THE DEFENSE LINE

A Publication From The Maryland Defense Counsel, Inc.

October 2018

Telemedicine Liability: A Blended Standard of Care for the Modern World

Rachel E. Brown

Also Featured

President's Message

Welcome to the latest edition of MDC's *Defense Line*. Big thanks to Sheryl Tirocchi, Caroline Payton, Julia Houp and Brian Greenlee for all their hard work on this issue. They have been joined by a number of MDC members and others who have contributed substantive articles and information. We hope you find this issue interesting and informative.

John T. Sly, Esquire
Waranch & Brown, LLC

Our Executive Committee, President-Elect Dwight Stone of Miles & Stockbridge, Secretary, Colleen O'Brien of Wilson/Elser, and Treasurer, Katherine Lawler of Nelson, Mullins, are focused on making MDC the place you can turn to for timely information, quality programming, and civic engagement. I wish to express my deep appreciation for all their hard work.

2018–2019 is an exciting time for MDC. In particular, we are happy to announce that we have hired Marisa Capone, Esq. as our Executive Director. Marisa worked in Baltimore as a civil defense attorney before stepping into the role of General Counsel at a local medical practice. Having been a MDC member and a practicing attorney, she understands what we are about. Plus, she brings a wealth of knowledge and experience in running an organization. Of course, she has big shoes to fill. Kathleen Shemer, who retired last year, had served as our Executive Director for over twenty years. Our deepest thanks go out to Kathleen!

In May of 2018, the Board and a number of past presidents were led through an in-depth strategy session by Steve Manekin of Ellin & Tucker. The goal was to better understand how MDC can provide real value to its members. A lot of great ideas came out of that effort and we thank Steve for all his insight. We also appreciate the foresight of our Immediate Past President, Marisa Trasatti of Wilson/Elser, who put the program together.

What became clear during the strategy session is that MDC's members want quality programming, top-notch publications, and activities that directly advance their practices. To that end we will be holding our highly acclaimed deposition bootcamp in November 2018, training sessions on appellate skills, and how to prepare, take and defend a corporate representative deposition, and programming designed to enhance the ability of our members to develop their practices. Plus, our "world famous" crab feast will be bigger and better than ever.

In order to bring you the best training available by helping rising leaders build their practices, MDC is proud to announce it has partnered with Strategy Horse Consulting Group, a Baltimore firm that has worked with some of the biggest names in industry. Strategy Horse will conduct a four-part program in the winter and spring of 2019. Firms will be able to identify certain rising attorneys as "MDC Fellows" who will then go through the Strategy Horse training at substantially reduced rates over market price. Skill acquisition will focus on building confidence, identifying strengths, and developing marketing and leadership skills. We think this will bring real value to our members as they build their careers while strengthening their firms. We anticipate this small group program will be in high demand so look for our sign-up announcement coming soon.

We also continue to be the leading voice for our members and our clients in Annapolis. Venable's John Stierhoff helps us understand the issues being considered in the Legislature and how best to advocate for our positions. John's team and our Legislative Committee co-Chairs, Nikki Nesbit of Goodell/Devries and Mike Dailey of Schmidt, Dailey & O'Neill, work with a number of MDC members to testify on bills and issues of interest and to engage with our State leaders on cutting-edge issues.

Of course, where most of us make our living is working in the judicial and administrative processes. Our Workers' Compensation Committee regularly meets with commissioners and drafts new legislation designed to make the process more efficient and fair. In addition, Winn Friddell of Bodie Law and James Benjamin, Jr. of Gordon/Feinblatt co-chair our Judicial Selections Committee. Winn and James, together with MDC volunteers throughout Maryland, personally interview every willing candidate for the bench above district court and provide their considered opinions to the respective Judicial Nominating Commission. We think MDC's input helps ensure the highest level of professionalism on the Workers' Compensation Commission and bench. If you want to make a direct difference in your practice, join on the local teams that interview candidates. You can learn more about interviewing judicial candidates by contacting either Winn or James.

MDC wants to be a valued partner in your practice. Please join us for our social and educational events and please let us know how we can continue to make your MDC better for you.

THE DEFENSE LINE

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Maryland Defense Counsel
6535 N. Charles Street
Suite 220
Baltimore, MD 21204

E-mail:
ed@mddefensecounsel.org
www.mddefensecounsel.org

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MDC and StrategyHorse present: "Rising Leader Academy"

The Challenge

Firms all over the state are struggling with recruiting, retaining and developing future leaders within their ranks. In addition to strong technical ability, associates need to develop their *executive presence* to both deliver value to current clients, as well as attract future ones. By 2020, around half of the workforce will be comprised of Millennial attorneys that view their legal careers in a different way than their predecessors, and over the next 5-10 years, statistics show that most firms will lose around 40% of their partners. Younger lawyers are dedicated to professional excellence but require the right investment in professional development to empower them to contribute significantly to the sustainability of their firms.

What does *executive* presence look like?

Business development acumen
Growth strategy planning ability
Leadership skills
Client retention/relationship management skills
Recruiting ability

The Solution

StrategyHorse has created an innovative curriculum designed to engage and inspire the confidence and competency younger professionals need to lead their firms into the future. The curriculum has been applied to a series of interactive workshops designed specifically for promising lawyers between 26-46, those that are expected to secure the legacy of their firms. Each workshop has been carefully created with an understanding that real progress cannot happen without first revealing-and addressing-the motivation (cares, fears, wants) behind the behavior of the next generation of law firm leadership.

Who Should Participate?

Associate and junior partner attorneys with at least 3 years' experience that have demonstrated an interest in firm leadership and growth.

The Outcome

Other training platforms focus on delivering conventional advice and step-by-step directives that are disconnected from the unique challenges facing the future partners of law firms. The StrategyHorse program is committed to facilitating the success of ambitious Rising Leaders in an individualized and personalized manner, a critical approach to helping these attorneys to "get out of their own way"— the most common reason for failure. These workshops are engineered to provide firms with an effective and affordable means to invest in the stewards of their legacies.

The program will be broken down into 4 modules:

1) Confidence
2) Growth Strategy & Business Development Best Practices for Attorneys
3) Networking Strategy & Skills for Those that Dislike Networking
4) Vision & Accountability

Module 1: Confidence

This workshop will provide participants with the means to identify, understand and promote one's individual value proposition, an essential component for effective leadership and business development. We will address the importance of self-advocacy as well as how each Rising Leader can both position themselves and others to be ambassadors for their personal brand and the brand of their firm. We will discuss the creation of stakeholders in the community, including peers and referral sources, and establish criteria for qualifying and cultivating "best clients". Towards the end of the session the attorneys will understand how to apply what they've learned to their role in the recruitment and development of other younger lawyers.

Module 2: Growth Strategy & Business Development Best Practices

This workshop will cover all aspects of personal branding. Participants will learn how to position themselves as either a *Thought Leader* or *Center of Impact*. We will discuss how to become a *lawyer for the future* by being relatable and articulating/addressing the needs of younger clients. The greatest opportunity for growth for any attorney is to become a Trusted Advisor to their clients and the community. We will delve into what this looks like and how to develop this reputation.

Module 3: Networking Strategy and Skills for Those Who Dislike Networking

Most lawyers are uncomfortable in traditional networking settings for a variety of reasons. Introverted personalities, time management concerns and a variety of other things pose a challenge to those who feel the pressure to network but struggle with embracing it. This workshop will provide attendees with tailored guidance designed to identify creative, effective and enjoyable approaches to networking. We will demonstrate how effective networking practices will yield career-long business development dividends. Participants will learn how to design and execute a strategic and effective networking plan to improve origination, complement recruitment efforts and build brand.

Module 4: Vision & Accountability

To become an effective practice group leader and/or equity partner of a firm, attorneys must be vision-oriented and possess the ability to approach growth in a strategic manner. Many younger lawyers are conditioned to think in a silo, only focusing on their immediate tasks and growing their own practice. For those who wish to enter the leadership queue, it is essential to be able to project, plan for, executive on and measure individual/practice group/firm goals, ensuring that all are properly aligned.

Each workshop will be approximately 2 hours in duration and be interactive in nature. Participants will receive a brief pre-workshop summary to help prepare them to get the most out of their participation.

The cost of each workshop is $225 a person and $750 for a package of all 4 workshops.

Telemedicine Liability: A Blended Standard of Care for the Modern World

Rachel E. Brown

Telemedicine is a new, rapidly growing medium for providing health care electronically.[1] It is a process of delivering health care services that enables health care providers to remotely treat, diagnose and manage patient care through the use of telecommunication technology.[2] Telemedicine has the potential to positively transform health care because it allows for greater patient access to quality health care at reduced costs.[3] However, major legal concerns have emerged with the advancement of telemedicine. Health care providers are concerned with how the use of telemedicine may affect their liability.[4] Telemedicine presents new questions for the traditional medical malpractice framework given the unique nature of telemedicine patient-physician encounters.[5] One important question is: what standard of care applies in a telemedicine medical malpractice case?

This Paper surveys this issue and seeks to offer a solution on how Maryland should define the standard of care in telemedicine medical malpractice cases. Part I begins with a brief, general overview of telemedicine and its benefits. Part II specifically focuses on telemedicine in Maryland, including current telemedicine technologies and regulations. Part III sets out the standard of care issue in telemedicine medical malpractice cases and examines two distinct approaches to defining the standard. Finally, Part IV proposes that Maryland adopt a novel approach to the telemedicine standard of care that maximizes patient safety without hindering health care providers' adoption of telemedicine.

I. What is Telemedicine?

A. Defining Telemedicine

There is no consensus on a single definition of telemedicine, and the term is often used interchangeably with telehealth.[6] The World Health Organization provides a commonly cited definition of telemedicine:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, [and] research and evaluation, . . . all in the interests of advancing the health of individuals and their communities.[7]

More simply stated, telemedicine traditionally refers to patient care that is delivered by technology.[8] Telemedicine is not a new form of health care; rather, it provides a new technology-based means of delivering traditional health care services.[9]

The broader term "telehealth" normally encompasses telemedicine and includes a wide range of health care services including education, public health and health administration.[10]

B. The Benefits of Telemedicine

Modern advancements in technology and the widespread use of real-time communication tools, such as smartphones, tablets and computers, have made telemedicine a highly beneficial, practical means of providing health care.[11] The American Telehealth Association reports that "[t]elemedicine is a significant and rapidly growing component of health care in the United States."[12] About 15 million Americans receive some form of remote medical care every year.[13] Major hospitals and health care systems are adopting telemedicine as a tool with the potential to reinvent health care.[14] In fact, over half of all United States hospitals use some form of telemedicine.[15] For example, in 2016, Johns Hopkins Hospital created its Office of Telemedicine that uses "technology to con-

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1 *See*, *e.g.*, Melinda Beck, *How Telemedicine Is Transforming Health Care*, THE WALL STREET JOURNAL (June 26, 2016), https://www.wsj.com/articles/how-telemedicine-is-transforming-health-care-1466993402 ("Doctors are linking up with patients by phone, email and webcam. They're also consulting with each other electronically—sometimes to make split-second decisions on heart attacks and strokes. Patients, meanwhile, are using new devices to relay their blood pressure, heart rate and other vital signs to their doctors so they can manage chronic conditions at home.").

2 *See* Heather L. Daly, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future*, 9 ANNALS HEALTH L. 73, 76 (2000).

3 *See*, *infra*, Part I.B.

4 *See* Daly, *supra* note 1 at 74.

5 *See id.* at 100.

6 *See What is Telehealth?*, CENTER FOR CONNECTED HEALTH POLICY, http://www.cchpca.org/what-is-telehealth (last visited April 26, 2018). For the sake of consistency, this Paper uses the term telemedicine rather than telehealth and focuses on the use of telemedicine in clinical settings.

7 WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES 9 (2010), http://www.who.int/goe/publications/goe_telemedicine_2010.pdf

8 *See What is Telehealth?*, *supra* note 6.

9 Carl Benjamin Lewis, *Private Payer Parity in Telemedicine Reimbursement: How State-Mandated Coverage Can Be the Catalyst for Telemedicine Expansion*, 46 U. MEM. L. REV. 471, 474 (2015).

10 *See id.* at 474–475.

11 *See* MARYLAND HEALTH CARE COMMISSION, MARYLAND TELEMEDICINE TASK FORCE FINAL REPORT 10 (2014), http://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/tlmd/tlmd_ttf_rpt_102014.pdf.

12 *See About Telemedicine*, AMERICAN TELEMEDICINE ASSOCIATION, http://www.americantelemed.org/main/about/telehealth-faqs- (last visited March 26, 2018).

13 *See* Dhruv Khullar, *Telemedicine Is Getting Trendy, But Doctors May Not Be Keeping Up*, THE WASHINGTON POST (April 22, 2018), https://www.washingtonpost.com/national/health-science/telemedicine-is-getting-trendy-but-doctors-may-not-be-keeping-up/2018/04/20/681e1644-2178-11e8-badd-7c9f29a55815_story.html?noredirect=on&utm_term=.106059ffe50d.

14 *See* THE PHYSICIAN'S GUIDE TO TELEMEDICINE IN 2017, PROGNOCIS 4 (2017), https://prognocis.com/wp-content/uploads/2017/01/Telemedicine-Whitepaper.pdf [hereinafter THE PHYSICIAN'S GUIDE].

15 *See About Telemedicine*, *supra* note 12.

MDC's 2018 Past Presidents Reception

Maryland Defense Counsel ("MDC") hosted its annual **Past Presidents Reception** at Miles & Stockbridge, PC in Baltimore on **Tuesday, September 25, 2018**. We were joined by MDC Presidents spanning five decades and representation from the bench. Also with us were a number of sponsors and MDC supporters. The event was focused in the beautifully designed central board room with Baltimore's Inner Harbor as a backdrop.

Our special guest was **Toyja Kelley** of Saul/Ewing. Toyja is a past President of MDC and has been elected **President of the Defense Research Institute ("DRI")** with his term to begin in October 2018. **Robert "Bob" Scott** of Wilson/Elser and **John Parker Sweeney** of Bradley, Arant, Boult, Cummings, LLP presented Toyja with a plaque commemorating his dual presidential roles. Bob and John have also served as presidents of MDC and DRI.

In thanking the gathering, Toyja said, "Thank you to the Maryland Defense Counsel for this honor. MDC is where it all started for me and I am proud to be a member."

MDC wishes to thank our sponsors, our Executive Director, Marisa Capone, and Miles & Stockbridge, PC for making this a memorable evening.

Watch Out for Double Damages!

Christina N. Billiet

Medical malpractice plaintiffs' attorneys have become interested in an oft-overlooked provision of the Medicare Secondary Payer Act ("MSPA"). Why? Because it *seems* to offer them the opportunity to recover "double damages."

We represented a Maryland hospital in a wrongful death case that was tried in Circuit Court and resulted in a small verdict for Plaintiffs (medical bills only). The Plaintiffs' Decedent was a Medicare beneficiary and Medicare had asserted a lien to recover its conditional payments.

Prior to paying the judgment, the hospital filed a motion to reduce the verdict to "medical bills paid" pursuant to Maryland law; the motion was granted. The hospital also requested a tax identification number for the estate of the Decedent, which Plaintiffs refused to provide.

During the parties' disagreement regarding the tax identification number, Plaintiffs filed suit against the hospital in Federal Court pursuant to the MSPA. Plaintiffs' Federal complaint alleged the hospital "failed" to reimburse Medicare for the conditional payments made on behalf of the Decedent and, thus, was liable for double damages. They relied upon the following provision of the MSPA:

> There is established a private cause of action for damages ***(which shall be in an amount double the amount otherwise provided)*** in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) ….

42 U.S.C. § 1395y(b)(3)(A) (emphasis added).

The hospital paid the revised Circuit Court judgment against it approximately two weeks after suit was filed in Federal Court (and 37 days after the revised — and "final" — Circuit Court judgment).

On behalf of the hospital, we filed a Motion to Dismiss/Motion for Summary Judgment in Federal Court arguing (a) Plaintiffs had no standing because they suffered no "injury in fact" and (b) the hospital did not "fail" to reimburse Medicare, because it had satisfied, in full, the pending judgment. Our Motion was granted by the District Court, which found that the hospital had paid Plaintiffs the entire judgment, including the portion due Medicare (and thus had not "failed" to reimburse Medicare).

Plaintiffs appealed to the Fourth Circuit Court of Appeals. Again, the hospital took the position that Plaintiffs had no standing and that the hospital had not "failed" to reimburse Medicare. Following oral argument in March 2018, the Fourth Circuit issued a published opinion in July 2018, affirming the District Court's grant of judgment in favor of the hospital. The Fourth Circuit held:

> 1) Plaintiffs did have standing because they suffered an injury-in-fact or, in the alternative, because Congress had effected a "partial assignment" of the government's right of action under the MSPA (Judge Traxler, who authored a dissent, agreed with the hospital that Plaintiffs had no standing because they had suffered no injury-in-fact. Thus, he believed neither the District Court nor the Fourth Circuit should have reached the merits of Plaintiffs' case.); and
>
> 2) The hospital did not "fail to pay" or reimburse Medicare under the MSPA. The Fourth Circuit explained that the hospital had showed its intention to pay Plaintiffs the judgment owed them and did pay that judgment in a timely manner after a revised, final judgment was issued.

In sum, while this was an appellate victory for our client, it raises a complex set of issues for defense counsel and our clients. Because the MSPA "double damages" provision and case law across the country are unclear as to precisely when "double damages" are available and who is entitled to their recovery (these issues are disputed across the Circuits), **special care is warranted in the event of a judgment involving a Medicare lien.** You and your client may consider placing the full Medicare lien amount in escrow pending the resolution of any post-judgment motions, or even paying the Medicare lien amount directly to Plaintiffs and their counsel before the post-judgment motions are decided.

Netro v. Greater Baltimore Med. Ctr., Inc., 891 F.3d 522, 524 (4th Cir. 2018)

Christina Billiet is a trial attorney and Partner at Waranch & Brown, LLC. She has extensive experience defending medical malpractice cases, as well as representing physicians, nurses and other health care providers in a variety of Board of Physician, guardianship and hospital privileging matters. Ms. Billiet has successfully handled cases and appeals in the Circuit and appellate Courts of Maryland, as well as the United States District Court for the District of Maryland and the Fourth Circuit Court of Appeals. She has acted as lead counsel at trial, obtaining defense verdicts in multimillion-dollar cases.

An Opportunity to Lower Costs of Arbitration

James W. Constable

Commercial disputes generally arise out of agreements between parties involved in a business relationship. Some agreements have a clause that refers the resolution of disputes that might arise to arbitration as opposed to referrals to the state or federal courts. The clause might require arbitration under a particular arbitration administer such as the American Arbitration Association or JAMS for domestic disputes or the International Centre for Dispute Resolution or the International Chamber of Commerce for international business ventures. There are many others.

Smaller cases, such as those under $75,000 in requested damages, are usually handled under expedited rules if administered by the American Arbitration Association. The cost is a major concern in the larger and more complex cases. The arbitration clause may require a panel of three as opposed to having the matter decided by a single arbitrator. This is frequently the case when the parties anticipate the possibility of disputes that involve complex issues, complicated facts, and large sums. Absent an agreement on the number of arbitrators, arbitration rules may provide a guide. For instance, under the Commercial Rules of the American Arbitration Association, claims or counterclaims seeking damages of at least $1,000,000 would be assigned to a panel of three unless the parties agree to one. If they all agree, the parties are free to choose a single arbitrator no matter what the size of the claims or what the arbitration clause says.

Arbitration has many advantages over litigating in court — speed, confidentiality, having decision makers that are experienced in the subject matter or industry, and streamlined procedures that place limits on protracted pretrial maneuvering. However, unlike the courts, the parties pay for the service of arbitrators. The cost can be considerable.

Three experienced minds may be better than one at sorting out the facts and law of a large and factually complex case, particularly at the evidentiary hearing. However, the cost and expenses add up, particularly when all three participate in every ruling at every stage of the proceeding – from filing fee to award. In fact, studies have shown that a panel of three can cost as much as five times the cost of a single arbitrator.

Responding to cost concerns and in an effort to make the choice of arbitration more appealing, the American Arbitration Association recently adopted a procedure called the Streamlined Three-Arbitrator Panel Option. It allows the parties to use a single arbitrator for managing preliminary matters, discovery and motions, including dispositive motions. The Option actually has

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Editors' Corner

Welcome to a new year and a new edition of MDC's *The Defense Line*! We are privileged to publish this edition and showcase some our esteemed colleagues and members of MDC. A big thanks to our contributors for this edition: **Rachel E. Brown, J.D.**, **Christina N. Billiet, Esq.** of Waranch & Brown, **James W. Constable, Esq.** of Wright, Constable & Skeen, **Benjamin A. Beasley**, **Esq.** of Rollins, Smalkin, Richards & Mackie, and **Justin Fine, Esq.** of Pessin Katz Law.

This year, the editors are committed to highlighting the people who matter most to our organization: YOU, the members of MDC. We want to celebrate with you and share your victories, promotions, and recognitions. We are also looking for articles and case updates for publication and will accept those submissions at any time.

We hope that you enjoy this edition of *The Defense Line*. If you have any comments, suggestions, or would like to submit material for a future publication, please contact one of the editors below. We look forward to hearing from you.

Sheryl A. Tirocchi
Chair, Publications Committee
GodwinTirocchi, LLC
(410) 418-8778

Caroline E. Payton
Vice-Chair,
Publications Committee
The Law Offices of
Frank F. Daily, P.A.
(410) 584-9443

Julia L. Houp
Vice-Chair,
Publications Committee
Semmes, Bowen & Semmes
(410) 385-3983

See photos
from past events at
mddefensecounsel.org/
gallery

Message from Judicial Selections

James R. Benjamin, Jr. and **Winn C. Friddell** co-chair the Maryland Defense Counsel's Judicial Selections Committee. The Judicial Selection Committee is committed to identifying and supporting qualified, experienced and diverse judicial candidates who will ensure the fair and efficient administration of civil justice in Maryland's court system and especially candidates who understand and appreciate the needs and interests of the MDC and its members' clients. Members of the Committee review applications of those judicial candidates above the District Court who have agreed to be interviewed by the MDC and then conduct interviews of the candidates. The MDC then makes its recommendations to the Maryland Judicial Nominating Commission based on its review of the candidates.

During the Spring and Summer of 2018, the Committee had the pleasure of interviewing candidates for the Circuit Court of Charles County, Circuit Court for St. Mary's County, Circuit Court for Prince George's County, Circuit Court for Anne Arundel County, and Circuit Court for Baltimore County. This Fall, the Committee will be interviewing candidates for the Circuit Court for Montgomery County as well as the Circuit Court for Howard County. The Committee will also be interviewing candidates for the Court of Special Appeals (Seventh Appellate Judicial Circuit — Montgomery County and At-Large) and the Court of Appeals (First Appellate Judicial Circuit).

The Committee is always looking for new members. If you are interested in participating, please contact either James R. Benjamin, Jr. at jbenjamin@gfrlaw.com or Winn C. Friddell at wfriddell@bodie-law.com, or provide MDC with your e-mail address and someone will be happy to follow-up with you.

(ARBITRATION) *Continued from page 11*

two variations. Under the first version, which I will call Option 1, the panel is selected under the normal rules after invitation to serve, acceptance, disclosures and appointment. The selection is usually made from lists of qualified arbitrators in the AAA's roster. A chairperson is selected by the panel or the AAA if necessary. In cases in which each party selects an arbitrator (party appointed arbitrators) and the first two select the third neutral, the third arbitrator becomes the chairperson. The chairperson is given the power to handle all pre-evidentiary hearing matters, including dispositive motions. The parties may, however, chose to have dispositive motions decided by all three.

During the preliminary scheduling conference, the panel and parties determine the process for keeping the so called "wing" arbitrators informed of the case and updated. The wing arbitrators are placed on hold. They would participate in the hearing and award, and in some cases would hear argument of dispositive motions. They would calendar the evidentiary hearing and the hearing of dispositive motions if they are to participate. At any time prior to the evidentiary hearing, the parties have the right to release the wing arbitrators and have the evidentiary hearing proceed before the chairperson alone.

Under the second version, Option 2, the parties select a single arbitrator at the outset. The single arbitrator handles the case alone — controlling all prehearing matters including exchange of information and motions. No later than sixty days prior to the scheduled evidentiary hearing, the parties select two additional arbitrators. The original arbitrator serves as chairperson of the newly comprised panel. The new arbitrators would be provided with a summary of the case. Generally, the process of educating the new arbitrators will be determined at the preliminary scheduling conference and incorporated in the scheduling order. For instance, the scheduling order might provide that the summary of the case be included in the pre-hearing briefs. Alternatively, the summary could be prepared by the chairperson. The full panel would hear the case and collaborate in the award. The parties could also agree to dispense with a panel, or if the two additional arbitrators have been selected, may dismiss them and proceed with the chairperson as a single arbitrator.

What if one party becomes dissatisfied with the Streamlined Option? Either party can opt-out. The opt-out must be in writing. In that case, the wing arbitrators will be reactivated and be part of all future actions. If the parties are operating under Option 2, the chairperson will immediately cease handling the case until the two new arbitrators needed to fill out the panel are selected either through the AAA roster or by the parties in a party appointed case. If a dispositive motion has been argued before the single arbitrator prior to the opt-out, the single arbitrator will make the ruling prior to reactivation of the wing arbitrators or selection of the remaining two, as the case may be.

The potential benefits of the Streamlined Option are primarily savings in arbitrators' costs and avoiding difficulties in scheduling prehearing conferences if the entire panel must be involved in all facets of the case. There are also drawbacks. If the parties chose Option 2, a party fearing an unfavorable ruling might use the appointment of the two new arbitrators as an opportunity to stall. Under either option, the wings may not be fully informed or engaged or have a feel for the subtleties of the case and may come to the hearing with insufficient background. There is also a risk that the chairperson may lack experience, temperament, or knowledge required to be effective. This is more of a concern under Option 2. In considering the merits of adopting the Streamlined Three-Arbitrator Panel Option, counsel must consider all pros and cons, keeping in mind that most of the streamlining features are often used and available anyway and can be adopted at the scheduling conference without formal adoption of this new option.

James Constable is a partner at Wright, Constable Skeen and has years of experience representing closely held businesses and their owners in all facets of their commercial and legal needs. James has been an arbitrator and mediator for over forty years and been involved in hundreds of arbitrations. He is on the roster of qualified commercial and construction arbitrators of the American Arbitration Association and the International Centre for Dispute Resolution. He has arbitrated cases of all sizes and complexity. He has also arbitrated for the International Chamber of Commerce.

Expert Information Inquiries

The next time you receive an e-mail from our Executive Director containing an inquiry from one of our members about an expert, please respond both to the person sending the inquiry and Mary Malloy Dimaio (mmd@cls-law.com). She is compiling a list of experts discussed by MDC members which will be indexed by name and area of expertise and will be posted on our website. Thanks for your cooperation.

"Analytical Gaps" Analysis Re-examined by Maryland Court of Appeals

Stanley Sugarman, et. al. v. Chauncey Liles, Jr., July 31, 2018 (Court of Appeals of Maryland)

Benjamin A. Beasley

Last summer, the Maryland Court of Appeals issued an opinion in *Rochkind v. Stevenson*, 454 Md. 277, 164 A.3d 254 (2017), holding that the trial court abused its discretion when it admitted expert testimony linking a plaintiff's ADHD diagnosis with lead poisoning when the expert relied on studies that did not adequately demonstrate a causal link between lead exposure and a general and specific ADHD diagnosis. Judge Adkins wrote for the *Rochkind* court concluding that the expert's testimony suffered an "analytical gap" between the data relied upon by the expert and expert's proffered testimony, and, therefore, should not have been admitted. The Maryland Court of Appeals recently issued an opinion in *Stanley Sugarman v. Chauncey Liles, Jr.* in which the court reexamined its analysis in *Rochkind*.

The underlying facts and procedure in *Rochkind* and *Sugarman* are strikingly similar. Both were lead-paint tort suits filed by minors alleging that lead exposure caused cognitive defects in the form of attention decrements. In both trials, the respective plaintiffs introduced expert testimony from pediatricians who reviewed, relied upon, and based their respective opinions on findings contained in the Environmental Protection Agency's publication entitled "Integrated Science Assessment for Lead" ("EPA-ISA"), which, on appeal, was the subject of intense scrutiny.

The EPA-ISA is an integrated science assessment that collected, reviewed, synthesized, and broadly evaluated high quality epidemiological studies and their various health outcomes. The EPA-ISA analysis reveals a causal relationship between lead exposure and attention decrements, impulsivity, and hyperactivity in children. The EPA-ISA does not specifically identify types of attention decrements found, nor does it specifically discuss processing speed or auditory encoding. The EPA-ISA also does not make a general or specific causal connection between lead exposure and certain neuropsychological disorders such as ADHD.

Following verdicts in favor of the plaintiffs in the *Rochkind* and *Sugarman* trials, the respective defendants appealed. On appeal, the *Rochkind* and *Sugarman* defendants argued that the trial court erred in admitting the plaintiffs' respective pediatric experts' causation opinions for lack of an adequate factual basis pursuant to Maryland Rule 5-702. Unlike the outcome in *Rochkind*, however, the *Sugarman* opinion affirmed the trial court's decision to permit the causation testimony of the plaintiff's pediatric expert. This decision hinged on critical distinctions in the analyses and opinions offered by the experts in each case.

In *Rochkind*, the plaintiff's pediatric expert testified that that the plaintiff's lead poisoning was a significant contributing factor to all of the plaintiff's neuropsychological problems, including the plaintiff's ADHD diagnosis. The Maryland Court of Appeals noted that the studies in the EPA-ISA do not go so far as to state that lead exposure causes ADHD. The court further noted that the EPA-ISA recognized that an ADHD diagnosis is also attributable to factors such as socioeconomic status and parenting. Without any other scientific evidence or epidemiological studies to support the opinions that lead exposure ***causes*** ADHD in general, the *Rochkind* court held that the plaintiff's pediatric expert's testimony was not based on an adequate supply of data as required by Maryland Rule 5-702.

In the *Sugarman trial*, the plaintiff introduced the findings of a neuropsychological examination showing the plaintiff exhibited deficits in auditory encoding of information and information processing speed. The plaintiff's pediatric and neuropsychological experts testified that these deficits are factors of attention, were within the realm of general attention deficits, and the literature states that general attention deficits can result from lead exposure. The plaintiff's pediatric expert further opined that the cognitive deficits identified by the neuropsychological exam were caused by the plaintiff's early lead exposure and are permanent. In contrast with *Rochkind*, the *Sugarman* plaintiff offered no expert testimony on whether lead exposure caused or contributed to any specific learning disability or behavioral disorder.

The Maryland Court of Appeals held that the *Sugarman* plaintiff's pediatric expert's opinions were supported by the findings in the EPA-ISA, and were based on an adequate factual basis comporting with Maryland Rule 5-702. The court explained that the *Sugarman* pediatric expert was permitted to reasonably extrapolate from existing data in support of the expert's opinions, which is, in fact, what the *Sugarman* pediatric expert did when analyzing the results of the plaintiff's neuropsychological examination results in concert with the review of the EPA-ISA. The court distinguished *Sugarman* from *Rochkind* noting that the *Sugarman* plaintiff's experts testified to generalized attention deficits that the EPA-ISA identified as being caused by lead exposure, rather than offering opinions that the lead exposure caused or contributed to specific diagnoses or disorders. Accordingly, the court found that the pediatric expert's opinions in *Sugarman* did not suffer the same "analytical gap" as the opinions of pediatric expert in *Rochkind*.

A review of *Rochkind* and *Sugarman* serves as an important reminder for practitioners when vetting experts to thoroughly examine the literature upon which experts base their opinions to ensure there are no perceived "analytical gaps" that threaten to invalidate the admissibility of the expert's critical opinions.

Ben Beasley joined ROLLINS, SMALKIN, RICHARDS & MACKIE, LLC as an associate in April 2016. His practice focuses on insurance defense litigation. Mr. Beasley is an adjunct faculty member of the University of Baltimore School of Law as well as a member of the Baltimore County Bar Association.

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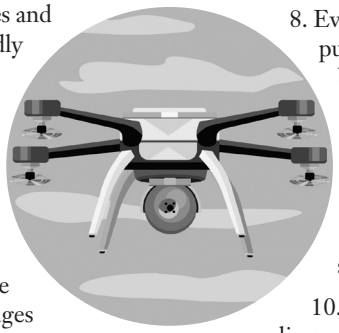
Ten Things Attorneys and Insurance Professionals Should Know About Using Drones in Insurance Claims

Justin Fine

The commercial application of drones is increasing. Drones are being used to fight forest fires, for commercial agriculture, and to deliver medical supplies to remote areas.

Insurance companies are also increasingly using drones, which can be useful for capturing evidence during the claims process. However, there are plenty of pitfalls in using drones, including the admissibility of evidence during litigation. Further, the legal landscape for drones is changing all the time. The States and the Federal Aviation Administration ("FAA") are rapidly issuing new laws and regulations.

In the likely event that you come across the use of a drone in an insurance claim, here are ten things to consider in order to anticipate and respond to potential issues.



1. Drones are helpful for investigating accidents, mapping debris fields, and preserving evidence at the scene of a loss because of their ability to capture images from a birds-eye-view that are not readily visible from the ground.
2. Drones can carry more than just cameras. They also carry sensors to measure distance, heat, radiation, sound, and light.
3. Drones can be easily deployed in the field. Modern drones are compact enough that they can fit into a camera bag.
4. Both personal and commercial drone use are regulated by the FAA.
5. Evidence obtained from drones used in violation of FAA rules and regulations may not be admissible in court.
6. Several states, including Maryland, Texas, Delaware, California, and Florida, have specific laws about the use and admissibility of evidence obtained by drones.
7. When evaluating the admissibility of evidence, consider that there are greater restrictions on the commercial use of drones, including the regulations set out in 14 C.F.R. § 107 et seq.
8. Even the incidental use of a drone for a commercial purpose, such as inspecting the roof of a business, can be subject to the commercial drone-use regulations.
9. Some restrictions to keep in mind when considering the admissibility of evidence obtained from a drone is that drones cannot fly over people (including sporting events), must fly below 400 feet, cannot fly in restricted airspace, and must remain within the sight of the pilot.
10. Additionally, commercial drone pilots must be licensed, although personal drone pilots generally do not have to be.

Justin Fine is an Associate in Pessin Katz Law's General Litigation Group where he focuses his practice on insurance defense and coverage matters. Justin graduated magna cum laude from the University of Baltimore School of Law in 2011. While in law school, Justin was the Editor in Chief for the Law Review. He was also awarded the Dean's Citation for exceptional service to the law school community.

Spotlights

Joe Cardile and Thomas, Thomas & Hafer, LLP recently secured defense verdicts in the Circuit Court for Baltimore City

Joe Cardile wins a defense verdict for a UM/UIM carrier in the Circuit Court of Baltimore City.

On August 30, 2018, following a one-day jury trial in the Circuit Court for Baltimore City, **Joe Cardile** won a defense verdict in connection with a phantom vehicle case. Mr. Cardile represented an insurance company, the UM/UIM carrier for a vehicle in which both Plaintiffs were occupants. The Plaintiffs alleged that their vehicle was struck from behind by a truck driven by a Co-Defendant. It was further alleged that prior to the collision, a phantom vehicle cut the Plaintiffs off and caused the Plaintiff driver to brake suddenly, resulting in injuries due to the rear-end impact from the Co-Defendant's vehicle. At trial, Mr. Cardile successfully argued that the Plaintiffs had failed to establish that the alleged phantom vehicle was negligent. A Baltimore City Jury returned a verdict that the phantom vehicle was not negligent, and that the vehicle that rear-ended the Plaintiffs was negligent. As a result, the insurance company's UM/UIM policy did not apply.

Joe Cardile and Mike Burgoyne win directed verdict in furnace fire case.

In May 2018, TT&H Attorneys **Joe Cardile** and **Mike Burgoyne** won a directed verdict in a subrogation case brought by Nationwide Mutual Fire Insurance Company. Nationwide sought to recover some $595,000.00 in payments made to its insured as a result of a residential house fire in Baltimore City. Nationwide brought suit against an HVAC contractor in Baltimore City Circuit Court and requested a jury trial, alleging that the HVAC contractor caused a high temperature limit safety switch to be bypassed, or observed the bypassed switch and failed to correct the condition. Nationwide alleged that the contractor thereby permitted an unsafe operation of the furnace, which subsequently overheated and ignited the wood structure above the furnace, consuming the home in a fire.

Representing the HVAC contractor, Attorneys **Cardile and Burgoyne** pursued an alternative theory for the origin and cause of the fire through their own experts. They also challenged the failure of Nationwide's fire investigator to follow NFPA 1033 and NFA 921, and to preserve the scene for other investigators. Motions in limine were denied, but at trial, the Court permitted cross examination on issues of spoliation of evidence. Following a five-day jury trial, and after a motion made by Attorney Cardile, the Court entered judgment for the defendant contactor. The motion was based upon Nationwide's failure to prove when the safety switch had been bypassed, which in turn meant a failure on the part of Nationwide to establish any duty on the part of Attorney Cardile's client.

BBSCJ Obtains an Appellate Victory for Mental Health Care Providers

Siobhan R. Keenan and **David J. McManus** of **Baxter, Baker, Sidle, Conn & Jones, P.A.**, obtained a Court of Appeals decision that clarifies and extends the scope of immunity for mental health professionals involved in involuntary commitment proceedings. *Bell v. Chance*, No. 36, SEPT.TERM, 2017, 2018 WL 3409919 (Md. July 12, 2018). Brandon Mackey was admitted to Bon Secours hospital after emergency medicine physicians submitted an application for involuntary commitment due to a suspected suicide attempt. He came under the care of psychiatrist, Dr. Leroy C. Bell, Jr., and was scheduled for an administrative hearing. After several days of observation and treatment, and before the administrative hearing, Dr. Bell discharged Mr. Mackey to continue treatment in an outpatient setting. Tragically, Mr. Mackey committed suicide the following day. Mr. Mackey's mother brought suit, claiming he was discharged too soon. Prior to trial, the lower court declined to apply immunity to Dr. Bell's decision to discharge Mr. Mackey, holding that this immunity, set forth in Health-General § 10-618 and Court & Judicial Proceedings § 5-623, only applied to the initial application, and not to the decision to release an individual after he has entered the hospital. After the jury returned a verdict in favor of the plaintiff, the trial court, citing the recent opinion in *Williams v. Peninsula Regional Medical Center*, 213 Md. App. 644 (2013), *aff'd*, 440 Md. 573 (2014), granted judgment notwithstanding the verdict. The Court of Special Appeals overturned that decision, without addressing the immunity issue, and the Court of Appeals granted Defendants' petition for a writ. The Court of Appeals, in an unanimous decision, overturned the Court of Special Appeals and held that immunity for mental health professionals engaged in determining if a patient should be involuntarily committed for psychiatric treatment applies to the entire commitment process, from the initial application up to the commitment hearing before an administrative law judge.

Goodell DeVries Prevails on Behalf of OB/GYN in Malpractice Claim, Excludes Testimony on Economic Daubert Motion

September 2018

GDLD attorneys **Kelly Hughes Iverson**, **Michael J. Wasicko**, and **Sean Gugerty** successfully obtained a jury verdict for an OB/GYN physician and his practice group in the U.S. District Court for the District of Maryland. The plaintiff alleged that the child's neonatal brachial plexus palsy had been caused by excessive clinician traction and sought in excess of $2 million in damages. Echoing a recent trend across the country, the plaintiff had attempted to exclude defense testimony about the maternal forces of labor, including testimony from the defendant's expert in biomedical engineering and certain literature about the effects of maternal forces. Following an evidentiary Daubert hearing, at which the biomedical engineer testified and a library of medical literature about neonatal brachial

plexus palsy was presented to the court, the defense team defeated the plaintiff's attempt, presented the literature to a jury, and introduced the testimony of the biomedical engineer, a neurosurgeon, and two expert OB/GYNs describing the maternal forces of labor. Brant Poling of Poling Law, LLC joined the trial team as co-counsel.

Pre-trial, the defense team filed an economic Daubert motion to exclude the testimony of plaintiff's economist, who had opined that the child had sustained a roughly $500,000 loss of earning capacity. At the evidentiary Daubert hearing, the GDLD lawyers presented the testimony of an economist who highlighted the methodological flaws in the plaintiff's expert testimony. The federal trial court found the plaintiff's economist lacked a basis to conclude that the child had the earnings loss claimed and excluded the conclusory opinion testimony. Firm partner Derek M. Stikeleather participated in the Daubert briefing.

Goodell DeVries Prevails on Behalf of Howard County Surgeon in Medical Malpractice Suit

August 2018

Amy B. Heinrich and **Meghan Hatfield Yanacek** obtained a defense verdict in the Circuit Court for Howard County for their client, a general surgeon. The plaintiff alleged that, despite having symptoms and imaging consistent with gallbladder disease, the general surgeon should have suspected agenesis of the gallbladder — a very rare condition in which the gallbladder is congenitally absent — and should not have recommended gallbladder removal surgery. The plaintiff further alleged that the common bile duct was negligently injured during the surgery necessitating additional treatment. The defense argued that the surgery was indicated for this patient given the imaging and clinical presentation, that the surgery was performed appropriately, and that the patient had an unforeseeable and unavoidable complication given the atypical anatomy. After a seven-day trial, the jury rendered a verdict in favor of the doctor on both a count of medical negligence and on a count of lack of informed consent.

Goodell DeVries Prevails on Behalf of Crown Equipment Corporation in Product Liability Case in Iowa

July 2018

After a two-week trial in the United States District Court for the Northern District of Iowa, Eastern Division before Judge Mark W. Bennett, **Thomas J. Cullen, Jr.**, **Margaret C. O'Neill**, **Kali Enyeart Book**, and **Ryan M. Cullen** obtained a defense verdict in favor of Crown Equipment Corporation, a leading manufacturer of material handling equipment. In *Dustin Reinard, et al. v. Crown Equipment Corporation*, plaintiffs alleged Crown's stand-up rider forklift's open operator compartment was defective in design because it lacked a compartment door which allegedly caused plaintiff's below-the-knee leg amputation. Plaintiffs requested damages of $15 million. Plaintiffs also presented a punitive damages claim to the jury. Thomas J. Cullen, Jr. argued that a compartment door could exacerbate injuries and put forklift operators at risk of serious or fatal injuries in off-the-dock or tipover accidents. The jury deliberated for approximately 4 hours before returning a full defense verdict on the design defect claim.

Goodell DeVries Prevails on Behalf of Baltimore Hospital in Medical Malpractice Suit

June 2018

Donald L. DeVries, Jr. and **Meghan Hatfield Yanacek** obtained a defense verdict in the Circuit Court for Baltimore City for their clients, a cardiologist and Baltimore City hospital. The plaintiffs were the family of a 65-year-old patient who died while hospitalized after presenting with several significant medical conditions. The plaintiff alleged that the cardiologist should have recommended an urgent mitral valve replacement to prevent her death. The defense argued that the surgery was neither indicated for this patient, nor was she a surgical candidate. After a six-day trial, the jury quickly decided that the cardiologist acted reasonably and appropriately and entered a verdict in favor of the defendants.

Natalie McSherry is one of five **Kramon & Graham** principals named Baltimore "Lawyer of the Year" in the 2019 edition of The Best Lawyers in America. She is recognized for her work in Medical Malpractice Law.

Amy E. Askew of **Kramon & Graham** is also recognized in the publication for her work in Professional Malpractice Law — Defendants and Railroad Law.

James R. Benjamin, Jr. has joined **Gordon Feinblatt LLC** as a Member in the Firm's Litigation, Business Law and EMERGE practice groups. James handles complex environmental/toxic tort matters on behalf of property owners and regularly counsels clients on regulatory issues involving real property. He also advises minority-owned and women-owned businesses (MBEs and WBEs) on certification and procurement matters. James currently serves as the Co-Chair of MDC's Judicial Selections Committee. Congratulations on the move!

The firm of **GodwinTirocchi, LLC** is pleased to announce its formation as of October 1, 2018. GodwinTirocchi is a litigation firm focusing on the defense of workers' compensation and general liability matters. Congratulations to the following attorneys and MDC members on their exciting move: **David O. Godwin, Jr.**, **Sheryl A. Tirocchi**, **William H. Schladt**, **Ashlee K. Smith**, **James A. Turner**, and **Fatima H. Garland**.

Please Welcome MDC's New Members

Derek G. Challenger	Jacob White

(TELEMEDICINE LIABILITY) *Continued from page 5*

nect medical experts to patients and experts to other experts around the world."[16]

Telemedicine is a convenient and flexible method of connecting patients and health care providers without regard to their respective locations.[17] One study found that it takes an average of twenty days to secure a twenty minute in-office appointment with a physician, which requires a total of two hours including travel and wait time.[18] In contrast, telemedicine allows patients to quickly connect with providers electronically without the cost of travel and time.[19] This increased access and convenience is especially beneficial for full-time employees, homebound patients and rural patients.[20]

Telemedicine also allows for improvements in care over traditional channels of health care delivery.[21] It allows for faster, easier patient access to different types of health care providers.[22] Participants in the practice of telemedicine include physicians, both generalists and specialists, along with nurses and other medical personnel.[23] It also facilitates the rapid dissemination of information, which means faster intervention and treatment of health problems.[24]

Telemedicine programs also have the potential to reduce health care costs.[25] Although the overall economic impact has not been fully assessed, studies report significant savings.[26] Telemedicine services have been shown to reduce health care costs "through better management of chronic diseases, shared health professional staffing, reduced travel times, and fewer or shorter hospital stays."[27] One study found that telemedicine has the ability to deliver cost-effective health care services to the 20% of persons who account for 80% of health care expenditures.[28]

II. Telemedicine in Maryland

Rules defining telemedicine differ widely from state to state and are constantly evolving.[29] In Maryland, telemedicine falls within the scope of the broader concept of telehealth.[30] Maryland statutorily defines telemedicine as the delivery of health care services through "the use of interactive audio, video, or other telecommunications or electronic technology … [t]hat enables the patient to see and interact with the health care provider at the time the health care service is provided to the patient."[31] Telehealth is more broadly defined as the "delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner."[32] Telehealth includes the use of real-time audio video conferencing, store-and-forward communication, remote patient monitoring, and mobile health technologies.[33]

A. Current Telemedicine Practices in Maryland

Maryland health care providers practice telemedicine through the use of live video, store-and-forward technology and remote patient monitoring ("RPM").[34] A fourth application, mobile health ("mHealth"), is a new and rapidly evolving mode of health care practice.[35]

Live video uses audio-visual technology to facilitate two-way, real time communications between patients and health care providers, serving as an alternative to in-person visits.[36] Live video is a particularly effective health care tool for emergency support, consultations and health education.[37] For example, specialists can examine patients with limited mobility at home or in their local primary care provider's office.[38] In an emergency situation, live video can connect emergency providers with remote specialists who would otherwise not be available to provide care.[39]

Store-and-forward technology is used to electronically transfer medical information, such as X-rays, MRIs, photos, patient data and video-exam clips, to another health care provider for follow-up or evaluation.[40] This method is primarily used among health care

Continued on page 23

16 *See* Andrea K. McDaniels, *Telemedicine is becoming more widespread*, THE BALTIMORE SUN (Oct. 31, 2016), http://www.baltimoresun.com/health/blog/bs-hs-telemedicine-20161031-story.html; *About Telemedicine*, JOHNS HOPKINS MEDICINE, https://www.hopkinsmedicine.org/telemedicine/about-telemedicine/ (last visited April 26, 2018).

17 *See* DANIEL CASTRO ET AL., THE INFORMATION TECHNOLOGY AND INNOVATION FOUNDATION, UNLOCKING THE POTENTIAL OF PHYSICIAN-TO-PATIENT TELEHEALTH SERVICES 2 (2014), http://www2.itif.org/2014-unlocking-potential-physician-patient-telehealth.pdf.

18 *See* THE PHYSICIAN'S GUIDE, *supra* note 14 at 4.

19 *See id.* at 6; *see also* E. Ray Dorsey & Eric J. Topol, *State of Telehealth*, 375 N. ENGL. J. MED. 154, 154 (2016) (noting that by allowing patients to be treated in their own homes, patients are able to save time and travel expenses).

20 *See* Kimberly L. Rockwell, The Promise of Telemedicine, 96 MICH. B. J. 38, 38 (2017).

21 *See* Daly, *supra* note 1 at 80.

22 Laura E.A. Wibberley, *Telemedicine in Illinois: Untangling the Complex Legal Threads*, 50 J. MARSHALL L. REV. 885, 888 (2017).

23 *See* Meghan Hamilton-Piercy, *Cybersurgery: Why the United States Should Embrace This Emerging Technology*, 7 J. HIGH TECH. L. 203, 210 (2007). This paper, however, focuses on physicians.

24 *See id.* at 80–81.

25 *See Telemedicine Benefits*, AMERICAN TELEMEDICINE ASSOCIATION, http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits (last visited March 26, 2018).

26 *See* DANIEL CASTRO ET AL., *supra* note 17 at 8. Not all studies have found telemedicine to be cost saving, however, with 31% of studies finding it more costly. *Id.*

27 *See Telemedicine Benefits*, *supra* note 25.

28 *See* THE PHYSICIAN'S GUIDE, *supra* note 14 at 4.

29 *See* PUBLIC HEALTH INSTITUTE CENTER FOR CONNECTED HEALTH POLICY, STATE TELEHEALTH LAWS AND MEDICAID PROGRAM POLICIES: A COMPREHENSIVE SCAN OF THE 50 STATES AND DISTRICT OF COLUMBIA 1 (April 2018), http://www.cchpca.org/sites/default/files/resources/50%20STATE%20PDF%20FILE%20APRIL%202017%20FINAL%20PASSWORD%20PROTECT.pdf. Telemedicine is not regulated on a national level. See DANIEL CASTRO ET AL., *supra* note 17 at 10.

30 *See* MARYLAND HEALTH CARE COMMISSION, *supra* note 11 at 4.

31 *See* MD. CODE ANN., HEALTH–GEN. § 15-105.2(b)(1)(iii).

32 *See* MARYLAND HEALTH CARE COMMISSION, *supra* note 11 at 4–5.

33 *See id.* For purposes of continuity, this paper will still use the term telemedicine.

34 *See* MARYLAND HEALTH CARE COMMISSION, *supra* note 11 at 5. For additional examples of various telemedicine applications in Maryland, *see id.* at 14.

35 *See id.*

36 *See* MARYLAND DEPARTMENT OF HEALTH, PROGRESS REPORT ON TELEHEALTH – MARYLAND MEDICAID PROGRAM ACTIVITIES 3 (2018), https://mmcp.health.maryland.gov/Documents/JCRs/2017/telehealthupdateJCRfinal12-17.pdf; *Video Conferencing*, CENTER FOR CONNECTED HEALTH POLICY, http://www.cchpca.org/what-is-telehealth/video-conferencing (last visited April 26, 2018).

37 *See Video Conferencing*, *supra* note 36.

38 *See id.*

39 *See id.*

40 *See* MARYLAND DEPARTMENT OF HEALTH, *supra* note 36; *Store and Forward*, CENTER FOR CONNECTED HEALTH POLICY, http://www.cchpca.org/store-and-forward (last visited April 26, 2018).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(TELEMEDICINE LIABILITY) *Continued from page 21*

providers to aid diagnoses and medical consultations without the need for real-time or face-to-face interactions.[41] Store and forward technologies are most commonly used in the fields of dermatology, pathology, and radiology.[42] For example, primary care providers can take digital photos of their patients' skin conditions and forward the images to dermatologists for review.[43]

RPM allows health care providers to use digital technology to monitor and collect health data from patients at a remote location.[44] The devices electronically transmit patient information, such as blood pressure, heart rate, blood sugar and electrocardiograms, securely to health care providers in a different location for assessment and recommendations. [45] This type of telemedicine is prominently used for managing chronic conditions, such as diabetes, congestive heart failure and chronic obstructive pulmonary disease, helping to reduce patient hospitalizations and readmissions.[46]

Recently, a form of mobile health ("mHealth") has begun to emerge that uses mobile devices, such as smart phones, laptops and tablets, to facilitate the provision of health care services.[47] mHealth combines health care services with mobile technology through applications downloaded onto patient devices.[48] Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks.[49] For example, patients can use mHealth apps on their smartphones to record themselves taking prescribed medications at a specific time, which allows providers to better track and manage medication adherence.[50]

B. Current Telemedicine Regulations in Maryland

The Maryland Board of Physicians ("MBP") has adopted regulations governing the practice of telemedicine.[51] The stated purpose of the regulations is to govern the practice of medicine that incorporates telecommunications systems as an adjunct to, or in replacement of, traditional face-to-face patient visits.[52] The MBP defines telemedicine as the "practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunication systems."[53]

The MBP is currently evaluating a new set of telemedicine regulations.[54] The new rules would replace the term "telemedicine" with "telehealth," and expand the definition to expressly allow for the use of live video, store and forward technology, and RPM.[55] These changes would be more aligned with the broader scope of telehealth in Maryland.

III. Telemedicine Medical Malpractice: The Standard of Care Issue

While telemedicine has created a beneficial new medium of practice for health care providers, it also presents new legal questions in the context of medical malpractice claims against physicians.[56] Telemedicine medical malpractice claims will most likely be analyzed similarly to traditional medical malpractice claims.[57] Under the traditional medical malpractice framework, a plaintiff must plead and prove the standard of care applicable to the defendant physician, that the defendant breached this standard of care, and that the breach caused the plaintiff's injuries and resulting damages.[58]

The standard of care is a critical aspect of a medical malpractice claim because it is the criterion against which a physician's conduct is measured to determine whether the care provided was negligent.[59] Physicians are not liable if they act within the appropriate standard of care.[60] Maryland law is currently unsettled as to the proper standard of care that applies when physicians utilize telemedicine to provide patient care.[61] The following sections describe two different approaches for defining the standard of care in a telemedicine medical malpractice case.

A. Same-Standard Approach

One alternative is to use the same standard of care that applies in traditional medical malpractice cases. Under the same-standard approach, physicians utilizing telemedicine would be held to the same standard of care as if they were providing patient care in-person.[62]

There are two main standards of care in traditional medical malpractice cases: (1)

Continued on page 25

41 *See Store and Forward*, *supra* note 40.
42 *See* Adelyn B. *Boleman*, *Georgia's Telemedicine Laws and Regulations: Protecting Against Health Care Access*, 68 MERCER L. REV. 489, 492 (2017).
43 *See Store and Forward*, *supra* note 40.
44 *See* MARYLAND DEPARTMENT OF HEALTH, *supra* note 36 at 3.
45 Remote Patient Monitoring, CENTER FOR CONNECTED HEALTH POLICY, http://www.cchpca.org/remote-patient-monitoring (last visited April 26, 2018).
46 *See* MARYLAND DEPARTMENT OF HEALTH, *supra* note 36 at 7; *Remote Patient Monitoring*, *supra* note 45.
47 *See* MARYLAND DEPARTMENT OF HEALTH, *supra* note 36 at 3.
48 *See* Mobile Health, CENTER FOR CONNECTED HEALTH POLICY, http://www.cchpca.org/mobile-health (last visited April 26, 2018).
49 *See What is Telehealth?*, *supra* note 6.
50 Eric Wicklund, *mHealth Program Uses Smartphones to Monitor Medication Adherence*, MHEALTH INTELLIGENCE (April 26, 2018), https://mhealthintelligence.com/news/mhealth-program-uses-smartphones-to-monitor-medication-adherence.
51 *See* MD. CODE REGS. 10.32.05 (2018).
52 *See id.* at 10.32.05.01 (2018).
53 *See id.* at 10.32.05.02(B)(8) (2018); see Nathaniel M. Lacktman, *Ten Things To Know About Maryland's Proposed Telehealth Rules*, HEALTH CARE LAW TODAY (Jan. 24, 2018), https://www.healthcarelawtoday.com/2018/01/24/ten-things-to-know-about-the-marylands-proposed-telehealth-rules/.
54 *See Lacktman*, *supra* note 53.
55 *See id.*
56 Telemedicine creates a long list of other potential medical malpractice issues. *See*, *e.g.*, Phyllis Forrester Granade, *Medical Malpractice Issues Related to the Use of Telemedicine: An Analysis of the Ways in Which Telecommunications Affects the Principles of Medical Malpractice*, 73 N.D. L. REV. 65, 67 (1997) (discussing the multiple issues facing health care providers diagnosing or treating patients through the use of telemedicine technologies).
57 There is currently no case law dealing with negligent care administered through telemedicine. See PAUL HILDEBRAND, M.D., TEAMHEALTH, TELEMEDICINE RISK MANAGEMENT 7 (2013). My updated research also did not yield any results.
58 *See* Puppolo v. Adventist Healthcare, Inc., 215 Md. App. 517, 534, 81 A.3d 620, 629 (2013).
59 *See Wibberley*, *supra* note 22 at 909.
60 *Id.*
61 The MBP has only recently considered a proposed standard of care regulation. *See*, *infra* notes 54–55 and accompanying text.
62 *See* Bradley J. Kaspar, Note *Legislating for A New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iow*a, 99 IOWA L. REV. 839, 855 (2014).

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the national standard, and (2) the locality standard.[63] Under the national standard, physicians are generally obligated to use the degree of skill and care of a reasonable physician under the same or similar circumstances.[64] The national standard compares a physician's conduct to prevailing customary practice throughout the United States.[65] Unlike the national standard, the locality rule takes the physician's location into consideration by comparing a physician's conduct to customary practice in the same or similar community.[66]

In 1975, the Maryland Court of Appeals in *Shilkret v. Annapolis Emergency Hospital Association*[67] endorsed a national standard of care and denounced any use of the locality rule in Maryland.[68] The *Shilkret* Court held that "[a] physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."[69]

However, in 1998 the Maryland Legislature enacted legislation that purportedly abandoned the national standard of care, stating that health care providers would only be held to the standard of care in the "same or similar communities" as that of the health care provider.[70] The statute, which remains the law in Maryland, reads as follows:

> In any action for damages filed under this subtitle, the health care provider is not liable for the payment of damages unless it is established that the care given by the health care provider is not in accordance with the standards of practice among members of the same health care profession with similar training and experience *situated in the same or similar communities* at the time of the alleged act giving rise to the cause of action.[71]

It is unclear whether the addition of the "same or similar communities" language in the statute actually modifies the national standard of care enunciated in *Shilkret*.[72] Maryland courts continue to cite to *Shilkret*, often in alongside § 3-2A-02(c)(1), as authority for the standard of care in medical malpractice cases.[73] Furthermore, Maryland's Civil Pattern Jury Instructions currently define the standard of care for health care providers as the national standard of care enunciated in *Shilkret*.[74]

Numerous states,[75] along with the Federation of State Medical Boards, [76] have endorsed the same-standard approach. In fact, the MBP is currently evaluating new regulations, including a standard of care provision stating that "a telehealth practitioner is held to the same standards of practice as those applicable in traditional health care settings…."[77]

Despite Maryland's idiosyncratic approach to the standard of care, the same-standard approach would help ensure that all patients receive the same level of care, whether in-person or otherwise.[78] Proponents of the same-standard approach argue that it is necessary for patient safety.[79] Physicians' diagnostic abilities may be inhibited outside the traditional in-person patient care setting.[80] For example, due to the physical limitations often associated with telemedicine, a physician utilizing telemedicine technologies may not "observe first hand clinical clues, such as the smell of a patient's breath."[81] Therefore, the same-standard approach forc-

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63 See J. Kelly Barnes, *Telemedicine: A Conflict of Laws Problem Waiting to Happen—How Will Interstate and International Claims Be Decided?*, 28 HOUS. J. INT'L L. 491, 529 (2006). A minority of states utilize the locality standard. *See* Marc D. Ginsberg, *The Locality Rule Lives! Why? Using Modern Medicine to Eradicate An Unhealthy Law*, 61 DRAKE L. REV. 321, 324 (2013).

64 *See* W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS 187 (W. Page Keeton ed., 5th ed. 1984).

65 *See id.*

66 *See Barnes*, *supra* note 63 at 529.

67 276 Md. 187 (1975).

68 *See id*. at 199–200 (1975). The *Shilkret* Court set out the standard of care as follows: A physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances, and under this standard, advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, together with all other relevant considerations, are to be taken into account. *Id.* at 200—201.

69 *Id.* at 200.

70 *See* MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-02; *see also* John M. Williams Jr., Note, *A "Familiar" Standard of Care: What the Same or Similar Communities Standard Could Mean For Maryland*, 41 BALTIMORE L. REV. 193, 205 (2011).

71 MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-02 (emphasis added).

72 *See* Williams Jr., *supra* note 70 at 206.

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

74 *See* MD. CIVIL PJI, 27:3 STANDARD OF CARE – DEFINED (2017) ("The standard of care for a health care provider is that degree of care and skill that would be used by a reasonably competent health care provider engaged in a similar practice and acting in similar circumstances.").

75 *See*, e.g., TENN. CODE ANN. § 63-1-155(c)(1)(A) (2017) (stating that "[a] healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area or specialty that is providing the same healthcare services through in-person encounters, and nothing in this section is intended to create any new standards of care."); N.H. REV. STAT. ANN. § 329:1-d (2017) (creating the standard of care for physicians and surgeons: "[a] physician providing services by means of telemedicine directly to a patient shall: (a) Use the same standard of care as used in an in-person encounter; (b) Maintain a medical record; and (c) Subject to the patient's consent, forward the medical record to the patient's primary care or treating provider, if appropriate."); S.C. CODE ANN. § 40-47-37 (2017) (stating, "A licensee who establishes a physician-patient relationship solely via telemedicine . . . shall adhere to the same standard of care as a licensee employing more traditional in-person medical care and be evaluated according to the standard of care applicable to the licensee's area of specialty."); COLO. REV. STAT. § 10-16-123(2) (2017) (requiring that "[a]ny health benefits provided through telemedicine is the same standard of care as for in-person care.").

76 *See* FEDERATION OF STATE MEDICAL BOARDS, MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE 4 (2014), http://www.fsmb.org/globalassets/advocacy/policies/fsmb_telemedicine_policy.pdf ("Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings.").

77 *See* Lacktman, *supra* note 53. The existing Maryland regulations do not expressly set forth any standard of care for telemedicine. See MD. CODE REGS. 10.32.05 (2018).

78 *See* Kaspar, *supra* note 62 at 855.

79 *See* FEDERATION OF STATE MEDICAL BOARDS, *supra* note 76 at 2 (providing a model policy for use by state medical boards that promotes "widespread appropriate adoption of telemedicine technologies for delivering health care while ensuring the public health and safety."); *see id.* at 7 ("Temedicine technologies … must implement measures to uphold patient safety in the absence of traditional physical examination.").

80 *See* Kaspar, *supra* note 62 at 856.

81 *See* Kelly K. Gelein, Note, *Are Online Consultations a Prescription for Trouble? The Uncharted Waters of Cybermedicine*, 66 BROOK. L. REV. 209, 253 (2000).

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es physicians to determine for themselves whether they have sufficient information to provide adequate patient care without in-person interaction.[82]

However, the same-standard approach also poses significant barriers to the growth of telemedicine.[83] The same-standard approach would likely result in telemedicine physicians being held liable anytime they did not detect something that would have been identifiable if care was provided in-person.[84] Therefore, this approach may increase the risk of medical malpractice claims against telemedicine physicians.[85] Physicians will be reluctant to rely upon telemedicine technology for patient care, despite its great potential benefits.[86]

B. Type of Telemedicine Approach

Another alternative is to determine the standard of care based on the nature of the telemedicine. More specifically, this approach asks whether a physician was at a diagnostic disadvantage simply because care was rendered through telemedicine rather than in-person.[87] If provision of the service using telemedicine is virtually the same as providing that service in-person such that there is no diagnostic disadvantage, the same standard of care should apply to both telemedicine and traditional medicine medical malpractice cases.[88] When the opposite is true, an identical standard should not be imposed. [89]

To illustrate, consider a medical malpractice lawsuit brought against a radiologist for allegedly failing to diagnose a patient's lung cancer after reviewing the patient's chest x-rays.[90] It is irrelevant whether the radiologist interpreted the x-rays at the site they were generated or at a remote location upon receiving the x-rays via store-and-forward telemedicine technology because both teleradiologists[91] and traditional radiologists should read x-rays the same way.[92] Therefore, there is no diagnostic disadvantage and the standard of care should be defined by the traditional medical malpractice standard of care.[93] This makes sense because the standard used "should not excuse subpar care in areas of telemedicine that do not put physicians at a disadvantage simply because assistance was rendered through telemedicine."[94]

On the other hand, using telemedicine to provide patient care may differ significantly from providing the same care in-person by placing the telephysician at a diagnostic disadvantage. For example, a hospital emergency room may use video conferencing to connect emergency providers with a remote specialist who otherwise would not be available for consults.[95] Despite the substantial benefits of these video consultations, there are certain diagnostic limitations that accompany this use of telemedicine.[96] As discussed in Part III, Section A, *supra*, there may be significant differences in the provision of health care via technology rather than in-person, placing telephysicians at a disadvantage simply due to the use of telemedicine technologies.[97] Under those circumstances, the type-of-telemedicine approach provides that the standard of care in a telemedicine medical malpractice case should not be defined by the traditional medical malpractice standard of care. At least one state, Hawaii, appears to be utilizing this approach by holding telephysicians "to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit ....". [98]

It is unclear, however, what standard of care should be used when the practice of telemedicine differs significantly from traditional medicine. At least one commentator suggests that telephysicians should be held to a higher standard of care than traditional physicians in order to ensure that the lack of in-person interaction does not hinder patient care.[99] The heightened standard would aim to "effectively deter physicians from making inappropriate decisions as a result of limited data and encourage telephysicians to defer these decisions to the on-site physician."[100] Conversely, another commentator argues that telephysicians should be held to a lower standard of care in order to accommodate the lack of in-person interaction often associated with telemedicine.[101] The lower standard takes into account that telephysicians may not observe first-hand physical patient symptoms to the extend observable in by traditional physicians interacting with a patient in-person.[102]

Nevertheless, determining the standard of care based on the nature of the medical procedure helps alleviate some concerns, discussed in Part III.A, *supra*, about holding telephysicians to the same standard of care as traditional physicians.[103] The type-of-telemedicine approach, however, also poses significant implementation issues. It would necessitate the legislature to enumerate the types of telemedicine that should be held to varying standards of care.[104] Otherwise, there is the risk of inconsistent and arbitrary decisions by fact-finders regarding the nature of the telemedicine treatment.[105]

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82 *See* DANIEL CASTRO ET AL., *supra* note 17 at 9.
83 *See* Wibberley, *supra* note 22 at 911.
84 *See* Kaspar, *supra* note 62 at 864.
85 *See* Wibberley, *supra* note 22 at 911.
86 *See* Kaspar, *supra* note 62 at 856.
87 *See id.* at 862.
88 *See id.* at 855; Lisa Rannefeld, *The Doctor Will E-Mail You Now: Physicians' Use of Telemedicine to Treat Patients Over the Internet*, 19 J. L. & HEALTH 75, 100 (2004).
89 *See* Rannefeld, *supra* note 88 at 100.
90 *See* Feinberg v. Feit, 23 A.D.3d 517, 806 N.Y.S.2d 661 (2005).
91 For more information on teleradiology, a subset of telemedicine, see generally Vivek Nayar, *Teleradiology: Images of an Improved Standard of Medical Care?*, 35 RUTGERS COMPUTER & TECH. L.J. 104 (2008).
92 *See* Rannefeld, *supra* note 88 at 100.
93 *See id.*
94 *See* Kaspar, *supra* note 72 at 862–63.
95 *See* Video Conferencing, *supra* note 37.
96 *See*, *supra* notes 80–82 and accompanying text.
97 *See*, *supra* notes 80–84 and accompanying text.
98 Haw. Rev. Stat. § 453-1.3(c) (2017).
99 *See* Rannefeld, *supra* note 88 at 100.
100 *See id.*
101 *See* Gelein, *supra* note 81 at 253 n. 257.
102 *See id.*
103 *See*, *supra* notes 83–86 and accompanying text.
104 *See* Kaspar, *supra* note 82 at 856.
105 *See id.*

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IV. Recommendation for Maryland's Standard of Care: A Blended Approach

Maryland should follow a two-part, blended approach for the standard of care in telemedicine medical malpractice cases.[106] In both telemedicine and traditional medical malpractice cases, Maryland Pattern Jury Instruction should be the same and read as follows: "[t]he standard of care for a health care provider is that degree of care and skill that would be used by a reasonably competent health care provider engaged in a similar practice and acting in similar circumstances."[107] However, in telemedicine medical malpractice cases, additional consideration should be given to the "similar practice and acting in similar circumstances" language in the standard of care jury instructions.[108]

Therefore, under the blended approach, the fact-finder in a telemedicine medical malpractice case must undertake a two-part inquiry. First, the fact-finder must determine whether a reasonably competent physician would have used telemedicine to provide patient care under the circumstances of a given case. If the fact-finder determines the decision to use telemedicine was reasonable, the fact-finder then must compare the telephysician's conduct to the conduct of other physicians practicing telemedicine, rather than physicians employing traditional in-person medical care, to determine whether the telephysician adhered to the standard of care.

In effect, the first inquiry follows the same-standard approach by requiring telemedicine health care providers to exercise the same standard of care as that of a traditional in-person standard of care when deciding whether it is appropriate to use telemedicine to render patient care in a given case.[109] Utilizing the same-standard approach for this first inquiry forces telephysicians to ensure technology is sufficient to provide the same necessary information as if the exam had been performed in-person.[110] This way, patient safety is maximized by ensuring telephysicians have enough information to provide adequate care regardless of the medium through which it is provided.[111] This approach also prevents telephysicians from using technology as an excuse for subpar patient care.[112]

Moreover, by focusing on the health care provider's *choice* to use telemedicine, this approach avoids the need to classify the types of telemedicine that should be held to varying standards of care due to diagnostic disadvantages.[113] Instead, the fact-finder may consider any alleged diagnostic disadvantages under the first inquiry in determining whether the choice to use telemedicine was reasonable.[114]

The second inquiry takes into consideration the nature of telemedicine by placing emphasis on the "similar practices" and "similar circumstances" language in Maryland's standard of care jury instructions. Despite the fact that telemedicine is merely a means through which health care is delivered, it often requires special skills and knowledge that should be taken into consideration.[115] As one commentator explained:

> Telemedicine proposes a new and different way of practicing medicine, one that requires both a knowledge of unconventional equipment and a recognition and understanding of the unique interaction between physicians and patients in remote locations using video, electronic, and digital equipment. Insofar as telemedicine practitioners possess knowledge and skills far different from those of traditional practitioners, courts should judge them in comparison with others in their own specialty.[116]

Therefore, this blended approach will help accommodate potential conflicting viewpoints between telephysicians and traditional physicians as to what constitutes reasonable care under the circumstances. Further, placing special consideration on the "similar practices" and "similar circumstances" will help ease health care provider liability concerns when deciding whether to practice telemedicine in Maryland.[117]

The MDC Expert List

The MDC expert list is designed to be used as a contact list for informational purposes only. It provides names of experts sorted by area of expertise with corresponding contact names and email addresses of MDC members who have information about each expert as a result of experience with the expert either as a proponent or as an opponent of the expert in litigation. A member seeking information about an expert will be required to contact the listed MDC member(s) for details. The fact that an expert's name appears on the list is not an endorsement or an indictment of that expert by MDC; it simply means that the listed MDC members may have useful information about that expert. MDC takes no position with regard to the licensure, qualifications, or suitability of any expert on the list.

V. Conclusion

Telemedicine has the potential to positively transform health care because it allows for greater patient access to quality health care at reduced costs.[118] In order to encourage health care providers to utilize telemedicine, while also maintaining quality patient care, Maryland should set the standard of care for telemedicine according to the blended approach explained in Part IV, *supra*. The blended approach helps ensure telephysicians are not held liable simply because something that may have been detectable in-person was not detectable using telemedicine, as long as the decision to use telemedicine in the first place was reasonable.

Rachel E. Brown, J.D. is a 2018 honors graduate of the University of Maryland Francis King Carey School of Law. Rachel is currently the judicial law clerk for the Honorable Colleen A. Cavanaugh in the Circuit Court for Baltimore County. Rachel can be reached at brownra1213@gmail.com.

106 Based on my research, this is an entirely novel approach that has not been suggested in any other articles.
107 *See* MD. CIVIL PJI, 27:3 STANDARD OF CARE – DEFINED (2017).
108 *See id.*
109 *See*, *supra* Part II.A.
110 *See* Wibberley, *supra* note 22 at 931.
111 *See*, *supra* note 78 and accompanying text.
112 *See id.* at 925–926 (2017).
113 *See*, *supra* notes 104–105 and accompanying text.
114 *See* Kaspar, *supra* note 62 at 863.
115 *See* Lynette A. Herscha, *Is There A Doctor in the House? Licensing and Malpractice Issues Involved in Telemedicine*, 2 B.U. J. SCI. & TECH. L. 8, 41 (1996)
116 *See id.*
117 *See*, *supra* notes 83–86 and accompanying text.
118 *See*, *supra* note 3.

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