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IN THE COURT OF APPEALS OF NORTH CAROLINA

No. COA19-1073

Filed: 1 December 2020

Forsyth County, No. 16 CVS 860

WINIFRED HAUSER, Plaintiff,

v.

BROOKVIEW WOMEN'S CENTER, PLLC and DONALD E. PITTAWAY, MD,
Defendants.

Appeal by Defendants from judgment entered 11 February 2019 by Judge John W. Smith in Superior Court, Forsyth County. Heard in the Court of Appeals 11 August 2020.

Kennedy, Kennedy, Kennedy, and Kennedy, LLP, by Harvey L. Kennedy and Harold L. Kennedy, III, for Plaintiff-Appellant.

Coffey Law, PLLC, by Tamara D. Coffey, for Defendants-Appellees.

McGEE, Chief Judge.

Winifred Hauser (“Ms. Hauser” or “Plaintiff”) appeals from a judgment entered upon a jury verdict finding no negligence on behalf of Brookview Women’s Center, PLLC (“Defendant Brookview”) and Donald E. Pittaway, MD (“Defendant Doctor”) (collectively, “Defendants”). On appeal, Plaintiff argues the trial court erred by (1)

instructing the jury on the presumption of a valid consent and (2) excluding character evidence of Defendant Doctor. We hold that the trial court did not err.

I. Factual and Procedural Background

This case arises from a medical malpractice action filed by Ms. Hauser against Defendants on 12 February 2016. The complaint alleged that Defendant Doctor was an employee, agent, and partner of Defendant Brookview at all relevant times. Ms. Hauser was scheduled to undergo a laparoscopic-assisted vaginal hysterectomy (“LAVH”) by Defendant Doctor at Forsyth Medical Center in Winston-Salem on 3 September 2009. During the procedure, however, Defendant Doctor determined that he could not successfully perform the LAVH and performed a total abdominal hysterectomy (“TAH”) instead. The complaint alleged that Defendant Doctor was negligent in his care and treatment of Ms. Hauser.

Evidence presented at the 14 January 2019 trial tended to show that in June of 2005, Ms. Hauser first went to Defendant Brookview. Defendant Doctor testified that Ms. Hauser’s “symptoms related to prolapse of the vaginal wall, and an enlarging fibroid uterus that was also prolapsing or descending down the vaginal canal.” A gynecologist at Defendant Brookview diagnosed Ms. Hauser with urgency symptoms and cystocele, “a bulge of the interior vaginal wall[.]” A year later, Ms. Hauser returned to Defendant Brookview for her annual exam and was seen, for the first time, by reproductive endocrinologist Defendant Doctor. At this appointment,

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Defendant Doctor had a discussion with Ms. Hauser about his surgical recommendation that she undergo a total vaginal hysterectomy (“TVH”).

Ms. Hauser returned to Defendant Doctor on 14 July 2006 and complained of a worsening bulge and pressure in her vagina. Defendant Doctor testified that he informed Ms. Hauser that the surgical approach “would be a TVH” and, in regard to the incontinence, “anterior repair with TOT sling procedure, possible but doubtful posterior repair and uterosacral colopexy.” Ms. Hauser agreed to contact Defendant Brookview to schedule the procedure; however, Ms. Hauser never called, and the procedure was not scheduled. A year later, on 30 July 2007, Ms. Hauser returned to Defendant Brookview. At that appointment, the complaints of Ms. Hauser and the surgical recommendation of Defendant Doctor remained unchanged from the 14 July 2006 appointment.

Ms. Hauser returned to Defendant Doctor on 16 December 2008 with the same uterovaginal prolapse complaints and new complaints of increased menstrual flow and clotting. When Defendant Doctor performed an ultrasound on Ms. Hauser, he testified that he discovered a uterine fibroid about two inches in size “impinging the cavity.”¹ According to Defendant Doctor, prior to that date, Ms. Hauser had been a candidate for a TVH based on the size of her uterus; however, when the ultrasound revealed a “significant change” in the size of her uterus, Defendant Doctor “did not

¹ In his deposition, Defendant Doctor testified that “[w]hen a fibroid is involving the cavity, then there’s likely to be bleeding problems from that.”

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believe that a vaginal hysterectomy was appropriate at that point.” As a result, Defendant Doctor and Ms. Hauser discussed a LAVH. In his notes from the 16 December appointment, Defendant Doctor reported, “I discussed again the surgical approach which would now be a LAVH/BSO, anterior repair with TOT sling procedure, possible but doubtful posterior repair and possible uterosacral colpopexy.” Ms. Hauser expressed her intent to proceed with the LAVH and agreed to contact Defendant Brookview when she was prepared to move forward.

When Ms. Hauser returned to Defendant Doctor on 4 August 2009, she complained of increasing uterine bleeding and clots. According to Defendant Doctor’s notes from the appointment, he “[h]ad a long discussion about [Ms. Hauser’s] symptoms and the fact that the uterine fibroid is partially submucous” and Ms. Hauser “elect[ed] to proceed with LAVH at which time will do an anterior repair as well.”

Ms. Hauser returned to Defendant Brookview for a pre-operative appointment on 1 September 2009. In his records from that appointment, Defendant Doctor noted that he “reviewed the surgery in detail” and, “[a]fter a full discussion, the patient elected to proceed.” Defendant Doctor also gave Ms. Hauser a pamphlet entitled “Laparoscopic Assisted Vaginal Hysterectomy,” published by the American College of Obstetricians and Gynecologists (the “ACOG pamphlet”). On that same day, Ms.

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Hauser had a pre-operative hospital appointment, where she was given a surgical consent form that stated:

1. I give my permission for the following operation, procedure or treatment: Laparoscopic assisted vaginal hysterectomy, anterior repair, transvaginal tape, obturator urinary sling procedure.

....

3. I understand the following. I agree that my healthcare provider has discussed with me:

- a. Nature of my illness.
- b. Nature and purpose of the operation, procedure or treatment
- c. Benefits of having the operation, procedure, or treatment.
- d. Usual and most often risks of the operation or procedure. This includes the risk that such operation, procedure or treatment may not accomplish the goal of the operation or procedure.
- e. All reasonable options and their risks.
- f. The risk of no operation, procedure or treatment
- g. I have had a chance to ask questions. My questions have been answered.
- h. No guarantees have been made or implied as to the results of this operation, procedure or treatment.

4. Unexpected events may happen during the operation. These events may cause the operation to last longer than expected. They may require a different procedure from that listed above. If this happens, I give permission for such surgical procedures determined to be necessary.

....

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By signing here, I fully understand the contents of this document. I understand that any rights and obligations that relate to my care shall apply only to the Novant Facility in which I am being treated. I have the ability to make and communicate my healthcare decisions.

Ms. Hauser signed the hospital's consent form (the "Consent Form") on 1 September 2009; Defendant Doctor signed the Consent Form on 3 September 2009.

Ms. Hauser came to Forsyth Medical Center on 3 September 2009 for her hysterectomy. During the procedure, according to Defendant Doctor's notes, Defendant Doctor realized Ms. Hauser's "uterus was much larger than was evident on physical exam and was more like 18 weeks[.]" meaning "[t]here was essentially no access to the lateral aspects of the uterus to be able to perform the surgery laparoscopically." Defendant Doctor proceeded "with the repair of the cystocele and TOT urinary sling procedure[.]" however, he was unable to perform the LAVH. Instead, Defendant Doctor performed a TAH "with right salpingo-oophorectomy," wherein he removed Ms. Hauser's uterus, right tube, and ovary through an abdominal incision. In his notes from the surgery, Defendant Doctor reported: "There was essentially no access to the lateral aspects of the uterus to be able to perform the surgery laparoscopically. For that reason, I proceeded with the repair of the cystocele and TOT urinary sling procedure and then performed a TAH with RSO."

On the night of 5 September 2009, Defendant Doctor received a call that Ms. Hauser had collapsed while walking around the nurse's station. In addition to her

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elevated heart rate, Ms. Hauser's blood test showed a high level of creatin and her CT scan revealed a left ureteral obstruction. Ms. Hauser was diagnosed with a pulmonary embolus, "a blood clot that goes into the blood vessels of the lungs." As a result, a Greenfield filter and a nephrostomy tube were inserted by a urologist and Ms. Hauser coded three times. Approximately ten days later, Ms. Hauser was discharged from the hospital. Ms. Hauser underwent a ureteral stent placement on 19 October 2009.

At trial, during the charge conference, the parties discussed the pattern jury instruction on informed consent, N.C.P.I.—Civ. 809.45. Defendants argued that N.C. Gen. Stat. § 90-21.13 governed informed consent for medical treatment and Defendant Doctor was entitled to a rebuttable "presumption by statute on the issue of consent." Accordingly, Defendants asked the trial court to add the statutory presumption to the pattern instruction. In response, Plaintiff argued that the "presumption has nothing to do with [this] case" because the statutory presumption only arises "in a situation where somebody is contending that they only signed the paper as a result of fraud or deception or misrepresentation of a material fact." Plaintiff explained that "the whole basis of [this] case deals with the fact that we allege that [Defendant Doctor] never explained the alternative to the surgery, and did not explain the risk of the procedure before the surgery had been done." The trial court declared:

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since you have both oral and written contentions, as to the consent and whether he had informed her, it appears to me that the statutory provision where a written consent is evidence is a correct statement of the law and it's been requested. And it's not totally irrelevant. I understand your argument, that that's a distinction that can be clarified by argument.

Plaintiff objected on the basis that the “statute didn’t apply to the theory that [they’re] pursuing.” The trial court overruled the objection and agreed, at Plaintiff’s request, to add “fraudulent concealment” to the statutory presumption instruction.

II. Jury Instructions

Plaintiff argues that the trial court erred by instructing the jury on the rebuttable presumption of a valid consent. We disagree.

We review the sufficiency of jury instructions under a *de novo* standard of review. *State v. Osorio*, 196 N.C. App. 458, 466, 675 S.E.2d 144, 149 (2009). “A trial court must give a requested instruction that is a correct statement of the law and is supported by the evidence.” *State v. Conner*, 345 N.C. 319, 328, 480 S.E.2d 626, 629 (1997) (citation omitted). Therefore, we review *de novo* whether Defendants’ requested instruction is a correct statement of law and supported by the evidence.

N.C. Gen. Stat. § 90-21.13(b) provides in pertinent part:

A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact. A

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consent that meets the foregoing standards, that is given by a patient, or other authorized person, who under all the surrounding circumstances has capacity to make and communicate health care decisions, is a valid consent.

N.C. Gen. Stat. § 90-21.13(b) (2019). The trial court specifically instructed the jury on the statutory presumption as follows:

A consent which is evident in writing and which meets the foregoing standards and which is signed by the patient or other authorized persons shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof of such consent was obtained by fraud, deception or misrepresentation *or fraudulent concealment of a material fact*. A consent that meets the foregoing standards that is given by a patient or other authorized person, who under all the surrounding circumstances has the capacity to make and communicate healthcare decisions, is a valid consent.

(Emphasis added). The trial court's instruction tracks, nearly verbatim, the language of N.C. Gen. Stat. § 90-21.13(b). The language "fraudulent concealment of a material fact" was added to the jury instruction at Plaintiff's request. Because the instruction was in full accordance with the statute, we hold Defendants' requested instruction is a correct statement of the law.

Next, we determine whether the evidence supports Defendants' requested instruction. It is undisputed that LAVH was the procedure identified on the Consent Form that Ms. Hauser signed. It is also undisputed that Defendant Doctor performed a TAH. Plaintiff contends that the Consent Form "did not give Defendant Doctor the authorization to do an open surgical procedure" and "[t]here is no way that a

‘presumption’ instruction should be given to the jury regarding a written consent form where the physician performs a different surgery from what is listed on the written consent form.” However, this assertion ignores the explicit language of the Consent Form:

Unexpected events may happen during the operation. These events may cause the operation to last longer than expected. They may require a different procedure from that listed above. *If this happens, I give permission for such surgical procedures determined to be necessary.*

(Emphasis added). Based on the plain language of the Consent Form, Ms. Hauser’s signature evidenced her authorization for Defendant Doctor to perform the LAVH and “such surgical procedures determined to be necessary.”

As stated above, N.C. Gen. Stat. § 90-21.13(b) establishes a presumption that a written consent, that is signed by the patient or other authorized person and “meets the foregoing standards,” is a valid consent. Accordingly, to determine whether the instruction was supported by evidence, we must determine whether the Consent Form “meets the foregoing standards” referenced in N.C. Gen. Stat. § 90-21.13(b) and set forth in N.C. Gen. Stat. § 90-21.13(a):

(1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and

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(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; or

(3) A reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this subsection.

N.C. Gen. Stat. § 90-21.13(a).

Ms. Hauser asserts that Defendant Doctor never informed her of the risks of the LAVH and never discussed the possibility of converting the LAVH into an open procedure or a TAH; Defendant Doctor asserts he explicitly discussed with Ms. Hauser each consideration listed on the Consent Form, including the risks of the LAVH and the possibility that the LAVH may be transformed to a TAH. Our review of Defendants' requested instruction is limited to a determination of whether there is evidence of N.C. Gen. Stat. § 90-21.13(a)(1) and either N.C. Gen. Stat. §§ 90-21.13(a)(2) or (a)(3).

First, as to whether Defendant Doctor obtained Ms. Hauser's informed consent in accordance with the standards of care under N.C. Gen. Stat. § 90-21.13(a)(1), Defendants presented expert testimony from obstetrician gynecologists Dr. Andre Hall ("Dr. Hall") and Dr. John Lafferty ("Dr. Lafferty"). Dr. Hall testified

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that upon reviewing Defendant Doctor's "[f]airly methodical" medical records, he was able to "follow the progression of [Ms. Hauser's] visits and the progressive symptoms" "from 2005 as we march toward 2009." Referencing Defendant Doctor's records from specific appointments with Ms. Hauser, Dr. Hall's opinion was that it was common for Defendant Doctor to engage in lengthy discussions with Ms. Hauser regarding her condition, his surgical recommendations, and the next steps. Indeed, in Dr. Hall's opinion, Defendant Doctor completed a thorough physical and historical evaluation of Ms. Hauser every time he saw her. Dr. Hall explained that although the ACOG pamphlet provided to Ms. Hauser by Defendant Doctor was "not part of the consent form[,]" it was "part of the informed consent process" and it placed Ms. Hauser on notice that an open abdominal procedure was a possibility. In sum, Dr. Hall's opinion was that Defendant Doctor's discussions with Ms. Hauser and the materials he provided to Ms. Hauser met the standard of care for obtaining Ms. Hauser's consent.

Dr. Lafferty testified that he discovered, upon review of Defendant Doctor's records, that "[t]here were several discussions [between Defendant Doctor and Ms. Hauser] in the years leading up to the operation." Dr. Lafferty testified that in his opinion,

[Ms. Hauser] was apprized (sic) to the risk of the surgery. That can be done in many different ways. The way [Defendant Doctor] does it, which is absolutely the way many gynecologists do, is hand [his patients] the official ACOG form on this that talks about the risks, talks about the indications. And that was given to [Ms. Hauser] before

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surgery. The appropriate form was filled out, the actual form where the patient has to sign. And that was signed by her and by [Defendant Doctor]. And in that way, I think the appropriate informed consent was done.

The testimony of Dr. Hall and Dr. Lafferty was sufficient evidence that Defendant Doctor complied with the standard of care among similarly trained GYN surgeons in Winston-Salem in obtaining Ms. Hauser's informed consent for the 3 September 2009 hysterectomy.

Second, we determine whether, pursuant to N.C. Gen. Stat. § 90-21.13(a)(2), there is evidence that a reasonable person would have a general understanding of the procedure and of the usual and most frequent risks and hazards inherent in the procedure. Defendant Doctor's records indicate that at every appointment from 2006 to 2009, Defendant Doctor and Ms. Hauser discussed Ms. Hauser's evolving symptoms, Defendant Doctor's treatment recommendations, and any associated risks. Additionally, the ACOG pamphlet given to Ms. Hauser at the 1 September 2009 pre-operative appointment provided the risks associated with a LAVH, including blood clots in the veins or lungs. The ACOG pamphlet states, "[i]n some cases, an abdominal hysterectomy may be required if a LAVH could not be done." Finally, the Consent Form signed by Ms. Hauser explicitly states that "[b]y signing here, I fully understand the content of this document." Ms. Hauser's signature on the Consent Form evinced her acknowledgment that Defendant Doctor had discussed with her—and that she understood—the nature and purpose of the operation, the

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benefits of the operation, the usual and most often risks of the operation, all reasonable options and their risks, and the risk of no operation. Thus, there was evidence presented that a reasonable person would have a general understanding of the procedure and its inherent risks.

Plaintiff contends that the presumption instruction is not pertinent to the facts of this case and posits that “[i]t cannot be realistically argued that if a patient agreed in a valid written consent form to have minor hand surgery on his left hand that the surgeon could do major surgery on his right foot.” However, Dr. Hall clarified that the “actual consent” evinced by Ms. Hauser’s signature on the Consent Form was to “remove the uterus;” Dr. Hall explained that it “would have been a completely different issue, if for example this was a consent for a hysterectomy and Ms. Hauser, say, woke up and her gall bladder was removed. That is a different organ being removed.” In regard to the procedure explicitly listed on the Consent Form—the LAVH—Dr. Hall explained, “we try and put as much information as possible” on a written consent form regarding “what our plan is going in” and “what we intend to do.” According to Dr. Hall, in this case, a LAVH “was the plan moving forward[;]” however, “things changed that altered what [Defendant Doctor] had to do and decisions he had to make intraoperatively.” Thus, we reject the contention that the presumption instruction was not pertinent to the evidence.

In sum, we hold that Defendants' requested instruction was a proper statement of the law and was supported by the evidence.

III. Character Evidence

Plaintiff contends that the trial court erred by prohibiting her from cross-examining Defendant Doctor about additional requirements that were placed on his surgical privileges in 2013. Specifically, Plaintiff contends that Defendant Doctor's "testimony on direct examination about his outstanding medical career and reputation entitled . . . Plaintiff to cross-examine him regarding his career and reputation." We disagree.

In reviewing evidentiary rulings by the trial court, "we defer to the trial court and will reverse only if the record shows a clear abuse of discretion." *Gray v. Allen*, 197 N.C. App. 349, 352, 677 S.E.2d 862, 865 (2009). A trial court abuses its discretion "where its ruling is manifestly unsupported by reason or is so arbitrary that it could not have been the result of a reasoned decision." *Id.* at 353, 677 S.E.2d at 865 (internal citation and quotation marks omitted). However, "an error in the admission of evidence is not grounds for granting a new trial or setting aside a verdict unless the admission amounts to the denial of a substantial right." *Suarez v. Wotring*, 155 N.C. App. 20, 30, 573 S.E.2d 746, 752 (2002). "The burden is on the appellant to not only show error, but also to show that he was prejudiced and a different result would have likely ensued had the error not occurred." *Id.*

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In this case, the trial court allowed Plaintiff to conduct a *voir dire* of Defendant Doctor about: (1) surgical complications he encountered in the years prior to Ms. Hauser's surgery; (2) restrictions placed on his surgical privileges in 2013; and (3) two internet complaints about him. At the *voir dire* hearing, Defendant Doctor testified that he had encountered complications in the performance of ten surgeries before he operated on Ms. Hauser. Defendant Doctor also testified that after a 2013 review of his surgeries revealed he "had lost more blood than typical[,] he was instructed by a GYN oncologist at Forsyth that he "needed to have a physician assistant on difficult cases." Defendants objected to the admissibility of that evidence based on Rules 404(b) and 608(b) of the North Carolina Rules of Evidence. The trial court sustained Defendants' objections as to the internet complaints and the surgical restrictions; the trial court explained "the similarity to this procedure and relevance to this case is weak, prejudicial effect is high. Under 404, the objection is sustained. It will not be permitted." However, in regard to Defendant Doctor's prior history of surgical complications, the trial court overruled Defendants' objection and ruled that Plaintiff could cross-examine Defendant Doctor about the ten surgical complications he had encountered. Plaintiff asked the court to reconsider its decision to exclude evidence of the surgical restrictions placed on Defendant Doctor; the trial court stated, "[i]f it were closer in time or more similar in procedure, I might balance it

differently. But it's too remote, too distinct to have sufficient relevance and outweigh the prejudicial effect.”

We note that Plaintiff advances no argument that evidence of Defendant Doctor's restricted privileges was admissible under Rule 404(b) or Rule 608 of the North Carolina Rules of Evidence. *See* N.C. Gen. Stat. §§ 8C–1, Rules 404(b) and 608 (2019). Instead, Plaintiff argues that Defendant Doctor's testimony on direct examination “opened the door” to an inquiry about his restricted surgical privileges and appears to challenge the trial court's decision to exclude the evidence under Rule 403 of the North Carolina Rules of Evidence. We address each in turn.

The Supreme Court has held that under certain circumstances, “otherwise inadmissible evidence may be admissible if the door has been opened by the opposing party's cross examination of the witness.” *State v. Baymon*, 336 N.C. 748, 752, 446 S.E.2d 1, 3 (1994). “Opening the door refers to the principle that where one party introduces evidence of a particular fact, the opposing party is entitled to introduce evidence in explanation or rebuttal thereof, even though the rebuttal evidence would be incompetent or irrelevant had it been offered initially.” *Id.* at 752–53, 446 S.E.2d at 3 (quoting *State v. Sexton*, 336 N.C. 321, 360, 444 S.E.2d 879, 901 (1994)).

Plaintiff asserts that when Defendant Doctor testified about his educational background and medical career, she should have been afforded the opportunity to rebut this evidence on cross-examination. However, Defendant Doctor's direct

testimony about his career did not include admissible evidence that in 2013, restrictions were placed on his surgical privileges. Indeed, evidence of the imposition of surgical restrictions four years after Ms. Hauser's procedure in no way rebuts Defendant Doctor's testimony about his academic and medical career path. Thus, Plaintiff has failed to show that Defendant Doctor opened the door to questions about the restrictions placed on his surgical privileges.

Plaintiff also appears to challenge the trial court's decision to exclude evidence that restrictions were placed on Defendant Doctor's surgical privileges under Rule 403. Rule 403 permits a trial court to exclude evidence "if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury." *State v. Triplett*, 368 N.C. 172, 178, 775 S.E.2d 805, 808–09 (2015); N.C. Gen. Stat. § 8C–1, Rule 403 (2019). The trial transcript shows that the trial court conducted an appropriate Rule 403 balancing analysis. The trial court looked to the weak relevance of the evidence and remote proximity in time and weighed it against the "high" prejudicial effect. Because Plaintiff has failed to show that the trial court's decision was not the result of a reasoned decision, we hold the trial court did not abuse its discretion in excluding evidence of the surgical restrictions.

Assuming, *arguendo*, that the trial court erred by not allowing Plaintiff to cross-examine Defendant Doctor on the restrictions placed on his surgical privileges,

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Plaintiff has failed to demonstrate prejudice. Over Defendants' objection, the trial court admitted evidence that Defendant Doctor had encountered surgical complications on ten occasions prior to the date he operated on Ms. Hauser. Plaintiff returned to this evidence during closing arguments:

Members of the jury, ten, ten, ten women who were injured by [Defendant Doctor] before he ever got to Mrs. Hauser. And we'll never know their names. We'll never see their faces because we have HIPAA laws and privacy laws that protect their personal information. But their spirits, I would contend to you, are in this courtroom today. Who were those ten? Who were those ten? But he entered those ten women and he never took responsibility for any of those ten, just like he's never taken responsibility for injuring and severely damaging the life of Mrs. Hauser.

Thus, because the trial court admitted evidence of Defendant Doctor's prior history of ten surgical complications, Plaintiff has failed to demonstrate prejudice.

Finally, Plaintiff argues, for the first time on appeal, that Defendant Doctor gave misleading testimony that he voluntarily gave up his surgical privileges because he "never acknowledged that Forsyth Medical Center 'involuntarily' restricted his hospital privileges." Plaintiff contends that Defendant Doctor's testimony is admissible under Rule 611(b) of the North Carolina Rules of Evidence because it "raises an issue of credibility." However, Plaintiff did not preserve this argument before the trial court and, as a result, she has waived any right to appellate review of this issue. *Khaja v. Husna*, 243 N.C. App. 330, 349, 777 S.E.2d 781, 792 (2015) ("As

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a general rule, the failure to raise an alleged error in the trial court waives the right to raise it for the first time on appeal.”).

IV. Conclusion

For the reasons discussed above, we find no error in the jury’s verdict or in the trial court’s judgment entered thereon.

NO ERROR.

Judges TYSON and COLLINS concur.

Report per Rule 30(e).