Circuit Court for Wicomico County
Case No. 22-C-16-000101

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 956

September Term, 2017

BRENDA HALL, *et al.*

v.

CARMEN MASSEY, *et al.*

Wright,
Reed,
Eyler, Deborah S.,
(Senior Judge, Specially Assigned)

JJ.

Opinion by Wright, J.

Filed: December 7, 2018

This appeal arises out of a medical malpractice action against Carmen Massey, D.O. ("Dr. Massey"), Brian Delligatti, M.D. ("Dr. Delligati"), and Emergency Service Associations, P.A., collectively appellees.[1] Judgment was entered after a jury rendered a verdict, at the conclusion of a week-long trial, that appellees did not breach the standard of care in their treatment of Brenda Hall ("Hall"), appellant.[2] Appellees now challenge the Wicomico County Circuit Court's decision to admit the trial testimony of Douglas Wilhite, M.D. ("Dr. Wilhite").[3]

Appellants present the following questions for our review, which we have renumbered and consolidated for clarity:[4]

[1] Emergency Service Associations, P.A., is the medical practice that provides doctors, physician assistants, and nurse practitioners to the hospital and emergency room at Peninsula Regional Medical Center (PRMC).

[2] Hall's husband, Wayne Hall, joins her as an appellant in this case.

[3] Dr. Wilhite is the Medical Director of PRMC's Vascular Diagnostics Laboratory and the Co-Medical Director of PRMC's Vascular Institute.

[4] Appellants presented their questions to the Court as follows:

> I. Did the Trial Court Err by Allowing Dr. Wilhite, a Fact Witness, to Render Testimony Beyond What He Observed and Did in the Treatment of Mrs. Hall?
>
> II. Did the Trial Court Err by Allowing Dr. Wilhite to Render Speculative Testimony?
>
> III. Did the Trial Court Inappropriately Heighten Appellants' Burden of Proof by Forcing Appellants to also Prove that the Hypothetical

1. Did the circuit court err in admitting Dr. Wilhite's testimony?

2. Did the circuit court's admission of Dr. Wilhite's testimony erroneously raise the appellant's burden of proof?

For the reasons to follow, we answer both questions in the negative and affirm the circuit court's judgment.

BACKGROUND

A. *Appellant's Medical Care*

On January 9, 2015, at approximately 3:00 a.m., Hall woke up with swelling and pain in her left leg. About a month earlier, she had undergone the surgical removal of her right lung. Hall called an ambulance and arrived at Peninsula Regional Medical Center's ("PRMC")[5] Emergency Department at 4:30 a.m. Hall's vital signs showed that both her pulse and respiratory rates were high.

Just before 5:00 a.m., Hall was seen by Dr. Massey, who determined that Hall had swelling to both legs, with greater swelling on the left than the right, as well as leg pain and diminished pulses. Believing that Hall was suffering from deep vein thrombosis ("DVT"),[6] Dr. Massey ordered a venous duplex ultrasound of Hall's leg veins. The

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Treatment of a Subsequent Physician Breached the Standard of Care?

[5] PRMC is located in Salisbury, Maryland.

[6] "Deep vein thrombosis ("DVT") refers to the formation of one or more blood clots (a blood clot is also known as a 'thrombus,' while multiple clots are called 'thrombi') in one of the body's largen veins, most commonly in the lower limbs (e.g., lower leg or calf). The clot(s) can cause partial or complete blocking in circulation to the vein, which in some patients leads to pain, swelling, tenderness, discoloration, or redness of the affected area, and skin that is warm to the touch." The U.S. Department of Health

ultrasound confirmed the presence of extensive clots in both legs and showed that Hall still had pulses in both legs. The situation was not yet thought to be emergent.

Dr. Massey then performed a digital rectal exam on Hall and discovered that Hall had visible bright red blood from her rectum. This result suggested that Hall had an active bleed in her gastrointestinal ("GI") tract.[7] Dr. Massey also ordered that blood studies be run on Hall. Results from those studies indicated that Hall was anemic, having lost about a third of her blood volume in the period of time since her lung removal surgery. Though anticoagulants, or "blood thinners," are usually given to a patient suffering from DVT, Dr. Massey decided, based on Hall's anemic state, to forego anticoagulants in an effort to avoid causing a fatal hemorrhage.

Dr. Massey contacted Usman Zulfiqar, M.D., PRMC's on-duty hospitalist physician, to admit Hall to PRMC. Dr. Massey told Dr. Zulfiqar that she believed Hall had an arterial occlusion or blockage, and after re-examining Hall, Dr. Massey confirmed that Hall lost pulses in her legs between 6:30 a.m. and 6:50 a.m. At this time, the situation became emergent. At 7:36 a.m., Dr. Massey completed a CT Angiogram on

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and Human Services, *The Surgeon General's Call to Action to Prevent Deep Vein Thrombosis and Pulmonary Embolism*, 7 (2008).

[7] The GI tract is part of the human digestive system, and "is a series of hollow organs joined in a long, twisting tube from the mouth to the anus. The hollow organs that make up the GI tract are the mouth, esophagus, stomach, small intestine, large intestine, and anus." *Your Digestive System & How it Works*, National Institute of Heath: National Institute of Diabetes and Digestive and Kidney Diseases, https://www.niddk.nih.gov/health-information/digestive-diseases/digestive-system-how-it-works. Last visited November 18, 2018.

Hall, which confirmed the extensive blockage in Hall's left leg. Dr. Massey then attempted to consult a vascular surgeon at PRMC, but learned that one was not on call at the time.

After learning that Hall had an arterial occlusion, Dr. Zulfiqar contacted Kurt Wehberg, M.D., the cardiothoracic surgeon who removed Hall's lung, to discuss Hall's treatment. Thereafter, Dr. Massey, Dr. Zulfiqar, and Dr. Wehberg concluded that Hall's situation was too complex to handle at PRMC and that Hall should be transferred to another hospital. Dr. Massey then contacted a vascular surgeon at University of Maryland Medical Center ("UMMC") which accepted Hall.

Initially, efforts were made to transfer Hall to UMMC, located in Baltimore, Maryland, by way of helicopter. However, personnel at PRMC soon learned that neither of their two regular helicopter transport services could fly that morning due to high winds and icing. Dr. Massey arranged ambulance transportation for Hall, and ordered that Hall be given a blood transfusion because of the anemia found in her lab studies.

At approximately 7:45 a.m., Dr. Massey signed out Hall's care to Dr. Delligatti. At 8:00 a.m., Dr. Wilhite assumed vascular surgery call responsibility at PRMC. However, according to Dr. Delligatti, "[g]iven the transport plan [was] already in place, the complexity of the situation, and the expectation that the ambulance would be arriving imminently," he did not contact Dr. Wilhite when Dr. Wilhite came on call. Dr. Wilhite reviewed the venous duplex scan at approximately 9:05 a.m., but was not asked to examine Hall and had no involvement in her treatment. Dr. Delligatti was responsible for Hall's care until she left PRMC at 9:30 a.m.

Hall arrived at UMMC at 11:44 a.m. and was taken into surgery about five hours later. Physicians at UMMC determined that they would not be able to salvage Hall's left leg and ultimately amputated the leg.

B. *Appellant's Medical Malpractice Claim*

Appellants filed their complaint against the appellees in the Circuit Court for Wicomico County on January 1, 2016.[8] At trial, regarding the failure to comply with the standard of care, appellants presented expert testimony that Dr. Massey and Dr. Delligatti made "insufficient efforts to acquire vascular bedside assessment and treatment during the hours that Mrs. Hall sat in the PRMC emergency department." Further, appellants' experts opined that a reasonably competent vascular surgeon would have administered anticoagulants to stop the DVT from worsening, and would have performed procedures to reduce the blood clots.[9] On the issue of causation, appellants' experts stated that

[8] Appellees brought two counts in their original complaint: negligence and loss of consortium. The negligence claim is at the center of the instant appeal. The Court of Appeals previously explained the burden that plaintiffs must meet in order to succeed in a medical negligence claim as follows: "in medical malpractice actions[,] . . . plaintiffs bear the burden of proof of demonstrating that the healthcare provider breached the requisite standard of care or skill and that such breach was a direct cause of the injury." *Rodriguez v. Clarke*, 400 Md. 39, 71 (2007) (citations omitted).

[9] Specifically, appellants contend that a vascular surgeon could have performed two procedures that would have helped her condition. First, she contends that a vascular surgeon could have performed a fasciotomy. A fasciotomy is an "[incision] that [is] made to open the fascia - which is the connective tissue component that surrounds the bundles of muscle, nerve, and blood vessel through the leg - to relieve pressure buildup. Second, she asserts that a vascular surgeon could have performed a percutaneous venous thrombectomy, if necessary. A percutaneous venous thrombectomy is "a minimally invasive surgery where the vein is assessed in the leg and efforts are made to remove or break up the blood clot, or DVT."

appellees' failure to perform such procedures led to Hall losing her leg. According to appellants' experts, if these procedures took place at PRMC, Hall's leg could have been salvaged.

In defense, appellees called two experts, Jeffery Smith, M.D., an emergency medicine physician, and Peter Mackerell, M.D., a vascular surgeon. Appellees' experts testified that "given Ms. Hall's complex situation, with the clots and the presumptively active GI bleed, the Appellees complied with the standard of care by not utilizing anticoagulants." Dr. Smith testified that "the Appellees complied with the standard of care in not calling a vascular surgeon at [PRMC], but instead transferring Ms. Hall to . . . [UMMC] for tertiary level treatment." Additionally, Dr. Mackerell testified as to the "treating conundrum" created by Hall's situation.[10]

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[10] When asked how a "reasonably competent vascular surgeon" should have addressed Hall's situation, Dr. Mackerell stated:

> So the problem . . . is that, at the moment she comes in, you don't know whether she's having active bleeding and so . . . you have to deal with two, probably three, vascular problems in her. Number one is extensive DVT. So you've got to fix that, and that's going to be very hard to fix because . . . the whole leg is clot. Then you have to fix the fact that she has an occluded aorta, and so ultimately they had to do a laser of the clot, put a stent graft in, so that's not an easy thing to do, particularly in an emergent situation. Then you take the fact that she has . . . tibial disease in the right side, that's bad enough so she has all her tibials [sic] occluded. All clinical evidence at the time she arrives that she has tibial disease and the fact that she has coronary disease and had her lung out recently and has a big effusion.
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> So her thing is her tibial is occluded, so she has tibial artery blockages, no flow and tibial DVT, . . . that's really complicated because you can't fix that. Fixing all this clot generally requires

C. *Dr. Wilhite's Role in the Trial*

Appellees also called Dr. Wilhite as a witness at trial. At oral argument, counsel for appellees confirmed that Dr. Wilhite was called to testify on the issue of causation. Specifically, appellees intended to elicit testimony from Dr. Wilhite to establish that Hall could not receive the treatment required to salvage her leg at PRMC, and that he too would have sent Hall to UMMC.

Prior to trial, on December 14, 2016, appellants' counsel sent a letter to Dr. Wilhite's attorney asking to meet with Dr. Wilhite. Appellants' counsel wanted to ask Dr. Wilhite two questions: (1) whether he would have come to see Hall if he had been contacted about her situation on the morning of January 9, 2015; and (2) whether, based on his evaluation of Hall's records, he would "not have found this patient so complicated that she would have to be [sent to UMMC for treatment]."

> heparin, and a lot of it . . . . Well, mass amounts of heparin can lead to mass amount of bleeding, so that's a problem . . . . So if you go the whole thing, you're basically committing her to what may be ten, twelve hours of operating, and she just had a lung out and has coronary arterial disease and she has a GI bleed.
>
> [. . .]
>
> In this case, I wouldn't have done it. I think the things she had would have had a high likelihood of her not leaving the hospital alive.

Dr. Wilhite was deposed by appellants' counsel on May 22, 2017.[11] At the deposition, Dr. Wilhite confirmed that he was not contacted or consulted by anyone in relation to Hall's care. Additionally, he stated that due to his lack of involvement in Hall's care, any opinions that he could give about the treatment that Hall did receive, or could have received, were "speculative."

After the deposition, appellants filed a motion *in limine* "seeking to preclude Dr. Wilhite from testifying to matters beyond his limited treating role of reviewing the one venous duplex scan." Further, they sought to "preclude Dr. Wilhite from offering any testimony about what he would have done and/or whether Mrs. Hall's leg was salvageable[.]" The circuit court denied appellants' motion. Appellants then filed a motion for reconsideration, which was also denied.

At trial, in an effort to explain that sending Hall to UMMC would be the inevitable result, appellees called Dr. Wilhite as a witness and he gave the following testimony:

> APPELLEES' COUNSEL: So coming back to the questions you were asked to address by [appellants' counsel], one is, I think, if you were available and had been called, would you have come? I think that was the question.
>
> A: If I'm available and called, if I'm on call and the ER asks me to come, I'll come in a minute. If I'm not on call, if I'm available to and they tell me that they need me, I'll do my best to try to come.
>
> I think the question in this case was . . . would I come for this patient. And with the description that I was given . . . the most common type of treatment for this type of clotting problem . . . is

[11] Dr. Wilhite's first deposition occurred on April 5, 2017. Though he was questioned by counsel for appellees, Dr. Wilhite ended the deposition prior to questioning by appellants' counsel because his attorney was not in attendance.

thrombolysis, where I pump tPA[12] . . . through the clot to try to break it up and restore blood flow. With the patient's recent major surgery, that alone is a contraindication to doing that procedure. Meaning she could bleed . . . from the surgical site, which could cause her to die. Her cancer indication is also a contraindication to the thrombolysis. And then the report of active GI bleeding is a third absolute contraindication to thrombolysis. She had three reasons that I couldn't do the thing that I would do for this problem. So if I had spoken on the phone about this case with an ER physician, I would have said . . . that [this] person . . . needs to get to [UMMC] because I don't have something to offer.

APPELLANTS' COUNSEL: Objection. Move to strike[,] [y]our Honor.

THE COURT: Overruled.

[. . .]

APPELLEES' COUNSEL: Was the second question that [appellants' counsel] had asked you to address . . . , was it whether Ms. Hall was the type of patient who could benefit from limb salvage surgery at PRMC?

A: Yes, that was the question he asked me.

APPELLEES' COUNSEL: And your answer was?

A: No.

APPELLANTS' COUNSEL: Objection[,] [y]our Honor.

THE COURT: Overruled.

APPELLEES' COUNSEL: Your answer was what?

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[12] Tissue plasminogen activator: (tPA) An enzyme that helps dissolve clots. tPA is made by the cells lining blood vessels and has also been made in the laboratory. It is systemic thrombolytic (clot-busting) agent and is used in the treatment of heart attack and stroke. Activase (alteplase) is a tissue plasminogen activator produced by recombinant DNA technology. Recombinant tPA is abbreviated r-tPA. www.medicenet.com/script/main/art.asp? Articlehey=40687. Last visited November 13, 2018.

A: Was no.

APPELLEES' COUNSEL: And why is that?

A: For the reasons I just expressed to you, . . . the procedure I felt I would have had to offer her I did not feel I could offer her . . . . There was no surgery I would offer her that would help.

On June 23, 2017, the jury returned a verdict, that the appellees had not breached the standard of care.

Additional facts will be included as they become relevant to our discussion below.

STANDARD OF REVIEW

The Court of Appeals has explained the standard for reviewing a circuit court's admission of evidence as follows:

> [O]rdinarily a trial court's ruling[s] on the admissibility of evidence are reviewed for abuse of discretion. A court's decision is an abuse of discretion when it is well removed from any center mark imagined by the reviewing court and beyond the fringe of what the court deems minimally acceptable. Further, even with respect to a discretionary matter, a trial court must exercise its discretion in accordance with correct legal standards. As such, we examine a trial court's admissibility determinations for an abuse of discretion.

Wheeler v. State, 459 Md. 555, 560 (2018) (internal citations and quotations omitted). Under the abuse of discretion standard, "a reviewing court should be reluctant to substitute its judgment for that of the trial court." *Cobrand v. Adventist Healthcare, Inc.*, 149 Md. App. 431, 437 (2003) (citation omitted).

Additionally, our review of the circuit court's admission of testimony is guided by Md. Rule 5-103(a), which states that "[e]rror may not be predicated upon a ruling that admits or excludes evidence unless the party is prejudiced by the ruling[.]" Stated

differently, "[t]o justify reversal, an error below must have been '. . . both manifestly wrong and substantially injurious.'" *Crane v. Dunn*, 382 Md. 83, 92 (2004) (citations omitted). This Court has previously explained how it determines whether a circuit court committed a prejudicial error:

> Whether an error was prejudicial is determined on a case-by-case basis. In determining whether improperly admitted evidence prejudicially affected the outcome of a civil case, the appellate court balances the probability of prejudice from the face of the extraneous matter in relation to the circumstances of the particular case. It is not the possibility, *but the probability*, of prejudice which is the object of the appellate inquiry.

Lewin Realty III, Inc. v. Brooks, 138 Md. App. 244, 273-74 (2001), *judgment aff'd* 378 Md. 70 (2003) (internal quotations omitted).

DISCUSSION

A. *Dr. Wilhite's Testimony*

As stated above, in order to prove that the circuit court committed reversible error in admitting Dr. Wilhite's testimony, appellants must prove: (1) that the circuit court erred in admitting Dr. Wilhite's testimony; and (2) that the admission was prejudicial. As explained below, though we assume *arguendo* that the circuit court erred in admitting Dr. Wilhite's testimony, we conclude that the admission was not prejudicial, and therefore no reversible error was committed.

i. Admission of Dr. Wilhite's Testimony

Appellants aver that "the trial court erred by allowing Dr. Wilhite to testify to matters beyond his personal knowledge about what he did and observed[,]" and "by permitting Dr. Wilhite to testify to matters which Dr. Wilhite, himself, conceded were

speculative in nature." In response, appellees contend that given the relevance of Dr. Wilhite's testimony, as well as the circuit court's broad discretion to determine which evidence will be admitted at trial, the testimony was properly admitted.

As a preliminary matter, we recognize that Dr. Wilhite was called as a fact witness, not as an expert witness. Appellees did not identify Dr. Wilhite as an expert witness in their Expert Designation, nor did they do so in their Pre-Trial Statement. Instead, he was specifically identified as a "Non-Expert Witness." Further, Dr. Wilhite was never qualified nor accepted by the circuit court as an expert in this case. *See* Md. Rule 5-702. As such, we conclude that Dr. Wilhite was testifying only as a fact witness and will address his testimony accordingly.[13]

[13] Appellants contend that "[t]he trial court . . . erred by allowing Dr. Wilhite to give speculative opinion testimony." To support this contention, appellants cite to Md. Rule 5-702, which establishes the requirements for admitting expert testimony, as well as several cases that focus on expert testimony. In doing so, appellants seem to argue that Dr. Wilhite offered impermissibly speculative expert opinions. However, since we have concluded that Dr. Wilhite was testifying as a fact witness and not as an expert witness, we will not address this contention.

In the brief of the appellees, they contend that given Dr. Wilhite's credentials, background, and experiences, "[a]ppellants [cannot] argue that Dr. Wilhite was unqualified to give expert opinion." Therefore, appellees argue, "Dr. Wilhite had a sufficient factual basis to render [expert] opinions." This argument is unavailing. Md. Rule 5-702 states that before expert testimony can be admitted, a circuit court must find: (1) that the witness is qualified as an expert; (2) that the expert testimony is appropriate given the subject matter; (3) that a "sufficient factual basis exists to support the expert testimony." Since the circuit court made none of these findings, the argument that Dr. Wilhite was an expert witness, and that he should have been permitted to give expert testimony is unavailing.

To support their argument that the circuit court erred in admitting Dr. Wilhite's testimony, appellants rely on the Court of Appeals' holding in *Little v. Schneider*, 434 Md. 150 (2013). In that case, the Court explained the scope of a fact witness's testimony. The case arose when Little filed suit against Schneider for injuries she sustained during an attempted bypass surgery, wherein she alleged that Schneider used the wrong size graft to complete the surgery. *Little*, 434 Md. at 154. During trial, Schneider attempted to testify about a chest CAT scan that he alleged "could be used to determine the actual size of Little's abdominal aorta." *Id*. at 167. Though he could not produce any evidence to suggest that he actually relied on the scan during his treatment, Schneider argued that his testimony should be permitted because, as a fact witness, he should be able to testify as to the "objective, factual image" on the CAT scan. *Id*. at 169. In holding that Schneider's testimony was not admissible, the Court explained:

> It is well established that fact witnesses must have personal knowledge of the matters to which they testify. *See Walker v. State*, 373 Md. 360, 388 n.8 (2003) ("[T]he threshold standards for calling any fact witness are merely that the witness have personal knowledge of the matter attested to and that the matter be relevant to the case at hand."). As we explained in *Dorsey* - a medical malpractice action - when a defendant physician testifies as a fact witness, the physician's testimony must be "limited to a *recitation of what he observed and what he did* on the occasion [of the patient's] visit." [*Dorsey*,] 362 Md. 241, 251 (2001).

Little, 434 Md. at 169 (emphasis added).[14]

[14] In *Dorsey v. Nold*, 362 Md. 241 (2001), the Court of Appeals dealt with the issue of whether appellants could introduce evidence that appellee, who was testifying at trial, failed the board examination on his first try. *Id*. at 250. In explaining that the evidence was inadmissible because appellee was merely a fact witness, the Court stated:

In the instant case, Dr. Wilhite's only involvement in Hall's treatment was his reading of the venous duplex scan. Appellants contend that since Dr. Wilhite was merely called as a fact witness, his testimony should have been limited "to a recitation of what he observed and did." *Little*, 434 Md. at 169. Specifically that Dr. Wilhite should have been permitted to testify only about his observation of the scan. However, appellants contend, the "trial court inappropriately allowed the defense to elicit hypothetical and opinion testimony from Dr. Wilhite regarding what Dr. Wilhite would have done had he been contacted."

Appellees provide a number of contentions to counter appellants' argument on the circuit court's admission of Dr. Wilhite's testimony. First, appellees argue that in constructing its holding in *Little*, the Court of Appeals went too far in its reliance on the language from *Dorsey*. *See supra* n.9. Specifically, appellees aver that in *Little*, the Court quoted and relied on language from *Dorsey* that was "not a holding . . . , but was merely a description of [appellant's] testimony . . . ." Though we recognize that the *Little* Court may have expanded the intended use of the language in *Dorsey*, since we are only assuming, without deciding, that Dr. Wilhite's testimony exceeded the permissible limits for fact witness testimony, we will not address this issue.

> [Appellee] did not testify as an expert in this case. His testimony was limited to a recitation of what he observed and what he did on the occasion of [the patient's] visit. He did not opine with respect to the standard of care, and the fact that he failed the board examination on his first try had little or no probative value with respect to whether his conduct was negligent.
>
> *Id*. at 251.

Additionally, appellees contend that Dr. Wilhite's testimony was not speculative, but that it was merely a "factual recitation about his willingness to respond if called from the emergency department, and regarding his capacity to perform surgical procedures [on a patient such as Hall.]" This testimony was offered as to the issue of causation and whether the appellees' failure to act was the proximate cause of Hall's injuries. Dr. Wilhite was not asked whether the appellees used the degree of care and skill which a reasonably competent healthcare provider, engaged in a similar practice and acting in similar circumstances, would use.

Appellees also argue that since appellants "solicited" Dr. Wilhite's testimony in their December 14, 2016, letter to Dr. Wilhite's counsel, they should be "estopped from arguing that it is inadmissible expert testimony." Appellees do not cite any legal authority to support this argument, and we are not aware of any authority stating that a party that gathers certain evidence during discovery is then estopped from arguing that such evidence is inadmissible during trial. As such, we are not persuaded by this argument.

Finally, appellees argue that Dr. Wilhite's testimony was properly admitted because it was "relevant to facts of consequence in the litigation, and the trial court had a wide range of discretion to admit [it]." This contention is similarly unavailing. Though Md. Rule 5-402 states that relevant evidence is *generally* admissible, there are a number of provisions that limit the admissibility of relevant evidence. *See, e.g.*, Md. Rule 5-403 (explaining that relevant evidence may be inadmissible if its "probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or

misleading the jury . . . ."); Md. Rule 702 (establishing the findings that a circuit court must make before expert testimony may be admitted). Therefore, simply proving that Dr. Wilhite's testimony was "relevant to facts of consequence in the litigation" alone, is not sufficient to establish that the testimony was admissible.

Taking into consideration all of the parties' arguments, we will assume, without concluding, that Dr. Wilhite's testimony exceeded the scope of permissible fact witness testimony. As appellants assert, Dr. Wilhite testified to matters beyond his observation of the venous duplex scan, and he gave "speculative" opinions about how he would have treated Hall if given the chance. His testimony seemingly went beyond "a recitation of what he observed and did." *Little*, 434 Md. at 169. However, since we ultimately hold that the circuit court's admission of Dr. Wilhite's testimony did not result in any prejudice and was harmless error, we are not required to make a final conclusion on this issue.

ii. Effect of Dr. Wilhite's Testimony

Considering the above, the next step to reach our conclusion is to determine whether the circuit court's error was prejudicial. *See* Md. Rule 5-103(a).

The Court of Appeals has previously summarized the harmless error doctrine:

> It has long been the policy in this State that this Court will not reverse a lower court judgment if the error is harmless. The burden is on the complaining party to show prejudice as well as error.
>
> Precise standards for determining prejudice have not been established and depend upon the facts of each individual case. Prejudice can be demonstrated by showing that the error was likely to have affected the verdict below; an error that does not affect the outcome of the case is harmless error. We have also found

> reversible error when the prejudice was substantial. The focus of our inquiry is on the probability, not the possibility, of prejudice.

Flores v. Bell, 398 Md. 27, 33-34 (2007) (internal citations omitted).

Appellants argue that that "Dr. Wilhite's improper opinion testimony clearly had the probability to affect the verdict[,]" and that "there was no more damaging testimony to Appellants' case than the jury hearing from PRMC's vascular director that nothing could have been done for Mrs. Hall." In response, appellees contend that all of Dr. Wilhite's testimony was consistent with testimony provided by their other witnesses, thereby making the admission of the testimony cumulative and not prejudicial.

We note, as appellants pointed out in their brief, that "in certain cases the mere inability of a reviewing court to rule out prejudice, given the facts of the case, may be enough to declare an error reversible." *Barksdale v. Wilkowsky*, 419 Md. 649, 670 (2011). Indeed, there are "limited circumstances" in which courts will employ a "presumption of prejudice[,]" including "[f]or the more egregious civil errors." *Id*. at 659. However, "[o]ther than [those] limited circumstances, the burden to show error in civil cases is on the appealing party to show that an error caused prejudice." *Id.* at 660. As the Court of Appeals has previously explained, "prejudice is not presumed . . . 'when the jury considers evidence admitted by the trial court which is later determined to have been erroneously admitted.'" *Merritt v. State*, 367 Md. 17, 33 (2001) (citing *State Deposit v. Billman*, 321 Md. 3, 16 (1990)). As such, appellants have the burden of proving that it is "probable" that the circuit court's admission of Dr. Wilhite's testimony affected the outcome of the case.

In attempting to meet their burden, appellants contend that Dr. Wilhite, as the on-call vascular surgeon at the time of Hall's treatment, was in a unique position to influence the jury about the treatment that could have been provided to Hall at PRMC. Further, appellants contend that appellees used Dr. Wilhite's testimony to argue that they complied with the standard of care by transferring Hall to UMMC. We are not persuaded by either of these arguments.

In *Beahm v. Shortall*, 279 Md. 321 (1977), the Court of Appeals dealt with a set of facts similar to those in the instant case. There, the Court improperly admitted as substantive evidence a physician-witness's testimony about the "subjective symptoms" that Shortall was allegedly suffering from. *Id*. at 332. While the Court did conclude that the physician's testimony should not have been admitted, it held that the error was harmless because the same evidence was "properly before the jury apart from the testimony of [the physician]." *Id*. at 332.

Similarly, in *Hollingsworth & Vose Co. v. Connor*, 136 Md. App. 91 (2000), this Court faced a similar issue. In that case, the circuit court impermissibly admitted expert testimony that was in the form of hearsay, and that exceeded the scope of the witness's expertise. *Id*. at 131. However, this Court ultimately held that "although the trial judge may have erroneously admitted [the expert's] testimony, this was harmless error, as there was other testimony that used similar language and produced similar results." *Id*. at 135. Taken together, *Beahm* and *Hollingsworth* establish that even when testimony is improperly admitted, if the evidence is before the court through some other, proper means, then only harmless error has occurred.

Here, Dr. Wilhite provided testimony as to the analysis that he would have undertaken had he been called to treat Hall, and as to whether he could have treated Hall at PRMC. The testimony was solicited to respond to the argument that any breach of the standard of care caused the complained of harm to Hall. *Puppulo v. Adventist Healthcare, Inc.*, 215 Md. App. 517, 534 (2013). Though Dr. Wilhite's testimony *may* have been improperly admitted, the substance of his testimony properly came before the jury in other ways. Specifically, as appellants themselves point out in their brief, Dr. Massey testified that, in deciding to transfer Hall to UMMC, she considered whether Hall could be treated at PRMC and ultimately concluded that UMMC was a "better facility to care for her." Similarly, Dr. Delligatti also testified that UMMC was the closest place where Hall could receive the care she needed. In addition, Dr. Mackerell testified to the various considerations that must be made when determining how to best treat Hall given the circumstances involved. *See supra* n.7.

In analyzing the testimony provided by other witnesses in this case, there is simply nothing to support appellants' contention that appellees used Dr. Wilhite's testimony to "bolster" their defense. Rather, as appellees assert in their brief, "[a]ll of this testimony was without any reference to Dr. Wilhite's view that he would not have been able to perform surgery at PRMC on a patient like Mrs. Hall." The fact that appellees' counsel briefly mentioned Dr. Wilhite's testimony in closing arguments does not change this calculus.

It is clear that the testimony that was properly given by other witnesses was substantially similar to that provided by Dr. Wilhite. Therefore, Dr. Wilhite's testimony,

to the extent to which it touched upon the standard of care, was merely cumulative, and it cannot be said that the admission of his testimony had a "probable" effect on the outcome of the case. As was the case in *Beahm* and *Hollingsworth*, we conclude that the admission of Dr. Wilhite's testimony was merely harmless error, and that there are not grounds to reverse the circuit court's judgment.

B. *Appellant's Burden of Proof*

Appellants contend that "by allowing [Dr. Wilhite] to testify about what he hypothetically would have done" to treat Hall, "the lower court inappropriately heightened [a]ppellants' burden of proof." Specifically, appellants state that "instead of just proving that [a]ppellees breached the standard of care, [they] were forced to prove that the subsequent treater would have acted reasonably contrary to the treater's own testimony." To support this contention, appellants do not cite any Maryland authority, but instead cite to an opinion from the Florida Supreme Court, *Saunders v. Dickens*, 151 So.3d 434 (Fla. 2014).[15]

[15] In *Saunders*, Dickens defended against a medical malpractice claim based on failure to diagnose the cause of Saunders's quadriplegia by introducing testimony from a subsequent treating physician. *Saunders*, 151 So.3d at 437-39. Specifically, the physician's testimony stated that even if Dickens had complied with the standard of care, the physician still would not have completed the surgery that Saunders alleges should have been performed. *Id*. at 438-39. In closing arguments, Dickens's counsel argued that due to the physician's testimony, Saunders could not establish that appellee's conduct was the cause of any injuries. *Id*. The jury returned a general verdict in favor of appellee. *Id*. at 439.

In reversing the verdict, the Supreme Court of Florida held:

> [T]hat testimony that a subsequent treating physician would not have treated the patient plaintiff differently had the

In responding to this argument, appellees assert that "[n]o Maryland case has directly addressed this issue, and it does not appear that any state other than Florida has adopted this approach." Additionally, appellees aver that there is "no reason for this court . . . to create new Maryland law based on a Florida Supreme Court opinion."

We agree with appellees. As both parties stated in their briefs, the State of Maryland has never adopted the approach that hypothetical testimony from a subsequent treating physician raises the plaintiff's burden of proof in a medical malpractice case. Rather, appellate courts in Maryland have consistently held that "in medical malpractice actions[,] . . . plaintiffs bear the burden of proof of demonstrating that the healthcare provider breached the requisite standard of care or skill and that such breach was a direct cause of the injury." *Rodriguez*, 400 Md. at 71; *Nolan v. Dillon*, 261 Md. 516, 534 (1971) ("The burden of proof is on the plaintiff to show both a lack of the requisite skill or care on the part of the doctor and that such want of skill or care was a direct cause of the injury[.]"); *Suburban Hospital Ass'n v. Mewhinney*, 230 Md. 480, 484 (1963) ("It is settled in Maryland that the burden of proof in a malpractice case is on the plaintiff to show a lack of the requisite skill or care on the part of the physician and that such want of

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> defendant physician acted within the applicable standard of care is irrelevant and inadmissible and will not insulate a defendant physician from liability for his or her own negligence. Instead, the burden on the plaintiff with regard to causation is only to establish that adequate care by the physician more likely than not would have avoided the plaintiff's injury.

Id. at 443.

skill or care was a direct cause of the injury[.]").

In applying this burden of proof to cases throughout the years, Maryland's appellate courts have never adopted the approach that testimony from a subsequent treating physician raises a plaintiff's burden of proof. In spite of the rationale of our sister court in Florida, we will not adopt such an approach today. Therefore, we hold that the circuit court did not improperly heighten Hall's burden of proof by admitting Dr. Wilhite's testimony.

JUDGMENT OF THE CIRCUIT COURT FOR WICOMICO COUNTY AFFIRMED; COSTS TO BE PAID BY APPELLANTS.