IN THE COURT OF APPEALS OF MARYLAND

No. 12, September Term, 2017

SHELIA DAVIS, et al.

Appellants,

v.

FROSTBERG FACILITY OPERATIONS, LLC,

Appellee.

Appeal from the Court of Special Appeals of Maryland
No. 540, September Term, 2015
and
Circuit Court for Allegany County, Maryland
(The Honorable W. Timothy Finan, Judge)

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND MEDCHI, THE MARYLAND STATE MEDICAL SOCIETY

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QUESTION PRESENTED

Whether the lower courts properly found that a nursing home patient's injury stemming from fall from a mechanical lift administered by a medical professional is a "medical injury" requiring Appellant to file a claim in the Maryland Healthcare Alternative Dispute Resolution Office before filing a lawsuit?

INTEREST OF *AMICI CURIAE*

Amici believe that it is in the interests of Maryland physicians, patients, and public health to address claims of injuries related to medical care through the arbitration process before resorting to lengthy and expensive litigation.

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state, including Maryland, and in every medical specialty. The AMA supports reforms to the medical liability system, including affidavit of merit requirements, such as that at issue in this case, which help eliminate meritless lawsuits and reduce the costs of litigation. *See* Am. Med. Ass'n, Federal Medical Liability Reform H-435.978, Policy H-435.978(2)(a) (2015), *at* https://policysearch.ama-assn.org/policyfinder/detail/H-435.978?uri=%2FAMADoc%2FHOD.xml-0-3821.xml; Am. Med. Ass'n, Medical Liability Reform Now 30 (2017), *at*

https://www.ama-assn.org/sites/default/files/media-browser/premium/arc/mlr-now.pdf [hereinafter "AMA, Medical Liability Reform"].

MedChi, The Maryland State Medical Society, is a statewide, non-profit association of Maryland physicians. It is the largest physician organization in Maryland. MedChi, formally known as The Medical and Chirurgical Faculty of Maryland, was founded in 1799 by an act of the Maryland General Assembly. Today, MedChi's mission is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health. MedChi supports initiatives that improve the possibility of resolution of a claim prior to the filing of a lawsuit, which has the effect of decreasing medical liability cases while allowing claimants appropriate relief.

STATEMENT OF THE CASE

This is an appeal from the Court of Special Appeals' January 27, 2017 opinion affirming an order of the Circuit Court for Allegany County granting Frostberg Facility Operation, LLC's Motion to Dismiss Appellants' Second Amended Complaint. *Davis v. Frostberg Facility Ops.*, LLC, No. 540, 2017 WL 383454 (Md. Ct. App. Jan. 27, 2017). The Court of Special Appeals ruled that the Health Care Malpractice Claims Act ("the Act"), Md. Code, Cts. & Jud. Proc. §§ 3-2A-01 to 3-2A-09, required the Appellants to file their claim with the Maryland Healthcare Alternative Dispute Resolution Office ("ADR Office") before filing a lawsuit in the Circuit Court. *See id.* at *6. The Court of Special Appeals recognized that Ms. Davis's claim alleges a "medical injury" subject to the Act's prerequisites. *See id.* The court properly found that irrespective of how Appellants worded their complaint, as a patient admitted to Frostberg Village for

medically-specific recovery and rehabilitation, Ms. Davis alleged that the healthcare provider committed professional negligence, either by failing to properly attach her bed to its frame or by failing to use a mechanical lift designed to return patients to their beds after a fall. *Id.*

STATEMENT OF FACTS

Amici provide this Statement of Facts to amplify facts included in the parties' briefs that are most significant to *Amici's* Argument.

Ms. Davis was admitted to Frostberg Village for recovery and physical rehabilitation services following back surgery. (E 33). Appellants allege that on October 26, 2011, Ms. Davis fell from her bed. (*Id.*). After her roommate called for the assistance of a nurse, a nurse responded and informed Appellant that Frostberg was a "no lift facility." (E. 34). The nurse then retrieved a mechanical lift. (*Id.*). Appellants allege that in the course of raising Ms. Davis from the floor to her bed using this specialized piece of medical equipment, the nurse dropped Ms. Davis from above the height of the bed, causing her to fall back to the floor and suffer significant injuries. (*Id.*). Appellants allege that the nurse indicated that she had not operated the mechanical lift before. (*Id.*).

SUMMARY OF THE ARGUMENT

The Maryland General Assembly has adopted a process for weeding out meritless claims and facilitating resolution of disputes involving medical care. This process, which the Appellants did not use, requires individuals who allege medical injuries to file a claim along with a certificate of a qualified expert and report with the ADR Office before filing a lawsuit. The legislature adopted this system to avert a medical liability crisis. It is at

the foundation of reforms that have stabilized the medical liability insurance market for Maryland physicians and preserved access to healthcare for the state's residents. Maryland courts have repeatedly rejected attempts to sidestep these simple requirements and proceed directly to court.

Here, the Appellant presents her fall from a mechanical lift at a nursing home, where she was admitted for rehabilitation after a surgery, as an injury to a mere resident stemming from ordinary negligence. But such artful pleading cannot mask that the crux of her claim is that a healthcare professional negligently used medical equipment, and that the Appellee, a healthcare provider, did not adequately train her. *Amici* urge this Court to affirm the decision of the Court of Special Appeals, and, in doing so, preserve the integrity of a system that avoids unnecessary, costly litigation.

ARGUMENT

I. PROPER APPLICATION OF THE HEALTH CARE MALPRACTICE CLAIMS ACT IS ESSENTIAL TO PRESERVING AFFORDABLE MEDICAL CARE IN MARYLAND

Courts should not allow individuals who allege injuries caused by a healthcare provider's negligent provision of care to sidestep Maryland's alternative dispute resolution system by creatively drafting complaints. The Court of Special Appeals properly rejected such an attempt. Permitting otherwise would open the door to more meritless lawsuits against doctors and unnecessary, costly litigation, thwarting the intent of the General Assembly in establishing this system.

In the mid-1970s, insurance rates for medical malpractice coverage spiked in Maryland. The state's largest insurer, facing a $10 million deficit and continuing to lose

money, planned to stop offering insurance coverage to Maryland physicians. *See St. Paul Fire & Marine Ins. Co. v. Ins. Comm'r*, 275 Md. 130, 133-39, 339 A.2d 291, 293-95 (1975). No other insurer offered to provide coverage to the 3,600 Maryland physicians it insured. *Id.*, 275 Md. at 138-41, 339 A.2d at 295-97. To avert a crisis, the General Assembly enacted the Health Care Malpractice Claims Act ("the Act") in 1976. At the heart of these reforms is an arbitration system requiring claimants alleging a medical injury to submit a certificate of a qualified expert supporting the claim before the case is allowed to move forward. *See Attorney General v. Johnson*, 282 Md. 274, 280-81, 385 A.2d 57, 61 (1978).

These requirements, along with other reforms, improved Maryland's medical liability climate. The Act discourages non-meritorious claims because the lack of evidence supporting a claim is revealed prior to filing a lawsuit. *See Carrion v. Linzey*, 342 Md. 266, 275, 675 A.2d 527, 531 (Md. 1996). Even when lawsuits lack merit, they result in significant costs for healthcare providers and their insurers. The average cost of defending a medical liability claim, even when it is voluntarily dismissed or withdrawn is over $30,000. *See* AMA, Medical Liability Reform at 4 (citing 2015 data provided by PIAA, a trade association of medical liability insurers). By contrast, the cost of defending a lawsuit that goes to trial is $191,341 when a defendant prevails and $262,141 when a plaintiff obtains a favorable verdict. *Id.* Thus, Maryland's prerequisites to filing a medical malpractice claim significantly impact the costs of defending meritless claims. As this Court has recognized, the HCMCA's purpose "is to screen malpractice claims, ferret out meritless ones, and, in theory, thereby lower the cost of malpractice insurance

and the overall cost of health care." *Alder v. Hyman*, 334 Md. 568, 575, 640 A.2d 1100, 1103 (1994). Further, this system also encourages early resolution of claims that may have merit. *See Carrion,* 342 Md. at 275, 675 A.2d at 531.

The requirements of the Act are easy to meet. They provide a minimal, yet essential, framework for resolving disputes about medical care without the need for litigation. Any claim against a healthcare provider due to a medical injury that seeks more than $30,000 in damages must be initially filed with the ADR Office, where the claim is subject to nonbinding arbitration. *See* Md. Code, Cts. & Jud. Proc. §§ 3-2A-02(a), 3-2A-04(a). Filing a claim with the ADR Office satisfies the three-year statute of limitations, ensuring that a claimant can later file a lawsuit if the complaint is unresolved. *Id.* § 5-109(a), (d).

A claim submitted to the ADR Office must be accompanied by a certificate and a report of a qualified expert or supported by the filing of such materials within 90 days. *See* Md. Code, Cts. & Jud. Proc. § 3-2A-04(b)(1)(i). This requirement is particularly important to achieving the public policy goals of the Act. "The obvious purpose of the certificate requirement reflects the General Assembly's desire to weed out, shortly after suit is filed, nonmeritorious medical malpractice claims." *D'Angelo v. St. Agnes Healthcare, Inc.*, 157 Md. App. 631, 645, 853 A.2d 813, 822 (2004). Ensuring that a physician who is familiar with the applicable standard of care has reviewed the allegations and found that a healthcare provider's deviation from that standard caused the claimant's injury before a claim proceeds also "assist[s] the plaintiff or defendant in evaluating the merit of the health claim or defense." *Walzer v. Osborne*, 395 Md. 563,

583, 911 A.2d 427, 438 (2006). This requirement "has proven to be a strong impediment to frivolous suits." Peter Stackpole, *Recent Decisions: The Maryland Court of Appeals*, 57 Md. L. Rev. 925, 930 (1998).

A 1995 Amendment to the Act provides that once a claimant has properly filed a claim with the ADR Office, including the certificate of qualified expert, the claimant may unilaterally waive the alternative dispute resolution process and request a transfer order from the ADR Office. *See* Md. Code, Cts. & Jud. Proc. § 3-2A-06B(b)(1). At this point, most claimants elect to proceed to court. *See* A. Thomas Pedroni & Ruth F. Vadi, *Mandatory Arbitration or Mediation of Health Care Liability Claims*, Md. B.J. 54, 56 (Mar./Apr. 2006). Otherwise, the case continues to arbitration, where a three-member panel, experienced in medicine, can expeditiously reach decisions and award damages when appropriate. *See Carrion*, 342 Md. at 275, 675 A.2d at 531. Panel members are chosen at random from a list of qualified persons maintained by the Director of the ADR Office. *See* Md. Code, Cts. & Jud. Proc. §§ 3-2A-03(c). If the parties accept the award, then it becomes final and binding. *See id.* § 3-2A-05(h). Alternatively, either party can contest the award by filing an action in court within thirty days; the arbitration decision is admissible and presumed correct. *See id.* § 3-2A-06(a), (d).

Since adoption of this system and other reforms, Maryland's medical malpractice insurance market has stabilized.[1] Data indicates that the number of medical malpractice

[1] When insurance rates again climbed, the General Assembly added safeguards to the solid foundation of the arbitration and certificate of qualified expert process. *See* H.B. 2 (Md. 2005) (establishing a separate cap on noneconomic damages in medical liability cases and temporarily freezing amount of limit and making apologies

payments and the amounts of those payments has been stable in Maryland for at least the past decade. *See* Nat'l Practitioner Data Bank, NPDB Research Statistics, *at* https://www.npdb.hrsa.gov/resources/npdbstats/npdbStatistics.jsp (providing medical malpractice payment data reported by Maryland medical practitioners between 2006 and 2016). Likewise, the rates paid by Maryland physicians for malpractice insurance have held steady or decreased for over a decade. *See* Md. Ins. Admin., 2015 Report on Availability and Affordability of Health Care Medical Professional Liability Insurance in Maryland, Exh. A5 (Oct. 2015), *at* http://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Availability-and-Affordability-of-Health-Care-Medical-Professional-LiabilityInsMD-Report-2015.pdf. Narrowly interpreting the "medical injury" as the Plaintiffs suggest, would allow them to circumvent these reforms and jeopardize this progress.

II. A PATIENT'S FALL FROM MEDICAL EQUIPMENT OPERATED BY A HEALTHCARE PROFESSIONAL IS A "MEDICAL INJURY" TRIGGERING THE ALTERNATIVE DISPUTE RESOLUTION PROCESS

Maryland courts have established a set of principles for evaluating whether a claim alleges a "medical injury" that falls within the requirements of the Health Care Malpractice Claims Act. Here, as the lower courts properly found, Appellants' claim falls squarely within the Act, requiring the filing of a claim with the ADR Office before resorting to litigation. This Court should reaffirm these principles and remind plaintiffs

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inadmissible as an admission of liability, among other reforms); S.B. 558 (Md. 1986) (establishing limit on noneconomic damage awards applicable to all personal injury cases, requiring juries to itemize damage awards, and allowing periodic payment of future economic damages).

that any ambiguity as to whether a claim falls within the Act should be resolved by the ADR Office.

The Act provides that "[a] person having a claim against a health care provider for damage due to a medical injury shall file his claim with the Director . . . ." Md. Code, Cts. & Jud. Proc. § 3-2A-04(a). The Act defines a "medical injury" as an "injury arising or resulting from the rendering or failure to render health care." *Id.* § 3-2A-01(g). Claims that fall within the Act generally (1) involve a healthcare provider-patient relationship; (2) involve an act or omission by a medical professional acting within that capacity; and (3) allege a breach of a duty of care in exercising professional skills and duties. *See Cannon v. McKen*, 296 Md. 27, 36-37, 459 A.2d 196, 201 (1983).

By way of contrast, when a visitor to a health care facility alleges an injury, it generally does not fall within the Act. *See Swam v. Upper Chesapeake Med. Ctr.*, 397 Md. 528, 539, 919 A.2d 33, 39 (2007) (holding daughter of patient whose hand was punctured by uncapped hypodermic syringe left on counter did not allege medical injury, but alleged improper disposal of medical waste). A patient who alleges an intentional tort that is unrelated to medical treatment, such as that a doctor maliciously struck a patient, also need not first go to arbitration. *See Nichols v. Wilson*, 296 Md. 154, 161, 460 A.2d 57, 61 (1983) ("In no way can it be said that the legislature intended [a claim sounding in traditional assault and battery terms] to be within the Act . . . ."). Likewise, the victim of a crime committed by a fellow patient on hospital grounds does not fall within the Act because the injury was "not inflicted by a medical care provider or as a result of that provider's treatment or failure to treat." *Afamefune v. Suburban Hosp., Inc.*,

385 Md. 677, 694, 870 A.2d 592, 602 (2005) ("[A]n assault, rape, or attempted rape can in no way be described as medical service. . . .").[2]

Claims brought against a provider stemming from its status as a premises owner or arising from other non-professional circumstances do not trigger an obligation to proceed to arbitration before filing a lawsuit, but this is not such a case. *See Cannon*, 296 Md. at 34-35, 459 A.2d at 200. A slip-and-fall allegedly caused by water left on the floor of a hospital bathroom by cleaning staff to a fall on a poorly maintained stairway in a nursing home, for example, present common negligence actions that would not fall within the scope of the Act. *See id.*

Here, Appellants attempt to fall within this exception by presenting their action as one for "ordinary negligence" from a fall at her "residence." However, Appellants cannot mask that the "factual landscape" of this case: a patient admitted to a health care facility for recovery and rehabilitation after a surgery, who fell from her bed and affirmatively requested the assistance of a nurse, and who was further injured when she fell from a mechanical lift operated by the nurse. *See Davis v. Frostberg Facility Ops.*, LLC, No. 540, 2017 WL 383454, at *6 (Md. Ct. App. Jan. 27, 2017). As the court below recognized, the crux of the claim is that a medical professional dropped a patient as a result of negligently using special medical equipment and that the hospital inadequately

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[2] *Cf. Goicochea v. Langworthy*, 345 Md. 719, 729, 694 A.2d 474, 479 (1997) (finding claim fell within Act where plaintiff alleged doctor caused groin injury resulted from improperly conducted hernia examination irrespective of presenting claim as one for "assault and battery"); *Jewell v. Malamet*, 322 Md. 262, 274, 587 A.2d 475, 481 (1991) (holding claim alleging inappropriate sexual contact by doctor during examination fell within Act because alleged contact could have had valid medical explanation).

trained its nursing staff. *See id.* Although this Court has recognized that an injury resulting from a *malfunction* of medical equipment may in some instances present "a closer situation" than the typical medical negligence claim, *see Cannon*, 296 Md. at 36, 459 A.2d at 201, this case is not a close call. The Appellants do not claim that the lift was faulty or defective; they allege negligent use of the equipment. That is precisely the type of claim involving professional skill that falls within the Act.

When there is some ambiguity as to whether a claim alleges a medical injury—which there is not in this instance— this Court has repeatedly instructed that a plaintiff must file the "borderline" claim with the ADR Office, as the General Assembly has provided it with statutory authority to make an initial determination. *See Swam*, 397 Md. at 541, 919 A.2d at 40 (citing *Goicochea*, 345 Md. at 729, 694 A.2d at 479, and *Jewell*, 322 Md. at 274, 587 Ad.2d at 480). Nevertheless, here, Appellants did not take this path and the Circuit Court properly dismissed the claim.

CONCLUSION

For these reasons, this Court should affirm the lower courts.

Respectfully submitted,

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CERTIFICATE OF WORD COUNT AND COMPLIANCE WITH RULE 8-504

1. This brief contains 2,978 words, excluding the parts of the brief exempted from the word count by Rule 8-503.

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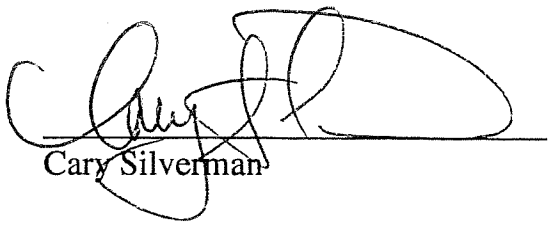

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of July, 2017, two copies of the foregoing Brief of *Amici Curiae* were sent by first class U.S. mail, postage prepaid, to the following:

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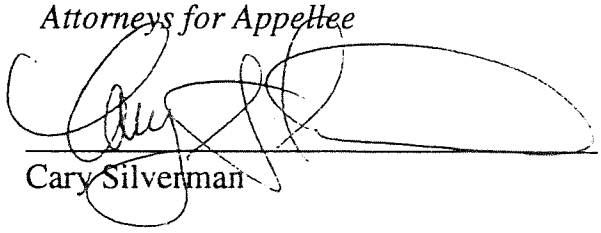

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