RENDERED: APRIL 29, 2005; 10:00 A.M.
NOT TO BE PUBLISHED

Commonwealth Of Kentucky

Court of Appeals

NO. 2004-CA-000918-MR

ARTHUR HARBOLT — APPELLANT

v.

APPEAL FROM JEFFERSON CIRCUIT COURT
HONORABLE DENISE G. CLAYTON, JUDGE
ACTION NO. 01-CI-008024

ABDULLA ATTUM, M.D. — APPELLEE

OPINION
AFFIRMING

** ** ** ** **

BEFORE: COMBS, CHIEF JUDGE; DYCHE AND KNOPF, JUDGES.

COMBS, CHIEF JUDGE: Arthur Harbolt appeals from a directed verdict and trial judgment dismissing his claim of medical malpractice against the appellee, Dr. Abdulla Attum. The Jefferson Circuit Court directed a verdict in favor of Dr. Attum at the close of Harbolt's proof based on Harbolt's failure to offer expert testimony establishing the requisite elements of his negligence claim. Harbolt argues that the matter was suitable for submission to the jury under a theory of *res ipsa loquitur.* Harbolt also contends that he was denied a fair trial because the court excluded opinions of his treating physician,

Dr. Brian Ganzel, that were critical of Dr. Attum. Finding no error, we affirm.

In reviewing the propriety of the entry of a directed verdict, we must evaluate the evidence in the light most favorable to the party opposing the motion. Lovins v. Napier, 814 S.W.2d 921 (Ky. 1991). Viewed from that perspective, the evidence established that Harbolt began experiencing chest pains in the summer of 2000. Tests determined that he had a blockage in his left anterior descending artery (LAD). He underwent two separate angioplasty procedures -- both of which failed to open the artery. Because he had only one artery with significant coronary disease, Harbolt's cardiologist, Dr. David Dageforde, recommended that he undergo a minimally invasive direct coronary artery bypass (MIDCAB) -- a complex bypass procedure involving a small incision on the left side of the chest performed while the heart continues to beat.

Dr. Attum is one of only a few cardiothoracic surgeons in the country who performs the MIDCAB. Dr. Attum discussed with Harbolt the advantages of the procedure over that of the sternotomy –- a traditional open heart surgical procedure. He also informed Harbolt that often in the course of the MIDCAB, it was necessary to convert to the more invasive sternotomy and that he would need to do so if he encountered any complications.

Harbolt gave Dr. Attum his consent to perform a sternotomy if necessary.

Upon commencing the MIDCAB, Dr. Attum discovered that Harbolt's vessels were intramyocardial; that is, they were deeply buried within his heart muscle. Dr. Attum testified he would not have considered the MIDCAB as a viable option for bypassing the diseased artery if pre-surgical tests had revealed this condition. Believing that he could nonetheless locate the LAD, Dr. Attum testified that he decided not convert to a sternotomy. He completed the surgery as initially planned and grafted Harbolt's mammary artery to what he believed was the LAD.

Following the surgery, Harbolt continued to experience chest pain. A catheterization two months after the MIDCAB revealed that Dr. Attum had not bypassed the LAD but instead had bypassed the second diagonal artery, a branch of the LAD. Harbolt then selected Dr. Ganzel to perform a sternotomy, using the saphenous vein to bypass the artery. Harbolt ultimately enjoyed a successful recovery.

On November 26, 2001, Harbolt filed a complaint in which he alleged that Dr. Attum "negligently and carelessly performed the operation of November 24, 2000 when he bypassed the wrong artery." He further claimed that the doctor's negligence constituted a breach of his duty to him and a "breach

of the accepted standard of care." Charging that his "longterm result was compromised," Harbolt sought damages for the additional surgery that he was required to undergo as well as compensation for past and future pain and suffering and medical expenses.

Trial was scheduled to commence on November 4, 2003. In answers to interrogatories filed on March 13, 2002, Harbolt was unable to identify the experts who would testify on his behalf at trial. However, he named Dr. Ganzel as a fact witness who might be called to testify and disclosed the following information about him:

> Dr. Ganzel told me that the surgery performed by Dr. Attum was beneath the standard of care. Dr. Ganzel also told me that because of Dr. Attum's negligence, I had to undergo a second surgery that Dr. Ganzel performed and that the first operation was rendered useless.
>
> Dr. Ganzel also told me that by not being able to use the mammary artery, my result has been compromised. Dr. Ganzel stated that it is well established in the literature that at 10 years post-surgery, the mammary artery graft has a 95% success rate and that the saphenous vein has just a 45%-55% success rate at 10 years post-surgery.

Pursuant to the original trial order, Harbolt was given a deadline of August 6, 2003, on which to provide the identity of his expert witnesses and the substance of their

anticipated testimony as required by CR[1] 26.02(4)(a)(i). Harbolt did not identify any expert witnesses by that date. Instead, on August 11, 2003, he filed a motion seeking a continuance of the trial. The trial court granted Harbolt's motion and postponed the trial to March 23, 2004, allowing Harbolt until November 1, 2003, to identify his expert witnesses and to provide the required disclosures.

In late October 2003, nearly two years after the filing of the complaint, Harbolt requested a thirty-day extension of the deadline for disclosing his experts. He stated that he had "formally identified" Dr. Ganzel as an expert witness who would "provide opinions regarding the standard of care and causation as it pertains to the treatment provided" by Dr. Attum. However, he cited the need for additional time because he had not received final reports from the two remaining experts with whom he had consulted. The motion was denied.

On October 31, 2003, Harbolt filed his expert witness disclosure. He reiterated that he was unable to identify his experts because he had not yet received their reports. He now stated that although Dr. Ganzel had not been retained as an expert witness, he would testify consistently with the opinions previously expressed with respect to Dr. Attum's sub-standard medical care.

[1] Kentucky Rules of Civil Procedure.

Following this disclosure, Dr. Attum filed a motion for summary judgment predicated on Harbolt's failure to produce expert testimony in support of his complaint and his failure to comply with CR 26.02. Harbolt responded that Dr. Ganzel would supply the necessary expert testimony –- even though he had not been formally retained in the capacity of an expert witness. In the alternative, Harbolt argued that such testimony was not required because Dr. Attum admitted to bypassing the wrong vessel and to conditions resulting in the need to convert to a sternotomy.

In denying the motion for summary judgment, the trial court reasoned that Dr. Attum's own admissions might establish the necessary evidence to render the case submissible to the jury. However, the court refused to permit Dr. Ganzel to express any expert opinions critical of Dr. Attum because of Harbolt's failure to comply with CR 26.02(4)(a)(i) by stating the substance of the expected testimony or by summarizing the grounds of each of the medical opinions. When Harbolt later took Dr. Ganzel's videotaped deposition for trial, he failed to make a record by avowal of the doctor's opinions that had been excluded by the trial court.

At the conclusion of Harbolt's proof, the trial court granted Dr. Attum's motion for directed verdict. It held that there was no proof offered as to the standard of care, no proof

concerning the risks inherent in this type of surgery, and no proof of a breach of the standard of care in Dr. Attum's decision not to convert to a sternotomy. This appeal followed.

Citing Perkins v. Hausladen, 828 S.W.2d 652 (Ky. 1992), Harbolt argues that the doctrine of *res ipsa loquitur* should have applied to preclude entry of a directed verdict on his claim. In Hausladen, the Kentucky Supreme Court analyzed *res ipsa loquitur* in the context of medical negligence claims:

> The trial court and the Court of Appeals have framed the issue in terms of whether the doctrine of *res ipsa loquitur* applies here. As applied to this case the term means nothing more than whether the facts and circumstances are such that negligence can be inferred, even in the absence of expert testimony. As Prosser explains, *res ipsa loquitur* is a "Latin phrase, which means nothing more than the thing speaks for itself," and is simply "[o]ne type of circumstantial evidence." *Prosser and Keeton on Torts*, Sec. 39 (5th ed. 1984). Speaking on how the doctrine applies to the "question of duty. . . in cases of medical malpractice," *Prosser* advises that "ordinarily" negligence cannot be inferred simply from an "undesirable result"; expert testimony is needed. *Id.* at 256. But there are two important exceptions, one involving a situation where "any layman is competent to pass judgment and conclude from common experience that such things do not happen if there has been proper skill and care"; illustrated by cases where the surgeon leaves a foreign object in the body or removes or injures an inappropriate part of the anatomy. *Id.* The second occurs when "medical experts may provide a sufficient foundation for *res ipsa loquitur* on more complex matters." *Id.*

Id. at 654-55.

Harbolt contends that his case falls within both of these two exceptions. He first argues that by virtue of common knowledge, laypersons could infer that Dr. Attum negligently performed the MIDCAP in failing to identify and to by-pass the LAD.

> Dr. Attum plainly and simply failed to by-pass the LAD! The thing speaks for itself and it says that without any excuse or explanation, a heart surgeon who failed to by-pass the LAD after it was positively identified, exposed and accessed did not use proper skill and care. Any layman is competent to understand what happened in this case and to pass judgment and conclude from common experience that in the absence of any excuse or explanation, at all, by-passing the wrong vessel does not happen if there has been proper skill and care.

(Appellant's reply brief at p. 4.)

We first observe that Harbolt erroneously states that Dr. Attum failed to provide an explanation for his inability to bypass the LAD. Dr. Attum testified that based on his experience and several markers within the heart, he believed that he had correctly located the LAD. Therefore, he decided not to convert to the more invasive sternotomy. In retrospect, and upon viewing the catheterization two months following the surgery, Dr. Attum realized that he had misidentified the second diagonal artery as the LAD.

We agree with the trial court that Harbolt failed to establish an adequate foundation upon which to invoke the doctrine of *res ipsa loquitur*. A jury would have had to infer that the bypass of the wrong artery could not have occurred but for negligence on the part of the surgeon. However, the record is devoid of any evidence that the bypass of the wrong artery must inevitably result from negligence. Not every error constitutes negligence.

Hausladen sets forth three elements as a predicate for invoking the doctrine of *res ipsa loquitur*: (1) the injury was not "an ordinary risk of surgery"; (2) the technique employed "was within the exclusive control" of the doctor; and (3) the injury was not in any manner attributable to the patient. Id. at 655; see also, Lewis v. Wolk, 312 Ky. 536, 539, 228 S.W.2d 432, 433 (1950). While the second and third elements clearly exist in this case, there is no evidence that a graft to a branch of the wrong artery must *per se* be negligence as distinguished from a possible or even an anticipated risk of such surgery. Average laymen are not knowledgeable about the risks and complications of heart bypass surgery. The only testimony in the record pertaining to this issue indicates that the very error that occurred in this case (namely, misidentifying the second diagonal artery as the LAD and grafting a new artery onto it) is a well-recognized risk of

bypass surgery. Thus, we believe that the doctrine of *res ipsa loquitur* does not govern in light of the facts of this case.

Harbolt contends that Dr. Attum's own testimony supplied the requisite standard-of-care testimony and established the breach of the care that he owed to his patient. Harbolt focuses on Dr. Attum's admission that the MIDCAB procedure is contra-indicated if it is known **prior** to surgery that the patient's blood vessels are deeply buried in the heart muscle. It was only after the surgery had begun that Dr. Attum discovered that Harbolt's blood vessels were not easily accessible. Nonetheless, Harbolt argues that the jury should be permitted to infer that Dr. Attum breached the standard of care by failing to resort to the sternotomy.

> The reasons for not doing the minimally invasive surgery in the first place are still present once the chest is open and it is determined that the vessels are intramyocardial. That is, there is a limited, bloody, moving surgical field making it more difficult to identify and expose the buried target coronary artery.
>
> This is simple common sense. It does not take a cardiothoracic surgeon to understand this concept. If the surgeon can't see the vessel in the first place it stands to reason that he would take the appropriate steps necessary to gain the best view possible, in this case convert to an open sternotomy.

(Appellant's brief, p. 11.)

Harbolt assumes that the standard of care as it existed prior to surgery remains unchanged once surgery is begun and other conditions become manifest. We cannot conclude that a jury should speculate on its own as to whether Dr. Attum was required to convert to a sternotomy in order to satisfy a shifting standard of care.

The evidence revealed that a misidentification of the LAD is a risk inherent both in a MIDCAB and in a sternotomy. Dr. Attum acknowledged that it would have been easier for him to have seen the proper vessel if he had converted to a sternotomy. However, he also testified that he could have "fallen into the same trap" (*i.e.*, misidentified the LAD) even if he had switched to the more conventional procedure. We agree with the determination of the trial court that without expert testimony to establish and to define the standard of care, the jury should not have been at liberty to infer or to speculate that Dr. Attum was negligent in exercising his judgment not to convert to the sternotomy.

Harbolt last argues that the trial court erred in preventing him from offering opinions of his treating physician that were critical of Dr. Attum. He maintains that "[e]nough information regarding [Dr. Ganzel's] testimony was provided given the relative simplicity of the medical issues." He also

contends that there is no precedent to prohibit a treating physician from giving expert opinions in a malpractice case.

Like Dr. Attum, Dr. Ganzel is a cardiothoracic surgeon. Although Dr. Ganzel does not perform MIDCAB procedures, he was undoubtedly qualified to express opinions in this matter. However, as Dr. Attum correctly observed, it is impossible to discern from the record before us whether Dr. Ganzel was truly willing to testify as an expert in this matter. In his answers to interrogatories and in his expert disclosure, Harbolt was careful to state that he had not formally retained Dr. Ganzel as an expert witness. Even if Dr. Ganzel could offer comments critical of Dr. Attum, and even if he had been willing to share his medical reservations with the jury, Harbolt cannot excuse his own failure to disclose the substance of those opinions as contemplated by CR 26.02.

In order to preserve properly the trial court's exclusion of evidence for our review, Harbolt was required to offer the testimony by avowal. The Supreme Court has recently re-emphasized this duty of preservation in Hart v. Commonwealth, 116 S.W.3d 481, 483 (Ky. 2003) as follows:

> A reviewing court requires more than the general substance of excluded evidence in order to determine whether a defendant has suffered prejudice. In *Partin v. Commonwealth*, Ky., 918 S.W.2d 219 (1996), we held that a description of proposed testimony by defense counsel was

> insufficient to preserve an alleged error in exclusion of evidence for review. "Counsel's version is not enough. A reviewing court must have the words of the witness." *Id.* at 223. More recently, in *Commonwealth v. Ferrell*, Ky., 17 S.W.3d 520 (2000), we reaffirmed our holding in *Partin*, stating: "a party must offer an avowal by the witness in order to preserve for appellate review an issue concerning the exclusion of evidence." *Id.* at 525.

As noted earlier, Harbolt failed to elicit the opinions of Dr. Ganzel that were allegedly critical of Dr. Attum when Dr. Ganzel's deposition was taken just days before the trial. Accordingly, we shall not disturb the decision of the trial court.

The judgment of the Jefferson Circuit Court is affirmed.

ALL CONCUR.

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