IN THE
DISTRICT OF COLUMBIA COURT OF APPEALS

Appeal No. 22-CV-532

WASHINGTON HOSPITAL CENTER CORPORATION d/b/a WASHINGTON WOMEN'S WELLNESS CENTER AT WASHINGTON HOSPITAL CENTER,

Appellant

v.

SHANAYE BATEY, et al.

Appellee

Appeal from the Superior Court for the District of Columbia
(The Honorable Juliet McKenna)
Case No. 2019 CA 006716 M

REPLY BRIEF OF APPELLANT

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INTRODUCTION

Plaintiffs' appellate arguments ignore that Ms. Dunbar twice did not follow agreed-upon instructions that would have prevented her injury if she had complied. Controlling law imposes on patients a clear duty to follow medical instructions and cooperate in their care. The evidence required instructions on contributory negligence, and the Hospital is entitled to raise the defense at a new trial.

But the new trial cannot include a claim for failing to obtain informed consent to treatment. The informed-consent doctrine applies only to patients who both consented and *submitted* to the relevant treatment. It covers patients harmed by *following* their healthcare providers' instructions or advice without necessary information. Ms. Dunbar was injured because she did *not* submit to or comply with agreed-upon instructions to return for testing on February 9 and 14. The informed-consent doctrine does not cover harms caused by noncompliance. The only claim to be re-tried on remand should for be traditional medical negligence.

Finally, Plaintiffs continue to minimize that the Wrongful Death Act limits recovery to *pecuniary* loss. It is impossible to award $15 million for pecuniary wrongful-death damages that are neither "lost household services," nor sentimental loss. Despite their denials, Plaintiffs' continued plea to compensate three children for the "loss of a mother" and losing their mother's "comfort" seeks non-pecuniary recovery for sentimental loss. The Act does not allow that.

ARGUMENT

I. The Hospital cannot be precluded from raising its contributory-negligence defense.

A. Plaintiffs' brief ignores that Ms. Dunbar twice failed to follow medical instructions that she had agreed to follow.

Plaintiffs and the trial court have all conceded, as they must, that controlling precedents give patients a duty to follow medical instructions and cooperate with their care providers. *See* Appellant's Br. at 12-13. This Court's *Waas* opinion instructs that a patient's duty to cooperate is "widely recognized."[1] So any evidence from which a reasonable juror could conclude that a patient did not follow instructions or cooperate with her care providers creates a jury question on contributory negligence (unless the patient's negligence was plainly harmless).

The trial evidence showed that Ms. Dunbar was told that her sonogram was abnormal and may indicate an ectopic pregnancy. She was twice instructed that she "*needs* to come back" for testing on February 9 and 14. *See* App. at 289-90. Despite twice agreeing to do so, Ms. Dunbar did not follow the instructions to return. If she had returned either time, as a reasonably prudent patient would have done, she would have prevented her injury on February 17. That put contributory negligence squarely at issue and required jury instructions on the defense.

[1] *George Wash. Univ. v. Waas*, 648 A.2d 178, 185 (D.C. 1994).

Medical care is a collaborative process rooted in "shared decision-making." *See* Appellees' Br. at 27. The duty to follow instructions exists because reasonably prudent people do exactly that. They do so even without being told that noncompliance could kill them. And they do what they and their healthcare providers have agreed that they "need" to do. Patients who do not want to comply with instructions must share their concerns or objection with the healthcare provider, who can explain why the instructions are necessary. That is why courts repeatedly recognize the patient's *duty* to follow medical instructions and cooperate with medical treatment. *See*, *e.g.*, Appellant's Br. at 12-13.

Any reasonable juror could find that not following a healthcare provider's repeated instructions is unreasonable and risky—especially when the healthcare provider calls the noncompliant patient and instructs her again to be tested the very next day. Facts this stark may compel a finding of patient negligence.

Yet Plaintiffs bluff that there is no evidence from which any reasonable juror could find that Ms. Dunbar contributed to her injury by breaching her duty to follow instructions and cooperate. They consider Ms. Dunbar's conduct reasonable as a matter of law because she is a responsible adult who might have had valid, or at least understandable, reasons for not returning both times. That misses the point.

In negligence cases, the reasonable person "is a fictitious person, who is *never* negligent, and whose conduct is *always* up to standard."[2] Jurors would not be resorting to "speculation" if they found that Ms. Dunbar did not act reasonably or "up to standard" when not following instructions or cooperating in her care *twice* in six days. *See* Appellees' Br. at 24. And jurors presumably get to decide whether Ms. Dunbar acted negligently or reasonably when her failure to follow medical instructions to return on February 14 leads directly to her death three days later.

Precluding a contributory negligence defense denied the Hospital a fair trial.

B. Plaintiffs invent new contributory-negligence requirements for a patient who failed to follow agreed-upon medical instructions.

The trial court erroneously prevented the jury from even considering contributory negligence because it wrongly believed that it needed evidence that Nurse Belna told Ms. Dunbar *why* ectopic pregnancies are dangerous. *See* App. at 669. Contributory negligence requires much less. Evidence that Ms. Dunbar contributed to her injury by (1) not following medical instructions or (2) not cooperating with her healthcare provider suffices. She breached both duties.

The trial court misconstrued the medical instruction that a pregnant patient "needs to come back" (i.e., it is imperative to return) on a set date as somehow *not* imperative, even after being told that she may have an ectopic pregnancy. *See* App. at 289-90; 669. That usurps the jury's role. Yet, Plaintiffs try to save the trial

[2] Restatement (Second) of Torts, § 283 comment c (emphasis added).

court's parsing of mere "needs" and "imperative needs" by asking the Court to consider whether Ms. Dunbar viewed her need to return as an "urgent need" or "pressing need," as if that changes the analysis. *See* Appellees' Br. at 21, 23. It does not. The only thing that matters for raising a jury question of contributory negligence here is that Nurse Belna twice instructed her to return, which she agreed to do both times but then failed to do.

Plaintiffs offer other deflections. They argue that "Ms. Dunbar was not contributorily negligent for relying on NP Belna to inform her of the implications" of her sonogram or for failing to "self-diagnose" her "complex medical condition" or for "not acting expeditiously." *See id.* at 23, 26, 31. But the Hospital has never faulted Ms. Dunbar for any of that. In fact, relying on Nurse Belna would have *prevented* the injury. Her contributory negligence was twice not following Nurse Belna's instructions, which a reasonably prudent patient would do.

Plaintiffs also ask whether Ms. Dunbar (1) knew that she might have a potentially fatal ectopic pregnancy, (2) had a duty to know the significance or recognize the urgency of her possible medical condition, or (3) knew or should have known that not cooperating with her pregnancy care and not following Nurse Belna's instructions involved risks of *fatal* pregnancy complications. *See id.* at 23-24, 32. Such specific knowledge is not required to be contributorily negligent when the patient twice fails to follow clear medical instructions.

And, although the trial court was legally wrong to demand evidence that Nurse Belna told Ms. Dunbar that she might have an ectopic pregnancy, it was factually wrong to find such evidence missing. Ample evidence showed that Nurse Belna had told Ms. Dunbar that she might have an ectopic pregnancy. Nurse Belna testified that, when performing an ultrasound and forming her differential diagnosis, she would "tell patients exactly what I saw and *what the possibilities of it could mean.*" App. at 419. She further testified—and Appellees (at 10) even emphasize—that her differential diagnosis included an "ectopic pregnancy." *Compare* App. at 419-430; 453-54 *with* App. at 669. The possibility of ectopic pregnancy was among the things she "discussed with Ms. Dunbar." App. 449.

The court, thus, usurped the jury's role by finding that Nurse Belna never uttered the words "ectopic pregnancy" when treating Ms. Dunbar on February 7. *See* App. at 285; 669. The evidence would have allowed the jury to reasonably find that she did. *See*, *e.g.*, App. at 419-430; 449; 453-54.

Finally, realizing that the jury had evidence that Ms. Dunbar breached her duty of self-care, Plaintiffs incorrectly argue that Ms. Dunbar's fatal pregnancy complications were unforeseeable as a matter of law. *See* Appellees' Br. at 2, 24-26. But a dangerous pregnancy complication is not unforeseeable when the patient disregards clear instructions for managing her pregnancy. Pregnancy complications would be the *most* foreseeable problems from a patient's failure to follow medical

instructions or cooperate in her pregnancy care. Plaintiffs gain nothing from citations to precedents that recognize unforeseeable harm as harm from "forces which form *no part* of the recognized risk in the actor's conduct" or affirm a plaintiff's contributory negligence as a matter of law.[3] *See id*. at 18-19.

The law is clear that patients should know that it is not safe to disregard healthcare providers' instructions. This is certainly true for patients who are told they may have an abnormal pregnancy. Plaintiffs cannot shake patients' "widely recognized" tort duty to cooperate in their care and follow medical instructions.

C. Plaintiffs still have no case law that supports their extreme position.

Repeatedly challenged to produce a decision from this Court—or *any* court—holding that a patient's harmful failure to follow medical instructions during a course of treatment somehow does not create a jury question (or factual question in a bench trial) on contributory negligence, Plaintiffs still cannot. (The patients in *Stager*[4], *Nelson*[5], and *Rotan*[6] followed their medical instructions.).

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[3] *District of Columbia v. Sterling*, 578 A.2d 1163, 1166 (D.C. 1990) (emphasis added) (citing Restatement (Second) of Torts § 291 official comment). *Safeway Stores, Inc. v. Feeney*, 163 A.2d 624, 627 (D.C. 1960).

[4] *See Stager v. Schneider*, 494 A.2d 1307, 1312 (D.C. 1985).

[5] *See Nelson v. McCreary*, 694 A.2d 897, 899 (D.C. 1997).

[6] *See Rotan v. Egan*, 537 A.2d 563, 564-65 (D.C. 1988).

Durphy[7] and *Dennis*[8] are this Court's only decisions whose holdings address a patient's failure to follow medical instructions. But both cases require a contributory-negligence instruction here. *Durphy* required that contributory negligence go to a jury.[9] The *Dennis* court similarly held that the jury appropriately considered the patient's contributorily negligence, despite her denial that her surgeon had told her that her smoking might be problematic.[10]

And, in *Hall v. Carter*, there were no disregarded medical instructions.[11] The *Hall* patient's physician had merely "casually informed" her that he preferred that she reduce her smoking to help heal from surgery. But even that was enough to instruct the jury on contributory negligence.[12]

D. Bodily autonomy in healthcare does not eliminate patients' duty to cooperate and follow medical instructions.

Without any authority to excuse the trial court's profound error, Plaintiffs offer irrelevant arguments about bodily autonomy and patient's rights. *See* Appellees' Br. at 27. They suggest that Ms. Dunbar's bodily autonomy and control over her healthcare decisions relieves her of the duty to follow medical instructions

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[7] *Durphy v. Kaiser Found. Health Plan of Mid-Atlantic States*, 698 A.2d 459 (D.C. 1997).

[8] *Dennis v. Jones*, 928 A.2d 672 (D.C. 2007).

[9] *See* 698 A.2d at 466.

[10] *See* 928 A.2d at 678-79.

[11] 825 A.2d 954, 961 (D.C. 2003).

[12] *See id*. at 956, 960-61.

and cooperate with her healthcare providers. *See id.* But the argument conflates two fundamentally different concepts. Of course, Ms. Dunbar has personal autonomy and patient rights. She did not have to do whatever Nurse Belna told her to do. Ms. Dunbar had the right to tell Nurse Belna that she might not, or even certainly would not, return for testing. She had the right to reject all care.

But she also had the *duty* to convey that vital information to Nurse Belna, which would have prompted more discussion on the treatment plan. Ms. Dunbar never exercised her uncontested right to object to her treatment plan; instead, she agreed to return as instructed and twice told Nurse Belna that she would return. When she twice failed to do so, she breached her duty of reasonable self-care.

Rights come with responsibilities. The freedom to do whatever one legally wants to do does not shield patients from the consequences of their risky behavior. Plaintiffs are correct that Ms. Dunbar had the right to not show up for agreed-upon testing or not cooperate *at all* with her medical care. (Pregnant women also have the right to drink wine, smoke, and decline all prenatal care.) That is not the issue.

When patients breach their duty to follow medical instructions and later sue their care providers for damages, they cannot prevent jurors from considering their role in the resulting harm. If any evidence shows that a patient's lack of due care

caused or contributed to the harm, the jury must be instructed on it.[13] Ms. Dunbar cannot be absolved—as a matter of law—from responsibility for her choices.

Plaintiffs pad their misguided patients-rights argument with a list of irrelevant scenarios in which other patients might reasonably refuse to follow medical instructions because either the (1) the instructions are bad or (2) the patient cannot comply. *See id.* at 27. But the circumstances plainly do not apply here, and Plaintiffs have never argued that they do. No one can contend that Ms. Dunbar's refusal to return was reasonable as a matter of law. No evidence suggests she could not comply with Nurse Belna's instructions. Instead, she just chose not to follow the instructions, as she was entitled to do. But her personal autonomy does not immunize her from her lack of due care when her estate files a negligence action.

E. The Hospital did not need to request a special verdict form to preserve its contributory-negligence argument.

Plaintiffs argue incorrectly—and without any explanation—that the Hospital's contributory-negligence defense applies to *only one* of Nurse Belna's two purportedly harmful breaches. *See id.* at 16-17. The two-page argument contends that the Hospital needed a special verdict form that distinguished the two purported breaches to now show prejudice. *See id.* But the perfunctory argument quickly fails because contributory negligence applies to *both* purported breaches.

[13] *See*, *e.g.*, *Durphy*, 698 A.2d at 466.

Plaintiffs' special-verdict argument ignores the timeline. Nurse Belna allegedly breached the applicable standard of care twice between February 7 and February 13 by (1) not examining Ms. Dunbar's fallopian tubes on February 7 and (2) not impressing upon her the "urgent need" to comply with further treatment when instructing her that she needed to return on certain dates. *Id*. at 16. The injury that Plaintiffs seek to recover for—under any liability theory—did not occur until February 17, when the ectopic pregnancy ruptured Ms. Dunbar's fallopian tube. Ms. Dunbar's contributory negligence caused and contributed to her February 17 injury regardless of whether Nurse Belna negligently (1) performed the February 7 exam or (2) failed to advise Ms. Dunbar of her health risks.

Plaintiffs have no basis to argue that Ms. Dunbar's contributory negligence is irrelevant to Nurse Belna's purported negligence on February 7 and the February 17 injury. Following the medical instructions that she had agreed to follow and returning on either February 9 or February 14 would have completely prevented her February 17 injury under either alleged breach. Contributory negligence is as relevant to the first purported breach as it is to the second. No special verdict form is needed for this Court to consider the contributory-negligence argument.

II. If the Court remands for a new trial, there is insufficient evidence to support an informed-consent claim.

Plaintiffs' response to the Hospital's brief ignores the central point of the Hospital's informed-consent argument. Informed-consent claims require patients

who were harmed by consenting *and submitting* to the relevant treatment. But Plaintiffs' informed-consent claim alleges that Ms. Dunbar was harmed by *not submitting* to additional testing (despite agreeing to do so) because she was not properly informed. That is not an informed-consent claim.

Patients harmed by noncompliance with recommended treatment cannot claim "lack of informed consent" for injuries caused by *not* submitting to agreed-upon treatment. Plaintiffs still cannot cite a decision that has ever accepted a patient's harmful failure to submit to recommended treatment as a predicate for an informed-consent claim. Such allegations relate only to the existing negligent-treatment claim. This Court's controlling precedents do not allow it to revolutionize the informed-consent doctrine, as Plaintiffs propose.

A. There is insufficient evidence for informed-consent liability and no case law endorsing Plaintiffs' proposed expansion of the doctrine.

The informed-consent doctrine was created to address injuries from a risky treatment or procedure that (1) the patient agreed to undergo and (2) the physician competently performed.[14] The doctrine appreciates that patient consent and competent performance should not excuse the physician's harmful failure to disclose the procedure's material risks and other reasonable alternatives.[15]

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[14] *See*, *e.g.*, *Dennis v. Jones*, 928 A.2d 672, 676 (D.C. 2007); *Miller-McGee v. Washington Hosp. Ctr.*, 920 A.2d 430, 439 (D.C. 2007); *Cleary v. Group Health Ass'n, Inc.*, 691 A.2d 148, 155 (D.C. 1997).

[15] *See Dennis*, 928 A.2d at 676.

Traditional medical-negligence law provided no recovery in these circumstances because the patient had consented to the procedure (i.e., no battery) and the physician had performed it competently (i.e., no breach of the standard of care).[16]

Over the last century, medical ethics and patients' rights both evolved to recognize a separate duty to obtain the patient's informed consent to treatment.[17] In *Crain*, this Court described the "duty to inform [the patient] of the risks associated with treatment of her condition so that her consent to treatment would be an informed one."[18] In the decades since, this Court's informed-consent jurisprudence has repeatedly recognized that a patient was wrongfully harmed if the evidence showed (1) that "if he had been informed of the material risk, he would not have consented to the procedure and [2] that he had been injured *as a result of submitting to the procedure*."[19]

Here, the exact opposite has happened. Ms. Dunbar was injured "as a result of [**not**] submitting to" Nurse Belna's instructions to return. Ultimately, she did not consent to care, she refused it. Eager to argue about the duty to disclose the risks of

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[16] *See*, *e.g.*, *Jones v. Howard Univ., Inc.*, 589 A.2d 419, 422 n.4 (D.C. 1991); *see generally Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

[17] *See generally Canterbury*, 464 F.2d 772.

[18] *Crain v. Allison*, 443 A.2d 558, 561 (D.C. 1982).

[19] *Dennis*, 928 A.2d at 676 (quoting *Miller-McGee.*, 920 A.2d at 439; *Cleary*, 691 A.2d at 155).

non-treatment, Plaintiffs overlook this crucial predicate of informed-consent liability: submission to the recommended care.[20]

This Court's *Kelton* opinion explained that the improper failure to disclose "is not actionable in negligence *unless it induces* a patient's uninformed *consent* to a risky operation from which damages actually result."[21] Informed-consent doctrine does not contemplate a parallel informed-*noncompliance* doctrine. Although Plaintiffs quote general statements on the duty to disclose all relevant risks of the patient's condition and treatment, their informed-consent argument flips the doctrine on its head. The doctrine protects patients harmed by "submitting to" the proposed treatment plan without adequate risk information. It does not protect those harmed by *not* submitting to agreed-upon treatment.[22]

No case has ever stretched informed-consent liability to cover failure to obtain informed *noncompliance* with care. Plaintiffs' telling response to the Hospital's argument that no American court has apparently ever done this is not to present a case that disproves the assertion or even to deny the premise but to fault the Hospital for not citing a case that says "no case has ever said this." *See* Appellees' Br. at 35. Apparently, no court has ever *had* to say it before now.

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[20] *See id.*

[21] *Kelton v. District of Columbia*, 413 A.2d 919, 922 (D.C. 1980).

[22] *See*, *e.g.*, *Dennis*, 928 A.2d at 676; *Miller-McGee.*, 920 A.2d at 439; *Cleary*, 691 A.2d at 155.

Without any support for their radical proposed expansion of informed-consent law, Plaintiffs vaguely assert that the Hospital's position "is at war with this Court's jurisprudence" on informed consent. Appellees' Br. at 35. But their only cited support for the assertion is *Dennis v. Jones*[23], a seemingly crucial authority about which Plaintiffs have little to say. After briskly suggesting that *Dennis* involved an informed-consent claim based on a patient's failure to follow instructions to stop smoking (*see id.* n.46), Plaintiffs drop the case. *Id.* at 34-39.

Their analysis and parenthetical summary obscures that *Dennis* also presents a quintessential informed-consent claim. The plaintiff "Ms. Jones said that she '*would not have had the surgery*' had she known about the increased risks posed by her obesity, smoking, and hypertension, or by undergoing abdominoplasty and liposuction at the same time."[24] In other words, the patient alleged that she *submitted* to a harmful surgical procedure but would not have if informed of its risks. *That* states an informed-consent claim under this Court's precedents.[25]

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[23] 928 A.2d 672 (D.C. 2007).

[24] *Id.* (emphasis added).

[25] *See*, *e.g.*, *Crain v. Allison*, 443 A.2d 558, 561 (D.C. 1982) ("Mrs. Allison testified that she was not warned of the risk of infection and that had she been warned, she would not have permitted the cortisone injections."). *Miller-McGee*, 920 A.2d at 442 (holding that informed-consent liability could be based on evidence that, if patient, who was injured by forceps delivery, had "known of the risk of a rectovaginal fistula, she could have and would have opted for some method of delivery other than a forceps-assisted vaginal delivery").

Plaintiffs' contention that Nurse Belna negligently caused Ms. Dunbar not to submit to agreed-upon treatment by not elaborating on the risks of possible ectopic pregnancy alleges negligent medical treatment. Traditional medical negligence claims often allege that physicians negligently harmed patients by not properly communicating information related to potential treatments or risks. Doing so does not reflexively implicate informed-consent liability.[26] The *Cleary* court rejected the plaintiff's attempt to apply informed-consent doctrine to his claim that his physician negligently gave inadequate information about a potential surgical procedure because the physician was *not* proposing the procedure.[27]

Here, as in *Cleary*, there cannot be informed-consent liability, even if Plaintiffs retain a negligent-treatment claim, because the "circumstantial predicate for [the informed-consent] doctrine was not present."[28] Patient submission to treatment is the required predicate to any claim that the consent was not informed.

The rest of Plaintiffs' informed-consent argument chases straw-men. The Hospital has never parsed informed-consent law to cover "procedures" but not "treatment." *Cf.* Appellees' Br. at 37-38. The Hospital's brief (at 33-37) repeatedly applies informed-consent law to "treatment" (and procedures) including twice with italicized emphasis in the first sentence of its informed-consent argument (at 33).

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[26] *See Cleary v. Grp. Health Ass'n*, 691 A.2d 148 (D.C. 1997).

[27] *Id.* at 154.

[28] *Id.* at 150.

Nor has it argued that informed-consent claims preclude traditional negligent-treatment claims. Yet Plaintiffs lead with that non-issue. *Cf*. *id*. at 34. The two claims can be brought concurrently when the underlying facts and liability theories support both claims. If the patient is harmed by (1) submitting to an agreed-upon treatment or procedure without proper disclosures *and* (2) a breach of the relevant standard of medical care, she can pursue both claims. That is why, as just one example, the *Dennis* jury found that the surgeon "was not negligent, but that he failed to obtain her informed consent."[29] Here, the facts and Plaintiffs' theories simply do not support both claims. The informed-consent claim cannot be re-tried.

B. The remand for a new trial on contributory negligence makes even waived issues appropriate to address on this appeal.

Plaintiffs insist that, without a pre-verdict Rule 50 motion for judgment, this Court cannot even address whether Plaintiffs' evidence supports a *prima facie* informed-consent claim. *See* Appellees' Br. at 33. But in appeals where "a remand is necessary," this Court often deems it "appropriate to address certain issues that are likely to arise on remand."[30] Here, the trial court's contributory-negligence errors at the initial trial will require remand and a new trial on all claims. And at the new trial, the Hospital will again argue that Plaintiffs' unprecedented theory—

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[29] *Dennis*, 928 A.2d at 676.

[30] *E.g.*, *Fleming v. United States*, 224 A.3d 213, 224 (D.C. 2020) (quoting *District of Columbia v. Dep't of Emp't Servs.*, 713 A.2d 933, 936 (D.C. 1998)).

negligent failure to warn patient of the risks of noncompliance with agreed-upon treatment—has never been recognized as supporting a claim for failure to obtain informed consent. The claim does not exist under D.C. law. To avoid a third trial, this Court's guidance on remand would be most appropriate. It would not be efficient or appropriate to have the trial court guess what this Court would do.

III. Plaintiffs continue to try to justify the excessive damages award on impermissible grounds.

Plaintiffs' response to the Hospital's excessive-damages argument again avoids its central point. The Wrongful Death Act limits recovery to *pecuniary* loss. That means that the Act does not allow minors to recover money for not having their mother during holidays. That is sentimental loss.

Plaintiffs try to escape this reality first by flirting with the idea that their counsel's incorrect reference to some wrongful-death damages as "noneconomic," while discussing jury instructions out of the jury's presence, lets the jury award noneconomic damages under the Wrongful Death Act. Appellees' Br. at 41. Of course, they cite no authority for this. The Act, which plainly forbids non-pecuniary damages, cannot allow noneconomic damages.

From there, Plaintiffs suggest that a permissible award for the pecuniary "loss of parental guidance, care, support, and education," apart from lost household services, includes compensation for the loss of a mother's "comfort." *Id*. at 43. They ask this Court to defer to the jury's valuation of the "loss of a mother." *Id*. at

46. That is what created this excessive verdict to begin with. Plaintiffs disavow any intent to recover for sentimental loss or grief but then argue for exactly that.

Plaintiffs also argue—without citing any cases or their awarded amounts—that an award of $5 million per child for pecuniary "loss of parental guidance, care, support, and education," somehow "compares favorably" to other verdicts. *Id*. at 48. Their only cited authority is the trial court opinion that is being challenged here. *See id.* (citing App. at 841-42). Such arguments cannot justify a legally indefensible award based on emotional appeals. The Act has never allowed that.

Finally, to justify their *Colston* arguments, Plaintiffs conflate their wrongful-death and survival claims. *Colston* applies only to survival claims, which allow non-pecuniary recovery for pain and suffering.[31] But in a wrongful-death claim, statutory beneficiaries can recover only "the pecuniary benefits that [they] might reasonably be expected to have derived from the deceased had [s]he lived."[32] They cannot recover "non-pecuniary losses, such as grief, mental anguish, or sentimental loss."[33] D.C. does not permit recovery of damages for the loss of a parent at "holidays, first dates, driving a car, getting married, having a baby," yet those were exactly the losses that Plaintiffs were "trying to replace" with their improper

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[31] *See District of Columbia v. Colston*, 468 A.2d 954 (1983).

[32] *See Semler v. Psychiatric Inst. of Washington, D.C.*, 575 F.2d 922, 924-25 (D.C. Cir. 1978).

[33] *Himes v. MedStar Georgetown,* 753 F. Supp. 2d 89, 94 (D.D.C. 2010).

Colston argument. The result, $5 million per child, dwarfed any pecuniary loss in evidence and could only be to compensate for grief and sentimental loss.

CONCLUSION

For these reasons, the Hospital respectfully asks the Court to vacate the judgment below and order a new trial that is limited to deciding liability, if any, for negligent treatment and any resulting damages.

Dated: February 16, 2023 Respectfully submitted,

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CERTIFICATE OF SERVICE

I CERTIFY that, on this 16th day of February 2023, a copy of the Appellant's Reply Brief was electronically filed and served via the Court's electronic filing system upon:

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District of Columbia
Court of Appeals

REDACTION CERTIFICATE DISCLOSURE FORM

Pursuant to Administrative Order No. M-274-21 (filed June 17, 2021), this certificate must be filed in conjunction with all briefs submitted in all cases designated with a "CV" docketing number to include Civil I, Collections, Contracts, General Civil, Landlord and Tenant, Liens, Malpractice, Merit Personnel, Other Civil, Property, Real Property, Torts and Vehicle Cases.

I certify that I have reviewed the guidelines outlined in Administrative Order No. M-274-21 and Super. Ct. Civ. R. 5.2, and removed the following information from my brief:

1. All information listed in Super. Ct. Civ. R. 5.2(a); including:

   - An individual's social-security number
   - Taxpayer-identification number
   - Driver's license or non-driver's' license identification card number
   - Birth date
   - The name of an individual known to be a minor
   - Financial account numbers, except that a party or nonparty making the filing may include the following:

     (1) the acronym "SS#" where the individual's social-security number would have been included;
     (2) the acronym "TID#" where the individual's taxpayer-identification number would have been included;
     (3) the acronym "DL#" or "NDL#" where the individual's driver's license or non-driver's license identification card number would have been included;
     (4) the year of the individual's birth;
     (5) the minor's initials; and
     (6) the last four digits of the financial-account number.

2. Any information revealing the identity of an individual receiving mental-health services.

3. Any information revealing the identity of an individual receiving or under evaluation for substance-use-disorder services.

4. Information about protection orders, restraining orders, and injunctions that "would be likely to publicly reveal the identity or location of the protected party," 18 U.S.C. § 2265(d)(3) (prohibiting public disclosure on the internet of such information); *see also* 18 U.S.C. § 2266(5) (defining "protection order" to include, among other things, civil and criminal orders for the purpose of preventing violent or threatening acts, harassment, sexual violence, contact, communication, or proximity) (both provisions attached).

5. Any names of victims of sexual offenses except the brief may use initials when referring to victims of sexual offenses.

6. Any other information required by law to be kept confidential or protected from public disclosure.

Signature

22-CV-532

Case Number(s)

Derek M. Stikeleather

Name

February 16, 2023

Date

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