PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 18-1693

KAYLA BUTTS, Individually and on behalf of her daughter A.F., a minor,

Plaintiff - Appellee,

v.

THE UNITED STATES OF AMERICA,

Defendant - Appellant,

and

BERKELEY MEDICAL CENTER; WEST VIRGINIA UNIVERSITY HOSPITAL, INC.; SHENANDOAH WOMEN'S HEALTH CENTER; SHENANDOAH COMMUNITY HEALTH CENTER; SHENANDOAH MIDWIVES; AVINASH PUROHIT, M.D.; TRACY SWALM, CNM; SARA SPURGEON, R.N.; SHELLY PALKOVIC, R.N.; REBECCA PFENDER, CNM; SARAH HARDY, M.D.; SONYA JUSTICE, R.N.,

Defendants.

Appeal from the United States District Court for the Northern District of West Virginia, at Martinsburg. Gina M. Groh, Chief District Judge. (3:16-cv-00053-GMG-MJA)

Argued: May 7, 2019 Decided: July 11, 2019

Before HARRIS, RICHARDSON and QUATTLEBAUM, Circuit Judges.

Reversed by published opinion. Judge Quattlebaum wrote the opinion, in which Judge Harris and Judge Richardson joined.

ARGUED: Joshua Marc Salzman, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellant. Barry John Nace, PAULSON & NACE, PLLC, Washington, D.C., for Appellee. **ON BRIEF:** Joseph H. Hunt, Assistant Attorney General, Mark B. Stern, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C.; William J. Powell, United States Attorney, OFFICE OF THE UNITED STATES ATTORNEY, Wheeling, West Virginia, for Appellant. Matthew A. Nace, PAULSON & NACE, PLLC, Washington, D.C.; D. Michael Burke, BURKE, SCHULTZ, HARMAN & JENKINSON, Martinsburg, West Virginia, for Appellee.

QUATTLEBAUM, Circuit Judge:

This case arises from a tragic set of events involving A.F., a baby born with severe respiratory problems who developed permanent brain damage. Kayla Butts ("Butts"), A.F.'s mother, brought this action claiming A.F.'s brain damage was caused by the medical

malpractice of Dr. Sarah Hardy. More specifically, Butts contends that Dr. Hardy should have transferred A.F. from the hospital where A.F. was born to a hospital with a neonatal intensive care unit ("NICU") that could have provided the care A.F. needed in the hours after her birth. After a bench trial, the district court agreed and awarded Butts over seven million dollars in damages. On appeal, we consider whether Butts presented sufficient evidence to establish that Dr. Hardy violated the applicable standard of care. Because the district court's finding on this issue was clearly erroneous, we reverse the district court's order and vacate the judgment against Dr. Hardy.

I.

Butts delivered A.F. at Berkeley Medical Center ("Berkeley") in Martinsburg, West Virginia. Berkeley did not have a NICU, so infants who required additional support were cared for in Berkeley's "Max Care Nursery." The Max Care Nursery offered specialized care to newborn infants, including an oxygen-delivery system and equipment to provide intubation. However, the Max Care Nursery did not have all the equipment found in a NICU, including a breathing device known as a continuous positive airway pressure ("CPAP") machine. Infants delivered at Berkeley who needed specialized care Berkeley could not provide were often transported to the NICU at Winchester Medical Center ("Winchester") in Virginia.

At the time of these events, Berkeley was working to establish a NICU of its own. To that end, Berkeley hired Dr. Avinash Purohit, a board-certified neonatologist, to establish and manage a NICU. But Dr. Purohit arrived at Berkeley only a few days before A.F.'s birth and had not yet established a NICU.

A.F. was born at Berkeley around 9:00 a.m. and immediately exhibited signs of respiratory distress. In the minutes following delivery, A.F.'s Apgar score —a diagnostic tool that allows a physician to evaluate a child's physical health by measuring breathing effort, heart rate, muscle tone, reflexes and skin color— was low. Nurses provided immediate treatment to aid A.F.'s breathing, including suctioning A.F.'s airway. Ten minutes after birth, A.F.'s Apgar score had improved, but, because of these initial complications, she was transferred to Berkeley's Max Care Nursery.

Dr. Hardy, a pediatrician, was on call the morning of A.F.'s birth. Soon after A.F. was delivered, the hospital paged Dr. Hardy, and she arrived around 9:15 a.m. Dr. Hardy noticed A.F.'s respiratory distress and low glucose levels. She prescribed antibiotics to prevent infection and ordered a range of tests and diagnostics to assess A.F.'s breathing problems. Dr. Hardy also placed A.F. under an oxyhood, a device that provides supplemental oxygen.

Dr. Hardy then returned to her office for a few hours, while maintaining telephone contact with the attending nurse. While she was away, A.F., with the aid of the oxyhood, maintained acceptable oxygen-saturation

levels, but continued to experience breathing difficulty. Dr. Hardy came back to Berkeley around noon. At that time, A.F. was not improving. For that reason, Dr. Hardy initially decided to transfer A.F. to the Winchester NICU. However, a nurse manager at Berkeley suggested that Dr. Hardy consult Dr. Purohit prior to transfer. Dr. Hardy consulted with Dr. Purohit around 1:30 p.m. that afternoon. Dr. Purohit assured Dr. Hardy that Berkeley had the necessary equipment and staffing for him to provide care to A.F., and he specifically told Dr. Hardy that a transfer to the Winchester NICU was unnecessary. After that discussion, Dr. Purohit agreed to take A.F. on as his patient.

After taking over A.F.'s care, Dr. Purohit ordered tests and altered A.F.'s treatments. While there is some dispute as to whether Dr. Hardy complied with Berkeley's internal procedures for completing a formal transfer of responsibility for A.F.'s care to Dr. Purohit, the district court assumed that Dr. Hardy's responsibility for A.F. terminated at 2:45 p.m.

Over the next twenty-four hours, A.F.'s condition continued to deteriorate. Ultimately, on the afternoon of the day following A.F.'s birth, Dr. Purohit ordered her to be transferred to the NICU at Winchester. A.F. remained there for nearly a month. While the parties dispute the timing and cause, there is no dispute A.F. suffered irreversible brain injury from the insufficient flow of oxygenated blood to her brain.

As a result of A.F.'s injuries, Butts sued multiple defendants including Berkeley, Dr. Purohit and Dr.

Hardy alleging medical malpractice. Because Dr. Hardy was employed by a federally-funded hospital, the United States substituted itself on behalf of Dr. Hardy under the Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 1346(b), 2671-2680. Prior to trial, all defendants except the United States settled with Butts.

Butts's claim against the United States proceeded to a bench trial. After the trial, the district court issued findings in favor of Butts. The district court concluded "the standard of care required that A.F. be transferred to a NICU and receive the level of care that is only available in a NICU, such as the one at [Winchester]." J.A. 281. The court found "Dr. Hardy should have transferred A.F. to [Winchester] the same afternoon A.F. was born. . . ." J.A. 281. The court further found Dr. Hardy was not absolved by her transfer of care to Dr. Purohit because, even though he was a board-certified neonatologist, he "was without a NICU. Thus, at a minimum, he lacked the appropriate equipment, specialized staff or necessary protocols to adequately assess and treat a baby who needed intensive care." J.A. 281. The district court concluded that Dr. Hardy's failure to follow the applicable standard of care caused A.F.'s injuries and awarded Butts over seven million dollars in damages.[1]

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[1] The district court did not apportion liability among the other defendants that settled prior to trial. Furthermore, the district court did not offset the damages award by the amount of Medicaid and Supplemental Security Income payments that the federal government will make to A.F. for her injuries.

The United States filed a timely appeal. We have jurisdiction of this appeal under 28 U.S.C. § 1291.

II.

We review a judgment following a bench trial under a mixed standard of review. *Equinor USA Onshore Properties Inc. v. Pine Res., LLC*, 917 F.3d 807, 813 (4th Cir. 2019). While conclusions of law are examined de novo, we may reverse factual findings only if they are clearly erroneous. *Id.* The clearly erroneous standard "does not entitle a reviewing court to reverse the finding of the trier of fact simply because it is convinced that it would have decided the case differently." *Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573 (1985). Rather, "[i]f the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently." *Id.* 573-74.

But while clear error review is deferential, it is not toothless. *United States v. Wooden*, 693 F.3d 440, 452 (4th Cir. 2012). A finding is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." *Anderson*, 470 U.S. at 573 (quoting *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948)). Pertinent here, this Court's conviction that a mistake has been committed may be properly based upon a

conclusion that the findings under review "are not supported by substantial evidence" in the record.[2] *Miller v. Mercy Hosp., Inc.*, 720 F.2d 356, 361 (4th Cir. 1983).

III.

On appeal, the United States argues Butts did not introduce sufficient evidence to support a conclusion that Dr. Hardy breached the applicable standard of care.[3] To establish breach, West Virginia law[4] requires a party bringing a medical malpractice claim to show that "[t]he health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the

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[2] In reviewing this case, the standard we apply is effectively the same standard a trial judge applies in considering a motion for judgment as a matter of law under Federal Rule of Civil Procedure 50 in the context of a jury trial.

[3] The United States also raises the following issues on appeal: (1) whether the district court erred in concluding Butts introduced evidence supporting a finding that Dr. Hardy's treatment was the proximate cause of A.F.'s injuries; (2) whether the district court erred by failing to consider whether a share of liability should have been apportioned to other defendants who settled before trial; (3) whether the damages award must be reduced by the amounts that plaintiff will receive from federal benefits programs as compensation for the same injuries covered by the damages award; and (4) whether the district court erred in refusing to reduce the damages award by the amounts that plaintiff received from settling co-defendants as required by West Virginia law.

[4] Because this is an action brought under the FTCA, we apply "the substantive law of the state in which the act or omission giving rise to the action occurred." *Myrick v. United States*, 723 F.2d 1158, 1159 (4th Cir. 1983). Accordingly, we apply the substantive law of West Virginia in resolving this appeal.

profession or class to which the health care provider belongs acting in the same or similar circumstances. . . ." W. Va. Code § 55-7B-3(a)(1); *see also MacDonald v. City Hosp., Inc.*, 715 S.E.2d 405, 423 n.22 (W. Va. 2011). The applicable standard of care, and the defendant's failure to meet the standard of care, must be established by the "testimony of one or more knowledgeable, competent expert witnesses if required by the court." *Id.* § 55-7B-7. A physician is not required to provide a patient with "the highest degree of care possible." *Bellomy v. United States*, 888 F. Supp. 760, 765 (S.D.W. Va. 1995) (citing *Schroeder v. Adkins*, 141 S.E.2d 352, 357 (W. Va. 1965)). "Moreover, where there is more than one method of medical treatment accepted and applied by average physicians similarly situated, the physician may take into account the particular circumstances of each case and may exercise his honest and best judgment in selecting a course of treatment for individual patients." *Id.* at 765-66. In fact, if there is more than one acceptable method of treatment, the physician need not choose the best one. *Id.* at 766 (citing *Maxwell v. Howell*, 174 S.E. 553, 554-55 (W. Va. 1934)).

On the issue of whether Dr. Hardy breached the applicable standard of care, Butts first called Dr. John C. Partridge, a physician who is board-certified in pediatrics and neonatal perinatal medicine. Dr. Partridge, the expert the district court found to be the most credible, testified to a reasonable degree of medical probability that by noon "the child, I think would have been better served, far better served in a different hospital." J.A. 500. Dr. Partridge further opined

that, because of A.F.'s continuing symptoms and deteriorating condition, "that child should have been transferred." J.A. 501. But Dr. Partridge significantly qualified his opinion on cross-examination when he acknowledged that transfer to a NICU was not required. Rather, Dr. Partridge opined "the child should have been transferred either to a higher level of care within Berkeley Medical Center or to a NICU." J.A. 525. Dr. Partridge then acknowledged that Dr. Hardy did in fact transfer A.F. to Dr. Purohit, a board-certified neonatologist who had been hired to start a NICU at Berkeley. Dr. Partridge also opined on cross that the first time Dr. Purohit was required to transfer A.F. under the applicable standard of care was at 11:15 p.m. that night. Critically, this was almost nine hours after Dr. Hardy transferred care to Dr. Purohit.

Based on Dr. Partridge's testimony, Dr. Hardy did not violate any generally applicable standard of care. As discussed, a physician is not required to provide a patient with "the highest degree of care possible." *Bellomy*, 888 F. Supp. at 765. Additionally, where there is more than one acceptable method of treatment, the physician need not choose the best method. *Id.* at 766. Here, Dr. Partridge testified that Dr. Hardy could satisfy the standard of care by either transferring A.F. to a higher level of care within Berkeley Medical Center or to a NICU. The facts show, and Dr. Partridge acknowledges, that Dr. Hardy chose to transfer A.F. to a higher level of care within Berkeley by transferring care to Dr. Purohit. Based on Dr. Partridge's own testimony this was an acceptable method of treatment for

Dr. Hardy to pursue, whether or not it was the best method of treatment. Therefore, Dr. Partridge's testimony fails to establish that Dr. Hardy breached the standard of care.

Butts next presented the testimony of Dr. Carol Miller, a board-certified pediatrician. Dr. Miller testified that Dr. Hardy breached the applicable standard of care by not transferring A.F. to a NICU. While she testified generally about other benefits of a NICU, Dr. Miller explained that A.F. needed to be transferred to a NICU to receive treatment with a CPAP machine or intubation. More specifically, when asked about the care A.F. would have received at a NICU that she did not receive at Berkeley, Dr. Miller responded "[m]ost importantly is enhanced respiratory support. . . . That could be in the way of CPAP, which is a method of giving increased pressure, or it could be intubating, which is what this baby needed. . . ." J.A. 755-76. Dr. Miller did not testify that a CPAP machine was medically necessary or preferable to intubation. Rather, she indicated that either a CPAP machine or intubation could be used under the circumstances. Dr. Partridge agreed, testifying that the choice between using a CPAP machine and intubation is "a management style choice." J.A. 481-82.

Whether Dr. Miller realized it or not, intubation was available at Berkeley. Indeed, Dr. Purohit testified that he intubated a baby the first day he arrived at Berkeley, and the district court identified only one specific NICU-level intervention, a CPAP machine, that was not available at Berkeley. Because Dr. Hardy

transferred A.F. to Dr. Purohit, who had the expertise and equipment to perform the treatment Dr. Miller said A.F. needed, Dr. Hardy's conduct did not fall below the standard of care.

We are mindful of our responsibility to consider the district court's findings on breach in light of the entire record. With that in mind, when the complete testimony of Dr. Partridge and Dr. Miller is considered together, Butts presented evidence that Dr. Hardy was required to transfer A.F. to a higher level of care to receive enhanced respiratory intervention. But that is what Dr. Hardy did. Dr. Hardy transferred A.F. to a board-certified neonatologist, Dr. Purohit, who assured Dr. Hardy that he had the equipment and ability to care for A.F. at Berkeley. Dr. Purohit had the ability to provide more aggressive respiratory intervention, including intubation. Intubation is the exact procedure that Dr. Miller said was required. And Dr. Partridge opined that once Dr. Hardy transferred care to Dr. Purohit, Dr. Purohit was not required to transfer A.F. to a NICU until 11:15 p.m. that evening. If Dr. Purohit was not required to transfer A.F. to a NICU until 11:15 p.m., it cannot have been malpractice for Dr. Hardy to transfer A.F. to Dr. Purohit to receive an elevated level of care at 1:45 p.m. earlier that afternoon.[5]

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[5] The deficiencies in the testimony offered by Butts's experts are exacerbated because neither clearly articulated a standard of care in the first place. While they both used the "standard of care" label during their testimony, neither explained any meaningful criteria for judging A.F.'s conditions that required transfer. Put another way, neither expert appropriately said what was right before saying what was wrong.

IV.

After reviewing the whole record, we are firmly convinced the district court's finding that Dr. Hardy breached the standard of care was a mistake. The district court's finding as to breach was not supported by substantial evidence in the record and was thus clearly erroneous. Specifically, the district court's finding on breach was not supported by Butts's own expert testimony. Therefore, despite the sympathy we feel for A.F., the district court's order finding Dr. Hardy liable for medical malpractice must be reversed.

Because we hold the district court erred in finding Dr. Hardy liable for malpractice, we need not address the remaining issues raised by the United States. The judgment of the district court is reversed, and the district court is directed to enter judgment in favor of the United States.

REVERSED

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT
OF WEST VIRGINIA
MARTINSBURG**

**KAYLA BUTTS,
individually and on
behalf of her daughter
A.F., a minor,**

Plaintiffs,

v.

**UNITED STATES
OF AMERICA,**

Defendant.

**CIVIL ACTION NO.:
3:16-CV-53
(GROH)**

**ORDER OF BENCH TRIAL FINDING
IN FAVOR OF THE PLAINTIFFS**

In this action, Plaintiffs allege that Plaintiff A.F., a minor child, suffered permanent and severe brain damage injuries that resulted from the medical negligence of Defendant shortly after A.F. was born. Specifically, Plaintiffs aver that Dr. Sarah Hardy failed to meet the standard of care, and her failure caused A.F.'s injuries.

I. Introduction

A four-day bench trial commenced on May 23, 2017, wherein the parties called fifteen witnesses and submitted four deposition transcripts. Several exhibits, including Plaintiffs' medical records, were admitted into

evidence. Subsequently, the parties submitted proposed findings of fact and conclusions of law. ECF Nos. 180, 181 & 182. On August 8, 2017, Plaintiffs also submitted a supplementation of recent legal authority. ECF No. 183. Having presided over the trial in this matter and carefully reviewed all of the admitted testimony, depositions and exhibits, along with the parties' proposed findings of fact and conclusions of law, the Court, upon thoughtful consideration of the relevant statutes and legal precedent and for the following reasons, hereby finds for the Plaintiffs.

II. TESTIMONY

Dr. Sarah Hardy was the first attending physician charged with A.F.'s care. Dr. Hardy was a defendant in this civil action, but, under the Federal Tort Claim Act ("FTCA"), the United States of America substituted itself as the Defendant in her place.

Dr. Hardy became board certified in October 2012, and the first position she held after completing her residency was at Shenandoah Community Health ("Shenandoah"). T 181. Beginning at 8:00 a.m. on the morning A.F. was born, Dr. Hardy was on call at Berkeley Medical Center. Dr. Hardy was at her home when nursing staff at BMC paged her because of A.F.'s poor condition.

Dr. Hardy arrived at the hospital around 9:10 a.m., approximately twenty minutes after A.F. was born. T 187. Dr. Hardy took note of A.F.'s low Apgar readings of two and four at one and five minutes of life, respectively. T 189. Dr. Hardy testified that A.F. was born in

mild to moderate respiratory distress, crying and not vigorously moving around. T 193. She stated that a baby who is hypoxic for long periods of time does not have the pulmonary vasculature dilation to allow oxygenation of the blood and being hypoxic can make that worse. T 194. Dr. Hardy also testified that a baby's oxygen level dropping even one or two percentage points could cause decreased blood flow to the lungs, which, in turn, causes the saturations to lower rapidly. Id. Dr. Hardy testified that upon her initial exam of A.F. she was predominantly concerned with A.F.'s respiratory status and noted there was an increased respiratory rate with grunting, flaring and retracting. T 196. Dr. Hardy testified that it could sometimes take up to five hours for a baby to be able to breathe and function normally.

Dr. Hardy explained that meconium aspiration is the "syndrome of respiratory distress following the ingestion of meconium." T 199. Dr. Hardy testified that upon receiving A.F.'s lab results at around 10:00 a.m., she decided to provide supplemental fluids and glucose, continue to give antibiotic therapy and supplemental oxygen for another hour or two and monitor A.F. for any change in her status. T 204-05. However, if any time thereafter A.F. started breathing harder, needed more oxygen, failed to improve or got worse, then Dr. Hardy planned to transfer A.F. to a neonatal intensive care unit ("NICU"). T 205.

After initially seeing A.F., Dr. Hardy went to her office at Shenandoah. On direct examination Dr. Hardy testified that while at Shenandoah she spoke with

A.F.'s nurse five or six times over a ninety-minute timespan. T 206. During cross examination, Dr. Hardy conceded that she exaggerated how many times she spoke with A.F.'s nurse. T 243-44. Specifically, she admitted that she did not speak with A.F.'s nurse five or six times as she previously testified, but it was more likely only two or three times. However, Dr. Hardy also acknowledged that BMC's records indicated she spoke to A.F.'s nurse once. Id.

Dr. Hardy testified that A.F.'s arterial blood base excess was a little abnormal at negative five and four-tenths. T 209. After talking to A.F.'s nurse, Dr. Hardy learned that A.F. was breathing faster and harder. Dr. Hardy thought she needed "to transfer [A.F.] to a NICU level of care because it looked like she was not . . . improving significantly with the treatment that [Dr. Hardy] was giving her at the time[,]" and it was at that point in time Dr. Hardy intended to transfer A.F. to Winchester Medical Center's ("WMC") NICU. T 210. Dr. Hardy testified that she made a note in the history and physical ("H&P") at 10:41 a.m. that if A.F. did not improve she would transfer her to a NICU. T 224. BMC did not have a NICU. T 225.

Dr. Hardy testified that only two or three times since being out of medical school had Dr. Hardy seen a child in A.F.'s condition. T 234. She testified that A.F. had a glucose reading so low it did not register, followed by a reading of twelve. Dr. Hardy testified that A.F.'s glucose readings indicated she was under stress during the delivery process. T 237. Dr. Hardy testified that A.F. was in respiratory distress for the duration of

her care. T 251. She agreed that A.F. could develop brain damage if an inadequate amount of oxygen reached her brain. T 238. She also testified that once A.F. reached two to three hours of life, considering her vital signs and overall circumstances, A.F. needed more than a pediatrician. T 252. Everything Dr. Hardy observed indicated that A.F. needed to be transferred to the NICU at WMC. Id.

However, BMC's nurse manager approached Dr. Hardy and asked her to consider consulting with Dr. Avinash Purohit rather than transferring A.F. to WMC. Dr. Hardy acquiesced and called in Dr. Purohit. T 210-11.

Dr. Hardy testified that Dr. Purohit had the ability to provide a higher level of care than she because he went to a storeroom and retrieved a nasal cannula. T 249-50. Indeed, Dr. Hardy was unaware that BMC had a nasal cannula. T 250. Dr. Purohit began his employment at BMC on the 14th of October—three days before A.F. was born—and he was the only neonatologist at the hospital. D 15. Dr. Purohit was hired to start and manage a NICU at BMC. D 18. A.F. was the first child Dr. Purohit cared for at BMC. D 21. BMC did not have a NICU or even a CPAP machine at that time. D 19.

When Dr. Hardy was asked if she was required to write a note in the record that she transferred A.F.'s care to another provider, Dr. Hardy testified that she was sure she was not required to do so. T 226. However, Dr. Hardy admitted that she did not know if she had ever viewed BMC's policies and procedures. T 226-27.

Prior to caring for A.F., Dr. Hardy only transferred babies from BMC to other doctors at WMC. T 227.

The Plaintiffs called BMC's designated representative, Samantha Richards, who testified about the hospital's policy regarding attending physicians transferring on-call responsibilities, as it was written in October 2013. T2 139. Ms. Richards read the policy, which stated:

> A physician member of the Staff shall be responsible for the medical care of each patient in the Hospital. The attending practitioner shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary special instructions to include isolation if necessary, and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service concerned in the treatment of the disease which necessitated admission. In the case of a patient requiring admission who has no practitioner, he or she shall be referred to the practitioner on-call for the service to which

> the illness of the patient indicates assignment.

T2 139-40.

Ms. Richards also testified that the physician who originally evaluated the patient should enter an order transferring care. T2 144. Further, she explained that the transferor physician is supposed to author a progress note summarizing the patient's condition. T2 146. Ms. Richards testified that although there are times when either physician could write the progress note, in the event a patient's condition worsens or does not improve, then both transferor and transferee physicians would write a progress note. T2 145-46.

Dr. Hardy was unaware of this policy, and she never made a note that A.F.'s care was transferred to Dr. Purohit. T 253-54.

A.F. was transferred to the NICU at WMC the day after she was born. By the time A.F. was transferred to WMC, her condition had considerably worsened since Dr. Hardy's decision to consult Dr. Purohit rather than transfer her to WMC.

Dr. Edward Lee was the attending physician charged with A.F.'s care during her lengthy stay at WMC. He is a neonatologist at WMC who cares for high-risk babies. D 7. His testimony was admitted via deposition.

Dr. Lee is board certified in both pediatrics and perinatal and neonatal medicine. D 8. He started practicing medicine at WMC in 1998 and has remained

there to the present. D 10. He routinely received referrals from BMC. D 12-13. In reviewing the transport records, he noted that it was about 12:13 p.m. on October 18 when he spoke to someone at BMC regarding A.F. D 19. He was told that A.F. was a one-day-old baby with meconium-stained fluid and was on oxygen. He was also advised that A.F. was dyspneic, and BMC was unable to give high respiratory support. D 20.

Dr. Lee testified that when WMC's transport team arrived at BMC, A.F.'s oxygen saturation was eighty-one, she was cyanotic and had paradoxical breathing. D 26-27. Dr. Lee noted that a normal saturation would be in the mid-nineties or higher. Dr. Lee's team started A.F. on CPAP and discovered more meconium when they attempted to intubate her on two separate occasions. D 44-45. Dr. Lee also explained that an X-ray revealed something in A.F.'s lungs, which was not allowing them to fill with as much air as necessary. D 47.

Once A.F. was intubated and on CPAP, Dr. Lee's team was able to get A.F.'s oxygen saturation up to ninety-nine percent. D 49. He said it was unclear whether A.F. had an infection, but the cultures were all negative. D 51. Dr. Lee also noted that WMC administered an electroencephalogram ("EEG") on A.F. D 61. Although he could not be one hundred percent certain that A.F. suffered from meconium aspiration, he was led toward that conclusion. D 66-67.

Dr. Lee testified that hypoxia is a "decrease in the oxygen level" and ischemia is a lack of perfusion. He further explained that encephalopathy is a reaction of

the brain to what has happened. Dr. Lee opined that there was a hypoxic ischemic event based upon the magnetic resonance imaging ("MRI") report, which showed that different parts of the brain lacked perfusion. D 68-69.

Dr. Lee opined there was a lack of blood flow—and consequently oxygenated blood—which led to cellular injury, specifically to A.F.'s brain cells. D 76-77. Dr. Lee testified that apnea is not normal in a term baby, and he described apnea as ceasing to breathe; in this case, it was forgetting to breathe. D 83. Dr. Lee opined that what he observed was consistent with severe acute anoxic/hypoxic injury.

Dr. Lee's team was able to control A.F.'s seizures. D 86. However, he opined that the diagnosis of seizures will always be active during any future hospitalization. A.F.'s respiratory difficulty was his primary focus. D 91. His team worked to stabilize A.F.'s oxygenation. D 91. Once A.F. got to WMC, she was admitted directly into its NICU. D 92. A.F. had mature lungs. D 95. Dr. Lee opined that meconium aspiration was the most likely diagnosis. D 95-97.

Plaintiffs called John C. Partridge, M.D., as an expert witness. Dr. Partridge is a neonatologist and pediatrician, who works predominantly in a NICU. T 86-87. He is board certified in pediatrics and neonatal perinatal medicine. T 88. He testified that he has treated children with hypoglycemia and explained that if the blood is not carrying proper glucose or if there is a decreased blood flow to the brain even with good glucose, there

may be cellular aberrations and metabolism of brain cells resulting in their destruction. T 95. He testified that the brain needs oxygen, which it receives through red blood cells. T 96.

Dr. Partridge reviewed medical records from BMC pertaining to the birth of A.F., records from WMC, and depositions of Dr. Hardy, Dr. Purohit and various nurses. T 99. He noted that once in Dr. Hardy's care, A.F. was hypoglycemic and in respiratory distress. T 100. A.F. needed and received resuscitation at birth, but her Apgar scores remained low thereafter. T 101. He testified that the records indicate A.F. had respiratory problems and neonatal hypoglycemia. T 106-107. Dr. Partridge also opined that grunting, flaring and retracting are all signs that a baby is trying to breathe adequately but is either acidotic or is not receiving sufficient oxygen. T 110. He noted that A.F.'s oxygen saturation at ten minutes of life was seventy-five percent. Dr. Partridge testified that seventy-five percent is too low and means that only seventy-five percent of the red blood cells in A.F.'s blood were carrying hemoglobin. T 111. Dr. Partridge opined that a glucose reading of twelve indicates that the metabolic demands have exceeded the ability of the child to make her own glucose. T 114. He also stated that A.F. was tachypneic.[1] T 115.

Referring to the medical records, Dr. Partridge noted that the hospital called Dr. Hardy to return later in the morning because A.F. was deteriorating with tachypnea and decreased saturations and she needed

[1] More than sixty breaths per minute in a neonate.

increased oxygen. T 131. Dr. Partridge opined that if A.F. had been in a NICU, the unit would have had the ability to give oxygen adequately because NICU providers can intubate and ventilate. T 133-34. Dr. Partridge opined that A.F. deteriorated the first day of life, which is typical of a child with pulmonary hypertension. He also opined that A.F. needed a physician at the bedside and absolutely needed to be in a NICU. T 135. To a reasonable degree of medical certainty, Dr. Partridge agreed with Dr. Lee's diagnosis that A.F. had anoxic ischemic encephalopathy. T 139.

Dr. Partridge also opined within a reasonable degree of medical certainty that Dr. Hardy should have transferred A.F. at noon, the same day she was born—more than twenty-four hours before A.F. was actually transferred to WMC. T 141. He opined that Dr. Hardy certainly was the attending physician from 9:30 to 2:46 PM. T 151. He also opined that merely putting A.F. on a nasal cannula and increasing oxygen was not appropriate under the circumstances. T 152. He opined that A.F. was actually getting worse during Dr. Hardy's care, which was *her* criteria for transferring A.F. to a higher level of care. T 165-66. Dr. Partridge also opined within a reasonable degree of medical certainty that it was very unlikely A.F. had a prenatal brain injury. T 171. He opined that A.F.'s history was much more indicative of immediate postnatal cerebral palsy. T 172.

Carol Miller, M.D., is a board certified pediatrician. Her testimony was presented via videotape with a transcript and generally parallels Dr. Partridge's testimony. Dr. Miller reviewed the pertinent hospital

records in this case. D 187-188. According to Dr. Miller, A.F. had meconium aspiration and was not breathing well following delivery, not stable and was hypoxic. D 193-194. She noted that A.F.'s glucose was extremely low, risking injury to the brain; that there was fast breathing, tachypnea, flaring, grunting; and A.F. appeared to be having problems establishing adequate ventilation. D 197-200. Dr. Miller opined that A.F. needed the care available in a NICU following delivery, and it was below the standard of care when Dr. Hardy did not transfer her to a NICU. D 200. Dr. Miller opined that had A.F. been admitted to a NICU, she would have received the necessary support for proper respiration. D 208-209.

Dr. Miller opined that the standard of care required A.F. to receive CPAP or intubation. D 209. Dr. Hardy testified that BMC did not have CPAP available. T 188. In Dr. Miller's opinion, A.F.'s inadequate breathing, respiration and oxygen delivery to the cells of the body, including the brain, were the result of Dr. Hardy's actions, which fell beneath the standard of care. D 214-221.

Dr. Miller also opined within a reasonable degree of medical certainty that A.F. developed hypoxic-ischemic encephalopathy because of Dr. Hardy's violation of the standard of care and that Dr. Hardy had full responsibility for A.F. D 220-21. Dr. Miller opined that had the standard of care been followed, A.F. would not have experienced hypoxic-ischemic encephalopathy. D 221. She further opined that Dr. Hardy's care did not end once she brought Dr. Purohit into the matter

as a consulting physician. D 229. Dr. Miller also noted that even though Dr. Purohit was a neonatologist, he could do nothing more than Dr. Hardy in the absence of a NICU at BMC. D 250.

Dr. Jonathan Muraskas testified as an expert witness on behalf of the Defendant. T2 151. Dr. Muraskas has testified under oath in malpractice cases 100 to 115 times. Although he said he was not concerned with media attention, his curriculum vitae indicated otherwise. T2 189.

Although Dr. Muraskas testified that everything in A.F.'s medical history is very suggestive of infection, he noted that A.F.'s white count was normal and that she had both normal hemoglobin and hematocrit. T2 177. Dr. Muraskas testified that he did not believe A.F. needed to be transferred to Winchester. T2 180. He believed that there was an evolving infection, specifically chorioamnionitis. T2 182. Dr. Muraskas testified that chorioamnionitis affects ten percent of pregnancies. Id. He noted that A.F.'s mother's white blood cell count was not overwhelming, and A.F.'s arterial blood gases were completely normal. T2 185-86.

Dr. Muraskas believed that WMC appropriately diagnosed A.F. with hypoxia ischemic encephalopathy. T2 192-93. He opined that Dr. Hardy's inclination to transfer A.F. to WMC was not necessarily the correct decision. T2 198. He did not know the exact physical set up at BMC but conceded that a maximum care nursery is not a NICU. T2 198-99. He opined that A.F. did not need CPAP. T2 199. He noted that an Apgar of

two was not normal and that a five-minute Apgar of four is also not normal. T2 205. He opined that grunting and flaring is normal in a newborn. He also testified that an oxygen saturation of seventy-five is normal. However, he later changed his testimony and said it was abnormal but irrelevant. T2 207-208. He agreed that a heart rate of one hundred sixty-eight to one hundred eighty, a glucose reading of twelve, a respiratory rate of ninety and cyanosis are all not normal. T2 208-11. He agreed that apnea is never normal in a baby. T2 215. Dr. Muraskas opined that A.F. needed to be intubated at some time while she was at BMC. T2 218. However, Dr. Muraskas could find nothing in the record that indicated to him that A.F. may have suffered brain damage before leaving BMC. T2 219. Dr. Muraskas also opined that A.F.'s apnea was actually seizures, which caused her encephalopathy later that evening. T2 219.

Dr. Muraskas testified that dilated pupils indicate brain damage. T2 220. A.F.'s pupils were dilated before being transported to WMC. However, Dr. Muraskas opined that A.F. simply was doomed upon birth. T2 223. He also disagreed with Dr. Lee's finding that A.F. had meconium aspiration syndrome. T2 225. But, Dr. Muraskas agreed that A.F. suffered from hypoxic ischemic encephalopathy. T2 225.

Thomas Rugino, M.D., is a triple-board-certified physician in pediatrics, physical medicine and rehabilitation and neurodevelopmental disabilities. He is one of only a dozen physicians in the country with the above-referenced triple board certification. T 20. Dr.

Rugino has practiced at Children's Specialized Hospital in New Jersey for more than fifteen years, treating children with neurologic and musculoskeletal injuries and cognitive type disabilities.

Dr. Rugino reviewed medical records, school records, and A.F.'s birth-to-three records for his report. T 20; 26. He noted that A.F.'s mother was Group B strep positive and treated with Flagyl. However, Dr. Rugino opined there was no evidence that it affected A.F.'s outcome. T 29. He noted that A.F. sustained significant injury in several areas of her brain. T 29. Dr. Rugino opined that an EEG confirmed within a reasonable degree of medical certainty that A.F. had hypoxic-ischemic encephalopathy. T 31. He believed that "the neurological issues were due to hypoxic-ischemic events." T 32-33. Dr. Rugino also testified that at the time he examined A.F., she was not meeting her gross motor skills, walking or jumping, or communicating effectively, and she had a very, very limited ability to follow directions, as well as being very delayed in all areas of development. T 37. He noted that her right hand is dysfunctional. Dr. Rugino demonstrated basic tests with A.F. during the trial, which revealed many of A.F.'s disabilities for the Court. T 46. Dr. Rugino also noted that A.F. has a moderate to severe cognitive disorder. T 48.

Dr. Rugino testified that A.F. has no prospect of walking independently and has no possibility of true community ambulation. T 52. He opined within a reasonable degree of medical certainty that the hypoxic ischemic injury caused of A.F.'s disabilities. T 56. He opined that she suffers from spastic quadraparetic

cerebral palsy with multifocal seizures, oral dysphagia, gross and fine global development delays, communication delays, visual reception, social skills, contractures of the iliopsoas muscles bilaterally, bilateral hip abductor and bilateral hamstring injuries all as a direct result of the hypoxic ischemic encephalopathy. T 62-63.

Dr. Rugino concluded that A.F. has no prospect whatsoever of approaching normal development. T 64. In his opinion, A.F. will not graduate from school with any marketable skills, will remain completely and permanently disabled from any type of meaningful, gainful employment, will need continuous safety supervision and will not be able to make any life decisions on her own. T 66.

Dr. Rugino reviewed A.F.'s life care plan and testified that the life care planner followed his recommendations. T 70. He expected A.F. would have a normal life expectancy because she does not have any conditions or disorders that are likely to result in premature death. T 71. Dr. Rugino noted that an MRI taken of A.F. at four days old showed extensive edema and diffusion restriction typical of a perinatal injury, and he opined that the injury occurred on A.F.'s first day of life. T 82-83.

Thus, it was Dr. Rugino's opinion within a reasonable degree of medical probability that A.F. suffered from meconium aspiration syndrome with resultant respiratory failure requiring mechanical ventilation, which led to her hypoxic-ischemic brain injury. Dr. Rugino further opined within a reasonable degree of medical

probability that as a direct result of the immediate prenatal distress, complicated by meconium aspiration syndrome with prolonged hypoventilation, A.F. suffered neonatal metabolic acidosis, hypoglycemia and hyperbilirubinemia. Therefore, the immediate prenatal distress complicated by the meconium aspiration syndrome and resultant continuous respiratory deficiencies caused A.F.'s permanent brain injuries.

The Defendant called Dr. Harry Chugani as an expert. Dr. Chugani is a board certified pediatric neurologist. T2 6. His work generally includes using a position emissions tomography ("PET") machine to find an epileptic focus and map out areas for removal by a surgeon. T2 8. A PET scan is another form of imaging. T2 9. Dr. Chugani's practice in Delaware does not include neuromuscular diseases. T2 10. He was not a practicing pediatrician, and his work emphasis was epilepsy. T2 15-16. He did not review any PET scans for this case, and he never examined A.F. T2 16. Although he disagreed with many of Dr. Rugino's conclusions, Dr. Chugani agreed that A.F.'s injury could have occurred any time prior to her MRI. T2 36. He also agreed that A.F. had serious developmental issues with injuries that were multi-focal. T2 65.

Laura Lampton testified regarding the life care plan she created for A.F. Ms. Lampton is a life care planner and member of the American Association of Nurse Life Care Planners. In preparing A.F.'s life care plan, Ms. Lampton conferred with Dr. Rugino and also met with A.F. T3 11-12. Ms. Lampton testified that as A.F. progresses, her condition will stabilize and

plateau. She opined that necessities for A.F. should continue through age eighteen. T3 23. Because A.F.'s mother, Kayla Butts, needs respite assistance to work and do other activities, Ms. Lampton included that expense until A.F. reaches forty-eight years of age. T3 25. The gross cost of future care totaled between $7.2 and $7.7 million. T3 26-27. Ms. Lampton's life care plan also recommended less physical therapy, occupational therapy and other similar activities than A.F. is currently receiving. T3 36.

The Defendant called Nancy Forest to testify about the life care plan Ms. Lampton developed. Ms. Forest did not independently create a life care plan for A.F. Instead, she reviewed Ms. Lampton's plan and then discussed her impressions with Dr. Chugani. T4 38. She opined that the majority of Nurse Lampton's life care plan was reasonable, including the respite assistance, attendant care and vehicle issues. T4 46. Ms. Forrest had no medical education. T4 49. Ms. Forest relied heavily upon information from Dr. Chugani in developing her opinion regarding Ms. Lampton's life care plan for A.F. T4 50. Chad Staller was called as an expert to testify regarding the economic damages in this case. Mr. Staller works at the Center for Forensic Economic Studies. T3 86. In reaching his conclusions and preparing his report, Mr. Staller utilized data from various sources, including the Journal of Forensic Economics, Worklife Estimates and US Vital Statistics. T3 90. He offered his opinion of the current value of future costs and lost earnings capacity. T3 97. Mr. Staller took into account factors like inflation, productivity

and discounting. T3 99. He utilized generally accepted methodology. T3 100. Based upon standard data, he determined that A.F. would obtain a high school diploma or GED. T3 101. He did not make calculations for college because she only had an eighteen percent chance of completing college. Instead, Mr. Staller used a high school graduate's status because A.F. had a sixty-nine percent likelihood of graduating. T3 102. He explained how he determined that A.F. would likely have worked for forty-two years in the labor force. Because healthcare costs increase at a rapid pace, Mr. Staller isolated the rising cost of healthcare compared to general inflation and wage growth. T3 107. He opined, within a reasonable degree of economic certainty, that the need for future medical care reduced to present value would be $4,607,834.00. T3 108. Mr. Staller further opined that A.F.'s future lost earnings capacity was between $1,318,522.00 and $1,631,125.00. Plaintiffs' Ex. 24.

The Defendant called Homayoun Hajiran as an expert economist. Mr. Hajiran was asked to critique Mr. Staller's report. T4 69. Mr. Hajiran did not independently create his own report. Mr. Hajiran disagreed with Mr. Staller's determination regarding A.F.'s likely educational attainment. T4 71-72. Mr. Hajiran opined that A.F. would have had a fifty-fifty chance to finish high school. T4 78. He also testified that he could not say what A.F.'s chances of completing high school were. T4 91. He agreed that eighty-eight percent of American children obtain a high school diploma. T4 91. Mr. Hajiran testified that because A.F.'s great-grandfather

committed murder, she was less likely to graduate from high school. T4 95.

A.F.'s mother, Kayla Butts, testified that even though she gave birth to A.F. when she was sixteen years old, she graduated from high school with her class. T2 98. Ms. Butts testified that she is, and always has been, A.F.'s primary caretaker. Ms. Butts testified that she probably spends at least twelve hours a day taking care of A.F. T2 120. She also testified that A.F. goes to Pikeside pre-school but cannot walk or talk and often becomes very frustrated. T2 116.

III. Findings of Fact

Plaintiff Kayla Butts was a 16-year-old girl who had a difficult pregnancy, which included bacterial infection, fever, dehydration and multiple occasions of pre-term labor, including one instance where she was transported by helicopter to Morgantown, West Virginia. T2 123-26. Kayla also tested positive for GBS, which, if passed to the baby, can be very dangerous.

On October 17, 2013, after her water broke at approximately 2:30 a.m., Kayla Butts went to BMC. Terminal meconium was noted at A.F.'s birth. The medical records also indicate that A.F. did not cry, deep suctioning was performed, and stimulation was required. She was making minimal effort to cry. An Apgar score is a way to measure a newborn's breathing effort, heart rate, muscle tone, reflexes, and skin color. A.F. had low Apgar scores. Three minutes after birth, the nurse noted that A.F. still was not breathing spontaneously

and performed deep suctioning again, which recovered a small amount of thick mucus. At five minutes, her Apgar was still only four out of ten. At that point, one of the nurses again suctioned A.F., and more meconium was removed. Based upon her condition, A.F. was taken to what BMC referred to as their maximum care nursery. A.F. was observed grunting and flaring with tachycardia, and her oxygen saturations were between seventy-five and eighty-three while under an oxyhood set to fifty percent oxygen.

Dr. Hardy, a pediatrician employed by Shenandoah, was on call for deliveries on October 17, 2013. Around 9:15 a.m., Dr. Hardy arrived at BMC to examine A.F., and she noted that A.F. continued to grunt, flare, and exhibit signs of respiratory distress. A chest x-ray was taken at 9:30 a.m. At 9:45 a.m., A.F.'s glucose level was unreadable. A.F.'s first recorded glucose was twelve at 9:55 a.m. A normal range is forty to one hundred. Dr. Hardy ordered glucose for A.F. She also ordered blood tests, which revealed low red blood cell, hemoglobin and hematocrit counts. Each of these findings were nearly twenty-five percent below the lowest indicator within the respective normal range. A blood culture taken from A.F. on October 17, 2013, was negative for an infection after five days incubation. Plaintiffs' Ex. 11 at 1054-1055.

Through the remainder of the morning, A.F. continued to exhibit an increased respiratory rate, grunting, and low oxygen saturation. Id. at 1071-72. Dr. Hardy's differential diagnosis for A.F. included normal transition; TTN; neonatal sepsis or pneumonia; cardiac

defect; and meconium aspiration syndrome. T1 198-99. A.F. continued showing signs of respiratory distress, including grunting, retracting, and flaring. Plaintiffs' Ex. 11 at 1003, 1071-1075. Dr. Hardy also ordered intravenous antibiotics ampicillin and gentamycin for A.F. These antibiotics are considered the gold standard of care in managing potential infection or sepsis in newborns. T 200.

Dr. Hardy returned to BMC from her office at Shenandoah around noon. T 209. Although Dr. Hardy believed A.F.'s arterial blood gasses to be reasonable given A.F.'s age, A.F.'s condition was not improving. Thus, Dr. Hardy planned to transfer A.F. to the NICU at WMC. T 209-10. However, a nurse manager, Melanie Riley, approached Dr. Hardy in the nursery and suggested that she consult BMC's newly hired neonatologist, Dr. Purohit. T 210.

Dr. Purohit came to BMC to be the director of neonatology and create a NICU. Dr. Purohit assumed his responsibilities as a neonatologist at BMC on October 14, 2013. D 15-16. Prior to A.F.'s birth and during her care BMC did not have a NICU. Dr. Hardy consulted with Dr. Purohit around 1:30 p.m. on October 17, 2013. T 211-12. Dr. Purohit was willing to take A.F. onto his service as a patient. T 212.

At Dr. Purohit's request, Dr. Hardy, who remained the treating physician, entered an order around 2:00 p.m. for a chest x-ray to be taken of A.F. at 4:00 p.m. T 213. Over the course of the next twenty-four hours,

A.F.'s condition persistently worsened, until she finally was transferred to WMC's NICU.

The neonatal transport record indicated the transfer of a term infant, one day old and with meconium stained fluid. Plaintiffs' Ex. 11 at 2001. It also noted that A.F.'s pupils were dilated and her color was slightly cyanotic and pale. Id. Further, she had paradoxical breathing, diminished breathing sounds on the left and was still grunting and retracting and her abdomen was distended and firm. Id. A.F. was admitted to WMC under the care of Dr. Lee, where she remained for nearly a month. A.F. presently suffers from immediate postnatal cerebral palsy due to anoxic ischemic encephalopathy caused by meconium aspiration and respiratory distress.

In determining the appropriate award for Plaintiffs' damages, this Court first notes that the evidence in this case demonstrates A.F. has no prospect whatsoever of approaching normal development, will not graduate from high school with any marketable skills, will remain completely and permanently disabled from any type of meaningful, gainful employment, will need continuous safety supervision, will not be able to make any life decisions on her own, and she is going to be dependent on a caretaker, conservator or guardian to make decisions on her behalf. She will never be able to walk without a walker or some sort of assistance. It is likely she will suffer from seizures. She needs physical therapy, occupational therapy and speech therapy to maximize her basic, functional skills. However, A.F.

has a normal life expectancy because none of these conditions are likely to cause an early death.

The Court finds that A.F. is entitled to all non-economic damages allowed under West Virginia law: $673,453.49.

Plaintiffs presented a nurse life care planner, Ms. Lampton, whose report was admitted into evidence as Plaintiffs' Exhibit twenty-two. Only Dr. Rugino and Ms. Lampton met with A.F., examined her and analyzed the difficulties she faces. The Government's experts merely criticized the reports of Plaintiffs' experts. Plaintiffs' Exhibit twenty-two presents the future medical care A.F. will most likely require. Although nobody can predict the future, Dr. Rugino and Nurse Lampton offered opinions the Court finds sufficiently competent and legally adequate based upon their education, training, and expertise, to support the Court's conclusions herein. Further, the Government's expert witness testified that most of Ms. Lampton's report was reasonable. Mr. Staller, the Plaintiffs' economist, reduced the future medical care costs to their present value. His report is designated as Plaintiffs' Exhibit twenty-four. The figure for future healthcare costs is $4,607,834.00.

Mr. Staller also calculated lost earnings using an individual with a high school education and presented a range of $1,318,822.00 to $1,631,125.00 depending on A.F.'s projected time spent in the workforce. Plaintiffs' Ex. 24. It makes no difference whether taxes are considered because of the relatively small earnings and lost fringe benefits that would have been earned.

Mr. Staller also did not include vacation or sick leave compensation in his calculations.

The Court finds no reason to deduct taxes in this case. Thus, the total economic loss for A.F. including lost earnings, fringe benefits and cost of future care is $6,331,933.00. The Court relies upon Mr. Staller's report and testimony at trial, which it finds competent, credible, and correct. The Court also notes that Mr. Staller arrived at the abovementioned figures after adjusting for present value.

With respect to Kayla Butts, the parties stipulated to medical bills in the amount of $99,246.98. The Court also finds that Ms. Butts is entitled to some economic damages. Given the level of care A.F. has required, and evidence presented at trial that Ms. Butts has not only been a good mother, but also a necessary care provider, the Court finds she should be compensated for the first four years of A.F.'s life consistent with the value of the attendant care, at $31,308.00 per year, for a total of $125,232.

IV. CONCLUSIONS OF LAW

The events giving rise to the negligence in this case occurred in West Virginia. Therefore, West Virginia law applies. See Cutlip v. United States, Civil Action No. 2:10-1314, 2015 WL 1726799, at *8 (S.D. W. Va. Apr. 15, 2015); Honeycutt v. United States, 622 F. Supp. 2d 350, 354 (S.D. W. Va. 2008). For a plaintiff to prevail, she must prove by a preponderance of the evidence that "(1) [t]he health care provider failed to exercise

[the] degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and (2) [s]uch failure was a proximate cause of the injury." W. Va. Code § 55-7B-3(a); see also Dawson v. United States, 11 F. Supp. 3d 647, 651 (N.D. W. Va. 2014).

"A physician has a duty to render reasonable and ordinary care in the diagnosis and treatment of a patient." Runion v. United States, Civil Action No. 2:11-cv-00525, 2013 WL 4881727, at *4 (S.D. W. Va. Sept. 12, 2013) (citing Syl. Pt. 3, Utter v. United Hosp. Ctr., Inc., 236 S.E.2d 213 (W. Va. 1977)). Deviating "from this duty is malpractice." Id. (citing Kuhn v. Brownfield, 12 S.E. 519, 521 (W. Va.1890)). West Virginia courts apply a national standard of care, Syl. Pt. 1, Paintiff v. City of Parkersburg, 345 S.E.2d 564 (W. Va. 1986), and "[w]hether a physician breached the applicable standard of care is to be judged at the time of his or her alleged negligent acts." Runion, 2013 WL 4881727, at *4 (citing Bellomy v. United States, 888 F. Supp. 760, 765 (S.D. W. Va. 1995)). A plaintiff generally must establish the standard of care and its breach through expert testimony. W. Va. Code § 55-7B-7(a); see also Dawson, 11 F. Supp. 3d at 651.

"The proximate cause of an injury is the last negligent act contributing to the injury and without which the injury would not have occurred." Syl. Pt. 8, Judy v. Grant Cnty. Health Dep't, 557 S.E.2d 340, 341 (W. Va. 2001) (per curiam) (internal quotation and citation omitted) (quoting Syl. Pt. 5, Sergent v. City of Charleston,

549 S.E.2d 311 (W. Va. 2001)). Proximate cause "must be understood to be that cause which in actual sequence, unbroken by any independent cause, produced the wrong complained of, without which the wrong would not have occurred." Mays v. Chang, 579 S.E.2d 561, 565 (W. Va. 2003) (internal quotation omitted) (quoting Syl. Pt. 3, Webb v. Sessler, 63 S.E.2d 65 (W. Va. 1950)). A medical expert's testimony "as to the causal relation between a given physical condition and the defendant's negligent act . . . need only state the matter in terms of a reasonable probability"—not in terms of a reasonable degree of medical certainty. Hovermale v. Berkeley Springs Moose Lodge No. 1483, 271 S.E.2d 335, 340 (W. Va. 1980).

Damages may be recovered "for the reasonable value of . . . medical services rendered" if the plaintiff can demonstrate the necessity of those services. Jordan v. Bero, 210 S.E.2d 618, 637 (W. Va. 1974). In contrast, damages for pain and suffering are "indefinite and unliquidated . . . and there is no rule or measure upon which [they] can be based." Syl. Pt. 2, Big Lots Stores, Inc. v. Arbogast, 723 S.E.2d 846 (W. Va. 2012) (internal quotation omitted) (quoting Syl. Pt. 2, Richmond v. Campbell, 136 S.E.2d 877 (W. Va. 1964)). Future damages are awarded "for, among other things: (1) [r]esiduals or future effects of an injury which have reduced the capability of an individual to function as a whole man; (2) future pain and suffering; (3) loss or impairment of earning capacity; and (4) future medical expenses." Syl. Pt. 10, Bero, 210 S.E.2d 618. To receive an award of future damages, "[t]he permanency or

future effect of [the] injury must be proven with reasonable certainty." Id. at Syl. Pt. 9

A health care provider may not escape a finding of negligence on the basis of a "mere mistake in judgment." Syl. Pt. 5, Pleasants v. Alliance Corp., 543 S.E.2d 320 (W. Va. 2000); Syl. Pt. 4, Mays v. Chang, 213 W.Va. 220, 579 S.E.2d 561 (2003). However, a bad result does not necessarily mean that the physician deviated from the standard of care. Schroeder v. Adkins, 141 S.E.2d 352, 357-358 (W. Va. 1965).

"A statute is presumed to operate prospectively unless the intent that it shall operate retroactively is clearly expressed by its terms or is necessarily implied from the language of the statute." Syl. pt. 4, Arnold v. Turek, 407 S.E.2d 706 (W. Va. 1991) (quoting Syl. pt. 3, Shanholtz v. Monongahela Power Co., 270 S.E.2d 178 (W. Va. 1980) (quoting Syl. pt. 2, State ex rel. Manchin v. Lively, 295 S.E.2d 912 (W. Va. 1982))). In this case, the MPLA prior to the 2016 amendment is the controlling version of the statute.

V. CONCLUSION

Accordingly, this Court finds that the services rendered by Dr. Hardy to A.F. fell below the applicable standard of care and did in fact cause A.F. to sustain the damages alleged by the Plaintiffs. Specifically, Dr. Hardy recognized that A.F. needed to be transferred to WMC's NICU shortly after A.F. was born. A.F.'s condition did not improve, and BMC did not have the requisite equipment or staff to care for a child in her condition.

The Court finds Dr. Partridge's testimony most credible with regard to the appropriate standard of care, A.F.'s medical condition shortly after birth and the level of care A.F. required. Dr. Partridge's testimony was competent and candid. The Court finds that, most conservatively, A.F. was in Dr. Hardy's care until approximately 2:45 p.m. the day she was born.[2] During that time, A.F. was in respiratory distress, had low glucose levels, exhibited retracting, grunting and flaring, and never significantly improved.

Although the Government argues that Dr. Hardy should be absolved from any liability because she transferred care to Dr. Purohit, a neonatologist, the Court finds this argument to be without merit under the circumstances.

Indeed, a paramedic would not escape his obligation by transferring care to a surgeon at the site of a car accident on the interstate; the surgeon would be ill equipped outside a hospital operating room without the proper equipment, environ, tools, and staff to carry out his scope of practice. Although he would have more education and training than a paramedic, training and knowledge alone are ill-suited replacements for

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[2] Although the Court is inclined to find that Dr. Hardy's care for A.F. was not terminated precisely at 2:45 p.m., it is not necessary for the Court to go that far in its analysis. Indeed, there is enough evidence before this Court to conclude Dr. Hardy, perhaps inadvertently because she was unfamiliar with BMC's policies, never properly effectuated a transfer of care to Dr. Purohit. Regardless, the Court finds that the evidence established at trial that Dr. Hardy was negligent prior to the Government's proposed transfer to Dr. Purohit.

scalpels, forceps, retractors, tables, monitors, extra personnel and a sterile environment. The same is true here: Dr. Purohit, regardless of his training and education, was without a NICU. Thus, at a minimum, he lacked the appropriate equipment, specialized staff or necessary protocols to adequately assess and treat a baby who needed intensive care.

Dr. Hardy should have transferred A.F. to WMC the same afternoon A.F. was born, and she believed as much herself. Dr. Hardy allowed a nurse manager to persuade her not to transfer A.F. to another hospital. As a result, A.F. continued to struggle breathing, became cyanotic, and developed cerebral palsy. It is clear to this Court, and it so finds that the standard of care required that A.F. be transferred to a NICU and receive the level of care that is only available in a NICU, such as the one at WMC.

Therefore, because A.F. suffered irreversible brain damage as a result of the improper treatment she received and Dr. Hardy's failure to meet the appropriate standard of care, the Court **RULES IN FAVOR of the PLAINTIFFS** in the following amounts:

Kayla Butts for past medical bills	$99,246.98[3]
Kayla Butts for past services (4 years)	$125,232.00

[3] The parties have previously stipulated to this amount. See ECF No. 171.

A.F. for future lost earning capacity	$1,631,125.00
A.F. for future healthcare costs	$4,607,834.00
A.F. for non-economic Damages	$673,453.49
TOTALING:	**$7,136,891.47**

Pursuant to West Virginia's Medical Professional Liability Act, W. Va. Code § 557B-9a, the Court shall hold a post-verdict, pre-judgment collateral source hearing on February 6, 2018, at 9:00 a.m.

The Clerk of Court is **DIRECTED** to transmit copies of this Order to all counsel of record herein.

DATED: January 17, 2018

/s/ Gina M. Groh
GINA M. GROH
CHIEF UNITED STATES
DISTRICT JUDGE

FILED: September 9, 2019

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 18-1693
(3:16-cv-00053-GMG-MJA)

KAYLA BUTTS, Individually and on behalf of her daughter A.F., a minor

Plaintiff - Appellee

v.

THE UNITED STATES OF AMERICA

Defendant - Appellant

and

BERKELEY MEDICAL CENTER; WEST VIRGINIA UNIVERSITY HOSPITAL, INC.; SHENANDOAH WOMEN'S HEALTH CENTER; SHENANDOAH COMMUNITY HEALTH CENTER; SHENANDOAH MIDWIVES; AVINASH PUROHIT, M.D.; TRACY SWALM, CNM; SARA SPURGEON, R.N.; SHELLY PALKOVIC, R.N.; REBECCA PFENDER, CNM; SARAH HARDY, M.D.; SONYA JUSTICE, R.N.

Defendants

ORDER

The court denies the petition for rehearing and rehearing en banc. No judge requested a poll under

Fed. R. App. P. 35 on the petition for rehearing en banc.

Entered at the direction of the panel: Judge Harris, Judge Richardson, and Judge Quattlebaum.

For the Court

/s/ Patricia S. Connor, Clerk