel of his opinion that Dr. Goad was negligent. The Supreme Court of Appeals disagreed finding that Plaintiff discovered or, by the exercise of reasonable diligence, should have discovered that her injuries may have been caused by Dr. Goad after being diagnosed with a postoperative infection and

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[40] Under Section 55-7B-6(b) of the West Virginia Medical Professional Liability Act ("MPLA"), W. Va. Code §§ 55-7B-1, *et seq.*, Plaintiff provided a notice of claim to the defendants on or about July 7, 2015 followed by a screening certificate of merit on or about October 1, 2015. The MPLA provides that a plaintiff's claim is tolled by providing a notice of claim and certificate of merit. Here, the tolling period ended on October 31, 2015 (30 days after defendants' response to the certificate of merit would have been due). *See* W. Va. Code 55-7B-6(e). Therefore, defendants argued that Plaintiff's November 24, 2015 Complaint was filed at least 24 days after the tolling period ended.

enterocutaneous fistula on July 11, 2013. This is further supported by the fact that she sought legal counsel in late July. Finally, per the Court's prior holdings in *Gaither v. City Hospital Inc.*, 199 W.Va. 706, 715, 487 S.E.2d 901, 910 (1997) and *McCoy v. Miller*, 213 W.Va. 161, 167, 578 S.E.2d 355, 361 (2003), Plaintiff was not required to know the exact nature of the claim for the statute of limitations to commence. Accordingly, her claims were barred.

Prerequisites for Filing an MPLA Action: Service

The primary question in *Butts v. Berkeley Medical Center et al.*, Slip Op. No. 3:16-CV-71 (N.D. W. Va. December 9, 2016), was whether service of the notice of claim to a health care provider's former address (but the correct address on file with the West Virginia Board of Medicine) was sufficient under the MPLA. The defendant physician, Dr. Amira Khokar, argued that Plaintiff did not comply with the pre-suit filing requirements of the MPLA because he never actually *received* the notice of claim. The U.S. District Court for the Northern District of West Virginia denied the motion to dismiss, focusing on the statutory purposes of the pre-suit filing requirements and the good faith efforts of the plaintiff to serve the notice of claim.

First, the Court recited the purposes of the pre-suit filing requirements, which are (1) to prevent frivolous medical malpractice lawsuits, and (2) to promote early resolution of non-frivolous medical malpractice lawsuits. *Id.* at *3 (citing Syl. Pt. 2, *Westmoreland v. Vaidya*, 664 S.E.2d 90, (W. Va. 2008)). Second, the Court found plaintiffs reasonable, good faith efforts to serve the defendant: "Here, the Plaintiffs 'deposited in the mail' a notice [of claim] and screening certificate of merit on April 15, 2016. The same was delivered on April 19, 2016, to the address Dr. Khokar had on file with the West Virginia Board of Medicine." The Court found "no reason to penalize [the Plaintiffs] with dismissal of [their] suit when the record fails to show that [they were] not acting in good faith or otherwise [were] negligent to put forth a reasonable effort to further the statutory purpose." *Id.* at *4 (citing *Elmore v. Triad Hospitals, Inc.*, 640 S.E.2d 217, 223 (W. Va. 2006)). The Court noted "dismissal based upon procedural grounds is a severe sanction which runs counter to the general objective of disposing cases on the merit." *Id.* (citing *Westmoreland*, 664 S.E.2d at 97).

The U.S. District Court for the Southern District of West Virginia made a similar ruling on December 20, 2016 in *Foster v. Tannenbaum*, Slip Op. 3:16-4101 (S.D. W. Va. December 20, 2016). In *Foster*, on March 15, 2016, plaintiff attempted to serve notice of claim upon a defendant health care provider using the address on the "Find a Doctor" website curated by the Charleston Area Medical Center. *Id.* at *1. A return receipt indicated the mail was unclaimed and could not be forwarded. The address turned out to be correct, but it was the address of the health care provider's former employer. On April 16, 2016, the plaintiff mailed the notice of claim to the health care provider's attorney, who would not accept service. On May 11, 2016, the health care provider was served with a summons and complaint at her residence. She subsequently filed a Motion to Dismiss, alleging the plaintiff failed to comply with the MPLA's pre-suit filing requirements, in part, because she never *received* the notice of claim. *Id.*

Similar to *Butts v. Berkeley Medical Center*, the Court ruled that, although the defendant did not receive the notice of claim, the plaintiff made a "reasonable effort to further the statutory purpose" by sending the notice of claim to a proper (albeit former) address and then attempting to serve the notice on the defendant's attorney. *Id.* at *3. The Court recognized the "Fourth Circuit's preference for cases to be decided on the merits." *Id.* at *4.

Collateral Source Hearings

In *Simms v. United States*, 839 F.3d 364 (4th Cir. 2016), Plaintiff Simms brought a "wrongful birth" action against Defendant Valley Health Systems, Inc., a federally-supported health care system in West Virginia, claiming that its physicians detected potential fetal abnormalities early on but failed to notify the her. Subsequently, Ms. Simms gave birth to her son, who suffered severe brain malformation and multiple other related developmental conditions. The medical bills were paid by West Virginia Medicaid and Medicaid Waiver programs. Plaintiff filed her Federal Tort Claim in the U.S. District Court for the Southern District of West Virginia on November 21, 2011. After a bench trial, the District Court issued a memorandum opinion finding for the plaintiff and awarded the plaintiff a total of $12,222,743 in damages.

The government appealed to the Fourth Circuit challenging the District Court's award of damages on several grounds. Notably, the government argued that the District Court erred in refusing to reduce the damages award under the provisions of the MPLA. *Id.* at 368. The MPLA modifies the common law collateral source rule and entitles a defendant to a post-verdict, prejudgment hearing regarding payments received by the plaintiff from collateral sources. W. Va. Code §55-7B-9a(a). At the post-verdict hearing, the court is to reduce the economic damages award by the "net amount of collateral source payments received or to be received by the plaintiff" before entering the judgment. *Id.* at §55-7B-9a(f). However, the court may not reduce the award with respect to amounts "which the collateral source has a right to recover from the plaintiff through subrogation, lien, or reimbursement." *Id.* The MPLA qualifies Medicaid payments as collateral source. See §55-7B-2(b).

The District Court did not conduct a post-verdict collateral source hearing before entering judgment; instead, it ruled that the MPLA did not entitle the government to any damages reduction because "the West Virginia state Medicaid program has a subrogation lien against any verdict in Plaintiff's favor." *Id.* at 371. Because the District Court did not explain its basis for this conclusion, the Fourth Circuit remanded the case back to the District Court for such a hearing.

However, the Fourth Circuit emphasized the necessity of such a hearing: "First, even if the state Medicaid program does not hold a subrogation lien . . . the state of West Virginia may have 'a right to recover' the amount it has paid for [] medical care by some other means that would bar the district court from reducing Simm's award. . . . [and], regardless of whether West Virginia has a right to reimbursement with respect to the damages awarded for past medical expenses, such a right would not resolve whether the [MPLA] requires a reduction in

the damages for *future* medical expenses." *Id.* at 372 (emphasis in original) Accordingly, the Fourth Circuit underscored that the collateral source hearing is the proper vehicle for the parties to present evidence on these issues and for the Court to make findings on the statutory preconditions for collateral sources under the MPLA before entering judgment. *Id.*

W. Va. Code §55-7B-9c Trauma Limitation Does Not Apply

On November 15, 2016, Judge Irene C. Burger issued a Memorandum Opinion and Order following a medical professional liability bench trial under the Federal Tort Claim Act.

In *Lambert v. United States*, Slip Op. 15:14-cv-30075 (S.D. W. Va. Nov. 15, 2016), Plaintiff alleged that Dr. Roy Wolfe, an obstetrician-gynecologist, did not meet the applicable standard of care for her post-partum hemorrhage because he did not attempt all available treatment options before performing a hysterectomy, which resulted in the loss of her fertility. She relied on expert witness testimony demonstrating alternative treatment modalities that Dr. Wolfe could have attempted but chose not to. The Court ruled in favor of the plaintiff finding that Dr. Wolfe's treatment "fell egregiously below the standard of care" by not attempting safe and simple alternate procedures "[s]ome [of which] would have taken only seconds to perform." Therefore, the plaintiff was entitled to receive damages for medical expenses, loss of her fertility, early menopause and/or hormonal changes, emotional distress, and marital problems/loss of consortium.

Although the MPLA imposes a $500,000 cap for total damages in cases involving emergency care rendered at a designated trauma center (which is what occurred in this case), such limits do not apply if the medical treatment provided is performed "in willful and wanton or reckless disregard of a risk of harm to the patient; or in clear violation of established written medical protocols for triage and emergency health care procedures . . . ." W. Va. Code §55-7B-9c(h). Here, the Court found that "Dr. Wolfe's failure to attempt alternative treatments prior to performing a hysterectomy, on a twenty-four-year-old patient with stable vital signs and no evidence of hemodynamically instability, constitutes reckless disregard to a risk of harm to the patient." *Id.* at *7.

Therefore, the Court found there was no limitation on economic damages for plaintiff's claims; instead, the Court applied the $500,000 cap on non-economic damages only pursuant to W. Va. Code §55-7B-8, for cases involving wrongful death, loss of limb, or (as applicable here) loss of use of bodily organ system. *Id.*

Immunity Afforded in Hospital Credentialing Decisions is Weakened

In a case of first impression, the Court held in in *Camden-Clark Mem. Hosp. Corp. v. Nguyen*, 240 W.Va. 76, 807 S.E.2d 747 (2017) that claims brought under West Virginia's Patient Safety Act take precedence over a hospital's immunity with respect to credentialing decisions, regardless of how clear the hospitals bylaws are regarding its criteria for eligibility to apply for medical staff privileges. The new syllabus point articulated in *Nguyen* is even broader, stating

that while courts have limited review of "purely administrative decisions of private hospitals, the courts of this state do have jurisdiction to hear cases alleging torts, breach of contract, violation of hospital bylaws or other actions that contravene public policy."

In *Nguyen*, a physician's medical staff privileges were not renewed after the hospital discovered that he had not obtained board certification in his area of specialty within five years of completing his residency. Per the hospital's bylaws, a physician must obtain such certification in order to be eligible to apply for hospital privileges. After his medical staff privileges were not renewed by the hospital, Dr. Nguyen was terminated by the physician corporation for whom he worked because maintaining privileges at the hospital was a condition of his employment.

Under the employment contract, if terminated, the physician was responsible for purchasing tail insurance coverage; Dr. Nguyen did not do so, and his employer paid the premium and filed an action seeking repayment. Dr. Nguyen asserted a counterclaim against the physician corporation and a third-party complaint against the hospital, alleging that the denial of his medical staff privileges and termination were retaliatory and based on his reporting of alleged patient safety issues. The hospital moved for summary judgment on the third-party complaint. The circuit court denied the motion and the Supreme Court of Appeals affirmed.

It had been well-established under *Mahmoodian v. United Hosp. Ctr., Inc.*, that a hospital's decision to "revoke, suspend, restrict, or refuse to renew the staff appointment or clinical privileges of a medical staff member is subject to limited judicial review to ensure that there was substantial compliance with the hospital's medical staff bylaws . . . ." The Supreme Court, however, affirmed the trial court's denial of the hospital's motion to dismiss, which was based solely on grounds of the immunity provided to hospitals under *Mahmoodian*.

The *Nguyen* court, despite acknowledging that courts should "be reluctant to interfere in decisions that are grounded in hospitals' areas of expertise," held that such issues are "largely marginalized . . . when a health care worker alleged retaliatory or discriminatory conduct prohibited by statute under a legislative policy that seeks to safeguard the health and safety of hospital patients." Focusing solely on policy grounds, the Court found that the legislature "has made clear that courts should not ignore allegations that a hospital's action contravenes this significant public policy simply because credentialing standards or staffing privileges are implicated."

After *Nguyen*, a physician who has been terminated or denied renewal of his or her credentials can easily engage a hospital in expensive and time-consuming discovery regarding whether the physician made good faith "reports" or "advocated" for patient safety—both terms are undefined under the statute and thus may include even the broadest definitions of "reporting" or "advocacy." This is true even when it is undisputed that the physician does not meet the minimum criteria for medical staff eligibility, and even, as Justice Loughry acknowledged, when the retaliation claim is clearly brought to "leverage the hospital with a

separation-induced financial dispute." As Justice Loughry further explained in his dissent, "[b]y simply phrasing a challenge to a staff appointment as 'retaliatory' or 'discriminatory,' a physician may now evade the construct established in *Mahmoodian* of limited judicial review. . . . The ease with which a physician can conjure such assertions, and thereby entirely circumvent the limited review of staffing decisions, is troubling."

Subpoenas for Mental Health Records

Barber v. Camden-Clark Mem. Hosp. Corp., 815 S.E.2d 474 (2018) has good news and bad news for West Virginia hospitals. The bad news is that a hospital who "scrupulously" responds to a subpoena by providing sealed records to a judicial officer in response to a subpoena issued with notice to the patient as allowed by W. Va. Code § 57-5-4a(a) (1981) is subject to a private tort cause of action for a violation of W.Va. Code, 27-3-1, which governs disclosure of confidential information, if those records contain mental health treatment. The good news is that after an amendment to § 27-3-1, the hospital's actions would have been proper (had they occurred after July 1, 2018) as noted in the majority opinion in footnote 10.

In *Barber*, the Court reversed the circuit court's dismissal of Barber's suit against the hospital. In the underlying action Barber sued Sedgwick, whose counsel issued a subpoena to the hospital, citing W.Va. Code § 57-5-4a(a) with notice to Barber. The subpoena provided explicit directions that the hospital was not to comply for fifteen days to allow Barber to object and, even then, was to produce the records in a sealed envelope. Barber "did not file a motion to quash nor object in any way." The hospital provided "all" records in a sealed envelope and the lawyers who issued the subpoena sent copies to the patient. Some of the medical records reflected that "Ms. Barber had received in-patient mental health treatment when she was a teenager," but "Ms. Barber's counsel did not review the documents, and Ms. Barber never informed her counsel of her mental health treatment as a teenager." Barber's counsel admitted he did not look at the records he received prior to Ms. Barber's deposition at which she testified that she never had mental health treatment. During the deposition she was confronted with the records by her own lawyer. Thereafter, she sued the hospital for disclosing the mental health records in response to the subpoena claiming wrongful release under § 27-3-1. Finding that the hospital complied with W. Va. Code § 57-5-4a(a) and that the patient had an opportunity to object and failed to do so, the circuit court dismissed the complaint.

The Supreme Court reversed the dismissal, even though, as Justice Loughry wrote, "[i]n this case, there is no dispute that Camden Clark complied with the statutory procedure for production of its records. The issue is whether Ms. Barber has a claim against Camden Clark because it included documentation of her mental health treatment in the records it produced although no court order or written consent authorized the disclosure."

The Court determined that because § 27-3-1 did not authorize release of mental health records upon subpoena, "[t]o adopt Camden Clark's position would render West Virginia Code § 27-3-1 meaningless." That the patient had notice and did not object was of no moment because "West Virginia Code § 27-3-2 mandates that authorization for disclosure of mental

health records be in writing and signed by the patient. A failure to object to a subpoena does not satisfy the written consent requirement of West Virginia Code § 27-3-2 to permit disclosure of mental health records under the Act."

The Court also repeated its holding in *R.K. v. St. Mary's Med. Ctr., Inc.*, 229 W.Va. 712, 735 S.E.2d 715 (2012) that "common-law tort claims based upon the wrongful disclosure of medical or personal health information are not preempted by the Health Insurance Portability and Accountability Act of 1996." The Court held "[a]accordingly, we now hold that a hospital's compliance with the Act and HIPAA when responding to a subpoena for a patient's records does not preclude an action based on the wrongful disclosure of confidential information in violation of West Virginia Code § 27-3-1."

Footnote 10 suggests that the 2018 amendment to § 27-3-1 will obviate this issue in the future:

> As set forth in note 3, *supra*, West Virginia Code § 27-3-1 was amended in 2018. The amended statute, which becomes effective ninety days from the passage date of March 8, 2018, includes additional exceptions for disclosure of confidential information under West Virginia Code § 27-3-1(b). Of particular significance to future, similar circumstances is the provision that will permit disclosure
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> > [p]ursuant to and as provided for under the federal privacy rule of the Health Insurance Portability and Accountability Act of 1996 in 45 CFR § 164, as amended under the Health Information Technology for Economic and Clinical Health Act of the American and the Omnibus Final Rule, 78 FR 5566[.]
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> W.Va. Code § 27-3-1(b)(6) (2018). Notably, 45 C.F.R. § 164.512 permits disclosure for judicial and administrative proceedings in response to a subpoena. *See* note 6, *supra*.

Justice Workman wrote a spirited dissent, stating "[w]ith blinders squarely in place, the majority has misinterpreted a statute aimed at mental health providers and facilities and thereby rendered a hospital's fully statutorily-compliant acts actionable." Justice Workman first described the hospital's "scrupulous" compliance with "the extraordinarily detailed procedure for production of hospital records under subpoena as set forth in West Virginia Code §§ 57-5-4a through 4j (Repl. Vol. 2012)," and noted there was no dispute as to any of the facts, including that "Petitioner's counsel admitted that he did not review the records upon production." Justice Workman challenged the majority's statutory construction, stating the "canon of statutory construction — 'specific over general' — is not only inapplicable but its misapplication creates a wholly untenable scenario as pertains to the ability to subpoena hospital or other medical records." Closely examining West Virginia Code § 57-5-4a et seq., she noted that it "outlines the procedure to be followed by hospitals and litigants with regard

to subpoenas specifically for '[h]ospital records,'" noting the wide range of records included "without restriction," noting that "[n]owhere does it exempt records which fall within its unrestricted definition which involve, more specifically, mental health treatment." The statute states hospitals "must" produce copies of "all" records with a method to seal, identify and open them. To the contrary, Justice Workman found section 27-3-1 is in a Chapter of the West Virginia Code related to *mental health facilities and providers* and thus *does not apply to hospitals*.

> It is clear given the tenor and language of this statute that it is intended to advise mental health facilities and providers that their records—in fact, the mere existence of them—are confidential. It places no undue burden on these facilities or providers to constrain their ability to disclose the very fact of or the details regarding their treatment of their entire patient or clientele base. The conditions under which these facilities may make disclosures regarding their treatment make it quite obvious that the statute is intended to provide guidance to such specialized facilities in producing records insofar as is necessary for purposes such as voluntary and involuntary commitment proceedings, commitment of criminal defendants, and National Instant Criminal Background Check System reporting. The entire purpose, therefore, of the statute is to provide limitations on and guidance to mental health facilities as to how and under what circumstances their very specialized records may be utilized in the course of rendering and reporting on mental health treatment records may be utilized in the course of rendering and reporting on mental health treatment or coordinating with other mental health entities or procedures.

Justice Workman charged the majority with being "myopically focused on a superficial reading of the statute," that it placed an "onerous" burden on "unsuspecting" hospitals "which may happen to have records of or merely some reference to prior mental health treatment contained within the volumes upon volumes of records which it maintains." Rather than harmonize the two statutes, she found the majority "does just the opposite: it saddles Camden Clark with liability for merely adhering to a long-standing statutory procedure *expressly directed at the conduct of its business specifically* on the basis of a statute that applies to the obligations of very specific entities as part of an independent statutory scheme." She chastised the majority for misapplying statutory construction principles: "The canon of statutory construction requiring a specific statute to be "given precedence" over a general statutory provision applies only to "inconsistent statutes which, *together, form a part of a comprehensive body of law . . ." Carvey v. W. Virginia State Bd. of Educ.,* 206 W. Va. 720, 731, 527 S.E.2d 831, 842 (1999)."

> Rather, the mental health record statute is specifically part of a body of law *exclusively* addressing "mentally ill persons," and governing mental health facilities and providers. The hospital subpoena statute pertains *specifically* to a hospital's production of records in response to a subpoena, as part of our general laws regarding evidence and witnesses. Accordingly, the mental health confidentiality statute is not a "more specific" iteration of medical record production rules. Rather, as pertains to a hospital producing medical records in

> response to a subpoena, the statutory scheme governing precisely that activity by that entity could not possibly be more specific to that activity or entity and plainly purports to preempt and govern that process exclusively.

Given the hospital's "scrupulous" efforts to follow the records statute, which provided notice and an opportunity for the patient to take action to prevent disclosure, this is a disappointing decision. However, given the amendment to § 27-3-1, the opinion's effect should be short lived.[41]

Arbitration Provisions in Nursing Home Contracts

In *AMFM v. Shanklin*, 818 S.E.2d 882 (2018), an opinion by Justice Ketchum, the court reversed the Circuit Court's order denying the nursing home defendant's motion to dismiss and to enforce arbitration. At issue was the enforceability of an arbitration provision in the admission contract signed by the resident's daughter (Kimberly) who acted under a Durable Power of Attorney (DPOA). At issue was the fact that the daughter was not the assigned durable power of attorney – her brother was. Rejecting this argument, the Court stated "[t]he nursing home accepted the DPOA from Kimberly at the time of Mother Nelson's admission and relied on her authority. Pursuant to W.Va. Code § 39B-1-119(c), the nursing home could rely on the DPOA as long as it was without actual knowledge (1) that the DPOA was void, invalid or terminated, (2) that Kimberly's authority was void, invalid or terminated, or (3) that Kimberly was exceeding or improperly exercising her authority. Upon review, we find that the nursing home could rely on Kimberly's authority to serve as her mother's DPOA." The Court found the daughter "exercised her rights and duties under the DPOA 1) for two years prior to the nursing home admission, 2) during the nursing home admission process, 3) throughout Mother Nelson's residency at the nursing home, and 4) after Mother Nelson left Hillcrest and moved into Montgomery General Elderly Care. Conversely, there is no evidence that Stephen Nelson exercised any rights and duties granted to him under the DPOA — his inaction demonstrates that he declined to serve as Mother Nelson's DPOA." Thus, the Court found the daughter had the authority to enter into the arbitration provision. The case was remanded for entry of an order dismissing the complaint and compelling arbitration. While the Court's opinions have been trending towards enforcement of arbitration agreements, this opinion is significant because it is not in a commercial context. For the first time, the Court affirmed the use of arbitration agreements in nursing home contracts.

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[41] See also, West Virginia Code §§ 16-29-1 and -2, which set forth patients' rights to access medical records and establishes the cost-based fees a practitioner may charge for copies. These Sections were amended in April 2017 to allow a patient's personal representative, as defined under HIPAA, to obtain copies of medical records within 30 days following written request, and further provides that the copies may be provided in a downloadable format via secure web portal. The amendments in Section 2 provide a specific fee structure for the furnishment of health care records. Finally, while the article previously did not apply to records subpoenaed or otherwise requested through court process, effective July 6, 2017, the fee provisions set forth in Section 2 now apply to subpoenaed records.

CONCLUSION

While the Supreme Court of Appeals of West Virginia did not issue a lot of health care related opinions, *Minnich*, *Barber* and *Nguyen* are important cases, particularly to hospitals. Plaintiffs continue to actively litigate the applicability of the MPLA in cases involving whether Notices of Claim and Certificates of Merit are required and whether the MPLA applies to all or some of their claims. Certainly, the change in justices at the Supreme Court of Appeals in 2019 makes ongoing MPLA and related litigation an interesting topic. Good luck.