

# MEDICAL MALPRACTICE LAW IN INDIANA

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## INTRODUCTION

In the early 1970's, Indiana's health care system was on the verge of a crisis. The cause was readily apparent. Medical malpractice suits were being filed too often and jury verdicts were reaching inordinate amounts. In its findings for 1975-76, the Indiana Medical Malpractice Study Commission<sup>1</sup> noted that the average medical malpractice insurance premium for physicians had increased 410% from 1970 to 1975.<sup>2</sup> Insurance companies issuing medical malpractice policies for physicians in Indiana had operated at a loss for the years 1970 through 1974.<sup>3</sup> The frequency of claims filed against physicians had increased by forty-two percent.<sup>4</sup> The average damage award had increased from \$12,993 in 1970 to \$34,297 in 1975.<sup>5</sup> A harrowing practice also came to light. Sixty-five percent of the physicians in Indiana ordered procedures for their patients which they considered superfluous for fear of being sued.<sup>6</sup>

Immediate action was necessary to avert a certain breakdown of the health care system. However, it was evident that such action would be ineffective unless the many people involved—physicians, malpractice insurance underwriters, attorneys, and most of all, health care consumers—worked together toward a solution. That solution was realized in

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1. The Medical Malpractice Study Commission (Commission) was created by section 2 of Public Law 146 of Indiana Acts 1975 to study the problem of medical malpractice and its effect on the people of Indiana. The Commission was divided into three subcommittees: Residual Authority Subcommittee, Short-range Study Subcommittee, and Long-range Study Subcommittee. The members of the Commission included: Gilbert Wilhelmus, M.D., Chairman; H.P. Hudson, Commissioner of Insurance, Secretary; Sen. Leslie Duvall; Sen. Adam Benjamin; Rep. Philip T. Warner; Rep. Joseph P. Harris; Mr. William Davey; Mr. Don Hamachek; Ms. Betty Mumaw; Mr. Willis Zagrovich; Mr. John Carr, Jr.; Mr. Charles Hoodenpyl; and William Cast, M.D. Staff members included Mr. Harold S. Rhodes, Office of Fiscal and Management Analysis, and Mr. William R. Uffelman, Office of Bill Drafting and Research.
2. FINAL REPORT OF THE MEDICAL MALPRACTICE STUDY COMMISSION § 5.100 (December 31, 1976) (a copy of which is on file at the offices of the *Journal of Legislation*) [hereinafter cited as STUDY COMMISSION REPORT].
3. *Id.*
4. *Id.* In 1970, one out of every thirty-six physicians had at least one malpractice claim filed against him. In 1975, the percentage had increased to one out of every twenty-one.
5. STUDY COMMISSION REPORT, *supra* note 2.
6. *Id.* Furthermore, forty-one percent of Indiana's physicians ordered procedures for their patients which they considered *completely* superfluous. X-rays were the most commonly ordered such procedure.

the form of Indiana House of Representatives bill 1460,<sup>7</sup> the genesis of the Indiana Medical Malpractice Act (the Act).<sup>8</sup> This article will examine the causes of the problem, the Act as passed and subsequently amended, and the effects of the Act on the medical malpractice dilemma in Indiana.

### THE PROBLEM

The Indiana Medical Malpractice Study Commission found that medical malpractice claims in Indiana had increased for three reasons. First, patients were more aware of medical malpractice and the legal redress available to them.<sup>9</sup> Second, patients had developed greater expectations of a cure for their ailments, and their disappointments led to lawsuits.<sup>10</sup> Third, there were strong indications of an increasing deterioration of the rapport between doctors and patients which precipitated, in turn, a growing number of malpractice claims.<sup>11</sup>

Furthermore, rapidly rising malpractice insurance premiums left many physicians, especially those in high risk specialties, without insurance or with inadequate coverage.<sup>12</sup> Some primary care physicians were taking early retirement in areas which were already in short supply.<sup>13</sup> Surgeons stopped doing more complicated procedures which entailed greater risks.<sup>14</sup> Hospitals discontinued some emergency services and canceled some types of surgery because of the threat of malpractice claims.<sup>15</sup>

The origins of the problem date back to the end of World War II with the explosion of medical knowledge and the consequential increase in specialization. Patients had less reluctance to sue a specialist than their family doctor. They expected a great deal from the specialist and knew him less well. In addition, with increased specialization came the feeling that care was less intimate and was being replaced by cold technology which focused on the organ system instead of the whole person.

Several new causes of action allowed by the courts have contributed to the burgeoning number of malpractice claims. Among these are claims for "wrongful life,"<sup>16</sup> "wrongful birth,"<sup>17</sup> and "wrongful concep-

7. H.R. 1460, 99th Gen. Ass., 1st Sess., 1975 Ind. Acts 146.

8. 1975 Ind. Acts 146 (codified as amended at IND. CODE § 16-9.5 (1976 & Supp. 1981)) [hereinafter referred to as the Act].

9. STUDY COMMISSION REPORT, *supra* note 2, § 5.200.

10. *Id.*

11. *Id.*

12. COMMITTEE ON LABOR AND THE ECONOMY, REPORT TO THE HOUSE OF REPRESENTATIVES, 99th Gen. Ass., 1st Sess., *reprinted in* 1975 INDIANA HOUSE OF REPRESENTATIVES JOURNAL 577 [hereinafter cited as HOUSE REPORT].

13. *Id.*

14. *Id.*

15. *Id.*

16. *See, e.g.,* Cockrum v. Baumgartner, 99 Ill. App. 3d 271, 54 Ill. Dec. 751, 925 N.E.2d 968 (1981); Kennedy v. McKesson Co., 58 N.Y.2d 500, 448 N.E.2d 1344, 462 N.Y.S.2d 421

tion."<sup>18</sup> In fact, advances in medical science forced the issue upon the medical profession. We have taken pride in the fact that we can diagnose fetal sex and intrauterine fetal defects.<sup>19</sup> At the same time, however, such causes of action as noted above have resulted in awards for damages because of the birth of a physically or mentally handicapped child.<sup>20</sup>

Seven of the ten insurance companies that underwrote most of the medical malpractice policies in Indiana stopped writing new policies, canceled others, or limited their new business and their liability.<sup>21</sup> They blamed more lawsuits and higher jury awards.<sup>22</sup> In 1975, 20,000 medical malpractice claims were filed nationwide.<sup>23</sup> For those claims of "in hospital origin" that went the full route to a jury, the average award was \$350,000.<sup>24</sup> These were factors which neither the entire health care delivery system nor the public could bear.

### LEGISLATIVE HISTORY

On February 4, 1975, House bill 1460 (H.R. 1460),<sup>25</sup> authored by Representatives Chester F. Dobis and Alan Lloyd Zirkle, was introduced in the Indiana House of Representatives.<sup>26</sup> It was entitled, "Medical Malpractice: Liability Claims, Review Panel and Insurance."<sup>27</sup> After several amendments, H.R. 1460 was passed by the House on March 11, 1975 and was immediately referred to the Senate.<sup>28</sup> The engrossed House bill, again after several amendments, was

(1983); *Payton v. Abbott Labs*, 386 Mass. 540, 437 N.E.2d 171 (1982); *Turpin v. Sortini*, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982).

17. See, e.g., *Ochs v. Borrelli*, 187 Conn. 253, 445 A.2d 883 (1982); *Schork v. Huber*, M.D., 648 S.W.2d 861 (Ky. 1983); *Kingsbury v. Smith*, M.D., 122 N.H. 287, 442 A.2d 1003 (1982); *Naccash, M.D. v. Burger*, 223 Va. 406, 290 S.E.2d 825 (1982).

18. See, e.g., *Schroeder v. Perkel*, M.D., 87 N.J. 53, 432 A.2d 834 (1981); *Mason v. Western Pennsylvania Hospital*, 453 A.2d 974 (Pa. 1982); *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); *Wilbur v. Kerr*, M.D., 275 Ark. 239, 628 S.W.2d 568 (1982).

19. See generally 10 COLLIER'S ENCYCLOPEDIA, *Genetic Counseling* 617-20 (1981 ed.).

20. *Curlender v. Bio-Science Laboratories*, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980).

The conclusion must be that any physician who undertakes pregnancy care has the responsibility to assess genetic risk, that is, to test and test correctly for fetal defects. Obviously, this will be expensive and counter to cost containment.

21. HOUSE REPORT, *supra* note 12, at 577.

22. *Id.*

23. Minutes of the Medical Malpractice Study Commission (statement of H.P. Hudson, Chairman of the Residual Authority Subcommittee) (October 30, 1975) (a copy of which is on file at the offices of the *Journal of Legislation*).

24. *Id.*

25. See H.R. 1460, *supra* note 7.

26. 99th Gen. Ass., 1st Sess., 1975 INDIANA HOUSE OF REPRESENTATIVES JOURNAL 224 [hereinafter cited as HOUSE JOURNAL]. Representatives Philip T. Warner, Clifford D. Arnold, John R. Larson, and James Jontz served as co-authors. *Id.* at 224, 240, 418, 553. Senators Elden F. Lundquist and Adam Benjamin, Jr., sponsored the engrossed House bill in the Senate, with Senators Robert L. Sheaffer, Charles E. Bosma, and Graham A. Richard as co-sponsors. 99th Gen. Ass., 1st Sess., 1975 INDIANA SENATE JOURNAL 539, 718 [hereinafter cited as SENATE JOURNAL].

27. See H.R. 1460, *supra* note 7.

28. Upon its introduction, H.R. 1460 was referred to the House Labor and the Economy Committee. HOUSE JOURNAL, *supra* note 26, at 224. It was reported out of committee after sub-

passed by the Senate on April 3, 1975.<sup>29</sup> The House concurred with the Senate amendments on April 4, 1975.<sup>30</sup> I signed the bill into law on April 24, 1975.<sup>31</sup>

House bill 1460, as originally introduced, was comparable to workmen's compensation legislation. It required that a medical malpractice claim be brought before an arbitration panel, thereby removing the action from litigation except for judicial review of the panel's final decision.<sup>32</sup> The bill also proposed a statutory award cap, a restrictive statute of limitations, and an attorney fee limitation.<sup>33</sup> The majority of these objectives were achieved with the passage of the Medical Malpractice Act, with the exception that a malpractice complaint may still be filed in any court having requisite jurisdiction.<sup>34</sup> Thus, the right to trial by jury remains.<sup>35</sup>

## THE ACT

### *Qualification*

Health care providers, to qualify under the provisions of the Act,<sup>36</sup> must file proof of financial responsibility with the insurance commissioner<sup>37</sup> and pay the surcharge assessed on all health care providers.<sup>38</sup> Proof of financial responsibility may be established by: (1) the health care provider's insurance carrier certifying to the insurance commissioner that the health care provider is insured by a policy of malpractice liability insurance; (2) filing and maintaining with the

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stantial amendment with a "do pass as amended" recommendation. *Id.* at 577-86. The report was adopted by the House on March 5, 1975. *Id.* at 586. It was handed down by the Speaker of the House for second reading, amended again, and ordered engrossed on March 7, 1975. *Id.* at 630-33. It was passed by the House on third reading by a vote of 81 to 16. *Id.* at 660.

29. The engrossed House bill was referred to the Senate Judiciary Committee where everything after the enacting clause was stricken and the new text was substituted. SENATE JOURNAL, *supra* note 26, at 539, 755-59. It was reported out of committee with a "do pass as amended" recommendation. The report was adopted on March 27, 1975. *Id.* at 759. It passed second reading, was amended further, and was ordered engrossed on April 2, 1975. *Id.* at 795-801. It passed on third reading by a vote of 47 to 2. *Id.*

30. HOUSE JOURNAL, *supra* note 26, at 920.

31. *Id.* at 1017. SENATE JOURNAL, *supra* note 26, at 1005.

The provisions of the law did not apply to any act of malpractice which occurred before July 1, 1975, the effective date of the law. IND. CODE § 16-9.5-1-7 (1976).

32. See H.R. 1460, *supra* note 7. The digest of the original bill reads:

Adds IC 1971, 16-9.5 to provide for the establishment of a patients' compensation board of Indiana to hear and determine claims for damages which are based on an assertion of medical malpractice; to provide for a schedule of compensation; to establish a statute of limitations; to regulate attorney fees; to provide for a guarantee of financial responsibility for health care providers; to provide for a catastrophic injury fund; and to provide that costs of administration be funded by fixed assessments collected from certain health care providers.

33. *Id.*

34. IND. CODE § 16-9.5-1-6 (1976).

35. *Id.*

36. A health care provider who fails to qualify under the Act will be subject to liability under the law without regard to the provisions of the Act. *Id.* § 16-9.5-1-5 (1976).

37. *Id.* § 16-9.5-2-1(a)(1) (1976 & Supp. 1981).

38. *Id.* § 16-9.5-2-1(a)(2) (1976 & Supp. 1981).

commissioner a cash or surety bond; or (3) if the health care provider is a hospital, by submitting annually a verified financial statement demonstrating its ability to satisfy all potential malpractice claims.<sup>39</sup> The policy amount requirements are \$100,000 per occurrence for a physician (\$300,000 in the annual aggregate); \$2,000,000 in the annual aggregate for a hospital with 100 beds or less; and \$3,000,000 in the annual aggregate for a hospital with more than 100 beds.<sup>40</sup>

### *Limitation of Recovery*

The Medical Malpractice Act established a maximum award limitation of \$500,000 which a prevailing claimant may recover as a result of injury or death due to medical malpractice.<sup>41</sup> Of this amount, an individual health care provider may not be held liable for more than \$100,000 for any single claim of malpractice.<sup>42</sup> Any excess amount up to the aggregate limitation of \$500,000 must be paid out of the Patient's Compensation Fund (the Fund).<sup>43</sup>

If the health care provider or his insurer agrees to settle a liability claim by the payment of his policy limit of \$100,000 and the claimant demands a greater amount, the Act provides for a special procedure leading to a hearing of the dispute among the insurance commissioner, the claimant, the health care provider, and the insurer of the health care provider.<sup>44</sup> If these parties cannot agree on the amount, if any, to be paid out of the Fund, then the presiding court, after hearing all relevant evidence, will determine the appropriate amount. Only an amount in excess of the health care provider's policy limits will be paid out of the Fund.<sup>45</sup>

### *Statute of Limitations*

To recover under the Medical Malpractice Act, the patient must file a malpractice claim within two years of the date of the alleged negligent act or omission.<sup>46</sup> Only by limiting the period during which a

39. *Id.* § 16-9.5-2-6(a)(1)-(3) (1976 & Supp. 1981). The 1975 Act, Public Law 146, was amended by Public Law 65 § 5 (1976) to permit alternative proofs of liability insurance. The original Act specified that:

[f]inancial responsibility of a health care provider under this chapter (defined at IND. CODE § 16-9.5-1-1(a) (1971) to include both physicians and hospitals) may be established *only* by filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars (\$100,000) per occurrence.

1975 Ind. Acts 146 (codified at IND. CODE § 16-9.5-2-6 (1971)) (emphasis added).

40. IND. CODE § 16-9.5-2-6(a)(1), (3) (1976 & Supp. 1981).

41. *Id.* § 16-9.5-2-2(a) (1976 & Supp. 1981). However, no specific dollar amount may be included in the demand of a malpractice complaint. The complaint must ask for reasonable damages under the circumstances of the alleged malpractice. *Id.* § 16-9.5-1-6 (1976).

42. *Id.* § 16-9.5-2-2(b) (1976 & Supp. 1981).

43. *Id.* § 16-9.5-2-2(c) (1976 & Supp. 1981). See also *infra* notes 48-55 and accompanying text.

44. *Id.* § 16-9.5-4-3 (1976 & Supp. 1981).

45. *Id.* § 16-9.5-4-3(5) (1976 & Supp. 1981).

46. *Id.* § 16-9.5-3-1 (1976). The Act thus adopts the minority rule in the United States (*i.e.*, the statute of limitations begins to run from the date of the alleged negligent act or omission).

patient may file a claim could the Act effectively and fairly control the inordinate number of claims being filed. An exception is provided for children with possible birth injuries. A child under the age of six years who is injured may have a malpractice claim filed on his behalf until he reaches the age of eight.<sup>47</sup> Furthermore, the Act does not limit the causes of action that can be brought on a child's behalf merely to birth injuries.

#### *Attorney's Fee Limitation*

The Act places a statutory limit on the fee that an attorney can charge his client for prosecuting a medical malpractice claim.<sup>48</sup> Open negotiations are permitted on the first \$100,000, which is the physician's liability, but a limit of fifteen percent of any recovery from the Fund is imposed.<sup>49</sup> This provision thus ensures that an injured claimant will receive the lion's share of any award he may be granted under the Act.

#### *Patient's Compensation Fund*

The Medical Malpractice Act provided for the establishment of the Patient's Compensation Fund.<sup>50</sup> The purpose of the Fund is to make money available to individuals who have been permanently disabled as a result of medical malpractice, some of whom require lifetime, around-the-clock care. The Fund was initially created and is maintained by contributions from health care providers. These contributions take the form of a surcharge required of each health care provider to qualify under the Act.<sup>51</sup> The amount of the surcharge is determined by the insurance commissioner based upon actuarial principles and cannot exceed twenty-five percent of the cost to each health care provider of maintaining financial responsibility.<sup>52</sup>

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*See* Guy v. Schuldt, 236 Ind. 101, 138 N.E.2d 891 (1956); Gangloff v. Apfelbach, 319 Ill. App. 596, 49 N.E.2d 795 (1943); Rod v. Farrell, 96 Wis. 2d 349, 291 N.W.2d 568 (1980). The majority rule holds that the statute of limitations begins to run from the date of the discovery of the alleged act or omission, or from the date when the alleged act or omission "should have been" discovered. Teeters v. Currey, 518 S.W.2d 512 (Tenn. 1974); Davis v. Bonebrake, 135 Colo. 506, 313 P.2d 982 (1957); McFarland v. Connally, 252 S.W.2d 486 (Tex. Civ. App. 1952). A middle of the road view also exists which holds that the statute of limitations must begin to run upon the termination of the physician-patient relationship regardless of whether the patient has discovered the injury. Glenboski v. St. Alexis Hospital, 65 Ohio App. 2d 165, 417 N.E.2d 108 (1979).

47. *Id.* § 16-9.5-3-1 (1976).

48. *Id.* § 16-9.5-5-1(a) (1976).

49. *Id.*

50. *Id.* § 16-9.5-4-1(a) (1976 & Supp. 1981).

51. *Id.* § 16-9.5-4-1(b) (1976 & Supp. 1981).

52. *Id.* The original Act provided that the surcharge could not exceed ten percent of the cost to the health care provider of maintaining financial responsibility. 1975 Ind. Acts 146 (codified at IND. CODE § 16-9.5-4-1(b) (1971)). The surcharge was increased by amendment to the present twenty-five percent in 1982 to "beef up" the Fund, which had been substantially depleted. IND. CODE § 16-9.5-4-1(b) (1976 & Supp. 1981), *as amended by* Pub. L. No. 121 § 1 (1982). The insurance commissioner first expressed concern at the end of 1979 when more money was paid out of the Fund than was taken in during the year. HUDSON, REPORT

A 1976 amendment changed the original division of liability between the Fund and the health care providers involved.<sup>53</sup> As the law was originally adopted, a provider's insurance carrier was liable for up to \$100,000 for each act of negligence no matter how many acts had been committed.<sup>54</sup> The amendment established an annual aggregate limit to the insurance carrier's liability of \$300,000 for an individual; \$2,000,000 for hospitals with 100 beds or less; and \$3,000,000 for hospitals with more than 100 beds.<sup>55</sup> Concurrently, the amendment made the Fund liable for the first dollar of an award if the health care provider's insurance carrier had already paid an amount equal to its annual aggregate limit.<sup>56</sup>

### *Residual Malpractice Insurance Authority*

The Act also provided for the establishment of a Residual Malpractice Insurance Authority (the Authority) to insure physicians whom insurance companies would not underwrite.<sup>57</sup> This was a necessity especially for new physicians just entering practice who could not obtain coverage. Health care providers were not eligible for this special state coverage unless they presented evidence that they had been denied coverage by at least two insurers.<sup>58</sup> Furthermore, the premiums to be charged were set at double the cost of private insurance companies to prevent the state coverage from being sought first and thus in competition with private enterprise.<sup>59</sup> When the law was first enacted, the Indiana Department of Insurance reported that it was receiving up to eighty calls each day from health care providers seeking insurance coverage.<sup>60</sup> Shortly thereafter, the insurance commissioner stated that the Authority was no longer needed and advised that it be sold.<sup>61</sup>

### *Reporting of Claims*

Under the reporting provisions of the Act, all malpractice claims

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OF THE INSURANCE COMMISSIONER TO THE MEDICAL MALPRACTICE STUDY COMMISSION (June 26, 1980) (a copy of which is on file at the offices of the *Journal of Legislation*).

53. IND. CODE § 16-9.5-2-7 (1976), as amended by Pub. L. No. 65, § 6 (1976).
54. See the text of the original Act, *supra* note 39.
55. IND. CODE § 16-9.5-2-6(a)(1)-(3) (1976 & Supp. 1981), as amended by Pub. L. No. 65, § 5 (1976).
56. IND. CODE § 16-9.5-2-7 (1976). As of January 1, 1983, fifty-three payments had been made from the Fund since its inception for a total amount of \$16,386,713.70. 1982 YEAR END REPORT, PATIENTS' COMPENSATION DIVISION, INDIANA DEPT. OF INSURANCE [hereinafter cited as 1982 YEAR END REPORT].
57. IND. CODE § 16-9.5-8-2 (1976).
58. *Id.* § 16-9.5-8-6 (1976).
59. Although the premiums to be charged by the Authority were never expressly codified, the Residual Authority Subcommittee of the Medical Malpractice Study Commission acknowledged that "200 [percent] of . . . November, 1974 rates would be the basic rates for Authority policies." STUDY COMMISSION REPORT, *supra* note 2, § 3.100.
60. Memorandum from Mr. Robert Sullivan to Indiana State Medical Association Executive Director Donald Foy (Sept. 17, 1982) (discussing statement of Interim Study Committee on Medical Malpractice (Sept. 14, 1982)).
61. *Id.*

settled or adjudicated against a health care provider must be reported to the insurance commissioner by the claimant's attorney and by the health care provider or the provider's insurance carrier or risk manager within sixty days of settlement or adjudication.<sup>62</sup> The report must detail the nature of the claim, the damages asserted and the alleged injury, attorney's fees and expenses incurred, and the amount of the settlement or judgment.<sup>63</sup>

The insurance commissioner must report any findings of malpractice against a health care provider, except a hospital, to the appropriate board of professional registration and examination.<sup>64</sup> The purpose of this procedure is to review the health care provider's fitness to remain in practice.<sup>65</sup> The Act gives the board the power to censure, to place on probation, to suspend, or to revoke the license of a health care provider.<sup>66</sup> In turn, the board must report to the commissioner its findings, any action taken, and the final disposition of each case.<sup>67</sup>

### *Medical Review Panels*

The Medical Malpractice Act provided for the establishment of medical review panels to review all proposed malpractice complaints against health care providers.<sup>68</sup> The panels, comprised of an attorney and three physicians,<sup>69</sup> consider evidence submitted by the respective parties and issue their expert opinion on whether or not a particular case involves malpractice.<sup>70</sup> The opinion of the panel is admissible in court but is not binding.<sup>71</sup> To ensure unfettered consideration of the issues and evidence, the Act grants absolute immunity from civil liability to each panelist "for all communications, findings, opinions, and conclusions made in the course and scope of [their] duties. . . ."<sup>72</sup> The aim of the panels is to reduce nuisance suits and to assist in the more responsive settlement of claims by avoiding lawsuits whenever possible.<sup>73</sup>

No court action may be taken against a health care provider before the patient's complaint is filed with a medical review panel and the

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62. IND. CODE § 16-9.5-6-1 (1976).

63. *Id.* § 16-9.5-6-1(a)-(d) (1976).

64. *Id.* § 16-9.5-6-2(a) (1976 & Supp. 1981).

65. *Id.*

66. *Id.*

67. *Id.* § 16-9.5-6-2(c) (1976 & Supp. 1981).

68. *Id.* § 16-9.5-9-1 (1976 & Supp. 1981).

69. *Id.* § 16-9.5-9-3 (1976 & Supp. 1981).

70. *Id.* § 16-9.5-9-7 (1976).

71. *Id.* § 16-9.5-9-9 (1976).

72. *Id.*

73. In *Johnson v. St. Vincent Hospital, Inc.*, — Ind. —, 76 Ind. Dec. 131, 404 N.E.2d 585 (1980), wherein the Supreme Court of Indiana upheld the constitutionality of the Medical Malpractice Act, *see infra* notes 92-95 and accompanying text, the court noted that the medical review panel proceeding "will tend to reduce total aggregate time for trial preparation." 404 N.E.2d at 592. Moreover, the court recognized that the participation of the claimant, the insurer, and the health care provider in the proceedings "will encourage the mediation and settlement of claims and discourage the filing of unreasonably speculative lawsuits." *Id.* at 595.



panel renders its expert opinion.<sup>74</sup> So as not to adversely affect a claimant, the filing of a proposed complaint with a review panel tolls the statute of limitations until ninety days after the claimant receives the opinion of the review panel.<sup>75</sup>

Either party may request the formation of a panel twenty days after a complaint has been filed.<sup>76</sup> To expedite the hearing of the review panel, a 1979 amendment allowed the presiding court to order the parties to proceed in a speedy manner, to fully disclose relevant information, and to allow discovery during the hearings.<sup>77</sup> To expedite the decision of the review panel, a 1976 amendment mandated that it be reported within 180 days of the selection of the last member of the panel.<sup>78</sup>

### THE RESULTS

There has been much debate on the Indiana Medical Malpractice Act, but in my judgment and, I believe, in the judgment of most people in Indiana, the 1975 malpractice law as amended has been good for health care consumers, the medical profession, the insurance industry, and the legal profession. Complaints have come mainly from plaintiff's attorneys, which is understandable given their advocacy on behalf of those individuals who initiate malpractice suits. Notwithstanding these complaints, plaintiff's attorney F. Boyd Hovde, then Legislative Chairman of the Indiana Trial Lawyers Association, stated that "[l]awyers as well as doctors have a stake in a law that keeps liability insurance alive. It stands to reason that a trial lawyer would rather be able to get as much as half a million dollars for a client than tell the client he can't collect because the doctor has no insurance."<sup>79</sup>

From a medical standpoint, the law has stabilized malpractice insurance premiums and enabled physicians to return their full attention to the practice of medicine.<sup>80</sup> Many physicians who had cut back on their services and were considering closing their offices have returned to their normal activities.<sup>81</sup> Furthermore, the number of physicians

74. IND. CODE § 16-9.5-9-2 (1976). As of January 1, 1983, 2,138 complaints had been filed with the Indiana Dept. of Insurance since the effective date of the Act. 1982 YEAR END REPORT, *supra* note 56. Of this number, 479 claimants had requested the formation of a review panel; 540 had not requested a review panel; 387 panels had rendered an opinion; 655 cases had been settled prior to the rendering of a panel opinion; and 77 cases were classified as "problem status" because they did not come under the jurisdiction of the Act. *Id.* Of the 53 payments that had been made from the Fund since its inception, 19 cases had had panel opinions rendered while 34 had been settled prior to the rendering of a panel opinion. *Id.*

75. IND. CODE § 16-9.5-9-1 (1976 & Supp. 1981), *as amended by* Pub. L. No. 187, § 4 (1976).

76. *Id.*

77. *Id.* § 16-9.5-10-1 (1976 & Supp. 1981), *as amended by* Pub. L. No. 152, § 5 (1979).

78. *Id.* § 16-9.5-9-3.5(a) (1976 & Supp. 1981), *as amended by* Pub. L. No. 65, § 11 (1976).

79. Ferber, *Indiana's Malpractice Law: The Results So Far*, MEDICAL ECONOMICS 29, 45 (March 22, 1976).

80. *Id.* at 41.

81. *Id.*

practicing in Indiana has increased markedly.<sup>82</sup> In 1975, 5,584 physician health care providers were registered with the Patients' Compensation Division of the Indiana Department of Insurance.<sup>83</sup> By 1978, the number had jumped to 6,772.<sup>84</sup> As of January 1, 1983, the number had reached 8,038.<sup>85</sup> Doctor Steven C. Beering, Dean of the Indiana University School of Medicine, has noted that "the law is attracting out-of-staters who formerly had no intention of practicing [here]."<sup>86</sup> Medical groups thus find recruitment of new physicians much easier.<sup>87</sup>

Perhaps the best early news was that "[s]oon after the law took effect, a freeze on new policies was lifted by Indiana's leading malpractice insurance carrier—The Medical Protective Company, headquartered in Fort Wayne."<sup>88</sup> Moreover, new companies began writing policies in Indiana.<sup>89</sup> This trend, together with the establishment of the Residual Malpractice Insurance Authority, as Dean Beering has said, "made it certain that no one in the state will need to practice without insurance."<sup>90</sup> Furthermore, the cost of malpractice insurance began to level. In fact, some health care providers who switched carriers paid lower premiums.<sup>91</sup>

The Supreme Court of Indiana upheld the constitutionality of the Medical Malpractice Act in *Johnson v. St. Vincent Hospital, Inc.*, decided on May 16, 1980.<sup>92</sup> The court consolidated several cases challenging the constitutionality of the Act in the *Johnson* opinion. In upholding the statute, the court noted that "[t]he Legislature was undoubtedly moved because of its appraisal that the services of health care providers were being threatened and curtailed contrary to the health interest of the community because of the high cost and unavailability of liability insurance."<sup>93</sup> The court found that "[t]his cost and unavailability was . . . the product of an increase in the number of malpractice claims and large judgments and settlements in connection with them. . . ."<sup>94</sup> As to the method which the Indiana Legislature chose to deal with the crisis, the court held that

[w]hen a state legislature enacts a statute such as this which is related to the public health and welfare, such statute in order to be consistent with due process 'need not be in every respect logically consistent with its aims to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legisla-

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82. *Id.*

83. 1982 YEAR END REPORT, *supra* note 56.

84. *Id.*

85. *Id.*

86. Ferber, *supra* note 79, at 41.

87. *Id.*

88. *Id.* at 32.

89. *Id.*

90. *Id.*

91. 1982 YEAR END REPORT, *supra* note 56.

92. — Ind. —, 76 Ind. Dec. 131, 404 N.E.2d 585 (1980).

93. 404 N.E.2d at 594.

94. *Id.*

tive measure was a rational way to correct it.<sup>95</sup>

Reactions to the Act have gone from one extreme to the other.<sup>96</sup> Some physicians were elated and said they had achieved most of what they wanted. Others saw the law as a pattern that could end the medical malpractice liability crisis across the country.<sup>97</sup> Others, including members of the legal bar, were cautious and warned that "[t]he law is an *experiment* and we don't know what it will do."<sup>98</sup> Still others were adamantly opposed and talked of ways to overturn the law.<sup>99</sup> Since it has had time to work, there has been "an apparent narrowing of the gap between lawyers' initial pessimism and doctors' initial optimism."<sup>100</sup> Lawyers seem more reconciled to working within the law but still not without thoughts of changing the limitation provisions that apply to amount, time, and pay.<sup>101</sup> Furthermore, the number of claims brought has continued to increase and the damage payments from the Fund have been higher than expected.<sup>102</sup>

A universally salutary effect of the Act is that the public is more knowledgeable about the problem of medical malpractice, which has led to more open discussion and rapport between the doctor and his patients about their care.

#### NEED FOR FURTHER CHANGE

Indiana's Medical Malpractice Act is still in need of improvement. While we have achieved many of our objectives and have corrected several flaws by amendment, questions still remain. Does the medical review panel take away a patient's rights? Are the limits on liability too low? Is the statute of limitations too short? Should the time for bringing a suit begin to run from the time of discovery rather than from the time of the occurrence? Should attorney's fees be limited? Since physicians make up the medical review panels, are we sending the fox to watch over the chicken coop? By insulating physicians from many lawsuits, are we nurturing medical carelessness?

Another question that has been raised is whether the state insurance commissioner has adequate means to protect the Patient's Compensation Fund. The present statute imposes no duty on the liability insurer to defend the Fund if the health care provider or the liability insurer agrees to settle a claim for an amount over \$100,000.<sup>103</sup>

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95. *Id.* (citations omitted).

96. Ferber, *supra* note 79, at 26.

97. *Id.*

98. *Id.* (emphasis in original).

99. *Id.*

100. *Id.*

101. Ferber, *supra* note 79, at 40.

102. 1982 YEAR END REPORT, *supra* note 56. The number of complaints filed with the Patients' Compensation Division of the Indiana Dept. of Insurance totaled one in 1975, 18 in 1976, 142 in 1977, 272 in 1978, 319 in 1979, 401 in 1980, 431 in 1981, and 554 in 1982. *Id.*

103. Ferber, *supra* note 79, at 42.

There also remains the issue of disciplinary action against those health care providers who have been found guilty of malpractice. As of March, 1982, only one physician had been disciplined.<sup>104</sup>

### CONCLUSION

Based upon the results thus far, the Indiana Medical Malpractice Act is not accomplishing all that its most euphoric backers first thought it would and still think it should accomplish. But its positive aspects—physicians in practice, insurance availability at reasonable costs, emergency room doors open, anesthetists on the job, and needed high risk surgery being performed—outweigh its deficiencies.

Medical malpractice problems differ from state to state depending on many factors. For that reason they should be addressed one on one, state by state. A federal malpractice effort would require a congressional bulldozer where perhaps a sensitive state hand is all that is needed. Every health care provider, and above all, every health care consumer, deserves our best shot at the problem.

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104. KING, INDIANA STATE MEDICAL ASSOCIATION, AD HOC MALPRACTICE COMMITTEE REPORT (March 23, 1982). In contrast to the near absence of disciplinary action taken against health care providers found guilty of malpractice, as of January 1, 1983, 147 physicians in Indiana had had a total of 3 or more malpractice complaints filed against them. Of this number, 86 had 3 complaints filed against them, 38 had 4, 12 had 5, 5 had 6, 3 had 7, 2 had 8, and one physician had 9 complaints filed against him. 1982 YEAR END REPORT, *supra* note 56. In addition, 6 dentists had had 3 or more malpractice complaints filed against them. *Id.* With regard to hospitals, 59 had had 5 or more complaints filed against them. Of this number, 8 had 5 complaints filed against them, several had between 5 and 25 complaints filed against them, one had 26, one had 39, one had 45, one had 48, one had 56, and one hospital had 86 complaints filed against it. *Id.*