IN THE DISTRICT OF COLUMBIA COURT OF APPEALS

Case No. 24-CV-1187

ESTATE OF BARRY MICHAEL PEARSON, *et al.*

Appellants

v.

MEDSTAR WASHINGTON HOSPITAL CENTER, *et al*.

Appellee

On Appeal from the Superior Court for the District of Columbia
(The Honorable Maurice A. Ross)
Case No(s). 2022 CA 00001213 M and 2022 CA 001311 M

BRIEF OF APPELLEE MEDSTAR WASHINGTON HOSPITAL CENTER

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RULE 28(a)(2) LIST OF PARTIES AND COUNSEL

At present, the parties and their counsel in this appellate proceeding are:

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The parties and their counsel before the trial court were:

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Counsel for MedStar Washington Hospital Center certifies that no other parties or counsel appeared in the Superior Court in this action. *See* D.C. Court of Appeals Rule 28(a)(2)(B). Counsel further certifies that no individual has filed an amicus brief in connection with this appeal. These representations are made so that the judges of this Court may evaluate possible disqualification or recusal.

Dated: July 30, 2025

Respectfully submitted,

/s/ *Jared M. Green*

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RULE 26.1(a) CORPORATE DISCLOSURE STATEMENT

Medstar-Washington Hospital Center, Inc. is a not-for-profit corporation with no corporate subsidiaries, owned by MedStar Health, Inc. *See* D.C. Court of Appeals Rule 26.1(a).

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STATEMENT OF JURISDICTION

This appeal is from a final judgment that disposes of all parties' claims. *See* D.C. Court of Appeals Rule 28(a)(5).

STATEMENT OF THE ISSUES PRESENTED

1. Did the trial court correctly grant the defense motion for summary judgment on the claim for medical negligence because *res ipsa loquitur* cannot reliably be applied to the medically complex circumstances of this case?
    a. Did the trial court reasonably conclude that *res ipsa loquitur* cannot reliably be applied under the circumstances of this case?
    b. Did the trial court soundly exercise its discretion in excluding the opinions of Plaintiff's experts sounding in *res ipsa loquitur*?
    c. Did the trial court correctly enter summary judgment in favor of the defense, where Plaintiff otherwise failed to adduce expert testimony necessary to prevail on a claim for medical negligence?
2. Did the trial court correctly grant the defense motion for summary judgment on the claim for lack of informed consent where Plaintiff failed to support the claim with the necessary expert testimony?
3. Did the trial court correctly grant the defense motion for summary judgment on any claims for medical negligence relying on apparent/ostensible agency as a theory of liability?

STATEMENT OF THE CASE

In August 2023, the Appellant Sylvia Pearson ("Plaintiff or "Mrs. Pearson"), as personal representative of the Estate of Barry Michael Pearson ("Mr. Pearson"), filed the operative complaint ("Complaint") against the Defendant/Appellee MedStar Washington Hospital Center ("MWHC"), and Defendants/Appellees Kaiser Foundational Health Plan of the Mid-Atlantic States, Inc. and Mid-Atlantic Permanente Medical Group, P.C. (collectively "Kaiser"). (A175). The Complaint asserted claims of medical negligence, lack of informed consent, and derivative wrongful death and survival action claims related to Mr. Pearson's three-month hospitalization from September 19, 2019, until his passing on December 24, 2019. (A182-188). The Complaint did not name any specific healthcare professional as a defendant in connection with any of these claims.

In September 2024, MWHC and Kaiser moved (1) to exclude the testimony of Plaintiff's designated experts Dr. Salvador Guerrero and Thureiyya Rodriguez on the basis that their opinions were grounded in the doctrine of *res ipsa loquitur* which could not be reliably applied to the complex medical circumstances of this case, and (2) for summary judgment (A206, A456; A541, A544). On November 20, 2024, the trial court held a hearing on the motions, which the trial court thereafter granted by Orders issued on December 13, 2024. (A1142-1157). This timely appeal followed. (A1158).

RELEVANT FACTS

A. Relevant Medical History

On September 19, 2019, Mr. Pearson was transported from Kaiser Permanente Largo Medical Center to MWHC for complaints of chest pain – later diagnosed as a type of heart attack. (A476.001, 476.003-005, 476.008). He was 67-years-old with a history that included (1) paroxysmal atrial fibrillation; (2) end-stage renal disease on hemodialysis; (3) chronic obstructive pulmonary disease; (4) pulmonary fibrosis; (5) pulmonary hypertension; and (6) heart failure. (A476.003-004, 476.007).

On admission, Mr. Pearson was placed in Kaiser's Unit. (A256). His medical records reflect that in the days following admission he was given a pressure redistribution support surface, could shift independently (9/20, 9/21, 9/22, 9/26, 9/27, 9/28), and was occasionally out of bed. (A476.143, A476.144, A476.146, A476.147-152, A76.350, A476.351-352). The records also reflect occasions when he was not shifting independently (9/23, 9/25), and was manually repositioned. (A476.143, A476.145). His records also reflect the use of other pressure interventions during this time, such as floating his heels, using pillows, and encouraging mobility. (A476.140-146).

On September 29, 2019, Mr. Pearson was transferred to the medical intensive care unit (MICU) at MWHC for a suspected upper gastrointestinal bleed following two rapid response events for lethargy and hypotension, and required vasopressors

to maintain adequate blood pressure. (A476.006, A476.008, A476.036-037). On that date, a "skin tear" on his right buttock was identified, which was assessed, cleaned, and dressed daily during his stay in the MICU. (A476.335-340). In the MICU, he was also provided an alternating air pressure redistribution surface. (A476.349-350). His medical records reflect that he continued to be repositioned approximately every two hours, in conjunction with other pressure-relieving interventions including floating his heels and using pillows. (A476.135-140).

On October 4, Mr. Pearson was transferred back to the medical floor (A478), and a Plan of Care titled "RePositioning – High Risk Pressure Injury" was implemented under which he was repositioned every two hours. (A476.060-071). That Plan of Care remained in place throughout the remainder of his hospitalization, as reflected in dozens of daily chart entries by various providers. (A476.060-071). Mr. Pearson was also on an alternating air pressure redistribution surface while on the medical floor (A476.348-349), and any skin abnormalities were assessed daily. (A476.308-334). On October 7, he began receiving care from a wound care nurse, who noted Stage 2 "pink, shallow" pressure injuries on his sacrum and right lower buttock. (A476.029).

On October 17, Mr. Pearson returned to the MICU after exhibiting worsening weakness and suffering a right frontal subacute stroke. (A476.008-009). He also

exhibited "agonal breathing and hypoxia," necessitating intubation. (A476.009). He was also hypotensive, and again required vasopressors. (A476.046, A476.053).

By October 18 (less than one month into his hospitalization) the Pulmonary/Critical Care Fellow documented that Mr. Pearson was "*actively dying* and unlikely to recover from his acute on chronic illness." (A476.039-040, A476.041). (emphasis added). By October 22, Mr. Pearson was already being was followed by the Palliative Care Team (A476.038). By October 31, Mr. Pearson's status was changed to Do Not Resuscitate by Mrs. Pearson. (A476.016). During this period, Mr. Pearson continued to require vasopressors to maintain adequate blood pressure. (A476.038, A476.045). His Stage 2 sacral pressure injury, at times described as unstageable, continued to be assessed daily and was treated by cleaning, dressing, and applying wound care products. (A476.265-308). He remained on an alternating air pressure redistribution support surface and continued to be repositioned approximately every two hours, in conjunction with additional pressure-relieving measures such as floating his heels and using foam wedges. (A476.346-348, A476.066-070, A476.107-127).

On November 10, he was briefly transferred back to the medical floor, before returning to the MICU on November 13 after exhibiting fever, increased brown/tan secretions from his tracheostomy collar, concerns for pneumonia, and hypotension during hemodialysis. (A479-481; A476.010).

On November 14 (approximately two months into the hospitalization) a family meeting was held to discuss Mr. Pearson's medical condition and the goals of care. (A476.049-050). A palliative care physician was present. (A476.050). The providers explained (1) Mr. Pearson could no longer tolerate hemodialysis due to a drop in blood pressure necessitating vasopressors; (2) the brown-colored secretions raised concerns of a new gastrointestinal bleed, (3) he had developed pneumonia, and (4) he was ventilator dependent. (A476.050). They believed his "prognosis [was] very poor" and medical therapy would not "help prolong his life much[.]" (A476.050). On November 22, a consultation with the Ethics Team reflects most of the treatment team believed that Mr. Pearson should transition to comfort care, but Mrs. Pearson insisted on continuing care interventions that many providers considered non-beneficial. (A476.013-014).

Mr. Pearson's condition continued to deteriorate. On November 29, a percutaneous endoscopic gastronomy (PEG) tube was inserted as he was no longer able to eat. (A476.057-059). He continued to be repositioned every two hours, along with additional pressure-relieving intervention. (A476.060-066). The sacral pressure injury continued to be assessed daily; it was described as unstageable and eventually, in December 2019, as a Stage 4 pressure injury. (A476.153-264). In addition to cleaning and applying wound care products, the pressure injury was also debrided on December 13 and December 15. (A476.051-052, A476.055-056).

On December 17, Mr. Pearson was hypotensive overnight and re-started on vasopressors. (A476.034). On December 18, the ethics team was consulted again (A476.011-012), and a plan was made to transition Mr. Pearson to comfort care on December 20. (A476.033). As of December 21, Mr. Pearson was persistently hypotensive and remained on vasopressors. (A476.031-032). On December 24, his pulse stopped, and he was pronounced dead at 4:15 pm. (A476.048).

B. Plaintiff's Medical Negligence Lawsuit and Designated Experts

The Plaintiff alleges that Mr. Pearson developed the Stage 4 pressure injury as a result of negligence by every healthcare professional who provided any treatment over the course of his three-month hospitalization, and that such injury was the proximate cause of his death. In support of that claim, she designated two expert witnesses who opined that such an injury cannot occur in the absence of medical negligence.[1]

[1] MHWC and Kaiser also designated several experts, such as Dr. Robert Jayes who opines that the pressure injury was "the inevitable consequences of multiple failing organ systems and the continued stresses on his skin by his acute illness" (A131) (emphasis added), and Dr. Christian Merlo who opines "that Mr. Pearson's development of wounds at MWHC during the at-issue hospital admission was unavoidable given his medical condition and multiple co-morbidities" (A142), and Dr. Amanda Owen who opines that, "the wound arose as a result of Mr. Pearson's underlying medical compromise, and could not be healed for the same reason." (A161). Plaintiff chose not to depose these experts.

1. Dr. Thureiyya K. Rodriguez[2]

In her report, Dr. Thureiyya Rodriguez asserted that MWHC and Kaiser "failed to meet the standard of care" which "caused Mr. Pearson to develop significant and serious pressure injuries during his hospitalization that he did not have on admission to the facility." (A64). The report listed purported breaches in the standard of care – e.g., failing to "maintain skin integrity," "implement prevention strategies," and "maintain accuracy in wound documentation" (A64-64) – but did not expressly articulate an opinion as to a legally cognizable causal relationship between any specific act or omission and Mr. Pearson's Stage 4 pressure injury.

At deposition, Dr. Rodriguez opined that if a patient develops a pressure injury during hospitalization, it *must* have been caused by a breach of the standard of care. Specifically, when asked, "Just because a patient acquires a pressure injury in a hospital does not in and of itself mean that the standard of care was breached, correct?" She replied, "I can't agree," indicating, "the nurse, the healthcare provider and any other provider who has made contact with the patient, they are responsible for maintaining the skin integrity from the beginning of admission all the way until the time of discharge." (A347).

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[2] Mrs. Pearson refers to this witness as "Dr." presumably because the witness "holds a *doctorate in healthcare administration and nursing registration*[.]" (Appellant's Br. at 10). For the sake of simplicity, MWHC will use the same title, but notes that the witness is not a Doctor of Medicine.

Similarly, when asked "just because . . . that patient's pressure injury progresses or gets worse, that fact in and of itself does not mean . . . that there was a breach in the standard of care?" Dr. Rodriguez maintained, "there is a breach still in the standard of care because it is still the responsibility of the healthcare professional to maintain skin integrity during the admission." (A348).

At the same time, Dr. Rodriguez acknowledged that skin injuries can be unavoidable "when a person is about to die," because "they go into organ failure" and "the skin is an organ . . . it's one of those organs that are dying." (A350). However, she maintained that Mr. Pearson's pressure injury was not an unavoidable injury associated with organ failure during the dying process, but rather, "a result of not moving and then the lack of blood supply in the area." (A351). Even still, she acknowledged that skin failure can occur when "the patient is terminal" (A350), and that malnutrition as well can also alter tissue tolerance and hinder wound healing. (A352-53).

Ultimately, Dr. Rodriguez testified that her opinion that MWHC and Kaiser breached the standard of care by "failing to maintain skin integrity," was based on (1) the basic fact that Mr. Pearson developed the Stage 4 pressure injury; and (2) "CMS guidelines that [such an injury] is a never event and [sic] is the responsibility of the health care provider and *anyone* who comes into contact with that patient to maintain skin integrity upon admission." (A355) (emphasis added).

2. Dr. Salvador Guerrero

In his report, Dr. Salvador Guerrero opined that MWHC and Kaiser violated the standard of care and that "such failure was the proximate cause of Mr. Pearson's injury and death." (A278).

Similar to Dr. Rodriguez, Dr. Guerrero acknowledged that pressure injuries can be unavoidable, but only "when somebody is already dying," "they are agonizing," "they are about to expire and then the body goes through a breakdown." (A312). However, he asserted this was not applicable in Mr. Pearson's case because, according to Dr. Guerrero, it only applies "within hours, sometimes within a day or two and then there is end of life." (A312). At the same time, Dr. Guerrero conceded (1) that hemodynamic instability (*i.e.*, inadequate blood flow) can contribute to rendering a pressure injury unavoidable, and (2) "from the day of [Mr. Pearson's] admission to the date of his death he went through several episodes of hemodynamic instability." (A313).

Despite acknowledging that (1) pressure injuries can be unavoidable in patients who are actively dying, and (2) hemodynamic instability can contribute to rendering a pressure injury unavoidable, and (3) Mr. Pearson had "several episodes" of hemodynamic instability during his hospitalization, Dr. Guerrero maintained that Mr. Pearson's pressure injury could not have developed in the absence of medical negligence. (A318).

Dr. Guerrero was directed to Mr. Pearson's Plan of Care, which reflects that, as of October 5, 2019 – when he was first transferred back to the medical floor from the MICU – he was repositioned approximately every two hours until his passing on December 24, 2019. When asked how these records factored into his opinion that the pressure injury was caused by a breach of the standard of care, Dr. Guerrero simply declared that the medical records could not be true: "*if this was in fact what was happening and actually they were doing the repositioning, then [he] wouldn't have developed*" the pressure injury and "*[if] these strategies had been implemented, this wound would not have progressed*." (A325-326) (emphasis added).

C. The Trial Court Grants the Defense Motions to Exclude the Testimony of Plaintiff's Experts and for Summary Judgment.

On September 27, 2024, MWHC filed a motion, joined by Kaiser, to exclude the expert opinion testimony of Dr. Rodriguez and Dr. Guerrero on the basis that the opinions sounded in *res ipsa loquitur* and the doctrine could not reliably be applied to the complex medical circumstances of this case. (A456; 541).

Alongside the experts' own concessions, the motion relied without objection on literature published by the National Pressure Ulcer Advisory Panel (NPUAP), an organization both experts viewed as authoritative (A369; A326), and Dr. Guerrero referred to as the "gold standard." (A369; A326). *See* Joyce Black, *et al.*, *Pressure Ulcers: Avoidable or Unavoidable? Results of the National Pressure Ulcer Advisory Panel Consensus Conference*, Ostomy Wound Management (February 2011). The

literature was published in 2011, following a multidisciplinary conference on the "situations in which [pressure ulcers] are unavoidable[.]" (A527). "The panelists unanimously voted that not all pressure ulcers are avoidable because there are patient situations where pressure cannot be relieved and perfusion cannot be improved." (A533). The literature published by NPUAP explained:

> An unavoidable pressure ulcer can develop *even though* the provider evaluated the individual's clinical condition and pressure ulcer risk factors; defined and implemented interventions consistent with individual needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

(A533) (emphasis added).

"The majority of the consensus conference was focused on patient situations that change the ability of the body to reperfuse the tissue." (A535). "The panelists reached consensus that unavoidable pressure ulcers may develop in patients who are hemodynamically unstable, terminally ill, have certain medical devices in place, and are nonadherent with artificial nutrition or repositioning." (A539).

MWHC also moved for summary judgment as to (1) all claims, in the event the trial court granted the motion to exclude the experts' testimony; (2) all claims alleging breaches of the standard of care by unidentified providers; (3) all claims seeking to hold MWHC liable under a theory of apparent/ostensible agency; (4) the claim for lack of informed consent; (5) the duplicative claim of general negligence; and (6) the claim for punitive damages. (A210).

On October 15, 2024, Ms. Pearson filed Oppositions to the above motions. (A544; A1074). On October 22, 2024, MWHC filed replies in support of its motions to exclude expert testimony and for summary judgment. (A1108; A1118).

On November 20, 2024, the parties appeared remotely for a motions hearing. At the outset, the trial court observed that the Plaintiff's diffuse theory of liability (*i.e.*, *any provider* who treated Mr. Pearson at *any point* during his hospitalization was liable for negligence based on *res ipsa loquitur*) was practically impossible to defend against: "somebody must be negligent. But we don't know who. We don't know what they did." (Tr.10-11).

The trial court also doubted whether *res ipsa loquitur* could reliably be applied to the complex medical circumstances of this case: "they [Plaintiff's experts] don't have a basis for saying it wouldn't have happened, but for the negligence of the hospital because they've also acknowledged that there are three or four existing factors . . . that could have caused the bedsore without negligence." (Tr.8). When Plaintiff's Counsel insisted that, "the experts say that a pressure ulcer such as this does not occur in the absence of negligence[,]" the trial court reiterated, "[t]hey both asserted that. But they also agreed that you can have a pressure ulcer when someone who's actively dying, someone who's [sic] has hemodialysis[3], someone who had nutritional issues." (Tr.12-13).

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3 The trial court clarified that it meant "hemodynamic instability." (Tr.23).

Counsel for MWHC emphasized that not only was *res ipsa loquitur* the sole basis for Plaintiff's experts' theory of causation with respect to the pressure injury, it was also the primary basis for the opinions on the threshold issue of breach, which required disregarding the various treatment and preventive measures reflected throughout Mr. Pearson's medical records. Specifically, Counsel for MWHC argued, "[e]ven though the records say all of the wound care, treatment, and preventative measures that were done, the experts say, no, that wasn't done. . . . *because* the wound developed." (Tr.31) (emphasis added). In other words, the Plaintiff's experts essentially opine that the pressure injury could not have occurred if the standard of care was met, and thus, "because the wound developed, all of the documentation in the medical record didn't occur." (Tr.33).

At the end of the hearing, the trial court signaled that it was inclined to grant the defense motions to exclude the testimony of Plaintiff's experts as lacking sufficient reliability, as well as the motions for summary judgment indicating, "we're at the end of discovery, and it's all conclusory . . . even the experts." (Tr.57). On December 13, 2024, the trial court issued a series of Orders granting the motion to exclude the testimony of Plaintiff's experts, and entering summary judgment in favor of MWHC and Kaiser as to all claims. (A1142-1157).[4]

[4] The Plaintiff's Oppositions did not address the claim of general negligence or the claim for punitive damages, and Mrs. Pearson does not raise an appellate challenge to the entry of summary judgment as to those claims.

SUMMARY OF ARGUMENT

> "If the maxim, 'Res ipsa loquitur,' were applicable to a case like this, and a failure to cure were held to be evidence, however slight, of negligence on the part of the physician or surgeon causing a bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the 'ills that flesh is heir to."

Quick v. Thurston, 290 F.2d 360, 364 (D.C. Cir. 1961) (quoting *Ewing v. Goode*, 78 F. 442, 443 (C.C.S.D. Ohio 1897). The above observation was true in 1897, it was true when it was reiterated in 1961, and is vividly illustrated in the present case.

This case does not involve a surgery performed on the wrong body part. Rather, this case involves a pressure injury that developed during a three-month hospitalization, during which Mr. Pearson experienced multiple organ failure, numerous episodes of hemodynamic instability, and was "actively dying" by the end of the first month. Plaintiff's own experts acknowledge that these and similar circumstances can render pressure injuries unavoidable, a fact that is confirmed by literature published by the NPUAP – an organization that both of Plaintiff's experts consider authoritative. As the trial court rightly found, these circumstances do not permit a reliable *res ipsa loquitur* inference. The trial court therefore soundly exercised its discretion by excluding the contrary opinions of Plaintiff's experts, and in the absence of otherwise sufficient expert testimony, correctly entered summary judgment in favor of MWHC as to the claim of medical negligence.

ARGUMENT

I. Applicable Law and Standards of review.

The admissibility of expert testimony is governed by Fed. R. Evid. 702. *Motorola Inc. v. Murray*, 147 A.3d 751, 752 (D.C. 2016). "The purpose of expert testimony is to *avoid* jury findings based on mere conjecture or speculation," and "the sufficiency of the foundation for expert opinions should be measured with this purpose in mind." *Giordano v. Sherwood*, 968 A.2d 494, 498 (D.C. 2009) (emphasis added; cleaned up). The trial court's role is "'to deny admission to expert testimony that is not reliable,'" and only "admit that which is 'derived from reliable principles that have been reliably applied.'" *Govan v. Brown*, 228 A.3d 142, 155 (D.C. 2020) (quoting *Motorola*, 147 A.3d at 755, 757). Critically, trial courts are "not required to admit opinion evidence that is connected to the existing data only by the *ipse dixit* of the expert." *Russell v. Call/D, LLC*, 122 A.3d 860 (D.C. 2015) (quoting *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 157 (1999)).

Rule 702 imposes an affirmative burden on the proponent of expert testimony to demonstrate to the trial court that the testimony is reliable, and thus admissible. *See* Rule 702. Ultimately, the trial court's ruling on the admissibility of expert testimony is reviewed under the deferential abuse of discretion standard. *Russell*, 122 A.3d at 867. Under this standard, "the trial court's decision will be 'sustained unless it is manifestly erroneous.'" *Russell,* 122 A.3d at 867 (citations omitted).

This Court reviews a trial court's summary judgment rulings *de novo*. *Flagstar Bank v. Advanced Fin. Invs., LLC*, 333 A.3d 851, 857 (D.C. 2025). "Summary judgment should be granted in favor of a moving party when there is 'no genuine issue of material fact' so that the moving party is 'entitled to judgment as a matter of law.'" *Id*. at 858 (cleaned up). A dispute is "genuine" only if "the evidence is such that a reasonable jury could return a verdict for the non-moving party." *Baker v. Chrissy Condo. Ass'n*, 251 A.3d 301, 305 (D.C. 2021).

II. The trial court correctly granted summary judgment on the claim for medical negligence because the doctrine of *res ipsa loquitur* cannot reliably be applied to the complex medical circumstances of this case.

The central issue in this appeal is whether the doctrine of *res ipsa loquitur* can reliably be applied to the complex medical circumstances of this case. Specifically, whether negligence can reliably be inferred from the fact that Mr. Pearson – who was "actively dying" less than a month into this hospitalization, and whose providers thus urged (in vain) should be transferred to comfort care – had a pressure injury that eventually progressed to Stage 4 by the time of his death.

As more fully explained below, *res ipsa loquitur* cannot reliably be applied under the complex medical circumstances of this case. The trial court thus soundly exercised its discretion in granting the motion to exclude the contrary opinions of the Plaintiff's experts, and correctly entered summary judgment in favor of MWHC on the claim of medical negligence. (A1167).

A. The doctrine of *res ipsa loquitur* cannot reliably be applied to the complex medical circumstances of this case, and the trial court soundly exercised its discretion by excluding the contrary opinions of Plaintiff's experts.

To prevail on a claim of medical negligence, "the plaintiff must prove [1] the applicable standard of care, [2] deviation from that standard of care and [3] a causal relationship between the deviation and the injury." *Travers v. District of Columbia*, 672 A.2d 566 (D.C. 1996). Expert testimony is usually required to establish each of these elements, "except where proof is so obvious as to lie within the ken of the average lay juror.'" *Derzavis v. Bepko*, 766 A.2d 514, 529 (D.C. 2000) (quoting *Washington v. Washington Hospital Center*, 579 A.2d 177, 181 (D.C. 1990)).

"The doctrine of res ipsa loquitur, *when applicable*, permits the jury to infer negligence *from the mere occurrence* of an accident [or adverse result, or injury]." *Quin v. George Washington University*, 407 A.2d 580, 583 (D.C. 1979) (emphasis added). However, it is axiomatic that, "[d]ue to the 'great variety of infections and complications which, despite all precautions and skill, sometimes follow accepted and standard medical treatment,' an inference of negligence cannot be based solely on the fact that an adverse result follows treatment." *Giordano*, 968 A.2d at 498 (quoting *Quin*, 407 A.2d at 583, in turn quoting *Quick*, 290 F.2d 360, 363-64). Accordingly, "res ipsa loquitur is not to be invoked lightly in any case, and *particularly* not where medical malpractice is claimed[.]" *Gubbins v. Hurson*, 885 A.2d 269, 282 (D.C. 2005) (emphasis added).

To support a reliable *res ipsa loquitur* inference, the plaintiff is required to prove that, under the facts of the given case, the injuries "(1) ordinarily do not occur in the absence of negligence, (2) are caused by an agency or instrumentality within the exclusive control of the defendant, and (3) are not due to any voluntary action or contribution on the part of the plaintiff." *Gubbins*, 885 A.2d at 282 (quoting *Quin*, 407 A.2d at 583). The first two requirements are the focus in this case.

While expert testimony is *necessary* to establish that an injury "ordinarily" would not have occurred without negligence, such testimony "is not always *sufficient* to entitle the plaintiff to invoke the doctrine." *Gubbins*, 885 A.2d at 282 (emphasis added). A trial court can reasonably conclude that such testimony is **not** sufficient to support a reliable *res ipsa loquitur* inference where the record "indicates a lack of consensus in the medical field as to the cause of [the injury] following [treatment], despite agreement that such [injury] is a rarity." *Quin*, 407 A.2d at 584. As this Court articulated in *Quin*, "we must be fair to the patient who has received a result which . . . ordinarily would not occur without negligence, and to the doctor if there is a result which could occur without negligence." *Id*. at 584. Accordingly, if the record supports "two equally plausible conclusions" as to cause of the injury, one of which is consistent with natural causes, the reliability of a *res ipsa loquitur* inference is undermined. *Id.* at "It would do violence to the concept to permit a jury to balance possibilities rather than probabilities." *Id*.

Even if the injury ordinarily would not have occurred absent negligence, the plaintiff still must introduce "evidence with sufficient probative force to support an inference that [the] injury was 'probably' caused by an instrumentality under defendant's exclusive control." *Id*. at 585. "[This] inference may flow automatically where a defendant is in complete control of a procedure which results in an injury, and he alone has the means of knowing what occurred." *Id*. But "when plaintiff relies on circumstantial evidence to establish causation as an element of res ipsa loquitur, the evidence must make plaintiff's theory reasonably probable, not merely possible, and more probable than any other theory based on the evidence." *Id*.

This Court's decisions in *Quin*, 407 A.2d 580 and *Gubbins*, 885 A.2d 269, are instructive as to the practical application of these requirements, as this Court held that a *res ipsa loquitur* inference could reliably be drawn under the circumstances presented in the latter case (*Gubbins*), but not the former (*Quin*).[5]

In *Quin*, hours after undergoing a splenectomy Quin "was found in a state of respiratory arrest" and "manifested signs of abdominal hemorrhaging." *Quin*, 407 A.2d at 581. An exploratory surgery identified an "open hole in the splenic vein" as the source of the bleeding, "although the vessel had been previously ligated at the

[5] Both decisions involved refusals to give a *res ipsa loquitur* instruction to the jury. This distinction in terms of posture does not obviate the instructive value. Indeed, whether a party is entitled to a jury instruction on a particular theory hinges on "'whether it is supported by evidence in the case.'" *Washington v. United States*, 111 A.3d 16, 23 (D.C. 2015) (cleaned up).

previous procedure." *Id*. at 581-82. The vein was religated but Quin continued to bleed and, despite treatment efforts, eventually "died of liver failure due to extensive blood loss resulting from abdominal hemorrhaging." *Id*. at 582.

At trial, Quin's wife produced two experts – Drs. Golkin and Barrick – who opined that the surgeons (Drs. Shorb and Knoll) improperly ligated major splenic vessels and the suture slipped off. *Id.* at 582. Both experts "opined that the injury would not have occurred if standard operating procedure had been followed," and "[n]either had ever heard of a spontaneous rupture of the splenic vein following a splenectomy." *Id*. at 582. Dr. Barrick (similar to Dr. Guerrero in the present case) "admitted that the splenectomy as described in the post-operative notes followed accepted procedures," yet "based on the injury he concluded that defendants deviated from the standard procedure by improperly ligating the vein." *Id*. at 584.

Conversely, Dr. Knoll's own position was that "a spontaneous rupture of the vein took place due to a weakened vessel wall," and Dr. Knoll, along with Dr. Shorb, referenced "medical journal articles on which they based their opinions that a spontaneous rupture could occur." *Id*. at 582. Ultimately, the trial court declined to instruct the jury on *res ipsa loquitur* observing, "while Mr. Quin's death may have been caused by profuse bleeding from the splenic vessel, the cause of that bleeding is not known inasmuch as there is conflicting evidence on that point." *Id*. at 585.

This Court affirmed the trial court's ruling in *Quin* for two reasons. First, in connection with the threshold requirement that Quin's injury "ordinarily" would not have occurred in the absence of negligence, this Court observed that the evidence "show[ed] two *equally plausible* conclusions were deducible, *i.e.*, the hole in the splenic vein arose from improper ligation by surgeons, or from natural causes (spontaneous rupture)." *Id*. at 584 (emphasis added). This Court distinguished that dynamic from a "mere dispute in the evidence," as to which "reasonable men may differ as to the 'balance of probabilities.'" *Id*. (quoting *Cho v. Kempler*, 177 Cal, pp. 2d 342 (1960)).[6] This Court reasoned, "it would do violence to the concept to permit a jury to balance possibilities rather than probabilities." *Id*. at 585.

Second, the required inference that Quin's injury was actually caused by an instrumentality under the exclusive control of Drs. Shorb and Knoll did not arise automatically given the evidence that it "could have resulted from natural causes." *Id*. at 585. Nor did circumstantial evidence make that inference "more probable than *any other theory* based on the evidence." *Id*. (emphasis added).

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[6] In *Cho,* Cho underwent eye surgery, after which "the left side of her face was crooked, paralyzed, numb; her left eye remained constantly open; she was subject to uncontrollable drooling." *Cho*, 177 Cal. App. 2d at 344. A second procedure revealed that the surgeon, "had completed severed [Cho's] facial nerve[.]" *Id*. at 345. The eye surgeon "admitted that he severed the nerve where it is encased in a bony cavity," and "[he] *gave no explanation for the transaction of the nerve with a rongeur in an area in which . . . severance was virtually impossible*." *Id*. at 346-47 (emphasis added).

In *Gubbins*, this Court reached the opposite conclusion. There, after a bladder surgery (performed by a Dr. Hurson) involving the administration of anesthesia via epidural catheter (by a Dr. Kim), Gubbins "experienced numbness and weakness in her legs, fell to the floor, and was unable to stand or walk." *Gubbins*, 885 A.2d at 274. An EMG revealed nerve damage to her spine, yet she "was unable to obtain an explanation of her nerve injury from her health care providers." *Id*.

At trial, Gubbins called two experts, Dr. Severino and Dr. Battle. Dr. Severino opined that the nerve injury was attributable to improper technique by Dr. Kim, citing the "incautious" size of the large initial dose, coupled with placing the catheter too close to the nerve root. *Id*. at 280. Dr. Battle opined that the nerve injury occurred either as a result of Dr. Hurson leaving Gubbins' legs extended under unrelieved stress for over two hours, or Dr. Kim's faulty technique. *Id*. at 280-81. Both experts "opined that the injury could not have occurred absent negligence in the operating room, when Gubbins was under the defendants' exclusive control." *Id*. at 281.

Dr. Hurson and Dr. Kim, "did not deny . . . that the nerve injury . . . ordinarily would not have occurred absent medical negligence of some kind in the operating room." *Id*. at 280. Ultimately, "no defense witness was able to explain how Gubbins was injured or to rule out negligence as the probable case." *Gubbins*, 885 A.2d at 281 (emphasis added). Nevertheless, the trial court in *Gubbins* refused to instruct the jury on the theory of *res ipsa loquitur*. *Id*. at 278-80. This Court reversed.

This Court acknowledged that, "[r]es ipsa loquitur is not to be invoked lightly in any case, and particularly not where medical malpractice is claimed," and that, "a trial court properly may refuse to instruct on *res ipsa loquitur* if it finds that 'two equally plausible conclusions' as to the presence or absence of negligence are deducible from the testimony *in toto*." *Gubbins*, 885 A.2d at 282-83 (quoting *Wash. Metro. Area Transit Auth. v. L'Enfant Plaza Props., Inc.*, 448 A.2d 864, 868 (D.C. 1982); citing *Quin*, 407 A.2d at 584).

However, the record "did not establish a lack of medical consensus on the question of whether Gubbins' nerve injury was most probably caused by negligence of some kind on the part of the physicians attending her in the operating room." *Id.* at 283. This Court observed the only attempt to articulate a non-negligent cause for Gubbins's nerve injury came from her treating neurologist (Dr. Anderson), and the theory was grounded in an admittedly rare "hypersensitivity" to medication that was wholly unsubstantiated by any facts specific to the case:

> It was a possibility . . . that was not independently substantiated; even though such hypersensitivity was admittedly rare, the defense produced no test results or other evidence that Gubbins in fact was unusually allergic or sensitive to the anesthetic used in her operation. In our view, the undeveloped evidence that Gubbins' nerve injury *could have been* an idiosyncratic, unpredictable and uncommon drug reaction fell short of rebutting the expert testimony that such an injury *ordinarily* does not occur in the absence of negligence. **In other words, no "equally plausible" alternative to negligence was shown**.

Gubbins, 885 A.2d at 283 (bold emphasis added).

As more fully explained below, the present case is **far** more analogous to *Quin* than it is to *Gubbins*. As in *Quin*, the record indicates a lack of medical consensus as to whether Mr. Pearson's pressure injury was caused by medical negligence, and that it is *at least* "equally plausible" that it resulted from natural causes.[7] *Quin*, 407 A.2d at 584. Moreover, Plaintiff did not demonstrate that her experts' theory as to the cause of Mr. Pearson's pressure injury (*i.e.*, medically negligent treatment) is "more probable than *any other theory* based on the evidence." *Id*. at 585.

This Court should thus affirm the trial court's assessment that *res ipsa loquitur* cannot reliably be applied to the medically complex circumstances of this case, and hold that the trial court soundly exercised its discretion in excluding the contrary opinions of Plaintiff's experts.

1. The record indicates a lack of medical consensus as to whether the pressure injury at issue was caused by negligence, and it is at least equally plausible that the injury resulted from natural causes.

Notwithstanding the opinions of the Plaintiff's experts that Mr. Pearson's Stage 4 pressure injury ordinarily would not have occurred in the absence of negligence (Appellant's Br. at 11, 13; A318; A347-48), the record indicates a lack of medical consensus on that point, and that it is *at least* equally plausible that the pressure injury resulted from natural causes.

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[7] MWHC submits that it is considerably *more plausible* that the pressure injury resulted from natural causes.

In contrast to *Gubbins*, where the only alternative explanation for the nerve injury involved a rare idiosyncratic condition without any factual basis in the record, Plaintiff's experts acknowledged that pressure injuries can be unavoidable due to numerous factors that are the same as or similar to circumstances present in this case. The record basis for the natural causes explanation in this case is comparable to, if not stronger than, the record basis of the natural causes explanation in *Quin*.

Specifically, Dr. Rodriguez acknowledged that skin breakdown can become unavoidable in terminally-ill patients with organ failure: "they go into organ failure," "the skin is an organ . . . it's one of those organs that are dying." (A350). Dr. Guerrero similarly acknowledged that pressure injuries can be unavoidable "when somebody is already dying," and "the body goes through a breakdown." (A312). At the time of his admission, and over the course of his hospitalization, Mr. Pearson experienced multiple organ failures implicating his heart, lungs, and brain, and was deemed to be "actively dying" less than a month into his hospitalization.

Dr. Guerrero also acknowledged that hemodynamic instability is a factor that contributes to rendering pressure injuries unavoidable, and that Mr. Pearson "went through several episodes of hemodynamic instability" over the course of his hospitalization. (A313). Mr. Pearson's medical records confirm he was repeatedly hypotensive (and persistently so in the days leading up to his death) and thus required vasopressor medication to maintain adequate blood pressure.

The above acknowledgements are consistent with literature published by the NPUAP – an organization specializing in pressure ulcers which both of Plaintiff's experts consider authoritative – following a 2010 multidisciplinary conference focused on the unavoidability of pressure ulcers. (A527). "The panelists unanimously voted that not all pressure ulcers are avoidable because there are patient situations where pressure cannot be relieved and perfusion cannot be improved." (A533). Significantly, contrary to the experts' testimony that "end of life" ulcers only arise within hours or days of death (A312, 350), the NPUAP literature observes, "patients with these wounds sometimes die in a matter of hours and *sometimes live for more than 6 weeks*." (A535) (emphasis added).

Consistent with Dr. Guerrero's testimony that hemodynamic instability contributes to the unavoidability of pressure injuries, the literature observes that "[t]he majority of the consensus conference focused on patient situations that change the ability of the body to reperfuse tissue." (A535). The literature also observes that medications used to maintain blood pressure can "constrict peripheral blood vessels, diminishing perfusion to the skin and other tissues under pressure." (*Id*.) Indeed, "[e]ven when blood pressure can be maintained at a relatively stable level, 82% of the panel agreed that local tissue perfusion can be so impaired that any amount of pressure is sufficient to cause an ulcer." (*Id*.).

The NPUAP literature concludes that "unavoidable pressure ulcers may develop in patients who [like Mr. Pearson] are hemodynamically unstable," or "terminally ill" (A539), and explains that "unavoidable pressure ulcers" are injuries that develop even despite proper treatment within the standard of care. (A533). Accordingly, given the acknowledgements of Plaintiff's experts that factors present in this case can contribute to pressure injuries being unavoidable, and the consistent conclusions in literature published by an organization which both experts view as authoritative, the record supports the conclusion that it is *at least* "equally plausible" that Mr. Pearson's pressure injury resulted from natural causes, as opposed to medical negligence. The trial court correctly concluded that a *res ipsa loquitur* inference cannot reliably be drawn under these circumstances.

In arguing otherwise, Plaintiff relies heavily on the assertion that Stage 4 pressure injuries are designated as "never events," by the Centers for Medicare and Medicaid Services,[8] which, she suggests, "signals a consensus in the medical field that such injuries should never occur given that they are preventable through the use of evidence-based guidelines." (Appellant's Br. at 11). This suggestion is misguided. First, the term "never event" is a misnomer, as it contemplates an event which is only "*usually* preventable – recognizing that some events are *not always avoidable, given the complexity of health care*[.]" (A804) (emphasis added).

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[8] The Plaintiff does not cite to any specific code provision.

Second, as the Ohio Court of Appeals recently observed in *Stuck v. Miami Valley Hosp.*, 141 N.E.3d 290, 99 (Ohio Ct. App. 2020), among the appellate courts that have considered "never events" in the context of medical negligence claims, "none appears to have concluded that that the occurrence of a 'never event' amounts to negligence per se or otherwise alters the proof that the plaintiff must present." *Id*. at 299. This Court should decline the Plaintiff's invitation to be the first, and should reject the notion that labelling a Stage 4 pressure ulcer as a "never event" somehow obviates the otherwise equally plausible (if not *more* plausible) conclusion that the pressure injury's progression to Stage 4 by the time of Mr. Pearson's death was the unfortunate, but unavoidable, result of natural causes.

Finally, this Court should reject Plaintiff's misplaced reliance on unpublished trial court decisions from another jurisdiction. (Appellant's Br. at 13-14) (citing *Rivera v. Jewish Home Life Care*, 2024 N.Y. Misc. LEXIS 13868, 10 (New York County, October 30, 2024); *McGuire v. Cold Spring Hills*, 2020 NY. Misc. LEXIS 2908, 12-13 (Queens County, May 21, 2020); *Rigney v. North Shore Univ. Hosp.*, 2013 N.Y. Misc. LEXIS 2130, 18 (Suffolk County, May 14, 2013)). Aside from broadly lacking any precedential value, the foreign unpublished decisions should be disregarded to the extent they are inconsistent with the District of Columbia's appropriately cautious caselaw jurisprudence on *res ipsa loquitur* in the context of medical negligence.

The unpublished trial-court decisions reflect an approach whereby a plaintiff is entitled to proceed under a theory of *res ipsa loquitur* unless a defendant presents "evidence to establish *as a matter of law* how [plaintiff] suffered [the] injuries." *Rivera*, 2024 N.Y. Misc. LEXIS 13868, at *10 (emphasis added). This conflicts with the District of Columbia's approach, which recognizes that (1) *res ipsa loquitur* "is not to be invoked lightly in any case, and particularly not where medical malpractice is claimed," and (2) trial courts can soundly conclude that a *res ipsa loquitur* inference cannot be reliably drawn where "'two equally plausible conclusions' as to the presence or absence of negligence are deducible," *Gubbins*, 885 A.2d at 282-83 (cleaned up). This Court should hold that a reliable *res ipsa loquitur* inference cannot be drawn in this case given the equally plausible conclusion that the injury resulted from natural causes, and Plaintiff's argument to the contrary should be rejected.

2. The record does not demonstrate that the Plaintiff's theory as to the cause of Mr. Pearson's pressure injury is both reasonably probable, and more probable than any other theory based on the evidence.

Even if the record did not reflect a lack of medical consensus as to whether Mr. Pearson's pressure injury ordinarily would not have occurred in the absence of negligence, it would remain for Plaintiff to demonstrate that the injury was, in fact, caused by "an instrumentality under [MWHC's (or Kaiser's)] exclusive control." *Quin*, 407 A.2d at 585. That did not occur.

This case does not involve a situation where the defendants were in "complete control of a procedure which result[ed] in injury, and [they] alone [had] the means of knowing what occurred," so as to allow the instrumentality inference to be drawn "automatically" as "[f]orcing the plaintiff in such a situation to allege how and by what means his injury occurred . . . would do violence to the principle behind res ipsa loquitur." *Quin*, 407 A.2d at 585 (emphasis added; citing *Shields v. King*, 317 N.E.2d 922, 927 (Ohio Ct. App. 1973)).[9]

Rather, this case involves circumstances analogous to *Quin*. As in *Quin*, the record establishes that Mr. Pearson's pressure injury, at the very least, could have resulted from natural causes. *Quin*, 407 A.2d at 585. As in *Quin,* Plaintiff has not demonstrated that the circumstantial evidence makes her expert's opinions to the contrary (*i.e.*, that the pressure injury was actually caused by medical negligence) "reasonably probable, not merely possible, and *more probable than any other theory based on the evidence*." *Id*. (emphasis added). Indeed, for the reasons in the preceding section (Section II.A.1), and the interventions and treatments reflected in the medical records (*supra* at 4-7), the record demonstrates that it is more probable that Mr. Pearson's pressure injury resulted from natural causes. Plaintiff's argument to the contrary should be rejected. (Appellant's Br. at 16).

[9] In *Shields*, the decedent was receiving hemodialysis treatments twice a week for kidney disease and, during a treatment in which he received his own blood, he went into shock and died within 30 minutes. *Shields*, 317 N.E.2d at 79.

3. The trial court soundly exercised its discretion in excluding the opinions of Plaintiff's experts sounding in *res ipsa loquitur*.

For the reasons set forth in the above sections (Section II.1-2), the trial court correctly found a *res ipsa loquitur* inference cannot reliably be drawn under the medically complex circumstances of this case. This Court should therefore hold that the trial court soundly exercised its discretion in excluding the contrary causation opinions of the Plaintiff's experts – *i.e.*, that Mr. Pearson's State 4 pressure injury could not have occurred in the absence of, and thus must have been caused by, medical negligence.

B. The trial court correctly entered summary judgment in favor of MWHC on the claim of medical negligence.

As indicated at the outset, to prevail on a claim of medical negligence, the plaintiff must prove (1) the applicable standard of care; (2) a deviation from that standard; *and* (3) a causal relationship between the deviation and the injury. *Travers*, 672 A.2d at 568. While *res ipsa loquitur*, in an appropriate case, "permits the jury to infer negligence *from the mere occurrence* of an [injury]," *Quin*, 407 A.2d at 583, this is not such a case. *See infra* Section II.A. Accordingly, expert testimony was necessary to establish each of the above elements of medical negligence. *Berkow v. Hayes*, 841 A.2d 776, 779-80 (D.C. 2004). Because the trial court soundly exercised its discretion in excluding the causation opinions of Plaintiff's experts, MWHC was entitled to summary judgment.

In arguing to the contrary, Plaintiff relies on *Bell v. Taplin*, 2019 D.C. Super. LEXIS 204 (June 6, 201), as support for the assertion that "the trial court erred in denying Plaintiffs the right to pursue a *res ipsa loquitur* argument at the summary judgment stage," and "refus[ing] to permit Plaintiffs from fully placing on the record during the hearing a sufficient factual predicate for the application of the doctrine." (Appellant's Br. at 18). This reasoning is unavailing, and should be rejected.[10]

First, as Plaintiff observes, any "factual foundation" for Plaintiff's position was set forth "in Plaintiffs' oppositional filings" (Appellants' Br. at 18), which were obviously already before the trial court at the time of the motions hearing. Second, during the hearing, the trial court advised Plaintiff's Counsel, "I want to get it right. And it's important for both sides. And I want you to be heard." (Tr.34-35). Third, after going beyond the initially scheduled hearing time, the court indicated it had to adjourn to accommodate a previously scheduled trial, but confirmed that it would afford the Plaintiff an opportunity to express objections to the ruling in writing before the trial court made a final decision. (Tr.60). The Plaintiff availed herself of that opportunity. (A1124). Plaintiff's complaint that she was denied the opportunity to make a record as to her experts' opinions grounded in *res ipsa loquitur* should be rejected.

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[10] It bears noting the alleged injury in *Bell* was such that expert testimony was not necessary to establish a *prima facie* claim, as the plaintiff alleged that the defendant "negligently *spilled* a toxic solution onto her." *Bell*, at *12-13.

To the extent Plaintiff argues that her experts otherwise proffered reliable opinions as to the cause of Mr. Pearson's Stage 4 pressure injury independent from *res ipsa loquitur*, sufficient to proceed on a traditional theory of medical negligence, that position should be rejected.

In articulating his opinion that the Stage 4 pressure injury was caused by negligence, Dr. Guerrero purported to discount Mr. Pearson's medical records, but he did so entirely on the basis of circular logic grounded in *res ipsa loquitur*. Essentially, Dr. Guerrero testified (1) Mr. Pearson's Stage 4 pressure injury could not have occurred without medical negligence, and *therefore*, (2) medical records indicating that Mr. Pearson received treatment consistent with the standard of care must be disregarded. Dr. Guerrero did not articulate any basis for discounting the medical records, either in his expert report or at deposition, other than the fact they conflicted with his *res ipsa loquitur* causation opinion.

Dr. Rodriguez identified various examples of what she opined were breaches in the standard of care, most of which related to perceived inaccuracy/inconsistency in terms of documentation. However, she did not articulate, either in her report or at deposition, an opinion to a reasonable degree of medical certainty that any particular related act or omission was a proximate cause of the Stage 4 pressure injury, other than to say that the injury could not have occurred in the absence of negligence; *i.e.*, *res ipsa loquitur*.

In terms of the perceived documentation issues Dr. Rodriguez identified the manner in which those points are set forth in Plaintiff's brief calls for clarification. (Appellant's Br. at 30-31). As to the suggestion that "prevention strategies" were not implemented until Mr. Pearson was at risk for friction and shearing based on his Braden score on September 23, 2019 (A64-65), his medical records reflect that various interventions were already in place at that time (*supra* at 4), even if they did not include each and every example of interventions that "can be" used. (A64).

Plaintiff also references Dr. Rodriguez's position that providers did not adhere to the plan of care in place from October 4 to December 24, in terms of repositioning Mr. Pearson every two hours, because "medical records state that [he] was shifting his position independently," and thus, the argument goes, "medical personnel were not actually performing the directed repositioning function." (Appellant's Br. at 30) (A64). Even accepting, *arguendo*, that it is a breach of the standard of care not to reposition a patient who is shifting independently, the only two instances identified were early in the hospitalization, on October 4 and October 6. (A64). Dr. Rodriguez did not hazard an opinion as to how those two events constitute a proximate cause of the Stage 4 pressure injury.

Plaintiff also references Dr. Rodriguez's position that providers failed to "accurately maintain Mr. Pearson's wound documentation," based on what she characterized as "inconsistent" Braden scoring. (Appellant's Br. at 30). The specific

examples of "inconsistency" include Braden scores of 18 & 20 on September 22; scores of 16 & 18 on September 23; and a score of 13 on September 27. (A65). As the trial court astutely observed, "she's saying it's inconsistent," "but his condition was unstable and inconsistent." (Tr.40-41).[11] But even accepting, *arguendo*, that "inconsistent" Braden scores on September 22, 23, and 27 constitute a breach of the standard of care, Dr. Rodriguez did not articulate an opinion to a reasonable degree of medical certainty how these identified instances constitute a proximate cause of Mr. Pearson's Stage 4 pressure injury.

In addition to Dr. Rodriguez's position that some entries were "inconsistent," Plaintiff references her position that, "certain documentation appeared to be copy and pasted from previous entries, suggesting a lack of authenticity and accuracy[.]" (Appellant's Br. at 31). As the trial court astutely observed, "they can't win. Either they write the same documentation and . . . really didn't do it [or] to the extent that it's inconsistent . . . it's inaccurate because they have differing observations." (Tr.43). In any event, as with the other purported breaches discussed in Plaintiff's brief, Plaintiff does not point to any legally sufficient opinion offered as to the necessary causal link between these alleged breaches and the injury at issue.

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[11] As the report reflects, the Braden score is not a mathematical measurement, but rather, an aggregate metric comprised of various factors (e.g., level of mobility, level of moisture, sensory function, etc.) (A64-65), which will often require the provider to make discrete judgments.

Accordingly, because the trial court correctly found that *res ipsa loquitur* could not reliably be applied to the circumstances of this case, and thus soundly exercised its discretion by excluding the contrary opinions of Plaintiff's experts, Plaintiff's claim of medical negligence cannot prevail a matter of law. The trial court correctly entered summary judgment in favor in MWHC on that claim, and the judgment below should be affirmed.

III. The trial court correctly granted summary judgment on the claim for lack of informed consent which did not correspond to any specific procedure or treatment and was not supported by expert testimony.

The trial court also correctly granted MWHC's motion for summary judgment on the informed consent claim for two reasons. First, the Complaint did **not** allege any lack of informed consent with respect to any of the myriad medical procedures and treatments that Mr. Pearson received during his three-month hospitalization, but only with respect to the hospitalization itself. (A186). That is not a proper predicate for a claim of lack of informed consent.

A claim for lack of informed consent concerns "the duty of a physician to inform the patient of the consequences of *a proposed treatment*," and the scope of that duty is consistently defined in terms of "the nature of the condition, the nature of the proposed treatment, any alternate treatment procedures, and the nature and degree of risks and benefits inherent in undergoing and in abstaining from the *proposed treatment*.'" *Miller-McGee v. Wash. Hosp. Ctr.*, 920 A.2d 430 (D.C. 2007)

(emphasis added; quoting *Crain v. Allison*, 443 A.2d 558 (D.C. 1982)). Plaintiff's claim for lack of informed consent did not identify any "proposed treatment" at all, but only the hospitalization incidental to the treatments/procedures he was receiving. That is not a cognizable predicate for a claim for lack of informed consent.

In any event, Plaintiff's lack of informed consent claim fails as a matter of law because it is not supported by expert testimony. To prevail on a claim for lack of informed consent, "a plaintiff must prove [1] there was an undisclosed risk that was material; [2] that the risk materialized, injuring plaintiff, and [3] that plaintiff would not have consented to the procedure if [he] had been informed of the risk." *Hill v. Medlantic Health Care Group*, 933 A.2d 314, 329-30 (D.C. 2007) (quoting *Miller-McGee v. Washington Hosp. Ctr.*, 920 A.2d 430, 440 (D.C. 2007)).

Causation in this context is resolved on an objective basis, "in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance." *Canterbury v. Spence*, 464 F.2d 771, 791 (D.C. Cir. 1972)). To enable a jury to resolve that question, "expert testimony is 'required to establish the nature of the risks inherent in a particular treatment, the probabilities of therapeutic success, the frequency of the occurrence of particular risks, the nature of available alternatives to treatment and whether or not disclosure would be detrimental to a patient." *Miller-McGee*, 920 A.2d at 440 (quoting *Cleary v. Group Health Ass'n.*, 691 A.2d 148, 153-54 1997)).

Plaintiff argues that neither MWHC nor Kaiser informed Mr. Pearson that a long-term hospitalization posed a "risk of a fatal Stage IV hospital-acquired pressure injury, along with the associated risks of pain, infection, and disfigurement," and had he been informed of those risks, "he would have insisted that he be transferred to a skilled nursing facility that was fully prepared to properly treat and heal the injury before it advanced to its fatal state." (Appellant's Br. at 34). In other words, "he would have foregone the lengthy hospitalization and sought alternative treatment." (*Id*. at 35). The Plaintiff did not adduce the expert testimony necessary to prevail on a claim for lack of informed consent on this basis.

Specifically, Plaintiff did not adduce expert testimony regarding the varying "probabilities of therapeutic success" in terms of treating the pressure injury at a skilled nursing facility as opposed to MWHC or the Kaiser Unit, or indeed whether such variance even existed. Nor did Plaintiff adduce expert testimony to demonstrate that transfer to a skilled nursing facility to treat the pressure injury, or otherwise "forego[ing] the lengthy hospitalization," was a viable "alternative" given the dire state of Mr. Pearson's health, and the numerous comorbidities and complications that prompted repeated transfers to MWHC's MICU. Absent expert testimony on these points, a juror would have no meaningful basis for resolving "what a prudent person in the patient's position would have decided [in terms of transfer] if suitably informed of all perils bearing significance." *Canterbury*, 464 F.2d at 791.

In her appellate brief, the Plaintiff suggests that Dr. Rodriguez was prevented from giving an opinion relevant to this claim during deposition, because "Defendants' counsel discontinued the line of questioning so the opinion could not be provided on the record." (Appellant's Br. at 34-35) (citing A943). This suggestion calls for significant clarification.

First, Dr. Rodriguez did not include any opinions bearing on the claim for lack of informed consent in her expert report. (A63-68). Second, the "line of questioning" was one which asked Dr. Rodriguez if she saw "any other notes in the chart regarding meetings with hospice," other than in the days leading up to his death. (A943). She replied, "I did not," but then indicated that she did see that Mr. Pearson "was referred to a subacute rehab at the beginning of his – during his admission time." (A943). The reference to "subacute rehab" was unresponsive and, to the extent counsel "discontinued" the line of questioning, it had nothing to do with informed consent in the first place. Nor did the Plaintiff move to supplement Dr. Rodriguz's report to incorporate any related opinion.

Accordingly, because the Plaintiff failed to adduce the expert testimony necessary to prevail on the claim for lack of informed consent, the trial court correctly entered summary judgment in favor of MWHC as to that count, and the judgment should therefore be affirmed.

IV. The trial court correctly rejected Plaintiff's effort to invoke the theory of apparent/ostensible agency liability in this medical malpractice case.

Finally, the trial court correctly entered summary judgment in favor of MWHC, as to "[a]ll claims seeking to impose liability on MWHC under a theory of apparent or ostensible agency" (A1170-71) – *i.e.*, any claims seeking to hold MWHC liable for the alleged medical negligence of non-MWHC healthcare providers.

First and foremost, apparent or ostensible agency is not a recognized theory of liability for medical negligence in the District of Columbia. Despite Plaintiff's suggestion that "it appears this Court has not made a determination on the issue of apparent or ostensible agency" (Appellant's Br. at 21), this Court has had opportunities to recognize apparent or ostensible agency in the context of a claim for medical malpractice but has not done so. *See Hill v. Medlantic Health Care Group*, 933 A.2d 314, 331 n.17 (D.C. 2007); *Street v. Washington Hospital Center*, 558 A.2d 690, 692-93 (D.C. 1989). Other jurisdictions, such as Virginia, have declined to adopt the theory of apparent/ostensible agency liability in the medical malpractice context, given the complex employment relationships typically involved. *Sanchez v. Medicorp Health System*, 618 S.E.2d 331, 335-36 (Va. 2005). The Plaintiff does not grapple with the threshold issue of whether this Court should recognize apparent or ostensible agency liability in the context of a medical negligence claim – something that this Court heretofore has not done.

Second, even if the District of Columbia did recognize apparent or ostensible agency liability in the context of a medical malpractice claim, Plaintiff's invocation of that theory would still fail as a matter of law under the facts of this case. Specifically, liability under a theory of apparent agency attaches if, but only if, one "represents that another is his [or her] servant or other agent and *thereby causes* a third person [*i.e.*, the plaintiff] justifiably to rely upon the care or skill of such apparent agent[.]" *Street*, 558 A.2d at 692 (emphasis added; quoting Restatement (Second) Agency, § 267 (1958)).

There is insufficient evidence to support a claim that MWHC ever represented to Mr. Pearson that the Kaiser physicians or other non-MWHC providers were MWHC's agents, *or* that such representation *thereby caused* him to rely upon the care or skill of such providers. Mrs. Pearson testified that Mr. Pearson chose MWHC based on its proximity to the Kaiser Facility (A654) – not due to any representation by MWHC.

Accordingly, even if the District of Columbia did recognize the theory of apparent/ostensible agency liability in the context of medical negligence claims, the Plaintiff did not adduce evidence sufficient to support its invocation in this case. The trial court's entry of summary judgment in favor of MWHC in this regard should therefore also be affirmed.

CONCLUSION

For these reasons, the Hospital asks the Court to affirm the trial court's grant of the motion to exclude the testimony of Plaintiff's experts, and the trial court's grant of the motion for summary judgment in favor of MWHC as to all claims.

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Respectfully submitted,

/s/ *Jared M. Green*

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CERTIFICATE OF SERVICE

I CERTIFY that, on this 30th day of July 2025, a copy of the Appellees' Brief was electronically filed and served via the Court's electronic filing system upon:

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