Case Nos. 23-CV-777 & 24-CV-562

IN THE DISTRICT OF COLUMBIA COURT OF APPEALS

MICHAEL A. SARACO
Appellant,

v.

MEDSTAR-GEORGETOWN MEDICAL CENTER, INC. *ET AL.*
Appellees.

ON APPEAL FROM THE
SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

BRIEF OF APPELLANT MICHAEL A. SARACO

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CERTIFICATE REQUIRED BY RULE 28(a)(2) OF THE RULES OF THE DISTRICT OF COLUMBIA COURT OF APPEALS

Pursuant to Rule 28(a)(2) of the Rules of the District of Columbia Court of Appeals, the undersigned counsel of record for Appellant Michael A. Saraco certifies as follows:

1. The following listed parties appeared below before the Superior Court of District of Columbia: Michael A. Saraco was the plaintiff, represented by

Patrick G. Senftle, Esq. of Pressler Senftle & Wilhite, P.C. Defendants Medstar-Georgetown Medical Center, Inc. and Medstar-Georgetown University Hospital were defendants, represented by Janet A. Forero, Esq., Sean Gugerty, Esq., and Carrie J. Williams, Esq. of Goodell, DeVries, Leech & Dann, LLP.

2. The following listed parties appear in the appellate proceeding: Appellant Michael A. Saraco is represented by Patrick G. Senftle, Esq. of Pressler Senftle & Wilhite, P.C. Appellees Medstar-Georgetown Medical Center, Inc. and Medstar-Georgetown University Hospital are represented by Janet A. Forero, Esq., Sean Gugerty, Esq., and Carrie J. Williams, Esq. of Goodell, DeVries, Leech & Dann, LLP.

Dated: 12/17/24

Respectfully submitted,

/s/Patrick G. Senftle
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STATEMENT THAT APPEAL IS FROM FINAL ORDERS

The trial court's Orders of August 18, 2023 and June 14, 2024 were final orders that disposed of all of Plaintiff's claims.

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether the trial court erred when striking Plaintiff's expert and granting summary judgement on the basis that Plaintiff's expert had not established a foundation and basis for his knowledge of the national standard of care for the performance of a laminectomy.

2. Whether the trial court erred in holding, as a matter of law, that there was no genuine issue of fact concerning the level of Plaintiff's preoperative pain on his first post-operative visit and thereby concluding that Vikram Nayer M.D.'s had no further duty to order additional MRI imaging notwithstanding Plaintiff's subsequent ongoing medical condition.

3. Whether the trial court erred in holding that Plaintiff's expert opinion on the national standard of care for ordering of additional MRI imaging following a laminectomy was too broad to allow Dr. Nayer to measure his actions.

4. Whether the trial court erred when striking Plaintiff's expert and granting summary judgement on the basis that Plaintiff's expert had not established a foundation and basis for his knowledge of the national standard of care for the ordering of additional MRI imaging following a laminectomy procedure.

STATEMENT OF CASE

On October 18, 2020, Plaintiff Michael A. Saraco filed a medical malpractice action against Defendant Medstar-Georgetown Medical Center, Inc. On August 18, 2023, the trial court granted Defendant's Motion to Exclude Testimony of Plaintiff's Expert and for Summary Judgment. On September 14, 2023, Appellant filed a Motion for Reconsideration of the Court's Order of August 18, 2023. On June 14, 2024, the trial court denied Plaintiff's Motion for Reconsideration. On September 15, 2023 and June 18, 2024, Plaintiff timely filed his notices of appeal. By Order of July 24, 2024, this court consolidated the subject appeals for all purposes.

STATEMENT OF FACTS

Plaintiff Michael Saraco was a career Metropolitan Police officer.[1] On April 24, 2017, Plaintiff was pushing a vehicle out of the roadway in the line of duty and experienced back pain radiating down his legs. (App. 59-60). At the L4-5 level, MRI imaging of May 5, 2017 revealed "moderate facet and ligamentum flavum hypertrophy and epidural lipomatosis at L4-5 causing severe spinal canal stenosis with compression of the thecal sac and bilateral neural foraminal narrowing." (App. 190-191).[2] On July 19, 2017, while within the scope of his employment with Medstar-Georgetown Medical Center, Inc., Vikram Nayer, M.D. performed a laminectomy on Plaintiff. (App. 21-28, ¶ 5; App. 192-193).

Plaintiff identified Brian Holmes, M.D. as a neurological expert on issues including liability, causation, and damages. (App. 79-84)[3] Dr. Holmes advanced

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[1]By consent Praecipe, the parties dismissed the Defendant Medstar-Georgetown University Hospital which is a trade name. The only appellee in this appeal is Medstar-Georgetown Medical Center, Inc. (App. 30).

[2]At the L4 level, the L4 nerve passes through exit holes (neural foramen or intervertebral foramen) on both sides as the nerve splits off from the main spinal cord. In Plaintiff's case, overgrown facets joints (also anatomically known as "superior articular process") severely impinged on the L4 nerve root as it entered the neural foramen on both sides. The overgrown facets also impinged on the L5 nerve at it passed through the lateral recesses (or space adjacent to the foramen). (App. 82, 126, & 188-189).

[3]By stipulation, the parties have waived the requirement of formal expert reports. *Sup. Ct. Civ. Pro. Rule* 26(a)(2)(B). (App. 29).

two primary liability opinions. He has opined that the national standard of care for a neurosurgeon, with similar training and experience, situated in similar circumstances as Dr. Nayer, is that a neurosurgeon is required to remove hypertrophic (overgrown) bone and ligament and other soft tissue to achieve the goal of decompression of the dural sleeve and exiting nerve roots in the lateral recesses and proximal neural foraminal. A nerve is decompressed "when you can look at it through its path from where it exits the dural sac to where it exits the foramen and that you've assured that you've removed all of the overhanging and compressive tissue." (App. 82-84 & 145-146).[4]

He has also opined that a neurosurgeon, under a national standard of care, is required to order repeat MRI imaging in follow-up when a patient undergoes a lumbar laminectomy without significant improvement of symptoms and continues to experience significant pain (only %50 improvement while on medication with increased pain when walking) to a degree that a patient remains disabled. (App. 82,

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[4]Of note, Dr. Nayer's breach was substantial and highly apparent because only a very limited amount of medial facet tissue/bone was removed and the subject nerves remained severely compressed. In fact, a subsequent MRI of 2019 and Cat Scan of 2021, based on straight surgical margins, revealed minimal surgical removal of medial facet joint tissue/bone and significant neural compression. (App. 82-83, 95-96, 99-100 & 133-135). Given the serious nature of the breach, it was not just a matter of surgical judgment, as Defendant contends, to conduct such a substandard procedure.

100, 122-125 & 155).[5] Specifically, Dr. Holmes clarified, under the facts of this case, that it was a breach of the national standard of care not to order a repeat MRI *promptly* in follow-up by the time of the last post-operative visit on November 17, 2017.[6] (App. 96, 100, 122-125 & 155)[7]

In his report of September 13, 2021, Dr. Holmes stated that for over 25 years he has had significant clinical neurosurgical experience in the "management of spinal disease and performance of spinal surgery, including lumbar laminectomy, as well as follow-up care and management of patients following laminectomy." (App. 80)[8] He also stated that he was "board certified in the specialty of neurosurgery" and that he was a member of the American Board of Neurological

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[5]Under either theory of negligence, Dr. Nayer would be liable. *See DC Standard Jury Instruction 5.12 (Cause Defined)* (plaintiff only needs to establish that defendant's negligence was *a* cause of plaintiff's damages)

[6]In deposition, Dr. Holmes testified that, as of the November 17, 2007 visit, MRI imaging was required "at that time" in follow-up. (App. 124-125). By summary judgment affidavit, Dr. Holmes expounded on his opinion and clarified that further imaging was required "promptly" after the postoperative visit of November 17 to meet the standard of care. (App. 100).

[7]Dr. Holmes has also opined that the foregoing breaches and departures from the national standard of care directly and proximately caused Plaintiff to sustain permanent lumbar neurological injury with resultant disabling back and leg pain rendering him medically unemployable. (App. 81-83).

[8]Dr. Holmes performs approximately 2 laminectomies per week or a 100 per year. (App. 107-108).

Surgeons and the North American Spine Society. (App. 80). Dr. Holmes further explicitly stated: *"I have regularly attended national neurosurgery conferences where spinal decompression surgery, including laminectomy procedures, were discussed and reviewed.* (App. 80)[9] (emphasis added). Lastly, he has stated that "I am highly familiar with the national standard of care in cases of lumbar spine surgery." (App. 80).

In his Supplemental Rule 26 Disclosure, Plaintiff further expounded on the basis of Dr. Holmes' opinions:

> Dr. Holmes will testify on the issues of standard of care, causation and damages. Dr. Holmes' opinions are based, *inter alia*, on his review of Plaintiff's medical history, including facts and circumstances surrounding Plaintiff's surgery on July 19, 2017; his review of produced medical records and imaging studies; his physical examination of the Plaintiff; his review of applicable medical literature; his review of discovery materials including the below depositions; his education, knowledge, training, and experience in his field of neurosurgery; and *his regular attendance at national neurosurgical conference where consensus of the applicable standard of care for laminectomy procedures are reached and discussed.* (App. 94-95)[10]

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[9]On page 6 of his report, Dr. Holmes stated that his opinions where based on his knowledge and education in his field. This knowledge would also include knowledge obtained through attendance at national neurosurgical as referenced on page 2 his report. (App. 80 & 84).

[10]While Plaintiff did provide a formal expert report with his initial expert disclosure, Plaintiff's Supplemental Rule 26 Disclosure is properly part of the summary judgment record because the parties stipulated to waive the formal expert report requirement of Rule 26. (App. 29).

(emphasis added)

Dr. Holmes has further directly relied on authoritative medical literature to establish the basis for his opinion that that the national standard of care requires a neurosurgeon to decompress adequately the exiting nerves (in lateral recesses and proximal neural foramina) to achieve decompression-- and that Dr. Nayer breached the standard because he only removed a very limited amount of medial facet tissue/bone--thereby negligently leaving the subject nerve roots severely compressed. (App. 82-83, 95-96, 99-100, 126-128, & 145-146). [11]

Dr. Holmes relied upon H. Hunt Batjer, M.D. et. al, *Textbook of Neurological Surgery*, Lumbar Spinal Stenosis and Laminectomy (Chap.149) [12] and R. Pluta, M.D. et al., *Lumbar Facetectomy*, Medscape (2018). (App. 158-178). Dr. Batjer's textbook supports that adequate decompression (by removal of

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[11]Contrary to Defendant's suggestions, Dr. Holmes has clarified how the concept of surgical judgment applies to the instant case. As explained in deposition and his summary judgment affidavit, the standard requires a neurosurgeon to remove compressing bone and tissue which is the goal of the surgery. While a surgeon, as a general matter, can leave compressing bone and tissue in the operative field for a valid surgical reason, there is no evidence of any such reason in this case. Dr. Nayer, as a defense, has also not offered any such reason for leaving the nerves substantially compressed in the surgical field. (App. 99-100 & 111-113).

[12]Dr. Holmes has testified that the foregoing literature is authoritative. (App. 103-104). A jury can also infer that the textbook has a national scope because it is a medical textbook published by a national publisher with multiple national and international locations. (App. 158).

tissue/bone) is achieved only when the nerve root is visualized as decompressed in its entirety from emergence from the thecal sac to the exiting point below the pedicle. (App. 164-165).[13] Similarly, Dr. Pluta's publication states that decompression is only achieved if a rounded instrument can pass without resistance through the applicable foramen to confirm decompression.[14] (App 175).[15]

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[13]As explained by Dr. Holmes, while the above textbook was written in 2003, there is substantially no difference in the basic procedures for performing an open laminectomy in 2003 versus one in 2017. (App. 128-129). Lumbar laminectomy is a commonly performed and straightforward neurosurgical procedure --the evident goal of which remains to remove tissue/bone to free up compressed nerves. (App. 82). A reasonable jury could also infer that Dr. Batjer's textbook reflected the standard of care in 2017 because Dr. Holmes has also testified that he considered Dr. Batjer's textbook to be reasonably reliable source in the neurological surgery area in 2017 (time of surgical procedure) and 2021 (time of Dr. Holmes' deposition). (App. 103-104).

[14]A court can also take judicial notice of the readily determinable fact that Medscape (the publisher of Dr. Pluta's paper) is a national (and global) publisher of authoritative professional education literature with a strict and accurate editorial policy. *See www.Medscape.com* (See also App. 399-401). Notably, a jury could also infer that Dr. Pluta's publication, written in 2018, corroborates Dr. Holmes testimony that the basic laminectomy procedure remains unchanged particularly with respect to the basic goal of releasing compressed nerves. (App. 168-178).

[15]Dr. Holmes also stated that he subscribes and *regularly reviews* the *Journal of Neurosurgery*, *Neurosurgery*, *Contemporary Neurosurgery*, and *Clinical Neurosurgery*. These publications are readily determinable (and on their face) to be known authoritative and national neurosurgery journals *See Journal of Neurosurgery* (https:/thejns.org)(authoritative national journal of the American Association of Neurological Surgeons); *Neurosurgery* (journals.lww.com/neurosurgery) (authoritative national journal for Congress of

As to Plaintiff's course of treatment and persistent pain level, Plaintiff remained hospitalized at Medstar Georgetown University Hospital (MGUH) for two weeks following his surgery until August 3, 2017.[16] (App. 194). Plaintiff was then hospitalized at Medstar National Rehabilitation Hospital (MNRH) until August 11, 2017.)(App 258).[17] Plaintiff was discharged from MGUH while taking Gabapentin, Oxycodone, and Tramadol. (App. 202-203)[18] Because of Plaintiff's increased pain symptoms, the providers at MNRH doubled his dosage of Gabapentin to 600 mg. (App 260).[19] At discharge from MNRH on August 11, 2017, Plaintiff complained of pain at level 8. (App. 264).

On August 16, 2017, Plaintiff commenced physical therapy at MNRH. Two

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Neurological Surgeons); *Contemporary Neurosurgery* (journals.lww.com/contempneurosurgery)(authoritative journal written by leading specialist); *Clinical Neurosurgery* https://www.cns.org/publications/clincal-neurosurgery) (supplement to *Neurosurgery* and compilation of Congress of Neurological Surgeons national annual meeting). (See also App. 395-398)

[16]Patients in Plaintiff's age group are usually released within 24 hours following a laminectomy. (App. 105-106).

[17]It is uncommon in Plaintiff's age group to be impaired enough following a laminectomy to required inpatient rehabilitation for loss of function and pain. (App. 114).

[18]Gabapentin is a drug for nerve pain. (App. 332-333). Oxycodone and tramadol are opioid-based pain relievers.

[19]A dosage of 600 mg is high and most post-surgical patients only require a lower dosage. (App. 147).

days before Plaintiff's first post-operative visit to Dr. Nayer on August 18, 2017, the physical therapist reported back and leg pain at a level "8-9" notwithstanding Plaintiff being significantly medicated. (App. 217). At Plaintiff's initial visit (only a week after being discharged from rehabilitation hospital), however, Dr. Nayer claimed that Plaintiff stated he had 100% improvement in pain. (App. 207). Plaintiff denies this history and recalls a pain level of 7-8. (App. 62-65). Physical therapy records of November 7 and 16, 2017 reflect ongoing pain (6/10 and 5/10 while still on medication). (App. 242 & 246). At Plaintiff's next postoperative visit, three months later, on November 17, 2017, there was 50% improvement with Plaintiff's preoperative pain level. (App. 210).[20]

Plaintiff's Police and Fire Clinic records also support Plaintiff's persistent back/leg symptomology. On August 18, 2017, John Reilly, M.D. reported improvement but noted "sciatic like pain bilaterally partially relieved by Tramadol and Gabapentin." (App. 213). On November 27, 2017, Dr. Reilly reported persistent and minimally improved pain in bilateral anterior thighs and that Plaintiff's condition had hit a plateau. Dr. Reilly referred Plaintiff to pain management. (App. 215).

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[20]Plaintiff's preoperative pain was at a level "10". (App. 204).

On November 30, 2017, Plaintiff presented to Matthew D. Maxwell, M.D. for pain management. At that time, Plaintiff reported that his continued pain interfere with his rehabilitation and daily function. Dr. Maxwell noted pain with lumbar flexion/extension and positive facet loading test.[21] Dr. Maxwell prescribed Nucynta and Lyrica.[22] (App. 269-271).

[21]Facet loading test (Kemp test) determines if facet impingement is causing neurological pain. (App. 334).

[22]Nucynta is a strong opioid prescription used to manage severe pain. Lyrica is indicated to treat spinal cord nerve pain. (App. 328-331).

SUMMARY OF ARGUMENT

Plaintiff has Established a Proper Foundation and Basis for his Knowledge of The National Standard of Care for Laminectomy Procedures Based on Dr. Holmes' Participation in National Conferences, Membership in National Boards and Organizations, and References to Literature/Publications

An expert can establish that a particular course of treatment is followed nationally by laying a foundation and testifying as to the basis for his knowledge of the national standard of care. *Hill v. Medlantic Health Care Group*, 933 A.2d 314, 319 (D.C. 2007)(expert not providing personal opinion where he is providing an independent basis for his knowledge of the applicable national standard of care). The proper foundation and basis can be established through testimony concerning an expert's "certification process, [review of] current literature, conference or discussion with other knowledgeable professionals, *any* of which would have been legally sufficient to establish a basis for [expert's] discussion of the national standard of care." *Strickland v. Pinder*, 899 A.2d 770,774 (D.C. 2006)(emphasis added). Accordingly, once an expert states "the basis for his or her knowledge of the national standard of care, he may state what the national standard of care is." *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170, 189 (D.C. 2009).

Here, Dr. Holmes has established a proper foundation and basis because he has regularly attended national neurosurgery conferences where laminectomy procedures were discussed and reviewed; he is board certified in the specialty of

neurosurgery and a member of the American Board of Neurological Surgeons and the North American Spine Society; and he has relied on authoritative and national literature, directly on point, to establish a basis for his national standard of care testimony.

The Trial Court Improperly Substituted its Judgement for the Jury When Concluding That Plaintiff had 100 % Improvement at First Post-Operative Visit

The trial court concluded that there was no genuine issue of fact with respect to Plaintiff's 100% improvement in pain level during his first post-operative visit (i.e., August 18, 2017), and that, therefore, Dr. Nayer did not have to take any action to order an MRI. Plaintiff's initial pain level is disputed, and a classic question of fact, because Plaintiff denied that he reported to Dr. Nayer that he was pain free; a physical therapist reported that Plaintiff's pain level was 8-9 (notwithstanding that Plaintiff was significantly medicated) only two days before Dr. Nayer's first post-operative visit; Plaintiff had also just been discharge from rehabilitation care only a week before (where providers doubled Plaintiff's Gabapentin dosage because of increased pain); and providers had ordered, at that juncture, that Plaintiff undergo outpatient pain management. Accordingly, weighing all this evidence together, a jury could reject Dr. Nayer's testimony, and credit Plaintiff's testimony, finding that Plaintiff was experiencing significant pain (that Dr. Nayer knew, or should have known about) at his first post-operative visit.

Moreover, the trial court did not focus on the postoperative visit of November 17, 2017, and Plaintiff's condition at that time, which was a key operative fact related to Dr. Holmes' opinion regarding the prompt reordering of an MRI. Because Plaintiff undisputedly reported in November 2017 that he was experiencing only 50% improvement in his pre-operative pain and changes in his clinical presentation (increased pain while walking), this change in condition would negate the trial court's reasoning that there could be no breach just because Dr. Nayer was allegedly told that there was 100% improvement in preoperative pain at the first visit. Accordingly, even if Plaintiff's pain level was 100% improved initially (which Plaintiff contests), that improvement did not last and the change in plaintiff's symptoms was the ultimate condition that Dr. Nayer had a duty to evaluate, and thereupon order additional imaging to meet the national standard of care.

Dr. Holmes has Set Forth an Opinion for the Ordering of Additional Imaging with a Time Frame Sufficient For Dr. Nayer to Measure his Actions

The trial court ruled that Dr. Holmes' opinion on ordering additional imaging was too broad because there is no evidence of when the "window" for ordering an MRI commences, terminates, or is determined. Plaintiff respectfully submits that Dr Holmes has stated an opinion sufficient for Dr. Nayer to weigh his actions.

It is settled that an expert must articulate an opinion that is sufficient to allow a defendant's actions to be measured against. *Sullivan v. AboveNet Communs., Inc.*, 112 A.3d 347 (D.C. 2015). Here, there is sufficient evidence of when the window commenced because Dr. Holmes has opined that an MRI should have been ordered "at that time" or *promptly* following Plaintiff's November 17, 2017 visit (i.e., as of four months post-op) when Plaintiff was still experiencing significant symptoms. Promptly is defined as "with little or no delay" or "without delay". A logical inference from this testimony is that the "window" commenced and Dr. Nayer had a duty to order additional imaging "without delay" in a follow-up appointment as of the November appointment when his patient remained significantly symptomatic.

As to a termination time for the "window", a reasonable jury, under the facts of this case, could conclude that a termination time for the "window" was not relevant because Dr. Nayer discharged Plaintiff on November 17, 2017, while he was still symptomatic (before any follow-up and ordering of the requisite imaging).

There is also evidence how the "window" is determined because Dr. Holmes has opined that additional imaging is required based on patient's presentation and symptoms over time. Given plaintiff's age, type of surgical procedure, and persistent pain (only 50% improvement and pain when walking) four months post-

op, Dr. Holmes has opined that a physician must take prompt action at that time to order a follow-up MRI to determine the cause of a patient's persistent pain and to determine the outcome of the surgery.

There is a Sufficient Foundation and Basis to Establish that Dr. Holmes' Opinion Related to Additional MRI Imaging is Part of the National Practice

The trial court also determined that there was no basis through publication or references to national medical conferences to establish a breach of the national standard of care for the ordering of additional MRI imaging. There is evidence establishing a basis for Dr. Holmes' knowledge of the national standard of care thereby linking his testimony to the national practice. Dr. Holmes has regularly attended national neurosurgery conferences where spinal decompression surgery, including laminectomy procedures, was discussed and reviewed. A reasonable jury could infer that encapsulated in the review of laminectomy procedures are discussions pertaining to follow-up neurosurgical care and management of post laminectomy patients. An attendant and inherent part of a laminectomy procedure is the post-operative care by neurosurgeons. A jury, therefore, could ultimately infer that Dr. Homes' opinion testimony concerning the ordering of an additional MRI, following a laminectomy, is part of the national practice.

ARGUMENT

I. Standard of Review

Appellate review of a trial court's order granting summary judgment is *de novo* with the appellate court applying the same standard as the trial court. *Snyder v George Wash. Univ.*, 890 A.2d 237 (D.C. 2006); *Osei-Kuffnor v. Argana*, 618 A.2d 712 (1993). An appellate court must view the evidence in the light must favorable to the non-moving party when weighing all rational inferences. *Strickland v. Pinder*, 899 A.2d 770 (D.C. 2006). In doing so, the court must take care "to avoid weighing the evidence, passing on the credibility of witnesses or substituting its judgment for that of the jury. *Id.* (quoting *Majeska v. District of Columbia*, 812 A.2d 948, 950 (D.C. 2002)) If it is possible "to derive conflicting inferences from the evidence, the court should allow the case to go the jury. *Id.*

II. Plaintiff has Established a Proper Foundation and Basis for his Knowledge of The National Standard of Care for Laminectomy Procedures Based on Dr. Holmes' Discussions in National Conferences, Membership in National Boards and Organizations, and References to Literature/Publications

In its initial Order of August 18, 2023, the trial court struck Dr. Holmes' testimony as to the standard of care for a laminectomy procedure because Dr. Holmes had failed to articulate a national standard of care. The Court concluded:

> Here, Dr. Holmes has not articulated the national standard of care through publications or presentation of relevant data regarding the standard procedure for laminectomy surgery and post-operative care. Dr. Holmes made no reference of conversations with other professionals at seminars or

> conventions, and simply failed to explain the national standard of care with the proper foundation. (App. 39).

While acknowledging that the court was incorrect in stating that "Dr Holmes made *no* reference of conversations with other professional at seminars or conventions", the trial court denied Plaintiff's motion for reconsideration because it concluded that Dr. Holmes did not provide sufficient details about his discussions at national conferences to support the basis of his knowledge of the applicable national standard of care. (App. 54-55)[23] Plaintiff respectfully submits that the trial court subjected him to too high a hurdle under applicable case law.

An expert can establish that a particular course of treatment is followed nationally by laying a foundation and testifying as to the basis for his knowledge of the national standard of care. *Hill v. Medlantic Health Care Group*, 933 A.2d 314, 319 (D.C. 2007)(expert not providing personal opinion where he is providing an independent basis for his knowledge of the applicable national standard of care). The proper foundation and basis can be established through testimony concerning an expert's "certification process, [review of] current literature, conference or discussion with other knowledgeable professionals, *any* of which would have been

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[23]Of note, Defendant apparently never saw any issue and did not challenged whether Dr. Holmes had established a proper foundation or basis for his knowledge of the national standard of care. The trial court raised the issue *sua sponte*.

legally sufficient to establish a basis for [expert's] discussion of the national standard of care." *Strickland v. Pinder*, 899 A.2d 770,774 (D.C. 2006)(emphasis added). The D.C. Court of Appeals in *Nwaneri V. Sandidge*, 931 A.2d 466, 471-472 (D.C. 2007) particularly noted the it *expanded* its prior holdings in *Travers* and *Hawes*[24], "recognizing that it was reasonable to infer from expert testimony that a medical standard is nationally recognized, so long as the testimony presents a sufficient basis upon which an inference can be made. *Nwaneri*, 931 A.2d at 471-472. (emphasis added). Accordingly, once an expert states "the basis for his or her knowledge of the national standard of care, he may state what the national standard of care is." *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170, 189 (D.C. 2009).

Importantly, if an expert establishes that his familiarity and basis of his knowledge for the national standard of care is based on discussions at national conferences about a given subject area (e.g., laminectomy procedures), even without technical details, that fact is sufficient to establish a basis for his discussion of the national standard of care. S*ee Convit v Wilson*, 980 A.2d 1104 (D.C. 2009)(attendance at nationwide conferences of plastic surgeons where expert discussed plastic surgery, even if specific details of procedure at issue were not

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[24]*Travers v. District of Columbia*, 672 A.2d 566 (D.C. 1996); *Hawes v. Chua*, 769 A.2d 797 (D.C. 2001).

discussed, was sufficient); *see also Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170, 191-192 (D.C. 2009)(testimony of expert that he attended interdisciplinary breast conferences where cases of breast cancer cases were discussed, although not specific procedure details for treatment at issue).[25]

Here, Dr. Holmes stated in his report that his "clinical practice [of 25 years] involves the management of spinal disease and performance of spinal surgery, including lumbar laminectomy, as well as follow-up care and management of patients following laminectomy." He further explicitly stated: *"I have regularly attended national neurosurgery conferences where spinal decompression surgery, including laminectomy procedures, were discussed and reviewed.* In the Supplemental Rule 26 Disclosure, Plaintiff further disclosed that the basis of Dr. Holmes' opinions included his *regular attendance at national neurosurgical conference where consensus of the applicable standard of care for laminectomy procedures are reached and discussed.*

Accordingly, a sufficient foundation and basis for his opinion was well

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[25]This testimony would be sufficient to establish a foundation for admissibility as well as provide sufficient evidence to support a prima facie case. *See e.g., Snyder v. George Washington Univ.*, 890 A.2d 237 (D.C. 2006); *see also Coulter*, 964 A.2d at 191-192 (D.C. 2009)(quoting *Nwaneri*, 931 A.2d at 473) (listing "discussion with other knowledgeable professionals" in a list of credentials "*any* of which would be have been legally sufficient to establish a basis of [expert's] discussion of the national standard of care").

established because a jury could infer that Dr. Holmes was familiar and had a sufficient basis for his knowledge about the national standard of care for the performance of laminectomies--and "state[d] what the national standard of care is." *Coulter*, 964 A.2d at 189. He was not just testifying to his "personal opinion" nor engaging in "mere speculation or conjecture." *Synder*, 890 A.2d at 246.

The foundation and basis of an expert's knowledge of the national standard of care can further be established through an expert's testimony about his certification process and membership in national organizations. *Strickland*, 899 A.2d at 774; *see Convit v Wilson*, 980 A.2d at 1124 (expert testified about his board certification in his field and membership in national organizations such as the American Society of Plastic Surgeon and American Society of Maxillofacial Surgeons). In his report, Dr. Holmes has stated that he was "board certified in the specialty of neurosurgery" and that he was a member of the American Board of Neurological Surgeons and the North American Spine Society.

Dr. Holmes has also directly relied on authoritative literature to establish the basis for his national standard of care testimony. Dr. Holmes has relied on H. Hunt Batjer, M.D. et. al, *Textbook of Neurological Surgery*, Lumbar Spinal Stenosis and Laminectomy (Chap.149) and R. Pluta, M.D. et al., *Lumbar Facetectomy*, Medscape (2018). Dr. Batjer's textbook supports that adequate decompression is achieved only when the nerve root is visualized as decompressed

in its entirety from emergence from the thecal sac to the exiting point below the pedicle. Dr. Pluta's later paper (published 2018) corroborates Dr. Batjer's treatise stating that decompression is only achieved if a rounded instrument can pass without resistance through the applicable foramen to confirm decompression.[26]

The case of *Convit v Wilson*, 980 A.2d 1104 (D.C. 2009) is on point. Similar to Dr. Holmes, in *Convit* the expert testified the he was board certified; had membership in national organizations such as American Society of Plastic Surgeons; attended nationwide conferences where he discussed plastic surgery procedures; and how he regularly kept up with the literature in the field of plastic surgery. In affirming the lower court's denial of post-verdict motion for judgment, the court agreed that the expert had established the foundation and basis for his knowledge of the national standard of care. *Convit v Wilson*, 980 A.2d at 1124-1125. Of note, the court in *Convit* did not require that the expert state the technical or detailed substance of discussions at national conferences because a proper foundation and the basis of an expert's knowledge can be established by the fact that the expert has had discussions at national conferences with other knowledgeable professionals about the course of treatment (e.g., laminectomy

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[26]In his report, Dr. Holmes also stated that he subscribes *and regularly reviews* the Journal of Neurosurgery, Neurosurgery, Contemporary Neurosurgery, and Clinical Neurosurgery.

procedures).

Snyder v. George Washington Univ., 890 A.2d 237 (D.C. 2006) is also instructive. In *Synder*, the expert (who never even mentioned "national standard of care") testified that the basis for his knowledge of the national standard of care in this area was discussions at College of Surgeons conference and national surgical society meetings, and that he made an effort to keep current with relevant scholarly literature. *Snyder,* 890 A.2d at 246. In reversing the trial court's granting of summary judgment, the court in *Snyder* found that the expert's opinion "reflected evidence of a national standard and was not . . . based upon [his own] personal opinion, nor mere speculation or conjecture," and was legally sufficient to establish evidence of the national standard of care. *Id.*at 245-246.

Like the expert in *Synder*, Dr Holmes has participated in national neurosurgical conferences where laminectomy procedures have been discussed with knowledgeable professionals and has referenced and relied upon an authoritative textbook and paper—any of which would be legally sufficient. S*ee Strickland v. Pinder*, 899 A.2d at 774. His expert opinion, therefore, reflects "evidence of a national standard" and was "not based upon [his own] personal opinion, nor mere speculation or conjecture." *Synder*, 890 A.2d at 246.

Accordingly, taking all inferences in favor of Plaintiff, Dr. Holmes has sufficiently established a foundation and basis for his knowledge of the national

standard of care to meet the "primary concern" of whether it is "reasonable to infer from the testimony that [the] standard is nationally recognized." *Synder* 890 A.2d at 245 (*quoting Phillips v. District of Columbia*, 714 A.2d 768, 775 (D.C. 1998).

III. Post-Operative MRI

A. The Trial Court Improperly Substituted its Judgement for the Jury When Concluding That Plaintiff had 100 % Improvement at First Post-Operative Visit

In its Order, the court concluded that there was no genuine issue of fact with respect to Plaintiff's 100% improvement in pain level during his first post-operative visit (i.e., August 18, 2017), and that, therefore, Dr. Nayer did not have to take any action to order an MRI. (App. 42-43 & 55-56). Plaintiff respectfully disagrees. As an initial matter, Plaintiff denied that he reported to Dr. Nayer that he was pain free which creates a question of fact. Plaintiff has testified that his pain was 7 to 8 on August 18, 2017.

Further, surrounding circumstances and medical care support Plaintiff's version of his pain level at the first post-operative visit. Only two days before Dr. Nayer's first post-operative visit, a physical therapist reported that Plaintiff's pain level was 8-9 notwithstanding that Plaintiff was significantly medicated. Plaintiff had also just been discharge from rehabilitation care only a week before (i.e., on 8/11/17), where the providers at MNRH doubled Plaintiff's Gabapentin dosage

because of increased pain.[27] At this time, providers had also ordered Plaintiff to undergo outpatient pain management.[28] Accordingly, weighing all this evidence together, a jury could reject Dr. Nayer's testimony, and credit Plaintiff's testimony, finding that Plaintiff was experiencing significant pain (that Dr. Nayer knew, or should have known about) at Plaintiff's first post-operative visit.[29]

Moreover, Plaintiff respectfully submits that the trial court failed to focus on the operative visit of November 17, 2017, and Plaintiff's condition at that time, which was a key operative fact related to Dr. Holmes' opinion regarding the prompt reordering of an MRI. Plaintiff undisputedly reported in November 2017 that he was experiencing only 50% improvement in his pre-operative pain and changes in his clinical presentation (increased pain while walking).[30] Even

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[27]Upon discharge from rehabilitation on August 11, 2017, Plaintiff reported a pain level of 8.

[28]Dr. Holmes has further opined that such a sudden and complete improvement in pain followed by a 50% increase in pain is unlikely and not a normal progression of pain symptoms—further questioning the accuracy of Plaintiff's history as taken by Dr. Nayer. (App. 149).

[29]For the same reasons above, Blake Choplin, M.D.'s note of August 18, 2017, wherein Defendant points to additional history of Plaintiff's improved back pain is also questionably reliable. Further, Plaintiff's testimony also controverts Dr. Choplin's history which is ultimately of no moment because the key issue, as set forth below, is Plaintiff's ongoing and developing symptoms in November 2017. (App. 315).

[30]Dr Nayer concedes that Plaintiff only had 50% improvement in preoperative pain at the November postoperative visit. (App. 210).

assuming Plaintiff reported 100% improvement in pain at the first visit (which he contests), the condition changed (as undisputedly known by Dr. Nayer) and would negate the trial court's position that there could be no breach just because Dr. Nayer was allegedly told that there was 100% improvement in preoperative pain at the first visit. Accordingly, even if Plaintiff's pain level was 100% improved initially[31], that improvement did not last and the change in plaintiff's symptoms was the ultimate condition that Dr. Nayer had a duty to evaluate, and thereupon order additional imaging to meet the national standard of care.

B. Dr. Holmes has Set Forth an Opinion with Respect to Ordering of Additional Imaging with a Time Frame Sufficient For Dr. Nayer to Measure his Actions

Plaintiff also respectfully submits that Dr. Holmes has rendered an opinion with sufficient timelines for when the national standard of care required Dr. Nayer to order a repeat MRI. The trial court has concluded that Dr. Holmes' opinion was

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[31]In this regard, as defendant contends, Dr. Holmes never relied on Dr. Nayer's self-serving history of 100% improvement and changed his opinion when discovering the note from the initial visit did not state 0% improvement. (App. 40). Initially, an issue arose as to whether the note stated 0% improvement or 100% improvement. Plaintiff investigated the issue through discovery and did not pursue the point (which is irrelevant for the instant appeal). In any event, Dr. Holmes, based on Plaintiff's version of his pain level at the time of the initial post-operative visit in August, and, more importantly, the fact that Plaintiff's pain had not improved (with symptoms when walking) by November, clarified in his deposition and summary judgment affidavit, that an MRI had to be ordered promptly at that time in follow-up. (App. 82, 96, 100, & 122-125).

too broad because there is no evidence of when the "window" for ordering an MRI commences, terminates, or is determined. (App. 43 & 56). Plaintiff respectfully submits that Dr Holmes has stated an opinion sufficient for Dr. Nayer to weigh his actions.

It is settled that an expert must articulate an opinion that is sufficient to allow a defendant's actions to be measured against. *Sullivan v. AboveNet Communs., Inc.*, 112 A.3d 347 (D.C. 2015). Here, there is sufficient evidence of when the window commenced because Dr. Holmes has opined that an MRI should have been ordered "at that time" or promptly following Plaintiff's November 17, 2017 visit (i.e., as of four months post-op) when Plaintiff was still experiencing significant symptoms. Promptly is defined as "with little or no delay" or "without delay".[32] A logical inference from this testimony is that the "window" commenced and Dr. Nayer had a duty to order additional imaging "without delay" in a follow-up appointment[33] when his patient remained significantly symptomatic four

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[32]See *Oxford Language Dictionary* (Oxford University Press) (https://languages.oup.com.>dictionaries) & *Merriam Webster Dictionary* (https://www.merriam-webster.com).

[33]Dr. Holmes testified that Dr. Nayer was required to order an MRI at a follow-up appointment. (App. 124-125).

months post-op.[34]

As to a termination time for the "window", a reasonable jury, under the facts of this case, could conclude that a termination time for the "window" was not relevant because Dr. Nayer discharged Plaintiff on November 17, 2017, while he was still symptomatic (before any follow-up and ordering of the requisite imaging).[35]

There is also evidence how the "window" is determined because Dr. Holmes has opined that additional imaging is required based on patient's presentation and symptoms over time. Given plaintiff's age, type of surgical procedure, and persistent pain (with only 50% improvement and pain when walking), as of four months post-op,[36] Dr. Holmes has opined that a physician must take prompt action

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[34]Contrary to the trial court's assertion, Dr. Holmes was not broadly conceding that the failure to perform a post-operative MRI was not necessarily negligent or that he could not identify when the standard of care required a follow-up MRI. (App. 43). Under a fair reading of Dr. Holmes' deposition, he was only emphasizing that it was not a breach if Dr. Nayer did not perform or order an MRI on "that day" (i.e., on visit of November 17, 2017) or an actual specific day, but that it was required to be ordered promptly in a follow-up appointment. (App. 96, 100, 122-125, & 155).

[35]As explained by Dr. Holmes, Dr Nayer breached the standard of care by discharging the Plaintiff before ordering the requisite imaging, which was an opinion imbedded in his primary opinion that follow-up imaging was required to assess the severity of Plaintiff's persistent pain and symptoms. (App. 96 & 155).

[36]Plaintiff's second post-op visit was November 17, 2017 which was four months

at that time to order a follow-up MRI to determine the cause of a patient's persistent pain and to determine the outcome of the surgery. (App. 96, 100, 122-125, & 155).

The case of *Sullivan v. AboveNet Communs., Inc.*, 112 A.3d 347 (D.C. 2015) is on point. In *Sullivan*, a road contractor repaved an area around a manhole and engaged in some compacting of the pavement. The plaintiff's expert opined that the material must be further compacted "during the backfilling process to avoid air pockets from forming and depressions from occurring." *Sullivan*, 112 A.3d at 358. He further opined that the contractor deviated from the standard because depressions formed in the pavement as show in accident photographs. The trial court granted a motion for judgment on the basis that plaintiff's expert had not established specific enough details of how the standard of care was breached. *Id.* at 357. While the expert did not address details about the degree and extent of the required compacting, the court reversed the trial court, as the expert had sufficiently articulated a standard so that a defendant could weigh his actions against the standard. *See Id.*

Likewise, in this case, Dr. Holmes' testimony was sufficient to articulate a national duty of care by which Dr. Nayer's actions could be measured (i.e., Dr.

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after the July 19, 2017 surgery.

Nayer was required to take "prompt" action without delay). Any "shortcomings" in Dr. Holmes' analysis, if any, should therefore go to the "weight of his testimony rather than its admissibility" thereby presenting "an issue for the jury to decide." *Id.* at 359 (*quoting NCRIC, Inc. v. Columbia Hosp. for Women Med. Ctr. Inc.*, 957 A.2d 890 (D.C. 2008).

District of Columbia v. Price, 759 A2d 181 (D.C. 2000) is also instructive. In *Price*, the expert sufficiently testified that the national standard of care required law enforcement to "immediately" call an ambulance when encountering an intoxicated or ill prisoner. *Price*, 759 A2d 183-184. Similarly, in this case, Dr. Holmes has opined that Dr. Nayer was required to order an MRI "promptly" which was not so broad or an unacceptable time frame from which a jury could measure Dr. Nayer's actions.

C. There is a Sufficient Foundation and Basis to Establish that Dr. Holmes' Opinion Related to Additional MRI Imaging is Part of the National Practice

Lastly, the trial court also determined that there was no basis through publication or reference to national medical conferences to establish a breach of the national standard of care as to the ordering of additional MRI imaging. For reasons set forth above, there is evidence establishing a basis for Dr. Holmes' knowledge of the national standard of care thereby linking his testimony to the national practice. As noted, Dr. Holmes has regularly attended national

neurosurgery conferences where spinal decompression surgery, including laminectomy procedures, was discussed and reviewed. A reasonable jury could infer that encapsulated in the review of laminectomy procedures are discussions pertaining to follow-up neurosurgical care and management of post laminectomy patients. An attendant and inherent part of a laminectomy procedure is the post-operative care by neurosurgeons.[37] (See App. 80) Accordingly, based on Dr. Holmes's foregoing discussions about laminectomy procedures, at national conferences with knowledgeable professionals, a jury could ultimately infer that Dr. Homes' opinion testimony concerning the standard of care for the ordering of additional MRI imaging, following a laminectomy, is part of the national practice.

[37]Recall Dr. Homes' practice regularly involved the performance of spinal surgery, including lumbar laminectomy and follow-up care/management of patients following a laminectomy.

CONCLUSION

Appellant Saraco requests this Court to vacate the trial court's orders granting summary judgment and denying his motion for reconsideration, remanding this case for further proceedings and trial on the merits.[38]

Respectfully submitted,

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[38]For the same reasons set forth above, Plaintiff appeals the trial court's denial of his motion for reconsideration so as to correct clear error and prevent manifest injustice. *In re Estate of Derricotte*, 885 A.2d 320, 324-325 (D.C. 2005). Further, in his motion for reconsideration, Plaintiff attached a second affidavit from Dr. Holmes to further amplify Dr. Holmes' underlying opinions. The trial court did not consider this affidavit. (App. 55). In this appeal, Plaintiff is not relying on the second affidavit, because Plaintiff contends that the remaining record adequately supports the issues raised on appeal.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Appellant's Brief was electronically served through the Court's EFS systems this 17th day of December, 2024, to:

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