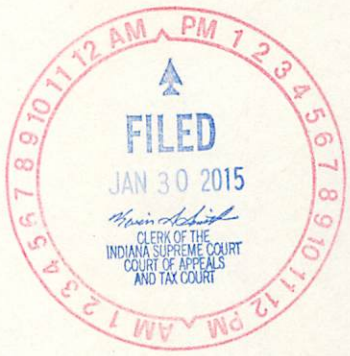
IN THE INDIANA COURT OF APPEALS

CAUSE NO. 49A05-1404-CT-00165



Kathy L. Siner, Personal Representative of the Estate of Geraldine A. Siner, Deceased; and John T. Siner, prior EPOA & Medical Representative	Appeal from the Marion Superior Court 12
v.	Lower Court Cause No: 49D121305-CT-020123
Kindred Hospital, limited Partnership d/b/a Kindred Hospital of Indianapolis, et al., D. Nicely, Administrator, D. Uhrin, RN, and Mohammed Majid, Attending Physician	The Honorable Heather Welch, Judge

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REPLY OF APPELLANT

Kathy Siner, pro se, legal representative of Geraldine A. Siner, deceased; & Tim Siner, pro se.
1807 Commerce Ave. , Indianapolis, IN 46201 (317) 266-9453

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SUMMARY OF ARGUMENT 1 : Dr. Majid and Kindred, et al, both argue that their medical expert's opinion was "undisputed". The Court accepted these arguments by listing Dr. Krueger's, statements as "undisputed fact". It was claimed that we offered no medical expert opinion to counter Dr. Krueger's. We repeatedly countered that the Indiana Department of Insurance Medical Panel's unanimous opinion of Malpractice, was "expert medical opinion which disputed Dr. Krueger's opinion. As a result, the defense did not established that their prima facie case. **Trial Rule 56(c) "Summary Judgment is appropriate only where there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law."**

ARGUMENT 1 The Opinion of the Medical Review Panel from the IDOI process was:

The panel is of the unanimous opinion that the evidence supports the conclusion that the defendants failed to comply with the appropriate standard of care, and that their conduct may have been a factor of some resultant damages, but not the death of the patient. (Appendix p.74)

This opinion is not divided, but rather *unanimous* that the evidence supported the conclusion that 1) the defendants failed to comply with the appropriate standard of care – that they committed malpractice. 2) The listed " defendants" were Kindred Hospital et al, Dr. Majid (Gerri Siner's 'attending physician') , Dennis Nicely (Kindred's Chief Administrator at the time of these incidents), David Uhrin (the nurse directing other nurses at the time of the key event of 11/11/07), and a healthcare worker, Jeff Clearwater, all of whom were included as having committed malpractice 4) The panel was also unanimous that "their conduct may have been a factor of some resultant damages". Only the issue of 'resultant damages' is less than conclusive.

The Defendant's medical expert, Dr. Krueger, was one of 3 doctors on the IDOI Panel, and in his Affidavit for Dr. Majid, he wrote of his original panel opinion : " I determined that a breach in

the standard of care occurred in the case of Geraldine Siner." (Appendix p.108) However he expressly acknowledged that he had changed his opinion since then.(App. p108, and p197) The unanimous Panel opinion was that all 5 listed Defendants had breached the standard of care (committed malpractice), (App p.27) but Krueger's reversed his opinion and affirmed that all of the listed parties ***met*** the 'standard of care' (none committed malpractice). (App p.109 and p.198)

At no point did Dr. Krueger claim that his own opinion was shared by others on the panel, (nor have we ever claimed he did, contrary to Kindred's assertions); instead, we objected that such was implied in statements made by the Defense attorneys and by the Court in classifying Dr. Krueger's opinion as 'undisputed fact' in Summary Judgment. Dr. Krueger made statements such as: "I did not differentiate among the healthcare providers that rendered care to Geraldine Siner when I rendered this opinion." (Appendix p. 108) He claimed his opinion of malpractice was based solely on the 'prolonged use of the CPAP mask'. (Appendix p108)

We argued that it was unlikely all Panel members simply didn't pay attention to who the defendants were or what role they played, as Dr. Krueger said of himself. We pointed out that our IDOI brief discussed Dennis Nicely, Kindred Hospital's chief administrator, only in the context of the DNR issues, rather than anything to do with "the prolonged use of the CPAP mask". It would be particularly odd to render a unanimous opinion of malpractice against a hospital's CEO based solely on the prolonged use of a CPAP mask. Further, a unanimous panel opinion of malpractice on all listed parties including a Hospital is quite rare; and in a prior search, I could find no other unanimous finding of malpractice against an Indianapolis hospital and all listed defendants on the IDOI website. For all of these reasons, it seemed unlikely that

that the Panel as a whole limited their consideration to the CPAP mask, or that all would not pay attention to who was being said to have committed malpractice, as Dr. Krueger claimed he had.*

*Note: Other Panel members said they had been involved in prolonged conversations with the Defense lawyers when I spoke to them for the first time since their decision a month or so later. One member said he had been hired by Kindred to help them write a policy for DNR procedures. One was hired by both Defendants as their Medical Expert. The 3rd said he needed to ask the lawyer who chaired the Panel before speaking about the matter, and then declined to do so.

We argued that the IDOI Opinion by a panel of doctors had standing as 'medical expert' opinion 'disputing' Krueger's changed opinion. " Therefore, Dr. Krueger's change of mind is not an undisputed opinion. It is disputed by the original Panel Opinion itself." (Appendix p 63)

This argument was given in our original Response to Dr. Majid (Appendix. p 21) , during Majid's hearing, and in our Motion to Correct Error (Appendix p. 59). This argument was also given in Response to Kindred's Motion for Summary Judgment (Appendix p.110) . Based on the 'dispute' between medical experts, we contend that the Standard for Summary Judgment was not met, in that the Defense did not show establish a prima facie case based on undisputed fact.

The Defense for Dr. Majid argue at length that this case is similar to cases where the panel opinion was divided, or where the only two options were that there was no causation, or that causation was incapable of being established, or where a jury was told that an injury "could possibly have been aggravated" by actions taken, etc. However, these cases do not seem similar enough to the present case to establish precedent for it. In this case, there was a unanimous Panel opinion on all matters, but Dr. Krueger later denied all the conclusive opinions of the Panel. The panel's statement that this malpractice "may" have caused "some" resultant damages is stretched to the point that the Defendants make statements implying that the full panel thought

damages were impossible to determine. Krueger suggested such, but the Panel did not claim such in this case. Further, when we obtained experts, their opinions included damages.

Throughout the Summary Judgment process and hearings, we argued that the IDOI's Medical Panel Opinion was expert medical opinion which was '**in dispute**' with Dr. Krueger's changed opinion, and that his 'changed opinion' did not alter the unanimous panel opinion, or render it 'divided'. Otherwise, any panel opinion could be altered from unanimous to divided after the fact, when members can be paid for their opinion; this would be a conflict of interest for a process that requires neutrality. The Panel Opinion stands, and it stands 'in dispute' with the affidavit offered by Dr. Krueger for the Defense, when he altered his opinion to argue that there was no breach of duty by Dr. Majid or Kindred.

" Therefore, Dr. Krueger's change of mind is not an undisputed opinion. It is disputed by the original Panel Opinion itself." (Appendix p 63) This argument was given during hearing, and in the Motion to Correct Error, in our original Response to Dr. Majid (Appendix. p 100) and in our Response to Kindred's Motion for Summary Judgment (Appendix p.111) . Based on this 'dispute', the Standards for Summary Judgment were not met.

"Summary Judgment is appropriate when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Ind. T.R. 56 (C); Crawfordsville Square, LLC v. Monroe Guar. Ins. Co.; 906 N.E. 2nd 934, 937 (Ind.Ct. App. 2009).

"The purpose of summary judgment is to terminate litigation about which there can be no factual dispute and which may be determined as a matter of law." Bastin v. First Ind. Bank, 694 N.E.2d 740, 743 (Ind. Ct. App.1998)

"A party moving for summary judgment bears the initial burden of showing no genuine issue of material fact and the appropriateness of judgment as a matter of law. *Monroe Guar. Ins. Co. v. Magwerks Corp.*, 829 N.E.2d 968, 975 (Ind.2005).

If the movant fails to make this prima facie showing, then summary judgment is precluded regardless of whether the non-movant designates facts and evidence in response to the movant's motion. ***Id"***

SUMMARY OF ARGUMENT 2: The Defense repeatedly argues that we failed to establish damages as part of causation, and that it was essential to do so. Since the Panel's opinion 'lacked certainty', it is claimed our case must fail. However, the Defenses' medical expert said in his Affidavit that "the source of facial wounds were documented" as being from the 'prolonged use of the CPAP mask'. Therefore on the sole issue of malpractice which he discusses, he offered "specific, conclusive expert testimony of resultant damages".

ARGUMENT 2: Dr. Majid's attorney's central argument supporting his Summary Judgment is: *Summary judgment was appropriate because the Plaintiff failed to present non-speculative expert testimony supporting the element of causation."* (Majid Brief, pg. 9) This is also the central argument of Kindred, et.al , titled: *"Kathy's Medical Malpractice Claim Fails As A Matter of Law Absent The Essential Element Of Causation."* (Kindred Brief, pg.8) Both Defendants repeatedly make assertions such as: " Siner failed to designate admissible expert testimony to demonstrate the existence of a genuine issue as to causation of injury." (Majid Brief, pg). This argument is repeated in the Summary Judgment.

" It is well settled that in a medical negligence claim, the plaintiff must prove by expert testimony not only that the defendant was negligent, but also that the defendant's negligence proximately caused the injury. *Schaffer v. Roberts, 650 N./e2nd 341, 342 (Ind.Ct.App. 1995); and Nasser v. St. Vincent Hosp. and Health Services, 926 N.E.2nd 43 (Ind.Ct.App.2010).* (SJ p.5)

However, in Dr. Krueger 's Affidavit, he says : "...it would be speculation to say that she (Gerri Siner) perceived any harm related to prolonged application of CPAP, although the source of facial wounds were documented." (App p.108)

It is worth noting that he never asserts that Gerri Siner was not harmed, but rather he says that "...with severely impaired mentation...it would be speculation to say that she ***perceived*** any harm.." (emphasis added). This seems to be a speculative argument against her suffering, but it is not a denial of damages, which he admits were documented. In that the Defense's Medical Expert attests that damages "were documented" on the sole issue of malpractice to which he limited his opinion, this is adequate to establish by "non-speculative medical expert opinion" that damages occurred.

Dr. Krueger's admission of damages, plus the medical experts of the medical review panel, can be used to establish our prima facie case. The Medical Expert Opinion of the IDOI Panel unanimously affirmed that 1) A duty existed; 2) That duty was breached; 3) that this malpractice was by all 5 listed parties listed. (Most panel cases specify only some parties, and parties differ in their findings, but theirs did not.) 4) Specific, non-speculative, damages from that malpractice were affirmed by a medical expert.

Despite the Defendant's repeated and repeated claims that "Kathy failed to meet the burden required to bring a medical malpractice claim... by not presenting expert medical testimony – indeed any evidence at all – on the essential element of causation." (e.g., Kindred Brief, p.15), despite lack of complete medical records, despite a lack of our own ability to pay experts, despite a Strike against the bulk of our evidence for Dr. Majid's hearing, we provided the required

prima facie case via medical experts, simply on the basis of these 2 statements from medical experts alone.

Our arguments, at minimum, establish genuine issues of material fact, and as such they should have blocked Summary Judgment.

A genuine issue of material fact exists where facts concerning an issue which would dispose of the litigation are in dispute or where the undisputed material facts are capable of supporting conflicting inferences on such an issue. Commercial Coin Laundry Systems v. Enneking, 766 N.E.2nd 438 citing Gilman v. Hohman, 725 N.E. 2d 425, 428 (Ind. App. 2000, trans denied).

Dr. Majid's medical expert, Dr. Krueger, argued that 'pulmonary services', not Dr. Majid or Kindred Hospital, et al, was responsible for the 'prolonged use of the CPAP mask' - the only malpractice issue he discussed. We have given many arguments against this contention which the Defendants for the most part simply dismissed without mention. We turn summarize a few.

SUMMARY OF ARGUMENT 3: Dr. Krueger's attribution of responsibility to 'Pulmonary services', rather than to Dr. Majid, is circular, in that it leads right back to Majid as being responsible, as a matter of law. A patient's "attending physician" is obligated to provide the accepted standard of care, and per 2007 law, is the person legally liable to follow very specific legal steps to reduce that standard of care. The requirement that the patient must be "terminal" is a designation that is specifically limited by law to the "attending physician". This is not, as the Defendant claims, an argument that counters their expert's opinion and "rests on speculation only." It is a matter of law. Medical code has stronger standing than even 'the accepted standard of care'. (However, our medical expert's later Affidavit confirmed that such is also the 'acccptcd standard of care'.)

ARGUMENT 3: Dr.Krueger argued that : "Pulmonary service" kept Gerri Siner on a CPAP mask because measures such as "tracheotomy and intubation were not appropriate in a terminal patient." However, as we said at Majid's Summary Judgment 11/19/13 hearing: ***"Terminal' is the key word."*** **Per 2007 law**, this designation is the "attending physician's" responsibility.

IC 16-36-5-12 Issuance of DNR order Sec. 12. An out of hospital DNR order: (1) may be issued only by the declarant's attending physician; and (2) may be issued only if both of the following apply: (A) The attending physician has determined the patient is a qualified person. (B) The patient has executed an out of hospital DNR declaration under section 11 of this chapter.

The legal requirement of being a " qualified person" (Appendix p.141) stipulates among other things, that the "attending physician" certify the patient as "terminal":

IC 16-36-5-13

13. (a) The attending physician shall immediately certify in writing that a person is a qualified patient if the following conditions are met: (1) The attending physician has diagnosed the patient as having a terminal condition. (2) The patient has executed a living will declaration or a life prolonging procedures will declaration in accordance with this chapter and was of sound mind at the time of the execution.

(b) The attending physician shall include a copy of the certificate in the patient's medical files.

When Dr. Krueger claims that Pulmonary service recommended continuing the use of the CPAP because alternative treatments "such as tracheotomy and intubation were not appropriate in a terminal patient", this designation of 'terminal' points the finger back to Majid.

This section of the law continues with additional specific requirements for the "attending physician" to follow before any DNR Order can be made - yet ***none*** of those requirements were followed by Dr. Majid or anyone else at Kindred.

We discussed the law in our objections to Majid and Kindred, though they both ignore such arguments in their responses: e.g. See our Designated Evidence in our Appendix: Dr.Majid was

the 'attending physician" for Geraldine Siner, (this was never disputed, and is evidenced on hospital records such as Appendix p. 57.) Per **2007 law , IC16-36-5-12** , (Appendix p85) it is the "attending physician" (Dr. Majid) who must determine that a patient is 'qualified' which includes the diagnosis of being 'terminal'. Per **IC 16-36-4-13 (Kindred App code p.118 of Siner's designated law p.38)** Also see Appendix p.85,86, etc.

The defendant's medical expert Dr. Krueger said he had originally found malpractice in the prolonged use of the CPAP /Bpap, (when the acceptable standard of practice would have been ""intubation or 'tracheotomy'). However, " Given...the decision that aggressive measures such as **tracheotomy and intubation were not appropriate in a terminal patient,** treatment options were limited." (Emphasis added.) What limited those treatment options for pulmonary services, was the ***'terminal'*** designation. Dr. Krueger went on to say " *Based on the involvement of Pulmonary service, I have determined that it is reasonable for Dr. Majid to defer to their judgment."* (App p 108) (Note: Despite extensive search, I objected during the hearing that documentation of Pulmonary services recommending such could not be found on the medical records given to us; and if such was based on verbal explanations given to their Medical expert, such should be substantiated with affidavits.)

This argument was based on law alone, and was made in the hearing and briefs surrounding Summary Judgment. E.g., See these sections of 2007 law on the Issuance of DNR order

(Appendix p.37), and the law submitted by us 2/18/13 for Kindred's Hearing, found in Kindred's Appendix p.38 through p.104.) Neither of the Defendants ever referred to Code to substantiate any of their arguments.

Majid's Defense contends that "..the plaintiff argues without expert support and contrary to Dr. Krueger's expert opinion, that Dr. Majid actually was responsible for the patient's pulmonary care. ... her claim for causation rests on speculation only." (Majid's Brief, p.14) Our arguments were supported by law, not sheer speculation. Law has greater standing than matters determined by conventionally accepted norms. However, Dr. Pohlman indicated that this matter of law was also a matter of accepted practice.

Dr. Timothy Pohlman, the Medical Director of Trauma Intensive Care at Indiana University Health – Methodist HospitaL said in his Affidavit regarding Gerri Siner's treatment:

"...continuing CPAP was recommended because alternative treatments 'such as tracheotomy and intubation were not appropriate in a terminal patient'. However, the designation of 'terminal patient' is typically made by a patient's attending physician, and not by a division such as 'Pulmonary Services'." (Appendix p.190)

SUMMARY OF ARGUMENT 4: Dr. Majid's Order, issued 11/22/07, which ruled out 'standard of care' treatments, establishes proximate causation for the malpractice and damages from the prolonged use of the CPAP mask, with resulting facial wounds; this is the sole issue to which Dr. Krueger limited his personal opinion of malpractice. An Order which limited treatment options has greater standing and causal proximity than a decision made by Pulmonary services, which was made to stay ***within*** the treatment option limitations imposed by that Order.

ARGUMENT 4 Dr. Majid on 11/22/07 issued *"Physician's Life Support Orders"* (See Exhibit D, App p. 93), designated "NO CPR IN THE EVENT OF CARDIOPULMONARY ARREST, DO NOT PERFORM THE FOLLOWING: Vasopressors, Intubation, Cardioverson, ... " etc.

Dr. Majid's Order prohibited alternative treatments options (such as tracheotomy or intubation,) which would have avoided the damages from the prolonged use of the CPAP/ BiPAP masks such as facial wounds. This Order takes priority and has proximate causal force over any recommendation from a division such as "pulmonary services". As we verbally argued , anyone defended illegal or damaging actions saying that someone else (who they would not name) , or another group (which we objected could not be found on the medical records we had been given as even 'recommending' such actions,) it is difficult to imagine such being accepted as the proximate cause of harm in any other court case. If someone, with legal authority, orders a limitation on action, while another decides on an option within those limitations, would the person giving the order actually be 'excused' from liability for damages that resulted from a decision made in compliance with their imposed limitations? Or simply, if a person does a criminal action because someone recommended it, are the exempt from liability for their action?

SUMMARY OF ARGUMENT 5 : Dr. Majid's Order of 11/22/07 was illegal, per 2007 Indiana Code, in that it did not comply with the legal requirements for such an order restricting treatment options. One violation of law was that it contradicted treatment instructions from Gerri Siner's medical representative, Enduring Power of Attorney, and family. One who issues such an order is also liable for the damages which result from that limitation on treatment.

ARGUMENT 5 : Dr. Majid entered an order on 11/22/07 expressly prohibiting 'the appropriate standard of care' of tracheotomy or intubation, etc. (See App p.93) This Order was diametrically opposed to the Instructions of Gerri Siner's family, which had been to keep her "Full Code" from the beginning. It also went against the accepted 'Standard of Care'.

Our instructions for full code and Kindred/ Majid's refusal to follow them are well documented in Kindred Hospital medical records, but we will limit this argument to the Designated Evidence submitted with our brief in opposition to Summary Judgment, timely on 11/1/14 for Majid's hearing (Appendix p.26-49) (Omitting the further substantiating hospital records filed on the day of his hearing, which the Judge Struck (Summarized on Appendix p.50 & 51).

On page 49 of our Appendix, is a "Physician's Life Support Orders" form which we submitted to Gerri Siner's medical file after our Full Code instructions continued to be ignored. **We circled "CATEGORY 1 The patient will receive CPR and all life sustaining therapies."**

We wrote, at the top, one concession to Dr. Majid's and Kindred's continual attempts to get Tim Siner to reduced Gerri Siner's code (after the event of 11/11/ 07). Dr. Majid had warned Tim that CPR would crush our mother's ribs. Since paddles, and not compression CPR are nearly always used in hospitals, this seemed disingenuous, however, we wrote the following:

GERALDINE SINER HAS BEEN FULL CODE UP UNTIL THIS CHANGE **11/20/07**

ONLY EXCEPTION: FOLLOW PROCEDURES FOR ELDERLY AND BABIES IN COMPRESSION CPR AS TO MINIMIZE RISK OF CRUSHING HER CHEST OR BREAKING HER RIBS. (See Designated Evidence in our Appendix, p.94)

Despite these explicit instructions, Dr. Majid entered an Order, two days later on **11/22/07** (Appendix p 47) that still prohibited the 'Standard of Care' treatment options which would have avoided the injury Dr. Krueger admitted to, and left Gerri Siner as a No Code (Category 3) in all ways, with the only exception being "****INFANT 2-FINGER CPR ONLY***" (which he claimed raised her to a Category 2, though it kept her a no code except for an exception that was not what was requested.)

If you view the form we entered, Category 1 is clearly circled, while Dr. Majid's order in restricting her to No Code with the only exception being 'infant 2-finger CPR' (which a nurse commented was laughable), was in contradiction to what we had written and verbally related to Majid.

Even the "Attending Physician" is not allowed to over-ride the family or designated Medical Representative, as a matter of law. After the 11/11/07 incident, we told Majid and Kindred that they needed to take us to court if they wanted to change Gerri Siner's code from what Tim Siner, as her medical representative and enduring power of attorney, and her family, had designated.

2007 Indiana Code 16-36-1-7 (a) An individual who may consent to health care under section 3 of this chapter may appoint another individual as a representative to act for the appointer in matters affecting the appointer's healthcare. .....

(g) Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the appointer, except when the appointer is capable of consenting.

This 'priority to act' is not conditional, except when the appointer is capable of consenting. In light of her Alzheimer's, no one has argued that Gerri Siner was capable of such decisions at the time she was in Kindred Hospital; and Tim Siner was documented as her legal Medical Representative and Enduring Power of Attorney, and reasonably available to act.

The new POST form adopted since 2007 (Physician's Orders for Scope of Treatment) now requires that the Patient or their Representative sign on any limitations of the patient's Scope of Treatment. Doctors and hospitals were previously restricted by code and the ' Patient's Right to Self Determination' (as printed on Kindred's Intake forms', etc.) but now that is made more explicit on the physician's orders. In 2007, we resorted to notes on the form, not being aware of

the law except as a basic right acknowledged in intake documents. We hope our case and others helped to bring about such revisions.

Majid's illegal actions were exampled in the Plaintiff's Nov. 1st Designation of Evidence, Exhibits D and E. This was not simply 'medical negligence' on the part of Dr. Majid, it was in violation of Indiana and federal law regarding a Patient's Right to Self-Determination. Such matters are not determined by 'standard practice', but are explicitly defined in law itself. The attending physician's Order has standing as a proximate cause, and not merely a non-specified 'recommendation' from an unidentified doctor or outside 'service'.

We turn to Kindred, et al 's arguments that Pulmonary services, not Kindred, was responsible for the prolonged CPAP use. This was also disputed in this case, yet the Defense only restates their arguments and does not address our objections. With Kindred's hospital records, Medical Expert affidavits, and 2007 law, (all of which were timely filed as Designated Evidence, including medical expert affidavits,) we made the following arguments against Kindred's Motion for Summary Judgment. These Exhibits can be found in Appellant's Appendix p.116 through p. 195. This Designated Evidence is extensive. It is not subject to Kindred's request to Strike evidence, even if such should prevail.

Again, we will outline various arguments we have given against their claims that pulmonary services was responsible for the sole issue of malpractice their medical expert discussed.

SUMMARY OF ARGUMENT 6: The action of Kindred's 'Ethics committee' was the first chronological and proximate cause of the reduction of Gerri Siner to the 'No Code' limitation on treatment.

ARGUMENT 6: Kindred's 'Ethics Committee' decided to reduce Gerri Siner's Code from Full Code, to 'No Code' "Category 3", which was entered into the hospital records to instruct staff shortly after their meeting of 11/16/07. (Appendix p.128) This was 5 days after we allege that Kindred's staff initially refused to resuscitate Gerri Siner when she Coded. This was despite her being designated as 'Code One' from the beginning of her stay at Kindred Hospital by the transferring doctor, and her Medical Representative and family. This decision denied her of treatment options. On page 128 of the Appellant's Appendix, this Life Support Order can be read:

" **CATEGORY 3 No CPR and no life sustaining therapies will be administered in the event of cardiac or pulmonary arrest or clinical deteriorations.**" And it is hand-written: **Code Form completed per Ethics committee decision / note from 11/16/07.** It is signed by "Ober" though he was not Gerri Siner's "attending physician".

Dr. Timothy Pohlman, the Medical Director of Trauma Intensive Care at Indiana University Health – Methodist Hospital said in his Affidavit regarding Gerri Siner's treatment:

"... Kindred's Ethics Committee recommended over-riding the wishes of the family and instructions of the patient's medical representative for full treatment, and instituted a 'Do Not Resuscitate' (DNR) order, which ruled out such alternative treatments." (App p.188)

This decision has standing as a proximate cause in prohibiting the acceptable standard of care treatment, as instructed by Gerri Siner's medical representative and family. So ordering a

reduction in Scope of Treatment not approved by the patient or their representative and family, is a violation of law and contract, and of constitutional human rights. On this issue, our medical expert expressed a forceful condemnation of Kindred's Ethics committee's actions.

SUMMARY OF ARGUMENT 7: Our Medical Expert, R. Lawrence Reed II, MD, FACS, FCCM , is currently the Director of Indiana University Health's Methodist Trauma Center, and a tenured Professor of Surgery at Indiana University School of Medicine. His Curriculum Vitae of experience, publications, and honors fills 57 pages. Dr. Reed's Affidavit expressed a forceful opinion on the violations by Kidred's Ethics committee in this case.

ARGUMENT 7: On pages 119 through 122 of the Appellant's Appendix, the Designated Evidence of an Affidavit of R. Lawrence Reed II, MD, FACS, FCCM, affirms the following ***"under penalties for perjury"***:

" I have reviewed some of the medical records on the case, including documentation on 11/16/ 2007 that the Ethics Committee met and decided to make the patient, Geraldine Siner, a "No Code" – i.e., a DNR ("Do Not Resuscitate") – patient even though they knew such a status designation was against the family's wishes, including the patient's designated health care representative.

3. The standard of care requires that the patient, the patient's next of kin, or the patient's designated health care representative be in agreement with the patient's 'Code' or 'No Code' status.

4. The care provided to Geraldine Siner was substandard in this respect.

5. Kindred Hospital's "*Statement of Ethical Policies*" states compliance with state laws governing Termination of Life Support requests, but does not outline policies for the termination of life support without such a request originating from the *"patient, patient's family, agent or other representative".*

6. However, Kindred's '*Protocol Form for Review of Ethics Cases*' explicitly states that the decision to be made by the Ethics Committee concerning Geraldine Siner was "*Whether to override family decision to keep patient as a code 1 (full code) and making patient a code 3 (no code)*', and that they had '*Legal concerns with changing code status despite family opposition.*"

7. It was therefore clearly known by Kindred that they were acting against both the family's objections and legal responsibilities when the Hospital's Ethics Committee recommended reducing the patient from a 'full code' Scope of Treatment to a 'no code' designation, where treatment is withheld.

8. Further, Kindred's 'Statement of Ethical Policies' states that '*Certain paperwork is required to be completed in compliance with state law. This documentation is reviewed by Hospital Administration and the attending/consulting physician.*" Kindred's Administrator, and Geraldine Siner's attending physician, would therefore also be culpable in this denial of treatment to the patient.

(Note: Kindred's Administrator was Dennis Nicely, who is currently defended by Kindred's lawyers; and Gerri Siner's attending physician was Dr. Majid.)

9. To withhold medical treatment, when that is what the patient or their medical representative has contracted and instructed a health care facility to do, is as serious a

breach of medical duty as any. Such is to deny the services contracted and paid for on behalf of the patient.

(Note: In Summary Judgment hearings, and even in the original complaint, violation of contract was argued, and the complaint was never limited to 'medical negligence'.)

10. Such a practice would jeopardize the care of all patients when a hospital unilaterally decides that a patient's care is futile or unethical, given the serious conflict of interest involved."

(Note: In that Kindred's 'Ethics Committee' decision to reduce Gerri Siner from Category 1 (full code and treatment) to Category 3 (No code and treatment) was made 5 days after we allege their staff initially refused to resuscitate Gerri Siner when her hospital record designated her to be 'full code', such an action indicates just such a probable 'conflict of interest'.)

11. This breach in the standard of care by Kindred is very serious and should be thoroughly evaluated to prevent its recurrence.

Far from thoroughly evaluating this breach in the standard of care, and as we argued, violation of law and a patient rights grounded in Constitutional Rights, these arguments, even our experts, were ignored.

SUMMARY OF ARGUMENT 8: The action of Kindred's Ethics committee was in violation of their own ***"Statement of Ethical Policies"*** and ***"Your Right to Decide"*** given to patients at intake.

ARGUMENT 8: Kindred's documents given to patients at intake: ***"Statement of Ethical Policies"*** and ***"Your Right to Decide"***, aligned with the legal requirements of the Patient Self Determination Act and Indiana Code, but the actions of the Ethics committee in the case of Gerri Siner did not. As can be read on page 171 of our Appendix, in our Designated Evidence for Summary Judgment, Kindred's ***"Statement of Ethical Policies"*** reads:

" No individual will be discriminated against or have admission or treatment conditioned on whether the individual has executed or waived any advance directives. In the event that a patient, patient's family, agent or other representative desires to make a treatment decision which involves removal/ withholding of life supporting treatment, they must make this request known to the hospital or medical staff. A review by the Ethics committee may be required. Certain paperwork is required to be completed in in compliance with state law. This documentation is reviewed by Hospital Administration and the attending/consulting physician." Appendix p.171

This certainly doesn't outline a process for Kindred or their Ethics committee to over-ride a patient or their legal Medical Representative (who is the same legally, as the patient,) and decide to deprive them of treatment.

Further, when Dr. Majid (the attending physician) and Kindred's Administrator, Dennis Nicely, met with us and said the committee changed Gerrri Siner to 'no code', we testify that we repeatedly asked how they had the right to do so, we asked to be shown something in writing to explain such a decision, yet nothing in writing was provided until Discovery. I also tried to insist that they needed to take us to court if they disagreed with our decision, and we tried to insist that she immediately be transferred - which turned out to be a requirement of law, per ***IC-36-5-13 Transfer of patient to*** another ***physician.***

Designated Evidence against Kindred's Summary Judgment included Exhibits F : Tim Siner's legal designation as Enduring Power of Attorney; G: Tim's legal designation as Gerri Siner's

Medical Representative; H: Kindred's Intake document displaying that Tim Siner was her Legal Representative. (Appendix p.155-168)

" The patient's right of self-determination is the sine qua non of the physician's duty to obtain informed consent."

"Recognition of the basic natural rights of each person to life and liberty is the starting point for courts in dealing with cases of this class. Article 1, Section 1, Indiana Constituion. ... Courts must be vigilant in cases coming before them to protect these basic natural rights.

IN Supreme Court in the case of Lawrence No. 29S04-9106-CV-00460, pg. 38)

SUMMARY OF ARGUMENT 9: We disputed the legal line separating 'Pulmonary services' from Kindred Hospital on several grounds, including Designated Evidence. We also requested in our submissions against Kindred's Motion for Summary Judgment, that the Court allow further Discovery for evidence of the legal relationship of Kindred and "Pulmonary Services", and said the same during the hearing. As Kindred pointed out, we did say that what we had offered should be enough to dispute their legal separation, which we hoped would be adequate challenge to avoid Summary Judgment . Kindred's brief argues that we offered no evidence to dispute this distinction. We show below that we did.

ARGUMENT 9: Kindred's Affidavit from their current CEO, asserted that 'Pulmonary services' oversaw Gerri Siner's pulmonary treatment while at Kindred, including the CPAP mask. She references Kindred's intake document's paragraph regarding the LEGAL RELATIONSHIP BETWEEN PHYSICIANS AND KINDRED HOSPITAL, which instructs patients to "understand these providers (types of physicians previously listed) are independent contractors and not employees or agents of the hospital. Kindred is not responsible for their actions." She also says that "These contractual agreements establish that the physicians are

independent contractors for Kindred and must bill patients separately for all patient services provided at Kindred." (Kindred's Brief, p.24)

However, we disputed this legal separation, saying that the intake document (Kindred's Appendix, page 34) did not assert or disclose that divisions such as 'Pulmonary services' were 'independent contractors', but only such physicians. Specific disclosures have been required in legal cases in order to avoid legal liability. Instead, Kindred's intake document only said that certain physicians, not divisions, were 'contractors'.

We also provided Designated Evidence (Appendix p. 184) to show Kindred's Bill (for over $296,000 an approx. 40 day stay) included Gerri Siner's oxygen treatments, etc.; such was not on a separate bill from ' IU Pulmonary service' as their CEO indicated. We challenged whether that was perhaps currently the case, but not in 2007, as such was not billed separately.

Further, we Designated Evidence of a chart on a Code incident of Gerri Siner's, displaying that the Pulmonary Therapist and other team members were Kindred employees (Appendix p. 185). All of this we contend should have been adequate to establish a 'genuine issue of material fact' concerning Kindred et.al, and Dr. Majid's, legal connection with these pulmonary tasks and treatments. Further, as we have already argued, the limitations placed on treatment by both parties are a more 'proximate' and primary cause of the injury which their Medical Expert said was 'documented'.

It was pointed out during the hearing that their CEO and Kindred's defense fluctuated in referring to a 'division' and at times, to a doctor', and we questioned who the unidentified Doctor was, but Kindred refused to specify who. We questioned if the doctor referred to was a Dr. Sheski, who was a pulmonary specialist. In that he "co-signed" some of Majid's

withdrawals of treatment for Gerri Siner, such seemed likely. We submitted Designated Evidence that showed he was listed on Kindred Hospital records as **Kindred's Medical Director** at the time of Gerri Siner's hospitalization. Such is obviously a Kindred Hospital position. See Appendix, p57, which lists Frank Sheski, M.D, as Kindred's "Medical Director".) Again, the argument circles back to point the proximate cause as Kindred, et al.

In spite of all of this Designated Evidence to dispute their alleged legal separation. we also asked, in our brief against Summary Judgment, and in hearing, to be granted further Discovery if our exhibits were not deemed adequate to dispute this legal relationship. Such requests weren't adequate to result in a continuance.

Contrary to the repeated statements by the defense that: "Kathy offers a litany of accusations and arguments on appeal, much of which is unsupported by cogent reasoning or legal authority, none of her assertions support the existence of proximate cause.." (Kindred Brief, p. 6) ,we assert that the above arguments actually show that the Defendants, by illegally imposing limitations on Gerri Siner's treatment, prohibited the Standard of Care, caused damages. All of these arguments support that the "proximate cause" of the specific injuries which both parties discuss, and try to limit this case to, were the illegal actions of both Kindred and Dr. Majid.

SUMMARY OF ARGUMENT 10: The 'damages' and malpractice committed were far greater than the limited scope to which the Defense attorneys and their medical expert tried to narrow this case: that of the malpractice surrounding the prolonged use of the CPAP/ BiPAP and it's "documented damages". We offered additional Medical Expert opinion of additional damages.

ARGUMENT 10: In his Affidavit (App. p 188), Dr. Pohlman, who holds the high position of Medical Director of Trauma Intensive Care at Indiana University Health – Methodist Hospital, affirmed the following:

" 3. On December 8, 2007, Geraldine A. Siner was transferred from Kindred Hospital to Methodist Hospital's ICU, by request of her family and healthcare representative, John T. Siner. The patient required intubation and immediate bronchoscopy for left atelectasis (collapsed lung) which I found on initial imaging studies. I recall that Gerri Siner's family expressed shock when informed of her collapsed lung, saying that Kindred Hospital had not informed them of this. According to patient records obtained from Kindred Hospital, the left lung atelectasis was known on December 5th, 2007. In my opinion, the lack of timely resolution of the lung collapse on December 5th represents a deviation from the Standard of Care.

4) I recall that Gerri Siner had wounds on her cheeks indicating the prolonged use of a BiPAP and CPAP mask, which were documented by our wound team. In my opinion, the prolonged use of the BiPAP and CPAP to the point of facial wounds, constitutes a breach in the accepted Standard of Care. .....

5) Moreover, continuing CPAP was recommended because alternative treatments "such as tracheotomy and intubation were not appropriate in a terminal patient". However, the designation of 'terminal patient' is typically made by a patient's attending physician, and not by a division such as 'Pulmonary Services'. Further, Kindred's Ethics Committee recommended over-riding the wishes of the family and instructions of the patient's medical

representative for full treatment, and instituted a Do Not Resuscitate' (DNR) order, which ruled out such alternative treatments.

6) Methodist records document that Gerri Siner was also suffering from over-whelming infection, and septic shock at the time of intake. There is no documentation produced for me that indicate SCCM Surviving Sepsis Guidelines, even from 2004, were followed (Crit Care Med, 2004;32:858-73). These guidelines were not followed apparently because the patient was under a DNR order. This is an additional breach in the Standard of Care.

7) Full damages and suffering that more likely than not resulted from re-prioritization of treatment modalities for Gerri Siner based on her existing DNR order, that was left in place without full agreement and consent of her Surrogate decision makers would warrant reassessment of her care at Kindred Hospital.

While Dr. Pohlman indicates that he has not yet given a full assessment of the damages and suffering " that more likely than not resulted from Majid's and Kindred et al's reduction of Gerri Siner's Scope of Treatment" , what he did say is quite adequate to establish damages, though Kindred, et.al, and the Court contend that no damages were established.

To be left on BiPap and CPAP masks for such prolonged periods as to create wounds, rather than to follow the "appropriate standard of care" of tracheotomy or intubation, and to not receive appropriate treatment for 'over-whelming infection' and 'septic shock', to have a collapsed lung receive no treatment for 3 days, because your doctor and the hospital decided to ***not*** treat you, is certainly 'damages, pain, and suffering', as well as refusal to do what they were contracted to do: Provide Healthcare.

As we argued in both Dr. Majid's and Kindred's Summary Judgment hearing and briefs, when basic treatment and life sustaining measures are denied, and the effects of lack of water and hydration are witnessed, it is evident as a matter of common knowledge that the results are not those when due care is used. If ***we*** had let our mother go without adequate hydration and nutrition while caring for her at home, no one would hesitate to debate whether such was acceptable or harmful or if it actually caused 'damages'. While Kindred claimed Gerri Siner's bed scale was broken so they did not record her weights, etc. hopefully further medical records will be produced, to further substantiate what we eye-witnessed. Others experienced the same.

The doctrine of *res ipsa loquitur* is applicable in a medical malpractice actions only when a layman is able to say that as a matter of common knowledge the consequences of the professional treatment are not those which ordinarily result if due care is exercised.
Kranda v. Houser-Norborg Medical Corp, (1981) Ind. App, 419 N.E.2nd 1024.

ARGUMENT 11: This case was not filed as a Complaint limited to issues of 'medical negligence' and 'wrongful death'. Our Complaint (Appendix p.1) lists various 'acts and occurrences' of malpractice, of contract violations, and of the violation of patient's rights as defined by Indiana Code. These are not simply matters conventionally determined 'Standard of Care'. These rights are matters of law, and have been defended by the Indiana Supreme Court to be Constitutional Rights. (e.g., Lawrence) The Defense has repeatedly ignored these violations of law.

ARGUMENT 12 The Defense objects that matters not discussed in the lower court cannot now be discussed. Abuse or bias of discretion however. is not the same other topics, in that patterns are the primary indicator, rather than isolated events. I attempted to object in the lower court by filing Motions to Rcconsidcr, ctc. I only ask that this Court consider the sequence of events and

decisions previously outlined, and if to the Court there seems a pattern of abuse of discretion or bias, to please encourage fairness to those of us who are left to struggle on our own if we are to have our day in court and pursue justice.

CONCLUDING REMARKS

We would welcome a reading of our Complaint, (App p.1).

Our Complaint was filed as a list of separate 'acts and occurrences' some of which were medical negligence, some were breaches of contract, some were violations of Constitutional rights, etc. We have not been able to focus on the real issues of this case to date, due to the narrow confines to which the Defense directs arguments. This is a case regarding the breach of assumed contract to care and provide medical assistance. Unlike most medical malpractice cases, which hinge on the medical expert testimony, this case largely hinges on medical law and patient's rights. Tort law covers both medical malpractice and violation of contract. Kindred dismissed the arguments I've made by repeatedly saying they are not "cogent", but simply saying they aren't convincing without any critique of them makes response difficult. The issues of patient rights are foundationally Constitutional: the right to live and die as one chooses. The legal issue is not whether or not anyone agrees or disagrees with another's life or death decisions, but rather whether or not you have the right to make those decisions for yourself. The law says we do.

The issues surrounding the DNR issues are certainly not limited to how the limitations placed on treatment by Dr. Majid and Kindred's Ethics Committee resulted in the prolonged use of the CPAP/ BiPAP mask with resultant facial wounds. We allege that the damages from the prolonged depravation of oxygen, on 11/11/07 when Kindred's staff initially refused to resuscitate Gerri Siner, were far more extensive. We attest that she died on that date; yet some of Kindred's staff denied such after the fact. We attest that some staff told us things that were later removed from her medical records. We attest that she lost use of her limbs after 11/11/07, and that she did not speak after that date. Her damages were extensive.

We had taken her there for emergency care. That care was denied. As an eye witness, I know that my mother died in front of me that day. She lurched back in her chair, with eyes crossed and mouth open. She fell motionless. And the staff all around us refused to help. It was a shocking abandonment. A breach of contract. We allege that Kindred had already started treating her as DNR prior to that day. The fact that the hospital records do not reflect what we know, as eye witnesses, happened, is deeply disturbing – we only hope that such lacked the integrity will be revealed if Discovery is completed, if persons must respond under oath, there were enough persons in the room that someone will be truthful. That pursuit of truth is profoundly important. It was far too serious a breach to ignore. Yet, in this case I've continually been denied the truth even on basic medical data that any patient has a right to request. This case has repeatedly been side tracked to matters not nearly as ethically significant as a patient's rights, and such violations in professional standards of conduct. I hope this case can continue to allow for disclosure of the 'truth'.

In this appeal, sadly one of my primary 3 issues for appeal was that the judge ruled that there 'was no just reason for delay' dismissing the entire DNR issue. I argued this in my Brief, and

have devoted the bulk of my efforts and arguments, research, etc. to that matter, yet failed to list it in my faulty attempt to render my issues of appeal more detailed.

In that both Defendants said they had not followed my list of Issues, but only argued those matters which they felt were essential to their own case, perhaps the Court can allow consideration of whether this issue should have been retained when the lower court threw out consideration of the other issues. The arguments on how the limitation in treatment also affected the sole issue to which the Defendants wished to limit this case, however, compels consideration of that issue as it is embedded in even that issue. It is relevant to every aspect of this case.

While we have established the legal components of a prima facie case of causation, the Defendants repeated statements of our failure to 'prove' the case is misleading. 'Causation' is never a matter of proof, but rather one of probability. Causation is empirical and inductive, never certain. When the Defendants repeatedly claim that we must 'prove' damages, they are requesting a standard of certainty, that no inductive argument can achieve. However, we have done far more than challenge the certainty of their claims. We disputed their facts, and showed our own arguments to be 'matters of law'.

Courts will construe all facts and reasonable inferences derived from those facts in the light most favor of the nonmoving party. *Wilson v. Lincoln Federal Savings Bank, 790 N.E.2d 1042, 1046; Lake Cent. Sch. Corp. v. Hawk Dev. Corp., 793 NE. E.2d 1080, 1083 (Ind. Ct.App. 2003).*

If the court has any doubts concerning the existence of a genuine issue of material fact, the court must resolve those doubts in favor of the non-moving party and deny summary judgment. *Wilson, 790 N.E.2d, at 1046, citing McGee v. Bonaventura, 605 N.E. 2d 792, 793 (Ind. App 1993).*

Thank you for your time and consideration of these issues.

Respectfully Submitted,

Kathy Siner (and Tim Siner) pro se

I affirm under penalty of purgury that these statements are true & accurate to the best of my knowledge. 1/29/15

WORD COUNT CERTIFICATE

I certify that this document contains 8,548 words (including cover page, contents, certificates, authorities, etc. This is a combined Reply Brief, addressing both Kindred et al, and Dr. Majid's Briefs, each of which allows for 15 pages, or 7,000 words per Rule 44, combined total allowance: 30 pages, or 14,000 words.

Signed, _____

CERTIFICATE OF SERVICE

I, Kathy Siner, certify that on January 29, '15 a copy of the forgoing document was mailed, via first class mail, to the following:

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