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Commonwealth Of Kentucky

Court of Appeals

NO. 2002-CA-001983-MR
AND
CROSS-APPEAL NO. 2002-CA-002043-MR

BARRY GORDON, INDIVIDUALLY AND ALSO AS SURVIVING SPOUSE AND PERSONAL REPRESENTATIVE OF THE ESTATE OF LORI GORDON, DECEASED; AND STUART GORDON, BY AND THROUGH HIS PARENT AND NEXT FRIEND, BARRY D. GORDON; AND SAMANTHA GORDON, BY AND THROUGH HER PARENT AND NEXT FRIEND, BARRY D. GORDON — APPELLANTS/CROSS-APPELLEES

v.

APPEALS FROM JEFFERSON CIRCUIT COURT
HONORABLE GEOFFREY P. MORRIS, JUDGE
ACTION NO. 97-CI-003774

WARREN KEMPER, M.D. — APPELLEE/CROSS-APPELLANT

OPINION AND ORDER
AFFIRMING IN PART
REVERSING AND REMANDING IN PART
APPEAL NO. 2002-CA-001983-MR AND
DISMISSING CROSS-APPEAL NO. 2002-CA-002043-MR

** ** ** ** **

BEFORE: MINTON, SCHRODER, AND TAYLOR, JUDGES.

TAYLOR, JUDGE: This is an appeal from a Final Judgment entered by the Jefferson Circuit Court upon a jury verdict dismissing a

medical malpractice action against Warren Kemper, M.D. Barry Gordon, individually and also as surviving spouse and personal representative of the estate of Lori Gordon, deceased, and Stuart Gordon, by and through his parent and next friend, Barry D. Gordon, and Samantha Gordon, by and through her parent and next friend, Barry D. Gordon (collectively referred to as appellants) bring Appeal No. 2002-CA-001983-MR from an April 3, 2002, Final Judgment of the Jefferson Circuit Court. Warren Kemper, M.D. brings Cross-Appeal No. 2002-CA-002043-MR from the April 3, 2002, Final Judgment of the Jefferson Circuit Court. We affirm in part and reverse and remand in part Appeal No. 2002-CA-001983-MR. We dismiss Cross-Appeal No. 2002-CA-002043-MR.

In early February 1996, Lori, then 38 years of age and otherwise in good health, suddenly experienced severe nausea, chest pain, and dizziness. By ambulance, Lori was transported to Baptist Hospital East in Louisville, Kentucky. She received a cardiovascular evaluation by Dr. George Stacy but was subsequently discharged without a firm diagnosis.

On April 14, 1996, Lori was at the movie theater with one of her children when the symptoms suddenly returned. The nausea and chest pain were so severe that an ambulance was needed. Lori was again taken to Baptist Hospital East, and the emergency room physician, Dr. Charles Smith, found nothing

medically wrong with Lori. He prescribed Ativan for anxiousness and recommended she see an internist.

One day later, on April 15, Lori saw Dr. Kemper, an internist, at his office. At this time, Lori's weight was reported to be 137 pounds. Dr. Kemper ordered an ultrasound of the gallbladder to rule out gallbladder disease. He also prescribed Xanax for anxiety. Dr. Kemper subsequently interpreted the ultrasound to be within normal limits.

It appears that Lori and/or her husband called Dr. Kemper several times after April 15. Lori's symptoms continued to worsen. Because of the severity of Lori's symptoms, a family trip to Disney World was cancelled. The nausea had even caused Lori to pass out at her child's preschool. In late April 1996, Dr. Kemper ordered a Computed Axial Tomography (CAT) Scan of the abdomen; the CAT Scan report revealed a two-centimeter cavernous hemangioma on the right lobe of the liver and a two-centimeter right ovarian cyst. Dr. Kemper interpreted this report as being within normal limits. Having ruled out what he believed to be all physical causes for Lori's symptoms, Dr. Kemper opined that her symptoms were caused by anxiety and/or panic attacks. He believed Lori needed psychiatric care, not medical treatment for her condition.

In June and July 1996, Lori was examined by Dr. Larry Mudd, a psychiatrist. Dr. Mudd diagnosed Lori with an anxiety

disorder and began to treat her with medication. In late August 1996, Lori's symptoms had not abated but continued to worsen, so she consulted with another internist, Dr. Robert Ellis. At this time, Lori's weight was reported to be 125 pounds. Having obtained no medical explanation for her symptoms, Lori saw a psychologist, Dr. Carroll Macy in September 1996, and consulted with another psychiatrist, Dr. Karen Head, in October 1996. In December 1996, Lori began treatment with yet another psychiatrist, Dr. Ken Davis. Dr. Davis also diagnosed Lori with anxiety. By December 1996, Lori's weight was reported to be 117 pounds.

From April 1996 to December 1996, Lori experienced unexplained weight loss of some twenty pounds. During this time, Lori believed that something was physically wrong with her. Lori was so fatigued that she could barely get out of bed and so nauseated that she could hardly eat. She reported hair loss, chronic urinary tract infections, and severe chest pains. In December 1996, Lori discovered two enlarged lymph nodes in her neck. She immediately called Dr. Ellis to set up an office visit.

After examining Lori, Dr. Ellis referred her to Dr. Janet Chipman for biopsy of the lymph nodes. The biopsy revealed adenoma carcinoma. On February 4, 1997, Lori was admitted to the hospital, and a repeat biopsy of the lymph nodes

was performed. The pathology revealed Grade III adenoma carcinoma. A CAT Scan of the abdomen and pelvis also revealed extensive adenopathy. Lori was finally diagnosed with metastasized gastric (stomach) cancer.

On July 7, 1997, Lori filed a medical malpractice action against, *inter alios*, Dr. Kemper and Dr. Ellis.[1] Therein, Lori particularly claimed that Dr. Kemper Afailed to take reasonable and appropriate steps to make a timely diagnosis of . . . [her] stomach cancer, thereby allowing the disease to progress in size, scope and severity.@

Lori died on January 13, 1998, during the pendency of the action, and the personal representative of her estate was substituted. A jury trial ensued. After the case was submitted to the jury but before a verdict was reached, appellants and Dr. Ellis entered into a settlement agreement. The jury was not informed of the settlement and eventually returned a verdict in favor of Dr. Kemper and Dr. Ellis. On April 3, 2002, the trial court entered judgment pursuant to the jury verdict and dismissed all claims against Dr. Kemper. These appeals follow.

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Appellants raise several issues for our consideration. We shall begin with the most troublesome issue – whether the

[1] The other defendants either settled with Lori or were dismissed from the action.

trial court's jury instructions were erroneous. Specifically, appellants complain of instruction 2, which reads:[2]

INSTRUCTION NO. 2

> It was the duty of defendant, Warren Kemper, M.D., to use in his care and treatment of Lori Gordon, that degree of care and skill which is expected of a reasonably competent internist, acting under the same or similar circumstances. Do you believe from the evidence that Dr. Kemper failed to use the degree of care imposed upon him by this Instruction, and that such failure was a substantial factor in causing the injury to Lori Gordon about which you have heard evidence?

During trial, appellants proposed an alternative instruction that asked the jury to determine whether Dr. Kemper breached the applicable standard of care and, if so, whether such breach was a substantial factor in causing Lori to suffer a delay in diagnosis/treatment.

Juxtaposing instruction 2 and appellants' proposed jury instruction, it becomes readily apparent that each instruction differs in its respective definition of the legally compensable injury.[3] Under instruction 2, the injury was generally defined as "the injury to Lori Gordon about which you

[2] The jury answered "no" to Instruction 2.

[3] The elements of a medical malpractice action are generally: (1) duty; (2) breach of duty; (3) causation; and (4) injury. As the elements of duty, breach of duty, and causation were merged in jury instruction 2, it is impossible to determine whether the jury found that Dr. Warren Kemper did not breach the standard of care or that Dr. Warren Kemper did breach the standard of care but such breach was not a substantial factor in causing the injury.

have heard evidence"; whereas, under appellants' proposed instruction, the injury was essentially defined as the failure to diagnose or treat Lori that resulted in a diminished chance of survival.

This Commonwealth has yet to recognize a diminished chance of recovery/survival as a distinct compensable injury in tort law.[4] A growing number of other jurisdictions have done so,[5] and the analytical foundation supporting this growing

[4] In this Commonwealth, there has been no published case formally accepting or rejecting the recognition of a delay in diagnosis/treatment resulting in a diminished chance of survival as a legally compensable injury. Kemper cites Walden v. Jones, 439 S.W.2d 571 (Ky. 1968) as authority rejecting such recognition. In Walden, the Court was concerned with the issue of causation and, specifically, with whether causation must be proved by evidence establishing a reasonable probability or mere possibility. The Court held that "proximate" cause must be established by the reasonably probable standard. The Court was not called upon and did not decide the issue of whether the lost chance of recovery should be recognized as a legally compensable injury in tort law. Accordingly, we view Walden as distinguishable.

[5] The following jurisdictions have adopted the loss-of-chance doctrine in some form:

- Thompson v. Sun City Community Hospital, Inc., 688 P.2d 605 (Ariz. 1984).
- Sharp v. Kaiser Foundation Health Plan, 710 P.2d 1153 (Colo.App. 1985).
- Borkowski v. Sacheti, 682 A.2d 1095 (Conn.App. 1996).
- Richmond County Hospital Authority v. Dickerson, 356 S.E.2d 548 (Ga.App. 1987).
- Holton v. Memorial Hospital, 679 N.E.2d 1202 (Ill. 1997).
- Cahoon v. Cummings, 734 N.E.2d 535 (Ind. 2000), vacating Cahoon v. Cummings, 715 N.E.2d 1 (Ind.App. 1999); Mayhue v. Sparkman, 653 N.E.2d 1384 (Ind. 1995).
- DeBurkarte v. Louvar, 393 N.W.2d 131 (Iowa 1986).
- Roberson v. Counselman, 686 P.2d 149 (Kan. 1984).
- Hastings v. Baton Rouge General Hospital, 498 So.2d 713 (La. 1986).
- Wollen v. DePaul Health Center, 828 S.W.2d 681 (Mo. 1992).
- Aasheim v. Humberger, 695 P.2d 824 (Mont. 1985).
- Perez v. Las Vegas Medical Center, 805 P.2d 589 (Nev. 1991).
- Lord v. Lovett, 770 A.2d 1103 (N.H. 2001).
- Scafidi v. Seiler, 574 A.2d 398 (N.J. 1990).

acceptance is commonly referred to as the "loss-of-chance doctrine." See Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 Yale L.J. 1353 (1981).

The loss-of-chance doctrine was developed in response to the often harsh results of the traditional "all or nothing rule." See George J. Zilich, Cutting Through The Confusion of The Loss-of-Chance Doctrine Under Ohio Law: A New Cause of Action or A New Standard of Causation?, 50 Clev. St. L. Rev. 673 (2002-2003). Historically, this Commonwealth has adhered to the all-or-nothing rule in medical malpractice cases.[6] Under the traditional all-or-nothing rule, plaintiff must prove within a reasonable probability that defendant's breach of the standard of care was a substantial factor in causing the underlying injury. As the compensable injury is viewed as the underlying injury, plaintiff must prove within a reasonable probability that she would have recovered or survived absent defendant's

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- Alberts v. Schultz, 975 P.2d 1279 (N.M. 1999).
- Kallenberg v. Beth Israel Hospital, 357 N.Y.S.2d 508 (N.Y. App.Div. 1974).
- Roberts v. Ohio Permanente Medical Group, Inc., 668 N.E.2d 480 (Ohio 1996).
- McKellips v. Saint Francis Hospital, Inc., 741 P.2d 467 (Okla. 1987).
- Hamil v. Bashline, 392 A.2d 1280 (Pa. 1978).
- Herskovits v. Group Health Coop. of Puget Sound, 664 P.2d 474 (Wash. 1983).
- Thornton v. CAMC, Etc., 305 S.E.2d 316 (W.Va. 1983).
- Ehlinger v. Sipes, 454 N.W.2d 754 (Wis. 1990).

[6] For a further analysis, refer to Footnote 4. There has yet to be a published case either rejecting or accepting the loss-of-chance doctrine.

negligent conduct. If plaintiff is unable to prove a reasonable probability of recovery/survival, she would recover nothing; it is in these narrow cases that the loss-of-chance doctrine would be implicated.

Under our interpretation of the loss-of-chance doctrine, plaintiff is required to prove that defendant's breach of the standard of care was a substantial factor in causing a diminished chance of recovery/survival from the underlying injury. See Deutsch v. Shein, 597 S.W.2d 141 (Ky. 1980) (adopting the substantial factor test of Restatement (Second) of Torts § 431); see also, Pathways, Inc. v. Hammons, 113 S.W.3d 85 (Ky. 2003); Bailey v. North American Refractories Co., 95 S.W.3d 868 (Ky.App. 2001). Most often, the loss-of-chance doctrine would be employed where the breach of the standard of care involved a failure or delay in diagnosis or treatment. It must be stated with specificity that the compensable injury is viewed as the lost chance of recovery/survival.

Under the loss-of-chance doctrine, the substantial factor test set forth in Restatement (Second) of Torts § 431 is applied to determine causation. The substantial factor test is also utilized in traditional malpractice actions coming under the all-or-nothing rule; thus, causation remains congruous under the loss-of-chance doctrine. The degree of certainty required to establish causation, likewise, remains the same – "reasonable

probability." See Walden v. Jones, 439 S.W.2d 571 (Ky. 1968). Reasonable probability is defined as "more probable than not" or "more likely than not." See 61 Am. Jur. 2d Physicians, Surgeons, and Other Healers § 332 (2002); George J. Zilich, Cutting Through The Confusion of The Loss-of-Chance Doctrine Under Ohio Law: A New Cause of Action or A New Standard of Causation?, 50 Clev. St. L. Rev. 673 (2002-2003); Miller v. Paulson, 97 Ohio App.3d 217, 646 N.E.2d 521 (1994). From a statistical viewpoint, we equate reasonable probability with a greater than 50 percent chance. See Dalebout v. Union Pac. R.R. Co., 980 P.2d 1194 (Utah Ct.App. 1999); Fid. & Guaranty Ins. Underwriters, Inc. v. Gary Douglas Elec., Inc., 48 Ohio App.2d 319, 357 N.E.2d 388 (1974); Shawn M. Nichols, Jorgenson v. Vener: The South Dakota Supreme Court Declares Loss-of-Chance Doctrine as Part of Our Common Law in Medical Malpractice Torts., 46 S.D. L. Rev. 618 (2000-2001).

The sole distinction between the traditional all-or-nothing rule and the loss-of-chance doctrine is the compensable injury. Under the all-or-nothing rule, the compensable injury is viewed as the underlying injury; by contrast, under the loss-of-chance doctrine, the compensable injury is viewed as the lost opportunity of recovery/survival from the underlying injury.[7]

[7] For example, the all-or-nothing rule would require a plaintiff/patient to prove that defendant's/physician's negligence caused the loss of the patient's eye; under the loss-of-chance doctrine, a plaintiff would be

Although the traditional all-or-nothing rule and the loss-of-chance doctrine are similar, the right of recovery is vastly different. For example, a patient suffering from a potentially terminal illness alleges that the physician failed to timely diagnose and treat that illness. Expert medical testimony uncontrovertibly established that the physician's failure to timely diagnose and treat the illness was a breach of the standard of care. The medical evidence also established it was more probable than not that the breach of the standard of care caused a lost chance of survival. Specifically, the patient had a 45 percent chance of survival at the time the physician negligently failed to diagnose the illness. Later, when the illness was properly diagnosed, the patient's chance of survival diminished to only 15 percent.[8] The patient eventually died as a result of the illness.

Under the traditional all-or-nothing rule, the patient would recover nothing as it could not be shown within a reasonable probability that the physician's failure to diagnose caused the patient's death. Conversely, under the loss-of-chance doctrine, the patient could recover for the lost chance

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required to prove that defendant's negligence caused the plaintiff to suffer a diminished chance of saving the eye.

[8] We note that if the patient had a greater than 50 percent chance of survival at the time the physician negligently failed to diagnose the illness the patient would recover under the traditional all-or-nothing rule and the loss-of-chance doctrine would be inapplicable.

of survival on a proportional basis. As the medical evidence proved within a reasonable probability that the physician's failure to diagnose caused a 30 percent diminished chance of survival, the patient could recover damages proportionate to that 30 percent lost chance of survival. If the patient's total damages were $100,000.00, the patient would recover 30 percent of that amount, or $30,000.00.

The above example highlights the public policy reasons supporting the legal recognition of the lost chance of recovery/survival as a distinct compensable injury in tort law. Such recognition would allow proportionate recovery for a patient whose opportunity to recover/survive had been diminished by the negligence of a medical professional. A proportionate recovery would better comport with traditional notions of fair play and justice, than the all-or-nothing rule that would leave the patient without a remedy.

In deciding whether to adopt the loss-of-chance doctrine, we are also guided by the Kentucky Supreme Court's decision in Davis v. Graviss, 672 S.W.2d 928 (Ky. 1984).[9] In Davis, the Supreme Court recognized the right to recovery for an "increased risk of future harm." Id. at 930. There exist striking similarities between recovery for an increased risk of

[9] We note that Davis v. Graviss, 672 S.W.2d 928 (Ky. 1984) was overruled on other grounds by Sand Hill Energy, Inc. v. Ford Motor Co., 83 S.W.3d 483 (Ky. 2002). Thereafter, Sand Hill was vacated by Ford Motor Co. v. Smith, 538 U.S. 1028, 123 S. Ct. 2072, 155 L. Ed. 2d 1056 (2003).

future harm and for a lost chance of survival. Indeed, it has been observed that "because the increased risk analysis is so similar to the loss of chance doctrine, some scholars see the former merely as an extension of the latter." Kira Elert Dillon v. Evanston Hospital: Illinois Adopts The New Increased Risk Doctrine Governing Recovery For Future Injury, 34 Loy. U. Chi. L.J. 685, 715 (2003). As the Supreme Court has already signaled its intent to permit recovery for an increased risk of future harm, we believe it would, likewise, be inclined to permit recovery for a lost chance of recovery/survival.

Accordingly, we now hold that a lost chance of recovery/survival should be recognized as a legally compensable injury in medical malpractice cases where the chance of recovery/survival is 50 percent or less before the negligent act or omission. In cases where the chance of recovery/survival was greater than 50 percent, the traditional all-or-nothing approach would apply and the compensable injury would still be viewed as the underlying injury.

To maintain an action for a lost chance of recovery/survival, plaintiff must still prove that defendant breached the applicable standard of care and that such breach was a substantial factor in causing a diminished chance of recovery/survival from the underlying disease or injury. Plaintiff must present evidence proving causation by a

reasonable probability and establishing the chance of recovery/survival was 50 percent or less before the negligent act or omission.[10] Evidence establishing causation or plaintiff's chance of recovery/survival need not be expressed in terms of percentages; this is a question for the jury.

Where the evidence warrants submission both as a traditional malpractice action under the all-or-nothing rule and as a malpractice action under the loss-of-chance doctrine,[11] the jury may be instructed pursuant to the following model instructions:

> 1. It was the duty of [physician's name] to use, in his care and treatment of [patient's name], that degree and skill which is expected of a reasonably competent [physician's specialty] acting under the circumstances. Do you believe from the evidence that [physician's name] failed to use the degree of care imposed by this instruction?
>
> _____ Yes
>
> _____ No
>
> If you answer the above instruction in the affirmative, proceed to Instruction 2. If

[10] If plaintiff's chance of survival/recovery was greater than 50 percent before the negligent act or omission, the case would not come within the purview of the loss-of-chance doctrine but rather would come within the ambit of the all-or-nothing rule and proceed as a traditional malpractice action.

[11] This would necessarily be a case where there was conflicting evidence as to plaintiff's chance of recovery/survival. For example, there was expert medical testimony that plaintiff's chance of recovery/survival was greater than 50 percent when the physician negligently failed to diagnose/treat, and there also was expert medical testimony that plaintiff's chance of recovery/survival was less than 50 percent when the physician negligently failed to diagnose/treat.

you answer the above instruction in the negative, you shall find in favor of [physician's name].

2. Do you believe from the evidence that [physician's name] failure to exercise reasonable care was a substantial factor in causing [patient's name] [injury or death].

_____ Yes

_____ No

If you answer the above instruction in the affirmative, you shall find in favor of [patient's name] and proceed to Instruction ___ [damage instruction]. If you answer the above instruction in the negative, proceed to Instruction 3.

3. Do you believe from the evidence that [physician's name] failure to exercise reasonable care was a substantial factor in causing [patient's name] to suffer a lost chance of recovery or survival from the underlying [disease or injury]. For purposes of this instruction, a lost chance of recovery or survival is defined as a 50 percent or less chance of recovery or survival at the time [physician's name] failed to exercise reasonable care in his treatment of [patient's name].

_____ Yes

_____ No

If you answer the above instruction in the affirmative, proceed to Instruction 4. If you answer the above instruction in the negative, you shall find in favor of [physician's name].

4. What do you find, in terms of a percentage, represents [patient's name] chance of recovery or survival, at time of [physician's name] failure to exercise

> reasonable care in his treatment of [patient's name]. The percentage you find cannot be greater than 50 percent.
>
> _____ % (50 percent or less)
>
> Proceed to Instruction 5.
>
> 5. What do you find, in terms of a percentage, represents [patient's name] chance of recovery or survival at the time she was properly diagnosed and treated?
>
> _____ %
>
> [Patient's name] lost chance of recovery or survival will be determined by subtracting the percentage you find under Instruction 5 from the percentage you find under Instruction 4. The Judge then will determine [patient's name] award by multiplying the total amount you determine as damages by the percentage previously determined to represent the lost chance of recovery or survival (subtracting the percentage under Instruction 5 from the percentage under Instruction 4).

The next instruction will ask the jury to fix the amount of total damages plaintiff suffered. This instruction will be the traditional medical malpractice instruction upon damages.

In summation, to recover under the loss-of-chance doctrine, the jury must find that the physician breached the standard of care under Instruction 1, and that such breach was not a substantial factor in causing the underlying injury under Instruction 2.[12] If the jury finds that the physician's breach

[12] Instruction 2 would only be given when the evidence also warranted submission as a traditional medical malpractice claim. Where the evidence

of the standard of care caused the underlying injury, plaintiff would be entitled to damages ordinarily recoverable in a traditional malpractice action. However, if the jury finds that such breach was not a substantial factor in causing the underlying injury, the jury may then consider whether such breach caused a lost chance of recovery/survival[13] under Instruction 3 and fix the exact percentage representing that lost chance under Instructions 4 and 5. The judge will then determine the amount of damages by multiplying the total damages by the percentage representing the lost chance of survival.

We thus conclude that it was reversible error not to instruct the jury upon Lori's lost chance of survival. Upon remand, the jury should be instructed under the above model instructions with the omission of Instruction 2. Instruction 2 essentially asks the jury whether Dr. Kemper's failure to exercise reasonable care was a substantial factor in causing Lori's injury. The jury was previously so instructed and answered in the negative. As we view appellants' specific allegations of error regarding the trial proceedings to be without merit, appellants are not entitled to retry whether Dr. Kemper's negligence caused the underlying injury.

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warrants submission solely under the loss-of-chance doctrine, the above model instructions would still be applicable except Instruction 2 would be omitted.

[13] We emphasize that the lost chance of recovery/survival is defined as a 50 percent or less chance of recovery/survival at the time the physician failed to exercise reasonable care in his treatment of plaintiff.

As to appellants' remaining issues, we view them to be without merit.

Accordingly, we are of the opinion that appellants are entitled to a new trial upon the narrow issue of whether Dr. Kemper negligently failed to diagnose or treat Lori and whether such failure caused Lori to suffer a lost chance of survival. The jury should be instructed under the above model instructions with the exception of Instruction 2.

CROSS-APPEAL NO. 2002-CA-002043-MR

Dr. Kemper pursues what is commonly described as a "protective" cross-appeal. A protective cross-appeal is generally limited to legal issues that would arise if the judgment appealed from was reversed and remanded. See Michael E. Tigar & Jane B. Tigar, Federal Appeals Jurisdiction and Practice, § 6:10 (3d ed. 2003). On cross-appeal, Dr. Kemper raises the issue of whether the trial court should have excluded certain testimony of Dr. Ellis's expert witness, Dr. Peter L. Thurman. As Dr. Ellis settled with Lori, it is impossible for this precise issue to be raised again upon retrial. The law in this Commonwealth is clear that "[w]e may not render advisory opinions concerning moot or hypothetical issues." Commonwealth v. Deweese, 141 S.W.3d 372, 375 (Ky.App. 2003). As Dr. Ellis is no longer a party, we conclude that any

opinion upon the issue of Dr. Thurman's testimony would be merely advisory.

The Court hereby, *sua sponte*, ORDERS Cross-Appeal No. 2002-CA-002043-MR DISMISSED.

For the foregoing reasons, Appeal No. 2002-CA-001983-MR is affirmed in part and reversed and remanded in part for proceedings consistent with this opinion; Cross-Appeal No. 2002-CA-002043-MR is dismissed.

ALL CONCUR.

ENTERED: March 25, 2005

/s/ Jeff S. Taylor
JUDGE, COURT OF APPEALS

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