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MEDICAL MALPRACTICE LAW

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I. INTRODUCTION

With President George W. Bush's promise to continue working toward tort reform, medical malpractice issues are once again garnering media and voter attention.[1] This article examines recent judicial decisions and statutory amendments affecting patients and health care providers in the commonwealth in the context of medical malpractice law.

II. THE MEDICAL MALPRACTICE ACT

Following the medical malpractice crisis of the mid-1970s, the General Assembly passed Virginia's Medical Malpractice Act ("the Act") in an effort to contain rising costs and protect health care providers from increasing malpractice insurance premiums.[2] The Act provides a pre-trial screening tool, in the form of a Medi-

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1. Press Release, The White House, President Discusses Comprehensive Immigration Reform (June 1, 2006), *available at* http://www.whitehouse.gov/news/releases/2006/06/print/20060601.html.

2. *See* INTERIM REPORT OF THE JOINT SUBCOMM. STUDYING VA. MED. MALPRACTICE LAWS, H. Doc. No. 21 (1985).

cal Malpractice Review Panel,[3] and a cap on damage recoveries.[4] For injuries occurring between July 1, 2006 and June 30, 2007, the cap stands at $1.85 million.[5] While the cap has increased annually by $50,000 from its inception, the Act states that it shall increase by $75,000 in July of 2007 and 2008, with the 2008 increase being the final increase.[6]

A. *Definitions*

Virginia Code section 8.01-581.1 defines the individuals and entities that are considered "health care providers" for purposes of the Act.[7] In 2006, the General Assembly added licensed marriage and family therapists to the definition of "health care provider."[8] Podiatrists were added to the definition of "physician" under the provision of the Act granting immunity to physicians for failing to review laboratory tests in certain situations.[9]

In addition to those changes made to Virginia Code section 8.01-581.1, the General Assembly expanded the scope of practice of various health care providers through revisions to other sections of the Code. Physician assistants may now perform examinations on those persons employed to drive school buses,[10] share child immunization information for the purpose of protecting the public health,[11] conduct certain prenatal tests,[12] determine those activities in which nursing home patients and assisted living facility residents may participate,[13] be compensated for performing follow-up infant audiological examinations under the Board of Medicine's plan for medical assistance services,[14] and sign medi-

3. *See* VA. CODE ANN. § 8.01-581.2 (Cum. Supp. 2006).

4. *Id.* § 8.01-581.15 (Cum. Supp. 2006).

5. *See id.*

6. *Id.*

7. *Id.* § 8.01-581.1 (Cum. Supp. 2006).

8. Act of Apr. 5, 2006, ch. 638, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. § 8.01-581.1 (Cum Supp. 2006)).

9. Act of Apr. 19, 2006, ch. 877, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. § 8.01-581.18 (Cum. Supp. 2006)).

10. VA. CODE ANN. § 22.1-178(G) (Repl. Vol. 2006).

11. *Id.* § 32.1-46(E) (Cum. Supp. 2006).

12. *Id.* § 32.1-60 (Cum. Supp. 2006).

13. *Id.* § 32.1-138(A)(13)–(15) (Cum. Supp. 2006) (discussing the rights of nursing home patients); *id.* § 63.2-1808(A)(18) (Cum. Supp. 2006) (discussing the rights and responsibilities of residents of assisted living facilities).

14. *Id.* § 32.1-325(A)(21) (Cum. Supp. 2006).

cal statements for those individuals wishing to cancel their health spa contract due to medical reasons.[15] After July 1, 2006, nurse practitioners may prescribe Schedules II through VI controlled substances.[16] Finally, individuals who have completed a training program in dialysis patient care may now engage in provisional practice to gain experience prior to receipt of their certification requirements.[17] To provide patient care, the dialysis technician-in-training must be under the direct and immediate supervision of a licensed dialysis technician and must be identified as a "trainee."[18]

B. *Privileged Communications*[19]

In *HCA Health Services of Virginia, Inc. v. Levin*,[20] the Supreme Court of Virginia affirmed the purpose underlying Virginia Code section 8.01-581.17, stating:

> The obvious legislative intent is to promote open and frank discussion during the peer review process among health care providers in furtherance of the overall goal of improvement of the health care system. If peer review information were not confidential, there would be little incentive to participate in the process.[21]

This statute provides that certain "proceedings, minutes, records, and reports" of medical staff and review committees are privileged communications, not to be disclosed or obtained in discovery unless the court orders such disclosure after a hearing and a showing of extraordinary circumstances by the party seeking these communications.[22] In 2004, the General Assembly added "[o]ral communications regarding a specific medical incident" as a type of communication protected under the statute.[23] The pro-

15. *Id.* § 59.1-297(A)(3) (Repl. Vol. 2006).

16. *Id.* § 54.1-2957.01(A) (Supp. 2006).

17. *Id.* § 54.1-2729.3(B) (Supp. 2006).

18. *Id.* § 54.1-3408(R) (Supp. 2006).

19. For a focused discussion of the discoverability of healthcare provider policies, procedures, and incident reports, see Michael L. Goodman, Kathleen M. McCauley & Suzanne S. Duvall, *Annual Survey of Virginia Law: Discovery Divide: Virginia Code Section 8.01-581's Quality Assurance Privilege and Its Protection of Healthcare Provider Policies and Incident Reports*, 39 U. RICH. L. REV. 61 (2004).

20. 260 Va. 215, 530 S.E.2d 417 (2000).

21. *Id.* at 221, 530 S.E.2d at 420.

22. VA. CODE ANN. § 8.01-581.17(B) (Cum. Supp. 2006).

23. Act of Mar. 31, 2004, ch. 250, 2004 Va. Acts 372 (codified as amended at VA. CODE

tected oral communications are limited to those made within twenty-four hours after the medical incident at issue.[24] At the General Assembly's most recent session, another category of documents was added to the statute: "[r]eports produced solely for purposes of self-assessment of compliance with requirements or standards of the Joint Commission on Accreditation of Healthcare Organizations" ("JCAHO").[25] By encouraging facilities to report medical errors and, thereby, identify those areas ripe for change, one of JCAHO's initiatives is to focus hospital accreditation standards toward the overall goal of improving patient safety.[26] The General Assembly's inclusion of JCAHO reports in those documents protected from discovery under Virginia Code section 8.01-581.17 supports not only the goals of JCAHO,[27] but also the purpose of the privilege statute as set forth by the Supreme Court of Virginia in *Levin*.[28]

C. *Physician Immunity*

In the last year, the statute dealing with physician immunity for laboratory results has sparked the interest of both the Supreme Court of Virginia and the General Assembly. On June 9, 2005, the Supreme Court of Virginia issued its opinion in *Auer v. Miller*,[29] affirming the trial court's grant of immunity to Edward Miller, M.D., under Virginia Code section 8.01-581.18.[30] The plaintiff in *Auer* was admitted to the hospital by Lenox Baker, M.D., his cardiovascular surgeon, for removal and replacement of Auer's aortic valve.[31] On the day of the surgery, Dr. Baker requested a culture and sensitivity test ("C & S") of Auer's native aortic valve.[32] Neither Dr. Baker nor Dr. Miller, Auer's cardiolo-

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ANN. § 8.01-581.17(B) (Cum. Supp. 2006)).

24. *See* VA. CODE ANN. § 8.01-581.17(B) (Cum. Supp. 2006).

25. Act of Apr. 5, 2006, ch. 678, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. § 8.01-581.17(I) (Cum. Supp. 2006)).

26. *See* BARRY R. FURROW ET AL., HEALTH LAW 183–84 (5th ed. 2004).

27. *Id.*

28. *See* HCA Health Servs. of Va., Inc. v. Levin, 260 Va. 215, 221, 530 S.E.2d 417, 420 (2000).

29. 270 Va. 172, 613 S.E.2d 421 (2005), *overruled by* Oraee v. Breeding, 270 Va. 488, 621 S.E.2d 48 (2005).

30. *Auer*, 270 Va. at 177, 613 S.E.2d at 424.

31. *Id.* at 175, 613 S.E.2d at 422–23.

32. *Id.* at 175–76, 613 S.E.2d at 423.

gist, reviewed the C & S.[33] The C & S revealed the presence of staphylococcus, and, indeed, Auer later developed an infection in his prosthetic valve.[34] He subsequently was diagnosed with endocarditis and died shortly thereafter.[35]

The court's decision was based upon the "clear and unambiguous" language of Virginia Code section 8.01-581.18(B).[36] At the time of the court's ruling, that subsection provided for the immunity of:

> Any physician . . . from civil liability for any failure to review, or to take any action in response to the receipt of, any report of the results of any laboratory test or other examination of the physical or mental condition of any person, which test or examination such physician neither requested nor authorized in writing, unless such report is provided directly to the physician by the person so examined or tested with a request for consultation . . . .[37]

The court concluded, based upon a plain reading of this statute, that Dr. Miller was entitled to immunity, for he did not request or authorize the C & S, nor was it provided to him with a request for consultation.[38]

The court's "plain reading" of Virginia Code section 8.01-581.18(B) was short-lived, for, in *Oraee v. Breeding*,[39] decided less than five months later, the Supreme Court of Virginia overruled its decision in *Auer*.[40] Dr. Oraee was called in for a neurology consultation when plaintiff's decedent was presented to the emergency room for complaints of facial drooping.[41] Dr. Oraee confirmed through MRI that the decedent had suffered multiple strokes, the causes of which were unknown, but Dr. Oraee confirmed a potential diagnosis of a clotting disorder perhaps caused by antiphospholipid antibody syndrome.[42] Dr. Oraee requested a rheumatology consultation by Dr. Kivanc, who ordered multiple

33. *Id.* at 176, 613 S.E.2d at 423.
34. *Id.*
35. *Id.*
36. *Id.* at 177, 613 S.E.2d at 423.
37. VA. CODE ANN. § 8.01-581.18(B) (Repl. Vol. 2000).
38. *Auer*, 270 Va. at 177, 613 S.E.2d at 424.
39. 270 Va. 488, 621 S.E.2d 48 (2005).
40. *Id.* at 491, 621 S.E.2d at 49.
41. *Id.* at 492, 621 S.E.2d at 49.
42. *Id.*

tests for the decedent, of which Dr. Oraee was aware.[43] Upon the decedent's follow-up visit with Dr. Oraee, Dr. Oraee had not requested the results of the laboratory tests ordered by Dr. Kivanc, and, as a result, Dr. Oraee was unaware that the tests confirmed the diagnosis of antiphospholipid antibody syndrome.[44] Twelve days later, the plaintiff's decedent suffered a massive stroke and was admitted to the hospital, where the diagnosis was confirmed and the decedent was placed on anticoagulants.[45] The patient died approximately one month later as a result of the second stroke.[46] The expert testimony at trial established that had Dr. Oraee been aware of the results of the laboratory tests on the initial follow-up visit and had the patient been placed on anticoagulant medication at that time, the second stroke would not have occurred.[47]

At issue on appeal was whether the trial court properly denied a grant of immunity for Dr. Oraee under Virginia Code section 8.01-581.18(B) for his failure to request the results of the tests ordered by Dr. Kivanc.[48] Writing for the 4-3 majority, Justice Kinser asserted that subsections A and B of the statute should be read in conjunction, so as to conform with the court's duty "'to interpret the several parts of a statute as a consistent and harmonious whole so as to effectuate the legislative goal.'"[49] Reading the subsections together, the court held that physicians are only afforded immunity under Virginia Code section 8.01-581.18(B) when the physician fails to review or take action regarding the receipt of a laboratory report when the test or examination at issue was conducted "'not at the request or with the written authorization of a physician.'"[50] In interpreting the intent of the General Assembly, the majority reasoned: "Overall, the provisions of Code § 8.01-581.18, create a mechanism for handling reports of the results of laboratory tests or examinations requested by an individual rather than by a physician. The statute does not pertain to reports of laboratory tests or examinations requested

43. *Id.*
44. *See id.* at 493, 621 S.E.2d at 50.
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.* at 494, 621 S.E.2d at 50.
49. *Id.* at 498, 621 S.E.2d at 52–53 (quoting Va. Elec. & Power Co. v. Bd. of County Supervisors, 226 Va. 382, 388, 309 S.E.2d 308, 311 (1983)).
50. *Id.*, 621 S.E.2d at 53 (quoting VA. CODE ANN. § 8.01-581.18(A) (Repl. Vol. 2000)).

or authorized by a physician."[51] Applying this interpretation of the statute, the court held that Dr. Oraee was not entitled to immunity, for the tests he failed to review were ordered by a physician.[52] With this holding, the court was forced to overturn its decision in *Auer*, stating that "[w]hile we adhere strongly to the doctrine of *stare decisis* in this Commonwealth, this is one of those rare situations in which we cannot perpetuate a clearly incorrect application of the law."[53] The dissenting opinion, authored by Justice Agee, disagreed with the majority's conjunctive reading of the subsections, stating that "[w]e have not held that a statutory subsection must be read solely in reference to the subsection it follows; rather, we are always guided by the plain language of the statute as the General Assembly has written it."[54]

The controversy was put to rest by the General Assembly in the 2006 session when it separated subsections A and B of the statute into two distinct sections.[55] Former subsection B is now codified at Virginia Code section 8.01-581.18:1, and, while it remains substantially the same, the General Assembly expanded and placed conditions on the physician's immunity.[56] No physician will be liable for failure to review laboratory tests that he or she did not order, unless the report is provided directly to the physician, the physician assumed responsibility for the result, or the physician had reason to know that the tests were necessary in order to properly treat the patient.[57] Moreover, the physician will not be granted immunity unless that physician can establish that: (1) no physician-patient relationship existed when the results were received; (2) the physician received the results without a request for consultation and had not assumed responsibility for the results; (3) the results were not critical to the physician's management of the patient's care; or (4) the interpretation of the results was beyond the physician's scope of practice.[58]

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51. *Id.* at 499, 621 S.E.2d at 53.

52. *See id.*

53. *Id.*, 621 S.E.2d at 53–54.

54. *Id.* at 502, 621 S.E.2d at 55 (Agee, J., dissenting).

55. Act of Apr. 5, 2006, ch. 684, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. §§ 8.01-581.18, -581.18:1 (Cum. Supp. 2006)).

56. *Id.*

57. VA. CODE ANN. § 8.01-581.18:1(A) (Cum. Supp. 2006).

58. *Id.*

D. *Expert Witness*

An essential component of a medical malpractice case, for both the plaintiff and defendant, is retaining an expert who can testify to a reasonable degree of medical probability that the defendant either breached or complied with the standard of care in Virginia.[59]

In *Hinkley v. Koehler*,[60] the Supreme Court of Virginia clarified the expert witness requirement of Virginia Code section 8.01-581.20, holding that to qualify as an expert witness, the expert must meet both a "knowledge requirement" and an "active clinical practice requirement."[61] Virginia Code section 8.01-581.20 provides that:

> A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action.[62]

The court explained that, based upon its earlier holding in *Wright v. Kaye*,[63] the active clinical practice requirement must be defined in terms of "the 'relevant medical procedure' at issue"[64] and in "'the context of the actions by which the defendant[s] [are] alleged to have deviated from the standard of care.'"[65] In *Hinkley*, the allegedly negligent conduct concerned the defendants' direct care of the plaintiff during the course of her pregnancy.[66] The expert whose qualifications were in question served as an obstetrical teacher and consultant, but he had not directly cared for any patients within the one-year statutory period set forth in Virginia Code section 8.01-581.20.[67] The court noted that "[o]ne of the pur-

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59. *See id.* § 8.01-581.20 (Cum. Supp. 2006).

60. 269 Va. 82, 606 S.E.2d 803 (2005).

61. *Id.* at 88, 606 S.E.2d at 806 (quoting Wright v. Kaye, 267 Va. 510, 518, 593 S.E.2d 307, 311 (2004)).

62. VA. CODE ANN. § 8.01-581.20 (Cum. Supp. 2006).

63. 267 Va. 510, 593 S.E.2d 307 (2004).

64. *Hinkley*, 269 Va. at 89, 606 S.E.2d at 807 (quoting *Wright*, 267 Va. at 522, 593 S.E.2d at 313).

65. *Id.* (alteration in original) (quoting *Wright*, 267 Va. at 523, 593 S.E.2d at 314).

66. *Id.* at 89–90, 606 S.E.2d at 807.

67. *Id.* at 90, 606 S.E.2d at 807.

poses of [the active clinical practice] requirement is to prevent testimony by individuals who do not provide healthcare services in the same context in which it is alleged that a defendant deviated from the standard of care."[68] With this note, the court held that the expert's qualifications did not meet the active clinical practice criteria, and, therefore, the circuit court abused its discretion in permitting his testimony on the standard of care.[69]

While the *Hinkley* decision further defined the necessary requirements for expert testimony, the Supreme Court of Virginia's decision in *Pettus v. Gottfried*[70] distinguished between expert and factual testimony from a treating physician.[71] The defendant doctor in *Pettus* designated for introduction at trial certain portions of treating physician Dr. Purohit's deposition testimony,[72] as well as testimony from the deposition of Dr. Evans, the treating emergency room physician.[73] The plaintiff objected to Dr. Purohit's testimony on the grounds that it was speculative and amounted to expert testimony not given to a reasonable degree of medical probability.[74] Further objection was made to Dr. Evans's testimony as being speculative and not documented in the medical record, in violation of Virginia Code section 8.01-399(B).[75] The supreme court found that Dr. Purohit's testimony was his explanation of the impressions and conclusions he formed while treating the patient and was not the provision of a diagnosis; as a result, this factual testimony need not be rendered to a reasonable degree of medical probability.[76] Moreover, because the medical records referred to the "possibility of a central nervous system embolic event," Dr. Purohit's testimony that the patient "could have" experienced a central nervous system event did not deviate from the medical records and was proper under Virginia Code section 8.01-399.[77] The court excluded the remainder of Dr. Purohit's testimony, as it found that the testimony did not address his opinions formed at the time of his treatment of the patient, but

68. *Id.* at 91, 606 S.E.2d at 808.
69. *Id.*
70. 269 Va. 69, 606 S.E.2d 819 (2005).
71. *Id.* at 78, 80–81, 606 S.E.2d at 825–26.
72. *Id.* at 73 & n.2, 606 S.E.2d at 822 & n.2.
73. *Id.*
74. *Id.* at 73, 606 S.E.2d at 822.
75. *Id.* at 74, 606 S.E.2d at 822–23.
76. *Id.* at 77–78, 606 S.E.2d at 824–25.
77. *Id.*

rather constituted an expert opinion not offered to a reasonable degree of medical probability.[78] As for Dr. Evans's testimony regarding the emergency department nurses, the court held this testimony inadmissible as speculative.[79] Dr. Evans further testified regarding the possibility of hospital admission for the patient.[80] In reference to this testimony, the court stated that it was admissible as factual evidence, for part of Dr. Evans's care of the patient was to formulate a treatment plan.[81] The court was unable to decide whether Dr. Evans's testimony complied with Virginia Code section 8.01-399, as the plaintiff may not have placed the complete record before the court, and, therefore, the court could not determine whether Dr. Evans's notes lacked any documentation regarding a potential hospital admission for Mr. Pettus.[82] The court was forced to remand the case for a new trial, affirming in part and reversing in part the circuit court's decision.[83]

As the court's decision in *Pettus* makes clear, adherence to the requirements of Virginia Code section 8.01-399 is essential to the successful navigation of a medical malpractice case. In 2005, the General Assembly passed several amendments to this statute, which in one sense narrowed and in one sense broadened the scope of physician-patient communications that may be disclosed in a medical malpractice case.[84] The amendments included the addition of "signs and symptoms, observations, evaluations, [and] histories" to the list of medical documentation that may be disclosed when the physical or mental condition of a patient is at issue in civil litigation.[85] The amendments narrowed the scope of the statute by requiring that these signs, symptoms and diagnoses be contemporaneously documented at the time the physician obtained or formulated the information.[86] Prior to this amendment, plaintiff and defense counsel could utilize, for example, a letter from a treating physician to a specialist, detailing the treating physician's opinion concerning the patient. However, because

78. *Id.* at 78, 606 S.E.2d at 825.
79. *Id.* at 80, 606 S.E.2d at 826.
80. *Id.*
81. *Id.* at 80–81, 606 S.E.2d at 826.
82. *Id.* at 81, 606 S.E.2d at 827.
83. *Id.*
84. *See* Act of Mar. 23, 2005, ch. 649, 2005 Va. Acts 905 (codified as amended at VA. CODE ANN. § 8.01-399 (Cum. Supp. 2006)).
85. *Id.* (codified as amended at VA. CODE ANN. § 8.01-399(B) (Cum. Supp. 2006)).
86. *Id.*

such a letter invariably may contain opinions which were not contemporaneously documented with the treating physician's care and treatment of the patient, such a letter would now be inadmissible under Virginia Code section 8.01-399(B).[87]

In addition to retaining a qualified expert to testify at trial, a plaintiff must now secure an expert prior to filing suit.[88] In 2005, the General Assembly added Virginia Code sections 8.01-20.1 and 8.01-50.1.[89] These sections require that, at the time a plaintiff requests service of process, the plaintiff must have obtained a written opinion from an expert witness that the defendant on whom service is requested deviated from the applicable standard of care, and that such deviation was a proximate cause of the plaintiff's injuries.[90] The expert witness must be one who the plaintiff believes would qualify as an expert under the Act.[91] If a plaintiff fails to obtain such a certification, the court will impose sanctions and may dismiss the case with prejudice.[92] The statutes further provide that, if a defendant makes a written request, the plaintiff shall provide, within ten days of the request, a certification form detailing that the plaintiff had obtained the written opinion from an appropriate expert or that one was unnecessary because the alleged negligence is within the common knowledge and experience of a lay jury.[93]

In *Nance v. Bon Secours*,[94] Judge Gary Hicks of the Henrico County Circuit Court considered the interplay between Virginia Code section 8.01-20.1 and service of process under Rule 3:3 of the Rules of the Supreme Court of Virginia.[95] The court held that when a defendant waives service of process and makes a general appearance, that defendant waives his or her right to proof of expert certification under Virginia Code section 8.01-20.1.[96] Under

87. *See* VA. CODE ANN. § 8.01-399(B) (Cum. Supp. 2006).

88. *See id.* § 8.01-20.1 (Cum. Supp. 2006).

89. Act of Mar. 23, 2005, ch. 649, 2005 Va. Acts 905 (codified at VA. CODE ANN. §§ 8.01-20.1, -50.1 (Cum. Supp. 2006)).

90. VA. CODE ANN. §§ 8.01-20.1, -50.1 (Cum. Supp. 2006). Virginia Code section 8.01-50.1 is identical to section 8.01-20.1, but the former section pertains solely to wrongful death actions. *See id.*

91. *Id.*

92. *Id.*

93. *See id.*

94. No. CL05-698, 2005 Va. Cir. LEXIS 313 (Cir. Ct. Oct. 7, 2005) (Henrico County).

95. *See id.*

96. *Id.* at *6.

the statute, the plaintiff is required to certify that he or she had expert certification for his or her claim prior to requesting service of process.[97] The statute makes no provision, however, for expert certification when the defendant waives service of process.[98] Therefore, in *Nance*, the defendant's general appearance by waiver of service of process constituted defendant's agreement to the suit, and "no longer entitled [the defendant] to certification pursuant to [Virginia Code] § 8.01-20.1."[99] After this decision, defendants should consider the import of the expert certification statute prior to waiving service of process.

At issue in most, if not all, medical malpractice cases are the damages sustained by the plaintiff or the plaintiff's decedent. Expert testimony is usually required to establish the damages of the plaintiff, and speculative expert testimony is prohibited by Virginia Code section 8.01-401.1.[100] This section states that an expert witness in a civil case may testify and render an opinion "from facts, circumstances or data made known to or perceived by such witness at or before the hearing or trial."[101] The information relied upon by the expert in forming his or her opinion "need not be admissible in evidence" if that information is the type of information normally relied upon by experts in forming their opinions regarding the subject at issue.[102] While not a medical malpractice case, the Supreme Court of Virginia's decision in *Vasquez v. Mabini*[103] clarified that, while the information relied upon by the expert may be inadmissible, the testimony of the expert will nevertheless be inadmissible if that testimony lacks evidentiary support.[104] In *Vasquez*, the expert's measure of the plaintiff's damages was based upon the expert's assumption that the decedent would have worked full-time, that she would have received retirement benefits from that full-time work, and further that her income would have increased each year.[105] The defendant was

97. VA. CODE ANN. § 8.01-20.1 (Cum. Supp. 2006).

98. *Id.*; *accord Nance*, 2005 Va. Cir. LEXIS 313, at *5.

99. *See Nance*, 2005 Va. Cir. LEXIS 313, at *6.

100. *See* VA. CODE ANN. § 8.01-401.1 (Repl. Vol. 2000 & Cum. Supp. 2006); *see also* Tarmac Mid-Atlantic, Inc. v. Smiley Block Co., 250 Va. 161, 166, 458 S.E.2d 462, 465–66 (1995) (interpreting VA. CODE ANN. § 8.01-401.1 (Repl. Vol. 2000 & Cum. Supp. 2006)).

101. VA. CODE ANN. § 8.01-401.1 (Repl. Vol. 2000 & Cum. Supp. 2006).

102. *Id.*

103. 269 Va. 155, 606 S.E.2d 809 (2005).

104. *See id.* at 159, 606 S.E.2d at 811.

105. *Id.* at 160–61, 606 S.E.2d at 811–12.

able to prove, however, that the decedent had been seeking full-time employment but had never actually found full-time work.[106] Therefore, the court found that the expert's testimony was purely speculative and inadmissible, despite the fact that the information he relied upon was normally the type relied upon by experts in his field.[107]

E. *Expressions of Sympathy*

The effect of a health care provider's apology to a patient is a topic of much debate in both the legal and medical communities. The Veteran's Administration Hospital in Lexington, Kentucky adopted a novel disclosure policy concerning possible negligence, including requirements to notify patients of potential problems with their care and to hold face-to-face meetings with patients and their families to fully disclose all aspects of these problems.[108] Several states have taken legislative approaches to this issue, enacting laws that provide civil immunity for those health care providers who express sympathy and benevolence to their patients.[109] Massachusetts sparked the trend in 1986, excluding expressions of sympathy by health care providers from admissibility at trial.[110] The trend continued with similar enactments in Texas, California, Florida, and Washington.[111] To date, more than twenty-four states have either passed or introduced similar legislation.[112]

Virginia is following the trend; health care providers in the commonwealth can now say "I'm sorry" to patients without fear of these sentiments being construed as an admission of liability at trial. The Virginia General Assembly incorporated into the Medical Malpractice Act a section focused solely on expressions of sympathy by health care providers.[113] Virginia Code section 8.01-

106. *Id.* at 160, 606 S.E.2d at 811–12.

107. *See id.* at 160–61, 606 S.E.2d at 811–12.

108. *See* Catherine A.G. Sparkman, *Health Policy Issues: Legislating Apology in the Context of Medical Mistakes*, 82 AORN J. 263, 264 (2005), *available at* http://www.aorn.org/journal/2005/aughpi.htm.

109. *Id.* at 264, 266.

110. *Id.* at 264.

111. *Id.* at 266.

112. *See id.*

113. Act of Mar. 23, 2005, ch. 649, 2005 Va. Acts 905 (codified at VA. CODE ANN. § 8.01-581.20:1 (Cum. Supp. 2006)).

581.20:1 provides that any "statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, or general sense of benevolence" made by a health care provider are inadmissible as evidence of liability or an admission against interest when suit is brought against the health care provider by the patient to whom such expressions of sympathy were made.[114]

F. *Theories of Liability*

While the Virginia Medical Malpractice Act governs the mechanics of a medical malpractice suit, the plaintiff decides the theory under which the health care provider may be found liable. In three recent cases, the Supreme Court of Virginia narrowed the range of liability theories available, including narrowing the scope of the Act itself.

In *Sanchez v. Medicorp Health System*,[115] the Supreme Court of Virginia declined again to adopt the theory of vicarious liability in medical malpractice actions in Virginia.[116] This medical malpractice action arose out of allegedly negligent care and treatment provided to plaintiff Leasly Sanchez at the Mary Washington Hospital emergency room.[117] As part of his suit, Sanchez claimed that the emergency room physician was "held out" by the hospital as its employee, and, therefore, the hospital was vicariously liable for the physician's negligence under the theory of apparent or ostensible agency.[118] While the issue of the physician's negligence under this theory had not been addressed by the court prior to this decision,[119] the court looked to its decisions involving claims of vicarious liability in other areas of the law, such as contract law.[120] However, in the tort context, the court noted it had never decided the issue of apparent agency.[121] The court declined to hold the hospital in this case liable under a theory of apparent agency, stating: "[W]e have not previously imposed vicarious liability on an employer for the negligence of an independent con-

114. VA. CODE ANN. § 8.01-581.20:1 (Cum. Supp. 2006).
115. 270 Va. 299, 618 S.E.2d 331 (2005).
116. *Id.* at 301, 618 S.E.2d at 332.
117. *Id.* at 301–02, 618 S.E.2d at 332.
118. *Id.* at 302, 618 S.E.2d at 332.
119. *Id.* at 306, 618 S.E.2d at 334.
120. *Id.* at 306–07, 618 S.E.2d at 335.
121. *See id.*

tractor on the basis of apparent or ostensible agency, or agency by estoppel. We find no reason to do so in the specific context presented in this case."[122]

In a claim based solely on the theory of vicarious liability, the Supreme Court of Virginia has found that a dismissal with prejudice of the physician does not necessarily exonerate the physician's employer.[123] In *Shutler v. Augusta Health Care for Women, P.L.C.*, the court considered whether a dismissal with prejudice of the allegedly negligent physician, Dr. Brooks, would preclude Shutler from pursuing her claims against the physician's group, Augusta Health Care.[124] Shutler alleged that, at all times relevant to the allegedly negligent conduct at issue, Dr. Brooks was an agent and employee of Augusta Health Care and acting within the scope of his employment.[125] Therefore, she asserted a claim of vicarious liability against the group.[126] The day prior to trial, Shutler filed a motion to dismiss Dr. Brooks with prejudice but proceeded against Augusta Health Care.[127] The trial court entered an order consistent with Shutler's motion, and counsel for defendants endorsed the order with no objections.[128] On the same day the order was entered, Augusta Health Care filed a motion for summary judgment, claiming that the dismissal "with prejudice" of Dr. Brooks was equivalent to a determination on the merits that he was not liable; therefore, since Augusta Health Care's liability was predicated upon the liability of Dr. Brooks, Augusta Health Care should be exonerated.[129] The trial court granted summary judgment for Augusta Health Care.[130]

On appeal, Shutler contended that, with its endorsement of the order, Augusta Health Care waived its right to assert that the dismissal of Dr. Brooks precluded the plaintiff's claims against the group.[131] The Supreme Court of Virginia noted that ordinarily a dismissal with prejudice operates as an adjudication on the

122. *Id.* at 307–08, 618 S.E.2d at 335.

123. Shutler v. Augusta Health Care for Women, P.L.C., 272 Va. 87, 93, 630 S.E.2d 313, 316 (2006).

124. *Id.* at 89, 630 S.E.2d at 314.

125. *Id.*

126. *Id.*

127. *Id.* at 90, 630 S.E.2d at 314.

128. *Id.*

129. *Id.*, 630 S.E.2d at 314–15.

130. *Id.* at 91, 630 S.E.2d at 315.

131. *Id.* at 92, 630 S.E.2d at 315.

merits and a final disposition of the claim.[132] However, such a dismissal must be considered in light of the relevant circumstances,[133] and, in the circumstances of this case, the order specifically provided that only Dr. Brooks would be dismissed and the action would proceed against Augusta Health Care.[134] In light of that order, the court held that the dismissal of Dr. Brooks with prejudice would "have [no] preclusive effect on Shutler's ability to pursue her claims against Augusta Health Care."[135] Justice Kinser, joined by Justice Agee, dissented, stating that the matter did indeed proceed against Augusta Health Care, albeit for a short period of time.[136] The terms of the order did not preclude Augusta Health Care from seeking summary judgment.[137]

The reach of the Medical Malpractice Act was considered by the Supreme Court of Virginia in *Harris v. Kreutzer*.[138] In this case, the court considered whether a physician performing an independent medical examination under Rule 4:10 of the Rules of the Supreme Court of Virginia could be held liable for negligence under the Medical Malpractice Act.[139] The trial court in an automobile accident matter ordered the plaintiff to submit to a Rule 4:10 medical examination; Dr. Kreutzer was the physician retained to perform the examination.[140] The plaintiff later brought a medical malpractice action against Dr. Kreutzer, alleging he failed to comply with the standard of care during the Rule 4:10 examination by failing to appropriately examine the plaintiff and by being deliberately abusive to her.[141] Moreover, Harris's complaint alleged intentional infliction of emotional distress, stating that Dr. Kreutzer's performance of the examination was "'intentionally designed to inflict emotional distress upon [her] or was done with reckless disregard for the consequences when he knew . . . that emotional distress would result.'"[142] In considering Harris's medical malpractice claim, the trial court held that, while a

132. *Id.*, 630 S.E.2d at 316.

133. *Id.* at 93, 630 S.E.2d at 316 (citing Reed v. Liverman, 250 Va. 97, 100, 458 S.E.2d 446, 447 (1995)).

134. *Id.*

135. *Id.*, 630 S.E.2d at 316–17.

136. *Id.* at 96, 630 S.E.2d at 318 (Kinser, J., dissenting).

137. *Id.* (Kinser, J., dissenting).

138. 271 Va. 188, 624 S.E.2d 24 (2006).

139. *Id.* at 196, 624 S.E.2d at 29.

140. *Id.* at 193, 624 S.E.2d at 27.

141. *Id.* at 194, 624 S.E.2d at 27.

142. *Id.*, 624 S.E.2d at 28 (alteration in original).

cause of action under the Medical Malpractice Act could be cognizable in the context of a Rule 4:10 exam, this case was "not such an example."[143] The trial court further held that the claim did not possess the requisite elements to support a finding of intentional infliction of emotional distress.[144] In considering these same issues, the supreme court found that, by bringing her personal injury action, Harris had put her mental or physical condition at issue, and thereby gave her implied consent to the independent medical examination and formed "a limited relationship with Dr. Kreutzer for purposes of the examination."[145] The court further determined that Dr. Kreutzer owed a legal duty to Harris, stating, "[U]nder the plain language of the malpractice statute . . . a cause of action for malpractice may lie in the context of a Rule 4:10 examination because 'health care' is provided by a 'health care provider' to a 'patient' which allegedly resulted in personal injury."[146] In holding that Dr. Kreutzer could be held liable under the Act, the court limited the Rule 4:10 physician's duty to comply with the standard of care to the actual context of the examination itself.[147] In reference to the emotional distress claim, the court held that Harris did not plead facts sufficient to meet the "outrageous and intolerable conduct" element or the severity element.[148] The conduct alleged to have caused Harris emotional distress was, among other things, Dr. Kreutzer's verbal abuse, raising his voice to the plaintiff, and his accusing the plaintiff of faking.[149] The court found that, even if all these accusations were true, Dr. Kreutzer's conduct, while perhaps "insensitive and demeaning," did not rise to the level of outrageous or intolerable conduct.[150] Furthermore, Harris's emotional distress was not severe, according to the court.[151] Harris's symptoms included sleeplessness, loss of self-esteem, and depression.[152] These symptoms were not ones which no reasonable person could be expected to endure, and, as such, the court held that Harris's distress was not severe.[153]

143. *Id.* at 195, 624 S.E.2d at 28.
144. *See id.*
145. *Id.* at 199, 624 S.E.2d at 30.
146. *Id.* at 200, 624 S.E.2d at 31.
147. *Id.* at 202, 624 S.E.2d at 32.
148. *Id.* at 204–05, 624 S.E.2d at 34.
149. *Id.* at 204, 624 S.E.2d at 33.
150. *Id.*, 624 S.E.2d at 33–34.
151. *Id.* at 204–05, 624 S.E.2d at 34.
152. *Id.*
153. *Id.* at 205, 624 S.E.2d at 34.

Yet another decision in which the Supreme Court of Virginia considered the scope of the Medical Malpractice Act concerned the sexual assault of a nursing home patient. In *Alcoy v. Valley Nursing Homes, Inc.*,[154] the court concluded that the sexual assault of the patient occurred as a result of the nursing home's failure to provide proper personnel and security systems.[155] The *Alcoy* case concerned the sexual assault of an elderly resident of a Northern Virginia nursing home.[156] The resident died approximately eight months after the assault, and the administrator of her estate filed an action against the nursing home alleging negligence, sexual assault, and battery.[157] The trial court found that the plaintiff's claims fell within the purview of the Medical Malpractice Act, and the court granted summary judgment for the nursing home because the plaintiff's witnesses were not qualified to render expert testimony on the standard of care.[158] The plaintiff appealed, contending that all of the claims arose, not from medical care provided to the decedent, but from the nursing home's failure to provide adequate security and personnel to protect the residents from physical harm.[159] The supreme court agreed, finding that the alleged negligence did not involve the provision of medical services at all.[160] Rather, the negligence involved:

> [A]dministrative, personnel, and security decisions related to the operation of the [nursing home], rather than to the care of any particular patient. . . .
>
> By their terms, the definitions of "malpractice" and "health care" [in the Act] apply to patients on an individual basis, rather than to the staffing and security of any medical facility in which the patients are located.[161]

This decision underscores the need to examine the exact, negligent act to determine whether the Medical Malpractice Act applies.

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154. 272 Va. 37, 630 S.E.2d 301 (2006).
155. *Id.* at 43, 630 S.E.2d at 304.
156. *Id.* at 40, 630 S.E.2d at 302.
157. *Id.*
158. *Id.*
159. *Id.* at 40–41, 630 S.E.2d at 302.
160. *Id.* at 43, 630 S.E.2d at 304.
161. *Id.*

III. EVIDENCE IN MEDICAL MALPRACTICE ACTIONS

Thornton v. Glazer[162] concerns a trial court's refusal to allow deposition testimony of a treating physician as part of a rebuttal and refusal to offer an adverse witness jury instruction regarding deposition testimony introduced during the plaintiff's case-in-chief.[163] In rebuttal to the defendant's expert witness, the plaintiff sought to introduce the deposition testimony of treating physician, Dr. Jones, who had previously testified and been released.[164] The court refused to allow the plaintiff to introduce the rebuttal deposition testimony on the grounds that Rule 4:7 of the Rules of the Supreme Court of Virginia does not apply once a witness has attended trial and been released.[165] Rule 4:7(a)(4) provides for the use at trial of deposition testimony if the court determines:

> [T]hat the witness is a judge, or is a superintendent of a hospital for the insane more than 30 miles from the place of trial, or is a physician, surgeon, dentist, chiropractor, or registered nurse who, in the regular course of his profession, treated or examined any party to the proceeding . . . .[166]

On appeal, the Supreme Court of Virginia found that Rule 4:7(a)(4)(E) does not require unavailability of the witness as a prerequisite to introduction of his or her deposition testimony.[167] The court held that "a party is entitled to offer into evidence the deposition testimony of a treating physician even if the physician is available, unless the trial court finds 'good cause' . . . to order attendance to testify ore tenus."[168] The court further held that the adverse witness jury instruction was proper and should not have been refused.[169] When a plaintiff introduces testimony from an adverse witness, even if that testimony is by deposition, an adverse witness jury instruction is appropriate.[170]

The Supreme Court of Virginia has determined that the affirmative defense of mitigation of damages need not be specifi-

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162. 271 Va. 566, 628 S.E.2d 327 (2006).
163. *Id.* at 568, 628 S.E.2d at 327.
164. *Id.* at 569, 628 S.E.2d at 328.
165. *Id.*
166. VA. SUP. CT. R. 4:7(a)(4)(E).
167. *Thornton*, 271 Va. at 570, 628 S.E.2d at 328–29.
168. *Id.*, 628 S.E.2d at 329.
169. *Id.* at 571–72, 628 S.E.2d at 329–30.
170. *See id.*, 628 S.E.2d at 329.

cally pled prior to its assertion at trial, if the issue has been shown by the evidence.[171] In *Monahan v. Obici Medical Management Services, Inc.*,[172] the court held that, though the defendant had not raised mitigation of damages as an affirmative defense in any of the pleadings, the defendant should be allowed to offer an instruction on mitigation of damages, provided that the evidence supports such an instruction.[173] However, the court ultimately ruled that the trial court erred in granting the defendant's instruction on mitigation of damages as there was no evidentiary basis to support this instruction.[174]

The importance of the contemporaneous objection rule was affirmed by the Supreme Court of Virginia in *Bitar v. Rahman*.[175] At trial in Fairfax County, plaintiff offered the testimony of Dr. Elliot W. Jacobs as an expert on the standard of care for a reasonably prudent plastic surgeon.[176] At the close of the plaintiff's case, the defendant moved to strike the testimony of Dr. Jacobs, stating that Dr. Jacobs failed to express his expert opinions to a reasonable degree of medical probability.[177] The trial court took the motion under advisement, but when the defendant renewed the motion at the conclusion of all the evidence, the court denied the motion, finding the motion untimely as no objection was made contemporaneously with Dr. Jacobs's testimony.[178]

On appeal, the defendant, Dr. Bitar, asserted that the trial court erred in not striking Dr. Jacobs's testimony as it was not offered to a reasonable degree of medical probability and, further, that Dr. Jacobs's testimony was insufficient to establish a breach of the standard of care and causation.[179] The supreme court held that Dr. Bitar's objection challenged the admissibility of the evidence, rather than the sufficiency.[180] Therefore, any objections to the testimony should have been made when the evidence was pre-

171. Monahan v. Obici Med. Mgmt. Servs., Inc., 271 Va. 621, 631–32, 628 S.E.2d 330, 336 (2006).
172. 271 Va. 621, 628 S.E.2d 330 (2006).
173. *Id.* at 634, 628 S.E.2d at 337.
174. *Id.* at 637, 628 S.E.2d at 339.
175. 272 Va. 130, 630 S.E.2d 319 (2006).
176. *See id.* at 134, 630 S.E.2d at 321.
177. *Id.* at 135, 630 S.E.2d at 322.
178. *Id.* at 136, 630 S.E.2d at 322–23.
179. *Id.* at 137, 630 S.E.2d at 323.
180. *Id.* at 140, 630 S.E.2d at 325.

sented, not after the opposing party had rested their case.[181] While the court recognized that a contemporaneous objection would have been difficult, it stated that the defect in Dr. Jones's testimony was obvious by the end of the direct examination and objection should have been made at that time.[182]

The other issue on appeal was the sufficiency of Dr. Jacobs's testimony to establish a breach of the standard of care and a causative link between the alleged breach and the plaintiff's damages.[183] Dr. Jacobs opined that Dr. Bitar was negligent in his performance of a tummy tuck upon the plaintiff; specifically, Dr. Jacobs opined Dr. Bitar was negligent in removing an excessive amount of tissue from the plaintiff, which caused "tension upon the abdominal flap, which resulted in inadequate blood supply, death of the tissue, and 'a cosmetically displeasing appearance to [the plaintiff's] lower abdomen.'"[184] Based upon these statements, the court concluded that Dr. Jacobs's testimony provided sufficient evidence to support the verdict for the plaintiff.[185]

IV. WRONGFUL DEATH

In a case of first impression in Virginia, the Supreme Court of Virginia ruled that an estate administrator may not proceed pro se in a wrongful death action.[186] Venunadh Kone, the administrator of the estate of Jampal R. Gummalla, filed three separate wrongful death actions against Bon Secours-St. Mary's Hospital, Dr. Michael D. Mandel, and Dr. Claude W. Wilson.[187] Subsequently, these three actions were nonsuited, and Kone filed a single wrongful death action against the same three health care providers.[188] This single action was filed by Kone pro se.[189] The defendants moved to dismiss the action, asserting that the motion for judgment constituted a nullity, as it was not signed by a li-

181. *Id.* at 139, 630 S.E.2d at 324 (quoting Kondaurov v. Kerdasha, 271 Va. 646, 655, 629 S.E.2d 181, 185 (2006)).

182. *Id.* at 140, 630 S.E.2d at 325.

183. *See id.* at 141, 630 S.E.2d at 325.

184. *Id.* at 142, 630 S.E.2d at 326.

185. *Id.* at 142–43, 630 S.E.2d at 326.

186. Kone v. Wilson, 272 Va. 59, 62–63, 630 S.E.2d 744, 746 (2006).

187. *Id.* at 61, 630 S.E.2d at 745.

188. *Id.*

189. *Id.*

censed attorney, and the statute of limitations had not been tolled.[190] The trial court granted this motion and dismissed the action with prejudice.[191]

Kone appealed the decision of the circuit court, contending that he, as the personal representative, "step[ped] into the shoes" of the decedent, and, under the language of Virginia Code section 8.01-50, could bring the action in his own name.[192] Virginia Code section 8.01-50 provides, in pertinent part, that "[e]very [wrongful death action] shall be brought by and in the name of the personal representative of such deceased person."[193] The court disagreed, finding that, while the statute vests the right of action in the personal representative, the action is brought on behalf of the decedent's beneficiaries.[194] The court held:

> [B]ecause Kone's right of action existed only to permit him to prosecute the cause of action belonging to [Gummalla's] statutory beneficiaries, and not to maintain any cause of action personal to Kone himself, he was not entitled to file the wrongful death action pro se. His surrogate status precluded a pro se filing because he was acting in a representative capacity for the true parties in interest, [Gummalla's] beneficiaries. Therefore . . . the circuit court correctly concluded the Kone could not file a valid wrongful death action pro se.[195]

Kone further argued that the action should not have been dismissed by the circuit court, but, rather, the court should have allowed Kone's attorney to file an amended motion for judgment or entered an order relating back his counsel's signature to the initial pleading.[196] The Supreme Court of Virginia disagreed with both arguments.[197] Both of these arguments require the existence of a valid initial pleading, but Kone's initial pleading was invalid and without legal effect.[198] Without a valid motion for judgment, there were no pleadings before the court which could be amended

190. *Id.* at 62, 630 S.E.2d at 745.
191. *Id.*
192. *Id.*
193. VA. CODE ANN. § 8.01-50(B) (Repl. Vol. 2000 & Cum. Supp. 2006).
194. *Kone*, 272 Va. at 62, 630 S.E.2d at 746.
195. *Id.* at 62–63, 630 S.E.2d at 746.
196. *Id.* at 63, 630 S.E.2d at 746.
197. *Id.* at 62, 630 S.E.2d at 745.
198. *Id.* at 63, 630 S.E.2d at 746 (citing Nerri v. Adu-Gyamfi, 270 Va. 28, 31, 613 S.E.2d 429, 430 (2005)).

nor any pleadings to which a signature could have related back.[199] Moreover, the relation back statutes—Virginia Code sections 8.01-6 to -6.2—are limited to instances in which a party seeks to correct a misnomer, add a party, or add a claim or defense.[200] The court stated that a defect in a signature cannot be corrected through relating back a valid signature.[201]

V. VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM

The Virginia Birth-Related Neurological Injury Compensation Program ("the Program") was enacted by the Virginia General Assembly in 1987, in response to the growing costs of malpractice insurance coverage.[202] For those infants born in the commonwealth with qualifying birth-related neurological injuries, the Program provides coverage for those necessary expenses which insurance fails to cover, including medical expenses, hospital expenses, rehabilitation expenses, and in-home nursing care.[203]

In 2006, the General Assembly amended the process for reviewing certain birth-related injury cases. Senate Bill 632 extended the date—from July 1, 2000, to July 1, 2007—by which the legal representative of a child born between January 1, 1988 and July 1, 1993 may file an application for review.[204] The bill further simplified the conditions for the filing of such an application for review; the claim must have been timely filed for the child and dismissed upon a finding that the child's injuries did not qualify under the Program requirements.[205]

199. *Id.*

200. *Id.*

201. *Id.*

202. Act of Mar. 27, 1987, ch. 540, 1987 Va. Acts 830 (codified at VA. CODE ANN. §§ 38.2-5000 to -5021 (Repl. Vol. 2002 & Cum. Supp. 2006)).

203. *See* Virginia Birth-Related Neurological Injury Compensation Program, Who We Are, http://www.vabirthinjury.com/WhoWeAre.htm (last visited Oct. 4, 2006).

204. S.B. 632, Va. Gen. Assembly (Reg. Sess. 2006) (enacted as Act of Apr. 19, 2006, ch. 919, cl. 2, 2006 Va. Acts ___).

205. *Id.*

VI. THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

The Virginia Department of Health Professions ("DHP") is composed of various health regulatory boards,[206] which have the authority to, among other things, license and discipline the health care providers in the commonwealth.[207] In 2006, the legislature revised several statutes pertaining to the DHP, regarding matters from fees to reporting disciplinary actions.

Virginia Code sections 54.1-113 and 54.1-2505 were amended by the General Assembly to prohibit certain transfers of fees collected on behalf of health regulatory boards.[208] Funds which are generated by fees collected on behalf of the boards must now be held exclusively to cover the expenses of the boards, the Health Practitioner's Intervention Program, and the DHP and may not be transferred to another agency.[209] An exception is made for the additional fee charged to those persons being licensed as practical or registered nurses; this fee will continue to be deposited into the Nursing Scholarship and Loan Repayment Fund and be utilized to fund scholarships for full-time nursing students.[210]

A new addition to the Board of Medicine's licensure capabilities allows the Board to issue restricted volunteer licenses to health care practitioners for voluntary practice in clinics organized exclusively or partially for the provision of free health care services.[211] The restricted volunteer license is available to a practitioner who: (1) held an unrestricted license to practice at the time the license expired or became inactive; (2) is currently practicing within the limits of his license; and (3) attests to knowledge of the laws and regulations governing the practice of medicine in Virginia.[212] If the practitioner does not meet the requirement of having an active, unrestricted license and has not been engaged in active practice within the past four years, a physician with an active, unrestricted license must review "the quality of care" ren-

206. VA. CODE ANN. § 54.1-2503 (Repl. Vol. 2005).

207. *Id.* § 54.1-2400 (Repl. Vol. 2005).

208. Act of Apr. 5, 2006, ch. 631, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. §§ 54.1-113, -2505 (Supp. 2006)).

209. VA. CODE ANN. §§ 54.1-113(B), -2505(11) (Supp. 2006).

210. *See id.*; *id.* §§ 54.1-3011.1, -3011.2(B) (Repl. Vol. 2005).

211. *See id.* § 54.1-2928.1 (Supp. 2006).

212. *Id.* § 54.1-2928.1(A) (Supp. 2006).

dered by the volunteer practitioner at least every ninety days.[213] The fees for the restricted volunteer license will be no more than one-half of the renewal fee for a similar inactive license, and the restricted license may be renewed every two years.[214]

When a complaint has been filed with the DHP regarding a health care provider and the relevant board determines not to conduct a disciplinary proceeding, that board may now send an advisory letter to the provider who was the subject of the complaint.[215] The board may also inform the complainant that (1) an investigation has been conducted, (2) the matter was closed with no disciplinary proceeding, and (3) if appropriate, an advisory letter was sent to the subject of the complaint.[216]

The legislature further extended the time period within which a hearing must be held for the practitioner who has applied for reinstatement of a license which was suspended.[217] Previously, the practitioner was entitled to a hearing within thirty days of receipt of the application for reinstatement,[218] but that time has been extended to sixty days.[219]

VII. CONCLUSION

In response to the ever-changing and fast-growing arena of medical malpractice law, the General Assembly established the Joint Subcommittee to Study Risk Management Plans for Physicians and Hospitals.[220] The Joint Subcommittee was continued once in 2005, and, in 2006, the General Assembly again continued the Joint Subcommittee and ordered it to report its findings to the Assembly in 2007.[221] This committee was directed to study the effectiveness of the current laws regarding medical malpractice, as well as the feasibility of establishing a multi-jurisdictional

213. *Id.* § 54.1-2928.1(C) (Supp. 2006).
214. *Id.* § 54.1-2928.1(D), (F) (Supp. 2006).
215. *Id.* § 54.1-2400.2(F) (Supp. 2006).
216. *Id.*
217. Act of Mar. 30, 2006, ch. 367, 2006 Va. Acts ___ (codified as amended at VA. CODE ANN. § 54.1-2409(D) (Supp. 2006)).
218. VA. CODE ANN. § 54.1-2409(D) (Repl. Vol. 2005).
219. *Id.* (Supp. 2006).
220. Act of Apr. 14, 2004, ch. 822, cl. 2, 2004 Va. Acts 1264.
221. H.J. Res. 183, Va. Gen. Assembly (Reg. Sess. 2006).

pilot health court and, subsequently, a network of health courts throughout the commonwealth.[222] While the findings of this committee drastically may alter the current landscape of medical malpractice law, one thing remains certain: as long as there are health care providers and patients, medical malpractice law will remain.

222. *Id.*