Circuit Court for Allegany County
Case No. C-01-CV-24-000081

UNREPORTED*

IN THE APPELLATE COURT

OF MARYLAND

No. 1596

September Term, 2024

CHRISTIAN OTTO

v.

UPMC WESTERN MARYLAND CORPORATION, *et al.*

Arthur,
Ripken,
Kehoe, Christopher B.,
(Senior Judge, Specially Assigned),

JJ.

Opinion by Ripken, J.

Filed: December 11, 2025

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

In the Circuit Court for Allegany County, Christian Otto ("Otto"), appellant, brought a medical malpractice action against UPMC Western Maryland Corporation ("UPMC"),[1] appellee, claiming that UPMC's negligent prevention, diagnosis, and treatment of his sacral decubitus ulcer led to emotional, physical, and economic damages.

As required for medical malpractice claims in Maryland,[2] Otto filed a certificate of qualified expert ("CQE") and accompanying report ("report"), written by his proposed expert, Nicholas Verdura, M.D. ("Dr. Verdura"), and addressing the allegations of breach. UPMC moved to dismiss, asserting that Otto's CQE and report were insufficient under CJP §§ 3-2A-01 *et seq.* Following a hearing on the issue, the circuit court granted UPMC's motion to dismiss. Otto noted this timely appeal, and presents the following issues for our review:[3]

[1] In the original complaint Otto also filed suit against the following healthcare providers: Allegany Imaging, PC; Allegany Surgical Associates, PA; Proactive Pain and Neurology, LLC; UPMC Western Maryland Health Services Corporation; and UPMC Western Maryland Health Services, LLC. These defendants were dismissed with prejudice by stipulation between the parties, leaving Otto's claims only as to UPMC Western Maryland Corporation and its agents, servants, and employees.

[2] Maryland Health Care Malpractice Claims Act, Md. Code (1974, 2020 Repl. Vol.), sections 3-2A-01 *et seq.* of the Courts and Judicial Proceedings Article ("CJP").

[3] Rephrased from:

> I. Under Md. Courts and Judicial Proceedings Code Ann. § 3-2A-02(c)(2)(ii)1B can a general surgeon certify a case as meritorious as to health care professionals when it comes to seeing, recognizing, and addressing a pressure ulcer in the context of seeing a patient in a hospital?
>
> II. Did Appellant's Certificate of Qualified Expert & Attesting Report sufficiently state what standards of care Appellee breached in its care and treatment of Appellant?

1. Whether the circuit court erred in granting the motion to dismiss based on CJP § 3-2A-02(c)(2)(ii)1B's peer-to-peer requirement.

2. Whether the circuit court erred in granting the motion to dismiss based on CJP § 3-2A-02's standard of care requirement.

For the reasons to follow, we hold that the circuit court erred in granting UPMC's motion to dismiss.

FACTUAL AND PROCEDURAL BACKGROUND

On November 3, 2020, Otto was admitted to the emergency room at UPMC Western Maryland with drowsiness and intermittent loss of consciousness. Upon admission, and throughout his two-week stay, Otto was treated by a myriad of physicians and nurses at UPMC.[4] Although consultation reports noted that Otto presented as morbidly obese, a

[4] Dr. Mohammed Ali was the admitting physician, and Lindsey Deaner, RN and Wendy LaFrambroise, RN were the initial triage nurses. On the first night Otto was in the hospital, he received a Portable Chest, Single View Procedure performed by Dr. G. Michael Dwyer. The following day, Otto received a pulmonary consultation by Dr. Maria Mayorga and a progress examination from Dr. Wondwoossen Bekele.

On November 5, Otto's echocardiogram was reviewed, and the report signed, by Dr. Pratikkumar Patel. Four days later, Dr. Benjamin Goldstein performed a palliative care consultation, noting that the patient's skin was "warm and moist." On November 10, Dr. Dennis Dey performed a neurology consultation, noting that the patient's skin was "dry without rashes."

On November 11, eight days after Otto's admission to the hospital, Dr. Mehmet Sayiner, an internal medicine doctor, saw Otto and noted that he had a sacral pressure ulcer. Dr. Sayiner ordered a bariatric bed. Dr. Sayiner saw Otto again on November 12, 13, 15, 16, and 17, each time reporting the same ulcer and again ordering a bariatric bed. Dr. Ayham Bataineh saw Otto on November 14 and diagnosed the pressure ulcer, reporting that it was "presented on admission" to the hospital. On November 17, Family Nurse Practitioner Lynn Metcalf reported that Otto had "no ulceration." On November 18 and 19, Dr. Khaled Awad saw Otto and noted the ulcer, also ordering a bariatric bed.

bariatric bed was not ordered for him until November 11, eight days following admission to the hospital. At that time, Otto was diagnosed with a sacral pressure ulcer. Otto underwent surgical debridement of the ulcer, and was discharged three days later on November 27.

Nearly two weeks later, after losing consciousness, Otto visited the Hampshire Memorial Hospital Emergency Room, where he was diagnosed with a stage III sacral decubitus ulcer. Otto received further treatment and transport to the Winchester Medical Center, and was subsequently discharged. In Otto's discharge assessment it was noted that for six months he would have severe discomfort from the ulcer, including the inability to sit for more than two hours at a time.

Per CJP section 3-2A-01, *et. seq.*, Otto filed a medical malpractice claim with the Health Care Alternative Dispute Resolution Office (the "Office") before filing his claim with the Circuit Court for Allegany County, asserting that UPMC's negligence, through their agents and employees, proximately and directly caused Otto "past and future mental anguish, emotional pain and suffering, physical pain and suffering, loss of society, companionship, and comfort as well as economic damages" associated with the infected

Dr. Milton Lum diagnosed Otto with a sacral pressure ulcer, and performed surgery on the ulcer on November 23. Following surgery, Dr. Awad examined Otto for an infected sacral decubitus ulcer. On November 24, Dr. Feiyu Hong also examined the "possibl[ly] infected sacral decubitus ulcer[.]" Dr. Christina Sensabaugh discharged Otto on November 27, with instructions to treat his infected ulcer with antibiotics and follow up with "general surgery and with Wound Care."

ulcer. Alongside Otto's claim to the Office, he filed the requisite CQE and accompanying expert report.

Otto's CQE, written by board-certified surgeon Dr. Nicholas Verdura, stated the opinion that

> [b]ased upon [Dr. Verdura's] experience in surgery as well as the medical records and information provided in this case [that] . . . within a reasonable degree of medical probability [UPMC] . . . and their agents, servants, and employees including but not limited to Mohammed Z. Ali, M.D., George Michael Dwyer, M.D., Wondwo[o]ssen Ayenew Bekele, M.D., Maria A. Mayorga, M.D., Benjamin S. Goldstein, M.D., Dennis Daniel Dey, M.D., Pratikkumar J. Patel, M.D., Mehmet Sayiner, M.D., Milton Yew Fair Lum, M.D., Feiyu Hong, M.D., Ayham Mahmoud Batineh, M.D., Khaled S[.] H[.] Awad, M.D., Christina Sensabaugh, M.D., Benjamin Goldstein, M.D.; Lynn Metcalf, NP; Lindsey Deaner; RN; and Wendy M. LaFramboise, RN violated the standard of care and that such violation proximately caused the injuries as alleged by [Otto].[5]

The report expanded upon Dr. Verdura's opinion in the CQE. Because of conflicting reports on when the ulcer first developed, the report identified two theories of alleged negligence:

> [1.] If we are to assume that Dr. Bataineh was correct and that there was an ulcer upon admission, all of the treating healthcare providers who saw [Otto] from the time of admission until November 14, 2020 failed to adhere to the standard of care in documenting the ulcer, monitoring the ulcer, treating the ulcer, and requesting consultations for the ulcer.
>
> [2.] If we are to assume that there was no ulcer upon admission, all of the treating healthcare providers who saw [Otto] from the time of admission until November 14, 2020 also failed to adhere to the standard of care in failing to monitor him for the development of an ulcer, failing to properly order[] nursing instructions for the preemptive treatment to avoid the development of the ulcer, in failing to take note of the objective findings that would

[5] The doctors and nurses listed in this part of the CQE will hereinafter be referred to as the "named providers," unless further specification of the provider is necessary.

> indicate a need to prevent the development of the ulcer, and in ultimately allowing the ulcer to develop.

The report then added that

> [S]ubsequent to November 14, 2020, all health care providers who were treating [Otto] failed to adequately control the development of the ulcer and allowed it to progress ultimately to an unstageable ulcer.
>
> These deviations [from] the standard of care allowed for the development of the ulcer, the subsequent treatment of the ulcer, and the current sequelae of the ulcer that [Otto] still suffers from today.

UPMC moved to dismiss the claims, asserting that Otto's CQE and report were deficient and therefore the statutory pre-claim requirements had not been satisfied. Following a hearing, the circuit court granted UPMC's motion to dismiss. The circuit court, relying on *Hinebaugh v. Garrett County Memorial Hospital*, 207 Md. App. 1 (2012), ruled that "a related specialty is one in which there is an overlap in treatment and procedure." The court noted that, under *Hinebaugh*, Dr. Verdura's board certification in general surgery and the named providers' certifications in internal medicine, pulmonary medicine, and infectious diseases may overlap as to "perform[ing] physicals"; however, "the overlap in treatment ends there." Otto noted a timely appeal. Additional facts are included below as they become relevant.

DISCUSSION

I. THE CQE MEETS THE STATUTORY PEER-TO-PEER REQUIREMENT.

A. Party Contentions

Otto contends that the circuit court's holding that the CQE and report were deficient—because Dr. Verdura's experience as a general surgeon did not sufficiently

overlap with the named providers' work in pulmonology, internal medicine, or infectious diseases—was in error. Otto asserts instead that, because the specific procedure or treatment in this case is examination for diagnosis, treatment, and prevention of a sacral decubitus ulcer, "[a]ny doctor doing a thorough history and physical would have discovered the ulcer and treated it appropriately or [given] directives to other treaters to handle it appropriately . . . regardless of specialty."

UPMC posits that, because none of the named healthcare providers are board certified in surgery and the treatment at issue did not involve surgery,[6] the circuit court did not err in granting the motion to dismiss based on the allegedly defective CQE.[7] Further, UPMC avers that the CQE and report do not address general deficiencies in "physical examinations" that overlap between specialties, but instead address the named providers' documentation of "objective findings that would indicate a need to prevent the

[6] UPMC asserts that Dr. Lum, a surgeon, who was "the only provider against whom Dr. Verdura could arguably have certified against," was voluntarily dismissed by stipulation when his employer, Allegany Surgical Associates, was dismissed in that manner. Despite this, under the laws of apparent agency in Maryland, a hospital may be vicariously liable for a non-employee surgeon's negligence where the patient was admitted through the hospital's emergency room and there was no reasonable notice given to the patient that emergency room staff, including the surgeon, were independent contractors. *See Williams v. Dimensions Health Corp.*, 480 Md. 24, 46, 53–54 (2022); *see also Mehlman v. Powell*, 281 Md. 269, 274–75 (1977). Here—where there are no allegations of notice given to Otto regarding Dr. Lum's employment but instead allegations that Otto was admitted through the UPMC emergency room—Dr. Lum was an apparent agent for UPMC and UPMC may be vicariously liable for his negligence, if found. Because there is no information in the record of Dr. Lum's board certification, and it does not affect the outcome *sub judice*, we do not reach whether Dr. Verdura can opine as to Dr. Lum specifically.

[7] Otto made no direct criticisms of his surgical ulcer debridement in the report, but the surgery and post-operative care fall under his treatment "subsequent to November 14, 2020[,]" which are criticized.

development of an ulcer." That type of work, UPMC asserts, is not sufficiently shared between general surgeons and any of the specialties held by the named providers.

B. Standard of Review

"Where an order [of the trial court] involves an interpretation and application of Maryland constitutional, statutory or case law, our Court must determine whether the trial court's conclusions are legally correct under a *de novo* standard of review." *Mayor and City Council of Baltimore v. Thornton Mellon, LLC*, 478 Md. 396, 410 (2022) (internal quotation marks and citation omitted). Therefore, "[w]hether a [CQE] and report of attesting expert are satisfactory under CJP section 3-2A-01 *et seq.* 'is a determination to be made as a matter of law.'" *Hinebaugh v. Garrett Cnty. Mem'l Hosp.*, 207 Md. App. 1, 17 (2012) (quoting *Carroll v. Konits,* 400 Md. 167, 180 n.11 (2007)). "Dismissal is only appropriate if, after assuming the truth of the assertions in the [CQE] and report, and all permissible inferences emanating therefrom, the requirements set forth in the Act are not satisfied." *Id.* (brackets omitted).

C. Analysis

The Health Care Malpractice Claims Act ("HCMCA"), CJP sections 3-2A-01 through 3-2A-10, requires any party who has a medical malpractice claim against a healthcare provider to first go through an arbitration process with the Health Care Alternative Dispute Resolution Office. CJP § 3-2A-04(a)(1)(i); *see also Puppolo v. Adventist Healthcare, Inc.*, 215 Md. App. 517, 526 (2013). "As a part of that process, unless the sole issue in the claim is lack of informed consent, the claimant must file a '[CQE] . . . attesting to departure from standards of care, and that the departure from standards of care

is the proximate cause of the alleged injury[.]'" *Canton Harbor Healthcare Ctr., Inc. v. Robinson*, 492 Md. 1, 6 (2025) (plurality opinion) (quoting CJP § 3-2A-04(b)(1)(i)); *see Robinson*, 492 Md. at 72 (Booth, J., concurring and dissenting). A report of the attesting expert, expounding on the expert's opinion, must accompany the CQE. *Walzer v. Osborne*, 395 Md. 563, 579–80 (2006).

Further, the CQE has a peer-to-peer requirement between the defendant and the attesting expert. *Robinson*, 492 Md. at 11 (plurality opinion); *id.* at 42–43 n.3 (Watts, J., concurring) (citing CJP § 3-2A-02(c)(ii)).

> In addition to any other qualifications, a health care provider who attests in a certificate of a qualified expert . . . concerning a defendant's compliance with or departure from standards of care . . . [s]hall have had clinical experience, provided consultation relating to clinical practice, or taught medicine in the defendant's specialty or a *related field of health care*, or in the field of health care in which the defendant provided care or treatment to the plaintiff, within 5 years of the date of the alleged act or omission giving rise to the cause of action[.]

CJP § 3-2A-02(c)(2)(ii)(1) (emphasis added). If a defendant is board certified in a medical specialty, then the attesting expert "shall be board certified in the same or *related specialty* as the defendant." CJP § 3-2A-02(c)(2)(ii)1B (emphasis added).

The purpose of the HCMCA, and its requirements, is to "screen malpractice claims, ferret out meritless ones, and, in theory, thereby lower the cost of malpractice insurance and the overall costs of health care." *Robinson*, 492 Md. at 6 (plurality opinion) (quoting *Adler v. Hyman*, 334 Md. 568, 575 (1994)); *Robinson*, 492 Md. at 39 (Watts, J., concurring) ("The General Assembly's purpose in amending the HCMCA to include the CQE requirement was to 'weed out' non-meritorious claims."); *Robinson*, 492 Md. at 81 (Booth,

J., concurring and dissenting) ("The General Assembly enacted the Act for purposes of weeding out non-meritorious claims and to reduce the costs of litigation.") (internal citation and alterations omitted). Under the HCMCA, "if a proper [CQE] has not been filed, the [statutory] condition precedent to maintain the action has not been met and dismissal is required[.]" *Carroll*, 400 Md. at 181 (citations omitted).

This Court defined the term "related specialty" as used in the HCMCA in *Hinebaugh*, writing that specialties are related "when there is an overlap in treatment or procedures within the specialties and therefore an overlap of knowledge of treatment or procedures among those experienced in the fields or practicing in the specialties, *and the treatment or procedure in which the overlap exists is at issue in the case.*" 207 Md. App. at 17–18 (emphasis added). *See also DeMuth v. Strong*, 205 Md. App. 521, 543–44 (2012) ("If a procedure is common to two specialties, an inference of relation is created between the two specialties. However, if the procedure is one [with] which the purported expert does not have experience or performs with a meaningfully different standard of care, then the expert does not qualify under the [HCMCA].") (quoting *Jones v. Bagalkotakar*, 750 F. Supp. 2d 574, 581 (D. Md. 2010)).

The appellate courts in Maryland have applied CJP section 3-2A-01, *et seq.* on several occasions, providing useful illustrations. This Court in *DeMuth* held that a board-certified vascular surgeon could opine as to the standard of care for a board-certified orthopedic surgeon as to postoperative care and vascular complications of orthopedic surgery, because vascular surgery and orthopedic surgery procedures contain overlap in training and treatment of those procedures. 205 Md. App. at 544–46. In *Nance v. Gordon*,

this Court held that nephrology and urology were related fields in the context of the action because the treatment rendered—a differential diagnosis at the time the patient presented to the emergency room—is regularly performed by specialists in both fields. 210 Md. App. 26, 41 (2013). In contrast, the Supreme Court of Maryland recently held that while a nurse could opine to the standard of care for nurses at a nursing facility, the nurse could not opine regarding physicians at the nursing facility because nurses and doctors did not have overlapping procedures or treatment methods at issue in the case. *Robinson*, 492 Md. at 25 (plurality opinion); *id.* at 57–58 (Booth, J., concurring and dissenting). Finally, in *Hinebaugh*—the case the circuit court here found dispositive—an oral surgeon was determined not to be in a field related to family medicine or radiology where the procedure at issue was front line diagnosis of facial fractures, because the oral surgeon did not diagnose facial fractures as a part of front line intake similar to what the family medicine doctor and radiologist performed; he instead saw patients after they had already been diagnosed with a facial injury. *Hinebaugh*, 207 Md. App. 1, 23–26 (2012).

Moreover, a CQE that satisfies the peer-to-peer requirement as to some named providers, but not others, satisfies the requirement overall because "[t]he claimant or plaintiff is *not required to prove his or her case* with the [CQE,]" and in reviewing the CQE the trial court is to "accept[] the assertions in the certificate, just as courts accept a plaintiff's well-pleaded facts and allegations in a complaint." *Kearney v. Berger,* 416 Md. 628, 652–53 (2010) (emphasis added). *See also Robinson*, 492 Md. at 34–35 (plurality opinion) (in analyzing whether an attesting expert meets the HCMCA peer-to-peer requirement in cases with multiple named providers in the report or CQE, where the named

providers are agents or employees of the same defendant, "[t]he presence of [some] opinions in the report that . . . violate the peer-to-peer requirement do[] not invalidate the [CQE]" if other opinions fall within the peer-to-peer requirement).

Here, Dr. Verdura is a board-certified general surgeon, and the named providers who are physicians are board-certified in internal medicine, infectious diseases, neurology, pulmonary disease, radiology, hospice and palliative medicine, and geriatric medicine, in addition to the nurses.[8] Dr. Verdura is also trained and certified in advanced wound care and, "included in [Dr. Verdura's] field of surgery is also post-surgical follow up care." The procedure at issue is the failure to monitor the development of—or in other words, physical examination for, and the documentation and treatment of, sacral decubitus ulcers.

As in *DeMuth* and *Nance*, the treatment at issue here—physical examination of a patient sitting for days in a hospital bed—is one shared between the specialties, whether performed by surgeons before and after surgery or as a hospitalist by the internal medicine doctor. *See* 205 Md. App. at 544–46; *see also* 210 Md. App. at 41. In contrast to *Robinson*, where nurses could not opine as to the standard of care for doctors because nurses and physicians inherently lack a peer-to-peer relationship, the internal medicine doctors and general surgeon here both had the same type of initial training and share a basic knowledge and skills of the profession. *See* 492 Md. at 32–33.

[8] While not relevant to the analysis, we note that UPMC stated in its motion to dismiss that one of the named providers—Dr. Patel—was board-certified in cardiology. The resume UPMC attached to its motion to document this claim did not indicate that Dr. Patel had completed board certification in cardiology, although he had completed a cardiology fellowship.

Finally, while it has applicability here, the circuit court did not correctly apply *Hinebaugh* in its grant of UPMC's motion to dismiss. In *Hinebaugh*, the proffered oral surgeon expert and family medicine doctor and radiologist defendants may have had related specialties as to treatment of some medical issues, but they did not overlap in the front-line diagnosis work at issue in the case. 207 Md. App. at 23–26. *Hinebaugh* stands for the proposition that an overlap in treatment between specialties means the specialties are related if that overlapping treatment is at issue in the case. *Id.* at 17–18. In granting UPMC's motion to dismiss here, the circuit court acknowledged that board certification in general surgery and internal medicine may overlap as to "perform[ing] physicals"; however, "the overlap in treatment ends there." This is correct; however, the circuit court did not recognize that an overlap as to "performing physicals" as a doctor is what is needed in a case where the procedure at issue is a proper physical exam of a patient.

Under the specific facts of this case, examining, documenting, and diagnosing medical problems, including ulcers, is a procedure shared by both general surgeons and internal medicine doctors. Additionally, because the peer-to-peer requirement is met as to the named physicians who are board certified in internal medicine, the CQE is sufficient as to the peer-to-peer requirement even though the same requirement may not be met for the named nurses or other specialties.[9] *See Kearney*, 416 Md. at 652–53. *See also Robinson*, 492 Md. at 34–35 (plurality opinion) (because the CQE requirement was made to "ensure that completely spurious claims do not go forward," a CQE and report meet the peer-to-

[9] As explained further in the next section, *supra*, all named providers are agents or employees of UPMC.

peer requirement even if some opinions in the report do not satisfy the requirement, so long as other opinions in the report do) (quoting *Powell v. Breslin*, 421 Md. 266, 285 (2011)). For the foregoing reasons, the circuit court erred in granting UPMC's motion to dismiss based on the contention that HCMCA's peer-to-peer requirement was lacking.

II. THE CQE AND REPORT SUFFICIENTLY STATE THE STANDARD OF CARE AND IDENTIFY THE DEFENDANT.

A. Party Contentions

Otto contends that Dr. Verdura "detailed a number of deviations in the standard of care" in the CQE and report and therefore the court erred in granting UPMC's motion to dismiss.[10]

UPMC asserts that the CQE and report were deficient because they did not properly state the standard of care UPMC allegedly breached. UPMC also contends that Otto failed to sufficiently name the defendant in the CQE as required by Maryland CJP § 3-2A-02 because the report did not identify which acts of the named providers were negligent. Therefore, UPMC argues, the circuit court did not err in granting their motion to dismiss.

[10] Otto additionally posits that, because UPMC's motion did not specifically criticize the CQE and report as to each named provider, and all named providers who were not UPMC employees were UPMC's agents and therefore required an address, it was not a complete motion to dismiss and instead "a motion in *limine*, at best." UPMC responds, contending that whether the non-employee named providers were UPMC's agents is a conclusion of fact for the jury and even if it were not, they did point out the deficiencies in the CQE and report as to all named providers in their motion supplement. Upon review, UPMC's supplement addressed any named providers not previously mentioned in the original motion. Thus, we agree with UPMC as to sufficiency of the motion's contentions.

B. Standard of Review

Whether a CQE and report of a qualified expert are sufficient "is a determination to be made as a matter of law." *Hinebaugh*, 207 Md. App. at 17 (quoting *Carroll*, 400 Md. at 180 n.11 (2007). Questions of law are reviewed *de novo*. *Id. See also Jordan v. Elyassi's Greenbelt Oral & Facial Surgery, P.C.*, 256 Md. App. 555, 567 (2022).

C. Analysis

A valid CQE "must identify with specificity, the defendant(s) . . . against whom the claims are brought, include a statement that the defendant(s) breached the applicable standard of care, and that such a departure from the standard of care was the proximate cause of the plaintiff's injuries." *Carroll*, 400 Md. at 172. *See* CJP § 3-2A-04(b)(1)(i); *Kearney,* 416 Md. at 647–48; *D'Angelo v. St. Agnes Healthcare, Inc.*, 157 Md. App. 631, 645–46 (2004). UPMC challenges Otto's CQE as to identification of the defendant and the applicable standard of care. We address each of those requirements in turn.

i. Identification Requirement

In *Dunham v. University of Maryland Medical Center*, this Court found that a CQE was insufficient where the defendant hospital and its servants, agents, and employees were identified but no specific healthcare providers were named as said servants, agents, and employees in the document. 237 Md. App. 628, 652–53 (2018). The Court found dispositive that, in accordance with the purpose of the HCMCA, the naming requirement dictates that the CQE "identify, with some specificity, the person whose actions should be evaluated." *Id.* (quoting *Carroll*, 400 Md. at 181); *see also Robinson*, 492 Md. at 76–78

(Booth, J., concurring and dissenting) (summarizing cases that confirm CQEs must identify the individuals alleged to have breached the standard of care).

A defendant hospital may be held vicariously liable for the negligent actions of its employee healthcare providers through the doctrine of *respondeat superior*. *See Retina Grp. of Wash., P.C. v. Crosetto*, 237 Md. App. 150, 172 n.13 (2018) ("[A] health care provider agent need not be sued individually for the agent's principal to be liable under *respondeat superior*. It is sufficient that the principal is sued."). *See also Robinson*, 492 Md. at 31 (plurality opinion) (noting that the defendant nursing home could be liable for negligence in the care of its residents "because one or more of its agents was negligent"). A defendant hospital is liable for harm caused by the negligence of a non-employee healthcare provider when the hospital "represents that [the provider] is [the hospital's] servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent[.]" *See Mehlman v. Powell*, 281 Md. 269, 273, 275 (1977) (citing *B.P. Oil Corp. v. Mabe*, 279 Md. 632, 643 (1977) (quoting § 267 of Restatement (Second) of Agency)). Where medical treatment is rendered by nurses or physicians working in a hospital, and no notice is given to the contrary, "all ordinary expectations" would be that the providers are servants, agents, or even employees of the hospital. *See id.* at 274–75. *See also Williams v. Dimensions Health Corp.*, 480 Md. 24, 32 (2022).

If a CQE names individual healthcare providers who are all the servants, agents, or employees of the defendant, then the defendant has been sufficiently identified. *Dunham*, 237 Md. App. at 652–53; *cf. Carroll*, 400 Md. at 196–97 (finding that the CQE did not

sufficiently identify the defendant where some providers named in the CQE were the defendant's agents, but other providers in the CQE were unnamed).

Here, unlike in *Dunham*, the CQE specifically provides the names of healthcare providers whose actions should be evaluated to determine UPMC's liability. *Cf. Dunham*, 237 Md. App. at 652–53. All the named providers are UPMC employees, and any that are not employees are apparent agents of UPMC. Under Maryland agency law, the non-employee named providers here are likely apparent agents because they treated Otto inside UPMC's hospital and, without any allegations of notice given regarding independent contractor status, therefore were justifiably represented as agents of UPMC. *See Mehlman*, 281 Md. 273–75. In addition, Otto alleged in his complaint that the named providers were "agents, servants and/or employees" of UPMC. Otto's CQE identified UPMC, and its agents, servants, and employees. Naming the providers at issue is akin to naming the defendant and is sufficient under the statute as to the identification requirement. *See id.*; *see also Carroll*, 400 Md. at 172.

ii. *Standard of Care Requirement*

The HCMCA requires that a CQE "include a statement that the defendant(s) breached the applicable standard of care." *Carroll*, 400 Md. at 172. *See* CJP § 3-2A-04(b)(1)(i). To do so, the report or CQE must indicate what the applicable standard of care was or how the named provider departed from the standard of care. *Kearney*, 416 Md. at 645; *Walzer,* 395 Md. at 579–80 (the standard of care requirement can be met by language in either the CQE or the report, or both, because "the General Assembly intended for the

attesting expert report to be a part of the certificate of qualified expert and not for the report and certificate to constitute two separate and distinct documents").

In *Kearney*, the CQE did not sufficiently identify the standard of care where there was no report attached identifying what the applicable standard of care was and how the healthcare providers had departed from it, and the CQE only stated that "the care rendered fell below the standards of care applicable to the treatment of [patient.]" 416 Md. at 634, 668. The Court found that the CQE did not "explain what the standard of care was, what [the defendant] should have done to satisfy that standard of care, or include any details at all about what happened when [the defendant] allegedly violated the standard of care[,]" and thus the requirement was not satisfied. *Id.* at 650. In so finding, the Court relied on *Carroll*. In *Carroll*, the CQE indicated that the treatment given to the patient fell below the standard of care and that the patient suffered complications from "having a catheter in place for longer than what is standard treatment." 400 Md. at 175, 195. The *Carroll* Court found that these statements did not satisfy the standard of care requirement because they did not provide information as to what should have been done by practitioners to meet the standard of care, nor which provider should have taken such measures. *Id.* at 197–98.

Here, in the report, Dr. Verdura identified each named provider's treatment of Otto and relevant findings the providers noted in their examinations. In the CQE, Dr. Verdura wrote that, in the situation where the ulcer was present upon admission, "all treating healthcare providers" who saw Mr. Otto during his time at UPMC until November 14

> failed to adhere to the standard of care in failing to monitor him for the development of an ulcer, failing to properly [order] nursing instructions for the preemptive treatment to avoid the development of the ulcer, in failing to

> take note of the objective findings that would indicate a need to prevent the development of the ulcer, and in ultimately allowing the ulcer to develop.

In the scenario where the ulcer was not present upon admission, Dr. Verdura wrote that

> all of the treating healthcare providers who saw [Otto] from the time of admission until November 14, 2020 failed to adhere to the standard of care in documenting the ulcer, monitoring the ulcer, treating the ulcer, and requesting consultations for the ulcer.

Finally, Dr. Verdura added that "subsequent to November 14, 2020, all health care providers who were treating [Otto] failed to adequately control the development of the ulcer and allowed it to progress ultimately to an unstageable ulcer."

As noted in *Walzer*, the CQE and report are to be read together as a single document. 395 Md. at 579–80. Doing so here, Dr. Verdura identified how each named provider treated Otto and that the actions taken were insufficient as to the applicable standard of care. Unlike in *Kearney* and *Carroll*, the report and CQE *sub judice* make clear that the alleged standard of care is the inverse of the care provided here—that the named providers should have monitored, documented, and requested consultations to treat the ulcer, along with additional actions. In both *Kearney* and *Carroll*, there were no detailed reports specifying the role of each provider in treating the patient; nor did the CQEs directly state how the patients should have been treated. *See* 416 Md. at 634, 668; 400 Md. at 197–98. Here, assuming the truth of all the assertions in the CQE and report under the *de novo* standard,

Otto's CQE was not deficient, and the circuit court erred in granting UPMC's motion to dismiss.[11]

ORDER OF THE CIRCUIT COURT FOR ALLEGANY COUNTY REVERSED. COSTS TO BE PAID BY APPELLEES.

[11] We additionally note that, at this stage of the litigation, we make no findings as to the reliability of any opinions made by Dr. Verdura in the CQE or report. *Kearney*, 416 Md. at 652–53; *see also Robinson* 492 Md. at 36–37 (plurality opinion).