

A close-up, monochromatic image of a person's eyes, looking directly at the camera. The image is in shades of blue and grey, with a soft, slightly blurred background.

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In general, a plaintiff in a medical malpractice case bears the burden of proof on four issues:

- 1) *the applicable standard of care;*
- 2) *a deviation from the standard of care by a healthcare provider(s);*
- 3) *a causal relationship between the deviation from the standard of care and plaintiff's injury; and*
- 4) *proof of plaintiff's injury.*

The necessary proof for each of the above elements may vary from jurisdiction to jurisdiction. As a result, a litigant must carefully choose an attorney who is familiar with the local requirements for proving medical malpractice/negligence. This is particularly true in the District of Columbia. This article provides a primer on what a litigant must do in the District of Columbia to establish the applicable standard of care for a healthcare provider (i.e. hospital, clinic, physician, nurse or other health care provider) in a medical malpractice/negligence case.

As noted above, a plaintiff must prove: the applicable standard of care, a deviation from that standard by the defendant, and a causal relationship between that deviation and the plaintiff's injury.¹ Each of these issues must be supported by expert testimony.²

An expert's testimony with respect to the standard of care must address what a reasonably prudent health care provider with defendant's specialty would have done under the same or similar circumstances, *not in the community or locally, but nationally.*³ Furthermore, an expert must establish that he is familiar with the national standard of care in defendant's specialty.⁴ However, the expert is not required to be a health care provider in the same specialty as the defendant as long as he/she is familiar with the standard of care in defendant's specialty. Such familiarity can be established "either through reference to a published standard, discussion of the described course of treatment with practitioners outside the District at seminars or conventions, or through presentation of relevant data."⁵ In assessing the admissibility of standard of care testimony, the following factors should be considered: 1) is the expert merely using the words "national standard" to claim familiarity with the standard of care; 2) is the testimony based on the expert's personal opinion; 3) is the testimony based on speculation or conjecture; and 4) is the expert relying on any published materials or attendance at national meetings/seminars to support his opinion.⁶

¹ *Woldeamanuel v. Georgetown Univ. Hosp.*, 703 A.2d 1243 (D.C. 1997)

² *Cleary v. Group Health Ass'n*, 691 A.2d 148 (D.C. 1997)

³ *Nwaneri v. Sandidge*, 931 A.2d 466 (D.C. 2007)

⁴ *Strickland v. Pinder*, 899 A.2d 770 (D.C. 2006)

⁵ *Snyder v. George Washington Univ.*, 890 A.2d 237 (D.C. 2006)

⁶ *Hawes v. Chua*, 796 A.2d 797 (2001)

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If an expert does not link his testimony to any certification process, current literature, conference or discussion with other knowledgeable professionals, there is no basis for his discussion of the national standard of care. The personal opinion of a testifying expert as to what he or she would do in a particular case is insufficient to prove the applicable standard of care. Moreover, an expert's educational and professional background alone is insufficient to establish his familiarity with the national standard of care.⁷

Finally, it is the duty of plaintiff's counsel to lay the requisite foundation to establish an expert's familiarity with the national standard of care.⁸ Once an expert's basis for his knowledge of the national standard of care is established, the expert must then describe what the national standard of care requires. Once an expert has established his/her familiarity with the national standard of care and has articulated what the standard of care requires, he/she is then qualified to provide testimony about specific acts of negligence (i.e., deviations from the standard of care) by a healthcare provider(s).

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⁷ *Travers v. District of Columbia*, 672 A.2d 566 (D.C. 1996)

⁸ *Hill v. Medlantic Health Care Group*, 933 A.2d 314 (D.C. 2007)