SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
CIVIL DIVISION

Christine Gambino, *et al.*,	:	
	:	
Plaintiffs,	:	
	:	**Case No. 2016 CA 001884 M**
v.	:	**Hon. Hiram Puig-Lugo**
	:	
MedStar Georgetown Medical Center Inc., d/b/a MedStar Georgetown University Hospital,	:	
	:	
Defendant.	:	
	:	

PLAINTIFFS' OPPOSITION TO DEFENDANT'S MOTION FOR JUDGMENT AS A MATTER OF LAW OR NEW TRIAL OR REMITTITUR

Georgetown's motion lacks even a shred of merit and should be denied for the following reasons:

1. The motion for judgment as a matter of law is based on a false premise: that there was some controversy at trial over what the national standard of care was. To the contrary, both plaintiff and defense experts agreed on the standard; the case was tried on whether or not Georgetown's nurse complied with the agreed standard. Another fatal flaw in the argument, even if one ignores the agreement among all experts, is that Georgetown tries to shoehorn nationally published experts on a topic into the diminished status of "mere personal opinion" as if it's meaningless that they articulated, not for courts but their peers, their views of the national standard of care for many years before this case.
2. Georgetown's objection to the *Pannu* jury instruction misunderstands the testimony that did provide a basis for the instruction.

3. Nurse Gardner's opinion about the amount of fluid that infiltrated into the tissue was fully supported by the evidence, and a *Daubert*-type challenge was perfunctory at most and without merit.
4. The size of the verdict was amply justified by the evidence of the nature and extent of R.G.'s lifelong disfiguring injury, none of which Georgetown even mentions in its brief, instead relying on a flawed and superficial comparison to other verdicts.

Further grounds in opposition are set out below.

I. Georgetown's Motion for Judgment Notwithstanding the Verdict or a New Trial is Without Merit

The Court already rejected these same arguments from Georgetown, and, in ruling on Georgetown's motion made at the close of evidence, took into account the testimony of Georgetown's own expert. (Def. Ex. 3, Tr. at 58:8-13.) Yet Georgetown now ignores its own expert's testimony, focusing solely on the testimony of plaintiffs' experts. This is remarkable given the Court's prior ruling and the standard of review for a motion for judgment or new trial, which focuses on the evidence as a whole – not simply plaintiffs' evidence. *See Bahura v. S.E.W. Inv'rs*, 754 A.2d 928, 939 (D.C. 2000).

This is important here, since Georgetown's only standard of care expert, Nurse Derenda Hodge, testified to the same standards of care as the plaintiffs' experts, who agreed that the standard of care required 1) hourly checks of R.G.'s peripheral i.v. (PIV) site and 2) removal of the PIV at the first signs of infiltration. All experts agreed that Georgetown's policies regarding neonatal PIV monitoring matched these standards. Therefore, even if the Court were to now agree with Georgetown's arguments regarding the sufficiency of the plaintiffs' experts' standard of care testimony, it would still have to find that the jury had sufficient evidence to conclude that

a national standard of care had been proven, based on the testimony of Nurse Hodge, and that Georgetown was negligent based on all the evidence. Therefore, the Court should deny Georgetown's motion for judgment or new trial.

A. Legal Standard

"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 for that party." *District of Columbia v. Wilson*, 721 A.2d 591, 596 (D.C.1998) (quoting *District of Columbia v. Cooper*, 445 A.2d 652, 655 (D.C.1982)) (en banc).

"To grant a motion for a new trial, the trial court must find that the verdict is against the weight of the evidence, or that there would be a miscarriage of justice if the verdict is allowed to stand." *Bond v. Ivanjack*, 740 A.2d 968, 972 (D.C. 1999) (citing *United Mine Workers of America v. Moore*, 717 A.2d 332, 337 (D.C.1998) and *Daka, Inc. v. Breiner*, 711 A.2d 86, 96 (D.C.1998)).

In *Bahura v. S.E.W. Inv'rs*, 754 A.2d 928, 939 (D.C. 2000), the Court of Appeals surveyed caselaw both here and in other jurisdictions and concluded that on a motion for judgment made after the close of evidence, the trial court must take into account *all* evidence presented at trial:

> In *Greet v. Otis Elevator Co.*, 187 A.2d 896, 897 n. 1 (D.C.1963), the Court of Appeals stated the applicable principle:
>
> > If a plaintiff has made out a prima facie case, a motion for a directed verdict at the close of plaintiff's evidence should be denied without restriction. The theory or theories upon which the case is submitted to the jury should be determined at the close of all the evidence because some evidence elicited from defendant's witnesses may be advantageous to plaintiff.
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> *Accord*, *Harris v. Plummer*, 190 A.2d 98, 99 (D.C.1963); *see also J. Maury Dove Co. v. Cook*, 59 App.D.C. 61, 62, 32 F.2d 957, 958 (1929).

> The former Supreme Court of Errors of Connecticut has correctly explained that[t]he jury were not confined to the evidence offered by the plaintiff or any one witness. The truth in closely contested cases does not always lie altogether upon one side. It is often found partly in the evidence of a plaintiff and partly in that of a defendant.

Giambartolomei v. Rocky DeCarlo & Sons, Inc., 143 Conn. 468, 123 A.2d 760, 763 (1956).

Furthermore, "In ruling on a motion for judgment n.o.v., the court must view the evidence as a whole, not in fragments. Like the pieces of a mosaic, the individual studies showed little or nothing when viewed separately from one another, but they combined to produce a whole that was greater than the sum of its parts." *Oxendine v. Merrell Dow Pharm., Inc.*, 506 A.2d 1100, 1110–11 (D.C. 1986).

B. The Jury Heard Ample Evidence of the National Standard of Care

1. Sandra Gardner Testified to the National Standard of Care

In a medical malpractice case, "the testifying expert must establish that the relevant standard of care 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.'" *Coulter v. Gerald Family Care, P.C.*, 964 A.2d 170, 189 (D.C. 2009) (quoting *Strickland v. Pinder,* 899 A.2d 770, 773 (D.C.2006)).

Importantly, the expert must "link his testimony to [a] certification process, current literature, conference or discussion with other knowledgeable professionals," at a national level to establish a "basis for his discussion of the national standard of care." *Cardenas v. Muangman*, 998 A.2d 303, 308 (D.C. 2010) (quoting *Strickland,* 899 A.2d at 774). In *Cardenas*, the Court of Appeals overturned the trial court's ruling that the plaintiffs' liability expert had not sufficiently testified to a national standard of care, where he testified that he

reviewed national literature, attended national conferences, and had discussed the specific standard of care in that case with other physicians in "various areas of the country." *Id.* at 310-311.

In this case, Nurse Sandra Gardner testified to a national standard of care, linked to nationally published literature (including the textbook that she edits), attendance at conferences, and discussions with other knowledgeable professionals. Nurse Gardner testified:

> 5 Q. Aside from editing this textbook, how else are
> 6 you familiar with these standards?
> 7 A. Attend national meetings. I'm a member of the
> 8 National Nursing Organizations and professional nursing
> 9 set standards for our profession. I read journals cover
> 10 to cover. I go to the medical library most every Sunday
> 11 and dig up the pediatric -- the medicine journals and read
> 12 articles that are relevant to neonatal care.

(Defense Ex. 1, Gardner Tr. at 14:5-15.) In regard to the literature, she testified:

> 15 The standards are written for all nurses like
> 16 the American Journal of Nurse -- I mean the American
> 17 Nurses Association. They write the code of ethics and all
> 18 the subspecialty organizations ascribe that nurses, as a
> 19 registered anything that you will practice ethically. The
> 20 standards are written as a minimal requirement of nurses
> 21 when we are doing our work.

(*Id.* at 15:15-21.)

She also testified that she had worked for 37 years as a NICU nurse, first in Kentucky, then in Colorado, where she also taught at the Colorado School of Nursing and traveled around Colorado and the seven surrounding states, teaching NICU nursing. (*Id.*at 4-6.)

Importantly, not only did Nurse Gardner testify that she was familiar with the standards of care, she showed the jury how the literature supported her testimony, testifying that she edits a textbook, Merenstein and Gardner's Handbook of Neonatal Intensive Care, (Plaintiffs' Trial Ex. 90) now in its 8th edition, which is reliable authority in the field of NICU nursing (Defense Ex. 1,

Gardner Tr. at 33:22-25) and specifically discusses the standard that applied in this case. (*Id.* at 30:20-24). These standards included hourly checks of a PIV site, which she testified had been the standard of care for NICU nurses going back to at least the 2nd edition of her textbook, published in 1989. (*Id.* at 31:11 – 33:2.)

Since this is a national textbook for providing neonatal intensive care, the defendant's suggestion that this book is merely Nurse Gardner's personal opinion, or anything other than reflective of her national standard of care testimony, is absurd. The textbook is not Nurse Gardner's personal memoir, not is it state- or locality-specific. The fact that this treatise is about to be republished in its ninth edition is itself evidence of the book's widespread acceptance as authority in its field. Georgetown would have this Court use the fact that Nurse Gardner and Dr. Hermansen (see below) have published on IV infiltrations against them, demoting their publications to mere "personal opinions." On the contrary, not only are Nurse Gardner and Dr. Hermansen familiar with the national standards of care – they and their publications are recognized by their peers as authorities on what the standards of care are.

Nurse Gardner also cited an article from the American Journal of Nursing, which is the official journal of the American Nursing Association. (*Id.* at 33:6-19; Plaintiffs' Trial Ex. 86). This article, called Infiltration and Extravasation: Preventing a complication of IV catheterization, also stated the standard of care:

> [At] the very first sign or symptom of infiltration or extravasation, immediately stop the infusion or the injection.
>
> Estimate the volume of fluid or medication that escaped into the subcutaneous tissue according to the flow rate, the condition of the site in comparison with the previous observation, and the length of time between observations.

(*Id.* at 34-35.)

Georgetown's own policies and procedures reflected this same standard of care. (Ex. 1, Georgetown's NICU Policies, Plaintiffs' Trial Ex. 47.) These policies required Georgetown's NICU nurses to check the IV site hourly and to remove a PIV at the first sign of infiltration.

> 7) Assess the catheter insertion site and perfusion to the areas distal to the catheter insertion, with appropriate documentation, at least hourly.
>
> 8) If signs of infiltration are noted, stop the infusion immediately.

(*Id.* at 2.)

"A plaintiff's expert may point to rules or guidelines set forth in a defendant's own guidebook or its standard operating procedures as evidence of the standard of care" as long as the expert adequately demonstrates that those rules or guidelines reflect or embody a national standard of care. *Robinson v. Washington Metro. Area Transit Auth.*, 941 F. Supp. 2d 61, 68 (D.D.C. 2013), *aff'd*, 774 F.3d 33 (D.C. Cir. 2014) *(citing Clark v. Dist. of Columbia,* 708 A.2d 632, 635 (D.C.1997)).

Not only did Georgetown's policies and procedures (which were entered into evidence without objection) facially match Nurse Gardner's national standard of care testimony, but Nurse Gardner explained several times how Georgetown's policies were consistent with the national standard of care. (Def. Ex. 1, Gardner Tr. at 34:4-8; 39:16-21). Georgetown attempts to argue that Nurse Gardner's testimony regarding national and local standards of care confused the jury, but Nurse Gardner clearly linked the national standards to the local, i.e. Georgetown's, own policies. The jury would have no reason to be confused about what standards of care applied in this case – they were consistent throughout.

The defense cites *Travers* v. *District of Columbia*, 672 A.2d 566 (D.C. 1996), for the proposition that an expert cannot testify to the national standard of care based simply on

attending national meetings, especially when that particular standard wasn't discussed at such meetings. (Def. Brief at 3.) That is not what occurred in this case.

The Court of Appeals has never ruled that a witness who testifies as thoroughly about the national standard of care as Nurse Gardner did in this case should be excluded. Nurse Gardner's testimony was not her "personal opinion" about what the standard of care is, as the defense suggests, but was consistent with the national standard of care as articulated by the literature, both her own and others, the defendant's policies, and the other experts – both plaintiff and defendant – in this case.

2. Dr. Hermansen Testified to a National Standard of Care

Like Nurse Gardner, plaintiffs' expert Dr. Marcus Hermansen testified about his experience with the standard of care for nurses monitoring a PIV site, which included working in hospitals in different states practicing medicine in NICUs for 35 years as a board-certified neonatologist and pediatrician. (Def. Ex. 2, Hermansen Tr. at 54-55.)

Dr. Hermansen also pointed to the literature to demonstrate the standard of care, citing his own chapter, called Complications of IV Therapy, published in a book called Clinics in Perinatology, which is "a series of books that come out three or four times a year for continuing education for doctors in my field." (*Id.* at 56.) Summarizing the standard of care as articulated in his article, Dr. Hermansen testified:

> We've learned over 50 years it's safe to check these IVs hourly. If we are checking them hourly and the most we have is one hour [of] fluid, that's the absolute most it could be, that's safe. We don't see tissue damage.

(*Id.* at 64-65.)

The actual text of Dr. Hermansen's article was published to the jury during the testimony of defense expert Derenda Hodge, who agreed that his article was authoritative

in the field. (Ex. 3, Hodge Tr., Vol. 2 at 96-97.) Nurse Hodge, who worked her entire career as a NICU nurse in Tennessee, agreed with this standard set out in Dr. Hermansen's article:

> The best method of avoiding permanent extravasation injury resides with not with treating the injury, but in preventing it. Infiltration injury can be reduce by providing good visibility of catheter insertion site, performing frequent hourly or more inspections of the site and immediately removing any catheter if there is a concern of a possible infiltration or phlebitis.

(*Id.* at 98:20-99:5.)

Dr. Hermansen also testified that Georgetown's policies were consistent with the national standard of care. (Def. Ex. 2, Hermansen Tr. at 57:12-58:7.) So, Dr. Hermansen, like Nurse Gardner, conclusively testified to the national standards of care – checking a PIV site hourly, removing the IV at the first sign or concern of infiltration – based on his training and experience and the national literature, which is also reflected in Georgetown's own policies.

3. Defendant's Expert Nurse Derenda Hodge Testified to the Same Standards of Care as Plaintiffs' Experts

Georgetown ignores the testimony of its own expert in making its arguments, and apparently also ignored that her testimony factored into the Court's denial of the defendant's motion for judgment, made at the close of all evidence. (Def. Ex. 3, Tr. at 58:8-13.)

Nurse Hodge testified, "It is the national standard that we would hourly watch IVs and monitor them." (Ex. 2, Hodge Tr. Vol. 1 at 27:22-23.) Nurse Hodge also testified that the customs and habits of Nurse Kim in response to seeing puffiness at a PIV site – aspirating and flushing, touching the PIV site to asses temperature and blanching, and making more frequent checks of the site – would also have been standard of care. (Ex. 3, Hodge Tr. Vol. 2 at 6; 27.)

In terms of when a PIV should be removed, Nurse Hodge did not disagree with the standard stated by Nurse Gardner – "when in doubt, pull it out" – but said that this determination

"involved nursing judgment." (*Id.* at 23:12-17.) Nurse Hodge later explained, "You just try to maintain a line as long as you can until it declares itself. Q: All right. Just very briefly, what do you mean by declares itself? A: That you would see symptoms that as you are judging what is going on that would indicate that it is infiltrated." (*Id.* at 24:10-16.)

In other words, Nurse Hodge agreed that a PIV should be removed when the symptoms of infiltration are present, though she couched her opinion by saying that a nurse would have to "judge" an infiltration to be occurring in order for the standard to require that it be removed.

In short, every expert at trial agreed, and all the literature and policies shown to the jury stated, that national standards of care call for PIV sites in newborns to be checked hourly, and that PIVs should be removed at the first signs of infiltration.

Ultimately, the question of liability wasn't about disputed standards of care, but was about what Nurse Kim did or didn't do. The jury could well have found that Nurse Kim negligently failed to comply with the agreed standard to monitor R.G.'s PIV site hourly. R.G.'s grandmother, Shirley Goss, testified that Nurse Kim told her shortly after 3 pm, when the infiltration was first discovered and when the two of them were standing over R.G.'s incubator, that it had been two hours since anyone checked on R.G. This testimony alone, coupled with the agreed standard for hourly checks, would defeat Georgetown's motion. Plaintiffs' experts corroborated the nurse's admission to the grandmother in their testimony that this severe Stage IV infiltration wound likely developed over a period of at least two hours and could not have happened in less than one hour. (*See* Def. Ex. 1, Gardner Tr. at 95:2-8; Def. Ex. 2, Hermansen Tr. at 64:22-65:4.) Georgetown does not now challenge the sufficiency of this causation testimony from Nurse Gardner or Dr. Hermansen.

There was also, of course, a dispute over what actions Nurse Kim took when she first observed puffiness at the PIV site at 2 pm. Nurse Kim had no recollection of this event, and her testimony about what she would have done was based on her alleged habit and custom – and therefore the jury was free to disregard that she actually did any of these things: aspirated and flushed, touched the PIV site to asses for blanching, and made more frequent checks after 2 pm. If the jury believed that Nurse Kim hadn't taken these steps, it also could have found her to be in violation of the standard of care, as articulated by Georgetown's own expert. (*See* Ex. 3, Hodge Tr. Vol. 2, 6:5-16.) In short, abundant testimony in this case more than satisfied plaintiff's burden to show, by the end of the trial, national standards of care whose violation proximately caused R.G.'s injuries.

C. The Court Correctly Gave the *Pannu* Instruction

The Court gave Standardized Civil Jury Instruction for the District of Columbia § 9.02 (rev. ed. 2018), taken from *Pannu v. Jacobson*, 909 A.2d 178, 199 (D.C. 2006), which states, "A reasonable professional under the standard of care changes his or her conduct according to the danger he or she knows or should know, exists. Therefore, as the danger increases, a reasonable professional under the standard of care acts in accordance with those circumstances." In *Pannu*, the Court of Appeals had found it an abuse of discretion for the trial court to not have given that instruction, which is perhaps one reason why it has not become a standard instruction. *Id.*

In this case, there was evidence that the "danger increased," once Nurse Kim noted puffiness on R.G.'s chart at 2 pm. Nurse Kim recognizing that puffiness is among the first signs of infiltration, testified that she would have undertaken a slew of tasks in light of seeing puffiness, including aspirating and flushing the PIV line, physically touching the site to check for

blanching, and most importantly, beginning more frequent checks of the site so that she would have examined in several more times in the hour following 2 pm.

Nurse Hodge agreed with this approach, saying it was a "good thing" for Nurse Kim to have checked the site more often between 2 pm and 3 pm. (Ex. 3, Hodge Tr. Vol. 2 at 27: 6-17.)

The only reason a nurse would check a PIV site more frequently following an observation of puffiness is that puffiness, i.e. swelling or edema, is a potential sign of trouble. In other words, the presence of puffiness means that the danger has increased, and therefore a *Pannu* instruction was appropriate. All parties agreed that a nurse should take additional steps in light of puffiness at a PIV site – the disputes, in this case, were 1) whether Nurse Kim actually was observing the site hourly; 2) whether Nurse Kim should have removed the PIV when she observed puffiness; and 3) whether Nurse Kim actually took all the steps that she said were her custom and practice. Therefore, the Court appropriately gave the *Pannu* instruction. In any case, the instruction was never quoted in closing argument, and Georgetown does not try to make a case for why this alleged error was harmful to the point of requiring a new trial.

D. Nurse Gardner Had A Sufficient Basis for Her Opinion About the Amount of Fluid that Infiltrated

Georgetown ignores its own policies and procedures in arguing that Nurse Gardner did not have a sufficient basis to give her opinion about how much fluid appeared to have infiltrated into R.G.'s right leg.

The District of Columbia now applies a *Daubert/Kumho* standard for reviewing expert opinions, under *Motorola, Inc. v. Murray,* 147 A.3d 751 (D.C. 2016). The objective of the court's gatekeeping requirement "is 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 (citing *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 141, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999)).

Nurse Gardner testified that she estimated the amount of fluid that infiltrated into R.G.'s foot by 1) looking at how much fluid was infusing through R.G.'s PIV per hour, 2) looking at the first documentation of "trouble," which was puffiness noted at 1400, and 3) looking at a photo showing the appearance of the foot taken a day after the infiltration. (Def. Ex. 1, Gardner Tr. at 88.) She testified that this was a "standard approach" (*Id.*) and also testified extensively about how she was trained as a nurse to make such estimates. (*Id.* 83-84.)

This is such a standard approach that it is contained in both the literature that Nurse Gardner told the jury about, as well in Georgetown's own policies. As was stated above on pg. 5-6 of this brief, the American Journal of Nursing calls for nurses to "Estimate the volume of fluid or medication that escaped into the subcutaneous tissue according to the flow rate, the condition of the site in comparison with the previous observation, and the length of time between observations." (*Id.* at 34-35.)

Georgetown's own policies tell its nurses *three times* to estimate the amount of fluid in an infiltration wound:

> Perform assessment and documentation of the infiltration area, including color, perfusion, pulse, range of motion, and estimated amount of infiltrated fluid based on time of discovery." (Ex. 1, Plaintiffs' Trial Ex. 47 at 2.)
>
> Document assessment of the infiltrate, including color, perfusion, pulse, range of motion, and estimated amount of infiltrated fluid based on time of discovery. (*Id.* at 2.)
>
> Perform assessment and documentation of the infiltration area, including color, perfusion, pulse, range of motion, and estimated amount of infiltrated fluid based on time of discovery. (*Id.* at 4.)

In light of Nurse Gardner's testimony, the objective nationally published literature, and its own policies and procedures, Georgetown cannot now credibly claim that Nurse Gardner's estimate of the amount of fluid in R.G.'s infiltration was anything other than a standard approach in the field of NICU nursing.

II. Remititur is Inappropriate in this Case

A. Legal Standard

Georgetown concedes that the standard for reducing a jury's assessment of the amount of damages is that the verdict must have "shocked the conscience" of the court. But it never grapples with the high legal hurdle that creates for its motion. Instead, Georgetown veers off into a summary of other cases of what it calls "intravenous infiltration injuries" as the sole basis for its argument, ignoring literally all of the evidence about R.G.'s injury.

Because the defense goes astray in failing to follow this standard correctly, it is appropriate to briefly review the case law. The District of Columbia Court of Appeals – and before it, the D.C. Circuit – has used various formulations of the legal standard for when a trial court is authorized to reduce a jury's verdict for personal injury damages. The trial court must find that the verdict "shocks the [court's] conscience,"[1] or "was the result of passion, prejudice,

[1] *District of Columbia v. Hawkins,* 782 A.2d 293, 304 (D.C. 2001): "Only where the verdict is so excessive as to shock the conscience will a substantial remittitur or new trial be warranted."

or mistake,"[2] or was "monstrous,"[3] or a combination of these words.[4] All of these formulations work to accommodate the balance that the court must strike between respecting the jury's constitutional role under the 7th Amendment to decide the facts of the case and exercising judicial oversight when there has been a miscarriage of justice.

In addition, the jury verdict bears a presumption of validity. In *Louison v. Crockett,* 546 A.2d 400, 403 (D.C. 1988), the court introduced its discussion of a remittitur issue with this quotation from the often-cited case of *Vassiliades v. Garfinckel's, Brooks Bros.*, 492 A.2d 580, 595 (D.C. 1985): "Trial courts have historically given great weight to jury verdicts, granting a new trial only where there are unusual circumstances which convince the trial judge, who has also heard the evidence and seen the witnesses, that the jury had been improperly influenced by non-germane factors or that its verdict is clearly unreasonable."[5] The *Louison* court went on to remand the case to the trial court for a written explanation of why it had denied the defendant's request for remittitur, while stressing that it owed deference both to the trial court's decision and

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[2] *Capitol Hill Hospital v. Jones,* 532 A.2d 89, 93 (D.C. 1987), quoting *May Department Stores v. Devercelli,* 314 A.2d 767, 775 (D.C. 1973)

[3] *Taylor v. Washington Terminal Co.*, 133 U.S. App. D.C. 110, 113 n.9, 409 F.2d 145, 148 n.9, cert. denied, 396 U.S. 835 (1969); *City Stores Co. v. Gibson*, 263 A.2d 252, 252-53 (D.C. 1970).

[4] *District of Columbia v. Murtaugh,* 728 A.2d 1237, 1241 (D.C. 1999) (overruled on other grounds): "Before granting a motion for a new trial, the court must find that the verdict is against the weight of the evidence, or that there would be a miscarriage of justice if the verdict is allowed to stand. An excessive verdict is one which is "beyond all reason, or is so great as to shock the conscience. *Wingfield v. People's Drug Stores Inc.*, 379 A.2d 685, 687 (D.C. 1977)."

[5] See also *Croley v. Republican Nat'l Committee,* 759 A.2d 682, 703 (D.C. 2000), in which the appellate court quoted with approval the trial judge's rationale in refusing to reduce the verdict: "Trial courts have historically given great weight to jury verdicts. [Citation omitted.] And when parties have chosen the jury process as the means of resolving a legal dispute, it only seems proper for the court to afford significant deference to the collective wisdom of the jury."

to the jury's verdict. The court commented, "In exercising this so-called double deference, *i.e.*, deference to both jury and trial court, this court has been so reluctant to reverse a trial court's denial of a motion for remittitur or new trial that we have yet to do so." *Id.*, 546 A.2d at 404.

Georgetown cites a case from New Jersey as comparable to this one and thus supporting its position. (Def. Brief at p. 10.) Ironically, the New Jersey Supreme Court made it very clear in its recent decision of *Cuevas v. Wentworth Group,* 226 N.J. 480, 144 A.3d 890 (2016), that verdict comparison is the wrong approach in deciding a remittitur issue. The Court said:

> We do not believe that having our trial courts review snippets of information about cases that are not truly comparable is a worthwhile use of judicial resources or likely to bring greater justice to either plaintiffs or defendants. We therefore disapprove of the comparative-case analysis in deciding remittitur motions.

Id., 144 A.3d at 906-907. The Court stressed the need to focus on the facts of the case at issue, as opposed to verdicts in other cases, and concluded:

> In the end, a thorough analysis of the case itself; of the witnesses' testimony; of the nature, extent, and duration of the plaintiff's injuries; and of the impact of those injuries on the plaintiff's life will yield the best record on which to decide a remittitur motion.

Id., 144 A.3d at 907.

Just such a trial court's analysis of the evidence was praised by the D.C. Court of Appeals in *WMATA v. Jeanty,* 718 A.2d 172, 180 n. 14 (D.C. 1998). The appellate court quoted at length from Judge Weisberg's decision refusing to reduce the verdict, in which he wrote that the verdict for the plaintiff's pain and suffering was "much higher than the court would have predicted based on the evidence, but not so high as to shock the court's conscience …" The trial court went on to describe details of the plaintiff's "painful and debilitating" shoulder injury and concluded, "The award, while substantial, represents a permissible exercise of the authority our system gives to jurors to arrive at an amount which, in their collective and unanimous judgment, will fairly

and reasonably compensate a person injured by the negligence of another not only for so-called "special damages," but also for the more intangible elements of damages, including pain, suffering, inconvenience, disability and the like. The court is not empowered to deprive plaintiff of her verdict simply because it may think the jury should have awarded a lower amount." At the end of this quotation of the trial court's reasoning, the appellate court concluded: "We believe that the judge addressed the issue of damages candidly and in a balanced manner, and we discern no error of law." *Id*. at 180 n.14.

For its part, the D.C. Court of Appeals has not categorically ruled out a comparative verdict analysis in the way New Jersey's highest court has. Nonetheless, a review of D.C. cases shows that the comparative verdict approach has NEVER, to our knowledge, persuaded the Court of Appeals to reduce a verdict for alleged excessiveness. And as discussed below, the only appellate case in which a trial court used a verdict comparison to justify its decision on a motion to remit, *May Dep't Stores v. Devercelli,* 314 A.2d 767 (D.C. 1973), actually prompted the Court of Appeals to reverse and direct the trial court to focus not on verdict comparisons but on the facts of the injury before it.

For example, in the case quoted by Georgetown to the effect that comparison to other awards "may be helpful," *District of Columbia v. Hawkins,* 782 A.2d 293 (D.C. 2001), the Court of Appeals rejected the D.C. government's argument that the verdict for the decedents' pain and suffering for a period of two to five minutes should be reduced proportionally to a time-of-suffering amount approved in another case. Immediately after describing the District's argument, the Court observed:

> While reference to other awards may be helpful, in the end "excessive verdicts should not be measured strictly on a comparative basis." *Capitol Hill Hosp., supra, 532 A.2d at 93*. The trial court must determine whether "on the totality of facts before it whether [the damage award] was the result of passion, prejudice, or mistake." *Id*. (quoting *May Dep't*

> *Stores v. Devercelli*, 314 A.2d 767, 775 (D.C. 1973)). When we determine whether the standard has been met for an excessive verdict, we must examine the extent and nature of the damages proved by the evidence. *See Weinberg v. Johnson*, 518 A.2d 985, 994 (D.C. 1986).

Id. at 305.

The Court went on to describe the evidence from an expert and from an eyewitness at the scene about the amount and nature of the decedents' suffering at issue, and concluded that the trial court had not abused its discretion in not further reducing the pain-and-suffering verdict beyond what the trial court had done. *Id.*

The other case cited by Georgetown, *Capitol Hill Hospital v. Jones*, 532 A.2d 89 (D.C. 1987), also rejected comparisons to other verdicts as decisive in any remittitur analysis. That court affirmed a trial court's refusal to reduce a pain and suffering verdict and said: "While the parties cite cases granting both higher or lower amounts for pain and suffering to bolster their contentions about this verdict, *we have said that excessive verdicts should not be measured strictly on a comparative basis.* Rather: 'Each case in this area necessarily rises or falls on its own facts and the trial court in ruling on the question of whether or not a jury verdict is excessive must determine on the totality of facts before it whether it was the result of passion, prejudice, or mistake.' *May Department Stores v. Devercelli*, 314 A.2d 767, 775 (D.C. 1973)." *Jones*, 532 A.2d at 93. (Emphasis added.) In the *May Dept. Stores* case, the trial court had actually used its own informal survey of other verdicts to deny a remittitur motion. The Court of Appeals remanded for reconsideration of the defendant's motion, directing the trial court to refocus on the injury before it, and holding:

> The question is whether the amount of the verdict in this case, regardless of its comparative size, was the result of passion, prejudice or mistake. Each case in this area necessarily rises or falls on its own facts and the trial court in ruling on the question of whether or not a jury verdict is excessive must determine on the totality of facts before it whether it was the result of passion, prejudice or mistake.

314 A.2d 775.

The solitary D.C. case we have found that explicitly looked at comparable verdicts to measure the reasonableness of the amount of a verdict was in the very different context of punitive damages, where the U.S. Supreme Court has directed courts to conduct such comparisons to assess the constitutionality of a punitive award. *See Howard Univ. v. Wilkins,* 22 A.3d 774, 781 (D.C. 2011), citing *State Farm Mutual Ins. Co. v. Campbell,* 538 U.S. 408, 418 (2003). Such punitive awards, of course, focus on the defendant's conduct, unlike compensatory damages in personal injury cases, where the jury is asked to assess the unique circumstances of an individual plaintiff's injuries and damages. In assessing the reasonableness of compensatory damages, it is a fool's errand to try to compare the detailed evidence of what happened to the individual plaintiff with snippets of summaries about other cases.

B. The Facts Easily Justify the Amount of the Verdict

As this Court saw with its own eyes when R.G. was brought into court on the second day of trial for a brief and unobjected-to appearance, R.G. at age 5 has a significant deformity in her right ankle from the chemical burn she suffered at age two weeks in the defendant's newborn intensive care unit. The ankle has a large scar that wraps around the inside, back and front of her lower leg. The ankle appears withered from the burn-out of subcutaneous fat below the skin, caused by the chemical burn. The withered appearance will grow more noticeable in her teen years, when she will have a normally developed calf just above the area of scarred ankle that will remain without a normal fat pad. Dr. Redett, her treating plastic surgeon at Johns Hopkins, called this a "contour deformity" and testified that there is nothing that can be done to improve the cosmetic appearance. (*See* Ex. 4, Plaintiffs' Demonstrative Trial Ex. 4, showing R.G.'s leg as it

will likely appear when she is an adult vs. how it now appears.) As a pediatric plastic surgeon, Dr. Redett receives referral cases of bad IV infiltrate injuries, and he characterized R.G.'s as one of the worst he has ever seen. Dr. Redett has done six laser surgeries under general anesthesia to try to loosen up the tightening in R.G.'s ankle joint from the injury, and although her skin is now more supple in that area, the tightness remains. The Court and of course the jury could also see this: R.G. walks without putting her right heel down to the floor and favors the outside of the foot.

Dr. Arkader, the only orthopedic surgeon to testify in this case, testified that R.G. will need at least two serious orthopedic procedures. She needs to have the ankle capsule opened and the tendons inspected and potentially her Achilles tendon lengthened. (Ex. 5, Arkader Tr. at 27:1-28:11.) That surgery will require teamwork with a plastic surgeon because it will be difficult to close the surgical wound without transplanting a flap of skin from elsewhere on the body. (*Id.* at 86:14-87:3.) Dr. Redett testified that such a flap procedure is fraught with peril because there are only three arteries that naturally feed blood to the ankle and foot, and one of them will have to be diverted to feed the new flap. Dr. Arkader also testified that R.G. has a significantly shorter right leg that has thrown off the balance in her pelvis when she stands, because of the worsening length discrepancy compared to the normal left leg. (*Id.* at 18:8-16.) He said she will need surgery to stop the growth of the normal leg around age 10, to try to even out the two legs. (*Id.* 49:2-50:13.) He hopes that those two surgeries will give her a normal gait but she will likely be more than an inch shorter than she would otherwise be (*Id.* at 51:10-14.), and he ruled out a certain level of athletic competitiveness. (*Id.* at 85:9-86:4.)

The jury also heard evidence about how it took many months for the initial burn injury to close and scar over, how R.G. had to undergo serial leg casting at age one to reduce the tightness

in the ankle, how she faces another round of casting in the near future, and many other details, most undisputed. The only difference of opinion in damages came on the last day of trial when the jury heard from a plastic surgeon named Dr. Silverman. He testified that he agreed she needs surgery to fix the tightness in the ankle but believes it might be possible without a skin flap and using only a simple skin graft. The jury was entitled to put less weight on Dr. Silverman, who has seen R.G. only once, compared to the 20 or more times Dr. Redett has examined and treated her.

As plaintiff's counsel argued without objection in closing, the cosmetic aspect alone of this injury is quite profound. R.G.'s disfigurement is not merely on a noticeable part of the body, but a body part that for many women is an important aspect of feminine beauty. Even when a woman is not wearing the latest fashion to call attention to her ankles, it is still typical and ordinary for a woman to show her ankles throughout the day. R.G. throughout her lifetime of 80-plus years will not have that option unless she is willing to bear the stares of strangers. In short, we have here a profound injury fully justifying the jury's verdict.

C. The Defense Argument Against the Verdict Disregards the Evidence

In the face of all this evidence, and with no contention that the jury was improperly instructed on damages,[6] or that plaintiff's counsel made some inflammatory argument, the defense mounts a thin protest that does nothing more than collect some old verdicts and apply a present value calculator to them.

[6] See *Hechinger Co. v. Johnson*, 761 A.2d 15 (D.C. 2000), where the court rejected a contention of an excessive verdict, ruling among other reasons that the jury was properly instructed on the measure of damages and is presumed to follow its instructions. As noted below, the court in *Hechinger* also affirmed plaintiff's use of a *Colston* argument in closing.

The defense does not even contend that the verdict was "against the clear weight of the evidence." It just says the verdict was too high in comparison to other cases. This is a fatal flaw for the defense motion, because it ignores the long-standing law here and elsewhere that jury verdicts rise or fall on the specific evidence of the case, not on extraneous matters.

While there is no hard-and-fast rule against using comparative case analysis, still, our Court of Appeals, as previously discussed, has repeatedly made clear that the analysis must focus first and foremost on the facts of the case. On that, the defense is utterly silent. The defense says not one word about the injury suffered by R.G., except to lump it into other IV infiltration injuries and to imply that verdicts in court should follow some sort of workers' compensation-type schedule of so much for an eye and so much for a disfigured ankle.

D. Plaintiffs' "*Colston* Argument" Was Not Improper

This Court ruled before closing arguments, in accordance with a substantial body of case law in this jurisdiction, that it would be proper for plaintiff's counsel to make a *Colston*-type argument for money damages. Counsel then did so, without a word of objection from Georgetown's counsel. (Def. Ex. 3 at 81.)

In *District of Columbia v. Colston*, 468 A.2d 954 (D.C. 1983), which concerned an injury that left the plaintiff blind in one eye, plaintiff's counsel said to the jury in closing argument: "How much is a healthy eye worth? You cannot restore his vision but you can compensate him for the loss. Is an eye worth five hundred thousand? Eight hundred thousand? A million? That is for you to say. That is for you to decide." *Id.* at 956, 957 n. 1.

The Court of Appeals said the argument was "not improper" and that such an argument was a proper effort by plaintiff's counsel "to stress those aspects of the case that contribute to its seriousness." Id. at 958 (internal citations omitted).

To the same effect is *Hechinger Co. v. Johnson*, 761 A.2d 15 (D.C. 2000). In that case, a patron sued a hardware store for damages for the serious brain injury he sustained when an employee of the store assaulted him. *Id.* at 18-19. In closing, plaintiff's counsel argued: "I can't tell you what his injuries are worth. That's up to you to determine how much he is to receive. *I can't tell you if it is a million dollars, if it is two million dollars, or if it is three million dollars. That is for you to decide*. *Id.* at 22 (emphasis in original).

On appeal, the Court found "no material difference between the dollar figure argument sanctioned in *Colston* and the one that [the plaintiff's] counsel made in this case. Neither counsel asked the jury to award a specific dollar amount, and both told the jury that it was for them to decide the proper measure of damages." *Id.* Also, as in *Colston*, "the trial court instructed the jury that it must base its decision on the evidence, without sympathy, prejudice or passion, and that the statements of counsel are not evidence. The jury is presumed to follow the court's instruction." *Id.*

Now all that Georgetown says is that plaintiffs' number in the "high seven figures" was too high in comparison to other verdicts involving intravenous infiltrations. (Def. Brief at p. 13.) Importantly, though, Georgetown does not argue that plaintiffs' argument was improper, in this or any other way. Thus, another basis for remittitur – that improper arguments somehow whipped the jury into an irrational frenzy – vanishes, because Georgetown implicitly acknowledges there was nothing improper about plaintiffs' argument on damages.

Conclusion

Georgetown presents no real challenge to this jury's verdict. The thinness of its arguments goes only to show how meticulously and fairly this Court conducted the trial. The motion should be denied in its entirety.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing Opposition brief was served upon all counsel of record registered with the Court's electronic filing system on this 12th day of December 2018.

/s/ Daniel C. Scialpi

SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
CIVIL DIVISION

Christine Gambino, *et al.*,	:	
	:	
Plaintiffs,	:	
	:	**Case No. 2016 CA 001884 M**
v.	:	**Hon. Hiram Puig-Lugo**
	:	
MedStar Georgetown Medical Center Inc., d/b/a MedStar Georgetown University Hospital,	:	
	:	
Defendant.	:	
	:	

ORDER

UPON CONSIDERATION of the Defendant's Motion for Judgment as a Matter of Law or New Trial or Remittitur, and Plaintiffs' Opposition thereto, and it appearing that good cause is lacking for the granting of said Motion, it this _____ day of _____, 20____, hereby

ORDERED that the Motion be and is hereby DENIED.

Date_____ _____

Hon. Hiram Puig-Lugo
D.C. Superior Court

Copies to all parties via Case File Express