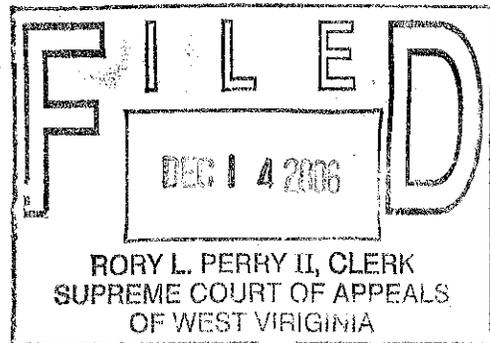


No. 33189



IN THE
SUPREME COURT OF APPEALS
OF
WEST VIRGINIA

THE ESTATE OF ALEXIA SHEREE FOUT-ISER,)
 By Maranda L. Fout-Iser, Fiduciary)
 and MARANDA L. FOUT-ISER, Individually,)
 and JERRY T. ISER, Individually,)
)
 Appellants,)

vs.)

JOHN L. HAHN, M.D., and HAHN MEDICAL)
 PRACTICES, INC.; THOMAS JOSEPH SCHMITT,)
 M.D.; BRUCE W. LESLIE, M.D.; MYUNG-SUP)
 KIM, M.D.,; GRANT MEMORIAL HOSPITAL)
 REGIONAL HEALTH CARE CENTER, a corpora-)
 tion; POTOMAC VALLEY HOSPITAL OF W.VA.,)
 INC., a corporation; and ANITA M. RHEE,)
 Administratrix of the Estate of Russell)
 Rhee, M.D.,)
)
 Appellee.)

BRIEF ON BEHALF OF APPELLANTS

Appeal Granted September 20, 2006

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B. THE TRIAL COURT ERRED IN FINDING THAT A DEFENDANT MEDICAL PROVIDER'S VIOLATION OF THE APPLICABLE STANDARD OF CARE MUST BE " <u>THE</u> " CAUSE OF INJURY RATHER THAN " <u>A</u> " CAUSE OF INJURY	
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Administratrix of the Estate of Russell)
Rhee, M.D.,)

Appellee.)

BRIEF ON BEHALF OF APPELLANTS

To: The Honorable Justices of the Supreme Court of Appeals of the
State Of West Virginia:

I.

PROCEEDINGS AND NATURE OF RULINGS

This medical malpractice action arose out of the medical care and treatment provided to Maranda Fout-Iser, who presented to Potomac Valley Hospital Emergency Room with obstetrical problems during her thirty-third week of pregnancy. Specifically, it was alleged that there was a significant delay in transferring Maranda Fout-Iser from Potomac Valley Hospital to a proper hospital which could take care of her emergency obstetrical problems. The emergency room doctor, Thomas Schmitt, found and the obstetrical ultrasound demonstrated that the baby was alive at Potomac Valley Hospital. After a significant delay and lengthy transfer to Grant Memorial Hospital, it was determined that the baby was dead.

Appellants settled the claims against all defendants with the exception of the Estate of Russell Rhee, M.D. (hereinafter "Defendant Rhee" and/or "Dr. Rhee"). Appellants allege that appellee was responsible for the significant delay in performing the ultrasound and which contributed to Alexia Sheree Fout-Iser's death.

Appellee Rhee filed a motion for summary judgment. The Circuit Court utilized the wrong standard of proof required in proving liability, applied an erroneous causation standard and erroneously granted the summary judgment despite genuine issues of material fact.

II.

STATEMENT OF FACTS

Maranda L. Fout-Iser was approximately 33 weeks pregnant and presented to the emergency room at Potomac Valley Hospital on July 30, 1999, at approximately 4:45 p.m. The emergency room physician examined Maranda, who had complaints of inability to urinate, lower abdominal cramping, vomiting, blurred vision and her color was pale. The emergency room personnel reported "fetal movements" and a fetal heart rate of 160 beats thereby confirming that the baby was alive.

The E.R. doctor ordered that a STAT ultrasound be performed at 4:45 p.m., and the requisition for the ultrasound was timed at 5:14 p.m.

The medical records indicate that Appellant Maranda went to x-ray at 5:10 p.m. The records further indicate that Maranda remained in the x-ray department for almost two hours (approximately 7:00 p.m.) when an ambulance arrived and transported her to Grant Memorial Hospital with an arrival time at approximately 8:00 p.m.

Maranda was immediately seen at Grant Hospital by Dr. Hahn, who ruptured her membranes and determined by fetal

monitor that the baby, Alexia Sheree Fout-Iser, was dead. Maranda was then transferred to Ruby Memorial Hospital with a discharge diagnosis of eclampsia, acute renal failure, tonic-clonic seizures as a result of eclampsia and disseminated intravascular coagulation.

Appellants' theory against Dr. Rhee, the radiologist, was that he was on call on July 30, 1999, and he refused to come into the hospital to help an inexperienced technician who had great difficulty obtaining proper ultrasound films. Appellants also allege that there was a delay in transferring Maranda Fout-Iser and that the delay in large part was caused in the radiology department because Dr. Rhee refused to go to the hospital or provide assistance when requested by the technician.

The ultrasound (also called a sonogram) consisted of two segments of filming done by a technician and then representative pictures were transmitted by telephone line to Dr. Rhee at his home. Typically the radiologist would then interpret the representative pictures, which is called "teleradiology," and provide an impression.

Dr. Schmitt, the emergency room doctor and a settling defendant, testified to the standard of care for the timing of an obstetrical ultrasound as follows:

"Q. And with an abdominal sonogram in a patient like Ms. Iser on July 30, 1999, would the standard of care have been to get those - have the sonogram done by the hospital, sent out and interpreted within approximately 45 minutes?

"A. Yes, sir.

"Q. And the results of this appear to have been in excess of two hours; is that correct?

"A. Yes."

"Q. And in excess of an hour and 15 minutes longer than what you consider the standard of care for getting those results back?

"A. Yes." [Deposition of Thomas J. Schmitt, M.D., November 10, 2003, p. 113 (Exhibit D of Defendants' Motion for Summary Judgment).]

Dr. Schmitt further testified that the delay in reporting the ultrasound result affected the needed medical action for Ms. Iser, which was transfer to another hospital. (See Schmitt Depo., pp. 118-120.)

The reason for the significant delay in performing the ultrasound was detailed through the testimony of Marla Niland, who was the radiological technologist who performed the ultrasound studies on Maranda Fout-Iser on July 30, 1999.

Marla Niland was a novice in obstetrical ultrasounds and had only participated in approximately five previous ultrasounds, all of which were probably in her training. This may have been her first obstetrical ultrasound by herself.

"Q. And if it wasn't the first, it was one of the first couple that you'd ever done, one or two by yourself then, basically. Is that correct?

"A. I'd have to say probably yes to that."
(Deposition of Marla Niland, January 15, 2005, p. 43.)

Ms. Niland also testified that Maranda was one of the most seriously ill patients she had ever encountered in x-ray.

"Q. You have your hands full with one of the most seriously ill patients you've ever encountered in x-ray and not having really - - with all due respect to you -- hardly any experience in the ultrasound. It that right?

"Q. That's what happened?

"A. Yes, that's right." (Niland Depo., p. 134.)

Tech Niland described Maranda as "sweating; she was in a tremendous amount of pain; she couldn't lie still; and she was throwing up and she knew something bad was happening." (Niland Depo., pp. 96, 97.)

The tech ran the first ultrasound film from 5:22 p.m. to 5:38 p.m. (Niland Depo., p. 79.) She then transmitted by phone line (teleradiology) the film to Appellee Rhee at his home. Ms. Niland explained to Dr. Rhee, the on-call physician, that she was having difficulty with the ultrasound study and Dr. Rhee became "nasty." (Niland Depo., p. 112.) Appellee Rhee utilized the "f" word on several occasions, and despite Tech Niland's request for him to come to the hospital to help, he refused. Ms. Niland testified to the conversation with Dr. Rhee as follows:

"Q. So you were up to the point that he then responds to you with, I guess, these vulgarities. Is there anything else that you told him in that first conversation?

"A. I said tell me -- if there's something specifically that you want me to look at, tell me what it is.

"Q. You were looking for direction?

"A. Yes.

"Q. And that was what you understood he was supposed to provide you if you had questions; is that right?

"A. Yes.

"Q. Okay. Because he's the doctor?

"A. Yes.

"Q. Okay, so what was his response, as best as you can recall, and if you prefer to just say the F word without voicing it?

"A. That's one that I just remember him saying numerous times, because I hate that word, but --

"Q. It's very offensive --

"A. Yes.

"Q. -- to you.

"A. He told me that --

"Q. Let me ask you, did he use the F word in describing the machine or the patient or you, because a person usually just doesn't say F, F, F, F. They usually say F'ing patient and -- with ing, I think that's called a gerund."

"A. No. He -- when he looked at the films, he said -- I think he said it twice. He just said F, F, and he said -- and I said, LOOK, I NEED HELP HERE. I'VE NEVER -- I'VE NOT SEEN THIS BEFORE, AND I NEED HELP, AND HE SAID -- I SAID WE DON'T DO THAT MANY OB ULTRASOUNDS, AND I'VE NOT SEEN THIS BEFORE, AND HE TOLD ME THAT IT WAS MY JOB TO KNOW WHAT TO DO.

"Q. Did he basically accuse you of not being competent or not being experienced enough to do it?

"A. In not so many words, but the --

"Q. That's what you understood?

"A. Yeah, that was the implication.

"Q. Was that the message?

**"A. AND HE SAID I DON'T HAVE TIME TO COME TO
KEYSER TO DO AN F'ING ULTRASOUND.**

"Q. Huh, just didn't have the time to come to do the ultrasound for Maranda at that time. Is that right?

"Q. That's what he said?

"A. That's what he said.

**"Q. AND YOU HAD CONVEYED TO HIM FULLY AT
THAT TIME THAT THIS WOMAN WAS VERY ILL, AND
THERE WERE MAJOR PROBLEMS IN GETTING THIS
ULTRASOUND STUDY DONE. IS THAT RIGHT?**

"A. THAT'S CORRECT.

"Q. Is there any question in your mind that you had told this doctor that this very ill -- that this was a very, very sick and ill woman that you were having major problems with? Any question in your mind?

"A. That I didn't tell him that?

"Q. Yes, any question?

"A. No.

"Q. Absolutely certain -- and I realize there's been time. That's why I'm asking. Are you positive that you conveyed the message that this was a very, very ill patient and you were having great difficulty

in getting the study done and what you -- the little bit that you had indicated stuff that you weren't knowledgeable about at that point. Any question in your mind that you did not convey that message?

"A. No, because --

"Q. You're positive you conveyed that type of a message to him with those elements in it?

"A. Yes, because otherwise, I would have a lot to answer for as to why it was such a incomplete, not good study." (Niland Depo., pp. 118-122.) [Emphasis added.]

Tech Niland testified that she had stopped the initial ultrasound film at 5:38 p.m. because Maranda was thrashing about in the bed, vomiting and was just a very, very ill woman. (Niland Depo., p. 104.) At some point during the almost two hours in the radiology department, Tech Niland received a phone call from somebody at the emergency department asking what was taking so long, and she responded that she was having trouble, had a sick patient and was having difficulty. (Niland Depo., pp. 143, 144.)

Forty-seven minutes after the conclusion of the first ultrasound attempt, Ms. Niland attempted a second filming between 6:25 and 6:35 p.m. (Niland Depo., p. 80.) Ms. Niland had a second discussion with Dr. Rhee, who indicated he

probably would come in; however, the patient was transported before Dr. Rhee ever arrived.

Appellants' expert radiologist, Jeffrey Dicke, M.D., was designated as an expert on the issue of Dr. Rhee's liability. At Dr. Dicke's deposition, he testified specifically that Dr. Rhee, to a REASONABLE MEDICAL PROBABILITY, violated the standard of care.

"Q. Okay. So what you have stated thus far is your view, is your opinion, rather, to a reasonable medical probability, that Dr. Rhee, by not doing what you suggested, violated some medical standard of care?

"A. Yes.

"Q. Well, what is the violation of the standard of care? I'm still not clear.

"A. Dr. Rhee, in his capacity as a radiologist, was responsible for providing an interpretation of the images. Per Ms. Niland's testimony, Dr. Rhee was not satisfied with the quality of the images he was receiving. Since he is the one that's responsible for rendering that interpretation, I would consider it his responsibility to provide some additional either guidance or direction by himself or somebody else that would allow him to be comfortable rendering an interpretation of the patient and the images that he received." (Deposition of Jeffrey Michael Dicke, M.D., August 9, 2005, pp. 10-11.)

Appellants also designated Richard McLaughlin, M.D., a specialist in obstetrics and gynecology, who testified that the delay in radiology caused or contributed to the death of the baby and injuries to Maranda Fout-Iser. Dr. McLaughlin testified as follows:

"Q. And your second criticism, if you would, please?

"A. Would be OVERALL TIME DELAY while she was at Potomac Valley, contributed, in part, by failing to order laboratory tests on a stat or on an emergency basis; A DELAY IN ULTRASOUND; and a delay in reporting the presence of this patient to Dr. Hahn, along with the information that had been collected on her. (Deposition of Richard McLaughlin, May 3, 2004, p. 50.) [Emphasis added.]

Dr. McLaughlin further testified at deposition as follows:

"Q. Doctor, do you know that the outcome of the fetus would have been any different, in your opinion?

"A. Well, the outcome of the fetus as it stands is a dead baby. The baby was alive in your emergency room [Potomac Valley Hospital], and earlier treatment with a rescue C-section could have saved the life of the baby.

"Q. Doctor, are you certain within a reasonable degree of medical certainty that the outcome for the fetus would have been different, assuming that the fetus presented as a live, viable fetus?

"A. A 32-week fetus has a greater than 90 percent chance of surviving, so yes."
(McLaughlin Depo., p. 72.)¹

The ultrasound films taken at Potomac were interpreted by Dr. Rhee on July 30, 1999, and by another radiologist (Dr. Kim) the following day, and both radiologists agreed that the baby was alive at the time of the ultrasound study at Potomac Valley Hospital.

Appellants' expert, Dr. Dicke, testified that Dr. Rhee had violated the standard of care to a reasonable degree of medical probability thereby causing a delay in the transport of Maranda Fout-Iser. Dr. McLaughlin testified that the delay, including specifically the delay in the radiology department, was a proximate cause of the baby's death and damages and injuries to appellants. Defendant Dr. Schmitt also testified that the delay in radiology violated the standard of care.

Appellee Rhee filed a motion for summary judgment which was granted by the trial court. In arriving at its decision, the trial court employed the wrong standard of proof for liability, namely, "reasonable degree of medical certainty"

¹ Despite repeated attempts to obtain the deposition of Marla Niland, Potomac Valley Hospital indicated that she was no longer an employee and that they could not locate her. She ultimately was located shortly before the scheduled trial and after Dr. McLaughlin's deposition and also after the November, 2004, deposition of Dr. Dicke.

rather than "reasonable degree of medical probability." The trial court also utilized an incorrect test for causation, namely, that the deviation from acceptable standards of care was "the" cause of injury rather than "a" proximate cause of injury. The trial court also incorrectly concluded that there were no genuine issues of material fact despite the opinions of appellants' experts on liability and causation, together with the emergency room physician's opinion on liability and causation and Tech Niland's testimony.

III.

ASSIGNMENTS OF ERROR

A. THE TRIAL COURT ERRED IN UTILIZING A REASONABLE DEGREE OF MEDICAL CERTAINTY STANDARD FOR PROOF OF LIABILITY IN CONSIDERING A MOTION FOR SUMMARY JUDGMENT IN A MEDICAL MALPRACTICE CLAIM.

B. THE TRIAL COURT ERRED IN FINDING THAT A DEFENDANT MEDICAL PROVIDER'S VIOLATION OF THE APPLICABLE STANDARD OF CARE MUST BE "THE" CAUSE OF INJURY RATHER THAN "A" CAUSE OF INJURY.

C. THE TRIAL COURT ERRED IN GRANTING SUMMARY JUDGMENT WHEN THERE WERE GENUINE ISSUES OF MATERIAL FACT.

D. THE TRIAL COURT ERRED BY REQUIRING EXPERT TESTIMONY IN A MEDICAL MALPRACTICE ACTION WHEN THE MEDICAL SITUATION PRESENTED ROUTINE AND NONCOMPLEX MATTERS WHICH ARE COGNIZABLE UNDER COMMON KNOWLEDGE OR EXPERIENCE OF LAY JURORS.

IV.

POINTS AND AUTHORITIES RELIED ON

A.

Syllabus Points

1. "A circuit court's entry of summary judgment is reviewed de novo." Syl. Pt. 1, Painter v. Peavy, 192 W. Va. 189, 451 S.E.2d 755 (1994).

2. "Summary judgment is viewed with suspicion and, on appeal; facts are to be construed in the light most favorable to party opposing motion." Syl. Pt. 1, Hicks v. Chevy, 178 W. Va. 118, 358 S.E.2d 202 (1987).

3. "A motion for summary judgment should be granted only when it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law." Syl. Pt. 3, Aetna Cas. & Sur. Co. v. Federal Ins. Co. of New York, 148 W. Va. 160, 133 S.E.2d 770 (1963).

4. In a medical malpractice claim, the burden is on the plaintiff to prove by a preponderance of the evidence that the health care provider was negligent and that such negligence was a proximate cause of the injury. Syl. Pt. 2, Walton v. Given,

158 W. Va. 897, 215 S.E.2d 647 (1975); Arbogast v. Mid-Ohio Valley Medical Corp., et al., 214 W. Va. 356, 589 S.E.2d 498 (2003).

5. The applicable standard of care and a defendant's failure to meet said standard, if at issue, shall be established in a medical professional liability case by testimony of one or more knowledgeable, competent expert witnesses. W.Va. Code §55-7B-7.

6. In a medical malpractice claim, an expert testifying to the applicable standard of care and a defendant's failure to meet said standard must testify to such opinion within a reasonable medical probability. W. Va. Code §55-7B-7(b).

7. In a medical malpractice claim, a claimant must prove a failure to follow the accepted standard of care was "a" proximate cause of the injury or death. W.Va. Code §55-7B-3.

8. A party in a tort action is not required to prove that the negligence of one sought to be charged with an injury was the sole proximate cause of the injury. Everly v. Columbia Gas, 171 W. Va. 534, 301 S.E.2d 165 (1982).

9. "In medical malpractice cases where lack of care or want of skill is so gross, so as to be apparent, or the alleged breach relates to noncomplex matters of diagnosis and treatment

within the understanding of lay jurors by resort to common knowledge and experience, failure to present expert testimony on the accepted standard of care and degree of skill under such circumstances is not fatal to a plaintiff's *prima facie* showing of negligence." Syl. Pt. 4, Totten v. Adongay, 175 W. Va. 634, 337 S.E.2d 2 (1985); Syl. Pt. 6, McGraw v. St. Joseph's Hospital, 200 W. Va. 114, 488 S.E.2d 389 (1997).

10. "The trial court is vested with discretion under W.Va. Code §55-7B-7 (1986) to require expert testimony in medical professional liability cases, and absent an abuse of that discretion, a trial court's decision will not be disturbed on appeal." Syl. Pt. 8, McGraw v. St. Joseph's Hospital, 200 W.Va. 114, 488 S.E.2d 389 (1997).

B.
Table of Authorities

CASES

Aetna Cas. & Sur. Co. v. Federal Ins. Co. of New York, 148 W. Va. 160, 133 S.E.2d 770 (1963).

Arbogast v. Mid-Ohio Valley Medical Corp., et al., 214 W. Va. 356, 589 S.E.2d 498 (2003).

Banfi v. American Hospital for Rehabilitation, 207 W.Va. 135, 529 S.E.2d 600 (2000).

Buskirk v. Bucklew, 115 W. Va. 424, 176 S.E. 603 (1934).

Everly v. Columbia Gas, 171 W. Va. 534, 301 S.E.2d 165 (1982).

George v. Blosser, 157 W. Va. 811, 204 S.E.2d 567 (1974).

Hicks v. Chevy, 178 W. Va. 118, 358 S.E.2d 202 (1987).

Lengyel v. Lint, 167 W. Va. 272, 280 S.E.2d 66 (1981).

McGraw v. St. Joseph's Hospital, 200 W.Va. 114, 488 S.E.2d 389 (1997).

Mountain Lodge Ass'n v. Crum & Forster Indem. Co., 210 W. Va. 536, 558 S.E.2d 336 (2001).

Painter v. Peavy, 192 W. Va. 189, 451 S.E.2d 755 (1994).

Powderidge Unit Owners Ass'n v. Highland Properties, Ltd., 196 W. Va. 692, 474 S.E.2d 872 (1996).

Totten v. Adongay, 175 W. Va. 634, 337 S.E.2d 2 (1985).

Walton v. Given, 158 W. Va. 897, 215 S.E.2d 647 (1975).

STATUTES

W.Va. Code §55-7B-3.

W.Va. Code §55-7B-3(b)

W.Va. Code §55-7B-7.

W.Va. Code §55-7B-7(b).

W.Va.R.Civ.P. 56

Medical Professional Liability Act of 1986

V.

STANDARD OF APPELLATE REVIEW

The circuit court's entry of summary judgment is reviewed de novo. Syl. Pt. 1, Painter v. Peavy, 192 W. Va. 189, 451 S.E.2d 755 (1994); Syl Pt., 1, Mountain Lodge Ass'n v. Crum & Forster Indem. Co., 210 W. Va. 536, 558 S.E.2d 336 (2001).

VI.

DISCUSSION OF LAW

As indicated in the Statement of Facts, the principal theory of negligence against the medical providers in this case was that they delayed transferring Maranda Fout-Iser to an appropriate medical facility and as a result of the delays, Maranda's 33-week old baby died.

The majority of the delay occurred in the radiology department after an ultrasound had been ordered at approximately 4:45 p.m. The ultrasound technician was inexperienced, and this probably was the first ultrasound she ever performed by herself. She transmitted the ultrasound pictures by teleradiology to the appellee, Dr. Rhee, who was on-call. The tech advised Dr. Rhee that she was having great difficulty in obtaining proper films and the patient was seriously ill. Rather than go to the hospital, Appellee Rhee became abusive and refused to go to the hospital to help obtain proper films.

Maranda Fout-Iser was not transferred from the radiology department until approximately 7:00 p.m., more than two hours after the ultrasound was ordered as "STAT." The emergency room

physician, the patient and the ultrasound films all evidence that the baby was alive at Potomac Hospital with a heart beat and fetal movements. This determination of viability was also confirmed by Appellee Rhee and another radiologist from Potomac Valley Hospital (Dr. Kim). Based on all of the medical findings at Potomac Valley Hospital, the baby died during the approximately 50-minute transfer to Grant Memorial Hospital.

Appellants settled and/or resolved all differences with all of the medical providers with the exception of Dr. Rhee, and the trial was scheduled to begin on August 29, 2005. Appellee Rhee filed a motion for summary judgment, together with multiple supplements, and appellants duly responded by memoranda.

The trial court made six findings of fact and conclusions of law in support of its ruling granting appellee's summary judgment. The Order contains multiple errors, the most glaring of which was the trial court's conclusion that liability in a medical malpractice case must be proven "to a **REASONABLE DEGREE OF MEDICAL CERTAINTY**" (Conclusion 4 of the Order of August 30, 2005) rather than **MEDICAL PROBABILITY**.

The trial court also incorrectly concluded that appellants expert, Dr. Jeffrey Dicke, was the only doctor who would testify about the standard of care and causation relating to Appellee Rhee. (See Conclusions 3 and 5 of the Order.) As will be shown hereinafter, Dr. Dicke was plaintiffs' radiology liability expert, and he clearly testified that Dr. Rhee violated acceptable standards of care. In addition, appellants employed Dr. Richard McLaughlin, an expert in obstetrics and gynecology, who testified that the delay, including the delay in the radiology department, caused the baby's death.

The trial court also incorrectly concluded as a matter of law that the violation of the standard of care must be "the" cause of injury. This conclusion by the trial court is contrary to the statutory elements of proof, specifically W.Va. Code §55-7B-3(b), which requires that "such failure was a proximate cause of the injury or death."

The trial court further failed to appreciate that Appellee Rhee's negligence was so obvious that an expert was not necessary because of the common knowledge doctrine.

A.
Summary Judgment

The issue upon a motion for summary judgment pursuant to Rule 56 of the West Virginia Rules of Civil Procedure is not whether the plaintiff has met the burden of proof on material aspects of his or her claim but rather whether a material issue of fact exists on the basis of the factual record developed to that date. See Lengyel v. Lint, 167 W. Va. 272, 280 S.E.2d 66 (1981). Summary judgment is not a substitute for a trial of an issue of fact but rather is a determination that as a matter of law there is no issue of fact to be tried. George v. Blosser, 157 W. Va. 811, 204 S.E.2d 567 (1974). It is often said that the function of a summary judgment is to pierce the boiler plate of the pleading and evaluate the party's proof in order to determine whether a trial is actually required. Powderidge Unit Owners Ass'n v. Highland Properties, Ltd., 196 W. Va. 692, 474 S.E.2d 872 (1996).

In Hicks v. Chevy, 178 W. Va. 118, 358 S.E.2d 202 (1987), this court held that "summary judgment is viewed with suspicion and, on appeal, facts are to be construed in [a] light most favorable to [the] party opposing [the] motion."

In considering a motion for summary judgment, it has been held that:

"A motion for summary judgment should be granted only when it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law." Syl. Pt. 3, Aetna Cas. & Sur. Co. v. Federal Insurance Company of New York, 148 W. Va. 160, 133 S.E.2d 770 (1963).

B.
Standard of Proof of
Liability in a Medical Malpractice Claim

The trial court in its Order granting summary judgment made the following finding of fact and/or conclusion of law:

"4. Dr. Dicke [plaintiffs' liability expert] testified in both his depositions that he could not say to a REASONABLE DEGREE OF MEDICAL CERTAINTY that Dr. Rhee violated the standard of care. (Deposition of Dr. Dicke on 11/4/04 at 31; 52-53; 57.)" [Emphasis added.]

The Court clearly committed error by utilizing the standard of reasonable medical "certainly" rather than the required standard of reasonable medical "probability."

In 1986, the legislature enacted W. Va. Code §55-7B-7, which specifically set forth the requirements for an expert's

testimony on the standard of care, including the degree of proof. W. Va. Code §55-7B-7 defines an expert's requirements in a medical malpractice action and specifically sets forth the standard of proof as:

"(b) The opinion can be testified to with REASONABLE MEDICAL PROBABILITY." [Emphasis added.]

Even before the Medical Professional Liability Act of 1986, this Court has held for years that the standard of proof on liability issues in medical malpractice claims was by a "preponderance of the evidence." See Syl Pt. 2, Walton v. Given, 158 W. Va. 897, 215 S.E.2d 647 (1975). Also see Arbogast v. Mid-Ohio Valley Medical Corp., et al., 214 W. Va. 356, 589 S.E.2d 498 (2003).

The trial court applied an incorrect standard of proof for liability of plaintiffs' expert in Finding and/or Conclusion No. 4 of the Order granting summary judgment, and for this reason alone, the summary judgment order should be reversed.

C.
Standard of Proof of
Causation in a Medical Malpractice Claim

The trial court further erred in its findings and conclusions by requiring that the plaintiffs must prove that the violation of the standard of care was "the" cause of injury.

"6. Under West Virginia law, plaintiffs must prove through expert testimony that Dr. Rhee violated the applicable standard of care and that the violation of the standard of care was **"THE"** cause of injury. W. Va. Code §55-7B-3 (2004)." [Emphasis supplied.]
Order August 30, 2005.

The trial Court's conclusion is clearly erroneous.

W.Va. Code §55-7B-3 sets forth the elements of proof in a medical malpractice claim and Subsection (b) addresses the element of causation. Specifically, W. Va. Code §55-7B-3 provides that:

"(b) Such failure was **'a' proximate cause** of the injury or death. [Emphasis supplied.]

The trial court's conclusion that the violation of the standard of care had to be "the" proximate cause is plainly wrong.

In 1982, this Court forever eliminated any doubt that the test in tort claims for causation was "a" and not "the" proximate cause. In Everly v. Columbia Gas, 171 W. Va. 534, 301 S.E.2d 165 (1982), this Court held:

"A party in a tort action is not required to prove that the negligence of one sought to be charged with an injury was the sole proximate cause of the injury. Divita v. Atlantic Trucking Co., 129 W. Va. 267, 40 S.E.2d (1946), is overruled to the extent it states a contrary rule."

The Medical Professional Liability Act of 1986 adopted existing West Virginia case authority by requiring proof that a violation of acceptable standards of care was "a" proximate cause of injury or death and never required proof that such violation was "the" cause of injury or death.

The trial court's conclusion of law set forth in Item 6 of its Order granting summary judgment is clearly erroneous and therefore the order granting summary judgment must be reversed.

D.

Genuine Issues of Material Fact

Even assuming the court had utilized the correct standard for proof of liability and the correct law relating to

causation, the Court incorrectly found that Dr. Dicke was the only expert who would testify to the violation of the standard of care and causation as it related to Dr. Rhee. Item No. 3 of the trial court's Order of August 30, 2005, indicates that appellants' expert, Dr. Dicke, was the only expert designated to testify as to both the violation of the standard of care and causation relating to Dr. Rhee. The trial Court then found in Finding 5 of the summary judgment order that Dr. McLaughlin would not be rendering any opinion as to Dr. Rhee. These findings and/or conclusions are both erroneous and are not supported by the deposition testimony of appellants' experts.

Dr. Dicke, a radiologist, was a liability expert and testified that Dr. Rhee violated acceptable standards of care and caused delay in the transport of Maranda Fout-Iser. Dr. McLaughlin, an obstetrician/gynecologist, was solely a causation expert, and he testified that the delay in transporting caused the death of the baby and injuries and damages to Maranda. The trial court failed to appreciate the roles of the two experts, one on liability and one on causation. There is absolutely no rule that requires that a single expert testify to both liability and causation. Quite to the contrary, in most medical negligence cases, one expert will testify to liability and another expert will testify on

causation issues. Such is the case with Dr. Dicke and Dr. McLaughlin.

The following testimony by way of deposition by appellee's counsel elicited from Dr. Dicke on August 9, 2005:

"Q. Okay. So what you have stated thus far is your view, is your opinion, rather, to a reasonable medical probability, that Dr. Rhee, by not doing what you suggested, violated some medical standard of care?

"A. Yes.

"Q. Well, what is the violation of the standard of care? I'm still not clear.

"A. Dr. Rhee, in his capacity as a radiologist, was responsible for providing an interpretation of the images. Per Ms. Niland's testimony, Dr. Rhee was not satisfied with the quality of the images he was receiving. Since he is the one that's responsible for rendering that interpretation, I would consider it his responsibility to provide some additional either guidance or direction by himself or somebody else that would allow him to be comfortable rendering an interpretation of the patient and the images that he received." (Deposition of Jeffrey Michael Dicke, M.D., August 9, 2005, pp. 10-11.)

Without question, Dr. Dicke testified that Dr. Rhee violated acceptable standards of care to the requisite degree of proof, i.e., reasonable medical probability.

In addition to the liability established by appellants' expert radiologist, Dr. Dicke, the emergency room physician at Potomac testified that the delay in the radiology suite was a violation of the standard of care. Dr. Thomas Schmitt, a settling defendant in the case, testified on November 10, 2003, as follows:

"Q. And with an abdominal sonogram in a patient like Ms. Iser on July 30, 1999, would the standard of care have been to get those - have the sonogram done by the hospital, sent out and interpreted within approximately 45 minutes?

"A. Yes, sir.

"Q. And the results of this appear to have been in excess of two hours; is that correct?

"A. Yes."

"Q. And in excess of an hour and 15 minutes longer than what you consider the standard of care for getting those results back?

"A. Yes." [Deposition of Thomas J. Schmitt, M.D., November 10, 2003, p. 113 (Exhibit D of Defendants' Motion for Summary Judgment).]

The delay in radiology was specifically explained by Marla Niland. Ms. Niland was the radiological tech who performed the ultrasound studies on Maranda Fout-Iser on the evening of July 30, 1999, and which may have been the first obstetrical ultrasound she had ever performed by herself. Ms. Niland testified that she had experienced significant problems in obtaining proper films because the patient was thrashing about in the bed and seriously ill. After she had teleradiologically transmitted the films to Dr. Rhee, the on-call doctor, she contacted him for his impression, and during this conversation she advised him that she was having great difficulty in obtaining proper films and needed his help. Rather than helping, Defendant Rhee became verbally abusive to Ms. Niland using the "f" word on several occasions and then telling her "**I DON'T HAVE TIME TO COME TO KEYSER TO DO A F'ING ULTRASOUND.**"

(Niland Depo., pp. 119-120, 123.) [Emphasis supplied.]

Ms. Niland then proceeded to call another tech who also refused to come into the hospital and then she attempted a second filming by ultrasound which was also sent to Dr. Rhee. Sometime during the two hours in the X-Ray Department, the emergency room contacted Ms. Niland and asked her what was taking so long. (Niland Depo., pp. 143, 144.) The ambulance

for transport ultimately picked up Maranda from the radiology department around 7:00 p.m.

Appellants employed Dr. Richard McLaughlin as a causation expert on the injuries to Maranda Fout-Iser and the death of her baby. Dr. McLaughlin's deposition was taken on May 3, 2004, eight months before the deposition of the radiological tech, Ms. Niland.²

Dr. McLaughlin testified at his deposition that although he did not then know the cause of the delay in radiology he nonetheless clearly established that the delay was a cause of the death of the baby.

"Q. And you[r] second criticism, if you would, please?

"A. Would be OVERALL TIME DELAY while she was at Potomac Valley, contributed, in part, by failing to order laboratory tests on a stat or on an emergency basis; A DELAY IN ULTRASOUND; and a delay in reporting the presence of this patient to Dr. Hahn, along with the information that had been collected on her. (Deposition of Richard McLaughlin, May 3, 2004, p. 50.) [Emphasis added.]

² Appellants and all parties had been requesting, since the filing of the Complaint, the deposition of Ms. Niland, who had left the employment of Potomac Valley Hospital. Counsel for Potomac Valley Hospital indicated that they were searching for her but were unable to find her. Counsel for Potomac Valley Hospital ultimately located Ms. Niland shortly before her deposition of January 15, 2005, and eight months after the deposition of plaintiffs' causation expert, Richard McLaughlin, M.D.

Dr. McLaughlin further testified as follows:

"Q. Doctor, in your earlier testimony, you were critical of the time that Mrs. Iser spent in ultrasound. Am I correct?

"A. Yes.

"Q. Do you have any understanding as to what happened in ultrasound that may have caused any delay?

"A. No. (McLaughlin Depo., pp. 66, 67.)

"Q. Doctor, do you know that the outcome of the fetus would have been any different, in your opinion?

"A. Well, the outcome of the fetus as it stands is a dead baby. The baby was alive in your emergency room. [Potomac Valley Hospital], and earlier treatment with a rescue C-section could have saved the life of the baby.

"Q. Doctor, are you certain within a reasonable degree of medical certainty that the outcome for the fetus would have been different, assuming that the fetus presented as a live, viable fetus?

"A. A 32-week fetus has a greater than 90 percent chance of surviving, so yes."
(McLaughlin Depo., p. 72.)

It should be noted that the standard of medical certainty rather than medical probability was utilized by defense counsel and Dr. McLaughlin even agreed with this improper standard of proof on causation.

Genuine issues of material fact exist as a result of Dr. Dicke's unequivocal testimony that there was a violation of the standard of care by the delay in radiology which he attributed to Dr. Rhee. Furthermore, Dr. McLaughlin, an expert obstetrician/gynecologist, testified that the delay caused the baby's death and specifically related it in part to the significant delay in the radiology department.

Furthermore, Dr. Schmitt, the emergency room doctor, testified that the delay in the radiology department constituted a violation of the standard of care. The radiological tech, Marla Niland, testified to the facts which in large part constituted the delay, including Dr. Rhee's refusal to come into the hospital despite being the on-call physician.

The Court's Finding of Fact / Conclusion of Law Nos. 3 and 5 are wrong, and although Dr. McLaughlin did not render any opinions as to Dr. Rhee's negligence/liability (because he was only a causation witness), he rendered opinions relating to causation for the delay caused by Dr. Rhee's failure to follow acceptable standards of care.

The trial court failed to find that there clearly are genuine issues of material fact created by the testimony of

appellants' experts, as well as the emergency room physician, Dr. Schmitt, and the radiological tech, Marla Niland, and for this reason the summary judgment order should be reversed.

E.
Necessity of Expert Testimony
In Certain Medical Malpractice Claims

The court's findings of facts and conclusions of law fail to address the issue as to whether an expert would even be required in a case where a medical provider's lack of care is so gross as to be apparent and where the violation of the standard of care relates to a non-complex matter of diagnosis or treatment.

In Banfi v. American Hospital for Rehabilitation, 207 W.Va. 135, 529 S.E.2d 600 (2000), this Court held that:

"In medical malpractice cases where lack of care or want of skill is so gross, so as to be apparent, or the alleged breach relates to noncomplex matters of diagnosis and treatment within the understanding of lay jurors by resort to common knowledge and experience, failure to present expert testimony on the accepted standard of care and degree of skill under such circumstances is not fatal to a plaintiff's prima facie showing of negligence." *Id.*, at Syl. Pt. 4. Also see Totten v. Adongay, 175 W. Va. 634, 337 S.E.2d 2 (1985).

As previously indicated, an extremely long delay occurred in the radiology department when Maranda Fout-Iser was having her ultrasound. The tech in charge of Maranda was inexperienced, and this may have been her first attempt to perform an obstetrical ultrasound without trained assistance. To further complicate the situation, Tech Niland testified that Maranda was one of the most ill patients she had ever treated and she had great difficulty in performing the ultrasound. Ms. Niland transmitted the ultrasound films to Dr. Rhee, who was "on call" and overseeing the reading of the ultrasound. Dr. Rhee became abusive to the tech, utilizing the "f" word on multiple occasions and despite the tech's plea for help and assistance, Appellee Rhee refused to come to the hospital in order to help insure a proper and timely ultrasound study on this significantly-ill patient.

Assuming Ms. Niland's testimony to be true for the purpose of the summary judgment motion, it is clear that the actions and inactions of Dr. Rhee are within routine and noncomplex matters which would be cognizable under "common knowledge" or "experience" of lay jurors. Lay jurors recognize that hospitals have on-call doctors who if summoned must go to the hospital to render assistance and help. The facts and circumstances of the

case at bar require application of the "common knowledge doctrine" and an expert on the issue of appellee's liability is not even necessary to establish a *prima facie* case.

In Buskirk v. Bucklew, 115 W. Va. 424, 176 S.E. 603 (1934), the plaintiff, Buskirk, filed a medical malpractice action. Plaintiff received x-ray treatment for ringworm and developed significant burns on her hand. Despite the burning sensation and redness, the doctor continued treating her. During the litigation the defendant moved to dismiss the action because plaintiff did not have an expert on liability. The court, with little discussion, found that expert testimony was not necessary.

In Totten v. Agongay, *supra*, plaintiff alleged the defendant failed to properly diagnose and treat an injury to his right wrist. Plaintiff did not offer expert testimony concerning liability and a directed verdict for the defendant was granted at trial. On appeal, the court agreed that the "common knowledge" exception applied and found that the failure to detect a fracture admittedly shown on an x-ray of the injured area was the result of a breach of the standard of care. Specifically the court stated that:

"A jury, relying upon common knowledge as they do in nonmalpractice injury cases, would have a sufficient basis for a conclusion as to the reasonableness -- the essence of any negligence determination -- of the defendant's oversight."

The facts as testified to by Marla Niland represent gross negligence of an area of medicine which is common to lay persons and which did not require expert testimony. For these reasons, the trial court's summary judgment order must be reversed.

VII.

RELIEF REQUESTED

Appellants respectfully pray that the trial court's order of August 30, 2005, granting Appellee Rhee's Motion for Summary Judgment be reversed and that the trial court be directed to enter an order denying Appellee Rhee's Motion for Summary Judgment in that issues of material fact exist and for such further relief as this Court deems just and proper.

Respectfully submitted,

**THE ESTATE OF ALEXIA
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CERTIFICATE OF SERVICE

Service of the foregoing **BRIEF ON BEHALF OF APPELLANTS** was made upon the appellee by mailing a true copy thereof by United States mail, postage prepaid, to her attorneys on the 12th day of December, 2006, as follows:

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