Click to return to Table of Contents

West Virginia Medical Professional Liability & Health Care Litigation Review 2012-13[1]

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2013

Annual Meeting Notebook

Myrtle Beach, South Carolina

Introduction

This article reviews current developments in Medical Professional Liability in West Virginia for the past year or so. The Court addressed a range of issues including arbitration clauses in nursing home admission contracts, due process requirements for administrative claims against health care professionals.

MPLA at a Glance

The Medical Professional Liability Act (MPLA), first passed in 1986 and amended in 2001 and 2003, governs all "medical professional liability actions" defined to include any actions in tort or contract against health care providers by patients arising from health care.[2] The 1986 MPLA (MPLA I), applied to injuries occurring after June 6, 1986,[3] defined the elements of an medical professional liability action, established a one million dollar cap on non-economic damages,[4] and limited joint and several liability.[5] MPLA I also restricted the statement of damages in *ad damnun* clauses,[6] require

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1 This paper is an update of the law which follows a series of prior papers. 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 W.Va. Code § 55-7B-2(d) (1986).

3 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 Pallotine Missionary*, 211 W.Va. 16, 560 S.E.2d 491 (2001).

4 W.Va. Code § 55-7B-8 (1986).

5 W.Va. Code § 55-7B-9 (1986).

6 W.Va. Code § 55-7B-5 (1986).

expert testimony and set forth qualifications of expert witness,[7] established a shortened statute of limitations for claims by minors[8] and a ten year statute of repose,[9] and various pretrial procedures.[10]

MPLA II (H.B. 601), passed in 2001, applies to *actions filed after* March 1, 2002,[11] and included service of Notice of Claim and Certificate of Merit as a mandatory prerequisite to filing suit;[12] mandatory mediation;[13] exchange of medical records;[14] various management and scheduling directives designed to expedite actions;[15] voluntary summary jury trials;[16] an increase in the number of jurors from six to twelve with nine required to prevail;[17] and elimination of third party claims under the Unfair Trade Practices Act.[18]

MPLA III (H.B. 2122) applies to *actions filed after* July 1, 2003,[19] and added provisions for expedited resolution of cases;[20] limitations on the use of "loss of chance";[21] elimination of joint and several liability;[22] collateral source adjustment;[23] expert qualifications;[24] restrictions on ostensible agency;[25] limits on actions against health care providers by third parties;[26] lowering of the non-economic caps to $250,000, and $500,000 for more serious cases;[27] and an overall $500,000 cap on all damages (both economic and non-economic) in "trauma" cases.[28] H.B. 2122 also created a patient compensation fund.[29]

The MPLA and its amendments have been subject to a variety of challenges. In general, the Court will construe the provisions of the MPLA narrowly. In *Phillips v. Larry's Drive In Pharmacy,* 220 W. Va. 484, 647 SE 2d 920 (2007), the Court held that MPLA does not apply to pharmacies as they

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7 W.Va. Code § 55-7B-7 (1986).
8 W.Va. Code § 55-7B-4(b) (1986).
9 W.Va. Code § 55-7B-4(a) (1986).
10 W.Va. Code § 55-7B-6 (1986) (This section, as amended, is now §55-7B-6b).
11 W.Va. Code § 55-7B-10(a) (2001).
12 W.Va. Code § 55-7B-6 (2001).
13 W.Va. Code § 55-7B-6b(b) (2001).
14 W.Va. Code § 55-7B-6a (2001).
15 W.Va. Code § 55-7B-6b (2001).
16 W.Va. Code § 55-7B-6c (2001)
17 The twelve person jury was struck down as unconstitutional in *Louk v. Cormier*, 218 W.Va. 81, 622 S.E.2d 788 (2005).
18 W.Va. Code § 55-7B-5(b). 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).
19 W.Va. Code § 55-7B-10(b) (2003).
20 W.Va. Code § 55-7B-6d (2003).
21 W.Va. Code § 55-7B-3(b) (2003).
22 W.Va. Code § 55-7B-9 (2003).
23 W.Va. Code § 55-7B-9a (2003).
24 W.Va. Code § 55-7B-7 (2003).
25 W.Va. Code § 55-7B-9a(g) (2003).
26 W.Va. Code § 55-7B-9b (2003).
27 W.Va. Code § 55-7B-9c (2003).
28 W.Va. Code § 55-7B-9c (2003).
29 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).

are not included in the definition of "health care providers" in the MPLA, West Virginia Code §55-7B-2(c) [1986]. Syllabus point five in *Phillips* states:

> 5. Where there is any doubt about the meaning or intent of a statute in derogation of the common law, the statute is to be interpreted in the manner that makes the least rather than the most change in the common law.

The MPLA I provision setting qualifications for experts was struck down as an unconstitutional legislative intrusion into the Court's rule-making power[30] as was the twelve person jury established in MPLA II.[31] While the pre-suit requirement of Notice of Claim and Certificate of Merit has been challenged several times, the Court has declined to strike it down on constitutional grounds. The Court's opinions, however, demonstrate it is reluctant to affirm dismissal of complaints where plaintiffs fail to comply with W.Va. Code § 55-7B-6d.[32] The original one million dollar "cap" on noneconomic loss was affirmed as constitutional on two occasions, and the caps in the 2003 amendments were upheld last year, in *MacDonald v. City Hospital*, 715 S.E.2d 405 (2011).

Notice of Claim and Certificate of Merit

The latest case on W.Va. Code §55-7B-6(c) is *Cline v. Kreasa Reahl*, 728 S.E.2d 87 (W.Va. 2012), here, where the Court affirmed dismissal of an MPLA complaint because plaintiff did not serve a certificate of merit thirty days before filing suit. The plaintiff served a Notice of Claim asserting the defendant physician failed to provide informed consent for thrombolytic therapy and took the position that no certificate of merit was required.

The plaintiff's decedent was admitted to the Emergency Department with stroke like symptoms and was examined by the defendant neurologist, who decided the patient was not a candidate for thrombolytic (clot buster) therapy for stroke because of a history of prostate cancer. The defendant admitted the patient to the Intensive Care Unit and he later died. The plaintiff claimed the neurologist wrongly failed to obtain informed consent for thrombolytic therapy and, as a result, denied the decedent the opportunity to decide to undergo the therapy. Thus, "petitioner argue[d] that to the extent she has alleged an informed consent claim, well-established precedent holds that an expert is unnecessary to establish a breach of the standard of care. As such, she claims that no screening certificate of merit is required per W. Va. Code §55-7B-6(c)."

As required by *Hinchman v. Gillette*, 217 W. Va. 378, 618 SE 2d 387(2005), defense counsel responded in writing, asserting a certificate of merit was required. Plaintiff declined, and filed suit. On motion of the defendant, the circuit court dismissed the action, and the plaintiff appealed.

On appeal, the plaintiff continued to argue that because the claim was grounded in informed consent, which is governed by the patient need standard, no expert witness was required. The Supreme Court disagreed.

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30 *Mayhorn v. Logan Medical Foundation*, 193 W.Va. 42, 454 S.E.3d 87 (1994).

31 *Louk v. Cormier*, 218 W.Va. 81, 622 S.E.2d 788 (2005).

32 *See*, *State ex rel Miller v. Stone,* 216 W.Va. 379, 607 S.E.2d 485, 2004 W.Va. Lexis 174 (2004); *Boggs v. Camden Clark Memorial Hospital,* 216 W.Va. 656, 609 S.E.2d 917, 2004 W.Va. Lexis 217 (2004)*; Hinchman v. Gillette*, 217 W.Va. 378, 618 S.E.2d 387, 2005 W.Va. Lexis 102 (2005); *Gray v. Mena,* 218 W.Va. 564, 625 S.E.2d 326 (2005)..

As to the claim the defendant did not provide informed consent for thrombolytic therapy, the Court found, consistent with prior law, that physicians are under no duty to obtain informed consent for procedures *not recommended*. See, *Hicks v. Ghaphery*, 212 W. Va. 327, 571 SE2d 317 (2002). Instead, the Court found the failure of the defendant to recommend or perform a procedure must be judged as a matter of standard of care. "As in *Hicks*, it is respondent's failure to recommend a treatment that is the crux of petitioner's case. This is precisely the type of allegation which does not implicate informed consent, as set forth in *Hicks*." The Court stated:

> The continued wisdom of our holding in *Hicks* is apparent. To suggest that respondent–or any physician–had a duty to obtain informed consent for a non-recommended treatment modality is nonsensical and creates an unnecessary and untenable basis of liability against a physician. If thrombolytics were a viable and medically appropriate treatment for Mr. Cline, respondent's failure to administer the medication would give rise to a claim for medical negligence, as was, in fact, alleged in the complaint but unsupported by a screening certificate of merit. If thrombolytics were not medically indicated for Mr. Cline in the medical judgment of the respondent, then she had no duty to advise petitioner or her decedent about such treatment. Such a requirement would force physicians to describe and discuss treatment options that they have no intention of administering even if, after discussion, the patient would select it (footnotes omitted).

In an opinion written by Justice Workman, the Court issued a new syllabus point::

> 5. The duty of disclosure set forth in *Cross v. Trapp*, 170 W. Va. 459, 294 S.E.2d 446 (1982), is predicated upon a recommended treatment or procedure. A jury must assess a physician's failure to recommend a procedure or treatment under ordinary medical negligence principles.

The Court also recognized that informed consent cases require expert testimony to prove the range of alternatives and causation; therefore, informed consent claims require service of a certificate of merit: "[U]nder certain circumstances the failure of a physician to advise his patient about medically indicated alternative treatments may potentially form the basis of a cause of action. However, in full consonance with Syllabus Point 5 of *Cross*, expert testimony would unquestionably be necessary to establish that such alternatives were medically reasonable and should have been presented to the patient. To that end, a screening certificate of merit would be required to comply with the MPLA's pre-suit requirements." The Court further stated,

> Having determined that petitioner did not plead a recognized informed consent claim, we need not address whether informed consent qualifies as a "well-established legal theory of liability which does not require expert testimony supporting a breach of the applicable standard of care," concomitantly obviating the need for a screening certificate of merit. Per our holding in *Hicks*, we find that the cause of action alleged by petitioner requires her to prove that the failure to recommend thrombolytics violated the applicable standard of care.

Examining the pre suit filings, the Court found the defendant provided a timely, specific objection to the Notice of Claim, and plaintiff declined to provide a certificate of merit.

> As discussed more fully *supra*, petitioner's cause of action does not qualify for the exception to the screening certificate of merit, but rather constitutes traditional medical negligence, necessitating compliance with W. Va. Code § 55-7B-6(b). Given the complete absence of a screening certificate of merit, the good faith analysis established in *Hinchman* to determine its "sufficiency" is academic, at best. Regardless, the trial court determined that given petitioner's refusal to reassess the necessity of a screening certificate of merit after one was demanded by respondent, she did not demonstrate a good faith and reasonable effort to further the MPLA's statutory purposes.

The Court therefore affirmed the dismissal of the action, stating:

> The instant case certainly does not present the "unique case" illustrated in *Westmoreland*. Petitioner had multiple opportunities, both pre- and post-suit to correct her deficient pre-suit compliance, but refused to do so. Her refusal to do so, as discussed supra, was based on a very narrow reading of *Cross* and her contention that *Hicks* should be overruled. Most importantly for purposes of our analysis, however, the circuit court's dismissal was without prejudice. Like the plaintiff in *Davis*, petitioner was free to re-file her complaint pursuant to the savings statute after complying with the pre-suit requirements of the MPLA. The circuit court properly undertook the good faith analysis set forth in *Hinchman* and inasmuch as its dismissal was without prejudice, the court did not "restrict or deny citizens' access to the courts." *Hinchman*, 217 W. Va. at 385, 618 S.E.2d at 394.

Moreover,

> As illustrated above, this Court has been exceedingly protective of a litigant's access to the courts under the MPLA, reversing draconian results which prevented litigation of otherwise meritorious claims; however, commensurately, we have expressly and repeatedly warned litigants to err on the side of caution in complying with the MPLA. Therefore, this Court can hardly discern any reversible error when a trial court applies the plain language of the statute and our caselaw, which application properly results in dismissal, but with no discernable prejudice to the litigant.

This language follows *Davis v. Moundview*, 640 S.E.2d 91, 220 W. Va. 28 (2006) and provides the plaintiffs a year from dismissal to "cure" their pre-filing error, as the affirmance is of an order of dismissal without prejudice. Nonetheless, *Kreasa-Reahl* is an important decision because it (1) confirms the mandatory nature of 55-7B-6; (2) affirms that informed consent claims require expert testimony, and therefore require certificate of merit pre-suit; and (3) affirms that plaintiffs must reasonably respond to pre-suit *Hinchman* objections.

Venue

In *Jewell v. Peterson*, No. 11-1354 (W.Va. Nov. 16, 2012)(opinion here), plaintiff filed suit in Fayette County alleging that for over a year, the defendant physician negligently failed to diagnose that the decedent, Ms. Jewell, had lung cancer. The physician practiced, and the treatment occurred, in Fayette County. Plaintiffs, however, brought suit in Kanawha County. The plaintiffs argued venue was proper because the decedent died at a hospital there Kanawha County, and the cause of

action therefore "arose" there. The Kanawha County Circuit Court, finding venue was not proper, dismissed the action, and the plaintiff appealed.

The Supreme Court affirmed, rejecting plaintiff's venue argument, stating "we agree that under the specific facts as alleged therein, any cause of action against these respondents arose in Fayette County. Because respondents are not residents of Kanawha County, and because the cause of action did not arise in Kanawha County, dismissal was proper."

Arbitration Provisions in Nursing Home Contracts

In *Marmet Health Care Center, Inc. v. Brown*, 565 U.S. __, 132 S. Ct. 1201(2012), the United States Supreme Court vacated a decision by the Supreme Court of Appeals of West Virginia which struck down pre-dispute agreements requiring arbitration of claims of personal injury or wrongful death against nursing homes.

The vacated opinion was *Brown v. Genesis Healthcare Corporation*, 724 S.E.2d 250 (2011), where the West Virginia court issued an opinion in a trio of cases concerning the enforceability of arbitration clauses in nursing home agreements, finding them unconscionable and therefore unenforceable as a matter of law. Central to the ruling was the fact the arbitration agreements were entered into by the resident or resident's representative at the time of the resident's admission to the nursing home and prior to the alleged negligence and injury.

In *Brown*, the West Virginia court initially concluded that even though the Federal Arbitration Act ("FAA") requires courts to honor arbitration agreements, the agreements in questions were unconscionable and therefore unenforceable under West Virginia law. While the court found the FAA preempted section 5(c) of West Virginia's Nursing Home Act, which effectively prohibits arbitration clauses, "after considering the history and purposes of the FAA," the court determined:

> Congress did not intend for the FAA to apply to arbitration clauses in pre-injury contracts, context of pre-injury nursing home admission agreements, we do not believe that such arbitration clauses are enforceable to compel arbitration of a dispute concerning negligence that results in a personal injury or wrongful death.

The court declined to enforce the agreements, holding "as a matter of public policy under West Virginia law, an arbitration clause in a nursing home admission agreement adopted prior to an occurrence of negligence that results in a personal injury or wrongful death, shall not be enforced to compel arbitration of a dispute concerning the negligence." The Court, therefore, held the FAA did not preempt West Virginia's public policy against "pre-dispute arbitration agreements that apply to claims of personal injury or wrongful death against nursing homes."

United States Supreme Court reversed in *Marmet Health Care Center, Inc. v. Clayton Brown*, 565 U.S. __, 132 S. Ct. 1201 (2012), finding "[t]he West Virginia Court's interpretation of the FAA was both incorrect and inconsistent with clear instruction and the precedence of this Court." Analyzing its prior cases, the Court concluded that state laws which prohibit outright arbitration of a particular type of claim are subject to the FAA. Accordingly, "West Virginia's prohibition against pre-dispute agreements to arbitrate personal-injury or wrongful-death claims against nursing homes as a categorical rule prohibiting arbitration of a particular type of claim, and that rule is contrary to the terms and coverage of the FAA."

The Supreme Court also addressed the West Virginia Court's alternate holding that the arbitration clauses were "unconscionable." Finding the decision unclear, the Court vacated the opinion and remanded the case for the Supreme Court of Appeals of West Virginia to "consider whether, absent that general public policy, the arbitration clauses in . . . are unenforceable under state common law principles that are not specific to arbitration and preempted by the FAA."

On remand, the Supreme Court of Appeals of West Virginia scheduled oral arguments on the as single issue: "Was this Court's determination that the arbitration clauses were unconscionable influenced by its categorical holding that pre-dispute agreements to arbitrate personal injury or wrongful death claims are not governed by the Federal Arbitration Act."

A week after oral argument, the West Virginia court issued an opinion which overruled its original holding that the arbitration clauses were not pre-empted by the Federal Arbitration Act and were unenforceable as a matter of law in West Virginia (as ordered by the U.S. Supreme Court). *Brown v. Genesis Healthcare,* 729 S.E.2d 217 (2012). The Court maintained its stance on unconscionability noting "[w]e are hostile toward contracts of adhesion that are unconscionable and rely upon arbitration as an artifice to defraud a weaker party of rights clearly provided by the common law or statute." Rather than simply holding the arbitration provisions were unconscionable, the Court remanded two of the three cases (*Brown* and *Taylor*) to the trial court to develop evidence on the issues of procedural and substantive unconscionability.

Arbitration clauses were at issue again in *State ex rel AM FM v. King*, No. 12-0717 (W.Va. Jan. 24, 2013)(here), where the nursing home, after being sued by a resident, moved to enforce an arbitration provision contained in its admission contract. The circuit judge refused to enforce the arbitration provision, concluding that because the authority of the health care surrogate, who signed the agreement which contained the arbitration clause, "was limited to making health care decisions on behalf of [the resident] and did not extend to the subject Arbitration Agreement." The nursing home sought a writ of prohibition, but the Supreme Court affirmed the circuit court ruling. In an opinion authored by Justice Davis, the Court agreed, issuing new syllabus points:

> 6. The West Virginia Health Care Decisions Act, W. Va. Code § 16-30-1 et seq., authorizes a health care surrogate to make health care decisions on behalf of the incapacitated person for whom the surrogate has been appointed.
>
> 7. The health care decisions that a health care surrogate is authorized to make on behalf of the incapacitated person for whom the surrogate has been appointed are "decision[s] to give, withhold or withdraw informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation." W. Va. Code § 16-30-3(i) (2002) (Repl. Vol. 2011).
>
> 8. An agreement to submit future disputes to arbitration, which is optional and not required for the receipt of nursing home services, is not a health care decision under the West Virginia Health Care Decisions Act, W. Va. Code § 16-30-1 *et seq.*

These cases strongly suggest the Court continues to take a dim view of arbitration agreements. *Genesis* demonstrates strongly the Court believes the agreements are *per se*

unconscionable, and *AM FM* shows arbitration provisions will be narrowly construed, and are not considered "health care" decisions where the resident can be bound by the health care surrogate.

Verdict Form

The first appellate salvo arising from the award by a Kanawha County jury of $91.5 against a nursing home and related corporations was a narrow procedural issue. In *SER Manor Care, Inc., et al. v. Honorable Paul Zakaib, Jr., Judge, et al.*, No. 12-0443 (W. Va. May 24, 2012)(here), the Circuit Judge's refused to allow the post-trial filing of the defendant's proposed jury verdict form, which it had previously refused in favor of the form submitted by plaintiff. Even though both verdict forms were considered by the Circuit Judge during the jury charge argument at trial, the defendant did not formally file its suggested form with the Clerk. When counsel sought leave to file the verdict form post trial, the plaintiffs objected and the judge refused. The defendants sought a Writ of Prohibition.

The Court issued the Writ, finding "[a]t some point after the trial the petitioners learned that their proposed verdict form was not made part of the record…." and filed a motion to correct the record by making the proposed form part of the record. Despite the fact that both sides submitted verdict forms to the court, argued about them before the judge who made a ruling on the record, the circuit judge refused to allow post trial filing of the defense verdict form. The Court, in a Memorandum Decision, held the circuit court abused its discretion in refusing the filing, and remanded the action.[33]

Nursing Board Required to Hold Timely Hearings

In *SER Fillinger v. Rhodes*, No. 12-1055 (W.Va. Mar. 12, 2013)(here), the Court chastised the Board of Nursing for not timely pursuing complaints against nurses. Nurse Fillinger sought a writ of prohibition requiring the Board to dismiss two complaints filed against her in 2008 and 2009 because, despite several requests, the Board never gave her a hearing. The Court granted the Writ despite the announcement of a settlement due to the important issues raised.

The two charges against the nurse stemmed from complaints filed by two hospitals which fired her for drug use, specifically for obtaining drugs from a machine using a passcode. The Board presented both charges, and sent her a proposed consent order which she rejected, demanding a hearing. Starting in July 2011, a series of hearings were set and cancelled by the Board, until the petitioner moved to dismiss the charges arguing "the Board's continuances of the scheduled hearings were contrary to law, had deprived the petitioner of substantial resources and had improperly delayed the entry of a final administrative decision." The Board didn't respond, but set another hearing, which the parties agreed to suspend so the Nurse could seek a writ. Granting the Writ, the Court issued a new syllabus point:

> 2. In adjudicating a contested case concerning the revocation or suspension of a nurse's license to practice registered professional nursing, the West Virginia Board of Examiners for Registered Professional Nurses must follow the procedural requirements set forth in Chapter 30 of the West Virginia Code, as well as the

[33]On remand, the defendants continued with post trial challenges to the verdict. In two orders entered April 10, 2013, Circuit Judge Paul Zakaib denied the defense motions in their entirety, upholding the jury's verdict on liability, damages and punitive damages. The defendants have filed notice of appeal to the Supreme Court, so there is more to come in this case.

> contested case hearing procedure set forth in Title 19, Series 5, of the West Virginia Code of State Rules.

The Court, upon review of several sections of the Code, concluded the Nursing Board violated the law by failing to proceed to a hearing when requested, provide information about charges prior to the hearing, provide reasons for continuances and complete the process within a year. The Court emphasized the hearing process must be fair to the professional charged.

Justice Benjamin chimed in separately to emphasize his agreement with the award of fees and costs. "I agree with the Majority's decision to grant the requested writ of prohibition. I write separately only to emphasize that by repeatedly violating the West Virginia Code, the West Virginia Code of State Rules, and Ms. Fillinger's due process rights, the West Virginia Board of Examiners for Registered Professional Nurses engaged in excessively vexatious conduct. In past cases, such conduct has warranted awarding attorney fees and costs to the harmed party." Justice Loughry filed a separate opinion, expressing concern that the Board's inaction allowed serious charges related to drug abuse by a health care provider to be dropped.

DHHR Subrogation

In re: E.B., 729 S.E.2d 270 (2012)(here), deals with reimbursement due to DHHR for medical and other benefits paid upon settlement of a personal injury claim. The child in *In re: E.B.* was born with "severe brain damage, which has required and will continue to require significant medical care." His mother "applied for and received Medicaid benefits from the Ohio Department of Job and Family Services ("ODJFS") until February, 2007, when she and E.B. moved to Hancock County, West Virginia." Then, she "applied for and received Medicaid benefits from the West Virginia DHHR." The mother brought suit in federal court in Ohio against the hospital and doctors, and settled with the doctor for $1 million. According to the Court,

> The settlement constituted the policy limits of the defendants' insurance coverage and was contingent upon court approval. The settlement agreement did not allocate the amount recovered among the various elements of damages suffered, i.e., medical expenses, pain and suffering, lost wages, etc. DHHR sought reimbursement for its medical payments from the settlement proceeds Holly G. had obtained on E.B.'s behalf.

The mother filed a petition for approval of the settlement in the Circuit Court of Hancock County, and "requested that the Court pay her attorney's fees and legal expenses from the settlement funds, that Medicaid not be reimbursed due to the enormous costs of future care….[for the child]." DHHR opposed and the Circuit Court, after approving the settlement, directed the plaintiff and DHHR to attempt to reach a resolution. After the plaintiff received an additional $2.6M in settlement, she again petitioned to block recovery by the DHHR. The DHHR estimated the medical bills at $550,000, and agreed to reduce them by 40% to reflect attorney's fees. The circuit court approved the settlement, ordered the plaintiff to deposit in escrow the disputed fund, and ordered briefing.

Plaintiff argued that under *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), the true value of the case was "$25,373,937.20, which included $1,255,329.95 for past medical expenses, $19,118,608 for future medical expenses, and $5,000,000 for noneconomic loss, and that the $3,600,000 settlement thus represented a

recovery of 14.19% of the claim's value. Therefore, according to Holly G., DHHR was only entitled to 14.19% of its reimbursement, or $79,053.16." The WV DHHR disputed apportionment arguing "under W. Va. Code § 9-5-11, [it had] a priority right to full reimbursement for its expenses from any settlement and/or judgment recovered from a liable third party." The DHHR also asserted that *Ahlborn* did not control under the doctrine of *lex loci contractus*. "In other words, because Petitioner and E.B. are citizens of West Virginia, and they contracted for Medicaid benefits in West Virginia, West Virginia law should apply to this dispute." DHHR also argued that W. Va. Code § 9-5-11 does not conflict with *Ahlborn* because West Virginia statutes limit recovery language to the "actual expenses paid by the State on behalf of the Medicaid recipient for which a third party is liable to the extent the Medicaid recipient is reimbursed for them." DHHR also argued that under the MPLA, the non-economic loss was capped.

The parties put on evidence of medical bills paid, and the plaintiffs presented a life care planner. The circuit court applied *Ahlborn*, found the case was worth $25M, and the settlement therefore "represented 14.1878% of the full value of the minor's claim. Thus, the court found that DHHR was entitled to $79,040.82 and that ODJFS was entitled to $99,062.70. As to its findings regarding non-economic damages, the circuit court found that Ohio state law applied," meaning non economic damages were not capped. DHHR moved to stay and petitioned for appeal.

After explaining the Medicaid program and federal and state law related to recovery by DHHR, the Court stated,

> However, based on *Ahlborn*, we conclude that DHHR's attempt to recover from an unallocated lump sum amount under W. Va. Code § 9-5-11 violates the federal anti-lien provision (1) because the assignment giving the State the ability to recover medical expenses paid is not limited to a recovery only from a recipient's right to recover for past medical expenses, and (2) because it permits the State to become subrogated for past medical expenses from "all portions" of the cause of action or settlement in this case. Under *Ahlborn*, DHHR may obtain reimbursement for medical expenses paid from only that portion of the settlement, compromise, judgment, or award obtained by a recipient of Medicaid assistance that constitutes damages for past medical expenses.

Thus, "[a]s it applies to W. Va. Code § 9-5-11, the only way for the State to ensure compliance with *Ahlborn* is to provide for a specific allocation of damages in a settlement, compromise, judgment, or award obtained by a recipient of Medicaid assistance."

> Having established that an allocation must be made that indicates what portion is for past medical expenses as distinct from other damages, we hold that after a settlement, compromise, judgment, or award has been obtained in a Medicaid assistance recipient's claim to recover damages for injuries, disease, or disability, all reasonable efforts should be made to obtain the agreement of DHHR regarding the allocation of that portion thereof that represents the recipient's past medical expenses. No such settlement, compromise, judgment or award shall be consummated or judicially approved, if necessary, until DHHR has been notified and afforded such opportunity to agree to the parties' allocation of damages or to challenge said allocation.

> If DHHR and the parties cannot agree on an allocation of damages in a settlement context once DHHR is notified and provided an opportunity to protect its interest, the parties must seek judicial allocation through the court. If judicial allocation becomes necessary, the trial court is required to hold an evidentiary damages hearing, whereupon all parties and DHHR are provided ample notice of the same and are given just opportunity to present the necessary evidence, including fact witness and expert witness testimony, to establish what each contends is an appropriate allocation of damages. In challenging an allocation of damages proposed by the parties, DHHR has the burden of proof to establish a proper allocation. As discussed more fully below, the trial court must necessarily employ certain safeguards to ensure that the allocation of damages is fair and equitable, balancing the interests of the plaintiff recipient, the taxpayers, and the State.

Essentially, circuit courts must apply *Ahlborn* and consider the "full" value of the case, and may apply a ratio approach. The circuit court must hold an evidentiary hearing and demonstrate its approach by Findings of Fact and Conclusions of Law. The opinion contains these new syllabus points:

> 4. Pursuant to *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), the West Virginia Department of Health and Human Resources may obtain reimbursement for medical expenses paid from only that portion of the settlement, compromise, judgment, or award obtained by a recipient of Medicaid assistance that constitutes damages for past medical expenses.
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> 5. West Virginia Code § 9-5-11 (2009) is preempted to the extent that its assignment and subrogation provisions conflict with federal law. To the extent that our prior decision in *Grayam v. Department of Health and Human Resources*, 201 W. Va. 444, 498 S.E.2d 12 (1997), provided that pursuant to W. Va. Code § 9-5-11 the Department of Health and Human Resources possesses a "priority right to recover full reimbursement from any settlement, compromise, judgment, or award obtained from such other person or from the recipient of such assistance if he or she has been reimbursed by the other person," that holding is overruled.
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> 6. If another person is legally liable to pay for medical assistance provided by the West Virginia Department of Health and Human Resources, the Department possesses a priority right to be paid first out of any damages representing payments for past medical expenses before the recipient can recover any of his or her own costs for medical care.
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> 7. After a settlement, compromise, judgment, or award has been obtained in a Medicaid assistance recipient's claim to recover damages for injuries, disease, or disability, all reasonable efforts should be made to obtain the agreement of the Department of Health and Human Resources regarding the allocation of that portion thereof that represents the recipient's past medical expenses. No such settlement, compromise, judgment or award shall be consummated or judicially approved, if necessary, until the Department has been notified and afforded such

opportunity to agree to the parties' allocation of damages or to challenge said allocation.

8. If the Department of Health and Human Resources and the parties cannot agree on an allocation of damages in a settlement context once the Department is notified and provided an opportunity to protect its interest, the parties must seek judicial allocation through the court. If judicial allocation becomes necessary, the trial court is required to hold an evidentiary damages hearing, whereupon all parties and the Department are provided ample notice of the same and are given just opportunity to present the necessary evidence, including fact witness and expert witness testimony, to establish what each contends is an appropriate allocation of damages. In challenging an allocation of damages proposed by the parties, the Department of Health and Human Resources has the burden of proof to establish a proper allocation.

9. For purposes of appeal, the circuit court's judicial allocation decision should be set forth in a detailed order containing the requisite findings of fact and conclusions of law supporting its rulings.

Statute of Limitations

In *Cook v. Raleigh General Hospital,* Civil Action No. 5:12-cv-06558 (S.D.W.Va. 2012)(here), plaintiffs filed a complaint more than two years after the infant death. Because the compliant named as a defendant a physician covered by the Federal Tort Claims Act, the United States removed the complaint to federal court. The action against the United States was then dismissed because plaintiff did not exhaust administrative remedies under the FTCA. The remaining claim against the hospital was not covered by the FTCA. The District Judge exercised discretion to retain jurisdiction and entered an order granting the hospital's motion to dismiss, finding the action was filed beyond the two year statute of limitations under the wrongful death statute. After examining the *Dunn v. Rockwell* factors and found the plaintiff was not entitled to the benefit of the discovery rule or the doctrine of fraudulent concealment to extend the statute. See, *Dunn v. Rockwell*, 689 S.E.2d 255 (2009). *Cook* is currently pending on plaintiff's appeal in the United States Court of Appeals for the Fourth Circuit.

Breach of Employment Contract

In *Henick v. Fast Track Anesthesia*, No. 11-1145 (W.Va. Nov. 2012)(here), the plaintiff alleged the defendant "breached his employment contract by terminating his employment and by failing to reimburse his accrued, unused vacation leave in violation of the Wage Payment and Collection Act ("WPCA"), West Virginia Code §21-5-1 to -18." On appeal, he argued "[t]he circuit court also found in favor of respondents on their counterclaims against petitioner for defamation *per se* and breach of contract." Plaintiff, however, had breached his employment contract by pre-signing prescriptions, which the West Virginia Board of Medicine determined was a violation of the Medical Practice Act; however, because he let his West Virginia license lapse, the Board had no jurisdiction against his license. Plaintiff was also found to have defamed the defendant by falsely claiming his supervisor instructed him to sign prescriptions in advance.

State Law Claim for Breach of Medical Records Privacy
Not Preempted by HIPAA and Not Subject to the MPLA

Hospitals and other health care providers are subject to suit for damages where medical records are released in violation of HIPAA regulations under *R.K. v. St. Mary's Medical Center*, No. 11-0924 (W.Va. Nov. 15, 2012)(opinion here). In *R.K.*, the Court reversed the circuit court's dismissal of plaintiff's complaint alleging breach of medical record confidentiality and held the action (1) was not preempted by HIPAA, and (2) not subject to the limitations of the West Virginia Medical Professional Liability Act.

Claims for breach of medical record confidentiality have long been allowed in West Virginia, like many other states. See, *Morris v. Consolidation Coal Co.,* 191 W. Va. 426, 446 S.E.2d 648 (1994)(prohibiting *ex parte* contact with physicians); *Allen v. Smith*, 368 SE 2d 924, 179 W. Va. 360 (1988)(allowing suit for violation of statute providing confidentiality to psychiatric records). These cases pre-dated the enactment of HIPAA, so *R.K. v. St. Mary's Medical Center* presented the Court with the federal preemption issue for the first time.

The hospital argued below that HIPAA expressly preempted common law suits for violation of medical records privacy as it contained broad preemption language. "Title 42 specifically states, '[A] provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1320d-l through 1320d-3 of this title, shall supersede any contrary provision of State law ....' 42 U.S.C. § 1320d-7 (1996)." Respondent's Brief at 6 (the lower court order and the parties' briefs are here). As the statute and its' extensive regulations did not provide for suit for damages over violations, the hospital argued HIPAA preempted any such actions under state law. The circuit court agreed, relying upon 42 U.S.C. § 1320d-7 and finding HIPAA contained no private right of action.

The circuit court also held the action was subject to the MPLA, concluding that the obligation to maintain confidentiality was "health care" as defined in West Virginia Code § 55-7B-2. Thus, the plaintiffs were required under West Virginia Code § 55-7B-6 to serve the defendant with pre-suit notice of claim and certificate of merit. Their failure required dismissal of the complaint.

On appeal, the Supreme Court of Appeals of West Virginia flatly rejected both holdings. As to preemption the Court stated,

> [W]e conclude that state common-law claims for the wrongful disclosure of medical or personal health information are not inconsistent with HIPAA. Rather, […] such state-law claims compliment HIPAA by enhancing the penalties for its violation and thereby encouraging HIPAA compliance. Accordingly, we now hold 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.

In *R.K.*, the Court also discussed the proper use of evidence of violation of HIPAA regulations in civil actions: "[w]e note that, contrary to finding state common-law claims preempted by HIPAA, several courts have found that a HIPAA violation may be used either as the basis for a claim of negligence *per se*, or that HIPAA may be used to supply the standard of care for other tort claims."

The *R.K.* Court also held the MPLA does not apply to actions alleging breach of medical record confidentiality:

> Examining the factual circumstances in which this Court has found the MPLA to apply, we agree with the circuit court that the allegations asserted in the instant case, which pertain to the improper disclosure of medical records, does not fall within the MPLA's definition of "health care," and, therefore, the MPLA does not apply. Accordingly, we affirm the circuit court's order insofar as it refused St. Mary's motion to dismiss for failure to comply with the pre-suit requirements of the MPLA.

Justice Ketchum dissented, stating "I believe the plaintiff's causes of action are preempted by HIPAA."

West Virginia is not alone in allowing these actions, as shown by the decisions cited in the opinion. In Pennsylvania, *Baum v. Keystone Mercy Health Plan*, 826 F. Supp. 2d 718, 721 (E.D. Pa. 2011) allowed a state-law tort case over medical records release. The Ohio Supreme Court reached the same conclusion, finding "in Ohio, an independent tort exists for the unauthorized, unprivileged disclosure to a third party of non-public medical information that a physician or hospital has learned within a physician-patient relationship" *Biddle v. Warren Gen. Hosp.*, 86 Ohio St. 3d 395, 401, 715 N.E.2d 518, 523 (1999). See also, *Fairfax Hosp By and Through INOVA Health Sys. Hosps., Inc. v. Curtis*, 254 Va. 437, 442, 492 S.E.2d 642, 645 (1997).

West Virginia Code 55-7B-6 Preempted by EMTALA

Another case involving preemption was *Cox v. Cabell Huntington Hospital,* 863 F. Supp. 2d 568 (S.D. W.Va. 2012)(here). Judge Charles Chambers, following Fourth Circuit precedent, ruled the MPLA requirements that a plaintiff serve a Notice of Claim and Certificate of Merit before were preempted by EMTALA.

> These requirements directly conflict with the EMTALA private right of action and are therefore preempted. This result is directed by the Fourth Circuit's decision in *Power v. Arlington Hosp. Ass'n*, 42 F.3d at 856, which held that Virginia's pre-suit requirements for medical malpractice actions directly conflict with EMTALA, and its decision in Brooks, which expressed significant skepticism as to whether Maryland's pre-suit requirements for medical malpractice actions could be "tolerated" by EMTALA. 996 F.2d at 714. In *Power*, the court reasoned that the direct conflict arises because the timing requirements in state pre-suit procedures, and the time consumed in complying with those procedures, has an adverse effect on EMTALA's statute of limitations. 42 F.3d at 866.
>
> West Virginia's MPLA contains specific waiting periods, and therefore directly conflicts with EMTALA's statute of limitations. See W. Va. Code § 55-7B-6(b) ("At least thirty days prior to the filing of any medical professional liability action against a health care provider, the claimant shall serve . . . a notice of claim on each health care provider the claimant will join in litigation."). However, even if the Court considers only the screening certificate requirement, and not the wait period requirement (as Defendant appears to urge), the time involved in obtaining an expert and executing a

> certificate of merit under oath would also conflict with EMTALA through an adverse effect on EMTALA's statute of limitations. See *Brooks*, 996 F.2d at 175 (noting that the Maryland pre-suit requirement in that case—not a wait period, but an arbitration requirement—might conflict with EMTALA by its "adverse effect" on EMTALA's statute of limitations). See also *Holmberg v. Armbrecht*, 327 U.S. 392, 395 (1946) ("If Congress explicitly puts a limit upon the time for enforcing a right which it created, there is an end of the matter. The Congressional statute of limitation is definitive."); *Vogel v. Linde*, 23 F.3d 78, 80 (4th Cir.1994) (strictly construing EMTALA's statute of limitations). Thus, the MPLA pre-suit requirements at issue in this case are preempted because they directly conflict with EMTALA through their adverse effect on EMTALA's statute of limitations.

The opinion also notes that the requirement for certificate of merit – that an expert opine on a breach of the standard of care – conflicts with the screening requirement that is the heart of EMTALA and therefore conflicts with the federal cause of action. Thus, a plaintiff bringing an EMTALA cause of action need not comply with West Virginia Code §55-7-6.

Medical Staff Members are Not Agents of the Hospital

Cunningham v. Thomas Hospital, No. 11-0398 (W.Va. Nov. 20. 2012)(here), affirmed summary judgment for the defendant hospital, finding no actual employment or agency relationship, or joint venture, between a hospital and physicians employed by companies who had contracts with the hospital to supply surgical and hospitalist physicians.

The plaintiff was admitted to Thomas Hospital's emergency department (ED), and required a surgical consult. The general surgeon on call, Dr. Fogle, was employed by Delphi, which had a contract with the hospital to provide two doctors to take surgical call from the ED. Fogle performed surgery, and the plaintiff (a physician) developed an abscess. He was also seen by Dr. Doromal, the other Delphi doctor, as well as Drs. Tarakji and Rittinger, who were employed by a hospitalist group which contracted with TMH to provide a hospitalist program.

Dr. Cunningham sued TMH, the four doctors, and Delphi and HMP, and "sought to hold Thomas Hospital vicariously liable for the alleged negligence of Drs. Tarakji, Rittinger and Fogle on the theory that the doctors were employees or actual agents of the hospital, or that the doctors and corporate defendants Delphi and Hospitalist Medicine were engaged in a joint venture with the hospital." After the surgeon and his group settled, the hospital sought summary judgment on the agency issued. Judge King initially denied the motion, but after further discovery, granted summary judgment finding the physicians were not agents or employees of the hospital and there was no joint venture.

The Supreme Court affirmed Judge King's order, holding, in a *per curiam* decision,

> [W]e find the Circuit Court of Kanawha County did not err in granting summary judgment in favor of Thomas Hospital based upon the circuit court's conclusion that Drs. Fogle, Tarakji and Rittenger were not agents or actual employees of Thomas Hospital. We further find that the circuit court did not err in concluding that Thomas Memorial was not engaged in a joint venture with the other defendants to this action. Accordingly, the circuit court's order of February 3, 2011, is affirmed.

The opinion contains a detailed discussion of the evidence demonstrating the physicians were the employees of Delphi and HMP, and not the hospital, and concluding there was no joint venture. First, the court noted that a theory of ostensible agency is prohibited by W. Va. Code § 55-7B-9 (2003) (Repl. Vol. 2008), noting the physicians carried $1M in insurance coverage.

Discussing plaintiff's claim of *actual* agency, the Court applied the four part test of *Paxton v. Crabtree*, 184 W. Va. 237, 400 S.E.2d 245 (1990): "(1) Selection and engagement of the servant; (2) Payment of compensation; (3) Power of dismissal; and (4) Power of control. The first three factors are not essential to the existence of the relationship; the fourth, the power of control, is determinative…."

> *Selection and engagement*: The court found the physicians were selected not by TMH, but by Delphi and HMP. Even though the hospital evaluated the physicians, according to the deposition testimony, Delphi and HMP were responsible for selection.
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> *Payment of compensation*: The physicians were also compensated by Delphi and HMP and not TMH, nor did the hospital bill for their services or pay their insurance.
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> *Power of dismissal*: The hospital did not have the power to terminate the physicians. Under the contracts, the physicians were required to maintain certain qualifications, and if they did not, the contracts provided Delphi/HMP would resolve the issue or find a substitute physician. "There is nothing in [either] agreement that granted Thomas Hospital the authority to terminate [the physicians'] agreement[s] with Delphi or [HMP]…"
>
> *Power of control*: As to control, the court found no evidence the hospital selected the physicians for the patient or that any of the physicians was a "manager" of the hospital (finding management duties and compensation for them came from Delphi and HMP and not TMH). As to actual control, the court scrutinized the evidence, finding none:
>
> > Moreover, we have carefully and thoroughly reviewed the record in this case and find no evidence to establish a question of fact with regard to the element of control exercised by the hospital over Drs. Fogle, Tarakji and Rittinger. On the contrary, the evidence is clear that the hospital merely exercised a level of control commensurate with that approved by this Court in *Shaffer v. Acme Limestone Co., Inc.* To reiterate, under *Shaffer*, Thomas Hospital was permitted to exercise "broad general powers of supervision and control as to the results of the work so as to insure satisfactory performance of the contract[.]" Syl. pt. 4, *Shaffer*, 206 W. Va. 333, 524 S.E.2d 688.

Thus, the Court concluded there was no actual agency relationship between the hospital and the defendant physicians, and affirmed summary judgment.[34]

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[34] See also, *All Med LLC v. Randolph Engineering Co.*, 723 SE 2d 864, 228 W. Va. 634 (2012).

Professional Claims Made Insurance Policies

Interpretation of a professional Claims Made policy issued to a law firm was the focus of *Lindsay v. ALPS*, Slip Op. No. No. 11-1651 (W.Va. April 25, 2013)(opinion here). Because most health care providers are insured under claims made policies, *Lindsay* bears comment here. Lawyers, sued by a client claiming improper and fraudulent handling of trust account funds, did not immediately report the suit to their carrier, choosing instead to defend in the belief the action would be resolved quickly. The circuit court granted summary judgment finding the claim was "was not 'first reported' within the policy period in which it was 'first made,' as required by the insuring clause. The undisputed evidence demonstrates that Mr. Smith first asserted his claim during the 2007 Policy period and that [Tabor Lindsay] did not report it until nearly two years later, during the 2010 Policy period."

The Supreme Court affirmed: "[S]tated succinctly, based upon the particular facts presented in this case, we conclude that the circuit court correctly determined that Tabor Lindsay failed to provide timely notice of the claim to ALPS, which failure precluded coverage under the claims-made-and-reported policies at issue." Take note the filing of an amended complaint did not constitute a new claim for purposes of claims made reporting. Note also, that in light of accusations of misappropriation of trust funds, the Court (in footnote 7) referred the matter to Disciplinary Counsel, "[d]ue to the nature of the allegations made against Tabor Lindsay, we find a referral of this matter to the Office of Disciplinary Counsel to be warranted."[35]

Discussion

The court continues to enforce the requirement of notice of claim and certificate of merit under West Virginia Code 55-7B-6, although the dismissals for failure to comply are coupled with the recognition that plaintiffs gain an additional year to file. *Cline v. Kreasa-Reahl* is significant for its recognition that informed consent cases require expert testimony to establish the range of risks and causation.

R.K. v. St. Mary's shows the Court will continue to tightly construe the MPLA; *R.K.* strips the hospital of any protection under the MPLA. Since the issues in *Douglas v. Manor Care* center, to some extent, on the coverage of the MPLA to "ordinary" negligence, this will continue to be an important issue for health care providers.

Cunningham v. Thomas Memorial Hospital importantly recognized that hospitals are simply not the employers or principals of physicians with medical staff privileges, providing relief from being generally named in suits alleging agency relationships.

Arbitration provisions in nursing home contracts appear to be all but enforceable, although the *Genesis* cases will undoubtedly wind their way back to the Court.

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[35] *Lindsay* is the second case in the January 2013 term where the Court referred the allegations about the lawyers involved to the Office of Disciplinary Counsel (ODC). In *Addair v. Island Creek*, Slip Op. No. 12-0708 (W.Va. April 17, 2013)(opinion here), after affirming dismissal as a sanction for repeated disobeying of court deadlines, the Court (in a footnote) stated: "Due to the nature of the conduct giving rise to the circuit court's 'Sanctions Order,' we find a referral of this matter to the ODC to be warranted. '[W]hen this Court believes a case before it presents the appearance of conduct that does not comport with [the Rules of Professional Conduct ('RPC')], we will comply with the Rule 8.3(a) of the RPC and Canon 3D(2) of the Code of Judicial Conduct, and refer the matter to the [ODC] for its review.'"

On the horizon is the defense appeal of the $91.5 nursing home verdict in *Douglas v. Manor Care*, which will undoubtedly raise interest next term.