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The 1975 Indiana Medical Malpractice Act

Symposium

The 1975 Indiana Medical Malpractice Act

Introduction: The Indiana Act in Context

The malpractice "crisis" defies definition. The scope of the problem and its solution are dependent upon the perspective from which the crisis is observed. In this sense all proposed "solutions" to the crisis must be evaluated in terms of their effect upon those elements of the malpractice problem which they are specifically designed to remedy, as well as upon those elements of the problem which they are required, by the limitations of their focus, to ignore.

From the perspective of the medical profession, the malpractice dilemma encompasses two distinct elements. First, the uneven applica-

tion of legal doctrines to professional liability cases[1] has forced physicians to employ practices which they might not normally employ, and to refrain from procedures they might otherwise employ, for fear of increasing the potential for a malpractice action. These are the basic considerations which are embodied in the phrases "positive"[2] and "negative"[3] defensive medicine. A distinguished panel has recently designated five areas in which the law has been applied unevenly, to the prejudice of health care professionals.[4] In summary form, these are:

(1) the doctrine of informed consent to treatment,

(2) the discovery rule under the statute of limitations,

(3) the terms of the statute of limitations,

(4) the doctrine of res ipsa loquitur, and

(5) liability for breach of express contracts.

The second element of the malpractice problem perceived by the medical profession can loosely be described as the crisis of liability insurance coverage. The new physician, the intern, and the once-negligent practitioner may find liability coverage most difficult to obtain.[5] This

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[1] *See* U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 31 (1973) [hereinafter cited as COMMISSION REPORT].

[2] Defensive medicine refers to "the alteration of modes of medical practice, induced by the threat of liability," COMMISSION REPORT at 14. *Positive* defensive medicine is "the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical legal liability." *Id.*

[3] *Negative* defensive medicine "occurs when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question." *Id.*

Defensive medicine can also involve a doctor's reluctance to publish case reports of adverse effects of diagnostic or therapeutic treatment for fear they will be used as evidence in a lawsuit. *See generally* A. HOLDER, MEDICAL MALPRACTICE LAW 414–15 (1975); Bernzweig, *Defensive Medicine* in COMMISSION REPORT, Appendix 38; STAFF OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 2 (Comm. Print 1969); Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939.

[4] COMMISSION REPORT at 31. The Commission also recommended that a broad-based group, representing the health care system, the legal profession, and the general public, develop appropriate definitions and guidelines in the form of a Restatement of the Law of Medical-Legal Principles.

Such a Restatement would, at the least, focus on some of the legal rules and doctrines which have created considerable confusion, for example,

(a) informed consent;
(b) res ipsa loquitur;
(c) the locality rule;
(d) evidentiary rules relating to the qualification of expert witnesses;
(e) discovery rule, as applied to statutes of limitations;
(f) oral guarantees of results of treatment; and
(g) definitions of death and other medical-legal questions involved in treatment of dying patients.

[5] *Id.* Gills, *Insurance Crisis: Availability to Physicians in Jeopardy*, in 3 AMERICAN TRIAL LAWYERS ASSOCIATION, QUALITY MEDICAL CARE—THE CITIZEN'S RIGHT at 1235

element of the crisis has manifested itself in the near shutdown of emergency services at several Indiana hospitals,[6] and the withdrawal of a number of policy writers from this field of insurance.[7] Physicians and surgeons in the so-called "high risk" categories[8] face insurance premiums so high that it is not unusual to hear of specialists who abandon their chosen fields for lower risk practices.

The patient's position in the malpractice dilemma is more simply stated and less susceptible to inflated or self-serving presentation than that of the medical profession. Medical services are being priced out of the range of the typical consumer. Indeed, the presumed inelasticity of medical service demand is open to question as some patients refrain from all but the most essential medical services. Defensive medical practices have inflated the costs of even the simplest services, and ever-increasing insurance premiums are inevitably passed on to the patient through increased service costs. Beyond doubt, the ultimate loser in the malpractice crisis is the medical consumer.

It is conceivable that the continuous rise in the number of malpractice claims commenced,[9] and claim files opened,[10] can be traced to the fact that the patient, burdened with the increasing costs of medical services and the profession's proclivity for defensive medical techniques, has come to expect a greater degree of expertise from the physician than medical science can presently provide. Indeed, the large volume of

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(1975); Cast, *Indiana's Medical Liability Problem*, 68 J. IND. ST. MED. ASS'N. 21 (1975); Little, *Malpractice Insurance Costs Hurt Public Too*, Fort Wayne News-Sentinel, Nov. 14, 1974, at 1B. *See generally* Van Valkenburg, *Can Our Courts be Saved?*, 50 MICH. ST. B.J. 75 (1971).

[6] *See* Bloomington Daily Herald-Telephone, Jan. 13, 1975, at 1.

[7] *See* Segar, *Is Malpractice Insurable?*, 51 IND. L.J. 128 n.1 (1975), *infra;* Gray, *The Insurer's Dilemma*, 51 IND. L.J. 120, 127 (1975), *infra;* Fort Wayne News-Sentinel, June 13, 1975, at 20B.

[8] Physicians are divided into various risk classes, depending upon the risk of malpractice, and young doctors in "Class 5" specialties such as orthopedic surgeons, neurosurgeons, cancer therapists, psychiatric shock therapists, obstretricians, and anesthesiologists, sometimes cannot get insurance at all. Little, *Malpractice Insurance Costs Hurt Public Too*, Fort Wayne News-Sentinel, Nov. 14, 1974, at 1B.

[9] The Indiana State Medical Association reports that the number of suits filed has increased 64 percent since 1969. Bloomington Daily Herald-Telephone, Jan. 14, 1975, at 1.

[10] On the average working day in 1970, the 26 or so major malpractice insurance companies opened approximately 70 medical malpractice claim files, or about 18,000 files for the year. Not all of these files represented malpractice claims made by or on behalf of patients. In fact, based upon comparable data for files closed in 1970, only 70% (or about 12,600) of the files represented claims asserted by patients; the remaining 30 percent were files that in all likelihood will be closed without a claim ever being made. Insurance companies opened these pre-claim files solely on the basis of reports by insured doctors and hospitals of adverse medical incidents or threats made by patients.

COMMISSION REPORT at 6 (footnote omitted). *Cf. id.*, Figure I, at 7.

successful malpractice suits,[11] and the hyperbolic increase in jury damage awards,[12] lend credence to such a theory.

Finally, the malpractice crisis is a crisis of the insurance industry itself. The increasing frequency of claims and the unpredictability of jury awards are said to render intelligent ratemaking impossible. Insurers are rushing to abandon the professional liability field.[13]

Proposals for salvaging the competitive[14] professional liability insurance industry abound. The plan most often discussed calls for transition from a claims-incurred basis for coverage to a claims-made system similar to that traditionally employed by Lloyds of London.[15] Even this technical change has met continued resistance from insurers.[16]

The legal profession has not been immune to criticism with respect to the malpractice crisis. In fact, it is not unusual to find responsibility placed squarely upon the broad shoulders of the plaintiffs' bar. In particular, the contingent fee system has been the object of passionate criticism, and repeated calls have been made for its modification or abolition.[17]

Thus, it is evident that the malpractive crisis is multifaceted and capable of assessment from a number of competing perspectives. Not surprisingly, these divergent perspectives have given rise to an ever-increasing number of proposals for remedial legislation, as well as reforms initiated by the judiciary, the medical profession, and the insurance industry.

THE QUEST FOR REFORM

Three major categories of remedial action have been proposed as "solutions" to the malpractice crisis. The first category consists of proposals directed to the insurance industry and to the mechanisms currently employed, through professional liability coverage, to compensate

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[11] *See* COMMISSION REPORT at 10.

[12] *See* Bloomington Daily Herald-Telephone, Jan. 14, 1975, at 1; COMMISSION REPORT at 10; U.S. NEWS & WORLD REPORT, Jan. 20, 1975, at 53.

[13] *See* note 7 *supra.*

[14] *See generally* Segar, *Is Malpractice Insurable?*, 51 IND. L.J. 128, 132-33 (1975), *infra.*

[15] Kendall & Haldi, *The Medical Malpractice Insurance Market,* COMMISSION REPORT, Appendix 494, at 508. *See* text accompanying notes 19–22 *infra.*

[16] COMMISSION REPORT, Appendix 494, at 508. *See also* Segar, *Is Malpractice Insurable?* 51 IND. L.J. 128, 131 (1975), *infra.*

[17] See F. MACKINNIN, CONTINGENT FEES FOR LEGAL SERVICES (1964). For a general discussion of the contingent fee problem, see Mallor, *A Cure for the Plaintiff's Ills?*, 51 IND. L.J. 103, 118 (1975), *infra;* Stewart, *The Malpractice Problem—Its Cause and Cure: The Physician's Perspective,* 51, IND. L.J. 134, 138 (1975), *infra. But see* COMMISSION REPORT at 32–33, which contends that the contingent fee system does not encourage litigation, nor does it grossly over-compensate plaintiff's attorneys for legal services rendered.

the malpractice victim and to protect the physician from personal liability for his actions. The second category embraces proposals for reform of the traditional tort litigation process as it applies to malpractice actions. Finally, there are proposals to eliminate the litigation process in the malpractice area, and to substitute various procedures in place of trial by jury.

Ratemaking and premium determination are complex actuarial processes.[18] As noted above, the malpractice crisis has apparently rendered intelligent ratemaking impossible, and has stimulated insurers and insurance industry analysts to seek modifications of the present system which will help to re-establish professional liability insurance as a profitable, and actuarially sound, enterprise.

Under the standard "claims-incurred" coverage, the insured is covered for any claim arising from an incident which occurred, or is alleged to have occurred, during the policy period, regardless of when the claim is actually made.[19] The uncertainty inherent in this system has spurred proposals for adoption of "claims-made" coverage, in which the insured is covered for any claim made while the policy is in force.[20] Coverage ceases when the policy lapses. Furthermore, claims-made policies are usually written to exclude claims based on incidents occurring prior to the effective date of the policy.[21] Thus, a degree of actuarial certainly could be added to the writing of professional liability policies. Nevertheless, many carriers have voiced opposition to such coverage unless the entire system of professional liability insurance is converted to claims-made policies.[22]

The proposals for modification of the tort litigation process are nearly as numerous and cumbersome as some elements of the process itself. The abolition, or at least the restriction of, the doctrine of res ipsa loquitur in medical cases has been suggested.[23] Similarly, calls for

[18] *See generally* Gray, *The Insurer's Dilemma*, 51 IND. L.J. 120 (1975), *infra;* and Segar, *Is Malpractice Insurable?* 51 IND. L.J. 128 (1975), *infra.*

[19] *See* Kendall & Haldi, *The Medical Malpractice Insurance Market*, COMMISSION REPORT, Appendix 494, at 508; *see also* Segar, *Is Malpractice Insurable?*, 51 IND. L.J. 128, 131 (1975), *infra.*

[20] *See* Kendall & Haldi, *The Medical Malpractice Insurance Market*, COMMISSION REPORT, Appendix 494, at 508. *See also* Segar, *Is Malpractice Insurable?* 51 IND. L.J. 128, 131 (1975), *infra.*

[21] Kendall & Haldi, *The Medical Malpractice Insurance Market*, COMMISSION REPORT, Appendix 494, at 508.

[22] *Id.* Of course, the situation would then leave the physician uncovered for claims *incurred* under the prior system but *made* under a claims-made system in which the policy excluded claims based on incidents prior to the effective policy date. It would appear that, at least initially, claims-made policies could not be written to exclude prior claims, or the physician will be unprotected against so called "long tail" actions.

[23] Interestingly, in Alaska, the first state in the nation to eliminate the applicability of res ipsa loquitur, approximately 20 percent of the physicians in the state are now

the restriction of the evolving doctrine of informed consent to treatment[24] are not uncommon. A few commentators who have focused on the troublesome area of contractual liability of physicians have argued for modification of the present evidentiary rules.[25] Moreover, a federal commission studying the malpractice crisis has concluded that professionals should not be singled out for uneven or biased application of the law.[26]

The principal focus of discussion in recent years has been upon alternatives to the tort litigation process. Numerous articles have carefully described the "deleterious consequences" which result from the present fault-liability approach to resolving malpractice claims. One article has summarized these consequences as follows:

A. *Patient-Claimant*

- Difficulty in uncovering medical evidence to prove provider negligence
- High cost of pursuing claims through legal channels thereby requiring the payment of large attorney fees (high contingency fee percentage and expenses) in the event of favorable disposition
- Difficulty in obtaining competent legal assistance for relatively minor claims thereby discouraging their filing
- Ambivalence in subjecting health care provider to stigma and adverse publicity
- Large disparity of awards and settlements for comparable injuries and circumstances
- Induces the patient-claimant to exaggeration and fraud.

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practicing without any form of malpractice insurance. *Malpractice Laws After Six Months: Some Progress: More Problems*, 16 MEDICAL WORLD NEWS 76, 81 (1975).

[24] A patient must be given sufficient information about the risks possible in a course of treatment, to allow him to give an effective or informed consent after an intelligent evaluation of the choices available. This may impose an unreasonable responsibility on the physician. COMMISSION REPORT at 29–30. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). *See generally* Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974).

[25] Indeed, some authors have proposed that any contractual liability be based on written contracts. *See* Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457 (1973); Note, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361 (1975).

The 1975 Indiana Medical Malpractice Act takes this approach. IND. CODE § 16-9.5-1-4 (Burns Supp. 1975). *See* Appendix, *infra*.

[26] COMMISSION REPORT at 31.

B. *Health-Care Provider*

- Long delays cause anxiety as to outcome of claims
- Negative reflection on professional stature
- Impedes the willingness to apply new techniques in favor of tried and proven procedures
- Degrades the relationship with patient by introducing suspicion and hostility
- Encourages practice of defensive medicine
- Results in loss of time from practice in preparing for defense.

C. *Insurance Carrier*

- Incurs large administrative costs
- Presents difficulties in setting actuarially-sound rates because of low predictability of number of claims and their dispositions, and size of settlements and awards.

D. *Public-at-Large*

- Increases cost of health care as a result of the alleged practice of defensive medicine and need to offset high malpractice insurance costs of health care providers and institutions
- Delays introduction of improvements in the delivery of health care services because of threat of malpractice claims as perceived by health care providers.[27]

In response, a number of proposed plans for statutory non-fault based compensation systems have been presented.[28] Such a plan has recently been enacted in New Zealand.[29] In fact, judges in at least two noteworthy cases have advocated *judicial* imposition of strict liability

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[27] Roth & Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, COMMISSION REPORT, Appendix 450, at 457.

[28] *See, e.g.*, A. HOLDER, MEDICAL MALPRACTICE LAW 431–34 (1975); J. O'CONNELL, ADDING INSULT TO INJURY (1975); Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward Displacement of Liability for "Medical Malpractice"*, 31 U. CHI. L. REV. 279 (1964); Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 459 (1972); Havighurst & Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 HEALTH AND SOC'Y 125 (1973); O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973); O'Connell, *It's Time for No Fault for All Kinds of Injuries*, 60 A.B.A.J. (1974); O'Connell, *Elective No-Fault Insurance For Many Kinds of Accidents: A Proposal and an "Economic Analysis"*, 42 TENN. L. REV. 145 (1974); Roth & Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, COMMISSION REPORT, Appendix 450. *But see* Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 616 (1973).

[29] *See* Bernstein, *"No-Fault" Compensation For Personal Injury in New Zealand*, COMMISSION REPORT, Appendix 836.

for medical maloccurrences.[30] Courts have been hesitant to adopt such a procedure,[31] and it would appear that implementation of such a non-fault based compensation system is more properly a function of the legislature than of the courts.

Perhaps the most widely discussed modification of, or alternative to, the present litigation system has been the screening panel approach.[32] The panel approach defies concise explanation, since panels have been proposed for widely divergent purposes, and there is no agreement on the composition of the panel. For example, under a statutory procedure which went into effect on January 1, 1972 in New Hampshire, claims against doctors, lawyers, and dentists are heard by three-member panels consisting of one state court judge, one member of the public, and one member of the profession against whom the claim was filed.[33] In two counties in New York, and on a statewide basis in New Jersey, the courts have established screening panels with membership markedly different from the New Hampshire plan.[34] Among the other plans which have been proposed, or which have taken effect, the plan currently employed in Pima County, Arizona, has received the most attention.[35]

Arbitration is another alternative which has been suggested as a substitute for the litigation process.[36] The Ross-Loos Medical Group,

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[30] Clark v. Gibbons, 66 Cal.2d 399, 414, 426 P.2d 525, 535, 58 Cal. Rptr. 125, 135 (1967) (Tobriner, J., concurring); Helling v. Carey, 84 Wash.2d 514, 521–22, 519 P.2d 981, 984–85 (1974) (three justices concurring).

[31] *See, e.g.*, Carmichael v. Reitz, 17 Cal. App.3d 958, 95 Cal. Rptr. 381 (1971) (drug reaction); Silverman v. Mount Zion Hosp., 20 Cal. App.3d 1022, 98 Cal. Rptr. 187 (1971) (broken surgical needle); Magner v. Beth Israel Hosp., 120 N.J. Super. 529, 295 A.2d 363 (1972) (plastic surgery); Magrine v. Krasnica, 94 N.J. Super. 228, 227 A.2d 539 (Co. Ct. 1967), *aff'd per curiam sub. nom.* Magrine v. Spector, 100 N.J. Super. 223, 225–41, 241 A.2d 637, 638–47 (1968) (dissent advocated strict liability), *aff'd per curiam*, 53 N.J. 259, 250 A.2d 129 (1969).

[32] *See* A. HOLDER, MEDICAL MALPRACTICE LAW 416–23 (1975); Winikoff, *Medical-Legal Screening Panel as an Alternative Approach to Medical Malpractice*, 13 WM. & MARY L. REV. 695 (1972); Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, COMMISSION REPORT, Appendix 214.

[33] N.H. REV. STAT. ANN. ch. 519-A (1974). The decision of the panel is not final; it may be accepted or rejected by the parties who may thereafter settle or sue.

[34] Under the New York plan, the panel consists of a physician, always a specialist in the field of the patient's complaint, a member of the New York City Bar, and an appellate judge. The New Jersey plan uses a panel consisting of two physicians, two attorneys, and a judge who acts as chairman. A. HOLDER, MEDICAL MALPRACTICE LAW 420 (1975). *See generally* note 37 *infra*.

[35] *See, e.g.*, Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, COMMISSION REPORT, Appendix 214, at 248–50 (comparing Pima and Maricopa County is Arizona); Mallor, *A Cure for the Plaintiff's Ills?*, 51 IND. L.J. 103, 109–10 (1975), *infra*.

[36] The following summary of screening panel systems is adopted from Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, COMMISSION REPORT, Appendix 214, at 280–81.

which furnishes pre-paid health care to some 90,000 California subscribers, has required an arbitration provision in all subscription agree-

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The form, purpose, and essential characteristics of the alternative plans to litigation are discussed in the paragraphs which follow.

Physician Screening Panels

These panels are usually composed solely or predominantly of doctors, who advise potential defendant doctors and their insurers whether to defend or settle claims made against them. Although many medical associations throughout the country have had one of these peer review or defense advisory committees for many years, only the following representative sample was reviewed:

- Idaho Medical Association, "Mediation Committee"
- Maine Medical Association, "Medical Advisory Committee"
- Medical Chirurgical Faculty of Maryland, "Physicians' Defense Committee"
- New Hampshire Medical Society, "Committee on Jurisprudence"
- Oregon Medical Association, "Professional Consultation Committee"
- Rhode Island Medical Society, "Committee on Mediation"

Physician-and-Advisory Screening Panels

In two instances, physicians supplemented their decision-making panel membership by including representatives of other professions:

- Honolulu (Hawaii) Medical Society, "Medical Practices Committee," which includes an attorney and a member of the clergy
- King County (Washington) Medical Society and Seattle-King County Bar Association, "Professional Liability Panel," which includes one member of the local bar association

Medical-Legal Screening Panels

These plans comprise the largest category. Plans listed below, from all known and existing screening panels, were reviewed:

- Alaska Bar Association Medical-Legal Committee
- Pima County (Arizona) Bar Association and Pima County Medical Society, "Medical Legal Plan"
- Maricopa County (Arizona) Bar Association and Maricopa County Medical Society, "Pima Plan for Medical Malpractice Claims"
- Colorado Bar Association and Colorado Medical Society, "Joint Medico-Legal Plan for Screening Medical Professional Liability Cases"
- Joint Medico-Legal Committee of the Delaware Bar Association and Delaware Medical Society, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Hillsborough County (Florida) Medical Association and the Tampa-Hillsborough County Bar Association, "Joint Medical-Legal Committee"
- South Central Idaho Medical Society and Bar Association of the 4th and 11th Judicial Districts of Idaho, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Scott County (Iowa) Bar Association and Scott County Medical Society, "Joint Interprofessional Relations Committee of the Scott County Medical Society and the Scott County Bar Association"
- Cumberland County (Maine) Medical Association and the Cumberland County Bar Association, "Medical-Legal Review Committee"
- Androscoggin County (Maine) Bar Association and Androscoggin County Medical Society, "Joint Medical-Legal Plan for Medical Malpractice Cases"
- Montana Medical Association and Montana Bar Association, "Medical-Legal Plan for Screening Medical Malpractice Cases"
- State Bar of Nevada and the Nevada State Medical Association, "Joint Medical-Legal Plan for Screening Medical Malpractice Cases"
- New Mexico Medical Society and State Bar of New Mexico, "Joint Medical Legal Plan for Screening Medical Negilgence Cases"
- Legal-Medical Committee of the Nassau County (New York) Bar Association and the Nassau County Medical Society, "Impartial Legal-Medical Advisory Panel"

ments since 1930.[37] Data from this system indicate that the arbitration approach has been uniquely successful.[38] In Philadelphia and Allegheny County, Pennsylvania courts have initiated a rule requiring arbitration of all tort disputes involving less than $10,000.[39]

- Suffolk County (New York) Medical Society and the Suffolk County Bar Association, "Joint Medical-Legal Program for Binding Arbitration of Medical Malpractice Cases"
- Academy of Medicine of Columbus and Franklin Counties (Ohio) and Columbus Bar Association, "Franklin County Medical Arbitration Plan"
- Montgomery County (Ohio), "Medical Arbitration Plan"
- Berks County (Pennsylvania) Medical Society and Berks County Bar Association, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Philadelphia County (Pennsylvania) Medical Society and Philadelphia Bar Association, "Professional Liability Consultation Service"
- Joint Medico-Legal Committee of the Medical Society for Virginia and Virginia State Bar, "Joint Screening Panel of the Medical Society of Virginia and Virginia State Bar"
- Pierce County (Washington) Medical-Legal Committee
- Spokane County (Washington), "Medical-Legal Panel for the Review of Possible Medical Malpractice Suits"
- Milwaukee County (Wisconsin), "Medical-Legal Panel Regarding Advisory Determination of Claims Allegedly Arising From Medical Malpractice"

Court-Sponsored Screening Panels

Two jurisdictions have established panels under the sponsorship of the courts for screening medical malpractice claims. Plans analyzed in this category were:

- State of New Jersey Administrative Office of the Courts, "Rule 4:21—Professional Liability Against Members of the Medical Profession"
- New York Supreme Court Appellate Division, First Judicial Department, "Medical Malpractice Mediation Program"

Statutory Plan

Only one state, New Hampshire, has recognized the institution of the screening panel through its legislature:

- New Hampshire Revised Statutes Annotated, Section 519-A:1 to 519-A:10, "Professional Malpractice Claims" (effective January 1, 1972)

Arbitration Plans

Arbitration includes procedures contracted for by the parties, in which they agree to substitute a private forum for the courts for the resolution of their disputes. The following arbitration plans were examined:

- California Hospital Association and California Medical Association, "Hospital Arbitration Regulations" and "Conditions for Admission"
- Southern California Kaiser Foundation, "1971 Amendment to Group Medical and Hospital Service Agreement of the Kaiser Foundation Health Plan, Inc."
- Ross-Loos Medical Group, Los Angeles, California
- Casualty Indemnity Exchange, Denver, Colorado, "Application, Treatment, and Arbitration Agreement"

[37] A. HOLDER, MEDICAL MALPRACTICE LAW 423 (1975). *See generally* Rubsamen, *The Experience of Binding Arbitration in the Ross-Loos Medical Group*, COMMISSION REPORT, Appendix 424.

[38] Few claims against the group (about 160 physicians and some 400 other personnel) have gone to full arbitration and most are settled prior to that point at an average annual cost of about $30,000. A. HOLDER, MEDICAL MALPRACTICE LAW 423 (1975); *see generally* Rubsamen, *The Experience of Binding Arbitration in the Ross-Loos Medical Group*, COMMISSION REPORT, Appendix 424, at 427–44, for analysis of 35 closed cases.

[39] A. HOLDER, MEDICAL MALPRACTICE LAW 423 (1975); COMMISSION REPORT at 92. The COMMISSION REPORT recommends more widespread use of imposed arbitration as an alternative method for resolving malpractice disputes. *Id.* at 93–94.

CONCLUSION

This discussion of suggested solutions to the malpractice "crisis" is by no means exhaustive. Nor is it intended to be. Instead, this brief introduction is designed to illustrate the context in which the Indiana legislature developed its own unique approach to the malpractice dilemma. Obviously, the success of the new Indiana procedure, as well as the success of other alternatives to the current system, is dependent not only upon the procedure's acceptability to the medical service consumer, but also upon its reception in the medical, legal, and insurance communities. Whether the Indiana Act will gain the approval of these varied constituencies remains to be seen.

APPENDIX

MALPRACTICE LAWS BY STATE AS OF MID-JULY 1975

	Joint Underwriters Association	Self-Insurance Plan	State Insurance Fund	Arbitration	Limit on Doctor's Liability (X 1,000)	MD-financed Catastrophic Fund	Tort Law Changes	Statute of Limitations (Years)	Limit on Lawyers' Fees (%)	Study Commission Established	Insurer Reports Claims to Commission	Major Insurance Carrier
Alabama*												Employers of Wausau
Alaska							★					Mutual F.I.M.
Arizona												Travelers
Arkansas	★											St. Paul
California*	★		★									Argonaut, Travelers
Colorado										★		Hartford
Connecticut										★		Aetna
Delaware												Aetna
Florida	★		★	100	★	★	4					Argonaut
Georgia	★											St. Paul
Hawaii	★											Argonaut
Idaho	★			150			★					St. Paul
Illinois	★		★	500				5				Hartford
Indiana		★	★	100	★	★	2	15†	★	★		Medical Protective
Iowa	★						6	‡	★			Medical Protective
Kansas									★			Medical Protective
Kentucky												Medical Protective
Louisiana		★	★	100	★	★	3	50	★			Hartford
Maine	★								★			Hartford
Maryland	★	★										Self Insurance Plan
Massachusetts	★		★				★	3	★			St. Paul
Michigan*		★	★					2½	N.J.	★		Medical Protective
Minnesota												St. Paul
Mississippi												St. Paul
Missouri		★						2		★		Medical Protective
Montana								3		★		Aetna
Nebraska										★		St. Paul
Nevada	★		★				★					Imperial
New Hampshire	★									★		Hartford
New Jersey									N.J.			Chubb & Son
New Mexico												Travelers
New York	★	★	★									JUA-Self-Ins.
North Carolina	★											St. Paul
North Dakota		★						6				St. Paul
Ohio*												Medical Protective
Oklahoma												Ins. Co. of N.A.
Oregon		★		¶	★	★	5	33⅓			★	CNA conglomerate
Pennsylvania*												Medical Protective
Rhode Island	††									★		St. Paul
South Carolina	★									★		St. Paul
South Dakota								6		★		St. Paul
Tennessee	★		★				★	3	33⅓			Shelby Mutual
Texas	★							2		★		Medical Protective
Utah												Aetna
Vermont												Aetna
Virginia												St. Paul
Washington							★					Aetna
West Virginia										★		Aetna
Wisconsin	★			200	★							Medical Protective
Wyoming										★		Aetna

**Legislature still in session*
†On fees collected from catastrophic fund
‡Court decides fees
¶Class 1 and 2: $100,000
Class 3 and 4: 300,000
Class 5 and 6: 500,000
††Non-statutory

N.J. The so-called New Jersey rule, based on a sliding scale, as follows:
40% on first $5,000
33⅓% on next $45,000
20% on next $50,000
10% of anything over $100,000
(In N.J. this rule is nonstatutory.)