

A Medical View of COVID-19 and Workers' Compensation

By James K. MacAlister and Atiq Rahman, MD

"May you live in interesting times," an age-worn axiom forewarns. During the preceding year of 2020, a global pandemic made its way to the United States, infecting millions of Americans. This virus, COVID-19, quickly overwhelmed hospital emergency rooms/intensive care units with highly contagious patients gasping for breath – in addition to other life-threatening symptoms. Worse still, it has claimed the lives of over 400,000, and the daily death counts at the time of this writing are on the uptick. Not since the Spanish Influenza of 1918-1919, which killed more people than the total number of soldiers who perished in World War I, has the nation had to cope with such a virulent, lethal virus.

Among the victims of the pandemic are workers who attribute their COVID-19 infection to an occupational exposure. Common sense suggests that, if someone gets sick at work, the illness and the financial consequences of that illness should be covered by Maryland Workers' Compensation. Proving the axiom that the only "common" aspect of "common sense" is that it is "uncommon," the legal and evidentiary hurdles COVID claimants must clear are substantial.

COVID-19 spreads by people-to-people contact. The contagion is exhaled, coughed, and sneezed, wherever and whenever it is "shed" (quits) the body of a "host" (infected person). The contagion remains there, aerosolized or on contact surfaces, until it can find a new host (infect). Notably, nothing in this process is unique to the workplace. Given that claimants have the burden of proving compensability, it is vital that COVID Claimants' counsel understand the legal and factual issues associated with meeting this burden of proof.

In this article, we will analyze the legal issues of

whether/when a workplace infection is a cognizable occupational disease and/or accidental injury, and strategies to assist with meeting the burden linking infection to the workplace. Then we will turn to the medical issues, offering insight into the types of information experts rely upon when called upon to attribute where and when a patient contracted the virus. To assist practitioner screening potential COVID claims¹ we will suggest areas of inquiries counsel should explore during initial consultations with would-be COVID claimants.

Compensability: Different Roads, Same Destination?

Understanding how and why viral infection can be both an "occupational disease" and "accidental injury" claim requires a brief history lesson.² When first adopted, Maryland's Workers' Compensation Act covered only accidental injuries. During the ensuing years, the Court of Appeals of Maryland recognized that, under certain circumstances, an employee sickened as a result of workplace exposure to a contagion suffered a compensable "accidental injury."

A 1939 amendment entitled employees disabled or killed by specific enumerated occupational diseases to compensation "as if such disablement or death were an injury by accident."³ In the early 1950's, the General Assembly repealed the list of enumerated ailments as a path to accidental injury, replacing it with a stand-alone compensable claim, titled "occupational disease." The effect of this change was to expand coverage to include unspecified ailments, but to limit the scope of compensability by requiring an "occupational" qualifier.

Though the Maryland General Assembly expressly decided to cover occupational diseases, there is no suggestion that this legislation repealed or limited the accidental injury/contamination caselaw that preceded its adoption. As a result, COVID-19 infection is not only a likely "occupational disease," but it may be an "accidental injury" as well.

1 Also contributing to this article is John Keskula, a retired workers' compensation insurance supervisor with decades of experience adjusting these claims.

2 Maryland Workers' compensation encompasses two main categories of compensable events: accidental injury and occupational disease." *Montgomery Cty. v. Cochran*, 471 Md. 186 (2020).

3 *Polomski v. Mayor & City Council of Baltimore*, 344 Md. 70, 77-78 (1996)

Occupational Disease: Importance of “Post-If” Occupational Nexus

The Act covers employees diagnosed with an “occupational disease,”⁴ an ailment “contracted” by a worker: (1) as the result of and in the course of employment; and (2) that causes the covered employee to become temporarily or permanently, partially or totally incapacitated.⁵ Compensability of an “occupational disease” that meets this definition, must “cause death or disability,” only “IF” - and it is this statutory mandate referred to herein as the “post-if” occupational nexus - the alleged disease:

- (i) is due to the nature of an employment in which hazards of the occupational disease exist and the covered employee was employed before the date of disablement; or
- (ii) has manifestations that are consistent with those known to result from exposure to a biological, chemical, or physical agent that is attributable to the type of employment in which the covered employee was employed before the date of disablement; and
- (iii) on the weight of the evidence, it reasonably may be concluded that the occupational disease was incurred as a result of the employment of the covered employee.

Over the years, much appellate ink has been spilled defining precisely when an employee’s job duties are sufficiently rigorous to establish the requisite causal linkage between employment and ailment.⁶ The following discussion appears in a 1994 decision, *Davis v. Dynacorp*:

“Simply because a disease falls within § 9-101(g)’s definition of occupational disease, however, does not mean it is compensable. Section 9-101(g) must be read in conjunction with § 9-502(d), which limits an employer’s and insurer’s liability to those cases where the occupational disease that causes the disablement is either “due to the nature of an employment in which hazards of the occupational disease exist” or the disease “has manifestations that are consistent with those known to result from exposure to a biological, chemical, or physical agent that is attributable to the

⁴ *Davis v. Dynacorp*, 336 Md. 226, 235-236 (1994) (explaining legislative history).

⁵ Md. Lab. & Empl. Art. §9-101(g).

⁶ *Balt. Cty. v. Quinlan*, 466 Md. 1 (2019) summarizes “post-if” occupational nexus caselaw

*[employee’s] type of employment.”*⁷

In dictum, worthy of note, the opinion says “it should be borne in mind that the Act is designed to provide compensation to workers injured by the *effects of industry*,” and therefore, “the definition of occupational disease should not be read too loosely... while a claimant might prove that a common cold was contracted in the workplace and that lost time resulted, compensation for that occurrence would far exceed the scope of remedy contemplated by the General Assembly.”⁸

Davis did not involve “a common cold” or an “uncommon” lethal influenza virus, so it is difficult to know what to make of this dictum, standing alone.

Balt. Cty. v. Quinlan,⁹ a 2019 decision, may hold the answer. There, an EMT claimed an occupational disease related to overuse of his knees, as he knelt and lifted patients in the course of his employment. Summarizing out-of-state authority, then deeming it “consistent” with Maryland law, the Court explains that, for a disease to be “occupational” – rendering it “post-if” compensable - there must be evidence that the “employment exposed him to greater risk than the public generally.”¹⁰ Dismissing the County’s claim that Quinlan was required to point to rigors “unique” to his personal duties, the Court reasoned:

“The County, too, points to the commonality of knee injuries among other professions as disqualifying here. Assuming, without deciding, that such a characterization is accurate, ‘uniqueness’ is not a required element of LE § 9-502(d)(1)—being within the “nature” of the employment is the precise statutory language. See also Victory Sparkler, 147 Md. at 379 (occupational disease must have ‘its origin in the inherent nature or mode of work of the profession or industry, and it is the usual result or concomitant’). As Judge Andrea Leahy wrote for the court below, ‘the Act

⁷ 336 Md. 226, 235-236 (1994)

⁸ 336 Md. at 235-36 (emphasis original). In light of this restrictive standard, a computer operator’s “mental stress,” owing to bullying by co-workers, though a cognizable “disease,” failed to satisfy the statutory “post-if” occupational/causal nexus required by Section 9-502, because alleged injurious forces (hazing) bore no relationship to the demands of the data entry work he had been commissioned by the employer to perform.

⁹ 466 Md. 1 (2019).

¹⁰ *Harvey v. Raleigh Police Dep’t*, 85 N.C. App. 540, 355 S.E.2d 147, 150 (N.C. Ct. App. 1987)

does not limit occupational diseases to rare diseases or those exclusive to a specific profession.”¹¹

In light of these cases, how does one prove “post-if” nexus between working and contracting COVID-19? *Quinlan* requires proof that, by virtue of having to do his or her job, a claimant was exposed to a greater physical demands/risk of infection than the public at large. With this in mind, COVID-19 claimants, assuming they can prove workplace infection, were undeniably sickened because they left the safety of their home and went to work. For many types of work, “phoning it in” is not an option. Grocery store cashiers and those stocking shelves cannot work remotely. Accordingly, those who contracted the virus because they showed up for work establish an occupational “post-if” nexus between their vocation and risk of infection that is undeniably greater than the stay-at-home general public.

For certain classes of workers, the risk of occupation exposure is considerably higher than it is for other classes of employees who must report for work. Public safety employees, such as police officers, fire fighters and correctional officers, for example, cannot socially distance, because their work requires otherwise. The same argument can be made for teachers and childcare workers, whose duties necessitate close personal interactions.

Analysis of “post-if” occupational versus general risk must also consider the degree of danger associated with occupational exposure to COVID-19, when contrasted with the risk of catching the common cold at work. Few, if any, public or private institutions enforce demanding protocols to prevent workers from catching colds, so, workers and their counterparts in the general public are exposed to an equal degree to the likelihood of infection. In contrast, given the catastrophic risks of medical complications and death associated with contracting COVID-19, public and private institutions have instituted rigorous preventative measures, including social distancing, mask mandates, contact tracing, and lockdowns. Employers’ adoption of these safeguards is a recognition that workers who have to go to work are exposed to a higher demand or risk of harm than are their counterparts who can work remotely. Additionally, because employers are uniquely empowered to implement and enforce COVID-19 “best practices” safety protocols, an expansive reading of “post-if” occupational nexus will incentivize them to adopt these protective measures - if for no other reason than to rebut any suggestion that any of its employees could have been infected at work.

11 466 Md. at 17

Accidental Injury

The Act states “an accidental injury that arises out of and in the course of employment... or... a disease or infection that naturally results from an accidental injury that arises out of and in the course of employment, including: (i) an occupational disease; and (ii) frostbite or sunstroke caused by a weather condition.”¹²

Not long after Maryland first adopted workers’ compensation, the Court of Appeals ruled that being sickened by a workplace exposure constituted an “accident,” without proof that the “bacillus” or toxic agent entered the body as a result of trauma.¹³ Construing the term accidental to mean “unusual,” the claimant was required to point to actions by the employer that resulted in a hazard that was different than the perils of a given line of work.¹⁴ For example, if an employer imported well water that contained typhoid, then the claim of a sickened worker compassable; the opposite would be true if the plant was connected to the same city water available to the general public.¹⁵

Notably, in *Montgomery v. Athey*, a 1962 decision, the Court of Appeals found that a police officer could state a claim for accidental injury, provided he was able to prove that he contracted tuberculosis due to exposure to infected persons.¹⁶ This holding, coming two decades after Maryland adopted statutory coverage for occupational diseases, signals that COVID-19 patients can still make accidental injury claims.

The Court of Appeals in *Harris v. Bd. of Educ.*,¹⁷ held that the legislative use of adjective “accidental,” did not require proof of an “accident” – a slip, twist or fall. Post-Harris, the mere happening of an injury, unless it was expected or intended by the claimant, constituted a compensable “accidental injury.”¹⁸

Regarding the application of this standard to workers sickened on the job, recall that, prior to the adopting of coverage for occupational diseases, on the job contamination/infection was only deemed an accidental injury if there was proof of an “unusual” risk, owing to the employer having created a danger that is not associated with doing that type of work. *Harris* references

12 Md. Lab. & Empl. Art. §9-101(b).

13 *Victory Sparkler & Specialty Co. v. Francks*, 147 Md. 368, 380 (1025).

14 147 Md 379-80

15 *Union Mining Co. v. Blank*, 181 Md. 62, 78-79 (1942).

16 227 Md. 312, 314 (1962).

17 375 Md. 21 (2003)

18 375 Md. at 53.

these cases, noting that contamination and infection are no less injurious physical injuries. Then, in the last sentence of the opinion, *Harris* expressly overrules three prior cases and “similar holdings.”

Given that *Harris* removes the term “unusual” from accidental injury analysis, it appears COVID-19 claimants need only prove an “accidental” infection, one that was neither expected nor intended by the claimant. In other words, absent proof that the claimant wanted to get sick, viral infection traceable of a workplace exposure should be sufficient to prove a compensable accidental injury.

Proof: Expert Required?

Proving that a worker has tested positive for COVID-19 simple: the test result speaks for itself. Whether the virus was contracted at work poses a greater challenge.

“When a complicated issue of medical causation arises, expert testimony is almost always required.”¹⁹ Because “a physician need not be a specialist in order to be competent to testify on medical matters,”²⁰ the easiest way to meet this burden is to secure the opinion from one of the treating health care providers – even though he or she does not treat infectious diseases on a regular basis.

Can a claimant meet the burden of proof without an expert? The answer to this question begins with the rules of evidence that govern Commission hearings. A “commissioner may admit evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs, and give probative effect to that evidence.”²¹ Next, Maryland’s judiciary recognizes that an expert’s opinion is not required if when there is “an obvious cause-and-effect relationship that is within the common knowledge of laymen.”²² *S.B. Thomas v. Thomas*, involved an argument by the defense that it should be allowed to admit proof of a prior injury, to question the extent to which a workers’ compensation claimant’s accidental injury was in fact related to the earlier injury.²³ This was deemed a complicated medical issue, requiring an expert, because the linkage, if any, between the residual effects of trauma to a body part and a reinjury to that same body

part is one lay people are unlikely to understand – without an explanation from a medical expert.

Applying this standard to COVID-19 infection, it is unclear whether determining the probable infection site, where a claimant “got sick,” requires an expert to explain what happened. My co-authors outline sources of this evidence below, infected co-workers/uninfected family members; the availability of protective equipment and its adequacy; CDC protocols that define exposure, to name a few. None of these factual issues require an expert to explain how exposure to a highly contagious virus at work, and the absence of similar exposure at home, support a probable workplace infection.

But there is *Montgomery v. Athey*,²⁴ the previously alluded-to decision that holds that mere exposure to people infected with tuberculosis fails to meet the burden of proving a police officer contract the ailment at work. *Montgomery* can be distinguished because there was no evidence that mere exposure to tuberculosis can infect. In contrast, CDC guidelines establish state that anyone who come “into close” contact with someone who has the virus should quarantine.²⁵ For those claimants who can demonstrate they were in “close contact” with someone infected, shouldn’t a commissioner accept that as sufficiently linking infection to the workplace, without an expert? Such a finding would not only meet the Commission’s relaxed evidentiary rules, but it would effectuate the command that the workers’ compensation laws be interpreted to protect the workers from the consequences of workplace hazards.²⁶

Virology 101: COVID-19 - An Influenza Virus on Steroids

A virus, unlike a germ, is not a living organism, but, in the realm of infectious medicine, it functions in a similar manner. It requires a host, a body where it can “set up shop.” Inside that body, it attaches itself to a cell and breaches the cell’s outer wall. There, the virus hijacks the cell’s DNA, and turns it into a factory that replicates copies of the virus. These newly-minted viruses infect other cells, causing each of them to replicate even more copies of the virus, which, in turn infect more cells.

Cells, once commandeered, may no longer perform the function the host’s body requires of them, and, in some

19 *Giant Food, Inc. v. Booker*, 152 Md. App. 166, 178, cert. denied, 378 Md. 614 (2003).

20 *Ungar v. Handelsman*, 325 Md. 135, 146 (1992).

21 COMAR 14.09.03.09(c)(4)

22 *S.B. Thomas, Inc. v. Thompson*, 114 Md. App. 357, 382-383 (1997).

23 114 Md. App. 357 (1997).

24 227 Md 312 (1962).

25 <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html>

26 Md. Lab. & Empl. Art. §9-102(a)

cases, the replication process creates toxic byproducts. The body responds by creating antibodies to attack the infection and its temperature may rise to a feverish level that is less hospitable to the virus. In some, but not all, victims, the cumulative effect of commandeered cells, toxins, detritus of antibody-virus combat can cause symptoms generally associated with having the flu. God willing, in most cases, the host's body prevails, vanquishing the pathogen.

To perpetuate itself, a virus must find a new host before its current host's body eradicates it. Newly replicated viruses look for opportunities to "jump" to a new host – someone not previously infected. This process begins early in the infection timeline, often before the host begins to experience symptoms. In other words, asymptomatic hosts, unaware they are infected/contagious, go about their normal daily routines, all the while shedding the viruses their bodies are expelling. The same is true for those infected, but asymptomatic.

And it is here the replicated influenza and respiratory viruses have a built-in escape mechanism that can make them super spreaders. Namely, they infect the respiratory system in a manner that causes the host to cough and sneeze them into the air. Additionally, each exhalation breathes them out. The new host inhales the aerosolized particles or rubs his or her eyes, after touching a contaminated surface - beginning the process anew.

With this knowledge of viral pathology in mind, the COVID-19 virus is uniquely equipped to spread. It owes its virulence to its ability to infect, and to shed replicated viruses in hosts who do not know they are infected, let alone contagious. In addition to a higher than average asymptomatic infection rate, COVID-19 takes longer than average flu viruses to produce symptoms. As a result, on any given day, there is an ever expanding population of asymptomatic and pre-symptomatic hosts unwittingly shedding virus.

Screening Covid Cases: Is the Juice Worth the Squeeze?

Garden variety claims for accidental injury follow a common timeline. For compensable claims, a year or two after the claim is filed, the claimant may seek an award for permanent disability benefits. Due to the novel nature of COVID-19, there may be claims where patient recovers with no residual impairment. This means that no monetary/indemnity benefits awarded to a claimant, other than perhaps a couple of weeks of temporary total disability.

Given these financial dynamics, counsel conducting an initial consultation for a prospective COVID-19 claim needs to answer two important questions: 1) Can I prove occupational exposure – with or without an expert, and 2) is there a sufficient likelihood of permanent disability from which to pay the legal fees and expenses needed to prove the occupational exposure?

Exposure and Compensability

Turning to the application of this virology to tracing infection to the workplace, the starting point is proving "exposure." The CDC advises that anyone with "close contact" with someone who has the virus should quarantine.²⁷

With these principles in mind, the following facts may assist in proving an occupational infection:

1. **Co-workers Infected:** If there are other co-workers who have symptoms, it is likely they were shedding the virus for at least 10 days prior to contracting the virus, even though they did not exhibit symptoms for some of that time period. Additionally, many employers collect information regarding employees who have reported test results.
2. **Family Infection:** It is not uncommon for workers who contract the virus to infect members of their household. But household members can contract the virus, perhaps without symptoms, from other sources. If household members do in fact test positive, it is important to determine if the testing occurred before or after the worker got sick. Obviously, if the family member was positive prior to the workplace exposure, it will be harder to attribute the infection to the workplace.
3. **Exposure:** The CDC generally requires people who have had "close contact" -defined as "within 6 feet of someone who has COVID-19 for a total of 15 minutes or more."²⁸ The same guideline cites hugging, kissing, and working with a COVID-19 patient as close contact. With these standards in mind, the would-be client should be questioned about, not only his or her proximity to the infected workers, but to those who were had "close contact" with that person.
4. **Medical Records:** For much of 2020, patients

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²⁸ <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html>

reported symptoms to health care providers, who may not have realized they were treating someone infected with COVID-19. Subsequent doctors who see this patient often parrot the same incorrect diagnosis. A proper diagnosis, as of the date of this writing is generally confirmed by two tests: rapid test and PCR. The former generates immediate results but is only approximately 60% accurate. The latter is 90% accurate but requires three days for a lab to generate results. It is important to correlate examination findings with the test result because some tests results are wrong.

5. Blood Testing: COVID-19 leaves immunoglobins that can confirm diagnosis, and perhaps shed light on when an infection might have taken place. The immunoglobins (IgM) appears 2-4 weeks after contracting the virus and is then replaced by IgG. Accordingly, the presence of IgM suggests a relatively recent infectious exposure.

6. Employer Precautions: Any employer adopted plan to safeguard workers from infection must include the “Three W’s” – wash hands, watch distance, wear a mask. To what degree did the employer adopt/enforce a Covid-19 protocol? Inquire as well about the types of personal protective gear provided, in light of the probable risk. A paper mask might be appropriate in one setting, while front line health care workers may require the additional protections of an N-95. With respect to the N-95 mask, its effectiveness is compromised substantially if it does not fit snugly over the mouth and nose.

7. Contact Tracing: In the initial intake, while it is still fresh in the client’s mind, it is important to create a list of persons the client came into contact with, during the period of likely exposure. Employers may be reluctant to share this information, citing confidentiality. The information may be sought by a Commission subpoena to the employer. A failure to respond to this subpoena arguably gives rise to an inference that the employer is hiding information that, if disclosed, would be favorable to the claimant. Alternatively, it wise to ask the claimant for the names of co-workers, or to have the claimant canvass co-workers regarding employees who have tested positive. This type of news travels fast, but it is time-specific. Precisely how many co-workers were infected at the time the claimant was infected is information that co-workers will likely know, early on. As time passes, the clarity and accuracy of co-worker testimony regarding the workplace exposure

of a given claimant diminishes, as new infections, occurring after the claimants are incorporated into workplace gossip.

Permanency: Complete Recovery Means No Recovery for Counsel

During the preceding year, infectious disease specialists thought that those who survive COVID-19 would be no worse off than those who recover from the flu, with a few exceptions. During the ensuing months, now almost a year, doctors report ongoing a significant number of complaints stemming from the viral infection. Over the course of 2020, it became apparent to the Doctor that this optimistic prognosis was premature. Patient after patient got “better,” but continued to experience lingering health issues. Medical literature, as studies of the novel virus are completed, is increasingly finding long-term impact from having been sickened with the virus.

Note at the outset, determining whether a patient might have permanent impairment from a COVID-19 infection, is complicated by comorbidities, unrelated health problems/genetic predispositions that, cause patients infected with COVID-19 to experience the most severe, life threatening, symptoms. Gaining an early understanding of these pre-existing conditions helps medical experts rating impairment to demarcate the extent to which the virus impacted the health of a patient who may not have been in good health at the time he or she contracted the virus.

As a general rule, the most permanent impairment can be diagnosed with a high degree to confidence approximately 6 months post-COVID. By that time, most people who are lucky enough to recover without any residuals are “out of the woods” – they have no impairment and they are not likely to contract the virus again. Prior to six months, the likelihood of permanent as **probable, possible and unlikely**, with regard to the following:

Probable:

- Blood Clots (newly acquired or exasperation of previous condition)
- Organ damage due to blood clots
- Loss of limbs due to blood clots
- Lung and/or heart damage due to intubation
- Loss of vision
- Loss of hearing
- COPD (newly acquired or exasperation of previous condition)
- Chronic fatigue Syndrome

Possible:

- Uncontrolled blood pressure
- Memory loss, dizziness confusion
- Difficulty breathing
- Tiredness
- Muscular aches and pains

Unlikely:

- Loss of senses (taste and smell)
- Restless Leg(s)
- Fever
- Hair loss
- Memory loss, dizziness (with resolution)
- Confusion (with resolution)
- Difficulty breathing, (with resolution)
- Tiredness (with resolution)
- Muscular aches and pains (with resolution)
- Loss of vision (with resolution)
- Loss of hearing (with resolution)

Additionally, experts offer the following screening criteria:

1. Hospitalization: An admission, as opposed to being seen in the ER and released to home, suggests the patient's symptoms were severe, and a complete recovery is less likely. It is important to inquire about what medical procedures accompanied the admission. Was someone hospitalized for observation or were they placed on oxygen or a respirator?
2. Medical History: Because many COVID-19 patients have co-morbidities, it is vital to inquire extensively into the patient's medical history – the goal being to establish that the viral infection was dramatic departure from the pre-infection baseline medical condition. Another term for "dramatic departure," is "permanent impairment" attributable to having contracted COVID-19.
3. Current Medical History: Everyone knows the virus attacks the lungs. But it can also damage the heart and other organs. For example, someone who tested positive, and complains of residual abdominal pain, may not be aware that COVID-19, as with all viruses, can damage the liver. We also believe that a significant number of COVID patients continue to suffer from chronic fatigue syndrome, after their traditional symptoms abate. Given that the medical science is evolving, obtaining a detailed post-COVID history may turn up residual complaints that might be later linked to having contracted the virus.
4. Testing: Certain medical tests, pulmonary function tests and echocardiograms/EKG's are inexpensive,

and can establish that a patient's functional capacity has been compromised as a result of contracting the virus. More expensive testing, such as a CAT scan of the chest, can also prove an objective change in condition. Before commissioning an expert to perform a full analysis of permanent impairment, it may be prudent to see if any of these tests confirm residual deficits.

Conclusion

Our goal in writing this article is to inform practitioners about the legal and factual hurdles to anticipate, before deciding to invest the time and money needed to prove a COVID-19 workers' compensation claim. The law governing such claims is evolving, as is the medical science relating to diagnosing and treating the virus. Asking the right questions before signing up a prospective COVID workers' compensation claim, avoids the unfortunate plight of the practitioners who didn't: in the words of Yogi Berra: "I wish I had an answer to that because I'm tired of answering that question."

Biographies

James K. MacAlister is an attorney at Cohen, Snyder, Eisenberg & Katzenberg, PA in Baltimore focusing on personal injury and workers' compensation cases. In practice for nearly 40 years, he is a recipient of numerous awards including MAJ's *Trial Lawyer of the Year* in 2015 and the *Robert J. Zarbin Memorial Legislative Advocacy Award* in 2018. He is also a current member of the MAJ Board of Governors and co-chair of the Workers' Compensation Section. He was also a recipient of the *Leadership in the Law Award* from *The Daily Record* in 2013.

Atiq Rahman, MD is a Board Certified physician who specializes in the outpatient treatment of Infectious Diseases and he performs IMES at his office in Glen Burnie, Maryland. Dr. Rahman is a graduate of the Fellowship in Infectious Disease Program at Johns Hopkins and previously graduated from King Edward Medical College, Lahore, Punjab University in Pakistan. He has spent his entire medical career specializing in infectious disease care and diagnostic medicine. His resume includes serving as the chairman of Infection Control Committee, chief of teaching service for the Infectious Diseases Department of Medicine and as an instructor of infectious diseases to medical residents & students at Medstar Harbor Hospital. He also currently serves as a consultant at Baltimore Washington Medical Center.