IN THE

DISTRICT OF COLUMBIA

COURT OF APPEALS

No. 07-CV-1221

ESTATE OF RONALD D. KURSTIN, M.D.

Appellant,

v.

JOHN B.M. LORDAN, et al.,

Appellees.

ON APPEAL FROM THE SUPERIOR COURT

OF THE DISTRICT OF COLUMBIA, CIVIL DIVISION

Brief of Appellees

Patrick A. Malone
Patrick Malone & Associates, P.C.
1331 H Street, N.W., Suite 902
Washington, D.C. 20005
202-742-1500

Attorneys for Appellees

CERTIFICATE REQUIRED BY RULE 28(a)(1) OF THE RULES OF THE DISTRICT OF COLUMBIA COURT OF APPEALS

The undersigned, counsel of record for Appellees, certifies that the following parties appeared below:

Estate of Ronald D. Kurstin, M.D.	Defendant below, Appellant
John B.M. Lordan and Surgical Anesthesia Associates, PLLC	Cross-Plaintiffs below, Appellees

The undersigned previously represented the plaintiff Rosalee Blue before undertaking the representation of Drs. Lordan and others on their cross-claim.

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

Table of Contents

Certificate Required by Rule 28(a)(1) by the Rules of the District of Columbia Court of Appeals……ii

Table of Contents……iii

Table of Authorities……v

Statement of the Issues……1

Statement of the Case ……2

Statement of the Facts……4

Introduction……4

Basis for the National Standard of Care……5

Applicable National Standard of Care……7

Dr. Kurstin's Breach of the National Standard of Care……10

Proximate Cause of Ms. Blue's Injuries……12

Reasonableness of Settlement in Light of Ms. Blue's Damages……...15

Standard of Review……16

Summary of Argument……...…..17

Argument……..18

I. The Settlement Agreement and Release Expressly Reserved The Right For Dr. Lordan to Prosecute a Claim for Contribution against Dr. Kurstin. Thus This Claim Was Not Barred……..……18

a. The Plain Language of the Settlement Agreement and Release Provided Dr. Lordan with the Right to Bring the Contribution Claim Against Dr. Kurstin…….……..……19

b. That Dr. Lordan Agreed that the Proceeds of the Contribution Action Would Ultimately Be Paid By Him to Ms. Blue and Her Counsel Does Not Provide a Basis to Negate the Plain Language of the Settlement Agreement and Bar Dr. Lordan's Contribution Claim……21

II. As Required Under *M. Pierre Equipment*, The Court Correctly Concluded That Dr. Kurstin was a Joint Tortfeasor, And The Amount Of The Settlement, Including the Potential of An Additional $1 Million From The Contribution Claim, Was Not Unreasonable In Light Of Her Severe Injuries……...……26

a. There Exists No "Judicial Determination" Requirement for a Settling Tortfeasor to Pursue a Contribution Claim……...……...26

b. There Is Ample Evidence that Dr. Lordan Is a Joint Tortfeasor…….30

c. The Reasonableness of the Settlement Is Beyond Dispute…….32

III. Dr. Lordan Established a National Standard Of Care Applicable To Dr. Kurstin, and The Trial Court Correctly Determined That Dr. Kurstin Violated That Standard Of Care……..34

IV. Dr. Lordan Proved That Dr. Kurstin Proximately Caused Ms. Blue's Injuries……..42

a. There Was a Direct and Substantial Causal Relationship Between Dr. Kurstin's Breach of the National Standard of Care and Ms. Blue's Injuries……42

b. It Was Foreseeable that Dr. Kurstin's Request for Dr. Lordan to Administer Lovenox Intravenously During the Operation Would Result in the Injuries Sustained by Ms. Blue……43

Conclusion……46

Table of Authorities

Cases Page

Berg v. Footer,
673 A.2d 1244 (D.C. 1996)…… 26,27,33

Brandenburger & Davis Inc. v. Estate of Lewis,
771 A.2d 984 (D.C. 2001)……..…… 23

Burke v. Scaggs,
867 A.2d 213 (D.C.2005)…… 34

**Caglioti v. District Hosp. Partners, LP*,
933 A.2d 80, (D.C. 2007)……...……...……. 21,23

District of Columbia v. Washington Hospital Center,
722 A.2d 332 (D.C. 1998)……..…… 28

District of Columbia v. Zukerberg,
880 A.2d 276 (D.C.2005)…… 42

Early Settlers Ins. Co. v. Schweid,
221 A.2d 920 (D.C.1966)…..…… 28

Ferrell v. Rosenbaum,
691 A.2d 641 (D.C. 1997)…… 42

Flack v. Laster,
417 A.2d 393 (D.C. 1980)……...…….. 23

Garvey v. O'Donoghue,
530 A.2d 114 (D.C. 1987)…… 38

George Washington University v. Bier,
946 A.2d 372 (D.C. 2008)…… 29

GLM P'ship v. Hartford Cas. Ins. Co.,
753 A.2d 995 (D.C. 2000)……16,21

Graham v. Roberts,
441 F.2d 995 (D.C. Cir. 1970)……...……45

Hall v. George A. Fuller Co.,

621 A.2d 848 (D.C. 1993)…… 21

**Hawes v. Chua*,
769 A.2d 797 (D.C. 2001)…… 36

Hill v. Medatlantic Health Care Group,
933 A.2d 314 (D.C. 2007)…… 36

Hinton v. Sealander Brokerage Co.,
917 A.2d 95 (D.C. 2007)…….. 16,34

Leftwich v. Leftwich,
442 A.2d 139 (D.C. 1982)……..…….. 17

Lucy Webb Hayes Nat. Training School for Deaconesses & Missionaries v. Perotti,
419 F.2d 704, 136 U.S.App.D.C. 122 (D.C.Cir.1969)……. 41

Machesney v. Larry Bruni, M.D., P.C.,
905 F. Supp. 1122 (D.D.C. 1995)…… 43

Majeska v. District of Columbia,
812 A.2d 948 (D.C.2002)…… 42

M.A.P. v. Ryan,
285 A.2d 310 (D.C. 1971)…… 41

** M. Pierre Equipment Co. v. Griffith Consumers Co.*,
831 A.2d 1036 (D.C. 2003)…….1,27

National Health Laboratories v. Ahmadi,
596 A.2d 555 (D.C.1991)…… 42

National Union Fire Ins. Co. v. Riggs Nat'l Bank,
646 A.2d 966 (D.C. 1994)…….…….. 22

Pannu v. Jackson,
909 A.2d 178 (D.C.2006)……..….. 34

Paul v. Bier,
758 A.2d 40 (D.C. 2000)…… 29

Phillips v. District of Columbia,
714 A.2d 768 (D.C. 1998)……. 39

Psychiatric Inst. of Washington v. Allen,
509 A.2d 619 (D.C.1986)…….…… 42,44

Reid v. District of Columbia,
391 A.2d 776 (D.C. 1978)…….. 33

Richter v. Analex Corp.,
940 F. Supp. 353 (D.D.C. 1996)…….. 23

Sacks v. Rothberg,
569 A.2d 150 (D.C. 1990)…… 17

Snyder v. George Washington University,
890 A.2d 237 (D.C. 2006)…….. 36,42

Strickland v. Pinder,
899 A.2d 770 (D.C. 2006)…… 39

Taylor v. Telez,
610 A.2d 252 (D.C. 1992)…… 28

Talley v. Varma,
689 A.2d 547 (D.C.1997)……... 34

Travers v. District of Columbia,
672 A.2d 566 (D.C. 1996)……..…… 39

Washington v. Washington Hosp. Center,
579 A.2d 177 (D.C. 1990)…… 36

Zimmerman v. Safeway Stores, Inc.,
410 F.2d 1041 (D.C.Cir. 1969)……..…….. 43

District of Columbia Code

D.C. Code § 28-2301 (2001 ed.)…… 23

D.C. Code § 28-2304 (2001 ed.)…….. 23

Other Sources

Black's Law Dictionary, 7th Edition…….…… 22

Restatement (Second), Torts § 457 (1965)…….…..... 43

*= Cases principally relied on.

STATEMENT OF THE ISSUES

1. As a matter of contract interpretation, did paragraphs 5 and 14 of the settlement agreement and release between Dr. Lordan and Ms. Blue properly reserve the right for Dr. Lordan to bring a cross-claim for contribution against the non-settling defendant, Dr. Kurstin, so that the cross-claim was not barred by the release, notwithstanding a contemporaneous agreement between Ms. Blue and Dr. Lordan in which Dr. Lordan agreed to pay the proceeds of his contribution claim to Ms. Blue and her counsel?

2. Did the trial court correctly conclude that Dr. Lordan met his burden under *M. Pierre Equipment Co. v. Griffith Consumers Co.*, 831 A.2d 1036 (D.C. 2003), of showing that (1) the amount of settlement between the settling defendant, Dr. Lordan, and the plaintiff was reasonable; and (2) Dr. Kurstin and Dr. Lordan were jointly liable for Ms. Blue's injuries, where (a) the settling defendant sought contribution from the non-settling defendant in a pre-trial cross-claim, (b) the settling defendant admitted in the settlement agreement and through his attorney at trial that he was a "joint tortfeasor," (c) the non-settling defendant never disputed during the course of the trial on the contribution claim that the settling defendant was a joint tortfeasor, and (d) in fact, the non-settling defendant put on a vigorous defense asserting over the course of a four-day trial that the settling party was the *sole* liable party?

3. Did the trial court correctly determine that there was a national standard of care, where Dr. Lordan's experts testified to the national standard of care, based on the manufacturer's "black box" warning, the FDA public health advisory, a published consensus report, and Sibley Hospital's written policy, among other things, and that Dr. Kurstin violated this standard of care by ordering intra-operative Lovenox for Ms. Blue without specifying any required delay in its administration, when he knew she had just received an epidural catheter for post-operative pain

management?

4. Did the trial court correctly determine that Dr. Kurstin, along with Dr. Lordan, was a proximate cause of Ms. Blue's injuries, where the evidence showed that but for the intra-operative administration of the Lovenox, which was ordered by Dr. Kurstin, Ms. Blue would not have sustained a serious spinal cord injury?

STATEMENT OF THE CASE

On August 13, 2004, Rosalee Blue filed a medical malpractice action in the Superior Court for the District of Columbia against appellee Dr. John B.M. Lordan, M.D., her anesthesiologist for a surgery performed on her in April 2004 to repair an abdominal hernia, and his practice group, Surgical Anesthesia Associates, PLLC (hereinafter both are referred to jointly as "Dr. Lordan"). (A. 15.) Ms. Blue filed a second amended complaint on February 14, 2005, adding as a defendant the appellant Dr. Ronald D. Kurstin, M.D., the surgeon who performed the hernia repair.[1] (A. 14, 16-19.) In her complaint, Ms. Blue maintained that Dr. Lordan and Dr. Kurstin had negligently caused her to sustain serious injury to her spinal cord as the result of their improper decision to administer a blood-thinning (anticoagulant) drug during her operation, contrary to the national standard of care.

Shortly before trial, Ms. Blue entered into a settlement agreement and release with Dr. Lordan, which was embodied in two related documents, both dated February 2, 2007. (A. 635-42; 644-45.) The first document provided that Dr. Lordan would pay Ms. Blue $2 million and stated in two separate provisions that the parties reserved the right for Dr. Lordan to proceed

[1] Dr. Kurstin died while this case was pending. His Estate is the named appellant. The parties agreed in the trial court proceedings to waive the formality of appointing a personal representative for the estate, inasmuch as the contribution claim was fully covered by Dr. Kurstin's insurance. In this brief, the appellant will be referred to as "Dr. Kurstin."

with a contribution claim against Dr. Kurstin. (A. 638, 641.) It further set forth Dr. Lordan's admission that he was a "joint tortfeasor" for purposes of the settlement agreement. (A. 636-37.) The second document (which referenced the first document) was a letter agreement in which Dr. Lordan agreed to pay the proceeds from the contribution action to Ms. Blue's attorneys and Ms. Blue's attorneys would represent him in the contribution action without charge. (A. 644.) Ms. Blue and her attorneys also had a retainer agreement between them providing that, after deducting their legal fees and expenses, all proceeds obtained from any defendants would be paid to her. (A. 669-70.) Dr. Kurstin refused to participate in the settlement, and contributed nothing toward the $2 million paid by Dr. Lordan. Nonetheless, Dr. Kurstin was named in the settlement agreement as one of the "Released Parties." (A. 635.)

On February 5, 2007, in conformity with the settlement agreement between Ms. Blue and Dr. Lordan, Dr. Lordan filed his cross-claim for contribution against Dr. Kurstin. (A. 8, 20-22.) The bench trial on the contribution claim took place from February 5 to 8, 2007. (A. 7-8.) At the start of the trial, Dr. Lordan's counsel in the medical malpractice action, Robert Goodson, informed the court and parties that, as the result of a settlement agreement reached between Dr. Lordan and Ms. Blue, he was filing a praecipe of dismissal against all defendants, withdrawing his appearance, and that Ms. Blue's attorney would be representing Dr. Lordan on his contribution claim, which would be tried at that time. (A. 28-29, 32.) Dr. Kurstin's counsel raised no objection to proceeding with the trial on the contribution claim.

On June 25, 2007, Dr. Kurstin filed a Motion for Judgment as a Matter of Law. (A. 6.) This motion did not address the merits of the contribution claim, but rather, made a variety of arguments seeking to bar the claim as a matter of law because, among other things, Ms. Blue was the ultimate beneficiary of the $1 million contribution claim (less attorneys' fees). (*See* A. 615-

45.) The trial court denied Dr. Kurstin's motion on September 26, 2007. (A. 5, 673.) On October 9, 2007, the trial court entered an order setting forth the court's findings of fact and conclusions of law. (A. 5, 674-709.) The court concluded that Dr. Kurstin had breached the national standard of care and was a proximate cause of Ms. Blue's injuries, was a joint tortfeasor, and thus was liable to pay Dr. Lordan $1 million, or one-half of the amount previously paid by Dr. Lordan to Ms. Blue under the settlement agreement. Dr. Kurstin then noticed this appeal. (A. 4.)

STATEMENT OF FACTS

Introduction

Rosalee Blue was 59 years old when she entered Sibley Memorial Hospital on April 9, 2004 for surgery to put a mesh into her abdominal wall to fix a bulging hernia. She could walk normally without pain before the procedure. (A. 674.)[2] Ms. Blue suffered a spinal cord injury in connection with her surgery from bleeding in the spinal cord. As a result, she has permanent paralysis of her right foot, impaired sensation in both legs, chronic pain in the legs for which she must take narcotic pain relievers, and lack of control over bowel and bladder function. (A. 674.) In the evidence presented to the trial court, all parties agreed that the spinal cord bleeding occurred because of a medication error during the surgical procedure. (A. 676.) The surgeon, Dr. Kurstin, had instructed the anesthesiologist, Dr. Lordan, to administer a blood-thinning drug (anticoagulant) known as Lovenox, a member of a class of drugs known as low-molecular-weight heparin, and this drug caused the bleeding in the cord and subsequent severe injuries. However, Dr. Kurstin denied liability and claimed that the error was entirely the responsibility of

[2] Citations in the Statement of Facts are both to the Court's findings of fact and the basis in the record to support the finding.

Dr. Lordan. (A. 676.) Dr. Lordan admitted his own fault in causing the injury (A.52) but asserted that Dr. Kurstin was jointly liable.

Basis for the National Standard of Care

Dr. Lordan's expert witness, Dr. Charles Goldman, testified at length concerning the applicable national standard of care that applied in this case, which boils down to a requirement that Lovenox should not be administered during surgery when the patient has had anesthesia injected near her spinal cord, because of the unacceptable risk of bleeding in or near the spinal cord before the puncture wound from the anesthetic needle has clotted off. Dr. Goldman is a physician board-certified in general surgery who is a fellow of the American College of Surgeons. (A.516.) He is associate professor of surgery at West Virginia University School of Medicine. *Id.* His distinctions include "surgical educator of the year" at three different medical centers and director of the surgical clerkship program at West Virginia. (A.515-16.)

Dr. Goldman's basic surgical training was a five-year program similar to Dr. Kurstin's. (A. 224). He also has two years of advanced training in cancer surgery. (A.197). Dr. Goldman has taught surgery at various academic centers since finishing his own training in 1987. (A.198). He runs review courses for residents taking certification boards and for older surgeons obtaining re-certification. (A.198). Dr. Goldman has been involved in developing both national and local consensus guidelines for various aspects of surgery and cancer treatment. (A.199). He developed standard methods – or "clinical pathways" – to regularize the treatments for prevention of blood clots in obese patients undergoing weight-loss surgery at West Virginia University Medical Center (WVUMC), including the use of the drug Lovenox. (A.201). Prevention of post-operative blood clots falls in the domain of the operating surgeon. (A.201-202). General surgeons are expected to know the standard protocols for timing and dosage of the drugs they use

for blood clot prevention. (A.217).

Dr. Goldman testified that the "clinical pathway" which he developed for the timing of Lovenox use at WVUMC in bariatric surgery patients is comparable to Ms. Blue's case because bariatric patients are at high risk for blood clots and thus they would receive the most aggressive form of clot prevention treatment that was thought to be reasonably prudent. (A.335). To develop the "clinical pathway," Dr. Goldman testified that he reviewed the protocols of other bariatric surgeons, including the University of Pittsburgh, and also reviewed the literature for Lovenox and two other "low molecular weight heparin" drugs. (A.333-334). He reviewed the consensus statement from the American Society of Regional Anesthesia (ASRA) (A.334); cross-claimants' Ex. 12 (A.537). In addition, he reviewed some of the primary references from the consensus statement to verify its accuracy. (A.334). He also reviewed some of the original data from pharmaceutical manufacturers in devising the clinical pathway. (A. 228-229).

Dr. Goldman's protocol for his own hospital called for delaying use of Lovenox after surgery for 12 to 24 hours (depending on whether the dosing regimen was once a day or twice a day). (A. 333,337). Dr. Goldman testified that the ASRA consensus statement represented the minimum standard of care for timing of Lovenox use after regional anesthesia. (A.224-225; 227, 237-238). He said the consensus statement had made "the most exhaustive look at the reports and the literature," (A.237), which included data on multiple millions of uses of Lovenox over the years in both Europe and the United States. (A.238). He also relied on the fact that the ASRA consensus statement had been quoted by other groups that promulgated guidelines. (A.222). Dr. Goldman further testified that Dr. Horlocker, the first author on the consensus statement, had been referenced by the FDA itself and that she had published multiple articles on the same topic of use of low-molecular weight heparins with epidural and spinal anesthesia. (A.227).

By contrast, Dr. Bartolozzi, the defense general surgery expert, had no non-litigation experience in developing hospital protocols for the use of Lovenox in surgical patients. Dr. Bartolozzi was unable to cite any literature at all in support of his opinion about the standard of care for timing the use of Lovenox after epidural and/or spinal anesthesia. He had never read the ASRA consensus statement until the night before he testified. (A.416). Unlike Dr. Goldman, the defense expert had made no independent evaluation of the literature behind the ASRA consensus statement. The defense expert could not cite any surgeons anywhere in the United States who followed Dr. Kurstin's practice of ordering the drug intra-operatively, and he identified no hospitals that permitted such use. Dr. Bartolozzi had not looked up his own hospital's policies on Lovenox use before he testified. (A.374-375). Dr. Bartolozzi was shown to be unaware of some of the important reasons for the development of the standard practice of delaying use of Lovenox after regional anesthesia. On cross-examination, he at first maintained that European surgeons had experienced fewer cases of epidural and spinal bleeding with use of Lovenox because they used once-a-day dosing of 40 milligrams, whereas in the United States, the original practice was to give the drug 30 mg twice a day. (A.418). Dr. Bartolozzi was impeached on this when it was shown that the ASRA consensus article had concluded that the delayed timing of the use of Lovenox in Europe, not the dosing regimen, was responsible for the fewer bleeding injuries there. (A.419-420).

Applicable National Standard of Care

In 1995, after frequent reports of spinal cord injuries in the United States following the use of Lovenox during surgery, the Lovenox manufacturer and the FDA recommended in the official labeling that first use of the drug be timed to correspond with the delay used in Europe, six to twelve hours after surgery. (A. 681, 219-20.) When cases of spinal cord injury still were

reported after the labeling change, in December 1997, the U.S. Food and Drug Administration issued an "FDA Public Health Advisory" addressed to "Dear Health Care Professional." (A. 534, 681, 219-20.) The advisory stated that that FDA "would like to call to your attention recent post marketing reports of patients who have developed epidural or spinal hematomas with the concurrent use of low molecular weight heparin and spinal/epidural anesthesia or spinal puncture. Many of the hematomas caused neurologic injury, including long-term or permanent paralysis." (A. 681-82, 534-37.)

In 2003, the American Society of Regional Anesthesia published its "second consensus conference" guidelines (the first came in 1998) stating that after one uses regional anesthesia – i.e., anesthesia drugs injected into the epidural or spinal space, one should wait at least six to eight hours before administering Lovenox. (A. 682, 545.) By 2004, when Ms. Blue's procedure occurred, there was no longer any controversy that the timing of Lovenox should be delayed after surgery, although various authorities recommended different delays from two to 24 hours, according to Dr. Goldman. (A. 682, 226-27.) In addition to the ASRA consensus report and the official labeling, he cited a published consensus statement from the American College of Chest Physicians. (A. 682, 226.) The ASRA second consensus statement published in 2003 represented a national standard of care, according to Dr. Goldman, because "it was the most exhaustive look at the reports and the literature," and referred to studies involving multi-millions of doses of the drug. (A. 682, 237-38.)

The official label of the drug approved by the FDA carries a "black box" warning about the potential of paralysis from spinal/epidural hematomas when Lovenox is used too close in time to regional anesthesia, although the official label as now revised does not advise any particular time delay. (A. 682-83, 237-38.) After the FDA publicity and the changes in the

official labeling of Lovenox, a large number of surgeons changed their practice to delay the use of Lovenox, and subsequently there was a "significant drop" in the number of cases of paralysis and other spinal injuries reported to the FDA, proving the effectiveness of the delayed timing, according to Dr. Goldman. (A. 683,228-229).

Dr. Goldman said that the two institutions with which he was familiar, his own hospital at West Virginia University and the University of Pittsburgh, recommended a delay of at least twelve hours after surgery with regional anesthesia in the first dose of Lovenox. (A. 683,228-229). He further testified that intra-operative administration of Lovenox does not confer any benefits for the patient: the extensive studies published on this topic demonstrated conclusively that the rate of deep vein thrombosis (DVT, or blood clots in the deep veins of the legs) which Lovenox is intended to prevent does not improve with administration given before the surgery versus delaying for hours after surgery, and by the same token, intra-operative use could confer no benefit. (A. 683, A.324-325.)

Sibley Hospital's written policy called for waiting two hours after regional anesthesia before giving the first Lovenox injection. (A. 684, 513.) This policy was distributed to all departments in the hospital in August 2000 and was widely available at the time of Ms. Blue's procedure in 2004 through the hospital's computer "Intranet." (A. 684, Deposition testimony of Dr. Carl Sylvester 35-37, A.555; A. 501-503.) Sibley Hospital expected all its surgeons to familiarize themselves with and follow the policy on Lovenox. (A. 684, 356.) Dr. Sylvester, who was president of the medical staff at Sibley from 2000 to 2004 and is currently chief of its anesthesiology department, testified that Sibley made the Lovenox timing delay a mandatory "policy" rather than a "guideline" because the hospital wanted to take away their surgeons' discretion on the timing of the drug's use. (A. 683-84, 471-72.) The Sibley policy was intended

to avoid having the potentially harmful effect of Lovenox in the blood near the time when the spinal area has been punctured for epidural catheters or for spinal anesthesia. (A. 684, A.473-474). The hospital also had pharmacists available to give advice to anyone calling from anywhere in the hospital, including the operating room, for guidance on drug administration policies. (A. 684, Deposition testimony of hospital spokeswoman Yolanda Douthard p. 28, A.533.)

Dr. Kurstin's Breach of the National Standard of Care

Dr. Kurstin said in his deposition that he was unaware of the Sibley written policy (A. 686; Kurstin dep. 53, A.530), and he could not give specifics of any of the other published guidelines about the timing of Lovenox after epidural/spinal anesthesia. (A. 686; Kurstin dep. 31-32, A.525.) He also testified that he wanted to have anticoagulant in Ms. Blue immediately at the time of surgery, because blood clots can start to form during the surgery itself. (A. 686, Kurstin dep. 30, A.525.) However, according to Dr. Goldman, if the surgeon wanted an immediate anticoagulant effect at the time of surgery, Dr. Kurstin could have safely ordered pre-operative Lovenox as long as there was a suitable delay between the Lovenox injection and the spinal anesthesia. (A. 686, A.254-255.)

Dr. Kurstin testified that he had been aware that timing of the drug should not be done too closely to the use of an epidural catheter, (dep. 32, A.525), but said that his own experience had been that no unusual bleeding occurred with use of Lovenox. (A. 686, Kurstin dep. 32-33, A.525-26.) Dr. Goldman testified that it was not appropriate for a surgeon to rely on his own personal experience in the face of much larger national experience reported in the medical literature. (A. 686, A.256-257). He said Dr. Kurstin also was wrong to rely on his personal observations about lack of unusual bleeding, because bleeding at the surgical site has no bearing

on the hidden bleeding that can occur in the area of the spinal cord. (A. 686, A.257-258).

Dr. Kurstin conceded, in an interrogatory answer No. 21, which was read into evidence (Tr. Feb. 7, 2007, p. 133), that there is no known literature of any kind in the surgical field recommending Lovenox be ordered intra-operatively as Dr. Kurstin had done. According to Dr. Goldman, Lovenox would never be used by a general surgeon during surgery except possibly for vascular surgery in which blood vessels are being clamped. (A. 687, A.249.) Dr. Kurstin produced no evidence to the contrary that would justify the order to give the Lovenox intraoperatively. In addition, according to Dr. Goldman, intraoperative use of Lovenox made no sense because patients are cold during surgery and have "fluid shifts" that make the absorption of such drugs "very unpredictable." (A.324-325). This evidence was unrebutted by Dr. Kurstin, and was credited by the trial court. (A. 687.)

Dr. Goldman further testified that while Ms. Blue was at risk for blood clots because of obesity, the hernia procedure itself is known to be low in risk for blood clots (unlike other surgeries like bone surgery which involve more immobility and which manipulate blood vessels, inciting clots). (A. 687, A.215-216). It was appropriate to give her Lovenox, but there was no unusual level of risk that justified going outside the written recommendations of the various bodies that have considered the safety of this drug.

Dr. Kurstin called Dr. Mark Bartolozzi, a general surgeon, as an expert witness. Dr. Bartolozzi testified that the Lovenox timing guidelines were "controversial" and "variable" in 2004. (A. 688, 398, 439). However, he could identify no surgeons in the United States (not even himself or his surgical partners) who ordered the drug intra-operatively as Dr. Kurstin had. (A. 688, 439). He also could identify no medical textbooks or articles that supported intra-operative use.

Proximate Cause of Ms. Blue's Injuries

The great weight of the evidence presented at trial showed that Dr. Kurstin's negligent order to give the Lovenox during the surgery was a proximate cause of Ms. Blue's injury, inasmuch as it led to her receiving the drug prematurely (and also by the wrong route of administration, directly into a vein, which heightened the effect of the early delivery of the drug to her system). (A. 684.) Dr. Lordan testified that he only gave the Lovenox intra-operatively because "Dr. Kurstin asked me to." (A. 689, A.123). Dr. Lordan had never given the drug during surgery on his own volition. (A. 689, A.125). It is undisputed that Lovenox is primarily a drug used by surgeons and is not an anesthetic drug. (A. 689-90, Testimony of Drs. Goldman, Bartolozzi, Sylvester and Lordan.)

In light of Lovenox's function, the trial court credited Dr. Lordan's testimony that he would not have administered this drug but for Dr. Kurstin's request that he do so, which the Court found was negligently given.[3] (A. 690.) Thus, there is a direct causal link between Dr. Kurstin's negligent order of the Lovenox and the injury that Ms. Blue experienced. (A. 690.) However, Dr. Kurstin continued to maintain that he bore no responsibility for the injury because he contended that the intravenous administration of the drug by Dr. Lordan, not its premature use, had caused the injury. Dr. Kurstin contended that despite his order to give the Lovenox during the operation, it was primarily Dr. Lordan's choice about the timing of the drug, and that

[3] In opening statement, Dr. Kurstin contended that use of Lovenox was a "red herring" (A.90) and that the evidence would show that Ms. Blue's spinal cord injury was entirely the fault of Dr. Lordan for allegedly hitting the cord with a spinal needle and injecting the cord with anesthetic fluid, with Lovenox playing no role whatever in the injury. (A. 91, 92, 96.) This defense was abandoned when the defense called its only expert witness, Dr. Bartolozzi. The expert conceded that Lovenox had turned what could have been a trivial injury (or no injury at all) from the spinal needle nicking the spinal cord, into the major permanent injury that she suffered. (A.409-413.)

Dr. Lordan administered the drug intravenously when he should have given it subcutaneously, which would have slowed its absorption. (A. 690-91.)

The trial court concluded that the intravenous administration had not been proven to be the exclusive cause of the injuries to Ms. Blue. Dr. Kurstin participated in the decision for both the timing and route of administration of Lovenox because he gave the order to administer the drug without specifying the route and in a manner that meant to an experienced anesthesiologist to give the drug as soon as it became available. (A. 691.) When Dr. Lordan asked Dr. Kurstin to confirm the dosage of 40 milligrams just before he gave it, Dr. Kurstin had an opportunity to specify the route of administration and to ask Dr. Lordan to wait for at least two hours. But he did not do so. (A. 691.) Dr. Lordan testified that he administered the Lovenox as soon as the drug came up from the pharmacy, in accordance with Dr. Kurstin's order, which he verified with Dr. Kurstin before the injection. (A.131-132, 133). The drug came up in a pre-loaded syringe which was handed to Dr. Lordan by a nurse without any accompanying labeling. (A.133-134). Dr. Lordan testified that when the syringe was handed to him during the procedure, "I asked Dr. Kurstin, again, what was the dose that he wanted. And it was 40 milligrams, and I gave 40 milligrams intravenously." (A.133).

Dr. Lordan testified that he gave the drug intravenously because he knew it was a form of heparin and that other times he had administered heparin intraoperatively at a surgeon's request, it had always been through the i.v. line. (A.134). Moreover, Dr. Lordan and Dr. Bartolozzi both testified that anesthesiologists typically administer drugs during surgery through the intravenous route. (A.454).

The only time that ambiguity can creep into an order for a drug like Lovenox is when the surgeon chooses to order it orally, during the operation itself, as Dr. Kurstin did here. When

surgeons at Sibley order a drug like Lovenox either before or after an operation, such orders must be in writing and must specify both dosage and route of administration. (A. 480-481). The record in this case shows the post-operative orders signed by Dr. Kurstin specify "Lovenox 40 mg subq q day." ("Subq" means subcutaneous and "q day" means once a day.) Sibley A-18. Other written orders in the record specify for each medication the dosage, timing and route of administration. See, for example the order sheet for April 11-12, Sibley A-23, which states "give Lasix 20 mg IV now." (A.509.)

Plaintiff's primary expert witness on the causation issue was Dr. Richard Katz, a neurologist from Philadelphia who described extensive experience in treating patients with brain and spinal cord injuries related to anticoagulation. Dr. Katz testified that while the i.v. use of the drug was "critical" in causing the bleeding in the spinal cord, Katz A.345, he also believed that it was a combination of premature timing and i.v. route that caused the bleeding here, based on the experience in the literature and the guidelines being based on delaying use of subcutaneous Lovenox by at least six hours so that the patient is past the window of vulnerability. (A. 347-348, 351). The issue with premature use of the Lovenox is the same as with intravenous use. Both would give the patient an anticoagulated state before the puncture wound from the anesthetic needle had healed, thus contributing to bleeding in the cord. (A. 693.)

Dr. Bartolozzi testified that it was his opinion that the intravenous route was solely responsible for the injury. He conceded that his specialty in general surgery did not give him expertise in spinal hematomas (A. 366), or the hematology of Lovenox. (A.415.) He further conceded that all the published case reports of spinal injury caused by Lovenox in connection with regional anesthesia were from use with the correct subcutaneous route but timed too close to the regional anesthesia. (A.362).

The policy on Lovenox timing is intended to prevent spinal cord injuries such as occurred to Ms. Blue. In light of the 1997 FDA warning that the concurrent use of the drug with spinal/epidural anesthesia or spinal puncture had been found to result in hematomas, many of which caused paralysis, it was foreseeable in 2004 that the intra-operative use of this drug would result in that type of injury. Indeed, the statistical evidence from the ASRA second consensus conference on anticoagulation and regional anesthesia is that use of Lovenox near the time of regional anesthesia increases the risk of spinal cord injury from five- to fifty-fold. Dr. Goldman so testified. (A. 237).

Reasonableness of Settlement in Light of Ms. Blue's Damages

Ms. Blue lost the ability to work because of her injury, which left her largely confined to her bedroom because of her inability to use the one leg and her difficulty with bowel and bladder function. Dr. Kurstin never contested the reasonableness of her settlement with Dr. Lordan, even after he learned that she stood to gain another $1 million if the cross-claim for contribution succeeded. (A. 615-32.) Her damages set forth in the joint pretrial statement included $3 million in future medical and caretaking needs, along with lost earnings of $160,000 and past medical expenses of $114,500. (Joint Pretrial Statement at page 12.) The injuries that this healthy 59-year-old woman suffered, based on the event on April 9, 2004 when she underwent surgery with Dr. Kurstin and Dr. Lordan, were described in the same statement:

> Today, Ms. Blue has poor control of her bowel and bladder functions. She has frequent accidents of both. She also continues to have weakness and severe neuropathic pain in her legs. Her right foot is completely paralyzed ("a drop foot"). She cannot walk more than a few steps with a walker and wearing a right foot brace. She is required to take strong narcotic medications to cope with the searing pain she experiences. She also must take sleeping pills and antidepressant medications. She has swelling and numbness in her feet and legs. She spends most of her time confined to her bedroom and has chronic depression from her pain and her loss of mobility and independence. … Before she was admitted for the surgery, Ms. Blue was healthy, fully functional and independent. She worked

> as a housekeeper for a family, regularly cared for the elderly mother of her employer, and ran her own household, taking a major role in raising her grandchildren. Now she cannot work and depends on others for help with basic activities of daily living – dressing, movement, bathing, toileting and preparing meals, among other things.

(Joint Pretrial Statement at 5-6.)

Thus, even taking into account the additional $1 million assigned by Dr. Lordan in addition to the $2 million, had this case proceeded to trial before a jury, the defendants would have been exposed potentially to millions of additional dollars when the jury considered the obvious pain, suffering, and loss of enjoyment of life, and loss of earnings sustained by a previously healthy person.

STANDARD OF REVIEW

Whether the settlement agreement and release was ambiguous is a question of law and is reviewed *de novo*. *GLM Partnership v. Hartford Casualty Ins. Co*., 753 A.2d 995, 998 (D.C. 2000). Where the language is clear and unambiguous, a "release is a form of contract, and the rules of contract construction govern its interpretation. . . . [I]ts plain language is relied upon in determining the parties' intention. Where the terms of the document leave no room for doubt, the effect of the release can be determined as a matter of law." *Id.* (quoting *District of Columbia v. Washington Hosp. Center*, 722 A.2d 332, 342 (D.C. 1998)).

A trial court's "findings of fact will not be disturbed unless they are clearly erroneous." *Hinton v. Sealander Brokerage Co.*, 917 A.2d 95 (D.C. 2007). Thus, the court's findings of fact that underlie its determination that Dr. Kurstin breached his duty of care to Ms. Blue and that breach caused her injuries should be reviewed by this Court under the clearly erroneous standard. "In reviewing an appeal from a non-jury trial, we may review both as to the facts and the law, but *the judgment may not be set aside except for errors of law unless it appears that the*

judgment is plainly wrong or without evidence to support it" when the evidence is viewed "in the light most favorable to the prevailing party." *Id.*[4]

SUMMARY OF ARGUMENT

Dr. Kurstin made a mistake: he decided to order an anticoagulant drug for his patient intra-operatively, while she was under an epidural anesthesia. Dr. Kurstin based this decision solely on his past personal experience, in the face of a mountain of published data and literature and his own hospital's policy, all of which taught that such a decision carried an unacceptable risk of serious injury. Ms. Blue paid the price for Dr. Kurstin's mistake when she sustained bleeding in her spinal cord, leaving her debilitated and unable to work.

Everyone now agrees that Ms. Blue's injury was caused by the drug that Dr. Kurstin ordered. But rather than step up and contribute toward compensating Ms. Blue for the injuries caused by his negligence, Dr. Kurstin refused to settle with Ms. Blue. He now continues stubbornly to try to push the entire burden of her claim onto Dr. Lordan, the anesthesiologist who carried out Dr. Kurstin's negligent order, despite the large body of evidence that he failed his responsibility to correctly prescribe this drug.

Dr. Kurstin also contends that the settlement between Ms. Blue and Dr. Lordan somehow

[4] Citing *Leftwich v. Leftwich*, 442 A.2d 139 (D.C. 1982) and *Sacks v. Rothberg*, 569 A.2d 150 (D.C. 1990), Dr. Kurstin argues that a less deferential standard of review should apply because the trial court adopted the vast majority of findings of fact and conclusions of law proposed by Dr. Lordan. In *Sacks*, this Court rejected such an argument. This case is very similar to *Sacks*. As in *Sacks*, there is no evidence that the trial court failed to "independently" review the findings and underlying record. To the contrary, the trial transcript shows that the presiding judge was highly engaged and asked relevant questions of witnesses and counsel throughout the four-day trial. The court made at least two significant additions to the findings of fact, concluding that the use of Lovenox was exclusively Dr. Kurstin's decision, and that the settlement between Ms. Blue and Dr. Lordan was "just and reasonable." (A. 676, 706.) The court used its independent judgment when setting forth the findings of fact. There is no reason to depart from the usual "clearly erroneous" standard of review.

bars Dr. Lordan's contribution claim as a matter of law because Ms. Blue released her claims against Dr. Kurstin. The defendant overlooks the fact that it is Dr. Lordan's cross-claim for contribution which is being pursued here, and there exists no document releasing that claim. Dr. Kurstin's real argument is that Dr. Lordan should not be allowed to pay the money of his contribution claim to Ms. Blue as his settlement with her requires. There is nothing wrong with the way that Dr. Lordan and Ms. Blue structured their settlement. This Court has held that equitable claims are freely assignable. Ms. Blue would suffer no windfall whatever if this court were to uphold the intent and terms of her settlement agreement with Dr. Lordan, because a $3 million settlement is perfectly reasonable in light of Ms. Blue's significant injuries and damages. The only potential windfall in this case would go to Dr. Kurstin if this court were to let him walk away and pay nothing for the significant injury whose cause he clearly contributed to by his negligent order of a drug.

Dr. Kurstin contends inconsistently that Dr. Lordan is entirely at fault for the negligent administration of the Lovenox, but also that Dr. Lordan's status as a tortfeasor has been insufficiently proven to trigger Dr. Lordan's right to seek contribution from Dr. Kurstin. The trial court correctly found that overwhelming evidence existed to find liable the surgeon who ordered the drug, Dr. Kurstin, as well as the anesthesiologist who incorrectly administered it, Dr. Lordan.

ARGUMENT

I. The Settlement Agreement and Release Expressly Reserved The Right For Dr. Lordan To Prosecute a Claim For Contribution Against Dr. Kurstin. Thus This Claim Was Not Barred.

As a threshold issue, Dr. Kurstin contends that Dr. Lordan's contribution claim against him should be barred by the settlement agreement and release between Dr. Lordan and Ms. Blue.

Dr. Kurstin's argument is mainly based on the erroneous premise that Ms. Blue's release of her claims against all of the defendants somehow precluded Dr. Lordan from agreeing with Ms. Blue that he would turn over any judgment proceeds to her after pursuing a contribution action against Dr. Kurstin. This argument flies in the face of the plain language of the agreement and the clear intent of the settling parties, and neither District of Columbia law, nor public policy considerations, provides any support for Dr. Kurstin.

A. The Plain Language of the Settlement Agreement and Release Provided Dr. Lordan with the Right to Bring the Contribution Claim Against Dr. Kurstin

Dr. Kurstin first argues that Dr. Lordan's contribution claim against him was barred by the terms of the settlement agreement and release between Ms. Blue and Dr. Lordan, purportedly because of the agreement's "plain language." (Appellants' Brief at 10.) In fact, the plain language of the agreement makes clear that Ms. Blue and Dr. Lordan, the settling party, expressly reserved the right for Dr. Lordan to proceed against the non-settling party, Dr. Kurstin. That should be the end of the matter.

The settlement agreement and release refers to Dr. Lordan's right to maintain a contribution claim in two separate provisions of the agreement. The first provision is entitled "Consideration." After stating that "[a]s consideration for the sums paid under this Agreement, [Ms. Blue] shall cause all of her claims . . . be dismissed WITH PREJUDICE as against all parties," the parties then agreed "[h]owever, the Praecipe of Dismissal shall reserve the rights of John B.M. Lordan, M.D. [and related entities] to prosecute a claim against Ronald D. Kurstin, M.D. and/or the Estate of Ronald D. Kurstin, M.D. for contribution." (A. 638.) The second provision is entitled "Contribution Claim" and states that Ms. Blue "acknowledges and agrees that John B.M. Lordan, M.D. [and related entities] have retained the right to pursue any claim for

contribution, equitable contribution or any other similar claims that John B.M. Lordan, M.D. [and related entities] may have against Ronald D. Kurstin, M.D., and/or the Estate of Ronald D. Kurstin, M.D." (A.641.) Based on this plain language, no other conclusion can be reached but that the settling parties intended for Dr. Lordan to retain the right to bring a contribution claim against Dr. Kurstin.

Indeed, Dr. Kurstin did not have any problem with this interpretation at the start of the trial on the contribution claim when Mr. Goodson stated on the record that Ms. Blue and Dr. Lordan had reached a settlement agreement that released all claims and was thereby filing a praecipe of dismissal "with the express reservation that . . . Dr. Lordan [is] reserving the right as far to pursue [his] claim for contribution/identification [sic] against Dr. Kurstin and [his] estate." (A. 29.) The first time that Dr. Kurstin objected to the contribution claim came when he found out that Ms. Blue stood to benefit if the contribution claim succeeded. Dr. Kurstin's protestations about what would happen to the money after he was adjudged jointly liable for Ms. Blue's injuries are neither here nor there. The critical question is whether Dr. Lordan had the right to pursue the contribution action in the first place; a plain reading of the settlement agreement and release confirms that he did.

Grasping at straws, Dr. Kurstin cites a number of cases from foreign jurisdictions dating back to 1957 that stand merely for the proposition that a broadly worded release in a settlement agreement, without an express reservation of rights, precluded the parties included in the agreement from filing a claim for contribution. It is true that the settlement agreement in this dispute contained a broadly worded release of Ms. Blue's claims, but equally true is the inescapable fact that the settling defendant expressly retained the right to proceed in an action for contribution against Dr. Kurstin. Thus, the cited cases are inapposite.

Moreover, none of the cases cited by Dr. Kurstin addresses the circumstance in which, as here, the settling defendant agreed to pay the proceeds of the contribution claim to another party (who in this case was the attorney for the plaintiff) and that the plaintiff would ultimately receive the proceeds herself, after the attorney deducted its legal fees. Like any other contract, the courts interpret the plain language and enforce a settlement agreement and release as written. *GLM P'ship v. Hartford Casualty Ins. Co.,* 753 A2d 995, 998 (D.C. 2000); *Caglioti v. District Hosp. Partners, LP*, 933 A.2d 800, 808 (D.C. 2007). As this Court has stated, "[P]arties are free to contract and enter into settlement agreements as they determine, and reasonable contracts are to be upheld." *Caglioti*, 933 A.2d at 816 n.17. In this case, the plain language clearly provided that Dr. Lordan could pursue a contribution claim against Dr. Kurstin.

Dr. Kurstin's argument also fails to consider that Dr. Lordan never agreed in the settlement agreement to release *anybody*. The settlement agreement refers only to Ms. Blue ("The Undersigned")'s release of the various defendants. (See A. 635, 636.) A claim for contribution is by definition a claim between joint tortfeasors. *See Hall v. George A. Fuller Co.*, 621 A.2d 848, 850 (D.C. 1993). Accordingly, as the plaintiff, Ms. Blue had no contribution claim to release or reserve.

B. That Dr. Lordan Agreed that the Proceeds of the Contribution Action Would Ultimately Be Paid By Him to Ms. Blue and Her Counsel Does Not Provide a Basis to Negate the Plain Language of the Settlement Agreement and Bar Dr. Lordan's Contribution Claim.

Faced with a clearly worded reservation of rights, Dr. Kurstin resorts to the untenable argument that Dr. Lordan's claim should be barred because Dr. Lordan agreed in a related contract between the parties to pay to Ms. Blue and her counsel the proceeds of any contribution claim against Dr. Kurstin. This argument cannot be reconciled either with District of Columbia case law or the public policy that favors encouraging settlement between parties to litigation and

free assignability of claims.

First, the case law makes clear that a party can enter a contract to pay the proceeds of his contribution lawsuit to anyone. The settlement agreement does not "assign" the claim in the sense of surrendering the right to bring the claim to another person.[5] The agreement states expressly at paragraph 14 that Dr. Lordan and the related anesthesia entities "have retained the right to pursue any claim for contribution … against Ronald D. Kurstin, M.D." (A. 641.) The retainer agreement between Dr. Lordan, Surgical Anesthesia Associates and Ms. Blue's attorneys obligates Dr. Lordan and his group "to fully cooperate" with the law firm "in the prosecution of their claims against" Dr. Kurstin's estate. (*See* A. 645.) Dr. Lordan and his group further agreed to pay all proceeds of the contribution claim to Ms. Blue's attorneys, who had their own obligation to pay the net proceeds to her. In substance, then, the agreement is one in which Dr. Lordan and his employer had retained their right to contribution and agreed to prosecute it for the benefit of Ms. Blue.

Second, even if the settlement is characterized as an "assignment," there is nothing wrong with it under District of Columbia law. This is not a claim for personal injuries; it is a claim that the non-settling tortfeasor equitably should be required to pay half of what the settler paid. The overall settlement was $2 million, so the claim against Dr. Kurstin's estate is for $1 million. That is a liquidated sum.

Claims for a sum certain, or for economic harm in general, are freely assignable in the District of Columbia. As one often-quoted decision said: "District of Columbia law evinces a policy of free assignability of claims." *National Union Fire Ins. Co. v. Riggs Nat'l Bank*, 646

[5] *Black's Law Dictionary* (7th ed.) says "assignment" is "the transfer of rights or property."

A.2d 966, 971 (D.C. 1994). A District of Columbia statute, D.C. Code § 28-2304 (2001 ed.), expressly includes "choses in action" as something that can be assigned and that the assignee can pursue in his own name. There is no exception in the statute or the case law for contribution claims.

As another decision said:

> In general, all contractual rights may be assigned, including the right to sue for enforcement of a claim. The right to assign is presumed, based upon principles of unhampered transferability of property rights and of business convenience.

Brandenburger & Davis Inc. v. Estate of Lewis, 771 A.2d 984, 988 (D.C. 2001) (quoting *Flack v. Laster*, 417 A.2d 393, 399 (D.C. 1980) (footnote omitted); *see also Richter v. Analex Corp.*, 940 F. Supp. 353, 358 (D.D.C. 1996) (legal malpractice claim in District of Columbia is assignable since it concerns only economic harm, unlike a personal injury suit).

In this case, since Dr. Lordan and his employer have retained the right to pursue the contribution claim, but have agreed to turn over its proceeds to Ms. Blue's counsel, the assignment (if that is the correct term, since it is not one used by the parties to the settlement) is more akin to the assignment of a judgment, which is expressly allowed under another District of Columbia statute, D.C. Code § 28-2301 (2001 ed.).

Indeed, this Court recently held in *Caglioti v. District Hospital Partners L.P.*, 933 A.2d 800 (D.C. 2007), that a settling tortfeasor could assign to the plaintiff the settler's right of equitable indemnification against a non-settling successor tortfeasor. The *Caglioti* case stands squarely for the proposition that a plaintiff like Ms. Blue can properly structure a settlement with a defendant such as Dr. Lordan, in which she accepts both cash payment and proceeds of an equitable claim that the settler has against another tortfeasor. In a scholarly review of cases from other jurisdictions, the *Caglioti* Court concluded there was nothing improper in the plaintiff

settling her entire case (including claims against the non-settler) with the settling tortfeasor and at the same time accepting an assignment of the settler's indemnification/contribution claim against the non-settler. Reversing a trial court that held to the contrary, this Court determined that public policy considerations of free assignability of claims, avoidance of a potential windfall to the non-settler, and promotion of settlements all favored approval of assignment of the settling defendant's claims to the plaintiff.

While *Caglioti* has some points of distinction from the present case – it involved successor tortfeasors and not joint tortfeasors, a right of indemnification, not contribution, and the structure of the assignment was set up differently from this case – there is no real substantive difference between it and this case, notwithstanding Dr. Kurstin's efforts to read *Caglioti* narrowly. All of the same considerations of free assignability of claims, avoidance of a potential windfall to the non-settler, and promotion of settlements come into play in this case.

Dr. Kurstin's position of non-assignability here, aside from undermining the public policy of free assignability of claims, would further foreclose the possibility of Ms. Blue benefiting to the extent contemplated by the settling parties when she entered into the agreement with Dr. Lordan. The settling parties intended for Ms. Blue to receive two million dollars plus the potential of another one million dollars should Dr. Lordan prevail in a contribution action against Dr. Kurstin. Had Ms. Blue not secured Dr. Lordan's promise to pursue and turn over any proceeds from a contribution claim against Dr. Kurstin, she would not have settled the claim, and the parties — including Dr. Kurstin — would have had to proceed to trial with all the attendant costs and risk of further liability. (A. 603.) Moreover, that the parties considered the potential for an additional million dollars to be part and parcel of the consideration for Ms. Blue's release against the defendants is made clear by including reference to the contribution claim in a

provision of the contract entitled "Consideration." (A. 638.)

Finally, after refusing to participate in the settlement with Ms. Blue and Dr. Lordan – despite his ultimate adjudication as a tortfeasor – Dr. Kurstin is ill-suited to argue that he should be insulated from paying on the contribution claim because of how the settlement was structured.[6] Understandably, Dr. Kurstin's estate would prefer to avoid paying one million dollars to anyone. But such a result is just the sort of windfall to the non-settling party that this Court said in *Caglioti* would be against public policy. *See Caglioti*, 933 A.2d at 815: "If [the injured party] is not allowed to pursue his claim, it is the medical providers who could potentially be the recipients of any windfall as they could evade liability and not have to pay any amount, even if they were negligent as alleged." Dr. Kurstin wants to have it both ways by avoiding participation in the settlement, thus contributing nothing in the way of consideration for his release from the medical malpractice action, and not paying anything now, even assuming that he was a joint tortfeasor, as found by the trial court. Such a result is unfair and outrageous. This result was rejected by the trial court and likewise should be rejected by this Court.

Finally, it is worth noting that Dr. Kurstin's late protestations about the contribution claim, simply because the judgment money ultimately inures to Ms. Blue's benefit, are curious because it implies that the recipient of a judgment award is not free to then do whatever he wants with his own money. Indeed, Dr. Lordan could have contracted to transfer the proceeds of the award, or even gifted it, to any one of the hundreds of millions of people living in the United States, and Dr. Kurstin presumably would have had no issue with it. There is simply no basis for

restraining Dr. Lordan from doing what he desires with his own money just because the recipient happens to be the victim of his (and Dr. Kurstin's) negligent actions.

II. As Required Under *M. Pierre Equipment,* The Court Correctly Concluded That Dr. Kurstin was a Joint Tortfeasor, And The Amount Of The Settlement, Including the Potential of An Additional $1 Million From The Contribution Claim, Was Not Unreasonable In Light Of Her Severe Injuries.

Dr. Lordan paid $2 million to Ms. Blue, admitted in the settlement agreement that he was a joint tortfeasor, and admitted at trial, through his attorney's opening statement (A.52), that he was liable to her. According to Dr. Kurstin's estate, none of that is good enough to establish his *bona fide* right to pursue a contribution claim. Rather, Dr. Kurstin contends there must be a "judicial determination" or a stipulation agreed to by *all* parties, *before* Dr. Lordan can pursue a contribution claim. Dr. Kurstin is wrong on two counts: First, there is no requirement that Dr. Lordan prove his own liability first before suing for contribution; second, even if there were such a requirement, there was ample evidence in the record before the trial court to establish Dr. Lordan's status as a tortfeasor, and the consequent reasonableness of his settlement with Ms. Blue.

A. There Exists No "Judicial Determination" Requirement for a Settling Tortfeasor to Pursue a Contribution Claim

The policy of this jurisdiction favors settlement of civil controversies. *See Berg v. Footer*, 673 A.2d 1244 (D.C. 1996). As between two defendants, one of whom has recognized his obligation to the plaintiff and has settled out of court, and the other of whom has refused to settle and has forced the case to trial, the law generally favors the settling party.

---

[6] As one court has observed, "[T]he assignment to the injured party of an alleged tortfeasor's claim against another alleged tortfeasor may serve the interests of both the injured party and efficient judicial administration by providing *an additional means of settling the underlying*
(footnote continued on next page)

Yet if Dr. Kurstin is correct, then any non-settling tortfeasor could skip out of his entire obligation to an injured victim, even if he is provably at fault, unless the party who stepped up and settled the entire case jumps through the additional procedural hurdle of proving his own liability in a court hearing. In a case like this, the import of this position is that Dr. Lordan presumably would have to call expert witnesses against himself, inasmuch as his admission of liability is deemed insufficient by Dr. Kurstin's logic, to prove both his negligence and the causal link between his negligence and the victim's damages. Without such proof, according to Dr. Kurstin, the settler is merely a volunteer who has charitably donated $2 million to the plaintiff and who cannot ask someone like Dr. Kurstin to share in such payment – even if Dr. Lordan could prove that Dr. Kurstin was at fault for Ms. Blue's injury.

Dr. Kurstin derives this dubious doctrine by completely misreading the case law of the District of Columbia. The cases he cites deal with the quite different situation in which a non-settling tortfeasor is trying to establish its right to a *pro rata* credit for a settler's payment, rather than a less generous *pro tanto* (dollar-for-dollar) credit. Those cases uniformly hold that the *non-settler* (here, Dr. Kurstin) has the burden of proving that the settler is a joint tortfeasor if the non-settler wants to enjoy the higher *pro rata* credit. *See, e.g.*, *Berg v. Footer*, 673 A.2d 1244 (D.C. 1996).

Where the opposite situation obtains – the settler is seeking money from the non-settler – there is no requirement that the settler must prove his own liability first. This issue was decided in *M. Pierre Equipment Co. v. Griffith Consumers Co.*, 831 A.2d 1036 (D.C. 2003), where the Court held:

---

personal injury case." *Kimball Int'l, Inc. v. Northfield Metal Prods.*, 760 A.2d 794, 803 (N.J. Super. 2000) (emphasis added), *cited in Caglioti*, 933 A.2d at 814.

> "[W]e now hold that a settling tortfeasor who brings a contribution action against a non-settling tortfeasor in the District of Columbia has the burden of establishing the liability of the non-settling tortfeasor, and the reasonableness of its settlement with the injured person(s)."

831 A.2d at 1039.

Pierre Equipment is the first reported decision in the District of Columbia concerning whether a tortfeasor who settles a plaintiff's entire claims against all defendants before trial has a right to pursue a contribution claim against non-settling tortfeasors. The issue had been left open in *District of Columbia v. Washington Hospital Center*, 722 A.2d 332, 342-43 (D.C. 1998) (en banc), in which the Court held that the D.C. government had no right of contribution or indemnification against a hospital because its settlement did not discharge any liability of the hospital to the injured party, a prerequisite to such a contribution or indemnification action. *Pierre Equipment* decided that there is such a right by the settling tortfeasor to bring a contribution action against a non-settler, as long as the settler has discharged the non-settler's liability to the injured party. The *Pierre Equipment* court said there are two elements in proving such a claim: "liability of the non-settling tortfeasor,"[7] and the reasonableness of the settlement.

The latter prong, reasonableness of the settlement, protects non-settling tortfeasors from being trapped into paying half of an outrageously high or improvident settlement. There is also implied in this requirement some element of the settler's own liability – because it would not be a reasonable settlement if the settler had little to no exposure in the case.[8] But there is no

---

[7] The decision sometimes uses the less precise term "common liability" for the clearer term "liability of the non-settling tortfeasor."

[8] See also *Early Settlers Ins. Co. v. Schweid*, 221 A.2d 920, 922 (D.C.1966), and *Taylor v. Telez*, 610 A.2d 252, 253-54 (D.C. 1992). In both cases, this Court rejected the contentions of defendants being sued for contribution that the party seeking contribution was barred by not having sufficiently established its own liability.

specific requirement in the law that the settler must put on at trial a complete evidentiary proof of his own liability. Does the law really say that a defendant can settle a case to avoid the embarrassment and expense of an official judicial finding of liability, but that same defendant cannot seek contribution from a co-defendant because the very act of settling left him without an essential "judicial determination" of his own liability? This is Kurstin's argument, but it contradicts the essential holding of the controlling case, *Pierre Equipment.*

Dr. Kurstin cites the Court's recent decision in *George Washington University v. Bier*, 946 A.2d 372 (D.C. 2008), in a last-ditch effort to support his contention that Dr. Lordan was required as a settling party somehow to prove his status as a joint tortfeasor. The *Bier* case has significantly different features from this case. First, the Court had previously decided in *Paul v. Bier,* 758 A.2d 40 (D.C. 2000), that GWU, the settling defendant in that dispute, had waited too long (post-verdict) to bring a claim for contribution against Dr. Bier, the non-settling defendant. Thus, the Court refused to allow GWU to avoid that result by bringing a subsequent, independent claim for contribution against Dr. Bier. Second, the Court determined that the settlement agreement was silent on the issue of the parties' respective rights were the settling defendant to make a claim for contribution against the non-settling defendant. Third, the court noted that GWU "could have enhanced the attractiveness of its own claim for contribution" by reaching a settlement that released all defendants. 946 A.2d at 378.

In stark contrast, Ms. Blue released all of the defendants before the trial started, so that there was no trial and no verdict in the underlying medical malpractice case, and, in any event, Dr. Lordan had filed a timely cross-claim for contribution. Moreover, in this case, the underlying medical malpractice dispute ended in a settlement expressly reserving a right of contribution for the settling defendant.

The case is also distinguishable on the ground that the settlement agreement in *Bier* allowed GWU to exit the case while "maintain[ing] that [it was] not liable on any of the claims and causes of action asserted therein." 946 A.2d at 373. Thus, there was no stipulation of joint liability *at all* by the settling defendant. Here, of course, Dr. Lordan conceded in the settlement agreement that he was a "joint tortfeasor."[9]

Finally, even if there were a requirement in this case that *all* the parties stipulate to Dr. Lordan's status as a tortfeasor, Dr. Kurstin's admissions before, during, and after the trial on Dr. Lordan's role in causing the injury are tantamount to a stipulation. Not only did Dr. Kurstin never dispute that Dr. Lordan was a tortfeasor, he argued vigorously throughout the trial that Dr. Lordan was the sole responsible tortfeasor. Indeed, as recently as page 36 of his appellate brief, Dr. Kurstin was *still* maintaining that Dr. Lordan was the "sole cause of Ms. Blue's injuries." (Appellants' Brief at 36.)

B. There Is Ample Evidence that Dr. Lordan Is a Joint Tortfeasor

In any event, even if there was a requirement that the settling tortfeasor procure a "judicial determination" of his own liability before he can demand contribution from a non-settling joint tortfeasor when the settlement has distinguished the primary liability of all defendants, there was plenty of evidence in this case to warrant a finding that Dr. Lordan qualifies as a tortfeasor with respect to Ms. Blue's injuries.

Dr. Lordan admitted, through his counsel's opening statement, that he was at fault for Ms. Blue's injury. (A.52.) He admitted the same in the settlement agreement he and his

[9] *Hall v. George A. Fuller Co.*, 621 A.2d 848 (D.C. 1993), another case relied on by Dr. Kurstin, is also distinguishable. In *Hall*, *all* of the defendants in the case had settled with the plaintiff; thus there was no basis upon which a contribution claim could proceed. Further, none of the settling defendants admitted liability.

employer reached with Ms. Blue. The evidence at trial underscored his own fault by focusing on the decision to give Lovenox in the operating room and its role in causing injury to Ms. Blue by prompting bleeding in her spinal cord. The intra-operative timing of the drug violated all the known standards for use of Lovenox: Sibley Hospital's own official policy, the published guidelines of the American College of Chest Physicians, and the published guidelines of the American Society of Regional Anesthesia. In addition, it was established at trial that Dr. Lordan's intravenous use of the drug violated the manufacturer's instructions to give it subcutaneously. (A. 681, 219-220.)[10]

The cross-claimants' trial evidence conceded Dr. Lordan's violation of the standard of care but asserted that Dr. Kurstin shared responsibility for the proper administration of the Lovenox when Kurstin ordered this drug that was within Kurstin's expertise but which Dr. Lordan had never used before.

The entire thrust of Dr. Kurstin's trial defense was to push the responsibility for the negligent administration of the Lovenox away from the doctor who ordered it (Kurstin) and onto the shoulders of the doctor who carried out the order (Lordan). In arguing, for example, that any negligence by Dr. Kurstin was superseded by allegedly unforeseeable conduct of Dr. Lordan, the Kurstin proposed findings of fact and conclusions of law states: "Such layer upon layer of unimaginable deviation from the norm by Dr. Lordan could not be reasonably foreseeable to Dr. Kurstin." (Proposed Findings of Fact and Conclusions of Law at 21.) And on page 26: "The evidence proves not a joint-tortfeasor status but Dr. Lordan's singular and sole responsibility for

[10] At the end of the plaintiff's case-in-chief, when Dr. Kurstin's counsel first argued that Dr. Lordan's own status as a joint tortfeasor had not been sufficiently established, the trial court remarked: "I think it was a clear admission. I just think that I can take judicial notice, the way
(footnote continued on next page)

injuring Ms. Blue." Indeed, Dr. Kurstin's own expert testified that at trial that Dr. Lordan was solely responsible. (A. 385.)

In essence, Dr. Kurstin now argues that the Court should find that Dr. Lordan's conduct was so outrageous and unforeseeable that Dr. Kurstin should be relieved from liability as a joint tortfeasor, or, in the alternative, that Kurstin should be excused from the case because Dr. Lordan was not a tortfeasor at all. This goes well beyond mere lawyerly "arguing in the alternative." Rather, Kurstin asks the court to take seriously, at the same time, two diametrically opposite and irreconcilable positions.

Dr. Lordan's actions in settling the claim for $2 million plus the proceeds of his contribution claim speak loudly to whether he recognized the risk of being held liable to Ms. Blue and whether he should now have the right to pursue contribution from the man who told him to give the drug that caused the injury. That Dr. Lordan did not insist first that a court or jury find him liable should be to his credit and should not provide an escape hatch to his adversary Dr. Kurstin.

C. The Reasonableness of the Settlement Is Beyond Dispute

As noted above, the requirement that the settling tortfeasor show the reasonableness of the settlement amply protects the non-settler's interest in not being dragged into a share of a grossly inflated settlement by someone who had no serious exposure himself.

In this case, the reasonableness of the settlement, whether at $2 million alone from Dr. Lordan or at $3 million if one includes the contribution claim proceeds, is beyond fair dispute. The injuries and damages that this healthy 59-year-old woman suffered, based on the event on

---

Dr. Lordan testified and the tone and manner, that this was a beaten man admitting that he made a mistake and that he was liable for the injury…." (Tr. Feb. 7, 2007 at p. 165.)

April 9, 2004 when she underwent surgery with Dr. Kurstin and Dr. Lordan, is set forth with great specificity in the Joint Pretrial Statement. (*See* Joint Pretrial Statement at 5-6, 12, cited *supra*, in Statement of Facts.)

Dr. Kurstin contends in his Brief that Dr. Lordan's contribution action is actually "a laundered claim for additional damages brought on Ms. Blue's behalf . . . in circumvention of the 'cardinal principle of law' that 'a plaintiff can recover no more than the actual loss suffered. . . .'" (Appellants' Brief at 21 (quoting *Reid v. District of Columbia*, 391 A.2d 776, 777 (D.C. 1978).) He further claims that the trial court's finding that the settlement was "just and reasonable" means that turning over to Ms. Blue the proceeds from the contribution action would improperly provide her with a recovery greater than her injuries. This argument is meritless. The trial court did not find that the $2 million *equaled* the amount of her actual damages, merely that it was not an excessive amount in the context of Dr. Lordan's contribution action, and the trial court further found that the settlement was reasonable even after it was fully apprised of the cross claim and Ms. Blue's financial stake in it (see A.676, fn.1).[11]

Caglioti addresses and rejects this precise argument in the context of an assignment of a claim, providing the "collateral source" doctrine as an example of an exception to the "full satisfaction" rule. Indeed, this Court concluded, in allowing the assignment of an indemnification claim to a patient, that it was preferable to have a potential "windfall" inure to the benefit of an injured patient rather than to his negligent physician. *See Caglioti*, 933 A.2d at 815; *see also Berg v. Footer*, 673 A.2d 1244 (D.C. 1996).

III. Dr. Lordan Established A National Standard Of Care Applicable To Dr. Kurstin, And The Trial Court Correctly Determined That Dr. Kurstin Violated That Standard Of Care.

Finally, Dr. Kurstin argues that on the merits, Dr. Lordan failed to establish a national standard of care for surgeons and failed to establish that Dr. Kurstin violated any such national standard of care or proximately caused Ms. Blue's injuries. To the contrary, the trial court had ample evidence before it to conclude under the applicable case law that Dr. Kurstin was liable for Ms. Blue's injuries. Because the court's findings were not clearly erroneous, the judgment should be affirmed. *Hinton v. Sealander Brokerage Co.*, 917 A.2d 95, 101 (D.C. 2007).

For a physician to be liable in the District of Columbia for injury to a patient, the patient must show three elements by a preponderance of the evidence: "'(1) the applicable standard of care; (2) a deviation from that standard of care by the defendant; and (3) a causal relationship between *that deviation* and the plaintiff's injury.'" *Burke v. Scaggs*, 867 A.2d 213, 217 (D.C.2005) (emphasis in original) (quoting *Talley v. Varma*, 689 A.2d 547, 552 (D.C.1997)); *Pannu v. Jackson*, 909 A.2d 178, 192 (D.C.2006). Dr. Kurstin claims that Dr. Lordan failed to establish a national standard of care, as required under District of Columbia law. Dr. Kurstin's argument borders on the frivolous in the face of the mountain of evidence showing a clear standard of care for the timing of administering Lovenox and Dr. Kurstin's failure to abide by that standard. Likewise, the evidence clearly showed Dr. Kurstin's deviation from that standard of care.

---

[11] *See Caglioti*, 933 A.2d at 809-10 (stating that "promise to assign its 'right' to pursue a claim for equitable indemnification (*with the possibility of recouping additional money*) *together* constituted full satisfaction of [patient's] claims") (emphasis added). Similarly, the full satisfaction of Ms. Blue's claims was *at least* the $2 million paid by Dr. Lordan together with the possibility of recouping $1 million from the contribution claim, as the parties agreed.

Dr. Lordan's expert witness at trial, Dr. Goldman, testified to the following bases for his opinion that a national standard of care existed in 2004 for general surgeons in the timing of the administration of Lovenox: (1) in 1995, the Lovenox manufacturer and the FDA recommended in official labeling that the first use of the drug be timed to correspond with the delay used in Europe, 6-12 hours after surgery; (2) in 1997, the FDA issued a public health advisory to health care professionals referring to "post marketing reports of patients who have developed epidural or spinal hematomas with the concurrent use of low molecular weight heparin and spinal/epidural anesthesia or spinal puncture. Many of the hematomas caused neurologic injury, including long-term or permanent paralysis"; (3) in 2003, the American Society of Regional Anesthesia published a "consensus conference" guideline stating that after regional anesthesia is employed, one should wait at least six to eight hours before administering Lovenox; (4) the official label of the drug carries a "black box" warning about the potential of paralysis from spinal/epidural hematomas when Lovenox is used too close in time to regional anesthesia, although the revised label does not advise any particular time delay; (5) two institutions with which he was familiar, his own hospital at West Virginia University and the University of Pittsburgh, recommended a delay of at least twelve house after surgery in the first dose of Lovenox; and (6) extensive studies published on the topic demonstrated conclusively that the rate of deep vein thrombosis (DVT) which Lovenox is intended to prevent, does not improve with administration given before the surgery versus delaying for hours after surgery, and thus there could be no benefit from intra-operative use.

Notwithstanding the cumulative force of this evidence, which was credited in its entirety by the trial court, Dr. Kurstin still tries to argue that it provided an inadequate basis for Dr. Goldman to offer his opinion that there was a national standard of care and that Dr. Kurstin

violated that standard by deciding to give the order to Dr. Lordan to administer Lovenox during Ms. Blue's operation. Essentially, his argument boils down to three equally invalid points: (1) despite all of Dr. Goldman's testimony at trial, Dr. Lordan's counsel somehow failed to lay the foundation for Dr. Goldman to give his expert opinion on the national standard of care; (2) none of the evidence is relevant because Dr. Kurstin happens to be a surgeon and no professional association of *surgeons* has spoken on the question of timing of Lovenox, and (3) Dr. Kurstin was absolved of any responsibility to follow a national standard of care because he could not be held responsible for the negligent actions of the anesthesiologist who carried out his orders.

First, with respect to laying a proper foundation for Dr. Goldman's testimony regarding the national standard of care, this Court recently stated: "The expert must explicitly indicate the *basis* for his or her knowledge of the national standard of care, state what the national standard of care is, and provide a basis for his or her opinion testimony that another doctor has deviated from that standard." *Hill v. Medatlantic Health Care Group*, 933 A.2d 314, 328 (D.C. 2007) (emphasis in original). In *Hill*, the Court discussed three leading cases, *Snyder v. George Washington Univ.*, 890 A.2d 237 (D.C. 2006); *Hawes v. Chua*, 769 A.2d 797 (D.C. 2001); and *Washington v. Washington Hosp. Center*, 579 A.2d 177 (D.C. 1990). Two of the cases turned on the expert testifying to a legitimate basis for his opinion, which the expert in *Hill* had failed to do. In *Snyder*, "the expert did not use the exact term 'national standard of care' but testified that his knowledge of the standard of care was *based upon* attendance at national meetings and keeping up to date with literature regarding the national standard." *Hill*, 933 A.2d 314, 325-26 (emphasis in original) (quoting *Snyder*, 890 A.2d at 245-46). According to the Court in *Hill*, *Hawes* set forth the seven principles that are important in assessing foundation for national standard of care. *See id.* at 326 (citing *Hawes*, 769 A.2d at 806). Again, in *Hawes*, the expert

testified that his testimony was "based on" reading literature and attending national meetings, among other things. Id. at 326 (citing *Hawes*, 769 A.2d at 807). In *Washington*, the Court concluded that other evidence in the record, in combination with the expert's testimony, established a standard of care, such as testimony that the standard was followed by teaching hospitals. By contrast, in *Hill*, the court found that the expert was never even asked by counsel to describe the basis for his opinions regarding the national standard of care, and there had been no evidence admitted from which such a standard could be inferred.

Based on the teachings of *Hill*, *Snyder*, *Hawes*, and *Washington*, Dr. Goldman's testimony clearly satisfied the requirements for laying a foundation in this case. The following testimony amplified the basis for Dr. Goldman's opinion:

Mr. Malone: What's your opinion about why what he did in ordering the Lovenox during the surgery violated the national standard? . . .

Dr. Goldman: My opinion is that the drug was given in too close proximity to the placement of the catheter.

Mr. Malone: What's the basis for saying that that was improper, that that violated a national standard?

Dr. Goldman: Because the national standard evolved from one in which the drug was given almost immediately after surgery to delaying at least 2 hours -- actually, delaying it 6 hours, and now out to 12 hours in many settings. And with that change in dosing the complication is not seen with the same frequency anymore.

The Court: *Is your opinion based on the . . . Horlocker article and the FDA advisory?*

Dr. Goldman: *And subsequent articles by Dr. Horlocker. And also subsequent conversations with my own pain management anesthesia people because this is a constant issue for us, we use epidurals all the time.*

The Court: And when you say your own pain management people, are you talking about just in West Virginia or broader than that?

Dr. Goldman: Well, they are *bringing back information from their meetings* back to me when we have these discussions.

The Court: Are those -- are those local meetings or national?

Dr. Goldman: Those would be *national meetings.*

(A. 246-48 (emphasis added).)

None of the cases cited by Dr. Kurstin stand for the proposition that not only does the testifying expert have to provide a national standard of care but that it must be a standard published by an organization that matches the defendant physician's precise medical specialty. Such a requirement would go well beyond what is required under District of Columbia law. *See, e.g., Washington*, 574 A.2d at 183. Moreover, Dr. Kurstin's argument amounts to a sanctioning of professional ignorance — that a doctor need only be aware of information about a drug he prescribes if there is a standard published by his own society of surgeons, and otherwise can turn a blind eye to a body of published evidence regarding that drug, even when such evidence is generally available to all doctors, such as the drug's official prescribing information.

In fact, Dr. Goldman's testimony relied on a number of sources — Lovenox's manufacturer's product information,[12] the FDA's black box warning and a public health advisory, a published consensus statement from the American College of Chest Physicians and the American Society of Regional Anesthesia that he testifies represented a national standard of care because it was "the most exhaustive look at the reports and the literature" and referred to studies involving multi-millions of doses of the drug, as well as the recommended practice at two institutions outside of the District of Columbia, with which he was familiar. The evidence was not narrowly limited to an anesthesia society but was widely published and widely available to surgeons such as Dr. Kurstin.

[12] This product information is published in the Physicians Desk Reference, which this court has recognized in *Garvey v. O'Donoghue*, 530 A.2d 1141, 1146 (D.C. 1987) "as both prima facie evidence of the standard of care and physicians' notice of their contents."

Dr. Kurstin repeatedly quotes his own expert Dr. Bartolozzi's testimony but fails to acknowledge that the trial court appropriately gave less weight to Dr. Bartolozzi because, unlike Dr. Lordan's experts' testimony, the defense expert's opinion lacked support from any objective written guidelines or standards.[13] (A. 688.) This Court has emphasized that reference to objective outside sources is an important benchmark of the credibility of an expert's statements concerning national standard of care. *See, e.g., Phillips v. District of Columbia*, 714 A.2d 768 (D.C. 1998).

In sum, there is no possible way for a court to conclude that this evidence, examined together, failed to satisfy the District of Columbia's requirements of showing a course of treatment followed nationally 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." *Strickland v. Pinder*, 899 A.2d 770, 773-74 (D.C. 2006) (quoting *Travers v. District of Columbia*, 672 A.2d 566, 568-69 (D.C. 1996)). The only testimony vulnerable to attack for lack of foundation was that of Dr. Bartolozzi, who made sweeping assertions that there was no standard of care but who could identify no published authority, no hospital, no surgeon, no objective evidence whatever in support of his opinion.

The "captain of the ship" doctrine, referred to by Dr. Kurstin in his brief, applies only when a patient tries to hold one of his doctors responsible for the negligence of another doctor on a vicarious liability theory of *respondeat superior*. Dr. Lordan has never contended that Dr. Kurstin has vicarious liability. Dr. Lordan claims that Dr. Kurstin was *personally* negligent in

[13] Significantly, Dr. Bartolozzi "could identify no medical textbooks or articles that supported intra-operative use" of Lovenox. (A. 688.)

his handling of his *own* professional duties to Ms. Blue. This contention is well supported by the record. Indeed, Dr. Kurstin conceded that there was a "joint decision" between him and Dr. Lordan to administer Lovenox during the operation. (A.524; Kurstin dep p. 26 ln 14.) Dr. Kurstin cites to cases where courts have declined to hold a surgeon liable for an anesthesiologist's administration of anesthetic drugs. In this case, Dr. Lordan does not contend that Dr. Kurstin negligently failed to oversee the anesthetic drugs used for Ms. Blue, which arguably would fall within the exclusive expertise of the anesthesiologist and not the surgeon, but rather a blood-thinning drug used not by anesthesiologists but typically by surgeons, to avoid blood clots after surgery. In such a situation, it is patently unreasonable to shift responsibility for a negligent decision solely onto the anesthesiologist who negligently carried out the orders of the surgeon.

Finally, beyond the weight of Dr. Goldman's persuasive and credited testimony, Dr. Kurstin also fails to diminish the force of the remaining evidence proffered by Dr. Lordan at trial that contributed to a national standard of care. According to Dr. Carl Sylvester, who was president of the medical staff at Sibley Hospital from 2000 to 2004, the hospital had placed into effect in August 2000 and had widely distributed a mandatory policy that required doctors to wait two hours before giving the first Lovenox injection after regional anesthesia such as Ms. Blue had. (A. 513.) Dr. Sylvester was familiar with the use of Lovenox by surgeons at Sibley and testified he was unaware of a single instance when the drug was ordered by a surgeon for intra-operative use *except* by Dr. Kurstin for Ms. Blue. Sylvester (A.477). Part of the national standard of care requires a surgeon to be familiar with his own hospital's policies on the drugs he orders. The defendant's expert Dr. Bartolozzi conceded a surgeon should know his own

hospital's policies on drugs the surgeon has occasion to order. (A.424).[14] District of Columbia law similarly holds that violation of a hospital's own policy is evidence of negligence. *Lucy Webb Hayes Nat. Training School for Deaconesses & Missionaries v. Perotti,* 136 U.S.App.D.C. 122, 419 F.2d 704 (D.C.Cir.1969).[15]

Dr. Kurstin acknowledged awareness of such recommendations regarding the timing of Lovenox but testified that he nonetheless decided when to use the drug on his own patients based on his own experience. Dr. Kurstin deviated from the applicable standard of care by ordering the administration of Lovenox to Ms. Blue on an intra-operative basis despite hospital policy and other warnings that the drug should only be given well before or well after administering an epidural catheter or spinal anesthesia, as were both used in her case. Although the various authorities differed on precisely how long a surgeon should wait before giving Lovenox after surgery, the evidence was uniform that it should not be given *during the operation.* That is the standard that Dr. Kurstin breached. Remarkably, the evidence shows that Dr. Kurstin was virtually alone in his practice of intra-operative Lovenox use; no one else at Sibley did it that way, and the defense could point to no other hospital, no other surgeon and no other authoritative literature that followed Dr. Kurstin's approach. In sum, Dr. Kurstin's stubborn refusal to follow the standard of care amounted to negligence in his treatment of Ms. Blue, as the trial court correctly found, and he cannot now be absolved of all blame for that negligence by pointing the

---

[14] But remarkably, Dr. Bartolozzi had no knowledge of whether or not hospital policies or guidelines were in effect in the two hospitals he had privileges at in Woodbridge, Virginia, and he had not inquired about them before he testified. (A. 374-375.)

[15] Decisions of the United States Court of Appeals for the District of Columbia Circuit constitute binding precedent in this jurisdiction when they were issued before February 1, 1971, the effective date of court reorganization. *M.A.P. v. Ryan,* 285 A.2d 310, 312 (D.C. 1971).

finger at another doctor who made the mistake of carrying out his order.

IV. Dr. Lordan Proved That Dr. Kurstin Proximately Caused Ms. Blue's Injuries.

To establish causation, a plaintiff must prove two elements: "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." *Snyder v. George Washington University,* 890 A.2d 237, 246-47 (D.C. 2006) (emphasis in original) (quoting *Psychiatric Inst. of Washington v. Allen,* 509 A.2d 619, 624 (D.C.1986). In this case, the trial court correctly found that Dr. Lordan satisfied his burden of proving both elements by the preponderance of the evidence.

A. There Was a Direct and Substantial Causal Relationship Between Dr. Kurstin's Breach of the National Standard of Care and Ms. Blue's Injuries

A plaintiff need not establish that the defendant's breach of a standard of care was the only possible cause of her injuries. *See, e.g., District of Columbia v. Zukerberg,* 880 A.2d 276 (D.C.2005). To the contrary, there can be multiple causes of an injury, and multiple tortfeasors can be held liable for breaches which were substantial factors in causing the injury.[16] Thus, that Dr. Lordan might have done well to challenge Dr. Kurstin's choice of the drug or to request special instructions on its administration does not provide Dr. Kurstin with a defense. *See, e.g., Majeska v. District of Columbia,* 812 A.2d 948 (D.C.2002) (restating the rule that "Although the intervening act of another makes the causal connection between the defendant's negligence and the plaintiff's injury more attenuated, such an act does not by itself make the injury

[16] *See, e.g., National Health Laboratories v. Ahmadi,* 596 A.2d 555, 557 (D.C.1991) (stating "when two tortfeasors jointly contribute to harm to a plaintiff, both are potentially liable to the injured party for the entire harm."); *Machesney v. Bruni,* 905 F. Supp. 1122, 1135 (D.D.C. 1995); *Ferrell v. Rosenbaum,* 691 A.2d 641 (D.C. 1997).

unforeseeable. '[A] defendant will be responsible for the damages which result, despite the intervention of another's act in the chain of causation, if the danger of an intervening negligent or criminal act should have been reasonably anticipated and protected against.' " (citations omitted)).

Dr. Kurstin's deviation from the standard of care directly and substantially caused the sequence of events in which Dr. Lordan administered the drug intravenously during the operation. But for Dr. Kurstin's request, Dr. Lordan would not have administered this drug. Further, Dr. Kurstin's intra-operative decision to give this particular drug, whether administered intravenously or by subcutaneous injection, was a substantial factor in Ms. Blue's spinal cord injury. *Machesney v. Larry Bruni, M.D., P.C.*, 905 F. Supp. 1122, 1135 (D.D.C. 1995).

B. It Was Foreseeable that Dr. Kurstin's Request for Dr. Lordan to Administer Lovenox Intravenously During the Operation Would Result in the Injuries Sustained by Ms. Blue.

The foreseeability of negligence by medical practitioners is generally accepted. *See, e.g., Zimmerman v. Safeway Stores, Inc.*, 410 F.2d 1041, 1043 (D.C.Cir. 1969) (remarking that parties assumed that malpractice in treating plaintiff for injuries caused by store's negligence flowed from that negligence for purposes of damages and citing *Restatement (Second), Torts § 457* (1965)). The general rule is that the initial tortfeasor is liable not only for the injuries he causes but also for injuries suffered through a third party's negligent or non-negligent efforts to treat the plaintiff when those efforts are a foreseeable result of the first tortfeasor's conduct. *See Restatement (Second), Torts § 457* cmt. d (1965).

The law does not require that the "defendant…have foreseen the precise injury, nor should [he] have had notice of the particular method in which a harm would occur, if the possibility of harm was clear to the ordinarily prudent eye'." *Psychiatric Institute of Washington*

v. *Allen*, 509 A.2d 619, 625 (D.C.1986) (internal quotations omitted). Dr. Lordan was therefore not required to prove that Dr. Kurstin should have foreseen the precise events which resulted in Ms. Blue's injury. Rather, he met his burden by proving that Ms. Blue's injury fell into the class of injuries made foreseeable by defendant's decision to use this drug despite the hospital policy and well-disseminated literature on its known risks and proper use.

In this case, the trial court correctly determined that Dr. Lordan's intravenous administration of Lovenox to Ms. Blue during her operation fell foreseeably within the scope of the risk created by Dr. Kurstin's negligent request to Dr. Lordan to administer that very drug. The injury to Ms. Blue's spinal cord, caused by the bleeding occasioned by the administration of the Lovenox, was a foreseeable result of the improper timing and administration of the drug. Her injury falls squarely into the scope of risk to which surgeons were alerted by the Sibley hospital policy, the 1995 manufacturer's warning, and the 1997 FDA advisory. Furthermore, Dr. Kurstin failed to show that any event in the series of events that befell Ms. Blue was a superseding cause so as to break the causal chain between his negligence and her injuries. It has not been established that there was anything extraordinary about Dr. Lordan's administration of the Lovenox intra-operatively by the i.v. route. Dr. Kurstin admitted that he had made the decision, and Dr. Lordan testified without contradiction that he gave the drug at Dr. Kurstin's behest in the ordinary manner in which anesthesiologists administer drugs in the operating room, which is into the patient's i.v. line.[17]

While it might have been preferable for Dr. Lordan to have clarified the route of

[17] Even if the intravenous route were the exclusive cause of the injury, Dr. Kurstin conceded that Dr. Lordan would not have administered the drug at all if it had not been for Dr. Kurstin's order during the operation. Thus, Dr. Kurstin's negligence still bears a causal relationship to the injury.

administration that Dr. Kurstin wanted, Dr. Kurstin bears responsibility for announcing his order without specificity and at a time when misunderstanding could occur. Dr. Kurstin also could have made clear that timing of use should be delayed for two hours after the regional procedure, but he did not do so, even when Dr. Lordan asked him about the dosage just before administering the drug. In light of these facts, there was nothing extraordinary or unforeseeable about Dr. Lordan's decision to give the drug intravenously or at the time he did so.

The trial court correctly noted that "Courts around the country have repeatedly rejected the defense that an initial medical tortfeasor should be relieved from liability because of the negligent subsequent conduct of another medical provider, even when there is much less connection between the two physicians' acts than in this case." See the cases discussed in the trial court's conclusions of law at A.703-705.

Dr. Kurstin described the choice of Lovenox as a "joint decision." He cannot establish that he did not contribute to the event in which it was administered. When multiple tortfeasors' breaches have resulted in a single indivisible injury, the plaintiff need not prove the degree to which each tortfeasor contributed to her injury. *See Graham v. Roberts*, 441 F.2d 995, 998 n.3 (D.C. Cir. 1970).

Dr. Kurstin now tries to rewrite the facts of the case to suit his argument, contending, for example, that Dr. Lordan's expert Dr. Katz had testified that Ms. Blue's injuries were caused by Dr. Lordan's use of a spinal anesthetic. (Appellants' Brief at 5.) To the contrary, Dr. Katz testified that the spinal needle itself would have caused no permanent injury but for the interference with coagulation caused by the premature use of Lovenox. (A.340-341.) Dr. Kurstin further misstates the facts when he contends Dr. Lordan disregarded his instructions in giving the spinal anesthetic. (Appellants' Brief at 35.) There was no testimony that Dr. Lordan

was instructed not to use the spinal anesthetic.[18] Further, as the trial court found, "There was no testimony that Dr. Lordan acted negligently in choosing spinal anesthesia or in his technique with the spinal needle, much less that his use of the spinal needle was extraordinarily unforeseeable, which would be necessary to establish that the spinal needle was a superseding cause. The correct focus is on what role the use of the negligently ordered Lovenox played in this patient's injury, and all experts agreed it was crucial and that Dr. Kurstin set the train of events in motion by his untimely order of the Lovenox." Findings of Fact at ¶ 67 (A. 695).

In sum, there was ample evidence in the trial record for the court to conclude based upon District of Columbia law that Dr. Lordan had sustained his burden of proving proximate causation.

CONCLUSION

The defendant's many other fact arguments all were ably answered by the trial court in its comprehensive findings of fact and conclusions of law. The defendant spills much ink rearguing the significance of various facts but cannot point to a single factual finding for which the trial court lacked a reasonable basis. This is a far cry from the clear error that this Court would have to find to justify reversal.

For all the foregoing reasons, the trial court's judgment should be affirmed.

Respectfully submitted,

_____
Patrick A. Malone

[18] The fact that Dr. Kurstin apparently was unaware of the spinal anesthetic was also no excuse. As the trial court found, "Both plaintiff's and defendant's general surgery expert witnesses testified that Dr. Kurstin had an obligation to learn before the surgery of the anesthetic technique being used." Findings of Fact at ¶ 18 (A.680).

D.C. Bar No. 397142
Patrick Malone & Associates, P.C.
1331 H Street, N.W., Suite 902
Washington, D.C. 20005
(202) 742-1500

Attorneys for Appellees

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on July 8, 2008, a copy of the foregoing Appellees' Brief was emailed and mailed first-class, postage prepaid to:

Andrew H. Baida
Rosenberg/ Martin / Greenberg, LLP
25 S. Charles Street, 21st Floor
Baltimore, Maryland 21201

Attorneys for Appellant

_____
Patrick A. Malone