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

REPLY BRIEF OF APPELLANT MICHAEL A. SARACO

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STATEMENT OF FACTS

Based on Defendant Medstar-Georgetown Medical Center, Inc.'s ("Defendant") argumentative statement of facts, Plaintiff Michael Saraco ("Plaintiff") states: [1]

In the Complaint, Plaintiff's primary allegation was not limited to the contention that Dr. Nayar "negligently cut his dura and failed to properly perform the decompression laminectomy surgery." (Hosp. Br., p.8) The Complaint further alleged that Dr. Nayar failed "to decompress the involved nerves" and failed to provide "timely post-surgical care and follow-up including the ordering of diagnostic studies." (App. 15, ¶4). Dr. Holmes, therefore, "did not take a sharp

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[1]Defendant's claim that the Plaintiff did not include all materials in the Appendix is incorrect. Defendant's counsel originally wanted memorandum of law to be included in the Appendix. Plaintiff's counsel informed counsel that memorandum of law should not be included in the Appendix pursuant to *D.C. Ct. App Rule* 30. Defendant then forwarded exhibits it wished to be included in the appendix. By Email of December 12, 2024, staff for Plaintiff's counsel sent a complete set of Appendix exhibits for Defendant's counsel review. By return email, counsel acknowledge receipt of the entire Appendix. By a later Email of December 12, 2024, Defendant's counsel requested the addition of three exhibits (which Plaintiff added) and stated that the Appendix "looks great". (Supp. App., pp. 1-9). The "Hospital Appendix" now improperly contains memorandum of law. (Hosp. App. 1-17 & 68-77). Defendant has also included duplicative hospital and rehabilitation records that were already contained in the original Appendix. (Compare Hosp. App. 19-58 with App. 238-241, 248-251 & 275-314.)

departure from Mr. Saraco initial theory and did not just raise two new standard of care opinions". (Hosp. Br., pp. 8-9)

Dr. Holmes has never opined that the dura tear was a breach,[2] but has always stated two national standard care opinions: 1) that the national standard of care for a neurosurgeon, with similar training and experience, situated in similar circumstances as Dr. Nayar, is that a neurosurgeon is required to remove hypertrophic (overgrown) bone and ligament and other soft tissue to achieve the goal[3] of decompression of the dural sleeve and exiting nerve roots in the lateral recesses and proximal neural foraminal (App. 82-84 & 145-146); and 2) 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, 100, 122-125 & 155). Dr. Holmes opined, under the facts of this case, that it was a breach of the national

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[2]The torn dura was an initial allegation that was not pursued.

[3]Defendant plays semantics with the word "goal". (Hosp. Br., pp. 11 & 31). As used by Dr. Holmes, the word "goal" is in the context of the obvious point that the standard requires decompression of the nerve that is the source of the pain which is the purpose of the procedure. Goal is not being used in the context of an aspirational result.

standard of care not to order a repeat MRI *promptly* in follow-up as of the time of the last post-operative visit on November 17, 2017.[4] (App. 96, 100, 122-125 & 155)

In deposition, Dr. Holmes also did not abandoned his initial opinion, pertaining to Dr. Nayer's surgery, simply because he acknowledged that a surgeon, in an appropriate case, could exercise surgical judgment and not remove all the compressive tissue and bone.[5] (Hosp. Br., pp. 9-10, 13) A correct and fair reading of Dr. Holmes' deposition testimony was that he was acknowledging--while finding it difficult to separate the failure to remove the compressive structures with a non-negligent situation--that not in "every case" would the failure to decompress nerves amount to negligence given exigent circumstances. Dr. Holmes clarified the point in his summary judgment affidavit stating: "Surgical circumstances may warrant the need to leave bone/tissue in the surgical field ….However, a neurosurgeon is not always free of negligence by leaving nerve compression

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[4]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 further clarified that imaging was required "promptly" as of the postoperative visit of November 17 to meet the standard of care. (App. 100).

[5]Defendant misstates Dr. Holmes' opinion when it claims that Dr. Holmes stated that that national standard of care "always" requires a neurosurgeon to remove compressive bone and tissue. (Hosp. Br., p. 9). Dr. Holmes never stated such an opinion. (App. 82).

bone/tissue simply as a matter of surgical judgment." (App. 99-100).

In this case, Dr. Holmes has testified that Dr. Nayar's breach was substantial and highly apparent because only a very limited amount of medial facet tissue/bone was removed, leaving the subject nerves severely compressed. (App 99-100). There is no evidence of any valid surgical reason and, as a *defense*, Defendant is free to offer a reason why Dr. Nayar left the surgical field severely compressed or cross-examine Dr. Holmes on the point.[6]

As to literature relied upon by Dr. Holmes, the fact that the authors of the Batjer textbook chapter referred to "our technique" is of no moment. (Hosp. Br., p. 11). Dr. Holmes has opined that the standard of care requires nerve decompression regardless of the surgical approach. He acknowledges that surgeons can take different approaches as long as nerve decompression is achieved as required under the standard of care. (App. 128-129). Dr. Holmes is critical of Dr. Nayar for significantly failing to complete the decompression surgery, and not for his surgical approach.[7]

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[6]Dr. Holmes did address the issue of the risk of removing too much bone and causing instability. He testified that the bone can be remove all the way to the pedicle. Dr. Nayar, however, only removed a small amount of bone and instability was never an issue. (App. 99-100, 128-129). There is also no evidence proffered that Dr. Nayar was concerned about instability.

[7]The authors make clear that a nerve is decompressed only when the nerve root is visualize as decompressed in its entirety from the emergence from the thecal sac to

In deposition, Dr. Holmes also testified that the Batjer chapter was a reasonably reliable source of information for a neurosurgeon in 2017 (year of Dr. Nayer's surgery) and was similar to "many" such representative sources. (See App. pp. 101-104). Dr. Holmes, therefore, was not using the source merely as "representative" or suggestive of his position and was contending that the source was authoritative even though it was not a "standalone, knock down, drag-out source that trump all others." (Hosp. Br., p. 11).[8]

As to his MRI opinion, Dr. Holmes also did not repudiate his initial opinion. (Hosp. Br., pp. 12-13). In his initial report, Dr. Holmes opined that Dr. Nayar was required to order an MRI after the post-operative visit on August 19, 2017. Without rejecting his underlying opinion (that a patient with persistent symptoms requires an MRI), Dr. Holmes, in deposition and summary judgment affidavit, expounded on his opinion that additional post-surgical monitoring time would be necessary and that the national standard of care required MRI imaging promptly as

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the exiting point below the pedicle. (App. 164-165).

[8]Despite Defendant's contention, the Pluta study is also relevant. (Hosp. Br., p.14). While involving facetectomies, the procedures are done in connection with laminectomies and involve the decompression of impinged nerves in the same surgical field. The study supports Dr. Homes' opinion stating that decompression is only achieved if a rounded instrument can pass without resistance through the applicable foramen (i.e., hole) to confirm decompression. (App. 175).

of the November 17, 2017 appointment in follow-up care. (App. 100, 124-125).

Further, Plaintiff's additional statement, in his Supplemental Rule 26 Disclosure, as to Dr. Holmes' participation in national conferences, was not a new disclosure. (Hosp. Br., p. 13). In his initial report, Dr. Holmes stated that he regularly attended national neurosurgery conferences where laminectomy procedures were discussed and reviewed. (App. 80) In his supplemental statement, Plaintiff expounded on the basis of Dr. Holmes' opinions stating, *inter alia*, that Dr. Holmes' opinions are based on 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). Plaintiff's further clarification in his supplemental statement was consistent with Dr. Holmes' initial report and properly part of the summary judgment record.

Following his rehabilitation care, in November 2017 Plaintiff presented to Matthew D. Maxwell, M.D. for pain management. On January 5, 2018, Dr. Maxwell reported that Plaintiff was still experiencing significant pain (5-6/10) notwithstanding the addition of a stronger opioid medication. On February 2, 2018, Plaintiff reported significant "loopiness" when using Nycynta and Lyrica and pain of 6 while on these medications. (App. 269-282).

In May 2018 Plaintiff reported that "he continues to have some significant pain with activity." (App 288). On September 12, 2018, Plaintiff reported that his

pain was 8 at worst and 5 at best when taking three different medications. (App. 252). In August 2019, Plaintiff presented to Dr. Maxwell with acute worsening pain. (App. 304). Dr. Maxwell ordered a lumbar MRI which revealed that medial facet joint tissue remained severely compressed and a protrusion at the L4-5 level (App. 83 & 313).

On November 6, 2019, Joseph O'Brien, M.D. performed an oblique lumbar interbody fusion (OLIF) salvage surgical procedure. He substantially removed the protruding disc and replaced it with a spacer. The spacer had the effect of elevating the vertebrae that would help to indirectly decompress the L4 overgrown facets left by Dr. Nayar's surgery. (App. 83). Dr. Holmes has opined that Dr. Nayar's negligent surgical decompression of July 19, 2017 was the main and substantial contributing factor for Plaintiff's continued pain symptoms. (App. pp. 85-86). [9]

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[9]With respect to standard of review, Defendant contends that a separate standard of review applies to each of the trial court's decision. However, where the trial court grants summary judgment, based on the exclusion of expert testimony, *de novo* review is the appropriate standard. *Strickland v. Pinder*, 899 A.2d 770 (D.C. 2006)(*de novo* review where directed verdict based on striking of expert testimony); *Snyder v. George Washington Univ.*, 890 A.2d 237 (D.C. 2004) (same). The denial of a motion for reconsideration is reviewed for an abuse of discretion. *In re Estate of Derricotte,* 885 A.2d 320 (D.C. 2005).

ARGUMENT

I. Dr. Holmes' Standard of Care Opinion for Laminectomy Procedures

A. Defendant Misreads the Trial Court's Findings and Plaintiff did Not Waive an Issue That was not Held by the Trial Court.

As an initial matter, contrary to Defendant's contention, the trial court did not hold that Dr. Holmes failed to articulate a measurable national standard of care because he had not identified circumstances where a surgeon would not have to complete neural decompression surgery based on surgical judgment (which Plaintiff contests below). (Hosp. Br., pp. 20-21). The Court excluded Dr Holmes' testimony on foundational grounds holding that Dr. Holmes had not established that his standard of care opinion was national in scope based on his discussions of laminectomy procedures at national conferences or presentation of relevant data. (App. pp. 39-40). Because of this "deficiency", the trial court found that the trial of fact would only be able to speculate as it had no opinion to weigh Dr. Nayar's conduct. (App. pp. 39-40). The trial court, therefore, was not even questioning the "measurability" of the standard, but excluded the opinion for lack of foundation. Accordingly, Plaintiff also did not waive an issue in his moving brief that was never ruled upon by the trial court and is now not properly before this Court.[10]

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[10]Moreover, in his moving brief, Plaintiff did raise how the concept of surgical judgment properly applies to this case (See Plaintiff's Brief, p. 5 n. 4 & p. 8 n. 11).

B. Defendant Reconstructs Dr. Holmes' Opinion In an Attempt to Argue that Dr. Holmes has not Articulated a Clear Standard for Weighing Dr. Nayar's Actions

Defendant attempts to reconstruct Dr. Holmes' opinion by contending that Dr. Holmes has opined that a neurosurgeon, as a rule and not an exception, can forgo decompressing nerves as a matter of surgical judgment. Dr. Holmes' opinion is straight forward. Under the national standard of care, a neurosurgeon is required to remove hypertrophic (overgrown) bone and ligament and other soft tissue that are compressing the subject nerves which is the purpose of the procedure. As explained in Dr Holmes' deposition, surgical circumstance may make complete decompression not possible in every case, which is the exception and not the standard. Dr. Holmes further clarified the point in his summary judgment affidavit stating that surgical circumstances may warrant the need to depart from the primary standard requiring nerve decompression of the subject nerves, but that a neurosurgeon is not free of negligence based on carte blanche surgical judgment. Dr. Holmes' actual opinion, therefore, provides a basis for Dr. Nayar to weigh his conduct.

Here, there is no evidence of any such surgical circumstance and none have been advanced by Defendant.[11] As a *defense*, Defendant is free to offer a reason

[11]As Dr. Holmes testified, Dr. Nayar's breach was substantial because he only removed a very limited amount of tissue/bone. As such, there is particularly no

why Dr. Nayar left the surgical field with nerves still severely compressed. Defendant can also cross-examine Dr. Holmes in an attempt to establish a reason for Dr. Nayar's departure from the national standard of care.

C. Plaintiff has Established a Proper Foundation and Basis for Dr. Holmes' Knowledge of The National Standard of Care

1. National Conferences

In the cases of *Snyder v. George Wash. Univ.*, 890 A2d 237 (D.C. 2006) and *Strickland v. Pinder*, 899 A2d 770 (D.C. 2006), this Court *expanded* upon its "holdings of *Travers* and *Hawes* recognizing that it was reasonable to "infer" from expert testimony" that a medical standard is part of the national practice "so long as the testimony presents a sufficient basis upon which an inference can be made," *Nwaneri v. Sandidge*, 931 A.2d 466, 472-473 (2007). A reasonable inference can be raised if an expert testifies *how* he became aware of the standard. *Nwaneri*, 931 at 472-473 (sufficient inference raised in *Snyder* where expert never mentioned the term "national standard" and testified that he attended "frequent meetings [at] College of Surgeons" on the subject medical procedure with no greater details about his discussions). Accordingly, under the broadened holdings of *Travers* and *Hawes*, a sufficient link and inference is raised where the expert states how he

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evident or plausible surgical reason for leaving nerves in such a compressed condition.

gained his knowledge (i.e., attendance at national conferences) and is not required to state the details of how the discussions at those conferences informed him. The fact that an expert has had discussions on the subject medical procedure at national conferences alone raises an inference that he has knowledge of the national standard to which he can testify. 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 stated in his report: *"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.* There is, therefore, a sufficient basis for Dr. Holmes' testimony on the national standard of care for laminectomy procedures. Defendant is free to cross-examine Dr. Holmes as to the details of Dr. Holmes' discussions at national conferences.[12]

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[12]As set forth above, Plaintiff respectfully submits that the trial court (and the Defendant) has placed too high a bar for establishing a basis for Dr. Holmes testimony. Under applicable case law, however, the fact that an expert has discussed the subject procedure at national conferences establishes a basis for his

2. Literature

Defendant's contention that Dr. Holmes' cited literature does not support a national standard of care is without merit. Defendant's first complaint is that the Batjer textbook chapter refers to "our technique". Defendant misses the point. The "technique" refers to the surgical approach that Dr. Holmes acknowledges can differ between surgeons as they access the subject nerves. Dr. Holmes' opinion, however, focuses on the fact that Dr. Nayer did not decompress the impinged nerves as required under the national standard of care. As supported by the Batjer chapter, decompression is achieved when the nerve is visualized and appears decompressed in its entirety from its emergence from the thecal sac to the exiting point below the pedicle. (App. 164-165).

Defendant also incorrectly states that the Pluta study focuses narrowly on facetectomies without any discussion of surgical considerations related to laminectomies. However, the Pluta study addresses facetectomies that are done in connection with laminectomies, which are procedures commonly done together,

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knowledge of the national standard from which a reasonable inference can be raised that the standard is part of the national practice. The primary concern is whether "it is reasonable to infer from the testimony that such a standard is nationally recognized. *Snyder*, 890 A2d at 245 (quoting *Phillips v. District of Columbia*, 714 A.2d 768, 775 (D.C. 1998). Further, Defendant in its papers below never raised the issue. While Defendant states that it was raised in a reply below, a review of those pages, cited by Defendant, reveal that the issue was never raised. (Hosp. Br., p. 29).

and involve the decompression of facet tissue/bone in the same surgical field areas. (App. 170, 173-175).

Dr. Holmes also did not state in deposition that he was using the Batjer textbook chapter merely as representative or suggestive of his positions or contending that the source was not authoritative because it was "not [an] authoritative, standalone, knockdown drag-out source." (Hosp. Br., pp.11 & 31). Dr. Holmes did testify that the Batjer chapter was a reasonably reliable source of information for a neurosurgeon in 2017 and was similar to "many" such sources. (App. pp. 101-104).

Defendant also attempts to distort Dr Holmes' use of the word "goal", contending that Dr. Holmes standard of care testimony only amounts to aspirational surgical results. (Hosp. Br., pp. 11 & 31). As set forth by Dr. Holmes, the standard of care sets forth what a surgeon is required to do during surgery. It is not aspirational. Here, a surgeon is required to decompress the subject nerves which is the purpose of the procedure.

3. Court Precedent

Defendant attempts to twist this Court's precedent to establish that an expert can only establish a basis for his knowledge of the national standard of care if the expert provides greater details about his discussions at national conferences to demonstrate how the sources helped to support his opinion. (Hosp. Br. pp. 33 &

35). However, all is required is "some basis for [the expert's] knowledge of the national standard of care. *Nwaneri v. Sandidge*, 931 A2d 466, 475 (D.C. 2007). In particular, if an expert has had discussions on the subject medical procedure at national conferences, an inference is raised that he has knowledge of the national standard and then can testify as to the standard. *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170, 189 (D.C. 2009).

Defendant's case of *Travers v. District of Columbia*, 672 A.2d 566 (D.C. 1996) is distinguishable. First, *Travers* was decided before the cases of *Snyder* and *Strickland* [13] where this Court *expanded* the holdings in *Travers* and *Hawes* requiring only an *inference* that a standard was nationally recognized. *Nwaneri,* 931 A.2d at 472. Testimony that an expert engaged in discussions on a given medical procedure at national conferences was sufficient to raise such an inferences. *Convit v. Wilson*, 980 A2d 1104, 1124-1125 (D.C. 2009).

In *Travers* the expert also only broadly testified that he attended medical conferences all over the country where only "medical issues" were discussed. He never testified that the subject medical procedure (splenectomy) was discussed at these national conferences. He also admitted the he could not even remember if splenectomy surgery was discussed at the conferences. Here, Plaintiff has

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[13] *Snyder v. George Washington Univ*, 890 A.2d 237 (D.C. 2006); *Strickland v. Pinder*, 899 A.2d 770 (D.C. 2006).

established that Dr. Holmes has discussed and reviewed laminectomy procedures at national conferences where consensus of the applicable standard of care for laminectomy procedures are reached and discussed. Accordingly, there is a link and some basis for Dr. Holmes' knowledge sufficient to raise an inference that the standard which he espouses is part of the national practice.

The outcome of *Nwaneri* is also distinguishable. In Nwaneri the expert broadly testified that he "regularly receive[d]" and not reviewed, "journals that related to vascular surgery." *Nwaneri* 931 A.2d at 475. The expert made no attempt to link his broad statement to the procedure (vascular below-the-knee surgery) at issue. Because it was not clear that any of the national journals involved content related to the subject procedure, there could be no inference raised that the journals would even have provided any information about the national standard of care related to the procedure. *Id.*

Defendant also attempts to distinguish the cases of *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170 (D.C. 2009) and *Convit v. Wilson*, 980 A.2d 1104 (D.C. 2009). In *Coulter* the expert generally testified that he attended interdisciplinary breast conferences where patient cases and techniques were discussed. In *Convit*, the expert also broadly testified the he had attended nationwide conferences where

he discussed plastic surgery procedures.[14] In both, however, there was no testimony concerning any details about discussions pertaining to the actual procedures (i.e., breast examination protocol and infectious disease shunt surgery) involved in the cases.[15]

II. Post-Operative MRI

A. The Trial Court Improperly Substituted its Judgement for the Jury When Concluding That Dr. Nayar Could not Breach the Standard of Care Because Plaintiff had 100 % Improvement at The First Post-Operative Visit Notwithstanding the Fact That Plaintiff's Condition Significantly Worsened on the Next Post-Operative Visit

In its initial order, the trial court concluded that Dr. Nayar had no duty at any time to order an MRI solely because there was no genuine issue with respect to the fact that Plaintiff reported 100% improvement in pain level at his first post-

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[14]Defendant incorrectly attempts to distinguish *Convit* because the expert's only disputed testimony involved a breach of the standard of care. An accurate reading of the case, however, reveals that the expert still had to establish a foundation and basis for his standard of care testimony. *Convit*, 980 A.2d at 1124-1125.

[15]While not ruled upon by the trial court, and beyond the scope of this appeal, Defendant also seeks to uphold the exclusion of Dr. Holmes' testimony on the basis of *Daubert v. Merrell Dow Pharms., Inc.* 509 U.S. 579 (1993). As set forth above, Plaintiff has establish a proper foundation and basis for Dr. Holmes' standard of care opinion. His testimony is relevant, supported, and measurable. Moreover, it is well established that a physician's experience can provide a reliable basis for an expert opinion. *Perkins v. Hansen*, 79 A.3d 342 (D.C. 2013). As noted in Plaintiff's moving brief, Dr. Holmes is a highly experienced neurosurgeon whose experience alone can support a reliable opinion under a *Daubert* analysis.

operative visit (i.e., August 18, 2017) (App 43). The trial court made the finding solely based on Dr. Nayar's version of events. As an initial matter, Plaintiff recalled a pain level of 7 to 8 at the first visit which creates a question of fact whether he reported 100% improvement to Dr. Nayar.[16] Only two days before Dr. Nayar'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 doubled Plaintiff's Gabapentin dosage because of increased pain. At this time, providers had also ordered Plaintiff to undergo outpatient pain management. Accordingly, a jury could question whether Plaintiff advised Dr Nayar that he was pain free at Plaintiff's first post-operative visit.

Moreover, while the trial court baldly indicated that it consider Plaintiff's pain level at the post-operative visit of November 17, 2017, the trial court failed to analyze Plaintiff's changing pain level at this time. Plaintiff undisputedly reported in November 2017 that he was experiencing increased pain and changes in his clinical presentation (increased pain while walking). The trial court, however, notwithstanding these change in symptoms (even assuming that Plaintiff was pain

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[16]Defendant incorrectly claims that Plaintiff never refuted Dr. Nayar's entry of 100% improvement in pain level. Plaintiff's actual deposition testimony was that he did not remember the details of his visit, but recalls his pain level was 7 or 8 while at the first visit. (App. 63-64).

free in August 2017), ignored the second visit and still concluded that Dr. Nayar had no duty to order an MRI solely because Plaintiff allegedly reported to Dr. Nayar that he was experiencing 100% improvement in pain at the first visit. A jury, however, could disagree and conclude that Plaintiff was significantly symptomatic at the first visit and/or by the time of the second visit that would trigger Dr. Nayar's duty to order an MRI. Plaintiff respectfully submits that trial court improperly usurped the function of the jury when evaluating the foregoing evidence.

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

As to reordering an MRI, Dr. Holmes has opined that it was a breach of the national standard of care not to order a repeat MRI promptly in follow-up as of November 17, 2017. The applicable test is whether Dr. Nayar could measure his actions against this standard. *Sullivan v. AboveNet Communs., Inc.*, 112 A.3d 347 (D.C. 2015). Using the above standard as a measuring stick, it required Dr. Nayer to order a repeat MRI promptly (at the next follow-up visit or soon thereafter) as of November 17, 2017. Dr. Nayar's duty, therefore, started as of November 17, 2017 and was required to be done promptly (i.e. without delay). As to an ending point, contrary to Defendant's assertion, the period was not open-ended because the MRI had to be done promptly. (Hosp. Br. p. 41). Further, a termination date was not

relevant because Dr. Nayar discharged Plaintiff on November 17, 2017. (App 96 & 155).[17] The trial court should not have excluded the opinion because there was nothing vague about it.[18]

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

Plaintiff respectfully submits that the trial court erred when it excluded Dr. Holmes' MRI standard of care opinion because it was not part of the national practice. Plaintiff has established a foundation and basis for Dr. Holmes' knowledge of the national standard of care for the performance of laminectomies. Dr. Holmes has regularly attended national neurosurgery conferences where spinal decompression surgery, including laminectomy procedures, were discussed and reviewed. A reasonable inference is 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. Dr. Holmes,

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[17]Dr. Holmes has testified that Dr. Nayar's discharge of Plaintiff without imaging was a further breach of the standard of care. (App. 96 & 155).

[18] Defendant's statement that Dr. Holmes never testified that the standard of care required Dr. Nayar to order an MRI as of the post-operative visit of November 17, 2017 is incorrect. (Hosp. Br., pp 12 & 41). An accurate reading of the deposition reflects that Dr. Homes was stating that an MRI should have been order "at that time" but not necessarily literally on that date. (i.e., November 17, 2017). (App. 124-125).

therefore, through his discussions of laminectomy procedures at national conferences has establish a basis for his knowledge of the national standard of care for the reordering of MRI imaging, thereby linking his testimony to the national practice. Dr. Holmes' opinion should not have been excluded.

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.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Appellant's Reply Brief was electronically served through the Court's EFS systems this 7th day of March, 2025, to:

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