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Andrew C. Mallor
Applegate and Pratt

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ANDREW C. MALLOR*

In recent years negligence lawyers have been castigated as the villains of the malpractice problem.[1] In 1975, a full page newspaper advertisement was placed by the medical staff of a county hospital soliciting public support for legislation abolishing the contingency fee system, the legal doctrines of informed consent and res ipsa loquitur, and the availability of punitive damages in malpractice actions.[2] Responsibility for the malpractice crisis was placed on the plaintiffs' bar and the court system.[3] In truth, the malpractice problem cannot be resolved by narrowly focusing on the legal system. The malpractice problem is complex and far reaching, and easy solutions simply do not exist.

This article will analyze the Indiana Medical Malpractice Act insofar as it affects the rights and interests of the plaintiff in a malpractice action. Special emphasis will be placed on the effects of the Indi-

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*B.A. 1971, J.D. 1974, Indiana University; Associate: Applegate and Pratt, Bloomington, Indiana.

[1] *See, e.g.*, 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 1.03 (1973) [hereinafter cited as LOUISELL & WILLIAMS]; Caswell, *A Surgeon's Thoughts on Malpractice*, 30 TEMP. L.Q. 391 (1957); Hamacher, *Toward an Effective Attorney-Physician Relationship*, 4 GONZAGA L. REV. 45 (1968); Oleck, *A Cure for Doctor-Lawyer Frictions*, 7 CLEV.-MAR. L. REV. 473 (1958).

[2] TODAY, March 9, 1975, reprinted in 2 THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA, QUALITY MEDICAL CARE—THE PATIENT'S RIGHT 1081 (1975) [hereinafter cited as ATLA]. One leading plaintiff's attorney, Barry D. Goldberg of Goldberg and Goldberg, Chicago, Illinois, has responded to similar complaints against the legal system by suggesting the following as possible long term solutions to the problem:

1. Stringent controls upon doctors and hospitals to prevent unnecessary surgeries and improper use of prescription drugs.
2. Stricter policing of the medical profession.
3. Insurance coverage must be made available to qualified doctors at reasonable rates, and, if necessary, through mandatory reinsurance or assigned risk programs.
4. Preservation of the contingency fee.
5. Preservation of the doctrine of informed consent and res ipsa loquitur as well as a liberal and realistic statute of limitations.
6. Eliminate ad damnums publication of prayers and other verdicts.
7. Eliminate the required consent of defendant before settlement.

Goldberg, ILLINOIS INSTITUTE FOR LEGAL EDUCATION, MEDICAL MALPRACTICE Introduction (1975).

[3] *See, e.g.*, Stetler, *Medical-Legal Relations—The Brighter Side*, 2 VILL. L. REV. 487, 488-89 (1957). The antagonism between the medical and legal professions has been discussed in many articles. *See* sources cited note 1 *supra*.

ana Medical Malpractice Act in aiding or retarding the plaintiffs' bar in seeking redress for injuries caused by medical malpractice.

THE ROLE OF PLAINTIFFS' BAR IN THE MALPRACTICE CRISIS

The Indiana Medical Malpractice Act was promulgated with an emergency clause making the effective date July 1, 1975.[4] The nature of the emergency is not articulated in the Act. However, the malpractice problem has generally been defined in terms of the inability of health care providers to purchase professional liability insurance at reasonable rates.[5] The premiums that health care providers must pay for this insurance have increased significantly, supposedly because of the drastic rise in the number of malpractice actions filed each year.[6]

The apparent increase in malpractice litigation was first comprehensively studied in 1969 by the Subcommittee on Executive Reorganization of the United States Senate.[7] The introductory statement, authored by Chairman Abraham Ribicoff, is a concise and articulate discussion of the malpractice problem. Gathering data from lawyers, health care providers, insurance companies, and the Department of Health, Education and Welfare, the Committee reached several conclusions concerning the malpractice crisis.[8] The Committee concluded, *inter alia,* that the majority of the malpractice claims were justifiable, resulting from injuries suffered by patients during medical treatment or surgery.[9] The Committee also found that the plaintiffs' bar adequately screened

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[4] IND. CODE § 16-9.5-1-1 *et seq.* (Burns Supp. 1975) [hereinafter referred to as the Act].

[5] *See* STAFF OF SUBCOMM. ON EXECUTIVE REORG. OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 12 (Comm. Print 1969) [hereinafter cited as MEDICAL MALPRACTICE]; Bernzweig, *The Malpractice Problem: The Need for a Perspective,* statement to a meeting convened by the Secretary of Health, Education & Welfare to discuss the malpractice crisis, reprinted in ATLA at 61.

[6] *See, e.g.,* Averbach, *Rx for Malpractice,* 19 CLEV. ST. L. REV. 20, 21 (1970); Winikoff, *Medical-Legal Screening Panels As An Alternative Approach to Malpractice Claims,* 13 WM. & MARY L. REV. 695, 702 (1972); Note, *Malpractice Suits: The Increased Cost of Health Care,* 8 TULSA L.J. 223 (1972).

[7] *See* MEDICAL MALPRACTICE. *See also* Winikoff, *supra* note 6, at 695.

[8] MEDICAL MALPRACTICE at 1-2. *See also* Winikoff, *supra* note 6 at 703, 709; Note, *Comparative Approaches to Liability for Medical Maloccurrences,* 84 YALE L.J. 1141, 1141 n.6 (1975).

[9] MEDICAL MALPRACTICE at 1. *See also,* Project, *The Medical Malpractice Threat: A Study of Defensive Medicine,* 1971 DUKE L.J. 939; Malpractice Cost Driving Doctors Off, New York Times, Oct. 5, 1974, at 12.

the majority of claims.[10] Nevertheless, the number of claims filed has risen markedly.[11]

The increased number of claims made for malpractice is certainly a factor in the increased cost of professional liability insurance.[12] However, the majority of these costs do not inure to the injured plaintiff, nor to the plaintiff's attorney, but rather are costs of defense.[13] As a general rule, a malpractice action, due to the need to present expert testimony, will be far more expensive, both to prosecute and to defend, than most personal injury actions. Furthermore, the malpractice claim takes longer for resolution than most personal injury claims.[14] Many physicians, by refusing to cooperate with plaintiffs' attorneys in investigating the claim before it is filed, or by refusing to serve as expert witnesses in malpractice actions, have actually increased the legal costs of malpractice litigation and, as a result, the premiums charged by the insurance industry.[15] The failure of the medical community to make available to the plaintiffs' bar the records and data needed to make a preliminary determination of whether a claim is meritorious has forced attorneys to file lawsuits in order to obtain discovery.[16]

There have been many proposals for reducing litigation costs. One proposal is to submit all claims below a specified dollar amount to arbitration.[17] Another proposal is to institute screening panels to determine

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[10] *The Medical Malpractice Threat, supra* note 9, at 947–48.

The malpractice liability system is meant to police the quality of care that patients receive, and to compensate the victim when care is administered negligently. Different systems may be judged by how well they reduce the sum of three separate costs: 1) the cost of the maloccurrence, *i.e.,* the harm; 2) the cost of avoidance; and, 3) the cost of administration, *i.e.,* the legal cost. *See* Note, *Comparative Approaches to Liability for Medical Maloccurrences, supra* note 8, at 1143, in which the writer discusses replacing the negligence system with strict liability, and the special problems associated with malpractice. *See also* Keeton, *Compensation for Medical Accidents,* 121 U. PA. L. REV. 590, 616 (1973).

[11] U.S. DEP'T. OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 12 (1973) [hereinafter cited as COMMISSION REPORT].

[12] *Id.* at 13; Morris, *Medical Reports: Malpractice Crisis—A View of Malpractice in the 1970's,* 38 INS. COUNSEL J. 521 (1971). Richard P. Bergen, of the Office of the General Counsel, American Medical Association, in *Protection Against Malpractice Litigation,* 101 ARCH. OCOLARYNGOL 182 (1975) lists the following factors: (1) awards or settlements paid to patients; (2) legal fees for defense; (3) fees for defense expert witnesses; (4) expenses for investigation; and (5) general administration expenses.

[13] MEDICAL MALPRACTICE at 10.

[14] COMMISSION REPORT at 11. Winikoff, *supra* note 6, at 700–01.

[15] Winikoff, *supra* note 6, at 700–01.

[16] MEDICAL MALPRACTICE at 11.

[17] In two Pennsylvania counties, all personal injury actions involving less than $10,000 are submitted to arbitration. *See* COMMISSION REPORT at 92–94. Arbitration speeds the handling of claims, saves parties time, promotes informal proceedings, and encourages a fact-finding procedure without the emotional overtones and adversary nature of a courtroom. *Id.* at 94. *See also id.* Appendix, at 214–449. Another suggested proposal is the

early in the proceeding whether or not the claim is well founded.[18] Any proposal to lessen the legal costs involved in malpractice actions must reflect a delicate balance between relieving the competent health care provider from the pressure of potential malpractice suits and guaranteeing the injured patient protection and compensation from acts of negligence and incompetence.[19] The public interest is best served by that system which guarantees the availability of professional liability insurance to competent practitioners at reasonable rates and which also guarantees that the victims of malpractice will be compensated swiftly and fairly.[20] The Indiana Act introduces several substantive and procedural changes which will affect both of these interests.

THE MEDICAL REVIEW PANEL

One of the recommendations made by the Ribicoff Report was the establishment of medical review screening panels. The Indiana Act contains the country's first legislatively created system of review panels.[21] Hereafter, a condition precedent to the bringing of any malpractice action will be the submission of the case to a medical review board. The panel will determine whether there was a failure on the part of the health care provider to comply with the appropriate standard of care as charged in the complaint, and whether this conduct was, or was not, a factor in any injury.[22]

The plaintiffs' bar would readily welcome the creation of a neutral and objective medical review panel. As a practical matter, the plaintiff in a malpractice case will always require expert testimony.[23] One of

adoption of a no-fault or strict liability plan. *See* Note, *Comparative Approaches to Liability for Medical Maloccurrences, supra* note 8.

[18] *See* MEDICAL MALPRACTICE at 10; Winikoff, *supra* note 6; Anderson v. Florence, 289 Minn. 497, 181 N.W.2d 873 (1970).

[19] MEDICAL MALPRACTICE at 13.

[20] The patient faces four major problems in his attempt to secure a favorable verdict against the physician in a medical malpractice action: (1) preparing the case for trial; (2) obtaining competent expert witnesses; (3) overcoming, especially in less urban areas, the image of the physician in the community; and (4) financial capacity to endure prolonged litigation and delay in obtaining compensation for the injury. The patient must have medical evidence before trial to competently prepare his case. Winikoff, *supra* note 6, at 700.

[21] Winikoff, *supra* note 6, at 713 (listing jurisdictions). *Cf.* N.H. REV. STAT. ANN. ch. 519-A (1974) (imposed arbitration).

[22] IND. CODE § 16-9.5-9-2 (Burns Supp. 1975) provides:

> No action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter [16-9.5-9-1—16-9.5-9-10] and an opinion is rendered by the panel.

[23] *See* D. SHARTEL & M. PLANT, THE LAW OF MEDICAL MALPRACTICE 130 (1959); Note, *Overcoming the Conspiracy of Silence: Statutory and Common Law Innovations*, 45 MINN. L. REV. 1019 (1961); Note, *Evidence—Expert Testimony—Oregon Medical-Malpractice Cases*, 40 ORE. L. REV. 343, 345 (1961).

the major complaints of the plaintiffs' bar has been the difficulty in obtaining a medical expert who will testify to facts or give opinions in a malpractice action.[24] This reluctance on the part of physicians to testify against each other is often referred to as the "conspiracy of silence."[25] This so-called conspiracy has resulted in a great many miscarriages of justice.[26] Generally, the reasons given for the existence of the conspiracy are that doctors feel they will be found negligent where there has been no malpractice and that jurors are ill-equipped to deal with the intricate problems presented by malpractice litigation. Unfortunately, many doctors seem to believe that all malpractice cases are meritless and are the result of either greedy attorneys or greedy patients. It is ironic that the physician's reluctance to testify has forced the courts to apply those legal doctrines which are most reprehensible to the medical profession in an attempt to make certain that the victim of professional negligence is compensated.[27]

There have been many extrajudicial plans aimed at eliminating the conspiracy of silence and providing a mechanism for the equitable and expeditious settlement of malpractice claims.[28] The medical review panel was designed to serve this function in Indiana.

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[24] *See* Note, *Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative,* 18 U. OF FLA. L. REV. 623, 626 (1966) [hereinafter cited as *Malpractice Litigation*]; Note, *An Evaluation of Changes in the Medical Standard of Care,* 23 VAND. L. REV. 729, 743 (1970), discussing the impossible burden facing the plaintiff absent an expert witness. *See also* Hurspool v. Ralston, 48 Wash. 6, 290 P.2d 981 (1955); Skodje v. Hardy, 47 Wash. 557, 288 P.2d 471 (1955).

[25] *See, e.g.,* Markue, *Conspiracy of Silence,* 14 CLEV.-MAR. L. REV. 520 (1965); Seidelson, *Medical Malpractice Cases and the Reluctant Expert,* 16 CATH. U.L. REV. 187 (1966); Morgan v. Rosenburg, 370 S.W.2d 685 (Mo. App. 1963).

[26] *See, e.g.,* Graham v. Sisco, 248 Ark. 6, 8, 449 S.W.2d 949, 951 (1970); Agnew v. Parks, 172 Cal. App. 756, 343 P.2d 118 (1959). Even when a plaintiff is able to secure expert testimony there are many hurdles which his counsel must overcome. The plaintiff normally is forced to rely upon an expert from another community. This can greatly reduce the impact of the testimony on the jury. The defendant physician's insurance carrier, on the other hand, can normally rely upon the testimony of many experts from within the community. Insurance companies have been known to spend thousands of dollars in fees for expert local witnesses. The defendant physician will most often win the "battle of experts." The plaintiff is faced with the financial burden of hiring expert witnesses and of enduring long and protracted litigation. *See* Winikoff, *supra* note 6, at 701, for a very good discussion of this problem.

[27] *Malpractice Litigation* at 624. *See also* COMMISSION REPORT at 31, in which the legal doctrines are discussed.

Winikoff, *supra* note 6, states:

> The primary motives of the physician in refusing to testify probably have very little to do with protecting his fellow physicians. In most cases, the offending physician will be censured, or if the offense is serious enough, he may be forced to leave the hospital staff or even the community.

Id. at 702.

[28] *See, e.g., Malpractice Litigation* at 632. The major disadvantages of the traditional trial procedure and the reasons for the adoption of a screening panel are discussed in Winikoff, *supra* note 6, at 709. They are: 1) the long delay between the filing of a suit

THE COMPOSITION OF THE PANEL

The medical review panel will be comprised of four members.[29] Each party to the action will select one physician and the two physicians will select the third physician panelist. The parties will then appoint an attorney to serve in an advisory capacity and as chairman. The three physicians will be entitled to vote. The attorney will serve in a non-voting capacity.[30] The composition of the panel will change with each claim of malpractice. Plaintiffs will still be left with the dilemma of finding a physician who will be willing to pass judgment on a fellow physician; however, since the physician is called upon not to testify against a fellow physician, but rather to participate in the review of the evidence and the rendering of an independent judgment, the difficulty in finding a physician may be reduced. The physician will also have the support of two colleagues in rendering a decision. The method of selecting the panel is apparently unique to the Indiana plan.[31] It is extremely likely that the plaintiff's attorney will attempt to appoint those physicians who have in the past given testimony in malpractice actions. It is also likely that the defendant's insurance carrier will look to those physicians who have taken an extremely negative position on the subject of malpractice. While this type of selection process is a distinct possibility, it will hopefully not become a reality. The success or failure of the medical review panel depends on its objectivity. The panel must serve as a completely neutral body willing to make decisions that may be less than favorable to their medical colleagues.

The panel is to consider all evidence submitted by the respective parties.[32] The evidence will be submitted in written form and may include reports from physicians, hospital records, photographs, and any and all other relevant information. The panel has the duty, imposed by

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and final disposition, causing long delays in the compensation of valid claims; 2) the difficulty encountered by the patient in obtaining medical experts to help in preparing the case and testifying in court; 3) the filing of nuisance suits potentially damaging to the physician's reputation and practice; 4) the high cost to both patient and physician in preparing a case for trial; 5) the complex nature of most medical malpractice cases and the degree of specialized education and sophistication necessary to make competent findings of fact make questionable the ability of a judge or jury to render a competent decision as to whether there is malpractice.

[29] IND. CODE § 16-9.5-9-3 (Burns Supp. 1975).

[30] IND. CODE § 16-9.5-9-3 (Burns Supp. 1975).

[31] *See* Winikoff, *supra* note 6, at 713.

[32] IND. CODE § 16-9.5-9-4 (Burns Supp. 1975) provides:

> The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only. The evidence may consist of medical charts, X-rays, lab tests, excerpts of treatises, depositions of witnesses including parties and any other form of evidence allowable by the medical review panel. . . .

the statute,[33] to request all necessary information. The panel is given the opportunity to consult with medical authorities. In deciding whether there was malpractice, the panel is not limited to the information and evidence supplied by the parties, but is required to render its decision based on all of the evidence that is necessary in order to make a fair and proper decision. The parties will have the opportunity, upon request, to question the panel concerning any matters relevant to the issue to be decided by the panel.[34]

THE POTENTIAL EFFECTIVENESS OF THE INDIANA MEDICAL REVIEW PANEL

The assumption that medical review panels will decrease legal costs and increase efficiency is premised on the theory that a finding of malpractice will result in a quick settlement, and that the finding of no malpractice will result in a dismissal. If a claimant with a meritorious claim is not satisfied with the defendant's offer of settlement he may file his claim in the court and the report of the panel may be introduced as evidence. The party may also, at his own cost, call any member of the medical review panel as a witness.[35] The medical review panel provides the plaintiff's attorney with an expert witness in all malpractice cases. The person whose claim has been rejected by the panel may also proceed to the courts.[36] As impressive as the scheme appears on paper, the realities of the current medical malpractice situation may greatly reduce the effectiveness of the medical review panel.

One of the earliest screening panels was created by the Pima County plan, established in 1957 by physicians and lawyers in Tucson, Arizona.[37] The panel consists of nine doctors and nine lawyers. When a case is presented to the panel, it is reviewed and, if necessary, the panel consults with medical experts.[38] As in Indiana, a decision is reached as

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[33] IND. CODE § 16-9.5-9-6 (Burns Supp. 1975) provides:
The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided.

[34] IND. CODE § 16-9.5-9-5 (Burns Supp. 1975).

[35] IND. CODE § 16-9.5-9-9 (Burns Supp. 1975) provides:
Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify.

[36] The decision of the review panel is not binding upon the parties or the court on review. *See* IND. CODE § 16-9.5-9-9 (Burns Supp. 1975).

[37] *See* Winikoff, *supra* note 6, at 706-09; MEDICAL MALPRACTICE at 479.

[38] *See* MEDICAL MALPRACTICE at 479.

to whether there are reasonable grounds to believe that malpractice was committed by the doctor and whether such directly caused the patient's injuries.[39] If the answers to both questions are in the affirmative, the medical society agrees to furnish the necessary medical experts to testify on behalf of the plaintiff at trial. However, if the answer to either question is in the negative, then the patient is informed and that party's attorney agrees not to undertake the case. The only exception would arise where the attorney was personally satisfied that strong and overriding reasons compelled the filing of a lawsuit to protect the interests of his client. Obviously, the success of such a voluntary plan depends upon the professional good faith of all concerned. Since the plan was not imposed by the legislature, it is not binding on physicians or attorneys. However, the Pima County plan is so well regarded that it is now utilized by virtually all members of both the health and medical professions in the county.[40] The legal profession believes that the physician panelists have been fair in their appraisal of whether malpractice has occurred and the medical panelists believe that the lawyers have also acted fairly.

Other localities that have attempted to adopt the Pima County plan have faced the problems created by physicians who look upon the plan as a means of insulating fellow physicians from liability, and by lawyers who look upon the plan as a means of fabricating a malpractice case where there is none.[41] In these communities, the plan has failed horribly.

There is one major and important difference between the Pima County plan and the Indiana Act. The panel in the Pima County plan is composed of an equal number of attorneys and doctors, all with a vote. The Indiana Act, by electing not to include voting attorney panelists, has overlooked the fact that malpractice is both a medical and a legal problem, the existence of which has traditionally been determined by a trier of fact.[42] Physicians are competent to testify as to medical

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[39] *See* Winikoff, *supra* note 6, at 706. The Pima plan is reprinted in the Winikoff article. *See also* Hamacher, *supra* note 1, for a discussion of the plan.

[40] *See generally* Hamacher, *supra* note 1.

[41] MEDICAL MALPRACTICE at 479.

> At the National AMA-ABA Medico-Legal Meeting at Salt Lake City, Utah, in 1959, a doctor from Seattle, Washington, told the audience that the Seattle Medical Society had tried such a plan [*i.e.*, the Pima plan], but had given up in disgust after a two year bitter experience of finding that the plan was a "one-way street" in favor of the patient only, because the patients and their attorneys were never deterred from suing by an adverse finding of the panel.

Id.

[42] One major problem is whether the panel is to serve as the ultimate trier of fact, or merely as a screening mechanism to determine whether there may have been malpractice. The Pima plan provides that the medico-legal panel should determine whether there is a reasonable possibility that the acts complained of constitute professional negligence. The

standards of care and certain procedural questions. However, failure to exercise the requisite care is a legal and not a medical question. What guidelines are to be imposed upon the panelists in deciding whether there has been malpractice?[43] Attorney panelists would give the medical panelists a view of the malpractice problem that is foreign to most physicians. Likewise, the medical panelists could, in many cases, inform the legal community that what appears to be negligence is simply a calculated risk that was understood by the doctor and explained to the patient.

A variation of the Pima County plan, which is akin to the Indiana Act, is the plan adopted in New Mexico. That plan has been sanctioned by both the state medical society and the state bar. The New Mexico panel consists of three doctors and three attorneys. Prior to submission to the panel, the patient agrees not to sue if the panel finds against him, unless there are overriding reasons to sue.

Cooperation between lawyers and doctors has made the panel procedure extremely successful. If the plaintiff prevails before the panel, an expert is selected by the medical association for the plaintiff.[44] However, this expert is not a member of the panel and has had no prior connection with the case.[45] In Indiana, on the other hand, each physician-panelist knows that he or she may be called upon to testify in court for or against a colleague. This may cause the panelists to search for a standard of care that is so low that no physician could be found negligent. It may cause a panelist to look only for the most blatant instances of negligence and to overlook other cases which have merit and which should be submitted to a jury. In New Mexico, however, the panelists are never called upon to testify in court and their deliberations are not part of the public record. The rationale behind the Indiana procedure is that a panelist who knows that future testimony may be necessary will be more apt to render a decision which is fair and supported by the evidence. Every physician knows that the plaintiff, absent his

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Indiana Act, however, requires the medical panel to find that the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint.

[43] The question of standard of care is extremely complex. One writer has noted that the medical profession is unique in that, because of the requirement for expert witnesses, the medical profession has set its own standard of conduct. A few recent cases have shown a willingness on the part of the courts to require more of a doctor than mere compliance with the customary standard, by considering the customary practice as only one factor among others in the determination of negligence. Commentary, *Physicians and Surgeons—Standard of Care—Medical Specialist May Be Found Negligent as a Matter of Law Despite Compliance With the Customary Practice of the Speciality*, 28 VAND. L. REV. 441–46 (1975) (discussing Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974)).

[44] MEDICAL MALPRACTICE at 480.

[45] *Id.*

assistance, will have a very difficult time in obtaining expert testimony. Ultimately, the panel may be protected by the very conspiracy of silence which it was created to overcome. Again, the inclusion of attorneys as voting panelists might militate against this occurrence.

One of the major issues facing any medical review panel is the quantum of evidence necessary for a finding of malpractice. The Indiana Act does not establish the quantum of evidence necessary for such a finding.[46] The cases which will undoubtedly cause the panel the most difficulty are those in which there is conflicting evidence. In these cases, it is absolutely necessary that there be attorney panelists. The differing value systems of lawyers and doctors will cause a medical review panel composed solely of physicians to set an excessively high standard for a finding of malpractice. There is a natural disparity between the professional values of doctors and lawyers. One noted work views the differences in the professional education of doctors and lawyers as the cause of this disparity.[47]

> The modern law curriculum is essentially a continuing socratic dialogue. Medical instruction is largely didactic and authoritative. Perhaps the reasons for this largely inhere in the nature of the medical education, although one may question whether its techniques are excessively dogmatic. A controversial method is meat of the lawyer not only because he has been nurtured in controversy from his first day in law school. The physician on the other hand has been conditioned to objective scientific inquiry and to him notorious contest with its emotional overtones, is apt to be a disruptive element in the search for facts. While the lawyer typically sees challenge in open disputation, the physician may see it only as unnecessary insult, especially

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[46] IND. CODE § 16-9.5-9-7 (Burns Supp. 1975) provides:

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 the 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.

[47] *See* LOUISELL & WILLIAMS ¶ 1.03.

when his own or a brother physician's treatment of a patient is called into question.[48]

In order for a proper standard to be articulated, attorney panelists must be included, and the continuity of the panel must be assured. Both of these elements are absent from the Indiana legislation. The quantum of evidence required must be understood by all panelists and must be administered uniformly. The attorney member of the medical review panel in Indiana is to be chosen by the parties. If the parties cannot agree on an attorney, he is to be chosen from the roll of attorneys in the state. This procedure may well result in the selection of an attorney with no expertise in malpractice litigation to advise the physician members on malpractice. Furthermore, since the panel will change with each claim, there is no continuity of membership. One panel may view the evidence from the standpoint of what a jury would do given the evidence; another may view the evidence from the standpoint of whether or not there is sufficient evidence to present the case to a jury. Experience dictates that the success or failure of medical review panels depends on the cooperation between physicians and attorneys.[49] The plaintiff's attorney must be satisfied that the decision of the panel is based upon an objective inquiry applying the proper standards. The absence of attorney panelists or of experts in malpractice litigation as advisors reduces the possibility of an effective medical review panel. The panel should be a medical-legal panel.

The review panel could also be the first step in improving medical-legal relations. If the panel system is to have any efficacy, state bar and medical associations should now begin to educate their members concerning the legal and medical aspects of malpractice. The medical profession should be instructed on the law of malpractice and on the lawyer's duties to his client. The legal profession should reach a better understanding of the physician's job and problems.[50] The plaintiffs' bar should insure the medical profession that the only cases which will be presented to the review panel are those cases in which the plaintiff's attorney believes there is a possibility of malpractice. Likewise, the

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[48] *Id.*

[49] *See* Winikoff, *supra* note 6, at 700. Insurance companies also play a dominant role in the success or failure of a panel. In many communities the insurance companies have adopted a posture adverse to screening panels. Carriers are afraid that the panels will increase the claimants' possibility of success. Even in those states in which panels have reduced litigation cost, the premiums charged practitioners have not decreased because insurers group states on a regional basis. *Id.* at 716–17.

[50] *See generally* LOUISELL & WILLIAMS at 14–67 ¶ 2.01–2.30 where the authors devote one full chapter to understanding the doctor and medical science.

medical profession should insure the public that redress will be provided for professional negligence.

LIMITATION OF RECOVERY: AN UNNECESSARY ADDITION TO THE ACT

One problem facing the seriously injured victim of malpractice is that henceforth there will be a limitation on the amount of recovery. The Indiana Act imposes a $500,000 damage limitation for persons who are victims of malpractice. The first $100,000 is to be guaranteed by insurance of the health care provider. The balance, up to the ceiling, is to be paid by the statutorily-created patient's compensation fund.[51] In opting to include the limitation of recovery for any injury or death, the legislature may have done irreparable damage to the public interest by precluding the seriously injured victim from obtaining a satisfactory award.

An assumption underlying all proposals for limitation of recovery is that jury awards in malpractice cases are excessive.[52] There is little evidence to support this assumption.[53] Recently gathered statistics show that only a very small percentage of malpractice actions result in verdicts in excess of $100,000.[54] However, there are those cases in which the injury is so catastrophic that the limitation imposed by the Act will be patently unfair to the injured victim.

Recently, the Supreme Court of Iowa decided the case of *Schelby v. Baker*.[55] The trial judge, sitting without a jury, awarded damages in the amount of $912,000.[56] The malpractice consisted of a series of gross medical blunders resulting in permanent brain damage to an infant. An economist testified as to the economic impact of the injury. The Iowa Supreme Court held that the damages awarded were reasonable and hinted very strongly in their opinion that higher damages could

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[51] IND. CODE § 16-9.5-2-2 (Burns Supp. 1975) provides:

(a) The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars [$500,000].

(b) A health care provider qualified under this article [16-9.5-1-1–16-9.5-9-10] is not liable for an amount in excess of one hundred thousand [$100,000] for a claim of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a) and (b), shall be paid from the patients' compensation fund pursuant to provisions of section 3 [16-9.5-4-3], chapter 4. [IC 1471, 16-9.5-2-2, as added by Acts 1975, P.L. 146, § 1, p——.]

[52] *See* COMMISSION REPORT at 18.

[53] *Id.* at 10.

[54] *Id.* at 11.

[55] —— Iowa ——, 217 N.W.2d 708 (1974).

[56] *Id.* at ——, 217 N.W.2d at 717.

have been awarded.[57] The limitation of recovery in Indiana would have prevented adequate compensation in such a case. Such catastrophes are rare, but when they occur recovery should not be barred by legislative whim.

The present system provides protection against any potentially excessive jury award. Where the issue on appeal is excessive damages, the appellate standard of review is whether the damages are so excessive and unjust that the court or jury must have been influenced by passion or prejudice.[58] In discussing this review of damages, known as remittitur, the Indiana Court of Appeals has stated that there are only general guidelines for compensating the malpractice victim and each case must be individually studied to determine adequate compensation. Remittitur has been applied in a number of personal injury cases involving malpractice.[59] No other liability system based on fault limits recovery so absolutely. The limitation of recovery by the patient in the Indiana Act is unjust and unfounded and should be abandoned.

The Act also includes a limitation of liability for the health care provider. If this limitation causes a reduction of professional liability insurance premiums for the competent health care provider, that is all to the good. However, the patient turned plaintiff must be guaranteed that there is a fund from which compensation will be paid in the event of an injury caused by professional negligence. Whether this fund is exclusively provided by the insurance industry or partially by a state insurance pool is of no import so long as the injured victim is fully and completely compensated.

The Indiana Act includes a mechanism for the reporting and review of all claims against health care providers.[60] The Board of Professional Registration and Examination for the particular health care provider will determine whether the health care provider is fit to practice his profession. There have been numerous complaints that the medical profession will not police itself and that the only policing mechanism is the courts. Here the Act provides an innovative solution.

STATUTE OF LIMITATIONS

A special malpractice statute of limitations has been in effect in

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[57] *Id.* at ——, 217 N.W.2d at 725.

[58] Carpenter v. Campbell, 149 Ind. App. 189, 197, 271 N.E.2d 163, 169 (1971) (malpractice action).

[59] *See, e.g.*, Christy v. Salitermann, —— Minn. ——, 179 N.W.2d 288 (1970); Lake v. St. Francis Cardiac Hosp., 28 App. Div. 2d 895, 282 N.Y.S.2d 976 (1967); Larrimore v. Homeopathic Hosp. Ass'n., 54 Del. 449, 181 A.2d 573 (1962).

[60] IND. CODE § 16-9.5-6-1-2 (Burns Supp. 1975).

Indiana since 1941.[61] Under both the new Malpractice Act and the former special malpractice statute of limitations there is a two year limitation from the date of the act, omission or neglect.[62]

Courts, attempting to avoid the inequities caused by the strict application of the two year statute, have refused to apply the statute literally.[63] Indiana recognizes the doctrine of fraudulent concealment.[64] The Seventh Circuit Court of Appeals, in interpreting the Indiana statute, held that the statute does not commence to run until there is knowledge of the act causing the damage, or until termination of the doctor and patient relationship.[65] The exceptions to the two year statute are judge-made. The court is required to determine whether or not the equities dictate a less than literal reading of the statute.

Recently, the Indiana Supreme Court decided the case of *Chaffin v. Nicosia*.[66] The issue before the court was the constitutionality of the prior malpractice statute of limitations, which is substantially the same as the statute of limitations provided by the Act. The major difference is that the new Act significantly changes the law as it applies to claims of minors. Before the passage of the Act, Indiana allowed a minor to bring a medical malpractice action within two years of reaching majority. The new act gives a minor under the age of six only until the age of eight to bring a claim. All other minors are to bring claims within the two year limitation period.[67] The supreme court in *Chaffin* was asked to decide whether the two year statute of limitations for medical malpractice was an exception to the statute allowing minors to sue within two years after reaching majority. The court held that there were no conflicts between the medical malpractice statute of limitations and the statute concerning legal disability:

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[61] IND. CODE § 34-4-19-1 (Burns 1971).

[62] IND. CODE § 16-9.5-3-1 (Burns Supp. 1975) provides:

> No claim, whether in contract or in tort, may be brought against a health care provider based upon professional services or health care rendered or which should have been rendered unless filed within two [2] years from the date of the alleged act, omission or neglect except that a minor under the full age of six [6] years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability.

[63] Doctrines such as "the continuous treatment rule," and "fraudulent concealment" have developed. *See* Lillich, *The Malpractice Statute of Limitations in New York's Civil Practice Laws and Rules*, 14 SYRACUSE L. REV. 42 (1962); Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597 (1969).

Some courts have refused to apply any doctrine which would alleviate the hardship of the statute. *See, e.g.*, Tantish v. Szendey, 158 Maine 228, 182 A.2d 660 (1962).

[64] Guy v. Schuldt, 236 Ind. 101, 138 N.E.2d 891 (1956).

[65] Ostojic v. Buckman, 405 F.2d 302 (7th Cir. 1968).

[66] —— Ind. ——, 310 N.E.2d 867 (1974).

[67] IND. CODE § 16-9.5-3-1 (Burns Supp. 1975).

> To construe the medical malpractice statute as a legislative bar on all malpractice actions under all circumstances unless commenced within two years from the act complained of (discoverable or otherwise) would raise substantial questions under the Article I, § 12 guarantee of open courts and redress for injury to every man, not to mention the offense to lay concepts of justice.[68]

The Indiana legislature chose to ignore this rather strong language. The court also opined that the two year statute for a minor could cause some extraordinarily harsh results which would be inconsistent with the statute relating to legal disability, which was designed for the protection of minors.[69] While the medical community and the insurance industry would certainly prefer a short statute of limitations in order to improve the ability of the ratemaker to predict the potential claims within a time period, and to decrease the period of vulnerability for the physician, the shortening of the statute and the elimination of a legal remedy should not be at the expense of the public.[70] The innocently ignorant malpractice victim should not be denied judicial relief. If the medical review panel adheres strictly to the language of the statute of limitations contained in the Act, the Indiana Supreme Court will probably remedy the situation by reading into the Act those exceptions which will protect the seriously injured victim.

The Oregon State Bar has issued a position paper in response to a bill proposed in that state which would impose a two year limit on the time a doctor can be sued for medical negligence regardless of when the injury is discovered.[71] Under the present law in Oregon a patient must sue within two years from the time the injury is discovered, or in the exercise of reasonable care should have been discovered, provided that such action must be commenced within five years of the date of the treatment, omission, or operation upon which the action is based.[72] The Oregon State Bar, in opposing a two year statute of limitations, used the example of a person who discovers he has leukemia, only later finding out that the leukemia was caused by an excessive dosage of radiation administered more than two years ago.[73] The proposed statute in Oregon, and the statute promulgated in Indiana, if strictly interpreted, would leave this person without a remedy.

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[68] —— Ind. at ——, 310 N.E.2d at 870.

[69] *Id.* at ——, 310 N.E.2d at 871.

[70] The doctrines of fraudulent concealment, and the discovery rule, as well as the minor's diability, lengthen the two year period. The ratemaker (the insurance carrier) allegedly cannot plan with the certainty that could be achieved with a strict two year statute.

[71] ATLA at 890.

[72] ORE. REV. STAT. § 12.110(4) (1971).

[73] ATLA at 891.

LIMITATION OF ATTORNEY'S FEES

The contingency fee has been the subject of much controversy in the malpractice area. Under the Indiana Act there is no regulation of the contingency fee for any recovery below the $100,000 limit.[74] Statistically, less than one percent of all the cases surveyed by the HEW Commission resulted in awards in excess of $100,000.[75] The Commission noted that the occasional large verdict or settlement has tended to give the impression that most malpractice cases are settled for large amounts and that the attorney fees are correspondingly great.[76] The Commission found that by reducing the average plaintiff's lawyer's contingent fee to an hourly basis for purposes of comparison, there was no gross discrepancy between the average rates charged by the plaintiffs' bar and defense bar in malpractice cases.[77] The limitation of the contingency fee from the patients' compensation fund, to a maximum 15 percent,[78] cannot be justified on the theory that such a limitation will reduce the amount of monies to be expended by the fund since the contingency fee makes no difference in the amount of judgment. The fee is not part of the evidence of damage.

Although the total amount of the award which will go directly to the plaintiff is increased by such fee regulations, it should be borne in mind that the amount of the award is often commensurate with the skill of the attorney. The cases involving catastrophic injury involve a commitment of time and energy far greater than in most cases. Cases of the catastrophic sort often are far more expensive and present legal and factual issues which can only be handled by the experienced trial lawyer. If, as the HEW Commission found, the malpractice contingency fee is not excessive, then it is difficult to see why attorneys' fees should be limited solely in the context of the malpractice action.

CONCLUSION

The plaintiff's attorney, the present court system, and the contingency fee are neither the primary, nor even the secondary, causes of the malpractice "crisis."[79] They are, at best, symptomatic of the underlying problem. All of the symptoms should be considered in diag-

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[74] *See* IND. CODE § 16-9.5-5-1 (Burns Supp. 1975).

[75] COMMISSION REPORT at 33.

[76] *Id.* at 33-34.

[77] *Id.* at 33.

[78] IND. CODE § 16-9.5-5-1 (Burns Supp. 1975).

[79] Bernzweig, *The Malpractice Problem: The Need for a Perspective*, statement to a meeting convened by the Secretary of Health, Education & Welfare to discuss the malpractice crisis, reprinted in ATLA at 60.

nosing the disease and in prescribing the cure. Unfortunately, in the current strife between the medical and legal professions, one party has been too frequently overlooked: the injured patient.[80] Legislation addressing the malpractice crisis must be carefully scrutinized with the interest of the patient in mind. A facile and expeditious solution may deprive an injured party of the right to seek redress and adequate compensation.

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[80] Page, *Why Patients Lose Their Patience,* The Wall St. Journal, April 14, 1975, at 14.