Circuit Court for Baltimore City
Case No. 24-C-19-005417

UNREPORTED*

IN THE APPELLATE COURT

OF MARYLAND

No. 1461

September Term, 2021

HARBOR HOSPITAL, INC.

v.

J.B.

Kehoe, Christopher**
Tang,
Adkins, Sally D.***
(Senior Judge, Specially Assigned),

JJ.

Opinion by Tang, J.

Filed: October 2, 2025

*This is an unreported opinion. This opinion may not be cited as precedent within the rule of stare decisis. It may be cited for its persuasive value only if the citation conforms to Rule 1-104(a)(2)(B).

** Kehoe, Christopher, now retired, participated in the hearing of this case while an active member of this Court; after being recalled pursuant to the Constitution, Article IV, Section 3A, he also participated in the decision and the preparation of this opinion.

*** Adkins, J., participated in the hearing of the case and in the conference, but did not participate in the adoption of this opinion because she was no longer serving as a Senior Judge of the Appellate Court. The remaining judges sitting on the panel constitute a quorum. Because they are in agreement as to the reasoning and outcomes of the appeal, there is a "concurrence of a majority of [the] panel." Md. Code, Cts. & Jud. Proc., § 1-403(b); *see also Jackson v. State*, 408 Md. 231, 239–40 (2009).

This case involves a medical malpractice action in the Circuit Court for Baltimore City. J.B. (the "Child"), a minor,[1] by and through his mother (the "Mother"), alleged that Harbor Hospital, Inc. (the "Hospital") was negligent in the post-delivery care provided to him, which resulted in his suffering from cerebral palsy.

After a two-week trial, the jury determined that the Hospital had breached its standard of care and that this breach caused the Child's injury. The jury rendered a verdict of $34,770,292.89 against the Hospital.

On appeal, the Hospital raises two issues for our review, which we have rephrased for clarity:[2]

[1] We refer to the child by his initials to protect his privacy. *See J.A.B. v. J.E.D.B.*, 250 Md. App. 234, 242 n.4 (2021).

[2] The Hospital presents the following questions in its brief:

> 1. *Meda v. Brown*, 318 Md. 418 (1990), allows quasi-*res ipsa loquitur* medical-expert opinions for certain, rare injuries that ordinarily require medical negligence. [The Child's] experts (and the court) relied on *Meda* to pass pre-trial Rule 5-702 scrutiny. But, at trial, they testified how Hospital nurses negligently harmed [the Child]—without testifying that [the Child's] injury ordinarily requires negligence. Did the court abuse its discretion under Rule 5-702 and *Meda* by allowing speculative medical-expert testimony?
>
> 2. The *Martinez* rule allows medical-negligence defendants that deny liability to argue that someone else's negligence caused the injury by (1) presenting evidence of others' relevant, dangerous conduct and (2) characterizing it as *negligent*. Here, the court precluded evidence that, while pregnant, [the M]other smoked, ended her prenatal hospitalization early against medical advice, and declined recommended prenatal care *because* her actions showed parental negligence. Did the rulings deny the Hospital a fair trial under *Martinez* [*ex rel. Fielding v. Johns Hopkins Hosp.*, 212 Md. App. 634 (2013)]?

Regarding the first issue presented, although the Hospital refers to the Child's "experts" (plural), it challenges the expert testimony of only one expert, Dr. William Malcolm, in the argument section of its brief.

I. Did the circuit court abuse its discretion by admitting the opinion of Dr. Malcolm, the Child's standard-of-care expert?

II. Did the circuit court err or abuse its discretion by precluding evidence regarding the Mother's prenatal conduct based on Courts & Judicial Proceedings § 10-910?

We answer the first question in the negative and the second question in the affirmative. Consequently, we vacate the judgment and remand this case for further proceedings.

I.

BACKGROUND

The Child claimed that he suffered a brain injury shortly after birth while being monitored in the Hospital's special care nursery. The Hospital denied causing the Child's injury; it claimed that the injury resulted from circumstances during the prenatal period. We summarize the relevant facts and procedural history.

A.

Prenatal Period

In December 2006, when the Mother was seventeen years old, she became pregnant with male twins. The pregnancy was considered high-risk due to concerns about the twins' growth and the possibility of premature birth.

The Mother's antepartum records indicated that she used tobacco and smoked half a pack of cigarettes per day for three years; however, it was unclear whether this smoking

occurred before or during her pregnancy.[3] A toxicology report indicated that the Mother tested positive for marijuana during her pregnancy on May 29, 2007.

On June 9, 2007, the Mother was admitted to the Hospital for preterm labor. On June 20, she was transferred to Johns Hopkins Hospital due to a risk of delivering prematurely. There, she was placed on bed rest and a specific treatment plan to manage her preterm labor.

The hospitals took ultrasounds of the fetuses. Based on an ultrasound taken by Johns Hopkins Hospital, the Child weighed "1411 grams which is less than a 5th percentile. Of note, this is considered intrauterine growth restriction." The Child was "small for gestational age[.]"

The Mother became unhappy with the care she was receiving at Johns Hopkins Hospital and chose to leave "against medical advice" on July 24, as noted in the medical records. At the time, she was about thirty-two weeks pregnant. The medical records from Johns Hopkins Hospital indicated that before her release, she was counseled of the risk to herself and her fetuses, which included fetal death, rupture of membranes, head entrapment, the inability to resuscitate the fetuses if delivered at a facility without appropriate NICU care, and other possible complications.

The Mother signed a "Release against Medical Advice," in which she handwrote: "I understand the risks of leaving this hospital against medical advice, including the risks of

[3] During her deposition, the Mother acknowledged that she smoked cigarettes before the pregnancy but claimed she stopped once pregnant.

harm to myself and my unborn children including infection, hemorrhage, preterm delivery, and possible maternal or fetal death." She was encouraged to follow up with her primary obstetrician, but she never did.

B.

Birth and Immediate Postnatal Care

On August 19, the Mother was admitted to the Hospital at 3:05 a.m. Dr. Dennis Stern, the obstetrician/gynecologist, delivered the twins. The Child was born at 4:28 a.m., followed by his twin brother a few minutes later. The Child's gestational age at birth was thirty-five weeks and four days.

After delivery, suctioning the baby, and cutting the umbilical cord, Dr. Stern's standard practice was to pass the baby to the pediatric nurse. He ordered a pathology examination of the placenta, as well as analysis of the umbilical cord and cord blood gases. According to Dr. Stern, the results of these reports were not concerning, and he believed he had delivered two healthy babies. However, he acknowledged that "you never know if something happens antenatally [before labor] that you just don't know about." He noted an abnormality in the pathology report regarding the placement of the Child's umbilical cord in relation to the placenta. The cord was "on the side of the placenta" instead of in the center, which Dr. Stern testified could indicate "damage or compression to the cord antenatally [before labor]."

Dr. Ethel Adeloye, the attending pediatrician, arrived in the delivery room shortly after the Child was born. She noted in the medical records that the Child was "thickly

meconium stained. Baby was being suctioned on arrival. He was apneic per suctioning, and was bagged with 100 percent O2, and stimulated" to breathe on his own.[4] Five minutes after birth, Dr. Adeloye noted that the Child was "breathing well with a weak cry." The Apgar scores recorded were six at one minute, seven at five minutes, and eight at ten minutes, out of a maximum of ten.[5]

The Child was taken to the special care nursery, which was equipped with cribs and facilities for up to thirteen infants. The "critical" babies, like the Child, who needed constant monitoring, were placed in one of four warmer beds. The pediatrician's call room was located adjacent to the nursery, and nurses could reach the pediatrician via pager. Depending on the number of infants in the nursery, the staff on duty varied from two to five nurses.

All babies were monitored for various vital signs. The monitors were programmed to track heart rate, respiratory rate, blood pressure, and oxygen saturation. The monitors were programmed to emit an alarm—a single beep accompanied by a colored light—when oxygen saturation fell below 90%. If oxygen saturation dropped below 80%, the alarm changed to three beeps and a different-colored light.

[4] Meconium is "[t]he first intestinal discharges of the newborn infant, greenish in color and consisting of epithelial cells, mucus, and bile." Stedman's Medical Dictionary 533600, Westlaw (last accessed Sept. 2025) ("Stedman's"). Apnea is the "[a]bsence of breathing." Stedman's A58590.

[5] Apgar scores evaluate a "newborn infant's physical status by assigning numerical values (0-2) to each of five criteria: heart rate, respiratory effort, muscle tone, response stimulation, and skin color; a score of 8-10 indicates the best possible condition." Stedman's A57620.

Nurses in the special care nursery documented information about the babies in their care using flow sheets and progress notes. The nursing practice at the Hospital followed a "charting by exception" method, meaning that nurses documented abnormal findings in the progress notes rather than writing "minute-by-minute" entries.

Upon arrival at the nursery at 4:35 a.m., Dr. Adeloye noted the Child's "color was pink with good perfusion [blood flow]" and the oxygen saturation in the blood ranged from 95% to 96% while he was on room air. However, she observed mild nasal flaring, indicating that the Child was still having some difficulty breathing.

At 5:00 a.m., the Child was placed in a warmer bed in the nursery. Nurse Gladys Wambaa recorded the Child's oxygen saturation at 98%. Sometime after 5:00 a.m., Nurse Sondra Manuel, who was senior to Nurse Wambaa, took over the Child's care.[6]

At 5:15 a.m., the Child's oxygen saturation dropped to between 88% and 90%. Nurse Manuel responded by administering "blow-by oxygen," which involved placing oxygen near the Child's nose. This temporarily raised the Child's oxygen saturation to between 90% and 95%. Once the blow-by oxygen was removed, the Child's oxygen saturation again fell to between 88% and 90%. As a result, Nurse Manuel switched to delivering oxygen via nasal cannula. After the nasal cannula was applied, the Child's oxygen saturation level rose to 100%.

[6] Nurse Manuel, who was primarily responsible for caring for the Child during his first few hours in the nursery, passed away before trial and was not available to testify.

At 5:30 a.m., Nurse Manuel and Nurse Maria Libit, whom Nurse Manuel was training, administered routine procedures. A neonatal IV line was inserted into the Child's arm, and blood was drawn from the other arm. Vitamin K was injected into the Child's thigh, and antibiotic ointment was applied to his eyes. There was no mention in the medical records of the Child experiencing any apnea or breathing problems during these procedures.

Nurse Manuel recorded that, at 5:40 a.m., the Child "has [an] apneic episode." The Child's color was "dusky," and his oxygen saturation levels were in the 40s. The note indicated that the nurses initiated bag and mask ventilation, which increased the oxygen saturation to the 90s.

At some point, the nurses called Dr. Adeloye to the nursery. Upon her arrival, Dr. Adeloye took over the bag and mask ventilation and evaluated the Child. At that point, she intubated the Child and placed him on a ventilator. The ventilator therapy department recorded the Child's heart rate at 154 beats per minute at 5:40 a.m.

Around 2:00 p.m. that day (August 19), the Child began experiencing seizures. Subsequent testing showed a brain injury (a bilateral diffuse anoxic ischemic injury).[7]

[7] Anoxia is the "[a]bsence or almost complete absence of oxygen from inspired gases, arterial blood, or tissues." Stedman's 45130. Ischemia is a "[l]ocal loss of blood supply due to mechanical obstruction . . . of the blood vessel." Stedman's 457640.

C.

Child's Condition

Due to the brain injury, the Child has severe cerebral palsy. At trial, the Child presented testimony from experts who testified about the type of care he would need for the rest of his life. They also discussed the lost wages and care expenses he would incur over his lifetime due to his injury. Since damages are not an issue on appeal, summarizing the details of their testimony is not necessary.

D.

Malpractice Action

In October 2019, the Child, by and through the Mother and next friend, filed a lawsuit against the Hospital for medical malpractice.[8] He alleged that the Hospital nurses breached the standard of care by failing to properly and continuously monitor his condition upon transfer to the special care nursery and failing to timely and adequately treat the oxygen desaturation while he was in the unit, which resulted in his brain injury.

The Hospital's defense was that it did not cause the Child's brain injury. It claimed that the injury was a result of umbilical cord compression in the womb, which occurred before delivery. The Mother had been at Johns Hopkins Hospital for monitoring for preterm labor, but she left against medical advice when she was thirty-two weeks pregnant. The Hospital claimed that the Mother's decision to leave early during this critical period led to

[8] The Child named MedStar Health, Inc. as a co-defendant but later stipulated to the dismissal of all claims against it.

a lack of monitoring for the Child, whose condition was already compromised in the womb before labor, ultimately resulting in the brain injury. Additionally, the Hospital claimed that the Mother had smoked both cigarettes and marijuana during her pregnancy and that these actions also contributed to the Child's brain injury.

E.

Hospital's Motion to Exclude Child's Standard of Care Expert

One of the disputes in this case was whether the nurses breached the standard of care in monitoring the Child while in the nursery, which turned on precisely when the nurses had contacted Dr. Adeloye in response to the recorded apneic episode. During discovery, the Hospital took the deposition of the Child's standard of care expert, Dr. William Malcolm, a pediatrician in neonatal medicine. During his deposition, he testified to (1) the cause of the Child's brain injury and (2) the standard of care of the nurses and physicians who took care of the Child at the Hospital.

As to causation, he testified that based on the medical records, the Child suffered his hypoxic-ischemic injury[9] before being intubated at 5:40 a.m. According to Dr. Malcolm, "[W]e don't know what happened . . . between 5:30 and 5:40 [a.m.]" He indicated that if there was an apneic event lasting two minutes or less without associated bradycardia (slowness in heartbeat), that would not be enough to cause a permanent neurologic injury to the brain. However, he opined that the Child experienced a hypoxic

[9] "Hypoxia" means a "[d]ecrease below normal levels of oxygen in inspired gases, arterial blood, or tissue, without reaching anoxia." Stedman's 431380.

insult of at least four to five minutes that likely led to his being bradycardic and resulted in the Child's injury.

Dr. Malcolm indicated that, even though there was no documentation of bradycardia in the medical records between 5:30 and 5:40 a.m., the Child could have experienced bradycardia that the nurses did not document. He explained that he did not know whether the nurses left the Child's bedside between 5:30 and 5:40 a.m. Dr. Malcolm testified that the records indicated only that a nurse placed an IV, started fluids, and tried to draw labs unsuccessfully, stating that she may have left momentarily to retrieve necessary supplies: "I don't know if she suspended alarms . . . to draw the labs, I don't know if she went . . . to get new supplies . . . because she was unable to get the labs. . . . [T]here's nothing in there . . . about heart rate [in those ten minutes] so I don't know if . . . there was bradycardia or not."

He explained that the injury must have occurred while the Child was in the nurses' care based on documentation of the Child's condition before and after the hypoxic episode:

> [I]t's just the only time during this whole duration between when he started having acidosis, seizures, all these sorts of effects of a serious neurologic injury [documented later] and birth, where we know he was normal, had good gases, had good Apgar scores, had a normal physical exam. It's the only time period that's charted during that period that . . . that is a logical time for this [injury] to have occurred.

Dr. Malcolm explained:

> [A]fterwards, we have all th[ese] lab findings and . . . clinical findings of . . . a brain injury. And so I'm putting all the pieces together. Maybe each individual piece doesn't . . . add up, but . . . when you put it all together[,] we had a child who was born normal and apparently after an hour of life has a severe brain injury[.]

Regarding the standard of care, Dr. Malcolm testified that the "whole team," including the nurses, failed to properly monitor and respond to the hypoxic episode that occurred in the nursery in a timely manner. When asked whether he would testify at trial that the nurses left the Child's bedside between 5:31 and 5:39 a.m., Dr. Malcolm responded, "What I'm going to say is that we don't know what happened up until 5:40—between 5:30 and 5:40" a.m. He opined that the nurses had a duty to monitor the Child's oxygenation because it was essential to his health, and their failure to do so could cause hypoxia and neurologic damage.

On November 25, 2020, the Hospital moved to exclude Dr. Malcolm's standard of care and causation opinions because they lacked a sufficient foundation under Rule 5-702 and *Rochkind v. Stevenson*, 471 Md. 1 (2020). It argued that his opinion that the nurses' failure to respond to the five-to-six-minute episode of alleged apnea and bradycardia was not supported by the medical records. It pointed out that the records do not indicate an apneic event until 5:40 a.m. and contained no evidence of bradycardia whatsoever. The Hospital argued that Dr. Malcolm "fill[ed] in the blanks" with "speculation and conjecture" to explain how the providers missed a five-to-six-minute period of apnea and bradycardia. It further argued that Dr. Malcolm's opinion that the Child experienced bradycardia was not only unsupported but was also contradicted by the records. Moreover, Dr. Malcolm was

not able to support his opinions with any medical literature. In essence, the Hospital claimed that Dr. Malcolm's opinion was nothing more than an *ipse dixit*.[10]

The Child opposed the motion. Counsel for the Child highlighted that Dr. Malcolm considered the records from before, during, and after birth and concluded that the Child's brain injury could have occurred only in the case of negligence by the nurses. He argued that, under *Meda v. Brown*, 318 Md. 418 (1990), and *Tucker v. University Specialty Hospital*, 166 Md. App. 50 (2005), Dr. Malcolm's conclusion that the nurses' negligence caused the Child's injury was a permissible inference based on the facts presented. Counsel further argued that the nurses' failure to monitor the Child and respond immediately to the Child's hypoxia proximately caused his injury.

Following a March 1, 2021 hearing, the court denied the Hospital's motion to exclude the testimony, determining that Dr. Malcolm's opinion satisfied both Rule 5-702 and *Rochkind*:

> [F]irst, just to address Rochkind[,] [t]his does not appear to be any sort of novel method or approach. . . . [T]his is a differential diagnosis approach that's well-tested and accepted. The fact that . . . [Dr.] Malcolm [was] unable to bring in or supply a journal article or some sort of study, I'm not persuaded that that defeats th[is] expert[]. . . .
>
> [O]ne of the Rochkind factors is whether the facts support the conclusion. The [c]ourt agrees with [the Child's] counsel that there is a sufficient factual basis, under both 5-702 and the [Maryland Supreme Court] standard, that the experts reviewed the entire record, that there's evidence that the child was healthy at birth, and there is data to support that. The assessments, for example, the APGAR score, the cord blood gases. Further . . . [Dr. Malcolm] considered the fact that it was only after the hypoxic event that there was evidence of the brain injury.

[10] The Latin phrase *ipse dixit*, which means "he himself said it," is used to describe "[s]omething asserted but not proved." *Ipse Dixit*, Black's Law Dictionary (12th ed. 2024).

> [Dr. Malcolm] indicate[s] that the lack of a record in this time period is consistent with either an unnoted or an unnoticed or an untreated event. The metabolic acidosis, the seizures, the evidence of kidney injury in some of the labs, and the imaging being consistent with [his] opinion that there was an injury that occurred at this time or in this time frame.
>
> So I do find that the—that both under 5-702, clearly, there's been no argument that they're unqualified or that this is not an appropriate subject matter for expert testimony, and the [c]ourt finds that there is [a] sufficient factual basis.

The court also found *Meda* and *Tucker* "highly persuasive and similar to what we've got here" in that the medical record in those cases also did not contain any record of the mechanism of injury. It found language in *Tucker* that quoted *Dover Elevator Co. v. Swann*, 334 Md. 231 (1994), helpful in guiding the court's ruling in denying the motion to exclude.[11]

In addition to filing the motion to exclude Dr. Malcolm's opinions, the Hospital moved for summary judgment, arguing, in relevant part, that if the court granted the motion to exclude, it would have to grant summary judgment in the Hospital's favor. This was so, asserted the Hospital, because, absent Dr. Malcolm's expert opinions, the Child had no other evidence to prove the standard of care element of his claim. Because the court denied the motion to exclude Dr. Malcolm's testimony, it declined to grant summary judgment on this basis.

[11] We will discuss these cases below.

F.

Child's Motion to Exclude the Mother's Prenatal Conduct

In supplemental discovery responses before trial, the Hospital articulated its defense that it did not cause the Child's brain injury and the evidence it intended to introduce at trial to support that defense:

> [The Hospital] does not contend that [the Child's] action . . . is barred by the contributory negligence of [the Mother]. However, [the Hospital] does reserve the right to introduce evidence establishing that the conduct of [the Mother] to include not following medical advice during the pre-natal period was a contributing cause of [the Child's] injuries and damages. [The Hospital] intends to rely upon and introduce the medical records of [the Mother] . . . on the issue of causation as evidence of independent causes of [the Child's] injuries and damages and to establish that [the Child's] injuries and damages were not caused by [the Hospital].

The Child moved *in limine* to exclude evidence of the Mother's prenatal conduct, including evidence of the Mother's leaving Johns Hopkins Hospital against medical advice and any smoking and marijuana use. On July 28, 2021, the day before the trial began, the court heard arguments on the motion.

The Child's counsel argued that such evidence was inadmissible under CJP § 10-910 and irrelevant.[12] He asserted that, even if it was relevant, the probative value of such evidence was outweighed by the risk of unfair prejudice to the Child. Moreover, he argued that no defense expert could testify that either factor (smoking while pregnant or leaving

[12] CJP § 10-910 provides, "In an action on behalf of an infant to recover for death, personal injury, or property damage the negligence of the parent or custodian of the infant may not be imputed to the infant."

against medical advice) caused the Child's brain injury within a reasonable degree of medical probability.

The Hospital opposed the motion. It argued that CJP § 10-910 did not preclude evidence of the Mother's prenatal conduct because the Hospital was not arguing that her negligence barred the Child's claim. At the motions hearing, the Hospital reiterated that it was "not going to say that [the Mother's] negligence supports a motion for judgment as a matter of law after [the Child] present[s] [his] case." Instead, the Hospital asserted the theory that, because the Mother had checked herself out against medical advice, "there was continuing cause in neurologic injury during that period of time" and the "alternative cause is that ongoing injury was happening during this period of time when she had left" Johns Hopkins Hospital. The Hospital contended that the Mother's decision to leave Johns Hopkins Hospital against medical advice was relevant to give the jury a complete picture of the facts and rebut the Child's claim that the Hospital's actions were the proximate cause of his brain injury.

The Hospital cited deposition testimony of various experts to support its claim that the Mother's decision to leave against medical advice was a contributing cause of the Child's injury. One of the Child's experts, Dr. Edward Karotkin, whom the Child did not end up calling at trial, stated that it is "probably the case" that "if [the Mother] had not checked herself out against medical advice from John[s] Hopkins, that [the Child] would be neurologically normal today;" that it was "probably true" that, had the Mother stayed at Johns Hopkins Hospital, the Child "would have received much better care, the monitoring

equipment would have been hooked up[,] and he would not have suffered apneic episodes"; that there would have been "a greater likelihood that the pregnancy would have gone a little bit longer"; and that even if the Child had experienced an apneic spell, "more likely than not [he] would not have suffered the hypoxia as a consequence of that spell[.]"

Dr. Keith Eddleman, the Hospital's expert, pointed to various risk factors that had existed in the Mother's pregnancy as potential contributing factors to the Child's condition. He testified that the Mother's absence of prenatal care for about a month, "at a very critical time in the pregnancy," following her decision to leave Johns Hopkins Hospital against medical advice and before presenting to the Hospital for labor and delivery, constituted a risk factor. He explained that there was "poor interval growth" of the Child between June 21 and July 23, which "tells you there is poor placental perfusion." This meant that the "placenta is not . . . delivering oxygen and nutrients to the fetus like it should," which "in and of itself is enough to compromise a fetus." Dr. Eddleman testified that, "had [the Mother] been seen, it could have been that [the Child] would have been . . . delivered at a time before continued injury from this poor placental perfusion contributed to the already compromised baby from an earlier insult or earlier abnormality."

In addition, the Hospital argued that evidence of the Mother's smoking and marijuana use was relevant to give the jury a complete picture of the facts and rebut the Child's claim that the Hospital's actions were the proximate cause of the Child's brain injury. For support, the Hospital cited the following deposition testimony of defense experts that it wanted to call at trial:

- Dr. Eddleman testified that the Mother's smoking and marijuana use "could have contributed to" the Child's brain injury. He supported this conclusion by opining "that smoking can cause vascular abnormalities in the placenta and maternal circulation that can lead to poor placental perfusion, which can in and of itself lead to hypoxic ischemic encephalopathy."
- Dr. Paul Fisher testified that both marijuana use and cigarette smoking could have contributed to the Child's brain injury.
- Dr. Michelle Owens testified that marijuana use could have contributed to the Child's brain injury. She also testified that any kind of smoking during pregnancy "can be associated with issues that alter the availability of oxygen to a fetus." She would not say that cigarette smoking caused the Child's brain injury but testified "that it could further potentiate or worsen a situation that could already be problematic."

The Hospital argued that this testimony, along with that of other experts, was relevant to show that the Child was predisposed to neurological injury before birth due to various factors, including the Mother's smoking.

During the motions hearing, the Child's counsel stated that he had no objection to the Hospital providing testimony about the Mother leaving Johns Hopkins Hospital. However, he objected to the evidence that she left against medical advice. In response, the Hospital expressed concern that excluding such evidence could lead the jury to draw a "negative inference" that Johns Hopkins Hospital allowed her to go home for bed rest because she was fine, which, according to the Hospital, was not accurate. The Child's counsel agreed not to argue any such inference to the jury.

The Hospital responded that, despite the Child's counsel's stipulation, the jury might still draw the inference:

> [COUNSEL FOR THE HOSPITAL]: The inference that is drawn, whether [the Child's counsel] says it or not, is that [the Mother] was okay, that she

> was allowed to go home. The physicians [at Johns Hopkins Hospital] allowed her out of [Johns Hopkins H]ospital, even though we're saying that she –
>
> THE COURT: Well . . . [the Child's counsel] just said he's not going to argue that.
>
> [COUNSEL FOR THE HOSPITAL]: . . . But the jury will have the same question. They'll be like why did [the Mother] get to leave? If they're doing serial fetal ultrasounds every couple of weeks, why did they allow her to leave? Why did they allow her to leave? And they'll be wondering that.
>
> And if we're precluded from telling the truth to the jury, which is they didn't allow her to leave, it will give [the jury] the inference that it was okay . . . . I think that's improper and highly prejudicial. It changes the facts and dynamics of what happened at that hospital.

In the end, the court granted the Child's motion *in limine*, excluding evidence that the Mother left Johns Hopkins Hospital against medical advice and any evidence of the Mother's smoking and marijuana use during pregnancy. The court based its decision solely on the application of CJP § 10-910. It explained:

> The [c]ourt has considered the written submission[s] of the parties; their arguments; as well as the relevant legal principles, specifically [CJP §] 10-910, which provides that . . . in an action on behalf of an infant to recover for death, personal injury, or property damage, the negligence of the parent or custodian of the infant may not be imputed to the infant.
>
> I will note that there is a possibility that a parent's negligence could be so severe as to displace the negligence of the underlying tortfeasor. But those circumstances, as addressed in the case law, are extraordinary and rare. It's only in the somewhat extraordinary situation where the parent's negligence is such as to constitute an independent and superseding cause of the child's injury where that evidence might be admissible. So independent superseding cause, circumstances that are extraordinary and rare. That does not exist in this case.

G.

Trial

A jury trial was held over a two-week period between July 29 and August 16, 2021. We summarize the portions of the trial relevant to this appeal.

1. Opening Statements

During opening statements, the Child's counsel stated that the Child had an apneic event between 5:30 and 5:40 a.m. while in the nursery under the nurses' care at the Hospital. Counsel argued that the injury could not have occurred during the prenatal period because the Mother was being monitored by Johns Hopkins Hospital and nothing in the records indicated a problem with the Child during the Mother's stay during her preterm labor management. The Child's counsel drew the jury's attention to the period between June 20 and July 24, when the Mother was at Johns Hopkins Hospital after being transferred there from the Hospital:

> High risk, monitoring those kids, because things can go wrong with twins, especially identical twins. There's things you want to watch for. Johns Hopkins Hospital, one of the finest hospitals in the world, was monitoring this mother and these fetuses. *There's not one mention in those 45 days with any problems with the babies*.
>
> *They're being monitored*, their heart rate, the amount of amniotic fluid in the womb, *not one mention of a problem. As a matter of fact, just the opposite. You see the word, you'll see it, "reassuring."* They're monitoring them. Because, you know, there could be a point in time where you see something, and you think there's a problem with the babies, one or the other, and you do a c-section. You don't wait for a vaginal delivery.
>
> So that's what the doctors at Hopkins were doing. . . . *Hopkins doctors, when they were treating [the Mother], saw nothing*.

(Emphasis added).

Later in his opening statement, the Child's counsel addressed the Hospital's theory that the Child's injury occurred while in the womb before delivery:

> [T]he whole time . . . [the Mother is] being monitored at Hopkins. The high risk doctors are monitoring this woman to make sure they try to preserve these babies. *Because if there's a problem, you do [deliver] them by c-section. You don't wait. You deliver them. There's not a hint in the Hopkins records that they thought they should deliver by c-section*. [T]hey were monitoring them. They were looking for problems. They weren't like putting blinders on. They were watching very carefully. They were watching issues for twin to twin transfusion. Didn't happen. . . .
>
> Hopkins is watching for [the amount of amniotic fluid]. . . . They're watching for cord compression. They're monitoring the heart rate of the children. They're hooked up to monitors to the fetuses. They're not oblivious to these problems that [the Hospital's] experts now say were there. Hopkins was watching. The size of the children, they're monitoring them on ultrasound. . . . [T]hey're watching the head circumference. They're watching these issues.

(Emphasis added).

During a recess from the Child's counsel's opening statements, the Hospital reminded the court that the Child's counsel had stipulated at the motions hearing to refrain from making an inference that the Mother was fit to leave Johns Hopkins Hospital and that the hospital permitted her discharge. It contended that the Child's counsel had "opened the door so wide" that evidence of the Mother leaving against medical advice "has to come in, or it's un[d]uly prejudicial[.]"

The court disagreed. It acknowledged that the Child's counsel reneged on his agreement not to make a negative inference about the Mother leaving Johns Hopkins Hospital, but ultimately concluded, as at the motions hearing, that the evidence that she left against medical advice was inadmissible under CJP § 10-910:

> I do believe [the Child's counsel] . . . opened the door with what [he] said and went back on – and everything we discussed [at the motions hearing], that [he] wouldn't make this negative inference. With that being said, there's still a statute that prohibits [the Mother's] contributory negligence, and that's the against medical advice piece. That's the contributory negligence.

The court permitted the Hospital to make other points to the jury, but emphasized that it could "not mention that she left against medical advice."

The Hospital reiterated that the evidence of the Mother's leaving against medical advice was "important because the reason that [doctors] needed her in the hospital was to monitor her and potentially do a [c-section]." However, the court questioned how CJP § 10-910 could be overcome. The Hospital explained that the statute was "not a sword to prevent an alternative causation argument." It asserted that it had the right to explain to the jury that the reason the Child suffered an injury was that the doctors at Johns Hopkins Hospital "couldn't do anything" because the Mother left the hospital, even though they had advised her not to do so. The court responded that the Hospital could "do that without referencing that she left against medical advice. That's my ruling."

During its opening statement, the Hospital presented its theory to the jury that it was not the cause of the Child's brain injury. The Hospital focused on its claim that the Child's injury developed before delivery as a result of cord compression, which limited oxygen from getting to the Child inside the womb.

2. Child's Expert Testimony Regarding Standard of Care and Causation

The Child's expert, Dr. Stephen Thompson, a pediatric neurologist, opined that the Child sustained a catastrophic brain injury due to a lack of oxygen, which was first

observed by nursery staff at 5:40 a.m., when the Child was noted to be apneic and dusky, and his oxygen saturation was in the 40s. There was no documentation of the Child's oxygen levels or heart rate in the ten minutes between 5:30 a.m., when his status was recorded, and 5:40 a.m. Dr. Thompson opined that the injury occurred within that ten-minute period. He testified that, "within a minute the most vulnerable brain cells start to die," and that "within four to five minutes [of] decreased oxygen delivery, you have significant, permanent injury to the brain." He contrasted the Child's "reassuring Apgar scores" and normal arterial blood gases immediately after delivery with blood gases documented later that day, which were consistent with an injury that occurred around 5:40 a.m. He also relied on the results of an ultrasound, a CT scan, and an MRI taken after delivery, which supported his opinion that the injury occurred around 5:40 a.m.

Dr. Thompson ruled out the possibility that the Child's injury occurred before delivery during the Mother's stay at Johns Hopkins Hospital. He cited medical records for that period, stating, "Nowhere in the Hopkins records, nowhere in the pre-delivery record, is there anything that suggests any type of abnormality in the monitoring that would suggest an injury had occurred" during her stay at Johns Hopkins Hospital. The expert highlighted daily progress notes indicating that the fetus's well-being was "reassuring," meaning that the doctors there did not think there was anything that required medical intervention. He testified that if the fetus had suffered from some catastrophic brain injury at Johns Hopkins Hospital, then the doctors would not have noted "reassuring and all these normal findings."

Instead, the doctors would have intervened and performed an emergency c-section on the Mother, who was just over twenty-eight weeks pregnant on June 28.

The Hospital objected on similar grounds to those raised during the Child's opening statements. It argued that the Child's expert suggested that the twins "were fine at Hopkins" and that the doctors could have performed a c-section on the Mother at twenty-eight weeks, even though that was not feasible. The Hospital maintained that, without the ability to present evidence showing that the Mother left Johns Hopkins Hospital against medical advice, the jury would be left with the misleading impression that the hospital allowed her to go home because it considered the pregnancy safe. The Hospital explained:

> [The Child's expert] is saying that they're giving [the Mother] fetal ultrasounds every couple of weeks in case so . . . if . . the baby's suffering brain damage, [the doctors] can determine if they need to intervene. But they can't intervene too early, [s]o they want to watch. . . .
>
> [T]hen [the doctors] say, ["]don't leave because . . . your babies could die if [you] do it.["] And that's the critical period. She left during the absolute critical period, and [the Child's expert] is creating the inference that [the doctors] let her leave. It's entirely prejudicial.

While the court ruled that evidence regarding the appropriate timing of a potential c-section was "fair game," it did not "see any negative inference, or anything associated with [the Mother] leaving Johns Hopkins Hospital against medical advice, that would prejudice" the Hospital. The court reiterated its earlier ruling to exclude evidence that the Mother left against medical advice.

Dr. Mark Landon, an obstetrician specializing in maternal-fetal medicine, testified consistently with Dr. Thompson. He testified that there was no evidence of a hypoxic brain injury occurring before or during delivery based on the medical records.

During cross-examination, the Hospital asked Dr. Landon if the Mother "followed up" with an obstetrician or fetal medicine physician again after leaving Johns Hopkins Hospital and before she presented to Harbor Hospital on August 19, 2007. Dr. Landon responded that she did not. The Child's counsel objected to the question, claiming that the Hospital was attempting to impute the Mother's negligence to the Child, which was prohibited by CJP § 10-910. The court noted that the expert had already answered the question. However, with respect to further questions related to the Mother's failure to follow up with a doctor after she left Johns Hopkins Hospital, the court remarked that the Hospital was suggesting that the Mother "did something wrong."

The Hospital responded that such evidence was "absolutely relevant to our causation defense." The Hospital reiterated, moreover, that the Child's experts had opened the door to allowing the Hospital to introduce evidence that the Mother had left against medical advice.

The court disagreed, stating, "I think you can do all of what you're saying without mentioning the mother and what the mother did or did not do. And that's my ruling. I stand by that." The court concluded that the Hospital could elicit testimony that the Mother did not have ultrasounds during the period after she left Johns Hopkins Hospital and before she was admitted to the Hospital because, without more, that would not suggest the Mother was contributorily negligent. However, the court precluded the Hospital from eliciting testimony that the Mother "didn't follow up" with an appointment.

Dr. Malcolm, who was admitted as an expert in pediatrics, testified that the health care providers who cared for the Child in the special care nursery deviated from the standard of care. According to him, "as soon as there's a change in the status [of a newborn in the special care nursery], [nurses] need to notify the upper level [physician]." He testified that the hypoxic event that caused the Child's injury occurred between 5:30 and 5:40 a.m. He explained, among other things, that nurses deviated from the standard of care when "the proper chain of command wasn't notified and it was notified too late."

Addressing causation, he acknowledged that oxygen saturation of 88% for less than a minute would not result in brain damage. However, based on the medical records, he opined that a neonate like the Child sustained a catastrophic brain injury after experiencing low levels of oxygen saturation for about four to five minutes. He acknowledged that the Child was not hypoxic at 5:15 a.m. but that, by 5:40 a.m., the Child had already suffered a significant brain injury that could have been prevented if the nurses had notified Dr. Adeloye as soon as there was a change to the Child's well-being.

Dr. Malcolm further testified that the Child's brain injury "clearly" did not occur before birth based on his review of the medical records and that "there was nothing that was concerning to the treating OB about [the Child's] prenatal and perinatal time period."

3. Hospital's Motion for Judgment

At the close of the Child's case, the Hospital moved for judgment on the ground that the Child had not met his burden with respect to the standard of care or the causation element of his claim. Regarding the standard of care, the Hospital noted that Dr. Malcolm

testified about two opinions regarding the standard of care. First, the standard of care required the nurses to contact Dr. Adeloye at 5:15 a.m. The Hospital argued that, even if there had been a breach at 5:15 a.m., the Child had failed to show that it caused the Child's brain injury.

Dr. Malcolm's second opinion as to the nursing standard of care was that the nurses should have called Dr. Adeloye when the apneic episode occurred, which he opined was sometime between 5:30 and 5:40 a.m. The Hospital argued that the Child had not presented any evidence that Dr. Adeloye was not called then; in fact, Dr. Adeloye testified that she was likely called. The court denied the motion for judgment. It explained that whether Dr. Adeloye was called during the times in question was a dispute of fact for the jury to decide, and that based on the evidence, the jury could reasonably infer that the nurses did not call her in a timely manner.

4. Hospital's Expert Testimony Regarding Standard of Care and Causation

In its case, the Hospital called expert witnesses, including Dr. Fisher, a pediatrician with a specialty in neurology; Dr. Thomas Wiswell, who was admitted as an expert in pediatrics, neonatal nursing, and neonatology; Patricia Mahoney-Harmon, a clinical nurse specialist; Dr. Robert Tyson, a pathologist; and Dr. Richard Towbin, a radiologist.

Regarding causation, Dr. Fisher testified that the Child's brain injury occurred before delivery. He testified that the onset of the injury was sometime between June 11 and July 23, 2007, but that there could still be ongoing injury throughout the pregnancy. He explained that the Child's brain injury was caused by a compressed umbilical cord, which

resulted in reduced blood flow to the brain. He also testified about the relationship between inadequate blood flow and deceleration in the Child's brain growth in the womb. Based on his review of the medical records, Dr. Fisher opined that the Child had "preexisting illness. He had not only a preexisting brain injury, but he had other markers of injury when he was born . . . that had been longstanding. He was not a healthy baby when he was born." He stated that the Child's low blood sugar and poor muscle tone at birth, and the tightening of extremities later, indicated a prenatal brain injury.

Dr. Fisher testified that it was impossible for the five-minute apneic episode that the Child allegedly experienced around 5:40 a.m. to have resulted in brain damage. He testified that the heart rate would have to be zero before there is permanent brain damage, something there was no evidence of. He opined that the fact that the Child demonstrated redness and tightening of extremities at 5:40 a.m. meant he was most likely having a seizure, which is a byproduct of an earlier brain injury. He further testified that the location of the brain damage was more consistent with a chronic injury than an acute one. Dr. Fisher disagreed with the Child's experts' opinions that the Child's post-delivery imaging was consistent with the injury having been caused by an acute hypoxic episode occurring shortly after birth. He testified that the imaging showed a decrease in the Child's head circumference, which indicated "a process that occurred over weeks."

On cross-examination, the Child's counsel inquired about the Mother's admission to Harbor and then to Johns Hopkins Hospital before delivery. He asked if the hospitals were monitoring the well-being of the fetuses during that time. The Hospital objected on

the basis that the Child's counsel was "trying to create an inference that [the Mother] left [Johns Hopkins Hospital] at 32 weeks because the physicians allowed her to do so. . . . [W]hen Your Honor ruled on that pretrial, [the Child's counsel] said that they weren't going to attempt to create any inference." The Hospital explained that it had refrained from asking Dr. Fisher why no fetal ultrasounds were performed between thirty-two and thirty-four weeks of pregnancy because that was the period when the Mother had left Johns Hopkins Hospital against medical advice. It contended that the Child's counsel was now using the Hospital's inability to elicit such evidence as "a sword."

The court cautioned the Child's counsel to be "precise" with his questioning and overruled the objection. The Child's counsel proceeded to confirm with Dr. Fisher that the medical records during the Mother's prenatal stay at Johns Hopkins Hospital indicated that a certain testing result related to the Child was "reassuring" but that the records did not specifically reference the Child's neurology.

Dr. Wiswell testified that the brain injury occurred before delivery, specifically due to umbilical cord compression between twenty-six and thirty-six weeks of gestation. He explained that the records showed the Child's umbilical cord was inserted at the margin into the fetal membrane, rather than the center of the placenta. This condition, known as a velamentous insertion, was dangerous because the paper-thin membrane offers less protection to the umbilical cord than the placenta, increasing the risk of fetal injury or death. He opined that the Child started to experience neurological injury at around twenty-six weeks of gestation. The records indicate that the Child's head began growing more

slowly after that point, which Dr. Wiswell explained was an indicator of prenatal brain injury. He further opined that the Child's injury could not have been caused by four or five minutes of apnea in the nursery because an injury of that severity requires at least ten minutes of bradycardia, which there was no evidence of.

Dr. Tyson testified that, based on a review of placental pathology reports, the Child's injury occurred before delivery due to "multiple compressive events" involving his umbilical cord, which affected the flow of blood and oxygen to the fetus's brain. On cross-examination, the Child's counsel inquired about the Mother's medical records during her stay at Johns Hopkins Hospital before delivery and asked the expert why there would not have been any indication of cord compression in those records. Counsel suggested through questioning that Johns Hopkins Hospital had monitored the fetuses regularly and that the hospital was "one of the best hospitals in the country."

The Hospital objected, stating that the Child's counsel was again violating his promise not to create an inference that Johns Hopkins Hospital allowed the Mother to leave the hospital because physicians had no concerns with the fetuses:

> I believe he's now opened the door repeatedly to me being able to bring in that [the Mother] left against medical advice between 32 and 34 weeks, because to overcome this inference, what I now have to do is get up and say, "Do you know why she wasn't being monitored . . . at this great institution . . . between 32 and 36 weeks? [It's b]ecause she signed a document saying, 'My babies could die if I leave,' and she left anyway."

The court cautioned the Child's counsel that he was "getting closer to this line of drawing an inference," but it ultimately disagreed with the Hospital's position:

> [A]s I now understand this case, having sat through it for almost two weeks, it becomes much clearer, and my ruling becomes much clearer. The issue is the records that were available. It has nothing to do with her leaving the hospital against medical advice.

Dr. Towbin also opined that the Child's injury occurred before delivery, based on his review of brain imaging studies, which indicated a partial prolonged pattern of injury.

Regarding the nurses' standard of care, Dr. Wiswell opined that Nurses Manuel and Libit complied with the standard of care. Dr. Wiswell explained that when a nurse starts blow-by oxygen, they do not need authority from a physician. If the blow-by oxygen does not work, the nurse does not need to immediately call a physician, as there are levels of increased support that a nurse is allowed to provide within the scope of their practice. If a nurse initiates the next level of support, in this case, a nasal cannula, the nurse does not require authority from a physician. He testified that if the baby is responding appropriately and doing well with the nasal cannula, the physician does not need to be contacted immediately. At some point, usually within half an hour to an hour, the nurse will call the physician. He concluded that, based on the information in the nurses' notes, the Child did not need to be attended to by a physician at 5:15 a.m.

With respect to the note at 5:30 a.m. related to the IV, Dr. Wiswell testified that this procedure usually takes a minimum of five to ten minutes and that nurses generally do not leave the bedside when they are starting an IV. According to Dr. Wiswell, the notes therefore indicate that Nurses Manuel and Libit were at the Child's bedside between 5:30 and 5:40 a.m. He opined that, because the records noted that the Child was on the ventilator at 5:40 a.m., the apneic event happened sometime between 5:30 and 5:40 a.m. while the

nurses were watching the Child's IV fluid. Nurses then administered bag ventilation until Dr. Adeloye took over.

Ms. Mahoney-Harmon testified consistently with Dr. Wiswell's testimony. Specifically, she opined that the nurses' monitoring of the Child in the nursery between 5:00 and 5:40 a.m. did not violate the standard of care because the nurses timely recognized changes in the Child's condition and responded with appropriate interventions.

5. Verdict

During closing statements, the Child's counsel highlighted that the Mother had been treated at Johns Hopkins Hospital and noted her "reassuring" condition before she left to support the theory that the Child's injury could only have occurred after delivery:

> This is when he goes to Hopkins. The same thing, ladies and gentlemen. They're measuring—they know what to look for. This is a high risk pregnancy at Johns Hopkins Hospital, one of the top hospitals in the country, maybe in the world. She's there.
>
> They know there's risks to [the Child and his twin brother]. They're watching. They're watching carefully. And each and every day; reassuring, reassuring, reassuring, reassuring, reassuring. And this is the time period when they claim [the Child] suffered this catastrophic brain injury. . . . Because the babies were being monitored and the mother was being monitored.
>
> This is the heart rate every day at Hopkins; normal, normal, normal, normal.

In the end, the jury found that the Hospital breached the standard of care in the care and treatment of the Child and that the breach of the standard of care caused the Child's brain injury. The jury awarded the Child $1,189,000.89 for past medical expenses, $32,207,525 for future medical expenses, and $1,373,767 for future loss of earnings, totaling $34,770,292.89. The jury did not award non-economic damages.

6. Hospital's Post-Trial Motions

After trial, the Hospital filed various post-trial motions. In relevant part, it moved for a judgment notwithstanding the verdict ("JNOV") based on similar arguments made in its motion for judgment, *supra*. It also argued that Dr. Malcolm's opinions lacked a sufficient factual basis under the third prong of Rule 5-702. Therefore, it asserted, there was no competent evidence connecting the allegations of negligence to the claimed damages. Separately, the Hospital moved for a new trial, arguing that the court should not have precluded it from offering testimony about the Mother's actions that support its alternative theory of causation. The court denied the motions.

This appeal followed. Additional facts will be introduced as needed in the discussion.

II.

DISCUSSION

To prevail in a medical malpractice negligence action, a plaintiff must prove four elements: "(1) the defendant's duty based on the applicable standard of care, (2) a breach of that duty, (3) that the breach caused the injury claimed, and (4) damages." *Am. Radiology Servs., LLC v. Reiss*, 470 Md. 555, 579 (2020). "Because of the complex nature of medical malpractice cases, . . . [plaintiffs must present expert testimony] to establish breach of the standard of care and causation." *Stickley v. Chisholm*, 136 Md. App. 305, 313 (2001) (citation omitted); *accord Frankel v. Deane*, 480 Md. 682, 699 (2022).

To prove causation, a plaintiff must establish that "but for the negligence of the defendant, the injury would not have occurred." *Barnes v. Greater Balt. Med. Ctr., Inc.*, 210 Md. App. 457, 481 (2013). "Proximate cause" means that a plaintiff must prove with reasonable certainty, or that it is "more likely than not," that a defendant's negligence was a cause of the plaintiff's injury. *Barton v. Advanced Radiology P.A.*, 248 Md. App. 512, 533–34 (2020) (citing *Maryland Pattern Jury Instruction-Civil* 1:14 ("In order to prove something by a preponderance of the evidence, a party must prove it is more likely so than not so.")). Reasonable "[p]robability exists when there is more evidence in favor of a proposition than against it (a greater than 50% chance that a future consequence will occur)." *Weimer v. Hetrick*, 309 Md. 536, 549 (1987) (citation omitted). "Mere possibility exists when the evidence is anything less." *Id.* at 549–50 (citation omitted).

"In a negligence case, a plaintiff has two burdens: First, the threshold inquiry is whether a defendant's conduct produced an injury, or causation-in-fact." *Barton*, 248 Md. App. at 534. "Causation-in-fact concerns the threshold inquiry of 'whether defendant's conduct actually produced an injury.'" *Pittway Corp. v. Collins*, 409 Md. 218, 244 (2009) (citation omitted). "The second being the burden of production, showing that as a matter of law a defendant's conduct caused a legally cognizable injury." *Barton*, 248 Md. App. at 534. "This part of the causation analysis requires us to consider whether the actual harm to a litigant falls within a general field of danger that the actor should have anticipated or expected." *Pittway Corp.*, 409 Md. at 245. "Together, the two burdens establish tort liability." *Barton*, 248 Md. App. at 534.

The Hospital's contentions on appeal center on the first three elements of negligence. First, it argues that the court abused its discretion in admitting Dr. Malcolm's opinion that the nurses breached the standard of care and that the breach caused the Child's injuries. Second, it argues that the court erred in excluding evidence that the Mother's negligence caused the Child's brain injury. We address each issue in turn.

A.

Dr. Malcolm's Testimony

In the context of most medical malpractice cases, we have articulated that, "because of the complexity of the subject matter, expert testimony is required to establish negligence and causation." *Meda v. Brown*, 318 Md. 418, 428 (1990); *accord Reiss*, 470 Md. at 580. To be admissible, expert testimony must satisfy the requirements of Maryland Rule 5-702, which provides:

> Expert testimony may be admitted, in the form of an opinion or otherwise, if the court determines that the testimony will assist the trier of fact to understand the evidence or to determine a fact in issue. In making that determination, the court shall determine
>
> (1) whether the witness is qualified as an expert by knowledge, skill, experience, training, or education,
>
> (2) the appropriateness of the expert testimony on the particular subject, and
>
> (3) whether a sufficient factual basis exists to support the expert testimony.

The third requirement requires an adequate supply of data and a reliable methodology. *Rochkind v. Stevenson*, 471 Md. 1, 22 (2020). Absent either, the opinion is mere speculation and conjecture. *Id.* (citation omitted). Opinions connected to existing data

only by the *ipse dixit* of the expert should be excluded if there is "simply too great an analytical gap between the data and the opinion proffered." *Id.* at 36 (citation omitted).

Appellate courts review a trial court's decision concerning the admissibility of expert testimony under Maryland Rule 5-702 for abuse of discretion. *See id.* at 10. Under this standard, an appellate court does not reverse "simply because the . . . court would not have made the same ruling." *Devincentz v. State*, 460 Md. 518, 550 (2018) (citation omitted). "Rather, the trial court's decision must be 'well removed from any center mark imagined by the reviewing court and beyond the fringe of what that court deems minimally acceptable.'" *Id.* (citation omitted).

The issue raised by the Hospital involves the third requirement of Rule 5-702. The Hospital argues that the circuit court erred in denying its motion to exclude Dr. Malcolm's expert testimony regarding his opinion that the nurses breached the standard of care between 5:30 and 5:40 a.m. by failing to either adequately respond or timely advise Dr. Adeloye of the post-5:30 a.m. hypoxic episode and that the breach caused the Child's brain injury. It contends that Dr. Malcolm's opinion was impermissibly based on the mere fact of the Child's injury and its timing and amounted to guesswork with no factual basis or competent methodology. Therefore, according to the Hospital, the court should have granted the motion, and Dr. Malcolm should not have been permitted to testify regarding this opinion at trial.

1. The Hospital Failed to Preserve its Methodology-Based Objection to Dr. Malcolm's Testimony.

Under Maryland Rule 8-131(a), we will ordinarily not decide an issue "unless it plainly appears by the record to have been raised in or decided by the trial court." The purpose of this rule is to "require counsel to bring the position of his client to the attention of the lower court at the trial so that the trial court can pass upon, and possibly correct any errors in the proceedings." *Chimes v. Michael*, 131 Md. App. 271, 288 (2000) (citation omitted). In the evidentiary context, unless the trial court grants a continuing objection, Rule 2-517(a) requires that an objection "be made at the time the evidence is offered or as soon thereafter as the grounds for objection become apparent. Otherwise, the objection is waived."

"[W]hen a motion in limine to exclude evidence is denied, the issue of the admissibility of the evidence that was the subject of the motion is not preserved for appellate review unless a contemporaneous objection is made at the time the evidence is later introduced at trial." *Morton v. State*, 200 Md. App. 529, 540–41 (2011) (citing Rule 4-323, governing the methods of making objections at a criminal trial); *see Turgut v. Levine*, 79 Md. App. 279, 287 (1989) (explaining that Rule 2-517, which governs the method of making objections in civil cases, is textually identical to Rule 4-323).

In *Morton v. State*, 200 Md. App. 529 (2011), this Court considered whether the appellant's argument in a motion *in limine* was preserved for appellate review when no objection to the testimony had been made at trial on the ground contained in the motion. *Id*. There, in a pretrial motion, Morton sought to preclude the expert testimony of a nurse,

contending that the State had failed to timely identify her as an expert witness, as required by Maryland Rule 4-263(d). *Id.* at 540. The trial court denied the motion and permitted the nurse to testify at trial. *Id.* After conducting voir dire of the nurse, before qualifying her as an expert, Morton objected to her testimony, "arguing that she was not qualified to render an expert opinion regarding the significance of her findings in a pediatric patient"; he did not renew his objection to the testimony based upon the discovery violation. *Id.* On appeal, this Court held that Morton failed to preserve his discovery-related objection to the expert's testimony. *Id.* at 541.

Similarly, in its motion, the Hospital sought to exclude Dr. Malcolm's expert testimony, contending that his opinion failed to satisfy the *third* prong under Rule 5-702 (adequate supply of data and reliable methodology). However, during trial, the Hospital objected to Dr. Malcolm's testimony regarding his qualifications as an expert in the standard of care for nursing, which implicated the *first* prong under Rule 5-702 (whether the witness is qualified as an expert by knowledge, skill, experience, training, or education). The Hospital explained, "He's not a registered nurse. . . . So I object to his being able to offer any opinions on the nursing standard of care in this case."

The court understood the objection to implicate the first requirement under Rule 5-702. The Child's counsel pointed to the Hospital's motion to exclude as indicating that the Hospital had not taken any issue with Dr. Malcolm's qualifications in this regard. In response, the Hospital clarified and acknowledged that "at that point in time" when it filed

the motion, the Hospital was "challenging his methodology" under the third requirement of Rule 5-702.

The Hospital proceeded to argue why Dr. Malcolm was not qualified to testify on the standard of care for nursing under the first requirement of Rule 5-702. The court noted the Hospital's objection "as to that issue"—referring to the first requirement under Rule 5-702—and admitted the doctor as an expert in pediatrics. The Hospital requested a continuing objection each time the Child's counsel asked Dr. Malcolm a question about the standard of care of the nurses, which the court granted. When Dr. Malcolm proceeded to testify regarding his opinions, the Hospital did not renew its methodology-based objection under the *third* requirement of Rule 5-702. Therefore, the objection on this basis is not preserved.

2. The Circuit Court Did Not Abuse Its Discretion in Denying the Hospital's Motion to Exclude Dr. Malcolm's Expert Testimony.

We shall address the Hospital's contention that the court abused its discretion in denying its motion to exclude Dr. Malcolm's expert testimony. In doing so, we are mindful that our review is limited to the information before the court at the time it ruled on the motion. The Supreme Court of Maryland has explained:

> Because we evaluate a trial court's decision to admit or exclude expert testimony under an abuse of discretion standard, our review is necessarily limited to the information that was before the trial court at the time it made the decision. A trial court can hardly abuse its discretion in failing to consider evidence that was not before it.

Abruquah v. State, 483 Md. 637, 656 (2023). In ruling on the motion, the court here had before it only the evidence contained in the exhibits attached to the Hospital's motion, the

Child's opposition to the motion, and the Hospital's reply to the opposition. This included the relevant portions of the deposition testimony of Dr. Malcolm and other witnesses, as well as pertinent medical records.

As mentioned, the third prong of the Rule 5-702 analysis—sufficient factual basis—includes two subfactors: an adequate supply of data and a reliable methodology. *Rochkind v. Stevenson*, 454 Md. 277, 286 (2017).

> To constitute more than mere speculation or conjecture, the expert's opinion must be based on facts sufficient to indicate the use of reliable principles and methodology in support of the expert's conclusions. To demonstrate a sufficient factual basis, an expert must establish that her testimony is supported by both subfactors.
>
> The data supporting an expert's testimony may arise from a number of sources, such as facts obtained from the expert's first-hand knowledge, facts obtained from the testimony of others, and facts related to an expert through the use of hypothetical questions.
>
> * * *
>
> In addition to drawing from an adequate supply of data, an expert must use a reliable methodology to reach her conclusions. To satisfy this prong, an expert opinion must provide a sound reasoning process for inducing its conclusion from the factual data and must have an adequate theory or rational explanation of how the factual data led to the expert's conclusion. We have explained that for an opinion to assist a trier of fact, the trier of fact must be able to evaluate the reasoning underlying that opinion. Thus, conclusory statements of opinion are not sufficient—the expert must be able to articulate a reliable methodology for how she reached her conclusion.

Id. at 286–87 (cleaned up).

"Medical negligence may be proven with both direct and circumstantial evidence." *Frankel*, 480 Md. at 700. In *Meda v. Brown*, 318 Md. 418 (1990), the plaintiff had undergone a breast biopsy while under anesthesia and awoke with an ulnar nerve injury, which affected motor and sensory functions in part of her hand. *Id.* at 421. The plaintiff

sued Dr. Meda, an anesthesiologist, for medical malpractice. *Id.* The trial testimony established that the anesthesiologist not only had a duty to administer anesthesia and periodically monitor vital signs, but also to assure that the patient was properly positioned so as to prevent the application of pressure against certain vulnerable nerves and blood vessels. *Id*.

The plaintiff called two expert witnesses to prove that Dr. Meda was negligent. *Id.* at 424. The first expert could not say whether the plaintiff's ulnar nerve was compressed by contact with the edge of the board, the cushion, the rigid edge of the cushion, or some crease or fold in the covering of the board in the operating room. *Id.* at 427. Nor could he say whether the arm had been improperly positioned at the start of the operation, or properly positioned but improperly secured so that it later rotated to an improper position. *Id.* He testified, however, that it was his opinion within a reasonable degree of medical probability that the injury to the plaintiff's ulnar nerve occurred in the operating room as a result of one of these causes, and that to permit such an injury to happen was not in keeping with the standard of care required of the anesthesiologist. *Id.* The second expert similarly concluded that "there was a deviation from the standard of care in that Dr. Meda failed to adequately protect the ulnar nerve during the procedure." *Id.*

The jury found in favor of the plaintiff. *Id.* at 422. However, the trial judge granted Dr. Meda's motion for judgment notwithstanding the verdict, holding that there was no legally sufficient evidence to support the verdict because the testimony of the plaintiff's

two experts rested upon inferences and thus constituted the kind of *res ipsa loquitur* evidence that was barred in complex medical negligence cases.[13] *Id.* at 420.

The Supreme Court of Maryland disagreed. Preliminarily, the Court noted that the case did not go to the jury on the theory of *res ipsa loquitur*. *Id.* at 422. Instead, the plaintiff offered proof of negligence through two of her experts. *Id.* at 424. The Court explained:

> The closest that this case comes to reliance upon *res ipsa loquitur* is in the inferential reasoning process used by the plaintiff's experts in arriving at their conclusions that Dr. Meda was negligent. [N]either [of the plaintiff's experts] could testify as to the precise act of negligence that caused injury to [the plaintiff's] ulnar nerve. Each doctor, based upon his knowledge of the facts and upon his expertise, concluded that [her] injury was one that ordinarily would not have occurred in the absence of negligence on the part of the anesthesiologist. *This inferential reasoning has a familiar ring to it. It is a major part of the concept of res ipsa loquitur. It is not, however, res ipsa loquitur. Res ipsa loquitur*, as we now utilize that concept in the law of negligence, means that in an appropriate case the jury will be permitted to infer negligence on the part of a defendant from a showing of facts surrounding the happening of the injury, unaided by expert testimony, even though those facts do not show the mechanism of the injury or the precise manner in which the defendant was negligent.

Id. at 424–25 (emphasis added).

[13] *Res ipsa loquitur* (translated as "the thing speaks for itself") simply describes a set of evidentiary conditions that permit, but do not require, a fact finder to infer negligence based upon proof that certain facts are more probable than not. *Norris v. Ross Stores, Inc.*, 159 Md. App. 323, 329 (2004). To rely upon the doctrine successfully, a plaintiff must present evidence of "(1) a casualty of a kind that does not ordinarily occur absent negligence, (2) that was caused by an instrumentality exclusively in the defendant's control, and (3) that was not caused by an act or omission of the plaintiff." *Holzhauer v. Saks & Co.*, 346 Md. 328, 335–36 (1997). If the plaintiff presents evidence as to each of these conditions, and if the jury finds each condition to be more probable than not, the jury may find negligence even in the absence of evidence as to the exact mechanism of injury or the precise manner in which the defendant was negligent. *Tucker v. Univ. Specialty Hosp.*, 166 Md. App. 50, 58–59 (2005).

The Court explained that the plaintiff's experts each "relied in part on circumstantial evidence in reaching his opinion that Dr. Meda was negligent." *Id.* at 427. The Court rejected Dr. Meda's argument that the plaintiff's experts' opinions were based on speculation and conjecture and thus inadmissible because they could not identify with particularity the specific act of negligence and precise mechanism of injury. *Id.* The Court explained, however, that "[n]egligence, like any other fact, can be established by the proof of circumstances from which its existence may be inferred." *Id.* at 428 (citation and internal quotations omitted).

The Court explained the distinction between "an inference [that] may be drawn by an expert with . . . an inference [that] may be drawn by a layman." *Id.* "If this plaintiff had offered no expert testimony, but had simply shown the onset of an ulnar nerve injury to her arm following a breast biopsy, the jury would not have been permitted to infer negligence from the facts alone." *Id.* "In other words, *res ipsa loquitur*—as recognized in Maryland—is simply not available in cases that are of such a complex nature that they require expert testimony." *Tucker v. Univ. Specialty Hosp.*, 166 Md. App. 50, 61 (2005) (citing *Meda*, 318 Md. at 428).

The Court explained that the jurors in *Meda* were not asked to draw an inference unaided by any expert testimony:

> The plaintiff's experts, armed with their fund of knowledge, drew certain inferences from the circumstances. Having examined the testimony of the experts, we conclude that the trial judge did not err in permitting that testimony and allowing the doctors to base their opinions on a combination of direct and circumstantial evidence. The doctors recited in detail the physical facts they considered, and the medical facts they added to the

> equation to reach the conclusion they did. The facts had support in the record, and the reasoning employed was based upon logic rather than speculation or conjecture.

318 Md. at 428 (citations omitted).

Our appellate courts have discussed the principle in *Meda* in subsequent cases. In *Dover Elevator Co. v. Swann*, 334 Md. 231 (1994), the Supreme Court of Maryland clarified the distinction between an inference of negligence made by an expert under *Meda* and the application of the traditional *res ipsa loquitur* doctrine:

> If expert testimony is used to raise an inference that the accident could not happen had there been no negligence, then it is the expert witness, not an application of the traditional *res ipsa loquitur* doctrine, that raises the inference. The expert testimony offered in these "quasi *res ipsa loquitur* cases" differs somewhat from more traditional expert testimony because, instead of testifying that a *particular act* or omission constituted a failure to exercise due care, the expert testifies to the *probability* that the injury was caused by the failure to exercise due care. *See Meda,* 318 Md. at 428. The expert also testifies that the accident ordinarily would not occur unless there was a failure to exercise the appropriate degree of care. Like a *res ipsa loquitur* case, such expert testimony is offered to explain why there is a probability of negligence, which may be inferred from the circumstances of the accident, even though the expert is unable to pinpoint any particular negligent conduct. Although such testimony does not isolate the specific negligent conduct, it does allow the jury to find negligence as the result of the expert's opinion rather than by circumstantial evidence and common knowledge as in the usual *res ipsa loquitur* case.

Dover Elevator Co., 334 Md. at 254. Under *Meda*, the "application of *res ipsa loquitur* is not appropriate in a case which uses expert testimony to resolve complex issues of fact." *Id.*

In *Kennelly v. Burgess*, 337 Md. 562 (1995), the Supreme Court of Maryland cited *Meda* to clarify that an expert might "use the fact of an unsuccessful result in medical

treatment as a basis for an opinion that the physician was negligent." *Id.* at 578. The Court continued: "As we held in *Meda*, an expert, as distinguished from a mere lay witness, may, in appropriate circumstances, rely on an unsuccessful result in concluding that a physician was negligent." *Id.*

In *Tucker v. University Specialty Hospital*, 166 Md. App. 50 (2005), this Court applied the principle in *Meda* to a case involving a patient who had fatally overdosed on pain medication following surgery. In *Tucker*, the patient was admitted to the hospital for wound care and rehabilitation after having undergone surgery at another facility. *Id.* at 54. During her stay at the hospital, she received multiple prescription medications, including oxycontin, a narcotic drug used for pain relief. *Id.*

A nurse assigned to the patient's care administered doses of oxycontin to the patient at 9 and 10 p.m. one evening. *Id.* at 55. When the nurse visited the patient at 6:55 a.m. the next morning, the plaintiff was "sleepy" but "easily arousable." *Id.* The nurse and another nurse counted the narcotics assigned to the patient's room and confirmed that no medication was missing. *Id.* At 7:25 a.m., the patient was found in her room blue, with frothy secretions coming from her mouth. *Id.* The patient was pronounced dead at 8:20 a.m. *Id.* The evidence established that the patient died as a result of a lethal dose of oxycontin. *Id.*

The patient's parents and children brought a medical malpractice claim against the hospital. The plaintiffs' two experts opined that the lethal dose of oxycontin was ingested within about an hour of the patient's death. *Id.* at 56. Addressing the standard of care issue,

one expert acknowledged that he could not determine specifically how the patient got the lethal dose of oxycontin, or who administered it, but he nevertheless expressed his opinion that the hospital breached the standard of care it owed to the patient. *Id.* In this regard, the expert testified that "the patient was under the exclusive control of hospital personnel at the time of her death, and the type of occurrence in a hospital setting, with a toxic level of a narcotic analgesic, should not occur except in a case of negligence." *Id.*

The hospital moved for summary judgment, arguing that, under *Meda*, the expert testimony was insufficient to make out a prima facie case of negligence. *Id.* at 57. The hospital also contended that Maryland law does not permit recovery under the doctrine of *res ipsa loquitur* in medical malpractice cases. *Id.* In granting the hospital's motion for summary judgment, the judge ruled that *Meda* was not applicable. *Id.* The judge further ruled that the plaintiffs were not entitled to have their case submitted to the jury on a *res ipsa loquitur* theory. *Id.*

On appeal, we held that the plaintiffs presented sufficient evidence, including expert testimony, to permit inferences of negligence under the rule enunciated in *Meda*. *Id.* Because these inferences of negligence were permissible from the evidence in the record, it was inappropriate to enter summary judgment in favor of the hospital. *Id.* We reiterated the principles set forth in *Meda* and related cases:

> Although a jury is not permitted to apply a *res ipsa* analysis to infer negligence, unaided by expert testimony, in a complex case, the [Maryland Supreme Court] made clear in *Meda* that a qualified expert may use inferential reasoning in reaching the expert's opinions and conclusions. In other words, in cases requiring expert testimony, experts may testify not only to their understanding of the facts and circumstances, but they may also use

> their knowledge, training, and experience to draw inferences from those facts and circumstances. And the fact that an expert is unable to identify the specific act of negligence or the precise mechanism of injury does not preclude that expert from drawing an inference of negligence from the circumstances. Such an inference may be drawn because negligence, like any other fact, can be established by the proof of circumstances from which its existence may be inferred.

Id. at 61–62 (cleaned up).

In *Frankel v. Deane*, 480 Md. 682 (2022), the patient brought a medical malpractice suit against the oral surgeon who removed her lower and upper wisdom teeth, among other providers. *Id.* at 689–90. She alleged that she suffered permanent loss of feeling in her tongue because the surgeon severed the lingual nerve while extracting her wisdom teeth. *Id.* at 690.

In moving for summary judgment, the surgeon argued that under *Meda*, the "evidence must show the injury is not something that happens in the absence of surgical negligence." *Id.* at 694. He argued that the inference of negligence made by the plaintiff's experts was speculative. *Id.*

The circuit court granted summary judgment. *Id.* at 696. The court interpreted *Meda* as standing for the proposition that, "[i]f the subject injury is a well-known complication or risk of medical or dental procedure and could occur in the absence of any medical or dental negligence on behalf of the surgeon, then an expert opinion upon an 'inference of negligence theory' is not viable or admissible[.]" *Id.* at 710. Citing the plaintiff's signature on the informed consent form from the day of the oral surgery as well as certain medical authorities, the court found "that the conditions that Plaintiff complains of are well known

complications of the procedure Plaintiff underwent and do occur in the absence of negligence by the surgeon." *Id.* Because the court concluded that the injuries allegedly suffered by the plaintiff were known risks that could be realized without negligence on the surgeon's part, it determined that the plaintiff's expert's "inference of negligence" was inadmissible under *Meda*. *Id.*

The Supreme Court of Maryland concluded that the circuit court misapplied *Meda*. *Id.* at 711. It noted that one of the plaintiff's experts in *Meda* testified that the injury suffered by the plaintiff in that case—compression injury to the ulnar nerve—was a well-known risk in the medical profession, but that "the standard of care requires that the arm be positioned and secured in such a manner that nerve compression will not occur." *Id.* at 712 (quoting *Meda*, 318 Md. at 426). The *Meda* plaintiff's experts could not determine precisely how the plaintiff's nerve was compressed—as there were several possible ways it could have happened—but both experts opined that the injury was caused by the defendants' deviation from the standard of care in failing to protect the ulnar nerve during the procedure. *Frankel*, 480 Md. at 712 (citing *Meda*, 318 Md. at 427).

The Court in *Frankel* explained that the plaintiff's theory of negligence substantially tracked the analysis permitted under *Meda*. *Id.* at 713. In *Meda*, the plaintiff's experts applied their medical expertise to infer from the circumstantial evidence that medical negligence caused the plaintiff's injury. Likewise, in *Frankel*, the plaintiff's expert applied his knowledge and experience to infer negligence based on the plaintiff's testimony about her symptoms and another expert's assessment that the lingual nerve was severed. 480 Md.

at 713. Accordingly, the Court concluded that the circuit court mistakenly applied *Meda* in excluding the plaintiff's experts. *Id.*

We return to the case at hand. In its reply brief, the Hospital clarifies that it does not challenge the admissibility of Dr. Malcolm's opinion that the Child's brain injury occurred between 5:30 and 5:40 a.m. Instead, it challenges Dr. Malcolm's opinion, as it did in its motion to exclude, that the nurses acted negligently between 5:30 and 5:40 a.m. by failing to either adequately respond or timely advise Dr. Adeloye of the post-5:30 a.m. hypoxic episode. The Hospital claims that Dr. Malcolm's opinion is based on the "mere fact and timing of an injury," which, by itself, is not evidence of the nurses' negligence. Therefore, according to the Hospital, Dr. Malcolm's opinion was inadmissible *ipse dixit* and was not supported by a sufficient factual basis.

We disagree. During his deposition, Dr. Malcolm testified that he reviewed the medical records, the nurses' notes, and Dr. Adeloye's notes. The notes did not document any events between 5:30 and 5:40 a.m. Dr. Malcolm testified that there was no documentation or other direct evidence that a nurse or Dr. Adeloye was at the Child's bedside during this time, and he could not tell from the notes what the nurses did or did not do in monitoring the Child during that time. Moreover, neither the nurses nor Dr. Adeloye had an independent recollection of caring for the Child over a decade ago. Because he was working with limited information, Dr. Malcolm's opinion about what probably happened was necessarily inferential. Based on the medical record, the notes, and his training and experience as a pediatrician in neonatology, Dr. Malcolm inferred that the nurses violated

the standard of care by failing to properly monitor and respond to the hypoxia in a timely manner. He did not engage in speculation when he drew inferences from the available facts.

The Hospital contends that the evidence indicated that the nurses and Dr. Adeloye were present at the Child's bedside during this critical period. It suggests that, in assessing the admissibility of Dr. Malcolm's opinion under the third requirement of Rule 5-702, the court should have recognized this fact. The Hospital contends that the court erred in accepting Dr. Malcolm's opinion, which contradicts this fact.

Again, we disagree. There was a factual dispute regarding whether the nurses or Dr. Adeloye were present at the Child's bedside between 5:30 and 5:40 a.m. "[A] trial court is not permitted to resolve disputes of material fact in determining whether a sufficient factual basis exists to support an expert's opinion. Doing so is a clear abuse of discretion." *Oglesby v. Balt. Sch. Assocs.*, 484 Md. 296, 333 (2023). As the Supreme Court of Maryland explained in endorsing the view espoused by the committee notes for Federal Rule 702, the federal analogue to Maryland Rule 5-702,

> [w]hen facts are in dispute, experts sometimes reach different conclusions based on competing versions of the facts. The emphasis in the amendment on 'sufficient facts or data' is not intended to authorize a trial court to exclude an expert's testimony on the ground that the court believes one version of the facts and not the other.

Id. (quoting Fed. R. Evid. 702, advisory committee notes to 2000 amendment).

Finally, the Hospital contends the court erroneously interpreted and misapplied the principles in *Meda* and *Tucker*. According to the Hospital, these cases hold that medical experts can infer negligence from an injury's timing "only if" they testify that the injury

ordinarily would not have occurred in the absence of negligence. It contends that, because Dr. Malcolm never testified to this, the principles in *Meda* and *Tucker* do not apply, and therefore his opinion should have been excluded.

Neither *Meda* nor *Tucker* held that medical experts can infer negligence *only if* they testify that the injury ordinarily requires negligence. As the Hospital correctly observes, the plaintiff's experts in *Meda* concluded, based upon their knowledge of the facts and their expertise, that the injury "was one that ordinarily would not have occurred in the absence of negligence on the part of the anesthesiologist." *Id.* at 425. Similarly, in *Tucker*, the plaintiff's experts could not determine specifically how the decedent had obtained the lethal dose of oxycontin, or who had administered it, but explained that "death due to a toxic level of Oxycontin would typically not occur in the hospital setting in the absence of negligence." 166 Md. App. at 56.

Although the experts in both *Meda* and *Tucker* testified in each instance that the respective injuries would not have occurred in the absence of negligence on the part of the medical provider, we do not read these cases to require experts to invoke a specific incantation for their opinions to satisfy the third prong of Rule 5-702. In *Meda*, the "plaintiff's experts, armed with their fund of knowledge, drew certain inferences from . . . a combination of direct and circumstantial evidence." 318 Md. at 428. Because that evidence "had support in the record, and the reasoning employed was based upon logic rather than speculation or conjecture"—in other words, *not* because the experts had testified the injuries would ordinarily have occurred *only* in the case of the defendants'

negligence—the Court concluded that the experts' inference was permitted. *Id.* The teachings of *Meda* merely affirmed the principle that "[n]egligence, like any other fact, can be established by the proof of circumstances from which its existence may be inferred." *Meda*, 318 Md. at 427–28 (quoting *W. Md. R.R. Co. v. Shivers*, 101 Md. 391, 393 (1905)). *Meda* clarified that, when experts in complex medical negligence cases use their training and experience to infer medical negligence from circumstantial evidence, those inferential opinions may satisfy the third prong of Rule 5-702.

Here, Dr. Malcolm's theory of negligence substantially tracked the analysis permitted under *Meda* and its progeny cases. In *Meda*, the plaintiff's experts applied their medical expertise to infer from circumstantial evidence that medical negligence caused the plaintiff's injury. Likewise, Dr. Malcolm used his knowledge and experience to infer negligence based on the medical records and notes of the nurses' actions during the relevant time. *Accord Frankel*, 480 Md. at 713 ("Ms. Deane's expert . . . applied his knowledge and experience to infer negligence based on Ms. Deane's testimony about her symptoms and [another expert's] assessment that the lingual nerve was severed."). Given these facts and circumstances, we cannot say that Dr. Malcolm's opinion that the nurses acted negligently between 5:30 and 5:40 a.m. by failing to either adequately respond or timely advise Dr. Adeloye of the post-5:30 a.m. hypoxic episode was speculative or conjecture. For the

reasons stated, we conclude that the court did not abuse its discretion in denying the Hospital's motion to exclude Dr. Malcolm's opinion.[14]

[14] Along with its claim that the court erred in denying the motion to exclude Dr. Malcolm's expert testimony, the Hospital also asserts that the court erred when it denied the Hospital's motion (1) for summary judgment, based on the inadmissibility of Dr. Malcolm's expert testimony, and (2) for a JNOV. Neither argument is persuasive.

As we have explained in Parts I.E and II.A of this opinion, the court did not err when it denied the Hospital's motion to exclude Dr. Malcolm's expert testimony. Because his testimony was admissible, the court did not err in denying the Hospital's motion for summary judgment on this basis. The trial court has discretionary power when denying a motion for summary judgment. *Webb v. Giant of Md., LLC*, 477 Md. 121, 135 (2021). We will set aside a discretionary decision by the trial court only if the court has abused its discretion. A court abuses its discretion "when the ruling is clearly untenable, unfairly depriving a litigant of a substantial right and denying a just result, when the ruling is violative of fact and logic, or when it constitutes an untenable judicial act that defies reason and works an injustice." *Devincentz v. State*, 460 Md. 518, 550 (2018) (citation omitted). The court's decision to deny the Hospital's motion for summary judgment does not come close to meeting this standard.

Nor did the court err in denying the Hospital's motion for a JNOV. A motion for a JNOV "tests the legal sufficiency of the evidence," *Impala Platinum Ltd. v. Impala Sales (U.S.A.), Inc.*, 283 Md. 296, 326 (1978), and "is reviewed under the same standard as a judgment granted on motion during trial." *Mahler v. Johns Hopkins Hosp., Inc.*, 170 Md. App. 293, 317 (2006) (citation omitted). As this Court has explained,

> [a] party is not entitled to [a JNOV] unless evidence on the issue and all inferences fairly deducible therefrom, when viewed in the light most favorable to the party against whom the motion is made, are such as to permit only one conclusion with regard to the issue. To this end, we must assume the truth of all credible evidence and all inferences of fact reasonably deductible from the evidence supporting the party opposing the motion. If there is any competent evidence, however slight, leading to support the plaintiff's right to recover, the case should be submitted to the jury and the . . . motion for [JNOV] denied.

Id. at 317–18 (cleaned up). Viewing Dr. Malcolm's testimony in the light most favorable to the Child, we conclude that the court did not err when it denied the Hospital's motion for a JNOV.

B.

Mother's Prenatal Conduct

The Hospital argues that the circuit court erred in granting the Child's motion *in limine* to exclude evidence of the Mother's prenatal conduct while pregnant under CJP § 10-910. The Hospital's theory was that it was not negligent at all. It was prepared to call various experts to testify that the Mother's prenatal conduct, including leaving Johns Hopkins Hospital against medical advice and smoking cigarettes and marijuana while pregnant, plausibly contributed to the Child's injuries. The Hospital argues that the court denied it a fair trial because it could not present its complete causation defense or the "full story" of the Child's injury.

The Child responds that the court properly excluded evidence of the Mother's prenatal conduct under CJP § 10-910. Even if CJP § 10-910 did not bar the introduction of evidence of the Mother's alleged prenatal negligence, he argues that the evidence was properly excluded because the Hospital "failed to meet the evidentiary threshold for establishing that [the Mother's] conduct was the proximate cause of [the Child's] injuries." Specifically, he contends that the Hospital's claim that its experts were prepared to testify that the Mother's prenatal conduct plausibly contributed to the Child's injury was not enough to establish that her actions in fact caused his injury.

1. Overview of CJP § 10-910

Prior to 1956, the rule in Maryland was that, "[i]f the child be so young as not to be able to take care of itself, then parental neglect, resulting in injury, may be imputed to the

child." *Graham v. W. Md. Dairy*, 198 Md. 210, 214 (1951); *see Balt. City Passenger Ry. Co. v. McDonnell*, 43 Md. 534, 544 (1876); *United Rys. & Elec. Co. v. Carneal*, 110 Md. 211, 230 (1909); *Caroline Cnty. Comm'rs v. Beulah*, 153 Md. 221, 226–27 (1927). The doctrine involved imputing the negligence of the parent or custodian to one who is too young to be guilty of negligence himself and thus barring recovery by the infant for his injuries. One legal commentator explained the purpose of the doctrine of imputed negligence:

> The doctrine ar[o]se out of an attempt to balance the rights and duties of the infant and the person with whose property he comes into contact. The concept of negligence cases embraces reciprocal rights and duties of the persons involved. The courts recognized, however, that an infant of tender years could not be expected to exercise such, if any, care for his own safety as was required to keep the rights and duties in balance. Therefore, the courts attempted to cast the negligence aspect, where a young infant was injured, in proper balance by imputing to the infant the duty of the parent or custodian to use reasonable care in his custodial undertaking.

Samuel D. Hill, *Imputing Parental Negligence to Bar Recovery by an Infant*, 15 Md. L. Rev. 248, 249–50 (1955). The doctrine applied only "to cases where an infant through his next friend [was] seeking to recover for personal injuries suffered by the infant[,] as distinguished from cases where a parent or guardian [was] seeking recovery for injuries to the infant." *Id.* at 250.

Maryland was in the minority of states that recognized this doctrine. *See* Annotation, *Imputing Negligence of Parent or Custodian to Child in Action by or on Behalf of Child for Personal Injury*, 15 A.L.R. 414 (1921) (minority view). Professor Prosser rejected the doctrine, characterizing it as "a barbarous rule which denie[d] the innocent victim of the

negligence of two persons redress against either[.]" Hill, *supra*, at 249 (quoting William L. Prosser, *Handbook of the Law of Torts* 420 (1941)). The rationale for refusing to apply the doctrine was that an infant "is entitled to protection of the law equally with persons who have attained their majority[.]" *Id.* (quoting 38 Am. Jur. *Negligence* § 240 (1955)). "[T]o refuse [the infant] relief on the ground of his parents' indifference or negligence would be to deny it to him; and that to impute to [the infant] negligence of others is harsh in the extreme, whether the negligence so imputed is that of his parents, their servants, or his guardian." *Id.* (quoting 38 Am. Jur. § 240)

In 1956, the General Assembly abrogated the imputation of negligence from parent to child by legislation. *See* Article 75, § 2, of the Annotated Code of Maryland (1956). Section 2 read:

> In all actions to recover damages, for death, or injury to the person or property of an infant, by or on behalf of an infant, the negligence of the parent or other custodian of the infant shall not be imputed to the infant from the fact of such parenthood or custodianship.

In 1974, the General Assembly recodified the statute as § 10-910 of Courts & Judicial Proceedings, making only stylistic changes to the text. *See* CJP § 10-910, Revisor's Note (1974). The statute now reads as follows:

> In an action on behalf of an infant to recover for death, personal injury, or property damage the negligence of the parent or custodian of the infant may not be imputed to the infant.

CJP § 10-910.

The statute means that the contributory negligence of the parent cannot be imputed to the child to defeat the child's recovery.[15] *See Caroline v. Reicher*, 269 Md. 125, 130 (1973); *BJ's Wholesale Club, Inc. v. Rosen*, 435 Md. 714, 737 n.20 (2013) ("This statute acts only to prevent the doctrine of contributory negligence [of the parent] from being asserted against a minor.").

Significantly, the statute does not "relieve[] a parent of a child of tender years from all supervision over such child." *Caroline*, 269 Md. at 130; *Laser v. Wilson*, 58 Md. App. 434, 445 (1984) ("The statute was not intended to relieve parents from all supervision of a child."). Under the caselaw that has developed since the statute's enactment, one context in which a parent's negligence may bar a child's recovery is where such negligence is the intervening and superseding cause of the child's injury. *See Richwind Joint Venture 4 v. Brunson*, 335 Md. 661, 681 n.8 (1994) (explaining that while a parent's contributory negligence would not be relevant because the contributory negligence of a parent may not

[15] Contributory negligence "occurs whenever the injured person acts or fails to act in a manner consistent with the knowledge or appreciation, actual or implied, of the danger or injury that his or her conduct involves." *Campbell v. Montgomery Cnty. Bd. of Educ.*, 73 Md. App. 54, 64 (1987) (quoting Paul T. Gilbert, *Maryland Tort Law Handbook*, § 11.4.1, at 94 (1st ed. 1986) ("Gilbert")). "Even though the defendant is negligent and that negligence was the major part of the cause of the plaintiff's damages, the plaintiff may not recover if he/she contributed to the happening of the incident." Gilbert § 11.4.1, at 94. "In theory, if the defendant's negligence is 99.99% of the total negligence comprising the incident, and the plaintiff's negligence is .01%, the plaintiff is not, as a matter of law, entitled to recover." *Id.*; *see Wooldridge v. Price*, 184 Md. App. 451, 461 (2009) ("In Maryland, contributory negligence on the part of a plaintiff completely bars recovery against a negligent defendant."). "Contributory negligence is an affirmative defense and the burden of proving the plaintiff's contributory negligence rests upon the defendant." *Batten v. Michel*, 15 Md. App. 646, 652 (1972).

be imputed to the child under the statute, a parent's negligence "can bar recovery," but "[o]nly where such alleged negligence supersedes the defendant's negligence").

The Supreme Court of Maryland has explained the circumstances under which the intervening negligent act of another may be invoked as an affirmative defense to a claim of negligence. "When multiple negligent acts or omissions are deemed a cause-in-fact of a plaintiff's injuries, the foreseeability analysis must involve an inquiry into whether a negligent defendant is relieved from liability by intervening negligent acts or omissions." *Pittway Corp. v. Collins*, 409 Md. 218, 247 (2009).

> [T]he defendant is liable where the intervening causes, acts, or conditions were set in motion by his earlier negligence, or naturally induced by such wrongful act, or omission, or even it is generally held, if the intervening acts or conditions were of a nature, the happening of which was reasonably to have been anticipated, though they have been acts of the plaintiff himself.

Id. at 248 (quoting *Penn. Steel Co. v. Wilkinson*, 107 Md. 574, 581 (1908)). "Liability is avoided only if the intervening negligent act or omission at issue is considered a superseding cause of the harm to the plaintiffs." *Id.* at 248.

An intervening act is generally considered a superseding cause when it is an "unusual" or "'extraordinary' independent intervening" act "that could not have been anticipated by the original tortfeasor." *Id.* at 249. In other words, "[a]n intervening force is a superseding cause if the intervening force was not foreseeable at the time of the primary negligence." *Yonce v. SmithKline Beecham Clinical Labs., Inc.*, 111 Md. App. 124, 140 (1996).

In the context of CJP § 10-910, the Court has stated that "a parent's negligence will be deemed to constitute an 'independent and superseding cause of the child's injuries' in only an 'extraordinary situation.'" *Matthews v. Amberwood Assocs. Ltd. P'ship, Inc.*, 351 Md. 544, 579 (1998) (quoting *Caroline*, 269 Md. at 130). The Court explained:

> That Code section, which prohibits the imputation of a parent's negligence to a child, changed the law of this State. Prior to its enactment in 1956, the rule in Maryland was that: "If the child be so young as not to be able to take care of itself then parental neglect, resulting in injury, may be imputed to the child." While we do not think that Art. 75, [§] 2 [the predecessor to CJP § 10-910] relieves a parent of a child of tender years from all supervision over such child, *we do think that, if that section is to have any meaning, it is only in the somewhat extraordinary situation where the parent's negligence is such as to constitute an independent and superseding cause of the child's injuries, that the dormant negligent act of another is discharged*.

Caroline, 269 Md. at 130 (citations omitted and emphasis added).

In *Caroline v. Reicher*, the Supreme Court of Maryland addressed the statute in the context of whether there was sufficient evidence to give a jury instruction on superseding cause. In that case, the mother rented an apartment and moved in with her three daughters, one of whom was then one year old. 269 Md. at 127. Prior to renting the apartment, the mother inspected the apartment and noted chipped, cracked, and peeling paint. *Id.* After occupying the apartment for about fifteen months, the one-year-old was diagnosed with lead poisoning and suffered permanent injuries. *Id.*

The child and her mother sued the landlord corporation and its individual officers for negligence in maintaining the apartment in an unsafe condition. *Id.* at 128. During trial, mother testified that she never left the child unsupervised and she swept away paint chips daily. *Id.* at 135. Despite efforts by the mother to prevent the child from accessing paint

chips, she observed the child ingest the chips on a few occasions. *Id.* The child's doctor gave uncontroverted expert testimony that young children of a certain age would place non-food substances in their mouths and ingested them covertly in a vast majority of cases and that this child probably had ingested pain chips about the size of a nickel or quarter on the average of two or three times a week for at least three months and probably a year. *Id.* at 134–35.

At the close of their case, the trial court entered directed verdicts in favor of the individual officers but denied the motion as to the corporation. *Id.* at 128. The case was submitted to the jury on the issue of the corporation's liability. *Id.* The court instructed the jury on the mother's acts or omissions as a superseding cause of the child's injury under the statute. *Id.* at 129–30. The mother and child objected to the jury instructions. *Id.* at 129. The jury returned a verdict in favor of the corporation, and the mother and child appealed. *Id.* at 128.

The basis of the mother's and child's objection was that there was insufficient evidence in the case to warrant an instruction that the negligence of the mother could be considered as a superseding cause to relieve the landlord of liability. *Id.* at 130. They argued that, while the instruction correctly stated that the negligence of the parent cannot be imputed to the child, there was insufficient evidence of the mother's superseding negligence to justify giving the instruction. *Id.*

The Court held that the evidence in the case was insufficient, as a matter of law, to establish that the mother's actions constituted independent and superseding negligence. *Id.*

at 131 (recognizing that "the facts of a case may place it in the middleground where the issue of the existence of superseding negligence is properly left for the trier of fact; but some cases are such that they gravitate so close to one or the other of the two poles that resolution of the issue becomes one of law"). The Court suggested that the acts or omissions of the mother in failing to keep a proper lookout for the child were not so unusual or extraordinary as to be unreasonable, and the foreseeable acts or omissions by the mother would be but the normal response to a situation created by the landlord's failure to remedy the paint chip problem. *See id.* at 134–36. Accordingly, the Court reversed and remanded for a new trial. *Id.* at 137.

Other cases before and after *Caroline* are in accord. *See Farley v. Yerman*, 231 Md. 444, 449 (1963) (reversing grant of directed verdict in defendant landlord's favor where, as a matter of law, alleged parent's failure in supervising four-year-old child burned by gas log in apartment was not superseding cause relieving landlord of liability because parent's inability to supervise child at all times is not so unusual or extraordinary and was foreseeable); *Katz v. Holsinger*, 264 Md. 307, 314–15 (1972) (affirming jury verdict in favor of plaintiff child who fell through broken porch railing; Court rejected defendant landlord's claim that mother's failure to supervise child was superseding cause of injury because mother's acts or omissions were not so unusual or extraordinary to be unreasonable and were foreseeable); *Palms v. Shell Oil Co.*, 24 Md. App. 540, 545 (1975) (reversing grant of directed verdict in defendants' favor where allegation of parental negligence in

failing to supervise child who slipped and fell could not be determined as a matter of law, and the issue of superseding negligence should have been left to the trier of fact).

2. The Circuit Court Erred in Excluding Evidence of the Mother's Prenatal Conduct Under CJP § 10-910.

In denying the motion to exclude evidence of the Mother's prenatal conduct, the circuit court relied solely on CJP § 10-910. The court appeared to evaluate whether the proffered evidence sufficed to establish an independent and superseding cause that could operate to bar the Child's recovery under related caselaw. It explained that while

> a parent's negligence could be so severe as to displace the negligence of the underlying tortfeasor[,] those circumstances, as addressed in the case law, are extraordinary and rare. It's only in the somewhat extraordinary situation where the parent's negligence is such as to constitute an independent and superseding cause of the child's injury where that evidence might be admissible. So independent superseding cause, circumstances that are extraordinary and rare. That does not exist in this case.

In other words, the court reasoned that the evidence of the Mother leaving Johns Hopkins Hospital against medical advice and smoking during pregnancy did not rise to the "extraordinary and rare" level necessary to relieve the Hospital of liability. As a result, it concluded that the evidence was inadmissible.

We hold that the court erred in excluding evidence of Mother's prenatal conduct under CJP § 10-910. The statute does not operate as a blanket rule of exclusion of any evidence of alleged parental negligence in a case where a child seeks to recover against a defendant. *See Caroline*, 269 Md. at 130. Instead, the statute prohibits the imputation of a parent's negligence to the child to bar the child's recovery. *See BJ's Wholesale Club, Inc.*, 435 Md. at 737 n.20; *Richwind*, 335 Md. at 681 n.8. Thus, if a defendant seeks to introduce

evidence to establish a parent's contributory negligence to bar the child's recovery, such evidence would be irrelevant. This is because a parent's contributory negligence cannot be imputed to their child. *See Richwind*, 335 Md. at 681 n.8.

As the above cases illustrate, a parent's negligence can, however, bar a child's recovery if the parent's negligence is an intervening and superseding cause of the child's injuries. Thus, if a defendant seeks to introduce evidence of a parent's alleged negligence to establish that the parent's act or omission was an intervening and superseding act, such evidence would be relevant. Notably, in the cases cited above, the admissibility of alleged parental negligence was not at issue; rather, the issue in these cases was whether evidence of parental negligence in a given case was sufficiently superseding (extraordinary and rare) to support a directed verdict (as in *Farley* and *Palm*, *supra*), a jury verdict (as in *Katz*, *supra*), or the giving of a jury instruction on intervening and superseding cause (as in *Caroline*, *supra*). As the Court explained, "the facts of a case may place it in the middleground where the issue of the existence of superseding negligence is properly left for the trier of fact; but some cases are such that they gravitate so close to one or the other of the two poles that resolution of the issue becomes one of law." *Caroline*, 269 Md. at 131.

In this case, the court's reliance on the "extraordinary and rare" language was misguided. The Hospital's defense was not based on the claim that the Mother's prenatal conduct constituted a superseding act or omission that broke the chain of causation stemming from the Hospital's alleged negligence. Therefore, the court's application of this

defense—and by extension the "extraordinary and rare" language—to the proffered evidence was inapt. Moreover, the court erred in assessing the admissibility of the evidence on whether it was sufficiently superseding (extraordinary and rare) in relieving the Hospital of its alleged negligence, rather than under the applicable rules of evidence (i.e., Rules 5-402 and 5-403).

The court compounded the error during trial. Throughout trial, the court reaffirmed its pretrial ruling, indicating that admitting evidence of the Mother's prenatal conduct was barred by the statute because such evidence implicated the Mother's contributory negligence. However, as stated, the Hospital did not seek to introduce evidence of the Mother's prenatal conduct to establish that her contributory negligence barred the Child's recovery. Instead, the Hospital completely denied liability and sought to introduce evidence of the Mother's prenatal conduct to undermine the Child's evidence of causation.

Over the past century, the only cases that have identified what is excluded under CJP § 10-910's prohibition on the imputation of parental negligence have focused on parental negligence that is intervening and superseding in nature. Therefore, the court's reliance on the language used in *Caroline* and associated cases, while inapt, is understandable. In this appeal, we examine what is excluded under the statutory prohibition in a different context. Relatively recent cases in the area of medical malpractice provide helpful guidance.

In *Martinez ex rel. Fielding v. The Johns Hopkins Hospital*, 212 Md. App. 634, 665 (2013), we established for the first time under Maryland law that a defendant in a medical

malpractice case generally may introduce evidence of a non-party's medical negligence to prove that he or she was not negligent or that his or her negligence did not cause the plaintiff's injuries. In *Martinez*, the child, by and through his parents, sued a hospital alleging that, by negligently failing to perform a timely caesarean section, the hospital had caused the child to suffer birth injuries, including cerebral palsy. *Id.* at 643–44. The child's mother, who was ten days overdue, chose to have a natural birth at home with the assistance of a registered nurse midwife. *Id.* at 640. The mother was in labor for over 19.5 hours before the midwife eventually called an ambulance to take the mother to the hospital. *Id.* Ultimately, the baby was not delivered in good health and suffered from cerebral palsy, among other things. *Id.* at 643. The hospital argued that the midwife was solely responsible for the child's injuries. *Id.* at 644.

Before trial, the circuit court granted the child's motion *in limine* to exclude evidence, including expert testimony, about the standard of care for midwives and the midwife's breach of the standard of care in treating the mother. *Id.* at 647–48. The jury found in favor of the child but reduced the jury's award. The child appealed, and the hospital appealed. *Id.* at 639.

This Court reversed, holding that "evidence of both negligence and causation attributable to a non-party is relevant where a defendant asserts a complete denial of liability." *Id.* at 664. We explained that "the [h]ospital was entitled to try to convince the jury that not only was it *not* negligent and *not* the cause of [the baby's] injuries, but that [the midwife] *was* negligent and *did* cause the injuries." *Id.* at 665 (emphasis in original).

Because the hospital's theory was that it was not negligent at all and that the midwife's negligence was instead the cause of the child's injuries, it was entitled to introduce evidence of the standard of care applicable to midwives and the midwife's alleged breach in treating the mother. *Id.* at 666. We further explained that, "[b]y precluding such evidence, the jury was given a materially incomplete picture of the facts, which denied the [h]ospital a fair trial." *Id.* Accordingly, we held that the circuit court erred in excluding evidence of the standard of care applicable to midwives and whether the midwife breached the standard of care in treating the mother. *Id.* at 678–79.

In *Copsey v. Park*, 453 Md. 141 (2017), the Supreme Court of Maryland established that a defendant may generally introduce evidence of a non-party's medical negligence to prove that the non-party's acts or omissions were a superseding cause that broke the chain of causation running from the defendant's negligence. There, a decedent's widow sued a radiologist and several subsequent treating physicians, alleging that they had failed to diagnose the medical conditions that led to her late husband's fatal stroke. *Id.* at 152. The radiologist argued that he was not negligent and that, even if he was, the medical negligence of the subsequent treating physicians was a superseding cause of the decedent's injuries. *Id.* at 153.

Before trial, the plaintiff dismissed her claims against all the treating physicians, except the radiologist and his employer. *Id.* at 152–53. The circuit court denied the plaintiff's motion *in limine* to prevent the radiologist from introducing evidence that the

negligence of the subsequent treating physicians was a superseding cause of the claimed injuries. *Id.* at 153.

At trial, the evidence was that, in the days after the radiologist was alleged to have negligently failed to diagnose blockages in the patient's vertebral arteries, the patient's condition continued to worsen significantly. *Id.* at 151–52. While hospitalized, he exhibited symptoms of a stroke, and an MRI suggested an acute infarction (an obstruction of the blood supply) in the brain. *Id.* at 151. Despite the concerning MRI results, the patient was released from the hospital. *Id.* at 150. When the patient returned home from the hospital, he suffered a stroke. *Id.* at 152. His wife took him back to the hospital, where he was diagnosed with having multiple acute brainstem and cerebellar strokes. *Id.* His condition continued to deteriorate, and he died three days later. *Id.*

A number of experts, including one of the plaintiff's experts, testified that the subsequent treating physicians had breached the standard of care by failing to communicate with one another and the patient about the disturbing results of the new MRI scan. *Id.* at 154–55. One expert testified that, because of the negligence of the subsequent treating physicians, the decedent did not receive the emergency treatment that would have saved his life. *Id.* at 155. Instead, he was released from the hospital, unaware of his condition, and he suffered a stroke at home. *Id.*

The jury found that the radiologist did not breach the standard of care. *Id.* at 156. The Supreme Court of Maryland affirmed, explaining that "a defendant generally denying liability may present evidence of a non-party's negligence and causation as an affirmative

defense." *Id.* It held that a physician could introduce evidence of a non-party's medical negligence to prove "that he was not negligent and that if he were negligent, the negligent omissions of the other three subsequent treating physicians were intervening and superseding causes of the harm to the patient." *Id.* at 156–57. The Court explained that "[e]vidence of a non-party's negligence was relevant and necessary in providing [the radiologist] a fair trial; [and that] the potential prejudice did not outweigh the probative value of the evidence." *Id.* at 156. The Court also held that "causation was an issue for the jury to determine." *Id.*

As stated, in this case, the Hospital's defense was that it did not cause the Child's injury and that the Mother's acts or omissions did cause or at least contribute to the Child's injury. The question becomes whether CJP § 10-910 precludes a defendant from introducing evidence of alleged non-party negligence when the plaintiff is a child and the allegedly negligent non-party is the child's parent.

We hold that the Hospital is not precluded from presenting such evidence solely because the allegedly negligent non-party happened to be the Child's parent. Consistent with the teachings in *Martinez*, the Hospital is entitled to try to convince the jury that not only was it not negligent and not the cause of the Child's injury, but that a non-party—the Mother—was negligent and did cause the injury. *See* 212 Md. App. at 665. By excluding such evidence under CJP § 10-910, the court permitted the jury to be given a materially incomplete picture of the facts and thereby denied the Hospital a fair trial. *Id.* at 666; *id.* at 673 ("[W]hen a defendant asserts a complete denial of liability, the jury *should* be made

aware of an alleged non-party tortfeasor, in order to provide a complete story to the jury." (emphasis in original)).

The Hospital's entitlement to present evidence of the Mother's potentially causative role in the Child's condition immediately before birth is not a circumvention of the statute, which, in light of its legislative history, was intended to prevent actors who had negligently harmed children from escaping liability on the ground that the child's parent was contributorily negligent. The purpose of the Hospital's evidence—to show that it did not cause the injury in question and that someone and/or something else did—supports a theory of alternative causation that is distinguishable from the affirmative defense of contributory negligence that would bar the claim.

Decisions by courts in other jurisdictions, though scant, are instructive. In *Vaughan v. Saint Francis Hospital*, 815 N.Y.S.2d 307 (N.Y. App. Div. 2006), a mother brought her 26-month-old son to the emergency room at Saint Francis Hospital for vomiting, fever, and slight listlessness. *Id.* at 308. A physician's assistant examined the child, diagnosed the child with a "viral syndrome," and discharged the child without being seen by a physician. *Id.* at 308–09. The discharge directions provided, in relevant part, that the child should "[r]eturn for increased fever, vomiting"; that "[i]f symptoms worsen, return immediately"; and that the child be seen by his pediatrician the next morning. *Id.* at 309 (alterations in original).

The mother did not take the child to the pediatrician the following day. *Id.* The child next received medical care when he was brought back to the emergency room at the

hospital a few days later. *Id.* At that time, the child had a fever, was vomiting, and had seizures. *Id.* A physician examined the child and transferred the child to another medical center. *Id.* The child was diagnosed with bacterial meningitis, which caused him to suffer various severe injuries, including brain damage, spastic quadriparesis, and cortical blindness. *Id.*

The mother, acting on the child's behalf, filed a medical malpractice action against the hospital and other individuals. *Id.* The hospital answered the complaint with the defense that any damages should be diminished by the mother's culpable conduct. *Id.* The mother moved to preclude any evidence regarding "parental negligence and redact[] any references to parental negligence from any documents," including not permitting the hospital's emergency room discharge instructions into evidence. *Id.* (alterations in original).

The hospital argued that the discharge instructions were vital to its defense, which was premised in part on the assertion that the appropriate standard of care included discharging the child with the instructions provided. *Id.* The trial court granted the motion seeking to preclude all evidence of parental negligence but denied the request to preclude the hospital's discharge instructions because it was relevant and necessary to rebut the mother's contention that the hospital was negligent in providing inadequate discharge instructions. *Id.*

Thereafter, the mother withdrew the allegation of inadequate discharge instructions and moved to renew her motion to preclude the hospital's discharge instructions as well as any evidence regarding the instructions. *Id.* The trial court granted the renewed motion and

held that the hospital and third-party defendants were precluded from offering the discharge instructions into evidence or referring to them in any way at trial. *Id.* In excluding the evidence, the trial court relied on the General Obligations Law § 3-111, an analog to CJP § 10-910, which provides that "[i]n an action brought by an infant to recover damages for personal injury the contributory negligence of the infant's parent or other custodian shall not be imputed to the infant." *Id.* at 310.

On appeal, the Supreme Court, Appellate Division of New York, held that the trial court erred in its application of § 3-111. *Id.* at 310. It explained that, under the statute, "[w]hat a defendant cannot do (if found to have breached a duty that was a proximate cause of a child's injuries) is attempt to use a parent's negligence to reduce the child's damages." *Id.* at 311. However, "alleged acts or omissions of a parent may, in some circumstances, be relevant to present a coherent and complete case to the jury on whether a breach of duty by defendant occurred." *Id.* at 310 (citing *Akins v. Sonoma Cnty.*, 430 P.2d 57, 64 (Cal. 1967) ("While it is true that the negligence, if any, of parents is not imputable to the child in an action by the latter for injuries, such negligence may nevertheless be relevant in determining whether a third person is liable for such injuries." (internal citation omitted))). The appellate court explained that "[p]recluding the hospital's discharge instructions from evidence prevents the hospital from attempting to show that it satisfied the standard of care that its expert will testify applies." *Id.* at 311. This preclusion "significantly undercut[] the primary theory of the hospital, i.e., that discharging the child with specific instructions to the parent fell within the acceptable standard of care." *Id.* at 310.

Vierregger v. Robertson, 609 N.W.2d 409 (Neb. 2000), presented a scenario in a different procedural context: whether the parent was entitled to a cautionary jury instruction regarding the imputation of parental negligence in a medical malpractice case. In that case, the mother, who had maternal diabetes, was pregnant with her second child. *Id.* at 411. The mother's doctors instructed her to test her blood sugar level four times a day and to record the results in a logbook to monitor her condition. *Id.* To lower the mother's glucose level, they also adjusted her insulin usage, put her on a calorie-restricted diet, and referred her to diabetes educational classes. *Id.*

The mother was fairly consistent about measuring her blood sugars as instructed and brought her logbook for the doctors' review to all of her examinations except one. *Id.* Her day-to-day readings from mid-June until the baby's delivery at the end of September fluctuated, and very high readings occurred every few days. *Id.* at 412. These high readings were very serious and were potentially dangerous for the baby. *Id.*

When the mother was admitted to the hospital, labor was induced. *Id.* During delivery, the baby's shoulder became stuck against the mother's pelvis, which required the doctor to reach in and grab an arm and maneuver the baby out of the vagina. *Id.* The child suffered injuries, including significant and permanent injury to his right arm. *Id.*

The parents filed a lawsuit against the doctors for negligently treating the mother during her pregnancy and in delivering the child. *Id.* Before trial, the parents moved to exclude any evidence related to possible contributory negligence on the mother's part. *Id.*

Although the doctors did not plead contributory negligence as a defense, the trial court sustained the motion. *Id.* at 412–13.

At trial, the doctors offered evidence that their care of the mother and delivery of the child met the standard of care and that while the injury was caused by shoulder dystocia, the delivering doctor did not "ha[ve] anything to do with that." *Id.* at 413. After receiving various instructions, the jury found in favor of the doctors. *Id.* The parents appealed, claiming, among other things, that the court should have instructed the jury that the negligence or acts or omissions of the parents cannot be imputed to the child. *Id.*

Notably, the Court of Appeals of Nebraska recognized that evidence introduced at trial "regarding [the mother] and things which she did or did not do which had a causative role in the baby's condition immediately before birth" "was necessarily admitted," but not to support a defense of contributory negligence, which the doctors did not raise. *Id.* at 416. Instead, the evidence was introduced "for other reasons, for example, to establish the medical conditions that [the doctors] were treating and the risks posed to the baby." *Id.* Examples of such evidence included "references to [the mother's] weight (a risk factor for macrosomatia) and testimony regarding her consistency in testing her blood sugar at home." *Id.* The Court of Appeals noted that "[t]he evidence was not offered to intentionally blame" the mother for the child's injury. *Id.*

In light of this evidence, the Court of Appeals held that the requested jury instruction should have been given. *Id.* In its reasoning, the court articulated the tension between the defendant's right to present a defense based on lack of proximate cause—not based on

contributory negligence—and the possibility that the jury might misuse the evidence of the mother's negligence:

> [I]t is readily apparent that in this factual setting, some jurors may well have trouble finely differentiating between the mother's actions or inactions which admittedly impact the fetus and how the doctors were duty bound under the applicable standard of care to properly handle the mother's predelivery care and the child's birth process. The jury must differentiate during its consideration of proximate cause. The mother's weight and diabetes has a natural tendency to become connected with the baby's injury in the minds of some jurors, even though the defense has not even made such a contention. The cautionary instruction sought would guard against a decision on an improper basis and could not have been harmful to the defense which did not assert contributory negligence. Even though contributory negligence was not raised as a defense, the evidence was such that [the mother's] conduct was prominent enough in the evidence that the jury could easily become distracted from its effort to answer the real question presented by this case, which was whether [the doctors] were negligent and whether any such negligence proximately caused [the child's] injury. The requested jury instruction should have been given, and its absence adversely affected the substantial rights of [the child].

Id.[16]

Martinez, as well as other cases discussed above, support our conclusion that the evidence regarding the Mother's prenatal conduct was relevant to the Hospital's theory that it did not cause the Child's injury and that the Mother's acts or omissions did cause or at least contributed to the Child's injury. The Hospital did not offer the evidence to support a defense of contributory negligence to bar the Child's claim, and thus, it did not fall within the scope of CJP § 10-910's prohibition. For the reasons stated, the court erred in excluding

[16] *See also Copsey*, 453 Md. at 162 (endorsing the use of cautionary instructions to jury to avoid improper inference and prejudice). The court in this case gave the following cautionary instruction to the jury: "A minor cannot be held responsible for the negligence of the minor's parents, guardian, or custodian."

evidence of Mother's prenatal conduct on the basis that such evidence was precluded under CJP § 10-910. Because the error permeated the trial, as we recounted in Part I.G of this opinion, we vacate the court's judgment and remand this case for a new trial.

3. Admissibility of Expert Testimony Regarding the Mother's Prenatal Conduct

We are careful to constrain our holding to the issue before us, that is, whether the court erred in relying on CJP § 10-910 to exclude evidence of the Mother's prenatal conduct. The Hospital's entitlement to present relevant evidence of a non-party's negligence does not mean that the experts' testimony the Hospital seeks to introduce regarding the Mother's prenatal conduct *must* be admitted. Indeed, the court must function as the gatekeeper in determining the admissibility of expert testimony.

As noted earlier, the Child argues that, even if CJP § 10-910 does not bar the introduction of evidence of the Mother's alleged prenatal conduct, the testimony of the experts the Hospital wanted to call failed to meet the evidentiary threshold for establishing that the Mother's conduct was the proximate cause of the Child's injuries. Specifically, he contends that these experts could not testify that the Mother's prenatal conduct caused the Child's injury to a reasonable degree of medical probability and, therefore, that such testimony should be excluded.

In its reply brief, the Hospital responds that its right to defend itself with plausible alternative causes does not require proof of each alternative to a reasonable degree of medical probability. Instead, the opinion of an expert as to the probability, or even the possibility, of the cause of a certain condition may assist the jury, and that proof of a

possible causal relationship is admissible if there is other evidence introduced at trial that allows the fact finder to determine the issue.

We are unable to address these arguments because when the court granted the Child's motion *in limine* to exclude evidence of the Mother's prenatal conduct, it decided the question solely on the application of CJP § 10-910 and not on the Child's alternative ground regarding the admissibility of the experts' testimony. *See Rochkind*, 454 Md. at 285 ("[T]he admissibility of expert testimony is a matter largely within the discretion of the trial court." (citation omitted)). Accordingly, we leave those determinations for the court's review on remand.[17]

III.

CONCLUSION

We hold that the circuit court erred in granting the Child's motion *in limine* to exclude evidence of the Mother's prenatal conduct based on CJP § 10-910. Accordingly, we vacate the court's judgment and remand the case for a new trial consistent with this opinion. On remand, the court will have the discretion to determine whether the expert testimony the Hospital seeks to present is admissible. Such discretion will include, but is not limited to, permitting additional briefing and hearing on the matter.

[17] The Child claims that the court expressed skepticism regarding the deposition testimony of one expert, Dr. Karotkin, who indicated that the Child would not have suffered the injury if the Mother had not discharged herself from Johns Hopkins Hospital. However, the court's assessment of this expert's testimony was in connection with its ruling on a different motion—the Hospital's motion for summary judgment based on the Mother's prenatal conduct, which is not before us.

We further hold that the court did not abuse its discretion in denying the Hospital's motion to exclude Dr. Malcolm's expert testimony that the nurses acted negligently between 5:30 and 5:40 a.m. by failing to either adequately respond or timely advise Dr. Adeloye of the post-5:30 a.m. hypoxic episode.

JUDGMENT OF THE CIRCUIT COURT FOR BALTIMORE CITY VACATED; CASE REMANDED FOR FURTHER PROCEEDINGS CONSISTENT WITH THIS OPINION. COSTS TO BE DIVIDED EQUALLY BETWEEN THE PARTIES.