

Reform Revisited: A Review of the Indiana Medical Malpractice Act Ten Years Later

JAMES D. KEMPER*
MYRA C. SELBY**
BONNIE K. SIMMONS***

I. INTRODUCTION

In the mid-1970's, both the private and public sectors nationwide became alarmed at the significant costs associated with malpractice liability in the health professions.¹ Indiana, one of the first states to seek a legislative solution to the perceived problem of increasing costs, enacted the Indiana Medical Malpractice Act² (Act) in 1975. However, a nationwide reassessment of the malpractice controversy has been triggered in the mid-1980's by the recurrence of a marked increase in malpractice claims against physicians and hospitals and by reports of drastic increases in the cost of liability insurance. The direction of current solutions to the malpractice controversy is decidedly different from earlier reforms.

In the 1980's, the focus of legislative solutions is not on wholesale tort law reform. Rather, the activity is directed toward reassessing the reforms made in the 1970's with a goal of making additional reforms to respond to the economic realities of the 1980's. The conflicting forces of plaintiffs seeking larger recoveries and defendants attempting to limit recovery make medical malpractice litigation an obvious area for continued efforts for legislative reform.

It is important that legislators and lobbyists reflect on the history of the reforms of the 1970's before considering what changes are appropriate in the 1980's. Although evaluations of the success of earlier medical malpractice reforms must be subjective, an objective assessment of the impact of the reforms can be made. This Article will review the reform in medical malpractice litigation in Indiana by considering the

*Partner, Ice, Miller, Donadio & Ryan, Indianapolis. B.S., Indiana University, 1969; J.D., Indiana University, 1971.

**Associate, Ice, Miller, Donadio & Ryan, Indianapolis. B.A., Kalamazoo College, 1977; J.D., University of Michigan, 1980.

***Associate, Ice, Miller, Donadio & Ryan, Indianapolis. B.S., Indiana University, 1978; J.D., Indiana University, 1985.

¹See, e.g., NAT'L CENTER FOR HEALTH STATISTICS, DEP'T OF HEALTH, EDUCATION, & WELFARE, MEDICAL MALPRACTICE CLOSED CLAIM STUDY 1976 (1978); NAT'L CENTER FOR HEALTH STATISTICS, DEP'T OF HEALTH, EDUCATION & WELFARE, MEDICAL MALPRACTICE CLOSED CLAIM STUDY 1970 (1973).

²IND. CODE §§ 16-9.5-1-1 to -10-5 (1982).

original purpose of the Act, the functioning of the medical review panel established by the Indiana statute, constitutional challenges to the Indiana statute, and the effect of changes in federal law on state malpractice reforms.

II. THE PURPOSES AND GOALS OF THE INDIANA ACT

The Indiana Medical Malpractice Act was passed in response to an outcry over drastic increases in malpractice insurance premiums for health professionals.³ The legislature believed that these increased costs, along with the unavailability of insurance for some health professionals, caused health care providers to discontinue services, thereby reducing the health care services available to the public.⁴ The Act was intended to protect the public from decreased services by protecting health care providers from the cancellation of insurance coverage.⁵

While there has been no agreement among commentators as to the cause of the increased premiums,⁶ to date at least thirty states have enacted legislation attempting to resolve this perceived crisis.⁷ In an effort to balance the interest of the private plaintiff with the public's interest in preserving the health care industry, the legislative solution in Indiana was twofold. The Act provides for (a) limiting the amount of damages and attorney's fees that a plaintiff can recover and (b) a process of screening malpractice claims by a medical review panel.⁸

The effectiveness of the Act and how well the solution has worked

³LaCava, *A Legislative Response: The Indiana Experience*, 3 HEALTH SPAN 14, 14 (1986).

⁴Rohrbaugh v. Wagoner, 274 Ind. 661, 667, 413 N.E.2d 891, 894 (1980); Johnson v. St. Vincent Hosp., 273 Ind. 374, 387, 404 N.E.2d 585, 594 (1980).

⁵*Id.*

⁶Some authors suggest the rise in cost was due to a widespread reaction to one company's poor investments. See Neubauer & Henke, *Medical Malpractice Legislation: Laws Based on a False Premise*, TRIAL, Jan. 1985, at 64, 65. Others reason that an increase in the size and frequency of claims led to the rise in premiums. See Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. OF HEALTH POL. POL'Y & L. 629 (1985).

⁷It is difficult to determine the exact number of states enacting such legislation because several states are in the process of revising, enacting, or revoking their legislation. A state by state statutory review is beyond the scope of this article. However, it is clear that Indiana is not alone in attempting to remedy the medical malpractice crisis. See generally Klein, *A Practical Assessment of Arizona's Medical Malpractice Screening System*, 1984 ARIZ. ST. L.J. 335, 343. For examples of comparative legislation in other states, see ARIZ. REV. STAT. ANN. §§ 12-561 to -569 (1982 & Supp. 1985); MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01 to -09 (1984 & Supp. 1985); MASS. GEN. LAWS ANN., ch. 231, § 60B (West 1985 & Supp. 1986).

⁸IND. CODE §§ 16-9.5-1-1 to -10-5 (1982).

have been subject to considerable debate.⁹ Panels, in theory, handle claims more quickly with lower costs than trial litigation.¹⁰ Moreover, they encourage settlement of meritorious claims while discouraging baseless claims.¹¹ Critics, however, point out that panel review adds another layer of proceedings, is likely to involve substantial legal expenses, and may encourage the filing of claims by providing an informal, initially less expensive proceeding.¹² While the use of a panel has not been proven to encourage settlement, to resolve cases more quickly, or to reduce the size of awards or number of lawsuits filed,¹³ a panel may serve other purposes. It can be a tool for early trial preparation, and because the opinion of the panel is nonconclusive evidence at a subsequent trial,¹⁴ use of the panel may encourage thorough preparation of evidence early in litigation.

The impact of the Indiana Act on medical malpractice litigation has been more dramatic than merely a change in procedure, however. The changes appear to reflect an attitudinal change toward the purpose of tort law. It may no longer be the sole purpose of tort resolution in the medical malpractice area simply to compensate the victim for damages and deter harmful behavior. There now seems to be a legislatively-recognized goal of promoting the economy and protecting the health care industry. Compensation for harm resulting from deviation from the standard of care required of a doctor now seems to be tempered by an economically motivated leveler.

It is beyond the scope of this Article to speculate whether this legislative action simply replaces historical societal limitations. In the past, close, lifelong doctor-patient relationships functioned to restrain patients from filing medical malpractice claims. In today's more impersonal society, such lawsuits are no longer taboo. Also, the ability of a community to process information about the competence of a doctor no longer seems sufficient to "weed out" or control less competent doctors. To insure that all victims of medical malpractice can recover in today's more litigious atmosphere, the Act limits the amount of damages and attorney's fees recoverable by the plaintiff and provides for panel review of malpractice claims before lawsuits are filed.¹⁵

⁹See LaCava, *supra* note 3.

¹⁰See Sloan, *supra* note 6.

¹¹See LaCava, *supra* note 3, at 16.

¹²See Sloan, *supra* note 6, at 636.

¹³*Cf.* Daughtrey & Smith, *Judges' Views of Medical Malpractice Review Panels*, VA. B.A.J., Spring 1985, at 14; Klein, *supra* note 7.

¹⁴IND. CODE § 16-9.5-9-9 (1982).

¹⁵See *id.* §§ 16-9.5-1-1 to -10-5.

III. FUNCTIONING OF THE ACT

A. How Medical Panels Work—The Statutory Scheme

Essentially, the Indiana Act calls for a specific timetable. Before the plaintiff may file any action in court, he must first file a proposed complaint with the Indiana Department of Insurance.¹⁶ Upon receipt of the proposed complaint, the Department of Insurance will, within ten days, forward a copy to each health care provider named as a defendant.¹⁷ After twenty days from the filing of the proposed complaint with the Department of Insurance, either party may serve on the Commissioner of Insurance by registered or certified mail a request for the formation of a medical review panel.¹⁸

Within fifteen days of filing this request, the parties should select a chairperson by agreement.¹⁹ If they cannot agree on the selection, the Act states that,

either party may request the clerk of the supreme court to draw at random a list of five (5) names of attorneys qualified to practice and presently on the rolls of the supreme court and maintaining offices in the county of venue designated in the proposed complaint or in a contiguous county.²⁰

The party making such a request is required to pay a fee.²¹ Beginning with the plaintiff, each side then has five days to strike a name from the list. If a party does not strike a name, the opposing side may request in writing that the clerk strike for the party, and the clerk must strike.²² Striking continues until one name remains. Within five days after the last name remains, the clerk must notify that person and the parties of the name of the selected chairperson.²³ The chairperson then must either send a written acknowledgment of his appointment to the clerk within fifteen days, or if he does not want to serve, he must show that service would constitute an unreasonable burden or undue hardship.²⁴

After the chairperson is selected, the parties must select the other panel members.²⁵ Within fifteen days after the chairperson is selected,

¹⁶*Id.* §§ 16-9.5-9-1, -2.

¹⁷*Id.*

¹⁸*Id.*

¹⁹*Id.* § 16-9.5-9-3(a).

²⁰*Id.*

²¹*Id.*

²²*Id.*

²³*Id.*

²⁴*Id.* § 16-9.5-9-3(a), (c).

²⁵*Id.* § 16-9.5-9-3(b)(1)-(2).

each side chooses one health care provider to serve on the panel. Within fifteen days of their selection, these two providers then select a third provider for the panel.²⁶ If the two providers do not choose a third panelist, the chairperson selects the third provider.²⁷

Challenges without cause may be made to any selection within ten days after selection of that panel member.²⁸ If two such challenges are made, the chairperson within ten days proposes a special list of three qualified panelists.²⁹ Each side then has ten days to strike one of the three, with the party whose appointment was challenged striking last.³⁰ When the final member is named, the chairperson should, within five days, notify the Commissioner of Insurance and the parties of the names and addresses of panel members and the date on which the last member was selected.³¹ The panel is then required to render its expert opinion within 180 days after the selection of the last member.³²

The entire panel review process should take nine months.³³ However, the reality is much different from the mechanism set out in the Act.

B. How Medical Panels Work—Reality

The nine-month statutory timetable is rarely, if ever, met. One reason is that the large number of complaints filed has caused delays. The number of complaints filed has skyrocketed since the Act was passed. In 1975, the year of enactment, only one complaint was filed, but 773 complaints were filed with the Commissioner in 1985.³⁴ As of December 31, 1985, 4,225 complaints had been filed; of those, only 1,171 were closed.³⁵ An average complaint took 23.4 months to go through the process as of May 31, 1983.³⁶ These delays are not simply the fault of "the system;" delays can also be caused by the actions of the parties and of the chairperson, as well as by outside circumstances.

The parties themselves cause delays when the parties do not follow the statutory procedures for panel review. For example, delays arise

²⁶*Id.* § 16-9.5-9-3(b)(2).

²⁷*Id.*

²⁸*Id.* § 16-9.5-9-3(b)(3).

²⁹*Id.*

³⁰*Id.*

³¹*Id.* § 16-9.5-9-3(b)(4).

³²*Id.* § 16-9.5-9-3.5.

³³*See id.* § 16-9.5-9-3.

³⁴*See* PATIENTS COMPENSATION DIV., IND. DEP'T OF INS., YEAR END REPORT AND ACTUARIAL STUDY (1985) [hereinafter YEAR END REPORT].

³⁵*Id.*

³⁶*Cha v. Warnick*, 476 N.E.2d 109, 112 (Ind. 1985), *cert. denied*, 106 S. Ct. 249 (1985); *see also* Williams, *Indiana Medical Malpractice Act—The Developing Law*, 27 RES GESTAE 494, 497 (1984).

when the complaint is improperly filed by the plaintiff.³⁷ In addition, the parties rarely request the formation of the panel as quickly as the Act allows.³⁸ Further delays occur because the parties rarely invoke the procedure under the authority of the clerk of the supreme court to select a chairperson.³⁹ Moreover, the nominations of the health care providers are often not made in fifteen days.⁴⁰ And finally, delays by the parties in submitting evidence also contribute to the time lag.⁴¹

The chairperson of the panel also has a significant impact on the flow of the case regardless of the actions of the parties. Novice chairpersons may take a considerable amount of time to become familiar with the Act and may fail to be aware of statutory deadlines or to apply those deadlines strictly.⁴²

Delays can also occur after the panel is convened. For example, there can be delays in receiving evidence. Although all evidence submitted to the panel must be in written form, the Act provides that after submission of all evidence, either party may convene the panel in order to question panel members at a time and place agreeable to the panelists.⁴³ Because the panelists may have other responsibilities, significant delays can occur in finding a time and place agreeable to them.⁴⁴

Further delays may be created when either of the parties or the Insurance Commissioner calls into play the provisions of Chapter 10 of the Act. Either party may file a motion in a court having jurisdiction over the subject matter to determine questions of "any affirmative defense or issue of law or fact that may be preliminarily determined under Indiana Rules of Procedure" or to compel discovery.⁴⁵ The panel proceedings are then stayed until the court rules on the motion.⁴⁶ Court involvement at this point is limited to the matters set out in the statute.⁴⁷ Once the court rules on the motion, its jurisdiction ends, and the panel resumes its consideration of the case.⁴⁸ The court's jurisdiction is not properly invoked again until a complaint is filed, after the panel issues an opinion.⁴⁹

³⁷A total of 76 claims filed from 1975 through 1985 involved problems with the initial complaint. YEAR END REPORT, *supra* note 34.

³⁸Pinkus, *The Role of the Panel Chairman*, 1984 IND. CONTINUING LEGAL EDUC. FORUM ON PRESENTING A CASE BEFORE MEDICAL REVIEW BOARD IV-1, IV-7.

³⁹*Id.*

⁴⁰*Id.*

⁴¹*Id.*

⁴²*Id.*

⁴³IND. CODE § 16-9.5-9-5 (1982).

⁴⁴See *supra* notes 37 to 43 and accompanying text.

⁴⁵IND. CODE § 16-9.5-10-1 (1982).

⁴⁶*Id.* § 16-9.5-10-4.

⁴⁷*Id.* § 16-9.5-10-2.

⁴⁸*Id.* §§ 16-9.5-10-1 to -4.

⁴⁹See *Johnson v. Methodist Hosp. of Gary*, 547 F. Supp. 780, 782 (N.D. Ind. 1982).

Some of these delays can be discouraged by the use of judicially-imposed sanctions, for example, fines against the delaying parties or judicial reprimands. Although the Act does not contain specific sanctions for a party's failure to comply with its provisions, the Act does state:

A party, attorney or panelist who fails to act as required by this chapter without good cause shown is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction.⁵⁰

Under Chapter 10 of the Act, a party may make a motion for sanctions, but the procedure for the court's ruling on such a motion can create its own problems. A judicial decision on a motion made under Chapter 10 is to be rendered within thirty days after the matter is heard.⁵¹ If there is no hearing, the decision must be rendered within thirty days after the last written response to the motion is filed.⁵² However, the Act does not provide explicit sanctions for the failure of a judge to render a decision within the prescribed time. At least one Indiana court has concluded that this time limitation and its purpose are similar to those provided for other civil actions under Indiana Trial Rule 53.1(A).⁵³ The court of appeals has held that the appropriate sanction for a judge who fails to rule on a Chapter 10 motion within the prescribed time period is disqualification under trial rule 53.1.⁵⁴ Perhaps other analogies as to appropriate sanctions could be persuasively made.

C. Statute of Limitations

In addition to the procedural structure of the Act, another important provision is the time limitation for bringing a medical malpractice action. The Act provides:

No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or that should have been rendered unless filed within two (2) years from the date of the alleged act, omission, or neglect, except that a minor under the full age of six (6) years shall have until his eighth birthday in which to file.⁵⁵

This period is triggered by the occurrence of the act, omission or neglect, *not* by the discovery that the cause of the injury was a health care

⁵⁰IND. CODE § 16-9.5-9-3.5(b) (1982).

⁵¹IND. CODE § 16-9.5-10-3.

⁵²*Id.*

⁵³*Hepp v. Pierce*, 460 N.E.2d 186, 189 (Ind. Ct. App. 1984).

⁵⁴*Id.*

⁵⁵IND. CODE § 16-9.5-3-1 (1982).

provider's act, omission or neglect.⁵⁶ However, where the entire conduct of the doctor constitutes fraudulent concealment, the doctrine of equitable estoppel may prevent a defendant doctor from taking advantage of his deceit by barring the doctor from asserting the statute of limitations as a defense.⁵⁷ Fraudulent concealment includes both affirmative acts to conceal information and passive failure to disclose information required by the duties of the doctor-patient relationship.⁵⁸ Where the concealment is passive, the concealment is considered to end when the doctor-patient relationship ends; at that time the statute of limitations begins to run.⁵⁹

The statute of limitations may also be tolled under a continuing wrong theory. As described in *Frady v. Hedgcock*,⁶⁰ "[w]hen an entire course of conduct combines to produce an injury, the conduct may constitute a continuing wrong so as to delay the running of the statute of limitations. . . . Under this theory, the statutory period commences at the end of the continuing wrongful act."⁶¹ In *Frady*, a wrongful death action was brought under the Act against a physician whose patient had died of renal failure, thought to be caused by the allegedly excessive medication prescribed by the physician. The physician last saw the patient for treatment more than one month before her death. A complaint was filed more than two years after the date of her last visit, but less than two years after her death. The court of appeals found that a material issue of fact existed as to whether the doctor's treatment was a continuing wrong as late as the date of death, so as to toll the limitation period until the date of death.⁶² The court also made clear that the statute of limitations of the Act could apply to a wrongful death action if malpractice was the basis of the action. The statutory time period for wrongful death actions would be inapplicable in this case.⁶³ Therefore, wrongful death actions based upon medical malpractice must be filed within two years of the act, omission, or neglect, not within two years of the date of death.⁶⁴

A recent decision by the Indiana Court of Appeals has an uncertain impact on interpretation of the statute of limitations provision. In *Barnes v. A. H. Robins Co.*,⁶⁵ the court of appeals adopted a "discovery" rule

⁵⁶*Colbert v. Waitt*, 445 N.E.2d 1000, 1002 (Ind. Ct. App. 1982).

⁵⁷*Id.* at 1002-03.

⁵⁸*Id.* at 1003.

⁵⁹*Id.*; *Weinstock v. Ott*, 444 N.E.2d 1227, 1236 (Ind. Ct. App. 1983).

⁶⁰497 N.E.2d 620 (Ind. Ct. App. 1986).

⁶¹*Id.* at 622.

⁶²*Id.* at 622-23.

⁶³*Id.* at 622.

⁶⁴*Id.*

⁶⁵476 N.E.2d 84 (Ind. Ct. App. 1985).

and found that the statute of limitations commenced when the plaintiff knew or should have discovered that an injury was suffered and was caused by a product or act of another, in this case, an intrauterine device.⁶⁶ The court limited this rule to situations where “[the] injury to a plaintiff [was] caused by a disease which may have been contracted as a result of protracted exposure to a foreign substance.”⁶⁷ In *Walters v. Owens-Corning Fiberglass Corp.*,⁶⁸ the United States Court of Appeals for the Seventh Circuit held that exposure to asbestos over a twenty-five year period constituted “protracted exposure to a foreign substance” and allowed the tolling of the statute of limitations until the time of discovery, based on *Barnes*.⁶⁹ Future malpractice plaintiffs may use these decisions to argue for broader application of such a rule where the statute of limitations has otherwise expired and may succeed in having the discovery rule apply to occurrences of medical malpractice.

D. Scope of the Act

The Indiana statute is extremely restrictive. It does not apply to all defendant-doctors, and it does not cover all occurrences of malpractice. This strictness causes confusion and statute of limitations problems when the plaintiff is trying to decide if his action is subject to panel review under the Act or if he should proceed directly in court.

1. *Qualified Health Care Providers.*—The Act applies only to health care providers qualified therein.⁷⁰ If the health care provider is not included in the coverage of the Act, the Act is inapplicable and the patient must pursue remedies outside the Act.⁷¹ A qualified health care provider is one who files proof of financial responsibility and pays the surcharge provided for in the Act.⁷² If the patient files his complaint in a timely fashion with the Department of Insurance, but the defendant is not a qualified provider under the Act, the filing is apparently ineffective for torts statute of limitation purposes. Although the Act provides for tolling the statute of limitations upon filing of a proposed complaint until ninety days after the panel opinion is issued,⁷³ this provision is inapplicable if the provider is not qualified. The result is that the statute of limitations will continue to run, and if the time is near, as it inevitably is, it may be too late to file a complaint in court.

⁶⁶*Id.* at 87-88.

⁶⁷*Id.* at 87.

⁶⁸781 F.2d 570 (7th Cir. 1986).

⁶⁹*Id.* at 572.

⁷⁰IND. CODE § 16-9.5-1-5 (1982).

⁷¹*Id.*

⁷²*Id.* § 16-9.5-2-1.

⁷³*Id.* § 16-9.5-9-1.

Certainly the reverse is true. Where the defendant health care provider is qualified, the action must proceed under the Act.⁷⁴ The plaintiff's proposed complaint must be filed with the Department of Insurance. If the complaint is mistakenly filed in court instead, it may be subject to summary judgment.⁷⁵ If the statutory time limit expires after the filing in court but before dismissal of the action, the plaintiff cannot start over and file the complaint with the Department of Insurance.⁷⁶ In other words, if the plaintiff files a complaint within the prescribed time limit but in the wrong forum, it may be too late to correct the mistake. This has been held true in one case despite evidence that the plaintiff had been told incorrectly by the Department of Insurance that the health care provider was not qualified, leading the plaintiff to file the action in the wrong forum.⁷⁷

The Department of Insurance works within a limited budget and with limited resources.⁷⁸ Beyond the expected human errors that can occur in recordkeeping, the Act contains provisions that complicate matters even more. The Act provides for a 180-day grace period from the termination of insurance coverage and a showing that coverage is being renewed.⁷⁹ Because of this grace period, it may be difficult for a plaintiff to determine if a defendant is qualified under the Act. Because of these complications as well as the unfortunate result to the plaintiff if he files a complaint in the wrong forum, plaintiffs are commonly advised to file both with the court and the Department.⁸⁰

2. *Situations Covered by the Act.*—The Act contains very broad definitions, which make many types of conduct subject to its provisions. "Malpractice" is defined as "any tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient."⁸¹ "Health care" is broadly defined as "any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement."⁸²

Although, clearly, typical acts of malpractice are covered by the

⁷⁴*Id.* §§ 16-9.5-1-5, -9-2.

⁷⁵*See* Whitaker v. St. Joseph's Hosp., 415 N.E.2d 737, 742-45 (Ind. Ct. App. 1981).

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸Clegg, *Insurance Commissioner's Role*, 1984 IND. CONTINUING LEGAL EDUC. FORUM ON PRESENTING A CASE BEFORE MEDICAL REVIEW BOARD II-1, II-7.

⁷⁹IND. CODE § 16-9.5-4-1(e) (1982).

⁸⁰*See* Clegg, *supra* note 78, at II-7; Murphy, *Pitfalls in Medical Malpractice Panel Practice*, 29 RES GESTAE 178, 178 (1985).

⁸¹IND. CODE § 16-9.5-1-1(h) (1982).

⁸²*Id.* § 16-9.5-1-1(i).

Act, a curious line of cases has found less typical occurrences also covered.⁸³ In *Ogle v. St. John's Hickey Memorial Hospital*,⁸⁴ the rape of one patient by another, allegedly caused by negligence on the part of the hospital, was determined to be a tort action subject to the Act.⁸⁵ In *Methodist Hospital of Indiana v. Rioux*,⁸⁶ the Act was found to apply to a slip-and-fall action of a patient against a hospital.⁸⁷ The *Rioux* decision met with disapproval in *Winona Memorial Foundation v. Lomax*,⁸⁸ a later, similar case. The *Lomax* court found that the Act did not apply where the fall occurred during a time when the patient was not receiving treatment or care, nor was attended by any hospital employees.⁸⁹ The *Lomax* court felt that literal application of the Act to these circumstances would be absurd, contradictory, and not within the intent of the legislature.⁹⁰ These conflicting interpretations are unresolved. Certainly factors of each decision should be weighed by plaintiffs in trying to decide where to file and by defendants in deciding whether to challenge a court action in order to obtain panel review.

Another example of the less typical occurrences found to be covered by the Act arose in *Detterline v. Bonaventura*.⁹¹ The court of appeals found that in an action for wrongful commitment to a mental hospital, the claim must be submitted to a medical review panel under the Act.⁹² This decision required a broad reading of the statutory definition of "patient" because the plaintiff had never been examined or seen by the defendant doctor. The patient's wife had arranged for the doctors to sign the commitment papers; her action on the patient's behalf created a sufficient relationship to qualify the plaintiff as a patient.⁹³

3. Multiple Defendants.—The Act also creates potential problems when multiple defendants are involved. Compliance with the Act is difficult when some of the defendants are qualified health care providers and some are not. The defendants falling under the Act should be named in a complaint filed with the Department of Insurance, but those not

⁸³See *Ogle v. St. John's Hickey Memorial Hosp.*, 473 N.E.2d 1055 (Ind. Ct. App. 1985); *Detterline v. Bonaventura*, 465 N.E.2d 215 (Ind. Ct. App. 1984); *Winona Memorial Found. v. Lomax*, 465 N.E.2d 731 (Ind. Ct. App. 1984); *Methodist Hosp. of Ind. v. Rioux*, 438 N.E.2d 315 (Ind. Ct. App. 1982).

⁸⁴473 N.E.2d 1055 (Ind. Ct. App. 1985).

⁸⁵*Id.*

⁸⁶438 N.E.2d 315 (Ind. Ct. App. 1982).

⁸⁷*Id.*

⁸⁸465 N.E.2d 731 (Ind. Ct. App. 1984).

⁸⁹*Id.* at 741-42.

⁹⁰*Id.* at 734-39.

⁹¹465 N.E.2d 215 (Ind. Ct. App. 1984).

⁹²*Id.* at 216.

⁹³*Id.* at 219.

covered by the Act will be sued in a court.⁹⁴ In this way, the plaintiff can file against all possible defendants before the statute of limitations runs out.⁹⁵ The defendants in the court proceeding will probably want to obtain a stay until a panel opinion has been issued.⁹⁶ This allows defendants not only additional time, but also the benefit of learning about the case through its development before the panel.⁹⁷

4. *Impact of Recent Amendments.* — Recent amendments both to the Act and to the Indiana comparative fault statute affect both the amount of damages a plaintiff can recover and a defendant's liability under the Act. Effective September 1, 1985, plaintiffs with claims of \$15,000 or less may choose not to proceed before a panel.⁹⁸ However, if the plaintiff chooses to go straight to court, he cannot recover more than \$15,000.⁹⁹ This new provision allows for a quicker, less costly settlement where the amount involved is small. If the plaintiff discovers after the action has begun that the bodily injury is more serious than previously believed and that \$15,000 is insufficient compensation, the plaintiff may move that the action be dismissed without prejudice, and upon dismissal, the plaintiff may proceed as usual under the Act.¹⁰⁰ In such a case, the statute of limitations is extended by 180 days.¹⁰¹ A 1985 amendment to Indiana's comparative fault statute provides that the comparative fault statute does not apply to an action brought under the Medical Malpractice Act.¹⁰² Thus a malpractice plaintiff cannot invoke the provisions of the comparative fault statute, and a malpractice defendant may be able to utilize defenses such as contributory negligence.¹⁰³

E. How to Participate in the Panel: Cautions and Encouragements

In litigating a malpractice case under the Act, parties can take alternative stances based on their feelings about the panel. They may choose to participate as little as possible, or they may choose to use the panel proceedings as an opportunity to prepare for trial. The first alternative cannot be carried too far, however, without creating the threat of sanctions.¹⁰⁴

⁹⁴See *supra* notes 70 to 80 and accompanying text.

⁹⁵Shula, *How to Present Defendant's Case to the Medical Review Panel*, 1984 IND. CONTINUING LEGAL EDUC. FORUM ON PRESENTING A CASE BEFORE MEDICAL REVIEW BOARD III-1, III-2.

⁹⁶*Id.* at III-2.

⁹⁷*Id.*

⁹⁸IND. CODE § 16-9.5-9-2.1(a) (Supp. 1985).

⁹⁹*Id.*

¹⁰⁰*Id.* § 16-9.5-9-2.1(b).

¹⁰¹*Id.* § 16-9.5-3-1(b).

¹⁰²*Id.* § 34-4-33-1.

¹⁰³See *id.*

¹⁰⁴See *supra* notes 50-54 and accompanying text.

The Act also provides that the panel consider the issues as charged in the complaint when determining its opinion.¹⁰⁵ Although the panel members will concentrate on submissions and medical records, not merely the complaint,¹⁰⁶ any complaint filed in court after panel review should duplicate the proposed complaint considered by the panel.¹⁰⁷ If new theories are submitted to a court after the panel opinion is rendered, the defendant has a basis to argue for reconvening the panel and submitting the new claims to the panel.¹⁰⁸ Furthermore, failure to submit all issues and evidence to the panel is likely to insure an unfavorable decision from the panel. Because the panel opinion is admissible at trial as nonconclusive expert evidence,¹⁰⁹ a party who submits little or no data to the panel risks an unfavorable panel opinion that has a significant effect on the fact-finder at trial. Courts from other jurisdictions have held that a nonparticipating party cannot reveal to the jury that no evidence was presented to the panel.¹¹⁰ The delay and expense incurred at the panel level should be balanced with these results. The degree of nonparticipation may be limited by these considerations.

However, the disadvantage of plunging into full preparation at the panel stage is the risk of revealing too much to opposing parties. The use of affidavits from experts may lead to early deposition of these people, for example. Balancing this threat, however, is the availability of the three panel members to testify as witnesses at trial and of up to three opinions for submission at trial.¹¹¹ (The Act appears to allow multiple opinions from the panel.)¹¹² The purposes of the Act, then, are probably better served by full participation.

Because the panel is not bound by formalities, the parties can encourage the progress of the proceedings. Because the chairperson is the only attorney on the panel,¹¹³ legal issues and submissions should be restricted to that person, who can present them as appropriate to

¹⁰⁵IND. CODE § 16-9.5-9-7 (1982).

¹⁰⁶See Shula, *supra* note 95, at III-11.

¹⁰⁷*Id.* at III-12.

¹⁰⁸*Id.*

¹⁰⁹IND. CODE § 16-9.5-9-9 (1982).

¹¹⁰See, e.g., Phoenix Gen. Hosp. v. Superior Court, 138 Ariz. 504, 506, 675 P.2d 1323, 1325 (1984) (en banc); Herrera v. Doctor's Hosp., 360 So. 2d 1092, 1096 (Fla. Dist. Ct. App.), *aff'd*, 367 So. 2d 204 (Fla. 1978).

¹¹¹IND. CODE § 16-9.5-9-9 (1982); see also Hobbs v. Tierney, 495 N.E.2d 217, 222 (Ind. Ct. App. 1986) (discussion of panel member's competency as an expert witness to testify in malpractice actions).

¹¹²See Kranda v. Houser-Norborg Medical Corp., 419 N.E.2d 1024, 1034 (Ind. Ct. App.) *reh'g denied*, 424 N.E.2d 1064 (Ind. Ct. App. 1981), *appeal dismissed*, 459 U.S. 802 (1982).

¹¹³IND. CODE § 16-9.5-9-3 (1982). The other panel members are health care providers, although they may evidently be physician-attorneys.

the other members. Direct discussion about legal issues with the medical members of the panel can lead to unnecessary confusion and risks misunderstanding. Also, the parties may find it appropriate to monitor the chairperson's compliance with statutory deadlines, particularly when dealing with an inexperienced chairperson. In addition, parties can control the speed of the formation of the panel through the selection of the chairperson and the other members by prompt contact with the clerk of the court and, subsequently, with the chairperson.

Parties should also recognize that the Department of Insurance acts only as a recordkeeping body.¹¹⁴ The Commissioner has no control or interest in creation of the panel, compelling discovery, distribution of evidence to panel members, or determination of sanctions on opposing parties.¹¹⁵ The Department should not be expected to distribute information, and parties should not involve that body unnecessarily.

Parties must submit evidence to the panel in written form only.¹¹⁶ Commonly, the chairperson will set up a staggered submission schedule beginning with the plaintiff.¹¹⁷ In addition to medical records, parties may wish to include medical literature, treatises, and letters from experts.¹¹⁸ The parties may also want to provide the chairperson with briefs on legal issues which the chairperson is then required to explain to the other panel members.¹¹⁹

Although no trial or formal hearing occurs, either party can convene the panel at a time and place agreeable to all the panel members and question panel members about any matter relevant to the issues.¹²⁰ Aside from the potential for delays in finding a suitable time and place,¹²¹ this provision can be advantageous to the parties. The practical application of this provision is expansive. Some parties make formal records of the meeting hoping to use statements made by panel members to impeach the members at trial if the panel opinion is adverse.¹²² Meetings can also be used to discover potential biases and to determine areas of uncertainty. A party may find it appropriate at panel proceedings to guide a chairperson so that arguments are not presented and only the legitimate inquiry allowed by the Act occurs.

The opinion of the panel is no more than an opinion.¹²³ It is

¹¹⁴See *supra* note 80.

¹¹⁵*Id.*

¹¹⁶IND. CODE § 16-9.5-9-4 (1982).

¹¹⁷See Shula, *supra* note 95, at III-9.

¹¹⁸IND. CODE § 16-9.5-9-4 (1982).

¹¹⁹*Id.*

¹²⁰*Id.* § 16-9.5-9-5.

¹²¹See *supra* notes 43 to 44 and accompanying text.

¹²²Murphy, *supra* note 80, at 179-80; Shula, *supra* note 95, at III-8, n.1.

¹²³IND. CODE §§ 16-9.5-9-7, -9 (1982).

considered expert testimony, not a judgment or determination of either legal issues or damages.¹²⁴ The panel has the following four statutory options for its opinion:

(a) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered:

(1) any disability and the extent of duration of the disability, and

(2) any permanent impairment and the percentage of the impairment.¹²⁵

A party who still wishes to go to trial after issuance of the panel opinion must file his complaint in court ninety days following the receipt of the opinion.¹²⁶ Even with a favorable panel opinion, a plaintiff may wish to file a complaint in court to avoid statute of limitations problems if a settlement is delayed. A defendant of course must simply wait for the plaintiff's next steps; an opinion favorable to the defendant is no guarantee that the plaintiff will stop pursuing his claim.

IV. CONSTITUTIONALITY

The Indiana Act withstood early constitutional challenges shortly after its enactment.¹²⁷ Several years later, in *Warnick v. Cha*,¹²⁸ plaintiffs were again unsuccessful in challenging the constitutionality of certain provisions of the Act. The plaintiffs in *Warnick* alleged that the provisions of the Act that require submission of a claim to a medical review panel

¹²⁴*Id.*

¹²⁵*Id.* § 16-9.5-9-7.

¹²⁶*Id.* § 16-9.5-9-1.

¹²⁷See *Johnson v. St. Vincent Hosp.*, 273 Ind. 374, 404 N.E.2d 585 (1980).

¹²⁸No. SD 83-163 (Jasper Super. Ct. Nov. 2, 1983).

before filing a lawsuit in court¹²⁹ violated state and federal constitutional rights to trial by jury and access to courts as well as the equal protection and due process clauses of the fourteenth amendment.¹³⁰

Warnick originated with the filing of a complaint for a declaratory judgment seeking to have the Act declared unconstitutional.¹³¹ The plaintiff had previously filed a medical malpractice action against the same defendant that resulted in a default judgment against the defendant.¹³² The Indiana Court of Appeals vacated the default judgment and remanded the case for further proceedings.¹³³ The Indiana Supreme Court denied transfer.¹³⁴

In the subsequent declaratory judgment action, the trial court held the Act unconstitutional on several bases. The court found that the delay caused by mandatory submission of a malpractice claim to a medical review panel violated the right of free access to courts as guaranteed by the constitution of the state of Indiana and the United States Constitution. The court also held that the mandatory submission provisions violated the right to trial by jury as provided by the constitution of the state of Indiana,¹³⁵ as well as the equal protection and due process clauses of the fourteenth amendment to the Constitution of the United States.¹³⁶

On direct appeal, the Indiana Supreme Court reversed the trial court and upheld the constitutionality of the Act.¹³⁷ The court discussed *Johnson v. St. Vincent Hospital*,¹³⁸ the earlier case, stating that it had recognized in *Johnson* the potential for delays created by the Act but found the delay constitutionally permissible.¹³⁹ The court stated, "In other words, the mere fact that there is a delay which may be as long as 23.4 months from the time of filing until the time the panel opinion is rendered is not enough to hold Indiana's Malpractice Act unconstitutional."¹⁴⁰ The court recognized that delays to the claimant were an acceptable trade-off in light of the benefits to be derived. Despite the delays, the Act was a reasonable means to achieve the stated compelling state interest in insuring the continuation of medical services within the state and in dealing with the malpractice insurance emergency that threatened the

¹²⁹IND. CODE §§ 16-9.5-1-1 to -9-10 (1982).

¹³⁰*Warnick*, No. SD 83-163, at 1.

¹³¹*Id.*

¹³²*Id.* at 1-2.

¹³³*Cha v. Warnick*, 455 N.E.2d 1165 (Ind. Ct. App. 1983), *trans. denied*.

¹³⁴*See Cha*, 476 N.E.2d at 109.

¹³⁵*Warnick*, No. SD 83-163, at 7-10.

¹³⁶*Id.* at 10.

¹³⁷*Cha*, 476 N.E.2d at 109.

¹³⁸273 Ind. 374, 404 N.E.2d 585 (1980).

¹³⁹*Cha*, 476 N.E.2d at 112.

¹⁴⁰*Id.*

availability of these services. Therefore, the Act was not unconstitutional.¹⁴¹ The lynchpin of the court's analysis of the constitutionality issue was that the plaintiffs failed to show that a medical malpractice insurance emergency no longer existed in the state. Thus, the *Johnson* analysis that the Act was a reasonable means to respond to that emergency still applied.¹⁴²

Warnick seems decisively to foreclose any attack on the constitutionality of the Act based on delays resulting from the medical review panel process. However, other aspects of the panel procedure may be subject to constitutional challenge. *Warnick* seems to suggest, though, that any such challenge, in order to be successful, would have to rest on evidence that invalidates or undermines the legislative judgment underlying the Act.¹⁴³

Interestingly, other provisions of the Act were not challenged in *Warnick*. For example, the provision limiting a plaintiff's recovery to a certain amount was not challenged by the *Warnick* plaintiffs. Indiana remains one of a relatively small number of states that limit the amount of damage awards to plaintiffs in medical malpractice cases.¹⁴⁴

V. BEYOND THE PANEL

It may never be possible to determine conclusively whether the statutory measures serve the goals for which they were intended. Despite the limitation on recovery and despite the effect of panels in discouraging lawsuits and encouraging settlements, some costs remain unaffected. Both parties can suffer large degrees of non-monetary cost, including the psychological and emotional strain of adversarial actions. The Act makes the goal of compensating victims for damages secondary to that of assuring that insurance companies can reliably and predictably insure doctors. The long-term effect is that health care providers are encouraged to maintain insurance because of increased protection. This continued availability of insurance in turn increases the likelihood that plaintiffs will actually receive damages, albeit limited damages, rather than pursuing collection from bankrupt, uninsured defendants.

The goal of tort law of deterring malpractice is unaffected by this statute, however. Although the threat of large monetary costs is removed from health care providers qualified under the Act, many penalties remain untouched. The accusation of malpractice before a panel or a court exacts costs in the form of social stigma, loss of prestige, embarrassment,

¹⁴¹*Id.* at 112-113.

¹⁴²*Id.* at 113.

¹⁴³See *Cha*, 476 N.E.2d at 113.

¹⁴⁴See *Medical Malpractice: The States Respond*, 9 HEALTH LAW VIGIL 11, 18 (1986).

anxiety, and time. These costs cannot be easily legislated away. Indeed, the only alternative may be to cap the number of malpractice lawsuits at a specific level—a change not likely to occur without drastic change in the current attitude about justice.

The true deterrents to negligent behavior by a physician are probably the non-monetary costs of an accusation of medical malpractice, not the possibility of increased financial costs.¹⁴⁵ The accusation alone may be a sufficiently negative sanction to change a doctor's methods of practice. One result of the perceived medical malpractice crisis has been the practice of defensive medicine, the increased use of costly procedures and tests to foreclose accusations of malpractice.¹⁴⁶

VI. IMPACT OF FEDERAL LAW

Medical treatment decisions are not made in a vacuum. Increasingly, medical practice is affected by changes in the economics of practice. Prior to the advent of Medicare,¹⁴⁷ doctors and hospitals relied upon patients and private insurance for reimbursement. In 1965, Medicare came into being to pay for medical expenses for the elderly.¹⁴⁸ The goals of the program, to improve health care for the elderly by paying for specified services, have come into conflict with the restrictive attitude toward federal spending in the 1980's. Increases in the cost of medical care, whether from inflation or technological advances, and the perceived need for the federal government to contain those costs have led to significant changes in federal reimbursements under Medicare.

The Health Care Financing Administration (HCFA) reimburses hospitals for services covered by Medicare.¹⁴⁹ At the direction of Congress, HCFA has now developed prospective rating formulas designed to determine the amount of Medicare reimbursement according to the diagnosis-related group (DRG) category applicable to a patient.¹⁵⁰ Because reimbursement is no longer based on the cost of services rendered, hospitals are encouraged to keep their costs to a minimum.¹⁵¹

In addition to DRGs, quality control Peer Review Organizations (PRO's) have been established.¹⁵² These organizations are made up of

¹⁴⁵Bell, *Legislative Intrusion into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of the Tort Liability*, 35 SYRACUSE L. REV. 939 (1984).

¹⁴⁶*Id.*

¹⁴⁷42 U.S.C. §§ 1395, 1395a to 1395xx (1982).

¹⁴⁸*Id.*

¹⁴⁹*Id.* § 1395ww.

¹⁵⁰See 97 Stat. 65 (1983); 42 C.F.R. § 412 (1985).

¹⁵¹See Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1006 (1985).

¹⁵²See Gosfield, *Hospital Utilization Control by PROs: A Guide Through the Maze*, 2 HEALTHSPAN 3 (1985), for a general history of legislation concerning review of utilization of hospital services.

physicians and contract with the Department of Health and Human Services to review health care provided by hospitals and to validate reimbursements.¹⁵³ These reviews perform watchdog duties to insure that hospitals do not abuse the Medicare system.¹⁵⁴ The motivation for this legislation was also cost efficiency.¹⁵⁵ PRO review does provide some protection from liability; the law shields physicians and other health care providers from civil liability "on account of any action taken . . . in compliance with or reliance upon professionally developed norms of care and treatment applied by an organization under contract"¹⁵⁶ The degree to which this immunity will protect a doctor is uncertain, however.¹⁵⁷ The primary goal of the legislation is not to change malpractice liability, but to decrease costs.¹⁵⁸

The philosophy underlying these measures directly conflicts with that of defensive medicine. Defensive medicine is an effort to protect against the accusation of malpractice by using every indicated procedure to diagnose and treat illness.¹⁵⁹ This practice is fundamentally opposed to the concept of minimizing service costs. In the world of reducing costs for services, defensive medical procedures may be the first to fall.¹⁶⁰ This change is already occurring in some public hospitals.¹⁶¹

The recent emphasis on cost-cutting in medical care may also affect the tort principle of standard of care. In Indiana, the standard of care is determined by a "modified locality rule."¹⁶² The competence of medical care is evaluated in the context of the medical care rendered by physicians in the same or a similar locality.¹⁶³ The standard therefore is self-determined by the profession. In conjunction with advances in medical technology, heightened patient expectations, and the spread of defensive medicine, the standard of care has become increasingly higher.¹⁶⁴ This higher standard of care compounds the problem of increased costs. Physicians perform more tests to ward off malpractice suits, which, in

¹⁵³42 U.S.C. § 1320(c) (1982).

¹⁵⁴Gosfield, *supra* note 152, at 6-7.

¹⁵⁵See Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 1984 LAW, MED. AND HEALTH CARE 245, 245.

¹⁵⁶42 U.S.C. § 1320(c)-6(c) (1982).

¹⁵⁷Gosfield, *supra* note 152, at 8.

¹⁵⁸See Kapp, *supra* note 155, at 245.

¹⁵⁹Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 942-943.

¹⁶⁰See Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEXAS L. REV. 1401 (1981).

¹⁶¹*Id.* at 1402.

¹⁶²*Kranda v. Houser-Norborg Medical Corp.*, 419 N.E.2d 1024, 1040 (Ind. Ct. App. 1981).

¹⁶³*Joy v. Chau*, 177 Ind. App. 29, 36, 377 N.E.2d 670, 675 (1978).

¹⁶⁴See Note, *supra* note 151, at 1009.

turn, increase the standard of care. This, in turn, increases the likelihood of allegations of malpractice if tests are not performed, thereby reinforcing the need to perform more tests. The new Medicare prospective reimbursement system breaks this circle.¹⁶⁵

Now, the medical profession is confronted with a cost containment philosophy that has repercussions on the standard of care in the community. Although the community of doctors may consider tests or procedures appropriate, the cost-cutting pressures exerted by the federal government may influence a doctor's decisions regarding treatment. The federal changes are dictated by economic considerations. These considerations conflict with the historical medical ethic to spare no expense to treat a patient, which had been reinforced by tort law. While federal law demands that the benefit of additional tests be weighed against the costs, the prevailing attitude in tort cases minimizes this balancing. The effect of this economic balancing on tort law standards has yet to be determined.¹⁶⁶

The conflicting philosophies of cost-containment and tort law arise from different perspectives. Cost-containment looks at the medical care system as a whole and institutes changes on a system-wide basis.¹⁶⁷ The decision-making process in a tort suit looks at a specific case and addresses problems on an individual basis.¹⁶⁸ As one commentator noted:

[I]t is generally difficult to distinguish between medically indicated costcutting undertaken without regard for medical efficacy. The distinction becomes even more elusive when the criteria used to make it depend on whether one views the problem from the perspective of a legislature seeking to cut costs in general or that of a jury deciding whether malpractice was committed in a specific case.¹⁶⁹

The conflict inherent in these different viewpoints will lead to conflicts in the responses generated by both the medical profession and the judicial system.¹⁷⁰

Hospitals will become more susceptible to malpractice claims as cost-cutting measures influence care given to patients.¹⁷¹ Where federal cost-cutting pressures are exerted on physicians, the hospital may be more likely to be allocated part of the liability. Of particular concern to society

¹⁶⁵See *supra* notes 147-158 and accompanying text.

¹⁶⁶See Note, *supra* note 151, at 1009.

¹⁶⁷See Rosenblatt, *supra* note 160, at 1422.

¹⁶⁸*Id.*

¹⁶⁹See Note, *supra* note 151, at 1013 (citations omitted).

¹⁷⁰For discussion as to resolution of this conflict, see *id.* at 1017-19.

¹⁷¹For a good discussion of the impact of cost cutting measures on those eligible for Medicare and Medicaid, see Rosenblatt, *supra* note 160, at 1401.

will be the federal government's pressure on hospitals to monitor physicians and control decision-making regarding treatment. Whether this will subject hospitals to broader liability for patient care is yet to be determined.

It is also possible that patients who believe they have been harmed as a result of cost-cutting measures such as prospective payment will include insurers as defendants in malpractice suits. In a recent California case involving a prospective payment mechanism, a patient who was discharged from a hospital sooner than her physician initially recommended and who suffered a leg amputation due to complications that would have been detected had she stayed in the hospital named the third-party payer as a defendant in a negligence suit.¹⁷² Although the appellate court found the insurer not liable in this case,¹⁷³ the holding does not preclude insurer liability in other circumstances.

VII. CONCLUSION

The Indiana legislature's reaction in 1975 to the rise in medical malpractice insurance costs resulted in a trade-off of time and amounts recovered for preserving the protection of insurance.¹⁷⁴ Although the Act contemplates a relatively short period for review of malpractice claims, implementation of the Act has caused significant delays.¹⁷⁵ However, neither the procedural roadblock the Act creates for plaintiffs nor the reality of delays has been sufficient to support a constitutional challenge to the Act.¹⁷⁶ Further, much of the delay can be controlled by assertion of the statutory provisions. However, the statutory solution offers not only opportunities to prepare for litigation, but also traps for those who are not familiar with the intricacies of the Act, including who is covered by the Act, what kind of actions are considered malpractice, and how the statute of limitations applies.

Although Indiana's legislative solution to the medical malpractice problem represents a change in attitudes about victim recoveries, it does not affect the deterrent goal of tort law. The deterrent goal is, however, affected by changes in federal law.¹⁷⁷ The federal government's encouragement of cost-containment in health care discourages practices that shield doctors and hospitals from accusations of medical malpractice.¹⁷⁸ Viewed in the context of the federal changes, Indiana mal-

¹⁷²Wickline v. State, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986).

¹⁷³*Id.*

¹⁷⁴See *supra* notes 4-14 and accompanying text.

¹⁷⁵See *supra* notes 34-54 and 136-142 and accompanying text.

¹⁷⁶See *supra* notes 136-142 and accompanying text.

¹⁷⁷See *supra* notes 154-171 and accompanying text.

¹⁷⁸*Id.*

practice reform takes on greater import. Although the Indiana Act's provisions for panel review and limitation of damages do not change the deterrents of negligent behavior,¹⁷⁹ the federal law does.

Yet, both state and federal law reflect similar changes in attitude, which taken together have a greater impact than if they stood alone. The state law represents a choice of affordable insurance and at least partial compensation for victims as opposed to full compensation recoverable from only a few deep pockets. The federal law represents a choice of economy at the risk of omissions in health care—care that might be provided if costs were not a barrier.

Although the parties involved would acknowledge the importance of providing the best quality health care, or full compensation where care is not the best, the changes represent an implicit acknowledgment of certain realities. Both federal and state legislatures have recognized the impact of the economics of medical care. Ultimately, it is this economic reality which any future steps toward reform must consider.

¹⁷⁹See *supra* notes 154-161 and accompanying text.