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Commonwealth of Kentucky

Court of Appeals

NO. 2009-CA-000265-MR

WILLIAM WALTON, M.D. and
NEW LEXINGTON CLINIC d/b/a
LEXINGTON CLINIC, P.S.C. APPELLANTS

v.

APPEAL FROM FAYETTE CIRCUIT COURT
HONORABLE THOMAS L. CLARK, JUDGE
ACTION NO. 04-CI-01441

PATRICIA JOHNSON and
ROBERT JOHNSON APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: DIXON, MOORE, AND STUMBO, JUDGES.

MOORE, JUDGE: This is an appeal of a plaintiff's verdict in a medical negligence action alleging failure to properly diagnose and treat rectal cancer. After careful review of the record, we affirm.

STATEMENT OF FACTS

On October 4, 2000, Appellee, Patricia Johnson, first presented to Appellant, William Walton, M.D., a general surgeon who practices at the Lexington Clinic, with complaints of severe rectal pain and some bleeding. While performing an initial evaluation, Dr. Walton visualized an anal fissure and prescribed medication. Over the course of the following two months, Patricia continued to see Dr. Walton for treatment of these problems; during this time, Dr. Walton noticed that the fissure's appearance had changed and decided to obtain a biopsy. On January 4, 2001, Dr. Walton reported to Patricia that the biopsy revealed a cancerous lesion. On January 12, 2001, Dr. Walton performed surgery on Patricia to remove the lesion.

Prior to surgery, Dr. Walton ordered a CEA (carcinoembryonic antigen)[1] test to monitor the growth of Patricia's cancer. This test uses CEA produced by cancer cells as a marker for surveillance of patients with certain types of cancer; CEA levels over a certain level may indicate the growth of cancer cells. At trial, Patricia's experts stated that a normal CEA level for a nonsmoker, such as Patricia, was 2.5, and 5.0 for a smoker. Patricia's cancer produced this compound, was able to be measured by it, and the result of this test was approximately 118.

For the next year and a half following surgery, Dr. Walton continued to monitor the levels of CEA in Patricia's body. On July 6, 2001, Dr. Walton

[1] Carcinoembryonic antigen is a glycoprotein present in fetal gastrointestinal tissue, generally absent from adult cells with the exception of some carcinomas. THE AMERICAN HERITAGE STEDMAN'S MEDICAL DICTIONARY 127 (2001).

performed the first CEA test on Patricia since performing the surgery; the result of that test was 1.7. On October 23, 2001, Dr. Walton performed another CEA test on Patricia; the result of this test was 5.2. The next CEA test that Dr. Walton performed was in August of 2002; the result of this test was 68.3. On August 29, 2002, Dr. Walton mailed a letter to Patricia stating that this CEA result "looks quite good," and that he did "not see anything to suggest malignancy." Dr. Walton admits that he missed the results of the August 2002 test and concedes that, had he seen this result, he would have suspected a recurrence. On February 25, 2003, Patricia returned to see Dr. Walton with complaints of perineum pain. Walton ordered a CEA test, which resulted in a level of 112.2. A biopsy was performed on March 31, 2003, and revealed a recurrence of the cancer in Patricia's pelvis.

On April 9, 2003, Dr. Walton referred Patricia to Dr. Dana Johnson, an oncologist who is not related to Patricia. Dr. Johnson treated Patricia with chemotherapy and radiation ("adjuvant therapy") in June of 2003. After completing the course, Patricia's CEA level dropped to 26.5, indicating that her cancer was sensitive to the treatments. However, because Patricia's cancer recurred in a different location (*i.e.*, in the sacrum, rather than the rectum), Patricia's doctors defined it as a metastasis.[2] Following surgery on September 12,

[2] The parties introduced conflicting evidence regarding whether Patricia's cancer did, in fact, metastasize. "Metastasis" is defined as "1. Transmission of pathogenic microorganisms or cancerous cells from an original site to one or more sites elsewhere in the body, usually by way of the blood vessels or lymphatics," or "2. A secondary cancerous growth formed by transmission of cancerous cells from a primary growth located elsewhere in the body." THE AMERICAN HERITAGE STEDMAN'S MEDICAL DICTIONARY 512 (2001).

2003, Patricia's CEA levels returned to normal. However, on November 19, 2003, Patricia's CEA levels began to rise again, this time to 6.9. Because this indicated a second recurrence, Patricia's doctors informed her that curative treatment was no longer an option and that her cancer was terminal. Thereafter, Patricia's doctors transitioned her to palliative treatment.[3]

Patricia had a second local recurrence of cancer in March of 2008, for which she underwent surgery at Ohio State University. Dr. Walton has not treated Patricia since 2003.

PROCEDURAL HISTORY

On March 31, 2004, Patricia and her husband, Robert Johnson, filed a complaint in the Fayette Circuit Court alleging medical malpractice against Dr. Walton and the Lexington Clinic. In sum, Patricia contended that, but for Dr. Walton's failure to properly treat her cancer and appropriately monitor her thereafter, her cancer would not have recurred and metastasized. The matter was tried before a jury. Patricia presented the testimony of two medical oncologists, Malin Dollinger, M.D. and Dana Johnson, M.D., and a colorectal surgeon, Marvin Corman, M.D. Dr. Walton moved for a directed verdict at the close of Patricia's evidence and at the close of his own case, arguing there was insufficient evidence of causation to submit the case to the jury. The trial court overruled these motions.

The jury returned a verdict for Patricia, and the trial court entered a judgment consistent with this verdict. Dr. Walton timely filed a motion for

[3] "Palliative treatment" is "Treatment to alleviate symptoms without curing the disease." THE AMERICAN HERITAGE STEDMAN'S MEDICAL DICTIONARY 599 (2001).

judgment notwithstanding the verdict, again alleging that Patricia's causation evidence was insufficient as a matter of law. The trial court entered a final and appealable order overruling Dr. Walton's motion. This appeal followed.

ANALYSIS

On appeal, Dr. Walton renews his contention that Patricia failed to produce sufficient evidence of causation at trial and that the verdict should be reversed upon that basis. Alternatively, Dr. Walton argues he is entitled to a new trial because the trial court erred in admitting certain testimony from one of Patricia's experts and a large volume of Patricia's medical records. The facts regarding these evidentiary issues will be developed, as necessary, in our analysis below.

I. CAUSATION

Dr. Walton first argues that Patricia failed to adduce evidence at trial sufficient to prove, within reasonable medical probability, that his failure to refer Patricia for additional radiation and chemotherapy ("adjuvant therapy") after her surgery caused her rectal cancer to recur. Thus, he contends it was error for the trial court to deny his motions for a directed verdict, or judgment notwithstanding the verdict, regarding that issue. We disagree.

As stated by the Kentucky Supreme Court in *Grubbs ex rel. Grubbs v. Barbourville Family Health Ctr., P.S.C.*, 120 S.W.3d 682, 693-694 (Ky. 2003),

> [i]n Kentucky, a medical malpractice action is merely a "branch of [the] well traveled road [of common law negligence]," and a medical malpractice plaintiff must

> demonstrate the same prima facie case- consisting of duty, breach, causation, and injury-required in any negligence case. Thus, a medical malpractice plaintiff must "prove that the treatment given was below the degree of care and skill expected of a reasonably competent practitioner and that the negligence proximately caused injury[.]"

The sole element at issue in Dr. Walton's argument is causation. In Kentucky, a plaintiff must prove within reasonable medical probability that she would have recovered absent the doctor's negligent conduct, in order to recover on a theory of medical malpractice. *See Kemper v. Gordon*, 272 S.W.3d 146, 149-150 (Ky. 2008). Stated differently, a plaintiff must prove, by a probability greater than or equal to 51%, that she would have recovered absent the alleged malpractice. However, the standard to be applied in ruling upon motions for directed verdict or judgment notwithstanding the verdict, as is the case herein, is that the party against whom the motion is made is entitled to the most favorable inferences and construction of which the evidence is fairly and reasonably susceptible. *See Johnson v. Vaughn*, 370 S.W.2d 591 (Ky. 1963); *see also, National Collegiate Athletic Association v. Hornung*, 754 S.W.2d 855 (Ky. 1988).

Regarding the issue of the effectiveness of providing adjuvant therapy subsequent to surgery, one of Patricia's expert witnesses, Dr. Malin Dollinger, provided the following testimony:

> Q: You told Mr. Fulkerson in his deposition of you that basically surgery alone in the treatment of the rectal cancer that Mrs. Johnson had should have been 75 percent curative, correct?

Dollinger: Correct.

Q: So let me write that down. 75 percent curative, and you're aware there are other resources, doctors who think that the curative percentage of that surgery is higher, correct?

Dollinger: Yes, because no two cancer centers have exactly the same group of patients they happen to have seen and reported on. I would not object to 70 or 80, but that is the general ballpark.

Q: And what you also testified to Mr. Fulkerson when we took that deposition was if she'd had adjuvant therapy, that her chances of survival as a statistical matter would have increased by another 10 percent, correct?

Dollinger: I don't recall the number, but that's about right, yes. The number that I stated then.

Q: Oh, okay. Actually, as Mr. McDonner pointed out at page 63 of your deposition—let me just show it to you to maybe help-- what you said was that it would increase it by 5 to 10 percent, correct?

Dollinger: Correct.

Q: Okay. And that 5 to 10 percent is what you're calling the reasonable probability or substantial likelihood of cure above and beyond surgery, correct?

Dollinger: Anything over—anything over 50 percent means reasonable medical probability.

Q: Right. And this is 5 to 10 percent, correct?

Dollinger: Correct, in addition to the surgery, of course.

Q: Well, yeah, but the surgery you're saying wasn't enough. Of course, we haven't even gotten into why adjuvant therapy wasn't performed, but that's a 5 to 10 percent additive to what Dr. Walton already did, correct?

Dollinger: Correct.

In sum, Dr. Dollinger testified that out of 100 people with cancer identical to Patricia's, 75 people, or between 70 to 80 people, would have no recurrence of cancer solely as a result of surgery. Of the remaining 20 to 30 people, 5 to 10 would have no recurrence as a result of radiation and chemotherapy treatments in addition to surgery, but 10 to 25 people would have a recurrence of cancer regardless of any combination of surgery, chemotherapy, and radiation.

Another of Patricia's experts, Dr. Johnson, testified to the following during Dr. Walton's cross examination:

> Q: Okay. She was a stage two. So, even without any chemotherapy or radiation, she had a 75 percent cure rate with an appropriate surgical procedure?
>
> Johnson: No.
>
> Q: Well, that's what Dr. Dollinger told us yesterday. How do you differ from that?
>
> Johnson: Well, I mean, she had a high risk stage two. There is a difference within stage two. So, that is the general number for all stage two's. And, so, she was a high risk stage two. So, no, that isn't the-- the number for her, no.
>
> Q: And you also, then, don't agree with the idea that the addition of radiation and chemotherapy, according to Dr. Dollinger, would have added another five to ten percent reduction in the chance of her resection or needing a resection? Of a recurrence, let's put it that way.
>
> Johnson: Could you repeat the question, I'm sorry.

> Q: Sure. Do you disagree, then, with Dr. Dollinger who said that in addition to that, chemotherapy and radiation, his estimation would add another five to ten percent reduction in the likelihood of a recurrence?
>
> Johnson: I think the number is debatable. It's certainly in the five to fifteen percent range, yes.
>
> Q: Okay. So, you think her survivability is less than Dr. Dollinger did with surgery alone and you feel, nevertheless, that generally speaking, chemotherapy and radiation, whatever you feel this figure is, adds another five to fifteen percent reduction in chance of local recurrence; fair? I just want to make sure I—is this the likelihood? This is the first time I've heard it and I want to make sure I understand precisely what it is.
>
> Johnson: Local and systemic recurrence.

In sum, Dr. Johnson disagreed with Dr. Dollinger's assessment that the surgery, alone, should have been curative for 75 out of 100 people with cancer identical to Patricia's, but testified that, of those 100 people, 5 to 15 would have no recurrence as a result of radiation and chemotherapy treatments in addition to surgery.

Dr. Walton does not contend these estimates and statistics are speculative or contest the science behind these conclusions. As such, taking all of this evidence in the light most *favorable* to Patricia, and because a jury is entitled to disregard the whole or any part of the testimony of any witness,[4] a fair construction of this information provides that, of 100 people with cancers identical to Patricia's,

- One group of 75 people could have been cured by virtue of surgery alone;

[4] *See Howard v. Louisville Ry. Co.*, 32 Ky. 309, 105 S.W. 932, 933 (1907).

- One group of 15 people could have been cured through a combination of surgery and adjuvant therapy; and
- One group of 10 people could not have been cured, regardless of any treatment.

Regarding when adjuvant therapy could have effectively prevented a recurrence of Patricia's cancer, and what event should have put Dr. Walton on notice that it was necessary, Dr. Dollinger testifed:

> Dollinger: First of all, the 5.2 [CEA test result of October 23, 2001] is abnormal. The—the blue line here —I drew a diagram similar to this. It's not nearly as pretty as this one, but I have the same question within my mind as how we can make a picture showing this so that I can understand it more—better by looking at the diagram because clearly that—since she's a nonsmoker, the upper limit of normal is 2.5. So the 5.2 is double the normal value even there. And it tripled from [Patricia's July 6, 2001 CEA test result of] 1.7.
>
> We're worried about the CEA going up, whether it reaches a certain number, 20, 50, or 100 or some arbitrary number is not so much a consideration as the fact that it went up. The normal thing to do would be to repeat that 5.2 a week or two weeks later. Is that some kind of allowed fluctuation? Is it really there? Because we're about to do all kinds of fancy things because of that 5.2. We're going to get a CAT scan. We're going to talk to the oncologist again or the radiotherapist again, the surgeon, we're all going to get together and talk about what we should do about the 5.2, much less about the 68.3 [CEA test result of August of 2002]. So even the 5.2 is a signal.
>
> . . .
>
> Dollinger: I believe within reasonable medical probability she would have been cured had this combined radiation/chemotherapy, which is [sic] the NCCN

> [National Comprehensive Cancer Network] says—we haven't gone over that graph, but with the arrows yet, but she would have been cured had that been given.
>
> Q: Okay. Now, at what level, looking at your graph, the 1.7, the 5.2, the 6.8 [sic]—where is the cure rate going to be?
>
> Dollinger: She's curable throughout 2001.
>
> Q: Okay.
>
> Dollinger: She may have been curable even at the [sic] 2002, but I can't say so within reasonable medical probability. She might have been, but she definitely within medical probability was cured [sic] in 2001. She recurred in March of 2003. That's a year and three months beginning with the first of 2002. So during 2001 she was curable with—with this sort of treatment that we're talking about, the chemo and the radiation.

In total, Dr. Dollinger testified that Patricia needed to receive adjuvant therapy sometime in 2001 to expect any benefit from it. Dr. Walton admits that, had he not missed Patricia's elevated CEA levels in August of 2002, he would have suspected a recurrence at that time. However, Drs. Dollinger and Corman testified that Dr. Walton also should have detected an abnormality in Patricia's CEA levels as early as October 23, 2001, by virtue of Patricia's CEA level of 5.2. Taking this testimony in the light most favorable to Patricia, Dr. Walton should have eliminated her from the group of 75 people cured from surgery, alone, at that time. As a result, two groups would have remained: A group of 15 people able to be cured through a combination of surgery, radiation, and chemotherapy; and a group of 10 people who could not be cured at all. In this most favorable

construction of the evidence, to which Patricia was entitled under the standard of a directed verdict, Patricia would have been 60% likely to achieve a cure had she received adjuvant therapy prior to 2002 because 15 is 60% of 25. As such, Patricia met the 51% threshold necessary to overcome a directed verdict based upon causation, and Dr. Walton's argument is without merit.

II. DR. JOHNSON'S TESTIMONY

Dr. Walton's next contentions of error regard testimony provided by Dr. Johnson. Dr. Walton asserts that the trial court allowed Dr. Johnson to testify beyond the scope of his CR 26.02(4)(a) expert disclosure and state several opinions and that these specific opinions should have been excluded. These opinions, he argues, undermined the opinions of his experts to the extent that his case was prejudiced, warranting a new trial. We disagree.

Our standard of review of a trial court's ruling as to admitting or excluding evidence is limited to determining whether the trial court abused its discretion. *Goodyear Tire and Rubber Co. v. Thompson*, 11 S.W.3d 575, 577 (Ky. 2000). The test for abuse of discretion is whether the trial judge's decision was arbitrary, unreasonable, unfair, or unsupported by sound legal principles. *Id*. at 581, *citing Commonwealth v. English*, 993 S.W.2d 941, 945 (Ky. 1999). With respect to an expert's offer of an opinion, CR 26.02(4) requires parties to disclose, upon request before trial, "facts known and opinions held by experts," including, "the subject matter on which the expert is expected to testify, and . . . the substance of the facts and opinions to which the expert is expected to testify and a summary

of the grounds for each opinion." CR 26.02(4)(a)(i). The purpose of the rule is to allow the opposing party to adequately prepare for the substance of the expert's trial testimony. If an expert offers an opinion at trial not disclosed pursuant to this rule, and the court admits it into evidence over a timely objection, a new trial is warranted if the opinion "seriously undermines" the opposing party's own expert opinions. *See Clephas v. Garlock*, 168 S.W.3d 389, 395 (Ky. App. 2004).

Here, Dr. Johnson's expert disclosure states, in its entirety, the following: "Dr. Dana Johnson is Patricia Johnson's treating physician and will testify as per his deposition dated January 9, 2007."[5] Dr. Walton contends he objected to several of Dr. Johnson's opinions because they fell outside the scope of the January 9, 2007 deposition. These opinions concerned the following issues: 1) how long Patricia will live; 2) how treatment subsequent to his January 9, 2007 deposition has changed his opinions in that deposition; 3) whether the NCCN guidelines play a role in establishing the standard of care in treating cancer; 4) whether adjuvant therapy can be given, post-operatively, in the presence of a wound or infection; 5) whether Patricia would have been cured of her cancer, but for her failure to receive adjuvant therapy; 6) whether failing to order neoadjuvant therapy was a breach of the applicable standard of care; and 7) whether failing to

[5] Dr. Walton also states that Dr. Johnson's review of medical records, depositions, and literature in preparation for trial was much broader than his review of documents prior to his deposition, and that Dr. Johnson's expert disclosure made no mention of this fact. Upon discovering this fact at trial, however, Dr. Walton allowed Dr. Johnson's testimony to proceed and made no motion to disqualify Dr. Johnson as a witness.

appreciate and/or follow up with Patricia's rising CEA levels was a breach of the applicable standard of care.

With regard to how long he expected Patricia to live, Dr. Johnson testified in his deposition that Patricia would not be cured from cancer, would eventually die from it, and had, at most, two years to live. At trial, Dr. Johnson testified that

> a 70-year-old woman in this country that's healthy probably has a life span up to age 84 or 85 statistically. And I can't imagine a situation where she can go 14 years and having local recurrence because that's just so outside the norm for this type of cancer. It—it's possible but it's—it's a very big long shot.

The trial court sustained Dr. Walton's objection to the extent that Dr. Johnson would not be permitted to state how and when Patricia would die. However, Dr. Walton and Patricia agreed to permit Dr. Johnson to testify that Patricia would not live to be 84 and that her cancer would recur. Subsequently, Dr. Johnson testified he had stated in his deposition that Patricia had approximately two years to live, that it had been one year and six months since his deposition, and that Patricia was still alive.

Upon review of the record, we cannot find any other instance of an opinion of Patricia's potential lifespan in Dr. Johnson's testimony, and Dr. Walton cites to no other instance in his brief. As Dr. Johnson's testimony regarding Patricia's lifespan appears consistent with his deposition and as Dr. Walton

allowed him to state that Patricia would not live to be 84, there is no merit to this contention.

With regard to how treatment rendered to Patricia subsequent to Dr. Johnson's deposition may have changed the opinions Dr. Johnson stated in that deposition, Patricia asked Dr. Johnson: "And has [sic] there been other things medically that you are aware of that have happened after your deposition that would effect--." Dr. Walton objected before Dr. Johnson was able to answer. Upon review of the record, we cannot find any instance of Dr. Johnson answering this question, and Dr. Walton cites to no such instance in his brief. As such, there is no merit to this contention.

With regard to the NCCN guidelines, Dr. Johnson described the role they played in his treatment plan for Patricia's cancer. Dr. Walton contends it was error for the trial court to allow this testimony because 1) Patricia never disclosed that Dr. Johnson would render an opinion regarding the standard of care as it related to the NCCN guidelines, and 2) Dr. Johnson had not discussed the NCCN guidelines in his deposition. While there is no record of Dr. Johnson discussing the NCCN guidelines before testifying at trial, we nevertheless disagree.

To begin, the trial court limited Dr. Johnson's testimony with respect to these guidelines, per Dr. Walton's objection, to his personal experience. Dr. Johnson stated that he used these guidelines in his practice, he used them in treating Patricia's cancer, and that he believed they were "appropriate." Upon review of the record, however, we cannot find any instance of Dr. Johnson's

stating that the NCCN guidelines established the standard of care for treating cancer, and Dr. Walton cites to no such instance in his brief.

Moreover, if the trial court did err in permitting Dr. Johnson to testify about the NCCN guidelines, on the basis that they were outside the realm of his deposition and expert disclosure, such error was harmless. As Dr. Walton acknowledges in his brief, Patricia also elicited testimony from Drs. Dollinger and Corman at trial about the NCCN guidelines, as well as their role in establishing the standard of care. While Dr. Walton argues that Dr. Johnson's testimony regarding the NCCN guidelines seriously undermined the opinions of his experts, he fails to demonstrate how Dr. Johnson's testimony differed from, or was any more effective than, the testimony regarding the NCCN guidelines supplied by Patricia's other experts. Furthermore, Dr. Walton had ample opportunity at trial to cross examine each of these experts on this subject.

With regard to Dr. Johnson's opinion on the issue of whether adjuvant therapy can be given, post-operatively, in the presence of a wound or infection, the following exchange is at issue:

> Q: In your own treatment of patients, have you treated patients like that that have had surgery and have had some—well, surgical wound with infections and things like that?
>
> Dr. Johnson: Yes.
>
> Q: Have you been able to start the chemotherapy before the infections are totally cured?

Dr. Johnson: Yes, depending on the clinical situation, yes.

Q: Do you meet with a surgeon and make a joint decision based upon this infection and based upon your knowledge of chemo to decide together if chemo can be started at that time?

Dr. Johnson: I—I consider "meet with" to be physically meet but you certainly would discuss it with them—with them by telephone or—or possibly meet with them. Yes, absolutely.

Q: Okay. But instead of just a phone call conversation, both of you would have knowledge of Pat's care and treatment would you not?

Dr. Johnson: We would both have seen the patient, yes.

After this exchange, Dr. Walton objected on the ground that this opinion was also never disclosed. However, the record demonstrates that the trial court sustained Dr. Walton's objection. If Dr. Walton believed the court should have taken further action to limit the effect of Dr. Johnson's testimony on this issue, it was incumbent upon him to request the trial court to do so. He did not, and we therefore find no error in this regard.

Dr. Johnson's three remaining opinions (*i.e.*, that Patricia would have been cured of her cancer, but for her failure to receive adjuvant therapy; that Dr. Walton's failure to order neoadjuvant therapy was a breach of the applicable standard of care; and that Dr. Walton's failure to appreciate and/or follow up with Patricia's rising CEA levels was a breach of the applicable standard of care) stem from the following exchange:

Q: Okay, so, according to your deposition and then asking the last question, in your deposition, did you state under oath to the lawyers that represented Dr. Walton, that there was in fact a deviation from reasonable care in the treatment [Patricia] received from Dr. Walton?

Dr. Johnson: Yes.

Q: And can you please tell us what that deviation from reasonable care was?

Dr. Johnson: I think there are—there is more than one deviation, so I'll have to go through them in order.

Q: Go ahead.

Dr. Johnson: I'll go through it chronologically in a sense of how her case went.

The original deviation is the question of whether she should have had chemotherapy and radiation prior to surgery. That was certainly a standard in many areas and a standard for us at the point for a low rectal lesion which she had. That was one question I would think that should be raised.

The second issue then is if she had surgery as the primary treatment originally, which she did, that she was not offered either consultation with an oncologist and the opportunity to have chemotherapy and radiation which is the appropriate treatment for her stage of cancer at that point.

And, then, lastly, my concern would be the appropriateness of a follow-up with a surgeon and the rising CEA that wasn't dealt with appropriately at that time.

Q: And those deviations from reasonable care, within reasonable medical probability you said that the hospital that you worked in did this type of chemo and—well, chemotherapy and radiation therapy before the surgical procedures for cancers like Pat had; right?

Dr. Johnson: Yes, that was being done where I was at that time, absolutely.

> Q: And can these various deviations that you told us—can you tell us within reasonable medical probability that they, in fact, well, had an effect on Pat and if so, what effect?
>
> Dr. Johnson: Certainly, I can say within reasonable medical probability that the chance for cure was lost in the period that she wasn't treated, yes.
>
> Q: And the opportunity?
>
> Dr. Johnson: The opportunity for cure, right.
>
> Q: Is that based upon sooner rather than later?
>
> Dr. Johnson: It's based on the fact that treatment is effective in this situation given sooner rather than later, yes.

Dr. Walton contends that he objected to these opinions because they also fell outside the scope of Dr. Johnson's deposition. Upon review of the record, we find Dr. Walton made no objection to this testimony. Nor, for that matter, does Dr. Walton cite to where, in the record, he may have objected to it. However, even if we found to the contrary, any error resulting from the admission of this testimony was harmless because Patricia's other experts, Drs. Corman and Dollinger, rendered identical opinions in their testimony with respect to these issues. Dr. Walton makes no argument as to how Dr. Johnson's opinions were somehow more effective, or that his opinions relied upon different evidence. As such, we cannot find prejudice in this instance sufficient to warrant a new trial.

III. PATRICIA'S MEDICAL RECORDS

For his final contention of error, Dr. Walton asserts that the trial court abused its discretion by admitting hundreds of pages of medical records, relating solely to the diagnosis and follow-up treatment of Patricia's rectal cancer, into evidence. Dr. Walton directs the attention of this Court to the objection he made immediately prior to the admission of these documents. In this objection, Dr. Walton conceded the authenticity of these medical records, made no argument that any of these records were irrelevant, made no argument that prejudice arising from their introduction would outweigh their probative value, made no argument that they were unduly cumulative, and in fact stated that he had no objection to their admissibility.[6] Rather, the basis of Dr. Walton's objection, as explained by his counsel, was

> Dr. Walton's counsel: I have no objection to its [the medical records'] admissibility. However, someone, some doctor has to explain relevance. For each page. Now this is case law—
>
> Patricia's counsel: Each page?
>
> Dr. Walton's counsel: That you choose to admit. Otherwise, you're inviting the jury, ordinary people, to scan through the record and guess and conjecture about what they mean and how to apply them. And this is black letter law that we're talking about.

With regard to Dr. Walton's argument (*i.e.*, that Patricia failed to provide a separate foundation, consisting of supporting testimony from a doctor, for each of the several hundred pages of medical records prior to introducing them

[6] Dr. Walton addresses the issues of the relevance of these documents and their prejudicial value for the first time on appeal. As these issues were not raised below, we do not address them.

into evidence), we note as a preliminary matter that testimonial evidence is not necessary to support medical records satisfying the evidentiary requirements of authenticity. *Baylis v. Lourdes Hosp., Inc.*, 805 S.W.2d 122, 123 (Ky. 1991). As Dr. Walton conceded the authenticity and admissibility of these documents, no supporting testimony was required.

In addition, the case that Dr. Walton cites in support of this proposition, *Young v. J.B. Hunt Transportation, Inc.*, 781 S.W.2d 503 (Ky. 1989), is distinguishable from the circumstances of this case. There, at issue were several authenticated medical documents relating to an injury the plaintiff had sustained in a prior automobile accident. The defendants waited until the end of testimony to introduce these documents into evidence, rather than doing so through the doctor who had treated the plaintiff on earlier occasions. The trial court excluded these documents, in spite of the defendants' argument that they were properly authenticated, after expressing concern that it had not been informed as to the contents of the records and that the records contained undeleted references to insurance. *Id*. at 508. In its review of this case, the Supreme Court of Kentucky held that a trial court is not required to admit authenticated documents into the record; rather, the trial court may use its discretion to exclude any relevant evidence, provided the prejudicial effect of that evidence threatens to outweigh its probative value, or that the evidence will unduly confuse the issues. *Id*. The Court also observed that one of the inherent dangers under the circumstances of that case was that

> if appellant's voluminous prior hospital records had been admitted in mass and without the prior treating physician or any physician available to explain the records, counsel would have been free to draw whatever conclusions they wished without fear of evidentiary contradiction. In the heat of trial, there is probability that distortion, confusion or misunderstanding would have resulted.

Id. The Court then stated, under the circumstances of that case, the trial court had not abused its discretion in excluding those documents.

Unlike *Young*, the danger of counsel being free to draw whatever conclusions they wished without fear of evidentiary contradiction was not present in this case. These records were introduced prior to Dr. Walton's case in chief, several physicians were available to explain these records, and Dr. Walton was free to provide testimony from his own experts interpreting these documents if he chose to do so. Finally, in *Young*, the trial court noted that not a single witness had commented upon or explained the records at issue to the jury. Here, at the time of the admission of this evidence, the trial court noted that two experts had commented upon the medical records at issue and testified they had relied on their review of these records to formulate their opinions. In light of the above, and because the admissibility of evidence lies within the sound discretion of the trial court, we cannot find that the trial court's decision to allow these records into evidence over Dr. Walton's objection constituted an abuse of that discretion.

CONCLUSION

For the foregoing reasons, we AFFIRM the decision of the Fayette Circuit Court.

STUMBO, JUDGE, CONCURS.

DIXON, JUDGE, CONCURS IN RESULT.

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