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Commonwealth of Kentucky

Court of Appeals

NO. 2009-CA-001116-MR

ROBERT CARROLL — APPELLANT

APPEAL FROM JEFFERSON CIRCUIT COURT
v. HONORABLE IRV MAZE, JUDGE
ACTION NO. 04-CI-007959

UNIVERSITY MEDICAL CENTER, INC.
d/b/a UNIVERSITY OF LOUISVILLE
HOSPITAL; EMILY CHAN, M.D.; AND
UNIVERSITY SURGICAL
ASSOCIATES, P.S.C. — APPELLEES

AND NO. 2009-CA-001211-MR

UNIVERSITY MEDICAL CENTER, INC.
d/b/a UNIVERSITY OF LOUISVILLE
HOSPITAL ROBERT CARROLL — CROSS-APPELLANT

CROSS-APPEAL FROM JEFFERSON CIRCUIT COURT
v. HONORABLE IRV MAZE, JUDGE
ACTION NO. 04-CI-007959

ROBERT CARROLL — CROSS-APPELLEE

<u>OPINION</u>
<u>AFFIRMING</u>

** ** ** ** **

BEFORE: KELLER, MOORE AND STUMBO, JUDGES.

KELLER, JUDGE: Robert Carroll (Carroll) appeals from a jury verdict and judgment in favor of University Medical Center (UMC) and Emily Chan, M.D. (Dr. Chan). UMC cross-appeals from the trial court's denial of its pre-trial motion for partial summary judgment.

On appeal, Carroll argues that the trial court erred when it would not permit him to introduce certain medical literature or evidence that UMC violated accreditation standards. He also argues that the court improperly permitted UMC to use exhibits and to call a witness when neither had been identified or disclosed prior to trial. Finally, Carroll argues that the trial court prevented him from playing portions of testimony during his closing argument, which fatally hindered his ability to argue his theory of the case.

On cross-appeal, UMC contends that it could not be held liable for the actions of a physician who had been dismissed by summary judgment. Therefore, according to UMC, the trial court erred when it failed to grant summary judgment to it on that issue.

Having reviewed the record, the briefs, and the arguments of the parties, we affirm the jury verdict and the trial court's judgment. Because we affirm, we do not address UMC's cross-appeal.

FACTS

UMC operates the University of Louisville Hospital (University Hospital), which employs the non-physician personnel who work there. The University of Louisville School of Medicine (the School of Medicine) employs the residents and attending physicians who practice at University Hospital. The attending physician in this appeal, Dr. Emily Chan (Dr. Chan), is also employed by University Surgical Associates, P.S.C.

On October 1, 2003, Carroll sought treatment at University Hospital's emergency department for complaints of abdominal pain and vomiting. Carroll was discharged that evening with a prescription for anti-nausea medication, and he was advised to follow-up at an outpatient clinic.

The following day, Carroll's symptoms worsened and he was transported to University Hospital by ambulance. On the morning of October 3, 2003, Carroll underwent a CT scan, which revealed a mass in his colon, and he was diagnosed with an acute bowel obstruction. Dr. Monica Hall (Dr. Hall), a surgical resident, concluded that Carroll needed surgery, and the attending trauma surgeon who was on duty at that time agreed with that conclusion.

The next day, Carroll was taken to surgery and placed under anesthesia at approximately 9:30 a.m. Dr. Hall attempted to contact Dr. Robert Fulton (Dr. Fulton), who was the attending surgeon on duty at that time, to request his assistance with the surgery. When she did not hear from Dr. Fulton, Dr. Hall placed Carroll in the lithotomy position to allow access to Carroll's anus so that a sigmoidoscopy could be performed. Dr. Hall then began the surgery. Sometime

thereafter, Dr. Fulton called Dr. Hall and stated that he did not feel comfortable performing the surgery. He advised Dr. Hall to contact a colorectal surgeon. Dr. Hall then contacted University Surgical Associates, who paged Dr. Emily Chan (Dr. Chan). Dr. Chan arrived at University Hospital at approximately 12:30 p.m., and examined Carroll's large intestine with a sigmoidoscope. She then continued the surgery that Dr. Hall had begun, and Dr. Hall left the surgical suite.

At approximately 4:00 p.m., nurse Debbie Leake expressed her concern to Dr. Chan that Carroll had been in the lithotomy position for several hours and should be moved. Dr. Chan acknowledged nurse Leake's concern, but did not change Carroll's position.

At approximately 10:40 p.m. Dr. Chan finished the surgery. Shortly thereafter, it was discovered that Carroll had no pulse in either leg. Blood flow soon returned to his right leg, but it never returned to his left. As a result, Carroll's left leg was amputated below the knee on October 12, 2003.

Carroll filed the instant action against UMC, Drs. Hall and Chan, University Surgical Associates, and several others. Carroll's claim centered on his assertions that UMC failed to timely schedule and prepare for his surgery and permitted Dr. Hall to begin surgery without an attending physician present. Carroll also asserted that Dr. Chan negligently failed to reposition him during surgery, which resulted in a loss of blood flow to his left leg and the consequent amputation.

Prior to trial, all defendants, other than Dr. Chan, University Surgical Associates, and UMC, had been dismissed by agreement or summary judgment. Notably, the court granted Dr. Hall's motion for summary judgment because Carroll could not present any evidence that she had breached any standard of care resulting in the amputation of Carroll's leg.

Prior to trial, UMC filed motions *in limine* seeking to prohibit Carroll from introducing: (1) evidence or arguing at trial that an attending physician was unavailable at the beginning of Carroll's surgery; (2) standards and regulations promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and its decision to only conditionally accredit UMC; and (3) evidence regarding the School of Medicine's decision to terminate a physician on its staff in 2007 for alleged violations of JCAHO Guidelines. The court granted UMC's motions.

On March 28, 2008, UMC filed a motion for partial summary judgment arguing that it could not be held liable for Dr. Hall's conduct. In support of its motion, UMC noted that it did not employ Dr. Hall and that Dr. Hall had been dismissed by summary judgment. The court denied UMC's motion.

The trial began on November 17, 2008. As noted above, Carroll maintained at trial that UMC was negligent for failing to prepare for his surgery and by permitting Dr. Hall to begin surgery without an attending physician. As to Dr. Chan, Carroll asserted that she was negligent because she failed to reposition him during surgery. Both defendants asserted that they complied with the

applicable standards of care and that Carroll's amputation resulted from his previously undiagnosed peripheral vascular disease. After hearing the evidence, the jury returned a defense verdict and this appeal and cross-appeal followed.

STANDARD OF REVIEW

We review a trial court's evidentiary rulings for an abuse of discretion. *Goodyear Tire and Rubber Co. v. Thompson*, 11 S.W.3d 575, 577 (Ky. 2000). We use that same standard with regard to "matters pertaining to closing arguments." *See Hawkins v. Rosenbloom*, 17 S.W.3d 116, 120 (Ky. App. 1999). "The test for abuse of discretion is whether the trial judge's decision was arbitrary, unreasonable, unfair, or unsupported by sound legal principles." *Goodyear Tire and Rubber Co.* at 581. With these standards in mind, we separately address the issues raised by Carroll on appeal and UMC on cross-appeal below.

ANALYSIS

1. Exclusion of Medical Literature

Prior to trial, the court ruled that Carroll could not introduce any medical literature published after October 4, 2003, the date of Carroll's surgery. Carroll argues that, during trial, one of the Appellees' defenses was that advances in medical equipment made repositioning of Carroll unnecessary. In doing so, the Appellees, and in particular Dr. Chan's experts, attacked the validity of the medical literature that recommended repositioning as being outdated. Carroll argued that the Appellees, by offering evidence in support of this defense, opened the door to the admission of post-October 2003 medical literature, which indicated that the

advances in medical equipment espoused by Dr. Chan did not obviate the need for repositioning. The court disagreed and maintained its ban on the use of post-October 2003 medical literature.

On appeal, Carroll acknowledges that any medical literature post-October 2003 would not have been admissible to establish the standard of care. However, he argues that post-October 2003 medical literature was admissible to rebut Dr. Chan's proof regarding causation. According to Carroll, the court's ban of the use of that literature fatally hampered his ability to refute Dr. Chan's causation argument. The Appellees argue that, because the articles post-dated the surgery, they would have confused the jury as to the applicable standard of care. They also argue that the information in the articles was unnecessarily duplicative and that Carroll's expert witness, Dr. Camazine, did not rely on the articles in formulating his opinions.

During a pre-trial hearing regarding Dr. Camazine's deposition, Carroll's counsel admitted that there were only two articles at issue. According to counsel, other articles dealt with the same issues; however, the 2006 articles were "more definitive." In his avowal testimony, Dr. Camazine testified that the article "Lower Limb Acute Compartment Syndrome After Colorectal Surgery in Prolonged Lithotomy Position"

> talks about some of the mechanisms of compartment syndrome and ischemia in the leg that we discussed, including this vicious cycle that we discussed. It also talks about - - it says that the simple act of leg elevation in healthy subjects decreases the mean arterial pressure at

> the toe by .8 millimeters of mercury per centimeter of elevation. So for instance, if you raised the legs you know, ten centimeters, you drop the pressure by eight. And raising it ten centimeters would be pretty small. And then it talks about the types of management to avoid the problems, it talks about repositioning the patient. It also talks about there is debate about the combine [sic] use of compression stockings and intermittent compression devices while the legs are elevated.

When asked if that article helped him "in establishing [his] opinion as to the cause of Mr. Carroll's loss of his leg," Dr. Camazine stated, "Not anymore than I've already done."

As to the second article, "Compartment Syndrome of the Lower Leg After Surgery in the Modify [sic] Lithotomy Position," Dr. Camazine stated that it "talks about prolonged operation times. It talks about some of the mechanisms. We talked about the push of the blood into the leg. They talk about how it's best to use Yellofin Allen Stirrups so the legs can be lowered without any problem." When asked if this article would "be of benefit . . . in not only establishing but also ratifying your opinions as to the causation in this case," Dr. Camazine responded that it would.

This avowal testimony by Dr. Camazine goes primarily to the issue of standard of care, not to the issue of causation. Furthermore, Dr. Camazine admitted that the first article did nothing to add to his opinion. Dr. Camazine stated that the second article would "be of benefit" in establishing and formulating his opinion as to causation; however, he did not state that the article was key to his opinion or how it would have been useful. Nor did he state how the information in

that article differed from any other articles he had reviewed. These articles appear to be duplicative and, because they primarily appear to address the standard of care, the appellees' argument that they would confuse the jury is well taken. Therefore, we discern no abuse of discretion by the trial court in excluding testimony regarding these two articles.

2. Exclusion of JCAHO Guidelines

Carroll argues that the trial court erred by excluding evidence about the JCAHO standards. JCAHO is a national organization that surveys and accredits hospitals and health care organizations on a voluntary basis, and provides national standards for patient care. According to Carroll, under JCAHO standards, UMC was required to: (1) ensure that his surgeon, a resident, was supervised by an attending surgeon; (2) inform him of the identity of his surgeon(s); (3) ensure that the attending physician was "immediately available" during surgery; and (4) adequately plan for the surgery.

In support of his argument, Carroll cites *Humana of Kentucky v. McKee*, 834 S.W.2d 711 (Ky. App. 1992). In *McKee*, the McKees' son was born with phenylketonuria (PKU), a condition that, if not detected soon after birth, can lead to significant disabilities. Hospital personnel are required to check for this condition because measures can be taken to prevent those disabilities. The McKees did not learn of the condition until several years after their son's birth, when he began exhibiting symptoms of PKU-related disability. When they discovered that their son had PKU, the McKees sued the hospital alleging, in

pertinent part, that it had failed to test for PKU. As part of their proof, the McKees introduced the JCAHO standards. This Court held that those standards are admissible to show what procedures a reasonably prudent hospital would follow, but not to establish the standard of care. *Id.* at 723.

McKee is distinguishable for two reasons. First, the hospital procedures regarding the drawing and processing of blood samples from newborns were directly at issue in *McKee* and were procedures implemented and controlled by the hospital. Herein, the procedures with regard to when an attending needed to be consulted, when a resident could begin a procedure, and whether an attending needed to be in the surgical suite were procedures dictated by the School of Medicine, not UMC.

Second, Carroll's experts did not identify the JCAHO standards as a basis for their opinions in their discovery responses or in their discovery depositions. In the absence of any evidence that Carroll's experts relied on, or even reviewed, the JCAHO standards, the court properly granted the Appellees' motion to exclude them.

Finally, we note that Carroll's argument as to causation was that he was kept in the lithotomy position for too long. There is no evidence that, had UMC complied with the JCAHO standards, the surgery would have taken less time. Therefore, UMC's non-compliance with the standards was of little relevance and would only have served to confuse the jury.

3. Exclusion of Testimony Regarding Medical Staff Policies

Carroll argues that the trial court erred when it excluded testimony of Dr. Kristine Kruger (Dr. Kruger), the director of UMC's medical staff, regarding staff policies. For the reasons set forth above, we discern no error in the trial court's exclusion of Kruger's testimony.

4. Introduction of Undisclosed Exhibits

Carroll argues that the trial court erred by permitting Dr. Chan and UMC to introduce photographs of the operating room and surgical equipment that had not been identified in mandatory pre-trial disclosures. According to Carroll, he was unduly prejudiced by the surprise introduction of these photographs. The Appellees note that Carroll did not object to their use of the photographs during their opening statements and did not object to their use of the photographs during trial. In fact, as noted by the Appellees, Carroll used some of the photographs during trial. Furthermore, Carroll asked the Appellees if the parties should move to introduce the photographs as a group exhibit. The Appellees did not agree; however, Dr. Chan subsequently moved for admission of the photographs, and Carroll did not object.

The Court of Appeals is without authority to review issues not objected to and not ruled on by the trial court. *Fischer v. Fischer*, 197 S.W.3d 98, 102 (Ky. 2006). Because Carroll did not object, we cannot address the issue he raises on appeal regarding the introduction of the photographs. Furthermore, based on Carroll's use of the photographs and his suggestion that they be introduced as a

group exhibit, his argument that the photographs unduly prejudiced him is disingenuous at best.

5. Testimony from Undisclosed Witness

On November 25, 2008, after the close of evidence for the day, counsel for UMC advised the parties that she would be calling Dr. McMasters the next day. Counsel for Carroll indicated that he had not previously heard of Dr. McMasters and counsel for UMC stated that she had listed "a representative from the University of Louisville School of Medicine residency program" in UMC's witness list. No further discussion of substance took place that day.

On November 26, 2008, counsel for Carroll stated that he first heard of Dr. McMasters the previous afternoon. Counsel for Carroll noted that Dr. Cheadle had been deposed by UMC and it was his understanding that Dr. Cheadle was the person referred to as the School of Medicine representative in UMC's witness list. Counsel for UMC agreed that she had deposed Dr. Cheadle; however, she stated that Dr. Cheadle was not UMC's witness, but the person identified by a co-defendant, University Surgical Associates, as its representative. Counsel for UMC also stated that, although not disclosed by name, Dr. McMasters fit the description of the person referred to by UMC in its witness list as a representative from the School of Medicine. Counsel for UMC also stated that Dr. McMasters fell within the description of a person referred to in the witness list of University Surgical Associates. Finally, Counsel for UMC argued that Carroll should have asked for a more specific identification if he had wanted one.

After hearing arguments of counsel and after admittedly struggling with the issue, the court ruled that UMC could call Dr. McMasters as a witness. Dr. McMasters, the head of the residency program and a physician at University Surgical Associates, testified regarding the relationship between UMC and the School of Medicine. According to Dr. McMasters, UMC and the School of Medicine are separate entities. Dr. McMasters testified that resident surgeons, who are in post-medical school training, are employed by the School of Medicine and receive their training at UMC. Residents are supervised by attending surgeons, who are employed by the School of Medicine and/or University Surgical Associates. The residency program is operated through the School of Medicine and policies related to the residency program are developed and implemented by the School of Medicine, not UMC.

Dr. McMasters testified that, prior to undertaking surgery; a resident should consult with an attending surgeon. The attending surgeon may, depending on the type of surgery, simply consult, either in person or over the telephone, or may assist the resident with the surgery.

Carroll argues that, because he had not had the opportunity to depose Dr. McMasters, he was significantly prejudiced by Dr. McMasters's testimony. Having reviewed Dr. McMasters's testimony, we discern no significant prejudice. In fact, Dr. McMasters's testimony did not differ significantly from Dr. Cheadle's testimony, which Carroll presented. At its worst, Dr. McMasters's testimony was

cumulative of Dr. Cheadle's and its admission by the trial court was not an abuse of discretion.

6. Restrictions on Closing Argument

Finally, Carroll argues that the trial court improperly restricted his ability to argue his theory of the case during his closing. The trial court is vested with wide discretion in controlling the scope and nature of closing argument. *Hawkins,* 17 S.W.3d at 120.

Carroll maintains that he should have been permitted to argue to the jury that: an attending physician was unavailable to perform Carroll's surgery; he should have been permitted to play portions of the testimony for the jury; and the jury should have heard that important information was lost when UMC was unable to produce medical records regarding Carroll's care in the post-anesthesia care unit. We address each issue in turn below.

The evidence indicates that an attending physician, Dr. Fulton, was in the hospital at the time Dr. Hall began surgery. While Dr. Fulton did not ultimately complete the surgery, the evidence did not support an argument that no attending physician was available.

The Appellees asked the trial court to prohibit the parties from playing portions of testimony during closing because doing so could unnecessarily confuse the jury and inappropriately highlight and/or skew the evidence. The court agreed, as do we.

In *Morgan v. Scott,* 291 S.W.3d 622, 636 (Ky. 2009), the Supreme Court of Kentucky held that a trial court may permit counsel to play portions of videotaped depositions during closing argument. However, the court has the discretion to make that determination. Before it permits a party to play testimony during closing, the court must review the testimony to ensure "that the segments presented to the jury are not overly lengthy, do not overly emphasize one party's case, and are not a misrepresentation of the witness' testimony." *Id.* (Footnote omitted.) Based on the length of trial, the number of witnesses who testified, the apparent inability of counsel to agree on even the simplest of matters, and the number of parties involved, we discern no error in the trial court's action. In fact, after our review of this matter, it appears likely that a hearing to determine what portions of testimony could be played may have taken as long as, if not longer than, the trial.

As to the missing post-surgery records, Carroll alleged negligence occurred before and/or during surgery, not afterward. Therefore, we discern no error in the court's ruling on this issue.

CONCLUSION

For the reasons set forth above, we discern no error in the trial court's rulings and affirm. Because we affirm, UMC's Cross-Appeal is moot.

MOORE, JUDGE, CONCURS.

STUMBO, JUDGE, DISSENTS AND FILES SEPARATE OPINION.

STUMBO, JUDGE, DISSENTING: I respectfully dissent from the majority on two issues. First, I would hold that the circuit court improperly excluded Carroll's usage of post-2003 literature. While the circuit court correctly determined that post-2003 literature could not be introduced for the purpose of demonstrating the standard of care as it existed in 2003, UMC and Dr. Chan opened the door to the introduction of post-2003 literature for other purposes by arguing that the extended use of the lithotomy position could not have caused Carroll's hypotension and resultant loss of his lower left leg. The defense argued both in opening argument and by way of its inquiry of expert witness Dr. Camazine that Dr. Chan's extended usage of the lithotomy position could not have proximately resulted in the loss of Carroll's leg, and they sought to attribute Carroll's post-operative hypotension to his then undiagnosed peripheral vascular disease. By barring Carroll from introducing post-2003 literature on the issue of causation, Carroll was prevented from effectively rebutting the defense assertion that the lithotomy position was not the cause of Carroll's post-operative hypotension and resultant amputation. Additionally, I am also persuaded that the jury could be admonished on remand to consider the standard of care as it existed in 2003, and that any literature published after 2003 could be considered only as it related to the issue of whether the extended use of the lithotomy position causes hypotension in the legs. I would reverse on this issue.

I would also hold that the circuit court erred in allowing Dr. McMasters to testify at trial. Dr. McMasters was not identified in UMC's pre-trial compliance nor identified as a witness in discovery. Carroll contends that he had never heard of Dr. McMasters until the evening before McMasters took the stand, when UMC stated that it would be calling him the next day.

During discovery, UMC identified the School of Medicine representative as Dr. William Cheadle, who was subsequently deposed by Carroll. It was not until the middle of the trial, after Carroll had closed his case in chief that UMC announced its intention to call to the stand the following day Dr. McMasters rather than Dr. Cheadle. Carroll strongly objected to the introduction of Dr. McMasters' testimony, as he claimed he was never given the opportunity to depose Dr. McMasters, to consider the import of Dr. McMasters' testimony, or to formulate rebuttal to the testimony. The circuit court denied Carroll's motion to bar UMC from offering Dr. McMasters' testimony, and this denial in my view was erroneous. While the majority has concluded that McMasters' testimony was similar to that which Cheadle would have given, this conclusion is speculative and we do know that Carroll was deprived of the opportunity to utilize at trial any inconsistencies between Cheadle's deposition testimony and his trial testimony. UMC should have been made to comply with the circuit court's pre-trial compliance and discovery orders, and barred from introducing a new witness during the middle of the trial who was not disclosed to Carroll nor made available for deposition. I would reverse on this issue as well.

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