DATE FILED: September 11, 2018 10:58 AM
FILING ID: 56C40431CF432
CASE NUMBER: 2018CA46

COURT OF APPEALS, STATE OF COLORADO
2 East 14th Avenue, Denver, CO 80203

Appeal from the District Court of Boulder County,
District Court Case No. 2016CV30714
Honorable Judith L. LaBuda, District Court Judge

Plaintiff-Appellant:
ROBERT DELAND

v.

Defendant-Appellee:
RICHARD FOX, M.D.

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ANSWER BRIEF

Defendant-Appellee, Richard Fox, M.D. ("Dr. Fox"), by his counsel, submits this Answer Brief.

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with all requirements of C.A.R. 28 and C.A.R. 32, including all formatting requirements set forth in these rules. Specifically, the undersigned certifies that:

The brief complies with C.A.R. 28(g).

Choose one:
☒It contains 9,458 words.
☐It does not exceed 30 pages.

The brief complies with C.A.R. 28(k).

☐For the party raising the issue:
It contains under a separate heading (1) a concise statement of the applicable standard of appellate review with citation to authority; and (2) a citation to the precise location in the record (R.__, p.___), not to an entire document, where the issue was raised and ruled on.

☒For the party responding to the issue:
It contains, under a separate heading, a statement of whether such party agrees with the opponent's statements concerning the standard of review and preservation for appeal, and if not, why not.

Dated: September 11, 2018.

JAUDON & AVERY LLP

s/ David H. Yun

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ISSUES PRESENTED

1) Whether Plaintiff properly and timely objected to Dr. Fox's allegedly undisclosed testimony.

2) Whether the district court abused its discretion in permitting Dr. Fox to testify to opinions concerning Plaintiff's intraoperative parathyroid hormone ("PTH") levels when those opinions were expressed in his medical chart and deposition and his expert disclosure informed Plaintiff he would testify consistently with his chart and deposition.

3) Even assuming, *arguendo,* it was error to admit Dr. Fox's testimony that Plaintiff objected to (which Dr. Fox disputes), whether that alleged error was harmless when the jury's verdict was independently supported by other substantial evidence.

STATEMENT OF THE CASE

I. NATURE OF THE CASE

In this medical malpractice case, Plaintiff-Appellant, Robert Deland ("Plaintiff"), appeals a judgment entered in favor of Defendant-Appellee, Dr. Richard Fox, following a five-day jury trial in August of 2017. Plaintiff claimed that Dr. Fox improperly removed healthy parathyroid glands during surgery. As a result, Plaintiff alleged that he had to undergo additional medical treatment and

suffered injuries and damages. After considering the evidence, the jury found for Dr. Fox, determining that he was not negligent and did not cause Plaintiff's alleged injuries.

Plaintiff now appeals the judgment, challenging the trial court's discretionary ruling. Specifically, Plaintiff argues the trial court abused its discretion in allowing Dr. Fox to express an unendorsed opinion that "pathologically normal parathyroid glands can be 'high secretors.'" (*Opening Brief, pp. 1-2*). There are multiple reasons to reject Plaintiff's argument, including: 1) Plaintiff has incorrectly characterized Dr. Fox's actual testimony; 2) that testimony was properly and timely disclosed before trial; 3) Plaintiff did not properly or timely object; 4) the district court did not abuse its discretion; and 5) the admission of the testimony was harmless. Because Plaintiff received a fair trial, there is no merit to Plaintiff's appeal.

II. STATEMENT OF FACTS

Dr. Fox is a board-certified general surgeon who has practiced for more than fifteen years. (*TR 8/24/17(AM), pp. 81:10-82:4, 83:8-13, 85:20-22*). He performs a high volume of parathyroid surgeries every year. (*TR 8/24/17(AM), pp. 82:23-83:7*). Plaintiff saw Dr. Fox for the first time on May 29, 2014 for evaluation of primary hyperparathyroidism, a disorder of the parathyroid glands. (*TR*

8/24/17(AM), p. 87:7-11). Although he was only 26, Plaintiff had low bone mass in his spine and forearm, both consistent with primary hyperparathyroidism. (*TR 8/23/17(PM), p. 10:2-25; TR 8/24/17(PM), pp. 17:16-19, 34:13-35:2*).

The human body typically contains four parathyroid glands, which are located in the neck and are each approximately the size of a grain of rice, about three millimeters in size and weighing approximately 30 milligrams each. (*TR 8/24/17(AM), pp. 86:8-20, 91:23-92:8*). Parathyroid glands help regulate the body's calcium function. (*TR 8/24/17(AM), pp. 86:21-87:6*). Hyperparathyroidism exists when one or more parathyroid glands is functioning abnormally. (*TR 8/24/17(AM), pp. 87:12-89:8*). Approximately 85% of patients with primary hyperparathyroidism have one abnormal parathyroid gland. (*TR 8/24/17(AM), pp. 90:2-91:9*). Another 10-15% of patients with primary hyperparathyroidism have abnormalities in multiple glands. (*TR 8/24/17(AM), p. 93:1-12*). Even a smaller percentage of patients have either abnormally located glands or extra glands. (*TR 8/22/17(PM), pp. 17:24-18:8*); *TR 8/24/17(PM), p. 116:1-11)*.

When he met with Dr. Fox, Plaintiff complained of worsening fatigue, slowed thinking, constipation, weight gain, frequent urination, irritability, and muscle aches. (*TR 8/24/17(PM), pp. 15:24-17:5*). Before seeing Dr. Fox, Plaintiff

had undergone a Sestamibi scan on January 27, 2014, which showed no evidence of parathyroid adenoma. (*TR 8/23/17(PM), pp. 8:6-9:11; TR 8/24/17(PM), pp. 3:22-7:16, EX. Q-004, p.765, admitted TR 8/24/17(PM), p. 3:9-17*). Plaintiff's endocrinologist performed an ultrasound on May 19, 2014 and his report suggested it showed a suspected right neck cervical lymph node. (*TR 8/24/17(PM), pp. 9:14-14:16*). During their first visit, Dr. Fox performed an ultrasound of Plaintiff which suggested a possible abnormal parathyroid gland on the right side of Plaintiff's neck. (*TR 8/24/17(PM), pp. 23:22-24, 24:20-25:13*).

Dr. Fox testified that, in his clinical judgment, the preoperative workup of Plaintiff was consistent with multi-gland disease. (*TR 8/24/17(PM), p. 80:17-18*). Dr. Fox recommended a four-gland surgical exploration with either a single gland or multi-gland parathyroid excision depending on the operative findings because neither the Sestamibi scan nor the pre-op ultrasounds convincingly disclosed a localized adenoma. (*TR 8/23/17(PM), pp. 19:10-20:1; TR 8/24/17(PM), pp. 21:20-22:21, 35:3-37:7*). On multiple occasions, Dr. Fox discussed the risks and benefits of parathyroidectomy with Plaintiff and his family, including persistent or recurrent hyperparathyroidism, post-operative hypoparathyroidism, failure to identify gland, and additional surgery. (*TR 8/24/17(PM), pp. 23:22-23:21, 36:17-23, 41:2-43:4, EX 1, p. 41*). Plaintiff consented to the surgery. (*EX 1, p. 41, TR*

8/24/17(PM), p. 43:9-12).

On June 27, 2014, Dr. Fox performed parathyroid exploration surgery. (*EX 1, pp. 44-45*). During surgery, Dr. Fox visualized each of Plaintiff's four parathyroid glands. (*Id.; TR 8/24/17(PM), pp. 44:17-48:9*). He began by examining the parathyroid gland in Plaintiff's right lower neck, where he suspected an abnormality based upon the ultrasound. (*TR 8/24/17(PM), p. 45:14-20*). He visualized that gland and determined that it was clinically enlarged and abnormal appearing. (*TR 8/24/17(PM), pp. 45:14-46:6*). Specifically, it was approximately one centimeter in size, firm, round, rubbery, and dark. (*TR 8/24/17(PM), p. 46:7-14*). Dr. Fox, consistent with his preoperative ultrasound findings, removed that parathyroid gland. (*TR 8/24/17(PM), pp. 45:21-46:6*).

Dr. Fox then continued his exploration. (*TR 8/24/17(PM), pp. 46:15-48:9*). He determined that Plaintiff's upper right parathyroid gland was normal in appearance. (*TR 8/24/17(PM), p. 47:4-9*). Dr. Fox then looked at the left side of Plaintiff's neck, determining that both parathyroid glands on the left side were abnormal in appearance because they were enlarged, rubbery, and dark. (*TR 8/24/17(PM), p. 46:10-18*). Accordingly, Dr. Fox took biopsies of those parathyroid glands. (*TR 8/24/17(PM), pp. 47:23-48:9*).

After removing Plaintiff's lower right parathyroid gland and taking the

biopsies of the left parathyroid glands, Dr. Fox assessed Plaintiff's PTH level and compared it to his pre-operative level at various intervals to determine whether the lower right gland was responsible for the abnormal PTH readings. (*TR 8/24/17(PM), pp. 48:17-50:10*). Plaintiff's pre-operative PTH reading was 87.7, and the target PTH level, after removal of the lower right gland, was 45. (*TR 8/24/17(PM), pp. 49:3-17, 49:24-50:10*). Plaintiff's PTH reading ten minutes after the gland was removed was 133.7. (*TR 8/24/17(PM), p. 50:11-22*). This reading indicated that Dr. Fox had manipulated an overactive or hyperfunctioning gland. (*TR 8/24/17(PM), pp. 50:23-51:10*). Dr. Fox testified he would not expect the PTH level to increase if he removed a normal parathyroid gland. (*TR 8/24/17(PM), p. 51:11-18*).

Plaintiff's PTH reading fifteen minutes after the right gland was removed was 132.6. (*TR 8/24/17(PM), p. 51:19-23*). Twenty minutes after the right gland was removed, Plaintiff's reading was 139.3. (*TR 8/24/17(PM), p. 53:14-17*). Dr. Fox explained that these continued elevated readings indicated that Plaintiff still had overactive or hyperfunctional parathyroid glands. (*TR 8/24/17(PM), pp. 54:21-55:13*). Indeed, manipulating normal parathyroid glands would "[a]bsolutely not" raise Plaintiff's PTH level. (*TR 8/24/17(PM), p. 55:14-16*). Thus, the readings suggested Plaintiff had multi-gland disease. (*TR 8/24/17(PM),*

pp. 51:24-53:7, 53:18-54:5).

Dr. Fox also discussed the case intraoperatively with the pathologist, Dr. Howland. (*TR 8/24/17(PM), p. 54:6-20*). They discussed the fact that all three parathyroid glands were large—including one that was three times the normal size—and possibly hypercellular. (*TR 8/24/17(PM), p. 91:5-12*). Dr. Howland informed Dr. Fox that the biopsies "showed probable hypercellular right lower pole tissue with a paucity of fat. The left-sided glands were possibly hypercellular with slightly more fatty tissue than the contralateral side." (*TR 8/24/17(PM), p. 57:16-20; TR 8/22/17(PM), pp. 71:23-74:24*). Given the operative findings, Dr. Fox elected to perform a subtotal parathyroidectomy, a standard treatment for multi-gland hyperparathyroidism, which involved the removal of Plaintiff's left parathyroid glands, but left his normal-appearing upper right parathyroid gland in place. (*TR 8/24/17(PM), pp. 89:22-93:17*). Based on post-operative pathology, Dr. Fox opined that the glands he removed were "extremely heavy," which supported the decision to perform a multi-gland resection. (*TR 8/24/17(PM), pp. 94:4-96:16*).

Plaintiff suggests that "all parathyroids removed from Mr. Deland were pathologically/histologically normal." (*Opening Brief, p. 5*). However, there was conflicting evidence on the significance of the pathology findings. Dr. Fox

testified the statement in the pathology report that Plaintiff's parathyroid glands were "normal cellular" did not mean they functioned normally. (*TR 8/24/17(AM), p. 80:14-16; TR 8/24/17(PM), p. 98:14-25; TR 8/25/17 p. 94:13-18*). He explained:

> So histology – what a gland looks like histologically or morphologically doesn't necessarily correlate to what the gland is producing or what it's overproducing. It's just a visual look and one element of the case.
>
> The functionality, it's the parathyroid hormone level that actually measures the gland capacity. How much it's secreting or over-secreting. So they are measuring two different aspects of the parathyroid gland.

(*TR 8/25/17, pp. 113:5-114:14*).

Plaintiff further asserts that "[w]hether a gland is adenomatous or hyperplastic is a pathologic diagnosis." (*Opening Brief, p. 13*). Again, however, the evidence on this issue was conflicting. Dr. Fox presented evidence that pathology was only a "piece of the puzzle" in determining whether a parathyroid gland was abnormal. (*TR 8/23/17(PM), pp. 22:7-17, 25:10-26:3*). Indeed, the pathology report specifically stated "[c]linical correlation is recommended." (*EX 1, p. 47*). Dr. Fox denied that the three parathyroid glands he removed were normally functioning. (*TR 8/24/17(AM), p. 80:11-13*; *TR 8/24/17(PM), p. 43:5-8*). He explained that "cellularity is by no means directly correlated with parathyroid

or hormone production." (*TR 8/25/17, p. 122:9-13*). He testified the fact a pathologist determined that a parathyroid gland was "normal cellular" did not mean it was normally functioning because "frozen sectioning in pathology **has no way of determining functionality of a gland**…." (*TR 8/24/17(PM), p. 58:1-21* (emphasis added)). He further testified that frozen sections are only the "gold standard" for confirming the type of tissue, i.e. parathyroid. (*TR 8/24/17(PM), p. 116:12-17*). And there was evidence that frozen sectioning considers only a sliver of the parathyroid, may contain artifact, and is rushed. (*TR 8/23/17(PM), p. 24:2-18*).

Dr. Fox testified the glands he removed "were not normal appearing by any means." (*TR 8/24/17(PM), p. 99:4-23*). For one thing, a normal parathyroid gland would not show up on ultrasound, (*TR 8/24/17(PM), pp. 33:20-34:4*), yet it is undisputed Plaintiff's did. (*Opening Brief, p. 2*). Additionally, even the pathology findings indicated the removed parathyroid glands "were completely out of the normal range" because they each weighed far more than a typical parathyroid gland and because Plaintiff's post-operative PTH reading was back down to 83, approximately where it was before surgery. (*TR 8/24/17(PM), p. 99:4-23*).

Ultimately, Plaintiff's PTH levels did not drop even following the subtotal resection of parathyroid glands. (*TR 8/24/17(PM), pp. 97:10-98:13*). This

indicated that Plaintiff might have a fifth parathyroid gland, an aberrant anatomy that exists among only 5% of the population. (*TR 8/24/17(PM), pp. 97:10-98:13, 99:24-100:9; TR 8/22/17(PM), pp. 17:24-18:8*). Accordingly, Dr. Fox ordered a post-operative 4-D CT scan of Plaintiff's neck, which was interpreted as normal. (*TR 8/24/17(PM), pp. 100:10-101:15*). Further correlation with additional ultrasound revealed a suspected abnormal fifth parathyroid gland behind Plaintiff's carotid artery. (*TR 8/24/17(AM), pp. 96:13-97:10; TR 8/24/17(PM), pp. 101:15-103:12*). This gland was not detected by the pre-operative ultrasound due to the spatial limitations of that examination. (*TR 8/24/17(PM), p. 111:11-24*). Another physician later removed the abnormal fifth parathyroid gland on March 11, 2015. (*TR 8/24/17(PM), pp. 111:25-112:24*).

Dr. Fox's care of Plaintiff was reasonable and appropriate and his care did not cause Plaintiff's claimed injuries. (*TR 8/23/17(PM), pp. 7:4-9, 37:20-38:10; TR 8/24/17(PM), pp. 119:25-120:6; TR 8/25/17, p. 100:17-22*). Based on the pre-operative and clinical findings during surgery, Dr. Fox's decision to remove three of Plaintiff's parathyroid glands was reasonable. (*TR 8/23/17(PM), pp. 19:23-20:9*). Expert surgeon Dr. William Haun testified that, given Plaintiff's post-operative lab values, he would not expect Plaintiff to suffer any long-term symptoms. (*TR 8/23/17(PM), pp. 35:22-37:9*). And, because Plaintiff had multi-

gland disease, even if Dr. Fox had discovered and removed Plaintiff's fifth abnormal parathyroid gland alone, it would not have cured Plaintiff's hyperparathyroidism. (*TR 8/24/17(AM), pp. 96:13-97:4, TR 8/24/17(PM), p. 119:3-16*).

III. COURSE OF PROCEEDINGS

A. Lawsuit

On June 27, 2016, Plaintiff filed a malpractice suit against Dr. Fox, asserting that his surgery was inappropriate. (*CF, pp. 1-5*). The parties had competing theories regarding Plaintiff's condition and Dr. Fox's treatment. Plaintiff's theory was that this was a simple case of single gland disease caused by an adenoma behind his right carotid artery that Dr. Fox did not remove. (*CF, pp. 2-3, ¶¶10, 12-13, 18, p. 434, ¶5; TR 8/25/17, pp. 141:23-142:18; Opening Brief, p. 21*). Consequently, Plaintiff asserted that Dr. Fox had inappropriately removed three normal parathyroid glands. (*CF, pp. 2-3, ¶¶10, 12-13, 18*). On the other hand, Dr. Fox consistently maintained that Plaintiff's disease was a complex case of supernumerary disease (5 glands) with multi-gland hyperparathyroidism. (*CF, p. 434, ¶5*).

During his deposition, Dr. Fox testified that, in his clinical judgment, the preoperative workup of Plaintiff, including the preoperative ultrasound finding of a

right neck abnormality which was not present in Plaintiff's Sestamibi scan, was suspicious for multi-gland disease. (*CF, pp. 339 at 26:22-27:22, 340 at 30:14-31:14, 342-343 at 41:23-43:7*). He explained, "frequently when a [S]estamibi scan is normal," it can indicate "a higher incidence they may have multi-gland disease." (*CF, p. 339 at 27:17-22*).

Dr. Fox also testified in his deposition that, based on his intraoperative examination of Plaintiff's parathyroid glands, three were abnormal by appearance, size, and weight, a finding consistent with multi-gland hyperparathyroidism. (*CF, pp. 339 at 27:1-11, 341 at 34:12-35:5*). Dr. Fox explained:

> And in my clinical examination, as I was examining the patient, I had identified four glands … with certainty. **Three of them looked physically abnormal. They were not soft, flat, yellow-brown glands. They were firm. They didn't have the normal shape or color to them.** And so the clinical context was that … the one is probably hypercellular, the other two looked possibly hypercellular, and my clinical, you know, realtime game-decision … it fits the story for multi-gland hyperplasia.
>
> ***
>
> If you look at the weights of all the glands, they all weigh more than normal, albeit some had a little piece of fat or some had a little thyroid. **If you add it all up and you take into account that all four glands in an adult male should weigh approximately 120 milligrams, three out of those glands all together weighed much more than that, and even if you subtract some of the added … amounts of tissue in them.**

(*CF, pp. 339 at 27:1-11, 341 at 34:23-35:5*) (emphasis added).

He further testified that Plaintiff's elevated intraoperative PTH levels, which did not decrease, were also consistent with multi-gland disease. (*CF, p. 340 at 30:14-31:14*). He explained:

> **I sent off intraoperative parathyroid hormone numbers, which you were mentioning before over here.**
>
> ***
>
> And when I had my discussion with the pathologist that the one was probably hypercellular, the other two were possibly hypercellular, and **my [PTH] numbers didn't decrease**, that was the game-time decision, is this multi-gland disease, and at that point, based upon my experience, and my clinical judgment … this is a case of multi-gland disease. It was part of the working suspicion before we started, the intraoperative findings correlated with it, the pathology findings correlated with it, and **my intraoperative parathyroid hormone levels did not drop by taking out the one most abnormal of those three.**

(CF, *p. 340 at 30:24-31:14* (emphasis added)).

B. Expert Disclosures

Following his deposition, on May 17, 2017, Dr. Fox was properly endorsed as a non-retained expert pursuant to C.R.C.P. 26(a)(2)(B)(II). (*CF, pp. 325-326*). His endorsement states:

> Dr. Fox is the defendant in this case. His deposition was taken on April 28, 2017 and is hereby incorporated into this disclosure. Dr. Fox will also explain his and other entries in the medical chart as well as his interaction with Robert Deland as well as the other medical care providers and family members. Dr. Fox will explain the reasons for his actions as well as the custom and habit of a surgeon caring for a patient such as Mr. Deland under all the circumstances of this case. Dr. Fox will explain why he believes his actions in caring for Mr.

Deland was prospectively reasonable and not negligent.

(*CF, pp. 325-326*).[1]

Dr. Fox also endorsed expert witness Dr. William Haun to testify that:

> Plaintiff's expert also claims Dr. Fox removed 3 normocellular parathyroid glands and left the patient hyperparathyoid with an even higher PTH level than any previously documented preoperative PTH level. This is not an unusual intraoperative occurrence secondary to the manipulation and trauma during removal of an enlarged parathyroid gland(s). Following this Dr. Fox assumed the patient had multiglandular hyperparathyroidism and made the decision to remove the other 2 "abnormal" glands based on his intraoperative visual inspection and his verbal discussion with the pathologist that the left upper and lower parathyroid glands were "possibly" hypercellular.

(*CF, p. 328*).

C. Trial

Plaintiff's malpractice claim against Dr. Fox went to trial beginning on August 21, 2017. On the afternoon of the fourth day of trial, Dr. Fox was asked: "Is an abnormal gland, is that a clinical diagnosis or a pathological diagnosis?" (*TR 8/24/17(PM), p. 59:2-3*). He responded as follows:

> An abnormal gland can have both aspects. The visual is the first part of it because in order to get the gland to the lab, we suspect something in the first place. And then we have the laboratory part to identify what is the tissue type. And then we have the clinical correlation that goes with it. What is the functional capacity of those glands, despite what they look like under the microscope, and what are they doing to

[1] Plaintiff has never argued that the reference to Dr. Fox's deposition testimony in his endorsement was inappropriate.

> the patient, most importantly.
>
> And just to expand on the pathologist, what we are engrained to understand is that with all of our tests there's a limit on any test we do, whether it's imaging studies or lab studies, it's all how we apply it to the clinical scenario. But what we are all engrained, and Dr. Haun also talked about yesterday, is most importantly, can the pathologist confirm parathyroid tissue. We know the complete limits on the frozen section.

(*TR 8/24/17(PM), p. 59:4-21*).

In response to Dr. Fox's testimony, Plaintiff's counsel asked to approach the bench and stated:

> Judge, I have been giving Dr. Fox a fair amount of leeway, but he's not endorsed to say any of this stuff. This is the first time anybody has ever suggested that there can be a hyperfunctioning normal pathological parathyroid gland. Dr. Haun was not endorsed to testify to that. Dr. Fox is not endorsed to testify to that. Dr. Fox didn't testify to that in his deposition. And Dr. Fox provided no expert witness report. He was just endorsed as an expert to testify concerning his treatment in the case. So **I would ask that <u>any further testimony</u> concerning this be stricken**.

(*TR 8/24/17(PM), p. 60:1-11* (emphasis added)). After a lengthy colloquy, the court sustained Plaintiff's objection. (*TR 8/24/17(PM), pp. 60:12-67:3*).

Subsequently, Dr. Fox was asked, "Doctor, can you diagram that for the jury about all the different decision points that creates your medical judgment in a surgery like this?" (*TR 8/24/17(PM), pp. 67:25-68:2*). In response, Plaintiff's counsel again approached the bench, and stated: "We should make it clear to the

doctor that his diagrams should not include his opinion that stimulating what he believed to be the visually abnormal glands caused the PTH to rise because that's the subject of my previous objection." (*TR 8/24/17(PM), p. 68:14-18*). After excusing the jury, the court asked Plaintiff's counsel to state his objection again, and Plaintiff's counsel stated:

> My objection is lack of disclosure, lack of endorsement of Dr. Fox as a witness to testify that manipulating a visually abnormal gland would cause PTH levels to rise. That's not been endorsed, it was not testified to in his deposition, and it shouldn't be part of this trial.
>
> ***
>
> Dr. Fox is going to be drawing a diagram that describes his analysis in the case, and I am fearful that he is going to go into this notion that manipulating a pathologically normal gland that looks visually abnormal is what causes parathormone levels to rise when that is something that has never been endorsed and is trial by ambush.

(*TR 8/24/17(PM), p. 72:2-18*).

After an extended colloquy, the court asked for clarification, stating:

> Mr. Paulsen, I may not, then, have understood your argument correctly. So I want you to correct me if I'm wrong here. I understood the argument to be that you felt that Dr. Fox, the defendant, had not disclosed that the manipulation of the pathologically normal but visually appearing abnormal gland caused an increase in the PTH level versus the removal of the pathologically normal but visually appearing abnormal gland.

(*TR 8/24/17(PM), p. 85:8-16*). Plaintiff's counsel responded: "They're the same thing. The removal of the gland occurs at the same time that the manipulation of

the gland does." (*TR 8/24/17(PM), p. 85:17-19*). Given this clarification, the court overruled the objection, stating "there's sufficient evidence in the deposition based on the portions that Mr. Robinson pointed to in order to support that it was disclosed." (*TR 8/24/17(PM), p. 86:5-9*).

Ultimately, after considering all of the evidence, the jury found in favor of Dr. Fox and against Plaintiff. (*CF, pp. 220, 306-307*). It found that Dr. Fox was not negligent and did not cause Plaintiff's alleged damages. (*CF, p. 306*). The court entered judgment on the jury verdict. (*CF, p. 572*).

D. Plaintiff's Motion for a New Trial

On September 7, 2017, Plaintiff filed a motion for a new trial arguing that the court improperly allowed Dr. Fox to testify to the previously undisclosed opinion that "pathologically normal parathyroid glands which look abnormal can be 'high secretors.'" (*CF, p. 311*). In a detailed written order, the district court denied Plaintiff's motion. (*CF, pp. 553-557*).

The court found that Plaintiff initially objected to evidence "that histologically normal parathyroid glands which appear to be abnormal to the surgeon can be 'hyper secretors' or secrete excess levels of parathormone." (*CF, p. 555*). However, after the court asked Plaintiff to clarify his objection, Plaintiff objected to testimony that "'manipulating a pathologically normal gland that

appears to … to be abnormal would cause PTH levels to rise.'" (*CF, p. 555*). It further noted that "[t]he majority of Plaintiff's Motion seeks to identify and clarify the objection Plaintiff made at trial and why the objection should have been sustained by the Court." (*CF, p. 556*). The court noted that it had heard lengthy argument from counsel concerning Plaintiff's objection and, after considering those arguments, "the Court found Defendant's deposition testimony contained sufficient evidence to support a finding that Defendant's trial testimony was disclosed." (*CF, pp. 556-557*). Because Plaintiff merely sought to re-litigate an issue that the court had already decided, the court denied Plaintiff's motion. (*CF, p. 557*). The court found "there was sufficient disclosure, … the testimony did not amount to surprise; and was not newly discovered material evidence that Plaintiff could not have discovered with reasonable diligence." (*CF, p. 557*).

SUMMARY OF THE ARGUMENT

The district court correctly overruled Plaintiff's objection to Dr. Fox's testimony. First, Plaintiff permitted both Dr. Haun and Dr. Fox to testify at length concerning Plaintiff's intraoperative PTH levels before making any objection. Even then, per his clarification, Plaintiff objected to further testimony that *manipulating* pathologically normal parathyroid glands can cause them to secrete excess PTH. Because Plaintiff did not object to all testimony concerning his

intraoperative PTH levels, and has not specifically identified any objectionable testimony that was elicited after he objected, he failed to preserve his objection for appeal.

Second, Plaintiff's argument is based on an inaccurate characterization of Dr. Fox's testimony. Dr. Fox did not testify that he elected to remove Plaintiff's left side parathyroid glands because, though pathologically normal, they were "hyper secretors." To the contrary, he opined that he removed Plaintiff's left sided parathyroid glands because Plaintiff had multi-gland parathyroid disease, based on: 1) Dr. Fox's pre-operative workup; 2) Dr. Fox's clinical findings during surgery including the abnormal appearance, size, and weight of his parathyroid glands; 3) the fact that Plaintiff's PTH readings increased after Dr. Fox removed his abnormal right parathyroid gland and did not subsequently decrease; and 4) the pathologist's statement that Plaintiff's left parathyroid glands were possibly hypercellular. Indeed, Plaintiff's brief does not identify any trial testimony by Dr. Fox that he removed Plaintiff's left sided parathyroid glands because, though pathologically normal, they were "hyper secretors." Because Dr. Fox did not actually testify that pathologically normal parathyroid glands can be "hyper secretors," the Court did not err in overruling Plaintiff's objection.

Third, assuming Plaintiff is actually arguing that he objected to Dr. Fox's

testimony that he removed Plaintiff's left-sided parathyroid glands in part based upon Plaintiff's elevated intraoperative PTH levels, Dr. Fox's opinions were not a new theory. To the contrary, Dr. Fox's operative report, medical records, and deposition testimony all made clear that he based his determination that Plaintiff was suffering from multi-gland parathyroid disease, which provided the basis for his decision to remove Plaintiff's left parathyroid glands, in part on Plaintiff's elevated intraoperative PTH readings. Because Dr. Fox's expert disclosure incorporated the opinions in his medical chart and his deposition, Dr. Fox's opinions concerning Plaintiff's intraoperative PTH levels were properly disclosed and the district court appropriately admitted them.

Fourth, assuming *arguendo* that any of Dr. Fox's opinions concerning Plaintiff's intraoperative PTH levels were not properly disclosed, the district court did not err in declining to exclude those opinions because they did not cause Plaintiff harm or prevent him from having a reasonable opportunity to respond to the evidence. To the contrary, Plaintiff allowed substantial testimony by both Dr. Haun and Dr. Fox concerning Plaintiff's intraoperative PTH levels before objecting, and any testimony occurring after the objection was harmless because it was cumulative of testimony that was already admitted. Additionally, Plaintiff has not identified any specific allegedly objectionable testimony admitted after his

objection. Plaintiff was not deprived of an opportunity to respond to any of Dr. Fox's testimony because his expert testified that Plaintiff's intraoperative PTH levels actually demonstrated that Dr. Fox removed the wrong parathyroid gland and breached the standard of care. The trial court also gave Plaintiff an opportunity to present rebuttal testimony, but Plaintiff chose not to.

Fifth, to the extent that the district court erroneously admitted Dr. Fox's opinions, any error was harmless. Dr. Fox's expert, Dr. Haun, testified without objection that Dr. Fox did not deviate from the standard of care and did not cause Plaintiff's injury. Plaintiff also did not object to most of Dr. Fox's testimony. Because there was sufficient evidence independent of the allegedly improper testimony by Dr. Fox to support the verdict, this Court should affirm the judgment.

ARGUMENT

I. THE DISTRICT COURT CORRECTLY ADMITTED DR. FOX'S TESTIMONY CONCERNING PLAINTIFF'S INTRAOPERATIVE PTH LEVELS.

Plaintiff argues that the district court erred because, under C.R.C.P. 37(c), it should have precluded Dr. Fox from testifying to the allegedly undisclosed theory that he removed Plaintiff's left-sided parathyroid glands because those glands, although pathologically normal, could "be hyper secretors and therefore he had to exercise his medical judgment and remove those hyper secretors…." (*Opening*

Brief, p. 19). This argument fails.

A. Preservation.

Plaintiff did not preserve his objection to testimony that "pathologically normal parathyroid glands can be hyper secretors and therefore he had to exercise his medical judgment to remove those hyper secretors," (*Opening Brief, p. 16*), for multiple reasons. First, "[i]n order to properly preserve an objection to evidence admitted at trial, a timely and specific objection must appear in the trial court record." *Am. Family Mut. Ins. Co. v. DeWitt*, 218 P.3d 318, 325 (Colo. 2009); *see also* C.R.E. 103(a)(1). A court need not consider allegations of error in the admission of evidence where no timely and specific objection is made in the trial court. *Hancock v. State, Dep't of Revenue, Motor Vehicle Div.*, 758 P.2d 1372, 1376 (Colo. 1988). Before Plaintiff objected, Dr. Fox testified at length that Plaintiff's intraoperative PTH levels were elevated and did not decrease as expected, and that he believed, in part based on these readings, that Plaintiff had multi-gland disease. (*TR 8/24/17(AM), pp. 80:11-21, 96:13-20; TR 8/24/17(PM), pp. 43:5-8, 44:17-48:9, 48:17-55:16, 58:4-59:1, 59:2-21*). Plaintiff did not object to, or move to strike, this testimony when he subsequently made his objection. Plaintiff only objected to any *further* testimony that pathologically normal parathyroid glands could be "hyper secretors." (*TR 8/24/17(PM), p. 60:1-11*).

Consequently, Plaintiff did not preserve this issue for appeal.

Second, Plaintiff's objection was to different evidence than the evidence he challenges on appeal. While Plaintiff initially objected to testimony "that there can be a hyperfunctioning normal pathological parathyroid gland," (*TR 8/24/17(PM), p. 60:1-11*), he subsequently clarified that he was objecting to testimony "that **manipulating** a visually abnormal gland would cause PTH levels to rise." (*TR 8/24/17(PM) p. 72:2-18* (emphasis added)). This is the objection the trial court overruled. (*TR 8/24/17(PM), p. 86:5-9*). Given Plaintiff's clarification, Plaintiff did not specifically or timely object to evidence that pathologically normal parathyroid glands could be "hyper secretors" or to Dr. Fox's testimony that Plaintiff's elevated PTH readings indicated he had multi-gland parathyroid disease. Because Plaintiff objected to different evidence, he did not preserve the issue of whether the trial court properly admitted evidence that pathologically normal parathyroid glands could be "hyper secretors," (*Opening Brief, p. 16*), for appeal. *DeWitt*, 218 P.3d at 325.

Third, as Plaintiff acknowledges, the trial court initially sustained Plaintiff's objection but subsequently changed its ruling. (*Opening Brief, p. 14*). Where "the court changes its initial ruling," a party must object "when the evidence is offered to preserve the claim of error for appeal." *United States v. Fonseca*, 744 F.3d 674,

683–84 (10th Cir. 2014). This is because "[t]he error, if any, in such a situation occurs only when the evidence is offered and admitted." *Id*. Here, Plaintiff has failed to identify any portion of the record after the trial court's ruling where Plaintiff objected to testimony by Dr. Fox that pathologically normal parathyroid glands could be hyper secretors. Because Plaintiff did not contemporaneously object to such evidence *after* the trial court changed its ruling, he failed to preserve this issue for appeal. *Fonseca*, 744 F.3d at 683–84; *DeWitt*, 218 P.3d at 325 (timely objection necessary to preserve issue).

Fourth, "[t]o preserve an evidentiary error, a party must have made a specific, timely objection or motion to strike, before or during trial." *People v. Butler*, 224 P.3d 380, 386 (Colo. App. 2009). Such an objection must be made contemporaneously with the court's ruling to "alert the trial court that an error may have been made" and to provide "the judge with an opportunity to immediately correct any erroneous rulings." *Blades v. DaFoe*, 704 P.2d 317, 322-23 (Colo. 1985), *overruled on other grounds by Laura A. Newman, LLC v. Roberts*, 2016 CO 9, ¶ 26. "[F]ailure to object to proffered evidence at trial constitutes a waiver of the objection, and such objection may not thereafter be raised on appeal." *People v. Lucero*, 724 P.2d 1374, 1376 (Colo. App. 1986). Given the foregoing authority, Plaintiff's post-trial motion for a new trial was not sufficient to preserve an

evidentiary objection because Plaintiff did not object to evidence that pathologically normal parathyroid glands could be "hyper secretors" during trial or give the trial court an opportunity to correct its alleged error before the close of the evidence. Consequently, Plaintiff failed to preserve this issue.

B. Standard of Review.

Dr. Fox agrees the trial court's decision to overrule Plaintiff's objection to Dr. Fox's testimony is reviewed for abuse of discretion. (*Opening Brief, p. 16*); *see also Alhilo v. Kliem*, 2016 COA 142, ¶ 8 ("Evidentiary rulings are reviewed for an abuse of discretion."); *Clements v. Davies*, 217 P.3d 912, 915 (Colo. App. 2009) (trial court's ruling on a request for "sanctions under C.R.C.P. 37" is reviewed "for abuse of discretion."). A court abuses its discretion if its "decision is manifestly arbitrary, unreasonable, or unfair" or if it "applies the incorrect legal standards…." *Jackson v. Unocal Corp.*, 262 P.3d 874, 880 (Colo. 2011).

C. Dr. Fox Did Not Testify he Removed Plaintiff's Parathyroid Glands Because they were "Hyper Secretors."

Plaintiff inaccurately or incompletely characterizes Dr. Fox's trial testimony and the defense theory. Dr. Fox did not testify that he removed Plaintiff's left-sided parathyroid glands because they were "hyper secretors." In fact, Dr. Fox never used the word "hyper secretor." Instead, Dr. Fox testified that he removed Plaintiff's left-side parathyroid glands because he determined that Plaintiff had

multi-gland disease based upon his preoperative examination, and the clinical findings during surgery, including: (1) their abnormal size, weight, and appearance; (2) Plaintiff's increased PTH levels during surgery; and (3) the pathologist's report that the biopsies of Plaintiff's left-side parathyroid glands were possibly hypercellular. (*TR 8/24/17(PM), pp. 46:10-18, 48:17-53:7, 53:14-54:5, 54:21-55:16, 57:16-20, 71:23-74:24. 91:5-12*). Because Dr. Fox did not testify that Plaintiff's left-side parathyroid glands were "hyper secretors," or that he removed them for that reason alone, the district court did not abuse its discretion in admitting Dr. Fox's testimony or overruling Plaintiff's objection.

D. Dr. Fox's Testimony Regarding Plaintiff's Intraoperative PTH Levels was Properly Disclosed.

To the extent Plaintiff asserts that his objection to testimony that his parathyroid glands were "hyper secretors" was meant to include testimony regarding Plaintiff's increased intraoperative PTH levels, the district court did not abuse its discretion in admitting Dr. Fox's opinions because they were properly disclosed before trial.

C.R.C.P. 26(a)(2)(B)(II) governs the disclosure of non-retained expert witnesses. It provides that the party disclosing a non-retained expert must disclose a written statement or report containing "a complete description of all opinions to be expressed and the basis and reasons therefor." C.R.C.P. 26(a)(2)(B)(II)(a).

C.R.C.P. 26(e) further provides:

> If a party intends to offer expert testimony on direct examination that has not been disclosed pursuant to section (a)(2)(B) of this Rule on the basis that the expert provided the information through a deposition, the report or statement previously provided shall be supplemented to include a specific description of the deposition testimony relied on. Nothing in this section requires the court to permit an expert to testify as to opinions other than those disclosed in detail in the initial expert report or statement except that **if the opinions and bases and reasons therefor are disclosed during the deposition of the expert by the adverse party, the court must permit the testimony at trial unless the court finds that the opposing party has been unfairly prejudiced by the failure to make disclosure in the initial expert report**.

C.R.C.P. 26(e) (emphasis added).

C.R.C.P. 37(c) creates an enforcement mechanism for the disclosure obligations contained in C.R.C.P. 26. *Catholic Health Initiatives Colorado v. Earl Swensson Assocs., Inc.*, 2017 CO 94, ¶ 11. It provides, in pertinent part:

> A party that without substantial justification fails to disclose information required by C.R.C.P. 26(a) or 26(e) shall not be permitted to present any evidence not so disclosed at trial or on a motion made pursuant to C.R.C.P. 56, unless such failure has not caused and will not cause significant harm, or such preclusion is disproportionate to that harm.

C.R.C.P. 37(c).

As the Supreme Court has explained, "Rule 37(c)(1)'s framework is flexible, not absolute, and the trial court has the discretion to fashion an appropriate sanction proportionate to any harm caused." *Catholic Health Initiatives*, 2017 CO

94, ¶ 11. C.R.C.P. 37(c) does not create an automatic rule of exclusion for evidence that is not properly disclosed. *Id*. at ¶¶12-14. Rather, the court must assess the harm, if any, attributable to the disclosure violation, as well as whether sanctions are proportional to that harm in determining whether sanctions should be imposed. *Id.* at ¶ 15.

Here, to the extent Plaintiff contends his objection encompassed Dr. Fox's testimony that he removed Plaintiff's left parathyroid glands in part because Plaintiff's intraoperative PTH levels did not decrease, that opinion was properly disclosed long before trial. Dr. Fox's operative report stated: "[p]reoperative PTH level was 70. Subsequent levels were 130. Failing to have seen a drop in levels, it was opted to proceed with a subtotal resection. The complete left upper and lower pole glands were removed." (*EX 1, p. 42*). Additionally, Dr. Fox's medical records contemporaneously documented Plaintiff's abnormal PTH levels following Dr. Fox's manipulation of his abnormal parathyroid glands, which specifically reflected that Plaintiff's pre-operative PTH level was 87, that ten minutes after manipulation it was 133.7, that fifteen minutes after manipulation it was 132.6 and that twenty minutes after manipulation it was 139.3. (*EX 1, pp. 68-71*).

In his deposition, Dr. Fox testified Plaintiff's PTH level should have dropped by fifty percent following the removal of Plaintiff's abnormal right

parathyroid. (*CF, p. 344 at 46:6-25*). He further testified in his deposition that Plaintiff's PTH levels indicated that Plaintiff had multi-gland disease, explaining:

> Q. You have frozen sections of the left lower and left upper node where the nomenclature is possibly hypercellular, and based on that information you removed those two nodes. Is that true?
>
> A. Let me give you a little more detail.
>
> Q. Okay.
>
> A. So we -- so visually three looked abnormal, one looked normal. We took out the one that was suspect, abnormal, based upon the prior ultrasounds, and I did a small incisional or a little small sample of the two left-sided glands. I sent off intraoperative parathyroid hormone numbers, which you were mentioning before over here.
>
> Q. Correct.
>
> A. And when I had my discussion with the pathologist that the one was probably hypercellular, the other two were possibly hypercellular, and my numbers didn't decrease, that was the game time decision, is this multi-gland disease, and at that point, based upon my experience and my clinical judgment at that point, this is a case of multi-gland disease. It was part of the working suspicion before we started, the intraoperative findings correlated with it, the pathology findings correlated with it, and my intraoperative parathyroid hormone levels did not drop by taking out the one most abnormal of the three.

(*CF. p. 340 at 30:14-31:14*).

Dr. Fox's expert disclosure clearly incorporated both his deposition and the entries in his medical chart, (*CF, pp. 325*), and Plaintiff has never objected to Dr.

Fox's disclosure on the grounds that the incorporation of his medical records or his deposition testimony was inadequate. Moreover, Dr. Fox's disclosures also state that Dr. Fox would "explain the reasons for his actions" and "why he believes his actions in caring for Mr. Deland was prospectively reasonable and not negligent." (*CF, pp. 325-326*). Consequently, Dr. Fox's testimony regarding PTH levels did not involve a new or previously undisclosed theory of defense and Plaintiff was well-aware of the substance of Dr. Fox's testimony as well as the defense theory concerning Plaintiff's intraoperative PTH readings before trial. Because Dr. Fox's testimony was properly disclosed, the district court did not abuse its discretion in declining to exclude Dr. Fox's opinions.

Plaintiff contends the pathologist, Dr. Howland, was not endorsed to testify that pathologically normal parathyroid glands can be "hyper secretors." (*Opening Brief, p. 20*). However, Dr. Howland did not testify to any opinions concerning Plaintiff's intraoperative PTH levels. (*TR 8/22/17(PM), pp. 75:6-76:14*). Because Dr. Fox's opinions were properly disclosed, Dr. Fox's alleged failure to include similar opinions in his disclosure of Dr. Howland provides no basis for excluding Dr. Fox's opinions.

Plaintiff similarly argues that Dr. Haun's endorsement does not disclose any opinions that pathologically normal parathyroid glands can be "hyper secretors."

(*Opening Brief, pp. 20-21*). However, Dr. Haun was specifically endorsed to testify that "manipulation and removal" of enlarged parathyroid glands was responsible for the documented elevation in Plaintiff's PTH readings. (*CF, p. 328*). He testified in his deposition that Plaintiff's PTH levels should have, but did not, drop following the removal of his abnormal right parathyroid gland and that Plaintiff's elevated PTH readings supported the clinical decision to remove his left parathyroid glands. (*CF, pp. 424 at 24:5-13, 425 at 47:21-48:17, 426 at 49:17-50:1, 427 at 55:23-56:12, 428 at 57:12-58:12*). He subsequently testified in trial **without objection** that Plaintiff's elevated PTH hormone levels likely resulted "from manipulation and trauma to that enlarged right lower parathyroid gland, perhaps even biopsying the two left sided parathyroid glands" and that Plaintiff's readings were consistent with "multiglandular disease." (*TR 8/23/17(PM), pp. 23:10-14, 23:17-19, 23:23-24:1*). Thus, Dr. Haun's disclosure, deposition testimony, and trial testimony, in combination with Dr. Fox's medical records and deposition testimony, placed Plaintiff on notice of the defense theory that Plaintiff's intraoperative PTH levels were consistent with multi-gland parathyroid disease and supported the removal of Plaintiff's left parathyroid glands.

Plaintiff suggests that Dr. Fox's testimony was improper because he conflated the concepts of "multi-glandular disease or four-gland hyperplasia and

pathologically normal parathyroid glands which are high secretors or hyper secretors." (*Opening Brief, p. 21*). Plaintiff argues: "[w]hile it is clearly true that multi-gland hyperplasia can secrete excess amounts of parathormone, Mr. Deland did not have four-gland hyperplasia. Mr. Deland had an adenoma behind his right carotid artery that Dr. Fox did not remove or even get close to according to Dr. Fox." (*Id.*). Plaintiff relies on a post-trial affidavit from his retained expert witness for the proposition that pathologically normal parathyroid glands cannot be "hyper secretors" "because they are not hyper cellular." (*Opening Brief, p. 22*).

Plaintiff is essentially asking this Court, under the guise of reviewing an evidentiary ruling, to resolve a disputed issue of fact in a manner contrary to the jury's verdict by holding that Dr. Fox's theory was impossible and, as a result, that Plaintiff had a single adenoma rather than multi-gland disease. (*Opening Brief, p. 21*). However, whether Plaintiff had multi-gland disease or a single adenoma was disputed at trial, Dr. Fox testified unequivocally that Plaintiff had multi-gland disease. (*TR 8/24/17(PM), pp. 51:24-53:7, 53:18-54:5, 80:17-18*). Plaintiff's request is inappropriate because Plaintiff already advanced this single adenoma theory at trial, (*TR 8/25/17, pp. 141:23-142:18*), and it was rejected by the jury which found in favor of Dr. Fox. (*CF, pp. 220, 306-307*).

The Court should reject Plaintiff's argument because it is required to view

the evidence in favor of the verdict, which was for Dr. Fox. *Ovation Plumbing, Inc. v. Furton*, 33 P.3d 1221, 1225 (Colo. App. 2001) ("An appellate court must evaluate the record in the light most favorable to the verdict, and every inference fairly deducible from the evidence should be drawn in favor of the verdict.") Additionally, this Court may not substitute itself as a factfinder by resolving this disputed factual issue. *People v. Mejia-Mendoza*, 965 P.2d 777, 780 (Colo. 1998) ("Appellate courts are not the appropriate forum to resolve factual discrepancies or to determine the credibility of witnesses."). Accordingly, Plaintiff's factual argument that he had a single gland adenoma rather than multi-gland disease does not provide a basis for reversing the district court's evidentiary ruling.

E. Any Alleged Undisclosed Opinions did not Harm Plaintiff.

The Court should also affirm the district court's rulings because even if Dr. Fox testified to opinions concerning Plaintiff's intraoperative PTH levels that were not disclosed, those opinions were not harmful to Plaintiff. Preclusion is not required if a disclosure violation is substantially justified or will not harm the Plaintiff. C.R.C.P. 37(c). "A trial court does not err in declining to impose sanctions for a discovery violation if the failure to disclose was harmless." *State ex rel. Coffman v. Robert J. Hopp & Assocs., LLC*, 2018 COA 69, ¶ 88. As the Supreme Court explained:

> In evaluating whether a failure to disclose evidence is harmless under Rule 37(c), the inquiry is not whether the new evidence is potentially harmful to the opposing side's case. Instead, the question is whether the failure to disclose the evidence in a timely fashion will prejudice the opposing party by denying that party an adequate opportunity to defend against the evidence.

Todd v. Bear Valley Village Apartments, 980 P.2d 973, 979 (Colo. 1999).

Colorado courts consider several factors[2] in determining whether a deficient disclosure is substantially justified or prejudicial, including:

> (1) the importance of the witness's testimony;
>
> (2) the explanation of the party for its failure to comply with the required disclosure;
>
> (3) the potential prejudice or surprise to the party against whom the testimony is offered that would arise from allowing the testimony;
>
> (4) the availability of a continuance to cure such prejudice;
>
> (5) the extent to which introducing such testimony would disrupt the trial; and
>
> (6) the non-disclosing party's bad faith or willfulness.

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[2] Plaintiff argues the Court should apply factors considered by federal courts, as articulated in *Jacobsen v. Deseret Book Company*, 287 F.3d 936, 953 (10th Cir. 2002). (*Opening Brief, pp. 17, 23-26*). However, this Court does "not consider arguments raised for the first time on appeal." *Meyer v. Haskett*, 251 P.3d 1287, 1293 (Colo. App. 2010). Instead, this Court reviews "only the specific arguments a party pursued before the district court." *Valentine v. Mountain States Mut. Cas. Co.*, 252 P.3d 1182, 1188 (Colo. App. 2011). Plaintiff never cited *Jacobsen* in support of his objection and never argued the *Jacobsen* factors supported the exclusion of Dr. Fox's testimony. (*TR 8/24/17(PM), pp. 60:1-86:9*). Consequently, Plaintiff's argument is not properly before the Court.

Todd, 980 P.2d at 978; *see also Catholic Health Initiatives*, 2017 CO 94, ¶ 15 (citing the *Todd* factors with approval after the 2015 amendment to C.R.C.P. 37(c)).

Here, even if Dr. Fox testified to undisclosed opinions concerning Plaintiff's intraoperative PTH levels, the district court was not required to exclude his testimony. First, Dr. Fox's explanation of why he believed Plaintiff had multi-gland disease was central to his defense and the intraoperative PTH levels were one of the several reasons why he removed Plaintiff's left-side parathyroid glands. Thus, Dr. Fox's testimony was undoubtedly important to his defense and to the jury's understanding of the reasons he removed Plaintiff's parathyroid glands. *Todd*, 980 P.2d at 978.

Second, Dr. Fox did not violate the disclosure requirements of C.R.C.P. 26(a)(2) because his disclosures, which incorporated his deposition testimony and medical chart, were sufficient to inform Plaintiff of the substance of his opinions concerning Plaintiff's intraoperative PTH levels and Plaintiff has not identified any objectionable testimony that was admitted after he made his objection. *Todd*, 980 P.2d at 978.

Third, Plaintiff was not prejudiced by Dr. Fox's allegedly undisclosed opinions. Before Plaintiff objected to those opinions, both Dr. Haun and Dr. Fox

testified regarding Plaintiff's elevated intraoperative PTH levels and specifically testified those readings were indicative of multi-gland disease. (*TR 8/23/17(PM), pp. 22:18-24:1*; *TR 8/24/17(AM), pp. 80:11-21, 96:13-20; TR 8/24/17(PM), pp. 43:5-8, 44:17-48:9, 48:17-55:16, 58:4-59:1, 59:2-21*). Any evidence admitted over Plaintiff's subsequent objection was cumulative of this evidence, which had already been admitted, and, therefore, was harmless. *Antolovich v. Brown Grp. Retail, Inc.*, 183 P.3d 582, 598 (Colo. App. 2007) (cumulative evidence is not prejudicial).

Plaintiff's Opening Brief does not identify any specific testimony "that pathologically normal parathyroid glands can be hyper secretors and therefore [Dr. Fox] had to exercise his medical judgment and remove those hyper secretors which were unequivocally pathologically normal," (*Opening Brief, p. 16*), elicited after his objection. Because Plaintiff only objected to "further" testimony, he cannot even establish that improper testimony was admitted, much less that he was unable to respond to that testimony. *People v. Wieghard*, 709 P.2d 81, 85 (Colo. App. 1985) (district court's ruling that Indiana convictions could be used to impeach the defendant's testimony was harmless where "defendant did not testify" and the "convictions were never improperly admitted into evidence.").

Dr. Fox's testimony was also harmless because Plaintiff presented expert

testimony responding to the defense theory concerning the intraoperative PTH levels. Plaintiff's expert testified the fact that Plaintiff's PTH levels increased following the removal of Plaintiff's right parathyroid gland indicated that Dr. Fox "did not cure the patient" and breached the standard of care. (*TR 8/22/17(AM), pp. 22:8-24:11*). The expert testified the fact that Plaintiff's elevated PTH levels did not decrease should have told Dr. Fox that he had not removed the gland that was producing extra PTH and should have caused him to go back and look at his imaging. (*TR 8/22/17(AM), pp. 24:12-28:9*). The expert testified that, had he done so, he could have removed Plaintiff's fifth parathyroid gland, which would have caused Plaintiff's PTH levels to stabilize. (*TR 8/22/17(AM), pp. 36:24-37:5*). Because Plaintiff presented testimony that the elevated intraoperative PTH levels were actually consistent with his single adenoma theory, he was able to defend against Dr. Fox's opinions and was not prejudiced. *Todd*, 980 P.2d at 979.

And, Plaintiff was specifically given the opportunity to present rebuttal testimony, (*TR 8/25/17, p. 132:1-3*), and could have called his retained expert to rebut testimony concerning Plaintiff's intraoperative PTH levels or to testify to the opinions in his post-trial affidavit. (*Opening Brief, p. 23; CF, pp. 320-321*). However, Plaintiff chose not to present rebuttal testimony. (*TR 8/25/17, p. 132:1-3*). Because Plaintiff had the opportunity to present rebuttal evidence in response

to Dr. Fox's allegedly "new" opinions, but chose not to, any error is harmless. *State v. Beckerman*, 85 A.3d 655, 668 (Conn. App. 2013) (error in admission of evidence is harmless where "defendant had the opportunity to present his own expert witness' testimony" in response, but chose not to do so); *Wesby v. State*, 535 N.E.2d 133, 137 (Ind. 1989) (improper admission of rebuttal testimony was "harmless where the defendant is given but declines the opportunity to present surrebuttal.").

Fourth, though Plaintiff now asserts he was unable to guard against Dr. Fox's alleged untimely disclosure, (*Opening Brief, p. 25*), Plaintiff did not request a continuance or any other measure to ameliorate the alleged prejudice he claims resulted from the introduction of Dr. Fox's opinions. (*TR 8/24/17(PM), pp. 60:1-67:3, 68:14-86:9*). Instead, Plaintiff made the strategic decision to continue on with the trial. "Courts have looked with disfavor upon parties who claim surprise and prejudice but who do not ask for a recess so they may attempt to counter the opponent's testimony." *Johnson v. H.K. Webster, Inc.*, 775 F.2d 1, 8 (1st Cir. 1985). Because Plaintiff could have, but did not seek a continuance, mistrial, or other similar remedy at the time the alleged disclosure violation occurred, his assertions of prejudice are insufficient to establish an abuse of discretion. *Tiller v. Baghdady*, 294 F.3d 277, 281 (1st Cir. 2002) ("the appropriate course for parties

who uncover discovery violations is 'not to seek reversal after an unfavorable verdict,' but to request a continuance 'at the time the surprise occurs,' (citation omitted)); *see also Averyt v. Wal-Mart Stores, Inc.*, 265 P.3d 456, 468 (Colo. 2011) (Marquez, J., concurring) (trial court erred in granting a new trial where party asserting surprise from disclosure violation "did not move for a mistrial, request a continuance, seek to have the testimony stricken, or otherwise request any immediate relief to mitigate any prejudice").

Fifth, Dr. Fox's testimony did not disrupt the trial. *Todd*, 980 P.2d at 978. Plaintiff asserts the alleged "disclosure violation occurred during the testimony of the last witness at trial." However, he does not explain how Dr. Fox's testimony disrupted the trial. *Todd*, 980 P.2d at 978. Although Plaintiff was given the opportunity to present rebuttal testimony, (*TR 8/25/17, p. 132:1-3*), he declined to call any rebuttal witness or request a mistrial.

Sixth, Plaintiff argues that Dr. Fox's conduct could support a finding of bad faith because medical literature does not support the proposition that "a pathologically histologically normal parathyroid gland [can be] a 'hyper secretor.'" (*Opening Brief, p. 26*). However, Dr. Fox did not actually say what Plaintiff claims, Plaintiff does not explain why any of Dr. Fox's opinions constituted "bad faith," and no court has ever made a finding of bad faith. *Todd*, 980 P.2d at 978.

Furthermore, Plaintiff's expert's suggestion in his post-trial affidavit that pathological examination is the "gold standard" by which a parathyroid gland's function is measured is contrary to the current medical literature, which states that surgeons are relying exclusively on intraoperative PTH monitoring rather than pathologic examination to determine the secretory function of glands. (*CF, pp. 412, 433-470*). Consequently, the admission of Dr. Fox's opinions was substantially justified or harmless and the district did not abuse its discretion in overruling Plaintiff's objection.

II. ANY ERROR IN ADMITTING DR. FOX'S TESTIMONY WAS HARMLESS.

Even assuming, *arguendo*, the district court abused its discretion in admitting Dr. Fox's testimony regarding intraoperative PTH readings, the Court should still affirm the judgment because, viewed in the context of the entire record, any error was harmless. Under Colorado law, "[t]he court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties." C.R.C.P. 61; C.A.R. 35(e). "This proposition is simply a recognition of the fact that minor mistakes inevitably occur in the course of a trial since a perfect trial is more often than not a virtual impossibility." *Banek v. Thomas*, 733 P.2d 1171, 1178 (Colo. 1986). "An error affects a substantial right when it can be said with fair assurance that the error

substantially influenced the outcome of the case or impaired the basic fairness of the trial itself." *Id.*

Here, the admission of Dr. Fox's allegedly undisclosed opinions did not influence the outcome of the case or impair the basic fairness of the trial because there was substantial evidence, independent of Dr. Fox's purportedly improper testimony, that supported the verdict. *Blecha v. People*, 962 P.2d 931, 944 (Colo. 1998) (error in admitting hearsay was harmless where independent evidence corroborated witness's account of murder); *People v. Blehm*, 791 P.2d 1177, 1179 (Colo. App. 1989) (alleged error in admitting similar transaction evidence was harmless where independent evidence overwhelmingly established the defendant's guilt). Plaintiff's own expert, Dr. Hardy, testified that Dr. Fox met the standard of care in many respects. He testified that Dr. Fox's informed consent discussion and preoperative care, including the ultrasound he performed, met or exceeded the standard of care. (*TR 8/22/17(AM), pp. 22:17-24, 72:21-73:25*). He also testified that Dr. Fox's surgical approach, monitoring of the intraoperative PTH levels, and removal of the right lower gland met the standard of care. (*TR 8/22/17(AM), pp. 74:1-5, 76:19-77:2, 81:22-82:3, 23:1-14*). Moreover, defense expert, Dr. Haun, without any objection, testified that Dr. Fox met the standard of care in all respects and that he did not cause Plaintiff's alleged injury. (*TR 8/23/17(PM), pp. 7:4-9,*

19:23-20:9, 35:22-37:9, 37:20-38:10). He testified that Dr. Fox proceeded in a logical manner in performing a four-gland exploration surgery. (*TR 8/23/17(PM), pp. 19:3-20:5).* He testified the PTH level increased significantly when Dr. Fox removed the right lower gland. (*TR 8/23/17(PM), pp. 23:5-24:1).* He explained the main purpose of the pathology examination was to determine whether the tissue being removed was parathyroid gland and the histologic findings must be correlated clinically. (*TR 8/23/17(PM), pp. 24:2-18, 25:10-26:3, 88:24-89:9*). He testified that based on the intraoperative PTH levels, the size, weight, and appearance of the glands, and the preoperative workup, Dr. Fox correctly determined Plaintiff had multi-gland disease and properly removed the three abnormal glands. (*TR 8/23/17(PM), pp. 22:18-24:1, 21:22-22:6, 19:14-20:1, 26:4-27:4).*

Additionally, Plaintiff did not object to most of Dr. Fox's testimony. He did not object to Dr. Fox's testimony that he met the standard of care or that Plaintiff had multi-gland disease. (*TR 8/24/17(PM), pp. 119:25-120:6; TR 8/24/17(AM), p. 80:17-18).* He did not object to Dr. Fox's testimony that he properly removed the abnormal right lower gland seen on the ultrasound. (*TR 8/24/17(PM), pp. 45:14-46:14, 47:23-24*). He did not object to Dr. Fox's testimony that Plaintiff's glands (except for the one on the right upper pole) were abnormal based on the size,

weight, and appearance. (*TR 8/24/17(PM), pp. 47:1-48:9*). He did not object to Dr. Fox's testimony concerning the intraoperative PTH levels contained in the medical records. (*TR 8/24/17(PM), pp. 47:21-50:22, 51:19-23, 53:14-17*). He did not object to Dr. Fox's opinion that Plaintiff had multi-gland disease in part because his intraoperative PTH levels went up and stayed up after the right lower gland was removed. (*TR 8/24/17(PM), pp. 51:1-55:16*). Nor did Plaintiff object when Dr. Fox testified that "normal cellular" did not mean the glands functioned normally. (*TR 8/24/17(AM), p. 80:14-16; TR 8/24/17(PM), p. 98:14-25; TR 8/25/17, p. 94:13-18*). Instead, Plaintiff's sole argument is that Dr. Fox should not have been allowed to testify that pathologically normal parathyroid glands can be "hyper secretors." *See Liscio v. Pinson*, 83 P.3d 1149, 1156 (Colo. App. 2003) (finding the admission of evidence was harmless when it merely consisted of several questions and one comment in closing argument). Because this alleged testimony did not substantially influence the outcome of the case or impair the basic fairness of the trial, it was harmless.

CONCLUSION

For the foregoing reasons, the Court should affirm the district court's judgment.

Respectfully submitted on September 11, 2018.

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CERTIFICATE OF SERVICE

It is hereby certified that on September 11, 2018, a true and correct copy of the foregoing Answer Brief was electronically filed with the Clerk of the Court of Appeals and served via Colorado Courts E-Filing system to the following:

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