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# Comments: A "Familiar" Standard of Care: What the Same or Similar Communities Standard Could Mean for Maryland

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# A "FAMILIAR" STANDARD OF CARE: WHAT THE SAME OR SIMILAR COMMUNITIES STANDARD COULD MEAN FOR MARYLAND.

## I. INTRODUCTION

Picture yourself as a doctor with years of training and experience, treating a patient. You discuss with your patient the risks and benefits of a test you could perform that would screen for a disease. The patient refuses, and you do not order the test. You later find out that the patient has this disease when a medical malpractice claim is brought against you. In states that use a "locality rule" for medical malpractice cases, if the standard practice in that area was to order the test without asking the patient, you could be held liable for a failure to meet the standard of care even if your decision was the most prudent by national standards.[1]

Imagine instead, the more likely scenario, that you are a patient. You begin to experience what you believe to be adverse effects of a procedure you underwent at a hospital, so you do some research. You find that the procedure is no longer practiced in most hospitals across the country because of the same effects you are experiencing. You bring a medical malpractice claim against your health care provider and retain an expert witness who will testify that ordering the procedure violated the national standard of care. In a locality rule state, you will likely be uncompensated if the procedure is commonly ordered in your health care provider's medical community. In fact, your expert's testimony will probably be excluded for failing to address the relevant standard of care.[2]

Maryland has wisely operated under the national standard of care since 1975.[3] In 1993, the Maryland General Assembly passed House Bill 1359, which was intended to reform the small group health insurance market.[4] A provision in this bill, dealing with the legal

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1. *See* Amy Lynn Sorrel, *Liability by Locality: Practical Standard or Outdated Notion?*, AM. MED. NEWS (Jan. 18, 2010), http://www.ama-assn.org/amednews/2010/01/18/prsa0118.htm. Physician Daniel J. Merenstein, MD, was involved in such a case. *See id.*
2. *See infra* Part II.C.1.
3. *See infra* Part III.B.
4. *See* Maria S. LoBianco et al., *A Model for Case Management of High Cost Medicaid Users*, NURSING ECON., Sept.-Oct. 1996, at 303–07, 314, *available at* http://findarticles.com/p/articles/mi_m0FSW/is_n5_v14/ai_n18607072/.

standard of care for medical malpractice cases in Maryland, was added with little-to-no discussion, and went unnoticed by many.[5] The provision added new language to the Courts and Judicial Proceedings Article of the Maryland Code, stating that health care providers would only be held to the standard of care in the "same or similar communities" as that of the health care provider.[6] While this language was added in 1993, its meaning and effect are still in debate because it is in direct conflict with Maryland's national standard, previously established by common law.[7] The Court of Special Appeals of Maryland recently addressed this issue and provided its guidance as to how the statute should be applied.[8]

This comment will focus on the effect the "same or similar communities" language in the Courts and Judicial Proceedings Article[9] will have on the standard of care in medical malpractice cases in Maryland. Part II provides background on how the standard of care operates,[10] describes the three different types of standards,[11] and explains why it is critical for the legal standard of care to be clearly defined for both plaintiffs[12] and physicians.[13] The consequences of an unclear standard for plaintiffs will be illustrated using North Carolina's application of a same or similar communities standard and examining the problems that have arisen there.[14] Part III chronicles the evolution of Maryland's standard of care jurisprudence from common law before 1975,[15] to the recent Court of Special Appeals decision in *Daee v. Lucas*.[16] Part IV details the possible decisions the Court of Appeals of Maryland could make as to the standard of care issue,[17] and ends by imploring the court that if it insists on applying a same or similar communities rule for Maryland,

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5. *See* Dan J. Loden, *Community Standard in Health Law May Burden Malpractice Plaintiffs*, THE DAILY RECORD, Sept. 18, 1993, at 11 (noting that the legislation was likely pushed by lobbyists for the insurance industry). The bill was primarily focused on health insurance issues, not medical malpractice law. *See* LoBianco et al., *supra* note 4.
6. 1993 Md. Laws 529, 546.
7. *See infra* Part III.B.3.
8. *See* discussion of Daee v. Lucas, No. 2485 (Md. Ct. Spec. App. Feb. 15, 2011) *infra* Part III.E.
9. MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-02(c)(1) (LexisNexis 2011).
10. *See infra* Part II.A.
11. *See infra* Part II.B.
12. *See infra* Part II.C.
13. *See infra* Part II.D.
14. *See infra* Part II.C.2.
15. *See infra* Part III.A.
16. *See infra* Part III.E.
17. *See infra* Part IV.A.

it should establish clear guidelines for applying the standard as soon as possible in order to avoid problems exemplified by North Carolina.[18]

## II. IMPORTANCE OF A CLEAR STANDARD OF CARE

### *A. The Expert Testimony Requirement*

To understand the effect that the legal standard of care for medical malpractice has, it is first necessary to grasp the interplay between the standard of care and the expert testimony requirement. To establish a prima facie case of medical malpractice, Maryland law requires that a plaintiff plead and prove through expert testimony, the standard of care applicable to the defendant health care provider, that the health care provider deviated from the standard of care, that the deviation was a cause of the plaintiff's injury, and that damages resulted from that injury.[19] Expert medical testimony under Maryland law must be based on a "reasonable degree of medical probability."[20] In order for a medical expert to produce such testimony, the expert must be familiar with the standard of care.[21] The law governing the standard of care determines what standard the expert must be familiar with and, therefore, who is eligible to give the expert testimony medical malpractice plaintiffs must provide.

### *B. The Three Standards of Care*

#### 1. Strict Locality

The "strict locality" standard is the most onerous of the three standards of care.[22] In Maryland, it was first described as "whether or not [the physician] did fail to exercise the amount of care, skill and diligence as a physician and surgeon which is exercised generally in the community . . . in which he was practi[c]ing by doctors engaged in the same field."[23] Under the strict locality rule, plaintiffs must provide testimony from an expert familiar with the standard of care specific to the defendant physician's community, which usually

18. *See infra* Part IV.B.
19. Rodriguez v. Clarke, 400 Md. 39, 71, 926 A.2d 736, 755 (2007).
20. Kearney v. Berger, 416 Md. 628, 651, 7 A.3d 593, 606 (2010) (quoting Carroll v. Konits, 400 Md. 167, 211, 929 A.2d 19, 45 (2007) (Greene, J., dissenting)).
21. *See id.* at 651–52, 7 A.3d at 606.
22. Marvin Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207, 208 (1973).
23. State *ex rel.* Solomon v. Fishel, 228 Md. 189, 195, 179 A.2d 349, 352 (1962).

requires the expert to practice in the same community as the defendant.[24] The rationale behind this rule is that a physician who has practiced in a medical community similar to that of the defendant physician with the same standard of care might still lack the requisite familiarity with the applicable standard to qualify as an expert.[25]

2. Similar Locality

The "similar locality" rule is slightly more relaxed than the strict locality rule.[26] This standard was enunciated by the Supreme Judicial Court of Massachusetts in *Small v. Howard* as requiring "that skill only which physicians and surgeons of ordinary ability and skill, practi[c]ing in similar localities, with opportunities for no larger experience, ordinarily possess."[27] Rather than requiring expert testimony as to the standard of care in the specific locality in which the defendant physician practices, testimony about a similar locality is permissible.[28] For instance, under this rule, a doctor familiar with the standard of care in a small, rural town in Maryland could provide expert testimony against a practitioner in a small, rural town in Massachusetts.[29]

3. National Standard

The "national standard" eliminates familiarity with any particular location from the analysis.[30] This standard was described by the Court of Appeals of Maryland as the "duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which [the defendant] belongs, acting in the same or similar circumstances," taking into account "advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, [and] all other relevant considerations."[31] A doctor familiar with the national standard of

24. *See* Ellin, *supra* note 22, at 208.
25. *See id.*
26. *See id.* at 216.
27. Small v. Howard, 128 Mass. 131, 136 (1880), *overruled by* Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).
28. *See* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 195–96, 349 A.2d 245, 249–50 (1975).
29. *See* Ellin, *supra* note 22, at 216.
30. *See* Kobialko v. Lopez, 576 N.E.2d 1044, 1047 (Ill. App. Ct. 1991) ("[A] doctor familiar with the national, uniform standards . . . is considered sufficiently knowledgeable of all localities." (citing Purtill v. Hess, 489 N.E.2d 867, 874 (Ill. 1986))).
31. *Shilkret*, 276 Md. at 200–01, 349 A.2d at 253.

care can testify under this rule without any familiarity with the defendant physician's community or a similar community.[32]

### C. *The Standard of Care Must Be Clear for Plaintiffs*

#### 1. Failing to Establish the Standard of Care

A plaintiff's failure to establish the applicable standard of care will be fatal to a case of medical malpractice.[33] The strict locality rule, being the most onerous standard, provides an illustration. In *Dunham v. Elder*, the Court of Special Appeals of Maryland[34] held that a urologist who had never practiced in any capacity in the state was not qualified to provide expert testimony as to the standard of care under the strict locality rule.[35] The plaintiffs provided a second witness who had not practiced in Maryland either and on that basis he did not qualify as an expert at trial.[36] Testifying as an "examining physician," the second witness stated that the standard of care in the defendant physician's specialty was that of a general practitioner, but did not testify as to what that standard would entail.[37] The court ruled that the plaintiffs did not make a prima facie case of medical malpractice because, without a qualified expert, the "testimony was insufficient to establish what was the standard of medical care and skill required . . . in Prince George's County," the defendant physician's medical community.[38] Where the strict locality rule demands the exclusion of a critical expert witness, the plaintiff will lose the case, as in this example.

Because the standard of care controls who may provide expert testimony, it also controls whom parties in a medical malpractice case select as their experts. In order for plaintiffs to provide an expert qualified to testify as to the standard of care, the requirements for qualifying that expert to the court must be known. Uncertainties about the law can cause this selection to be difficult and stressful because a plaintiff's claim is at risk.

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32. *See Kobialko*, 576 N.E.2d at 1047 (citing *Purtill*, 489 N.E.2d at 874).
33. *See, e.g.*, Dunham v. Elder, 18 Md. App. 360, 366–67, 306 A.2d 568, 572 (1973).
34. Note, though, that Maryland no longer applies this standard. *See infra* Part III.
35. *Elder*, 18 Md. App. at 365, 306 A.2d at 571. The witness was permitted to testify as an expert in urology, but not to the applicable standard. *Id.*
36. *Id.* at 366, 306 A.2d at 572.
37. *Id.*
38. *Id.* at 366–67, 306 A.2d at 572.

2. North Carolina's Problems with an Unclear Standard

Locality rules demand an extra requirement of proving an expert's familiarity with the defendant physician's community or a similar community.[39] North Carolina applies such a standard, but the familiarity requirements under North Carolina law are uncertain.[40] North Carolina's experience illustrates the importance of clarifying the familiarity requirements to ensure plaintiffs have a fair shot at acquiring adequate expert testimony.

North Carolina abandoned the strict locality rule for a same or similar communities standard at common law,[41] and subsequently codified that rule by statute in 1975.[42] The North Carolina General Assembly's report on that statute indicated that it specifically adopted a same or similar communities standard of care to avoid further interpretation by the state's high court that "might lead to regional or national standards for all health care providers."[43]

*a. The "familiarity" requirement*

Two North Carolina decisions caused much confusion as to the degree of familiarity an expert witness must have in order to testify to the standard of care in the same or similar community as the defendant physician. In *Henry v. Southeastern OB-GYN Associates*, the plaintiff's expert was excluded because he was found to be unfamiliar with the medical community in Wilmington, North Carolina, the community in which the defendant physician

39. *See id.* at 363–64, 306 A.2d at 570–71.

40. *See* Casey Hyman, Comment, *Setting the "Bar" in North Carolina Medical Malpractice Litigation: Working with the Standard of Care that Everyone Loves to Hate*, 89 N.C. L. REV. 234, 236 (2010).

41. *See* Wiggins v. Piver, 171 S.E.2d 393, 397–98 (N.C. 1970).

42. *See* N.C. GEN. STAT. ANN. § 90-21.12 (West 2010).

> In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.

*Id.*

43. Henry v. Se. OB-GYN Assocs., 550 S.E.2d 245, 246 (N.C. Ct. App. 2001) (quoting N.C. PROF'L LIAB. INS. STUDY COMM'N, REPORT TO THE GENERAL ASSEMBLY OF 1976, at 32 (1976)), *aff'd per curiam*, 557 S.E.2d 530 (N.C. 2001).

practiced.[44] Plaintiffs argued that the standard of care in the defendant's community was a national standard, and because their expert could testify as to the national standard of care, it was error to exclude his testimony.[45] Plaintiffs also argued that their expert was familiar with the standard of care in Spartanburg, South Carolina, which would be the same standard applied in Durham and Chapel Hill, North Carolina.[46]

The Court of Appeals of North Carolina rejected both arguments, stating that there was no evidence that the national standard of care was practiced in the defendant's community, that the standard in Durham or Chapel Hill was the standard practiced in the defendant's community, or that Durham or Chapel Hill were similar communities to Wilmington.[47] The court noted that it had "recognized very few 'uniform procedures' to which a national standard may apply, and to which an expert may testify."[48] The court relied on the intent behind the General Assembly's adoption of the similar community rule "'to avoid the adoption of a national or regional standard of care for health providers.'"[49] The Supreme Court of North Carolina affirmed this decision per curiam, providing no guidance as to what level of familiarity may have been sufficient.[50]

Four years later, the Supreme Court of North Carolina affirmed the lower appellate court's decision in *Pitts v. Nash Day Hospital, Inc.*,[51] which held that a medical expert was sufficiently familiar with the same or similar medical community as the defendant.[52] As in *Henry*, the expert testified that the applicable standard of care was a national standard.[53] However, the court looked to the expert's testimony as a whole, and held that he met the familiarity requirement by testifying that he was similarly trained as the defendant physician, practiced in multiple communities inside North

44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.* at 246–47.
48. *Id.* at 247 (citing Haney v. Alexander, 323 S.E.2d 430, 434 (N.C. Ct. App. 1984) (nurses taking and reporting vital signs); Page v. Wilson Mem'l Hosp., 272 S.E.2d 8, 10 (N.C. Ct. App. 1980) (nursing practices associated with bedpan use)).
49. *Id.* at 246 (quoting *Page*, 272 S.E.2d at 10), *aff'd per curiam*, 557 S.E.2d 530 (N.C. 2001).
50. *Id.* at 530.
51. Pitts v. Nash Day Hosp., 605 S.E.2d 154 (N.C. Ct. App. 2004), *aff'd per curiam*, 614 S.E.2d 267 (N.C. 2005).
52. *Id.* at 157.
53. *Id.* at 156.

Carolina like the defendant, and that the "facilities, equipment, funding, and the physical and financial environment of both the communities in which [the expert] practiced" and in the community in which the defendant practiced were similar.[54] The court also found that the expert had practiced in communities with "population[s] and median income[s]" similar to the defendant's medical community, relating them as to "population served, rural nature, depressed economy, and limitations on resources."[55] Lastly, before the proffered expert testified, he had "observed the community [in which the defendant practiced and] noted the size of [the defendant's hospital]."[56] The court therefore held that the proffered expert was sufficiently familiar with the community's standard to meet the expert witness qualifications of North Carolina's same or similar communities standard, but again defined no evidentiary standard that the expert had met.[57]

From the *Henry* and *Pitts* decisions, it is difficult to ascertain the requirements for establishing an expert's familiarity with the defendant physician's community under the same or similar communities standard. These cases perhaps did just as much to confuse the requirements as to clarify them for North Carolina.[58]

*b. Maintaining "flexibility"*

The Supreme Court of North Carolina had its chance to clarify the state's standard of care requirements when it was handed two more cases with expert familiarity at issue: *O'Mara v. Wake Forest University Health Sciences*[59] and *Crocker v. Roethling*.[60] The court, however, passed again on an opportunity to set clear guidelines for establishing an expert witness's familiarity with the same or similar communities as the defendant physician.[61]

The Supreme Court of North Carolina determined the review of *O'Mara* was improvidently allowed and therefore did not decide on the case.[62] The court's decision in *Crocker* added just as little clarity. In *Crocker*, the trial court excluded the plaintiff's expert because his

54. *Id.* at 156–57.
55. *Id.* at 157.
56. *Id.*
57. *Id.* at 199.
58. *See* Hyman, *supra* note 40, at 236.
59. 646 S.E.2d 400 (N.C. Ct. App. 2007), *disc. review improvidently allowed by* 678 S.E.2d 658 (N.C. 2009).
60. 646 S.E.2d 442 (N.C. Ct. App. 2007), *rev'd*, 675 S.E.2d 625 (N.C. 2009).
61. Hyman, *supra* note 40, at 237.
62. 678 S.E.2d at 658.

affidavit lacked evidence that he was familiar with the standard of care in the same or similar community as the defendant.[63] The Supreme Court of North Carolina held that a "trial court may not automatically disqualify an expert witness simply because the witness indicates reliance on a national standard of care during a discovery deposition."[64] The court stated that while the plaintiff does have a duty to establish the witness's familiarity with the same or similar communities in which the defendant practiced, it does not have to be done at the discovery deposition stage.[65]

The expert's sworn affidavit stated that he had "reviewed information" about care in the defendant physician's community, the defendant, and the defendant's practice.[66] The affidavit also stated plainly that the expert was familiar with the relevant standard of care in the defendant's community at the time of the alleged malpractice.[67] The *Crocker* court stated that there was no requirement under North Carolina law for the expert to provide "documentation of his research or attempt to explain to the trial judge how his knowledge about the community enabled him to ascertain the relevant standard of care."[68] However, the only guidance provided by the court, as to fulfilling the familiarity requirement, is a recommendation that "the trial court[s] should apply well-established principles of determining relevancy under Evidence Rules 401 and 701"[69] and that, because the court desires to "preserve flexibility," many methods of becoming familiar with a given community are possible.[70]

The court continues to adhere to this non-standard, which has prompted the following riddle: "When is a board certified doctor with 20 years of directly related surgical experience not qualified to testify as a surgical expert on the standard of care in a medical malpractice case? When he or she is asked to testify in a North Carolina courtroom."[71] Unclear standards like those in North Carolina create an unfair situation for plaintiffs who could have their case thrown out if they fail to meet arbitrary familiarity requirements.

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63. 675 S.E.2d at 627.
64. *Id.* at 631.
65. *Id.*
66. *Id.*
67. *Id.*
68. *Id.*
69. *Id.* at 632.
70. *Id.* at 631.
71. Mark Canepa, *Making Your Way Through the Minefield of Expert Witness Selection in Malpractice Cases in North Carolina*, 10 N.C. STATE BAR J. 6, 6 (2005), *available at* http://www.ncbar.com/journal/archive/Journal%2010,4.pdf.

### *D. The Standard of Care Must Be Clear for Physicians*

The uncertainty surrounding the standard of care requirements is arguably even more stressful for doctors because the critical decisions they make, based on what they believe to be the applicable standard of care, could be the focus of a medical malpractice claim.[72] The standard of care must be understood so that doctors know what level of care is legally required.[73] Doctors practicing medicine in Maryland deserve to know the standard of care they must meet in their day-to-day professional life if they are going to be held responsible for not meeting it.[74] Doctors that intend to testify as expert witnesses in medical malpractice cases also need to know what standard applies if they are going to provide an opinion, to a reasonable degree of medical probability, on whether a doctor breached the required standard.[75]

In a June 2007 article written by three doctors, at least two of whom studied medicine in the Maryland area, the authors argue that "adherence to the locality rule can create uncertainty for physicians when they must choose between following local practice standards and national, evidence-based standards of care."[76] The article advocates a national standard of care to ensure the standard is clear, stating that location should only be taken into account when considering access to facilities or specialists, not the knowledge or skill expected from the physician.[77] Considerations of such factors can be accomplished under the national standard without a locality rule.[78]

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72. *See* Sorrel, *supra* note 1.

73. *See* Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 JAMA 2633, 2633 (2007) [hereinafter *Physician's Dilemma*].

74. *Id.*

75. *See supra* note 20 and accompanying text. Doctors have come under attack by disciplinary boards for allegedly misstating the standard of care. *See generally* Maureen Glabman, *Scared Silent: The Clash Between Malpractice Lawsuits & Expert Testimony*, PHYSICIAN EXECUTIVE, (July-Aug. 2003), *available at* http://findarticles.com/p/articles/mi_m0843/is_4_29/ai_105542617/?tag=content;col1 (describing how neurosurgeon Dr. Gary Lustgarten's medical license was threatened with revocation by the North Carolina Medical Board for expert testimony he provided for a plaintiff in a medical malpractice case).

76. *Physician's Dilemma*, *supra* note 73, at 2633. Note, though, that the authors are speaking generally, not just about Maryland.

77. *Id.* at 2636.

78. Maryland's national standard considers such factors. *See supra* note 31 and accompanying text.

Michael D. Frakes, a Harvard Law School graduate, has analyzed whether changes in the legal standard of care have affected physician behavior in states moving from a locality rule standard to a national standard.[79] Using cesarean section utilization as a model, the author found a significant convergence toward national trends once a national standard of care is adopted.[80] This shows that at least some facets of physician behavior are controlled by the legal standard of care,[81] and that an ultimate decision on the standard of care in Maryland might truly affect the care that patients receive from their doctors.

## III. EVOLUTION OF MARYLAND'S STANDARD OF CARE

### *A. Maryland's Common Law Before 1975*

Prior to 1975, to establish the standard of care for medical malpractice in Maryland, parties were bound by a strict locality rule.[82] In *Dunham v. Elder*, the court stated that Maryland precedent called for the application of the strict locality rule, but seemed hesitant, noting that the rule was a minority view, which most jurisdictions shied away from.[83] The Court of Appeals in *Raitt v. Johns Hopkins Hospital* addressed the *Dunham* court's concerns, and held that even under a strict locality rule, excluding any proffered witness who had not practiced in Maryland was improper because that was only one factor in the inquiry.[84]

### *B. Maryland's 1975* Shilkret *Decision*

#### 1. Abandonment of the Strict Locality Rule

In 1975, the Court of Appeals of Maryland reexamined the strict locality rule in *Shilkret v. Annapolis Emergency Hospital*

79. Michael D. Frakes, Essays on Malpractice Law and Physician Behavior, 18 (June 2009) (unpublished Ph.D. dissertation, Massachusetts Institute of Technology), *available at* http://dspace.mit.edu/bitstream/handle/1721.1/49706/436449488.pdf?sequence=1.

80. *Id.* at 57–58.

81. *See id.*

82. Dunham v. Elder, 18 Md. App. 360, 364, 306 A.2d 568, 571 (1973).

83. *Id.* at 364–65, 306 A.2d at 571. However, the court said that the plaintiff had not provided sufficient evidence as to *any* standard of care, so the issue of what the standard of care *should* be in Maryland was not before the court. *Id.* at 366, 306 A.2d at 571. The Court of Special Appeals decided *Dunham* just two years before Maryland would adopt a national standard of care. *See infra* Part II.B.3.

84. Raitt v. Johns Hopkins Hosp., 274 Md. 489, 500–01, 336 A.2d 90, 96 (1975).

*Association*.[85] The court stated that the strict locality rule was created to protect physicians in remote rural areas from being held to the same standard as physicians in urban areas who have better access to modern medical research, medical techniques, and facilities.[86] Such a rule had become less necessary with the "national accrediting system[,] which ha[d] contributed to the standardization of medical schools throughout the country," and advances in communication (essentially equal access for all physicians to resources).[87] According to the court, the rule had amounted to collusion, a "'conspiracy of silence,'" among local practitioners.[88] Because many doctors refused to provide expert testimony against doctors they knew, and because plaintiffs were required to use doctors from the same locality as the defendant physicians for their expert witnesses, plaintiffs could almost never have a successful case.[89] Also problematic were situations in which a sole practitioner, the only physician in a locality, could effectually define their own standard of care.[90]

2. Rejection of the Similar Locality Rule

The *Shilkret* court then considered the similar locality rule.[91] The court stated that this standard can answer some of the problems associated with the strict locality rule (such as collusion and sole practitioner problems),[92] but it did not "effectively alleviate the other potential problem, a low standard of care in some of the smaller communities, because the standard in similar communities is apt to be the same."[93] The court also identified the additional difficulty in defining what communities are similar.[94] While the court noted that

85. 276 Md. 187, 349 A.2d 245 (1975).
86. *Id.* at 193, 349 A.2d at 248.
87. *Id.* at 194, 349 A.2d at 249.
88. *Id.* (quoting Case Note, *Michigan Abandons "Locality Rule" with Regard to Specialists*, 40 FORDHAM L. REV. 435, 438 (1971)).
89. *Id.*

> [The] strict locality standard could create a harsh result—the possibility that a plaintiff might be left without a remedy in a locality which had only one physician, in a locality where all physicians were below the standards generally set for rural communities or where a "conspiracy of silence" in the plaintiff's locality eliminated the possibility of securing expert testimony.

Case Note, *supra* note 88, at 438 (footnote omitted).
90. *Shilkret*, 276 Md. at 193–94, 349 A.2d at 249.
91. *Id.* at 195–96, 349 A.2d at 250.
92. *See supra* notes 88–90 and accompanying text.
93. *Shilkret*, 276 Md. at 196, 349 A.2d at 250.
94. *Id.*

some states had moved to a similar community standard, the court expressly rejected its adoption for Maryland.[95]

3. Adoption of the National Standard of Care

Lastly, the court discussed the national standard of care.[96] The court stated that a national standard of care was well justified, noted the superiority of accredited medical institutions compared to medical schools of the past, and stated:

> [V]astly superior postgraduate training, the dynamic impact of modern communications and transportation, the proliferation of medical literature, frequent seminars and conferences on a variety of professional subjects, and the growing availability of modern clinical facilities are but some of the developments in the medical profession which combine to produce contemporary standards that are not only much higher than they were just a few short years ago, but also are national in scope.[97]

The court ultimately decided to abandon locality rules in favor of a national standard of care in Maryland.[98] Therefore, a physician from any locality who was familiar with the national standard of care could provide expert testimony in a Maryland medical malpractice case.[99]

*C. Maryland's 1993 Enactment of § 3-2A-02(c)*

Eighteen years later in 1993, while the *Shilkret* national standard was still the law of Maryland, the Maryland General Assembly inserted § 3-2A-02(c)[100] into the Courts and Judicial Proceedings Article of the Maryland Code (now section 3-2A-02(c)(1)) through the enactment of House Bill 1359, which read as follows:

> In any action for damages filed under this subtitle, the health care provider is not liable for the payment of damages unless it is established that the care given by the health care provider is not in accordance with the standards of practice among members of the same health care

95. *Id.* at 198–99, 349 A.2d at 251–52.
96. *Id.* at 199–200, 349 A.2d at 252–53.
97. *Id.* at 199, 349 A.2d at 252.
98. *Id.* at 199–200, 349 A.3d at 252–53.
99. *Id.* at 200, 349 A.2d at 252–53.
100. 1993 Md. Laws 529, 546.

> profession with similar training and experience *situated in the same or similar communities* at the time of the alleged act giving rise to the cause of action.[101]

The legislation could be argued as an abandonment of Maryland's national standard for a similar locality rule (like that discussed in *Shilkret*), but the statute has not been acknowledged as a change by the Court of Appeals.[102] When interpreting the statute, it is presumed that the legislature knew the law, and therefore, by using language that annunciates an entirely different standard of care, must have intended to alter the standard.[103]

> In construing a statute, [the court will] look first to the plain language of the statute, and if that language is clear and unambiguous, [the court will] look no further than the text of the statute. A plain reading of the statute assumes none of its language is superfluous or nugatory.[104]

The phrase "same or similar communities" does not appear to be ambiguous. The preceding language indicates that it is an evidentiary issue: "[T]he health care provider is not liable . . . unless it is established that the care given . . . is not in accordance with the standards of practice among members . . . situated in the same or similar communities . . . ."[105]

The next step to determine legislative intent is to look at the statute as a whole, the prior case law, and the legislative history.[106] Unfortunately, the legislative history is essentially nonexistent.[107] The only information available is that the Conference Committee

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101. *Id.* (emphasis added).

102. *See* Terry L. Trimble, Recent Development, *Delegates Deliver a Deathblow to Maryland's Health Claims Arbitration System*, 55 MD. L. REV. 893, 899 (1996).

103. *In re* Special Investigation No. 236, 295 Md. 573, 576, 458 A.2d 75, 76 (1983) ("The cardinal rule of statutory construction is to ascertain and carry out the real legislative intent. . . . The General Assembly is presumed to have had, and acted with respect to, full knowledge and information as to prior and existing law and legislation on the subject of the statute and the policy of the prior law.")

104. Bost v. State, 406 Md. 341, 349–50, 958 A.2d 356, 361 (2008) (citation omitted.

105. CTS. & JUD. PROC. § 3-2A-02(c)(1) (2011).

106. *Newell*, 407 Md. at 641, 967 A.2d at 766. Even if a statute seems clear, an inquiry does not have to stop with the plain language of a statute, and other persuasive material may be taken into account for its interpretation. Kaczorowski v. Mayor and City Council of Baltimore, 309 Md. 505, 514–15, 525 A.2d 628, 632–33 (1987).

107. *See* Loden, *supra* note 5, noting that the "provision was inserted at the last minute, without adequate testimony, and has not been discussed in the media or understood by the public."

rejected the Senate Amendments to House Bill 1359 and adopted the Conference Committee Amendments, which included § 3-2A-02(c) as Amendment No. 4.[108] The same or similar communities language is not used elsewhere in the statute. This provides no evidence of the legislature's intent other than that the language was only to apply to § 3-2A-02(c) entitled, "Establishing liability of health care provider; qualifications of persons testifying."[109] These sources provide meager guidance as to the legislature's intent, and the case law following the statute's enactment is no more helpful for interpretation.[110]

### *D. Maryland's Standard of Care Jurisprudence 1993–2011*

Since the same or similar communities language was inserted into the Maryland Code in 1993, the Court of Appeals has cited both *Shilkret* and § 3-2A-02(c) as authority for the standard of care in Maryland, but has never addressed whether the statute modifies the standard announced in *Shilkret*.[111] The Court of Appeals of Maryland, the Court of Special Appeals of Maryland, and the U.S. Court of Appeals for the Fourth Circuit all have cited § 3-2A-02(c)(1) and used the statutory language, "same or similar communities," when describing the standard of care in Maryland.[112] However, since the court's adoption of the national standard of care in 1975, *Shilkret* has been cited in almost every medical malpractice decision reported in Maryland, and has never been overruled by the Court of Appeals.[113]

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108. *See* 1993 Md. Laws 529, 546. Included among the legislative history, available on microfilm at the Maryland State Law Library, is an article by Dan J. Loden, originally from the "Law Watch" section of THE MARYLAND LAWYER dated Saturday, September 18, 1993, concerning the same or similar communities provision. *See* Loden, *supra* note 5. Also included is a photocopy of North Carolina's same or similar communities standard codified in North Carolina's General Statutes § 90-21.12. *See supra* note 42 and accompanying text.

109. CTS. & JUD. PROC. § 3-2A-02(c) (2011).

110. The effect of the "same or similar communities" language was not addressed until *Daee v. Lucas*, discussed *infra* Part III.E.

111. Daee v. Lucas, No. 2485, slip op. at 14 (Md. Ct. Spec. App. Feb. 15, 2011).

112. Brooks v. Md. Gen. Hosp, Inc., 996 F.2d 708, 713 (4th Cir. 1978); Dingle v. Belin, 358 Md. 354, 368, 749 A.2d 157, 164 (2000); Waldt v. Univ. of Md. Med. Sys. Corp., 181 Md. App. 217, 243, 956 A.2d 223, 238 (Md. Ct. Spec. App. 2008).

113. *See* Trimble, *supra* note 102, at 899 & n.50.

There are approximately 600 medical malpractice claims filed every year in Maryland,[114] but not one appellate decision has even suggested that the *Shilkret* standard had been abandoned.[115] In *Dingle v. Belin*,[116] the Court of Appeals cited the *Shilkret* standard directly before using the statutory language of § 3-2A-02(c)(1), and did not indicate that the statutory language meant anything different than the *Shilkret* standard.[117] The case law is therefore unhelpful for interpreting the statute.

### *E. Maryland's 2011* Daee *Decision*

Although the courts have cited both *Shilkret* and § 3-2A-02(c) as authority for the standard, there are no reported cases in which an expert's qualifications have been challenged based on the statutory same or similar communities language.[118] A Maryland appellate court has only recently addressed the issue.

#### 1. The Trial

In *Daee v. Lucas*, a wrongful death action arising out of the treatment of a gunshot injury, plaintiffs offered two expert witnesses at trial.[119] Plaintiffs established their first expert's education, training, and experience as a surgeon through voir dire.[120] Defense counsel, after conducting their own voir dire, objected to the witness "being

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114. *See* FRANK CLEMENTE & NEAL PATTISON, PUB. CITIZEN'S CONG. WATCH, THE FACTS ABOUT MEDICAL MALPRACTICE IN MARYLAND 11 fig. 2 (2004), *available at* http://www.citizen. org/documents/Maryland_MedMal_Report_2004.pdf.

115. *See* Trimble, *supra* note 102, at 899 & n.50.

116. 358 Md. 354, 749 A.2d 154.

117. *Id.* at 368. This section of *Dingle* reads:

> The negligence consists of the breach of the duty that a physician has "to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which [the physician] belongs, acting in the same or similar circumstances." Shilkret v. Annapolis Emergency Hosp., 276 Md. 187, 200, 349 A.2d 245, 252 (1975). To recover in such an action, the plaintiff must show that the doctor's conduct–the care given or withheld by the doctor–was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the act (or omission) giving rise to the cause of action. *See* Maryland Code, § 3-2A-02(c) of the Courts and Judicial Proceedings Article.

*Id.* (alteration in original).

118. Daee v. Lucas, No. 2485, slip op. at 14 (Md. Ct. Spec. App. Feb. 15, 2011).

119. *Id.* at 5.

120. *Id.* at 6.

qualified as an expert on pancreatic surgeries and as a trauma surgeon."[121]

The court overruled the objection, "noting that Dr. Daee's objection went to the weight to be afforded [to the expert's] testimony, not his qualifications."[122] The expert witness then testified to various breaches in the standard of care, without which, he claimed, the doctor's patient would still be alive.[123] He based his opinions on what he said was "the known standard" that he knew from his training.[124] The parties stipulated to the qualifications of the second expert witness.[125]

The defendant moved for judgment at the close of the plaintiffs' case, arguing that the plaintiffs had not proven the standard of care in the same or similar communities as the defendant physician.[126] This motion was denied, renewed at the close of all the evidence, and denied again.[127] The jury was instructed about the standard of care, without objection by the defendant, according to Maryland Civil Pattern Jury Instruction 27:1 as follows: "A health care provider is negligent if the health care provider does not use that degree of care and skill which a reasonably competent health care provider, engaged in a similar practice and acting in similar circumstances, would use."[128] The jury returned a verdict for the plaintiffs.[129]

2. The Appeal

The Court of Special Appeals discussed the conflict between the *Shilkret* standard and the statutory same or similar communities language, and noted that "there are no reported cases . . . challenging an expert's qualifications to testify based on [the same or similar communities] standard or explaining the manner of establishing that this standard has been met."[130] The court held that the statutory same or similar communities requirement is a foundational requirement

121. *Id.* at 6–7.
122. *Id.* at 7.
123. *Id.*
124. *Id.* at 8.
125. *Id.*
126. *Id.* at 9.
127. *Id.* at 9–10.
128. *Id.* at 10 (citing MD. CIVIL PJI 27:1 (Md. State Bar Ass'n, Inc. 2009)).
129. *Id.* at 4.
130. *Id.* at 14.

"satisfied through the *voir dire* qualification of the expert witnesses who are called to testify about the standard of care."[131]

One reason the court provided for characterizing the statutory language as a foundational requirement is the caption of § 3-2A-02(c), which reads, "[e]stablishing liability of health care provider; qualifications of persons testifying."[132] The court also noted that defense counsel had treated the issue as foundational by establishing his own experts' familiarity with the standard of care in the same or similar community as the defendant physician through voir dire questioning.[133]

The court found that the voir dire testimony in this case provided sufficient evidence to qualify the plaintiffs' two expert witnesses.[134] The court then held that, because the defendant did not challenge the experts on the basis that their "training, experience, and knowledge . . . did not pertain" to the same or similar community as the defendant physician, that issue was waived for appellate review.[135] The court also held that there is no obligation that an admitted expert "opine specifically that [the defendant] deviated from the standard of care practiced 'in the same or similar communities' as [that of the defendant]."[136]

## IV. WHAT SHOULD MARYLAND DO?

The Court of Special Appeals in *Daee* decided that § 3-2A-02(c) applies to an expert witness's qualifications when proffered to the court, but does not apply to the sufficiency of the expert's testimony once admitted.[137] The court proposed a framework that could give some effect to the same or similar communities language, but gave little rationale for doing so.[138] The court also provided no guidance as to how an expert's familiarity with the defendant's community will be analyzed when the expert's qualifications are challenged. The

131. *Id.* at 15.
132. *Id.* at 16.
133. *Id.* at 17 n.12.
134. *Id.* at 16.
135. *Id.* at 16–17.
136. *Id.* at 17. Appellees, in harmony with the Amicus Curiae, argued that such a requirement elevates form over substance. Brief of Appellee at 22–23, Daee v. Lucas, No. 2485 (Md. Ct. Spec. App. Feb. 15, 2011); Brief of Maryland Ass'n for Justice as Amicus Curiae in Support of Appellees at 8–9, Daee v. Lucas, No. 2485 (Md. Ct. Spec. App. Feb. 15, 2011).
137. *Daee*, No. 2458, slip op. at 15, 17–18.
138. *See supra* text accompanying notes 132–33.

Court of Appeals could easily decide not to follow the decision strictly.

### *A. Possible Decisions*

#### 1. Avoid the Statute

There is essentially no legislative history behind the insertion of section 3-2A-02(c) through the enactment of House Bill 1359.[139] The Court of Appeals could avoid the same or similar communities language by finding no clear legislative intent that § 3-2A-02(c) should supersede *Shilkret*'s national standard of care. This is an unlikely scenario, as the court will usually give deference to the legislature's choice to include the particular language.[140]

Alternatively, the court could find that while the statute adopts the same or similar communities legal standard in Maryland, Maryland's statewide medical standard of care is still the national standard. This is a reasonable path as it recognizes the reality of modern day medical care—that physicians, most of whom are Board Certified,[141] and hospitals, most of which are nationally accredited,[142] are practicing medicine according to a national standard of care. Even if there is a same or similar communities requirement for expert testimony, any expert familiar with the national standard may testify because the physicians in every community in Maryland have applied the national standard of care since the *Shilkret* decision. Essentially, because *Shilkret* imposed a national standard of care in every medical

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139. *See supra* notes 107–08 and accompanying text.

140. *See supra* note 103 and accompanying text.

141. *See States' Doctors Compared By HealthGrades*, HEALTHGRADES (Nov. 17, 2005), http://www.healthgrades.com/media/dms/pdf/PhysicianComparisonPressRelease111705.pdf. Maryland ranked 15 out of the 50 states and D.C. for percentage of doctors board certified in their specialty (90.02%). *Id.* at 2 tbl.1.

142. *See Maryland Hospital Performance Evaluation Guide: Overview of Maryland Regulatory System for Hospital Oversight*, MD. HEALTH CARE COMM'N, http://mhcc.maryland.gov/consumerinfo/hospitalguide/patients/other_information/overview_of_maryland_regulatory_system_for_hospital_oversight.html (last updated Oct. 7, 2010).

> The Joint Commission (TJC) approves all acute-care hospitals. TJC is an independent, not-for-profit group that evaluates and accredits health care organizations and programs in the United States. . . .
>
> Once a hospital has received TJC accreditation . . . Maryland renews the hospital's license. Maryland does not require the OHCQ to review a hospital that the TJC has accredited . . . .

*Id.*

community across Maryland, the communities cannot now be differentiated—there is no going back.

2. Apply the Statute

The court could find that the General Assembly intended to adopt a same or similar communities standard. It is entirely possible that the statute only overrules the limited portion of *Shilkret* that held that the standard of care is national rather than based on locality.[143] It could keep intact the holding "that a physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."[144] This explains how the Court of Appeals could cite both the *Shilkret* standard and the statutory language without identifying a conflict: the *Shilkret* holding can be applied under a same or similar communities standard.[145] The rationale for such a decision could mimic that of the Court of Special Appeals in *Daee*,[146] or it would be appropriate for the court to examine scholarly writing from both the legal and medical fields to see what those professionals believe the legislature intended.[147]

An example of such persuasive evidence is provided in comment A.1. under Maryland Civil Pattern Jury Instruction 27:1[148] titled, "Health Care Providers – Standard of Care."[149] Section 3-2A-02(c) is cited and described as "establishing [the] locality rule, overruling *Shilkret* in part."[150] This shows that the lawyers and judges that help to guide the way Maryland law is practiced, as well as explained by

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143. *Shilkret*, 276 Md. 187, 200, 349 A.2d 245, 253 (1975).

144. *Id.*

145. *See* Dingle v. Belin, 358 Md. 354, 368, 749 A.2d 157, 164 (2000).

146. *See supra* Part III.E.2.

147. *See* Kaczorowski v. Mayor and City Council of Baltimore, 309 Md. 505, 514–15, 525 A.2d 628, 632–33 (1987).

> When [the Court] pursue[s] the context of statutory language, [it is] not limited to the words of the statute as they are printed in the Annotated Code. [It] may and often must consider other "external manifestations" or "persuasive evidence," including . . . other material that fairly bears on the fundamental issue of legislative purpose or goal, which becomes the context within which [it] read[s] the particular language before [it] in a given case.

*Id.*

148. Interestingly, this instruction was read to the jury in *Daee*, but the court did not note the discussion in comment A.1. *See supra* note 128 and accompanying text.

149. MD. CIVIL PJI 27:1 (Md. State Bar Ass'n, Inc. 2009).

150. *Id.* at cmt. A-1.

judges to the jury, understand the statute as an adoption of a same or similar communities standard.

In the *Physician's Dilemma* article, Maryland was noted as having a same or similar communities standard, distinct from those states with a national standard.[151] This indicates that there are at least some in the medical field who understand the standard of care in Maryland to follow a same or similar communities rule. It may be useful information for the courts to know what the majority of health care providers in Maryland understand the standard of care to be.[152]

While these may not be the traditional sources utilized by the courts to interpret statutory language, at the very least they provide an interesting reflection. Even if only a minority of those examining the standard of care understand it to have been changed by § 3-2A-02(c), this still shows that there is a question that must be answered.

### B. *The Court of Appeals Should Address All Standard of Care Issues up Front in Order to Avoid the Problems Exemplified by North Carolina*

If the court decides that Maryland has adopted a same or similar communities standard, the Maryland courts will face the additional issues foreseen by the *Shilkret* court when it considered the similar locality rule in 1975.[153] The first issue will be how to define what makes medical communities similar. The second issue will be how to determine the degree of community familiarity required for an expert witness to qualify. The Maryland courts will need to address these questions sufficiently in order to avoid a chaotic and unfair situation for plaintiffs who would now have to acquire expert witnesses that "both conform to the 'same or similar' community standard but still have sufficient expertise to qualify as experts."[154]

Medical malpractice jurisprudence in Maryland courts must avoid going the way of the North Carolina courts. The Supreme Court of North Carolina has stated that its system evidences a desire to "preserve flexibility in . . . proceedings" concerning an expert witness's familiarity with the same or similar communities in which the defendant practices.[155] The proverbial three-dollar value of "flexibility" will give little comfort to plaintiffs who miss out on the

151. *Physician's Dilemma*, *supra* note 73.

152. This could provide rationale for the decision that the standard in every Maryland community is national. *See supra* Part IV.A.1.

153. *See supra* Part III.B.2.

154. Loden, *supra* note 5.

155. Crocker v. Roethling, 675 S.E.2d 625, 631 (N.C. 2009).

compensation they deserve simply because they were given unclear guidance on how to meet the familiarity requirement.

Maryland's same or similar communities statute is unique from North Carolina's adoption of that standard in a number of ways. First, Maryland would be moving, legally, from a national standard,[156] while North Carolina moved directly from a strict locality rule.[157] Second, the medical communities of Maryland have been operating under the national standard prior to any change,[158] whereas North Carolina's medical communities never operated under a strictly national standard.[159] Third, the North Carolina General Assembly stated its intent in adopting a same or similar communities standard, which was to avoid a national standard.[160] The Maryland General Assembly did not state its intention behind the language of § 3-2A-02(c), and the statute lacks crucial legislative history.[161] Last, North Carolina's transition began at common law, so when the North Carolina General Assembly codified the rule by statute, case law already existed to guide the courts.[162] Maryland's case law provides no guidance outside the national standard of care established in *Shilkret*.[163]

The Court of Appeals of Maryland has much more room to interpret § 3-2A-02(c) than did the North Carolina Court with its same or similar communities statute. This could be a good thing if the court keeps the pitfalls North Carolina faced in mind, but it could mean a potentially bigger mess if they do not. Leaving the familiarity requirements undecided would allow the Court of Appeals to wait and see how the standards develop in the trial courts, but this can be a problem where, as in North Carolina, the standard develops into one that is unclear and arbitrary.[164]

For the sake of preserving clarity, the Court of Appeals of Maryland should acknowledge that the medical standard of care across Maryland is a national standard by continuing to allow all physicians familiar with the national standard of care to qualify as experts. However, if the court chooses to differentiate medical communities in Maryland, it should do so only prospectively and

156. *See supra* Part III.B.
157. *See supra* notes 41–42 and accompanying text.
158. *See supra* Parts III.B, III.D.
159. *See supra* Part II.C.2.
160. *See supra* note 43 and accompanying text.
161. *See supra* notes 107–08 and accompanying text.
162. *See supra* notes 41–42 and accompanying text.
163. *See supra* Part III.D.
164. *See supra* Part II.C.2.a.

provide clear guidelines for establishing an expert's requisite familiarity with a community and what makes two communities sufficiently similar.

## V. CONCLUSION

Under the national standard of care, which was adopted by Maryland's highest court in 1975, the expert testimony requirements are clear. To plunge into unclear waters at the direction of insurance company lobbyists[165] is unwise and counterproductive. If the Maryland courts decide to require expert witnesses in medical malpractice cases be familiar with the same or similar communities in which the defendant health care provider practices, they must do so prospectively and establish a clear standard for proving sufficient familiarity. When compensation for the potentially catastrophic injuries involved in medical malpractice cases is on the line, the courts must avoid presenting a deficient, vague standard for the sake of appearing flexible.

The courts must also consider the effect that the standard of care will have on Maryland's physicians in their professional decision-making. Fairness and prudence are both important policy considerations that require Maryland's courts to be crystal clear as the standard of care requirements are determined. It is critical that doctors know which standard of care is legally required, not only for the sake of fair legal liability, but also for the sake of the patients who receive their care. The most prudent decisions should be encouraged over substandard community trends.

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165. *See* Loden, *supra* note 5.

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