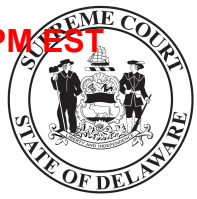

IN THE SUPREME COURT OF THE STATE OF DELAWARE

HEATHER E. TURNER, Plaintiff Below Appellant, v. DELAWARE SURGICAL GROUP, P.A., ERIC D. KALISH, M.D. and MICHAEL K. CONWAY, M.D., Defendants Below Appellees,	No. 410, 2012 Court Below: Superior Court of New Castle County C.A. No. 09C-07-219 RRC

APPELLANT'S REPLY BRIEF

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I. STATEMENT OF FACTS

On July 24, 2007, appellee Dr. Eric D. Kalish ("Dr. Kalish") performed a routine laparoscopic (minimally invasive) appendectomy on appellant Heather Turner ("Turner"). Eight days later, on August 1, 2007, Turner was readmitted to Christiana Hospital for abdominal pain and diagnosed with a partial small bowel obstruction. Dr. Kalish decided to perform surgery the very next day, even though his expert in General Surgery, Dr. Matt Kirkland, admitted that a) over the last 15 to 20 years, there has been a movement to manage both partial and complete, uncomplicated bowel obstructions (those caused by adhesions, as opposed to complicated obstructions caused by hernias) without surgery, and b) given sufficient time, the majority of such obstructions resolve with nonoperative management. B-104. During Turner's second surgery, Dr. Kalish removed about 2 centimeters (one inch) of Turner's small bowel. A647-8.

Turner's highly qualified expert in General Surgery, Dr. Howard Beaton, opined that Dr. Kalish breached the standard of care in several respects. First, Dr. Kalish failed to provide nonoperative treatment for a sufficient amount of time to allow the bowel obstruction to resolve itself without surgery, which is the standard of care. A403-5, 410-1, 413-6. Dr. Beaton explained that in the early postoperative period, meaning the first 30 days after surgery, the vast majority of bowel obstructions resolve without surgery. A415. Dr. Beaton opined that, if Dr. Kalish had provided adequate nonoperative management, Turner's partial obstruction, which was caused by a newly formed adhesion from her appendectomy, would have

resolved without surgery, as is the case with the vast majority of such obstructions. A413-6. Second, during the exploratory bowel surgery, after Dr. Kalish released the adhesion and thereby resolved the obstruction, he went on to perform an unnecessary small bowel resection, and removed a mere two centimeters of small bowel. A416-9. By doing so, Dr. Kalish put his patient Turner at risk for the very serious complications of bowel resection surgery, including future small bowel obstructions caused by adhesions from the unnecessary bowel resection. A419. And that is precisely what happened to Turner, causing her to have three, additional major surgeries and severe, permanent injuries.

Dr. Kalish's operative report for the bowel resection surgery, quoted below, describes how there was an "easy release" of the adhesion, which was causing the obstruction. A416, 645. According to Dr. Beaton, had Dr. Kalish stopped there, Turner would not have required her third surgery by Dr. Conway to address a further, and truly serious bowel obstruction, caused either by Dr. Kalish's poor surgical technique or extensive adhesions from his unnecessary bowel resection. A419. In addition, Turner would not have needed the subsequent surgery by Dr. Bennett to remove a mass from her liver, caused by spillage which occurred during Dr. Conway's surgery. A423-5. Finally, she could have avoided the surgery by Dr. Clayton and Dr. Chang to repair the incisional hernia from her two open abdominal surgeries by Dr. Kalish and Dr. Conway. A424-5.

A central issue at trial, then, was whether the 2 centimeters of small bowel removed by Dr. Kalish was bruised and compromised tissue

that had to be removed surgically. Dr. Kalish was deposed on April 13, 2011. B2. His operative report for the August 2, 2007 small bowel resection surgery, dictated the day after surgery, was marked as exhibit 5. B15. During the deposition, he testified that the decision to resect the bowel is "an intraoperative judgment that's made on every small bowel obstruction and is basically -- it's based on potential for that segment of bowel to have a problem afterwards in terms of its viability." B21. He further testified that "the prudent course is to resect it back to healthy bowel …." B21. During the deposition, he was asked about the condition of the one inch segment of small bowel he observed during surgery:

> Q. What is it about the condition of the small bowel in this circumstance that made you question its viability?
> A. The appearance, the color, the potential bruising of the bowel. I don't specifically remember how bruised the bowel looked in this case, but the bowel that's involved in the process such as this can have a significantly altered viability, and that's usually pretty easy to tell visually.

B25.

Dr. Kalish did not describe bruising or discoloration of the small bowel in his operative report. A645-6. Instead, he described "multiple dilated loops of small bowel." A645. Dr. Kalish's expert, Dr. Kirkland, conceded that mere dilation of the small bowel does not require its removal. B99. That is why Dr. Kalish removed a mere 2 cm of small bowel, and not the multiple dilated loops. Furthermore, Dr. Kalish's report stated that "there was easy release of the small bowel obstruction." A645. According to Dr. Beaton, once Dr. Kalish released the obstruction, he should have stopped there. A416-9.

Dr. Kalish's operative report further states:

> There was an imprint and stricturing of the ileum causing the bowel obstruction approximately 6 inches from the ileocecal valve. This was apparently from a folding of small bowel at this point and it's (sic) subsequent adherence to the staple line where the appendix was removed. The small bowel at this point was too narrowed to leave it alone and at this point we performed a resection of this strictured area to encompass approximately 1 inch of small bowel.

A645. Therefore, his only recorded observations were that the small bowel was "strictured" and "too narrowed." A645.

The Pathology Report for the small bowel resection surgery was not marked as an exhibit to Dr. Kalish's deposition, and Dr. Kalish only mentioned it once, in the context of describing the length of the bowel segment removed. B34. Dr. Kalish's counsel did not ask any questions and did not elicit any opinions at his deposition. B40.

The Pathology Report for the 2 centimeters of small bowel removed by Dr. Kalish describes healthy tissue, not bruised, discolored tissue. A647-8. Under "Gross Description," the Report identified the 2.0 cm small bowel specimen as "pink tan smooth glistening serosa" (the outer layer of the bowel observed by the surgeon). A647. The Pathologist opened the specimen to inspect the inner lining, and described "pink tan smooth glistening mucosa [the inner layer of the bowel] with normal to slight flattened dilated folds…." A647.

In contrast, the Pathology Report for the bowel resection later performed by Dr. Conway on December 2, 2007, describes a "65 cm. segment of small bowel surfaced by dusky red purple serosa" and except for the margins which were "slightly dusky glistening tan pink and appears viable," "[t]he mucosa throughout the remainder of the bowel segment is dusky purple black-green…." A663.

Purple and black-green tissue is plainly discolored and non-viable, whereas tan pink tissue is healthy and viable. Because the Pathology Report described healthy tissue, it contradicted Dr. Kalish's deposition testimony. A647. While Dr. Kalish testified at deposition that he could not remember specifically how bruised the small bowel was, he said that he removed it because of "the appearance" and "the color," it was bruised, it had "significantly altered viability," and that would have been "pretty easy to tell visually." B25.

Turner's expert, Dr. Beaton, agreed with defense expert Dr. Kirkland's deposition testimony that there are many instances where a surgeon addresses a small bowel obstruction by simply performing lyses of adhesions to free up the obstruction, does not resect the bowel, and closes the patient. A417 (85:7 – 86:12). Dr. Beaton explained that this was not a case where the blood supply to the bowel was compromised, or the bowel looked purple or black, and not viable. A417. The operative report did not describe bruising, a compromised blood supply, or an abnormal appearance other than Dr. Kalish felt it was narrowed. A418. Dr Beaton noted that Dr. Kalish was assisted in the surgery by Dr. James Larson, and his findings for the surgery state: "Terminal ileum adhesions to the staple line at recent appendectomy; easily separated. Ileal stricture at adhesion site, <u>no necrotic bowel</u>. (Emphasis added.) A418.

Dr. Beaton reviewed the Pathology Reports for Dr. Kalish's and Dr. Conway's bowel resection surgeries. A421-3. He compared the two and noted that the gross description of the 2 cm small bowel segment

removed by Dr. Kalish was "pink, tan, smooth, glistening serosa" and therefore normal in color, and not purple or black. A421. He opined that there was nothing in the Pathology Report that suggests that the one-inch segment of small bowel needed to be removed. A422. He reviewed the microscopic description and opined that, under a microscope, magnified possibly several hundred times, the Pathologist saw a tiny ulcerated area, which had "no clinical significance at all." A422. Dr. Beaton observed that the focal point of ulceration was limited to the very inner lining of the bowel, the mucosa. A422. Dr. Kalish could not have seen this one focal point of microscopic ulceration with the naked eye, and, in any event, it was inside the bowel and not in Dr. Kalish's field of view during surgery. A422-3.

Defendants served answers to expert interrogatories on July 30, 2010, but did not identify Dr. Kalish as an expert. A686, 701-3. On April 12, 2011, defendants served expert disclosures which identified Dr. Kalish as an expert, but made no disclosure of any opinions he held, or any facts or grounds for such opinions. A732-5. Dr. Kalish was deposed the following day, and Turner's counsel marked his Operative Report for the August 2, 2007 bowel resection surgery as an exhibit and questioned Dr. Kalish about the surgery. However, Dr. Kalish did not have the Pathology Report marked as an exhibit and did not disclose any opinions or facts pertaining to the Report. His only reference to the Pathology Report was that it contained an indication of the length of the small bowel segment he removed. B34.

On April 3, 2012, defendants served supplemental disclosures for their trial experts Dr. Matt Kirkland (General Surgery) and Dr. Steven

Peikin (Gastroenterology), but Dr. Kalish was not mentioned. A720-9. Prior to trial, Turner served a request for supplementation of responses under Rule 26(e), which encompassed plaintiff's expert interrogatories. In their April 10, 2012 response, defendants referred to the April 3, 2012 expert disclosures, and made no mention of Dr. Kalish's opinions, including any about the Pathology Report. A717-8. Appellee Dr. Conway was deposed on June 15, 2011. Even though he has held management positions at Christiana Hospital, Dr. Conway testified at deposition that he did not believe there is any requirement at Christiana to have operative reports completed within any set time period, he was unaware of any rule about dictating operative reports within 24 hours of surgery, and it was not uncommon for such reports to be dictated "down the road." A132-3, A137-8. He did not agree that his recollection would be better if his operative report was dictated closer to the time of surgery. A134-45.

The trial commenced on June 18, 2012. Defense expert Dr. Kirkland was called as a witness on June 21, 2012. Dr. Kirkland testified that Turner needed the bowel resection surgery by Dr. Kalish, in part, because her pain had gone from intermittent to constant during the brief course of her hospital stay, which is indicative of a more serious bowel problem. However, on cross-examination, Dr. Kirkland was forced to admit that, in the six hours between the time of Turner's last exam (around 8:40 a.m.) and the time of surgery (around 3 p.m.), there was no record of an examination by Dr. Kalish, and the medical records did not state whether her pain was constant or intermittent. B88-90. Dr. Kirkland also admitted that the

medical records contained no indication of her pain level during that critical time period, and that it could have gone down to a 1 or 2 (on a scale of 1 to 10, with 10 being highest). B88-92.

Dr. Kirkland testified on direct about the Pathology Report for the surgery by Dr. Kalish, including the "Microscopic Description." On cross examination, Dr. Kirkland admitted that the dilated portion of Turner's bowel did not have to be removed, establishing that dilation of the bowel does not mean it is injured and nonviable. B99 (218:10-4). Dr. Kirkland admitted that the "Gross Description" in the Pathology Report described healthy tissue: "Serosa at the point that this was removed was viable, based on what they saw in the lab. Yes." B99 (220:15-6). Dr. Kirkland was then asked about the "Microscopic Description" where it stated: "Sections show a focal small intestinal ulceration with transmural extension of acute inflammation to the serosa." B99-100. Dr. Kirkland agreed that the Pathologist was describing one small point of ulceration on the inner lining of the small bowel, which he said could only be seen under a microscope. B99-101. Dr. Kirkland further admitted that, when a surgeon resects a small bowel, in order to create an anastomosis that will close and heal, the surgeon must connect healthy bowel tissue to healthy bowel tissue. B101-3. Therefore, the surgeon must remove a certain amount of healthy bowel tissue at each of the two ends (margins) of the resection, to increase the chances that, when the two ends of the small bowel are stapled together, the anastomosis will not leak or fail. B101-3. Dr. Kirkland indicated that the surgeon would need to cut into the healthy bowel tissue on either side of the site for the

anastomosis about one to one and one-half centimeters. B101-2; B103 (235:1 – 236:10). The length of the bowel removed by Dr. Kalish was two centimeters. If, as Dr. Kirkland admitted, Dr. Kalish had to cut away at least two to three centimeters of healthy bowel tissue while performing the resection, his decision to remove only two centimeters suggested that all of the tissue he removed was healthy and viable. The healthy nature of the tissue Dr. Kalish removed is confirmed by the Pathology Report.

At trial, over Turner's objection, Dr. Kalish was permitted to offer expert testimony about the Pathology Report for the small bowel resection surgery he performed. A500-1. Dr. Kalish rebutted Dr. Beaton's testimony, and opined that the microscopic description in the report demonstrated "tissue damage, that's full thickness" through "four layers of the bowel" and not merely limited to the mucosa. A501. He further contradicted Dr. Beaton saying that the microscopic description did not mean that the tissue damage and ulceration of the small bowel could only be seen under a microscope, and testified that "[t]hese are things that the naked eye can see." He expressed the opinion that "this is not normal bowel." A501. Dr. Kalish testified that the reference in the Report to "denuded epithelium" meant tissue damage to the inner lining of the small bowel, and "[p]robably that's just before an ulcer." He testified that the Report also described early signs of an abnormal bowel, and in his opinion, then you get the "purplish discoloration, the dark purple, black, what's called liquefaction." A501.

At trial, it was established that Dr. Conway used a standard surgical device called a GIA stapler to resect Turner's small bowel and create the anastomosis. While the stapler minimizes the risk of spillage from bowel resection surgery, it does not eliminate it, so spillage does occur. A529 (72:2-8); B105 (241:18 – 242:17).

Dr. Joseph Bennett was called by the defense to testify at trial. Dr. Bennett performed the September 26, 2008 surgery to remove the contaminated mass from Turner's liver a little more than nine months after Dr. Conway's surgery. A667-8. Dr. Bennett dictated his operative report the same day as the surgery and said this about the contaminated mass: "My impression was that this could have been some sort of spillage from her intra-abdominal operation such as an appendicolith or small piece of stool or inflammatory process from her prior surgery that tunneled down in the posterior hepatic space and Morrison space." A667-8.

II. ARGUMENT

A. THE TRIAL COURT ABUSED ITS DISCRETION AND COMMITTED REVERSIBLE ERROR BY REPEATEDLY PRECLUDING THE PLAINTIFF FROM PRESENTING EVIDENCE TO IMPEACH DR. CONWAY THAT WENT WELL BEYOND PROOF OF THE 24-HOUR RULE.

Reading Appellees' Brief, one would think that this aspect of Turner's appeal is limited to the trial court's erroneous decision to exclude reference to the 24-hour rule, which is indisputably contained in the Bylaws and Operating Room Rules and Regulations of Christiana Hospital. A150-4. As the notice of appeal demonstrates, throughout the trial, Turner was repeatedly precluded from presenting any evidence that would impeach Dr. Conway, or attack the timeliness, completeness, and accuracy of his operative report. For example, Turner was precluded from presenting undisputed evidence that: a) Dr. Conway performed at least 27 surgeries between the date he operated on Turner and the date he dictated his operative report; b) Dr. Bennett, a colleague who is in business with Dr. Conway and Dr. Kalish, and was called by the defense, not only knows the 24 hour rule, but – wholly apart from the rule – considers the operative report as part of the surgery itself, and does it at the time of surgery "because I think it's the most accurate recollection, as opposed to doing it 30 surgeries later." A493; c) operative reports are prepared at the time of surgery to help guide patient treatment and for patient safety, d) surgeons at Christiana Hospital dictate their operative reports within 24 hours in more than 90% of cases, A162-8; and e) the other testifying surgeons, including the defense expert Dr. Kirkland, routinely dictate their operative reports at the time of surgery or shortly after, in order to assure accuracy and for the reasons stated

above. These rulings are plainly erroneous and an abuse of discretion, denied Turner a fair trial, and merit reversal.

Regarding the 24-hour rule, itself, the trial court initially refused to permit plaintiff to present evidence about it because plaintiff allegedly could not prove that Dr. Conway's violation of the rule caused actual physical injury to Turner. A343-5. The ruling is plainly erroneous because Dr. Conway's inability to comply with the rule was circumstantial evidence that he was too pressed for time to prepare it, and his surgical schedule was such that he hurried through Turner's complex surgery (which was not elective, and had to be performed somewhat urgently), leading to spillage, thereby causing Turner injury. A125-6. Further, the untimely dictation of the report implied bias, prejudice, and a motive on Dr. Conway's part to insulate himself and Dr. Kalish from liability. A125-6.

Turner's response, limited to four pages by Superior Court practice, addressed the untimeliness of the report as grounds for impeachment and proof of bias. A123-6. Admittedly, the focus was on its use as proof of negligence. This was proper, as the defense papers never asked the Court to exclude the evidence for purposes of impeachment or bias. "Impeachment" is nowhere to be found in their moving papers or argument. Therefore, Turner's focus on negligence was consistent with the way the defense framed the issue. An issue does not have to be the focus of a party's papers in order to be preserved for reargument or appeal. And Turner's negligence argument was correct. The trial court erred in rejecting it.

Operative reports properly dictated within 24 hours of surgery are more likely to contain complete, accurate, and "unfiltered" information. For example, Dr. Kalish's timely operative report was inconsistent with his deposition testimony about observing bruised, discolored bowel. Dr. Bennett's timely operative report related his impression that the mass on Turner's liver "could have been from some sort of spillage … from her prior surgery" including a "small piece of stool." A667-8.

Appellees contend that the 24-hour rule "is in no way relevant evidence." Dr. Conway's operative report was relied upon by his expert to opine that there was no spillage during his surgery. The fact that Dr. Conway delayed 52 days in preparing the report and thereby deliberately and grossly violated a written hospital rule that accredited hospitals nationally are required to adopt, and which is designed to assure proper patient treatment and patient safety, demonstrates his bias, prejudice, and motives in connection with the late preparation of the report. The fact that he denied the existence of the rule under oath, before the issue surfaced in the discovery record, and his deliberate defiance of the rule reflect on his credibility. The fact that his patient Turner has a right to rely on his compliance with hospital rules while treating her, and he chose to ignore the rule, reflects on his attitude toward her treatment and safety. After Dr. Conway gave his deposition testimony, plaintiff developed overwhelming evidence which would have proven that Dr. Conway knew about the rule, its importance, the fact that Christiana Hospital tracks compliance, and that he was willing to testify falsely

about it. Not only would such evidence impeach Dr. Conway's credibility, it would have called into question the completeness and accuracy of the operative report; a key document upon which his expert relied in expressing the opinion that Dr. Conway did not breach the standard of care.

The trial court's initial decision was directed to the 24-hour rule and excluded the evidence because a) there was no evidence that the lateness of the report caused the subsequent injuries, and b) under Rule 403, the probative value was outweighed by considerations of prejudice and confusion to the jury. A342-6. Turner timely moved for reargument as the trial court misapprehended both the law and the facts. A201-34. While the motion for reargument devoted more space to impeachment, bias, prejudice, and motive than Turner's original response, they were not entirely omitted from the original response and argument, and so the issues were not waived. Moreover, the trial had not started, and a challenge to an evidentiary ruling could not have been untimely. The trial court denied the motion, and during the course of the trial, repeatedly expanded on the ruling by excluding relevant evidence, that was not the subject of the defense motion, for example, that Dr. Conway performed at least 27 surgeries between the date of plaintiff's surgery and the date he dictated the operative report. In a case where the credibility of the defendant doctors was critical to the outcome, Turner was precluded from impeaching Dr. Conway and his operative report at every turn.

Appellees contend that "plaintiff's experts did not offer any testimony critical of the operative note at issue…." Appellees'

Answering Brief ("AAB") 13-4. Dr. Beaton's November 10, 2010 expert report says that "Dr. Conway's operative note is not sufficiently descriptive for me to form an expert opinion as the etiology of this obstruction." A142, 191. In Turner's October 11, 2011 expert interrogatory answers, she identified Dr. Beaton and disclosed that he was expected to testify about the 24-hour rule, and "the lack of detail in Dr. Conway's operative report for the December 2, 2007 surgery, which was dictated on January 23, 2008." A249. Either statement would support an argument that Dr. Conway's report was purposefully lacking in detail.

Appellees argue that Turner "could not show that the report was incorrect or lacked credibility." AAB 11. According to appellees, unless Turner first proved that the report was inaccurate, it must be accepted as gospel. Dr. Conway's deliberate violation of the 24-hour rule, his denial of its existence under oath, and his performance of at least 27 surgeries over 52 days before dictating it, is the very evidence which shows that the report is untrustworthy.

Appellees argue that the violation of the 24-hour rule was not a matter of consequence and there was no proof that it involved a breach of the standard of care. AAB 14. The expert interrogatory answers for Dr. Beaton establish otherwise. A247-9.

Appellees argue that the probative value of the evidence of delay in completing the operative report was far outweighed by the danger of prejudice and confusion to the jury. AAB 15-6. All evidence used for impeachment, or to prove bias, prejudice, or improper motive, is prejudicial. The question is whether the prejudice is "unfair" as

required by Rule 403. Appellees arguments about unfair prejudice are unsupported by the record, illogical, or legally flawed.

Neither the trial court nor the appellees have ever explained how the jury would be confused by the 24-hour rule or the other evidence Turner sought to present. A rule requiring a surgeon to dictate an operative report within 24 hours is about as straightforward as an issue can get. Evidence that Dr. Conway performed at least 27 surgeries between Turner's surgery and the dictation of his report makes the point that her surgery was not a unique event, and it would be difficult for a surgeon (e.g., Dr. Bennett) to remember the details 52 days and 27 surgeries later. If a high-ranking, experienced police officer failed to prepare a report of a multi-vehicle accident for 52 days in violation of a departmental rule requiring its preparation within 24 hours, did so only after investigating at least 27 other accidents, and denied under oath that the rule existed, a plaintiff or criminal defendant would certainly be permitted to prove those facts to attack the credibility of the officer and his report.

Appellees argue that there could not have been any spillage of bowel contents during the surgery by Dr. Conway, citing a statement by Dr. Kirkland that the bowel specimens sent to Pathology were unopened. AAB 20. The Pathology Report identified four specimens, and only two were unopened. A665. Furthermore, Dr. Beaton testified that the GIA stapler minimizes spillage, but does not eliminate it. A529 (72:2-8); B105 (241:18 – 242:17). And Dr. Bennett, who read Dr. Conway's operative report, suggested that there even could have been spillage of a small piece of stool. A667-8.

B. THE TRIAL COURT ABUSED ITS DISCRETION AND COMMITTED REVERSIBLE ERROR WHEN IT PERMITTED DR. KALISH TO PRESENT EXPERT TESTIMONY NOT DISCLOSED PRIOR TO TRIAL.

Under *Barrow v. Abramowicz*, 931 A.2d 424 (Del. 2007), a healthcare defendant who "takes the stand as an expert witness must satisfy the same requirements as any other expert witness." *Barrow* sets two requirements for disclosures: (i) timely identification of the defendant's role as an expert; and, (ii), a timely disclosure of his opinions and the bases for his opinions." *Barrow*, 931 A.2d 424, 434 (Del. 2007), *following Bush v. HMO of Delaware,* 702 A.2d 921 (Del. 1997). Here, Appellees satisfied only the first requirement. They violated *Barrow*, because the Court there held that it was reversible error for the trial court to permit the defendant doctor to testify about an undisclosed expert opinion, and not "limit the scope of [the doctor's] trial testimony to the observed facts related to standard of care that he disclosed at his pretrial deposition." *Id.* at 435.

Appellees cite *Bush v. HMO of Delaware* and argue that deposition testimony satisfies the requirement for pre-trial disclosure of expert opinions. 702 A.2d 921 (Del. 1997). *Bush* held that the trial court was correct in permitting a treating physician "to testify in disclosed areas of his expertise but not in matters lacking discovery." *Id.* at 923. Therefore, a treating physician is only permitted to give expert opinions on matters disclosed at his deposition.

In *Bush*, the treating physician was identified as an expert in the pre-trial stipulation. *Id.* at 923-24. Like Dr. Kalish, certain of his opinions were never specifically disclosed before trial. *Id.* at 923. Only the matters disclosed in his deposition were admitted. The

decision was upheld on appeal, and followed in *Barrow*. *Id.*, *see also Barrow*, 931 A.2d at 435 (The trial judge erred when he failed to limit the scope of the trial testimony of Dr. Abramowicz to the observed facts disclosed at his pretrial deposition.).

Dr. Kalish's "expert" opinions and the grounds for his opinions were not set forth in the Appellees' expert disclosures or answers to interrogatories. A732-5. Dr. Kalish did not have the Pathology Report marked as a deposition exhibit and did not disclose any opinions concerning the Report or any facts contained therein. B1-41. Unlike the disclosure for Dr. Kirkland, Dr. Kalish's disclosure offered no opinions, and was never supplemented, despite a timely request under Rule 26(e). A720-9, A717-8. Dr. Kalish's opinion testimony about the findings in the Pathology Report should have been excluded.

Contrary to Appellees' argument, Dr. Kalish's testimony was not merely factual. It was not within the purview of a lay witness, and would not qualify as lay witness opinion under D.R.E. 701. It was testimony demonstrating "scientific, technical or other specialized knowledge" used to "assist the trier of fact to understand the evidence or to determine a fact in issue…." D.R.E. 701. Using the findings in the Pathology Report Dr. Kalish contradicted Dr. Beaton and opined that there was "tissue damage, that's full thickness" through "four layers of the bowel" and not limited to the mucosa. A501. He further contradicted Dr. Beaton by testifying that the tissue damage under the microscopic description could be seen with the naked eye. A501. He opined that the Report showed that "this is not normal bowel" and the "denuded epithelium" referenced in the report would, in

the future, develop into an ulcer and purple and black discoloration, thereby necessitating removal. A501.

Defendants argue that Dr. Kalish's expert opinions were harmless error, because Dr. Kirkland offered similar opinions. Dr. Kalish's opinions differed from Dr. Kirkland's, and went much further, as Dr. Kalish sought to justify his conduct. Dr. Kalish gave his undisclosed opinions on June 20, 2012, the day before Dr. Kirkland testified, giving the defense two experts to Turner's one. A501, B45.

Under *Barrow v. Abramowicz*, 931 A.2d 424 (Del. 2007), the admission of a treating expert's undisclosed opinions is reversible error, even if the testimony is cumulative. In *Barrow*, the defendant Dr. Abramowicz was permitted to testify at trial that certain radiographic abnormalities appearing in the upper lobe of the decedent's lung were benign, and not cancerous, even though his opinion was not disclosed before trial. *Id.* at 428. His expert, Dr. Creech, testified to the same effect. *Id.* at 429. As here, the defense pointed to Dr. Creech's testimony to argue that it was not error for Dr. Abramowicz to offer the same opinions. *Id.* at 434. Dr. Abramowicz also noted that the plaintiff called four experts who addressed the very same issue of cancer in the upper lobe. Even though the plaintiff's experts outnumbered the defense experts four to two, and Dr. Abramowicz's testimony was cumulative, this Court held that the admission of Dr. Abramowicz's opinions was reversible error. Here, the opinion testimony of Dr. Kalish was not merely cumulative. And its admission meant that the defense presented two experts on an issue that went to the heart of the case, against Turner's one expert.

III. CONCLUSION

Plaintiff-below, appellant Turner respectfully submits that this is the exceptional case where the trial court abused its discretion in making several critical rulings, caused Turner substantial prejudice, and denied her a fair trial. In a hotly contested case, where the credibility of the defendant surgeons was a paramount consideration, the trial court repeatedly refused to admit relevant evidence for impeachment and to prove bias, prejudice, and improper motive. The trial court's rulings precluded Turner from fairly attacking the credibility of Dr. Conway and his operative report, a key document specifically relied upon by the defense expert. The rulings were devastating to Turner's case, went to the heart of her claim against Dr. Conway, and almost certainly affected the outcome of the trial.

The trial court's decision to allow undisclosed expert testimony by Dr. Kalish caused Turner severe prejudice, as it too went to the very heart of Turner's claim against him, almost certainly affected the outcome of the trial, and rendered the pretrial discovery process and Rule 26(e) meaningless. The trial court's errors, independently and taken together, necessitate a new trial. Turner respectfully requests that the rulings be overturned and a new trial granted.

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