

Medical Malpractice

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I. INTRODUCTION

In five medical malpractice cases decided during the survey period, Indiana courts set new precedent. The areas of law addressed in these decisions are: (A) limitation of actions against diagnostic (as opposed to treating) health care providers; (B) the ability/inability of corporations to practice medicine and therefore be responsible for negligent acts; (C) how to proceed where there are multiple defendants, some of whom are "qualified" under the Indiana Medical Malpractice Act¹ (the "Act") and others are not so qualified; (D) plaintiff's burden of proof on damages where there is a preexisting medical condition and other possible causes of injury; and (E) the authority of trial courts: (1) to order a medical review panel to render a specific expert opinion; (2) to determine the standard of care in lack of informed consent cases; and (3) to define the term, "a factor," as used in Indiana Code section 16-9.5-9-7(e). The 1988 legislative session brought one relatively minor addition to the Act.

This survey will first review the cases setting new precedent. A discussion of the one legislative change and criticism of the overall lack of action in the legislature will follow.

II. COURT DECISIONS

A. *Limitation of Actions Against Diagnostic Health Care Providers*

Indiana's statute of limitations in medical malpractice actions is an "occurrence" rather than a "discovery" statute.² A lawsuit for medical malpractice must be filed within two years from the date the alleged negligent act occurred rather than from the date it was discovered. However, there are exceptions where the negligent act is a "continuing wrong" and where the health care provider has failed to disclose material information to the patient. The continuing wrong theory is applicable

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1. IND. CODE §§ 16-9.5-1-1 to -10-3 (1988).

2. IND. CODE § 16-9.5-3-1(a)(1988); *Corlbert v. Waitt*, 445 N.E.2d 1000, 1002 (Ind. Ct. App. 1982).

where the entire course of conduct combines to produce an injury. The statute of limitations is tolled so that it does not commence running until the continuing wrongful act ceases.³

The doctrine of fraudulent concealment operates to estop a defendant from asserting a statute of limitations defense when he has, either by deception or violation of a duty, concealed from the plaintiff material facts thereby preventing the plaintiff from discovering the malpractice The failure of the physician's duty to disclose that which he knows, or in the exercise of reasonable care should have known, satisfies the conduct requirement and constitutes a constructive fraud. This constructive fraud terminates with the termination of the physician/patient relationship and the statute of limitations begins to run. Also, when a patient learns of the malpractice, or discovers information which would lead to discovery of a malpractice, if the patient exercises reasonable diligence, the statute will commence to run.⁴

In *Walters v. Rinker*,⁵ decided March 29, 1988, the court addressed how the principles of "continuing wrong" and "constructive fraud" should be applied for determining limitations to the right of action against a diagnostician engaged by a patient's treating physician. In *Walters*, Rinker was examined by his family doctor, G. R. Hershberger, who referred him to a specialist, Dr. Mortola. Dr. Mortola examined Rinker on July 14, 1983, and found a lump in Rinker's right thigh area. The lump was surgically removed and then analyzed by a pathologist, defendant William Walters, D.O. On August 16, 1983, Dr. Hershberger received Walters' report which ruled out malignancy. Rinker's health declined and he was admitted to another facility and was diagnosed as having large cell lymphoma on April 5, 1985. The proposed complaint against Dr. Walters was filed with the Indiana Insurance Commissioner on July 10, 1986. Dr. Walters invoked the jurisdiction of the trial court for the purpose of raising the affirmative defense of the statute of limitations.⁶ The defendant's motion to dismiss was based on two arguments: the running of the statute of limitations and no physician/patient relationship between defendant and plaintiff. The trial court denied the motion to dismiss but granted Dr. Walters' motion for

3. *Fraday v. Hedgcock*, 497 N.E.2d 620, 622 (Ind. Ct. App. 1986).

4. *Spoljaric v. Pangan*, 466 N.E.2d 37, 40 (Ind. Ct. App. 1984), *quoted in Ferrell v. Geisler*, 505 N.E.2d 137, 139 (Ind. Ct. App. 1987).

5. 520 N.E.2d 468 (Ind. Ct. App. 1988).

6. IND. CODE § 16-9.5-10-2 (1988).

certification of the interlocutory appeal, which was then entertained by the Court of Appeals.

The appeals court first dealt with Dr. Walters' argument that no physician/patient relationship existed. This argument was found to be without merit due to the broad language setting out the scope of the Act.⁷ The court also found no merit to another of Dr. Walters' contentions, *i.e.*, that the relationship between himself and Rinker was a non-consensual one because Rinker did not personally seek Dr. Walters' assistance. The court found that a consensual physician/patient relationship existed between Walters and Rinker because Rinker's family physician requested the diagnostic work on Mr. Rinker's behalf.⁸

Finally, the court determined the duration of the physician/patient relationship between Walters and Rinker. The duration issue was crucial in applying either the "continuing course of treatment" or "fraudulent concealment" theories to determine when the statute of limitations began to run. Rinker argued that the doctor was a part of a therapeutic team of physicians whose relationship with Rinker did not terminate until he was no longer under the care of his family physician, Dr. Hershberger. The court found no Indiana cases on this question and turned to New York law for its analysis. In the past, New York courts had held that a diagnostician constructively participated in the treatment of a patient so long as the treatment continued.⁹ Constructive participation by a pathologist in the patient's treatment was accepted by New York courts until reversed in a series of decisions from 1982 through 1986.¹⁰ The New York courts reasoned:

Generally, a laboratory neither has a continuing or other relevant relationship with the patient nor, as an independent contractor, does it act as an agent for the doctor or otherwise act in relevant association with the physician. A laboratory does not have the opportunity to discover an error in a report. Instead, it must rely upon the treating physician to discover any diagnostic mistake. Therefore, the policy underlying the continuous treatment doctrine generally will not apply to the independent laboratory.¹¹

The *Walters* court found the current New York view persuasive and held that Dr. Walters' relationship with Mr. Rinker terminated on August

7. *Walters*, 520 N.E.2d at 471. See IND. CODE § 16-9.5-1-1(h), (i) (1988).

8. 520 N.E.2d at 472.

9. *Fonda v. Paulson*, 46 A.D.2d 540, 363 N.Y.S.2d 841 (1975).

10. *Meath v. Mishrick*, 68 N.Y.2d 992, 503 N.E.2d 115, 510 N.Y.S.2d 560 (1986); *McDermott v. Torre*, 56 N.Y.2d 339, 437 N.E.2d 1108, 452 N.Y.S.2d 351 (1982).

11. *Walters*, 520 N.E.2d at 473 (quoting *McDermott*, 56 N.Y.2d at 408, 437 N.E.2d at 112, 452 N.Y.S.2d at 355).

10, 1983, when he signed his pathology report and sent it to the family physician. Further, the court found the New York rule to be consistent with Article 1, Section 12 of the Indiana Constitution which provides, in pertinent part: "All courts shall be open; and every person, for injury done to him in his person . . . shall have remedy by due course of law."¹² Hence, Rinker's suit was barred as of August 11, 1985.

Because of the significance of pathology reports in analyzing potential medical malpractice claims, this decision places a large burden on Indiana practitioners and their patients. If there has been an error committed by a medical laboratory or a hospital pathology department, this error oftentimes is not discovered until more than two years after the report. Treating physicians who rely on an erroneous pathology report should not be held responsible for the report's errors where the treating physician has no reason to doubt the validity of the report. However, this leaves no recourse for the victim of a diagnostician's negligence where the errors are not found until two years or longer after the diagnostician's last report.

A more equitable limitations of action policy would be to allow medical malpractice actions to be brought within two years following the discovery of the negligent act or the discovery of information which, in the exercise of reasonable diligence, would lead to discovery of the malpractice. This could be combined with the current absolute "occurrence" rule, however, for a longer period of time. One suggestion is seven years, which is the time period a physician is required to maintain medical records for a patient.¹³ Thus, most actions would have to be brought within two years of the date of the negligent act. Where the negligent act could not have been discovered, even with due diligence, until a later time, the patient would be given up to seven years from the date of the negligent act to bring his action. Because the Indiana Medical Malpractice Act specifically addresses the question of limitations of action,¹⁴ legislative action will be required to alleviate the harshness of the current law.

B. Corporations as Health Care Providers

In *Sloan v. Metropolitan Health Counsel of Indianapolis, Inc.*,¹⁵ decided December 23, 1987, the court of appeals reversed the long-standing principle of Indiana law that a corporation cannot practice medicine and therefore cannot be vicariously liable for the malpractice

12. IND. CONST. ART I, § 12.

13. IND. CODE § 16-4-8-12 (1988).

14. IND. CODE § 16-9.5-3-1 (1988).

15. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

of a physician in its employ.¹⁶ Defendant Metro-Health Plan (Metro) is a not-for-profit corporation providing prepaid health care. Its operations are regulated under Indiana law for health maintenance organizations.¹⁷ Metro physicians labor under an "employment contract;" they are paid a salary; they receive benefits; and their practice is subject to review by a medical director physician, who also determines medical policy matters for the corporation.

Plaintiff Sloan brought an action against Metro alleging negligent failure to diagnose. Defendant Metro invoked the jurisdiction of the trial court pursuant to Indiana Code section 16-9.5-10-1. The trial court granted summary judgment to Metro on the theory that a corporation cannot be vicariously liable for the malpractice of a physician in its employ. The court of appeals reversed, holding "where the usual requisites of agency or an employer/employee relationship exist, a corporation may be held vicariously liable for malpractice for acts of its employee/physicians."¹⁸

A long line of Indiana decisions prior to *Sloan* held that because no Indiana statute existed permitting corporations to practice medicine, a public policy prohibited corporations from practicing medicine.¹⁹ These cases ruled that the doctrine of *respondeat superior* was inapplicable where employees of a corporation were medical practitioners.²⁰ In *Sloan*, the court found this reasoning to be illogical, and if any such public policy ever existed, it was abolished by the Professional Corporation Act of 1983.²¹

The court explained its holding by embracing the reasoning of *Estate of Mathes v. Ireland*.²² In *Mathes*, the court recognized that many physicians hold staff privileges at one or more hospitals, and their mere treatment of a patient at a given hospital does not give rise to hospital liability for any negligence on the part of the physician. However, the court further reasoned:

[W]e find no logical basis for denying liability under proper circumstances on the ground that the professional must exercise a professional judgment that the principal may not properly control. The general rule of liability that presupposes *authorization* of acts of the agent in order to bind the principal applies

16. See *Interman v. Baker*, 214 Ind. 308, 15 N.E.2d 365 (1938); *South Bend Osteopathic Hosp. Inc. v. Phillips*, 411 N.E.2d 387 (Ind. Ct. App. 1980).

17. IND. CODE §§ 27-8-7-1 to -21 (1988).

18. *Sloan*, 516 N.E.2d at 1109.

19. See cases cited *supra* note 16.

20. See cases cited *supra* note 16.

21. *Sloan*, 516 N.E.2d at 1109 (citing IND. CODE § 23-1.5-1-1 (1988)).

22. 419 N.E.2d 782 (Ind. Ct. App. 1981).

to a principal's contractual or *non-tort* liability. The *tort* liability of the principal expressed in the doctrine of respondeat superior is based not upon the agency relationship (authorization or ratification) but upon the employer-employee relationship. Thus, the touchstone of the principal's liability for the tortious acts of his agent is merely whether they are done within the course and scope of the employment.²³

In future decisions, the courts will no doubt be asked to explain exactly what relationships will give rise to the application of the doctrine of *respondeat superior* in the health care field. For example, are hospitals responsible for the negligent acts of emergency room physicians who contract with the hospital, who are paid a salary, and who are subject to professional reviews by the medical director of the hospital? These are some of the critical questions left unanswered by *Sloan*.

C. Actions Where One Defendant Is a "Qualified Health Care Provider" and Others Are Not So "Qualified"

The Indiana Medical Malpractice Act requires each person who has a claim against a health care provider, qualified for the Act's protections,²⁴ to first file a proposed complaint with the Indiana Insurance Commissioner.²⁵ A panel of health care providers is then formed, and the panel issues a professional opinion based on its review of medical records and other documentation provided to the panel by the parties. All this is a prerequisite to filing a medical malpractice action against a health care provider who is "qualified" under the Act.²⁶ The Act does not address the question of what happens when multiple defendants are sued and one or more of the defendants is not a "qualified health care provider."

In *State ex rel. Hiland v. Fountain Circuit Court*,²⁷ the Indiana Supreme Court shed significant light on this question. In *Hiland*, plaintiffs brought an action against a qualified health care provider, Manual Cacadac, M.D., and others who were not qualified for the protections

23. *Sloan*, 516 N.E.2d at 1109 (quoting *Estate of Mathes v. Ireland*, 419 N.E.2d 782 (Ind. Ct. App. 1981) (emphasis in original) (citations omitted)).

24. "Qualified health care providers" are those who meet the requirements of the Act by purchasing professional liability insurance, contributing to the Indiana Patient Compensation Fund and complying with other provisions of Ind. Code section 16-9.5-2-1 (1988). The benefits for being "qualified" include a limitation of liability or "exposure" to \$100,000.00 for each incident pursuant to Ind. Code section 16-9.5-2-2 (1988).

25. IND. CODE § 16-9.5-9-1 (1988).

26. IND. CODE § 16-9.5-9-2 (1988).

27. 516 N.E.2d 50 (Ind. 1987).

of the Indiana Medical Malpractice Act. On the same day, a proposed complaint against Dr. Cacdac was filed by Hiland with the Indiana Insurance Commissioner. Hiland sought a court order imposing a stay upon all proceedings against Cacdac in the state court action until after the medical review panel had rendered its decision. Cacdac moved to dismiss the complaint against him and objected to any participation in striking of counties pursuant to codefendant's Motion for Change of Venue. The court of appeals found that Indiana Code sections 6-9.5-10-1, -2 specifically authorized resolution of change of venue matters as a "preliminary determination" for which the trial court had limited subject matter jurisdiction.²⁸ The court further stated, "In addition to these purposes, we observe that just and efficient judicial administration is not served by the sanctioning of a procedure that unnecessarily requires duplicitous multiple trials of the same factual issues, nor by inviting the prospect of inconsistent and contradictory verdicts."²⁹

Thus, the court approved the practice in multiple defendant actions to keep the entire case together in order to avoid needless expense and additional burden on the courts. This ruling, coupled with the provisions of Indiana Code section 34-4-33-11,³⁰ gives Indiana practitioners an outline of how to proceed in such cases. First, the lawsuit against both qualified and non-qualified defendants is filed with the trial court. At the same time, a proposed complaint is filed against the qualified health care providers with the Indiana Insurance Commissioner. Next, the trial court may make preliminary determinations regarding matters such as venue. The trial court is required to grant reasonable delays until the medical review panel procedure has been completed as to the qualified health care providers.³¹ After the panel has rendered its opinion in the claim against the qualified health care provider, the trial court is required to resume proceedings involving the qualified health care providers as

28. *Id.* at 51.

29. *Id.* at 52.

30. IND. CODE § 34-4-33-11 (1988) in entirety provides:

Sec. 11. When an action based on fault is brought by the claimant against one (1) or more defendants who are qualified health care providers under IC 16-9.5, and, also is brought by suit against one (1) or more defendants who are not qualified health care providers, upon application of the claimant, the trial court shall grant reasonable delays in the action brought against those defendants who are not qualified health care providers until the medical review panel procedure can be completed as to the qualified health care providers. When an action is permitted to be filed against the qualified health care providers, the trial court shall permit a joinder of the qualified health care providers as additional defendants in the action on file against the nonhealth care providers.

31. *Id.*

additional defendants in the action on file against the other defendants.³²

D. Damages and Preexisting Conditions

With the exception of some "unnecessary treatment" cases, almost every medical malpractice case involves a preexisting illness or medical condition. In *Dunn v. Cadiente*,³³ the Indiana Supreme Court discussed plaintiff's burden of proof on damages where there is a preexisting medical condition in existence before intervention by a defendant health care provider. In *Dunn*, plaintiff appealed a trial court award of \$24,065 in damages. The court of appeals reversed, finding the judgment clearly erroneous because the evidence at trial showed medical expenses to be no less than \$65,700 and future loss of earnings to be in excess of \$600,000.³⁴ The Indiana Supreme Court reversed.³⁵

The court affirmed the principle that the preexisting condition or susceptibility, if aggravated by defendant's conduct, may result in defendant's full liability for resulting injury and loss.³⁶ However, if the preexisting condition, standing alone, independently causes injury and loss, then defendant will not be liable for those damages.³⁷ The court pointed to testimony of the plaintiff's medical expert that the resulting impairment was to some extent inevitable notwithstanding the alleged negligence of defendant.³⁸

What distinguishes Justice Dickson's opinion from earlier case law is his analysis of the parties' burdens of proof where there is an illness or medical condition before negligent treatment by a health care provider defendant. The court first adopted the reasoning of Professor Prosser:

Where a logical basis can be found for some rough practical apportionment, which limits a defendant's liability to that part of the harm which he has in fact caused, it may be expected that the division will be made. Where no such basis can be

32. *Id.* This statute uses the term "joinder" for the procedure of resuming proceedings after the delays necessary for the medical review panel to render its opinion. However, a true joinder of parties as contemplated by Trial Rule 20 of the Indiana Rules of Trial Procedure is a slightly different concept. T.R. 20 outlines which persons may be included as parties plaintiff or defendant in one lawsuit. The statute discussed here, on the other hand, describes a procedure for keeping all defendants in one lawsuit where some, but not all, are covered by the protections and additional procedural requirements of the Act.

33. 516 N.E.2d 52 (Ind. 1987).

34. *Dunn v. Cadiente*, 503 N.E.2d 915 (Ind. Ct. App. 1987).

35. 516 N.E.2d at 57.

36. *Id.* at 56.

37. *Id.*

38. *Id.*

found and any division must be purely arbitrary, there is no practical course except to hold the defendant for the entire loss, notwithstanding the fact that other causes have contributed to it.³⁹

Thus, where there is no basis for apportioning defendant's liability to that part of the harm which he had in fact caused, then the defendant will be held liable for the entire loss, notwithstanding the fact that other causes have contributed to it. However, the court placed the burden of proof on the plaintiff to show the absence of any such basis for apportionment.⁴⁰

The decision appears to put claimants in most medical malpractice cases in the position of being required to "prove a negative," *i.e.*, the *absence* of a basis for apportionment of damages. This raises a number of questions. Is expert testimony required? How is the jury to be instructed on this question? The practical application of this burden of proof in medical malpractice trials will be difficult.

E. Jones v. Griffith: New Insights on the Authority of Trial Courts over Medical Review Panels

The opinion by the United States District Court for the Northern District of Indiana in *Jones v. Griffith*⁴¹ is remarkable in several respects. First, the entry includes an order from the federal trial court to an Indiana medical review panel to render a specific finding under Indiana Code section 16-9.5-9-7(c).⁴² Second, the court found that the standard of care for "informed consent" cases necessarily is dependent both on expert opinion and questions of fact requiring lay witness testimony. Third, the court defined the term "factor" used in Indiana Code section 16-9.5-9-7(e) and distinguishes that term from the phrase "substantial factor" as that phrase is used under Indiana law to define the standard for proximate cause in medical malpractice cases.

Plaintiff Carol Jones was the personal representative of the estate of Jon W. Jones, who died following a femoral angiographic procedure performed by defendant Harold M. Griffith, M.D. The procedure involved injection of contrast media into the patient's vascular system, and it appeared Mr. Jones had an anaphylactic reaction to the angiographic

39. *Dunn*, 516 N.E.2d at 56 (quoting W. PROSSER, HANDBOOK OF THE LAW OF TORTS, 314 (4th ed. 1971)).

40. *Id.*

41. 688 F. Supp. 446 (N.D. Ind. 1988) (Lee, J.).

42. *Id.* at 462 "The court directed the medical review panel to find in the words of the statute "that there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury." IND. CODE § 16-9.5-9-7(c) (1988).

dye contract material. Mr. Jones was not told about any of the risks of the procedure. Plaintiff's claims were based on both lack of "informed consent" and negligence in responding to Mr. Jones' anaphylatic reaction. A proposed complaint was filed naming both Dr. Griffith and Parkview Memorial Hospital as defendants, both of whom were "qualified" health care providers under the Act.⁴³ The hospital was dismissed, leaving Dr. Griffith as the sole defendant.

A medical review panel was formed in accordance with the Act, and plaintiff filed in federal district court a copy of the proposed complaint and a written motion seeking a preliminary determination in accordance with Indiana Code section 16-9.5-10-1.⁴⁴ In the motion for preliminary determination, the plaintiff sought rulings on two issues. First, the court was asked to find that the appropriate standard for informed consent under Indiana law necessarily involves issues of fact not requiring expert opinion. Second, plaintiff asked the court to determine that the phrase "a factor" in Indiana Code section 16-9.5-9-7(d) means something different from the phrase "substantial factor" as that phrase describes the standard for proximate cause in negligence cases.

The court first dealt with questions relating to its jurisdiction to rule on plaintiff's motion. Under Indiana Code section 16-9.5-10-1, the parties may file a copy of the proposed complaint and a written motion seeking a preliminary determination of an issue of fact or law. The statute requires the moving party or his attorney to serve by summons the Indiana Commissioner of Insurance, each non-moving party to the proceeding, and the chairman of the medical review panel.⁴⁵ Because

43. IND. CODE § 16-9.5-9-7(c) (1988). *See also supra* note 24.

44. IND. CODE section 16-9.5-10-1 provides:

A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner under this article may, upon the filing of a copy of the proposed complaint and a written motion under this chapter, (1) preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the Indiana Rules of Procedure; or (2) compel discovery in accordance with the Indiana Rules of Procedure; or (3) both. The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the medical review panel under I.C. § 16-9.5-9-7(a), (b) and (d). The court has jurisdiction to entertain a motion filed under this chapter only during that period of time after a proposed complaint is filed with the commissioner under this article but before the medical review panel renders its written opinion under I.C. § 16-9.6-9-7. The failure of any party to move for a preliminary determination or to compel discovery under this chapter before the medical review panel renders its written opinion under I.C. § 16-9.5-9-7 shall not constitute the waiver of any affirmative defense or issue of law or fact.

45. *Id.* § 16-9.5-10-2 (1988).

both the Commissioner and the panel chairman were citizens of Indiana, defendant argued that diversity jurisdiction⁴⁶ had been destroyed. Defendant also argued that the federal court doctrine of abstention required the court to refuse to rule on the issues presented in plaintiff's motion.

With regard to diversity jurisdiction, the court found that neither the panel chairman nor the commissioner were real parties to the controversy and therefore diversity jurisdiction was not defeated.⁴⁷ The court also dismissed the abstention question by observing that the issues involved in the case were difficult, "but the mere difficulty in ascertaining state law questions does not justify abstention."⁴⁸

According to Judge Lee, the "informed consent" issue involved two questions. First, what is the appropriate standard of care in informed consent cases under Indiana Law? Second, can the medical review panel render an "expert opinion" regarding compliance with this standard of care, or is there a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the jury?⁴⁹

The informed consent doctrine is an extension of the negligence concept in the context of medical treatment. Health care providers owe a duty to patients to make a reasonable disclosure of material facts relevant to the decision which the patient is requested to make.⁵⁰ Judge Lee rejected defendant's argument that the standard of care in informed consent cases is based solely on what other doctors in the medical community would disclose to similar patients.⁵¹

The test for determining whether a potential peril must be divulged was its materiality to the patient's decision.⁵² All risks potentially affecting the decision must be unmasked. The court held that the risks involved and the type of potential harm in question were issues requiring expert opinion; however, lay witness testimony could establish what a reasonable patient would want to know.⁵³

The court found that the question of informed consent necessarily involves some issues that require expert opinion and other issues where

46. 28 U.S.C. § 1332 (1982).

47. *Jones*, 688 F. Supp. at 452. 28 U.S.C. § 1332 requires complete diversity among the parties.

48. *Jones*, 688 F. Supp. at 454. See also *Meredith v. City of Winterhaven*, 320 U.S. 228 (1943).

49. *Jones*, 688 F. Supp. at 455.

50. *Joy v. Chau*, 377 N.E.2d 670 (Ind. Ct. App. 1978); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

51. *Jones*, 688 F. Supp. at 457-58.

52. *Id.* at 456. See also *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Revord v. Russell*, 401 N.E.2d 763 (Ind. Ct. App. 1980); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972).

53. 688 F. Supp. at 457.

expert opinion is not needed. The patient's right of self decision can be exercised effectively only if the patient possesses adequate information to enable an intelligent choice.

The court then reviewed the options available for the panel under Indiana Code section 16-9.5-9-7, which gives medical review panels the choice of rendering one or more of four expert opinions.⁵⁴ The court found that because there clearly were material issues of fact not requiring expert opinion which bear on the issue of liability, the court held that the medical review panel was bound to issue its opinion under Subsection (c) of Indiana Code section 16-9.5-9-7.⁵⁵

The court then turned to the second aspect of plaintiff's motion. The court was asked to determine that the phrase "a factor" in Indiana Code section 16-9.5-9-7(d) means something different from the phrase "substantial factor" as the phrase is used in Indiana law. Indiana Code section 16-9.5-9-7(d) defines the standard for proximate cause in negligence cases. The court agreed with plaintiff's argument that the Indiana Legislature's use of the phrase "a factor" indicated a lower threshold of proof for causation than the "substantial factor" test.⁵⁶ The court found the plain meaning of the term to be unambiguously, "any of the circumstances, conditions, etc. that bring about a result."⁵⁷ Judge Lee declined plaintiff's invitation to define "a factor" as "any increase in risk of harm or decrease in chance of survival" which is used in some

54. IND. CODE § 16-9.5-9-7 (1988). This section reads:

The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty (30) days, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

- (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 and duration of the disability, and (2) any permanent impairment and the percentage of the impairment.

55. 688 F. Supp. at 460.

56. *Id.* at 461.

57. *Id.* See also Webster's New World Dictionary (2d College ed. 1978); Black's Law Dictionary (5th ed. 1979).

jurisdictions.⁵⁸ The court instructed the medical review panel, "Dr. Griffith's conduct was a factor if it was a circumstance or condition that brought about Jones' death. The panel is further instructed that it is not to determine whether Dr. Griffith's conduct was a 'substantial factor.' That is a matter for the jury."⁵⁹

Judge Lee found authority for his order in Indiana Code section 16-9.5-10-1 as interpreted in *Johnson v. Padilla*.⁶⁰ In *Johnson*, the plaintiff alleged that the defendant doctor negligently performed a dilation and curettage. Before the medical review panel had issued its expert opinion, the court made a preliminary determination that Dr. Padilla was not the treating physician and rendered summary judgment for defendant.⁶¹ Judge Lee reasoned that if a court can grant summary judgment in cases like *Johnson*, it can instruct the panel to make a finding that there is a factual dispute.⁶²

The *Jones* ruling is helpful in distinguishing which issues are suitable for expert opinion in "informed consent" cases. It is also significant because it is the first case where a court ordered a medical review panel to make a certain finding. However, the significance of that aspect of the case will probably be limited to informed consent cases where material factual issues are in dispute.

In contrast, the court's definition of the term "a factor" will likely have a more far-reaching effect. Chairmen of medical review panels can instruct the health care provider members of the newly clarified definition of the term "factor." And it may be somewhat easier for medical review panels to find in favor of claimants because "factor" presents a lower standard than "substantial factor." However, it is still unclear after *Jones* what evidence is needed to create a jury question on causation where plaintiffs have no other expert opinion than the medical review panel opinion.

III. LEGISLATION

The only legislative change to the Indiana Medical Malpractice Act in 1988 related to Indiana Code section 16-9.5-9-3.5.⁶³ New subsections were added to address the problems of panel chairman or health care

58. *Jones*, 688 F. Supp. at 462. See, e.g., Annotation, *Medical Malpractice: "Loss of Chance" Causality*, 54 A.L.R. 4th 10 (1987).

59. 688 F. Supp. at 462.

60. 433 N.E.2d 393 (Ind. Ct. App. 1982).

61. *Id.* at 395-96. The court found that the language of Indiana Code section 16-9.4-10-1 provides that courts may preliminarily rule on factual issues contained in Indiana Code section 16-9.5-9-7(c).

62. *Jones*, 688 F. Supp. at 456-60.

63. IND. CODE § 16-9.5-9-3.5 (1988).

provider members who were not fulfilling their duties. Subpart (c) provides that the commissioner may replace a dilatory chairman; and subpart (d) provides that the chairman may remove dilatory panel members. Both the chairman and the panel member have to be replaced in accordance with section 3 of the Act.⁶⁴

In order to obtain a ruling from the Indiana Insurance Commissioner that a panel chairman should be removed, a written petition will likely be required.⁶⁵ The petition should be verified and set forth the reasons why a new panel chairman is needed.⁶⁶

Other than this relatively minor change, the Indiana Legislature was silent on medical malpractice questions despite a significant need to make adjustments in the Act. The hardships imposed by the strict "occurrence" rule for the limitations of actions should be alleviated.⁶⁷ An important change would be to increase the maximum amount of recovery for medical costs permitted by statute.⁶⁸ Assuming that \$500,000 was a rational limit in 1975, the year the Act was passed, it no longer is reasonably related to medical costs. Medical costs in 1986 were 257% greater than what they were in 1975.⁶⁹ Hospital room costs are 318% of 1975 costs.⁷⁰ The costs for medical care have increased at approximately one and one-half times the rate of the consumer price index during that eleven-year period.⁷¹ As time without legislative action goes by, more and more cases involving catastrophic injuries are or will be resolved with the claimant obtaining the maximum recoverable, but with an award which is insufficient to pay for past and future medical costs caused by the health care provider's negligence.

The current legislative scheme providing for a maximum recoverable amount is overly simplistic. First, the Act was the legislature's response to a "crisis."⁷² Whether the crisis was real or imagined, the legislature opted to make certain that medical care would be provided. The situation the legislature sought to avoid was the non-existence of medical care or

64. *Id.* § 16-9.5-9-3.

65. Interview with Mrs. Marsha Harrison-Pitcher, Indiana Insurance Commissioner, Patient Compensation Fund (August 1, 1988) (the Commission has not as yet adopted formal rules to carry out its responsibilities under Indiana Code section 16-9.5-9-3.5).

66. *Id.*

67. *See supra* text accompanying notes 13-14.

68. IND. CODE § 16-9.5-2-1 (1988).

69. Statistics from Terrance C. Parks, Ph.D., Professor of Economics, Indiana State University, based on data published in STATISTICAL ABSTRACT OF THE UNITED STATES, BUREAU OF CENSUS, U.S. DEPARTMENT OF COMMERCE (108th ed. 1988).

70. *Id.*

71. *Id.*

72. *Johnson v. St. Vincent Hosp., Inc.*, 273 Ind. 374, 399-400, 404 N.E.2d 585, 599 (1980) (the court held the Indiana Act constitutional).

practitioners acting without insurance.⁷³ The cap on the amount recoverable in a medical malpractice action was supposed to alleviate the problems associated with the uninsured practice of medicine and/or no medical care at all.⁷⁴ However, problems apparent on the face of the Act were not considered. Most notably, there is no formula for determining when the "crisis" has ended. Thus, the harsh result originally imposed on the patients most seriously injured by medical malpractice has now become oppressive and dramatically outweighs any benefit derived from maintaining the Act.

The reason why the Act should be abolished or altered is that statutory caps are a drastic measure which should only be instituted when there is no other solution. A statutory cap should never be a permanent solution; it should only be used in a critical situation and should be maintained only temporarily until another solution can be found. Indiana maintains the harshest statutory cap of any state in the United States.⁷⁵ It is noteworthy that statutory caps have fallen into disfavor in a growing number of states. Texas and Virginia courts have

73. *Id.*

74. *Id.*

75. ALASKA STAT. § 09.17.010 (1986) (\$500,000 limit for noneconomic damages in personal injury actions, not including disfigurement or severe physical impairment); CAL. CIV. CODE § 3333.2 (West 1975) (\$250,000 limit for noneconomic damages in medical malpractice cases); COLO. REV. STAT. § 13-21-102.5 (1986) (\$250,000 limit for noneconomic damages generally, \$500,000 limit for noneconomic damages where there is clear and convincing evidence which justifies such a finding by the court); HAW. REV. STAT. § 663-8.5, -8.7 (1986) (\$375,000 limit for pain and suffering, distinguished from other noneconomic damages of mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other pecuniary losses or claims); IND. CODE ANN. § 16-9.5-2-2 (Burns, 1975) (\$500,000 limit on all damages recoverable for injuries in a medical malpractice action); KAN. STAT. ANN. § 60-340 (1986) (\$250,000 limit on noneconomic damages in medical malpractice cases); LA. REV. STAT. ANN. § 40:1299.39 (West 1986) (\$500,000 limit on all damages except medical expenses); MD. CTS. & JUD. PROC. CODE ANN. § 11-108 (1987) (\$350,000 limit on noneconomic damages in any action for personal injury); MASS. GEN. LAWS ANN. ch. 231, § 60H (West 1986) (\$500,000 limit for noneconomic damages in medical malpractice actions—does not apply to wrongful death actions); MICH. COMP. LAWS § 600.1583 (1986) (\$225,000 limit for noneconomic damages in medical malpractice cases); MINN. STAT. § 549.23 (1986) (\$400,000 limit on embarrassment, emotional distress, and loss of consortium); MO. REV. STAT. § 538.210 (1986) (\$350,000 limit for noneconomic damages in medical malpractice cases); NEB. REV. STAT. § 44-2825 (1984) (\$1,000,000 limit on all damages in medical malpractice cases); N.H. REV. STAT. ANN. § 508:4-d (1986) (\$875,000 limit on noneconomic damages for personal injury cases); S.D. CODIFIED LAWS ANN. § 21-3-11 (1986) (\$1,000,000 limit for all damages in medical malpractice cases); UTAH CODE ANN. § 78-14-7.1 (1987) (\$250,000 limit on noneconomic damages in medical malpractice cases); WASH. REV. CODE § 4.56.250 (1986) (variable cap on noneconomic damages for personal injury cases); W. VA. CODE § 55-78-8 (1986) (\$1,000,000 for noneconomic damages in medical malpractice cases); WIS. STAT. § 893.55 (1986) (\$1,000,000 limit for noneconomic damages in medical malpractice cases).

recently struck down caps on tort recovery.⁷⁶ Florida courts have struck down caps as unconstitutionally overbroad when not aimed at a specific crisis concerning compelling state interests,⁷⁷ even though the state had an insurance crisis far worse than faced by Indiana.⁷⁸ Louisiana modified its statutory cap in medical malpractice cases, based on Indiana's Act, to allow plaintiffs to recover full medical expenses.⁷⁹

An approach which would be better suited to the needs of each individual case, if a cap is still necessary, would be to provide for no maximum dollar amount for past and future medical expenses and lost earnings or earning capacity. A maximum could be set on pain, suffering and mental anguish. A cap on the "intangible" award would more fairly distribute the economic burden involved in medical malpractice cases while fulfilling the same policy goals underlying the current Act. Insurance carriers could reasonably predict their liability for the quantifiable tangible losses, such as medical costs and lost wage and earnings capacity. It would remove the unquantifiable variable of intangible loss. Seriously injured victims of medical malpractice would not have to bear the economic burden of medical costs not recoverable under the current Act. Finally, few Indiana medical malpractice cases are tried to a jury, but this scheme would prevent juries (or judges in bench trials) from "running away" and awarding excessive verdicts based on the more intangible elements of the claimant's damages.

IV. CONCLUSION

Although some questions were answered by the Indiana courts and legislature during the survey period, new issues remain which require future action both by the courts and by the Legislature. In the area of limitation of medical malpractice actions, what is the best way to alleviate

76. *Detar Hosp., Inc. v. Estrada*, 694 S.W.2d 359 (Tex. 1985), (invalidating TEX. REV. CIV. STAT. ANN. art. 4590: §§ 11.01-11.05 (Vernon Supp. 1985)); *Boyd v. Bulala*, 647 F. Supp. 781 (1986) (invalidating VA. CODE ANN. § 8.01-581.15 (1983)).

77. *Smith v. Department of Ins.*, 507 So. 2d 1080 (Fla. 1987) (invalidating FLA. STAT. ANN. § 768.80 (West 1986)).

78. See Shulte, *Availability, Affordability, and Accountability: Regulatory Reform of Insurance*, 14 FLA. ST. U. L. REV. 557 (1986).

79. LA. REV. STAT. ANN. § 40:129939 (West 1986). The change was a response to *Sibely v. Board of Sup'rs. of Louisiana*, 462 So. 2d 149 (La. 1985). In *Sibely*, the Louisiana Supreme Court upheld the constitutionality of the flat cap. The only issue the Court addressed concerned the constitutionality of the \$500,000 limit on recovery in medical malpractice cases. Liability had already been definitively established. At the time of the trial, the plaintiff's medical expenses already exceeded \$423,000. The injuries did not alter her life expectancy—she had been preparing for college at the time of the malpractice. After the malpractice, she would never achieve a significant degree of self sufficiency and faced the life-long costs of custodial care. *Id.*

the harshness of the strict "occurrence" rule in some situations? In which specific situations will the courts find that the doctrine of *respondet superior* applies to corporate health care providers? In cases where "qualified" health care providers are co-defendants with others who are not protected by the Act, how will the courts deal with the non-"qualified" defendants who are prejudiced by the delays necessary to keep all defendants in one case? What testimony and other evidence will carry plaintiff's burden to show the absence of any basis for apportioning damages caused by the defendant in cases involving pre-existing illness? In the face of rising costs of medical care, what adjustments should be made in the Act's limitations on damages for claimants? Each of these issues present fertile ground for future legislative initiative and judicial resolution regarding medical malpractice law in Indiana.

