Health Law Update: A Survey of Recent Developments in Indiana Law Governing Health Care Providers

J. Michael Grubbs*

During the survey period significant judicial and legislative developments added to the growing body of Indiana law governing health care providers. Judicial opinions addressed the issues of physician-hospital relations, the physician-patient privilege, and "patient-dumping." The Indiana General Assembly enacted statutes dealing with peer review privilege, access to medical records, and Medicaid provider sanctions for solicitation of out-of-state clients.

I. Judicial Opinions

A. Hospital Bylaw Provisions and Due Process

In *Friedman v. Memorial Hospital of South Bend*,[1] the court of appeals addressed the standard of review Indiana courts will apply in breach of contract cases based on a hospital's alleged lack of compliance with its bylaw provisions governing physician disciplinary hearing procedures. The case involved an appeal from a summary judgment entered in favor of the defendant hospital in an action brought by a physician who had been disciplined by the hospital.

Friedman's surgical performance had been the subject of two disciplinary hearings conducted by the Executive Committee of the hospital's Board of Directors which was acting in the capacity of a peer review committee. In the trial court Friedman first alleged that he had been denied due process of law because the hospital failed to notify him of the charges against him prior to the first hearing. The court of appeals noted that the trial court's finding that due process had been provided by the hospital was "irrelevant" because "absent some state action, the due process rights found within the fifth and fourteenth amendments are inapplicable" to private institutions.[2]

Based on prior appellate court decisions holding that medical staff bylaws create a contract between a hospital and its medical staff,[3] the

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* Associate, Locke Reynolds Boyd & Weisell, Indianapolis. B.A. DePauw University, 1977; M.B.A. Butler University, 1982; J.D. Indiana University School of Law - Indianapolis, 1987.

1. 523 N.E.2d 252 (Ind. Ct. App. 1988).

2. *Id.* at 253 (citing Pepple v. Parkview Memorial Hosp., Inc., 511 N.E.2d 467, 469 (Ind. Ct. App. 1987)).

3. Terre Haute Regional Hosp., Inc. v. El-Issa, 470 N.E.2d 1371 (Ind. Ct. App. 1984).

court of appeals confined its review to a provision in the hospital bylaws which were in effect at the time of the first disciplinary hearing. The bylaws stated that a practitioner requesting a hearing is entitled to notice of the "scheduled place, time, and date" of the hearing but did not require that the physician be notified of the pending changes.[4] The court found that the hospital had complied with its bylaws, because the bylaws did not literally require the hospital to notify the physician of the charges which were the basis for a hearing, although the court noted that "the better practice would be for the notice to contain such information."[5]

Prior to the second hearing, the hospital modified the bylaws by adding a provision which required that prior to a hearing the practitioner must be notified of the "alleged acts or omissions" in a notice containing "a list by number of the specific or representative patient records in question . . . ."[6] The notice of the second hearing sent to Friedman listed the patients by name rather than by number. In response to Friedman's claim that a breach of contract occurred because the hospital failed to comply with this bylaw provision, the court held that "[w]hile we agree that the notice failed to strictly comply with the by-laws in this regard, the standard is one of substantial compliance."[7] The court found that the hospital had substantially complied with its bylaws because the patient names supplied in lieu of record numbers permitted the physician to obtain and review the records of the cases which were the subject of the charges to be discussed at the hearing. Therefore, the court found the minor deviation from the bylaws caused no harm to the physician.

The articulation of a substantial compliance standard by the court appears to grant flexibility to hospitals in applying procedures established under their bylaws. The opinion also implies that the degree of flexibility will vary with each provision. The court's reliance on the lack of harm in selecting a substantial compliance standard in this case implies that in other cases strict compliance with hospital bylaw provisions involving physician discipline will be required if a physician can show harm was caused by even a minor deviation.

Another decision during the survey period involving a hospital-physician disciplinary action was *Pepple v. Parkview Memorial Hospital, Inc.*,[8] the third judicial opinion arising from a 1982 decision by a hospital

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4. *Friedman*, 523 N.E.2d at 253.
5. *Id.*
6. *Id.*
7. *Id.* at 254 (citing Terre Haute Regional Hosp., Inc. v. El-Issa, 470 N.E.2d 1371 (Ind. Ct. App. 1984)).
8. 536 N.E.2d 274 (Ind. 1989).

board of directors to limit the surgical privileges of one of its physicians.[9] In this opinion, the Indiana Supreme Court overruled in part an earlier court of appeals decision, *Kennedy v. St. Joseph Memorial Hospital*,[10] which permitted review of a private hospital's action under an arbitrary and capricious standard.[11]

The *Pepple* court held that, although the distinction between public and private hospitals has been "blurred by the influx of governmental funds and concerns for the public interest," private conduct is not subject to scrutiny under the fourteenth amendment's Due Process Clause "no matter how unfair that conduct may be."[12] The court held that the test is "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity that the action of the latter may fairly be treated as that of the State itself."[13]

In a footnote, the court noted with approval that Judge Ratliff's concurring opinion in *Kiracofe v. Reid Memorial Hospital*[14] discusses the evidence necessary to establish the nexus required to establish the presence of state action. The court found no state action in this case because no evidence had been offered to attempt to establish that the hospital's restriction of a licensed physician's surgical privileges constituted an act of the state.

B. Limits on Abrogation of the Physician-Patient Privilege Under Child Abuse Reporting Statutes

In *Daymude v. State*,[15] a local welfare department learned of an instance of suspected child abuse and filed a "child in need of services" petition[16] which resulted in court-ordered admission of the child to an

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9. Parkview Memorial Hosp., Inc. v. Pepple, 483 N.E.2d 469 (Ind. Ct. App. 1985) (peer review proceedings conducted by an *ad hoc* committee of physicians and the executive committee of the board of directors are subject to the confidentiality and privilege provisions of IND. CODE § 34-4-12.6-2 in general civil actions as well as medical malpractice actions); Pepple v. Parkview Memorial Hosp., Inc., 511 N.E.2d 467 (Ind. Ct. App. 1987) (due process clause does not apply to action between private hospital and physician).

10. 482 N.E.2d 268 (Ind. Ct. App. 1985).

11. *Pepple*, 536 N.E.2d at 276.

12. *Id.* (quoting from Justice Stephens' opinion in National Collegiate Athletic Association v. Tarkanian, 109 S. Ct. 454, 461 (1988)).

13. *Id.* (citing Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974)). The court also affirmed a prior Court of Appeals decision in Terre Haute Regional Hosp., Inc. v. El-Issa, 470 N.E.2d 1371 (Ind. Ct. App. 1984), holding that hospital staff bylaws can constitute a contract between a hospital and its staff. However, no breach of that contract was found in this case because all procedural rights provided in the bylaws were afforded to the physician.

14. 461 N.E.2d 1134, 1141-44 (Ind. Ct. App. 1984).

15. 540 N.E.2d 1263 (Ind. Ct. App. 1989).

16. IND. CODE § 31-6-4-10 (1988).

in-patient facility and the court-ordered counseling of the alleged victim, the alleged victim's mother, and the father of the alleged victim. During the course of a counseling session, the father disclosed instances of alleged sexual abuse of his child.[17]

Based on information unrelated to the disclosures to the counselor, the father was charged with child molesting,[18] criminal deviate conduct,[19] and incest.[20] The prosecutor sought to depose the counselor as to the content of communications made to the counselor by the alleged abuser.[21] In an opinion authored by Judge Baker,[22] the Court of Appeals for the First District reversed the circuit court, which had required the counselor to answer questions relating to the privileged confidential communications.

Although the case discusses the physician-patient privilege as it relates to the child abuse reporting statutes, the counselor was not a physician. The counselor was a certified clinical mental health counselor under contract with the hospital who counseled the father pursuant to a referral by the hospital's chief psychiatrist.[23] Turning to the issue whether the child abuse reporting statutes abrogate the physician-patient privilege, the court noted that the physician-patient privilege cannot be waived except by the patient.[24] Indiana Code section 34-1-14-5 provides in part that: "The following persons shall not be competent witnesses. . . . Physicians, as to matter communicated to them, as such, by patients, in the course of their professional business, or advice given in such cases, except as provided in IC 9-4-4.5-7."[25]

This privilege is in conflict with the child abuse reporting statute which provides that "*any individual* who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by statute."[26] In order to resolve the conflict, the legislature enacted Indiana Code section 31-6-11-8 which specifically abrogates certain legally recognized privileges when reporting child abuse. That provision states:

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17. 540 N.E.2d at 1264.
18. IND. CODE § 36-42-4-2 (1988).
19. *Id.* § 36-42-4-3.
20. *Id.* § 35-26-1-3.
21. 540 N.E.2d at 1264.
22. *Id.*
23. *Id.*
24. *Id.* at 1264-65.
25. IND. CODE § 34-1-14-5 (1988). *Id.* § 9-4-4.5-7 (1988) was repealed and replaced by IND. CODE ANN. § 9-11-4-6 (West Supp. 1989), which abrogates the privilege in cases involving chemical tests in criminal investigations under Title 9. IND. CODE ANN. § 34-1-14-5 (West Supp. 1989) was accordingly revised for corrective changes. Pub. L. No. 3-1989, Sec. 208, 1989 Ind. Acts 219.
26. IND. CODE § 31-6-11-3 (1988) (emphasis added).

> The privileged communication between a husband and wife, between a health care provider and that health care provider's patient, or between a school counselor and a student is not a ground for:
> (1) excluding evidence in any judicial proceeding resulting from a report of a child who may be a victim of child abuse or neglect, or relating to the subject matter of such a report; or
> (2) failing to report as required by this chapter.[27]

In a case of first impression, the *Daymude* court held that:

> The privileged communications were made long after the report of the child abuse. Since the abuse already had been reported, the purpose of the reporting statute had been fulfilled. To allow the abrogation of the privileged communication under these specific facts goes beyond the purpose of the statute.[28]

The court held that disclosures subsequent to the initial report of child abuse were privileged and not abrogated by the statute because the specific language of the child abuse reporting statute only deals with the duty to *report* suspected child abuse and the admissibility of evidence so obtained.[29]

C. "Patient-Dumping"

During the survey period, an Indiana court was called upon to interpret a relatively new federal statute which imposes a duty upon most hospitals to treat certain types of patients. The Consolidated Omnibus Reconciliation Act of 1986[30] ("COBRA") represents the most recent federal attempt to address a phenomenon known as "patient dumping," which is defined by some commentators as "the transfer of unstable patients or refusal to render emergency treatment to patients based on grounds unrelated to need or the hospital's ability to provide services," or "the refusal of a hospital to provide necessary treatment to an emergency patient or woman in active labor on a basis (primarily the inability to pay for services) unrelated to the hospital's capability to provide care or the patient's need for care."[31] COBRA's anti-dumping

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27. *Id.* § 31-6-11-8.
28. Daymude v. State, 540 N.E.2d 1263, 1268 (Ind. Ct. App. 1989).
29. *Id.*
30. Pub. L. No. 99-272, § 921, 100 Stat. 164 (1986) (codified at 42 U.S.C. 1395dd (1986)).
31. Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals, Medicare & Medicaid Guide (CCH) ¶¶ 37,436, 37,580 (Aug. 1988).

provisions, which are codified at 42 U.S.C. § 1395dd ("section 1395dd"), affect any hospital which participates in the Medicare program regardless whether the patient is a Medicare beneficiary.[32]

1. Duties Imposed by COBRA.—Under section 1395dd, if an individual goes to an emergency department and requests an examination or treatment, the hospital must "provide for an appropriate medical screening examination" to determine whether an emergency medical condition or active labor exists.[33] The hospital's obligation to "provide for" a medical screening examination is arguably met if, regardless of the patient's ability to pay, the hospital makes its facilities and personnel available to an emergency room physician in order that the physician may actually provide the examination.[34]

An emergency medical condition is defined as a condition which manifests:

> [A]cute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -
> (A) placing the patient's health in serious jeopardy,
> (B) serious impairment to bodily functions, or
> (C) serious dysfunction of any bodily organ or part.[35]

Active labor is present when delivery is "imminent," a safe transfer to another hospital cannot be effected prior to delivery, or a transfer "may pose a threat" to the health and safety of the mother or child.[36] If the medical screening examination reveals that an emergency medical condition or active labor is not present, the patient may be transferred without violating the statute.[37]

If, however, during the course of the medical screening examination the physician determines that an emergency medical condition or active labor exists, the hospital must either "provide for" stabilizing treatment or an appropriate transfer.[38] The amount of treatment which must be provided by the physician in order to "stabilize" the patient is defined as "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deteri-

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32. 42 U.S.C. § 1395dd(a)(e)(3) (Supp. V. 1988).
33. *Id.* § 1395dd(a).
34. *Id.*
35. *Id.* § 1395dd(e)(1).
36. *Id.* § 1395dd(e)(2).
37. *Id.*
38. *Id.* § 1395dd(b)(1); *see also id.* § 1395dd(e)(1) (emergency medical condition defined), 1395dd(e)(4) (stabilize defined), 1395dd(c)(2) (appropriate transfer defined).

oration of the condition is likely to result from the transfer of the individual from a facility."[39]

Once the patient's emergency medical condition or active labor is stabilized within the meaning of the statute, the patient may be transferred without violating section 1395dd. A transfer is defined as "the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital . . . ."[40] This definition is broad enough to permit a hospital to discharge a stabilized patient without effecting a transfer to another medical facility.

Patients who are in active labor and patients with emergency medical conditions who are not stabilized or cannot be stabilized with the resources available at the hospital may not be discharged and may only be transferred under certain conditions specified in section 1395dd. Such patients may be transferred if the patient or a legally responsible person acting on behalf of the patient requests a transfer.[41] These patients may also be transferred if the physician determines that "based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer . . . ."[42] Even if the physician determines that the benefits of transfer outweigh the risks of transfer, a written certification to that effect must be recorded in the patient's chart and an "appropriate transfer" must be arranged.[43]

The elements of an appropriate transfer specify that the receiving hospital must be contacted prior to the transfer to verify that the receiving hospital will agree to accept the patient and provide appropriate treatment, the medical records of the transferring hospital must be sent to the receiving hospital, and the transfer must be effected by using qualified transportation equipment staffed by personnel qualified to provide any life support procedures which may be "required" or "medically appropriate" during the transfer.[44]

Violations can result in suspension or termination of the hospital's Medicare provider agreement and civil money penalties levied against

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39. *Id.* § 1395dd(e)(4)(A).

40. *Id.* § 1395dd(e)(5).

41. *Id.* § 1395dd(c)(1)(A)(i).

42. *Id.* § 1395dd(c)(1)(A)(ii). If a physician is not "readily available" in the emergency department, other "qualified medical personnel" may make the necessary certification and arrange for an appropriate transfer. *Id.*

43. *Id.*; *see also id.* § 1395dd(c)(1)(B).

44. Patient Dumping After COBRA: Assessing the Incidence and the Perspectives of Health Care Professionals, Medicare & Medicaid Guide (CCH) ¶ 37,436 (Aug. 1988).

the hospital.[45] A hospital's knowing and willful or negligent violation of any of the provisions of Section 1395dd can result in suspension or termination, while only knowing violations can support a civil money penalty.

Certain physicians who are classified as "responsible physicians" are also subject to exclusion from Medicare participation and civil money penalties. A "responsible physician" is defined as a physician who:

> (i) is employed by, or under contract with, the participating hospital, and
> (ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.[46]

Responsible physicians are only subject to exclusion from Medicare or civil money penalties for knowing violations of section 1395dd.[47]

In addition to the administrative sanctions of suspension, termination and fines, civil suits by individuals are provided for in section 1395dd(d)(3)(A), which states:

> PERSONAL HARM. Any individual who suffers personal harm as a direct result of a participating hospital's violation of . . . [this statute] may, in a civil action against the . . . hospital, *obtain those damages available for personal injury under the law of the State in which the hospital is located*, and such equitable relief as is appropriate.[48]

Section 1395dd contains an additional civil enforcement provision available to a "medical facility." Section 1395dd(d)(3)(B) provides:

> FINANCIAL LOSS TO OTHER MEDICAL FACILITY. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in

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45. 42 U.S.C.A. § 1395dd(d) (West Supp. 1989).

46. *Id.* § 1395dd(d)(2)(C).

47. *Id.* 42 U.S.C.A. § 1395dd(d)(2)(B) permits the assessment of civil money penalties for knowing violations and 42 U.S.C.A. § 1395dd(d)(1) permits exclusion of physicians under 42 U.S.C. § 1395u(j)(2)(A) (Supp. V. 1988) only "[i]f a civil money penalty is imposed." The statute's definition of "responsible physicians" seems to include non-treating physicians who "have professional responsibility for" providing examinations or treatments. 42 U.S.C.A. § 1395dd(d)(2)(C) (West Supp. 1989).

48. 42 U.S.C.A. § 1395dd(d)(3)(A) (West Supp. 1989) (emphasis added).

> which the hospital is located, and such equitable relief as is appropriate.[49]

Therefore, a hospital that is "dumped on" may bring a civil action for monetary damages.

The relationship between the duties imposed by COBRA's anti-dumping provisions on hospitals which participate in Medicare to the duties which are already imposed on all hospitals and physicians under State laws is set out at section 1395dd(f), which states:

> PREEMPTION. The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement *directly conflicts* with a requirement of this section.[50] (Emphasis added.)

2. COBRA and the Indiana Medical Malpractice Act.—During the survey period, the third reported case in the nation involving section 1395dd, *Reid v. Indianapolis Osteopathic Medical Hospital*,[51] was decided here in Indiana. In *Reid*, the plaintiff's wife was seriously injured in an automobile accident and was transported to the emergency room at the defendant hospital. After initial treatment, arrangements were made to transfer her to another hospital where she later died.[52]

Instead of filing a proposed complaint of malpractice, plaintiff filed suit in federal court claiming that the defendant hospital had violated section 1395dd because it failed to provide "appropriate medical care" for his wife, failed to provide her with "necessary stabilizing treatment," and had transferred her in an unstable condition.[53] The defendant hospital moved to dismiss the complaint asserting that the plaintiff's allegations fell within the scope of the Indiana Medical Malpractice Act ("Act"). The hospital argued that the case should be dismissed because the plaintiff had not yet filed a proposed complaint with the Indiana Department of Insurance as required by the Act.[54] Although the court denied the defendant hospital's motion to dismiss, the opinion authored by Judge Barker went beyond the procedural issues to consider whether the Acts'

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49. *Id.* § 1395dd(d)(3)(B).

50. 42 U.S.C. § 1395dd(f) (Supp. V 1988).

51. 709 F. Supp. 853 (S.D. Ind. 1989). The first reported cases were Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490 (E.D. Pa. 1988) (section 1395dd creates a federal cause of action that can be pursued in federal courts), and Maziarka v. St. Elizabeth Hosp., [New Developments] Medicare & Medicaid Guide (CCH) ¶ 38,010 (E.D. Ill. 1989). Several administrative enforcement actions are also in process. *See* Inspector General v. Burditt, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 38,027 (July 28, 1989).

52. *Reid*, 709 F. Supp. at 853.

53. *Id.*

54. *Id.* at 854.

cap on damages applies to section 1395dd claims and the "standard of care" in such cases.

The court refused to accept the defendant's argument that Indiana's procedural limitations on medical malpractice actions create a bar to federal court jurisdiction under section 1395dd.[55] The court found that even if Congress had intended to incorporate state limitations on patient dumping claims, Section 1395dd would still preempt the medical review panel procedures of the Indiana Act because of a "direct conflict" between them as to when a cause of action arises.[56] The Act provides that no cause of action arises until after the medical review panel renders an opinion, whereas the anti-dumping statute provides a cause of action arises whenever "[a]ny individual . . . suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section. . . ."[57]

Although no further comment was required to dispose of the defendant hospital's motion to dismiss for lack of subject matter jurisdiction, the court found another area of conflict when it stated that section 1395dd is "based on a strict liability standard."[58] The court reasoned that even if a medical review panel "were permitted to screen" complaints alleging violations of section 1395dd prior to commencing an action in federal court, a medical review panel's negligence determination "would, at best, be totally irrelevant . . . [and] [a]t worst . . . 'directly conflict' with the strict liability standards of the federal statute."[59] Presumably, if a plaintiff chooses to file both a civil enforcement suit in federal or state court based on an alleged violation of Section 1395dd *and* a complaint with the Department of Insurance for alleged medical malpractice arising from the same facts, then this dicta suggests that the opinion of the medical review panel would either be irrelevant to the section 1395dd issue or be preempted by the same.

Despite the procedural conflicts found by the court, the court found no barrier which prevented the application of the Act's cap on damages to section 1395dd civil enforcement suits. Plaintiff argued that section

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55. *Id.* at 854 n.1 (citing Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490 (E.D. Pa. 1988)).

56. *Id.* at 854-55.

57. 42 U.S.C. 1395dd(d)(3)(A) (Supp. V 1988).

58. *Reid*, 709 F. Supp. at 855. It is unclear from the opinion whether the defendant hospital conceded that strict liability is the "standard" to be applied under section 1395dd. In response to the defendant hospital's motion to dismiss, the plaintiff argued that the Indiana Medical Malpractice Act is preempted by the federal statute because of a "direct conflict" between the two acts. Plaintiff's perceived conflict was based on his interpretation that section 1395dd employs a strict liability standard which "directly conflicts" with the negligence standard applied under the Act.

59. *Id.*

1395dd(d)(3)(A)'s reference to "those damages available for personal injury" should not be read as "those damages available for personal injury [due to medical malpractice]"[60] and therefore the Act's cap on the *amount* of damages recoverable in an action for medical malpractice does not apply to a civil enforcement suit under section 1395dd.[61]

The court stated that the legislative history of section 1395dd was "completely silent" as to whether Congress intended state medical malpractice caps to apply to a civil enforcement suit under section 1395dd.[62] The court, however, relied on the legislative history of section 1395dd for the proposition that because Congress was "clearly aware of a growing concern in some states that excessive damage awards were fueling a medical malpractice 'crisis'," Congress "apparently wished to preserve" state medical malpractice caps by choosing to incorporate "those damages available for personal injury under the law of the state" when it enacted Section 1395dd.[63] The court also noted that it was unaware of any state which had limited the amount of damages recoverable in personal injury suits other than medical malpractice actions.[64] The court concluded that unless section 1395dd was read to incorporate the Act's cap on the amount of damages, the phrase "those damages available for personal injury under the law of the state" would be rendered meaningless.[65]

The court construed the reference in section 1395dd to "those damages" to refer to the "amount" of damages recoverable.[66] It then held that a civil enforcement suit under section 1395dd seeking damages for personal injury is subject to the Act's "substantive limitation on the maximum amount recoverable for personal injury from a health care provider"[67] because "the amount of damages that would be 'available' for a personal injury claim against a health care provider would be *only* those damages available under [the] medical malpractice statute itself."[68]

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60. *Id.*
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.* at 856. The court ordered that "all future action in this case relating to *the measure of plaintiff's damages under the Act*, if any, shall be subject to the analysis and holding in this entry." (emphasis added). *Id.*
68. *Id.* at 855 (emphasis in original). The Act limits civil damages in actions against "qualified" health care providers to $100,000. IND. CODE § 16-9.5-2-2(b) (1988). A "qualified" provider is one who files proof of malpractice insurance coverage with the Department of Insurance. *Id.* § 16-9.5-2-1. Plaintiffs who recover the maximum civil damage award may file a claim for additional damages up to $400,000 against the Patient's Compensation Fund. *Id.* § 16-9.5-2-2(d).

3. Implications of Reid.—The court's opinion in *Reid* will undoubtedly be of great concern to hospitals and their counsel who desire to ensure that hospital emergency room triage and transfer procedures do not run afoul of the anti-dumping statute. Despite the fact that the discussion of strict liability as the proper "standard" to be applied is merely dicta because the opinion was limited to a ruling on the defendant hospital's motion to dismiss, the court implied that strict liability is a "standard" to be applied in civil suits arising under section 1395dd.

A strict liability statute is defined as a statute "which imposes criminal sanction for an unlawful act without requiring a showing of criminal intent."[69] Under section 1395dd's administrative enforcement provisions, intent must be shown because the termination/suspension sanctions may only be imposed on a hospital which "knowingly and willfully, *or negligently*" violates the statute[70] and the civil money penalty sanctions may be levied only if a hospital "knowingly violates" the statute.[71] The "knowingly and willfully, or negligent" element precludes the ultimate penalty of termination or suspension of a hospital's Medicare provider agreement unless the administrative agency can prove either that the statute was violated with criminal intent or that the duties imposed by the statute were breached. A breach may occur, for example, where the medical screening examination which was provided was not appropriate or the treatment provided was not sufficient to stabilize the patient before the patient was transferred. The lesser sanction of civil fines can be imposed if the duties imposed by the statute were unintentionally breached.

The administrative enforcement provisions of the statute are clearly not part of a strict liability statutory scheme because Congress provided that administrative agencies must meet the burden of showing that a violation of section 1395dd was either an intentional or negligent act in order to impose an administrative sanction. The only difference between the civil enforcement provision and the administrative enforcement provisions is that the civil enforcement provision contains no reference to either criminal intent or negligence. It is presumably the omission of this language which caused the court in *Reid* to label the civil enforcement provision a strict liability provision.

The omission of language regarding the intent of a physician or hospital to violate the provisions of section 1395dd or language regarding the applicable standard of care has been cited by at least one commentator as the basis for using statutory construction principles to conclude that

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69. BLACK'S LAW DICTIONARY 1275 (5th ed. 1979).
70. 42 U.S.C.A. § 1395dd(d)(1) (West Supp. 1988).
71. *Id.* § 1395dd(d)(2)(A).

Congress intended that strict liability apply in civil enforcement cases.[72] Section 1395dd does not, however, change the standard of care applicable to certain physicians and hospitals merely because they participate in the Medicare program. Strict liability is not a standard of care; it is a theory of liability imposed on sellers of defective or hazardous products.[73] Liability for the provision of substandard care and treatment to emergency room patients by *any* physician or hospital is governed by common-law negligence and statutory medical malpractice concepts regardless of whether the physician or hospital participates in the Medicare program.

Section 1395dd merely creates some duties which previously were not imposed on physicians and hospitals which participate in Medicare. Whereas before the enactment of section 1395dd participating hospitals were under no duty to treat all patients, section 1395dd now requires that two classes of persons be treated: women in active labor and persons with emergency medical conditions.[74] Once the person has been accepted for a medical screening examination or treatment, section 1395dd actually imposes few duties that are not already imposed on all hospitals. After the enactment of section 1395dd, medical screening examinations must now be provided upon the request of any person who comes to the emergency department of a participating hospital.[75] Transfers and discharges of certain patients can only be made after a physician either treats the patient or documents the reasons for deciding on transfer or discharge.[76] The written reasons must include an assessment of the risks of transfer versus the benefits of treatment elsewhere.[77] Hospitals must get receiving hospitals to agree to accept patients and records must be sent with the patient.[78]

Apart from the new duties imposed on some physicians and hospitals, section 1395dd does not change the standard of care against which all hospitals and physicians are judged when treating patients who are accepted for treatment. Questions such as whether a hospital provided for, or whether a physician performed, "an appropriate medical screening;"[79] whether in the course of performing such a screening a physician failed to detect the presence of an "emergency medical condition" or "active labor;"[80] whether a hospital provided for and a physician per-

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72. McClurg, *Your Money or Your Life: Interpreting The Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 208 (1989).
73. BLACK'S LAW DICTIONARY 1275 (5th ed. 1979).
74. 42 U.S.C. § 1395dd(b)(1) (Supp. V 1988).
75. *Id.* § 1395dd(a).
76. *Id.* § 1395dd(b)(1).
77. *Id.* § 1395dd(c)(1)(A)(ii).
78. *Id.* § 1395dd(c)(2).
79. *Id.* § 1395dd(a).
80. *Id.* § 1395dd(e)(1)-(2).

formed a "medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor;"[81] and whether a physician properly certified that "the medical benefits reasonably expected from provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer,"[82] can only be answered by expert testimony as to what a reasonable physician or hospital would have done under the same or similar circumstances. If expert testimony establishes that the physician or hospital provided substandard care and treatment, the duty to provide care and treatment in accordance with the standard of care has been breached.[83] If that breach was a proximate cause of the plaintiff's injuries, the plaintiff has a claim under either state medical malpractice statutes, section 1395dd, or both, depending on the source of the underlying duty.

If section 1395dd is viewed as simply creating new duties, breaches of which can only be proved by expert testimony as to the standard of care applicable to hospitals and physicians, the civil enforcement provision merely creates a negligence *per se* theory of liability.[84] A negligence *per se* theory is consistent with the court's holding that "the amount of damages that would be 'available' for a personal injury claim against a health care provider would be *only* those damages available under [the] medical malpractice statute itself."[85] The Act defines "malpractice" as a "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."[86] The Act defines "tort" as "any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another."[87] This definition is broad enough to encompass intentional or negligent violations of federal statutory provisions such as Section 1395dd.

The recent Illinois case of *Maziarka v. St. Elizabeth Hospital*[88] illustrates how another court interpreted that state medical malpractice law and section 1395dd were intended to be applied together. In *Maziarka* the plaintiff sought actual damages, an injunction requiring the hospital

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81. *Id.* § 1395dd(b)(1)(A).

82. *Id.* § 1395dd(c)(1)(A)(ii).

83. *See* Inspector General v. Burditt, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 35,027 (July 28, 1989).

84. *See* McClurg, *supra* note 70, at 209-10.

85. Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F. Supp. 853, 855 (S.D. Ind. 1989) (emphasis in original).

86. IND. CODE § 16-9.5-1-1(h) (1988).

87. *Id.* § 16-9.5-1-1(g).

88. [New Developments] Medicare & Medicaid Guide (CCH) ¶ 38,010 (E.D. Ill. 1989).

to comply with Section 1395dd, and punitive damages.[89] The *Maziarka* court found that Illinois law does not permit the recovery of punitive damages in medical malpractice cases.[90] The court dismissed plaintiff's claim for punitive damages despite plaintiff's assertion that the action was not a malpractice claim but rather a claim "for a violation of a statute which provides its own basis for relief."[91] The court ruled that "the only claim plaintiff could have against defendants under the law of Illinois is for medical malpractice. . . ."[92]

The holding in *Maziarka* illustrates that a civil enforcement suit under section 1395dd is a species of medical malpractice. It also provides additional insight into the interpretation of the phrase "those damages available under the personal injury law of the state." The *Reid* court interpreted "those damages" to refer to the *amount* of damages which are recoverable.[93] The *Maziarka* court found that "those damages" also refers to the *type or character* of damages, *e.g.*, punitive damages, consequential damages, *etc.*[94] The opinions in *Reid* and *Maziarka* both recognize that Congress clearly intended for state and federal courts to look to the medical malpractice law of the state to supply the answers to such questions as whether state malpractice caps apply and what types of damages are recoverable.

The relationship between section 1395dd and the Indiana Medical Malpractice Act raises an interesting dilemma for both plaintiffs and courts in *Reid* and its progeny. The plaintiff in *Reid* will clearly be limited to a maximum recovery of $100,000 if a trial on the merits finds that a breach of the duties imposed by Section 1395dd was the proximate cause of his wife's damages. A subsequent claim against the Patient Compensation Fund will be barred by the Act,[95] however, because no complaint has been filed with the Department of Insurance.

On the other hand, if the plaintiff in *Reid* had also filed a proposed complaint with the Department of Insurance alleging medical malpractice arising from the acts which led to his wife's death, the two year statute of limitations applicable to Section 1395dd would have been tolled and the plaintiff could have ultimately recovered damages of up to $500,000. Although the *Reid* court has analyzed section 1395dd(d)(3)(A) as a strict

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89. *Id.*
90. *Id.*
91. *Id.*
92. *Id.*
93. Reid v. Indianapolis Osteopathic Medical Hosp., Inc., 709 F. Supp. 853 (S.D. Ind. 1989).
94. *Maziarka*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 38,010 (E.D. Ill. 1989).
95. IND. CODE § 16-9.5-1-1 (1988).

liability statute which renders the expert testimony of a medical review panel as "irrelevant," a panel could clearly render an opinion as to whether the statutory duties have been breached. This opinion would be as relevant as the opinion of any other expert. While the filing of a proposed complaint with the Department of Insurance is clearly not required after *Reid*, no direct conflict with section 1395dd is created by filing claims in either state or federal court *and* with the Department of Insurance.

Although "patient dumping" is a new and unfamiliar territory for Indiana courts, practitioners involved in future proceedings should carefully examine the relationship between Section 1395dd and the Indiana Medical Malpractice Act in order to fill the gaps left open by Congress.

II. Legislative Developments

A. Peer Review Legislation

Public Law 292-1989 (Senate Enrolled Act ("SEA") 240)[96] extends the applicability of the Indiana Peer Review Statute and also permits the Attorney General to obtain records of privileged communications in certain circumstances.

Section 1 of SEA 240 adds community mental health centers and private psychiatric hospitals to the list of "professional health care providers and organizations" covered by the Act.[97] A "peer review committee" covered by the Act now also specifically includes committees organized by the governing board of a hospital or professional health care organization, a hospital medical staff, or a governing board of a preferred provider organization or prepaid health care delivery plan.[98]

The scope of privileged communications is also broadened by expansion of the definition of "evaluation of patient care" to include a peer review committee's assessment of "quality" care.[99]

Section 2 provides that waivers of the evidentiary privilege may now be executed on behalf of the peer review committee in favor of the Attorney General for the purpose of conducting an investigation under Indiana Code section 25-1-7, provided that the information so released must be kept confidential except to the extent that the information is otherwise discoverable from original sources such as personal knowledge

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96. 1989 Ind. Acts 2008 (codified at Ind. Code Ann. § 34-4-12.6 (West Supp. 1989)).

97. Ind. Code Ann. § 34-4-12.6-1 (West Supp. 1989).

98. *Id.* § 34-4-12.6-1(c)(1). This statute codifies the Court of Appeals holding in Parkview Memorial Hosp., Inc. v. Pepple, 483 N.E.2d 469 (Ind. Ct. App. 1985).

99. Ind. Code Ann. § 34-4-12.6-1(b)(2) (West Supp. 1989).

of a committee member or one who has testified before the committee.[100] This section also provides for the issuance of subpoenas by the Attorney General to obtain applications for staff privileges or applications for employment completed by professional staff members, incident reports documenting the circumstances of "an accident or unusual occurrence involving a professional staff member" which are not prepared as part of a peer review committee investigation, and information otherwise discoverable from original sources.[101]

Section 3 now enumerates the "legitimate internal business purposes" for which information obtained by the committee may be used, including: quality review and assessment; utilization review and management; risk management and incident reporting; safety, prevention, and correction; reduction of morbidity and mortality; scientific, statistical, and educational purposes, and; legal defense.[102]

The exception to the peer review privilege providing for investigations by the Attorney General under Indiana Code section 25-1-7 and for the legal defense of the hospital constitute a new limit on a privilege which courts have traditionally held to be absolute. In *Terre Haute Regional Hospital v. Badsen*,[103] the court of appeals refused to impose any limitations on the privilege when it ruled that even communications made in bad faith are privileged under the statute. The court reasoned that access to such information would derogate the quality of the peer review process which is designed to:

> [f]oster an effective review of medical care. An effective review requires that all participants to a peer review proceeding communicate candidly, objectively, and conscientiously. Absent the protection of a privilege, the candor and objectivity of peer review communications and the effectiveness of the peer review process would be hindered. Thus, the peer review privilege provides protection by granting confidentiality to all communications, proceedings, and determinations connected with a peer review process.[104]

It remains to be seen whether the newly created exceptions to the peer review privilege will inhibit the candor and objectivity of peer review communications.

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100. *Id.* § 34-4-12.6-2(j).

101. *Id.* § 34-4-12.6-2(k).

102. *Id.* § 34-4-12.6-4.

103. 524 N.E.2d 1306 (Ind. Ct. App. 1988).

104. *Id.* at 1311. This holding by the First District of the Court of Appeals was followed by the Third District in Frank v. Trustees of Orange County Hosp., 530 N.E.2d 135 (Ind. Ct. App. 1988).

B. Release of Medical Records

Public Law 291-1989 (Senate Enrolled Act ("SEA") 270)[105] revises the method in which a hospital is required to respond to subpoenas or court orders requiring the production of hospital medical records of patients which contain information regarding alcohol and drug abuse treatment, treatment for mental illness, and treatment for communicable diseases including HIV infections and confirmed cases of AIDS.[106] Records containing such information are confidential under the provisions of either federal or state laws.[107]

Upon receiving either a subpoena or court order requiring the production of records containing information in one of these three categories, the hospital employee with custody of the original medical records is now required to execute a verified affidavit identifying the record or part of the record that is confidential.[108] The affidavit must also state that the confidential material will only be produced under "federal procedure" in the case of alcohol or drug abuse records or pursuant to a court order after *in camera* review in the case of records containing information regarding treatment for mental illness or treatment for communicable disease including HIV infections and confirmed cases of AIDS.[109]

Under prior law, a verified affidavit was used only when the hospital did not have all or part of a particular medical record requested.[110] Preparation of the required affidavit did not indicate the existence of confidential information as to alcohol/drug abuse, mental illness, or communicable diseases. On the other hand, hospitals were without any guidance as to the proper method of response to a subpoena or court order requiring the production of a record in its possession which contained confidential information regarding these highly sensitive areas.

SEA 270 attempts to provide a vehicle for hospitals to respond to such requests for production in a manner that does not require the preparation of motions to quash or other documents that normally require the assistance of counsel. Although the statute is well-intentioned, at

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105. 1989 Ind. Acts 2004 (codified at IND. CODE ANN. § 34-3-15.5 (West Supp. 1989)).

106. IND. CODE ANN. § 34-3-15.5-6(f) (West Supp. 1989) (alcohol and drug abuse treatment); *id.* § 34-3-15.5-6(g) (treatment of mental illness); *id.* § 34-3-15.5-6(h) (treatment of communicable disease, HIV infection, and confirmed cases of AIDS).

107. *See* 42 U.S.C. § 290dd-3 (Supp. V 1988) (alcohol treatment); *id.* § 290ee-3 (drug abuse treatment); *id.* § 16-14-1.6-8(b); *id.* § 16-14-1.6-8(f) (treatment for mental illness or developmental disabilities); *id.* § 16-1-9.5-7 (treatment for communicable disease, HIV infection, or a confirmed case of AIDS).

108. IND. CODE ANN. § 34-3-15.5-6(a) (West Supp. 1989).

109. *Id.* § 34-3-15.5-6(f)-(h).

110. IND. CODE § 34-3-15.5-6(e) (1988).

least in the area of records containing information regarding federally funded treatment for alcohol or drug abuse, hospitals responding to subpoenas or court orders by submitting the affidavit required by the statute may unwittingly violate federal regulations.

The confidentiality provisions of title 42 of the United States Code, sections 290dd-3 (alcohol abuse treatment) and 290ee-3 (drug abuse treatment), are implemented by part 2 of title 42 of the Code of Federal Regulations which imposes penalties upon individuals or entities that disclose confidential information regarding alcohol or drug abuse treatment in a manner that fails to comply with the regulations.[111] Any hospital which provides substance abuse diagnostic, treatment, or referral services and which also receives federal assistance funds, including Medicare or other financial assistance, even though those funds are not used to pay for the diagnosis, treatment or referral of substance abuse patients, is subject to the restrictions on disclosure of information regarding treatment for substance abuse.[112]

Under the federal regulations, a response by a facility to a subpoena or court order which implies that the patient has been treated for substance abuse is an impermissible disclosure.[113] Disclosure of "any information which would identify a patient as an alcohol or drug abuser" is prohibited.[114] Covered information includes "any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with [or for the purpose of] the treatment or referral for treatment of alcohol or drug abuse" even if the information is never utilized in treatment or referral.[115]

Disclosure of information is permitted only with specific written consent[116] of the patient or pursuant to a court order which has been issued after a proceeding in which the court has found that sufficient cause exists to require production of the records such as to either protect third parties against an existing threat to life or serious bodily harm or to prosecute someone charged with an "extremely serious crime" such as homicide, rape, kidnapping, armed robbery, assault with a deadly

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111. Any person who violates any provision of 42 C.F.R. Part 2 or the enabling statutes "shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense." 42 C.F.R. § 2.4 (1988).

112. *Id.* § 2.12. Any entity that holds itself out as providing substance abuse services which also receives federal assistance in any form is also covered.

113. *Id.* § 2.12(e).

114. *Id.* § 2.12(e)(3).

115. *Id.* § 2.12(e)(4).

116. *Id.* § 2.31 (form of written consent). Disclosures made pursuant to a proper written consent must be accompanied by a notice prohibiting redisclosure. *Id.* § 2.32 (specific language required for restriction on redisclosure).

weapon, or child abuse and neglect.[117] A court may also order disclosure if it finds that the patient has offered testimony or other evidence in a civil or administrative proceeding regarding the contents of the confidential communication.[118] It is clear from the limitations on court ordered disclosure set out in the regulations that many confidential communications will remain beyond the reach of a court order. It is also clear that until the required judicial proceedings have been held, no records or patient identifying information can be released.

The regulations specifically address the manner in which a hospital should respond to a request for disclosure that is not permitted by the regulations. The hospital must initially assume that even subpoenas and court orders are requesting disclosure in an impermissible manner since the restrictions on disclosure apply "whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations."[119] The mere fact that a subpoena has been issued or a court order has been obtained does not assure the hospital that the procedures required by the regulations were complied with in obtaining the subpoena or court order. In fact, the regulations specify that before a proper order can be issued, the keeper of the records must be given an opportunity to appear and respond to an application for the issuance of the order to produce the documents.[120]

Accordingly, the regulations specify that:

> Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. *An inquiring party* may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but *may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.* The regulations do not restrict a disclosure

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117. *Id.* § 2.63. The preamble to the final regulations stated the rationale for this procedure:

> Our aim is to strike a balance between absolute confidentiality for "confidential communications" on one side and on the other, to protect against any existing threat to life or serious bodily harm to others and to bring to justice those being investigated or prosecuted for an extremely serious crime who may have inflicted such harm in the past. 52 Fed. Reg. 21,796, 21,802 (June 9, 1987).

118. 42 C.F.R. § 2.63(a)(3) (1988).

119. *Id.* § 2.13(b).

120. *Id.* §§ 2.64(b), 2.65(b).

that an identified individual is not and never has been a patient.[121]

The required federal procedure for responses to requests for disclosure of records containing confidential alcohol/drug abuse information prohibits the use of an affidavit such as the one now required under Indiana Code section 34-3-15.5-6(f)(1)(B) because an affidavit citing the federal alcohol/drug information confidentially statutes identifies the individual whose records have been requested as an alcohol/drug abuser. The Indiana statute imposes a duty on a hospital that receives a subpoena duces tecum or court order requiring the production of medical records for a particular individual to first determine whether the records contain information related to substance abuse which is confidential under federal law.[122] If the hospital determines that confidential information regarding substance abuse is contained in the records, it must submit a verified affidavit "stating that the confidential record or part of the record will only be provided under the federal procedure for production of the record."[123]

The Indiana statute's requirement that the hospital must reply that production of the record is subject to federal restrictions directly conflicts with the regulatory prohibition against affirmatively stating that federal regulations restrict the disclosure of the records of an identified patient. The very act of complying in the manner specified in the newly amended Indiana statute violates the federal procedures and may subject the hospital and its personnel to penalties.

C. Solicitation of Out-of-State Residents by Medicaid Providers

House Enrolled Act 1270 was enacted out of a concern by legislators that Indiana Medicaid providers were actively soliciting out-of-state residents and thereby increasing the Medicaid burden on Indiana taxpayers. Indiana Code section 12-1-7-16.2 was added by the Act which defines "solicitation" as:

> [a] direct communication initiated by a provider doing business in Indiana to an individual or a provider in another state with the intent of inducing a nonresident of Indiana to relocate the person's residence to Indiana for the purpose of obtaining medical assistance under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).[124]

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121. *Id.* § 2.13(c)(2) (emphasis added).
122. IND. CODE ANN. § 34-3-15.5-6(f) (West Supp. 1989).
123. *Id.*
124. *Id.* § 12-1-7-16.2(a).

The Act states that: "A provider licensed by the state and doing business in Indiana may not make a solicitation to a person who is eligible for medical assistance under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.)."[125]

A provider may "market" or "advertise" its services to the general public including the fact that it offers special services such as services to ventilator-dependent patients, AIDS patients, Alzheimer's disease patients, and children.[126] The Act does not, however, specify whether these enumerated permissive acts include marketing or advertising outside the state.

Violations of this particular provision of the Act can result in the denial of payment for *all* services provided during a specified period of time, termination of the provider agreement, or fines of three times the amount of reimbursement received by the provider plus interest.[127]

D. Unauthorized Practice of Medicine

Public Law 237-1989 (Senate Enrolled Act ("SEA") 289)[128] amends Indiana Code section 25-22.5-1-2, which governs the unauthorized practice of medicine. Subsection (a) of this provision formerly excluded certain persons and entities from the application of the statute.[129] SEA 289 adds to the list of exclusions several previously omitted entities, including hospitals licensed under Indiana Code sections 16-10-1 and 16-13-2 (psychiatric hospitals). Also excluded under the new Act are organizations such as corporations, facilities, or institutions "licensed or legally authorized by this state to provide health care or professional services" in any of the health professions.[130]

The exclusion extended to these entities is ostensibly limited by new subsection (c) which prevents these entities from exercising control over the medical judgment of individual practitioners:

> An employment or other contractual relationship between an entity described in subsection (a)(20) through (a)(21) and a licensed physician does not constitute the unlawful practice of medicine under this article if the entity does not direct or control

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125. *Id.* § 12-1-7-16.2(b).

126. *Id.* § 12-1-7-16.2(c).

127. *Id.* § 12-1-7-15.3.

128. 1989 Ind. Acts 1755 (codified at IND. CODE ANN. § 25-22-5-1-2 (West Supp. 1989)).

129. IND. CODE § 25-22.5-1-2(a) (1988), *amended by* IND. CODE ANN. § 25-22.5-1-2 (West Supp. 1989).

130. Pub. L. No. 237-1989, Sec. 1, 1989 Ind. Acts 1755.

> independent medical acts, decisions, or judgment of the licensed physician.[131]

Even with this apparent restriction against the corporate practice of medicine, if direction or control over a physician's medical judgment is exercised by the entity under the umbrella of a peer review committee such control is expressly excluded from the definition of the unauthorized practice of medicine.

New subsection (d) states that:

> This subsection does not apply to a prescription or drug order for a legend drug that is filled or refilled in a pharmacy owned or operated by a hospital licensed under IC 16-10-1. A physician licensed in Indiana who permits or authorizes a person to fill or refill a prescription or drug order for a legend drug except as authorized in IC 16-6-8-3 is subject to disciplinary action under IC 25-1-9. A person who violates this subsection commits the unlawful practice of medicine under this chapter.[132]

Section 2 of SEA 289 makes the act of misrepresenting oneself as a physician with the intent to defraud a misdemeanor under Indiana Code section 35-43-5-3.

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131. IND. CODE ANN. § 25-22.5-1-2(c) (West Supp. 1989).
132. *Id.* § 25-22.5-1-2(d).