IN THE DISTRICT OF COLUMBIA COURT OF APPEALS

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

MICHAEL A. SARACO

Appellant

v.

MEDSTAR-GEORGETOWN MEDICAL CENTER, INC.

Appellee

On Appeal from the Superior Court for the District of Columbia
(The Honorable Ebony M. Scott)
Case No. 2020 CA 004379 M

BRIEF OF APPELLEE

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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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By consent Praecipe filed with the Superior Court, the parties dismissed Defendant MedStar-Georgetown University Hospital. Thus, the only appellee in this appeal is Medstar-Georgetown Medical Center, Inc.

While this action was proceeding before the trial court, and initially on appeal, Defendant/Appellee MedStar-Georgetown University Hospital was also represented by Carrie J. Williams, Esquire. By Order dated January 22, 2025, this Court granted a consent motion to withdraw the appearance of Ms. Williams. Other than Ms. Williams and the counsel listed above, counsel for Medstar-Georgetown Medical Center, Inc. and Medstar-Georgetown University Hospital 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: February 18, 2024

Respectfully submitted,

/s/ *Sean L. Gugerty*

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RULE 28(a)(2) CORPORATE DISCLOSURE STATEMENT

Medstar-Georgetown Medical Center, Inc. is a not-for-profit corporation with no corporate subsidiaries. It is wholly owned by MedStar Health, Inc. *See* D.C. Court of Appeals Rule 28(a)(2)(B).

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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. Whether the trial court was within its discretion to preclude Dr. Brian Holmes' opinion as to the standard of care for performing the laminectomy, when Dr. Holmes failed to articulate a measurable standard of care, and failed to give a proper foundation for his opinion.
2. Whether the trial court was within its discretion to Dr. Holmes' opinions as to the standard of care for a post-operative MRI and how the Hospital's surgeon breached that standard, when Dr. Holmes failed to say when the post-operative MRI needed to be performed and failed to give a proper foundation for his MRI opinions.
3. Whether the trial court was legally correct to grant summary judgment based upon its preclusion of Dr. Holmes' standard of care opinions.
4. Whether the trial court was within its discretion to deny Mr. Saraco's motion for reconsideration.

STATEMENT OF THE CASE

Plaintiff/Appellee Michael A. Saraco ("Mr. Saraco") filed a medical malpractice action against Defendant/Appellee Medstar-Georgetown Medical Center, Inc. (the "Hospital") and MedStar-Georgetown University Hospital. (App. 14-19.)[1] By consent Praecipe filed with the Superior Court, the parties dismissed MedStar-Georgetown University Hospital, a trade name, leaving the Hospital as the only defendant. (App. 30.) The trial court granted the Hospital's motion to exclude the testimony of Mr. Saraco's sole medical expert, Dr. Brian Holmes, and for summary judgment. (App. 31-44.) Mr. Saraco timely noticed an appeal to this Court and simultaneously moved for reconsideration before the trial court. The trial court denied Mr. Saraco's motion for reconsideration. (App. 45-57.) Mr. Saraco timely noticed an appeal from denial of his motion for reconsideration. By Order dated July 24, 2024, this Court consolidated the appeals.

RELEVANT FACTS

A. Relevant Medical History

On April 24, 2017, Mr. Saraco was on duty as a police officer and was pushing a stalled car when he developed constant "10 out of 10" pain radiating from his back down to his legs. (App. 32, 204-206; Hosp. App. 03, ¶ 1.)[2] An MRI

[1] "App." is Mr. Saraco's Appendix.

[2] "Hosp. App." is the Hospital's Appendix, which contains materials the Hospital asked Mr. Saraco to include in his appendix, but which Mr. Saraco did not include.

on May 5, 2017 found an injury to his lumbar spine.[3] (App. 32, 190-91; Hosp. App. 03, ¶ 2.) The primary impression was "degenerative facet changes[4] and epidural lipomatosis[5] at L4-5 causing severe spinal canal stenosis[6] with compression of the thecal sac[7] and bilateral neural foraminal narrowing.[8]" (App. 32, 190-91.) Other findings included "moderate facet and ligamentum flavum[9] hypertrophy[10]" at the L4-5 level. (App. 32, 190-91.)

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[3] The lumbar spine is the lower portion of the spinal column consisting of five vertebrae identified as L1 through L5. Cleveland Clinic, "Lumbar Spine," available at https://my.clevelandclinic.org/ health/articles/22396-lumbar-spine.

[4] "Degenerative facet changes" refer to the gradual deterioration of facets, which are the joints that connect the spinal bones. UC Health, "Facet joint syndrome," available at https://www.uchealth.org/diseases-conditions/facet-joint-syndrome.

[5] "Epidural lipomatosis" is a congenital condition where excess fat tissue accumulates in the epidural space – the area between the spinal cord and the spinal column. Cedars Sinai, "Epidural Lipomatosis," available at https://www.cedars-sinai.org/health-library/diseases-and-conditions/e/epidural-lipomatosis.html.

[6] "Lumbar spinal stenosis" is a condition in which the spinal canal in the lumbar region becomes narrowed, putting pressure on the nerves that exit the spinal cord. Cleveland Clinic, "Lumbar Spine," *supra*.

[7] The "thecal sac" also known as the "dural sac", is a fibrous membrane that surrounds and protects the spinal cord and nerve roots. Merriam-Webster Medical Dictionary, "Thecal Sac," available at https://www.merriam-webster.com/medical /thecal%20sac.

[8] A "neural foramen" is an opening in the spine that allows spinal nerves to exit and connect to the rest of the body. Cleveland Clinic, "Lumbar Spine," *supra*.

[9] "Ligamentum flavum" are ligaments that cover and protect a spinal cord from behind. Cleveland Clinic, "Lumbar Spine," *supra*.

[10] "Hypertrophy" refers to "thickening" or "increase in bulk" of a body part. Merriam-Webster Medical Dictionary, "Hypertrophy," available at https://www.merriam-webster.com/dictionary/hypertrophy#medicalDictionary.

On May 15, 2017, Mr. Saraco consulted neurosurgeon Dr. Vikram Nayar,[11] an employee of the Hospital. (App. 32, 204-206; Hosp. App. 03, ¶ 3.) After reviewing imaging and assessing the patient, Dr. Nayar opined that Mr. Saraco "would benefit from decompressive L4-5 laminectomies."[12] (App. 205.) Dr. Nayar explained the risks of the procedure to Mr. Saraco, including the potential for persistent back or leg pain. *Id.* Dr. Nayar also advised that the surgery might be more effective at relieving Mr. Saraco's leg pain than his back pain. *Id.* Mr. Saraco elected to undergo the surgery. *Id.*

On July 19, 2017, Mr. Saraco underwent a laminectomy at the Hospital, performed by Dr. Nayar. (App. 32, 192-93; Hosp. App. 03, ¶ 4.) In his surgical note, Dr. Nayar described removing lamina at the L4-L5 level and resecting the hypertrophic ligamentum flavum to "completely decompress the nerve roots." (App. 193.) During the surgery, an unintended tear in the dura (the membrane that encases the spinal cord) occurred, and was immediately recognized and repaired. (App. 32, 193; Hosp. App. 03, ¶ 4.)

Two weeks after his surgery, on August 3, 2017, Mr. Saraco was discharged from the Hospital. (App. 32, 194-203; Hosp. App. 04, ¶ 5.) Mr. Saraco then

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[11] Mr. Saraco misspells Dr. Nayar's name as "Nayer" throughout his brief.

[12] "Lamina" are "bony arches of the spinal canal." Cleveland Clinic, "Lumbar Spine," *supra*. A laminectomy is a surgical procedure to remove lamina, as well as bone and thickened ligament if needed. *Id.*

completed inpatient physical rehabilitation at a different facility and was discharged home on August 11, 2017. (App. 32, 258-67; Hosp. App. 04, ¶ 5.) At time of discharge from the rehabilitation facility Mr. Saraco reported pain at 8 out of 10. (App. 264.)

On August 18, 2017, Mr. Saraco "went to three outpatient medical appointments with different doctors, including Dr. Nayar." (App. 32; Hosp. App. 04, ¶ 6.) Mr. Saraco "advised each doctor of an improvement in his condition, compared to his pre-operative benchmark, and each doctor in turn recorded such improvements in their visit notes." *Id.* In the first visit, at a clinic for D.C. police and firefighters, Dr. John Reilly noted that Mr. Saraco was "doing much better" but reported some "sciatic like pain" partially relieved by medications. (App. 213; Hosp. App. 04, ¶ 6.) Later that day, when Mr. Saraco saw an internist at the Hospital, he "denie[d] low back pain." (App. 315-16; Hosp. App. 04, ¶ 6.) Finally, Dr. Nayar's note states that Mr. Saraco reported "close to 100% improvement in his preoperative pain."[13] (App. 32, 207-209; Hosp. App. 04, ¶ 6.)

[13] Mr. Saraco initially disputed whether Dr. Nayar's note in fact said "100% improvement," and claimed to be in possession of a different version of the note that stated ":00%" improvement in condition. (App. 33.) The Hospital responded that the note, which had been photocopied, was simply a distorted copy with a crease partly obstructing the "1" in the phrase "100% improvement." (Hosp. App. 04-05, ¶¶ 7-8.) Ultimately, Mr. Saraco abandoned his claim that the note stated ":00%" after a corporate designee of the Hospital testified in deposition that all versions of the note in the Hospital's electronic medical record stated "100% improvement." (App. 33, 42, 374.)

Dr. Nayar also recorded in his note that Mr. Saraco had "done well since surgery" and had a normal gait and good strength in his lower extremities. *Id.*

On November 17, 2017, Mr. Saraco saw Dr. Nayar for a second post-operative visit. (App. 33, 210-11; Hosp. App. 05, ¶ 9.) Mr. Saraco reported "about 50% improvement" from his preoperative pain level. *Id.* Dr. Nayar recorded that Mr. Saraco's radiating leg pain "had essentially resolved," although he had some lingering back pain and paresthetica. *Id.*

On November 30, 2017, Mr. Saraco started treatment with pain management physician Dr. Matthew Maxwell. (App. 33; Hosp. App. 06, ¶ 11, Hosp. App. 27.) Mr. Saraco also continued to attend outpatient physical therapy through February 14, 2018. He reported leg and back pain, but the pain was gradually improving and he was meeting therapy goals. (App. 33; Hosp. App. 05, ¶ 10, Hosp. App. 18-25.) On February 19, 2018, Mr. Saraco stopped physical therapy in order to undergo a urethral reconstruction surgery, unrelated to the injuries alleged in this case. *Id.*

Under treatment with Dr. Maxwell, Mr. Saraco's had a "substantial improvement" and "significant relief" from his pain, and he was "relatively stable" for over a year. (App. 33; Hosp. App. 06, ¶ 12-13, Hosp. App. 42-43, 45, 48.) Then, on August 12, 2019, Mr. Saraco returned to Dr. Maxwell reporting a "severe acute worsening" of the pain in his back, which eventually spread to his thighs. (App. 33; Hosp. App. 48-51.) On September 9, 2019, Mr. Saraco underwent an

MRI which showed a new disc protrusion into the spinal canal. (App. 33-34; Hosp. App. 56-58.) Mr. Saraco subsequently underwent a surgery to remove the protruding disc and replace it with a surgically implanted spacer. (App. 34; Hosp. App. 06, ¶ 15, Hosp. App. 59-67.) Following that second surgery, Mr. Saraco reported some improvement but with lingering pain. *Id.*

B. Mr. Saraco's Lawsuit and Expert Discovery

On October 16, 2020, Mr. Saraco filed his Complaint, alleging one count of medical negligence against the Hospital. (App. 14-17.) His primary allegation was that Dr. Nayar "negligently cut his dura and failed to properly perform the decompression laminectomy surgery." (App. 15, ¶ 2.)

1. Dr. Holmes' Initial Report

Mr. Saraco designated neurosurgeon Dr. Brian Holmes as his sole medical expert as to the standard of care, breach, and causation. (App. 79-84.) In his report, Dr. Holmes made a sharp departure from Mr. Saraco's initial theory of the case, conceding that the dural tear "was not" a breach of the standard of care. (App. 83.) Instead, Dr. Holmes raised two new standard of care opinions.

First, he asserted that "[t]he national standard of care" for a laminectomy "is that a neurosurgeon removes the hypertrophic (overgrown) bone and ligament and other soft tissue to achieve the goal of decompression of the dural sleeve and exiting nerve roots . . . ." (App. 82.) Dr. Holmes opined that Dr. Nayar breached

that standard by not removing enough overgrown bone, ligament, and tissue during Mr. Saraco's July 19, 2017 laminectomy. *Id.*

Second, Dr. Holmes asserted that "the national standard of care requires a neurosurgeon to order imaging" when a patient experiences significant post-operative pain, and that Dr. Nayar breached the standard of care by not ordering an MRI as of the first post-operative visit on August 18, 2017. (App. 82.)[14]

Dr. Holmes asserted that he was board-certified in neurosurgery, and that in his 25-year career "had significant clinical experience" in that field, including in the performance of lumbar laminectomies and other spinal surgeries. (App. 80.) He also described regular attendance at national neurosurgery conferences, and regular review of neurosurgical journals. *Id.* Notably, Dr. Holmes did not describe how his discussions at conferences or review of literature informed his opinions.

2. Dr. Holmes' Deposition

At deposition, Dr. Holmes abandoned his initial opinion that the national standard of care always requires a neurosurgeon to remove all potentially compressive bone and tissue during a laminectomy. He acknowledged that, in his own practice, he has had "occasions after performing a laminectomy with decompression that [he] later found out there was residual bone or tissue still

[14] The report erroneously states that the first post-operative visit was on "8/8/17." *Id.* However, it is undisputed that the visit was on August 18, 2017. (Mr. Saraco Br. at 10-11.)

compressing the site." (App. 110.) And he conceded that a surgeon performing a laminectomy *can* exercise surgical judgment to leave residual bone or tissue within the surgical field, end the surgery without achieving the ideal goal of total decompression, and still "not be negligent[:]"

> Q. Doctor, you've already told me that there have been instances in your career where you had performed decompressive laminectomies where there was, at the end of the day, inadequate decompression because of residual bone or tissue, and those instances were not the result of negligence on your part, simply surgical judgment that turned out maybe not to be completely right?
> . . .
> A. Again, it's difficult for me to separate the two. But yes, you are saying if one doesn't achieve the goals of surgery that one sets out, does that automatically constitute negligence? It does not.
> . . .
> Q. And you [Dr. Holmes] were not negligent in those situations; right? It was something that you used your surgical judgment, and your surgical judgment simply wasn't correct in the sense that there was additional decompression necessary, right?
>
> A. And I can't recall specific cases. I'm just saying, in general, I can't say this never happened, but it would not be negligent in and of itself in every case.

(App. 38, 112-13.)

Dr. Holmes also addressed the sole piece of medical literature he had produced as of that date regarding performance of a laminectomy—a chapter from a 2003 medical textbook, Ciric, et al., "Lumbar Spinal Stenosis and Laminectomy," Ch. 149 in Batjer and Loftus, TEXTBOOK OF NEUROLOGICAL SURGERY, Vol. 2 (2003) (hereinafter "Batjer textbook chapter"). (App. 158-66.) Dr. Holmes pointed to

statements in that chapter regarding extensive removal of facet bone and tissue during a laminectomy. (App. 127-29.)

The authors of the chapter, however, referred to this surgical approach only as "our technique," and did not assert that approach is widely followed nationally. (App. 164.) Likewise, while Dr. Holmes said he believed the Batjer textbook chapter and another article[15] were "reasonably reliable," he clarified that he was relying on them only as sources "representative of" his positions and "make some mention of the points that [he was] going to make." (App. 102-103.) Dr. Holmes also acknowledged that these sources were "not standalone, knock-down, drag-out sources that trump all others." (App. 102 (emphasis added).)[16]

Moreover, when questioned about the chapter, Dr. Holmes acknowledged that the extensive removal of facet bone and tissue described in the Batjer textbook chapter represented only "a surgeon's goal" during a laminectomy. (App. 128-29.) Dr. Holmes admitted that there were risks of removing too much bone or tissue, such that a surgeon had to make a "clinical judgment" as to how much to remove. *Id.*

[15] The other article, in the Journal of Neurosurgery: Spine (JNS: Spine), addressed return-to-work time after a laminectomy. (App. 104.) Dr. Holmes did not rely on that article for his opinions as to the standard of care or breach.

[16] Despite these clear statements by Dr. Holmes, Mr. Saraco baselessly asserted throughout his brief that Dr. Holmes declared the Batjer article to be "authoritative." (*Cf.* Mr. Saraco's Br. at 8, 8 n.12, 14, 22.)

Dr. Holmes also repudiated his initial opinions as to the post-operative MRI. He testified that, based upon Mr. Saraco's report to Dr. Nayar at the initial August 19, 2017 post-operative visit, an MRI "would not be indicated" at that time. (App. 120-21.) Dr. Holmes also agreed that the standard of care did not require Dr. Nayar to order an MRI as of the second (and final) post-operative visit on November 17, 2017. (App. 124-25.) Dr. Holmes instead asserted, vaguely, that an MRI would be required at some other unspecified time. *Id.*

C. Summary Judgment

1. Summary Judgment Briefing and Supplemental Materials Filed by Mr. Saraco

The Hospital moved to exclude Dr. Holmes' opinions as to the standard of care and causation and for summary judgment.[17] (Hosp. App. 01-17.) Mr. Saraco filed an opposition, including as an exhibit an undated affidavit signed by Dr. Holmes. (App. 99-100.) The Hospital then filed a reply. (Hosp. App. 68-78.)

In Dr. Holmes' affidavit, he cited to his initial opinion that, under the national standard of care, a surgeon is "required" to remove overgrown bone and tissue to "achieve the goal" of decompression and relieving pressure on nerves. (App. 99, ¶ 2.) But, in the very next paragraph, Dr. Holmes acknowledged that he

[17] The motion included a statement of undisputed material facts with supporting exhibits, in accord with D.C. Sup. Court Rule Civ. P. 56(b)(2)(A). (Hosp. App. 03-08.)

had abandoned that view at deposition. He conceded that a surgeon performing a laminectomy can appropriately rely on "surgical judgment" to leave some compressive bone or tissue depending on the "[s]urgical circumstances":

> As stated in my deposition, a neurosurgeon is not negligent, as a general matter, solely because a neurosurgeon leaves compressive bone/tissue in the operative field. Surgical circumstances may warrant[ ] the need to leave such bone/tissue in the field. However, a neurosurgeon is not always free of negligence by leaving nerve compressing bone/tissue simply as a matter of surgical judgment. . . .

(App. 99-100, ¶ 3 (emphasis added).)

In the same affidavit, Dr. Holmes also acknowledged his testimony at deposition that the standard of care did not require Dr. Nayar to order an MRI on either post-operative visit, including the second visit on November 17, 2017. (App. 100, ¶ 4, 125.) However, Dr. Holmes added a new opinion that as of November 17 "Dr Nayer [sic] was in the time period that a follow up MRI was required under the standard of care . . . ." *Id.* Dr. Holmes also opined for the first time that it was "a breach of the standard of care not to order a . . . MRI promptly after the second post-operative follow-up appointment of November 17, 2017." *Id.*

As a separate exhibit to the opposition, Mr. Saraco also submitted a Supplemental Rule 26 Disclosure. (App. 94-98.) The disclosure added a new statement that Dr. Holmes' opinions were based, in part, on "his regular attendance at national neurosurgery conference [sic] where consensus of the applicable standard of care for laminectomy procedures are reached and discussed." *Id.*

Finally, Mr. Saraco also attached to his opposition an article, Pluta, et al., Lumbar Facetectomy, Medscape (Dec. 23, 2018) (hereinafter, "Pluta article"). (App. 167-78.)[18] The Pluta article addressed lumbar facetectomies, which are surgical procedures focusing on decompression of nerve roots near the facet joint, sometimes performed "in conjunction with" a laminectomy. (App. 169-70.) Like the Batjer textbook chapter, the Pluta article addressed surgical technique, but did not purport to set forth a national standard of care even for facetectomies, much less for laminectomies performed in conjunction with facetectomies.

2. Summary Judgment Ruling

On August 18, 2023, the trial court issued an order granting the motion to exclude Dr. Holmes' testimony and entering summary judgment in favor of the Hospital. (App. 31-44.) The court held that Dr. Holmes had failed to articulate an admissible opinion on the standard of care for performance of the laminectomy:

> Dr. Holmes' testimony fails to articulate a national standard of care. In his Expert Report, Dr. Holmes states that his opinions were based on a, "review of Mr. Saraco's medical history and medical records; review of diagnostic imaging, physical examination of Mr. Saraco, review of discovery material, as well as upon [his] knowledge, skill, experience, training and education in the specialty of neurological surgery." . . . These skills, background, and record[s] alone are insufficient to establish a national standard of care. Indeed, experts must "establish that a particular course of treatment is followed *nationally* either through reference to a published standard, discussion of the described course of treatment with practitioners outside the

[18] A month after Dr. Holmes was deposed, Mr. Saraco's counsel sent an email advising that Dr. Holmes "may" rely on the Pluta article. (App. 167.)

> District at seminars or conventions, or through presentation of relevant data." *Hill v. Medlantic Health Care Group*, 933 A.2d 314, 325 (D.C. 2007) (internal citations omitted). Here, Dr. Holmes has not articulated the national standard of care through publication or presentation of relevant data regarding the standard procedure for laminectomy surgery and post-operative care. Dr. Holmes made no reference of conversations with other professionals at seminars or conventions, and simply fails to explain the national standard of care with the proper foundation. *See* Pl.'s Ex. 20, at ¶¶ 2-5.[19] Given this deficiency, the trier of fact cannot discern (without much conjecture) at what point Dr. Nayar's conduct deviated from reasonable surgical judgment to negligence, and [Dr. Holmes'] testimony shall therefore be excluded.

(App. 39-40.) The trial court also excluded Dr. Holmes' opinions on the standard of care and alleged breach regarding a post-operative MRI:

> Here, based on the entire record herein, there exists no genuine issue with respect to [Mr. Saraco's] pain level (which undergirds Dr. Holmes' opinions) during [Mr. Saraco's] visits with Dr. Nayar. While [Mr. Saraco] questions the August 18, 2017 note, it is undisputed that Dr Nayar reported 100% improvement in pain, which eliminates the possibility of breach considering no pain was reported to Dr. Nayar and thus Dr. Nayar had no factual basis to take further action such as ordering an MRI.
>
> Further, on this record, it is simply not clear whether Dr. Nayar beached the national standard of care by failing to order a postoperative MRI. Dr. Holmes conceded that not performing a postoperative MRI was not necessarily negligent but was negligent in this scenario because it was in the "window" in which an MRI should be ordered. *See* Def.'s Ex. 12, Holmes Dep. 114:12 – 115:14. Although Dr. Holmes opines that Dr. Nayar was negligent, there is no evidence in this record on when this window commences or terminates, how the "window" is determined and whether the "window" reflects the national standard of care. Dr. Holmes attempts

[19] Dr. Holmes' affidavit was Exhibit 20 to Plaintiff's opposition to the Hospital's motion to exclude and for summary judgment. (*See* App. 99-100.)

> to distinguish Dr. Nayar's conduct from the national standard, however he fails to establish the standard in the process. *See* Def.'s Ex. 12, Holmes Dep. 114:12 – 115:14, Pl.'s Ex. 20, ¶ 4. In addition to Dr. Holmes' testimony not outlining a timeframe in which Dr. Nayar should have acted, there is no basis through publication or reference to medical conferences for a trier of fact to find that Dr. Nayar breached the national standard of care.

(App. 42-43.)

D. Denial of Plaintiff's Motion for Reconsideration

Mr. Saraco thereafter moved for reconsideration, submitting along with his motion a second affidavit signed by Dr. Holmes. (App. 46-47.) The Hospital opposed the motion. (Hosp. App. 01-17.)

On June 14, 2024, the trial court denied the motion for reconsideration. (App. 45-57.) The court "agree[d] with [the Hospital] that the . . . Motion for Reconsideration seems to attempt to patch up the holes the [trial court] explicitly pointed out in Dr. Holmes' opinion in the [court's] August 18, 2023 Order, which is insufficient to grant a Motion for Reconsideration under Rule 59(e)." (App. 53.) Nonetheless, the trial court considered and addressed each of Mr. Saraco's arguments for reconsideration, rejecting them based on the same reasoning it had applied in its earlier summary judgment ruling. (App. 53-57.) The trial court also declined to consider new or additional statements in the second affidavit of Dr. Holmes, finding that Mr. Saraco had failed to show why he could not have raised those points at the summary judgment stage, in Dr. Holmes' initial affidavit. *Id.*

SUMMARY OF ARGUMENT

This Court has consistently held that an expert in a medical malpractice action must lay out what the standard of care requires, to give jurors a baseline measurement they can use to weigh whether the defendant committed a breach. Further, an expert must link his opinions to supporting national sources, such as literature or discussions at national conferences, and show *how* those sources support that the national standard of care is what the expert says it is.

Here, the trial court was well within its discretion to exclude Dr. Holmes' opinions—because he failed to meet those threshold requirements as to any of his standard of care opinions.

Dr. Holmes acknowledged that surgeons performing a laminectomy can, in some circumstances, make a judgment call to leave some overgrown bone and tissue. Yet he failed to explain what those circumstances were, when they might arise, or how to objectively determine when a doctor crosses the line from surgical judgment into negligence. Thus, the opinion fails to articulate a measurable standard of care—it fails to provide jurors with a yardstick they could use to objectively weigh whether Dr. Nayar's allegedly leaving some excess bone and tissue was negligent, as opposed to reflecting reasonable surgical judgment. Further, Dr. Holmes failed to adequately link his testimony to supporting national sources and show how those sources support him—leaving this Court with no

evidence, beyond Dr. Holmes' bare word, that the national standard of care matches Dr. Holmes' description of it.

Dr. Holmes' post-operative MRI opinions are also inadmissible, for similar reasons. While Dr. Holmes ultimately asserted that an MRI should have been ordered "promptly" after the second post-operative visit, court after court has found that "promptly" is context-dependent and does not mean "immediately." Thus, a juror could not determine from use of the word "promptly" when the national standard of care required Dr. Nayar to order an MRI. Further, Dr. Holmes simply did not say that any journals he reviewed or discussions at national conferences addressed post-operative care after a laminectomy—a fatal gap in the foundation for his MRI opinions. And even assuming *arguendo* that one of those sources might have addressed post-operative MRIs, Dr. Holmes once again failed to draw an adequate link and explain how sources he reviewed support his position that a post-operative MRI was mandatory.

As noted above, once the trial court had made the discretionary decision to exclude Dr. Holmes' opinions, it then entered summary judgment in favor of the Hospital. That grant of summary judgment was legally correct, because it is well-settled that Mr. Saraco required admissible expert support as to the standard of care to state a *prima facie* case for malpractice.

The trial court also appropriately denied Mr. Saraco's motion for reconsideration, rejecting arguments that he had previously raised and declining to consider a belated second affidavit for Dr. Holmes (a decision that even Mr. Saraco declined to challenge on appeal).

The trial court's rulings should be sustained.

ARGUMENT

I. Standard of review.

A separate standard of review applies to each of the trial court's key decisions: its exclusion of Dr. Holmes' opinions, grant of summary judgment, and denial of reconsideration.

The trial court's exclusion of Dr. Holmes' opinions is reviewed for an abuse of discretion. *Russell v. Call/D, LLC*, 122 A.3d 860, 867 (D.C. 2015); *see also Motorola Inc. v. Murray*, 147 A.3d 751, 755 (D.C. 2016) ("The abuse of discretion standard of review applies, regardless of whether the trial court decided to admit or exclude scientific evidence." (citations omitted)). Under an abuse of discretion review, "the trial court's decision will be 'sustained unless it is manifestly erroneous.'" *Russell,* 122 A.3d at 867 (citations omitted).

If this Court concludes that the trial court acted within its discretion and committed no manifest error in excluding Dr. Holmes' opinions, this Court should

then apply *de novo* review to decide if the exclusion of Mr. Saraco's sole expert warranted summary judgment. *Russell,* 122 A.3d at 873.

Lastly, the trial court's denial of Mr. Saraco's motion for reconsideration is reviewed for an abuse of discretion. *Dist. No. 1 -- Pac. Coast Dist., Marine Eng'rs' Ben. Ass'n v. Travelers Cas. & Sur. Co*., 782 A.2d 269, 278 (D.C. 2001). At the reconsideration stage, that discretion is especially broad. A trial court may decline to consider "new argument[s] and new facts" when the party moving for reconsideration has no justification for not presenting them earlier. *Id.* at 279.

II. The trial court correctly precluded Dr. Holmes' standard of care opinion as to the performance of the laminectomy.

A. Dr. Holmes failed to explain what the standard of care requires for a surgeon performing a laminectomy.

The trial court correctly found that Dr. Holmes failed to articulate a measurable national standard of care. (App. 39-40.) As described above, at deposition and in his signed affidavit, Dr. Holmes acknowledged that a surgeon performing a laminectomy can appropriately rely on "surgical judgment" to leave some compressive bone or tissue depending on the "[s]urgical circumstances." (App. 99-100, ¶ 3, App. 112-13.) Yet he never identified the circumstances when that would be appropriate, or those when it would not. Because of that omission, "the trier of fact cannot discern (without much conjecture) at what point Dr. Nayar's conduct deviated from reasonable surgical judgment to negligence." (App. 39-40.)

In his brief on appeal, Mr. Saraco failed to challenge this part of the trial court's ruling, and has thereby waived the point. Further, even if this Court reaches the merits, it is well-settled that an expert who fails to articulate a measurable standard of care should be excluded.

1. Mr. Saraco has waived any challenge to exclusion of Dr. Holmes' laminectomy opinion for failure to articulate the standard of care.

In his opening brief, Mr. Saraco did not contest the trial court's exclusion of the laminectomy opinion based on Dr. Holmes' failure to explain when incomplete removal of bone/tissue crosses the line from surgical judgment to negligence. Therefore, Mr. Saraco has waived the right to contest that point. *Gant v. Lynne Experience Ltd.*, 325 A.3d 407, 417 (D.C. 2024) (appellant who appealed from grant of summary judgment has "certainly has abandoned any particular points" that she failed to make in her opening brief). That, alone, is sufficient ground for this Court to sustain the trial court's exclusion of the opinion.

2. The trial court correctly analyzed Dr. Holmes' opinion as later modified in his sworn testimony and affidavit.

Further, the trial court was correct to evaluate Dr. Holmes' opinion as modified at deposition and in his signed affidavit. In *Allen v. District of Columbia*, 312 A.3d 207 (D.C. 2024), this Court addressed a grant of summary judgment in a purported class action. The plaintiff alleged that pre-addressed envelopes sent out by the District along with traffic tickets (to facilitate payment of the tickets) were

highly susceptible to being rejected by the U.S. Postal Service. *Id.* at 208. The plaintiff's expert "had to ultimately backtrack from his initial opinion that the pre-addressed envelope came pre-printed with an invalid IMB code," "abandoned that view[,]" and shifted to a new criticism in his supplemental report and deposition that the use of red-color ink on the envelopes led them to be rejected in the mail. *Id.* at 213. This Court held that the trial court appropriately considered the expert's opinions as modified during discovery, and correctly excluded the opinions and granted summary judgment because the new red-ink opinion was a "bare" and "conclusory" assertion, without any valid reasoning or supporting basis. *Id.*[20]

Applying the holding of *Allen* here, the trial court was well within its discretion to consider Dr. Holmes' opinions as modified during his deposition and the affidavit attached to Mr. Saraco's opposition to the summary judgment motion. Mr. Saraco evidently agrees, as he repeatedly referenced and relied upon that affidavit in his brief. (*See* Mr. Saraco Br. at 6 n.6, 8 n.11, 27 n.31, 29-31.)

3. Dr. Holmes' failure to articulate a standard of care is fatal under well-established law in this District.

Additionally, under well-established precedent, the trial court was well within its discretion to exclude Dr. Holmes' opinion due to his failure to explain when

[20] *See also Royal Ins. Co. of Am. v. Miles & Stockbridge, P.C.*, 138 F. Supp. 2d 695, 701 (D. Md. 2001) ("[S]ummary judgment is proper when a plaintiff's expert testifies at deposition that a defendant's conduct was not a breach of the standard of care, regardless of the expert's initial conclusions concerning certain conduct.").

leaving some bone or tissue during a laminectomy crosses the line from reasonable surgical judgment into negligence.

"In a medical malpractice case, the plaintiff has the burden of proving the applicable standard of care, a deviation from that standard by the defendant, and a causal relationship between that deviation and the plaintiff's injury." *Derzavis v. Bepko*, 766 A.2d 514, 519 (D.C. 2000). For cases involving surgical decisions that call for "the exercise of professional skill and judgment," it is well-settled that "expert testimony [is] required to make a *prima facie* showing" as to the standard of care and breach. *Id.* (citations omitted.) The "purpose of expert testimony [on the standard of care] is to avoid jury findings based on mere conjecture or speculation." *Nwaneri v. Sandidge*, 931 A.2d 466, 470 (D.C. 2007) (citations omitted).

In *Hawes v. Chua*, 769 A.2d 797 (D.C. 2001), this Court thoroughly analyzed existing precedent on the admissibility of expert evidence on the national standard of care, and concluded that "in this jurisdiction, at least seven legal principles are important in assessing the sufficiency of national standard of care proof." *Id.* at 806. The first principle is that "the standard of care focuses on '*the course of action* that a reasonably prudent doctor with the defendant's specialty would have taken under the same or similar circumstances.'" *Id.* (quoting *Meek v. Shepard*, 484 A.2d 579, 581 (D.C. 1984) (emphasis added).) Thus, a medical malpractice expert must, at a bare minimum, explain what course of action the standard of care requires for a given

procedure. *See id.; see also Nwaneri*, 931 A.2d at 470; *Strickland v. Pinder*, 899 A.2d 770, 773 (D.C. 2006); *Derzavis*, 766 A.2d at 520.

The rationale for that principle of law is straightforward. "[D]octors do not and cannot guarantee results, [and] the mistakes that a particular doctor makes are not actionable unless they cause the doctor's performance to fall below the applicable standard of care." *Meek*, 484 A.2d at 581. Thus, without an adequate explanation of what the standard of care required, the danger is that the jury may improperly speculate that the doctor is liable merely because the plaintiff experienced an unfortunate result.[21]

This Court has affirmed the exclusion of a plaintiff's expert who failed to explain *what*, specifically, the standard of care required a defendant to do. In *Derzavis v. Bepko*, 766 A.2d 514, this Court addressed criticisms of negligence for use of a "Cytobrush" tool during a routine Pap smear. *Id.* at 516. The Court held that "the only applicable standard of care that Ms. Derzavis' expert identified . . . was that a doctor should know how to use a Cytobrush correctly. . . but she never stated what that 'correct use' was." *Id.* at 520 (emphasis added). That testimony "was not sufficient to establish the applicable standard of care." *Id.*

[21] Indeed, the concept that physicians must be judged against the national standard of care and not merely an unfortunate result is so fundamental that it is embodied in a pattern jury instruction that "[a] doctor . . . is not negligent simply because [his] [her] efforts are not successful…."). Standard Civil Jury Instructions for D.C., § 9.06 (rev. ed. 2003); *see also Wild v. Alster*, 377 F. Supp. 2d 186, 190 (D.D.C. 2005).

Derzavis squarely applies to Dr. Holmes' laminectomy standard of care opinion. Dr. Holmes acknowledged that leaving some residual bone/tissue can be within the standard of care and non-negligent depending on the "surgical circumstances" (App. 99-100, ¶ 3), but never stated *what* those circumstances were. Thus, his testimony likewise "was not sufficient to establish the applicable standard of care[,]" and was properly excluded. *See Derzavis*, 766 A.2d at 520.

This Court's precedent from other types of tort actions also supports exclusion of Dr. Holmes' opinion. Indeed, Mr. Saraco has conceded that it is "settled" law that an expert must articulate a standard of care opinion "that is sufficient to allow a defendant's actions to be measured against." (Mr. Saraco Br. at 16 (citing *Sullivan v. AboveNet Communs., Inc.*, 112 A.3d 347, 357-58 (D.C. 2015).) To give a measurable opinion, "at the very least the expert must be specific as to what standards were violated and how they were violated." *Sullivan*, 112 A.3d at 358 (citing *District of Columbia v. Carmichael*, 577 A.2d 312, 314 (D.C. 1990)). Mere "'[g]eneralized references'" to national standards are insufficient[.]" *Id.* (citing *Briggs v. Wash. Metro. Area Transit Auth.*, 481 F.3d 839, 846 (D.C. Cir. 2007) (collecting other D.C. cases).) Because Dr. Holmes never explained how a jury could objectively determine when a surgeon performing a laminectomy crosses the line from permissible surgical judgment to negligence, he failed to set forth a measurable standard of care, as required by *Sullivan*, *Carmichael*, and *Briggs*.

4. Cases applying the *Daubert* standard further reinforce that Dr. Holmes' laminectomy standard of care opinion is inadmissible.

i. Under *Daubert*, courts apply gatekeeping scrutiny for whether an expert opinion is reliable and relevant.

In *Motorola Inc. v. Murray*, 147 A.3d 751 (2016), this Court adopted the standard for the admission of expert testimony established by Federal Rule of Evidence (FRE) 702 and *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993). The Court explained that expert testimony must be assessed using the "*Daubert* trilogy," as embodied in the versions of FRE 702 revised in 2000 and 2011. The Court recognized that "[e]xpert evidence can be both powerful and quite misleading because of [jurors'] difficulty in evaluating it" and requires appropriate scrutiny. *Motorola*, 147 A.3d at 754-55. For that reason, the trial court exercises a "robust gatekeeping function" with the "objective . . . to make certain that an expert . . . employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Id.* at 755 (internal citations omitted).

The primary focus is whether the expert testimony is sufficiently *reliable* to be admitted. *Motorola*, 147 A.3d at 754. The trial court must look primarily at the expert's reasoning and methodology. *Id.* (citing *Daubert*, 509 U.S. at 593-94). But "conclusions and methodology are not entirely distinct from one another," and a trial court can properly preclude "*ipse dixit*" opinions that display "too great an analytical gap between the data and the opinion proffered." *Id.* at 755 (citing *General Electric*

Co. v. Joiner, 522 U.S. 136, 146 (1997)). As stated in the commentary to FRE 702, "[t]he trial court's gatekeeping function requires more than simply taking the expert's word for it." FRE 702 Advisory Comm. Note 2000 (citations omitted).

Additionally, a trial court must ensure that the expert testimony is *relevant* to the issues in dispute. *Motorola*, 147 A.3d at 755 (citing *Daubert*, 509 U.S. at 597). The Supreme Court described this prong of the inquiry as one of "fit," *i.e.*, whether the proposed expert testimony fits the facts of the case and will be of assistance to the trier of fact. *Daubert*, 509 U.S. at 591. "Expert testimony which does not relate to any issue in the case is not relevant and, ergo, non-helpful." *Id.* (citations omitted); *see also Garlinger v. Hardee's Food Sys.*, 16 F. App'x 232 (4th Cir. 2001) (excluding expert testimony as not relevant under *Daubert*/FRE 702).

Importantly, under FRE 702, "[t]he proponent of the expert testimony bears the burden to establish the admissibility of the testimony" as sufficiently reliable and relevant. *United States v. McGill*, 815 F.3d 846, 903 (D.C. Cir. 2016).[22]

ii. A medical expert who fails to articulate a measurable standard of care is inadmissible under *Daubert*.

Applying FRE 702 and *Daubert*, courts have repeatedly held that when an expert in a medical malpractice case fails to articulate a measurable standard of care,

[22] *See also* FRE 702 Advisory Comm. Note 2023 (explaining that FRE 702 was revised "to clarify and emphasize that expert testimony may not be admitted unless the proponent demonstrates to the court that it is more likely than not that the proffered testimony meets the admissibility requirements set forth in the rule.").

his opinions are inadmissible. For example, in *Thomas v. Lewis*, 289 So. 3d 734 (Miss. 2019), the court affirmed the exclusion of plaintiff's sole neurosurgical expert—the same specialty as Dr. Holmes—"[b]ased on the deferential abuse-of-discretion standard of review and [the expert's] inability to articulate a specific standard of care." *Id.* at 741. Similarly, in *Rodriguez v. Hosp. San Cristobal, Inc.*, 91 F.4th 59 (1st Cir. 2024), the court affirmed the exclusion of a standard of care opinion as to performance of a pelvic surgery when the expert "identifie[d] no national standard of care against which those defendants' assertedly negligent acts or omissions could be measured by the trier of fact." *Id.* at 72. Other courts applying *Daubert* have held similarly.[23] Thus, Dr. Holmes' opinion is just as inadmissible under the newer FRE 702 standard as it is under this Court's pre-*Motorola* precedent.

B. Dr. Holmes failed to link his standard of care opinion on the laminectomy surgery to a legally permissible basis.

1. Mr. Saraco misstates the trial court's finding as to why the opinion lacked an adequate foundation.

The trial court also separately found that Dr. Holmes' laminectomy standard of care opinion is inadmissible for lack of an adequate foundation because he failed

[23] *See Nat'l Emergency Med. Servs. v. Smith*, 889 S.E.2d 162, 170 (Ga. Ct. App. 2023) (expert was inadmissible under *Daubert* when he "has not established that a recognized standard of care" required more of an emergency medical services defendant); *Rupert v. Tandias*, 843 N.W.2d 712, 2014 Wisc. App. LEXIS 55 at *4 & n.5 (Wis. Ct. App. 2014) (*per curiam*) (plaintiff's expert excluded under *Daubert* when he failed to articulate the standard of care that applied to a surgery).

to show that it is supported by national sources (*e.g.*, literature or discussions at national conferences). (App. 39.) On appeal, Mr. Saraco misstates the nature of that finding. Specifically, he incorrectly asserts that the trial court found that "Dr. Holmes did not provide sufficient details about his discussions at national conferences to support the basis of his knowledge of the applicable standard of care." (Mr. Saraco Br. at 19 (emphasis added).) Not so. Rather, the trial court acknowledged that Dr. Holmes had reviewed literature in his field and attended national conferences that addressed laminectomy surgery, but still found that his opinion was inadmissible because "Dr. Holmes does not tie or link these broad assertions to his standard of care opinion, and thus, is unable to establish a basis upon which to support his opinion." (App. 54-55 (emphasis added).)[24]

That finding is well-supported by the record. As noted above, Dr. Holmes stated in his report that he has "regularly attended national neurosurgery conferences

[24] Mr. Saraco also incorrectly asserts that the Hospital never challenged whether Dr. Holmes established a proper foundation for the national standard of care for performance of a laminectomy, and the trial court reached that result "*sua sponte*." (*Cf.* Mr. Saraco's Br. at 19 n.23.) It is true that the Hospital's initial motion focused on Dr. Holmes' MRI opinions—but only because it appeared to the Hospital that, given Dr. Holmes' concessions at deposition, Mr. Saraco was longer critical of how the laminectomy was performed. (Hosp. App. 07-08, ¶ 19.) When Mr. Saraco's opposition to that motion made clear that Dr. Holmes *would* still offer standard of care opinions as to performance of the laminectomy, the Hospital then challenged the foundation of those opinions in its reply brief. (Hosp. App. 68-73.) Moreover, even assuming *arguendo* that the trial court reached any portion of its ruling *sua sponte*, it was permitted to do so under D.C. Sup. Court Rule Civ. P. 56(f).

where spinal decompression surgery, including laminectomy procedures, were discussed and reviewed," and that he subscribed to and reviewed various neurosurgical journals. (App. 80.) Mr. Saraco later submitted a Supplemental Rule 26 Disclosure that added that Dr. Holmes had attended national conferences at which a "consensus" on the standard of care for laminectomies was discussed. (App. 94-95.) But, as the trial court correctly found, Mr. Saraco "still fails to demonstrate *how* Dr. Holmes' attendances at conferences or review of relevant literature supports or establishes his standard of care opinion." (App. 54 (emphasis added).)

Indeed, Dr. Holmes' report, deposition, summary judgment affidavit, and the supplemental disclosure all fail to describe *how* any of the discussions regarding laminectomy surgeries at national conferences informed Dr. Holmes' standard of care opinion. Thus, there is simply no evidence that other surgeons attending those national conferences also adhered to the remarkably vague standard set forth by Dr. Holmes: that a surgeon can at times leave some residual hypertrophic bone or tissue during a laminectomy based on surgical judgment, but at other times is required to remove *all* such bone/tissue. (App. 99-100, ¶ 3.)

Likewise, literature proffered by Mr. Saraco does not show that the nationally recognized medical standard is what Dr. Holmes said it was, for two reasons:

First, the literature does <u>not</u> set forth a broadly applicable, national standard of care for a laminectomy. Indeed, neither source even purports to do so. The Batjer

textbook chapter's authors refer to the extensive removal at the lumbar spinal facets only as "our technique." (App. 164.) And the Pluta article focuses narrowly on facetectomies without any discussion of other surgical considerations that may apply when a facetectomy is done in conjunction with a laminectomy. (App. 169-70.) Further, Dr. Holmes was explicit at deposition that the Batjer textbook chapter was only something "representative of" his opinions and was not an authoritative "standalone, knock-down, drag-out source[.]" (App. 102.) And Dr. Holmes said nothing at all about the Pluta article, which was produced via email from Mr. Saraco's counsel after Dr. Holmes' deposition. Thus, there is no evidentiary basis for this Court to find that either piece of literature reflects a uniform *national* standard of care that would apply to the procedure Dr. Nayar performed here.

Second, the literature offers nothing to bolster *Dr. Holmes' articulation* of the standard of care. The Batjer textbook chapter and Pluta article describe only a broad surgical *goal* of complete removal of all bone and tissue that could potentially compress nerves running through the spinal vertebrae. (App. 158-70.) Mr. Saraco recognizes as much, describing both sources as merely setting forth the "goal" of a laminectomy procedure. (Mr. Saraco Br. at 9, n.13, n.14.) So too does Dr. Holmes, who testified at deposition that the extensive removal of facet bone and tissue described in the Batjer textbook chapter represented only "a surgeon's goal" during a laminectomy. (App. 128-29.) Thus, these sources shed no light on the critical,

unanswered questions of *what* circumstances would permit leaving some residual overgrown bone/tissue during a laminectomy as an exercise of surgical judgment, or *when* those circumstances would exist, or *how* a trier of fact could objectively determine that the surgeon has crossed the line from permissible surgical judgment to negligence. As such, they cannot and do not fill in the glaring gaps in the foundation for Dr. Holmes' standard of care opinion.

2. The trial court's finding that Dr. Holmes' opinion lacked an adequate foundation is consistent with settled precedent.

The trial court's finding—that Dr. Holmes' testimony was inadmissible because he failed to link discussions at national conferences or literature to his national standard of care opinion (*see* App. 39-40, 54)—is fully consistent with this Court's precedent.

It is well-settled that an expert's "personal opinion . . . as to what he or she would do in a particular case" is insufficient to establish the standard of care. *Nwaneri*, 931 A.2d at 470 (quoting *Strickland*, 899 A.2d at 773). "Instead, the expert must establish that a particular course of treatment is followed nationally either through 'reference to a published standard, [discussion] of the described course of treatment with practitioners outside the District . . . at seminars or conventions, or through presentation of relevant data.'" *Id.*

This Court has repeatedly held that an expert cannot establish this foundation merely by asserting, in conclusory fashion, that he has attended conferences where

other doctors would discuss certain medical issues, or that he has reviewed and relied on medical journals in his field. Rather, the expert must actually "link his testimony" on the standard of care to discussions at national conferences, supporting literature, or other sources of data. *Nwaneri*, 931 A.2d at 473 (emphasis added); *see also Strickland*, 899 A.2d at 773.

In other words, even if the expert has consulted the types of sources that *might* establish a national standard of care (*e.g.*, discussions at national conferences or literature), the opinion can only be admitted if the expert shows those sources *actually did* support "that the national standard of care was what [the expert] said it was." *Nwaneri*, 931 A.2d at 475. Two cases from this Court are particularly instructive on that crucial point.

First, in *Travers v. District of Columbia*, 672 A.2d 566 (D.C. 1996), this Court affirmed the entry of judgment for a defendant hospital when plaintiff's expert "failed to prove the existence of a national standard of care." *Id.* at 567. The plaintiff underwent a splenectomy (surgical removal of the spleen) following an auto accident, ultimately developed a blood clot and gangrene that required amputation of his foot, and sued for failure to give aspirin after the procedure. *Id.* The plaintiff's sole expert stated that "the consensus" of five or six fellow local surgeons was that aspirin should be provided under the circumstances. *Id.* at 569. The expert testified that he had "attended various medical conferences all over the country where doctors

would discuss medical issues," but was unable to state that *his* standard of care opinion (*e.g.*, that it was necessary to give aspirin post-splenectomy) was ever discussed at those national conferences. *Id.* The Court held that the opinion failed to establish a national standard of care because the expert "did not relate any basis . . . that other physicians around the country held the same viewpoint" as the expert and his local colleagues. *Id.* at 569-70.

Second, in *Nwaneri v. Sandidge*, 931 A.2d 466 (D.C. 2007), this Court held that a plaintiff's expert's opinion that a below-the-knee surgery was negligently performed was not "grounded in" a national standard of care and was improperly admitted at trial. *Id.* at 467. The plaintiff's expert was a board-certified and well-credentialed vascular surgeon who regularly reviewed journals in the field of vascular surgery. *Id.* at 475-77. He had also authored a paper that referenced below-the-knee surgery in its title and gave a presentation based on that paper at a national vascular surgery conference. *Id.* But this Court nonetheless held that the expert's testimony should have been precluded because "there is no evidence that the journals [the expert] received, or the abovementioned paper, contained information about the national standard of care, or revealed what that standard was." *Id.* at 475.

Travers and *Nwaneri* are squarely applicable here. Just like in *Travers*, Mr. Saraco has stated that Dr. Holmes has some general familiarity with laminectomy procedures from attending national conferences, but failed to provide any evidence

that other physicians attending such conferences agree with Dr. Holmes' articulation of the standard of care. 672 A.2d at 569-70. And just like the expert in *Nwaneri*, Dr. Holmes was board-certified, was a member of various professional societies, and reviewed journals in his field. But Dr. Holmes failed to draw the requisite link between national sources and his opinions, *i.e.*, he failed to show how his review of literature or attendance at conferences supported his position as to what the standard of care required. 931 A.2d at 475. Further, the literature Dr. Holmes *did* specifically rely upon: (a) do not purport to set forth a national standard of care, and Dr. Holmes testified were not authoritative, and (b) address the surgical goal of decompression during a laminectomy but say nothing about when a surgeon can permissibly rely on surgical judgment to leave some residual bone or tissue, and when the line is crossed from surgical judgment to negligence. *See*, *supra* Argument Part II.B.1.

Mr. Saraco misconstrues *Nwaneri*, arguing that it should be read as permitting courts to infer that an expert's opinion is based on a national standard of care even when the expert only generally refers to attendance at national conferences. (Mr. Saraco Br. at 20.) But the *Nwaneri* court specifically rejected that very position. Although there was evidence that the *Nwaneri* plaintiff's expert had attended relevant conferences and published in the field, the expert failed to link his opinions to those sources and show how they supported him. Thus, the Court was "unable to infer from [the expert's] testimony what the basis was for his national standard of

care testimony" and "would be forced to make an impermissible leap or to speculate" to hold it admissible. *Nwaneri*, 931 A.2d at 476.

Several other cases cited by Mr. Saraco also reached the same result as in *Nwaneri*—excluding a plaintiff's expert who did not link his standard of care opinion to supporting sources. *See Hill*, 933 A.2d at 324-27; *Strickland*, 899 A.2d at 774. Still other cases that Mr. Saraco relies upon were addressed and distinguished in *Nwaneri*. For instance, *Hawes* is distinguishable because the expert did more than generally reference his attendance at national meetings and review of medical journals. Ultimately, the expert *also* testified that his opinion of the medical standard for monitoring fetal growth during the plaintiff's pregnancy was supported by textbooks, medical research, and standards published by the leading obstetrical society. *See Hawes*, 769 A.2d at 802, 807; *Nwaneri*, 931 A.2d at 474. Similarly, the expert in *Snyder v. George Washington University*, 890 A.2d 237 (D.C. 2006) testified that he was basing his standard of care opinion for management of a stick in a femoral artery upon "literature with regard to the national standard on treating and managing" that specific complication. *Id.* at 246; *Nwaneri*, 931 A.2d at 472.

Neither of Mr. Saraco's remaining cases supports his position. In *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170 (D.C. 2009), the Court affirmed exclusion of one of the plaintiff's experts for lack of foundation on the standard of care, but found a "somewhat closer question" as to a second expert who had attended national

conferences and testified that he had learned specific "techniques" and other data at those conferences that informed his opinions. *Id.* at 191-92. However, the Court never held that the second expert's opinion was admissible, instead affirming because neither expert could testify as to causation. *Id.* Here, Dr. Holmes failed to provide similar testimony as to *how* his attendance at national conferences supports his views, and thus has not generated even a close question.

Convit v. Wilson, 980 A.2d 1104 (D.C. 2009), on which Mr. Saraco also relies, is even more readily distinguishable. In that case, the plaintiff and defendant's experts *agreed* as to the national standard of care that applied to the procedure at issue. *Id.* at 1124 & n.59. The only issue on appeal was whether the plaintiff's experts had a sufficient basis to opine that the standard was breached. *Id.* at 1124-25. Thus, *Convit* is simply irrelevant here.

3. Cases applying *Daubert* support exclusion based on Dr. Holmes' failure to link his opinion to a supporting source.

Courts have repeatedly held that conclusory "because-I-say-so" statements of the standard of care are unreliable and inadmissible under *Daubert*, *Joiner* and the Advisory Committee notes to FRE 702. *See Nat'l Emergency Med. Servs.*, 889 S.E.2d at 170-71 (expert's standard of care opinion was inadmissible *ipse dixit* when he failed to show support for his opinion in any "standard, protocol, law, or regulation," and there was no evidence of support for the opinion from "experience

. . . of others in his profession applicable to the situation at issue").[25] These decisions further confirm that the trial court acted well within its discretion in excluding Dr. Holmes' opinion for his failure to explain *how* his standard of care opinion is supported by discussions with other experts or medical literature.

III. The trial court correctly precluded Dr. Holmes' opinions on standard of care and breach as to a post-operative MRI.

A. The trial court considered Mr. Saraco's reports of post-operative pain, yet still found Dr. Holmes' MRI opinions inadmissible.

Mr. Saraco contends that the trial court excluded Dr. Holmes' MRI opinions based on "improperly substitut[ing] its judgment for the jury" as to the initial August 18, 2017 post-operative visit, and then "fail[ing] to focus" on Mr. Saraco's pain levels as reported to Dr. Nayar at the second post-operative visit on November 17, 2017. (Mr. Saraco Br. at 14-15, 25-27.) Mr. Saraco is wrong on both points.

The trial court did not purport to find what Mr. Saraco's pain levels subjectively were as of August 18, 2017. Rather, the court focused narrowly on Mr. Saraco's reported pain levels "during his visits with Dr. Nayar[.]" (App. 42.)

[25] *See also Clemente-Vizcarrondo v. United States*, No. 17-1144 (RAM), 2020 U.S. Dist. LEXIS 26494, at *12 (D.P.R. Feb. 14, 2020) (expert opinion was "inherently unreliable" when the expert lacked supporting literature and other data and failed to give "even a . . . basic explanation of how [his] conclusion was reached"); *Ferguson v. United States*, No. CIV-15-178-M, 2016 U.S. Dist. LEXIS 205287, at *6-*8 (W.D. Okla. Sep. 20, 2016) (precluding expert's opinion because he "never explain[ed] what constitutes the standards of care and why those alleged standards are, in fact, the standard accepted in the medical community").

Specifically, the court found that it was undisputed that "no pain was reported to Dr. Nayar" during the initial August 18 post-operative visit, "which eliminates the possibility of breach" as of that date.[26] (App. 42-43.) But the trial court did not exclude Dr. Holmes' MRI opinions on that basis alone. To the contrary, the trial court went on to explain that it was precluding Dr. Holmes' MRI opinions because he failed to establish a measurable standard of care or when it was breached, and also failed to link his opinion to a reliable foundation. (App. 43, 56-57.)

Further, the trial court did not discount Mr. Saraco's reported pain levels as of the November 17, 2017 post-operative visit. In its summary judgment order, the trial court specifically noted Mr. Saraco's report of 50% improvement in post-operative pain at the November 17 visit. (App. 33). Further, when the trial court specifically outlined why it was excluding the MRI opinions, it cited to the paragraph in Dr. Holmes' affidavit addressing the November 17 post-operative visit. (App. 43 (citing App. 100, ¶ 4).) Later, in denying reconsideration, the trial court explicitly found that Dr. Holmes' opinions must be excluded "even assuming" Mr. Saraco experienced pain at the November 17 post-operative visit. (App. 55-56.)

[26] As explained below, there are separate and independent grounds for this Court to affirm the trial court's exclusion of Dr. Holmes' opinions specific to the August 18, 2017 visit because: (1) he withdrew those opinions at deposition and (2) the trial court's findings as to what was reported to Dr. Nayar on August 18 are well-supported by the record. *See*, *infra*, Argument Part III.D(1)-(2)

Thus, there is no basis to hold that the trial court's exclusion of the MRI opinions was premised on a misinterpretation of the factual record, or an inadequate reading of that record.

B. Dr. Holmes was impermissibly vague as to when an MRI needed to be ordered.

The trial court precluded Dr. Holmes' MRI opinions in part because he was unclear as to *when* the MRI needed to be ordered. Dr. Holmes ultimately asserted that there was a general "time period" in which the MRI should have been ordered (*see* App. 100, ¶ 4), which the trial court referred to as a "window." Yet, as the court correctly found, Dr. Holmes failed to describe when that "window" began or ended:

> Dr. Holmes conceded that not performing a postoperative MRI was not necessarily negligent but was negligent in this scenario because it was in the "window" in which an MRI should be ordered . . . . Although Dr. Holmes opines that Dr. Nayar was negligent, there is no evidence in this record on when this "window" commences or terminates . . .

(App. 43.)

The trial court did not abuse its discretion in excluding the MRI opinions as impermissibly vague. As noted above, it is well-settled that an expert must set forth a *measurable* standard of care and how it was breached. In other words, "at the very least the expert must be specific as to what standards were violated and how they were violated." *Sullivan*, 112 A.3d at 357-58 (citing *Carmichael*, 577 A.2d at 315); *see also Briggs*, 481 F.3d at 846; *Rodriguez*, 91 F.4th at 72.

Dr. Holmes failed to meet those minimal requirements because he never said when the "window" to order an MRI opened or closed. Mr. Saraco now argues that this Court could infer that the "window" commenced as of the November 17 post-operative visit. Of course, Dr. Holmes never testified to that effect and in fact testified that the standard of care did not require the ordering of an MRI on November 17. (*Compare* Mr. Saraco Br. at 28 *with* App. 125.) The Court can and should reject the argument for that reason alone.

Moreover, there is no basis for the Court to make any inferences as to the starting or ending point of the "window." It is true that this Court has, on rare occasions, drawn inferences about the basis of an expert's standard of care opinion—though only when an expert said enough about his basis that the Court is not "forced to make an impermissible leap or to speculate." *Nwaneri*, 931 A.2d at 476. But Mr. Saraco cites to no authority where an expert failed to state *when* a defendant needed to act, and the Court then stepped in to fill in the gap and "infer" what the expert did not say. Such a rule would run counter to the holdings of *Sullivan* and *Carmichael* that the expert must state a measurable standard of care. Further, it would run counter to the Court's "gatekeeping" role described in *Daubert* and *Motorola*.

Moreover, Plaintiff's focus on when the window "commenced" obscures the real issue: Dr. Holmes' failure to say when the window closed, *i.e.*, the final date by which Dr. Nayar could have ordered an MRI for Mr. Saraco and still acted within

the national standard of care. Mr. Saraco argues that this omission is "not relevant" based on Dr. Holmes' affidavit statement that an MRI should have been ordered "promptly" after the November 17 visit. (Mr. Saraco Br. at 28-30.) But "[a]ll that promptly means is within a reasonable time." *US Right to Know v. Nat'l Nuclear Sec. Admin.*, 721 F. Supp. 3d 1198, 1208 (D.N.M. 2024) and *Elec. Wholesale Supply Co. v. Fraser*, 356 P.3d 254, 261 (Wy. 2015) ("'[P]romptly' is not an exact term" and "what is 'prompt' depends upon the situation."). A jury cannot determine from that testimony whether Dr. Nayar was required to order an MRI within days, weeks, or months after the November 17 visit. Given that ambiguity, Dr. Holmes failed to provide "a standard of care by which the defendant's actions can be measured" and his opinions were properly precluded. *See Sullivan*, 112 A.3d at 357-58 (citing *Carmichael*, 577 A.2d at 314).

Neither of the cases cited by Mr. Saraco support that Dr. Holmes' MRI opinions are admissible. In *Sullivan*, the expert testified that the standard if care required a contractor installing a manhole to compact pavement "during the backfilling process" to ensure it is properly restored, and that the contractor had failed to do so. 112 A.3d at 358. Thus, the expert in that case laid out what the standard of care required, including the specific actions the defendant needed to have taken, and when it needed to take those actions.

District of Columbia v. Price, 759 A.2d 181 (D.C. 2000) is likewise of no help to Mr. Saraco. In *Price*, the plaintiff's expert properly established the standard of care and breach by relying on a published regulation for municipal police officers that injured prisoners should be "immediately" taken to a hospital. *Id.* at 184. But that is of no help to Mr. Saraco here because, as multiple courts have held, "promptly does not mean immediately." *US Right to Know v. Nat'l Nuclear Sec. Admin.*, 721 F. Supp. 3d at 1208; *Bryant v. City of N.Y.*, 404 F.3d 128, 137 (2d Cir. 2005) ("Clearly, 'prompt' does not mean 'immediate.'").

C. Dr. Holmes failed to lay an adequate foundation for his MRI opinions.

The trial court correctly found that Dr. Holmes "fails to establish the [national] standard" for a post-operative MRI after a laminectomy, and also provides "no basis, through publication or reference to medical conferences, for a trier of fact to find that Dr. Nayar breached the national standard of care" with respect to ordering a post-operative MRI. (App. 43.) Indeed, Dr. Holmes' MRI opinions on the standard of care and breach suffer from a glaring lack of foundation, just like his laminectomy standard of care opinion.

As set forth above, Dr. Holmes discussed laminectomies with other physicians at national conferences and he produced some literature regarding laminectomies. *See*, *supra*, Argument Part II.B(2)-(3). Dr. Holmes' laminectomy opinion is nonetheless inadmissible for a lack of foundation because he failed to link that

opinion to discussions at national conferences or other permissible sources and show how those sources support his articulation of the standard of care, and the articles he produced do not fill in the gap. *See*, *supra*, Argument Part II.B(2)-(3).

As to the MRI opinions, Dr. Holmes has failed even to reference discussions with physicians at national conferences regarding post-operative MRIs. Likewise, he failed to proffer any supporting literature regarding post-operative MRIs. Nor has Mr. Saraco pointed to any other permissible source that might provide a basis for Dr. Holmes' MRI opinions. *See Hawes*, 769 A.2d at 806 (listing such sources).

Instead, Mr. Saraco argues that a "jury could infer" that Dr. Holmes' discussions at national conferences as to laminectomies also included "discussions pertaining to follow-up neurosurgical care and management of post laminectomy patients," which Mr. Saraco asserts are "[a]n attendant and inherent part of a laminectomy procedure." (Mr. Saraco Br. at 32 (emphasis added).) That argument is without merit. Judges, not juries, make a threshold gatekeeping determination as to the basis and foundation of expert opinions. *See Nwaneri*, 931 at 470 (applying judicial scrutiny into basis for medical malpractice standard of care opinions); *Motorola*, 147 A.3d at 755 (same for all types of expert opinions). And when a court finds an opinion lacks a reliable foundation, it is excluded from the jury.

Further, while a court can "infer" that a medical standard is nationally recognized, it can do so only when "the testimony presents a sufficient basis upon

which an inference can be made." *Nwaneri*, 931 A.2d at 472. There is no such basis here. Mr. Saraco's only support for post-operative MRIs being an "inherent" part of Dr. Holmes' discussions on laminectomies is Dr. Holmes' statement in his initial report that "my clinical practice involves . . . lumbar laminectomy, as well as follow-up care/management of patients following laminectomy" (App. 80 (emphasis added).) But that "personal opinion" specific about Dr. Holmes' own practice "is insufficient to prove the applicable standard of care." *Nwaneri*, 931 A.2d at 470.

Additionally, Dr. Holmes also failed to link his MRI opinions to national sources and show that such sources support that his MRI opinions reflect a nationally recognized standard. Thus, just like his laminectomy opinion, his MRI opinions are similarly inadmissible under: (a) the well-established line of cases in the District of Columbia excluding experts who fail to show how national sources support that the national standard of care is what the expert says it is, *see Nwaneri*, 931 A.2d at 473; *Strickland*, 899 A.2d at 773; *Travers*, 672 A.2d at 569-70; *Hill*, 933 A.2d at 324-27; and (b) persuasive authority reaching the same result applying *Daubert* and FRE 702, *see, e.g., Nat'l Emergency Med. Servs.*, 889 S.E.2d at 170-71.[27]

[27] The *Sullivan* and *Price* cases Mr. Saraco raises pre-date this Court's adoption of FRE 702 and did not involve medical malpractice. Further, the experts in those cases pointed to a specific, published standard as setting the standard of care. *Sullivan*, 112 A.3d at 351-52, 358 (expert relying on "manuals" on pavement backfilling from a national association); *Price*, 759 A.2d at 184 (expert relying on municipal regulation embodying national standard). Dr. Holmes, by contrast, never identified and relied on any published standard as to post-operative care after a laminectomy.

D. Dr. Holmes' MRI opinions specific to the August 18, 2017 visit are also inadmissible on separate grounds.

A separate and independent basis to sustain the trial court's exclusion of Dr. Holmes' post-operative criticism specifically as to the August 18, 2017 visit is that there is no evidence that Mr. Saraco reported any pain to Dr. Nayar at that time. As noted above, Dr. Nayar's note stated that Mr. Saraco had reported "close to 100% improvement in [Mr. Saraco's] preoperative pain." (App. 207.)

Contrary to Mr. Saraco's assertions on appeal, Mr. Saraco never refuted Dr. Nayar's entry. (*Cf.* Mr. Saraco Br. at 11, 25.) Indeed, Mr. Saraco testified that he had no specific recollections of the August 18, 2017 visit. (App. 62-65.) While he generally recalled a pain level of "7 or 8" out of 10 around that time, he did not testify that he reported an elevated pain score to Dr. Nayar on August 18. *Id.* Further, Dr. Holmes never opined that Dr. Nayar had a duty to seek out information from Mr. Saraco's other healthcare providers outside of the Hospital, and there is no evidence that Dr. Nayar did so. Thus, the pain reports from Mr. Saraco's visits to other physicians cited by Mr. Saraco are irrelevant. (*Cf.* Mr. Saraco Br. at 9-11.)

IV. The trial court was legally correct to grant summary judgment.

When a medical malpractice plaintiff fails to put forth a *prima facie* showing of admissible expert testimony to support the applicable standard of care and breach of that standard, the defendant is entitled to summary judgment. *Berkow v. Hayes*, 841 A.2d 776, 780 (D.C. 2004). Here, for the reasons given above, the trial court

acted within its discretion in precluding Dr. Holmes' opinion on standard of care for performance of the laminectomy, and further precluding his opinions on standard of care and alleged breach as to the post-operative MRI. Because Mr. Saraco lacked admissible standard of care testimony, the trial court was legally correct to enter summary judgment.

V. The trial court was within its discretion to deny Mr. Saraco's motion for reconsideration and refuse to consider the second affidavit of Dr. Holmes.

The trial court acted well within its discretion in denying Mr. Saraco's motion for reconsideration. The trial court found that the motion "seems to attempt to patch up the holes the Court explicitly pointed out in Dr. Holmes' opinion in the Court's August 18, 2023 [summary judgment] Order, which is insufficient to grant a Motion for Reconsideration under [D.C. Superior Court] Rule 59(e)." (App. 53.) The trial court also specifically found that it had already considered and addressed all points raised by Mr. Saraco on reconsideration, except as to the belated second affidavit of Dr. Holmes, which the court declined to consider. (App. 53-57.)

While Mr. Saraco has appealed from denial of the motion for reconsideration, he did not challenge the trial court's ruling that it would not consider Dr. Holmes' second affidavit—and has thereby waived that point on appeal. *See Gant*, 325 A.3d at 417. Further, beyond general disagreement with the trial court's grant of summary judgment, Mr. Saraco provides no specific argument as to why the trial court abused

its discretion in denying reconsideration. Thus, this Court should affirm the denial of reconsideration for the same reason as it should affirm the grant of summary judgment: the trial court correctly excluded Dr. Holmes' standard of care opinions, and Mr. Saraco could not proceed past summary judgment without them.

CONCLUSION

For these reasons, the Hospital asks the Court to affirm the trial court's exclusion of Dr. Holmes' standard of care opinions, grant of summary judgment, and denial of reconsideration as to its summary judgment ruling.

Dated: February 18, 2025 Respectfully submitted,

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CERTIFICATE OF SERVICE

I CERTIFY that, on this 18th day of February 2025, a copy of the Appellees' Brief was electronically filed and served via the Court's electronic filing system upon:

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