UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 1277

September Term, 2014

RICHARD ROSE, ET AL.

v.

ALEXANDROS POWERS, ET AL.

Eyler, Deborah S.,
Kehoe,
Thieme, Raymond G., Jr.
(Retired, Specially Assigned),

JJ.

Opinion by Eyler, Deborah S., J.

Filed: July 8, 2015

*This is an unreported opinion, and it may not be cited in any paper, brief, motion, or other document filed in this Court or any other Maryland court as either precedent within the rule of *stare decisis* or as persuasive authority. Md. Rule 1-104.

A jury in the Circuit Court for Montgomery County returned a verdict in favor of Alexandros Powers, M.D., and his employer, Washington Brain and Spine Institute, the appellees,[1] in a medical negligence action brought against them by Richard and Diane Rose, the appellants. Sixteen days after the entry of judgment, the Roses filed a motion for new trial. They did not file a notice of appeal within 30 days of the entry of judgment. After the court denied their motion, the Roses noted an appeal. Because they did not file a timely notice of appeal from the judgment, only from the denial of their motion for new trial, the sole issue on appeal is whether the trial court abused its discretion by denying that motion. We answer that question in the negative and shall affirm the order of the circuit court.[2]

FACTS AND PROCEEDINGS

In 2007, Mr. Rose began experiencing upper chest pain. He sought medical treatment with his primary care physician. His physician ruled out cardiac and gastrointestinal problems and, in 2009, ordered him to undergo an MRI of his thoracic spine. The MRI, performed on June 23, 2009, revealed a calcified herniated disc at the level of his T5 and T6

[1]For ease of discussion, we shall refer to the appellees collectively as Dr. Powers.

[2]In their opening brief, filed on March 9, 2015, the Roses presented two questions:

> I. Whether the trial court erred in failing to issue a limiting instruction which reflected the trial court's prior rulings?
>
> II. Whether counsel's closing argument improperly prejudiced the jury by suggesting that the injuries complained of were the proximate result of another surgeon's medical care and treatment.

The next day, this Court issued an order limiting the issue on appeal "to whether the circuit court erred in denying Appellants' motion for a new trial."

vertebrae, causing "mild cord compression" and a "somewhat narrowed and compressed thoracic cord representing myelomalacia," which is a radiological finding indicating injury to the spinal cord. Based on the MRI result, Mr. Rose's primary care physician referred him to Dr. Powers.

On July 2, 2009, Dr. Powers met with Mr. Rose. Mr. Rose's chief complaints were the aforementioned upper chest pain and occasional numbness in his legs. During an examination, Dr. Powers observed that Mr. Rose had hyperactive reflexes and a slightly abnormal gait. These findings, coupled with the MRI images showing a "high intensity signal" at the T5 and T6 vertebrae, led Dr. Powers to concur with the radiologist's finding of myelomalacia. Myelomalacia is a permanent spinal cord injury that cannot be repaired. However, the progression of the condition may be stopped if the source of the damage to the spinal cord can be halted through a surgical intervention.

Initially, Dr. Powers recommended conservative treatment with steroids. He advised Mr. Rose that a surgical intervention likely would be necessary, however, for "long-term control of [his] symptomatology." He ordered MRIs of Mr. Rose's cervical spine and lumbar spine to rule out abnormalities in those areas.

Mr. Rose returned to see Dr. Powers on August 4, 2009. Dr. Powers reviewed the new MRI films, noting that the cervical and lumbar MRIs showed "spondylosis" or disc degeneration. Notwithstanding this finding, Dr. Powers concluded that Mr. Rose's "symptomatology [was] most consistent with the T5-6 disc herniation identified [in the June

23, 2009 MRI]." On that basis, he recommended surgery by means of a posterior or transpedicular approach to remove all or part of the calcified, herniated disc or, if that were not possible, to decompress the spinal cord and the nerve roots by removing portions of the bony vertebrae behind the spinal cord.

On October 7, 2009, Dr. Powers operated on Mr. Rose at Suburban Hospital. The goal of the surgery was to "expand the diameter of the spinal canal" to try to "halt the . . . progression" of the myelomalacia. Dr. Powers used a right-side posterior approach, meaning that he entered the vertebral column through the back of a right pedicle at the T5 and the T6 levels.[3] Intra-operatively, Dr. Powers determined that the calcified, herniated disc was "really hard" and that removal of the majority of it would be unsafe because of the risk of damaging the spinal cord or causing a leak in the thecal sac, which is the fluid-filled sac that surrounds the spinal cord. Dr. Powers removed approximately ten percent of the disc and performed a laminectomy at the T5 and T6 levels, which is the removal of the bone on the back of the spine. Dr. Powers observed that the thecal sac "[v]isibl[y] reexpan[ded]" after bone was removed, indicating that decompression had been achieved. Mr. Rose was discharged from the hospital the next day.

Three days later, on October 11, 2009, Mr. Rose was readmitted to Suburban Hospital with complaints of an unsteady gait and pain. Dr. Powers prescribed steroids, pain

[3] The pedicles are the bony extrusions of the vertebrae to the left and the right of the spinal column.

medication, and muscle relaxers and ordered an MRI. The MRI revealed no new pathology of the spinal cord and normal swelling of the paraspinal muscles in the area of the surgery. Dr. Powers was of the opinion that Mr. Rose's new symptoms were due to that swelling, which was causing posterior compression of the spinal cord. He advised Mr. Rose that once the swelling went down, the decompression of the spinal cord accomplished by the removal of the bones at the back of the spine would resume. Mr. Rose was discharged on October 15, 2009.

By the end of October, Mr. Rose was improving, but was unhappy with the rate of his improvement. Consequently, on November 2, 2009, Dr. Powers performed a re-exploration surgery on Mr. Rose to release the sutures on the paraspinal muscles and expand the space around the spinal cord to alleviate the pressure caused by post-surgical swelling.

Between November 2009 and March 2010, Mr. Rose saw Dr. Powers for routine follow-up appointments. Dr. Powers referred Mr. Rose for physical therapy. Dr. Powers was satisfied that Mr. Rose was continuing to improve at an appropriate pace. Mr. Rose continued to be unhappy with his recovery, however, and in March of 2010, Dr. Powers ordered a new MRI. Mr. Rose did not return to see Dr. Powers after that.

The MRI was performed on April 14, 2010. The radiologist's report stated that Mr. Rose's myelomalacia was unchanged from the time of the June 23, 2009 MRI, and that the herniated disc remained at the T5/T6 vertebrae.

On May 26, 2010, Mr. Rose was seen by Joshua Ammerman, M.D., a neurosurgeon. Dr. Ammerman noted that Mr. Rose had been improving since the October 2009 and November 2009 surgeries, but that he "ha[d] continued mild spasticity" in his legs and "some burning in the legs and a burning pain across the chest and top of the shoulders." Mr. Rose's April 14, 2010 MRI films showed "residual disc material" at the T_5 and T_6 vertebrae; the "beginning of a kyphotic . . . deformity," which is a tilting of the spine; and myelomalacia. Dr. Ammerman recommended further surgery at the T5 and T6 vertebrae. He advised Mr. Rose that the surgery was intended to "arrest the process" of myelomalacia to prevent "paraplegia," and would likely not alleviate most of his current symptoms.

On June 30, 2010, Dr. Ammerman, assisted by a thoracic surgeon, operated to completely remove the calcified portion of the herniated disc and fuse Mr. Rose's spine at the T5 and T6 vertebrae with "screws and rods." Both procedures were performed using an anterior or transthoracic approach. The thoracic surgeon cut through the side of Mr. Rose's chest, removed part of a rib, deflated one of his lungs, and created an access route to the spine. Dr. Ammerman then operated on the spinal column to remove the herniated disc and perform the fusion. Mr. Rose was required to wear a back brace for several weeks after the surgery.

Mr. Rose continued to see Dr. Ammerman for routine follow up care over the next two years. His condition was stable, but he experienced chest wall pain, spasticity in his legs, and a sensation of heaviness in his right leg. Dr. Ammerman prescribed narcotic pain

medication, muscle relaxers, and medication to treat nerve pain. In August of 2012, Dr. Ammerman referred Mr. Rose to a pain management specialist, Jose Suros, M.D. Dr. Suros ultimately terminated Mr. Rose from his practice.[4] In August of 2013, Dr. Ammerman referred Mr. Rose to Reza Ghorbani, M.D., also a pain management specialist.

Meanwhile, on May 3, 2013, the Roses filed suit against Dr. Powers. They alleged that Dr. Powers had breached the standard of care by, *inter alia*, failing to perform the appropriate operation; failing to perform the operation at the "correct level of the spinal cord"; failing to use the "appropriate surgical approach"; and "[b]eing otherwise negligent." They alleged that, as a result, Mr. Rose sustained a "spinal cord injury which ha[d] caused permanent and severe injuries." They set forth counts for medical negligence and loss of consortium and sought economic and non-economic damages.

The Roses designated one standard of care expert: Frank Kevin Yoo, M.D., a neurosurgeon. Dr. Powers designated two standard of care experts: Neal Naff, M.D., and Carlos Bagley, M.D., both neurosurgeons. Expert reports prepared by Drs. Naff and Bagley stated that Dr. Powers did not breach the standard of care in his performance of the October 2009 and November 2009 surgeries, and that the care and treatment provided by Dr. Powers was not a proximate cause of the injuries and damages claimed by the Roses. Dr. Powers designated Inder Chawla, M.D., a physiatrist, as an expert in rehabilitative medicine. In his

[4]Dr. Suros terminated Mr. Rose for non-compliance with the opiate contract after a routine urine screening was positive for an opiate that Dr. Suros had not prescribed.

expert report, Dr. Chawla opined that, based upon Dr. Powers's and Dr. Ammerman's records, Mr. Rose "present[ed] no evidence of myelopathy on examination"[5]; that he had "reached maximum medical improvement"; and that he did not require any "further medical treatment or follow up." Finally, Dr. Powers designated James Provenzale, M.D., a neuroradiologist, as an expert witness, and gave notice that he intended to call Drs. Ammerman, Suros, and Ghorbani.

During discovery, the Roses did not depose any of Dr. Power's expert witnesses or any of Mr. Rose's treating physicians. They propounded interrogatories pertaining to expert testimony. In one such interrogatory they asked whether Dr. Powers contended that "anyone, whether or not a party to this action, performed any act or failed to perform any act that caused or contributed to any of the injuries suffered by [the Roses]?" In another, they asked whether Dr. Powers contended that any of Mr. Rose's injuries were "due to a pre-existing medical condition and/or that these injuries were not caused by your actions or inactions." Dr. Powers objected to both interrogatories, stating that he "den[ied] negligence of any sort," and arguing that each interrogatory improperly shifted the burden to him to prove the cause of Mr. Rose's injuries. Dr. Powers noted that, as discovery proceeded, he "reserv[ed] the right to rely upon any fair inferences to be drawn from the facts and evidence" and would supplement his answer as necessary. Neither interrogatory answer was supplemented prior to trial.

[5]Myelopathy is the clinical manifestation of myelomalacia.

On May 19, 2014, eight days before trial, Dr. Ghorbani's *de bene esse* deposition was taken. Dr. Ghorbani started treating Mr. Rose in August of 2013, and had last treated him in April of 2014. At his first appointment, Mr. Rose complained of "neck pain as well as chest wall pain, anterior chest wall pain, and cervical radiculopathy and some right leg spasm." As relevant to the issues on appeal, on cross-examination, Dr. Ghorbani was asked whether Mr. Rose's neck pain and "cervical radiculopathy" could be related to an injury to his thoracic spine. He replied that because the thoracic area was in "close proximity to the neck" it was possible that these symptoms were related. Dr. Ghorbani also was asked if he knew whether Mr. Rose had any "abnormalities" or "pathology" in his cervical spine or neck. He replied that he had never viewed any of Mr. Rose's MRI or CT films and, consequently, could not say whether there was any abnormality in Mr. Rose's cervical spine.

Three days later, the Roses moved *in limine* to preclude Dr. Powers from presenting any "undisclosed opinion" evidence that Mr. Rose had an underlying cervical neck injury that caused or contributed to any of his injuries. They argued that Dr. Powers had not disclosed that he intended to offer any expert testimony that Mr. Rose had a preexisting condition that was causing him pain. Rather, in their view, it had been Dr. Powers's position that Mr. Rose did not have *any* injury. Dr. Powers opposed the motion.

Trial began on May 27, 2014. After the jury was selected, the court heard argument on the Roses' motion *in limine*. The court denied the motion as to Dr. Powers's opening statement, and reserved on it as to the trial.

In their case, the Roses testified and called Dr. Powers, Dr. Yoo, a coworker of Mr. Rose, and an economist. They also played the *de bene esse* depositions of Drs. Ammerman and Ghorbani. Dr. Powers testified about the reasons he decided to use the posterior surgical approach, as opposed to the anterior surgical approach later used by Dr. Ammerman. He explained that the posterior approach is a much smaller surgery and has significantly lower rates of associated morbidity and mortality than the anterior approach. He also testified about why he had decided not to remove the calcified disc during the first and second surgeries, and Mr. Rose's recovery.

Dr. Yoo testified that the symptoms Mr. Rose experienced in July of 2009, were consistent with "cord compression from [an] anterior calcified disc at T5/6." He opined that Dr. Powers breached the standard of care by not removing the entire disc during the first or the second surgery. He testified that, had the disc been removed, "more likely than not" Mr. Rose "would have had less problems than he has now. Less pain, more function." On cross-examination, Dr. Yoo acknowledged that Dr. Powers's decision to use the posterior approach was within the standard of care, that his decision during the October 2009 surgery not to remove the herniated disc was the correct decision, and that his intra-operative decision to perform a laminectomy to decompress Mr. Rose's spinal cord also was "very appropriate." He opined, however, that Dr. Powers breached the standard of care after the October 7, 2009 surgery by failing to recommend or perform additional surgery to "remove[] the [entire] calcified portion" of the disc.

Dr. Ammerman testified about the June 2010 surgery he performed and Mr. Rose's post-surgical recovery. He explained that over time, the herniated disc had injured Mr. Rose's spinal cord and that his ongoing pain and neurological symptoms had resulted from that damage, which was not reversible. On cross-examination, he acknowledged that Mr. Rose's myelomalacia predated the surgeries Dr. Powers had performed and that it was impossible to determine when it first occurred.

Dr. Ammerman also was asked (without objection) whether Mr. Rose ever had complained of neck pain. Dr. Ammerman replied that he had not, but agreed that any neck pain would not have been related to Mr. Rose's thoracic spine pathology. Dr. Ammerman confirmed that his clinical notes reflected a referral for deep tissue massage for Mr. Rose's right shoulder in December of 2010. He agreed that shoulder pain also would not be related to thoracic spine pathology. He had not treated Mr. Rose since July of 2012, when he referred him to a pain management specialist.

On the fourth day of trial, May 30, 2014, before Dr. Powers's case commenced, the Roses made an oral motion *in limine* to preclude Dr. Powers's standard of care experts, Drs. Naff and Bagley, from opining that any of Mr. Rose's injuries were caused by the surgery performed by Dr. Ammerman. The court also heard renewed argument on the pre-trial motion *in limine* pertaining to testimony about preexisting cervical spine (and lumbar spine) degeneration. After reviewing Dr. Powers's answers to interrogatories (discussed *supra*), the court found that, to the extent Dr. Powers intended to offer expert testimony that

preexisting conditions or the surgery by Dr. Ammerman had caused Mr. Rose's claimed injuries, there had been "inadequate disclosures." The court granted the motion in part, ruling that Dr. Naff could not testify that any preexisting condition or Dr. Ammerman's surgery proximately caused of any of Mr. Rose's injuries. Dr. Naff could, however, offer an opinion to "specifically rebut[] whatever he believe[d] Dr. Yoo got wrong." The court stated that its ruling was not a discovery sanction, but a limitation to keep "the witness within the boundaries of that which was disclosed." The court reserved on the motion with respect to other witnesses.

As relevant here, Dr. Naff testified that the MRI scans of Mr. Rose's cervical spine and lumbar spine revealed "age related" degeneration in both areas. He opined, without objection, that the degeneration in the lumbar spine could cause leg pain. He further testified that the posterior approach used by Dr. Powers in the surgeries to decompress Mr. Rose's spinal cord and nerve roots was consistent with the standard of care because it protected the spinal cord. Given that Mr. Rose already had an injury to his spinal cord, this was particularly important. Dr. Naff further opined, without objection, about the risks attendant to the anterior surgical approach later utilized by Dr. Ammerman, which include "pain from the rib resection," injuries to lungs, damage to major blood vessels, and injury to the nerves that run along the bottom of each rib. Finally, Dr. Naff opined that he did not believe that the remaining portion of the herniated disc had caused any further damage to Mr. Rose's

spinal cord between the November 2009 surgery by Dr. Powers and the June 2010 surgery by Dr. Ammerman.

Dr. Powers's other standard of care expert, Dr. Bagley, testified, without objection, about the differences between the posterior and anterior approaches to spinal surgery for a herniated disc with cord compression. He opined that the anterior approach used by Dr. Ammerman was "more direct" because the disc is anterior to the spinal cord. That approach carries "significant morbidity," however, because the surgeon must crack the ribs or remove a section of the ribs and work around the lungs, the heart, and major arteries, all of which can be injured. In contrast, the posterior approach is "more indirect," but eliminates most of the major risks of injuries to other organs. Dr. Bagley opined, without objection, that the anterior approach "routinely" causes "residual chest wall pain" and that the pain can be "very significant." The removal of a rib and the attached nerve (as a means to access the vertebrae) is the source of the chest wall pain.

Dr. Powers was recalled during his case. He testified that the reason he used the posterior approach to decompress the herniated disc was that the anterior approach carried a greater risk of morbidity, including nerve pain in the chest wall. He further testified that, although he could have recommended the anterior approach after the October 2009 surgery, which did not result in removal of the majority of the herniated disc, he did not because, in his opinion, the October 2009 surgery (and the November 2009 surgery) adequately

decompressed Mr. Rose's spinal cord and halted the progression of the myelomalacia. Thus, in Dr. Powers's view, the risks of another surgery outweighed any benefit.

After Dr. Powers's testimony, the court took a recess to discuss jury instructions. The Roses asked the court to propound the following limiting instruction:

> You have heard testimony regarding considerations of performing a thoracotomy approach [*i.e.*, anterior approach] versus a transpedicular approach [*i.e*., posterior approach]. This evidence has been admitted for the limited purpose of explaining the considerations employed by Dr. Powers in determining how to provide treatment. You shall not consider this testimony as evidence of any other issue in this case, including causation and damages.

Dr. Powers opposed the request, arguing that the jurors were free to draw reasonable inferences from the direct and circumstantial evidence, including the testimony of Drs. Powers, Bagley, and Naff, that the surgery performed by Dr. Ammerman may have contributed to the chest wall pain Mr. Rose was experiencing. The court declined to give the instruction, stating that it was not persuaded that the instruction was necessary and that it would reconsider its ruling upon "an objection to somebody's closing or [if] the jury asks a question." After the court instructed the jurors, counsel for the Roses did not except to the court's failure to give the limiting instruction he had requested.[6]

In closing, defense counsel argued that the central claim of negligence was that Dr. Powers had failed to "adequately decompress [Mr. Rose's] spinal cord [thus] caus[ing] Mr.

[6]The Roses also requested a limiting instruction with respect to the evidence of degeneration in Mr. Rose's cervical and lumbar spine. The court agreed to instruct the jury that that evidence was admitted solely to explain the treatment decisions made by Drs. Powers and Ammerman, and should not be considered with respect to any other issue.

Rose's already diseased spine to worsen." He pointed out that Dr. Yoo and the defense experts had opined that the posterior approach utilized by Dr. Powers was within the standard of care. Dr. Powers had "weighed various considerations" and determined that the posterior approach was best for Mr. Rose because it was "a smaller surgery" with "[v]ery low morbidity." This was in contrast to the anterior approach, which was "a larger surgery" with "higher morbidity." In particular, defense counsel emphasized Dr. Bagley's opinion that the anterior approach carried with it a significant risk of permanent and significant chest wall pain.

After discussing the October 2009 and November 2009 surgeries, defense counsel argued that Mr. Rose had a normal post-surgical course and was improving by any objective measure between the November 2009 surgery and March 2010, when he last saw Dr. Powers. He emphasized that the April 14, 2010 MRI showed that there had been "no worsening in . . . [the] condition of [Mr. Rose's] spinal cord [since the June 23, 2009 MRI.]" Defense counsel argued that this was objective evidence that the 90 percent of the calcified herniated disc left behind after the October 2009 surgery had had "no impact whatsoever" on Mr. Rose's spinal cord.

Turning to causation, defense counsel explained that the injury Mr. Rose was claiming was "that his spinal cord . . . got worse," resulting in chronic pain and necessitating pain management. Defense counsel argued that the records of Mr. Rose's treating physicians revealed that there were "multiple components of his pain":

I'll submit to you Dr. Ammerman did the surgery. When Dr. Powers testified that when he last saw – when he last treated Mr. Rose, he [Mr. Rose] wasn't seeing a pain management specialist. He wasn't even on pain killers. He wasn't getting any pain meds. He wasn't getting any muscle relaxants or anything like that. He was getting some Neurontin to help manage the, you know, the nerves – treat the nerves a little bit. But no pain management, no problems with that area. He had improved to the point that he was off of all of that, had been tapered off.

When did he start to get pain management? When did he start complaining of these issues, these problems? After Dr. Ammerman's surgery. Dr. Ammerman performs the surgery that Dr. Bagley told you – and, again, in no uncertain terms – is going to cause you chest-wall pain, is going to cause you more symptoms, has a lot of different morbidities. You're – again, you're pulling away the lung. You have to deflate the lung, pull it away. You have to cut ribs out, impact nerves. It's going to cause you problems. And that's exactly what happened. What happens after Dr. Ammerman's surgery?

I'm not suggesting that Dr. Ammerman did anything wrong. Don't take it as I'm suggesting that. Dr. Ammerman, again, tried to make Mr. Rose happy. He performed the surgery. He gave Mr. Rose an option – a surgical option to treat his pain. Mr. Rose was not happy with the rate of improvement. He wanted something a little bit more expedential. He gave him an option. He performed surgery. But there was a tradeoff for the performance of that trans-thoracic approach surgery. And that tradeoff was more pain. He was going to get worse. How do we know he got worse? Dr. Ammerman – after two years of trying to treat him himself, Dr. Ammerman, for the first time, sends him to Dr. [Suros], a pain-management specialist.

Now Mr. Rose is continually – the whole claim in this case was that Dr. Powers should have removed the disc. Well, Dr. Ammerman removed the disc. The disc is gone, and Mr. Rose is no better off with the disc gone. In fact, he's worse off now, if you listen to his testimony. He can't do household services that he could do before. He's got permanent pain management. He worse off [sic] after Dr. Ammerman's surgery. And we know he's not worse off because of anything that Dr. Powers did because we have the April 14th, 2010 MRI that shows that his myelomalacia didn't get any worse during that time.

Now, after Dr. Ammerman's surgery, he's going to pain management. He's getting multiple pain medications after that surgery. . . . [Dr. Suros testified h]e was treating [Mr. Rose] for cervical spine problems. If you look at the records that I brought to your attention, he diagnosed Mr. Rose with cervical stenosis.

. . . Dr. Powers never touched Mr. Rose's cervical spine.

We know that Mr. Rose also had pathology in his cervical spine as early as July 20th, 2009. His July 20th, 2009 MRI showed mild C3–C4 through C6-[C]7 spondylosis. . . . He had pathology in his cervical spine before he even met Dr. Powers, and Dr. [Suros] testified that he was treating him for it and diagnosed him with cervical stenosis.

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Here's an element of Mr. Rose's damages in this case that plaintiff's own expert says has nothing to do with Dr. Powers' care. So, when you get to causation of damages – when you get to that point, that's something you have to think about. When you're asked a question, "Did Dr. Powers' negligent conduct cause plaintiff's injury?" His injury is chronic pain. A component of his chronic pain is his cervical pain in his neck, shoulders, upper back. None of that has is unrelated [sic] to Dr. Powers' care as admitted by their own expert.

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Dr. Powers can only be responsible for the things that his care and treatment caused, not, "Oh, he's got an issue. He says his thoracic spine hurts. He's got pain in his thoracic spine. He had work on his thoracic spine." It has to be caused by Dr. Powers' negligence – something Dr. Powers did wrong.

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When you're looking at these records, consider the portion of the care that would have nothing to do with Dr. Powers' care, let alone his negligence, that's part of his cervical spine, his lumbar spine, and the thoracic spine that preexisted before he came to Dr. Powers. And then, secondly, within that thoracic spine as well, to the extent that he's complaining of problems in his thoracic spine, he had that anterior thoracotomy discectomy [performed by Dr. Ammerman].

And again, I submit to you there was no indication – you heard Dr. Powers, you heard Dr. Bagley, and you heard Dr. Naff testify to it, and the records tell you – he had no pain management referral . . . until after Dr. Ammerman's procedure – after Dr. Ammerman did the thoracotomy that Dr. Bagley said, in no uncertain terms, is going to cause problems.

Counsel for the Roses did not object at any time during the above quoted argument. He did object, however, when defense counsel paraphrased testimony by the Roses' expert economist. At the ensuing bench conference, the Roses' lawyer argued about whether defense counsel had improperly paraphrased the economist's testimony and noted that he also would "have an objection when he's finished." The court inquired about the nature of the objection he would "have when [defense counsel was] finished?" Counsel replied, "Oh, he's been talking about this lumbar and cervical areas [sic]. He's been –." The court interjected, "You didn't make a contemporaneous objection." Counsel responded, "Well, I can't object to [unintelligible]. I'm making it now. And also, objection to the references to Mr. Ammerman, [sic] blaming Dr. Ammerman for everything. We've been through this. He told him not to do it. And he did it." The court responded, "We'll take it up after argument."

After closing arguments, and after the jury was excused, the following exchange occurred:

> [PLAINTIFFS' COUNSEL]: . . . I'd like to object to the closing argument. What we heard which I think was in opposition to the rulings that we had in this case about lumbar and cervical issues, and also about Dr. Ammerman. This was a clear account of placing damages on Dr. Ammerman, and I think that was totally improper. The things were said out of context as we went through it.
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> THE COURT: What are you asking me to do?
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> [PLAINTIFFS' COUNSEL]: I'm sorry?
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> THE COURT: What are you asking me to do? I mean, the usual remedy to this is we try the case twice.

> [PLAINTIFFS' COUNSEL]: That's why the plaintiff is always placed in a difficult spot. What I'm going to ask you to do, I have to at this point make my record, as I think I've done, and I'll probably go through it and make a lot more, and we'll see what happens. I think that's the best I can do for my client at this point.
>
> THE COURT: Are you asking me to declare a mistrial?
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> [PLAINTIFFS' COUNSEL]: Am I asking you to do what?
>
> THE COURT: Are you asking me to declare a mistrial?
>
> [PLAINTIFFS' COUNSEL]: I am not.
>
> THE COURT: Thank you.
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> [PLAINTIFFS' COUNSEL]: I understand it's a fair question, Your Honor, but I can't do that. I understand. I think I've done all I can do.

The case was sent to the jury on a special verdict with three questions: 1) whether the jurors found "by a preponderance of the evidence that Dr. Powers deviated from the standard of care?"; 2) whether the jurors found that the "deviation from the standard of care . . . was a cause of an injury to Mr. Rose?"; and 3) the amount of any damages for past medical bills, future medical bills, loss of household services, pain and suffering of Mr. Rose, and damage to the marital relationship. The verdict sheet instructed the jurors only to move on to the next question if they answered "Yes" to the preceding question.

On June 6, 2014, the jurors returned their verdict. They answered "No" to the first question, finding that Dr. Powers had not deviated from the standard of care. Accordingly, the jurors did not answer the latter two questions. The judgment on the verdict was entered on the docket on June 10, 2014.

Sixteen days later, the Roses moved for a new trial and for sanctions. They argued that during defense counsel's closing argument, he "repeatedly and consistently argued that Dr. Ammerman caused Mr. Rose's injuries and that Mr. Rose had preexisting conditions which caused his pain" and that this amounted to "an intentional violation of the Court's Order" on the motions *in limine* argued at trial. The Roses asked the court to order a new trial and, further, to sanction Dr. Powers by striking his answer and entering judgment in favor of the Roses on the issues of negligence and causation. They alleged, moreover, that after the verdict, counsel for both parties met with four of the six jurors and that those jurors said that they had found Dr. Powers not to be negligent because "the true cause of Mr. Rose's injuries was the surgery performed by Dr. Ammerman." On this basis, the Roses argued that defense counsel's improper argument plainly had prejudiced them.

Dr. Powers opposed the motion. He asserted that there was nothing in the record to suggest that "the jury's verdict was based upon anything other than the evidence elicited." Dr. Powers argued that the Roses had waived their contentions of error by not lodging a contemporaneous objection to any of the complained of statements by defense counsel in closing argument and that they did not move for a mistrial or otherwise request any remedy. Dr. Powers noted, moreover, that the jurors did not even reach the issue of causation and thus even if the court were to agree that defense counsel's causation argument was improper, that argument plainly had no impact on the verdict. Dr. Powers also took issue with the Roses' characterization of the jurors' remarks after the trial. He explained that the four jurors who

agreed to be interviewed by counsel all stated that a comparison of the April 14, 2010 MRI to the June 23, 2009 MRI convinced them that Dr. Powers properly had decompressed Mr. Rose's spinal cord and therefore had not breached the standard of care. Finally, Dr. Powers argued that defense counsel's closing argument had been proper because the court's ruling on the motions *in limine* only limited the opinion testimony that Dr. Powers could elicit from his expert witnesses at trial, not the argument defense counsel could make based upon the evidence properly admitted.

On July 17, 2014, the court denied the motion for a new trial and for sanctions. This appeal followed.

DISCUSSION

As explained, the only issue before us in the instant appeal is whether the trial court abused its discretion by denying the Roses' motion for new trial. *Mason v. Lynch*, 151 Md. App. 17, 28 (2003) (holding that standard of review for denial of motion for new trial is abuse of discretion). The Court of Appeals has explained that

> the breadth of a trial judge's discretion to grant or deny a new trial is not fixed and immutable; rather, it will expand or contract depending upon the nature of the factors being considered, and the extent to which the exercise of that discretion depends upon the opportunity the trial judge had to feel the pulse of the trial and to rely on his own impressions in determining questions of fairness and justice.

Buck v. Cam's Broadloom Rugs, Inc., 328 Md. 51, 58-59 (1992). The court's discretion is at its broadest when "the decision has necessarily depended upon the judge's evaluation of the character of the testimony and of the trial when the judge is considering the core question

of whether justice has been done." *Id.* at 57. By contrast, the trial court has "virtually no 'discretion' to refuse to consider newly discovered evidence that bears directly on the question of whether a new trial should be granted." *Id*. at 58.

The Roses contend that the trial court had limited discretion to deny their motion for new trial because they presented the court with "new information . . . which demonstrated that the jury was improperly swayed by prejudicial closing argument." They argue that, in light of this "new information," our review of the denial of their motion should be *de novo*. They contend that defense counsel's closing argument was improper because it violated the trial court's prior ruling limiting the evidence that Dr. Powers could introduce about the impact on Mr. Rose's injuries of preexisting cervical and lumbar spine degeneration and Dr. Ammerman's surgery. Moreover, the Roses assert that the prejudicial impact of the closing argument was compounded by the trial court's erroneous decision not to give their requested limiting instruction.

Dr. Powers responds that for several reasons the trial court did not abuse its broad discretion by denying the Roses' motion for new trial. First, the motion was filed outside the ten-day window for post-trial motions and could have been denied as untimely on that basis. Second, because the jurors did not even reach the issue of causation, the Roses could not have been prejudiced by defense counsel's argument that Mr. Rose's injuries were caused by preexisting conditions or by Dr. Ammerman's surgery. Third, defense counsel's argument did not violate the trial court's prior ruling and was not improper and, in any event, the

Roses' failure to make a contemporaneous objection to any of the allegedly improper statements made in closing argument amounted to a waiver.

As noted, the Roses did not lodge a contemporaneous objection to any of the complained of remarks during closing argument. At the bench conference that took place immediately after closing arguments, their counsel did not ask the court to strike any of the complained of statements, did not request a mistrial, and did not ask the court to supplement its jury instructions by giving the limiting instruction the court previously had declined to give. Having failed to seek any remedy at trial, the Roses may not be heard to complain that the trial court erred by not limiting defense counsel's closing argument, much less that it abused its discretion by denying a motion for new trial premised on this error. On this basis alone, we would affirm the order of the circuit court.

Even if the Roses had not waived their contentions of error, we still would not find any abuse of discretion by the trial court in denying the motion for new trial. As noted, the Roses argue that this ruling should be reviewed under a *de novo* standard because the court failed to consider the "new information" concerning the basis for the jurors' verdict. This contention lacks merit. In the memorandum of law in support of the Roses' motion for new trial, they alleged, without any supporting evidence, that four of the six jurors found that Dr. Powers was not negligent because they were persuaded that the injuries to Mr. Rose were caused by Dr. Ammerman's surgery. Dr. Powers rebutted that characterization of the jurors' remarks. These conflicting accounts of the jurors' post-verdict remarks are not competent

evidence of anything, much less evidence that the trial court was required to consider in deciding the motion for new trial.

In this case, the court's discretion to grant or deny the new trial motion was at its broadest because it was tasked with assessing whether defense counsel's closing argument violated the court's prior ruling and/or was improper in light of all of the evidence admitted throughout the course of trial; and, if so, whether that argument, coupled with the court's denial of the requested limiting instruction, prejudiced the Roses in such a way as to deprive them of a fair trial. The court was in the best position to assess whether defense counsel had violated the court's ruling on the motions *in limine*. That ruling limited the expert opinion testimony that Dr. Powers could elicit from one witness: Dr. Naff. The Roses never renewed their motion with respect to Dr. Bagley or any other witness.

Over the course of the trial, expert and lay witnesses testified without objection that the anterior approach used by Dr. Ammerman was associated with greater morbidity and, in particular, with chest wall pain. Multiple witnesses testified without objection that Mr. Rose continued to suffer from chest wall pain. Similarly, radiological reports in evidence and Dr. Powers's testimony showed that Mr. Rose had preexisting cervical and lumbar spine degeneration. The testimony of Drs. Ammerman and Ghorbani -- witnesses presented by the Roses -- established that Mr. Rose complained of and sought treatment for neck and shoulder pain at various points in time. Dr. Suros was called by Dr. Powers and testified that Mr. Rose reported neck and lower back pain. Mr. Rose's medical records also were admitted into

evidence and showed his complaints of chest wall pain, cervical pain, and back pain made over time.

Defense counsel was free to argue, based upon this properly admitted evidence, that even if the jurors found that Dr. Powers was negligent and caused injury to Mr. Rose, Dr. Powers's negligence was not the proximate cause of ***all*** the claimed injuries. This was so because the primary injury -- chronic pain -- was not limited to complaints related to Mr. Rose's thoracic spine or to any alleged damage to his thoracic spinal cord during the period between November of 2009 and June of 2010. For all of these reasons, the trial court did not abuse its discretion by denying the Roses' motion for new trial.

ORDER OF THE CIRCUIT COURT FOR MONTGOMERY COUNTY AFFIRMED. COSTS TO BE PAID BY THE APPELLANTS.