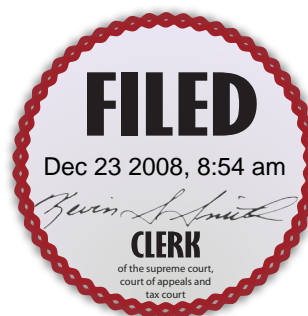


Pursuant to Ind.Appellate Rule 65(D), this Memorandum Decision shall not be regarded as precedent or cited before any court except for the purpose of establishing the defense of res judicata, collateral estoppel, or the law of the case.



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**IN THE
COURT OF APPEALS OF INDIANA**

NILES D. SCHWARTZ, M.D.,)

Appellant-Defendant,)

vs.)

No. 02A05-0805-CV-308

PARKER SHELTON,)

Appellee-Plaintiff.)

APPEAL FROM THE ALLEN SUPERIOR COURT
The Honorable Stanley A. Levine, Judge
Cause No. 02D01-0510-CT-461

December 23, 2008

MEMORANDUM DECISION - NOT FOR PUBLICATION

BROWN, Judge

Niles D. Schwartz, M.D., appeals a judgment against him in a medical malpractice action brought by Parker Shelton. Dr. Schwartz raises one issue, which we restate as whether the trial court's amended findings of fact and conclusions of law are clearly erroneous. We affirm.¹

The relevant facts follow. In 2001, sixty-one-year-old Parker Shelton, who was the owner of a martial arts instruction school, consulted with Dr. Michael Lee, an orthopedic surgeon, regarding his knees. Dr. Lee discovered that Shelton had "some significant arthritis of the patellofemoral joints." Appellant's Appendix at 325. On December 21, 2001, Dr. Lee performed an arthroscopic debridement and lateral release on both of Shelton's knees. On January 1, 2002, Shelton contacted Dr. Lee because he was having increasing pain and swelling in the left knee. Dr. Lee sent Shelton to the St. Joseph Hospital where Dr. Schwartz, an orthopedic resident, saw Shelton. Dr. Schwartz aspirated 100 cc of fluid from the joint capsule on Shelton's left knee. Dr. Schwartz did not believe the fluid had "any infectious look to it" and did not "send it for culture." Id. at 214.

On January 3, 2002, Shelton saw Dr. Lee for a previously scheduled follow-up appointment. Shelton reported that his pain in the left knee was getting worse. Dr. Lee aspirated 30 cc of "cloudy looking fluid" and sent the fluid for "culture and cell analysis." Id. at 172. Dr. Lee was "highly suspicious of a septic knee" given Shelton's degree of

¹ We note that many portions of Dr. Schwartz's brief are single spaced. See Appellant's Brief at 9-18. We remind Dr. Schwartz's counsel that Ind. Appellate Rule 43(E) requires that "[a]ll printing in the text shall be double-spaced except lengthy quotes and footnotes shall be single-spaced."

pain and recurrent swelling and the difference between the right knee and the left knee. Id. Dr. Lee sent Shelton to the hospital for “admission for pain control as well as intravenous antibiotics.” Id. On the same day, Dr. Lee performed another surgery to irrigate and debride² the left knee. To maximize the chance of getting rid of the infection, Dr. Lee performed another irrigation and debridement on Shelton’s left knee on January 5, 2002.

The infection was ultimately diagnosed as staphylococcus aureas, which Dr. Lee described as “a bit more aggressive with regard to some of the damage it may cause.” Id. at 162. The infection resulted in osteomyelitis³ because it “had spread out of the joint into the surrounding boney structures, the kneecap, the femur or the thigh bone, and the tibia, the bigger of the two shin bones.” Id. at 109. The infection also spread to Shelton’s bloodstream. As a result of the infection, Shelton was hospitalized for twelve days and required antibiotics for eighteen weeks, including eight weeks of intravenous antibiotics.

Shelton filed a proposed complaint against Dr. Schwartz with the Indiana Department of Insurance. A medical review panel concluded that: (1) the evidence presented did not support a conclusion that Dr. Schwartz failed to meet the appropriate standard of care, and (2) the conduct complained of was not a factor of the resultant

² Debridement involves the removal of a superficial layer of the joint lining that typically harbors the bacteria. Appellant’s Appendix at 162.

³ Osteomyelitis is “an infectious usually painful inflammatory disease of bone that is often of bacterial origin” MERRIAM-WEBSTER’S MEDICAL DICTIONARY, available at <http://medical.merriam-webster.com/medical/osteomyelitis>.

damages. Shelton then filed a medical malpractice complaint against Dr. Schwartz.⁴ Shelton alleged that Dr. Schwartz's failure to have the fluid aspirated from his knee cultured was a breach in the standard of care and that, as a result of the delay in diagnosis, he suffered additional injuries and damages. After a bench trial, the trial court entered sua sponte findings of fact and conclusions of law in favor of Shelton. Dr. Schwartz filed a motion to correct error, which the trial court granted in part.⁵ The trial court then entered amended findings of fact and conclusions of law *nunc pro tunc* in favor of Shelton. The trial court concluded, in part, that:

1. Dr. Schwartz did not meet the standard of care in documenting infection as a differential diagnosis and in ruling out that infection by ordering a culture of fluid drained from Shelton's knee.

* * * * *

5. [Dr. Schwartz] did not meet the standard of care in documenting the infection as a differential diagnosis, and in ruling out that infection by ordering a culture of the cloudy fluid drained from Shelton's post-surgical swollen left knee.

* * * * *

10. The conclusion of Dr. Schwartz that the fluid aspirated from Shelton on January 1, 2002 "did not have an infectious look to it" and his determination that Shelton was not suffering from an infection and

⁴ Shelton's complaint also included a claim against Dr. Schwartz's employer, the Fort Wayne Medical Education Program. However, the trial court dismissed this claim, and Shelton does not appeal the dismissal.

⁵ In the original findings of fact and conclusions of law, the trial court found: "Alternatively, under an 'increased risk of harm' analysis, Shelton also proved that Dr. Schwartz was negligent, the delayed care of his infection increased the risk of harm and that Dr. Schwartz's conduct was a substantial factor in causing such harm." Appellant's Appendix at 53. In his motion to correct error, Dr. Schwartz argued that the increased risk of harm doctrine was neither pled nor litigated in the case. The trial court granted the motion to correct error in part and struck the increased risk of harm finding. On appeal, neither party presents an argument regarding the increased risk of harm doctrine.

therefore the fluid did not have to be sent for culture did not meet the standard of care in that visual inspection of the fluid is an unreliable method of determining if infection exists.

* * * * *

12. Due to [Dr. Schwartz's] failure to diagnose or rule out infection as the cause of [Shelton's] left knee swelling and pain, Shelton's treatment for infection was delayed by at least 42 hours.
13. A delay of even 42 hours in treating a serious infection like the partially resistant staph infecting Shelton's left knee is known to cause serious harm.
14. The spread of Shelton's infection from his knee joint into his blood and into the surrounding tissue and bone area is due to the delay in treatment of Shelton's post-surgical staph infection, which in turn was brought on by [Dr. Schwartz's] negligence.
15. [Dr. Schwartz's] negligence and the resultant delay in treatment of [Shelton's] infection was a substantial factor in proximately causing the following harms to Shelton:
 - a. His extended intravenous and other antibiotic care from an expected four to six weeks to 18 weeks.
 - b. The delay allowed the joint infection to spread into the blood and surrounding bone/tissues.
 - c. The delay created fluid retention issues due to kidney suppression and fluid overload due to extended antibiotics medications.
 - d. Shelton was prevented from timely attempting to rehabilitate his knee so that he incurred greater atrophy and limitations than would normally be expected.
 - e. The need for medical care and expense extended beyond the expected four to six weeks of antibiotics, further including: two debridement surgeries and an ambulance run.

* * * * *

22. [Shelton] met his burden of proof to show that [Schwartz] was negligent, and that such negligence proximately caused injury and harm to [Shelton].
23. More specifically, [Shelton] met his burden of proving that the delay in treatment, which resulted from [Dr. Schwartz's] negligence, was a factor in proximately causing the spread of Shelton's infection from his knee joint, which produced injury and harm, such as set forth in Conclusion paragraph 15, above,

* * * * *

26. Based upon the foregoing Findings of Fact and Conclusions of Law, the Court finds in favor of [Shelton] and awards judgment against [Dr. Schwartz] in the sum of \$300,000.00. . . .

Appellant's Appendix at 70-74.

The issue on appeal is whether the trial court's amended findings of fact and conclusions of law are clearly erroneous. The trial court here entered sua sponte findings of fact and conclusions of law. Sua sponte findings control only as to the issues they cover, and a general judgment will control as to the issues upon which there are no findings. Yanoff v. Muncy, 688 N.E.2d 1259, 1262 (Ind. 1997). We will affirm a general judgment entered with findings if it can be sustained on any legal theory supported by the evidence. Id. When a court has made special findings of fact, we review sufficiency of the evidence using a two-step process. Id. First, we must determine whether the evidence supports the trial court's findings of fact. Id. Second, we must determine whether those findings of fact support the trial court's conclusions of law. Id.

Findings will be set aside only if they are clearly erroneous. Id. "Findings are clearly erroneous only when the record contains no facts to support them either directly or by inference." Id. A judgment is clearly erroneous if it applies the wrong legal standard to properly found facts. Id. In order to determine that a finding or conclusion is clearly erroneous, an appellate court's review of the evidence must leave it with the firm conviction that a mistake has been made. Id.

In general, a plaintiff must prove each of the elements of a medical malpractice case, which are that: (1) the physician owed a duty to the plaintiff; (2) the physician breached that duty; and (3) the breach proximately caused the plaintiff's injuries. Mayhue v. Sparkman, 653 N.E.2d 1384, 1386 (Ind. 1995). According to Dr. Schwartz, Shelton failed to prove that any negligence by Dr. Schwartz due to the delay in diagnosing the infection proximately caused injuries to Shelton.⁶ An indispensable element of a negligence claim is that the act complained of must be the proximate cause of the plaintiff's injuries. Bader v. Johnson, 732 N.E.2d 1212, 1218 (Ind. 2000). "A negligent act is the proximate cause of an injury if the injury is a natural and probable consequence, which in the light of the circumstances, should have been foreseen or anticipated." Id. "At a minimum, proximate cause requires that the injury would not have occurred but for the defendant's conduct." Id.

Dr. Schwartz argues that several of the trial court's findings of fact and conclusions of law are clearly erroneous.⁷ We will address each separately.

A. Finding No. 62.

⁶ Dr. Schwartz makes no argument concerning his duty to Shelton or his breach of that duty.

⁷ Dr. Schwartz also challenges the trial court's finding that "[a]fter his release from the hospital, Shelton continued to have difficulties because the infection had grown and spread." Appellant's Appendix at 63 (Finding No. 44). Dr. Schwartz argues that the finding implies the infection was growing and spreading at the time Shelton was released from the hospital. However, a more reasonable reading of the finding is that Shelton continued to have difficulties after he was released from the hospital because the infection had grown and spread after Dr. Schwartz's consultation. The finding is not clearly erroneous.

Further, Dr. Schwartz challenges the trial court's finding that "Shelton had a fair amount of arthritis in that part of the knee post-operatively." Appellant's Appendix at 65 (Finding No. 53). Shelton concedes that the term "post-operatively" should be "pre-operatively." Although a typographical error was apparently made in the finding, we conclude that the error was harmless. The trial court did not find

We first address Dr. Schwartz's challenge to the trial court's finding that:

Shelton's left knee surgery, unlike the successful right knee surgery, left him with many limitations. Because of the debridement surgeries and atrophy that occurred over his long antibiotic therapy, Shelton has weakness in the leg, restricted bending that again prevented him from bowing in classes that he would attempt to teach, increased pain and a stiff knee/leg that resulted in a slight limp and a pitching to the right that was evidenced by the way he wore out shoes irregularly due to his abnormal gait.

Appellant's Appendix at 66-67. Dr. Schwartz argues that Shelton's condition in his left knee is similar to his pre-surgery condition, that Dr. Schwartz did not cause the infection itself, that Shelton would have required the debridement surgeries regardless of the delay in diagnosis, and that Shelton's condition was not causally related to any negligence by Dr. Schwartz. Dr. Schwartz argues that Shelton presented no medical expert evidence that he suffered permanent harm as a result of Dr. Schwartz's delay in diagnosing the infection. According to Dr. Schwartz, Shelton relies upon testimony that is speculative and does not establish causation to a reasonable degree of medical certainty.

“[E]xpert medical opinion does not need to be given to a ‘medical certainty.’”

Biehl v. State, 738 N.E.2d 337, 338 n.1 (Ind. Ct. App. 2000), trans. denied. The Indiana Supreme Court has noted:

It is readily apparent that an attempt to quantify degrees of certitude in terms such as those employed by witnesses does, to some extent, inject semantics into the matter of expert opinion testimony. The various phrases and words do not, in and of themselves, connote exact degrees of certainty or conclusiveness; usage of any particular term by an expert witness, as a consequence, may turn on the manner in which a question is propounded or

that Dr. Schwartz's conduct proximately caused post-operative arthritis. See Appellant's Appendix at 72-73.

the witness's subjective assessment of the meaning of the phrase or word used to express the opinion.

At the same time, to hinge the question whether an expert's opinion is admissible and probative on the willingness and ability to say that such-and-such is "reasonably certain," as opposed to "probable" or "possible," is to impose on the expert a question which elevates the law's demand for certainty in language over the state of the particular art and the value of the advances made therein. Medicine, for instance, is not yet an exact science; to demand reasonable certainty in medical opinions places a sometimes insurmountable barrier in the face of the candid and straightforward medical expert.

Noblesville Casting Div. of TRW, Inc. v. Prince, 438 N.E.2d 722, 727 (Ind. 1982)

(internal citation omitted).

In Strong v. State, 538 N.E.2d 924, 930 (Ind. 1989), the Indiana Supreme Court discussed whether the evidence was sufficient to sustain the defendant's murder conviction where the physician testified the victim's death was, "within a reasonable medical probability," caused by the brain injury. Approving of the Noblesville Casting decision, the Court noted:

[N]o threshold level of certainty or conclusiveness is required in an expert's opinion as a prerequisite to its admissibility. Assuming the subject matter is one which is appropriate for expert testimony and that a proper foundation has been laid, the expert's opinion or conclusion that, in the context of the facts before the witness, a particular proposition is "possible," "could have been," "probable," or "reasonably certain" all serve to assist the finder of fact in intelligently resolving the material factual questions. The degree of certainty in which an opinion or conclusion is expressed concerns the weight to be accorded the testimony, which is a matter for the jury to resolve.

Notwithstanding the probative value and admissibility of an expert's opinion which falls short of "reasonable scientific or medical certainty," we also reiterate that standing alone, an opinion which lacks reasonable certainty or probability is not sufficient evidence by itself to support a verdict. . . .

Of course, an expert's opinion that something is "possible" or "could have been" may be sufficient to sustain a verdict or award when it has been rendered in conjunction with other evidence concerning the material factual question to be proved.

538 N.E.2d at 931 (quoting Noblesville Casting, 438 N.E.2d at 731). The Court then held that the physician's opinion in combination with another physician's testimony and the victim's injuries "compel[led] [the Court] to conclude that a reasonable trier of fact could find the element of causation of death proven beyond a reasonable doubt." Id. at 932.

Here, it is undisputed that Dr. Schwartz did not cause the infection and that Shelton would have been required to undergo the debridement surgeries regardless of the delay in diagnosis. However, the point of the trial court's finding was that Shelton has ongoing problems with his left knee as a result of the delay in diagnosis. A review of the evidence supports this finding.

According to Shelton's expert witness, Dr. John Black, Shelton's pre-operative condition of both knees was "similar," and the post-operative "outcome in the uninfected knee was excellent." Appellant's Appendix at 99. Dr. Black explained that an infection begins in the joint fluid and, within two or three days, spreads to the articular cartilage. Id. at 116. If left untreated any longer, the infection penetrates "through the cartilage, through the protective outer layer of the bone called the periosteum and gets into the bone itself." Id. Dr. Black opined that, at the time Dr. Schwartz examined Shelton, the infection "more likely than not" had not spread into the bone. Id. A bone infection, or osteomyelitis, was "very unusual" in this type of infection and was "an indication that

this infection had been brewing longer than is typical.” Id. Based on the date of onset of the symptoms and the symptoms at the time of Dr. Schwartz’s examination, Dr. Black’s “best estimate” was that the infection had not spread to Shelton’s bone at the time of Dr. Schwartz’s examination. Id. at 119.

According to Dr. Black, the osteomyelitis in Shelton’s bones “contributed to the slowness of his infection to respond to antibiotics, contributed to the overall inflammation in and around the knee, and more likely than not contributed to any disability that he retained after the whole episode, after his treatment was concluded.”⁸ Id. at 116. Dr. Black noted that the majority of patients with such joint infections after surgery “have to go through several weeks of intravenous antibiotics and extensive physical therapy but within six to eight weeks have a fairly functional knee and within a few months have a result that they would have if they’d not had an infection.” Id. at 109. However, Shelton’s recovery was “prolonged given the spread of the infection.” Id. Although a four to six week course of antibiotics is typical for a joint infection after surgery, Shelton required eighteen weeks of antibiotics, including eight weeks of intravenous antibiotics. Dr. Black also noted that Shelton had an infection in his bloodstream, which likely spread from the knee infection, and Shelton developed systemic inflammatory response syndrome as a result. Id. at 118.

⁸ In a footnote, Dr. Schwartz notes that “no other physician testifying in this case believed that there was demonstrable osteomyelitis.” Appellant’s Brief at 15 n.6. However, Dr. Black testified that Shelton had osteomyelitis, and Dr. Schwartz’s notation is merely a request that we reweigh the evidence, which we cannot do.

Further, Dr. Lee noted that, although all patients having knee arthroscopy will have “some quadriceps muscle weakness and atrophy to one degree or another,” Shelton’s “multiple surgeries, combined with the prolonged relative immobility, contributed to more advanced atrophy than a patient would typically otherwise have.” Id. at 164. Further, Dr. Lee noted that “[a] delay in treatment of an infected joint may ultimately affect the outcome.” Id. at 163. Dr. Lee testified that, when he examined Shelton in October 2002, Shelton had some ongoing limitations in his left knee. Shelton testified at trial that, more than five years after the surgeries, his right knee was fine but that he had ongoing problems with his left knee, including limited mobility, a limp, pain, and a lack of strength. The trial court observed Shelton’s limp and gait.⁹

Dr. Black testified that, at the time Dr. Schwartz examined Shelton, the infection “more likely than not” had not spread into the bone. Id. at 116. His opinion regarding the harm was certainly more than a “possibility” or “could have been.” We conclude that based upon Dr. Black’s testimony, combined with Dr. Lee’s testimony and the evidence of Shelton’s ongoing problems with his left knee, the trial court reasonably concluded

⁹ Dr. Schwartz also argues that Shelton demonstrated no difference between his pre-operative condition and his post-operative condition. Dr. Lee’s pre-operative records regarding Shelton demonstrate that Shelton had pain in both knees and was having trouble with squatting. Appellant’s Appendix at 326. However, Shelton’s right knee was more “bothersome” than his left knee. Id. In Shelton’s second consultation with Dr. Lee, repeat x-rays demonstrated “some mild to moderate changes, right greater than left.” Id. at 325. There is no mention in any of the records of a problem with limping before the surgeries. Dr. Lee testified that, when he examined Shelton in October 2002, Shelton had some ongoing limitations in his left knee. However, Dr. Lee reviewed Shelton’s x-rays and found no “significant difference” between the pre-operative and post-operative arthritic process. Id. at 164. At the time of the trial, Shelton testified that his right knee was fine, but he had ongoing problems with his left knee, including limited mobility, a limp, pain, and a lack of strength. While the October 2002 x-rays do not demonstrate a significant difference in the arthritic process in Shelton’s left knee, the trial court was entitled to weigh this evidence against Shelton’s pre-operative condition and his post-operative limitations.

that Dr. Schwartz's failure to timely diagnose the infection caused harm and injuries to Shelton that were ongoing. Given this evidence, we conclude that the trial court's finding was not clearly erroneous.

B. Finding No. 77, 78, and 79.

Next, Dr. Schwartz challenges the following findings:

77. The nature of Shelton's injuries has had an effect on his abilities to function as a whole.
78. Said injuries are permanent in nature.
79. Shelton has experienced physical pain and suffering and will experience physical pain and suffering in the future due to his injuries.

Appellant's Appendix at 69-70. Dr. Schwartz argues that the findings indicate permanent harm to Shelton and that Shelton presented no medical evidence of any permanent residual injury as a result of Dr. Schwartz's delay in diagnosis.

As noted above, Dr. Black testified that, as a result of the delayed diagnosis, Shelton contracted a bone infection, or osteomyelitis. The osteomyelitis "more likely than not contributed to any disability that [Shelton] retained after the whole episode, after his treatment was concluded." Id. at 116. Dr. Black noted that the majority of patients with such joint infections after surgery "have to go through several weeks of intravenous antibiotics and extensive physical therapy but within six to eight weeks have a fairly functional knee and within a few months have a result that they would have if they'd not had an infection." Id. at 109. Dr. Lee testified that, when he examined Shelton in October 2002, Shelton had some ongoing limitations in his left knee. Shelton presented

evidence that, more than five years after the surgeries, he has ongoing problems with his left knee, including limited mobility, a limp, pain, and a lack of strength. The trial court observed Shelton's limp and gait. Given this evidence, we conclude that the trial court's finding of fact regarding ongoing, permanent injuries is not clearly erroneous.¹⁰

C. Conclusion No. 15(d).

Dr. Schwartz next challenges the trial court's conclusion that, as a result of Dr. Schwartz's failure to timely diagnose the infection, "Shelton was prevented from timely attempting to rehabilitate his knee so that he incurred greater atrophy and limitations than would normally be expected."¹¹ Appellant's Appendix at 72. Dr. Schwartz argues that no evidence was presented of any permanent atrophy. However, the conclusion does not state that Shelton incurred *permanent* atrophy, and Shelton presented evidence that he incurred more atrophy than would be expected.

Dr. Lee testified that, although all patients having knee arthroscopy will have "some quadriceps muscle weakness and atrophy to one degree or another," Shelton's

¹⁰ Dr. Schwartz also challenges the trial court's conclusion that, as a result of Dr. Schwartz's failure to timely diagnose the infection, Shelton suffered the injuries described in Finding No. 77, 78, and 79. See Appellant's Appendix at 73(Conclusion No. 15(f)). Having concluded that Finding No. 77, 78, and 79 are not clearly erroneous, we also hold that the portion of Conclusion No. 15(f) referring to Finding No. 77, 78, and 79 is not clearly erroneous.

¹¹ Dr. Schwartz also challenges the trial court's conclusion that "[a] delay of even 42 hours in treating a serious infection like the partially resistant staph infecting Shelton's left knee is known to cause serious harm." Appellant's Appendix at 72 (Conclusion No. 13). Dr. Schwartz argues that no evidence was presented that the infection was "partially resistant." While we agree that no evidence was presented that the infection was "partially resistant," we conclude that any error was harmless. It is undisputed that Shelton had a staphylococcus aureas infection. The point of the trial court's conclusion is that the delay in treatment can cause serious harm, and Shelton presented evidence to support this conclusion. See Appellant's Appendix at 105 (Dr. Black testifying that the delay in diagnosis of the infection "caused avoidable harm"); Appellant's Appendix at 163 (Dr. Lee testifying that "[a] delay in treatment of an infected joint may ultimately affect the outcome").

“multiple surgeries, combined with the prolonged relative immobility, contributed to more advanced atrophy than a patient would typically otherwise have.” Id. at 164. Further, Dr. Black noted that the majority of patients with such joint infections after surgery “have to go through several weeks of intravenous antibiotics and extensive physical therapy but within six to eight weeks have a fairly functional knee and within a few months have a result that they would have if they’d not had an infection.” Id. at 109. However, Shelton’s recovery was “prolonged given the spread of the infection.” Id. Given this testimony, we conclude that the trial court’s conclusion regarding the atrophy is not clearly erroneous.

D. Conclusion No. 15(e).

Dr. Schwartz contests the trial court’s conclusion that, as a result of his failure to timely diagnose the infection, “[t]he need for medical care and expense extended beyond the expected four to six weeks of antibiotics, further including: two debridement surgeries and an ambulance run.”¹² Appellant’s Appendix at 72. Dr. Schwartz argues that the two debridement surgeries were unrelated to any negligence on his part. Shelton concedes that the debridement surgeries were unrelated to Dr. Schwartz’s actions. We agree, but we conclude that the error was harmless. The point of the trial court’s

¹² Dr. Schwartz also challenges the trial court’s conclusion that, as a result of his delay in diagnosis, “Shelton incurred medical expenses for infection related care (including complications) in the amount of \$67,382.27.” Appellant’s Appendix at 70 (Conclusion No. 15(f)). The extent of Dr. Schwartz’s argument is that the medical expenses include more than antibiotic care for an additional twelve weeks. Dr. Schwartz provides no citations to the record and makes no cogent argument, and, thus, the argument is waived. See Ind. Appellate Rule 46(A)(8); Kelly v. Bennett, 792 N.E.2d 584, 588 (Ind. Ct. App. 2003), trans. denied.

conclusion was that Shelton required an extended course of antibiotics as a result of the delay in diagnosis, and evidence was presented to support this conclusion. See id. at 109, 116 (Testimony of Dr. Black that the infection “more likely than not” had not spread into the bone at the time of Dr. Schwartz’s examination, that the bone infection “contributed to the slowness of his infection to respond to antibiotics [and] contributed to the overall inflammation in and around the knee” and that Shelton required an extended course of antibiotics).

E. Conclusion No. 22, 23, and 26.

Lastly, Dr. Schwartz challenges three of the trial court’s final conclusions. Specifically, Dr. Schwartz contests the trial court’s conclusion that “[Shelton] met his burden of proof to show that [Dr. Schwartz] was negligent, and that such negligence proximately caused injury and harm to [Shelton].” Appellant’s Appendix at 74. Further, he challenges the trial court’s conclusion that “[Shelton] met his burden of proving that the delay in treatment, which resulted from [Dr. Schwartz’s] negligence, was a factor in proximately causing the spread of Shelton’s infection from his knee joint, which produced injury and harm, such as set forth in Conclusion paragraph 15, above,” Id. Finally, Dr. Schwartz challenges the trial court’s conclusion finding in favor of Shelton and awarding judgment against Dr. Schwartz in the sum of \$300,000.00.

We note that, in addition to the challenged findings and conclusions discussed above, the trial court concluded that, as a result of Dr. Schwartz’s delay in diagnosing and treating the infection, Shelton suffered the following harms:

- a. His extended intravenous and other antibiotic care from an expected four to six weeks to 18 weeks.
- b. The delay allowed the joint infection to spread into the blood and surrounding bone/tissues.
- c. The delay created fluid retention issues due to kidney suppression and fluid overload due to extended antibiotics medications.

Id. at 72. Dr. Schwartz did not challenge these findings. Given Dr. Schwartz's failure to dispute these findings and our conclusion that the challenged findings above are not clearly erroneous, we also hold that these conclusions are not clearly erroneous. Shelton presented sufficient evidence that, as a result of Dr. Schwartz's failure to timely diagnose his infection, he suffered injuries and damages.

For the foregoing reasons, we affirm the trial court's judgment for Shelton.

Affirmed.

ROBB, J. and CRONE, J. concur