Survey of Recent Developments in Medical Malpractice Law

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The Indiana Court of Appeals and the Indiana Supreme Court addressed a number of medical malpractice issues during the survey period. There was little activity, however, in either the Indiana Legislature or the United States Court of Appeals for the Seventh Circuit during the survey period. Six categories of cases decided by the Indiana Court of Appeals and the Indiana Supreme Court will be examined in this Article: (1) cases in which applicability of the Medical Malpractice Act[1] is in question, (2) cases involving the issue of informed consent, (3) the case that discarded the modified locality rule, (4) cases involving the doctrine of continuing wrong and the statute of limitations, (5) cases addressing procedural matters, and (6) cases regarding proof of proximate cause in medical malpractice cases. This Article will summarize those cases and provide a more extended discussion and analysis of proof of proximate cause in Indiana, as well as how the law on causation in negligence cases, in general, relates to proof of proximate cause in medical malpractice cases.[2]

I. SUMMARY OF MEDICAL MALPRACTICE DECISIONS IN 1992

A. Cases in Which Applicability of the Act Is in Question

In *Miller v. Terre Haute Regional Hospital*,[3] a suit for wrongful death, the Indiana Supreme Court confirmed that the filing of a proposed

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1. *See* IND. CODE §§ 16-9.5-1-1 to -10-5 (1988 & Supp. 1992).

2. Three important cases for medical malpractice practitioners are not within the scope of this Article. For a discussion of the Federal Emergency Medical Treatment and Active Labor Act and preemption, see HCA Health Servs. of Ind., Inc. v. Gregory, 596 N.E.2d 974 (Ind. Ct. App. 1992), which appears to conflict with Power v. Arlington, 800 F. Supp. 1384 (E.D. Va. 1992). *See also* Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F. Supp. 853 (S.D. Ind. 1989); J. Michael Grubbs, *Health Law Update*, 23 IND. L. REV. 391, 391-406 (1990). For a discussion of limits on discovery of incident reports as being subject to the peer review privilege, see Community Hosps. of Indianapolis, Inc. v. Medtronic, Inc., 594 N.E.2d 448 (Ind. Ct. App. 1992). For recognition of preconception torts, see Yeager v. Bloomington Obstetrics and Gynecology, Inc., 585 N.E.2d 696 (Ind. Ct. App. 1992).

3. 603 N.E.2d 861 (Ind. 1992).

complaint against a health care provider with the Indiana Department of Insurance tolls the statute of limitations until the parties are informed that the provider was not qualified under the Act at the time of the alleged malpractice. The court held that "upon such notice [that the provider was not qualified], the statute of limitations begins to run again and the claimant must file an action in court or risk being time barred."[4] This rule of law was clearly enunciated in *Guinn v. Light*.[5] In *Guinn*, the court declared the new procedure regarding the effect of filing a proposed complaint with the Department upon the medical malpractice statute of limitations to be prospective and exempted the plaintiff Guinn from its application. The court found Guinn's filing to have been made timely, stating, "we will not hold Guinn accountable for failing to follow procedure where the proper procedure was unsettled."[6]

The procedural facts in *Miller* are substantially similar to those in *Guinn*. Miller's son died at Terre Haute Regional Hospital on November 21, 1986. Miller filed a proposed complaint against the hospital with the Department on November 18, 1988. Thereafter, the Department sent a letter indicating that the hospital was not a qualified health care provider under the Act.[7] Miller received a copy of the letter on November 29, 1988.

On December 20, 1988, Miller filed a complaint against the hospital in the Vigo Circuit Court. The circuit court granted summary judgment in favor of the hospital because plaintiff's action was time barred. The court of appeals, rigidly followed *Guinn* and affirmed, holding that the two-year limitations period was tolled three days before its expiration.[8] Miller failed to file his complaint within the three days after being notified that the hospital was not a qualified provider.[9] Therefore, the court held that Miller's action was not timely commenced.[10]

The supreme court noted that the court of appeals' calculation was correct for factual situations arising after *Guinn*. However, Miller filed his complaints in 1988, before *Guinn* was decided. "Thus, like Guinn, Miller was unaware of the proper procedure to follow after a determination that a health care provider is not qualified under the Act. Application of the new rule announced in *Guinn* to a plaintiff in Miller's position would be patently unfair."[11] Thus, the court vacated the court

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4. *Id.* at 863 (citing Guinn v. Light, 558 N.E.2d 821, 824 (Ind. 1990)).
5. 558 N.E.2d 821 (Ind. 1990).
6. *Id.* at 824.
7. *See* IND. CODE § 16-9.5-1-5 (Supp. 1992).
8. *Miller*, 603 N.E.2d at 862.
9. *Id.* at 863.
10. *Id.*
11. *Id.*

of appeals' decision and reversed the circuit court's entry of summary judgment.[12]

In *Van Sice v. Sentany*,[13] the court was faced with the issue of whether the plaintiff's allegations of the intentional torts of fraud and battery removed his complaint from the requirements of the Act. This case raised the question of the extent to which allegations of intentional torts against qualified health care providers lie within the scope of the Act. Dr. Sentany performed an operation on Van Sice to treat a tumor in his finger. Van Sice alleged fraud and misrepresentation in that the recommended course of treatment involved unnecessary surgery. Van Sice also alleged battery in that the doctor did not fully inform him about the course of treatment.

The court determined that the substance of the plaintiff's allegations of fraud and battery were actually claims for malpractice.[14] The court noted that to maintain his claim of fraud, the plaintiff would first have to prove that the course of treatment was improper. The question of whether a given course of treatment is medically proper "is the quintessence of a malpractice case."[15] Regarding the plaintiff's allegation of battery, because Dr. Sentany failed to fully disclose the inherent risks of, and alternatives to, the course of treatment, the court reiterated that "acts which constitute a breach of the duties to disclose information and obtain informed consent . . . are malpractice."[16] Therefore, the court held plaintiff's complaint was within the scope of the Act.[17]

In *Collins v. Covenant Mutual Insurance Co.*,[18] the Indiana Court of Appeals was presented with the issue of insurance coverage for acts in which there was a question as to whether the alleged acts were claims for intentional tort or medical malpractice.[19] The plaintiff, Covenant, was the insurer of Dr. Thakkar, whom Collins had filed suit against for wrongful abortion, assault and battery, and intentional infliction of emotional distress.[20] Covenant brought an action against Thakkar, Col-

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12. *Id.* at 864.
13. 595 N.E.2d 264 (Ind. Ct. App. 1992).
14. *Id.* at 267.
15. *Id.*
16. *Id.* (quoting Boruff v. Jesseph, 576 N.E.2d 1297, 1299 (Ind. Ct. App. 1991)).
17. *Id.*
18. 604 N.E.2d 1190 (Ind. Ct. App. 1992).
19. In Collins v. Thakkar, 552 N.E.2d 507 (Ind. Ct. App. 1990), the court concluded that Collins' claims of intentional tort were not torts based on health care or professional services rendered by a health care provider and, therefore, Collins was not required to submit those claims to a medical review panel before bringing her action against Thakkar. Collins later filed a second suit against Thakkar alleging that his acts constituted medical malpractice. Collins' two actions against Thakkar were consolidated and venued to the Shelby Circuit Court, where the case is pending. *Covenant*, 604 N.E.2d at 1192.
20. *Covenant*, 604 N.E.2d at 1192.

lins, and several of Thakkar's other patients who had filed similar actions against him, seeking a declaratory judgment in regard to its obligations for Thakkar's acts under Thakkar's professional liability insurance policy.[21] Covenant moved for summary judgment against Collins and the trial court granted it. The trial court concluded:

> Plaintiff's motion for Summary Judgment is hereby GRANTED, as there are no genuine issues of material fact. Plaintiff CMIC is entitled to judgment as to Count 1 of its declaratory judgment complaint, as a matter of law. A review of the uncontested factual basis of Defendant Collins' claims against defendant Thakkar, a review of the terms of the subject insurance policy issued to defendant Thakkar by CMIC and its predecessor, and a review of *Collins v. Thakkar*, 552 N.E.2d 507 (Ind. App. 1990), *transfer denied*, ____N.E.2d ____(Ind. 1990), decided on identical facts as presented by this record, compel the conclusion that there is no coverage under the subject insurance policy for the claims of defendant Collins against defendant Thakkar. Therefore, defendant Collins has no right to or interest in any proceeds of the subject insurance policy.[22]

In deciding whether the trial court properly entered summary judgment in Covenant's favor, the court of appeals stated that its conclusion in *Collins v. Thakkar*[23] "in no way prevented her from pursuing a malpractice action against Thakkar."[24] The court further stated that in *Collins v. Thakkar* they had not concluded "that the facts on which those claims were based could not also support malpractice allegations."[25]

Covenant's insurance policy provided, in pertinent part, that Covenant would "'pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages arising out of individual professional liability; personal injury caused by error, omission, or negligence in *providing health care services*, rendered or which should have been rendered by the insured.'"[26] Covenant, in moving for summary judgment, claimed that Thakkar's actions, being intentional torts, did not constitute the rendition of health care services and, therefore, were not covered by his policy. Collins maintained that her complaint against Thakkar contained four separate allegations of negligence in the rendering

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21. *Id.*
22. *Id.* at 1193 (quoting trial court record at 186-87).
23. 552 N.E.2d 507 (Ind. Ct. App. 1990).
24. *Covenant*, 604 N.E.2d at 1195.
25. *Id.*
26. *Id.* at 1194 (quoting trial court record at 23) (emphasis in court's opinion, but not in original).

of health care services: "(1) that Thakkar entered into a sexual relationship with her while she was his patient, (2) that Thakkar impregnated her while she was his patient, (3) that Thakkar told her she was not pregnant when she was, and (4) that Thakkar mistreated her after the exam and failed to properly treat the wound he inflicted."[27]

The court disagreed with Collins' assertion that her first two claims against Thakkar were malpractice. After examining decisions of other courts which have addressed the issue of a physician's sexual conduct with a patient,[28] the court concluded that Thakkar's sexual relationship with Collins "cannot be characterized as the provision of health care services and is therefore not within the scope of coverage of his insurance policy with Covenant."[29]

In regard to Collins' other two allegations, that "Thakkar misinformed her of the results of a medical procedure and that he negligently performed that medical procedure,"[30] the court found that those claims could "arguably be construed as claims for 'personal injury caused by error, omission or negligence in providing health care services' as covered by Covenant's insurance policy."[31] The court stated: "As the evidence submitted by Covenant demonstrates that Collins alleged that Thakkar negligently provided health care services to her, causing her personal

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27. *Id.* at 1195.

28. The court looked to other jurisdictions that had considered whether a physician's sexual conduct with a patient was actionable as medical malpractice. "The general rule is that a physician's sexual relationship with a patient does not constitute rendition of health care services, and is not actionable as medical malpractice." *Id.* at 1196 (citing Standlee v. St. Paul Fire & Marine Ins. Co., 693 P.2d 1101 (Idaho Ct. App. 1984)). The court found that a distinction has been made between the therapist-patient relationship and a physician-patient relationship, because the former offers a course of treatment and counselling predicated upon handling the transference phenomenon. Transference occurs when patients reveal their innermost feelings and thoughts to the therapist, develop intense, intimate relationship with the therapist and often "falls in love" with the therapist. The therapist must encourage the patient to express the transferred feelings, while rejecting any erotic advances. This may be difficult to do and presents an "occupational risk." The therapist in this situation has a duty, imposed by professional standards of care as well as by ethical standards of behavior, to refrain from a personal relationship with the patient, whether during or outside therapy sessions. *Id.* (quoting St. Paul Fire & Marine Ins. Co. v. Love, 459 N.W.2d 698, 701 (Minn. 1990)).

> So absent a patient-therapist relationship, in which the risk of mishandling the transference phenomenon is an occupational hazard generally within the scope of professional liability insurance coverage, a physician's sexual activity with a patient does not give rise to an actionable claim of medical malpractice and does not constitute the provision of health care services.

Id. at 1196-97 (citations omitted).

29. *Id.* at 1197.

30. *Id.*

31. *Id.* (quoting trial court record at 23).

injury, Covenant has failed to establish that it is entitled to judgment as a matter of law."[32] The court of appeals held that the trial court erred when it relied on the appeals decision in *Collins v. Thakkar*[33] to enter summary judgment against Collins on her negligence claims.[34]

In *St. Anthony Medical Center v. Smith*,[35] the Indiana Court of Appeals held that the trial court had subject matter jurisdiction over plaintiff's medical malpractice claim after the medical review panel rendered its opinion and the plaintiff filed a motion for reinstatement.[36] On July 8, 1987, Smith filed her medical malpractice complaint in the Lake Circuit Court.[37] On July 9, 1987, Smith filed an identical complaint with the Department. On February 23, 1989, the medical review panel concluded that St. Anthony Medical Center (SAMC) failed to comply with the appropriate standard of care.[38] On May 8, 1989, Smith filed a motion to reinstate her complaint with the trial court. Thereafter, on August 29, 1989, the defendant, SAMC, filed a motion to dismiss for lack of subject matter jurisdiction.

The circuit court denied defendant's motion to dismiss and rendered judgment for plaintiff, although reducing the jury's award of damages to the amount allowed by the Malpractice Act.[39] On appeal, SAMC argued that the trial court did not have subject matter jurisdiction over Smith's claim because it did not meet the procedural requirements of the Act. Indiana Code section 16-9.5-9-2 provides:

> Except as provided in subsection (b) and in section 3.5 of this chapter, no action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter and an opinion is rendered by the panel.[40]

Smith's original complaint was filed in circuit court before the medical review panel had issued its opinion. Because the plaintiff filed a motion for reinstatement after the panel had rendered its opinion, the court of appeals held that the trial court did have subject matter jurisdiction over plaintiff's claim.[41]

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32. *Id.* at 1197-98.
33. 552 N.E.2d 507 (Ind. Ct. App. 1990).
34. *Covenant*, 604 N.E.2d at 1198.
35. 592 N.E.2d 732 (Ind. Ct. App. 1992).
36. *Id.* at 736-37.
37. The case was assigned to Jasper Circuit Court on Sept. 11, 1989.
38. *St. Anthony*, 592 N.E.2d at 735.
39. *Id.* For applicable liability limits see IND. CODE § 16-9.5-2-2 (Supp. 1992).
40. IND. CODE § 16-9.5-9-2 (1988).
41. *St. Anthony*, 592 N.E.2d at 736. Had the defendant filed its motion to dismiss

B. Allegations of Lack of Informed Consent in Medical Malpractice Cases

In *Tudder v. Torres*,[42] the Indiana Court of Appeals held that the trial court did not err in admitting into evidence the medical review panel's opinion "which concluded that (1) the evidence did not support the allegations of failure to meet the applicable standard of care, and (2) there did not exist a material issue of fact, not requiring expert opinion, which needed to be considered by the fact finder."[43] After undergoing gastric bypass surgery in order to lose weight, the plaintiffs, Tudder and Gibson, developed complications. Alleging that the defendants were negligent for performing surgery without their informed consent, the plaintiffs filed a proposed complaint with the Insurance Department.[44] During trial, the panel's opinion was admitted into evidence over the plaintiffs' objections. Judgment was entered on a jury verdict in favor of the defendants.

On appeal, the plaintiffs argued that the panel exceeded its statutory authority by resolving a conflict in the evidence related to whether the plaintiffs were advised of the risks and possible complications involved with the surgery.[45] The plaintiffs argued that the panel should have rendered the opinion "that there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury."[46] The court, after examining the statutory language of the Act and analyzing the court's reasoning in *Dickey v. Long*,[47] concluded that the panel's opinion was properly introduced into evidence.[48]

One of two informed consent cases decided on October 29, 1992, by the Indiana Supreme Court was *Culbertson v. Mernitz*.[49] After a physical examination, Dr. Mernitz recommended that the plaintiff undergo a surgical procedure known as the Marshall Marchette Krantz (MMK) procedure. Dr. Mernitz contended that prior to the surgery he

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before the panel rendered its opinion, when the trial court did lack subject matter jurisdiction over the complaint, the court would have been required to dismiss the cause of action without prejudice, leaving Smith free to refile her complaint after the panel rendered an opinion. *Id.*

42. 591 N.E.2d 656 (Ind. Ct. App. 1992).

43. *Id.* at 657.

44. *Id.*

45. *See* IND. CODE § 16-9.5-9-7 (1988).

46. *Tudder*, 591 N.E.2d at 657.

47. 575 N.E.2d 339 (Ind. Ct. App. 1991), *opinion adopted by* Dickey v. Long, 591 N.E.2d 1010 (Ind. 1992). In *Dickey*, the panel resolved a question of fact which did not require an expert opinion in issuing its opinion. *See infra* notes 123-32 and accompanying text.

48. *Tudder*, 591 N.E.2d at 658.

49. 602 N.E.2d 98 (Ind. 1992).

advised the plaintiff of (1) the general risks of any surgery; (2) the risk that the bladder suspension procedure could fail and she would be unable to void;[50] and (3) that the plaintiff would have severe vaginal discharge for two weeks, and a milder discharge for six weeks, after the surgery. The plaintiff, on the other hand, denied that any of these risks were explained to her. Both parties, however, agreed that Dr. Mernitz did not advise the plaintiff of the risk that the cervix could become adhered to the wall of the vagina.

The plaintiff filed a proposed complaint with the Department alleging four counts, one of which was "that Dr. Mernitz failed to inform Mrs. Culbertson of the alternatives to surgery and the inherent risks and complications of surgery."[51] The medical review panel opinion concluded:

> [Dr. Mernitz] did not advise [Mrs. Culbertson] of the complication of cervical adhesion to the vagina; the Panel further determines that such non-disclosure does not constitute a failure to comply with the appropriate standard of care, as such complication is not considered a risk of such surgery requiring disclosure to the patient.[52]

The plaintiff proceeded by filing an action against Dr. Mernitz. Relying on the expert opinion issued by the medical review panel, Dr. Mernitz moved for summary judgment. The trial court granted Dr. Mernitz's motion for summary judgment on all four counts.[53]The plaintiff appealed on the informed consent issue, arguing "that expert medical testimony is not necessary to make a *prima facie* case of lack of informed consent because the 'prudent patient' standard is the law in this State and such standard does not contemplate the necessity of expert medical testimony."[54] The court of appeals agreed with the plaintiff and held that the trial court erred in granting defendant's motion for summary judgment in regard to the issue of informed consent because an issue of fact remained which did not require expert testimony in regard to the materiality of the issue.[55]

The Indiana Supreme Court vacated the court of appeals' opinion and affirmed the trial court's grant of summary judgment in favor of Dr. Mernitz.[56] The supreme court was called upon to determine the role

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50. To eliminate solid or liquid waste from the body. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 1321 (1984).

51. *Culbertson*, 602 N.E.2d at 99.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 104.

to be played by expert medical opinion in resolving claims of medical malpractice premised upon a failure to obtain an informed consent.[57] After analyzing the prudent physician standard versus the prudent patient standard, and the rationale for each, the court determined that the law in Indiana remains unchanged and that the prudent physician standard governs medical malpractice cases involving informed consent.[58] Accordingly, the supreme court held that "except in those cases where deviation from the standard of care is a matter commonly known by lay persons expert medical testimony is necessary to establish whether a physician has or has not complied with the standard of a reasonably prudent physician."[59] Because the plaintiff failed to provide expert medical testimony to refute the unanimous opinion issued by the panel, the court held her claim did not present "a material issue of fact as to what a reasonably prudent physician would have discussed during this proposed surgery."[60] The supreme court affirmed the trial court's entry of summary judgment against the plaintiff.[61]

On October 29, 1992, the Indiana Supreme Court was faced with another case involving an informed consent issue in *Griffith v. Jones*.[62] However, before reaching the issue of informed consent, the court raised, sua sponte, the issue of whether the trial court exceeded its authority in acting upon a motion for preliminary determination of law. The issue of informed consent raised by the parties was not considered because of the way the court disposed of case, but the court did refer the parties to its opinion in *Culbertson*.[63]

In *Griffith*, the plaintiff filed a motion for preliminary determination of law with the court before the panel could render its opinion. The plaintiff requested that "the court order the medical review panel to find that there were material issues of fact not requiring expert opinion bearing on liability for consideration by the court or jury as regards

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57. For a historical discussion of Indiana jurisprudence regarding informed consent, see *id.* at 101-03.

58. *Id.* at 104.

59. *Id.*

60. *Id.*

61. *Id.*

62. 602 N.E.2d 107 (Ind. 1992). Jones underwent a femoral angiography performed by Dr. Griffith. Jones was not advised that there was a risk of death associated with the procedure. After the surgery was performed, Jones suffered anaphylactic shock brought on by a reaction to the radiographic contrast dye used during the procedure. Epinephrine was administered intermuscularly, although it should have been administered intravenously. Jones could not be resuscitated and died. Jones' personal representative filed a proposed complaint with the Department. Part of her allegations focused on Dr. Griffith's failure to obtain the informed consent of Jones. *Id.* at 108-09.

63. *See supra* notes 49-61 and accompanying text.

the issue of informed consent."[64] She also requested the court to construe the term "a factor"[65] and to enter partial summary judgment in her favor on the issue of informed consent.[66] The trial court issued certain findings of fact and conclusions of law as preliminary determinations.[67] Dr. Griffith appealed from this order. "The court of appeals affirmed the trial court in its entirety, and held that the weight of authority in Indiana supports the trial court's determination that the 'prudent patient standard of care in informed consent cases . . . has been adopted in Indiana.'"[68] Additionally, the court of appeals affirmed the trial court's instructions to the panel, as well as its denial of the motion for partial summary judgment.[69]

The Indiana Supreme Court raised sua sponte the issue of the trial court's authority to preliminarily determine the issues requested by plaintiff. The court noted that section 16-9.5-10-1 of the Indiana Code:

> grants to a court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner the power to "preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the Indiana Rules of Procedure; or (2) compel discovery in accordance with the Indiana Rules of Procedure; or (3) both."[70]

In examining the "interplay between the legislature's intended informal functioning of the panel and its empowering of the trial court to preliminarily determine certain matters,"[71] the court found that "the grant of power to the trial court to preliminarily determine matters is to be narrowly construed" as governed by the Indiana Trial Rules.[72] The court held that Indiana Code section 16-9.5-10-1 "specifically limits the power of the trial courts of this State to preliminarily determining affirmative defenses under Trial Rules, deciding issues of law or fact that may be

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64. *Griffith*, 602 N.E.2d at 109. *See* IND. CODE § 16-9.5-9-7(c) (1988).

65. *See* IND. CODE § 16-9.5-9-7(d) (1988) ("The conduct complained of was or was not *a factor* of the resultant damages.") (emphasis added).

66. *Griffith*, 602 N.E.2d at 109.

67. The court's pertinent findings of fact and conclusions of law were: (1) the "prudent patient" standard applied in informed consent cases, (2) the panel cannot render expert opinion regarding compliance with the prudent patient standard, (3) motion for partial summary judgment was denied but the panel was directed to find that there were material issues of fact not requiring expert opinion, (4) the phrase "a factor" lowers the traditional threshold of causation. *Id.*

68. *Id.* (quoting Griffith v. Jones, 577 N.E.2d 258, 264 (Ind. Ct. App. 1991)).

69. *Id.*

70. *Id.* at 110 (quoting IND. CODE § 16-9.5-10-1 (1988)).

71. *Id.*

72. *Id.*

preliminarily determined under Trial Rule 12(D), and compelling discovery pursuant to Trial Rules 26 through 37, inclusively."[73]

The court further held that "the trial courts of this State do not have jurisdiction to instruct the medical review panel concerning definitions of terms and phrases used in the Medical Malpractice Act, the evidence that it may consider in reaching its opinion, or the form or substance of its opinion."[74] The court determined that the medical review panel "should be allowed to operate in the informal manner which was contemplated by the legislature."[75] Accordingly, the court of appeals' opinion was vacated and the trial court's preliminary rulings were reversed because the Indiana Supreme Court held that the trial court exceeded its authority to preliminarily determine the law in this case.[76]

C. Abandonment of Indiana's Modified Locality Rule

In *Vergara ex rel. Vergara v. Doan*,[77] the Indiana Supreme Court abandoned the modified locality rule, finding "that the reasons for the Modified Locality Rule are no longer applicable in today's society."[78] The modified locality rule circumscribes the standard of care as: "that degree of care, skill and proficiency which is commonly exercised by ordinarily careful, skillful and prudent [physicians], at the time of the operation and *in similar localities*."[79] The court noted that "the disparity between small town and urban medicine continues to lessen with advances in communication, transportation, and education, [and that] . . . widespread insurance coverage has provided patients with more choice of doctors and hospitals by reducing the financial constraints on the consumer in selecting caregivers."[80]

The Indiana Supreme Court adopted the following standard of care for medical malpractice: "A physician must exercise that degree of care, skill and proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the

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73. *Id.*
74. *Id.* at 111.
75. *Id.*
76. *Id.*
77. 593 N.E.2d 185 (Ind. 1992). Javier Vergara was born on May 31, 1979, in Decatur, Indiana. His parents claimed that negligence on the part of Dr. Doan during Javier's delivery caused him severe and permanent injuries. The jury returned a verdict for Dr. Doan and plaintiffs appealed. The court of appeals affirmed the lower court and plaintiffs sought transfer to the Indiana Supreme Court, asking the court to abandon Indiana's modified locality rule. *Id.* at 186.
78. *Id.* at 186.
79. *Id.*
80. *Id.* at 187.

same or similar circumstances."[81] The court further explained that "this standard uses locality as but one of the factors to be considered in determining whether the doctor acted reasonably. Other relevant considerations would include advances in the profession, availability of facilities, and whether the doctor is a specialist or general practitioner."[82]

D. The Doctrine of Continuing Wrong and the Statute of Limitations

Two cases were decided in 1992 by the Indiana Court of Appeals regarding the statute of limitations and the doctrine of continuing wrong in medical malpractice cases.[83] In *O'Neal v. Throop*,[84] O'Neal sought medical treatment from Dr. Throop for a knee injury on June 22, 1988. On June 30, 1988, Throop reattached O'Neal's torn medial collateral ligament to the bone with a metallic staple. After the surgery Throop prescribed physical therapy. O'Neal sought therapy at Rehab Works on July 19, 1988, and continued therapy at Rehab Works through August 19, 1988. O'Neal's progress was slow. On September 7, 1988, O'Neal saw Throop again and Throop concluded the staple had come loose. On September 8, 1988, O'Neal sought treatment from another orthopedic surgeon who purportedly told O'Neal that Throop had attached the staple incorrectly. In his complaint, O'Neal alleged that Dr. Throop provided negligent medical treatment for his knee and that Rehab Works negligently failed to inform Dr. Throop that O'Neal was making little progress in physical therapy.

O'Neal filed his proposed complaint with the Department on September 13, 1990, and filed a complaint in the Marion Superior Court on the same day. Defendants filed motions for summary judgment alleging that O'Neal's actions were time-barred. After a hearing, the trial court granted defendants' motions and dismissed O'Neal's complaint.[85] Section 16-9.5-3-1 of the Indiana Code, which is a two-year statute of limitations, "has repeatedly been held to be an 'occurrence' rather than a 'discovery' statute."[86] O'Neal argued on appeal that the defendant's negligent medical care was a continuing wrong, and therefore, the statute of limitations did not begin to run on his claims until the

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81. *Id.*

82. *Id.*

83. O'Neal v. Throop, 596 N.E.2d 984 (Ind. Ct. App. 1992); Babcock v. Lafayette Home Hosp., 587 N.E.2d 1320 (Ind. Ct. App. 1992).

84. 596 N.E.2d 984 (Ind. Ct. App. 1992).

85. *Id.* at 986.

86. *Id.* (citing Havens v. Ritchey, 582 N.E.2d 792, 794 (Ind. 1991); Babcock v. Lafayette Home Hosp., 587 N.E.2d 1320, 1323 (Ind. 1992); Hospital Corp. of Am. v. Hilland, 547 N.E.2d 869, 872 (Ind. Ct. App. 1989)).

conduct ceased. The court of appeals found that O'Neal's actions were time barred and affirmed the trial court's dismissal.[87]

Even under the doctrine of continuing wrong, O'Neal's complaint was not timely. "The doctrine of continuing wrong is applicable when an entire course of conduct combines to produce an injury. Under the doctrine, the two-year statute of limitations does not begin to run until the wrongful course of conduct ceases."[88] Dr. Throop informed O'Neal about the loose staple in O'Neal's knee and recommended its removal on September 7, 1988. Therefore, the alleged wrong ceased on September 7, 1988, or at the latest, on September 8, 1988, when another doctor told O'Neal that the staple had been attached improperly. Therefore, the court held under the doctrine of continuing wrong O'Neal had until September 8, 1990, to file his proposed complaint.[89]

O'Neal also argued that Dr. Throop and Rehab Works were estopped from asserting the statute of limitations defense due to the doctrine of fraudulent concealment. The two-year statute of limitations does not apply under the doctrine of fraudulent concealment. Rather, "the plaintiff claiming fraudulent concealment has a duty to bring the action within a reasonable time after discovering the malpractice."[90] "[T]he plaintiff must exercise due diligence in bringing the claim."[91] The court found that even if Throop fraudulently concealed the malpractice, O'Neal was not diligent in filing his claim.[92] He waited more than two years after he learned that Dr. Throop may have attached the staple improperly. The court held that that delay was unreasonable as a matter of law.[93] The court also held that O'Neal's delay in filing against Rehab Works was also unreasonable as a matter of law in that the physician/patient relationship terminated, at the latest, on August 23, 1988, and he did not file his claim until September 13, 1990.[94]

In *Babcock v. Lafayette Home Hospital, Women's Clinic*,[95] the Indiana Court of Appeals affirmed the trial court's grant of defendant's

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87. *Id.* at 988.
88. *Id.* at 987.
89. *Id.* at 987-88.
90. *Id.*
91. *Id.*
92. *Id.*
93. *Id.* at 987.
94. *Id.*
95. 587 N.E.2d 1320 (Ind. Ct. App. 1992). On March 10, 1986, a hysterectomy was performed on Babcock at Lafayette Home Hospital. A second surgery was performed the next day because of complications arising from the first operation. Chest X-rays were taken on March 12, which showed an unexplained pocket of air in Babcock's body cavity. She was later discharged on March 17, 1986. Babcock was examined in the doctor's office on April 14, 1986, where she was informed that she was recovering well, but might

motions for summary judgment based on the expiration of the two-year statute of limitations.[96] Under the doctrine of continuing wrong, "the conduct that produces the injury must be of a continuing nature, not an isolated event."[97] The court found that leaving a surgical sponge in Babcock's body cavity and misreading a chest X-ray were isolated events and, therefore, the doctrine of continuing wrong did not apply.[98]

Babcock argued that the doctrine of fraudulent concealment estopped the defendants from proffering the statute of limitations as a defense.[99] The court upheld the trial court's grant of summary judgment in regard to the issue of fraudulent concealment on two alternative grounds.[100] First, the physician-patient relationship was terminated, at the latest, in July of 1986. The relationship between the hospital and Babcock ended on March 17, 1986, the date of her discharge. Therefore, even if the doctrine of fraudulent concealment applied, the two-year statute of limitations had expired. Second, "Babcock did not use due diligence in initiating her action after discovering the alleged malpractice."[101] The court stated that the plaintiff was not entitled to "two full years from the discovery of the alleged malpractice to file his or her claim."[102] The court stated, "'A plaintiff should have a reasonable time within which to commence an action after discovery of the malpractice.'"[103] Because Babcock waited until June 1, 1989, more than one year after learning of the damage and more than three years after the acts, to file her

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continue to experience symptoms of an upset stomach and be unable to eat spicy foods. Both of which were normal circumstances following a hysterectomy. Approximately four to five months after the hysterectomy, Babcock began to feel "sick all the time." *Id.* at 1322. In May 1988, Babcock sought treatment for a backache from a chiropractor. The chiropractor informed Babcock that X-rays revealed an object may have been left in her body cavity from the hysterectomy. In September, 1988, Babcock consulted another doctor for treatment of a vaginal itch. She was later seen on December 13, 1988 by a hospital emergency room physician for the same problem. "At that time an X-ray revealed a ribbon-like opacity projected over the upper pelvic region." *Id.* Babcock was referred to another doctor who removed a sponge from Babcock's pelvis on January 17, 1989. Babcock filed her proposed complaint with the Department on June 1, 1989. *Id.*

96. *Id.* at 1323-25.

97. *Id.* at 1323.

98. *Id.*

99. Fraudulent concealment tolls the running of the statute of limitations until either the physician/patient relationship ends or the patient discovers the malpractice or learns information which, in the exercise of reasonable diligence, would lead to discovery of the malpractice. *Id.* at 1324.

100. *Id.* at 1324.

101. *Id.*

102. *Id.*

103. *Id.* (quoting Ferrell v. Geisler, 505 N.E.2d 137, 139 (Ind. Ct. App. 1987)).

proposed complaint with the Department, the court found that this delay was unreasonable as a matter of law.[104]

E. Indiana Decisions Affecting Procedural Aspects of Medical Malpractice Cases

In *Surgical Associates, Inc. v. Zabolotney*,[105] the Indiana Court of Appeals determined that proposed members of a medical review panel are not required to answer interrogatories from one of the parties concerning their qualifications to serve on the panel. Plaintiff's counsel filed with the chairman of the panel a list of thirty-five interrogatories to be answered by panel nominees. The defendants objected, and the chairman petitioned the Whitley Circuit Court for the preliminary determination of an issue of law.

The circuit court ruled that the parties were entitled to submit questions to nominees, that the chairman had discretion to control the nature and number of questions, and that any charges by nominees were to be paid as other panel costs.[106] The court then certified the matter for interlocutory appeal.[107]

The court of appeals noted that section 16-9.5-10-1 of the Indiana Code permits the trial court to compel discovery relevant to the subject matter of the pending claim. However, the court went on to note that no provision of the Act affords discovery procedures concerning potential members of the panel. The court emphasized the Act's legislative scheme was designed to secure a fair and acceptable panel. In addition, the court stated that the legislative intent to expedite malpractice panel review was clear. "[T]he time limits the Act seeks to invoke would normally be thwarted by the procedure [of requiring panelists to answer interrogatories] and substantial expense would be added to the proceeding if a number of panelists had to be surveyed."[108] The court also noted that a decision by a review panel is only *evidence* in a subsequent civil action and that the parties have the right to call any members of the panel as witnesses.[109] For these reasons, the court refused to require prospective members of the panel to answer interrogatories proposed by the parties concerning their qualifications to serve on the panel.

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104. *Id.* at 1325.
105. 599 N.E.2d 614 (Ind. Ct. App. 1992).
106. *Id.* at 615.
107. *Id.*
108. *Id.* at 616.
109. *See* IND. CODE § 16-9.5-9-9 (1988).

In *Oelling v. Rao*,[110] the Indiana Supreme Court held that the affidavit of the plaintiff's expert witness was insufficient to raise an issue of fact to prevent summary judgment.[111] The supreme court's holding affirmed the circuit court's grant of summary judgment for the defendants. The defendant moved for summary judgment and submitted the opinion of the medical review panel as support. The court found that the panel's opinion was sufficient to satisfy the defendant's burden of showing no genuine issue of material fact; and therefore, if the plaintiff could not show a breach of the standard of care, the defendants would be entitled to judgment as a matter of law.[112] Once the movant has satisfied its burden, the opponent must set forth specific facts showing that there is a genuine issue for trial.[113] The Oellings attempted to do this by presenting an affidavit of an expert. "To refute the defendants' evidence, the affidavit needed to set out the applicable standard of care and a statement that the treatment in question fell below that standard."[114] The court found that the affidavit of plaintiff's expert "stated only that *he* would have treated Mr. Oelling differently, not that Dr. Rao's treatment fell below the applicable standard."[115]

This case was decided on the same day as *Vergara ex rel. Vergara v. Doan*,[116] which abandoned Indiana's modified locality rule. The court in *Oelling* stated that the new standard differed only slightly from the modified locality rule, which Indiana had been using and proof of the new standard still required expert testimony regarding what "other reasonable doctors similarly situated would have done under the circumstances."[117] The expert's affidavit failed to set out any standard at all. Therefore, the court held it was "insufficient to raise a material issue of fact in regard to whether the defendants' conduct fell below that which was reasonable under the circumstances."[118]

In *Becker v. Plemmons*,[119] the Indiana Court of Appeals decided that the trial court's refusal to allow the defendant Becker to have ex

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110. 593 N.E.2d 189 (Ind. 1992). A patient brought a medical malpractice action against physicians, alleging that cardiac catheterization performed on the patient was unnecessary and resulted in the patient having to undergo cardiac surgery to correct the complications.

111. *Id.* at 190.

112. *Id.*; *see* IND. TRIAL R. 56(C) ("The judgment sought shall be rendered forthwith if the designated evidentiary matter shows that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.")

113. *Oelling*, 593 N.E.2d at 190 (citing IND. TRIAL R. 56(E)).

114. *Id.* at 190 (citing Marquis v. Battersby, 443 N.E.2d 1202 (Ind. Ct. App. 1982)).

115. *Id.* at 190-91.

116. 593 N.E.2d 185 (Ind. 1992); *see supra* notes 77-82 and accompanying text.

117. *Oelling*, 593 N.E.2d at 191.

118. *Id.*

119. 598 N.E.2d 564 (Ind. Ct. App. 1992). Plemmons was admitted to Clark County

parte conferences with Plemmons' treating physicians was not reversible error. Although not in the record, Becker alleged that the trial court orally denied the motion on the basis of physician-patient privilege. The court of appeals addressed the issue as if the trial court did make such ruling. The court noted that when "a party-patient places a condition in issue, he waives the physician-patient privilege as to '. . . all matters causally or historically related to that condition, and information which would otherwise be protected from disclosure by the privilege then becomes subject to discovery.' "[120]

The court then analyzed the methods of discovery allowed in Indiana under Indiana Trial Rule 26(A)(1)-(5) in order to determine if the ex parte conference was an authorized method of discovery. Discovery methods set forth in Indiana Trial Rule 26(A)(1)-(5) include oral and written depositions, interrogatories, requests for production of documents, and requests for admissions. "Nowhere in our trial rules does it provide for informal *ex parte* conferences; hence, the trial court did not abuse its discretion in denying that Becker's motion for a protective order."[121] The court indicated Becker could have used other authorized methods of discovery to obtain information from Plemmons' treating physicians. Thus, the court held that the trial court did not abuse its discretion in denying Becker's motion.[122]

In *Dickey v. Long*,[123] the Indiana Supreme Court decided that a medical review panel's report was admissible when the panel determined a material issue of fact not requiring expert opinion. Dickey brought a medical malpractice action against an optometrist. The panel's opinion concluded that "the evidence does not support the conclusion that the defendant, James A. Long, II, O.D., failed to comply with the appropriate standard of care as charged in the Complaint."[124] After the panel issued its opinion, Dickey filed a complaint in Allen Superior Court.

Hospital for elective shoulder surgery on January 13, 1986. Dr. Karia, Dr. Jimenez and Becker, a certified registered nurse anesthetist, were to perform the anesthesia during the surgery. Becker, however was the only anesthetist present during Plemmons' surgery. The blood pressure and heart rate monitor was turned on at approximately 7:31 a.m. and the monitor began recording at 7:45 a.m. Sometime between 8:16 a.m. and 8:21 a.m., Plemmons had no recordable blood pressure or heart rate. Plemmons was in cardiac arrest. The code for cardiac arrest was not called until 8:30 a.m. Plemmons was eventually resuscitated and stabilized. Plemmons was later pronounced brain dead and his respirator was removed. He died on January 16, 1986. *Id.* at 566.

120. *Id.* at 569 (quoting Owen v. Owen, 563 N.E.2d 605, 608 (Ind. 1990)).

121. *Id.* at 569. Becker filed a pretrial motion for a protective order requesting the trial court to authorize *ex parte* conferences with the plaintiff's treating physicians.

122. *Id.*

123. 591 N.E.2d 1010 (Ind. 1992).

124. *Id.* at 1010.

Prior to trial, Dickey sought a motion in limine to exclude the panel's report from evidence. The motion was denied as was Dickey's objection during trial when the report was offered into evidence.

On appeal, Dickey argued that "the decision of the panel was inadmissible because it exceeded the panel's statutory authority in that one member of the panel allegedly conceded that his decision was based on a determination of a material issue of fact that did not require expert opinion."[125] Dickey claimed that the court of appeals' decision conflicted with the prior opinion of *Spencer v. Christiansen*.[126] Dickey argued the court in *Spencer* held a panel's report was inadmissible "if the medical review panel assumed or determined a disputed fact not requiring expertise in making its decision."[127] The supreme court dismissed Dickey's argument by finding that the quotation relied on from *Spencer* was "merely *dicta*."[128] The court in *Spencer* specifically held that the panel had not resolved the disputed fact and, consequently, could not have exceeded its authority.[129]

The supreme court relied on Indiana Code section 16-9.5-9-9, which states:

> *[A]ny* report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law . . . .[130]

The supreme court declared that "[t]he provision for admissibility is unambiguous and absolute."[131] The court held that the court of appeals' opinion was correctly reasoned and that the panel's report was admissible as evidence.[132]

F. Decisions by the Indiana Court of Appeals Regarding Causation Issues

In *Malooley v. McIntyre*,[133] the court of appeals declared that a plaintiff in a malpractice suit must proffer some evidence of causation when a medical review panel unanimously finds that no causation exists

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125. *Id.*
126. 549 N.E.2d 1090 (Ind. Ct. App. 1990), *trans. denied.*
127. *Dickey*, 591 N.E.2d at 1010 (citing *Spencer*, 549 N.E.2d at 1091).
128. *Id.*
129. *Id.* at 1010-11 (citing *Spencer*, 549 N.E.2d at 1091-92).
130. *Id.* at 1011 (citing IND. CODE § 16-9.5-9-9 (1988) (emphasis in court's opinion, but not in original)).
131. *Id.* (quoting Dickey v. Long, 575 N.E.2d 339, 340 (Ind. Ct. App. 1991)).
132. *Id.*
133. 597 N.E.2d 314 (Ind. Ct. App. 1992).

between the defendant's actions and the plaintiff's injury or ailment.[134]

In *Malooley,* the plaintiff failed to produce expert evidence that the conduct complained of was a factor in the plaintiff's injuries. McIntyre was admitted to University Heights Hospital on July 19, 1986, and evaluated and treated by Dr. Malooley, a neurologist. Electroencephalogram (EEG) and CT-scan tests were performed on McIntyre that produced abnormal results. Dr. Malooley released McIntyre and prescribed physical therapy and medication. Later, she was examined by Dr. Cure, who after consulting with Dr. Malooley, prescribed pain medication and also released her. On August 21, 1989, McIntyre was taken to Methodist Hospital Emergency Room, where Dr. Malooley ordered another CT Scan and lumbar puncture. McIntyre was later admitted to the Neuro Constant Care Unit at Methodist. On August 26, 1986, she underwent a clip ligation of a carotid artery aneurism. McIntyre died at Methodist on August 29, 1986.

The estate of McIntyre filed a proposed complaint with the Department of Insurance against Dr. Cure and Dr. Malooley. The medical review panel decided that there was no causal link between McIntyre's death and the actions of the defendants. Two of the panel members found the doctors' conduct was not a factor in the death. The third member found it was impossible to tell from the evidence whether the doctors' conduct was a factor.

The estate of the deceased filed suit in civil court, and Dr. Malooley and Dr. Cure filed separate motions for summary judgment. The defendants argued that: the panel did not find a causal link between McIntyre's death and the actions of the doctors, and that the estate presented no expert opinion or other evidence of a causal link.[135] The trial court denied both motions, and the defendants appealed.[136]

The issue before the court of appeals was whether summary judgment is proper in a medical malpractice case in which there is no expert evidence that the defendants' conduct was a factor in the plaintiff's damages. The court recognized expert opinion is not always required in medical malpractice cases. Cases which the court recognized as not requiring expert testimony are those in which negligence may be inferred by resorting to common knowledge,[137] or those based on the doctrine of res ipsa loquitur.[138]

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134. *Id.* at 319.
135. *Id.* at 316.
136. *Id.*
137. *Id.* (citing Stumph v. Foster, 524 N.E.2d (Ind. Ct. App. 1988)).
138. *Id.* at 319. *See also* Killebrew v. Johnson, 404 N.E.2d 1194, 1197 n.2 (Ind. Ct. App. 1980).

The court noted that the cases recognizing the exceptions to the expert testimony requirement relate to the issue of the standard of care only. This case was different. The standard of care and the breach of the standard were established by evidence. Only the question of proximate cause had not been proven by independent evidence. The court stated that the issue of causation involved "the delicate inter-relationship between a particular medical procedure and the causative effect of that procedure upon a given patient's structure, endurance, biological make-up and pathology" and that such an issue was not susceptible to resolution by common knowledge.[139]

Thus, the court held that when no member of a review panel opines that causation exists, the plaintiff in a civil suit must do more than rest upon his complaint.[140] Evidence must be proffered so that the trial court could reasonably infer a causal link between the health care provider's actions and the complainant's damage.[141]

In *Dillon v. Glover*,[142] the court of appeals held that the Patient's Compensation Fund of Indiana may argue that the wrong standard was adopted for compensation of an injury in a petition for excess damages from the Fund, but that it cannot litigate the issue of proximate causation after a provider has settled its liability.[143] In *Dillon,* the complainant settled with the defendants out of court for $100,000. The complainants then petitioned for excess damages from the Fund, pursuant to Indiana Code section 16-9.5-4-3.[144] The trial court awarded $400,000 from the

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139. *Malooley*, 597 N.E.2d at 319.

140. *Id.*

141. *Id.*

142. 597 N.E.2d 971 (Ind. Ct. App. 1992). Glover, a cigarette smoker, began experiencing pain in the right side of his chest in 1983. On January 11, 1984, X-rays of Glover's chest were taken and analyzed by Dr. Garvish at Radiology Services, Inc. ("RSI"). Dr. Garvish determined that the X-ray revealed no abnormality and no further tests were performed. In October, 1984, X-rays were again taken and a cancerous tumor in his lung was discovered. The tumor had grown 400% since January and the growth prevented surgical treatment of the tumor. Glover died on June 12, 1986. The personal representative of Glover's estate instituted a medical malpractice action against Dr. Garvish and RSI for wrongful death, claiming that their negligence in misreading Glover's X-ray proximately caused his death.

143. *Id.* at 973-74.

144. Section 16-9.5-4-3 provides, in pertinent part:

> If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of $100,000, and the claimant is demanding an amount in excess thereof, then the following procedure must be followed:
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> . . .
>
> (5) . . . if the Commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the *amount*, if any, to be paid out of the patient's compensation fund, then the Court, *after hearing any relevant*

Fund to Glover's wife for loss of love, care, and affection. The Fund[145] appealed and argued the defendants' negligence did not proximately cause Glover's death. Rather, they argued it only cost him a *chance* to live and that cancer was the proximate cause of Glover's death. Therefore, they argued that plaintiff should not be compensated by the Fund.

The court examined Indiana Code section 16-9.5-4-3, which contemplates that, upon a petition for excess damages, the trial court will determine the *amount* of damages, not *whether* the provider is liable for damages. The appeals court declared: "This statute is unambiguous, in fact it could be characterized as a paragon of clarity."[146]

The court then found that "[i]n determining the amount to be paid from the Fund 'the court shall consider the liability of the health care provider as admitted and established' if it has agreed to settle its liability."[147] The court distinguished this case from *Eakin v. Kumiega*,[148] by recognizing that injuries from negligent infliction of emotional distress are noncompensable, whereas death is a compensable injury.[149]

In *Chambers ex rel. Hamm v. Ludlow*,[150] the Indiana Court of Appeals recognized that not every element of a prima facie case of medical malpractice must be established by *one* expert opinion and that there are certain circumstances in which testimony is better divided among more than one expert.[151] Chambers' proposed complaint was submitted to a medical review panel. Two of the doctors on the panel opined that the evidence did not support the conclusion that the defendants breached

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evidence on the issue of claimant's damages, submitted by any of the parties described in this section, shall determine the *amount* of claimant's damages, if any, in excess of the $100,000 already paid by the insurer of the health care provider. The Court shall determine the *amount* for which the fund is liable and render a finding and a judgment accordingly. In approving a settlement or determining the *amount*, if any, to be paid from the patient's compensation fund, the Court shall consider *the liability of the health care provider as admitted and established.*

IND. CODE § 16-9.5-4-3 (Supp. 1992) (emphasis supplied).

145. The Fund refers to the appellant-respondent, John Dillon, the Commissioner of Insurance of Indiana and the Administrator of the Patient's Compensation Fund of Indiana.

146. *Dillon*, 597 N.E.2d at 973.

147. *Id.* (quoting IND. CODE § 16-9.5-4-3 (Supp. 1992)).

148. 567 N.E.2d 150 (Ind. Ct. App. 1991).

149. *Dillon*, 597 N.E.2d at 973 (citing IND. CODE § 34-1-1-2 (1988)).

150. 598 N.E.2d 1111 (Ind. Ct. App. 1992). Chambers was delivered by caesarean section after numerous attempts were made to deliver him naturally. Later, he was diagnosed as having severe metabolic acidosis, severe respiratory depression, seizures, and a possible inter-cranial hemorrhage. Chambers is mentally retarded. Chamber's complaint alleged that his mental retardation was the result of injuries he sustained during his birth caused by the medical malpractice of Dr. Ludlow and the hospital.

151. *Id.* at 1117.

the applicable standard of care. The other panelist opined that the defendants did breach the applicable standard of care but that the "conduct complained of was not a factor of the resultant damages."[152]

The plaintiff filed a medical malpractice action in the trial court and the defendants moved for summary judgment, submitting the medical review panel's opinion as support. The court stated that when the medical review panel opines that the plaintiff failed to satisfy any element of his prima facie case, as it did in this case, the plaintiff must produce expert medical testimony to refute the panel's opinion to survive summary judgment.[153] In opposition to the motion, plaintiff submitted affidavits of two physicians. One opined that the medical care and treatment rendered to Chambers and his mother by Ludlow and the hospital fell below a reasonable standard of care and resulted in the birth injuries. The other opined that the injuries Chambers suffered at birth caused his mental retardation.

To establish a *prima facie* case of medical malpractice, the plaintiff must establish by expert testimony three things: (1) the applicable standard of care, (2) how the defendant doctor breached that standard of care, and (3) that the defendant doctor's negligence in doing so was the *proximate cause* of the injuries complained of.[154] When the Medical Review Panel opines that the plaintiff has failed to satisfy any one element of his *prima facie* case, the plaintiff must then come forward with expert medical testimony to refute the Panel's opinion in order to survive summary judgment.[155]

The defendants asserted that the plaintiff's affidavit failed to set out the applicable standard of care under Indiana law. The Court refused to express an opinion on the issue because the medical review opinion of one panelist established for the purposes of summary judgment that the defendants did fail to comply with the appropriate standard of care as charged in plaintiff's complaint.[156] The panelist's opinion established all but the third element of Chamber's prima facie case, the element of proximate cause. Therefore, the plaintiff was "able to survive summary judgment by establishing, through expert medical testimony that the medical negligence charged in his complaint was the proximate cause of his complained of injuries and damages."[157] The court held that for the

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152. *Id.* at 1114.

153. *Id.* at 1116 (citing Malooley v. McIntyre, 597 N.E.2d 314 (Ind. Ct. App. 1992); Stackhouse v. Scanlon, 576 N.E.2d 635 (Ind. Ct. App. 1991), *trans. denied*).

154. *Id.* (citing Bethke v. Gammon, 590 N.E.2d 573 (Ind. Ct. App. 1991)).

155. *Id.*

156. *Id.* at 1117.

157. *Id.* at 1117-18.

purpose of summary judgment, the affidavits were competent to establish that the conduct Chambers complained of was the proximate cause of his injuries and mental retardation.[158]

II. Proximate Cause in Medical Malpractice Cases

A. Proximate Cause in Indiana — General Standards in Negligence Cases[159]

It is settled law in Indiana that tortious conduct need not be the *sole* proximate cause of the injury to support recovery of damages.[160] "It is sufficient if the act, concurring with one or more efficient causes, other than the plaintiff's fault, is the proximate cause of the injury."[161] As the Indiana Court of Appeals explained in *Boyle v. Anderson Firefighters Ass'n Local 1262*,[162] "[T]here can be more than one proximate cause attributed to a particular injury, and 'the fact that accidental or innocent causes or conditions and concurring wrongful acts of other parties joined to produce a given injury does not affect the liability of any one of the wrongdoers.'"[163]

Indiana law on proximate cause is illustrated by the analysis in *Ortho Pharmaceutical Corp. v. Chapman*.[164] The plaintiff there prevailed on a showing that the defendant's failure to provide an adequate warning in regard to the health hazards of its oral contraceptive was a proximate cause of the plaintiff's injuries. The defendant had argued that the injury was not causally connected to the inadequacy of the warning due to the occurrence of several other factors. The factors included evidence that even an adequate warning would not have been heeded, that the drug was used beyond the prescription dosage, and that the plaintiff failed to report preliminary symptoms. The court examined each factor and concluded that, despite the convergence of these independent cir-

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158. *Id.* at 1118.

159. Special thanks to Todd A. Richardson of Lewis & Kappes for his research and analysis on the law of proximate cause in Indiana.

160. *E.g.*, Elder v. Fisher, 217 N.E.2d 847, 852 (Ind. 1966).

161. *Id.*

162. 497 N.E.2d 1073 (Ind. Ct. App. 1986).

163. *Id.* at 1083 (quoting City of Indianapolis v. Bates, 205 N.E.2d 839, 848 (Ind. Ct. App. 1965) (quoting South Bend Elec. Co., N.E.2d 786, 793 (Ind. Ct. App. 1980))); *see also* Ortho Pharmaceutical Corp. v. Chapman, 388 N.E.2d 541, 555 (Ind. Ct. App. 1979) ("The defendant's acts need not be the sole proximate cause; many causes may influence a result."); Surratt v. Petrol, Inc., 312 N.E.2d 487, 495 (Ind. Ct. App. 1974) ("To effect liability, the law does not require defendant's conduct to be the *only* causative act.").

164. 388 N.E.2d 541, 555-58 (Ind. Ct. App. 1979).

cumstances, judgment for the plaintiff was soundly supported by evidence that the inadequacy of the warning was a substantial contributing factor of the injury.[165]

Under Indiana law, the ultimate test of proximate cause is reasonable foreseeability. "In determining whether a cause of injury is actionable, the test is to be found not in the number of intervening events, but in the character of the original act and its natural and probable consequences."[166] "[I]t is well-settled that for a negligent act or omission to be a proximate cause of injury, the injury need be only a natural and probable result thereof; and the consequence be one which in the light of the circumstances should reasonably have been foreseen or anticipated."[167] Indiana courts have consistently held that the fundamental test of proximate cause is one of reasonable foreseeability, even in the presence of allegedly intervening causes.[168]

B. Evidence Required to Prove Proximate Cause in Medical Malpractice Cases

To establish a prima facie case of medical malpractice, a plaintiff must demonstrate "(1) a *duty* on the part of the defendant in relation to the plaintiff; (2) *failure* on the part of defendant to conform his or her conduct to the requisite standard of care required by the relationship; and (3) an *injury* to the plaintiff resulting from that failure."[169]

> Generally, in order to maintain a claim of medical malpractice, the plaintiff must establish by expert medical testimony (1) the applicable *standard of care* required by Indiana law; (2) *how*

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165. *Id. See* Johnson v. Bender, 369 N.E.2d 936, 939-40 (Ind. Ct. App. 1977) ("Thus, if the defendant's negligence is a substantial factor in producing plaintiff's injury, and if the particular injury suffered is one of a class that was reasonably foreseeable at the time of the defendant's wrongful act, then there is a causal relation in fact as well as legal cause."). *See also* Harper v. Guarantee Auto Stores, 533 N.E.2d 1258, 1264 (Ind. Ct. App. 1989); Yater v. Keil, 351 N.E.2d 920, 924 (Ind. Ct. App. 1976).

166. *Harper*, 533 N.E.2d at 1264.

167. Elder v. Fisher, 217 N.E.2d 847, 852 (Ind. 1966). *See also* Peavler v. Board of Comm'rs of Monroe County, 557 N.E.2d 1077, 1080 (Ind. Ct. App. 1990).

168. *See* Dreibelbis v. Bennett, 319 N.E.2d 634, 638 (Ind. Ct. App. 1974) ("[T]he ultimate test of legal proximate causation is reasonable foreseeability. The assertion of an intervening, superseding cause fails to alter this test."); City of Indianapolis v. Falvey, 296 N.E.2d 896, 903 (Ind. Ct. App. 1973) ("The question of whether or not an intervening act is present does not change the test of reasonable foreseeability in determining proximate cause."); Stauffer v. Ely, 270 N.E.2d 889, 892 (Ind. Ct. App. 1971) ("In short, reasonable foreseeability is still the fundamental test of proximate cause, and this rule is not changed by the existence of an intervening act or agency.").

169. Oelling v. Rao, 593 N.E.2d 189, 190 (Ind. 1992) (citations omitted) (emphasis added).

> the defendant health care provider *breached* that standard of care; and (3) that the defendant doctor's negligence in doing so was the *proximate cause* of the injuries complained of.[170]

Expert opinion evidence is not, however, always required in medical malpractice cases.[171] One category of such cases are those which fall within the "common knowledge" exception to the need for expert testimony.[172] Where negligence on the "part of a doctor is demonstrated by facts which can be evaluated by resorting to common knowledge, expert testimony is not required."[173] In addition, Indiana courts have also "occasionally dispensed with the need for expert opinion based upon the doctrine of *res ipsa loquitur*."[174]

The exceptions to the expert testimony requirement have mainly been applied to cases dealing with the issue of breach of the standard of care.[175] The court of appeals in *Malooley* recognized:

> Application of this exception in such cases is appropriate when limited to situations in which the complained-of conduct is so obviously substandard that one need not possess medical expertise in order to recognize the breach. It is otherwise when the question involves the delicate inter-relationship between a particular medical procedure and the causative effect of that procedure upon a given patient's structure, endurance, biological make up, and pathology. The sophisticated subleties of the latter question are not susceptible to resolution by resort to mere common knowledge.[176]

Based on this statement, the medical malpractice practitioner choosing not to use expert opinion to establish the causal link between the complainant's injuries and the defendant's acts or omissions may be taking a risk. It would be a prudent measure to establish the element of proximate cause by means of expert testimony. When the panel opinion states that the complainant failed to establish any element of the mal-

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170. Chambers *ex rel.* Hamm v. Ludlow, 598 N.E.2d 1111, 1116 (Ind. 1992) (citing Bethke v. Gammon, 590 N.E.2d 573 (Ind. Ct. App. 1991)) (emphasis added). The defendant's conduct only has to be a "factor" causing plaintiffs harm or injury. IND. CODE § 16-9.5-9-7(D) (1988).

171. Malooley v. McIntyre, 597 N.E.2d 314, 318 (Ind. Ct. App. 1992). *See supra* notes 133-41 and accompanying text.

172. *Malooley*, 597 N.E.2d at 318.

173. Stumph v. Foster, 524 N.E.2d 812, 816 (Ind. Ct. App. 1988) (quoting Mascarenas v. Gonzales, 497 P.2d 751, 753-54 (N.M. Ct. App. 1992)).

174. *Malooley*, 597 N.E.2d at 319. *See supra* note 135.

175. *Id.*

176. *Id.*

practice case, it is imperative that the plaintiff submit expert opinion in the form of affidavit[177] proving such element.

The issue of sufficiency of medical testimony to establish proximate cause of a plaintiff's injury was addressed in *Ingersoll-Rand Corp. v. Scott*.[178] Scott's medical witness testified in terms of mere possibility, as opposed to probability or reasonable medical certainty. The court stated:

> An emphasis upon the standard used to evaluate medical testimony is appropriate when such evidence is the *only evidence to establish proximate cause*. Where, however, there is other independent evidence from which a reasonable trier of fact may find the causal link, medical testimony which is not counted in terms of certainty or strong probability is not fatal to a plaintiff's verdict.[179]

In *Ingersoll*, there was independent evidence which related to causation. The court in *Ingersoll* stated, "The evidence here as to the occurrence itself gives rise to a permissible conclusion of proximate cause."[180]

Indiana case law has explicitly determined that when a member of a medical review panel opines that causation does not exist or cannot be determined from the evidence, the complainant, to avoid summary judgment, must present evidence from which the trial court can reasonably infer a causal link between the health care provider's acts or omissions and the complainant's injuries.[181]

It is also established that to withstand summary judgment, the opinion of the medical review panel is sufficient to establish at least some of the elements of the complainant's prima facie case.[182] As in *Chambers*, additional expert opinion testimony may be necessary to establish one of the three elements of the medical malpractice case not established by the panel's opinion, such as the element of proximate cause.[183]

Thus, it appears that the general rules regarding proof of proximate cause in negligence cases apply to medical malpractice cases, but that there are special considerations regarding proof of this element of the tort. Plaintiffs are required to prove that the negligence (*i.e.*, breach of the standard of care) was a substantial factor in causing harm to the

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177. *See* IND. TRIAL R. 56(C).

178. 557 N.E.2d 679 (Ind. Ct. App. 1990).

179. *Id.* at 681.

180. *Id.* (footnote omitted).

181. *E.g.*, Malooley v. McIntyre, 597 N.E.2d 314, 319 (Ind. Ct. App. 1992).

182. *E.g.*, Chambers *ex. rel.* Hamm v. Ludlow, 598 N.E.2d 1111, 1117 (Ind. Ct. App. 1992); *see supra* note 156 and accompanying text.

183. *See supra* note 157 and accompanying text.

plaintiff. The test for whether or not the negligent act was a substantial factor will be the foreseeability of the harm to the plaintiff from the point of the negligent act. Further, the question of proximate cause is one for the trier of fact.

Proof of proximate cause in medical negligence cases will come in three forms. First, in a limited number of cases, the proximate cause issue will be so obvious from the evidence of the standard of care and breach that the jury may be allowed to refer to its "common knowledge" in arriving at a decision on the issue of proximate causation. An example of this may be leaving scissors inside a body cavity following surgery.

Second, there may be "independent evidence" relating to causation, such as in the *Ingersoll* case. This may come from evidence relating to the medical treatments required to correct the problem created by the defendant's breach of the standard of care, or from physical evidence relating of plaintiff's condition before the negligence of the defendant, as compared with plaintiff's physical condition after the negligent act.

Finally, there can be specific opinion testimony from a qualified expert regarding whether the negligence of the defendant was a substantial factor causing harm to the plaintiff. An expert may specifically testify that the harm to the plaintiff was one of the untoward consequences that could have been foreseen from the point of the defendant's negligent act.