MEDICAL MALPRACTICE UPDATE

by Mark A. Lienhoop

This is a brief summary of recent significant cases involving allegations of medical malpractice. The cases included were decided in 1992 or later. The cases listed and the discussions of them are not intended to be exhaustive, only illustrative.

NOTE: Indiana's Medical Malpractice Act (the Act) has been moved from Title 16. It is now found at I.C. 27-12-1-1 et. seq.

Act's Application

Plaintiffs usually file in state court at the same time they file with the Department of Insurance. This protects against the occasional health care provider who had not "qualified" under the Act. It also protects against the assertion that the allegations do not come within the ambit of the Act.

Nevertheless, the filing of a state court complaint proved unnecessary in *Van Sic v. Sentany*, 595 N.E.2d 264 (Ind. Ct. App. 1992). In *Van Sic*, the patient consulted defendant for treatment of a finger tumor. The defendant performed operations on the finger to remove cancerous tissue. Besides a proposed complaint based on medical malpractice, the patient also filed a state court complaint alleging fraud and battery. The patient claimed that the defendant falsely represented that the method of treatment was proper and that a battery was committed because of the defendant's failure to get an informed consent.

The court in *Van Sic* held that "malpractice" refers to any tort, including intentional torts. Only conduct unrelated to the promotion of a patient's health or the provider's professional skill is excluded. *Id.* Therefore the trial court's dismissal of the state court complaint was affirmed.

The state court complaint was also dismissed in *Putnam County Hosp. v. Sells*, 619 N.E.2d 968 (Ind. Ct. App. 1993). Sells fell from her bed in the recovery room while still under anesthesia after an operation. The court distinguished this from a premises liability claim because Sells was not alleging faulty premises or equipment. Instead, the allegations were essentially that the hospital had used poor professional judgment in failing to take certain precautions regarding surgical patients recovering from anesthesia.

As *Van Sic* and *Putnam County* illustrate, plaintiffs' counsel must state the claim very carefully to avoid the procedural requirements of the Act or its limitation on damages.

How to do this was perhaps best illustrated in *Collins v. Covenant Mut. Ins. Co.*, 604 N.E.2d 1190 (Ind. Ct. App. 1992). Originally the patient had filed a state court complaint against her doctor alleging assault and battery and intentional infliction of emotional distress. The patient claimed that she had a sexual relationship with the doctor. When the doctor examined her to determine if she was pregnant, she claimed he told her she was not, performed some crude abortion, then left her unattended.

The original case went up on appeal when the trial court dismissed it for not first going through the panel. The Court of Appeals reversed, holding that these claims were not based on health care or professional services.

Later the same patient filed a claim for medical malpractice based on the same facts, alleging that the doctor had misinformed her about her pregnancy and had not properly treated her for the wound he had inflicted.

The doctor's malpractice insurer filed a declaratory judgment action alleging there was no coverage. Based on the Court of Appeals' first decision, the trial court granted the insurer summary judgment. The Court of Appeals reversed. It said that its first decision held that those particular claims did not involve the rendering of health care.

However, that did not mean that the facts on which those claims were based could not also support these malpractice allegations. *Id*. at 1195.

After reading *Van Sic*, *Putnam County*, and *Collins*, the safest practice continues to be filing in state court at the same time the proposed complaint is filed with the Department of Insurance. Indeed, there is little incentive not to, since there have been no appellate cases holding unnecessary state court filings as frivolous.

When a plaintiff files a true malpractice claim against a "qualified" provider in state court before going through the panel, the defendant can move to dismiss without prejudice. *St. Anthony Medical Center v. Smith*, 592 N.E.2d 732, 736 (Ind. Ct. App. 1992). If the defendant fails to do so, however, then plaintiff's early state court complaint may be sufficient to avoid any post-panel limitation problem. It was in *St. Anthony, supra*.

Causation

Of course, expert opinion is usually required to establish a breach of the standard of care. This requirement and its exceptions will be discussed under the heading **Expert**-below. In addition, expert opinion on the issue of causation is also necessary, if the panel has found no causation and the matter is not one of "common knowledge." This is according to *Malooley v. McIntyre*, 597 N.E.2d 314 (Ind. Ct. App. 1992).

McIntyre died despite treatment by several doctors. Two of the medical review panel members found a breach of the standard of care but no causation. One panel member found a breach of the standard of care and found that it was not possible to determine whether the breach was a factor resulting in the patient's death.

The defendants sought summary judgment based on the panel's opinion. The trial court denied it but the Court of Appeals reversed. Because this was not a situation within people's common knowledge, the plaintiff was required to come forward with expert opinion creating an issue of fact on the causation element.

Summary judgment was granted on the same basis in *Weaver v. Robinson*, 627 N.E.2d 442 (Ind. Ct. App. 1993). In *Weaver*, the plaintiff presented affidavits from an apparently qualified expert who stated that certain defendants breached the standard of care. However, the affidavits did not state that the breaches were a proximate cause of the plaintiff's injuries.

A very different causation issue was decided by the Indiana Supreme Court in *Walker v. Rinck*, 604 N.E.2d 591 (Ind. Ct. App. 1992). In *Walker* the Court held that having additional children after the parents knew of Rh sensitization was not an intervening, superseding cause of the children's health problems.

The parents had alleged that the lab had incorrectly determined that the pregnant mother had Rh positive blood. Consequently, the medication to prevent antibodies from

developing that could harm future Rh positive fetuses was not given. The parents went on to have more children after knowing this, and suit was brought alleging that certain health problems of these children were the result of the failure to prevent the harmful antibodies from developing during the first pregnancy.

The Court in *Walker* held that a superseding, intervening cause must be unforeseeable. Since the very purpose of giving this medicine was to prevent this type of harm to the couple's future children, their having more children with these types of problems was entirely foreseeable. Therefore, the parents' continuing procreation did not break the chain of causation.

Another causation issue addressed recently involved the doctrine of res ipsa loquitur. That doctrine is a rule of evidence which infers negligence where the "injuring instrumentality" is under the "exclusive control" of the defendant and the result probably does not happen unless the defendant was negligent. *Vogler v. Dominguez,* 624 N.E.2d 56 (Ind. Ct. App. 1993).

In *Vogler* the court reminds us that even in a *res ipsa* case, if causation is not within common sense and experience, expert testimony is required. The facts and reasoning behind the Vogler decision are discussed in greater detail under the heading **Expert**- below.

Undoubtedly the biggest change in Indiana law regarding the element of causation in medical malpractice cases was the adoption of the loss of chance doctrine in *Mayhue v. Sparkman*, 627 N.E.2d 1354 (Ind. Ct. App. 1994). Mrs. Sparkman underwent radiation treatment for cervical cancer in 1981. Her pap smears in 1989 showed abnormal cells. She was referred to Dr. Mayhue who thought the abnormal cells were the result of inflamation and not a recurrence of the cancer. He was wrong and Mrs. Sparkman died in November of 1990.

The panel found a breach of the standard of care, but also found that the breach was not a factor in the result. Dr. Mayhue filed a motion for summary judgment. Several experts agreed that Mrs. Sparkman would have had less than a fifty percent (50%) chance of survival if Dr. Mayhue had promptly diagnosed the recurrence of the cancer.

In a two (2) to one (1) decision the Court of Appeals for the Fifth district adopted what they called the "pure" loss of chance doctrine. Under this doctrine, the plaintiff must show that it is more likely than not that the patient lost a substantial chance of survival because of the physician's malpractice. What a "substantial" chance is must be determined on a case by case basis. Damages are for the lost chance and not for the death itself. The measure is "the percentage probability by which the defendant's tortious conduct diminished the likelihood of achieving some more favorable result."

The court stated that the doctrine is applicable to any lost chance for a better result and is not limited to cases where the patient dies.

As of this writing, this opinion had not been released for publication in the permanent law reports. Until released it is subject to revision or withdrawal.

Damages

Two recent similar decisions held that the Act's limitations on total damages and on damages against any individual provider applies per injury and not per act of malpractice.

The first of these is *St. Anthony Medical Center v. Smith*, 592 N.E.2d 732 (Ind. Ct. App. 1992). There the court found that the Act allows recovery of a limited total for "any injury or death." Thus, the surviving widow in *St. Anthony* was limited to recover only once for the death of her husband, regardless of the number of separate acts of malpractice. Although the statutory language regarding limits on individuals is different, the court held that to interpret "occurrence" (regarding the individual limit) as less comprehensive than "injury or death" (regarding the total limit) would be inconsistent with the overall intent of the Act.

The same result was reached in *Bova v. Roig*, 604 N.E.2d 1 (Ind. Ct. App. 1992). In *Bova*, the patient alleged that through a series of malpractice acts he received several

injuries ultimately resulting in loss of the sight in his left eye. The court cited *St. Anthony* with approval and decided that Bova had really suffered but one injury, blindness in his left eye. Therefore, Bova was bound by the Act's limitations on total damages.

The total damage limit of the Act is significant because in both *St. Anthony* and in *Bova* the jury had returned verdicts in excess of the Act's total damage limit. In each case the court reduced the judgment to the total damage limit and in each case the Court of Appeals upheld the limitation on damages as constitutional.

Counsel has not yet been inventive enough to circumvent the total damage limit of Indiana's Medical Malpractice Act.

Defenses

Indiana has a "Good Samaritan Law" found at I.C. 34-4-12-1. It essentially provides that anyone who gratuitously renders emergency care at the scene of an accident, or to the victim of an accident, is not civilly liable except for gross negligence or for willful or wanton misconduct.

Doctors in two recent cases tried to use this statute defensively but in both cases the Court of Appeals rejected their arguments.

The trial court's denial of this defense was affirmed in *Beckerman v. Gordon*, 614 N.E.2d 610 (Ind. Ct. App. 1993). Dr. Beckerman was called to the Gordons' home in

the middle of the night. He was not her regular physician but was in practice with the Gordons' family doctor and lived nearby. Apparently he failed to initially diagnose Mrs. Gordon's serious cardiac problem and she died as a result. The medical review panel found a breach of the standard of care and found that the breach was a factor in her death.

The court strictly construed the statute as applying only to "accidents", which the court distinguished from the broader term "emergency." The Court of Appeals seemed to concede that the situation was an emergency but concluded that it did not involve an accident.

Relying on Beckerman the court made short work of *Steffey v. King*, 614 N.E.2d 615 (Ind. Ct. App. 1993). In *Steffey* the attending doctor could not be found when the mother began spontaneous delivery. With the father holding the baby's legs, the nurse went for help. A different doctor arrived and delivered the baby. The parents claimed the child was injured during delivery.

Again, the court seemed to acknowledge that this was certainly an emergency, but again noted that it was not at an accident scene nor did it involve the victim of an accident.

The Court of Appeals combined the two cases on rehearing and approved the application of the sudden emergency doctrine to malpractice cases. *See* 618 N.E.2d 56.

That doctrine "provides physicians with a relaxed standard of care" when the physician is forced to respond to an emergency they did not create. *Id.*, at 57.

Duty

Here we revisit a case discussed above under "Causation", *Walker v. Rinck*, 604 N.E.2d 591 (Ind. 1992) (Rh sensitization). The facts of the case are summarized under that category.

Dr. Rinck argued that he did not owe any duty to his patient's children because they were never his patients. The court used its now familiar balancing test and analyzed the relationship between the parties, the reasonable foreseeability of harm to the person injured, and the public policy concerns.

Regarding relationship, the court found that the children were beneficiaries of the physician-patient relationship and that Dr. Rinck had actual knowledge that the only reason for giving the medication was to protect these future children of his patient.

Regarding foreseeability, the court noted that the injuries to the children were obviously foreseeable as prevention of those injuries was the medical reason to give the medication.

As to public policy, the administration of the medication neither benefits nor harms the mother but is given only to protect potential fetuses. The court had no trouble finding that such was to be encouraged as the public policy of our state.

Based on the above analysis the Indiana Supreme Court held that Indiana recognizes an action for a "pre-conception tort" by children allegedly harmed by failure to properly prevent Rh positive antibodies.

Ex Parte Interviews

In a case of first impression, the Court of Appeals has decided that a trial court cannot order a plaintiff to sign a release allowing defense counsel to have private interviews with plaintiff's medical care providers. *Cua v. Morrison*, 626 N.E.2d 581 (Ind. Ct. App. 1993).

> We hold that the trial judge abused her discretion in ordering discovery to be conducted in this manner and that *ex parte* interviews with a party-patient's health-care providers by opponent's counsel impermissibly compromises the physician-patient privilege.

Id., at 582.

Of course defense counsel can still talk privately with plaintiff's health care providers if the plaintiff authorizes it, or fails to specifically prohibit it, depending on your point of view. However, it is now clearly up to the plaintiff and if the plaintiff prohibits defense counsel from holding ex parte interviews with plaintiff's health care providers, then it cannot be done.

Expert

The battle continues over when an expert is required and, when required, what foundation is required for the expert's testimony to be considered.

An expert is ordinarily not required when the breach by the health care provider is a matter of common knowledge or where the doctrine of *res ipsa loquitur* applies. *E.g., Windmeyer v. Faulk*, 612 N.E.2d 1119 (Ind. Ct. App. 1993) (expert testimony needed where oral surgeon lacerated tongue during certain procedure with particular instrument). *See also, Malooley v. McIntyre*, under **Causation**-above. The doctrine of *res ipsa* was discussed above in **Causation**-concerning *Vogler v. Dominguez*. Although there is a technical distinction between the common knowledge exception and the doctrine of res ipsa, in most cases there is no practical difference.

Despite the general rule, the issue of when an expert is required arises even in cases where *res ipsa loquitur* has been established. In *Vogler, supra*, the court reversed a denial of summary judgment for the hospital. The patient had underwent surgery to repair a cerebrospinal leak. Following the surgery the patient had a loss of motor function and pain in the left arm. This was diagnosed as a brachial plexus stretch and evidence was presented that this probably resulted from negligence in the handling of the patient during surgery.

The court found that even though the plaintiff had presented sufficient evidence to invoke the doctrine of *res ipsa loquitur* against the hospital, the plaintiff had failed to introduce the necessary expert evidence to establish that the standard of care applicable to

surgical nurses was such that they should have known the handling of the patient during surgery was negligent.

Expert testimony is also required where *res ipsa* applies to some defendants but not to all of them. That was the case regarding a surgeon, a radiologist, and a hospital in *Wright v. Carter*, 622 N.E.2d 170 (Ind. Ct. App. 1993).

A surgeon had performed a biopsy of the patient's left breast. Dr. Donner was the radiologist who had inserted a wire into the breast before the biopsy to aid the surgeon in locating the non-palpable mass to be removed. After inserting the wire, Dr. Donner's only involvement was to examine the mass removed by the surgeon. Dr. Donner was not present during the biopsy. Evidently the wire was improperly left in the breast at the conclusion of the biopsy.

The Court agreed that leaving the foreign object in the breast raised an inference of negligence as to the surgeon and hospital, but not as to Dr. Donner because he did not have "exclusive control." Because there had been no expert testimony to refute the panel's opinion in favor of Dr. Donner, the Indiana Supreme Court reversed the trial court and the Court of Appeals and remanded with instructions to grant summary judgment for Dr. Donner.

Turning now to the foundation requirement, the Indiana Supreme Court did away with the modified locality rule in *Vergara v. Doan*, 593 N.E.2d l85 (Ind. 1992). Under

that rule the applicable standard of care was that of reasonable physicians in the same or similar localities. The court declared the new standard as follows:

> [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 same or similar circumstances.

Id. at 187. Locality is only one factor to be considered, along with such things as advances in the profession, availability of facilities, and whether the doctor is a specialist or general practitioner. *Id*.

Qualification is easy. The bare assertion by the expert that the expert is familiar with the standard of care, that defendant breached that standard, and that the breach was a proximate cause of the plaintiff's injuries is sufficient to resist summary judgment. This is true if stated in the expert's deposition, even if the same expert says in the same deposition that they do not know the applicable standard of care. *See, Vogler, supra,* at 60. This would seem to violate the rule that a question of fact cannot by created by a witness's own inconsistency. *See, Gaboury v. Ireland Road Grace Brethern, Inc.*, 446 N.E.2d 1310 (Ind. 1983).

Although qualification is easy, counsel must remember to do it. Summary judgement was granted for defendant when the affidavit of plaintiff's expert failed to refer to the standard of care in *Oelling v. Rao*, 593 N.E.2d 189 (Ind. Ct. App. 1992). In *Oelling*, the affidavit of plaintiff's expert stated only that he would have treated Mr.

Oelling differently, not that the defendant's treatment fell below the applicable standard of care. *Id*. at 190.

In addition, the qualification must come from the expert in an acceptable form. For example, hearsay assertions by a party in their answers to interrogatories as to the opinion of an expert are insufficient to defeat summary judgment. *McGee v. Bonaventura*, 605 N.E.2d 792, 793 (Ind. Ct. App. 1993). Apparently the courts will limit to its facts the liberal holding of *Winbush v. Memorial Health Systems, Inc.*, 581 N.E.2d 1239 (Ind. 1991) (unsworn expert report considered for plaintiff where improperly authenticated panel opinion considered for defendant).

In addition, the expert must make it clear that they are testifying to the standard applicable to the provider involved. For instance, a cardiologist's testimony as to how a cardiologist would have treated a patient is insufficient to get a case to the jury regarding a family practitioner. *Bonnes v. Felder*, 622 N.E.2d 197, 200 (Ind. Ct. App. 1993).

Once qualified, a medical expert can now testify as to whether or not the standard of care was met or to the legal conclusion that the provider's treatment was or was not negligent. *Mundy v. Angelicchio*, 623 N.E.2d 456, 462 (Ind. Ct. App. 1993). This is apparently a new exception to the general rule that even an expert may not state a legal conclusion. *E.g., Harmon v. C.E. & M., Inc.*, 493 N.E.2d 1319, 1321 (Ind. Ct. App. 1986).

Even experts who are not, or cannot be, qualified to give testimony as to the appropriate standard of care may be very useful and in some cases necessary to establish

the element of causation. This was the court's holding in *Chambers by Hamm v. Ludlow*, 598 N.E.2d 1111, 1117 (Ind. Ct. App. 1992). See **Causation**-above.

Fund

Once a qualified health care provider has settled a claim for the required limits, the only issue remaining is whether the plaintiff is entitled to further money from the Patient's Compensation Fund. Liability is deemed established and, therefore, causation is not an issue. *Dillon v. Glover*, 597 N.E.2d 971 (Ind. Ct. App. 1992).

The Commissioner unsuccessfully argued in *Glover* that a settlement in the amount entitling plaintiff to petition the fund for additional compensation meant only that a breach of the applicable standard should be presumed. Based on this approach, the Commissioner contended that any presumed breach in *Glover* was not the proximate cause of the damages claimed.

The Court of Appeals explained that the statute said in such cases that "liability" is considered established, not merely breach, and liability presupposes proximate cause. *Id*. at 973.

However, *Glover* does not apply where the Commissioner argues that the doctor's conduct did not constitute health care services. *Dillon v. Callaway*, 609 N.E.2d 424, 427 (Ind. Ct. App. 1993). In *Callaway* the defendant had allegedly engaged in sexually abusive and perverted acts with the patient under the guise of therapy. The Court

allowed the Commissioner to argue that these acts were not health care. While the court agreed with this position generally, the court held that there was an exception for cases of therapy because of the "transference phenomenon."

Hospitals

There have been few recent cases discussing the well settled law regarding when a hospital may be liable for malpractice. Plaintiff put a slight twist on the usual arguments in *Weaver v. Robinson*, 627 N.E.2d 442 (Ind. Ct. App. 1993). In *Weaver*, the doctor was employed by the hospital, but in a limited teaching capacity. The doctor also had a private gynecology practice in which he performed various surgeries. The doctor had assisted with the plaintiff's surgery and later examined the plaintiff at the surgeon's request when the surgeon was unavailable. In addition, the record showed that the doctor was paid for his services to the plaintiff pursuant to his private practice and not as the hospital's employee.

Based on these facts the court found that the plaintiff had not shown that the doctor was acting within the course and scope of his employment with the hospital when he treated the plaintiff. Since an agency or employer/employee relationship was not shown, the usual rule that a hospital is not liable for the negligence of its staff physicians applied.

Informed Consent

Except in cases where breach is a matter of common knowledge, expert testimony is necessary to establish what information a reasonably prudent physician would give to a patient so that the patient can give an informed consent regarding a course of treatment. *Culbertson v. Mernitz*, 602 N.E.2d 98 (Ind. 1992). The Indiana Supreme Court, by a three (3) to two (2) decision in *Culbertson*, specifically rejected the "prudent patient" standard set forth by the Court of Appeals in *Griffith v. Jones*, 577 N.E.2d 258 (Ind. Ct. App. 1991).

Limitation Periods

The Court of Appeals again confirmed that the medical malpractice statute of limitations is two years from the date of the occurrence and that the tolling theories of continuing wrong and fraudulent concealment end, at the latest, when the patient learns of the malpractice. *O'Neal v. Throop*, 596 N.E.2d 984 (Ind. Ct. App. 1992).

The Indiana Supreme Court also confirmed that filing with the Department of Insurance tolls the statute of limitations until the parties are informed that the provider had not "qualified" under the Act. *Miller v. Terre Haute Regional Hosp.*, 603 N.E.2d 861, 863 (Ind. 1992). This was a reaffirmation of the ruling in *Guinn v. Light*, 558 N.E.2d 821 (Ind. 1990). Under *Miller* and *Guinn*, the statute begins to run again after the plaintiff receives notice that the defendant had not "qualified." For instance, if there were two days left in the limitation period before the proposed complaint was filed with

the department, then the plaintiff would have two days to file a state court complaint after learning that the provider had not "qualified."

Of course, the rule remains that in medical malpractice cases children under six (6) have until their eighth (8th) birthday to file. *Walker v. Rinck*, 604 N.E.2d 591, 596 (Ind. 1992). This is, of course, different from the usual rule of eighteen (18) plus two (2) years for tort cases involving minors.

A new rule was announced, however, in *Jordan v. Deery*, 609 N.E.2d 1104 (Ind. 1993). Until *Jordan*, many practitioners and judges had interpreted I.C. 16-9.5-9-1(b) [now I.C. 27-12-7-3(a)] as providing a ninety (90) day limit for the plaintiff to file a state court complaint after receiving the panel opinion. The Supreme Court in *Jordan* held that what the statute really says is that the limitation period is suspended when the proposed complaint is filed and begins to run again ninety (90) days after the plaintiff receives the panel decision. *Id*. at 1107. So, if the plaintiff had two (2) months left in the limitation period before filing, then the plaintiff would have two (2) months and ninety (90) days to file the state court complaint after receiving the panel opinion. Consequently the Supreme Court in *Jordan* vacated the opinion of the Court of Appeals and reversed the trial court on this issue.

The Panel

There were some very interesting recent decisions regarding what can and cannot be done with panel members, admissibility of panel decisions, and what can and cannot be required of panel chairmen.

The plaintiff wanted prospective panel members to answer interrogatories regarding their background, qualifications, and experience in *Surgical Associates, Inc. v. Zabolotney*, 599 N.E.2d 614 (Ind. Ct. App. 1992). The defendant objected. The panel chairman petitioned the trial court for a preliminary determination of law. [See **Preliminary Determinations –** below]. The trial court held for the plaintiff but allowed the defendant to take an interlocutory appeal. The Court of Appeals reversed, observing that the Act did not expressly authorize such and to allow it would be contrary to the prompt and informal procedure intended by the Act.

This was essentially the same basis for the Supreme Court's decision in *Griffith v. Jones*, 602 N.E.2d 107 (Ind. 1992). There the court found that trial courts cannot instruct the medical review panel concerning definitions of terms and phrases in the Act, the evidence it may consider, or the form or substance of its opinion. *Id*. at 111. *Griffith* is discussed in greater detail under **Preliminary Determinations**-below.

Besides this limitation on trial courts, attorneys too are limited in what can be said to panel members. Indiana code 16-9.5-9-5 [now I.C. 27-12-10-18] prohibits communicating *ex parte* with a panel member before the panel's written decision is

rendered. To do so not only violates the statute but also violates the Rules of Professional Responsibility and can result in disciplinary sanctions. *See Matter of LaCava*, 615 N.E.2d 93 (Ind. 1993). Additionally, although the Act does not require disclosure to opposing counsel of personal and professional relationships with prospective panel members, the court noted that it would be "prudent and fair" to disclose relationships which detract from perceptions of impartiality. *Id*. at 96.

If you have a favorable panel opinion, it is good to know that it is still absolutely admissible. *Dickey v. Long*, 591 N.E.2d 1010 (Ind. 1992). In *Dickey* the plaintiff objected to the introduction of the opinion. Plaintiff argued that it exceeded the panel's authority since one member allegedly conceded that his decision was based on a determination of material fact that did not require expert opinion. *Id*. at 1010. The Indiana Supreme Court found this argument without merit, holding that the statutory provision for admissibility was "unambiguous and absolute". *Id*. at 1011.

Although the statute makes the panel opinion absolutely admissible it "does not waive the rules of evidence requiring that official documents be properly authenticated before they become admissible." *Bonnes v. Feldner*, 622 N.E.2d 197, 201 (Ind. Ct. App. 1993). The Court of Appeals in *Bonnes* held that the copy of the panel opinion offered into evidence was improperly admitted. *Id.* The panel opinion had not been certified by the Indiana Department of Insurance. *Id.*

The court in *Bonnes* did not say that such was the only way to authenticate the panel opinion. Another way which has been held sufficient is by affidavit from the panel chairman declaring that the opinion offered is a true and correct copy of the original. *Jordan v. Deery*, 609 N.E.2d 1104, 1108 (Ind. 1993).

Of course, failure to timely contest the authentication of the panel opinion waives that objection. *E.G.*, *McGee v. Bonaventura*, 605 N.E.2d 792, 794 fn. 1 (Ind. Ct. App. 1993).

Finally in this area, the Court of Appeals has held that the panel chairman may not testify as to what the members of the panel said during their informal meetings. *Mundy v. Angelicchio*, 623 N.E.2d 456, 465 (Ind. Ct. App. 1993). In addition, the chairman may not interpret their discussions or give an opinion of how the chairman thinks the panel should have decided the case. *Id*. "An attorney-chairman should not be allowed to say what he thinks the experts really thought." *Id*.

Preliminary Determinations

The most significant recent decision in this area was partially discussed above under **The Panel**-; it is *Griffith v. Jones*, 602 N.E.2d 107 (Ind. 1992).

Preliminary determinations are a special statutory procedure provided by the Act which allow a party to stay the panel proceedings and have a trial court determine certain issues of law or fact, or to compel discovery. This provision is now found at I.C 27-12-11-1 *et. seq*. [formerly I.C. 16-9.5-10-1 *et. seq*.]

In *Griffith* the Indiana Supreme Court made it very clear that the only matters a trial court may preliminarily determine are affirmative defenses under the trial rules, issues of law or fact under Trial Rule 12(D), and motions to compel discovery between the parties pursuant to Trial Rules 26 through 37, inclusive. *Id.* at 110. There is nothing else a trial court can do in a preliminary determination procedure.

The strict dictates of *Griffith* were followed to the letter in *Santiago v. Kilmer*, 605 N.E.2d 237 (Ind. Ct. App. 1992). Kilmer filed a proposed complaint and before the panel rendered its opinion the defendants served Kilmer with a Request to Admit that the medical treatment given to the patient had met the standard of care.

When the Request to Admit was never denied, the defendants moved for summary judgment arguing that by this admission Kilmer had conceded that the defendants were not negligent. The trial court initially granted the summary judgment, then later set it aside when Kilmer got new counsel.

The Court of Appeals affirmed the setting aside of the summary judgment. It held that the initial summary judgment was void because a trial court has no subject

matter jurisdiction over the issue of the standard of care. Citing *Griffith*, the court held that this was not an affirmative defense, issue of law or fact that could be preliminarily determined under the trial rules, or an order compelling discovery.

The court also noted that the trial court had no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for the medical review panel to decide. This was pursuant to I.C. 16-9.5-10-1(b) [now I.C. 27-12-11-1(b)].

According to the court, to grant summary judgment to the defendants in this situation would be deciding that they did not breach the standard of care, which is an issue of fact reserved for the medical review panel. *Id*., at 240.

It is this writer's opinion that the court in *Santiago* misconstrued both the statute and the holding in *Griffith*. If a plaintiff admits that there was no negligence, either in a deposition, answer to interrogatory, or by failing to respond to a Request to Admit, then there should be no reason to have to go through the remainder of the panel process. When this happens, the court is not deciding an issue of fact; the fact has been decided by the admission of the plaintiff. In such a case the court is simply entering a judgment based on the decided fact.

If the court in *Santiago* thought that to hold otherwise was too harsh, the court could have reached the same result simply by allowing Kilmer to withdraw the admission, if justice so required, pursuant to Trial Rule 36 (B).

In contrast, *Griffith* was not even discussed in *Blackden v. Kaufman*, 611 N.E.2d 663 (Ind. Ct. App. 1993). The Blackdens had failed to make their submission to the medical review panel within the time limits set by the chairman, despite having several continuances to do so. Their submission was finally made four days before the one hundred and eighty (180) day time limit within which the panel was to render its decision.

The defendants filed a motion for a preliminary determination of law requesting that the proposed complaint be dismissed with prejudice because the Blackdens had prevented the panel from reaching its decision within the prescribed limit. The trial court granted the motion and the Court of Appeals affirmed.

On appeal the Blackdens argued that they could not be sanctioned for failing to make a submission because no submission is required by the Act and because the defendants had not made a submission either. The court, however, said that without any materials, the review panel is unable to express its expert opinion on the standard of care. *Id.* at 666. In addition, only after the plaintiff's materials are submitted is the defendant compelled to come forward with materials in response. *Id*. at 666.

The Blackdens also argued that the trial court erred in relying on Trial Rule 41(E) in dismissing the complaint. The court noted that the record reflected that the trial court relied on I.C. 16-9.5-10-1 [now I.C. 27-12-11-1] (regarding preliminary determinations),

I.C. 16-9.5-9-3.5 [now I.C. 27-12-10-14], and Trial Rule 41(E). *Id*., at 666 fn.5. The court held that I.C. 16-9.5-9-3.5 alone was sufficient.

That provision provides that any party who fails to act as required by the chapter regarding the panel, without good cause, is subject to sanctions by the trial court designated in the proposed complaint. I.C. 16-9.5-9-3.5 [now I.C. 27-12-10-14].

Blackden can be read consistently with *Griffith* as indicating that I.C. 27-12-10-14 is an additional jurisdictional method to preliminarily determine sanctions for failure to comply with the chapter regarding the panel. Counsel are advised to specifically request relief under this statute, when applicable, to avoid a finding that jurisdiction is lacking under *Griffith* and *Santiago*.

The last recent case to be discussed under this heading involves venue. It is *Price v. Methodist Hospitals, Inc.*, 604 N.E.2d 652 (Ind. Ct. App. 1992). Price had filed a proposed complaint with the insurance commissioner and had filed a state court complaint in the Lake Circuit Court. The hospital venued the state court action to the Porter Superior Court.

A discovery dispute arose and the hospital filed a motion in the Lake Superior Court for a preliminary determination of law to compel discovery. Price argued on appeal that the Lake Superior Court did not have jurisdiction to compel discovery since jurisdiction of the case was already established in the Porter Superior Court.

The Court of Appeals held that jurisdiction in the Lake Superior Court was proper since it was for the limited purpose of the discovery dispute pursuant to a motion for a preliminary determination of law. Therefore, the rule of *Price* is that the party filing the motion for preliminary determination can choose the forum.

Tort Claims Act

Even in medical malpractice actions the plaintiff may be required to give a tort claims notice. I.C 34-4-16.5-9 provides that a claim against a political subdivision is barred unless the notice required by the tort claims act is filed with the governing body within one hundred and eighty (180) days after the loss claimed. Pursuant to I.C. 34-4-16.5-2(f) a county hospital is a political subdivision. The plaintiff failed to give the required notice and the plaintiff's case against the county hospital was dismissed in *Hasty v. Floyd Memorial Hosp.*, 612 N.E.2d 119 (Ind. Ct. App. 1992).

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