Circuit Court for Harford County
Case No. C-12-CV-22-000283

UNREPORTED*

IN THE APPELLATE COURT

OF MARYLAND

No. 2218

September Term, 2023

ESTATE OF LINDA KAY NEWTON, ET AL.

v.

HALEEMA JAVID, M.D., ET AL.

Nazarian,
Tang,
Kehoe, S.,

JJ.

Opinion by Nazarian, J.

Filed: May 22, 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 persuasive value only if the citation conforms to Maryland Rule 1-104(a)(2)(B).

Linda Newton died at Harford Memorial Hospital ("Hospital") after falling into septic shock. Her estate ("Estate") alleges that she died as a result of malpractice on the part of a radiologist, Haleema Javid, M.D., who read an x-ray taken when she presented to the Hospital with abdominal pain. The Estate filed a medical malpractice claim against Dr. Javid and the Hospital in the Circuit Court for Harford County and, after discovery, sought to offer an expert opinion on the issue of causation, *i.e.*, that Dr. Javid's failure to refer Ms. Newton immediately for surgery caused her to develop sepsis that increased her risk of death. After a hearing, the circuit court granted the Hospital's and Dr. Javid's motions to exclude the expert's testimony and, as a result, their motions for summary judgment. The Estate appeals these rulings, and we affirm.

I. BACKGROUND

Ms. Newton was sixty-six years old at the time of her death on October 21, 2020. She had been diagnosed a few months earlier with Stage IV uterine cancer. She died from sepsis that appears to have resulted from a perforation in her descending colon. Surgeons repaired the perforation after it was identified, but the question is whether that perforation, or at least the possibility of a perforation, should have been identified earlier and, if it had, whether earlier surgery might have prevented her from developing sepsis.

A. Medical History

Ms. Newton first presented to the Hospital's emergency department on October 19, 2020, complaining of abdominal pain. The medical team conducted a computerized tomography ("CT") scan that ruled out a small bowel obstruction. They administered pain

medication and sent her home with instructions to follow up with her healthcare providers and to return if her symptoms worsened.

Ms. Newton returned to the Hospital early in the morning on October 20, complaining again of abdominal pain. The emergency department ran a series of tests and discharged her again with instructions to return if she suffered severe pain, nausea, vomiting, fever, chest pain, or shortness of breath.

Shortly after returning home, Ms. Newton passed out in her son's arms and returned to the Hospital by ambulance. It is this third visit that is the focus of the lawsuit before us. After she re-arrived at the Hospital, she underwent a series of tests, most notably an abdominal x-ray. Providers ordered this x-ray at 6:45 a.m. which, when read an hour later, revealed gas-filled loops of colon and small bowel and suggested Ms. Newton may have had an ileus or enterocolitis. The medical team placed a nasogastric tube in Ms. Newton's nose at 8:20 a.m.[1] and ordered another abdominal x-ray to confirm that the tube tip was in her stomach. At 10:07 a.m., Dr. Javid reviewed the x-ray and confirmed the placement of the nasogastric tube, but didn't make any other significant findings.

The tube dislodged sometime later, and the medical team placed a new tube in Ms. Newton's nose. At 11:17 a.m., providers performed another abdominal x-ray to confirm the location of the new tube. Dr. Javid reviewed this x-ray at 11:33 a.m., confirmed the tube tip's location, and noted "lucency below the bilateral hemidiaphragm," which "may

[1] We did not see this exact time noted in the record, however, neither party disputes that this is the time of Ms. Newton's first nasogastric tube insertion.

represent free intraperitoneal air." A minute later, Dr. Javid created an addendum to her reading of the previous x-ray to add a notation that "there is lucency below the bilateral hemidiaphragm[,] which may represent free intraperitoneal air." This reading led to a "stat" abdominal and pelvic CT scan at 11:53 a.m. A physician read the scan at 12:13 p.m., which revealed "[i]nterval development of gross pneumoperitoneum with decompression of the colon and fluid and heterogenous debris in the abdomen suggesting colonic perforation." The medical team then requested a surgical evaluation.

A half-hour later, Ms. Newton went into septic shock. The anesthesiologist conducted a pre-anesthetic evaluation at 1:00 p.m. then transferred Ms. Newton to the operating room for an exploratory laparotomy. Anesthesia began at 1:41 p.m., and the surgery itself began at 2:14 p.m. and ended at 4:37 p.m. Although the surgeons were able to perform the necessary repairs, Ms. Newton's septic shock continued. The surgeons also discovered, given her advanced uterine cancer, "ischemic markings of the terminal ileum (*i.e.*, the final segment of the small bowel), which was likely crushed by the uterus in the pelvis causing localized areas of ischemia spanning over 15 cm." The medical team transferred Ms. Newton to the intensive care unit, where her condition continued to deteriorate, and she died the following day.

B. Procedural History.

Ms. Newton's estate filed suit, alleging medical malpractice against the Hospital and Dr. Javid. There are no issues about the validity of the pleadings or discovery—this appeal turns on the circuit court's decision to grant Dr. Javid's and the Hospital's motions

to exclude the testimony of the Estate's proffered expert, Dr. Karen Jubanyik, and for summary judgment. In addition, there does not appear to be any dispute about the standard of care or whether it was violated. The only question is whether Dr. Jubanyik should have been permitted to testify on the issue of causation, and specifically the causal link between Dr. Javid's delay in discovering free air on the x-ray—and, in turn, the initiation of surgery—and the onset of sepsis and septic shock.

Dr. Jubanyik is a board-certified emergency medicine physician who trained at Yale School of Medicine and serves both as an associate professor in the Department of Emergency Medicine at the Yale School of Medicine and as an attending physician in the Yale New Haven Hospital Emergency Department. Her experience includes treating patients who present to emergency departments with suspected bowel perforations and the need to respond immediately. She isn't a radiologist or a surgeon, and she acknowledged that a surgeon would make decisions about treatment and interventions and that she would have to defer to a surgeon on the question of when surgery should have occurred had a perforation been identified earlier.

The Estate offered Dr. Jubanyik as an expert to opine on causation, specifically that Ms. Newton's death was caused by undergoing surgery for a bowel perforation while in a state of septic shock. Had Dr. Javid read the second x-ray at 10:07 a.m. to indicate a potential bowel perforation, Dr. Jubanyik opined, Ms. Newton would have gone into surgery before developing sepsis. Thus, according to Dr. Jubanyik, the ninety-minute delay was a cause of Ms. Newton's death. She offered this opinion in greater depth in her

deposition:

> Q. Can you tell me your causation opinions in this case and then we'll go back through and break them down and go through them all together.
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> A. Sure. So the causation, so the patient came to the emergency department at approximately 6:30 in the morning on the 20th of October 2020 after having a syncopal episode and vomiting while trying to go back up her stairs after an overnight emergency department visit. And so she arrived with stable vital signs. Her physical exam, other than her abdomen, but in terms of her cardiac, her lung, her neurologic status was all recorded by multiple people as good, very good.
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> So the main issue here is that on the third X-ray if it was noted by the radiologist that there was free air under the diaphragm, so pneumoperitoneum we call it. And that was read by Dr. Javid, and that apparently prompted Dr. Javid to go back and look at the second X-ray, which she had also read as normal at 10:07. That X-ray that had been done at about 8:30 wasn't read until about 10:07, but was read as normal.
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> And then at 11:30 after the third X-ray, she went back, he or she it appears went back and noted that, and wrote an addendum that there was actually free air on that second X-ray that wasn't present at the first X-ray when the patient first arrived.
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> [T]he hour and a half delay until about 11:30, that was a time during which there was obviously a decent-sized hole in the sigmoid colon that was allowing air to accumulate under the diaphragm, which was the indicator. And that amount of time that the patient sat there with basically stool, you know, because the sigmoid—sorry, transverse colon.
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> So this is relatively distal in the colon, so that's pretty feculent material and a significant rent in that transverse colon allowing a lot of stool to go into the peritoneum. . . .
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> It's kind of like if you had a hole in your basement, your sewage pipe, you know, would you like a big hole in your sewage pipe pumping sewage into your basement for an extra hour and a half when you have to clean out your basement after

a flood.

So that's the—so I base, I primarily base my causation opinions on that she was stable when she got there. She was stable for hours based on labs, vital signs, physical examination, and during that time that delay got her to the point where by the time she went to the operating room, she was unstable.

And when you look at the people who didn't survive in this paper, the people who didn't survive were people who were in septic shock by the time they went to the operating room. . . .

* * *

Q. Sure. So can you explain to me how the 90 minutes essentially caused this patient to die?

A. Well, she had 90 extra minutes of stool pumping into her peritoneum, and she arrived stable. . . . You know, the rest of her labs, her white count, everything that you could look at show that she was stable when she arrived and that she—and that in an hour and a half with a transverse colon hole pumping out stool into her peritoneum, an hour and a half is a big deal.

* * *

Q. . . . What's the basis that the perforation and that 90 minute delay caused the patient's death?

A. Because as I said before, she came in, she was hemodynamically stable, her labs were stable. She was on all aspects of physical exam showed stable organ system function, and she declined while waiting for surgery. And as soon as they realized what was wrong, they did rush her immediately to the operating room because that is the treatment when somebody has, their source control issue is a hole in the distal colon that's significant enough to pump out stool. . . . Feculent matter in the peritoneum makes people very sick very fast. And an extra hour and a half is an unnecessary delay.

Q. So at what point in time could surgery or interventions have been performed to prevent this patient's death?

A. Well, all evidence points to the fact that needing to be in the operating room before septic shock, because once somebody's in septic shock their odds ratio of dying is over 3. It's like 3.2, so you have a 3.2 heightened chance of dying if they're in septic shock once they go to the operating room.

* * *

> So this odds ratio means that once you exclude for other factors, if you go to the operating room already having experienced septic shock your chance of death is 3.2 times your chance of death if you had been operated on before going into septic shock.
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> So had . . . at 10:07 had the radiologist correctly read the film as showing free air, she would have been in the operating room . . . before she was in septic shock, which was at 12:42, you know, give or take. But that's the basis for my opinion.

Dr. Jubanyik grounded her opinion about the odds ratio—the increased chance of death from waiting—in a study about abdominal surgeries in cancer patients. And at bottom, she opined that the time that elapsed between the reading of the second x-ray (at 10:07 a.m.) and the third (at 11:33 a.m.) caused Ms. Newton to go into septic shock before she underwent surgery.

At other parts of her deposition, though, Dr. Jubanyik admitted that she couldn't say what a surgeon would or would not have done if notified ninety minutes earlier about the possible perforation. She recognized that there likely would be disagreements among surgeons and acknowledged that her role as an emergency physician would be to get a surgeon involved as soon as possible and, importantly, that the surgeon would decide whether and how to intervene. She also acknowledged that the mortality rate for each person depends on a number of variables: "[E]very patient is different. It depends on how big the perforation is. It depends on where the perforation is. It depends on how fast the perforation is developing. It depends on a lot of things." When asked if she could analyze those variables in Ms. Newton's case, she couldn't. And she conceded as well that bowel ischemia could cause sepsis and offered only her generalized "medical opinion" ruling out

the bowel ischemia found in Ms. Newton during surgery as the cause of her sepsis.

The Hospital and Dr. Javid filed motions to preclude Dr. Jubanyik's testimony and for summary judgment (and they'd be entitled to summary judgment as a matter of law if the Estate lost its expert). They argued that under Maryland Rule 5-702(1), Dr. Jubanyik wasn't qualified to render causation and that the causation opinion she offered was inadmissible under Rule 5-702(3) and the *Daubert*/*Rochkind* standard. After hearing argument, the circuit court agreed with the Hospital and Dr. Javid and granted the motions. The court agreed with both defense arguments, concluding that Dr. Jubanyik lacked the expertise to opine about Ms. Newton's survival chances had the second x-ray been read to show air ninety minutes earlier and that Dr. Jubanyik's opinion lacked a sufficient factual basis or reliable methodology:

> Here's my opinion. The admissibility of expert opinion is controlled as everybody has argued here by Maryland [R]ule 5-702 and the case law addressing *Daubert* and *Rochkind*. Under Maryland [R]ule 5-702, it's the Court's role to determine one, whether the witness is qualified as an expert by knowledge, skill, experience, training, or education. Here, clear to the Court that Dr. Jubanyik has extensive experience as an emergency room technician and has experience with dealing with patients who have perforated colon and the complications of having a perforated colon. She has had experience with patients that are taken on an emergency basis to surgery for a perforated colon, so she certainly has the experience that would aid the jury in understanding the severity of having a perforated colon and the potential of developing septic shock, and the consequences of that condition.
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> She is being offered, however, as a causation expert who will specifically opine that had Ms. Newton's bowel perforation been detected at 10:07 and the second x-ray was signed and reviewed, instead of 90 minutes later, her bowel perforation would have been treated 90 minutes earlier which would have

prevented the onset and worsening of septic shock and she would not have died. Dr. Jubanyik is not a surgeon, nor is she involved with the treatment of patients after a patient is handed over to a surgeon nor does she have the experience following patients after a patient is turned over to a surgeon and the decision making that goes on to determine at what point surgery is to be performed. While she certainly can testify that in her experience, patients had been moved to surgery quickly, she does not have the expertise to opine that had the x-rays been read differently 90 minutes earlier, Ms. Newton would have survived. Thus, she cannot offer her opinion.

Moreover, Maryland [R]ule 5-702 also requires two other prongs to be met. Number two, the second prong, is the appropriate[ness] of the expert testimony on a particular subject. Here, if she had the experience and training for it, the testimony would be appropriate and helpful to the jury. The third prong, however, is problematic, whether sufficient factual basis exists to support the expert testimony[,] which includes a sufficient factual basis that is having adequate data, and number two, a reliable methodology [for] analyzing the data. *Rochkind* and its adoption of *Daubert* provide factors for the Court to consider when determining—what to consider when determining the admissibility of expert testimony. The *Rochkind* Court added several overarching items of guidance in adopting the *Daubert* standard. The reliability inquiry is flexible, so it's not rigid. Trial courts must focus solely on principles and methodology and not on the conclusions that they generate, although they are not entirely distinct, and thus, a trial court may consider the relationship between the two. A trial court need not admit any opinion evidence that is connected to existing data only because the expert said so. Rather, a Court may very well find that there is simply too great of an analytical gap between the data and the opinion offered. All of the Daubert factors are relevant in the reliability inquir[y], but not necessarily all of them dispositive. Some may apply, and others may not, and Rochkind did not up-end the trial court's gatekeeping function.

* * *

In looking at the factors here, number one, rather theory can be or has been tested, there are no studies that the expert is relying on that establish how soon surgery has to occur. The theory of

sooner is better is a theory, but it is not quantified with any data that has been offered to the Court. Certainly, the expert has experience in having patients moved on to emergency surgery, but even in her deposition, she did not provide any specifics as to how soon and what else was going on with the patient.

Number two, whether the theory or technique has been subjected to peer review and publication. The Cauley article is not an article that addresses timeline for surgery. As I noted earlier, it is an article written with the goal of improving a surgeon's ability to prognosticate patient[s'] outcomes and inform pre-operative conversations about treatment preferences and palliative care. It does not address at all a timeline, and Dr. Jubanyik acknowledges that in her deposition. The article provides some statistics about 34 percent of patients dying within 30 days who have certain conditions[,] including septic shock, and 66 surviving, but no breakdown as to the overall conditions these patients had when they arrived, survived, and at what point during surgery the surgery was actually performed. The other article that was included in the plaintiff's opposition is a sampling of 117 patients from a study related to morbidity and mortality after surgery for intestinal perforation, but that article does not discuss the timing of surgery, nor does the study focus on patients with advanced cancer like Ms. Newton.

* * *

Number six, whether experts are proposing to testify about matters growing naturally and directly out of research that have conducted independent of litigation or whether they have developed their own opinions expressly for purposes of testifying. Dr. Jubanyik is an emergency room physician, and she does not conduct research on when surgery needs to occur. Her testimony on the timing of the surgery in this case is solely developed for this litigation.

Number seven, whether the expert has unjustifiably extrapolated from an accepted premise to an unfounded conclusion. I do find that Dr. Jubanyik has unjustifiably extrapolated that but for the 90-minute delay, Ms. Newton would have survived. The study she relied upon does not speak to timing. In addition, the findings that I make for factor eight also implicate this factor. Whether the expert has adequately accounted for obvious alternative explanations. Dr. Jubanyik

> has not adequately accounted for obvious alternative explanations. While she does in her deposition testify that she considered everything else, but that Ms. Newton's vitals and labs all nominally got worse later, she provided no explanation as to how her condition of stage four uterine cancer and the conditions that were seen by the surgeon at the time of the surgery with the uterus extended and pressing on the colon, the presence of ischemia contributed to the septic shock as opposed to simply a delay in reading correctly the x-ray. She was questioned about this in her deposition and she provided no specifics, just medical opinion. The conclusion is so generalized, it is challenging to determine what her basis is to conclude but for the 90-minute delay, Ms. Newton would have survived.
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> In considering all of these factors, I find that Dr. Jubanyik's opinion that the 90-minute delay was the cause of Ms. Newton's death is not based on factual data that supports her opinion nor reliable methodology. I also find that there's too great of an analytical gap between her experience as an ER physician, and using that experience to conclude that but for the 90-minute delay, Ms. Newton would have been taken to surgery sooner and would not have died. For these reasons, she is precluded from offering her opinions. Without an expert on causation, the Court must grant the summary judgment in favor of defendants.

The Estate filed a timely notice of appeal.

II. DISCUSSION

The Estate raises one issue in this Court: "Did the trial court improperly apply *Daubert*/*Rochkind* when excluding [Ms. Newton's] medical expert who offered opinions on the issue of causation?" The circuit court's decision to exclude Dr. Jubanyik's expert opinion, a decision grounded in post-*Rochkind* questions about the permissible scope of expert testimony, had an all-or-nothing effect in this medical malpractice case: without an expert to support Ms. Newton's theory of causation, the Hospital and Dr. Javid are entitled

to summary judgment as a matter of law. *Am. Radiology Servs., LLC v. Reiss*, 470 Md. 555, 580 (2020). So this case depends ultimately on whether the circuit court erred in finding that the proposed causation testimony of Dr. Jubanyik, an emergency physician, exceeded the scope of her expertise. On this record, we agree with the circuit court that the expert's proposed causation testimony was attenuated from her expertise and was excluded properly.

A. The Circuit Court Did Not Err In Excluding The Expert's Proposed Causation Testimony.

Maryland courts assess the admissibility of expert testimony against the standard set forth in Maryland Rule 5-702.[2] At the threshold, expert testimony must assist the trier of fact—a jury, were this case to go to trial—to understand the evidence or to determine a fact in issue. Md. Rule 5-702. When considering proposed expert testimony, the trial court

[2] The Estate argues repeatedly in its brief that these questions are governed by Federal Rule of Evidence 702. They're not. To the contrary, our Supreme Court has only *reiterated* its commitment to the overall structure of Maryland Rule 5-702 after deciding *Rochkind v. Stevenson*: when the Supreme Court's Standing Committee on Rules of Practice and Procedure recommended changes to Rule 5-702 shortly after *Rochkind* that would have amended the Rule to include the *Daubert* factors expressly, the Court rejected the amendments outright. *See* Rules Order for the 221st Report 2 (April 5, 2024), *archived at* https://perma.cc/66RX-Z436 (rejecting proposed amendments to Rule 5-702). And although there have been some post-*Rochkind* growing pains as courts apply the Rule and the *Daubert* factors to real cases, *see Katz, Abosch, Windesheim, Gershman & Freedman, P.A. v. Parkway Neuroscience and Spine Inst., LLC*, 485 Md. 335, 385–407 (2023) (Booth, J., concurring) (observing that "our traditional formulation of the abuse of discretion standard is not the best or most accurate way of describing our abuse of discretion review in the context of reviewing expert testimony admissibility determinations" and suggesting that the "Court reformulate the definition of our abuse of discretion standard in the context of appellate review of expert witness testimony admissibility determinations"), the Court hasn't supplanted Rule 5-702 with its federal counterpart.

"shall determine":

> (1) whether the witness is qualified as an expert by knowledge, skill, experience, training, or education,
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> (2) the appropriateness of the expert testimony on the particular subject, and
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> (3) whether a sufficient basis exists to support the expert testimony.

Id. And in assessing these required components of proposed expert testimony, the court measures their ultimate reliability against the factors set forth in *Daubert v. Merrill-Dow Pharm., Inc*., 509 U.S. 579 (1993), as adopted by our Supreme Court in *Rochkind v. Stevenson*, 471 Md. 1 (2020). The court may admit expert testimony after considering five of the *Daubert* factors:

> (1) whether a theory or technique can be (and has been) tested;
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> (2) whether a theory or technique has been subjected to peer review and publication;
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> (3) whether a particular scientific technique has a known or potential rate of error;
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> (4) the existence and maintenance of standards and controls; and
>
> (5) whether a theory or technique is generally accepted.

Rochkind, 471 Md. at 35 (*citing Daubert*, 509 U.S. at 593–94). From there, the trial court has discretion to consider five additional factors:

> (6) whether experts are proposing to testify about matters growing naturally and directly out of research they have conducted independent of the litigation, or whether they have developed opinions expressly for purposes of testifying;
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> (7) whether the expert has unjustifiably extrapolated from an accepted premise to an unfounded conclusion;
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> (8) whether the expert has adequately accounted for obvious

> alternative explanations;
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> (9) whether the expert is being as careful as he [or she] would be in his [or her] regular professional work outside of his [or her] paid litigation consulting; and
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> (10) whether the field of expertise claimed by the expert is known to reach reliable results for the type of opinion the expert would give.

Id. at 35–36 (*citing* Fed. R. Evid. 702 Advisory Comm. Note).

We review a circuit court's decision to exclude expert testimony for abuse of discretion. *Katz,* 485 Md. at 360–61. This is a deferential review:

> 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) (internal quotation marks and 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 the court deems minimally acceptable." *Id*. (internal quotation marks and citation omitted); *see also Williams v. State*, 457 Md. 551, 563 (2018) ("An abuse of discretion occurs where no reasonable person would take the view adopted by the circuit court."); *Jenkins v. State*, 375 Md. 284, 295–96 (2003) ("Abuse occurs when a trial judge exercises discretion in an arbitrary and capricious manner or when he or she acts beyond the letter or reason of the law.").

Id. at 361 (*quoting State v. Matthews*, 479 Md. 278, 305–06 (2022)).

The Estate argues that the circuit court erred in the way it applied the *Daubert* factors to Dr. Jubanyik's opinion. In the Estate's view, "the role of the Court as gatekeeper is not to determine if an opinion is more likely than not correct. Instead, it is simply to determine if the opinion is supported by facts, principles and methodology," and "[d]oubts about expert testimony should be resolved in favor of admissibility." Generally speaking, those principles are correct as far as they go. But the circuit court, after considering Rule

5-702(1)–(3) and the *Daubert* factors, found that the facts, principles, and methodologies grounding Dr. Jubanyik's opinions were too attenuated from the opinion itself. And on this record, we agree.

The Estate's brief opens by stating, in precisely these words, that "[t]his is a radiology malpractice case." Dr. Jubanyik isn't a radiologist, but also wasn't asked to opine on any radiology failures—indeed, the Estate says that "[v]iolations of the standard of care are not at issue in this appeal and do not appear to be seriously disputed." Instead, Dr. Jubanyik's role as an expert was to connect the causal dots between the alleged failure of Dr. Javid—specifically, her failure to read the possibility of a bowel perforation in the second of Ms. Newton's abdominal x-rays—and Ms. Newton's death from sepsis and complications from surgery. Except Dr. Jubanyik also isn't a surgeon. She is, to be sure, a well-credentialed emergency medicine physician. And in that role, she opined, and the Estate sought to offer the opinion, that the ninety-minute delay between the initial reading of the second x-ray and the follow-up reading caused Ms. Newton to develop sepsis before surgery and caused her death.

The problem, though, is that Dr. Jubanyik couldn't testify to an appropriate degree of medical certainty, from her own experience or expertise or any data she produced, that involving a surgeon ninety minutes earlier would have made any difference in Ms. Newton's condition. Dr. Jubanyik conceded that a surgeon, not the emergency medicine physician, would have made any decisions about whether or when or how to intervene and that surgeons could well disagree about whether and when to intervene, even with earlier

notice of a possible bowel perforation. And the one study on which she relied couldn't bridge the gap either. Although the study found that patients got better results from surgery that began before developing sepsis than after, it didn't provide any data or analysis that could support an opinion in this case that Ms. Newton's sepsis resulted from the delay between the two readings of the second and third x-rays. The study didn't help identify the cause of the sepsis here, and Dr. Jubanyik couldn't either. She offered an opinion based on her experience but acknowledged that she couldn't rule out other causes, including the ischemia caused by Ms. Newton's uterus pressing on her colon.

As the Estate argues, it may well be that intervening sooner would have been better. But the issue in this case is whether the circuit court erred in finding that Dr. Jubanyik's opinions about the causal effect of any delay were too attenuated from her experience, expertise, or data. And although Dr. Jubanyik's theory may well have been plausible, the circuit court didn't abuse its discretion in concluding, on this record and with the acknowledged limitations of Dr. Jubanyik's testimony, that her expert opinion failed to satisfy Rule 5-702 and was not sufficiently reliable when measured against the *Rochkind*/*Daubert* factors. We affirm the court's decisions to exclude the expert testimony and, as a result, to grant summary judgment in favor of the Hospital and Dr. Javid.

JUDGMENT OF THE CIRCUIT COURT FOR HARFORD COUNTY AFFIRMED. APPELLANT TO PAY COSTS.