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Virginia's Birth-Related Neurological Injury Compensation Act: Constitutional and Policy Challenges

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COMMENTS

VIRGINIA'S BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT: CONSTITUTIONAL AND POLICY CHALLENGES

I. INTRODUCTION

In 1987, Virginia's General Assembly enacted the Virginia Birth-Related Neurological Injury Compensation Act (the Act).[1] Although there is a dearth of official legislative history for the Act, newspaper reports provide some insight as to the intended purpose and scope. Reportedly, the Act was a response to medical malpractice insurers' refusal to provide coverage for obstetricians.[2] Proponents of the Act feared critical shortages of obstetrical services if action was not taken to ensure the availability of liability insurance.[3]

The Act apparently was precipitated, at least in part, by *Boyd v. Bu-*

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1. VA. CODE ANN. §§ 38.2-5000 to -5021 (Supp. 1987).

2. The Philadelphia Hospital Insurance Company announced that beginning November 1, 1986, it would not renew coverage for physicians not employed by a hospital or practicing with a group of 10 or more physicians. The Virginia Insurance Reciprocal and St. Paul's Fire and Marine Insurance Company previously had announced moratoriums on new obstetrical policies. THE LIABILITY INSURANCE CRISIS AND THE NEED FOR TORT REFORM, REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA, S. DOC. No. 11, 1987 Sess. 12-13 (1987) [hereinafter THE LIABILITY INSURANCE CRISIS].

The Virginia Insurance Reciprocal agreed to lift its moratorium on writing malpractice policies for obstetricians and lower premiums on currently effective policies if the possibility of lawsuits for birth-related neurological injuries was eliminated. Wash. Post, Feb. 17, 1987, at B5, col. 5. The Virginia Insurance Reciprocal is a state-based physicians' group which insures about one third of Virginia's doctors. Richmond Times-Dispatch, Nov. 16, 1987, at A2, col. 4.

3. Delegate Clifton A. Woodrum, the Act's chief sponsor, reported that the Act was designed to alleviate " 'a crisis in health care' resulting from huge malpractice awards that made it difficult for obstetricians to get insurance." Wash. Post, Feb. 17, 1987, at B5, col. 4.

According to a survey conducted by the Medical Society of Virginia and the Virginia Hospital Association, 40% of Virginia's 600 obstetricians planned to stop delivering babies unless a solution was found. *Id.*

According to Delegate Woodrum, insurance companies lifted the ban on writing malpractice policies 10 days after passage of the Act. Wash. Post, Dec. 31, 1987, at B3, col. 3.

lala.[4] In *Boyd*, a federal district court held that Virginia's cap on medical malpractice damages,[5] violated the plaintiffs' constitutionally guaranteed right to a jury trial.[6] Mr. and Mrs. Boyd filed an action against Dr. Bulala alleging that they and their daughter were injured as a result of the physician's negligent delivery of the infant. As a result of the perinatal injury, the minor-plaintiff, Veronica Lynn Boyd, sustained profound physical and mental handicaps.[7] The jury awards against the defendant totaled $8,300,000 in compensatory and punitive damages.[8] Dr. Bulala's post-trial motion to reduce the damage award in accordance with section 8.01-581.15 of the Code of Virginia was denied on the basis that the statute was unconstitutional.[9]

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4. Boyd v. Bulala, 647 F. Supp. 781 (W.D. Va. 1986).

Boyd is the only "huge malpractice award" in Virginia which could support Delegate Woodrum's claims. *See supra* note 3. Virginia's statutory cap on medical malpractice verdicts has been in effect since 1977. *See infra* note 5. The average medical malpractice claim paid in Virginia in 1984 was $17,000. In the Richmond area, the average medical malpractice award during 1982-1985 was $302,000. *See* THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 8. *See generally Debate on Malpractice Award Cap is Revived*, Richmond Times-Dispatch, Nov. 16, 1986, at A1, col. 1.

5. VA. CODE ANN. § 8.01-581.15 (Repl. Vol. 1984). In 1983, the statute was amended to allow recovery up to $1,000,000. *Id.* A bill to reduce the ceiling to $500,000 in 1987 was not enacted. H.B. 130, Va. Gen. Assembly, 1987 Sess. The provision in effect at the time of the *Boyd* trial provided for a $750,000 limit on recovery against health care providers:

> In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after April one, nineteen hundred and seventy-seven, which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed $750,000.

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

Ambiguity as to whether the cap applied to each plaintiff or to the action as a whole was not resolved in *Boyd* since the court held that the statute was unconstitutional. *Boyd*, 647 F. Supp. at 790 n.8.

6. The seventh amendment to the United States Constitution does not apply to the states through the fourteenth amendment. *Boyd*, 647 F. Supp. at 788 (citing New York Cent. R.R. v. White, 243 U.S. 188 (1917); Minneapolis & St. L.R.R. v. Bombolis, 241 U.S. 211 (1916); Walker v. Sauvinet, 92 U.S. 90 (1876)).

The *Boyd* court found that the right to jury trial guaranteed by article I, section 11 of the Virginia Constitution is equivalent to the federal seventh amendment right. *Boyd*, 647 F. Supp. at 789.

Interpretations of both the federal and Virginia constitutional rights to jury trial establish that damage awards, as well as liability determinations, are properly within the province of the jury. *See id.* at 788-89 (citing Dimick v. Schiedt, 293 U.S. 474, 486 (1935); Danville Community Hosp. v. Thompson, 186 Va. 746, 43 S.E.2d 882 (1947); E.I. duPont de Nemours & Co. v. Taylor, 124 Va. 750, 98 S.E.2d 866 (1919).

For a searching analysis of *Boyd*, see Comment, *The Constitutional Attack on Virginia's Medical Malpractice Cap: Equal Protection and the Right to Jury Trial*, 22 U. RICH. L. REV. 95 (1987).

7. *Boyd*, 647 F. Supp. at 784. The child's disabilities included cerebral palsy, quadriplegia, blindness, and mental retardation. *Id.* at 792-93.

8. The award included a total of $2,000,000 in punitive damages for injuries to the infant and her mother. *Id.* at 784.

9. *See supra* note 6.

In the wake of the *Boyd* decision, the Virginia Birth-Related Neurological Injury Compensation Act[10] was passed. In accordance with malpractice insurance carriers' specifications,[11] the drafters, in an attempt to ensure that *Boyd* would not be repeated, completely removed similarly injured infants from the tort system. The wisdom of this Act is questionable. The elimination of fault-based liability is antithetical to the deterrent goal of the traditional tort system.[12] The Act, if upheld, could result in increased birth-related injuries. This Comment will discuss bases for constitutional and policy challenges to the Act.

II. Provisions and Scope of the Act

The Act defines a class of severely injured children[13] and abolishes the traditional common law rights and remedies of the children, their personal representatives, parents, dependents or next of kin "arising out of or related to a medical malpractice claim with respect to such an injury."[14]

Effective January 1, 1988, the Act prescribes the exclusive remedy for catastrophic brain and spinal cord injuries[15] caused by the malpractice[16]

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10. Va. Code Ann. §§ 38.2-5000 to -5021 (Supp. 1987).

11. *See supra* note 2 and accompanying text.

12. *See infra* notes 122-133 and accompanying text.

13. It is estimated that approximately forty children per year will suffer birth-related neurological injuries as defined in the Act. Wash. Post, Dec. 31, 1987, at B3, col. 3.

In an earlier report, the Act's chief sponsor, Delegate Clifton A. Woodrum, reported that 40 to 50 of the 65,000 babies born in Virginia each year would be affected. *Id.* Feb. 17, 1987, at B3, col. 5. An opponent of the Act, Delegate Bernard S. Cohen, estimated that only two or three such cases per year result from malpractice. *Id.* at B5, col. 6.

14. Va. Code Ann. § 38.2-5002(B) (Supp. 1987).

Arguably, this provision precludes actions by relatives in their own rights for injuries related to malpractice during the delivery of the child. Therefore, damages such as those awarded to the parents in Boyd v. Bulala, 647 F. Supp. 781 (W.D. Va. 1986) would be disallowed. In addition to compensatory awards for past and future medical costs for their child, the parents in *Boyd* received substantial damage awards for their own injuries related to the birth. Mrs. Boyd received $2,575,000 in compensatory and punitive damages. *Id.* at 784. Mr. Boyd was awarded $1,175,000 in compensatory damages for emotional distress. *Id.* at 792.

15. The birth-related neurological injuries covered under the Act are brain or spinal cord injuries, caused by oxygen deprivation or mechanical injury during delivery, which render the child "permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." Va. Code Ann. § 38.2-5001.

16. The Act does not foreclose civil actions "against a physician or hospital where there is *clear and convincing evidence* that such physician or hospital *intentionally or willfully caused or intended to cause* a birth-related neurological injury." Va. Code Ann. § 38.2-5002(C) (emphasis added). This section requires claimants to show specific malicious intent. However, an action based on gross negligence or reckless disregard would have to be brought under the Act's provisions.

of "participating"[17] physicians or hospitals. The Act does not provide compensation for similar disabilities caused by genetic or congenital conditions.[18] However, to the extent that such injuries occur when adequate medical care is provided during labor and delivery, the Act provides compensation without regard to fault.[19]

All claims within the scope of the Act must be filed with the Industrial Commission of Virginia, which has exclusive authority to make compensatory awards for such injuries.[20] The Industrial Commission neither determines nor considers fault in assessing damages.[21] The authority to review the quality of medical care rendered by participating physicians or hospitals is exclusively delegated to the Board of Medicine or Department of Health, respectively.[22]

In contrast to the monetary limitation on total damages which was held unconstitutional in *Boyd v. Bulala*,[23] the Act limits the *types* of damages which may be recovered. Claimants may recover "medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel."[24] The Act requires that expenses be actually incurred before payment to avoid potential "windfalls" resulting from damage awards based on inaccurate estimates of future medical expenses or future loss of earnings.[25]

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17. "Participating" physicians and hospitals include licensed Virginia health care providers who have: (1) agreed to provide obstetrical care to indigent patients; (2) agreed to submit to review by the State Board of Medicine or State Department of Health; and (3) paid assessments prescribed by administrators of the Birth-Related Neurological Injury Compensation Fund created by the Act. VA. CODE ANN. § 38.2-5001.

18. *Id.* § 38.2-5014.

19. *Id.* § 38.2-5008.

20. *Id.* § 38.2-5004.

21. *Id.* § 38.2-5008.

A panel of "three qualified and impartial physicians" will review each claim and submit to the Industrial Commission a report "as to whether the injury alleged is a birth-related neurological injury within the meaning" of the Act. "The Commission must consider, but shall not be bound by, the recommendations of the panel." *Id.* § 38.2-5008(B).

If the Commission determines that the injury is covered by the Act, an award is made in accordance with § 38.2-5009 of the Code of Virginia.

Reconsideration of the Commission's determination of coverage or the amount of an award may be obtained by timely application for rehearing by the full Commission. *Id.* § 38.2-5010. Appeals lie from the full Commission to the Court of Appeals. *Id.* § 38.2-5011.

22. *Id.* § 38.2-5004(B), (C). If the Board of Medicine or Department of Health "determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care" the agency "shall take any appropriate action" in accordance with authority to impose sanctions granted under separate statutes. *Id.*

23. 647 F. Supp. 781; *see also supra* notes 5-6 and accompanying text.

24. VA. CODE ANN. § 38.2-5009(1).

25. State provisions requiring periodic payment of medical malpractice awards and cessation of payment upon death of the patient have been upheld. *See* Florida Patient's Compensation Fund v. Stetina, 474 So. 2d 783 (Fla. 1985); State *ex rel* Strykowski v. Wilkie, 81

In addition to compensation for medical expenses actually incurred by the claimants, the Act provides limited compensation for loss of earnings after the child reaches eighteen years of age,[26] and reasonable expenses incurred in filing the claim, "including 'reasonable attorneys' fees."[27] Notably absent from the Act is any provision for noneconomic losses suffered as a result of birth-related injuries.[28]

In summary, the Act abolishes the common-law cause of action for birth-related neurological injuries resulting from medical malpractice. In place of common-law tort remedies, the Act creates a no-fault economic compensation scheme. The Industrial Commission of Virginia is vested with exclusive authority to make limited compensatory awards based on actually incurred economic losses.

Wis. 2d 491, 261 N.W.2d 434 (1978). *But see* Carson v. Maurer, 120 N.H. 925, ___, 424 A.2d 825, 838 (1980) ("Although there may be a windfall to the claimant's family if the periodic payments are not terminated at the claimant's death, there is also a windfall benefit to the defendant's insurer . . . if the claimant dies.").

Legislation abrogating or modifying the collateral source rule has been upheld in several states. *See, e.g.*, Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977); Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368, *appeal dismissed*, 474 U.S. 892 (1985); Pinillos v. Cedars of Lebanon Hosp. Corp., 403 So.2d 365 (Fla. 1981).

In *Boyd*, the infant plaintiff died six weeks after the trial. *Boyd*, 647 F. Supp. at 784. The jury had awarded $2,850,000 in compensatory and punitive damages to the child. In addition, the parents were jointly awarded $1,700,000 for past and future medical expenses until the child reached 18 years of age. *Id.* However, the court denied the defendant's motions to reopen the record to present evidence of death and have the court set aside these verdicts which arguably were based on incorrect estimates of the child's life expectancy. *See id.* at 796.

26. VA. CODE ANN. § 38.2-5009(3).

27. *Id.* § 38.2-5009(4).

28. In [workmen's] compensation, unlike tort, the only injuries compensated for are those which produce disability and thereby presumably affect earning power . . . . For example, while common-law verdicts of great size are common for facial disfigurement, it is usually held that, in the absence of an express provision making disfigurement compensable, no allowance can be made for it . . . . There is no place in compensation law for damages on account of pain and suffering, however dreadful they may be.

1 A. LARSON, LARSON'S WORKMEN'S COMPENSATION LAW § 2.40 (1985).

Virginia's Act is unique in that it denies a class of medical malpractice victims any recovery for noneconomic losses. Less stringent legislative provisions limiting awards to medical malpractice victims for noneconomic losses have been reviewed by several courts. *Compare* Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (upholding $250,000 cap on noneconomic losses), *appeal dismissed*, 474 U.S. 892 (1985) *with* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) ($250,000 cap on noneconomic damages unconstitutional); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (Ct. C.P. 1976) (dicta indicating $200,000 limit on "general damages" unconstitutional) *and* Baptist Hosp. v. Baber, 672 S.W.2d 296 (Tex. Ct. App. 1984) ($500,000 limit on damages, excluding medical expenses, unconstitutional), *writ of error revoked*, 714 S.W.2d 310 (Tex. 1986).

III. CONSTITUTIONALITY OF THE ACT

A. *Analogy to Constitutionally Valid Workers' Compensation Laws*

Virginia is not alone in enacting legislation to respond to a real or perceived medical malpractice crisis. The Act incorporates limitations on malpractice liability which have been attempted elsewhere. For instance, statutory limitations on recovery,[29] abrogation of the collateral source rule,[30] and limits on attorneys' fees[31] have been enacted and reviewed in other states.

However, Virginia's Birth-Related Neurological Injury Compensation Act[32] is unique in that it defines a small class of severely injured children[33] and completely removes them from the tort system.[34] The Act apparently was modeled after workers' compensation statutes.[35] The constitutionality of workers' compensation laws has been upheld by the United States Supreme Court.[36] Thus, proponents of the Act may assert that it is constitutionally valid. However, the Act is distinguishable from workers' compensation laws in significant respects.

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29. *See* cases cited *supra* notes 25 & 28; *see also* Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980) (upholding $500,000 limit on total recovery); Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977) (plurality opinion) (upholding $500,000 limit on total recovery); State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978) (upholding $500,000 limit on recovery if compensation funds fall below specified levels). *But see* Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977), *modified on remand*, Nos. 55527 and 55586 (4th Dist. Idaho, Nov. 3, 1980) (on remand, $300,000 limit on damages unconstitutional); Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976) ($500,000 limit on damages unconstitutional); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) ($300,000 limit on damages unconstitutional).

30. *See* cases cited *supra* note 25.

31. At least twenty states have enacted legislation restricting contingent fee agreements. *See* Essen & Aldred, *The American Medical Association v. The American Tort System*, 8 CAMPBELL L. REV. 241, 255 (1986).

Limits on plaintiffs' attorneys' fees were held unconstitutional in *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980). *But see* Roa v. Lodi Medical Group, 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (limitation of attorneys' fees upheld), *appeal dismissed*, 474 U.S. 990 (1985); *Johnson*, 273 Ind. 374, 404 N.E.2d 585 (1980) (limitation of attorneys' fees constitutional; direct relationship between statute's limitation on total recovery and limitation on fees to plaintiffs' attorneys); *Prendergast*, 199 Neb. 97, 256 N.W.2d 657 (legislative provision for judicial review of attorneys' fee arrangements valid).

32. Dicta in Boyd v. Bulala, 647 F. Supp. 781 (W.D. Va. 1986), may have provided inspiration for the Act. In *Boyd*, the court held that Virginia's limitation on malpractice damages was an unconstitutional infringement on the right to jury trial in civil actions. *Id.* at 788-89. However, the court also noted that "the legislature may abolish the common-law right of action and, if it desires, replace it with a compensation scheme." *Id.* at 789. Perhaps the Act was drafted in reliance on this dicta.

33. *See supra* notes 13 & 15 and accompanying text.

34. *See supra* notes 2 & 14 and accompanying text.

35. *See* Wash. Post, Feb. 17, 1987, at B5, col. 6.

36. Mountain Timber Co. v. Washington, 243 U.S. 219 (1917); Hawkins v. Bleakley, 243 U.S. 210 (1917); New York Cent. R.R. v. White, 243 U.S. 188 (1917).

"The necessity for workmen's compensation arose out of the coincidence of a sharp increase in industrial accidents attending the rise of the factory system and a simultaneous decrease in the employee's common-law remedies for his injuries."[37] By contrast, the Act and other tort reform legislation have been enacted in response to dramatic increases in insurance premium costs.[38] Thus, contrary to the impetus behind workers' compensation laws, tort reform[39] is an effort to protect the alleged tortfeasor and his insurer rather than the injured party.[40]

Workers' compensation statutes provide limited compensation to employees for all employment-related injuries, regardless of fault. By contrast, the scope of the Act is more limited—it provides limited compensation to a small class of infant patients for catastrophic birth-related injuries, regardless of fault.

Under the common law, employers could assert a number of fault-based defenses which would preclude employee recovery: for example, contributory negligence, fellow servant's negligence, and assumption of risk.[41] Under the Act, there is no probability that a fault-based defense could be asserted to preclude common-law recovery for the covered injuries.[42] Arguably, the nature and severity of injuries defined in the Act

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37. 1 A. LARSON, *supra* note 28, at § 4.00.

38. In 1974-1975, medical malpractice insurance premiums increased at rates of up to 500% in some states. P. DANZON, MEDICAL MALPRACTICE, 97 (1985). Although the crisis subsided in the late 1970's, premium costs began rising again in the mid-1980's. *Id.* Malpractice premium costs in 1984 were approximately three billion dollars. *Id.* at 18.

Notwithstanding the premium increases, a 1981 study indicated that physician earnings were sufficiently high to offset premium costs. On the average, malpractice insurance coverage represented only 3.6% of physicians' yearly gross income. *Id.* at 187-88; *see also The Doctor-Lawyer War*, NEW REPUBLIC, June 24, 1985, at 4 (the 2.9% of gross income the average physician spends on medical malpractice premiums is slightly higher than the 2.3% spent on professional car maintenance).

39. Proponents of tort reform generally argue that the system encourages frivolous suits and excessive jury awards which result in increased premium costs. *See The Doctor-Lawyer War, supra* note 38, at 4; Lacayo, *The Malpractice Blues*, TIME, Feb. 24, 1986, at 60.

40. Legislative impediments to medical malpractice litigation have coincided with judicial acceptance of substantive legal theories which tend to expand health care providers' liability. "With respect to medical malpractice litigation, the courts giveth and the state legislatures taketh away." B. WERTHMAN, MEDICAL MALPRACTICE LAW: HOW MEDICINE IS CHANGING THE LAW 127 (1984).

41. *See* New York Cent. R.R. v. White, 243 U.S. 188, 197 (1917).

42. The Act is applicable only to birth-related injuries sustained during the course of labor and delivery, or during resuscitation in the immediate post-delivery period. Therefore, the infants covered by the Act are incapable of contributory negligence or assumption of risk. The only bar to liability under a common-law malpractice theory for such injuries would be the plaintiff's failure to prove that the physician or hospital rendered substandard care. The Act obviates the plaintiff's burden of proving fault under the common law in these circumstances. However, since there is no probability of contributory negligence or assump-

support a conclusion that such injuries rarely would occur in the absence of malpractice.[43]

B. *Due Process Analysis*

1. Quid Pro Quo Considerations

The Act abrogates common-law tort actions for birth-related injuries, arising out of or related to alleged malpractice, which render a child "permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living."[44] In place of the common-law cause of action, the Act substitutes a no-fault compensation scheme which basically reimburses claimants for necessary and reasonable expenses actually incurred.[45]

Although the Act is unique in its total abrogation of the common-law action for medical malpractice, several courts in other states have considered due process challenges to legislative modifications of the common-law cause of action.[46] The United States Supreme Court has pronounced that common-law rights may be legislatively altered: "No person has a vested interest in any rule of law entitling him to insist that it shall remain unchanged for his benefit."[47]

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tion of risk, the defendant does not forfeit the opportunity to prevail by proving any affirmative, fault-based defenses.

43. "Birth-related neurological injury" means injury to the brain or spinal cord of an infant *caused by deprivation of oxygen or mechanical injury* occurring in the course of labor, delivery or resuscitation . . . in a hospital *which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.*

VA. CODE ANN. § 38.2-5001 (Supp. 1987) (emphasis added).

Congenital and hereditary defects are specifically excluded from coverage under the Act. *Id.* § 38.2-5014.

Some commentators have proposed a limited no-fault plan which would provide compensation for "designated compensable events" (DCEs) without regard to fault. The DCEs would be outcomes which are most frequently associated with negligent treatment. *See* P. DANZON, *supra* note 38, at 217. Arguably, the birth-related injuries defined in the Act are "more often than not associated with negligent treatment." *Id.*

Danzon discusses a number of disadvantages inherent in the DCE proposal. DCEs would not significantly lessen current litigation costs since, by definition, the injuries presumably involve clear-cut liability. However, increased litigation could result over the issue of whether an injury is a covered DCE. Present distortions in medical care resulting from defensive medicine and inadequate deterrence under the negligence system might increase under the partial no-fault system. *Id.* at 217-18.

44. VA. CODE ANN. § 38.2-5001 (Supp. 1987).

45. *See supra* notes 24-28 and accompanying text.

46. *See, e.g.*, cases cited *infra* notes 50, 53, & 56.

47. Munn v. Illinois, 94 U.S. 113, 134 (1876), *followed in* New York Cent. R.R. v. White, 243 U.S. 188, 198 (1917); Chicago & Alton R.R. v. Tranbarger, 238 U.S. 67, 76 (1914); Second Employers' Liability Cases, 223 U.S. 1, 50 (1912); Martin v. Pittsburg (sic) & L.E. R.R., 203 U.S. 284, 294 (1906); Hurtado v. California, 110 U.S. 516, 532 (1884).

Statutory limitations on medical malpractice damages have survived due process challenges in some courts.[48] General due process analysis requires consideration of "whether the new arrangement is *arbitrary and unreasonable, from the standpoint of natural justice.*"[49] Unfortunately, the concept of "arbitrary and unreasonable" is sufficiently nebulous to allow subjective and arbitrary decisions regarding due process violations.

The United States Supreme Court has not definitively established a quid pro quo requirement for legislative abrogation of common-law rights.[50] However, in upholding workers' compensation legislation[51] and limitations on liability for nuclear power plant accidents,[52] the Court specifically noted in each case that the challenged legislation provided a quid pro quo for the alteration of common-law remedies.

A quid pro quo requirement provides meaningful parameters for the "arbitrary and unreasonable" concept; however, the analysis can be skewed. For instance, in upholding limitations on medical malpractice recoveries two courts have accepted societal quid pro quo arguments.[53] In

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48. *See, e.g.*, Fein v. Permanente Medical Group, 38 Cal. 3d 137, ___, 695 P.2d 665, 682, 211 Cal. Rptr. 368, 385 ($250,000 limit on noneconomic damages did not violate due process), *appeal dismissed*, 474 U.S. 892 (1985); Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, ___, 404 N.E.2d 585, 599 (1980) ($500,000 limit on total recovery, "not arbitrary and irrational, but furthers the public purposes of the Act").

49. *New York Cent. R.R.*, 243 U.S. at 202 (emphasis added).

50. *See* Boyd v. Bulala, 647 F. Supp. 781, 786 (W.D. Va. 1986); *see also* State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, ___, 261 N.W.2d 434, 447-48 (1978) (declining to adopt quid pro quo test "fashioned" by other states).

51. Nor is it necessary, for the purposes of the present case, to say that a State might, without violence to the constitutional guaranty of "due process of law," suddenly set aside all common-law rules respecting liability as between employer and employee, *without providing a reasonably just substitute* . . . it perhaps may be doubted whether the State could abolish all rights of action on the one hand, or all defenses on the other, *without setting up something adequate in their stead.* No such qustion is here presented, and we intimate no opinion upon it.

New York Cent. R.R., 243 U.S. at 201 (emphasis added).

52. In Duke Power Co. v. Carolina Envtl. Study Group, 438 U.S. 59, 88 (1978), the Court left the quid pro quo question open after specifically finding that the statute's provisions provided a reasonably just substitute for common-law remedies.

53. *See Fein*, 38 Cal. 3d at ___ n.18, 695 P.2d at 681-82 n.18, 211 Cal. Rptr. at 385 n.18 ("Even if due process principles required some 'quid pro quo' to support the statute, it would be difficult to say that the preservation of a viable medical malpractice insurance industry in this state was not an adequate benefit for the detriment the legislation imposes on malpractice plaintiffs"); *Johnson*, 273 Ind. at ___, 404 N.E.2d at 599 ("To the extent that limitation upon recovery is successful in preserving the availability of health care services, it does so to the benefit of the entire community including the badly injured plaintiff.").

However, in Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, ___, 347 N.E.2d 736, 742 (1976), the court rejected the defendants' argument that the loss of potential recovery to some malpractice victims is offset by the societal quid pro quo of "lower medical care costs for all recipients of medical care." The court noted, "[t]his *quid pro quo* does not . . . serve to bring the limited recovery provisions within the rationale of the cases upholding the constitutionality of the Workmen's Compensation Act." *Id.*

contrast, quid pro quo findings by the United States Supreme Court have rested on the extent to which the legislature substitutes personal benefits for the statutory abrogation of the individual's common-law rights.[54]

Presumably, no legislature will enact legislation which clearly violates societal interests. The quid pro quo analysis is more reasonably applied to ensure that individual rights are not arbitrarily and unreasonably abrogated, even for the benefit of the majority. While societal benefits may be a factor in considering the legitimacy of legislative goals, they cannot serve as a quid pro quo justification for the abrogation of individual rights. Perhaps in recognition of this logic, the quid pro quo analysis also has been utilized by some courts reviewing equal protection and special legislation challenges.[55] The authorities suggest that, although not definitively required, a quid pro quo may provide a safe harbor against due process challenges. In *Baptist Hospital v. Baber*,[56] the court was reluctant to adopt a quid pro quo requirement. However, the *Baber* court noted, "it is safe to reflect, we think, that where a true quid pro quo does exist, it strengthens the statutes' constitutionality."[57]

The Act does not meet the quid pro quo standard. Under the Act, a child's right to have a jury determine liability and damages is exchanged for a no-fault provision. Furthermore, the damages disallowed by the Act are substantial. In *Boyd v. Bulala*, evidence regarding noneconomic damages and future loss of earnings was introduced. The court sustained the award of $1,000,000 in punitive damages and $1,850,000 in compensatory damages to minor-plaintiff Veronica Boyd. In addition to this compensatory damage award, $1,700,000 was awarded to Mr. and Mrs. Boyd for

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54. If the employee is no longer able to recover as much as before in case of being injured through the employer's negligence, he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of damages . . . . On the other hand, if the employer is left without defense respecting the question of fault, he at the same time is assured that the recovery is limited, and that it goes directly to the relief of the designated beneficiary.

New York Cent. R.R., 243 U.S. at 201.

The Price-Anderson Act's limitation of liability in the event of nuclear accidents was in part justified as a mechanism to ensure recovery for individual plaintiffs. The Court noted the probability that a defendant with theoretically unlimited liability would be unable to pay judgments. *Duke Power Co.*, 438 U.S. at 89-90.

55. *See, e.g.*, Arneson v. Olson, 270 N.W.2d 125, 136 (N.D. 1978) ("Restrictions on recovery may encourage physicians to enter into practice and remain in practice, but do so only at the expense of [plaintiffs] with meritorious claims."); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, ___, 355 N.E.2d 903, 910 (Ct. C.P. 1976) ("[t]his court rejects . . . the societal quid pro quo argument that some must give up their rights to damages so that all can achieve cheaper medical care.").

56. 672 S.W.2d 296, 298 (Tex. Ct. App. 1984), *writ of error revoked*, 714 S.W.2d 310 (Tex. 1986); *see also Boyd*, 647 F. Supp. at 786 (the court refused to adopt a quid pro quo requirement).

57. *Baptist Hosp.*, 672 S.W.2d at 298.

medical expenses until Veronica reached age eighteen. In sustaining the compensatory damage award, Judge Michael noted that evidence regarding Veronica's severe and permanent physical and mental disabilities "provided a sufficient foundation for the jury to conclude that Veronica's capacity to appreciate and enjoy life had been permanently destroyed."[58] The Act denies affected children noneconomic and punitive damages such as those awarded in *Boyd*,[59] and allows only minimal compensation for future loss of earnings.[60]

The Act provides compensation comparable to that of workers' compensation statutes which have withstood due process challenges.[61] The Act and worker's compensation statutes replace the common-law cause of action for negligence with a statutory no-fault compensation scheme. In both contexts, the elimination of fault is arguably a benefit that offsets the abrogation of the common-law cause of action which could provide much higher recovery. However, the historic purposes[62] and practical effect of no-fault provisions[63] in worker's compensation laws are distinguishable from those of the Act. The quid pro quo rationale underlying workers' compensation laws cannot justify the Act. The Act takes much from and gives little to injured children.[64]

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58. *Boyd*, 647 F. Supp. at 793. The court concluded that under Virginia law, "the negligently inflicted and permanent destruction of an individual's capacity to appreciate and enjoy life is a loss [or injury] for which compensatory damages are appropriate." *Id.* at 792 (citing Giant of Virginia, Inc. v. Pigg, 207 Va. 679, 685, 152 S.E.2d 271, 276 (1967)).

59. In 1987, the Virginia General Assembly enacted a $350,000 limit on punitive damages, applicable to all personal injury actions. Section 8.01-38.1 provides in pertinent part:

> In any action accruing on or after July 1, 1988, *including an action for malpractice* . . . the total amount awarded for punitive damages against all defendants found to be liable shall be determined by the trier of fact. In no event shall the total amount awarded for punitive damages exceed $350,000.

VA. CODE ANN. § 8.01-38.1 (Supp. 1987) (emphasis added).

60. Under the Act, a child who survives to the age of 18

> [s]hall be conclusively presumed to have been able to earn income from work from the age of eighteen through the age of sixty-five, if he had not been injured, *in the amount of fifty percent of the average weekly wage* in the Commonwealth of workers in the private, nonfarm sector.

VA. CODE ANN. § 38.2-5009(3) (Supp. 1987) (emphasis added).

61. *See* cases cited *supra* at note 36.

62. *See supra* text accompany notes 37-40.

63. *See supra* text accompanying notes 41-43.

64. It might be suggested that provisions requiring "participating" physicians and hospitals to render obstetrical services to indigent patients provides a sort of societal quid pro quo. *See* VA. CODE ANN. § 38.2-5001 (Supp. 1987).

The better view seems to be that the quid pro quo must involve a direct benefit to the injured patient whose rights are limited by the legislation. *See supra* notes 51-55 and accompanying text.

2. General Due Process Considerations

Even if a quid pro quo is not specifically required, the Act must withstand due process challenges that it is "arbitrary and unreasonable from the standpoint of natural justice."[65] Statutory limitations on medical malpractice damages have survived due process challenges in several cases,[66] including *Boyd v. Bulala.*[67] The *Boyd* court concluded that the right to full recovery in tort is not a fundamental right under the federal or Virginia constitutions.[68] The court held that the cap was "a rational means to achieve the legislative goal of securing the provision of health care services by maintaining the availability of malpractice insurance at affordable rates."[69]

The Act much more severely limits recovery than medical malpractice caps. Under the Act, children with birth-related neurological injuries receive no compensation for devastating noneconomic losses. There is no dispute that freedom from pain and suffering and the capacity to enjoy and appreciate life are invaluable. However, some commentators advance the bizarre argument that because these qualities are priceless, they should also be noncompensable.[70]

In *Fein v. Permanente Medical Group*,[71] the California Supreme Court upheld a $250,000 cap on noneconomic damages applicable to all medical malpractice actions. However, in a vigorous dissent, Chief Justice Bird noted that "[i]n order to provide special relief to negligent health care providers and their insurers, [California's malpractice statute] arbitrarily singles out a few injured patients to be stripped of important and well-established protections against negligently inflicted harm."[72]

No other state has completely abrogated noneconomic damages in medical malpractice cases and, in 1987, the Virginia General Assembly refused to adopt a limit on noneconomic damages which would have affected all tort victims.[73]

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65. New York Cent. R.R. v. White, 243 U.S. 188, 202 (1917).

66. *See, e.g.*, Fein v. Permanente Medical Group, 38 Cal. 3d 137, ___, 695 P.2d 665, 682, 211 Cal. Rptr. 368, 385 ($250,000 limit on noneconomic damages upheld: "[W]e know of no principle of California—or federal—constitutional law which prohibits the Legislature from limiting the recovery of damages in a particular setting."), *appeal dismissed*, 474 U.S. 892 (1985); Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, ____, 404 N.E.2d 585, 598 (1980) ($500,000 limit on total recovery upheld as "proper exercise of the State's police power for the promotion of the peace, safety, health or welfare of the public").

67. 647 F. Supp. 781, 787-88 (W.D. Va. 1986) ($750,000 cap on total recovery not violative of due process).

68. *Id.* at 787 (citing Munn v. Illinois, 94 U.S. 113, 134 (1876)).

69. *Id.*

70. *See, e.g.*, Morris, *Liability for Pain and Suffering*, 59 COLUM. L. REV. 476 (1959); Plant, *Damages for Pain and Suffering*, 19 OHIO ST. L.J. 200 (1958); Zelermyer, *Damages for Pain and Suffering*, 6 SYRACUSE L. REV. 27 (1955).

71. 38 Cal. 3d 137, ___, 695 P.2d 665, 682, 211 Cal. Rptr. 368, 385.

72. *Id.* at ___, 695 P.2d at 687, 211 Cal. Rptr. at 390 (Bird, C.J., dissenting).

73. *See infra* notes 88 & 90 and accompanying text.

The avowed purpose of the Act is to ensure the availability of obstetrical services throughout the state.[74] Proponents assert that the Act was essential to avert medical malpractice insurers' threats to stop covering obstetricians.[75] However, serving up the rights of catastrophically injured infants to pacify medical malpractice insurers is not a reasonable means of achieving any goal.

Due process and equal protection analyses are often inextricably intertwined. The equal protection analyses which follows supports the conclusion that the Act is "arbitrary and unreasonable from the standpoint of natural justice."[76]

C. *Equal Protection Analysis*

1. The Argument for Strict or Intermediate Scrutiny

The equal protection clause of the fourteenth amendment provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws."[77] In essence, this is a command "that all persons similarly situated should be treated alike."[78] The Act denies children who have sustained birth-related neurological injuries the common-law rights and remedies which are available to all other medical malpractice victims, including children who have sustained less severe birth-related injuries.

In *United States v. Carolene Products Co.*,[79] an early equal protection case, the United States Supreme Court noted: "[P]rejudice against discrete and insular minorities may be a special condition, which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry." In *San Antonio Independent School District v. Rodriquez*,[80] the United States Supreme Court referred to "traditional indicia of suspectness." The Court identified as suspect a class "*saddled with such disabilities*, or subjected to such a history of purposeful unequal treatment, *or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.*"[81]

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74. *See supra* note 3.
75. *See supra* note 2.
76. *See New York Cent. R.R.*, 243 U.S. at 202.
77. U.S. CONST. amend. XIV, § 1.
78. City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 439 (1985) (citing Plyer v. Doe, 457 U.S. 202, 216 (1982)).
79. 304 U.S. 144, 153 n.4 (1938).
80. 411 U.S. 1, 28 (1973).
81. *Id.* (emphasis added).

The Act discriminates against the small class of children[82] who will sustain catastrophic birth-related neurological injuries each year in Virginia. The affected children will suffer immutable[83] physical and mental disabilities as a result of brain or spinal cord injuries; they will be "permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living."[84]

The political powerlessness of the children is best illustrated by the fate of comparable legislative proposals which would have affected all tort victims.[85] A legislative report regarding "The Liability Insurance Crisis"[86] included numerous tort reform proposals. The joint subcommittee[87] recommended, *inter alia*, legislation to limit noneconomic damages in all tort cases[88] and legislation to mandate periodic, rather than lump sum, payments of awards for future damages in excess of $250,000.[89] Neither of these proposals was as harsh as the Act's provisions which completely

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82. *See supra* note 13 and accompanying text.

83. The existence of immutable physical characteristics which distinguish certain classes has triggered heightened judicial scrutiny in equal protection challenges. *See, e.g.*, Frontiero v. Richardson, 411 U.S. 677, 686 (1973) (plurality opinion) (invalidating statute which discriminated on the basis of sex, "an immutable characteristic").

However, the significance of immutable personal characteristics in identifying suspect classifications has been challenged.

> [C]lassifications based on physical disability and intelligence are typically accepted as legitimate, even by judges and commentators who assert that immutability is relevant. The explanation, when one is given, is that *those* characteristics (unlike the one the commentator is trying to render suspect) are often relevant to legitimate purposes. At that point, there's not much left of the immutability theory, is there?

J. ELY, DEMOCRACY AND DISTRUST 150 (1980) (footnote omitted) (emphasis in original).

84. VA. CODE ANN. § 38.2-5001 (Supp. 1987).

85. One commentator has noted that malpractice victims are not protected from unfair reform by normal political processes.

> [I]t seems highly unlikely that many individuals actively contemplate the relatively remote risk that they may become malpractice victims. The number of actual victims is not large enough to generate widespread public concern for personal safety, nor is notice of the restrictive legislation sufficiently prominent to draw the attention of individuals who may rationally assume that they continue to possess an effective judicial remedy.

Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143, 186 (1981) (citations omitted).

When the Act was passed the affected children were unborn. In addition, most people do not consider the possibility of having a catastrophically injured child. Therefore, no one was in a position to take a personal stand against the Act when it was proposed.

86. THE LIABILITY INSURANCE CRISIS AND THE NEED FOR TORT REFORM, *supra* note 2.

87. The official title of the joint subcommittee was the "Joint Subcommittee Studying the Liability Insurance Crisis and the Need for Tort Reform."

88. THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 5; *see* S.B. 402, Va. Gen. Assembly, 1987 Sess.

89. THE LIABILITY INSURANCE CRISIS *supra* note 2, at 5; *see* S.B. 411, Va. Gen. Assembly, 1987 Sess.

eliminate noneconomic damages and limit recovery to reimbursement for actually incurred expenses. However, neither measure was enacted.[90]

In addition to the Act, which was *not* recommended by the joint subcommittee, several other measures were passed which limit obstetricians' liability. The joint subcommittee's specific proposals to alleviate the "obstetrical malpractice crisis" were enacted. In accordance with the joint subcommittee's recommendations, the statute of limitations for medical malpractice actions no longer is tolled until injured children reach the age of majority.[91]

Under the amendment, minor children have two years to file a claim unless they were less than eight years old at the time of the occurrence. In that case, they have until their tenth birthday to file suit. A "good samaritan" provision also was enacted to grant immunity from civil liability for malpractice when free obstetrical services are rendered.[92]

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90. Senate Bill 411, which required periodic payment for judgments of future damages in excess of $250,000, apparently died after referral to the Committee for Courts of Justice. *See* 1 SENATE J., 11 (1987); 2 SENATE J. 43 app. (1987).

Senate Bill 402, which proposed a limitation of noneconomic damages of $250,000 or three times the amount of economic damages, was also referred to the Committee for Courts of Justice. *See* SENATE J., 10, (1987).

Senate Bill 402 was the subject of vigorous debate during a public hearing before the Committee for Courts of Justice. Three hundred people attended the hearing and clearly expressed their opposition to the limitation on noneconomic damages. *See* Richmond News Leader, Jan. 23, 1987, at 4, col. 1. Representatives of the Virginia AFL-CIO, the Virginia Citizens Consumer Council, the United Methodist Church, and the Virginia Poverty Law Center protested the proposed limitation on damages for "pain and suffering." *Id.* at 4, col. 2. Attorney General Mary Sue Terry also appeared to assert her position that Virginia citizens should not be penalized for high insurance losses in other states. *Id.* at 4, col. 5.

Senate Bill 402 was radically amended in the House of Delegates and subsequently enacted as a $350,000 limit on punitive damages. *See* 1 SENATE J., 801-02; *see also supra* note 59.

91. [A]ny cause of action accruing on or after July 1, 1987, *on behalf of a person who was a minor* at the time the cause of action accrued *for personal injury or death against a health care provider . . . shall be commenced within two years* of the date of the last act or omission giving rise to the cause of action *except that if the minor was less than eight years of age* at the time of the occurrence of the malpractice, *he shall have until his tenth birthday to commence an action.*

VA. CODE ANN. § 8.01-243.1 (Supp. 1987) (emphasis added).

The shorter statute of limitations was recommended "in order to provide more predictability to the loss assessment process, reduce the risk of providing coverage for these losses and thereby, make the necessary liability insurance coverage more widely available at a reasonable cost" THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 5.

92. *See* VA. CODE ANN. § 8.01-225.

According to testimony heard by the joint subcommittee, in order to reduce liability exposure, many physicians and hospitals throughout Virginia were refusing to participate in the delivery of indigent women, who are considered high-risk patients because of poor prenatal care. THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 14.

Whether by design or coincidence, it appears that the good samaritan provision and the Act obviate Medicaid budget problems. In order to obtain matching federal funds, the State

The limitation on punitive damages in all personal injury actions, which was enacted in 1987, will also decrease liability for obstetrical malpractice.[93] By previous legislation, the General Assembly had authorized a joint underwriting association to alleviate availability problems.[94] However, the joint subcommittee questioned the efficacy of Virginia's Joint Underwriting Association which was activated on December 3, 1986.[95] These measures combined are sufficient to alleviate the "obstetrical malpractice crisis" without usurping the due process and equal protection rights of injured children.

The Act denies affected children the recourse that every other medical malpractice victim has to recover in tort from the physicians or hospitals which have caused disabilities. Arguably, the Act creates a suspect or quasi-suspect classification which should be reviewed with strict or intermediate scrutiny.[96] However, the United States Supreme Court has recognized only race, national origin, alienage, gender, and illegitimacy as suspect or quasi-suspect classifications.[97]

Medicaid Program must reimburse participating providers at rates sufficient to ensure availability of the covered services to recipients. A survey of Northern Virginia physicians revealed that less than half would accept Medicaid patients because the $350 Medicaid reimbursement rate is "far short" of the $1,232 fee which would be reasonable. Wash. Post, Feb. 17, 1987, at B5, col. 5.

The Act requires that "participating" physicians and hospitals provide obstetrical care to indigent patients. *See* VA. CODE ANN. § 38.2-5001 (Supp. 1987). In conjunction with the good samaritan provision, the Act ensures that Medicaid access requirements can be met without budget increases.

93. *See* VA. CODE ANN. § 8.01-38.1 (Supp. 1987).

94. *See Id.* § 38.2-2800 to -2814 (Repl. Vol. 1986 & Supp. 1987).

95. THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 13.

96. Statutory provisions which create distinctions based on suspect classifications invoke strict scrutiny. Under strict scrutiny analysis, the statute must further a compelling state interest. Loving v. Virginia, 388 U.S. 1, 11 (1967). Statutes rarely survive strict scrutiny. The test has been characterized as "strict in theory and fatal in fact." *See* Gunther, *Foreward: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972).

Quasi-suspect classifications such as gender and illegitimacy are subjected to intermediate scrutiny. *See, e.g.*, Trimble v. Gordon, 430 U.S. 762 (1977) (illegitimacy); Craig v. Boren, 429 U.S. 190 (1976) (gender-based discrimination). Intermediate scrutiny requires a showing that the classification is reasonable and supported by "some ground of difference having a fair and substantial relation to the object of the legislation." Reed v. Reed, 404 U.S. 71, 75-76 (1977) (quoting Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920)).

Intermediate or means-focused scrutiny has been the basis for some state court decisions that medical malpractice caps violate equal protection. *See, e.g.*, Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976) (the court did not specifically label its scrutiny intermediate; however, it apparently applied intermediate scrutiny); *see also* Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) (statute violated state constitution's equal protection guarantee).

97. *Trimble*, 430 U.S. 762 (illegitimacy); *Craig*, 429 U.S. 190 (1976) (gender); Graham v. Richardson, 403 U.S. 365 (1971) (alienage); *see* Brown v. Board of Educ., 347 U.S. 483 (1954) (race); Korematsu v. United States, 323 U.S. 214 (1944) (national origin).

2. Rational Basis Analysis

a. The Mere Rationality Standard

Several courts have held that statutory limitations on medical malpractice damages violate equal protection.[98] However, in accordance with other authorities,[99] the court in *Boyd v. Bulala*[100] held that Virginia's limitation on damages did not violate equal protection. The statutory cap survived the most deferential rational basis analysis.[101] The *Boyd* court concluded that Virginia's cap on damages in all medical malpractice actions neither created a suspect classification nor infringed upon a fundamental right.[102] Despite the similar purposes of the statute in *Boyd* and

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98. *See, e.g.*, Carson v. Maurer, 120 N.H. 925, ___, 424 A.2d 825, 836-37 (1980) ($250,000 cap on noneconomic damages distinguishes between medical malpractice victims with noneconomic losses that exceed $250,000 and those with less egregious losses, as well as between medical malpractice victims and other tort victims); Arneson v. Olson, 270 N.W.2d 125, 136 (N.D. 1978) ($300,000 limitation on medical malpractice recovery violative of equal protection in the absence of finding of state availability or cost crisis); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, ___, 355 N.E.2d 903, 911-12 (Ct. C.P. 1976) ("there is no crisis situation, short of civil insurrection, sufficient to deprive, water down or make less valuable the right to seek redress of grievances, to a dollar amount fully compensating one for his loss, though [sic] the medium of a free and unfettered jury trial"); *see also* Wright v. Central Du Page Hosp. Ass'n, 63 Ill. 2d 313, ___, 347 N.E.2d 736, 743 (1976) ("to the extent that recovery is permitted or denied on an arbitrary basis a special privilege is granted in violation of the Illinois Constitution"); Baptist Hosp. v. Baber, 672 S.W.2d 296, 298 (Tex. Ct. App. 1984) ($500,000 limitation on hospitals' malpractice liability unconstitutional as violation of equal protection), *writ of error revoked*, 714 S.W.2d 310 (Tex. 1986).

99. Fein v. Permanente Medical Group, 38 Cal. 3d 137, ___, 695 P.2d 665, 683, 211 Cal. Rptr. 368, 386 ($250,000 limit on recovery of noneconomic losses in medical malpractice cases not violative of equal protection), *appeal dismissed*, 474 U.S. 892 (1985); Johnson v. St. Vincent Hosp., Inc., 273 Ind. 374, ___, 404 N.E.2d 585, 601 (1980) ($500,000 limit on recovery valid; "rational justification for the difference in treatment accorded the various groups identified within the rationality of the program launched by the Legislature to protect vital societal interests"); Prendergast v. Nelson, 199 Neb. 97, ___, 256 N.W.2d 657, 669 (1977) (plurality opinion) ($500,000 limit on total recovery valid; court "will not set aside a statutory discrimination if any state of facts exists to justify it").

100. 647 F. Supp. 781, 788 (W.D. Va. 1986).

101. Rational basis analysis often results in an automatic validation of legislation. "[A] statute will be sustained if the legislature could have reasonably concluded that the challenged classification would promote a legitimate state purpose." Exxon Corp. v. Eagerton, 462 U.S. 176, 196 (1983). The actual efficacy of the legislation is not questioned in mere rational basis analysis. The courts will defer to legislative judgment so long as the legislature "*could rationally have decided*" that the statute would further a legitimate purpose. Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456, 466 (1981).

102. 647 F. Supp. at 787. However, in Weber v. Aetna Casualty & Sur. Co., 406 U.S. 164 (1972), the United States Supreme Court held that a Louisiana statute which denied illegitimate children the right to recover workers' compensation benefits for the death of their natural father violated the equal protection clause of the fourteenth amendment. The *Weber* majority identified two essential questions in equal protection challenges: "*What legitimate state interest does the classification promote? What fundamental personal rights might the classification endanger?*" *Id.* at 173 (emphasis added).

the Act, the Act should not be reviewed under "the liberal standard of review normally accorded economic regulations under equal protection . . . analys[i]s."[103] Since the children affected by the Act meet the traditional definition of a suspect class, they should be protected by a more exacting standard of review than mere rational basis analysis.

b. The Argument for Heightened Rational Basis Analysis

In *City of Cleburne v. City of Cleburne Living Center, Inc.*,[104] the United States Supreme Court refused to recognize "the large and amorphous class of the mentally retarded" as quasi-suspect. The Court's reluctance to treat the class as quasi-suspect was tempered by its reaffirmation of the equal protection requirement that "legislation that distinguishes between the mentally retarded and others must be rationally related to a legitimate government purpose."[105] In fact, the Court's assurance that the mentally retarded would not be left "entirely unprotected from invidious discrimination"[106] was substantiated by the holding that the statute in question, as applied, was an unconstitutional violation of equal protection. Concurring, Justice Marshall, joined by Justices Brennan and Blackmun, criticized the majority's analysis in *City of Cleburne* and refused to "accept the Court's disclaimer that no 'more exacting standard' than ordinary rational-basis review [was] being applied."[107] In his concurring opinion, Justice Stevens, joined by Chief Justice Burger, rejected the notion that equal protection decisions are reached by applying varying levels of scrutiny.[108]

Illegitimacy has been recognized as a quasi-suspect classification which requires heightened scrutiny. *See supra* notes 96-97. However, the *Weber* Court's analysis suggests that discrimination against illegitimate children was not the only basis for heightened scrutiny. The equal protection standard formulated in *Weber* implies that the Court considered the children's right to recovery a "fundamental personal right." *See Weber*, 406 U.S. at 182-83 (Rehnquist, J., dissenting).

103. *Boyd*, 647 F. Supp. at 787. The prohibition against discrimination contained in article I, section 11 of the Virginia Constitution is applicable only to classifications based on religion, race, color, sex, or national origin. *See id.* at 786 (citing Archer v. Mayes, 213 Va. 633, 638, 194 S.E.2d 707, 711 (1973)).

The *Boyd* court concluded that article IV, section 14 of the Virginia Constitution which prohibits special legislation does not provide greater protection than the equal protection clause of the fourteenth amendment to the United States Constitution. *Id.* (citing Bray v. County Bd. of Arlington County, 195 Va. 31, 35, 77 S.E.2d 479, 483 (1953)).

The court found that the medical malpractice cap was "clearly a rational means to achieve the legislative goal of securing the provision of health services by maintaining the availability of malpractice insurance at affordable rates." *Id.* at 787.

104. 473 U.S. 432, 445-46 (1985).

105. *Id.* at 446.

106. *Id.*

107. *Id.* at 456 (Marshall, J., concurring in part and dissenting in part).

108. *Id.* at 451-52 (Stevens, J., concurring). According to Justice Stevens,

> [Rationality] includes a requirement that an impartial lawmaker could logically be-

There are salient distinctions between the mentally retarded class in *City of Cleburne* and the children affected by the Act. Primarily, mental retardation is not one of the disabilities enumerated in the Act. The children may or may not suffer from mental retardation in addition to the profound mental and physical disabilities specifically enumerated in the Act.[109] In addition, in contrast to "the large and amorphous class of the mentally retarded,"[110] the Act applies to a carefully defined minority of infants whose catastrophic injuries pose the greatest liability risks in the obstetrical field.

Regardless of whether the children are labeled as a suspect or quasi-suspect class, the Act should at least be reviewed with heightened scrutiny, such as that applied in *City of Cleburne*. "The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws whenever he receives an injury."[111] Justice demands that these children not be arbitrarily denied the right to the actions and remedies available to every other medical malpractice victim. Proponents of the Act may argue it was necessary to remove injured children from the tort system in order to ensure the availability of obstetrical services in Virginia.[112]

The availability of medical malpractice coverage is unquestionably related to physicians' willingness to render medical services. However, the availability of insurance does not guarantee that a physician will not be exposed to substantial personal liability for negligently inflicted injuries. For instance, the *Boyd* jury awarded compensatory and punitive damages totalling $8,300,000. By statute, Virginia physicians may contract for insurance coverage of punitive damages.[113] However, it would be rare for a physician to request or obtain sufficient coverage for the amount of dam-

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> lieve that the classification would serve a legitimate public purpose that transcends the harm to members of the disadvantaged class. Thus, the word "rational" . . . includes elements of legitimacy and neutrality that must always characterize the performance of the sovereign's duty to govern impartially.

Id. at 452 (Stevens, J., concurring) (footnote omitted).

109. Although the Act purports to apply to brain *or* spinal cord injuries, the inclusion of aphasia necessarily implies that all of the affected children have sustained brain damage. *See* VA. CODE. ANN. § 38.2-5001 (Supp. 1987). Aphasia is defined as "impaired or absent communication by speech, writing, or signs, *due to dysfunction of brain centers in the dominant hemisphere.*" STEDMAN'S MEDICAL DICTIONARY 96 (5th unabr. lawyers ed. 1982) (emphasis added).

The presence of brain damage does not necessarily mean that any or all of the affected children will be mentally retarded. However, it may be reasonable to assume that many of the children who suffer injuries of the nature and severity defined in the Act will also be mentally retarded.

110. *City of Cleburne*, 473 U.S. at 445.

111. Marbury v. Madison, 1 5 U.S. (1 Cranch) 137, 163 (1803).

112. *See supra* notes 2-3 and accompanying text.

113. VA. CODE ANN. § 38.2-227 (Repl. Vol. 1986).

ages awarded in *Boyd*.[114] In the absence of a bad faith refusal to settle for the policy limits, medical malpractice insurance carriers are not liable for awards in excess of the policy limits.[115]

Malpractice insurance carriers can control their risks by limiting policy coverage and negotiating settlements in good faith. By contrast, physicians face limitless exposure in cases involving extraordinary damage awards. In response to this exposure, the Act was drafted in accordance with the specifications of the Virginia Insurance Reciprocal, a state-based physicians' group.[116] It is physicians, then, particularly those who render substandard care, who primarily benefit from the Act.

The Act will undoubtedly make obstetrical care more attractive to physicians. In fact, by conferring a special immunity from tort liability for the most serious obstetrical injuries, the Act may cause an increase in the number of physicians who practice obstetrics. The Act's apparent goal is to ensure the availability of obstetrical care,[117] but the goal must be to ensure the availability of *competent* obstetricians. Insulating negligent obstetricians from tort liability is not rationally related to the legitimate goal of ensuring the availability of competent obstetricians.

IV. Policy Considerations

The tort system has two generally recognized goals—compensation, which is intended "to make the plaintiff whole,"[118] and deterrence. The Act denies compensation for noneconomic losses and provides only limited compensation for economic losses.[119] The Act also thwarts the tort system's deterrence goal.[120]

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114. In 1983, only 41% of all doctors carried malpractice coverage of $1,000,000 or more. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability*, 35 Syracuse L. Rev. 939, 954-55 n.77 (1984) (citing Holoweiko, *Malpractice Premiums: Hefty Today, Huge Tomorrow*, Med. Econ., Nov. 28, 1983, at 87, 96)).

After *Boyd*, Dr. Ronald K. Davis, a leader in the Medical Society of Virginia, commented: "Nobody knows how much insurance we need . . . . We can't get $5 million; the insurance companies won't write it." *See Debate on Malpractice Award Cap is Revived, supra* note 4, at A2, col. 4.

115. *See* Aetna Casualty & Sur. Co. v. Price, 206 Va. 749, 146 S.E.2d 220 (1966); *see also* Comment, *Insurers' Liability for Excess Judgments in Virginia: Negligence or Bad Faith?*, 15 U. Rich. L. Rev. 153 (1980).

116. *See supra* note 2.

117. *See supra* note 3.

118. Klaven, *The Jury, the Law, and the Personal Damage Award*, 19 Ohio St. L.J. 158, 160 (1958).

119. *See supra* notes 23-28 and accompanying text.

120. It is not possible to obtain punitive damages under the Act. However, if a claimant can show, by clear and convincing evidence, that a health care provider willfully caused or intended to cause a birth-related meurological injury, a traditional common-law medical malpractice action can be filed. *See supra* note 16.

There is much debate about the correlation between actual occurrences of professional negligence and the increasing number of malpractice claims filed.[121] However, there is evidence that the frequency of medical malpractice warrants concern. A widely-cited California study indicates that approximately one percent of hospital admissions results in injuries due to negligence. "Most physicians may well act in their patient's best interests most of the time, even without the threat of liability, nevertheless the incidence of medical negligence is too common to be ignored."[122]

Under the Act, awards for covered injuries are made by the Virginia Industrial Commission,[123] and paid from the Birth-Related Neurological Injury Compensation Fund,[124] without regard to fault. Participating physicians and hospitals pay uniform, annual assessments to the Fund.[125] Negligence affects neither the provider's liability for any given claim, nor his assessment rate.[126] In fact, there is no guarantee that any definitive determination regarding a provider's fault will be made at all.[127]

In 1987, the Virginia General Assembly enacted a $350,000 limit on punitive damages, applicable to all tort actions. VA. CODE ANN. § 8.01-38.1 (Supp. 1987).

121. Physicians argue that statistically "the doctor most likely to be sued is a middle-aged physician at the height of his or her career" who necessarily attempts innovative, high risk procedures on gravely ill patients. Browning, *Doctors and Lawyers Face Off*, A.B.A. J., July 1, 1986, at 38, 41.

By contrast, lawyers point to statistics which "show that most malpractice actions arise from a series of multiple mistakes made by a small percentage of doctors." *Id.* at 40. For example, reportedly 10 Wisconsin physicians accounted for $8,000,000 of the medical malpractice judgments in the state during a 10 year period. *Id.* at 41.

122. P. DANZON, *supra* note 38, at 221-22. Even on a purely economic level, quality control is essential. Danzon estimates that negligent injury costs are several times higher than malpractice insurance premium costs. *Id.* at 222.

123. *See supra* note 20.

124. VA. CODE ANN. § 38.2-5015 (Supp. 1987).

125. *Id.* §§ 38.2-5019 to -5020.

126. The Act can be analogized to partial no-fault systems which have been proposed by some commentators. *See supra* note 43. Under such no-fault systems, if premiums are not experience-rated, the incentive for injury avoidance is reduced. P. DANZON, *supra* note 38, at 218. However, when premiums are experience-rated, physicians may avoid high-risk patients and high-risk procedures, or charge higher fees to cover the higher liability risk. *Id.*

127. The Act requires that a copy of the claimant's petition regarding claims against a participating physician or hospital be provided for the Board of Medicine and Department of Health. These agencies are directed to evaluate the quality of care and impose sanctions if appropriate. VA. CODE ANN. § 38.2-5004(2) (Supp. 1987).

Statistics regarding the number of cases heard by the Virginia Board of Medicine during 1987 were obtained. Computerized information is available for cases heard by the Board since July 1986. However, no records are kept on the number of "complaints" which result in no action. Preliminary investigations of "serious" complaints take from six months to one year.

In 1987, the Board of Medicine heard 378 cases. No violations were found in 232 cases; violations were found in 106 cases, and 40 cases were "undetermined." Of the complaints significant enough to be heard by the Board, only 28% resulted in findings of violations.

A sample of 88 violations acted on by the Board in 1987 revealed only eight cases involv-

The drafters may have intended to replace the deterrent effect of the tort system by providing for claim reviews by the Board of Medicine and Department of Health.[128] However, physicians,[129] as well as lawyers,[130] recognize the ineffectiveness of disciplinary mechanisms within the medical profession. Neither the economic[131] nor moral deterrents[132] associated with tort liability are replaced by the Act. Virginia already has an exceptionally high infant mortality rate.[133] The possibility of increased obstetrical malpractice undercuts the purported societal benefits of the Act.

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ing "standard of care" violations. The following sanctions were imposed: reprimand or warning (2); probation (4); revocation of license (1); and voluntary surrender of license (1). Additionally, two cases were classified as "inability to practice"; the sanctions were probation in one case and refusal to renew the physician's license in the other.

Approximately 41% of the 88 sample violation cases from 1987 involved personal drug use, excessive prescribing, indiscriminate dispensing, incomplete drug records, or the catch-all category "drug related." The second largest group of violations was unprofessional conduct (23%). An additional 21 cases involved unlicensed practice, fraud, criminal conviction, sexual abuse, and inappropriate advertising.

128. It may be asserted that the risk of sanctions, including revocation of professional licenses, will serve as an adequate deterrent for malpractice. *See* VA. CODE ANN. § 38.2-5004(2) (Supp. 1987).

129. President-elect of the American Medical Society, Dr. William S. Hotchkiss, a surgeon from Chesapeake, Virginia, acknowledged the difficulties doctors have policing their own ranks. He also criticized current procedures for removing imcompetent physicians from practice.

Dr. Hotchkiss recommended legislation to provide increased authority and immunity for disciplinary board members and noted that state boards are "terribly handicapped" by the threat of litigation. Dr. Hotchkiss also advocated using medical licensing fees to fund proper investigations. *See* Richmond News Leader, Aug. 7, 1986, at A8, col. 2.

130. Of the 450,000 licensed physicians in the United States, only 1,400 were disciplined by state medical licensing boards in 1984. *See* Browning, *supra* note 122, at 39. The Federation of State Medical Boards of the United States reports that actually, 1,687 disciplinary actions were taken in 1984. Accurate statistics were not available for preceding years. *Id.* at 41.

Various quality control systems, including medical licensure and hospital accreditation, state boards of quality assurance, and hospital oversight committees, could serve as alternatives to the tort system's deterrent function. However, "these systems provide only gross filters, designed to eliminate the seriously incompetent physician . . . and to the extent that they rely on peer review, they lack strong incentives to take disciplinary action." *See* P. DANZON, *supra* note 38, at 222.

131. *See generally*, Landes & Posner, *The Positive Economic Theory of Tort Law*, 15 GA. L. REV. 851 (1981).

132. One commentator concludes that the essential deterrent value of the tort liability system with respect to malpractice is psychological. Bell concludes that the real deterrent is "the declaration of wrongfulness and the social stigma that goes with that." *See* Bell, *supra* note 115, at 992. The no-fault compensation system prescribed by the Act precludes public adjudication of fault. *See supra* notes 123-128 and accompanying text.

133. *See* Richmond Times-Dispatch, Feb. 5, 1988, at B6, col. 1. Virginia's infant mortality rate is higher than that of 21 other states. The Statewide Council on Infant Mortality urges that Virginia must reduce its high infant mortality rate, which rivals that of Third World countries. *Id.* at B6, col. 1.

revealed that "Virginia occupies a preferred position among other states with respect to loss experience. In the medical malpractice area, Virginia has the third best loss ratio in the country."[134] Virginia's Attorney General, Mary Sue Terry, has expressed concern that Virginia citizens are subsidizing insureds in other states with bad loss experiences.[135] The joint subcommittee's report also noted that loss claims in insurance company reports can be exaggerated.[136] The General Assembly's abrogation of the rights of children who sustain birth-related neurological injuries therefore creates a dangerous precedent. Insurance companies may fabricate new crises in the future and look to Virginia for additional subsidies.

V. CONCLUSION

John Ely has observed, "[c]onstitutional law appropriately exists for those situations where representative government cannot be trusted, not those where we know it can."[137] The rights of the tiny minority of infants who will sustain birth-related neurological injuries, as defined by the Act, have been eviscerated by the machinery of majoritarian politics. The constitutional guarantees of due process and equal protection must be invoked to protect these children.

Although the Supreme Court has not definitively established a quid pro quo requirement, it is submitted that where a legislature totally abrogates a common-law cause of action, the statute's validity should rest upon a quid pro quo finding. Contrary to workers' compensation statutes which have withstood due process challenges, the Act cannot meet the quid pro quo requirement. The differences between the historic purposes and practical effect of the workers' compensation laws and those of the Act belie the argument that the quid pro quo justification for workers' compensation can support the Act.

The children affected by the Act satisfy traditional indicia of a suspect classification. The children's political powerlessness and disabilities are evident. Since the Act denies an important right to children who arguably constitute a suspect class, heightened scrutiny should be invoked to protect the children from the arbitrary and unreasonable actions of a majoritarian legislature. Moreover, the Act violates equal protection because it insulates negligent physicians, and their insurers, from tort liability at the expense of catastrophically injured children. Therefore, the Act is not rationally related to the legitimate goal of ensuring the availability of *competent* obstetricians.

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134. *See* THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 11.

135. *Id*; *see also supra* note 90.

136. Critics of the insurance industry contend that the companies can easily manipulate their records. According to the National Consumer Organization, insurance profit, after tax, for 1985 was five billion dollars. *See* THE LIABILITY INSURANCE CRISIS, *supra* note 2, at 8.at 8.

137. *See* J. ELY, *supra* note 83, at 183.

Finally, the Act threatens the welfare of other Virginia citizens. The possibility of increased obstetrical malpractice, resulting from tort immunity, is a risk the Commonwealth cannot afford. Moreover, the legislature's willingness to sacrifice these childrens' rights increases the probability that similar sacrifices will be expected of other groups when new "liability crises" arise.

Jane R. Ward