The Proper Scope of Claimant Coverage Under the Indiana Medical Malpractice Act

Introduction

The Indiana Medical Malpractice Act[1] has spawned numerous problems, one of which is the proper scope of claimant coverage. That is, what types of claims, other than those which clearly and unambiguously fall within the Act, should the courts interpret the Act to include? The issue elicits many questions. Can only patients with malpractice claims be required to abide by the Act? Only patients and/or their legal representatives? Must temporarily incompetent persons, made patients by involuntary commitment to a health care facility, abide by the Act when later filing a malpractice claim? What about patients injured by other patients within the confines of a hospital? Are third-party, derivative claims covered under the Act? Do third-party, non-patient claims by those injured as a result of medical treatment of patients fall within the Act?

The third-party context is the primary emphasis of this Note. This area of inquiry lies on the penumbra of the Act's application. However, these questions have arisen and will continue to arise in Indiana, and it is possible, through a careful analysis of the field as it exists today, to resolve them consistently with the language and purposes of the Act. This Note has three main goals. First, it surveys the types of claimants who fall within the Act according to the Indiana courts' existing interpretations. Second, it analyzes these Indiana cases focusing on their consistency with the statutory language, with one another, and with the probable legislative intent underlying the Act. Third, it suggests an approach for future consideration of this set of issues in Indiana.

This Note consists of five main sections in addition to an introduction and a conclusion. Section I provides background on the questions central to the later sections. Section II discusses the legislative intent of the Act. Section III addresses the placement of derivative claims within the Act. Section IV concerns marginal cases involving the definition of "patient" under the Act. Section V develops the extension of the Malpractice Act to cover third-party, non-derivative claims which allege medical malpractice. These five sections combine to demonstrate, from different conceptual angles, this Note's conclusion that all third-party

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1. Ind. Code §§ 16-9.5-1-1 to -10-3 (1988). Throughout this Note these statutes are referred to as "the Act" or the "Medical Malpractice Act."

claims based on malpractice ought to come within the Act, whether these claims are direct or derivative.

I. Background

An apparent ambiguity in the language of the Act is at the heart of nearly all the disputes concerning claimant coverage. Three central provisions create this ambiguity and typically require construction by courts. The first provides that "*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 and an opinion is rendered by the panel."[2] The second provision defines "malpractice" as any "*tort* or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, *to a patient*."[3] The third defines "tort" as any "*legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another*."[4]

The first quoted section suggests that the Act extends to any action whatsoever against a qualified health care provider. The second section suggests that only a patient may sue under the Act and that only patients' claims are governed by its provisions. Finally, if the definition of "tort" were substituted in place of the term "tort" into the definition of "malpractice,"[5] the Act would again appear to include claims other than those by patients.

The most recent case addressing a third-party claim, *Midtown Community Mental Health Center v. Estate of Gahl*,[6] provides a focal point

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2. Ind. Code § 16-9.5-9-2 (1988) (emphasis added).

3. Ind. Code § 16-9.5-1-1(h) (1988) (emphasis added).

4. Ind. Code § 16-9.5-1-1(g) (1988) (emphasis added).

These are not, of course, the only three provisions which trouble interpreters of the Act when addressing questions of the scope of claimant coverage. They are, however, central to virtually all disputes over coverage of the Act. Several other provisions are discussed later in this Note in the context of case analysis.

5. If this were done, the definition of "malpractice" would read: "'malpractice' means *a [legal wrong, breach of duty, or negligent or unlawful act or omission* proximately causing injury or damage *to another*] or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, *to a patient.*" (emphasis added). It would therefore include both the possibility of injuries directly to patients, and the possibility of injuries to "another" affected by treatment or omission thereof to a "patient."

6. Midtown Community Mental Health Center v. Estate of Gahl, 540 N.E.2d 1259 (Ind. Ct. App. 1989), *trans. denied*. The claim in *Gahl* is advanced by Thomas E. Gahl's wife, Nancy L. Gahl, as administratrix of his estate and on behalf of Christopher T. Gahl and Nicholas K. Gahl, their children. Throughout this Note, the estate (plaintiff-

for this Note. In *Gahl*, the court held that the estate of probation officer Thomas E. Gahl, who was killed by the hospital's former patient, was not required to bring its claim against the defendants to the medical review panel in conformity with the Act, even though several of the claims were for alleged malpractice in connection with the hospital's treatment of the patient.[7] The court concluded that the Indiana Medical Malpractice Act requires only patients and those with strictly derivative claims to come within the Act.[8]

The remainder of this Section briefly presents and classifies, as a prelude to specific analysis, the previous Indiana cases which turn on questions regarding the scope of claimant coverage under the Act.

In 1980, the First District Court of Appeals held in *Sue Yee Lee v. Lafayette Home Hospital, Inc.*[9] that parents seeking recovery for loss

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appellee) will be referred to as "Gahl," "estate of Gahl," or some similar designation. The defendants are jointly designated as "Midtown" (defendant-appellant). Also joined as defendants were: Health and Hospital Corporation of Marion County, Indiana; Wishard Memorial Hospital; Alan D. Schmetzer, M.D.; Michael J. Trent, PSW; Eugene S. Turrell, M.D.; and the Trustees of Indiana University.

7. Brief for Appellant in Support of Petition to Transfer at 16-17, *Gahl*, 540 N.E.2d 1259 [hereinafter Brief for Appellant]. The claims involved failure to supervise, abdication of duty, incorrect diagnosis, failure to properly medicate, and failure to warn Thomas Gahl of the patient's dangerousness.

Indiana has, since the filing of the claim in *Gahl*, enacted legislation which provides partial immunity from civil liability to third persons for "health care providers" (defined in IND. CODE ANN. § 34-4-12.6-1 (West Supp. 1990)) who either fail to warn or fail to predict dangerous behavior on the part of their patients. IND. CODE ANN. § 34-4-12.4-2 (West Supp. 1990) provides:

> A mental health service provider is immune from civil liability to persons other than the patient for failing to:
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> (1) predict; or
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> (2) warn or take precautions to protect from;
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> a patient's violent behavior unless the patient has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others.

This provision does not grant absolute immunity to the health care provider, nor does it limit the element of foreseeability only to those who are individually identifiable. It provides immunity only for failure to warn when the provider has not had adequate warning as to the dangerous propensities of the patient relative to identifiable persons or, more generally, "to others." Thus, even though providing limited immunity, the statute does not render the outcome in future cases like *Gahl* certain.

This provision is also limited in that the immunity provided is confined to failure to warn, and is silent about any other potential medically-based cause of action stemming from treatment of a psychiatric patient.

8. *Gahl*, 540 N.E.2d at 1262.

9. 410 N.E.2d 1319 (Ind. Ct. App. 1980).

of services and medical expenses for their minor child were required to abide by the provisions of the Act. Although the issues in *Sue Yee Lee* are distinct from those in *Gahl* because the claim in *Sue Yee Lee* is clearly derivative, neither case involved a claim brought by the patient himself. The *Gahl* court cited *Sue Yee Lee* as the primary basis for limiting third-party claims to unambiguously derivative ones.[10] The court in *Gahl* read *Sue Yee Lee* as adopting the view that the legislature intended that the "act appl[y] not only to cases where the patient was the plaintiff, but also to cases where a third-party plaintiff's claim was derived from the patient, such as a parent's claim based upon a minor child's injury."[11] However, the *Gahl* court also acknowledged a more sweeping conclusion in *Sue Yee Lee*: that the Act covered all claims "where the *underlying basis for liability* is medical malpractice."[12] This tension inherent in the language of the *Sue Yee Lee* court and acknowledged by the *Gahl* court suggests judicial uncertainty over the proper scope of the Act's coverage of third-party claims.

The *Gahl* court, in order to distinguish *Sue Yee Lee*, stressed that only third-party claims that are derivative of patients' claims come within the provisions of the Act.[13] This distinction may or may not satisfactorily distinguish *Gahl* and *Sue Yee Lee*, but the view that only derivative claims, as in *Sue Yee Lee*, are covered under accepted theories of professional negligence is not universal.[14]

In a different setting, but one in which claimant coverage was again the central issue, the court of appeals concluded in *Winona Memorial Foundation of Indianapolis v. Lomax*[15] that the Malpractice Act was not applicable to a plaintiff who fell and was injured while in the hospital even though the claimant was a patient there at the time of the injury. The court reasoned that the sort of premises liability claim the plaintiff asserted was not within the intended scope of the Act.[16]

However, in *Methodist Hospital v. Rioux,*[17] the same court concluded two years earlier that the Malpractice Act applied to a plaintiff in very

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10. 540 N.E.2d at 1261.

11. *Id.*

12. *Id.* (emphasis added). This conclusion is dicta, but resulted from the *Sue Yee Lee* court's construction of the terms of the Act. *See infra* Section V of this Note.

13. *Id.*

14. *See, e.g.,* Hedlund v. Superior Court of Orange County, 34 Cal. 3d 695, 669 P.2d 41, 194 Cal. Rptr. 805 (1983); *Gahl,* 540 N.E.2d at 1263 (Hoffman J., dissenting); Thompson v. County of Alameda, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980); Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979).

15. 465 N.E.2d 731 (Ind. Ct. App. 1984).

16. *Id.* at 740.

17. 438 N.E.2d 315 (Ind. Ct. App. 1982).

similar "slip and fall" circumstances as those in *Lomax*. In *Rioux*, the court reasoned that the claim was based primarily on a failure of appropriate care in a medical setting and was therefore covered by the Act.[18] The *Lomax* court distinguished its *Rioux* decision by noting the presence in *Lomax* of a clear and unambiguous premises liability claim, which the court concluded took the claim out of the Act.[19]

Several other Indiana cases which involve variations on the general issue at stake in *Gahl* are the focus of later discussion.[20] Some of these cases deal with the practical application of the definition of "patient" under the Indiana Medical Malpractice Act.[21] Others concern the issue of potential duties of health care providers to protect patients or third parties from assault or other injury.[22]

Several years ago commentators noted the tension in this area[23] and the courts' failure to achieve resolution.[24] The recent decision in *Gahl*, and the silence on the particular issues involved in *Lomax* and *Rioux*, suggest the issues remain unresolved in Indiana. A strong dissent by Judge Hoffman in *Gahl*[25] adds to this uncertainty. The dissent relies heavily on interpretations of the Louisiana Medical Malpractice Act,[26] the language of which is almost identical to Indiana's in this area.[27] The Louisiana case of *Thomas v. LeJeune, Inc.*[28] held that "*all* claims against health care providers for malpractice must first go through the Medical Malpractice Act procedure, regardless of whether the claimant is a patient or a non-patient."[29] Judge Hoffman's dissent in *Gahl* likewise

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18. *Id.* at 316-17.

19. 465 N.E.2d at 742.

20. Scruby v. Waugh, 476 N.E.2d 533 (Ind. Ct. App. 1985); Ogle v. St. John's Hickey Memorial Hosp., 473 N.E.2d 1055 (Ind. Ct. App. 1985); Detterline v. Bonaventura, 465 N.E.2d 215 (Ind. Ct. App. 1984); Estate of Mathes v. Ireland, 419 N.E.2d 782 (Ind. Ct. App. 1981).

21. *See, e.g., Scruby*, 476 N.E.2d 533; *Detterline*, 465 N.E.2d 215.

22. *See, e.g., Ogle*, 473 N.E.2d 1055; *Mathes*, 419 N.E.2d 783.

23. Kemper, Selby & Simmons, *Reform Revisited: A Review of the Indiana Medical Malpractice Act Ten Years Later*, 19 IND. L. REV. 1129 (1986).

24. *Id.* at 1139.

25. 540 N.E.2d at 1262-63 (Hoffman, J., dissenting).

26. LA. REV. STAT. ANN. § 40:1299.47 (West Supp. 1990).

27. LA. REV. STAT. ANN. § 40:1299.47(B)(1)(a)(i) (West Supp. 1990) states: "No action against a health care provider . . . may be commenced in any court before the claimant's proposed complaint has been presented to a medical review panel. . . ."

28. 501 So. 2d 1075 (La. Ct. App. 1987). In *LeJeune*, the plaintiff slipped and fell in a tavern. Third-party issue arose out of the tavern owner's claim made against a former health care provider of the plaintiff. The factual setting is, therefore, different in the two cases, but the inclusiveness of the malpractice statute in each case is at issue.

29. *Id.* at 1077 (emphasis in original). Notwithstanding the use made of *LeJeune* by the parties in *Gahl*, several Louisiana cases evince the same tension inherent in Indiana's

stressed the importance of a malpractice claim by Gahl's estate, regardless of the status of Gahl as a patient. Judge Hoffman concluded:

> The Act should cover *all claims* against health care providers whether the claimant is a patient or nonpatient. This is regardless of whether the patient will derive some benefit from the nonpatient claim. The essential element is that the claim is based on alleged medical malpractice as in this case.[30]

This Note suggests that this conclusion is the most appropriate in light of discernable legislative intent, previous case law, and the special role of the medical review panel created by the Act.

II. Legislative Intent and Social Policy of the Act

This Section reviews the established and often-cited analysis of the Indiana Supreme Court in *Johnson v. St. Vincent Hospital, Inc.*[31] regarding the legislative intent and underlying social policies of the Medical Malpractice Act.[32] This Section also analyzes *Gahl*, the focal point case, in light of legislative intent.

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decisions. For example, although Louisiana courts have decided to allow derivative claims to come within the scope of the medical malpractice act, *see* Gobble v. Baton Rouge Hosp., 415 So. 2d 425 (La. Ct. App. 1982), they have denied coverage to a patient-plaintiff in a case very much like *Lomax*, *see* Head v. Erath Gen. Hosp., Inc., 458 So. 2d 579 (La. Ct. App. 1984), *cert. denied*, 462 So. 2d 650 (La. 1985). They have also denied coverage of their medical malpractice act to a claim that improper security in a hospital resulted in the assault, battery, and rape of a patient. *See* Reaux v. Our Lady of Lourdes Hosp., 492 So. 2d 233 (La. Ct. App. 1986), *cert. denied*, 496 So. 2d 333 (La. 1986).

Further, the Louisiana legislature in 1984 amended a portion of its medical malpractice act's limitation on recovery section to read: "A health care provider qualified under this Part is not liable for an amount in excess of one hundred thousand dollars for all malpractice claims because of injuries to or death of any one patient." La. Rev. Stat. § 40:1299.42(B)(2) (West Supp. 1990). This section previously read "person" where it now reads "patient," making it quite arguable that the legislature intended to remove the question of third party claims like that in *Gahl* from its scope.

However, suggesting a more liberal reading in certain contexts, a Louisiana court has held that, even when alternative theories of liability are available, claims of improper conduct which reasonably come within the definitions of the Act ought to be pursued through the Act. *See* Cashio v. Baton Rouge Gen. Hosp., 378 So. 2d 182 (La. Ct. App. 1979).

30. *Gahl*, 540 N.E.2d at 1263 (Hoffman, J., dissenting) (emphasis in original).

31. 273 Ind. 374, 404 N.E:2d 585 (1980).

32. For discussions detailing the underlying conditions precipitating the enactment of the Indiana Medical Malpractice Act, see *The 1975 Indiana Medical Malpractice Act*, 51 Ind. L.J. 91 (1975), a symposium which contains several articles related directly to the insurability of malpractice and the intended effects of the Act.

Johnson is primarily valuable to this Note for its delineation of the policies underlying the Act. This is important because in each sub-class of claimant coverage disputes, the strength of the position taken by plaintiff and defendant will be judged in part by its conformity to these underlying goals. *Johnson* affirms the constitutionality of the Medical Malpractice Act,[33] and itself involves a derivative claim of parents for wrongful death of a minor child.[34] In *Johnson*, the Indiana Supreme Court analyzed several key provisions of the Act, and focused heavily on the requirement of a pre-trial medical review panel hearing.[35]

Each of the four consolidated cases in *Johnson*[36] involved issues related to the Act's constitutionality. In one of these, *Mansur v. Carpenter*, the defendant produced voluminous evidence, which the court reviewed extensively, as to the condition of the health care industry in Indiana prior to the Act.[37] Various factors played a role in the legislative determination to implement some sort of protection from escalating claims, reduction of coverage availability, and increased health care costs. The court specifically cited the cessation or reduction of malpractice insurance coverage by seven of ten insurance companies then writing policies; a 1200 percent increase in malpractice insurance premiums among those who continued to write policies; the flight of physicians in certain "high-risk" categories of practice into states where coverage was easier or cheaper to obtain; and, the discontinuation of health care services, such as elective surgery, in some locations.[38]

According to the *Johnson* court "[the Act] reflects a specific legislative judgment that a causal relationship existed at the time between the settlement and prosecution of malpractice claims against health care providers and the actual and threatened diminution of health care services."[39] Underlying this legislative conclusion was another conclusion

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33. 273 Ind. at 393, 404 N.E.2d at 597.

34. The derivative nature of the claim by the Johnsons was not an issue on appeal.

35. 273 Ind. at 387-400, 404 N.E.2d at 591-98; *see* IND. CODE § 16-9.5-9-2 (1988). As originally enacted, by Pub. L. No. 146-1975, § 1, this provision read: "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 and an opinion is rendered by the panel." IND. CODE ANN. § 16-9.5-9-2 (West 1984).

In 1985, Pub. L. No. 177-1985, § 8, amended this provision. The amendment left the language above intact, but added a provision which allowed the parties to agree not to have a panel convened. *See* IND. CODE § 16-9.5-9-2(b) (1988), which refers to IND. CODE § 16-9.5-9-3.5 (1988), which delineates time limitations for panel action.

36. Johnson v. St. Vincent Hosp. Inc.; Bova v. Kmak; Mansur v. Carpenter; Hines v. Elkhart Gen. Hosp.

37. *Johnson*, 273 Ind. at 379, 404 N.E.2d at 589.

38. *Id.* at 379-80, 404 N.E.2d at 589-90.

39. *Id.* at 379, 404 N.E.2d at 590.

that the escalating levels of malpractice claims and subsequent judgments were causally linked to several facts. First, "the processes by which evidence of negligent conduct was being gathered, evaluated, and used were faulty."[40] Second, habitually negligent health care providers were not being effectively dealt with.[41] Third, excessive attorney's fees were driving up the claimed damages.[42]

The first of these facts, the faulty processes for gathering, evaluating, and using evidence of negligent conduct, is especially relevant to the requirement that all malpractice claims be presented to the medical review panel prior to court action. Regarding this requirement the *Johnson* court noted:

> [Medical malpractice cases] . . . routinely require the ascertainment of technical and scientific facts, procedures, and expert opinions for the purposes of determining whether a breach of legal duty has occurred. The panel submission requirement serves this requirement and tends to insure that a resolution of a dispute will be based upon the ascertainment of the true facts and circumstances and will be fair. . . .[43]

The court concluded that "[t]he requirement of the statute that malpractice claims be first submitted to a medical panel for evaluation is one reasonable means of dealing with the threatened loss to the community of health care services. . . ."[44]

This Note proposes that these justifications are equally viable for third-party claims alleging malpractice, and that inclusion of a broader range of potential claimants than the present case law allows is similarly justifiable. The parties in *Gahl*, arguing on a motion to transfer to the Indiana Supreme Court, each addressed whether the intent of the Act is broad enough to cover the claims made in *Gahl*.[45]

Gahl's estate argued that the circumstances upon which its claim was made render the underlying policy rationale for the Medical Malpractice Act inapplicable.[46] Gahl based this conclusion upon two main points, both of which involve the sort of policy arguments outlined in *Johnson*. First, rather than the Medical Malpractice Act, with its provisions limiting damages to $500,000,[47] the Indiana Tort Claims Act

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40. *Id.* at 380, 404 N.E.2d at 590.
41. *Id.*
42. *Id.*
43. *Id.* at 393, 404 N.E.2d at 597.
44. *Id.* at 387, 404 N.E.2d at 594.
45. Brief for Appellee in Opposition to Petition to Transfer at 13-15, 540 N.E.2d 1259 [hereinafter Brief for Appellee]; Brief for Appellant, *supra* note 7, at 22-25.
46. Brief for Appellee, *supra* note 45, at 12-14.
47. *Id.* at 14.

should apply.[48] According to Gahl, the Indiana Tort Claims Act should apply because all of the defendants are "political subdivisions or employees thereof."[49] This argument carries some weight because there is a limitation of liability of $300,000 under the Tort Claims Act, thereby reducing plaintiff's potential damages.[50] This potential reduction, Gahl argued, undercuts the defendant's policy argument because the cost-cutting rationale of the Act is thereby made irrelevant.[51] Second, the estate noted that the provision of the Medical Malpractice Act limiting recovery explicitly states that "[t]he total amount recoverable for an injury or death of a *patient* may not exceed $500,000."[52] The explicit use of the term "patient" is conclusive in Gahl's view of the intended scope of the Act.[53]

Midtown's policy argument[54] was that excluding this claim from the Act's coverage "has the effect of placing a third-party in a better position than a patient even when the cause of action is based on the same negligent act."[55] This is so, Midtown argued, because third-party claimants would not be subject to a limitation on damages in some cases, nor would they be subject to the medical review panel pre-trial hearing requirement.[56]

Midtown's argument is more consistent with legislative intent. The court's reasoning in denying Midtown's argument could lead to the anamolous result of having extremely similar claims proceeding through different legal channels, with quite different procedural requirements. The difference would be based entirely upon the identity of the claimant rather than the theory of the claim. Further, the decision to exclude third-party, non-derivative claims will not further the explicit legislative goal of reducing either the amount of judgments or health care costs because many claims will not be subject to other limitations such as those imposed by the Indiana Tort Claims Act for claims against governmental bodies.

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48. *Id.* (citing IND. CODE § 34-4-16.5-1 to 34-4-16.5-21 (1988)).

49. *Id.* at 13 (citing IND. CODE § 34-4-16.5-2 (1988)).

50. *Id.* at 13.

51. The appropriate response to this point is to note that the legislature foresaw this potentiality and included a provision to bring such entities within the Medical Malpractice Act. IND. CODE § 16-9.5-1-9 (1988). "A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental entity, as those terms are defined in IC 34-4-16.5, shall be governed exclusively by this article if the governmental entity or employee is qualified under this article." *Id.*

52. Brief for Appellee, *supra* note 45, at 14 (citing IND. CODE § 16-9.5-2-2 (1984) (emphasis added)).

53. *Id.* at 14.

54. Brief for Appellant, *supra* note 7, at 22-25.

55. *Id.* at 24.

56. *Id.*

III. The Inclusion of Derivative Claims

There is little controversy about whether derivative claims alleging malpractice should come within the Act. This Section presents the conventional rationale for their inclusion and suggests that this rationale applies equally well to third-party non-derivative claims alleging medical malpractice.

Sue Yee Lee v. Lafayette Home Hospital, Inc.[57] is the leading case extending coverage of the Act to derivative claims. The action was brought by a minor for personal injuries and by her parents for loss of services and past, present, and future medical expenses.[58] The claims were all based on medical malpractice. The physicians and hospitals named as defendants filed motions either for summary judgment or to dismiss[59] on the ground that because the claims were based on malpractice, a medical review panel, which had not been convened, was required. The trial court granted defendants' motions, thereby requiring the plaintiffs to file a proposed complaint with the panel.[60]

After holding, on the basis of *Johnson*, that the Act was constitutional,[61] the court addressed the Lees' contention that the parents' action for loss of services and medical expenses fell outside the scope of the Act, and that they therefore should not be required to file their complaint with the medical review panel.[62] The court approached the problem from two angles. First, the court construed the Act[63] because it was "ambiguous and unclear in meaning with regard to whether or not the action of parents for loss of services of, and medical expenses for, a minor child is subject to the act."[64] Second, the court addressed the underlying policy for the Act's creation.[65]

The court's construction of the Act focused upon several definitional and substantive provisions. The most important of the definitions are those of "representative," "tort," "malpractice," and "health care."[66]

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57. 410 N.E.2d 1319 (Ind. Ct. App. 1980).
58. *Id.* at 1320.
59. *Id.*
60. *Id.*
61. *Id.* at 1320-21.
62. *Id.* at 1321.
63. *Id.* at 1322-23.
64. *Id.* at 1323.
65. *Id.*
66. *Id.* at 1321 (quoting Ind. Code § 16-9.5-1-1 (1976)):

(f) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

(g) "Tort" means any legal wrong, breach of duty, or negligent or unlawful

In addition to these definitional sections, the court also noted the substantive provision granting the right to file suit under the Act. The statute provides that "*a patient or his representative* having a claim under this article for bodily injury or death on account of malpractice may file a complaint."[67]

Finally, the court noted the language of the provision requiring that all such claims go through a medical review panel: "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 and an opinion is rendered by the panel."[68]

Though not addressing each section separately, the court agreed with the defendants' reading of these sections of the Act and held that the Lees' claims ought to be governed by the Act's provisions.[69] Specifically, it noted that the inclusion of "representative" along with "patient" as among those with a right to state a claim under the Act evinced a legislative intent not to restrict coverage exclusively to patients.[70]

The Lees further argued that because their claim for loss of services was not expressly mentioned in any of the relevant provisions, the principle of *expressio unius est exclusio alterius* ought to apply and exclude their claim from coverage under the Act.[71] The court rejected this argument in strong, sweeping language based not only on its reading of specific provisions, but also on perceived legislative intent:

> [W]e believe the conclusion is inescapable that our *General Assembly intended that all actions the underlying basis for which is alleged medical malpractice are subject to the act.* Since the obvious purpose of the act is to provide some measure of protection to health care providers from malpractice claims, and to preserve the availability of the professional services of physicians and other health care providers in the communities and

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act or omission proximately causing injury or damage to another.

(h) "Malpractice" means any tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

(i) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment or confinement. . . .

67. *Id.* at 1321 (quoting IND. CODE § 16-9.5-1-6 (1976) (emphasis added)).
68. *Id.* at 1322 (quoting IND. CODE § 16-9.5-9-2 (1976)).
69. *Id.* at 1324.
70. *Id.*
71. *Id.* at 1322.

> thereby protect the public health and well-being, *it is totally inconceivable that the legislature intended to extend this protection only to actions wherein the actual patient was the party plaintiff and to exclude other claims for medical malpractice wherein the plaintiff was not the actual patient, but one whose right of action was derived from the patient such as the parents' claim here.*[72]

The court reasoned that the principle of *expressio unius est exclusio alterius* is a tool to aid in determining legislative intent and not a rule of law.[73] Thus, because the court was certain as to the legislative intent, to apply the principle mechanically in this case would have been absurd.[74]

The above-quoted passage not only refers specifically to derivative claims, but also to "all claims the underlying basis for which is alleged malpractice." Moreover, the court immediately thereafter explicitly repeats the broader scope of its decision in stating that "we believe all persons having causes of actions founded upon alleged medical malpractice are subject to, and must comply with the act."[75] This language clearly creates a larger class of potential claimants, which includes the Lees, but the outer limits of which are not foreclosed by the type of derivative claim they brought. This inclusive language suggests that drawing fine distinctions among different types of malpractice claims by parties attempting to relieve themselves from the structures of the Act is inappropriate.

The claimant in *Gahl* argues that the sub-class of derivative claims acknowledged in *Sue Yee Lee* is the full extent of the intended scope of claimant coverage under that decision. Gahl further argued from the very existence of an inquiry into the identity of the party pressing the claim that had the court thought inclusion or exclusion of a claimant from the Act turned only on the form of claim, it would not have had to address the Lees' position in relation to the patient.[76]

Gahl also cited a decision by the Indiana Supreme Court, *Community Hospital v. McKnight*,[77] as grounds for limiting the field of potential claimants under the Act to patients and representatives only.[78] In *McKnight*, the court held that "representatives" included a spouse and son of a patient within the meaning of the Medical Malpractice Act, and that

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72. *Id.* at 1324 (emphasis added).
73. *Id.* at 1324.
74. *Id.*
75. *Id.*
76. Brief for Appellee, *supra* note 45, at 11.
77. 493 N.E.2d 775 (Ind. 1986).
78. Brief for Appellee, *supra* note 45, at 12.

they did not have to meet conditions precedent under the Indiana Wrongful Death Statute[79] prior to filing a claim for malpractice. In so holding, the court stated that the definitions of "patient" and "representative" of the Medical Malpractice Act "clearly designate who is qualified to prosecute a claim."[80] The definition of "representative" appears earlier in this Note.[81] The definition of "patient" under the Act is as follows:

> (c) "patient" means an individual who receives or should have received health care from a licensed health care provider, under a contract, express or implied, *and includes any and all persons having a claim of any kind, whether derivative or otherwise, as a result of alleged malpractice on the part of a health care provider.* Derivative claims include, but are not limited to, the claim of a parent or parents, guardian, trustee, child, relative, attorney or any other representative of the patient including claims for loss of services, loss of consortium, expenses and other similar claims.[82]

This definition, along with that for "representative," and that section of the Act allowing "a patient or his representative having a claim under this article for bodily injury or death on account of malpractice [to] file a complaint,"[83] formed the basis for the Indiana Supreme Court's holding in *McKnight* that a spouse and child of a patient need not comply with the Wrongful Death Statute because they clearly fall within the Medical Malpractice Act language.[84]

Gahl used this holding as grounds for the conclusion that *only* those named in these sections are able to file under the Act. This rationale is virtually identical to the rejected argument in *Sue Yee Lee* that the principle of *expressio unius est exclusio alterius* applied, and it is subject to the same critique. The principle is a tool of interpretation of the statute as a whole and not a rule of law. Therefore, mechanical application of the principle would beg the very question at issue, the

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79. 493 N.E.2d at 777 (citing IND. CODE § 34-1-1-2 (1982)).

80. *Id.*

81. *See supra* note 66 and accompanying text. The definition of "representative" remained the same between the two cases.

82. IND. CODE § 16-9.5-1-1(c) (1988) (emphasis added). This subdivision was amended by Pub. L. No. 120, § 1, emerg. eff. Feb. 19, 1982. Prior to this amendment it read: "'Patient' means a natural person who receives or should have received health care from a licensed health care provider, under a contract, express or implied."

83. *See* IND. CODE § 16-9.5-1-6 (1988).

84. 493 N.E.2d at 777. The Supreme Court in *McKnight* found the language of the Act unambiguous with respect to the standing of those pressing derivative claims, although the court in *Sue Yee Lee* found it ambiguous and unclear. *See Sue Yee Lee*, 410 N.E.2d at 1323.

character of legislative intent. The court in *Sue Yee Lee*, finding the language of the sections under scrutiny ambiguous, took an overview of the Act in an attempt to elicit from the Act's general thrust who should be included and excluded from the Act's coverage.

In opposition, Midtown, in its brief, cited the broad, inclusive language of *Sue Yee Lee* in arguing for inclusion of Gahl's claim within the Act.[85] There was a further, textual argument available to Midtown. The net cast by the legislature in its new definition of "patient" is so broad ("any and all persons having a claim of any kind, whether derivative or otherwise, as a result of alleged malpractice on the part of a health care provider"),[86] that one may infer that this language was the legislature's attempt to adopt the broadest possible definition of the term. This definition, if read in connection with the court's broad language in *Sue Yee Lee*, although clearly encompassing "patients" within the common sense meaning of the term, may be read as including the sort of claimant represented by the estate of probation officer Gahl.

Broadening the scope of claimant coverage through the definition of the term "patient" is awkward in one respect, but makes good sense in another. It is awkward because of the tension between the clarity of the common sense meaning of the term and the conceptual difficulty of including others who are not "patients" within this meaning. The definition of "patient," however, clearly and explicitly includes those who have derivative claims. These persons would not be "patients" within any common sense meaning of the term, yet they are included within the statutory definition of the term. Nor did the legislature stop there; it provided for all claims "whether derivative or otherwise."[87] Had it intended to limit the scope of coverage to patients and those with derivative claims, the legislature could have chosen much narrower language.

Notwithstanding the conceptual stretch required to insert claimants "derivative or otherwise" into a definition of "patient," to do so makes good sense. Because patients are the paradigmatic claimants in malpractice suits, one would look to the definition of "patients" first in order to understand the intended scope of claimant coverage.[88] Therefore, it makes

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85. *See* Brief for Appellant, *supra* note 7, at 15-16.

86. IND. CODE § 16-9.5-1-1(c) (1988).

87. *Id.*

88. If the legislature did intend, or will wish in the future, to include third-party claims such as those in *Gahl*, and thereby merge to some degree the notions of "claimant" and "patient," it would make sense, given the conceptual awkwardness of this merging, to create a new definition of "claimant" and have it read to include, explicitly, third-party claims which are not derivative. Alternatively, a definition of "malpractice" could be phrased to include specifically third-party claims as long as the claim involved alleged

little sense to separate derivative and non-derivative third party claims on the basis of the statutory definition of "patient."

IV. Marginal Cases Involving Actual Patients

A. "Slip and Fall" Cases

This Section discusses cases involving patients within the ordinary meaning of that term, but whose claims only marginally arise from their status as patients. It begins with a case limiting the scope of the Act, but concludes that courts generally have been flexible in their interpretations of who belongs in the category of "patient" under the Act. The Section ends with the suggestion that this flexibility should also be applied to the third-party, non-derivative medical malpractice claim.

The decision in *Winona Memorial Foundation of Indianapolis v. Lomax*[89] is in contrast to the expansive view of the Act's coverage represented by *Sue Yee Lee*. In *Lomax*, the court held that the claim of a patient who fell while in the hospital was not a malpractice claim within the meaning of the Act, and it refused to require the plaintiff to conform to the requirements of the Act.[90] The court rested its conclusion on the fact that included within the plaintiff's claim, and in her affidavit filed in response to defendant's motion for summary judgment,[91] was a clear and unambiguous premises liability claim,[92] and that the Act therefore was not controlling. The court thus focused on the form of the claim and not the character of the claimant in deciding whether or not the Act controlled the dispute.

As did the court in *Sue Yee Lee*, the *Lomax* court relied heavily on the legislative history of the Act and on its underlying purposes. The *Lomax* court, however, invoked legislative history and purpose to support its conclusion that this claim fell outside the intended scope:

> [T]he conditions that were the impetus for the legislature's enactment of the Medical Malpractice Act had nothing to do with

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acts of malpractice. In fact, the present definition of "malpractice" may do just that when combined with the definition of "tort." *See supra* note 5 and accompanying text. To make this even clearer, the legislature could effect this combination in a new definition of "malpractice."

89. 465 N.E.2d 731 (Ind. Ct. App. 1984).

90. *Id.* at 742.

91. The court cited *Rioux* (*see supra* note 17) as a case wherein the plaintiff failed to respond adequately when faced with a motion for summary judgment. In *Rioux*, the plaintiff rested on her pleading in response to a motion by defendants for summary judgment and the court refused to allow the factual allegations in her pleadings to suffice for a response. 438 N.E.2d 317.

92. *Lomax*, 465 N.E.2d at 742.

> the sort of liability any health care provider - whether a hospital or a private practitioner - risks when a patient, or anyone else, is injured by the negligent maintenance of the provider's business premises. That not being the sort of liability that brought about passage of the Act, it is absurd to believe the legislature would have reached out to restrict such liability by including it within the Act.[93]

In tandem with the policy justification for its decision, the *Lomax* court rested on a logically related evidentiary issue. A primary rationale for the existence and function of the medical review panel is to provide a regulated forum for expert testimony on the medical issues present in a case.[94]

The traditional justification for expert testimony is that the facts about which such witnesses testify are outside the common knowledge of lay witnesses.[95] According to the *Lomax* court, "[s]uch matters as the maintenance of reasonably safe premises are within the common knowledge and experience of the average person."[96] Therefore, expert testimony in the form of the panel is unnecessary and not required when the issue is couched in premises liability terms, or in any terms which the court determines state a claim about which common knowledge is sufficient.[97]

This reasoning is compelling, but there is a troublesome inconsistency between the *Lomax* decision and the earlier *Rioux* decision.[98] In *Rioux*, the court reversed a lower court decision denying summary judgment to a defendant asserting that the plaintiff's claim came within the Act and should go before the medical review panel. The facts of *Rioux* are

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93. *Id.* at 739.

94. *Id.* at 740. The opinion of the medical review panel is made admissible as evidence in courts of law and panel members are required to testify at trial if called by either party. *See* IND. CODE § 16-9.5-9-9 (1988).

95. There is no more certain test for determining when experts may be used than the common sense inquiry whether the untrained layman would be qualified to determine intelligently and to the best possible degree the particular issue without enlightenment from those having a specialized understanding of the subject involved in the dispute.

Ladd, *Expert Testimony*, 5 VAND. L. REV. 414, 418 (1952), *quoted in* FED. R. EVID. 702 advisory committee's note.

96. 465 N.E.2d at 740.

97. The attorney for the hospital in *Gahl* cited the court's reasoning here in arguing that the claim in *Gahl* was not outside the Act. He agreed with the *Lomax* court's focus on the type of claim made and not on the identity of the person making the claim. Brief for Appellant, *supra* note 7, at 13.

98. *Rioux*, 438 N.E.2d 315 (Ind. Ct. App. 1982).

very similar to those in *Lomax*,[99] but the complaint in *Rioux* was grounded more heavily upon the appropriateness of the hospital's care and less heavily on any other common law theory such as the premises liability claim in *Lomax*.[100]

Although the *Lomax* court's attention to the theory of the claim is legitimate, given its need to decide whether the complaint alleged a malpractice claim or some other, it is arguable that the court rested too heavily on the theory, rather than on the facts presented, in determining the treatment of the claim. Hospital-bound persons-patients are often in a condition different enough from the ordinary person to justify expert testimony on even the custodial aspects of their treatment.

A spectrum of possible factual situations exists, externally similar to *Lomax* and *Rioux*, but wherein various conditions of the patient tend to make the question either one of malpractice or one of simple negligence. Facts suggesting lack of appropriate medical care arise, for example, in situations where a patient, unable to walk without the aid of a mechanical device or the help of another, or one whose vision is impaired, is allowed to move freely and falls on a stair. Conversely, where a patient, who is within the hospital simply for testing, falls on a stair, the occurrence suggests nothing more than simple negligence.

Between these two extremes are many ambiguous possibilities. For example, suppose a hospital which has written policy requirements for patients experiencing alcoholic tremors, admits a patient for chronic alcoholism who displays mild, intermittent tremors. If this patient were injured in a fall during a period of relatively good bodily control, questions would arise whether he had been in a condition making medical care necessary at the time of the injury. To allow a plaintiff's formulation of his complaint to control the initial disposition of the claim is to place in his hands a fundamental function of the finder of fact.

Counsel for a patient injured under circumstances suggesting both simple ministerial negligence and lack of appropriate medical care may be tempted to allege whichever claim would yield a higher potential recovery. Yet, the finder of fact should be entitled to determine, with expert testimony if necessary, all of the conditions under which the injury occurred and whether there was a malpractice element involved in the injury.

Even if only a simple negligence claim would lie from certain facts arising outside a medical setting, the character of a claim based on

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99. In each case the patient fell during a hospital stay. Assuming that the court in *Lomax* adequately distinguished *Rioux* on the procedural ground, the underlying question of coverage of the Act remains.

100. *Lomax*, 465 N.E.2d at 741.

similar facts, if arising within a medical setting, should be determined not only by the terms of the claim itself, but by the condition of the patient. It will often require expert opinion on that medical condition to determine whether, in fact, the claim is simply a non-medical tort claim, or whether there were medical factors at issue. The medical review panel's consideration should not be limited only to those claims predetermined by one or all of the parties as medical or non-medical. It follows from the panel's primary duty to aid the trier of fact in understanding medical issues, that the panel should be allowed to distinguish between such marginal claims on medical grounds as part of its duties. Otherwise the parties, especially plaintiffs, may indirectly decide the law. A broader field of view for the medical review panel would help eliminate strict reliance by the courts solely on the "form" of the claimant's allegation, and possibly cost less money because the need for interlocutory appeals as in *Gahl* could be avoided.

In cases like *Lomax* and *Rioux* the panel would be able, if the facts and issues were presented to them, to decide whether the condition of the patient and the circumstances of the patient's injury were such as to require expert opinion on the medical aspects, if any, of the dispute. There may very well be issues of fact, based on the patient's condition, which render appropriateness of medical care relevant to determination of whether malpractice occurred.

The *Lomax* reasoning also arguably undermines the contract-based theory of medical malpractice claims.[101] Patients admitted to a health-care facility, or even those on a routine office visit, arguably enter into a contract, either implicit or explicit, for care by the health-care provider. This places even a disputably non-medical claim in a different context than the analogous common law claim because, in any case, the admitted party contracts for an appropriate level of care, and that level of care depends, at least in part, on the condition of the patient. This is not to deny that there are some claims which simply do not come within the scope of the legislature's intent underlying the Act. It is strongly inferable, however, that medical care of patients is at issue whenever the role of caretaker is assumed by a health care provider.

The Indiana Supreme Court, in its consideration of whether to grant Midtown's motion to transfer *Gahl*, was faced with competing interpretations of the appropriate precedential value of *Lomax* and *Rioux*. Midtown, in its motion in support of petition to transfer, argued that the Court of Appeals erred in its focus upon the identity of the claimant

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101. IND. CODE § 16-9.5-1-1(c) (1988). "'Patient' means an individual who receives or should have received health care from a licensed health care provider, *under a contract, express or implied*, ..." (emphasis added).

as determinative of the coverage issue under the Act.[102] Instead, Midtown urged, it should have focused on the fact that malpractice was alleged in the claim and upon the facts supporting the claim. Midtown relied heavily upon the *Rioux* holding that "the Act applies to *any* legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury to another based on any act or treatment performed or furnished, or which should have been performed or furnished . . . [to the patient]."[103]

In contrast, Gahl's estate, in its brief opposing the petition to transfer, passed lightly over *Rioux*[104] and focused heavily upon *Lomax* for support for its contention that only patients and representatives must proceed under the Act.[105] Gahl's argument treats the identity of the plaintiff and the form of the claim as necessary conditions, though neither as sufficient by itself, to the inclusion of a claim within the Act.[106] Gahl's estate, relying on its reading of *Rioux* and *Lomax*, argued that Indiana courts have "implicitly recognize[d] that before a plaintiff is required to proceed under the Act, it must be established that a plaintiff is a patient."[107]

Stated in the terms of each side's briefs in *Gahl*, the issue presented by *Lomax* and *Rioux* becomes a disjunction: either the focus ought to be on the malpractice character of the claim and the facts underlying it (according to Midtown) or upon the identity of the claimant in combination with the character of the claim (according to Gahl). Gahl's position is simply too narrow a view in light of the legislative intent and the majority of existing case law. The determination of the placement of claims in ambiguous cases ought to be made by the medical review panel on the basis of as clear and unambiguous a statement of the facts as possible. When marginal cases are brought to court before being filed with a medical review panel, the trial court should require a panel opinion in those cases which reasonably can be construed as coming within the Act.[108] The tension created by *Lomax* and *Rioux* sets up a

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102. Brief for Appellant, *supra* note 7, at 13.

103. *Id.* (quoting 438 N.E.2d at 316).

104. Brief for Appellee, *supra* note 45, at 9 (noting only that in *Rioux* the issue was not whether the claimant was a patient).

105. *Id.* at 10, 13.

106. *Id.*

107. *Id.* at 10.

108. Under IND. CODE § 16-9.5-10-1 (1988), if an action arguably based on malpractice is filed with the commission of insurance, before the panel renders its decision, the trial court may rule preliminarily on issues of fact or law not requiring expert opinion. *See, e.g.*, Johnson v. Padilla, 433 N.E.2d 393 (Ind. Ct. App. 1982); State *ex rel.* Hiland v. Fountain Circuit Court, 516 N.E.2d 50 (Ind. 1987).

In the present discussion, this provision is important as a safety value through which cases may go if, indeed, there are *no* issues which require expert medical opinion. However,

situation in which certain plaintiffs may, simply by stating their claims in a specific form, bypass the Act unjustifiably and at the very least create delay in the efficient adjudication of their claims.

B. "Involuntary" Patients

The next area of concern with the scope of claimant coverage under the Act is represented by two similar cases: *Detterline v. Bonaventura*[109] and *Scruby v. Waugh*.[110] Each case deals with a wife who, with the cooperation of a physician, had her husband involuntarily committed to a mental facility. In each case, the husband later sued the physician without filing a proposed complaint with the medical review panel, but ultimately was required to file anyway. This outcome, as well as the reasoning which supports it, is further evidence that the courts have broadly interpreted the scope of the Act, and have seen beneath the literal language of the Act to allow ambiguous claims to be included.

In both *Detterline* and *Scruby* the issue was largely confined to the definition of "patient" under the Act.[111] The wife in *Detterline* had pleaded with her own physician, Dr. Bonaventura, to sign commitment papers for her husband. Without examining the husband (Mr. Detterline), Dr. Bonaventura signed these papers on the basis of Mr. Detterline's alleged "[m]ental confusion [and] delusions due to chronic alcoholism and cirrohosis of the liver."[112] Mr. Detterline was then involuntarily committed to a hospital for custody, care, and treatment. The commitment papers required the physician to state that an examination of the "patient" occurred and required the physician to specify the date of the examination. Dr. Bonaventura filled in this section, falsely stating that the examination took place on the day he had met with the wife. At trial, Dr. Bonaventura made no claim that he had examined Mr. Detterline on the day designated on the commitment papers.

The court focused on the fact that nearly one year before the commitment Dr. Bonaventura took Mr. Detterline's blood pressure, which established as a minimal showing that there was a patient-physician relationship between the two men.[113] The court further held that the

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when the issue of an appropriate standard of patient care is raised, this ought to be prima facie grounds for proceeding to the panel. A Louisiana court has held that even when alternative theories of liability are available, claims of improper conduct which reasonably can be said to come within the definitions of the Act, ought to be pursued through the Act. Cashio v. Baton Rouge Gen. Hosp., 378 So. 2d 182 (La. App. 1979).

109. 465 N.E.2d 215 (Ind. Ct. App. 1984).

110. 476 N.E.2d 533 (Ind. Ct. App. 1985).

111. *See supra* note 82 and accompanying text for the definition of "patient."

112. *Detterline*, 465 N.E.2d at 216.

113. *Id.* at 217.

requirement, contained in the statutory definition of "patient," that the relationship between physician and patient be based on a "contract, express or implied," did not require the contract to be between the patient and the physician: "[A]lthough a contract is required for health care services, the person receiving the health care need not be a contractual party."[114] Mrs. Detterline's contract with Dr. Bonaventura fulfilled this loosened requirement in this case.

In *Scruby*, decided a year after *Detterline*, the question was almost identical to that in *Detterline*. In *Scruby*, however, the relationship between the committing physician and the committed patient was much closer. As in *Detterline*, the physician signed commitment papers without an immediately preceding examination. In *Scruby*, however, the physician clearly made several examinations very near the date of commitment.[115] The court reversed the lower court decision which denied the physician's motion for summary judgment on identical grounds and cited *Detterline*.[116]

The flexibility of the courts' interpretations of the term "patient" suggests an analogous flexibility in the broader third-party context at issue in *Gahl*. The contract requirement, from the language of the Act, appears to apply to the typical patient-physician relationship. Yet, when the claim is clearly one which has a malpractice claim at its base, the courts are willing to find that the contract requirement is flexible enough to cover cases in which the "patient" is not a party to the contract. Similarly, in *Gahl*, where the court appears to find at least some of the essential elements of malpractice present,[117] analogous reasoning could be used to include the claim even though literally not *all* the elements of the definition of "patient" are present when a contract between the physician and patient is lacking. This argument is especially compelling when, as in *Detterline*, the physician admitted that he signed the commitment papers for Mr. Detterline under false pretenses of examining him on the date specified, and the court was still willing to find the statutory requirements satisfied.

Midtown chose not to discuss the potential relevance of these two cases in any of the briefs presented on behalf of the defense. Gahl,

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114. *Id.* at 219 (citing Gooley v. Moss, 398 N.E.2d 1314 (Ind. Ct. App. 1979) (The court held that a woman, who had been involuntarily sterilized and later filed suit against the surgeon with whom she had not contracted, was a "patient" due to a contract between the physician and the Department of Public Welfare.)).

115. 476 N.E.2d at 535.

116. *Id.* at 536.

117. The court in *Gahl* stated that "[a]ssuming the defendants had a duty to properly medicate and supervise Jackson, we believe that a breach of that duty could constitute malpractice as to Jackson, but not as to third parties with whom Jackson might come into contact." 540 N.E.2d at 1262.

however, cited both and argued that the very need to decide whether the husband in each case was a "patient" within the meaning of the Act conclusively demonstrated that the character of the claimant is an integral factor in the decision whether a claim falls within the Act.[118] This is a compelling point, but answerable with two contentions. First, the courts in both *Detterline* and *Scruby* decided the issue of whether the claimant was a patient because those claims turned on the existence of a contract, although in *Gahl* this was not an issue. Second, the courts' stretch, especially in *Detterline*, to include a marginal claimant evinces a desire for inclusiveness rather than exclusiveness. The behavior of a health care provider is neither more nor less negligent because of the identity of the ultimate recipient of the injury resulting from that negligence.[119]

Hypothetical examples illustrating this point include a wide range of common sense circumstances. For instance, consider the over- or under-medication of a patient with a condition affecting muscular control, such as epilepsy. Injury to a patient clearly could include unexpected and dangerous seizures. Injury to third-parties may result from an automobile accident due to an unexpected seizure or lack of alertness associated with over-medication. To argue that the *medical* issues involved in each case are different, or that the medical review panel has a different job to do or no job at all, depending on the ultimate recipient of the injury, would be groundless. The court may consider these other issues after the medical review panel renders its decision on the strictly medical issues. The sub-group of medical issues, however, still requires medical expert testimony, not on the basis of the recipient of the injury, but on the basis of the provision of medical care to the party receiving it.

V. Protection of Third-Parties Under the Act: Should the Act be Read to Reach This Far?

In the sort of case discussed at the end of the last Section, the injured party may not be a patient, but a third party allegedly injured as a result of medical action taken or omitted on behalf of a patient. The first Indiana case considered here which is relevant to problems

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118. Brief for Appellee, *supra* note 45, at 12-13.

119. Of course, questions of causation loom large when a third party is the recipient of the injury, and this issue must be considered with extreme care in this context. But, because of this special need to focus on causation, the standard of care, the very center of the medical negligence cause of action, will become an even more crucial element in the third party context. Therefore, expert medical opinion on this standard of care will be even more important. Thus, the removal of these cases from the malpractice context may be positively counterproductive to the ultimate purpose underlying the statutory regulation of these causes of action.

raised by these situations is *Ogle v. St. John's Hickey Memorial Hospital.*[120] The claimant in *Ogle* was a patient, but the case raises a question analogous to the situation presented in *Gahl.* In *Ogle*, a patient who was raped by another patient while being held in a psychiatric ward of a hospital sued the hospital for failure to provide adequate security, and the court granted the defendant's motion to dismiss based on the plaintiff's failure to submit the claim to the medical review panel.[121]

In affirming the lower court's dismissal of claims against the defendants, the court of appeals was compelled to place the case either in the class of cases represented by *Rioux* or the class of cases represented by *Lomax.* Citing *Rioux*, counsel for the hospital claimed that the plaintiff placed in issue the appropriateness of care provided by the hospital by alleging that the hospital provided improper security.[122] Counsel for plaintiff cited *Lomax* as controlling on the ground that the claim was, as in *Lomax*, "ministerial" or non-medical in nature and ought to be controlled by a general liability theory.[123]

The court, by agreeing with the hospital, confronted several of its own earlier decisions which held that "neither the guarding and protection of mental patients nor the decision to restrain a patient confined in a wheelchair are medical acts."[124] The court held that these decisions had been, "in effect . . . overruled by exercise of the legislative will expressed in broad language."[125] With this conclusion the court re-opened the door to the sort of claim at issue in not only the third-party claimant context, but also in the "slip and fall" context involved in *Lomax* and *Rioux.* The *Ogle* court took a liberal view of the legislative intent in passing the Act: "[T]hose seeking to avoid coverage under the Act travel a rocky road. The framers of the Act used *broad* language."[126]

However, the court did not approach the question of malpractice from the point of view of the care provided to the patient accused in the rape; it focused instead on the protection provided to the patient raped. This was the most logical course for the court to take because the plaintiff was a patient at the time of the injury. However, had the plaintiff taken the former course in alleging a malpractice claim, the court would have encountered a question more closely analogous to the

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120. 473 N.E.2d 1055 (Ind. Ct. App. 1985).

121. *Id.* at 1056.

122. *Id.* at 1057.

123. *Id.*

124. *Id.* at 1059 (citing Breese v. State, 449 N.E.2d 1098 (Ind. Ct. App. 1983)); Emig v. Physicians' Physical Therapy Serv., Inc., 432 N.E.2d 52 (Ind. Ct. App. 1982); Fowler v. Norways Sanitorium, 112 Ind. App. 347, 42 N.E.2d 415 (1942).

125. *Ogle*, 473 N.E.2d at 1059.

126. *Id.* at 1057 (emphasis in original).

question in *Gahl*. That is, could the care provided to the patient-assailant, rather than to the patient-plaintiff, have been grounds for a malpractice claim? The Act is silent with respect to this question, and *Gahl* is the only Indiana case which addresses the question in the context of the Act. The *Ogle* court's reasoning, however, suggests a tendency toward inclusiveness.

Classification of injuries to third parties through the conduct of psychiatrists also suggests inclusiveness in the present context. In several jurisdictions without malpractice statutes or without statutes comparable to Indiana's, courts have held psychiatrists liable for injury to third parties which proximately resulted from the psychiatrist's treatment.[127] Courts have also held that a psychiatrist may be held liable, regardless of his treatment of a patient, for failure to warn a potential victim if he knows a patient presents a danger to an identifiable victim.[128] This, of course, would also be in line with Indiana legislation allowing partial immunity to mental health care providers for failure to warn, but which also disallows immunity in cases in which the patient had made threats to identifiable victims or generalized threats.[129]

The closest Indiana courts have come to deciding this issue is in *Estate of Mathes v. Ireland*,[130] which arose six years prior to the mental health care immunity provision. In *Mathes*, the appellate court reversed the trial court's dismissal of claims against two psychiatric centers for wrongful death brought by the estate of a woman killed by a former psychiatric patient. The court held that, "if the centers, or either of them, had actually taken charge of Pierce [the patient-accused] . . ., and additionally had actual knowledge that Pierce was extremely dangerous, . . . then we think they were bound to exercise reasonable care[5] under the circumstances."[131]

In footnote "5," the court addressed the issue of the standard of care: "We observe, without deciding, that those jurisdictions which permit

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127. *See, e.g.*, Watkins v. United States, 589 F.2d 214 (5th Cir. 1979); Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980); Merchants Nat'l Bank & Trust Co. v. United States, 272 F. Supp. 409 (D.N.D. 1967); Lungren v. Fultz, 354 N.W.2d 25 (Minn. 1984); McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979); Homere v. State, 48 A.D.2d 422, 370 N.Y.S.2d 246 (1975); Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1980). For recent law review articles discussing liability of psychiatrists for injury to third parties, see Note, Kirk v. Michael Reese Hosp. Medical Center: *The Treatment of a Third Party Plaintiff in a Medical Context*, 38 De Paul L. Rev. 749 (1989); Note, *Physician Negligence and Liability to Third Persons*, 22 Suffolk U.L. Rev. 1153 (1988).

128. Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

129. *See supra* note 7.

130. 419 N.E.2d 782 (Ind. Ct. App. 1981).

131. *Id.* at 785.

an action on this basis are careful to define *the standard of reasonable care as that due from similar professionals in a field where there remains considerable uncertainty of diagnosis and tentativeness of professional judgment.*"[132]

This language again raises that part of the policy rationale underlying the establishment of the medical review panel concerning the need for a regulated forum of uninterested expert medical opinion. The plaintiff in *Mathes* based its complaint on the Wrongful Death Statute, so the issue of coverage of the malpractice statute did not arise.[133] The court was clearly aware of the evidentiary implications of the claim regardless of the theory under which it was brought. It evinced sensitivity to the need for expert opinion in an area confusing both to those who practice in the field, and to laypersons who are neither conversant nor able to form sufficiently informed opinions without the help of experts.

In *Gahl*, Midtown focused on this aspect of the *Mathes* decision.[134] Under the various decisions cited in *Mathes* from other jurisdictions where the question received greater attention,[135] the rule which emerges, in Midtown's view, is that recovery is conditioned upon: 1) the existence of a patient-therapist relationship, 2) actual or constructive knowledge on the therapist's part that the patient was dangerous, 3) the foreseeability of the plaintiff as a victim, and 4) whether the therapist took reasonable care under the circumstances to discharge his duty to the plaintiff.[136] Within this rule there are intertwined questions of law and fact which must be sorted out by the court and the finder of fact at trial. The decision of a medical review panel on the existence or non-existence of malpractice in these circumstances is beneficial to the court and the finder of fact at trial in deciding the ultimate issues in the case. The explicit language of the Act does not preclude the need for a medical review panel opinion in this area.

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132. *Id.* n.5 (emphasis added).

133. In *Mathes*, Justice Hoffman argued, in an opinion concurring in part and dissenting in part, that medical malpractice actions "may be initiated only by the patient or his immediate family. The duty to use reasonable care in the diagnosis and treatment, including commitment proceedings, does not exist for the benefit of strangers to the physician-patient relationship. The complaint therefore fails to state a claim for relief in this regard." *Id.* at 788. This position is in tension with Justice Hoffman's position in his dissent in *Gahl*. *See supra* note 30 and accompanying text.

134. Brief for Appellant, *supra* note 7, at 19.

135. *Id.* at 20. White v. United States, 780 F.2d 97 (D.C. Cir. 1986); Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983); Michael E.L. v. County of San Diego, 183 Cal. App. 3d 515, 228 Cal. Rptr. 139 (1986); Thompson v. Alameda County, 27 Cal. 3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980); Bardoni v. Kim, 151 Mich. App. 169, 390 N.W.2d 218 (1986); Bader v. State, 43 Wash. App. 223, 716 P.2d 925 (1986).

136. Brief for Appellant, *supra* note 7, at 20.

The reasoning above is relevant to the decision in *Gahl*. However, in light of the Indiana statute which grants limited immunity to mental health care workers,[137] enacted after Gahl's complaint was filed, the reasoning will be slightly different. This new provision grants immunity for failure to warn or predict, unless the health care provider received some form of notice. It provides two exceptions to this limited immunity: first, where the patient communicated an actual threat to a "reasonably identifiable victim or victims," and second, where the patient "evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death *to others*."[138] Thus, facts related to these issues will need to be the focus of inquiry before liability can be assigned, but the basic logic of the *Mathes* holding will still be applicable.

Further, this provision does not grant immunity for any other form of potential treatment provided by a health care provider to a psychiatric patient. This failure to name other sources of liability as among those for which providers are immune implies that the legislature intended to immunize only for the limited area of failure to warn or predict when there has been no sign given to mental health care workers of dangerousness. It would have been logical for the legislature, had it intended a broader immunity, simply to immunize mental health care workers from suits based on *any* treatment afforded patients.

In a case such as *Gahl*, and perhaps *Ogle*, the plaintiff may forward claims which are completely separate from these two potential areas of provider responsibility. In fact, in *Gahl* the complaint states several allegations of malpractice which fall distinctly outside the scope of the immunity provision.[139] These claims are commonly cited grounds for malpractice claims. The argument that the facts supporting the allegations, rather than the identity of the claimant, should determine the application of the Act is supported here, even in the context of the immunization provision.

VI. Conclusion

The conclusion which emerges from analysis of the legislative intent, statutory language, and existing case law under the Indiana Medical Malpractice Act, in all of the areas discussed in this Note, is that a liberal inclusiveness is the appropriate approach for courts to take when

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137. *See supra* note 7 for statute.

138. Ind. Code § 34-4-12.4-2 (1988) (emphasis added).

139. Brief for Appellant, *supra* note 7, at 16-17 (citing paragraphs 10, 21, 23, and 33 of complaint dealing variously with failure to properly medicate, abdication of treatment, misdiagnosis, and wrong recommendations in the treatment of the patient-defendant).

confronted with an ambiguous case. There is no clear language in the Act which limits the class of claimants to a specified group. On the contrary, the broad definitions of such terms as "patient" yield the conclusion that the legislature intended to be inclusive rather then exclusive of borderline claims.

The case law yields a similarly expansive interpretation of the Act's coverage. Only in *Lomax* and *Gahl* have the courts read the Act narrowly. Perhaps the *Detterline* court's willingness to stretch the notion of contract to include a physician-patient relationship created by means of a false examination record may be the most obvious illustration of the preference in favor of flexibility in interpreting the scope of the Act.

Underlying both statutory interpretation and case law analysis is the original intent of the legislature in enacting the Indiana Medical Malpractice Act in 1975, as outlined by the Indiana Supreme Court in *Johnson*. This intent is construed, in *Sue Yee Lee* for example, in language easily broad enough to cover claims by third parties injured through alleged malpractice to patients. This spirit of inclusiveness should guide the courts in future disputes involving the scope of claimant coverage under the Indiana Medical Malpractice Act.

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