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MEDICAL MALPRACTICE REVIEW PANELS IN OPERATION IN VIRGINIA

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I. INTRODUCTION

The last major revision of Virginia statutes relating to medical malpractice was in 1976. At that time the General Assembly provided for medical malpractice review panels[1] and mandated a method of reporting medical malpractice claims.[2] These innovations were in response to a perceived medical malpractice crisis in the mid-1970's.[3] A symptom of the crisis was the astronomical rise in the cost of medical malpractice insurance premiums.[4] This increase plagued patients as well as physicians, hospitals, and other health care providers.[5] The higher premiums, of course, were reflected in fees for services rendered by providers. In addition, prov-

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1. VA. CODE ANN. §§ 8.01-581.1 to .20 (Repl. Vol. 1984). Panels are provided for in the first ten sections; other sections allow civil immunity for certain providers, establish monetary limitation on recovery in certain malpractice actions, and define standard of care.

2. *See id.* § 38.1-389.3 (Repl. Vol. 1981), *repealed by* 1982 Va. Acts ch. 229.

3. DiAntonio v. Northampton-Accomack Mem. Hosp., 628 F.2d 287, 290 (4th Cir. 1980). The Fourth Circuit noted the following with respect to the legislative intent of the Act:

> There was a legislative finding that the high cost of medical malpractice insurance was beyond the means of some health care providers and that they were ceasing to render services. It was thought that the passage of the Act would lower the cost of medical malpractice insurance since the panel would weed out the frivolous claims and would perform a mediation function with respect to other claims. In consequence of the panel's performance of these functions, it was believed that the amount of medical malpractice litigation would be substantially reduced, thus substantially lowering the cost of medical malpractice insurance.

Id.

4. Lipman, *Huge Malpractice Suits, Premiums Threaten Insurers and Health Care*, Wall St. J., Sept. 21, 1983, § 2, at 35, col. 4.

5. *Id.*

iders began to practice "defensive medicine."[6] Upon learning of huge, well publicized verdicts against at least a few of their brethren, they defensively ordered costly medical and laboratory tests and examinations to avoid the possible inference of laxity and culpability.[7] These procedures added to the patient's bill.[8]

Virginia's response to the national phenomenon included a Medical Malpractice Act,[9] which established the panel system, and separate legislation for the collection of certain data on medical malpractice claims.[10] The perceived intent of the panel statute was to eliminate litigation of a significant number of medical malpractice disputes.[11] The express purpose of the data-collection statute was to obtain information in order to review the reasonableness of malpractice insurance premium rates.[12]

The panel legislation, before long, will have been in effect for a decade. However, the reporting statute was repealed in 1982[13] since it never provided useful information.[14] It is now time to evaluate the panel system and to consider enactment of a data collection statute that will result in conclusions as to the efficacy of medical malpractice review panels in discouraging expensive and unnecessary litigation. In 1984, the General Assembly instituted its own investigation into the possible need for a major revision of the laws relating to panels, data collection, and other areas affecting claims of malpractice.[15]

This article focuses briefly on the panels in operation based

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6. *Id.*
7. *Id.*
8. *Id.*
9. VA. CODE ANN. §§ 8.01-581.1 to .20 (Repl. Vol. 1984).
10. *Id.* § 38.1-389.3 (Repl. Vol. 1981), *repealed by* 1982 Va. Acts ch. 229.
11. Diversion in Virginia and other states of medical malpractice claims from the court system is distinguished by the fact that this action was taken not in response to problems of court congestion, but to escalating liability insurance premiums. *See* P. EBNER, COURT EFFORTS TO REDUCE PRETRIAL DELAY: A NATIONAL INVENTORY xv-xvi (1981).
12. VA. CODE ANN. § 238.1-389.3.C (Repl. Vol. 1981), *repealed by* 1982 Va. Acts ch. 229.
13. 1982 Va. Acts ch. 228, at 370-78.
14. 1981 data study conducted by Virginia Bureau of Insurance (study furnished in letter from R. Rollins, Bureau of Insurance to Virginia Division of Legal Services (July 27, 1983)) (study recommended repeal of section 38.1-389.3 given inherent inadequacies of the data base developed and the availability of superior information sources).
15. *See* H.J.R. 20, 1st Reg. Sess., 1984 Va. Acts (requesting the House Committee of Justice and the Senate Committee for Courts to establish a joint subcommittee to study the medical malpractice laws of the Commonwealth); H.J.R. 25, 1st Sess., 1984 Va. Acts (requesting a joint committee of the House and Senate Courts of Justice Committees to study the question of the continued need for Medical Review Panels).

upon data covering their first eight years of existence.[16] It is hoped that the article will enlighten lawyers who have never handled a medical malpractice claim, provide some interesting data for those who have, and suggest some changes in the law in the public interest in order to be more certain that the panel system helps contain costs in the disposition of medical malpractice claims. The data and suggestions will follow a short explanation of the panel statute.

II. Framework of the Act

The Virginia Medical Malpractice Act[17] provides for screening panels designed to keep both meritorious and frivolous claims out of the court system. A major goal of the legislation is to help contain the cost of medical malpractice insurance by encouraging compromise settlements and abandonments of nonmeritorious claims.[18] Lower premiums logically follow avoidance of litigation. In turn, the cost containment of premiums will be reflected in what patients must pay for medical services.

Since the advent of the innovative Medical Malpractice Review Panels (panels) on July 1, 1976, the Chief Justice of the Supreme Court of Virginia has appointed over 900 panels involving claims against over 1,800 health care providers.[19] On the average, each panel renders opinions involving two prospective defendants.[20] Approximately 2,700 practicing attorneys and the same number of health care providers have served as panelists, some individuals serving as panelists more than once.

The framework for the operation of panels is uncomplicated. The Act provides that no action may be brought against a health care provider (provider) unless the claimant first notifies the provider, in writing, of the claim prior to the institution of suit.[21]

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16. The data we processed were available in raw form through the office of the Executive Secretary of the Virginia Supreme Court. Various participants in the panel process must provide data as required by the Medical Malpractice Rules of Practice promulgated by the Chief Justice. *See* Medical Malpractice R. 1-7, *reprinted in* 11 Va. Code Ann. at 295-302 (Repl. Vol. 1984).

17. Va. Code Ann. §§ 8.01-581.1 to .20 (Repl. Vol. 1984).

18. *See* DiAntonio v. Northampton-Accomack Mem. Hosp., 628 F.2d 287, 290 (4th Cir. 1980).

19. *See supra* note 16.

20. *Id.*

21. Va. Code Ann. § 8.01-581.2A (Repl. Vol. 1984) (provides that the notification include the time of the alleged malpractice with a reasonable description of the act or acts of malpractice and further provides that the claimant or the provider may file a written request

Within sixty days of such notice, either the provider, the claimant, or both of them may request that the Chief Justice appoint a panel to review the case.[22] Upon this request by either party, appointment of a panel is mandatory.[23]

At the direction of the Chief Justice, the claim is then forwarded to a panel chairman. The chairman must be either a sitting or a retired circuit court judge in the geographic area in which the cause of action arose.[24] Six other panelists, including three impartial health care providers, licensed and actively practicing their professions in Virginia,[25] are selected by lists furnished by the Virginia State Bar and the State Board of Medicine, respectively.[26] "Impartial" was defined by a 1981 amendment to the Act,[27] generally in response to the hesitance of some individuals to serve as panelists, not because of allegations of bias on the part of individual panelists. Certain business or professional relationships between a panelist and one of the parties or his family or business associates preclude service as a panelist.[28]

The panel process affords both claimants and providers the opportunity for full presentation of their respective positions. The testimony of expert witnesses is offered in over fifty percent of the panel presentations.[29] Other evidence includes medical charts, X-rays, laboratory tests, excerpts of treatises, and depositions, as well

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for panel review within 60 days of such notification).

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.* § 8.01-581.3 (provides for the composition of the panel, addresses the circumstances under which the chairman shall have a vote and directs that non-judge panelists shall be sworn by the chairman to render an opinion faithfully and fairly).

26. *Id.*

27. *Id.*

28. *Id.* § 8.01-581.1(7)-(8) (provides more specifically that the attorney-panelist shall not have represented either the claimant, his family, his partners, co-proprietors or his other business interests; nor the provider, his family his partners, his co-proprietors or his other business interests. The provider-panelist shall not have actually examined or treated or anticipate examination or treatment of the claimant or his family; nor shall such panelist be an employee, partner or co-proprietor of the prospective defendant.).

29. We conducted an independent mail survey during summer 1984 of the 117 Virginia circuit court judges sitting as of Jan. 1 of that year to inquire as to certain aspects of panel operations. Of the sixty judges responding who had chaired panels, 35% had heard testimony of expert witnesses at all panel hearings, 51% at most hearings, and 5% at none of the hearings; 8% did not respond to the question about proffer of expert testimony at the panel level. W. Daughtrey & C. Smith, Medical Malpractice Review Panel Questionnaire (Jan. 1, 1984) (canvassing Virginia Circuit Court judges) (available at University of Richmond Law Library).

as oral testimony of witnesses.[30] Since 1979, both parties have the right to an *ore tenus* hearing;[31] in the same year, it was made clear by statutory amendment that depositions of witnesses, including the parties, are permitted at the discretion of the chairman.[32] According to the judges who have chaired panels, depositions are commonly used at the panel level; sixty-three percent of the judges reported that depositions were routine,[33] twenty-three percent of the judges reported that depositions were taken at least once during each panel.[34] Indeed, the law encourages thorough preparation for presentations to the panel. In particular, the statute provides that the panel's written opinion is admissible as evidence in any subsequent action.[35] Unless one is satisfied that an unfavorable opinion will not harm his case before the jury, he must prepare for the panel as diligently as he would for trial.

Remembering that the panel system is designed to provide an expeditious resolution of disputes between claimants and providers, the General Assembly in 1981 specified that the opinion shall be rendered no later than six months *from the designation* of the panel unless *extraordinary* circumstances warrant chairmen granting an extension not to exceed ninty days.[36] If an opinion is not rendered within the time allowed, the claimant is free to institute suit.[37] Also, any late opinion is inadmissible as evidence unless the delay was caused by the claimant.[38]

Attorneys and their clients apparently found that the six-month time constraint did not allow adequate time to prepare in all instances. While there is no recorded legislative history to cite, it is

30. VA. CODE ANN. § 8.01-581.4 (Repl. Vol. 1984) (comprehensive and obviously designed to allow for thorough preparation prior to presentation at the panel hearing).

31. *Id.* § 8.01-581.5 (also requires notice to the parties by adequate means to assure their presence at the time and place of the hearing).

32. *Id.* § 8.01-581.4 (provides that the chairman shall rule on the admissibility of all or any part of a deposition offered as evidence at the hearing).

33. *See supra* note 29.

34. *Id.*

35. VA. CODE ANN. § 8.01-581.8 (Repl. Vol. 1984) (grants either party the right to call at his cost any non-judge member of the panel as a witness in any action subsequently brought. Although the reason(s) for this right are unstated, the trier of fact in the subsequent action can know the basis for the panel opinion if panelist(s) are called by any party.).

36. *Id.* § 8.01-581.7:1 (must be read with recently amended section 8.01-581.3 (Repl. Vol. 1984) providing as of July 1, 1984, the six months shall begin to run only upon certification by the parties that discovery has been completed and all relevant documents and statements have been submitted).

37. *Id.*

38. *Id.*

suggested that this time constraint, at least in part,[39] led to the 1984 amendment which delays designation of the attorney and the health care panelists (i.e., the full panel) until certification of the parties that discovery has been completed and that all relevant documents and statements have been submitted.[40] Formerly, all panelists were appointed soon after the Chief Justice received the request for panel treatment. Since the clock does not begin to run until after the designation of the full panel, there is considerably more time now for discovery and other pre-panel preparations than there was before the 1984 amendment. Oddly, the current statute appears to place no limit on the amount of time that may lapse between the request for a panel and certification of the parties that they are ready for the hearing. By analogy, Virginia procedural law allows a court, in its limited discretion, to discontinue certain actions under certain circumstances which have been docketed for more than two years and to dismiss them after five.[41] Given this analogy, however, even a two year delay appears inconsistent with the goal of speed in the resolution of claims at the panel level.

Panel opinions, when rendered, address two of the elements that a claimant must prove to obtain a judgment against a provider: (1) malpractice, usually involving allegations that the provider failed to comply with the appropriate standard of care, but also may include intentional torts and (2) proximate cause.[42] Each panelist, except for the chairman, selects one of four legislatively mandated opinions.[43] In brief, the opinion must be that the evidence:

(1) does *not* support the allegations of malpractice;

(2) does support allegations of both malpractice and proximate cause;

(3) does support allegations of malpractice, but does *not* support

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39. Another justification for the amendment is that there is no need to appoint attorney and provider panelists and to schedule a hearing until after the parties certify that discovery has been completed and that all relevant documents and statements have been provided for distribution to the panelists. The certification of completion is a strong indication that the panelists must meet as a group and that the date for the meeting will not be changed after it has been set. This consideration for panelists should help minimize reluctance to serve for what is essentially pro bono work.

40. VA. CODE ANN. § 8.01-581.3 (Repl. Vol. 1984).

41. *Id.* § 8.01-335.

42. *Id.* § 8.01-581.7.A. Interestingly, this is the only section relating to panels which has not been amended or repealed since 1976.

43. *Id.*

the proximate cause element; or

(4) reveals a material issue of fact, not requiring an expert opinion, but rather an issue which deserves consideration by a judge or jury.[44]

One cannot say with certainty when the fourth opinion is appropriate. Perhaps the legislature included it to blunt a constitutional challenge based on the argument that panels deny access to the courts. However, the statute would be constitutional without this choice, since "the jury is free to accept or reject the conclusion of the panel majority in light of all of the evidence [subsequently] brought before it."[45] One trial lawyer writes that the issue-of-fact opinion "covers the situation where the case involves a 'swearing contest,' wherein the claimant states that HCP [health care provider] did or did not do a certain thing, and the HCP disputes the contention."[46] Whatever the fourth type of opinion covers, it has been selected by panels in only thirty-five of 1,351 instances of alleged medical malpractice brought before them.[47]

When one of these four choices receives at least a majority vote, that choice is the opinion of the panel.[48] The chairman votes only in the case of a tie.[49] The opinion must be in writing and signed by all panelists who agree with it.[50] A non-concurring panelist may note his dissent.[51] Most chairmen furnish a typewritten opinion sheet allowing each panelist to note the specific choice which the panelist deems appropriate at the conclusion of the deliberations, although the statute does not prescribe any particular form for the required writing.

Ideally the written opinion will result in a compromise settlement or the abandonment of a non-meritorious claim. However, the panel's opinion is binding upon no one.[52]

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44. *Id.*

45. DiAntonio v. Northampton-Accomack Mem. Hosp., 628 F.2d 287, 291 (4th Cir. 1980).

46. Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions It Raises*, 11 U. RICH. L. REV. 51, 56 (1976).

47. *See supra* note 1; *see also* Table 4, *infra* note 116.

48. VA. CODE ANN. § 8.01-581.6(5) (Repl. Vol. 1984).

49. *Id.* § 8.01-581.3(ii).

50. *Id.* § 8.01-581.7C (provides also that all opinions shall be mailed to claimant and provider within five days of the date of their rendering).

51. *Id.*

52. DiAntonio v. Northampton-Accomack Mem. Hosp., 628 F.2d 287, 292 (4th Cir. 1980).

III. Views of Others

The panel law received attention soon after its enactment in three articles: *Virginia's New Medical Malpractice Review Panel and Some Questions it Raises*,[53] *A Guide to Medical Malpractice in Virginia*,[54] and *Virginia's Medical Malpractice Act: A Constitutional Analysis*,[55] appearing respectively in 1976, 1979 and 1980. The first two articles are written by trial attorneys. The third article is written by a law student. All three offer *theoretical* insight into the operation of the panel system. They outline the screening process and raise questions. However, these questions can only be answered when there is enough data to truly evaluate the efficiency of the panel system *in practice.*

The earliest article, *Virginia's New Medical Malpractice Review Panel*, pessimistically concludes that the worth of the panel legislation "is inversely proportional to the haste with which it was drafted and enacted."[56] The author's concerns arise mainly from the provisions allowing the opinion to be introduced at trial although "(1) the rules of evidence need *not* be observed [at the panel hearing] and (2) a [mere] *majority* of the panel may render an opinion."[57] The author also expressed the view that the Virginia Medical Malpractice Act may be unconstitutional.[58]

The two later articles are more optimistic about the panels. One article concludes that "since the panel procedure provides a more informed basis for the screening of medical malpractice cases than heretofore available, and in a speedier and less expensive manner, it is anticipated that an overwhelming majority of future medical malpractice claims will be handled by panel review."[59] The Comment, also optimistic for the future of panels, predicted correctly that a court might well sustain the Act against separation of powers, equal protection, and due process challenges.[60]

The concerns expressed by the authors regarding the constitutionality of the Act were addressed in *DiAntonio v. Northampton-*

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53. *See* Harlan, *supra* note 46.

54. Scott, *A Guide to Medical Malpractice in Virginia*, 5, No. 1 VA. B.A.J. 5 (1979).

55. Comment, *Virginia's Medical Malpractice Act: A Constitutional Analysis*, 37 WASH. & LEE L. REV. 1192 (1980).

56. *See* Harlan, *supra* note 46, at 68.

57. *Id.* at 56.

58. *Id.* at 60.

59. *See* Scott, *supra* note 54, at 22.

60. *See* Comment, *supra* note 55, at 1205.

Accomack Memorial Hospital.[61] In *DiAntonio*, the plaintiff sued the defendant health care providers in federal court in an attempt to avoid the notice-of-claim requirements of the Virginia law, and indeed to avoid the screening process completely. The U.S. Court of Appeals for the Fourth Circuit rejected constitutional challenges to the Virginia notice-of-claim requirements which were based upon separation of powers, equal protection, and due process. The plaintiff was required to comply with the Virginia Medical Malpractice Act. The court accepted the legislative finding that "the high cost of medical malpractice insurance was beyond the means of some health care providers and that they were ceasing to render services . . . [and that] it was believed that the *amount* of medical malpractice *litigation* would be substantially reduced, thus substantially lowering the cost of medical malpractice insurance."[62]

The *theoretical* underpinning of the Virginia panel statutes are supported by *DiAntonio* and two of the three commentators who discussed the statute. No one, however, has considered whether the legislative goals of speed and cost-containment have been realized in practice. Have the now 900 panels resulted in a substantial reduction of litigation and the attendant substantial reduction of the cost of medical malpractice insurance premiums? Do panels shorten or lengthen the time between the making of a claim and its resolution? Or are panels simply a neutral factor in the length of dispute resolution without any cost savings to claimants, providers and insurance carriers, but nevertheless taking the time of court system personnel and the panelists: judges, practicing attorneys and health care providers? These are difficult rhetorical questions and answering them is a formidably technical task. Such answers are accurate only to the extent necessary data is available and collectible. These questions need to be addressed now that the panel mechanism has operated for almost a decade.

While we do not have all of the answers, we have collected available data revealing some of the aspects of panels in operation from July 1, 1976 through June 30, 1983. Before presenting these data however, the efforts of other states to reduce the number of medical malpractice suits is noted.

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61. 628 F.2d 287 (4th Cir. 1980).
62. *Id.* at 290 (emphasis added).

IV. Efforts in Other States

Two recent Rand Reports are instructive in identifying the variety of panel authorizations from state to state.[63] These Reports taken together not only reveal the lack of uniformity of systems among the thirty states which authorized panels, but also reveal that panel systems are no longer operational in six of these states. Since the Rand Reports, two additional states, Nevada[64] and Rhode Island,[65] abolished screening mechanisms. No state has enacted new panel legislation since 1978, although existing statutes continue to be amended.[66]

One of the Rand Reports criticizes the panel systems instituted nationwide because the systems did not provide for data collection to determine their effectiveness.

> Screening panels were generally established without any provision for evaluation, and perhaps as a result, statistical data on the operation of panels and their impact on the settlement of cases are not collected in many states and are incomplete in most others. Although the variation in procedures provides a good opportunity for evaluating the effects of a number of factors, no such comparative analysis has been conducted. Nor has there been an empirical evaluation of the panels' effects on medical liability insurance premiums.[67]

Variations among the states make it difficult to determine by comparisons which particular provisions best balance the conflicting interests of claimants and providers. Variables to be manipulated in drafting or amending an act include:

(1) Time of assignment of the claim to a panel—whether before or after suit is filed;[68]

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63. *See* P. Danzon, The Frequency and Severity of Medical Malpractice Claims, R-2870 ICJ/HCFA, prepared for the Institute for Civil Justice, Rand Corp. 43-45 (1982). *See also* P. Ebner, *supra* note 11, at 56-68.

64. *See* Lipman, *supra* note 4.

65. R.I. Gen. Laws §§ 10-19-1 to -7 (1976) (repealed in 1983 in its entirety by ch. 19, Tit. 10 of the Laws of Rhode Island); *see also* Boucher v. Sayeed, ___ R.I. ___, 459 A.2d 87 (1983) (declaring the statute unconstitutional on equal protection grounds in that no rational basis exists to support the distinction between medical malpractice claimants and tort plaintiffs as a whole).

66. *See* P. Ebner, *supra* note 11, at 58.

67. *Id.* at 68.

68. For the time of assignment of the claim to a panel in Virginia, see *supra* text accom-

(2) The size and composition of the panel; also, compensation of, and immunity from suit for, the panelists;[69]

(3) Time constraints on panel consideration;[70]

(4) The admissibility of evidence and the degree of formality required in the panel's deliberations;[71]

(5) The scope of the panel's findings, i.e., failure to comply with the appropriate standard of care, proximate cause and/or damages;[72] and

(6) The admissibility and weight of the panel's opinion at trial when litigation follows.[73]

The variations must, of course, always be considered in light of equal protection, due process, separation of powers, and other state and federal constitutional requirements.

Considering the conflicting interests of claimants and providers, and the numerous variations in design of panel systems, it is not surprising that the constitutionality of many of the disparate statutes have been challenged in the courts. By 1979, ten states had upheld the constitutionality of their panel system.[74] Some of the screening mechanisms, however, have not withstood constitutional attack. The Illinois statute constituted an impermissible restriction

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panying notes 22-36.

69. *See supra* text accompanying notes 25-26. In Virginia, the panel is composed of a judge chairman, 3 lawyers and 3 providers. Effective July 1, 1984, each panelist receives $50—up from $25—per diem plus actual and necessary expenses. *See* VA. CODE ANN. § 8.01-581.10 (Repl. Vol. 1984). Panelists have absolute immunity from civil liability for all communications, findings, opinions, and conclusions in the course and scope of their panel duties. *See id.* § 8.01-581.8.

70. There is some uncertainty as to the time constraints imposed by Virginia's panel system. *See supra* text accompanying notes 36-41.

71. *See* VA. CODE ANN. § 8.01-581.6 (Repl. Vol. 1984) (provides, in part, that it is not necessary to follow the rules of evidence). *But see supra* note 35 and accompanying text (discussing the power of the panel chairmen to rule on the admissibility of all or any part of a deposition).

72. *See* VA. CODE ANN. § 8.01-581.7(A)-(B) (Repl. Vol. 1984); *see also supra* text accompanying note 42.

73. *See* VA. CODE ANN. § 8.01-581.8 (Repl. Vol. 1984). (panel's opinion is not conclusive); *see also* DiAntonio v. Northampton-Accomack Mem. Hosp., 628 F.2d 287, 292 (4th Cir. 1980) (panel's opinion is binding on no one).

74. New York, Florida (later declared unconstitutional in practice), Nebraska, Arizona, Idaho, Louisiana, Maryland, Wisconsin, Pennsylvania (later declared unconstitutional in practice) and Indiana as listed in Hines v. Elkhart Gen. Hosp., 465 F. Supp. 421, 434 (N.D. Ind.), *aff'd*, 603 F.2d 646 (7th Cir. 1979). Virginia's panel system was held constitutional in 1980 in *DiAntonio*. *See supra* notes 61-62 and accompanying text.

on the right of trial by jury guaranteed by the state constitution.[75] The North Dakota statute providing for the total abolition of trial by jury was also declared unconstitutional.[76] The Missouri Professional Liability Review Board was declared unconstitutional on the ground that it denied access to the courts.[77] The New Hampshire and Rhode Island courts struck down the screening system as a denial of equal protection in view of potential litigational advantages of one class of tort defendants over another.[78] As noted earlier, the legislatures of Rhode Island and Nevada repealed their review panel statutes.[79] The repeal in Rhode Island was a response to the court decision declaring it unconstitutional.[80]

Although several panel statutes failed because they violated constitutional rights, most of the thirty statutes were drafted to withstand constitutional challenges. Recently, however, panel systems have been subject to a new attack; claims are now being made that the panel systems in their operation rather than in theory violate constitutional rights. This approach has been successful in two states.

In 1976, in *Carter v. Sparkmen*,[81] the Florida Medical Mediation Act was declared constitutional. Respondents in *Carter* unsuccessfully argued that the Act was facially invalid because it denied equal protection, was arbitrary and capricious, and effectively insulated medical personnel from legal accountability. Four years later, in *Aldana v. Holub*[82] the same statute was again challenged. This time, however, the court declared the statute unconstitutional, recognizing that "[w]hat was originally contemplated as an inexpensive summary procedure would now extend to twelve, fourteen, or possibly even sixteen months or more, thereby effectively denying one's access to the courts."[83]

The facts in *Aldana*, actually two cases consolidated upon ap-

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75. Wright v. Central Dupage Hosp. Ass'n, 63 Ill. 2d 313, ___, 347 N.E.2d 736, 739-41 (1976).

76. Arneson v. Olson, 270 N.W.2d 125, 135 (N.D. 1978).

77. State *ex rel.* Cardinal Glennon Mem. Hosp. v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979).

78. P. DANZON, *supra* note 63, at 43. The Rhode Island case striking down the panel statute is Boucher v. Sayeed, ___ R.I. ___, 459 A.2d 87 (1983).

79. *See supra* note 65 and accompanying text.

80. *Id.*

81. 335 So. 2d 802 (Fla. 1976).

82. 381 So. 2d 231 (Fla. 1980).

83. *Id.* at 238.

peal,[84] are worthy of note. Under Florida's law, the jurisdiction of the panel terminated ten months from the time the injured party filed a statement of claim with the clerk of the trial court.[85] In *Aldana*, the misconduct of a panelist required a "mistrial." Because of the court's crowded calendar, the hearing could not be rescheduled to within the ten month period.

In the second of the two cases decided in *Aldana, Abel v. Kirchgessner*, the judicial referee set the hearing within the ten months allowed, but allotted only one-half hour for the hearing. The opening statements were made on the appointed day. However, the matter was continued to another date which was seven days beyond the expiration of the ten-month period.[86] These facts, coupled with a "painstaking examination of over seventy [other] cases cited to us . . . and those of which we take judicial notice . . .,"[87] led the Florida Supreme Court to declare the panel statute unconstitutional in its operations; the statute was "unconstitutional in its entirety as violative of the due process clauses of the United States and Florida Constitutions."[88]

The justices in *Aldana* were unanimous in their belief that there had been a denial of the doctors' due process rights in losing the opportunity for panel consideration. However, one justice, dissenting in part, would not have struck down the entire statute. He would limit the decision to the two cases before the court.[89] While judicial restraint is usually admirable, a case by case analysis would have substantially increased the amount of litigation in Florida. The dissent noted that "there probably have been thousands of mediation cases throughout this state where the jurisdictional time period has not run and neither the claimants nor the doctors have been deprived of any constitutional rights."[90] Unfortunately, there was no data to support this statement.

Less than one year after the Florida decision, the Pennsylvania Health Care Services Malpractice Act was also declared unconsti-

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84. The cases were *Aldana*, and Abel v. Kirchgessner. *See id* at 231.

85. The court found no reasonable basis for it to save the constitutionality of the statute by inferring legislative permission to extend the ten month period—to do so would transcend the outer limits of constitutional tolerance. *Aldana*, 381 So. 2d at 237-38.

86. *Id.*

87. *Id.*

88. *Id.* at 238.

89. *Id.* at 239.

90. *Id.*

tutional. In *Mattos v. Thompson*[91] the Pennsylvania panels were found to have failed in their goal of expeditious resolution of medical malpractice claims, resulting in an impermissible infringement upon the right to a jury trial guaranteed in the Pennsylvania constitution.

Two years before *Mattos*, the Pennsylvania court had found its screening system constitutional "on the theoretical plane."[92] Data on claims filed between April 6, 1976 and May 31, 1980 demonstrated to a majority of the *Mattos* court, however, that delays in processing claims under the Pennsylvania version of screening panels resulted in oppressive delay and impermissibly infringed upon the right to a jury.[93] The majority opinion includes and relies upon data collected during this period; the data revealed that of the total 3,452 cases filed with the panel Administrator only 936 had been resolved, settled or terminated. Seventy-three percent of the cases filed had not been resolved.[94]

Many other statistics are cited in the opinion, including the average time between filing a certificate of readiness for panel consideration and the appointment of a panel chairperson: 7.57 months.[95] The opinion is noteworthy because it is based on statistical analysis of the performance of the Pennsylvania panel system in operation over a period of years.

One justice, concurring in part and dissenting in part, indicated that he would have found the Pennsylvania statute unconstitutional on its face earlier, and he would do so again.[96] Another justice, in dissent, concluded that the Pennsylvania statute was constitutional both in theory *and* in practice.[97] He noted that the legislature attempted in 1979 to improve the Act by decreasing the size of the panel from seven members to three and by requiring certificates of readiness to be filed within one year of the date of initiation of the action.[98] Further, the dissenting opinion predicted that the amendment would insure litigants a panel hearing within

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91. 491 Pa. 385, 421 A.2d 190 (1980).

92. Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, ___, 394 A.2d 932, 942-43 (1978).

93. *Mattos*, 491 Pa. at ___, 421 A.2d at 194-96.

94. *Id.* at ___, 421 A.2d at 194.

95. *Id.*

96. *Id.* at ___, 421 A.2d at 196-97 (Larsen, J., concurring and dissenting).

97. *Id.* at ___, 421 A.2d at 197-99 (Roberts, J., dissenting).

98. *Id.* at ___, 421 A.2d at 198-99.

fifteen months of initiation of an action.[99]

Is the Virginia panel statute constitutional in practice? In no reported case has the issue been addressed. As illustrated in *Mattos*, statistical analysis of the performance of a panel system may be used in constitutionally challenging or defending a statute. The following section summarizes available data regarding Virginia's panel statute.

V. Virginia Data Summary

During the period of study, in the first eight years of panel existence, 874 cases were opened.[100] During the first few years of the panel system, the annual number of requests for panels was erratic. For example, eighty-seven cases were opened during the first year of panel operation (July 1, 1976 - June 30, 1977), but only forty-three were opened during the second year.[101] Since July 1, 1979, however, there has been steady growth in the number of panels appointed each year. These periods have shown a compound growth rate of twenty percent. One hundred seventy-eight cases were opened during the 1983-84 panel year.[102] If the recent growth trend continues, approximately 215 cases could be opened during the 1984-85 year.

The median time for a case, from receipt of panel request to issuance of the opinion of the panel or withdrawal from panel con-

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99. *Id.* at ___, 421 A.2d at 199.

100.

TABLE 1
NUMBER OF PANELS REQUESTED PER MMRP YEAR

Period	Opened		Still Open
1 (1976-77)	87		0
2 (1977-78)	43		0
3 (1978-79)	101		2
4 (1979-80)	86		4
5 (1980-81)	110		3
6 (1981-82)	128		8
7 (1982-83)	141		11
SUBTOTAL		696	TOTAL 28
8 (1983-84)	178		(Data not available for period 8)

101. *Id.*

102. *Id.*

sideration, is 245 days, or slightly over eight months.[103] When median time is calculated on the basis of prospective defendants (rather than by panels) the time consumed by panel consideration is also just over eight months.[104] Following the 1979 amendments, which allow *ore tenus* hearings as a matter of right and discovery depositions in the discretion of the chairman, one might have expected a substantial increase in the time consumed by panel consideration of a case. In the first year under the amendments, the duration of panel consideration (280 days) was significantly longer than in the three preceding years which had medians of 240, 251 and 238 days.[105]

The 1981 legislation which imposed a six month time constraint between a panel request and opinion was presumably intended to expedite panel consideration of claims.[106] Not surprisingly, the shortest median performance for resolution of claims occurred during the 1982-83 panel year, the first year following the 1981 amendment. During that year, the median time for a case to be open was 209 days.[107]

New rules, which took effect in July, 1984, seem to loosen considerably the time restrictions on the process since the panel need not be designated until certification by the parties that discovery is complete.[108] While data has not yet been generated which will permit an evaluation of the effect of this 1984 change, the median times established in prior years will serve as a benchmark to determine the desirability of increased time for discovery and other ac-

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103.

TABLE 2
AVERAGE TIME OPEN

Period	No. of Closed Cases		Time Open (Days) Median	Mean	No. of Providers	Time Open (Days) Median	Mean
1 (1976-77)	87		240	319	157	234	331
2 (1977-78)	43		251	305	79	254	310
3 (1978-79)	99		238	318	217	251	386
4 (1979-80)	82		280	350	175	324	425
5 (1980-81)	107		259	309	189	259	305
6 (1981-82)	120		251	283	241	240	281
7 (1982-83)	130		209	224	293	216	224
TOTAL:	668	OVERALL:	245	296	TOTAL: 1351	OVERALL: 248	315

104. *Id.*

105. *Id.*

106. *See supra* note 36 and accompanying text.

107. *See supra* note 103.

108. *See supra* notes 39-41.

tivities in preparation for the panel hearing.

As of June 30, 1983, a total of 668 closed cases had been brought before the panels, and 1,351 providers had been involved as prospective defendants.[109] In approximately forty percent of the panels, no opinion was rendered because of withdrawal, dismissal of the panel request, or settlement.[110] Perhaps some of the claimants' requests for a panel served as stimuli to compromise before and after panel hearings. Also, perhaps some of the requests by providers may have forced claimants to evaluate their positions earlier than they would have in the absence of the panel mechanism. Thoughtful evaluations of rather weak claims should lead to prompt abandonment of the claims in almost all cases.

Approximately fifty percent of the providers were found by the panels to be free of malpractice.[111] However, it is more instructive for some purposes to focus only on those situations where panels rendered opinions—cases involving 826 of the 1,351 proposed defendants. In these cases the panel found the providers guilty of malpractice proximately causing the injury less than ten percent of the time.[112] Some data suggests that the panel decisions overwhelmingly favored the provider regardless of which party requested the panel.[113] More importantly, this data also suggests that, in more than two-thirds of the claims, a panel decision in favor of the defendant led to the abandonment of the claim with-

109. *See supra* note 103.

110.

TABLE 3
DISPOSITION SUMMARY

Type of Disposition	Number of Providers	% of Opinions
1. No malpractice	683	82.7%
2. Malpractice *and* cause	76	9.2%
3. Malpractice, but *not* cause	32	3.9%
4. Issue of fact	35	4.2%
Subtotal	826	
5. Withdrawn, dismissed or settled	520	
6. Unknown	5	
Subtotal	525	
Total	1351	

111. *Id.*

112. *Id.*

113. *The Virginia Medical Malpractice Review Panel-Present Status: Hearing of the Va. Gen. Assembly's Joint Subcomm. Studying Virginia's Medical Malpractice Laws* (Sept. 12, 1984) (remarks by K. Nelson) (available at Division of Legislative Services, General Assembly Building, Richmond, Va.).

out filing suit.[114] Based on these figures, some may argue that panel decisions too often favor providers to the detriment of claimants, indicating a predisposition in favor of prospective defendants—especially on the part of provider panelists. However, it may also be argued that the panels are simply discouraging litigation of nonmeritorious claims. Moreover, by use of the panel system, claimants are able to obtain an opinion without the testimony of expert witnesses. Success at trial requires expert testimony in most instances.[115]

Approximately eighty-five percent of panel opinions have been unanimous.[116] Analysis of data shows that there is a significantly greater probability of an opinion favoring the provider when the panel's decision is unanimous.[117] Only eight percent of the panel opinions were against the provider when the vote was unanimous.[118] When the panel opinion was divided, about sixteen percent of the opinions were against the provider.[119] One explanation of these findings is that the panels unanimously find a proportion of the claims nonmeritorious. However, another related explanation may be that the claims favoring the claimants are inherently more difficult and complex and are more likely to result in a lack of panel unanimity.

The Virginia panel statute defines providers—as prospective defendants—to include medical doctors (physicians), hospitals, den-

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114. *Id.*

115. For requirements for expert testimony at trial and vagaries incident to such proffer, see Maxwell v. McCaffrey, 219 Va. 909, 252 S.E.2d 342 (1979); Ives v. Redford, 219 Va. 838, 252 S.E.2d 315 (1979); Noll v. Rahal, 219 Va. 795, 250 S.E.2d 741 (1979); Little v. Cross, 217 Va. 71, 225 S.E.2d 387 (1976); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

116.

TABLE 4
PANEL OPINION VIS-A-VIS STRENGTH OF PANELISTS AGREEMENT

Panel Opinion	No. Providers	Unanimous	Split
1. No malpractice	683	598	85
2. Malpractice and cause	76	55	21
3. Malpractice, but not cause	32	18	14
4. Issue of fact	35	23	12
TOTAL	826 (100%)	694 (84%)	132 (16%)

117. *Id.* (the relationship was statistically significant at the 0.005 level using the Chi-square test for independence).

118. *See supra* note 116.

119. *Id.*

tists, pharmacists, registered or licensed practical nurses, optometrists, podiatrists, chiropractors, physical therapists, physical-therapist assistants, clinical psychologists, and certain nursing homes.[120] The most likely prospective defendants, in decreasing order of frequency, are medical doctors (a category excluding psychiatrists, opthalmologists, and pathologists), hospitals, dentists, professional corporations, nurses, podiatrists, and psychiatrists.[121] These seven types of providers account for ninety percent of the providers receiving panel consideration between July 1, 1976 and June 30, 1983.[122] The medical doctor category alone represents fifty-five percent of the prospective defendants.[123] When hospitals are excluded, medical doctors represent two-thirds of the prospective defendants. The breakdown of panel findings according to the type of provider who allegedly malpracticed has also been

120. VA. CODE ANN. § 8.01-581.1(1) (Repl. Vol. 1984).

121.

TABLE 5-A
PROSPECTIVE DEFENDANT FREQUENCIES

Type	Number	Percentages
Medical Doctors	738	54.6%
Hospitals	248	18.4
Dentists	113	8.4
Professional Corporations	70	5.2
Nurses — RN and LPN	59	4.4
Podiatrists	20	1.5
Psychiatrists	15	1.1
All Other	88	6.5
TOTAL	1351	100.0

TABLE 5-B
PROVIDER TYPES VIS-A-VIS CERTAIN DISPOSITIONS

	Malpractice	No Malpractice	Malpractice not Cause	Issue of Fact	No opinion; Withdrawn Dismissed or Settled	Total
Medical Doctors	48	400	23	13	254	738
Hospitals	9	132	5	5	97	248
Dentists	8	44	2	3	56	113
Professional Corporations	6	37	2	0	25	70
Nurses — RN and LPN	0	28	0	1	30	59
Podiatrists	0	7	0	2	11	20
Psychiatrists	1	3	0	0	11	15
TOTAL	72	651	32	24	484	1263

122. *Id.*

123. *Id.*

determined.[124]

Under the Virginia statute, provider panelists are to be selected with due regard to "the nature of the claim and the nature of the practice of the health care provider."[125] Accordingly, the appointing authority designates at least one panelist who represents the medical specialty involved in the claim. Therefore, the number of times members of various specialties have served on the 668 closed panels, involving the appointment of approximately 2,000 provider panelists, also suggests the extent of involvement of these specialties in medical malpractice claims. This information was available with somewhat more detail concerning the medical specialty of the physician-patients than the prospective defendant data cited above.[126] The following seven specialties—in decreasing order of frequency—account for about two-thirds of provider panelists: general surgery, hospital administration, obstetrics-gynecology, general practice, orthopedic surgery, internal medicine, and dentistry.[127] These 2,000 professionals who served as panelists received only $25 per day (now set at $50 per day) plus actual and necessary expenses.[128]

With regard to the legislative goal of the panel system, to provide for a speedy resolution of malpractice disputes by abandonment of frivolous claims or by prompt payment of meritorious claims, we focused on the average amount of time that a claim receives consideration at the panel level as a function of the ultimate panel disposition (i.e., the time elapsed between panel request and withdrawal, settlement/dismissal, or the rendition of a particular

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124. *Id.*

125. VA. CODE ANN. § 8.01-581.3 (Repl. Vol. 1984).

126.

TABLE 6
SPECIALTIES MOST FREQUENTLY REPRESENTED

Specialty	No. of Panelists
General Surgery	260
Hospital Administration	209
Obstetrics-Gynecology	200
General Practice	182
Orthopedic Surgery	166
Internal Medicine	166
Dentistry	156

127. *Id.*

128. *See supra* note 69.

panel opinion).[129] Not surprisingly, cases expected to be more complex and difficult (i.e., those cases involving the proximate cause issue) tended to have the longest time open. Cases with a "No Malpractice" opinion had a median time open of eight and one-half months, about one month less than the cases with "Malpractice" opinions.[130] Cases settled before a panel opinion was rendered were open for a median of seven months after the panel request.[131]

On the average, each panel considers claims against two providers. The 668 closed panels included claims against 1,351 providers.[132] One particular panel considered claims against fifteen providers.[133] One hundred thirty-nine panels had two prospective defendants before them. It was thought that opinions would be less favorable for claimants naming large numbers of prospective defendants. This hypothesis, however, did not receive statistically significant support from the findings on the seven-year period for which data was collected.

129.

TABLE 7
TIME OPEN VIS-A-VIS TYPE DISPOSITION

Disposition by Opinion of		No. of HCPs		Median Days		Mean Days	
1. No Malpractice		683		253		314	
2. Malpractice		76		278		368	
3. Malpractice, but not cause		32		289		385	
4. Issue of fact		35		287		310	
			OVERALL		255		322
Withdrawn, settled or dismissed		525		206		304	
	TOTAL	1351	OVERALL		248		315

130. *Id.*
131. *Id.*
132. *Id.*
133.

TABLE 8-A
NUMBER OF PROVIDERS PER CLOSED PANEL

No. of Providers		No. of Providers		No. of Providers	
Panel	Frequency	Panel	Frequency	Panel	Frequency
1	363	6	9	11	3
2	139	7	7	12	2
3	87	8	6	13	0
4	38	9	2	14	0
5	10	10	1	15	1
				TOTAL	668

It appears from a mail survey of panel chairmen[134] that the success or failure of a panel depends heavily on the attitude of the particular judge who chairs the panel. Many judges report that it is difficult to schedule a hearing on a date convenient to the claimant, the prospective defendant(s), their attorneys, and the six non-judge panelists. Some judges are by nature more insistent than others in encouraging prompt resolution at the panel level. Some judges apparently equate the hearing to a mini-trial, necessitating time for extensive preparation including procurement of expert testimony. Other judges seem to view panels differently and insist that six months is enough time for pre-hearing discovery in all instances. One factor analyzed in panel performance was the rate with which the claim advanced to a hearing and the panel rendered an opinion.[135] The variations by locality for the median and mean times for the handling of cases may reflect the predominant attitude of the judges in a given area.[136] Cases in the Roanoke area, for example, have shown a relatively rapid resolution. The median time open in that locality is almost three months less than the me-

TABLE 8-B
DISPOSITIONS VIS-A-VIS SIZE OF PROVIDER GROUP

	NUMBER OF PROVIDERS					
	Less than 5		Five or more		TOTAL	
1. No Malpractice	530	(39.2)	153	(11.3)	683	(50.6)
2. Malpractice	66	(4.9)	10	(0.7)	76	(5.6)
3. Malpractice, but not Cause	28	(2.1)	4	(0.3)	32	(2.4)
4. Issue of Fact	30	(2.2)	5	(0.4)	35	(2.6)
Withdrawn, settled or dismissed	398	(29.5)	127	(9.4)	525	(38.9)
TOTALS	1052	(77.9)	299	(22.1)	1351	(100.0)

(Percentages of the total are in parentheses)

134. *See supra* note 29.
135. *Id.*
136.

TABLE 9-A
TIME OPEN BY LOCALITY

Area*	No. of Cases	Median (Days)	Mean (Days)
1. Charlottesville Area	23	221	285
2. Northern Virginia	157	236	277
3. Richmond Metro	90	245	296
4. Roanoke Metro	38	204	222
5. Tidewater Area	132	286	346
6. Southern Piedmont Area	40	246	263

dian time open in the Tidewater area.[137]

VI. RECOMMENDATIONS

The Virginia Medical Malpractice Act has provided a forum for the screening of malpractice claims since 1976. The Act survived a constitutional challenge in *DiAntonio v. Northampton-Accomack Memorial Hospital.*[138] In theory, the Virginia panel system does not deny any party equal protection or right to a jury trial. Furthermore, the Act does not violate similar provisions of the Virginia Constitution.

The General Assembly, originally and by subsequent amendments, has made a diligent effort to design the panel system to accommodate the various and conflicting interests of claimants and prospective defendants. Amendments respond to the difficulty inherent in all panel systems of allowing enough time for a thorough preparation for the panel presentation without unreasonable delay in the final resolution of the malpractice dispute. From 1976 until mid-1981, the legislature did not place any limit on the time that could transpire between appointment of a panel and the rendition of its opinion. After 1981, an opinion had to be rendered no later than six months from the panel's appointment. An additional ninety days may be granted by the chairman upon a showing of extraordinary circumstances. This limitation was virtually aban-

TABLE 9-B
DISPOSITIONS BY LOCALITY

Disposition by Opinion of	Charlotte-ville	No. Va.	Richmond Metro	Roanoke Metro	Tide-water	Southern Piedmont
1. No malpractice	13 (86.7%)	95 (83.3%)	46 (83.6%)	15 (83.3%)	45 (76.3%)	17 (65.4%)
2. Malpracitce	1 (6.7%)	9 (7.9%)	3 (5.5%)	3 (16.9%)	10 (16.9%)	5 (19.2%)
3. Malpractice, but not cause	1 (6.7%)	5 (4.4%)	3 (5.5%)	0 (0%)	1 (1.7%)	1 (3.8%)
4. Issue of fact	0 (0%)	5 (4.4%)	3 (5.5%)	0 (0%)	3 (5.1%)	3 (11.5%)
TOTAL	15	114	55	18	59	26
Withdrawn, settled or dismissed	8	43	35	20	73	14

137. *Id.* Another explanation for these dispositions may be suggested. It appears that the median time and mean time for case resolution may be, in part, a function of the number of claims filed. Analysis of the results, however, does not support this explanation. In Roanoke, disputes were resolved noticeably quicker than in Charlottesville, where fewer cases were filed and in Southern Piedmont, where approximately the same number of cases were resolved.

138. 628 F.2d 287 (4th Cir. 1980). For a discussion of the case, see *supra* notes 61-62 and accompanying text.

doned in 1984 by the amendment providing that the six months begin to run only after the parties certify that discovery has been completed and all relevant documents have been submitted.

The data covering the period from 1976 to 1983 does not indicate that the panel system causes any oppressive delay in the final resolution of medical malpractice disputes. But care must be taken to insure that it does not unreasonably prevent a timely disposition of claims in the future, especially now with the relaxation of the time limit between the filing of a request for a panel and the panel's opinion. One party may be before the panel involuntarily and, therefore, may experience some unwanted delay prior to his day in court.

This involuntary, unwanted delay, resulted in Florida and Pennsylvania declaring their panel laws unconstitutional in the actual operations of the statutes. Panels must be designed and administered around the competing risks involved in too long a delay and too short a time in which to prepare adequately for the panel hearing. Legislatures cannot rely on courts scrutinizing only the theoretical burdens placed on claimants or providers. Now there is an additional concern: Does the time for actually processing claims in a particular panel system result in an infringement of constitutional rights? If a panel system takes too long to process claims, parties may successfully argue that they are denied right to a jury. If too short a time limit is put on panel consideration, parties may successfully argue that they are denied due process. Therefore, an acceptable time constraint must be of such duration that will allow for adequate preparation and presentation to the panel.

Not only do legislatures and courts need to know how much time a panel system takes to process a claim, they also need to know how efficient the system is in preventing unnecessary and expensive litigation. The *DiAntonio* court accepted the legislative finding that a medical malpractice crisis existed. The court also accepted the legislative hypothesis that the panel system would *substantially* reduce the amount of litigation in the subject area and, thereby, *substantially* lower the cost of medical malpractice insurance. The court accepted this hypothesis without citing any facts or legislative history which would support their conclusions. Such deference to the legislative branch of government may no longer be appropriate. Now that the Virginia panels have operated for almost ten years, the time has come for the hypothesis to be tested.

One measure of effectiveness is whether the panel system resolves sufficient medical malpractice cases to warrant the additional costs imposed upon claimants and providers, and the additional burden placed on judges, panelists and state employees, whose time is required to make the process work. Even if the system is generally effective in preventing litigation, the time it takes for resolution of a claim cannot represent an unreasonable delay in gaining access to the courts—a party has the right to have the claim or defense decided by a jury. While rhetoric is important in detecting potential problems, reliable data is needed to determine whether the Virginia panels deter expensive and unnecessary litigation without infringing upon constitutional rights.

Sensible consideration of these concerns requires the systematic collection of relevant statistical data. Not only would the information allow for knowledgeable and intelligent analyses by the Virginia General Assembly of the effectiveness of the panel system, but the data would also provide legislatures of other states and scholars with general information regarding the success of the Virginia Medical Malpractice Act during a time when other statutes with similar goals have failed.

The Bureau of Insurance in the State Corporation Commission was the designated depository for detailed statistical data to be furnished by insurers and by attorneys for claimants and providers.[139] Although the Bureau's authority was for the express purpose of collecting data to review the reasonableness of premium rates, success in the collection would have helped provide answers about the efficacy of the panel system. Specifically, one could determine (1) the percentage of medical malpractice claims disposed of without use of the system, and (2) the percentage of claims that went on to litigation although the panel had rendered an opinion.[140]

New legislation providing for the collection of data for a future determination of the effectiveness of panels is needed. The information collected must allow for an analysis of how well panel opin-

139. VA. CODE ANN. § 38.1-389.3 (Repl. Vol. 1981), *repealed by* 1982 Va. Acts ch. 229.

140. While collection of the necessary data from insurers by the State Corporation Commission with other data to review the reasonableness of insurance premium rates would be one satisfactory method, there are superior ways. For example, the General Assembly could provide that a separate medical malpractice docket be maintained in each circuit court and that certain information be forwarded from this docket at appropriate intervals to a central office of the state. Whatever is done to provide an adequate database, it does not appear fair or realistic for claimants' and providers' attorneys to be the source of the information. *See also supra* note 14.

ions predict the outcome of the claim in the event suit is filed. The systematic and thorough collection of data will avoid the situation in Florida where the panel system was declared unconstitutional after a court considered less than eighty cases.[141] As the dissent in *Aldana* noted: "[T]here probably have been thousands of mediation cases throughout this state where . . . neither the claimants nor the doctors have been deprived of any constitutional rights."[142]

VII. Conclusion

The Virginia Medical Malpractice Act has survived a constitutional attack on its facial validity; similar statutes in other states have not. This survivorship is an indication that Virginia's panel system is perceived as fostering the goals of speed and cost-containment in resolving disputes arising out of allegations of medical malpractice. Some data collected and presented here appear to support these perceptions.

Statutes similar to Virginia's Medical Malpractice Act, however, are now being successfully challenged as unconstitutional in their actual application. The data already collected is not enough to fully analyze the effectiveness of Virginia's Act in practice. Virginia's statute may also be unconstitutional in its actual application. Hypotheses that panels serve to reduce the number of suits filed in Virginia, and that panels in operation do not unreasonably infringe upon access to the courts, can best be tested through additional data collection, analysis and publication.

ADDENDUM

On March 17, 1985, the Govenor signed House Bill 1434, reenacting a requirement of reporting certain medical malpractice claims.[1] The Bill substantially tracks subsection A of the repealed reporting statute.[2] Two significant changes are that reports need only be made annually, and the reports must now include information about the specialty of the health care provider.[3] In addition,

141. Aldana v. Holub, 381 So. 2d 231 (Fla. 1980).

142. *Id.* at 239 (Alderman, J., concurring in part and dissenting in part).

1. Va. H. 1434, 1985 Va. Acts. ch. 318 (Approved Mar. 17, 1985) (to be codifed at Va. Code Ann. § 38.1-389.3:1).

2. Va. Code Ann. § 38.1-389.3 (Repl. Vol. 1981), *repealed by* 1981 Va. Acts ch. 229.

3. *Compare* Va. H. 1434 (reports shall be made annually and shall include the specialty of each health care provider) *with* Va. Code Ann. 38.1-389.3 *repealed by* 1982 Va. Acts ch. 229 (reports shall be made within 60 days following the final disposition of the case).

the entity reporting the information, either the health care provider or the provider's insurer, must provide the Commissioner of Insurance with "a statistical summary of the information collected in addition to an individual report on each claim."[4]

4. Va. H. 1434.