Circuit Court for Baltimore City
Case No. 24-C-18-002909

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 1585

September Term, 2019

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

v.

ERICA BYROM, et al.

Friedman,
Beachley,
Woodward, Patrick L.
(Senior Judge, Specially Assigned),

JJ.

Opinion by Friedman, J.

Filed: February 1, 2021

A fully informed patient has the right to make the decisions about her own healthcare. A necessary corollary of that right, however, is that absent negligence by the healthcare professional, the patient is responsible for the consequences of the choices she makes. In this case, Appellee Erica Byrom, fully informed of the choices and the risks attendant to each of those choices, chose an induced vaginal delivery over a cesarean section. Precisely as her doctors predicted, the consequences of that choice were disastrous. The jury, obviously and understandably sympathetic to Ms. Byrom, found in her favor. For the reasons that follow, however, we hold that the trial court erred by not setting aside that verdict.

FACTUAL BACKGROUND

On October 20, 2014, 16-year-old Erica Byrom[1] was diagnosed with early-onset preeclampsia, an urgent pregnancy complication marked primarily by elevated maternal blood pressure. Left untreated, preeclampsia can lead to seizures or stroke and can be life-threatening to both baby and mother. Preeclampsia is thought to be caused by problems with the placenta, and the only effective treatment is to deliver the baby and empty the uterus. At the time that Ms. Byrom developed preeclampsia, she was only in the second trimester of pregnancy and delivery of the baby would have been extremely premature. Because Ms. Byrom's local hospital did not have a Neonatal Intensive Care Unit (NICU),

[1] Ms. Byrom had emigrated to the United States in July 2014 to live with her adoptive parents. Her medical records indicate that she did not receive any prenatal care until her pregnancy was in the second trimester. The first ultrasound on record was done on October 6, 2014.

Ms. Byrom was airlifted to Appellant Johns Hopkins Bayview Medical Center in Baltimore City for treatment.

Upon her admission to Bayview, Ms. Byrom signed a general consent form authorizing the Johns Hopkins Bayview team to provide treatment for "Labor and Delivery – Management of labor and vaginal delivery; possible oxytocin augmentation or induction; fetal monitoring (external or internal); possible fetal scalp blood sampling; possible episiotomy; possible vacuum or forceps delivery; possible [c]esarean [s]ection." The form noted that the reason for treatment was preeclampsia, that the benefit of receiving treatment was "maternal/fetal well-being," and that the probability of success was "fair."

When she arrived at Bayview, Ms. Byrom had elevated blood pressure and liver enzymes that were twice the normal level, both signs of severe preeclampsia. In addition, there were numerous complications to the pregnancy. Although the gestational age of the fetus calculated by the date of the last reported menstrual cycle was 25 weeks 4 days, the fetus had severe intrauterine growth restriction and was measuring at a size consistent with a gestational age of only 23 weeks 5 days. Ultrasound examination showed oligohydramnios, a low level of amniotic fluid that can cause inadequate blood flow through the placenta depriving the fetus of adequate oxygenation and nutrition. Doppler ultrasound examination of the umbilical artery showed absent end-diastolic flow, meaning that there was not constant forward blood flow through the umbilical cord to the fetus. Finally, ultrasounds also showed that the fetus had a small pericardial effusion, which is an excess of fluid around the heart.

Despite the severity of Ms. Byrom's condition, she and the fetus were stable enough to temporarily delay delivery. Fetal monitoring strips of the baby's heartrate were overall reassuring, and the biophysical profile was good.[2] Ms. Byrom was treated with magnesium sulfate to control her blood pressure and help protect against the onset of seizures. In addition, she was started on a course of the steroid Betamethasone to help accelerate fetal lung development. The immediate treatment goal was to try to delay delivery until Ms. Byrom had received the full course of Betamethasone to give the fetus a better chance of survival outside the womb. Ms. Byrom was given her second dose of Betamethasone at around 5 p.m. on October 21st, with induction considered possible 24 hours later.

The treatment team began meeting with Ms. Byrom and her adoptive mother to discuss treatment options and risks. Treatment options included termination of the pregnancy,[3] induction of labor for vaginal delivery, or delivery by cesarean section. If

[2] A biophysical profile is a measurement of fetal well-being done with a combination of ultrasound and fetal heart tracing. It monitors fetal movements, extension of limbs, regular breathing, and pockets of amniotic fluid. A good score indicates that the baby is stable at the time of the examination, whereas a low score would indicate that the baby may need to be delivered quickly. The fetus, soon named Zubida, had a good score of 8 out of 8.

[3] Termination of the pregnancy was briefly considered an option due to Bayview's initial uncertainty about the gestational age of the fetus. Based on Ms. Byrom's last reported menstrual cycle, the gestational age was approximately 25 weeks 4 days at the time of her admission to Bayview. Measurements done by ultrasound, however, estimated the gestational age at only 23 weeks 5 days. Gestational age calculations done during the second trimester are less accurate and have a margin of error of one to two weeks. Within this gestational age range, a fetus is considered "periviable," meaning that it is questionable whether the baby would be able to survive outside the womb. Under Bayview's policy, prior to the gestational age of 24 weeks, a parent would have the option to terminate a pregnancy or to decline full resuscitative effort after delivery. When Ms. Byrom's treatment options were first discussed, doctors believed that the baby could be in this

vaginal labor was induced, a cesarean section could still be a consideration for the life and health of either the mother or fetus. Doctors also explained to Ms. Byrom that, due to the gestational age of the fetus a cesarean section would have to be done with a classical vertical incision in the uterus rather than the more common horizontal incision. This type of "classical" cesarean section was a more complicated procedure and carried a risk of increased blood loss. In addition, because the incision would cut through the muscles of the uterus, any future pregnancies would have to be delivered by cesarean section.

The Bayview treatment team explained to Ms. Byrom that regardless of the route of delivery, there was a high probability that the baby would have medical problems due to both the existing pregnancy complications and prematurity. Notes from the initial NICU consultation stated that Ms. Byrom was informed that:

> the baby would be born sick with a high likelihood of death or neurodevelopmental disability. [She] would require intubation and mechanical ventilation, a prolonged hospital course, and was at high risk due to gestational age and IUGR [intrauterine growth restriction] for NEC [necrotizing enterocolitis] and

periviable stage and informed Ms. Byrom of all of the options that might be available to her, including termination. When it was more conclusively determined that the small fetal size was due to intrauterine growth restriction and the gestational age aligned with the last reported menstrual cycle, termination was no longer offered as an available option.

At trial, plaintiffs' counsel harangued Bayview for listing termination as a potential alternative treatment. In its brief to this Court, Bayview complains that the trial judge's failure to curtail this attack constituted an abuse of discretion. It is clear that, but for the mistaken computation of the fetus's gestational age, termination was a medically appropriate and legally protected option that, for the reasons discussed below, should have been listed at least as an alternative course of action for Ms. Byrom. We view plaintiffs' counsel's attacks on this basis as inappropriate and misleading, but we need not reach the question of whether permitting those attacks constituted an abuse of the trial court's discretion.

> feeding difficulties, ROP [retinopathy of prematurity]/blindness, and developmental disability including CP [cerebral palsy], intellectual disability, difficulty with speech or learning.

The NICU notes recorded that Ms. Byrom and her mother appeared to understand the risks and were undecided as to whether she would like full resuscitative efforts after delivery or if she would elect to have a cesarean section if there were signs that the fetus was in distress.

Ms. Byrom's condition was being closely monitored, and medical professionals returned to her room frequently to check on her and review her treatment options. At some point during the day on October 21st, Ms. Byrom informed members of her treatment team that she did not want a cesarean section to try to save the baby if there were signs of fetal distress, but she was otherwise undecided about how to proceed.

During the evening hours on October 21st, the fetal monitor began to detect decelerations in the baby's heart rate, and Ms. Byrom's doctors approached her about the possibility of intervening to save the baby. Ms. Byrom confirmed her earlier decision that she did not want a cesarean section at signs of fetal distress. The doctor's note entered at 11:37 pm on October 21st states:

> Came to discuss plan of care again with patient given FHR [fetal heart rate] decel[eration].
>
> Discussed w/p[atien]t, p[atien]t's mother, and RN that baby had a fetal heart rate decel[eration] and may continue to have these overnight. I asked whether she would want us to intervene overnight to save the baby knowing that that intervention would be a cesarean.
>
> *Ms. Byrom's main concern is the pain associated with her various management options. Given the pain associated with a*

> *cesarean, she clearly stated that she would not want cesarean section.*
>
> She understands that we will discontinue monitoring at this time as we would not intervene surgically for fetal distress. She also understands that the fetus may have other decelerations and possibly intrauterine demise tonight while not being monitored. She accepts this.

(Emphasis added). Because Ms. Byrom did not want the doctors to intervene to save the baby at signs of fetal distress, continuous fetal monitoring was halted.[4]

Medical records admitted at trial show that even after the fetal monitor was removed, Ms. Byrom's doctors continued to consult with her about her treatment options and recommend a cesarean section. Ms. Byrom consistently reconfirmed her decision that she did not want a cesarean section, even if the fetus was in distress and the procedure was necessary for its life or health. Additional doctor's notes in the medical record memorialize the discussions that the doctors had with Ms. Byrom leading up to delivery.[5] A doctor's note recorded at 9:37 a.m. on October 22nd stated:

> After sign out, reviewed with patient and her mother their preferences regarding care for mother and fetus. After extensive overnight counseling, patient and her mother decided

[4] Bayview explained that it is standard practice to turn off the fetal monitor if a patient has been clear about not wanting surgical intervention at signs of fetal distress. Because the monitor must remain in the patient's room when it is on, leaving it on "makes it very difficult for the mother to watch that."

[5] Dr. Cynthia Argani, Medical Director of Labor and Delivery at Bayview, testified that because Ms. Byrom's decision to decline a cesarean section at that gestational age was so unusual, members of her treatment team, including social work, met with her numerous times to repeat their recommendation for a cesarean section and to make sure Ms. Byrom understood the implications of her decision to induce vaginal delivery and that the treatment plan was honoring her wishes.

> she would not want to intervene surgically for fetal distress. Fetal monitoring was therefore discontinued. BP and HELLP labs have been stable and currently Ms. Byrom denies symptoms. Patient and her mother understand that by declining a [cesarean] section last night, there is a possibility fetal status has worsened, baby has been under perfused, and sustained irreversible brain damage. They have expressed a desire for "nature to take its course", which on further clarification is a desire not to have NICU present to resuscitate the baby at delivery. They have clearly stated they do not want to compromise maternal health and future childbearing potential for a baby that could have lifelong disability.

And another note entered at 12:50 p.m. the same day:

> Case has been reviewed with [Labor and Delivery] director, NICU, BVBMC GYN/OB chair[6] and JHH GYN/OB chair.[7] Although prognosis for fetus is very poor, Ms. Byrom is currently at viability by gestational age and weight. Therefore[,] if and when we proceed toward delivery, her options are [cesarean] section or induction of labor per usual OB protocol. Indications for delivery would be for worsening maternal status or for fetal distress. Given viability, NICU will be called for delivery; based on assessment at delivery, resuscitation will be provided if appropriate. If the baby is resuscitated, it will be evaluated further in the NICU and further recommendations made to the family, including if withdrawal of care would be appropriate.
>
> Reviewed the information with the family, who expressed understanding. The patient has continued to express her desire to avoid a [cesarean] section, and recognizes this may mean potential compromise of fetal status including fetal death or outcome for fetus that would be worse than if she had undergone earlier [cesarean] section. Given she continues to decline [a cesarean section, we] will not perform fetal monitoring; reminded the family that without fetal monitoring, we will not be able to recognize worsening fetal distress. If

[6] Chair of the Department of Gynecology and Obstetrics at Bayview.

[7] Chair of the Department of Gynecology and Obstetrics at Johns Hopkins Hospital.

> later Ms. Byrom changes her mind and would like a [cesarean] section for fetal distress, the baby may have already been compromised by insult not observed but sustained during periods without monitoring.
>
> Explained to the family that her BP have been stable and predominantly mild range. She is still asymptomatic and her LFT are slightly improved. From a maternal standpoint, there is currently no indication for delivery.
>
> Family has confirmed they do not want a [cesarean] section for fetal distress. After multiple discussions, the patient and her family have two primary concerns. The first is they would like to avoid the morbidity to the patient of a classical [cesarean] section. Second, they would prefer to "let nature take its course" and risk having a stillbirth rather than inducing labor at this time and potentially having a seriously compromised infant. Indications for delivery will be in case of FDIU or worsening maternal status.

The following day, October 23rd, Ms. Byrom's condition began to worsen and the doctors recommended that immediate delivery was necessary for maternal health. Doctors again recommended a cesarean section for fetal wellbeing. An entry in Ms. Byrom's medical record at 12:54 p.m. on October 23rd states:

> P[atien]t clearly states understanding that induction of labor will likely impose additional stress to the fetus, and may result in fetal loss or extreme compromise resulting in permanent disability. She declines [cesarean] section for fetal indications. She understands that she may need a [cesarean] ultimately for worsening maternal status, and will accept a [cesarean] for maternal reasons if deemed necessary. She also voices understanding that the infant may survive the course of induction, and that the NICU will be present for resuscitation. She understands that [the] infant would likely have a better chance of intact survival if a [cesarean] section were performed now versus pursuing an induction of labor.

Induction of vaginal labor was started at 4:13 p.m. on October 23rd. As the induction continued, Ms. Byrom eventually signed a second consent form, at 12:35 p.m. on October 24th, explicitly declining a cesarean section for fetal distress:

> 1) I hereby give my consent and authorize *Dr. Donald Garland & colleagues* and the Johns Hopkins treatment team, to perform the following operation(s), treatment(s) or procedure(s)
>
> *Cesarean section for maternal indications (including worsening preeclampsia leading to critical health status or uterine rupture, placental abruption), management of labor and induction of labor for worsening preeclampsia.*
>
> 2) The indications, benefits, and probability of success of the operation(s), treatment(s) or procedure(s) have been explained to me in a manner that I understand. These include:
>
> *I decline a cesarean section for fetal indications with the understanding that induction of labor will impose additional stress to the fetus and may result in fetal loss or extreme compromise resulting in permanent disability. I understand that the infant would have a better chance of intact survival if a cesarean section were performed now versus pursuing induction of labor.*
>
> 3) The major risks and complications of the operation, treatment or procedure have been explained to me in a manner that I understand. These may include such items as failure to obtain the desired result, discomfort, injury, need for additional treatment(s) and death. Additional risks include:
>
> *Please see above*
>
> 4) I understand that the reasonable alternatives to the proposed operation(s), treatment(s) or procedure(s),

including the major risks, benefits, and side effects of those alternatives are:

Cesarean section for fetal indications – better probability of intact survival of fetus

* * *

7) By signing below I agree:

That a provider has explained and answered all of my questions related to:

Cesarean section for maternal indications, decline cesarean section for fetal indications

(italics indicate handwritten text). Zubida Byrom was delivered at 2:45 p.m. on October 24, 2014. At birth, Zubida was unresponsive and had to be resuscitated by the NICU team. She is severely mentally and physically disabled and will require life-long dependent and medical care.

In May 2018, Erica Byrom bought suit against Johns Hopkins Bayview on behalf of herself and Zubida, asserting that Zubida's injuries were sustained exclusively during the labor and delivery process. In three counts, Ms. Byrom asserted that Bayview had violated her right to informed consent in regard to her delivery options and had provided negligent treatment to her and Zubida by inducing vaginal labor without fetal monitoring rather than performing a cesarean section.

At trial, Ms. Byrom did not testify and presented her case entirely through the testimony of expert witnesses. To support her allegations of negligent treatment, Ms. Byrom presented Dr. Michael Cardwell, a maternal-fetal medicine specialist, who

testified that he believed that Bayview had erroneously focused on negative warnings rather than giving Ms. Byrom encouragement for a positive outcome to convince her to consent to a cesarean section. He further testified that because under the circumstances the only safe option for delivery was by cesarean section, Bayview had violated the standard of care by offering induction of vaginal delivery as a treatment option and by discontinuing fetal monitoring. To support her claim that Bayview breached her right to informed consent, Ms. Byrom relied on Dr. Corinne Leach, a neonatologist who testified that Bayview's prenatal evaluation of Zubida was inaccurate and Ms. Byrom's doctors had overstated the likelihood that Zubida would be born with severe disabilities due to pregnancy complications and prematurity.

The jury found in favor of Ms. Byrom and Zubida on all counts and awarded damages in the amount of $229,640,000. The damage award included $3,620,000 for past medical expenses, $200,000,000 for future medical expenses, $1,020,000 for loss of earnings, and $25,000,000 for non-economic damages.[8] Bayview moved for judgment notwithstanding the verdict and a new trial. The trial court denied both.

On appeal, Bayview challenges three rulings made by the trial court. *First*, Bayview challenges that the trial court erred in denying its motions for judgment notwithstanding the verdict on the issues of negligent treatment and breach of informed consent because the evidence presented at trial was insufficient to support the jury's findings. *Second*, Bayview

[8] The award for non-economic damages was later remitted from $25,000,000 to $740,000 to comply with the statutory cap. *See* MD. CODE, CTS & JUD. PROC. ART. ("CJP") § 3-2A-09(c)(2).

argues, in the alternative, that the trial court erred in denying its motion for a new trial because the trial court erred in admitting prejudicial and inflammatory argument about abortion. And finally, *third*, Bayview argues that, should the jury verdicts on liability be affirmed, the trial court erred in not granting either a new trial on damages or a remittitur to the maximum amount testified to by Ms. Byrom's expert witnesses.

Because we conclude that the evidence presented at trial was not sufficient to support findings of either negligent treatment or breach of informed consent, we hold that the trial court erred by not granting Bayview's motions for judgment notwithstanding the verdict. We reverse the judgments.[9]

STANDARD OF REVIEW

We review a trial court's ruling on a motion for judgment notwithstanding the verdict without deference to determine whether it was legally correct. *Univ. of Maryland*

[9] Due to our resolution of Bayview's first issue, we do not address the remaining issues. Should a higher court disagree with our primary conclusion that the trial court erred in not granting Bayview's motion for judgment notwithstanding the verdict, to avoid the necessity of a remand we note that had we reached the issue, we would have held that the trial judge erred by failing to remit the damages to the maximum amounts supported by the evidence admitted at trial. For future medical expenses, the maximum amount for which Ms. Byrom offered evidence was $42,275,000. Despite that, the jury awarded $200,000,000. In addition, there was no evidence offered to show past medical expenses, for which the jury nonetheless awarded $3,620,000. Although Appellees' counsel argues that the life care plan admitted into evidence to establish future medical expenses could have been used by the jury to estimate past medical costs, a jury award for past medical expenses is limited to the actual amount paid by or on behalf of the plaintiff and any amounts "incurred but not paid by or on behalf of the plaintiff for which the plaintiff or another person on behalf of the plaintiff is obligated to pay." CJP § 3-2A-09(d)(1). The life care plan does not contain any evidence regarding past medical care or expenses incurred. In the absence of evidence, the trial court erred by failing to reduce the award to the maximum amount supported by the evidence: $44,035,000.

Med. Sys. Corp. v. Gholston, 203 Md. App. 321, 329 (2012). The amount of evidence needed to create a question for the jury is slight. *Gholston*, 203 Md. App. at 329. We view the evidence in the light most favorable to the non-moving party and ask, "whether on the evidence presented a reasonable fact-finder could find the elements of the cause of action by a preponderance of the evidence." *Id*. (citing *Washington Metro. Area Transit Auth. v. Djan*, 187 Md. App. 487, 491-92 (2009)).

DISCUSSION

I. CLAIM FOR LACK OF INFORMED CONSENT

The doctrine of informed consent is predicated on patient autonomy. *Sard v. Hardy*, 281 Md. 432, 438-39 (1977). The Court of Appeals has explained that "the paramount purpose of the informed consent doctrine [is] to vindicate the patient's right to determine what shall be done with [her] own body and when." *Sard*, 281 Md. at 444. The Court explained:

> the doctrine of informed consent imposes on a [healthcare professional], before [the professional] subject[s] [a] patient to medical treatment, the duty to explain the procedure to the patient and to warn … of any material risks or dangers inherent in or collateral to the therapy, so as to enable the patient to make an intelligent and informed choice about whether or not to undergo such treatment.

Id. at 439. For consent to be "informed," before beginning a treatment or procedure (whether physical or nonphysical), a healthcare professional must provide the patient with "a fair and reasonable" explanation about the "material risks," specifically, those risks that the healthcare professional knows or should know would be significant to a reasonable

person in the patient's position. *Id*. at 439, 444. Although there is no specific checklist that dictates what information must be provided to a patient to satisfy the right to informed consent, *Goldberg v. Boone*, 396 Md. 94, 123 (2006), a healthcare professional is generally required to provide a patient with information concerning: (1) the nature of the patient's ailment; (2) the nature of the proposed treatment; (3) the probability of success of the contemplated treatment; (4) alternative methods of treatment; (5) the risk of failure or unfortunate side effects associated with the contemplated treatment; and (6) other factors that a reasonable patient would consider material in making a decision to undergo a particular treatment. PAUL MARK SANDLER & JAMES K. ARCHIBALD, PLEADING CAUSES OF ACTION IN MARYLAND 322 (6th ed.) (explaining *Sard*, 281 Md. at 440).

To evaluate whether a medical professional has satisfied this duty, we apply an objective standard of reasonableness: for consent to be informed, a medical professional must provide information that "would be significant to a reasonable person in the patient's position in deciding whether or not to submit to a particular medical treatment or procedure." *Sard*, 281 Md. at 444. It is a breach of a patient's right to informed consent for a doctor to withhold "information that [is] material to [the patient's] assessments of the risks and benefits prior to … engaging in a treatment or a procedure." *McQuitty v. Spangler*, 410 Md. 1, 30 (2009) (citing *Faya v. Almaraz*, 329 Md. 435, 450 (1993)). In identifying the material risks, it is not relevant whether a treatment (or an alternative) would be contraindicated for a specific patient under a professional standard of care. *Shannon v. Fusco*, 438 Md. 24, 48-49 (2014) (citing *Univ. of Md. Med. Sys. Corp. v. Waldt*, 411 Md.

207, 235-36 (2009)). Rather, this materiality test focuses on the needs of a patient to have enough information to make an informed decision.

To prevail in a case alleging lack of informed consent, the patient must prove that a reasonable person would not have consented to the treatment if the risk had been disclosed at the time the decision was made. *Sard*, 281 Md. at 448-49. While a plaintiff's testimony about what, in hindsight, they would have done is relevant, it is not controlling in this objective test. *Id*. at 450. Moreover, even if the treatment is performed without negligence, the healthcare professional may still be liable for failing to disclose material information that would have altered the patient's decision. *McQuitty*, 410 Md. at 30-31 (citing *Faya*, 438 Md. at 450). And while expert testimony might be necessary to help the trier of fact understand the nature of the treatment and the likelihood of the risks, expert testimony is not required to determine what information would have been material to the patient in making a decision. *Shannon*, 438 Md. at 50; *Waldt*, 411 Md. at 232; *Sard*, 281 Md. at 447.

To prove that Bayview had violated her right to informed consent, Ms. Byrom needed to show that, as she was weighing her treatment options, there was some material piece of information withheld by her doctors that, if she had known about it, would have changed her decision. But there is no such evidence in the record.

Ms. Byrom's expert witnesses reviewed her medical records and agreed with Bayview's assessment that she had severe preeclampsia that posed a threat to her life and the life of the fetus, and that the only treatment was to deliver the fetus and "empty [the uterus] as quickly as possible." They agreed with Bayview's assessment that the

ultrasounds showed oligohydramnios, absent end-diastolic flow of the umbilical artery, fetal pericardial effusion, and intrauterine growth restriction. They agreed with Bayview's conclusion that all of these conditions posed risks that the fetus could suffer disabling injuries while remaining in the uterus. They agreed that there could be complications to the fetus's health due to the premature gestational age. Ms. Byrom's experts agreed with Bayview's assessment that the recommended treatment was delivery by cesarean section because it was the best way to optimize the outcome for the fetus. They agreed with Bayview's determination that due to the fetus's gestational age, the cesarean section would have to be done with a vertical incision to the uterus that would cause Ms. Byrom to need a cesarean section delivery for any future pregnancies. And Ms. Byrom's experts agreed with Bayview that induction of labor for vaginal delivery was not recommended because the laboring process posed a significant risk of permanent harm or death to the fetus. The evidence at trial was clear and undisputed that Ms. Byrom was given all of this information.

Where Ms. Byrom's experts disagreed, however, was with Bayview's assessment of the probability that the fetus would be born with disabling injuries. Ms. Byrom's experts criticized Bayview for its tone and emphasis on the risk of injury to the fetus. According to Ms. Byrom's experts, Bayview overstated the likelihood that the fetus would not survive or would be born with severe disabilities and withheld positive information about the status of the fetus that would have persuaded Ms. Byrom to make different treatment decisions

for the benefit of the fetus.[10] Specifically, Dr. Cardwell testified that Bayview should have emphasized the positive findings about the fetus, such as the biophysical profile and fetal monitoring strips, to convince Ms. Byrom to consent to a cesarean section for the benefit of the baby's life and health. In Dr. Cardwell's opinion, Bayview should not have offered Ms. Byrom the choice of induction of labor for vaginal delivery because "the only option to optimize the outcome to the mother and the baby was to [deliver] by timely cesarean section."[11] Dr. Cardwell further testified that after Ms. Byrom had declined a cesarean section, her treatment team should have "[kept] giving [her the] information in order for her to make an informed consent. Under the circumstances a reasonable person with the

[10] The only factual inaccuracy pointed out by Ms. Byrom's experts was a single notation in the record made by a nurse practitioner that the fetal weight was estimated to be 400 grams, rather than 600 grams. Dr. Leach described this erroneous record entry as "tragically wrong" because the likelihood of survival of a fetus of 400 grams was significantly lower than that for a fetus of 600 grams. While it is clear that the record entry misstates the fetus's estimated weight, this lone mistaken entry does not, as a matter of law, constitute the withholding of material information that would violate the right to informed consent. As Bayview points out, there were at least a dozen entries—some before and some after—noting the correct estimated fetal weight. There is no evidence that Ms. Byrom did, or that any reasonable patient would, take note of and rely upon this one mistake to the exclusion of the abundance of accurate information repeatedly explained by her doctors.

[11] Dr. Cardwell's testimony that Bayview should not have given Ms. Byrom information about the option to have vaginal labor induced is based on his assessment that the procedure was not medically recommended for her. Evidence that a treatment or procedure is contraindicated for a patient, while relevant to a claim of negligence, is neither relevant nor admissible in a cause of action for lack of informed consent. *Shannon v. Fusco*, 438 Md. 24, 61 (2014).

facts given would have come to the decision to do a cesarean section."[12] Dr. Leach testified to her belief that Bayview miscalculated the fetus's chances of survival: Bayview estimated the chances of survival at 65%, but she believed it was closer to 74%. Moreover, while Dr. Leach agreed that it was important to tell an expectant parent about possible bad outcomes, in her opinion Bayview had been "very dramatic" about what they expected to happen with

[12] During cross examination, Dr. Cardwell was asked several times what he believed Bayview should have done in response to Ms. Byrom's refusal to consent to a cesarean section. He testified that:

> She did agree, and it's in the records and you made mention of it, that she agreed to have a [cesarean] section for maternal indications. If she refused to have a [cesarean] section for fetal indication, you can't do a [cesarean] section. You can't really do anything else. But her condition will even worsen further. Then it comes to a point you have to do a [cesarean] section for maternal reasons.

Dr. Cardwell's testimony here advocated that Bayview should have overridden Ms. Byrom's autonomous decision-making in favor of the decision that Dr. Cardwell (and Bayview) preferred. We note two problems. *First*, Dr. Cardwell's view is incompatible with the patient autonomy that underlies the doctrine of informed consent. "[I]t is the patient's exclusive right to weigh [the] risks [of the procedure] together with [her] individual subjective fears and hopes and to determine whether or not to place [her] body in the hands of the surgeon or physician." *Sard*, 281 Md. at 443. Informed consent is not a decision controlled by medical judgment, and indeed, the general standard adopted by the Court of Appeals was intended to protect patients "against a possible conspiracy of silence, wherever it may exist among physicians." *Id*. (citations omitted). Thus, it was Ms. Byrom's right to select the course of treatment she preferred. And, *second*, this view puts Bayview in an impossible position of either coercing its patient into an unwanted procedure or acting as the guarantor of the consequences of the patient's decision. Bayview made numerous objections to Dr. Cardwell's testimony that were overruled. Although it was not raised as an issue in this appeal, we note that any portion of Dr. Cardwell's testimony that was inconsistent with a patient's right to fully-informed, autonomous decision-making should have been excluded as inconsistent with Maryland law and cannot form any part of a *prima facie* case for lack of informed consent.

the fetus. She believed that in discussing the risks to the fetus, Bayview should not have gone into specific detail about the possible injuries and disabilities but should have described them in broad categories and noted that they could range "anywhere from mild to severe." Dr. Leach testified that, in her opinion, Bayview failed to tell Ms. Byrom "anything about the baby being viable or surviving or having a good outcome."

It is apparent from the record that Ms. Byrom's experts disagreed with the tone and emphasis with which Bayview counseled her. Their testimony was not, however, that Bayview failed to disclose material risks related to Ms. Byrom's treatment options, but rather that Bayview gave Ms. Byrom too much information about the risks to the fetus from prematurity, oligohydramnios, absent end-diastolic flow, intrauterine growth restriction, and pericardial effusion, and failed to emphasize the positive information enough to convince Ms. Byrom to consent to a cesarean section. Because Ms. Byrom did not testify at trial, the jury could only speculate about her subjective impressions and motivations, but the position advocated by plaintiffs' counsel at trial was that Bayview's overemphasis on the risk that the fetus could be born with severe disabilities had given Ms. Byrom such a negative impression that she gave up hope and, as a result, she made her treatment decision based on her own comfort rather than for the benefit of the fetus.

The role of expert testimony in an informed consent case is to aid the trier of fact in understanding the nature of the patient's condition, and the severity and likelihood of the risks of the treatment option, so that the trier of fact can better determine what information would be material to a patient's decision. *Shannon*, 438 Md. at 50. The scope of a

healthcare provider's duty to disclose is not defined, however, by professional custom or medical judgment. *Sard*, 281 Md. at 443, 447. Because the very purpose of the informed consent doctrine is to protect the "patient's right to exercise control over [her] own body," the standard for determining materiality is what a reasonable patient would want to know, not what information would guide them to the healthcare professional's preferred option. *Id*. at 447.

The question to be answered here is whether Bayview conveyed to Ms. Byrom the information that would be material to an expectant mother with severe preeclampsia who needed to make an informed decision about her care. Ms. Byrom was counseled that there were two treatment options: (1) induced vaginal delivery or (2) a cesarean section. Bayview made clear that the recommended treatment was a cesarean section and repeatedly stressed that that procedure gave the fetus the best chance for survival. Bayview repeatedly cautioned against inducing vaginal delivery and warned that the laboring process would put stress on the fetus and could result in severe permanent disability or death.

A healthcare professional disclosing material information to a patient is not required to provide a "mini-course in medical science" detailing every consideration. *Sard*, 281 Md. at 444. The focus is on "those [risks] which are material to the intelligent decision of a reasonably prudent patient." *Id*. The Court of Appeals has held that "disclosure is not required where the *risk* is either known to the patient or is so obvious as to allow us to assume the knowledge." *Id.* at 445 (emphasis added). A logical corollary is that explicit disclosure by the healthcare professional is not required where the *benefit* of the procedure

is known to the patient or should be so obvious as to allow us to assume the knowledge. *Id*. Each time Bayview recommended a cesarean section, it explained to Ms. Byrom that the procedure was the best way to minimize the risk of disability and to give the fetus the best chance for survival. For Bayview to have violated Ms. Byrom's right to informed consent, the record would have to show that when she was making her decision to decline a cesarean section, a reasonably prudent patient in her position would not have understood that, inherent in Bayview's treatment recommendation, was the possibility that the baby would live.

Against Bayview's clear advice, Ms. Byrom refused to consent to a cesarean section unless her own life was in danger. She chose to induce vaginal delivery despite Bayview's warnings. The consequences were tragic. The injuries to the baby were just as Bayview warned. But the record clearly shows that Ms. Byrom received all of the material information necessary to make an informed decision about her care.

II. CLAIM FOR NEGLIGENT TREATMENT

In addition to the claim that Bayview violated her right to informed consent, Ms. Byrom argues that Bayview's actions in providing care also constituted negligent treatment. Unlike informed consent, which focuses on the information given to a patient, negligent treatment focuses on "the performance (or non-performance) of a course of therapy or a medical procedure" provided by a doctor. *Dingle v. Belin*, 358 Md. 354, 368 (2000). To recover, a plaintiff must show: (1) there was a standard of care owed; (2) that standard was breached; (3) the breach was the cause of the injury; and (4) there were

compensable damages. *Gholston*, 203 Md. App. at 330. The standard of care owed by a physician is "to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which [the physician] belongs, acting in the same or similar circumstances." *Dingle*, 358 Md. at 368 (quoting *Shilkret v. Annapolis Emergency Hosp.*, 276 Md. 187, 200 (1975)) (internal quotation marks omitted).[13]

Ms. Byrom's main theory of negligence is based on what she characterizes as negligent communication. She begins by noting that when she was first admitted to Bayview, she consented to a cesarean section to save the baby's life, but then later withdrew that consent. Her lawyers claim that she changed her consent in this way only because Bayview had told her that there was almost no chance that the baby would survive and if it did, it would be severely disabled. The proximate cause analysis for negligent treatment claims based on a physician's negligent communication can be "analogous to that applied in informed consent cases," *Reed v. Campagnolo*, 332 Md. 226, 235 (1993), but while causation in an informed consent claim is based solely on the content of the physician's communications, causation in a negligent treatment claim must be based on the actions the patient takes in response to the communication. Thus, to show causation for her

[13] It is well established that informed consent and negligent treatment "are separate, [distinct] theories of liability." *McQuitty*, 410 Md. at 18. The Court of Appeals has been clear that when the two causes of action are tried together, "care must be taken to keep the actions separate and not to allow the theories, elements, and recoverable damages to become improperly intertwined." *Dingle*, 358 Md. at 367. Despite that guidance, many of the arguments pursued by plaintiffs' counsel at trial and in this appeal mixed the two types of claims.

negligence claim, Ms. Byrom needed to offer some piece of evidence showing that the communication caused her decision.

The only evidence in the record stating any reason for Ms. Byrom's decision, however, came from the provider notes in her medical records. The provider note on October 21st stated that "Ms. Byrom's main concern is the pain associated with her various management options. Given the pain associated with a cesarean, she clearly stated that she would not want cesarean section." A provider note on October 22nd described that Ms. Byrom and her family "have clearly stated they do not want to compromise maternal health and future childbearing potential for a baby that could have lifelong disability." A follow-up note on October 22nd further explained that

> the patient and her family have two primary concerns. The first is they would like to avoid the morbidity to the patient of a classical [cesarean] section. Second, they would prefer to "let nature take its course" and risk having a stillbirth rather than inducing labor at this time and potentially having a seriously compromised infant.

Ms. Byrom's experts (and attorneys) disputed the reasons given in her medical records and speculated that the actual reason was that Bayview had erroneously convinced her there was no hope for the baby no matter what. But in the absence of evidence supporting that theory of causation—which could only have come from Ms. Byrom or her family, none of whom testified—Ms. Byrom's negligent communication claim must fail.

Ms. Byrom's experts also asserted that it was a violation of the standard of care for Bayview to have removed the fetal monitor before and during the induction of labor because without it, the doctors could not be alerted to fetal distress necessitating a cesarean

section for the fetus's life and health. As noted above, Bayview provided testimony that it was its standard practice to turn off the fetal monitor when the mother has declined surgical intervention so that the mother does not have to hear it. *See supra*, n.4. More critically for negligence purposes, Bayview took these actions only because of the treatment decisions that Ms. Byrom made, against Bayview's advice.

A medical professional's ability to provide care for a patient is limited, first and foremost, by the patient's consent to be treated. Bayview's duty of care was thus defined by the consent that Ms. Byrom had given or denied. While healthcare professionals may make recommendations based on their own medical judgment, deciding upon a course of treatment is "the capable patient's prerogative." *McQuitty*, 410 Md. at 32 (quoting *Matties v. Mastromonaco*, 310 N.J. Super. 572 (1998)). This right to individual autonomy includes the right to refuse treatment or to withdraw consent to treatment at any time, even if the decision "has a detrimental effect, so long as the individual is competent." *Baer v. Baer*, 128 Md. App. 469, 481 (1999); *see also McQuitty*, 410 Md. at 31-32. "If the patient selects a course, even from among reasonable alternatives, which the physician regards as inappropriate or disagreeable, the physician is free to refuse to participate and to withdraw from the case upon providing reasonable assurances that basic treatment and care will continue." *McQuitty*, 410 Md. at 32. But "the law does not allow [healthcare professionals] to substitute [their] judgment for that of the patient in the matter of consent to treatment." *Sard*, 281 Md. at 440 (citing *Collins v. Itoh*, 160 Mont. 461 (1972)). We hold that, as a

matter of law, Ms. Byrom failed to establish that Bayview provided negligent medical treatment. [14]

CONCLUSION

There is no evidence in the record that Bayview withheld any material information from Ms. Byrom that violated her right to informed consent, nor is there any evidence that Bayview was negligent in providing treatment. We hold, therefore, that the trial court erred in denying Bayview's motions for judgment notwithstanding the verdict.

JUDGMENT OF THE CIRCUIT COURT FOR BALTIMORE CITY REVERSED. COSTS TO BE PAID BY APPELLEES.

[14] In her brief, Ms. Byrom argued that Bayview was also negligent for offering to terminate the pregnancy even though the fetus was viable and for using a higher than normal dosage of Cytotec to induce labor. We reject those theories too:

- As previously discussed, listing termination as a possible treatment was a medically appropriate and legally protected option. *See supra* n.3.

- Although the amount of Cytotec was more than recommended by Bayview's standard protocol, there was no suggestion that this caused any harm. To the contrary, Dr. Cardwell testified that it was "fortunate that [the] high dose of Cytotec worked. If it was a normal induction [Ms. Byrom] could have been in labor for days and they still [could have] ended up doing a [cesarean] section."

Thus, neither of these additional theories of negligence supported the jury's award or could have been a basis for denying Bayview's motion for judgment notwithstanding the verdict.