IN THE
DISTRICT OF COLUMBIA
COURT OF APPPEALS

No. 02-CV-1395

LEROY SAUNDERS,

PLAINTIFF-APPELLANT,

v.

GEORGE WASHINGTON UNIVERSITY,

DEFENDANT-APPELLEE.

Appeal from the Superior Court of the District of Columbia, Civil Division

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BRIEF OF APPELLANT

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No. 02-CV-1395

LEROY SAUNDERS v. GEORGE WASHINGTON UNIVERSITY

CERTIFICATE REQUIRED BY RULE 28(A)(1) of the Rules of the District of Columbia Court of Appeals:

The undersigned, counsel of record for Leroy Saunders, certifies that the following listed parties and amici (if any) appeared below:

1. Leroy Saunders, plaintiff-appellant,

2. George Washington University, defendant-appellee,

3. George B. Bren, M.D., defendant, dismissed, no appeal taken.

4. Anne Thompson, M.D., defendant, dismissed, no appeal taken.

5. Dr. Fred Veroto, defendant, never served with process.

These representations are made in order that the judges of this Court, inter alia, may evaluate possible disqualification or recusal.

_____

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STATEMENT OF THE ISSUES

I. Whether there was evidence, when viewed in the light most favorable to the plaintiff, from which a juror could reasonably infer that there was a breach of the standard of care that caused plaintiff's injuries.

II. Whether Dr. Brownlee's deposition should have been excluded for failure to show familiarity with the national standard of care.

STATEMENT OF THE CASE

Leroy Saunders (Mr. Saunders or the plaintiff) filed his amended complaint against George Washington University (defendant hospital or the

defendant) on May 18, 2001. Rec. 51.[1] A meeting of counsel was held pursuant to Super. Ct. R. Civ. P. 16 on January 16, 2002. The joint pretrial statement was filed on April 22, 2002. Rec. 128.

The case was tried before the Honorable Steffan W. Graae and a jury on September 9, 10, 11, 12, 13 & 16, 2002. After the close of the plaintiff's evidence, the trial court granted the defendant judgment pursuant to Super. Ct. R. Civ. P. 50. 9/16/02 Tr. 3-46 & Rec. 221.

The trial court denied Mr. Saunders' motion for a new trial by order entered November 18, 2002. Rec. 469.

Mr. Saunders timely filed his notice of appeal. Rec. 495.

STATEMENT OF THE FACTS

Mr. Saunders retired from his work as a statistician with the United States Department of Labor in early 1984. 9/10/02 Tr. 39. On September 20, 1996, Mr. Saunders went to the emergency room at George Washington University Hospital due to nausea and shortness of breath. 9/10/02 Tr. 42-43

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[1] The record on appeal consists of one volume and 9 supplements. They are the papers in the case, the exhibits and eight volumes of transcript. The transcripts were filed in the order of their completion and the volume numbers so reflect. To promote clarity, the transcripts are therefore cited by date, e.g., 9/9/02 Tr. ___, 9/12/02 Supp. Tr. ___, etc.

The papers in the case are consecutively paginated and will be cited Rec. ___. Supplemental Record No. 3 consists of various exhibits introduced at trial. It will be cited Rec. 3-___.

& 111. Mr. Saunders had undergone a triple coronary bypass at defendant hospital several months earlier. 9/11/02 Supp. Tr. 11-12.

Mr. Saunders was admitted to the coronary care unit on September 21, 1996. Plaintiff's Ex. No. 5, Rec. 3-32. His cardiac problems were noted as was "chronic renal insufficiency." *Id*.

On September 25, a renal scan indicated that Mr. Saunders had atrophied and poorly functioning kidneys. Plaintiff's Ex. No. 20, Rec. 3-1, 9/11/02 Tr. 110. The nephrologist, in consultation with the cardiologist, ordered a digital subtraction angiogram in order to rule out renal artery stenosis. *Id*.

On September 27, Doctors Sor, Winick and Roberts, interventional radiologists, performed an aortogram and a renal arteriogram. Since stenosis was found, an angioplasty of the left renal artery was performed and resulted in a significant improvement of the diameter of the stenosis. Plaintiff's Ex. No. 10, Rec. 3-6, 9/11/02 Tr. 117. The angioplasty is an invasive procedure. 9/11/02 Tr. 117.

Heparin is an anti-coagulant or blood thinner that had been given to Mr. Saunders beginning on September 25. 9/11/02 Tr. 113 & 9/12/02 Tr. 39-40. The Heparin was stopped only two or three hours before the procedures, which Dr. Hoffler, plaintiff's expert, testified was not a sufficient time be-

fore the procedure. 9/12/02 Tr. 54-55. The Heparin was started again after the procedure. Plaintiff's Ex. No. 10, Rec. 3-6, 9/11/02 Tr. 117.

September 27, 1996 was a Friday and Doctors Sor, Winick and Roberts did not return until the following week. 9/12/02 Tr.15.

A coagulation report reflecting partial thromboplastine time (PTT), a test which measures the coagulation of the blood and inferentially the level of Heparin therein, showed a dramatic increase in the level of medication in Mr. Saunders' bloodstream post procedure, so much so that his blood would not clot. Plaintiff's Ex. No. 85, Rec. 3-3, 9/11/02 Tr. 113-14; 9/11/02 Tr. 127-28 & 9/12/02 Tr. 35-44. Normal levels are 25-35 and this was in excess of 100. As a result, Mr. Saunders was at increased risk to bleed. 9/11/02 Tr. 115.

On Saturday, September 28, Mr. Saunders' hematocrit level had dropped, which indicated that he was bleeding. Plaintiff's Ex. No. 27, Rec. 3-7, 9/11/02 Tr. 121-25. Although the Heparin was decreased at this time, Dr. Hoffler described this as "a red flag. A patient who had had an interventional procedure like this should not have pain and should not have bleeding." 9/11/02 Tr. 124. Dr. Hoffler described the reduction as "insignificant," and as an "incomplete reaction to a serious situation." 9/12/02 Tr. 49.

As a result, the defendant should have taken additional steps to make a diagnosis. *Id*. By 7:30 p.m., Mr. Saunders was complaining of pain. Plaintiff's Ex. No. 28, Rec. 3-8, 9/11/02 Tr. 125.

On Sunday, September 29 at 2:20 a.m., Dr. Mora, an intern-employee of defendant, was called to investigate Mr. Saunders' pain and abnormal test results. He found the PTT to be "borderline." Plaintiff's Ex. No. 29, Rec. 3-9, 9/11/02 Tr. 127-30. He ordered the test to be repeated in four hours and a transfusion. *Id*. Dr. Hoffler testified that this response was insufficient and that Dr. Mora was under a duty to discover the cause of the bleeding and stop it.

In particular, Dr. Mora was confronted with complaints of pain and weakness. 9/11/02 Tr. 129. Such complaints aren't normal because usually simple pressure to the puncture of the needle stops any bleeding. *Id*. However, Mr. Saunders was bleeding and reference to his PTT levels should have caused Dr. Mora to conclude that the Heparin was causing Mr. Saunders' body to be incapable of stopping the bleeding. *Id*. He should have obtained a new PTT level at that time rather than continuing to transfuse Mr. Saunders and waiting an additional four hours. *Id*. In fact, the transfusions exacerbated the problem. 9/12/02 Tr. 46.

At 5:54 p.m., Mr. Saunders continued to have pain and his blood count continued to drop. Plaintiff's Ex. No. 32, Rec. 3-11, 9/11/02 Tr. 133-36. By 7:30 p.m., Mr. Saunders' hematocrit and hemoglobin counts were still down. Plaintiff's Ex. No. 31, Rec. 3-10, 9/11/02 Tr. 130-33. During this time, Mr. Saunders was still being transfused and was still receiving Heparin. 9/11/02 Tr. 132.

By Monday, September 30 at 1:25 p.m., Mr. Saunders was continuing to lose blood and his "blood pressure was gone." Plaintiff's Ex. No. 34, Rec. 3-12, 9/11/02 Tr. 136-38. Dr. Hoffler testified that these symptoms should have been immediately investigated. Specifically, a CT scan, which would have disclosed the bleeding, should have been ordered. 9/11/02 Tr. 138-39. At this time, Mr. Saunders was still receiving Heparin. 9/11/02 Tr. 136. His blood pressure was "flat 100 [over] 60 and sitting 74 over 50." 9/11/02 Tr. 137. He had "severe pain, right lower back, right buttocks, and right leg." *Id*. "House officer made aware of blood pressure and pain." *Id*.

Mr. Saunders fell and by 11:30 p.m. was so weak he could not uncross his legs. Plaintiff's Ex. No. 37, Rec. 3-13, 9/11/02 Tr. 139-41; 9/12/02 Tr. 16.

It was not until October 1 at 5:20 a.m., that Mr. Saunders' condition was correctly diagnosed. Plaintiff's Ex. No. 38, Rec. 3-14, 9/11/02 Tr. 142-

43. By this time a spinal cord infarct had occurred. An infarction is the death of tissue, in this case the conus medullaris, a component of the lower part of the spinal cord. 9/11/02 Tr. 143-44. At this time, Mr. Saunders was paralyzed and it was too late to do anything. 9/11/02 Tr. 143.

At 7:15 a.m., Mr. Saunders was diagnosed with paralysis of his right leg. "Bleeding was more likely the cause than embolus." Plaintiff's Ex. No. 39, Rec. 3-15, 9/11/02 Tr. 144-45.

By 12:30 p.m., the chart reflects that both of Mr. Saunders's legs were paralyzed. Plaintiff's Ex. No. 41, Rec. 3-16, 9/11/02 Tr. 145-48.

On October 2, Mr. Saunders was transferred to the intensive care unit where he was intubated and treated for blood pressure support and septic shock. Plaintiff's Ex. No. 5, Rec. 3-32. Finally, on October 3, an abdominal CT scan was performed that revealed the right retroperitoneal bleed. *Id*.

On October 21, Mr. Saunders was transferred to the National Rehabilitation Hospital. Plaintiff's Ex. Nos. 5 & 136, Rec. 3-32. There, he was treated for his paraplegia and the loss of use of his bowel and bladder suffered while at defendant hospital. 9/12/02 Supp. Tr. 12 & Plaintiff's Ex. No. 136, Rec. 3-39.

Mr. Saunders was treated by Lauro Halstead, M.D., a rehabilitation physician. 9/12/02 Supp. Tr. 6. Mr. Saunders was treated for the "obviously

devastating" psychological effects of his injuries as well as physically coping with his paraplegia and incontinence. 9/12/02 Supp. Tr. 15-16. While he was a patient at NRH, his wife passed away. 9/10/02 Tr. 38-39. He was discharged from NRH on December 17, 1996. Plaintiff's Ex. No. 135. Thereafter, Mr. Saunders was a patient at Carol Manor Nursing Home. 9/10/02 Tr. 67.

In September of 2000, Mr. Saunders had a colostomy at the Washington Hospital Center. 9/10/02 Tr. 76-77.

Mr. Saunders' right foot became infected, and in December 2000, the infection was debrided at Southern Community Hospital. 9/10/02 Tr. 94-96. In early 2001, the right leg was amputated at Providence Hospital. 9/10/02 Tr. 79-80.

Mr. Saunders also continued his rehabilitation as an outpatient at NRH until September 2001. 9/10/02 Tr. 68-69.

Mr. Saunders can't get in and out of his bed, a chair or a car. 9/10/02 Tr. 41. His condition requires that he have a live-in assistant who is his constant companion. He cannot bathe and clothe himself. 9/10/02 Tr. 67 & 73. Initially, he coped with his incontinence by means of catheters and diapers. 9/10/02 Tr. 76. During this time, Mr. Saunders' son had to learn to catheter-

ize his father. 9/10/02 Tr. 121-22. Now, his colostomy bag requires service twice per day. 9/10/02 Tr. 78.

Mr. Saunders has no transportation and uses Metro Access buses to go to his dialysis three times per week. 9/10/02 Tr. 88. In his home, he cannot access his basement, the shower or certain rooms, the doors of which are too narrow for a wheelchair. *Id*. Some of the doors in his home have been widened, a wheelchair ramp was built and some modifications to the bathroom and kitchen were made. 9/10/02 Tr. 131.

Mr. Saunders was formerly an active member of his church, his school's alumni association and his fraternity as well as a fisherman. 9/10/02 Tr. 123 & 151.

Mr. Saunders' past expenses total $193,850.00. 9/12/02 Supp. Tr. 79. Mr. Saunders' future expenses are estimated at $568,782.00.

SUMMARY OF THE ARGUMENT

Mr. Saunders walked into the emergency room at defendant hospital. He may not have been in perfect health, but he walked into the hospital. He did not walk out. Instead, he became a paraplegic. Mr. Saunders may have had heart problems, high blood pressure and kidney problems, but he was continent and ambulatory. He led a full and active life.

The procedures performed on Mr. Saunders were not in themselves life-threatening. The fact that he bled from the site in his femoral artery where the instruments were inserted is not unusual. What is unusual is that here defendant hospital had a patient who they knew had had an invasive procedure. They knew he was on anticoagulants. They knew his blood counts were down. They knew the coagulation studies were off the charts. In short, they were on notice that he was prone to bleed and that he was, in fact, bleeding. Yet for four days little or nothing was done. The anticoagulant was reduced, but not enough. It was not stopped.

Defendant hospital also knew that Mr. Saunders was complaining of pain when he should not have been. They knew his legs were becoming progressively weaker. Yet it was not until he had practically lost the use of his legs that they performed a CT scan that showed what was wrong.

Two general surgeons testified that the standard of care required a diagnosis of the bleeding complication and that had it been done in a timely manner, the paraplegia, incontinence, and amputation would have been avoided.

Central to the defense's theory on both of the issues before the Court, is the preposterous notion that general surgeons are not competent to diag-

nose and manage bleeding complications. There is nothing in the law or evidence to support that notion.

As to Dr. Hoffler's testimony, the defense convinced the trial court that the "mechanism" of the injury had to be stated in a hyper-technical fashion. This caused the trial court to view the evidence restrictively against Mr. Saunders instead of in the light most favorable to him as was required. Dr. Hoffler, who qualified as an expert, testified that the injuries were caused by the defendant's repeated breaches of the standard of care. It was for the jury, not the court, to accept or reject this testimony along with all of the other evidence in the case.

As to the deposition of Dr. Brownlee taken before he died, the defense convinced the trial court that the deposition was not admissible because the words "national standard" don't appear in the deposition. As to causation, national standard is not even a relevant concept. Moreover, the deposition is replete with facts from which it can be inferred that Dr. Brownlee was familiar with the national standard of care.

The defense led the trial court to believe that Mr. Saunders had failed to lay a proper foundation for admission of the deposition; however, in reality there appears to have been a carefully orchestrated effort to surprise Mr. Saunders with this objection. No objection was made at the taking of the

deposition when the foundation could have been laid. None was made when the deposition was proffered in the joint pre-trial statement. The obvious strategy was to wait to make the objection until a time when there was nothing that could be done about it.

The exclusion of the deposition and the grant of the motion for judgment unfairly deprived Mr. Saunders of his right to present his case to a jury. The judgment must be reversed and the case remanded for a new trial.

ARGUMENT

I. Whether there was evidence, when viewed in the light most favorable to the plaintiff, from which a juror could reasonably infer that there was a breach of the standard of care that caused plaintiff's injuries.

Standard of Review

The trial court granted the defendant a motion for judgment pursuant to Super. Ct. R. Civ. P. 50. On appeal from the grant of judgment depriving the plaintiff of his right to a jury trial, the evidence is viewed in the light most favorable to the plaintiff. *Travers v. District of Columbia*, 672 A.2d 566, 568 (D.C. 1996), *Spain v. McNeal*, 337 A.2d 507, 508-09 (D.C. 1975).

Although stated in the context of a ruling on a judgment n.o.v., the same considerations apply in taking the case away from the jury:

> A judgment notwithstanding the verdict is proper only in 'extreme' cases, in which no reasonable person, viewing the evidence in the light most favorable to the prevailing party, could

> reach a verdict in favor of that party. When there is some evidence from which jurors could find that the elements of negligence have been established or where disputed facts or resolution of credibility issues determine the outcome, the case is for the jury. The motion may be granted only when the evidence, viewed in the light most favorable to the nonmoving party, permits only one reasonable conclusion as to the proper judgment. Cases in which issues of negligence and proximate cause will not be for the jury are unusual.

District of Columbia v. Watkins, 684 A.2d 395, 401 (D.C. 1996) (internal quotations and citations omitted).

The trial court must not weigh the evidence, pass on the credibility of witnesses, or substitute its judgment for that of the jury. *Robinson v. Group Health Ass'n*, 691 A.2d 1147, 1150-1151 (D.C. 1997), *Jackson v. Condor Management Group, Inc.*, 587 A.2d 222, 226 (D.C. 1991), *Corley v. BP Oil Corp.*, 402 A.2d 1258, 1263 (D.C. 1979).

Discussion

The trial court granted the motion for judgment on two bases: that there was insufficient proof of "the nature of the alleged breach of a standard of care and, more significantly, (assuming there was a breach), its causal relationship to the injuries plaintiff suffered." Order Denying Motion for New Trial, Rec. 469.[2]

[2] The defendant hospital concedes that the cause of action for negligent infliction of emotional suffering rises and falls with the cause of action for medical malpractice because Mr. Saunders' "negligent infliction of emo-

"In a medical malpractice action, the plaintiff must prove the applicable standard of care, deviation from that standard and a causal relationship between the deviation and the injury." *Travers v. District of Columbia*, 672 A.2d 566, 568 (D.C. 1996), *citing*, *Washington v. Washington Hospital Center*, 579 A.2d 177, 181 (D.C. 1990).

The trial judge ruled that neither the "nature" of the deviation nor how it caused the injuries had been proven. The record does not support, and in fact contradicts, these conclusions.

A. Dr. Hoffler Identified the Deviation from the Standard of Care.[3]

Dr. Hoffler testified that Mr. Saunders had "a procedure done that normally doesn't upset the patient's condition. You do these and you do not have pain and weakness and all. You have to have them lie down for an

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tional distress claim is derivative of his medical negligence claim." Opposition to Motion to Vacate Judgment and for New Trial, Rec. 319. Thus, a reversal and reinstatement of the claim for medical malpractice should be accompanied by reinstatement of the claim for negligent infliction of emotional suffering.

[3] While defendant hospital did not concede that Mr. Saunders had met his "standard of care burdens," it based nearly its entire argument on the issue of causation. *See* Opposition to Motion to Vacate Judgment and for New Trial, Rec. 313. Likewise, while the trial judge did not so limit his ruling, he referred to his finding with respect the lack of expert opinion as "more significant" as they regarded causation. Order Denying Motion for New Trial, Rec. 469.

hour. Put pressure over the area where you stuck the needle and usually they can get up and go home afterwards." 9/11/02 Tr.129.

Dr. Hoffler testified that given the blood counts and patient complaints in the record, "You are required to find out if the patient is bleeding." 9/11/02 Tr. 56. The coagulation studies showed "that his Heparin level was so high, his anti-coagulation level was so high that he couldn't stop bleeding." 9/11/02 Tr. 129.

In particular, the standard of care required the defendant "to follow the patient very carefully because he had had an intervention performed." 9/12/02 Tr. 23. The standard required the defendant to follow Mr. Saunders all the more closely because he was bleeding and complaining of pain. *Id*. The standard required the defendant to employ diagnostic procedures, including specifically a CT scan, in an effort find out why Mr. Saunders was bleeding and complaining of pain. *Id*. "All of these should have been rendered in a much more timely manner than they were." *Id*.

Dr. Hoffler testified that pre-procedure, the Heparin was not discontinued long enough in advance to guard against excessive bleeding being caused by the intervention. 9/12/02 Tr. 54-55. Post-procedure, the reduction in the level of Heparin was "insignificant," and an "incomplete reaction to a

serious situation." 9/12/02 Tr. 49. The level was not sufficiently reduced. 9/12/02 Tr. 50.

All of this testimony went to what the reasonable medical provider should have done under the same or similar circumstances.

B. Dr. Hoffler Testified That the Deviation from the Standard of Care Caused the Injuries

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In this case there was what is called a silent bleed. It is silent because you cannot see it. It is latent. Standard of care testimony is required to show that the bleed should have been discovered. However, once past the point where the bleed should have been discovered, it is not entirely clear that expert testimony is even required to show that it is incumbent on the defendant to *try* to stop the bleeding. This defendant did almost nothing for four days. A jury understands that uncontrolled bleeding must be controlled. Arguably, once the jury understands that Heparin is an anti-coagulant, they would not even need standard of care testimony to infer that the level of Heparin in the blood should have been reduced or stopped. In any event, the point is that all of the facts and circumstances of the case must be considered. At a minimum it takes a lesser quantum of proof to show that uncontrolled bleeding ought to be controlled than it does to prove a more complex case.

The doctors who performed the procedures on a Friday did not return to see Mr. Saunders until the following week. 9/12/02 Tr. 15. The hospital

staff, including Dr. Mora, Dr. Dudek and Nurse Lauren, didn't employ available diagnostic procedures to determine the cause of the complication. 9/12/02 Tr. 25. As a result, Mr. Saunders "had a prolonged period of hypotension." 9/12/02 Tr. 26. "They did not diagnose this in a timely manner." *Id*. As a direct result of these deviations from the standard of care, "The harm suffered was a loss of the use of the patient's legs and his abdominal organs secondary to the results of the treatment or procedures performed on him." *Id*. Mr. Saunders' decubitus ulcers, colostomy and amputation of his right leg all resulted from the paralysis of his legs and his abdominal organs. 9/12/02 Tr. 28-29.

Dr. Hoffler testified that if Mr. Saunders had been followed more closely and if available diagnostic procedures had been employed, the complications of the procedures could have been corrected and the injuries avoided. 9/12/02 Tr. 31.

> To establish proximate cause, the plaintiff must present evidence from which a reasonable juror could find that there was a direct and substantial causal relationship between the defendant's breach of the standard of care and the plaintiff's injuries and that the injuries were foreseeable." *Psychiatric Inst. of Wash. v. Allen*, 509 A.2d 619, 624 (D.C. 1986) (emphasis deleted). The evidence is adequate to establish proximate cause if the expert "states an opinion, based on a reasonable degree of medical certainty, that the defendant's negligence is more likely than anything else to have been the cause (or a cause) of a plaintiff's injuries." *Id*. A "'reasonable' medical certainty, reflects an objectively well-founded conviction that the likelihood

> of one cause is greater than the other; it does not mean the expert is 'personally certain' of the cause or that the cause is discernable to a certainty." *Clifford v. United States*, 532 A.2d 628, 640 n.10 (D.C. 1987) (citing *Psychiatric Inst.*, 509 A.2d at 624).

Watkins, *supra*, 684 A.2d at 402-403 (footnote omitted).

Dr. Hoffler's testimony met this standard. That the defendant finds it not to be specific enough under the guise of not specifying the "mechanism" is an argument that goes properly to the weight of the evidence. This argument led the trial court to improperly weigh the evidence and to substitute its judgment for that of the trier of fact.

> 'The fact of causation is incapable of mathematical proof, since no one can say with absolute certainty what would have occurred if the defendant had acted otherwise.' W. PROSSER & W. KEETON, THE LAW OF TORTS § 41, at 269-270 (5th ed. 1984). The expert need only state an opinion, based on a reasonable degree of medical certainty, that the defendant's negligence is more likely than anything else to have been the cause (or a cause) of the plaintiff's injuries. See Fitzgerald v. Manning, 679 F.2d 341, 351 (4th Cir. 1982); W. PROSSER & W. KEETON, supra at 269.

District of Columbia v. Wilson, 721 A.2d 591, 596 (D.C. 1998).

In fact, the testimony in *Wilson* is strikingly similar to the testimony here: "if [plaintiff's decedent] had received timely health services during the night when the condition was worsening . . ., his life very likely could have been saved." *Id*. at 595-96.

In a medical malpractice case, expert medical testimony is ordinarily required on the issue of causation. *Allen v. Hill*, 626 A.2d 875, 877-878 (D.C. 1993). However, at least in some malpractice cases, no medical evidence is required to show causation. *See e.g. Washington Hospital Center v. Martin*, 454 A.2d 306, 308 (D.C. 1982) (whether appellee was in fact under restraints immediately prior to her fall and, if not, whether the hospital was negligent in leaving her unattended), *Martin v. Washington Hospital Center*, 423 A.2d 913, 916 (D.C. 1980) (whether symptoms were consistent with a mental disorder likely to persist from the time of discharge to the time of the fatal accident later that day.)

This recognizes the fact that the jury is not required to ignore the direct evidence in the case.

> There are, unquestionably, many occasions where the causal connection between a defendant's negligence and a disability claimed by a plaintiff does not need to be established by expert testimony. Particularly is this true when the disability develops coincidentally with, or within a reasonable time after, the negligent act….

Jones v. Miller, 290 A.2d 587, 590-591 (D.C. 1972), *quoting*, *Wilhelm v. State Traffic Safety Comm'n*, 230 Md. 91, 185 A.2d 715, 719 (1962). *See also Bahura v. S.E.W. Investors*, 754 A.2d 928, 942 (D.C. 2000).

Taken together these cases indicate at the very least that the jury was not required to ignore the fact that the onset of Mr. Saunders' paraplegia was

immediately following the procedure, the complications of which Dr. Hoffler has testified caused the injuries. Surely the defendant wished to show that the cause was otherwise, but this was a matter for evidence and submission to the jury.[4]

The trial court did not view the evidence in the light most favorable to Mr. Saunders. Instead, it took a hyper-technical view of the evidence in the light most favorable to the defendant. Thus, the action of the trial court in granting the motion for judgment deprived Mr. Saunders of his right to a jury trial. Dr. Hoffler, a board-certified general surgeon and Fellow of the American College of Surgeons, who was accepted by the trial court as an expert, testified that the paraplegia, incontinence and amputation were all caused by defendant hospital's negligence. That is all that is required.

[4] The trial court, without objection, permitted defendant hospital to call one of its medical experts out of order and prior to the conclusion of Mr. Saunders' case. 9/13/02 Tr. 35-119. The witness testified that there was a different cause for the spinal cord infarct. This testimony is ignored for this analysis both because the evidence was not a part of plaintiff's case and because, under the standard of review, evidence contrary to the plaintiff's evidence is disregarded.

II. Whether Dr. Brownlee's deposition should have been excluded for failure to show familiarity with the national standard of care.

Standard of Review

The admission or exclusion of expert testimony is committed to the trial court's broad discretion. *In re Melton*, 597 A.2d 892, 901 (D.C. 1991) (en banc).

In the exercise of that discretion, however, the trial court must apply the correct rule of law, and the judge's legal rulings are reviewed *de novo*. *District of Columbia v. Sierra Club*, 670 A.2d 354, 361 (D.C. 1996). In other words, a trial court "by definition abuses its discretion when it makes an error of law." *Koon v. United States,* 518 U.S. 81, 100 (1996).

Discussion

The trial court erred in excluding the deposition of Dr. Brownlee.[5] The defendant argued that the deposition ought to be excluded for a wide variety of reasons. *See* Opposition to Motion to Vacate Judgment and for New Trial, Rec. 319-23. The trial court, however, made clear that its ruling was based on "the requirement … that you have to lay a foundation with the witness for

[5] The deposition was not marked as an exhibit at the time of the trial court's ruling; however, it was attached to Mr. Saunders' Amendment to Motion to Vacate Judgment and for New Trial as Exhibit G, Rec. ___. The deposition is cited herein by reference to the transcript page numbers, e.g., Dep. Tr. ___.

the national standard of care in order to qualify that witness." 9/10/02 Tr. 178. The defendant's argument is flawed for several reasons. First, the record does reflect a sufficient familiarity with the national standard of care. Second, the defendant waived any objection to Dr. Brownlee's qualifications by not objecting at the time the deposition was taken. Third, the defendant waived any objection to Dr. Brownlee's qualifications by failure to preserve that objection in the joint pre-trial statement.

The deposition of William H. Brownlee, M.D. was taken by defendant on August 22, 2000. Dr. Brownlee died on December 20, 2001. A joint pre-trial statement was executed after the required meeting of counsel on January 16, 2002. The statement was signed by counsel for both parties. In the joint pre-trial statement, plaintiff gave notice of his intention to offer Dr. Brownlee's deposition at trial. The defendant reserved no objection. At the conclusion of the second day of the trial, Mr. Saunders moved the admission of the deposition into evidence. 9/10/02 Tr. 167. The defendant argued that Dr. Brownlee had not been qualified as an expert. *Id*. Defendant argued it was "basing [the objection] entirely on Rule 32(b), which is objections to admissibility." 9/10/02 Tr. 174.

A. There was evidence from which to infer familiarity with the national standard of care.

Dr. Brownlee's deposition was offered to prove causation. 9/10/02 Tr. 179. However, the deposition contains opinions both as to the standard of care and its breach on the one hand and as to causation on the other. In analyzing the admissibility of the deposition it is important to keep in mind the simplicity of the case, namely that it is the failure to diagnose and treat a bleeding complication.

As Dr. Brownlee's deposition testimony related to causation, the requisite foundation need not have included reference to a national standard of care. "[T]he grounded reference to a national standard is a *requisite for any opinion regarding standard of care* in a medical malpractice case." *Hawes v. Chua*, 769 A.2d 797, 806 (D.C. 2001) (emphasis supplied). In addition to this recent statement on the subject, it is clear that the foundation of familiarity with the national standard of care has no application to causation testimony from the fact that, at least in some cases, no medical evidence whatsoever is required to show causation. *See supra* at 19 (citing cases). Yet, the trial judge ruled that for causation, "Again, the foundation still would have had to have been laid." 9/10/02 Tr. 181. This was an error of law.

As to causation, Dr. Brownlee testified that the patient "bled back into his retroperitoneal space, and then of course, developed a subsequent neuro-

logical problem as a result of the bleed back into the retroperitoneal space, the development of a hematoma." Dep. Tr. 9-10. The hematoma caused the "compression of the lumbricals and the causation of his cord infarct." The lumbricals "are the vessels leading from the aorta that supply the cord." *Id*.

A CAT scan should have been done on September 28 or 29. Dep. Tr. 33. Had that been done, the resulting neurological loss would have been prevented or lessened. Dep. Tr. 36.

For a causation witness, it must only be shown that he has the necessary skill and experience to state how the injury occurred. This is common sense, particularly in the facts of this case. Defendant hospital cannot show or cite to any authority for the proposition that a patient bleeds differently or that a hematoma forms differently or that a hematoma compresses the vessels to the spinal cord differently from one jurisdiction to another because they do not. National standard testimony is not essential to these inquiries.

As to the standard of care and its breach, familiarity with a national standard of care is reflected in the deposition. In this case, the breach of the standard of care is that "you've got a patient who has shown symptoms of a problem following a procedure that was not properly investigated, who did what we call a silent bleed." Dep. Tr. 9-10. The breach is not the "stick" of the femoral artery or the ensuing bleeding. "The breach is from the lack of

recognition of the complication occurring with the manifestation of symptoms." Dep. Tr. 25-26. Anticoagulants were maintained because the hospital's employees didn't recognize that Mr. Saunders was bleeding when the records reflect that he was losing blood. *Id*. It is a breach of the standard of care not to recognize the bleed and to continue the patient on the anticoagulants. Dep. Tr. 31.

This Court has ruled that the mere words "national standard" have no talismanic quality. A trial judge errs when he rules that "[a]s long as you say there's a national standard of care, that's sufficient." *Hawes*, *supra*, 769 A.2d at 803. In this light, it would be odd indeed to require a trial judge to ignore all of the other evidence and rule the expert unqualified simply because there was no mention of the word 'national.'

This Court has, in fact, held that the lack of the words "national standard" is not fatal. In the case of *District of Columbia v. Watkins*, 684 A.2d 395 (D.C. 1996), there does not appear to have ever been any mention of the words 'national standard' yet this Court affirmed the trial judge's acceptance of the testimony.

The question is really whether "[i]t is reasonable to infer from [the] testimony that such a standard is 'nationally recognized'." *Phillips v. District of Columbia*, 714 A.2d 768, 775 (D.C. 1998). All that is required to meet

this standard is that it "(a) reflected some evidence that it was based on a national standard, and (b) was grounded on neither the expert's personal opinion, nor mere speculation or conjecture." *Hawes*, *supra*, 769 A.2d at 799. The testimony in this case meets these requirements.

Important factors to note in making this evaluation are that Dr. Brownlee gave his responses regarding the deviation from the standard of care "without restricting his responses to a particular locality." *See Watkins*, *supra*, 684 A.2d at 401-402. Moreover, the mere use of the words "I think" in the testimony does not render the response a personal opinion. The question is whether "the testimony, fairly read, expresses the witness' opinion of the standard of care, rather than what he would do himself." *Id*. at 402. There is nothing in Dr. Brownlee's testimony from which to infer that his opinions were personal in nature or were based on speculation or conjecture.

Dr. Brownlee, a board-certified general surgeon, testified in terms of a reasonable degree of medical certainty. Dep. Tr. 13. He continually referred to "the standard." *See e.g.* Dep. Tr. 24-26 & 30-31.

Dr. Brownlee testified that he did not consult any publications specifically in regard to this case. Dep. Tr. 19-20. He did, however, testify that his knowledge and experience upon which he based his opinions was derived in part from the review of published materials. *Id*. In particular, he had "re-

viewed the literature that applies to this case within the last year." Dep. Tr. 19. In addressing the particular the particular complication at issue, Dr. Brownlee made reference to how "[w]e are trained in my field of general surgery." Dep. Tr. 52.

In addition, Dr. Brownlee made reference to part of his education that occurred outside of the District of Columbia when he was trained at Norfolk Community Hospital in Norfolk, Virginia, by Dr. Hoffler, Mr. Saunders' other expert who was qualified as to the national standard of care. Dep. Tr. 44-45.

The defense argued that because Dr. Brownlee was not an interventional radiologist and had never done arteriograms, aortograms or angioplasties, that he was not qualified to testify. The trial court did not base its decision on this argument and was correct in rejecting that portion of the defendant hospital's argument. Defendant is trying to import a concept of multiple standards into the law.

The standard is "that degree of reasonable care and skill expected of members of the medical profession under the same or similar circumstances." *Morrison v. MacNamara*, 407 A.2d 555, 561 (D.C. 1979). "[T]here is but one uniform standard of conduct: that of reasonable care under the cir-

cumstances." *Ray v. American Nat'l Red Cross*, 696 A.2d 399, 402 (D.C. 1996) (internal quotations and citations omitted).

As previously noted, it is important to keep in focus that the standard and breach in this case relate to the failure to diagnose and stop bleeding. Once it is established that there are symptoms that should have led to the detection of the bleeding, the next step, namely that uncontrolled bleeding should have been controlled is not a giant leap. This is reflected in the evidence in this case that the standard of care, namely to diagnose and stop bleeding, applies to "anybody that's in service to the patient." Dep. Tr. 76.

Dr. Brownlee testified that he performed a wide variety of general surgical procedures, including hernia surgery, totaling some 100-120 cases per year. Dep. Tr. 5. In particular, in hernia surgery performed by general surgeons, "we can sometimes stick the femoral vessel. We know if we stick the femoral vessels you can get a retroperitoneal bleed from it." Dep. Tr. 30. General surgeons are trained to be cognizant of the problem of bleeding and how to control it. Dep. Tr. 52. In fact, when interventional radiologists do procedures of the kind involved here, the standard requires that "they have a urologist or general surgeon available" in case there are bleeding complications. Dep. Tr. 18. The trial court correctly rejected the apparently meritless

argument that general surgeons are not trained in the diagnosis and treatment of bleeding complications.

> The rule for the use of depositions at trial provides, in part, that:
>
> The deposition of a witness, whether or not a party, may be used by any party for any purpose if the court finds…that the witness is dead.

Super. Ct. R. Civ. P. 32(a)(3)(A).

The strong language of this rule recognizes the devastating impact that the death of a witness can have upon the substantial rights of parties to litigation. For this reason, the rule requires the trial judge in determining admissibility to balance the interests of the opponent of the evidence to procedural fairness and the right, perhaps the very ability, of the proponent of the evidence to maintain his cause of action.

In this light, the Eleventh and Fifth Circuits, interpreting the identical federal rule have upheld the "introduc[tion] into evidence [of] the discovery deposition of an expert witness who died prior to trial." *Gill v. Westinghouse Electric Corp.*, 714 F.2d 1105, 1107 (11th Cir. 1983). *See also Savoie v. Lafourche Boat Rentals, Inc.*, 627 F.2d 722, 724 (5th Cir.1980) and *Wright Root Beer Co. v. Dr. Pepper Co.*, 414 F.2d 887 (5th Cir.1969).

Dr. Brownlee's deposition reflects that had he been present and testifying, he was qualified to express opinions as to both causation and standard

of care. Thus, in view of the fact that the witness was dead, the balance is all the more weighted towards Mr. Saunders' right to maintain his cause of action over the defendant hospital's right to procedural fairness.

B. The defendant waived any objection to Dr. Brownlee's qualifications by not objecting at the time the deposition was taken.

The defendant admitted that a deposition can be used, but contended that it could be used only "so far as admissible under the rules of evidence applied as though the witness were then present and testifying." Super. Ct. R. Civ. P. 32(a). The defendant's argument, however, ignored the remainder of the language in the commencement of the rule which provided that such use be "in accordance with any of the following provisions" of the rule. *Id*.

It is true that under the rule, "objection may be made at the trial or hearing to receiving in evidence any deposition or part thereof for any reason which would require the exclusion of the evidence if the witness were then present and testifying." Super. Ct. R. Civ. P. 32(b). However, this is a general provision and it is expressly made subject to the provisions of subdivision (d) (3) of the rule. *Id*.

The usual rule for objections is that "errors of any kind which might be obviated, removed, or cured if promptly presented, are waived unless seasonable objection thereto is made at the taking of the deposition." Super. Ct. R. Civ. P. 32(d)(3)(B). In addition, "Objections to the competency of a wit-

ness or to the competency, relevancy, or materiality of testimony are not waived by failure to make them before or during the taking of the deposition, *unless the ground of the objection is one which might have been obviated or removed if presented at that time*." Super. Ct. R. Civ. P. 32(d)(3)(A) (emphasis supplied). The common thread is the ability to address the alleged deficiency at the time. The common example given is "the failure to lay an adequate foundation." *Jordan v. Medley*, 711 F.2d 211, 218 (D.C. Cir. 1983) (Scalia, J.).

Clearly, Dr. Brownlee's qualifications are foundational in nature. The trial judge so noted. 9/10/02 Tr. 177-78. Equally clearly, any question about Dr. Brownlee's qualifications could have been remedied by bringing the subject up at the time of the deposition. In fact, the precise opposite conclusion than that urged by the defendant is warranted. It is quite reasonable to infer that the there really were no questions regarding Dr. Brownlee's qualifications or the defendant would have inquired into the suspected lack of qualifications at the time of the deposition. No such inquiry or objection was made.

"If the opposing party had notice of the deposition or was present but chose to conduct an investigatory rather than adversarial interrogation, that

alone is not reason for exclusion of the deposition testimony at trial." *Shives v. Furst*, 521 A.2d 332, 336 (Md. App. 1987).

The defendant waived this objection by not making it at the deposition when counsel and the witness were available and the subject could have been easily addressed.

C. The defendant waived any objection to Dr. Brownlee's qualifications by failure to preserve the objection in the joint pre-trial statement

.

A joint pre-trial statement was executed after the required meeting of counsel on January 16, 2002. Rec. 128. Counsel for both parties signed the statement. Rec. 184. In the joint pre-trial statement, plaintiff gave notice of his intention to offer Dr. Brownlee's deposition in evidence at trial. Rec. 171. The defendant reserved no objection.

Failure to file an objection to the deposition within the required time operated as a waiver. Super. Ct. R. Civ. P. 16 (e)(5).

Doctor Brownlee's qualifications were sufficiently shown. Even if they were not, the defendant waived this objection first by not making it at the deposition when it could have been corrected and then again by not objecting to the proffer in the joint pre-trial statement. The deposition should have been admitted.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this Honorable Court reverse the judgment of September 16, 2002 and remand the case for a new trial.

Respectfully submitted,

LEROY SAUNDERS

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[6] Appearing *pro hac vice* by order of this Court entered January 24, 2003.

CERTIFICATE OF SERVICE

I, Donald L. McClure, Sr., a member of the Bar of this Court, hereby certify that on December 1, 2003, I served a copy of the foregoing document on the following listed persons, which include all of the parties required to be served, by depositing it in a United States mailbox with first class postage prepaid and addressed to:

Mr. James P. Gleason, Jr.
Mr. Larry D. McAfee
Gleason, Flynn & Emig
451 Hungerford Drive, Suite 600
Rockville, MD 20850

_____
Donald L. McClure, Sr.

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ADDENDUM

Super. Ct. R. Civ. P. 16. Pretrial Conferences; Scheduling; Management.

*****

(e) One Week Prior to Pretrial Conference. One week prior to the pretrial conference, the parties shall file with the Court and deliver to the assigned judge … a joint pretrial statement which shall…include the following items:

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(5) … Objections, if any, by a party to the exhibits submitted by any other party also must be made at this time as a part of the joint pretrial statement. A party raising an objection to an exhibit of another party shall attach to the statement of objection a copy of the exhibit to which objection is made. The Court will not consider any objection or alternative language which is filed beyond the time frames prescribed by this Rule unless the party can establish that the objection or suggestion could not, for reasons beyond the party's control, be timely filed.

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Super. Ct. R. Civ. P. 32. Use of Depositions in Court Proceedings.

(a) Use of Depositions.

*****

(3) The deposition of a witness, whether or not a party, may be used by any party for any purpose if the court finds:

(A) that the witness is dead; or

*****

(b) Objections to Admissibility.

Subject to the provisions of Rule 28(b) and subdivision (d)(3) of this rule, objection may be made at the trial or hearing to receiving in evidence any deposition or part thereof for any reason which would require the exclusion of the evidence if the witness were then present and testifying.

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(d) Effect of Errors and Irregularities in Depositions.

*****

(3) As to Taking of Deposition.

*****

(B) Errors and irregularities occurring at the oral examination in the manner of taking the deposition, in the form of the questions or answers, in the oath or affirmation, or in the conduct of parties, and errors of any kind which might be obviated, removed, or cured if promptly presented, are waived unless seasonable objection thereto is made at the taking of the deposition.

(C) Objections to the form of written questions submitted under Rule 31 are waived unless served in writing upon the party propounding them within the time allowed for serving the succeeding cross or other questions and within 5 days after service of the last questions authorized.

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Super. Ct. R. Civ. P. 50. Judgment as a Matter of Law in Jury Trials ….

(a) Judgment as a Matter of Law.

(1) If during a trial by jury a party has been fully heard on an issue and there is no legally sufficient evidentiary basis for a reasonable jury to find for that party on that issue, the court may determine the issue against that party and may grant a motion for judgment as a matter of law against that party with respect to a claim or defense that cannot under the controlling law be maintained or defeated without a favorable finding on that issue.

(2) Motions for judgment as a matter of law may be made at any time before submission of the case to the jury. Such a motion shall specify the judgment sought and the law and the facts on which the moving party is entitled to the judgment.

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