RENDERED: NOVEMBER 22, 2019; 10:00 A.M.
NOT TO BE PUBLISHED

Commonwealth of Kentucky

Court of Appeals

NO. 2018-CA-001223-MR

JAMES HACKER APPELLANT

v. APPEAL FROM CLAY CIRCUIT COURT
HONORABLE OSCAR G. HOUSE, JUDGE
ACTION NO. 15-CI-00125

DR. DANA EDWARDS APPELLEE

OPINION
AFFIRMING

** ** ** ** **

BEFORE: GOODWINE, NICKELL, AND SPALDING, JUDGES.

NICKELL, JUDGE: James Hacker filed a medical malpractice suit against Dr. Dana Edwards and Manchester Memorial Hospital (“Manchester”)[1] alleging failure to recognize and treat complications from gallbladder surgery—specifically, failure

[1] The notice of appeal, filed August 6, 2018, lists both Dr. Edwards and Manchester as parties to this appeal. Manchester filed its own summary judgment motion and was dismissed by the trial court from the underlying suit with prejudice in an order entered September 7, 2018. Similarly, in an order entered October 23, 2018, this Court dismissed Manchester from this appeal. Manchester is not a party to, and has not participated in, this appeal.

to diagnose a biliary leak. After deposing Hacker's expert witness—who did not testify Dr. Edwards deviated from the standard of care as required in a medical malpractice case[2]—Dr. Edwards moved for and was granted summary judgment by the Clay Circuit Court. Claiming two medical experts—an internist and a critical care paramedic—would establish the standard of care and deviation from it, Hacker appeals, arguing summary judgment was improperly granted. On review of the record, briefs and law, we affirm.

NONCOMPLIANCE WITH COURT RULES

We begin by noting Hacker's failure to comply with CR[3] 76.12 and specifically CR 76.12(4)(c)(v). That provision requires

> [a]n "ARGUMENT" conforming to the statement of Points and Authorities, with ample supportive references to the record and citations of authority pertinent to each issue of law and which shall contain at the beginning of the argument a statement with reference to the record showing whether the issue was properly preserved for review and, if so, in what manner.

The argument portion of Hacker's brief contains citations to his expert's deposition but little else. Several cases, and even CR 76.12(4)(b)(i), are listed in a "Table of Citations" near the beginning of the brief, but these citations are never mentioned

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[2] *Lake Cumberland Regional Hospital, LLC v. Adams*, 536 S.W.3d 683, 690-91 (Ky. 2017), *reh'g denied* (Feb. 15, 2018).

[3] Kentucky Rules of Civil Procedure.

in the text of the argument and their applicability is unexplained. Moreover, CR 76.12(4)(c)(iii) dictates inclusion of "A STATEMENT OF POINTS AND AUTHORITIES," not a Table of Citations. Hacker's "argument" does not begin with a statement of preservation—it appears at the end of the brief's conclusion and is wholly inadequate. It reads, "The issues are preserved in the Judgment of the Circuit Court's Order[4] re Summary Judgment." That sentence tells this Court nothing about where, or whether, counsel made to the trial court the precise arguments contained in the brief we are reviewing. An argument cannot be made to us for the first time. *Jones v. Livesay*, 551 S.W.3d 47 (Ky. App. 2018). If the trial court was not given an opportunity to correct the alleged error, we are not authorized to review the claim.

Hacker's argument does not contain "ample supportive references to the record[.]" He mentions the informed consent form he signed but does not reveal where it can be found in the record. He mentions a deponent's affidavit and CV without hinting where or whether they are in the record. He mentions a summary judgment motion without citation. He quotes a synopsis prepared by a

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[4] We quote the trial court's order in its entirety:

> This matter having come before the Court May 3, 2018 on Defendant Dana Edwards, M.D.'s Motion for Summary Judgment and having considered the pleadings and response, the motion is hereby GRANTED. The Plaintiff's claims against this Defendant are hereby dismissed, with prejudice, as a matter of law. There being no just cause for delay, this is a final and appealable order.

potential expert witness without providing any record citation. The brief for appellant quotes in full a cell phone text supposedly sent by Hacker to counsel during his expert's deposition. Again, there is no indication of where this can be found in the record or that the trial court was aware of it or considered it. If an item is not contained in the certified record, we cannot consider it on appeal. *Ray v. Ashland Oil, Inc*., 389 S.W.3d 140, 145 (Ky. App. 2012) (citations omitted).

Hacker's brief runs afoul of other aspects of CR 76.12(4)(c). His brief begins with something called "Legal Standard," an item not listed in the rule which mandates, "[t]he organization and contents of the appellant's brief shall be as follows . . . ." The "Legal Standard" portion of Hacker's brief quotes CR 56.03 and cases dealing with summary judgment. It also cites and quotes Rule 56 of the Federal Rules of Civil Procedure. It does not, however, weave those citations into the argument. The brief does not apply the rules and cases cited to the facts.

On the heels of "Legal Standard," Hacker includes a "Statement of Case and Procedural Background," another topic not specified in the rule. CR 76.12(4)(c)(iv) does require a "Statement of the Case" which is to be a

> chronological summary of the facts and procedural events necessary to an understanding of the issues presented by the appeal, with ample references to the specific pages of the record . . . .

Hacker's two-page segment is devoid of record citations.

We list these errors because every time we do not enforce the rules we erode them. As an appellate court, we have no duty to search the record for support of a party's argument. *Milby v. Mears*, 580 S.W.2d 724, 727 (Ky. App. 1979). Furthermore, we have no duty to search the record to determine whether an issue has been preserved for our review as required by CR 76.12(4)(c)(v). *Id.* Those tasks are assigned to counsel and are essential for complete and accurate review of the case.

This brief was not filed by a *pro se* litigant. It was filed by an attorney who is expected to be familiar with and follow court rules. *Jones,* 551 S.W.3d at 50 and *Oakley v. Oakley*, 391 S.W.3d 377, 379 (Ky. App. 2012), are shining examples of attorneys who have run afoul of the rules. Considering our result, we will not impose a sanction even though we would be well within our authority to do so.

FACTS

Having experienced abdominal pain for one to two months, along with diarrhea and bloating, Hacker saw Dr. Edwards for the first time on June 12, 2014. Based on testing, a laparoscopic cholecystectomy was recommended. The procedure was performed at Manchester at 11:30 a.m. on July 21, 2014. No complications were noted and Hacker was discharged to home. No allegations are made regarding the surgical procedure itself.

Around 6:30 that evening, Hacker came to the Manchester emergency room ("ER") complaining of intense upper abdominal pain and right shoulder pain—both indicative of gas in a post-surgery patient. An EKG, ECG, and lab work—including liver enzymes and bilirubin—were all within normal limits. Hacker's white blood count was "mildly" elevated, but still within the normal range. An elevated white blood count indicates many things; a significantly elevated white blood count indicates infection. Bile in the gallbladder fossa indicates a bile leak.

The Manchester ER doctor telephoned Dr. Edwards. The precise content of the call is unknown, but Dr. Edwards said he wanted to see Hacker the following morning. Not meeting criteria for hospital admission, Hacker was sent home with prescriptions for Demerol and Phenergan, as well as instructions to see Dr. Edwards the next day.

On July 22, Hacker telephoned Dr. Edwards' office reporting severe pain. Dr. Edwards prescribed Naprosyn and told Hacker to call back with any additional issues.

Later that morning, Dr. Edwards received a telephone call from an ER doctor at St. Joseph Hospital in London, Kentucky. Hacker had arrived at that hospital's ER doubled over and complaining of severe pain. While Hacker appeared to be in acute distress, his lab values were within the normal range except

for an elevated white blood count. A CT scan revealed a small amount of free fluid in Hacker's pelvis, but none around the gallbladder fossa; no leak was confirmed. Fluid in the pelvis is a common bodily response to surgery. Dr. Edwards decided to admit Hacker to Manchester, but the London ER physician did not call back.

Dr. Kristin Moore, a general surgeon, had admitted Hacker to the London hospital. She initially suspected Hacker's pain was "related to insufflation[5] and that would dissipate." After waiting twenty-four hours, a second HIDA scan[6] was performed revealing a small leak undetected by the CT scan which did not affect Hacker's bilirubin level. Dr. Moore conveyed these new results to Dr. Edwards stating a stent would be inserted to relieve the pressure and allow the bile to drain. Two weeks later, Hacker was fully healed.

Hacker believes Dr. Edwards deviated from the standard of care causing him to suffer pain, additional surgery, and emotional distress. He further believes Dr. Edwards "turned him away" and "Manchester didn't want anything to do with me after the surgery [on July 21, 2014]."

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[5] Insufflation is defined as "the act of blowing something [such as a gas, powder, or vapor] into a body cavity." Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/insufflation (last visited October 18, 2019).

[6] An imaging test used to view the liver, gallbladder, bile ducts, and small intestine. It is unclear when the first HIDA scan was performed.

Hacker was given sixty days to name his expert witness. He chose Dr. Thomas von Unrug—a board-certified internist with no other specialties. He is not certified in general surgery. When deposed on January 23, 2018, Dr. Unrug limited his opinion to how a first contact provider in the ER should evaluate a patient complaining of post-cholecystectomy pain. He specified he would not testify as to a surgeon's standard of care; was not critical of Dr. Edwards' decision to perform a laparoscopic cholecystectomy; and would not offer an opinion about the technical performance of the surgery itself. He saw the issue as whether the Manchester ER properly diagnosed Hacker's complication—ultimately determined to be a post-surgery bile duct leak. Our review of Dr. Unrug's deposition revealed no point at which Dr. Edwards was described as deviating from the standard of care or performing a negligent act. Instead, his actions were deemed "reasonable."

Dr. Unrug described a standard evaluation as including

> obviously the blood work, looking for white count, that's called a CMP and a CBC. A CMP looks at liver function tests, bilirubin, and the such. The other evaluation that I think should have been done would be an ultrasound evaluation of the belly and probably a CT. One of the things that was assumed is that the patient had postoperative gas, which was causing the problem. That could easily have been visualized on the CAT scan. You have to have a certain amount of it to be problematic. Also, at the same time, if a large amount of bile is noted in the gallbladder fossa, then obviously you have the diagnosis of a bile leak, which in that case usually need [sic] to be addressed with an – with a – with probably a stenting procedure.

Dr. Unrug acknowledged a CT scan was performed in London on July 22, revealing only a small amount of fluid. He also admitted had the CT scan been performed at Manchester a day earlier, when Hacker went to the Manchester ER, it would have shown an even smaller amount of fluid.

Dr. Unrug conceded Dr. Edwards' plan to see Hacker on July 22, the day after the surgery, was reasonable considering the patient's generally negative CT scan, normal bilirubin level, and mildly elevated white blood count. The possibility of a bile leak was not confirmed as an actual leak until the second HIDA scan was performed on July 23, twenty-four hours after Hacker had arrived at the London ER. Soon thereafter, Hacker underwent the least invasive treatment available to correct his condition—an ERCP[7] followed by insertion of a stent to open the bile duct and drain the leak. Dr. Unrug testified the treatment would have been the same whether performed on July 21, 23, or 24. When asked about Hacker's outcome, Dr. Unrug—who had never seen Hacker—responded, "I assume he did well."

Before Dr. Unrug's deposition concluded, this exchange with defense counsel occurred:

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[7] Endoscopic Retrograde Cholangiopancreatography – threading an endoscope through the mouth, into the stomach, and then into the small intestine to examine pancreatic and bile ducts.

Q. You described this as a small biliary leak; is that right?

A. Based on the CAT scan.

Q. Do you believe that a small biliary leak of this type constitutes an emergency medical condition that has to be treated in the ER? Will you testify that it should be treated in the ER and diagnosed in the ER?

A. No.

Q. So I just want to make sure I understand you; the limit of your opinion here is that the patient should have been admitted to the hospital on the 21st –

A. Correct.

Q. — is that correct?

A. Right.

Q. And that's all?

A. That I think is the — is the main premise of my testimony.

Dr. Unrug's position was Hacker should have been admitted to the Manchester ER when he presented with severe abdominal pain and an elevated white blood count on the evening of July 21, 2014. Dr. Unrug testified a twenty-three-hour observation period would have been appropriate during which Hacker's pain would either improve or worsen. If his discomfort was caused by air, it would resolve quickly; if it was caused by a leak, it would get progressively worse. He

went on to say, if the Manchester ER lacked the ability to treat Hacker, he should have been transferred to a different facility, not discharged to home. Despite believing Hacker should have been admitted to the Manchester ER, Dr. Unrug twice testified Dr. Edwards approached the case reasonably. At one point, counsel asked,

> Q. In your opinion, given that consultation and Dr. Edwards' plan to see the patient the following morning in the office, has Dr. Edwards deviated from the standard of care in any way in Mr. Hacker's treatment, care and treatment on the evening of the 21st?
>
> A. So let me explain a little bit. The emergency room called Dr. Edwards, is my understanding —
>
> Q. Correct.
>
> A. — and presented the patient. I don't know exactly what was said, but I think it is reasonable for Dr. Edwards to say, I will see that patient first thing in the morning and evaluate them. On the other hand, what I do not know what transpired, is whether or not the emergency room physician appropriately presented the patient to Dr. Edwards. And I'm saying that based on the presentation to Saint Joseph's, which was rather acute.

Later in the deposition this exchange took place between Dr. Unrug and defense counsel:

> Q. Would you agree with me, Doctor, that if you take the CT findings from the 22nd of no fluid within the gallbladder fossa, a bilirubin on the 21st that's within normal limits, and a mildly elevated white

> count, and finally, pain that is responsive to Toradol, that it would be reasonable for a physician like Dr. Edwards to say, I'm going to see the patient the next morning?
>
> A. I think that's reasonable, yes.

Dr. Unrug's deposition failed to show deviation from the standard of care, or lack of reasonableness by Dr. Edwards, prompting the filing of a motion for summary judgment. Against this backdrop we consider whether awarding summary judgment in favor of Dr. Edwards was proper.

ANALYSIS

Courts grant summary judgment

> to expedite litigation. *Ross v. Powell*, 206 S.W.3d 327, 330 (Ky. 2006). It is deemed to be a "delicate matter" because it "takes the case away from the trier of fact before the evidence is actually heard." *Steelvest, Inc. v. Scansteel Service Center, Inc.*, 807 S.W.2d 476, 482 (Ky. 1991). In Kentucky, the movant must prove no genuine issue of material fact exists, and he "should not succeed unless his right to judgment is shown with such clarity that there is no room left for controversy." *Id*. The trial court must view the evidence in favor of the non-moving party. *City of Florence v. Chipman*, 38 S.W.3d 387, 390 (Ky. 2001). The non-moving party must present "at least some affirmative evidence showing the existence of a genuine issue of material fact[.]" *Id*. On appeal, our standard of review is "whether the trial court correctly found that there were no genuine issues as to any material fact and that the moving party was entitled to judgment as a matter of law." *Scifres v. Kraft*, 916 S.W.2d 779, 781 (Ky. App. 1996). Furthermore, because summary judgments do not involve fact-finding, our

> review is *de novo*. *Pinkston v. Audubon Area Community Services, Inc.*, 210 S.W.3d 188, 189 (Ky. App. 2006).

Keaton v. G.C. Williams Funeral Home, Inc., 436 S.W.3d 538, 542 (Ky. App. 2013).

Medical malpractice cases require proof the provider under attack deviated from the standard of care.

> "In medical malpractice cases[,] the 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 or death." *Reams v. Stutler*, 642 S.W.2d 586, 588 (Ky. 1982) (citing *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970)).

Adams, 536 S.W.3d at 690-91. Hacker's chosen expert, Dr. Unrug, testified Dr. Edwards' approach to Hacker's pain was reasonable. He did not testify Dr. Edwards in any way deviated from the governing standard of care. Furthermore, there was no testimony Dr. Edwards negligently performed the surgery or negligently provided post-surgery care. Thus, Dr. Unrug did not substantiate Hacker's claim against Dr. Edwards.

Hacker argues in addition to Dr. Unrug, a critical care paramedic—Lori Barton, who screens cases for the attorney practicing this case—was also identified as an expert witness. Barton's analysis of the case was copied into the complaint.

The record appears to be devoid of Barton's credentials, preventing us from determining whether she would have qualified as an expert under KRE[8] 702—at least we have not been directed to a listing of her education and work experience. If this information is in the record it was incumbent on Hacker to direct us to it and to specify where he argued Barton's qualifications to the trial court.

Barton seems to have been offered as an expert because—as stated in Hacker's brief—"she has had this procedure done and is imminently familiar with it." We are given no details of the procedure she underwent, what necessitated it, nor who performed it. More importantly, we are cited no authority for a prior patient to establish the standard of care a physician should observe when a post-surgical patient presents with complications. Nor have we been cited authority for a critical care paramedic to speak with authority about how a surgeon should respond to a post-operative patient. In contrast, citing *Tapp v. Owensboro Med. Health Sys., Inc.*, 282 S.W.3d 336, 340 (Ky. App. 2009), Dr. Edwards' brief maintains "Kentucky courts have not squarely addressed whether a paramedic can testify as an expert on the standard of care of a physician."

[8] Kentucky Rules of Evidence.

Additionally, Barton may have misinterpreted the record. This is problematic for multiple reasons. Before addressing the ultimate concern, we must revisit a more basic issue—non-compliance with the rules. Hacker included Barton's synopsis in the complaint without attribution. He also quotes it at page 9 of his brief—labeling it "Synopsis by Lori Barton." However, he has not told us where this document appears in the record. This is a blatant violation of CR 76.12(4)(c)(v). *Hallis*, 328 S.W.3d at 696-97. If the synopsis is part of the certified record, we could find it on our own, but we have no responsibility to search the record to make his argument for him. *Milby*, 580 S.W.2d at 727. If it is not in the record, Hacker cannot rely on it, nor can we. Merely typing language into a brief does not put it squarely before us. The lesson here is simple. Read and follow CR 76.12. Ensure all documents on which you intend to rely are part of the record certified to the appellate court and when constructing your brief, specify where the item supporting your argument is located.

As previously highlighted in this opinion, Hacker's brief ignored CR 76.12(4)(c)(v) multiple times, but at least twice on this single topic. His brief quoted Barton's synopsis and a cell phone text Hacker sent to counsel during Dr. Unrug's deposition. He never tells us where these apparently crucial items were argued to the trial court. Counsel also apparently fails to realize the two quotes are diametrically opposed.

Barton's synopsis states:

> The problem was that the patient returned to the ER with symptoms relating to those with post operative [sic] complications and was advised to see DR Edwards the next morning. *When* [*Hacker*] *saw DR Edwards, the Dr failed to recognize the symptoms associated with biliary tree injury* from the gallbladder surgery and sent him home.

(Emphasis added). Based on the foregoing, Barton believes Dr. Edwards saw Hacker on July 22, 2014—the day after the surgery. We now quote Hacker's own cell phone text to counsel.

> I went back once the day of the surgery, *the hospital called Dr. Edwards while I was at the hospital, and he wouldn't come see me.* He told them to give me more pain meds, and he told them to tell me to call him in the morning. So *we called him the following morning and he still wouldn't see me*, he said he would call me in some more pain meds. By this time I was in terrible shape. So I was going to go back to the hospital that morning. My sister arrived at my house, and she said no, that I was not going to manchdster, [sic] so she took me to St. Joes. And they found out what the problem was. The thing is, manchester [sic] didn't want anything to do with me after the surgery.

(Emphasis added). Contrary to Barton's synopsis, Dr. Edwards did not see Hacker the day after the surgery. Hacker's allegation—as stated at page 7 of Hacker's brief—is "Dr. Edwards turned Hacker away, failed to see him, and thus failed to diagnose his leak that caused him to seek care from St. Joseph's Hospital in

London." It appears Barton misconstrued the entirety of Dr. Edwards' role and Hacker's concerns.

The record before us does not demonstrate Dr. Edwards deviated from the standard of care or acted with negligence. We affirm the award of summary judgment in Dr. Edwards' favor.

ALL CONCUR.

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