SUGGESTED CHANGES TO INDIANA'S MEDICAL MALPRACTICE ACT

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A former Indiana legislator said it's good most people don't know how statutes are made, and it's often better to leave bad enough alone. Despite those words of wisdom, this author will offer for consideration some changes to Indiana's Medical Malpractice Act [En. 1] ("Act"). These will not include the obvious wish of some plaintiffs' attorneys that it be repealed completely. These suggestions are the author's own, and he welcomes any comments or criticisms the reader may have.

I. MAKE IDOI RECORDS RELIABLE

Like a state court's chronological case summary, everyone must be able to rely on an official record from the Indiana Department of Insurance ("IDOI") as to whether or not a health care provider was qualified under the Act during the time of the health care at issue. [En. 2] This should be a natural byproduct of Indiana Code § 34-18-3-6, which provides that within five business days after the IDOI receives the required information, the commissioner shall notify health care providers that they are qualified and the date upon which they became qualified. So the information for the official record should already exist.

Yet the IDOI often supplies incorrect information about whether a health care provider was qualified under the Act. As a result, medical malpractice plaintiffs' counsel typically file court complaints against a named health care provider, just in case that health care provider was not qualified, while also filing a proposed complaint with the IDOI just in case the health care provider was qualified.

Plaintiffs' counsel was called to task for following this general practice in *Kho v. Pennington*. [En. 3] The court essentially ruled that the plaintiffs' lawyer could be sued for not using an anonymous state court complaint, as per Indiana Code§ 34-18-8-7. The *Kho* court discounted that the summons and praecipe named the defendant and were public records available to anyone. Regardless of the correctness of *Kho*'s legal analysis, the problem is that the anonymous statute applies only to qualified health care providers and the IDOI information as to that status is unreliable.

The problem is not solved by cases such as *Miller v. Terre Haute Regional Hospital,* [En. 4] which held that the statute of limitation is tolled where a proposed complaint is filed with the IDOI and begins to run again when the plaintiff is advised that the health care provider was not qualified at the pertinent time. Miller does not solve the problem because the result still depends on the IDOI providing correct status information.

As a result of this problem (and the problem discussed in the next section of plaintiffs' counsel not knowing until it is too late whether a particular claim is covered by the Act), dual filing is a common practice despite the decision in *Kho*.

Having medical malpractice plaintiffs' counsel duplicate filings results in wasted time for both sides when the health care provider was in fact qualified during the pertinent time. This wastes the plaintiff counsel's time in preparing and filing an appearance, a summons, and a complaint; it wastes the court filing fee; and it wastes the court clerk's time in docketing a new law suit and issuing service. If service is by sheriff, it also wastes the time of the sheriff’s civil

process division and of those deputies serving process who then need to complete and file a return regarding the service.

It further wastes the health care provider's time in getting the complaint to his medical malpractice insurer; wastes the insurer's time getting the complaint to defense counsel; wastes defense counsel's time in preparing and filing an appearance, typically accompanied by a motion for an extension of time to plead and a proposed form of order; wastes defense counsel's time in preparing and filing an answer to the complaint; wastes defense counsel's time in getting an affidavit from the IDOI that the defendant is, in fact, qualified; wastes defense counsel's time in preparing a motion to dismiss with a proposed form of order; and wastes defense counsel's time in preparing and filing a memorandum in support of the motion to dismiss, which is prudent to do just in case the trial court judge is unfamiliar with the Act's requirements, and in any event may be required by the trial court's local rules.

Multiply that wasted time by the number of medical malpractice cases filed each year in Indiana, then multiply that by the number of health care providers named on average for each malpractice case, and the amount of wasted time becomes significant. And while the above may seem perfunctory, the importance of the health care provider being qualified is critically important.

If a health care provider is qualified under the Act, then all that provider's attorneys' fees and expenses to defend, as well as the entire amount of any settlement or judgment, will be paid by that provider's insurer and, if necessary, by the Patient's Compensation Fund. [En. 5]

A health care provider who is not qualified under the Act is not covered by it. [En. 6] This effectively repeals the act as to that health care provider. This means there will be no medical review panel and, more important, that there is no limit to the amount necessary to settle the case or pay any judgment.

A health care provider who was not qualified may have an insurance policy that pays defense costs, but with the proliferation of multi-million dollar verdicts, that health care provider probably has an uninsured personal financial exposure.

Given the financial significance of whether or not a health care provider was qualified for a particular claim, coupled with the unreliability of the IDOI information regarding this status, it is understandable not only why plaintiffs' counsel has filed the complaint naming the health care provider but also why plaintiffs' counsel may file a response in opposition to the motion to dismiss. This response may take several different forms but some of the most common seem to be that the IDOI affidavit is conclusory, that it contradicts the IDOI's letter plaintiffs' counsel received when the proposed complaint was filed, that it does not contain a sufficient foundation to come within the business record exception to the hearsay rule, or that it allegedly attempts to give a legal conclusion prohibited under Indiana Evidence Rule 704(b).

The matter will most likely then be set for a hearing. Depending on the trial judge's outlook, one side or the other may then have to go through what is certainly not a perfunctory task of proving that there is or is not documentation to establish that the health care provider is or is not qualified. Indiana Code§ 34-18-3-2 provides that a health care provider becomes qualified under the Act upon filing with the IDOI proof of financial responsibility under Indiana Code § 34-18-4, along with payment of the surcharge assessed on all health care providers under Indiana Code § 34-18-5. Obtaining certified copies of all the required documentation can sometimes be time-consuming and frustrating, but given its importance, it sometimes must be done.

This may result in a second, evidentiary hearing.

Lest we forget, in the case where the health care provider turns out, in fact, to have been qualified under the Act, the sole purpose of all the time and expense has been to determine the threshold issue of whether the Act applies to the particular claim.

All this would be unnecessary if the IDOI records were reliable. Then the Act could provide that a party need only present a certified copy of the IDOI record of his qualification under the Act during the time in issue. It should be self-authenticating and create a rebuttable presumption. It should be made available for a nominal fee, and there should be no penalty, including any *Kho*-type action, attached to anyone who has relied on the IDOI's certified determination of a health care provider's qualified status.

II. CHANGE ANONYMOUS COMPLAINT TO COMPLAINT UNDER SEAL

The provision for the anonymous complaint in Indiana Code § 34-18-8-7 should be changed to allow medical malpractice plaintiffs to file court complaints, which must remain under seal until the medical review panel issues its opinion.

The current statute is a sieve. The summons and praecipe are not anonymous and cannot be anonymous if the plaintiff is to get proper service on the health care provider. The summons and praecipe are public records. In addition, there is nothing in the statute to prohibit a plaintiff's counsel from filing an anonymous complaint along with a proposed complaint, then holding a press conference to or issuing a press release to announce the filing.

Another reason to change the anonymous complaint statute is to provide for those cases where it is unclear whether the Act or common law applies. Indiana Appellate courts seem to decide these on a case-by-case basis. While sometimes this issue is clear at the outset, sometimes it does not become apparent until some discovery has been completed. [En 7, 8]

A plaintiffs' counsel who files this type of case and names a health care provider who is in fact qualified is subject to a suit by that provider for failing to use the anonymous complaint. [En. 9] The *Kho* court applied the plain meaning of the act and discounted that the summons and praecipe named the health care provider and were public records. As these examples show, the problem caused by *Kho* is that plaintiffs' counsel may not know whether the Act applies until after the medical review panel decision, then after a trial court ruling, a court of appeals opinion, and a Supreme Court opinion. [En. 10]

On the other hand, a medical malpractice plaintiffs' counsel filing an anonymous complaint against a health care provider who is not qualified under the Act would seem to run afoul of Indiana Trial Rules 7(a)(l) and 10(a). Trial Rule 7(a)(l) provides that a complaint is a pleading. Trial Rule 10(a) provides that every pleading "shall contain" a title and that the title in a complaint "shall include" the names of all parties. It has long been fundamental Indiana law that the Trial Rules trump statutes when they conflict. [En. 11]

In addition, an anonymous complaint seems contrary to the intent and purpose of Indiana Code § 5-14-3-1 *et seq*. and the Indiana Supreme Court's own Administrative Rule 9 regarding access to information in court records. The strict requirement in Administrative Rule 9 that must be followed to prevent information in court filings from being disclosed was emphatically enforced in *Travelers Casualty & Surety Co. v. United States Filter Corp*. [En. 12]

The statute does not really make the court filing anonymous, and puts plaintiffs' counsel in a trick box. It should be changed to require filing court complaints under seal, which would make them truly anonymous. In addition, there should be no penalty to a plaintiffs' counsel and

no adverse consequences to a plaintiffs claim if it turns out that a claim in the sealed court filing is not covered by the Act.

III. MEANINGFUL RELIEF FOR VIOLATING INDIANA CODE§ 34-18-8-3

There should be a penalty for failure to abide by Indiana Code§ 34-18-8-3, which prohibits a dollar figure in the complaint's demand unless proceeding under the $15,000 no-panel exception. This prohibition is like Trial Rule 8(A)(2) and suffers from the same anemia. There is currently no effective penalty for the violation of either.

The vast majority of plaintiffs' attorneys are professional and abide by this directive, but a few routinely insert enormous dollar demands, then issue a press release about the amount sought. About all a defendant can do is move to strike the demand clause, but the purpose of the rule has already been bypassed.

There should be a meaningful penalty for this violation such as sanctions, and either an automatic referral by the trial court to the disciplinary commission or an automatic dismissal of the claim without prejudice.

IV. CHANGING THE PANEL CHAIR SELECTION STATUTE

Panel chairs are usually selected by agreement from a group of attorneys known for serving as such. However, each has his own way of doing things, similar to a court's local rules. So even counsel with medical malpractice experience may disagree over naming the panel chair. Sometimes plaintiffs' counsel, the insurer, or defense counsel has had a bad experience with the proposed panel chair. A health care provider may have had the proposed chair on a prior claim or has the proposed chair on a pending claim and does not want the same panel chair again. Multiple health care providers with separate counsel increase the likelihood that an agreement cannot be reached.

Plaintiffs' attorneys may not routinely handle medical malpractice cases and may be unaware of the attorneys typically used as panel chairs. They may disagree to a defendant's proposal unless they happen to know and trust either the defense counsel or, more likely, the proposed panel chair.

The alternative to agreement is a nightmare. It is implemented through the Indiana Supreme Court clerk's random-draw process under Indiana Code § 34-18-10-4. It often takes the Supreme Court clerk a long time to supply the panel chair striking list. The attorney ultimately selected through the striking process often fails to respond to the clerk or to the parties, or asks to be excused. When that happens, a replacement panel chair has to be selected using the same drawn-out striking process. It can happen more than once.

Even when attorneys selected through this process are willing to fulfill their duty, those poor souls usually have no clue how to do it.

Instead of randomly selecting five attorneys from a list of all those with offices in the venue county, the random draw should be from attorneys in the venue county who have filed notice with the Supreme Court clerk that they are willing to serve as panel chairs. The Supreme Court clerk could then list by county those attorneys who are at least willing to serve. If there are not five such attorneys from the venue county on the list, then the Supreme Court clerk could continue to draw from those on the lists of contiguous counties, until there are five willing to serve as a panel chair.

V. CONVENING AND QUESTIONING Tim PANEL

What useful purpose is served by questioning the panel? (Note that instead of referring to "any" party, the statute refers to "either" party. It also refers to the panel's "report" as opposed to "expert opinion," the phrase used in Indiana Code § 34-18-10-22.) The statute provides that after submission of all evidence and before the issuance of the panel's report, either party has the right to convene the panel, at a time and place agreeable to the panel, and to question the panel. [En. 3]

Some attorneys or insurers routinely ask to convene the panel in person. The statute does not require that. In addition, demanding the panel to convene in person is a great inconvenience to the chair and the panel members, who otherwise could convene by phone. If there were proof that panels that convened in person issue better opinions, then by all means convene them in person. Until then, it should either be challenged to produce case law or be clarified by the legislature to allow convening the panel by conference call. The Indiana Supreme Court allows Indiana's trial courts to hear motions by telephone conference. [En 14] If it is good enough for judges to have lawyers conduct conference call hearings, it ought to be good enough for the convening of medical review panels.

Besides the right to convene the panel, the same statute also provides that either party has the right to question the panel concerning any matters relevant to issues to be decided by the panel. [En. 15] The language is a little stronger in Indiana Code § 34-18-10-22. It refers to the pre-panel questioning as an "examination."

Whether by phone or in person, the panel chair typically allows questions just before the panel meets to discuss the case and give its expert opinion. There is no case law interpreting what is allowed in questioning the panel. However, panel chairs routinely disallow substantive questions so the questions usually are a waste of time: Do you know any of the parties? Do you know any of the lawyers? Do you happen to know each other? In how many medical review panels have you participated? What did those involve? As to each prior panel, did you find in favor of the patient or the health care provider? Have you ever treated a patient with the condition at issue in this case? How many? When? Have you conducted any independent research in preparation for your panel meetings? Have you received the opinion of any other health care providers regarding any of the issues involved in this case? Did you receive all the submissions? Have you reviewed all the submissions?

Other than malting sure the panel has everything it needs and has reviewed everything it has, do any of the attorneys really need to know answers to these questions before the panel members give their opinion? Are the answers going to have any effect on a panel member's opinion?

Any panel chair with experience will cover most of these issues anyway. Counsel need only send questions to the chair ahead of time, then let the chair ask them and report the answers.

Some respected plaintiffs' attorneys have suggested that it should be changed to allow more in-depth and substantive pre-opinion questioning. But then pre-opinion questioning might seem like a deposition, with direct, cross, redirect, re-cross, and so forth. Could a party bring a court reporter to record the questions and answers? Would the pre-opinion oath the panel members have to sign under Indiana Code § 34-18-10-17 apply to the panel members' pre-panel opinion answers? Would the trial rules regarding depositions apply? Would the panel chair's ruling on objections be subject to judicial review? The answer to all of these questions should be no. Indiana Code § 34-18-10-20(b) provides that these pre-opinion meetings "shall be" informal.

A better remedy already exists. If either side thinks the panel opinion is wrong, it can talk to that panel member after receipt of the signed panel opinion. [En 16] Most panel members are willing to discuss their panel opinions. If that is insufficient, any party can take the panel member's deposition. Whether the panel member can charge his professional fee for the deposition depends on whether the questions involve only facts or include the panel member's expert opinion. [En. 17] However, it would seem fair to pay the panel member a reasonable fee for his post-panel expert opinions since he received only $350 to review all the submission materials and then give his expert opinion regarding them.

Indiana Code § 34-18-10-20 should be changed to make it clear that the pre-opinion meetings to which it refers can be by conference call, and that questioning or examination of panel members is limited to non-substantive questions.

VI. Do AWAY WITH THE ATTORNEYS' FEE STATUTE

Attorneys representing medical malpractice plaintiffs have their fees limited by statute to fifteen percent of any recovery from the patient's compensation fund. [En. 18] This should be repealed because it is unfair and forces plaintiffs' counsel to use a circuitous route to get their one-third fee.

The toes of medical malpractice plaintiffs' attorneys were accidently stepped on in a very odd way, through an attorney disciplinary proceeding. [En. 19] The attorney there received a public reprimand, and it appeared that the sanction was the result of the attorney's use of a sliding percentage of prefund fees recovered to circumvent the fifteen-percent limitation on payments by the fund. The court found this violated Rules of Professional Conduct 1.5(a) and 1.8(a).

The Indiana Trial Lawyers Association not surprisingly moved to intervene, and its motion was granted. The Supreme Court then reversed field in *In re Stephens*. [En. 20] It still held the discipline proper because the fees in that situation were unreasonable, but the court "clarified" its original opinion by expressly stating that while fees from the fund are limited to fifteen percent, there is no limit on fees from the health care providers. The only requirement is that the total fee is reasonable. So the sliding fee to circumvent the fifteen-percent limitation and get a fee near one-third from the total amount recovered remained alive.

The Indiana Trial Lawyers Association was correct that the fifteen-percent limitation could seriously impede a plaintiff’s ability to employ effective counsel. Medical malpractice cases constitute a genre unto themselves. Experience shows that parties whose counsel has significant experience with medical malpractice cases do much better than those who have counsel without such experience. In addition, medical malpractice cases can be some of the most complex and expensive to prepare for trial, while the maximum damages are limited to much less that other types of serious personal injury or death claims.

In the second *Stephens* opinion, the Indiana Supreme Court wrote all the right things about freedom of contract, and so forth. However, the Supreme Court felt it should avoid finding the statute unconstitutional. This was the correct holding, given what it had to work with. However, the statute should be repealed because it does not have its intended effect and the Indiana Supreme Court has now approved its circumvention. Repealing it would take the wink and nod out of allowing the statute to be circumvented, and it would most likely clarify the plaintiffs' understanding of the percentage of any recovery to which they are agreeing.

VII. THE BURDEN OF PROOF

It is perplexing that plaintiffs' attorneys almost universally argue they have no burden of proof at the panel stage. Here are four responses. The first is common sense. In every other type of legal proceeding the party making the claim has the burden of proof unless a statute or regulation specifies otherwise. The Act does not specify that the burden of proof is on the defendant. If there is no burden of proof on the plaintiff, what opinion is the panel to give if each member finds the evidence equally divided?

Second are the choices of panel opinions. [En. 21] The first choice is that the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint. [En. 22] The second choice is that the evidence fails to support that conclusion. [En. 23] Thus, plaintiff has charged the defendant's failure in plaintiff's complaint. If the evidence does not support that charge, then the panel must find for the defendant.

Third, the plaintiff is treated as having the burden of proof by the vast majority of panel chairs who allow them to file reply briefs. Why allow reply briefs unless plaintiffs have the burden of proof? The universal custom is that the party with the burden of proof opens and closes. [En. 24] There is no corresponding reply allowed to an opening statement or to evidence at trial. [En. 25]

Fourth, plaintiffs should want to embrace the burden of proof and emphasize that its standard is a preponderance of the evidence. A panel opinion favorable to the defendant does the parties little good if the panel member applied a standard of scientific certainty but in a post-panel phone call or deposition agreed that the panel member's opinion would be different if the standard was "more likely than not." This problem can be easily fixed by what is called for in the next section.

VIII. CLARIFYING THE PANEL OPINION

The way panel opinions are worded now is confusing to a jury, especially when there is a split decision. Why does Indiana Code§ 34-18-10-22(b)(l) use the phrase comply with the appropriate standard of care while Indiana Code§ 34-18-10-22(b)(2) uses the phrase meet the applicable standard care? Lawyers experienced with medical malpractice cases do not distinguish them. If there is no reason to word them differently, then they should be worded the same.

The legislature should remove the double negative from Indiana Code § 34-18-10-22(b)(2). It is confusing to panel members, clients, and jurors if the panel finds the evidence does not support that the defendant did not meet the standard of care. Why not simply make the choice one of the following: The evidence supports that the defendant did/did not meet the applicable the standard of care? While the phrases are familiar to lawyers and judges, jurors do not usually use them the same way, and so it is important in the panel opinion and in the instructions to the jury to use the phrase "meet the applicable standard of care."

Why does Indiana Code § 34-18-10-22(b) include at the end of the first two choices "as charged in the Complaint"? First of all, it is a proposed complaint. A complaint is what is filed in court. Getting by that, if notice pleading under the Trial Rules applies and if the statute is then read literally, it means a plaintiff need allege only that in treating the patient the defendant failed to use that degree of care, skill, and proficiency used by reasonably careful, skillful, and prudent

practitioners in the same class to which the defendant belongs, acting under the same or similar circumstances. This is the standard of care for medical malpractice in Indiana. [En. 26]

If this allegation is in the proposed complaint, and the proposed complaint is included as an exhibit to the plaintiff's submission, is that contrary to *Sherrow v. Gyn, Ltd.* [En. 27] ? *Sherrow* held that legal argument is not permitted in medical review panel submissions. However, how can the panelists find if the standard of care as charged in the complaint was met if the standard is not in the complaint?

Clarifying the third choice for a panel opinion in Indiana Code § 34-18-10-22(b) at first seems a bit trickier, but it is not. It reads: "There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury." What would be hard is to try and reword it, then try to succinctly define "material" and "bearing on liability". It is a Gordian knot better cut than untangled. Why not just change it to "Whether the health care provider met the standard of care depends on what or whom you believe, which we as panel members are not allowed to decide." Maybe it is the wording that leads so many panel members to ignore it. They do choose what and who to believe. The "what" is usually the medical record, and the "whom" is usually the person who put it in the record. Often it does not matter to them if a sworn statement of a plaintiff or a defendant is different from the medical records. The medical records then become either a sword or a shield depending on what they do or do not contain.

On the other hand, if this choice were clarified and followed literally, it would be easy to make almost every panel opinion choice number three. That can't be right either. The only reason not to jettison this third choice altogether is to rely on its appropriate application by seasoned panel chairs who know a real material dispute rather than a manufactured one. In other words, panel chairs should tend toward the federal summary judgment standard rather than Indiana's.

The fourth panel choice is in two parts. The first is that the conduct complained of was or was not a factor in the resultant damages. This choice can be frustrating in several ways. A plaintiff understandably finds it confusing that there could be one without the other. A defendant often does not understand why the panel found a failure to meet the standard of care if it was not a factor in the outcome.

It can also be frustrating for any party to fail to get a decision on whether it was a factor when the finding on standard of care is in that party's favor. The fourth panel choice is not superfluous. Anyone who has conducted more than a few of these cases knows that patients can have serious complications, even die, without any failure to meet the applicable standard of care. However, just because the standard of care was met may not change the fact that the patient died as a result of a defendant health care provider's act or omission.

For the same reason, when the standard of care is met, it is also important to have the panel's expert opinion if the defendant health care provider's conduct was not a factor in the result.

"Factor" is an odd choice of words. Is it intentionally vague or just the result of sausage making? A court attempted to define it in *Jones v. Griffith* [En. 28] as being less a substantial factor. However, that case was vacated by the Seventh Circuit. [En. 29]

Indiana courts have routinely found that a panel finding that a defendant's conduct was not a factor can be the basis for summary judgment on causation if expert testimony on causation is required and the plaintiff fails to produce such in response. [En. 30]

However, getting the concept of proximate cause involved at the panel stage would be a big mistake. Proximate cause is based on cause-in-fact and on the scope of liability. [En. 31]

The scope of liability is determined by whether the ultimate injury is reasonably foreseeable from the act or omission, as a natural and probable consequence under circumstance. [En. 32] Whatever is done, proximate cause should not be involved at the panel stage. Leave proximate cause in the courtroom where it is hard enough getting a jury to understand it.

Eschewing the technical swirl of statutory construction, it is a good bet that every panel member who ever signed this choice will tell you he thought he was finding something did or did not cause the result. "Factor" should be changed to "cause" because this is what the panel members are finding and what the courts are treating as proximate cause, and because if taken literally almost anything could be considered a factor.

The second part of the fourth choice is an enigma. If the panel finds the conduct complained of was a factor of the resultant damages, then it is to determine (1) the extent and duration of any disability suffered by the plaintiff and (2) the percentage of any permanent partial impairment suffered by the plaintiff. [En. 33]

The legislature was obviously making a distinction between disability and impairment, such as is made in worker's compensation law. For people who are unfamiliar with worker's compensation lingo, this distinction can be easily explained by the following example. If a concert violinist and an attorney each lose the pinky on their non-dominant hands, they have the same permanent partial impairment. However, they have completely different disabilities. It ruins the concert violinist's career while having no adverse effect on the attorney's continued work in the legal profession.

The panel never makes a finding under Indiana Code § 34-18-10-22. Most attorneys on both sides of the medical malpractice litigation equation would be shocked if the panel did make such a finding and would probably be unhappy with the result. Odds are that any panel member asked about this would say he did not know how to use the American Medical Association's *Guides to Permanent Partial Impairment*. Even if the panel comprises orthopedics who know how to use those guides, they say they would have to examine the patient for themselves. As to disability, they would add that it would take a vocational assessment along with the permanent partial impairment loss of function to make a stab at disability, and they were not provided the information with which to do so. Unlike their willingness to ask for additional information to determine if the standard of care was met, they do not seem interested in getting additional information regarding disability or impairment.

All those involved treat Indiana Code § 34-18-10-22(b)(4)(A) & (B) as if it does not exist and never has. It should be deleted from the statute before an eager young physician finds out about it and takes it seriously. Neither side would want that at the panel stage.

The panel oath should be modified and removed from Indiana Code § 34-18-10-17(e). The current oath states that the panel member's opinion shall be rendered based on the evidence submitted by the parties. This is contrary to Indiana Code § 34-18-10-21, which provides that the panel may consult with medical authorities and examine reports of other health care providers necessary to fully inform the panel regarding the issue to be decided. This is beyond the evidence submitted by the parties.

Also, instead of placing it in a separate document, why not put the oath just above the panel member's signature? It then becomes part of the panel opinion and has unquestioned admissibility once authenticated. It may also have a greater impact on a panel member than an oath taken quite a while before the opinion is signed, before the panelist reviews any submission materials, and before the panelist meets with the other panel members. [En. 34] It would have to read only: "I swear or affirm on my oath and under the penalties for perjury that I have reached

my panel opinion without bias or prejudice for or against any party, and I have not communicated with any parties or their representatives before reaching and signing my written panel opinion."

IX. LIMIT PAPER DISCOVERY

Proposed complaints usually tell defendants nothing about what they are alleged to have done wrong. Many Indiana cases have held that this should be no problem for Indiana practitioners since discovery is the expected way to develop, simplify, and formulate the issues. [En. 35]

However, when parties exchange paper discovery pre-panel they usually learn nothing of substance. "What do you claim defendant did wrong?" The answer is usually: I am not a doctor and so cannot answer this question (or) defendant failed to timely and properly take a history, do a proper physical exam, order appropriate diagnostic testing and properly interpret the results, timely refer me to the appropriate specialists, timely and properly diagnose me, and failed to timely and properly treat me. Neither answer tells the defendant anything. "Who are your experts?" We have not decided whether or not to use any experts in our panel submission. "What medical literature supports your position?" Objection, work product. Without waiving that objection we have not yet decided if we will use medical literature in our panel submission. Defendants give the same meaningless answers.

Unless pre-submission depositions are taken, the panel submission is the first time a party finds out another party's specific contentions or defenses, expert opinions, or supporting medical literature.

What should be done is to continue to allow depositions to be taken pre-panel; they are specifically referred to in Indiana Code § 34-18-10-21. Other than making sure everyone has a complete set of the same medical records, pre-panel paper discovery is almost always unnecessary, a waste of time, and could be jettisoned without any significant effect on the medical review panel process.

X. REFORMING THE PANEL NOMINATION PROCESS

This wastes a lot of time. Usually, each side strikes the other's nominations. So what's stopping each side from just using striking panels? Three answers are: a co-party will not agree, a client will not agree, an insurer will not agree. There are always one or more of those who want to make their preferred nomination, even if the other side has said it is going to strike anyone thus nominated. If the statute provides only for striking panels, the matter is solved.

Ten days to strike a nomination is too short a time. [En. 36] Regardless, it is honored in the breach. It should at least be doubled. This would add no delay if striking panels are used and the time limit enforced.

True, it will not solve all problems since there are often more than three physician defendants. Each wants a panel member of the same specialty. The defense has to agree on nominations. [En 37] There should be a panel member for each defendant's specialty. Otherwise, the panel opinion regarding the non-represented specialty can be attacked by either side.

Similarly, when there is only one physician-defendant, why do only two panel members need to be of the same specialty? [En 38] How is a dermatologist going to help two obstetricians

on an issue of prenatal care? Plaintiffs can too easily prevent getting even two of the same specialty by also naming a second health care provider such as medical practice, clinic, or hospital where the patient was seen. Perhaps a compromise is to insert in the statute what most good panel chairs already do: let the first two health care provider panel members decide what type of health care provider they want as the last member.

XI. DISMISSAL OR DEFAULT

There are four basic types of pre-panel motions to dismiss a proposed complaint against a qualified health care provider. These are (1) to determine an affirmative defense or issue of law or fact under Trial Rule 12(D); [En. 39] (2) to compel discovery; [En. 40] (3) for failure to act as required by Indiana Code § 34-18-10; or (4) to move to dismiss under Trial Rule 41(E). [En. 41]

The leading case on what can be decided under Indiana Code § 34-18-11-1 is *Griffith v. Jones*. [En. 42] The cases of *Munster Community Hospital v. Bernacke* [En. 43] and *Rivers v. Methodist Hospital, Inc.* [En. 44] have discussed dismissals for discovery violations.

Indiana Code§ 34-18-10-14 permits trial courts to mandate or sanction a party, attorney, or panelist who fails to act as required by Indiana Code § 34-18-10 without good cause shown. [En. 45]

Indiana Code § 34-18-8-8 provides that if no action has been taken by a party in two years then either party may move for the commissioner to file a motion in Marion County Circuit Court to dismiss the case under Trial Rule 41(E).

All these sections were discussed in a trilogy of appellate decisions involving the same case. This trilogy also gave a new interpretation to Trial Rule 41(E) within the context of Indiana Code § 34-18-8-8. The cases are *Adams v. Chavez I* [En. 46], *Adams v. Chavez II* [En. 47], and *Adams v. Chavez III* [En. 48]. The *Adams* trilogy is interesting. The dismissal with prejudice was essentially for an inmate plaintiff's failure to make a strike from a nomination panel. Ultimately, the Court of Appeals reversed. The *Adams* court found that there had been no evidence presented of intentional noncompliance that would justify a dismissal with prejudice. Despite past cases to contrary, the *Adams* court held that Trial Rule 41(E) was broader than Indiana Code § 34-18-10-14. Trial Rule 41(E) permitted relief if a party failed to prosecute for sixty days or if a party failed to comply with any trial rule. The court found it had to assume by the legislature referring to Trial Rule 41 in Indiana Code § 34-8-8 that if it had wanted to incorporate it into Indiana Code § 34-18-10-14 it would have done so. It did not. That meant that Trial Rule 41(E) relief is available only upon the Indiana Department of Insurance Commissioner's motion filed in Marion County.

Adams also held the grounds for relief under Indiana Code § 34-18-10-14 may include such things as failure to select a panel chair, failure to make a submission, and failure to comply with the panel chair's submission schedule. Without the failure to take these types of action, there is no relief available under Indiana Code § 34-18-10.

Adams was a departure from earlier cases that had allowed use of Trial Rule 41(E) other than under the strict procedure of Indiana Code § 34-18-8-8. [En. 49]

The above patchwork of statutes and cases are unnecessarily confusing. All that has to be done is to delete Indiana Code § 34-18-8-8 and Indiana Code§ 34-18-10-14. Then add to Indiana Code § 34-18-11-1 regarding preliminary determinations of law a new subsection (a)(3), which would state: "or determine appropriate sanctions against a plaintiff or defendant for failure

without just cause to prosecute, comply with discovery orders, or take any action required by chapter 10 of this article." That should just about cover it.

XII. CONCLUSION

The author will stop here for now. The changes that should be made to Indiana's Medical Malpractice Act-to save time, money, and make it as fair as possible-could fill a book. What both sides should want is the most reliable medical review panel opinion they can get. Even if it is better not to know how statutory changes are made, they should be attempted. We should not leave bad enough alone.

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End notes:

1. Ind. Code § 34-18-4-1.
2. Ind. Code § 34-18-2-14; Ind. Code § 34-18-2-24.5.
3. 875 N.E.2d 301 (Ind. 2007).
4. 603 N.E.2d 861 (Ind. 1992).
5. Ind. Code § 34-18-14-3.
6. Ind. Code § 34-18-3-1.
7. Examples of these types of cases where it was ultimately determined that the Act applied include the following. *Popovich v. Danielson*, 896 N.E.2d 1196 (Ind. Ct. App. 2008) (alleged assault and battery when evaluating plaintiff's injuries); *Winona Mem'l Hosp. v. Kuester*, 737 N.E.2d 824 (Ind. Ct. App. 2000) (negligent credentialing covered by Act); *Putnam County Hosp. v. Sells*, 619 N.E.2d 968 (Ind. Ct. App. 1993) (fall from bed while still under effects of anesthesia); *Collins v. Covenant Mut. Ins. Co.*, 604 N.E.2d 1190 (Ind. Ct. App. 1992) (some acts could be intentional and excluded or be health services and included); *Van Sice v. Sentany*, 595 N.E.2d 264 (Ind. Ct. App. 1992) (battery and fraud; Act neither specifically includes nor excludes intentional torts); *Bremer v. Community Hosps.*, 583 N.E.2d 780 (Ind. Ct. App. 1991) (Deceptive Sales Act); *Boruff v. Jesseph*, 576 N.E.2d 1297 (Ind. Ct. App. 1991) (battery due to no informed consent for particular health care provider to perform surgery); *Dove by Dove v. Ruff*, 558 N.E.2d 836 (Ind. Ct. App. 1990) (allergist's medicine preparation within Act and not a products case); *Scruby v. Waugh*, 476 N.E.2d 533 (Ind. Ct. App. 1985) (wrongful mental commitments); *Ogle v. St. John's Hickey Mem'l Hosp.*, 473 N.E.2d 1055 (Ind. Ct. App. 1985) (psychiatric in-patient raped by another patient); *Methodist Hosp. of Ind., Inc. v. Rioux*, 438 N.E.2d 315, 316 (Ind. Ct. App. 1982) (failure to provide appropriate care to prevent fall).
8. Examples of the types of cases where the Act was ultimately held not to apply include the following. *Fairbanks Hosp. v. Harrold*, 895 N.E.2d 732 (Ind. Ct. App. 2008) (neg staffing, hiring, training, and supervision of hospital employee involved with patient's care, for unwanted sexual advances to patient. Note: went through medical review panel); *Ob-Gyn Assocs. of N. Ind., P.C. v. Ransbottom*, 885 N.E.2d 734 (Ind. Ct. App. 2008) (cosmetic laser hair removal in doctor's office by nurse); *Doss v. BHC Meadows Hosp.,*

Inc., 884 N.E.2d 877 (Ind. Ct. App. 2008) (nonintentional breach of physician-patient privilege); *Madison Ctr., Inc. v. R.R.K.*, 853 N.E.2d 1286 (Ind. Ct. App. 2006) (psychiatric patient kicking another psychiatric patient while being restrained by staff *contra, Ogle v. St. John's Hickey Mem'l Hosp.*, 473 N.E.2d 1055 (Ind. Ct. App. 1985); *Mullins v. Parkview Hosp., Inc.*, 865 N.E.2d 608 (Ind. 2007), *vacating* 830 N.E.2d 586 (Ind. Ct. App. 2005) (patient's injury from failed intubation not intended by EMT student in training. Note: went through medical review panel); *Longa v. Vicory*, 829 N.E.2d 546 (Ind. Ct. App. 2005) (medical staff's negligent peer review and monitoring of patient deaths by nurse providing care to patients in hospital who, over time, killed many patients); *Community Hosp. v. Avant*, 790 N.E.2d 585 (Ind. Ct. App. 2003) (injury by personal training program designed for patient by a hospital subsidiary); *Peters v. Cummins Mental Health Inc.*, 790 N.E.2d 572 (Ind. Ct. App. 2003) (defamation and intentional infliction of emotional distress to mother for statements in son's psychiatric assessment that mother unfit); *Thomas v. Deitsch*, 743 N.E.2d 1218 (Ind. Ct. App. 2001) (breach by allowing intoxicated patient to drive away, then breach of confidentiality by notifying police of intoxication); *Weldon v. Univeral Reagents, Inc.*, 714 N.E.2d 1104 (Ind. Ct. App. 1999) (blood donor who was not a patient); *M.V. v. Charter Terre Haute Behavioral Health Sys.*, 712 N.E.2d 1064 (Ind. Ct. App. 1999), on *reh*. 706 N .E2d 1083 (Ind. Ct. App. 1999) (not discharging mental health patient, absent proper request under Indiana Code § 12-26-3); *Pluard v. Patient's Compensation Fund*, 705 N.E.2d 1035 (Ind. Ct. App. 1999), *trans. den*. (lamp falling from ceiling when positioned by nurse in preparation for procedure); *Grzan v. Charter Hosp.*, 702 N .E.2d 786 (Ind. Ct. App. 1998) (sexual relationship by psychiatric technician with psychiatric patient); *Murphy v. Mortell*, 684 N.E.2d 1185 (Ind. Ct. App. 1997) (technician molesting unconscious patient); *Smith v. State of Indiana*, 904 F. Supp. 877 (N.D. IN. 1995) (Americans with Disabilities Act claim against health care provider); *Doe by Doe v. Madison Ctr. Hosp.*, 652 N.E.2d 101 (Ind. Ct. App. 1995) (sexual assault on patient); *Collins v. Covenant Mut. Ins. Co.*, 604 N.E.2d 1190 (Ind. Ct. App. 1992) (some acts could be intentional and excluded or be health services and included; sexual relationship not included); *Harts v. Caylor-Nickel Hosp., Inc.*, 553 N.E.2d 874 (Ind. Ct. App. 1990) (patient fell out of bed with bed rails down); *Collins v. Thakkar*, 552 N.E.2d 507 (Ind. Ct. App. 1990) (doctor with personal relationship with patient examined her for pregnancy and during exam intentionally aborted pregnancy); *Methodist Hosp. of Ind., Inc. v. Ray*, 551N.E.2d 463 (Ind. Ct. App. 1990), adopted 558 N.E.2d 829 (Ind. 1990) (patient infected with Legionnella Pneumonia virus due to facility's negligent infection control); *Midtown Cmty. Mental Hosp. Ctr. v. Estate of Gahl*, 540 N.E.2d 1259 (Ind. Ct. App. 1989) (psychiatric hospital releases patient who then shoots non-patient); *Ogle v. St. John's Hickey Mem'l Hosp*., 473 N.E.2d 1055 (Ind. Ct. App. 1985) (inadequate security during psychiatric confinement allowed patient rape); *Winona Mem'l Found. v. Lomax*, 465 N.E.2d 731 (Ind. Ct. App. 1984), *trans. den*. (patient tripped over protruding floor board in medical facility and fell); *Emig v. Physicians Therapy Serv.*, 432 N.E.2d 52, 54 (Ind. Ct. App. 1982) (failure to restrain patient in wheelchair).

9. *Kho v. Pennington*, 875 N.E.2d 301 (Ind. 2007).
10. *E.g., Mullins v. Parkview Hosp., Inc.*, 865 N.E.2d 608 (Ind. 2007), *vacating* 830 N.E.2d 586 (Ind. Ct. App. 2005).
11. *Bowyer v. Indiana DNR*, 798 N .E.2d 912, 916 (Ind. Ct. App. 2003).

12. 895 N.E.2d 114, 115 (Ind. 2008).
13. Ind. Code § 34-18-10-20(a).
14. Ind. Trial R. 73.
15. Ind. Code § 34-18-10-20.
16. Ind. Code § 34-18-10-18.
17. *Riggin v. Rea Riggin & Sons, Inc.*, 738 N.E.2d 292, 309 (Ind. Ct. App. 2000); *State v. Bailey*, 714 N.E.2d 1144 (Ind. Ct. App. 1999); *Dominquez v. Syntex Labs., Inc.*, 149 F.R.D. 166, 168 (S.D. Ind. 1993); *Rosenbaum v. Warner & Sons, Inc.*, 148 F.R.D. 237 (N.D. Ind. 1993).
18. Ind. Code § 34-18-18-1.
19. *In re Stephens*, 851 N.E.2d 1256 (Ind. 2006).
20. 867 N.E.2d 148 (Ind. 2007).
21. Ind. Code § 34-18-10-22(b).
22. Ind. Code § 34-18-10-22(b)(l).
23. Ind. Code § 34-18-10-22(b)(2).
24. E.g., Ind. Jury Rule 27 (closing arguments).
25. E.g., Ind. Trial Rule 43(D); Ind. Jury Rules 21, 22. (True rebuttal evidence is very different from simply replying. *McCullough v. Archbold Ladder Co*., 605 N.E.2d 175, 179 (Ind. 1993)).
26. *Vergara v. Doan*, 593 N.E.2d 185, 187 (Ind. 1992).
27. 745 N.E.2d 880 (Ind. Ct. App. 2001).
28. 688 F. Supp. 446 (N.D. Ind. 1988).
29. 870 F.2d 1363 (7th Cir. 1989).
30. *Hassan v. Begley*, 836 N.E.2d 303 (Ind. Ct. App. 2005); *Etienne v. Caputi*, 679 N.E.2d 922 (Ind. Ct. App. 1997); *Malooley v. McIntyre*, 597 N.E.2d 314 (Ind. Ct. App. 1992).
31. *Kovach v. Caligor Midwest*, 913 N.E.2d 193 (Ind. 2009).
32. *Id*.
33. Ind. Code § 34-18-10-22(b)(4)(A)(B).
34. Ind. Code § 34-I8-10-17(e).
35. *E.g., GMC v. Aetna Cas. & Surety Co.*, 573 N.E.2d 885, 888 (Ind. 1991).
36. Ind. Code § 34-18-10-10.
37. Ind. Code § 34-18-19-7.
38. Ind. Code § 34-18-10-8.
39. Ind. Code § 34-18-11-1(a)(l).
40. Ind. Code § 34-18-11-1(a)(2).
41. Ind. Code § 34-18-8-8.
42. 602 N.E.2d 107, 110 (Ind. 1992).
43. 874 N.E.2d 611 (Ind. Ct. App. 2007) (reversed setting aside of dismissal as discovery violation and for pattern of dilatory conduct).
44. 654 N.E.2d 811 (Ind. Ct. App. 1995) (affirmed dismissal for failure to comply with discovery).
45. Past cases that seem to fit this category include the following. *Rambo v. Begley*, 796 N.E.2d 314 (Ind. Ct. App. 2003) (affirming dismissal where plaintiff made submission past 180-day deadline); *Beemer v. Elskens*, 677 N.E.2d 1117 (Ind. Ct. App. 1997) *reh. den., trans. den.* (dismissal for not filing submission reversed; good cause shown); *Gleason v. Bush*, 664 N.E.2d 1183 (Ind. Ct. App. 1996) (dismissal for plaintiff not

making submission within 180-day deadline reversed. Unable to tell if dismissal because no good cause shown or because 180-day deadline missed); *Jones v. Wasserman*, 656 N.E.2d 1195 (Ind. Ct. App 1995), *trans. den.* (Dismissal affirmed. Plaintiff never made submission within 180-day limit nor explained why had not); *Blackden v. Kaufman*, 611 N.E.2d 663 (Ind. Ct. App. 1993), *reh. den., trans. den.* (Dismissal affirmed. Chair had said no further extensions. Submission sent month late and caused failure to make 180-day deadline. Defendant not required to make submission until plaintiff has made a submission); *Ground v. Methodist Hosp.*, 576 N.E.2d 611 (Ind. Ct. App. 1991), *reh. den., trans. den.* (Dismissal affirmed. No plaintiff's submission within chair's schedule or 180-day limit. Called Indiana Code § 34-18-10-14 an administrative parallel to Trial Rule 41(E). No good cause); *Galindo v. Christensen*, 569 N.E.2d 702 (Ind. Ct. App. 1991) (Dismissal reversed. No submission within chair's schedule or 180-day limit. No evidentiary hearing to determine if good cause shown, if failure intentional or contumacious, and if prejudice. Only oral arguments allowed.).

46. 834 N.E.2d 233 (Ind. Ct. App. 2005).
47. 874 N.E.2d 1038 (Ind. Ct. App. 2007).
48. 877 N.E.2d 1246 (Ind. Ct. App. 2007), *on reh*.
49. *E.g., Beard v. Dominguez*, 847 N.E.2d 1054 (Ind. Ct. App. 2006).