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## The Limitation on Recovery in Medical Negligence Cases

Edward W. Taylor

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THE LIMITATION ON RECOVERY IN MEDICAL  
NEGLIGENCE CASES IN VIRGINIA

*Edward W. Taylor\**  
*William G. Shields\*\**

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The authors especially acknowledge James A. Eichner and Robert T. Hall who contributed greatly to the research of this article.

This article is dedicated to the memory of Christopher E. Carlson who died July 9, 1982 at the age of almost seven years. See Footnote 193 for details.

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## I. THE MEDICAL MALPRACTICE ACT IN VIRGINIA

### A. *Background*

Chapter 611, 1976 Acts of Assembly,<sup>1</sup> provided for sweeping changes in the laws of medical and hospital negligence in Virginia. The Act affects all medical negligence actions arising after July 1, 1976. The legislation was enacted during a time when many perceived a medical malpractice crisis in Virginia. This article will review the historical background which led to this perception and will analyze whether, in fact, this crisis did exist. Finally, the article will demonstrate that the Act is both unnecessary and more importantly, unconstitutional.

### B. *General Overview of the Act*

The title to Chapter 611 recites that the Act relates to "limitations on recovery for pain and suffering in certain actions . . . ."<sup>2</sup> A preamble to the Act states the legislative finding that the increased cost and difficulty of obtaining medical malpractice insur-

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1. Act of Apr. 9, 1976, ch. 611, 1976 Va. Acts 784 (codified at VA. CODE ANN. §§ 8.01-581.1 to -18 (Repl. Vol. 1977) and §§ 8.01-581.1 to -20 (Cum. Supp. 1982)). Section 8.01-581.12:2 provides that the Act shall not apply to any cause of action which arose prior to July 1, 1976.

2. 1976 Va. Acts, ch. 611.

ance had discouraged and would continue to discourage health care professionals from practicing in Virginia.

Whereas, the General Assembly has determined that it is becoming increasingly difficult for health care providers of the Commonwealth to obtain medical malpractice insurance with limits at affordable rates in excess of \$750,000; and

Whereas, the difficulty, cost and potential unavailability of such insurance has caused health care providers to cease providing services or to retire prematurely and has become a substantial impairment to health care providers entering into practice in the Commonwealth and reduces or will tend to reduce the number of young people interested in or willing to enter health care careers; and

Whereas, these factors constitute a significant problem adversely affecting the public health, safety and welfare which necessitates the imposition of a limitation on the liability of health care providers in tort actions commonly referred to as medical malpractice cases.<sup>3</sup>

The Act first added a section to the Virginia Code which placed a \$750,000 limitation on recovery against any health care provider in a malpractice action where the act or acts of malpractice occurred on or after April 1, 1977.<sup>4</sup> Another section grants immunity from civil liability to every member or consultant of any committee or group for "any act, decision, omission, or utterance done or made in performance of his duties while serving as a member of such [a body, whose primary function is] to review, evaluate or make recommendations"<sup>5</sup> on various matters which could give rise to a claim for medical malpractice, provided that the action is not taken in bad faith or with malice.<sup>6</sup> The Act also included a section establishing as privileged communication, free from legal discovery, the proceedings and reports of any medical staff committee, utilization review board, or other committee as well as all oral and written communication generated to or by these bodies.<sup>7</sup>

An article now entitled *Medical Malpractice Review Panels: Arbitration of Malpractice Claims* originally was added to the Code by this Act.<sup>8</sup> The article includes a section which broadly defines

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3. *Id.*

4. VA. CODE ANN. § 8.01-581.15 (Repl. Vol. 1977).

5. *Id.* § 8.01-581.16 (Cum. Supp. 1982).

6. *Id.*

7. *Id.* § 8.01-581.17 (Repl. Vol. 1977).

8. *Id.* § 8.01-581.1 to -12:2 (Repl. Vol. 1977).

"health care provider."<sup>9</sup> Malpractice is defined to mean "any tort based on health care or professional services rendered, or which should have been rendered by a health care provider, to a patient."<sup>10</sup>

Under the Act, no action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing before filing suit.<sup>11</sup> Within sixty days of notification, either party may file with the Chief Justice of the Virginia Supreme Court, a written request for a review by a Medical Malpractice Review Panel.<sup>12</sup> The Panel consists of three neutral attorneys and three neutral health care providers, licensed and actively practicing their professions in Virginia, and is chaired by a sitting judge of a circuit court.<sup>13</sup>

The Panel may make one or more of the following four findings: (1) the appropriate standard of care was observed; (2) a failure to meet the appropriate standard of care was the proximate cause of the alleged damages; (3) although the professional deviated from the standard, the deviation was not the proximate cause of the alleged injury; or (4) there is a material factual issue of liability, which does not require an expert opinion and which is appropriate for consideration by a court or jury.<sup>14</sup> The Panel's opinion is admissible as evidence in any legal action subsequently brought by the claimant.<sup>15</sup> Members of the Panel are given absolute immunity from civil liability from their conclusions. All members, except the chairman, may be called to testify in such actions.<sup>16</sup>

While the 1976 Act directed that all medical malpractice settle-

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9. Health care provider, as defined in VA. CODE ANN. § 8.01-581.1(1) (Repl. Vol. 1977), means a person, corporation, facility or institution licensed by the state to provide health care or professional services, including physicians, hospitals, dentists, pharmacists, registered or licensed practical nurses, optometrists, podiatrists, chiropractors, physical therapists, physical therapy assistants, clinical psychologists, nursing homes and officers, employees or agents of nursing homes.

10. VA. CODE ANN. § 8.01-581.1.5 (Cum. Supp. 1982).

11. *Id.* § 8.01-581.2.A (Repl. Vol. 1977).

12. *Id.*

13. *Id.* § 8.01-581.3 (Repl. Vol. 1977).

14. *Id.* § 8.01-581.7.A. The section further states that if the panel does find that a failure to meet the appropriate standard of care was the proximate cause of the injury, it may determine the nature of the impairment or disability and its degree and extent. The opinion shall be in writing, signed by the agreeing panelists, and mailed to the claimant and health care provider within five days of its issuance.

15. VA. CODE ANN. § 8.01-581.8 (Cum. Supp. 1982).

16. *Id.*

ments or judgments be reported to the Commissioner of Insurance for consideration of the reasonableness of malpractice insurance premium rates,<sup>17</sup> this section was repealed effective January 1, 1982.<sup>18</sup> The provisions of the Act are severable, and if any part is held unconstitutional by a court of competent jurisdiction, the decision of such court shall not affect or impair any of the remaining provisions.<sup>19</sup>

### C. *Limitation on Recovery*

The Virginia Code provides that "in any verdict returned against a health care provider in an action for malpractice ... the total amount recoverable for any injury to or, death of, a patient shall not exceed seven hundred fifty thousand dollars."<sup>20</sup> Several questions arise regarding the interpretation of this section. First, since the limit is said to apply to *a* health care provider, in an action against several health care providers alleging separate acts or omissions constituting negligence against each, is the \$750,000 cap applicable to each health care provider, or is the cap a total ceiling of recovery against all defendants who may each have separate insurance policies? Second, in actions on behalf of infants, is the limitation on recovery applicable to both the infants' and parents' cases? The total amount recoverable is said to apply to an injury to, or death of a "patient," defined as "any natural person who receives or shall have received health care from a licensed health care provider ...."<sup>21</sup> Does the word "patient" include the parents of an infant patient? Third, is the limitation, characterized as a limitation on "recovery for pain and suffering,"<sup>22</sup> a cap on damages for pain and suffering only? The Constitution of Virginia states that "no law shall embrace more than one object, which shall be expressed in its title."<sup>23</sup> Fourth, is the cap applicable to wrongful death cases where pain and suffering of a decedent are not elements of damages recoverable by a survivor? Fifth, does the recovery limit apply to cases arising under the Federal Tort Claims Act,<sup>24</sup> including claims against physicians at naval or veterans' hospitals? Finally,

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17. *Id.* § 38.1-389.3 (Repl. Vol. 1981).

18. *Id.* § 38.1-389.3 (Cum. Supp. 1982).

19. 1976 Va. Acts, ch. 611. This language is not codified.

20. VA. CODE ANN. § 8.01-581.15 (Repl. Vol. 1977).

21. *Id.* § 8.01-581.1.3 (Cum. Supp. 1982).

22. 1976 Va. Acts, ch. 611.

23. VA. CONST. art. IV, § 12.

24. 28 U.S.C. §§ 2671-2680 (1980).

does the ceiling apply to actions arising under Section 1983 of the Civil Rights Act?<sup>25</sup> These and many more questions still remain to be answered and indicate that further scrutiny of the Virginia Medical Malpractice Act is necessary.

## II. HISTORY OF THE ACT

The Virginia Medical Malpractice Act was a result of the so-called medical malpractice crisis of the early 1970's. The "crisis" followed on the coattails of the national movement to enact federal no-fault automobile insurance legislation. However, the federal No-Fault Bill for automobile reparations died in the House Commerce and Finance Sub-Committee.<sup>26</sup>

It was widely claimed during the early 1970's that the field of malpractice law was experiencing a crisis of the following nature:

At some point in the early 1970s, it was said that juries began to award verdicts so large that they could not have been anticipated by insurance companies, and as a consequence, medical insurers suffered huge losses on malpractice policies. These insurers responded by raising premiums sharply, which in turn led many doctors to refuse insurance and attempt to shield themselves from malpractice liability by other methods .... [B]oth insurers and the medical community pressed legislatures in many states [including Virginia] ... to take measures to limit the size of malpractice awards. Plaintiffs' lawyers opposed this legislation, arguing that jury verdicts were not excessive and that insurance company losses resulted from investment losses rather than from inordinately large awards.<sup>27</sup>

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25. 42 U.S.C. § 1983 (1980).

26. 17A A. TRIAL LAW. AM. NEWSLETTER 425 (1974). "[T]he attack will not only be against the tort system in the automobile reparations field, but will likely extend to all fields of tort law."

27. M. PETERSON & S. PRIEST, *THE CIVIL JURY* 34 (Rand Corp. Doc. No. R-2881-ICJ, 1982). Interested readers may wish to consult a forthcoming Rand Document, P. DANZON & L. LILLARD, *THE RESOLUTION OF MEDICAL MALPRACTICE CLAIMS* (Rand Corp. Doc. No. R-2792-ICJ, 1982), which reportedly examines some 6,000 medical malpractice claims filed during the mid-1970's. According to advance information, the article concludes that the net effect of caps on verdicts and other techniques for reducing the amount of damages "was to reduce trial awards by 30 percent, cut the average out-of-court settlement by 25 percent, raise the portion of cases dropped from 43 percent to 48 percent and reduce the share of cases going to actual verdict from 5.1 to 4.6 percent." INSTITUTE FOR CIVIL JUSTICE, *A REPORT ON THE SECOND PROGRAM YEAR 15* (1982) [hereinafter cited as ICJ]. Half the dollars paid to plaintiffs were said to be concentrated in only 3% of the claims, and most were cases of severe injury and heavy economic loss. The study estimates that half of the dropped claims (one fourth of the claims analyzed) would have resulted in a plaintiff's award if they had been taken to verdict. *Id.* at 16. The address for ordering the above cited documents is:

The medical malpractice crisis controversy is complex, involving many issues; and the authors cannot attempt here to evaluate the so-called crisis in its variations throughout the nation. However, a historical perspective of the situation as it existed in Virginia in the early 1970's will be provided.

### A. *The Perception of a Medical Malpractice Crisis*

#### 1. The St. Paul Position Paper—An Ultimatum

By 1975 St. Paul Fire and Marine Insurance Company, which wrote and still writes policies for approximately eighty to ninety percent of the Virginia physicians,<sup>28</sup> came forward with a position paper entitled *Preserving a Medical Malpractice Insurance, Marketplace: Problems and Remedies*.<sup>29</sup> The following is the authors' synopsis of the major points made by St. Paul:

1. There was, without doubt, a medical malpractice insurance crisis for insurers, for doctors, and for health care consumers.<sup>30</sup>

2. Under the then-current insurance system, doctors might be unable to obtain coverage in 1975.<sup>31</sup>

3. In 1969 St. Paul had one claim pending for every twenty-three doctors insured, but by 1974 the ratio had increased to one in ten.<sup>32</sup>

4. The average value of a claim in 1969 for St. Paul policyholders was \$6,705.00, and by 1974 it had almost doubled to \$12,534.00.<sup>33</sup>

5. St. Paul, which insured some 48,000 out of 300,000 doctors across the nation,<sup>34</sup> declared that it would "not write any new or renewal policies except on a claims made basis after June 30, 1975."<sup>35</sup>

6. Previously, St. Paul and other American insurers had been selling an "occurrence" policy, which pays for settling claims arising

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The Rand Corporation, 1700 Main Street, Santa Monica, California 90406.

28. BUREAU OF INSURANCE, STATE CORP. COMM'N, *MEDICAL MALPRACTICE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS* 12 (November, 1975).

29. St. Paul Fire & Marine Ins. Co., *Preserving a Medical Malpractice Insurance Marketplace: Problems and Remedies* (1976) (position paper).

30. *Id.* at 1.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* at 3.

35. *Id.* at 1.



ing out of incidents which have occurred while the policy is in force, no matter when the claim is made. An occurrence policy might be called a "pay-in-advance" policy in which its premiums are based on claims expected to be reported in the future.<sup>36</sup>

7. A claims made policy is a "pay as you go" policy, covering claims first made during the year the policy is in force. The insurance company can price the risk a year at a time on known data instead of predicting several years into the future, as with the occurrence policy.<sup>37</sup>

8. While St. Paul pushed for a claims made approach for the time being,<sup>38</sup> it threatened that, unless there were drastic changes in the tort system, the company could not predict or promise future rates. While the claims made approach would alleviate the insurance pricing uncertainty and afford an insurance market, the claims made policy would not "solve the fundamental malpractice problem."<sup>39</sup>

9. St. Paul insisted on sweeping changes in the tort system, similar to those advanced in automobile reparations: (a) binding arbitration panels of doctors, lawyers and lay people to render decisions on negligence and damages; (b) a return to the "locality" rule to establish the accepted standard of medical practice in the defendant's own community; (c) a shorter statute of limitations (two years was suggested); (d) elimination of the *ad damnum* clause (the dollar demand in the lawsuit); (e) elimination of the collateral source rule which excludes evidence and consideration of other benefits and services received by a plaintiff as a result of his injuries; (f) limitation of the doctrine of informed consent to comply with a locality rule; and (g) regulation of attorneys' contingent fees according to a sliding scale with lower percentage fees on higher awards or settlements.<sup>40</sup>

10. Nationally, in 1969, St. Paul claimed that it had experienced a net loss of \$5,507,198.<sup>41</sup>

11. In Virginia in the 1975 Rate Classification 1 (lower-risk specialties, such as psychiatrists, pediatricians, pathologists, radiolo-

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36. *Id.*

37. *Id.*

38. *Id.* at 1-2.

39. *Id.* at 2.

40. *Id.* at 7-10.

41. *Id.* at 3 of attached exhibits.

gists, internists, allergists, dermatologists and hematologists), St. Paul's rates for \$100,000/\$300,000 liability were \$433 for this coverage as opposed to \$135 in 1970. For Class 5 (including higher-risk specialties such as anesthesiologists, neurosurgeons, obstetrician/gynecologists, orthopedic surgeons and plastic surgeons), the rate as of January 1, 1975 was \$2,728 as opposed to \$824 for the same coverage in 1970.<sup>42</sup>

12. The following ranking was listed for frequency of allegations made for medical negligence: (a) surgical error, (b) post-operative problems, (c) improper surgical procedure, (d) failure to diagnose fracture, (e) improper treatment of fracture, (f) lack of supervisory control, (g) drug side effects, (h) improper treatment - infection, (i) birth related problems, and (j) lack of informed consent.<sup>43</sup>

## 2. Actions Taken by Some Other Companies

As of 1975 the Argonaut Company cancelled the policies of a large number of New York doctors and said that it would not renew the policies of some 4,000 California doctors as of May 1, 1975. The Travelers Insurance Company declined to commit itself on renewal of several thousand policyholders in California. Additionally, Argonaut said it would not renew the policies of some 500 doctors in Idaho,<sup>44</sup> and a bill was passed there to limit the malpractice liability of physicians, nurses, and hospitals to \$100,000.<sup>45</sup> Yet the insurance industry as a whole opposed both federal intervention and elimination of the fault system.<sup>46</sup> Several states were identified as apparently having serious "problems" as of March, 1975; notably Virginia was not listed among those states.<sup>47</sup>

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42. *Id.* at 5 of attached exhibits.

43. *Id.* at 6 of attached exhibits.

44. Letter from Douglas M. Smith to Thomas V. Monahan (March 14, 1975) (discussing medical malpractice insurance problems nationally).

45. IDAHO CODE §§ 39-4201 to -4213 (1977). The section was held unconstitutional in *Jones v. State Bd. of Medicine*, No. 55527 (Fourth Judicial District of the State of Idaho, Nov. 14, 1980). See also *Jones v. State Bd. of Medicine*, 97 Idaho 859, \_\_\_, 555 P.2d 399, 410-16 (1976), *cert. denied*, 431 U.S. 914 (1977) (remanding case for determination of whether discrimination between those claims exceeding \$150,000 and those with smaller claims bears substantial relationship to reasonable state purpose).

46. Smith, *supra* note 44.

47. *Id.* Nineteen states were identified as apparently having serious problems as of March, 1975: Alaska, Arkansas, California, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, West Virginia and Wisconsin.

### 3. The Indiana Plan

In Indiana, the Patients' Compensation Act,<sup>48</sup> introduced on behalf of the Indiana Medical Association, limited attorneys' fees to fifteen percent, limited the statute of limitations to six years in infants' cases, abolished breach of contract as a basis of a cause of action unless the agreement was in writing and signed by the doctor, eliminated the ad damnum clause, established a patient compensation fund for awards over \$100,000, and established a mandatory four-member panel consisting of three physicians and one lawyer (who had no vote).<sup>49</sup> This plan was endorsed by the Virginia Medical Society on June 29, 1975.<sup>50</sup>

### 4. Insurance Rates in Virginia

The so-called medical malpractice crisis was widely publicized in newspapers, magazines, professional and insurance journals. Physicians, hospitals, insurance carriers, lobbyists and some lawyers demanded change in the procedure for malpractice claims. Nevertheless, in Virginia, St. Paul, which insured at least eighty percent of Virginia's 5,000 to 5,500 practicing doctors,<sup>51</sup> assured that it would continue to cover any doctor belonging to the Virginia Medical Society. St. Paul claimed its Virginia rates were based exclusively on the company's Virginia experience and not on the experience of any other state. Specifically, St. Paul said its rates were based on its differing experience in three areas of Virginia: northern Virginia, having the highest rate structure; central Virginia, the second highest rate structure; and western Virginia, the lowest rate structure.<sup>52</sup> The crux of the problem in setting rates, according to St. Paul, is the inherent difficulty in adequately projecting future losses. Although these losses will not be paid until some future date, they arise from the current year's medical practice.

St. Paul reported to the Virginia legislature that in its medical malpractice lines in Virginia,<sup>53</sup> it incurred a loss of \$251,878 in

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48. IND. CODE ANN. § 16-9.5-4-3 (Burns Cum. Supp. 1982).

49. *Id.*

50. Letter from Edward W. Taylor to William W. Eskridge (July 8, 1975) (reporting on the Virginia Medical Society's vote and adoption of Indiana Plan).

51. BUREAU OF INSURANCE, *supra* note 28.

52. *Id.* at 12-15. According to a public statement issued by St. Paul, one out of every eleven doctors in central Virginia had a lawsuit pending against him at some point in 1974.

53. In 1975, there were 6,868 physicians licensed to practice medicine in Virginia (5,000-5,500 were actually engaged in practice). There were 5,891 short-term general and special hospitals nationwide, and 118 hospitals in Virginia. BUREAU OF INSURANCE, STATE CORP.

1972, a gain of \$40,758 in 1971, a loss of \$224,445 in 1970 and a loss of \$683,897 in 1969.<sup>54</sup> The company reported that the number of claims in Virginia had increased from 78 in 1968 to 269 in 1974, the frequency of claims per 100 doctors had increased from 2.3792% in 1968 to 6.5103% in 1974, and the severity of each claim had increased from \$6,792.31 in 1968 to \$9,649.09 in 1974.<sup>55</sup>

#### B. *Was There a Crisis in Virginia in 1976?*

The General Assembly grounded the Medical Malpractice Act and specifically the "cap" on two findings: (1) health care providers were finding it difficult to obtain medical malpractice insurance with limits at affordable rates in excess of \$750,000; and (2) the insurance problem was causing both early retirements and refusal of young people to enter medical careers.<sup>56</sup> The professional licensing boards contacted by the authors were unable to furnish any statistics regarding the loss and early retirement of health care providers in Virginia. Official state statistics regarding the number of licensed practitioners demonstrate that in every year from 1970 to 1981, the number of licensed physicians in Virginia has increased. For instance, over that ten year period the number of licensed physicians increased from 6,125 in 1970-71 to 9,914 in 1975-76 and finally 16,532 in 1980-81.<sup>57</sup> This is the same time period in which health care providers claimed that the threat of the so-called crisis had driven individuals out of the profession.

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COMM'N, DISTRIBUTION (1976) (quoting AMERICAN HOSP. ASS'N ANNUAL SURVEY, HOSPITAL STATISTICS (1974 ed.) and DEPARTMENT OF HEALTH, EDUC. AND WELFARE, STATISTICAL ABSTRACT 1974; PHYSICIAN VISITS, VOLUME AND INTERVAL U.S. 1971, VITAL AND HEALTH STATISTICS, SERIES 10, No. 97 (1974)) [hereinafter cited as DISTRIBUTION]. This report was distributed at the 1976 session of the Virginia General Assembly. See BUREAU OF INSURANCE, *supra* note 28, at 5, 11-12.

54. St. Paul Fire and Marine Ins. Co., Experience of St. Paul Fire and Marine Insurance Company: Physicians and Surgeons Professional Liability: Virginia Fund Analysis by Accident Year; Frequency-Severity by Reported Year (1976) (printed handouts distributed to the 1976 Virginia General Assembly).

55. *Id.*

56. See *supra* note 1 and accompanying text.

57. Letter from Ola M. Ferguson, Department of Health Regulatory Boards, State Board of Medicine, Commonwealth of Virginia, to Beale, Eichner, Wright, Denton & Shields, P.C. (March 16, 1981) (listing number of physicians licensed to practice in Virginia from 1970-1981). Furthermore the number of licensed osteopaths, podiatrists, chiropractors, clinical psychologists, physical therapists and physical therapy assistants has also increased during 1970 to 1980. Although the number of licensed practitioners in nursing has decreased on several occasions, the number of nurses licensed to practice in Virginia has increased from 32,245 in 1970 to 59,354 in 1981.

The remaining legislative justification for the "cap" given by the 1976 General Assembly in its preamble was the alleged increasing difficulty that Virginia health care providers were experiencing in obtaining medical malpractice insurance at affordable rates with limits in excess of \$750,000. However, Garland L. Hazelwood, Jr., Assistant Commissioner of Insurance for the Virginia State Corporation Commission, later testified under oath that there was never any insurance availability problem with respect to Virginia physicians.<sup>58</sup> He defined crisis as an "unavailability" of professional liability insurance.<sup>59</sup> Any problem Hazelwood saw during 1974 and 1975 dealt with the availability of insurance for hospitals and the problem which existed for hospitals only concerned coverage for the basic limits.<sup>60</sup> That is, the hospital, he said, was experiencing some difficulty in obtaining the primary coverage for the first \$300,000. However, there was never a lack of availability of coverage for limits over \$750,000, even for hospitals.<sup>61</sup>

Furthermore, according to Hazelwood, malpractice insurance policies were never keyed to a \$750,000 limit. Policies were written for either limits of \$100,000/\$300,000 or for \$1,000,000. Most St. Paul policies today are written for the latter amount. None are known to be written for \$750,000. It is clear that \$750,000 is a figure pulled out of the air by the 1976 legislature and is completely unrelated to any actual examinations, studies, insurance policies, statistics or figures. This limit is a classic example of a great deal of argument, noise and clamor made by powerful citizens which resulted in hurried legislation that did not fully consider its widespread repercussions.

It is also interesting to observe that St. Paul's claims experience in its medical malpractice line had leveled off in Virginia and many other states during 1975.<sup>62</sup> Normally, this fact would have triggered a timely rate filing by St. Paul during the following year, 1976. Such a filing would have promptly informed the Insurance Bureau

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58. *Riggan v. Nassef*, No. 42-5769 (Cir. Ct. County of Halifax, Va., Dec. 17, 1981) (deposition of Garland L. Hazelwood, Jr., at 5).

59. *Id.*

60. *Id.* at 8-9.

61. Case No. 19672 before the State Corp. Commission (March 26, 1976) (testimony of Warren Bessler, Resident General Counsel for St. Paul). An exhibit filed at that hearing showed that only 12 hospitals in Virginia claimed any renewal problems.

62. Letter from M.W. Harnish, State Filings Director, Insurance Law Department for St. Paul, to John G. Day, Commissioner, Insurance Commission of Virginia (Oct. 19, 1976) (available in the State Corporation Commission's file on St. Paul).

of the 1975 claims experience, a fact which may have had some influence on the 1976 legislature.<sup>63</sup> The legislature in 1976 did not have the benefit of this information as St. Paul's rate filing for that year was delayed.<sup>64</sup>

### C. *Responses to the Perceived Crisis*

#### 1. Association of Trial Lawyers of America

In April, 1975, the Association of Trial Lawyers of America (ATLA) reported that the medical malpractice problem had been blown out of proportion and developed into an emotional issue.<sup>65</sup> In ATLA's view, all the existing medical propaganda concentrated on the interests of doctors, lawyers and insurance companies, while the rights and welfare of the medical malpractice victim had been subordinate and forgotten. ATLA believed that this resulting malpractice immunity breeds irresponsibility.

Robert E. Cartright, President of ATLA, noted that, in 1974, the average annual premium for medical malpractice insurance was \$3,500 for each of California's forty thousand practicing doctors, totalling \$140,000,000.<sup>66</sup> However, insurance payments that year only totaled \$30,000,000 or \$750 per doctor.<sup>67</sup> Cartright questioned the \$110,000,000 difference and suggested the need for a full public investigation of insurance company practices.<sup>68</sup>

In June, 1981, ATLA announced that 5,500 southern California doctors had reached a settlement in their suit against The Travelers Insurance Company which alleged that the doctors had been overcharged by a sudden premium hike of 327% in 1976.<sup>69</sup> Travelers agreed to pay the doctors \$18,600,000 immediately as reimbursement for overcharges, and to make additional payments over the next nine years calculated as the difference between projected claims and actual claims; the total figure could reach almost \$50,000,000.<sup>70</sup> ATLA described this settlement as a tacit admission

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63. The Virginia Medical Malpractice Act was adopted April 9, 1976.

64. Letter, *supra* note 62.

65. 18 A. TRIAL LAW. AM. NEWSLETTER No. 3, 102-03 (1977).

66. *Id.*

67. *Id.* at 102. The \$30 million figure broke down to \$7.7 million in verdicts and \$22.3 million in settlements.

68. *Id.* at 103.

69. Southern Cal. Physicians Council Corp. v. Phoenix Ins. Co., No. C-35076 (Cal. App. Dep't Super. Ct., filed Feb. 4, 1981).

70. 24 A. TRIAL LAW. AM. REP. No. 5,194-95 (1981).

that the crisis had been contrived.<sup>71</sup>

## 2. Medical Society of Virginia

The Virginia Medical Society, in a report<sup>72</sup> to its membership at its annual meeting in October, 1975, claimed that there was no more urgent consumer problem facing the Virginia General Assembly in its 1976 session than the impending crisis in medical malpractice insurance. This crisis was said to affect not only physicians, hospitals and other health care providers, but also every resident of our state who requires health care. In a well-planned and well-orchestrated campaign, the Medical Society reported that it had developed a Medical Malpractice Insurance Relief Program for consideration and passage in the 1976 General Assembly. The Society reported that, while Virginia's current malpractice insurance difficulties had not reached crisis proportion, expert opinion was that within twelve to eighteen months coverage could be withdrawn.<sup>73</sup> The Medical Society admitted that the solution to this problem is a complex one, and recommended that immediate action be taken to reduce the frequency and severity of malpractice claims in Virginia.<sup>74</sup> The main features of the Virginia Medical Society proposal included: (1) a \$500,000 limitation on total recovery for a patient suffering injury or death with a \$100,000 cap per physician or hospital involved; (2) for minors, limitation on the period of liability to six years within the date of the alleged malpractice; (3) creation of a patient's compensation fund financed by a surcharge on premiums paid by health care providers; (4) a limitation, fifteen percent after the first \$100,000 awarded, of an attorney's fee made from the patient's compensation fund; (5) review of qualifications for fitness and possible disciplinary action by the appropriate licensing board of a health care provider who loses a malpractice suit; (6) establishment of a risk management authority to make insurance available to health care providers rejected by other insurers; (7) establishment of a medical review panel to review all malpractice claims before court action is commenced; and (8) use of binding arbitration as an alternative to adjudication in court.<sup>75</sup>

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71. *Id.* at 196.

72. REPORT TO THE MEMBERSHIP ON MEDICAL MALPRACTICE INSURANCE (October, 1975)(pamphlet distributed at the Annual Meeting of the Medical Society of Virginia, Roanoke, Virginia (Oct. 23-26, 1975)).

73. *Id.*

74. *Id.*

75. *Id.*

A professional public affairs firm participated in the medical malpractice insurance relief campaign launched by the Medical Society. Activities included: (1) a survey of public attitudes in Virginia on the medical malpractice problem; (2) mobilization of physicians and other health care providers and assistance in their preparation of testimony before regional hearings being held throughout the state by the House Sub-Committee on Medical Malpractice; (3) polls of members and candidates for the General Assembly; (4) the publication of special newsletters to keep its leadership informed about the problem; (5) in depth research on the issue; (6) contact with influential groups and associations around the state to seek support for the proposal; and (7) development of materials to assist physicians in waging the campaign in their communities.<sup>76</sup>

A public relations campaign was mounted on the grassroots level by physicians seeking public support for their position. Local delegates and senators were contacted; public forums for discussion of the problems including Lion's Clubs, Rotary and Jaycees were solicited; local newspaper editors were visited by the physicians; articulate physician spokesmen were encouraged to speak on the topic; and a letter writing campaign to patients and friends was mounted urging them to write to their delegates and senators to support the Medical Society's plan. The end result was House Bill 190 and Senate Bill 114, which included the Medical Society's version of the Indiana Plan sponsored by the Indiana State Medical Association and adopted there April 3, 1975.<sup>77</sup> Many of the definitions included in the Virginia version closely track the language of the Indiana Plan.

### 3. Virginia State Bar

The Virginia State Bar, in a position paper presented to the 1976 General Assembly, concluded that "currently, there is no malpractice crisis in Virginia."<sup>78</sup> In support of its contention that the references to "astronomical" insurance rates in Virginia were misleading, the State Bar reported that malpractice insurance rates in Virginia then ranked twenty-ninth in the nation.<sup>79</sup> In addition, the State Bar reported that, contrary to popular belief, Virginia juries were not generously awarding recoveries to plaintiffs against doc-

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76. *Id.*

77. H. 190, S. 114 Va. Gen. Assem. (1975).

78. Virginia State Bar, Statement on Medical Malpractice (1976).

79. *Id.* at 1.



tors. Instead, St. Paul's local claims manager had reported recently that there had not been a jury verdict against a physician in central Virginia in over five years.<sup>80</sup> The State Bar reported that St. Paul's chief trial counsel in the central Virginia area often had been heard to say that he had never lost a malpractice case.<sup>81</sup> The paper concluded that insurance coverage was currently available and that Virginia law served to protect the interest of health care providers. The State Bar charged that the crisis in other states had been precipitated, in large part, justifiably or not, by the insurance industry.<sup>82</sup> It pointed out that the President of Argonaut Insurance Company, in testifying before the New York State Legislature, and said that Argonaut had paid out only \$24,000 in claims although it had collected \$35,000,000 in premiums.<sup>83</sup> The company requested a premium increase based on actuarial speculation that there would be increased claims. The Bar reported, however, that there was precedent in Virginia to indicate that convoluted actuarial methods can demonstrate loss where there is, in fact, a gain.<sup>84</sup> It maintained that, currently, no satisfactory justification had been offered for providing the physician with special immunity or special rules of law for his sole protection.<sup>85</sup>

#### 4. Virginia Ad Hoc Committee of Attorneys

As a result of the so-called crisis, the bar groups of Virginia appointed the Virginia Ad Hoc Committee on Medical Malpractice in 1975. The Committee was comprised of two members from the Old Dominion Bar Association and four members from each of the following: the Virginia State Bar, the Virginia Bar Association and the Virginia Trial Lawyers Association.<sup>86</sup>

The Ad Hoc Committee reported its desire that the impact on

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80. *Id.*

81. *Id.*

82. *Id.* at 4.

83. *Id.* at 5.

84. *Id.*

85. *Id.* at 7.

86. Representing the Virginia State Bar were: Wilbur C. Allen, Clarence Flippo Hicks, Jackson L. Kiser and T.J. Markow; representing the Virginia Bar Association, Edward W. Taylor, Morton B. Spiro, John E. Clarkson and William W. Eskridge; representing the Virginia Trial Lawyers Association, Emanuel Emroch, Kenneth E. Trabue, Willard J. Moody and Marvin F. Cole (chairman); representing the Old Dominion Bar Association, George Minor, Jr. and Thomas L. Hicks, Jr. The Committee was completely unfunded and without any supporting staff. Some members of the Committee regularly represented St. Paul in defense of claims.

the patient seriously be considered by the General Assembly. This Committee believed that the solution to the medical malpractice problem was the elimination of malpractice itself and could be achieved by attacking the cause, incompetent practice, and improving the quality of health care. It was the unanimous opinion of the Ad Hoc Committee that all three bills, Senate Bills 114 and 115 and House Bill 190, then pending in the Virginia Legislature, be opposed in their entirety on constitutional grounds.<sup>87</sup> However, the Committee did support Senate Bill 122 which would establish a Medical Malpractice Joint Underwriting Association.<sup>88</sup>

#### D. *The SCC's Insurance Bureau Study: The John Day Report*

On February 6, 1975, the Virginia General Assembly adopted House Joint Resolution No. 174, which authorized the Commission to study costs in the administration of health care services and to study and report on malpractice insurance premiums for physicians. The Commission was directed to examine the possibility of requiring companies furnishing insurance in Virginia to base their malpractice insurance premiums on Virginia experience only.<sup>89</sup>

In November, 1975, the State Corporation Commission's Bureau of Insurance completed its study on medical malpractice insurance in Virginia.<sup>90</sup> It reported that since 1960, malpractice insurance premium rates across the United States had increased more than 1,000% due to the dramatic increase in the number and severity of malpractice claims.<sup>91</sup> It was estimated that over ninety percent of all medical malpractice claims made in the United States had been reported since 1965.<sup>92</sup> It reported that Virginia had begun to experience similar problems, although not to the degree experienced in many other jurisdictions. The annual premium for the minimum \$100,000/\$300,000 coverage for Virginia physicians under the Medical Society's program ranked only twenty-ninth in the nation.<sup>93</sup>

In July, 1975, then Insurance Commissioner John Day told the legislative study commission on malpractice insurance that the

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87. Ad Hoc Committee on Medical Malpractice, Report of the Ad Hoc Committee on Medical Malpractice (adopted Jan. 9, 1976).

88. *Id.*

89. H.R. Res. 174, Va. Gen. Assem. (1975).

90. BUREAU OF INSURANCE, *supra* note 28.

91. *Id.* and DISTRIBUTION, *supra* note 53.

92. *Id.*

93. *Id.*

availability of malpractice insurance was not yet a problem in Virginia.<sup>94</sup> Most Virginia doctors were still able to obtain the same coverage they had been receiving, new doctors were able to obtain coverage, and with several exceptions, insurance was still available to the state's acute care hospitals.<sup>95</sup> Day reported that his office had requested that insurance companies maintain the "status quo" until the 1976 meeting of the General Assembly with respect to hospitals that were threatened with the prospect of losing coverage.<sup>96</sup> Day urged that the legislature explore the matter of ensuring continued availability of malpractice insurance. He suggested that a possible vehicle for accomplishing this goal would be for the legislature to establish a joint underwriting association through which liability insurers in the state could participate in the drafting of their own malpractice policies.<sup>97</sup> Day explained that the malpractice insurance problem was the result of increasing medical claims and difficulties in predicting the number and severity of the claims.

In November, 1975, John Day presented a statement to the House and Senate Courts of Justice Committees regarding the State Corporation Commission's Medical Malpractice Report,<sup>98</sup> in which he reiterated that there were few problems regarding the availability of malpractice insurance. He attributed this to St. Paul Fire and Marine Insurance Company's continued willingness to remain in the Virginia area, because problems experienced in other parts of the country did not exist in Virginia at that time and were not expected in the foreseeable future.<sup>99</sup> Reporting on the recommendations of the State Corporation Commission, Day suggested that a joint underwriting association be established and stated:

With respect to the reduction of claims and the size of claims, the Commission analyzes various means by which the medical disciplinary system can be strengthened . . . . Based on this review and a review of the Virginia experience, the SCC believes that caution is warranted. This is so for several reasons. First, most of the legal doctrines complained of elsewhere are virtually non-existent in Vir-

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94. Richmond Times Dispatch, July 12, 1975, § B, at 1, col. 2 and § B, at 2, col. 6.

95. *Id.*

96. *Id.*

97. *Id.*

98. Day, *Medical Malpractice Insurance: Insurance Commissioner Proposes New Concept*, 24 VA. B. NEWS, No. 3, at 19 (1975).

99. *Id.* at 19.

ginia. In fact, many of Virginia's existing legal doctrines are more restrictive than the changes that have been made in other jurisdictions to remedy the problem . . . .

. . . .  
. . . The best available evidence to date indicates that at least 75% of all malpractice incidents caused by physicians and surgeons occurs within the confines of a hospital . . . .

. . . Because of these considerations, the SCC thought that some effort should be made to look at the possible solutions that focus on the hospital—an emphasis that up until recently has been nonexistent. . . .<sup>100</sup>

Day reported that one alternative would be for the hospital to be held responsible for all losses resulting from incidents occurring within the hospital.<sup>101</sup> To accomplish this, the hospital would purchase insurance to cover all losses and redistribute this cost through the per diem rate.<sup>102</sup> It was believed that this redistribution of cost would decrease the burden placed upon the individual physician and ultimately, the patient.<sup>103</sup> This program would provide incentive for doctors and hospitals to cooperate in improving the overall quality of patient care and providing some type of quality control.

The proposals offered by Day to the study commission went largely unheeded.<sup>104</sup> The Medical Society, as evidenced by public relations and lobbying activity expenditures, was determined to enact the Indiana Plan. The insurance industry, on the other hand, maintained a low profile. St. Paul had already announced that because of its claims made policy, it would continue to write coverage for Virginia's physicians. The proposed joint underwriting association would, therefore, be unnecessary.

Despite the proposals of John Day and the Insurance Commission Report, Virginia doctors, legislators and lobbyists were affected by the state of frenzy generated by the public relations campaign. The General Assembly passed sweeping changes in Virginia medical malpractice law because of panic and a feeling that the

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100. *Id.* at 19-21.

101. *Id.* at 22.

102. *Id.*

103. *Id.*

104. Senator Edward E. Willey, a retired pharmacist and former owner of a drug company, was chairman of the Commission, Katherine L. Goolsby was staff attorney to the Commission. It is perhaps worthy of note that Goolsby's husband, Allen C. Goolsby, III, was a lobbyist for the Virginia Medical Society.

tort law must be changed.

E. *Passage of the Medical Malpractice Act in Virginia*

On February 19, 1976, Senate Document Number 29 entitled *Interim Report of the Commission to Study the Costs and Administration of Health Care Services to the Governor and the General Assembly of Virginia* was distributed. This document incorporated much of the information contained in the Insurance Commission Report of November, 1975.

Senate Bill Number 115, offered on January 26, 1976, was amended in the nature of a substitute by a unanimous Senate on February 17, 1976. The amendment deleted portions of the original Bill which imposed a \$100,000 ceiling per claim against a health care provider and a total limitation of \$500,000. Portions forbidding actions for breach of contract, imposing a six-year limitation on infants' claims, establishing a patient's compensation fund, imposing a limit on attorneys' fees, establishing a residual malpractice insurance authority, and declaring the existence of an emergency also were eliminated.

The House prepared its own amendment in the nature of a substitute for Senate Bill 115. This substitute contained language regarding limitations on recovery for pain and suffering. The House version required that part of an award attributable to physical impairment and pain and suffering be limited to \$250,000. A parent, guardian or other person standing *in loco parentis* to an infant would have the right to recover any expenses incurred in an attempt to cure the infant. More importantly, the House inserted a severability clause in case any part of the Act should be held unconstitutional.

The total amount recoverable was increased to \$750,000, while the pain and suffering limitation was set at \$250,000 by a floor amendment to the House version of the Bill. Although the House passed the Bill as amended, the Senate flatly rejected the amendment. It was clear at this point that battle lines had been drawn between the Senate and the House regarding a ceiling or cap on recovery. The resulting Committee of Conferences on Senate Bill 115 agreed on what would become the preamble to Chapter 611 of the Acts of Assembly which has previously been discussed. The Committee agreed on the final language: "[T]he total amount recoverable for an injury to, or death of, a patient shall not exceed

\$750,000.”<sup>105</sup> However, the severability language insisted upon by the House and the language in the title of the original House version of the Bill placing the limitation “on recovery for pain and suffering” remained in the final version as it passed both houses.

*F. Factors Mitigating Against the Need for a Limitation on Recovery in Virginia*

1. Insurance Commission Makes No Recommendation with Reference To Limit on Recovery

The number of legislative members who had an opportunity to read Senate Document No. 29, first printed after February 19, 1976, is debatable. Nevertheless, it is clear that Senate Document No. 29 contained a definitive study of the problem as it then existed and its conclusions were in opposition to the ultimate legislative action. The Commission made no tort system recommendations regarding the statute of limitations, the doctrine of *res ipsa loquitur*, the doctrine of informed consent, the locality rule governing the standard of care which doctors must exercise, contingent fees, or the imposition of the monetary limit on the liability of health care providers. The Commission did recognize that the above matters were the subject of consideration by other legislative studies and did recommend tort system changes relating to the *ad damnum* clause, the collateral source rule and the review of malpractice claims by screening panels.<sup>106</sup> The Commission found the State Corporation Commission's hospital-based distribution proposal noteworthy, concluding that it offered the greatest possibility of a rational and effective solution to the problem.<sup>107</sup> It is clear that most members of the legislature had not read this report, for had they done so, they would have found that there was little need to impose a monetary limit on recovery in malpractice actions in Virginia.

As previously noted, the Insurance Commission reported that malpractice insurance coverage was available in Virginia to both physicians and hospitals.<sup>108</sup> This report demonstrated that St.

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105. 1976 Va. Acts, ch. 611.

106. COMMISSION TO STUDY THE COSTS AND ADMINISTRATION OF HEALTH CARE SERVICES, INTERIM REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA OF 1976, S. Doc. No. 29, at 7 (1976).

107. *Id.* at 8.

108. S. Doc. No. 29, *supra* note 106, Exhibit 1, Medical Malpractice Insurance in Virginia: The Scope and Severity of the Problem and Alternative Solutions, at 9-10.

Paul, through its agreement with the Virginia Medical Society, had written at least eighty percent of all Virginia physicians' policies since 1956.<sup>109</sup> Although the claims, as recorded by St. Paul, had increased from 89 in 1969 to 151 during the first half of 1975,<sup>110</sup> St. Paul, continued to insure approximately eighty percent of Virginia's practicing physicians. Such figures do not reflect the existence of a crisis. Further, the average value of a claim was \$4,182.03 in 1969 and \$10,190.66 in 1975.<sup>111</sup> This approximated the national experience for 1968 and 1974.<sup>112</sup> The increased claim figures for the periods 1968 and 1975 in Virginia and for the periods 1968 and 1974 across the nation, offered little support for the imposition of a limitation on recovery.

## 2. Charitable Immunity Exception

The Bureau of Insurance of the State Corporation Commission Report also pointed out that, prior to 1974, more than seventy percent of Virginia hospitals were exempt from malpractice liability because of the charitable immunity doctrine.<sup>113</sup> Even though amendments were made to the Virginia Code in 1976<sup>114</sup> providing for immunity to institutions which are exempt from federal taxation and the elimination of the words "charitable institution" from the amended Code section, approximately seventy percent of Virginia hospitals remain exempt from malpractice liability for damages greater than \$100,000 unless they voluntarily carry higher insurance limits.<sup>115</sup>

Claims against "for profit" hospitals in Virginia had increased from eleven in 1969 to sixty-eight for the first three quarters of 1975.<sup>116</sup> Claims against "not for profit" and state and local government hospitals increased from twenty-one in 1969 to ninety-eight for the first three quarters of 1975.<sup>117</sup> This was hardly an alarming occurrence in view of the fact that the latter group had approximately 4.6 million bed-patient days and the former group had 0.8

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109. *Id.* at 18.

110. *Id.* at 19.

111. *Id.*

112. *Id.* at 20.

113. *Id.* at 5.

114. VA. CODE ANN. § 8.01-38 (Repl. Vol. 1977).

115. BUREAU OF INSURANCE, *supra* note 28, at 23.

116. *Id.*

117. *Id.*

million bed-patients days.<sup>118</sup> More importantly, it was noted that seventy-five percent of all malpractice acts of physicians and surgeons occur within the confines of a hospital;<sup>119</sup> involve specialists;<sup>120</sup> and that, "prior to 1975, Virginia hospitals encountered little or no difficulty in obtaining malpractice insurance."<sup>121</sup>

### 3. Virginia's Short Statute of Limitation

With respect to the impact of Virginia's short statute of limitations, the Insurance Commission reported that "many states — particularly those having a severe malpractice problem — afford the claimant a much longer time within which he can bring suit."<sup>122</sup> "With respect to physicians and surgeons, Virginia's short statute of limitations appears to result in a relatively rapid reporting of malpractice claims when compared to the nation as a whole . . . ."<sup>123</sup>

### 4. Modest Payouts by Insurance Carriers

For the years 1969 through 1974, the report indicated that, in Virginia, St. Paul had a total of one hundred two claims against physicians; paid ninety; and paid out, or "reserved," \$1,307,243 for loss and "loss expense" anticipated for the five year period involved.<sup>124</sup> Additional data for 1969 indicated that of eighty-four claims made against Virginia hospitals, seventy-seven had been paid, and a total of \$136,786 had been paid out, or "reserved," for loss and "loss expense" by all other hospital insurance carriers.<sup>125</sup> These were hardly alarming figures.

### 5. Small Jury Verdicts in Virginia

With respect to the size of verdicts in Virginia in medical malpractice cases, the Insurance Commission reported that "[w]hile extremely large verdicts or settlements may be a severe problem in other jurisdictions, available data indicates that verdict or settlement size has not yet reached crisis proportions in Virginia."<sup>126</sup> Be-

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118. *Id.* at 22.

119. *Id.* at 28.

120. *Id.* at 29.

121. *Id.* at 10.

122. *Id.* at 24.

123. *Id.* at 25.

124. *Id.*

125. *Id.* at 26.

126. *Id.* at 27.



tween 1970 and the beginning of 1975 there was only one claim paid in Virginia which fell within the range of \$250,000 to \$449,999, and no claims were paid in excess of \$500,000. Only one claim fell within the range of \$150,000 to \$249,999. Five claims during this five year period fell between \$100,000 and \$149,999.<sup>127</sup>

### G. *Insurance Commission Solutions*

The Insurance Commission reported that there were three possible solutions to the problems of malpractice coverage:

(1) A hospital and/or physician-owned insurance company; (2) A state insurance fund operated by the state itself or by an insurance carrier selected by the state to manage the fund; and (3) A combination of private insurance carriers that are compelled to provide malpractice insurance coverage with provision for the distribution of resulting losses or gains among the participating insurance companies.<sup>128</sup>

#### 1. *Reciprocal Insurance Companies*

With respect to a hospital or physician-owned insurance company, "[a]vailability of coverage is assured because doctors and hospitals would have control over the insurance company."<sup>129</sup> Under insurance law existing in 1975, "such a company could be established in Virginia."<sup>130</sup> It is assumed that, largely because of the report's recommended alternative, the Virginia Hospital Insurance Reciprocal was formed in 1977; however, to date, no equivalent has been formed for individual physicians.

In 1979, the Virginia Hospital Reciprocal announced that it was the largest writer of insurance for hospitals in Virginia, representing over sixty-five percent of the licensed hospital beds in the Commonwealth.<sup>131</sup> The Virginia Hospital Reciprocal successfully increased its assets from \$4,891,018 in 1978 to \$10,143,618 in 1979.<sup>132</sup> With respect to any possible future "crisis" in hospital insurance, the Reciprocal reported that "[w]e have taken great care to ensure that our Reciprocal is properly structured, adequately re-

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127. *Id.* at 28.

128. *Id.* at 36.

129. *Id.* at 37.

130. *Id.*

131. VIRGINIA HOSP. INS. RECIPROCAL, 1979 ANNUAL REPORT 4 (1980).

132. *Id.* at 1.

served and financially sound so as to be able to withstand whatever the future may hold."<sup>133</sup>

As of 1975 a number of Virginia physicians were actively pursuing the alternative of forming a reciprocal. They decided that their company would not become operative unless approximately 1200 doctors elected to participate.<sup>134</sup> To date, there has been no indication that a physicians' reciprocal insurance company has been formed, possibly because St. Paul has continued to insure approximately eighty percent or more of Virginia physicians through its relationship with the Virginia Medical Society.<sup>135</sup>

## 2. State Fund Approach

With respect to the alternative of establishing a state fund, staffed by state employees, to provide malpractice insurance coverage, the Insurance Commission maintained that there would be cost savings. These savings would result from the elimination of agents' commissions and duplicative management, and the spread of losses among the entire population through the tax base rather than among policyholders, as occurs in the private sector. However, it was noted that only a few states had thus far adopted the state fund approach.<sup>136</sup> As far as this writer is aware, the 1976 General Assembly never seriously considered this suggestion.

## 3. The Joint Underwriting Association

The Insurance Commission's third alternative involved the formation of a Joint Underwriting Association (JUA) or a reinsurance facility. Under this format, insurance companies engaged in writing specified types of policies

would be required to form an association which would issue malpractice insurance coverage to all health care providers in accordance with underwriting standards established by legislation or by the Commissioner of Insurance. All losses or profits would be distributed among participating insurance companies in accordance with an equitable formula usually based on the premium volume that each company writes in the state. This standby mechanism would be activated by the Commissioner of Insurance whenever he

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133. *Id.* at 2.

134. BUREAU OF INSURANCE, *supra* note 28, at 38.

135. *Id.* at 12.

136. *Id.* at 40.

found, after a hearing, that malpractice insurance is not readily available through the voluntary market. The JUA would be managed by a single carrier with malpractice experience selected by the participating insurance companies in accordance with a plan of operation approved by the Commissioner of Insurance.<sup>137</sup>

It was noted that

[t]he vast majority of jurisdictions have opted for the JUA alternative rather than the reinsurance facility because ... [u]nder a reinsurance facility, all companies required to write malpractice insurance must service the policy sold by them even though the risk is reinsured with the facility. Since the vast majority of companies have no expertise in the malpractice area, each company would be required to either obtain staff with this experience or to rely on independent claims adjusters.<sup>138</sup>

As this article later discusses, the JUA, while temporarily implemented for hospitals prior to the formation of the Virginia Hospital Reciprocal, was never implemented for physicians because the Virginia Medical Society never requested it.<sup>139</sup>

The Medical Malpractice Joint Underwriting Association was enacted by the 1976 General Assembly.<sup>140</sup> The statute provided that the JUA was to be in effect until July 1, 1980 and further provided that "the [Joint Underwriting] [A]ssociation shall not commence underwriting operations . . . until the [State Corporation] Commission, after investigation and a hearing, has determined that medical malpractice insurance cannot be made reasonably available for a significant number of any class, type or group of providers of health care in the voluntary market."<sup>141</sup> The Code also provided for automatic dissolution of the JUA. After July 1, 1980, while the JUA remains in existence, "[t]he Association shall discontinue its underwriting operations and shall remain in existence for the sole purpose of completing its orderly dissolution."<sup>142</sup> It further states that "[w]hen the Commission finds that Association has met its obligations incident to termination of its business

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137. *Id.* at 42.

138. *Id.* at 43.

139. *Riggan v. Nassef*, No. 42-5769 (Cir. Ct. County of Halifax, Va., Dec. 17, 1981) (deposition of Garland L. Hazelwood, Jr., at 34).

140. VA. CODE ANN. § 38.1-776 (Repl. Vol. 1981).

141. *Id.* § 38.1-776(C).

142. *Id.* § 38.1-776.1(1).

affairs, the Commission shall by order issue a Certificate of Dissolution and the existence of the Association shall cease.”<sup>143</sup> The Corporation Commission shall also “be empowered to reactivate the joint underwriting association should it find that medical malpractice insurance cannot be made reasonably available in the voluntary market. . . .”<sup>144</sup>

At a hearing before the State Corporation Commission in March, 1976, the hospital group requested that the JUA be implemented as to its members. The physicians made no similar appearance before the Corporation Commission. The JUA has done no business in Virginia since 1977.<sup>145</sup>

### III. MALPRACTICE CLAIMS AND AMOUNTS OF RECOVERY FOLLOWING PASSAGE OF THE ACT

#### A. *Jury Verdict Trends in Medical Malpractice Cases*

While amounts of damage awards in medical and hospital negligence actions have increased in recent years, the number of jury verdicts in favor of plaintiffs has decreased to the point that verdicts are returned for plaintiffs in less than one-third of all cases.<sup>146</sup> According to a 1977 jury verdict research release (JVR) covering 1966 through 1971, of 540 cases collected, plaintiffs had an overall recovery rate against physicians of only 33%. Between 1971 and 1977, of the 783 cases studied, the recovery rate fell to 28%, a decrease of 15% of the 1971 rate. Of all liability situations, comparatively speaking, medical malpractice results in the lowest overall plaintiff recovery rate.<sup>147</sup> JVR also reported that plaintiffs in suits against hospitals have steadily been losing ground in recovery probabilities. In 1977, plaintiffs were found to be recovering against hospitals in only 46% of the cases as compared with 52% in 1971 and 53% from 1960 through 1965.<sup>148</sup>

Indications are that the number of liability suits against all professionals, including lawyers, engineers, veterinarians, bankers, chiropractors, dentists, and psychologists, has increased in the last

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143. *Id.* § 38.1-776.1(3).

144. *Id.* § 38.1-776.2.

145. *Riggan v. Nassef*, No. 42-5769 (deposition of Hazelwood at 16).

146. JURY VERDICT RESEARCH, INC., 3A PERSONAL INJURY VALUATION HANDBOOKS, No. 204, at 684 (1977).

147. *Id.*, No. 202 at 655.

148. *Id.*, No. 203, at 668.

few years.<sup>149</sup> The overall plaintiff recovery rate, in all situations, including automobile collisions, was reported by the 1977 study to be approximately 65%.<sup>150</sup> It should also be kept in mind that damage awards in all types of personal injury cases have increased in recent years. This fact may be explained by reference to the consumer price index increase. Awards on an annual basis since 1973 have increased each year an average of 10.23%, while the consumer price index has increased each year an average of 8.9%.<sup>151</sup>

In addition, the number of million dollar verdicts in all types of cases has increased in recent years. While these awards may appear unreasonable at first glance, they are generally made only to seriously injured plaintiffs; and the jury's decision to grant such a verdict is usually based upon testimony presenting legitimate computations of both the plaintiff's projected lost earnings and the projected medical expenses necessary to sustain him for life. According to JVR's latest report there has been a total of 536 verdicts of \$1,000,000 or more in all types of cases since 1962, when the first seven figure verdict was returned.<sup>152</sup> JVR has classed Virginia among those states with the fewest \$1,000,000 awards and in a class where there were only between one and four such awards in all types of cases.<sup>153</sup>

Of all \$1,000,000 awards in the nineteen-year span covered by the report, 231 (or 43%) fell into one of two liability categories: products liability or medical malpractice. One hundred and forty of these high awards were in products liability cases (26%) and 91 (17%) were returned in medical malpractice suits.<sup>154</sup> Conversely, automobile collision cases resulted in million dollar verdicts in only 68 (or less than 13%) of all such awards. Injuries suffered by plaintiffs in all million dollar suits included permanent paralysis, permanent brain damage, wrongful death, amputation of a limb and severe disabling burns.<sup>155</sup>

The first verdict of \$1,000,000 or more in a medical negligence case was recorded in 1971 and there has been a total of 74 during

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149. *Id.*, No. 201, at 645.

150. *Id.*, No. 202, at 656.

151. JURY VERDICT RESEARCH, INC., 1 PERSONAL INJURY VALUATION HANDBOOKS, No. 258, at 6 (1982).

152. *Id.* at 11.

153. *Id.* at 13.

154. *Id.* at 14.

155. *Id.*

the period from 1972 to 1980.<sup>156</sup> Excluding the \$1,000,000 verdicts, the average verdict nationwide in medical negligence cases during the year 1981 was \$220,068 with a mid-point verdict of \$175,000 compared with an average verdict in 1971 of \$153,974 and a mid-point of \$72,500.<sup>157</sup>

### B. *SCC Statistics Between 1976 and 1981*

Between 1976 and 1981 there were 2,676 medical malpractice claims in Virginia against hospitals, physicians or other health care providers.<sup>158</sup> Approximately 74% of the claims made arose from injuries incurred in a hospital-type setting. In slightly more than one-fourth (700) of these claims, some indemnity was paid by the carriers, whereas no payment was made to the remainder of the claimants.<sup>159</sup> In only 32 claims (1.5% of the total), was there payment in excess of \$100,000.<sup>160</sup> Even though 22% (589) of all claims were made for paralysis, loss of more than one limb, brain damage, or death, insurers paid out more than \$25,000 in only 141 claims.<sup>161</sup>

In more than three-fourths (77.9%) of all cases, no attorney's fee was paid to the plaintiff's attorney, whereas in 19.9% of the cases, there was an attorney's fee of between one dollar and \$25,000 paid to the plaintiff's attorney.<sup>162</sup>

### C. *Insurance Payouts Versus Company Earnings in the Late Seventies*

In 1977, St. Paul reported to the State Corporation Commission that for that year it had earned premiums in Virginia in its medical malpractice lines of \$14,731,607 and that it had paid \$226,836 in claims.<sup>163</sup> For 1978, St. Paul reported that it had written premiums of \$15,518,000, earned premiums of \$14,072,000, and paid out \$791,000 in claims in Virginia.<sup>164</sup> For 1979, St. Paul reported to the

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156. *Id.* at 17.

157. *Id.*

158. BUREAU OF INSURANCE, STATE CORP. COMM'N, PRESENTATION OF VIRGINIA MEDICAL MALPRACTICE DATA FREQUENCY DISTRIBUTIONS Table 1 (1981) (presented to House Courts of Justice Subcommittee on Nov. 23, 1981).

159. *Id.* at Tables 1 and 3.

160. *Id.* at Table 28.

161. *Id.* at Table 1.

162. *Id.* at Table 14.

163. BUREAU OF INSURANCE, STATE CORP. COMM'N, REPORT ON PROPERTY AND CASUALTY INSURERS TRANSACTING BUSINESS IN VIRGINIA DURING 1977 65R (1977).

164. BUREAU OF INSURANCE, STATE CORP. COMM'N, REPORT ON PROPERTY AND CASUALTY

SCC that it had written premiums of \$16,720,000, earned premiums of \$15,518,000, and paid out \$3,263,000 in claims.<sup>165</sup> Direct premium writings in Virginia during 1980 for all lines were \$40,816,000.<sup>166</sup>

According to A.M. Best Company, which publishes the financial statements of the nation's insurance companies, for the six years 1975-1980, St. Paul, on a nationwide basis earned premiums of \$717,098,000 and paid out losses of \$70,142,000<sup>167</sup> (approximately 9.8% of premium income).<sup>168</sup> For the six years St. Paul reserved \$257,620,000 for known claims and another \$458,254,000 for claims incurred but not reported (IBNR).<sup>169</sup> With approximately 65% of its assets, some \$2.1 billion, invested in bonds, it is estimated that St. Paul had investment income of \$91,251,000 over these years. This is some \$21 million more than it paid in claims.<sup>170</sup>

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INSURERS TRANSACTING BUSINESS IN VIRGINIA DURING 1978 65R (1978).

165. BUREAU OF INSURANCE, STATE CORP. COMM'N, REPORT ON PROPERTY AND CASUALTY INSURERS TRANSACTING BUSINESS IN VIRGINIA DURING 1979 65R (1979).

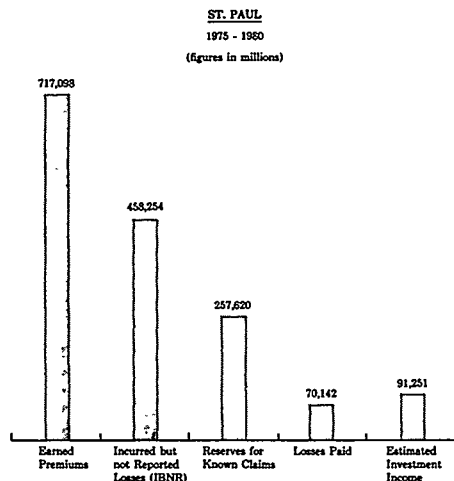
166. A.M. BEST CO., BEST'S INSURANCE REPORTS PROPERTY CASUALTY 1711 (1981).

167. *Id.*

168. ST. PAUL FIRE AND MARINE INS. CO., 1980 ANNUAL REPORT, Schedule P (1981).

169. An IBNR loss is an estimate of claims not now known, but which may be reported in the future. It is listed as a liability of the company although it may never be paid. See A.M. BEST CO., *supra* note 167.

170. A.M. BEST CO., *supra* note 167, app. The following graphically demonstrates the cited figures.



For the occurrence year 1975, St. Paul reserved \$38,080,000 for IBNR losses in its medical malpractice line and deducted this sum as an expense.<sup>171</sup> Six years later it estimated unpaid incurred losses for that year at \$24,816,000; this means that the St. Paul originally overestimated its 1975 reserves by some 35%. The company has consistently over estimated its IBNR reserves for the medical malpractice line for each year, averaging an overestimation of about 25% for the six years ending 1980. As a result, St. Paul has received tax deductions for losses it did not incur and has continued to receive income from the sums never paid out and retained in investments.

For the year 1975, A.M. Best Company reported St. Paul had earned premiums of \$52,718,000 in its medical malpractice lines only, actually paid out to claimants \$10,502,000, paid \$5,054,000 in loss adjustment expenses, and reserved \$9,261,000 for known losses (excluding IBNR reserves) and loss expenses.<sup>172</sup> As of 1980, the difference between what it earned (\$52.7 million) and what it had paid out (\$10.5 million) and spent for "loss adjustment expense" (\$5 million) was \$36.5 million. Yet, only another \$9.2 million remained to be paid.<sup>173</sup> A St. Paul executive reportedly told the Conference of Insurance Legislators that St. Paul *had lost money* in medical malpractice throughout 1975, but that the line had been "generally profitable" during 1976 and 1977.<sup>174</sup> St. Paul reported in 1980 it had earned during its corporate history, \$6.5 billion in premiums and had paid out \$2.7 billion in all lines of insurance.<sup>175</sup> In 1980 it had \$3.3 billion in assets, an increase of \$495 million from the previous year; St. Paul had a surplus of \$696 million plus another \$36 million in special reserve funds (\$732 million), as compared with \$184 million possessed at the end of 1975.<sup>176</sup> This is an increase in surplus of almost 400% over the five year period.

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171. ST. PAUL FIRE AND MARINE INS. CO., *supra* note 168. See BEST'S CASUALTY LOSS RESERVE DEP'T, MEDICAL MALPRACTICE, St. Paul Group, Data Bank No. 00080 (1981) [hereinafter cited as RESERVE].

172. RESERVE, *supra* note 171, Reports 01 and 03. The term loss expense includes all payments for legal expenses, including attorney's and witness' fees and court costs; salaries and expenses of investigators, adjusters and field men; rents; office supplies and expenses; salaries and expenses of office employees; home office expenses; and all other payments under or on account of such injuries.

173. A. TOBIAS, INVISIBLE BANKERS — EVERYTHING THE INSURANCE INDUSTRY NEVER WANTED YOU TO KNOW 31-32 (1982).

174. *Id.*

175. ST. PAUL FIRE AND MARINE INS. CO., *supra* note 168.

176. A.M. BEST CO., *supra* note 167.



The insurance industry is not regulated by the United States Government. Rather, the states have primacy in regulating insurance due to the McCarron-Ferguson Act passed in 1944.<sup>177</sup> Critics in the Congress and elsewhere have since charged that state insurance departments have not adequately protected insurance consumers. Whether this is true for Virginia remains to be seen.

The General Accounting Office (GAO) reported to Congress on October 9, 1979 on needed improvements in state regulation of the insurance business.<sup>178</sup> This report reviewed the resources and activities of all state insurance departments in the United States and evaluated some of them. It concluded that there were serious shortcomings in state laws and regulatory activities with respect to protecting the interest of insurance consumers in the United States. In particular, the GAO said that most state insurance departments do not have systematic procedures to determine whether insurance consumers are being treated properly regarding claims payments, rate-setting, and protection from unfair discrimination.

The GAO observed that in general, the number of individuals on insurance department staffs with relevant professional training is small. Departments spend little to upgrade staff skills, and salary levels are low in relation to the salaries of similar professionals elsewhere.<sup>179</sup> GAO stated that most states do not have specialized examiners and that few states have the capacity to do computerized audits.<sup>180</sup> The GAO found the degree of scrutiny given important increase requests varies among the states.<sup>181</sup> Among those states which the GAO examined, only Texas and Massachusetts conducted an original actuarial analysis enabling them to independently recommend the appropriate level of insurance rates. The GAO further observed that competition<sup>182</sup> was not effective in

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177. BUREAU OF INSURANCE, STATE CORP. COMM'N, COMPETITION IN THE PROPERTY AND CASUALTY INSURANCE INDUSTRY: AN EVALUATION OF ALTERNATIVE METHODS OF RATE REGULATION 12 (1978) [hereinafter cited as COMPETITION].

178. COMPTROLLER GENERAL, GENERAL ACCOUNTING OFFICE, PAD-79-72A, ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATIONS OF THE INSURANCE BUSINESS (1979). Copies of GAO Reports are available free of charge by writing: U.S. General Accounting Office, Distribution Section, Room 1518, 441 G. Street, N.W., Washington, D.C. 20548.

179. *Id.* at ch. 3.

180. *Id.* at ch. 4.

181. *Id.* at ch. 5.

182. See generally COMPETITION, *supra* note 177; BUREAU OF INSURANCE, STATE CORP. COMM'N, ADMINISTRATIVE ORDER (Aug. 25, 1975). Property and casualty insurance premiums, except for medical malpractice and workmen's compensation insurance, are rated competi-

achieving the best rates because of lack of consumer information in many lines of insurance.

Moreover, GAO reported that insurance regulation is not characterized by an arms-length relationship between the regulators and the regulated. About half of the state insurance commissioners were previously employed by the insurance industry, and approximately the same proportion joined the industry after leaving office.<sup>183</sup>

#### IV. THE BILLS BEFORE THE 1982 GENERAL ASSEMBLY

Two bills on the subject of medical malpractice insurance coverage were offered in the House of Delegates during the 1982 Session of the General Assembly. The first would have repealed the limitation on malpractice recovery specified by the Code.<sup>184</sup> The second bill, offered on the same date, affected two code sections and would have increased the minimum insurance requirement of tax exempt hospitals from \$100,000 to \$1,000,000.<sup>185</sup> In addition, that bill also would have increased the limit of recovery in medical malpractice actions from \$750,000 to \$1,000,000.<sup>186</sup>

Prior to the introduction of the two bills in question, a Subcommittee had been appointed by the House Courts of Justice Committee. Its charge was to study the constitutional issues regarding limitation on recovery in medical malpractice cases. The Subcommittee met prior to the 1982 session, and was chaired by Delegate Bernard Cohen of Alexandria. Appearing before the Subcommittee when it met in September, November and December of 1981 were several attorneys representing the Virginia Trial Lawyers Association, as well as lobbyists representing the Virginia Medical Society, the Virginia Hospital Association, the Virginia Hospital Insurance Reciprocal and other insurance carriers. The Medical Society conceded, through its lobbyists, that no claims of \$750,000 had been paid in Virginia to that date,<sup>187</sup> and indicated that it had employed

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tively in Virginia. VA. CODE ANN. § 38.1-279.29 to -.57 (Repl. Vol. 1981).

183. James W. Newman, who served as Virginia's Insurance Commissioner between 1976 and 1981, reportedly became a Vice President of the American Insurance Association (AIA), a trade and service organization of the property and casualty insurance industry. Part of AIA's role is to provide legislative services. St. Paul is a member of AIA, which lobbies throughout Virginia.

184. H. 951, Va. Gen. Assem. (1982).

185. H. 952, Va. Gen. Assem. (1982).

186. *Id.*

187. HOUSE COURTS OF JUSTICE SUB-COMMITTEE STUDYING CONSTITUTIONAL ISSUES SUR-

an actuarial firm to appear at the Subcommittee's January, 1982 meeting.<sup>188</sup> The representative from the American Insurance Association (AIA), comprised of 145 companies including St. Paul, conceded "that the premiums for medical malpractice insurance in Virginia are [sic] lower than the national average,"<sup>189</sup> and agreed that use of a medical panel was an economic rather than a policy decision. The AIA representative further conceded that the larger malpractice cases have not been going to the panel.<sup>190</sup>

The Executive Secretary of the Supreme Court of Virginia stated to the subcommittee that 125-130 panels had been conducted during 1981 (an average of two to three per week) and that in 79% of the cases a decision for the defendant resulted, while in only approximately 12 to 13% of the cases a decision was rendered for the plaintiff. The Executive Secretary also reported that the circuit judges do not feel that there is a need for a judge, who would act primarily as an administrator on the panel.<sup>191</sup> As a compromise to the complete repeal of the \$750,000 limitation on recovery, the Medical Society proposed to the House Courts Committee that the limitation be increased from \$750,000 to \$1,000,000.<sup>192</sup>

At a committee meeting in February, 1982, following an emotional presentation by Mrs. LaVerne Carlson, the mother of a four year old malpractice victim,<sup>193</sup> House Bill 952, increasing the limits to \$1,000,000, passed the Court of Justice Committee by a vote of 9-2, as amended to provide that the new \$1,000,000 limit apply separately to each health care provider. The bill included specific language referring to "provider and any other person insured under any malpractice liability insurance policy covering such provider"<sup>194</sup> and also stated that "in order for a health care provider to receive the benefit of legislation herein, such health care provider shall carry liability insurance in the amount of at least

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ROUNDING § 8.01-581.15, REPORT TO VIRGINIA GENERAL ASSEMBLY OF 1982 (1981) (minutes of Nov. 23, 1981, at 1) [hereinafter cited as SUB-COMMITTEE].

188. At the January, 1982, meeting of the Sub-Committee, the author did not observe the presence of an actuary employed by the Medical Society of Virginia.

189. SUB-COMMITTEE, *supra* note 187, minutes of November 23, 1981, at 1.

190. *Id.*

191. *Id.* at 2.

192. *Id.* at 1.

193. *Carlson v. Jamison*, No. A-830-L (Cir. Ct. City of Richmond, Va., 1980). Christopher E. Carlson suffered severe anoxic brain and kidney damage from which he never recovered. At the time of his death on July 9, 1982, his medical and hospital bills exceeded \$400,000. This paper is dedicated to Chris.

194. H. 952 as amended, Va. Gen. Assem. (1982).

\$1,000,000 per occurrence.”<sup>195</sup> Patron Cohen then moved to pass by indefinitely House Bill 951 which would have repealed the limit completely.

House Bill 952 reached the floor of the House late on Friday afternoon, February 19, 1982, where, with approximately 30% of the Delegates absent, it was curiously defeated on the second reading by a 35 to 35 tie vote.<sup>196</sup>

## V. THE CONSTITUTIONALITY OF LIMITING MAXIMUM RECOVERY IN MEDICAL NEGLIGENCE CASES

### A. *Differing Views of the Constitutionality of Limitations on Medical Malpractice Recovery*

The mid-1970's saw many states pass medical malpractice reform legislation which contained various provisions. The Virginia Act, like those of many other states, included a notice requirement, set up screening panels whose findings were admissible in subsequent trials, and set up a “cap” or ceiling on the amount a plaintiff could recover in a medical malpractice suit. The cap was by no means a universal provision; some states adopted them, many did not. For example, our neighboring states of North Carolina and West Virginia did not adopt caps.

A number of cases have questioned the constitutionality of these acts. Some of these cases have held entire medical negligence reform laws unconstitutional.<sup>197</sup> Others have upheld these acts despite constitutional challenges.<sup>198</sup> Many decisions find some portions of the act constitutional and other portions unconstitutional.<sup>199</sup> Several states have found the acts constitutional in early

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195. *Id.*

196. Journal of Virginia General Assembly (February, 1982) (regarding H. 952 as amended). At that time, approximately 30% of the delegates were absent, some being in an Appropriations Committee meeting, and others having left for the weekend. On a voice vote on the second reading, the vote was 35 to 35. Of the “nays,” thirty were Republican votes. There is speculation that the Virginia Medical Society and the American Medical Political Action Committee of the American Medical Association (AMA PAC) were large contributors to political candidates.

Total political contributions of the AMA PAC were second only to those of the Realtors PAC, which totaled \$1,536,573. Attorneys ranked tenth with a contribution of \$360,125. FED. ELECTION COMM'N REP. (1982).

197. See *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980) (Many provisions of the malpractice act were violative of equal protection, and the remaining portions were not severable.).

198. See *Johnson v. St. Vincent Hosp., Inc.*, — Ind. —, 404 N.E.2d 585 (1980).

199. See *Linder v. Smith*, — Mont. —, 629 P.2d 1187 (1981) (Unconstitutional portion of

decisions and later reversed themselves.<sup>200</sup> The reasonings of the courts are even more diverse than the holdings, but the significant point is that various provisions of the malpractice reform statutes have been held to be unconstitutional in many states.

### B. *Cases Holding Ceilings on Recovery Violative of State Constitutions*

A leading case holding a ceiling or "cap" on malpractice recovery unconstitutional is *Wright v. Central Du Page Hospital Association*.<sup>201</sup> This case dealt with the Illinois statute limiting recovery in medical malpractice actions to \$500,000. The Illinois Supreme Court distinguished both wrongful death actions and dram shop actions by stating that the legislature in each of those instances had created a right of action where none existed at common law.<sup>202</sup> The legislature could, therefore, condition a legislatively granted right by placing a limit on the recovery. Malpractice actions, on the other hand, were common law actions; and the legislature could not use analogies to wrongful death or dram shop actions to justify a limitation on recovery.

Workmen's compensation was also distinguished by the Illinois Court. The court found that the injured workman received a *quid pro quo* for loss of the right to sue for unlimited sums; his employer became liable without regard to fault.<sup>203</sup> The court rejected defense arguments that the badly injured plaintiff in a malpractice action also received a *quid pro quo* in the form of lower insurance premiums and lower medical costs. This brand of societal *quid pro quo* was simply too nebulous and uncertain to justify a trade-off.

The court held that the Illinois scheme denied recovery to the severely injured plaintiff on an arbitrary basis; the act therefore constituted a special privilege in violation of the Illinois Constitu-

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the act was severable; the remainder was complete and constitutional.).

200. Compare *Carter v. Sparkman*, 335 So. 2d 802 (Fla. 1976) (Statutes concerning mediation panels are constitutional.) and *Parker v. Children's Hospital of Philadelphia*, 438 Pa. 106, 394 A.2d 932 (1978) (Submission of claim to arbitration before jury trial does not violate right to jury trial.) with *Aldana v. Holub*, 381 So. 2d 231 (Fla. 1980) (Medical Mediation Act was held unconstitutional with prospective application only.) and *Mattos v. Thompson*, 491 Pa. 385, 421 A.2d 190 (1980) (Lengthy delay by arbitration system does burden right to jury trial.).

201. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

202. *Id.* at —, 347 N.E.2d at 741-42.

203. *Id.* at —, 347 N.E.2d at 742.

tion.<sup>204</sup> By basing the decision on the state constitution,<sup>205</sup> the Illinois Supreme Court was able to avoid examining the issue under equal protection standards of the United States Constitution.

*C. Evaluation of Constitutionality Based on the United States Constitution*

The traditional evaluation of an equal protection question begins with a determination of which standard of review will apply. Until the early 1970's, the United States Supreme Court had developed a well-recognized, two-tier approach to equal protection questions. Under this approach, the courts would either evaluate legislative classifications using a "strict scrutiny" standard or a "rational basis" test. The more stringent "strict scrutiny" standard requires that legislation be necessary to the promotion of a compelling state interest. It is employed when a statute creates a classification involving a "suspect class"<sup>206</sup> or limits a "fundamental right."<sup>207</sup> Classifications are considered suspect when "the class is ... saddled with such disabilities or subjected to a history of such purposeful, unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process."<sup>208</sup>

The courts also employ strict scrutiny analysis if a "fundamental right" is affected, even if the classification is not directed at a suspect class. The Supreme Court has limited the "fundamental rights" category to rights "explicitly or implicitly guaranteed by the Constitution."<sup>209</sup> If the strict scrutiny standard of review applies, that is, if a classification can be pigeonholed as affecting a fundamental right or suspect classification, it is virtually impossible to justify the classification.

On the other hand, if the classification is found not to involve a suspect category or fundamental right, it will be upheld if the court can discern any rationale nexus between the created classification and any permissible goal of government. It is not too harsh, to state, that under this two-tier approach, the courts have simply ignored the fairness of classifications not falling under the strict

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204. *Id.* at \_\_, 347 N.E.2d at 743.

205. ILL. CONST. art. IV, § 13.

206. See *Korematsu v. United States*, 323 U.S. 214, 216 (1944).

207. See *Shapiro v. Thompson*, 394 U.S. 618 (1969).

208. *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 28 (1973).

209. *Id.* at 33-34.

scrutiny standard of review. The second tier is usually known as the "rational nexus" standard. Under it, virtually any real or even speculative rationale will suffice to uphold a classification.

In the early 1970's, questions began to emerge which did not fall comfortably within this over-simplified two-tier scheme. Issues came before courts which did not involve fundamental rights or suspect categories, but which involved legislative categorizations so questionable that courts felt people should be able to obtain some relief. Courts have tried to work out appropriate solutions to this dilemma. Generally, the solution had been the adoption of an intermediate standard, sometimes called the "means focused" standard.<sup>210</sup>

Under this test, the standard can be stated as follows:

The Equal Protection Clause of that amendment [fourteenth amendment] does, however, deny to States the power to legislate that different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of that statute. A classification "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike."<sup>211</sup>

In examining the constitutionality of malpractice statutes, most courts have grappled with the question of which standard was applicable. While the court in *Wright v. Central Du Page Hospital Association*,<sup>212</sup> was able to avoid frontally addressing the standard of review examination by deciding the case under the Illinois Constitution,<sup>213</sup> the reasoning used was quite similar to this "means focused" standard.

The Supreme Court of New Hampshire faced the standard of review issue squarely in *Carson v. Maurer*.<sup>214</sup> The court evaluated a cap limiting non-economic losses to \$250,000 and determined that the legislative classification involved neither a suspect category nor any of the rights customarily considered fundamental. It did find that the right to recover for personal injuries was an im-

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210. See *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Reed v. Reed*, 404 U.S. 71 (1971).

211. 404 U.S. at 75-76 (quoting *Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920)).

212. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

213. ILL. CONST. art. IV, § 13.

214. 120 N.H. 925, 424 A.2d 825 (1980).

portant substantive right,<sup>215</sup> however, and adopted the intermediate "means focused" test. The court found that the cap was arbitrary and lacked a fair and substantial relationship to the object of the legislation; therefore, it could not pass this intermediate standard of review and was unconstitutional under the equal protection clause.

In *Arneson v. Olson*,<sup>216</sup> the North Dakota Supreme Court examined the three standards of review used by the federal courts in equal protection cases. The court chose the middle-tier approach which called for a "close correspondence between statutory classification and legislative goals."<sup>217</sup> The court ruled that the cap of \$500,000 was a violation of the state constitution's equal protection clause. The court could see no "nexus" between the cap and the availability of competent medical and hospital services in the state.<sup>218</sup>

Perhaps the most exhaustive examination of the issue has been in Idaho in *Jones v. State Board of Medicine*,<sup>219</sup> where, the supreme court, in a well-reasoned opinion, seriously questioned the constitutional validity of the 1976 Hospital Medical Liability Act.<sup>220</sup> The court adopted the "means focused" equal protection standard,<sup>221</sup> but ruled that there was not sufficient evidence to decide the case and remanded it to the trial court for additional evidence, findings, and conclusions. When the "means focused" test was applied in 1980 on remand to the Fourth Judicial District of the State of Idaho, the court found that the legislation adopted did not substantially affect the availability of a liability insurance market and, therefore, was unconstitutional based on equal protection grounds.<sup>222</sup>

Courts in Ohio and Florida have treated medical malpractice limitations on recovery in a similar manner.<sup>223</sup> The specific issues

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215. *Id.* at —, 424 A.2d at 830.

216. 270 N.W.2d 125 (N.D. 1978).

217. *Id.* at —

218. *Id.* at —

219. 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977), *on remand*, No. 55586 (4th Dist. Ct. Ada County, Idaho, Nov. 3, 1980).

220. IDAHO CODE §§ 39-4201 to -4313 (1977).

221. 97 Idaho at —, 555 P.2d at 407.

222. *Jones v. State Bd. of Medicine*, No. 55586 (4th Dist. Ct. Ada County, Idaho, Nov. 3, 1980).

223. See *Van Stetina v. Florida Medical Center, Inc.*, No. 81-05946 (Cir. Ct. Broward County, Fla. 1982); *Graleg v. Satayatham*, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (Ct. C.P.



addressed by the courts in applying the "means focused" test have been substantially the same. Each reviews a cap which has the effect of denying full recovery to the most severely injured victims of medical negligence. Virtually the entire economic burden of the acts, which limit recovery, is placed upon the victims who are least able to bear the burden. The beneficiaries of these limitations are the health care providers and their insurance carriers. Courts reviewing this situation usually find that the legislature has impermissibly divided the more seriously injured from the less seriously injured and has placed the whole burden upon those more seriously injured. This classification is not reasonably calculated to alleviate the crisis; hence the act is unconstitutional on equal protection grounds.

In limiting the amount of recovery for medical malpractice victims, the acts also distinguish victims of malpractice from the victims of any other form of negligence. If a crisis existed, there might be some justification for that distinction. However, courts have held the distinction to be an impermissible classification on the basis that the right to be made whole for an injury due to the negligence of someone else is very close to a fundamental right.<sup>224</sup> The evidence fails to show that this deprivation of the right of full recovery in a malpractice action is a reasonable way to correct a crisis of doubtful validity.

The courts also find it distasteful to relieve health care providers and their insurers of responsibility for their acts. Such a gratuitous benefit has been characterized as special legislation in violation of many state constitutions.<sup>225</sup> Courts have also held the cap unconstitutional on due process grounds because the cap denies full recovery to the plaintiff<sup>226</sup> and other courts have held the cap unconstitutional because it violates the plaintiff's right to a jury trial.<sup>227</sup>

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Cuyahoga County 1976) (noting recovery limit and citing *Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976)); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Ct. C.P. Montgomery County 1976) (declaring in dictum that the \$200,000 limit violated equal protection.).

224. *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Ct. C.P. Montgomery County 1976).

225. *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736, 743 (1976).

226. *American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc.*, 104 Cal. App. 3d 219, 163 Cal. Rptr. 513 (1st Dist. Ct. App. 1980).

227. *Arneson v. Olson*, 270 N.W.2d 125, 137 (N.D. 1978); *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736, 741 (1976).

#### D. Cases Holding Ceilings on Recovery Constitutional

In *Johnson v. St. Vincent Hospital, Inc.*,<sup>228</sup> the Supreme Court of Indiana squarely upheld the cap and other aspects of the Indiana malpractice scheme. It found the Act to meet both due process and equal protection standards. The court examined the applicable standards of review and decided that neither a fundamental right nor suspect classification was involved. The Act was to be tested to see whether the classification was arbitrary or unreasonable and whether a fair and substantial relationship existed between the classification and the purpose of the legislation creating it.<sup>229</sup> This approach at first glance would appear to place Indiana in the group of states which follow some sort of intermediate category. However, the case contains conflicting language, and when the rationale of the Indiana Supreme Court is reviewed it appears that the court actually followed the two-tier approach and applied the rational nexus test.<sup>230</sup> The Indiana opinion contains many speculative justifications for this application. The court conjectured that high recoveries would have been prevented or stymied prior to the enactment of the cap by physicians' refusal to insure, by their insuring with lesser policy limits, or by insurance company bankruptcies.<sup>231</sup> Therefore, the Act was justified. The Indiana decision is an excellent example of what is wrong with the rational nexus standard as applied to cases concerning ceilings on recovery. The decision is not founded on research, fact or evidence, but upon the judges' examination of an imaginary setting which supposedly provides justification for harshly penalizing Indiana's victims of malpractice.

In *Prendergast v. Nelson*,<sup>232</sup> the Nebraska Supreme Court is also said to have upheld a \$500,000 limit on malpractice recovery. Because of the language contained in the opinion, this decision is of questionable precedential value. Three of Nebraska's seven supreme court justices joined in a dissent finding the statutory cap unconstitutional.<sup>233</sup> A fourth justice refused to examine the issue of the statutory cap, because he considered the opinion advisory

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228. 76 Ind. 131, 404 N.E.2d 585 (1980).

229. *Id.* at —, 404 N.E.2d at 600.

230. *Id.* at —, 404 N.E.2d at 585.

231. *Id.* at —, —, 404 N.E.2d at 599, 601.

232. 199 Neb. 97, 256 N.W.2d 657 (1977).

233. *Id.* at —, 256 N.W.2d at 674 (White, C. Thomas, J., dissenting); *Id.* at —, 256 N.W.2d at 677 (McCoun, J., dissenting, and Boslaugh, J., dissenting).

only.<sup>234</sup> Nevertheless, this fourth justice, in dicta, stated that the Act contained two unconstitutional provisions, one being the statutory limitation. Upon examination of the views expressed in the plurality and dissenting opinions, it is unclear whether there was actually a majority of justices who considered the cap to be constitutional. Those justices who clearly upheld the cap did so under the rational nexus test.

The issue has been decided in California, but its present status is not entirely clear. In *American Bank and Trust Co. v. Community Hospital at Los Gatos-Saratoga, Inc.*,<sup>235</sup> a California appellate court held that the periodic payments provisions of amounts over \$50,000 under the 1975 Medical Injury Compensation Reform Act were unconstitutional as violative of equal protection and due process considerations. The court found that the classifications were under-inclusive and so arbitrary as to deny equal protection. It was concerned that the more severely injured rather than the less severely injured patients seem to carry the burden of reform. However in *Fein v. Permanente Medical Group*,<sup>236</sup> another California appellate court upheld the constitutionality of a \$25,000 cap for non-economic losses and the periodic payments provisions using a traditional two-tier/rational nexus approach. A definitive decision of California's position appears to await further litigation.

In summary, the majority of those states specifically ruling on the constitutionality of limitations of recovery have held them unconstitutional. Generally, the courts reviewing the limitation have found that the rights involved deserve judicial scrutiny and protection, even though these rights do not fall within the traditional suspect classifications or burden fundamental rights which require strict scrutiny. The limitation on recovery with its partial abolition of the right to full recovery via jury trial goes to the very core of our judicial system and is an issue of considerable long-range significance to our society as a whole. The loss of the right to full recovery must be the subject of serious review by a concerned and interested judiciary.

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234. Id. at \_\_\_, 256 N.W.2d at 677 (Clinton, J., dissenting).

235. 104 Cal. App. 3d 219, 163 Cal. Rptr. 513 (1st Dist. Ct. App. 1980).

236. 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (3d Dist. Ct. App. 1981).

## VI. VIRGINIA CONSTITUTIONAL CONSIDERATIONS

A. *Background on the Constitutionality Issue in Virginia*

Even while the cap was under consideration in Virginia, it was clear that such a cap would encounter serious constitutional objections. John Day, in a State Corporation Commission study, later, incorporated into Senate Document Number 29, stated:

Serious questions arise regarding the efficacy of these types of limits both from a constitutional and cost reduction standpoint. Constitutional questions arise because the limitations usually take something away from the injured patient without conferring some benefit. In fact, the injured patient usually will have a tougher job of recovering than he had prior to the enactment of these laws since these laws also eliminate some of the more liberal negligence doctrines. The presence of a quid pro quo is essential and in other contexts has made the difference between the law being declared constitutional or unconstitutional.<sup>237</sup>

Immediately after the adoption of the Act one of Virginia's leading medical negligence defense attorneys, Thomas J. Harlan, Jr., questioned the constitutionality of several portions of Virginia's malpractice act.<sup>238</sup> After a careful examination of *Wright v. Central Du Page Hospital Association*.<sup>239</sup> Mr. Harlan concluded his discussion of the cap in Virginia as follows:

Does not the Virginia statute's attempt to limit the common law right of recovery for medical malpractice to the sum of \$750,000 likewise constitute special legislation? In effect, does it not also attempt to "change the rules of evidence in a judicial proceeding" regarding the amount of damages that the plaintiff can recover in a medical malpractice suit?<sup>240</sup>

B. *Issues Concerning Constitutionality of the Limitation On*

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237. COMMISSION TO STUDY THE COSTS AND ADMINISTRATION OF HEALTH CARE SERVICES, INTERIM REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA OF 1976, S. Doc. No. 29, at 63-66 (1976).

238. Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions It Raises*, 11 U. RICH. L. REV. 51 (1976).

239. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

240. Harlan, *supra* note 238, at 67.

*Recovery*

## 1. Equal Protection

The threshold question in an equal protection case is what standard of review the court should employ. As previously discussed in this article,<sup>241</sup> the traditional approach has been a two-tier approach. If the legislatively created classification involves fundamental rights or suspect groups, then the action of the legislature is subject to strict scrutiny. If neither of those categories is involved, a rational nexus standard is applied. The malpractice cap may not involve either a suspect group or rights traditionally defined as fundamental.

Nonetheless, the legislature has created a number of important classifications. The Act classifies those who suffer damages in excess of \$750,000 differently from those who suffer damages in lesser sums;<sup>242</sup> the Act differentiates those persons who are injured by malpractice from tort victims injured in other ways;<sup>243</sup> and the Act treats health care providers differently from other tortfeasors. When the Act is considered as a whole, it is clear that health care providers are extended a considerable benefit at the expense of those few patients most severely injured by medical negligence. The innocent but seriously injured victim is forced to shoulder the load placed upon him by the wrongdoer to the benefit of the wrongdoer and only indirectly to the benefit of society. These types of laws impinge substantially on traditional notions of fair play and constitutionality. The courts are charged with the duty to protect innocent victims from this type of special interest legislation. Virginia courts should not avoid this duty under the guise of a largely mythical evaluation available under the rational nexus text.

The appropriate standard of review, adopted by most courts, is the "means focused" test which should be adopted by Virginia judges in evaluating the constitutionality of the malpractice cap.<sup>244</sup> The basis of the "means focused" test is that the equal protection clause denies the state the power to legislate different treatment for different categories of persons in ways that are wholly unrelated to the objectives of the statute. Classifications, in order to

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241. See *supra* notes 206-12 and accompanying text.

242. VA. CODE ANN. § 8.01-581.15 (Repl. Vol. 1977).

243. VA. CODE ANN. §§ 8.01-581.15 to -581.18 (Repl. Vol. 1977 and Cum. Supp. 1982).

244. See *supra* notes 210-23 and accompanying text.

meet the requirements of the equal protection clause, must be reasonable and not arbitrary, and they must rest upon some "ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike."<sup>245</sup>

The "means focused" test accepts the objective of the statute but then examines the class to see if the legislature is using the "means" reasonably, fairly, and realistically in achieving the objective. If the "means" does not meet this standard, the act violates equal protection. In a case testing the constitutionality of the malpractice act, the court would be expected to accept the objective that the legislature can correct a so-called crisis claimed by health care providers. But the court should examine the crisis to determine its nature and extent and then scrutinize the classifications made to see if they fairly and reasonably focus on alleviating the crisis. The Virginia Supreme Court, in cases decided since *Reed v. Reed*,<sup>246</sup> has followed the "means focused" test. It ruled that the Virginia General Assembly may not pass laws treating one class differently from another unless the classification relates in a reasonable way to the legislative objective.<sup>247</sup>

When a court applies the "means focused" test to the malpractice ceiling in Virginia, it will find that the crisis, as identified by the legislature, did not exist at the time the Act was adopted.<sup>248</sup> At most, hospitals had a brief availability problem in obtaining basic limits coverage;<sup>249</sup> this temporary problem was completely unrelated to large verdicts or a \$750,000 limitation. The court will find that there was no shortage of people entering the medical profession or other health care fields,<sup>250</sup> and will also find that there were no settlements or jury verdicts above \$750,000 in the five years preceding the adoption of the Act.<sup>251</sup> Therefore, it was impossible for large verdicts to have had any real effect on rates for malpractice insurance in Virginia.

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245. *Reed v. Reed*, 404 U.S. 71, 75-76 (1971) (quoting *Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920)).

246. 404 U.S. at 71.

247. *Duke v. County of Pulaski*, 219 Va. 428, 247 S.E.2d 824 (1978) (upholding classification scheme for automobile tax purposes); *Archer v. Mayes*, 213 Va. 633, 194 S.E.2d 707 (1973) (upholding different treatment of men and women eligible for jury service).

248. See *supra* notes 56-64 and accompanying text.

249. See *supra* note 60 and accompanying text.

250. See *supra* notes 56-57 and accompanying text.

251. See *supra* notes 146-48 and accompanying text.

Cases involving damages of \$750,000 or more are rare. Where there are such cases, many involve brain-damaged persons, often children. The medical costs alone, over the lifetime of the child, greatly exceed \$750,000. Under the Virginia Act, these persons are victimized a second time by a legal system which simply does not care what happens to them. This harsh injustice cries out for correction by the Virginia court system. Virginia has already recognized the "means focused" test, and under that test, the cap is clearly in violation of equal protection.

Because no malpractice recovery had exceeded \$750,000 prior to the enactment of the cap, it would take great leaps of legal imagination to determine how non-existent claims could have been affecting insurance rates, or how temporary unavailability of basic limits coverage for hospitals could have affected high-dollar coverage for physicians. It is thus apparent that a Virginia court applying an even lower level of scrutiny, the rational nexus test, could still find the Act unconstitutional. For Virginia, the situation a court would face under the rational nexus test is one where the legislature established a cap which eliminates claims above a limit which no medical malpractice case had surpassed. The rational nexus test was never intended to be a complete abdication of authority by the courts. Since the cap passed by the Virginia General Assembly is totally out of line with the history of claims in Virginia, and the crisis as identified by the legislature in its preamble is demonstrably erroneous, a court could conceivably hold the Virginia cap unconstitutional as bearing no rational nexus or relationship to the legislative goal.

## 2. Special Legislation Prohibitions

At least four prohibitions against special legislation are found in the Constitution of Virginia.<sup>252</sup> These include the prohibition that "no man, or set of men, is entitled to exclusive or separate emoluments or privileges from the community, but in consideration of public services."<sup>253</sup> A second provision prohibits the General Assembly, by special legislation, from granting relief in cases where the courts or other tribunals have jurisdiction.<sup>254</sup> A third provision prohibits the enactment of any local, special or private law "regulating the practice in, or the jurisdiction of, or changing the rules

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252. VA. CONST. art. I, § 4, and art. IV, § 14.

253. VA. CONST. art. I, § 4.

254. VA. CONST. art. IV, § 14 para. 2.

of evidence in any judicial proceedings or inquiry before the courts or other tribunals or providing or changing the methods of collecting debts ....<sup>255</sup> The final provision prohibits the General Assembly from enacting any law which grants to "any private corporation, association, or individual any special or exclusive right, privilege, or immunity."<sup>256</sup> Clearly, these prohibitions may apply to legislation which limits the recovery afforded victims of medical malpractice in the name of protecting the availability of medical malpractice insurance.

As the Illinois Supreme Court found in *Wright v. Central Du Page Hospital Association*,<sup>257</sup> there is an advantage to examining the state constitution. The state constitution in Virginia, and apparently in Illinois,<sup>258</sup> affords something similar to equal protection, although there is not an expressed equal protection clause. Moreover, the courts are unencumbered by the necessity of determining the appropriate standard of review under the equal protection clause. The Virginia Constitution does not expressly contain an equal protection clause; however, the four prohibitions against special legislation discussed previously,<sup>259</sup> stand on their own as part of the Constitution of Virginia.

The limitation on recovery in medical malpractice actions creates an exclusive privilege for the medical community by exempting it from the effects of its wrongdoing which may result in recoveries in excess of \$750,000. This privilege is not given in consideration of public services;<sup>260</sup> therefore, the limitation appears to be a facial violation of article I, section 4 of the Virginia Constitution. The special legislation prohibitions discussed above are also violated by the grant to the medical community of exclusive immunity from suits over \$750,000.<sup>261</sup> At the same time, the limitation deprives the most seriously injured victims of malpractice of their right to recover a debt owed them, and changes the rules of evidence to be used in proceedings regarding medical malpractice claims.<sup>262</sup>

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255. VA. CONST. art. IV, § 14(3).

256. VA. CONST. art. IV, § 14(18).

257. 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

258. ILL. CONST. art. IV, § 13.

259. See *supra* note 253 and accompanying text.

260. See *supra* note 253.

261. See *supra* note 256.

262. See *supra* note 255.



The Idaho Supreme Court in *Jones v. State Board of Medicine*,<sup>263</sup> made an extensive examination of the special legislative concept and decided that the general purpose of such constitutional provisions was to prevent the bestowing of favors on preferred groups. In Virginia in the middle 1970's, the physicians and other health care providers came to the legislature and asked for a special dispensation from the effects of their own acts of negligence, for their own economic benefit. The legislature obliged. It is the very purpose of special legislation provisions in Virginia's Constitution to prohibit precisely this sort of legislative favoritism.

### 3. Due Process

In addition to the equal protection and special law problems pervading Virginia's malpractice cap, this legislation also presents due process problems. By denying the most severely injured plaintiffs the full amount of their damages, a limit such as that found in Section 8.01-581.15 of the Virginia Code violates the concept of substantive due process.<sup>264</sup> Consistency with substantive due process under United States Supreme Court decisions requires that the legislation be neither arbitrary nor capricious.<sup>265</sup> The due process clauses of the United States Constitution<sup>266</sup> and the Constitution of Virginia<sup>267</sup> use virtually the same terms. In *Archer & Johnson v. Mayes*,<sup>268</sup> the Virginia Supreme Court held that the state constitution's due process clause was not broader than the federal provisions.<sup>269</sup> Therefore, due process arguments relating to federal standards are applicable to considerations of the state due process claims.

Commentators agree that the choice of any malpractice recovery limitation by a legislature must be an arbitrary one.<sup>270</sup> A view of

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263. 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied* 432 U.S. 914 (1977), *on remand*, No. 55586 (4th Dist. Ct. Ada County, Idaho, Nov. 3, 1980).

264. *American Bank & Trust Co. v. Community Hosp. of Los Gatos-Saratoga, Inc.*, 104 Cal. App. 3d 219, 163 Cal. Rptr. 513 (1st Dist. Ct. App. 1980); *Wright v. Central Du Page Hosp. Ass'n.*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

265. See *West Coast Hotel v. Parrish*, 300 U.S. 379 (1937); *Nebbia v. New York*, 291 U.S. 502 (1934); *Munn v. Illinois*, 94 U.S. 113 (1876).

266. U.S. CONST. amend. XIV, § 1.

267. VA. CONST. art. I, § 11.

268. 213 Va. 633, 194 S.E.2d 707 (1973).

269. *Archer* addressed the issue of sex discrimination only as it relates to the due process clauses of the Virginia and United States Constitutions.

270. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 Tex. L. Rev. 759, 784 (1977); Comment, *Recent Medical Malprac-*

the legislative history behind Virginia's enactment shows the most casual observer the arbitrariness and capriciousness of the General Assembly's decision on the \$750,000 amount. No legislative study recommended either this legislation or any statutory language placing a limitation on recovery.

The preamble to Chapter 611 of the 1976 Acts of Assembly is certainly a conclusion that is not binding on courts.<sup>271</sup> The recital of the "findings" that health care providers were entering a "difficult period" should not preclude the courts' inquiry regarding due process, or any other grounds for "the mere recitation of benign (statutory) purpose is not an automatic shield which protects against inquiry into the actual purposes underlying a statutory scheme."<sup>272</sup>

The United States Supreme Court, on several occasions, has held that it "need not in equal protection cases accept at face value assertions of legislative purposes, when an examination of the legislative scheme and its history demonstrates that the asserted purpose could not have been the goal of the legislation."<sup>273</sup>

The \$750,000 limitation, placed on medical malpractice liability in the waning hours of the 1976 Virginia General Assembly<sup>274</sup> after several quarter-million dollar jumps, was clearly an arbitrary figure, capriciously inserted at the whim of the Conference Committee of six members of the Assembly. This history demonstrates that Section 8.01-581.15 of the Virginia Code does violate the provisions of substantive due process of both the Virginia and the United States Constitutions, and should be declared invalid on this ground.

### C. *Practicality of Test by the Supreme Court of Virginia*

A number of factors hinder a constitutional challenge to the cap

*tice Legislation — A First Checkup*, 50 *TUL. L. REV.* 655, 668 (1976).

271. *See, e.g.*, *Jones v. State Bd. of Medicine*, 97 Idaho 859, 555 P.2d 399, 409-10 (1976).

272. *Weinberger v. Wiesenfeld*, 420 U.S. 636, 648 (1975), *cited in* *Graleg. v. Satayatham*, 74 Ohio Op. 2d 316, 343 N.E.2d 832, 837 (Ct. C.P. Cuyahoga County 1976).

273. *Weinberger*, 420 U.S. at 648; *see also* *Jimenez v. Weinberger*, 417 U.S. 628, 634 (1974) (holding that the effect of a statute regulating inheritance by illegitimates does not support the purpose stated); *United States Dep't of Agriculture v. Moreno*, 413 U.S. 528, 536-37 (1973) (holding that other provisions of a law regulating food stamps cast doubt on the stated purpose of the amendment); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding that the history and effect of a law regulating contraceptives reveal that the purpose derived from the title could not have been the real purpose).

274. *See supra* note 196 and accompanying text.

on recovery in malpractice action. First, a plaintiff must obtain a judgment over \$750,000. This is a herculean task in and of itself, because a verdict of that size is not easy to obtain from Virginia juries. Complicating this difficulty is the judicial delay and expense in preparing and trying complex cases. Because most plaintiffs who are egregiously injured cannot afford a three to four year delay and cannot afford the thousands of dollars required to prosecute a medical negligence case, few cases of this magnitude reach a verdict. Moreover, delay and expense are further increased by the panel system, for if a panel is requested, the case must in essence be prepared and tried twice. In addition, the case can be delayed another year by abuse in the discovery process. The appellate process alone, if a writ is granted, will take approximately two years. By the time a medical case works its way through the court system, many seriously injured plaintiffs may have died. The costs in time and effort, from the initiation of a suit to its final disposition, stagger the imagination.

Plaintiffs are encouraged to request trial courts to delay ruling on the constitutional question until after a large verdict, over \$750,000, is returned. After all, a verdict for less than that sum renders the limitation on recovery issue moot unless the jury has been advised of the limitation. Moreover, plaintiffs should be permitted to argue *ad damnum* without reference by anyone to the cap. Certainly, a reference by the trial judge or defense attorney to a \$750,000 limitation may unduly and unfairly influence most juries. Plaintiffs should further maintain that the limit on recovery, even if it meets a constitutional challenge, is a limit on pain and suffering only and is inapplicable to other damages and death cases.

Plaintiffs' lawyers should be aware of opportunities to raise this issue on cross-appeals and in other ways so that courts will be forced to confront and rule upon this important issue.

## VII. CONCLUSION

The limitation on recovery in medical negligence cases in Virginia is unconstitutional because it unfairly discriminates against those who are the most seriously injured. It grants a special privilege to a select few while working to the disadvantage of those severely injured by acts of medical malpractice. There was no demonstrated need for legislation in 1976 which limited recovery for malpractice and there remains no justification for it today.

Courts faced with this issue should declare the cap violative of the Constitution of Virginia, apply a "means focused" test to find it unconstitutional under the Equal Protection Clause of the United States Constitution, and declare it in violation of due process.

